BEHAVIORAL HEALTH SERVICES ACT COUNTY POLICY MANUAL

Version 1.4.0 – April 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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1. Policy Manual Introduction

This policy manual provides counties and two city-operated mental health authorities with guidance necessary to implement Behavioral Health Transformation (BHT) (WIC section 5963.05), a package of behavioral health policy reforms enacted by California voters through Proposition 1 (2024) and will take effect according to statutory timelines. Counties, providers, and other behavioral health stakeholders will find information on county planning, reporting, and fiscal requirements in this policy manual. The manual also contains information about the Behavioral Health Services Act (BHSA) service and program implementation requirements. Per Welfare and Institutions Code section 5963.05, DHCS has the authority to implement, interpret, or make specific amendments to the Behavioral Health Transformation through county letters, information notices, plan or provider bulletins, and other similar instructions, including this manual. The guidance in this manual will serve as regulations. Throughout the manual, there are references to relevant Department of Health Care Services webpages, Behavioral Health Information Notices, the Welfare & Institutions Code, and the California Code of Regulations for more information. The policy manual will be updated on a continual basis and will include a summary of changes between each version.

2. Behavioral Health Transformation

A. Introduction to Behavioral Health Transformation

In recent years, California has undertaken historic efforts to re-envision the state's publicly funded mental health and substance use disorder (SUD) services, with a special focus on county-administered specialty mental health and substance use disorder services. In March 2024, voters approved Proposition 1 to reform the Mental Health Services Act (MHSA) and fund needed behavioral health facility infrastructure through a general obligation bond. The efforts to implement Proposition 1 are referred to as Behavioral Health Transformation (BHT).

The primary goals of BHT are to improve access to care, increase accountability and transparency for publicly funded, county-administered behavioral health services, and expand the capacity of behavioral health care facilities across California. Under BHT,

county reporting will be uniform to allow for comprehensive and transparent reporting of the Behavioral Health Services Act (BHSA) funding in relation to all public local, state, and federal behavioral health funding.

BHT builds upon and aligns with other major behavioral health initiatives in California including the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT) initiative, the Children and Youth Behavioral Health Initiative (CYBHI), Medi-Cal Mobile Crisis services, the Behavioral Health Bridge Housing program, the Community Assistance, Recovery, and Empowerment (CARE) Act, Lanterman-Petris-Short Conservatorship reforms (WIC section 5402, subdivision (g)(2)), 988 expansion, and the Behavioral Health Continuum Infrastructure Program (BHCIP).

California continues to face behavioral health challenges impacted by many factors, including but not limited to the lack of affordable housing and increasing homelessness, the behavioral health workforce shortage, a youth mental health crisis, an older adult mental health crisis, and a shortage of culturally-responsive and diverse care. Many of these challenges make it difficult for individuals to navigate California's behavioral health care delivery systems and access services at the right time and in the right place. For example, 2022 survey research suggests that 23.5 percent of adult Californians across all payers living with a mental illness reported they did not receive the treatment they needed.

A.1 Bond

In addition to reforming the MHSA, Proposition 1 includes the Behavioral Health Infrastructure Bond Act of 2023. This bond authorizes $6.38 billion to build new behavioral health treatment beds and supportive housing units to help serve more than 100,000 people annually. This investment creates new, dedicated housing for people experiencing or at risk of homelessness who have behavioral health needs, with a dedicated investment to serve veterans. These settings will provide Californians experiencing behavioral health conditions with places to stay while safely stabilizing, healing, and receiving ongoing support.

- Department of Health Care Services (DHCS) will administer $4.4 billion of these funds to provide grants to public and private entities for behavioral health treatment and residential settings. $1.5 billion of the funds administered by DHCS will be awarded only to counties, cities, and tribal entities (with $30 million set aside for tribes).

- The California Department of Housing and Community Development (HCD) will administer up to $2 billion to support permanent supportive housing for individuals, including veterans, at risk of or experiencing homelessness and behavioral health challenges.

A.2 Behavioral Health Continuum Infrastructure Program

In 2021, DHCS was authorized to establish the Behavioral Health Continuum Infrastructure Program (BHCIP) and award $2.1 billion in funding to construct, acquire, and expand properties and invest in mobile crisis infrastructure related to behavioral health. DHCS has been releasing these funds through multiple grant rounds targeting various gaps in the state's behavioral health facility infrastructure.

The Behavioral Health Bond Act of 2023 leverages the success of BHCIP and authorizes DHCS to award up to $4.4 billion for BHCIP competitive grants. Please refer to the BHCIP webpage for the latest information.

B. Overview of the Behavioral Health Services Act

B.1 Behavioral Health Services Act Goals

The Behavioral Health Services Act (BHSA) is the first major structural reform of the Mental Health Services Act (MHSA) since it was passed in 2004. The MHSA imposed a 1 percent tax on personal income over $1 million. Counties and two city-operated mental health authorities receive these funds monthly to provide community-based mental health services. The MHSA was designed to serve individuals with serious mental illness (SMI) (WIC section 5600.3, subdivision (b)(2)) and individuals that may be at risk of developing serious mental health conditions. The MHSA created a broad continuum of prevention, early intervention, innovative programs, services, and infrastructure, technology, and training elements. MHSA has been a crucial resource to increase access to mental health services for all eligible populations.

The reforms within the BHSA expand the types of behavioral health supports available to Californians who are eligible for services and are in need by focusing on historical gaps and emerging policy priorities. The key opportunities for transformational change within the BHSA include:

1. **Reaching and Serving High Need Priority Populations**
    - Restructures funding allocations for the BHSA program components by focusing allocations on the areas of most significant need among Californians,

including individuals across the lifespan at risk of or experiencing justice and system involvement, homelessness, and institutionalization.

- Prioritizes early intervention, especially for children and families, youth, and young adults, to provide early linkage to services and prevent mental health conditions, co-occurring disorders, and substance use disorders from becoming severe and/or disabling.
- Prioritizes serving individuals experiencing homelessness or at risk of homelessness, especially individuals and families experiencing long-term homelessness. The BHSA dedicates revenue for counties to assist those with severe behavioral health needs to be housed and provides a path to long-term recovery, including one-time and allowable ongoing capital to build more housing options.
- Updates Full Service Partnerships (FSP) requirements to better serve individuals with the most significant needs by requiring FSP programs to include specified, evidence-based delivery models, community-defined evidence practices, and standardized levels of care.
- Aligns with initiatives aimed at improving care for Medi-Cal members living with significant behavioral health needs such as the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT) initiative, the Children and Youth Behavioral Health Initiative (CYBHI), Medi-Cal Mobile Crisis Services, the Behavioral Health Bridge Housing program, the Community Assistance, Recovery, and Empowerment (CARE) Act, Lanterman-Petris-Short Conservatorship reforms (WIC section 5402, subdivision (g)(2)), 988 expansion, and the Behavioral Health Continuum Infrastructure Program (BHCIP).

2. **Increasing Access to Substance Use Disorder Services, Housing Interventions, and Evidence-Based and Community-Defined Practices, and Building the Behavioral Health Workforce**

    - Expands the categories of services that may be funded with BHSA dollars to include treatment for substance use disorders, regardless of the presence of a co-occurring mental health condition.

- Provides ongoing funding for counties to assist people living with significant mental health conditions, substance use disorder needs and co-occurring behavioral health needs with housing and provides a path to long-term recovery, including one-time and allowable ongoing capital to build more housing options.
- Increases investments in the behavioral health workforce including efforts to support more culturally, linguistically, and age-appropriate care by building a more representative workforce.
- Requires implementation of specified evidence-based and community-defined evidence practices to improve outcomes for youth and adults with complex behavioral health conditions.

3. **Focusing on Outcomes, Transparency, Accountability, and Equity**
    - Requires counties to complete a county Integrated Plan for behavioral health services and outcomes, which will include information on all local behavioral health funding and services, including Medi-Cal and non-Medi-Cal specialty behavioral health programs and funding streams.
    - Requires counties to complete an annual county Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) to provide public visibility into county spending, disparities, and results.
    - Utilizes data through the lens of health equity to identify racial, ethnic, age, gender, and other demographic disparities and inform disparity reduction efforts.
    - County BHSA programs must include culturally responsive and linguistically appropriate interventions. These interventions must be able to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health and substance use disorder treatment services access, quality, and outcomes.

B.2 Timeline for Implementation

Table B.2.1. Timeline for Implementation

Requirement	Effective Date
Counties Submit Draft FY 2026-2029 County Integrated Plan to DHCS with County Administrative Officer (CAO) Approval	No later than March 31, 2026
Counties Submit Final FY 2026-2029 County Integrated Plan to DHCS County Board of Supervisors Approve Final Fiscal Year (FY) 2026-2029 County Integrated Plan	No later than June 30, 2026
County Integrated Plans Are Effective	July 1, 2026
Counties Submit Draft 2027-2028 County Annual Update to DHCS with CAO Approval	No later than March 31, 2027
Counties Submit Final FY 2027-2028 County Annual Update to DHCS County Board of Supervisors Approve Final FY 2027-2028 County Annual Update	No later than June 30, 2027
Submit Draft FY 2026-2027 County Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)	January 30, 2028
Submit Final FY 2026-2027 County Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)	January 30, 2029

B.3 Eligible Populations

Eligible populations are those that may receive services funded by the Behavioral Health Services Act (BHSA) and include children and youth, adults, and older adults who meet BHSA eligibility criteria.

Eligibility criteria for BHSA services are aligned with Medi-Cal specialty mental health services (SMHS) access criteria, and include individuals with substance use disorders as described below. However, it is important to note that BHSA eligible populations are not required to be enrolled in the Medi-Cal program (WIC section 5892, subdivisions (k)(7)(B) and (k)(8)(B)).

Eligible children and youth means persons who are 25 years of age or under who meet either of the following:

- Meet SMHS access criteria specified in subdivision (d) of WIC section 14184.402 and implemented in SMHS guidance (includes individuals 21-25 years of age who meet this criteria) OR

- Have at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders (WIC section 5891.5, subdivision (c)(1)).

Eligible adults and older adults mean persons who are 26 years of age or older who meet either of the following:

- Meet SMHS access criteria specified in WIC section 14184.402, subdivision (c) and implemented in DHCS guidance (only applies to individuals 26 years of age and older) OR
- Have at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders (WIC section 5891.5, subdivision (c)(1)).

Priority Populations

In addition to defining the populations eligible for services, the BHSA also requires counties to prioritize BHSA services for the populations listed below (WIC section 5892, subdivision (d)). While counties must prioritize BHSA services for the priority populations listed below, access to BHSA services is not limited to these priority populations. At-risk populations should be identified by counties based on local need and local planning processes, except for the criteria for at-risk of homelessness which can be found in the Housing Interventions chapter and below.

Eligible children and youth who satisfy one of the following:

- Are chronically homeless or experiencing homelessness or at risk of homelessness
- Are in, or at risk of being in, the juvenile justice system
- Are reentering the community from a youth correctional facility
- Are in the child welfare system pursuant to WIC sections 300, 601, or 602
- Are at risk of institutionalization (The DHCS ECM Guide defines institutionalization as "broad and means any type of inpatient, Skilled Nursing Facility, long-term, or emergency department setting.")

Eligible adults and older adults who satisfy one of the following:

- Are chronically homeless or experiencing homelessness or at risk of homelessness
- Are in, or at risk of being in, the justice system
- Are reentering the community from state prison or county jail
- Are at risk of conservatorship (WIC section 5350)
- Are at risk of institutionalization (The DHCS ECM Guide defines institutionalization as "broad and means any type of inpatient, Skilled Nursing Facility, long-term, or emergency department setting.")

For additional information about criteria or priority populations for Full Service Partnerships and Housing Interventions, including the definition for "chronically homeless", please refer to the corresponding sections within this manual.

C. Statewide Vision for Behavioral Health Quality and Equity

The state is committed to boldly taking action to provide Californians with quality, culturally responsive behavioral health services when, how, and where they need them. It will take cross-system collaboration and partnership across service delivery systems to address the statewide behavioral health goals discussed in this Policy Manual. DHCS, county behavioral health, Medi-Cal Managed Care Plans (MCPs), commercial plans, commercial plan regulators, and other key delivery system partners such as child welfare, public health, schools and others will share responsibility for improving the well-being of Californians in need of behavioral health services.

C.1 A Population Health Approach to Behavioral Health

The Behavioral Health Transformation presents a historic opportunity to transform behavioral health service delivery by:

- Taking a population health approach to align expectations across California's behavioral health delivery system.
- Establishing a vision for quality and equity and setting statewide goals to drive progress across the behavioral health delivery system.
- Using data to support continuous quality improvement.

A population health approach aims to address these gaps in access to care and connect individuals to the right services, in the right place, and at the right time.

A population health approach for the behavioral health delivery system:

- Considers the entire population eligible for public behavioral health services, not just those currently receiving behavioral health services and those seeking care (shown in Figure 2.C.3).
- Deploys whole-person care interventions, including addressing social drivers of health, which are the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning and quality of life outcomes and risk factors.
- Coordinates across service delivery systems, including cross-system collaboration and partnership across county behavioral health, Medi-Cal MCPs, commercial plans, commercial regulators, public health, and other key service delivery partners.
- Uses data to:
    - Identify underserved and unserved population groups for targeted interventions, including BHSA priority populations.
    - Improve quality across the behavioral health care continuum.
    - Monitor effectiveness of interventions across populations.
    - Support continuous improvement.
    - Identify and track racial and ethnic disparities in behavioral health outcomes.



Figure 2.C.3. Population Health Approach to Behavioral Health Quality and Equity

Like the Population Health Management (PHM) Program for Medi-Cal MCPs implemented in January 2023, a population health approach to behavioral health will reorganize and strengthen existing contract requirements, particularly requirements related to collaboration across the delivery system, and is targeted to the delivery system that DHCS oversees.

DHCS is working to align priorities and desired outcomes across the behavioral health delivery system, payers (e.g., Medi-Cal MCP Non-Specialty Mental Health Services (NSMHS) and Medi-Cal Specialty Mental Health Services (SMHS)), initiatives and funding sources (e.g., BHSA, Medi-Cal federal financing participation and non-federal share, and Realignment and Block Grants), while still allowing for initiative-specific goals.

As outlined in WIC section 5963.02, subdivision (c)(3)(A), each county shall develop an Integrated Plan (IP) and annual update (AU) aligned with statewide behavioral health goals and their associated measures. DHCS has defined statewide population behavioral health goals to identify the improvements that counties and the state should be working towards together across the behavioral health delivery system.

Specifically, DHCS is partnering with counties to participate in a cycle of continuous improvement to drive progress on the statewide behavioral health goals (shown in Figure 2.C.4):

1. Establish statewide behavioral health goals.
2. In consultation with behavioral health stakeholders and subject matter experts, identify at least one measure for each behavioral health goal.
3. Deliver measures to county behavioral health and Medi-Cal MCPs describing their performance on the statewide behavioral health goals and enabling them to:
    a. Utilize data on measure performance during the Community Planning Process (detailed in Chapter 3, section 3.B the Policy Manual) to work with key stakeholders to address the statewide population behavioral health goals;
    b. Make investments (such as workforce and infrastructure investments) that are expected to advance the goals; and
    c. Implement targeted interventions that are expected to improve progress on the goals.

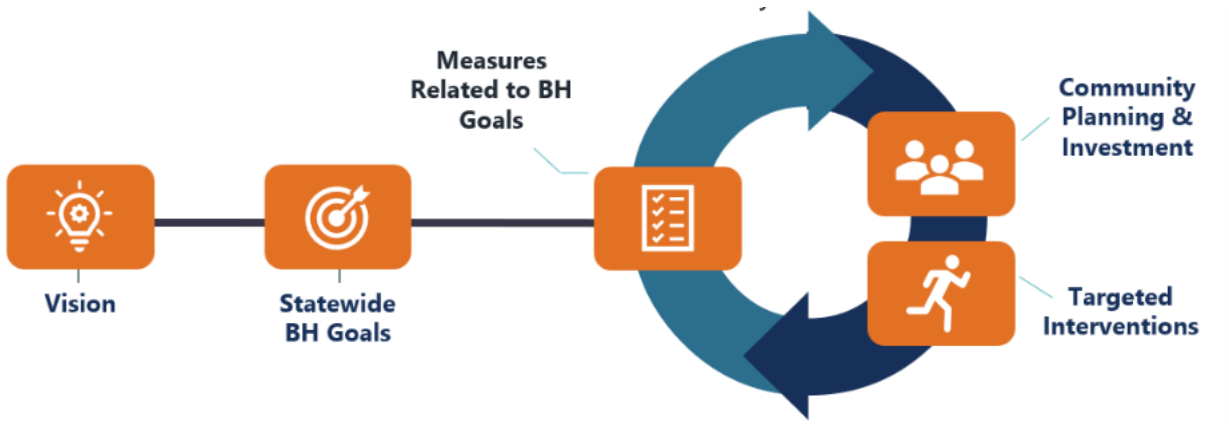


Figure 2.C.4. Population Behavioral Health Framework

DHCS recognizes that shifting to a coordinated, data-driven, population behavioral health approach will take time. As with the PHM Program, DHCS will phase in requirements and provide technical assistance to counties and other key stakeholders.

C.2 Statewide Population Behavioral Health Goals

DHCS, in consultation with behavioral health stakeholders and subject matter experts, has identified 14 statewide behavioral health goals focused on improving wellbeing (e.g., quality of life, social connection) and decreasing adverse outcomes (e.g., suicides, overdoses). These behavioral health goals (shown in Figure 2.C.5) will inform state and county planning and prioritization of BHSA resources, and DHCS will continuously assess statewide and county progress toward these goals under BHT.

Note that health equity, defined as the "reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations", will be incorporated in each of the statewide behavioral health goals. DHCS will endeavor to provide measures that can be stratified (e.g., by demographics such as age group and race/ethnicity, etc.) to enable visibility into disparities. In addition to identifying disparities, DHCS will ask counties and Medi-Cal Managed Care Plans (MCPs) to address disparities and DHCS will consider disparities when developing accountability measures.

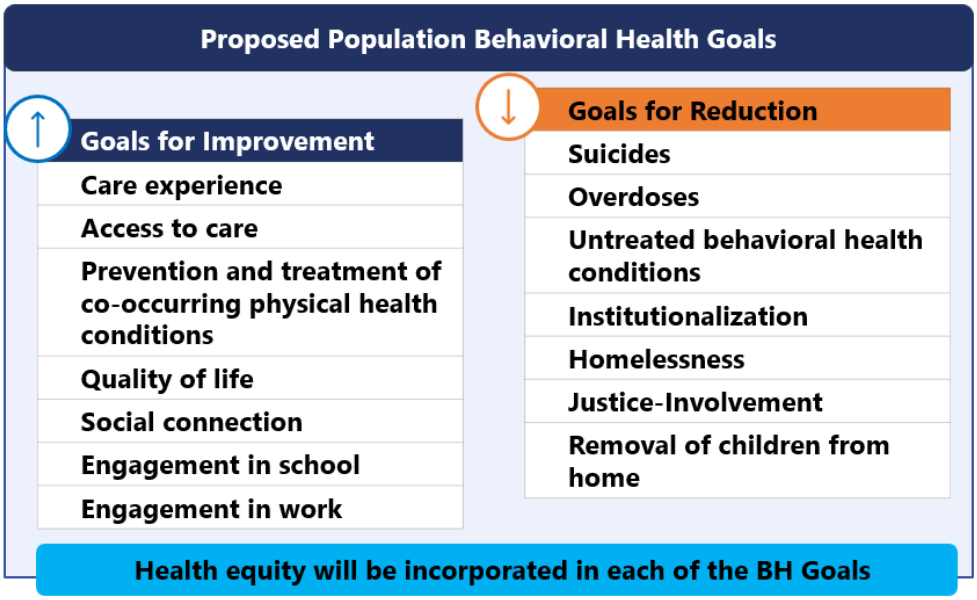


Figure 2.C.5. Statewide Population Behavioral Health Goals

DHCS selected these goals based on their strong indication of the health and wellbeing of Californians living with significant behavioral health needs. In alignment with the mission of BHT to improve behavioral health for Californians, the statewide population behavioral health goals lay out the vision that the state, counties, MCPs, and other key stakeholders must work towards to improve the overall well-being of Californians who are living with behavioral health needs (see Tables 2.C.1 and 2.C.2 for the goals' definitions and rationale for inclusion).

Table 2.C.1. Statewide Population Behavioral Health Goals: Goals for Improvement – Definition and Rationale

Goals for Improvement	Definition and Rationale
Care experience	Care experience refers to the range of interactions and quality of care that patients have and receive from the healthcare system that can impact level of engagement and length of treatment. Improving the care experience (e.g., care is culturally congruent and responsive, trauma-informed, etc.) in California's behavioral health delivery system is important; positive experiences with care can lead to greater treatment engagement, adherence, and remaining in treatment longer, leading to positive health outcomes.
Access to care	Access to care is defined as the timely and appropriate use of health services to achieve the best possible health outcomes, inclusive of all modalities. Improving Californians' access to care is necessary for improving outcomes. Compliance with provider availability as outlined in network adequacy requirements, strategies for navigating the complex care delivery system, and improving wait times for appointments will enable Californians to better access the right care at the right time.
Prevention and treatment of co-occurring physical health conditions	Co-occurrence in this goal refers to the prevention or treatment of a physical health condition in an individual with an existing BH condition. An integrated care approach that addresses both behavioral and physical health needs of individuals can lead to

Goals for Improvement	Definition and Rationale
	earlier treatment of uncontrolled chronic physical health conditions.
Quality of life	Quality of life is defined as an individual's "perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns." Individuals living with behavioral health conditions face challenges from symptoms and associated stigma, which can negatively impact daily functioning, wellbeing, and overall quality of life.
Social connection	Social connection refers to the degree to which an individual has the number, quality, and variety of relationships that they want to feel and have belonging, support, and care. Establishing and maintaining supportive relationships is vital for preventing and managing significant behavioral health needs along with other behavioral health conditions associated with loneliness and isolation.
Engagement in school	In this context, engagement refers to the degree of attention, curiosity, interest, passion, and optimism that an individual has towards school and related activities, including their enrollment and participation in as well as graduation from school. Enhancing engagement through prevention and treatment of behavioral health conditions can enable individuals to participate actively and meaningfully, leading to improvements in quality of life, independence, and wellbeing.
Engagement in work	Similar to above, engagement refers to the degree of attention, curiosity, interest, passion, and optimism that an individual has towards work and related activities. Enhancing engagement in the workplace as part of paid employment or unpaid work through prevention and treatment of behavioral health conditions can enable individuals to participate actively and

Goals for Improvement	Definition and Rationale
	meaningfully, leading to improvements in job performance, productivity, job satisfaction, and overall personal wellbeing.

Table 2.C.2. Statewide Population Behavioral Health Goals: Goals for Reduction – Definition and Rationale

Goals for Reduction	Definition and Rationale
Suicides	Suicide, including suicide attempts is defined as death or non-fatal, potentially injurious harm caused by self-directed injurious behavior with the intent to die as a result of the behavior. (DHCS does not have a formal definition for "suicide," but acknowledges it as a complex public health challenge involving many biological, psychological, social, and cultural determinants. More on its program can be found in the DHCS Suicide Prevention Fact Sheet). Strengthening California's behavioral health delivery system and providing targeted and tailored suicide prevention efforts is critical for reducing California's suicide rate.
Overdoses	A drug-related overdose can occur when a toxic amount of a drug, or combination of drugs, including prescription, illicit, or alcohol, overwhelms the body. In California, drug-related overdose deaths have doubled since 2017, reaching 10,898 in 2021, with the greatest impact among racial and ethnic minorities, and individuals experiencing homelessness, unemployment, and incarceration.
Untreated behavioral health conditions	Untreated behavioral health conditions refer to an individual's behavioral health condition that has not been diagnosed or attended to with appropriate and timely care. Living with untreated behavioral health conditions can lead to worsening symptoms, diminished quality of life, unemployment, reduced

Goals for Reduction	Definition and Rationale
	educational attainment, homelessness, and higher risk of severe outcomes such as suicide or self-harm.
Institutionalization	Minimize time in institutional settings by ensuring timely access to community-based services across the care continuum and in a clinically appropriate setting that is least restrictive. Reducing institutionalization entails maximizing community integration and making supportive housing options with intensive, flexible, voluntary supports and services available to all individuals who would benefit. Stays in institutional settings are sometimes clinically appropriate and therefore the goal is not to reduce institutional stays to zero.
Homelessness	Homelessness is defined below in Chapter 7, Section C.4.1.1 of the Housing Interventions chapter. Addressing the increase in statewide homelessness is crucial to ensuring unhoused individuals living with significant behavioral health needs receive regular access to behavioral health treatment and safe and stable housing where they can recover.
Justice-Involvement	Reducing justice involvement refers to reducing adults and youth living with behavioral health needs who are involved in the justice system - including those who have been arrested, are living in, who are under community supervision, or who have transitioned from a state prison, county jail, youth correctional facility, or other state, local, or federal carcel settings where they have been in custody of law enforcement authorities. More than 50 percent of incarcerated individuals living with a behavioral health condition. While incarcerated, justice-involved individuals living with behavioral health needs have limited access to treatment. Formerly incarcerated individuals are more likely to experience poor health outcomes, including higher risk for injury and death due to violence, overdose, and suicide. Promoting coordinated systems of care between the legal system and behavioral health plans and

Goals for Reduction	Definition and Rationale
	providers can have an impact on reducing justice involvement and improving outcomes for those who are justice-involved.
Removal of children from home	Removal of children from home, specifically those with an open child welfare status, refers to when children may be removed from their home due to abuse and/or neglect. Providing early intervention and intensive BH services to parents and additional members of the family unit living with a behavioral health condition can prevent family disruption and improve child welfare outcomes, as children are less likely to be placed in foster care and exposed to early childhood trauma.

C.3 BHT Performance Measures

DHCS is developing measures for each of the statewide behavioral health goals in two phases.

- **Phase 1:** In June 2025, DHCS published a set of one-time, population-level behavioral health measures, which are defined as measures of community health and wellbeing associated with the statewide behavioral health goals. These population-level measures (sometimes referred to as "Phase 1 Measures") were limited to publicly available measures with data from 2022-2024 (depending on the measure). They are statewide indicators for which counties are not exclusively responsible; it will take cross-service delivery system collaboration and partnership to move the needle on Phase 1 measures. These measures are listed in Chapter 3, Section E.6 of the Policy Manual.
    - For the first BHSA Integrated Plan (IP), they must be used in the county BHSA planning process and should inform resource planning and implementation of targeted interventions to improve outcomes (additional details on using population-level measures in IPs are in Chapter 3, Section E.6).
    - As part of the 2025 PHM Strategy Deliverable, Medi-Cal MCPs will also use statewide behavioral health goals and measures to inform resource

planning and implementation of targeted interventions to improve outcomes.

- **Phase 2**: In July 2026, DHCS will finalize a list of performance measures (sometimes referred to as "Phase 2 Measures") that will be used for transparency, planning, population, and accountability purposes and will focus on performance of county behavioral health and Medi-Cal MCPs specifically. Once finalized, BHT performance measures (or "Phase 2 measures") will replace the population-level behavioral health measures and be used in subsequent county planning and reporting to DHCS, including:
    - The BHSA IP, Annual Updates (AUs) and the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) for county behavioral health; and
    - The annual PHM Strategy Deliverable for Medi-Cal MCPs.

DHCS is developing performance measures in consultation with the Quality and Equity Advisory Committee (QEAC), which is comprised of behavioral health, county behavioral health, Medi-Cal MCP, and quality measurement leaders from across California and in partnership with key California state agencies following a three-step process:

1. Identification of the Medi-Cal and BHSA interventions that could advance the goal by developing a "Theory of Change" (a logic model for identifying interventions that research and data suggest will generate a desired impact);
2. Narrowing to the most impactful Medi-Cal and BHSA interventions; and
3. Selection and development of measures for the goal and the most impactful interventions.

The output of the steps above is being shared and discussed in public QEAC meetings throughout calendar years (CY) 2025 and 2026. QEAC meeting materials are available here, and summaries of the Theories of Change will be released later in 2026.

The performance measures fall into the following categories:

- **Goal Measures:** Measures of the overall performance on the statewide behavioral health goal for all people enrolled in Medi-Cal or eligible for other county behavioral health services, such as BHSA services. With the exception of the Access to Care, Untreated Behavioral Health Conditions, and Care Experience goals, Goal Measures are multi-stakeholder measures that require coordinated

efforts across BHPs, MCPs, and other external partners to advance progress on the goal. Some, but not all, goals also have a Sub-Goal Measure, which generally look at performance on the goal for a sub-population that is most likely to be reached by counties and MCPs or performance on an intermediate outcome anticipated from county and MCP interventions.

- **Intervention Measures:** Measures of county and MCP interventions that are most likely to advance progress on each goal.

As noted above in Chapter 2, Section C.2, health equity will be integrated into each of the statewide behavioral health goals. All performance measures will be stratified by key demographics, such as age group and race/ethnicity, and county behavioral health and Medi-Cal MCPs will be expected to address disparities in those measures in their IPs and PHM Strategy Deliverables. In addition, once measures have been developed across all 14 goals, DHCS will identify an additional set of statewide, cross-cutting measures and improvement targets intended to advance equity across all 14 goals. DHCS will finalize these cross-goal equity measures in June 2026.

DHCS expects to revisit performance measures on an ongoing basis, at least every three years, to ensure that they are appropriate and advancing the goals.

C.3.1 How Performance Measures Are Calculated

DHCS will calculate the performance measures using the following data sources:

- Medi-Cal encounters, claims, enrollment data, and other Medi-Cal data sources;
- Data collected through Individual Service-Level encounters (including data on BHSA services) submitted by county behavioral health to; and
- Data shared by other California state agencies, including but not limited to:
    - Homelessness Data Integration System (HDIS) from the California Interagency Council on Homelessness (CalICH);
    - State hospitals data from the California Department of State Hospitals (DSH);
    - Patient Discharge Dataset from the California Department of Health Care Access and Information (HCAI); and
    - Vital Records data from the California Department of Public Health (CDPH).

DHCS will publish BHT performance measures, stratified by county behavioral health and Medi-Cal MCPs and by age and key demographics, for public access annually. Via Medi-Cal Connect, a statewide data analytics solution and tool for population health management, DHCS will also provide updated measure calculations and associated underlying data to counties and MCPs as frequently as monthly, depending on the data sources. DHCS does not expect Medi-Cal MCPs or county behavioral health to calculate and submit measures to DHCS.

The first release of performance measures – which is planned for 2026 and is expected to report data from calendar year 2025 – will only include data for Medi-Cal members. Over time, DHCS will integrate data on people not eligible for Medi-Cal who receive behavioral health services from a county (i.e., people eligible for BHSA services).

DHCS will release a BHT Performance Measure Specifications Manual later in 2026 with additional details on how each performance measure is calculated, including the measure specifications.

C.3.2 How BHT Performance Measures Will Be Used

DHCS expects to use performance measures to support Transparency, Planning, Population Health, and Accountability.

Transparency

Performance on all measures, with key stratifications, will be shared with the public and stakeholders on an annual basis.

Planning

DHCS, counties, MCPs, and other stakeholders will use the performance measures to inform their planning for addressing statewide behavioral health goals.

- Prior to June 2026, counties and MCPs will use the one-time, population-level measures (i.e., Phase 1 measures) to support their community planning process (as outlined in Chapter 3, Section B). Counties will use these population-level measures in their first IP, and MCPs will use these measures in their 2025 PHM Strategy Deliverable.
- Starting in June 2026, counties and MCPs will transition to using the performance measures (i.e., Phase 2 measures) for all community planning processes and to support data-driven decision making for resource allocation and quality improvement. Counties will use the performance measures beginning with the

first AU and for all subsequent IPs and AUs. MCPs will use the latest available performance measures to inform their 2026 PHM Strategy Deliverable and subsequent 2026 PHM Strategy Deliverables.

Population Health

In addition to publishing the performance measures, DHCS expects to provide counties and MCPs with person-level data needed to support appropriate outreach and targeted interventions that would improve outcomes related to each goal.

This person-level data will be provided via Medi-Cal Connect based on role-based access and permissions in accordance with state and federal privacy laws, including, but not limited to, the California Information Practices Act, California GOV Section 11015.5, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Privacy Act of 1974, and 42 C.F.R. Part 2 ("Part 2"). For example, MCPs will only receive information on members that are currently assigned to their specific plan, and BHPs will only receive data on individuals with BH needs in their county of responsibility. HSC section 11845.5 is California's SUD privacy law, which imposes stricter requirements than federal substance use treatment laws, does not apply to disclosures made for BHSA-funded services pursuant to WIC section 14197.71(d), provided that the disclosures are authorized under the statute and consistent with federal law, including Part 2.

Data sharing within Medi-Cal Connect is only accessible to authorized Medi-Cal Connect users. DHCS expects that counties and MCPs will be able to share information with their contracted providers for the purpose of outreach and care management, and in accordance with state and federal privacy laws. In the case of Part 2 data, this redisclosure may necessitate additional individual consent. For more information regarding federal and state privacy laws, see the DHCS CalAIM Data Sharing Authorization Guidance.

In addition to providing person-level data in the Medi-Cal Connect platform, DHCS will establish an Application Programming Interface (API) that allows counties and MCPs to ingest individual-level data for the performance measures, including for purposes of integrating with their existing population health management tools and to support measure validation.

Accountability

DHCS will limit the use of performance measures to the three uses above for the first IP period (July 2026 to June 2029) to allow time for counties and MCPs to implement interventions and quality improvement activities after the measures are released.

Over time, and following the first IP period (July 2026 to June 2029), DHCS will have distinct accountability mechanisms for performance measures for BHSA and Medi-Cal. For new DHCS measures, DHCS will allow sufficient time to validate that the data reliably reflects the intent of the measure prior to establishing benchmarks (where relevant) or using the measure for accountability.

BHSA Accountability

DHCS will assess how well counties are addressing the needs of local communities via:

- Changes in performance measures over time, with consideration for external factors that may influence performance on Goal and Sub-Goal Measures; and
- BHOATR submissions, which will include a forum for counties to explain their performance on the measures.

DHCS does not plan to issue Corrective Action Plans (CAPs) for performance measures until the second IP period, which begins in July 2029.

Medi-Cal Accountability

Several of the BHT performance measures listed in this document are already monitored in existing Medi-Cal quality and monitoring programs, such as the Managed Care Accountability Set (MCAS), the Behavioral Health Accountability Set (BHAS), Network Adequacy Oversight, and others. Monitoring for these measures will continue in the respective DHCS programs. Beginning with the second IP period (meaning after July 1, 2029), DHCS may add a selection of validated BHT performance measures to these existing Medi-Cal quality and monitoring programs. For example, DHCS may add one or more of the BHT performance measures to BHAS. DHCS would consider Intervention Measures (and not Goal Measures) for inclusion in these quality and monitoring programs, with the exception of Access to Care, Untreated Behavioral Health, and Care Experience, where the Goal Measures may be considered for inclusion in quality and monitoring programs. When considering adding BHT performance measures to quality and monitoring programs, DHCS will follow the standard selection process for these

programs, including any applicable stakeholder feedback mechanisms, such as public comment.

BHT performance measures that are added to BHAS and MCAS in the future may be used to determine CAPs and monetary sanctions based on BHAS and MCAS performance.

C.3.3 BHT Performance Measures List

The list below enumerates the BHT performance measures, organized by statewide behavioral health goal. (For the list of one-time, population-level measures used only for the first IP, see Chapter 3, Section E.6.). Performance measures labeled as *DHCS Measure* indicate a new measure that DHCS has developed as part of the BHT performance measure set (sometimes referred to as "Phase 2 Measures").

1-3. Improving Access to Care, Reducing Untreated Behavioral Health Conditions, and Improving Care Experience

- **One or More BH Services for People with MH Needs** – *DHCS Measure*
- **One or More BH Services for People with Significant MH Needs** – *DHCS Measure*
- **Initiation of SUD Treatment** (**IET-I**) – *NCQA Measure*
- **One or More BH Services for People with Significant MH Needs and Co-Occurring SUD** – *DHCS Measure*
- **Three or More BH Services for People with MH Needs** – *DHCS Measure*
- **Three or More BH Services for People with Significant MH Needs** – *DHCS Measure*
- **Engagement in SUD Treatment** (**IET-E**) – *NCQA Measure*
- **Three or More BH Services for People with Significant MH Needs and Co-Occurring SUD** – *DHCS Measure*
- **Perception of Care with Respect to One's Cultural Background: SMHS** – *UCLA ISP and SAMHSA Measure*
- **Perception of Care with Respect to One's Cultural Background: DMC-ODS** – *UCLA ISP and SAMHSA Measure*
- **Perception of Care with Respect to One's Cultural Background: NSMHS** – *MCP CAHPS Measure*

- **Depression Screening and Follow-Up for Adolescents and Adults** (**DSF-E**) – *NCQA Measure*
- **Evidence-Based Practices for People Living with Significant MH Needs** – *DHCS Measure*
- **Follow-Up After Emergency Department Visit for Substance Use** (**FUA**) – *NCQA Measure*
- **Follow-Up After Emergency Department Visit for Mental Illness** (**FUM**)– *NCQA Measure*

4. **Improving Prevention & Treatment of Co-Occurring Physical Health Conditions**
    - **Ambulatory Services for Adults with Significant BH Needs** – *DHCS Measure*
    - **Well Child Visits for Children and Youth with Significant BH Needs** – *DHCS Measure*
    - **Dental Visits for People with Significant BH Needs** – *DHCS Measure*
5. **Reducing Homelessness**
    - **Homelessness Among People with Significant BH Needs** – *DHCS Measure*
    - **Permanent Housing for People with Significant BH Needs Who Experience Homelessness** – *DHCS Measure*
    - **Housing Services for People with Significant BH Needs Who Experience Homelessness** – *DHCS Measure*
    - **Full Service Partnership and Housing Services for People with Significant BH Needs Who Experience Homelessness** – *DHCS Measure*
6. **Reducing Institutionalization**
    - **Institutional Stays for People with BH Needs** – *DHCS Measure*
    - **Coordinated Specialty Care for First Episode Psychosis** – *DHCS Measure*
    - **Support for Transitions from Institutional BH Care** – *DHCS Measure*
    - **Follow-Up After Hospitalization for Mental Illness** (**FUH**) – *NCQA Measure*

- **Follow-Up After Other Institutional Stays for Behavioral Health** – *DHCS Measure*

7. **Reducing Justice Involvement**
    - **Justice-Involvement Among People with Significant BH Needs** – *DHCS Measure*
    - **Repeat Justice-Involvement Among People with Significant BH Needs** – *DHCS Measure*
    - **Post-Release BH Services for Justice-Involved People with Significant BH Needs** – *DHCS Measure*
    - **Continuation of MAT for Justice-Involved Reentry Enrollees** – *DHCS Measure*
8. **Reducing Overdoses**
    - **Deaths by Drug Overdose** – *DHCS Measure*
    - **Repeat ED Visit or Hospitalization for Drug Overdose** – *DHCS Measure*
    - **Contingency Management** – *DHCS Measure*
    - **Pharmacotherapy for Opioid Use Disorder** (**POD**) – *NCQA Measure*
    - **Follow-Up After High-Intensity Care for Substance Use Disorder** (**FUI**) – *NCQA Measure*
9. **Reducing Removal of Children from Home**
    - **Children and Youth in Foster Care** – *DHCS Measure*
    - **BH Services for Children and Youth in Foster Care** – *DHCS Measure*
    - **BH Services for Parents, Guardians, and Pregnant People with Significant BH Needs** – *DHCS Measure*
    - **High Fidelity Wraparound, Enhanced Care Management, or Intensive Care Coordination for Children and Youth in Foster Care** – *DHCS Measure*
10. **Reducing Suicides**
    - **Deaths by Suicide** – *DHCS Measure*

- **Repeat ED Visit or Hospitalization for Self-Harm** – *DHCS Measure*
- **Follow-Up MH Services After Crisis Services** – *DHCS Measure*

Proposed measures for the following four Statewide Behavioral Health Goals will be developed in Q1-Q2 2026:

11. **Improving Engagement in School**
12. **Improving Engagement in Work**
13. **Improving Social Connection**
14. **Improving Quality of Life**

3. Integrated Plan

A. Purpose of the Integrated Plan

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) (WIC section 5963) for Behavioral Health Services and Outcomes. Whereas the Three-Year Program and Expenditure Plan required under the Mental Health Services Act (MHSA) focused exclusively on MHSA dollars, the BHSA establishes the IP to serve as a three-year prospective global spending plan that describes how county behavioral health departments plan to use all available behavioral health funding, including BHSA, 1991 and 2011 Realignment, federal grant programs, federal financial participation from Medi-Cal, opioid settlement funds, local funding, and other funding to meet statewide and local outcome measures, reduce disparities, and address the unmet need in their community. In accordance with the BHSA, the IP provides a description of how counties will plan expenditures across a range of behavioral health funding sources and deliver high-quality, culturally responsive, and timely care along the Behavioral Health Care Continuum for the plan period (WIC section 5963, subdivision (a)(1)). The Department of Health Care Services (DHCS) is developing an IP Template, which will include the required elements for each county to submit in their IPs. A copy of the IP Template will be released in this policy manual to inform county planning. Counties will submit the IP through a DHCS web-based county portal.

IPs require counties to conduct a thorough data-informed local service planning process and provide transparency into county planning for expending BHSA funding and all other behavioral health funding sources overseen by counties. All BHSA services and programming must be planned in accordance with local data. In particular WIC section 5963.02, subdivision (b)(2) requires the county to use local substance use disorder (SUD) prevalence data and unmet SUD needs data. IPs will also facilitate local and statewide data collection by providing baseline data on services and planned expenditures and supporting analysis of county goals and outcomes.

A.1 Reporting Period

A draft IP will be due on March 31 for each three-year IP submission. The draft must have a letter from the County Administrative Officer (CAO) approving the draft IP, including the exemption and transfer requests. A final IP is due no later than June 30. County board of supervisor approval is required for submission by June 30 (WIC section 5963.02, subdivision (a)(3)). The board of supervisors is also required to confirm in each IP that the county will meet their realignment obligations (WIC section 14197.71, subdivision (c)(2)). The board of supervisors will attest that the county is meeting their

realignment obligations, including but not limited to time and distance standards and appointment time standards as set forth WIC section 14197.7 without utilizing waitlists, through the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) (see Chapter 4 of this policy manual for BHOATR requirements). DHCS will post each county's IP on the DHCS website.

A.2 Contents of Integrated Plan

The IP Template requires counties to report planned activities and projected expenditures for all county behavioral health department services provided under the following funding sources, services, and programs (WIC section 5963.02, subdivision (c)):

- Bronzan-McCorquodale Act (1991 Realignment)
- 2011 Realignment
- Medi-Cal behavioral health programs, including:
    - Specialty Mental Health Services (SMHS)
    - Drug Medi-Cal (DMC)
    - Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Federal block grants, including:
    - Community Mental Health Services Block Grant (MHBG)
    - Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)
    - Projects for Assistance in Transition from Homelessness (PATH) grant
- BHSA funds
- Any other federal, state, or local funding directed towards county behavioral health department services, including:
    - Commercial/private insurance
    - Opioid settlement funding (only funds received by the County Behavioral Health Department)
    - County general fund
    - Grant revenue
    - Other

The IP Template will include required sections on the following topics:

- County Demographics and Behavioral Health Needs
- Plan Goals and Objectives
- Community Planning Process
- Comment Period and Public Hearing
- County Behavioral Health Care Continuum Capacity
- Services by Total Funding Source
- Behavioral Health Services Fund Programs
- Workforce Strategy
- Budget and Prudent Reserve

A.3 Function of Annual Updates and Intermittent Updates

Counties will be required to update their IP through annual updates in the second and third years of the IP cycle. Annual updates will require the county to complete and submit all sections of the IP. Counties may prepare intermittent updates to their IP at any time during the IP cycle. For intermittent updates, counties must notify DHCS in advance of submission. Annual and intermittent updates will allow counties to be responsive to changes at the local level during the plan period.

Annual and intermittent updates are not subject to the stakeholder engagement requirements for the IP that are outlined in Chapter 3, Section B.1 of this policy manual. However, DHCS encourages stakeholder engagement on the annual and intermittent updates. Counties are required to post the annual updates and intermittent updates to their IP with a summary and justification of the changes made by the updates for a 30-day comment period prior to the effective date of the updates. Counties maintaining their local stakeholder engagement in developing the annual or intermittent updates must continue to comply with the local behavioral health board public hearing requirements outlined in Chapter 3, Section B.3 of this policy manual.

A.3.1 Reporting Period

Counties are required to submit annual updates for the second and third year of the IP period. Draft annual updates will be submitted by March 31 prior to the fiscal year the update will cover. The draft must have a letter from the CAO approving the annual update, including the exemption and transfer requests. A final annual update is due no later than June 30. County board of supervisor approval is required for submission by

June 30 prior to the fiscal year the update will cover. Counties may submit intermittent updates to their IP as needed.

Table A.3.1 Reporting Periods for Integrated Plans, Annual Updates, and Intermittent Updates

	Integrated Plan	Annual Updates	Intermittent Updates
Counties are Required to Complete and Submit (WIC section 5963.02, subdivision (a)(1))	Yes	Yes	If changes are requested
Submission Timeframe	Every 3 years	Second and third years of IP cycle	Counties may submit at any time
Submission Deadline for Draft (WIC section 5963.02, subdivision (d))	Draft due March 31 of year prior to fiscal years IP covers	Draft due March 31 of year prior to fiscal year annual update covers	Counties may submit at any time during the 3-year IP cycle
County Administrative Officer Letter Required	Yes, for draft IP submissions	Yes, for draft annual update submissions	No
Community Planning Process Required (WIC section 5963.03, subdivision (a)(1)-(2); WIC section 5963, subdivision (c)(2)(A))	Yes	No, but encouraged	No, but encouraged
30-day **Public Comment Period Required** (WIC section 5963.03, subdivision (a)(2)(B; WIC section 5963.03, subdivision (c)(2)(B))	Yes	Yes	Yes

	Integrated Plan	Annual Updates	Intermittent Updates
Behavioral Health Board Hearing Required (WIC section 5963.03, subdivision (b))	Yes	If county engages stakeholders	If county engages stakeholders
Board of Supervisors Approval and Submission (WIC section 5963.02, subdivision (a)(3))	Yes, for final IP, by June 30	Yes, for final AU, by June 30	Yes, submitted at any time in FY

A.3.2 Required Contents

Annual updates will include all sections required in the IP template. If there are no changes to a given section of the county's IP at the time of the annual update, the county may resubmit the information provided in the original IP as part of the update. Counties may update information in any section of the IP as needed through an intermittent update.

B. Community Planning Process

B.1 Stakeholder Involvement

Stakeholder engagement requirements (WIC section 5963.03) for the Integrated Plan (IP) are effective January 1, 2025. Counties must engage with local stakeholders (WIC section 5963.03, subdivision (a)(1)) to develop each element of their IP. The stakeholders that must be engaged) include, but are not limited to:

- Eligible adults and older adults (individuals with lived experience)
- Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience)
- Youths (individuals with lived experience) or youth mental health or substance use disorder organizations
- Providers of mental health services and substance use disorder treatment services
- Public safety partners, including county juvenile justice agencies
- Local education agencies
- Higher education partners

- Early childhood organizations
- Local public health jurisdictions
- County social services and child welfare agencies
- Labor representative organizations
- Veterans
- Representatives from veterans' organizations
- Health care organizations, including hospitals
- Health care service plans, including Medi-Cal managed care plans (MCPs) as defined in WIC section 14184.101, subdivision (j)
- Disability insurers (a commercial disability insurer that covers hospital, medical or surgical benefits as defined in INS section 106, subdivision (b))
- Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- The five most populous cities in counties with a population greater than 200,000
- Area agencies on aging
- Independent living centers
- Continuums of care, including representatives from the homeless service provider community
- Regional centers
- Emergency medical services
- Community-based organizations serving culturally and linguistically diverse constituents

In addition to the required stakeholders listed above, stakeholders shall include participation of individuals representing diverse viewpoints (WIC section 5963.03, subdivision (2)(A)(ii)), including, but not limited to:

- Representatives from youth from historically marginalized communities
- Representatives from organizations specializing in working with underserved racially and ethnically diverse communities
- Representatives from LGBTQ+ communities
- Victims of domestic violence and sexual abuse

- People with lived experience of homelessness

Counties are required to demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health and substance use disorder policy, program planning and implementation, monitoring, workforce, quality improvement, evaluation, health equity, evaluation, and budget allocations (WIC section 5963.03, subdivision (2)(A)(i)). Meaningful stakeholder engagement requires that counties conduct a community planning process that is open to all interested stakeholders and that stakeholders have opportunities to provide feedback on key planning decisions. Stakeholder engagement should not be limited to individuals who belong to organizations or advocacy groups.

Counties must demonstrate a partnership with constituents and stakeholders (WIC section 5963.03, subdivision (2)(A)(i)) as part of their community planning processes. Examples of meaningful partnership with stakeholders may include, but are not limited to, the following types of stakeholder engagement:

- Education and engagement to support meaningful involvement, including on policies that govern the behavioral health delivery system
- Listening sessions
- Conference calls
- Client advisory meetings
- Consumer and family group meetings
- Town hall meetings
- Video conferences
- Media announcements
- Targeted Outreach
- Public comment
- Public hearings
- Stakeholder workgroups and committees
- Focus groups
- Surveys
- Key informant interviews or engaging with subject matter experts
- Training, education, and outreach related to community planning

- Other strategies that demonstrate meaningful partnerships with stakeholders

To ensure that the community planning process is adequately staffed, the county may designate positions and/or units responsible for:

- The overall community planning process.
- Coordination and management of the community planning process.
- Ensuring that stakeholders have the opportunity to meaningfully and sufficiently participate in the community planning process (WIC section 5963.03, subdivision (2)(A)).

Training should be provided by the county as needed to their staff designated responsible for any of the functions that will enable staff to establish and sustain a community planning process.

A county may also provide supports, including, but not limited to, training and technical assistance, to ensure stakeholders, including peers and families, receive sufficient information and data to meaningfully participate in the development of Integrated Plans and annual updates.

Counties may allocate up to 5 percent of the total annual revenue received from the local Behavioral Health Services Fund (BHSF) to fund planning costs (WIC section 5892, subdivision (c)). For additional information on how counties can fund the community planning process, please refer to the County Planning Funds Chapter 3, Section B.4.

B.2 Considerations of Other Local Program Planning Processes

This section focuses on the requirements for Integrated Plan (IP) development related to collaboration with Medi-Cal Managed Care Plans (MCPs) and local health jurisdictions (LHJs). Per HSC section 124030, subdivision (f) a "Local health jurisdiction" means county health department or combined health department in the case of counties acting jointly or city health department within the meaning of HSC section 101185. Specifically, the Behavioral Health Services Act (BHSA) requires that each county must:

- Work with its LHJ on the development of its Community Health Improvement Plan (CHIP) (WIC section 5963.01, subdivision (b)).
- Consider the CHIP of each LHJ that covers residents of the county in preparing their IP and annual update (WIC section 5963.02, subdivision (b)(4)).
- Work with each MCP that covers residents of the county on the development of the MCP's Population Needs Assessment (PNA) (WIC section 5963.01, subdivision (a)).

    - The BHSA was written prior to the 2024 DHCS redesign of PNA requirements. MCPs no longer develop and submit a PNA to the Department of Health Care Services (DHCS). MCPs now fulfill their PNA requirement by meaningfully participating in the Community Health Assessments (CHA) and CHIPs conducted by LHJs. For more information, please see CalAIM: Population Health Management (PHM) Policy Guide.
- Consider the PNA of each MCP that covers residents of the county in preparing their IP and annual update (WIC section 5963.02, subdivision (b)(3)).

