BEHAVIORAL HEALTH Fiscal Academy

CalMHSA
California Mental Health Services Authority

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Behavioral Health Fiscal Academy

BHFA Session 6

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BH CONNECT EBP Claiming

Navigating EBP Requirements, Budget Planning, and Claiming Strategies

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Learning Objectives

- Learn how to navigate Evidence-Based Practice (EBP) fidelity requirements and budget implications.
- Build a team-based budget for an EBP.
- Evaluate a Dimension of the Benefits or Drawbacks of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) bundled rate.

Session Roadmap

- A High-Level Review of Evidence-Based Practices (EBPs) Across the SMH Landscape
- Considering the EBPs that Intersect with BHSA Requirements and BH-CONNECT
- Understanding the Fundamentals of BH-CONNECT
- System-Wide Implications of Opting into BH-CONNECT Bundled Billing
- The Fiscal Analyst's Role
- Key Budget Considerations for ACT, FACT, CSC for FEP, and IPS Supported Employment
- Building a Smart Budget Framework for Multi-Disciplinary EBP Teams Using ACT
- Evaluating the Bundled Rates Through BH-CONNECT

Evidence-Based Practices (EBPs), Fidelity and Team Budgets

Navigating a Complex Field of Requirements and Opt-Ins

Orientation: Evidence-Based Practices

EBPs span a wide spectrum of services – each with its own focus, delivery model, and staffing needs. These differences drive significant variation in cost structures, making thoughtful budgeting essential.

BHSA + BH-CONNECT Intersection ★

With BH-CONNECT already creating new opportunities and the July 1, 2026 BHSA requirements on the horizon, conversations about EBPs are more important than ever. Today, we'll focus on strategies to finance EBPs that intersect with BHSA mandates and BH-CONNECT opportunities.

Additional EBPs considered part of BH-CONNECT ★

County Behavioral Health Plans: EBP Reference Chart

EBP Name	Required Under	Primary Focus	Delivery Model
Assertive Community Treatment (ACT)	BHSA ★	Adults with SMI	Multidisciplinary Team (MDT)
Forensic ACT (FACT)	BHSA ★	Adults with SMI + justice-involved	MDT
Coordinated Specialty Care (CSC) for FEP	BHSA ★	First Episode Psychosis	MDT
Individual Placement & Support (IPS)	BHSA ★	Supported Employment	Specialist within MDT (often linked to ACT/CSC)
High-Fidelity Wraparound (HFW)	BHSA & EPSDT ★	Youth with SED	Care Coordination Team (family-driven)
Multisystemic Therapy (MST)	EPSDT	Youth with behavioral issues	Specialized MST Team
Functional Family Therapy (FFT)	EPSDT	Youth/family intervention	Individual Clinician (with family)
Parent-Child Interaction Therapy (PCIT)	EPSDT	Parent-child dyad	Individual Clinician
Intensive Care Coordination (ICC)	EPSDT	Youth with complex needs	Care Coordinator + Team
Intensive Home-Based Services (IHBS)	EPSDT	Youth/family in-home support	Paraprofessional + Clinician Team
Therapeutic Foster Care (TFC)	EPSDT	Youth in foster care	Foster Parent + Clinical Support Team
Therapeutic Behavioral Services (TBS)	EPSDT	Youth behavioral support	Paraprofessional under Clinician
Enhanced Community Health Worker (CHW)	Optional ★	Engagement & linkage	Individual CHW (sometimes team-based)
Clubhouse Services	Optional ★	Psychosocial rehabilitation	Peer-driven Team
Peer Support Services	Optional	Recovery support	Individual Peer or Embedded in a Team

What is BH-CONNECT

Key Points for Fiscal Analysts

What is BH-CONNECT?

