BEHAVIORAL HEALTH SERVICES ACT COUNTY POLICY MANUAL – MODULE 6

2. Behavioral Health Transformation

C. Statewide Vision for Behavioral Health Quality and Equity

C.4 Health Equity and Culturally Responsive and Linguistically Appropriate Care

DHCS considers health equity as a cross-cutting priority integrated into statewide goals and measures, community planning, workforce development, and culturally responsive and linguistically appropriate care requirements.

C.4.1 Culturally Responsive and Linguistically Appropriate Care Requirements

The population health approach, statewide behavioral health goals, and associated performance measures described above establish a robust framework for improving outcomes and advancing equity across California's behavioral health system. Achieving that framework in practice, however, also requires counties and providers to deliver care in ways that are responsive to the cultural, linguistic, and lived experiences of the communities they serve.

This section describes these requirements using the term "culturally responsive and linguistically appropriate care" instead of the historically used term "cultural competence" to better reflect the department's equity goals. It defines this type of care as "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" (WIC § 5840.6(g)(1)).

The BHSA promotes culturally responsive and linguistically appropriate care in several ways, including the following:

- **All county BHSA programs must include culturally responsive and linguistically appropriate interventions (WIC § 5840(b)(3)(C));**
- **Counties are encouraged to implement community-defined evidence practices that reflect the values, histories, and lived experiences of the communities served (WIC § 5892(k)(6));**
- **Counties may invest Workforce and Education (WET) funds to build and maintain a workforce that is culturally and linguistically representative of the populations served (WIC § 5892(k)(5));**
- **Each county Integrated Plan must describe how the county will provide high-quality, culturally responsive, and timely care across the full behavioral health continuum (WIC § 5963(a)(1)), address disparities, and include a workforce strategy that ensures a network of providers that are culturally and linguistically concordant with the communities served and robust enough to achieve the statewide and local behavioral health goals and measures. (WIC § 5963.02(c)(8));**
- **Community planning processes must affirmatively reach out to culturally and linguistically diverse stakeholders (WIC § 5963.03).**

Historically, DHCS has required Medi-Cal Behavioral Health Plans (BHPs)—i.e., Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) programs—to submit cultural competence plan (CCP) reports and annual updates, as required under regulation (9 C.C.R. § 1810.410) and outlined in counties' Medi-Cal contracts with DHCS and Information Notices 10-02 and 10-17 and their associated enclosures, issued in 2010.

Since that time, California's behavioral health landscape has evolved significantly. CCP related policy expectations—particularly those related to disparity identification, community engagement, workforce development, and language access—are now captured through Behavioral Health Act Service (BHSA) implementation and reporting mechanisms. In addition, certain MHSA based requirements, which sunset on June 30, 2026, were referenced in prior CCP guidance further necessitating an updated approach aligned with BHSA.

DHCS has superseded Information Notices 10-02 and 10-17 with updated policies on culturally responsive and linguistically appropriate care, as set forth in a

forthcoming BHIN and further described in this section of the BHSA County Policy Manual. Effective in 2026, BHPs are no longer required to submit standalone CCP reports. Instead, counties will satisfy CCP regulatory requirements under 9 C.C.R. § 1810.410 through existing BHSA reporting requirements and Medi-Cal reporting requirements including but not limited to provider directory requirements established under BHIN 25-026.

Beginning in 2028, DHCS will add a limited number of questions and prompts related to culturally responsive and linguistically appropriate care to the IP/AU, and progress will be captured in the BHOATR.

With these new updated reporting and planning requirements, DHCS has strengthened and streamlined its approach to culturally responsive and linguistically appropriate care by leveraging the BHSA implementation framework, bolstering quantitative metrics, consolidating county reporting requirements, and seeking alignment across NSMHS and SMHS delivery systems through contracting.

This section describes updates to county requirements for culturally responsive and linguistically appropriate care, including the new reporting requirements, organized as follows:

- **Strategies for reducing racial, ethnic, and linguistic disparities**
- **Workforce development and training; and**
- **Approach for ensuring language access.**

The updated requirements described below advance National CLAS standards, which were established by the U. S. Depart of Health and Human Services Office of Minority Health in 2010 (enhanced in 2013) to advance health equity, improve quality and reduce disparities. The focus of DHCS updated requirements is on CLAS standards related to measurement, workforce and language access.