DHCS is focused on building bridges across public health, MCPs, and behavioral health delivery systems. The BHSA transforms the Mental Health Services Act (MHSA) planning process into a broader county and regional planning process. The targeted points of integrations of BHSA community planning processes with the community- and population-level assessment and planning efforts led by public health with MCPs and other stakeholders will reduce siloes and increase cross-system collaboration to enable strategic alignment of funding for coordinated and complementary approaches. DHCS' goal is to improve upstream interventions and health outcomes for, and thus more effectively improve the lives of, community members. The CalAIM PHM Policy Guide defines upstream interventions include those that link to public health and social services and support members staying healthy through wellness and prevention services.

While perspectives and focus areas may vary, local public health, MCPs, and counties serve common communities, and local integration and partnerships are essential to paving a path toward better understanding the needs of local communities, strategizing appropriate interventions, addressing social determinants of health, and advancing health equity. With this goal in mind, in January 2024, DHCS coordinated with the California Department of Public Health (CDPH) and issued a new policy requiring the MCP PNA to be more closely aligned with LHJ local planning processes, as detailed further below. As the BHSA was written prior to the 2024 DHCS PNA policy change, this guidance explains the BHSA IP requirements in the context of these other recent policy developments.

This guidance addresses requirements for counties' IP submissions, specific to collaboration with MCPs and LHJs on Community Health Assessments (CHAs) and CHIPs, to promote greater alignment among public health, managed care, and behavioral health.

B.2.1. Local Planning Overview

This section provides background on MCP and LHJ local planning processes.

B.2.1.1 Background: LHJ, CHA and CHIP

As part of its local planning processes, most LHJs develop both a CHA and a CHIP, which emphasize participatory and collaborative practices centered on the community. For further details and additional context, see the California Department of Public Health December 26, 2023 Memo to All Local Health Jurisdictions and the CalAIM PHM Policy Guide (p. 8-10).

- The CHA describes the status of population health within a jurisdiction. Although the BHSA does not specifically reference the CHA and only the CHIP, the CHA and CHIP are part of the same local LHJ planning process, and the CHA is the essential precursor step to developing the CHIP.
- Informed by the CHA, the CHIP identifies how the public health entity will work with community partners to address key issues elevated in the CHA.

An array of tools and processes may be used to conduct a CHA and develop a CHIP; the essential feature is that these processes are informed by community collaboration and participation. Since the CHA and CHIP processes are tailored to address local community needs, there is no requirement to include prescribed topic areas such as specialty or non-specialty mental health, or other content areas.

At present, most LHJs complete or update their CHAs and CHIPs every five years when seeking to obtain and maintain voluntary Public Health Accreditation Board (PHAB) accreditation. Some LHJs are on a three-year submission cycle to align with local processes, such as non-profit hospital community health needs assessments. Currently, non-accredited LHJs can choose not to formally conduct CHAs and CHIPs.

Starting in 2028, as a part of the collaborative state efforts to improve local integration in community planning, the CHA and CHIP will be mandatory for all LHJs, and all LHJs will implement the same three-year submission cycle, as described below in Figure 3.B.2.1. This timeline is intentionally designed to align with and inform BHT IP planning processes as well as simplify the new PNA-CHA policy for MCPs operating in multiple local health jurisdiction areas.

B.2.1.2 Background: MCP PNA

The PNA is the mechanism that MCPs use to identify (1) priority needs of their local communities and members and (2) health disparities. Under the CalAIM Population Health Management (PHM) Program, since January 1, 2024, MCPs have fulfilled their

PNA requirement by meaningfully participating in the development of LHJ CHAs and CHIPs in the service areas where MCPs operate.

MCP meaningful participation includes:

- **Collaboration.** MCPs must participate in every LHJ CHA and CHIP in their service area and collaborate with other MCPs within the same service areas to foster a unified planning process.
- **Data-Sharing.** MCPs are expected to share data with LHJs in ways that support .the CHA and CHIP process.
- **Stakeholder Engagement.** MCPs must attend key CHA and CHIP meetings and serve on CHA and CHIP governance structures, as requested by LHJs.
- **Funding and/or In-Kind Staffing.** Starting on January 1, 2025, MCPs are required to contribute funding and/or in-kind staffing to support LHJ CHA and CHIP processes.

See the CalAIM PHM Policy Guide for additional details on MCP PNA Requirements (pages 7-10).

MCPs are required to complete an "MCP-LHJ Collaboration Worksheet" to demonstrate that they are meeting their PNA requirement. MCPs are not required to submit MCP-LHJ Collaboration Worksheet unless requested by DHCS. In addition, all MCPs are required to submit a PHM Strategy which provides details on MCPs' meaningful participation on LHJs' CHA and CHIP.

DHCS and CDPH collaborated to create a regulatory environment that supports effective and efficient joint work on CHAs and CHIPs between LHJs and MCPs. Thus, aligned with CDPH guidance, the cycles for LHJs' CHA and CHIP development will become standardized across California starting in 2028, as previously noted, and as displayed in the timeline below.

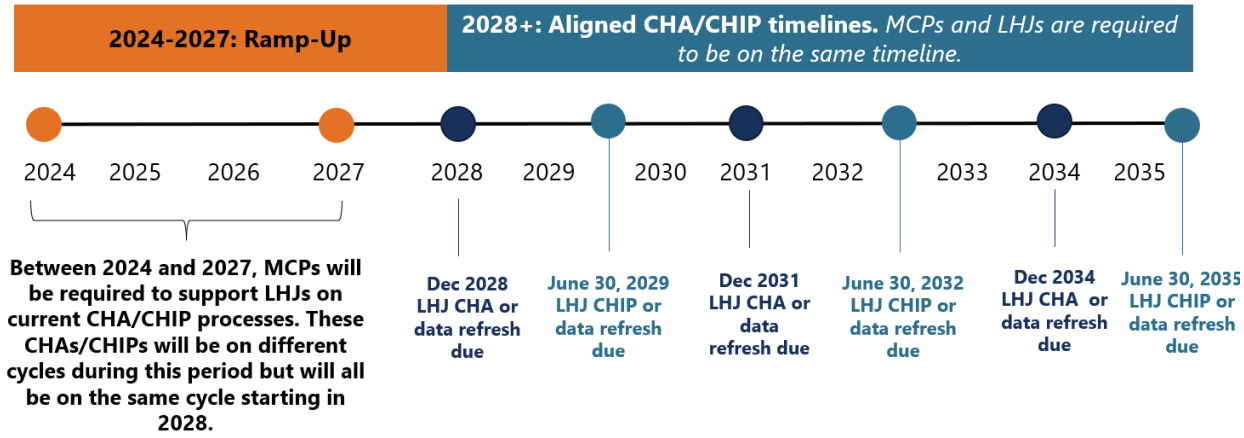


Figure 3.B.2.1. LHJ CHA and CHIP Submission Cycle Alignment Timeline

B.2.2 Overlap and Alignment with Other Local Program Planning Processes

County behavioral health departments (counties), LHJs, and MCPs share a common interest in identifying the needs of the populations and communities they serve. Points of integration existed before SB 326 and its IP mandate, and some counties, LHJs, and MCPs have been collaborating on CHA/CHIP processes for many years.

Specific to BHSA mandates that counties work with and consider LHJ CHAs and CHIPs, and MCP PNAs, DHCS has established the following guiding principles to work toward the achievement of common goals:

- Counties, LHJs, and MCPs serve overlapping local communities and should collectively be aware of key, population-level needs and challenges.
- There is an opportunity to employ complementary and coordinated strategies and interventions across delivery systems.
- As counties begin to engage in the PNA, CHA, and CHIP processes, alignment should lead to more integrated, *upstream*, and effective community health initiatives and prevention strategies to improve population health.
- Given the distinct focus areas and different populations that LHJs, MCPs, and counties serve, DHCS intends for this alignment to supplement the broader county IP requirements.

Figure 3.B.2.2 depicts the initial level of overlap anticipated as counties and LHJs embark on, or in some cases continue, collaborative efforts related to the development and alignment of community needs assessments and planning processes. Additionally, it demonstrates that the IP has numerous requirements unrelated to the LHJ CHA and CHIP. However, over time, as relationships advance, collaboration strengthens, and

timelines align, county, MCP, and LHJ overlap on CHAs and CHIPs will likely increase, and the overlap in these circles will expand.

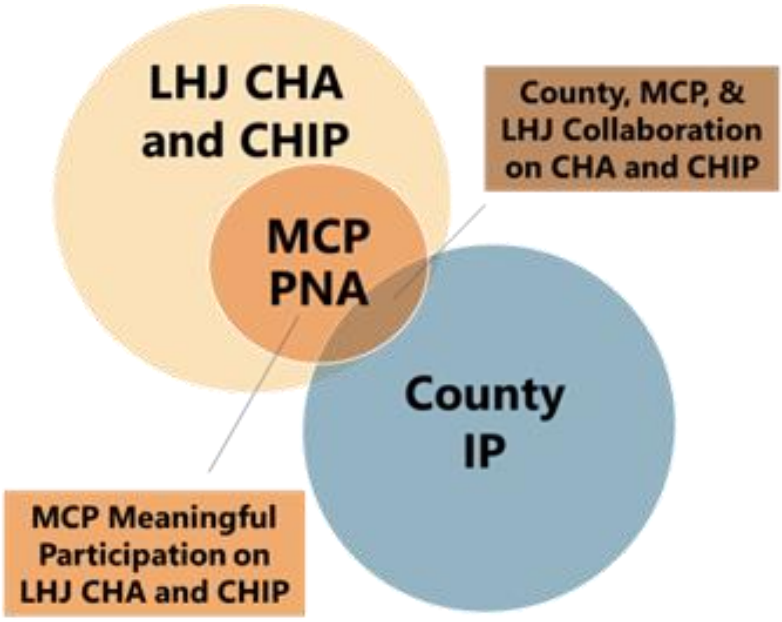


Figure 3.B.2.2 LHJ CHA and CHIP, MCP PNA, and County IP Overlap

B.2.3 County Requirements

This section provides county requirements, effective January 2025, for alignment with LHJs and MCPs in support of the IP submissions.

1. Engagement with Other Local Program Planning Processes

Counties are required to engage with LHJs and MCPs on CHAs and CHIPs, across the three areas described below. However, given that counties' IPs and LHJs' CHAs and CHIPs are driven by unique local needs, DHCS will allow for flexibility in how counties may work with LHJs and MCPs. For example, specific behavioral health topics and focus areas may vary from county to county.

Area 1: Collaboration. Over time, counties, LHJs, and MCPs can partner to focus on coordinated strategies for upstream interventions that can improve population health. To advance meaningful collaboration, counties are required to:

- Work with LHJs on the development of the CHA and CHIP in that county (or city, recognizing three city LHJs. For a complete list of LHJs, see CDPH's listing of local health services/offices.), along with MCPs, in fulfillment of their meaningful participation requirements. If multiple MCPs are present in the county or city, they will already be aligned in support of the LHJ in accordance with DHCS PHM Policy Guide mandates.

- Attend key CHA and CHIP meetings and serve on CHA and CHIP governance structures, including CHA and CHIP subcommittees, at the request of LHJs when discussions are relevant to behavioral health issues.

Area 2: Data-Sharing. Counties, LHJs, and MCPs all have access to their own siloed data. When this data is shared among these partners, it can be used to improve population health by creating a more holistic picture of the multiple factors contributing to a community's health. Counties are expected to work with LHJs and MCPs to determine the types of relevant data to be shared, taking into consideration the specific nature of CHAs and CHIPs, the needs of the counties, and how data should be de-identified/disaggregated, if needed. Counties are required to begin to identify Statewide Behavioral Health Goals (as described in Chapter 2, Section C.2 Statewide Population Behavioral Health Goals) to:

- Share data to support behavioral health-related focus areas of the CHA and CHIP. Counties will need to adhere to applicable federal and state privacy laws and regulations (e.g., consent requirements) and relevant frameworks (e.g. the California Health and Human Services Agency Data Exchange Framework if county is a signatory) while fulfilling the BHSA requirements to share and utilize data, as will MCPs and LHJs. BHSA includes broader data sharing and utilization requirements that counties must fulfill for their IP submissions.
- Utilize and stratify data from LHJs and MCPs to inform IP development.

Counties are subject to various and specific mandates regarding data sources, uses, and stratification for IP development that exceed the integration of LHJs' and MCPs' data. DHCS expects that counties must continue to meet any broader data requirements required by the IP that may not be fulfilled through the LHJ CHA and CHIP processes.

Area 3: Stakeholder Engagement. Given that BHSA identifies more than twenty specific populations and stakeholder groups that counties must engage in the development of the IP, counties should work with LHJs to look for opportunities where IP stakeholder engagement could be combined or integrated with CHA/CHIP processes to reduce duplication and community fatigue. LHJs generally involve a wide array of community stakeholders in the CHA and CHIP development processes. In order to streamline community input and reduce redundancy, counties are required to:

- Coordinate stakeholder activities for IP development with LHJ engagement on the CHA and CHIP to the extent possible.
- Consider input from diverse populations and a wide range of community stakeholders.

DHCS expects that counties must continue to meet any broader stakeholder engagement requirements that may not be fulfilled through the LHJ CHA and CHIP processes.

Because LHJ stakeholder engagement on CHAs and CHIPs is uniquely focused on the individual needs of each community, there are no prescribed topics or mandated focus areas. However, behavioral health may be a key focus area identified by communities. Counties are expected to participate in the CHA and CHIP as described above, and where behavioral health-specific needs arise through the progress, work with LHJs and MCPs to incorporate addressing such needs in its IP.

The county requirements across all three areas noted mirror MCP requirements for meaningful participation on LHJs' CHAs and CHIPs. DHCS does not require or expect counties to provide funding and/or in-kind staffing to support the LHJ CHA and CHIP processes. Per the CalAIM: PHM Policy Guide, however, MCPs are required to work with LHJs to determine what combination of funding and/or in-kind staffing the MCP will contribute to the LHJ CHA/CHIP process.

As mentioned previously, due to the current disparate submission cycles for LHJ CHAs and CHIPs, counties should consider the most recent CHA and CHIP on record, which could be up to four years old (depending on the submission cycle) and/or may not be available in all LHJs, when preparing their 2026 IP submissions. For the LHJs without CHAs or CHIPs available, counties should reach out to their respective LHJ to determine if a Strategic Plan is available for their review.

2. Technical Assistance: County-LHJ-MCP Collaboration Tool

In alignment with MCP PNA requirements and to support successful partnerships among counties, LHJs, and MCPs, DHCS will develop a "County-LHJ-MCP Collaboration Tool" (see Appendix; *placeholder- Tool to be added when finalized*). This tool may be used to support collaboration, data sharing, and stakeholder engagement.

Additionally, LHJs will be separately surveyed to provide their insight on the collaboration with counties.

3. Iterative Approach for Overlap and Alignment

Figure 3.B.2.3 below details the timeline for implementation of the county, LHJ, and MCP collaboration requirements for the first IP submission in 2026 through the 2029 IP submission.

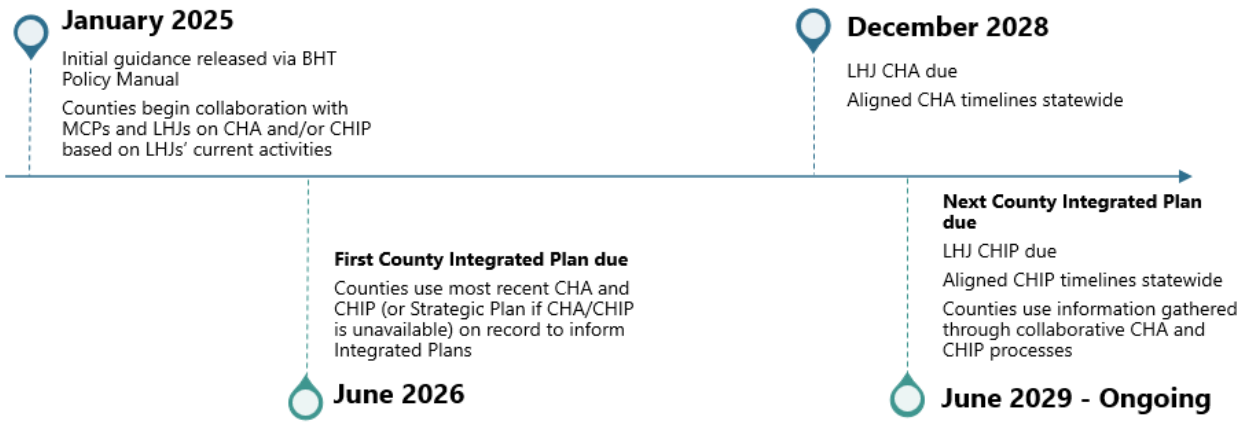


Figure 3.B.2.3 Timeline for Implementation of County, LHJ, and MCP Collaboration

Counties, LHJs, and MCPs should take time in 2025 to come to a common understanding of the respective key facts, goals, and language in each system.

- Opportunities should be identified for each entity to share background on their respective requirements and processes (relative to the IP, the PNA, and the CHAs and CHIPs) and how they utilize these tools.
- Counties, MCPs, and LHJs should ensure all parties are aligned on one another's roles and responsibilities, the populations they serve, and the services they are responsible for providing.

B.3 Public Comment and Updates to the Integrated Plan

Comment Period

Counties are required to provide 30 days for stakeholder comment on each IP. An IP and update shall be prepared and circulated for review and comment for at least 30 days (WIC section 5963.03, subdivision (a)(2)(B)) to representatives of stakeholder interests and any interested party who has requested a copy of the plans.

Local Behavioral Health Board

The local behavioral health board shall conduct a public hearing on the IP at the close of the 30-day comment period (WIC section 5963.03, subdivision (b)(1)).

Once an IP is ready for public comment, the local behavioral health board is required to review the draft plan and make recommendations to the local behavioral health agency for revisions (WIC section 5963.03, subdivision (b)(4)). The local behavioral health board is not required to approve county Integrated Plans.

The local behavioral health agency is also required to provide an annual report to the local governing body (WIC section 5963.03, subdivision (b)(5)), which is the local Board of Supervisors or city council, and DHCS that includes written explanations in response to any substantive recommendations made by the local behavioral health board that are not included in the final IP or update (WIC section 5963.03, subdivision (b)(5)).

Revisions to the Integrated Plan

After the 30-day comment period and public hearing are complete, counties are required to make the following revisions to the IP:

- Each IP should include a summary of substantive written recommendations (WIC section 5963.03, subdivision (b)(2)).
- The IP should also include a summary and analysis of the revisions made as a result of stakeholder feedback (WIC section 5963.03, subdivision (b)(3)).

Annual Updates and Intermittent Updates

Counties must prepare annual updates to their IP and may prepare intermittent updates, although intermittent updates are not required. When preparing Annual and Intermittent Updates, counties are encouraged, but not required, to comply with the stakeholder process outlined in WIC section 5963.03, subdivision (a) and WIC section 5963.03, subdivision (b). Counties may choose to elicit participation from stakeholders when preparing annual and intermittent updates. If counties choose to request stakeholder feedback, the county must comply with the local behavioral health board public hearing requirements (WIC section 5963.03) outlined above.

Counties must post Annual and Intermittent Updates to their IP and a summary and justification of changes to their website for a 30-day comment period prior to the effective date of the updates (WIC section 5963.03, subdivision (c)(2)(B)). Counties will submit annual and intermittent updates to DHCS through the county portal. Counties can download their completed IP from the county portal and submit to the Behavioral Health Services Oversight and Accountability Commission (BHSOAC).

B.4 County Planning Funds

B.4.1 Planning Costs

Counties may allocate up to 5 percent of the total annual revenue received from the local Behavioral Health Services Fund (BHSF) to fund planning costs. All allocations and expenditures for planning costs must be included in the county IP and Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). These planning costs (WIC section 5892, subdivision (c)) shall include funds for county mental health and

substance use disorder programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process.

Planning costs may be used to help pay for infrastructure and technologies that will support robust stakeholder engagement. Examples may include but are not limited to:

- Laptops and other technologies to help stakeholders participate in the planning process
- Web-based meeting platforms
- Virtual engagement tools
- Accessibility services
- Stipends, wages, and contracts to be paid to consumers and family members
- Translation/interpretation services
- Travel and transportation for stakeholders
- Childcare
- Eldercare
- Training and technical assistance (TTA) for stakeholders to be meaningfully involved including TTA on fiscal policies
- Other supports to help with stakeholder engagement

Counties may use planning funds to assess public behavioral health workforce needs required as part of the IP, including the number of providers and vacancies in the county, the county's ability to develop and maintain a robust workforce that provides adequate access to services and supports, and address statewide behavioral health goals described in Chapter 2, Section C of this policy manual. Counties will no longer be required to submit a separate Workforce Needs Assessment beyond what is included in the IP.

Planning costs do not include costs incurred as administrative costs or program expenditures. Additional information on administrative costs, including direct and indirect costs, can be found in Chapter 6.B.

C. Behavioral Health Care Continuum

C.1 Background

Each county's Integrated Plan (IP) and its associated budget template is required to describe how it will spend behavioral health dollars across a care continuum. Specifically,

each county is required to demonstrate, per (WIC section 5963, subdivision (a)(1)), how it will:

> "utilize various funds for behavioral health services to deliver high quality, culturally responsive, and timely care along the continuum of services in the least restrictive setting from prevention and wellness in schools and other settings to community-based outpatient care, residential care, crisis care, acute care, and housing services and supports."

To provide counties with more specificity as to what it means to provide care along "the continuum of services," the California Department of Health Care Services (DHCS) has defined a Behavioral Health Care Continuum. The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder (SUD) and mental health (MH) services. These frameworks will allow counties to describe their expenditures across key service categories, identify gaps in their service continuum, and articulate the investments they will make to expand access, close identified gaps, and improve performance as indicated through statewide behavioral health goals. The use of a standardized Behavioral Health Care Continuum also enables state-level analysis and comparison over time and across counties. The information that counties provide through the Behavioral Health Care Continuum in the IP will not be used to evaluate compliance with expenditure requirements for Behavioral Health Service Act (BHSA) funds.

C.2 Behavioral Health Care Continuum

Counties will report on *planned* service delivery and expenditures in the IP and budget template, and *actual* service delivery and expenditures in the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) and expenditure template, disaggregated by child/youth under age 21 and adults aged 21 and older, within the Behavioral Health Care Continuum service categories outlined below. Counties will plan expenditures in the IP by *totaling* the dollar amount *across all* behavioral health funding streams for each Behavioral Health Care Continuum service category and will report actual expenditures in the BHOATR by *listing* the dollar amount from *each* behavioral health funding stream for each Behavioral Health Care Continuum service category.

The Behavioral Health Care Continuum (shown in Figure 3.C.1) has eight service categories across discrete SUD and MH frameworks, which capture behavioral health programs and services delivered by county behavioral health agencies. The SUD framework includes services provided in facilities designated as Institutions for Mental

Disease (IMD) and services in non-IMD facilities. The Behavioral Health Continuum includes services provided in facilities designated as IMDs and services in non-IMD facilities. The IMD exclusion is only applicable to billing for Medi-Cal services. SUD services referenced in Figure 3.C.1 reflect the American Society of Addiction Medicine (ASAM) 3rd Edition; Medi-Cal guidance on ASAM 4th edition is forthcoming.

One category, Housing Intervention Services, will be reported as a single total across the SUD and MH frameworks within the IP. For the BHOATR, DHCS will ask counties to report actual spending on Housing Intervention Services distinctly in each of the SUD and MH frameworks.



Figure 3.C.1 Behavioral Health Care Continuum

The Behavioral Health Care Continuum does not include county expenditures on: 1) workforce investment activities; 2) capital infrastructure activities; 3) quality and accountability, data analytics, plan management, and administrative activities; and 4) other *non-clinical service* county behavioral health agency activities (e.g. Public Guardian, forensic activities, Community Assistance, Recovery and Empowerment (CARE) Act). Counties will report these expenditures in the IP and BHOATR distinctly from the Behavioral Health Care Continuum. These non-Continuum expenditure categories will be described in forthcoming guidance on IP and BHOATR reporting.

Tables 3.C.1 and 3.C.2 below describe each of the categories that span the SUD and MH frameworks. The tables below offer descriptions of each service category – informed by DHCS's previous assessment of California's Medi-Cal behavioral health service delivery system and tailored to the county landscape – as well as examples of the specific services that should be reported under the SUD and MH frameworks. A more detailed inventory cataloguing DHCS' recommended approach to reporting service expenditures across categories in the Behavioral Health Care Continuum will be provided with the release of the IP and BHOATR. Some services, like peer supports, medication services, and case management, may cut across several categories in the Behavioral Health Care Continuum; the funding for these services should be allocated according to the setting

in which services are delivered (i.e., peer support services delivered within an outpatient setting should be categorized within "outpatient services").

SUD and MH frameworks include county reporting on population prevention services. While DHCS recognizes BHSA funds for population prevention are exclusively with the California Department of Public Health (CDPH), counties have other funds that they may use for population prevention (e.g., Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), opioid settlement, Realignment, etc.) which DHCS anticipates this category will capture.

Table 3.C.1 Substance Use Disorder Care Continuum Service Categories, Definitions, and Example Services

Service Categories	Service Category Definition	Example SUD Services *(ASAM 3rd edition)*
Population Prevention Services	Includes services and activities that educate and support individuals to prevent substance misuse and substance use disorders from developing. These services/activities offer communities support in identifying and addressing issues, tools for coping with stressors and information on ways to promote resiliency. They may also include services and public health campaigns focused on overdose prevention. **Note**: BHSA funds for population prevention are exclusively with the California Department of Public Health.	• Substance use disorder education, such as paid media campaigns regarding "fentapills" • Targeted prevention, such as SUBG-funded prevention screenings and referrals
Early Intervention Services (WIC section 5840, subdivision (b)(1)-(3))	Includes interventions that take a proactive approach to identifying and addressing substance use issues among individuals who are showing early signs, or are at risk, of a substance use disorder. These interventions, such as outreach, access and linkage, and treatment services, help avert the development of a severe and disabling condition, discourage risky behaviors and support	• Screenings • Brief intervention, American Society of Addiction Medicine (ASAM) level 0.5 • Evidence-based practices, like motivational interviewing

Service Categories	Service Category Definition	Example SUD Services *(ASAM 3rd edition)*
	individuals in maintaining healthy lifestyles.	
Outpatient Services (WIC section 5887, subdivision (a)(4))	Includes a variety of therapeutic substance use disorder services that can be provided anywhere an individual is located, such as in school, home, clinic, office, or other outpatient settings. These services may help avert the need for, or be provided after, crisis care, inpatient, or residential treatment. These services are provided, if necessary, as part of stabilization and continued recovery/ongoing evaluation.	• ASAM level 1.0, including individual and group therapy • Contingency Management • Narcotic/Opioid Treatment Programs
Intensive Outpatient Services	Includes services to support individuals living with higher acuity SUD needs who may require assistance at a higher frequency and/or intensity, sometimes via a team-based approach. These services offer structure and monitoring when more support than routine outpatient visits is necessary.	• ASAM levels 2.1-2.5
Crisis and Field-Based Services	Includes a range of services that engage, assess, stabilize, treat, and/or coordinate care for individuals in need of substance use disorder services in field settings (e.g., homeless encampments, shelters, or syringe service programs). Services may be delivered in non-traditional settings where individuals work or reside.	• Mobile crisis • Assertive field-based initiation for substance use disorder treatment services (WIC section 5887, subdivision (a)(3)) • Post overdose follow up
Residential Treatment Services	Includes low- to high-intensity clinically managed residential treatment. Services may be delivered in short-term residential settings of any size.	• ASAM level 3.1-3.5 care
Inpatient Services	Includes 24-hour, intensive treatment services to individuals who require	• ASAM levels 3.7-4.0

Service Categories	Service Category Definition	Example SUD Services *(ASAM 3rd edition)*
	medical management or medical monitoring for substance use disorder needs.	• SUD services within a general acute care hospital (GACH), acute psychiatric hospital (APH), psychiatric health facility (PHF), or mental health rehabilitation center (MHRC)
Housing Intervention Services *(reporting is aggregated with the mental health framework)*	Includes services and supports designed to enable individuals to remain in their homes or obtain housing to support recovery and improved health outcomes. Services help individuals find and retain housing, support recovery and resiliency, and/or maximize the ability to live in the community.	• Permanent supportive housing • Housing tenancy and sustaining services • Recovery residences and sober living homes • Rent • Interim Settings

Table 3.C.2 Mental Health Care Continuum Service Categories, Definitions, and Example Services

Service Categories	Service Category Definition	Example MH Services
Population Prevention Services	Includes services and activities that educate and support individuals to prevent acute or chronic conditions related to mental health from ever developing. These services/activities may offer communities support in identifying and addressing issues before they turn into problems, tools for	• Mental health education, such as public health campaigns for suicide prevention or adverse childhood

Service Categories	Service Category Definition	Example MH Services
	coping with stressors and information on ways to promote resiliency.	experiences (ACEs) awareness • Community Health Workers
Early Intervention Services (WIC section 5840, subdivision (b)(1)-(3))	Includes interventions that take a proactive approach to identifying and addressing mental health issues among individuals who are showing early signs, or are at risk, of a mental health disorder. These interventions, such as outreach, access and linkage, and treatment services, help avert the development of a severe and disabling condition, discourage risky behaviors and support individuals in maintaining healthy lifestyles.	• Screenings • Evidence-based practices, such as coordinated specialty care for first episode psychosis
Outpatient & Intensive Outpatient Services (WIC section 5887, subdivision (a)(4))	Includes a variety of therapeutic mental health services that can be provided anywhere an individual is located, such as in school, home, clinic, office, field settings (e.g. homeless encampments, shelters, etc.) or other outpatient settings. Also includes services to support individuals living with higher acuity mental health needs who may require assistance at a higher frequency and/or intensity, sometimes via a team-based approach. These services may help avert the need for, or be provided after, crisis care, inpatient or residential treatment and are provided, if necessary, as part of stabilization and continued recovery/ongoing evaluation. They may also offer structure and monitoring when more support than routine outpatient visits is necessary.	• Individual therapy • Group therapy • Assertive Community Treatment/ Forensic Assertive Community Treatment (ACT/FACT) • High Fidelity Wraparound (HFW) • Intensive Outpatient Treatment/Day Treatment Intensive
Crisis Services	Includes a range of services and supports that assess, stabilize, and treat individuals experiencing acute distress. Services are designed to provide relief to individuals	• Crisis call centers • Crisis stabilization

Service Categories	Service Category Definition	Example MH Services
	experiencing a mental health crisis, including through de-escalation and stabilization techniques, and may be delivered in clinical and non-clinical settings.	• Crisis residential services • Mobile Crisis
Residential Treatment Services	Includes intensive treatment services that are provided in a structured, facility-based setting to individuals who require consistent monitoring for mental health needs on a longer-term basis. Services may be delivered in short-term residential settings to divert individuals from or as a step-down from hospital and acute services.	• Adult residential treatment services
Hospital and Acute Services	Includes treatment services that are provided in structured, hospital settings to individuals who require consistent monitoring and stabilization. These services may include comprehensive psychiatric treatment, including medication adjustments, and acute withdrawal services.	• Services within a psychiatric health facility (PHF), acute psychiatric hospital (APH), or psychiatric unit within a general acute care hospital (GACH).
Subacute and Long-Term Care Services	Includes intensive licensed skilled nursing care provided to patients with mental health needs, most frequently delivered in a skilled nursing facility (SNF) and special treatment programs (STPs).	• Services within a SNF & SNF-STP • Services within a MHRC
Housing Intervention Services *(reporting is aggregated with the substance use disorder framework)*	Includes services and supports designed to enable individuals to remain in their homes or obtain housing to support recovery and improved health outcomes. Services help individuals find and retain housing, support recovery and resiliency, and/or maximize the ability to live in the community.	• Permanent supportive housing • Housing tenancy and sustaining services • Residential Care Facilities for the Elderly (RCFE) and Adult Residential Care Facilities (ARF)

Service Categories	Service Category Definition	Example MH Services
		• Rent • Interim Settings

D. County Integrated Plan Alignment with Statewide Population Behavioral Health Goals

As outlined in WIC section 5963.02, subdivision (c)(3)(A), each county shall develop an Integrated Plan (IP) and annual update (AU) aligned with their associated measures. DHCS will identify and provide counties with measures of their performance relative to the statewide behavioral health goals. Counties will use those measures to inform resource planning in their IPs and AUs, as well as their approach to population health management and implementation of targeted interventions to drive progress on statewide behavioral health goals. In forthcoming guidance, DHCS will describe its approach to calculating performance measures and delineate expectations for counties, MCPs, and other stakeholders as part of a monitoring and accountability framework. See Chapter 2, Section C for more detailed information.

E. Guidance for Completing the Integrated Plan

E.1 Integrated Plan Template

The Integrated Plan template and budget template are provided as separate documents.

E.2 General Requirements

E.2.1 Integrated Plan Requirements

E.2.1.1 Draft Integrated Plan Requirements

All counties must submit a draft Integrated Plan (IP) by March 31 of the fiscal year prior to the fiscal years covered in the IP to the Department of Health Care Services (DHCS). All exemption or funding transfer requests must be submitted as part of the draft IP submission.

Counties must also include a letter from the County Administrator approving the draft IP, including the exemption and funding transfer request, within the draft IP submission. The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the

individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

In the IP, counties are required to report all planned activities for county behavioral health services provided under the funding sources listed in Chapter 3, Section A.2 of the Behavioral Health Services Act (BHSA) County Policy Manual. Counties are required to report planned expenditures for the activities and services reported in the IP in an accompanying budget template, described further in Chapter 3, Section E.2.2. below. DHCS will provide close-ended response options (e.g., yes/no questions, multiple-selection buttons, dropdown menus, or numerical responses) where possible to promote consistency and data analysis across county IPs.

To complete the IP and project estimates for the plan period, counties must refer to relevant data from the most recent sources available (WIC section 5963.02, subdivision (b)(2)) or from the dates specified by DHCS in the IP template. DHCS recognizes that some information required in the IP, particularly regarding population-level health and demographics, may change during the time period covered by the IP or annual update. The purpose of requiring such information in the IP is to provide background information on the county and the county's behavioral health delivery system that can be leveraged by counties and stakeholders during the community planning process.

For a draft IP to be considered complete, a county must include the following:

- Response to each required item in the IP template.
- Include certifications from both the county behavioral health director and the County Administration Officer (or other county equivalent) or their designee certifying compliance with fiscal accountability requirements and that all planned expenditures are consistent with applicable state and federal law (WIC section 5963.02, subdivision (c)(11)).

In order to have IPs that are effective July 1, DHCS anticipates that the draft IP submitted will be as close to final as possible, with minimal changes to the final IP submission.

E.2.1.2 Final Integrated Plan Requirements

IPs and annual updates are required to be circulated for a 30-day comment period. Counties may choose whether to circulate their IP before or after they submit their draft IP; however, it must occur prior to submitting the final IP.

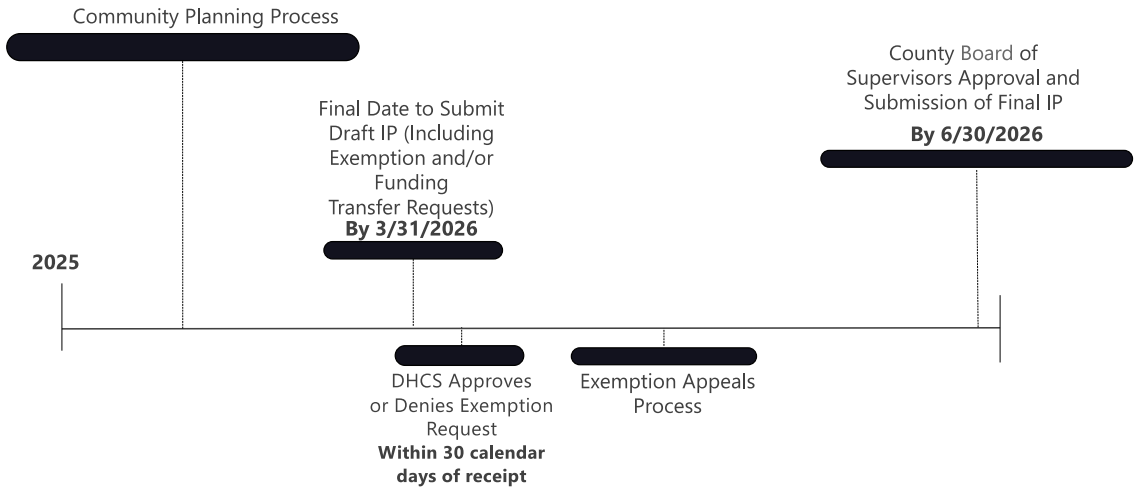
Then, after completing the 30-day public comment period, counties must submit their IP to the local behavioral health board for review. The behavioral health board must conduct a public hearing on the IP. The behavioral health board then must review the IP or update and make recommendations for revisions (WIC section 5963.03, subdivision (b)(4)).

Counties must also receive approval from the county Board of Supervisors and certification from the county behavioral health director, before submitting the final IP to DHCS by June 30 of the fiscal year prior to the fiscal years covered in the IP (WIC section 5963.02, subdivision (a)(3)).

For a final IP to be considered complete, a county must include the following:

- Response to each required item in the IP template.
- Include certification from the county behavioral health director, ensuring that the county has complied with all pertinent regulations, laws, and statutes (WIC section 5963.02, subdivision (c)(10)).
- Include certification by the county Board of Supervisors attesting the county will meet its realignment obligations (WIC section 14197.71, subdivision (c)(2)).

Figure E.2.1. FY 2026-2029 Integrated Plan Submission Timeline



E.2.2 Budget Template Requirements

In the IP budget template, counties must report all planned behavioral health service expenditures for each funding source listed in Chapter 3, Section A.2 according to the

Behavioral Health Care Continuum categories outlined in Chapter 3, Section C.2 of the Policy Manual. The planned expenditures included in the budget template must align with the services and activities the county reports in the IP.

In the "BH CC Expenditures" tab of the budget template, counties will total the dollar amount across the required behavioral health funding streams for each Behavioral Health Care Continuum service category (both Substance Use Disorder (SUD) and Mental Health (MH) frameworks), disaggregated by children/youth under age 21 and adults aged 21 and older. One category, Housing Intervention Services, will be reported as a single total across the SUD and MH frameworks within the IP. For the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR), DHCS will ask counties to report actual spending on Housing Intervention Services distinctly in the SUD and MH frameworks. The information provided in the "BH CC Expenditures" tab of the IP budget template will not be used to evaluate compliance with expenditure requirements for the Behavioral Health Service Act (BHSA) funds.

The Behavioral Health Care Continuum does not include projected expenditures for:

1. Workforce investment activities
2. Capital infrastructure activities
3. Quality and accountability, data analytics, plan management, and administrative activities
4. Other county behavioral health agency activities not otherwise captured in the Care Continuum (e.g. Public Guardian, LPS Conservatorship, DSH for housing, court diversion programs, Community Assistance, Recovery and Empowerment (CARE) Act)

Counties will report these expenditures separately in the "Other County Expenditures" tab of the budget template.

In addition to reporting expenditures according to the Behavioral Health Care Continuum, counties must report projected expenditures for each BHSA program component – Housing Interventions, Full Service Partnership (FSP) and Behavioral Health Services and Supports (BHSS) – in the respective tabs of the budget template. Counties will report BHSA administration costs that are directly related to each of the BHSA components within each component tab. Administrative costs that are associated with implementing the new requirements under BHSA should be included in the BHSA Plan Admin tab of the budget template. BHIN 25-016 provides instructions on how to claim

reimbursement for the new requirements. Detailed instructions for reporting projected expenditures for each BHSA program component are included in the respective tabs.

Counties must also report projected total behavioral health expenditures, BHSA component exemptions and transfers, plan administration expenditures, and prudent reserve assessments in accordance with the instructions provided in the budget template.

E.3 Process for Requesting Exemptions

E.3.1 Eligible Exemptions

Counties, if eligible, are allowed to request exemptions from some requirements for the BHSA Housing Interventions and FSP components. (All counties, regardless of population size, will be exempt from certain FSP requirements for the FYs 2026-2029 IP.) Please see Chapter 7, Section C.6.2 for information regarding Housing Intervention exemptions and Chapter 7, Section B.3.4 FSP Exemptions for information regarding FSP exemptions. For information about funding transfers, please see Chapter 6, Section B.4.

E.3.2 Exemptions Submission

Counties, if eligible, requesting an exemption from Housing Intervention and/or FSP requirements must submit the request through the county portal as part of the draft IP by March 31 of the fiscal year prior to the fiscal year covered in the IP (i.e., exemption requests for the 2026-2029 IP must be submitted to DHCS by March 31, 2026). Counties must begin their community planning process prior to submitting an exemption request to determine local priorities to make the exemption requests responsive to local needs. Exemption requests are only valid for the duration of the three-year plan. For each subsequent three-year plan submission, counties must submit updated exemption requests for DHCS approval.

E.3.3 Acceptance Criteria

DHCS will review the information provided in the county's IP and determine whether the exemption request aligns with the exemption criteria outlined in the Policy Manual. Counties requesting an exemption to either increase or decrease the required funding allocations for Housing Intervention programs must provide information that meets the criteria for Housing Intervention exemption requests in Chapter 7, Section C.6.2. Counties requesting one or more FSP exemption must provide information that meets the criteria for FSP exemption requests in Chapter 7, Section B.3.4.

E.3.4 Exemptions Approval

DHCS has 30 calendar days from receipt of the exemption request to approve or deny the county's request for exemption (WIC section 5892, subdivision (a)(1)(B)). The approval and/or denial of the exemption request will be completed through the county portal. If DHCS does not respond within 30 calendar days, the exemption request will be considered approved (WIC section 5892, subdivision (a)(1)(B)).

E.3.5 Appeals Process

Counties may appeal DHCS' decision to deny the county's exemption request. All appeals activities will occur through the county portal. Counties must submit their appeal request within 30 calendar days of receiving DHCS' denial. The appeal must include an explanation stating the basis of the appeal and supporting documentation. DHCS has 30 calendar days to approve or deny the appeal, starting with the date that DHCS confirmed receipt of the appeal. If an appeal is submitted after 30 calendar days from receipt of the denial, the appeal will be automatically denied.

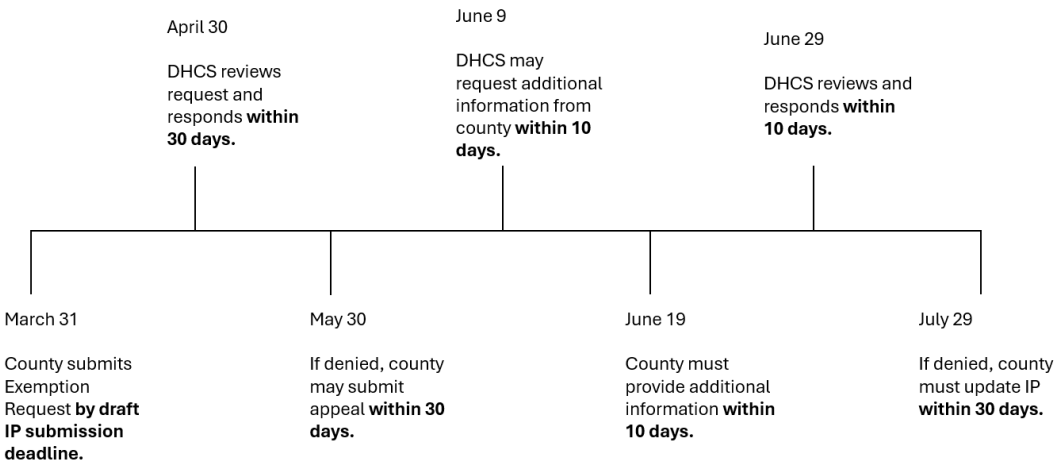
DHCS will have 10 calendar days from confirming receipt of the appeal to request additional documentation from the county; counties will supply additional documentation within 10 calendar days of confirming receipt of the request. DHCS will review and approve or deny the request within 10 calendar days of receiving the county's additional documentation. If DHCS rejects the exemption requested in the county's IP, the county must update their IP to reflect the denied exemption in their IP by June 30th of the year prior to the fiscal years the IP covers.

Exemption Appeals Process and Timeline:

1. County submits Exemption Request with the draft IP by March 31 deadline.
2. DHCS reviews request and approves or denies within 30 calendar days of request receipt.
3. If denied, county may submit an appeal through the county Portal within 30 calendar days of DHCS' decision.
4. DHCS may request additional documentation from the county within 10 calendar days of receipt of the appeal.
5. The county must respond to DHCS' documentation request within 10 calendar days of DHCS' request.
6. DHCS will review and approve or deny within 10 calendar days of receiving the additional documentation.

7. If the request is denied, DHCS will provide a justification for the denial and the county must update their IP by June 30th of the year prior to the fiscal years the IP covers.

Figure E.3.1. Exemption Request Appeals Timeline



E.4 Integrated Plan Submission

A final IP is due no later than June 30. County board of supervisor approval is required for submission by June 30 prior to the fiscal year the IP will cover. County Board of Supervisor approval (WIC section 5963.02, subdivision (a)(3)) of the first IP is due by June 30, 2026; this IP will cover fiscal years 2026-2029. Please refer to Figure E.2.1, the 2026-2029 Integrated Plan Submission Timeline, to see deadlines for the first IP.

Counties must also use the county portal to submit questions or concerns about IP submission and approval or for technical assistance with the submission.

Counties that fail to submit their IP by the March 31 and June 30 deadlines are out of compliance and may be subject to corrective action. DHCS' BHSA oversight policies will be discussed in future BHSA Policy Manual modules.

E.4.1 County Portal

Counties will develop and submit their IPs online through the DHCS county portal and may do so on a rolling basis once the county portal is publicly available. The county portal will include technical features that will increase transparency and give DHCS and stakeholders greater insight into the IP development process. The county portal will

allow county users to complete tasks such as filling in form-based prompts, documenting stakeholder involvement requirements, compiling fiscal information, and completing attestations. The county portal will support access for multiple county users, allowing multiple county teams to work concurrently to develop the IP. Counties must also use the county portal to submit questions or concerns about IP submission and approval or for technical assistance with the submission.

County portal technical features will include progress markers to track completion of each section of the IP, support tools allowing DHCS staff to review, collaborate on, and resolve questions from counties, and functionalities to distill key information into county profiles, which can show stakeholders where their county is in the community planning and IP development process. DHCS staff will be able to concurrently review county IP submissions and communicate directly with county contacts to resolve questions. The county portal will track both the county's progress in completing IP sections, DHCS staff review progress in a dashboard view, and for communication with counties about their plans.

E.4.2 DHCS Review Standards

DHCS will review a county's draft and final IP for completeness and validate that all IP content is aligned with guidance set forth in this Policy Manual and all BHSA statutory requirements. Upon submission, questions that require close-ended response options or document uploads will be automatically reviewed for completeness in the county portal. Line items in the budget template will be automatically validated where possible to ensure expenditures align with fiscal requirements outlined in this Policy Manual. DHCS staff will review IP submissions to ensure they include but are not limited to:

- Sufficient rationale for any requested exemptions or funding transfers (submitted with draft IP by March 31 for review of exemption and funding transfers).
    - Rationale for Housing Interventions or Full Service Partnerships (FSP) exemption requests must align with exemption criteria as described in Chapter 7, Section C.6 and Chapter 7, Section B.3.4 of this Policy Manual.
- Narrative content to ensure responses adequately address questions.
- Documentation of a complete community planning process and public comment period as described in Chapter 3, Section B of this Policy Manual.
- Goals for Population Behavioral Health measures and behavioral health disparities that are consistent with statewide behavioral health goals outlined in Chapter 2, Section C and Chapter 3, Section D of this Policy Manual and forthcoming related guidance.

- Projected expenditures and service utilization estimates across the Behavioral Health Care Continuum as described in Chapter 3, Section C of this Policy Manual.
- Projected BHSA component transfers, exemptions, and expenditure plans, BHSA administrative expenditures, prudent reserve information, and other county expenditures as outlined in the budget template and budget instructions.

Additionally, all proposed uses of behavioral health funding in the IP must be consistent with allowable expenditures for FSP, Housing Interventions, and Behavioral Health Services and Supports (BHSS). A complete IP must include a response to each required item in the county portal.

Table E.4.1 Submission Requirements for Draft and Final Integrated Plan

	Draft Integrated Plan	Final Integrated Plan
Deadline	By March 31, 2026	By June 30, 2026
Activities required prior to submission	Engage stakeholders through the local CPP	• Circulate draft IP for 30-day comment period • Conduct a public hearing by the local Behavioral Health bord on the IP • Behavioral Health Board reviews IP and/or makes recommendations for revisions • Revise draft IP, if requested by DHCS, within timeframes set in this policy manual in Chapter 3, sections E.3 and E.4
Items required to be included with submission	• Responses to each required item in the Integrated Plan and Budget Template	• Responses to each required item in the Integrated Plan and Budget Template

	Draft Integrated Plan	Final Integrated Plan
	• Funding Exemptions and Transfer Requests • Certification from County Administrative Officer, Chief Executive Officer, or designee to certify compliance with fiscal accountability requirements and that all planned expenditures are consistent with state and federal law • Certification from county Behavioral Health Director to certify compliance with fiscal accountability requirements and that all planned expenditures are consistent with state and federal law	• DHCS-approved Funding Exemptions and Transfer Requests • Certification from County Administrative Officer, Chief Executive Officer, or designee to certify compliance with fiscal accountability requirements and that all planned expenditures are consistent with state and federal law • Certification from the county Behavioral Health Director to ensure that the county has complied with all applicable regulations, laws, and statutes • Approval and certification by county Board of Supervisors attesting county will meet realignment obligations

County responses may be flagged for further review by DHCS monitoring divisions for follow-up regarding compliance issues. This is not a punitive process, rather an opportunity for DHCS to reach out to counties and assess whether technical assistance or other support may be needed, or to recommend revisions to the county's plan to align proposed activities with state guidance.

DHCS may require counties to revise their IP if DHCS determines the IP or annual update fails to adequately address the following local needs, as outlined in statute (WIC section 5963.02, subdivision (b)(2)):

- Prevalence of mental health and substance use disorder.

- Unmet need for mental health and substance use disorder treatment in the county.
- Behavioral health disparities.
- Homelessness point-in-time count.
- Allocation of funding between mental health and substance use disorder treatment services.

DHCS will review draft and final IPs for completeness and adherence to policy requirements prescribed in the Policy Manual and statute within 30 calendar days of submission. If DHCS deems a county's IP or annual update does not address a question directly or is inaccurate, DHCS will contact the county through the county portal to rectify and resubmit the IP as described in Chapter 3, Section E.2 of this Policy Manual. DHCS will contact all the county primary and secondary contacts listed in the IP submission to rectify and resubmit the IP. If DHCS requests the county revise their draft IP, the county will have 15 calendar days from the revision notice to address the issues raised by DHCS and resubmit the IP through the county portal. Counties are not required to undergo the stakeholder engagement process to resubmit their IP. DHCS will review the revised IP and respond through the county portal within 15 calendar days. IPs are effective beginning July 1 of the fiscal year the IP covers, and counties should move forward with their IP beginning July 1, even if the county is in the process of providing additional information to DHCS. Once the revised IP is resubmitted, DHCS will review the IP according to the criteria outlined in this section.

Submission for annual and intermittent updates will follow the same process as outlined above for the county IP. DHCS will review changes to the IP included in the annual and intermittent update as appropriate. Counties do not need to resubmit sections of the IP that have not changed in intermittent updates.

E.5 Joint Submission for Local Entities

This section describes the process for two or more county behavioral health departments acting jointly, or one or more city-operated programs or departments acting jointly with another city-operated program or department or county behavioral health department to submit a joint IP.

E.5.1 Submission Process

Counties that submitted joint three-year plans under the Mental Health Services Act (MHSA) (WIC section 5897, subdivision (b)) may continue to submit joint IPs under BHSA; the two city-operated mental health authorities receiving funds pursuant to WIC

section 5701.5 shall submit IPs independently from their counties under BHSA. Counties that have separate mental health and substance use disorder departments are required to collaborate on development of the IP and submit one joint IP to their county Board of Supervisors.

