California Behavioral Health Planning Council

ADVOCACY • EVALUATION • INCLUSION

Comments on Behavioral Health Transformation

Policy Manual - Module 2

December 23, 2024

Section 6 – Behavioral Health Transformation Fiscal Policies

B.6.1 and B.6.2 Full-Service Partnership Levels of Care: The Council recommends that this section include a "Transition Period" policy paragraph to account for the complex transition from Mental Health Services Act to Behavioral Health Services Act (BHSA) Integrated Plan (2026-29). Such a section would address a variety of questions that intersect planning, funding, and programming. Questions to consider addressing include but are not limited to:

- grandfathering or status of clients currently in Full-Service Partnerships designed with different focus in the existing Mental Health Services Act design.
- Whether they continue to exist as is or if they are also required to develop levels of care to fit into the new design of Full-Service Partnerships in the Behavioral Health Services Act.
- If clients get reassessed throughout the Behavioral Health Services Act Integrated Plan (2026-29) to be served in "right" level of care or if it is a process determined at county level.

The Transition policy should highlight best interests of clients being served in the public system at this time, their choices, and their needs so that continuity of care remains at the center of this change period.

Given that Levels 1 and 2 are in the Full-Service Partnership bucket and lowest intensity outpatient is in the Behavioral Health Services and Supports (BHSS) bucket, it is unclear on whether counties are required to have Behavioral Health Services and Supports level stepdown or is that optional. We recommend there be clarity on this piece as well as whether it is dependent on county planning process and available funding in that bucket is prioritized for that transition.

The Council also recommends the addition of a section regarding transitions in care between Medi-Cal Managed Care Plans and county Mental Health Plans based on the changes of the Behavioral Health Services Act. This would answer questions on whether client housing benefits and supports in the Behavioral Health Services Act remain in place if the client moves from Mental Health Plans to Managed Care Plans due to improved clinical presentation.

B.7.1 – Transition Policy: The Council recommends that the module provide examples of programs funded currently under the Mental Health Services Act which will not be included in the counties' first Implementation Plan under the Behavioral Health Services Act after June 2026. This may result in defunding existing prevention and early intervention programs at the local level. Therefore, these examples would be helpful for the planning process and funding decisions to avoid loss of programs. The local process may result in defunding existing Prevention and Early Intervention programs. Based on the language in this policy, it appears that all programs would have ending contract dates of June 2026 with no transition time beyond that date based on Behavioral Health Services Act funding reallocation.

It is stated that Innovation projects, approved by Mental Health Services Oversight and Accountability Commission still in progress, will be able to have funds encumbered for the duration of their term into the first Behavioral Health Services Act Integrated Plan (2026-29). Given the complexity of this transition, the Council recommends that some flexibility be given to Prevention and Early Intervention programs that are successfully operating through the first transition period in a similar manner that innovation programs will be supported. Prevention and Early Intervention programs that work with underserved communities that are front line of engagement fall into this category.

C.1 – Introduction: The Council asks that this section emphasize billing commercial insurance, clarify which entities are referenced as commercial plans (i.e. Medi-Cal Managed Care plans, Blue Cross, etc.), and outline the policies and procedures in place to enforce expedited timely payments for Managed Care Plans. The policy clearly states that Behavioral Health Services Act funds can be expended to pay for services rendered to commercially insured plans and that a complaint process is available. Given the implementation of 988 and other crisis response activities by Counties, the Council recommends that this section clearly define how the Department of Managed Care will enforce the payment processes to ensure individuals are best served in crisis. This will help remove the burden on Counties that often have to chase payments for services. Additionally, the eligibility criteria for medical necessity differs between Managed Care Plans and county Mental Health Plans which creates additional administrative burdens. The Council recommends that the state streamline criteria for medical necessity for both Managed Care Plans and county Mental Health Plans.

C.2.4 – Implementation seeking payment: The policy states that this is a transparency effort rather than enforcement until June 2029 for the first Integrated Plan. The Council recommends that the module clearly state that the timeline is the same for all insurers delivering behavioral health services.

