Stakeholder Advisory Committee & Behavioral Health Stakeholder Advisory Committee Meeting

Wednesday, October 28, 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

Unsatisfactory Immigration Status (UIS) Members: Transition from Managed Care to Fee-for-Service (FFS)

What the Transition to FFS Means for UIS Members (1 of 2)

Most Medi-Cal members get their benefits through a Medi-Cal health plan, which coordinates with local providers to help members access care and covers Enhanced Care Management (ECM) and Community Supports, like housing and transportation assistance. When they move to FFS, these members risk losing provider continuity and ECM/Community Supports. Other services, like pharmacy benefits, specialty mental health services, and substance use disorder treatment, remain unaffected.

Who is Impacted

1.93M Medi-Cal members must transition to FFS.

1.21M Had a service in the past year

AGE

12% <18 | 81% 19–64 | 9% 65+

LANGUAGE

73% Spanish - speaking

TOP 6 COUNTIES · 80% of high care disruption risk

County	UIS Members
Los Angeles	59,561
Orange	12,843
San Diego	10,111
Riverside	5,114
San Bernardino	5,964
Santa Clara	2,779

~40% have seen a primary care provider (PCP) in the past year

**Note: all numbers on this slide are preliminary.*

What the Transition to FFS Means for UIS Members (2 of 2)

What Services Continue

- **Pregnancy & prenatal:** Only 5.6% of care sits with not-ready providers.
- **Dialysis (really transportation):** Facilities are largely enrolled — the risk is getting there, not the treatment.
- **Nursing facilities:** Only 3.9% of nursing facility care is at risk.
- **Pharmacy benefit:** The pharmacy benefit already runs FFS; the prescriber is what needs protecting.
- **Community health centers:** 98% of centers are ready
- **Specialty mental health and substance use disorder:** Services covered through the county behavioral health plans are not impacted.

Where Members Lose Care Continuity

- **Transportation:** 86% of rides provided today are through brokers who can't enroll; this puts access to critical care at risk.
- **Home health:** Providers accounting for 82% of care are enrolled but not actively billing FFS.
- **Autism & Behavioral Health Treatment:** Of 1,286 providers, only 3 bill FFS.
- **Behavioral Health (BH) :** ~50% impacted; mild-to-moderate only; county specialty continues.
- **Homeless & Street Medicine:** 89,906 members are especially hard to reach – 35% have continuity risk.

**Note: all numbers on this slide are preliminary.*

How We're Supporting This Population

Three coordinated tracks are underway to protect continuity of care for members transitioning to FFS.

Managed Care Plan (MCP) Engagement

- **Direct plans** to help members transition their care: Identify urgent- and active-risk members and share FFS provider rosters.
- **Collect data** to improve member stratification and provide context to DHCS teams engaging members, enabling a smoother transition.
- **Share data** to support authorizations and ensure care continues.

Provider Engagement

- **Reaching out** to confirm providers continue caring for members in FFS.
- **Identifying providers** that can take more members in FFS.
- **Helping providers** understand FFS and enroll.
- **Collaborating** with community clinics and Federally Qualified Health Centers (FQHC) and Community Health Worker organizations.

Member Engagement and Support

- **Care Navigation** helps members find a provider and understand how to access care.
- **Nurse Advice Line** routes members with urgent clinical needs to the most appropriate care option.
- **Care Coordination and Care Management** facilitates provider coordination for members with complex needs. Provides 1:1 member support through assessment, care plan management, and care coordination.
- **Direct Member Communication** mail, text, email members notices, reminders and tools.

Ordering, Referring, and Prescribing (ORP) Provider Enrollment

Ordering, Referring, Prescribing (ORP) Background

- Federal Medicaid rules require all providers who order, refer, or prescribe to be enrolled in Medicaid with an individual (Type 1) National Provider Indicator (NPI) **and** for that NPI to be on the claim.
- DHCS launched a **multi-year, enterprise-wide effort** to implement and enforce these requirements across all delivery systems.
- Enforcement aligns with federal compliance requirements, improves data accuracy, strengthens payment controls, reduces improper payments, and protects program integrity.
- To minimize impacts, DHCS has conducted targeted outreach and education, secured additional resources to support timely application processing, and developed an implementation approach guided by data-driven go/no-go criteria.

ORP Enforcement Timeline and Provider Action

- ORP claim edits will be implemented from **February 2027 through June 2028.**
  - Medical CA-MMIS FFS **ordering claim edits** begin February 2027.
  - Pharmacy Medi-Cal Rx **prescribing claim edits** begin March 2027.
  - Medical CA-MMIS FFS **referring claim edits** begin April 2027.
  - Behavioral Health Short-Doyle **ordering claim edits** begin October 2027.
- Any changes to timelines will be communicated through provider manuals, bulletins, frequently asked questions (FAQ), the DHCS website, and DHCS subscription lists.
- DHCS strongly encourages **providers who are not enrolled**, and who order, refer, or prescribe, to **submit their Medi-Cal enrollment application today.**
  - For enrollment support, review the ORP Enrollment slide deck or utilize the Provider Inquiry Form.

Work and Community Engagement Requirements

Medical Frailty Exclusion for Work and Community Engagement Requirements

Beginning January 1, 2027, federal law requires certain adults ages 19 to 64 in the Medi-Cal expansion group to meet work and community engagement requirements as a condition of eligibility.

- Individuals in this group must demonstrate that they:
  1. Meet a specified exclusion and are not subject to work and community engagement requirements;
  2. Meet an exception for work and community engagement requirements; or
  3. Meet a qualifying activity for work and community engagement requirements.
- Individuals who meet the criteria for **medical frailty** are considered "specified excluded" and not subject to work and community engagement requirements . Timely identification and verification of these individuals will ensure they are not unnecessarily required to report on whether they meet work and community engagement requirements.
- The following slides outline DHCS' approach for developing a framework to identify and exclude individuals based on medical frailty.