E.5.2 Guidance for Joint Integrated Plan Completion

Entities that submit joint IPs should complete the IP and IP budget template to report all planned activities and projected expenditures for all behavioral health services provided by the entities that are part of the joint powers authority (GOV section 56047.7) or joint submission. Counties with separate mental health and SUD departments must also report all planned activities and projected expenditures for BHSA services. The planned activities and projected expenditures must be reported as a combined total in accordance with the budget template for all entities included in the joint powers authority, joint submission, or the multiple county departments submitting jointly. Entities submitting a joint IP must ensure that data in the IP is unduplicated, including number of eligible individuals, individuals served, and services provided.

Counties must consider input and feedback provided by stakeholders (WIC section 5963.02, subdivision (b)(8)) to develop their IP; counties that submit joint IPs must engage stakeholders from all counties included in the joint submission. Counties (including joint powers authorities and counties submitting a joint IP under another arrangement) that have a combined total population greater than 200,000 are required to engage with the five most populous cities in the county (WIC section 5963.02, subdivision (b)(7)) as part of the community planning process. Cities submitting IPs independently will not need to collaborate with other cities. Counties (including joint powers authorities and counties submitting a joint IP under another arrangement) and cities submitting IPs independently are subject to the population threshold requirements outlined in this Policy Manual related to fiscal requirements (Chapter 6, Section B) and FSP and Housing Interventions (Chapter 7, Section B.3.4 and Chapter 7, Section C.6.2, respectively) exemptions.

E.5.3 Approval Process for Joint Integrated Plans

The IP must be approved by the Board of Supervisors for each county represented in the joint IP or other local governing body prior to final submission to the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) and DHCS. Joint IP submissions must include certification from the joint entity's behavioral health director as described in Chapter 3, Section 3.E.2.

E.6 Statewide Behavioral Health Goals

DHCS, in consultation with behavioral health stakeholders and subject matter experts, identified 14 statewide behavioral health goals focused on improving wellbeing and decreasing adverse outcomes. These behavioral health goals will inform state and county planning and prioritization of resources, and DHCS will continuously assess statewide and county progress toward these goals.

Counties must refer to the statewide behavioral health goals and associated measures during the county BHSA planning process. In their IP, counties are required to address the actions they are taking on seven required goals, including six priority goals and at least one goal in which the county-wide data is higher or lower than the statewide rate or average, as appropriate:

1. Access to Care
2. Homelessness
3. Institutionalization
4. Justice-involvement
5. Removal of children from home
6. Untreated behavioral health conditions
7. County/City/Joint Powers Authority-selected goal (from the remaining eight statewide behavioral health goals)

Counties may select more than one additional statewide behavioral health goal. Planning for each goal must be informed by the measures and reflect an approach for improving overall performance on the goal and for addressing disparities.

For the first IP, each county will review its data for all population-level behavioral health measures (i.e., Phase 1 measures) to inform their planning. For all IPs, IUs, and AUs submitted after July 1, 2026, each county will use the performance measures (as listed in Chapter 2, Section C.3).

E.6.1 Instructions for Addressing the Goals in the First IP

Note: These instructions apply to the first IP, in which counties are required to review the population-level behavioral health measures for each goal, listed below. Performance measures will be used for future reporting of the IP and the Annual Update (AU) starting in 2027. This section will be removed from the BHSA Policy Manual after July 2026.

In the IP, DHCS identifies "primary" and "supplemental" population-level behavioral health measures (referred to as primary measures and supplemental measures). Primary measures reflect the community's status and wellbeing for each goal, as defined in the Policy Manual. There is one primary measure (or a pair of related primary measures) for each goal. Supplemental measures provide additional context and data that are useful to better understand the status of the goal and inform planning. There are up to two supplemental measures for each goal. The following list provides all primary and supplemental measures for the 14 goals, noting the data source in parentheses after each measure. While counties play a critical role in advancing these goals, it is important to acknowledge that achieving them will require coordinated efforts across multiple systems and sectors. Please note that future improvement on a goal may be indicated by a measure increasing or decreasing, dependent on the specific measure and goal.

For the population-health measures used only in the first IP, DHCS identified "primary" and "supplemental" population-level behavioral health measures (referred to as primary measures and supplemental measures).

- Primary measures reflect the community's status and wellbeing for each goal, as defined in the Policy Manual. There is one primary measure (or a pair of related primary measures) for each goal.
- Supplemental measures provide additional context and data that are useful to better understand the status of the goal and inform planning. There are up to two supplemental measures for each goal.

The following list provides all primary and supplemental measures for the 14 goals, noting the data source in parentheses after each measure. While counties play a critical role in advancing these goals, it is important to acknowledge that achieving them will require coordinated efforts across multiple systems and sectors. Please note that future improvement on a goal may be indicated by a measure increasing or decreasing, dependent on the specific measure and goal.

Priority Statewide Behavioral Health Goals for Improvement and Their Corresponding Population-Level Behavioral Health Measures (also referred to as "Phase 1 Measures")

1. **Access to Care**
    - **Primary Measure:** SMHS Penetration Rates for Adults and Children & Youth; California Department of Health Care Services (DHCS), FY 2023

- **Primary Measure:** NSMHS Penetration Rates for Adults and Children & Youth; California Department of Health Care Services (DHCS), FY 2023
- **Primary Measure**: Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 – 2023
- **Primary Measure**: Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023
- **Supplemental Measure:** Initiation of Substance Use Disorder Treatment (IET-INI); California Department of Health Care Services (DHCS), 2023

2. Homelessness

- **Primary Measure:** People Experiencing Homelessness Point-in-Time (PIT) Count (Rate per 10,000 people by CoC Region); U.S. Department of Housing and Urban Development (HUD), 2024. (This dashboard leverages data from the U.S. Department of Housing and Urban Development 2023 Annual Homeless Assessment Report to Congress (AHAR)).
- **Primary Measure:** Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 - 2024
- **Supplemental Measure:** PIT Count Rate of People Experiencing Homelessness with Severe Mental Illness (Rate per 10,000 people by CoC Region); U.S. Department of Housing and Urban Development, 2024
- **Supplemental Measure:** PIT Count Rate of People Experiencing Homelessness with Chronic Substance Abuse (Rate per 10,000 people by CoC Region); U.S. Department of Housing and Urban Development, 2024
- **Supplemental Measure:** People Experiencing Homelessness who Accessed Services from a Continuum of Care (CoC); Homelessness Data Integration System (BCSH) – California Interagency Council on Homelessness, 2023 (This measure will increase as people access services.)

3. Institutionalization

Note: Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.

Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment.

- **Primary Measure:** Inpatient Administrative Days; California Department of Health Care Services (DHCS) (adults; children and youth), FY 2023
- **Supplemental Measure:** Involuntary Detention Rates (14-day; 30-day; 180-day post certification); California Department of Health Care Services (DHCS), FY 2021 - 2022
- **Supplemental Measure:** Conservatorships (temporary; permanent); California Department of Health Care Services (DHCS) , FY 2021 - 2022
- **Supplemental Measure:** SMHS Crisis Service Utilization (Crisis Intervention; Crisis Residential Treatment Services; Crisis Stabilization); California Department of Health Care Services (DHCS) (adults; children and youth), FY 2023

Please note: Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities. In particular, crisis residential treatment is an important alternative to inpatient hospitalization.

4. **Justice-Involvement**
   - **Primary Measure:** Arrests: Adults and Juvenile rates; California Department of Justice (DOJ), Statistical Year 2023
   - **Supplemental Measure:** Adult Recidivism Conviction Rate; California Department of Corrections and Rehabilitation (CDCR), FY 2019 - 2020
   - **Supplemental Measure:** Incompetent to Stand Trial (IST) Counts; California Department of State Hospitals (DSH), 2023
5. **Removal of Children from Home**
   - **Primary Measure:** Children in Foster Care; California Child Welfare Indicators Project (CWIP), Jan 1, 2025 PIT Count
   - **Supplemental Measure:** Open Child Welfare Case SMHS Penetration Rates; California Department of Health Care Services (DHCS), 2022

- **Supplemental Measure:** Child Maltreatment Substantiations; California Child Welfare Indicators Project (CWIP), 2022

6. **Untreated Behavioral Health Conditions**
    - **Primary Measure:** Follow-Up After Emergency Department Visit for Substance Use (FUA-30); California Department of Health Care Services (DHCS), 2022
    - **Primary Measure:** Follow-Up After Emergency Department Visit for Mental Illness (FUM-30); California Department of Health Care Services (DHCS), 2022
    - **Supplemental Measure:** Adults that Needed Help for Emotional/Mental Health Problems or Use of Alcohol/Drugs who had No Visits for Mental/Drug/Alcohol Issues in Past Year; California Health Interview Survey (CHIS), 2023

Additional Statewide Behavioral Health Goals for Improvement

1. **Care Experience**
    - **Primary Measure:** Perception of Cultural Appropriateness/Quality Domain Score; Consumer Perception Survey (CPS), 2024
    - **Supplemental Measure:** Quality Domain Score; Treatment Perceptions Survey (TPS), 2024
2. **Engagement in School**
    - **Primary Measure:** Twelfth Graders who Graduated High School on Time; Annie E. Casey Foundation Kids Count Data Center, 2022
    - **Supplemental Measure:** Meaningful Participation at School; California Healthy Kids Survey (CHKS), 2023
    - **Supplemental Measure:** Student Chronic Absenteeism Rate; California Department of Education Data Quest, 2022
3. **Engagement in Work**
    - **Primary Measure:** Unemployment Rate; California Employment Development Department (CA EDD), 2023
    - **Supplemental Measure:** Unable to Work Due to Mental Problems; California Health Interview Survey (CHIS), 2023

4. **Overdose**
    - **Primary Measure:** All Drug-Related Overdose Deaths; California Department of Public Health (CDPH), 2022
    - **Supplemental Measure:** All Drug-Related Overdose ED Visits; California Department of Public Health (CDPH), 2022
5. **Prevention and Treatment of Co-Occurring Physical Health Conditions**
    - **Primary Measure:**
        - Adults' Access to Preventive/Ambulatory Health Services; California Department of Health Care Services (DHCS), 2022
        - Child and Adolescent Well-Care Visits; California Department of Health Care Services (DHCS), 2022
    - **Supplemental Measure:**
        - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; California Department of Health Care Services (DHCS), 2022
        - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing; California Department of Health Care Services (DHCS), 2022
6. **Quality of Life**
    - **Primary Measure:** Perception of Functioning Domain Score; Consumer Perception Survey (CPS), 2024
    - **Supplemental Measure:** Poor Mental Health Days Reported; Behavioral Risk Factor Surveillance System (BRFSS), 2024
7. **Social Connection**
    - **Primary Measure:** Perception of Social Connectedness Domain; Consumer Perception Survey (CPS), 2024
    - **Supplemental Measure:** Caring Adult Relationships at School; California Healthy Kids Survey (CHKS), 2023
8. **Suicides**
    - **Primary Measure:** Suicide Deaths; California Department of Public Health (CDPH), 2022

- **Supplemental Measure:** Non-fatal ED visits due to self harm; California Department of Public Health (CDPH), 2022

The population-health measures for all statewide behavioral health goals are available in the County Population-Level Behavioral Health Measure Workbook. The County Population-Level Behavioral Health Measure Workbook contains publicly available data for all measures by county, as well as detailed instructions to access the original source for the most recent data and to stratify by demographic groups. The Workbook also contains further detail and analysis for each measure, such as county-to-county comparisons and statewide rates, where available. This resource provides the necessary data for each county to view and assess its county-wide status across all statewide behavioral health goals.

4. Behavioral Health Outcomes, Accountability, and Transparency Report

A. Purpose of the Behavioral Health Outcomes, Accountability, and Transparency Report

The Behavioral Health Services Act (BHSA) requires counties to submit Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) to the Department of Health Care Services (DHCS) on an annual basis (WIC section 5963.04, subdivision (a)(1)). Whereas limited information is publicly available regarding the provision of services that are funded with federal grant programs and other county-administered behavioral health funding sources outside of Medi-Cal, the BHSA establishes the BHOATR to provide California with greater transparency into how counties spend behavioral health dollars and administer behavioral health care. Counties will use the BHOATR Template to report on implementation of the county Integrated Plan (IP) and the related annual and intermittent updates. Counties are required to report on behavioral health spending, service utilization, and achievement of goals and outcomes outlined for the reporting period. County boards of supervisors are required to attest that the BHOATR is complete and accurate before it is submitted to DHCS (WIC section 5963.04, subdivision (c)). Additionally, in accordance with WIC section 14197.71, subdivision (c)(2), county boards of supervisors are required to attest that the county is meeting its realignment obligations, including but not limited to time and distance standards and appointment time standards set forth in WIC section 14197.7 without utilizing waitlists, and will do so through the BHOATR.

DHCS will review county BHOATRs. After DHCS approves the county BHOATR, DHCS will develop a statewide BHOATR describing activities and opportunities in behavioral health delivery across California. DHCS will post each county's BHOATR and an aggregated statewide BHOATR on the DHCS website (WIC section 5963.04, subdivision (d)).

A.1 Reporting Period

The first BHOATR will cover fiscal year (FY) 2026-27. The due date for the first BHOATR will be January 30, 2029. Counties will submit a draft BHOATR for FY 2026-27 due January 30, 2028. This one-time draft submission will allow DHCS to provide technical assistance.

A.2 Required Contents

The BHOATR template will mirror the reporting requirements within the IP template. A detailed list of sections required for inclusion in the BHOATR template is forthcoming.

5. County Portal

Department of Health Care Services (DHCS) has developed an online county portal for each county to submit their Integrated Plans (IP), Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATR), and annual and intermittent updates. To facilitate county reporting and ensure comparability between county reports, data from publicly available sources will be pre-populated into each county's IP county portal where possible. Detailed information on how to use the county portal will be available in the DHCS Integrated Plan County Portal User Manual.

6. BHT Fiscal Policies

A. Funding Overview

This chapter provides requirements from the Behavioral Health Services Act (BHSA) including but not limited to allocation methodologies, reporting requirements, local Prudent Reserve (PR) levels, and local Behavioral Health Services Fund (BHSF) requirements, effective July 1, 2026.

B. Behavioral Health Services Act Fiscal Policies

B.1 Allocation Methodology

The allocation methodology for the Behavioral Health Services Act (BHSA) remains the same as under the Mental Health Services Act (MHSA). The allocation schedule is developed using a methodology established in Fiscal Year (FY) 2005-06 by the former Department of Mental Health, in consultation with the County Behavioral Health Directors Association of California (CBHDA). In FY 2015-16, the methodology was amended by removing the uninsured population as a factor. The criteria and data sources used to establish the allocation schedule for current fiscal years remains the same as in prior years. However, the data are updated each year with what is most currently available.

WIC section 5891, subdivision (c) requires the Department of Health Care Services (DHCS) to provide the State Controller's Office (SCO) a schedule for the monthly distribution of funds from the state-level Behavioral Health Services Fund (BHSF) to each county's local BHSF. The schedule is provided to the SCO in August for the current fiscal year, and the SCO publishes the monthly distribution schedule on its website.

The allocation methodology is developed in two phases. The first phase involves calculating a need for services for each county based on each county's share of the state population, population at poverty level, and prevalence of mental illness and substance use disorders in each county. The second phase involves adjusting the need for services, based on the cost of being self-sufficient in each county and other resources available to each county.

DHCS publishes guidance on the allocation methodology each year. This notice communicates the allocation schedule that DHCS provided to the SCO, describes the

methodology used to determine those allocation schedules, and provides the amount of money the Governor's budget has estimated will be available in the BHSF.

B.1.1 Funding Allocations

Counties are required to establish a local Behavioral Health Services Fund (BHSF) and appropriately allocate BHSA funds that have been distributed by the SCO (WIC section 5892, subdivision (g)). Additionally, counties are required to spend funds consistent with the proposed activities and projected expenditures that have been approved in their Three-Year Integrated Plan (IP), intermittent updates, and/or annual update (AU) (WIC section 5892, subdivision (h)). The allocation of money would include any re-distributed reverted funds and will be based on the percentages outlined below, unless they receive an approved exemption or funding transfer from DHCS. Counties are required to establish and maintain sub-accounts for each funding component (Housing Interventions, Full Service Partnership (FSP), Behavioral Health Services and Supports (BHSS)) within their local BHSF. In addition, it is recommended that counties maintain sub-accounts for each of the suballocations listed below under each component, particularly for those with additional reporting requirements (Housing Interventions, Early Intervention) and those with longer reversion periods (Workforce Education and Training (WET), Capital Facilities and Technological Needs (CFTN)).

- 30 percent to Housing Interventions programs (WIC section 5892, subdivision (a)(1)(A)(i)).
    - Of the funds distributed for the Housing Interventions program, counties are required to use 50 percent of funds for housing interventions for persons who are chronically homeless, with a focus on encampments (WIC section 5892, subdivision (a)(1)(A)(ii)).
    - Of the funds distributed for the Housing Interventions program, counties are required to expend no more than 25 percent of funds for capital development (WIC section 5892, subdivision (a)(1)(A)(iii).
- 35 percent to Full Service Partnerships programs (WIC section 5892, subdivision (a)(2)(A)).
- 35 percent to Behavioral Health Services and Supports (WIC section 5892, subdivision (a)(3)(A)).
    - Adult, Older Adult, and Children's system of care, excluding the services provided by Housing Interventions and FSP programs.

- Early Intervention
    - Of the funding allocated for BHSS, at least 51 percent must be used for early intervention programs (WIC section 5892, subdivision (a)(3)(B)(i)).
    - Of the funding allocated for early intervention programs, at least 51 percent must be used to serve individuals 25 years of age and younger (WIC section 5892, subdivision (a)(3)(B)(ii)).
- Outreach and Engagement.
- Workforce education and training.
- Capital facilities and technological needs.
- Innovative behavioral health pilots and projects.

Further guidance regarding allowable expenditures for programs and services for Housing Interventions, FSP, and BHSS will be found in their corresponding section of this Policy Manual.

B.2 State Directed Funding

Beginning on July 1, 2026, prior to the state distributing local funds to counties each month, up to 10 percent of total annual revenues for the State BHSF will be allocated to the state-level initiatives listed below.

1. California Department of Public Health (CDPH)
    a. The state will allocate a minimum of 4 percent of total funds to provide population-based mental health and substance use disorder prevention programs. At least 51 percent of these funds must be used for programs that serve individuals 25 years or younger (WIC section 5892, subdivision (f)(1)(E)). For more information regarding CDPH and their prevention programs, please visit their website.
2. Department of Health Care Access and Information (HCAI)
    a. The state will allocate a minimum of 3 percent of total funds to support initiatives focused on building the behavioral health workforce (WIC section 5892, subdivision (f)(1)(D)). For more information regarding HCAI-led initiatives to build the behavioral health workforce, please visit their website.

3. State-directed Purposes
    a. The state will allocate 3 percent of total funds to support the operations of state agencies and the BHSA Innovation Partnership Fund where up to $20M will be allocated annually for Fiscal Years (FY) 2026-27 to 2030-31 (WIC section 5892, subdivision (f)(1)(F)). State-directed purposes include developing statewide outcomes, conducting oversight of county outcomes, training and providing technical assistance to counties, providing assistance to consumers and their family members, conducting research and evaluation, and administering programs.

B.3 Local Prudent Reserve

Counties are allowed to use local BHSF money to fund their local Prudent Reserve (PR), which they are required to establish and maintain, to ensure Housing Intervention programs, FSP, and BHSS are not significantly impacted in years in which revenues for the Behavioral Health Services Fund are below recent averages (WIC section 5892, subdivision (b)(1)). Counties may transfer funds out of the PR for the purpose of expending those funds consistent with the requirements set forth in this policy manual in years where BHSF revenues are below recent averages adjusted by changes in the state population and the California Consumer Price Index. This information will be posted annually to the DHCS BHSA webpage.

B.3.1 Prudent Reserve Assessment

Counties must assess their PR funding levels every three years and include the assessment in their IP (WIC section 5892, subdivision (b)(5)(A)), beginning with the Fiscal Year (FY) 2026-29 IP. Additionally, counties must include a plan on how they will spend any funds exceeding the maximum amount in their IP (WIC section 5892, subdivision (b)(5)(A). The reassessment must include the maximum (WIC section 5892, subdivisions (b)(3) and (b)(4)) and the actual funding levels of the county's PR. DHCS will complete this annual calculation for all counties and post it on the DHCS BHSA Webpage. Counties will utilize the adjusted PR levels when submitting their annual IP update.

B.3.2 County Prudent Reserve Maximums

DHCS will calculate the maximum local PR levels for each county annually. The county will use the amount determined by DHCS as the maximum amount (WIC section 5892, subdivisions (b)(3) and (b)(4)) to establish the local PR based on deposits into the BHSF. Counties are then required to have their PR assessment certified by the Behavioral

Health Director for every PR assessment. Counties are not required to maintain a minimum level of PR. Counties may transfer funds from their monthly disbursement to their local PR after allocating funds to each component. Counties cannot transfer more than the calculated PR maximum, which is the percentage of the average total funds of the previous five years. The new PR maximums will take effect July 1, 2026. (Please note: PR maximums listed align with current statute. The maximums are subject to change based on decisions made by the Revenue Stability Workgroup. The Revenue Stability Workgroup Report outlining updates in policy is set to be published in 2025.)

- A county with a population of more than 200,000 will be considered a large county and will have a PR maximum that does not exceed 20 percent of the average of total funds distributed to the county in the previous five fiscal years.
- A county with a population of less than 200,000 will be considered a small county and have a PR maximum that does not exceed 25 percent of the average of total funds distributed to the county in the previous five fiscal years.

The calculation for PR maximum funding levels are as follows:

1. Add the total funds allocated to the county's total BHSF account over the previous five (5) fiscal years;
2. Divide the amount in #1 by five (5); and,
3. Multiply the amount in #2 by 20 percent for large counties and 25 percent for small counties to determine the maximum level.

B.3.3 Allowable Transfers

A county may transfer funds from its PR into its Housing Interventions, FSP, and/or BHSS account in a year in which DHCS determines BHSF revenues are below the average of the five previous fiscal years adjusted by changes in the state population and the California Consumer Price Index (WIC section 5892, subdivision (b)(1)). This information will be posted annually to the DHCS BHSA webpage.

When DHCS has determined that counties may access their PR, DHCS will provide guidance on the process and expenditure timeframes. Once this determination has been made, the counties must meet the following requirements:

- The transfer must be included in a county's IP, AU, or intermittent update;
- The transfer must be reported in their annual Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR); and

- The transfer must be within the county's allowable PR maximum.

B.3.4 Transfers into the Prudent Reserve

Counties may transfer funds to their local PR through the IP or annual update process. Funds may be transferred from any BHSA component. There is no restriction on the amount of funds that can be transferred from one component up to the maximum PR level. After the PR transfer occurs, counties must still meet the suballocation requirements for each component.

B.3.5 Transfers out of the Prudent Reserve

PR funds may be used on programs and services for any of the following BHSA components regardless of where the component funding came from when the initial transfer into the PR was done:

- Housing Interventions Programs
    - Exception: A county may not spend PR funds on capital development projects.
- Full Service Partnership
- Behavioral Health Services and Supports
    - The children's system of care, adult and older adult system of care.
    - Early Intervention programs.
    - Outreach and Engagement.

B.3.6 Excess Prudent Reserve Funding

A county in excess of their PR allowable maximum, shall spend excess funds on programs and services for the following BHSA Components:

- Housing Interventions Programs
- Full Service Partnership
- Behavioral Health Services and Supports

B.4 Funding Transfer Requests

Starting with the fiscal year (FY) 2026-2029 IP, all counties can request changes to the funding allocation percentages outlined in Table B.5.1 below. Counties may ask to transfer funds between these three components to change their funding allocation percentages. However, these changes in funding allocation percentages cannot exceed

7 percent of total funds allocated to the county in one fiscal year from any one component. Counties may only request a maximum of 14 percent of total funds allocated to the county to transfer in any given fiscal year (WIC section 5892, subdivision (c)(1)). Adjusting the distribution of funds within a county according to these guidelines does not exempt the county from adhering to any additional applicable laws or to the sub-allocation requirements (WIC section 5892, subdivision (c)(2)).

In a fiscal year, a county may transfer from its housing intervention funds up to 7 percent of its total BHSA allocation for that fiscal year. However, if a county uses housing intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the housing intervention component must be decreased by a corresponding amount (per DHCS guidance pursuant to WIC section 5892, subdivision (c)(1)). For example, if County A chooses to use 3 percent of its annual Housing Intervention funds for outreach and engagement, then County A would be able to transfer no more than 4 percent out of its Housing Interventions component into another funding component. Counties are not required to utilize Housing Interventions funding for outreach and engagement. Counties are also not required to transfer funds out of Housing Interventions. Counties shall retain discretion to transfer up to a total of 14 percent of its total BHSA allocation in a fiscal year.

All transfer requests between Housing Interventions, FSP, and/or BHSS components must be submitted to DHCS through the county portal and include all required information and documentation (WIC section 5892, subdivision (c)(4)). This includes details and rationale for the funding allocation transfer request. The rationale must specify how the transfer request is responsive to community needs and include local data and community input in the planning process. For instance, a county might demonstrate significant need within a particular component by showing that programs are unable to meet the demand of their community. Or, if a county is interested in decreasing a funding allocation percentage for a component, a county should demonstrate that there is limited need or show where there is sufficient funding from other sources.

Funding transfer requests must be submitted within the draft IP by March 31st of the year prior to the fiscal years the IP covers. Counties must also include a letter from the County Administrative Officer approving the IP, including funding transfer requests. DHCS will review transfer requests based on compliance with statutory requirements, evidence of alignment with local priorities, and community input (WIC section 5892, subdivision (c)(4)(A)). For transfer requests, counties are also required to adhere to local

stakeholder consultation requirements, as described in WIC sections 5963.02 and 5963.03. Additional information about the community planning process can be found in Chapter 3, Section B.1 of this policy manual.

B.5 Funding Component Allowances

The table below lays out the funding allocations and their corresponding sub-allocations for each BHSA component, beginning July 1, 2026 (WIC section 5892).

Table B.5.1 Overview of Funding Allowances

Statute	Allocation	Sub-Allocations
WIC section 5892, subdivision (a)(1)(A)	Housing Intervention Programs (30%)	• 50% of these funds shall be directed towards housing interventions for persons who are chronically homeless, with a focus on those in encampments. • No more than 25% shall be used for capital development projects. Housing Intervention funds may be used for capital development, under the provisions of WIC section 5831, and only for eligible populations under WIC section 5830, subdivision (a). If a county elects to use Housing Intervention funds for capital development, the units shall be available in a reasonable timeframe as specified by DHCS (WIC section 5830, subdivision (b)(2)(B)).
WIC section 5892, subdivision (a)(2)(A)	Full Service Partnership Program (FSP) (35%)	N/A - The sub-allocations of Housing Intervention services may be used towards individuals enrolled in an FSP program.
WIC section 5892, subdivision (a)(3)(A) WIC section 5892, subdivision (a)(3)(B)(i-ii)	Behavioral Health Services and Supports (BHSS) (35%)	At least 51% of BHSS services shall be used exclusively for early intervention programs. Of the BHSS funds allocated for early intervention programs, at least 51% shall be used for early intervention programs to serve individuals aged 25 years and younger.

B.5.1 Adjusting a Previously Approved Funding Allocation Percentage Change

Approved funding allocation percentage changes are final and cannot be adjusted again for the duration of the three-year plan, unless an annual change is approved by DHCS due to a state or local emergency (WIC section 5892, subdivision (c)(4)(C)). To be granted an annual change, a county shall demonstrate to DHCS that it is experiencing a state (GOV section 8625) or local (GOV section 8630) emergency, and the change is necessary because of the emergency. Counties may only request an annual change in funding allocations percentages for previously approved funding allocation percentage changes (WIC section 5892, subdivision (c)(4)(C)). If a county seeks to adjust the percentage allocations that were previously approved by DHCS as part of the IP, the county will submit the funding allocation percentage change request in the county portal. Counties are required to adhere to local stakeholder consultation requirements to adjust funding allocations (WIC section 5892, subdivision (c)(3)).

B.5.2 Process for Approval and Denial

DHCS has 30 calendar days to approve or deny funding allocation transfer requests following receipt of the request. The approval and/or denial of the transfer request will be completed through the county portal. If DHCS does not respond within 30 calendar days, the funding allocation transfer request will be considered approved (WIC section 5892, subdivision (c)(4)(C)).

If the transfer request is approved, funding allocation adjustments cannot be changed during the three-year IP period (WIC section 5892, subdivision (c)(4)(C)), unless an annual change is approved by DHCS. If the transfer request is denied, justification will be included with the decision. The county will be required to update their Integrated Plan (IP) to reflect the denial. Counties should be transparent with stakeholders throughout the community planning process and acknowledge where the IP will need to be adjusted if the exemption request is not approved.

If the county does not agree with DHCS's decision to deny the transfer request, the county may submit an appeal to DHCS within 30 calendar days of receipt of the denial. The appeal must include an explanation stating the basis of the appeal and supporting documentation. Appeals must be submitted through the county portal. DHCS has 30 calendar days to approve and/or deny the appeal, starting with the date that DHCS confirmed receipt of the appeal.

DHCS will have 10 calendar days from confirming receipt of the appeal to request additional documentation from the county. Counties will supply additional documentation within 10 calendar days of confirming receipt of the request.

If the appeal is denied, justification will be included with the decision. If an appeal is submitted after 30 calendar days from receipt of the denial, the appeal will be automatically denied.

If the county already submitted their IP and budget and the county receives notice that their funding transfer request was denied, the county is required to update the IP and budget to reflect the correct allocation amounts by June 30 of the year prior to the fiscal years the IP covers.

B.5.3 Reporting Requirements

Transfers between components will change the required allocation of BHSA funds dedicated to Housing Interventions (30 percent), FSP (35 percent), and BHSS (35 percent). As a result, counties are required to report approved transfers and updated BHSA allocations on the BHOATR, consistent with the transfers approved as part of the IP (WIC section 5963.04, subdivision (a)(2)).

Funds transferred between FSP, Housing Interventions, and BHSS components are subject to the same reversion requirements as before the transfer. Transferring funds does not alter the reversion period associated with those funds. The reversion period is the length of time a county has to spend its local Behavioral Health Services Fund (BHSF) money; the reversion period begins the fiscal year in which funds are transferred from the state BHSF to the local BHSF. For more information on reversion, please see the Reversion section of this policy manual in Chapter 6, Section B.

B.6 Reversion Policy

BHSA funds distributed to a county revert to the state Behavioral Health Services Fund (BHSF) if the county has not spent the funds within a specified period of time (i.e., reversion period). The reversion period depends upon the county's population and the program component (WIC section 5892, subdivisions (i)(1) and (i)(3)).

B.6.1 Reversion Period

The "reversion period" refers to the length of time a county has to spend its local money before the funds become subject to reversion and return to the state BHSF. Large counties are required to spend BHSA (Housing Interventions, FSP and BHSS) funds, within three years, and small counties within five years. Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN) funds must be

spent within ten years, regardless of county size. Any funds not spent within these time periods are subject to reversion.

B.6.2 Determining Population

DHCS will use the Department of Finance (DOF) January 1 population estimates for the prior fiscal year as reported in the DOF Population and Housing Estimates for Cities, Counties, and the State Report. DHCS will annually publish the county population data.

"Small county" means a county in California with a total population of less than 200,000, according to the most recent estimate by the California State DOF, as of the first day of the fiscal year.

"Large county" means a county in California with a total population of 200,000 or more, according to the most recent estimate by the California State DOF, as of the first day of the fiscal year.

B.6.3 Behavioral Health Outcomes, Accountability, and Transparency Report Submission Required to Calculate Reversion

Every Fiscal Year (FY), each county is required (WIC section 5963.04, subdivision (a)(1)) to submit a Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) to DHCS by the required deadline for DHCS to be able to calculate the amount of a county's unspent funds are subject to reversion. The first BHOATR will cover FY 2026-27 and is due to DHCS on January 30, 2028. All subsequent BHOATRs will be due annually on January 30 of the following years.

B.6.4 Failure to Submit the Behavioral Health Outcomes, Accountability, and Transparency Report

If the county does not submit the BHOATR by January 30, DHCS will notify the county's behavioral health director and BHSA coordinator by email within five business days. The behavioral health director and BHSA coordinator will also be notified by email if DHCS has determined the county has not submitted a complete or accurate BHOATR within 15 business days after the due date.

Counties have 30 calendar days from receipt of the email to submit a complete and accurate BHOATR to DHCS. If the county fails to do so, DHCS will instruct the State Controller's Office (SCO) to withhold 25 percent of the monthly distribution until the county becomes compliant with their BHOATR submission (WIC section 5963.04, subdivision (e)(3)(A)(i)). Once DHCS determines the county has submitted a complete

and accurate BHOATR, the county will be removed from the monthly withhold and the SCO will release the withheld funds to the county.

B.6.5 Notice of Funds Subject to Reversion

After the BHOATR submission and review process, DHCS will send a notice via email to each county notifying them of the amount of county BHSA funds that are subject to reversion. The notice will include a schedule of the county's BHSA funds subject to reversion from each component and will include data from the county's BHOATR that DHCS used to determine the amounts subject to reversion.

B.6.6 Methodology for Calculating Reversion

DHCS will calculate reversion amounts using the first-in-first-out methodology for components with revenue distributed to the county. The first-in first-out methodology assumes that the first dollar received is the first dollar spent. Reversion will be calculated by component. For components with suballocation requirements, counties will be expected to apply the reversion equally across the suballocations. DHCS will subtract BHSA expenditures reported in the BHOATR for each component from the remaining balance of funding in the oldest fiscal year within the reversion period for the county and component. If the expenditures minus the remaining balance of funding are greater than zero, DHCS will subtract the remaining balance of expenditures from the remaining balance of funding in the next fiscal year. DHCS will repeat this process until the balance of expenditures subtracted from the balance of funding is less than or equal to zero. DHCS will revert the balance of funding for a county and component that is greater than zero at the end of the reversion period. DHCS will continue to provide technical assistance to counties regarding reversion calculations.

B.6.7 County Submission of Appeal

If a county disagrees with DHCS's determination of the reversion amount, the county may submit an appeal to DHCS. To appeal, the county must submit the following documents through the County Portal.

- A completed Adjustments to Revenue or Expenditure Summary form.
- An executed BHSA Fiscal Accountability Certification form.

The county must submit an appeal within 30 calendar days (9 CCR section 3420.65, subsection (a)) of receiving the notice of the amount of the county's funds that are subject to reversion. DHCS will not consider late appeals. DHCS will review the appeal

documents and email a written decision to the county within 45 calendar days (9 CCR section 3420.65, subsection (c)) of receiving the appeal.

B.6.8 Offsetting Reverted Behavioral Health Services Act Funds Against Future Behavioral Health Services Act Allocations

If a county has not spent all their BHSA funds within the required time period, DHCS will revert unspent BHSA funds from a county and deposit the reverted funds into the State's Reversion Account. DHCS will instruct the State Controller's Office (SCO) to redistribute reverted funds back to all other counties for future use as BHSA funds consistent with the requirements set forth in this manual. Counties are required to spend BHSA funds within three or five years (WIC section 5892, subdivision (h)(1) and subdivision (h)(2)(A)) depending on county size. Counties have ten fiscal years to spend BHSS funds specified for Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN) projects.

If DHCS has determined that a county has BHSA funds that are subject to reversion, DHCS will instruct the SCO to offset the amount of reverted funds from the county's future monthly BHSA distribution and transfer the funds into the state's Reversion Account (WIC section 5892, subdivision (i)(1)).

The SCO will continue to offset the monthly distribution until the county has remitted all reverted funds. The offsetting of funds may extend over multiple months until the full amount the county owes to DHCS is offset. The SCO will transfer the funds into the state's Reversion Account. Previously, counties were required to remit a check to DHCS with the amount of funds that were subject to reversion within 60 days of receiving the final reversion notice. Offsetting funds from county's monthly distributions is a more efficient process than requiring counties to remit checks for reverted funds to DHCS, allowing DHCS to reallocate the reverted funds to counties more quickly. This process is also less administratively burdensome on counties. DHCS will instruct the SCO to begin offsetting a county's monthly BHSA distribution 60 days after the reversion notice is sent to the county (e.g., if a county receives a reversion notice in April, funds will be offset beginning with June's monthly distribution payment). DHCS will notify the counties after the reversion timeframe to appeal has ended to let them know when the SCO will begin offsetting the monthly distribution.

If a county has BHSA funds that are subject to adjustment due to a fiscal audit or other reasons, as determined by DHCS, the amount that is owed to the county will be transferred from the Reversion Account. If the balance of the Reversion Account is

insufficient, the funds that are owed to the county will be offset from the monthly distributions from other counties based on DHCS Allocation Methodology (WIC section 5892, subdivision (i)(2)(B)).

DHCS will prioritize offsetting reversion funds before implementing withholds (e.g., due to a late BHOATR) (WIC section 5892, subdivision (i)(2)(C)). If DHCS is actively withholding a county's monthly BHSA distribution due to not meeting statutory requirements, any funds that are subject to reversion will be offset first. If there are any remaining monthly distribution funds, DHCS will calculate the withhold amounts based on the remaining balance (WIC section 5892, subdivision (i)(2)(A)).

The frequency of offsetting and reallocating BHSA funds will be determined by DHCS. The SCO posts online the monthly BHSA distribution and will also reflect any offset and redistribution amounts.

B.6.9 Reversion Notice, Appeals, and Offsetting Timeline

1. DHCS reviews each county's BHOATR to determine the amount of unspent funds subject to reversion.
2. DHCS will send each county a reversion notice indicating the amount of funds subject to reversion and indicate when funds will begin to be offset (60 calendar days from the notice).
3. If the county disagrees with the reversion amount, the county may submit an appeal to DHCS. The county must submit an appeal within 30 calendar days of receiving the initial reversion notice. If a county does not submit an appeal, DHCS will assume the county agrees with the amount of unspent funds subject to reversion.
4. DHCS will review and approve or deny the appeal within 45 calendar days of receiving the county's appeal. After the appeal period has ended, DHCS will send the county a revised final notice of unspent funds subject to reversion and indicate when funds will begin to be offset (60 calendar days from the final notice).
5. DHCS will instruct SCO to begin offsetting the county's funds from the monthly distribution until the full amount has been offset depending on the amount subject to reversion, the full monthly distribution amount and subsequent monthly distributions may be offset, if necessary.
6. DHCS will reallocate reverted funds to other counties.

B.7 Mental Health Services Act to Behavioral Health Services Act Transition

B.7.1 Mental Health Services Act to Behavioral Health Services Act Transition Policy

Counties must continue to spend Mental Health Services Fund (MHSF) dollars consistent with an approved Integrated Plan (IP) or annual update through June 30, 2026. If counties are unable to spend all local MHSF before June 30, 2026, counties are required to direct any unspent MHSF towards the programs and components that fall under the BHSA. Beginning July 1, 2026, any unused MHSF monies are "converted" into BHSA monies and must be expended consistent with the requirements set forth in this manual. Beginning July 1, 2026, counties will no longer be allowed to allocate funds to Community Services and Supports (CSS), Prevention and Early Intervention (PEI) and Innovation (INN) components (WIC section 5892, subdivision (a)). Instead, Behavioral Health Services Fund (BHSF) dollars will be used towards BHSA programs and components (FSP, BHSS, Housing Interventions). Counties will have flexibility to allocate their unspent MHSA funds to the BHSA components (BHSS, Housing Interventions, FSP) at local discretion. However, once the unspent MHSA funds are allocated, counties will need to follow the suballocation requirements for each component, outlined in Chapter 6, Section B.1.1 (i.e., suballocations required for Early Intervention/youth within BHSS and chronically homeless/capital development within Housing Interventions). All unspent MHSA funds must be used for services and supports that are allowable within the BHSA components.

All funds transitioned from MHSF to BHSF will be subject to BHSA component requirements. This may mean that unspent MHSF that were dedicated to certain programs or services may no longer be used for those purposes, unless they align with new BHSA component requirements. Counties must consult BHSA requirements to determine whether existing uses of unspent MHSF are allowable under BHSA or whether funds need to be used for a new program or service. More detailed guidance regarding the new service components will be laid out in the (Housing Interventions, FSP, BHSS) sections below.

Counties must report in the IP how they allocated all unspent MHSA funds. For all BHSA funds that are distributed after July 1, 2026, counties will be required to allocate those funds in the following percentages: 30 percent Housing Interventions, 35 percent FSP,

and 35 percent BHSS. The reversion period does not change when unspent MHSA funds are transferred into the new BHSA components.

B.7.2 Innovation Funding

Under MHSA, counties were able to encumber INN funds upon approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC). Once the project was approved by the MHSOAC, the funds were encumbered for the term of the approved INN project. If a county currently has INN funds that were encumbered prior to July 1, 2026, and the INN project is operational, those INN funds will remain encumbered for the duration of the first IP, Fiscal Year (FY) 2026-29. Operational means any funds spent on the project prior to July 1, 2026. Counties will be required to report which INN projects are operational in the FY 2026-29 IP. This will allow counties time to complete approved INN projects that are currently operational. All INN projects are expected to be complete by July 1, 2029. If the funding encumbered for the INN is not expended by June 30, 2029, any remaining INN funds that are not reverted will become BHSA funds and will be tracked according to their original reversion period.

Counties must include the INN project in the IP and report all expenditures on the BHOATR. Counties may continue to keep separate fund accounts to track encumbered INN funds through June 30, 2029. Counties will not be allowed to newly encumber any BHSA funds for INN beginning July 1, 2026. Counties may pilot and test innovative behavioral health models of care programs or innovative promising practices for programs in all BHSA funding components (BHSS, FSP, Housing Interventions).

If the county's INN funds are encumbered in a previously approved INN project, but that project is not operational on July 1, 2026, those funds will be disencumbered and may be subject to reversion. The reversion period remains the same when funds are disencumbered.

B.7.3 Workforce Education and Training and Capital Facilities and Technological Needs Funding

Under the BHSA, WET and CFTN now fall under the BHSS component. MHSA funds for WET and CFTN will remain available for WET and CFTN expenditures within BHSS; the reversion period for these MHSA funds does not change. MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and

CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.

B.7.4 County Transition Planning

In preparation for this transition from MHSA to BHSA, counties will need to start planning early to determine how this may affect their current existing programs and funding. Counties are required to include this transition planning in their FY 2026-29 IP.

B.7.5 Reporting Requirements

Until June 30, 2026, counties must continue to expend MHSA funds for programs consistent with their current approved MHSA plan. Counties will still be required to report program expenditures on their county's Annual Revenue and Expenditure Report (ARER) for FY 2023-24, FY 2024-25 and FY 2025-26 (WIC section 5899, subdivision (g)).

Once BHSA becomes effective starting July 1, 2026, counties will be required to report program expenditures (WIC section 5963.04, subdivision (a)(2)) on their county's new BHOATR beginning with FY 2026-27 and expenditures must be consistent with the three-year IP.

B.7.6 Mental Health Services Act to Behavioral Health Services Act Transition and Reversion

Counties remain subject to the requirements to expend MHSF money and interest within the applicable reversion periods. This transition from MHSA to BHSA will not have any impact on reversion policy or timelines for MHSA funds already received by June 30, 2026. The same reversion requirements still apply for new BHSA funds that are distributed to counties starting on July 1, 2026, except for INN funds (please refer to Chapter 6, Section B.7.2 Innovation Funding for more information on encumbered funds for operational INN projects). Counties must spend BHSA funds for their authorized purpose within three years and CFTN and WET funds within ten years (WIC section 5892, subdivision (i)(1)).

B.8 Cost Principles

B.8.1 Administrative Costs

Starting July 1, 2025 (WIC section 5892, subdivision (e)(2)(C)), 2 percent, and up to 4 percent for small counties, of local MHSA revenue may be used to improve planning, quality, outcomes, data reporting, and subcontract oversight for all county behavioral health funding.

After July 1, 2026, counties may use 2 percent, and up to 4 percent for small counties, of local BHSA revenue for the same purposes as above and for fiscal and programmatic data reporting for the BHOATR. These types of administrative costs can be covered under BHSA for all county behavioral health programs including, but not limited to, county Medi-Cal behavioral health delivery system, programs funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant (MHBG), Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), and other SAMHSA grants. Administrative costs for county-contracted providers may be included as part of the total costs of contracted services and do not need to be reported as part of the county's administrative costs.

Administrative costs are costs that support the operations and overhead of county behavioral health programs (2 CFR 200). Administrative costs for BHSA do not include costs incurred as planning costs (outlined in Chapter 3, Section B.4) or service expenditures. Counties must report administrative costs consistent with 2 CFR 200 to ensure consistent claiming across funding sources. Administrative costs must be reported in the county Integrated Plan (IP) and Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) (WIC section 5963.04, subdivision (a)(2)(F)).

However, new administrative costs a county incurs on or after July 1, 2024, to implement the IP and BHOATR will not be captured in the county IP or BHOATR. Instead, counties may claim reimbursement for new administrative costs incurred on or after July 1, 2024, to implement the IP and BHOATR. These reimbursements cover costs related to preparing and submitting these reports, as well as Information Technology system enhancements. Counties can claim reimbursement for actual direct administrative costs using Form MH 1982 B, as long as those costs are clearly identifiable with the BHSA functions. Counties may submit claims on a quarterly basis to receive interim payments and must submit an annual claim to reconcile all interim payments to final costs. The claim form is posted to the Med CCC webpage.

B.8.2 Direct Costs and Indirect Costs

The classifications of activities that fall under direct and indirect costs are described in B.8.2.1 and B.8.2.2. BHSA aims to align the direct and indirect classifications with Medi-Cal behavioral health and Federal Grant (e.g., SUBG, MHBG) wherever possible.

B.8.2.1 Direct Costs

Direct costs are those costs that can be identified specifically with a particular final cost objective, such as an internally or externally funded activity, or costs that can be directly assigned to such activities relatively easily with a high degree of accuracy.

Direct costs may include, but are not limited to:

- Compensation of employees for the time devoted and identified specifically with the delivery of behavioral health services and supports or performing utilization review and quality assurance activities.
- Cost of materials and supplies.
- Cost of necessary services provided by contract.
- Travel expenses incurred.

Direct costs do not include:

- Capital improvements (unless amortized).
- Purchase or construction of buildings.
- Compensation to members of a local behavioral health board (except for reimbursement of expenses per WIC section 5604.3).

B.8.2.2 Indirect Costs

Indirect costs are those costs that are incurred for a common or joint purpose benefitting more than one cost objective, including general costs associated with organization-wide activities, and support the provision of behavioral health services and utilization review/quality assurance activities. Indirect costs cannot be identified specifically with a particular final cost objective relatively easily with a high degree of accuracy.

Indirect costs include, but are not limited to:

- Compensation of county behavioral health employees for time not devoted and identified specifically with the delivery of a reimbursable activity, performance of a specific administrative activity, or performance of a specific utilization review/quality assurance activity
- Legal services
- Personnel administration

- Procurement
- Accounting
- Executive officers' compensation
- Depreciation expense
- Interest expense
- Operating and maintaining facilities
- Depreciation or lease costs of buildings and equipment

Additional Notes

- The county must charge indirect costs to a BHSA program through an acceptable allocation method (2 CFR 200) that allocates the costs of support and administrative services to the benefiting programs.
- The share of costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. For example, if a county behavioral health department has a single administrative team that oversees both BHSA-funded programs and other general behavioral health services, the administrative costs should be split based on the proportion of clients served by each program.
- Proper documentation of the allocation methodology must be kept by the county to justify the use of BHSA funds for indirect administrative costs.

C. Promoting Access to Care Through Efficient Use of State and County Resources

C.1 Introduction

This section outlines the Department of Health Care Services (DHCS) fiscal policy for counties and Behavioral Health Services Act (BHSA)-funded providers (both county-operated and contracted). For the purpose of this chapter, "county-operated provider" means a provider who is employed, owned, or operated by a county government. Likewise, for the purpose of this chapter, "county-contracted provider" means a community provider (i.e., a provider who is not employed, owned, or operated by the county) that contracts with the county to furnish BHSA-funded or Medi-Cal services. As outlined in WIC section 5892, subdivision (k)(7)(8), counties may use BHSA dollars to

serve any individuals who meet the eligibility criteria for the particular service, including individuals who are uninsured. Counties may, in addition, use BHSA funds to support behavioral health programs authorized under other federal or state laws — such as financing their non-federal share for Medi-Cal and other federal matching grants subject to compliance with applicable requirements for each program (e.g., medical necessity, individual consent) and the BHSA expenditure guidance in this manual, in accordance with the population prioritization rubric in WIC section 5892, subdivision (d). The policy described in this section focuses on services that can be funded directly with BHSA dollars, and that are also eligible for payment under Medi-Cal, commercial insurance, or another funding sources. The goal is to expand access to high-quality care through the efficient use of state and county resources, ensure that BHSA funds are not used to wholly pay for services that Medi-Cal and commercial payers are obligated to cover, and to ensure that BHSA funds are directed where they are most needed.

DHCS' requirements for counties to meet the legislative intent of Senate Bill (SB) 326 are summarized in the text box below and codified in WIC sections 5813.5, subdivision (c), 5878.3, subdivision (a), 5830, subdivision (c), and 5891, subdivision (a).

Promoting Access to Care Through Efficient Use of State and County Resources:

A. Securing Medi-Cal Payment. Per WIC section 5891, subdivisions (a)(2), counties must ensure that the following requirements are met for all providers delivering a BHSA-funded service that is also covered by the county's Medi-Cal Behavioral Health Delivery System (BHDS), as defined in WIC section 14184.101, subdivision (i), (i.e., the county's administration of Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) or DMC Organized Delivery System (DMC- ODS) services). Per WIC section 5891, subdivision (a)(3),counties must also require providers delivering BHSA-funded non-specialty mental health services (NSMHS) and non-specialty substance use disorder (SUD) services to make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans. Counties must meet these requirements by July 1, 2027.

1. ***Participate in the County Medi-Cal BHDS***: Providers are contracted to deliver services/supports with their county Medi-Cal BHDS (including Medi-Cal enrollment and certification, as applicable).
2. ***Check for and Support Medi-Cal Enrollment***: Providers check whether individuals are enrolled in Medi-Cal (and also for Other Health Coverage (OHC)). If they are uninsured, the provider refers them for eligibility

screening.

3. ***Consistently Bill Medi-Cal BHDS***: Providers submit claims for Medi-Cal eligible services, in accordance with Medi-Cal billing rules.

B. Securing Payment from Commercial Health Insurance. Counties must require all providers delivering a BHSA-funded service that is covered by commercial health plans to make a good faith effort to meet the following requirements:

1. ***Check Insurance Status***: Providers check whether individuals are enrolled in a commercial health plan.
2. ***Consistently Bill Commercial Insurance***: Providers make a good faith effort to seek payment from commercial health plans, in accordance with each health plan's billing requirements.
3. ***Report Complaints About Commercial Health Plan Conduct***: If a commercial health plan imposes obstacles to obtaining payment, counties and providers are encouraged to report complaints to the Department of Managed Health Care (DMHC), the Department of Insurance (CDI), and/or DHCS' Third-Party Liability and Recovery Division (TPLRD), as applicable.

C. Appropriate Use of Other Non-BHSA Funds. Counties must consider how to optimize BHSA funds with other funding sources (e.g., state funds, federal block grants, and opioid settlement funds) to enhance access to high-quality behavioral health services. Counties are not required to exhaust these other funding sources before using BHSA funds. Counties must continue to comply with applicable requirements for each funding source.

In this section, DHCS defines requirements for counties on the appropriate and efficient uses of BHSA funds. Counties are, in turn, responsible for working with their contracted providers to meet these requirements (e.g., through updated requirements in their BHSA provider contracts), in addition to ensuring compliance by county-operated providers. As discussed further below, it is important to note that these policies apply only to services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, or a federal block grant.

