Systems and Medicaid Committee (SMC)

Meeting Minutes
Quarterly Meeting – June 19, 2025

Members Present:

Uma Zykofksy, Chairperson	Karen Baylor, Chair-Elect	Marina Rangel
Jessica Grove	Noel O'Neill	Tony Vartan
Ian Kemmer	Elizabeth Oseguera	Susan Wilson
Javier Moreno	Deborah Pitts	Milan Zavala
Dale Mueller		

Staff Present: Ashneek Nanua

Presenters: Elissa Feld, Kallie Clark, Debbie Innes-Gomberg, Dawan Utecht, Danielle Vosburgh

Meeting Commenced at 8:30 a.m.

Quorum Established: 13 out of 17 members

Item #1 Review and Accept April 2025 Draft Meeting Minutes

The Systems and Medicaid Committee reviewed the April 2025 draft meeting minutes. No edits were requested. The committee accepted the meeting minutes as written.

Action/Resolution
The approved minutes will be posted to the Council's Website.

Responsible for Action-Due Date
Ashneek Nanua – June 2025

Item #2 Overview of the Full-Service Partnership Model in the Behavioral Health Services Act and County Perspective of Implementation Impacts

Elissa Feld, the Director of Policy for the County Behavioral Health Directors Association (CBHDA), provided the committee with an overview of Full-Service Partnerships delivery model in the Behavioral Health Services Act (BHSA). The presentation included potential impacts at the county level. Thirty-five percent of Behavioral Health Services Act funds distributed to counties must be used for Full-Service Partnership programs. Counties with populations under 200,000 can request an

exemption for parts of the required 35 percent allocation. Counties also have the flexibility to transfer seven percent of funds between the Behavioral Health Services Act categories, with a maximum shift of fourteen percent.

The Full-Service Partnerships in the Behavioral Health Services Act will offer two levels of care for adults and older adults. Level Two is the highest level of care which will include Assertive Community Treatment (ACT). Level One features Intensive Case Management (ICM), a less intensive care level than Assertive Community Treatment. Individuals who transition from Level One to less intensive services would receive outpatient mental health and substance use disorder services under the Behavioral Health Services and Supports (BHSS) category of the Behavioral Health Services Act. For children and youth, counties will be required to provide High Fidelity Wraparound (HFW). Any child or youth may receive Assertive Community Treatment or Intensive Case Management if it is clinically and developmentally appropriate.

The program requirements include mental health and substance use disorder treatment services, Assertive Field-Based Services for substance use disorder treatment, and outpatient behavioral health services necessary for ongoing evaluation and stabilization of enrolled individuals. Assertive Field-Based Substance Use Disorder services encompass mobile field-based programs, low-barrier access to medications for addiction treatment, and data-informed outreach to individuals with substance use disorder needs. Other program requirements include ongoing engagement services, service plans, and housing interventions. Housing interventions will be funded through the Housing Intervention funds rather than Full-Service Partnership funds. Optional services allowed under Full-Service Partnership programs include primary substance use disorder services, additional evidence-based practices defined by the Department of Health Care Services, outreach, and other recovery-oriented services such as peer support and consumer-operated services.

The required evidence-based practices are Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), High Fidelity Wraparound (HFW), and Individual Placement and Support (IPS). The Department of Health Care Services has issued the policy guide for ACT, FACT, and IPS evidence-based practices. Counties will be responsible to achieve fidelity regardless of whether they have bundled Medi-Cal rates or non-bundled rates. The Department of Health Care Services will also release a concept paper on the fidelity requirements. The implementation of these evidence-based practices will start on July 1, 2026. Assertive Community Treatment is expected to be fully implemented within one year of the start date, Forensic Assertive Community Treatment is expected to be fully implemented within one year, and the Individual Placement and Support program is expected to be fully implemented within one year. Counties are expected to complete their fidelity reviews for all evidence-based practices by December 31, 2027, and to reach full fidelity by June 30, 2029.

The Full-Service Partnership programs will serve populations with substance use disorder under the authority of the Behavioral Health Services Act. Individuals who receive assertive, field-based treatment will be connected to Full-Service Partnership

teams, substance use disorder providers, and other necessary clinical services such as peer support. Providers will conduct the American Society of Addiction Medicine (ASAM) screening during assessments and refer individuals to appropriate substance use disorder treatments, which include options for medication-assisted treatment (MAT) with transportation support. Additionally, Full-Service Partnership teams will be trained to assist individuals with co-occurring mental health and substance use disorders through methods like Motivational Interviewing and education on Medication-Assisted Treatment for prescribers. Counties will also be required to implement billing and claiming strategies aligned with the appropriate delivery system for co-occurring care. For example, the State Plan Amendment has an "Other Qualified Provider" category that allows alcohol and other drug (AOD) counselors to document and bill for mental health services under the Specialty Mental Health Services System instead of billing through the Drug Medi-Cal Organized Delivery System.

