California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

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April 25, 2025

Behavioral Health Transformation

Department of Health Care Services

P.O. Box 997413

Sacramento, CA 95899-7413

RE: Behavioral Health Transformation Policy Manual-Module 3

Dear Behavioral Health Transformation Team:

The California Behavioral Health Planning Council appreciates the efforts made by the Department of Health Care Services (DHCS) to include stakeholders in the implementation of the Behavioral Health Transformation (BHT). The Behavioral Health Services Act (BHSA) will significantly shape the landscape of behavioral health services in California. We believe it is essential that individuals with lived experience of serious mental illness or substance use disorder are meaningfully included throughout this process—as consumers, family members, and partners in policy development.

The California Behavioral Health Planning Council submitted comments to Module 3 electronically by the April 25, 2025, deadline. This letter serves as a follow-up to address broader items that may not directly pertain to a specific section of Module 3, or that are of such great importance to our Council Members that we want to reiterate.

Stakeholder Engagement

We believe persons with lived experience of serious mental illness or substance use disorder should be prioritized as a key stakeholder group in the development of Three-Year Integrated Plans. Their perspectives are essential to ensuring that Behavioral Health Services Act funding decisions reflect the needs of those most impacted by the behavioral health system. Counties should be required to include persons with lived experience in all aspects of the planning process of the integrated plans, including how the

stakeholder engagement process occurs. The expansion of stakeholder engagement through the Integrated Planning process provides a valuable opportunity to strengthen services across California. To fully realize this opportunity, we encourage a focused effort to elevate the voices of consumers and family members throughout every phase of planning. We want to ensure that the critical perspectives of individuals with lived experience are not diluted or overlooked as the scope of stakeholders expands. Their participation is essential to achieving improved services and better behavioral health outcomes statewide.

Recommendation:

- **Require counties to include persons with lived experience on the teams responsible for designing and implementing the stakeholder engagement process for the Three-Year Integrated Plans.**

Goals and Performance Outcomes Measures

We recognize the value of statewide performance measures that tell a clear story of California's behavioral health landscape. At the same time, we believe some of the measures selected do not fully align with the intent of Behavioral Health Services Act or the specific responsibilities of Specialty Behavioral Health. The current framing of goals and outcomes may unintentionally imply that county behavioral health agencies are accountable for outcomes outside their scope or influence.

CBHPC supports accountability across systems and appreciates the state's efforts to help counties assess the services they provide to vulnerable populations. However, the goals, performance outcomes measures and the workbook may imply the county behavioral health agencies have responsibility for metrics identified. Additionally, statewide goals that are not stratified by payer type may contribute to public misunderstanding of the public behavioral health system's performance and role.

There is a risk that the public may perceive the Behavioral Health Transformation Implementation as falling short if outcome measures suggest poor performance despite effective service delivery. This could misrepresent the strengths of the public system, and the high-quality care provided across California.

Recommendations:

- **Consider re-evaluating the proposed goals and measures through the lens of the communities that will use them to determine what services are funded locally.**
- **Align goals and measures in the Integrated Plans with components of the BHSA and the public systems that implement them.**
- **Ensure shared accountability for population-based outcomes across payer types and systems and stratify performance data accordingly.**
- **Establish a standardized approach for collecting and integrating data from substance use disorder projects to ensure a more accurate and comprehensive understanding of substance use disorder trends and outcomes.**

Data Limitations Related to Substance Use Disorder Outcomes

Behavioral Health Transformation presents an opportunity for the state of California to fully integrate Substance Use Disorder services into the public behavioral health system. However, we are concerned that the data currently being used—derived from Mental Health Services Act (MHSA) reporting—does not fully capture Substance Use Disorder populations. This could lead to gaps in understanding and reporting on substance use disorder trends and outcomes.

Recommendation:

• Ensure that future measures include data sources that accurately represent individuals with lived experience of Substance Use Disorder and reflect the full continuum of care.

