Crosswalk Between Coverage of Behavioral Health Services in Medi-Cal and Private Plans in California

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Methodology

This crosswalk compares coverage requirements for mental health and substance use disorder (SUD) services for Medi-Cal and most individual and small-group market plans under California law. For Medi-Cal, we looked at the relevant sections of state law, Title 9 of the California Code of Regulations, as well as other guidance from the Department of Health Care Services (DHCS), including boilerplate County Mental Health Plans (MHP) contract language. We also looked at documents related to the California Advancing and Innovating Medi-Cal (CalAIM) initiative, particularly those that outline services available in counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS) program, and services related to the pending California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) waiver. Both required and optional DMC-ODS benefits were included in the crosswalk and in the table in Appendix 1, but we have identified optional benefits explicitly to highlight that such benefits are not available in all DMC-ODS counties. Those optional benefits include the recently implemented contingency management benefit to treat stimulant use disorders in counties that elect to cover the service.[1] In addition, we have identified benefits for which DHCS has requested approval from CMS to be covered, at county option, as Medi-Cal Specialty Mental Health Services (SMHS) by MHPs through the pending Section 1115 BH-CONNECT waiver.[2]

[1] For a comprehensive list of authorities in state law regarding Medi-Cal covered mental health and SUD benefits, see Chapters 3 and 4 of NHeLP's *An Advocate's Guide to Medi-Cal Services*, https://healthlaw.org/resource/an-advocates-guide-to-medi-cal-services/.

[2] *See* Cal. Dep't Health Care Servs., BH-CONNECT Waiver, https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx (last accessed May 20, 2024).

With regards to private plans, we evaluated the coverage requirements for non-grandfathered individual and small group market plans through California's Essential Health Benefit (EHB) base-benchmark plan: Kaiser Small Group HMO 30.[3] Under the Affordable Care Act (ACA) and implementing regulations, states have the authority to elect a benchmark plan to define the categories of EHB and which serves as a model for all non-grandfathered individual and small-group market plans. The benefits outlined below and in the table in Appendix 1 include all mental health and SUD services covered in the Kaiser plan, as well as other requirements under the ACA, including the separate requirement to cover all behavioral health preventive services with an A or B rating from the United States Preventive Services Task Force (USPTF).[4]

In addition, California recently enacted legislation, SB 855, to update the State's behavioral health parity law in order to require coverage of all medically necessary mental health and SUD services.[5] The Department of Managed Health Care (DMHC) subsequently promulgated regulations implementing SB 855, which include a long and non-exhaustive list of behavioral health services required to be covered pursuant to SB 855.[6] Some of those services listed are also covered in the Kaiser benchmark plan, but the rule also explicitly adds various services not otherwise covered in the EHB benchmark plan. We note that while SB 855 explicitly requires private plans to cover all medically necessary behavioral health services, its effectiveness and compliance by plans has not been evaluated. As such, this crosswalk and the table in Appendix 1 include those services explicitly included in the regulations, while leaving out other benefits that could be required under SB 855 if medically necessary.

Differences in Medical Necessity Criteria

While the crosswalk compares behavioral health coverage requirements between Medi-Cal and private plans, the medical necessity standards in Medi-Cal and private insurance also differ. This means that even when a benefit is covered by both Medi-Cal and private plans, the ability to access such service may not be equal. For example, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), all behavioral health care services in Medi-Cal are available for beneficiaries

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[3] *See* CAL. HEALTH & SAFETY CODE § 1367.005; CAL. HEALTH & SAFETY CODE § 1374.72; CAL. CODE REGS. tit 28 § 1300.67.005(c)(6). *See also* CMS, Information on Essential Health Benefits (EHB) Benchmark Plans, California, https://www.cms.gov/marketplace/resources/data/essential-health-benefits#California (last accessed April 20, 2024).
[4] 42 U.S.C. § 300gg-13.
[5] SB 855 (2020), https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855.
[6] CAL. CODE REGS. tit 28 §1300.74.72.01.