- 5-year Medi-Cal demonstration (1115 Waiver + SPAs)
- Expands community-based behavioral health services
- Integrates EBPs for better access and outcomes

County Participation Optional

- Bundled Billing: Bundled rates for EBPs (ACT/FACT, CSC, IPS, MST, HFW)
- IMD FFP: Short-term stays only + opt in for ACT/FACT, CSC, IPS, Peer Specialists (forensic specialty), CHWs
- Must meet fidelity requirements on EBPs
- May opt-in to one EBP bundle or phase-in all EBP bundles

Bundled Billing Basics

- One monthly bundled rate per member
- Contact thresholds (e.g., ACT full bundle: 6 contacts/month)
- If not met, bill unbundled services at FFS rates

Implementation Support

- Centers of Excellence (COEs) for training & TA
- Opt-in to more EBPs over time
- Support for budgeting and compliance

Important:

Counties only get bundled rate if they opt into providing it under the waiver. If they do not opt into the EBP, they are still required to provide it under BHSA, but it won't be paid at a bundled rate (will be paid at regular FFS rates - a la carte).

System-Wide Implications of Layering BH-CONNECT onto BHSA EBP Requirements

Entitlement Shift, Fidelity Requirements, and IMD FFP Guardrails

There are substantial system-wide implications for layering a required EBP from its BHSA mandate to the BH-CONNECT Opt-In bundle.

Major Opt-In Considerations:

- **Shifting to Entitlement:** Under BH-CONNECT, the EBP becomes a covered Medi-Cal service for *all* eligible members. This potentially creates additional strain on capacity.
    - Under BHSA (non-opt in), counties are required to provide the EBP, but not to all Medi-Cal eligible members. Under BH-CONNECT opt-in, the entitlement expands coverage to every Medi-Cal eligible member.
- **Fidelity Monitoring**: Fidelity requirements continue under BH-CONNECT, consistent with BHSA.
- **IMD FFP Participation:** While federal dollars for services in IMDs may appear to be a big win, actual benefit depends heavily on county readiness and how much counties are currently spending on IMDs, and
    - You must implement the full suite of adult EBPs under BH-CONNECT: ACT, FACT, CSC, IPS Supported Employment, Enhanced CHW, and Peer Support Services, including the Forensic Specialization.
    - You must also comply with IMD FFP guardrails, including:
        - ≤ 60-day episode cap per stay.
        - ≤ 30-day average length of stay in IMDs designated by the county (counties identify to the state which IMDs they want included as part of the waiver).

The Role of the Fiscal Analyst

Supporting the Big Picture, One Analysis at a Time

As we walk through these materials, keep in mind:

- Your job is likely not to solve for every system-wide implication tied to BHSA EBPs or opting into BH-CONNECT; but rather, make contributions to the team that support leadership's decision-making.

Take it one analysis at a time

We are going to focus on targeted points of analysis that will help you contribute to the big picture for answering some key questions for BHSA EBPs that overlap with BH-CONNECT:

- Budget Modeling
- Standard billing vs. Bundled Opt In from a single-focus revenue perspective

ACT/FACT, CSC for FEP & IPS for Supported Employment

Fidelity Required Team Compositions & Budget Implications

Fidelity Requirements in Focus

Defining “Fidelity” and its Implications

- In behavioral health programs such as Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Coordinated Specialty Care (CSC), and Individual Placement and Support (IPS), fidelity means delivering services exactly as designed – adhering to the model’s core components, staffing structures, training requirements, and practice standards. Maintaining fidelity ensures both effectiveness and quality of care.

- As we explore key considerations for financing Evidence-Based Practices (EBPs), we will place special emphasis on:
  - **Team Composition** – ensuring the right mix of roles and disciplines.
  - **Special Team Features** – such as enhanced training.

- These elements are core components for building accurate, sustainable budgets that support fidelity and program success.

Key Budget Considerations: ACT

Staffing for Fidelity

The ACT Team Leader should have full clinical, administrative, and supervisory responsibility for the team—and generally should not carry other program duties during the workweek.

EXAMPLE ONLY: Please note that the ACT team does not have to look like this one! If the county can meet fidelity, the team composition could look very different

Why?

Because ACT is a fidelity-driven model that depends on a consistent, integrated team. You cannot rotate clinicians in and out just to meet FTE requirements. The team is the team—stable, specialized, and fully dedicated to ACT.

