BEHAVIORAL HEALTH Fiscal Academy

CalMHSA
California Mental Health Services Authority

PRESENTED BY:
Amie Miller, *Executive Director*
Ryan Caceres, *Director of Behavioral Health Financing*

Behavioral Health Fiscal Academy

BHFA Session 7

CalMHSA

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Psychiatric Inpatient Fiscal Landscape

Funding Models, County Responsibilities, and Contracting Strategies

Ryan Caceres

Director of Behavioral Health Financing

BHFA@calmhsa.org

Learning Objectives

- Explain the concept of involuntary commitments and the county's fiscal obligations.
- Differentiate psychiatric inpatient facility types and identify key fiscal considerations for each type.
- Understand negotiation process for certain hospital facilities.
- Understand the Institutions for Mental Diseases (IMD) Exclusion and its implications.
- Psychiatric inpatient reimbursement and claiming pathways.
- Understand professional inpatient psychiatry fees.

Session Roadmap

1. Involuntary Commitment Costs
2. Inpatient Facilities: Fee-for-Service Medi-Cal (FFS/MC) Hospitals, Short-Doyle Medi-Cal (SDMC) Hospitals, Psychiatric Health Facilities (PHFs) & Department of State Hospital Facilities.
    a. Definition
    b. Contracting
    c. Rate Setting
3. The Institution for Mental Diseases (IMD) Designation
4. Mental Health Realignment Offsets as a Mechanism for funding the County's Nonfederal Share of specific Medi-Cal eligible inpatient services.
5. Receiving and Vetting Invoices From Out-of-County, Non-Contracted Inpatient Facilities
6. Professional Inpatient Psychiatry Services
7. Glossary of Behavioral Health Acute Psychiatric Inpatient Regulations & Policy Notices

Involuntary Commitments for Psychiatric Inpatient Care

CLIENT RIGHTS, HEARINGS, AND THE COUNTY'S FISCAL RESPONSIBILITIES

Involuntary Psychiatric Commitments

When a client is involuntarily committed to receiving acute psychiatric inpatient care, they have been determined to be a danger to themself, others, or as being gravely disabled.

These clients have rights under the Lanterman Petris Short (LPS) Act which include:

- **Probable Cause (PB) Hearing -** This is a legal safeguard required for individuals held involuntarily under a 5150 (72-hour hold) or 5250 (14-day hold). It ensures there is sufficient evidence ("probable cause") to justify continued detention for psychiatric treatment.
- **Riese Hearing (Medication Capacity Hearing) -** It determines whether a person on an LPS hold has the capacity to refuse psychiatric medications. If the patient is found not to have capacity, involuntary medication may be administered. Applies only when a medical professional seeks to administer medication without the patient's consent.

Senate Bill 43 (SB 43) *amended California's Lanterman-Petris-Short (LPS) Act to expand the definition of "gravely disabled." Under SB 43, a person may now meet criteria for involuntary psychiatric hold, treatment, or conservatorship exclusively due to a severe substance use disorder (SUD).*

Involuntary Commitments – Legal Costs

Legal Proceedings – Who Pays for Them?

Legal proceedings for involuntarily commitments under the LPS Act have costs incurred by the county where the proceedings are held. Let's examine a hypothetical scenario:

- County A's client is involuntarily placed in an acute psychiatric hospital in County B. County B incurs costs (such as providing a hearing attorney) to support the client's legal rights.
  - Who is ultimately responsible for funding these proceedings? County B paid for them, but is County B ultimately responsible for these costs, or should County A reimburse County B?

A county may interpret W&I Code §5110 as authorizing County B (county of placement) to pursue reimbursement from County A (county of residence) for certified hearing costs.

In the absence of a DHCS policy or information notice implementing WIC §5110, counties must collaborate to determine the best approach. When considering cross-county billing for legal fees and related costs, counties should ask:

- Will cross-billing for legal fees ultimately net out, since counties in the region all have inpatient facilities and clients frequently cross county lines for inpatient services?
- Does my neighboring county lack an inpatient facility, making the flow of clients (and costs) one-directional?

Note: *Clients may be admitted to psychiatric inpatient treatment voluntarily. The key fiscal question around voluntary admissions is whether medical necessity is met.*

Coming up!

Next, let's go over four of the most common hospital facilities you are going to encounter:

- Fee-for-Service Medi-Cal Hospitals
- Psychiatric Health Facilities
- Short-Doyle Medi-Cal Hospitals
- Department of State Hospitals

Fee-For-Service Medi-Cal Hospitals

DEFINITION, CONTRACTING, AND RATE SETTING

Fee-for-Service Medi-Cal Hospitals

Definition: Fee-For-Service (FFS)/Medi-Cal (MC) is a **payment mechanism**, not necessarily a facility classification. It refers to any hospital that provides psychiatric inpatient services to Medi-Cal beneficiaries and are reimbursed on a fee-for-service basis.

Hospitals that operate under the FFS/MC payment mechanism generally fall into two categories:

1. **Disproportionate Share Hospitals (DSH)** – A hospital that qualifies for DSH status because it serves a high volume of low-income patients, making it eligible for supplemental DSH payments from the State.
2. **Traditional Hospital** – A hospital that is not qualified as a DSH but still provides psychiatric inpatient services.

Despite being a payment mechanism, FFS/MC is the common way of referring to these facilities.

FFS/MC: Contracting Requirements

CCR §1810.430 – Contracting for Psychiatric Inpatient Hospital Service Availability:

Requires Mental Health Plans (MHPs) to contract with Disproportionate Share Hospitals (DSHs) and Traditional Hospitals that operate under the FFS/MC payment mechanism.

If an MHP chooses not to contract, it must submit a Request for Exemption to DHCS.

CCR §1820.110 – Rate Setting for Psychiatric Inpatient Hospital Services:

Establishes how per diem rates for psychiatric inpatient services are negotiated between hospitals and MHPs.

Applies to Fee-for-Service/Medi-Cal hospitals with contracts under §1810.430.

