

DocuSigned by:
Marlies Perez
C595D8936F1F429...

Department of Health Care Services

BEHAVIORAL HEALTH SERVICES ACT COUNTY POLICY MANUAL

Version 1. 2. 2 – April 2025



Table of Contents

Behavioral Health Services Act County Policy Manual	1
1. Policy Manual Introduction	6
2. Behavioral Health Transformation	7
A. Introduction to Behavioral Health Transformation.....	7
A.1 Bond	8
A.2 Behavioral Health Continuum Infrastructure Program	8
B. Overview of the Behavioral Health Services Act.....	9
B.1 Behavioral Health Services Act Goals	9
B.2 Timeline for Implementation.....	11
B.3 Eligible Populations	12
C. Statewide Vision for Behavioral Health Quality and Equity	14
C.1 A Population Health Approach to Behavioral Health	14
C.2 Statewide Population Behavioral Health Goals	18
C.3 Population Behavioral Health Framework	24
3. Integrated Plan.....	26
A. Purpose of the Integrated Plan	26
A.1 Reporting Period	26
A.2 Contents of Integrated Plan	27
A.3 Function of Annual Updates and Intermittent Updates.....	28
B. Community Planning Process	30
B.1 Stakeholder Involvement	30
B.2 Considerations of Other Local Program Planning Processes.....	33
B.3 Public Comment and Updates to the Integrated Plan	41
B.4 County Planning Funds.....	43
C. Behavioral Health Care Continuum.....	44
C.1 Background	44
C.2 Behavioral Health Care Continuum	45
D. County Integrated Plan Alignment with Statewide Population Behavioral Health Goals	52

4. Behavioral Health Outcomes, Accountability, and Transparency Report	53
A. Purpose of the Behavioral Health Outcomes, Accountability, and Transparency Report.....	53
A.1 Reporting Period	54
A.2 Required Contents.....	54
5. County Portal	54
6. BHT Fiscal Policies.....	54
A. Funding Overview.....	54
B. Behavioral Health Services Act Fiscal Policies.....	54
B.1 Allocation Methodology	55
B.2 State Directed Funding	57
B.3 Local Prudent Reserve	58
B.4 Funding Transfer Requests.....	61
B.5 Funding Component Allowances	62
B.6 Reversion Policy	66
B.7 Mental Health Services Act to Behavioral Health Services Act Transition	70
B.8 Cost Principles.....	73
C. Promoting Access to Care Through Efficient Use of State and County Resources	76
C.1 Introduction	76
C.2 Securing Medi-Cal Payment.....	79
C.3 Securing Payment from Commercial Health Insurance.....	85
C.4 Appropriate Use of Other Non-Behavioral Health Services Act Funds.....	93
7. BHSA Components and Requirements.....	95
A. Behavioral Health Services and Supports.....	95
A.1 Behavioral Health Services and Supports Expenditure Guidelines	95
A.2 Children's, Adult, and Older Adult Systems of Care	96
A.3 Outreach and Engagement	97
A.4 Workforce Education and Training	99
A.5 Capital Facilities and Technological Needs	109
A.6 Innovative Behavioral Health Pilots and Projects	113

A.7 Early Intervention Programs	113
B. Full Service Partnership	129
B.1 Full Service Partnership Funding	129
B.2 Introduction and Background	129
B.3 Full Service Partnership Program Requirements	130
B.4 Full Service Partnership Levels of Care	136
B.5 Individual Placement and Support Model of Supported Employment	148
B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services	150
C. Housing Interventions	159
C.1 Housing Interventions Funding	159
C.2 Introduction and Background	159
C.3 Program Priorities	160
C.4 Eligible and Priority Populations	160
C.5 Program Requirements.....	164
C.6 Transfers and Exemptions	164
C.7 Relationship to Medi-Cal Funded Housing Services.....	167
C.8 Flexible Housing Subsidy Pools	170
C.9 Allowable Expenditures and Related Requirements	170
C.10 Capital Development Projects	188
8. Documentation Requirements for BHSA Services.....	191
Appendix A: Select Definitions	193
1. Experiencing Homelessness	193
2. At-Risk of Homelessness	195
3. Chronically Homeless	196
Appendix B: Coverage of Settings	197
Appendix C: Promoting Access to Care through Efficient use of State and County Resources Appendices.....	199
1. Process Flow for Behavioral Health Services Act-Funded Providers: Checking for and Billing Medi-Cal or Other Health Coverage	199
2. Medi-Cal Billing and Documentation Resources.....	201

3. Commercial Health Insurance Billing Guidance and Resources204

4. Other Non-Behavioral Health Services Act Funds Guidance and Resources208

Appendix D: Policy Manual Definitions210

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),¹ 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 footnote 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.

¹ [W&I Code § 5963.05, subdivision \(a\)](#)

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, [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,¹ the behavioral health workforce shortage,² a youth mental health crisis,³

¹ California Budget and Policy Center. "[The Rise of Homelessness Among California's Older Adults](#)." (May 2024).

² Cal Matters. "[Mental health workers: Why California faces a shortage](#)." (September 2022).

³ Xiang, A., Martinez, M., & Chow, T. "[Depression and anxiety among US children and young adults](#)." *Journal of American Medical Association Open*. (2024).

an older adult mental health crisis,⁴ and a shortage of culturally-responsive and diverse care.⁵ 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.⁶

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,

⁴ UCLA Health. "[California must build workforce to serve older adults' behavioral health needs, UCLA report says.](#)" (January 2019).

⁵ Kaiser Family Foundation. "[Racial and Ethnic Disparities in Mental Health Care: Findings from the KFF Survey of Racism, Discrimination and Health.](#)" (May 2024).

⁶ Mental Health America. "[The State of Mental Health in America.](#)" (2022).

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.⁷ 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) and individuals that may be at risk of developing serious mental health conditions.⁸ 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

⁷ [BHCIP Request for Applications](#)

⁸ [W&I Code § 5600.3](#)

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, [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	No later than June 30, 2026
County Board of Supervisors Approve Final Fiscal Year (FY) 2026-2029 County Integrated Plan	
County Integrated Plans Are Effective	July 1, 2026

Requirement	Effective Date
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,⁹ 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.¹⁰

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 W&I Code section 14184.402 and implemented in SMHS guidance¹¹ (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

⁹ [BHIN 21-073](#)

¹⁰ [W&I Code § 5892, subdivision \(k\)](#)

¹¹ [BHIN 21-073](#)

Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders.¹²

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

- Meet SMHS access criteria specified in [W&I Code section 14184.402, subdivision \(c\)](#) and implemented in DHCS guidance¹³ (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.¹⁴

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.¹⁵ 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 homelessness¹⁶
- Are in, or at risk of being in, the juvenile justice system¹⁷
- Are reentering the community from a youth correctional facility
- Are in the child welfare system pursuant to W&I Code sections [300](#), [601](#), or [602](#)

¹² [W&I Code § 5891.5, subdivision \(c\)](#)

¹³ [BHIN 21-073](#)

¹⁴ [W&I Code § 5891.5, subdivision \(c\)](#)

¹⁵ [W&I Code §5892, subdivision \(d\)](#)

¹⁶ Additional information and definitions are referenced in the Housing chapter below. [Chapter 7, Section C](#).

¹⁷ [BHIN-21-073](#)

- Are at risk of institutionalization¹⁸

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

- Are chronically homeless or experiencing homelessness or at risk of homelessness¹⁹
- 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 conservatorship²⁰
- Are at risk of institutionalization²¹

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.²² 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:

¹⁸ The DHCS [ECM Guide](#) defines institutionalization as “broad and means any type of inpatient, Skilled Nursing Facility, long-term, or emergency department setting.”

¹⁹ Additional information and definitions are referenced in the Housing chapter below. [Chapter 7, Section C.](#)

²⁰ [W&I Code § 5350](#)

²¹ The DHCS [ECM Guide](#) defines institutionalization as “broad and means any type of inpatient, Skilled Nursing Facility, long-term, or emergency department setting.”

²² California Health and Human Services. [“Policy Brief: Understanding California’s Recent Behavioral Health Reform Efforts.”](#) (March 2023).

- 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 health²³ 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 system²⁴:

- 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 care²⁵ 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.²⁶
- 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.
 - Improve quality²⁷ across the [behavioral health care continuum](#).

²³ Population health is defined as the health of all individuals in a defined group, and the interdisciplinary, cross-sector approach that brings health-related resources together with medical care to achieve positive health outcomes for a defined group. This definition is derived from the American Journal of Public Health’s article, “[What is Population Health?](#)”.

²⁴ The population health approach for behavioral health is adapted from the population health strategy for DHCS’ [Population Health Management](#).

²⁵ Whole-person care is an approach that coordinates physical, behavioral, and social services in a patient-centered manner to address needs comprehensively and improve the overall health and wellbeing of individuals. This definition is derived from DHCS’ [Whole Person Care Pilots](#).

²⁶ SDOH definition is derived from the [DHCS Population Health Management Policy Guide](#).

²⁷ The Agency for Healthcare Research and Quality (AHRQ) defines “quality [in healthcare]” as “providing the right care at the right time in the right way for the right person and having the best results possible”:

- Monitor effectiveness of interventions across populations.
- Support continuous improvement.
- Identify and track racial and ethnic disparities²⁸ in behavioral health outcomes.

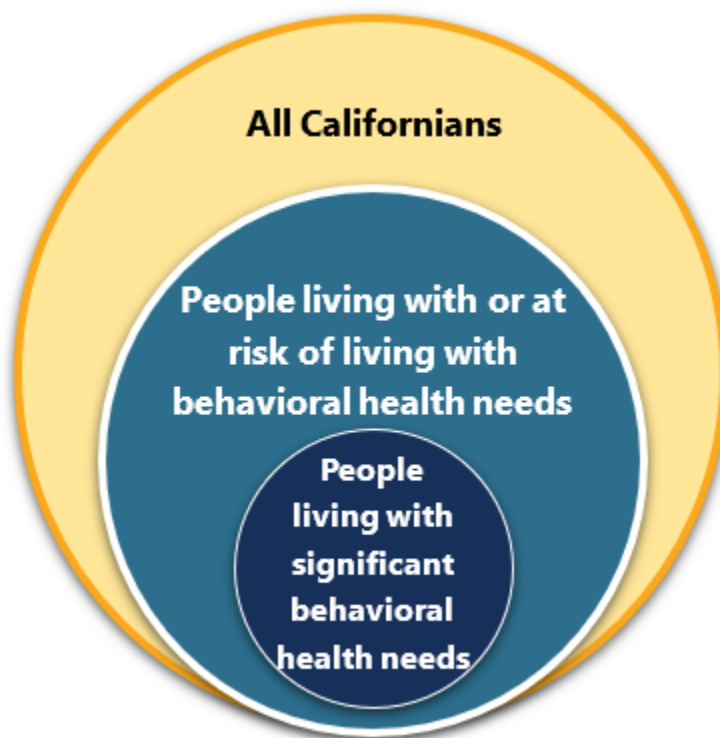


Figure 2.C.3. Population Health Approach to Behavioral Health Quality and Equity

Like the Population Health Management (PHM) Program²⁹ for Medi-Cal MCPs implemented in January 2023, a population health approach to behavioral health will reorganize and strengthen existing contract requirements, particularly requirements

[Best Practices in Public Reporting No. 2: Maximizing Consumer Understanding of Public Comparative Quality Reports: Effective Use of Explanatory Information.](#)

²⁸ "Disparities" is defined as the preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes that are experienced by underserved populations. Source: [Adapted from CDC.](#)

²⁹ DHCS' [Population Health Management \(PHM\) Program](#) is a cornerstone of CalAIM.

related to collaboration across the delivery system,³⁰ and is targeted to the delivery system that DHCS oversees.

DHCS will work 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,³¹ BH-CONNECT, and Realignment and Block Grants), while still allowing for initiative-specific goals.

As outlined in [W&I Code 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 will begin by defining statewide population behavioral health goals to define the improvements that counties and the state should be working towards together across the behavioral health delivery system. Measures associated with these goals will be developed in phases.

Phase 1 will use population-level behavioral health measures, which are defined as measures of community health and wellbeing associated with the statewide behavioral health goals. Phase 1 measures must be used in the county BHSA planning process and should inform resource planning and implementation of targeted interventions to improve outcomes. 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. As part of the 2025 PHM strategy (guidance forthcoming), Medi-Cal MCPs will also be working towards the statewide behavioral health goals and measures.

In Phase 2, measures will be used for monitoring and accountability purposes and will focus on performance of county behavioral health and Medi-Cal MCPs, respectively. The BHSA-funded interventions (e.g., Housing Interventions, Behavioral Health Services and Supports, Full Service Partnerships), as well as county behavioral health SMHS and Medi-

³⁰ See for example the [Memorandum of Understanding between \[Medi-Cal Managed Care Plan\] and \[Mental Health Plan\] template](#)

³¹ The Behavioral Health Services Act replaces the Mental Health Services Act of 2004. It reforms behavioral health care funding to prioritize services for people with the most significant mental health needs while adding the treatment of substance use disorders (SUD), expanding housing interventions, and increasing the behavioral health workforce. It also enhances oversight, transparency, and accountability at the state and local levels [Behavioral Health Services Act](#).

Cal MCP NSMHS, should impact the goals outlined in C.3. and their associated measures.

In both phases, counties should utilize the [Community Planning Process](#) detailed in the Policy Manual to work with key stakeholders to address the statewide population behavioral health goals.

C.2 Statewide Population Behavioral Health Goals

DHCS, in consultation with behavioral health stakeholders and subject matter experts, has identified 14 statewide behavioral health goals³² 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.4) 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”,³³ 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.

