CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING SUMMARY

DHCS STAKEHOLDER ADVISORY COMMITTEE (SAC)/BEHAVIORAL HEALTH-SAC (BH-SAC) JOINT MEETING SUMMARY

Date: October 16, 2024

Time: 9:30 a.m. – 3 p.m.

Type of Meeting: Hybrid

DHCS Staff Presenters: Michelle Baass, Director; Autumn Boylan, Deputy Director, Office of Strategic Partnerships; Tyler Sadwith, State Medicaid Director; Glenn Tsang, Policy Advisor, Homelessness and Housing; Palav Babaria, MD, MHS, Chief Quality Officer and Deputy Director, Quality and Population Health Management; Susan Philip, MPP, Deputy Director, Health Care Delivery Systems; Marlies Perez, Chief, Community Services

SAC Members in Attendance: Michelle Cabrera, Le Ondra Clark Harvey, Eileen Cubanski, Amanda Flaum, Michelle Gibbons, Kim Lewis, Jarrod McNaughton, Linda Nguy, Marina Owen, Chris Perrone, Katie Rodriguez, Janice Rocco, Kiran Savage-Sangwan, Laura Sheckler, Christine Smith, Al Senella, Ryan Witz

BH-SAC Membership in Attendance: Ken Berrick, Michelle Cabrera, Dannie Ceseña, Le Ondra Clark Harvey, Eileen Cubanski, Vitka Eisen, Sarah-Michael Gaston, Sara Gavin, Brenda Grealish, Samuel Jain, Linnea Koopmans, Karen Larsen, Kim Lewis, Hector Ramirez, Jason Robison, Kiran Savage-Sangwan, Al Senella, Chris Stoner-Mertz, Catherine Teare, Gary Tsai, Rosemary Veniegas, Jevon Wilkes

Additional Information: Here is the PowerPoint presentation used during the meeting. Please refer to it for additional context and details.

Introduction and Summary of Content

» The joint SAC/BH-SAC meeting addressed topics related to Medi-Cal and California's behavioral health landscape. Panel members received a Director's Update on recent legislation signed by the governor and their relevance to DHCS. The following topics were covered:

- Children and Youth Behavioral Health Initiative (CYBHI) Update
- CalAIM Justice-Involved Reentry Initiative

- Transitional Rent Update: DHCS Proposals and Related Policy Considerations
- Enhanced Care Management and Community Supports Update
- Behavioral Health Transformation Update

» The meeting concluded with a public comment period, allowing attendees to offer feedback to DHCS and panel members.

Topics Discussed

Director's Update (Legislative) – *Michelle Baass, Director*: DHCS provided an update on recent legislation passed and signed by the governor, including AB 177, AB 2115, AB 2073, SB 1238, SB 1289, and AB2376. These bills addressed health care data and funding, opioid treatment regulations, expanding behavioral health workforce access to care, improving Medi-Cal call center transparency, and expanding chemical dependency recovery services.

» **Discussion**

» A member raised concerns about the closing of obstetric units in California hospitals and the shift away from traditional OB/GYN practices. They proposed forming a workgroup with DHCS, health plans, and hospitals to explore the evolving model of care in obstetrics, maintain access for members, and forecast future needs considering these changes. DHCS acknowledged this issue as a concern for all payers statewide and expressed willingness to engage in discussions. Ongoing efforts to enhance capacity and access in acute care settings, including labor and delivery, were noted.

CYBHI Update – *Autumn Boylan, Deputy Director, Office of Strategic Partnerships*: The CYBHI strengthens behavioral health support for young people, particularly within school environments. This state-led effort funds several programs, including capacity-building grants for schools and mindfulness resources across counties, to foster an atmosphere that promotes student and staff well-being. A major component of the CYBHI is the new Fee Schedule program, which ensures schools, colleges, and universities are reimbursed for mental health and substance use disorder services for students under age 26. Reimbursement is based on Medi-Cal Fee-for-Service rates, offering schools a sustainable revenue stream to support the provision of mental health services, though it may not cover all associated costs.

The Fee Schedule provides funding for specific outpatient services delivered by licensed school staff and staff with a Pupil Personnel Services (PPS) credential, including psychologists, social workers, and counselors, but excludes reimbursement for specialty mental health services and any services mandated under a student's Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP). Details were provided about how the Fee Schedule program is implemented, the third-party administrator (TPA), and its phased rollout. The CYBHI's phased rollout began with an initial cohort of 46 local educational agencies (LEAs) and has expanded to more than 300 LEAs and several colleges, indicating widespread interest in establishing a durable behavioral health infrastructure within educational settings.