Specified Excluded vs. Applicable Individuals (1 of 2)

Specified Excluded Individuals

(not subject to work and community engagement requirements; evaluated in month of application)

- Medically frail individuals.
- Participants in a drug addiction or alcohol treatment and rehabilitation program.
- Parents, guardians, caretaker relatives, or family caregivers of a dependent child under age 14, or of a disabled individual.
- Veterans with a disability rated as total under 38 U.S.C. § 1155.
- Members of a household receiving Supplemental Nutrition Assistance Program (SNAP) and not exempt from SNAP work requirements.
- Individuals compliant with Temporary Assistance for Needy Families (TANF) work reporting requirements.
- American Indians and Alaska Natives.
- Former foster care youth under age 26 (i.e., individuals eligible under the former foster care youth (FFCY) eligibility group).
- Inmates of a public institution.
- Pregnant individuals or those entitled to postpartum Medi-Cal coverage.

Specified Excluded vs. Applicable Individuals (2 of 2)

Applicable Individuals *(subject to work and community engagement requirements)*

Exceptions
[evaluated in lookback month(s)]

Mandatory Exceptions:

- Under age 19.
- Entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B.
- Described in a mandatory eligibility group (e.g., parents/caretaker relatives within certain incomes, individuals receiving Supplemental Security Income).
- Incarcerated at some point in the three-month period prior to the relevant month.
- Specified excluded individuals (if relevant during the lookback month).

Optional Short-Term Hardships Exceptions:

- Receiving inpatient or institutional care*.
- Travel outside one's community for medical care for themselves or a dependent.*
- Living in a county with a federal emergency or disaster declaration.
- Living in a county with high local unemployment.

**Individual must request exception.*

Qualifying Activities
[evaluated in lookback month(s)]

- Work (at least 80 hours).
- Community service (at least 80 hours).
- Participation in a work program (at least 80 hours).
- Educational enrollment (at least half time).
- Any combination of the above listed activities (for a total of at least 80 hours).
- Income of at least $580/month (or for seasonal workers, an average $580/month income over a six-month period).

Federal Framework for Medical Frailty

June 2026 Interim Final Rule (IFR)

Defines medically frail as "an individual whose physical, mental, or other behavioral health condition **significantly impairs [their] ability to comply with the community engagement requirement**" and who:

- Is blind or disabled;
- With a substance use disorder, excluding stable recovery;
- With a disabling mental disorder;
- With a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or
- With a serious or complex medical condition.

September 2026 Operational Framework

- Clarifies that states must develop a list of health conditions to identify medically frail individuals. The list must be defensible and consistent with the definition of "medically frail."
- Confirms that states must verify medical frailty *ex parte** using reliable information available to the state (e.g., claims, encounter, and other available health data) to the maximum extent possible.
- Describes an example approach that places diagnosis and health care service codes into tiers to identify and verify individuals as medically frail.

**Using available electronic or other information first, without requesting information from the individual.*

California's Approach to Identifying and Verifying Medical Frailty

California is developing a multi-pronged approach to identifying and verifying medical frailty that prioritizes existing eligibility and health data while minimizing administrative burden on members, eligibility workers, and providers.

1. **Use a medical frailty screener at application and renewal** for individuals whose status cannot be established through available claims, encounter, or other administrative data. *(see next slide for more on the permissibility of self-attestation.)*
2. **Check existing eligibility and program data** to identify individuals who may qualify as medically frail based on blindness/disability or enrollment in Medi-Cal programs with eligibility criteria that align with medical frailty.
3. **Develop and apply a medical frailty code set to available health data** to establish medical frailty status when existing eligibility and program data are unable to do so.
4. **Conduct individualized review** when medical frailty cannot be established via program or health care data. This may include using a provider form, medical or treatment records, and/or MCP care management information.

Medical Frailty: Additional Considerations

Self-Attestation:

- In 2027, California will verify medical frailty based on self-attestation or data/documentation and maintain that status for 12 months before reverification.
- In 2028 and beyond, California will:
  - Verify medical frailty status based on self-attestation once per enrollment period and maintain that status for six months before reverification.
  - Verify medical frailty based on data/documentation and maintain that status for 12 months before reverification.

Ongoing Litigation:

- Litigation challenging key provisions of the federal Centers for Medicare & Medicaid Services (CMS) IFR remains pending, including the medical frailty requirement that a health condition significantly impair an individual's ability to comply with work and community engagement requirements and the 12-month limit on claims and encounter data used to verify medical frailty.
- A ruling on these provisions could come as late as November or December.

Good Faith Waivers

The IFR 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?

DHCS

Community Supports: Updates on Policies and Coverage

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DHCS

Purpose of this Update

As DHCS moves to make Community Supports a sustainable and durable service available in Medi-Cal, adjustments to policies and the approach of MCPs in managing these services are necessary.

Current State of Offerings

- Review MCP Community Supports elections, new service selections, and planned service terminations, effective January 1, 2027.

Safe Transitions

- Updates on activities to ensure continuity of care and safe transitions for members who will lose access to certain Community Supports, particularly Health Net's Assisted Living Facility Transitions (ALFT) and Personal Care and Homemaker Services (PCHS).

Policy Updates

- Overview of recent Policy Guide updates that give MCPs clearer utilization management tools while protecting access for members who need the services (ALFT, PCHS, Housing Transition Navigation Services (HTNS), and Housing Tenancy and Sustaining Services (HTSS)).

Open Discussion

- Seek SAC input on balancing sustainability, stewardship of Medi-Cal dollars, and true access for individuals who need Community Supports.

Current State of Offerings: DHCS' Menu of Community Supports Services

Community Supports help Medi-Cal members address health-related social needs, live healthier lives, and avoid higher-cost institutional care. MCPs elect which services to offer. Once a service is offered, it is a covered benefit for the calendar year. Members always retain access to core Medi-Cal benefits.