Implemented by BHIN 25-038

CCR §1820.115: *Pertains to Fee-for-Service/Medi-Cal hospitals that provide acute psychiatric inpatient services but do not have a contract with any MHP.*

FFS/MC: Rate Setting Process

Key Rules for Negotiating Rates (BHIN 25-038)

Rate Setting: The negotiated rate must be less than or equal to the lower of:

1. The hospital's usual and customary charge, meaning the regular price the hospital charges patients for a specific service as listed on its published charge schedule, or

2. The hospital's cost per day as determined by its most recently **settled or audited** CMS 2552 hospital cost report, trended forward to the rate year using the IHS Global Inc. CMS Market Basket Index for Inpatient Psychiatric Facilities (IPF) or another CMS-approved cost-of-living index.

Note: The negotiated rate covers ancillary room and board charges only and must not include professional inpatient psychiatry services (Pro fees). Pro fees follow separate claiming procedures from inpatient per diem and must be handled independently. If a county agrees to pay a hospital for Pro fees, the rate for the inpatient per diem and Pro fee must each be listed separately; the negotiated rate reported to DHCS must not be bundled to include these fees.

FFS/MC: Rate Setting Process

Comparing the Prior FFS/MC Hospital Rate Setting Process to Today

ASPECT	PRIOR METHOD (BHIN 23-034) Prior to 12/12/2023	NEW METHOD (SPA 23-0045) Effective 12/12/2023
Basis for Rate	Negotiated rates subject to DHCS requirements and limited to the regional rate caps.	Based on lower of the hospital's (1) cost per day from most recent settled CMS 2552, or (2) published charge schedule
Trending	No formal trending requirement: rates negotiated for the fiscal year	Cost trended forward from CMS 2552 FY using CMS Market Basket Index for IPFs or another CMS-approved index
Data Source	Historical rates, prior contracts, hospital proposals	Audited CMS 2552 cost report
Negotiation Limit	Rates must not exceed DHCS published limit	Rate must be lower of the trended cost/day or hospital's usual and customary charge
Reporting Requirement	Detailed in BHIN 23-034	Detailed in BHIN 25-038
Exemption Process	BHP must submit an exemption request per CCR 1810.430(c) if unable to contract	Exemption process remains aligned with 1810.430(c)

FFS/MC: Rate Setting Process (Steps 1 - 3)

A step-by-step walk theoretical walkthrough of the negotiation process

Step 1 – Request the most recently settled or audited CMS 2552 cost report from the hospital. If the hospital does not voluntarily provide the information, the county may submit a Freedom of Information Act request to CMS for the document.

Step 2 – On the CMS 2552, extract the costs related to (1) routine cost centers, (2) ancillary cost centers, (3) outpatient cost centers related to inpatient psychiatric care, and (4) identify the total days for psychiatric inpatient care to calculate the cost per day.

Step 3 – Use the CMS Market Basket for Inpatient Psychiatric Facilities to calculate the percentage increase from the fiscal year of the audited CMS 2552 to the current year being negotiated.

CMS Market Basket Index explained in detail next.

FFS/MC Rate Setting: Step 3 Deep Dive

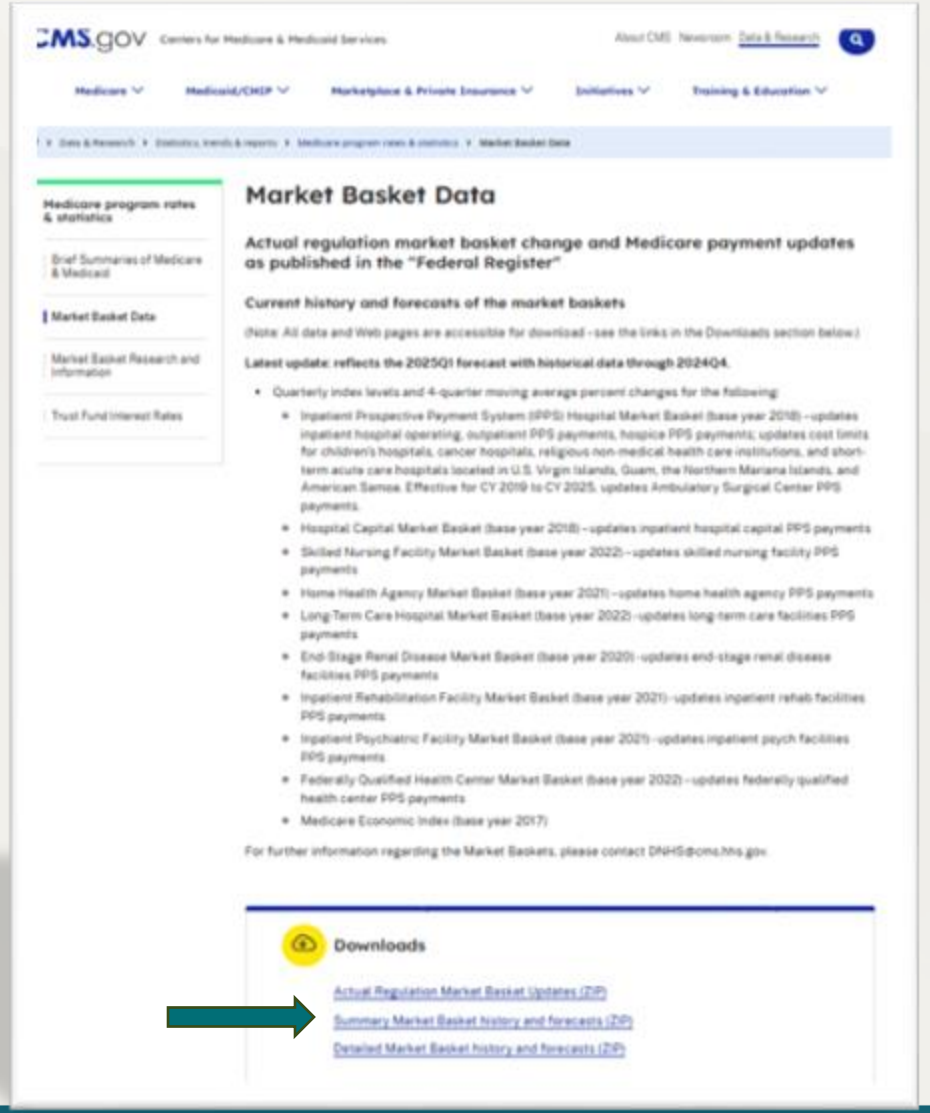
Unpacking the CMS Market Basket Index for Inpatient Psychiatric Facilities (IPF)

Step 3a - The **CMS Market Basket Index** for IPFs can be found at: **cms.gov**

Step 3b - Download the **Market Basket History and Forecasts**. This provides the quarterly cost index for Inpatient Psychiatric Facilities.