under 21 when the services are necessary to correct or ameliorate a behavioral health condition.[7] This expansive EPSDT medical necessity criteria is significantly broader than the adult medical necessity criteria for specialty mental health services (SMHS) covered by MHPs, non-SMHS covered by managed care plans, and SUD services covered by DMC and DMC-ODS plans. Those services are covered for adults when it is "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain."[8]

Despite the applicability of a single medical necessity criteria for Medi-Cal adults accessing behavioral health services, access to specialty behavioral health services is contingent on also meeting additional access criteria even if medical necessity has been established, which adds another layer to the analysis in the Medi-Cal program. SMHS, for example, are covered for beneficiaries who have a significant impairment and a reasonable probability of significant deterioration in an important area of life functioning, and when the beneficiary's condition is due to either a diagnosed mental health disorder or a suspected mental disorder that has not yet been diagnosed.[9] DMC-ODS services are available for adult beneficiaries who have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, and beneficiaries must meet American Society of Addiction Medication (ASAM) criteria in order to determine placement in the different settings and levels of care.[10] Of note, there is no equivalent specific access or placement criteria requirements for behavioral health services imposed on private plans in California, although, as explained below, plans are allowed to impose access criteria that adhere to generally accepted standards of care.

Both the EPSDT and the adult behavioral health services criteria in Medi-Cal differ from the medical necessity criteria applied by private plans. SB 855 defines medical necessity for private plans as extending to "a service or product addressing the specific needs of a patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

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[7] 42 U.S.C. § 1396d(r)(5); CAL. WELF. & INST. CODE § 14184.402(d); CAL. CODE REGS. tit 9 § 1810.215.
[8] CAL. WELF. & INST. CODE § 14059.5(a)
[9] CAL. WELF. & INST. CODE § 14184.402(c).
[10] Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-019 at 2–3 (May 14, 2021), https://www.dhcs.ca.gov/Documents/BHIN-21-019-DMC-ODS-%20Updated-Policy-on-Medical-Necessity-and-Level-of-Care.pdf.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider."[11]

In addition, SB 855 establishes the following guideline for plans to implement their selected criteria for accessing mental health and SUD services:[12]

> A health care service plan that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

As the above definition shows, private plans may apply their own medical necessity criteria as long as they adhere to generally accepted standards. While private plan may apply a broad criterion, in practice private plans are more likely to apply medical necessity determinations that, while generally accepted in the behavioral health space, are more stringent than the Medi-Cal medical necessity criteria.

Findings and Discussion

The crosswalk shows that, for adult beneficiaries, coverage of behavioral health services tends to be consistent between Medi-Cal and private plans in California, particularly given the services that the SB 855 regulations explicitly added to the coverage requirements. Nonetheless, several discrepancies still remain. One clear inconsistency is the coverage of behavioral health support services, such as peer support, care coordination, targeted case management, physician consultation, recovery supports, and dyadic services. These are services that Medi-Cal covers for adult and minor beneficiaries, whereas the EHB benchmark plan or the SB 855 regulations do not explicitly require them to be covered by private plans. The gap in coverage for those services will become even more clear if and when the Centers for Medicare and Medicaid Services (CMS) approves California's BH-CONNECT Section 1115 demonstration proposal, which significantly expands the number of support services that counties may offer as Medi-Cal behavioral health benefits.

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[11] CAL. HEALTH & SAFETY CODE § 1374.72(a)(3).
[12] CAL. HEALTH & SAFETY CODE § 1374.721(a).

Similarly, through a new demonstration, Medi-Cal now provides the option for DMC-ODS counties to offer contingency management treatment for stimulant use disorders.[13] Unsurprisingly, neither the EHB benchmark plan or the SB 855 regulations explicitly mention contingency management, as this evidence-based approach is relatively novel and seldom covered by private plans throughout the country. Again, we caution that these services may be required under SB 855 even if they are not outlined in the implementing regulations.