³² [W&I Code § 5963.02\(c\)\(3\)\(A\).](#)

³³ Sourced from [DHCS MCP Boilerplate Contract](#).

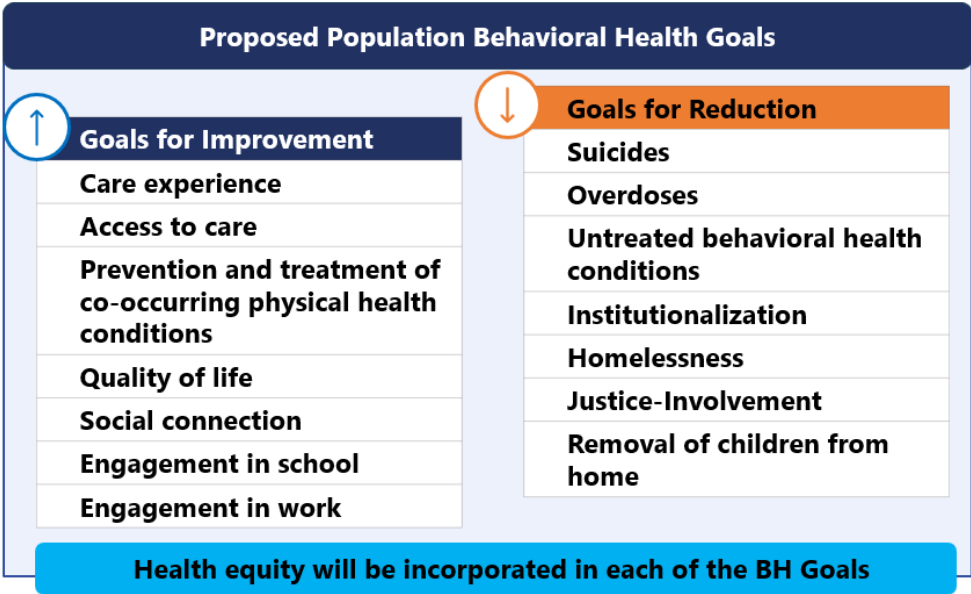


Figure 2.C.4. Statewide Population Behavioral Health Goals

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).

Measures associated with each goal are forthcoming.

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

Goals for Improvement	Definition and Rationale
	that can impact level of engagement and length of treatment. ³⁴ 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. ³⁵ 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 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,

³⁴ Definition derived from "[Patient Experience](#)" definition from the Agency for Healthcare Research and Quality, from the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

³⁵ Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services. [Access to Health Services - Healthy People 2030](#).

Goals for Improvement	Definition and Rationale
	standards, and concerns.” ³⁶ 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. ³⁷ 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. ³⁸ 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

³⁶ World Health Organization. [WHOQOL - Measuring Quality of Life](#). Division of Mental Health and Prevention of Substance Abuse. World Health Organization. March 2012.

³⁷ Center for Disease Control and Prevention. [Social Connection](#).

³⁸ Derived from “[Student Engagement](#)” definition on The Glossary of Education Reform.

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. ^{39,40} 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. ⁴¹ In California, drug-related overdose deaths have doubled since 2017, reaching 10,898 in 2021, ⁴² with the greatest impact among racial and ethnic minorities, and individuals experiencing homelessness, unemployment, and incarceration.

³⁹ Definition sourced from the [National Institute of Mental Health](#). In relation, “suicide attempt” refers to the non-fatal, self-directed, potentially injurious behavior with intent to die as a result of behavior, and “suicidal ideation” refers to thinking about, considering, or planning suicide.

⁴⁰ 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](#).

⁴¹ Referenced from the [California Department of Public Health](#).

⁴² Referenced from the [California Department of Public Health](#). Statistic is sourced from the [California Overdose Surveillance Dashboard](#).

Goals for Reduction	Definition and Rationale
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 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 institutionalization 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

Goals for Reduction	Definition and Rationale
	<p>living with a behavioral health condition.⁴³ 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.⁴⁴ Promoting coordinated systems of care between the legal system and behavioral health plans and providers can have an impact on reducing justice involvement and improving outcomes for those who are justice-involved.</p>
<p>Removal of children from home</p>	<p>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.</p>

C.3 Population Behavioral Health Framework

Under BHT, DHCS will partner with counties to participate in a cycle of continuous improvement to drive progress on the statewide behavioral health goals (shown in Figure 2.C.5):

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 counties describing their performance on the statewide behavioral health goals.

⁴³ Substance Abuse and Mental Health Services Administration. [About Criminal and Juvenile Justice](#).

⁴⁴ Ingrid A. Binswanger, Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. ["Release from Prison — A High Risk of Death for Former Inmates."](#) New England Journal of Medicine, January 2007.

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.

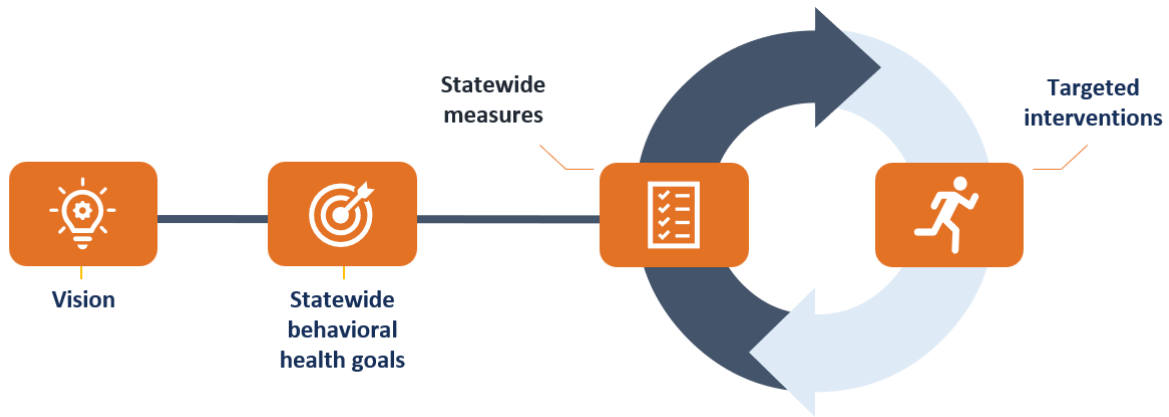


Figure 2.C.5. Population Behavioral Health Framework

3. Integrated Plan

A. Purpose of the Integrated Plan

The Behavioral Health Services Act (BHSA) requires counties¹ to submit three-year Integrated Plans (IPs) 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.² 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 [W&I Code 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,

¹ [W&I Code §§ 5963, subdivision \(a\); 5963.02, subdivision \(a\)](#)

² [W&I Code § 5963, subdivision \(a\)\(1\)](#)

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 30.³ The board of supervisors is also required to confirm in each IP that the county will meet their realignment obligations.⁴ 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 [W&I Code 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 programs⁵:

- 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)

³ [W&I Code § 5963.02, subdivision \(a\)\(3\)](#)

⁴ [W&I Code § 14197.71, subdivision \(c\)\(2\)](#)

⁵ [W&I Code § 5963.02, subdivision \(c\)\(1-2\)](#)

- 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 Submit⁶	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 Draft⁷	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 Required⁸	Yes	No, but encouraged	No, but encouraged
30-day Public Comment Period Required⁹	Yes	Yes	Yes

⁶ [W&I Code § 5963.02, subdivision \(a\)\(1\)](#)

⁷ [W&I Code § 5963.02, subdivision \(a\)\(3\)](#)

⁸ [W&I Code § 5963.03, subdivision \(a\)](#)

⁹ [W&I Code § 5963.03, subdivision \(c\)\(B\)](#)

	Integrated Plan	Annual Updates	Intermittent Updates
Behavioral Health Board Hearing Required¹⁰	Yes	If county engages stakeholders	If county engages stakeholders
Board of Supervisors Approval and Submission¹¹	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 for the Integrated Plan (IP) are effective January 1, 2025.¹² Counties must engage with local stakeholders to develop each element of their IP.¹³ The stakeholders that must be engaged include, but are not limited to¹⁴:

- Eligible adults and older adults¹⁵ (individuals with lived experience)
- Families of eligible children and youth, eligible adults, and eligible older adults¹⁶ (families with lived experience)

¹⁰ [W&I Code § 5963.03, subdivision \(b\)](#)

¹¹ [W&I Code §§ 5963.03, subdivision \(c\)\(10\)-\(11\)](#)

¹² [W&I Code §5963.03, subdivision \(e\)](#)

¹³ [W&I Code §5963.02, subdivision \(c\)](#)

¹⁴ [W&I Code §5963.03, subdivision \(a\)\(1\)](#)

¹⁵ [W&I Code § 5892, subdivision \(d\)\(1\)](#)

¹⁶ [W&I Code § 5892, subdivision \(d\)](#)

- 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)¹⁷
- Disability insurers (a commercial disability insurer that covers hospital, medical or surgical benefits as defined in Insurance Code 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,¹⁸ including, but not limited to:

- Representatives from youth from historically marginalized communities

¹⁷ [W&I Code § 14184.101, subdivision \(j\)](#)

¹⁸ [W&I Code § 5963.03, subdivision \(a\)\(2\)\(A\)\(ii\)](#)

- 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.¹⁹ 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 stakeholders²⁰ 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

¹⁹ [W&I Code § 5963.03\(a\)\(2\)\(A\)\(i\)](#)

²⁰ [W&I Code § 5963.03, subdivision \(a\)\(2\)\(A\)\(i\)](#)

- 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.²¹

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.²² 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).²³ Specifically, the Behavioral Health Services Act (BHSA) requires that each county must:

²¹ [W&I Code §5963.03, subdivisions \(a\)\(2\)\(A\)\(i\) and \(ii\)](#)

²² [W&I Code §5892, subdivision \(e\)\(1\)](#)

²³ 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 §101185.

- Work with its LHJ on the development of its Community Health Improvement Plan (CHIP) ([W&I Code section 5963.01, subdivision \(b\)](#)).
- Consider the CHIP of each LHJ that covers residents of the county in preparing their IP and annual update ([W&I Code 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) ([W&I Code 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.²⁴
- Consider the PNA of each MCP that covers residents of the county in preparing their IP and annual update ([W&I Code 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 interventions²⁵ and health outcomes for, and thus more effectively improve the lives of, community members. 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

²⁴ [CalAIM: Population Health Management Policy Guide \(May 2024\)](#)

²⁵ Upstream interventions include those that link to public health and social services and support members staying healthy through wellness and prevention services. For further details and additional context, see the [PHM Policy Guide \(p.4\)](#) and [CalAIM Population Health Management Initiative webpage](#).

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.²⁶

- The CHA describes the status of population health within a jurisdiction.²⁷
- 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

²⁶ 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 \(p. 8-10\)](#)

²⁷ 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.

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 includes²⁸:

- **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.

MCPs are required to complete an [“MCP-LHJ Collaboration Worksheet”](#) to demonstrate that they are meeting their PNA requirement.²⁹

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.

²⁸ See the [CalAIM PHM Policy Guide](#) for additional details on MCP PNA Requirements (p. 7-10)

²⁹ 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.

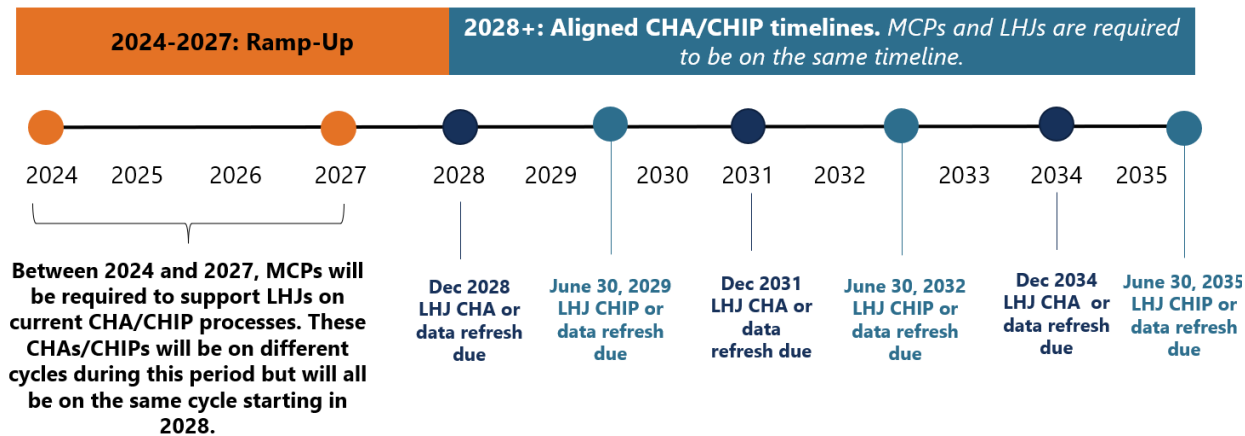


Figure 3.B.2.1. LHJ CHA and CHIP Submission Cycle Alignment Timeline

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.

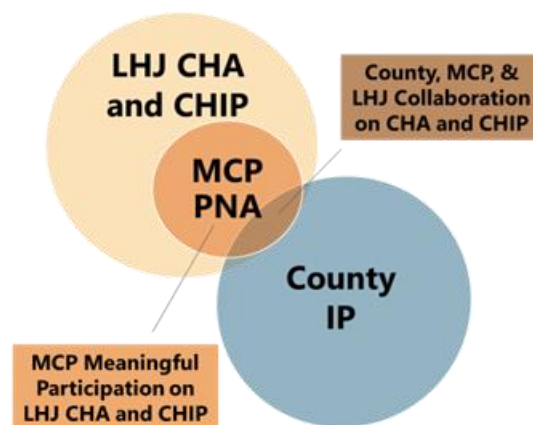


Figure 3.B.2.2 LHJ CHA and CHIP, MCP PNA, and County IP Overlap

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),³⁰ along with MCPs, in fulfillment of their meaningful participation requirements. If multiple MCPs are present in the county or city,

³⁰ For a complete list of LHJs, see CDPH's [listing of local health services/offices](#).

