CHCF

Managing California's Behavioral Health System

County Contracting Strategies

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About the Author

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About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Executive Summary

California is experiencing a transformational shift in its behavioral health system as a result of federal and state-level policy reforms and substantial new investments and requirements. These changes, including the CalAIM (California Advancing and Innovating Medi-Cal) initiative, bring new responsibilities for the state's 58 counties, which manage and deliver specialty mental health and substance use disorder services under Medi-Cal. As part of this evolving landscape, counties are expected to comply with an array of new Medi-Cal requirements for managed care operations, quality measurement performance, data reporting, member service functions, and expanded access to care. In recent years, federal managed care regulations have introduced an array of new requirements that have expanded counties' administrative responsibilities.[1] Navigating these demands while ensuring core coverage, coordination, and care delivery functions for enrollees presents challenges for counties, particularly those with fewer resources.

Contracting arrangements, either with third-party entities or through intergovernmental partnerships, present an opportunity to collectively address these challenges, bolster counties' capacity, facilitate resource sharing, and achieve economies of scale. Under existing California law, counties may act jointly to deliver or subcontract for the delivery of specialty mental health and substance use disorder services, with appropriate approvals. The California Department of Health Care Services (DHCS) has acknowledged this flexibility for counties and included Behavioral Health Regional Contracting in its CalAIM initiative. Although a specific timeline for implementation is not identified, CalAIM encourages counties, particularly those smaller and more rural, to develop multicounty or regional approaches to administer and deliver specialty behavioral health services to Medi-Cal enrollees. DHCS seeks input from county partners and stakeholders to explore potential pathways for adopting contracting arrangements and has committed to working with counties to offer technical assistance for developing regional contracts and establishing innovative partnerships.[2]

This paper explores options for improved administration and delivery of specialty mental health and substance use disorder services in California, focusing on how counties can leverage contracting arrangements to most effectively and efficiently meet managed care responsibilities. It aims to identify viable contracting and intergovernmental agreement models and to highlight operational, legal, and fiscal considerations that may impact uptake of these models across counties with diverse needs. Aurrera Health Group, in partnership with the California Health Care Foundation, conducted comprehensive research, legal analysis, and stakeholder interviews with county representatives, Medi-Cal managed care plans, health services entities, associations, state officials, and experts from both California and other states. Findings from this work are summarized in the paper, along with strategic considerations for stakeholders navigating this transition in California's evolving behavioral health system. For more information about how the findings described in this paper were informed, see Appendix A.

Key Findings

- **Counties face significant challenges in navigating an array of new state policies and managed care responsibilities.** Workforce shortages, limited resources, and demand for behavioral health services strain counties' ability to manage specialty mental health and substance use disorder services. The simultaneous rollout of major state and federal behavioral health reforms and increased managed care responsibilities has made it challenging for some counties, especially smaller and more rural ones, to meet certain new requirements.

- **Contracting and intergovernmental arrangements can help mitigate county challenges and improve efficiencies.** Counties acting jointly to pool resources and expertise can create efficiencies and economies of scale, particularly for low-volume services or in counties with limited staffing or administrative capacity. Under existing law, counties — acting either individually or jointly — can enter into arrangements with third-party entities and leverage contractor experience and existing infrastructure to manage certain administrative processes or service delivery functions or both to meet managed care requirements.
- **The viability and success of contracting and intergovernmental arrangements depend on unique county dynamics, contracting terms, and governance models.** County geography, resources, and the dynamics of working with local authorities and stakeholders can impact the feasibility of contracting arrangements. Although contracting can relieve certain administrative or service delivery burdens or both, counties vary in their capacity to oversee contracting arrangements and willingness to assume risk or cede decisionmaking authority to outside entities. Prepackaged or "off-the-shelf" solutions can also help less resourced counties engage in contracting arrangements by reducing the staff time and resources necessary to participate. To establish and maintain efficient arrangements, counties can consider competitive procurement processes, a detailed statement of work, clear processes for modifying contract terms, and inclusion of performance measures. Moreover, counties operating jointly can benefit from having an independent governing board or third-party entity facilitate decisionmaking and leveraging mechanisms like memoranda of understanding (MOUs) to clarify expectations and roles for member counties.
- **State-county collaboration is critical to advancing contracting approaches and addressing challenges.** Coordinated engagement between the state and counties can help establish processes and flexibilities that recognize the unique structure of various contracting and intergovernmental models. This may include enabling contractors to interact directly with the state and receive and share data to improve coordination and workflows and more fully realize potential efficiencies under existing legal and policy parameters. State-county collaboration can also help address broader county and state capacity challenges by enhancing understanding of challenges, illuminating opportunities to align and streamline requirements, and enabling tailored technical assistance and support that better recognizes county variation. Coordination can also help identify areas where additional state resources could help counties meet managed care requirements while still fulfilling their core coverage, coordination, and care delivery functions.

Background

In California, specialty mental health and substance use disorder (SUD) services are carved out of the state's Medi-Cal comprehensive managed care program, which covers physical health and non-specialty behavioral health benefits. Carved-out specialty mental health services are administered through county-based managed care plans. The majority of Medi-Cal enrollees (96%) reside in counties that participate in the Drug Medi-Cal Organized Delivery System (DMC-ODS). In these counties, specialty SUD services are also administered through county-based managed care plans. In counties that have not elected to participate in the DMC-ODS, carved-out specialty SUD services are administered through a county-based fee-for-service program (DMC only).

Counties, alongside local community partners, have a long history of administering and providing behavioral health services, beginning with the delivery of community mental health services in 1957 after

the passage of the Short-Doyle Act that provided state funding for local mental health programs.[3] Over time, state and federal policies have reshaped and expanded the county role in the provision of both mental health and SUD services. In 1980, the state established the Drug Medi-Cal (DMC) program under which counties administer and deliver SUD treatment services to eligible Medi-Cal enrollees through contracts with state-certified providers.[4] In 1995, the state created a single program for the administration and delivery of both inpatient and outpatient Medi-Cal specialty mental health services through county mental health plans (MHPs).[5] In 1991 and 2011, shifts in fiscal and program responsibilities between the state and counties, known as realignments, allocated additional dedicated tax revenues for public behavioral health services and expanded the county role in delivering, administering, and paying for Medi-Cal specialty mental health and SUD services.[6]

Medi-Cal managed care plans (MCPs) became responsible for management of non-specialty mental health services for all Medi-Cal enrollees in 2014. These services were historically covered under the state's fee-for-service program, and the shift to managed care created a new dynamic and associated requirements for coordination between counties and MCPs.[7] In 2015, the state obtained federal Medicaid Section 1115 waiver approval to launch the Drug Medi-Cal Organized Delivery System pilot program. Under DMC-ODS, counties can voluntarily implement a separate managed care plan contract with the state to expand the SUD service benefit (DMC) for Medi-Cal enrollees and enact additional administrative requirements intended to increase access, utilization, and quality of SUD treatment services coordinated with other systems of care.[8]

At the federal level, the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 mandates parity between physical and behavioral health care delivery systems to ensure that the financial processes and treatment limitations applied to mental health and SUD benefits are no more restrictive than those applied to physical health care benefits.[9] The Centers for Medicare & Medicaid Services (CMS) released its Medicaid Managed Care Final Rule in 2016, which introduced new requirements for managed care plans, including county behavioral health plans, and aimed to improve quality of care, establish more comprehensive enrollee protections, and strengthen program integrity.[10] Although the 2016 Final Rule does not apply to county DMC-only programs, the state has since applied several managed care requirements for those counties as a means of achieving compliance with federal parity law.[11] CMS released further Final Rule guidance in 2024 that imposes additional requirements for managed care plans aimed at further enhancing and streamlining reporting, monitoring, and evaluation of access to behavioral health services for Medi-Cal enrollees.[12]

