BEHAVIORAL HEALTH Fiscal Academy

CalMHSA
California Mental Health Services Authority

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Behavioral Health Fiscal Academy

BHFA Session 5

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Medicaid Reimbursement Pathways & Prop 30

Exploring Revenue Pathways Under Prop 30 and Medicaid for County BH Plans

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Learning Objectives

- Learn best practices for structuring Medicaid Administrative claims
- Establish documentation strategies for compliance
- Understand Proposition 30 allowable activities and reimbursement methodologies

Session Roadmap

- Medicaid Administration
  - Key activities, federal match rates, and claiming caps
- Utilization Review & Quality Assurance
  - Claiming rules, eligible activities, and documentation
- Structuring Backup Documentation
  - Time studies, objective allocation methods, and cost reporting
  - Best practices for audit-ready compliance
- Claiming Process & Forms
  - Summary of claiming workflow for Admin and UR/QA and timelines
  - Key forms (MC 1982B/C, MC 5312, DHCS 5311) and intervals
- Proposition 30 (2012) Overview
  - Fiscal protections, realignment integration, and mandate rules
  - Claiming considerations for Prop 30 costs
- Behavioral Health Administrative Integration
  - Timeline for integrated contracts and future claiming changes
- Prop 30 Allowable Activities
  - A comprehensive list of eligible activities by delivery system and claiming pathway.

Title XIX: Medicaid Administration & UR/QA Reimbursement

Federal Match Rates, Caps, and Policy Guidance

Understanding Medi-Cal Administrative Claiming

SMHS, DMC, and DMC-ODS vs. MAA Program

SMHS, DMC, and DMC-ODS Administrative Claims

- These quarterly claims allow counties to recover a portion of the administrative costs required to deliver high-quality Specialty Mental Health Services (SMHS) under the Mental Health Plan (MHP) contract, as well as Drug Medi-Cal (DMC) and DMC-Organized Delivery System (DMC-ODS) programs –using a cost-based methodology that is reconciled to actual administrative costs.

Today's focus!

Medicaid Administrative Activities (MAA) Program

- MAA Claims: These are for Medi-Cal Administrative Activities (e.g., outreach, referral, program planning) and are submitted under the MAA program. They are cost-based and reconciled to actual administrative costs.

Inside Medi-Cal Administrative Claiming

Medi-Cal Administration	Utilization Review & Quality Assurance

• Covers broad administrative functions necessary to run the Medicaid program and is reimbursed at:
  • 50% FFP for regular Medicaid services
  • 65% FFP for Medicaid's Children's Health Insurance Program (MCHIP) services
• The maximum amount claimable is capped at 15% of direct costs for regular services & 10% for MCHIP
• Claimable by MHPs, DMC State Plans, & DMC-ODS
	• Covers specialized clinical review and quality assurance activities, often performed by skilled professional medical personnel (SPMP):
	  • 75% FFP for SPMP
	  • 50% for Non SPMP
	• UR/QA activities are reimbursed separately from the general administrative costs and are not subject to the 15% administrative cap
	• Claimable by MHPs & DMC-ODS

The Key Distinction: *Medicaid Administration focuses on managing the program— coordination and oversight—while UR/QA zeroes in on ensuring services are clinically appropriate and high-quality for beneficiaries.*

A Little More on Medicaid UR/QA

DHCS Title XIX Reimbursement in Concept

Summary of UR/QA in Action

- Reviews to ensure services are reasonable, medically necessary, and meet professional health care standards.
- Includes monitoring of provider compliance, clinical performance improvement, and medication monitoring.
- Supports program integrity and compliance with federal and state requirements.
- Reimbursement **is not** limited in the same way as Administration.

Medicaid Administrative Reimbursement

Title XIX Reimbursement in Action

- Administrative claims are reimbursed at the lower of actual costs or the capped percentage of approved claims (15% for Regular Medicaid, 10% for MCHIP).
- In our example, Regular Medicaid costs exceeded the cap, so reimbursement was based on the claims cap.
- MCHIP costs came in below the cap, so reimbursement was based on those costs.

Medicaid Administrative Claiming & Reimbursement Example:

