Stakeholder Advisory Committee & Behavioral Health Stakeholder Advisory Committee Meeting

Wednesday, August 19, 2026

9:30 a.m. to 3 p.m. PDT

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Hybrid Meeting Tips

» Please use a computer or a phone for audio connection.

» Please mute your line when you're not speaking.

» Members are encouraged to turn on their cameras.

» Registered attendees can make oral comments during the public comment period.

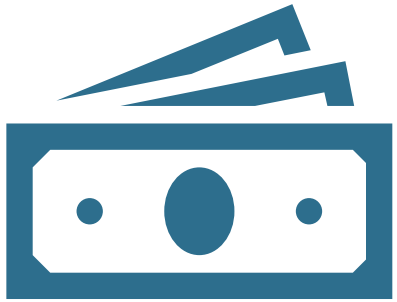
» For questions or comments, please email **SACinquiries@dhcs.ca.gov.**

Welcome and Roll Call

Director’s Update

2026-27 Budget Act

2026-27 Budget Act



- The Budget Act includes $337.7 billion in total funds for all health and human services programs.
  - The Budget includes **$226.3 billion in total funds** and **4,765.5 positions for DHCS.**
- Of this amount, $1.5 billion is State Operations (DHCS operations), while $224.7 billion is Local Assistance (program costs, partners and administration).
- The proposed budget continues to support the Department's purpose to provide equitable access to quality health care.

DHCS Major Budget Issues: Managed Care Organization (MCO) Tax

- The budget includes tax revenue of $2.5 billion in 2026-27 to support payment increases relative to calendar year 2024.
- The MCO tax renewal is effective January 1, 2027, and conforms to the new H.R. 1 federal requirements.
  - The budget includes net revenue of:
    - $575 million in 2026-27.
    - $2.3 billion in each of 2027-28 and 2028-29.
    - $1.7 billion in 2029-30.
  - This renewed MCO tax supports the Medi-Cal program and maintains targeted rate increases for primary, maternal and non-specialty mental health care.

DHCS Major Budget Issues: Unsatisfactory Immigration Status (UIS) to Fee-For-Service (FFS)

- Beginning January 1, 2027, members with UIS will transition to the FFS delivery system.
- The budget includes cost reductions for current year and ongoing:
  - 2026-27 $637.1 million ($524.9 million General Fund).
  - Ongoing $1.6 billion ($1.3 billion General Fund).
- The budget includes $39 million to provide care coordination and navigation services to this population.

DHCS Major Budget Issues: H.R. 1

» The Budget includes the following H.R. 1 (2025) highlights:

- **Affordable Care Act (ACA) Adult Expansion with UIS Federal Medical Assistance Percentage (FMAP) adjustment for Emergency Services.**
  - Results in an additional General Fund (GF) cost of $669 million in 2026-27.
- **Work and Community Engagement Requirement.**
  - Results in a cost reduction of $357.6 million in total funds ($90.3 million GF) in 2026-27 and $9.6 billion ($2.4 billion GF) by 2029-30. Projected disenrollments are 43,000 in 2026-27 and 1.1 million by 2029-30.
- **ACA Adult Expansion Population Six-Month Redetermination.**
  - Results in a cost reduction of $747.3 million in total funds ($186.4 million GF) in 2027-28 and $2.5 billion ($633 million GF) by 2029-30. Projected disenrollments are estimated to be zero in 5 2026-27 and approximately 278,600 in 2029-30.
- **Restrictions on Immigrant Eligibility.**
  - Full-scope Medi-Cal cost is projected to be $365 million GF in the budget year for a delayed July 1, 2027, transition to restricted-scope Medi-Cal.

DHCS Major Budget Issues

- **County Medi-Cal Administration Augmentation** –$709 million ($196.8 million GF) one-time augmentation in 2026-27 to support H.R. 1 implementation. The budget includes a total of $3.3 billion ($828.2 million GF) for Medi-Cal county administration in 2026-27.
- **Community Mobile Crisis Services** – $42.2 million in GF to extend the community-based mobile crisis response services benefit until June 30, 2027.
- The Budget includes additional funding for the following programs:
  - **988 and Behavioral Health Crisis Continuum** - $25.9 million in total funds.
  - **Behavioral Health Transformation** - $41.8 million in total funds for Behavioral Health Services Act (BHSA) ongoing implementation, oversight, and monitoring.

DHCS Major Budget Issues

- Refines criteria for **Enhanced Care Management** (ECM) and **Community Supports** including eligibility criteria, service definitions and utilization management criteria. The Budget includes General Fund savings of $41.4 million in 2026-27 and $99.2 million ongoing related to the ECM changes and General Fund savings of $26.9 million in 2026-27, $58.8 million in 2027-28, and $51.0 million ongoing related to the Community Supports changes.
- Includes a General Fund reduction of $68 million in 2026-27 increasing to $552 million in 2029-30 to strengthen utilization management controls for **applied behavioral health analysis** and **transportation** in the Medi-Cal program and eliminates the incentive component of the quality with hold and incentive program in Medi-Cal.
- Redirects the **Medical Loss Ratio** remittances to the General Fund to achieve a $25 million savings.

DHCS Major Budget Issues: Delay of 2025 Budget Act Actions

- The Budget includes increased costs due to the delay of the following 2025 Budget Act General Fund Solutions:
  - Delays elimination of **state-only prospective payment system (PPS) payments** to Federally Qualified Health Centers and Rural Health Clinics from July 1, 2026, to July 1, 2027.
  - Delays elimination of **dental benefits** for UIS and of **Dental Supplemental Payments** from July 1, 2026, to July 1, 2027.

DHCS Major Budget Issues

- Maintains the current **Medi-Cal asset limit** that went into effect January 1, 2026, and also reinstates the asset limit for seniors and adults with disabilities to $21,000 for an individual or $31,000 for a couple, effective no sooner than July 1, 2027.
- Includes General Fund savings of approximately $427.3 million in 2027-28, decreasing to approximately $314.3 million annually in 2029-30 from increasing **monthly premiums for adults with unsatisfactory immigration status** to $50, effective July 1, 2027, subject to a determination in the 2027-28 May Revision.

DHCS Major Budget Issues: One-Time Funding

» The Budget includes one-time funding for the following policies:

- Support for **Designated Public Hospitals** in the amount of $250 million General Fund for grants to support health care expenditures.
- **Proposition 36** funding for grants to county behavioral health departments in the amount of $20 million General Fund over three-years.
- One-time increases for **Private Duty Nursing**, $30 million General Fund, and **Congregate Living Health Facility**, $7.7 million General Fund.
- **Anosognosia Pilot Program** funding in the amount of $5 million General Fund for a one-time direct payment to CenCal Health to establish a pilot program for the treatment of severe schizophrenia or anosognosia.

Additional Information and Resources

- DHCS Website - **Governor's Budget Documents 2026-27**.
  - **DHCS FY 2026-27 Budget Act Highlights**.
  - **What Medi-Cal Members Need to Know**.
- Statewide Budget Website – **ebudget.ca.gov**.
- Department of Finance Website - **https://dof.ca.gov/**.
  - Budget Change Proposals - **Governor's Budget BCPs**.
  - Trailer Bill Language - **DOF Trailer Bill Language**.

Questions?

Centers for Medicare & Medicaid Services (CMS) Interim Final Rule: Impact on Medi-Cal Work and Community Engagement Requirements

Yingjia Huang, Deputy Director, Health Care Benefits and Eligibility

DHCS

New Work and Community Engagement Requirements in Medi-Cal

- **H.R. 1** establishes Medicaid **work and community engagement requirements** as a new condition of eligibility for members in the "New Adult Group."
- California must implement work and community engagement requirements by **January 1, 2027**, meaning individuals in this group must demonstrate compliance with or meet an exclusion or exception from the requirements to be determined eligible for Medi-Cal.
- **CMS issued an interim final rule** on June 1 that establishes the operational framework for work and community engagement requirements. The rule became final on July 31.

