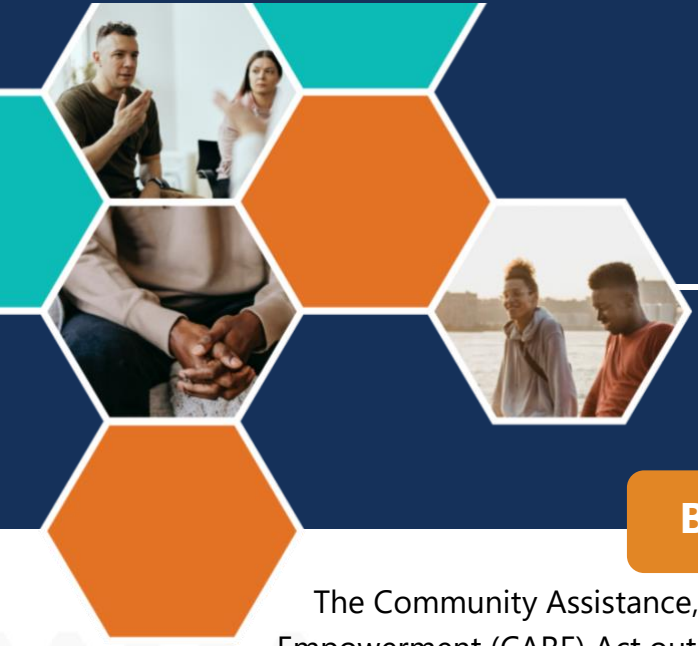


CARE Act

Community Assistance, Recovery, and Empowerment Act

Billing Health Plans for CARE Act Activities

The Community Assistance, Recovery, and Empowerment (CARE) Act outlined in **California Welfare and Institutions Code (W&I Code) sections 5970-5987** is a new civil court process that offers multiple pathways for eligible adults, promoting access to community-based behavioral health (BH) services and supports. **Eligible persons** are adult Californians living with schizophrenia spectrum or other psychotic disorders.

This brief is designed to help providers understand and implement effective strategies and processes for health plan/managed care plan (MCP) billing activities related to services and supports provided when a beneficiary is participating in the CARE process.

ADDITIONAL RESOURCES

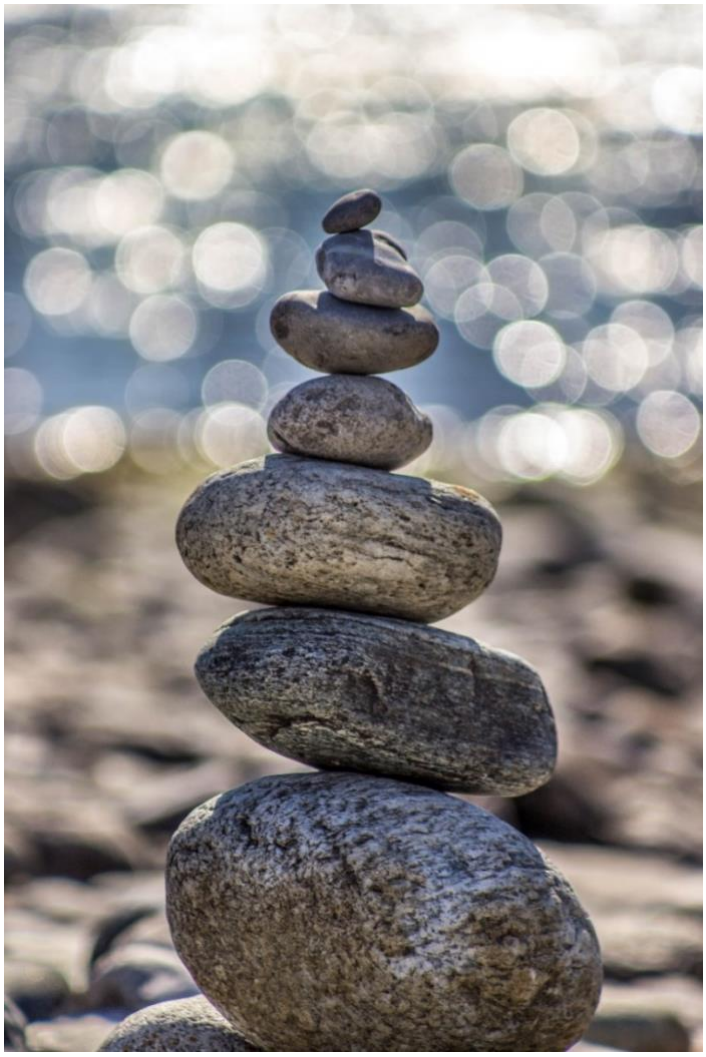
- Medi-Cal Managed Care Health Plan Directory
- Medi-Cal Managed Care Plans by County (As of 2023 and 2024)
- CalAIM Behavioral Health Initiative
- County Customer Claims Services (MedCCC) Library
- DHCS Specialty Mental Health Services Billing Manual – May 2024
- CMS Billing and Coding: Psychiatry and Psychology Services