County behavioral health departments can leverage external resources to fulfill the Full-Service Partnership requirements. For example, counties might utilize street medicine teams that provide medication-assisted treatment, which are not funded directly by county behavioral health departments. Federally Qualified Health Centers may also conduct outreach for low-barrier access to Medication-Assisted Treatment. Additionally, counties collaborate with other counties to share sustainability practices.

Committee Questions and Discussion:

- Committee members discussed the challenges to capture data on billing for substance use disorder services within the Specialty Mental Health System for individuals with co-occurring services.
- Small counties will determine how to meet the new program requirements under the Behavioral Health Services Act and which exemptions they may qualify for.
- Service Area Navigators and enhanced Community Health Workers are examples of navigation service providers that cannot claim or participate in Assertive Field-Based Substance Use Disorder treatment services, even though their functions are similar to those of providers eligible for these services under the Full-Service Partnership model.
- The fidelity requirements vary based on the evidence-based practice provided. Assertive Community Treatment has two fidelity scales, and the state has not yet decided which one to use. The Dartmouth scale is the original, while the Team ACT scale is a refinement of the Dartmouth scale. The Team ACT scale is more sensitive to change than the Dartmouth scale. For this reason, it is more difficult to detect fidelity changes with the Dartmouth scale. In addition to the two fidelity scales for ACT, there is also one fidelity scale for the Individual Placement and Support evidence-based practice.
- Many providers that serve foster youth and juvenile justice populations face challenges to deliver High-Fidelity Wraparound due to the high start-up costs. The state only provides technical assistance for these efforts. The Department of Health Care Services and the Department of Social Services seek to align California's wraparound standards required under the Department of Social Services with the Medi-Cal Benefit.

- Undocumented individuals may be eligible for services under the Behavioral Health Services Act if they meet the criteria to access the Specialty Mental Health System, but they do not need Medi-Cal to qualify. Therefore, undocumented individuals can receive services like High Fidelity Wraparound but cannot have Medicaid billed for these services.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #3 Public Comment

Stacey Dalgleish requested examples of tools clinicians have for Full-Service Partnerships. Elissa Feld responded that Full-Service Partnerships are a “whatever it takes” model that offers flexibility to deliver services that meet clients where they are. Counties also create guidelines that outline the necessary components of Full-Service Partnerships.

Steve McNally stated that voices from individuals with lived experience are not heard at state and county meetings. He stated that there are minimal opportunities for people outside of the known pathways to participate in public programs. Steve asked who had seen and understood the Behavioral Health Services Act modules in the community. He mentioned a need to document actions and ensure communities understand what happens from a policy perspective.

Reba Stevens mentioned that she has lived experience and serves as a Mental Health Commissioner in Los Angeles County. She expressed interest to learn more about the implementation of the “whatever it takes” approach. She asked what specific services are available to help and engage individuals, such as services that provide food, water bottles, and hygiene kits. Reba pointed out that the community’s needs go beyond what the policy outlines. She emphasized that individuals with lived experience should be part of the panel.

Debbie Innes-Gomberg stated that Los Angeles County offers client support services to fund whatever clients need. This is part of a non-Medi-Cal services funding, which is one way to help clients get a “whatever it takes” approach. The provider’s activities center around the clients’ needs, and where they are.

Action/Resolution
N/A

Responsible for Action-Due Date
N/A

Item #4 Overview of the Mental Health Services Act (MHSA) Full-Service Partnership 2024 Legislative Report

Kallie Clark, the Social Policy Researcher for the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) presented the committee with the 2024 Legislative Report on the Mental Health Services Act Full-Service Partnership. These partnerships serve approximately 45,000 clients annually and are estimated to operate at 70 percent capacity. The Commission supports counties with Full-Service Partnerships with data organization, storage, and capacity-building. It also assists providers with quality improvement and technical support. Senate Bill 465 requires the Commission to report on who is served, client outcomes, and recommendations for system-level improvements to Full-Service Partnerships. The Commission can utilize external data sources such as the Department of Health Care Access and Information, client services data, the Department of Education, and the Department of Justice to address information gaps. Notably, Department of Justice data will be included in the 2025 report but is not part of the 2024 report.