What is an Index? An index is an arbitrary reference number chosen to track cost changes over time. The initial value of the index is not important, what matters is its change between periods. The percentage change between two index points shows how costs have shifted.

- An index can start at 0, 1, or 100. The initial start is irrelevant, what matters is where it goes after it's first measurement year.



FFS/MC Rate Setting: Step 3 Deep Dive

Unpacking the CMS Market Basket Index for Inpatient Psychiatric Facilities (cont.)

Step 3c - Assume your FFS/MC hospital's audited CMS 2552 for FY 2022/23 shows a cost per day of $1,000 and you want to trend it forward to FY 2025/26.

Step 3d - Open the Market Basket History and Forecasts file to view the trend data.

Summary Web Table - CMS Market Basket Index Levels and Four-Quarter Moving Average Percent Changes *

Market Basket	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3	2023 Q4	2024 Q1	2024 Q2	2024 Q3	2024 Q4	Forecast 2025 Q1	Forecast 2025 Q2	Forecast 2025 Q3	Forecast 2025 Q4	Forecast 2026 Q1	Forecast 2026 Q2
2021-based Inpatient Psychiatric Facility:																
Index Levels	1.075	1.085	1.099	1.108	1.12	1.127	1.141	1.151	1.16	1.167	1.18	1.19	1.199	1.206	1.219	1.228
Four-Quarter Moving Average Percent Cha	5.3	5.5	5.5	5.1	4.8	4.4	4.1	3.9	3.8	3.7	3.6	3.5	3.5	3.4	3.3	3.3

Average Index	
2022/23	1.09
2023/24	1.13
2024/25	1.17
2025/26	1.21

Basis for Trending Forward			Trend
CMS 2552 Audit Year	2022/23	1.09	
Negotiation Year	2025/26	1.21	1.11

Factor to Trend Rate: 11%

Step 3e - Using this data, you can trend the rate forward from FY 2022-2023 to FY 2025-2026 by 11%, bringing the cost to $1,110.

FFS/MC: Rate Setting Process (Steps 4 - 5)

A step-by-step walk theoretical walkthrough of the negotiation process (cont.)

Step 4 - Request the hospital's published charge schedule containing usual and customary charges for each psychiatric inpatient accommodation code and age group.

Step 5 - Identify the lower of. The negotiated rate must be less than or equal to the lower of:

1. The hospital's usual and customary charge (as per their published charge schedule), or

2. The hospital's cost per day as determined by its most recently audited CMS 2552 cost report, trended to the rate year using the IHS Global Inc. CMS Market Basket Index for IPFs or another CMS-approved cost-of-living index.

FFS/MC: Rate Setting Process (Step 6)

A step-by-step walk theoretical walkthrough of the negotiation process (cont.)

Step 6 - If the calculated rate is deemed too low by the hospital and they refuse to accept it, consider the following options:

1. **Propose an alternative index -** If the IHS Global Inc. CMS Market Basket Index does not reflect the hospital's costs, submit Form MC 2024D to SDMCRates@dhcs.ca.gov with the subject line "Alternative Cost of Living Index" for DHCS review. If approved, recalculate the rate using the new index.

2. **Request DHCS Opt-Out -** If neither option is feasible and a rate cannot be negotiated; the county must request DHCS approval to opt out of the negotiation requirement. In this case, the hospital will be paid the non-negotiated regional rate set annually by DHCS.

Failure to Renegotiate Rates Per SPA 23-0045: *If your county still struggles to align hospitals with the new negotiation requirements, please know that claims past 700 days from the DOS will not be eligible for replacement.*

Short-Doyle Medi-Cal (SD/MC) Hospitals

DEFINITION, CONTRACTING, AND RATE SETTING

Short-Doyle Medi-Cal (SD/MC) Hospitals

Definition: SD/MC hospitals are facilities that provide acute psychiatric inpatient services under the Short-Doyle Act, which was integrated into Medi-Cal in the 1970s.

Historically, these hospitals were reimbursed on a cost-based methodology. Today, they are reimbursed using a state-established fee schedule, updated annually based on audited CMS 2552 cost reports. These are part of the payment reform FFS rate fee schedule.

Most SD/MC hospitals are county-operated, though some private hospitals may also participate.

Why do we have FFS/MC & SD/MC hospitals?
CBHDA recently hosted a webinar, History of Psychiatric Inpatient Hospital Services, with DHCS. Please review it for greater details.

Short-Doyle Medi-Cal (SD/MC) Hospitals List

- ✓ Santa Barbara County Psychiatric Health Facility
- ✓ San Mateo County Medical Center
- ✓ Gateways Hospital and Community Mental Health Center
- ✓ Riverside County Regional Medical Center
- ✓ Kedren Hospital and Community Mental Health Center
- ✓ Natividad Medical Center
- ✓ LAC/USC Medical Center
- ✓ Contra Costa Regional Medical Center
- ✓ Harbor/UCLA Medical Center
- ✓ Olive View/UCLA Medical Center
- ✓ San Francisco General Hospital
- ✓ Sempervirens Psychiatric Health Facility
- ✓ Ventura County Medical Center
- ✓ Santa Clara Valley Medical Center
- ✓ Alameda County Medical Center
- ✓ Arrowhead Regional Medical Center
- ✓ Rady Children Adolescent Psychiatric Services
- ✓ Mills-Peninsula Hospital
- ✓ Stanford University
- ✓ Shasta Psychiatric Hospital

Hospital list based off State Plan Amendment (SPA) #: CA-23-0045.