Individuals in the New Adult Group:

(1) Ages 19-64

(2) Not pregnant

(3) Not enrolled in or entitled to Medicare Part A or B

(4) Not otherwise eligible for another mandatory Medi-Cal eligibility group

(5) Have income less than 138% of the federal poverty level, which is $22,025 for an individual and $45,540 for a family of four.

Key Guidance Under the Interim Final Rule (1 of 2)

- **Defines Qualifying Activities:** Provides more granular definitions for each qualifying compliance activity in more detail (e.g., defines community service, adds in-kind and unpaid to work definition, and explains how half-time education will be calculated).
- **States Must Screen for Specified Exclusion First:** Before applying work requirements, states must check whether someone qualifies for an exclusion, such as being medically frail or a parent of a child under age 14.
- **Medical Frailty:** Departs from statutory definition and narrows medical frailty exclusion by requiring that qualifying conditions "significantly impair" an individual's ability to work.

Key Guidance Under the Interim Final Rule (2 of 2)

- **Short-Term Hardship Exceptions:** Establishes a lookback period (one month in California) for these exceptions and provides more granular definitions.
- **Self-Attestation:** Allows states to accept self-attestation in 2027, but limits use in 2028 and beyond.
- **Noticing and Outreach**: Specifies when and under what circumstances states must conduct noticing and outreach to members.
- **Good Faith Waivers:** Clarifies that CMS may approve good faith waivers for up to six months at a time and projects approving these requests in only two states.

Clarifications on Qualifying Compliance Activities

- Work
- Work Program
- Half-Time Educational Program
- Community Service
- Seasonal Workers

» Clarifies that **in-kind and unpaid work** are counted alongside traditional paid employment. This could include a property manager who receives free rent in exchange for building duties or an unpaid internship.

Clarifications on Qualifying Compliance Activities

- Work
- **Work Program**
- Half-Time Educational Program
- Community Service
- Seasonal Workers

» Includes **supervised job search or job search training** if it constitutes less than half of the required 80 hours. Job search activities conducted to comply with unemployment insurance requirements also count.

Clarifications on Qualifying Compliance Activities

Work

Work Program

Half-Time Educational Program

Community Service

Seasonal Workers

- Includes **high school** and **state-approved high school equivalency** programs.
- Clarifies that enrollment status **continues through normal vacation and recess** (e.g., summer break).
- **Defers to the institution** on whether a student is enrolled full-time, half-time, or less than half-time.
- Establishes a **credit hour conversion** standard for individuals enrolled less than half-time (e.g., 1 credit = 3 hours).

Clarifications on Qualifying Compliance Activities

- Work
- Work Program
- Half-Time Educational Program
- **Community Service**
- Seasonal Workers

» Defines community service as unpaid work **performed under a structured program** for the direct benefit of the community, **supervised by a public agency or nonprofit** (nonpartisan).

» Requires the agency or organization to **oversee the work, track activities, dates, and hours**, and provide a point of contact to verify participation.

Clarifications on Qualifying Compliance Activities

- Work
- Work Program
- Half-Time Educational Program
- Community Service
- Seasonal Workers

» **Reasonably Predictable Option:** Use reasonably predictable increases or decreases in future income across 12 months. For example, a seasonal worker who earns $1,500 per month from April through September, and nothing for the other six months of the calendar year, has a calculated monthly income of $750 ($1,500 x 6 = $9,000; $9,000 divided by 12 months = $750).

Required Process for Evaluating if an Individual is Required to Demonstrate Compliance with Work and Community Engagement Requirements

Step 1

Before applying work and community engagement requirements, states must check whether someone qualifies for an exclusion, such as being medically frail, an American Indian/Alaska Native, parent of a child under age 14, or compliant with Temporary Assistance for Needy Families.

Step 2

Individuals who are subject to work and community engagement requirements may be excepted under:

- *Mandatory Exceptions:* For example, under age 19 or incarcerated in the last three months); OR
- *Short-Term Hardship Exceptions.*

Step 3

If an individual does not meet a mandatory or short-term hardship exception, they must demonstrate compliance with a qualifying activity (e.g., work, community engagement, work program, or half-time educational program).

Medical Frailty Exclusion

- The rule confirms that states must use medical codes and other reliable data to identify medically frail individuals; however, **medical codes and claims do not convey information about ability to work.**
- **Further guidance from CMS is needed** to build out processes that link the severity of the condition to the individual's ability to work.
- With the narrowing of the definition, **eligible individuals may lose coverage** if they cannot readily access a provider or obtain the required documentation.

NOTE:

- *Medical Frailty Self-Attestation:*
  - Allowable in 2027.
  - In 2028 and beyond, allowable once per enrollment period, with documentation required thereafter if data is unavailable.
- *Verification Period:*
  - At state discretion, medical frailty can be reverified for up to 12 months at a time.

Short-Term Hardship Exception

California will offer all short-term hardship exceptions.

- Inpatient (and Similar) Care
- Medical Travel
- Declared Emergency
- High Unemployment

- **Individuals must request** the inpatient (and similar) care and medical travel exceptions.
- **California must automate** the declared emergency and high unemployment exceptions and grant them to individuals based on residence.
- **The rule requires a lookback period for these exceptions**, which could lead to gaps in coverage.
  - For example, an individual hospitalized in July who applies for Medi-Cal and requests a short-term hardship exception must demonstrate that they met an exception or complied with work and community engagement requirements in June to be eligible for coverage in July.

Verification Standards

<table>
<tr><th>Verifying</th><th>In 2027</th><th>In 2028 and Beyond</th></tr>
<tr><td rowspan="2">Specified Excluded Individual</td><td rowspan="2">If data are unavailable, may require documentation or accept other information (e.g., self-attestation).</td><td>» If available data are not enough, require documentation (when reasonably available).
» If documentation is not available, accept other information to verify eligibility (e.g., self-attestation). State cannot deny or terminate coverage solely due to lack of documents.</td></tr>
<tr><td>For Medical Frailty Only: Self-attestation allowed once per enrollment period; after that, require documentation if data are unavailable.</td></tr>
<tr><td>Applicable Individual Exceptions</td><td colspan="2">If application or renewal form indicates the person qualifies for an exception (including a specified exclusion), may accept self-attestation. This option does not apply to all specified excluded individuals (e.g., medically frail, inmates, or veterans with a disability rated as total).</td></tr>
<tr><td>Applicable Individual Compliance</td><td>If data are unavailable, may require documentation or accept other information (e.g., self-attestation).</td><td>» If available data are not enough, require documentation (when reasonably available).
» If documentation is not available, accept other information to verify eligibility. Do not deny or terminate coverage solely due to lack of documents.</td></tr>
</table>

Noticing and Outreach

The Interim Final Rule notes that states must conduct multiple-modality,* targeted outreach to all individuals eligible for and enrolled in the New Adult Group and provides specific guidance on content to include.

- **Initial Outreach:** Four months prior to the work and community engagement requirements implementation date (8/31/2026).
- **Outreach Upon Enrollment:** For individuals enrolled after the initial outreach is sent, but before the state implements work and community engagement requirements.
- **Periodic Outreach:** On an ongoing basis following enrollment, tied to certain events (e.g., to provide 10-days' advance notice upon the loss of specified excluded status for a member).
- **Ad Hoc Outreach:** On an ad hoc or routine basis.

**Via mail (or e-mail if elected by the individual) and one other modality.*

Good Faith Waivers

The Interim Final Rule outlines how states may seek approval for a good faith waiver to temporarily delay implementation for up to six months at a time through December 31, 2028.

Note: CMS has not provided guidance or submission instructions for the good faith waiver.