Medi-Cal Managed Care

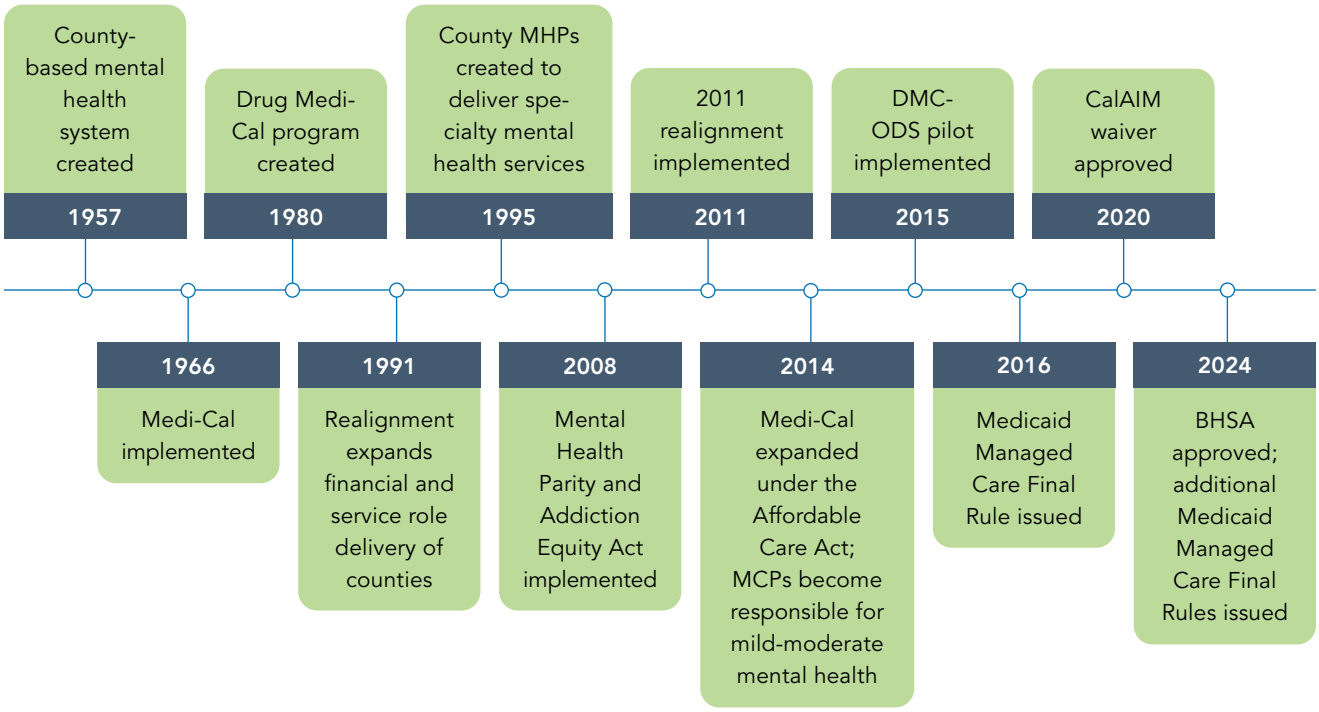
California contracts with Medi-Cal MCPs throughout the state to deliver covered health care services to Medi-Cal enrollees. MCPs are responsible for delivering non-specialty mental health services to Medi-Cal enrollees, and must coordinate screening and referral to county MHP, DMC, or DMC-ODS programs for enrollees that meet criteria for specialty mental health or SUD services or both. County MHPs and DMC or DMC-ODS programs are responsible for delivering specialty mental health and SUD services to enrollees with significant behavioral health needs. As county behavioral health plans, MHPs and DMC-ODS programs, like MCPs, must comply with federal and state Medi-Cal managed care requirements related to network adequacy, timely access to services, care coordination, and quality assurance and improvement. This dual-delivery system also requires collaboration, information sharing, and administrative oversight between MCPs and county behavioral health plans to coordinate care for enrollees.

In 2020, DHCS launched its CalAIM (California Advancing and Innovating Medi-Cal) initiative, a multiyear effort to improve outcomes for Medi-Cal enrollees through comprehensive delivery system, program, and payment reforms. Key CalAIM initiatives such as clinical documentation redesign and behavioral health payment reform require significant changes in the way county behavioral health plans operate.[13] Under CalAIM, counties must coordinate more closely with MCPs to support care for high-need enrollees through the implementation of standardized screening and transition tools for enrollees seeking mental health services, new memoranda of understanding requirements, and Enhanced Care Management and Community Supports services.[14] Additionally, through behavioral health administrative integration, CalAIM requires counties to integrate their existing MHP and DMC or DMC-ODS contracts into a single behavioral health plan contract by 2027. Notably, the CalAIM proposal that DHCS released in 2021 encouraged counties to consider multicounty or regional approaches for delivering specialty mental health services and highlights the potential benefits for small counties, rural/frontier counties, and counties with shared population centers or complementary resources. Other benefits of regional or multicounty approaches highlighted in the proposal include improved administrative efficiency and increased access to services for enrollees as counties pool resources and invest in administrative infrastructure, greater ability to meet network adequacy and other managed care requirements through reduced administrative burden, and the potential for counties not currently participating in DMC-ODS to do so through a regional approach.

In March 2024, Californians voted in favor of Proposition 1, a ballot measure to implement the Behavioral Health Services Act and the Behavioral Health Infrastructure Bond Act, which were passed by the California legislature in September 2023. Proposition 1 will require counties to adopt enhanced behavioral health planning and oversight processes that account for all services and sources of behavioral health funding in order to increase transparency and improve outcomes.[15] Taken together, these shifts reflect a broader transformation of California's behavioral health carve-out that has continually increased the scope of managed care responsibilities for counties.

Navigating the implementation of an array of new state policies and increasing managed care responsibilities while continuing to ensure high-quality care for enrollees presents challenges for counties. **Contracting and intergovernmental arrangements, including those across multiple counties, are one potential avenue for counties to address these challenges and improve the delivery of behavioral health services.** There are existing pathways for counties to adopt innovative contracting structures as well as various models already operating in the state. For example, in 1969 Sutter and Yuba counties collaborated to establish an arrangement under joint powers authority (JPA) to deliver specialty mental health and SUD services as a single entity across the two counties, known as Sutter-Yuba Behavioral Health.[16] The California Mental Health Services Authority (CalMHSA) is another example of a JPA and was formed by counties in 2009 to pool resources and collaboratively address behavioral health issues at the county level.[17] Some counties have executed contracts with third-party entities such as administrative services organizations (ASOs) or third-party administrators (TPAs) to manage certain administrative functions. For example, since 1997 San Diego County has contracted with an ASO to manage several administrative responsibilities that have supported the county to create system efficiencies and to achieve compliance with evolving managed care requirements.[18] In addition, certain counties in California also participate in regional or multicounty models, though not exclusively for behavioral health services. The County Medical Services Program (CMSP), for

Figure 1. Significant Federal and State Behavioral Health Policy Initiatives



Sources: "Major Milestones: 43 Years of Care and Treatment of the Mentally Ill," California Legislative Analyst's Office, March 2, 2000; *A Complex Case: Public Mental Health Delivery and Financing in California*, California Health Care Foundation (CHCF), July 2013; *Medi-Cal and Behavioral Health Services*, CHCF, February 2019; "The Mental Health Parity and Addiction Equity Act (MHPAEA)," US Centers for Medicare & Medicaid Services (CMS), last modified 2023; "Substance Use Disorder Treatment Services," California Dept. of Health Care Services (DHCS); "CalAIM Behavioral Health Initiative," DHCS; "Medicaid and CHIP Managed Care Final Rules," CMS, 2024; and "Passage of Proposition 1 Paves Way for Further Behavioral Health Transformation in California," DHCS, March 21, 2024.

example, provides health coverage for uninsured low-income, indigent adults in 35 counties.[19] More recently and specific to behavioral health services, seven small and medium-size counties in Northern California, including those with rural geographies, formed a Regional Model to jointly administer DMC-ODS services through an arrangement with Partnership HealthPlan of California (PHC).[20] This joint arrangement enabled participating Regional Model counties to expand SUD services for eligible Medi-Cal enrollees beyond those required under the existing DMC program. Further information on these contracting approaches and associated considerations are provided in the findings section below. Also, other states have experience with various behavioral health contracting approaches that may offer insights for California. Detailed information on contracting models employed by other states is available in Appendix C.