SD/MC Hospitals: Contracting Process

Contracting: Most SD/MC hospitals are county-operated. When privately operated, counties must ensure these hospitals meet licensing and network adequacy requirements. Contracting enables oversight, compliance, and proper Medi-Cal claiming.

- Contracting with out-of-county SD/MC hospitals is uncommon, as these facilities primarily serve their own county's clients. When it's an option, counties should rely on the host-county negotiated rate.

Rate Setting: DHCS publishes and updates the Short-Doyle Medi-Cal hospital fee schedule each year.

- For contracted facilities, counties have an interest in negotiating rates below the DHCS fee to ensure financial sustainability. The extent to which a county passes through its DHCS rate to the facility affects its ability to maximize Federal Financial Participation (FFP).

Impact of the Negotiated Rate Assumptions: DHCS Fee Schedule: $1,000 per day Federal Match (50%)	**Scenario 1:** Paying the full DHCS rate ($1,000): County Cost = $1,000 → Medi-Cal Claim = $1,000 → FFP = $500 County's Net Cost = $500
	Scenario 2: Paying 80% of the DHCS rate ($800): County Cost = $800 → Claim = $1,000 → FFP = $500 County's Net Cost = $300

SD/MC: Rate Setting Process

Final Consideration, Hospital Rates Should Include Ancillary Room & Board Charges Only

Just like FFS/MC hospitals, the negotiated rate for SD/MC hospitals covers ancillary room and board charges only and must not include the Pro fee.

If a county agrees to pay a SD/MC hospital for Pro fees, the per diem rate for inpatient care and the Pro fee rate must each be listed on separate contract lines, and the county must claim them distinctly in Short-Doyle.

There is no requirement for counties to report the negotiated rate with private SD/MC facilities to DHCS.

Psychiatric Health Facilities (PHF)

DEFINITION, CONTRACTING, AND RATE SETTING

Psychiatric Health Facilities (PHF)

Definition: PHFs provide inpatient psychiatric services and care for Medi-Cal beneficiaries.

- They are licensed by DHCS to provide medically necessary diagnosis and treatment of mental disorders.
- These facilities may be county or contractor-operated.
- PHFs are often considered to have 16 beds or fewer, however, there is no explicit licensing limit; the licensing requirements focus on staffing, services, and facility standards rather than a strict bed limit.
- PHFs are often capped at 16 beds not because of California licensing law, but because of the federal IMD exclusion tied to Medicaid reimbursement. The licensing framework is service- and staffing-based, but financing realities push programs to stick with 16 beds or fewer.

Contracting: Counties are responsible for ensuring that PHFs serving BHP members meet licensing and provider network requirements. Contracting with PHFs enables counties to oversee compliance, maintain network adequacy, and support Medi-Cal claiming.

PHF: Rate Setting Process

Negotiating Psychiatric Health Facilities Medi-Cal Rates

Rate Setting: DHCS publishes PHF rates annually on the SMHS 24-Hour Services fee schedule. (Note: fee schedule were part of Payment Reform).

- Like SD/MC facility contracts, counties aim to negotiate below the DHCS rate to maintain fiscal sustainability. Passing through or exceeding the DHCS rate impacts the county's ability to maximize FFP.

- PHFs may request rates above a county's DHCS-approved rate, especially for out-of-county placements when the host county's negotiated rate is higher.

    - Example: County A's DHCS PHF rate = $1,500; it negotiates $1,200 locally. County B's DHCS rate = $1,000, but the PHF in County A will only accept $1,200. County B may decline, but this can affect network adequacy.

Impact of the Negotiated Rate Assumptions: DHCS Fee Schedule: $1,000 per day Federal Match (50%)	**Scenario:** County agrees to pay PHF above its DHCS rate ($1,200): County Cost = $1,200 → Medi-Cal Claim = $1,000 → FFP = $500 County's Net Cost = $700 ($500 nonfederal share + $200 ineligible)

Department of State Hospitals

DEFINITION, CONTRACTING, AND RATE SETTING

DSH & CalMHSA: LPS State Hospital Placements

Acting as Counties' Administrative Agent and Liaison with the Department of State Hospitals

CalMHSA serves as the administrative agent and liaison between counties and the California Department of State Hospitals (DSH). Our role is to simplify and coordinate county access to state hospital resources by:

- **Negotiating Agreements:** Acting as the primary point of contact and lead negotiator for Memorandums of Understanding (MOUs) and bed rates on behalf of participating counties.
- **Ensuring Compliance & Coordination:** Serving as the liaison to ensure counties and DSH meet all terms and conditions outlined in agreements.
- **Exploring Local Alternatives:** Assessing the feasibility of local infrastructure projects to reduce reliance on state hospital placements.
- **Cost-Sharing Structure:** Receive an annual fee from counties to cover negotiation and administrative services.

Department of State Hospitals

Definition: Five state-operated psychiatric hospitals that provide secure inpatient treatment for individuals with severe mental illness, under forensic, Lanterman-Petris-Short (LPS), and Murphy commitments.

- **Forensic commitments** apply to individuals involved with the criminal justice system (e.g., Not Guilty by Reason of Insanity, Mentally Disordered Offender, or Incompetent to Stand Trial).
- **LPS commitments** are civil commitments under the LPS Act for individuals who, due to mental illness, are a danger to self, danger to others, or gravely disabled.
- **Murphy commitments** are specialized conservatorships for felony defendants found Incompetent to Stand Trial who also meet LPS grave disability criteria.

State hospitals provide the highest level of psychiatric care, including long-term treatment and competency restoration.

DSH has two bed types: Forensic and LPS.