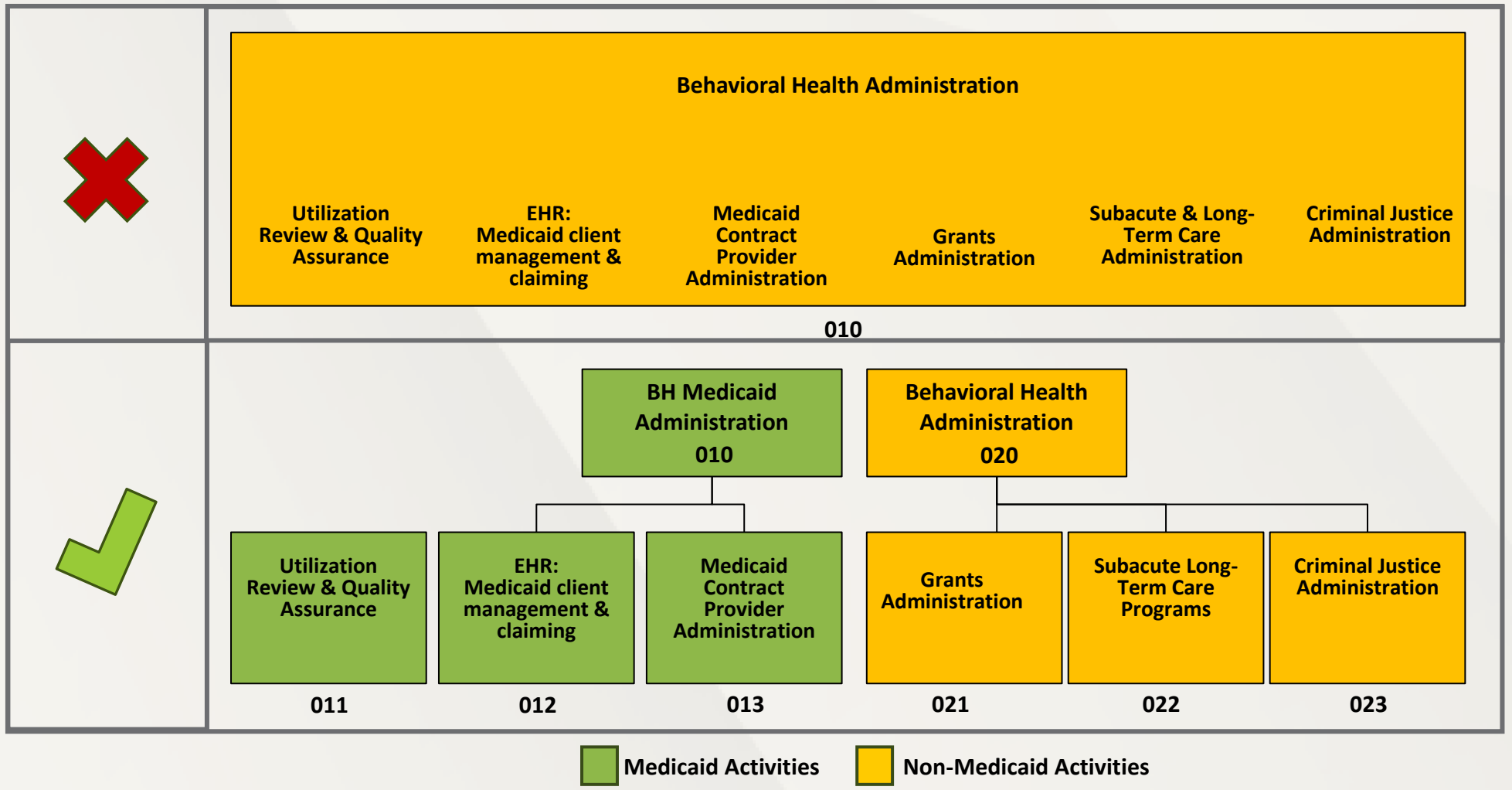
A county had the following approved claims during their report quarter:
Regular Medicaid: $1,000,000
MCHIP: $200,000

Step 1: Calculate the Max. Admin. Reimbursement Based on Approved Claims:
Regular Medicaid: 15% × $1,000,000 = **$150,000**
MCHIP: 10% × $200,000 = **$20,000**

Step 2: Identify the Actual Administrative Costs Incurred
Regular Medicaid: **$176,000**
MCHIP: **$17,400**

Step 3: Apply the "Lower of" Rule to Determine the County's FFP
Regular Medicaid: Lower of $150,000 or $176,000 → $150,000 × 50% = **$75,000**
MCHIP: Lower of $20,000 or $17,400 → $17,400 × 65% = **$11,310**

Building Cost Structures for Accurate Medicaid Claiming



Building Cost Structures for Accurate Medicaid Claiming (cont.)

Best Practices

✓ Create Separate Cost Centers or Sub-Accounts

- For Medicaid administrative activities; costs must be necessary, reasonable, and properly allocated to Medicaid functions.
- Non-Medicaid administrative activities (e.g., grant-funded programs, long-term subacute) should be isolated.
  - Non-Medicaid activities note: With changes through CalAIM and the benefits available to members such as Community Supports, it's important to challenge previous conceptions on what is and is not a Medicaid activity.

✓ Use Time Coding & Payroll Systems

- Ensure staff are coding their time to the correct cost center based on their activities, not job title.

✓ Document Everything

- Maintain clear documentation showing how costs flow from program → cost center → claim.
- Demonstrating a Direct Relationship to Medicaid is key

From Tasks to Data: Why Studies Matter for Medicaid Claiming

✓ **Review the Medicaid Admin & URQA Claiming Guide**

- Understand the guidance and consider the specific roles within your administration branch.

✓ **Map Roles to Cost Centers**

- Identify who performs which activities and ensure they time study to the correct cost centers or subaccounts you've set up. Note that some roles may need to allocate time across multiple cost centers if they perform both Medi-Cal and non-Medi-Cal activities.

✓ **Provide Quick-Reference Tools**

- Create easy-to-use guides with plain language and examples:
  - "Eligibility determination = YES"
  - "Direct therapy = NO"

✓ **Reinforce and Support**

- Assign a staff member to monitor monthly time studies and ensure staff are using the Admin and URQA codes correctly.
- Celebrate staff who consistently complete time studies accurately.

Some Activities Cannot Be Split via Time Study

Why this works:

- Uses an objective data point (client count)
- Aligns with OMB A-87 Rules:
  - Reasonable
  - Allocable
  - Supported by documentation
- Avoids claiming for the record and claims management of non-Medicaid clients.

Option: Splitting Up EHR Costs by Clients

Example: Allocate EHR costs based on proportional system utilization by unduplicated client type, since the EHR supports both Medicaid and non-Medicaid clients.