Information was provided about partnerships with community-based providers (CBP), mandates around health plan reimbursement, and DHCS' commitment to investing in school-based behavioral health services and community partnerships to build a lasting support network for youth mental health across California.

- **Discussion**
  - A member sought clarification on whether the TPA applies when a managed care plan (MCP) contracts directly with community providers for behavioral health services, specifically asking if the TPA is needed for claims when the MCP is directly paying the community provider. DHCS explained that if the community provider is in network with the MCP and serving a student, they can be reimbursed directly through the MCP. However, since LEAs often do not have contracts with all MCPs, the TPA remains beneficial for school-linked providers working with multiple MCPs. The member expressed concern about the complexity of the system, highlighting the challenges LEAs face with Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) compliance while managing onsite services. They asked how DHCS is supporting LEAs in navigating these complexities and ensuring legal compliance. DHCS responded by outlining several resources available to LEAs, including regular office hours, guidance on their website, FAQs, training modules, and infographics designed to simplify the process. DHCS is also collaborating with the California Health and Human Services Agency through a technical advisory committee to address HIPAA and FERPA issues. Furthermore, DHCS is developing a data-sharing toolkit for schools and exploring universal consent models. While participation is optional for schools, DHCS continues to work closely with LEAs and public colleges/universities to shape policies and procedures and ensure legal compliance.

- A member asked about the evaluation and data collection process for the program, particularly regarding student outcomes and disparities by race, ethnicity, health plan, and school district. They also inquired about the availability of data dashboards and when that might begin. DHCS responded that the evaluation is part of the CYBHI work, with Mathematica contracted to evaluate the program. While it is still early, DHCS is already considering key metrics, including reimbursements, stratification by demographics, and geographic distribution. DHCS is also working to understand how the program will impact rural areas through site visits. However, due to the program's early stages, no claims have been paid yet, and data collection is still in progress, with claims expected by the end of calendar year 2024.
- A member discussed the upcoming Medicaid final rule, which will require secret shopping to assess the compliance of MCPs, particularly regarding appointment wait times for behavioral health services. The member offered resources from Los Angeles County, including collaborations with children's hospitals, school-based health call centers, and Federally Qualified Health Centers (FQHC), which have addressed privacy and data issues in both education and health. The member asked whether the secret shopping requirements will apply to the TPA, MCPs, and LEAs, as the secret shoppers will assess accessibility and network adequacy for Medicaid providers. DHCS explained that school districts and universities are considered out of network for MCPs under current regulations. DHCS further clarified that while MCPs are required to pay for services regardless of network status, this secret-shopper requirement does not explicitly apply to school-based providers.
- A member expressed appreciation for the information sharing and collaboration with community-based organizations, thanking DHCS for quick responses and for attending events, which has been helpful to their members. They also thanked DHCS for its transparency regarding the challenges encountered during the rollout of the CYBHI program. The member emphasized the importance of community providers in delivering care year-round, particularly after school hours, and supported a team approach. Finally, members pointed out that there are contracting issues, noting that they frequently face difficulties in working with LEAs and encouraged DHCS to provide more technical assistance.
- A member asked how peer specialists can be involved in the Fee Schedule program. DHCS explained that there are various roles for peers within the Medi-Cal system, including community health workers (CHW), peer support

specialists, and wellness coaches. While peer support specialists are not currently reimbursed under the school-based services program, CHWs can be. Certified Wellness Coaches will also be eligible for reimbursement in 2025. DHCS highlighted a joint initiative with the Children's Partnership to pilot a peer-to-peer program in eight high schools, aimed at training students to mentor and provide peer support to their peers. This initiative will help inform future statewide standards for high school peer programs and reimbursement structures. DHCS acknowledged the importance of involving peers with lived experience in supporting students, as feedback from youth in the CYBHI indicated their preference for mentors closer to their own age.