Counties only fund LPS placements (including Murphy), not IST forensic placements.

DSH: Contracting & Rate Setting Process

LPS Placements in State Hospital Beds

Contracting: CalMHSA leads the development and execution of the tri-party Memorandum of Understanding (MOU) between the county, CalMHSA, and DSH. The MOU outlines responsibilities such as:

- Bed Allocation
- Admission Process
- Discharge Coordination
- Transportation Responsibilities
- Medical Records Access

In addition, CalMHSA executes separate Participation Agreements (PAs) with each county, outlining its role as administrative agent.

Rate Setting: Each county pays a daily bed rate for each occupied bed. All counties pay the same daily bed rate, established through the agreement negotiated between CalMHSA and DSH. These rates, specified in each county's MOU with DSH, are set by DSH and apply to every occupied bed. The rate structure includes three separate levels of care:

- Intermediate Care Facility (ICF)
- Acute Psychiatric Hospital (APH)
- Skilled Nursing Facility (SNF)

The IMD Exclusion

EXCLUSION CRITERIA, COUNTY RESPONSIBILITIES, AND FISCAL IMPACT

Medicaid's Institution for Mental Disease (IMD) Exclusion

Understanding County Financial Obligations for Adult Psychiatric Care

- **IMD Definition**: Under Medicaid law, an IMD is a facility with more than 16 beds primarily engaged in the diagnosis, treatment, or care of individuals with mental diseases, including medical and nursing services.

- **Medicaid Limitation**: The IMD Exclusion prohibits federal Medicaid (Medi-Cal) reimbursement for services provided to individuals ages 21–64 who are residing in an IMD.

- **County Obligation**: Under the Bronzan-McCorquodale Act, counties must fund acute psychiatric inpatient hospital services for eligible residents, including Medi-Cal beneficiaries aged 21–64, because these costs are not federally reimbursable. The Act established 1991 Realignment, dedicating sales tax and vehicle license fee revenues to counties to cover these non-reimbursable services, among other costs (e.g. community MH services, etc.)

IMD Exclusions

Inpatient Facilities Impacted

- Facilities cannot avoid the IMD Exclusion if they meet the federal definition:
  - More than 16 beds
  - Primarily engaged in mental health treatment

- **PHFs**: While often assumed to have ≤16 beds, PHF licensing does not cap bed count. If a PHF exceeds 16 beds, the IMD Exclusion applies.

- **Hospitals**: SD/MC hospitals, Disproportionate Share Hospitals, and other traditional hospitals reimbursed under FFS/MC are subject to the IMD Exclusion if they have more than 16 beds and are primarily engaged in mental health treatment.

- **State Hospitals**: Facilities operated by the Department of State Hospitals are also considered IMDs under federal law.

- **Other Facility Types**: MHRCs (Mental Health Rehabilitation Centers) and SNF (Skilled Nursing Facilities) Special Treatment Programs are also IMDs due to bed size and primary mental health treatment.

IMD Exclusions

Reading Between the Lines

A key phrase to keep in mind regarding the IMD Exclusion criteria is: "**primarily engaged in the diagnosis, treatment, or care of persons with mental diseases.**"

If a hospital consists of two distinct components—(1) general acute care beds and (2) psychiatric inpatient beds—the state will closely examine the proportion of beds to determine whether the facility is primarily engaged in psychiatric treatment.

For example, if a hospital has 70 general acute care beds and a separate unit with 30 acute psychiatric care beds, the facility is not considered primarily engaged in psychiatric treatment and can therefore avoid the IMD exclusion, even though it has more than 16 psychiatric beds.

BH-CONNECT Waiver

Unlocking FFP for IMDs

- Counties that opt into BH-CONNECT and implement ***the full suite*** of Evidence-Based Practices (EBPs) to fidelity under the new waiver gain access to federal financial participation (FFP) for IMD stays – a major shift from prior Medi-Cal claiming rules where these costs were 100% county-funded.
  - **Full suite of EBPs**: ACT/FACT, CSC, IPS, CHWs, and Peer Specialists, including forensic specialization

- Additional IMD FFP Draw Down Requirements
  - FFP is reimbursable only for short term stays: ≤60 days
  - Maintain an average length of stay that is ≤30 days for all IMD episodes claimed for FFP
  - For additional requirements, see BHIN 25-011

BEFORE BH-CONNECT

IMD costs 100% county-funded
Limited claiming flexibility
No federal match

WITH BH-CONNECT

IMD costs eligible for FFP reimbursement
Expanded claiming for EBPs and IMD stays
Shared federal-state-county funding

Inpatient Facility Medi-Cal Claiming & Funding Impact

Inpatient Facility Claiming & Funding Impact

	Psychiatric Health Facility (PHF)	Short-Doyle Medi-Cal (SD/MC) Hospital	Fee-for-Service Medi-Cal (FFS/MC) Hospital	Department of State Hospitals (DSH)	Facilities Designated as IMDs
Claiming	**Medi-Cal Clients**: Claims go through the county Short-Doyle claiming system. **Indigent/Uninsured Clients**: Not claimable through Short-Doyle; provider invoices the county.	**Medi-Cal Clients**: Claims go through the county Short-Doyle claiming system. **Indigent/Uninsured Clients**: Not claimable through Short-Doyle; provider invoices the county.	**Medi-Cal Clients**: Hospital bills Medi-Cal's Fiscal Intermediary (FI); no Short-Doyle interface. **Indigent/Uninsured Clients:** Hospital invoices the county; no Short-Doyle interface.	**Medi-Cal and Indigent/Uninsured Clients:** No SD/MC or FI claiming. Costs are settled via the SCO monthly offset to the county's Mental Health Realignment based on the County Actual Use Statement. Counties are not directly invoiced by DSH.	**Medi-Cal Clients Under 21 / 65 and older:** The IMD Exclusion does not apply. **Medi-Cal Clients 21 - 64 years old**: No FI or SD/MC claiming for the facility stay; provider invoices the county directly (DSH remains via SCO offset)
Funding Impact	**Medi-Cal Clients**: County claims FFP and covers the nonfederal share with local funds. **Indigent/Uninsured Clients**: No FFP, 100% net county cost.	**Medi-Cal Clients**: County claims FFP and covers the nonfederal share with local funds. **Indigent/Uninsured Clients**: No FFP, 100% net county cost.	**Medi-Cal Clients:** FI pays the hospital; county funds the nonfederal share, recovered monthly via SCO offset to Mental Health Realignment. **Indigent/Uninsured Clients:** No FFP, 100% net county cost.	**Medi-Cal and Indigent/Uninsured Clients:** Paid via SCO Mental Health Realignment offset; counties are charged for actual use and do not receive a direct invoice.	**Medi-Cal Clients Under 21 / 65 and older:** The IMD Exclusion does not apply. **Medi-Cal Clients 21 - 64 years old**: No federal match for the stay; 100% county cost (DSH via SCO offset; other facilities via direct invoice).