Our research also demonstrates inconsistencies between Medi-Cal and private plans with regards to coverage of behavioral health services that are targeted towards minors under age 21. The EPSDT medical necessity criteria is broad enough to extend to all behavioral health services that are not explicitly covered in California's state plan, including Medicaid benefits that California has elected not to cover for adult beneficiaries.[14] Through litigation on the EPSDT requirements, Medi-Cal beneficiaries under 21 have gained access to the following SMHS: intensive care coordination, therapeutic behavioral services, intensive home-based services, and therapeutic foster care.[15] In addition, DHCS is currently pursuing federal approval for clarification that EPSDT requires Medi-Cal MHPs to cover the following services: multisystemic therapy (MST), functional family therapy (FFY), and parent-child interaction therapy (PCIT).[16] EPSDT may also require coverage of other mental health services not explicitly outlined in DHCS guidance as well, including non-traditional therapies such as equine therapy, art therapy, music therapy, and movement therapy.

Neither SB 855 or the EHB benchmark plan, on the other hand, explicitly outline behavioral health services that are specific for minors. However, SB 855's mechanism of requiring coverage of all medically necessary behavioral health services could be read to mirror the EPSDT coverage requirement in that both provide for coverage of *all* medically necessary behavioral health services. As such, consumers in private plans may be able to gain access to some of these services if they are able to demonstrate they meet the medical necessity criteria under the SB 855 statute. Nonetheless, the experience from EPSDT enforcement shows that plans are more likely to cover services, and consumers are more likely to hold plans accountable, when the required services are explicitly listed in regulations or guidance.

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[13] CMS, Contingency Management and CBAS Protocol Approval (2022), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca.pdf.
[14] 42 U.S.C. § 1396d(r)(5).
[15] Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-073 (Dec. 10, 2021), https://www.dhcs.ca.gov/%20Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-%20Necessity-and-Other-Coverage-Req.pdf.
[16] Cal. Dep't Health Care Servs., BH-CONNECT Proposal (2023) at 9, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-bh-connect-pa-10202023.pdf.

While most of the gaps are present in private plans, there are some services that private plans are explicitly required to cover for which Medi-Cal coverage is less clear. For example, while transcranial magnetic stimulation (TMS) is a covered Medi-Cal benefit available as a SMHS (as described in the SMHS billing manual), the service is also listed in the TAR/Non-Benefit List as a non-benefit. TMS is not experimental and is widely covered by private plans and Medicare.[17] Services listed as non-benefits may nonetheless be covered when medically necessary subject to a Treatment Authorization Request (TAR).[18] Our experience, however, shows that Medi-Cal MCPs have denied coverage of TMS based on the fact that the service is listed as a Non-Benefit and regardless of findings of medical necessity from the corresponding providers. Such denials have been upheld in state Medi-Cal fair hearing appeals without considering whether the MCP appropriately referred the beneficiary to their county MHP for coverage of TMS as a SMHS. Thus, while there is no doubt that Medi-Cal covers TMS, its inclusion in the Non-Benefit List leads to unjustified denials, and DHCS should take additional steps to issue guidance to MCPs and MHPs and/or removal of TMS from the Non-Benefit list.

We also note that, while there are various behavioral health services that are explicitly covered by Medi-Cal, many of these are optional services for counties. For example, all DMC-ODS services, such as residential services not subject to the IMD exclusion, recovery services, care coordination, and physician consultation, are only available in counties participating in the DMC-ODS waiver. Moreover, DMC-ODS counties also have the option of covering certain additional benefits, such as partial hospitalization and contingency management for stimulant use disorders.

In addition, the pending Medi-Cal BH-CONNECT Section 1115 waiver seeks to give county MHPs the option to offer new specialty mental health services (Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (FACT); adult residential treatment not subject to IMD Exclusion; transitional rent for up to six months; Community Health Workers (CHWs); Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Individual Placement and Support (IPS) Model of

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[17] *See* Cal. Dep't Health Care Servs., TAR and Non-Benefit List, https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual%3Ffn%3Dtarandnoncd9.pdf&ved=2ahUKEwiK6OzGt9KFAxViSjABHXZdC8MQFnoECBsQAQ&usg=AOvVaw2GCobabQSqRgpba3qThGso.