The Commission held stakeholder engagement sessions to gather information for the report. Two public panels were held on Full-Service Partnerships. The Commission conducted targeted outreach to participants, organizations, and counties. There were also community forums, statewide surveys, and research through case studies, pilot projects, and site visits.

Kallie Clark reviewed the descriptive analysis of the report. Fifty-four percent of Full-Service Partnership participants were children and youth, and sixty percent were individuals who experience homelessness. Forty-eight percent of children and transition-age youth clients exited the program because they met their goals, compared to twenty-eight percent of adult clients. There was a decrease in service utilization for crisis services, psychiatric admissions, and hospital inpatient days in the year after they joined a Full-Service Partnership.

The data collection and reporting system has significant issues that affect the data reporting and transparency needs under the Behavioral Health Services Act. The Department of Health Care Services plans to improve the data collection and reporting system so the Commission’s report can be a helpful resource in these efforts.

Staffing and workforce shortages affect all aspects of Full-Service Partnership programs, which limits their capacity and impacts client outcomes. The Commission recommended an expansion of the behavioral health workforce pipeline, an increase in incentives and benefits, a reduction in provider stress, and the utilization of peers. The Commission’s report may support ongoing peer recruitment and certification efforts.

The Commission also offered recommendations for performance management and outcomes in the report. The Department of Health Care Services has issued a Request for Application to help counties with performance management. The Commission’s

findings may inform and strengthen these efforts. Technical assistance is one area where counties and providers need support and clearer guidance. The Centers of Excellence can help with these efforts.

Kallie Clark discussed the Commission's upcoming steps based on the report. She mentioned pilot projects in Sacramento and Nevada counties on performance management, with results expected to be presented to the Commission in the summer of 2025. Additionally, $20 million in Mental Health Wellness Act funds are allocated to improve Full-Service Partnership outcomes and service delivery, with $10 million of this funding designated for technical assistance and capacity building. The Commission also provides the following assistance to local jurisdictions:

- Creates toolkits for providers to support peers and paraprofessionals in the workforce.
- Outlines services and treatments for individuals with substance use disorders
- Supports step-down levels of care.
- Promotes outreach and engagement.
- Assesses child Full-Service Partnerships which will be included in the 2025 report.

Committee Questions and Discussion:

- A committee member expressed confusion about the presence of multiple guidance sources. The presenter clarified that the toolkit is intended as a resource specific to the provider level.
- A committee member mentioned that there might be a decrease in high-intensity services but not in other services. The presenter clarified that she does not expect a reduction in overall service usage.
- A committee member expressed difficulties securing the workforce's engagement in field-based services. The presenter stated that an investment and creative solutions are still needed in this area.
- A member emphasized that is important to include linguistic data and be careful about how the Commission identifies persons of color to avoid racial profiling.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #5 County Perspectives of the Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT) Within Full-Service Partnership Model

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Debbie Innes-Gomberg, the Deputy Director of Quality, Outcomes, and

the Training Division for the Los Angeles County Department of Mental Health presented on the county's implementation of the Full-Service Partnership levels of care required under the Behavioral Health Services Act. Debbie reviewed the client data for fiscal year 2023-2024 for Los Angeles County by age group, ethnicity, and service area. Eighty percent of the Full-Service Partnership providers are contracted with the county. The outcomes data for fiscal year 2023-2024 shows reductions in homelessness, justice involvement, psychiatric hospitalizations, and independent living.

The Los Angeles County Department of Mental Health conducts a needs assessment to plan steps to implement Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Intensive Case Management (ICM). The county examines the differences between individuals in various levels of care within the Full-Service Partnership program. The program's focus populations are homeless individuals, justice-involved persons, and high-utilizers of psychiatric services.

Debbie Innes-Gomberg reviewed the state's eligibility criteria for Assertive Community Treatment, which is not suitable for cases where the sole diagnosis is substance use disorders. The full payment rate covers six contacts on six different days within a month, while the partial rate covers at least four contacts on four different days within a month. Debbie also outlined the provider types included in the Assertive Community Treatment (ACT) full-size and small teams.

The county will participate in Federal Financial Participation for short-term stays in Institutes for Mental Disease (IMD) facilities under the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative. The county examines the bundled rate for Assertive Community Treatment (ACT), Coordinated Specialty Care for First Episode Psychosis, supported employment, Clubhouses, and enhanced Community Health Worker and Peer Support services. These services will become Medi-Cal entitlements for eligible clients.

