Systems and Medicaid Committee Agenda

Thursday, October 16, 2025
8:30 a.m. to 12:00 p.m.

Embassy Suites San Francisco Airport Waterfront
150 Anza Boulevard
Burlingame, California, 94010
Ambassador B Room

Zoom Meeting Link
Meeting ID: 830 8841 4333
Passcode: SMC2025

Join by phone: 1-669-900-6833
Passcode: *4206452#

Meeting Focus:	**Implementation of Senate Bill 43 / Changes to Lanterman-Petris Short Act**	
8:30 a.m.	**Welcome, Introductions, and Housekeeping** *Uma Zykofsky, Chairperson and All Members*	
8:35 a.m.	**Review and Accept June 2025 Draft Meeting Minutes (Action)** *Karen Baylor, Chair-Elect and All Members* • **Committee Discussion** • **Public Comment** • **Accept Minutes**	**Tab 1**
8:40 a.m.	**Overview of Senate Bill 43** *Elissa Feld, Director of Policy and Regulatory Affairs, County Behavioral Health Directors Association (CBHDA)*	**Tab 2**
9:20 a.m.	**Public Comment**	
9:25 a.m.	**Sutter Health Perspective on Senate Bill 43 Implementation** *Jodi Nerell, Director of Local Mental Health Engagement, Sutter Health*	**Tab 3**
10:05 a.m.	**Public Comment**	
10:10 a.m.	**Break**	

10:25 a.m.	**County Perspective for Local Implementation of Senate Bill 43** *Hillary Kunins, Director, San Francisco County Department of Public Health* *Kelly Dearman, Executive Director, Department of Disability and Aging Services*	**Tab 4**
11:05 a.m.	**Public Comment**	
11:10 a.m.	**Overview of CalAIM Concept Paper and 1915(b) And 1115 Demonstration Waiver Renewals** *Uma Zykofsky, Chairperson and All Members*	**Tab 5**
11:25 a.m.	**Public Comment**	
11:30 am	**Discussion of the 2025 Systems and Medicaid Committee Activities for the Council's Year-End Report (Action)** *Uma Zykofsky, Chairperson and All Members*	**Tab 6**
11:40 a.m.	**Public Comment**	
11:45 a.m.	**Election of 2026 Committee Chair-Elect (Action)** *Uma Zykofsky, Chairperson and All Members*	**Tab 7**
11:50 a.m.	**Public Comment**	
11:55 a.m.	**Wrap Up/Next Steps** *Uma Zykofsky, Chairperson and All Members*	
12:00 p.m.	**Adjourn**	

The scheduled times on the agenda are estimates and subject to change.

Public Comment: Limited to a **2-minute maximum** to ensure all are heard.

Systems and Medicaid Committee Members

Uma Zykofsky, Chairperson	Karen Baylor, Chair-Elect	
Amanda Andrews	Javier Moreno	Marina Rangel
Jessica Grove	Dale Mueller	Karrie Sequeria
Ian Kemmer	Noel O'Neill	Tony Vartan
Steve Leoni	Liz Oseguera	Susan Wilson
Catherine Moore	Deborah Pitts	Milan Zavala

Committee Staff: Ashneek Nanua, Health Program Specialist II

TAB 1

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, October 16, 2025

Agenda Item: Review and Accept June 2025 Draft Meeting Minutes (Action)

Enclosures: Systems and Medicaid Committee June 2025 Draft Meeting Minutes

Background/Description:

The Systems and Medicaid Committee will review the draft meeting minutes for the June 2025 Quarterly Meeting and have a chance to make corrections. The committee will then accept the meeting minutes.

Systems and Medicaid Committee (SMC)

Meeting Minutes - DRAFT
Quarterly Meeting – June 19, 2025

Members Present:

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

Staff Present: Ashneek Nanua

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

Meeting Commenced at 8:30 a.m.

