California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

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September 3, 2026

Behavioral Health Transformation

Department of Health Care Services

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Sacramento, CA 95899-7413

RE: Behavioral Health Services Act (BHSA) County Policy Manual – Module 6 Feedback

Dear Behavioral Health Transformation (BHT) Team:

The California Behavioral Health Planning Council (CBHPC) appreciates the considerable effort invested in releasing Module 6 of the Behavioral Health Services Act (BHSA) County Policy Manual, along with the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) Instruction Manual and BHOATR template for public comment. CBHPC has been actively engaged in reviewing the BHSA Modules and providing feedback, drawing on public input and the lived experiences of our members, many of whom have firsthand experience with serious mental illness and substance use disorders.

Our comments and recommendations for this module are included below.

Recommendation 1: Strengthen Cultural Competence Within Streamlined Reporting

CBHPC recognizes the importance of streamlining county reporting requirements to reduce unnecessary duplication and administrative burden. At the same time, we urge that any consolidation efforts preserve the clarity, detail, and accountability that have historically characterized Cultural Competence Plans. To ensure continued progress in advancing equity, we recommend that DHCS develop standardized reporting elements that enable stakeholders to effectively evaluate county performance in addressing disparities, providing culturally responsive services, ensuring workforce representation, and promoting language access.

Recommendation 2: Move Stakeholder Engagement Requirements to the Beginning of Each Subsection

Stakeholder engagement is a vital component to ensure that cultural and linguistically competent services are successful. Therefore, CBHPC recommends that the requirement for counties to engage with stakeholders be placed at the beginning of each subsection of **Section 2.C.4**, instead of at the end. Additionally, language regarding "minimal engagement" should be strengthened to communicate that meaningful stakeholder engagement is essential to identify community needs related to culturally responsive and linguistically appropriate care.

Recommendation 3: Enhance Guidance for Meaningful Community Engagement

CBHPC recommends that DHCS provide clearer guidance on what constitutes "meaningful engagement" and set consistent statewide expectations for how counties design and carry out community engagement activities. These expectations should ensure that counties proactively engage priority and underserved populations, offer accessible and culturally and linguistically appropriate pathways for participation, and consider compensation or other supports when appropriate. We also encourage DHCS to emphasize the importance of employing multiple engagement methods to reduce participation barriers and reflect the diverse needs of communities across the state.

To further strengthen accountability and support authentic community partnership, CBHPC encourages counties to describe how stakeholder perspectives informed their planning and decision-making. Reporting could include a summary of the recommendations received, the actions taken in response, any recommendations that were modified or not adopted, and the reasoning behind those decisions. Providing this context would help demonstrate that community engagement reflects meaningful participation rather than consultation alone.

Recommendation 4: Prioritize Meaningful Engagement with Consumers, Families, and People with Lived Experience

CBHPC encourages DHCS to emphasize the importance of meaningful and direct participation by individuals with lived experience as consumers and family members throughout county community planning and engagement efforts. While community-based organizations, advocacy

groups, and other partners provide valuable perspectives, their involvement should complement and not replace direct engagement with individuals receiving behavioral health and SUD services and their families.

We also encourage counties to demonstrate thoughtful efforts to include individuals from historically underserved and disproportionately impacted communities and to describe how this input shaped planning and decision-making. Highlighting these contributions would help reinforce authentic partnership and ensure community voices play a substantive role in shaping local behavioral health priorities.

Recommendation 5: Allow Use of Free Language Technology for Translation

CBHPC seeks clarification on whether providers may use free technological interpreter or translation services under **Section C.4.1.2 Approach to Ensuring Language Access**. California residents speak a wide range of languages and dialects, therefore limiting counties to paid services such as Language Line can create cost burdens in some parts of California or less access to rapid connection to services. Additionally, some established paid services or tools do not adapt to specific language usage and thus are not fully reliable, as they may be inaccurate or missing nuances such as less common languages and dialects. We ask DHCS to clarify whether policy changes have been made regarding the use of free language technology tools or local language resources that may better suit particular language needs. We recommend that the Department of Health Care Services (DHCS) allow counties to use free language translation technology, such as Google Translate, to connect with members who may need translation services. This practice is currently available and provides a broader cost-effective method to improve access to culturally responsive and linguistically appropriate care. We emphasize the need to use all applicable local language resources to continuously strive to ensure the availability of high-quality, accurate, and culturally appropriate communication in behavioral health services and the broader range of supportive services.

Recommendation 6: Create a Separate Section for Statewide Disparity Reduction Targets Related to Client Outcomes

In addition to addressing disparities in access and engagement under **Section C.4.2 Statewide Disparity Reduction Targets**, we recommend establishing a separate section specifically focused on statewide disparity reduction targets for client outcomes. This section should include outcomes disaggregated by race, ethnicity, sexual orientation, age, language, and other relevant member demographics. This approach would ensure that disparities in treatment effectiveness and recovery are measured and addressed alongside access and engagement. Our recommendation is focused on what is working in treatment in addition to the increase in access and/or engagement.

Recommendation 7: Increase Transparency in Statewide Disparity-Reduction Targets

CBHPC supports establishing statewide disparity-reduction targets and encourages DHCS to publish a clear and transparent methodology for developing and evaluating these targets. This should include how baselines are set, how populations and small sample sizes are handled, and how demographic and geographic differences across counties are considered. We also recommend creating a process to identify and respond to persistent disparities, with measures focused on demonstrating meaningful improvements in outcomes for populations experiencing inequities.

Recommendation 8: Preserve and Strengthen Local Identification of Behavioral Health Disparities

CBHPC appreciates DHCS's recognition that statewide disparities may not fully capture the needs of every county and encourages retaining the requirement for counties to identify and address locally significant disparities. Counties should continue to prioritize the most pressing behavioral health disparities affecting their communities, including those impacting smaller or locally significant populations that may not be visible in statewide data. Local disparity identification should complement and help deepen the State's broader equity priorities by ensuring that unique community needs remain centered in planning and implementation.

Recommendation 9: Allow Flexibility When Structural Barriers Limit Compliance

CBHPC encourages DHCS to ensure that reversion policy accounts for situations where counties or providers face statewide structural barriers and workforce shortages that limit their ability to deploy funds despite substantial effort. In cases where hiring challenges or capacity constraints make compliance unattainable, Flexibility and collaborative problem-solving are often more effective than sanctions, which can unintentionally harm providers, counties, and the consumers they serve.

Recommendation 10: Safeguard Service Continuity and Contracted Provider Capacity

CBHPC encourages DHCS to recognize that the current reversion policy may have unintended consequences, including reductions in services negatively impacting provider networks. Counties rely on community-based organizations and contracted providers to deliver behavioral health services, and abrupt changes in funding or payment arrangements can destabilize these networks, especially for smaller organizations and those serving specialized or underserved populations. Flexibility is essential to ensure that the remedy does not create greater harm than the intended financial penalty. We urge DHCS to implement reversion requirements in a way that safeguards service continuity and strengthens provider capacity, ensuring consumers continue to receive stable and accessible care.

These comments were submitted electronically by the September 3, 2026, deadline. We look forward to continuing our partnership in shaping policies that promote equity, resilience, and recovery. For questions, please contact Jenny Bayardo, Executive Officer, at Jenny.Bayardo@cbhpc.dhcs.ca.gov or at (916) 750-3778.

Sincerely,

Jenny Bayardo, Executive Officer
California Behavioral Health Planning Council

Cc: Paula Wilhelm, Deputy Director of Behavioral Health, DHCS
Marlies Perez, BHT Project Executive, DHCS