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.³¹
- 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

³¹ 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.

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.³²

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. Monitoring and Oversight

In alignment with MCP PNA requirements and to support successful partnerships among counties, LHJs, and MCPs, DHCS has developed, and will require submission of, a "County-LHJ-MCP Collaboration Worksheet" (see Appendix; *placeholder- Worksheet to be added when finalized*). This Worksheet will require input from all three partners attesting to their efforts across the three areas of collaboration, data sharing, and

³² 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 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.

stakeholder engagement. Completion of the Worksheet will offer insight into these cross-sector partners' experiences as they build relationships and begin working together towards shared goals.

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.

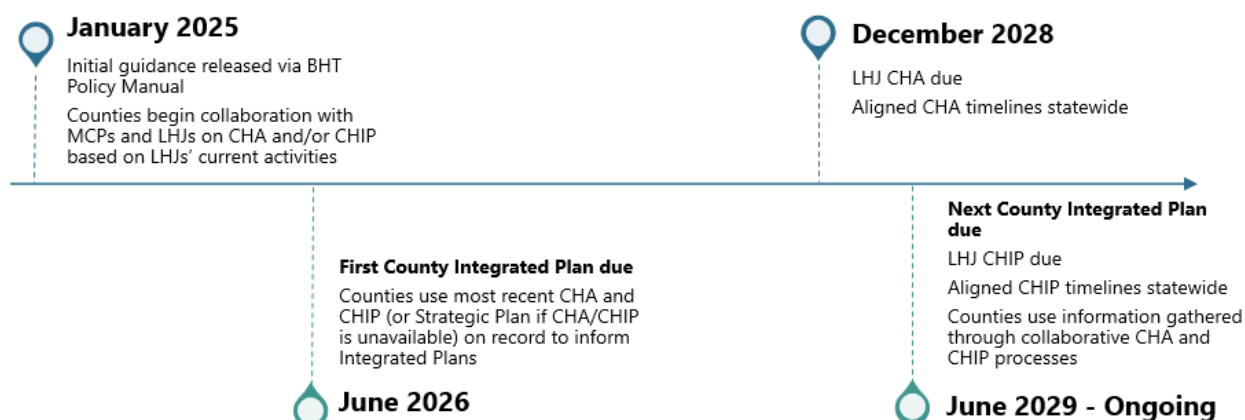


Figure 3.B.2.3 Timeline for Implementation of County, LHJ, and MCP Collaboration

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 draft IP. A draft IP and update shall be prepared and circulated for review and comment for at least

30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.³³

Local Behavioral Health Board

The local behavioral health board shall conduct a public hearing on the draft IP at the close of the 30-day comment period.³⁴

Once an IP has been drafted and 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. The local behavioral health board is not required to approve county Integrated Plans.³⁵

The local behavioral health agency is also required to provide an annual report to the local governing body, which is the local Board of Supervisors or city council, and DHCS that includes written explanations in response to any substantive recommendations³⁶ made by the local behavioral health board that are not included in the final IP or update.³⁷

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 draft IP should include a summary of substantive written recommendations.³⁸
- The draft IP should also include a summary and analysis of the revisions made as a result of stakeholder feedback.³⁹

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 not required to comply with the stakeholder process outlined in W&I Code section [5963.03, subdivision \(a\)](#) and W&I Code section [5963.03,](#)

³³ [W&I Code § 5963.03, subdivision \(a\)\(2\)\(B\)](#)

³⁴ [W&I Code § 5963.03, subdivision \(b\)\(1\)](#)

³⁵ [W&I Code § 5963.03, subdivision \(b\)](#)

³⁶ [W&I Code § 5963.03, subdivision \(d\)](#)

³⁷ [W&I Code § 5963.03, subdivision \(b\)\(5\)](#)

³⁸ [W&I Code § 5963.04, subdivision \(d\)](#)

³⁹ [W&I Code § 5963.03, subdivision \(b\)\(3\)](#)

[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 outlined above.⁴⁰

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.⁴¹ 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 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.⁴²

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

⁴⁰ [W&I Code § 5963.03, subdivision \(b\)\(1\)](#)

⁴¹ [W&I Code § 5963.03, subdivision \(c\)\(2\)\(B\)](#)

⁴² [W&I Code § 5892, subdivision \(e\)\(1\)\(B\)-\(C\)](#)

- 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 [Welfare and Institutions \(W&I\) Code 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.⁴³ 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.⁴⁴ 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.

⁴³ While informed by national behavioral health frameworks, the Behavioral Health Care Continuum is tailored to California's specific landscape and adjusted to reflect input from California stakeholders. The Continuum is also informed by [DHCS's previous assessment](#) of California's Medi-Cal behavioral health service delivery system.

⁴⁴ The Behavioral Health Care Continuum includes services provided in facilities designated as Institutions for Mental Disease (IMD) and services in non-IMD facilities. The IMD exclusion is only applicable to billing for Medi-Cal services.

Discrete SUD Service Categories	Primary Prevention Services	Early Intervention Services	Outpatient Services	Intensive Outpatient Services	Crisis and Field-Based Services	Residential Treatment Services	Inpatient Services	Housing Intervention Services
Discrete MH Service Categories	Primary Prevention Services	Early Intervention Services	Outpatient & Intensive Outpatient Services	Crisis Services	Residential Treatment Services	Hospital/ Acute Services	Subacute/ Long-term Care Services	

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 as well as examples of the specific services that should be reported under the SUD and MH frameworks. A more detailed inventory cataloguing DHCS's 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 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,⁴⁵ and Example Services

Service Categories	Service Category Definition	Example SUD Services ⁴⁶
Population Prevention Services⁴⁷	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.	<ul style="list-style-type: none"> • Substance use disorder education, such as paid media campaigns regarding “fentapills” • Targeted prevention, such as SUBG-funded prevention screenings and referrals
Early Intervention Services⁴⁸	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 individuals in maintaining healthy lifestyles.	<ul style="list-style-type: none"> • Screenings • Brief intervention, American Society of Addiction Medicine (ASAM) level 0.5 • Evidence-based practices, like motivational interviewing

⁴⁵Definitions are informed by [DHCS's previous assessment](#) of California's Medi-Cal behavioral health service delivery system and tailored to the county landscape.

⁴⁶ Services referenced reflect the ASAM 3rd edition. Medi-Cal guidance on the ASAM 4th edition is forthcoming. Available [here](#).

⁴⁷ While 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., SAMHSA SUBG block grant, opioid settlement, Realignment, etc.) which this category will capture.

⁴⁸ [W&I Code § 5840, subdivisions \(b\)\(1\)-\(3\)](#)

Service Categories	Service Category Definition	Example SUD Services ⁴⁶
Outpatient Services⁴⁹	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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • Mobile crisis • Assertive field-based initiation for substance use disorder treatment services⁵⁰ • 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.	<ul style="list-style-type: none"> • ASAM level 3.1-3.5 care

⁴⁹ [W&I Code § 5887, subdivision \(a\)\(4\)](#)

⁵⁰ [W&I Code § 5887, subdivision \(a\)\(3\)](#)

Service Categories	Service Category Definition	Example SUD Services ⁴⁶
Inpatient Services	Includes 24-hour, intensive treatment services to individuals who require medical management or medical monitoring for substance use disorder needs.	<ul style="list-style-type: none"> ASAM levels 3.7-4.0 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 <i>(reporting is aggregated with the mental health framework)</i>	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.	<ul style="list-style-type: none"> 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,⁵¹ and Example Services

⁵¹ Definitions are informed [by DHCS's previous assessment](#) of California's Medi-Cal behavioral health service delivery system and tailored to the county landscape.

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 coping with stressors and information on ways to promote resiliency.	<ul style="list-style-type: none"> • Mental health education, such as public health campaigns for suicide prevention or adverse childhood experiences (ACEs) awareness • Community Health Workers
Early Intervention Services⁵²	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.	<ul style="list-style-type: none"> • Screenings • Evidence-based practices, such as coordinated specialty care for first episode psychosis
Outpatient⁵³ & Intensive Outpatient Services	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	<ul style="list-style-type: none"> • Individual therapy • Group therapy • Assertive Community Treatment/ Forensic Assertive Community Treatment (ACT/FACT)

⁵² [W&I Code § 5840, subdivisions \(b\)\(1\)-\(3\)](#)

⁵³ [W&I Code § 5887, subdivision \(a\)\(4\)](#)

Service Categories	Service Category Definition	Example MH Services
	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.	<ul style="list-style-type: none"> • 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 experiencing a mental health crisis, including through de-escalation and stabilization techniques, and may be delivered in clinical and non-clinical settings.	<ul style="list-style-type: none"> • Crisis call centers • Crisis stabilization • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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).	<ul style="list-style-type: none"> • Services within a SNF & SNF-STP • Services within a MHRC
Housing Intervention Services	Includes services and supports designed to enable individuals to remain in their homes or obtain housing to support recovery and improved health	<ul style="list-style-type: none"> • Permanent supportive housing

Service Categories	Service Category Definition	Example MH Services
<i>(reporting is aggregated with the substance use disorder framework)</i>	outcomes. Services help individuals find and retain housing, support recovery and resiliency, and/or maximize the ability to live in the community.	<ul style="list-style-type: none"> • Housing tenancy and sustaining services • Residential Care Facilities for the Elderly (RCFE) and Adult Residential Care Facilities (ARF) • Rent • Interim Settings

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

As outlined in [W&I Code 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.

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 counties¹ to submit Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) to the Department of Health Care Services (DHCS) on an annual basis. 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.² Additionally, in accordance with [Welfare and Institutions \(W&I\) Code 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 [W&I Code 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.³

¹ [W&I Code § 5963.04, subdivision \(a\)\(1\)](#)

² [W&I Code § 5963.04, subdivision \(c\)](#)

³ [W&I Code § 5964.04, 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.

[W&I Code 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.¹ 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),

¹ [W&I Code § 5892, subdivision \(g\)](#)

intermittent updates, and/or annual update (AU).² 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.³
 - 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.⁴
 - Of the funds distributed for the Housing Interventions program, counties are required to expend no more than 25 percent of funds for capital development.⁵
- 35 percent to Full Service Partnerships programs.⁶
- 35 percent to Behavioral Health Services and Supports .^{7,8}:
 - 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.⁹

² [W&I Code § 5892, subdivision \(h\)](#)

³ [W&I Code § 5892, subdivision \(a\)\(1\)\(A\)\(i\)](#)

⁴ [W&I Code § 5892, subdivision \(a\)\(1\)\(A\)\(ii\)](#)

⁵ [W&I Code § 5892, subdivision \(a\)\(1\)\(A\)\(iii\)](#)

⁶ [W&I Code § 5892, subdivision \(a\)\(2\)\(A\)](#)

⁷ [W&I Code § 5892, subdivision \(a\)\(3\)\(A\)](#)

⁸ [W&I Code § 5892, subdivision \(a\)\(3\)\(B\)](#)

⁹ [W&I Code § 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.¹⁰
- 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.¹¹ 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.¹² For more information regarding HCAI-led initiatives to build the behavioral health workforce, please visit their [website](#).
3. State-directed Purposes

¹⁰ [W&I Code § 5892, subdivision \(a\)\(3\)\(B\)\(ii\)](#)

¹¹ [W&I Code § 5892, subdivision \(f\)\(1\)\(E\)](#)

¹² [W&I Code § 5892, subdivision \(f\)\(1\)\(D\)](#)

- a. The state will allocate 3 percent of total funds to support the operations of state agencies and the BHSI Innovation Partnership Fund where up to \$20M will be allocated annually for Fiscal Years (FY) 2026-27 to 2030-31.¹³ 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.¹⁴ 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 BHSI webpage.

B.3.1 Prudent Reserve Assessment

Counties must assess their PR funding levels every three years and include the assessment in their IP, beginning with the Fiscal Year (FY) 2026-29 IP.¹⁵ Additionally, counties must include a plan on how they will spend any funds exceeding the maximum amount in their IP.¹⁶ The reassessment must include the maximum and the actual funding levels of the county's PR.¹⁷ DHCS will complete this annual calculation for all counties and post it on the DHCS BHSI Webpage. Counties will utilize the adjusted PR levels when submitting their annual IP update.

¹³ [W&I Code § 5892, subdivision \(f\)\(1\)\(A\)\(F\)](#)

¹⁴ [W&I Code § 5892, subdivision \(b\)\(1\)](#)

¹⁵ [W&I Code § 5892, subdivision \(b\)\(5\)](#)

¹⁶ [W&I Code § 5892, subdivision \(b\)\(5\)](#)

¹⁷ [W&I Code § 5892 subdivision \(b\)\(5\)](#)

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 to establish the local PR based on deposits into the BHSF.¹⁸ 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.¹⁹ The new PR maximums will take effect July 1, 2026.²⁰

- 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

¹⁸ [W&I Code § 5892, subdivision \(b\)\(1\)](#)

¹⁹ [W&I Code § 5892, subdivision \(b\)\(3-4\)](#)

²⁰ 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.

California Consumer Price Index.²¹ 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.

²¹ [W&I Code § 5892, subdivision \(b\)\(2\)](#)

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.²² 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.²³

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.²⁴ 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.