Step 1: Determine Total EHR Cost: **$1,000**

Step 2: Identify the Mix of Client Records Managed:

Regular Medicaid	**50**	**50%**
MCHIP	**30**	**30%**
State-Only	**10**	**10%**
Uninsured/Indigent	**10**	**10%**
Total:	**100**	**-**

Step 4: Allocate **$1,000** EHR Cost by Client Category

Regular Medicaid **$500**

MCHIP **$300**

Non Claimable **$200** ($100 State Only + $100 Uninsured)

Some Activities Cannot Be Split via Time Study (cont.)

Why this works:

- Uses an objective data point (FTEs)
- Aligns with OMB A-87 Rules:
  - Reasonable
  - Allocable
  - Supported by documentation
- Avoids claiming portions of the facility that we infer do not support Medicaid.

Option: Splitting Facility Cost by FTEs

Example: Allocate facility costs based on FTE distribution and Medicaid-related duties.

Step 1: Determine Total Facility Cost: **$100,000**

Step 2: Identify the number of FTEs and the % they perform Medicaid Administrative functions:

Role/Function	FTEs	Medicaid Admin %
Billing Staff	**4**	**100%**
Fiscal Staff	**3**	**80%**
MHSA Analysts	**2**	**0%**
Program Manager	**1**	**60%**
Total	**10**	**-**

Step 3: Calculate Weighted Allocation
Total FTEs: **10**
Medicaid Allowable FTEs:
(4 x 100%) + (3 x 80%) + (2 x 0%) + (1 x 60%) = **7 FTEs**
Allocation ratio: 7 / 10 = **70%**

Step 4: Allocate the Facility Cost
$100,000 x 70% = **$70,000**
Claim $70,000 on your 1982B or MC 5312

Claiming Process

Process Summary for Medicaid Admin & UR/QA

Process Summary for Medicaid Admin & UR/QA

Differences	MHPs	DMC State Plan Counties	DMC-ODS Counties
Claiming Forms for Administration	MC 1982 B	MC 5312	MC 5312
Claiming Forms for UR/QA	MC 1982 C		DHCS 5311
Claiming for Proposition 30 Costs	Included on MC 1982 B and MC 1982 C forms	Included on MC 5312 and **DHCS 5311** forms	Included on MC 5312 and DHCS 5311 forms

Shared Attributes:

- **Administrative Claiming Interval:** May be quarterly or annual
- **UR/QA Claiming Interval:** Quarterly
- **Limit on Administrative Costs:** 15% of approved claims for regular clients & 10% for MCHIP
- **Final Annual Claims Submission Deadline:** December 31, six months after fiscal year end
- **Reimbursement for UR/QA Activities:** Separate from administrative costs and not limited based on approved claims. **DMC counties** still use the **5311** for UR/QA **Prop 30** eligible activities.
- **Documentation Requirements:** Actual incurred costs (which may include reasonably allocated costs) replacement claims allowed with proper supporting documentation and approval from DHCS
- **Administration Cost Settlement Process:** DHCS reviews quarterly claims and reconciles to final actual costs & approved claims annually.

Maximizing Medicaid Reimbursement

Allowable UR/QA Activities

Participants today will receive the following handout:

Medicaid Administration & Utilization Review/Quality Assurance Claiming Guide.

Medicaid Administration and Utilization Review/Quality Assurance Claiming Guide

Allowable Utilization Review/Quality Assurance (UR/QA) Activities Applicable to MHPs and DMC-ODS Counties

1. **Medical Necessity and Quality of Care Review**
   - *a.* Determining whether services are reasonable and medically necessary for diagnosis or treatment
     (MHSUDS IN 17-011)
2. **Monitoring and Training Related to Program Integrity**
   - *b.* Utilization review and training activities related to monitoring program integrity standards, including services by contracted providers
     (MHSUDS IN 17-011; MH LTR 05-11)
3. **External Quality Review Activities**
   - *c.* Validation of performance improvement projects, performance measures, compliance with contract standards, network adequacy, and administration or validation of consumer surveys
     (42 CFR §438.358)

Maximizing Medicaid Reimbursement (cont.)

Allowable Admin Activities

Medicaid Administration and Utilization Review/Quality Assurance Claiming Guide

Allowable Administrative Activities
Applicable to MHPs, DMC, and DMC-ODS Counties

1. **General Administration and Management**
    a. Health Care Service agency administration
    b. Local Mental Health Directors' administrative time (when not providing direct services)
    c. Accounting and budgeting
    d. Auditing
    e. Data processing
    f. Employee retirement system administration
    g. Legal services
    h. Motor pool administration
    i. Personnel administration
    j. Procurement
    k. Maintenance and operation of central or home office
    (MH LTR 05-10)
2. **Claims and Contract Administration**
    a. Contract administration activities related to providers
    b. Maintaining and updating Medicaid client records in an EHR system.
    c. Processing and submitting Medicaid claims.
    d. System functions that support Medicaid billing, reporting, and compliance.
    (MH LTR 11-01; 42 CFR 433.15)