1) Caregiver Respite Services
2) Assisted Living Facility Transition (ALFT)
3) Community or Home Transition Services (CHTS)
4) Personal Care and Homemaker Services (PCHS)
5) Environmental Accessibility Adaptations (Home Modifications) (EAA)
6) Medically Tailored Meals (MTM)/Medically Supportive Food (MSF)
7) Sobering Centers
8) Asthma Remediation
9) Housing Transition Navigation Services (HTNS)
10) Housing Deposits
11) Housing Tenancy and Sustaining Services (HTSS)
12) Day Habilitation Programs (Day Hab)
13) Recuperative Care (Medical Respite)
14) Short-Term Post-Hospitalization Housing (STPHH)
15) Transitional Rent

Current State of Offerings: Current Landscape

While most Community Supports remain widely available, there are definite shifts in MCP offerings that require careful transitions for members.

- **A Broad Menu with Local Variation:**
  - MCPs elect most Community Supports by county. A service's availability depends on the member's plan, county, and eligibility.
- **One Required Service:**
  - Transitional Rent is mandatory for members who meet the Behavioral Health Population of Focus criteria.
- **2027 Includes Additions and Terminations:**
  - MCP election changes and the statewide STPHH sunset require thoughtful transition approaches.

Current State of Offerings: Expanding Access - New Community Supports Offerings

Two MCPs will newly offer services in additional counties, increasing options for members.

Effective January 1, 2027

Health Net

- Inyo and Mono Counties
  - Recuperative Care (Medical Respite)
  - Sobering Centers
  - Asthma Remediation

Effective July 1, 2027

(Anthem) Blue Cross Partnership Plan of California

- Alpine and El Dorado Counties: Sobering Centers
- Inyo and Mono Counties: Sobering Centers and Asthma Remediation

Planned Service Changes: Effective January 1, 2027 (1 of 2)

Seven MCPs have notified DHCS of terminations across 20 counties. Members with existing authorizations will complete those authorizations; new referrals end on December 31, 2026.

Managed Care Plan	Services Terminating	Counties Affected
CalViva Health	Assisted Living Facility Transition (ALFT), Personal Care and Homemaker Services (PCHS)	Fresno, Kings, Madera
Community Health Plan of Imperial Valley (CHPIV)	ALFT, PCHS	Imperial
Contra Costa Health Plan (CCHP)	Caregiver Respite, Day Hab, Community/Home Transition Services (CHTS), PCHS, EAA, Asthma Remediation	Contra Costa

Planned Service Changes: Effective January 1, 2027 (2 of 2)

Managed Care Plan	Services Terminating	Counties Affected
Health Net	ALFT, PCHS	Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare, Tuolumne
Inland Empire Health Plan (IEHP)	Day Hab, CHTS, Asthma Remediation (+Sobering Centers in San Bernardino*)	Riverside, San Bernardino
San Francisco Health Plan (SFHP)	CHTS	San Francisco
CenCal Health	Asthma Remediation, CHTS	Santa Barbara, San Luis Obispo

**IEHP has indicated it intends to re-elect Sobering Centers on 1/1/2028. Partnership HealthPlan status pending confirmation.*

Current State of Offerings: Drivers of Service Terminations

Two primary drivers: (1) high service cost and rate pressure, and (2) low uptake, administrative overhead, or existing county/community alternatives.

High Cost / Rate Pressure

- Health Net
- CalViva
- Comm Health Plan of Imperial Valley
- Contra Costa Health Plan — Admin Cost

Low Utilization / Community Alternatives

- Contra Costa Health Plan
- SF Health Plan
- CenCal Health
- IEHP

Avoided Terminations:

Four other MCPs initially signaled potential terminations, but decided to continue offering services following DHCS discussions, technical assistance (TA), and clarifications on operational levers to ensure appropriate utilization.

Safe Transitions: Health Net - Transition Planning for ALFT and PCHS

Health Net notified DHCS in July. Corrective Action Plan (CAP) was issued due to provider terminations/continuity of care. Since then, Health Net has extended provider agreements for ALFT and PCHS through December 31, 2026.

Current Status

- Provider network agreements maintained through year-end following DHCS corrective action and oversight.
- Member-level transition plans required using the DHCS template (aligned with APL 21-003 and MCP contract requirements).
- Biweekly monitoring with Health Net leadership underway.

DHCS Team Next Steps

- Review and support member-specific transition (up to ~3,000 members).
- Ensure 30-day notices, timely authorizations, and person-centered planning.
- Coordinate with partners on priority pathways (e.g., Assisted Living Waiver enrollment where appropriate).
- Continues oversight to confirm safe transitions.

Safe Transitions: Health Net - Transition Planning for ALFT and PCHS

DHCS and Health Net are meeting frequently. Member-level tracking tools identify authorization risks, transition needs, grievances, and provider network impacts. No systemic member disruptions identified at this time.

Member Details and Provider Terminations	Total
Total Members Being Monitored	3,177
ALFT Members	2,925
PCHS Members	252
Total Provider Terminations (due to benefit termination on 1/1/2027)	93

Reported planning snapshot; counts may change. Counts include Health Net Members only; does not include CHPIV nor CalVIVA.

Safe Transitions: Transition Strategy and Member Protection Activities

DHCS and Health Net are proactively monitoring. Member-level tracking tools identify authorization risks, transition needs, grievances, and provider network impacts.

ALFT Activities

- Member-level transition monitoring through dedicated tracking tool.
- Coordination with Assisted Living Waiver (ALW) resources where appropriate.
- Assessment of members who may remain in current residential setting.
- Identification of members needing alternate placement or home-based options.
- Ongoing review of authorizations, level of care (LOC) assessments, and transition readiness.

PCHS Activities

- Member-level transition monitoring through dedicated tracking tool.
- Transition planning focused on In-Home Supportive Services (IHSS) and other alternative in-home supports.
- Monitoring authorization extensions through December 31, 2026.
- Member and provider notices being issued and tracked.
- Review of members lacking finalized transition plans.

Policy Updates: Strengthening Benefit Management and Sustainability

DHCS is providing clearer levers so MCPs can meet their responsibility to manage these benefits—getting services to the right people, at the right time, in the right setting—while ensuring real access for individuals who need them, all while serving as good stewards of Medi-Cal funds.