Quorum Established: 13 out of 17 members

Item #1 Review and Accept April 2025 Draft Meeting Minutes

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

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

Responsible for Action-Due Date
Ashneek Nanua – June 2025

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

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

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

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

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

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

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

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

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

Committee Questions and Discussion:

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

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

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

Item #3 Public Comment

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

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

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

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

Action/Resolution
N/A

Responsible for Action-Due Date
N/A

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

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

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

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

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

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

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

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

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

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

Committee Questions and Discussion:

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

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

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

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

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

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

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

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

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

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

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

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

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

Item #6 Public Comment

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

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

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

Action/Resolution
N/A

Responsible for Action-Due Date
N/A

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

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

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

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

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

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

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

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

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

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

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

Committee Questions and Discussion:

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

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

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

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

Item #8 Wrap Up/Next Steps

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

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

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

TAB 2

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, October 16, 2025

Agenda Item: Overview of Senate Bill 43

Enclosure: Senate Bill 43 Bill Text

How This Agenda Item Relates to Council Mission
To review, evaluate, and advocate for an accessible and effective behavioral health system.

The purpose of this agenda item is to provide the committee with information about the implementation of Senate Bill 43 from the counties' perspective. The committee will use this information to help guide policy recommendations related to the law's implementation, specifically for individuals living with mental health and substance use disorders.

Background/Description:

Senate Bill 43 amends the Lanterman-Petris-Short (LPS) Act, which governs the involuntary detention, treatment, and conservatorship of individuals with behavioral health conditions. The law updates diagnostic criteria and broadens the definition of "grave disability" to include people with a mental health disorder, a severe substance use disorder, or a co-occurring mental health and severe substance use disorder who cannot meet their basic needs or ensure their personal safety.

Elissa Feld, Director of Policy for the County Behavioral Health Directors Association (CBHDA), will give an overview of Senate Bill 43 and share the counties' perspective on its implementation. The committee will have an opportunity to ask questions after the presentation.

Presenter Biography:

Elissa Feld, the Director of Policy and Regulatory Affairs for the County Behavioral Health Directors Association (CBHDA), joined the County Behavioral Health Directors Association (CBHDA) in 2020. As Director of Policy, she is responsible for leading policy analysis and administrative advocacy to advance CBHDA's strategic priorities for California's county behavioral health agencies. Areas of focus include the Medi-Cal Specialty Mental Health and Drug Medi-Cal programs, California's 1915(b) and 1115 Medicaid waivers, data exchange and interoperability, Medicaid quality initiatives, and the implementation of federal managed care and parity regulations. Prior to joining CBHDA, Elissa spent a decade working for community-based organizations, providing Medi-Cal specialty mental health services to both youth and adults, and earned a Master's degree in Public Policy from California Polytechnic State University in San Luis Obispo.

TAB 3

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, October 16, 2025

Agenda Item: Sutter Health Perspective on Senate Bill 43 Implementation

Enclosure: Sutter Health Senate Bill 43 Presentation

How This Agenda Item Relates to Council Mission
To review, evaluate, and advocate for an accessible and effective behavioral health system.

The purpose of this agenda item is to inform the committee about how California's hospitals are implementing Senate Bill 43. The committee will use this information to shape policy recommendations related to the law to support individuals with mental health and substance use disorders.

Background/Description:

Sutter Health is a nonprofit health system serving over 3.5 million Californians. It features an integrated care model that provides treatment when, where, and how patients need it. Sutter also has psychiatric units that admit individuals for involuntary treatment.

Jodi Nerell, Director of Local Mental Health Engagement at Sutter Health, will present on Senate Bill 43 from the hospital's perspective. The presentation will address service capacity needs and challenges; how hospitals are monitoring changes in involuntary holds; stakeholder processes for implementation; plans for reporting outcomes; workforce adjustments; the law's impact on Institutes for Mental Disease (IMDs); and the successes and obstacles in implementing the bill. The committee will have the opportunity to ask questions after the presentation.

