

 <p><b>Behavioral Health Department</b> Alameda County Health</p>	<p>Signed by:            By: BA167CA0C0D444A...  <b>Karyn L. Tribble, PsyD, LCSW, Director</b></p>
<p><b>POLICY TITLE</b>   <b>No Wrong Door for Mental Health Services</b></p>	<p><b>Policy No:</b> 100-3-2   <b>Date of Original Approval:</b> 6/3/2022   <b>Date(s) of Revision(s):</b> 1/27/2026</p>

## PURPOSE

The purpose of this policy is to provide County Mental Health Plans (MHPs), Drug Medi-Cal (DMC) counties, and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties with guidance and clarification regarding the No Wrong Door for Mental Health Services Policy. This policy ensures that Medi-Cal members receive timely mental health services without delay regardless of the delivery system where they seek care, and that members are able to maintain treatment relationships with trusted providers without interruption. Corresponding guidance to Medi-Cal Managed Care Plans (MCPs) is contained in the Department of Health Care Services (DHCS) [All Plan Letter \(APL\) 22-005](#).

## AUTHORITY

- [DHCS Behavioral Health Information Notice \(BHIN\) No. 22-011 No Wrong Door for Mental Health Services Policy](#)

## SCOPE

All County-Operated programs and individuals providing specialty mental health services (SMHS) and substance use disorder (SUD) services under a contract or subcontract with Alameda County Behavioral Health Department (ACBHD) are required to adhere to this policy.

## BACKGROUND

With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, DHCS aims to address Medi-Cal members' needs across the continuum of care, ensure that all members receive coordinated services, and improve beneficiary health outcomes<sup>1</sup>. DHCS' goal is to ensure that members have access to the right care in the right place at the right time.

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including updates to the criteria to access SMHS, implementation of standardized statewide screening and transition tools, payment reform, and other changes summarized in the CalAIM proposal and BHINs.

Per forthcoming DHCS guidance, Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services (NSMHS), and the Medi-Cal Provider California Mental Health Services

<sup>1</sup> Please visit the CalAIM webpage for further information: <https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx>

Authority (CalMHSA) Manual: Non-Specialty Mental Health Services: Psychiatric and Psychological Services, MCPs are required to provide or arrange for the provision of the following NSMHS:<sup>2</sup>

- Mental health evaluation and treatment, including individual, group, and family psychotherapy;
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for purposes of monitoring drug therapy;
- Psychiatric consultation; and
- Outpatient laboratory, drugs,<sup>3</sup> and supplies and supplements.

MCPs must provide or arrange for the provision of the NSMHS listed above for the following populations:

- Members who are 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM);<sup>4</sup>
- Members who are under the age of 21, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;<sup>5</sup> and,
- Members of any age with potential mental health disorders not yet diagnosed.

In accordance with Welfare and Institutions (W&I) Code sections [14059.5](#) and [14184.402](#), for individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the standards set forth in [Section 1396d\(r\)\(5\) of Title 42](#) of the United States Code (U.S.C.). The Federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that are Medicaid coverable (as described in [Section 1396\(a\) of Title 42](#) of the U.S.C.) as needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in

<sup>2</sup> APLs are searchable on the APL webpage: (<https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>). Please visit the Medi-Cal provider manual: <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual> for [Non-Specialty Mental Health Services: Psychiatric and Psychological Services](#). See W&I Code section 14184.402(b)(1): ([https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14184.402](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14184.402)).

State law is searchable at: (<https://leginfo.legislature.ca.gov/faces/codes.xhtml>)

<sup>3</sup> This does not include medications covered under the Medi-Cal Rx Contract Drug List located at: (<https://medi-calrx.dhcs.ca.gov/home/cdl/>)

<sup>4</sup> Presence of a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not “mental health disorders” for the purpose of determining whether a beneficiary meets criteria to receive NSMHS. However, MCPs must provide or arrange for NSMHS for members with any of these or other co-occurring physical health or SUDs if they also have a mental health disorder (or potential mental health disorders not yet diagnosed) and meet criteria for NSMHS as described above.