²² [W&I Code § 5892, subdivision \(c\)\(1\)](#)

²³ [W&I Code § 5892, subdivision \(c\)\(2\)](#)

²⁴ [W&I Code § 5892, subdivision \(c\)\(4\)](#)

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.²⁵ 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.²⁶ For transfer requests, counties are also required to adhere to local stakeholder consultation requirements.²⁷ 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, 2026.²⁸

Table B.5.1 Overview of Funding Allowances

Statute	Allocation	Sub-Allocations	Special Considerations
W&I Code section 5892, subdivision (a)(1)(A)	Housing Intervention Programs (30%)	50% of these funds shall be directed towards	These housing interventions are focused on the chronically homeless, with a focus on encampments.

²⁵ [W&I Code § 5892, subdivision\(c\)\(4\)](#)
²⁶ [W&I Code § 5892, subdivision \(c\)\(4\)\(A\)](#)
²⁷ [W&I Code §§ 5963.02 and 5963.03](#)
²⁸ [W&I Code § 5892, subdivision \(l\)](#)

Statute	Allocation	Sub-Allocations	Special Considerations
		housing interventions for persons who are chronically homeless.	
		No more than 25% shall be used for capital development projects.	Housing Intervention funds may be used for capital development, under the provisions of W&I Code section 5831 , and only for eligible populations under W&I Code 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 (W&I Code section 5830, subdivision (b)(2)(B)).
W&I Code 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 a FSP program.
W&I Code section 5892, subdivision (a)(3)(A)	Behavioral Health Services and Supports (BHSS) (35%)	At least 51% of BHSS services shall be used exclusively for early	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.

Statute	Allocation	Sub-Allocations	Special Considerations
W&I Code section 5892, subdivision (a)(3)(B)(i-ii)		intervention programs.	

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.²⁹ To be granted an annual change, a county shall demonstrate to DHCS that it is experiencing a state³⁰ or local³¹ 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.³² 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.³³

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.³⁴

If the transfer request is approved, funding allocation adjustments cannot be changed during the three-year IP period, unless an annual change is approved by DHCS.³⁵ 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

²⁹ [W&I Code § 5892, subdivision \(c\)\(4\)\(C\)](#)

³⁰ [Gov. Code, § 8625](#)

³¹ [Gov. Code, § 8630](#)

³² [W&I Code § 5892, subdivision \(c\)\(4\)\(C\)](#)

³³ [W&I Code § 5963.03\(c\)\(1\)](#)

³⁴ [W&I Code § 5892, subdivision\(c\)\(4\)](#)

³⁵ [W&I Code § 5892, subdivision \(c\)\(4\)\(C\)](#)

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 within 90 days of receipt of the denial from DHCS, unless the county receives approval for an extension to this timeframe.

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.³⁶

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](#).

³⁶ [W&I Code § 5963.04, subdivision \(a\)](#)

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.³⁷

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 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.³⁸ The first BHOATR will cover FY 2026-27 and is due to DHCS on January 30,

³⁷ [W&I Code § 5892, subdivision \(i\)](#)

³⁸ [W&I Code § 5963.04, subdivision \(a\)\(1\)](#)

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.³⁹ 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

³⁹ [W&I Code § 5963.04, subdivision \(e\)\(3\)\(A\)\(i\)](#)

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.⁴⁰
- An executed BHSA Fiscal Accountability Certification form.⁴¹

The county must submit an appeal within 30 calendar days of receiving the notice of the amount of the county's funds that are subject to reversion.⁴² DHCS will not consider late appeals. DHCS will review the appeal documents and email a written decision to the county within 45 calendar days of receiving the appeal.⁴³

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, depending on county size.⁴⁴ 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

⁴⁰ [DHCS Form 1821](#)

⁴¹ [DHCS Form 1820](#)

⁴² [California Code of Regulations Title 9 § 3420.65, subdivision \(b\)](#)

⁴³ [California Code of Regulations Title 9 § 3420.65, subdivision \(c\)](#)

⁴⁴ [W&I Code § 5892, subdivision \(i\)](#)

future monthly BHSA distribution and transfer the funds into the state's Reversion Account.⁴⁵

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.⁴⁶

DHCS will prioritize offsetting reversion funds before implementing withholds (e.g., due to a late BHOATR).⁴⁷ 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.⁴⁸

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.

⁴⁵ [W&I Code § 5892, subdivision \(i\)\(2\)\(A\)](#)

⁴⁶ [W&I Code § 5892, subdivision \(i\)\(2\)\(B\)](#)

⁴⁷ [W&I Code § 5892, subdivision \(i\)\(2\)\(C\)](#)

⁴⁸ [W&I Code § 5892, subdivision \(i\)\(2\)\(C\)](#)

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.⁴⁹ 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

⁴⁹ [W&I Code § 5892, subdivision \(a\)\(1-3\)](#)

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 2025-26.⁵⁰

Once BHSA becomes effective starting July 1, 2026, counties will be required to report program expenditures on their county's new BHOATR beginning with FY 2026-27 and expenditures must be consistent with the three-year IP.⁵¹

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).⁵² Counties must spend BHSA funds for their authorized purpose within three years and CFTN and WET funds within ten years.⁵³

B.8 Cost Principles

B.8.1 Administrative Costs

Starting July 1, 2025,⁵⁴ 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.⁵⁵

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

⁵⁰ [W&I Code § 5899](#)

⁵¹ [W&I Code § 5963.04](#)

⁵² As outlined in Chapter 6, Section B.7.2 Innovation Funding, 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, FY 2026-29.

⁵³ [W&I Code § 5892, subdivision \(i\)](#)

⁵⁴ [W&I Code § 5892, subdivision \(e\)\(2\)\(C\)](#)

⁵⁵ [W&I Code § 5892, subdivision \(e\)\(2\)\(B\)](#)

Transition from Homelessness grant, the Community Mental Health Services Block Grant (MHBG), Substance Use 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.^{56,57} 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).⁵⁸

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:

⁵⁶ [W&I Code 5963.04, subdivision \(a\)\(2\)\(F\)](#)

⁵⁷ [W&I Code § 5963.02, subdivision \(c\)\(2\)](#)

⁵⁸ [W&I Code § 5963.04, subdivision \(a\)\(2\)\(F\)](#)

- Capital improvements (unless amortized).
- Purchase or construction of buildings.
- Compensation to members of a local behavioral health board.⁵⁹

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

⁵⁹ Except for reimbursement of expenses per [W&I Code § 5604.3](#).

- The county must charge indirect costs to a BHSA program through an acceptable allocation method ([2 CCR 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).⁶⁰ Counties may use BHSA dollars to serve any individuals who meet the eligibility criteria for the particular service, including individuals who are uninsured.⁶¹ 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.⁶² The policy described in this

⁶⁰ 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.

⁶¹ [W&I Code § 5892, subdivision \(k\)\(7\)\(8\)](#). For additional discussion of BHSA eligibility criteria and priority populations, see Chapter 2, Section B.3. For additional discussion of the eligibility requirements for specific BHSA services and supports, see Chapter 7.

⁶² These DHCS-approved uses of BHSA funds are deemed to comply with the population prioritization rubric in [W&I Code § 5892, subdivision \(d\)](#).

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.⁶³

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

- A. **Securing Medi-Cal Payment.** 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) (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).⁶⁴ 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.⁶⁵ 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

⁶³ Codified in W&I Code §§ [5813.5, subdivision \(c\)](#), [5878.3, subdivision \(a\)](#), [5830, subdivision \(c\)](#), and [5891, subdivision \(a\)](#).

⁶⁴ [W&I Code § 5891, subdivision \(a\)\(2\)](#); For the definition of the county's Medi-Cal Behavioral Health Delivery System, please see [W&I Code § 14184.101\(i\)](#).

⁶⁵ [W&I Code § 5891, subdivision \(a\)\(3\)](#)

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, Welfare and Institutions (W&I) Code section [5891, subdivision \(a\)\(2\)](#) directs counties to maximize Medi-Cal federal financial participation (FFP) for BHSA-funded services.⁶⁶ 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.⁶⁷ At the same time, W&I Code section [5891, subdivision \(a\)\(3\)](#) allows counties to use BHSA funds before exhausting reimbursement from Medi-

⁶⁶ W&I Code §§ [5878.3, subdivision \(a\)\(2\)](#) and [5813.5, subdivision \(c\)](#) have similar operative language, respectively applicable to children/youth and adults/older adults.

⁶⁷ [W&I Code § 5891, subdivision \(a\)\(3\)](#)

Cal MCPs. W&I Code section [5891, subdivision \(a\)\(3\)](#) does not alter the requirement under W&I Code section [5830, subdivision \(c\)\(2\)](#) that BHSA funds may not be used for Housing Intervention services, including rent, covered by Medi-Cal MCPs.⁶⁸ Under W&I Code 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.⁶⁹

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.⁷⁰

⁶⁸ [W&I Code § 5830, subdivision \(c\)\(2\)](#)

⁶⁹ More information on AEVS is available in DHCS' "[Medi-Cal Program and Eligibility Manual](#)." Providers can access AEVS in DHCS [Provider Portal for Transaction Services, Login to Medi-Cal](#).

⁷⁰ More information on clean claims can be found in [APL 23-020](#). Questions providers should ask MCPs are: What is your policy on timely filing? What are your clean claim billing instructions and requirements? How should I submit claims? Which clearinghouses do you accept?

- **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.⁷¹

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.⁷²
- Becoming certified as a specialty mental health services (SMHS)⁷³ and/or Drug

⁷¹ For timely payment of provider claims, see [Medi-Cal Managed Care Plan Contract](#), Exhibit A Attachment III, section 3.3.5, "Claims Processing," and APL [23-020](#), "Requirements for Timely Payment of Claims." For access requirements, see [Medi-Cal Managed Care Plan Contract](#), Exhibit A Attachment III, sections 5.2.5, "Network Adequacy Standards," 5.2.7, "Out-of-Network Access", and 5.5.3 "Non-specialty Mental health Services Providers," and [APL 23-001](#), "Network Certification Requirements," and [Attachment A](#), "Network Adequacy Standards."

⁷² These requirements are stated in BHINS [18-019](#) and [22-070](#).

⁷³ SMHS certification and recertification requirements are outlined in [9 CCR § 1810.435](#), the [Mental Health Plan: Certifications \(MHP-owned & operated Clinics\)](#) materials and the current county SMHS contract with DHCS, [Exhibit E, Attachment 1, Definitions](#).

Medi-Cal (DMC) provider.⁷⁴

- 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.⁷⁵
- 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).⁷⁶
- 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 at the time an individual first seeks BHSA-funded services, **unless** crisis or outreach services are needed urgently.⁷⁷

⁷⁴ DMC certification is described on DHCS's webpage, [Drug Medi-Cal Certification](#). DHCS's SUD Licensing and Certification Toolkit outlines the full process for Medi-Cal certification and enrollment for DMC/DMC-ODS providers, [DHCS Level of Care Designation and ASAM Level of Care Certification](#).

⁷⁵ The full list of providers and facilities eligible and required to enroll in Medi-Cal through PAVE is available on DHCS webpage "[Provider Enrollment Options](#)." See also DHCS webpage [Application Information by Provider Type](#). Providers apply for Medi-Cal enrollment with the [Provider Enrollment Division](#). Almost all individual SMHS providers and facilities are required to enroll in Medi-Cal, as described in [BHIN 20-071](#). SUD providers must become DMC certified before they can be county-contracted providers, as described in [W&I Code § 14124.24\(e\)](#) and are required to enroll in Medi-Cal, as described in [BHIN 20-071](#).

⁷⁶ 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.

⁷⁷ For more information about OHC, please see the DHCS Third Party Liability and Recovery Division webpage for [Other Health Coverage](#).

- 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).⁷⁸

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.

⁷⁸ More information on AEVS is available on DHCS webpage "[Medi-Cal Program and Eligibility Manual](#)." Providers can access AEVS in the DHCS [Provider Portal for Transaction Services, Login to Medi-Cal](#). The MEDS Account Request form is available: "[Medi-Cal Eligibility Data System \(MEDS\) Account Request](#)." 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 [W&I Code § 14018.2](#) and DHCS [Eligibility: Recipient Identification](#).

- 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.⁷⁹
- 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](#).

⁷⁹ A comprehensive list of county social service agencies is available on DHCS website "[County Offices](#)." An overview of information an individual must provide when applying for Medi-Cal is available on DHCS website "[Confirm Eligibility](#)."

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 IP by June 30, 2026. DHCS will use the Integrated Plan (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, Welfare and Institutions (W&I) Code 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 that the commercial plan covers.⁸⁰ State law allows counties to use BHSA funds before exhausting commercial insurance coverage.⁸¹

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

⁸⁰ The guidance in this section applies only to a service that is paid in whole or in part with BHSA.

⁸¹ [W&I Code § 5891, subdivision \(3\)\(A\)](#)

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.⁸² 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, many employer-sponsored plans are exempt from state requirements,⁸³ 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.⁸⁴ 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.⁸⁵

⁸² [H&S Code § 1374.72; Ins. Code § 10144.5; APL 24-007 – Implementation of Senate Bill 855 Regulation. Mental Health and Substance Use Disorder Coverage; 28 CCR §§ 1300.74.72, 1300.74.72.01, 1300.74.721.](#)

⁸³ [29 U.S.C. § 1144](#)

⁸⁴ [45 CFR § 146](#)

⁸⁵ Other Health Coverage (OHC) provider manuals can be found on DHCS website "[Other Health Coverage Resources](#)."

