CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

December 14, 2023

THIS LETTER SENT VIA EMAIL

County Behavioral Health Directors

SUBJECT: CalAIM Behavioral Health Payment Reform

Dear County Behavioral Health Directors:

The purpose of this letter is to provide information and support the implementation of CalAIM Behavioral Health Payment Reform.

The California Department of Health Care Services (DHCS) is committed to the success of Behavioral Health Payment Reform, which went into effect July 1, 2023. Behavioral Health Payment Reform shifts Medi-Cal specialty behavioral health payment away from Certified Public Expenditure methodologies, which are limited to costs incurred and subject to labor-intensive cost reconciliation, to fee-for-service reimbursement and Current Procedural Terminology coding. These changes are intended to facilitate alternative payment models that reward value, not volume, and better care and quality of life for Medi-Cal members.

DHCS acknowledges concerns raised by county behavioral health departments, contracted providers, and stakeholders regarding challenges that implementation partners have experienced with Behavioral Health Payment Reform. This letter reiterates fundamental obligations for county Mental Health Plans (MHPs), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Drug Medi-Cal (DMC) counties (hereafter referred to as Medi-Cal Behavioral Health Delivery Systems) that remain in effect even as Medi-Cal Behavioral Health Delivery Systems navigate significant policy and payment changes. This letter highlights key considerations and options that Medi-Cal Behavioral Health Delivery Systems and their contracted providers should consider in their efforts to resolve implementation challenges. In addition, we outline key steps that DHCS will take to support Medi-Cal Behavioral Health Delivery Systems and contracted providers to continuously improve their ongoing implementation of Behavioral Health Payment Reform and ensure member access to care throughout this critical period of transition.

I. Medi-Cal Specialty Behavioral Health Access Requirements

To support the successful implementation of Behavioral Health Payment Reform, DHCS hereby reminds Medi-Cal Behavioral Health Delivery Systems of their statutory, regulatory, and contractual requirements pertaining to member access to services. DHCS is authorized to enforce DMC State Plan, DMC-ODS and MHP compliance with applicable rules and obligations. It is the highest priority that Medi-Cal behavioral health delivery systems maintain member access to care throughout this critical period of implementation and meet their federal and state obligations as highlighted below.

Early and Periodic Screening, Diagnostic, and Treatment Mandate (EPSDT)

Medi-Cal Behavioral Health Delivery Systems are required to provide "medically necessary" services to adults over the age of 21, and to individuals under the age of 21. The provision of services shall meet the standards set forth in various regulations, including Titles 9 and 42.[1,2,3,4,5] For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan.

Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition, and are thus medically necessary and covered as EPSDT services. Medi-Cal Behavioral Health Delivery Systems must make information on "how" and "where" to access EPSDT services readily accessible to Medi-Cal members.

Intensive Services for Members Under 21 Years of Age (EPSDT Population)

As described above, behavioral health services must be offered and provided to Medi-Cal members under the age of 21 when medically necessary. Medi-Cal Behavioral Health Delivery Systems are obligated to maintain provider networks that can ensure access to covered specialty mental health and substance use services for youth. For youth with mental health needs, these services include Intensive Care Coordination,

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[1] Section 1396d(r)(5) of Title 42 of the United States Code
[2] DHCS MHP Boilerplate Contract.
[3] DHCS DMC-ODS Boilerplate Intergovernmental Agreement.
[4] DHCS DMC State Plan Contract Boilerplate.
[5] Behavioral Health Information Notice 22-003, Medi-Cal Substance Use Disorder Treatment Services for Beneficiaries under age 21.

Intensive Home-Based Services, Therapeutic Foster Care, and Therapeutic Behavioral Services in addition to other covered Specialty Mental Health Services (SMHS).[6]

For youth who need services for substance use, under the EPSDT mandate counties are obligated to provide all SUD treatment services that are coverable under 42 U.S.C. § 1396d(a)) whether or not it is covered under the Medicaid State Plan, including but not limited to covered DMC and DMC-ODS services, and regardless of whether the beneficiary under the age of 21 resides in a DMC State Plan County or a county participating in the DMC-ODS. This includes screening and early intervention services to beneficiaries under the age of 21 at risk of developing an SUD.[7]

