CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING SUMMARY

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

Date: Wednesday, May 21, 2025

Time: 9:30 a.m. – 3 p.m.

DHCS Staff Presenters: Michelle Baass, Director; Tyler Sadwith, State Medicaid Director; Krissi Khokhobashvili, Deputy Director, Office of Communications; Paula Wilhelm, Deputy Director, Behavioral Health; Glenn Tsang, Policy Advisor, Homelessness & Housing; Marlies Perez, Chief, Community Services Division, Project Executive, BHT

SAC Members in Attendance: Adam Dorsey, Al Senella, Amanda Flaum, Anna Leach-Proffer, Beth Malinowski, Bill Barcellona, Brianna Pittman-Spencer, Carlos Lerner, Carlos Marquez III, Chris Perrone, Christine Smith, Faith Colburn, Janice Rocco, Jarrod McNaughton, Jolie Onodera, Katie Rodriguez, Kim Lewis, Kiran Savage-Sangwan, Laura Sheckler, Le Ondra Clark Harvey, Linda Nguy, Marina Owen, Michelle Cabrera, Michelle Gibbons, Ryan Witz, Virginia Hedrick, William Walker

BH-SAC Members in Attendance: Al Senella, Carlos Marquez III, Jolie Onodera, Kim Lewis, Kiran Savage-Sangwan, Le Ondra Clark Harvey, Michelle Cabrera, Virginia Hedrick, William Walker, Angela Vasquez, Chris Stoner-Mertz, Dannie Ceseña, Gary Tsai, Hector Ramirez, Jason Robinson, Jei Africa, Jevon Wilkes, Karen Larsen, Kirsten Barlow, Linnea Koopmans, Robert Harris, Rose Veniegas, Sara Gavin, Sarah-Michael Gaston, Veronica Kelley, Vitka Eisen

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

Introduction and Summary of Content

- The joint SAC/BH-SAC meeting addressed topics related to Medi-Cal and California's behavioral health landscape. Panel members received a Director's Update on the recent budget proposed by the governor and its impact on DHCS. An update on Proposition 35 was provided that covered the proposed Spending Plan and the Protect Access to Health Care Act Stakeholder Advisory Committee (PAHCA-SAC). The State Medicaid Director provided an analysis of the cost effectiveness of

Community Supports and an update on upcoming California Advancing and Innovating Medi-Cal (CalAIM) renewals. The following topics were covered:

- Building a Stronger Medi-Cal Through Member Engagement
- BH-CONNECT Implementation: Updates and Dialogue
- Behavioral Health Transformation Update

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

Topics Discussed

Director's Update – *Michelle Baass, Director:* DHCS opened the meeting by reviewing the key elements of the May Revision to California's state budget, which proposes $193.4 billion in total funding, including $42.8 billion from the General Fund. Central to the budget are revenues from the Managed Care Organization (MCO) Tax and Proposition 35, with the latter allocating $1.6 billion over FY 2025–26 and 2026–27 to improve Medi-Cal reimbursement rates for various services. Behavioral health investments include $5 million for the CalHOPE Warm Line and $2.9 million for addressing Adverse Childhood Experiences (ACEs). Cost-saving measures include cuts to dental and long-term care for certain immigrants, reinstated asset tests, and stricter pharmacy controls. DHCS also shared early findings from its cost-effectiveness analysis of Community Supports (In Lieu of Services). Preliminary data from July 2022 to June 2024 suggest that many of the services, such as respite care, housing deposits, and personal care assistance, have already proven cost-effective in reducing high-cost utilization, such as hospital and emergency room use. The Director's update concluded with information on Proposition 35 implementation and the new advisory body, PAHCA-SAC.

» **Discussion**

» A member sought clarification on the proposed Medi-Cal enrollment freeze and premium requirements for individuals with unsatisfactory immigration status (UIS). DHCS clarified that the enrollment freeze applies only to undocumented individuals, while the $100 monthly premium applies to all with UIS. The member expressed concern that this premium could lead to significant coverage losses, especially for low-income families, potentially forcing them to choose between health care and basic needs. They highlighted the risk of a higher-than-estimated 20% disenrollment rate and urged DHCS to reconsider these eligibility changes.