Mental Health Realignment Offsets

A Review of Mental Health Realignment Offsets

How Counites Are Charged in Real-Time

- **State Hospital Offset:** The State Controller's Office (SCO) offsets the county's Mental Health Sales Tax distribution each month based on the County Actual Use Statement.
- **Managed Care Offset**: The SCO offsets the county's Mental Health Sales Tax distribution each month to recover the nonfederal share of Medi-Cal inpatient services provided at FFS/MC hospitals.

State Controller's Office
Remittance Advice
Allocation of Local Health and Welfare Realignment, Mental Health Sales Tax
Claim Schedule: 2400512A
Issue Date: August 27, 2025
Fiscal Year: 2024-2025
Collection Period: July 16, 2025 - Aug 15, 2025

Program Gross Allocation: $93,379,252

City/County	Rate	Gross Amount	Managed Care Offset 7-17-25 through 8-16-25	State Hospital Offset July 2025	BH IGT Offset Local Revenue Fund	Total Offset	Payment Amount	Year To Date
Alameda County Treasurer	0.047018	$4,390,522	-$97,283	-$343,700	$0	-$440,983	$3,949,539	$38,914,985
Alpine County Treasurer	0.000188	$17,572	-$47	$0	$0	-$47	$17,525	$205,121
Amador County Treasurer	0.000760	$70,968	-$3,198	$0	$0	-$3,198	$67,770	$710,357

Note: We'll review how counties can reconcile the Managed Care Offset backups posted by DHCS to ensure the charges are appropriate in ***BHFA Session 9.***

Receiving and Vetting Invoices From Out-of-County, Non-Contracted Inpatient Facilities

TO PAY, OR NOT TO PAY

Receiving and Vetting Invoices

Treatment Authorization Request (TAR) Forms

Purpose of TARs in Inpatient Reimbursement

- Medical Necessity & Authorization: TARs document medical necessity and request authorization for psychiatric inpatient hospital services.

- County Review: BHPs must review all TARs (PHF, SD/MC, FFS/MC) for medical necessity, maintain decision records, and ensure reviews are conducted by licensed clinicians, either in-house (often via the Quality Division) or through contracted vendors.

- Payment Dependency: Counties should require TAR approval for providers to receive reimbursement, denied TARs indicate the hospital provided a service that failed to demonstrate medical necessity.
  - The county's fiscal analyst charged with receiving and reimbursing invoices should implement a process whereby facility invoices are reconciled against the county's TAR log. Denied inpatient days should not be reimbursed.

Determining Facility Payment

When Clients Are Placed Out-of-county At Facilities Without An Existing Contract With The Placing County

With so many acute psychiatric hospitals statewide, counties may have clients placed in facilities where they do not have an active agreement.

When the county receives an invoice for an indigent/uninsured or IMD-excluded client placed in a FFS/MC hospital and the placing county does not have a contract with the facility, the counties steps should include:

- Verify the invoice is supported by an approved TAR for the client's stay and, if so,
- Pay the hospital (1) their host county's negotiated rate, or (2) the DHCS-published regional average rate if no host county contract exists.

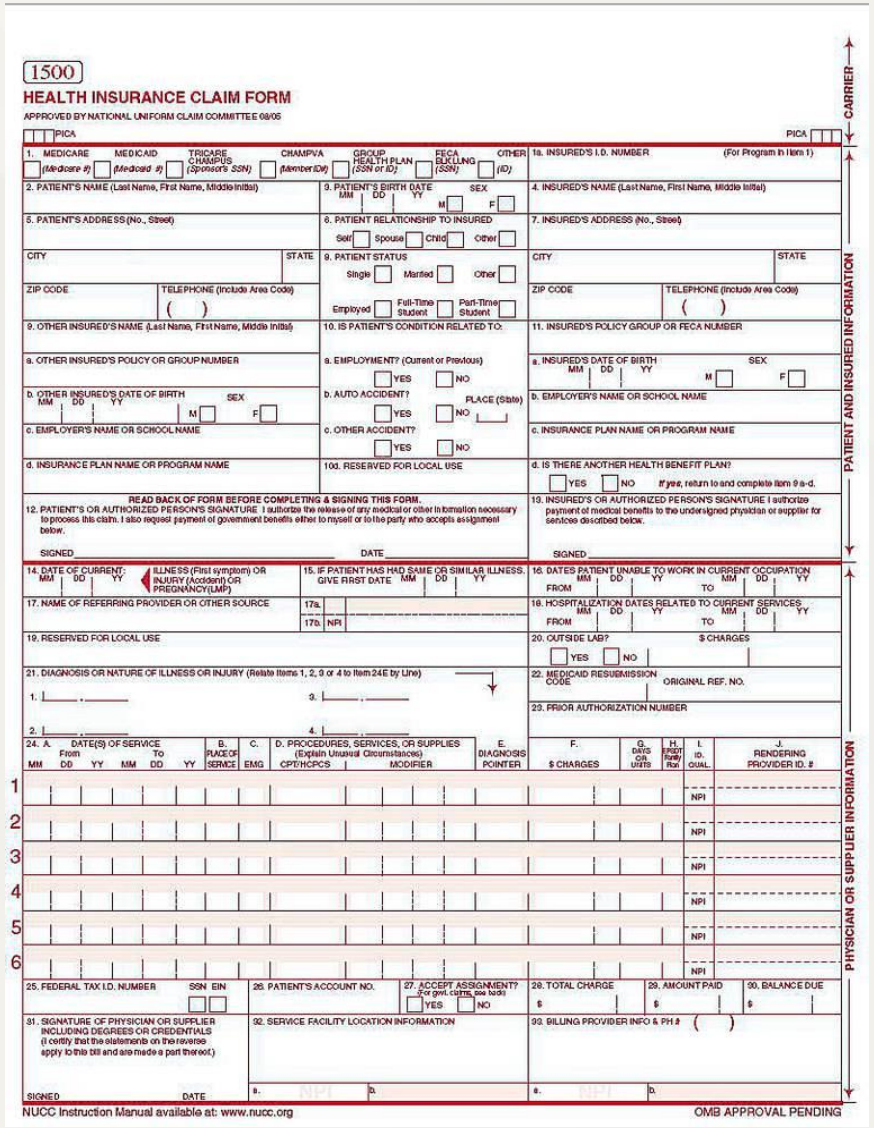
Client placements at out-of-county, non-contracted SD/MC hospitals or PHFs are uncommon because these facilities generally operate through contracts within the county's Short-Doyle system to ensure standards are maintained and the reimbursement processes are appropriately followed.