Findings

Through research, legal analysis, and stakeholder discussions, the authors identified four central findings around the challenges and opportunities for California county behavioral health plans in enhancing efficiencies, access, and quality for specialty mental health and SUD services across the state. For details about the legal parameters under which counties can develop various contracting models and intergovernmental arrangements, see Appendix B.

Counties Face Significant Challenges in Navigating an Array of New State Policies and Managed Care Responsibilities

Across California, counties are struggling with workforce shortages, limited resources, and significant demand for behavioral health services that make the provision of specialty mental health and SUD services challenging.[21] Workforce and resource limitations are particularly acute in small and rural counties, where it can be difficult to recruit and retain behavioral health providers and skilled county administrators.[22] These challenges, coupled with an array of new state and federal policies and enhanced managed care responsibilities, strain county capacity.

As the state is advancing several comprehensive behavioral health reforms, counties are simultaneously implementing large system transitions, including shifting from cost-based to fee-for-service reimbursement, integrating administration and streamlining clinical documentation for mental health and SUD services, and adapting processes for screening and transitioning enrollees with behavioral health needs. Also, as managed care responsibilities grow, counties are facing new administrative requirements related to network adequacy, availability of services, timely access, enrollee rights, and quality measurement and improvement.[23] The confluence of these initiatives and requirements has come with a high volume of policy guidance from the state (e.g., behavioral health information notices) and increasing expectations for counties to quickly come into full compliance. New administrative demands also impact how counties function in their traditional role of care delivery. Capacity limitations and competing priorities make it more challenging for counties to focus on the provision of services and to be responsive to community needs.

Contracting and Intergovernmental Arrangements Can Help Mitigate County Challenges and Improve Efficiencies

Existing California law provides flexibility for counties to develop contracting or intergovernmental agreements to support management and delivery of Medi-Cal behavioral health services. There are two primary pathways for counties that wish to enter such arrangements. One option is for multiple counties to jointly operate as a single Medi-Cal behavioral health delivery system that serves an entire region under a single contract with the state, such as through the formation of a JPA. Under this type of JPA arrangement, member counties participate in JPA governance but are not directly or individually contracted with the state for the functions rendered by the JPA. As a county government entity, the JPA would have the authority and obligation to act on behalf of its members. A second option is for counties to maintain their individual county responsibilities as separate Medi-Cal behavioral health delivery systems and independently or jointly delegate certain administrative or service delivery functions to a qualified contractor, such as a Medi-Cal MCP, administrative services organization (ASO), third-party administrator (TPA), or other county or governmental entity. For example, such arrangements may involve counties contracting individually with an entity that provides similar services to other counties, or multiple counties jointly selecting a contractor. Under these subcontracting models, each county would remain under direct contract with the state and be responsible for contractor oversight to ensure compliance with state and federal managed care requirements.

Through the CalAIM proposal, DHCS has encouraged counties to develop these kinds of multicounty or regional approaches to support efficient management and delivery of behavioral health services and to achieve compliance with state and federal managed care requirements around network adequacy,

quality oversight and improvement, enrollee rights and protections, and program integrity.[24] See Appendix B for more information on the various contracting models that counties may pursue and their associated authorities and legal parameters.

Joint county action, including through regional models and JPAs, allows for pooling of resources and expertise that can create efficiencies. Counties acting jointly may develop a unified staffing structure, share provider networks and contracts, invest in shared infrastructure, and consolidate Medi-Cal financing and reimbursement processes. Joint contracts may be used to delegate select administrative functions or the delivery of certain services or both, allowing counties to collectively leverage contractor experience and existing infrastructure rather than counties individually organizing and staffing their own internal systems. Depending on the goals of joint county arrangements, careful consideration of unique county factors such as patient volume, service type and utilization, and available service channels (in-person, telehealth, etc.) is valuable when designing potential joint contracting solutions. For example, four counties in Northern California use a shared contractor to deliver after-hours access line services for enrollees. This arrangement has brought economies of scale where each individual county would have otherwise used dedicated staff and administrative resources for a low-volume service.

Joint county arrangements can also foster shared strategies, resources, and tools that can be leveraged when capacity or expertise in a particular area is limited. CalMHSA, established under a JPA arrangement, plays an important role in creating and coordinating these types of opportunities across counties. For example, CalMHSA helps translate state enrollee-facing materials into other languages for use across counties; has coordinated with 26 counties to implement a semi-statewide electronic health record (EHR) to support behavioral health data collection, sharing, and reporting; and has contracted with a vendor to perform concurrent review and authorization for psychiatric inpatient hospital and psychiatric health facilities on behalf of participating counties.[25]

Contracting arrangements with third-party entities (e.g., ASOs, TPAs, MCPs) can also be helpful in filling gaps in staffing and expertise within county behavioral health systems. Contractors may be particularly valuable in supporting certain managed care and administrative functions including credentialing, facilitating contracts with providers, claims processing, and reporting, and can help counties adapt to changing state requirements and policies. The DMC-ODS Regional Model with PHC and seven small and medium-size Northern California counties, which went live in 2020, is an example of counties organizing regionally and delegating managed care responsibilities — including administrative functions, enrollment, care coordination, network adequacy, and billing — to a contractor (in this case, a Medi-Cal managed care plan). Although this arrangement has enabled these counties to pool resources and expertise to produce efficiencies in these areas, certain challenges persist around communication and delegation structures between the county, contractor, and the state that can hinder the objectives of the model. For example, there are limitations around contractors' ability to directly communicate or share data with the state on behalf of counties despite the regional nature of the arrangement. Despite these challenges, the Regional Model has allowed counties that would have been unable to implement the optional benefit on their own to pool resources and leverage external infrastructure and expertise to provide expanded SUD services to enrollees.

Counties can also contract independently with third-party entities to create efficiencies and address gaps in capacity and expertise. For example, since 1997 San Diego County has contracted with an ASO to

support a range of administrative functions, including managing access and crisis lines, conducting utilization management reporting, providing EHR help desk support and provider training, and managing the fee-for-service provider network, including functions related to provider enrollment, credentialing, contracting, and payment. These types of individual county arrangements can support efficient operations, compliance with state and federal requirements, and flexibility to adapt to changing policies but may be cost prohibitive for smaller, less resourced counties due to high fees and the level of monitoring necessary to ensure success.

Viability and Success of Contracting and Intergovernmental Arrangements Depend on Unique County Dynamics, Contracting Terms, and Governance Models

Unique County Dynamics

Counties have varied capacity and willingness to enter into contracting and intergovernmental arrangements. Larger, well-resourced counties, for example, are generally better able to dedicate the time and staff necessary to take on new contracting arrangements. However, these counties may face unique bureaucratic challenges and be less inclined to participate in multicounty or regional arrangements to achieve economies of scale, particularly if they involve bearing risk for other counties. Small and rural counties often have fewer resources and would benefit from joint contracting approaches but may find the initial costs to engage prohibitive.

Regardless of county capacity, contracting arrangements may be limited in the extent to which they can solve for network adequacy and access challenges in counties with large geographies and low patient volume. Moreover, although counties are expected to meet increased managed care requirements, county structures and decisionmaking authorities can present challenges to contracting and intergovernmental arrangements. County leadership, including county counsels and boards of supervisors, must be briefed on and approve decisions to alter county funding, service delivery, or administrative structures, including whether and in what manner to enter into contracting arrangements with other counties or third-party entities. Working through these local processes and political dynamics under existing governance and financing structures can be difficult, time-consuming, and may ultimately upend what may be a preferred path forward at the county agency level. Decisions may be influenced by a desire to retain independence and local control and hesitancy to relinquish certain responsibilities or to assume risk for other counties. Dynamics related to organized labor and other powerful stakeholder interests can also influence decisionmaking.