Network Adequacy and Timely Access Requirements

MHPs and DMC-ODS are required to maintain adequate networks of behavioral health providers and ensure timely access to covered services, in compliance with federal managed care regulations and specific standards established in California law.[8,9,10] DMC counties do not maintain closed provider networks but are obligated to monitor and ensure timely access to care.[11] DHCS emphasizes that network adequacy and timely access requirements for Medi-Cal Behavioral Health Delivery Systems remain in place throughout implementation of Behavioral Health Payment Reform. DHCS will continue to enforce BH delivery system compliance with these standards and may impose administrative or financial sanctions as needed.[12]

As Behavioral Health Payment Reform implementation continues, it is imperative that Medi-Cal Behavioral Health Delivery Systems continuously monitor the adequacy of their own networks. Both Medi-Cal Behavioral Health Delivery Systems and BH providers must navigate new financial risks under the CalAIM Behavioral Health Payment Reform model. DHCS expects Medi-Cal Behavioral Health Delivery Systems to proactively communicate and collaborate with providers to mitigate the risk of service reductions, closures, or contract terminations that may threaten network adequacy and member access to care.

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[6] DHCS MHP Boilerplate Contract.
[7] DHCS, Behavioral Health Information Notice 22-003, Medi-Cal Substance Use Disorder Treatment Services for Beneficiaries under age 21.
[8] 42 CFR Parts 438.68, 438.206, and 438.207
[9] Welfare & Institutions Code (W&I) Section 14197
[10] DHCS, Behavioral Health Information Notice 23-041, 2023 Federal Network Certification Requirements for County MHPs and DMC-ODS.
[11] DHCS, Behavioral Health Information Notice 22-070 and Enclosures, Parity Requirements for Drug Medi-Cal State Plan Counties, pages 19-21.
[12] DHCS, Behavioral Health Information Notice 22-045, Enforcement Actions: Administrative and Monetary Sanctions and Contract Termination.

For detailed information on network adequacy standards and reporting requirements, and DHCS' authority to enforce these standards, Medi-Cal Behavioral Health Delivery Systems should reference their state-county contracts and the following guidance:

- BHIN 23-041: 2023 Federal Network Certification Requirements for County MHPs and DMC-ODS
- BHIN 22-070: Parity Requirements for DMC Plan Counties
- BHIN 22-045: Enforce Actions: Administrative and Monetary Sanctions and Contract Termination

Notification Requirements: Significant Change in Network

DHCS further reminds MHPs and DMC-ODS plans that they are required to report significant network changes to DHCS within 10 business days of the change.[13] DHCS defines a significant change in plan networks as any of the following:

- Any decrease of the provider network, or a specific providers capacity to serve in a service type/modality, and/or demographic;
- Changes in the composition of, or payments to the plan's provider network;
- A change in benefits; a change in geographic service area;
- Enrollment of a new population; or
- Any significant change to the behavioral health plan's (BHP's) operations that would cause the BHP to become noncompliant with any of the requirements outlined in this BHIN.

A significant change may occur because of contract terminations, suspensions, or the decertification of a network provider or subcontractor. When notified of a significant change, DHCS may follow up to assess potential impacts to member access and initiate corrective action as needed.

II. Payment Reform: Background, Goals, and Medi-Cal Behavioral Health Delivery System Rates

DHCS seeks to support Medi-Cal Behavioral Health Delivery Systems in successfully implementing CalAIM Behavioral Health Payment Reform so that Medi-Cal Behavioral Health Delivery Systems can maintain and grow their provider networks and realize CalAIM goals of improving the quality of care and well-being of Medi-Cal members. Subsequent sections of this letter summarize key background and considerations for implementation of the new model; discuss promising strategies or practices that Medi-

[13] DHCS, Behavioral Health Information Notice 23-041, 2023 Federal Network Certification Requirements for County MHPs and DMC-ODS, pages 45-46.

Cal Behavioral Health Delivery Systems may wish to explore; offer reminders on key fiscal issues; and make note of available technical assistance opportunities.

Since 2021, DHCS has engaged extensively with Medi-Cal Behavioral Health Delivery Systems to design Behavioral Health Payment Reform and develop a comprehensive approach to set ample BH delivery system rates. Appropriate financing of county Medi-Cal Behavioral Health Delivery Systems is intended to support Medi-Cal Behavioral Health Delivery Systems in developing provider rates and payment arrangements that ensure continued access to care for Medi-Cal members, enable delivery system growth, where needed and ultimately improve quality of care through alternative payment models.