C.4.1.1 Strategies for Reducing Disparities

DHCS recognizes that identifying racial, ethnic, and linguistic disparities—and implementing culturally responsive strategies to address them—is essential to advancing equity in behavioral health outcomes and achieving the BHSA's goals. This priority aligns closely with the National CLAS Principal Standard, which calls for effective, equitable, understandable, and respectful quality care and services,

and with CLAS Standard 11, which emphasizes data-driven efforts to evaluate and improve service delivery and health equity. Without sustained, data-driven action, the BHSA's expanded services and equity requirements will not fully reach the communities experiencing the greatest gaps in access, utilization, and outcomes.

Beginning in 2028, counties must provide more details on their disparity reduction strategies in their IP/AU. To inform these strategies, counties will be expected to leverage core BHSA elements and take the following actions:

- **Conduct Data-Driven Assessments of Local Need to Inform Planning. In the BHSA Integrated Plan, counties must use BHT performance measures and other relevant state and local data to identify disparities, workforce and training gaps, and language access needs. Counties must demonstrate in their IP how this data informed their disparities strategy.**
- **Meaningfully Engage Culturally and Linguistically Diverse Communities in Planning. In developing the culturally responsive and linguistically appropriate care strategy in their IPs, counties must convene and engage a committee that is focused on this work and includes representation from culturally and linguistically diverse communities to inform the development of the disparity reduction strategy articulated in their IP.**
    - **To reduce duplication, counties may align this engagement with broader IP community planning where feasible. Counties may choose whether to maintain a standalone Cultural Competence Committee, which historically have been the primary stakeholder engagement forums for CCPs, to support this engagement, or incorporate this engagement in community planning forums established for the BHSA. Counties may also partner with community-based organizations, trusted messengers, and culturally and linguistically appropriate focus groups or town halls and ensure programs, services and stakeholder materials are culturally responsive and linguistically appropriate.**
    - **Counties must at minimum engage stakeholders to understand how disparities appear in practice and to elicit input on community-based, culturally grounded interventions—including community-defined evidence practices (CDEPs)—that build trust and promote healing and stability.**

- **Counties must summarize recommendations from stakeholders and how they informed their disparity reduction strategy in the IP.**

C.4.1.2 Workforce Development and Training

The BHSA establishes workforce development as a core equity strategy and allows counties to invest in a culturally and linguistically concordant workforce, with BHSS funds available to support training, recruitment, retention, workforce diversity, and integration of individuals with lived experience. See Section A.4 of this Policy Manual for detail on allowable uses. In addition, county contracts with DHCS also outline specific obligations for counties to train their staff and contracted providers under the Medi-Cal Behavioral Health Delivery System. This priority aligns with National CLAS Standards 3 and 4, which emphasize recruiting, promoting and training a workforce to respond to the cultural and language needs of the population.

Beginning in 2028, counties must provide more details on their workforce development and training strategies in their IP/AU. To inform these strategies, counties will be expected to leverage core BHSA elements and take the following actions:

- **Assess Workforce and Training Capacity and Gaps. Through the IP, counties must analyze their capacity and gaps related to workforce and training, with attention to cultural and linguistic discordance and especially for threshold languages spoken in the county. "Threshold Language" means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS) of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area (Cal. Code Regs. tit. 9, § 1810.410(a)).**
- **Meaningfully Engage Culturally and Linguistically Diverse Communities in Planning. In developing the workforce development and training strategy in their IPs, counties must convene and engage a committee that is focused on delivering culturally responsive and linguistically appropriate care and includes representation from culturally and linguistically diverse communities.**
  - **As noted in Section C.4.1.1, counties may align this engagement with broader IP community planning where feasible.**

- **Counties must at minimum engage stakeholders to understand community workforce needs, training gaps, and provider-client concordance and to identify effective strategies for improvement.**
- **Counties must summarize recommendations from stakeholders and how they informed their workforce development and training strategy in the IP.**

C.4.1.2 Approach to Ensuring Language Access

Language access includes ensuring that populations with limited English proficiency (LEP) have access to services and resources such as bilingual services, oral interpreter services, and written translation of materials. Counties are responsible for ensuring that their subcontractors and network providers comply with all applicable requirements related to language access under the Medi-Cal program, as well as those applicable to BHSA under state and federal laws and regulations, the counties' contracts with DHCS, this Policy Manual, and other DHCS guidance.

