CalMHSA DMC-ODS Multi-County Model Provider Webinar

Fiscal Structure, Billing Transitions, and Revenue Modeling

Preparing for the transition from Partnership administration to CalMHSA's DMC-ODS multi-county model administration

August 2026 | Provider Webinar

Today's Roadmap

Four sections, with time for questions throughout the conversation.

01

What Is Changing

Administration, rate structure, and the shift toward DMC-ODS payment reform logic.

02

Reading the New Rate Structure

Discipline-based hourly rates, procedure-code translation, residential and NTP schedules.

03

Billing Opportunities and Key Invoicing Workflows

Group methodology & care coordination opportunities and workflow expectations around OHC Medicare, denial resolution.

04

Revenue Modeling and Next Steps

Provider-specific model, timeline, and follow-up support.

Please bring questions as we go; this works best as a conversation rather than a presentation.

A Fiscal Transition, Not Just a Contract Transition

The administrator is changing and so is the underlying payment logic.

FROM

Partnership-administered network

TO

CalMHSA DMC-ODS multi-county model administration

- Partnership-era rates and workflows are being replaced
- CalMHSA will administer the DMC-ODS multi-county model network on behalf of the counties
- Provider reimbursement will align with DMC-ODS payment reform billing logic
- The goal is continuity, clarity, and financial sustainability

Key Fiscal Changes Providers Should Expect

Four areas where the day-to-day fiscal experience will feel different.

Rate Structure

Hourly, discipline-specific outpatient rates replace flat service-type rates.

Billing Translation

Hourly rates are converted into billable procedure-code units based units based on time.

Claims Workflow

Eligibility, OHC and Medicare, EOB documentation, invoicing, and invoicing, and denial resolution.

Revenue Planning

A provider-specific utilization and revenue model to support planning.

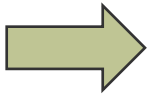
Example rates shown throughout this webinar are mock rates for illustration only.

From Partnership Fee Schedules to DMC-ODS Billing Methodology

Some payment differentiators are going away; others are being introduced.

PARTNERSHIP APPROACH

- Flat or service-type rates
- Outpatient service type drove payment (OP, IOP, care coordination, peer support)
- OP intensity modifiers applied
- Residential perinatal / non-perinatal modifiers
- Time-based distinctions not consistently reflected



DMC-ODS APPROACH

- Discipline-specific hourly rates
- Rendering provider discipline drives payment
- Procedure code and CPT / HCPCS billing logic
- Time-based billing units
- Group code divisor of 4.5
- Separate residential and NTP rate structures

Residential level of care and NTP service type remain payment differentiators under both approaches.

Hourly Rate → Billable Unit → Claim Value

The hourly rate is the starting point, not the amount paid per encounter.

1 Rendering Discipline

Start with who delivered the service and their hourly rate.

2 Code and Time Basis

Apply the relevant procedure code and its and its time increment.

3 Allowed Amount

Calculate the allowed amount for the claim line.

Hourly Rate × Billable Minutes ÷ 60 = Base Claim Value

Group services apply an additional divisor as covered in the next section.

A 15-minute code is generally one quarter of the hourly rate, before any group or modifier logic.

Worked Example: An Individual Outpatient Claim

Following one service from rendering discipline through to claim value.

SCENARIO A certified AOD counselor provides 45 minutes of individual counseling to one client.

1 Rendering discipline

$120 / hour

Certified AOD Counselor

2 Code and time basis

H0004

Individual counseling, 15-minute unit

3 Documented time to units

3 units

45 minutes of direct service

4 Per-unit value

$30

$120 ÷ 4 quarter-hours

3 units × $30 = $90 total claim value

The same 45 minutes rendered by a different discipline produces a different claim value.

Example only: $120 is a round demonstration rate. Actual rates carry cents. Only direct service time counts toward a unit.

Group Billing Changes the Per-Claim Calculation

A conceptual shift for providers accustomed to flat per-person group reimbursement.