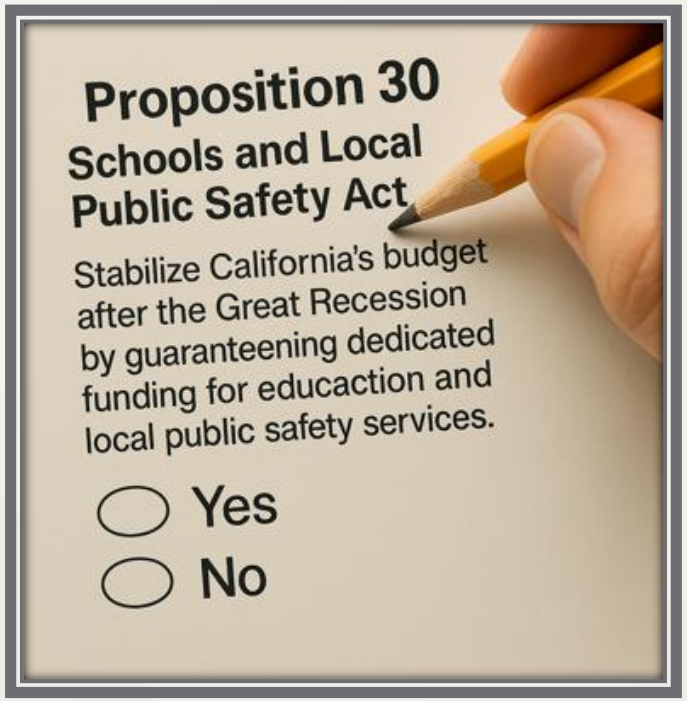
Taking a Moment for Prop 30

Before we review the claim forms for Administration and UR/QA; we need to take a moment to dive into Proposition 30 (2012)

Proposition 30 (2012)

Background, Reforms, & Fiscal Implications

Prop 30 (2012): Stabilizing State & Local Public Safety Funding



The Schools and Local Public Safety Protection Act of 2012

Purpose: Address severe budget shortfalls after the Great Recession

Goal: Stabilize state budget and protect education & public safety funding

Under the law, Public Safety Services include:

- **Hiring & Training**
  Recruiting and training law enforcement, prosecutors, and court security staff.
- **Substance Use Services**
  Preventing, treating, and supporting recovery from substance abuse.
- **Mental Health Services**
  Delivering care to reduce school failure, self-harm, homelessness, and preventable incarceration.
- **Child & Adult Protection**
  Preventing abuse, neglect, or exploitation; supporting at-risk children and families; providing adoption and adult protective services.
- **Corrections & Supervision**
  Operating local jails and providing housing, treatment, and supervision for juvenile and adult offenders.

Prop 30 (2012)

No Unfunded Mandates After Sept 30, 2012

State Mandates	Federal Mandates
• The state will fully reimburse counties for the entire non-federal share of costs that are required due to a new state mandate implemented after the 2011 Realignment.	• The state will reimburse counties for 50 percent of the non-federal share of costs that are required due to a new federal mandate implemented after the 2011 Realignment.

There are a few caveats to this that county fiscal analysts should keep in mind: **not everything new you do is Prop 30 claimable!**

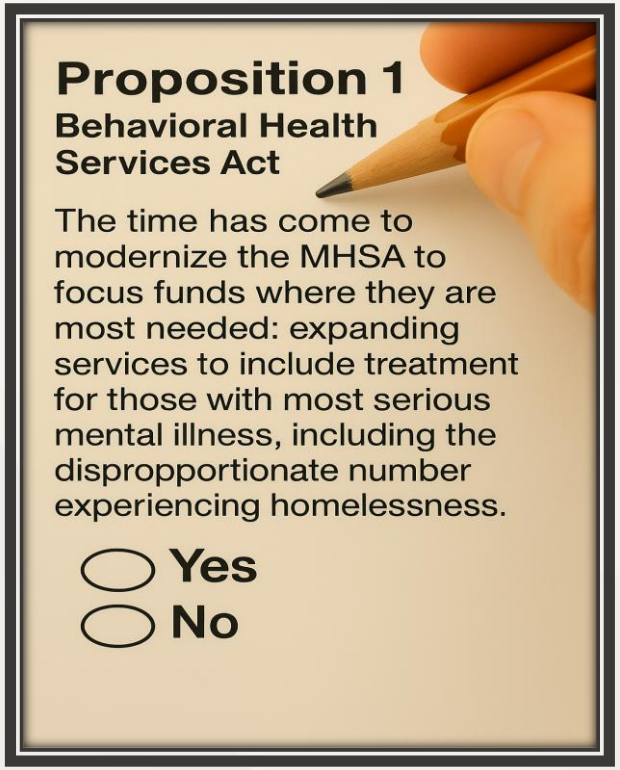
- Voter-Approved Ballot Measures
- Voluntary Assumption of Responsibilities

Prop 30 (2012)

No Unfunded Mandates After Sept 30, 2012

Voter-Approved Ballot Measure.

If a new cost arises from a statewide ballot measure approved by voters, the state is generally not required to reimburse counties. This is because the reimbursement requirements in Article XIII B, Section 6 of the California Constitution applies to legislative or administrative actions, **not voter initiatives.**



Voluntary Assumption of Responsibility

If a county voluntarily opts to take on a new responsibility (e.g., certifying peer support specialists), it is not considered a state-imposed mandate, so reimbursement is not triggered. The Commission on State Mandates and Government Code §17514 define a reimbursable mandate as one that is "required by the State."

KNOWLEDGE CHECK:

What's Claimable Under Medi-Cal Admin Claiming?

For each scenario, decide whether the activity is Claimable (under SMHS/DMC/DMC-ODS Admin or UR/QA) or Not Claimable (e.g., MAA-type, clinical, or non-Medi-Cal).

Medi-Cal Admin Claiming Scenarios

Scenario 1: Clinical Documentation Review

- A Quality Assurance Coordinator reviews treatment plans for Medi-Cal clients to ensure medical necessity and documentation compliance.