Adequate language access is foundational to achieving the BHSA goal of reducing disparities and delivering culturally responsive and linguistically appropriate care. This priority aligns with National CLAS Standards 5 and 8, which emphasize providing no-cost language assistance to LEP individuals and easy-to-understand written materials that support timely access to care and services.

Beginning in 2028, the IP/AU will include more specific questions about counties' language access strategies. To inform these strategies, counties will be expected to leverage core BHSA elements and take the following actions:

- **Conduct Data-Driven Assessments of Local Need to Inform Planning. Counties must review relevant BHT performance measures to identify language access gaps, specifically related to threshold languages spoken in the county, oral interpreter services, written translation of materials in threshold languages, and services in non-threshold languages.**
- **Meaningfully Engage Culturally and Linguistically Diverse Communities to Inform Planning. In developing the language access strategy in their IPs, counties must convene and engage a committee that is focused on delivering culturally responsive and linguistically appropriate care and includes representation from culturally and linguistically diverse**

communities. As noted in Section C.4.1.1, counties may align this engagement with broader IP community planning where feasible.

- **Counties must at minimum engage stakeholders to understand language needs and effective strategies for meeting those needs.**
- **Counties must summarize recommendations from stakeholders and how they informed their language access strategy in the IP.**

C.4.2 Statewide Disparity Reduction Targets

Recognizing the importance of taking action and having accountability around reducing disparities, DHCS will not only report stratifications of BHT performance measures, but will also establish statewide disparity reduction targets for the BHT cross-goal equity measures. These targets will focus statewide attention on reducing racial, ethnic, and language disparities in access to and engagement with behavioral health services and evidence-based treatment. By establishing statewide targets, DHCS will create a shared expectation that progress on behavioral health transformation must include measurable reductions in disparities, not only overall improvements in performance.

The statewide targets for the three cross-goal equity measures will complement the stratified reporting of all BHT performance measures by identifying where targeted action is needed to close gaps between population groups. DHCS will use these targets to support transparency, guide statewide and local planning, and inform technical assistance and quality improvement activities. Counties and Medi-Cal MCPs will be expected to review performance on the equity measures, assess the drivers of observed disparities, and incorporate strategies to reduce disparities into their planning and reporting processes, including the BHSA Integrated Plan.

While DHCS is committed to ensuring that the state collectively works to improve the identified disparities in our equity measures, the department recognizes that not all counties will have disparities for the target populations identified at the state level. For counties who do not have a disparity in the population targeted for state-wide improvement, DHCS will expect those counties to work on their county-specific disparities only.

DHCS recognizes that meaningful disparity reduction will require sustained, cross-system action and that baseline performance, data quality, and available interventions may vary across counties, MCPs, and populations. Accordingly, DHCS

will establish and refine targets in a manner that accounts for measure maturity, data reliability, and opportunities for improvement over time. The department will publish targets on the DHCS website and revisit the targets periodically.

4. Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)

A. Purpose of the Behavioral Health Outcomes, Accountability, and Transparency Report

The Behavioral Health Services Act (BHSA) requires counties to submit Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) to the Department of Health Care Services (DHCS) on an annual basis **(WIC section 5963.04).** The BHSA establishes the BHOATR to provide California with greater transparency into how counties spend behavioral health dollars and administer behavioral health care.

DHCS is using the BHOATR to monitor county implementation of their Integrated Plans (IPs), Annual Updates (AUs), and/or Intermittent Updates (IUs), whichever is the most current for the reporting period. The BHOATR template includes the required elements for each county to submit their BHOATR. DHCS will review and approve county BHOATRs. DHCS will post each county's BHOATR as well as statewide BHOATR information on the DHCS website within the Behavioral Health Public County Profile (see WIC section 5963.04 subdivision (d)).