Presenter Biography:

Jodi Nerell, LCSW, is the Director of Community Health, Mental Health & Addiction Services for Sutter Health. In her role, she facilitates cross-sector (hospital, Managed-Care Plans, Community-Based Organizations (CBO), Non-Profit Organizations (NPOs), and counties) and interdisciplinary partnerships (peer supports, Community Health Workers (CHWs), Registered Nurses (RNs), Medical Doctors (MDs), and clinicians) to better serve the behavioral health needs of our community. This includes addressing opportunities for innovation in the community setting specific to mental health and addiction - addressing ongoing systematic, programmatic, and operational issues for populations with complex health/social needs who are often faced with seeking care in acute settings due to lack of availability to or access to, outpatient behavioral health care.

California Behavioral Health Planning Council: Systems and Medicaid Committee – SB43

Jodi Nerell, LCSW
External Affairs-
Director- Community Health, Mental Health & Addiction Services

Sutter Health

Sutter- Facts at a Glance

Comprehensive, Integrated Care

Sutter Health is a not-for-profit healthcare system that provides comprehensive, high-quality care throughout California. Committed to closing care gaps and driving innovative healthcare solutions, Sutter is pursuing a bold new plan to reach more people and make excellent healthcare more connected and accessible.

300+ clinics, ambulatory surgery centers and urgent care sites

28 acute care facilities

22 cancer centers

7 neonatal intensive care units

5 mental health and addiction care centers

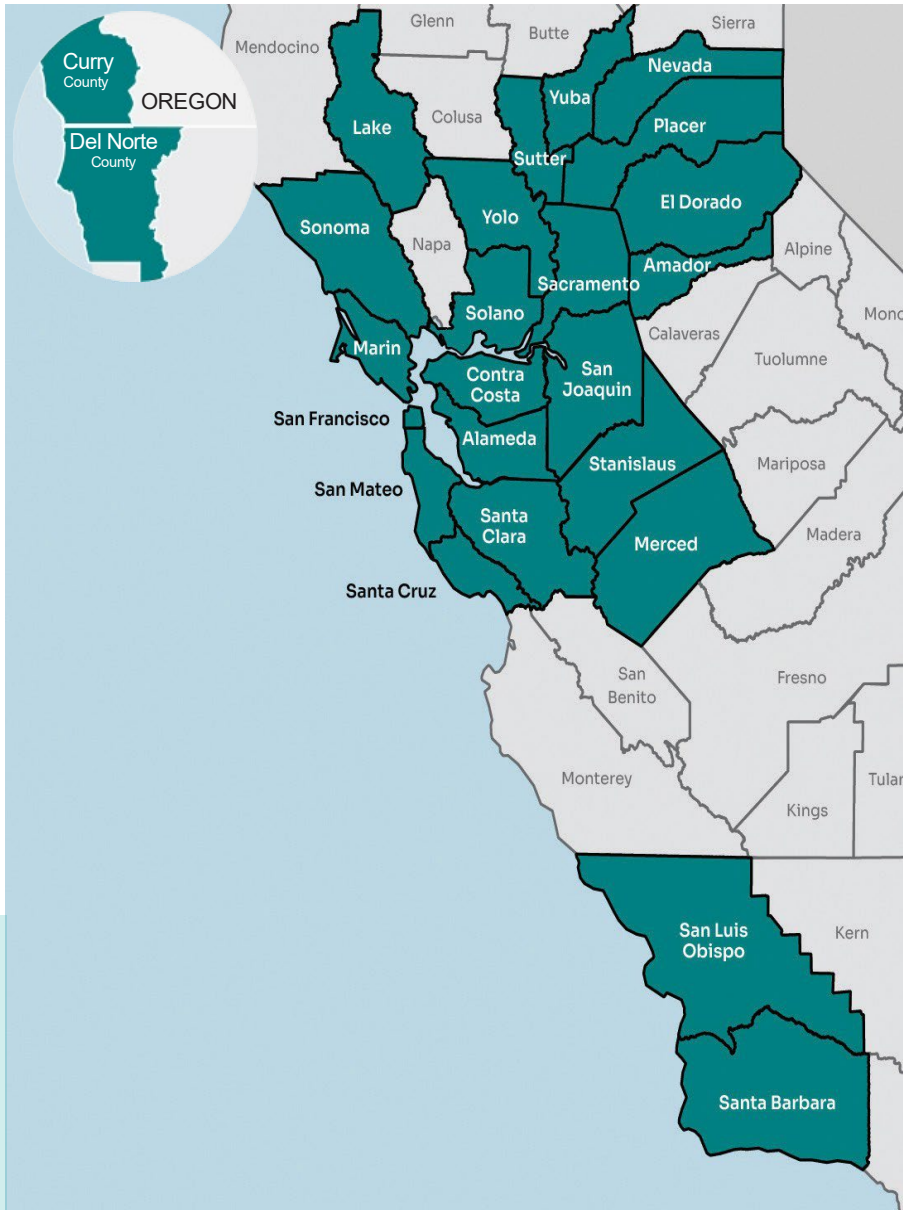
8 cardiac centers

3 acute rehabilitation centers

4 trauma centers

1 mobile stroke unit

Largest home health and hospice provider in Northern California



11th largest not-for-profit health system in the nation

3.5M patients served

8 medical groups

14,000 physicians and advanced practice clinicians

60,500+ employees, including nurses

SB 43 Overview

- ***What initiatives have hospitals took to make SB 43 effective?***
  - *Workforce - Hired Sutter ED Substance Use Navigators (Community Health Workers) , Addiction Medicine Providers*
  - *Expanding different levels of care Intensive Outpatient, Partial Hospitalization programming and Chemical Dependency Recovery Hospital across the enterprise*
  - *Care Act Pilot with one of our Inpatient Psychiatric Units*
  - *Retraining 5150 privileged staff in the updated criteria and forms*
  - *Updating MOUs with county partners to define roles and meet data reporting requirements (SB 929)*