✅ **Claimable: UR/QA activity under Medi-Cal Administrative Claiming**

Scenario 2: Clinician Completes Progress Notes

- A therapist documents a therapy session in the electronic health record system.

❌ **Not Claimable: Direct clinical service time**

Scenario 3: Fiscal Analyst Prepares Cost Report

- A county fiscal staff member compiles administrative expenditures and calculates the federal share for the quarterly Medi-Cal claim.

✅ **Claimable: Medi-Cal Admin activity**

Scenario 4: Community Outreach Event

- A Peer Support Specialist hosts a community resource fair to promote mental health awareness and provide referrals for local services.

❌ **Not Claimable: MAA outreach activity; not part of Medi-Cal Admin or UR/QA claiming**

Revisiting the Claiming Process

Let's Review Claiming and the Claim Forms with Prop 30 in Mind

Administrative Claiming with Prop 30 in Mind

Revisiting How to Split EHR Costs – Breaking Things Up for the Prop 30 Claim Lines

Step 1: Identify EHR Costs

Example: EHR Total Cost = **$1,100**

HIE/MCO Interface = **$100** → ***Prop 30***

EHR cost, less HIE/MCO = **$1,000**

Since we can distinguish some Prop 30 eligible costs, we'll put those aside and continue…

Step 2: EHR Client Breakdown (100 total)

MCHIP = 20 **(20%)**

Regular Medicaid = 40 **(40%)**

ACA Expansion = 20 **(20%)**

State-Only Expansion = 10 **(10%)**

Uninsured/Indigent = 10 **(10%)**

Step 3: Allocate $1,000 Cost by % of Clients

MCHIP = $200 **(MCHIP)**

Regular Medicaid = $400 **(Regular)**

ACA Expansion = $200 **(Regular)**

State-Only = $100 → ***Not Claimable***

Indigent = $100 → ***Not Claimable***

Step 4: Claim on 1982B

MCHIP: **$200**

Regular: **$600**

Not Claimable: **$200**

Prop 30 Line **Federal**: **$100** (HIE/MCO Interface)

Administrative Claiming with Prop 30 in Mind

Unpacking Our Results

Example Results:
MCHIP: **$200**
Regular: **$600**
Prop 30 Line Federal: **$100 (HIE/MCO Interface)**
Not Claimable: **$200 (State-Only + Indigent)**
Total: **$1,100**

The Challenge With Prop 30 and Medi-Cal Administration Costs Like in this Example

State-Only & ACA clients are managed within the county's EHR primarily because the State opted for the Undoc + UIS expansion & the ACA Expansion; however, the State does not currently hold the position that administration activities for these populations, like the EHR in our example, are eligible to distribute and claim under Prop 30.

Summary

- There are three claiming pathways on the Admin forms:
  - Regular
  - MCHIP
  - Prop 30 (Fed/State)

- If you are allocating Medi-Cal administrative costs for activities like the EHR, you may choose to use the client distribution method as shown in this example.
- If your vendor provides line-item details for specific EHR functions (e.g., HIE/MCO interface), that can serve as documentation to justify claiming a portion of your EHR on the appropriate line of your administrative claim form.

UR/QA – MC 5311 DMC-ODS Claim Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY		Department of Health Care Services			
DRUG MEDI-CAL (DMC) CLAIM FOR REIMBURSEMENT OF QUALITY ASSURANCE - UTILIZATION REVIEW (QA/UR) COSTS Form: DHCS 5311				*Fiscal Year: *Claim For Qtr:	
*Date:		*County Code:		*County:	
*DMC		Mark "X" if Replacement Claim:			

	**SPMP - Skilled Professional Medical Personnel	A SPMP**	B Other***
1	*Salary		
2	*Benefits		
3	*Training		
4	*Travel		
5	*General Expense		
6	*Communication		
7	*Facility Operation		
8	TOTAL (1 thru 7)	$0.00	$0.00
9	*Percent of Time Spent on QA/UR	100.00%	100.00%
10	*Percent of Time Spent on QA/UR for Medi-Cal	100.00%	100.00%
11	Claimable Amount (8) x (9) x (10)	$0.00	$0.00
12	FFP – 75% Amount (11A) x (0.75)	$0.00	
13	FFP – 50% Amount (11B) x (0.50)		$0.00
14	County Match to FFP (11A minus 12A) and (11B minus 13B)	$0.00	$0.00
15	*Prop 30 State		
16	*Prop 30 Federal		
17	Prop 30 FFP Amount Claimable	**$0.00**	**$0.00**
18	Prop 30 SGF Amount Claimable	$0.00	$0.00
19	TOTAL SGF AMOUNT CLAIMABLE	**$0.00**	
20	TOTAL FFP AMOUNT CLAIMABLE (12A + 13B)	**$0.00**	

DMC/DMC-ODS Admin Claim Form MC 5312

Let's review a few **Key Entries**:

- **7)** Enter the county's actual costs based on your quarterly admin cost center totals & time studies
- **8)** The form calculates your *Lower Of*
- **12)** Tells DHCS what you are claiming for Medi-Cal
- **13)** Tells DHCS what you are not claiming for Medi-Cal
  - Typically, **12 + 13 = 100%**
- **16)** Administrative expenses eligible for reimbursement under the American Rescue Plan's temporary FMAP increase for Medicaid Home and Community-Based Services.
  Example: will reimburse 100% of nonfederal CM Admin Costs (line 3).