Adequacy of Medi-Cal Behavioral Health Delivery System Rates

In coordination with the County Behavioral Health Directors Association (CBHDA), California Mental Health Services Authority (CalMHSA), Medi-Cal Behavioral Health Delivery Systems, and BH providers, DHCS engaged in extensive analysis and modeling to develop appropriate BH delivery system rates. DHCS produced unique rate methodologies to support the full array of covered Medi-Cal specialty BH services, inclusive of outpatient, intensive outpatient/day treatment, residential, and inpatient levels of care for SMHS and DMC/DMC-ODS. Feedback from Medi-Cal Behavioral Health Delivery Systems and providers, as well as external sources and benchmarks, indicate that BH delivery system rates are generally comparable with industry standards, and in the case of outpatient rates, may be significantly higher. Where DHCS has identified categories of rates that may be less robust, DHCS has begun to evaluate options for adjustments.

The Centers for Medicare and Medicaid Services (CMS) required DHCS to demonstrate that BH delivery system rates are “economic and efficient” to meet the local needs of the state and counties rendering services. CMS has noted that, due to certain factors included in California’s outpatient rate methodology that drove overall rates higher than historical costs, the resulting rates are “impressively high” (in some cases as much as ten times higher) compared to commercial and other governmental payers. In fact, DHCS’ outpatient rate methodology was deliberately constructed to ensure that the new rates could help address challenges associated with years of static financing methodologies (cost-based reimbursement). Medi-Cal Behavioral Health Delivery Systems and providers consistently expressed concerns that they were disadvantaged in recruiting and retaining staff over the commercial and educational market sectors due to the limitations of Medi-Cal reimbursement, and Medi-Cal Behavioral Health Delivery Systems were struggling to maintain network adequacy standards. Consequently, to

help ensure adequate payments after July 1, 2023, DHCS incorporated factors in the outpatient rate methodology that include, but are not limited to, the following:

1. DHCS developed outpatient cost surveys to gather data from counties and providers. DHCS designed the cost survey to capture an organization's total cost of doing business including required documentation and travel for field-based services, and all applicable staffing and operating costs (excluding only costs ineligible for Medi-Cal reimbursement).
2. DHCS subsequently compared salary information provided in the cost survey with aggregate Bureau of Labor Statistics (BLS) mean wage data and determined that BLS wages were higher on average. DHCS opted to use BLS data in lieu of cost survey data to represent the costs of provider wages and salaries in the outpatient rate build. This was a direct intervention to increase rates to compete with other payers in the health care sector.
3. Surveys also showed high vacancy rates among most practitioner categories. DHCS recommended and was approved to incorporate a "price elasticity of labor"[14] adjustment in the rate methodology, which increased all developed outpatient rates by 14 percent.
4. DHCS applied additional rate adjustments to ensure that rates for services provided by non-licensed paraprofessionals aligned with requirements for education, training and certification. For example, rates for peer support specialist were increased to be 105 percent of rates for "Other Qualified Providers"[15] of SMHS in counties where developed peer support specialist rates would otherwise have failed to reflect the more significant training requirements for peers. Similarly, SUD counselor rates were increased to be 105 percent of the peer support specialist rates in counties where the alcohol and drug counselor rates would otherwise have been less than 105 percent of the peer support specialist rates; this adjustment reflects credentialing requirements and the primary role of SUD counselors in delivering an array of outpatient SUD services.

Direct Patient Care Time and Fee-for-Service Payments

Notably, county and provider outpatient cost surveys included data on direct patient care time for the SMH and SUD delivery systems. On average direct patient care time for SMHS was 37 percent and SUD was 50 percent. Many responses to the survey showed extraordinarily low direct patient care time percentages, some below 10

[14] This literary source can be found on the Sage Journals website.
[15] California's Medicaid State Plan defines "Other Qualified Providers" of Specialty Mental Health Services as follows: "An individual at least 18 years of age with a high school diploma or equivalent degree plus two years of related paid or non-paid experience or related secondary education." (California State Plan, Sec. 3, Att. 3.1-A, Supp. 3).

percent. DHCS recognizes that in some cases, lower percentages of direct patient care time may result from specific service models; namely, if a provider offers many field-based services that require travel time, average direct patient care time will be lower. However, it is not clear that all low rates of direct patient care can be attributed to field-based service delivery.

Similarly, while most surveys revealed appropriate executive and administrative compensation, some surveys showed extraordinarily high costs associated with non-clinical staff. Under a strict, fee-for-service reimbursement model, providers that operate with low patient care time and high administrative costs will struggle to meet overall costs of rendering services. Counties and providers will need to partner thoughtfully to maximize appropriate claiming and devise provider reimbursement models that incentivize increases in efficiency while also supporting continued delivery of field-based services and other high-cost specialty services.

