California Behavioral Health Planning Council

ADVOCACY • EVALUATION • INCLUSION

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RE: **Proposed BHSA County Policy Manual Performance Measures**

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Dear Marlies and Behavioral Health Transformation team,

The California Behavioral Health Planning Council (CBHPC) serves as an advisory body to the Legislature and the Administration on behavioral health policies and priorities, as outlined in Welfare and Institutions Code §§ 5771 and 5772. In alignment with its statutory responsibilities under the Behavioral Health Services Act (BHSA) §§ 5604.2 (a), 5610 (a) (1), 5610 (b) (1), and 5664 (a), the Council plays a critical role in reviewing county performance outcome data, advising on reporting requirements, and collaborating with state agencies to improve and standardize behavioral health practices.

The Council has reviewed the first set of proposed Behavioral Health Services Act (BHSA) County Policy Manual Performance Measures released by the Department of Health Care Services (DHCS) on November 17, 2025.

We appreciate DHCS incorporating some recommendations from the Council's Population-Level Behavioral Health Measures Letter, dated February 17, 2025. We kindly request that DHCS review and consider the recommendations that were not adopted, which include the following topics:

- Include more individuals with lived experience on the Quality and Equity Advisory Committee (QEAC) and a statement

acknowledging that these individuals should be involved in developing and implementing the goals and measures.

- Explanatory examples in the release of statewide goals and measures to help the public understand the implications of the chosen outcome measures.
- Stratification of the measures by payer type with side-by-side comparisons of commercial plans, Managed Care Plans, Behavioral Health Plans, and ongoing funded projects by DHCS.
- Measure of system partner accountability, including data points from county Behavioral Health Plans and commercial plans.
- Definition of institutionalization under the Behavioral Health Transformation (BHT) and a measure based on this definition.
- Establish a metric that mandates education and referral to treatment after each overdose, ensuring links to community providers.
- Requirement for all providers receiving funding to meet timeliness standards, ensuring individuals experiencing an overdose are promptly triaged and have access to treatment.
- Recommendation for DHCS to dedicate time to inventory all grant-funded projects and evaluate their data collection processes.
- Establish a standardized method for collecting and integrating data from projects to ensure a more accurate and comprehensive understanding of substance use disorder trends and outcomes.

The Council thanks DHCS for consulting with the QEAC to develop the draft measures with opportunities for public comment. We urge DHCS to prioritize the comments of individuals with lived experience and their families and include them in each phase of the planning and implementation process. Additionally, we strongly recommend that the DHCS extend the public comment periods in the future **to at least 30 days**, in alignment with federal standards. This approach helps ensure adequate time to review proposals, gather meaningful input, and organize thoughtful recommendations.

The Council has concerns regarding the proposed outcome measures and the impacts of changes to Medi-Cal enrollment requirements on data accuracy. Specifically, the extensive new reauthorization requirements outlined in the Notice of Funding Opportunity (NOFO) and the passage of House of Representatives (H.R.) 1 pose significant barriers to enrollment. These changes, such as work requirements or the need to obtain

Supplemental Security Income (SSI) certification, make it exceptionally difficult for vulnerable populations (e.g., individuals experiencing homelessness or those with severe substance use disorders) to maintain continuous Medi-Cal coverage. Consequently, using Medi-Cal data as the primary source for outcome measures, as currently proposed, will yield inaccurate results. The proposal also includes data points involving BHSA populations, which will likely not be part of Medi-Cal Connect because of the eligibility issues that create extra work for county behavioral health departments and local entities to obtain this information.

Additionally, many proposed measures fall outside the jurisdiction of county behavioral health departments and are overseen by the Managed Care system. For example, the measure *BH-12, Depression Screening and Follow-Up for Adolescents and Adults*, illustrates a mixed measure of primary care and behavioral health, as most individuals are screened for depression by their Primary Care physician. This can confuse stakeholders and the public about which entity is responsible for addressing the issues reflected in the data. Therefore, we recommend that the parties responsible for each outcome measure be clearly defined in the BHSA County Policy Manual.

Additional Comments Regarding Federal Policy Impacts

It is uncertain how changes in federal funds might affect access to care. The Council recommends that DHCS examine the future of funding, including Realignment and other public funding sources in California. The federal policy changes introduced by NOFO and the passage of H.R. 1 in 2025 impact California's public health budget and those served by the public safety net. For example, H.R. 1 results in a $30 billion annual loss in Medi-Cal funding, risking coverage for up to 3.4 million residents in California. These budget cuts also limit access to care and create uncertainty for providers and patients, as noted in the California Budget and Policy Center's article, *How Federal Funding Cuts Threaten the Health of Californians*. The California Health Care Foundation (CHCF) also published an article, *How Massive Federal Cuts Will Create Unprecedented Challenges for Medi-Cal Patients and Providers*, stating that H.R. 1 restricts California's ability to use state-directed payments to supplement Medicaid reimbursements, which could weaken safety-net providers, especially in rural areas. We request that DHCS examine this area in collaboration with stakeholders to identify solutions to the impacts of federal budget cuts and changes to eligibility requirements.

