California Legislature

SENATE COMMITTEE ON HEALTH

SUSAN TALAMANTES EGGMAN
CHAIR

1021 O STREET
SUITE 3310
SACRAMENTO, CA 95814
TEL (916) 651-4111
FAX (916) 266-9438

STAFF DIRECTOR
MELANIE MORENO

CONSULTANTS
TERI BOUGHTON
REYES DIAZ
JEN FLORY
VINCENT D. MARCHAND

COMMITTEE ASSISTANT
WENDY BRYANT

Informational Hearing
Behavioral Health Modernization Proposal: Revamp of the Mental Health Services Act
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1021 O Street, Room 1200

This informational hearing of the Senate Health Committee will focus on Governor Gavin Newsom's proposal to revamp the Mental Health Services Act (MHSA) to better coordinate behavioral health services for some of the hardest to treat populations who suffer from under- and untreated mental illness and substance use disorders (SUDs). A convergence of worsening crises over the years has brought a stronger focus on the need for transforming the state's behavioral health system: housing shortage and unaffordability; a lack of treatment beds and community-based treatment options; and, a worsening of mental illness and SUDs, which were exacerbated by the COVID-19 pandemic. The California State Legislature has been working towards this transformation with the Newsom Administration in recent years through proposals like California Advancing and Innovating Medi-Cal (known as CalAIM), a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of the state's population by implementing broad delivery system, program, and payment reform in the Medi-Cal program; the Children and Youth Behavioral Health Initiative (CYBHI), a $4.4 billion investment to enhance, expand, and redesign the systems that support behavioral health for children and youth; and, the Behavioral Health Continuum Infrastructure Program, a $2.2 billion investment to construct, acquire, and expand properties, as well as invest in mobile crisis infrastructure related to behavioral health. A revamp of the MHSA is generally seen as a necessity in order to continue to provide counties flexibility in the use of this dedicated funding stream, in addition to improving and strengthening outcomes and accountability—which may have been lacking over the past decade. However, some stakeholders may disagree on the need for a transformation, or on the path towards strengthening the system. For this informational hearing, the Committee will hear testimony from the Newsom Administration on the need for transforming the MHSA and on key changes to the current "buckets" of funds that counties use to pay for services, which will ultimately require a ballot initiative and voter approval. The Legislative Analyst's Office (LAO) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) will present their analyses and provide considerations for the Legislature as the proposal makes its way through the process. Finally, the Committee will hear from various stakeholders who will highlight both the need and benefits of transforming the MHSA—such as improved and expanded uses of funds to bolster the dwindling

public mental health system workforce and maximize federal financial participation. Stakeholders will also express how this proposal might affect communities, particularly children and youth; historically under- and unserved, marginalized populations; and, schools.

Background

Approved by voters in 2004, the MHSA places a 1% tax on personal income over $1 million and dedicates the associated revenues to mental health services. According to the MHSOAC, the MHSA was informed and inspired by the emergence of effective practices for dealing with serious mental health conditions and legislatively sponsored pilot projects in comprehensive services that improved outcomes, including reductions in homelessness, criminal justice involvement, and hospitalizations for individuals with serious mental health conditions. Proposition 63, the voter initiative which enacted the MHSA, also incorporated recommendations from two Little Hoover Commission reports that were developed through two years of public hearings, advisory committee meetings, consultations, and site visits. The unanimous recommendations by the bipartisan Little Hoover Commission called for an end to rationed services and for transforming the mental health system by providing tailored and comprehensive care, and investing in prevention, early intervention, and innovation as essential to reducing human suffering.

The vast majority of MHSA revenues—at least 95%—goes directly to counties, which use it to support a variety of services for individuals with or at risk of mental illness. Currently, the MHSA establishes broad categories for how counties can spend the funding: Community Services and Supports (CSS), which funds direct service provision; Prevention and Early Intervention (PEI), which funds services that prevent mental illness before it becomes severe; and Innovation, which encourages counties to experiment with new approaches to addressing mental illness. The MHSA requires each county mental health program (CMHP) to prepare and submit a three-year plan to DHCS, after review from a local mental health board and approval from the board of supervisors. The plan must be updated each year and approved by DHCS after review and comment by the MHSOAC. DHCS is required to provide guidelines to counties related to each component of the MHSA. In the three-year plans, CMHPs are required to include a list of all programs for which MHSA funding is being requested, with local stakeholder input, and that identifies how the funds will be spent and which populations will be served. The MHSA makes explicit reference to those with co-occurring conditions and permits use of funds to treat those with a co-occurring SUD, as long as an individual has a primary mental health condition. CMHPs also must submit their plans for approval to the MHSOAC before they can spend innovation program funds. Counties generally have three years to spend funds (smaller counties have five years) before DHCS can revert funds back to the Mental Health Services Fund for redistribution to other counties.