- A member inquired about proposed cuts in the May Revision. DHCS clarified that the presentation was a summary and did not include all proposed changes. They highlighted several changes, including the elimination of acupuncture as a benefit, adjustment of Program of All-Inclusive Care for the Elderly (PACE) rates, and significant cuts to Proposition 56 supplemental payments—particularly for dental, women's health, and family planning services—saving $500 million annually. Other proposed cuts include removing incentive programs for skilled nursing facilities, backup power requirements, and limits on prior authorization for certain hospital services. The member raised concerns about the impact of eliminating Proposition 56 dental payments on access and provider participation, noting that 40% of California dentists now serve Medi-Cal patients. They also questioned the lack of modeling on the potential cost increase from cutting dental coverage for undocumented adults, referencing a past spike in emergency room costs after similar cuts in 2009. DHCS confirmed that no modeling had been done and noted that emergency dental services are federally reimbursable. Any changes to Proposition 56 payments would require federal approval and access considerations.
- A member requested clarification on the operational impact of proposed Medi-Cal policy changes affecting state-only populations, particularly the elimination of long-term care benefits and adjustments to payments for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC). They asked how member transitions, payment denials, and potential overpayments would be managed, and whether clinics would still receive base payments without Prospective Payment System (PPS) wrap payments. DHCS responded that long-term care services for state-only populations, including skilled nursing facility care, would end on January 1, 2026. Affected individuals would lose eligibility for those services, but DHCS plans to collaborate with managed care plans to transition members to alternative supports like community programs. For PPS wrap payments, DHCS said the system would be updated to deny such claims, but emphasized that clinics and plans could still negotiate payment arrangements, maintaining a structure similar to the current one. Many implementation details remain under development.

- A member expressed concern about the disproportionate impact of the proposed cuts on immigrant families, older adults, and people with disabilities. They asked whether undocumented youth who are aging out of coverage would transition into full scope Medi-Cal under the expansion population or be excluded due to the enrollment lockout. DHCS responded that individuals currently enrolled in coverage will maintain their Medi-Cal eligibility regardless of age, provided they continue to meet eligibility criteria and pay any required premiums. There is no age-based cutoff that would disqualify them. The member followed up by asking whether missing a premium payment would result in a lockout from re-enrollment. They also asked whether, considering the reinstatement of the asset test, DHCS and counties would work to automate the asset verification process to reduce administrative burdens on older adults and people with disabilities. DHCS confirmed that the asset verification program will be reinstated.
- A member commented on the disconnect they perceived between the proposed budget cuts and the state's stated values, particularly given California's status as the fourth-largest economy in the world. They expressed concern that the policy decisions underlying the budget may not have been informed by a complete analysis of the costs and consequences, especially for immigrant communities. The member noted that immigrant communities contribute significantly to the state's economy and questioned why they are being disproportionately impacted by proposals that would eliminate Medi-Cal coverage for certain populations. They emphasized that such disenrollments affect individuals, but also have broader impacts on families, work participation, education, and community well-being. They raised concerns about the strain these changes could place on the overall health system, including mental health services. Speaking from personal experience as a person with a disability, an immigrant, and a primary caregiver for an elderly parent, the member described Medi-Cal as a transformative support that enabled them to transition from public assistance to employment and self-sufficiency. They questioned whether the governor had been provided with updated policy analysis reflecting the full impact of the proposed cuts and asked when such information would be shared with the governor and legislators to support data-driven decision-making.

- A member echoed concerns about proposed Medi-Cal cuts affecting immigrant populations and the reinstatement of the asset test. They inquired whether In-Home Supportive Services (IHSS) would also be eliminated for individuals with unsatisfactory immigration status (UIS). DHCS confirmed this is proposed, though IHSS is overseen by the California Department of Social Services (CDSS). The member emphasized its relevance due to Medi-Cal's involvement. They also asked for projections on how many would lose Medi-Cal eligibility due to the asset test. DHCS estimated that around 112,000 individuals would lose coverage by June 2027, up from an earlier estimate of 40,000, due to updated caseload growth. Regarding federal budget impacts, DHCS clarified that the proposed six-month renewal cycle for asset verification applies only to Affordable Care Act (ACA) expansion populations and not non-Modified Adjusted Gross Income (MAGI) groups. The member further asked about projected savings from step therapy and prior authorization for prescription drugs. DHCS estimated $87.5 million in savings from step therapy and $62.5 million from prior authorization in the budget year, with those figures doubling in subsequent years. Specific drug-level details were not yet available.
- A member raised concerns about eligibility changes that affect coverage, highlighting difficulties, particularly with optional benefits and long-term care. They noted the need for coordinated analysis between DHCS and CDSS to assess the cumulative impact of cuts, asset tests, and policy changes on both coverage and workforce, especially in the long-term care sector. The member referenced IHSS workers' input shared recently and specifically mentioned the scheduled sunset of the Workforce & Quality Incentive Program (WQIP) program, expressing a desire to see the program complete its full term due to its benefits for skilled nursing facility providers. Additionally, the member made a broader comment urging the state to consider bolder, new revenue proposals beyond relying on premiums, suggesting that corporations or others in the system should contribute more to avoid service cuts.
- A member asked for a simplified explanation of proposed Medi-Cal pharmacy changes. DHCS outlined several key proposals: introducing a rebate aggregator for individuals with UIS, eliminating GLP-1 drugs for weight loss, removing some over-the-counter items (e.g., antihistamines,

COVID tests), and enhancing utilization controls, such as prior authorizations and diagnostic code restrictions. DHCS also plans to implement step therapy, increase rebate caps for HIV and cancer drugs, and require prior authorization for drug continuation beyond 100 days. The member found the explanation helpful but requested more details on potential impacts to the California Children's Services (CCS) population, particularly regarding delays or disruptions in treatment. DHCS responded that further details will be shared in the coming months if the proposals move forward.