<u>Committee Questions and Discussion:</u>

- A committee member asked about the low service utilization among transition-age youth compared to children and adults. The presenter explained that some children's programs will continue to serve transition-age youth through their teens, and some providers decide whether transition-age youth should move into adult programs once they reach a certain age.
- Committee members questioned the age that determines the older adult category.
- A member asked if board and care facilities were included in the program. The presenter will follow up on this question.
- A committee member stated that the California Department of Corrections and Rehabilitation (CDCR) works with the Community Assistance, Recovery, and Empowerment (CARE) Act and the CalAIM Initiative, and has found that Full-Service Partnerships are usually what justice-involved individuals need. However, it has been difficult to get this population into Full-Service Partnership programs because of the processes, paperwork, and lead time required. The

Enhanced Care Management (ECM) manager is assigned to a justice-involved client to connect them with services upon release from incarceration, but each county's knowledge base varies. The presenter stated that the county has a universal screener that indicates a client's level of care as a first step.

- A committee member asked what constitutes a less intensive level for individuals who step down from Intensive Case Management. The presenter explained that the step-down level corresponds to the Level of Care Utilization System (LOCUS) Level 3, which is defined as moderate intensity. An example of this is a highly depressed client who requires weekly Cognitive Behavioral Therapy. There will be programs available outside of the Full-Service Partnership program.
    - A committee member added that substance use is not included in Level 3; however, they may qualify through the eligibility criteria of self-neglect.
- A member asked how the county will measure the length of stay for inpatient care. The presenter stated that the county would need to impose data-informed time limits for inpatient stays.
- A committee member asked if the bundled rate for the Assertive Community Treatment teams will be specific to each county. The presenter confirmed that the rates are county-specific and posted online.
- Elissa Feld from the County Behavioral Health Directors' Association said the state will offer flexibility in team composition for the Full-Service Partnership teams.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #6 Public Comment

Reba Stevens commented on the racial demographics for the Full-Service Partnership data and noted that it can be difficult to identify where the disparities are. She suggested that zip codes also be included in the demographic data. Reba stated that it is hard to determine which geographic areas have increased or decreased service utilization.

Janet Frank asked for clarification on the independent living category for older adults. The presenter stated that she will provide this information to the committee.

Steve McNally inquired about the difference in the definition of individuals served under the county Mental Health Plan and the Managed Care Plan. He mentioned confusion during transitions of care between the two systems and emphasized that all entities should have consistent service definitions. Steve also noted that he has not seen the number of individuals who need services in the state data.

Action/Resolution
N/A

Responsible for Action-Due Date
N/A

Item #7 On-the-Ground Experience and Perspective of Provider Implementation of Assertive Community Treatment (ACT)/ Forensic Assertive Community Treatment (FACT) Within Full-Service Partnership Model

Dawan Utecht, the Senior Vice President and Chief Development Officer, and Danielle Vosburgh, the Senior Director of Community Care Delivery for Telecare Corporation, shared the provider organization's perspective on the implementation of Full-Service Partnership programs.

Telecare Corporation manages 46 programs across 16 California counties. It offers approximately 6,800 Full-Service Partnership slots in categories such as Assisted Outpatient Treatment, Care Court, Justice-Involved, Older Adult, Transition-Age Youth, and fidelity-based Assertive Community Treatment. Additionally, Telecare provides community services beyond the Full-Service Partnership program.

Danielle Vosburgh reviewed elements of Telecare's Full-Service Partnership programs. The program maintains a ten to one client-to-staff ratio with a target of averaging 8.7 direct-care hours per month. It provides crisis response by phone and in person 24 hours a day, seven days a week. Follow-up psychiatric services typically occur every three to four weeks for high and moderate intensity clients. The specialty services team includes a clinician, an Employment Specialist, a Substance Use Specialist, a Peer Support Specialist, and a Housing Support Specialist.

Telecare offers 13 tiered step-down programs across five counties, which include high-intensity services provided through Assertive Community Treatment, moderate-intensity services, and low-intensity services for individuals ready to transition from Full-Service Partnership services. The tiered model emphasizes recovery and reduces care disruptions. This approach has increased service capacity within the program and systems of care.