[18] Cal. Dep't Health Care Servs., Specialty Mental Health Services Billing Manual, https://www.dhcs.ca.gov/Documents/SMHS-Billing-Manual-v-1-4.pdf.

Supported Employment; and Clubhouse Services).[19] Similarly, CHWs, IPS Supported Employment and transitional rent may also be covered at the option of the DMC and DMC-ODS counties. These services are impactful and important; nonetheless, their limited availability as Medi-Cal benefits at county option prevents us from categorically asserting that their coverage is better in Medi-Cal than private plans, particularly considering that SB 855 may require coverage of these services if medical necessity is established.

Reliance on SB 855's Broad Coverage Requirements

As we have emphasized above, making an accurate comparison between coverage of behavioral health services in Medi-Cal and private plans depends to a large extent on the effectiveness and enforcement of SB 855's broad coverage requirements. While SB 855's requirements extend to all medically necessary services beyond those outlined in the regulations, we are concerned that failure to explicitly identify the required covered services will lead to a potential disparity of coverage by plans as well as confusion on the part of beneficiaries if plans fail to list all covered services in their evidences of coverage. As with the EPSDT benefit, coverage of behavioral health services under SB 855 may become dependent on additional DMHC guidance or even litigation. As such, while SB 855 is an important law, it is imperative that DMHC continue identifying potential gaps and discrepancies in coverage of behavioral health services in order to explicitly incorporate missing services to the regulations. In addition, plans should be required to list all the services identified in the SB 855 regulations as part of their evidences of coverage and to add a statement emphasizing that such list is non-exhaustive and that individuals may be eligible for other behavioral health services when medical necessity is established.[20]

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[19] Cal. Dep't Health Care Servs., Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration Proposal (2023), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-bh-connect-pa-10202023.pdf.

[20] We also note that, to the extent that SB 855 extends coverage requirements beyond those outlined in the EHB benchmark plan, California may inadvertently run into problems related to federal defrayal requirements for benefits considered in addition to EHBs. The ACA and implementing federal regulations require states to defray the cost of benefits mandated through state action (legislation or rulemaking) that are not adopted through the EHB benchmarking process. Behavioral health services explicitly listed in the SB 855 regulations that are not also listed in California's benchmark plan may be considered as additions to EHBs and may be subject to defrayal. For example, under EHB requirements, private plans in California are required to cover buprenorphine and naltrexone for opioid use disorders (OUD), but are not required to cover methadone maintenance treatment (MMT) for OUD. SB 855 regulations, on the other hand, explicitly list narcotic treatment programs (the only facilities authorized to provide MMT under federal law) as a covered benefit. Since the addition of MMT was not adopted pursuant to the EHB benchmarking process, which requires an

Conclusion and Recommendations

This crosswalk provides insight into the similarities and differences between behavioral health services coverage requirements in Medi-Cal and in private plans. The analysis shows that, in general, coverage requirements for behavioral health services in California are consistent for both Medi-Cal and private plans, particularly given the addition of SB 855's coverage requirements. However, there are several discrepancies related to accessing covered services based on different medical necessity criteria, as well as inconsistencies regarding coverage of specific benefits in Medi-Cal or private plans. To address these inconsistencies, we recommend the following actions:

- DHCS and DMHC should evaluate the possibility of harmonizing medical necessity criteria for adults in Medi-Cal and for private plan enrollees and, to the extent possible, should reduce reliance on access criteria in addition to the medical necessity criteria. This action may require the departments to propose legislative amendments to the corresponding statutes.
- DMHC should engage with the legislature to ensure additional benefits required pursuant to SB 855 are added to the EHB benchmark plan in order to avoid the possibility of defrayal.
- DMHC should identify remaining gaps in coverage and periodically review and update the SB 855 regulations in order to add services. Those services could include behavioral health support services, such as peer support, care coordination, targeted case management, physician consultation, recovery supports, and dyadic services, as well as contingency management for stimulant use disorders.
- DMHC should incorporate behavioral health services that are specific for minors into the SB 855 regulations.
- DHCS should provide guidance to MCPs and MHPs regarding coverage requirements for TMS and similar services that are listed in the TAR/Non-Benefit list. The guidance should address the requirement for MCPs to refer beneficiaries to MHPs for provision of TMS as a SMHS.
- DHCS should require all counties to cover the various benefits that are currently only optional for counties pursuant to Medi-Cal waivers.