CMS will consider the following when reviewing waiver requests:

- **Progress the state has made** toward implementing work reporting requirements.
- **Key barriers or challenges**, including funding, design, development, procurement, or system readiness.
- The state's **implementation plan**, including timeline and milestones.
- Any **exigent circumstances** (e.g., administrative or external emergencies) affecting implementation.

The rule anticipates that ten states will submit waiver requests and that CMS will only approve two.

Questions?

Break

Ordering, Referring, and Prescribing (ORP) Provider Enrollment

Erica Holmes, Assistant Deputy Director, Health Care Benefits and Eligibility
Mistie Chiddick, Division Chief, Provider Enrollment Division

DHCS

Agenda

- Overview of Federal Regulations for ORP Providers
- Potential Impacts and Mitigation Efforts
- Call to Action: How Key Partners Can Help
- ORP Provider Enrollment Information
- What ORP Providers Must Do
- Next Steps
- Q&A

Overview of Federal Regulations for ORP Providers

Overview of Federal Regulations and ORP

- Federal Medicaid rules (**42 CFR 455.410** and **455.440**) require all ORP providers to be enrolled in Medicaid and have a Type 1 (individual) National Provider Indicator (NPI).
- DHCS is launching a multi-year approach to implement enforcement of federal ORP provider requirements.
- Enrollment will be verified with claim edits applied across pharmacy, medical, and behavioral health (Short-Doyle) claim systems.

Overview of Federal Regulations and ORP: Definitions (1 of 2)

- **Ordering Provider:**
  A licensed provider who directs specific services or supplies to be furnished to a Medi-Cal member. Some typically ordered services include, but are not limited to, laboratory tests, durable medical equipment (DME), and home health services..
- **Referring Provider:**
  A licensed provider who sends a Medi-Cal member to another provider or facility for services, typically evaluation or treatment, that the referring provider cannot perform (for example, a primary care practitioner refers a Medi-Cal member to a gastroenterologist).
- **Prescribing Provider:**
  A licensed provider (e.g., a physician, nurse practitioner, or pharmacist) who writes a prescription for a medication or other pharmacy-dispensed item within their scope of practice.

Overview of Federal Regulations and ORP: Definitions (2 of 2)

- **Type 1 NPI (Individual):** For individual health care providers, such as physicians, nurse practitioners, pharmacists, and sole proprietors. Individuals are only eligible for one NPI.
- **Type 2 NPI (Entity):** For health care organizations, such as hospitals, nursing homes, and physician groups not organized as a sole proprietor group. Organizations can have multiple NPIs.

Overview of ORP Regulations: Why Compliance Matters

- Federal law requires providers who order, refer, or prescribe services to be **enrolled** with Medi-Cal and **identified on claims**.
  - Consistent with federal requirements, (1) when ORP provider information is not included on a claim, (2) it is inaccurate, (3) or the ORP provider is not enrolled, the claim submitted by the billing provider should not be paid by Medi-Cal.
- However, these rules are not currently uniformly enforced across systems due to technical and operational challenges.
- DHCS' 2023 Payment Error Rate Measurement (PERM) audit, administered by CMS and which measures improper payments in Medicaid and the Children's Health Insurance Program (CHIP), identified errors resulting from missing required NPI information and claims submitted by ORP providers who were not enrolled.
- DHCS must correct these issues to maintain compliance with federal regulations.

Overview of Federal Regulations and ORP: Why Enforcement Matters (1 of 2)

- Helps ensure program integrity and improves fraud prevention.
- Supports enhanced utilization management controls, audits, and overpayment recovery, and identifies improper billing practices.
- Protects **state** funding by preventing improper payments and mitigates False Claim Act violations and recoveries, as ORP provider enrollment helps validate that services are being authorized by qualified providers within their scope of practice, and services are medically necessary.

Overview of Federal Regulations and ORP: Why Enforcement Matters (2 of 2)

- Protects **federal** funding and ensures federal compliance, which helps ensure federal financial participation remains available and reduces the risk of future federal deferrals or disallowances.
- Supports greater accountability and oversight by improving data quality, increasing transparency, and uniformly applying the ORP provider enrollment requirement.

Potential Impacts and Mitigation Efforts

Mitigation Efforts to Address Potential Impacts

Potential Impacts	Mitigation Efforts
1. Medi-Cal members may face delays accessing medical and pharmacy benefits if their provider is not enrolled.	1. DHCS is performing early and targeted outreach to non-enrolled ORP providers, promoting early enrollment, and will gradually implement and enforce system edits.
2. Some Medi-Cal members may need to select a new ORP provider who is enrolled with Medi-Cal with their Type 1 NPI.	2. DHCS is coordinating with MCPs and the DHCS Helpline to aid members needing to find another provider.
3. Billing providers, including pharmacies, may experience claim denials if ORP provider information on the claim is not present/valid.	3. DHCS will provide clear billing guidance to reduce administrative burden and help prevent downstream claim denials.
4. Some ORP providers may choose not to enroll due to the perceived administrative burden.	4. DHCS is providing education and support to assist ORP providers with the enrollment process.

Approach to Implementation

- **Multi-year** approach.
- Balancing the need for compliance with the need to **minimize disruption to members and providers**.
- An approach **driven by data**.
- Early and frequent **communication** with stakeholders.

Call to Action

Call to Action: Stakeholders and Advocates (1 of 3)

- **Distribute DHCS-provided ORP provider enrollment reminders** through newsletters, listservs, and call centers, reaching ORP providers who may not receive DHCS bulletins directly or would benefit from reminder messaging.
- **Identify and notify** unenrolled ORP providers.
- **Clarify the requirement for non-billing ORP providers**. Some non-billing ORP providers may assume enrollment does not apply to them since they do not bill Medi-Cal directly. However, this is not true. If they order, refer, or prescribe for Medi-Cal members, the requirement applies.

Call to Action: Stakeholders and Advocates (2 of 3)

- Health care organizations, such as hospitals and clinics, should:
  - **Socialize to network providers** what must be done to enroll in Medi-Cal as ORP providers.
  - Establish **regular and proactive outreach** to ORP providers to share information through normal channels and provide technical assistance in navigating these changes.
  - **Use DHCS-provided information** to develop call center scripts, provider articles, member flyers, and other resources to assist ORP providers and members.
  - **Work with members** if/as needed to provide care coordination and assist with finding ORP providers who are enrolled in Medi-Cal.

Call to Action: Stakeholders and Advocates (3 of 3)