  - *Leverage opportunities through Behavioral Health Infrastructure funding to expand co-occurring bed capacity*
  - *Formalized additional community/county -based linkages (community clinics, Street & Mobile Medicine programs)*
- ***What training is provided to responders, providers, and other staff on the changes made by SB 43?***
  - *Counties are providing education & training on: SB 43 legislation; the updated 1801 form; SUD continuum of care; 5150 and Grave disability-including for non-clinical staff training on observable functional impairments ; conservatorship and case examples*
  - *CALMHSA updated their 5150 training platform last year covering the expanded Grave Disability criteria*
- ***How are hospitals measuring any changes in the number of holds?***
- *Sutter tracks the number of holds in each of our 21 Emergency Departments and the % of those patients transferred to higher level of care or safely dispositioned*

SB 43 Overview

- ***What is the plan to report on the effects of implementation, and does your organization have any data to share on the current or projected impact on the system?***
  - *Three counties have implemented SB 43 in the Sutter footprint. Our hospitals work closely with local county and/or hospital association on any implementation challenges. Generally, impact has been minimal as high proportion of population experience co-morbid conditions.*
- ***What are successes and challenges of implementation?***
  - *Success- Cross-sector collaboration with first responders, county and community-based organizations to encourage voluntary engagement in care; mobile crisis response teams triaging crises; sobering centers offering voluntary option as ED diversion or step down.*
  - *Challenge – Network capacity, 5150 retraining requirements and differential county requirements;*
- ***How does the law impacts IMDs?***
  - *Many of the same patients IMDs are serving struggle with co-occurring disorders; AB 1238*
- ***What are your concerns about funding or lack of facilities to cover any increase in holds, and how might this be addressed?***
  - *Ensuring access to the appropriate levels of care- BHCIP likely to address in future years, in interim, Braiding funding streams between MCPs and county behavioral health plans for immediate community-based options can reduce decompensation and use of involuntary holds.*

Thank You

TAB 4

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, October 16, 2025

Agenda Item: County Perspective for Local Implementation of Senate Bill 43

Enclosures: None

How This Agenda Item Relates to Council Mission
To review, evaluate, and advocate for an accessible and effective behavioral health system.