actuarial certification and approval from CMS, it is possible that the federal government could require California to defray the cost of the additional services. For more information on the EHB benchmarking process and defrayal, see Wayne Turner and Héctor Hernández-Delgado, Nat'l Health Law Prog., *Essential Health Benefits: Best Practices in State Benchmark Selection* (2022), https://healthlaw.org/resource/essential-health-benefits-best-practices-in-benchmark-selection/.

Future Research

Our research did not address cost-sharing, prior authorization, and other utilization management techniques commonly imposed on behavioral health services in California. However, we believe such barriers represent an important component in the modernization and alignment efforts. As such, we plan to evaluate how private plans differ from Medi-Cal in that aspect in an upcoming publication. Similarly, this crosswalk identifies coverage requirements in state law, but does not identify patterns in private insurance coverage or Medi-Cal MCPs in terms of coverage in excess of what is required in federal and state law. We also plan to research and address those patterns in a future publication.

Coverage Requirements of Mental Health Services in Medi-Cal and Private Plans

Levels of Care/Services		Medi-Cal	EHB Private Plans
Preventive Services	General Mental Health Evaluation and Assessment	X	X
	Psychological and Neurological Testing	X	X
	Screening for Depression and Suicide Risk	X	X
	Screening for Anxiety	X	X
	Preventive Interventions for Perinatal Depression	X	X
	Polysomnography	X	X
	Community Health Workers[a]	X	
Outpatient/Community-Based Services	Psychiatric Services	X	X
	Psychologist Services	X	
	Skilled Nursing	X	X
	Psychiatric Nursing Facility Services	X	
	Day Treatment	X	X
	Partial Hospitalization	X	X
	Intensive Outpatient Psychiatric Treatment	X	X
	Individual and Group Treatment	X	X
	Drug Therapy	X	X
	Electroconvulsive Therapy	X	X
	Transcranial Magnetic Stimulation	X[b]	X
	Intensive Care Coordination	X[c]	
	Intensive Home-Based Services	X[c]	X
	Therapeutic Behavioral Services	X[c]	
	Therapeutic Foster Care	X[c]	
	Assertive Community Treatment (ACT)	X (some counties)[d]	
	Forensic ACT	X (some counties)[d]	

	Behavioral Health Treatment for Pervasive Developmental Disorder or Autism Spectrum	X	X
Inpatient/Residential Services	Psychiatric inpatient hospital services	X	X
	Acute psychiatric inpatient hospital services	X	X
	Short-term Treatment in a Crisis Residential Program	X	X
	Residential Services	X[e]	X
Emergency Services	Crisis Intervention	X	X
	Crisis Residential Treatment	X	
	Mobile Crisis Services	X	
	Urgent Care Services[f]	X	X
Support Services	Psychiatric Transportation	X	X
	Peer Support	X	
	Targeted Case Management	X	
	Psychiatric Consultation	X	
	Dyadic Services	X	
	Transitional Rent (up to 6 months)	X (some counties)[d]	
	Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)	X (some counties)[d]	
	Individual Placement and Support (IPS) Model of Supported Employment	X (some counties)[d]	
	Clubhouse Services	X (some counties)[d]	
	Individualized Placement and Support (IPS) Supported Employment	X (some counties)[d]	