Beyond the resources and consensus building needed to initiate a contracting or intergovernmental arrangement, establishing and managing contracts require considerable staff time and administrative resources. The contract development process, including negotiating and setting terms for the contract, may be particularly time-consuming for multicounty or regional models, where a variety of perspectives must be considered. For example, initial county conversations to establish the DMC-ODS Regional Model began as early as 2013 and counties, PHC, and DHCS met frequently during the implementation process to determine how to delegate responsibilities ahead of the pilot program's launch in 2015.[26]

Once executed, ongoing management of contracts also requires significant staff resources to continuously monitor contracts and ensure compliance with federal and state program requirements. Playing an active role in contractor activities is also critical to ensuring alignment with county objectives, leveraging local perspective and expertise, and building an effective partnership. In deciding whether to

enter into contracting arrangements, counties must consider the costs and benefits associated with developing and managing a new contract versus building new capacities internally. For some counties, particularly smaller and rural counties, there may be substantial benefits to bringing in external contractors to fill capacity gaps, but those same capacity gaps may make it untenable to execute and oversee contracts.

Given the significant resource and time commitments involved with the development, implementation, and oversight of certain contracting and intergovernmental arrangements, prepackaged or "off-the-shelf" solutions that do not require the same level of commitment may enable less resourced counties to participate. These types of solutions include customizable templates and tools (e.g., requests for proposals or contract boilerplates) counties can use to support solicitation, procurement, and oversight of contractors. For example, CalMHSA has developed a Performance Improvement Plan template for county use to support activities required by the state under CalAIM's Behavioral Health Quality Improvement Program.[27] Off-the-shelf solutions can also include more direct administrative and management functions, such as CalMHSA's contract with a vendor to perform provider credentialing and oversight functions on behalf of select participating counties. Using this contract reduces the burden on counties to perform the functions that would be necessary to enter into the contract directly.[28] There is significant opportunity to learn from and leverage existing county experience. For example, experience in San Diego County and others that have successfully leveraged ASOs to perform a variety of functions could help inform procurement approaches and contract development in other counties. Counties could also work with consultants to develop solutions and products.

State Approaches That Recognize Unique County Dynamics

Pennsylvania is an example of a state that has taken steps to address unique county needs and dynamics in its behavioral health delivery system. In Pennsylvania, counties are required to contract with Behavioral Health Managed Care Organizations (BH-MCOs) to manage Medicaid-covered mental health and SUD services. To improve efficiencies across small counties, those with fewer than 10,000 Medicaid enrollees must partner with other counties to jointly contract with BH-MCOs and deliver specialty mental health and SUD services as a single entity. Conversely, state flexibilities have permitted Philadelphia County, the most populous county in the state, to establish its own BH-MCO without any requirements to partner with other entities. Washington State has also offered certain flexibilities and incentives for counties through recent integration of their physical and behavioral health delivery systems. Specifically, the state allowed the most populous county, King County, to retain oversight and coordination of behavioral health services and required MCOs to contract with it under its existing system. The state also offered incentive dollars and technical assistance to counties and providers to promote early implementation of the integrated system. For additional detail on Pennsylvania's and Washington's models, see Appendix C.

Contracting Terms and Governance

When contracting with third-party entities to execute administrative functions, counties can consider several strategies to establish and maintain efficient arrangements. A competitive procurement process that includes a detailed statement of work can be used to solicit qualified contractors with specific subject matter expertise and specialized experience, including working with public sector clients. Competitive procurement also allows for negotiation to refine expectations and define contract terms. During negotiations, it is helpful to consider

the structures necessary to ensure consistent coordination, communication, and performance monitoring throughout the duration of the contract. This may include defining clear and specific objectives and performance measures and establishing certain operational or financial structures, such as an incentive payment structure tied to specific performance measures. Codifying processes for updating and modifying contract terms within the contract is also helpful in addressing emerging issues, such as implementing new managed care requirements.

Counties operating jointly can benefit from designating a governing body or third-party entity that operates independently and can facilitate decisionmaking that serves all parties while considering diverse county perspectives and priorities. Similarly, it is important to consider how individual counties will be represented within the arrangement (e.g., voting powers, board chairs) to ensure that all counties' voices are heard and that no single county dominates policymaking or is saddled with disproportionate responsibilities. Although not specific to Medi-Cal behavioral health services, the California CMSP, whose governing board functions as the sole decisionmaking authority for the program, offers one example of a structure that has succeeded in facilitating decisions across many member counties.[29] The CMSP governing board is a separate entity that holds individual contracts with each member county. The 10 county officials on the governing board have equal voting authority.[30] CMSP member counties are broken into three groups based on population size, and each group has at least one representative on the governing board to ensure each county's concerns are heard. In addition to governance structure, mechanisms like MOUs can help clarify expectations for member counties and ensure accountability. Relationship building and consistent communication channels to develop trust across participating counties are also essential to the long-term success of these models.

Governing Bodies for Multicounty Arrangements

In Michigan, state statute lays out requirements for the composition and duties of Community Mental Health Services Boards, which govern the state's 46 Community Mental Health Services Programs (CMHSPs).[31]

CMHSPs may be a single county agency or an authority made up of multiple counties. Each CMHSP has a 12-member Community Mental Health Services Board composed of providers, mental health professionals, consumers, and public officials. Board members are appointed by local county boards of commissioners and serve three-year terms. Membership is proportional to county population, and each county has at least one member to ensure that the service needs of all member counties are considered. One-third of board members must be mental health consumers or family members, and no more than four members can be county commissioners, with exceptions for boards representing five or more counties (which may also have more than 12 members). For additional detail on Michigan's model, see Appendix C.

State-County Collaboration Is Critical to Advancing Contracting Approaches and Addressing Challenges

Close collaboration and support from the state is essential to strengthen existing contracting and intergovernmental arrangements and to encourage increased participation in new models. DHCS, as the state agency responsible for ensuring compliance with federal Medicaid law and regulations, is ultimately responsibility for ensuring counties adhere to Medi-Cal requirements regardless of their contracting approach. Increased collaboration between the state and counties, as well as with contractors, can help advance models that meet enrollee needs, support compliance activities, and ensure that

decisionmaking across all parties is aligned toward common objectives. Collaboration can also help inform streamlined processes and flexibilities, such as the use of shared templates that require only one approval or joint audits for counties involved in multicounty models, that support multicounty arrangements by recognizing their unique structure and easing the burden of the individual counties. Flexibilities and tailored approaches may be especially important for small and rural counties to address specific financial, capacity, and geographic challenges. Because of the integral role that contractors play in many of these arrangements, processes that allow them to interact directly with the state, participate in meetings, and receive and share data may help improve coordination and workflows wherever feasible and legally permissible. Although counties ultimately maintain responsibility over delegated functions as the entities holding Medi-Cal contracts, increased flexibility in state processes for interacting with contractors could increase the benefit of these arrangements and encourage counties to seek out partnerships that can fill gaps in expertise and improve quality of care. For example, recent state-county collaboration around the development and testing of network adequacy certification processes and data tools has enabled more direct engagement between the state and third-party contractors to best leverage their technical and subject matter expertise.

More coordinated, collaborative engagement between the state and counties could also help address broader state and county capacity challenges associated with the simultaneous rollout of multiple behavioral health reforms by enhancing understanding of issues on the ground, identifying opportunities to adapt requirements, and enabling tailored support. Although the state continues to provide technical assistance on new initiatives, the substantial nature of the shifts in county systems and operations may require closer partnership and strategies that recognize county variation, such as developing strengths-based approaches to meeting community behavioral health needs in rural counties and providing personalized technical assistance. For example, there may be opportunities for the state to support counties to maximize existing federal financial participation dollars through claiming for quality improvement and administrative activities. The state could also pursue data infrastructure improvements that allow counties to more easily access and use information needed both to assess the relative costs and benefits of certain contracting or intergovernmental models and to manage those arrangements over time. Also, increased funding could ensure that counties have the resources and personnel necessary to stand up or enhance the financial, data collection, and other reporting systems required to meet administrative requirements. Given ongoing workforce challenges, state funding could also help counties fill gaps by hiring internally or contracting out for necessary expertise.