The MHSOAC notes that some of the initial core values first envisioned during the implementation of the MHSA have matured as some of its current first principles, such as:

- Community engagement: Counties are required to engage with their communities to develop

three-year plans, PEI plans, and innovation plans. Local mental health boards are required to review these plans and county boards of supervisors are required to approve them.

- Community empowerment: The MHSOAC was structured to explicitly empower people with lived experience, family members, and private and public sector leaders to drive transformational change. The MHSOAC was established to build public support, address stigma, advocate for better results, and hold the system accountable to the community and California's taxpayers.

- Comprehensive and holistic care: The MHSA established in policy the imperative to provide wraparound services and adopt a "whatever it takes" approach, particularly through Full-Service Partnerships (FSPs) funded from the CSS bucket, to meet the complex needs of individuals and focus on recovery. As a ballot proposition, the MHSA was offered to the public as the right next step in building the long-neglected community service system that was promised when locked institutions were dramatically reduced some 40 years before. The MHSA was to bring a system focused on healing and recovery, self-reliance, personal connection, and hope.

- Prevention: The MHSA established a flexible funding stream—in addition to and separate from the more restrictive Medi-Cal funds—to support activities that can improve the social and economic determinants of health, including housing, education, employment, safety, and healthy family connections, with the goal of reducing homelessness, justice involvement, suicide, and suffering while also tackling disparities that pervade public services.

- Early intervention: Mindful of the consequences of rationing care to those with the most serious conditions, the MHSA dedicated funding to programs that can detect and respond more effectively to mental health conditions. This provision has been essential to deploying research discoveries that can significantly reduce the progression, and as a result, the consequences of serious mental health conditions.

- Flexible funding: While the MHSA requires counties to invest in specific categories—including FSPs, Innovation, and PEI—it provides counties with flexibility, unlike other restrictive funding streams, to pay for services and supports that are not covered by other public or private funding sources, and to meet the distinct needs of their communities.

- Focus on outcomes: The PEI provisions specifically identified seven negative outcomes that the MHSA seeks to reduce: out-of-home placement for children; school failure or dropout; unemployment; incarceration; homelessness; prolonged suffering; and, suicide.

- Innovation: The MHSA made an unprecedented commitment to innovation as an essential mechanism to finding better ways to achieve desired outcomes. Counties use 5% of MHSA funds (less than 1% of public mental health funding) to explore ways to improve services and results. If those innovations are proven to be promising, counties can continue funding those services with other MHSA funds.

Recent MHSA audits

Since its inception, there have been several audits on the MHSA. Two recent audits came about as a result of attention on large amounts of revenue in counties that were allegedly not spending the funds (although some argued that the nature of the MHSA allows counties to encumber funds while they are in county coffers), an increasing focus on the state's involuntary commitment laws, and overall state spending on the behavioral health system.

In February 2018, the California State Auditor (CSA) issued a report, "The State Could Better Ensure the Effective Use of MHSA Funding," and noted that a general lack of oversight from the state, particularly DHCS, resulted in CMHPs amassing unspent MHSA funds. As an example, for Fiscal Year (FY) 2015-16, CMHPs had accumulated $2.5 billion in unspent funds, of which $231 million should have been returned to the state to be redistributed among the CMHPs. For the same FY, CMHPs cumulatively held reserves of $535 million in MHSA funds, of which the CSA estimated between $157 million and $274 million were excessive and should have been returned to the state. The CSA attributed this to DHCS not having developed a process for recovering the unspent funds, known as reversion, nor developed a prudent reserve formula for CMHPs. Additionally, the CSA stated that DHCS's findings (through contracted consultants) that a formula with a range of between 64% and 82% of withheld funds for a prudent reserve maximum level was excessive when compared to the MHSA revenue trends. The CSA further stated that a lack of enforcement from DHCS, such as withholding funds to noncompliant CMHPs, does not incentivize CMHPs to submit required annual revenue and expenditure reports, which would assist DHCS in tracking unspent funds. The CSA noted that in the same FY, only one of the 59 CMHPs submitted its annual report by the regulatory deadline. The CSA further argued DHCS could use historical declines in MHSA funding for the CSS bucket to establish a reasonable prudent reserve level for CMHPs. The CSA identified 33% as the worst decline in MHSA funding to CMHPs in any one FY, while the average decline—for FYs in which declines occurred—was 23%. The CSA concluded that DHCS could use either of these numbers to determine a reasonable prudent reserve level and to establish a process for allowing CMHPs to move funds to or from their reserves. As a result, of this audit, SB 192 (Beall, Chapter 328, Statutes of 2018) established a reversion account within the Mental Health Services Fund and established the prudent reserve formula for CMHPs of no more than 33% of the CSS moneys received in the preceding five years.