a. CHWs are a Medi-Cal benefit that is available statewide as a preventive service for any physical or behavioral health condition. However, DHCS is requesting federal approval to offer the service as a SMHS in counties that elect to do so. Such waiver request is currently pending with CMS. While we have categorized CHWs as a covered benefit, we are concerned that the pending request may create confusion as to whether CHWs are already available, under the state plan, as a Medi-Cal service to address behavioral health conditions.
b. TMS is a covered benefit pursuant to the Specialty Mental Health Services Billing Manual. However, the benefit is also listed as a non-benefit in the Medi-Cal TAR and Non-Benefit List, which has created confusion among plans and administrative law judges.
c. For beneficiaries under 21.
d. Pending federal approval.
e. Service currently limited to facilities that are not Institutions for Mental Diseases (IMDs). The State has requested federal approval for the services to be rendered in IMDs as well. That request is currently pending.
f. Urgent care services are not explicitly listed as a covered Medi-Cal benefit; however, comparable services may be covered as emergency services, SMHS crisis services, or SMHS crisis stabilization services. For private plans, urgent care services are listed in the SB 855 regulations. A health plan must provide services on an urgent basis for both physical and behavioral health conditions if "the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including but not limited to, the potential loss of life, limb, or other major bodily functions, or the normal timeframe for the [health plan's] decision-making process…would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function." (CAL. HEALTH & SAFETY CODE §1367.01(h)(2)).

Coverage Requirements of SUD Services in Medi-Cal and Private Plans

Levels of Care/Services		Medi-Cal	EHB Private Plans
Preventive Services	Screening for Unhealthy Drug/Alcohol Use	X	X
	Brief Intervention and Referral to Treatment for Drug Use	X	X
	Tobacco Use: Primary Care Interventions for Adolescents	X	X
	Tobacco Smoking Cessation for Adults	X	X
	Community Health Workers[a]	X	
Outpatient Services	Narcotic Treatment Program	X	X
	Day Treatment	X	X
	Intensive Outpatient	X	X
	Partial Hospitalization	X (some counties)	X
	Contingency Management for Stimulant Use Disorders	X (some counties)	
Inpatient/Residential Services	Withdrawal Management/Inpatient Detoxification	X	X
	Transitional Residential (Sober Homes)		X
	Residential Services	X[b]	
Prescription Drugs	Naltrexone (OUD)	X	X
	Buprenorphine (OUD)	X	X
	Methadone (OUD)	X	X
	Acamprosate (AUD)	X	X
	Naltrexone (AUD)	X	
	Disulfiram (AUD)	X	X
Emergency Services	Crisis Intervention	X	X
	Mobile Crisis Services	X	
	Urgent Care Services	X[c]	X

Support Services	Peer Support	X (some counties)	
	Care Coordination	X (some counties)	
	Physician Consultation	X (some counties)	
	Recovery Services	X (some counties)	
	Transitional Rent (up to 6 months)	X (some counties)[d]	
	Individualized Placement and Support (IPS) Supported Employment	X (some counties)[d]	

a. CHWs are a Medi-Cal benefit that is available statewide as a preventive service for any physical or behavioral health condition. However, DHCS is requesting federal approval to offer the service as a DMC benefit in counties that opt to do so. Such request is currently pending. While we have categorized CHWs as a covered benefit, we are concerned that the pending request may create confusion as to whether CHWs are already available, under the state plan, as a service to address behavioral health conditions.
b. Service available statewide for beneficiaries under 21 under EPSDT and for perinatal beneficiaries. For other beneficiaries, service is only available in DMC-ODS counties.
c. Urgent care services are not explicitly listed as a covered Medi-Cal benefit; however, comparable services may be covered as emergency services, SMHS crisis services, or SMHS crisis stabilization services. For private plans, urgent care services are listed in the SB 855 regulations. A health plan must provide services on an urgent basis for both physical and behavioral health conditions if "the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including but not limited to, the potential loss of life, limb, or other major bodily functions, or the normal timeframe for the [health plan's] decision-making process…would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function." (CAL. HEALTH & SAFETY CODE §1367.01(h)(2)).
d. Pending federal approval.