WHERE TO START

1. As billing and reimbursement from the health plans related to CARE Act services is new and evolving, it is important to review and monitor updates to all **applicable laws, regulations, provider manuals, and bulletins** related to the CARE Act and BH billing, including the resource below.

All Plan Letter (APL) 23-016 - Implementation of SB 1338 (2022) (CARE): Pursuant to California Health and Safety Code (HSC) section 1374.723, **private/commercial insurance is required to pay for services provided pursuant to a CARE agreement or CARE plan**, whether the provider is in network or out of network and is also required to pay the Specialty Mental Health Medi-Cal rate. APL 23-016 instructs health plans to identify enrollees who are also CARE Act respondents, process claims, and ensure compliance with the CARE Act to improve access to community-based BH services, including mental health and substance use disorder (SUD) coverage. It mandates that plans must provide medically necessary treatment for BH conditions under the same terms and conditions applied to other medical conditions.

CARE Act: Billing Health Plans for CARE Act Activities



2. **Reach out to the identified CARE Act health plan contacts specific to your county** and discuss billing processes necessary to establish a reimbursement plan of CARE Act activities. Recommended topics to discuss include:
   - » Mode of alerting the health plan/MCP that this is a CARE Act billing activity.
   - » Identification of common Current Procedural Terminology (CPT) codes used for typical CARE Act activities.
   - » Claim submission options available to send claims to the MCP.
   - » Plan for regular communication with the **CARE Act health plan contacts** specific to your county.
3. When engaging with health plan/MCP CARE Act points of contact, consider **addressing key operational topics** related to credentialing, contracting, and claims submissions. These discussions will help clarify whether your organization should undergo credentialing or contracting to receive reimbursement for CARE Act services and whether you should explore alternatives such as ad hoc or single case agreements. Additionally, understanding the claims submission processes available for both contracted and non-contracted providers is crucial for ensuring timely and accurate reimbursement.
   - » Verify whether there are **credentialing and/or contracting requirements** for the organization and/or affiliated staff to receive reimbursement for CARE Act services.
   - » Confirm if **ad hoc/single case agreements** will be utilized in lieu of a contract.
   - » Identify the claim submission options that are available to contracted providers and non-contracted providers (837 claim file, direct data entry into provider portal, mailing paper claim form, etc.).

If a claim for services provided under CARE is denied, and you have exhausted the appeals process with the payer, you have the right to dispute the denial through the **Department of Managed Healthcare's Independent Medical Review & Complaint Process**.

BEST PRACTICES FOR BILLING MANAGED CARE

Timely reimbursement for CARE Act activities requires an organized approach. County BH and contracted providers can maximize their reimbursement by maintaining thorough and standardized clinical documentation, leveraging technology, and following appropriate coding and billing practices. Consider the following recommendations.

Develop Comprehensive Billing Policies

- Create clear and detailed billing policies specific to MCPs, ensuring policies comply with both state and federal regulations.
- Review payer-specific provider manuals for MCPs.

Staff Training and Education

- Provide regular training for staff on health plan/MCP billing procedures and updates.
- Offer educational resources on common billing issues and solutions.
- Provide training for clinical staff on documentation requirements for BH coding and billing.

Staff Credentials and/or Licensure

- Understand the reimbursement parameters for different clinical licensures.
- Identify whether staff have existing National Provider Identifier (NPI) numbers.