A.1 Reporting Period

A.1.1 Reporting Periods for Draft and Final BHOATRs

Reporting periods for county BHOATRs align with the fiscal year (FY). Counties are required to submit BHOATRs no later than 18 months after the end of the FY.

The first BHOATR covers **FY 2026-2027**. Counties **must** submit a ***draft*** BHOATR for FY 2026-**20**27 **to DHCS by** January 30, 2028. **The *draft* BHOATR will not be shared publicly and is a one-time requirement that allows** DHCS to provide technical assistance **to counties in advance of the first *final* BHOATR due to DHCS by January 30, 2029.**

DHCS will provide instructions for counties in the County Portal on completing the draft BHOATR.

~~**A.2 Required Contents**~~

A.2 Contents of the BHOATR

Per WIC section 5963.04, counties must submit a BHOATR that includes data and information on spending across funding sources for behavioral health services, service utilization, and other interventions undertaken by the county as part of their Integrated Plan including:

- **Allocations of state and federal behavioral health funds**
- **State, federal, and county behavioral health expenditures, including:**
  - **Spending on children and youth**
  - **Spending across funding sources including 1991 Realignment, 2011 realignment, county general funds, state general funds, SAMHSA PATH, MHBG, SUBG, Commercial Insurance reimbursements, and Opioid Settlement Funds, among other sources**
- **Administrative costs**
- **Service utilization data, including information on services provided to individuals covered by Medi-Cal, Medicare, commercial insurance, and those who are uninsured**
- **County performance and outcomes measures across behavioral health delivery systems**
- **Data and information on populations with identified disparities**
- **Information on county workforce strategies and provider vacancy rates**

Counties are required to submit a BHOATR that includes information on spending and service utilization across the Behavioral Health Care Continuum and BHSA Components.

The BHOATR is mainly quantitative, focused on service utilization, expenditures, and outcomes. The BHOATR mirrors the IP **budget** template **elements and, where available, includes some county projections from IP, AU, or IU— whichever is the most current for the reporting period. Counties may include narrative descriptions to accompany data reported in the BHOATR to describe differences between projected and actual data or provide other context on data reported in the BHOATR.**

A.3 Calculating Reversions

Starting in FY 2026 – 2027, the BHOATR replaces the MHSA Annual Revenue and Expenditure Report (ARER) to calculate reversion. The last reporting year of the ARER is FY 2025 – 2026 (submission to DHCS by January 30, 2027). For more information on reversion, please see Behavioral Health Services Act Policy Manual, Section 6: BHT Fiscal Policies.

B. Guidance for Completing the BHOATR

B.1 Data Requirements

DHCS collects statewide data on behavioral health utilization through Medi-Cal claims and requires counties to submit ISL encounters for all other individual-level behavioral health services beginning January 1, 2027. DHCS uses Medi-Cal claims and ISL encounters to pre-populate some information in the BHOATR.

While counties may submit ISL encounters beginning July 2026, counties are not required to submit ISL encounters to DHCS until January 2027, halfway through the first BHOATR reporting period. Therefore, DHCS is not using ISL encounter data for July – December 2026 to pre-populate elements of the FY 2026-27 BHOATR.

C.2 BHOATR Submission

C.2.1 BHOATR Submission Requirements

For a BHOATR to be considered complete, a county must include the following:

- **Response to each required item in the BHOATR template**
- **Approval from the county board of supervisors**
- **Certifications from both the county behavioral health director and the County Administration Officer (or other county equivalent) or their designee certifying compliance with fiscal accountability requirements and that all expenditures are consistent with applicable state and federal law. The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and holds the highest level of administrative authority in the county or be the**

designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Additionally, in accordance with WIC 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 WIC section 14197.7 without utilizing waitlists. This attestation must be submitted with the BHOATR.