Summary of Coverage Requirements

Mental Health Services – Medi-Cal for Adults and Minors

- Preventive Services
  - Mental Health Evaluation and Assessment
  - Psychological and Neurological Testing
  - Perinatal Depression: Preventive Interventions
  - Community Health Workers
- Inpatient Services
  - Psychiatric inpatient hospital services
  - Acute psychiatric inpatient hospital services
  - Psychiatric health facility services
  - Psychiatric inpatient hospital professional services
  - Crisis Residential
  - Adult Residential
  - Psychiatric Health Facility Services
- Outpatient Services
  - Individual, Group, and Family Psychotherapy
  - Medication Support and Drug Therapy Monitoring
  - Day Treatment Intensive Care and Rehabilitation
  - Psychiatric Services
  - Psychologist Services
- Crisis Intervention and Stabilization (including mobile crisis services)
- Support Services
  - Targeted Case Management
  - Peer Support
  - Psychiatric Consultation
  - Dyadic Services

Mental Health Services – Medi-Cal for Minors Pursuant to EPSDT (non-exhaustive list)

- Intensive Care Coordination
- Intensive Home-Based Services
- Therapeutic Behavioral Services
- Therapeutic Foster Care
- Other services necessary to correct or ameliorate a behavioral health condition

Mental Health Services – Medi-Cal Pursuant to Pending BH-CONNECT Waiver

- Assertive Community Treatment (ACT)
- Forensic ACT
- Adult Residential Treatment Not Subject to IMD Exclusion
- Transitional Rent (up to 6 months)
- Individualized Placement and Support (IPS) Supported Employment
- Community Health Workers
- Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
- Individual Placement and Support (IPS) Model of Supported Employment
- Clubhouse Services

Mental Health Services – Private Plans Pursuant to EHB Requirements

- Preventive Services
  - Mental Health Evaluation
  - Depression and Suicide Risk: Screening
  - Anxiety: Screening
  - Perinatal Depression: Preventive Interventions
  - Psychological testing when necessary to evaluate a Mental Disorder
- Inpatient Psychiatric Hospitalization
  - Partial hospitalization
  - Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a- day monitoring by clinical staff for stabilization of an acute psychiatric crisis
  - Psychiatric observation for an acute psychiatric crisis
- Individual and Group Outpatient Mental Health Evaluation and Treatment
  - Individual and group mental health treatment
  - Outpatient Services for the purpose of monitoring drug therapy
  - Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program

Substance Use Disorder Services – Medi-Cal in All Counties Pursuant to DMC

- Preventive Services
  - Alcohol and Drug Use Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)
    - Screening of unhealthy alcohol and drug use
    - Brief Assessment
    - Brief Interventions and Referral to Treatment
  - Services for Prevention of Tobacco Use
    - Initial tobacco use assessment with following annual visits
    - FDA-approved tobacco cessation medications
    - Individual, group, and telephone counseling
    - One-on-one counseling services for pregnant tobacco users
  - Community Health Workers
- Inpatient Detoxification
- Outpatient Chemical Dependency Evaluation and Treatment (each service includes the following components: assessment, care coordination, individual and group counseling, family therapy, MAT, medication services, patient education, recovery services, and SUD crisis intervention)
  - Outpatient Services
  - Intensive Outpatient
  - Individual and Group Counseling
  - Narcotic Treatment Programs
- Perinatal Residential Services
- Peer Support Services (optional for counties)
- Crisis Intervention Services (including mobile crisis services)
- Prescription Drugs
  - ALL formulations of naltrexone, buprenorphine, and methadone approved by the FDA for OUD (includes MMT in NTPs)
  - Assessment for MAT for OUD
  - Individual and Group counseling for MAT for OUD
  - Medical Psychotherapy for MAT for OUD
  - Non-MAT Medications related to OUD
  - Patient Education
  - Prescribing and monitoring
  - Crisis Intervention

Substance Use Disorder Services – Medi-Cal in DMC-ODS Counties (in addition to DMC services)

- Inpatient Detoxification/Withdrawal Management (at least one ASAM level)
- Partial Hospitalization (optional for counties)
- Residential Services not subject to IMD exclusion
- Recovery Services
- Care Coordination
- Contingency Management for stimulant use disorders (optional for counties)

Substance Use Disorder Services – Medi-Cal Pursuant to Pending BH-CONNECT Waiver

- Transitional Rent (up to 6 months)
- Individualized Placement and Support (IPS) Supported Employment
- Community Health Workers