ACT Team Composition

Full Team	FTEs	Partial Team	FTEs
LPHA, one serving as the ACT team lead	2	LPHA, one serving as the ACT team lead	1.5
Psychiatrist or Psychiatric Prescriber	0.8	Psychiatrist or Psychiatric Prescriber	0.5
Registered Nurses	2.85	Registered Nurse	1
Peer Support Specialists	2	Peer Support Specialist	1
AOD Counselor	1	AOD Counselor	1
Other Qualified Provider	1	Other Qualified Provider	1
Total FTEs	9.65	Total FTEs	6
Caseload	80 - 110	Caseload: <60 clients	<60

The team should be staffed to provide 24/7 crisis availability, including on-call rotations.

Key Budget Considerations: FACT

Building from ACT, with Added Requirements

FACT teams share a similar core staffing structure with ACT teams, so your budgeting approach will start with the ACT model.

However, there are important differences that impact costs:

- **Lived Experience Requirement**
  FACT teams must include at least one team member with lived experience related to the criminal justice system (e.g., prior arrests, convictions, incarceration, or supervision by courts or probation).
- **Alternative for Fidelity**
  Teams without a staff member with lived experience can still achieve Medi-Cal Fidelity Designation by meeting enhanced training requirements, but including such a member is strongly preferred for engagement and outcomes.
- **Enhanced Training Expectations**
  Even when a lived-experience member is present, FACT teams have additional training requirements compared to ACT, which should be factored into your cost estimates.
- **Higher Rate Structure**
  FACT rates are set 3.5% higher than ACT rates to account for the additional forensic specialization components. Counties should factor this differential into budget planning when considering FACT implementation.

Key Budget Considerations: CSC for FEP

Specialized Roles, Youth Focus, and Family Engagement

The following needs to be considered:

- **Specialized Clinical Roles** – Higher training costs for specialized interventions (CBT for psychosis, family psychoeducation).
- CSC targets early psychosis in youth and young adults roughly in the range of 15-30 years. It requires developmentally appropriate, **person-centered engagement and family involvement** as a core component.
- CSC likely entails additional family sessions and outreach compared to ACT/FACT, which could impact budget due to these specialized services.

CSC for FEP Team Composition

Recommended Staffing Structure	FTEs
LPHA serving as CSC team lead	1
psychiatrist or psychiatric prescriber	0.25
Peer Support Specialists	1
Other Qualified Providers	2
Total FTEs	4.25
Caseload	35 - 40

Key Budget Considerations: IPS for Supported Employment

Lower Clinical Costs, Higher Integration Needs - Any clinical position can be qualified as an employment specialist with IPS training; however, they will need to be actively engaged with clients' MH treatment teams.

Funding Complexity for Non-BH-CONNECT Counties - If you don't opt into BH-CONNECT, IPS often requires braided funding (Medi-Cal, Vocational Rehabilitation, grants) because many IPS fidelity activities are not billable under SMHS, such as:

- Employer engagement without the client present
- Job search and placement activities (e.g., searching job boards, submitting applications, contacting employers)
- Employer education and advocacy
- Transportation or accompaniment to interviews

IPS for Supported Employment	
Recommended Staffing Structure	**FTEs**
LPHA serving as Employment Supv	0.2
Employment Specialists	2
Total FTEs	2.2
Caseload	35 - 40

ACT/FACT, CSC for FEP & IPS Supported Employment Budget Development

Using ACT as the Foundation to Build Competencies for Other EBP Budgeting

The steps we'll cover in the next few slides to budget for ACT mirror the same process you'll use to develop cost estimates for other team-based models.

Throughout this discussion, ACT will serve as our core example.

Why?

Because it's one of the most structured, fidelity-driven EBPs – and learning to budget for ACT will give you the fiscal analysis skills and frameworks you need to apply to other models like FACT, CSC, and IPS for Supported Employment.

DEVELOPING THE BUDGET

Building a Smart Budget Framework for Multi-Disciplinary EBP Teams

Building on What We Have

Adjusting and Expanding Existing Programs to Meet EBP Requirements

One of the first considerations should be whether counties already have teams or programs doing similar work. For example:

- **FSP Teams** – May align with ACT/FACT requirements.
- **CSC-FEP Programs** – Already implemented in various counties through grants.
- **IPS SEP Models** – Some counties operate local variations.