Description	MCHIP	Drug Medi-Cal Administrative Expense
1. DMC Direct Services Treatment Expenses		
2. State Prop 30		
State Prop 30 Unused		
State Prop 30 Unused		
State Prop 30 Unused		
3. Contingency Management (CM) Administrative Expenses		
4A. Federal Prop 30 - Parity. State Plan Counties only.		
4B. Federal Prop 30 - Interoperability. ODS Counties only.		
Federal Prop 30 Unused		
Federal Prop 30 Unused		
5. Maximum Admin. Percent Allowed	10.00%	15.00%
6. Maximum Admin. Dollars (Line 1 x Line 5)		
7. Actual County DMC Admin. Expenses Including Prop 30 and CM		
8. Admin. Expenses Subject to Reimbursement (lower of Line 6 or 7)		
9. FFP Percentage	0.65	50%
10. Admin FFP (Line 8 x Line 9)	0	0
11. SGF Eligible Amount (From Lines 2 and 4)		
12. Medi-Cal Discount Percentage		
13. Non - Eligible Medi-Cal		
14. Total FFP	0	
15. Total SGF	0	
16. HCBS ARP Fund (From Line 3)		

Behavioral Health Administrative Integration

It's Implications on the Future State of Administrative and UR/QA Claiming

Behavioral Health Administrative Integration

Merging into a single contract

What is Changing?

- Under CalAIM, DHCS is requiring counties to combine the administration of SMHS and SUD services into one integrated behavioral health program operated under a single **contract** with DHCS.
- DHCS will **implement integrated** claiming for **QA/UR** and **administrative** activities across the SMHS and SUD delivery systems.
- Counties will continue to separately report Prop 30–eligible expenditures within the respective claim form.

Implementation Timeline

Phase 1 (2023–2024): Voluntary integration of county functions under existing contracts.
Phase 2 (2025–2026): Voluntary integrated contracts for early adopters (effective Jan 1, 2025).
Phase 3 (2027): Statewide requirement—all counties adopt integrated contracts (per AB 133/CalAIM).

Behavioral Health Administrative Integration (cont.)

What it Means for Administrative & UR/QA Claiming

- **As of September 2025, DHCS has not yet released new integrated claim forms for counties participating in Phase 2 (2025–2026) voluntary contract integration, effective January 1, 2025**.

- Counties will continue to use the existing claim forms for QA/UR and administrative activities until DHCS issues updated forms and instructions for integrated contracts.

Existing Forms: Counties still use forms such as MC 1982B (SMHS Admin), MC 1982C (SMHS QA/UR), MC 5312 (DMC/DMC-ODS Admin), and DHCS 5311 (DMC-ODS QA/UR) for quarterly and annual claiming.

Prop 30 Allowable Claims

Requirements & Claiming Process

Prop 30 Allowable Claims

Identifying delivery systems, programs, and claiming pathways

- The following slides will take a deep dive into a range of activities that are eligible for Proposition 30 reimbursement. For each activity, we'll highlight:
  - Which delivery system is impacted (e.g., SMHS, DMC, DMC-ODS)
  - Whether the requirement is state or federally mandated
  - The correct pathway for pursuing reimbursement

Please Note: The proceeding slides do not represent an exhaustive list; there may be additional Prop 30 claimable activities out there.

This approach will help you determine the correct reimbursement pathway for new eligible program costs.

Prop 30 Allowable Claims:

Delivery System(s) SMHS, DMC-ODS & DMC State Plan

Performance Outcomes Systems (POS)

📌 Applies To: SMHS, DMC-ODS, DMC State Plan

The POS is a statewide DHCS framework for collecting, analyzing, and reporting beneficiary outcomes for Medi-Cal Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services. POS supports accountability, quality improvement, and compliance with federal and state monitoring requirements.

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
State (100% Nonfederal Share Covered)	• Hardware and software upgrades across Medi-Cal SMHS Programs (MCHIP and others) • Assessment data entry activities • POS administration activities • POS provider training activities • Time expended for skilled professional medical personnel and their direct support staff • Time expended for non-medical professionals and non-enhanced clerical staff	MHP: Administrative Claim MC 1982B Form & UR/QA Claim MC 1982C Form DMC: Quarterly Administrative MC 5312 Claim Form
References: MHSUDS IN 17-052; BHIN 23-004		

Mobile Crisis Intervention Services

📌 Applies To: SMHS, DMC-ODS, DMC State Plan

The American Rescue Plan Act (ARPA) of 2021 section 9813 allows states to add qualifying community-based mobile crisis intervention services as a covered Medicaid benefit for a five-year period, beginning April 1, 2022, and ending March 31, 2027. As such, DHCS added Community-Based Mobile Crisis Intervention Services to the State Plan to be effective on January 1, 2023. These services address behavioral health crises through a multidisciplinary mobile response team.