Thank you for the opportunity to provide input on the Behavioral Health Transformation policies. We recognize the immense effort by both DHCS and county behavioral health systems to implement these changes under significant timelines and constraints. We remain committed to supporting these efforts and promoting policies that lead to equitable, effective and inclusive behavioral health systems statewide.

For questions, please contact Jenny Bayardo, Executive Officer, at Jenny.Bayardo@cbhpc.dhcs.ca.gov or by phone at (916) 750-3778.

Sincerely,

[redacted]

Tony Vartan
Chairperson

CC: Michelle Baass, Director, DHCS
Stephanie Welch, Deputy Secretary of Behavioral Health, CHHS
Paula Wilhelm, Deputy Director of Behavioral Health, DHCS
Tyler Sadwith, State Medicaid Director, DHCS
Erika Cristo, Assistant Deputy Director, Behavioral Health, DHCS

Enclosure: CBHPC Comments on BHT Policy Manual-Module 3

California Behavioral Health Planning Council

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Comments on BHT Policy Manual-Module 3

Behavioral Health Services Act Integrated Plan Template Version 1

- Clarification is needed on whether "recuperative care" is included as an allowable setting under both the county Behavioral Health Plan (BHP) and the Medi-Cal Managed Care Plan (MCP).

- Please address uncertainties in the coordination between Managed Care Plans (MCPs) and county Behavioral Health Plans (BHPs) regarding housing services:
    - Clear definitions of roles, responsibilities, and integration mechanisms are crucial to fostering effective collaboration and enabling stakeholders to provide meaningful input on the housing component of the Behavioral Health Services Act (BHSA). The stakeholder engagement would include but is not limited to consumers and family members.

- Page 67 of the Behavioral Health Services Act Integrated Plan Template Version 1 (Section B of the Full-Service Partnership section) speaks to the staffing ratios for the Full-Service Partnerships Tier 1 and Tier 2. Most counties are currently not implementing the Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) models as described under BH-CONNECT and fidelity is not yet established. It would be challenging to project the size of the ACT, FACT, and Intensive Case Treatment (ICT) with the existing staffing ratios and client base. Please defer the requirement in this section until counties receive support and assistance through the Centers of Excellence (COE). If deferring the requirement is not possible, please provide counties with flexibility to provide any data based on the level of implementation they are at and respond broadly until the Centers of Excellence may work with counties are not currently engaging in these programs.

County Performance Workbook – Measure Access Instructions & Notes

- Please address structural and data-related challenges that limit the effectiveness of Homeless Housing measures. Some counties operate within shared Continuum of Care systems, which complicates coordination due to separate behavioral health departments. Additionally, data on mental health and substance use disorders is often self-reported through limited interviews rather than the

Homeless Management Information System (HMIS). Furthermore, Continuum of Care reporting is restricted to federally funded programs or California-funded housing initiatives that require HMIS participation, leaving gaps in information for other populations. Strengthening data systems is crucial to better supporting individuals experiencing homelessness and behavioral health challenges.

- The primary measure, 12th graders who graduated high school on time, does not reflect outcomes relevant to the public behavioral health system. Additionally, the data from court and community schools is overly broad, omitting details on youth facing behavioral health challenges as well as how many students started versus how many completed schools. This data does not effectively support the intended goals.

Behavioral Health Services Act County Policy Manual

- **E.2.1 Integrated Plan Requirements**
    - Strengthen Requirements for Lived SUD Experience in Community Engagement
    - Please include and prioritize individuals with lived experience of mental health and substance use disorders in the planning and implementation process. This involves consulting with individuals with lived experience and family members on specific engagement strategies including ongoing involvement for oversight and evaluation, as well as a public record of how individuals with lived experience were involved in shaping priorities for the integrated plan requirements.

- **E.2.2 Budget Template Requirements**
    - Enhanced and Transparent Funding for the Full SUD Continuum of Care
    - To ensure investment in all critical levels of Substance Use Disorder Treatment, please include language that counties may use Behavioral Health Services Act (BHSA) funds to support the full continuum of substance use disorder care which would include the ability for counties to use these funds to match funding via Federal Financial Participation (FFP). There should be transparency and flexibility for counties to address their local needs particularly in underserved regions to make meaningful impacts on access to substance use disorder services and client outcomes.