Looking Forward

Contracting and intergovernmental arrangements that leverage the strengths of counties and third-party contractors have the potential to improve management of specialty mental health and SUD services in California. However, advancing contracting solutions will require collaboration, commitment, and creativity from the state, counties, and other stakeholders. Findings from this report highlight the many factors that may influence development of these arrangements and offer considerations for stakeholders. Although flexibility and willingness from all stakeholders to proactively engage will be important to the success of these models, there are also several targeted opportunities that may help bolster participation and long-term sustainability. Specific pathways include the following:

- **Using state authority to encourage or require development of multicounty arrangements** that

consolidate administrative and operational functions for specialty mental health and SUD services across counties, particularly those that manage services for a small number of Medi-Cal enrollees (e.g., <10,000), and establishing policy frameworks that treat participating counties as a single entity for claiming, reporting, and oversight.[32]

- **Focusing attention and resources on opportunities for multicounty contracting and intergovernmental agreements through existing state initiatives**, such as CalAIM behavioral health administrative integration and the proposed Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration. Examples include creating a dedicated workgroup of small and rural counties to identify opportunities for multicounty models as part of broader integration efforts and providing financial incentives for counties to adopt contracting models according to certain standards.
- **Establishing efficient communication and data sharing pathways between third-party contractors and the state** to enable contractors to most effectively fulfill managed care obligations on behalf of counties, when possible and legally permissible, as opposed to counties directly performing certain functions even with a subcontract. State guidance, similar to that which was recently released about CalAIM data sharing authorization, may be helpful in clarifying the allowable circumstances while emphasizing the need for counties to maintain oversight over contractors' delegated functions.[33] Further, the state could consider revising existing delegation requirements to increase flexibility and efficiencies.
- **Providing targeted technical assistance** (e.g., toolkits, webinars) to educate counties and other stakeholders on contracting models, including information on associated legal parameters, governance structures, opportunities, and risks. In areas where the state role may be more limited, such as developing template contracts and helping with contract development and oversight at the county level, other organizations may be able to offer technical supports to counties. Technical assistance could also allow counties to hear directly from those participating in current models, such as the DMC-ODS regional arrangement with Partnership HealthPlan.

Appendix A. Methods

The California Health Care Foundation (CHCF), in partnership with Aurrera Health Group, launched this project to explore options for improved administration and delivery of specialty mental health and SUD services in California, with a focus on how counties can most effectively and efficiently meet managed care responsibilities. The project sought to identify promising contracting models for Medi-Cal behavioral health services based on assessment of county needs and associated operational, legal, and resource considerations. Multiple modalities for information gathering were leveraged, including the following:

- **Research and literature review** to understand challenges and opportunities for more efficient management of specialty behavioral health services in California and across counties
- **Legal and policy analysis** to identify feasible pathways and legal parameters for potential contracting arrangements in California
- **Interviews** with key stakeholders, including counties, MCPs, health services organizations, county associations, state officials, and other state and national experts, to explore on-the-ground operations, policies, and political considerations

The stakeholders interviewed for this project represent diverse perspectives from across California and in other states; however, the project did not capture the perspective of every county or every type of stakeholder. Further, although the project examined several potential contracting structures that may serve as options for stakeholders in California, other possible viable models were not explored through this work. Findings from the project are intended to inform ongoing efforts across stakeholders in California to identify and address challenges in the management and delivery of specialty mental health and SUD services.

Appendix B. Overview of Contracting Models and Legal Parameters

Counties have significant flexibility under California law to develop contracting or partnership models to help further the delivery of behavioral health services. Thus, counties traditionally have the option of acting independently to contract for administrative services with a wide range of entities, including private companies (e.g., ASOs, TPAs), Medi-Cal MCPs, other counties, and other government entities. The two options identified below include structures where multiple counties agree to work together to jointly serve as a Medi-Cal behavioral health delivery system, or where each individual county retains its role as a Medi-Cal behavioral health delivery system but delegates some administrative functions to a qualified contractor that furnishes similar services to other counties. Under the latter option, counties seeking to increase operational efficiencies may coordinate in the selection of a single entity, or each may look to contract with entities also providing services to other counties.

Joint Contracting with Medi-Cal to Serve as a Behavioral Health Delivery System

Overview

The highest form of regional coordination among counties would be the establishment of joint responsibility for the delivery and financing of behavioral health services. This type of coordination has long been contemplated under state law, which authorizes the state to award behavioral health plan contracts to "counties acting jointly" or, with regard to DMC and DMC-ODS, through "a consortium of counties in a regional model." (See Welf. & Inst. Code §§ 14712, 14124.21, and 14184.401[b].) If a county sets up such a joint model or consortium, the Medi-Cal program could issue a single behavioral health delivery system contract that covers an entire region, allowing the contracted entity to do one or more of the following: create a single network,

establish uniform policies, consolidate reporting and oversight obligations. Although this option is typically conceptualized for increasing collaboration among counties in the same region, counties may pursue joint responsibility for delivering and financing behavioral health services irrespective of location.

To set up a joint Regional Model, the participants may form a "joint powers agreement" under which multiple counties (or other public agencies) agree to jointly exercise powers they hold in common (Cal. Gov. Code § 6502). The scope of joint powers agreements is broad, and powers common to counties or county behavioral health departments include those necessary to fulfill the responsibility to arrange for behavioral health services for Medi-Cal and indigent populations, including the ability to contract with the Medi-Cal program as well as with vendors, network providers, and other third parties.

Although counties may exercise powers jointly without creating a new, independent agency or "authority," California's Joint Exercise of Powers Act also authorizes counties to create such independent entities relatively simply. Creating a new joint powers authority (JPA) may offer significant advantages for a regional behavioral health delivery system, as the JPA would be able to enter into contracts in its own name, employ agents and employees, and hold and dispose of property (Cal. Gov. Code § 6508). The ability to exercise powers independently may help consolidate county functions, simplify contracting with providers and vendors, and improve branding and outreach.

General Requirements

An agreement to exercise powers jointly or form a JPA requires no additional legislation or voter approval. An initial step is the negotiation and execution of a joint powers agreement between the forming public agencies that sets forth the purpose of the arrangement or the power to be exercised and how this purpose will be accomplished or in which the power will be exercised (Cal. Gov. Code § 6503). A joint powers agreement concerning a regional behavioral health delivery system would be expected to address a variety of topics, including contracting or development of networks of providers; processes for administration and oversight; financing of the obligations of the behavioral health delivery system, including the provision of the nonfederal share of Medi-Cal payments; applicable governance and decisionmaking; and responsibilities and expectations for member counties. The joint powers agreement would need to be authorized by each of the participants' governing bodies (e.g., county boards of supervisors) (Cal. Gov. Code § 6502).

To form a new JPA responsible for the administration of the joint powers agreement, notices must be filed with the California Secretary of State and with the local agency formation commission in each participant county within 30 days after the effective date of the agreement (Cal. Gov. Code §§ 6503.5 and 6305.6). In addition, the treasurer of one of the authorizing counties (or another mutually acceptable certified public accountant) would be designated to have custody of the money of the joint powers authority and can receive money and pay money for the entity (Cal. Gov. Code § 6503.5). State law requires strict accountability for all funds and report of all receipts and disbursements for a joint powers authority or agreement (Cal. Gov. Code § 6505). Debts, liabilities, and obligations of the joint powers authority are considered debts, liabilities, and obligations of the parties to the agreement (Cal. Gov. Code § 6508.1).

Once properly established, a JPA can enter into a Medi-Cal behavioral health delivery system contract with the state and would have the same status and rights under such a contract as any other mental health plan (MHP) or DMC/DMC-ODS plan,

including the ability to file reports and appeals. The participant counties would remain liable for the actions of the JPA but would not otherwise be directly or individually contracted with the Medi-Cal program for the functions administered by the JPA.