In July 2020, the CSA released a report on the Lanterman-Petris-Short (LPS) Act, which focused largely on county implementation. The report focused on three counties' (Los Angeles, San Francisco, and Shasta) definitions of the criteria for involuntary holds and criteria for conservatorship, and whether the counties have consistently followed those criteria; differences in approaches among the counties; funding sources and whether funding is a barrier to implementing the LPS Act; and, the availability of treatment resources in each county. As part of the overall findings, the CSA concluded that the state does not know the extent to which billions in funding has assisted individuals with mental illness. The CSA stated that in FY 2018-19, counties received more than $7.5 billion in state and federal mental health dollars from three major types of funds: Medi-Cal; realignment; and, the MHSA. While the MHSA has the most comprehensive reporting requirements out of the three funding types, the CSA stated there is no source of consistent public reporting for the funds. Realignment funds, according to the CSA,

require some reporting, but it generally does not allow for the public to easily know how the funds are being spent or if they are helping those with mental illness. One report is not designed for public reporting, and another does not include all realignment funds. Likewise, the CSA stated that DHCS's reporting for Medi-Cal funds includes some legislatively mandated performance outcome reports, but that this reporting is insufficient for providing a comprehensive understanding of services offered by CMHPs because they are limited to the services for which Medi-Cal pays. (For instance, Medi-Cal does not pay for services provided at state hospitals for those being treated under the LPS Act.)

The CSA highlighted the MHSA as containing comprehensive public reporting requirements, but identified some issues that make it difficult for stakeholders to determine the balance of unspent funds that CMHPs maintain. For example, the CSA found that CMHPs' unspent funds after FY 2018-19, excluding funds they are permitted to reserve, represented between 73% and 175% of their respective 2018-19 MHSA revenues. The CSA stated that while some CMHPs argued that most of those funds were already allocated, it is still important for stakeholders to be able to access information about those unspent balances. One complication in being able to highlight that information is a result of DHCS changing the template it provides to CMHPs for yearly MHSA revenue and expenditure reporting, which no longer asks CMHPs to provide their total unspent funds. Additionally, according to the CSA, DHCS adopted regulations that effectively prohibit it from changing the content of the yearly CMHP reports without revising its regulations. Without that information, stakeholders and the MHSOAC are unable to completely understand MHSA funding and expenditures. As a result, the CSA recommended that the Legislature assign primary responsibility to the MHSOAC for comprehensive tracking of spending on mental health programs and service from major fund sources, and of program and service level and statewide outcome data, including CMHPs directly reporting to the MHSOAC.

Major changes under the Behavioral Health Services Act (BHSA) proposal
Generally, the MHSA already allows money to be used for SUDs, which is a mental health condition. But the proposed revamp, contained in SB 326 (Eggman) currently being considered by the Legislature, would explicitly permit counties to fund services for those with SUDs and not have to document that the person has a primary mental health condition. Other major transformations include a dedicated funding stream to bolster the public mental health system workforce and expand the allowable uses of those funds, such as for recruiting and retaining the current workforce, which consistently seeks opportunities in the private sector, and training. The proposal also places a strong focus on maximizing other funding streams, particularly drawing down federal dollars as a match for BHSA funds and ensuring that private insurance companies reimburse counties for the services they are responsible to provide. Following is a highlight of some of the major proposed changes:

Update to local categorical funding buckets: The MHSA currently requires counties to allocate approximately 20% to PEI and 80% to CSS, and 5% of those total funds for Innovative programs. The BHSA proposal would eliminate the separate PEI and Innovative funding buckets and restructure other funding in the following ways:

- 30% of the BHSA for housing interventions for individuals with serious mental illness/serious emotional disturbance and/or SUD. Counties will manage and direct the funds toward local priorities that meet designated purposes including, but not limited to, rental subsidies, operating subsidies, capital investments, and nonfederal share for transitional rent. Half of these funds must be used for housing interventions for individuals who are chronically homeless with a focus on those in encampments;