Professional Inpatient Psychiatry Services (Profees)

BILLING, CLAIM REVIEW, AND CREDETIALING REQUIREMENTS

Professional Inpatient Psychiatry Services (Profees)

- Except for Department of State Hospital placements, professional psychiatric services (“Profees”) are provided for inpatient admissions, concurrent care, and discharge.
- Profees are billed directly to the county on the CMS-1500 claim form by the hospital or its contracted provider(s).
- Professional psychiatric services must be billed separately from hospital bed and ancillary charges; all profee claims are processed through the county’s Short-Doyle system, even if the service was delivered in a FFS/MC facility.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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

9. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

OMB APPROVAL PENDING

CARRIER

PATIENT AND INSURED INFORMATION

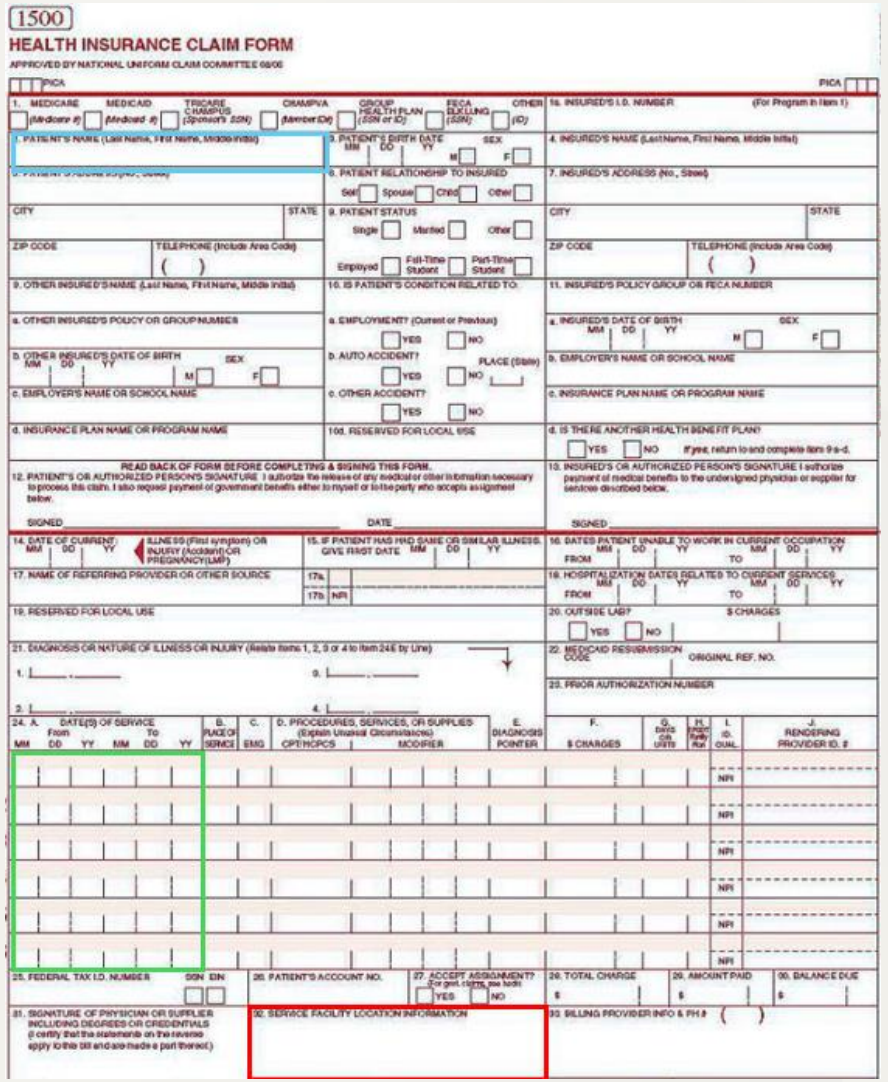
PHYSICIAN OR SUPPLIER INFORMATION

Profee Invoices: To Pay or Not To Pay

Screening the CMS-1500 involves technical checks like validating the provider NPI and ensuring all required fields are complete. In addition to these reviews, a profee invoice must be connected to an approved inpatient TAR for that invoice to be eligible for reimbursement:

- When the BHP receives a profee invoice, the following steps are essential for determining whether the service is connected to an approved TAR:
  - Review the CMS-1500 to identify the Service Facility, Dates of Service, and Client Name.
  - Reconcile these details with the county's internal TAR log.
  - Only invoices that match an approved inpatient TAR should be reimbursed. If the TAR is denied, medical necessity was not established, and the county should deny payment to the profee provider.