Other Considerations

To use a JPA to create a regional behavioral health delivery system, the participating counties would need to develop processes to financially support the new JPA, which may include the provision of the nonfederal share of Medicaid expenditures. Counties may use their realignment and CalMHSA funding to support the JPA. The JPA would also be expected to retain for its use any Medicaid revenue it receives. The California Supreme Court has affirmed the power of local governments to contribute funds for a joint purpose when the funds will be used outside the territorial limits of the contributing entity.[34] However, counties may wish to develop processes to allocate relative financial costs among the participating entities.

Subcontracting Models by Current Behavioral Health Delivery Systems

Overview

If counties do not wish to create a regional Medi-Cal behavioral health delivery system, a variety of other contracting structures to delegate a portion of their Medi-Cal behavioral health administrative responsibilities could promote system efficiencies and improve compliance with state and federal requirements. Acting individually, a county may delegate responsibilities under its existing MHP and DMC or DMC-ODS contracts to a qualified subcontractor, including an ASO, TPA, or existing Medi-Cal managed care plan. Such a subcontractor may work with only one specific county or may gain operational efficiencies by working with multiple counties of a similar type (e.g., similarities based on geography, size, or demographics). Counties may pursue such operational efficiencies by coordinating with other counties to enter into subcontracts with the same third-party entity or, acting independently, seeking out and contracting with such experienced entities. These contracts could be with private or public entities. Although private entities may have more flexibility and lower costs than public agencies, county procurement requirements are likely to apply. In contrast, procurement requirements may at times be waived when contracting with other public entities.

Under these subcontracting models, each county would remain under direct contract with the state. However, if multiple counties contracted or delegated to the same entity, they could achieve some of the efficiencies and consistency of a regional plan while retaining greater individual control over the scope of delegation.

One potential model for counties interested in subcontracting to a public entity to expand or consolidate certain functions in a region would be to create a JPA as described above for fulfilling those specific functions. Under that model, each county participating in the JPA would retain its contract with the Medi-Cal program but would also subcontract with the JPA to have the JPA fulfill certain functions — network development, cost reporting, claims processing, utilization review, etc. This approach could lead to the centralization of county expertise within the region while retaining authority for the individual counties to establish via contract the scope of services performed by the JPA and the financial and other terms.[35] As discussed below, use of a JPA (rather than a private entity) does not require a formal procurement process and may also allow counties to shift some of their own staff and resources to the JPA.

General Requirements Applicable to Subcontractors

Federal law provides broad opportunity to delegate Medi-Cal managed care plan functions to a subcontractor, as long as the plan maintains ultimate responsibility for the subcontractor's performance and the subcontractor fulfills the requirements of applicable regulations. (See 42 C.F.R. §§ 438.230 and 438.3[k].) This authority is incorporated into Medi-Cal behavioral health delivery system contracts. (See *July 1, 2022–July 1, 2027 Drug Medi-Cal Organized Delivery System [DMC-ODS] Contract* [PDF],[36] [hereafter "DMC-ODS contract"], Exhibit A, Attachment I §§ II.B.1.vi and II.E.8; and *July 1, 2022–June 30, 2027 Mental Health Plan Contract [with Peer Support Service]* [PDF],[37] [hereafter "MHP Contract"], Exhibit A — Attachment 1 §§ 3 and 4.) In general, counties must hold subcontractors to at least the standards the counties would be subject to if they were performing the function directly and should set out in writing the scope of delegated activities or obligations and the subcontractor's agreement to perform them in compliance with those standards. Subcontractors should also anticipate that their books and records may be subject to audit and evaluation and that they can be required to submit information about their ownership and control.

Other Considerations

DHCS Prior Approval May Be Required

Boilerplate special terms and conditions added by DHCS to federally funded service contracts and grant agreements, including the behavioral health delivery system contracts, establish additional requirements related to subcontracts, including a requirement for the department to provide prior written authorization of any subcontract of more than $5,000. (See DHCS Exhibit D[F], [hereafter "DHCS Special Terms and Conditions"], § 5.) This provision is expressly waived in the MHP contracts but not the DMC-ODS contracts. (See MHP Contract, Exhibit A — Attachment 1 § 4.A.) As a result, a county would need to reach out to DHCS for prior written approval of subcontractors (or written approval from DHCS waiving its right to such approval) if its executed DMC-ODS contract includes boilerplate provisions in the DHCS Special Terms and Conditions that include this provision. DHCS has released a template version of the 2022–23 DMC contract, but a county's executed contract should also be reviewed carefully to determine if there are any approval requirements for subcontracts.[38] These requirements may change due to CalAIM behavioral health administrative integration. In that process, DHCS–county contracts will be combined into a single, integrated contract including both specialty mental health services and SUD program services by 2027.

Procurement Requirements

Also potentially applicable are requirements for subcontracts to be subject to open procurement. The DHCS Special Terms and Conditions require that, in general, contractors seeking subcontracts exceeding $5,000 must obtain at least three bids or justify a sole source award (DHCS Special Terms and Conditions § 5.a). A number of exceptions to this requirement exist, including if the subcontractor is a local governmental entity or a JPA.

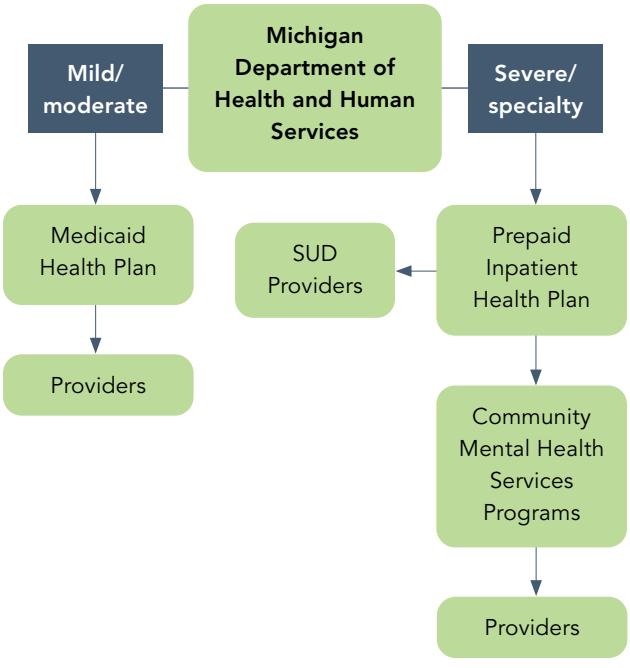
Appendix C. Other State Models

Other states have established models for the delivery and administration of carved-out mental health and SUD services that may offer lessons for California. Although not identical to California's, other states' experience with regional management of behavioral health services can provide insight about factors for success and common challenges. For example, state leadership has played a key role in other states, both to clarify expectations and roles for distinct entities and to define transition terms for new models, including through efforts to integrate physical and behavioral health delivery systems. States have also provided financial incentives and technical assistance to encourage adoption of new arrangements and used phased implementation to help mitigate transition challenges and to enable lessons from early adopters. Other state models also demonstrate the value of flexible approaches to account for uniquely situated counties, including small and rural counties as well as highly populous counties.