- A member inquired about the intersection between premiums and the enrollment freeze for undocumented persons, specifically if someone loses coverage for failing to pay their premium, if they can re-enroll in the program. DHCS responded that individuals who fail to pay premiums are disenrolled and become eligible only for emergency and pregnancy-related services. The member asked if there is a grace period, and DHCS confirmed that there is no grace period.
- The member asked if there are other elements separated within the undocumented immigrant population, noting IHSS applies to the undocumented expansion, but questioning if other sectors are included or excluded, and sought clarification on which proposals apply to documented versus broader immigrant populations. DHCS responded that the enrollment freeze and IHSS relate to the undocumented expansion, though IHSS is overseen by CDSS, so DHCS referred to their summary for details. DHCS added that remaining proposals apply to a broader undocumented immigrant population. The member also expressed concern about the $100 premium amount, questioning how it was determined given the low-income status of the population and whether different poverty levels were considered. DHCS explained that this is part of the May Revision proposal, and no further insight is available, confirming that IHSS is only for the undocumented population. The member concluded by expressing strong concern that the premium might cause people to lose coverage.
- The member asked how Californians' views on these changes are being considered. DHCS responded that the proposals are fiscal measures to address the state's budget shortfall. They acknowledged the seriousness of the conversation and emphasized the recognized importance of coverage

and community health. DHCS noted they are monitoring polling data regarding statewide support for coverage.

- A member asked for clarification on the elimination of Behavioral Health Bridge Housing Round Four, confirming that the May Revision does not restore funding but instead proposes a revenue swap using Behavioral Health Services Act (BHSA) administrative funds. DHCS clarified this is a funding source change, not a cut. The member raised concerns that eliminating Round Four could create a 6–12-month gap in housing support for vulnerable populations, potentially leading to housing loss. The member also questioned the lack of funding for SB 525's $25/hour minimum wage requirement for behavioral health workers, noting that while physical health has funding adjustments through managed care plans, behavioral health does not. DHCS explained that county behavioral health programs have never received direct funding for wage increases and are limited to mandated services. The member cited Proposition 30, pointing out that counties must be reimbursed for new mandates or allowed to opt out, and warned that without wage parity, behavioral health providers will face a competitive disadvantage in recruiting and retaining staff from the same labor pool as physical health providers.
- The member began by acknowledging the difficulty of the current time and noted that the proposals do not align with DHCS's usual collaborative approach with health plans. While recognizing the fiscal intent behind Proposition 35 funding changes, undocumented benefit cuts, and eligibility shifts, the member suggested a fourth option: evaluating Medi-Cal's cost-effectiveness to avoid unintended long-term system costs. They appreciated that children under age 18 retain eligibility, but noted most affected are adults, risking loss of important benefits like cancer screenings and asthma management. The member called for a more open, collaborative process with health plans to explore cost containment strategies that avoid service cuts or shifting risk to providers, focusing instead on reducing avoidable or duplicated services. DHCS responded positively, welcoming ideas and emphasizing that the proposals aim to save about $5 billion in General Funds due to rising spending, and they are open to suggestions that protect the program while addressing the budget deficit.

- The member asked when to expect trailer bill language specifically regarding UIS and the asset test. DHCS responded that the administration is working diligently to post all related materials on the Department of Finance website, but did not provide a specific date.
- The member asked if there are projections on how many adult undocumented individuals would remain in the program over the next three years, given the proposed block on re-enrollment, expressing a suspicion that only a small percentage would remain. DHCS clarified that the enrollment freeze applies only to the undocumented expansion for newly eligible individuals; enrollment for other UIS groups is not frozen. They projected enrollment for UIS, including the undocumented expansion, to be about 2.3 million in the budget year, but do not have projections for future years.
- The member asked whether individuals with current coverage who may lose it due to substance use disorder or mental health conditions can re-enroll under the proposed enrollment cap, suggesting an exception for these populations. DHCS responded that if eligibility is lost or discontinued, individuals would no longer qualify for full scope Medi-Cal, but would be eligible for limited-scope services, such as emergency and pregnancy care. The member then asked if there is an exemption from the $100 copay for these populations while engaged in treatment. DHCS stated that the proposal includes no exemptions to the copay requirement.
- The member asked about the proposal to cut PPS payments for FQHCs and RHCs serving undocumented immigrant populations, specifically how DHCS plans to share immigration status data with health centers for financial planning, given that health centers do not collect this data and managed care plans cannot share it due to patient safety and privacy concerns. DHCS responded that wrap payments are generally billed at the time of service through the fee-for-service delivery system, and year-end reconciliation compares RAP payments plus managed care revenue to PPS requirements, with adjustments made accordingly. Regarding immigration status information, DHCS said operational details are still being worked out but indicated that eligibility checks and flags may be used to share relevant information while protecting privacy.