The purpose of this agenda item is to inform the committee about how Senate Bill 43 is being implemented at the local level through a county behavioral health department. The committee will use this information to guide policy recommendations related to the law's implementation for individuals with mental health and substance use disorders.

Background/Description:

Hillary Kunins, the Director of Behavioral Health at the San Francisco Behavioral Health Services Department, will present on the local implementation of Senate Bill 43. The presentation will cover how counties are tracking the number of involuntary holds and whether there are more or fewer holds since implementing the bill, as well as the successes and challenges of the implementation. It will also discuss workforce changes and training provided to providers and staff, stakeholder involvement, plans for reporting outcomes, and how the law impacts Institutes for Mental Disease (IMDs). The committee will have an opportunity to ask questions after the presentation.

Presenter Biographies:

Hillary Kunins, MD, MPH, MS, is the Director for Behavioral Health Services and Mental Health San Francisco. Dr. Kunins is a public health, primary care and addiction medicine physician-leader who has dedicated her career to improving the health of people with behavioral health concerns, including substance use and serious mental illness, through science-based public health and healthcare programs and policy.

Dr. Hillary Kunins currently serves as the Director of Behavioral Health at the San Francisco Department of Public Health, where she has led the Behavioral Health Division since 2021 to implement mental health and substance use health services reform under San Francisco's Mental Health SF. Since 2021, under these reform efforts, the City has established behavioral health street health teams, established an Office of Coordinated Care to have a single point of access to the system of care, and expanded its residential care system by more than 400 beds, including a drug sobering center and crisis stabilization unit. The City has also established a coordinated overdose response system, including expanding its treatment network to include, among other initiatives, an evening telehealth program for immediate initiation of medications for addiction treatment.

Previously, Dr. Kunins served as the Executive Deputy Commissioner of Mental Hygiene (2019-2021) and Assistant Commissioner for the Bureau of Alcohol and Drug Use (2012-2019) at the New York City Department of Health and Mental Hygiene (DOHMH), where she led the reimagining of New York City's public health approach to substance use, including overdose as served as the Department of Health and Mental Hygiene (DOHMH) lead for Mayor Bill de Blasio's $60 million Healing NYC initiative to address the overdose epidemic. Dr. Kunins received her Medical Doctorate (MD) and Master of Public Health (MPH) from Columbia University and her Master of Science (MS) in Clinical Research from Einstein College of Medicine and completed her primary care-internal medicine residency and chief residency at Montefiore/Einstein. Dr. Kunins is a Fellow of American College of Physicians and Fellow of American Society of Addiction Medicine.

Kelly Dearman, Executive Director, Disability and Aging Services, coordinates services to veterans, older adults, adults with disabilities, and their families to maximize health, safety, and independence so that they can remain active in their community for as long as possible and maintain the highest quality of life.

Kelly has more than 15 years of experience developing policies and services to help ensure San Franciscans thrive as they age. Before joining DAS, Kelly was Executive Director of the San Francisco In-Home Supportive Services (IHSS) Public Authority, which helps older adults and people with disabilities live independently and participate in their communities. She is also the former President of the San Francisco Human Services Commission. Kelly currently serves on the California Association of Area Agencies on Aging executive board, is a member of the US Aging Board, co-chair of the San Francisco Aging and Disability Task Force, and co-chair of the San Francisco Palliative Care Workgroup.

Kelly has a Bachelor of Arts (BA) from the University of California, Berkeley, a Juris Doctor (JD) from University of California (UC) Hastings Law, and a Master of Arts (MA) in Political Science from Rutgers University. For ten years, she ran a small law practice specializing in elder issues and probate law. Previously, Kelly and her sister operated a real estate company founded by their grandmother more than 50 years ago.

Kelly was born and raised in San Francisco. She lives in the Cole Valley neighborhood with her family, living in the same house she grew up in. She lives with her husband, two children, and her parents.