Requirements for Billing Other Health Coverage

Because federal and state law requires Medi-Cal to be the payer of last resort,⁸⁶ 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.⁸⁷ 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.⁸⁸

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).

⁸⁶ [W&I Code § 14124.90; 42 CFR § 433 Subpart D.](#)

⁸⁷ Other Health Coverage (OHC) provider manuals can be found on DHCS website "[Other Health Coverage Resources.](#)"

⁸⁸ [DHCS Third Party Liability and Recovery Division](#)

- 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.⁸⁹
 - 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

⁸⁹ A comprehensive list of county social service agencies is available on DHCS website "[County Offices](#)." An overview of information an individual must provide when applying for Medi-Cal is described on DHCS website "[Confirm Eligibility](#)."

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 process⁹⁰ 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.⁹¹

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

⁹⁰ [H&S Code § 1367, subdivision \(h\)\(2\)](#) requires the commercial plan to make this dispute resolution process available for out of network providers.

⁹¹ [W&I Code § 5891, subdivision \(a\)\(3\)\(C\)](#)

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. W&I Code 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. See the footnote for additional information).⁹²

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.

⁹² A full list of the plans DMHC regulates is available on DMHC's website "[Choose a Health Plan](#)." The plans CDI regulates are available on CDI's website "[List of Insurers Providing Health Insurance Coverage](#)."

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

Complaint type	Submit to
<ul style="list-style-type: none"> • Claim denials • Failure to pay timely⁹³ 	<ul style="list-style-type: none"> • DMHC or CDI • DHCS/TPLRD (for OHC-related complaints)
Failure to contract or impeding providers' good faith efforts to contract.	<ul style="list-style-type: none"> • DMHC or CDI

⁹³ State-regulated health plans are required to pay all clean claims within 30 working (or business) days of receipt (45 working days for HMOs) unless the claim or portion of the claim is contested by the plan. See H&S Code §§ [1371, subdivision \(a\)\(1\)](#), [1371.35, subdivision \(a\)](#), [1373.10, subdivision \(b\)](#); 28 CCR §§ [1300.71, subdivision \(a\)\(9\)](#), [1300.71, subdivision \(g\)](#), [1300.71, subdivision \(h\)](#), [1300.71, subdivision \(g\)\(3\)](#).

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

Regulatory Agency	Submit to
DMHC	<p>Counties or providers submit a complaint by calling the provider complaint line:</p> <ul style="list-style-type: none"> 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	<p>Counties or providers submit a complaint online:</p> <ul style="list-style-type: none"> 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	<p>Counties or providers inform TPLRD of OHC-related issues and non-payment of claims via email: dhcs-tplrd.general@dhcs.ca.gov.</p>

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

In accordance with Welfare and Institutions (W&I) Code 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.⁹⁴ 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 (except that this non-supplant rule does not apply to the use of 2011 realignment funds).⁹⁵
 - 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).⁹⁶
- "Payer of last resort" requirements continue to apply to certain federal funds (e.g., SUBG block grants).⁹⁷

⁹⁴ W&I Code §§ [5813.5, subdivision \(c\)\(2\)](#), [5878.3, subdivision \(a\)\(3\)\(A\)](#), and [5891, subdivision \(a\)\(3\)\(A\)](#).

⁹⁵ [W&I Code § 5891, subdivision \(a\)\(1\)\(B\)](#). Note that this prohibition on BHSA funding supplanting state funds does not apply to counties' use of 2011 realignment funds.

⁹⁶ [DHCS, SUBG Policy Manual, Version 3.0 \(5.21.2024\), Sections 1.3.3 and 1.5.1](#), [SAMHSA, FFY 2024-2025 Combined Block Grant Application](#)

⁹⁷ [45 CFR § 96.137](#); [DHCS, SUBG Policy Manual, Version 3.0 \(5.21.2024\), Sections 1.3.3 and 1.5.1](#); [SAMHSA, FFY 2024-2025 Combined Block Grant Application](#); [BHIN 21-055](#) (September 2021).

- “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).⁹⁸
- 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).¹ 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

⁹⁸ Detailed in [SAMHSA, FFY 2024-2025 Combined Block Grant Application](#)

¹ [W&I Code, § 5892 subdivision \(a\)\(3\)\(A\)](#)

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.² 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.

² According to [W&I Code, § 5892 subdivision \(a\)\(3\)\(i\)](#), Children's System of Care services and requirements are described in Part 4, commencing with [W&I Code, § 5850](#). Adult and Older Adult System of Care services and requirements are described in Part 3, commencing with [W&I Code, § 5800](#). These services do not include Housing Interventions or Full Service Partnership services.

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 in the provision of activities.³

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 as 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:

³ [W&I Code, § 5892 subdivision \(k\)\(4\)](#)

- 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 Services⁴ including resource navigation.

⁴ Department of Health Care Services, [BHIN 22-026](#): Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS) and Specialty Mental Health Services (SMHS) Peer Support Services: "Peer Support Services include the following service components: [...] Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transition between levels of care and supporting beneficiaries in developing their own recovery goals and processes."

- Enhanced Community Health Worker services⁵ 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-

⁵ <https://www.dhcs.ca.gov/CalAIM/Pages/Opt-in-to-BH-CONNECT.aspx>

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 following⁶:

- 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

⁶ [W&I Code § 5892, subdivision \(k\)\(5\)](#)

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 Partnerships⁷ 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.

⁷ "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.

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. Sec. 1071 et seq.
- The Federal Direct Loan Program in 20 U.S.C. Sec. 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 Government Code 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 Government Code 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 in all BHSA funding components (Housing Interventions, FSP, and BHSS).⁸ 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 that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health.⁹ At least 51 percent of BHSS funding must be used to fund Early Intervention programs and services. 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.¹⁰ 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% requirement spent on individuals who are 25 years and younger. Early Intervention funds can also be used to support innovative behavioral health pilots and projects within these parameters to build the evidence base for the effectiveness of new statewide strategies.¹¹

⁸ [W&I Code, § 5892 subdivision \(a\)\(4\)\(A\)](#)

⁹ [W&I Code, § 5840 subdivision \(a\)\(1\), W&I Code, § 5892 subdivision \(a\)\(3\)\(A\)\(ii\)](#)

¹⁰ [W&I Code 5892\(a\)\(3\)\(B\), W&I Code, § 5892 subdivision \(a\)\(3\)\(B\)\(ii\)](#)

¹¹ [W&I Code, § 5892 subdivision \(a\)\(4\)\(A\)](#)

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:¹²

- 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 populations¹³ and address specific barriers related to racial, ethnic, cultural, language, gender, sexual orientation, gender identity, religion, age, economic, or other

¹² [W&I Code § 5840 subdivision \(d\)](#)

¹³ Underserved cultural populations means 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 2S/LGBTQ+ communities, victims of domestic violence and sexual abuse, and veterans, across their lifespans.

disparities in mental health and substance use disorder treatment services access, quality, and outcomes.¹⁴

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).¹⁵

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.¹⁶

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.

¹⁴ [W&I Code, § 5840.6, subdivision \(f\)\(1\), W&I Code, § 5840.6, subdivision \(f\)\(2\).](#)

¹⁵ [W&I Code, § 5840.6, subdivision \(f\)](#)

¹⁶ [Overview of the Institute of Medicine's Continuum of Care](#) is detailed by SAMHSA's Strategic Prevention Technical Assistance Center



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 and 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 and 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 priorities¹⁷:

- 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.¹⁸
- 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.

¹⁷ [W&I Code § 5840.7](#)

¹⁸ [W&I Code § 5840; W&I Code § 5892](#)

- Strategies targeting the mental health needs of eligible children and youth, as defined in [W&I Code 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 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](#).¹⁹ 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.²⁰ Counties may act jointly to meet these requirements.²¹

A.7.2.1 Childhood Trauma Early Intervention Programs²²

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.

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

¹⁹ [W&I Code § 5840.7, subdivision \(b\)](#)

²⁰ [W&I Code § 5840.7, subdivision \(b\)\(1\)\(B\)\(i\)-\(ii\)](#)

²¹ [W&I Code § 5840.7, subdivision \(b\)\(2\)](#)

²² [W&I Code § 5840.6, subdivision \(c\)](#)

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 components²³:

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.

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.²⁴ Outreach activities funded under BHSS Early Intervention must meet the following requirements:

- Be directed towards eligible high-risk individuals within BHSA priority populations,²⁵ including older adults²⁶ and youth.²⁷

²³ [W&I Code § 5840, subdivision \(b\)](#)

²⁴ [W&I Code, § 5840 subdivision \(b\)\(1\)](#)

²⁵ [W&I Code, § 5892 subdivision \(d\)](#)

²⁶ [W&I Code, § 5840.6 subdivision \(g\)](#)

²⁷ [W&I Code, § 5840.6 subdivision \(e\)](#)

- 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 include, but are not limited to, the following²⁸:

- 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.

²⁸ [W&I Code, § 5840.6 subdivision \(g\)](#)

Youth Outreach and Engagement

Youth outreach and engagement strategies target BHSA eligible out-of-school youth and secondary school-age youth, and include, but are not limited to, the following²⁹:

- 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.

²⁹ [W&I Code § 5840.6, subdivision \(e\)](#)

A.7.3.2 Access and Linkage to Care

Access and linkage 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.³⁰ 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 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.³¹

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 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.^{32, 33} Early intervention mental health and substance use disorder services must also be responsive to the cultural and linguistic needs of diverse communities.³⁴

When determining what practices to implement locally, counties may reference the biennial DHCS-provided list of EBPs and CDEPs.³⁵ 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

³⁰ [W&I Code § 5840, subdivision \(b\)\(2\)\(A\)](#)

³¹ [W&I Code, § 5840 subdivision \(b\)\(2\)\(B\)](#)

³² [W&I Code, § 5840 subdivision \(b\)\(3\)](#)

³³ Supports under the mental health and substance use disorder services and supports component are separate and distinct from “housing supports” provided within Housing Interventions.

³⁴ [W&I Code, § 5840 subdivision \(b\)\(3\)\(C\)](#)

³⁵ [W&I Code, § 5840 subdivision \(c\)\(4\)](#)

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,³⁶ 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 Programs³⁷

Early Psychosis Intervention (EPI) Plus programs encompass early psychosis and mood disorder detection and intervention. These programs 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.³⁸ EPI Plus programs may include, but are not limited to, all of the following:

³⁶ The DHCS [Trauma Informed Care](#) webpage includes the ACEs Aware screening tool and other resources.

³⁷ [W&I Code § 5835](#)

³⁸ [W&I Code § 5835, subdivision \(b\)\(2\)](#)

- 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.^{39,40} 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.⁴¹ Individuals who receive CSC for FEP

³⁹ [Nossel I., Wall, M., et. al. \(2018\) "Results of a Coordinated Specialty Care Program for Early Psychosis and Predictors of Outcomes." *Psychiatry Serv.* 1;69\(8\):863-870.](#)

⁴⁰ [Breitborde, N., Bell, E., et. al. \(2023\). "The Early Psychosis Intervention Center \(EPICENTER\): development and six-month outcomes of an American first-episode psychosis clinical service." *BMC Psychiatry.* 15\(266\).](#)

⁴¹ [Kane, M., Delbert, G., et.al. \(2015\). "Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes from the NIMH RAISE Early Treatment Program." *American Journal of Psychiatry.* 173\(4\).](#)

have also reported improved psychopathology and overall quality of life.⁴² 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 counties⁴³ 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.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

⁴² [Heinssen, R., Goldstein, A., and Azrin, S. \(2023\). "Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care."](#)

⁴³ A city receiving BHSA funding can meet this requirement if the county will be providing CSC for FEP and/or opting into the bundled benefit.

reimbursement rate under Medi-Cal in the Specialty Mental Health Services (SMHS) delivery system beginning in 2025.⁴⁴

Counties should use 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 training, technical assistance and fidelity requirements identified in the forthcoming BH-CONNECT EBP Behavioral Health Information Notice (BHIN). The BH-CONNECT EBP BHIN also includes coverage, payment and other compliance requirements for counties that elect to cover CSC for FEP in Medi-Cal.

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,

⁴⁴ 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.

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](#) regulations⁴⁵ and counties are required to seek reimbursement from commercial payers; see section C.3.3 regarding how to file a complaint with the appropriate regulatory agency.⁴⁶

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

DHCS will develop a non-exhaustive list of Early EBPs and CDEPs biennially.⁴⁷ The biennial list is an optional reference tool to support each county behavioral health department's community planning process discussions regarding which practices to implement locally.

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 a county to implement a particular EBP or CDEP from the DHCS biennial list.⁴⁸

Counties can include other county-specific CDEPs and can innovate and implement emerging and promising practices that are not included on the biennial list of EBPs and CDEPs provided by DHCS in their IP.

An Early Intervention EBP or CDEP on the biennial list may include population-based prevention elements. Counties will still be able to fund EBPs and CDEPs that may have very limited population-based prevention components in full with BHSS funds only if the EBP or CDEP is on the biennial list developed by DHCS.

DHCS leverages the following sources to identify EBPs and CDEPs:

- BH-CONNECT⁴⁹
- Children and Youth Behavioral Health Initiative's (CYBHI) EBPs and CDEPs grant program⁵⁰

⁴⁵ [APL 24-007 Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage](#)

⁴⁶ [W&I Code § 5891, subdivision \(a\)\(3\)\(A\)](#)

⁴⁷ [W&I Code § 5840, subdivision \(c\)\(1\)](#)

⁴⁸ [W&I Code § 5840, subdivision \(c\)\(5\)](#)

⁴⁹ DHCS. [Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment \(BH-CONNECT\) Initiative](#).