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
State (100% Nonfederal Share Covered)	• Time to coordinate with other Medi-Cal behavioral health delivery systems, community partners, and/or law enforcement • Time to conduct dispatch activities • Time to complete data reporting • Time to develop a mobile crisis implementation plan and other required policies and procedures • Initial face-to-face crisis assessment • Mobile crisis response • Crisis planning • Facilitation of a warm handoff • Referrals to ongoing services • Follow-up check-ins	Use HCPCS code H2011 with Place of Service (POS) code 15 MHP: Add modifier "HW" DMC: No modifier required DHCS-approved implementation plans required before claiming

References: BHIN 23-025; BHIN 23-023; Mobile-Crisis-FAQ (SMHS); Short Doyle Medi-Cal Billing Manual, Specialty Mental Health SFY 2024-2025, p. 65, 74 (SMHS); DMC-ODS Billing Manual SFY 204-2025, p. 68; DMC State Plan Billing Manual SFY 2024-2025, p. 54)

State-Only Medi-Cal Expansion Population

📌 Applies To: SMHS, DMC-ODS, DMC State Plan

The State-Only Medi-Cal Expansion Population reflects California's commitment to expanding Medi-Cal coverage to individuals with unsatisfactory immigration status, including children and youth under 19, young adults age 19-25, adults age 26-49, and older adults over age 50, who meet all other eligibility requirements. These populations are not federally eligible, and therefore their services are funded entirely with State General Fund (SGF).

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
State (100% Nonfederal Share Covered)	• Staff time for eligibility coordination and program oversight • Training for providers and staff on expansion coverage rules • Data reporting and system updates to track new beneficiaries • Utilization review and quality assurance activities tied to expansion beneficiaries • Administrative overhead for contracting, monitoring, and compliance	Claims are submitted through the SD/MC system using standard Medi-Cal rules. When the beneficiary's Aid Code signifies state-only eligibility (no federal match), costs are automatically financed by the State General Fund. No additional billing modifier is required.
References: SMHS Billing Manual May 2024, p. 63-65; Drug Medi-Cal ODS Billing Manual SFY 2024-2025; DMC State Plan Billing Manual SFY 2024-2025		

Prop 30 Allowable Claims:

Delivery System(s) SMHS & DMC-ODS

Interoperability & Patient Access Final Rule Compliance

📌 Applies To: SMHS and DMC-ODS

The CMS Interoperability Rule requires MHPs and DMC-ODS counties to implement and maintain secure, standards-based Patient Access Application Programming Interface (API) and a publicly accessible, standards-based Provider Directory API that can connect to mobile applications and are available through each plan's public-facing website. Compliance may involve adopting new software solutions and achieving technical capabilities to meet federal standards, including 42 CFR §438.242, 42 CFR §438.10, 45 CFR §170.215, and the information blocking provisions in the CMS Interoperability Rule 45 CFR Part 171.

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
Federal (50% Nonfederal Share Covered)	All direct and indirect costs the county incurs to come into compliance with this requirement may be submitted for reimbursement	MHP: Administrative Claim MC 1982B Form DMC-ODS: Quarterly Administrative MC 5312 Claim Form
References: BHIN 23-032; BHIN 22-068; DHCS-Proposition-30-Interoperability-Funds-FAQ		

Federal Medicaid Managed Care Final Rule & Parity Rule (PIHPs)

📌 Applies To: SMHS and DMC-ODS

The federal Medicaid Managed Care Final Rule (42 CFR Part 438) and the Mental Health Parity and Addiction Equity Act (MHPAEA) established new requirements for **Prepaid Inpatient Health Plans** (PIHPs), which include **MHPs** and **DMC-ODS** counties. These rules mandate compliance with beneficiary protections, access to care standards, utilization management protocols, and parity between behavioral health and physical health benefits. DHCS directed counties to implement these requirements beginning in 2016, with full compliance required across operational, reporting, and quality monitoring functions.

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
Federal (50% Nonfederal Share Covered)	The following provisions may result in increased costs for counties, including: • Hiring new employees • Redirecting existing staff time that has not been previously reimbursed by any state or federal source • Procuring new contracts to conduct new administrative and UR/QA activities • Translating written materials • Modifying information technology systems and programming necessary to ensure compliance with federal regulations • Increased document retention costs	MHP: Administrative Claim MC 1982B Form & UR/QA Claim MC 1982C Form DMC-ODS: Quarterly Administrative MC 5312 Claim Form
References: MHSUDS IN 18-012; Intergovernmental Agreement Overview of the 42 Code of Federal Regulations, Section 438		

Prop 30 Allowable Claims:

Delivery System(s) SMHS & DMC State Plan

ACA Optional Expansion Population

📌 Applies To: SMHS, DMC State Plan

The Affordable Care Act (ACA) gave states the option to expand Medi-Cal eligibility to low-income adults ages 19-64 who were previously ineligible, including adults without dependent children. In California, this expansion began in 2014 and provides full-scope Medi-Cal benefits to this population.

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
State (100% Nonfederal Share Covered)	• Only services delivered to clients with ACA aid codes	Claiming is done through specific ACA Aid Codes when billing Medi-Cal-eligible services delivered to eligible clients. Claims are submitted through the SD/MC system. Services provided to Medi-Cal beneficiaries enrolled under ACA Aid Codes are claimed without the need for an additional modifier.
References: BHIN 23-004; SMHS Billing Manual May 2024 p. 63-65; DMC State Plan Billing Manual SFY 2024-2025		

Prop 30 Allowable Claims:

Delivery System(s) SMHS

PSYCHIATRIC INPATIENT CONCURRENT REVIEW

📌 Applies To: SMHS

Psychiatric Inpatient Concurrent Review (PICR) is a utilization management process required of county Mental Health Plans (MHPs) to ensure that Medi-Cal beneficiaries receiving inpatient psychiatric care continue to meet medical necessity criteria for ongoing hospitalization. Under PICR, MHPs must review inpatient stays at regular intervals, document clinical justifications for continued services, and authorize or deny extensions of stay as appropriate. This process is designed to ensure timely discharge planning, continuity of care, and compliance with federal and state requirements for medical necessity.