- **ALFT:**
  - Clearer eligibility, imminence criteria, and utilization management (UM) levers.
- **PCHS:**
  - Stronger alignment with IHSS, referral pathways, and ongoing documentation.
- **MTM/MSF**
  - Requiring health care team referral and clarifying qualifying clinical conditions.
- **HTNS and HTSS:**
  - Standardized six-month authorization periods allowed, and reauthorization criteria clarified.

Policy Updates: Strengthening Benefit Management and Sustainability

Policy Guide updates were vetted with the Chief Medical Officer (CMO)/Chief Financial Officer (CFO) Utilization Management Forum and stakeholders and were shared during public comment periods during Quarter 3 2026.

- **In Quarter 3 2026, DHCS released the proposed updates to Community Supports through:**
  - Proposed Updates to Housing-Related Community Supports
  - Proposed Updates to the Community Supports Policy Guide, Volume 1
  - Community Supports Policy Guide Volume 1: ALFT And PCHS Additional Proposed Changes
- **In October 2026, DHCS released:**
  - Community Supports Policy Guide Volume 2 Addendum**:** Recuperative Care and Short-Term Post-Hospitalization Housing (STPHH) Sunset.
    - This includes updated Recuperative Care service definition, effective January 1, 2027, the STPHH sunset plan, and updated policy regarding the global cap on coverage of room and board services.
  - Draft Community Supports Pricing Resource for Recuperative Care**:** https://www.dhcs.ca.gov/file/recuperative-care-standalone-pricing-resource-pdf/
- **Community Supports Policy Guide Volumes 1 and 2 will be finalized in late October/early November.**
  - Volume 2 will undergo another update in Q1 2027 to integrate the updated Recuperative Care services definition.

Policy Updates: ALFT — Key Clarifications

Sustainability requires connecting eligible members with the right setting, ensuring non-duplicative services, and providing a network that can deliver. The rate structure seeks to incentivize keeping members in the community, when medically appropriate.

- **90-Day Nursing Facility Risk:**
  - Documented imminent nursing-facility admission within 90 days. Pathways include clinical determination, failed home supports, repeated emergency department (ED) use, functional decline, or need for ALF stabilization—each documented by the health care team.
- **Who and Where:**
  - "Community" includes private homes, subsidized housing, and members already in an ALF at risk of institutionalization (must show change in circumstance). Acute or post-acute stays still qualify. IHSS is insufficient when authorized hours cannot meet activities of daily living (ADL) safely at home.
- **Required Components:**
  1) Time-limited transition services and expenses.
  2) Ongoing assisted living services after move-in (no time limit). MCPs must offer both as appropriate. Where available, MCPs should work to connect members to ALW services and help enroll individuals into the waiver.

Policy Updates: PCHS - Clarifying Alignment with IHSS

PCHS is intended to bridge or supplement IHSS, not replace the IHSS pathway when it is available. IHSS remains the primary source of personal care support for eligible members.

- **When PCHS May Address Gaps:** Initial IHSS application is pending, request for increased IHSS hours is pending, or member is already authorized for maximum IHSS hours AND level-of-care assessment indicates additional hours are medically necessary.
- **Referral Pathway:** Inability to remain at home must be confirmed by the member's health care team. Referrals must come from the health care team and be signed by a licensed clinician. (Vendor-only referrals do not satisfy the requirement.)
- **Required Documentation:** Proof of IHSS application status and progress every 90 days to remain eligible. County processing delays are not considered lack of timely progression.
- **Higher Level of Care:** If a higher level of care is clinically appropriate and PCHS alone cannot safely meet the need, the MCP should support transition to the appropriate setting.

Policy Updates: PCHS - Authorization Pathway Clarification

Members Not Receiving IHSS

- Assess clinical/functional need → Confirm eligibility/application status and support referral → PCHS may bridge the gap while the application is pending → Monitor progression.

Members Receiving IHSS

- Conduct LOC assessment → Member requests reassessment/additional hours → PCHS may bridge the gap while the determination is pending → Reassess after IHSS action.

Maximum Hours / Ineligible

- Confirm status → Assess need and avoid duplication → For maximum hours: determine if supplemental PCHS is medically necessary, other supports can be leveraged, or if individuals need to move to a higher level of care → For ineligible: determine if short-term PCHS (for example, ≤60 days) can prevent a short-term skilled nursing facility (SNF) stay.

Policy Updates: HTNS and HTSS – Standardized Authorization Timeframes

Policy updates require MCPs to oversee the benefit and ensure members are receiving needed services during the authorized timeframes. MCPs are encouraged to review payment arrangements and incentives.

HTNS

- Allow initial authorization: 6 months.
- Reauthorizations: every 6 months.
- Must confirm ongoing need and progress toward housing (documents, applications, and leases).
- Discontinue if housing is obtained, unwillingness to engage, or provider cannot connect after multiple attempts.
- Encourage transition to HTSS once housed.

HTSS

- Allow initial authorization: 6 months.
- Reauthorizations: every 6 months.
- Most members need at least 12 months; needs fluctuate.
- Continue if not meeting discontinuation criteria.
- Discontinue if permanent subsidies accessed, unwillingness, cannot connect, goals met, or stably housed with lease obligations met.

Payment Alignment and Oversight: Payments should consider service intensity, outcomes, performance, and/or services rendered. Adjust payment levels based on acuity, progress, or changing needs. Reduce or discontinue payments during months when no services are delivered or link payments to achievement of milestones or outcomes. Use housing support plans to monitor delivery and progress.

Policy Updates: MTM/MSF: Referral Pathway and Eligible Condition Clarifications

Ensuring that Medically Tailored Meals (MTM)/Medically Supportive Food (MSF) is part of the clinical care plan.

Clarifying Conditions

- Qualifying conditions clarified. MCPs are expected to develop UM criteria based on clinical evidence for the qualifying conditions.

Health Care Team Referrals

- Ensuring that a member of the patient's health care team makes the referral -> ensures that MTM/MSF is part of the overall clinical treatment plan.