C.2 Securing Medi-Cal Payment

When an individual receives behavioral health services through the Medi-Cal delivery system, county Medi-Cal BHDS—together with Managed Care Plans (MCPs) and DHCS—take on responsibility for ensuring that individual has access to the full scope of Medi-Cal covered benefits. Moreover, unlike BHSA-funded services, the federal government contributes a percentage of the cost of eligible Medi-Cal expenditures. For these reasons, WIC sections 5878.3, subdivision (a)(2) and 5813.5, subdivision (c) directs counties to maximize Medi-Cal federal financial participation (FFP) for BHSA-funded services for children, youth, and adults. The policy in this section applies to providers (county- operated or contracted) who deliver "BHSA-funded and BHDS-covered services" – meaning the providers receive BHSA funding for Full Service Partnership (FSP) or Behavioral Health Services and Supports (BHSS) for activities that are also covered by the Medi-Cal BHDS in that particular county. DHCS requires each county to ensure providers meet the following three requirements:

1. **Participate in the County Medi-Cal BHDS:** Providers contract to deliver services/supports with their county Medi-Cal BHDS (including Medi-Cal enrollment and certification, as applicable).
2. **Check for and Support Medi-Cal Enrollment:** Providers check whether individuals are enrolled in Medi-Cal (and also for Other Health Coverage (OHC)). If they are uninsured, the provider refers them for eligibility screening.
3. **Consistently Bill Medi-Cal BHDS:** Medi-Cal-enrolled providers submit claims for Medi-Cal eligible services, in accordance with Medi-Cal billing rules.

Requirements for Securing Payment from Medi-Cal MCPs:

Although this section focuses on services covered by county BHDSs, counties must also require that BHSA-funded providers make a good faith effort to seek reimbursement from Medi-Cal MCPs for covered non-specialty mental health services (NSMHS) and non-specialty SUD services, per WIC section 5891, subdivision (a)(3). At the same time, WIC section 5891, subdivision (a)(3) allows counties to use BHSA funds before exhausting reimbursement from Medi-Cal MCPs. WIC section 5891, subdivision (a)(3) does not alter the requirement under WIC section 5830, subdivision (c)(2) that BHSA funds may not be used for Housing Intervention services, including rent, covered by Medi-Cal MCPs. Under WIC section 5891, subdivision (a)(3), counties must require

providers to take the following steps when furnishing BHSA-funded behavioral health services that are also covered by MCPs. For county-contracted providers, the county will meet these requirements if it contractually requires BHSA-funded providers to take the following steps:

1. **Enroll in Medi-Cal** consistent with Medi-Cal Policy 1 (Chapter 6, Section C.2.1, below).

Note: If a BHSA-funded provider furnishes behavioral health services that are covered by MCPs, but *not* covered by the BHDS, that provider is not required to complete the BHDS-specific steps described in Chapter 6, Section C.2.1 regarding certification and contracting.

2. **Check for and Support Medi-Cal Enrollment** as described in Medi-Cal Policy 2 (Chapter 6, Section C.2.2, below).

Note: To check for MCP enrollment, providers can check the Automated Enrollment Verification System (AEVS), the MCP's provider portal, or the member's health plan ID card as described in the Medi-Cal Program and Eligibility Manual.

3. **Consistently Bill Medi-Cal MCPs,** making a good faith effort to enter into network provider agreements as needed and submit clean claims to obtain payment consistent with the strategies described below under Commercial Health Insurance Policy 2 (Chapter 6, Section C.3.2).
    - Providers must obtain information from the MCP on their claims submission processes and requirements (e.g., policy on timely filing and clean claim billing instructions). Information on clean claims can be found in APL 23-020.
    - **Single Case Agreements, Letters of Agreement, and Network Contracts** (see Appendix C.3 for definitions and additional details): Under certain circumstances, it may be most effective or efficient for an out-of-network provider to establish an agreement with a Medi-Cal managed care plan rather than submit claims for out-of-network payment.
        - To the extent that BHSA-funded providers are providing certain services that may be considered Enhanced Care Management or covered Community Support services, providers are encouraged to

enter into Network Agreements with MCPs to participate as community-based providers in CalAIM.

- Counties may explore the possibility of contracting with a Medi-Cal managed care plan on behalf of a group of BHSA-funded providers (potentially including both county-operated and county-contracted providers.)

Medi-Cal MCPs must also comply with their legal and contractual obligations for access to services and timely payment. For additional information, see the Medi-Cal Managed Care Plan Contract (Exhibit A Attachment III, sections 3.3.5, 5.25, 5.27, and 5.53), APL 23-020, APL 23-001, and DHCS' Network Adequacy Standards Attachment A.

C.2.1 Policy 1: Participate in the County Medi-Cal Behavioral Health Delivery System

If a provider delivers services that are both BHSA-funded and BHDS-covered, the county must ensure the provider participates in the county's Medi-Cal BHDS if eligible to do so.

Depending on the provider type, this process may include one or more of the following:

- Ensuring all individual practitioners are credentialed per BHIN 18-019 and BHIN 22-070.
- Becoming certified as a specialty mental health services (SMHS) and/or Drug Medi-Cal (DMC) provider. See 9 CCR section 1810.435, Mental Health Plan: Certifications (MHP-owned & operated Clinics), and Exhibit E, Attachment 1, Definitions for SMHS certification information and the current county SMHS contract with DHCS; Drug Medi-Cal Certification and DHCS Level of Care Designation and ASAM Level of Care Certification for DMC certification.
- Enrolling as a Medi-Cal provider in the Provider Application and Validation for Enrollment (PAVE) portal if there is a state-level pathway for the provider to do so. Almost all individual SMHS providers and facilities are required to enroll in Medi-Cal per BHIN 20-071. SUD providers must become DMC certified before they can be county-contracted providers, as described in WIC section 14124.24, subdivision (e) and are required to enroll in Medi-Cal per BHIN 20-071.
- Contracting with the county Medi-Cal BHDS to deliver SMHS and/or DMC/DMC-ODS services in the county (not applicable to county-operated providers. Unlike DMC/DMC-ODS providers, SMHS providers are permitted to contract with a

BHDS and begin claiming for Medi-Cal services while their certification is pending.

- DHCS requires that a provider receiving BHSA funds from multiple counties will participate in the Medi-Cal BHDS for each county (assuming each county's Medi-Cal BHDS covers the provider's services).

C.2.2 Policy 2: Check for and Support Medi-Cal Enrollment

For BHSA-funded providers who are contracted with the Medi-Cal BHDS (in accordance with Policy 1), counties must require that these providers check whether individuals are enrolled in Medi-Cal (or potentially eligible for Medi-Cal) when delivering a BHDS-covered service. Counties must ensure their providers take the following steps (which are outlined in a process flow in Appendix C.1):

1. **Inquire if the individual has Medi-Cal and Other Health Coverage:**
    a. Providers must check for health coverage/other health coverage (OHC) at the time an individual first seeks BHSA-funded services, **unless** crisis or outreach services are needed urgently.
    b. For services that do not require prior authorization (e.g., assessment or crisis services), providers can submit the claim to the county within a certain time period after delivering the service per the terms in the county contract, even if the provider was not aware of the individual's coverage information at the time services were rendered. So, where a provider delivers BHSA-funded services and later discovers that the individual is enrolled in, or eligible for, Medi-Cal or OHC, the provider may bill for those services, as long as the provider has appropriate documentation and submits a claim within the billing window defined in the county contract (for Medi-Cal, counties then have twelve months from the date of service to submit the Medi-Cal claim).
2. **If the individual says they are enrolled in Medi-Cal, confirm their enrollment:**
    a. Ask to see the individual's Benefits Identification Card (BIC). Regardless of whether or not the individual has their BIC, the provider must check the individual's enrollment status (and OHC) through the AEVS – including the MCP's provider portal – or Medi-Cal Eligibility Data System Lite (MEDSLITE) account request form. Once a provider verifies an individual's enrollment,

the provider is accepting the individual as a Medi-Cal patient and must make a good faith effort to verify an individual's identity, as described in WIC section 14018.2 and DHCS Recipient Identification: Provider Obligations.

3. **If the individual says they are uninsured, or declines to answer:**
    a. **Document** the date of the inquiry.
    b. **Check the individual's enrollment status through the AEVS,** if the individual provided enough information.
    c. **Refer the individual to Department of Social Services (DSS) for eligibility screening and enrollment support.** Providers should reach out to County Eligibility Workers at the county social services agency.
    d. **At least monthly, conduct a new coverage check,** as described above.

C.2.3 Policy 3: Consistently Bill Medi-Cal Behavioral Health Delivery System

Counties must ensure that BHSA-funded providers submit claims to the Medi-Cal BHDS for all BHDS-covered services. This policy applies to BHSA-funded providers who are contracted with the Medi-Cal BHDS (as described above in Chapter 6, Section C.2.1 Policy 1) and providing a Medi-Cal covered service to an individual who is enrolled in Medi-Cal (as described in Chapter 6, Section C.2.2 Policy 2).

DHCS requires counties to help providers to understand and comply with Medi-Cal claiming requirements. Among other elements, counties must provide guidance to providers to support them to:

- Identify services that can readily be covered through Medi-Cal (and distinguish them from services that may not be covered).
- Confirm which services have prior authorization requirements and, when necessary, submit a prior authorization request.
- Maintain appropriate documentation in the member's medical record.
- Submit claims in accordance with Medi-Cal billing and coding requirements. If the claim is denied due to improper billing, the provider must correct the deficiencies and resubmit the claim to the county and the county must consistently correct claims submitted to DHCS.

DHCS reminds providers that they are required to comply with any plan-specific claiming requirements, including those in contracts with the county. To support providers identifying whether BHSA fiscal policy applies to them, DHCS has outlined process flows in Appendix C.1. Medi-Cal billing and documentation resources are provided in Appendix C.2.

In addition to using BHSA as the non-federal share for Medi-Cal covered services (consistent with all BHSA expenditure guidance in this manual), counties may continue to use BHSA funds (and other sources of funds) to cover costs not included within Medi-Cal payment rates and/or activities not billable under Medi-Cal or BHSA-funded providers.

C.2.4 Implementation Timeline for Securing Medi-Cal Payment

DHCS requires counties to implement the fiscal policies described above **by July 1, 2027**, allowing counties one year to implement this policy guidance after submitting the first Integrated Plan (IP) by June 30, 2026. DHCS will use the IP as a key tool to understand where counties are in implementing the fiscal policy requirements and gain visibility into how counties use BHSA funds. In the first IP due **by June 30, 2026, and in the annual updates for 2027 and 2028, counties will be required to report data such as**:

- Progress toward meeting the fiscal requirements described in Chapter 6, Section C.2.
- Report the number of BHSA providers who do and do not participate in the county's Medi-Cal BHDS network (excluding providers who do not offer BHDS-covered services).

Beginning with the annual update due in 2027, counties will explain their progress toward meeting these fiscal requirements and any challenges counties have encountered in meeting these three fiscal requirements related to securing Medi-Cal payments and explain how the county is working to overcome those challenges.

Upon submission of the second IP, due **by June 30, 2029**, DHCS will establish a concrete benchmark for counties regarding the proportion of BHSA-funded providers participating in Medi-Cal. To develop this benchmark, DHCS will review the data submitted by counties from 2026 to 2028, consult with counties, and consider factors such as the types of services the county funds with BHSA and the county's demographics (e.g. rates of uninsurance and Medi-Cal coverage). DHCS will establish

fiscal benchmarks for counties after DHCS begins collecting data from counties via the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR).

C.3 Securing Payment from Commercial Health Insurance

For individuals with commercial health insurance, WIC section 5891, subdivision (a)(3) requires counties and providers to make a good faith effort to seek payment from the commercial plan for any BHSA-funded services (paid in part or in whole with BHSA) that the commercial plan covers. Per WIC section 5891, subdivision (3)(A), state law allows counties to use BHSA funds before exhausting commercial insurance coverage.

To meet these requirements, counties must require all providers delivering a BHSA-funded service that is covered by commercial health plans make a good faith effort to meet the following requirements. For county-contracted providers, the county will meet these requirements if it contractually requires BHSA-funded providers to take the following steps:

1. **Check Insurance Status**: Providers check whether individuals are enrolled in a commercial health plan.
2. **Consistently Bill Commercial Insurance**: Providers make a good faith effort to seek payment from commercial health plans, in accordance with each health plan's billing requirements, including obtaining prior authorization from the plan, when applicable. This may include seeking a network provider agreement.
3. **Report Complaints About Commercial Health Plan Conduct**: Counties and providers are encouraged to report complaints through the process defined below to DMHC, CDI, or DHCS' Third-Party Liability and Recovery Division (TPLRD), as applicable, if a commercial health plan fails to make a good faith effort to contract, enter into agreements, or timely reimburse the county for services.

These policy requirements apply only where (1) an individual receiving a BHSA-funded service has commercial insurance, and (2) the individual's commercial health plan covers the BHSA-funded service. State-regulated commercial plans are required to cover medically necessary clinical services for behavioral health diagnosis and treatment, as well as mobile crisis services, as described in the textbox below.

If a provider follows DHCS's recommended billing approach and the commercial plan denies the claim or pays below the county's standard rate, counties may use BHSA funds to supplement the payment. In instances where the commercial plan reverses a denial

and pays a claim after the county pays the provider with BHSA funds for the service, the BHSA funds must be used for another BHSA eligible service. Counties may manage this through their own reconciliation process. DHCS encourages counties to report complaints to DMHC, CDI, or DHCS' TPLRD, as applicable, when commercial health plans fail to timely reimburse for services.

Requirements for Commercial Health Plans to Cover Behavioral Health Services:

California law (through Senate Bill (SB) 855 and Assembly Bill (AB) 988) requires that state-regulated commercial health plans cover medically necessary treatment of mental health and substance use disorders, including behavioral health crisis services. For additional information, see HSC section 1374.72; Ins. Code section 10144.5; APL 24-007; and 28 CCR sections 1300.74.72, 1300.74.72.01. These plans and insurers are also required to ensure medical necessity treatment determinations be consistent with generally accepted standards of care and are prohibited from limiting benefits to short-term or acute treatment. These laws apply to commercial plans sold on Covered California and some employer-sponsored plans. However, under ERISA, many employer-sponsored plans are exempt from state requirements, so benefits must be determined on a plan-by-plan basis.

Commercial plans can require cost sharing for behavioral health services (e.g., deductibles or copays) as long as these financial obligations are no more burdensome than for other covered services, consistent with federal parity requirements in . In addition, state-regulated plans must maintain a provider network sufficient to ensure timely access to covered services, and must allow members to seek care out of network if covered services are not available geographically or in a timely manner from an in-network provider.

If an individual receiving a BHSA-funded service has both Medi-Cal and commercial coverage, the provider must follow existing DHCS procedures for OHC detailed in OHC Provider Manuals described in the textbox below.

Requirements for Billing Other Health Coverage

Because 42 CFR 433 Subpart (D) and WIC section 14124.90 require Medi-Cal to be the payer of last resort, providers must advise individuals to use their OHC prior to Medi-Cal whenever possible. Medi-Cal members' OHC information is available to providers in the Automated Enrollment Verification System (AEVS). Providers are not permitted to deny

Medi-Cal services based upon potential liability of third-party payment. If DHCS learns that the member has OHC after a provider or county bills Medi-Cal, the claim is referred to DHCS' TPLRD to seek retroactive payment from the member's OHC.

C.3.1 Policy 1: Check Insurance Status

For any BHSA-funded service that could be covered under a commercial health plan, counties must require that providers make a good faith effort to check the health insurance status of all individuals receiving those services. These procedures resemble the procedures for checking for Medi-Cal coverage, as described above. For any BHSA-funded service that is both covered by the county BHDS and typically covered by commercial plans, providers should check for both types of health coverage. If the individual has Medi-Cal, the provider should follow OHC procedures, as described above.

If the individual does not have Medi-Cal, then providers must make a good faith effort to check for commercial insurance using the following steps:

1. Inquire if the individual has insurance. Providers must generally check for health coverage at the time an individual requests and receives BHSA-funded services, unless one of the following applies:
    a. The provider reasonably expects that commercial payment is not available for specific services (e.g., non-medical FSP supports) and/or the provider reasonably expects that the individual does not have commercial health plan (e.g., those experiencing homelessness or at risk of homelessness).
    b. The provider reasonably believes that crisis services are needed urgently.

    Note: In instances where a provider delivers BHSA-funded services and later discovers that the individual is enrolled in a commercial health plan, the provider may bill those services after providing services as long as the provider has appropriate documentation, requests authorization, and submits a claim within the payer's billing window. However, requesting authorization after providing the service may increase the likelihood of claim denial, particularly for services that require prior authorization. For services that commonly require prior authorization, counties must ensure that providers make a good faith effort to seek prior authorization from the commercial plan, as described below under Chapter 6, Section C.3.2.

2. If the individual says they have insurance, the provider must confirm their enrollment. The provider should ask the individual to allow the provider to make a copy of the individual's insurance card. The provider must seek authorization from the individual to submit a claim for payment, as described below.
3. If the individual says they are uninsured or declines to answer the provider's question about their commercial health insurance, the provider should:
    a. Document the individual's response to the inquiry,
    b. Refer the individual to the Department of Social Services (DSS) for eligibility screening and enrollment support. Providers should reach out to County Eligibility Workers at the county social services agency.
    c. At least monthly, conduct a new coverage check, as described above.

See Appendix C.1 for diagrams outlining these process flows for both Medi-Cal and commercial insurance.

C.3.2 Policy 2: Consistently Bill Commercial Insurance

When a commercially insured individual receives a BHSA-funded service that is likely covered by the individual's commercial plan, counties must require that providers make a good faith effort to seek payment from the commercial plan, including MCPs, as outlined briefly below, and as discussed in more detail in Appendix C.3. At a minimum, BHSA-funded providers should make a good faith effort to bill as out-of-network providers. However, they may wish to consider seeking network provider agreements with commercial plans as this may support timely and accurate billing and payment.

Standard Billing Requirements for Out-of-Network Providers. In the event the provider does not have a network agreement, an out-of-network provider should contact the individual's commercial health plan to confirm:

1. Whether the plan covers this service provided by an out-of-network provider.
2. Whether prior authorization is required (never required for emergency or mobile crisis services), and if so, what process to use and what information must be submitted.
3. What billing and coding requirements apply.
4. For higher-cost or longer-term services, any coverage limits (e.g., a maximum duration of services).

After providing the service, the out-of-network provider should:

1. Submit a complete claim, in accordance with the plan's requirements. For example, there may be a special claim form for out-of-network claims.
2. Bill at the provider's standard rate.
3. If necessary, pursue the plan's provider dispute resolution process per HSC section 1367, subdivision (h)(2) and file a complaint with the state if the outcome of the plan's provider dispute resolution is not satisfactory to the provider.

Prior Authorization. Counties must require providers make a good faith effort to comply with the commercial health plan's requirements for prior authorization, including what information must be included in a request for prior authorization, and how prior authorization requests must be submitted, per WIC section 5891, subdivision (a)(3)(C).

Single Case Agreements, Letters of Agreement, and Network Contracts. See Appendix C.3 for definitions and additional details). Under certain circumstances, it may be most effective or efficient for an out-of-network provider to establish a more formal agreement with a commercial plan rather than simply submitting claims for out-of-network payment. These circumstances may include a treatment plan involving longer-term services (e.g., weekly services for several months) or higher-cost services (e.g., crisis, residential, or inpatient services). In addition, an agreement may be helpful if a specific plan has denied or delayed payment for multiple claims, despite the provider following all the plan's requirements.

Counties may explore the possibility of contracting with a commercial health plan on behalf of a group of BHSA-funded providers (potentially including both county-operated and county-contracted providers) offering services coverable by commercial plans, including mobile crisis service.

C.3.3 Policy 3: Report Complaints about Commercial Health Plan Conduct

DHCS encourages counties and providers to report complaints about health plan's failure to make a good faith effort to enter into agreements or timely reimburse the county for services to the State, as described in Tables 6.C.1 and 6.C.2 below. WIC section 5891, subdivision (a)(4)(A) requires that DMHC or CDI timely investigate these complaints. More than 90 percent of state regulated commercially covered individuals are enrolled in plans regulated by DMHC; the health plans that are also regulated by CDI are available on CDI's website.

Table 6.C.1 summarizes which types of complaints should be submitted to TPLRD, in addition to DMHC or CDI. Table 6.C.2 lists contact information for submitting complaints to each agency.

Table 6.C.1. Submitting Types of Complaints about Health Plan Conduct

Complaint type	Submit to
• Claim denials • Failure to pay timely: ○ State-regulated health plans must pay clean claims within 30 working (or business) days of receipt for clean claims from state-regulated health plans (45 working days for HMOs) unless the claim or portion of the claim is contested by the plan, as required in HSC sections 1371, subdivision (a)(1), 1371.35, subdivision (a), 1373.10, subdivision (b); and 28 CCR sections 1300.71, subdivision (a)(9), 1300.71, subdivision (g), 1300.71, subdivision (h), 1300.71, subdivision (g)(3).	• DMHC or CDI • DHCS/TPLRD (for OHC-related complaints)
Failure to contract or impeding providers' good faith efforts to contract.	• DMHC or CDI

Table 6.C.2. Contact Information for Submitting Complaints to Regulatory Agencies

Regulatory Agency	Submit to
DMHC	Counties or providers submit a complaint by calling the provider complaint line: • DMHC provider complaint line: 916-324-8176 (Toll free: 1-877-525-1295) • Email: plans-providers@dmhc.ca.gov • https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan.aspx
CDI	Counties or providers submit a complaint online: • https://www.insurance.ca.gov/01-consumers/101-help/index.cfm • CDI encourages providers to become a registered user to be able to check the status of the complaint, upload follow up documentation related to the complaint, save a "draft" of your complaint prior to submission, and print a copy of the application completed at their convenience: https://cdiapps.insurance.ca.gov/HPP/login/
DHCS/TPLRD	Counties or providers inform TPLRD of OHC-related issues and non-payment of claims via email: dhcs-tplrd.general@dhcs.ca.gov.

C.4 Appropriate Use of Other Non-Behavioral Health Services Act Funds

In accordance with WIC section 5891, subdivision (a)(3), DHCS requires counties to optimize the use of funding other than Medi-Cal federal financial participation (FFP) and commercial insurance (e.g., federal, state, and local funds) to support their behavioral health delivery systems. However, counties may use BHSA funds, before exhausting these other funding sources, as defined in WIC sections 5813.5, subdivision (c)(2), 5878.3, subdivision (a)(3)(A), and 5891, subdivision (a)(3)(A). DHCS recognizes that counties generally receive fixed funding allocations and must make choices about the

mix of services. This BHSA fiscal policy for use of other funds carries forward DHCS' policies on blending and braiding funds.

See Appendix C.4 for additional detail regarding various sources of funding for behavioral health services, supportive services, and Housing Interventions, beyond Medi-Cal and commercial insurance.

Counties must continue to comply with all applicable federal, state, and local requirements for other funding sources, including:

- Permissible use of funds, consistent with state and federal laws.
- Non-supplantation and "maintenance of effort" requirements. For example:
    - BHSA funds may not supplant existing state or county funds that had previously paid for mental health services or SUD treatment services per WIC section 5891, subdivision (a)(1)(B) (except that this non-supplant rule does not apply to the use of 2011 realignment funds).
    - Maintenance of effort and non-supplantation requirements also exist for certain federal grants, such as the Community Mental Health Services Block Grant (MHBG) and the Substance Use Prevention, Treatment and Recovery Services Block Grant (SUBG, and referred to under federal law as SUPTBG) (see Sections 1.3.3 and 1.5.1 of the SUBG Policy Manual, Version 3.2 (2.5.2025) and the SAMHSA, FFY 2024-2025 Combined Block Grant Application).
- "Payer of last resort" requirements continue to apply to certain federal funds (e.g., SUBG block grants). For additional information, see SUBG Policy Manual Sections 1.3.3 and 1.5.1, SAMHSAs Combined Block Grant Application, and BHIN 21-055.
- "Set-aside" funding requirements continue to apply to some federal funds (e.g., SUBG prevention and perinatal set-aside's, MHBG crisis and first episode psychosis/Early Serious Mental Illness (ESMI) set-asides).
- Counties should consult applicable state and federal guidance for each funding source for more information. In addition to directly funding the provision of BHSA-funded services, counties may use BHSA funds (as well as realignment funds and county general funds) to finance their required non-federal share for the Substance Abuse and Mental Health Services Administration (SAMHSA)

Projects for Assistance in Transition from Homelessness (PATH) matching grant, and Medi-Cal non-federal share.

7. BHSA Components and Requirements

A. Behavioral Health Services and Supports

A.1 Behavioral Health Services and Supports Expenditure Guidelines

Counties are required to allocate 35 percent of their total local Behavioral Health Services Act (BHSA) allocations for Behavioral Health Services and Supports (BHSS) (WIC section 5892, subdivision (a)(3)(A)). BHSS categories include:

- Children's, Adult, and Older Adult Systems of Care
- Outreach and Engagement
- Workforce Education and Training
- Capital Facilities and Technological Needs
- Early Intervention Programs
- Innovative Behavioral Health Pilots and Projects

Of the 35 percent of funds allocated to BHSS, counties are required to use 51 percent of funds for Early Intervention Programs, and of that, 51 percent of the funds for Early Intervention Programs must be used to serve BHSA eligible individuals who are 25 years of age and younger. Counties may, but are not required to, fund BHSS categories other than Early Intervention. Counties will be required to report on the amount of BHSS funds, planned expenditures in the Integrated Plan and actual expenditures in the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR), apportioned to each BHSS category they choose to fund. Additional information on county allocation requirements can be found in Chapter 6, Section B.1.

Counties may include Innovative Behavioral Health Pilots and Projects across all BHSS categories. Additional information on Innovative Behavioral Health Pilots and Projects can be found below in Chapter 7, Section A.6.

Counties should maximize the use of other available sources of funding, including Medi-Cal, to provide BHSS services. However, counties are not required to exhaust these other funding sources before using BHSS funds. Additional information on requirements to maximize non-BHSA sources of funding can be found in Chapter 6, Section C.

Counties may use shared resources to advance multi-county BHSS projects. Each county will be expected to report on multi-county projects in their respective Integrated Plan.

A.2 Children's, Adult, and Older Adult Systems of Care

Counties may use a portion of BHSS funds to provide Children's, Adult, and Older Adult Systems of Care services, including substance use disorder services, to BHSA eligible and priority populations. System of care services are those pursuant to Part 4 for the Children's System of Care and Part 3 for the Adult and Older Adult System of Care (WIC section 5892, subdivision (a)(3)). Additional information on BHSA eligible and priority populations can be found in Chapter 2, Section B.3.

Children's, Adult, and Older Adult Systems of Care services funded under BHSS may not include Housing Interventions or services for individuals enrolled in a Full Service Partnership (FSP). Housing Interventions and FSP services should be funded under those components.

A.3 Outreach and Engagement

Counties may use a portion of BHSS funds for Outreach and Engagement (O&E). BHSS funds may be used for activities intended to reach, identify, and engage individuals, families, and communities in the behavioral health system and reduce disparities.

Counties may include evidence-based practices and community-defined evidence practices (WIC section 5892, subdivision (f)(ii)) in the provision of activities.

BHSS O&E activities involve broad engagement of unserved and underserved populations in the behavioral health system. These activities are distinct from those that may be funded as part of BHSS Early Intervention Programs, Housing Interventions, or FSP programs. County Early Intervention programs must include an outreach component, and counties may use FSP funding for outreach activities to enroll individuals in an FSP. Additionally, counties may utilize up to 7 percent of their Housing Intervention funds on identified Outreach and Engagement activities. O&E activities that are required as a part of BHSS Early Intervention programs or FSP should be funded and tracked in county Integrated Plans (IPs) and BHOATRs as part of those programs, rather than under the BHSS O&E category. Additional information on BHSS Early Intervention can be found in Chapter 7, Section A.7 and additional information on FSPs can be found in Chapter 7, Section B.

BHSS funds may be used for O&E activities to engage individuals in housing interventions, if the county is not funding these activities under Housing Interventions. For example, BHSS funds may be used to conduct outreach to individuals in

encampments to support connection to housing programs. Additional information on allowable uses of Housing Intervention funds can be found in Chapter 7, Section C.

When the county works in collaboration with other non-behavioral health community programs and/or services, only the costs directly associated with outreach and engagement activities to provide mental health and substance use treatment can be funded under the BHSS O&E category.

Examples of O&E activities that may be supported with BHSS funds include, but are not limited to:

- Outreach to and collaboration with individuals and entities that can help reach, identify, and engage individuals and communities in the behavioral health system, which may include but are not limited to:
    - Community-based organizations
    - Housing Agencies
    - Street medicine/field-based service providers
    - Harm reduction/syringe services programs
    - Community leaders
    - Schools
    - Early Care and Learning
    - Tribal communities
    - Primary care providers
    - Senior centers
    - Senior Housing (including affordable senior housing and other types of retirement communities, local Area Agencies on Aging, and the local Aging and Disability Resource Connections)
    - Hospitals (including emergency departments and behavioral health urgent care)
    - Federally Qualified Health Centers
    - Faith-based organizations

- Outreach to directly reach and engage individuals who may benefit from behavioral health services and engagement to support and encourage ongoing participation of the eligible population in behavioral health treatment, such as:
    - Peer Support Services including resource navigation.
    - Enhanced Community Health Worker services under Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), which include health navigation, health education, support and advocacy, and tailored preventive services for Medi-Cal members living with significant behavioral health needs.
    - Food, clothing, and other basic necessities, when the purpose is to engage unserved individuals and, when appropriate, their families in the behavioral health system. These services should support the ability to provide for the immediate needs of an individual.
- Strategies to reduce ethnic, racial, gender-based, age-based, or other disparities, such as:
    - Engaging individuals, families, and credible messengers from priority communities to design and provide input on outreach strategies and messages so that they meet the unique needs of those populations.
    - Outreach to individuals through community sites that are natural gathering places for priority populations.

A.4 Workforce Education and Training

Counties may use a portion of BHSS funds for Workforce Education and Training (WET). County-operated and/or county-contracted providers that are employed or volunteer in the county behavioral health delivery system may participate in WET activities.

Counties should incorporate efforts to increase the racial, ethnic, and geographic diversity of the behavioral health workforce, including incorporating individuals with lived experience into the workforce, across all WET activities. BHSS funds for WET activities must be spent within ten years, after which unspent funds will be subject to reversion. All transfers into WET are irrevocable and cannot be transferred out of WET. Additional information on fiscal policies can be found in Chapter 6, Sections B.7 and B.8.

A.4.1 WET Alignment with Statewide Workforce Initiatives

WET activities must supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties must prioritize available BH-CONNECT and other state-administered workforce programs whenever possible.

BHSS funds must be used to:

- Supplement workforce activities funded through BH-CONNECT and other state-administered programs (e.g., stipends for childcare or transportation to supplement a retention bonus available through the BH-CONNECT workforce initiative).
- Create WET programs within the county that complement state-administered workforce programs.

A.4.2 WET Allowable Activities

WET activities must only address the needs of the county behavioral health delivery system. Activities that may be supported with BHSS funds include, but are not limited to, the following, as outlined in WIC Section 5892, subdivision (k)(5):

- Workforce recruitment, development, training, and retention
- Professional licensing and/or certification testing and fees
- Loan repayment
- Retention incentives and stipends
- Internship and apprenticeship programs
- Continuing education
- Efforts to increase the racial, ethnic, and geographic diversity of the behavioral health workforce (e.g., individuals with lived experience)
- Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program.

BHSS funds for WET activities **may not** be used to:

- Address the workforce recruitment and retention needs of systems other than the county behavioral health delivery system, such as criminal justice, social services,

and other non-behavioral health systems, although county behavioral health may choose to *partner* with other systems in order to meet the intersecting needs of its clients.

- Pay for staff time spent providing direct behavioral health services.
    - Employers must not be reimbursed for the time an employee takes from their duties to attend training.
- Off-set lost revenues that would have been generated by staff who participate in WET programs and/or activities.

Counties may also use BHSS funds to support administration and coordination of all WET programs and activities (e.g., hiring a WET coordinator).

County-operated and/or county-contracted providers that are employed or volunteer in the county behavioral health delivery system may participate in WET activities. Certain WET activities require a commitment to employment in the county behavioral health delivery system over a certain time. Additional information on WET activities is provided in subsequent sections (Chapter 7, Sections A.4.3 – A.4.9).

A.4.3 Workforce Recruitment, Development, Training, and Retention

Counties may use BHSS funds for county-operated and county-contracted behavioral health workforce recruitment, development, training, and retention activities that include the following:

Recruitment and Retention

Recruitment and retention activities may include, but are not limited to, the following:

- Supporting workforce recruitment, including recruiting culturally and linguistically competent staff.
- Providing financial incentives to recruit or retain employees.
- Providing supported employment services to employees and individuals seeking employment.
- Creating and implementing promotional opportunities and policies that promote job retention.
- Establishing Regional Partnerships to support recruitment and retention.
- Providing wellness activities that promote retention and decrease burnout.

Training and Technical Assistance

Training and technical assistance activities may include, but are not limited to, the following:

- Education and training programs and activities for prospective and current employees, contractors, and volunteers.
- Collaboration and partnerships to develop curricula and provide training to groups such as individuals receiving services and their family members; individuals from underrepresented racial/ethnic, cultural, and linguistic communities; and other unserved or underserved communities.
- Activities that incorporate the input of individuals receiving services and their family members and, whenever possible, utilize them as trainers and consultants in WET programs and/or activities.
- Activities that promote cultural and linguistic competence and incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities.
- Payment to trainers for training, technical assistance, and consulting, and travel expenses of trainers and participants, including mileage, lodging, and per diem.
- Other costs of providing training, such as materials, supplies, and room and equipment rental costs; also staffing support around administrative tasks, such as paperwork and billing.
- Evaluation of the effectiveness of the training and its impact on service delivery.

Employees, contractors and volunteers in non-behavioral health systems, such as criminal justice, social services and health care may participate in training and technical assistance programs and activities; however, they cannot be the sole recipients.

Behavioral Health Career Pathway Programs

Behavioral health career pathway activities may include, but are not limited to, the following:

- Programs to prepare individuals receiving services and/or their family members for employment and/or volunteer work.

- Programs and coursework in high schools, adult education, regional occupational programs, colleges, and universities that introduce individuals to and prepare them for employment.
- Career counseling, training, placement programs, and/or outreach that increase access to employment to unserved and underserved groups and individuals who share the racial/ethnic, cultural, and/or linguistic characteristics of individuals receiving services, their family members, and others in the community with behavioral health needs.
- Supervision of employees that are in a Behavioral Health Career Pathway Program.

Workforce Staffing Support

Workforce staffing support may include, but are not limited to, the following activities:

- Staff to plan, recruit, coordinate, administer, support, and/or evaluate WET programs and activities when the staff is not funded through any of the other funding components.
- Staff to support Regional Partnerships when performing activities that address the following:
    - Shortages within the workforce or shortages of workforce skills identified as critical by the Regional Partnership.
    - Deficits in cultural and/or linguistic competence.
    - Promotion of employment and career opportunities for individuals receiving services and their family members.
- Staff to provide ongoing employment and educational counseling and support to individuals receiving services and/or their family members who are entering or currently employed in the workforce.
- Staff to provide education and support to employers and employees to assist with the integration of individuals receiving services and/or their family members into the workforce.

A.4.4 Professional Licensing and/or Certification Testing and Fees

Counties may use BHSS funds to cover fees associated with preparing for, applying for, or renewing a license or certification for individuals who are employed, on a full- or part-time basis, in the county behavioral health delivery system.

Counties may support a wide range of activities related to licensing and certification including, but not limited to:

- Any fees associated with preparing for, applying for, or renewing a license or certification, such as:
    - Academic membership fees
    - Application fees, including fees to obtain academic transcripts or have photos taken of the applicant
    - Exam fees
    - Background check fees
    - License renewal fees
    - Board of Behavioral Sciences (BBS) registration fees
    - Fees associated with transferring a license or certification from another state to California
    - Transportation fees associated with preparing for, applying for, or renewing a license or certification
    - Any activities that enable provider testing for a license or certification, such as training courses, costs of study material, or coaching.

A.4.5 Loan Repayment

Counties may use BHSS funds to establish locally administered loan repayment programs that pay a portion of the educational loans of individuals who make a commitment to work in the county behavioral health delivery system. Counties have the flexibility to establish loan repayment programs that meet local needs but must adhere to the following minimum requirements.

Eligible Educational Loans

Only loans held by an educational lending institution are eligible for assumption. Eligible educational loan programs include but are not limited to:

- The Federal Family Education Loan Program in 20 U.S.C. 1071 et seq.
- The Federal Direct Loan Program in 20 U.S.C. 1087b et seq.

The following fiscal liabilities are **not eligible** for loan assumption:

- An educational loan(s) that has not been disbursed at the time the applicant signs a loan assumption application and a loan assumption agreement
- An educational loan that was used for the educational expenses of someone other than the applicant
- An educational loan that has been consolidated with a loan of another person or with a non-educational loan
- Lines of credit
- Home equity loans
- Credit card debt
- Business loans
- Mortgages
- Personal loans
- Other consumer loans

Eligible Participants and Service Providers

Individuals must be employed on a full- or part-time basis and must commit to a county-determined term of employment. Counties must ensure terms of employment are met and establish processes to recoup funds should recipients not meet their service commitments, when appropriate.

Maximum Repayment Amount

Loan repayment will be subject to the maximum repayment amounts in alignment with the BH-CONNECT workforce initiative:

- There is no lifetime limit on loan repayment amount.
- Up to $240,000 per licensed practitioner with prescribing privileges and individuals in training to be a licensed practitioner with prescribing privileges, including but not limited to: Psychiatrists, Addiction Medicine Physicians, and Psychiatric Mental Health Nurse Practitioners.
- Up to $180,000 per non-prescribing licensed or associate level pre-licensure practitioner, including but not limited to: Psychologists, Clinical Social Workers, Professional Clinical Counselors, Marriage and Family Therapists; Occupational Therapists, and Psychiatric Technicians.

- Up to $120,000 per Alcohol or Other Drug Counselors, Community Health Workers, Peer Support Specialists, Wellness Coaches, and other non-prescribing practitioners meeting the provider qualifications for Community Health Worker services, Rehabilitative Mental Health Services, Substance Use Disorder Treatment Services, and Expanded Substance Use Disorder Treatment Services in the California Medicaid State Plan.

Service Obligation

Counties have the flexibility to define service obligations for participants that are commensurate with the loan repayment amount for up to two years for each year of loan repayment. Counties must ensure service obligations are met and have processes to recoup funds if commitments are not met.

Payments

Payments must be made directly to the lending institution and must be applied to the principal balance, if not otherwise prohibited by law or by the terms of the loan agreement between the participant and the educational lending institution.

A.4.6 Retention Incentives and Stipends

Retention incentives and stipends pay or reimburse individuals directly for expenses, or a portion of the expenses, associated with employment or participation in training, educational programs, or other activities in preparation for working in the county behavioral health delivery system. Employment must be on a full- or part-time basis, and recipients must commit to a county-determined term of employment that is commensurate with the incentive or stipend amount. Counties must ensure that the terms of employment are met and must establish processes to recoup funds should recipients not meet their service commitments.

The county may contract with a fiduciary entity, university, or accredited educational institution to establish incentive and stipend programs.

Counties have the flexibility to define which expenses are eligible for retention incentives and stipends and the level of payment. Examples of these types of incentives and stipends include:

- Scholarships, which may include, but are not limited to:
    - Tuition
    - Registration fees

    - Books and supplies
    - Room and board
    - Childcare
    - Eldercare
    - Transportation
    - Other costs and fees associated with attending an educational program
- Recruitment bonuses and retention bonuses, which may include, but are not limited to:
    - Signing bonuses
    - Performance bonuses
    - Spot bonuses
    - Referral bonuses
- Retention incentives and stipends, which may include, but are not limited to:
    - Travel expenses including commuting to work and mileage, lodging and per diem if travel is for the purpose of participating in an educational or training activity or for professional travel
    - Home office costs
    - Professional insurance
    - Childcare
    - Eldercare
    - Wellness
    - Moving or relocation expenses
    - Housing
    - Cellphone or internet services to support employment
    - Training and professional development costs

As described above, county BHSS funds should supplement activities funded through the BH-CONNECT or other state-administered workforce initiative. Use of BHSS funds to supplement BH-CONNECT programs may be particularly beneficial in scenarios where

certain costs are not allowable as part of the BH-CONNECT workforce program. For example, counties may use BHSS funds for stipends for childcare, housing, or other wraparound supports as an "add-on" to a recruitment or retention bonus available through BH-CONNECT.

A.4.7 Internship and Apprenticeship Programs

Counties may use BHSS funds for internship and apprenticeship programs. For activities that involve supervision of post-graduate interns, only faculty time spent supervising interns in programs designed to lead to licensure or certification may be funded.

Activities and expenses that may be funded as part of residency and internship programs include but are not limited to:

- Time required of staff, including university faculty, to supervise psychiatric residents or post-graduate interns training to work as psychiatric nurse practitioners; masters of social work; marriage and family therapists; clinical psychologists; clinical counselors; licensed marriage and family therapists; or certified addiction treatment, substance use disorder, or alcohol and other drug counselors.
- Time required of staff, including university faculty, to train psychiatric technicians or to train physician assistants to work in the county behavioral health delivery system and to prescribe psychotropic medications under the supervision of a physician.
- Addition of a mental health specialty to a physician assistant program.

A.4.8 Continuing Education

Counties may support a wide range of activities related to continuing education in order to develop and retain a well-trained behavioral health workforce, including:

- Costs associated with both virtual and in-person continuing education opportunities, including:
    - Registration fees.
    - Development and preparation for continuing education, including expenses and consulting fees.
    - Payment to trainers.
    - Other costs of providing continuing education, such as materials, supplies, and room and equipment rental costs.

- Travel expenses of trainers and county behavioral health delivery system participants, including mileage, lodging and per diem.

Costs associated with purchasing or renewing online training systems or platforms that offer continuing education courses.

A.4.9 Efforts to Increase the Racial, Ethnic, and Geographic Diversity of the Behavioral Health Workforce

Counties may use BHSS funds for activities to increase the racial, ethnic, and geographic diversity of the behavioral health workforce, including incorporating individuals with lived experience into the workforce. Efforts to diversify the workforce should be incorporated across WET activities in recognition of the need to develop a culturally and linguistically competent workforce that can meet the behavioral health needs of individuals of all backgrounds.

A.5 Capital Facilities and Technological Needs

Counties may use a portion of BHSS funds for Capital Facilities and Technological Needs (CFTN). BHSS CFTN projects include the acquisition and development of land, the construction or renovation of buildings, or the development, maintenance, or improvement of information technology to support behavioral health administration and services. Counties can also use BHSS funds as the required match for Behavioral Health Infrastructure Bond Act of 2023 Behavioral Health Continuum Infrastructure Program (BHCIP) awards. BHSS funds for CFTN projects must be spent within ten years, after which unspent funds will be subject to reversion. All transfers into CFTN are irrevocable and cannot be transferred out of CFTN. Additional information on fiscal policies can be found in Chapter 6, Sections B.7 and B.8.

A.5.1 Capital Facilities

BHSS funds may be used by counties for capital facility expenditures. Funds may be used to acquire, develop, or renovate buildings or to purchase land in anticipation of acquiring/constructing a building. Capital facility activities **do not** include Housing Interventions.

Capital facilities funds must be used for land and buildings, including administrative offices, that support behavioral health administration and services and enable the county to meet objectives outlined in its Integrated Plan. BHSS funds may be used by counties for capital facility expenditures for county owned and county contracted

providers providing behavioral health services to the county. Specific allowable uses include:

- Acquiring and building upon land that will be county-owned.
- Acquiring, constructing, or renovating buildings that are or will be county-owned (e.g., residential care/treatment facilities, clinics, clubhouses, wellness and recovery centers, office spaces, or buildings where behavioral health vocational, educational, and recreational services are provided). The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.
- Establishing a capitalized repair/replacement reserve for buildings, including administrative offices, that enable the county to meet objectives outlined in its Integrated Plan and/or personnel costs directly associated with a capital facilities project.
- Renovating buildings that are county or privately owned if the building is dedicated and used to provide county behavioral health services.
- Acquiring facilities not secured to a foundation that is permanently affixed to the ground (e.g., vehicles that provide mobile medication for opioid use disorder services, modular buildings for behavioral health services located on school grounds). Acquisition of these facility types is permissible for both the county and for non-profit behavioral health providers.
- Meeting the match requirements for Behavioral Health Infrastructure Bond Act of 2023 BHCIP awards (Bond BHCIP). Capital facilities funds used as a match for Bond BHCIP awards must meet all Bond BHCIP requirements. The use of BHSA funds for BHCIP match requirements is permissible for both the county and for non-profit behavioral health providers.

The following additional requirements apply to capital facilities projects:

- BHSS funds for capital facilities can only be used for those portions of land and buildings where county behavioral health services are provided.
- Land acquired and built upon or construction/renovation of buildings using BHSS funds must be used to provide county behavioral health services for a minimum of twenty years.
- All buildings under this component must comply with federal, state, and local laws and regulations, including zoning and building codes and requirements;

licensing requirements, where applicable; fire safety requirements; environmental reporting and requirements; hazardous materials requirements; the Americans with Disabilities Act (ADA), California GOV Section 11135, and other applicable requirements.

- Capitalized repair/replacement reserves must be controlled, managed, and disbursed by the county.
- Counties may "lease (rent) to own" a building if "lease (rent) to own" is preferable to the outright purchase of the building and the purchase of such property, with BHSS funds, is not feasible. Counties must provide information on why the purchase of the property is not feasible in their Integrated Plan.
- County Behavioral Health Departments may purchase land with BHSS funds even if they do not plan to use BHSS funds for the construction of a building or purchase of a building (e.g. modular, etc.) if they have other expected sources of income for the planned construction or purchase of a building upon this land and the purchase serves to increase the county's infrastructure. The purchase must serve to increase the county's infrastructure for behavioral health services. Counties must include an explanation of the timeline and expected sources of income for the land in their Integrated Plan.

Examples of costs for which BHSS funds **may not** be used for capital facilities activities include:

- Facilities where the purpose of the building is to provide housing.
- Master leasing or renting of building space.
- Purchase of vacant land with no plan for building construction.
- Acquisition of land and/or buildings and/or construction of buildings, and establishment of a capitalized repair/replacement reserve when the owner of record is a nongovernment entity.
- Operating costs for the building (e.g., insurance, security guard, taxes, utilities, landscape maintenance, etc.).
- Furniture or fixtures not attached to the building (e.g., desks, chairs, tables, sofas, lamps, etc.).

A.5.2 Technological Needs

BHSS funds may be used to 1) increase individual and family empowerment and engagement by providing the tools for secure access to their health information and 2) modernize and transform clinical and administrative information systems. Counties may combine their resources to advance multi-county technological needs projects.

BHSS funds may be used for technological needs expenditures that support behavioral health administration and services including, but not limited to, the following:

- Electronic health record (EHR) system projects including but not limited to:
    - Infrastructure, security, privacy
    - Practice management
    - Clinical data management
    - Computerized provider order entry
    - Full EHR with interoperability components (for example, standard data exchanges with other counties, contract providers, labs, pharmacies)
- Individual and family empowerment projects including but not limited to:
    - Individual/family access to computing resources projects
    - Personal health record system projects
    - Online information resource projects (expansion/leveraging information sharing services)
- Other technological needs projects and expenditures that support behavioral health operations including but not limited to:
    - Telemedicine and other rural/underserved service access methods
    - Pilot projects to monitor new programs and service outcome improvement
    - Data warehousing projects/decision support
    - Imaging/paper conversion projects
    - Multi-county technological needs projects
    - Maintenance costs, such as subscriptions to maintain EHRs or other systems

- Resources to support compliance with the Americans with Disabilities Act (ADA) Title II requirements for web content and mobile app accessibility, California GOV Section 11135 and other applicable requirements.

A.6 Innovative Behavioral Health Pilots and Projects

The goal of innovative behavioral health pilots and projects is to build the evidence base for the effectiveness of new statewide strategies. Counties are encouraged to pilot and test innovative behavioral health pilots and projects (WIC section 5892, subdivision (a)(4)) in all BHSA funding components (Housing Interventions, FSP, and BHSS). Counties should fund innovative behavioral health pilots and projects under each of those separate funding components.

A.7 Early Intervention Programs

Under the Mental Health Services Act, Prevention and Early Intervention made up one of the five program components. Now, Early Intervention is covered under BHSS to be provided by counties and four percent of total BHSA funding will be used by the California Department of Public Health (CDPH) for statewide Population-Based Prevention programs and activities.

Under BHSA, each county must establish and administer an Early Intervention program (WIC section 5890, subdivision (a)(3)) that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health (WIC 5840, subdivision (a)(1)). At least 51 percent of BHSS funding must be used to fund Early Intervention programs and services (WIC section 5892, subdivision (a)(3)(B)(i)). At least 51 percent of the BHSS Early Intervention funding must be used to serve eligible individuals who are 25 years of age and younger, including transitional aged youth (WIC section 5892, subdivision (a)(3)(B)(ii)). Early Intervention funds may also be used to provide supports and services to parents and caregivers. However, these services do not count toward the 51 percent requirement spent on individuals who are 25 years and younger unless the service is provided as part of an Early Intervention Evidence-Based Practice (EBP) or a Community-Defined Evidence Practice (CDEP). Services that are provided as part of Early Intervention EBPs or CDEPs that support parents and caregivers count towards the 51% requirement, even if the child/youth is not present, as long as the service is for the benefit of that child/youth. Early Intervention funds can also be used to support innovative behavioral health pilots and projects (WIC section 5892, subdivision (a)(4)) within these parameters to build the evidence base for the effectiveness of new statewide strategies.

County Early Intervention programs must also include a Coordinated Specialty Care for First Episode Psychosis (CSC for FEP) program beginning July 2026. More information on CSC-FEP requirements can be found in Chapter 7, Section A.7.5.

County Early Intervention programs must emphasize the reduction of the likelihood of the following adverse outcomes for BHSA eligible individuals, found in WIC section 5840, subdivision (d):

- Suicide and self-harm
- Incarcerations
- School suspension, expulsion, referral to an alternative or community school, or failure to complete (inclusive of early childhood zero to five years of age, Transitional Kindergarten (TK)-12, and higher education)
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes
- Overdose
- Mental illness in children and youth through social, emotional, developmental, and behavioral services and supports in early childhood

Culturally Responsive and Linguistically Appropriate Interventions

County Early Intervention programs must include culturally responsive and linguistically appropriate interventions. These interventions must be able to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, sexual orientation, gender identity, religion, age, economic, or other disparities in mental health and substance use disorder treatment services access, quality, and outcomes (WIC section 5840.6, subdivision (g)(1)).

County Early Intervention programs must create critical linkages with community-based organizations, including, but not limited to, service and treatment providers, youth centers, licensed and exempt clinics, facilities and providers licensed or certified by the DHCS, licensed or certified residential substance use disorder facilities, and licensed narcotic treatment programs. Community-based organizations may also include

organizations that provide evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) (WIC section 5840.6, subdivision (h)).

Counties are encouraged to partner with community-based organizations that specialize in serving specific populations that are underserved and address specific barriers in the above paragraphs. DHCS encourages the use of CDEPs at the local level to address historical behavioral health disparities. CDEPs are an alternative or complement to EBPs, that offer culturally anchored interventions that reflect the values, histories and life experiences of the communities that the provider is providing services. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

A.7.1 Early Intervention

Early Intervention is the proactive approach of identifying and addressing behavioral health concerns in their early stages before they escalate into more severe, disabling or chronic conditions. DHCS has adapted the Institute of Medicine's Continuum of Care to clarify the types of behavioral health services and supports that can be funded under BHSS Early Intervention programs.

Under the Institute of Medicine's Continuum of Care model, there is a spectrum that spans prevention and early intervention, and within the spectrum, there are differentiations based on type of intervention.