- **E.3 Process for Requesting Exemptions**
    - Please clarify the connection between exemption requests and fund transfers to address uncertainty about whether fund transfers from one funding bucket to another are contingent upon exemption requests. This clarity is essential to ensure counties can adequately develop their budgets and allocate funds without confusion or delays.

- **E.4 Integrated Plan Submission**

- Small counties, in particular, face barriers such as limited staff and resources, high Behavioral Health Director turnover, and tight timelines for stakeholder engagement, certification processes, and plan development. These issues are compounded by the absence of finalized population-based measures from the Department of Health Care Services (DHCS) and delays in data transmission. To mitigate these barriers, it is essential for the Department to provide timely measurement data, clear guidance, and consultation support to counties. These efforts will help establish realistic timelines, reduce staff burdens, and facilitate the successful implementation of the Integrated Plan.

- Many counties also face difficulties in completing a meaningful stakeholder engagement process due to insufficient time and unresolved questions about the alignment of funding buckets, existing programs, new initiatives, and substance use disorder (SUD) inclusion. The compressed timeline for stakeholder input, budget planning, provider estimations, and approval processes—such as those required by County CEOs and Boards of Supervisors—further complicates the submission process. DHCS should support counties with assistance needed to involve consumers and family members in a meaningful stakeholder process.

- **E.6 Statewide Behavioral Health Goals**

  - The statewide goals extend beyond the scope of the county behavioral health system. These measures often fail to specifically evaluate the services provided under the Behavioral Health Services Act (BHSA) and may misrepresent the role of the behavioral health system as the primary driver of broader societal factors, such as homelessness, which are influenced by external issues like affordable housing and employment. This misalignment risks creating public misconceptions about the effectiveness of the behavioral health system and unfairly holding it accountable for outcomes beyond its control. Additionally, the lack of stratification by payer type in the measures could negatively impact perceptions of the public behavioral health system.

    - Include background, definitions, and extensive notes including explanatory examples in the release of the Goals and Measures to assist the general public/community in their understanding of the implications of the Performance Outcomes selected.
    - System partner accountability should be a part of what is measured; therefore, we should include comparable data points from Commercial Plans and Managed Care Plans in addition to Behavioral Health Plans (Mental Health and SUD-ODS).
    - Data points should be stratified by payer type with side-by-side comparisons of Commercial Plans, Managed Care Plans, Behavioral Health Plans and ongoing funded projects by the

Department to provide a clearer and more accurate representation of the public behavioral health system's performance.

- Clarify Population-Level Behavioral Health Measures: Separate by System of Care: Under this policy, county behavioral health departments are required to report on and make improvements to population-level outcomes. To ensure that counties are only responsible for reporting and making improvements on populations they serve, the measures should be developed separately for county behavioral health departments, Managed Care Plans, and other Fee-For-Service providers. Please provide counties with flexibility to align the measures to their local needs.

- Clarify Applicability to Public Behavioral Health Systems: To ensure that each system of care is accountable to the populations they are responsible for serving, please explicitly state that the performance expectations linked to Initiation and Engagement of Treatment- Initiation Phase (IET-INI) metrics apply specifically for consumers in the public behavioral health system.

- Improve Data Transparency for Counties with Suppressed Sample Sizes Please support small and rural counties with data exchange to improve their planning process without violating any Health Insurance Portability and Accountability Act (HIPAA) confidentiality rules.

- Address challenges in achieving performance metrics for measures such as follow-up after emergency department visit for substance use and initiation of substance use disorder treatment.

- Provide clear guidance to strengthen connections between Medication-Assisted Treatment (MAT) induction programs, emergency departments, and county behavioral health systems. Enhancing follow-up and continuity of care is essential to meeting benchmarks and improving outcomes for individuals with substance use disorders.

  These elements address the disconnect between current programs and the populations served, which makes achieving these measures highly challenging.