Renewals Based Clinical Treatment Plan Adherence

- Given this intervention is not a standalone intervention -> involvement of the health care team to ensure ongoing benefit and adherence to the overall treatment plan.

Discussion: Making Community Supports Sustainable and a Durable Part of the Medi-Cal Managed Care Delivery System

Community Supports can remain a durable, high-value part of Medi-Cal when MCPs have the tools to manage them effectively, and providers are enabled to deliver high-quality care to eligible members.

- **Eligible Person:** Eligibility criteria and documentation ensure services reach members with demonstrated clinical or functional need.
- **Right Time:** Authorization periods, reauthorization criteria, and progress monitoring prevent open-ended utilization without benefit.
- **Right Setting:** Clear relationships to IHSS, ALW, and other services avoid duplication and support appropriate level of care.
- **Stewardship:** UM levers, payment alignment with intensity, and program integrity controls protect Medi-Cal dollars.
- **Real Access:** Members who meet criteria continue to receive services; transitions are person-centered and protective of continuity.

Questions?

DHCS

Behavioral Health Facility Throughputs Proposals

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DHCS

Behavioral Health Facility Throughputs

- Behavioral Health (BH) Facility Throughputs investments from Proposition 35 support the appropriate flow of members across the behavioral health continuum to improve member health and outcomes and mitigate capacity pressures on BH Facilities.
- Investments support a holistic approach to help members access support earlier, maintain stability in the community, improve care transitions, and experience more coordinated care across systems.
- New investments to further support behavioral health:
  - **Behavioral Health Data Exchange**, where DHCS will disburse funds to promote implementation of real-time behavioral health data exchange and consent management processes.
  - **Flexible Housing Subsidy Pools**, where DHCS aims to increase the capacity of local systems to make efficient and effective placements into permanent housing and improve housing outcomes for high acuity behavioral health populations.

Behavioral Health Facility Throughputs: Data Exchange

Data Exchange Background

- Real-time exchange of client data enables physical health, behavioral health, housing, and social service partners to **securely share information** needed to coordinate care and support transitions across settings.
- DHCS has prioritized advancing real-time data exchange through statewide initiatives, guidance, and the **Authorization to Share Confidential Member Information** (ASCMI) Initiative as directed in the data sharing APL 26-004 and BHIN 26-013.
- For individuals with behavioral health needs, effective care often requires coordination among multiple organizations and care settings and handling protected health data.
- Real-time information sharing remains challenging due to **inconsistent technical capabilities**, **limited interoperability**, and barriers related to obtaining, managing, and honoring consent for protected information.
- These challenges can delay care coordination and transitions of care, contribute to **fragmented care**, and create barriers to **effective behavioral health throughput**.

Behavioral Health Consent, Access, and Real-Time Exchange (BH-CARE) Grant Program

Seamless Real Time Data Exchange = ⬆ Throughput

Real time access to **behavioral health, physical health, and social service** information reduces treatment gaps and helps clients reach clinical and social stability in lower-acuity levels of care.

Funded by Proposition 35 BH Facility Throughput, BH-CARE advances real-time behavioral health data exchange across the organizations and settings that care for members with BH needs.

- **The challenge:** Exchange is limited by inconsistent technical capabilities, limited interoperability, and inconsistent consent processes across health and social services sectors.
- **Real-time data exchange increases throughput.**

Real-time Data Exchange Increasing Throughput

- Enabling admission and discharge (ADT) event notifications for **care management and discharge planning** to increase bed capacity and reduce Emergency Department visits, admissions, and lengths of stay.
- Sharing visit summaries and care plans to **support care transitions** into community-based BH settings.
- Coordinating care with community-based organizations to support **housing interventions** and services for high acuity behavioral health conditions.
- **Removing barriers to sharing protected data** through the ASCMI Form and a new Consent Management Portal (CMP) that verifies Part 2 consent.
- **Supporting medical frailty determinations** by enabling use of consented SUD information to identify members excluded from H.R. 1 work and community engagement requirements.

What is BH-CARE?

BH-CARE is a grant program that supports the secure, timely exchange of **protected behavioral health and other health and social service information** across health and social-service organizations.

Consent

- Implement standardized release forms and workflows for **obtaining and managing consent** to share **protected information** appropriately.

Access

- Enable the technical infrastructure to support **timely access** to coordinate care.
- Reduce gaps and **delays in care** as clients move across providers, counties, and care settings.

Real Time Exchange

- Enable timely, **bidirectional sharing** of behavioral health and social service data, without programmatic or intentional delay.
- Build **sustainable** capabilities aligned with **Data Exchange Framework (DxF)** policies and procedures.

Funding and Program Structure

Available Funding

Up to $59.9 million is available to support grantees in implementing key data exchange activities through December 2028.

Milestone Based Payments

Grant payments are tied to the completion and validation of applicable program milestones.

Round 1 Applicants

Round 1 funding is available to:

- County behavioral health agencies.
- Data exchange intermediaries.

Note: Medi-Cal Contracted BH Providers and Continuums of Care may be eligible to apply for in future rounds.

Program Administration and Support

- DHCS oversees the program.
- California Mental Health Services Authority (CalMHSA), a contracted third-party administrator, manages grant administration, validates milestone completion, and issues payments.
- Training and TA will be provided by CalMHSA to all grantees to support implementation of data exchange and consent management activities.

BH-CARE RFA Timeline

Round 1

Activity	Date
Round 1 RFA Released	October 2026
RFA Release Webinar	November 2026
Applications Due	November 2026
Application Review and Evaluation	Late December 2026
Grant Awards Announced	Early January 2027
Grant Funds Awarded	Mid-January 2027

Round 2

Activity	Target Date
Finalize and release Round 2 RFA	March 2027
Round 2 Grant Awards	May 2027

Behavioral Health Facility Throughputs: Flexible Housing Subsidy Pools

Housing and Behavioral Health Throughput

- Safe, stable housing is **a vital component** of effectively facilitating throughput for members with behavioral health needs out of hospitals and inpatient settings.
- Housing stability addresses a **critical gap in the behavioral health continuum** and supports throughput by:
  - Freeing up beds in EDs and inpatient psychiatric settings.
  - Reducing wait times for hospital discharge to community-based behavioral health care.
  - Reducing hospital readmissions.