<sup>5</sup> See Section 1396d(r)(5) of Title 42 of the U.S.C.: ([https://uscode.house.gov/view.xhtml?req=\(title:42%20section:1396d%20edition:prelim](https://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim)) (requiring provision of all services that are coverable under Section 1905(a) of the Social Security Act (42 U.S.C. § 1396d(a)):

[https://www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](https://www.ssa.gov/OP_Home/ssact/title19/1905.htm) and that are necessary to correct or ameliorate a condition, including a behavioral health condition, discovered by a screening service, whether or not such services are covered under the State Plan), U.S.C. is searchable at: (<https://uscode.house.gov/>)

the state's Medicaid State Plan. Consistent with Federal guidance from the Centers for Medicare and Medicaid Services (CMS), behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition.<sup>6</sup> Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition, and are thus medically necessary and covered as EPSDT services.

MCPs must also cover and pay for emergency room professional services as described in [Section 53855 of Title 22 of the California Code of Regulations](#) (CCR). This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Emergency services includes facility and professional services and facility charges claimed by emergency departments. MCPs must provide covered SUD services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for members ages 11 and older (including pregnant members) in primary care settings, and tobacco, alcohol, illicit drug screening. These services must be provided in accordance with [American Academy of Pediatrics Bright Futures](#) and United States Preventive Services Taskforce grade A and B recommendations for adults as outlined in [APL 21-014](#), Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. Further, MCPs must provide or arrange for the provision of:

- Medications for Addiction Treatment (MAT, also known as medication-assisted treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings; and
- Emergency services necessary to stabilize the member.<sup>7</sup>

The NSMHS and SUD services described above are covered services via the Fee-For Service (FFS) delivery system for Medi-Cal members who are not enrolled in a MCP. MHPs are required to provide or arrange for the provision of medically necessary SMHS for members in their counties who meet access criteria for SMHS as described in DHCS' [BHIN 21-073](#).

## POLICY

It is the policy of the county MHP to provide or arrange for clinically appropriate, covered SMHS to include prevention, screening, assessment, and treatment services. These services are covered and reimbursable even when:<sup>8</sup>

1. Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met;
2. The member has a co-occurring mental health condition and SUD; or

<sup>6</sup> CMS Federal EPSDT guidance: [https://www.medicaid.gov/sites/default/files/2019-12/epsdt\\_coverage\\_guide.pdf](https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf)

<sup>7</sup> Including voluntary inpatient detoxification as a benefit available to MCP members through the Medi-Cal fee-for-service program, as described in APL 18-001 at:

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2018/APL18-001.pdf>

<sup>8</sup> W&I Code section 14184.402(f): [California Code, Welfare and Institutions Code - WIC § 14184.402 | FindLaw](#)

3. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

## PROCEDURE

### **1. SMHS Provided During the Assessment Period Prior to Determination of a Diagnosis or Prior to Determination of Whether SMHS Access Criteria Are Met**

Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the member meets access criteria for SMHS.<sup>9</sup> Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the member does not meet criteria for SMHS. MHPs must not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that the member does not meet criteria for SMHS or meets the criteria for NSMHS.

Likewise, MCPs must not disallow reimbursement for NSMHS services provided during the assessment process if the assessment determines that the member does not meet criteria for NSMHS or meets the criteria for SMHS.

MHPs, DMC and DMC-ODS programs and providers may use the following options during the assessment phase of a member's treatment when a diagnosis has yet to be established:<sup>10</sup>

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).
- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a member's treatment when a diagnosis has yet to be established.
- In cases where services are provided for a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMHP in the CMS-approved ICD-10 diagnosis code list<sup>11</sup>, which may include Z codes. LPHA and LMHP may use any

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<sup>9</sup> For more information regarding coverage and reimbursement policies for DMC and DMC-ODS services during the assessment process, please refer to BHIN 21-071: (<https://www.dhcs.ca.gov/Documents/BHIN-21-071-Medical-Necessity-Determination-Level-of-Care-Determination-Requirements.pdf>) , and BHIN 21-075: (<https://www.dhcs.ca.gov/Documents/BHIN-21-075-DMC-ODS-Requirements-for-the-Period-2022-2026.pdf>), respectively.