- 35% for of the BHSA for FSPs (which currently fall under the CSS bucket, with the majority of CSS funds being required to be used for FSPs) to be optimized to leverage Medicaid as much as is allowable. Counties will not report federal financial participation in the FSP bucket, only BHSA expenditures. FSPs will have an established standard of care with levels based on an individual's acuity and criteria for step-down to an FSP level that provides the greatest degree of independence and self-determination;

- 30% for Behavioral Health Services and Supports (BHSS, non FSP), Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, Innovative pilots, and prudent reserve. A majority of the BHSS allocation must be spent on Early Intervention. This proposal is one of the most controversial for some stakeholders because it lumps PEI and Innovative programs into one bucket with other categories, and no longer requires counties (only permits them) to provide PEI services or pilot Innovative programs. The Administration maintains that PEI remains a key component and a priority within the proposal. Under the BHSA, prevention and early intervention programs will maintain at least 20% of local funding: 5% for population-based prevention, and at least 15% for early intervention, since a majority of the 30% of the new BHSS component must go to Early Intervention; and,

- 5% for Population-Based Prevention for mental health and SUD prevention programming. Counties may pilot and test behavioral health models of care programs, community defined practices, or promising practices for the programs specified in all the above. The goal is to build the evidence base for the effectiveness of new statewide strategies to implement an equitable behavioral system.

Broaden the target population to include those with debilitating SUDs: The proposal authorizes BHSA funding to provide treatment and services to individuals who have a debilitating SUD but do not have a co-occurring mental health disorder, and increases access to SUD services for individuals with moderate and severe SUD. The BHSA requires counties to incorporate SUD prevalence and local unmet need data into spending plans and uses data to inform and develop accountability to improve the balance of funding for SUD.

Workforce: The MHSA provided initial state funds for Workforce Education and Training (WET), and allowed counties to use local MHSA funds as an option for WET. The BHSA proposal expands the use of local BHSA funds under the WET component to include workforce recruitment, development, training, and retention; professional licensing and/or certification testing and fees; loan repayment; retention incentives and stipends; internship and apprenticeship

programs; continuing education; and, efforts to increase the racial, ethnic, and geographic diversity of the behavioral health workforce in the public system. There will also be a dedicated allocation of state-directed funds, which includes 3% to the California Health and Human Services Agency for statewide behavioral health initiatives. This 3% is in addition to the existing 5% of BHSA revenues that are used for state directed purposes. Of this, $36 million will go to DHCS for BH-CONNECT (part of the CalAIM 1115 demonstration waiver) for workforce investments of $480 million annually and $2.4 billion total for the five-year demonstration period, pending federal approval.

Focus on the most vulnerable: The proposal focuses on adults with serious mental illness (SMI) or SUDs who are or at risk of experiencing homelessness or who are at risk of being justice involved, at risk of institutionalization, and/or meet the criteria for behavioral health linkages under the CalAIM Justice Involved Initiative, as well as adults with SMI at-risk of conservatorship. Children and youth with serious emotional disturbance or a SUD, who are experiencing homelessness, are involved or at risk of being justice involved, at risk of institutionalization, and/or meet the criteria for behavioral health linkages under the CalAIM Justice Involved Initiative or are in or transitioning out of the child welfare system are also a major focus.

Fiscal accountability, updates to county spending, and revise county processes: The BHSA proposal requires counties to bill Medi-Cal for all reimbursable services in accordance with Medicaid State Plan and applicable waivers to further stretch scarce dollars and leverage BHSA to maximize federal funding for services. Counties are required to maximize funding from other sources, such as private insurance, and will be required to make a good faith effort to contract with commercial health plans. Counties will be able to report to regulators their complaints about a health plan's failure to work in good faith and/or failure to timely reimburse for services for which they are responsible. The proposal reduces allowable prudent reserve amounts from 33% to 15% for large counties and 20% for small counties and requires a reassessment of the prudent reserve more frequently from every five years to every three years. The BHSA proposal authorizes up to 2% of local BHSA revenue to be used for administrative resources to assist counties in improving plan operations, quality outcomes, reporting fiscal and programmatic data, and monitoring subcontractor compliance for all county behavioral health funding. The BHSA proposal includes a more comprehensive community planning process and county reporting to reflect all public behavioral health spending through the development of an Integrated Plan for Behavioral Health Services and Outcomes (which replaces the current three-year plan required of counties) that reflects uses of BHSA funding, as well as other funding. Counties will still be required to submit integrated plans every three years with annual updates (required under the MHSA). This BHSA proposal enhances county reporting of behavioral health spending, regardless of source of funding, and county reporting behavioral health outcomes.