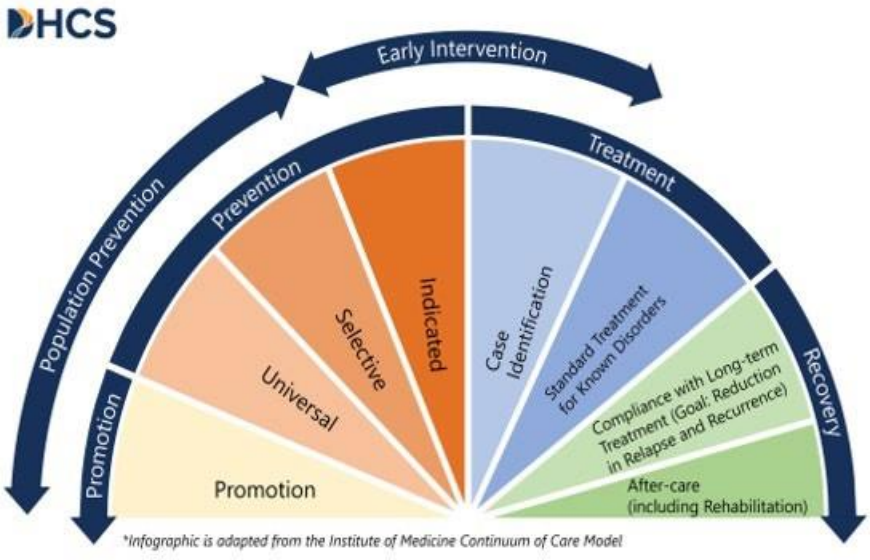


Figure 7.A.1. The Institute of Medicine's Continuum of Care and Spectrum of Early Intervention Services

Under this model, Early Intervention must focus on strategies and activities that are directed to an eligible individual, including indicated prevention and case identification.

Early Intervention services may be provided to individuals lacking a specific diagnosis. Indicated prevention interventions focus on BHSA eligible at-risk individuals who are at risk or experiencing early signs of a mental health or substance use disorder or who have experienced known risk factors for poor behavioral health outcomes, such as trauma, Adverse Childhood Experiences, or involvement with child welfare or corrections system. This at-risk individual may not yet meet the criteria of a diagnosable mental health or substance use disorder. Indicated prevention is the only prevention intervention that is allowable under Early Intervention, as shown in Figure 7.A.1. Examples of indicated interventions include, but are not limited to, outreach, training, and education for high-risk individuals and/or families who are at risk or experiencing early signs of a mental health or substance use disorder. Indicated interventions are preventive and often provided before an individual receives or meets diagnostic criteria for a behavioral health diagnosis. Case identification includes assessment, diagnoses, brief interventions, and activities needed to create access and linkages to care that connect individuals to the appropriate care.

County Early Intervention programs target BHSA priority populations and have the goal of identifying these individuals for access and linkage to services and treatment as

needed. Additional information on BHSA eligible and priority populations can be found in Chapter 2, Section B.3.

A.7.2 Priorities for Use of Funds

County Early Intervention programs must focus on the following priorities, found in WIC section 5840.7, subdivision (a)(1):

- Childhood trauma early intervention to deal with the early origins of mental health and substance use disorder treatment needs, including strategies focused on:
    - Eligible children and youth experiencing homelessness.
    - Justice-involved children and youth.
    - Child welfare-involved children and youth with a history of trauma.
    - Other populations at risk of developing a mental health disorder or condition as specified in subdivision (d) of WIC 14184.402 or substance use disorders.
    - Eligible children and youth in populations with identified disparities in behavioral health.
- Early psychosis and mood disorder detection and intervention and mood disorder programming that occurs across the lifespan.
- Outreach and engagement strategies that target early childhood zero to five, out-of-school youth, and secondary school youth. Partnerships with community-based organizations and college mental health and substance use disorder programs may be used to implement the strategies.
- Culturally responsive and linguistically appropriate interventions.
- Strategies targeting the mental health and substance use disorder needs of older adults.
- Strategies targeting the mental health needs of eligible children and youth, as defined in WIC section 5892, who are zero to five years of age, including, but not limited to, infant and early childhood mental health consultation.
- Strategies to advance equity and reduce disparities.
- Strategies to address the needs of individuals at high risk of crisis.

- Programs that include community-defined evidence practices and evidence-based practices and mental health and substance use disorder treatment services similar to those provided under other programs that are effective in preventing mental illness and substance use disorders from becoming severe and components similar to programs that have been successful in reducing the duration of untreated severe mental illness and substance use disorders to assist people in quickly regaining productive lives.

While the above priorities are required, counties may include other priorities (WIC section 5840.7, subdivision (d)(1)) for the use of their BHSS Early Intervention funds based on needs identified in their community planning process, in addition to the established priorities and consistent with Chapter 3, Section B. If a county chooses to include other programs, the Integrated Plan shall include a description of why those programs are included and metrics by which effectiveness of those programs is to be measured (WIC section 5840.7, subdivision (b)). Counties may act jointly (WIC section5840.7, subdivision (d)(2)) to meet these requirements.

A.7.2.1 Childhood Trauma Early Intervention Programs

The BHSA strengthens prioritization of resources to serve eligible children and youth with its dedicated allocation of BHSS Early Intervention funds. County Early Intervention programs must include specific interventions focused on childhood trauma (WIC section 5840.7, subdivision (a)(1)).

These programs target BHSA eligible children and youth exposed to, or who are at risk of exposure to, adverse childhood experiences (ACEs) and traumatic childhood events, environmental trauma including community violence, generational trauma, institutional trauma, and prolonged toxic stress. Childhood trauma Early Intervention programs aim to address the early origins of mental health and substance use disorder needs and prevent long-term mental health and substance use disorder concerns. These programs may include, but are not limited to, the following:

- Focused outreach and early intervention to at-risk and in-need populations, including youth experiencing homelessness, justice-involved youth, LGBTQ+ youth, and child welfare-involved youth.
- Implementation of appropriate trauma and developmental screening and assessment tools with linkages to early intervention services to eligible children and youth who qualify for these services.

- Collaborative, strengths-based approaches that appreciate the resilience of trauma survivors and support their parents and caregivers when appropriate.
- Support from peer support specialists, wellness coaches, and community health workers trained to provide mental health and substance use disorder treatment services with an emphasis on culturally and linguistically tailored approaches.
- Multigenerational family engagement, education, and support for navigation and service referrals across systems that aid the healthy development of children and youth and their families.
- Collaboration with county child welfare agencies and other system partners, including Medi-Cal Managed Care Plans, and homeless youth service providers, to address the physical and behavioral health-related needs and social needs of child-welfare-involved youth.
- Linkages to primary care and behavioral health settings, including, but not limited to, federally qualified health centers, rural health centers, community-based providers, school-based health centers, school-linked providers, and school-based programs and community-based organizations, early learning and care centers, Regional Centers, school-based health centers, specializing in serving underserved communities.
- Linkages to county and community-based organizations that will help address the adolescent's needs through the provision of continuing care and support services.
- Leveraging the healing value of traditional cultural connections and faith-based organizations, including policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served and recognition of historical trauma.
- Blended funding streams to provide individuals and families experiencing toxic stress comprehensive and integrated supports across systems.
- Partnerships with local educational agencies and school-based behavioral health professionals, early learning and care centers, county First Five commissions, and Regional Centers, to identify and address children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress.

A.7.3 Early Intervention Program Components

Each county must establish and administer an Early Intervention program that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health. County Early Intervention programs must include the following components, found in WIC section 5840, subdivision (b):

1. Outreach
2. Access and linkage to care
3. Mental health and substance use disorder early treatment services and supports

All services and supports provided within county Early Intervention programs must meet the requirements of their respective component. Each county must address all three components across its BHSA-funded Early Intervention programs, but no single Early Intervention program is required to include all three components.

A.7.3.1 Outreach

Outreach is the process of engaging, encouraging, educating, training, and learning about ways to recognize and respond effectively to early signs of potentially severe and disabling mental health and substance use disorders (WIC section 5840, subdivision (b)(1)). Outreach activities funded under BHSS Early Intervention must meet the following requirements:

- Be directed towards eligible high-risk individuals within BHSA priority populations (WIC section 5892, subdivision (d), including older adults and youth (WIC section 5892, subdivision (k)(7)(A) and (k)(7)(B)).
- Have the goal of identifying individuals for access and linkage to services and supports.
- Connect eligible individuals directly to access and linkage programs or to mental health and substance use disorder treatment services and supports, should an individual wish to be connected to services.

County outreach activities may include those that target:

- Families
- Employers
- Primary care health care providers

- Behavioral health urgent care and first responders
- Hospitals, inclusive of emergency departments
- Education, including early care and learning, TK-12, higher education
- Community-based organizations that specialize in serving underserved communities
- Others

Eligible older adults and youth may require tailored outreach strategies, as noted below.

Outreach Strategies for Older Adults

When targeting the mental health and substance use disorder needs of BHSA eligible older adults, outreach strategies (WIC section 5840.6, subdivision (h)) include, but are not limited to, the following:

- Outreach and engagement strategies that target caregivers, victims of elder abuse, and individuals who live alone.
- Outreach to older adults who are isolated and/or lonely.
- Programs for early identification of mental health disorders and substance use disorders.
- Outreach to organizations that provide services to older adults such as Area Agencies on Aging, Caregiver Resource Centers, and Aging and Disability Resource Connections.

Youth Outreach and Engagement

Youth outreach and engagement strategies (WIC section 5840.6, subdivision (f)) target BHSA eligible out-of-school youth and secondary school-age youth, and include, but are not limited to, the following:

- Establishing direct linkages for youth to community-based mental health and substance use disorder treatment services.
- Participating in EBPs and CDEP programs for mental health and substance use disorder treatment services.
- Providing supports to facilitate access to services and programs, including those utilizing EBPs and CDEPs, for underserved and vulnerable populations, including, but not limited to, members of ethnically and racially diverse communities,

members of the LGBTQ+ communities, victims of domestic violence and sexual abuse, and veterans.

- Establishing direct linkages for students to community-based behavioral health services for which reimbursement is available through the students' health coverage.
- Reducing racial disparities in access to behavioral health services.
- Providing school employees and students with education and training in early identification, intervention, and referral of students with behavioral health needs.
- Providing education and training opportunities in early identification, intervention, and referral of youth with behavioral health needs in community-based settings to target out-of-school youth and employees of organizations that work with youth.
- Providing strategies and programs for youth with signs of behavioral or emotional needs or substance misuse who have had, or are at risk of having, contact with the child welfare or juvenile justice system.
- Providing integrated youth behavioral health programming.

A.7.3.2 Access and Linkage to Care

Access and linkage (WIC section 5840, subdivision (b)(2)) to care must ensure that care can be provided by county behavioral health programs as early in the onset of behavioral health conditions as practicable, and that referrals for medical and social services are provided as needed. Access and linkage to care may include activities that support screening, assessment, and referral to behavioral health services, such as telephone help lines, mobile response teams, and supportive services such as Enhanced Care Management and Community Supports available to Medi-Cal members. Activities must also include the scaling of and referral to (WIC section 5840, subdivision (b)(2)(B)) the Early Psychosis Intervention (EPI) Plus Program, including Coordinated Specialty Care, or other EBPs and CDEPs for early psychosis and mood disorder detection and intervention programs.

A.7.3.3 Mental Health and Substance Use Disorder Services and Supports

Mental health and substance use disorder treatment services and supports provided under Early Intervention (WIC section 5840, subdivision (c)) must be proven to reduce the duration of untreated serious mental health illnesses and substance use disorders and assist people in quickly regaining productive lives (these supports are separate and

distinct from the "housing supports" provided within Housing Interventions). Early intervention mental health and substance use disorder services must also be responsive to the cultural and linguistic needs (WIC section 5840, subdivision (b)(3)(C)) of diverse communities.

When determining what practices to implement locally, counties may reference the biennial DHCS-provided list of EBPs and CDEPs (WIC section 5840, subdivision (c)). More information on EBPs and CDEPs can be found in Chapter 7, Section A.7.6.

Early intervention mental health and substance use disorder treatment services and supports to those eligible for BHSA may include:

- Mental health treatment services to address first episode psychosis.
- Mental health and substance use disorder services that prevent, respond, or treat a behavioral health crisis or activities that decrease the impacts of suicide, return to use of illicit substances or misuse of prescription drugs, and/or accidental overdose/poisoning.
- Early intervention services designed to address co-occurring mental health and substance use issues.

In addition to the BHSA Eligible Populations, early intervention mental health and substance use disorder services may be provided to the following eligible children and youth.

- Individual children and youth at high risk for a behavioral health disorder due to experiencing trauma, as evidenced by scoring in the high-risk range under a trauma screening tool such as an ACEs screening tool, involvement in the child welfare system or juvenile justice system or experiencing homelessness.
- Individual children and youth in populations with identified disparities in behavioral health outcomes.

A.7.4 Stigma and Discrimination Reduction

Stigma and discrimination reduction activities aim to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, substance use disorder or seeking behavioral health services. Stigma and discrimination reduction programs align with population-based prevention activities and cannot be funded with Early Intervention funding.

A.7.5 Early Psychosis Intervention Plus Programs

Early Psychosis Intervention (EPI) Plus programs encompass early psychosis and mood disorder detection and intervention. These programs (WIC section 5835, subdivision (a)(2)) utilize evidence-based approaches and services to identify and support clinical and functional recovery of individuals by reducing the severity of first, or early, episode psychotic symptoms and other early markers of serious mental illness, such as schizophrenia spectrum disorders and mood disorders, supporting individuals to engage in school or at work, and putting them on a path to better health and wellness. EPI Plus programs may include, but are not limited to, all of the following:

- Focused outreach to at-risk and in-need populations, as applicable.
- Recovery-oriented psychotherapy, including cognitive behavioral therapy focusing on co-occurring disorders.
- Family psychoeducation and support.
- Peer support services.
- Supported education and employment.
- Pharmacotherapy and primary care coordination.
- Use of innovative technology for mental health information feedback access that can provide a valued and unique opportunity to assist individuals with mental health needs and to optimize care.
- Case management.

EPI Plus programs must include CSC for FEP and may include other EBPs and CDEPs for early psychosis and mood disorder detection and intervention programs. See CSC for FEP requirements below.

A.7.5.1 Coordinated Specialty Care for First Episode Psychosis

CSC for FEP is a community-based service that provides timely and integrated support during the critical initial stages of psychosis with the strongest base of evidence among any intervention for improving outcomes for individuals experiencing early psychosis. CSC for FEP reduces the likelihood of psychiatric hospitalization, emergency room visits, residential treatment placements, involvement with the criminal justice system, substance use, and homelessness that are often associated with untreated psychosis. Research on CSC for FEP has demonstrated that individuals who receive this service are significantly less likely to develop a significant mental health condition over time

compared to those who receive standard care. Individuals who receive CSC for FEP have also reported improved psychopathology and overall quality of life. DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC) have made significant investments in expanding CSC for FEP throughout the state, such as through funding, technical assistance, and policy reforms. These efforts include contracting with University of California, Davis to fund FEP technical assistance for county behavioral health agencies, a $25 million commitment to further support and expand EPI-CAL, Assembly Bill (AB) 1315 establishment of the EPI Plus program, Children and Youth Behavioral Health Initiative (CYBHI) grants for CSC for FEP, and coverage of CSC for FEP as a bundled service under Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT).

County Early Intervention programs must implement CSC for FEP beginning July 2026. In addition to utilizing EI funds under BHSS, counties may meet the requirement to implement CSC for FEP programs using other non-BHSA funding sources including, but not limited to 2011 Realignment or Mental Health Block Grant funding, so long as this is accounted for in their Integrated Plan. To support implementation, DHCS will make available training, technical assistance, and fidelity monitoring supports for counties as they implement CSC for FEP.

Between July 1, 2026, and June 30, 2029, all counties must:

- Participate in ongoing training and technical assistance.
- Understand gaps to fidelity by December 31, 2027.
- Complete full fidelity reviews and demonstrate counties are implementing CSC for FEP with fidelity by June 30, 2029.

A city receiving BHSA funding meets these requirements if the county will be providing CSC for FEP and/or opting into the bundled benefit.

A.7.5.2 Aligning Coordinated Specialty Care for First Episode Psychosis in Early Intervention with Medi-Cal

In December 2024, CMS approved State Plan Amendment (SPA) 24-0042, which establishes CSC for FEP as a covered benefit in the Medi-Cal program. Counties have the option to provide CSC for FEP as a bundled service with a monthly bundled reimbursement rate under Medi-Cal in the Specialty Mental Health Services (SMHS) delivery system beginning in 2025. Consistent with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate, counties are required to provide CSC for FEP to Medi-Cal members under the age of 21 if the service is clinically appropriate.

Counties that elect to provide CSC for FEP as a bundled Medi-Cal service must meet the requirements in Behavioral Health Information Notice (BHIN) 25-009.

Counties should use the BH-CONNECT EBP Policy Guide to support implementation of CSC for FEP. The EBP Policy guide includes information about the evidence-based service criteria for CSC for FEP, staffing structure for teams of behavioral health practitioners delivering CSC for FEP, and other best practices for delivering CSC for FEP with fidelity to the evidence-based model.

In addition, all counties must adhere to the CSC for FEP requirements in forthcoming EBP training, technical assistance, fidelity monitoring and data collection guidance.

Counties that do not choose to offer CSC for FEP as a bundled Medi-Cal service are still required to deliver and bill Medi-Cal for medically necessary unbundled CSC for FEP services covered as SMHS.

These services may include the following SMHS:

- Assessment
- Crisis Intervention
- Medication Support Services
- Peer Support Services
- Psychosocial Rehabilitation
- Referral and Linkages
- Therapy
- Treatment Planning

Even if counties do not opt to take up the option to provide CSC for FEP as a bundled Medi-Cal service, counties must deliver CSC for FEP with fidelity and consistent with the requirements established for BH-CONNECT. For non-Medi-Cal BHSA eligible individuals, Early Intervention funding may be used for the fully uninsured. Commercial health plans are required to provide coverage for CSC for FEP under Senate Bill (SB) 855 regulations and counties are required to seek reimbursement from commercial payers; see Chapter 6, section C.3.3 regarding how to file a complaint (WIC section 5891, subdivision (a)(4)(B)) with the appropriate regulatory agency.

A.7.6 Biennial List of Evidence-Based Practices and Community-Defined Evidence Practices

DHCS developed a list of Early Intervention EBPs and CDEPs, which can be found in Appendix E. Additional information about the Early Intervention EBPs and CDEPs can be found in WIC section 5840, subdivision (c)(1). This list is not exhaustive and counties may implement EBPs and CDEPs not on the biennial list based on their local needs and community preferences. DHCS will update this list every two years (see A.7.6.1).

The only EBP that counties are required to provide as a part of Early Intervention is a CSC for FEP program, beginning July 2026. However, DHCS may require statewide implementation of a particular EBP or CDEP from the biennial list (WIC section 5840, subdivision (c)(5)) to address identified needs.

A.7.6.1 Developing the 2026 Biennial List of EBPs/CDEPs

EBPs and CDEPs included on the biennial list address mental health, substance use, and co-occurring disorders and at least one aspect of the required BHSA Early Intervention program components: outreach, access and linkage to care, and mental health and substance use disorder treatment services and supports.

To develop the biennial list, DHCS drew from the programs and sources below:

1. BH-CONNECT
2. Children and Youth Behavioral Health Initiative's (CYBHI) EBPs and CDEPs grant program
3. Family First Prevention Services Act
4. Blueprints for Healthy Youth Programs
5. The Athena Forum created by Washington State Health Care Authority
6. CDPH's California Reducing Disparities Project
7. Evidence-based Practices Resource Center developed by the Substance Abuse and Mental Health Services Administration
8. The Cognitive-Behavioral Interventions for Substance Use curriculum designed by the University of Cincinnati
9. California Evidence-Based Clearinghouse for Child Welfare

10. The County of Los Angeles Department of Mental Health, Prevention and Early Intervention EBPs, Promising Practices, and CDEPs Resource Guide 2.0. created by the California Institute for Mental Health

DHCS also solicited input from the California Department of Public Health (CDPH), the Behavioral Health Services Oversight and Accountability Commission (BHSOAC), stakeholders representing behavioral health providers, California's tribal communities, county departments of behavioral health and public health, and other subject matter experts. DHCS assessed the proposed EBPs and CDEPs based on the following criteria for inclusion in the biennial list:

- Availability of public materials and information about the EBP or CDEP, including an overview of the evidence base, details on how the program or intervention is structured, and information on how to implement.
- Availability of trainings on implementing the EBP or CDEP or sufficient informational resources for counties to adapt locally.
- Primary focus of the EBP or CDEP is on Early Intervention, as defined in the County Policy Manual, and fits in a category of Indicated (prevention) or Case Identification (treatment) on the Institute of Medicine's Continuum of Care and Spectrum of Early Intervention Services, as shown in Figure 7.A.1. EBPs and CDEPs may include some population-based prevention or treatment/recovery elements but are primarily focused on key areas of Early Intervention for individuals. Counties are only permitted to fund EBPs and CDEPs that may have very limited population-based prevention components or treatment/recovery elements in full with BHSS Early Intervention funds if the EBP or CDEP is on this list.

A.7.6.2 Organizing the Biennial List of EBPs/CDEPs

The EBPs and CDEPs are organized into the following categories based on population served: Children and Youth; Family-Centered; Adults and Older Adults; and General. Within those categories, EBPs and CDEPs are organized by condition addressed: Mental Health; Substance Use; and Co-Occurring. Some EBPs and CDEPs are included in multiple categories. Programs listed with an asterisk indicate a CDEP.

A.7.6.3 Updating the Biennial List of EBPs/CDEPs

DHCS will update the biennial list of EBPs and CDEPs every two years following the July 1, 2026 effective date for the inaugural biennial list of EBPs and CDEPs. The next update to the biennial list will be effective on July 1, 2028. Beginning one year prior (i.e., July 1, 2027), DHCS will consult with the BHSOAC, key agencies, counties, subject matter

experts, and behavioral health stakeholders to consider updates to the list. Following that, DHCS will publish an updated biennial list of EBPs and CDEPs for public comment at least six months prior (i.e., January 1, 2028) to the list's effective date. DHCS will update the biennial list based on its review of public comment and publish the final list in the BHSA County Policy Manual.

In between biennial updates, individuals and organizations may submit EBPs and CDEPs for DHCS' consideration. DHCS will track feedback and consider any newly proposed EBPs and CDEPs for inclusion in the next scheduled update to the biennial list of EBPs and CDEPs, aligning with the criteria and process described above.

B. Full Service Partnership

B.1 Full Service Partnership Funding

Counties are required to use 35 percent of the funds distributed by the State Controller's Office into their Behavioral Health Services Fund (BHSF) for Full Service Partnership (FSP).

B.2 Introduction and Background

FSP programs provide individualized, team-based care to individuals living with significant behavioral health needs through a "whatever it takes" approach. Participants benefit from a community-based, whole-person approach that is trauma-informed, recovery-focused, age-appropriate, and delivered in partnership with families or an individual's natural supports.

County FSP programs have been a core Mental Health Services Act (MHSA) investment over the last 20 years and continue to be a key component of California's behavioral health continuum of care. According to the Mental Health Services Oversight and Accountability Commission (MHSOAC) Report to the Legislature on Full Service Partnerships, FSP programs were developed from the early successes of late-90s' pilot programs "to fund comprehensive and integrated care for persons with high risk for homelessness, justice involvement, and hospitalization." While evaluations have found that county FSP programs achieve improved outcomes for FSP participants and cost savings, there is variance in county models and limited information available on the effectiveness of county FSP programs and the overall FSP initiative. A 2024 MHSOAC publication identified opportunities to improve FSP programs, many of which are reflected in the Behavioral Health Services Act (BHSA). The recommendations include:

- Establish a common set of service requirements.
- Develop standardized definitions and eligibility requirements.
- Develop a tiered system for FSP care and incorporate step-down planning into programs.
- Ensure FSP programs are equipped to serve a diverse population.
- Streamline data collection and clarify expectations.

Many policy changes that will be implemented under the BHSA are responsive to these MHSOAC recommendations. Under BHSA, FSP policies will include standardization of key evidence-based practices (EBPs) that must be included as part of county FSP programs across service delivery systems, a tiered model with opportunity for step-down planning, and greater consistency in FSP programs from county to county.

B.3 Full Service Partnership Program Requirements

B.3.1 Eligible and Priority Populations

FSP Eligible Populations include:

- Behavioral Health Services Act (BHSA) eligible adults and older adults, who meet the priority population criteria specified in WIC section 5892, subdivision (d), and
- BHSA eligible children and youth, which includes transitional age youth (TAY).

B.3.2 Baseline Requirements

- Given the expansion to include eligible individuals living with substance use disorder (SUD) in the BHSA, county FSP programs must include SUD treatment services where appropriate. County FSP teams must be capable of supporting FSP participants living with co-occurring mental health and substance use disorder conditions by providing integrated behavioral health care as part of the FSP program, inclusive of mental health, SUD and/or co-occurring services, or by closely coordinating the provision of SUD care for FSP participants.
- FSP services shall be provided in accordance with demonstrated clinical need and in alignment with the required high intensity service models: Assertive Community Treatment (ACT), Forensic ACT (FACT), FSP Intensive Case Management (ICM), and High Fidelity Wraparound (HFW). All of these services with the exception of ICM are covered as bundled Medi-Cal services with dedicated bundled rates. DHCS encourages counties to elect to provide these services as bundled Medi-Cal services. Counties that opt to provide these services as

bundled Medi-Cal services may use FSP funding for the non-federal share of services provided to Medi-Cal members. Please refer to the respective sections for details regarding required services and expectations for co-occurring capabilities.

- County FSP programs must provide ongoing engagement services to FSP participants in order to maintain their continued treatment. Providers are responsible for attempting to engage FSP-eligible individuals to ensure they are adequately supported in their recovery. If the team attempts to engage an FSP-eligible individual repeatedly for several months and are unable to engage them, the team should meet and discuss whether that individual should be moved to a lower level of care or disenrolled so that another FSP-eligible individual is able to receive services. Ongoing engagement services may include clinical and recovery-oriented services, such as consumer-operated services, peer support services, transportation, and services to support maintaining housing. However, Housing Interventions provided to FSP clients must be funded through the Housing Interventions component. All Medi-Cal billable services must be billed to Medi-Cal pursuant to WIC section 5891, subdivision (a)(1)(G)(2).
- County FSP programs must also include outpatient behavioral health services, either clinic or field based, necessary for the ongoing evaluation, and stabilization and recovery of an enrolled individual. Many of these outpatient behavioral health services are incorporated within the high intensity service models (ACT, FACT, FSP ICM, and HFW) county FSP programs are required to utilize.
- FSP teams are required to coordinate with an FSP program participant's primary care provider as appropriate. Ensuring coordination across systems, including primary care, is critical to participant engagement and satisfaction. Counties who are Enhanced Care Management (ECM) providers can deliver ECM to individuals receiving FSP. Counties also have discretion to prioritize FSP program slots for individuals not eligible for ECM. Please see the ECM Policy Guide for additional information.

B.3.3 Full Service Partnership Continuum

In accordance with WIC section 5887, county FSP programs must make the following specified services available:

- Mental health services, supportive services, and substance use disorder (SUD) services

- Assertive Community Treatment (ACT)
- Forensic ACT (FACT)
- FSP Intensive Case Management (ICM)
- Individual Placement and Support (IPS) model of Supported Employment
- High Fidelity Wraparound (HFW)
- Assertive field-based initiation for SUD
- Outpatient behavioral health services for evaluation and stabilization
- Ongoing engagement services
- Service planning (county FSP programs are expected to adhere to the service planning process outlined in WIC sections 5806 and 5868 and do not require documentation in a "standalone" treatment plan or service plan)
- Housing interventions (funded under the Housing Interventions category)

County FSP programs may additionally include behavioral health services the county determines are beneficial to an eligible individual's treatment, if not already covered by ACT, FACT, FSP ICM, or HFW, in collaboration with the individual and, when appropriate, the individual's family. Additional services that may be offered in addition to or in conjunction with the specified services listed above include but are not limited to:

- Primary SUD FSPs
- Additional evidence-based practices (EBPs)
- Outreach
- Other recovery-oriented services, including consumer-operated services and peer support services

DHCS has discretion to define additional EBPs, treatment models, and CDEPs and may do so in future iterations of the County BHSA Policy Manual. The addition of EBPs, treatment models, and CDEPs will include stakeholder consultation.

Counties may use FSP funding for outreach activities if the activities relate to enrolling individuals living with significant behavioral health needs in an FSP, consistent with WIC section 5887, subdivision (d). For example, counties are encouraged to use data systems (e.g., Medi-Cal Connect) to identify individuals who are not actively receiving behavioral health care through the county yet meet clinical criteria for FSP and conduct targeted

outreach to those individuals. For individuals receiving one of the required EBPs, initial outreach and ongoing engagement is embedded in the model. General outreach to individuals living with significant behavioral health needs who are not FSP eligible should be funded under other appropriate funding sources including Behavioral Health Services and Supports (BHSS) and Housing Interventions.

B.3.4 Full Service Partnership Exemptions

Fiscal Year (FY) 2026-2029 Integrated Plan

State law permits counties with a population of less than 200,000 to request an exemption from the FSP requirements in WIC section 5887, subdivision (a)(2). In addition, for the first Integrated Plan covering FYs 2026-2029, all counties, regardless of their size, will be exempt from the EBP fidelity requirements for ACT, FACT, IPS Model of Supported Employment, and HFW. Therefore, counties do not need to request an exemption from FSP EBP requirements in their first Integrated Plan. Counties are still required to begin offering the required EBPs by July 1, 2026.

To meet FSP EBP requirements, between July 1, 2026, and June 30, 2029, counties must:

- Participate in ongoing training and technical assistance for all FSP EBPs.
- Understand gaps to fidelity for each FSP EBP by December 31, 2027.
- Complete full fidelity reviews and demonstrate counties are implementing all FSP EBPs with fidelity by June 30, 2029.

DHCS will make available training, technical assistance, and fidelity monitoring supports for counties as they implement FSP EBPs: ACT, FACT, IPS and HFW.

State law permits counties with a population of less than 200,000 to request exemptions from these requirements for ACT, FACT, and/or IPS, consistent with WIC section 5887, subdivision (a)(2). Exemptions are not available for HFW because it is a mandatory Medi-Cal service pursuant to the Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit.

The criteria for FSP exemption requests include:

- Limited workforce (e.g., qualified providers)
- Limited need (e.g., the estimated population with a clinical need for an EBP
- Other hardships, subject to DHCS review

Exemption requests must include: documentation demonstrating that one or more of the criteria for an exemption are met (e.g., workforce or county demographic data, information from a COE consultation). Counties must request exemptions from each FSP EBP (ACT, FACT, and/or IPS) individually and provide corresponding documentation.

B.3.5 Full Service Partnership Co-Occurring Capabilities

The American Society of Addiction Medicine (ASAM) Criteria, Fourth Edition defines co-occurring capable as "Achieving co-occurring capability involves looking at all aspects of program design and functioning to embed integrated policies, procedures, practices, and training in the operations of the program to make it routine for clinicians to successfully delivery integrated care." FSP participants deserve access to co-occurring care consistent with industry standards. To that end, county FSP programs are required to implement the following:

- Connecting individuals to FSP teams, SUD providers, or other clinically necessary services including peer support, as appropriate, after they receive assertive field-based initiation for SUD treatment services.
- Conducting ASAM screening as part of an integrated assessment upon intake into the FSP, and connecting individuals to SUD providers, as appropriate.
- Offering medications for addiction treatment (MAT) services directly to clients or having an effective referral process in place (i.e., established relationship with a MAT provider and transportation to appointments for MAT). Please see BHIN 23-054 for DHCS's existing MAT policy and definition of an "effective referral."
- Equipping FSP program staff at all levels of care to provide comprehensive care to individuals living with significant co-occurring behavioral health needs (e.g., motivational interviewing, engagement, and training for prescribers who are not familiar or comfortable with prescribing MAT).
- Developing strategies for billing and claiming the appropriate service/delivery system within the context of co-occurring care delivery (e.g., Medi-Cal Specialty Mental Health Services (SMHS) versus Drug Medi-Cal (DMC)/Drug-Medi-Cal Organized Delivery System (DMC-ODS).

Counties may use FSP funding to develop strategies to build co-occurring capabilities.

For individuals living with SUD only, DHCS will allow but will not require SUD-only FSPs (see additional information in the Substance Use Disorder Primary Full Service Partnership Option section).

B.4 Full Service Partnership Levels of Care

Pursuant to WIC section 5887, subdivision (e), county FSP programs are required to have a standard of care, with levels of care to treat individuals based on acuity. The following subsections outline the requirements for the levels of care as they pertain to adults and to children and youth.

Behavioral Health Services Act (BHSA) Eligible Adults and Older Adults:

For BHSA eligible adults and older adults, two levels of coordinated care must be available depending on individualized need for service intensity. These are ACT, a stand-alone EBP as the highest intensity level, and FSP Intensive Case Management (ICM), which can be a standardized step-down level from ACT, or provided in order to avert the higher ACT level of care (see Figure 7.B.4.1). FSP ICM is for individuals who may not meet ACT eligibility criteria, but still have significant behavioral health needs and can benefit from FSP supports. Individuals stepping down from FSP ICM who no longer meet the threshold for FSP level of need can receive outpatient mental health (MH) and SUD services, funded through Behavioral Health Services and Supports (BHSS).

As described in subsequent sections of this manual, county BHSA FSP programs must implement EBPs in alignment with Medi-Cal guidance (where applicable). Medi-Cal guidance may include eligibility criteria and/or guidelines on clinical indicators of need for an ACT level of care. However, DHCS recognizes the role of the clinician and her/his team in determining an individual's appropriate level of care, and that movement between tiers may not be linear (i.e., the FSP participant may also need to step back up a level). DHCS will not establish requirements for standardized assessments specific to determining FSP levels of care; this is left to counties and to the clinical judgment and discretion of the treating provider. Under BH-CONNECT, DHCS anticipates issuing guidance for use of one or more Level of Care tools (guidance forthcoming). This guidance may assist counties with identifying individuals who need an FSP level of care but commonly used Level of Care tools do not differentiate between levels of high-intensity, community-based care, such as between ACT and FSP ICM.

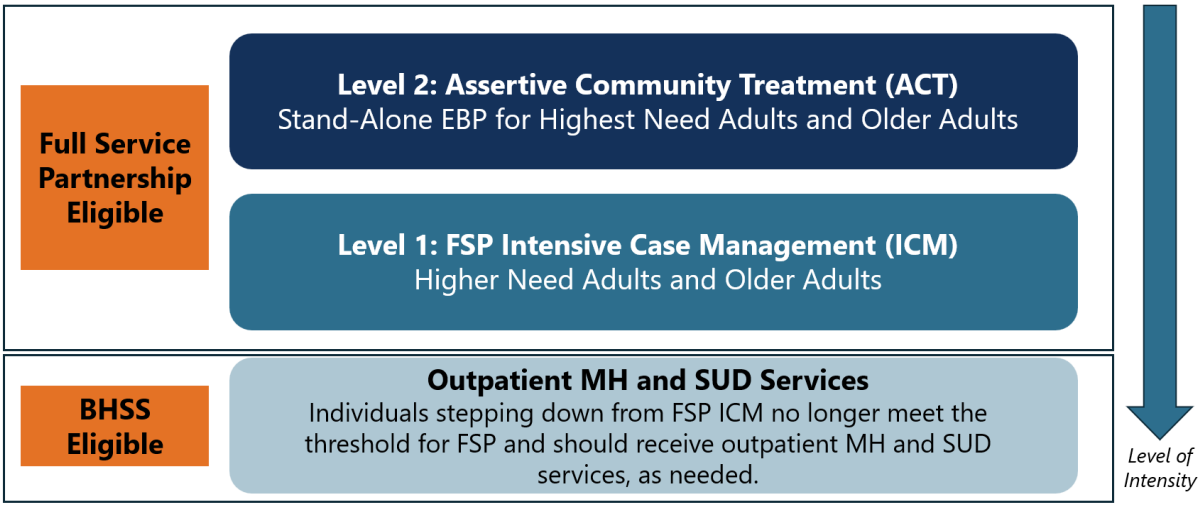


Figure 7.B.4.1. FSP Levels of Care

BHSA Eligible Children and Youth:

For BHSA eligible children and youth, counties shall provide High Fidelity Wraparound (HFW), an especially high intensity, comprehensive, holistic, youth and family-driven way of responding when children or youth experience significant behavioral health challenges. HFW is not restricted to children and youth receiving foster care or involved with child welfare and is intended to support a diverse range of needs and systems interaction.

HFW is the designated FSP level of care for children and youth. However, any child or youth may alternatively receive ACT or FSP ICM, if determined to be clinically and developmentally appropriate.

Among children and youth enrolled in HFW, the array of services required may vary based on individual need. In general, there is little evidence that an additional, lower level of case management – i.e., an approach "beneath" HFW – is effective for children and youth with significant behavioral health needs. As such, DHCS is not currently using its authority under WIC section 5887, subdivision (e) to require counties to develop multiple, dedicated levels of case management for FSP for children/youth.

BHSA Eligible Transitional Age Youth (TAY):

BHSA eligible TAY (aged 16-25) and those younger than TAY, may receive ACT, FACT, FSP ICM, or HFW if determined to be clinically and developmentally appropriate by the provider and FSP eligible individual. BHSA eligible TAY are included in the definition (WIC section 5892, subdivision (k)(7)(A)) for "Eligible children and youth." Counties shall

design FSP programming to meet the needs of all BHSA eligible individuals, including TAY.

Counties must make the appropriate EBP for FSP participants available based on clinical judgment and discretion reflecting individualized needs.

B.4.1 Level 2: Assertive Community Treatment and Forensic Assertive Community Treatment

B.4.1.1 Overview

ACT is an evidence-based practice to support individuals living with complex and significant behavioral health needs and a treatment history that may include psychiatric hospitalization and emergency room visits, residential treatment, involvement with the criminal justice system, homelessness, and/or lack of engagement with traditional outpatient services. ACT is one of the most established and widely researched evidence-based practices in behavioral health care for individuals living with significant mental illness. It has been extensively studied across various populations and settings around the world, with evidence supporting its effectiveness across rural areas, urban centers, and among homeless populations.

Pursuant to the BHSA (WIC section 5891, subdivision (a)(2)) and as described in the BHSA Fiscal Policies chapter, counties are required to bill Medi-Cal for services when possible, instead of using BHSA dollars for the full cost of the service. In alignment with the "whatever it takes" philosophy, FSP funding can be used for services not covered by Medi-Cal, as needed for Medi-Cal members. This includes outreach and engagement services (as outlined in Full Service Partnership Baseline Requirements) and recovery supports, including consumer-operated wellness centers and items that offer emotional support (e.g., a musical instrument). For Medi-Cal members, Peer Support Specialists and Community Health Workers (CHWs) may also provide covered outreach and engagement services, as appropriate and consistent with Medi-Cal guidance. For non-Medi-Cal members, who meet BHSA eligible criteria as defined in WIC Section 5892, FSP funding may be used for service components that commercial plans do not cover, or for all services for the fully uninsured. For example, pairing an intensive behavioral health service like ACT or FSP Intensive Case Management (ICM) with housing supports is a proven, recommended best practice for achieving long-term housing stability. The FSP component may not be used to fund housing interventions, including for FSP participants. FSP participants may receive housing supports through programs outside the BHSA, or from the BHSA Housing Interventions component, provided that the service is not covered by the participant's Medi-Cal managed care plan. Pursuant to WIC

5830, subdivision (c)(2), BHSA "funds shall not be used for housing interventions covered by a Medi-Cal managed care plan."

FACT builds upon the ACT model to address the complex needs of individuals with significant behavioral health needs who are also involved with the criminal justice system. Individuals with significant and complex behavioral health needs are often overrepresented in jails and prisons, are at higher risk of recidivism upon release, and face barriers to community reintegration, including difficulties accessing treatment, employment, housing, and other supports.

While some counties have historically delivered ACT or services that come close to the full ACT service model as part of their FSP programs, pursuant to BHSA, counties must implement ACT beginning in July 2026. Note that ACT is a stand-alone high-intensity mental health service delivery model and cannot be provided concurrently with FSP Intensive Case Management or HFW.

B.4.1.2 Aligning Assertive Community Treatment and Forensic Assertive Community Treatment in Full Service Partnership with Medi-Cal

In December 2024, Centers for Medicare & Medicaid Services (CMS) approved State Plan Amendment (SPA) 24-0042, which establishes ACT as a covered benefit in the Medi-Cal program, and also provides coverage for FACT. Counties have the option to provide ACT and FACT as bundled services with monthly bundled reimbursement rates in the Medi-Cal SMHS delivery system beginning in 2025. Consistent with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate, counties are required to provide ACT to Medi-Cal members under the age of 21 if the service is clinically appropriate. Counties that elect to provide ACT and FACT as bundled Medi-Cal services must meet the requirements in Behavioral Health Information Notice (BHIN) 25-009. Counties should use the BH-CONNECT EBP Policy Guide to support implementation of ACT and FACT. The EBP Policy guide includes information about the evidence-based service criteria for ACT and FACT, staffing structure for teams of behavioral health practitioners delivering ACT and FACT, and other best practices for delivering ACT and FACT with fidelity to the evidence-based model.

In addition, all counties must adhere to ACT and FACT requirements in forthcoming training, technical assistance, fidelity monitoring and data collection guidance.

Counties that do not choose to offer ACT or FACT as bundled Medi-Cal services are still required to cover and bill Medi-Cal on an unbundled basis for many SMHS that are part of ACT and FACT, including:

- Assessment
- Crisis Intervention
- Medication Support Services
- Peer Support Services
- Psychosocial Rehabilitation
- Referral and Linkages
- Therapy
- Treatment Planning

Notably, counties that do not choose to offer ACT or FACT as bundled Medi-Cal services are unable to bill Medi-Cal for key components of ACT and FACT, including employment and education support services as defined in the Medi-Cal State Plan, and support for non-billable activities essential to the coordinated, team-based model.

Even if they do not opt to take up the option to provide ACT or FACT as bundled Medi-Cal services, county FSP programs must deliver ACT and FACT with fidelity and consistent with the guidance in the BH-CONNECT EBP Policy Guide.

B.4.2 Level 1: Full Service Partnership Intensive Case Management

B.4.2.1 Overview

Intensive Case management (ICM), like the ACT model of care, emphasizes long-term community-and-team-based care for individuals living with significant behavioral health conditions. ICM is more than just case management with referrals; ICM has a small caseload size and is delivered by a multidisciplinary team that provides services and supports based on the unique needs of each client, including peer services, crisis intervention, psychosocial rehabilitation, psychotherapy, medication management, and more. Compared to standard care, ICM has been shown to improve general functioning, employment and housing outcomes, and reduce length of hospital stays. While ICM does not have set fidelity criteria like ACT, ICM includes many of the same components including low staff to client ratios, assertive outreach, and direct service delivery. Many current county FSP programs resemble the ICM service model.

The BHSA requires county FSP programs to have an established standard of care based on an individual's acuity and criteria for step-down into the least intensive level of care. For the purposes of California's FSP programs, FSP ICM is designed to be the least intensive FSP level of care. FSP ICM will include a comprehensive set of community-

based services for individuals with significant behavioral health conditions, delivered through a team-based approach. FSP ICM will look much like the flexible delivery model that is widespread in today's FSP programs.

Individuals who may appropriately receive FSP ICM may include those who were receiving ACT and have been clinically determined to no longer require the intensity of ACT and be ready to step down in level of care. Individuals who may receive FSP ICM also include those who need moderate to significant levels of support but do not meet clinical eligibility criteria for ACT. FSP ICM is a stand-alone high-intensity mental health service delivery model, and therefore cannot be provided concurrently with ACT or HFW. FSP ICM is appropriate for BHSA eligible individuals living with co-occurring mental health and SUD conditions and for those aged 18-26 or younger who are not connected to children's services, if determined to be clinically and developmentally appropriate.

B.4.2.2 Full Service Partnership Intensive Case Management Eligibility Criteria

When determining whether FSP ICM is the appropriate level of care, counties and service providers should consider the following:

- A current or suspected Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis consistent with a serious mental illness (SMI), serious emotional disturbance (SED), SUD, or co-occurring SMI and SUD; AND
- A moderate to significant functional impairment, including:
    - Consistent difficulty performing practical daily tasks needed to function in the community such as maintaining personal hygiene, meeting nutritional needs, caring for personal business affairs, obtaining medical, legal, and housing services, recognizing and avoiding common dangers or hazards to one's self and one's possessions;
    - Persistent or recurrent difficulty performing daily living tasks, except with moderate support or help from others such as friends, family, or relatives;
    - Difficulty maintaining consistent employment at a self-sustaining level or to carry out homemaker roles; and/or
    - Difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing); AND
- An indicator of continuous high-service needs, including:
    - Risk of hospitalization or crisis/emergency care without this service;

- Risk of returning to unsheltered homelessness after being placed in interim housing, or risk of returning to homelessness after being placed in permanent supportive housing without this service;
- Intractable (persistent or recurrent) severe major symptoms (e.g., affective, psychotic suicidal);
- Coexisting SUD of significant duration (greater than 6 months);
- High-risk or a recent history of being involved in the criminal justice system;
- In substandard housing, homeless, or at at-imminent risk of becoming homeless;
- Living in housing, but clinically assessed to need more intensive services to maintain housing;
- Living in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live more independently if intensive services are provided; and/or
- Inability to participate in traditional office-based services.

Individuals with a primary diagnosis of intellectual/developmental disabilities (I/DD) are not appropriate for FSP ICM. Additionally, counties are permitted but not required to mandate prior authorization or an equivalent process for FSP ICM.

As noted above, eligibility criteria for ACT are outlined in BH-CONNECT EBP Policy Guide; generally speaking, these criteria are similar to FSP ICM but rely on indicators of more significant need, risk, or acuity in comparison to FSP ICM.

B.4.2.3 Full Service Partnership Intensive Case Management Service Components

FSP ICM participants may need some or all of the same services as ACT including, but not limited to:

- Assessment
- Crisis Intervention (DHCS is not requiring an "on call" model of crisis intervention for FSP ICM participants.)
- Medication Support Services
- Peer Support Services
- Psychosocial Rehabilitation

- Referral and Linkages
- Therapy
- Treatment Planning

B.4.2.4 Full Service Partnership Intensive Case Management Team Structure

FSP ICM requires a team-based approach with an identified team lead. FSP ICM teams are required to have a ratio of no more than 25 participants per FSP ICM team lead.

In addition to the required team lead, FSP ICM teams should include a combination of partial and full-time providers such as prescribers, peer support specialists, registered nurses (RNs), and other qualified providers. Counties should align the staffing model with the needs of the individuals receiving services.

FSP ICM teams are expected to provide as many contacts as needed to support an FSP participant's recovery. In most cases, individuals receiving FSP ICM will need at least one contact a week. Individuals receiving FSP ICM will typically require fewer contacts than individuals receiving ACT, but more contacts than individuals receiving routine outpatient services. Given the intensity of their needs, conducting face-to-face contacts most of the time is recommended, though telehealth may be used judiciously for visits that exceed the once per week threshold. The type and frequency of ICM contacts should be determined based on the needs of each individual and the intensity of the service may be higher than four contacts per month.

B.4.2.5 Aligning Full Service Partnership Intensive Case Management with Medi-Cal

All of the primary FSP ICM service components are billable under Medi-Cal (see "Service Components" above) and should be billed accordingly for Medi-Cal members (i.e., case management plus additional Medi-Cal SMHS on an unbundled basis). In alignment with the "whatever it takes" philosophy, FSP funding can be used for services not covered by Medi-Cal, as needed. This includes outreach and engagement services and consumer-operated services. Peer Support Specialists and CHWs may provide these outreach and engagement services; both may be billable as covered services for Medi-Cal members as per Medi-Cal guidance.

For non-Medi-Cal BHSA eligible individuals, FSP funding may be used for service components that commercial health plans do not cover, or for all components for the fully uninsured.

B.4.3 High Fidelity Wraparound

B.4.3.1 Overview

High Fidelity Wraparound (HFW) provides a comprehensive, holistic, youth and family-driven, evidence-based way of responding when children or youth experience significant mental health or behavioral challenges. At its core, HFW is defined as adherence to the four phases and ten principles of the HFW model and a team-based and family-centered evidence- based practice that includes an "anything necessary" approach to care for children and youth with the most intensive mental health or behavioral challenges. The HFW model combines a team-based case management and facilitation approach with individualized and community-based mental health services and supports tailored to meet the individualized needs of the youth and family.

In 1997, CA Wraparound was established through Senate Bill 163 to allow counties to provide optional wraparound services to children and youth with child welfare involvement, and is the current model for wraparound delivery in California. The California Department of Social Services (CDSS) over the last several years has invested in ways to improve fidelity to the HFW model, including by aligning CA Wraparound standards with the National Wraparound Initiative's Wraparound Standards in collaboration with a state Wraparound Steering Committee, and – in partnership with DHCS – designating the UC Davis Resource Center for Family-Focused Practice to conduct approvals and certifications necessary to ensure standards of HFW are met for providers of the Family First Prevention Services Act Part IV aftercare services to ensure compliance with WIC Section 4096.6, subdivision (d)(2).

HFW is not restricted to children and youth receiving foster care or involved with child welfare. DHCS intends to strengthen and complement California's wraparound program by formally implementing HFW as a service within FSP and to support a diverse range of needs and systems interaction.

HFW is regarded as an alternative to out-of-home placement for children with complex needs, by providing intensive services in the family's home and community. HFW centers family voice and decision-making in developing a care plan to reach desired outcomes by providing a structured, creative, and individualized set of strategies that result in plans/services that are effective and relevant to the child, youth, and family.

When wraparound is delivered consistent with the High Fidelity Wraparound model, there is a strong evidence base for positive impact on youth and families. Studies have found that programs implementing HFW achieve more favorable outcomes, including

improved child behavior, mental health functioning, parent satisfaction, and reduced absences and suspensions from school. Supporting youth and families through HFW and keeping the family intact may also help achieve and maintain stable housing outcomes.

Pursuant to the BHSA, county FSP programs must implement HFW beginning in July 2026 (see Full Service Partnership Exemptions for county implementation requirements). HFW is a stand-alone high-intensity mental health service delivery model and cannot be provided concurrently with ACT, FACT or FSP ICM. In addition, DHCS is clarifying coverage of HFW as a Medi-Cal service bundle within SMHS to meet the goal of delivering care to children and youth that matches their level of need in the least restrictive environment.

By early 2026, DHCS will release detailed guidance to support counties in implementing HFW as a Medi-Cal service to fidelity. DHCS will seek to make available training, technical assistance, and fidelity monitoring support available to all counties. As county FSP programs work towards delivering HFW with fidelity, counties shall refer to the forthcoming Medi-Cal guidance which may include but not be limited to:

- Clinical indicators of need for HFW
- HFW team structure requirements
- Key functions of HFW teams
- Billing Medi-Cal for HFW services delivered to Medi-Cal members (find additional details about using BHSA funds for HFW services in the "Aligning HFW in FSP with Medi-Cal" section of this manual)
- Documentation requirements for HFW teams that bill Medi-Cal
- Training and technical assistance requirements

B.4.3.2 Aligning High Fidelity Wraparound in Full Service Partnership with Medi-Cal

Pursuant to the BHSA, counties must bill Medi-Cal for all Medi-Cal-covered services. Through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, HFW is covered statewide. As described above, county FSP programs must implement HFW beginning in July 2026. As will be specified in forthcoming Medi-Cal guidance, many of the components of HFW will be Medi-Cal billable on a bundled basis, where applicable.

One element of HFW that is not currently billable to Medi-Cal is "flexible funds," which can be used by the HFW team for anything determined necessary. The HFW practice model requires timely access to flexible funding to support and address the urgent and individualized needs of children, youth and their families when these needs are not readily met by other resources (i.e., Medi-Cal programs or community-based resources).

Counties may use FSP funding for any service components not covered through Medi-Cal or through other funding sources (e.g., Immediate Needs funds for children/youth in foster care, and Medi-Cal BH-CONNECT Activity Funds for all welfare-involved children and youth). FSP will be an important source of funding for flexible funds, as well as for caregiver respite, when it is unable to be covered as a Community Support through Medi-Cal Managed Care.

For the BHSA eligible fully uninsured, FSP funding may be used for all components.