Key Question: What do we already have in place that we can adjust or expand on to help meet the EBP requirements?

The Initial Fiscal Decision: Internal vs. Contracted Service Delivery

Key Question: Will the county operate the EBP internally or contract with a CBO?

Fiscal Implications:

- **Internal:** County bears full cost of staffing, overhead, and infrastructure.
- **Contracted:** Negotiated rate, less direct control, potential admin savings. Requires strong county oversight and monitoring of contracts and programs.

Decision Drivers: Workforce availability, infrastructure readiness, and cost-effectiveness.

As we proceed, we'll assume the direction the county chooses is to internally operate the ACT Team.

Building an ACT Team Budget

Step 1: Inventory Existing Staff

- Review current clinical staff roster and roles.
- Identify positions performing ACT-aligned functions (e.g., FSP Team, mobile services).
- **Goal:** Maximize reallocation before hiring new staff.

Step 2: Conduct a Needs Assessment

- Compare current staff to ACT fidelity requirements.
- Identify gaps in:
  - Clinical roles (psychiatrist, RN, substance use specialist).
  - Support roles (peer specialist, vocational specialist).
  - Determine if additional hires are required.

County Budget Development Position Forecast

Budget Year	Pos#	Classification	Cost Center	FTE
FY2025/26	1101	Other Qualified Provider	FSP Team	1
FY2025/26	1102	Other Qualified Provider	County Clinic	1
FY2025/26	1103	Mental Health Clinician-Licens	FSP Team	1
FY2025/26	1104	Mental Health Clinician-Licens	Mobile Crisis Team	1
FY2025/26	1105	Peer Support Specialist	Mobile Crisis Team	1
FY2025/26	1106	Substance Use Disorder Counselor	County Mobile Unit	1
FY2025/26	1107	Psychiatrist	County Clinic	1

Note: *The FTEs in the green box likely serve in roles that align with the ACT model.*

Estimating Personnel Costs

County Budget Development Position Forecast				
Budget Year	Pos#	Classification	FTE	S&B
FY2025/26	1101	LPHA	1.00	$ 158,500
FY2025/26	1102	Psychiatrist	1.00	$ 322,500
FY2025/26	1103	Registered Nurses	1.00	$ 158,596
FY2025/26	1104	Peer Support Specialists	1.00	$ 76,500
FY2025/26	1105	AOD Counselor	1.00	$ 84,000
FY2025/26	1106	Other Qualified Provider	1.00	$ 76,000

Step 3: Define Team Composition

- Align with ACT model structure (or county-approved variation).
- Coordinate with leadership for any role substitutions or additions to the minimum required FTEs.

Step 4: Calculate Salary & Benefits (S&B)

- Use the budget Personnel Forecast for cost estimates.
- Budget at least for each classification identified in Step 2.
- Begin to build your ACT Team Budget.

ACT Team Budget Buildout					
Full Team	FTEs	S&B	Partial Team	FTEs	S&B
LPHA	2.00	$ 317,000	LPHA	1.50	$ 238,000
Psychiatrist	0.80	$ 258,000	Psychiatrist	0.50	$ 161,000
Registered Nurses	2.85	$ 452,000	Registered Nurse	1.00	$ 158,000
Peer Support Specialists	2.00	$ 153,000	Peer Support Specialist	1.00	$ 76,000
AOD Counselor	1.00	$ 84,000	AOD Counselor	1.00	$ 84,000
Other Qualified Provider	1.00	$ 76,000	Other Qualified Provider	1.00	$ 76,000
Total	9.65	$1,340,000	Total FTEs	6.00	$ 793,000

Allocating Indirect & Operational Costs

Step 5: Apply Indirect Costs

- Apply your branch/agency's indirect cost per FTE to the team budget

Step 6: Estimate Operating Costs

- Use proxy method if direct data unavailable:
  - Select a similar clinical cost center (e.g., outpatient mobile unit).
  - Calculate annual operating cost ÷ clients served = cost per client.
  - Multiply by ACT team's projected caseload.