<sup>10</sup> <https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf>

<sup>11</sup> The ICD 10 Tabular: ([ICD-10 | CMS](#))

clinically appropriate ICD-10 code.<sup>12</sup> For example, these include codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services.”

## **2. Co-occurring Substance Use Disorder**

Clinically appropriate and covered SMHS delivered by MHP providers are covered Medi-Cal services whether or not the member has a co-occurring SUD. MHPs must not deny or disallow reimbursement for SMHS provided to a member who meets SMHS criteria on the basis of the member having a co-occurring SUD, when all other Medi-Cal and service requirements are met. Similarly, clinically appropriate and covered DMC services delivered by DMC providers and DMC-ODS services delivered by DMC-ODS providers are covered by DMC counties and DMC-ODS counties, respectively, whether or not the member has a co-occurring mental health condition. Likewise, clinically appropriate and covered NSMHS are covered Medi-Cal services via the FFS and MCP delivery systems whether or not the member has a co-occurring SUD. Similarly, clinically appropriate and covered SUD services delivered by MCP providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) are covered by MCPs whether or not the member has a co-occurring mental health condition.

## **3. Concurrent NSMHS and SMHS**

Members may concurrently receive NSMHS via a FFS or MCP provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative. When a member meets criteria for both NSMHS and SMHS, the member should receive services based on individual clinical need and established therapeutic relationships.<sup>13</sup> MHPs must not deny or disallow reimbursement for SMHS provided to a member on the basis of the member also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MCPs and MHPs to ensure member choice. MHPs must coordinate with MCPs to facilitate care transitions and guide referrals for members receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. Such decisions should be made via a member-centered shared decision-making process.<sup>14</sup>

<sup>12</sup> The Short-Doyle Medi-Cal Claim System accepts all valid CMS approved ICD-10-CM codes for outpatient services; refer to ICD 10 Tabular.

<sup>13</sup> Nothing in this BHIN supersedes the criteria for beneficiary access to SMHS described in BHIN 21-073: (<https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf>)

<sup>14</sup> This BHIN does not supersede members’ rights to request continuity of care consistent with federal regulations and state code, as described in MHSUDS 18-059:

- Members with established therapeutic relationships with a FFS or MCP provider may continue receiving NSMHS from the FFS or MCP provider (billed to FFS or the MCP), even if they simultaneously receive SMHS from a MHP provider (billed to the MHP), as long as the services are coordinated between these delivery systems and are non-duplicative (e.g., a member may only receive psychiatry services in one network, not both networks; a member may only access individual therapy in one network, not both networks).
- Members with established therapeutic relationships with a MHP provider may continue receiving SMHS from the MHP provider (billed to the MHP), even if they simultaneously receive NSMHS from a FFS provider or MCP provider (billed to FFS or the MCP), as long as the services are coordinated between these delivery systems and are non-duplicative.

DHCS has developed a set of statewide tools to facilitate screenings and care transitions for the SMHS, NSMHS and FFS systems. Information regarding the tools and the tools themselves are posted on this DHCS page: [Screening and Transition of Care Tools for Medi-Cal Mental Health Services](#).

The Screening Tools are not required or intended for use with members who are currently receiving mental health services or those who contact mental health providers directly to seek mental health services. Mental health providers who are contacted directly by members seeking mental health services are able to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with this policy.

## NON-COMPLIANCE

- Contractors not in compliance with contract provisions, or with State or Federal law and/or regulations, shall be immediately responsible for remedy.
- ACBHD may, at its discretion, issue a Corrective Action Plan (CAP) or Contract Compliance Plan (CCP), as appropriate.
- The cost to implement the CAP or CCP shall be borne by the Contractor.
- Staff shall report incidents of non-compliance to their department manager, who shall submit a Non-Compliance Report to ACBHD Quality Management (QM).
- Non-Compliance Reports shall be submitted within 15 days of reasonable awareness of the non-compliance.
- Failure to address identified issues may result in further action by ACBHD up to and including program termination, as specified in ACBHD policy # 1302-1-1, [Contract Compliance and Sanctions for ACBHD Contracted Providers](#).