Michigan

The Michigan Department of Health and Human Services oversees 46 local Community Mental Health Services Programs (CMHSPs) responsible for coordinating and administering specialty behavioral health services under Medicaid, either in-house or via contracted providers.[39] CMHSPs are public, county-based entities that may be a single county agency or an authority made up of multiple counties. Each CMHSP is connected to a Medicaid Prepaid Inpatient Health Plan (PIHP), which administers capitated funds, bears risk, and manages member care. PIHPs also manage federal substance use block grant and local substance use funding. There are currently 10 PIHPs statewide, seven of which contract with affiliations of four to 12 CMHSPs. Affiliations of multiple CMHSPs were formed to increase administrative efficiency and fiscal management. Medicaid funds are allocated to PIHPs based on the number of Medicaid enrollees in the PIHP service area, and PIHPs pay doctors, hospitals, and providers directly. Providers include CMHSPs themselves as well as community-based providers under contract with a CMHSP. PIHPs are governed by the CMHSPs in their region, which appoint members to the PIHP board of directors. In 2014, the number of PIHPs was reduced from 18 to 10 to create regional PIHPs (with the exception of Macomb, Oakland, and Wayne Counties, the three most populous counties in the state).[40] Even with these changes, many PIHPs struggle with persistent budgetary deficits, and the state faces capacity challenges in monitoring PIHP and CMHSP contracts.[41] The complexity of the state's multilevel behavioral health system also created inefficiencies and challenges in navigating care, especially for those with both physical and behavioral health needs. However, previous efforts to integrate physical and behavioral health care in the state, including

Figure C1. Michigan Behavioral Health System Financing/Contracting Structure



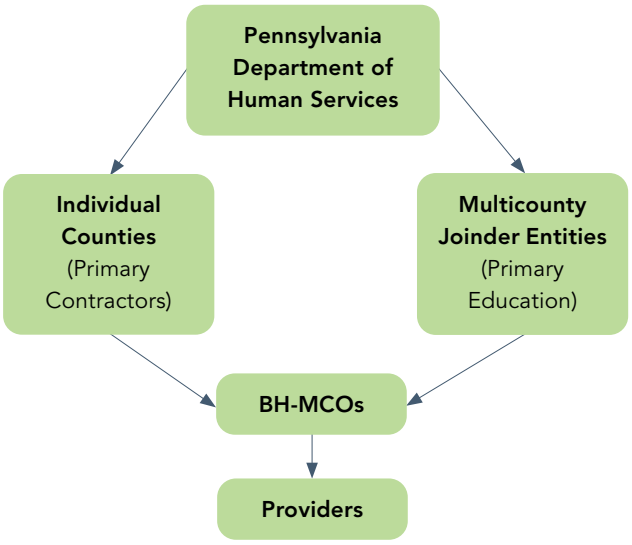
Source: *Description of the Current Financing System for Behavioral Health Services* (PDF), Michigan Dept. of Health & Human Services, 2017.

the Section 298 initiative that sought to transition management of the community mental health system to MHPs, have stalled despite years of discussion between stakeholders.[42]

Pennsylvania

Pennsylvania has carved the full spectrum of Medicaid mental health and SUD services out of managed care since 1997, and counties have the "right of first opportunity" to manage these services internally or to contract with a Behavioral Health Managed Care Organization (BH-MCO). Counties, either individually or as multicounty joinder entities, serve as "primary contractors" and use a competitive procurement process to contract with one of the five BH-MCOs in the state.[43] BH-MCOs manage mental health and SUD services regionally via contracted provider networks, while counties oversee BH-MCOs to ensure Medicaid mental health and SUD service requirements are met and to facilitate effective coordination with other services, including physical health care. Delegation of services and functions varies by county or joinder entity, and BH-MCOs may enter into risk-based or administrative services only agreements with primary contractors.[44] As required by state regulations, counties with fewer than 10,000 Medicaid members must partner with other counties through a joinder entity.[45] Smaller counties that participate in joinder entities benefit from pooled resources and may be better equipped to handle unexpected expenditures or regulatory changes, although larger, more resourced counties typically have greater influence in these arrangements, given their level of investment. Joinder entities are represented by administrative oversight entities that BH-MCOs contract and work with directly on behalf of the joinder counties. Philadelphia County, the most populous county in the state, established its own BH-MCO and does not partner with other entities. For financing, primary contractors establish per-member per-month (PMPM) reimbursement rates for BH-MCOs that

Figure C2. Pennsylvania Behavioral Health System Financing/Contracting Structure



Source: *Medical Assistance Capitation Funding for Drug and Alcohol Treatment Providers within the Commonwealth* (PDF), Joint State Government Commission of the General Assembly of the Commonwealth of Pennsylvania, June 2023.

cover medical spend and administrative costs and are based on state-allocated PMPM reimbursement rates, which vary by primary contractor based on member characteristics such as age and eligibility category. Rates are set annually by the state, and primary contractors use BH-MCO contract renewals to renegotiate rates and make adjustments to the base contract. BH-MCOs then set rates for their contracted providers.[46] Notably, Pennsylvania allows primary contractors to keep up to 3% of unspent capitation dollars for reinvestment projects to develop or expand programs and services, which can significantly benefit smaller, less resourced counties in joinder entities with larger counties.

Washington

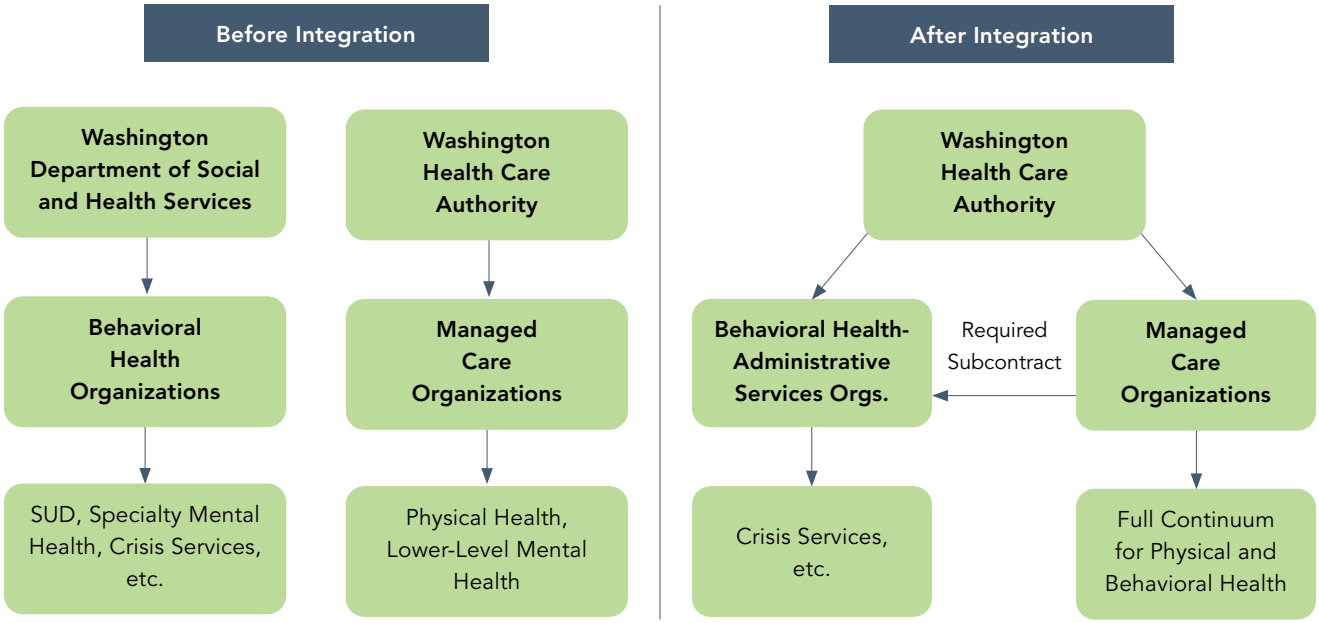
Washington's transition to integrated physical and behavioral health care was enacted via state legislation, and implementation took place between 2016 and 2020.[47] The legislation, developed with

input from the Washington Health Care Authority, clarified that managed care organizations (MCOs) were responsible for all Medicaid physical and behavioral health care and established a multi-year, phased integration approach to limit burden of the transition across the state's 10 designated regions. Before the integration of all physical and behavioral health care through MCOs, mental health and SUD services were first integrated into regional behavioral health organizations (BHOs), temporary entities that assumed risk for SUD services in addition to mental health services and that replaced the previous Regional Support Networks. With the transition to full integration, BHOs had first right of refusal to become Behavioral Health Administrative Services Organizations (BH-ASOs), which manage crisis services for all residents regardless of insurance status along with certain additional noncrisis services and administrative functions.[48] Seven of the 10 BHOs opted to become BH-ASOs, with Carelon Behavioral Health serving as the BH-ASO for the other three regions.[49]

The state contracts with the BH-ASO in each of its 10 regions, and the majority of BH-ASOs provide services for multiple counties, except for those in King and Pierce Counties, which have only one county in their region. Though MCOs became responsible for physical and behavioral health care after integration, the state allowed King County, the most populous county in Washington, to continue central coordination of behavioral health services and required MCOs to contract with the county using their existing system. The state also provided incentive dollars and technical assistance to encourage early adoption of the integrated system and support providers.[50]

Early warning systems were developed to quickly identify and resolve transition issues, and lessons from early implementers helped to inform next steps for administrative and clinical implementation in other regions. However, many regions waited until the final year to transition, putting a strain on the resources available for each region. In addition, impacts of the COVID-19 pandemic have made it difficult to assess outcomes of the transition.