ACT Team Budget Buildout

Full Team	FTEs	S&B	Partial Team	FTEs	S&B
LPHA	2.00	$ 317,000	LPHA	1.50	$ 238,000
Psychiatrist	0.80	$ 258,000	Psychiatrist	0.50	$ 161,000
Registered Nurses	2.85	$ 452,000	Registered Nurse	1.00	$ 158,000
Peer Support Specialists	2.00	$ 153,000	Peer Support Specialist	1.00	$ 76,000
AOD Counselor	1.00	$ 84,000	AOD Counselor	1.00	$ 84,000
Other Qualified Provider	1.00	$ 76,000	Other Qualified Provider	1.00	$ 76,000
Total	9.65	$ 1,340,000	Total FTEs	6.00	$ 793,000
Indirect Cost Allocation	(9.65 * $10K)	$ 96,500	(6 * $10K)		$ 60,000
Operational Costs	(100 clients * $4,800)	$ 480,000	(60 clients * $4,800)		$ 288,000

Budget Inputs

BH Indirect Costs Per FTE	$ 10,000
FY24/25 Mobile Unit Operating Costs	$ 1,200,000
FY24/25 Unique Clients Served	250
Operating Cost Per Client	$ 4,800

Explaining the Budget Inputs (Expenses):
-$10K indirect represents the county's indirect/overhead cost per FTE.
-FY24/25 Mobile Unit data is used to reflect a program that will have similar operating costs to ACT which gives you a reasonable operating cost-per-client.

Putting It All Together

1. Build the ACT Budget Expense Summary

2. Combine:

- Personnel (Salary + Benefits)
- Indirect Allocation
- Operating Costs

Key Takeaways for Developing Expenses:

- Start with internal resource optimization.
- Validate program buildout with leadership.
- Use standardized costing methods for transparency.
- Document all assumptions.

Let's get into revenue next!

Forecasting ACT Medi-Cal Revenue

Step-by-Step

Step 1: Identify the Comparison Population

- Pull approved Medi-Cal outpatient claims for FSP clients.
- Use one full prior fiscal year of data.
- Filter data for clients enrolled the entire year:
  - Exclude partial-year clients (new or discharged mid-year).
    - Why? This is meant to give you an annual picture of these client's utilization pattern.

Step 2: Calculate Average Annual Claims per Client

- From filtered dataset:
  - Sum approved outpatient claims for each client.
  - Identify the average annual claim & FFP amount per client.
  - Calculate the average FMAP per claim (FFP ÷ claim amount)

Step 3: Apply to ACT Caseload

- Determine ACT caseload, between 80-110 (full team) or 60 (partial team)
- Multiply:
  - Claims per client × projected caseload × FMAP

Now we can finish developing the budget!

Developed Budget

ACT Team Budget					
Full Team	**FTEs**	**S&B**	**Partial Team**	**FTEs**	**S&B**
LPHA	2.00	$ 317,000	LPHA	1.50	$ 238,000
Psychiatrist	0.80	$ 258,000	Psychiatrist	0.50	$ 161,000
Registered Nurses	2.85	$ 452,000	Registered Nurse	1.00	$ 158,000
Peer Support Specialists	2.00	$ 153,000	Peer Support Specialist	1.00	$ 76,000
AOD Counselor	1.00	$ 84,000	AOD Counselor	1.00	$ 84,000
Other Qualified Provider	1.00	$ 76,000	Other Qualified Provider	1.00	$ 76,000
Total S&B	9.65	$ 1,340,000	Total FTEs	6.00	$ 793,000
Indirect Cost Allocation	(9.65 * $10K)	$ 96,500	(6 * $10K)		$ 60,000
Operational Costs	(100 clients * $4,800)	$ 480,000	(60 clients * $4,800)		$ 288,000
Total Indirect/Operating		$ 576,500			$ 348,000
Total Expenses		$ 1,916,500			$ 1,141,000
Medi-Cal Revenue	(100 clients * $13,440)	$ 1,344,000	(60 clients * $13,440)		$ 806,400
Other Revenue	(Realignment, BHSA, etc.)	$ 572,500			$ 334,600
Total Revenue		$ 1,916,500			$ 1,141,000

Budget Inputs (Expenses)	
BH Indirect Costs Per FTE	$ 10,000
FY24/25 Mobile Unit Operating Costs	$ 1,200,000
FY24/25 Unique Clients Served	250
Operating Cost Per Client	$ 4,800

Budget Inputs (FFP)	
FY24/25 Outpatient Claims Per Client	$ 24,000
Average FMAP	56%
Medi-Cal Revenue Per Client	$ 13,440

From ACT to CSC, FACT, & IPS: Scaling the Budget Framework

The same core steps apply, but consider unique staffing and operating cost differences for the other EBPs.