PRIOR PARTNERSHIP-STYLE APPROACH

- Same service fee charged per participant
- A group of 3 members could pay 3 × the individual session rate
- Group and individual therapy priced the same per person

DMC-ODS GROUP METHODOLOGY

- Group services apply a 4.5 divisor
- Reimbursement reflects shared clinical resources
- Each attendee still has an individual claim line

Hourly Rate × Group Minutes ÷ 60 ÷ 4.5 = Amount per Participant Claim

The divisor applies regardless of how many people attend the group.

Worked Example: A Group Counseling Session

The same logic, with the 4.5 divisor applied.

SCENARIO The same certified AOD counselor facilitates a 90-minute group counseling session with 6 participants.

1 Base value for the session

$180

90 minutes at $120 / hour

2 Apply the group divisor

÷ 4.5

H0005 group counseling

3 Value per participant claim

$40

$180 ÷ 4.5

4 Total for the session

$240

$40 × 6 participants

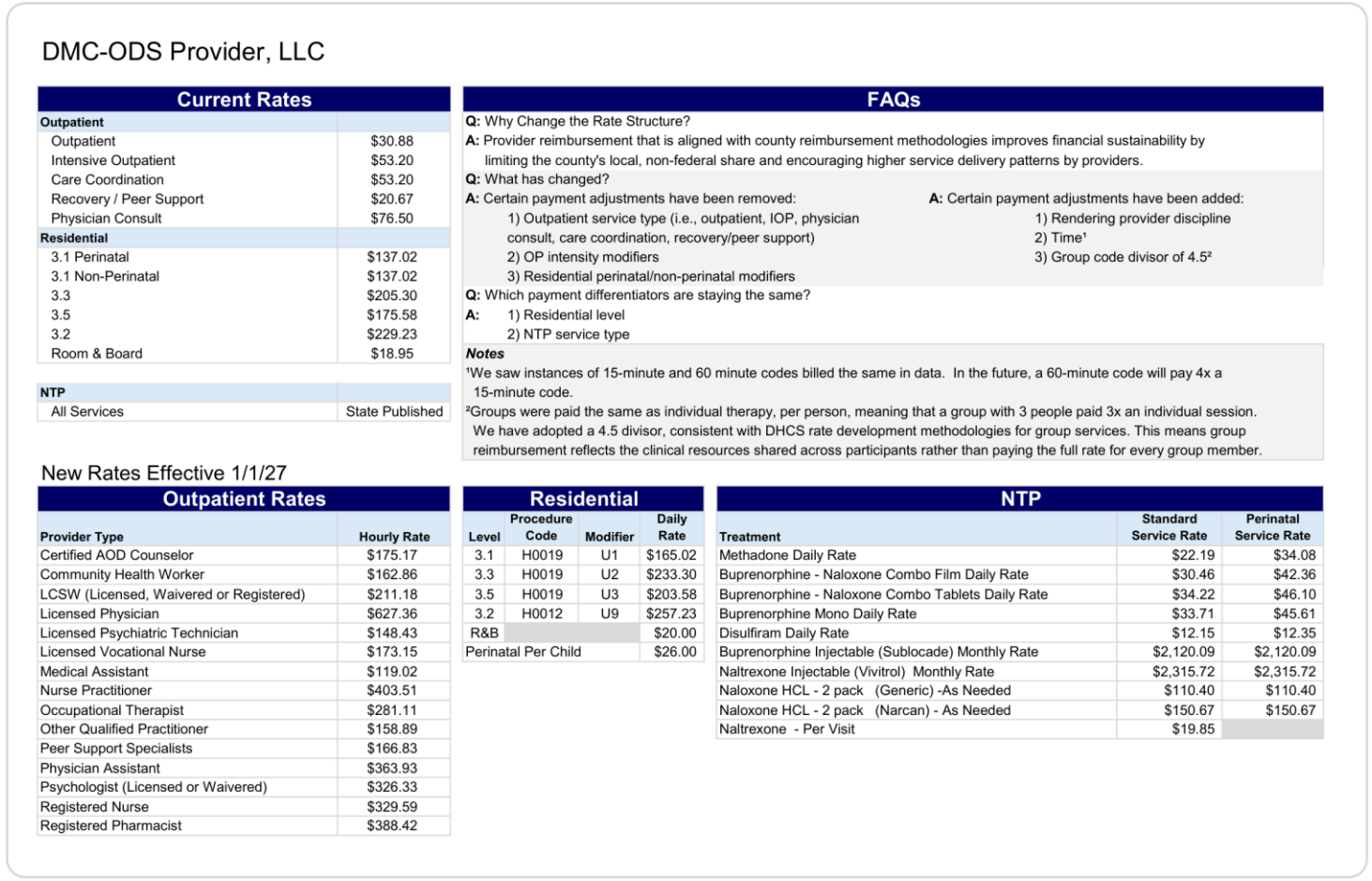
Six separate claim lines at $40 each, one per participant