- A member sought clarification on the TPA's role for LEAs, particularly if it covers claims for LEAs without MCP contracts. DHCS explained that LEAs can submit claims to the TPA, even if they have a contract with one MCP, as they may not have agreements with all MCPs. The TPA handles claims processing, benefits coordination, and provider credentialing. Initial funding is from the state, with a fee structure for MCPs to support funding starting next year. The member also inquired about care coordination, specifically if it could include helping students with Medi-Cal renewals. DHCS responded that while a solid framework is still under development, LEAs can currently assist with renewals through the Medicaid Administrative Activities program. DHCS is considering broader coordination of services, especially for periods when schools are not in session, and plans to refine this in the future. The member recommended including renewal assistance in care coordination efforts.
- A member commented on the importance of care coordination, noting that local plans have been focused on it from the outset. They recognized the current priority of getting the Fee Schedule program operational and the ongoing discussions with DHCS and the TPA to support this. The member stressed the need for care coordination, particularly when students receive mental health services at school, but lack other necessary care, such as well-child visits. They pointed out that care coordination becomes more complex when there is no direct contract between the schools and MCPs. The member also acknowledged that some schools have direct contracts with MCPs, particularly through the Student Behavioral Health Incentive Program (SBHIP), and these relationships remain significant as the Fee Schedule program is implemented and sustained.
- The member acknowledged the presentation and expressed support for the strategy to engage California State University (CSU) and University of

California (UC) institutions. They recommended ensuring that mental health services in educational settings are culturally responsive and free of stigma, particularly for marginalized communities. The member raised concerns about the effectiveness of Western clinical models for communities of color, including Native American and Indigenous, communities, and stressed the importance of an equity framework that focuses on accessibility, quality, and dignity. They also advocated for including traditional healers and peer workers in reimbursable services, emphasizing the value of lived experience in improving outcomes. The member expressed optimism for the program's potential, but urged attention to community accessibility and benefit. DHCS responded by clarifying that schools do not diagnose students and that a diagnosis is not required for reimbursement under the Fee Schedule program. They noted that this aligns with efforts to allow students to access services without a formal diagnosis, thus increasing access to mental health support in schools.

- The member expressed appreciation for the work being done, particularly in expanding the workforce through the Certified Wellness Coach role, and stressed the importance of broadening eligibility for these roles, especially at the bachelor's degree level. They also highlighted a concern about ensuring LEAs effectively engage community providers, noting that there seem to be multiple, disconnected efforts for technical assistance and training. The member advocated for a more coordinated approach to ensure that services are systematically available to students and families, rather than simply using funding for disconnected efforts. DHCS emphasized that the process of engagement may involve growing pains as schools adjust to new opportunities and that it's crucial for LEAs and community providers to collaborate. DHCS also noted that while the statute allows flexibility in engaging community partners, there must be a structured approach to ensure meaningful and effective partnerships with providers, rather than indiscriminately involving all community-based organizations.
- The member raised several points, including the need to consider 42 Code of Federal Regulations (CFR) and HIPAA regulations alongside network adequacy requirements for MCPs and commercial plans, and asked if the fee schedule impacts network adequacy for these plans. They also clarified that federal requirements for certified peer specialists include being at least 18 years old and having a high school diploma or equivalent. The member highlighted new restrictions on how counties can use the millionaire's tax to fund school-based services, noting a shift in funding to the grants program

at the California Department of Public Health. They expressed appreciation for the state's careful approach to implementing changes and stressed the importance of aligning these changes with the Behavioral Health Services Act transitions to ensure smooth integration at the local level over the next few years. DHCS responded by confirming that MCPs cannot use the Fee Schedule program to meet network adequacy requirements unless they have a contract with a LEA, and acknowledged the need to coordinate these changes at the state and local levels moving forward.

- A member clarified that the federal government has no age restrictions for peer support specialists billing Medicare. They noted that the Children's Partnership, in collaboration with the Center for Law and Social Policy, is working to get clearer guidance from the U.S. Department of Health and Human Services (HHS). The member emphasized that states, including California, have the authority to decide who can be certified as peer support specialists. This is particularly relevant to the Children's Partnership's work on high school peer support, and California has an opportunity to lead in supporting 16- and 17-year-olds in this role.

- **CalAIM Justice-Involved Reentry Initiative – *Autumn Boylan, Deputy Director, Office of Strategic Partnerships*:** The CalAIM Justice-Involved (JI) Reentry initiative focuses on enhancing health care and support services for individuals transitioning from incarceration back into the community. It provides Medi-Cal members with access to a targeted set of pre-release services, including but not limited to care management, clinical consultation, medications, laboratory and radiology, as well as behavioral health services, including Medication-Assisted Treatment (MAT) to reduce opioid-related deaths, stabilize health outcomes, and address health disparities faced by incarcerated people. A core focus of the initiative is connecting individuals to community-based Enhanced Care Management (ECM) services which aims to deliver holistic, wraparound support to address critical needs like housing, employment, and mental health for successful community reintegration.