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, October 16, 2025

Agenda Item: Overview of CalAIM Concept Paper and 1915(b) and 1115 Demonstration Waiver Renewals

Enclosures: Behavioral Health Stakeholder Advisory Committee (BH-SAC)
CalAIM Presentation Slides – July 2025 Meeting
Continuing the Transformation of Medi-Cal Concept Paper

How This Agenda Item Relates to Council Mission
To review, evaluate, and advocate for an accessible and effective behavioral health system.

The purpose of this agenda item is to inform the committee about the draft concept paper for renewing the CalAIM 1915(b) and 1115 Demonstration Waivers. The committee will use this information to build up the knowledge needed to give feedback on the draft CalAIM waivers once they are open for public comment.

Background/Description:

Uma Zykofsky, the Systems and Medicaid Committee Chairperson, will give an overview of the Continuing the Transformation of Medi-Cal Concept Paper. The concept paper describes the Department of Health Care Services' vision and goals for the next five years, including plans to renew the CalAIM waivers and other initiatives. The committee will have a chance to ask questions and discuss possible areas of the CalAIM 1915(b) and 1115 Demonstration Waivers they would like to provide feedback on once the public comment period is open.

TAB 6

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, October 16, 2025

Agenda Item: Discussion of 2025 Systems and Medicaid Committee Activities for the Council's Year-End Report (Action)

Enclosure: Systems and Medicaid Committee 2025 List of Completed Action Items

How This Agenda Item Relates to Council Mission
To review, evaluate, and advocate for an accessible and effective behavioral health system.

The purpose of this agenda item is to review the activities and action items the committee completed in 2025. The discussion will support the Council's 2025 Year-End Report.

Background/Description:

The California Behavioral Health Planning Council releases an annual report highlighting the achievements and activities of each committee. The Systems and Medicaid Committee will review the actions completed in 2025 in accordance with the committee's Work Plan. Committee members will have the opportunity to discuss and prioritize items for inclusion in the Systems and Medicaid Committee section of the Council's 2025 Year-End Report.

Systems and Medicaid Committee List of Completed Action Items - 2025

This document outlines the committee's accomplishments to inform the Systems and Medicaid Committee section of the Council's 2025 Year-End Report. The content below describes action items that the committee has taken in 2025 in accordance with the goals and objectives in the 2024-2025 Work Plan.

Goal #1: Leverage the Council's role in the State of California to influence policy changes the committee identifies as necessary to improve the state's behavioral health system.

Objective 1.1: Monitor implementation of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative to assess successes and challenges of the Initiative and provide policy recommendations to the Department of Health Care Services (DHCS).

Completed Action Items for Work Plan Objective 1.1:

- The committee submitted a letter of recommendations to the Department of Health Care Services regarding the draft policy for the CalAIM Adult and Youth Screening and Transition Tools in March 2025.
- The committee reviewed the CalAIM Waiver Concept Paper and submitted a letter to the Department of Health Care Services during the public comment period in August 2025.
- Staff and committee leadership attended the CalAIM Behavioral Health Workgroup, Behavioral Health Stakeholder Advisory Committee (BH-SAC), Behavioral Health Taskforce, and other state policy meetings to monitor and track the CalAIM Initiative.

Objective 1.2: Monitor and provide feedback to the Department of Health Care Services regarding the implementation of the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) 1115 Demonstration Waiver.

Completed Action Items for Work Plan Objective 1.2:

- The committee submitted a letter of recommendations to the Department of Health Care Services regarding the BH-CONNECT Evidence-Based Practices in January 2025.
- Staff and committee leadership attended the CalAIM and BH-CONNECT Behavioral Health Workgroup, Behavioral Health Stakeholder Advisory Committee (BH-SAC), Behavioral Health Taskforce, and other state policy meetings to monitor and track the BH-CONNECT Initiative.

Objective 1.3: Monitor and support efforts to improve access and quality of behavioral health care under the Behavioral Health Services Act (MHSA).