Telecare has 13 fidelity Assertive Community Treatment programs across three counties, which are not tiered programs. High fidelity (80 percent) is a contract requirement measured by third-party entities. New programs are given one to two years to achieve the high-fidelity standard. These services have proven effective for clients who transition out of long-term institutional settings. The Assertive Community Treatment model requires strict staffing standards to meet high fidelity and preserve resources for minimum staffing levels within programs in the system of care. However, this limits flexibility to meet the regional needs, create staffing efficiencies, and maintain client care. Staffing requirements affect the program's operational costs and the ability

to fill staff positions. Existing non-Assertive Community Treatment Full-Service Partnerships will likely need to adjust their staffing and align specific roles to comply with the fidelity model.

There are some challenges with the transition to Fidelity Assertive Community Treatment in the Behavioral Health Services Act. Telecare has addressed staffing issues with a focus on centralized scheduling to boost efficiency for difficult-to-fill and costly prescriber roles. This has allowed Telecare to reduce overall prescriber hours and maintain a high level of direct care and flexibility to meet client needs. Telecare has also implemented telehealth services in response to staffing challenges in rural communities.

The presenters reviewed the intensity of services for fidelity in Assertive Community Treatment and non-Assertive Community Treatment programs in California. The data measured average direct care hours per client monthly and quarterly.

In Fiscal Year 2024, Telecare received a grant to participate in a Learning Collaborative with Health Management Associates and the Department of Health Care Services. Telecare made significant progress in its ability to identify and serve clients with co-occurring substance use disorders under the collaborative. Staff were trained in Cognitive Behavioral Interventions – Substance Use Adults (CBI-SUA); made updates to their Electronic Health Record to support universal screening for substance use disorders; offered training sessions for medication-assisted treatment (MAT); and implemented the Substance Abuse and Mental Health Services Administration (SAMHSA) Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) toolkit to become dual diagnosis capable (DDC). Telecare provides mobile crisis, crisis stabilization, psychiatric health facilities (PHFs), crisis residential treatment, skilled nursing, and various other services to make all programs dual diagnosis capable.

The presenters discussed the impacts on the adult care system. Clients' access to and navigation of care can be delayed, so it is important to identify who meets eligibility criteria for the persons served and locate clients if referrals lack sufficient information. The teams also need to consider which housing resources are available, how they are managed within the system of care, and the needs of target populations.

Committee Questions and Discussion:

- A committee member asked how Telecare chooses telehealth providers. The presenters explained that Telecare has used external contractors for telehealth in the past, but now the organization has telehealth providers on their team who deliver services across counties.
- A member asked if Telecare focuses on co-occurring populations rather than solely on substance use disorder populations. The presenters stated that there will be specialists within the programs based on client needs, which go beyond the co-occurring population. The presenters added that dual diagnosis capability for providers is progress.
- There are some circumstances where housing programs do not want to collaborate with Full-Service Partnerships. A committee member asked about the relationship Telecare has with housing providers. The presenters stated that

Telecare offers a full range of services to support housing needs. They acknowledged that clients with housing needs require the most funding per person, especially those with the highest care needs, many of whom have been in long-term institutionalized care for years. The presenters emphasized the need for flexibility in providing housing supports within the programs. Some counties have designated housing providers, while others have run out of funds in their budgets for housing.

- Committee members and the presenters discussed the vulnerability of small counties. The presenters explained that small providers face delays in payments within the Fee-For-Service system because they lack the cash flow to cover costs in the meantime.
- A member asked if the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Workforce Initiative would help address workforce challenges. The presenters noted that the training and peer workforce initiatives has promise. The presenters hoped for a coordinated approach for an increase in the number of people who enter the behavioral health field, with more structure and a clear roadmap for recruitment and to access financial resources.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #8 Wrap Up/Next Steps

Chairperson Uma Zykofsky asked the committee for their feedback on potential topics or next steps for the upcoming quarterly meetings. Members suggested the following topics:

- Provide examples of how programs are integrated for clients who need wraparound services. There is a need to centralize initiatives to prevent issues related to service duplication. Examples of these initiatives include but are not limited to the Community Assistance, Recovery & Empowerment (CARE) Act, BH-CONNECT, and CalAIM.
- Identify and prioritize issues related to training and service provision for the substance use disorder population. It is crucial to consider how to ensure equal access to services for this group. Currently, there are ongoing discussions at the state level to create and re-establish core competency training for substance use disorder counselors.

Action/Resolution
Plan the agenda for the October 2025 Quarterly Meeting.
Responsible for Action-Due Date
Ashneek Nanua, Uma Zykofsky, Karen Baylor – October 2025