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
Federal (50% Nonfederal Share Covered)	• Total cost of implementing changes to the county's Utilization Management (UM) program to meet PICR standards • Staff time for utilization review • Preparation of clinical documentation • Coordination with hospitals and community providers • Administrative oversight to ensure compliance with PICR requirements	UR/QA Claim MC 1982C Form
References: BHIN 22-017		

POS: PSC-35 & CANS ONLY

📌 Applies To: SMHS

In 2017, DHCS adopted the Pediatric Symptom Checklist (PSC-35) and the Child and Adolescent Needs and Strengths (CANS) assessment tools to measure child and youth functioning, as required by WIC §14707.5. These assessment tools are core components of the Performance Outcome Systems (POS), which is DHCS's statewide framework for collecting, analyzing, and reporting outcomes for Medi-Cal Specialty Mental Health Services (SMHS).

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
State (100% Nonfederal Share Covered)	PSC-35 and CANS costs associated with: • Training clinicians to administer CANS • Time clinicians spend in training • Time clinicians spend administering CANS • Hardware and software upgrades needed to capture PSC-35 and CANS data • Staff time entering PSC-35 and CANS data into a data system • Staff time preparing and submitting PSC-35 and CANS data to DHCS	• Administrative Claim MC 1982B Form: Provider training, data entry, POS admin • UR/QA Claim MC 1982C Form: IT updgrades
References: MHSUDS IN 17-052		

FAMILY FIRST PREVENTION SERVICES ACT - QI

📌 Applies To: SMHS

Requires a qualified individual to provide certain services to children and youth before they are placed and while they are placed in a Short-Term Residential Therapeutic Program (STRTP); and states to provide 6-months of aftercare services after a child or youth is discharged from an STRTP.

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
Federal (50% Nonfederal Share Covered)	• Mental Health Services Assessment • Mental Health Services Plan Development • Intensive Care Coordination	Use proper procedures "HV" modifier is required for State General Fund (SGF) **Other modifiers optional, but no "HV" = no SGF**
References: BHIN 21-062; CDSS and Joint BHIN 21-055; Short Doyle Medi-Cal Billing Manual Specialty Mental Health SFY 2024-2025, p. 65		

CONTINUUM OF CARE REFORM

📌 Applies To: SMHS

Continuum of Care Reform (CCR), enacted through AB 403 and subsequent legislation, was designed to transform California's foster care system by promoting home-based care and ensuring that children and youth receive services in the least restrictive, most family-like settings. For county MHPs, CCR established new requirements to participate in Child and Family Teams (CFTs), provide trauma-informed SMHS, and strengthen coordination with child welfare and probation departments. MHPs are also responsible for assessing and delivering, or arranging for the delivery of, SMHS for children and youth placed in Short-Term Residential Therapeutic Programs (STRTPs), including participation in CFT meetings when mental health treatment is needed.

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
State (100% Nonfederal Share Covered)	New cost associated with CCR requirements for MHPs, including: • Staff time for CFT participation • Provision of trauma-informed care • Coordination with partner agencies • Contracting with STRTP providers • Administrative support for CCR implementation • Mental health assessments for children prior to placement in STRTPs	"HW" modifier for CCR Excludes CFT participation and ICC/IHBS assessments (pre-Prop 30 services not reimbursable)
References: Short Doyle Medi-Cal Billing Manual, Specialty Mental Health SFY 2024-2025 p. 64; MHSUDS IN 18-017		

Behavioral Health Quality & Equity

📌 Applies To: SMHS

The Behavioral Health Quality and Equity requirements reflect California's efforts to improve accountability, transparency, and equitable access to behavioral health care within Medi-Cal. These requirements include the adoption of standardized quality measures, stratification of data by race, ethnicity, language, sexual orientation, gender identity, and other demographic factors, and the development of strategies to reduce disparities in care and outcomes. Counties must also enhance data collection, reporting, and quality improvement processes to ensure compliance with state and federal equity initiatives.

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
State (100% Nonfederal Share Covered)	Administrative activities incurred to meet these requirements, including, but not limited to: • IT upgrades • Data system modifications • Staff training • Reporting • Equity-focused quality improvement activities	MHP: Administrative Claim MC 1982B Form & UR/QA Claim MC 1982C Form
References: BHIN 24-004; MHSUDS IN 18-012; Behavioral Health Quality Improvement& Health Equity Policy Guide		

Prop 30 Allowable Claims:

Delivery System(s) DMC State Plans

Medication Assisted Treatment (MAT)

📌 Applies To: DMC State Plan

Medication for Addiction Treatment (MAT) services are a covered benefit under SPA 20-0006-A for DMC State Plan counties. Proposition 30 cost-sharing applies to new state or federal requirements imposed after September 30, 2012, that increase county costs for realigned programs. MAT services fall under this category because they were added through a State Plan Amendment after that date. However, this excludes MAT provided in a Narcotic Treatment Program (NTP) settings because NTP is a mandated level of care that existed prior to September 30, 2012.

REQUIREMENT	ELIGIBLE COSTS	CLAIMING MECHANISM
Federal (50% Nonfederal Share Covered)	• MAT services provided in outpatient or other non-NTP settings are eligible for Prop 30 cost-sharing	Use “HV” modifier on MAT services claims
References: DMC State Plan Billing Manual, July 2025 (V3)		

BEHAVIORAL HEALTH
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Q&A

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Thank You!

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