Completed Action Items for Work Plan Objective 1.3:

- The committee consulted with state, county, and provider representatives on the Full-Service Partnership implementation under the Behavioral Health Services Act during the January 2025 and June 2025 quarterly meetings. The committee focused on how substance use disorder services will be implemented, as well as the implementation of Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT).

Goal #2: Collaborate with other entities on behavioral health system reform to address current system issues and provide recommendations for policy change.

Completed Action Items for Work Plan Goal #2:

- The committee consulted with the California Mental Health Services Authority (CalMHSA), counties, and provider representatives on the implementation and impact of the Semi-Statewide Electronic Health Record during the April 2025 Quarterly Meeting. The Electronic Health Record streamlines documentation, reporting, and data management for counties and behavioral health providers aimed to address behavioral health system administrative challenges and improve patient care.

Objective 2.1: Collaborate with state, county, and health plan partners to participate in priority initiatives that work towards increasing and improving behavioral health and student mental health services for children and youth.

Completed Action Items for Work Plan Objective 2.1:

- Members of the committee regularly attend and participate in the Council's Children and Youth Workgroup to raise awareness and drive action on issues related to the Children's System of Care in California.
- Committee staff took part in the Children and Youth Behavioral Health Initiative (CYBHI) feedback sessions focused on outreach and messaging.

Objective 2.3: Collaborate with state, county, and health plan partners to participate in priority initiatives that work towards increasing and improving Substance Use Disorder (SUD) services in the public behavioral health system.

Completed Action Items for Work Plan Objective 2.3:

- The committee met with state, county, and provider representatives in January 2025 to discuss the implementation of the Full-Service Partnership under the Behavioral Health Services Act. The meeting focused on how substance use

disorder services would be carried out under the Act.
- The committee wrote a letter of recommendations for the Department of Health Care Services' Statewide Assessment and Planning (SNAP) Report for the Substance Use Prevention, Treatment, and Recovery Services Block Grant Federal Reporting Requirement in July 2025.
- During the October 2025 Quarterly Meeting, the committee consulted with hospital and county representatives to evaluate the impact of Senate Bill 43, which expands the criteria for conservatorship to include individuals with substance use disorders.

Objective 2.4: Collaborate with state, county, and health plan partners, to participate in priority initiatives that work towards ensuring access and quality of behavioral health care for older adults and individuals on a Lanterman-Petris Act (LPS) conservatorship with SMI and SUD populations.

Completed Action Items for Work Plan Objective 2.4:

- During the October 2025 Quarterly Meeting, the committee discussed with hospital and county representatives the implementation and impact of Senate Bill 43, which broadens the definition of gravely disabled as it pertains to conservatorship criteria.

TAB 7

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, October 16, 2025

Agenda Item: Election of 2026 Committee Chair-Elect (Action)

Enclosures: None

How This Agenda Item Relates to Council Mission
To review, evaluate, and advocate for an accessible and effective behavioral health system.

This agenda item provides committee members with the opportunity to nominate the next Systems and Medicaid Committee (SMC) Chair-Elect. The Chair-Elect assists the Chairperson in leading committee activities.

Background/Description:

Each standing committee shall have a Chairperson and Chair-Elect. The Chairperson serves a one-year term with the possibility of re-nomination for another year. Karen Baylor is scheduled to serve as the Committee Chairperson in 2026. Committee members shall nominate a Chair-Elect to be submitted to the Council's Officer Team for appointment in 2025. The Chair-Elect will begin their term at the January 2026 Quarterly Meeting.

The role of the Chair-Elect is outlined below:

- Facilitate committee meetings as needed, in the absence of the Chairperson.
- Assist the Chairperson and staff with setting the committee meeting agenda and committee planning.
- Participate in the Executive Committee Meetings on Wednesday mornings during the week of quarterly meetings.
- Participate in the Mentorship Forums in person on the Thursday evening of the quarterly meetings.

Motion: Nominate a committee member as the Systems and Medicaid Committee Chair-Elect.