- A member appreciated the shared cost-effectiveness data and asked about the 1115 waiver authority and the CalAIM renewal in 2026, noting that short-term post-hospitalization housing and recuperative care are covered under the 1115 waiver, while transitional rent falls under the BH-CONNECT waiver. They expressed concern about potential federal restrictions on 1115 waiver policies, which could threaten health-related social needs services. DHCS acknowledged these concerns, confirming they are actively addressing them. They explained that short-term housing and medical respite are included in the 1115 waiver under CalAIM and that recent federal changes, like the Centers for Medicare & Medicaid Services (CMS) removing the Human Resources Management System (HRSM) framework, pose challenges. DHCS emphasized using cost-effectiveness data to support their case and described federal Medicaid policy as uncertain and reactive. They are exploring creative, strategic options for moving forward with waiver proposals.
- A member commented that the cost-effectiveness findings were positive and much needed. They emphasized the importance of careful and intentional consideration of housing-related services included in the community supports. The member noted that their community foundation is particularly interested in several housing-specific services and offered support for advancing those elements in the future.
- The member complimented DHCS for sharing the cost-effectiveness data and asked whether recuperative care and short-term post-hospital housing were included in the evaluation. They also shared that their homeless population recently exceeded the general population in primary care connectivity, attributing this improvement to Community Supports and Enhanced Care Management (ECM). DHCS responded that while they did not have the details memorized, both recuperative care and short-term post-hospital housing are indicated as cost-effective, and more specific data would be available in the full report.
- Member stated that the current MCO Tax is over three times higher than the historical MCO Tax revenue in California. They expressed concern that under the current proposal, there are no provider rate increases for primary care, specialty care, or family planning and abortion services in 2025. They said the absence of rate increases presents a policy concern, particularly because voters passed Proposition 35 with 68% approval and

are expecting increased support. They further stated that what is proposed for 2025 largely amounts to rate decreases, citing that Proposition 56 funding was largely swept in 2024 to pay for targeted rate increases (TRI), and the current proposal includes sweeping family planning, dental, and loan repayment funds. They concluded that this approach could negatively affect access to care and is not aligned with voter expectations under Proposition 35.

- A member asked whether DHCS has considered the potential impact of the federal reconciliation bill, provider tax freezes, and newly proposed regulations related to provider taxes on California's existing waiver and how those changes might affect the implementation of Proposition 35. DHCS responded that they recognize there are significant proposed changes under federal review and are actively evaluating their potential impacts. While they are not able to comment on specific effects to individual programs, payment methodologies, or funding mechanisms at this time, DHCS acknowledged that if the proposals are adopted as written, they could significantly reduce federal support for Medi-Cal and increase the need for state General Fund expenditures.
- A member followed up asking about a recent governor's press release that mentioned 3.4 million people losing coverage, $30 billion in cuts, and hospital closures, expressing concern and questioning whether DHCS had informed the governor or had an analysis to share. DHCS responded that the concerns are related to the CMS proposed rule, which if finalized would eliminate the transition period for stricter standards on provider taxes, including the loss of waivers for broad-based uniformity currently in place. This rule could take effect as soon as the upcoming fiscal year, whereas the federal bill allows discretion for up to a three-year transition. DHCS noted that these details are reflected in the governor's statements.
- A member asked for clarification on whether the CMS proposed rule would have an immediate impact on the MCO Tax waiver approval. DHCS confirmed that if the rule is finalized as proposed, it would have an immediate impact. DHCS explained they are submitting comments through the notice of proposed rulemaking process and encourage other stakeholders and impacted states to do the same to highlight the potential catastrophic effects on state budgets and programs. The member requested that DHCS share any materials or analysis to aid advocacy

efforts. DHCS responded that preliminary analyses are underway to fully understand the impacts, and they plan to engage stakeholders to ensure alignment and coordinated public comments, similar to past collaborative efforts, such as with the Medicaid Fiscal Accountability Regulation (MFAR) process.

- DHCS provided a technical correction regarding the cost-effectiveness findings for recuperative care and short-term post-hospitalization housing, clarifying that these services are not included in the current report on in lieu of services and that there is no cost-effectiveness data available yet for them. These services are part of the 1115 waiver, and DHCS indicated that more information will be provided in the future.

Building a Stronger Medi-Cal Through Member Engagement – *Krissi Khokhobashvili, Deputy Director, Office of Communications:* DHCS presented its strategy to enhance member engagement in line with new federal requirements under the 2024 CMS Access Final Rule. The rule requires each state Medicaid agency to establish both a Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Council (BAC). To meet these requirements, DHCS is building upon its existing Medi-Cal Member Advisory Committee (MMAC), a confidential, member-only group that provides insights based on lived experience. The MMAC will evolve to meet federal BAC standards, including term limits, structured applications, and conflict-of-interest disclosures, while continuing to hold private, trust-building meetings. Complementing the MMAC is the newly launched Voices and Vision Council, which will serve as the public-facing MAC. This council will include representatives from CBOs, Medi-Cal providers, managed care plans, and other state agencies. MMAC members will also hold seats on the Voices and Vision Council, ensuring continuity and representation. Both groups will advise DHCS on a wide range of issues, such as access to care, cultural competency, and enrollee communications. Recruitment, onboarding, and initial meetings are planned throughout the summer and fall of 2025.