  A key component of this initiative is California's federally approved 1115 waiver, making it the first state to offer comprehensive pre-release services under Medi-Cal. Counties are also required to process Medi-Cal applications prior to release, ensuring expedited access to health care.

- **Discussion**
  - A member asked about administrative and financial barriers to providing long-acting injectable buprenorphine for individuals released from jail at unpredictable hours, noting that current practices restrict medication to what was prescribed upon jail entry. They inquired if the JI Reentry Initiative supports initiating MAT and the use of long-acting injectables for eligible individuals during incarceration. DHCS responded that there is a detailed policy guide available on the website, which highlights the use of long-acting injectables for both substance use disorders and antipsychotic medications. Mandatory health risk assessments help identify individuals who would benefit from these treatments. DHCS offered technical assistance.
  - A member sought clarification on the governance structure of the JI Reentry Initiative, noting that while jails are legally required to implement by October 2026, various partners, including counties and ECM providers, are involved. They asked about the participation requirements and local-level coordination leadership. DHCS explained its oversight role under the 1115 waiver, detailing county responsibilities for service linkage and pre-release applications, even if facilities are not yet live. MCPs received guidance on ECM responsibilities. The member highlighted hospitals' challenges with patients released in unstable psychiatric conditions and asked about service connection protocols. DHCS stated that Medi-Cal MCP members are coordinated through JI liaisons, with county behavioral health agencies addressing inpatient needs. DHCS emphasized improving overnight release transitions and noted that hospitals can engage via MCPs or county-specific lead correctional health care agencies.
  - The member expressed appreciation for the collaborative efforts of DHCS and its partners to improve service linkages for individuals transitioning from incarceration, a long-identified CCJBH priority. They highlighted the importance of engagement with reentry partners, especially ECM providers, and called for incorporating individuals with lived experience to foster trust and improve post-release behavioral health outcomes.
  - Members asked if all jails and counties are expected to go live by the state-mandated deadline of September 2026 and whether implementation must be fully comprehensive or if partial compliance is permissible. They inquired about measuring and comparing progress among facilities, which may be at different stages of implementation. DHCS responded that all correctional facilities must meet certain core service requirements by the go-live date.

DHCS highlighted efforts to engage correctional facility partners and noted the importance of providing them with support and reasonable flexibility during the phased implementation period.

- A member expressed strong support for DHCS' response regarding the role of local plans in convening communities for the JI Reentry Initiative. The member emphasized the importance of support for both providers and justice partners and praised the incentive payment program for its focus on operational and staffing support to prepare for JI Reentry Initiative dates. They expressed confidence that these connections will prove invaluable in the long term. The member requested more coordinated meetings, suggesting that as implementation progresses, it would be beneficial for local plans, justice partners, and DHCS to convene to streamline communication, reduce silos, and accelerate collective learning.
- A member expressed strong enthusiasm and congratulated DHCS on its efforts. They suggested involving Court Appointed Special Advocates (CASA) in both the CYBHI and the juvenile aspects of the JI Reentry Initiative. As a former CASA, the member highlighted the program's value in connecting advocates with benefit offerings and believed their involvement would be beneficial in supporting DHCS' initiatives.
- A member asked who is responsible for covering the cost of in-reach services, questioning whether it falls to MCPs, institutions, or DHCS. DHCS clarified that services provided to individuals while in custody are paid through the Medi-Cal fee-for-service (FFS) delivery system. Providers performing in-reach services must be enrolled as Medi-Cal providers and submit claims under this system. When the member asked if individual providers, such as social workers, could independently contract to deliver in-reach services, DHCS explained that in-reach providers would primarily be network providers of MCPs or county behavioral health agencies, handling post-release support, and must contract with correctional facilities for pre-release services. The member further inquired whether the California Department of Corrections and Rehabilitation (CDCR) could act as a contracted in-reach provider. DHCS confirmed that CDCR and correctional facilities must enroll as Medi-Cal FFS providers, with claims submitted under their National Provider Identifier (NPI) numbers. The member acknowledged the response and emphasized the importance of developing a cohesive and comprehensive approach to in-reach services to support individuals

transitioning from custody, particularly within the CDCR system, while highlighting the value of peer support and credible messengers.