Approved profee claims are submitted through the Short-Doyle system. The psychiatrist discipline is the highest outpatient fee set by DHCS across counties; when reimbursing profee providers, consider your rate-setting strategy to maximize FFP.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7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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11. INSURED'S POLICY GROUP OR FECA NUMBER

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a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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										NPI
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32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

Profee and Credentialing

Out-of-Network Services and County Obligations

Counties often run into the question of whether to require the credentialing process for non-contract profee service providers prior to issuing payment.

- Based on the California Code of Regulations, Title 9, particularly §1830.220, §1810.216, §1820.225, and §1830.245, county Mental Health Plans (MHPs) are permitted to authorize out-of-network (out-of-plan) psychiatric inpatient services under specific circumstances, most notably in emergency or urgent situations, or when no contracted providers are reasonably available.

- §1830.220 defines "Out-of-Plan Services" and outlines when MHPs must authorize them, such as during emergency psychiatric admissions or when timely access to in-network providers is not feasible.

- These regulations do not explicitly require MHPs to credential out-of-network providers in the same way they must for in-network providers.

- Credentialing requirements typically apply to contracted providers under the MHP’s network, as part of ensuring quality and compliance with Medi-Cal standards.

Profee and Credentialing

MHP's Role: Authorizing, Not Credentialing

Practical Implications:

- If a psychiatrist is providing services at an out-of-network facility under an authorized out-of-plan admission, the credentialing responsibility generally falls to the facility (e.g., the hospital), not the BHP. The BHP's role is to ensure that the service is medically necessary and authorized under the applicable regulations—not to credential the individual provider.

- Some counties may choose to implement additional oversight or verification processes as part of their internal policies, even if not explicitly required by regulation.

Let’s wrap up with a review

Core concepts we've covered in the inpatient fiscal landscape:

- Major Facility Types
- Contracting Requirements
- Rate Setting Fundamentals
- Fiscal Impact Across Inpatient Facilities

What We've Learned So Far

Key Takeaways: Facilities, and Contracting

Major Facility Types

Fee-for-Service/Medi-Cal (FFS/MC): Is truly a *payment mechanism*, not a facility type. Hospital types this includes are Disproportionate Share Hospitals (DSH) and Traditional Hospitals.

Short-Doyle/Medi-Cal (SD/MC) Hospitals: Historically, cost-based, now reimbursed via a state fee schedule. Mostly county operated.

Psychiatric Health Facility (PHF): Licensed by DHCS, typically ≤16 beds, but no strict bed limit, but the # of beds impacts billing/reimbursement.

Department of State Hospitals: State-operated, secure psychiatric hospitals for individuals under forensic and LPS commitments.

Contracting Requirement

Counties must contract with their in-county hospitals that operate under the **FFS/MC** payment mechanism. Contracting/rate setting must adhere to State requirements.

Counties contract with the Department of State Hospitals **via MOU**, outlining bed allocation, admission/discharge, and rates.

Contracting with **PHFs** and **SD/MC hospitals** integrates them into the county's **Medi-Cal provider network**.

What We've Learned So Far

Key Takeaways: Rate Setting and Fiscal Impact

Rate Setting Fundamentals

FFS/MC Hospitals: Negotiated rate must be ≤ lower of hospital's usual and customary charge or trended cost per day (from audited CMS 2552 report, using CMS Market Basket Index).

SD/MC & PHF: DHCS publishes annual fee schedules. Counties may negotiate lower rates to maximize federal financial participation (FFP); negotiating higher rates is a financial risk.

DSH: Daily rates for LPS beds set by the Department of State Hospitals through negotiations with CalMHSA, counties pay for actual usage.

Fiscal Impact Across Inpatient Facilities

Claiming Pathways Vary by Facility Type:

- PHFs and SD/MC Hospitals follow similar claiming processes to other county network services, submitting claims through the SD/MC billing system, which interfaces with CA-MMIS (California Medicaid Management Information System) for Medi-Cal reimbursement.
- FFS/MC Hospital services are not claimed by the county and result in an offset from the county's MH Realignment to cover its nonfederal share.
- Disproportionate Share Hospitals (DSH) costs are always a net impact; there are no instances of federal match.

Age & IMD Status:

- The IMD Exclusion results in a tremendous fiscal impact to counties for adults 21 – 64.

Glossary of Behavioral Health Acute Psychiatric Inpatient Regulations & Policy Notices

- Following this presentation, an extensive glossary for key regulations and policy notices related to the psychiatric inpatient landscape will be made available to counties.

CalMHSA
California Mental Health Services Authority

CalMHSA.org

GLOSSARY OF KEY REGULATIONS & POLICY NOTICES FOR PSYCHITRIC INPATIENT SERVICES & FISCAL IMPLICATION

Regulation/Notice	Description & Fiscal Considerations
42 CFR § 435.1009(b)(2) (IMD Definition and Exclusion)	Defines Institutions for Mental Diseases (IMDs) and federal exclusion for Medicaid reimbursement for adults 21-64 in facilities >16 beds. Impacts county funding and eligibility for federal match. *Implemented by DHCS BHIN 22-017 and related IMD policy guidance.*
42 CFR § 456.170 & § 456.180	Requires medical evaluation and treatment plan for admission/payment for Medicaid-funded inpatient psychiatric services. *Implemented by DHCS BHIN 22-017.*
42 CFR Part 438 (CMS Managed Care Final Rule)	Sets standards for authorization, utilization management, and parity in managed care. Requires standard alignment across managed care organizations (i.e. BHPs & MCPs) to include authorization for services and utilization management (i.e. concurrent review). *Implemented by DHCS BHIN 22-017.*

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Q&A

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Thank You!

Ryan Caceres
Director of Behavioral Health Financing
BHFA@calmhsa.org

CalMHSA