C.3.3 - Report Complaints: The Council recommends that the state clarify which commercial plan entity types this policy applies to. Additionally, the Council asks the Department to clarify if the issued reports will include information on timely payments, implementation obstacles, and Managed Care Plan and Behavioral Health Plan interactions. There are new benefits in Managed Care Plans, such as Enhanced Care

Management and Community Supports. Therefore, the Council recommends that the state have periodic status reports on timely payments, issues around prior authorization, and out-of-county service delivery, rather than a complaint driven process. We recommend that the periodic status reports elements be included in this section of the module so that the Behavioral Health Services Act implementation is considered from the out-of-county lens as well.

Section 7 – Behavioral Health Services Act Components and Requirements

A.4 Workforce Education and Training: The Council recommends that the state provide greater detail about the current and planned State's Workforce Initiatives, so counties do not inadvertently duplicate statewide initiatives.

A.4.2 Allowable Activities: The Behavioral Health Services and Supports funding provides an opportunity to support non-certified providers such as Peer Specialists and Community Health Workers be paid for the services they have provided for many years. Therefore, we recommend there be flexibility to use Workforce Education and Training funds as counties see most appropriate. Additionally, we recommend that all entities providing services to Medi-Cal beneficiaries be included with parameters in place.

A.4.4 Professional Licensing and/or Certification Testing and Fees: In addition to the items listed for covered fees, the Council recommends the addition of transportation fees associated with preparing for, applying for, or renewing a license or certification. Transportation is a known barrier for some target populations, especially individuals with lived experience or low incomes that we would like to engage in the behavioral health workforce. These individuals often qualify for roles such as Peer Support Specialists, Community Health Workers, and Wellness Coaches. The coverage of transportation fees would support any qualified individual with financial burden to reach testing sites and locations that are associated with licensing and certification requirements.

A.5.1 Capital Facilities: The following recommendations aim to ensure Capital Facilities funds are utilized effectively to maximize their impact on behavioral health services across counties, enhancing overall infrastructure and community support:

- Access for Non-Profits: The Council recommends that the Department specify that non-profit organizations with existing contracts with counties to provide behavioral health services can access Capital Facilities project funding. This includes funds to acquire, develop, or renovate buildings and purchase land, modular buildings, and vehicles for mobile crisis response services. This will enable community organizations to enhance their service delivery capabilities in partnership with county behavioral health systems.
- Property Ownership by Non-Profits: The Council recommends that the Department clarify that properties acquired or developed using Capital Facilities funds can be owned by non-profit organizations. This will facilitate more efficient use of funds and promote collaboration between counties and non-profits.
- Use of Funds for BHCIP Matches: The Council cautions that use of Capital Facilities funds as a match for Behavioral Health Continuum Infrastructure

Program (BHCIP) awards could result in an increase in involuntary treatment facilities. Therefore, we recommend that the Department modify the policy to allow non-profit organizations to use the funding for BHCIP matches, ensuring a balanced and effective expansion of behavioral health infrastructure.

- Opposition to Land Banking: The Council does not support the policy provision that allows counties to purchase land without Behavioral Health Services Act funds budgeted for construction or acquisition based on expected income sources. This could lead to land banking, delaying the urgent expansion of behavioral health infrastructure and hindering timely service delivery. We recommend revising the policy to prevent land holding and ensure funds are used promptly and effectively.

A.7 Early Intervention Programs: The Council recommends that the Department work in consultation with the CA Behavioral Health Directors Association (CBHDA) and the CA Council of Community Behavioral Health Agencies (CBHA) to ensure the county and provider voice is represented. We also recommend that the voices of individuals with lived experience and their families are represented. These entities will be affected by the policies outlined for school-based early intervention services, especially in counties with a small population but a large geographical area. Since CA Behavioral Health Directors Association and CA Council of Community Behavioral Health Agencies represent counties and providers across the state, they may be able to speak to the different population demographics and implementation considerations for the Department Modules.