- **Transitional Rent Update: DHCS Proposals and Related Policy Considerations – *Tyler Sadwith, State Medicaid Director; Glenn Tsang, Policy Advisor, Homelessness and Housing*:** DHCS outlined the vision and updated proposals for transitional rent policies aimed at addressing social drivers of health through temporary rental assistance for vulnerable populations in California. Key aspects included an overview of revised policy proposals, eligibility criteria, and efforts to bridge service delivery gaps for transitional housing. The initiative would offer six months of transitional rent as a part of Medi-Cal's Community Supports services, filling a critical gap due to the state's limited rental subsidy offerings.

  DHCS highlighted a significant policy pivot in response to legislative changes, notably concerning the integration of Proposition 1's behavioral health services with Medi-Cal MCPs. This shift involved a clearer delineation of roles and responsibilities between managed care and county behavioral health systems, focusing on streamlined delivery and reducing service duplication.

  DHCS discussed plans for a new model involving flexible housing subsidy pools, leveraging diverse funding sources for unhoused populations. Stakeholders were encouraged to reference the comprehensive 40-page concept paper for more nuanced details on the proposed policies and their expected impact.

- **Discussion**
  - A member inquired about the inclusion of individuals experiencing domestic violence (DV) in the demonstration project, suggesting intentionality in addressing this population. They also recommended leveraging systems like 2-1-1 to support housing efforts and mentioned the state's Home Energy Assistance Program (HEAP) as a model. DHCS responded by confirming that individuals transitioning from DV shelters are recognized within the project's criteria.
  - A member asked about the application of the new transitional rent benefit in rural areas, where housing availability is often limited, and expressed concerns about the relocation of members to areas with available housing. They inquired about continuity of care when members move to another county, including the implications for MCP coverage and how long it would take for a member to re-establish residency with a new MCP or county. DHCS responded by clarifying that the state is not mandating member relocations,

but is instead providing subsidies for housing, with care coordination left to the MCPs and counties. DHCS acknowledged the concerns raised by rural counties and noted that the Behavioral Health Services Act's 30 percent housing intervention funding, which includes up to 25 percent for capital, may support local solutions. DHCS also highlighted the importance of local discussions about housing needs and potential new revenue sources. The member followed up by noting concerns about the impact on provider networks, particularly for members relocating to different counties, and the potential need for risk-based arrangements.

- A member expressed appreciation for DHCS' transitional rent benefit and suggested that housing navigation and Community Supports services, which many individuals may need prior to receiving transitional rent, should also be considered as a benefit. They inquired why DHCS prioritized transitional rent over these existing Community Supports, such as the housing trio. DHCS responded by acknowledging that the housing trio is already available as Community Supports in all counties and by all MCPs, and explaining that transitional rent was prioritized due to its structure and funding. DHCS emphasized its intention is to make these benefits available when possible, and the decision to introduce transitional rent first was driven by the design process and the clarity it provided, particularly in relation to Proposition 1.
- A member expressed appreciation for the release of the concept paper, acknowledging the complexity of the proposed changes and the anticipation from local plans. They emphasized the importance of getting into the details over the next year, particularly in preparation for 2026. The member highlighted the potential of the flex pool model, noting its success in Los Angeles County, but recognizing that it may not be applicable elsewhere. They also stressed the importance of the housing plan component, given the short six-month duration of transitional rent, and expressed hope that it would lead to longer-term housing solutions like permanent supportive housing. Additionally, the member raised concerns about potential changes in MCP membership for individuals who may need to relocate across counties for housing, suggesting that such changes should not occur until after the transitional rent period to avoid coverage gaps.
- A member shared a story about a situation in which a doctor reached out for help in finding housing for a family affected by DV, highlighting concerns about the challenges of navigating housing resources at the county level. They expressed excitement about the new benefit but stressed the

importance of improving communication and operational strategies at the frontline level, especially for situations requiring urgent housing assistance. DHCS responded by acknowledging the importance of timely housing solutions, sharing a similar example from a recent listening tour in Nevada County, where a community provider described the urgency of securing housing, including the need for deposits to be made quickly to avoid losing housing opportunities. DHCS emphasized that timely responses to housing needs are a significant operational challenge, given the current housing landscape.