FACT	CSC for FEP	IPS Supported Employment
⚖️ Legal system coordination (court appearances, jail visits)	🧠 Enhanced training costs for evidence-based psychosis interventions	🚗 Client transportation for interviews and work sites
🎓 Enhanced team training for the forensic population	👨‍👩‍👧 Family psychoeducation materials and engagement activities	💼 Employer engagement costs (job fairs, outreach)
🛡️ Possibly more security protocols and specialized insurance		

There are multiple ways to address these special considerations. As the fiscal analyst, your role is to identify which step in our ACT budgeting process needs to be adjusted to accurately capture these unique requirements.

Considering the Bundled Rates Through BH-CONNECT

Let's review the BH-CONNECT bundle opportunity for ACT as a foundation for analyzing other EBPs

To Bundle, or Not To Bundle?

Beginning July 1, 2026, counties will be required to provide these EBPs under BHSA, receiving FFP under their current FFS rates. It is optional to opt into BH-CONNECT and receive the bundled EBP rate, which then makes them an entitlement.

How do you know if the bundle will be financially worthwhile, strictly from a rate perspective?

Schedule of rates varying by provider type	vs.	Bundled monthly rate

Outpatient Rate vs ACT Bundle Methodology

Rate Component	Outpatient Rates	ACT Bundle	Bundle Impact
Wages + benefits + inflation + vacancy	BLS (area factor adjusted) + 62.25% load + home health index + 14.0%	Same	0
Support staff + indirect & operating	% load based on county surveys (varies by county)	Average % load based on county surveys (same for all counties)	± (-26% to +41%)
Productivity	% of a 2,080-hour work-year (average from county surveys)	90 clients/month per team	±
Swing Shifts	None	5.8% load	↑ (5.8%) [1]
Employment Specialist	None	$60.88 / hour, plus area factor and other loads	↑ (~7%) [1]

[1]These are benefits insofar as the county is committed to fidelity. If not, these increases just cover increased costs related to meeting fidelity.

Productivity

We must convert the ACT team's productivity to a % for comparability to OP rates. Calculation:

- Working hours / month = 2,080 / 12 = 173.33
- ACT team size = 9.65
- ACT team leader = 1
- Client-facing ACT team = 9.65 – 1 = 8.65
- Total team working hours / month = 173.33 x 8.65 = 1,499.33
- Clients per team = 90
- Visits per client = 6
- Average visit length (hours) = 1
- Team working time = 90 x 6 x 1 = 540
- Implied productivity = 540 / 1,499.33 = 36.0%

- **However**, assumptions above could vary, which could improve or worsen the view. For example:

Implied ACT bundle productivity		Average Sessions per Month			
		6	7	8	9
Average Session Length	30 minutes	18%	21%	24%	27%
	45 minutes	27%	32%	36%	41%
	1 hour	36%	42%	48%	54%

The ACT bundle will be more attractive when the implied productivity is lower.

Productivity – Interactive Example

- The example below is based on a county's actual rates for FY24-25 for OP and the ACT bundle.
- Click into the example and change the variables to understand the important drivers for your decision.
- **This example is for counties committed to fidelity, but trying to determine whether the bundle is worth it**

As *Clients* changes, the OP and ACT bundle revenue grow/shrink together, making it **not** an important factor for deciding.

Try moving the average session length up and down. The ACT bundles doesn't move at all, but OP does. Therefore, the bundle becomes more attractive as session length shortens.

For simplicity, we assumed that all disciplines would spend an equal percentage of their time seeing patients. That may not be right, and this column could be tweaked to reflect that. If productivity is higher in higher cost disciplines, the OP rates would become more attractive.