Early Intervention programs must reflect the cultural and ethnic diversity of California and those served in programs across both the mental health and substance use systems. The Council would like to highlight the importance of services for children 0-5 years old and their families as providing prevention services and education to families of young children will avoid the need of future navigation of services.

The Council recommends that the Department consider peer support services and non-traditional outreach to culturally diverse programs. We would like to strongly encourage the Department to Include the older adult system of care a priority category of Early Intervention. Further, we recommend the inclusion of respite care for adults, and particularly older adults and their caregivers.

A.7.1 Early Intervention: The Council agrees that counties should use Evidence-Based Practices. Community Based Practices can also be used when utilizing Behavioral Health Transformation funds in some cases. However, there will be variation in whether these activities can draw down Medicaid funds. Please consider the following:
A. Early Psychosis Interventions, as an Evidence-Based Practice, can almost always draw down Medicaid funding as significant symptoms exist. Parental consent is easily obtainable. Thus, medical necessity, treatment consent, and chart compliance can be accomplished.

B. Other Evidence-Based Practices, which fulfill the requirement of 51% of behavioral health services funding used for Early Intervention for youth under 21 years old, are rarely eligible for drawing down Medicaid funds. One example of this type of Evidence-Based Practice is the 2nd Step Program. These programs are administered school-wide without clinical charts. The population receiving the service often reside in classrooms. We are concerned that some parents will not agree to their child receiving behavioral health interventions. In these cases, medical necessity would not be present or documented, and thus no reimbursement can be expected. However, the interventions are important for teaching basic skills to whole classroom groups. It would also create the opportunity for children who need more significant intervention be referred for treatment in the Medi-Cal system.
C. Regarding Substance Use intervention for youth, prevention dollars in the Substance Abuse Treatment Grant can be used to underwrite activities in high schools and clubs in middle schools. Saturday Night Lights is an example of one of these programs. However, youth involved in these programs often do not have open clinical charts. Behavioral Health Transformation funds may be needed to support the limited Substance Abuse Treatment Grant Funds to carry out these important services. Youth who have a significant substance use disorder can be referred for Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Medicaid funds will be drawn down.

A.7.2. Priorities for Use of Funds: The Council recommends the inclusion of the Older Adult Systems of Care in these areas of consideration. For example, we recommend listing the Program to Encourage Active, Rewarding Lives (PEARLS) as an evidence-based practice for older adults. The Council recommends that older adults are included and considered throughout all sections of the Behavioral Health Services Act. Additionally, we would like to ensure that peer operated wellness and recovery services are fundable as an Evidence-Based Practice.

A.7.6 Coordinated Specialty Care for First Episode Psychosis: Please clarify the differences in role of the Centers of Excellence (COEs) that will provide technical assistance and monitoring compared to the Department's monitoring responsibilities.

B. Full-Service Partnerships:

B.3.2 Baseline Requirements: The Planning Council supports integrating substance use disorder into Full-Service Partnership teams. This requires the state to rethink existing models and understand the complexities of integration. Please see our recommended key changes for effective integration below:

- Retrain all Full-Service Partnership staff to reduce and remove historic biases and differences between mental health and substance use disorder systems of care. This includes but is not limited to the following:
    a. Educate providers and staff about the needs and stigmas present in each system.
    b. Create a Speaker's Bureau to elevate the voice of individuals with lived experience. Such bureaus exist at the county level for individuals with mental

illness. This would expand this effective client voice to substance use disorder as well.

c. Provide substance use disorder monthly trainings with case presentations and education for mental health staff to equip staff with the basic knowledge, skills, and capabilities to serve both mental health and substance use disorder populations.
d. Provide updated specialized trainings for substance use disorder providers including training for staff in harm reduction and Medication Assisted Treatment (MAT).
e. While it is important to add substance use disorder counselors to integrated teams, we recommend intentional integration efforts to promote organizational culture change and state of the art education.