Housing Instability = ↓ Throughput

When individuals with behavioral health needs struggle to connect to housing, they cycle between homelessness, EDs, inpatient and acute care services, and institutional care settings.

Safe, Stable Housing = ↑ Throughput

When individuals with behavioral health needs can access rental assistance and enter permanent housing more quickly, they gain stability and reduce their use of emergency and acute care services, resulting in lower costs, increased treatment adherence, and improved health.

Flex Pools Background

- Flex Pools are a proven model to **increase housing placements and retention for vulnerable populations**.
- Flex Pools do this by:
  - **Coordinating and sequencing funding streams, including Behavioral Health Services Act (BHSA) Housing Interventions and Transitional Rent**, allowing renters with behavioral health needs to be nimble and competitive in the private market;
  - Acting as a **fiscal intermediary** between funders and landlords;
  - Identifying, **securing, and supporting a portfolio of housing units** for participants; and
  - Coordinating with providers of **housing supportive services**.
- To advance Flex Pools, DHCS launched the **Flex Pool TA Academy** in 2025, through which 12 localities in California received a $125,000 planning grant and support from subject matter experts to launch or expand a Flex Pool.

Behavioral Health Flex Pool Investment Grants Structure and Funding Model

This investment would scale California's current Flex Pool support by pairing competitive Behavioral Health Flex Pool Investment Grants with structured technical assistance to help communities launch, expand, and sustain local Flex Pools focused on permanent housing placements for individuals with significant behavioral health needs.

- **Funding:** DHCS proposes a $60 million investment for Behavioral Health Flex Pool Investment Grant awards and supports.
- Grantees will be placed in one of two cohorts:
  1. **Operational Cohort:** Communities with an operational Flex Pool ready to house individuals with behavioral health needs at the time of application; eligible for larger awards of up to $6 million (estimated 6-8 grantees total).
  2. **Building Cohort:** Communities in planning or earlier implementation phases; eligible for awards up to $500,000, with the expectation that their Flex Pools become operational by the end of calendar year 2028 (estimated 12-15 grantees total).
- **TA:** All grant recipients will participate in TA activities (Academy 2.0), led by a team of Flex Pool experts responsible for the current Academy.

Behavioral Health Flex Pool Investment Grants Proposed Timeline

The proposed timeline would move quickly from RFA release in fall 2026 to grantee selection, Academy 2.0 launch, and first payments in spring 2027, with second payments and ongoing program monitoring in 2028.

Activity	Timeline
Release RFA and select grantees	Fall 2026
Official launch of Flex Pool Academy 2.0	Spring 2027
First Payment to Behavioral Health Flex Pool Investment grantees	Spring 2027
Second Payment to Behavioral Health Flex Pool Investment grantees	Winter 2028
All Behavioral Health Flex Pool Investment funds spent by grantees and completion of Flex Pool Academy 2.0 TA	Year end 2028

Questions?

DHCS

Behavioral Health Public County Profile Walkthrough

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

DHCS

Former State of Behavioral Health Data

- **No Shared Home**
  - Housed across many different systems and owners, with no shared home for the public to visit.
- **Technical**
  - Where data is public, it's often built for technical audiences, not for less familiar users trying to make sense of it.
- **Surface Level**
  - Published in high-level statewide reports, with no easy way to explore what's happening in a specific county.
- **Many Sources, No Shared View**
  - County BHPs
  - Provider Data
  - State Reports
  - MCPs
  - Data from other departments

Behavioral Health Public County Profile

- The Behavioral Health Public County Profile is California's first public-facing tool to combine county behavioral health data. It brings together data from a variety of funding sources and delivery systems to provide an overall snapshot of behavioral health.

- With the profile, DHCS has taken a significant step forward in delivering on the Behavioral Health Services Act's (BHSA) goal of making behavioral health data more transparent and accessible.

"We've never had anything like this"

- Public County Profile User

Why DHCS Built the Public County Profile

Unify

- Bring together data that currently lives in disconnected systems and reports into one accessible tool.

Clarify

- Make the data understandable: not just published, but visualized and explained.

Improve

- Support transparency, planning, behavioral health monitoring, and accountability across the behavioral health system.

Communicate

- Designed for a broad audience: the public, county staff, providers, advocates, and policymakers, not just data analysts.