- A member expressed appreciation for DHCS' work to introduce the new Medi-Cal benefit, particularly in response to member requests under the BH-Connect 1115 waiver, which addresses the intersection of behavioral health recovery and housing needs. They noted that prior to Proposition 1, county behavioral health systems did not have a specific mandate to provide housing, marking a significant shift with the introduction of the new benefit. However, they highlighted concerns about coordination, particularly the requirement that MCPs must first spend their full allocation on housing trio and transitional rent before Behavioral Health Services Act funds can be used. The member emphasized the need for flexibility and innovation in how counties, MCPs, and behavioral health systems can collaborate, particularly during the waiver period. They also raised concerns about long-term housing needs, given that many individuals with behavioral health conditions may not become self-sufficient within six months, and the potential market issues around rental caps, as Behavioral Health Services Act funds may not cover costs exceeding the proposed HUD cap. They urged DHCS to model the allocation of Behavioral Health Services Act funds and explore other housing support options with MCPs, hospitals, and charitable organizations. The member concluded by noting that populations, such as those with physical health conditions and survivors of DV, should also be considered eligible for housing assistance.
- A member asked about how individuals transitioning out of prison, particularly those with behavioral health needs, will be connected to housing and support services before the 90-day in-reach program is implemented, noting that navigation support is not part of the in-reach phase. They also inquired about the potential for a strategy to address housing and care for justice-involved individuals. DHCS responded that the details regarding workflow and model development have not been finalized. DHCS emphasized the importance of further discussion and noted the need to

define "transitioning" and establish a clear model for connecting individuals to services. The member also mentioned the issue of incomplete Social Security applications for those transitioning out of prison and suggested that ECM providers could support the completion of these applications post-release.

- A member commented on the importance of ensuring continuity and consistency across counties, particularly regarding the implementation of plans and documentation requirements. They noted challenges related to transition-age youth and emphasized the need for alignment across counties in these areas. The member also highlighted the state's ongoing need to address long-term housing solutions, pointing out that while transitional rent supports are helpful, ongoing rental subsidies are crucial due to the broader housing crisis in the state. They suggested that this issue should remain a key focus.
- A member commented on the importance of timeliness in providing rental assistance, particularly regarding the 30-day authorization period. They expressed concerns about how this will work in partnership with mental health and MCPs to ensure immediate access to services. The member emphasized the need for broader access, including community-based organizations providing rent-related supportive benefits, to prevent individuals from losing housing. They also discussed the challenges of the flex housing tool, especially in counties without specific housing funding or resources, and stressed the need for long-term housing solutions. Additionally, the member pointed out that foster youth, particularly those at risk of homelessness, may not be aware of the transitional rent benefit and suggested increased outreach to child welfare agencies, especially in counties where managed care enrollment is not mandatory.
- A member emphasized the importance of expanding the role of CHWs in the transitional rent concept, suggesting that CHWs could assist with outreach and provide additional support, such as housing education, tenant rights education, financial literacy, and help navigating housing and social service systems. They highlighted the opportunity to leverage the CHW benefit to enhance the implementation of transitional rent and commended DHCS for including boarding care coverage as part of potential future housing supports.
- A member asked for clarification on the eligibility criteria for transitional rent, particularly for individuals with chronic physical health conditions who are

ineligible for Full Service Partnerships (FSP). They expressed concern that individuals at risk of homelessness would not be eligible for assistance until they became homeless or institutionalized and questioned whether this approach is effective in preventing homelessness. DHCS responded by explaining the three eligibility categories: clinical criteria, at risk of homelessness, and those making transitions, such as from residential settings or meeting high-risk criteria. DHCS noted that while transitional rent is intended to assist individuals transitioning or at high risk, not everyone will meet the full eligibility criteria. The member further suggested simplifying the eligibility to prevent homelessness before it occurs and inquired whether the six-month limit on rental assistance applies regardless of the amount of subsidy needed. DHCS confirmed the six-month limitation and explained that it is a requirement from CMS, which frames transitional rent as a tool to assist individuals during transitions of care.

- A member commented on the need for more focus on supporting young people experiencing homelessness, particularly in the context of schools and higher education institutions, such as K-12 schools, community colleges, and CSU/UC. They highlighted that the HUD definition of homelessness is restrictive and does not adequately address the needs of unaccompanied youth. The member emphasized the importance of preventing the transition into chronic homelessness by providing support to these young people before that point. They also requested additional focus and clarity on how the transitional rent policy could better align with efforts to support youth homelessness prevention, especially in collaboration with LEAs.
- A member inquired about outreach efforts to DV survivors in relation to transitional rent support, referencing a report highlighting the impact of $400 in rental and other supports for preventing homelessness. They suggested that the six-month limitation on rental assistance may not be sufficient for DV survivors, particularly given the challenges of shelter space availability. The member proposed considering eligibility for transitional rent support without requiring entry into a shelter, as many shelters have long wait lists and limited space.