The divisor is applied per claim, not to the group as a whole.

Group size drives session value: at $40 per participant, 5 attendees ($200) exceeds the $180 that 90 individual minutes would return; 4 attendees ($160) does not.

Reading the Provider Rate Sheet

One page, five sections; here is how to orient yourself.



DMC-ODS Provider, LLC

Current Rates

Outpatient	
Outpatient	$30.88
Intensive Outpatient	$53.20
Care Coordination	$53.20
Recovery / Peer Support	$20.67
Physician Consult	$76.50
Residential	
3.1 Perinatal	$137.02
3.1 Non-Perinatal	$137.02
3.3	$205.30
3.5	$175.58
3.2	$229.23
Room & Board	$18.95
NTP	
All Services	State Published

FAQs

Q: Why Change the Rate Structure?
A: Provider reimbursement that is aligned with county reimbursement methodologies improves financial sustainability by limiting the county's local, non-federal share and encouraging higher service delivery patterns by providers.

Q: What has changed?
A: Certain payment adjustments have been removed:
1) Outpatient service type (i.e., outpatient, IOP, physician consult, care coordination, recovery/peer support)
2) OP intensity modifiers
3) Residential perinatal/non-perinatal modifiers

A: Certain payment adjustments have been added:
1) Rendering provider discipline
2) Time[1]
3) Group code divisor of 4.5[2]

Q: Which payment differentiators are staying the same?
A: 1) Residential level
2) NTP service type

Notes
[1]We saw instances of 15-minute and 60 minute codes billed the same in data. In the future, a 60-minute code will pay 4x a 15-minute code.
[2]Groups were paid the same as individual therapy, per person, meaning that a group with 3 people paid 3x an individual session. We have adopted a 4.5 divisor, consistent with DHCS rate development methodologies for group services. This means group reimbursement reflects the clinical resources shared across participants rather than paying the full rate for every group member.

New Rates Effective 1/1/27

Outpatient Rates

Provider Type	Hourly Rate
Certified AOD Counselor	$175.17
Community Health Worker	$162.86
LCSW (Licensed, Waivered or Registered)	$211.18
Licensed Physician	$627.36
Licensed Psychiatric Technician	$148.43
Licensed Vocational Nurse	$173.15
Medical Assistant	$119.02
Nurse Practitioner	$403.51
Occupational Therapist	$281.11
Other Qualified Practitioner	$158.89
Peer Support Specialists	$166.83
Physician Assistant	$363.93
Psychologist (Licensed or Waivered)	$326.33
Registered Nurse	$329.59
Registered Pharmacist	$388.42

Residential

Level	Procedure Code	Modifier	Daily Rate
3.1	H0019	U1	$165.02
3.3	H0019	U2	$233.30
3.5	H0019	U3	$203.58
3.2	H0012	U9	$257.23
R&B			$20.00
Perinatal Per Child			$26.00

NTP

Treatment	Standard Service Rate	Perinatal Service Rate
Methadone Daily Rate	$22.19	$34.08
Buprenorphine - Naloxone Combo Film Daily Rate	$30.46	$42.36
Buprenorphine - Naloxone Combo Tablets Daily Rate	$34.22	$46.10
Buprenorphine Mono Daily Rate	$33.71	$45.61
Disulfiram Daily Rate	$12.15	$12.35
Buprenorphine Injectable (Sublocade) Monthly Rate	$2,120.09	$2,120.09
Naltrexone Injectable (Vivitrol) Monthly Rate	$2,315.72	$2,315.72
Naloxone HCL - 2 pack (Generic) -As Needed	$110.40	$110.40
Naloxone HCL - 2 pack (Narcan) - As Needed	$150.67	$150.67
Naltrexone - Per Visit	$19.85	