Substance Use Disorder (Chemical Dependency) Services – Private Plans Pursuant to EHB Requirements

- Preventive Services Required Pursuant to USPSTF (Ratings A and B)
    - Screening for Unhealthy Drug Use
    - Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions
    - Tobacco Use in Children and Adolescents: Primary Care Interventions
    - Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions
- Inpatient Detoxification
- Transitional Residential Recovery Services (counseling and support)
- Outpatient Chemical Dependency Evaluation and Treatment
    - Day Treatment
    - Intensive Outpatient
    - Individual and Group Chemical Dependency Counseling
    - Medical treatment for withdrawal symptoms
- Prescription Drugs
    - Alcohol Deterrents
        - acamprosate tabs 250mg, 500mg
        - Antabuse tabs 250mg, 500mg
        - disulfiram tabs 250mg, 500mg
    - Opiate Antagonists
        - BELBUCA FILM 75mcg, 150mcg, 300mcg, 450mcg 4 NDS

- BELBUCA FILM 600mcg, 750mcg, 900mcg 5 NDS
- buprenorphine hcl subl 2mg, 8mg 2 NDS
- Buprenorphine hcl-naloxone hcl film 2 NDS
- Buprenorphine hcl-naloxone hcl subl 2 NDS
- buprenorphine ptwk 5mcg/hr, 7.5mcg/hr, 10mcg/hr, 15mcg/hr, 20mcg/hr 2 NDS
- LUCEMYRA TABS 5 NDS
- *naloxone hcl liqd* 2
- *naloxone hcl soct* 2
- *naloxone hcl soln* 2
- *naloxone hcl sosy* 2
- *naltrexone hcl tabs* 2
- NARCAN LIQD 3
- SUBLOCADE SOSY 100mg/0.5ml, 5 NDS 300mg/1.5ml NDS
- VIVITROL SUSR 5 NDS

Exclusions: Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Chemical Dependency Services" section (this would include methadone maintenance treatment at narcotic treatment programs).

Behavioral Health Services – Private Plans Pursuant to SB 855 Regulations (non-exhaustive list)

- Basic health care services
  - Emergency health care services
  - Urgent care services
  - Physician services
  - Hospital inpatient services, including services of
    - licensed general acute care,
    - acute psychiatric
    - chemical dependency recovery hospitals.
  - Ambulatory care services,
    - physical therapy
    - occupational therapy
    - speech therapy
    - infusion therapy
  - Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services.
  - Home health care service.
  - Preventive health care services, regardless of whether an enrollee has been diagnosed with a mental health condition or substance use disorder
  - Hospice care

- Behavioral health treatment for pervasive developmental disorder or autism spectrum disorder
- Coordinated specialty care for the treatment of first episode psychosis
- Day treatment
- Drug testing
- Electroconvulsive therapy
- For gender dysphoria, all health care benefits identified in the most recent edition of the *Standards of Care* developed by the World Professional Association for Transgender Health.
- Inpatient services, including but not limited to all the following:
    - American Society of Addiction Medication (*ASAM*) inpatient levels of care and withdrawal management
    - High intensity acute medically managed residential programs
    - Medically managed extended care residential programs
- Intensive community-based treatment, including assertive community treatment and intensive case management
- Intensive home-based treatment
- Intensive outpatient treatment
- Medication management
- Narcotic (opioid) treatment programs
- Outpatient prescription drugs prescribed for mental health and substance use disorder pharmacotherapy, including office-based opioid treatment
- Outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling
- Partial hospitalization
- Polysomnography
- Psychiatric health facility services
- Psychological and neuropsychological testing.
- Reconstructive surgery
- Residential treatment facility services, including all the following:
    - Intensive short-term residential services
    - Moderate intensity intermediate stay residential treatment programs
    - Moderate intensity long-term residential treatment programs
    - *ASAM* residential levels of care
- School-site services for a mental health condition or substance use disorder
- Transcranial magnetic stimulation
- Withdrawal management services