C.2.2 County Portal

Counties must develop and submit their BHOATRs online through the DHCS county portal. The county portal allows county users to complete tasks such as filling in form-based prompts, compiling fiscal information, and completing attestations. The county portal supports DHCS and counties in integrating statewide data into each county's BHOATR for the county's review. The county portal supports access for multiple county users, allowing multiple county users to work concurrently to develop the BHOATR. Counties must also use the county portal support center to submit questions about BHOATR submission or requests for technical assistance.

County portal technical features include progress markers to track completion of each section of the BHOATR, support tools allowing DHCS staff to review, collaborate on, and resolve questions from counties, and functionalities to distill key information from approved BHOATRs into county profiles.

C.2.3 DHCS Review Standards

DHCS will review a county's BHOATR for completeness and validate that all BHOATR content is aligned with guidance set forth in this Policy Manual and all BHSA statutory requirements. If a county does not submit the BHOATR by the required deadline, DHCS may impose a corrective action plan, monetary sanctions, or temporarily withhold payments to the county, per WIC section 14197.7.

DHCS will define quantitative standards for significant variance after the first IP period (FY 2026-2029). The first IP period will be used to collect data and set standards for significant variance. Starting in the second IP period (FY 2029-2032), DHCS may impose BHSA withholds or monetary sanctions if a county has

significant variance in projected spending of BHSA funds between its IP and actual spending.

C.2.4 Submission for Local City Entities

The two city-operated mental health authorities receiving funds pursuant to WIC, section 5701.5 shall submit BHOATRs independently from their counties under BHSA. DHCS will grant the same flexibilities to cities when completing the BHOATR that were granted to cities completing the IP, including reporting flexibilities related to funding sources like County General Fund, FFP, and non-applicable federal funds.

6. BHT Fiscal Policies

B. Behavioral Health Services Act Fiscal Policies

B.6 Reversion Policy

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 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.

For purposes of calculating reversion, a county's BHSA revenue is equal to the amount the SCO distributed to the county, including funds withheld, from July through June of the fiscal year, plus any interest earned. DHCS will use the amount of BHSA funds distributed to a county published on the SCO website and the amount of interest the county reported on its BHOATR.

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 (WIC section 5892, subdivision (h)(1) and subdivision (h)(2)(A)) depending on county size. 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 future monthly BHSA distribution and transfer the funds into the state's Reversion Account (WIC section 5892, subdivision (i)(1)).~~

~~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 (WIC section 5892, subdivision (i)(2)(B)).~~

~~DHCS will prioritize offsetting reversion funds before implementing withholds (e.g., due to a late BHOATR) (WIC section 5892, subdivision (i)(2)(C)). 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 (WIC section 5892, subdivision (i)(2)(A)).~~

~~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.~~

~~Counties are required to spend BHSA funds within the applicable statutory expenditure period, including within three or five years depending on county size, pursuant to WIC section 5892, subdivision (i)(1) and subdivision (i)(2)(A).~~

Counties are required to spend BHSA funds within the applicable statutory expenditure period, including within three or five years depending on county size, pursuant to WIC section 5892, subdivision (i)(1) and subdivision (i)(2)(A). County funds not spent within the applicable expenditure period are subject to reversion. If DHCS determines that a county's BHSA funds are subject to reversion, DHCS will instruct the State Controller's Office (SCO) to offset the reverted amount from the county's future monthly BHSA distribution.

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. The SCO will continue to offset the monthly distribution until the full amount of reverted funds has been recovered. 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. The frequency of offsetting and reallocating BHSA funds will be determined by DHCS. The monthly

BHSA distributions posted by the SCO will reflect offset and redistributed amounts.

~~**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.6.9 County Expenditure of Reverted Funds Distributed to the County

Counties will treat reverted funds the SCO distributes (from the Reversion Account) as BHSF revenue and allocate it in accordance with the BHSA allocation requirements. (WIC section 5892, subdivision (a)). Counties must allocate reverted funds across the Housing Interventions (30 percent), FSP (35 percent), and BHSS (35 percent) components consistent with the current BHSA allocation methodology, unless the county receives an approved housing exemption or funding transfer from DHCS. Reallocated reverted funds are subject

to all applicable BHSA expenditure, reporting, and accountability requirements contained in this policy manual.