Bond: The BHSA proposal also includes a $4.7 billion bond, contained in AB 531 (Irwin) currently being considered by the Legislature, to build more behavioral health treatment settings, including residential programs, and to build an estimated 1,800 supportive housing units, and 1,800 interim, transitional, and supportive housing units specifically for veterans experiencing or

at risk of homelessness who have behavioral health conditions. The Administration envisions that these residential settings will include multi-property settings like residential campus-style settings where multiple individuals can live, attend groups, recover, and further stabilize with a number of onsite supportive services. Another example would be cottage settings, where smaller residential settings provide many services but will also allow individuals to access existing services in the community. This proposal also requires a ballot initiative and voter approval.

Stakeholder concerns

The BHSA proposal, particularly the elimination of PEI and Innovation as separate funding buckets, is causing anxiety among some stakeholders. Children's advocates estimate the MHSA spends at least $700 million annually on children and youth, and under the BHSA proposal, there is no required spending for those populations. They further argue that some of the CalAIM improvements have been slow to roll out or have yet to be implemented. They applaud the state's investment in the CYBHI, but point out that most of those dollars are one-time funds. They maintain that it is premature to reroute funds from the MHSA because we have yet to fully realize and understand the impact of the investments in CalAIM and CYBHI. Lastly, concerning the proposed BHSA housing intervention bucket (which will prioritize the chronically homeless with an emphasis on those living in encampments), these advocates want unaccompanied youth to be prioritized as well. Education advocates agree with children's advocates on the points about the recent one-time investments the state has made. They state that if the priorities and funding categories for MHSA are amended in the way the BHSA proposal intends, most counties are likely to cut or eliminate their school-based programs and youth-focused services.

Racial equity advocates have similar concerns and are united behind the goal of preserving the current requirements for local funding of PEI and Innovation components. While the BHSA proposal includes a 5% for Population-Based Prevention programs, they argue that it is inadequate, and believe the state should not abdicate its leadership on this vital issue. They state that community-based providers currently using PEI funds for certain programs, like school-based mental health services where clinicians provide individual therapy to consumers/families, will be ineligible for this 5% because they serve individuals and are not population based.

County behavioral health directors state that the BHSA proposal will have the unintentional result of dramatically reducing the level of funding currently being spent on core mental health services, particularly funding for outpatient, crisis, and recovery services, which will destabilize consumers, and drive worse outcomes for the medically complex and vulnerable populations served through the county behavioral health safety net. They also argue that the addition of SUDs will further limit the availability of funding that is used to support county mental health services programs. This drop in funding is compounded by the historical lack of growth in 1991 and 2011 realignment, and county behavioral health funding is not tied to caseload or need. They would like to see the BHSA proposal allow for greater flexibility within funding categories, to allow counties to build funding levels according to local needs and priorities, rather than require spending according to fixed percentages and subcategories; require counties to prioritize certain programs and populations within proposed spending categories, rather than direct fixed percentages to allow counties to more flexibly tailor programs and services up and down the

continuum of care; and, avoid further restricting and diverting funds by imposing new funding requirements that will further restrict and limit the availability of funding for core outpatient, crisis, and recovery services. They state counties embrace the concept that housing is an essential part of supporting clinical and psychosocial recovery interventions. However, the proposal to earmark a third of the BHSA funding to pay for housing would require a much larger share of funding to be dedicated to housing and with more restrictions.

Considerations

The Newsom Administration's BHSA modernization proposal represents the biggest change to the MHSA in almost 20 years. As this dedicated funding source has become a sole source to support nontraditional services relied on by many communities that have historically been under- and unserved by more restrictive funding sources, the proposed changes have made a number of stakeholders nervous about the future. As the proposal works its way through the legislative process, and stakeholders express their concerns, there has been an understanding that some additional flexibilities may have to be included. This informational hearing will help bring to light some of the concerns and some of the improvements the Administration hopes this proposal will bring about.

Questions the Legislature should consider: Will eliminating the PEI bucket drastically reduce services for some of the most vulnerable communities, or will the BHSA proposal provide greater opportunity for counties to provide an array of services by ensuring they maximize funds by actively seeking federal financial participation, and holding private insurers accountable for the services they are responsible for providing? Will the proposed expansion of funds for workforce purposes help address the dwindling behavioral health workforce that has evaded the state for many years? Should counties be given flexibility in determining percentages for funding buckets, like housing interventions, when counties can demonstrate that the local need does not necessitate that level of funding dedication? Will encouraging contracting between counties and health plans/insurers be effective to maximize other funding streams for counties?