- **Discussion**
  - The member expressed appreciation for the presentation and raised concerns about the shift from cultural competency to equity-focused strategies. They questioned what updated approaches are being used to ensure meaningful representation of people with disabilities and other direct stakeholders, beyond symbolic or token inclusion. The member also noted a perceived lack of direct member representation in the current structure and asked about additional strategies to make the process more

inclusive and accessible for service users, such as seniors and people with disabilities. DHCS responded that accessibility and inclusivity are key priorities. They emphasized the goal for the membership to reflect the diversity of the Medi-Cal population, including people of all ages, disabilities, and language backgrounds. MMAC meetings are translated in real time, and the pace allows members adequate time to process and respond. DHCS shared examples of culturally responsive engagement, such as incorporating music, poetry, and art informed by member voices. They also hold check-in meetings with MMAC members to support preparation and provide materials in formats tailored to individual needs (mailed or emailed), ensuring members have ample time to review and engage meaningfully.

- The member appreciated the presentation and noted that CBOs are diverse, and no single CBO can represent all communities, issues, or priorities statewide. They asked how DHCS will ensure that the council includes multiple CBOs to provide broad and diverse representation. DHCS responded that they will consider this during the application review process and agreed on the need for diverse representation.
- The member expressed excitement about the new MAC/BAC requirements and noted that this was the first time they were seeing some of this information. They asked for clarification on whether the existing Medi-Cal Managed Care Advisory Group (MCAG), which has existed for many years, will be dissolved and replaced by the Voices and Vision Council as part of the 20-member total process. The member also inquired if the Voices and Vision Council meetings will be open to the public, with opportunities for public comment. DHCS confirmed that the MCAG, a longstanding stakeholder forum focused on managed care operations and policy, is in the process of being wound down following the launch of the new Medicaid Advisory Committee, the Voices and Vision Council. DHCS also confirmed that the Voices and Vision Council meetings will be open to the public and include opportunities for public comment. Former MCAG members are invited to apply for the Voices and Vision Council depending on their role and interest.
- A member thanked DHCS for the update and complimented the Department for its commitment to this work prior to the federal

requirement. They noted that leadership has maintained focus on this effort and expressed appreciation that it has not been sidelined.

BH-CONNECT Implementation: Updates and Dialogue – *Paula Wilhelm, Deputy Director, Behavioral Health; Glenn Tsang, Policy Advisor, Homelessness & Housing:* DHCS led a deep dive into the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative, which is designed to enhance behavioral health service delivery through expanded federal authorities, new evidence-based practices (EBP), and targeted reforms. Several key components of BH-CONNECT have received federal approval under the Section 1115 demonstration waiver or State Plan Amendments (SPA). These include services like Assertive Community Treatment (ACT), Forensic ACT (FACT), Coordinated Specialty Care (CSC) for First Episode Psychosis, Clubhouse Services, Enhanced Community Health Worker (CHW) Services, and the Individual Placement and Support (IPS) model of Supported Employment. DHCS detailed the Access, Reform, and Outcomes Incentive Program, which makes up to $1.9 billion available over five years to Behavioral Health Plans (BHP) that demonstrate improvements in access, quality, and system reform. DHCS also reviewed preliminary, non-binding county survey data indicating broad interest in implementing the new EBPs, with 35 counties (representing 85% of Medi-Cal members) indicating that they may adopt at least one of the adult EBPs.

A major focus was the upcoming launch of Transitional Rent, a new Community Support approved under federal waiver authority. Beginning in July 2025, Medi-Cal managed care plans may choose to offer up to six months of rent support to eligible members, with mandatory implementation for the Behavioral Health Population of Focus beginning January 1, 2026. The benefit is intended to serve as a bridge to permanent housing, particularly for people transitioning from institutions, homelessness, or others making other critical life transitions. DHCS emphasized the importance of Medi-Cal managed care plan and county behavioral health collaboration in implementing this new benefit, particularly to ensure continuity and alignment with county-administered BHSA housing interventions launching in mid-2026.

- **Discussion**
  - A member noted that BH-CONNECT adds optional Medi-Cal coverage for what, in some communities, are existing county behavioral health services, such as Community Health Workers (CHW) and Coordinated Specialty Care. At present these services may be funded by federal grants and the Mental Health Services Act (MHSA). They emphasized that the public sector has led in providing these services, unlike the commercial sector.