B.5 Individual Placement and Support Model of Supported Employment

B.5.1 Overview

The Individual Placement and Support (IPS) model of Supported Employment is an evidence-based intervention that engages individuals living with significant behavioral health needs in finding and maintaining competitive employment, which can play a crucial role in their recovery and integration into the community. IPS provides structure, purpose, and social connection and is shown to reduce isolation and combat stigma for individuals living with mental health conditions and SUDs.

IPS services can be delivered to an individual as a standalone service or alongside other FSP service models such as ACT, FACT, FSP ICM, and HFW, to offer a comprehensive approach to recovery that addresses both clinical and functional needs. The Evidence Base Practice (EBP) CSC for FEP funded under Early Intervention can also be provided alongside of IPS. Alternately, these FSP EBPs can incorporate flexible employment or education supports for individuals who choose not to pursue full participation in IPS but are interested in some employment or education services.

The IPS model is based on eight core principles:

- Competitive Employment
- Systematic Job Development
- Rapid Job Search

- Integrated Services
- Benefits Planning
- Zero Exclusion
- Time-Unlimited Supports
- Worker Preferences

In the model, an IPS team provides "pre-employment services," including vocational assessments, employment planning and job placement, and "employment sustaining services," which include career advancement support, job coaching, and ongoing follow-along supports.

Pursuant to BHSA, county FSP programs must implement IPS beginning in July 2026 (see Full Service Partnership Exemptions for county implementation requirements). In addition, in December 2024, CMS approved State Plan Amendment (SPA) 24-0051, which establishes IPS as a covered benefit in the Medi-Cal program. Counties have the option to provide IPS as a bundled service with a monthly bundled reimbursement rate under Medi-Cal in the Medi-Cal SMHS, Drug-Medi-Cal (DMC), and Drug- Medi-Cal Organized Delivery System (DMC-ODS) delivery systems beginning in 2025. Consistent with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate, counties are required to provide Supported Employment to Medi-Cal members under the age of 21 if the service is clinically appropriate. Counties that elect to provide IPS as a bundled Medi-Cal service must meet the requirements in Behavioral Health Information Notice (BHIN) 25-009.

Counties should use the BH-CONNECT EBP Policy Guide to support implementation of IPS. The EBP Policy guide includes information about the evidence-based service criteria for IPS, staffing structure for teams of behavioral health practitioners delivering IPS, and other best practices for delivering IPS with fidelity to the evidence-based model.

In addition, all counties must adhere to IPS requirements in forthcoming EBP training, technical assistance, fidelity monitoring and data collection guidance.

For counties that do not intend to deliver IPS as covered Medi-Cal services, find details about delivery and billing for IPS through FSP programs only below.

B.5.2 Aligning Individual Placement and Support Model of Supported Employment in Full Service Partnership with Medi-Cal

Pursuant to BHSA, counties must bill Medi-Cal for all Medi-Cal-covered services. As described above, beginning in 2025 counties have the option to cover IPS as a bundled Medi-Cal service. Counties that opt to deliver IPS as a Medi-Cal service will be eligible for a monthly reimbursement rate intended to fully support the cost of operating an IPS team. Counties that do not choose to offer IPS as a bundled Medi-Cal service are still required to bill Medi-Cal for unbundled IPS services provided to Medi-Cal members.

These services may include the following SMHS:

- Psychosocial Rehabilitation
- Referral and Linkages
- Treatment Planning

Even if they do not opt to take up the option to provide IPS as a bundled Medi-Cal service, county FSP programs must deliver IPS with fidelity and consistent with for the guidance in the BH-CONNECT EBP Policy Guide.

For non-Medi-Cal BHSA eligible individuals, FSP funding may be used for components commercial health plans do not cover, or for all components for the fully BHSA eligible uninsured.

B.6 Foundational Requirements for Full Service Partnership Evidence Based Practices

To meet FSP EBP requirements, counties must begin offering FSP EBPs by July 1, 2026 (full fidelity not required) and demonstrate they are implementing FSP EBPs with fidelity by June 30, 2029.

In addition to the FSP EBP requirements in Section B.3.4 Full Service Partnership Exemptions, counties must do all of the following:

- Complete county consultations with the respective Center of Excellence (COE) for each EBP;
- Ensure practitioners meet specified training, technical assistance, fidelity monitoring, and data collection standards; and
- Meet specified implementation milestones to demonstrate services are delivered with fidelity to the evidence-based models.

Details about each of these requirements for ACT, FACT and IPS are in the DHCS EBP Training, Technical Assistance, Fidelity Monitoring and Data Collection Policy Guide (link forthcoming). Details about requirements for HFW are forthcoming.

B.6.1 FSP EBP Service Capacity

Counties that do not qualify for or receive exemptions must establish teams of behavioral health practitioners to deliver each FSP EBP. Counties will use the IP and Annual Update (AU) to project the number of multidisciplinary ACT, FACT, IPS, and HFW teams the county will establish between 2026 and 2029.

DHCS recognizes that counties are starting from different places and have varying resources available to implement FSP EBPs. DHCS also understands it takes time to implement high-quality EBP programs to fidelity. Counties should assess internal capacity, use available data, and work with COEs to determine an appropriate number of ACT, FACT, IPS, and HFW teams the county aims to staff and train over the first IP period.

DHCS provided counties with data-driven estimates of the total number of BHSA-eligible individuals in the county who may have a clinical need for each EBP, and estimated the number of FTE practitioners and multidisciplinary teams needed to serve that entire population. These estimates are one data point to support county planning. The estimates do not account for county-specific resources and the time it takes to recruit, hire and train behavioral health practitioners. DHCS is not requiring counties to staff the number of teams needed to serve the entire BHSA-eligible population with a clinical need for each EBP.

In the 2026 IP, counties must project the number of FTE practitioners (including county-operated and county-contracted providers) and multidisciplinary teams they will staff to provide ACT, FACT, IPS and HFW in FYs 2026-2027, 2027-2028, and 2028-2029. Counties may adjust staffing projections as needed as part of the AU process. Projected staffing must account for both current practitioners and new practitioners the county intends to hire and/or contract with to deliver FSP EBPs. Counties that are requesting an exemption from ACT, FACT and/or IPS should input “0” for the projected number of FTE practitioners and teams for those EBPs in the IP/AU.

B.6.2 FSP EBP Fidelity Standards

The projected number of teams identified in the IP/AU for FY 2026-2027 must achieve Fidelity Designation as defined in the DHCS EBP Training, Technical Assistance, Fidelity

Monitoring and Data Collection Policy Guide (link forthcoming) on the following timeline:

- The FY 2026-27 projected number of teams delivering each EBP must complete baseline fidelity assessments and receive Baseline Fidelity Designation no later than December 31, 2027;
- The FY 2026-27 projected number of teams delivering each EBP must complete their first fidelity assessments and achieve Minimum Fidelity Designation no later than June 30, 2028; and
- The FY 2026-27 projected number of teams delivering each EBP must complete a second fidelity assessment and achieve Full Fidelity Designation no later than June 30, 2029.

Counties must ensure all teams of practitioners delivering EBPs also meet the training, technical assistance, fidelity monitoring, and data collection requirements outlined in the DHCS EBP Training, Technical Assistance, Fidelity Monitoring and Data Collection Policy Guide (link forthcoming).

Counties that are unable to ensure their projected teams of practitioners meet the fidelity requirements for the respective EBPs must consult with the respective COEs and establish county-specific EBP fidelity plans to meet DHCS' fidelity standards.

For example, if a county projects that it will have four ACT teams in FY 2026-2027 but only one ACT team completes a baseline assessment before December 31, 2027, the county must work with the ACT COE to establish a plan for expanding their ACT program and completing the requisite fidelity assessments for the remaining three teams. If a county projects that it will have four ACT teams in FY 2026-2027 and four ACT teams complete the baseline assessment in 2027, but only one ACT team achieves Minimum Fidelity Designation by June 2028, the county must also work with the ACT COE on a county-specific EBP fidelity plan to improve fidelity implementation for the remaining three teams. Counties must be prepared to share their county-specific EBP fidelity plans with DHCS upon request.

In the IP/AU, counties must also project the number of teams they will staff for each EBP for FYs 2027-2028 and 2028-2029. DHCS does not expect all teams established after FY 2026-2027 to achieve Full Fidelity Designation by June 2029; rather, all new teams must progress through the Fidelity Designation levels at the intervals specified in the DHCS EBP Training, Technical Assistance, Fidelity Monitoring and Data Collection Policy Guide (link forthcoming).

B.7 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

B.7.1 Overview

DHCS, in partnership with its counties, remains committed to expanding lifesaving care to individuals living with a SUD. DHCS and counties have worked to build and strengthen access to SUD treatment, particularly medications for addiction treatment (MAT), for individuals with opioid, alcohol, and stimulant misuse and use disorders in particular. Beyond traditional treatment settings and approaches, which only reach a small percentage of people living with SUDs, DHCS recognizes that more proactive strategies are needed to engage, prevent overdose, and improve access to MAT for most individuals living with SUD who remain unengaged in care. Pursuant to the Behavioral Health Services Act (BHSA) and in accordance with WIC section 5887, subdivision (a)(3), counties will be required to deploy assertive field-based initiation programs that proactively engage individuals living with SUD and offer low barrier access to MAT.

Assertive field-based initiation promotes a proactive "no-wrong door" approach to connect more individuals living with SUD to MAT on a voluntary basis, similar to assertive, field-based models that promote proactive engagement and treatment of individuals living with Serious Mental Illness (SMI). Assertive field-based initiation is focused on providing rapid access to MAT and connection to services for individuals at the highest risk of overdose. Counties are encouraged to identify these populations, including those who are unhoused/housing insecure, justice-involved and/or those with co-occurring mental health needs. Assertive field-based initiation requires counties to conduct ongoing, targeted outreach to engage and initiate individuals living with SUD into MAT in any community based and low barrier setting. Community based low barrier settings include the street, shelters, homeless encampments, consumer-operated wellness centers, drop-in centers, syringe service programs, medication and mobile Narcotic Treatment Programs (NTPs), and other easily accessible locations that aim to reach people where they are.

B.7.2 Assertive Field-Based Programmatic Requirements

Counties are required to **provide rapid access to all Food and Drug Administration (FDA) approved MAT** by strengthening existing and/or standing-up at least one initiative in each of the following three areas that comprise their assertive field-based programs:

1. Data-informed, targeted outreach on an ongoing basis to BHSA-eligible individuals with SUD needs to engage them in SUD services, including MAT, if needed.
2. Mobile field-based programs.
3. Open-access clinics.

Counties' assertive field-based programs are required to serve BHSA-eligible individuals living with SUD treatment needs and prioritize those who are at higher risk of overdose, including those known to have experienced overdose reversals, or who are experiencing homelessness and/or justice-involvement. Best practices include establishing coordinated surveillance and overdose identification systems with local emergency medical services, emergency departments, and public health authorities for rapid (e.g., daily or weekly) referrals to post-overdose follow-up teams.

Counties are also required to strategically locate their assertive field-based outreach and program models in settings where significant numbers of individuals living with SUD are located and/or areas with high rates of overdose reversals, which may include hospital Emergency Departments (EDs), homeless encampments, interim housing and permanent supportive housing units set aside for people formerly living in homeless encampments, syringe services programs, jails, and other identified areas.

Counties are encouraged to work with existing assertive field-based programs — defined as outreach, mobile field-based programs, including street medicine providers, and open access clinics — to meet the programmatic requirements detailed in this section. Counties can also strengthen existing initiatives and/or stand-up one comprehensive initiative that conducts data-informed, targeted outreach on an ongoing basis to BHSA-eligible individuals with SUD needs; operates mobile field-based program(s); and works out of open-access clinic(s). For example, under this approach, a county can work with a low barrier "brick and mortar" (e.g., consumer-operated wellness centers) or drop-in SUD clinic to establish mobile outreach teams that visit homeless encampments, interim housing and permanent supportive housing to engage individuals in SUD care, initiate and maintain MAT. Counties must ensure all of their field-based assertive initiation programs comply with existing confidentiality requirements.

The requirements in this section are designed to allow counties to build upon existing field-based SUD programs to the extent that they already offer them. DHCS recognizes counties may be at different levels of readiness to comply with assertive field-based

initiation requirements. Some counties may already have SUD field-based programs in place that meet or are close to meeting DHCS' requirements by July 1, 2026. Other counties may require additional effort and support to meet DHCS' requirements. As a result, DHCS is offering counties flexibility to gradually meet assertive field-based initiation requirements over a three-year time frame from July 1, 2026, to July 1, 2029. Counties will be required to describe their approach for meeting assertive field-based initiation for SUD treatment requirements in their Integrated Plans.

Promising and Best Practices

Counties are encouraged to promote a person-centered approach in their assertive field-based initiation programs to provide access to lifesaving care, prevent overdoses and improve the quality of life for individuals living with SUDs. Assertive field-based programs are encouraged to provide the following activities:

- **Harm Reduction**. Share harm reduction supplies, such as harm reduction kits with naloxone, as well as testing strips (including but not limited to fentanyl and xylazine testing strips).
- **Primary Care.** Provide individuals with necessary wound care, Hepatitis C and Human Immunodeficiency Virus (HIV) testing and care.
- **Post-Overdose Follow-Up Engagement Services**. Provide post-overdose follow-up engagement services as part of their assertive field-based programs (e.g., through targeted outreach or mobile field-based programs). When programs become aware that someone has survived an overdose, including through dedicated communication and coordination channels for this purpose, teams can conduct immediate community-based outreach (e.g., within 72 hours) after the known overdose and provide supports, education and facilitate rapid access to MAT. This approach has been successfully piloted in California counties like San Francisco and in other states, such as West Virginia, New Jersey, and Oregon.
- **Access to Peer Support Specialists**. As individuals with lived experience, peers personally understand the experience of the individuals they serve and can help clarify the most effective set of services for each individual's needs.

Counties may also collaborate to establish targeted outreach programs, field-based mobile teams, and open-access clinics to maximize resources and leverage geographic efficiencies to expand rapid access to MAT for individuals residing in adjoining counties. For example, under a cross-county collaboration approach, counties may pool together financial resources to design and support:

- **Mobile field-based programs**, such as street outreach programs with an embedded prescriber or mobile NTPs, to rotate through locations across multiple counties on designated days.
- **Open-access clinics**, to provide care and accept MAT referrals for individuals residing in partnering counties.

B.7.2.1 Rapid Access to Medications for Addiction Treatment

Counties are required to ensure that their outreach initiatives aim to reach priority populations who can benefit from MAT and mobile field-based programs and open-access clinics are able to provide rapid access for all Food and Drug Administration (FDA)-approved MAT and other medications clinically effective at treating alcohol, tobacco, opioid, and stimulant use disorders directly or through referrals. County field-based programs are expected to work toward ensuring same day MAT access, inclusive of leveraging existing initiatives that may sit outside of county behavioral health. Medication choice shall be individualized and tailored to the individual's clinical condition rather than based solely on availability. County field-based programs that are not certified to dispense methadone must provide referrals to NTPs, medication units, mobile NTPs, and EDs to rapidly initiate methadone. The "Three-Day Rule," as defined in 21 CFR 1306.07(b), allows prescribers unaffiliated with an NTP to administer methadone to a person "for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three days and may not be renewed or extended." Best practice is to follow-up with the individual to help ensure enrollment with the provider for continuing care.

To meet this requirement, field-based programs can employ or contract with MAT prescribers directly or refer individuals to providers who are able to rapidly initiate all FDA approved MAT, including CA Bridge programs, Federally Qualified Health Centers (FQHCs), Tribal Health programs, NTPs and medication units. Counties can also utilize telehealth models to facilitate rapid initiation of MAT. For individuals initiated on MAT, county field-based programs must provide or refer individuals to other programs for MAT maintenance. Counties must work to ensure all recovery-oriented services, including behavioral therapies and counseling, from MAT providers are accessible by individuals.

Counties will be required to detail how and when they will be able to assure same day access to MAT, inclusive of leveraging existing initiatives that may sit outside of county

behavioral health, and plans for medication continuation in their initial Integrated Plan. Counties that cannot assure same day access to MAT effective July 1, 2026, will be required to work towards providing same day access to MAT as detailed in their Integrated Plans by July 1, 2029.

B.7.2.2 Targeted Outreach

Counties will be required to conduct ongoing, targeted outreach to connect individuals with SUD services, including MAT, in accordance with WIC section 5806, subdivision (a)(2). Mobile field-based programs, open-access clinics, or other providers (e.g., Full Service Partnership) can conduct ongoing targeted outreach to priority populations.

Ongoing, targeted outreach services may be performed by new or existing mobile field-based teams (described below) or may be delivered through other models, such as a case management team embedded within a clinic that conducts outreach services, or case management teams supporting individuals living in interim housing and/or permanent supportive housing.

Recommended Best Practices

To identify the highest-need outreach locations, counties are encouraged to collaborate with Emergency Medical Services (EMS), law enforcement, managed care plans (MCPs), health systems and hospitals, FQHC/RHS', individuals with living or lived experience, and other partners to obtain data on regions and populations with high rates of overdose, overdose reversals, drug-related arrests, and other relevant statistics on a regular basis.

B.7.2.3 Mobile Field-Based Programs

Mobile field-based programs leverage teams to conduct "on the ground" field-based outreach to provide engagement, harm reduction support, trust building, motivational interviewing, and directly provide or facilitate rapid access to MAT and other SUD services. Counties can determine the composition of the mobile teams. Programs can rotate team members, who can include behavioral health providers (e.g., social workers, SUD counselors), peer support specialists, community health workers, nursing staff, physicians, and physician extenders. At a minimum, the mobile field-based teams must guarantee quick access to FDA-approved MAT, by embedding MAT prescribers or referring individuals to prescribers, including NTPs to ensure access to methadone.

Counties can work with existing mobile field-based programs across other delivery systems, including street medicine providers, and/or stand up new mobile field-based programs to facilitate rapid access to MAT directly or through referrals for all FDA-

approved MAT. Mobile field-based models that counties can utilize to meet requirements include:

- **Street Medicine Providers.** Counties may contract with street medicine providers to provide mobile field-based assertive initiation services. Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment per All Plan Letter (APL) 24-001. APL 24-001 also provides more information and the different contracting options MCPs can take with street medicine providers, through direct contracting to serve as primary care and/or enhanced care management (ECM) providers, or as referring or treating contracted providers. Street medicine providers may include primary care providers such as licensed medical providers (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), or Nurse Practitioner (NP)) who may prescribe MAT to people experiencing unsheltered homelessness. DHCS highly encourages MCP and county collaboration and coordination for street medicine related initiatives.
- **Street Outreach Programs with MAT Prescribers.** Street outreach focused on individuals experiencing homelessness is typically conducted by a mobile multidisciplinary team, which can include a psychiatrist, a nurse care manager, social workers, peer support specialists, community health workers and outreach workers with behavioral health expertise, including individuals with lived experience. The team can provide street-based behavioral health care, including evaluation, assessment, and treatment with medications provided directly in the field such as MAT; teams can also refer individuals to NTPs for methadone.
- **Mobile NTPs.** A mobile NTP delivers MAT in the field, including methadone, outside of the four-walls of an NTP clinic setting. A mobile NTP operates from a motor vehicle that serves as a mobile component (conveyance) and is operating under the registration of the NTP, and engages in maintenance and/or detoxification treatment with narcotic drugs in schedules II-V, at a location or locations remote from, but within the same state as, its registered location. Operating a mobile NTP is a coincident activity of an existing NTP, as per 21 CFR 1300.01. Effective July 28, 2021, the federal Drug Enforcement Administration (DEA) allows DEA registered, Substance Abuse and Mental Health Services Administration (SAMHSA) certified, and DHCS licensed NTPs to operate mobile NTPs that dispense methadone and buprenorphine if they meet federal, state,

tribal, and local requirements. Health and Safety Code (HSC) section 11839.6.1 authorized DHCS to regulate and establish a program for the operation of mobile NTPs. Effective January 4, 2024, DHCS issued Behavioral Health Information Notice (BHIN) 24-005 to implement mobile NTPs in California. This BHIN sets forth the minimum requirements that a mobile NTP shall comply with to lawfully operate in California and provides more detail regarding mobile NTP licensing.

B.7.2.4 Open-Access Clinics

Counties will be required to support open-access clinics, which are outpatient settings providing low barrier, low-threshold rapid access to MAT. Open-access clinics must directly provide or refer to the most appropriate form of MAT, including methadone. CA Bridge Sites located in EDs can refer individuals initiated on MAT to open-access clinics for ongoing MAT care.

To meet open-access program requirements, counties can leverage existing or stand-up new "brick and mortar" programs within their catchment areas to provide rapid access to MAT. Open-access clinic models that counties can utilize include:

- **Syringe Services Programs with Drop-in Clinic Services.** Syringe services programs provide harm reduction services to individuals with SUD and some offer clinic services for individuals who drop-in across California. Programs provide sterile syringes, naloxone, wound care and first aid; testing for HIV and hepatitis C; conduct overdose education; and directly provide or refer individuals to MAT, SUD and mental health treatment, as well as housing services and employment services. Syringe services programs often provide food, drinks, clothes, showers, and other basic supplies to support individuals experiencing or at risk of homelessness. Programs are located in a variety of settings, including churches, health departments and store fronts, and may provide home delivery.
- **Medication Units.** Licensed NTPs can establish medication units to dispense methadone and other MAT in community sites such as FQHCs, drop-in centers and county health departments.
- **Drop-in Outpatient Clinics with Open-Access Scheduling.** Counties can also support outpatient drop-in clinics across a range of providers, including FQHCs, community mental health centers, NTPs, hospital outpatient clinics (e.g., ambulatory outpatient CA Bridge Sites) and Indian Health Care Partners, where patients can be seen on the same day they "drop-in" or request to be seen.

Outpatient clinics are highly recommended to provide primary care, MAT, and behavioral health treatment, as well as care coordination.

B.7.3 Integrated Plan Requirements

All counties are required to include their assertive field-based implementation plans in their Integrated Plans. County Integrated Plans must describe county approaches and timelines for meeting assertive field-based requirements, including ensuring rapid access to medications for addiction treatment (MAT), conducting targeted outreach, and supporting mobile field-based and open-access programs.

B.7.4 Substance Use Disorder Primary Full Service Partnership Option

Senate Bill (SB) 326 does not prohibit counties from establishing FSP programs for individuals with (SUD) diagnoses (i.e., without co-occurring significant mental health needs). However, counties are not required to develop new, dedicated FSP Levels of Care specific to SUD. Many SUD services in California, including all services covered through Drug Medi-Cal and the Drug Medi-Cal Organized Delivery System, are currently organized and delivered consistent with the American Society of Addiction Medicine (ASAM) criteria and corresponding levels of care. DHCS does not plan to define SUD FSP levels of care that deviate from these industry standard guidelines. Counties are also not required to establish FSPs that are exclusively for SUD, apart from implementing new, assertive field-based initiation of SUD care requirements. As described in Chapter 7, Section B.3.5 Full Service Partnership Co-Occurring Capabilities, county FSP programs will be expected to be co-occurring capable and be equipped to provide comprehensive care to eligible individuals living with co-occurring significant behavioral health needs and SUD.

B.8 Innovative Behavioral Health Pilots and Projects

The goal of innovative behavioral health pilots and projects is to build the evidence base for the effectiveness of new statewide strategies. Counties are encouraged to pilot and test innovative behavioral health pilots and projects (WIC section 5892, subdivision (a)(4)) in all BHSA funding components (Housing Interventions, FSP, and BHSS). Counties should fund innovative behavioral health pilots and projects under each of those separate funding components.

C. Housing Interventions

C.1 Housing Interventions Funding

Counties are required to use 30 percent of the funds distributed by the State Controller's Office into their Behavioral Health Services Fund (BHSF) for Housing Interventions.

Of the funding distributed to counties for Housing Interventions:

- 50 percent must be used to support the housing needs of individuals who are chronically homeless, with a focus on those in encampments.
- Up to 25 percent may be used for capital development projects.
    - If a capital development project identifies chronically homeless individuals as a priority population, the project funding will contribute toward the 50 percent requirement.

C.2 Introduction and Background

Using the Behavioral Health Services Act (BHSA) Housing Interventions funding, counties can develop an ongoing behavioral health housing program to increase access to permanent supportive housing for people meeting BHSA eligibility who are chronically homeless, experiencing homelessness, or are at risk of homelessness.

These policies have been developed to give counties flexibility so that each community can develop a program that is reflective of its needs. The flexibilities of Housing Interventions are also intended to build upon other housing initiatives, including but not limited to Homekey+, Behavioral Health Bridge Housing (BHBH), No Place Like Home (NPLH), Homekey, Project Roomkey, the Community Care Expansion (CCE) Program, the Housing and Homelessness Incentive Program (HHIP), the Encampment Resolution Fund (ERF), and the Homeless Housing Assistance and Prevention Grant Program (HHAP). Housing Interventions are also intended to complement CalAIM Community Supports and Transitional Rent available through Medi-Cal Managed Care Plans (MCPs). The Transitional Rent benefit available through MCPs specifically to seamlessly connect BHSA eligible individuals receiving Transitional Rent to BHSA-funded Housing Interventions.

In the following sections, the Department of Health Care Services (DHCS) identifies a number of policies and procedures that counties must develop to support the

implementation of Housing Interventions. Those policies and procedures are not subject to approval by DHCS but must be provided to DHCS upon request.

C.3 Program Priorities

The development of Housing Interventions has been driven by the following priorities:

- Reduce homelessness among BHSA eligible individuals experiencing homelessness with a behavioral health condition, focusing efforts on the chronically homeless, with a focus on those in encampments.
- To the extent possible, provide individuals with permanent supportive housing, including voluntary, flexible, and intensive supports and services available such as Assertive Community Treatment, Intensive Case Management, and other supports funded under the BHSA and Medi-Cal consistent with best practice.
- Provide flexibility for counties to respond to local conditions and needs, and to innovate.
- Provide individuals receiving Housing Interventions access to clinical and supportive behavioral health services.
- Support the provision of low-barrier, harm reduction, and Housing First principles.
- Complement ongoing state, county, city, Continuum of Care, and tribal efforts to address homelessness, including but not limited to those provided through Medi-Cal.

C.4 Eligible and Priority Populations

C.4.1 Eligible Populations for Housing Interventions

As defined in WIC section 5830, individuals must meet the BHSA eligibility requirements, identified in this policy manual and meet the definition of:

- At-Risk of Homelessness, or
- Experiencing Homelessness, or
- Chronically Homeless, with a focus on those in encampments.

Pursuant to WIC section 5891.5, subdivision (a)(2), the provision of Housing Interventions to individuals with a substance use disorder (SUD) is optional for counties in alignment with the requirements in Section 5963.02(b)(2). However, when Housing

Interventions are provided to an individual living with a SUD, all housing intervention requirements in WIC section 5830 must be met.

C.4.1.1 Experiencing Homelessness and At Risk of Homelessness

WIC section 5892, subdivision (k)(3) provides that for purposes of the BHSA, "experiencing homelessness or at risk of homelessness" means people who are homeless or at risk of homelessness as defined by 24 CFR 91.5 or as otherwise defined by the State Department of Health Care Services for purposes of the Medi-Cal program.

For purposes of the BHSA, DHCS is adopting the definitions of experiencing homelessness and at risk of homelessness consistent with CalAIM Community Supports, which are the same as the definitions provided at 24 CFR 91.5 with three modifications, as follows:

- Individuals exiting an institution or carceral setting are considered homeless if they were homeless immediately prior to entering that institutional or carceral stay or become homeless during that stay, regardless of the length of the institutionalization or incarceration.
- The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness to 30 days.
- An individual or family is not required to have an annual income below 30 percent of median family income for the area.

Additionally, anyone who was homeless or at risk of homelessness prior to the receipt of Transitional Rent (as covered by a Medi-Cal managed care plan) or prior to the receipt of housing funded by MHSA is considered homeless for BHSA purposes.

C.4.1.2 Chronically Homeless

WIC section 5892, subdivision (k)(2) provides that for purposes of the BHSA, "chronically homeless" means an individual or family that is chronically homeless as defined in 42 U.S.C. 11360 or as otherwise modified or expanded by the State Department of Health Care Services.

DHCS is adopting the Department of Housing and Urban Development (HUD) definition of chronic homelessness, identified under 24 CFR 91.5 with two modifications, as follows:

- The requirement that a discontinuous period of 12 months of homelessness over the last three years occur on at least four separate occasions is eliminated; any

number of occasions will suffice so long as the combined duration equals at least 12 months.

- Consistent with the Medi-Cal modification to the definition of "homeless," anyone residing in an institutional care facility, defined according to the HMIS definition of "institutional situations," who was chronically homeless prior to entry retains that status upon discharge, regardless of length of stay.

Additionally, anyone who was chronically homeless prior to the receipt of Transitional Rent or prior to the receipt of housing funded by MHSA and is transitioning from either of these services to Housing Interventions services will be considered chronically homeless under Housing Interventions.

Regarding the requirement that 50 percent of Housing Interventions be directed to individuals experiencing chronic homelessness, the determination that an individual meets the definition of chronically homeless will be made by counties at enrollment and may maintain their status as such for the duration of their enrollment in Housing Interventions services.

C.4.1.3 People in Encampments

The BHSA requires (WIC section 5892, subdivision (a)(1)(A)(ii)) that 50 percent of a county's Housing Interventions funds be used for Housing Interventions for persons eligible for BHSA funding who are chronically homeless, "with a focus on those in encampments." The BHSA definition for encampments is in alignment with the Department of Housing and Urban Development (HUD) definition. An encampment includes the following:

- A group of people sleeping outside in the same location for a sustained period.
- The presence of some type of physical structures (e.g., tents, tarps, lean-to's).
- The presence of personal belongings (e.g., coolers, bicycles, mattresses, clothes).
- The existence of social support or a sense of community for residents.

Counties are expected to prioritize serving individuals living in encampments with methods consistent with the U.S. Interagency Council on Homelessness' 19 Strategies for Communities to Address Encampments Humanely and Effectively. It is essential that counties provide Housing Interventions services that are relevant and responsive to the needs of individuals in encampments who are chronically homeless and are BHSA eligible, including the provision of housing and behavioral health interventions that will help individuals transition out of encampments and into permanent supportive housing.

C.4.2 Priority Populations

In addition to specifying the populations who are eligible for Housing Intervention services ("Eligible Populations"), the BHSA identifies (WIC section 5892, subdivision (d)) a smaller subset of populations who should be prioritized for BHSA services (see BHSA requirements here).

Priority Populations:

Children and youth in the Eligible Population who also satisfy one of the following:

- In, or at risk of being in, the juvenile justice system;
- Reentering the community from a youth correctional facility;
- In the child welfare system; or
- At risk of institutionalization.

Adults or older adults in the Eligible Population who also satisfy one of the following:

- In, or are at risk of being in, the justice system;
- Reentering the community from prison or jail;
- At risk of conservatorship; or
- At risk of institutionalization.

C.4.3 Individuals Transitioning from MHSA to BHSA

For individuals housed under the MHSA as of June 30, 2026, the following policies apply:

1. Counties may transfer individuals housed in permanent housing directly to BHSA-funded Housing Interventions without eligibility redetermination.
2. Individuals receiving interim housing under the MHSA who are not enrolled in an MCP may also be transferred to BHSA Housing Interventions without eligibility redetermination.
3. For individuals in interim housing who are in an MCP, the county should connect the individual to their MCP for assessment of eligibility for Transitional Rent. The goal is for this to be seamless to the individual being served. This will require the delivery systems to put processes in place for effective coordination.
    a. Those determined eligible for Transitional Rent may be transferred to the MCP and may not receive rental assistance or housing under BHSA

Housing Interventions until they are no longer eligible for Transitional Rent.

b. Those determined ineligible for Transitional Rent may be transferred directly to BHSA Housing Interventions without eligibility redetermination.

4. Anyone who was chronically homeless when housed under MHSA, and who was transferred from MHSA to BHSA, will be considered chronically homeless for purposes of the requirement to direct 50 percent of Housing Interventions to individuals who are chronically homeless.

C.5 Program Requirements

In addition to the eligibility requirements, WIC section 5830, subdivision (a) specifies the following:

- Housing Interventions shall not be limited to individuals enrolled in either a Full Service Partnership or Medi-Cal.
- Counties shall not discriminate against or deny access to housing for individuals that are utilizing medications for addiction treatment or other authorized medications, or individuals who are justice-involved.
- Housing Interventions shall comply with the core components of Housing First, as defined in subdivision (b) of WIC section 8255, and may include recovery housing. See additional information in the Chapter 7, Section C.9.5.1 Housing First below.
- All Housing Interventions settings must be combined with access to clinical and supportive behavioral health care and housing services that will promote the individual's health and functioning and long-term stability. Access does not necessitate co-location. Housing Interventions may not be used for behavioral health services; however, these activities can be covered under Behavioral Health Services and Supports or other behavioral health funding sources.
- Counties may utilize up to 7 percent of Housing Intervention funds on identified Outreach and Engagement activities. If Housing Intervention funds are used for Outreach and Engagement activities under the Housing Intervention component, counties must adhere to transfer requirements, including required documentation, in Chapter 7, Section C.6 Transfers and Exemptions.

C.6 Transfers and Exemptions

C.6.1 Transfers

Beginning in Fiscal Year 2026, counties may request to transfer funds distributed to the counties Behavioral Health Services Fund to spend more than or less than 30 percent of their local BHSF on Housing Interventions. Please refer to the Funding Transfer Requests section for more information.

Transfer of funds into or out of Housing Interventions funds does not relieve the county from complying with:

- The requirement to use 50 percent of Housing Interventions funds on services for the chronically homeless.
- The requirement to use no more than 25 percent of Housing Interventions funds on capital development projects.

C.6.2 Exemptions

State law permits counties to request exemptions to Housing Interventions spending requirements. Exemptions are necessary for counties requesting a funding adjustment beyond the 7 percent allowed through the transfer process. Counties with a population of less than 200,000 may request exemptions beginning with the 2026-29 Fiscal Years' county Integrated Plan (IP), and all counties regardless of size may do so beginning with the 2032-35 Fiscal Years' county IP. Exemption requests must be submitted as part of the draft IP due by March 31st of the year prior to the fiscal years the IP covers. Counties must also include a letter from the County Administrative Officer approving the draft IP, including exemption requests. Exemption requests are subject to DHCS approval; counties may request exemptions from one or more of the following requirements (WIC section 5892 (a)(1)(B)):

- 30 percent of the BHSF funds distributed to the county for Housing Interventions services.
- 50 percent of the county's Housing Interventions funds on those who are chronically homeless.
- No more than 25 percent of Housing Interventions funds on capital development projects.

Table C.6.2.1 Criteria for Housing Exemption Requests

Requirement	Exemption Request Criteria
30 percent of BHSF for Housing Interventions	Criteria for increased/reduced percentage (beyond transfer allowance): • Very significant or very limited need (e.g., small/large eligible population). • Sufficient/insufficient funding from other sources to address housing needs. • Other considerations, subject to evidence requirements and DHCS review. Requests for exemptions must include information and data demonstrating that the exemption request criteria provided above are met (e.g., Point in Time Count (PIT), Housing Inventory Count (HIC), HMIS data, Coordinated Entry System data, Electronic Health Record data, etc.).
50 percent of the county's Housing Intervention funds on persons who are chronically homeless	Criteria for reduced percentage: • Very limited need (e.g., small number of BHSA eligible individuals experiencing chronic homelessness). • Sufficient funding from other sources to address housing needs. • Other considerations, subject to evidence requirements and DHCS review. Requests for exemptions must include information and data demonstrating that the exemption request criteria provided above are met (e.g., PIT, HIC, HMIS data, Coordinated Entry System data, Electronic Health Record data, etc.).
No more than 25 percent of the county's Housing Intervention funds on capital development projects	Criteria for increased percentage: • Significant capital development required to meet housing needs of eligible population (e.g., demonstrated lack of existing suitable housing facilities within the county). • Other funding sources insufficient to address need • Costs of accessibility improvements exceed 25 percent capital improvement limits. • Other considerations, subject to evidence requirements and DHCS review. Requests for capital development exemptions must include documentation demonstrating that the exemption request

Requirement	Exemption Request Criteria
	criteria provided above are met (e.g., a detailed budget with funding breakdown, partnership agreements/letters of support, evidence of need for housing production, and other supporting data).

C.7 Relationship to Medi-Cal Funded Housing Services

Per WIC section 5830, subdivision (c)(2), Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Accordingly, counties must work closely with MCPs to ensure that Housing Interventions funds are used to complement, not supplant, MCP-covered services. By working closely with MCPs to coordinate the delivery of housing-related Community Supports covered by MCPs prior to expending the BHSA Housing Interventions funding, counties and MCPs will play a key role in the prudent stewardship of taxpayer dollars and help ensure that funding sources other than the BHSA also contribute to meeting the housing-related needs of BHSA eligible Californians with behavioral health conditions. This statutory requirement will maximize the total amount of the BHSA Housing Interventions funding available to counties, allowing these dollars to go further to improve outcomes for Californians. The close coordination will also facilitate appropriate referrals to additional Community Supports, Enhanced Care Management, and other services delivered by MCPs.

C.7.1 Prohibition on Housing Interventions Coverage of Managed Care Plan-Covered Services

Pursuant to WIC section 5830, subdivision (c)(2), Housing Interventions "shall not be used for housing interventions covered by a Medi-Cal Managed Care Plan." Under CalAIM, MCPs are authorized to cover five housing-related "Community Supports". Additionally, in December 2024, the Centers for Medicare & Medicaid Services (CMS) approved the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration which authorizes MCP coverage of up to six months of Transitional Rent. Beginning January 1, 2026, MCPs are required to cover Transitional Rent for the "Behavioral Health Population of Focus." Detailed information about the criteria for inclusion in the Behavioral Population of Focus and MCP coverage of Transitional Rent and the other housing-related Community Supports can be found in the Community Supports Policy Guide, Volume 2.

Table C.7.1. Coverage of Housing-Related Community Supports

Service	Coverage
Housing Deposits	Covered by all MCPs in all counties
Housing Transition Navigation Services	Covered by all MCPs in all counties
Housing Tenancy and Sustaining Services	Covered by all MCPs in all counties
Recuperative Care	Varies by MCP
Short-Term Post-Hospitalization Housing	Varies by MCP
Transitional Rent	All MCPs required to cover for the Behavioral Health Population of Focus beginning January 1, 2026

The CalAIM Community Supports – Managed Care Plan Elections webpage provides up-to-date information about MCP coverage of the housing-related Community Supports.

Housing Interventions may not be used to cover any of the services identified in the table above when the individual is eligible for the service through their MCP. BHSA funding can be used if the MCP is not offering the Community Support in a county or if the individual has expended a benefit with a timeline restriction (e.g., the six month aggregate annual cap across Transitional Rent, Short-Term Post-Hospitalization Housing, and Recuperative Care; the limitation of six months per demonstration period for Transitional Rent). Additionally, if a Medi-Cal member is receiving housing services from their MCP, this does not preclude the individual from receiving simultaneous Housing Interventions not covered by the MCP. For example, an individual who is receiving Transitional Rent could also receive utility assistance funded by the BHSA Housing Interventions because Transitional Rent will only cover landlord-paid utilities that are part of rent, not utilities that the tenant is responsible for paying separately.

C.7.2 Expectations for Coordination with MCPs

Counties will be expected to coordinate closely with MCPs to:

1. Ensure that Housing Interventions are not used for services that are covered by the MCP.
2. Support seamless connections from the county to the MCP for coverage of housing services and vice versa.

3. Provide whole-person care and integrated housing services for MCP-enrolled members with significant behavioral health needs who meet BHSA eligible criteria.

At a minimum, counties are required to establish detailed policies and procedures for issuing referrals to MCPs for housing-related Community Supports (including Transitional Rent) in alignment with forthcoming DHCS guidance and receiving referrals for BHSA Housing Interventions services (guidance forthcoming). DHCS may provide additional information in the future regarding minimum standards for coordination with MCPs regarding housing-related Community Supports and the BHSA Housing Interventions funding.

In addition, counties are strongly encouraged to participate as providers of housing-related Community Supports covered by MCPs, including but not limited to: Transitional Rent, Housing Deposits, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services in particular. The BHSA Housing Interventions funding is intended to serve as a permanent rental subsidy for housing following MCP-covered Transitional Rent for BHSA eligible individuals, providing seamless continuity and supporting Californians with behavioral health conditions in achieving long-term housing sustainability. As such, it is critical to ensure that counties and MCPs work in full partnership to connect individuals to Transitional Rent and integrate this service with specialty behavioral health services. To that end, DHCS is designing a comprehensive policy approach to standardize processes and streamline requirements for the Transitional Rent benefit with the goal of directly enabling counties to serve as MCP-contracted providers of Transitional Rent and other housing-related Community Supports. Such arrangements will amplify MCP-county coordination of housing-related services and improve the experience of individuals receiving these supports.

C.8 Flexible Housing Subsidy Pools

While not required, Flexible Housing Subsidy Pools ("Flex Pools") are a strategy to support local partners, including counties, in braiding complementary funding sources and resources to provide permanent supportive housing. Flex Pools provide a model for administering and coordinating multiple streams of funding for rental subsidies and a model which shows potential for the coordination and administration of housing supports. This model for housing payments could facilitate the centralized deployment of housing location, navigation, and rental subsidy payments and supports administrative billing functions. With a Flex Pool, a centralized administrative entity can efficiently connect individuals to the units that best meet their needs from with

collective "housing pool". Flex Pools provide a solution to create economies of scale, reduce the burden of subsidy administration, and braid together resources seamlessly so that members are accessing housing more quickly and efficiently, and ensures individuals who become housed, remain housed.

Technical assistance will be made available on the use of Flex Pools to coordinate the administration of the BHSA Housing Interventions, housing-related Community Supports (including Transitional Rent), and other sources of housing support funding.

C.9 Allowable Expenditures and Related Requirements

Housing Interventions may be used for the following expenditures and are subject to the identified program requirements as discussed in the remainder of this chapter, which is organized as follows:

1. Rental Subsidies
2. Operating Subsidies
3. Allowable Settings
4. Other Housing Supports
    a. Landlord Outreach and Mitigation Funds
    b. Participant Assistance Funds
    c. Housing Transition Navigation Services and Tenancy and Sustaining Services
    d. Outreach and Engagement (up to 7 percent)
5. Other Housing Interventions Requirements
6. Capital Development Projects

C.9.1 Rental Subsidies

The terms rental subsidies and rental assistance as used in the manual are inclusive of multiple, specific types of rental assistance described in detail in this section. The intent of Housing Interventions is to place and sustain individuals in permanent housing settings including permanent supportive housing developed through the Homekey+ program and other state and locally funded supportive housing programs. While counties may establish short and medium-term rental assistance programs, particularly in interim settings as described below, the goal is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual

can be transitioned to an alternative permanent housing situation or rental subsidy source. Rental subsidies can be established either as scattered-site (multiple locations) or project-based assistance (one location), including master leasing. Counties are encouraged to work with housing providers in their regions to prioritize the BHSA Housing Interventions for projects serving BHSA eligible individuals within their regions.

C.9.1.1 Rental Assistance Requirements

All rental subsidies must be issued directly to property owners, managers, or providers contracted to administer BHSA-funded rental assistance.

Counties opting to provide rental subsidies must develop policies and procedures that, at a minimum, address the following:

- The setting in which the rental subsidy will be used (see Allowable Settings, below).
- The duration of payments (to be determined based on individual need and, to the extent possible, to continue as long as necessary or until an alternative subsidy or arrangement is in place).
- The calculation of rental assistance for permanent settings. The method elected must use either the rent reasonableness methodology or Fair Market Rents (FMRs) (FMRs includes Small Area Fair Market Rent or up to 120% Fair Market Rent or Small Area Fair Market Rent), to calculate allowable rental rates. Rent Reasonableness assesses rent based on similar unassisted units in the local area, considering factors like location, size, type, quality, and amenities. It adapts to the actual market dynamics and can be more accurate for specific neighborhoods or property types.
- The calculation and types of utilities that are allowed (e.g., electricity, natural gas, water, sewer services, trash collection and internet).
- The calculation of individual contribution towards rent. Counties may establish individual contribution requirements of zero to 30 percent of individual income, and the individual contribution requirements may vary by program or setting. Time-limited interim settings must not require tenants to pay rent. Importantly, BHSA-eligible individuals may not be denied Housing Interventions assistance due to lack of income (i.e., if income is zero, tenant pays zero). DHCS recommends 30 percent of adjusted income for permanent settings to match federal vouchers.

- The housing-related supportive services and resources that will be made available to individuals who are receiving rental subsidies that will remove barriers and help them obtain and/or maintain supportive housing.
- Fraud prevention measures, along with a designated and regular audit process.
- Record-keeping methods, including the process for the documentation of all payments issued.

These policies and procedures are not subject to review and approval by DHCS but must be provided to DHCS upon request.

C.9.1.2 Project-Based Housing Assistance

Project-Based Housing (PBH) assistance is a form of rental assistance that is tied to a particular housing unit. PBH differs from tenant-based rental assistance, which is a subsidy or federal voucher assigned to the program participant, and which may relocate with the participant to another unit if needed. PBH can occur in unit(s) of an apartment complex, duplex, triplex, or other structure that is leased, purchased, and/or otherwise subsidized for the purpose of providing housing to eligible individuals. Counties are encouraged to work with housing providers in their region constructing permanent supportive housing and other affordable housing for the eligible population to assess opportunities for project-based rental subsidies, especially through the Homekey+ program. Counties are also encouraged to assess the full pipeline of permanent supportive housing and affordable housing being built within their region so that this funding can be paired with eligible projects that meet the housing needs of BHSA priority populations.

In addition to the policies required for all rental assistance projects (See "Rental Assistance Requirements" section), counties providing PBH are responsible for ensuring policies and procedures governing such units, such as a property management guide for each property meet the requirements identified under "Program Requirements." The property management guide must also include tenant selection and occupancy procedures (for example, rent contributions, if any; and other core program and fiscal policies to be required by DHCS).

C.9.1.3 Master Leasing

A master lease is a legal agreement through which a master tenant (the county or its subcontracted provider or county grantee) leases a unit or multiple units from a property owner, and then subleases units to subtenants. Under a master lease strategy, the county or subcontracted provider enters into a lease with the property owner,

specifying the county/property owner roles and responsibilities, including tenant selection and responsibility for damage and repair. The county then would serve as a master tenant, and then enter into subleases or occupancy agreements with individual(s) who are eligible for Housing Interventions.

Master leasing can be used by counties to provide scattered-site or PBH. Units can include but shall not be limited to single and multi-family homes, apartments, and other privately owned properties.

C.9.2 Operating Subsidies

Housing Interventions allows the use of funds for operating subsidies for either new or existing housing on the allowable settings list provided below. Operating costs are those costs associated with the day-to-day physical operation of housing projects and may include utilities (including internet), maintenance and repairs, marketing and leasing costs taxes and insurance, property management, office supplies and expenses, legal and accounting services, security and/or site monitors, cleaning fees, and housing incidentals (refrigerators/appliances, water heater, transportation, furnishings, food, hygiene products etc.). Operating costs may not include costs for behavioral health services; however, these can be covered under BHSS and other behavioral health funding sources. Operating costs may not include costs for housing transition navigation or tenancy sustaining services; however, the costs for these services are included as allowable expenditures in the "other housing supports" component of Housing Interventions (see Chapter 7, Section C.9.4 below). Counties opting to provide operating subsidies as a Housing Intervention service must develop policies and procedures that, at a minimum, address the types of expenses which may be covered with Housing Interventions.

C.9.3 Allowable Settings

The aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings.

However, Housing Interventions may also be used in connection with placement in interim settings for a limited time. For BHSA eligible individuals who have exhausted the Transitional Rent benefit, counties may use the BHSA Housing Interventions funding to provide an additional six months of subsidy for placement in an interim setting. For BHSA eligible individuals who are not eligible for Transitional Rent, 12 months of coverage in an interim setting may be provided. After the 6- or 12-month time limit has

expired, Housing Interventions funds may only be used for placement in a permanent setting.

Housing Interventions funding will be permissible in the following settings:

Non-Time-Limited Permanent Settings:

- Supportive housing
- Apartments, including master-lease apartments
- Single and multi-family homes
- Housing in mobile home communities
- Single room occupancy units (Can be interim or permanent; if interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those who are not eligible for Transitional Rent. Please see Appendix B for a crosswalk of coverage by select programs.)
- Accessory dwelling units, including Junior Accessory Dwelling Units
- Tiny Homes (Only considered permanent if the settings have the hallmarks of a permanent setting such as requiring a lease, require payment of rent, has reasonable and ease of access to private bathrooms, kitchen areas, and utilities. Additionally, the settings must not have restrictive rules pertaining to curfews or having guests and has sufficient infrastructure to function as a permanent site.)
- Shared housing
- Recovery/Sober Living housing, including recovery-oriented housing
- Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
- License-exempt room and board
- Other settings identified under the Transitional Rent benefit

Time Limited Interim Settings:

- Hotel and motel stays
- Non-congregate interim housing models
- Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) (does not include behavioral health residential treatment settings)

- Recuperative Care
- Short-Term Post-Hospitalization housing
- Tiny homes, emergency sleeping cabins, emergency stabilization units
- Peer respite
- Other settings identified under the Transitional Rent benefit

Counties must ensure that individuals are voluntarily placed in the least restrictive, most community-integrated setting that can accommodate their physical and behavioral health needs.

Individuals should be placed in settings that reflect their preferences and goals, enables them to stay in their "home" communities and provides for community integration in accordance with all applicable federal and state law. Additionally, Housing Interventions may not be used to cover room & board in residential treatment settings.

C.9.3.1 Permanent Supportive Housing

Permanent Supportive Housing (PSH) is a proven and cost-effective model that provides long-term housing coupled with intensive case management services linking individuals with medical, behavioral health, and other services such as income supports. Those supports can be referrals to community-based providers or delivered onsite, depending on the nature of the project or the tenants' needs. When integrated with voluntary, flexible, intensive community-based services, PSH is an evidence-based practice that is nationally recognized as the standard solution for meeting the housing needs of people with serious mental illness. Basic tenets of PSH, including those enumerated in Housing First, include:

- **Permanent:** Tenants may live in their homes as long as they meet the basic obligations of tenancy, such as paying rent.
- **Supportive:** Tenants have access to the supportive services that they need and want to retain housing.
- **Housing:** Tenants have a private or shared and secure place to make their home, just like other members of the community, with the same rights and responsibilities.

PSH programs may be administered through tenant-based rental subsidies, which may be used in the private rental market, or through site-based subsidies or vouchers (rental assistance), that are attached to particular units. PSH requires a rental contract or lease

between the tenant/program participant and a property owner/landlord. The tenant may pay a portion of the rent (typically no more than 30 percent of the tenant's adjusted monthly income) and the PSH program covers the remaining portion of rent to the owner/landlord/property.

County-led PSH rental subsidy programs should adopt policies that outline the parameters and procedures of the administration of the subsidies. Among those are definition of eligible participants, eligible units (i.e., compliance with rent reasonableness and housing quality standards), and rental contribution income calculation methodology. Counties are encouraged to adhere to the Department of Housing and Urban Development (HUD) standards for PSH rental calculations.

Leases are required, and those leases or other occupancy agreements shall comply with state and local laws and not impose additional barriers or behavioral standards not contained in standard lease agreements.

PSH is an effective model even for individuals with significant and complex behavioral health conditions; individuals with frequent and long-term hospitalizations, homelessness, and incarceration succeed in PSH with intensive supports, such as Assertive Community Treatment (ACT) or Intensive Case Management (ICM). An independent evaluation from 2020 using a randomized control trial in Santa Clara County, for example, found that PSH is associated with increases in housing placement, increases in housing retention, increases in outpatient mental health service utilization, and decreases in psychiatric-related emergency department utilization among individuals with the most acute needs. Counties are encouraged to assess the opportunity to leverage BHSA Housing Interventions with other programs providing capital funding for PSH units for BHSA eligible individuals, including Veterans, such as Homekey+, No Place Like Home (NPLH), and Community Care Expansion (CCE).