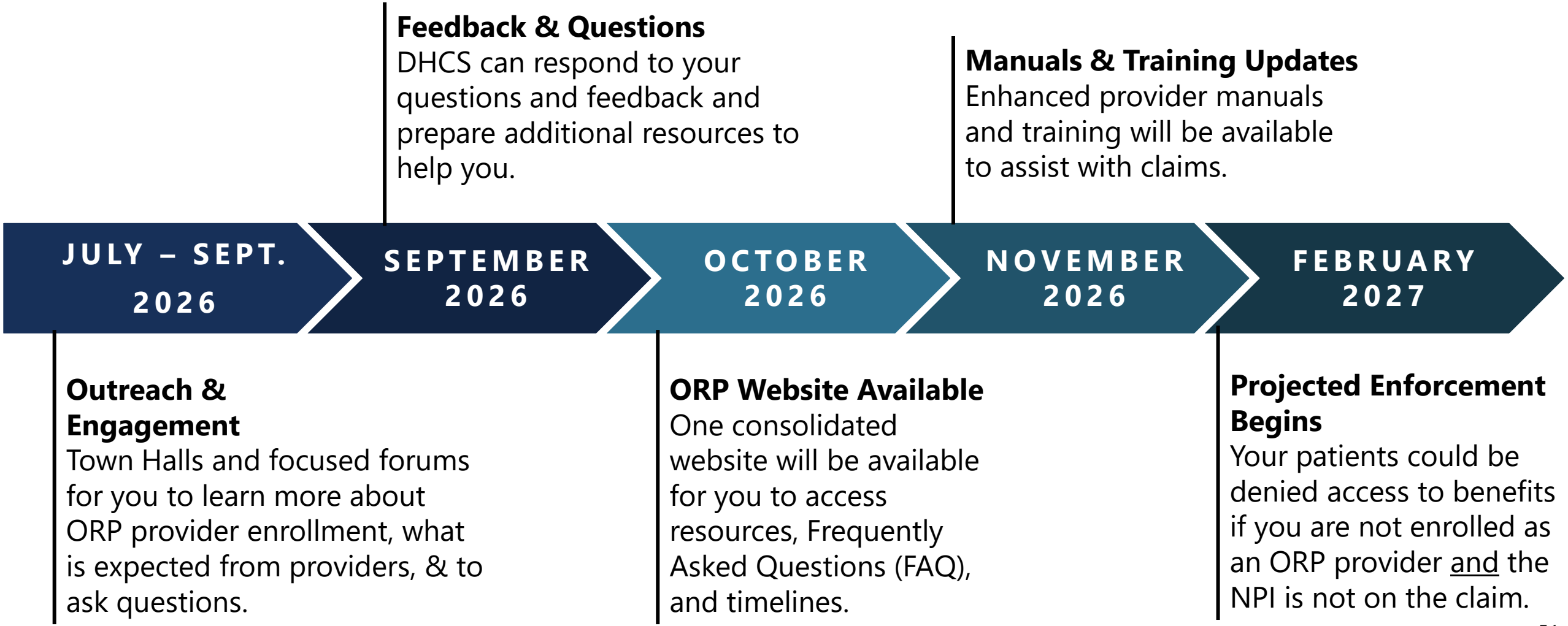
- **Stay informed** of implementation dates and messaging for ORP providers and members **by accessing updates on the DHCS and Medi-Cal websites**.
- **Subscribe to DHCS listservs** to stay informed on policy updates and upcoming implementation dates.
- **Prepare for ORP provider and member calls** for assistance with consistent messaging that aligns with DHCS' messaging.

ORP Provider Enrollment Information

- There are **three basic requirements for enrolling as an ORP provider** for Medi-Cal:
  - Must be of the specialty type eligible to order, refer, and prescribe in accordance with State law and applicable scope of practice.
  - Must be a **provider type** that can enroll in the Medi-Cal program.
  - Must enroll with an individual (Type 1) NPI.
    - An organizational (Type 2) NPI is unacceptable.

ORP Provider Enrollment Timeline

Don’t wait. Avoid delays. Enroll now.



Do I *really* need to enroll as an ORP Provider?

- If you can answer yes to any of the following questions, **you must enroll** as an ORP provider.

Do you…

- **Order**, **refer**, or **prescribe** any of the following?
  - lab tests.
  - home health services.
  - DME.
  - imaging or diagnostic services.
  - prescriptions filled and billed to Medi-Cal, including Medications for Addiction Treatment (MAT).
  - Specialty Mental Health, Drug Medi-Cal, or Drug Medi-Cal Organized Delivery system services as a licensed practitioner.
  - referrals to another provider for new or ongoing treatment, and that treatment requires a referral.
  - physical, occupational, or speech therapy.
- **Order**, **refer**, or **prescribe** anything a Medi-Cal member receives and don't already bill Medi-Cal directly under my own Type 1 (Individual) NPI?

Are you…

- Enrolled in Medicare, but still order, refer, or prescribe for Medi-Cal?
- Only seeing Medi-Cal patients through a MCP and do not bill fee-for-service?
- Supervising, employing, or contracting with other practitioners who list you as the ordering or referring provider?
- New to a group practice and think the group's enrollment covers you?
- In your residency program and working under a Postgraduate Training License (PTL)?
- Filling in for another provider temporarily and your patients' claims go through their name or their facility's billing?

Do I *really* need to enroll as an ORP Provider?

- If you answered yes to any of the previous questions, **you must enroll** as an ORP provider.

Next Steps

Upcoming Stakeholder Engagements

- **Focused Stakeholder/Association Forums**
  - DHCS is holding focused sessions with stakeholders in August to share the implementation timelines and solicit feedback.
- **ORP Second Provider Town Hall**
  - After targeted stakeholder meetings are completed in August and feedback is reviewed and integrated into the implementation plan, DHCS will hold a second town hall, targeted for late September, to provide more information and answer additional questions.

Additional Support and Resources

- For enrollment policy questions, review the **ORP Enrollment** slide deck, or use the **Provider Inquiry Form**.
- Medi-Cal Provider Enrollment Help Desk:
  - Phone (866) 252-1949
  - For more information, visit **Ordering/Referring/Prescribing Only Enrollment Information | DHCS**.
- For medical (CA-MMIS) questions, call the Telephone Service Center at (800) 541-5555 (outside of California, please call (916) 636-1980).
- Subscribe to **DHCS Stakeholder e-Notifications**.
- For additional questions, please contact **ORP@dhcs.ca.gov**.

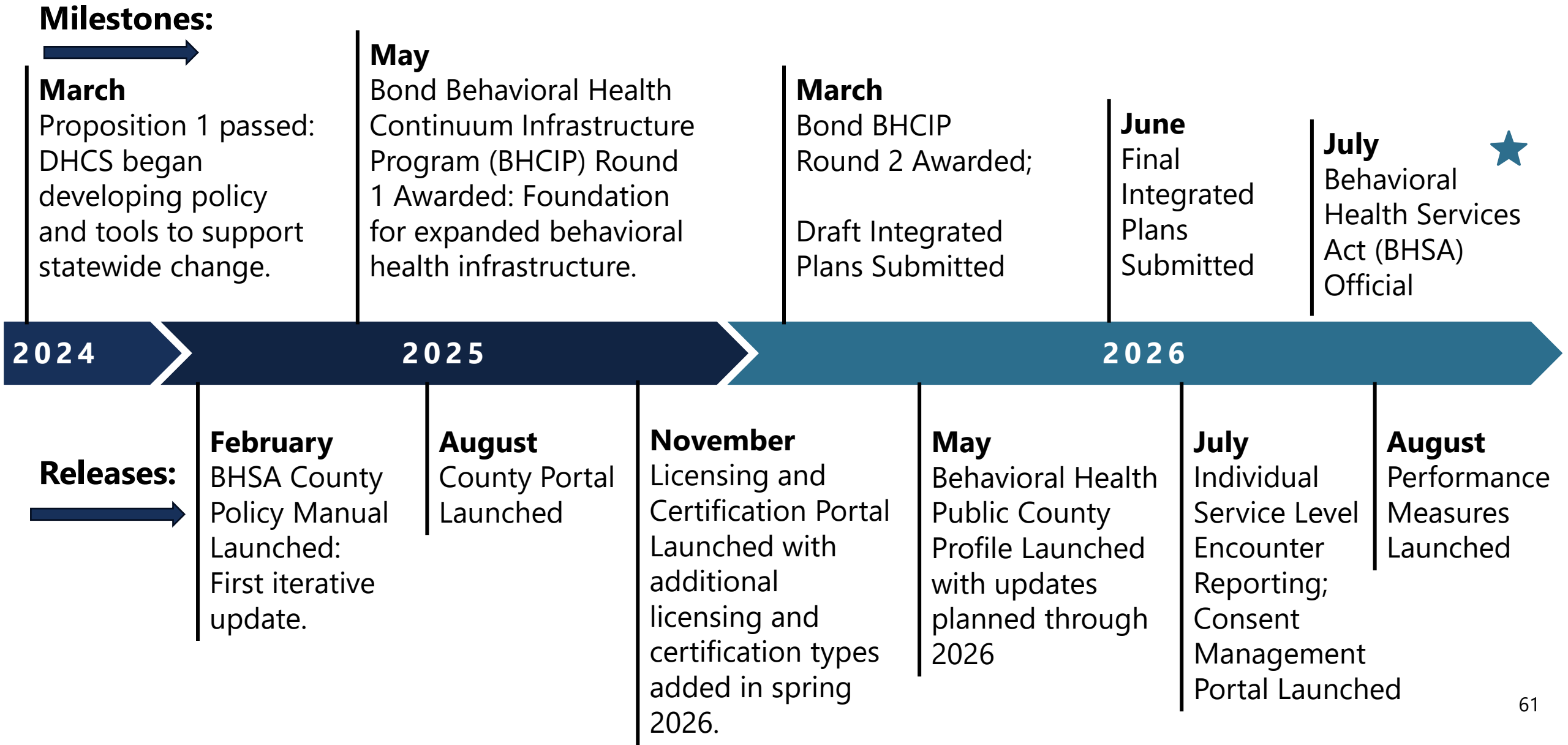
Questions?