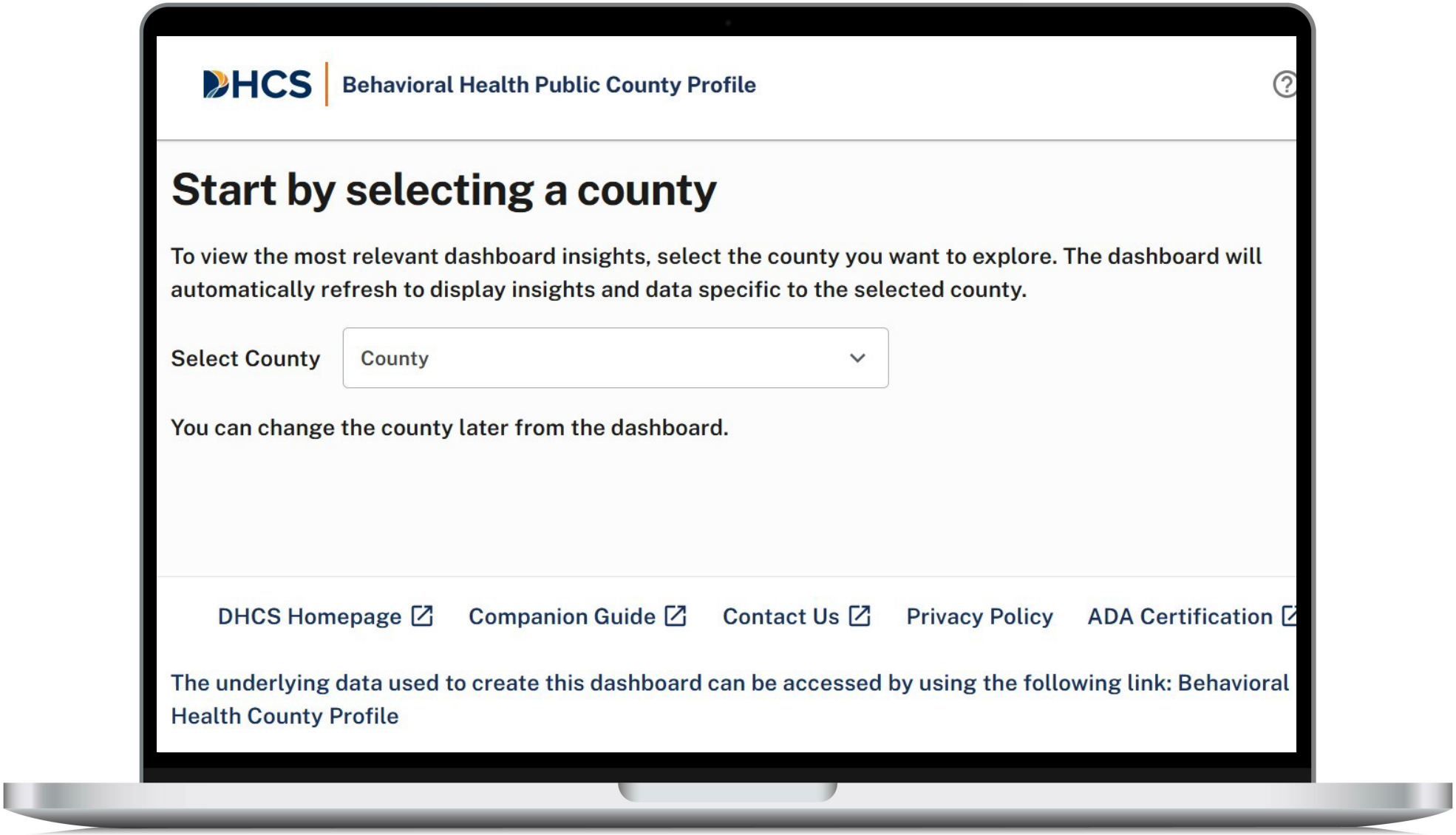
*The profile is accessible through the **DHCS Behavioral Health Transformation** webpage.*
Login not required.

What Is Currently on the Public County Profile?

The profile shows behavioral health data for every California county to support transparency and accountability. The following elements are included:

- **Overview:** County contact information and MCP(s) in county.
- **Demographics:** County population, Medi-Cal enrollment, and specialty mental health services, and substance use disorder treatment by sex, age, and race and ethnicity.
- **Integrated Plans:** Final Integrated Plan content can be exported and displayed.
- **Homelessness:** Medi-Cal members experiencing homelessness; ECM services and members receiving housing-related Community Supports.
- **Performance:** A subset of Behavioral Health Transformation performance measure results across the six priority statewide goals.
- **Behavioral Health Reporting:** Data from the Lanterman-Petris-Short Act, BH-CONNECT, and California's overdose surveillance dashboard.

Behavioral Health Public County Profile Demo



Questions?

DHCS

BH-CONNECT: Incentive Program Calendar Year 2025 County Performance Updates

Jeff Norris, MD, Value-Based Payment Branch Chief, Quality and Health Equity Division

DHCS

Driving Progress in Three Areas of Focus

The BH-CONNECT Incentive Program **rewards participating BHPs for demonstrating improved performance** on key measures within three "areas of focus":

» Improved **access** to behavioral health services.

» Improved **health outcomes** and quality of life.

» Targeted behavioral health **delivery system reforms.**

Overview of 2025 County Performance

- Inclusive of Submission 1, 45 counties earned more than **$135 million of $210 million incentive dollars (64.3%), nearly two-thirds of total possible funding.**
- Counties earned $86.4 million out of $160 million incentive dollars for 2025 (not including Submission 1), or 54% of total possible funding. Of 2025 funding to be paid in November 2026:
  - **$63.5 million** (39.7% of the $160 million possible funding) was earned through the base incentive program.
  - **$22.9 million** (23.7% of the remaining ~$96 million) was then earned through the high-performance pool (HPP).

2025 Performance by Measure Area

Counties earned the most funding on measures related to increasing access to care and on narrative measures. The table below breaks down funding earned across measure areas:

2025 Measure Area	% of Possible Funding Earned for Measure Area	Total Funding Earned (Base Program + HPP)
Improving Penetration and Engagement in Specialty Behavioral Health Services	95.71%	$22,971,061.23
Improving Utilization of ECM	94.60%	$11,351,976.78
Submission 2: Targeted Behavioral Health Delivery System Reforms)*	74.36%	$22,309,371.04
National Committee for Quality Assurance Behavioral Health Accreditation (BHA) Re-Assessment	78.56%	$7,856,041.33

**Details on next slides*

Submission 2: Targeted Behavioral Health Delivery System Reforms

- The specific questions counties answered and scoring rubric for payment are publicly posted.
- The **topics covered** included:
  - **Electronic consent management**, including the Authorization to Share Confidential Member Information (ASCMI) Form.
  - **Data sharing** with outside entities.
  - Processes and programs reported through the **Integrated Plan** (through Behavioral Health Transformation).
  - **Crisis services** programs and utilization.
- This submission **builds on what counties submitted in 2025** for Submission 1.