C.9.3.2 Shared Housing

Many communities have programs that use rental assistance for shared housing, which is when more than one person or household agrees to share a housing unit. Each person (or couple as they choose) must have their own bed and locked cabinet/bureau. In some cases, programs will offer private bedrooms. In all cases, participants must have access to common areas such as the kitchen, bathroom, and living room. Shared housing is an effective way to make housing more affordable, to maximize available housing stock, and to decrease isolation for people not used to living alone.

Typically, each household has its own lease or sublease, and shares expenses like utilities. Rent is split by the number of bedrooms, and the rent reasonableness standard is applied per tenant/household. The tenant's contribution may be based on percent of income as described above.

Shared Housing is a subset of rental assistance, and counties opting to provide shared housing should develop policies and procedures with specific callouts for best practices for shared housing. Those practices include the following:

- **Participant choice** is one of the hallmarks of success in shared housing programs. Participants should opt into shared housing and feel informed about the logistics and pros and cons of the arrangement as well as feel empowered in the creation of shared household rules and norms.
- **Roommate matching** is key to success; some roommate matches may occur organically, through meetings at shelter or in other programs. Many providers use a roommate matching process, much like those used for college dorms or other roommate situations, to help participants define preferences. For example, individual preferences for roommates may include gender, pets, substance use rules, quiet hours, or cleanliness.
- **Roommate agreements** can help support roommates in living in a shared space; and some programs will have peer or case management facilitation for this process and for dispute resolution.

C.9.3.3 Recovery Housing

Recovery housing is a housing intervention that is recognized by both Substance Abuse and Mental Health Services Administration (SAMHSA) and HUD as an important housing option for individuals with substance use disorders. Recovery housing, also referred to as sober living or recovery residences, offers shared housing in a milieu that is supportive of recovery and that builds a sense of community and mutual support. Recovery housing, including recovery-oriented housing, can provide valuable support for those in outpatient treatment, leaving residential treatment, or others seeking to live in an alcohol and drug-free environment that supports recovery and wellness. The American Society of Addiction Medicine (ASAM) Criteria, Fourth Edition, includes recovery residences as a part of the continuum of care.

People who want to live in a recovery environment should have access to recovery housing; however, individuals who prefer low-barrier housing must not be limited to

recovery housing. In other words, recovery housing should be an option but must never be the only option available to individuals in need of housing interventions.

Recovery housing should be designed to promote community, prosocial behaviors, and mutual support. Additionally, recovery housing providers must ensure the rights of privacy, dignity, and respect of residents and have policies in place that allow for all medications for addiction treatment approved by the FDA to treat substance use disorders. Other requirements include providing a lease or at minimum a participant agreement, supportive services for both relapse prevention and relapse support, and appropriate referrals for an individual who chooses not to stay or must leave. Recovery housing providers are encouraged to meet the National Association of Recovery Residences national standards for recovery housing.

Most recovery housing is transitional with people staying up to one year then moving to permanent housing once they have built their recovery capital and found supportive, affordable housing. There are different levels of recovery housing starting with varying staffing and services and requirements. Some recovery housing providers require participation in outpatient treatment. There is some recovery housing that is permanent housing with no maximum length of stay. There are also some recovery housing options designed for specific populations including transition age youth, families with children, LGBTQIA+ populations, and faith communities.

C.9.3.4. Assisted Living (Adult Residential Care Facilities, Residential Care Facilities for the Elderly, and Licensed Board and Care Facilities)

Housing Interventions may help to cover stays in Adult Residential Facilities, Residential Care Facilities for the Elderly, Board and Care facilities, and license-exempt room and board facilities. Such facilities provide 24/7 care to people who require it due to cognitive impairment or inability to perform activities of daily living (ADLs), along with room and board. These settings may be appropriate for some people experiencing homelessness who have serious behavioral health conditions, require assistance with ADLs, or have severe cognitive impairment.

Housing Interventions funding for these facility types is not time-limited. However, Title II of the Americans with Disabilities Act, as affirmed by the U.S. Supreme Court in Olmstead v. L.C. (1999), requires states to provide services to individuals with disabilities in the most integrated setting appropriate to their needs. This means that eligible individuals should only be placed in such settings where medically necessary and only for as long as medically necessary. Eligible individuals who are able to reside in PSH or other more independent settings should be transitioned as soon as possible.

C.9.3.5 Recuperative Care

Recuperative Care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

Recuperative Care is available as a Medi-Cal Community Support. If Recuperative Care can be covered by a Medi-Cal Managed Care Plan (MCP), the Medi-Cal service must be used before Housing Interventions. Housing Interventions may be used for the costs of room and board in Recuperative Care for BHSA eligible individuals not eligible to receive coverage of this service from their MCP. Behavioral health services provided during Recuperative Care cannot be funded through Housing Interventions.

C.9.3.6 Short-Term Post-Hospitalization Housing

Short-Term Post-Hospitalization Housing provides BHSA eligible individuals who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient facility (either acute or psychiatric or Chemical Dependency Recovery hospital, or psychiatric health facility), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or Recuperative Care and avoid further utilization of these services.

This setting must make available ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, utilizing case management, and accessing other housing supports. This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Short-Term Post-Hospitalization Housing is available as a Medi-Cal Community Support. If Short-Term Post-Hospitalization Housing can be covered by an MCP, the Medi-Cal service must be used before Housing Interventions. Housing Interventions funds may be used for the costs of room and board in Short-Term Post-Hospitalization Housing for BHSA eligible individuals not eligible to receive coverage of the service from their MCP.

Behavioral health services provided during Short-Term Post-Hospitalization Housing cannot be funded through Housing Interventions.

C.9.4 Other Housing Supports

Counties may provide other housing supports as identified by DHCS (WIC section 5830, subdivision (b)(1)(F)) in this guide, in addition to the housing interventions specifically identified in WIC section 5830, subdivision (b), including, but not limited to, those listed in the Medi-Cal Community Supports Policy Guide. Pursuant to this authority, counties may provide under the category of "other housing supports": (1) Landlord Outreach and Mitigation Funds, (2) Participant Assistance Funds, (3) Housing Transition Navigation Services and Housing Tenancy and Sustaining Services and (4) Outreach and Engagement (up to 7 percent). However, as described throughout this section, BHSA funds may not be used for Medi-Cal services that can be covered and funded through the individual's Medi-Cal managed care plan (MCP). In other words, BHSA funds can only be used for Community Supports if the MCP has chosen not to administer the service, the individual is not eligible for the service, or the individual's needs exceed service limitations and as such the service cannot be covered as a Community Support.

C.9.4.1 Landlord Outreach and Mitigation Funds

Landlord Outreach and Mitigation Funds may be used to support outreach to, and engagement of, landlords and property owners, which may include the development of presentations, outreach materials, campaigns, and support to help properties meet the requirements of Housing Interventions. Landlord Outreach and Mitigation Funds may also be used by counties to encourage and incentivize property owners to rent to eligible individuals. Additionally, counties may establish a mitigation fund to offset any damages caused by a Housing Interventions participant and/or for use in connection with potential or actual evictions as further described below.

Counties opting to provide Landlord Outreach and Mitigation Funds as part of their Housing Interventions must develop policies and procedures that, at a minimum, address the following:

- Enumerate the types of landlord outreach costs that Housing Interventions will cover and the maximum allowable reimbursement, examples include:
    - Development of outreach materials (e.g., graphic design).
    - Costs associated with advertising and campaigns focused on landlord recruitment, including networking events (e.g., attending/presenting at local landlord associations).

    - Landlord incentives (e.g., one-time incentives, signing bonus, referral bonus).
    - Holding fees (short term costs to hold a vacant unit before a tenant moves in).
- Enumerate the types of landlord mitigation costs that Housing Interventions will cover and the maximum allowable reimbursement, examples include:
    - Damage reimbursement outside of usual wear and tear.
    - Unit hold related costs and vacancy payment (if tenant leaves early) or if PBH unit is vacant for a specified number of days after sufficient marketing.
    - Eviction prevention costs which may include financial assistance, back-rent, mediation, tenant education, legal costs and connection to resources (if necessary for someone to maintain their housing or be relocated).
- Identify protocols for approving allowable costs and mechanisms for documenting costs.
- Identify processes for the prevention of fraud, waste, and abuse.
- Identify any overlap with other community funds and create procedures to avoid duplication.

These policies and procedures are not subject to review and approval by DHCS but must be provided to DHCS upon request.

C.9.4.2 Participant Assistance Funds

Counties may use Housing Interventions to establish Participant Assistance Funds that seek to remove barriers to housing and support people in meeting their immediate housing needs. Any support provided should be based on individualized assessment of needs. Examples of services and activities to be covered under a Participant Assistance Fund may include, but would not be limited to:

- Costs associated with obtaining government-issued identification and other vital documents
- Housing application fees
- Fees for credit reports
- Security deposits

- Utility deposits
- Storage fees
- Pet deposits and other pet fees
- Move-in costs, including costs associated with establishing a household such as:
    - Transportation
    - Food
    - Hygiene products
    - Moderate furnishings (including but not limited to items such as a bed, tables and chairs, cleaning tools, and other supplies that people need to settle into housing)
- Rent and utility arrears

The Medi-Cal Housing Deposits Community Support covers many of the expenses identified above. Housing Interventions may not be used to cover expenses that an individual's MCP would cover under the Housing Deposits Community Support (assuming the individual is enrolled in an MCP and eligible for Housing Deposits). However, Housing Interventions may be used for expenses not covered under Medi-Cal Housing Deposits, such as pantry stocking. For individuals not eligible for Housing Deposits or who have exhausted the Housing Deposits covered by their MCP, Housing Interventions may be used for the complete list of expenses covered by the county's Housing Interventions under its Participant Assistance Fund. For example, if an MCP covers the costs of Housing Deposits up to $8,000 and the individual has additional needs related to securing or establishing a home that cannot be met under this amount, additional expenses could be paid by Housing Interventions component. If the individual must pay fees or needs items not covered by the MCP, those too could be covered by Housing Interventions component

Counties opting to provide Participant Assistance Funds as a Housing Interventions service must develop policies and procedures that, at a minimum, address the following:

- Enumerate the types of costs that may be covered.
- Identify protocols for approving allowable costs and mechanisms for documenting costs.
- Identify processes for the prevention of fraud, waste, and abuse.

- Identify any overlap with other community resources (for example, the Housing Deposits Community Support or other rental assistance deposit funds) and create procedures to avoid duplication of services.

These policies and procedures are not subject to review and approval by DHCS but must be provided to DHCS upon request.

C.9.4.3 Housing Transition Navigation Services and Housing Tenancy Sustaining Services

Counties may fund Housing Transition Navigation Services and Housing Tenancy Sustaining Services for individuals not eligible for these services through a Medi-Cal MCP. Counties using Housing Interventions to fund Housing Transition Navigation Services and Housing Tenancy Sustaining Services shall refer to the Community Supports policy guide for a list of allowable activities but are not subject to the eligibility, restrictions/limitations, or licensing/allowable provider requirements set forth in the Medi-Cal guidance or any other requirements established for Medi-Cal, if not additionally specified as applicable to BHSA Housing Interventions. Counties may also become contracted Community Supports providers which enables counties to provide Housing Transition Navigation Services and Housing Tenancy Sustaining Services to individuals enrolled in Medi-Cal.

C.9.4.4 Outreach and Engagement

Outreach and engagement activities may only represent up to 7 percent of the Housing Interventions funding allocation in accordance with the transfer guidelines in C.6 Transfers and Exemptions. Outreach and engagement activities should be tracked and entered into HMIS to inform key metrics such as the number of individuals contacted, the percentage of individuals who received housing assistance, the housing retention rate, the number of new community partnerships formed, and qualitative feedback from participants and community partners.

In alignment with the engagement activities identified as allowable under the United States Department of Housing and Urban Development Emergency Solutions Grant funding, engagement activities may include the activities necessary to locate, identify, and build relationships with individuals or families living in unsheltered settings for the purpose of providing immediate support, intervention, and connections with homeless assistance programs or mainstream social services and housing programs. Outreach and engagement activities shall not duplicate services provided by Medi-Cal MCPs per WIC section 5830, subdivision (c)(2).

Activities may include but are not limited to:

- Building relationships either through one-on-one engagement or by conducting regularly-scheduled broad outreach in high-need areas in conjunction with community partners.
- The purchase and distribution of items like food, hygiene products, clothing, blankets, and water to provide immediate support and foster future service engagement.
- Providing immediate, onsite direct navigation to housing resources.
- Coordinating behavioral health service and housing resources for unsheltered individuals in collaboration with other outreach and engagement efforts.
- Travel by outreach workers, social workers, medical professionals, or other service providers during the provision of eligible street outreach services. Also includes the costs of transporting unsheltered people to emergency shelters or other service facilities.
- Harm reduction activities and the distribution of harm reduction supplies.

C.9.5 Other Housing Interventions Requirements and Policies

This section discusses other requirements and policies that apply to Housing Interventions services.

C.9.5.1 Housing First

Pursuant to WIC section 5830, subdivision (a)(5), Housing Interventions must be operated in compliance with the core components (WIC section 8255, subdivision (b)) of Housing First and "may include recovery housing." Housing First is defined in statute as "the evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible." (WIC section 8255, subdivision (d)(1)).

Consistent with the national Housing First model and WIC section 8255, subdivision (b), abstinence from alcohol or other substances cannot be a requirement or prerequisite for Housing Interventions services. Additionally, the use of alcohol or other substances in and of itself cannot be grounds for eviction and Housing Interventions services are informed by a harm-reduction philosophy that recognizes drug and alcohol use and substance use disorder (SUD) as a part of tenants' lives, where tenants are engaged in nonjudgmental communication regarding drug and alcohol use; and where tenants are offered education regarding how to avoid risky behaviors and engage in safer practices,

as well as connected to evidence-based treatment if the individual so chooses. However, Housing Interventions may be used to support recovery housing and sober living environments for individuals who request them. Counties must ensure that in their implementation of Housing Interventions, neither they, nor entities that receive the BHSA Housing Interventions dollars, discriminate against or deny access to housing for individuals who are utilizing medications for addiction treatment or other authorized medications.

In alignment with the California Interagency Council on Homelessness "Guide to California's Housing First Law" Housing First law applies to both permanent and interim housing settings. While the requirement of a lease may not be applicable to interim settings, they must use Housing First components and principles for screening and selecting participants and in providing services and other engagement with participants.

The Department of Housing and Urban Development (HUD) provides valuable resources on Housing First that a county may look to for guidance on how to apply Housing First principles.

C.9.5.2 Family Housing

All Housing Interventions, as appropriate, must be available to support Family Housing. As defined by HUD, "Family" includes, but is not limited to, regardless of marital status, actual or perceived sexual orientation, or gender identity, any group of persons presenting for assistance together with or without children and irrespective of age, relationship, or whether or not a member of the household has a disability. A child who is temporarily away from the home because of placement in foster care is considered a member of the family.

Family Housing means housing that prioritizes not separating individuals meeting the definition of family. Family housing includes housing that accommodates the family caregiver of a BHSA eligible child, adult, older adult, or a person living with a disability.

Family housing for children and youth considerations include:

- Design, location, and environmental impacts of the housing interventions provided to the family. Dedicated space for children and youth, including green space, open space, secure play areas and courtyards, as well as indoor space in which children may play and learn are some examples.
- Access to public transportation, walkable neighborhoods or bike path access benefit children and youth and their parents.

- Where a child is eligible for Housing Interventions, the family is eligible for Housing Interventions services, even if the parent or guardian is not independently eligible, provided that the parent or guardian lives with the child. Emancipated minors are eligible to receive Housing Interventions services directly. In the reverse situation (parent or guardian is eligible but child is not), the housing provided should accommodate the whole family living together (including children).

Family housing for adults and older adults considerations include:

- Accommodations that meet the needs of the BHSA eligible individual (e.g., wheelchair ramps) as well as proximity to amenities such as community spaces, public transportation, and clinical care.

C.9.5.3 Habitability Standards

Housing Interventions may only be used in connection with housing settings that meet minimum standards for habitability. Effective October 1, 2025, all units subject to HUD quality requirements will be required to meet a new set of standards titled the National Standards for the Physical Inspection of Real Estate (NSPIRE). This will replace the HUD Housing Quality Standards. While DHCS expects counties to seek to fund settings that meet NSPIRE standards whenever possible, an attestation that the housing is habitable as defined by state law (see, e.g., California Civil Code sections 1941, 1941.1, 1941.3) and meets applicable state and local building standards will meet the minimum requirement for Housing Interventions funding. These standards will be implemented in alignment with the standards identified under Transitional Rent. Inspection costs are an allowable expense under Housing Interventions.

C.9.5.4 Minimum Quality Standards

Counties must ensure that all settings for which Housing Interventions are expended meet minimum quality standards. Many of the settings eligible for coverage serve populations with significant needs but are unlicensed and have been found to be of widely varying quality. This would include, for example, recovery residences and sober living environments as well as license-exempt room and board facilities. These standards will be implemented in alignment with the standards identified under Transitional Rent.

C.9.5.5 Homeless Management Information System Requirements

Pursuant to WIC section 8256, subdivision (d)(3)(A), counties are required to operate Housing Interventions in accordance with the Homeless Management Information System (HMIS) reporting requirements.

Counties are required to enter into the local HMIS the Universal Data Elements (Items 3.01-3.917) and the Common Data Elements (Items 4.02-4.20 and Item W5 of the Individual Federal Partner Program Elements) as defined by the HUD HMIS Data Standards for the individuals and families served, as required by WIC section 8256, subdivision (d)(8).

Every Continuum of Care (CoC) must designate an HMIS lead entity. The HMIS lead is responsible for administering, implementing, and managing the HMIS database as well as training and supporting HMIS users. Counties should work closely with the HMIS lead in their community to complete program setup and ensure data quality is meeting expectations. This list of CoC leads in California includes the HMIS leads for most communities. Coordination with the local Coordinated Entry System (CES) is strongly encouraged but counties are not required to route referrals for housing interventions through the CES.

C.9.6 Capital Development Projects

Increasing the supply of PSH and other affordable housing is critical to addressing California's homelessness crisis. Housing Interventions may include capital development projects that increase the supply of PSH, or affordable units that provide long-term housing stability and supportive services to eligible individuals and their families. For individuals who meet the eligibility and priority populations criteria, maintaining residential stability without greater assistance can be difficult. Many of these individuals and families are challenged by health conditions, social isolation, and deep poverty, and face significant barriers to both work and housing. However, studies have shown that even high-risk individuals can be successfully housed if PSH is available.

Counties will be required to detail their proposed capital development projects in their Integrated Plans (IPs) and annual updates (AUs). DHCS encourages counties to employ and include in their IP, innovative practices to develop permanent supportive housing and other affordable housing in the most efficient, timely and cost-effective manner available to the county. This section provides guidance regarding the requirements for capital development projects.

C.9.6.1 Capital Development Project Funding

Counties may use no more than 25 percent (WIC section 5892, subdivision (1)(A)(iii)) of their Housing Interventions on capital development projects. Counties may use capital development project funds to fully fund a capital development project or to fill gaps in

funding within a larger development that includes a set number of units dedicated to PSH for BHSA eligible individuals and their families.

Key elements of capital development funding:

- Counties may accrue their capital development project funding for multiple years to cover the cost of a project provided that the county complies with the rules regarding reversion. See Chapter 6 for more details about the reversion of funding to the state.
- Generally, there is no single funding source for PSH developments. Consequently, counties and project developers may also combine funding from other federal, state, and local sources to develop properties that include PSH units provided that the project meets the requirements for capital development projects. Counties are encouraged to align their capital development funding requirements with other local, state and federal programs that will help braid requirements and funding from multiple programs – this practice can reduce administrative burden and related costs for counties and housing sponsors.
- The maximum amount of capital development funds that a county may use to fund the construction and/or rehabilitation of housing units under this program is $450,000 per unit.

C.9.6.2 Eligibility and Access Requirements

Counties may use capital development funding for the construction and/or rehabilitation of housing units provided that the projects meet the following eligibility and access requirements:

1. The housing units must be made available to individuals and families who meet the eligibility and priority populations criteria as defined in Chapter 7, Section C.4.1 "Eligible Populations".
2. Access to housing units may not be limited to individuals enrolled in Full Service Partnerships (FSP) or to those enrolled in Medi-Cal.
3. Capital development projects may not discriminate against or deny access to housing for individuals who are utilizing medications for addiction treatment or other authorized medications.
4. Capital development projects must comply with the core components of Housing First.

C.9.6.3 Capital Development Project Requirements

The following additional requirements apply to projects receiving capital development project funding:

1. The housing units constructed and/or rehabilitated must be affordable and satisfy the definition of "supportive housing." As provided in California GOV section 65582, subdivision (g), "supportive housing" means "housing with no limit on length of stay, that is occupied by the target population, and that is linked to onsite or offsite services that assist the supportive housing resident in retaining the housing, improving their health status, and maximizing their ability to live and, when possible, work in the community."
2. The housing units must be available for Eligible individuals and their families within a reasonable timeframe that is consistent with each county's approved Integrated Plan.
3. To constitute a "use by right" the project must meet all of the requirements under WIC section 5831, subdivision (a)(1).
4. The project must comply with any other requirements specified by DHCS for purposes of administering county capital development programs.
5. Funding for capital development projects are subject to the three and five-year reversion periods.

C.9.6.4 Exemption from the Low Rent Housing Project Requirements

Capital development projects are exempt from the low rent housing project requirements in the California Constitution and related statutes (WIC section 5830, subdivision (d)-(e)), which require voter approval of such projects. While there are multiple criteria for an exemption, BHSA projects are identified as one of the exemption criteria. Specifically, if the capital development project consists of the "acquisition, rehabilitation, reconstruction, alterations work or new construction or any combination" of these with respect to lodging facilities or dwelling units funded using moneys from the Behavioral Health Services Fund (BHSF), the project is exempt from the low rent housing project requirements in Section 1 of Article XXXIV of the California Constitution.

C.9.6.5 Exemptions Available to Projects that Meet "Use by Right" Requirements

To allow for the efficient use of capital development project funds and the timely construction and/or rehabilitation of PSH units, WIC section 5831 limits the application

of permitting, land use requirements and environmental requirements to capital development projects that satisfy the "use by right" requirements and meet specified criteria. These rules are intended to prevent capital development projects from being delayed by time-consuming subjective and discretionary approval processes and related litigation.

As further specified in the Appendix, the BHSA limits local governmental review of such projects to the application of objective zoning, subdivision, and design standards which must be applied within strictly limited timeframes. It also exempts BHSA-funded projects that meet the "use by right" requirements from the California Environmental Quality Act.

C.10 Innovative Behavioral Health Pilots and Projects

The goal of innovative behavioral health pilots and projects is to build the evidence base for the effectiveness of new statewide strategies. Counties are encouraged to pilot and test innovative behavioral health pilots and projects (WIC section 5892, subdivision (a)(4)) in all BHSA funding components (Housing Interventions, FSP, and BHSS). Counties should fund innovative behavioral health pilots and projects under each of those separate funding components.

8. Documentation Requirements for BHSA Services

The Department for Health Care Services (DHCS) is streamlining and standardizing documentation requirements for BHSA to align with documentation requirements for Medi-Cal Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. The purpose of this alignment is to standardize documentation standards across all county behavioral health delivery systems, while also improving alignment with national standards and physical health care documentation requirements.

Effective July 1, 2026, mental health and substance use disorder (SUD) services funded under BHSA (with the exception of hospital inpatient and Narcotic Treatment Program (NTP) services) must comply with documentation requirements established in Behavioral Health Information Notice (BHIN) 23-068, including:

- Standardized assessment requirements
    - Uniform assessment domains utilized for outpatient SMHS
    - American Society for Addiction Medicine (ASAM) assessment utilized for SUD services
- Dynamic problem list
    - Updated on an ongoing basis to reflect an individual's condition
- Progress notes
    - Progress notes are written in a narrative format and provide sufficient detail to support the service delivered
- Care Planning
    - Static treatment plans such as the Full Service Partnership (FSP) Individual Services and Support Plan (ISSP) are no longer required by DHCS
    - Care planning is an ongoing process that is documented flexibly in the clinical record, including through the problem list and progress notes

These documentation requirements apply to non-hospital, non-NTP mental health and substance use disorder services funded through FSP (WIC section 5887) or Behavioral Health Services and Supports (BHSS) please refer to the statutory requirements for adults and older adults (WIC section 5806) and children and youth (WIC section 5868) for additional information).

The documentation requirements do not apply to services and supports where this approach to clinical documentation requirements may be unsuitable, such as:

- BHSA housing services
- Outreach programs, including BHSS Outreach and Engagement and outreach funded under FSP, where gathering identifying information is not feasible (e.g., outreach to homeless individuals and others who are not yet comfortable providing their information)
- Warm lines and hotlines
- Food support provided under FSP

9. BHSA Oversight and Enforcement

A. Overview

One of the goals of Behavioral Health Transformation (BHT) is to increase accountability for publicly funded county-administered behavioral health services. This chapter describes the Department of Health Care Services' (DHCS') approach for monitoring county compliance with program requirements under the Behavioral Health Services Act (BHSA) and, where necessary, imposing administrative or monetary sanctions for noncompliance.

After describing DHCS' guiding principles for BHSA oversight and enforcement, this chapter reviews DHCS' policies and procedures for:

- Periodic BHSA compliance reviews, including DHCS' plans to streamline and align county compliance reviews across publicly funded behavioral health programs.
- Enforcement mechanisms for county noncompliance, including administrative sanctions such as corrective action plans (CAPs) and monetary sanctions.
- County oversight of BHSA-funded providers, including overarching provider standards and county monitoring of providers.

In addition, DHCS' monitoring and oversight will draw on the new BHSA reports: the Integrated Plan (IP), the Annual Update (AU), the Intermittent Update (IU) (if applicable) and the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR). Prior chapters discuss the contents for these reports, as well as the processes and timelines for county submission and DHCS review and approval.

B. Guiding Principles for BHSA Oversight

DHCS recognizes that counties are currently implementing ambitious reforms under BHT and other county-administered behavioral health programs. For BHSA, program requirements are set forth in state law, this Policy Manual, and the County Performance Contract (in accordance with WIC section 5897).

DHCS' oversight policies are informed by the following guiding principles.

- DHCS will align BHSA oversight with existing Medi-Cal policies wherever it is legally permissible and programmatically appropriate to do so. In addition to capitalizing on lessons learned from the Medi-Cal context, standardizing oversight policies will enhance efficiency for both county and state officials, as

well as behavioral health providers, consistent with BHT goals and recent amendments to WIC section 14197.7.

- DHCS will lead with technical assistance and encourage proactive collaboration on implementation challenges, particularly in the early years of BHT implementation and when counties seek DHCS assistance to address concerns about appropriate implementation of program requirements. As with all county-administered programs, DHCS encourages counties to contact DHCS with questions about program requirements or concerns about county-specific issues. Additionally, counties may refer to DHCS resources and attend technical assistance webinars and other collaborative learning opportunities. When deciding whether to impose administrative or monetary sanctions for noncompliance, DHCS will consider whether counties proactively disclosed compliance concerns and worked with DHCS in good faith to resolve them (among other factors).
- In various sections of the IP and the AU templates, DHCS has provided space for counties to disclose implementation challenges or concerns with certain requirements under BHSA, and other programs and funding sources administered by counties. These self-disclosures are optional, and DHCS does not view these disclosures as an automatic admission of noncompliance. Rather, DHCS seeks to gather data on common concerns to inform technical assistance efforts, whether targeted to specific counties or published as general guidance for all counties.
    - As with all DHCS communications, these IP and AU self-disclosures may inform DHCS' oversight of each county, such as decisions about which issues to focus on in the county's next scheduled compliance review. As noted, if DHCS does confirm instances of county noncompliance, DHCS' decisions about administrative or monetary sanctions will take into account whether the county proactively disclosed that issue to DHCS, whether through the IP or other means.
    - These self-disclosures should focus on new information. For example, if the county is under an active CAP to address 24/7 access line issues, there is no need for the county to disclose those specific issues via the IP. However, if the county has identified emerging 24/7 access line issues beyond the scope of DHCS's prior findings and the county's existing CAP, the county may wish to self-disclose that emerging issue.

- DHCS will escalate oversight and enforcement for serious or persistent violations. DHCS intends to lead with technical assistance, as noted above, and to begin with administrative sanctions before imposing temporary withholds or monetary sanctions for counties with persistent compliance issues (e.g., lack of good faith effort to implement an existing CAP). However, as described in the following sections, DHCS may move through these steps more quickly for serious violations that impair access to care, threaten individual health or safety, or create a risk of fraud or other program integrity concerns.

Note: Unlike in Medi-Cal, BHSA monetary sanctions imposed on a county will be returned to the county once it comes into compliance. For further discussion of monetary withholds and monetary sanctions, see Policy Manual Chapter 9, Section D.2 below.

C. Compliance Reviews

DHCS will conduct periodic reviews to assess each county's compliance with BHSA program requirements, as DHCS currently does for Mental Health Services Act (MHSA) and other county-administered behavioral health programs, and as required under WIC section 5897, subdivision (d).

DHCS currently anticipates conducting annual compliance reviews, with an onsite review occurring at least once every three years. DHCS anticipates beginning these routine compliance reviews no sooner than Fiscal Year (FY) 2027-2028, reviewing the reporting period of FY 2026-2027 (the first program year under the 2026 IP). In addition, DHCS may initiate targeted ad hoc reviews at any time as necessary to address a serious or urgent compliance concern.

The process for BHSA compliance reviews is modeled on the existing process for Medi-Cal compliance reviews, as described in Behavioral Health Information Notice (BHIN) 23-044. These reviews encompass four phases, described further below:

1. Review Preparation, including pre-review planning, document submissions, and DHCS desk review.
2. Compliance Review, including an onsite or virtual component.
3. Post Review Evidence & Exit Process, including opportunity for discussion of draft findings.
4. Findings Report, including any recommended corrective actions needed to achieve compliance.

To the greatest extent possible, DHCS intends to align the timing and procedures for each county's reviews across BHSA, Medi-Cal, the Community Mental Health Services Block Grant (MHBG), and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG).

Currently, as outlined in Table C.1 below, DHCS conducts three separate compliance reviews for county behavioral health programs:

- Medi-Cal Specialty Mental Health Services (SMHS): Once every three years.
- Concurrent reviews for Drug Medi-Cal (DMC), DMC Organized Delivery System (DMC-ODS), and SUBG: Every year.
- Concurrent reviews for MHBG and MHSA: Every three years.

Under the CalAIM initiative for Behavioral Health Administrative Integration, once all counties have adopted integrated Medi-Cal contracts, DHCS intends to conduct combined Medi-Cal compliance reviews for SMHS and DMC/DMC-ODS, plus concurrent review of SUBG.

Furthering that vision, DHCS is now considering the possibility of conducting a single compliance review for each county each year, either virtually or onsite. This concurrent review would simultaneously assess BHSA and the other county-administered programs listed above. By consolidating these reviews, DHCS aims to enhance efficiency at both the county and state level by avoiding duplicative requests for pre-review document submissions, aligning similar requirements across programs where feasible, and streamlining the review process itself to the extent possible.

As DHCS continues developing policies for combined and aligned reviews, DHCS will conduct additional stakeholder engagement and release further guidance.

Table C.1 Aligning Compliance Reviews Across County Behavioral Health Programs

Phase	Number of Reviews	Reviews
Current State	3 Reviews	1. **Medi-Cal (SMHS):** Triennial. 2. **Medi-Cal (DMC/DMC-ODS) + SUBG:** Annual Concurrent Reviews. 3. **MHBG + MHSA:** Triennial Concurrent Reviews.
Intermediate State *(Beginning no sooner than FY 2027-2028)*	2 Reviews	1. **Medi-Cal (SMHS + DMC/DMC-ODS) + SUBG:** Annual Concurrent Reviews. 2. **BHSA:** Annual review (concurrent **MHBG** review if county is due that year).
Future State	1 Review	1. **Single annual review for all programs, including BHSA** (**MHBG** included if county is due that year).

SMHS = Specialty Mental Health Services; MHSA = Mental Health Services Act; DMC = Drug Medi-Cal; DMC-ODS = Drug Medi-Cal Organized Delivery System. Integrated, annual Medi-Cal reviews will begin the year after counties adopt integrated contracts under Behavioral Health Administrative Integration, to the extent DHCS resources allow. 17 counties voluntarily adopted integrated contracts effective January 1, 2025. The remaining counties will adopt integrated contracts effective January 1, 2027.

C.1 Review Preparation

In this phase, DHCS determines which issues to focus on in each county's review, gathers the necessary documents, and performs a desk review ahead of the compliance review.

C.1.1 Review Planning

The BHSA compliance reviews may assess any program requirements that are defined under this Policy Manual, the County Performance Contract, and state laws, including:

- Allocation of funds and other BHSA fiscal policies;
- Stakeholder engagement;

- Program requirements for each BHSA component (Behavioral Health Services and Supports (BHSS), Housing Interventions, and Full-Services Partnerships (FSPs));
    - Note: BHSA compliance reviews will not focus on assessing the fidelity of evidence-based practices under BHSA. Those fidelity assessments will be conducted by Centers of Excellence, as described in Chapter 7.
- Coverage and authorization of services;
- BHSA provider oversight, workforce strategy and availability of services, as defined under WIC section 5963.02, subdivisions (c)(8)(A), (C)–(G), and (I);
- Program integrity;
- Reporting requirements; and
- Administration.

Prior to each county's BHSA compliance review, DHCS will identify priority areas for review. DHCS aims to review all program areas at least once every three years but may review certain issues more frequently. DHCS identifies priority areas for each county based on factors such as:

- The county's compliance history under MHSA/BHSA and other programs (e.g., unresolved CAPs);
- Issues identified based on DHCS' review of the IP, AU, BHOATR, and other county reports; and
- DHCS' assessment of potential impacts on individuals receiving BHSA-funded services and risks to program integrity.

C.1.2 Document Collection

At least 45 to 60 days prior to the scheduled review, DHCS will notify the county of the areas the review will focus on and the documentation that will be required. For example, required documentation may include county policies and procedures, evidence of practice, or sample language from BHSA provider contracts. Counties will submit all documentation to demonstrate compliance as requested to DHCS prior to the virtual or onsite review. In the future, as DHCS finalizes the policies for aligned compliance reviews across county-administered behavioral health programs, DHCS will release additional guidance regarding the timelines and procedures for submitting pre-review documents. To improve efficiency, DHCS will aim to reduce redundant document requests across various programs.

C.1.3 Desk Review

DHCS will review the documents submitted by the county, as well as additional documents available to DHCS (e.g., the IP and BHOATR), to determine which areas to focus on during the compliance review, and whether the compliance review should be conducted virtually or in person. As noted, DHCS anticipates conducting an onsite review at least once every three years but may conduct onsite reviews more often if deemed necessary.

C.2 Compliance Review (Virtual or Onsite)

During the BHSA compliance review, DHCS will interview key county personnel to assess compliance and evaluate the county's administration of BHSA programs. DHCS may request additional supporting documents as needed throughout the interview portion and may include review of client charts to assess provider services.

Unlike the current MHSA review process, but consistent with current Medi-Cal reviews, DHCS' compliance reviews will not generally include discussions with contracted service providers, program visits, client meetings, or housing visits. Counties will be responsible for monitoring their contracted providers, as described in Section E below. DHCS will review whether counties are effectively monitoring their providers for compliance. Effective monitoring will include adopting a monitoring schedule for BHSA-funded providers that includes periodic site visits; preserving provider monitoring records—including monitoring reports, county-approved provider CAPs, and confirmations of CAP resolutions; and providing monitoring records to DHCS at any time, upon DHCS' request.

C.3 Post Review Evidence/Exit Process

At the conclusion of the review, DHCS will share draft review findings with the county, at which point the county has a formal opportunity to discuss the draft findings with DHCS.

Specifically, a county will have 15 business days after receipt of the draft findings to indicate whether they agree, disagree, or partially agree with the findings (including any recommended corrective action) via a DHCS-provided template, as well as to submit any additional information or documentation for DHCS' review and consideration. This 15-day period is a formal timeframe available to counties in addition to the option to submit documentation at any time during the desk review or compliance review.

After a county submits the completed template and any additional information or documentation, DHCS will respond, make adjustments as it deems necessary and appropriate, and issue a final Findings Report, as described below.

C.4 Findings Report

DHCS will provide a final written Findings Report describing any findings of noncompliance and any recommended corrective actions. CAPs are discussed in Section D.1.1, below. DHCS will post all Findings Reports on the DHCS website.

To the extent possible, DHCS intends for the BHSA Findings Report to emphasize common issues identified across the county's behavioral health programs, such as compliance findings relating to access to services, provider oversight, or documentation. DHCS will clearly distinguish between BHSA-specific compliance findings and cross-program themes.

D. Enforcement: Administrative and Monetary Sanctions

If DHCS determines that a county is out of compliance with BHSA requirements, as set forth in state law, this Policy Manual, and the County Performance Contract, DHCS may pursue various enforcement actions including:

- Administrative sanctions, such as imposing a CAP or requiring a county to revise its IP or AU; and
- Temporary monetary withholds or monetary sanctions.

These enforcement actions, which are described further below, are authorized by WIC section 5897, subdivision (e); section 5963.04, subdivision (e); and section 14197.7. DHCS may impose administrative or monetary sanctions based on findings from a routine compliance review and may also impose these sanctions on an ad hoc basis.

DHCS' BHSA enforcement actions will generally follow the same procedures as under Medi-Cal, as described in BHIN 23-044 and BHIN 25-023 or subsequent guidance. However, there will continue to be certain differences in approach due to differences in DHCS's legal authority and policy decisions. For example, for BHSA, DHCS has not developed an equivalent to the Medi-Cal Enforcement Tiers for network adequacy and timely access, as described in the Attachments to BHIN 25-023.

As noted above, in the early years of BHSA implementation, DHCS expects to focus on training, technical assistance, and administrative enforcement mechanisms rather than imposing monetary sanctions. In general, DHCS expects to begin with administrative

sanctions before progressing to temporary monetary withholds and monetary sanctions; However, for serious or persistent violations, DHCS will consider imposing temporary monetary withholds and monetary sanctions in lieu of, or combined with, a CAP or other administrative sanctions.

D.1 Administrative Sanctions

D.1.1 Corrective Action Plans (CAPs)

When a county is out of compliance with BHSA requirements, DHCS may require the county to submit a CAP for DHCS' review and approval or may impose a DHCS-defined CAP on the county. The following CAP requirements and procedures are consistent with current Medi-Cal practices as described in BHIN 23-044 and BHIN 25-023.

D.1.1.A CAP Contents

A BHSA CAP shall include the following information, in accordance with DHCS' CAP template:

- Description of corrective actions that will be taken by the county to address identified findings, including actions required of county-contracted providers when applicable, and incremental milestones the county will achieve in order to reach full compliance.
- Timeline for implementation and/or completion of corrective actions.
    - In general, DHCS requires counties to resolve CAPs within 90 calendar days from the date of DHCS' acknowledgment of receipt of the CAP or, if DHCS imposes a defined CAP, within 90 days of the date DHCS provides the CAP to the county. DHCS may approve an extended timeline for resolution if necessary and appropriate.
- Proposed evidence of correction that will be submitted to DHCS.
    - If the county has evidence to support correction at the time the CAP is due, the county shall submit the actual evidence of correction to DHCS.
- Mechanism for monitoring the effectiveness of corrective actions over time.
- Behavioral Health Director or designee (e.g., compliance administrator) name, and the date of their approval of the CAP.

DHCS will publish all BHSA CAPs on its website, as required under WIC section 5897, subdivision (e)(2).

D.1.1.B CAP Process Following a Compliance Review

For CAPs following a compliance review, counties shall, within 60 calendar days of receipt of the Findings Report, submit a proposed CAP to DHCS for all identified findings. Upon receipt of the CAP, DHCS will provide an Acknowledgement Letter within five business days.

D.1.1.C CAP Resolution and Ongoing Monitoring Activities

DHCS will determine when the county has resolved the CAP and will issue a Resolution Letter to inform counties of the successful completion of the CAP. If CAPs are not resolved within the determined timeline for resolution, DHCS will consider heightened oversight including:

- Monitoring calls;
- Statewide/regional technical assistance and training;
- Focused technical assistance; and
- Focused ad hoc compliance review, which may be desk, virtual, or onsite, in addition to the county's routine compliance reviews.

D.1.2 Directing Counties to Revise their IP or AU

In certain circumstances, DHCS may require a county to revise its IP or AU as an administrative sanction. Specifically, as authorized under WIC section 5963.04, subdivisions (e)(1) & (2), DHCS may require a county to revise its IP or AU if:

- The submitted IP or AU fails to adequately address local needs, as described under WIC section 5963.02, subdivision (b)(2) and Policy Manual Chapter 3, Section E.4.2; or
- The county has failed to make adequate progress in meeting performance measures under BHSA, Medi-Cal, or other county-administered behavioral health programs, as defined in WIC section 5963.04, subdivision (b).
    - DHCS does not intend to exercise this authority until DHCS releases "Phase 2" performance measures which, as described in Chapter 2, Section C.1.A of this Policy Manual, are intended to be used for monitoring and accountability purposes.
    - DHCS can exercise this authority outside the standard IP/AU submission timeline, including after BHAOTR submission.

D.2 Monetary Withholds and Monetary Sanctions

DHCS has the authority to impose temporary monetary withholds and monetary sanctions for certain types of BHSA program violations. This section describes:

- Potential bases for DHCS to impose temporary monetary withholds and monetary sanctions;
- Maximum Temporary Monetary Withholds;
- Maximum Monetary Sanctions;
- Factors DHCS Will Consider When Imposing Temporary Withholds or Monetary Sanctions; and
- Notice and Appeal Rights.

If DHCS imposes temporary monetary withholds or monetary sanctions on a county, the county shall continue to comply with all BHSA program requirements unless directed otherwise. Generally, DHCS intends to begin with temporary withholds, but may escalate to sanctions for severe or repeat violations.

D.2.1 Bases for Temporary Monetary Withholds and Monetary Sanctions

Pursuant to WIC section 5963.04, subdivision (e)(3), DHCS has express authority to impose BHSA withholds or monetary sanctions if a county:

- Fails to follow stakeholder engagement requirements for the IP or the 30-day comment period for the AU and intermittent updates, as described in WIC section 5963.03 and Chapter 3, Section B of this Policy Manual.
- Fails to allocate BHSA funds in accordance with statutory requirements, as set forth at WIC section 5892 and Chapter 6, Section B of this Policy Manual.
- Fails to submit a complete, accurate, and timely BHOATR in accordance with WIC section 5963.04 and Chapter 4 of this Policy Manual. Specifically, if DHCS notifies a county of an overdue BHOATR and the county fails to submit the BHOATR within a reasonable time (as defined in DHCS' notice to the county), DHCS may withhold 25 percent of the county's monthly allocations from the Behavioral Health Services Fund (BHSF) until the county comes into compliance. This is consistent with DHCS' current approach for MHSA withholds in response to a late Annual Revenue and Expenditure Report.

- Spends BHSA funds in a manner that significantly varies from its budget in the IP, AU, or intermittent update. (This standard does not apply to any of the non-BHSA funding sources identified in the IP budget.)
    - In the short term, DHCS does not intend to define quantitative standards for "significant variance." For example, if a county's planned allocations to a particular service line over or underestimate actual spending, DHCS will not impose monetary sanctions. Rather, DHCS plans to use data from the initial IP period to inform a standard that reflects county experiences and spending patterns.
    - As a reminder, once approved in the IP, counties are not permitted to adjust their allocation of funding across BHSA components during the IP period except in emergencies, as described in Policy Manual Chapter 6, Section B.5.1. However, counties may adjust their suballocations within each component via an AU or any time needed outside of the submission timeframe for an AU or IP through an intermittent update (IU).

These sanction authorities apply over and above "any other applicable law that authorizes the department to impose sanctions or otherwise take remedial actions against a county" for BHSA violations, per WIC section 5963.04, subdivision (f).

D.2.2 Maximum Monetary Withholds

For a sanctionable violation, DHCS may temporarily withhold a portion of a county's monthly BHSF allocations until the county comes into compliance, as authorized under WIC section 5963.04, subdivision (e)(3).

The statute authorizes DHCS to withhold an amount of funds that DHCS "deems necessary to ensure the county…comes into compliance," pursuant to WIC section 5963.04, subdivision (e)(3)(C). To avoid undue financial hardship for the county, DHCS will withhold no more than 25 percent of a county's monthly BHSF allocations; depending on the circumstances, DHCS may withhold less than 25 percent after considering the factors enumerated below in section D.2.4. This maximum aligns with the statutory cap on monetary sanctions.

Any payments from the sanctioned county's BHSF shall be deposited into the Behavioral Health Services Act Accountability Fund. In accordance with WIC section 5963.04, subdivision (e)(3)(D), all monetary withholds imposed on a county shall be released to the county once DHCS determines that the county has come into compliance.

D.2.3 Maximum Monetary Sanctions

For a sanctionable violation, DHCS may impose monetary sanctions pursuant to WIC section 5963.04, subdivision (e)(3) and section 14197.7, subdivision (n)(5).

As under Medi-Cal, DHCS may impose monetary sanctions of up to $25,000 per violation for a first violation, up to $50,000 for a second violation, and up to $100,000 for each subsequent violation, in accordance with WIC section 14197.7, subdivision (f); depending on the circumstances, DHCS may impose smaller monetary sanctions after considering the factors enumerated below in section D.2.4.

- For a deficiency that impacts individuals receiving BHSA-funded services, each member impacted constitutes a separate violation.
- DHCS may separately and independently assess a monetary sanction for each day the county fails to correct an identified deficiency.

DHCS may collect monetary sanctions by withholding up to 25 percent of the county's monthly allocations from the BHSF. DHCS shall continue to offset the amount attributable to the sanction each month until it collects the full amount of the sanction. Any payments from the sanctioned county's BHSF shall be deposited into the Behavioral Health Services Act Accountability Fund.

In accordance with WIC section 5963.04, subdivision (e)(3)(B), all monetary sanctions imposed on a county shall be returned to the county once the county comes into compliance.

D.2.4 Factors DHCS Will Consider When Imposing Temporary Withholds or Monetary Sanctions

In alignment with current Medi-Cal practices under BHIN 25-023 and WIC section 14197.7, subdivision (g), when determining the amount of a temporary withhold or monetary sanction, DHCS will consider the following non-exhaustive factors:

- The nature, scope, and gravity of the violation, including the potential harm or impact on individuals eligible for BHSA-funded services.
- The good or bad faith of the county.
- The willfulness of the violation.
- The nature and extent to which the county:
    - Cooperated with DHCS' investigation;

    - Aggravated or mitigated any injury or damage caused by the violation; and
    - Has taken corrective action to ensure the violation will not recur.
- The county's financial status, including whether the sanction will affect the county's ability to come into compliance.
- The financial cost of the health care service that was denied, delayed, or modified, if applicable.
- Whether the violation is an isolated incident.
- The county's history of violations under BHSA and MHSA, including unresolved CAPs. In addition, for BHSA only, DHCS will take into account the county's history of similar violations under other behavioral health programs.
- The amount of the penalty necessary to deter similar violations in the future.
- Other mitigating factors presented by the county.

In connection with these factors, DHCS will consider whether the county proactively disclosed implementation challenges through the IP or other means, as described above in Section B. Although not required by statute, DHCS expects to consider similar factors when deciding whether to progress from administrative sanctions to monetary sanctions.

D.2.5 Notice and Appeal Rights

The notice and appeal rights for BHSA temporary withholds and monetary sanctions are identical to the current Medi-Cal procedures outlined in WIC section 14197.7, subdivisions (h), (k), (l) and (m) and BHIN 25-023.

D.2.5.A Notice

Except in exigent circumstances when DHCS determines that there is an immediate risk to the health of individuals receiving BHSA-funded services, DHCS will send a notice of sanction at least 30 calendar days before the sanction's effective date. The notice will identify the sanction's effective date, duration, and rationale, as well as details of county appeal rights.

- A county may request to meet and confer with DHCS regarding a proposed sanction. DHCS shall grant all requests submitted no later than two business days after a county's receipt of DHCS' notice of intent to impose a temporary withhold or monetary sanction.

- DHCS, at its discretion, may alert other persons and organizations that may be impacted or interested in the sanction.

D.2.5.B Filing an Appeal

A county has the right to appeal a temporary withhold or monetary sanction by filing a written appeal, with a copy of the sanctions notice, to the address specified in the notice.

For an appeal of a temporary withhold, the county must file the appeal within 30 calendar days from the date it receives notice of the withhold (or if the county requests a meet and confer with DHCS, within 30 calendar days from the date the county receives the final sanction notice following the meet and confer). The appeal shall be conducted in accordance with HSC section 100171 and WIC section 14197.7, subdivisions (k).

For a monetary sanction, the county must request a hearing within 15 working days after the date the county receives the notice of the sanction (or if the county requests a meet and confer with DHCS, within 15 working days from the date the county receives the final sanction notice following the meet and confer). The appeal shall be conducted in accordance with HSC section 100171.

D.2.5.C Stay of Temporary Withhold or Monetary Sanction

Temporary withholds and monetary sanctions shall be stayed until the hearing is completed and DHCS has made a final determination, in accordance with WIC section 14197.7, subdivision (k)(7) (temporary withholds) and subdivision (l)(2) and (3) (sanctions).

E. BHSA Provider Standards and County Oversight

Each county must "ensure its county and noncounty contracted behavioral health workforce is well-supported and culturally and linguistically concordant with the population to be served, and robust enough to achieve the statewide and local behavioral health goals and measures," as described in WIC section 5963.02(c)(8). In support of that function, counties are responsible for ensuring that their BHSA-funded providers comply with applicable requirements. This applies to providers that contract with the county as well as providers that are owned or operated by the county. This section discusses:

- The contracts that counties execute with county-contracted BHSA providers (i.e., providers that are not owned or operated by the county), as well as the corresponding policies and procedures for county-operated BHSA providers.

- Overarching requirements for BHSA providers, beyond the program requirements that apply to specific BHSA-funded services.
- County monitoring of BHSA providers.

As with BHSA compliance reviews and enforcement, DHCS seeks to promote alignment with Medi-Cal standards and processes wherever it is feasible and appropriate to do so.

E.1 BHSA Provider Contracts and Policies

E.1.1 Contracts with County-Contracted Providers

Counties must execute a contract with each county-contracted provider (i.e., providers that are not owned or operated by the county) that receives BHSA funds, consistent with historical MHSA practices. These written agreements play an important role in counties' oversight of BHSA providers, and in DHCS' oversight of counties to ensure appropriate use of BHSA funds. The county must also maintain records of actual expenditures sufficient to comply with BHOATR requirements. These provider contracts must:

- Specify the services for which the provider is receiving BHSA funds, as described in Chapter 7 of this Policy Manual.
- Require the provider to comply with:
    - All program requirements applicable to the provider's BHSA-funded services;
    - The BHSA fiscal policies on Medi-Cal participation and seeking reimbursement from Medi-Cal and other payers (if applicable to the provider's services), as set forth in Chapter 6, Section C of this Policy Manual;
    - The general provider standards described below in section E.2;
    - The county's BHSA provider monitoring activities, as discussed below in section E.3; and
    - Any requests for records, information, or onsite access by the county, DHCS or their designees for purposes of BHSA oversight. (In general, DHCS expects that counties will monitor BHSA providers, while DHCS monitors counties. However, DHCS reserves the right to directly monitor BHSA providers as needed.)

Counties must make a good faith effort to execute a provider's contract before the provider begins delivering BHSA-funded services. If a county is unable to execute a

contract before the delivery of BHSA-funded services—e.g., due to good-faith delays in contract execution, or when a non-contracted provider has delivered emergency services eligible for BHSA funding—the county must execute the contract within 120 calendar days from the commencement of BHSA-funded services, consistent with the time limit for provisional SMHS provider contracts.

E.1.2 Policies and Procedures for County-Operated Providers

Counties are not required to execute BHSA contracts with providers owned or operated by the county because these providers are subject to all the same requirements as the county itself. Counties must, however, maintain records of expenditures sufficient to comply with BHOATR requirements, and must maintain policies and procedures to ensure compliance with all the same requirements enumerated above.