⁵⁰ DHCS. ["Evidence-Based Practices and Community-Defined Evidence Practices Grant Program](#).

- Family First Prevention Services Act⁵¹
- Blueprints for Healthy Youth Programs⁵²
- The Athena Forum created by Washington State Health Care Authority⁵³
- CDPH's California Reducing Disparities Project⁵⁴
- Evidence-based Practices Resource Center developed by the Substance Abuse and Mental Health Services Administration⁵⁵
- The Cognitive-Behavioral Interventions for Substance Use curriculum designed by the University of Cincinnati⁵⁶
- California Evidence-Based Clearinghouse for Child Welfare⁵⁷
- 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 Health⁵⁸

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,

⁵¹ [AB 153](#)

⁵² [Blueprints for Healthy Youth Development](#)

⁵³ The Athena Forum. [Excellence in Prevention Strategy List](#).

⁵⁴ Psychology Applied Research Center of Loyola Marymount University, The California Reducing Disparities Project Phase 2 Statewide Evaluation / California Pan-Ethnic Health Network. [California Reducing Disparities Project Strategic Plan to Reduce Mental Health Disparities: Executive Summary](#).

⁵⁵ [SAMHSA. Evidence-Based Practices Resource Center](#).

⁵⁶ University of Cincinnati Corrections Institute. [Cognitive-Behavioral Intervention - Substance Use \(CBI-SU\) curriculum](#).

⁵⁷ California Department of Social Services' Office of Child Abuse Prevention. [Scientific Rating Scale](#).

⁵⁸ [Los Angeles County Department of Mental Health. Prevention and Early Intervention Plan](#).

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. 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."⁵⁹ 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.⁶⁰ A 2024 Mental Health Services Oversight and Accountability Commission (MHSOAC) publication identified opportunities to improve FSP programs, many of which are reflected in the Behavioral Health Services Act (BHSA). The recommendations include⁶¹:

- 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:

⁵⁹ MHSOAC. "[Report to the Legislature on Full Service Partnerships](#)". January 25, 2023

⁶⁰ Ibid.

⁶¹ MHSOAC. "[Transformational Change: Full Service Partnerships. Third Sector Report Summary](#)". May 23, 2024.

- Behavioral Health Services Act (BHSA) eligible adults and older adults, who meet the priority population criteria specified in [W&I Code 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).⁶² 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.⁶³ These services may include clinical and recovery-oriented services, such as consumer-operated services, peer support services, transportation, and services to support maintaining housing.⁶⁴

⁶² All of these services are covered Medi-Cal services with dedicated bundled rates (ICM is covered under Medi-Cal but does not have a dedicated bundled rate). DHCS encourages counties to opt-in to provide these services under Medi-Cal. When counties opt-in to provide these services under Medi-Cal, they will receive the bundled rate when providing services to Medi-Cal members and may use FSP funding for the non-federal share.

⁶³ 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.

⁶⁴ 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 [W&I Code § 5891\(a\)\(1\)\(G\)\(2\)](#).

- 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.⁶⁵

B.3.3 Full Service Partnership Continuum

In accordance with [W&I Code section 5887](#), county FSP programs must make the following specified services available:⁶⁶

- Mental health services, supportive services, and substance use disorder (SUD) services
- Assertive Community Treatment (ACT)
- Forensic ACT (FACT)
- FSP Intensive Case Management (ICM)⁶⁷
- 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

⁶⁵ Counties who are Enhanced Care Management (ECM) Providers can deliver ECM to individuals receiving FSP and counties have discretion to prioritize FSP program slots for individuals not eligible for ECM. Please see the [ECM Policy Guide](#) for additional information.

⁶⁶ DHCS has discretion to define additional evidence-based services, treatment models, and community defined practices and may do so in future iterations of the policy manual. The addition of evidence-based services, treatment models, and community defined practices will include stakeholder consultation.

⁶⁷ FSP ICM is a required service pursuant to [W&I Code § 5887\(e\)](#) directing DHCS to establish FSP levels of care and is explained later in the chapter.

- Service Planning⁶⁸
- 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

Counties may use FSP funding for outreach activities if the activities relate to enrolling individuals living with significant behavioral health needs in an FSP.⁶⁹ 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.

⁶⁸ County FSP programs are expected to adhere to the service planning process outlined in W&I Code sections [5806](#) and [5868](#) and do not require documentation in a “standalone” treatment plan or service plan.

⁶⁹ [W&I Code § 5887, subdivision \(d\)](#)

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 [W&I Code section 5887, subdivision \(a\)\(2\)](#). For the first Integrated Plan covering fiscal years 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. DHCS will make available training, technical assistance, and fidelity monitoring supports for counties as they implement FSP EBPs: ACT, FACT, IPS and HFW. 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, all 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, 2029.⁷⁰

FY 2029-2032 Integrated Plan

Subject to DHCS approval, for the second Integrated Plan covering fiscal years 2029-2032, **small counties (population less than 200,000)** may request an exemption from the ACT and FACT EBP. Small counties may also request an exemption from IPS and HFW⁷¹ EBP fidelity requirements.

The criteria for FSP exemption requests include:

- Limited workforce (e.g., providers)
- Limited need (e.g., the number of individuals eligible is too small for the county to

⁷⁰ Counties with populations under 200,000 that have not achieved fidelity implementation of one or more EBPs in advance of June 30, 2029, will have an opportunity to seek an exemption from ACT and FACT, or a fidelity exemption for IPS and HFW, for the 2029 - 2032 IP, and may use findings from the COE review or other supporting data to support that request.

⁷¹ Counties are still expected to meet fidelity requirements for HFW in accordance with providing these services through Medi-Cal under [EPSDT](#).

support the required EBP staffing for fidelity)

- Other considerations, subject to evidence requirements and DHCS review

Counties may use the findings from COE fidelity reviews and other data to determine whether they will seek an exemption in fiscal year 2029. Exemption requests must include:

- Documentation demonstrating that one or more of the criteria for exemption are met (e.g., workforce or county demographic data, COE informational fidelity review findings).
- A description of how counties will work towards improving fidelity scores or for counties that may never meet fidelity requirements, an explanation of why.

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:⁷²

- 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).⁷³
- 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.,

⁷² Strategies to build co-occurring capabilities are an allowable use of FSP funding.

⁷³ Please see [BHIN 23-054](#) for DHCS’s existing MAT policy and definition of an “effective referral.”

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).

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 [W&I Code 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.

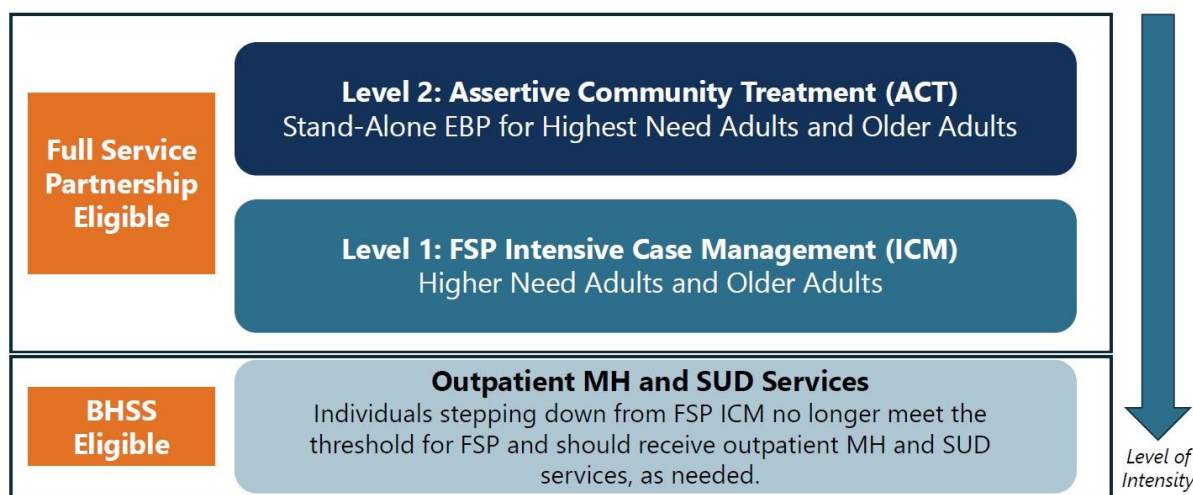


Figure 7.B.4.1. FSP Levels of Care

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 [W&I Code 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 for "Eligible children and youth."⁷⁴ 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.^{75,76,77} 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.^{78,79}

⁷⁴ [W&I § 5892, subdivision \(k\)\(7\)](#)

⁷⁵ van Vugt MD, Kroon H, Delespaul PA, Mulder CL. [Assertive community treatment and associations with substance abuse problems](#). Community Ment Health J. 2014 May;50(4):460-5. doi: 10.1007/s10597-013-9626-2. Epub 2013 Jun 15. PMID: 23771775.

⁷⁶ Marshall M, Lockwood A. [Assertive community treatment for people with severe mental disorders](#). Cochrane Database Syst Rev. 2000;(2):CD001089. doi: 10.1002/14651858.CD001089. Update in: Cochrane Database Syst Rev. 2011 Apr 13;(4):CD001089. doi: 10.1002/14651858.CD001089.pub2. PMID: 10796415.

⁷⁷ Penzenstadler L, Soares C, Anci E, Molodynski A, Khazaal Y. [Effect of Assertive Community Treatment for Patients with Substance Use Disorder: A Systematic Review](#). Eur Addict Res. 2019;25(2):56-67. doi: 10.1159/000496742. Epub 2019 Jan 30. PMID: 30699412.

⁷⁸ Aagaard J, Tuszewski B, Kølbæk P. [Does Assertive Community Treatment Reduce the Use of Compulsory Admissions?](#) Arch Psychiatr Nurs. 2017 Dec;31(6):641-646. doi: 10.1016/j.apnu.2017.07.008. Epub 2017 Aug 10. PMID: 29179833.

⁷⁹ Burns T, Catty J, Dash M, Roberts C, Lockwood A, Marshall M. [Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression](#). BMJ.

Pursuant to the BHSA 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.⁸⁰ 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).⁸¹ For non-Medi-Cal members, who meet BHSA eligible criteria as defined in W&I code 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 [W&I Code 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.

2007 Aug 18;335(7615):336. doi: 10.1136/bmj.39251.599259.55. Epub 2007 Jul 13. PMID: 17631513; PMCID: PMC1949434.

⁸⁰ [W&I Code § 5891\(a\)\(1\)\(G\)\(2\)](#)

⁸¹ 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.

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 2026.⁸²

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 2025.⁸³

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 the training, technical assistance and fidelity requirements identified in the forthcoming BH-CONNECT EBP Behavioral Health Information Notice (BHIN). The BH-CONNECT EBP BHIN also includes coverage, payment and other compliance requirements for counties that elect to cover ACT and FACT in Medi-Cal.

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

⁸² ACT is a stand-alone high-intensity mental health service delivery model and cannot be provided concurrently with FSP Intensive Services or HFW.

⁸³ 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.

- 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 supports 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 requirements established 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.⁸⁴ 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.^{85,86} Compared to standard care, ICM has been shown to improve general functioning, employment and housing outcomes, and reduce length of hospital stays.⁸⁷ While ICM does not have set fidelity criteria like ACT, ICM includes many of the same

⁸⁴ Dieterich M, Irving CB, Bergman H, Khokhar MA, Park B, Marshall M. [Intensive case management for severe mental illness](#). Cochrane Database of Systematic Reviews. 2017.

⁸⁵ Hangan C. [Introduction of an intensive case management style of delivery for a new mental health service](#). Int J Ment Health Nurs. 2006.

⁸⁶ Guarino, K. [Step by Step: A Comprehensive Approach to Case Management](#). 2011.

⁸⁷ Dieterich M, Irving CB, Bergman H, Khokhar MA, Park B, Marshall M. [Intensive case management for severe mental illness](#). Cochrane Database of Systematic Reviews. 2017.

components including low staff to client ratios, assertive outreach, and direct service delivery.^{88,89} 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:⁹⁰

- A current or suspected⁹¹ 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

⁸⁸ Schaedle, R.W., Epstein, I. [Specifying Intensive Case Management: A Multiple Perspective Approach](#). Ment Health Serv Res 2, 2000.

⁸⁹ Meyer, P., and Morrissey, J. [A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas](#). Psychiatric Services. 2007.

⁹⁰ Individuals with a primary diagnosis of intellectual/developmental disabilities (I/DD) are not appropriate for FSP Intensive Services.

⁹¹ Counties are permitted but not required to mandate prior authorization or equivalent process.

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.

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:⁹²

- Assessment
- Crisis Intervention⁹³
- 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.

⁹² Additional services may be provided on an as needed basis.

⁹³ DHCS is not requiring an "on call" model of crisis intervention for FSP ICM participants.

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.⁹⁴

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 way of responding when children or youth experience significant mental health or behavioral challenges.⁹⁵ 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

⁹⁴ For Medi-Cal members, peer support specialists and CHWs may also provide covered outreach and engagement services, as appropriate and consistent with Medi-Cal guidance.

⁹⁵ [National Wraparound Initiative](#), Portland State University

providers of the Family First Prevention Services Act Part IV aftercare services to ensure compliance with [W&I 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.⁹⁶ 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).⁹⁷ 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

⁹⁶ Bruns et al. [The Evidence Base and Wraparound](#). (2004)

⁹⁷ HFW is a stand-alone high-intensity mental health service delivery model and cannot be provided concurrently with ACT or FSP Intensive Services.

- HFW team structure requirements
- Key functions of HFW teams
- Billing Medi-Cal for HFW services delivered to Medi-Cal members⁹⁸
- 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.