Clients (X)	90
Average Session Length (hours) (Y)	1
Average Sessions per Client per Month (Z)	8

Sessions beyond 6 don't garner extra bundle revenue, but they do for OP. Therefore, the bundle is a better deal when sessions per month are kept near 6.

Discipline (A)	Staff (B)	Leader (C)	Staff (D)	ACT Bundle (E)	OP Rate (F)	Hours Available (G)	Monthly Sessions (H)	OP Rates (I)	ACT Bundle (J)
Calculation			D = B - C			G = D * 2,080 / 12	H = X * Z * D / SUM(D)	I = Y * F * H	J = X * E
MD	0.8		0.8		$1,752.79	138.67	66.6	$116,718	
RN	2.85		2.85		$711.96	494.00	237.2	$168,895	
PSY	1		1		$704.91	173.33	83.2	$58,675	
LPHA	2	1	1		$456.17	173.33	83.2	$37,970	
AOD	1		1		$378.38	173.33	83.2	$31,495	
PEER	1		1		$360.36	173.33	83.2	$29,995	
EMPL	1		1		$0.00	173.33	83.2	$0	
Total	**9.65**	**1**	**8.65**	**$ 4,922.58**			**720.0**	**$443,748**	**$443,032**

Bundle Examples from A to Z

County A and County B are deciding whether to take the bundle:

County A

- County A's OP rates have a higher-than-average load for support staff & indirect / operating, so the bundle reduces revenue -20%
- County A believes that the average ACT member will be seen 9 times a month for 45 minutes, making the bundle unfavorable by another -10%
- The bundle offers reimbursement for swing shifts and employment specialists, improving the bundle by +13%
- The final adjustments absent from the bundle that exist in the OP rates makes the bundle unfavorable by -1.5%
- Final calculation, bundle favorability: (1 – 0.2) x (1 – 0.1) x (1 + 0.13) x (1 – 0.015) – 1 = -19.9%
- **County A declines the bundle**

These factors impact both counties equally

County B

- County B's OP rates have a near average load for support staff & indirect / operating, so the bundle reduces revenue -2%
- County B believes that the average ACT member will be seen 8 times a month for 45 minutes, making the bundle favorable by another +5%
- The bundle offers reimbursement for swing shifts and employment specialists, improving the bundle by +13%
- The final adjustments absent from the bundle that exist in the OP rates makes the bundle unfavorable by -1.5%
- Final calculation, bundle favorability: (1 – 0.02) x (1 + 0.05) x (1 + 0.13) x (1 – 0.015) – 1 = +14.5%
- **County B accepts the bundle**

Should I Take the Bundle?

- Estimate the average session length and number of sessions for your ACT population to determine if bundling will increase or decrease your revenue.
- Plug those estimates into a spreadsheet like the interactive productivity example, which captures most of the differences between the OP rates and the bundle (e.g., swing shifts, employment specialist, support staff, final adjustments, etc.).
- Any analysis comparing the bundle to outpatient rates adds valuable insight, but counties must also weigh broader financial impacts:
    - How much existing FSP and EI budgets can support the shift.
    - Fidelity requirements that increase program costs and may reduce the number of people served.
    - Entitlement obligations under opt-in – all Medi-Cal members who quality must be served, not only up to available funding. for the team.
- This training centers on ACT but builds the core skills you'll need for analyzing complex, multilayered tasks. Though rate estimation methods for other EBPs may vary, the underlying principles stay consistent.

Opting in has system-wide implications, making this a complex decision that counties should evaluate carefully from multiple perspectives.

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Q&A

CalMHSA

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Thank You!

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Change Log

DATE	SLIDE #	SUMMARY OF CHANGE	BEFORE CHANGE
10/31/2025	12	1. Spelled out all the acronyms in the slide.	1. N/A
10/31/2025	20	1. Added a second sentence to read “Contracted: Negotiated rate, less direct control, potential admin savings. Requires strong county oversight and monitoring of contracts and programs.”	1. “Contracted: Negotiated rate, less direct control, potential admin savings.”