B.6.10 Allocation Requirements for a County From Which Funds Are Reverted

Under the process described in section B. 6.8 reverted funds are collected by offsetting county distributions rather than through a direct county remittance. As a result, the county must make a corresponding local accounting adjustment to reduce the component balance, and any applicable suballocation balance, from which the reverted funds were calculated. The county must reclassify the locally retained amount from that component into the broader local BHSA fund or revenue allocation account and allocate those funds, together with the remaining monthly SCO distribution, in accordance with the required 30 percent Housing Interventions, 35 percent Full Service Partnership, and 35 percent Behavioral Health Services and Supports allocation percentages, unless the county has an approved exemption or funding transfer.

This ensures that reverted funds are no longer treated as available within the component that caused the reversion and that the county's remaining BHSA funds continue to be tracked, allocated, reported, and expended pursuant to applicable BHSA requirements.

B.6.11 Adjustments, Withholds and Offsets

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 (WIC section 5892, subdivision (i)(2)(B)).

DHCS will prioritize offsetting reversion funds before implementing withholds (e.g., due to a late BHOATR) (WIC section 5892, subdivision (i)(2)(C)). 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 (WIC section 5892, subdivision (i)(2)(A)).

7. BHSA Components and Requirements

B. Full Service Partnership

B.3 Full Service Partnership Program Requirements

B.3.1 Eligible and Priority Populations

FSP Eligible Populations include:

- Behavioral Health Services Act (BHSA) eligible adults and older adults, who meet the priority population criteria specified in WIC section 5892, subdivision (d)~~;~~, and
- BHSA eligible children and youth, which includes transitional age youth (TAY).

FSP Presumptively Eligible Populations include BHSA eligible individuals who meet criteria specified in WIC section 5887, subdivision (d)(2)(A) and who are:

- **Currently experiencing unsheltered homelessness as described in Section 91.5 of Title 24 of the Code of Federal Regulations;**
- **Transitioning to the community after six months or more in a secured treatment or residential setting, including, but not limited to, a mental health rehabilitation center, institution for mental disease, or secured skilled nursing facility;**
- **Have been detained five or more times pursuant to Section 5150 over the last five years; and**
- **Transitioning to the community after six months or more in the state prison or county jail.**

FSP Presumptively Eligible Populations are sub-populations of the FSP Eligible Populations, representing BHSA priority populations and historically hard-to-reach individuals.

B.3.1.2 FSP Presumptive Eligibility Requirements

Beginning January 1, 2027, counties are required to develop processes to enroll individuals who are presumptively eligible in FSP. Counties are not required to enroll individuals if doing so would exceed FSP program capacity or funding, or conflict with contractual Medi-Cal obligations or court orders. Counties may use FSP funding for services provided to individuals who are presumptively eligible.

County policies and procedures should support rapid initiation of FSP services for individuals who are presumptively eligible. For example, counties can enable FSP providers to deliver and be paid for FSP services provided to individuals who are presumptively eligible without authorization for a set period of time while the county determines if the individual is eligible for FSP and if there is FSP program capacity and funding.

Counties are also encouraged to work closely with FSP providers to ensure there is FSP program capacity for individuals who are presumptively eligible whenever possible.

B.4.1 Level 2: Assertive Community Treatment and Forensic Assertive Community Treatment

B.4.1.1 Overview

ACT is an evidence-based practice, as recognized by Substance Abuse and Mental Health Services Administration (SAMHSA), 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, as demonstrated by studies published in the European Addiction Research Journal, the Cochrane Database of Systematic Reviews, and the Community Mental Health Journal. It has been extensively studied across various populations and settings around the world, with evidence from the British Medical Journal and the Archives of Psychiatric Nursing supporting its effectiveness across rural areas, urban centers, and among homeless populations. **ACT includes a full range of clinical treatment, psychosocial rehabilitation, care coordination, and community support services designed to promote recovery, and emphasizes assertive outreach to individuals living with significant mental illness who may have a clinical need for ACT. DHCS expects that many individuals in FSP Presumptively Eligible Populations described in Section B.3.1 may benefit from ACT.**