III. Medi-Cal Behavioral Health Delivery System Strategies for Success

DHCS seeks to highlight key considerations and options for county behavioral health departments and their contracted providers to consider in their efforts to continuously improve their implementation of Behavioral Health Payment Reform. Strategies counties should consider include:

Tailored or Targeted Provider Rate Design

While DHCS established county-wide rates for each outpatient practitioner type and for other types of services, DHCS neither requires nor recommends that counties adopt equivalent rate structures or reimbursements models for all of their network providers. DHCS strongly and unequivocally recommends that counties implement provider rate development strategies that incorporate adjustments, assumptions, inputs, and modifications that reflect the characteristics of providers' unique service delivery models for different types of care, and counties' contractual and legal obligations regarding access to care. Behavioral Health Payment Reform will not be successful if provider contract negotiations are limited to "one size fits all" rates that do not account for field-based and in-home service models (including Medi-Cal services pursuant to the *Katie A.* and *Emily Q.* settlements) and are not responsive to the gaps in counties' provider networks that reflect specific demographic, geographic, and clinical needs.

Critically, to avoid disincentivizing the delivery of clinically appropriate field-based services, counties should consider implementing rate differentials/enhancements that account for lower productivity standards and the travel time and costs associated with in-home services, street-based services, and services delivered in other non-clinical settings in the community. Such an approach may entail greater sensitivity and

sophistication in the rate setting methodology that permits service-specific and provider-specific adjustments. DHCS intentionally developed county rates that reflect travel time, costs, and productivity standards inherent to field-based care models, and counties should develop provider rates accordingly.

At the same time and as mentioned above, the fee-for-service payment model implemented under Behavioral Health Payment Reform may newly reveal administrative inefficiencies within provider organizations that were previously inconsequential under the prior cost-based reimbursement methodology, when such inefficiencies were reimbursed. It may be the case that, for some providers, their administrative and indirect cost rates are excessive, and their productivity rates are deficient, relative to industry standards and rates available under other payors. For example, Medi-Cal payments are not designed to cross-subsidize care provided to individuals who are not enrolled in Medi-Cal. As with any business model, providers should routinely and thoroughly assess for opportunities to reduce costs, increase revenue, and innovate. The transition from cost-based reimbursement to the fee-for-service payment model under Behavioral Health Payment Reform means this need may be especially pronounced.

Alternative Payment Models and Incentives

In addition to developing tailored rate structures that distinguish between different service types and service delivery models, counties including Los Angeles and Santa Clara have highlighted innovative incentive and alternative payment models they are developing in consultation with their network providers. Counties may wish to consider strategies like the following:

- Capacity building payments to network providers that meet programmatic targets.[16]
- Performance incentives to network providers that meet performance targets.[17]
- Rate differentials for field-based and home-based services such as Full-Service Partnerships, intensive service models for foster youth, and Short Term Residential Therapeutic Program Aftercare, including direct reimbursement of provider travel time.[18]

[16] http://publichealth.lacounty.gov/sapc/NetworkProviders/PaymentReform/032923/SAPCFY23-24CapacityBuilding.pdf

[17] Capacity building and incentive payments are consistent with Category 2A and Category 2C of the Alternative Payment Models Framework[17] established by the Health Care Payment Learning and Action Network; see https://hcp-lan.org/workproducts/apm-framework-onepager.pdf and https://hcp-lan.org/apm-framework/.

[18] Los Angeles Department of Mental Health CBO Bulletin 23-009

- Rate increases designed to attract new providers and build capacity for specific services, such as intensive outpatient or day treatment/day rehabilitation.
- Advance payments of up to 15 percent or higher of a contracted provider's estimated annual payment to mitigate risk and support cash flow during the payment model transition.[19]
- 1/12th financing, a monthly payment amount based on an annual contract amount, may serve as an interim option while providers transition to more efficient business practices.

DHCS will work with CBHDA and CalMHSA to circulate materials created by counties that describe these promising practices in additional detail.

Flexible Approaches to Provider Contracts

DHCS urges counties to achieve greater flexibility in the processes and terms used for provider agreements, procurements, and contracts to the extent necessary to maintain strong access to care. For example, counties and providers alike may benefit from more frequent rate renegotiations, more frequent contract term renegotiations, and additional flexibilities in contract terms. As counties and providers adapt to the demands of a flat fee-for-service reimbursement model, contract terms and rates should be adjusted accordingly (rather than remaining static for long periods of time). DHCS also encourages counties to consider options for increasing total contractual payment amounts in ways that incentivize direct patient care.