⁹⁸ Forthcoming Medi-Cal guidance will focus on billing Medi-Cal for HFW services, including meeting fidelity and other requirements. Find additional details about using BHSA funds for HFW services in the “Aligning HFW in FSP with Medi-Cal” section of this manual.

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.^{99,100} 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.¹⁰¹

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:¹⁰²

- Competitive Employment
- Systematic Job Development
- Rapid Job Search
- Integrated Services
- Benefits Planning
- Zero Exclusion

⁹⁹ IPS Employment Center, "[IPS Introductory PowerPoint](#)," July 2021.

¹⁰⁰ IPS Employment Center, "[Evidence for the Effectiveness of Individual Placement and Support Model of Supported Employment](#)," July 2022.

¹⁰¹ Marsden J, Anders P, Shaw C, Amasiatu C, Collate W, Eastwood B, Horgan P, Khetani M, Knight J, Knight S, Melaugh A, Clark H, Stannard J. [Superiority and cost-effectiveness of Individual Placement and Support versus standard employment support for people with alcohol and drug dependence: a pragmatic, parallel-group, open-label, multicenter, randomized, controlled, phase 3 trial](#). EClinicalMedicine. 2024 Jan 18;68:102400. doi: 10.1016/j.eclim.2023.102400. PMID: 38299044; PMCID: PMC10828604.

¹⁰² [IPS Employment Center](#), 2024

- 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.¹⁰³

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.¹⁰⁴ 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.

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 the training, technical assistance and fidelity requirements identified in the forthcoming BH-CONNECT EBP Behavioral Health BHIN. The BH-CONNECT EBP BHIN also includes coverage, payment and other compliance requirements for counties that elect to cover IPS in Medi-Cal.

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

¹⁰³ [IPS Fidelity Scale](#), 2008

¹⁰⁴ 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.

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 the requirements established for BH-CONNECT.

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 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

B.6.1 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.¹⁰⁵ Pursuant to the Behavioral Health Services Act (BHSA) and in accordance with [W&I Code 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

¹⁰⁵ Los Angeles County. [“Reaching the 95% Initiative.”](#)

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.6.2 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 overdose 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 Francisco¹⁰⁶ and in other states, such as West Virginia,¹⁰⁷ New Jersey,¹⁰⁸ and Oregon.¹⁰⁹
- **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.

¹⁰⁶ City and County of San Francisco. "[Street Overdose Response Team.](#)"

¹⁰⁷ West Virginia Office of Drug Control Policy. "Programs: [Quick Response Teams \(QRT\).](#)"

¹⁰⁸ New Jersey Division of Mental Health and Addiction Services (DMHAS). "[Opioid Overdose Recovery Program.](#)"

¹⁰⁹ City of Portland, Oregon. "Community Health Assess and Treat ([CHAT](#)) Medication for Opioid Use Disorder (MOUD) and Overdose Response Team (ORT) Pilot Programs."

- **Open-access clinics**, to provide care and accept MAT referrals for individuals residing in partnering counties.

B.6.2.1 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.¹¹⁰ 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

¹¹⁰ The "Three-Day Rule" ([21 Code of Federal Regulations \(CFR\) § 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."

required to work towards providing same day access to MAT as detailed in their Integrated Plans by July 1, 2029.

B.6.2.2 Targeted Outreach

Counties will be required to conduct ongoing, targeted outreach to connect individuals with SUD services, including MAT, in accordance with [W&I 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.6.2.3 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](#).¹¹¹ 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.¹¹² 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

¹¹¹ California Department of Health Care Services. "[All Plan Letter \(APL\) 24-001](#)." January 12, 2024. APL 24-001 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.

¹¹² [21 CFR 1300.01](#)

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.¹¹³

B.6.2.4 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.¹¹⁴
- **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.¹¹⁵

¹¹³ Please refer to [DHCS BHIN 24-005](#): “Mobile Narcotic Treatment Programs” for more detail regarding mobile NTP licensing.

¹¹⁴ California Department of Public Health. “[Syringe Services Programs in California: An Overview.](#)”

¹¹⁵ California Department of Health Care Services. “[Medication Unit Application Overview.](#)”

- **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.6.3 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.6.4 Substance Use Disorder Primary Full Service Partnership Option

Senate Bill (SB) 326 does not prohibit counties from establishing FSP programs for individuals with primary substance use disorder (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.¹¹⁶ 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.

¹¹⁶ 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.

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 Interventions¹¹⁷

Individuals must meet the BHSA eligibility requirements, identified in this policy manual¹¹⁸ and meet the definition of:

- [At-Risk of Homelessness](#), or
- [Experiencing Homelessness](#), or
- [Chronically Homeless](#), with a focus on those in encampments.

¹¹⁷ [W&I Code § 5830](#)

¹¹⁸ Pursuant to [W&I Code § 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 [W&I Code § 5830](#) must be met.

C.4.1.1 Experiencing Homelessness and At Risk of Homelessness

[W&I Code 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 section 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 section 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

[W&I Code 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. Code section 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 section 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 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."¹¹⁹ The BHSA definition for encampments is in alignment with the Department of Housing and Urban Development (HUD)¹²⁰ 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.

¹¹⁹ [W&I Code § 5892, subdivision \(a\)\(1\)\(A\)\(ii\).](#)

¹²⁰ [Unsheltered Homeless and Homeless Encampments in 2019](#)

C.4.2 Priority Populations

In addition to specifying the populations who are eligible for Housing Intervention services (“Eligible Populations”), the BHSA identifies a smaller subset of populations who should be prioritized for BHSA services ([see BHSA requirements here](#)).

Priority Populations¹²¹:

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.

¹²¹ [W&I Code § 5892, subdivision \(d\)](#)

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, [W&I Code 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 [W&I Code 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.¹²² 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 requirements¹²³:

- 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.

¹²² [W&I Code § 5892, subdivision \(c\).](#)

¹²³ [W&I Code § 5892, subsections \(a\)\(1\)\(B\)-\(C\)](#)

Table C.6.2.1 Criteria for Housing Exemption Requests

Requirement	Exemption Request Criteria
30 percent of BHSF for Housing Interventions	<p>Criteria for increased/reduced percentage (beyond transfer allowance):</p> <ul style="list-style-type: none"> • 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. <p>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.).</p>
50 percent of the county's Housing Intervention funds on persons who are chronically homeless	<p>Criteria for reduced percentage:</p> <ul style="list-style-type: none"> • 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. <p>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.).</p>
No more than 25 percent of the county's Housing Intervention funds on capital development projects	<p>Criteria for increased percentage:</p> <ul style="list-style-type: none"> • 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

Requirement	Exemption Request Criteria
	<ul style="list-style-type: none">• Costs of accessibility improvements exceed 25 percent capital improvement limits.• Other considerations, subject to evidence requirements and DHCS review. <p>Requests for capital development exemptions must include documentation demonstrating that the exemption request 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).</p>

C.7 Relationship to Medi-Cal Funded Housing Services

Per W&I Code 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

Housing Interventions “shall not be used for housing interventions covered by a Medi-Cal Managed Care Plan.”¹²⁴ Under CalAIM, MCPs are authorized to cover five housing-related “Community Supports”^{125, 126} :

Table C.7.1. Coverage of Housing-related Community Supports

Service	Coverage ^{127, 128}
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 ¹²⁹	All MCPs required to cover for the behavioral health population beginning January 1, 2026

Housing Interventions may not be used to cover any of the services identified 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

¹²⁴ [W&I Code § 5830, subdivision \(c\)\(2\).](#)
¹²⁵ As of September 6, 2024, 100 percent of MCPs cover the Housing Trio and 92 percent cover Recuperative Care and Short-Term Post-Hospitalization Housing. An additional six Medi-Cal managed care plans will offer Recuperative Care and Short-Term Post-Hospitalization Housing by 1/1/25. On 1/1/25, MCPs will have the option to cover Transitional Rent and on 1/1/26, coverage will be mandatory.
¹²⁶ [DHCS Medi-Cal Community Supports Policy Guide. July 2023.](#)
¹²⁷ [DHCS CalAIM Community Supports – Managed Care Plan Elections. Updated July 2024.](#)
¹²⁸ Coverage depicted as of date of publication – please refer to website for current status.
¹²⁹ [DHCS Transitional Rent Concept Paper. August 2024.](#)



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 within 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](#)¹³⁰ (FMRs), 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

¹³⁰ Fair Market Rent includes Small Area Fair Market Rent or up to 120% Fair Market Rent or Small Area Fair Market Rent.

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.¹³¹ 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.

¹³¹ Time-limited interim settings must not require tenants to pay rent.

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
- Accessory dwelling units, including Junior Accessory Dwelling Units
- Tiny Homes¹³²
- Shared housing
- Recovery/Sober Living housing, including recovery-oriented housing¹³³

¹³²Tiny homes would only be 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.

¹³³ Single Room Occupancy and recovery housing 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.

- 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)¹³⁴ (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.

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:

¹³⁴ Congregate settings do not include behavioral health residential treatment settings. Housing Interventions may not be used to cover room & board in residential treatment settings.

- **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.¹³⁵ 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.

¹³⁵ Substance Abuse and Mental Health Services Administration. [Best Practices for Recovery Housing](#). Publication No. PEP23-10-00-002. Rockville, MD: Office of Recovery, Substance Abuse and Mental Health Services Administration, 2023.

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 in this guide, in addition to the housing interventions specifically identified in [W&I Code section 5830, subdivision \(b\)](#), including, but not limited to, those listed in the [Medi-Cal Community Supports Policy Guide](#).¹³⁶ 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.

¹³⁶ [W&I Code § 5830, subdivision \(b\)\(1\)\(F\)](#).

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.¹³⁷ 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

¹³⁷ See [DHCS Medi-Cal Community Supports Policy Guide](#).

Interventions may be used for the complete list of expenses covered by the county's Housing Interventions under its Participant Assistance Fund.¹³⁸

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

¹³⁸ 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.

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 [W&I Code 5830\(c\)\(2\)](#).

Activities may include but 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

Housing Interventions must be operated in compliance with the core components of Housing First and “may include recovery housing.”^{139,140} Housing First is defined in statute¹⁴¹ 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.”

Consistent with the national Housing First model and [W&I Code 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.

¹³⁹ [W&I Code § 8255, subdivision \(b\)](#).

¹⁴⁰ [W&I Code § 5830, subdivision \(a\)\(5\)](#).

¹⁴¹ [W&I Code §§ 8255, subdivisions \(d\)\(1\)-\(2\)\(A\)](#).

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).¹⁴² 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 law¹⁴³ 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

Counties are required to operate Housing Interventions in accordance with the [Homeless Management Information System \(HMIS\)](#) reporting requirements.¹⁴⁴

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 [W&I Code 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.

¹⁴² [NSPIRE Final Rule](#).

¹⁴³ See, e.g., [California Civil Code §§ 1941, 1941.1, 1941.3](#).

¹⁴⁴ [W&I Code § 8256, subdivision \(d\)\(3\)\(A\)](#).

C.10 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.¹⁴⁵

Counties will be required to detail their proposed capital development projects in their Integrated Plans (IPs) and annual updates (AUs). The DHC 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.10.1 Capital Development Project Funding

Counties may use no more than 25 percent of their Housing Interventions on capital development projects.¹⁴⁶ 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

¹⁴⁵ [Study](#) finds Permanent Supportive Housing is effective for highest risk chronically homeless people.

¹⁴⁶ [W&I Code § 5892, subdivision \(a\)\(1\)\(A\)\(iii\).](#)

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.10.2 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.10.3 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 Government Code 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 [W&I Code 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.10.4 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, 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.¹⁴⁷

C.10.5 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, [W&I Code 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.

¹⁴⁷ [W&I Code § 5830, subdivision \(e\)\(8\)](#).

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)¹ 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

¹ Inpatient hospital services and Narcotic Treatment Programs are exempt from the Medi-Cal documentation guidance in BHIN 23-068 because they must follow documentation requirements specified in federal regulations and other state guidance.

These documentation requirements apply to non-hospital, non-NTP mental health and substance use disorder services funded through FSP or Behavioral Health Services and Supports (BHSS).²

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

² WIC § [5806, subdivision \(f\)](#); [5868, subdivision \(g\)](#); [5887, subdivision \(g\)](#).

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 of the Runaway and Homeless Youth Act ([42 U.S.C. 5732a](#)), section 637 of the Head Start Act ([42 U.S.C. 9832](#)), section 41403 of the Violence Against Women Act of 1994 ([42 U.S.C. 14043e-2](#)), section 330(h) of the Public Health Service Act ([42 U.S.C. 254b\(h\)](#)), section 3 of the Food and Nutrition Act of 2008 ([7 U.S.C. 2012](#)), section 17(b) of the Child Nutrition Act of 1966 ([42 U.S.C. 1786\(b\)](#)), or section 725 of the McKinney-Vento Homeless Assistance Act ([42 U.S.C. 11434a](#));

- 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 ([42 U.S.C. 5732a\(3\)](#)), 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 ([42 U.S.C. 14043e-2\(6\)](#)), section 330(h)(5)(A) of the Public Health Service Act ([42 U.S.C. 254b\(h\)\(5\)\(A\)](#)), section 3(m) of the Food and Nutrition Act of 2008 ([7 U.S.C. 2012\(m\)](#)), 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 (9) of the McKinney-Vento Assistance Act ([42 U.S.C. section 11360, subdivision \(9\)](#)), 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	<ul style="list-style-type: none"> Adult Residential Facilities¹ Residential Care Facilities for the Elderly² Licensed Board and Care³ 	<ul style="list-style-type: none"> Adult Residential Substance Use Disorder (SUD) Treatment Facilities⁴ Children's Crisis Residential Programs (CCRP)⁵ Peer Respite Perinatal Residential SUD Facilities⁶ 	<ul style="list-style-type: none"> 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~ 	<ul style="list-style-type: none"> 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

¹ Licensure: CDSS

² Licensure: CDSS

³ Licensure: CDSS

⁴ Licensure: DHCS

⁵ Licensure: CDSS

⁶ Licensure: DHCS

	Assisted Living	Community Residential Treatment (Settings eligible under BHCIP)	Interim Housing	Housing
			<ul style="list-style-type: none"> Tiny Homes, emergency sleeping cabins, emergency stabilization units Single room occupancy (SRO) units 	<ul style="list-style-type: none"> Shared housing License-exempt room and board SRO units
BHT Housing Interventions	Yes	Peer respite only	<p>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.</p> <p>The aim is to transition individuals to permanent housing as quickly as possible.</p>	Yes ⁷

⁷ DHCS will seek to align the list of eligible settings under BHT and Transitional Rent to ensure seamless transitions between funding sources.