Figure C3. Washington State Physical and Behavioral Health Integration



Sources: *Washington State Behavioral Health System: Funding and Accountability* (PDF), Addiction Technology Transfer Center Network, April 1, 2021; and *IMC Overview* (PDF), Washington Assn. of Sheriffs & Police Chiefs, 2021.

Endnotes

1 "Ensuring Access to Medicaid Services Final Rule (CMS-2442-F)," US Centers for Medicare & Medicaid Services (CMS), April 22, 2024.

2 *California Advancing & Innovating Medi-Cal (CalAIM) Proposal* (PDF), California Dept. of Health Care Services (DHCS), January 2021, 16–17, 91–93.

3 "Major Milestones: 43 Years of Care and Treatment of the Mentally Ill," California Legislative Analyst's Office, March 2, 2000.

4 "Substance Use Disorder Treatment Services," DHCS.

5 Margaret Tatar and Richard Chambers, *Medi-Cal Explained: Behavioral Health Services* (PDF), California Health Care Foundation (CHCF), February 2019.

6 Sarah Arnquist and Peter Harbage, *A Complex Case: Public Mental Health `Delivery and Financing in California*, CHCF, July 2013.

7 Tatar and Chambers, *Medi-Cal Explained*.

8 "Drug Medi-Cal Organized Delivery System," DHCS.

9 "The Mental Health Parity and Addiction Equity Act (MHPAEA)," CMS.

10 "Federal Managed Care Regulations," DHCS.

11 Ivan Bhardwaj (acting chief, Medi-Cal Behavioral Health Div.) to California Alliance of Child and Family Services et al., "Parity Requirements for Drug Medi-Cal (DMC) State Plan Counties" (PDF), Behavioral Health Information Notice 22-070, December 30, 2022.

12 "Ensuring Access," CMS.

13 "CalAIM Behavioral Health Initiative," DHCS.

14 "Memoranda of Understanding Between Medi-Cal Managed Care Plans and Third-Party Entities," DHCS; and "Enhanced Care Management and Community Supports," DHCS.

15 DHCS, "Passage of Proposition 1 Paves Way for Further Behavioral Health Transformation in California," press release, March 21, 2024.

16 *FY 2023-24 Proposed Budget* (PDF), County of Yuba, 2023, 6.

17 "Our Vision," California Mental Health Services Authority (CalMHSA).

18 "About Us," Optum San Diego.

19 "About the Governing Board," County Medical Services Program (CMSP).

20 Matthew Newman, *Expanding Substance Use Care: Health Plan Teams Up with Seven California Counties*, CHCF, March 2022.

21 Janet Coffman and Margaret Fix, *Building the Future Behavioral Health Workforce: Needs Assessment*, Healthforce Center at UCSF, February 2023.

22 "Health Professional Shortage Areas: Mental Health, by County, 2023 – California," Rural Health Information Hub, 2023.

23 Michele Wong (chief, Medi-Cal Behavioral Health Div. – Oversight and Monitoring Div.) to California Alliance of Child and Family Services et al., "2024 Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans," Behavioral Health Information Notice 24-020, May 28, 2024; Palav Babaria (deputy director, chief quality officer) to California Alliance of Child and Family Services et al., "Quality Measures and Performance Improvement Requirements," Behavioral Health Information Notice: 24-004; and 89 Fed. Reg. 41002 (May 10, 2024).

24 CalAIM Proposal, DHCS, 16–17, 91–93.

25 "Beneficiary Handbooks," CalMHSA, 2023; "Early Psychosis Intervention," CalMHSA; and "Authorizations," CalMHSA.

26 *Department of Health Care Services Drug Medi-Cal Organized Delivery System Waiver Implementation Plan for Regional Model Encompassing Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano, and Trinity Counties* (PDF), Partnership HealthPlan of California, November 2017.

27 "BHQIP Resources for Counties," CalMHSA.

28 "Credentialing," CalMHSA.

29 "About the Governing Board," CMSP.

30 "Board Members," CMSP.

31 Mich. Comp. Laws § 330.1212–1226 (1974).

32 Pennsylvania requires counties with fewer than 10,000 Medicaid enrollees to partner with other counties to jointly contract with Behavioral Health Managed Care Organizations (BH-MCOs) and deliver specialty mental health and SUD services as a single entity.

33 *CalAIM Data Sharing Authorization Guidance* (PDF), DHCS, October 2023.

34 Oakland v. Williams, 15 Cal. 2d 542 (Cal. 1940) (rejecting arguments from the auditor for the City of Oakland that Oakland's tax revenue could not be expended pursuant to a joint agreement of several cities to address the "public nuisance" or "sewage-laden mud flats of the East Bay" because they would be expended to study tideland flats of the other contracting cities).

35 As noted above, counties that form a JPA remain liable for the debts, liabilities, and obligations of the JPA. (Cal. Gov. Code § 6508.1).

36 *July 1, 2022–July 1, 2027 Drug Medi-Cal Organized Delivery System (DMC-ODS) Contract*, DHCS.

37 *July 1, 2022–June 30, 2027 Mental Health Plan Contract [with Peer Support Service]*, DHCS.

38 *2022–23 DMC Contract Template* (PDF), DHCS.

39 *Michigan's Mental Health and Substance Use Disorders System* (PDF), Community Mental Health Assn. of Michigan (CMHA).

40 *History of the System and the Association* (PDF), CMHA, May 2020.

41 Chad Livengood, "State of Confusion: Michigan's Mental Health System Has Many Layers for Those in Need to Navigate," *Crain's Detroit Business*, February 21, 2021.

42 Algeria Wilson, "MDHHS Announces Section 298 Pilots Have Come to an End," National Assn. of Social Workers Michigan Chapter, October 23, 2019; and "Background on the Section 298 Initiative," Michigan Dept. of Health & Human Services.

43 "Behavioral HealthChoices: Managed Care Organizations (BH-MCOs)," Pennsylvania Dept. of Human Services.

44 *Medical Assistance Capitation Funding for Drug and Alcohol Treatment Providers Within the Commonwealth* (PDF), Joint State Government Commission of the General Assembly of the Commonwealth of Pennsylvania, June 2023, 21.

45 *HealthChoices Behavioral Health Program: Program Standards and Requirements — Primary Contractor* (PDF), Commonwealth of Pennsylvania Dept. of Human Services, January 1, 2020, 3.

46 *Medical Assistance Capitation Funding for Drug and Alcohol Treatment Providers Within the Commonwealth: Staff Study* (PDF), Joint State Government Commission of the General Assembly of the Commonwealth of Pennsylvania, June 2023, 43.

47 Logan Kelly, *Washington State's Transition to Integrated Physical and Behavioral Health Care* (PDF), Center for Health Care Strategies, September 2020.

48 *Behavioral Health — Administrative Service Organizations* (PDF), Washington State Health Care Authority, November 2023.

49 *Behavioral Health-Administrative Services Organizations (BH-ASO)* (PDF), Washington Apple Health, November 2023.

50 *Kelly, Washington State's Transition; and Physical and Behavioral Health Integration FAQs* (PDF), Washington State Health Care Authority, October 2017.