Behavioral Health Transformation Update

Marlies Perez, Project Executive, Behavioral Health Transformation and Chief, Community Services Division

DHCS

Behavioral Health Transformation Progress



County Integrated Plan Update

County Integrated Plan Status Overview

- **As of August 5, 2026, 59 counties and cities total:**
  - 4 revisions in progress.
  - 0 in DHCS review.
  - 55 approved.

Transfer Requests by Type 22 counties · 29 requests		
Transfer Type	**Requests**	**Approved**
HI → BHSS	12	8
HI → FSP	4	3
FSP → HI	2	1
FSP → BHSS	9	9
BHSS → FSP	2	2
BHSS → HI	—	—
Total	**29**	**23**

BHSS = Behavioral Health Services and Supports

BHSA Component Exemptions by Type 16 counties · 24 requests		
Exemption Type	**Requests**	**Approved**
Housing Intervention (HI) – Max Cap	12	11
HI for Chronically Homeless	9	8
HI Funds – Capital Development	3	3
Total	**24**	**22**

Full Service Partnership (FSP) / Evidence-Based Practices (EBP) Exemptions by Program 24 counties requested exemptions from FSP EBPs		
Program	**Requests**	**Approved**
Assertive Community Treatment (ACT)	22	21
Forensic ACT (FACT)	22	21
Individual Placement and Support	24	23
Total	**68**	**65**

Individual Service Level (ISL) Encounter Reporting

Individual Service Level Reporting

Objectives:

- Provide a unified, statewide view of non-Medi-Cal behavioral health services delivered directly to clients by county behavioral health systems and provider networks.
- Give counties improved insight into the scope, quality, and consistency of behavioral health services across California.
- Provide counties access to real-time feedback on data quality and validation issues.

ISL Data Usage:

- Fulfill BHSA reporting, oversight, and compliance requirements (applies exclusively to services not reimbursed by DHCS through Medi-Cal).
- Provide insight into behavioral health service delivery.
- Support performance outcomes measurement.
- Connect services to funding utilized.
- Inform future policy decisions.

Individual Service Level Encounter Reporting

Individual Service Level (ISL) encounter reporting provides standardized collection of individual-level behavioral health services provided directly to clients by county behavioral health systems and provider networks.

ISL encounters will be:

- Submitted by counties through the County Portal.
- Linked to services tracked by Medi-Cal claims, where possible.
- Submitted for non-Medi-Cal-funded behavioral health services and expenditures delivered to individuals.

ISL encounters are not:

- Medi-Cal claims or a replacement for Short-Doyle claiming.
- Used for reimbursement or payment.

Staged Approach to Implementing ISL Reporting

Stage I Launched July 1, 2026

Optional for All Counties

- 14 counties **began** submitting ISL encounters since July 1, 2026, to support technical assistance, system testing, and other rollout improvement efforts.
- Data submitted during this first six-month period will not be used for performance measurement or monitoring.

Stage II Launches January 1, 2027

Mandatory for All Counties

- Counties are **required** to begin reporting ISL data on January 1, 2027.
- DHCS will **not require retroactive reporting** from counties that did not participate in Stage I.

At a minimum, counties must submit ISL encounters to DHCS annually, **no later than 90 days after the close of the FY** in which services were rendered. For the first year of ISL implementation, counties will be required to report only on encounters for services delivered on or after the mandatory January 1, 2027, go-live date; full fiscal-year reporting begins in subsequent years.

ISL Encounter Reporting Resources

- A **comprehensive set of tools and resources** are available to support counties in submitting ISL data, including:
  - **ISL Encounter Reporting Guidance:**
    Primary source of guidance for counties to implement ISL encounter reporting.
  - **ISL Encounter Fields:**
    List of the data fields counties are required submit to DHCS as part of each ISL encounter.
  - **ISL Code Library:**
    Standardized list of service codes for reporting ISL encounters.
- Additional resources available to county users:
  - **ISL Support Center**
  - **ISL Portal Navigation Guidance**
  - **ISL Technical Documentation**

DHCS-defined ISL Code Set

Service Name/Description	Additional Description	Code
State Hospital Bed Day	Bed day at a California Department of State Hospital facility (Atascadero, Coalinga, Metropolitan, Napa, Patton).	ISL100
Crisis Stabilization over 23 hours	Continuation of structured behavioral health services in a crisis stabilization setting provided beyond the initial 23-hour period of a crisis stabilization episode. While the first 23 hours of care are billable as crisis stabilization services, "over 23 hours" covers the medically necessary care, monitoring, and support that extend beyond this time frame to ensure the individual's safety, stabilization, and appropriate transition to the next level of care. All of the hours over 23 would be billed as a single fee.	ISL101
1:1 Monitoring/Services	Individualized, direct support provided to one person by a trained staff member on an hourly basis. This service ensures continuous observation, supervision, or assistance tailored to the individual's	ISL102

ISL Training and Technical Assistance

- **Individualized 1:1 ISL technical assistance** is provided to support Behavioral Health Plan (BHP) implementation planning, readiness, and operational problem-solving.
- Each BHP is assigned a **California Mental Health Services Authority (CalMHSA) ISL support team**, including a lead and coordinator, who can meet regularly with the BHP to provide tailored support.

March – June

108

Individual ISL technical assistance meetings completed or scheduled.