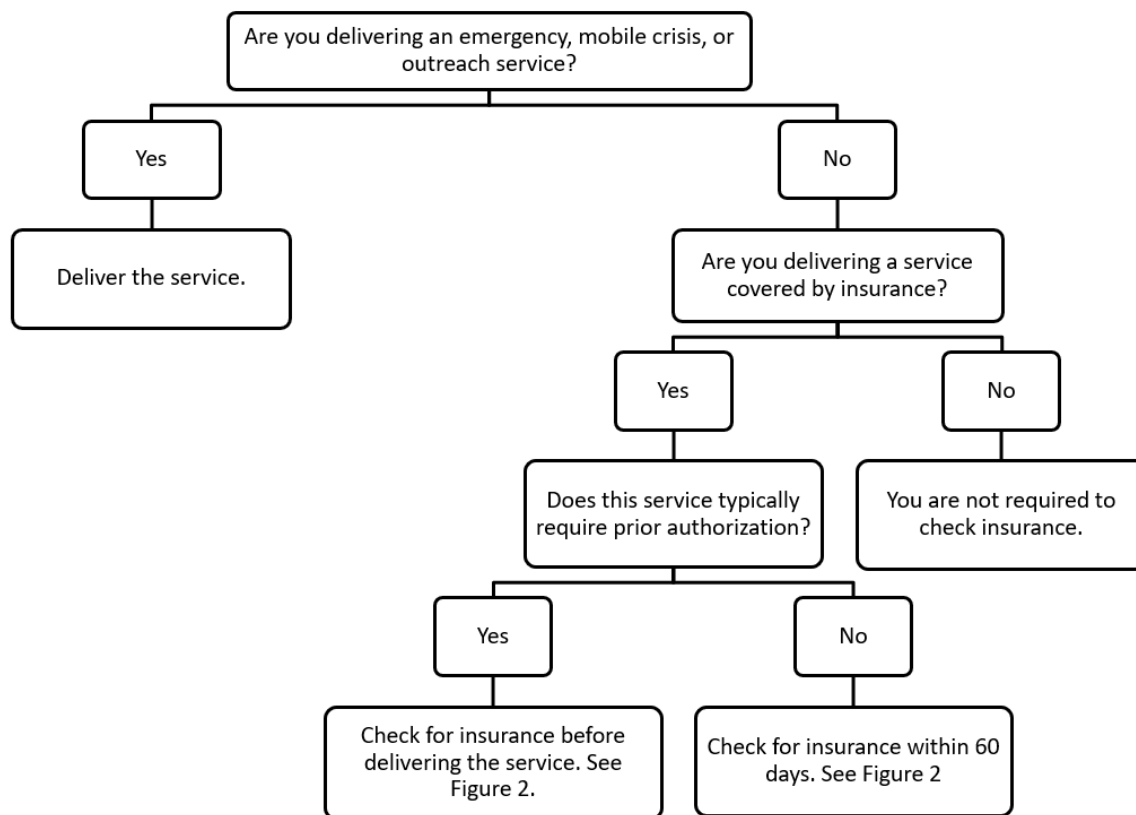
	Assisted Living	Community Residential Treatment <i>(Settings eligible under BHCIP)</i>	Interim Housing	Housing
Transitional Rent	No	Peer respite, when provided as transitional or recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming	Yes (see note) <i>~Note: Transitional rent is not available for Recuperative Care and Short-Term Post-Hospitalization.</i>	Yes

Appendix C: Promoting Access to Care through Efficient use of State and County Resources

Appendices

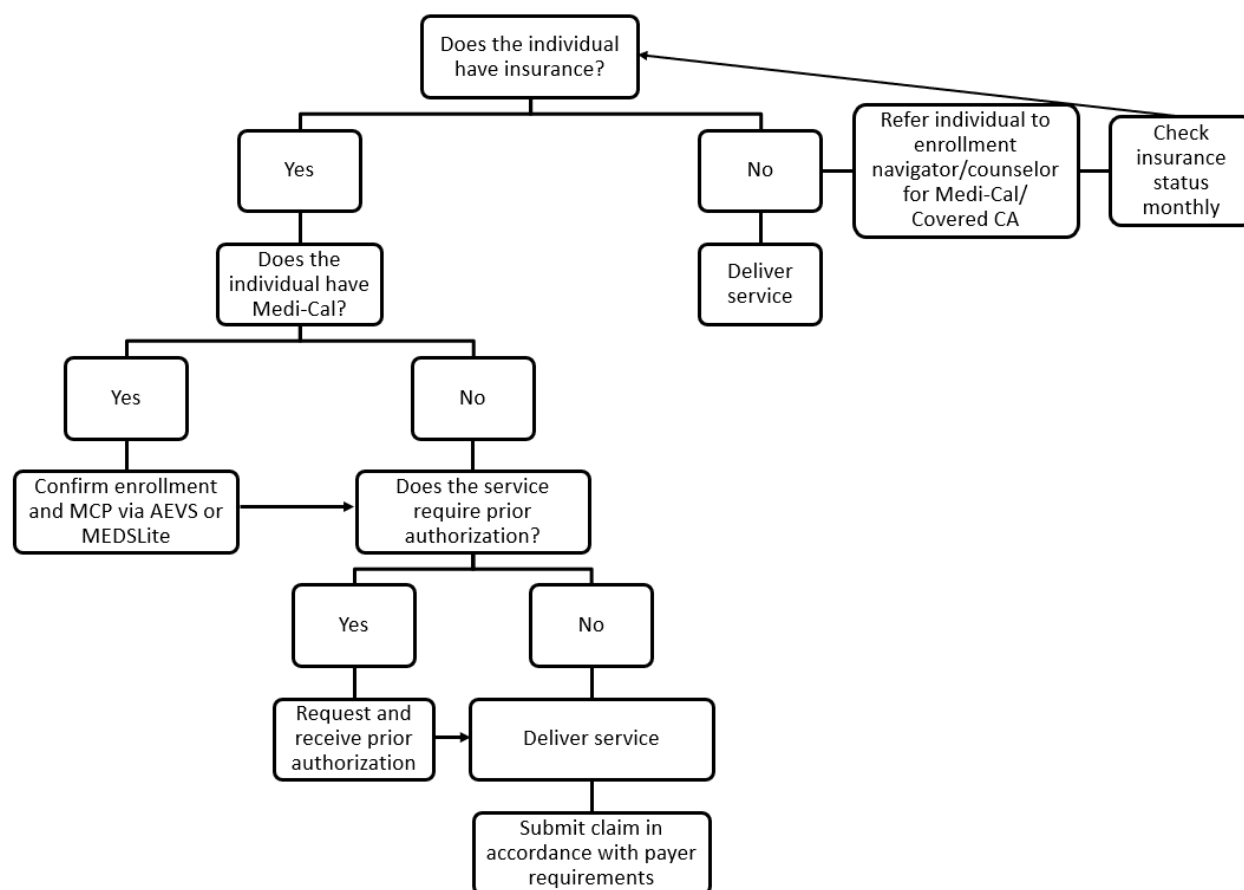
1. Process Flow for Behavioral Health Services Act-Funded Providers: Checking for and Billing Medi-Cal or Other Health Coverage

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.



Commercial insurers require prior authorization for most services. In the event a
Appendix Figure C.1.2. Process flow for BHSA-funded provider to check for and bill Medi-Cal or commercial insurance.

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.⁸ All providers—Behavioral Health Services Act (BHSA)-funded or otherwise—must continue to meet applicable requirements

⁸ All individual practitioners must be credentialed according to credentialing requirements stated in BHINs [18-019](#) and [22-070](#). The full list of providers and facilities eligible and required to enroll in Medi-Cal through PAVE is available on DHCS webpage "[Provider Enrollment Options](#)." See also DHCS webpage [Application Information by Provider Type](#). Providers apply for Medi-Cal enrollment with the [Provider Enrollment Division](#). Almost all individual SMHS providers and facilities are required to enroll in Medi-Cal, as described in BHIN [20-071](#). DHCS's SUD Licensing and Certification Toolkit outlines the full process for Medi-Cal certification and enrollment for DMC/DMC-ODS providers: "[DHCS Level of Care Designation and ASAM Level of Care Certification](#)." SMHS certification and recertification requirements are outlined in [9 CCR § 1810.435, the Mental Health Plan: Certifications \(MHP-owned & operated Clinics\) materials](#) and the [current county SMHS contract with DHCS](#).

Unlike DMC/DMC-ODS providers, SMHS providers are permitted to contract with a BHP and begin claiming for Medi-Cal services while their certification is pending. SUD providers must become DMC certified before they can be county-contracted providers, as described in in [W&I Code § 14124.24\(e\)](#).

Appendix Table C.2.1: Resources for Medi-Cal Billing and Documentation Requirements

Type of Resource	Description
DHCS	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.

Type of Resource	Description
Documentation Resources	<ul style="list-style-type: none"> • BHIN 23-068 describes DHCS' current documentation requirements for Medi-Cal behavioral health services.
California Mental Health Services Administration (CalMHSA) Resources	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.⁹ This section provides additional detail for counties to support providers in consistently billing commercial health insurance (Policy C.3.2).

⁹ [W&I Code § 5891, subdivision \(a\)\(3\)\(A\)](#)

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 [Health and Safety Code 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,¹⁰ unless the provider and plan previously executed a single case or letter of agreement.
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 process¹¹ 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.¹²
- 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.¹³

¹⁰ 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." [28 CCR § 1300.71\(a\)\(3\)\(B\)](#).

¹¹ [H&S Code § 1367\(h\)\(2\)](#) requires the commercial plan to implement these dispute resolution process for out of network providers.

¹² [H&S Code § 1367.03](#)

¹³ 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:**¹⁴ 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:**¹⁵ 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

¹⁴ Please see the definition in Appendix D.

¹⁵ "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 more than one episode of care for more than one patient, when the provider is out of network or the treatment is not covered under the patients' plan.

services as required by Senate Bill (SB) 855 and Assembly Bill (AB) 988.¹⁶ 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 in [Chapter 6, Section C.4](#) 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.¹⁷

¹⁶ [H&S Code § 1374.72; Ins. Code § 10144.5](#)

¹⁷ [Eligible services and programs are outlined in the Legislative Analyst's Office Report on 1991 Realignment](#). (October 2018). California Department of Social Services. (Updated May 2016). [2011 Realignment. Rethinking the 1991 Realignment](#). Legislative Analyst's Office. (August 2011). [2011 Realignment: Addressing Issues to Promote Its Long-Term Success](#).

- State General Fund.¹⁸
- **Opioid settlement funds**, as described in the California Opioid Settlements Allowable Expenditures resource.¹⁹
- **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.²⁰
 - 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.²¹
 - ***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.²²
- **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

¹⁸ 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.

¹⁹ California Department of Health Care Services. (September 2023). [California Opioid Settlements](#).

²⁰ California Department of Health Care Services. [Community Mental Health Services Block Grant](#).

²¹ DHCS outlines allowable use of SUBG, including prevention and perinatal set-aside requirements, in the SUBG Policy Manual. [SUBG Policy Manual, Version 3.0 \(5.21.2024\)](#).

²² DHCS outlines use of [SAMHSA PATH](#) on their webpage.

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](#); [Senate 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: [W&I Code 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 (Public Resources Code 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: Public Resources Code 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; W&I 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: [W&I Code 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 W&I Code 5701.5 References: [W&I Code 5849.2, subdivision \(f\); W&I Code 5701.5](#)

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: [W&I Code 5840.6, subdivision \(f\)\(1\)](#)

Department: “Department” means the State Department of Health Care Services.

Reference: [W&I Code 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: [W&I Code 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); [W&I Section 5963.01 subdivision \(b\)](#)

Medi-Cal Behavioral Health Delivery System: An entity or local agency that contracts with the department to provide covered behavioral health Medi-Cal benefits, including Medi-Cal Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and/or Drug Medi-Cal Organized Delivery System (DMC-ODS). Reference: [W&I Code section 14184.101 subdivision \(i\)](#)

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: [W&I Code 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](#); [W&I 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: [W&I Code sections 5892\(b\)\(1\)](#) [5892\(b\)\(3\)](#), [5892\(b\)\(4\)](#), and [5892\(b\)\(5\)\(A\)](#)

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: [W&I Code 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: [W&I Code 5892\(k\)\(1\), 5891.5\(b\)\(2\)](#).

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 438.2A](#)

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: [W&I Code 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: [W&I Code 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: [W&I Code 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 Public Resources Code." Reference: [W&I Code 5831, subdivision \(e\)\(2\)](#)