B.3.3 Full-Service Partnership Continuum: Evidence Based Practices (EBPs) for the implementation is effective for some population groups. However, these evidence-based practices can lack the necessary flexibility to adapt for some ethnic and cultural populations and diverse communities. Incorporating Community Defined Evidence Practices (CDEPs) explicitly in the expectations for Full-Service Partnership services is critical if equity and diversity goals are to be met.

B.3.5 Full-Service Partnership Co-Occurring Capabilities and B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services: The Council acknowledges that the Department of Health Care Services has included Assertive Field-Based Initiation for Substance Use Disorder Treatment Services, the use of Medication-Assisted Treatment for co-occurring disorders, and has recommended the training of staff to provide comprehensive care to individuals with co-occurring behavioral health needs. To strengthen the effectiveness of these policies, the Council recommends that Medication Assisted Treatment is available in a Full-Service Partnership in a similar way that psychiatric medications are available in a Full-Service Partnership. This would mean certified providers in a Full-Service Partnership model are able to deliver both services in the same clinic and receive full reimbursement. Recognizing that Psychiatrists and Nurse Practitioners can already prescribe Medication Assisted Treatment for Full-Service Partnership clients if they have the appropriate certification and training, Psychiatrists in the Full-Service Partnership that provide Medication Assisted Treatment could be the same medical staff that provides psychiatric medications. With changes in the federal guidelines that make Medication Assisted Treatment induction and continued follow-ups open to more sites, a successful model would integrate this into the field based Full-Service Partnership teams as well as the medication clinic and delivery system.

This model would be especially beneficial to mental health co-occurring clients who are established with and trust their mental health provider and do not need to go elsewhere for their Medication Assisted Treatment follow-up care. It will also reduce wait times and maximize workforce efficiency if a Full-Service Partnership team can provide this service to its clients instead of having to navigate another resource. Substance Use Disorder treatment is effective when the client is ready and trusts their provider instead

of them experiencing delays when navigating multiple systems. The Planning Council believes that this recommendation is in alignment with the spirit and intent of the Behavioral Health Services Act.

B.4 Full-Service Partnership Levels of Care: The tiered design for the Adult Full-Service Partnership Level of Care Framework under the Behavioral Health Transformation is a major change from the Mental Health Services Act (MHSA). The Council recommends the following:

1. Individuals with lived experience have an urgent opportunity to understand this change and weigh in with their ideas on how to serve individuals under Intensive Case Management prior to the finalization of this policy.
2. The Department conduct more discussion on this point and develop different options regarding the organization of Tiers based on feedback provided from clients in the system.
3. The Department clarify if it is required to have the Level 1 and Level 2 Tiers in the Full-Service Partnership funding category and Level 3 Tier in the Behavioral Health Services and Supports funding category, or if it is optional for counties to organize the funding categories in this manner. Clarification is critical as counties will have less flexibility with their Behavioral Health Services Act funds if the funding categories designated for each tier are required. Other considerations for this topic are the size and population of the county, how effectively staffed the county is, and how difficult transitions of care between the levels will be.
4. The Department look at lessons learned from the experiences in many counties where step-downs in the level of care have been attempted, and that DHCS hear from counties on how transitions would work.
5. All three levels be in the same Full-Service Partnership funding category, rather than include two tiers under the Full-Service Partnership funding category and one tier under the Behavioral Health Services and Supports funding category.
6. Regarding the continuity of care between Tiers, particularly for Tier Level 1 and stepdown into Tier Level 3, the Council recommends that the Department clarify the continuity of care protocols within the Behavioral Health Services Act so that clients do not get lost in this stepdown transition process. We ask the Department to clarify if the stepdown relates to current Medi-Cal protocols on continuity of care or it is separate and distinct.
7. The diagram of the Adult Full-Service Partnership Levels of Care Framework may be confusing in terms of the level of acuity. The Council recommends that Level 1 be labeled as the highest level of acuity (Assertive Community Treatment/Forensic Assertive Community Treatment) and Level 2 be labeled as the medium level of acuity (Intensive Case Management). We also ask that the Department clarify if the levels are based on the populations of focus and how the populations are determined for each level.
8. The Council asks the Department to clarify whether Level 3 Tier for Outpatient Specialty Mental Health Services will continue to have housing supports available. For example, if a client gets housing supports under Full-Service Partnership Level 1 (Intensive Case Management) and then gets stepped down

to Tier 3, will the housing supports continue under the non-Full-Service Partnership service?