1. **Current Partnership rates**
   Your baseline for comparison
2. **FAQ and payment differentiators**
   What changed, and what stayed
3. **Outpatient hourly rates**
   Listed by provider discipline
4. **Residential daily rates**
   By level of care, with modifiers
5. **NTP standard and perinatal rates**
   By treatment type

Mock data. Provider-specific sheets follow the webinar.

Discipline-Based Outpatient Rates

Who rendered the service determines the hourly rate that feeds the claim.

Outpatient Rates	
Provider Type	**Hourly Rate**
Certified AOD Counselor	$120.00
Community Health Worker	$111.57
LCSW (Licensed, Waivered or Registered)	$144.67
Licensed Physician	$429.77
Licensed Psychiatric Technician	$101.68
Licensed Vocational Nurse	$118.62
Medical Assistant	$81.53
Nurse Practitioner	$276.42
Occupational Therapist	$192.57
Other Qualified Practitioner	$108.85
Peer Support Specialists	$114.29
Physician Assistant	$249.31
Psychologist (Licensed or Waivered)	$223.55
Registered Nurse	$225.79
Registered Pharmacist	$266.09

NOTE: These are mock rates for example only

Residential Rates Are Daily Rates by Level of Care

Per diem based, with a defined set of services reimbursable separately.

Residential			
Level	Procedure Code	Modifier	Daily Rate
3.1	H0019	U1	$165.02
3.3	H0019	U2	$233.30
3.5	H0019	U3	$203.58
3.2	H0012	U9	$257.23
R&B			$20.00
Perinatal Per Child			$26.00

NOTE: These are mock rates for example only

Paid through the per diem

The daily rate covers the residential service components delivered that day.

Reimbursable separately from the residential day rate, when allowable

- Care coordination
- Recovery services
- Peer support specialist services
- MAT for OUD and MAT for AUD / non-opioid SUD

NTP Rates Have Their Own Structure

Distinct rate schedule and distinct coordination rules

NTP		
Treatment	Standard Service Rate	Perinatal Service Rate
Methadone Daily Rate	$22.19	$34.08
Buprenorphine - Naloxone Combo Film Daily Rate	$30.46	$42.36
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Standard and perinatal rates

Two rate columns by treatment type

Medication-specific rates

Daily, monthly, per-visit, and as-needed

Bundled drug cost

The NTP rate includes the drug administered

Counseling and care coordination

Claimable same day, based on the practitioner

NTP counseling is limited to 200 minutes per calendar month unless medical necessity supports more and documentation is completed timely.

Where CalMHSA Will Focus Provider Support

Technical assistance priorities

Care Coordination

Supporting T1017 capture where medically necessary, documented, and allowable.

Assessment Coding

Supporting standard use of appropriate ASAM assessment codes across the network (e.g., H0001 vs. G0397).

Screening and Brief Intervention

Clarifying when H0001, H0049, H0049, or other codes apply. apply.

NTP and Outpatient Counseling

Supporting complete and compliant service capture.

The goal is not to chase codes.

The goal is to make sure reimbursable work that is already being performed is documented, coded, and submitted correctly.

Capturing Care Coordination During Residential Treatment

Care coordination is a carve-out from the residential daily bundle.

Residential Stay + **Care Coordination Activity** = **Potential T1017 Claim**

when medically necessary, documented, and allowable

What CalMHSA observes across networks

- Some providers bill no T1017 during residential stays
- Some show modest utilization relative to residential units
- Some show ratios above 100% of residential units

Key concept to drive home

This is not about billing more for its own sake.

If medically necessary care coordination is already happening, documentation and billing workflows should support appropriate reimbursement for that work.