- **ECM and Community Supports Update – *Palav Babaria, MD, MHS, Chief Quality Officer and Deputy Director, Quality and Population Health Management; Susan Philip, MPP, Deputy Director, Health Care Delivery Systems*:** DHCS provided information about how many people ECM has served since

launching in 2022 and the increased enrollment among children and youth. DHCS also shared that in January 2024, ECM eligibility expanded to include two new populations: birth equity and JI individuals post-release. Lastly, DHCS provided information about its ECM and Community Supports Action Plan, which focuses on revising and reinforcing policies and implementing specific design initiatives across key areas. The key areas include standardizing eligibility, streamlining and standardizing referral/authorization processes, expanding provider networks and streamlining payments, strengthening market awareness, and improving data exchange.

- **Discussion**
  - There was a request for clarification on the "county behavioral health provider" category in ECM and Community Supports, specifically whether it refers to counties using only county employees or includes contracted community-based organizations. DHCS responded that it refers to counties directly providing services, with contractors falling under the behavioral health entity category. DHCS also noted that the data are manually reported, which could lead to data integrity issues. They added that DHCS is transitioning to using Medi-Cal enrollment data and NPI numbers for more accurate tracking. A member followed up by expressing appreciation for the comprehensive data available online and asked if DHCS has an estimate of the target ECM penetration rate or the number of eligible individuals. DHCS responded that ECM targets the top 3-5 percent of the Medi-Cal population by complexity, with no set penetration rate or targets. DHCS also mentioned that while the penetration rate is currently below 1 percent, it varies by county and MCP. The member inquired about the "market awareness" priority area mentioned in the presentation, asking whether it refers to providers or members. DHCS clarified that it applies to both and emphasized the importance of trusted referrals to increase ECM uptake, adding that new referral standards focus on educating ecosystems, like schools, and that incentive payments are being used to encourage MCPs to educate their providers about ECM and Community Supports.
  - A member expressed appreciation for the efforts to standardize documentation across MCPs to reduce provider burden and mentioned feedback from ECM providers, including specific requests for more technical assistance (TA) and reports of a lack of alignment. The member flagged concerns from providers serving populations with intellectual and developmental disabilities about the appropriateness of the exclusion criteria.

Additionally, the member reported that some providers feel they are not receiving enough TA from certain MCPs, with some MCPs stating they are still working on solutions. The member acknowledged that while some MCPs are working well, there is still progress to be made.

- A member inquired about how the learnings from the birth equity population of focus were approached, specifically asking if member experiences informed the assessment and how this approach aligns with the health equity roadmap work. DHCS responded that while the process could have been more robust, member outreach, feedback from providers, and collaboration with public health colleagues informed the design of the program. DHCS noted that creating eligibility criteria tied to racial and ethnic disparities is complex and emphasized they are not restricting individuals based on self-identification. DHCS also highlighted that frequently asked questions (FAQ) and best practices for screening were shared with stakeholders and mentioned that the forthcoming Birthing Care Pathway report, expected later this year, will provide further insights on the topic.
- A member asked if data on continuity or concentration for the ECM benefit will be provided, emphasizing that since ECM is not expected to be used regularly beyond the referral, understanding the concentration of services would be helpful in addition to penetration rates. DHCS responded that their monitoring strategy for ECM, set to roll out in 2025, will include the quality of services provided, distinguishing between limited contact (e.g., one phone call over three months) versus more intensive service (e.g., eight hours of services each week or month over a period of months). The member followed up by expressing appreciation to DHCS for updating its policy guide and shared concerns from legal aid advocates about the short timeline and delays in issuing housing deposits, which can result in people missing out on housing benefits, citing this as a reason for low utilization in the housing trio. The member also acknowledged the birth equity population of focus and encouraged DHCS to not only build but also maintain the provider network, citing issues around doula services related to denials or delays in payment, and expressing hope that the new doula billing code, expected to roll out next month, will help address these issues.
- A member raised concerns about awareness, sharing stories in which individuals contacted their MCP but were told they were unaware of ECM services, leading to confusion about the availability of the benefit. The member emphasized the need for clearer, front-door basic requirements to

avoid such misunderstandings. Additionally, the member suggested tracking individuals who are turned away from ECM services, including reasons for ineligibility, to ensure transparency. The member also expressed excitement about the closed-loop referral system and suggested that Community Supports services, such as transitional rent, should be presumptively available to ECM providers to address immediate needs without requiring additional approvals, as delays could result in lost opportunities. DHCS responded by acknowledging the need for greater efficiency in leveraging ECM and Community Supports providers and minimizing the need for individuals to go through multiple approval loops.