9. The Council recommends that the Department clarify if there is movement from Tier 3 in the county Mental Health Plan to a MCP benefit once the individual moves into the mild-to-moderate behavioral health status, and if populations served in Level 3 are eligible for Enhanced Care Management (ECM).

The Council is concerned about the tiered Full-Service Partnership (FSP) system described in the public listening session. The system's design presents challenges and unintended consequences. The Level 1 Tier includes Intensive Case Management, Level 2 includes Assertive Community Treatment and Forensic Assertive Community Treatment. However, Level 3, which includes Outpatient Specialty Mental Health Services (SMHS), separates clients from the FSP funding category by placing them in the Behavioral Health Services and Supports (BHSS) funding category. This could lead to competition for resources within the BHSS.

The Council is concerned about the unintended consequence of having one provider render services for all three tiers. This may lead to the growth of large providers and the loss of diverse, community-based providers, especially at the lowest acuity, Tier 3. This would impact local provider networks and service diversity. The Council emphasizes the importance of client voice and choice in their healthcare decisions, especially for those in the lowest acuity Tier, or under the described model.

B.4.2.1 Overview: The Full-Service Partnership (FSP) Intensive Case Management (ICM) is based on the recovery model, which emphasizes self-determination, personal recovery, and holistic well-being, including mental health, substance use, and social integration. This model often involves structured programs and treatment plans to support recovery from addiction before securing permanent housing. The Council supports the emphasis of the recovery model.

B.4.2.4 Full-Service Partnership Intensive Case Management Team Structure: The Planning Council asks the Department to consider a Full-Service Partnership model of care where a Primary Care Physician or Nurse is embedded in the Full-Service Partnership teams and programs. This practice will would require some creativity in administrative setup, certification, and payment protocols. This recommendation may also increase basic health follow-ups as well as increase workforce flexibility. There are successful models of Full-Service Partnerships where dually certified physicians have provided medical consultation but not with payment and full integration. This is a recommendation to consider further in discussions with Managed Care Plans (MCPs) so that all systems maximize payment and reimbursement to providers of care.

B.4.3 High-Fidelity Wraparound: Maintaining high fidelity is a workforce issue in terms of training and turnover, and it is expensive for providers to manage within their budgets. It is important to consider ways to address these issues with Centers for Excellence (COEs). We recognize that it is challenging to maintain high fidelity with the current workforce shortages. Fidelity to model should not be required for Assertive

Community Treatment since the staffing is so difficult to maintain. The Council recommends that the Department initiate a statewide discussion on this topic with counties who already implement these two evidence-based practices at any level of fidelity they are operating. The CBHPC also recommends that the state include Community-Defined Evidence Practices (CDEPs) in High Fidelity Wraparound Services.

B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services: There are examples across the state where separate billing structures for mental health and substance use disorder housing projects have worked efficiently. For mental health and substance use disorder treatment systems, we recommend simplifying certification standards to allow more efficient use of medical personnel in Full-Service Partnerships that have been designed with a mental health focus to give more clients access to both mental health and substance use disorder services.

Section 8 - Documentation Requirements for Behavioral Health Services Act Services

Documentation Requirements for Behavioral Health Services Act Services: Given that levels of care are built into both the crisis continuum and different elements of eligibility, clinical presentation, and programs, the Council recommends the state draw attention to Continuity of Care documents that are being maintained. This will ensure a seamless movement of care from inpatient to outpatient services or within outpatient levels of care. If these documents exist and are built into assessment documents and tools, we recommend that it be visible in the policy language.