Reduced Access for Immigrant Populations

Due to recent changes in federal eligibility and funding, immigrant communities are likely to experience decreased access to essential behavioral health supports. About 20% of families in California have mixed immigration statuses, and nearly all children in these families are U.S. citizens. However, the fear of deportation affects their decision to seek care. Community Health Workers, as mentioned in the CHCF article *Fears Over Past Immigration Policies Chill Medi-Cal Enrollment,* share that many immigrants refuse to enroll in Medi-Cal because they fear deportation or the risk of jeopardizing their family's legal status. We request that DHCS review this area with stakeholders to find solutions, as the data is only as valuable as its accuracy.

Improve Data Timeliness and Collection

The Council would like to bring to your attention that the data is currently two years old. The delay in data collection impacts the ability to make future projections. There is also insufficient data collection to support the new metrics that will be evaluated. Rather than eliminating current measures, the Council recommends that DHCS compile a list of specific concerns and recommendations to improve current data measures to ensure that the data narrative reflects system performance. Additionally, we suggest that the reported data be made publicly available for analysis in a timely manner to support local planning processes. These recommendations align with statements made by the County Behavioral Health Directors Association (CBHDA) and the California Coalition for Behavioral Health (CCBH).

New and Adapted Measures

In line with comments made by the CCBH, the Council recommends that DHCS distinguish data for individuals with behavioral health needs from data for those with significant behavioral health needs in the new outcome measures. Additionally, we suggest that DHCS create future opportunities for stakeholders to consider adding new measures and modifying current ones. We also request that DHCS provide transparent information to stakeholders about how the new measures are being developed, the reasons for creating them, and the process for addressing errors when faulty data is generated.

How Performance Measures Are Calculated

The Council wants to emphasize that the quality of the data collected will significantly impact how it can be utilized and the resources available to address gaps and needs in the public behavioral health system. We request that calculations related to performance measures that DHCS plans to provide to counties each month be shared with the Council and public stakeholders on a quarterly basis. The Council has an ongoing interest and responsibility to review data, as outlined in Welfare and Institutions Code (WIC) 5772. Additionally, we suggest that DHCS consider the status of pending claims and non-billable services for the claims data for calendar year (CY) 2025 when assessing the completeness of the data included in the performance measures.

How Performance Measures Will Be Used

Population Health

Regarding the request for DHCS to provide person-level data on individuals in each county identified as experiencing homelessness, the Council notes that it is challenging for individuals to access the behavioral health system. A Release of Information (ROI) is necessary to collect this data for people who are not in the Human Resources Information System (HRIS). Therefore, it may be difficult or unrealistic for DHCS to obtain person-level data for homeless individuals within population health. We recommend that the state improve this area in line with the defined population health goals.

BHSA Accountability

The Council recommends broadening the forum for counties to explain their performance measures by including community stakeholders to help them understand data points. The community should receive information that clarifies various systems, including the roles of County Behavioral Health Agencies, Managed Care Plans, private insurance coverage, and details specific to different health plans. We also suggest providing the public with information about the removal of children from their homes, clarifying when removal should occur, and addressing the complex causes of homelessness and justice involvement. Lastly, we recommend sharing information with stakeholders about federal activities that will impact performance in the coming years, such as hospital closures due to changes in the Health Maintenance Organization (HMO) tax and sanctions

related to providing services to individuals eligible under new federal rules. These recommendations align with our partners at the CCBH.

Regarding the statement on action plans, we suggest clarifying the language to state that "DHCS does not plan to issue Corrective Action Plans (CAPs) for performance measures until after the first year of the second IP period (July 2029)." Explicitly including the month and year in the statement would provide clearer guidance to stakeholders. The Council also highlights the importance of reevaluating performance measures before enacting any penalties.

Recommendations for Proposed Performance Measures

- Improving Access to Care, Reducing Untreated Behavioral Health Conditions, and Improving Care Experience: The Council agrees with the comments from the California Coalition for Behavioral Health (CCBH), which recommends that DHCS collect, differentiate, and communicate data on both access measures and performance outcomes across all categories in this section. This approach will help maintain a focus on equity by tracking outcomes while considering factors such as race/ethnicity, age, LGBTQIA2S+ status, homelessness, and justice involvement.

- BH-1. One or More Behavioral Health Core Clinical Services for Persons Living with Mental Health Needs: The Council recommends that DHCS clarify whether this data point applies only to outpatient services or if it also includes Medi-Cal reimbursable inpatient service claims or all services, regardless of whether the claim is on the Managed Care side or a county Behavioral Health Plan.

- BH-3. Initiation of Substance Use Disorder (SUD) Treatment: The term "initiation of SUD treatment" in this data point appears to mainly refer to Medication-Assisted Treatment (MAT) services. We request DHCS to clarify whether the treatment includes any SUD services, such as residential and outpatient programs.

- BH-5: Three or More Behavioral Health Core Clinical Services for Persons Living with Significant Mental Health Needs: It is unclear whether this data measure includes claims from county Behavioral Health Plans and Managed Care claims. We recommend DHCS

clarify what is meant by “other county behavioral health services” in the description for BH-5, and whether the data measure includes claims for individuals with mild-to-moderate behavioral health conditions served in the Managed Care system. Further, whether it includes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) data for children.