- A member commented positively on the spotlight documents and requested one for the JI population of focus. They mentioned that while the 90-day in-reach will be rolled out over the next year, having an ECM-related spotlight document now would be beneficial. The member also suggested that future updates include information tailored to both adult and youth populations, as their needs may differ. Additionally, the member highlighted the importance of involving justice system partners and noted that their organization contracts with lived experience project contractors who could help disseminate this information to relevant contractors across the state to improve awareness.

- **Behavioral Health Transformation Update – *Marlies Perez, Chief, Community Services*:** DHCS outlined key milestones since the last meeting, emphasizing stakeholder engagement and policy development. DHCS highlighted the release of the first round of Bond Behavioral Health Continuum Infrastructure Program (BHCIP) Request for Applications (RFA). DHCS also discussed the upcoming Behavioral Health Transformation (BHT) Policy Manual modules which will contain all of the policy for BHT. The first draft modules are scheduled for public release for feedback at the end of 2024. The development and feedback processes for the Behavioral Health Transformation policy were underscored as vital, with a focus on equity and reducing disparities in behavioral health.

  The update detailed the launch of the Quality and Equity Advisory Committee, aimed at improving performance measures, reducing disparities, and incorporating public feedback. Additional updates covered included the integration of substance use disorder (SUD) care into the broader Behavioral Health Services Act, Housing Interventions, Full Service Partnerships, and Behavioral Health Services and

Supports. The update concluded with information about the Bond BHCIP Round One funding application process and upcoming related opportunities.

- **Discussion**
  - A member commented on the ongoing efforts by children's advocates to emphasize the early intervention component of the Behavioral Health Services Act. They highlighted the importance of clarifying that early intervention services for children and youth should not be limited to those addressing existing symptoms or diagnoses, but should also include programs aimed at preventing the development of mental illness. The member expressed concern that current communication may reinforce a narrower interpretation of early intervention and encouraged DHCS to ensure its messaging aligns with the statutory intent.
  - The member emphasized the need for coordination across systems to implement Behavioral Health Transformation, specifically highlighting concerns about children and youth who may transition from Medi-Cal FFS to managed care or commercial plans without proper coordination, potentially leading to gaps in care. They also raised concerns about the alignment between the Housing and Community Development (HCD) investments and the Behavioral Health Services Act's transitional rent requirements, suggesting a missed opportunity for coordination. Additionally, the member recommended that BHCIP dollars be considered for building integrated mental health and SUD treatment facilities to support the expanded capacity required for policy changes, including SB 43.

- **Public Comment:** During the public comment period, attendees were allowed to voice their concerns and offer feedback to DHCS and panel members.
  - A member of the public shared concerns about their experience with DHCS Medi-Cal Managed Care Division phone line. They requested that their comments be included in the meeting minutes, emphasizing that there was no private information in their statement. They explained that on September 6, they called the Medi-Cal Managed Care Division at 916-449-5000, but was forced to leave a voicemail. They later received a call from the Ombudsman's office, which they felt was not the right office to address their concerns. Their intention was to discuss disparities in the Community Advisory Committee (CAC) meetings that DHCS mandates MCPs to hold. They described an experience attending a Health Net CAC meeting where, after signing up

anonymously, they were asked to provide identification and wear a name tag. They were approached by security officers, who said they were disrupting the meeting, even though they were merely participating within the allotted time. The speaker also raised issues with Anthem, stating they did not post their CAC meeting schedules on their website, only on Facebook, which limited accessibility. They said the Medi-Cal Managed Care Division's phone line was not helpful and led them to other departments like the eligibility office. They questioned the purpose of the phone line, suggesting it was a misuse of government resources. Finally, they mentioned a failure by DHCS to fulfill their request for meeting agendas and notices, which they believed violated the Bagley-Keene Act. The speaker concluded by clarifying they were addressing concerns about public CAC meetings, not the newer member stakeholder committee meetings, and reiterated their concerns about the accessibility and transparency of these public meetings.