Key Contract Provision to be Aware of

OHC and Medicare Must Be Addressed Before Claiming to Medi-Cal

Medi-Cal is the payer of last resort, Providers will be expected to adhere to the following workflow

1. Check eligibility and OHC / Medicare status
2. Bill Medicare or commercial OHC when applicable
3. Obtain EOB documentation documentation
4. Submit invoice batch with supporting documentation
5. CalMHSA processes for DMC-ODS claiming

The invoice CalMHSA receives should already reflect the provider's OHC and Medicare billing work.

The specific submission portal for EOBs and operational process will be provided in the forthcoming network provider contract terms.

What Happens If Medi-Cal Denies for OHC or Medicare

An exception workflow, with a defined provider response window.

1. CalMHSA submits the claim
2. Medi-Cal returns an OHC or Medicare-related denial
3. CalMHSA notifies the provider
4. Provider has 30 days to pursue billing and submit EOB or denial documentation
5. **Claim is cleared and resubmitted, or the original payment may be recovered**

Contract terms and operational specifics forthcoming.

What this means for providers

- Providers remain accountable for claim support
- Denial resolution may require provider documentation or payer follow-up
- Paid claims later denied by Medi-Cal may be subject to recovery
- Recovery may be avoided when the provider supports correction and resubmission

Anticipated Annual Utilization and Revenue Model

You will be receiving an annual utilization and revenue modeling template, populated with your own rates.

Section	What you enter	What the model returns
Outpatient	Expected staff FTE and productivity by discipline	Outpatient subtotal
Residential	Anticipated annual bed days by level of care	Residential subtotal
Room and board	Anticipated annual days	Included in residential subtotal
NTP	Annual units — standard and perinatal	NTP subtotal
Total	—	**Total anticipated annual revenue**

Rates arrive pre-populated
Your negotiated rates are already filled in

You supply the assumptions
FTE, productivity, bed days, and NTP units

Revenue calculates automatically
Subtotals roll into a single annual figure

A planning tool, not a guarantee
Estimates depend on your assumptions

The model is intended to help providers understand the rate transition, it does not represent a final revenue guarantee.

How to Use the Revenue Model After the Webinar

Three steps to arrive at your follow-up meeting prepared.

1 Review your rates

Open your provider-specific rate sheet and compare it against your current rates.

2 Enter your assumptions

Add realistic annual utilization for the sections that apply to you.

3 Prepare your questions

Use the output to frame questions for the 1:1 follow-up discussion.

- Focus on realistic annual utilization assumptions
- Review the outpatient, residential, and NTP sections as applicable to your programs
- Bring questions to the 1:1 follow-up process
- Use the model as a planning tool, not a final reimbursement guarantee

What Providers Can Expect From CalMHSA Around the Billing Process

Practical support through the transition.

Provider-Specific Rate Sheet

Your own rates, in the same structure shown today.

Annual Utilization and Revenue Model Workbook

A planning tool populated with your rates.

Training and Technical Assistance

Support on coding, documentation, and claims workflows.

Follow-Up and Contracting Support

1:1 meetings and support through contract finalization.

Our goal is to move providers into the new billing environment with enough clarity to avoid surprises and preserve access to care.

Timeline and Next Steps

Milestones ahead, some operational details are still being finalized.

TODAY	**Provider Webinar**	Fiscal structure and billing orientation.
AUG 21	**Rates and Model Distributed**	Provider-specific rate sheets and revenue model workbooks.
FOLLOWING WEEKS	**Provider Review and 1:1 Meetings**	Individual follow-up discussions and questions.
FALL 2026	**Contract Finalization and Training**	Contract terms, workflow training, and technical assistance.
JAN 1, 2027	**Go-Live**	New rate structure effective.

Dates reflect current planning and may adjust as contracting and operational details are confirmed.

Questions? Next Steps?

Please share questions, concerns, or areas where additional billing or fiscal training would be helpful as we move into provider-specific follow-up discussions.

For follow-up, please contact:

DMC-ODS@calmhsa.org

CalMHSA points of contact

- Karleen Jakowski, Senior Director, Cross-County Contracts and Partnerships
- Phebe Bell, Senior Director, Housing Solutions
- Ryan Caceres, Director of Behavioral Health Financing

CalMHSA
California Mental Health Services Authority

Rate and workflow details are subject to final contract terms and operational instructions.