53

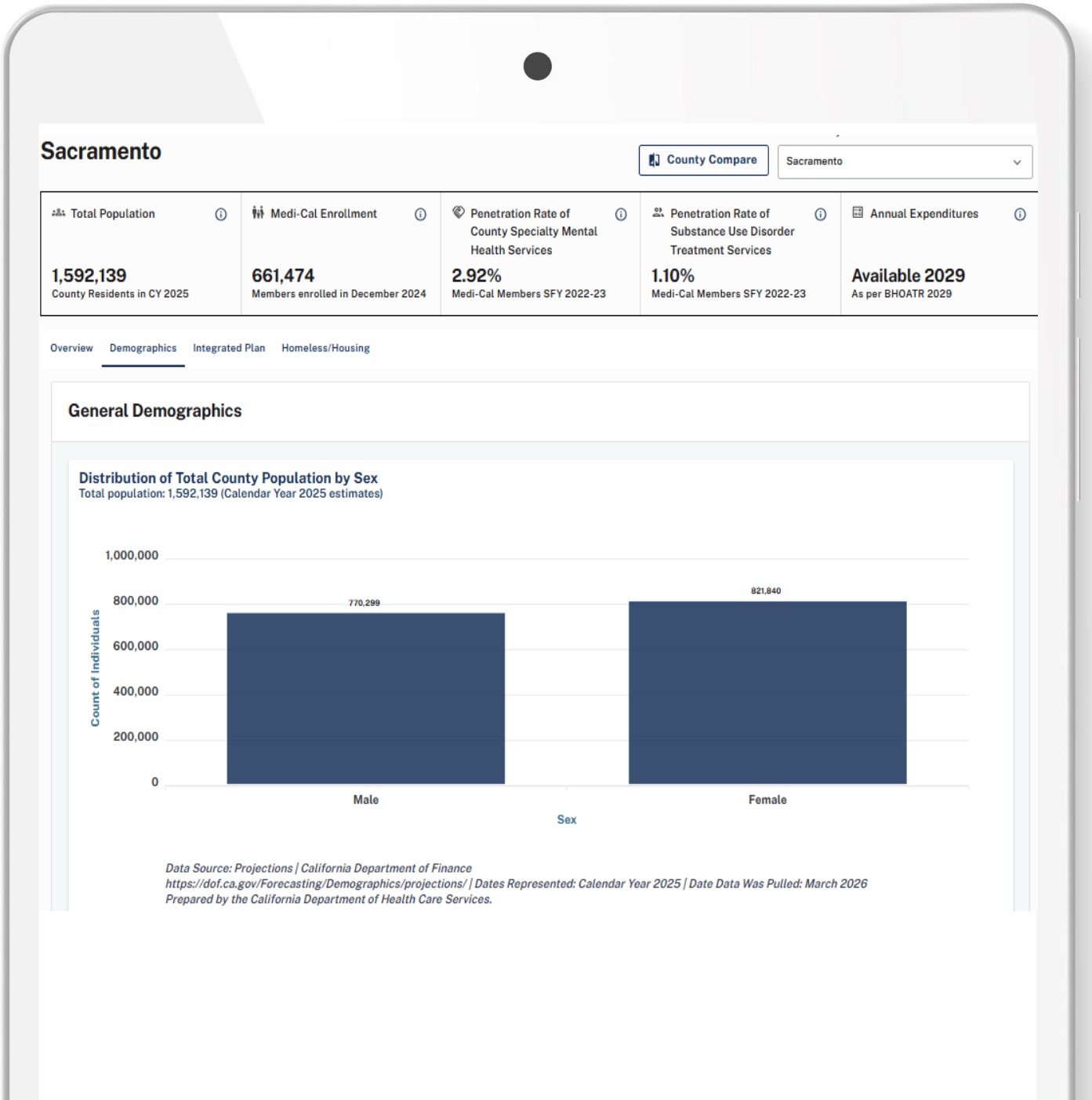
Counties and cities

Behavioral Health Public County Profile

Behavioral Health Public County Profile

Launched in May 2026

- Brings together a **variety of data sources into a single platform**.
- The profile goes beyond the county behavioral health system.
- **Increases transparency** and understanding of behavioral health data for the public through **clear visualizations and standardized context**.
- Accessible through the **DHCS Behavioral Health Transformation** webpage. Login not required.



Why DHCS Developed the Behavioral Health Public County Profile

- DHCS developed the Behavioral Health Public County Profile to make county-level behavioral health data **more accessible, consistent, and useful for the public**.
- Previously, information was available from multiple sources, but it was often difficult to compare or analyze across counties due to differences in format and terminology.
- Supports the **transparency and accountability goals** of the BHSA and behavioral health delivery system more broadly.
- Since initial launch on May 28, 2026:
  - Averaging **10-20 users per hour** visiting the profile.
  - Users spending an average of **25 minutes** on the site.

Behavioral Health Public County Profile Features

- Data is presented using **clear, audience-appropriate visuals**, such as charts and graphs.
- **Interactive features** include:
  - County-level views.
  - County comparison across two or more counties.
  - PDF exports to be available in the future for 3-year Integrated Plans and Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR).
- A **built-in companion guide** provides how-to information, FAQs, and reference links.

Behavioral Health Public County Profile Information Display: Available Now

- Information is organized into a limited number of intuitive, nonduplicative subject tabs.
- Data not yet available will be grayed and labeled “coming soon,” helping audiences anticipate future releases.

Public County Profile Version 1 Release

DHCS released the first version of the County Profile in May 2026, including the views and information outlined below.

Overview

County size, general population data, Medi-Cal enrollment by age group, and MCP information.

Demographics

Demographic breakdowns for each county's overall and Medi-Cal populations.

Integrated Plan

Downloadable draft Integrated Plan submissions outlining county strategies for the use of behavioral health funds.

Homelessness/ Housing

Information on services provided through the Homelessness Response System, BHSA-funded housing interventions, and Medi-Cal housing-related Community Supports and Enhanced Care Management (ECM).

Public County Profile Version 2 Release

DHCS will release an updated version of the Behavioral Health Public County Profile soon with expanded content and two new tabs.

Integrated Plan (Updated)

Final Integrated Plan submission content can be exported and displayed, including revenue projections, services projected by continuum of care, transfers and exemptions, base versus adjusted allocations, prudent reserve, and county priority goals.

Performance (New)

A subset of Behavioral Health Transformation performance measure results across the six priority statewide goals will be displayed.

Behavioral Health Reporting (New)

Data will also be available from:

- Community Assistance, Recovery, and Empowerment (CARE) Act
- Lanterman-Petris-Short (LPS) Act
- BH-CONNECT
- California's overdose surveillance dashboard

BHSA County Policy Manual
Module 6

BHSA County Policy Manual Updates

Module 6 is the **last module** for BHSA policy.

DHCS will finalize Module 6 of the Policy Manual this fall.

Thank you for all of the feedback in developing BHSA policy.

Topics Covered:

- **Narrative on BHOATR** – guidance on general BHOATR requirements.
- **BHOATR template** – draft BHOATR template.
- **ISL Data Reporting** – updated information on the ISL portal and mandatory reporting starting January 1, 2027.
- **FSP Presumptive Eligibility Requirements** – required enrolling for presumptive eligibility individuals begins January 1, 2027; policies and procedures for identifying and connecting populations to services.
- **Culturally Responsive and Linguistically Appropriate Care Plans** – guidance for counties on how to provide the Cultural Competency Plan requirements through the Integrated Plan.

Behavioral Health Outcomes, Accountability, and Transparency Report

- BHSA requires counties to submit BHOATRs to DHCS on an annual basis.
- DHCS will use the BHOATR to monitor county implementation of their Integrated Plans, Annual Updates, and/or Intermittent Updates, whichever is the most current for the reporting period.
- The first BHOATR will cover FY 2026-2027. The draft BHOATR is due on January 30, 2028 *(*draft is only required for the first BHOATR*)*.

	Planning FY 25-26				*Year 1 FY 26-27*				*Year 2 FY 27-28*				*Year 3 FY 28-29*				*Year 4 FY 29-30*			
Quarters, by calendar year	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Integrated Plan			D	**F**											D	**F**				
Annual Update							D	**F**			D	**F**							D	**F**
BHOATR 1					*Reporting year*						D				**F**					
BHOATR 2									*Reporting year*										**F**	
BHOATR 3													*Reporting year*							

D = Draft F= Final

BHOATR Template

The BHOATR template includes:

- County projections from the Integrated Plan to enable a side-by-side comparison with county actuals (at the total level).
- A limited narrative section for counties to explain differences between Integrated Plan projections and actuals in the BHOATR.
- For some BHOATR questions, separate columns for DHCS-populated data and supplemental county data.

BHOATR User Guide

- DHCS developed a user guide to help counties develop and submit the BHOATR.
- The guide provides step-by-step instructions, timelines, and requirements to ensure county BHOATRs are consistent with the **BHSA County Policy Manual**.
- The guide will be provided during the public comment period to assist with understanding the BHOATR components.

Module 6 Public Comment

- The public comment period is **now open** for Module 6 draft content in the BHSA County Policy Manual. Feedback will be accepted through **4 p.m. PDT on September 3, 2026**.
- After the public comment period closes, feedback will be reviewed and analyzed to identify common themes and concerns that may be incorporated into the final Module 6 materials.
- An **instructional training video** on the DHCS Behavioral Health Transformation webpage provides additional guidance on submitting comments.
- For any specific public comment-related inquiries, please email **BHTinfo@dhcs.ca.gov**.