Intensive Provider Outreach and Engagement

DHCS strongly encourages counties to develop forums and processes to regularly engage their network providers on Behavioral Health Payment Reform implementation. Many counties do this, and DHCS has heard positive feedback in cases where counties partner closely with their network to identify challenges and implement CalAIM policies collaboratively. At minimum, counties should clearly communicate mechanisms for providers to promptly escalate rate and contract concerns to county decision-makers. Promising practices for local engagement also include consistent updates from the county to all network providers to address implementation challenges and communicate new county policies, and regular forums that enable providers to ask questions and raise concerns. DHCS' goal is to support proactive communication and problem-solving among counties and providers so that payment challenges are resolved long before concerns are brought to DHCS, or contracts are terminated.

[19] See appendix.

IV. Technical Assistance

DHCS, CalMHSA, and CBHDA have partnered to develop and distribute policy guidance, technical assistance, and incentive funding to ensure counties have the appropriate information and financial resources to implement Behavioral Health Payment Reform. BHIN 23-013 outlines documentation and resources for review and intended to guide counties in successfully implementing Behavioral Health Payment Reform. Resources include online training through CalMHSA[20] on topics such as introductions to CPT codes, Optimization of CPT codes, introduction and optimization of IGTs, Fiscal modeling and best business practices. Both counties and providers can leverage these online trainings to gain a base understanding of Behavioral Health Payment Reform.

Further supporting counties and providers, CalMHSA published a Payment Reform Impact Modeling module for counties and providers to leverage. This module includes Fiscal impact models for DMC, DMC-ODS, SMH and Provider Rate Development tools for DMC, DMC-ODS and SMHS. To augment these tools, CalMHSA and DHCS have provided individual county trainings and technical assistance.

DHCS has also provided Behavioral Health Quality Improvement[21] (BHQIP) funds to support implementation of Payment Reform. Activities incentivized include training for providers, both contracted and county employed, to implement the transition to CPT codes, and implementation of county policies and processes to shift from cost-based reimbursement to a fee-for-service financing model.

DHCS in partnership with CalMHSA and CBHDA, will continue to offer individual technical assistance to counties and their provider groups upon request. Additionally, DHCS and its association partners are actively surveying counties implementing Payment Reform to uplift best financial, contractual and business practices in the coming weeks. Please see the closing section of this letter for additional notes on future technical assistance.

V. Additional Reminders and Considerations

DHCS would also like to highlight the following reminders and considerations related to financing, claiming, and expenditures following the implementation of Behavioral Health Payment Reform:

[20] https://www.calmhsa.org/calaim-support-for-counties/#prw
[21] https://www.dhcs.ca.gov/bhqip

Delay in Claims Submission

DHCS acknowledges the complexities associated with the transition from Health care Common Procedure Coding System Level II coding to CPT coding under Payment Reform, including vendor management, Electronic Health Record development, provider training and claim submission testing. To date, 35 counties have now submitted claims for services rendered on or after July 1, 2023, to DHCS's Short-Doyle Medi-Cal claiming system, for a combined total of $146 million in approved claims. While claiming has generally increased week over week, the amount claimed under Payment Reform is only one-third of anticipated claiming.

As a reminder, DHCS negotiated a $250 million State General Fund allocation[22] to support counties as they transition from cost-based reimbursement models to a fee-for-service model. It is expected that counties claim for services as soon as possible. In the event claiming is delayed past December 15th, 2023, counties must notify DHCS of the delay reason and corrective actions the county is taking to implement claiming via email to bhpaymentrefom@dhcs.ca.gov.

DHCS is available to respond to claiming questions and support resolution of systemic challenges that counties may be experiencing. In coordination with CalMHSA and CBHDA, DHCS will be outreaching directly to counties where claiming anomalies have been identified (for example, DHCS has identified an example of underclaiming where a county is billing less than the established fee schedule rate).