While some services under BH-CONNECT offer new federal funding, counties must evaluate whether this funding offsets added costs like fidelity monitoring. The member clarified that opting into BH-CONNECT does not mean launching a new service, nor does opting out mean the service is not available locally. They expressed concern that rural counties may struggle to participate due to funding and workforce shortages and recommended that Centers of Excellence strengthen rural expertise. While supportive of the initiative, they cautioned that not all counties may be able to join right away. DHCS responded by acknowledging that many counties already deliver components of the targeted practices. BH-CONNECT is intended to support consistent, high-fidelity service delivery through structured payment models. They also noted efforts to accommodate rural needs, such as using the flexible Tool for Measurement of Assertive Community Treatment (TMACT) fidelity tool.

- A member inquired about the expansion of Enhanced CHW services and oversight of Institutions for Mental Diseases (IMD). They thanked DHCS for supporting CHWs under managed care, but noted low uptake of the CHW benefit due to a lack of streamlined processes. They also pointed out that CHWs are not included in the Centers of Excellence and asked whether separate technical assistance would be available. DHCS explained that CHWs do not fit the EBP model used by the Centers of Excellence, and acknowledged many counties already engage in CHW-like outreach. They stated the enhanced CHW benefit allows counties to access federal funding for this work and that DHCS can offer separate guidance to support implementation. The member then raised concerns about oversight of IMDs, particularly as Medi-Cal becomes a more prominent payer and more facilities open across California. They asked about oversight responsibilities at the county, DHCS, and California Department of Public Health (CDPH) levels. DHCS responded that oversight expectations are included in BH-CONNECT requirements and each county's implementation plan. Oversight elements include county monitoring of facilities, DHCS and county monitoring of CMS quality milestones (e.g., discharge planning, coordination of care, average length of stay), medical necessity standards, and follow-up care. Counties must also show how they will reduce emergency room use and hospital stays. The member appreciated these standards but questioned whether state and county agencies have enough staff to conduct in-person oversight, citing media reports of serious issues in some facilities. DHCS acknowledged these concerns and emphasized that BH-CONNECT aims to

improve oversight and care transitions. They also referenced a proposed trailer bill that would allow CDPH to issue emergency regulations to strengthen staffing standards and expand oversight capacity.

- A member asked whether DHCS had analyzed responses from the recent non-binding survey to better understand why some counties are hesitant or planning delayed implementation. They emphasized that counties are balancing ambitious service expansion goals with real concerns about workforce strain and maintaining care quality, especially amid the simultaneous rollout of Proposition 1, Proposition 36, and SB 43. Delays, they explained, reflect serious capacity concerns—not a lack of interest. DHCS responded that these concerns are consistent with feedback from other counties, citing workforce shortages, system strain, and rural challenges. They reaffirmed their commitment to supporting counties through technical assistance, flexibilities, and a $1.9 billion BH-CONNECT workforce initiative over the next five years. DHCS also highlighted other supports, including increased Medi-Cal reimbursement rates, free technical assistance, fidelity monitoring, and clinical transformation help via the Centers of Excellence. They acknowledged the difficulty of system transformation, but expressed optimism based on strong county participation and interest shown in survey responses.
- A member expressed appreciation for the counties' efforts in advancing services like “High Fidelity Wraparound” and “Clubhouse Model,” and praised enhanced ECHW services as a valuable addition. They questioned whether individuals receiving ECHW services through the behavioral health system would be barred from accessing similar services through health plans. The member argued that CHWs in different systems often address distinct needs—like behavioral health vs. physical health issues (e.g., diabetes or COVID-19 coaching)—and that service duplication may be overstated. They urged DHCS to consider allowing access through both systems where appropriate, especially since CHW services do not appear to be overused. DHCS responded that the restriction was included in the proposal to solicit feedback and acknowledged the member’s point. They clarified that CHWs working through behavioral health providers can already address broader health topics, and that this wider scope originally motivated the duplication concern. However, DHCS welcomed continued input and said they would revisit the issue during implementation planning.
- A member thanked DHCS for its collaboration on the BH-CONNECT waiver but raised concerns about increased reliance on IMDs, which are often

large, for-profit, institutional facilities. They cited a Massachusetts study and internal investigations showing significantly higher rates of seclusion, restraint, and complaints in IMDs. The member shared a personal account of abuse witnessed while working in an IMD, which motivated their disability rights advocacy. They also stated that DHCS' mental health licensing records appear to lack transparency compared to CDPH, noting that DHCS' licensing and complaint data for IMDs is harder to access and may require Public Records Act requests. They asked whether DHCS plans to improve public access to this information and expand staffing for facility oversight. DHCS responded that they are working to improve web access to licensing data for the facilities they oversee, starting with substance use disorder facilities and aiming to expand to mental health facilities. They also said that increasing DHCS' oversight staffing is under consideration, especially as the state funds more facilities through the Behavioral Health Continuum Infrastructure Program (BHCIP) and the Behavioral Health Infrastructure Bond Act, with potential expansions tied to future budget processes.