Performance Measures

Statewide Behavioral Health Goals

DHCS is advancing a population behavioral health approach that is grounded in the following 14 goals. It will take cross-service delivery system collaboration to advance these goals.

Goals for Improvement

- Care experience
- Access to care
- Prevention and treatment of co-occurring physical health conditions
- Quality of life
- Social connection
- Engagement in school
- Engagement in work

Goals for Reduction

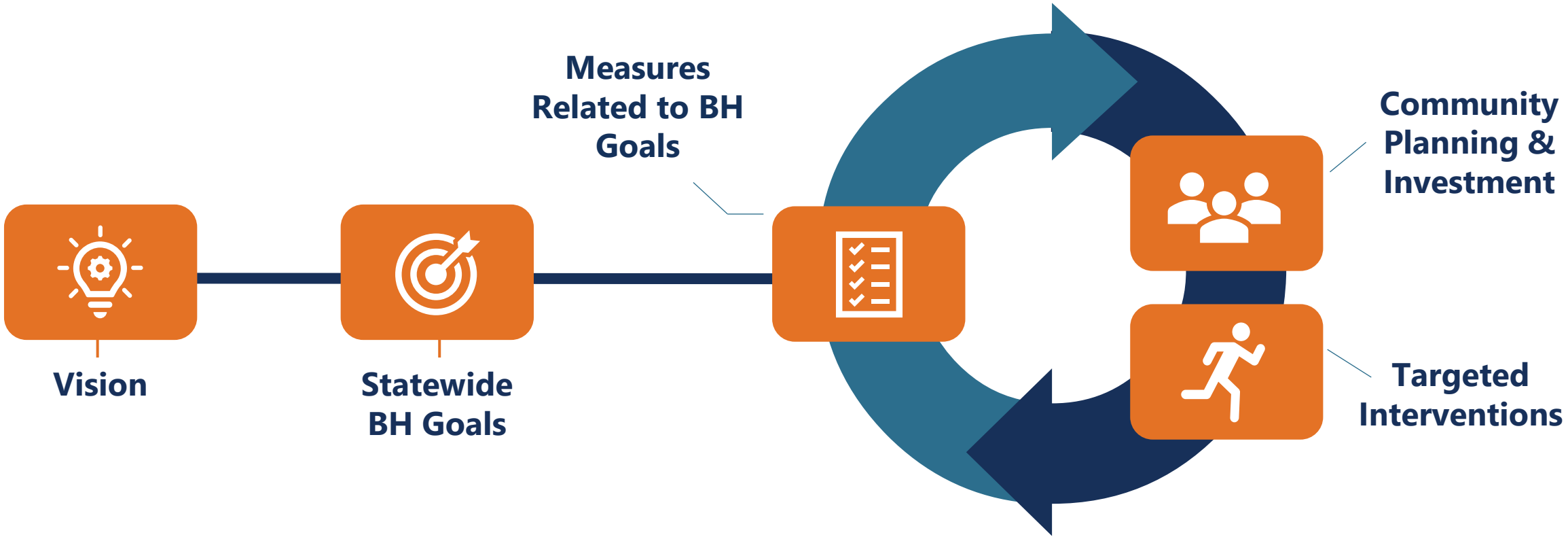
- Suicides
- Overdoses
- Untreated behavioral health conditions
- Institutionalization
- Homelessness
- Justice-involvement
- Removal of children from home

Health equity will be incorporated across each of these goals.

*Additional information on the statewide behavioral health goals is available in the **BHSA Policy Manual**.*

Population Behavioral Health Approach

DHCS is developing a population behavioral health approach to meet the needs of all individuals eligible for behavioral health services, improve community well-being, and promote health equity. The Population Behavioral Health Framework is designed to enable the behavioral health (BH) delivery system to make data-informed decisions to better meet the needs of individuals within the communities they serve.



QEAC Governance and Subcommittees

DHCS developed the BHT performance measures with structured input from the QEAC and subcommittees.

QEAC (Full Committee)

- **Purpose:** Advises DHCS on the statewide quality and equity strategy; reviews measures before release. Set the vision for measures development.
- **Composition:** About 40 members including: counties, MCPs, providers, researchers, subject matter experts, advocates, and individuals with lived experience.
- **Meeting Frequency:** Public meetings at key milestones: 11 held since October 2024.

QEAC Technical Subcommittee (QEAC-TS)

- **Purpose:** Reviews technical measure specifications between full QEAC meetings and provides input to QEAC.
- **Composition:** Subset of about 15 QEAC members with technical/data expertise.
- **Meeting Frequency:** As needed, to refine each measure cohort before full QEAC review.

Related QEAC Subcommittees

- Theory of Change (TOC) Subcommittee: Identifies interventions to advance each statewide Behavioral Health goal.
- QEAC Equity Subcommittee (QEAC-ES): Selects cross-goal equity measures and disparity populations of focus (cadence and structure similar to QEAC-TS).

Performance Measures Development

DHCS developed the first-of-their kind measures in two phases, with cohorts aligned to behavioral health goals developed and refined over time, with input from Subject Matter Experts and the Quality and Equity Advisory Committee to create a comprehensive statewide performance framework.

Phase 1: Population-Level Behavioral Health Measures

- 39 publicly available measures (19 primary, 20 supplemental).
- County-level reporting only.
- Supports BHSA Integration Plans and MCP Population Health Management planning activities.
- Not attributable to individual BHPs or MCPs.

Phase 2: Performance Measures

- 28 currently released measures based on individual-level data.
- Reported at goal, sub-goal, and intervention levels.
- Attributable to specific BHPs and MCPs.
- Support planning, population health management, and accountability.
- Replace Phase 1 measures.

Cohorts 1-3

- Cohorts 1 and 2 focused on high-priority outcomes such as homelessness, justice involvement, access to care, care experience, overdoses, and suicides.
- Cohort 3 addresses broader well-being outcomes including school engagement, employment, quality of life, and social connection.

About the Performance Measure Set (1 of 2)

To understand progress on those goals, DHCS has selected Behavioral Health Transformation performance measures (28 of which are currently released).

- Each of the 14 goals has a mix of:
  - Goal Measures, assessing overall goal performance; and
  - Intervention Measures, assessing BHP and MCP interventions expected to advance the goal).
- Measures were developed with input from Subject Matter Experts and stakeholder groups including the Quality and Equity Advisory Committee (QEAC).
- DHCS also selected 4 cross-goal measures: 3 equity and 1 BHSA priority population measures.
- DHCS has identified whether the responsible entities for improving performance on each measure are:
  - Cross-sector (i.e., extending beyond just BHPs and MCPs); or
  - County BHP and/or MCP (i.e., measures a contractually required service or policy).

About the Performance Measure Set (2 of 2)

Example: Measures for Reducing Homelessness		
Measure Category	**Measure Name**	**Responsibility**
Goal Measure	Homelessness Among People with Significant Behavioral Health Needs	Cross-Sector
Intervention Measure	Housing Services for People With Significant Behavioral Health Needs At Risk of or Experiencing Homelessness	Joint county BHP-MCP
Intervention Measure	Housing Services and Full Service Partnership for People with Significant Behavioral Health Needs At Risk of or Experiencing Homelessness	Joint county BHP-MCP

How Performance Measures Will Be Used

Transparency and Planning

- DHCS has published calculated measure rates, stratified by county/MCP and key demographics, for public access each year.
- DHCS, counties, MCPs, and other stakeholders will be able to use these measures to track progress on the goals and inform planning for addressing the goals.
  - Counties: Integrated Plans.
  - MCPs: Population Health Management Strategy Deliverables.