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([https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN\\_18-059\\_Continuity\\_of\\_Care/MHSUDS\\_Information\\_Note\\_18-059\\_Continuity\\_of\\_Care.pdf](https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-059_Continuity_of_Care/MHSUDS_Information_Note_18-059_Continuity_of_Care.pdf)). Please note the components of MHSUDS 18-059 that describe SMHS medical necessity criteria have been superseded by BHIN 21-073: (<https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf>).

- Staff shall not face retribution for submitting a notice of non-compliance.
- Any communication that contains protected health information (PHI) or otherwise confidential information (e.g., as defined by the Health Insurance Portability and Accountability Act (HIPAA), 42 Code of Federal Regulations (CFR), Part 2, etc.) shall be sent through secure methods such as email with secure encryption.

## CONTACT

ACBHD Office	Current As Of	Email
Quality Assurance Division	1/26/26	<a href="mailto:QATA@acgov.org">QATA@acgov.org</a>

## DISTRIBUTION

This policy will be distributed to the following:

- ACBHD Staff
- ACBHD Contract Providers
- Public

## ISSUANCE AND REVISION HISTORY

**Original Authors:** CalMHSA

**Original Date of Approval:** 06/03/2022

Revision Author	Reason for Revision	Date of Approval by (Name, Title)
Amy Saucier, Clinical Review Specialist Supervisor, Quality Assurance	Updated policy to align with current changes with DHCS, including addition of new standardized Screening and Transition of Care tools.	1/27/2026 by Dr. Karyn Tribble, Behavioral Health Director
Diana Alvarez, Behavioral Health Clinician, Quality Assurance		

## DEFINITIONS

Term	Definition
<b>Drug Medi-Cal (DMC)</b>	DMC is a treatment funding source for eligible Medi-Cal members. In order for DMC to pay for covered services, eligible Medi-Cal members must receive SUD services at a DMC certified program. SUD services funded by DMC are listed in Title 22, California Code of Regulations (CCR), Section <a href="#">51341.1</a> , <a href="#">(d)(1-6)</a> , <a href="#">Title 9</a> and <a href="#">Title 22</a> , CCR govern DMC treatment.
<b>Drug Medi-Cal Organized Delivery</b>	The DMC-ODS provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for SUD treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of

<b>System (DMC-ODS)</b>	resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the member with access to the care and system interaction needed in order to achieve sustainable recovery. DHCS initially received approval in August 2015 from CMS to implement the DMC-ODS through the State's prior Section 1115 demonstration. DHCS received approval from CMS on December 29, 2021 to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal delivery systems: Medi-Cal managed care, dental managed care, and SMHS.
<b>Fee-For-Service (FFS) Medi-Cal Delivery System</b>	Under the FFS delivery system, the state pays enrolled Medi-Cal providers directly for covered services provided to Medi-Cal members. FFS providers render services and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.
<b>Managed Care Plan (MCP)</b>	MCPs are responsible for the Medi-Cal physical healthcare benefit. They are also responsible for a portion of the mental health benefit and must provide specified services to adults diagnosed with a mental health disorder, as defined by the current DSM, that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary NSMHS to children under the age of 21. MCPs refer to and coordinate with county MHPs for the delivery of SMHS.
<b>Mental Health Plan (MHP)</b>	A MHP is an entity that enters into a contract with DHCS to provide directly or arrange and pay for SMHS to members in a county. A MHP may be a county, counties acting jointly, or another governmental or non-governmental entity.
<b>Non-Specialty Mental Health Services (NSMHS)</b>	NSMHS are delivered via MCP and FFS delivery systems and are provided to recipients 21 years and over with mild-to-moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders. NSMHS may be provided to recipients under age 21, to the extent otherwise eligible for services through EPSDT, regardless of level of distress or impairment or the presence of a diagnosis, and recipients of any age with potential mental health disorders not yet diagnosed.
<b>Specialty Mental Health Services (SMHS)</b>	SMHS include but are not limited to: Assessment, Plan Development, Rehabilitation Services, Therapy Services, Collateral, Medication Support Services, Targeted Case Management, Crisis Intervention, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Behavioral Services (TBS). SMHS are provided to Medi-Cal members through county MHPs. All the MHPs are part of county mental health or behavioral health departments and the MHP can provide services through its own employees or through contracted providers.

## APPENDICES

- None