Establish Strong Relationships with Payers

- As noted above, identify the health plans/MCPs operating in your county and establish a connection with the CARE Act point of contact to become acquainted with CARE Act claiming and to determine billing mechanisms. This contact may be in the BH department of the health plan/MCP.
- Designate a county BH CARE liaison to coordinate with the MCPs who can handle queries and resolve disputes promptly.
- Establish a recurring cadence of meetings with payers to maintain a relationship for organized processing of CARE Act claims.

Documentation and Reporting of Services

- Develop standardized forms and templates to collect the required documentation for billing, and to ensure consistency and compliance.

Claims Submission

- Ensure timely and accurate submission of claims, adhering to payer-specific requirements.

Auditing and Compliance

- Conduct regular internal audits to identify and correct billing errors.
- Ensure compliance with all relevant laws, regulations, and payer contracts.

Appeals Process

- Develop a robust process for handling denied claims and appeals.
- Track and analyze denial patterns to improve future claim submissions.

Use of Technology

- Utilize electronic health record (EHR) systems and/or patient registration systems to streamline submission and collection of billing/reimbursement files and information.
- If your county is using—or plans to use—SmartCare EHR, coordinate with the California Mental Health Services Authority (CalMHSA) regarding templates to support billing for CARE Act activities. CalMHSA can be reached at **EHR@calmhsa.org**.
- Utilize systems to monitor and evaluate claims processing and use reporting functions to monitor incoming revenue from CARE Act claims.

LIST OF COMMONLY USED CPT & HSC FOR MENTAL HEALTH & SUD SERVICES

Below is a list of CPT codes that may reflect CARE Act billable activities. Consider reviewing these CPT codes to identify which codes align with the services you provide.

It's important to note that each CPT code may be defined by a unit of service, such as the length of time (i.e. 15 minutes). Some codes may have maximum time limits or a limit on number of visits allowed per day per provider. Also, reimbursement rates for CPT codes can vary based on provider type and the place of service.

CPT CODE	DESCRIPTION
90863	Pharmacological management, including prescription and review of medication, when performed with psychotherapy services
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90807	Individual psychotherapy 45–50 minutes, with medical evaluation and management services
90832	Psychotherapy, 30 minutes with the patient
90834	Psychotherapy, 45 minutes with the patient
90837	Psychotherapy, 60 minutes with the patient
90839	Psychotherapy for crisis
90846	Family psychotherapy without the patient present (50 minutes)
90847	Family psychotherapy with the patient present (50 minutes)
90853	Group psychotherapy
99201-99205	Outpatient E/M services for a new patient, with each code representing a different length of the visit
99211-99215	Outpatient E/M services for an established patient, with each code representing a different length of the visit
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician
99510	Home visit for individual, group, or family therapy
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric or projective tests, and other accumulated data for medical diagnostic purposes.

CARE Act: Billing Health Plans for CARE Act Activities

CPT CODE	DESCRIPTION
90887	Individual collateral
90889	Preparation and writing for reports of client's psychiatric status, history, treatment, or progress
H0001	Alcohol and/or drug assessment
H0046	Individual psychotherapy, face to face 0-15 minutes
H0038	Self-help/peer services (per 15 minutes)
H0049	Alcohol and/or drug screening
H2011	Crisis intervention services
H2015	Individual rehabilitation service
H2019	Therapeutic behavioral services
H2023	Supported employment
T1006	Alcohol and/or substance abuse services; family/couple counseling
T1007	Alcohol and/or substance abuse services, treatment plan development and/or modification
T1016	Case management, 15 minutes
T1017	Targeted case management, 15 minutes
98966 - 98968	Telephone assessment/management provided by a qualified non-physician health care professional to a patient, parent, or guardian, with each code representing a different length of the visit.

ADMINISTRATIVE CLAIMING

Please note there are other CARE activities conducted by the county or contracted providers that are reimbursable through the State General Funds, such as outreach and engagement, court hearing time, court reports, and data reporting.

The **CARE Act Sanctions and Claiming Process** training provides a live demonstration of submitting claims to the Department of Health Care Services (DHCS) for reimbursement of CARE Act activities and an overview of the CARE Act claiming and sanctions process. The **CARE Act Resource Center** includes frequently asked questions (FAQs) on the topic of **"Claims/Billing"**. For more information, please reference **Behavioral Health Information Notice (BHIN) 24-015 CARE Act Reimbursement Rates and Billing Guidance.** Additional questions can be directed to **CARE_Claiming@dhcs.ca.gov**.