E.2 General Standards for BHSA Providers

In the IP, counties must describe how they will ensure that BHSA-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner, as specified under WIC 5963.02(c)(8)(C)–(F). To satisfy this requirement and promote alignment across programs, effective July 1, 2027, DHCS recommends that counties require BHSA-funded providers to comply with the same standards as Medi-Cal providers with respect to:

- Minimum provider qualifications for licensure, certification, training, experience, and credentialing, as applicable for each type of service. This requirement focuses on minimum standards to provide BHSA-funded services, and so does not incorporate standards specific to Medi-Cal.
- Nondiscrimination requirements, including ensuring physical access, reasonable accommodations, and accessible equipment for people with disabilities.
- Delivering services in a culturally competent manner to all individuals, including those with limited English proficiency and diverse cultural and ethnic backgrounds and disabilities, regardless of age, religion, sexual orientation, and gender identity.

As a reminder, under state law, BHSA and Medi-Cal providers are already subject to many of the same standards on provider qualifications and nondiscrimination. In addition, by July 1, 2027, most BHSA providers that offer Medi-Cal coverable services should already be participating in the county Medi-Cal Behavioral Health Delivery

System and should already be complying with Medi-Cal requirements. For additional details on this requirement, see Chapter 6, Section C.2 of this Policy Manual.

When filling out their IP, counties may check a box to indicate that they will require BHSA-funded providers to comply with the same Medi-Cal standards outlined above, either for all BHSA-funded providers or only for the subset of BHSA providers that also participate in Medi-Cal. If a county elects not to hold all BHSA providers to Medi-Cal standards, the county must describe its county-specific approach for ensuring provider qualifications, nondiscrimination, and cultural competence.

Regardless of the approach counties take, the applicable standards must be codified in counties' BHSA provider contracts and policies and procedures, as described above under Section E.1.

E.3 County Monitoring of BHSA Providers

In the IP, per WIC section 5963.02, subdivision (c)(8)(I), counties must describe how they will conduct oversight of BHSA providers to ensure compliance with all applicable federal and state laws, and as described in this Policy Manual. Effective July 1, 2027, counties must:

1. Adopt a monitoring schedule for BHSA-funded providers that includes periodic site visits;
2. Preserve provider monitoring records, including monitoring reports, county-approved provider CAPs, and confirmations of CAP resolutions; and
3. Provide monitoring records to DHCS at any time, upon DHCS' request.

As with the provider standards discussed in the prior section, DHCS recommends that counties adopt the same provider monitoring schedule for BHSA and Medi-Cal. Consistent with the integrated SMHS/SUD Medi-Cal contracts that all counties will adopt effective January 1, 2027, this would entail:

- Monitoring compliance at least annually for all BHSA provider locations; and
- Performing onsite monitoring at least once every three years.

DHCS encourages counties to implement efficient monitoring processes that minimize administrative burden for contracted providers. For example:

- Under an aligned monitoring schedule, a county may simultaneously monitor providers for compliance with requirements under Medi-Cal, BHSA, and any other applicable programs.

- If a provider furnishes BHSA-funded services in multiple counties, one county may rely on monitoring performed by another county, consistent with current practices for Medi-Cal provider monitoring.

When filling out their IP, counties may check a box to indicate that they will use the same provider monitoring schedule for BHSA and Medi-Cal, whether for all BHSA-funded providers or only for the subset of BHSA providers that also participate in Medi-Cal. If a county elects not to follow the Medi-Cal monitoring schedule for all BHSA-funded providers, the county must describe its county-specific monitoring approach, which must include the elements outlined above (periodic site visits and preservation of monitoring records).

Appendix A: Select Definitions

1. Experiencing Homelessness

1. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
    a. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
    b. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or
    c. An individual who is exiting an institution and was considered homeless immediately prior to entering the institution or becomes homeless during the institutional stay, regardless of the length of stay.
2. An individual or family who will imminently lose their primary nighttime residence, provided that:
    a. The primary nighttime residence will be lost within 30 days of the date of application for homeless assistance;
    b. No subsequent residence has been identified; and
    c. The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing.
3. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
    a. Are defined as homeless under section 387(3) of the Runaway and Homeless Youth Act (34 U.S.C. 11279(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (34 U.S.C. 12473(6)), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(l) of the Food and Nutrition Act of

2008 (7 U.S.C. 2012(l)), section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)), or section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2));

b. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;

c. Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and

d. Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment.

4. Any individual or family who:

a. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;

b. Has no other residence; and

c. Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.

2. At-Risk of Homelessness

1. An individual or family who:
    a. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
    b. Meets one of the following conditions:
        i. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
        ii. Is living in the home of another because of economic hardship;
        iii. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 30 days after the date of application for assistance;
        iv. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, state, or local government programs for low-income individuals;
        v. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        vi. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        vii. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.
    c. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (34 U.S.C. 11279(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (34 U.S.C. 12473(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(l) of the Food and Nutrition

Act of 2008 (7 U.S.C. 2012(l)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

d. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

3. Chronically Homeless

1. A homeless individual with a disability as defined in section 401, subdivision (10) of the McKinney-Vento Assistance Act (42 U.S.C. 11360(10)), who:

    a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and

    b. Has been homeless as defined in 7.C.4.1.1 Experiencing Homelessness and At Risk of Homelessness on any number of occasions in the last 3 years, as long as the combined occasions equal at least 12 months; or

2. An individual who is exiting an institution and met all of the criteria in paragraph (1) immediately prior to entering the institution regardless of the length of stay; or

3. A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2), including a family whose composition has fluctuated while the head of household has been homeless.

Appendix B: Coverage of Settings

	Assisted Living	Community Residential Treatment *(Settings eligible under BHCIP)*	Interim Housing	Housing
Settings	• Adult Residential Facilities (Licensure: CDSS) • Residential Care Facilities for the Elderly (Licensure: CDSS) • Licensed Board and Care (Licensure: CDSS)	• Adult Residential Substance Use Disorder (SUD) Treatment Facilities (Licensure: DHCS) • Children's Crisis Residential Programs (CCRP; Licensure: CDSS) • Peer Respite • Perinatal Residential SUD Facilities (Licensure: DHCS)	• Hotels/Motels • Peer Respite • Recovery Housing • Recuperative Care~ • Non-congregate interim housing models • Congregate settings with small number of individuals per room (i.e., not larger dormitory sleeping halls) • Short-Term Post-Hospitalization Housing~ • Tiny Homes, emergency	• Single-family and multi-family homes (e.g., apartments, duplexes, etc.) • Housing in mobile home communities • Accessory Dwelling Units (ADU) and Junior Accessory Dwelling units (JADUs) • Tiny Homes • Project-Based or Scattered Site Supportive Housing • Recovery/Sober living Housing • Apartments • Shared housing • License-exempt room and board

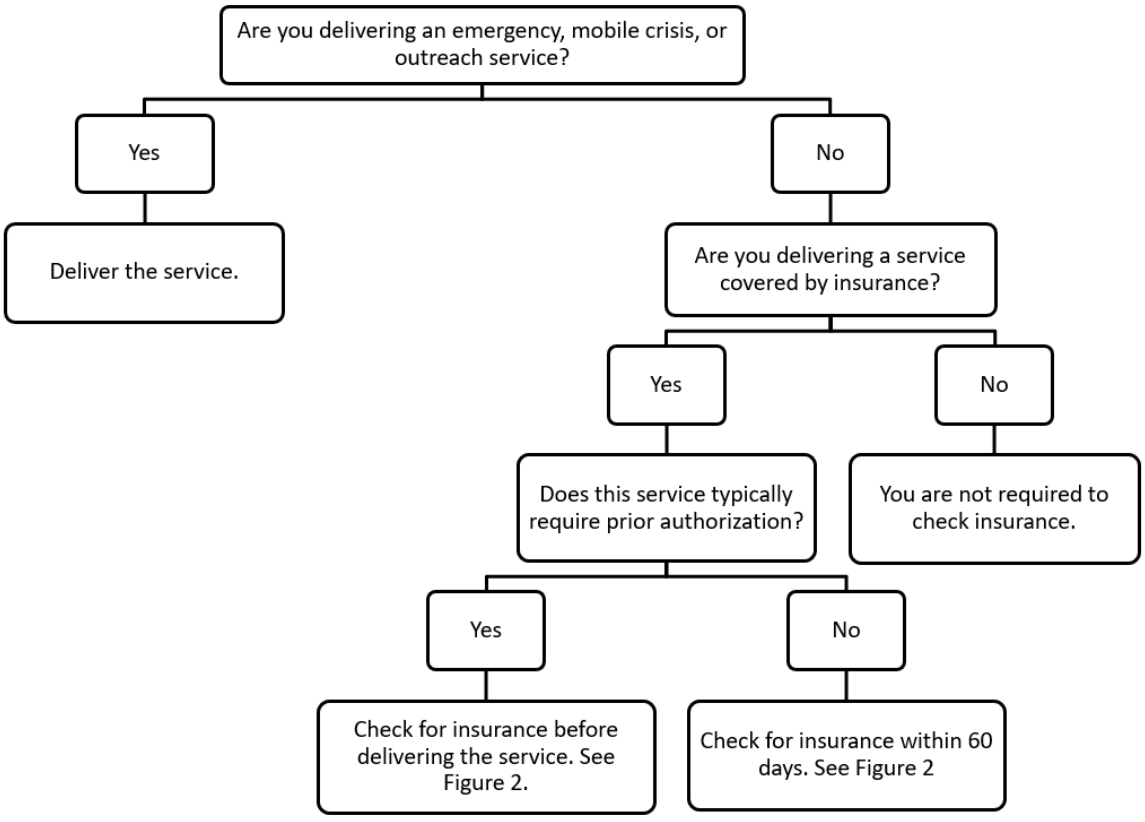
	Assisted Living	Community Residential Treatment *(Settings eligible under BHCIP)*	Interim Housing	Housing
			sleeping cabins, emergency stabilization units • Single room occupancy (SRO) units	• SRO units
BHT Housing Interventions	Yes	Peer respite only	Yes, can be used for an additional 6 months if member is receiving Transitional Rent under managed care or up to 12 months if member is not eligible for Transitional Rent. **The aim is to transition individuals to permanent housing as quickly as possible.**	Yes
Transitional Rent	No	Peer respite, when provided as transitional or recovery housing including bridge,	Yes (see note) *~Note: Transitional rent is not available for*	Yes

	Assisted Living	Community Residential Treatment *(Settings eligible under BHCIP)*	Interim Housing	Housing
		site-based, population-specific, and community living programs that may or may not offer supportive services and programming	*Recuperative Care and Short-Term Post-Hospitalization.*	

Appendix C: Promoting Access to Care through Efficient use of State and County Resources Appendices

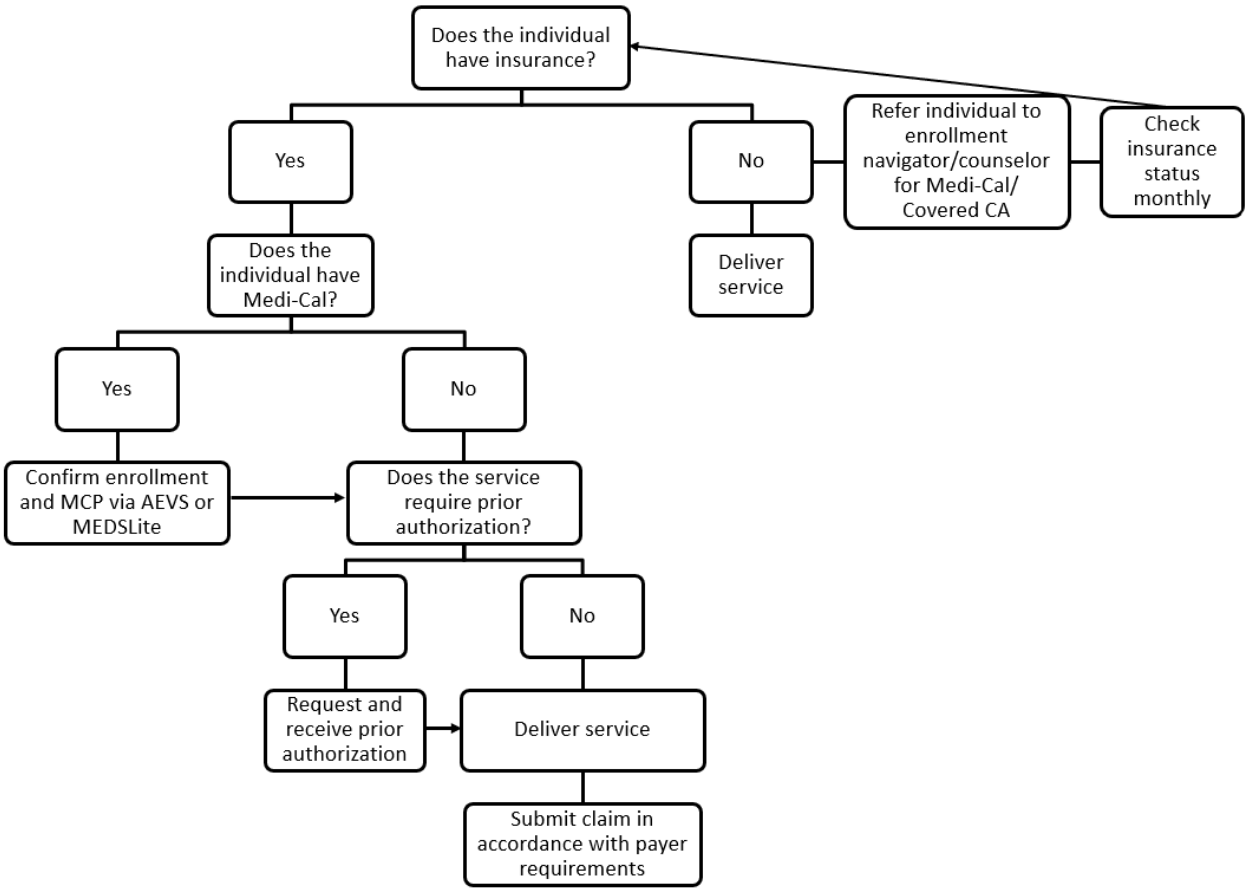
1. Process Flow for Behavioral Health Services Act-Funded Providers: Checking for and Billing Medi-Cal or Other Health Coverage

Appendix Figures C.1.1 and C.1.2 below bring together the requirements in overarching process flows for providers when seeking to bill Medi-Cal or Other Health Coverage. Appendix Figure C.1.1 displays the process for a Behavioral Health Services Act (BHSA)-funded provider to determine whether or not to check an individual's insurance coverage (public or commercial) in accordance with the policy described in this manual.



Appendix Figure C.1.1. Process flow to determine if BHSA-funded provider must check for an individual's insurance coverage.

For BHSA-funded providers who must check for public or commercial insurance as determined by Appendix Figure C.1.1 above, Appendix Figure C.1.2 is a process flow for individual BHSA-funded providers to check for and bill for public or commercial insurance.



Appendix Figure C.1.2. Process flow for BHSA-funded provider to check for and bill Medi-Cal or commercial insurance.

Commercial insurers require prior authorization for most services. In the event a provider obtains an individual's insurance information after the service, the provider may still pursue payment by seeking authorization and submitting a claim.

2. Medi-Cal Billing and Documentation Resources

The Department of Health Care Services (DHCS) acknowledges that standard Medi-Cal billing procedures outlined in Policy C.2.3 (Consistently Bill Medi-Cal) may be new for some providers. To support these providers, DHCS is providing a table summarizing current billing and documentation resources for Medi-Cal enrolled providers. DHCS also reminds counties that the fiscal policies outlined in this chapter do not supersede baseline licensing, certification, and credentialing requirements before a provider may deliver and/or bill Medi-Cal for behavioral health services (All individual practitioners must be credentialed according to credentialing requirements stated in BHINs 18-019 and 22-070.) All providers—Behavioral Health Services Act (BHSA)-funded or otherwise—must continue to meet applicable requirements.

Appendix Table C.2.1: Resources for Medi-Cal Billing and Documentation Requirements

Type of Resource	Description
DHCS	• DHCS releases and updates the Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and DMC Organized Delivery System (DMC-ODS) billing manuals, available on DHCS website MedCCC-Library and service rates at Medi-Cal Behavioral Health Fee Schedules. The service rates are the rates DHCS pays Medi-Cal Behavioral Health Delivery System (BHDS's) and are not the rates BHDS's necessarily pay contract providers. Providers are encouraged to negotiate rates. More information is described in the County Behavioral Health Directors' letter, "CalAIM Behavioral Health Payment Reform," December 14, 2023. • FAQs on Behavioral Health Payment Reform provide additional clarifications around claiming for services, Current Procedural Terminology (CPT) coding, Intergovernmental Transfers, payment methodologies, and fee schedules.
Authorization Resources	• BHIN 22-016 identifies prior authorization requirements for outpatient SMHS. • BHIN 24-001 describes prior authorization requirements for DMC-ODS. • BHIN-22-017 defines concurrent review standards for psychiatric inpatient hospital services and psychiatric health facility services.
Documentation Resources	• BHIN 23-068 describes DHCS' current documentation requirements for Medi-Cal behavioral health services.

Type of Resource	Description
California Mental Health Services Administration (CalMHSA)	• CalMHSA provides support to counties on the CalAIM transformation to implement a flexible, efficient, and effective administrative/fiscal structure, including resources on coding, documentation, and Payment Reform. • CalMHSA oversees a semi-statewide electronic health record (EHR) SmartCare for county behavioral health departments and provides technical assistance to counties billing Medi-Cal and commercial health plans through SmartCare, among several other supportive technical assistance programs.
Managed Care Plan (MCP) Resources	• APL-23-020 provides information on MCP obligations to timely pay for clean claims.
For specific Medi-Cal billing questions, providers may contact the Telephone Service Center, (800) 541-5555 (outside of California, 916-636-1980) or online at Contact Medi-Cal.	

3. Commercial Health Insurance Billing Guidance and Resources

When a commercially insured individual receives a BHSA-funded service that is covered or can be paid by the individual's commercial plan, counties must require that providers make a good faith effort to seek payment from the commercial plan (per WIC section 5891, subdivision (a)(3)(A)). This section provides additional detail for counties to support providers in consistently billing commercial health insurance (Policy C.3.2).

Contact the individual's commercial health plan for non-emergency services to confirm the following by calling the commercial health plan's provider services number listed on the member's identification (ID) card or the plans' webpage for providers. Have the member's name, date of birth, and ID number(s) available when you ask about:

1. ***Whether the plan covers this service provided by an out-of-network provider when prior authorization is obtained.*** If not, skip remaining steps and use BHSA funds.
2. ***Whether prior authorization is required.*** If so, submit a prior authorization request. (See below for additional discussion of prior authorization.)
3. ***What other billing and coding requirements apply*** for this service, including:
    a. Billing procedures
    b. Which billing codes to use
    c. Documentation requirements
    d. Special requirements for out-of-network billing, such as a specific billing form.
4. ***For higher-cost or longer-term services*** (such as inpatient detoxification or a residential program), what *coverage limits* the plan imposes (e.g., max covered days, or a requirement to request continuing authorization after a certain number of days), and whether the plan will pay the provider's standard rate.
    a. If the plan does not provide a clear answer or has a default rate significantly below the provider's standard rate, make a good faith effort to execute a single case agreement (as described below).

For an out-of-network provider to implement this policy after providing a service:

1. ***Submit a complete claim*** in accordance with HSC section 1371.35 and the commercial plan's requirements (e.g., using the plan's form for out-of-network billing, using the plan's required billing codes, or attaching any required documentation such as a prior authorization or single case agreement).
2. ***Bill at the provider's standard rate.*** The commercial plan may or may not agree to pay this rate, unless the provider and plan previously executed a single case or letter of agreement (DMHC regulations require commercial health plan to reimburse claims from out of network providers at a "reasonable and customary value for the health care services rendered" per 28 CCR section 1300.71(a)(3)(B).)
3. If the plan denies the claim, pays less than the agreed-upon amount, or delays payment past the legal deadline, pursue the plan's dispute resolution process (as required by HSC section 1367(h)(2)) and file a complaint with the state (as described below).

Prior Authorization. As under Medi-Cal, each health plan sets requirements for which services and prescription drugs require prior authorization, what information must be included in a request for prior authorization, and how prior authorization requests must be submitted.

- As the name suggests, prior authorization must be requested before the service is provided. If a provider furnishes services without seeking prior authorization, the plan will typically deny the claim, even if the provider otherwise complied with all applicable requirements. Additional notes on prior authorization:
- Prior authorization requirements are more common for higher-cost services than for lower-cost services and are more often required for out-of-network providers than for in-network providers.
- California requires health insurance plans to use prior authorization processes that assure the provision of covered services in a timely manner (as required by HSC section 1367.03. Depending on the plan, providers may be required or permitted to submit prior authorization requirements by mail, fax, and/or electronically. Providers may also need to check the status of the prior authorization request through plan-specific online portals For example, lists of services that require prior authorization are available on the following plan websites or portals: Health Net, Anthem, Blue Shield (list of services requiring PA), Blue Shield (general instructions on submitting PA).

Single Case Agreements, Letters of Agreement, and Network Contracts. Under certain circumstances, it may be most effective or efficient for an out-of-network provider to establish a more formal agreement with a commercial plan rather than simply submitting claims for out-of-network payment. These circumstances may include a treatment plan involving longer-term services (e.g., weekly services for several months) or higher-cost services (e.g., crisis, residential, or inpatient services). In addition, an agreement or contract with the health plan may be helpful to ensure claims are paid timely and at the agreed upon rate(s).

In these scenarios, the Department of Health Care Services (DHCS) encourages counties and providers to consider the following potential approaches:

1. ***Single Case Agreement (the definition can be found in Appendix C.):*** This type of agreement describes the terms of coverage and payment for an out-of-network provider delivering a single course of treatment to a single patient. These agreements are typically negotiated after the provider receives prior authorization for a service and/or before the provider begins furnishing services. However, each plan has its own policies and procedures for negotiating single case agreements.
2. ***Letter of Agreement (the definition can be found in Appendix C.):*** This type of agreement between a plan and out-of- network provider aims to avoid the need for multiple single case agreements. It may be used where a provider expects to treat multiple patients from the same plan, or where a single patient may need ongoing treatment over a longer time horizon, making it inefficient to continually amend the single case agreement to accommodate the evolving treatment plan. Like a single case agreement, letters of agreement define the terms of coverage and payment.
3. ***Network Participation Request from the Provider***: If a BHSA-funded provider has seen, or expects to see, multiple patients served by the same plan, it may be prudent for the provider to request to join the plan's provider network. DHCS expects this strategy may be more appropriate for larger providers offering clinical services covered under California's parity law and/or mobile crisis services as required by Senate Bill (SB) 855 and Assembly Bill (AB) 988. By participating in the plan's network, the provider would bypass many coverage restrictions and procedural requirements applicable to out-of-network providers. In addition, after being added to the plan's provider directory, the provider may gain

additional individuals covered by the plan. Most plans' provider websites include information about requesting to join the plan's network.

4. ***County-Facilitated Network Participation:*** Counties could explore the possibility of contracting with a commercial health plan on behalf of a group of BHSA-funded providers offering clinical or mobile crisis services (potentially including both county-operated and county-contracted providers). To pursue this option, counties may need to secure authorization from contracted providers to negotiate with plans on their behalf.

4. Other Non-Behavioral Health Services Act Funds Guidance and Resources

The fiscal policy outlined applies to the additional sources of funding that county behavioral health agencies utilize to deliver behavioral health services and supports other than Medi-Cal federal financial participation (FFP) and commercial insurance. The sources of funding are listed in Chapter 6, Section C.4 and described further below.

- **State funds**, including:
    - Realignment funds, which the state distributes to counties annually via formula. Counties use 1991 realignment funds for mental health services and 2011 realignment funds for both mental health and substance use disorder services. For additional information, see: Eligible services and programs outlined in the 1991 Realignment (WIC section 5600), 2011 Realignment, Rethinking the 1991 Realignment, and 2011 Realignment: Addressing Issues to Promote Its Long-Term Success.
    - State General Fund.
        - Counties may have other resources from State General Funds that are not impacted by this policy; for example, counties are eligible to apply for grants through the Children and Youth Behavioral Health Initiative (CYBHI) and CYBHI is an investment using State General Funds.
- Opioid settlement funds**,** as described in the California Opioid Settlements Allowable Expenditures resource.
- **Federal grants,** including:

- Block grants issued by the Substance Abuse and Mental Health Services Administration (SAMHSA), such as:
    - The *Community Mental Health Services Block Grant (MHBG),* which supports efforts to establish or expand an organized community-based system of care for providing mental health services to children living with serious emotional disturbances and adults living with serious mental illness.
    - The *Substance Use Prevention, Treatment and Recovery Services Block Grant (SUBG*, and referred to under federal law as SUPTBG), which funds authorized SUD prevention, treatment, and recovery support services.
    - *Projects for Assistance in Transition from Homelessness (SAMHSA PATH),* a federal matching grant that funds community based-outreach, mental health and substance abuse referral/treatment, case management, and other support services, as well as a limited set of housing services for adults who are homeless or at imminent risk of homelessness and have a serious mental illness.
- **Other sources of funding**, not otherwise mentioned, that county behavioral health agencies use to deliver services, such as non-federal grants and county general funds, and revenues collected from any fines or fees levied (such as those deposited in county Maddy and Statham funds, respectively), private grants, and community benefit funding from health systems.

Appendix D: Policy Manual Definitions

Behavioral Health Bridge Housing (BHBH): BHBH provides over a billion dollars in funding to county behavioral health agencies and tribal entities to operate bridge housing settings to address the immediate housing needs of people experiencing homelessness who have serious behavioral health conditions. The BHBH program was signed into law in September 2022 under Assembly Bill 179 and provides funding through June 30, 2027. Reference: Assembly Bill 179, 2022; Assembly Bill 107, 2024; BHBH

Behavioral health services: "Behavioral health services" means mental health services and substance use disorder treatment services, as defined in Section 5891.5. Reference: WIC section 5892, subdivision (k)(1)

California Environmental Quality Act (CEQA): The California Environmental Quality Act generally requires state and local government agencies to inform decision makers and the public about the potential environmental impacts of proposed projects, and to reduce those environmental impacts to the extent feasible. The laws and rules governing the CEQA process are contained in the CEQA statute (PRC Section 21000 and following), the CEQA Guidelines (California Code of Regulations, Title 14, Section 15000 and following), published court decisions interpreting CEQA, and locally adopted CEQA procedures. References: PRC Section 21000 and following; California Code of Regulations, Title 14, Section 15000 and following; California Environmental Quality Act

Commercial health plan: "Commercial health plan" means an individual health plan purchased on Covered California, or a group health plan sponsored by an employer, including both state-regulated group health plans and self-insured group health plans governed by the Employee Retirement and Income Security Act (ERISA). This term includes commercial plans regulated by both Department of Managed Health Care and California Department of Insurance. Reference: DMHC; Covered California; California Department of Insurance

Community Health Assessment (CHA): CHA is an assessment conducted by local health jurisdictions to systematically examine the health status indicators for a given population that is used to identify key problems and assets in a community. Reference: DHCS PHM Policy Guide; Alignment of Medi-Cal Managed Care Population Needs Assessment and Local Health Jurisdiction Community Health Assessments and Community Health Improvement Plans; Public Health Accreditation Board Standards and Measures

Community Health Improvement Plan (CHIP): CHIP is the output of the Community Health Assessment. The Community Health Improvement Plan is the action plan developed by Local Health Jurisdictions for how a community will use the data identified in the Community Health Assessment to improve health outcomes. Reference: DHCS PHM Policy Guide; Alignment of Medi-Cal Managed Care Population Needs Assessment and Local Health Jurisdiction Community Health Assessments and Community Health Improvement Plans; Public Health Accreditation Board Standards and Measures; WIC Section 5963.02, subdivision (b)(4)

Community-defined evidence-based practice (CDEP): CDEPs are an alternative or complement to evidence-based practices, that offers culturally anchored interventions that reflect the values histories and life experiences of the communities that the provider is providing services to. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time. Reference: WIC 5892, subdivision (k)(6)

Continuums of Care (CoCs): A regional or local planning body that coordinates housing and services funding for families and individuals experiencing homelessness. It is responsible for carrying out the responsibilities required under the CoC Program Interim Rule, including selecting a Homeless Management Information software solution and a Homeless Management Information System Lead. Reference: HUD Continuum of Care Program

County: "County" means the County Behavioral Health Department, two or more County Behavioral Health Departments acting jointly, and/or city-operated programs receiving funds pursuant to WIC 5701.5 References: WIC 5849.2, subdivision (f); WIC 5701.5

County Behavioral Health System: All county behavioral health programs, regardless of funding source. The umbrella term includes behavioral health delivery systems (BHDSs) for both Medi-Cal and the various non-Medi-Cal programs covered under County Performance Contracts (CPCs).

County Performance Contract Behavioral Health Delivery System: An entity or local agency that contracts with DHCS to provide behavioral health services and supports funded by sources other than Medi-Cal, including BHSA and federal SAMHSA grants.

Culturally responsive and linguistically appropriate: Culturally responsive and linguistically appropriate refers to the ability to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, gender

identity, sexual orientation, age, economic, or other disparities in mental health and substance use disorder treatment services access, quality, and outcomes. Reference: WIC 5840.6, subdivision (f)(1)

Department: "Department" means the State Department of Health Care Services. Reference: WIC 5963 subdivision (b)(2)

Evidence-based practice (EBP): EBPs are those with documented, empirical evidence (e.g., randomly controlled trials, peer-reviewed studies, and publications) of effectiveness in improving behavioral health. These programs and practices have been clinically reviewed and codified, meaning the practices have been manualized to ensure the fidelity of implementation in a variety of settings. At both the federal and state level, there are existing databases of EBP resources through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the California Evidence-Based Clearinghouse for Child Welfare (CEBC), respectively. Reference: DHCS CYBHI Grant Strategy, 2022

Homeless Management Information System (HMIS): HMIS is a local information technology system used to collect individual-, program-, and organization-level data on the provision of housing and services to individuals and families at risk of and experiencing homelessness. Continuums of Care are responsible for selecting an HMIS software solution that complies with HUD standards. Reference: WIC Section 8256; HMIS Requirements

HMIS Common Data Elements: Also referred to as Common Program Specific Data Elements, the common data elements have been cooperatively developed by HMIS Federal Partners and have multiple response categories for each element. Reference: HMIS Data Standards Manual

HMIS Universal Data Elements: HMIS Universal Data Elements are elements required to be collected by all projects participating in HMIS, regardless of funding source. Reference: HMIS Data Standards Manual

Local Health Jurisdiction (LHJ): "LHJ" means county health department or combined health department in the case of counties acting jointly or city health department within the meaning of Section 101185. Reference: (CA Health & Safety Code Section 124030(f)) & DHCSDOC-2067478743-514 (ca.gov); WIC Section 5963.01 subdivision (b)

Medi-Cal Behavioral Health Delivery System: An entity or local agency that contracts with DHCS to provide one or more categories of Med-Cal specialty behavioral health services: SMHS, DMC, and/or DMC-ODS benefits.

Medi-Cal Managed Care Plan (MCP): "Medi-Cal Managed Care Plan" means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of this chapter or Chapter 8 (commencing with Section 14200). Reference: WIC section 14184.101 subdivision (j)

Out-of-Network Provider: "Out-of-network provider" means a provider or group of providers who does not have a network provider agreement with the relevant public health insurance agency (e.g., DHCS or a County Behavioral Health Agency) or commercial health plan. A provider may be "out of network" for one insurance network but in the network with another one.

Population Needs Assessment (PNA): PNA is the mechanism that Medi-Cal Managed Care Plans use to identify the priority needs of their local communities and members and to identify health disparities. Reference: DHCS PHM Policy Guide; WIC section 5963.02, subdivision (b)(3)

Prudent Reserve: The prudent reserve is an account that counties may transfer a portion of their Behavioral Health Services fund monies into to ensure that the county can continue to provide services at the same level if their future funding decreases. References: WIC sections 5892(b)(1), 5892(b)(3), 5892(b)(4), and 5892(b)(5)(A)

Regional Partnership: "Regional Partnership" is defined as a group of county-approved individuals and/or organizations within geographic proximity that acts as an employment and education resource for the county behavioral health delivery system. The group may include educational and employment service entities, individuals and/or entities within the county behavioral health delivery system, and individuals and/or entities that have an interest in the county behavioral health delivery system, such as county staff, mental health or substance use treatment service providers, individuals receiving services, and their family members.

Reversion: Reversion refers to the process in which, other than Prudent Reserve dollars, Behavioral Health Services Act (BHSA) funds that are allocated to a county by the State Controller must be spent within a certain time period or the funds will revert back to DHCS for reallocation to other counties for future use. References: WIC 5892(b)(1), 5892(b)(3), 5892(b)(4), and 5892(b)(5)(A)

Single Case Agreement: "Single case agreement", sometimes referred to as a letter of agreement, means an agreement for reimbursement reflecting the terms and conditions of payment, including the payment amount, between a plan and provider for one

episode of care for one patient, when the provider is out-of-network or the treatment is not covered under the patient's plan. Agreements may be developed with Medi-Cal Managed Care Plans (MCPs), commercial health plans, and/or other health plans that differentiate in-network and out-of-network service providers.

Substance Use Disorder: Substance use disorder means an adult, child, or youth who has at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders. For purposes of this manual, substance use disorder treatment services include harm reduction, treatment, and recovery services, including all federal Food and Drug Administration approved medications. Reference: WIC 5891.5.

Subcontractor: "Subcontractor" means an individual or entity that has a contract with a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), or Primary Care Case Manager (PCCM) entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. Reference: Title 42 CFR 438.2

Supportive housing: Supportive housing means housing with no limit on the length of stay that is occupied by the target population, and that is linked to onsite or offsite services that assist the supportive housing resident in retaining the housing, improving their health status, and maximizing their ability to live and, when possible, work in the community. References: WIC 5830(b)(2)(C); HSC 50675.14; HSC 50675.2(h)

Supportive Services: Supportive Services refers to services necessary to support individuals' recovery and wellness, including, but not limited to, food, clothing, linkages to needed social services, linkages to programs administered by the federal Social Security Administration, vocational and education-related services, employment assistance, including supported employment, psychosocial rehabilitation, family engagement, psychoeducation, transportation assistance, occupational therapy provided by an occupational therapist, and group and individual activities that promote a sense of purpose and community participation. Reference: WIC 5887, subdivision (h)(3)

Underserved cultural populations: Underserved cultural populations refers to those who are unlikely to seek help from providers of traditional mental health and substance use disorder services because of stigma, lack of knowledge, or other barriers, including members of ethnically and racially diverse communities, members of the lesbian, gay,

bisexual, transgender, queer and/or questioning (LGBTQ+) communities, victims of domestic violence and sexual abuse, and veterans, across their lifespans. Reference: WIC 5840.6, subdivision (f)(2)

Use by right: Use by right refers to a capital development project that satisfies both of the following conditions: (A) The development project does not require a conditional use permit, planned unit development permit, or other discretionary local government review. (B) The development project is not a "project" for purposes of Division 13 (commencing with Section 21000) of the PRC." Reference: WIC 5831, subdivision (e)(2)

Appendix E: Behavioral Health Services Act Biennial Early Intervention Evidence-Based Practices and Community-Defined Evidence Practices List

DHCS developed a list of Early Intervention Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices (CDEPs). Counties may implement EBPs and CDEPs not on the biennial list based on their local needs and community preferences. DHCS will update this list every two years (see Chapter 7, section A.7.6.1).

EBPs and CDEPs are categorized below but may be used for a different population or behavioral health category, as appropriate. Some EBPs and CDEPs are included in multiple categories.

The following are criteria used for inclusion of EBPs and CDEPs in the biennial list:

- Availability of public materials and information about the EBP or CDEP, including an overview of the evidence base, details on how the program or intervention is structured, and information on how to implement.
- Availability of trainings on implementing the EBP or CDEP or sufficient informational resources for counties to adapt locally.
- Primary focus of the EBP or CDEP is on Early Intervention, as defined in the County Policy Manual, and fits in a category of Indicated (prevention) or Case Identification (treatment) on the Institute of Medicine's Continuum of Care and Spectrum of Early Intervention Services, as shown in Figure 7.A.1. EBPs and CDEPs may include some population-based prevention or treatment/recovery elements but are primarily focused on key areas of Early Intervention for individuals. Counties will still be able to fund EBPs and CDEPs that may have very limited population-based prevention components or treatment/recovery elements in full with BHSS funds only if the EBP or CDEP is on this list.

1. Children and Youth EBPs and CDEPs

Programs listed with an (*) below indicate a CDEP.

Mental Health

*A.C.O.R.N. Youth Wellness Program

AFFIRM Youth

allcove

*Aunties and Uncles Program

Blues Program

Bounce Back

Child and Family Traumatic Stress Intervention (CFTSI)

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Crossover Youth Practice Model

*Cultivating Acceptance Program (CAP) for LGBTQ+ Youth (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

Depression Treatment Quality Improvement (DTQI)

*Experience Hope for Teens (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

Felton Institute (re)MIND® Central

*GroundWork Program (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

Honoring Children, Mending the Circle (HC-MC)

Incredible Years

Infant and Early Childhood Mental Health Consultation

*San Francisco Community Health Center's Let's Connect (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

Mental Health Skill-Building Training Program

Mobile Response and Stabilization Services (MRSS)

OCAPICA Project HOPE

Pediatric Primary Care Behavioral Health (Pediatric PCBH)

Reconnecting Youth Program (RY)

*Safe Passages Law and Social Justice Career Program

Strong Beginnings

*The Sweet Potato Project (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

*T.R.I.B.E. (Turning Resilience Into Brilliance for Eternity)

UCLA Training, Intervention, Education, Services (TIES) for Families

*Youth Promotor Internship Program (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

Substance Use Disorder

Adolescent Community Reinforcement Approach (A-CRA)

Assertive Continuing Care (ACC)

Brief Alcohol Screening and Intervention of College Students (BASICS)

*Brief Risk Reduction Interview and Intervention Model (BRRIIM)

Early Risers "Skills for Success" Risk Prevention Program

Marijuana Brief Intervention

Teen Intervene

Co-occurring

Curriculum-Based Support Group (CBSG) Program

Early Psychosis Prevention and Intervention Centre (EPPIC)

Multisystemic Therapy (MST)

*The Oasis Model (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

Residential Student Assistance Program (RSAP)

*Sunnyside Mindfulness Club

2. Family-Centered EBPs and CDEPs

Programs listed with an (*) below indicate a CDEP.

Mental Health

*Centro de Apoyo Latino Program (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

Child Parent Psychotherapy (CPP)

Crisis Oriented Recovery Services (CORS)

*Cultura de Salud (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

EarlyStart Wellness Initiative

Effective Black Parenting Program

Family Acceptance Project

Family Centered Treatment

Family Check-Up

Family Connections (FC)

Family Spirit

Foothill Family's Healthy Futures Program

Functional Family Therapy (FFT)

*Indian Health Centers Strengthening Youth and Families (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

Mom Power®

Multidimensional Treatment Foster Care (MTFC)

*NAMI Family-to-Family

Parent Child Interaction Therapy (PCIT)

Parenting Wisely

*Parent-Practitioner Partnership Model

Portland Identification Early Referral Model (PIER)

*Positive Indian Parenting

Reflective Parenting Program (RPP)

The Strengthening Families Programs (SFP)

Structured Sensory Intervention for Traumatized Children, Adolescents, and Parents (SITCAP-ART)

Triple P - Positive Parenting Program (Triple P)

Substance Use Disorder

Behavioral Couples Therapy (BCT)

Caregiver Guide: Healthy Youth: Early Intervention Services for Youth At Risk of Substance Use Behaviors

Celebrating Families (CF)

Community Reinforcement and Family Training (CRAFT)

Creating Lasting Family Connection (CLFC)

Co-occurring

Brief Strategic Family Therapy (BSFT)

Culturally Informed and Flexible Family Treatment for Adolescents (CIFFTA)

Homebuilders

Integrated Co-Occurring Treatment (ICT)

Multisystemic therapy (MST)

Multidimensional Family Therapy (MDFT)

Nurturing Parenting Program (NP)

3. Adults and Older Adults EBPs and CDEPs

Programs listed with an (*) below indicate a CDEP.

Mental Health

Attachment and Biobehavioral Catch-Up (ABC)

Cognitive-Behavioral Interventions for Substance Use Adult (CBI-SUA)

Collaborative Care Model

*Convivencia

*The Essence of MANA Pacific Islander Project (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

FamilyWell: A Prevention and Early Intervention Initiative

Interpersonal Psychotherapy (IPT)

Mobile Crisis, including use of tools such as the Columbia Suicide Severity Rating Scale or the Stanley-Brown Safety Plan

The Mothers and Babies Course "Mamás y Bebés"

*NAMI Homefront

*Openhouse (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

Parents as Teachers (PAT)

Prevention of Suicide in Primary Care Elderly (PROSPECT)

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders

SafeCare

Shifa for Today Peer Counseling Program

Written Exposure Therapy (WET)

*The Zoosiab Program

Substance Use Disorder

Contingency Management (CM)

The Matrix Model

Motivational Interviewing (MI) and Motivational Enhancement Therapies (MET)

Parent Child Assistance Program (PCAP)

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Co-occurring

Common Elements Treatment Approach (CETA)

Trauma Recovery and Empowerment (TREM)

4. General EBPs and CDEPs

Programs listed with an (*) below indicate a CDEP.

Cross-Cutting Therapeutic Approaches

Acceptance and Commitment Therapy (ACT)

Cognitive Behavioral Therapies (CBT)

Holistic-based Recovery Services for Early Intervention

Motivational Interviewing (MI) and Motivational Enhancement Therapies (MET)

Relapse Prevention (RP/MBRP)

Twelve-Step Facilitation (TSF)

Mental Health

*Culture as Treatment

*The Community Wellness Program

*Cultura y Bienestar Program

Dialectical Behavior Therapy

Eye Movement Desensitization and Reprocessing (EMDR)

*Gender Health Center

*Living With Love

Managing and Adapting Practice (MAP)

*Mending Broken Hearts

*Mente Sana, Vida Sana Project

Mentalization-Based Therapy (MBT)

*Native Talking Circles

Problem Solving Treatment (PST)

*Traditional Healer Services and Natural Helper Services

Substance Use Disorder

Community Reinforcement (CRA, A-CRA, CRAFT)

Drug counseling (individual and group)

*Drum-Assisted Recovery Therapy for Native Americans (DARTNA)

Early Intervention Overdose Response and Navigation

Relapse Prevention (RP/MBRP)

Twelve-Step Facilitation (TSF)

Co-occurring

*The American Indian Traditional Treatment and Recovery Healing Model (Friendship House Model) (California Reducing Disparities Project Phase 2 Statewide Evaluation Report)

Cognitive Behavioral Approaches (for SUD and MH)

Collaboration Leading to Addiction Treatment and Recovery from Other Stresses Manual (CLARO)

*Gathering of Native Americans (GONA)

Hazelden Co-occurring Disorders Program

Seeking Safety (SS)

Wellness Recovery Action Plan (WRAP)

Appendix F: Acronym List

AB	Assembly Bill
ACEs	Adverse Childhood Experiences
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADLs	Activities of Daily Living
ADU	Accessory Dwelling Units
AEVS	Automated Enrollment Verification System
AHAR	Annual Homeless Assessment Report to Congress
AHRQ	Agency for Healthcare Research and Quality
APH	Acute Psychiatric Hospital
API	Application Programming Interface
APL	All Plan Letter
ARER	Annual Revenue and Expenditure Report
ARF	Adult Residential Care Facilities
ASAM	American Society of Addiction Medicine
AU	Annual Update
BBS	Board of Behavioral Sciences
BH	Behavioral Health
BHAS	Behavioral Health Accountability Set
BHBH	Behavioral Health Bridge Housing
BHCIP	Behavioral Health Continuum Infrastructure Program

BH-CONNECT	Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment
BHDS	Behavioral Health Delivery System
BHIN	Behavioral Health Information Notice
BHOATR	Behavioral Health Outcomes, Accountability, and Transparency Report
BHSA	Behavioral Health Services Act
BHSF	Behavioral Health Services Fund
BHSOAC	Behavioral Health Services Oversight and Accountability Commission
BHSS	Behavioral Health Services and Supports
BHT	Behavioral Health Transformation
BIC	Benefits Identification Card
Bond BHCIP	Behavioral Health Infrastructure Bond Act of 2023 BHCIP awards
BRFSS	Behavioral Risk Factor Surveillance System
CA EDD	California Employment Development Department
CalAIM	California Advancing and Innovating Medi-Cal
CalICH	California Interagency Council on Homelessness
CAO	County Administrative Officer
CAP	Corrective Action Plan
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARE	Community Assistance, Recovery, and Empowerment
CBHDA	County Behavioral Health Directors Association of California
CCE	Community Care Expansion

CCRP	Children's Crisis Residential Programs
CDCR	California Department of Corrections and Rehabilitation
CDE	California Department of Education
CDEP	Community-Defined Evidence Practice
CDI	California Department of Insurance
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CEBC	California Evidence-Based Clearinghouse for Child Welfare
CEQA	California Environmental Quality Act
CES	Coordinated Entry System
CFR	Code of Federal Regulations
CFTN	Capital Facilities and Technological Needs
CHA	Community Health Assessments
CHAT	Community Health Asses and Treat
CHIP	Community Health Improvement Plan
CHIS	California Health Interview Survey
CHKS	California Healthy Kids Survey
CMS	Centers for Medicare & Medicaid Services
CoC	Continuum of Care
CPC	County Performance Contract
CPS	Consumer Perception Survey
CPT	Current Procedural Terminology

CSC for FEP	Coordinated Specialty Care for First Episode Psychosis
CSS	Community Services and Supports
CWIP	California Child Welfare Indicators Project
CYBHI	Children and Youth Behavioral Health Initiative
DEA	Drug Enforcement Administration
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DMHAS	Division of Mental Health and Addiction Services
DMHC	Department of Managed Health Care
DO	Doctor of Osteopathic Medicine
DOF	Department of Finance
DOJ	California Department of Justice
DSH	California Department of State Hospitals
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSS	Department of Social Services
EBP	Evidence-Based Practice
ECM	Enhanced Care Management
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
EPI	Early Psychosis Intervention

EPSDT	Early and Periodic Screening, Diagnostic and Treatment
ERF	Encampment Resolution Fund
ERISA	Employee Retirement and Income Security Act
ESMI	Early Serious Mental Illness
FACT	Forensic Assertive Community Treatment
FDA	Food and Drug Administration
FFP	federal financial participation
FMR	Fair Market Rent
FQHC	Federally Qualified Health Center
FSP	Full Service Partnership
FUA-30	Follow-Up After Emergency Department Visit for Substance Use
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness
FY	Fiscal Year
GACH	General Acute Care Hospital
GED	General Education Development
GOV	Government Code
HCAI	Department of Health Care Access and Information
HCD	California Department of Housing and Community Development
HDIS	Homelessness Data Integration System
HFW	High Fidelity Wraparound
HHAP	Homeless Housing Assistance and Prevention Grant Program
HHIP	Housing and Homelessness Incentive Program

HIC	Housing Inventory Count
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HMIS	Homeless Management Information System
HSC	Health and Safety Code
HUD	Department of Housing and Urban Development
ICM	Intensive Case Management
ID	Identification
I/DD	intellectual/developmental disabilities
IMD	Institutions for Mental Disease
INN	Innovation
INS	Insurance Code
IP	Integrated Plan
IPS	Individual Placement and Support
ISSP	Individual Services and Support Plan
IST	Incompetent to Stand Trial
JADUs	Junior Accessory Dwelling units
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning
LHJ	Local Health Jurisdiction
MAT	Medications for Addiction Treatment
MCAS	Managed Care Accountability Set
MCO	Managed Care Organization

MCP	Managed Care Plan
MD	Doctor of Medicine
MEDS	Medi-Cal Eligibility Data System
MEDSLITE	Medi-Cal Eligibility Data System Lite
MH	Mental Health
MHBG	Community Mental Health Services Block Grant
MHRC	Mental Health Rehabilitation Center
MHSA	Mental Health Services Act
MHSF	Mental Health Services Fund
MHSOAC	Mental Health Services Oversight and Accountability Commission
MOUD	Medication for Opioid Use Disorder
NP	Nurse Practitioner
NPLH	No Place Like Home
NSMHS	Non-Specialty Mental Health Services
NSPIRE	National Standards for the Physical Inspection of Real Estate
NTPs	Narcotic Treatment Programs
O&E	Outreach and Engagement
OHC	Other Health Coverage
PA	Physician Assistant
PAHP	Prepaid Ambulatory Health Plan
PATH	Projects for Assistance in Transition from Homelessness
PAVE	Provider Application and Validation for Enrollment

PBH	Project-Based Housing
PCCM	Primary Care Case Manager
PEI	Prevention and Early Intervention
PHAB	Public Health Accreditation Board
PHF	Psychiatric Health Facility
PHM	Population Health Management
PIHP	Prepaid Inpatient Health Plan
PIT	Point-in-Time
PNA	Population Needs Assessment
PR	Prudent Reserve
PRC	Public Resources Code
PSH	Permanent Supportive Housing
QEAC	Quality and Equity Advisory Committee
QRT	Quick Response Teams
RCFE	Residential Care Facilities for the Elderly
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SCO	State Controller's Office
SED	Serious Emotional Disturbance
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness

SNF	Skilled Nursing Facility
SPA	State Plan Amendment
SRO	Single room occupancy
STPs	special treatment programs
SUBG	Substance Use Prevention, Treatment, and Recovery Services Block Grant
SUD	Substance Use Disorder
TAY	Transitional Age Youth
TK	Transitional Kindergarten
TPLRD	Third-Party Liability and Recovery Division
TPS	Treatment Perceptions Survey
TTA	Training and Technical Assistance
USC	United States Code
WIC	Welfare and Institutions Code
WET	Workforce Education and Training

Navigating the BHSA Policy Manual

Accessing the Cited Statutes and Regulations

The BHSA County Policy Manual references relevant sections of California and federal statute and regulations to support implementation of program requirements.

Users may access California state statutes referenced in the Policy Manual through the California Legislative Information website at leginfo.legislature.ca.gov. This includes Welfare and Institutions Code (WIC), Health and Safety Code (HSC), Public Resources Code (PRC), Insurance Code (INS), and Government Code (GOV). To locate a specific statute, go to "Quick Code Search," select the applicable Code from the drop-down menu, enter the Code section, and press "Go." The subdivision can be found within the text of the Code section.

Example: WIC section 5600.3, subdivision (b)(2)

- Quick Code Search: select "WIC"
- Code section: 5600.3
- Press "Go," and scroll to subdivision (b)(2)

Users may access state regulations referenced in the Policy Manual in the California Code of Regulations at govt.westlaw.com/calregs/Search/Index. To locate a specific regulation, enter the title (the number before "CCR") and the section (the number following "CCR"), and press "Search." The subsection can be found within the text of the regulation.

Example: 9 CCR section 3420.65, subsection (a)

- Title: 9
- Section: 3420.65
- Press "Search," and scroll to subsection (a)

Users may access federal statutes referenced in the Policy Manual in the United States Code at uscode.house.gov. To locate a section of the Code, go to "Jump To," enter the title (the number before "U.S.C.") and the section (the number following "U.S.C."), and press "Go." The search function allows users to include subsections (the text after the section number) in the "Section" search box.

Example: 42 U.S.C. 11434a(2)

- Jump To:

        - Title: 42
        - Section: 11434
            - Users may include the subsection (e.g., “a(2)”) in the “Section” search box to navigate to the exact location
    - Press “Go”

Users may access federal regulations referenced in the Policy Manual at www.eCFR.gov. To locate a regulation, enter the cited regulation in the search bar at the top of the page, beginning with the title (the number before “CFR”), the section or part number (the number following “CFR”), and press the “Enter” key. Users can include the subpart in the search; the subpart must be properly capitalized to find the correct section.

Example: 2 CFR 200

- Enter “2 CFR 200” in the search bar
- Press the “Enter” key