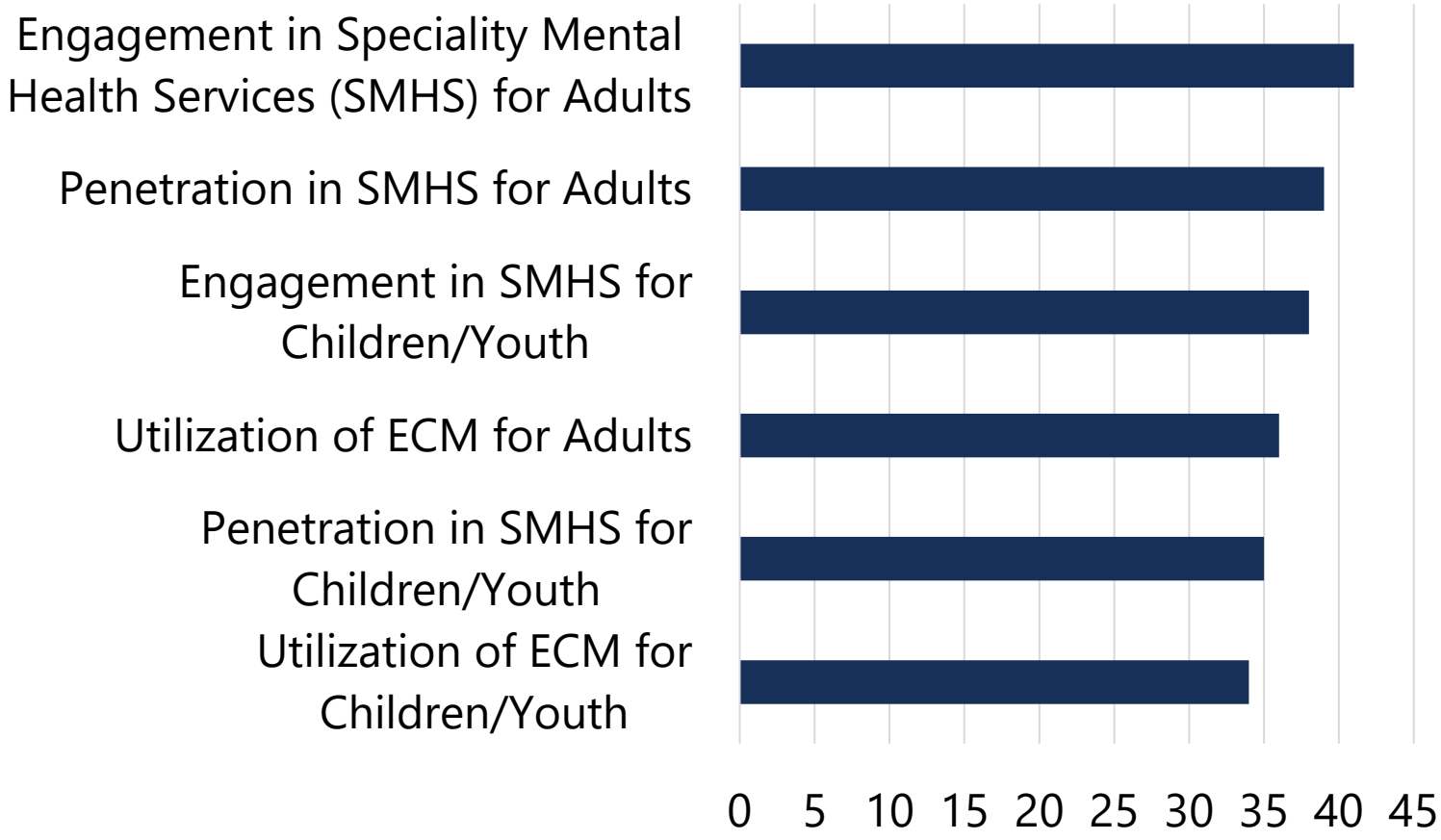
2025 County Success

Success Was Broad, in Small and Large Counties Alike

12 counties earned **75% or more** of their eligible funding: six with smaller allocations and six with larger ones.

5 counties* earned **80% or more,** including small rural counties

Number of Counties that Improved on Each Access Measure (of 45)



5 counties that earned 80% or more are **Lake, Mendocino, Colusa, Glenn, and Contra Costa.*

Making a Difference, One County at a Time

Success is happening across counties of different sizes and regions. **Several counties earned more than 75% of their total available funding.**

Figure 1: Counties Earning ≥75% of Their Available Funding

BH-CONNECT Resources

- BH-CONNECT on the DHCS Website
- Centers of Excellence
- Activity Funds Initiative | PPL
- HCAI's BH-CONNECT Website
- Engage with us at: BH-CONNECT@dhcs.ca.gov

Questions?

DHCS

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

- March 10, 2027
- June 9, 2027
- August 11, 2027
- October 6, 2027

Appendix

Director's Update: Work and Community Engagement Requirements

Medical Frailty Illustrative Scenario (1/2)

Scenario

- Linda is 49 years old and has a part-time job. She was recently diagnosed with breast cancer.
- She has a monthly income of $330.

At Application:

- In April 2028, Linda applies for Medi-Cal and is found eligible based on her income. Linda tells the county that she has breast cancer and is unable to meet work and community engagement requirements.
- The county reviews if Linda qualifies for any exclusions in the month she applies. Because the county cannot yet electronically verify her medical condition (there are no claims or other data because she just started treatment), it accepts her self-attestation that she is medically frail.
- Since Linda is medically frail, she does not have to meet work and community engagement requirements.
- Linda is enrolled in Medi-Cal and receives an approval notice.

Medical Frailty Illustrative Scenario (2 of 2)

Scenario

- Linda is 49 years old and has a part-time job. She was recently diagnosed with breast cancer.
- She has a monthly income of $330.

At Renewal:

- Linda is due for renewal six months later in September 2028. The county confirms that she still meets Medi-Cal income requirements.
- As part of the renewal process, the county reviews whether Linda still qualifies for a work and community engagement requirements exclusion. Because beginning in 2028, federal rules require states to verify medical frailty within six months of an initial self-attestation, the county must reverify her exclusion.
- The county identifies claims showing that Linda is being treated for breast cancer, but additional documentation is needed. Linda provides a doctor's note confirming that her condition prevents her from meeting work and community engagement requirements. Based on this information, the county confirms that Linda still qualifies for the medical frailty exclusion and does not need to meet work and community engagement requirements.
- Linda's Medi-Cal coverage is renewed, and she receives an approval notice.