- A member thanked DHCS for the opportunities created by BH-CONNECT, especially the ability to use Medi-Cal funding for services currently funded through 1991 Realignment and MHSA. Representing a county preparing to implement the program, they asked about risks related to CMS potentially withdrawing or letting the waiver expire. DHCS responded that there is no indication at this time that CMS intends to rescind components of BH-CONNECT during the five-year demonstration period. While recent CMS guidance may affect future policies around health-related social needs and financing, it does not impact currently approved waivers. DHCS noted that CMS is currently partnering with DHCS to support CalAIM and BH-CONNECT implementation. DHCS reaffirmed the Department's commitment to rapid implementation, including the workforce and incentive initiatives.
- A member praised DHCS' work on BH-CONNECT but raised concerns around implementing peer services amid reduced training capacity, especially for forensic peer specialists. They noted that funding for peer training from the Department of Health Care Access and Information (HCAI) is dropping from $14 million to $2 million, and there is no clear coordination with the California Mental Health Services Authority (CalMHSA) to ensure adequate specialized training. The member also criticized BHSA requirements that will govern counties' use of BHSA funding for peer respite, maternal health, and Full Service Partnerships

(FSP). They emphasized that BHSA funding is essential for peer respite services. DHCS responded that they are open to continued discussion and noted that peer training and certification could be supported through BH-CONNECT's workforce initiative, with funding coordination ongoing with HCAI. On peer respite, DHCS said they are exploring new Medi-Cal coverage options and that peer respite settings are now included under three Community Supports categories—recuperative care, short-term post-hospital housing, and transitional rent—providing multiple Medi-Cal funding pathways.

- A member expressed strong support for the state's clarifications regarding children's EBPs, stating alignment with DHCS' position that Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requires coverage of these services under federal and state law. They also expressed enthusiasm for the upcoming High-Fidelity Wraparound service and payment model, emphasizing that it would expand access, support fidelity-based care, and strengthen existing Intensive Care Coordination (ICC) services under Medi-Cal and the Katie A. lawsuit. They advocated for a bundled or case rate approach as more sustainable than 15-minute billing. DHCS thanked the member and said they look forward to discussing the High-Fidelity Wraparound model further in future forums.
- A member asked if state-only populations can access BH-CONNECT benefits and whether those benefits could support long-term care transitions after the planned 2026 phaseout. DHCS confirmed there are no exclusions; BH-CONNECT services, authorized through 2029, are available to all populations. They also affirmed that Community Supports like nursing diversion and transition services can aid individuals moving out of skilled nursing facilities. If the proposal moves forward, DHCS plans to collaborate with managed care plans to identify eligible individuals and create transition plans.
- A member asked whether counties could use BHSA housing funds to cover rent for individuals in short-term housing (e.g., FSP-funded) who do not qualify for BH-CONNECT's transitional rent benefit. They were concerned that BHSA may require use of the Medi-Cal benefit first once fully implemented. DHCS clarified that if an individual does not meet BH-CONNECT's transitional rent criteria, there is no requirement to use Medi-Cal first; counties can use BHSA housing funds directly in those cases.
- A member asked whether, under the transitional rent benefit, payments for recovery bridge housing, which counties currently fund as a service rather

than as rent, would be redefined as rent, thereby implying the need for a lease. DHCS responded that they would need to discuss the issue further but noted that their policy distinguishes between permanent and interim housing settings based on the presence of a lease. They explained that interim settings, by definition, typically do not involve a lease, and the transitional rent benefit can be used for such settings. The member followed up to confirm whether the benefit can be used in interim settings without leases. DHCS confirmed that it can.

Behavioral Health Transformation Update – *Marlies Perez, Chief, Community Services:* DHCS concluded the meeting with an update on California's broader Behavioral Health Transformation, launched to implement Proposition 1 in 2024. This initiative aims to modernize funding, expand the behavioral health workforce, and increase accountability. DHCS outlined progress on several fronts, including the development of the BHSA County Policy Manual, which guides counties in planning, fiscal reporting, and implementation. DHCS has released initial modules for public comment and plans to continue this process through 2025. Counties will be required to submit Integrated Plans for FY 2026–29, with draft plans due by March 31st, 2026. A centerpiece of the transformation is the Bond-funded BHCIP. The first round of "Launch Ready" awards—announced in May 2025—distributed $3.3 billion across 124 projects, supporting more than 5,000 new residential treatment beds and more than 21,000 outpatient slots. A second funding round focusing on "Unmet Needs" is expected in 2026. DHCS underscored the importance of stakeholder engagement, transparency, and ongoing public participation as the transformation unfolds.