Allowable Uses of Medi-Cal Payments

As a reminder, counties are permitted to use Medi-Cal patient care revenue to support a range of provider payment models and other investments in public behavioral health services. However, this revenue may not be diverted for purposes other than behavioral health-related services and activities. CalAIM statute includes the following requirements: *"The total intergovernmental transfer-funded payment amount, which includes the federal and nonfederal share, paid to a Medi-Cal behavioral health delivery system shall be for the support of behavioral health-related services and activities that benefit patients served by the Medi-Cal behavioral health delivery system, consistent with federal law."*[23]

VI. Next Steps

To conclude, we outline several actions that DHCS will take to support the successful implementation of CalAIM Behavioral Health Payment Reform and maintain member access to care.

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[22] BHIN 23-026
23 WIC Section 14184.403(c)

Compliance Monitoring and Enforcement

Medi-Cal Behavioral Health Delivery Systems are responsible for ensuring that they and their subcontractors comply with all contractual obligations[24,25, 26] and applicable state and federal laws and regulations. These requirements must be communicated by each Medi-Cal Behavioral Health Delivery Systems to all subcontractors. When a county behavioral health plan (BHP) or its subcontractors fail to meet Contractual Obligations, or fail to comply with applicable state and federal laws and regulations, or fail to comply with the state plan or approved waivers, or for good cause, DHCS may impose administrative and/or monetary sanctions.[27,28] DHCS may take any one or a combination of enforcement actions, including imposing sanctions on a BHP when the BHP fails to comply with contractual obligations or applicable state and federal laws and regulations or fails comply with the state plan or approved waivers, or for good cause.[29,30]

In particular and as noted above, DHCS may reach out to follow up on reports of provider closures, near closures, or contract terminations to discuss next steps with the Medi-Cal behavioral health delivery system, provide technical assistance, and to determine whether a significant change has occurred, which would significantly impact the Medi-Cal behavioral health delivery system's operations and would cause the Medi-Cal behavioral health delivery system to be out of compliance with any of the requirements outlined in BHIN 22-070 and BHIN 23-041.[31, 32] Medi-Cal behavioral health delivery systems may be required to provide a CAP to DHCS and demonstrate how they will come into compliance with requirements. BHPs found out of compliance

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[24] DHCS MHP Boilerplate Contract
[25] DHCS DMC-ODS Boilerplate Intergovernmental Agreement.
[26] DHCS DMC State Plan Contract Boilerplate.
[27] W&I Code section 14197.7,
[28] DHCS, Behavioral Health Information Notice 22-045, Enforcement Actions: Administrative and Monetary Sanctions and Contract Termination.
[29] Pursuant to subdivision (b) of W&I Code section 14197.7, DHCS "may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits, investigations, contract compliance reviews, quality improvement system monitoring, routine monitoring, facility site surveys, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, …."
[30] W&I Code section 14197.7(d); W&I Code section 14197.7(e); 42 CFR section 438.700; 42 CFR section 438.702(b)
[31] DHCS, Behavioral Health Information Notice 22-070, Parity Requirements for Drug Medi-Cal State Plan Counties.
[32] DHCS, Behavioral Health Information Notice 23-041, 2023 Federal Network Certification Requirements for County MHPs and DMC-ODS, pages 45-46.

with network adequacy requirements are subject to administrative and/or monetary sanctions.[33]

Technical Assistance

DHCS is actively exploring opportunities to provide additional, targeted technical assistance to support Medi-Cal Behavioral Health Delivery Systems and providers with Behavioral Health Payment Reform implementation. Potential focus areas for technical assistance include fiscal modeling, rate setting, benchmarks and ranges for productivity standards, administrative and indirect cost optimization, and fact-finding on root causes of provider risk. Please email BHPaymentReform@dhcs.ca.gov to suggest additional types of technical assistance from DHCS that would be most valuable.

Continued Touchpoints

Above all, DHCS is committed to sustaining continued and intensive dialogue with Medi-Cal Behavioral Health Delivery Systems, providers, and key stakeholders to support the success of Behavioral Health Payment Reform. We will continue to prioritize this initiative in our discussions with implementation partners and stakeholders, with the goal of continuously monitoring the status, trends, and impact of Behavioral Health Payment Reform on the Medi-Cal specialty behavioral health delivery system. We ask that you keep us apprised of the challenges you face during this initial stage of implementation. In addition, we ask that you keep us informed about your ongoing progress, innovative methods, and strategies to resolve challenges so that we can diffuse and scale your successful approaches.

Sincerely,

Original signed by

Tyler Sadwith
Deputy Director, Behavioral Health
Department of Health Care Services

[33] DHCS, Behavioral Health Information Notice 22-045, Enforcement Actions: Administrative and Monetary Sanctions and Contract Termination.