- BH-6. Three or More Behavioral Health Core Clinical Services for Persons Living with Significant Mental Health Needs: The Council recommends that DHCS clarify that this data measure includes outpatient services.

- BH-7. Engagement in SUD Treatment: We ask DHCS to provide stakeholders with clarity on why the number of days after treatment initiation is 34 days.

- HO-1. Homelessness Amongst People Living with Significant Behavioral Health Needs Compared to the Overall Population: This measure is the responsibility of multiple systems. For instance, there is already an Interagency Council on Homelessness that may look at this issue. The Council recommends that a clear statement be included in the document stating that data on homelessness is a multi-party responsibility, and that DHCS examine the quality of homelessness data.

- HO-2. Permanent Housing for Persons Living with Behavioral Health Needs Who Are Experiencing Homelessness: The Council wants to highlight that the Fiscal Year (FY) 2025 Continuum of Care (CoC) Notice of Funding Opportunity (NOFO) makes significant changes to how the federal government funds homelessness assistance programs, including a major budget cut for permanent housing programs from 87% to 30%. The NOFO could put as many as 170,000 people relying on CoC at risk of returning to homelessness. This federal policy will affect this measure, so we recommend that DHCS consider this federal change when evaluating this data measure.

  This measure only includes individuals who have achieved housing within a 12-month period with complete data. In line with

recommendations from the CCBH, the Council suggests that this data measure incorporate 1) reduction in the number of days of homelessness for individuals served by county behavioral health agencies within a 12-month period and 2) the percentage of individuals served by these agencies who have remained stably housed for over 12 months, such as those in Full-Service Partnerships and other wraparound programs. We also recommend that county behavioral health departments continue tracking reductions in Emergency Room Visits, the number of episodes for individuals receiving Crisis Stabilization Services, and the number of episodes and days of hospitalizations related to homelessness.

- IN-3. Transitions of Care Support for Persons In or Exiting Institutional Settings: The Council recommends adding more treatment facilities that offer transition of care support. We request that DHCS specifically includes social rehabilitation facilities in the list of institutions for this measure.

- Reducing the Removal of Children from the Home Section: We recommend that DHCS collaborate with stakeholders to determine when removing a child from their home is necessary and whether such removal is connected to behavioral health needs. Additionally, we recommend that the data highlight the balance between essential removals and those that could have been avoided with additional support and services.

- JI-1. Justice-Involvement Among People Living with Significant Behavioral Health Needs Compared to the Overall Population: This data measure only considers one episode of recidivism within 12 months of arrest and/or release from incarceration. In line with the CCBH, the Council recommends that the data reflect how many arrests and/or incarcerations occurred for justice-involved individuals during a 12-month period and also maintain and expand the currently reported data. We suggest that county behavioral health departments continue tracking reductions in Emergency Room visits, the number of episodes for individuals receiving Crisis Stabilization Services, and the number of episodes and days for hospitalizations. We also ask DHCS to clarify whether the

incarceration data is meant to reflect the percentage of people already incarcerated.

- SU-3. Follow-Up After Crisis Services: The Council wants to point out that Medi-Cal members may access services outside the Medi-Cal system, such as in crisis respite centers. This data point raises concerns about whether the data measure provides a complete view of the behavioral health system and if any populations are being excluded. Therefore, we recommend that DHCS clarify whether this data set includes services in crisis respite centers and other non-Medi-Cal locations, as well as whether emergency department visits are included in the measure.

Recommendations for Key Measure Definitions

- Experiencing Homelessness Definition: The Council recommends clarification on whether measures of homelessness use the BHSA definition or the Housing and Urban Development (HUD) definition. School districts apply a broader definition of homelessness than either HUD or BHSA. This broader definition includes children in overcrowded homes, which can inflate homelessness data by up to four times compared to excluding children in overcrowded homes. We advise DHCS to avoid using the school district definition, as it may misrepresent the true scope of homelessness relevant to BHSA services.

- Defining Permanent Housing: The Council notes that not all housing solutions are funded through the BHSA. For example, rent payments in other supportive housing programs may occur outside of BHSA funding sources. Therefore, we suggest that DHCS adopt a broader definition of permanent housing when developing outcome measures to ensure the data captures the full range of housing supports members may access, providing a comprehensive view of housing-related data.

The Council appreciates the opportunity to provide feedback on the proposed Performance Measures for the BHSA County Policy Manual, and we look forward to continuing our partnership in shaping policies that promote equity, access, and improved outcomes for individuals served by the public behavioral health system. For questions, please contact Jenny

Bayardo, Executive Officer, at Jenny.Bayardo@cbhpc.dhcs.ca.gov or at (916) 750-3778.

Sincerely,

Tony Vartan

Chairperson

Cc: Stephanie Welch, Deputy Secretary of Behavioral Health, CHHS
Paula Wilhelm, Deputy Director of Behavioral Health, DHCS
Erika Cristo, Assistant Deputy Director, Behavioral Health, DHCS
Marlies Perez, Community Services Division Chief and BHT Project Executive, DHCS