- **Discussion**
  - A member asked if there was an estimated timeframe for when Module Four of the Policy Manual will be released. They also requested clarification on whether upcoming CalMHSA trainings would be exclusively for counties or if providers would be included. Finally, they asked how DHCS was assessing and balancing the needs of youth and adults while matching applicant needs during the BHCIP source selection process. DHCS noted that implementation workgroups may begin in late June or early July, and that the release of module four is dependent on the engagement process and number of meetings needed before releasing a draft policy for public comment. Regarding the CalMHSA trainings, DHCS responded that it is unclear whether there will be provider-specific trainings. All materials and trainings will be made publicly available. Lastly, DHCS provided insight on the BHCIP application review, which includes analyzing existing studies,

county needs assessments, and applicant-submitted data. Evaluators consider facility types, geographic needs, and county support letters. They also assess applicant viability, ensuring they have experience or partnerships in behavioral health, and evaluate whether the proposed facility is feasible to construct within cost expectations. Balancing youth and adult needs are part of this comprehensive review approach.

- A member shared appreciation for DHCS' engagement, particularly around children, youth services, and early intervention. However, they raised concerns about new language in the final policy manual that could lead counties to misunderstand the role of parent engagement programs. While these programs are eligible for early intervention funding, they do not count toward the 51% spending requirement for children and youth, which may discourage investment in parent-focused models that are essential for supporting young children's mental health. They requested clearer guidance to emphasize that supporting parents and caregivers is integral to early intervention. They also cautioned that counties heavily rely on official policy manuals over supplemental lists like the upcoming evidence-based practices list. Finally, they recommended explicitly including youth and young people in the list of required stakeholders in local behavioral health planning. DHCS noted they are considering how certain EBPs that include prevention elements and caregiver involvement might count toward the 51% children and youth spending requirements. Additionally, they acknowledged that the list shared in the presentation was only a summary and not a complete list. The are existing requirements that include youth associations.
- A member thanked DHCS for the Round 1 awards benefiting the Central Coast and asked whether, for Round 2, DHCS is aiming for geographic coverage across all age groups. They also inquired whether previous applicants receive priority in the next round or if the assessment process starts fresh based on current needs. DHCS responded that Round 2 is open to all applicants, with no priority given to those who applied previously. Each round is a fresh and fair assessment based on current needs, letters of support, and county data. However, past applicants may benefit from lessons learned to strengthen their new applications.
- A member highlighted the growing demand for services due to new initiatives and facility types supported by recent legislation and Proposition 36, especially for substance use disorder and forensic behavioral health populations with complex, co-occurring needs. They emphasized the importance of addressing these in an integrated way and

asked whether the planning process will consider not just prior studies, but also newer developments and initiatives that are driving the need for expanded specialized services. DHCS responded that they are considering current initiatives when reviewing applications, particularly through the information provided in county applications and letters of support. Even non-county-operated facilities can reflect county priorities. While the 30-year commitment to behavioral health services is required, DHCS recognizes that needs can change over time and allows for changes in facility type or licensure through a formal process. Although rarely used so far, this flexibility is built into the system. DHCS noted they hope to continue to learn from county partners, legislative hearings, and emerging needs, especially related to substance use disorders, to inform decision-making.

  - A member reiterated concerns regarding the March deadline introduced in Module 3, stating that it leaves counties with too little time to draft plans, receive DHCS feedback, and obtain board approval by June 30. They expressed being worried that this could lead to noncompliance or delays and emphasized the need for the state to recognize the challenges and uniqueness of this initial transition period.
  - A member shared a key theme from their local community planning experience, which was the growing need for youth-focused services, including prevention and peer supports. They noted a program officer is actively conducting listening sessions with youth currently accessing services, with plans to share findings in a community planning presentation in Los Angeles County. The member expressed being open to sharing updates with the group and welcomed ideas on gathering information about accessibility and engagement at behavioral health sites.

- **Public Comment:** During the public comment period, attendees were allowed to voice their concerns and offer feedback to DHCS and panel members.
  - A member of the public expressed that the results of county surveys, including the National Committee for Quality Assurance (NCQA) surveys on gaps, should be made publicly available so stakeholders can see county responses. They also requested a list of counties that answered "yes" to specific survey questions to help local stakeholders understand what options or commitments are currently in play.
  - A member of the public asked if DHCS will issue an updated Behavioral Health Information Notice (BHIN) about peer support specialists needing forensic specialization to help employers prepare staff and support peers

in getting trained. They also inquired about additional funding to cover specialization training costs, noting that high costs have limited uptake despite potential funding for the 80-hour certification. Lastly, they requested clearer guidance for counties on the community planning process, particularly around expectations for ongoing stakeholder engagement in evaluation, quality assurance, and other areas where participation has been inconsistent.

- A member of the public shared they feel there is no clear forum or commission where advocates can specifically push for programs like suicide prevention within the county's Behavioral Health and Recovery Services (BHRS). They noted that existing commissions and equity initiatives do not serve this focused advocacy role. They suggested the need for a dedicated venue where advocates can work across the often-siloed BHRS system to promote integrated, collaborative efforts.
- A member of the public echoed earlier calls for greater transparency in sharing survey data between counties and agencies, believing it would enhance stakeholder engagement statewide. They also emphasized that reporting requirements should be accompanied by investments in infrastructure, technical support, and assistance, especially for providers in small or rural counties who may face additional challenges.