Population Health

- DHCS will provide monthly rate updates and associated person-level data to counties and MCPs in Medi-Cal Connect.
- These data will support population health activities (such as outreach and engagement, interventions, and other services) that would improve outcomes and performance on the measures.

Accountability

- DHCS will use measures to:
  - Inform and evaluate allocation of BHSA funding at the county level and the extent to which that allocation is addressing local needs (including in the BHOATR). DHCS will not issue BHSA Corrective Action Plans on performance before 2029.
  - Monitor BHP and MCP performance on delivery of Medi-Cal and BHSA services.

Rate Releases

Type	✓ June 2026	✓ Early Aug	Late Summer
Platform/ Format	**Application Programming Interface (API) and Medi-Cal Connect** *(HIPAA-protected environment)*	**Public Report**	**Public County Profile**
Content	» 12-month rolling measure rates: • For BHP/MCP and for the state. • With key demographic stratifications. » Associated person-level data.	» 12-month rolling measure rates, including: • Statewide rate. • Statewide demographic stratifications. • County BHP and MCP rates.	» 12-month rolling measure rates for 6 required goals, alongside other county utilization and expenditure data. » Future County Profile releases will contain all measures.
Audience	**County BHPs and MCPs**	**Public**	**Public**

Resources and Upcoming Meetings

Materials:

- DHCS released the following materials to support the rollout of the performance measures:
  - Updated **BHSA County Policy Manual** (with a **measures overview supplement**).
  - A Technical Specifications Manual.
  - A Theory of Change Summary.
  - Frequently Asked Questions *(coming soon)*.

Upcoming Meetings:

- 8/25-8/27: **Substance Use Disorder Integrated Care Conference**
- September Lunch and Learn – *to be scheduled*
- 10/14: **Behavioral Health Task Force Meeting**

DHCS is also providing orientation and implementation support for the performance measures directly to MCPs and county BHPs through existing technical assistance and communications forums.

Questions?

Public Comment

Public Comment Guidelines

- During the public comment period, we do not answer questions, but simply listen to public comments.
- All public comments are recorded in the meeting summary.
- Public comments may be made by members of the public here in the room as well as members of the public attending virtually.
- Please state your name and organization.
- Please keep your comments concise and no longer than 1 minute.

Final Comments and Adjourn

Upcoming 2026 Meeting Date

- October 28, 2026

Appendix

Behavioral Health Transformation Update

Performance Measures (1 of 5)

Reduce Homelessness
1. Homelessness Among People with Significant Behavioral Health (BH) Needs⁺*
2. Housing Services for People With Significant BH Needs At Risk of or Experiencing Homelessness^*
3. Full Service Partnership and Housing Services for People with Significant BH Needs At Risk of Or Experiencing Homelessness^
Reduce Institutionalization
1. Institutional Stays for People with BH Needs⁺
2. Coordinated Specialty Care for First Episode Psychosis^
3. Support for Transitions from Institutional BH Care^
4. Follow-Up After Hospitalization for Mental Illness – 7 Days (FUH)^*
5. Follow-Up After Other Institutional Stays for Behavioral Health^
Reduce Justice Involvement
1. Incarceration Among People with Significant BH Needs⁺
2. Repeat Justice-Involvement Among People with Significant BH Needs~
3. Post-Release BH Services for Justice-Involved Reentry Enrollees with Significant BH Needs^*
4. Continuation of Medications for Addiction Treatment (MAT) for Justice-Involved Reentry Enrollees^*

Legend:	**⁺Goal measures** ~Sub-goal measures ^Intervention measures	*Indicates a measure that DHCS expects to calculate in 2026 *See appendix for measure descriptions.*

Performance Measures (2 of 5)

Reduce Removal of Children from Home
1. Children and Youth in Foster Care⁺*
2. Specialty BH Services for Children and Youth in Foster Care^*
3. BH Services for Parents, Guardians, and Pregnant People with Significant BH Needs^*
4. High Fidelity Wraparound, Enhanced Care Management, or Intensive Care Coordination for Children and Youth in Foster Care^
Reduce Overdoses
1. Deaths by Drug Overdose⁺*
2. Repeat Emergency Department (ED) Visit or Hospitalization for Drug Overdose~*
3. Recovery Incentives – Contingency Management^*
4. Pharmacotherapy for Opioid Use Disorder (POD)^*
5. Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days (FUI)^*
Reduce Suicides
1. Deaths by Suicide⁺*
2. Repeat ED Visit or Hospitalization for Self-Harm~*
DHCS expects to develop an Intervention Measure for this goal in the second BHSA Integrated Plan period.

Legend:	**⁺Goal measures** ~Sub-goal measures ^Intervention measures	*Indicates a measure that DHCS expects to calculate in 2026 *See appendix for measure descriptions.*

Performance Measures (3 of 5)

Improve Access to Care
1. One or More BH Core Clinical Services for People with Mental Health (MH) Needs⁺*
2. One or More BH Services for People with Significant MH Needs⁺*
3. Initiation of Substance Use Disorder (SUD) Treatment (IET-I)⁺*
4. One or More BH Services for People with Significant MH Needs and Co-Occurring SUD⁺
Reduce Untreated Behavioral Health Conditions
1. Three or More BH Services for People with MH Needs⁺*
2. Three or More BH Services for People with Significant MH Needs⁺*
3. Engagement in SUD Treatment (IET-E)⁺*
4. Three or More BH Services for People with Significant MH Needs and Co-Occurring SUD⁺
5. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)^*
6. Evidence-Based Practices for People with Significant Mental Health Needs^
7. Follow-Up After ED Visit for Substance Use – 7 Days (FUA)^*
8. Follow-Up After ED Visit for Mental Illness – 7 Days (FUM)^*

Legend:	**⁺Goal measures** ~Sub-goal measures ^Intervention measures	*Indicates a measure that DHCS expects to calculate in 2026 *See appendix for measure descriptions.*

Performance Measures (4 of 5)

Improve Care Experience
1. Perception of Care with Respect to One's Cultural Background: Specialty Mental Health Services⁺*
2. Perception of Care with Respect to One's Cultural Background: Drug Medi-Cal Organized Delivery System⁺*
3. Perception of Care with Respect to One's Cultural Background: Non-Specialty Mental Health Services⁺*
Improve Prevention and Treatment of Co-Occurring Physical Health Conditions
1. Adults' Access to Preventive/Ambulatory Services: Significant BH Needs^*
2. Child and Adolescent Well-Care Visits: Significant BH Needs^*
3. Dental Visits for People with Significant BH Needs^*
Improve Engagement in School
1. Graduation Rates for Students with BH Needs⁺
2. Chronic Absenteeism for Students with BH Needs⁺
3. Care Coordination and Management Services for Children and Youth with BH Needs^
4. Developmental Screening in the First Three Years of Life (DEV)^*

Legend:	**⁺Goal measures** ~Sub-goal measures ^Intervention measures	*Indicates a measure that DHCS expects to calculate in 2026 *See appendix for measure descriptions.*

Performance Measures (5 of 5)

Improve Engagement in Work
1. Supported Employment for People with Significant BH Needs^
Improve Social Connection
1. Services that Strengthen Interpersonal Relationships for People with Significant BH Needs^
Improve Quality of Life
DHCS expects to develop a measure for this goal in the second BHSA Integrated Plan period.
Cross-Goal: Equity Measures
1. Disparities in BH Services for People with MH Needs+*   **2. Disparities in BH Services for People with Significant MH Needs+***   **3. Disparities in Pharmacotherapy for Opioid Use Disorder+**
Cross-Goal: BHSA Priority Population Measure
1. Multi-System Involvement for People with BH Needs Who Are Already System-Involved

Legend:	**+Goal measures** ~Sub-goal measures ^Intervention measures	*Indicates a measure that DHCS expects to calculate in 2026 *See appendix for measure descriptions.*