MHSOAC
Mental Health Services
Oversight & Accountability Commission

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Governor Newsom's Behavioral Health Modernization Proposal

Introduction

California's mental health system is among the most comprehensive and outcome-driven in the nation, yet it falls short of public expectations. The challenges of our mental health system drive feelings of hopelessness for the clients and families seeking services and deep frustration among the public who witness its outcomes and taxpayers who fund public programs.

The challenges are many:

- Increasing numbers of unhoused residents – many with unmet mental health and substance use needs.
- Gaps in access to care, particularly for Californians in the early stages of psychosis or other mental health and substance use needs.
- Over-reliance on law enforcement to respond to mental health needs.
- Large and ongoing annual increases in spending on institutional care, particularly for justice involved individuals.
- Persistent and pernicious disparities that expand the health, economic and life expectancy gaps that adversely impact California's communities of color, LGBTQ+, and others.

These and other challenges have prompted Governor Newsom to propose reforms to California's landmark Mental Health Services Act and to propose broad reaching reforms to California's behavioral health system, which encompasses mental health and substance use disorder (SUD) needs.

The Governor's Behavioral Health Modernization Proposal has several components. This analysis focuses on the reforms proposed in Senate Bill 326 (Eggman), which does the following:

- Renames the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA) and clarifies that BHSA funding can be used to support substance use disorder services in addition to traditional mental health care.

- Modifies how BHSA funding can be used by counties, with the following funding allocations:
  - Thirty percent for housing interventions for children and adults with serious mental health needs, including substance use disorders. Existing fiscal rules allow but do not require funding for housing interventions.
  - Thirty-five percent for Full-Service Partnerships (FSPs) which provide a range of recovery-oriented services targeted to individuals with severe and persistent mental health needs who are unhoused, at risk of becoming unhoused, justice involved or hospitalized. Under current MHSA requirements, a minimum 38 percent of MHSA funds must be dedicated to FSPs, with the option to spend more.
  - Thirty percent for Behavioral Health Services and Supports, which include non-FSP services, Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, innovative, and funding to support a prudent reserve. A majority of these funds – a minimum of 15 percent of total funding - must be spent on early intervention strategies. Under current law 19 percent of MHSA must be used for prevention or early intervention.
  - Five percent for Population-Based Prevention for mental health and substance use disorder prevention programming. As noted above, under current law 19 percent of MHSA funding must be spent on prevention and early intervention with counties having the authority to determine how those funds are distributed between prevention and early intervention.
- Proposes a more comprehensive community planning process to reflect all public behavioral health spending and the development of an Integrated Plan for Behavioral Health Services and Outcomes that reflects uses of the newly renamed BHSA funding, as well as other funding.
- Enhances county reporting of behavioral health spending, regardless of source of funding.
- Enhances county reporting on mental health and substance use outcomes.
- Sets aside three percent of total revenues to support state-directed initiatives to expand California's behavioral health workforce. Under existing MHSA rules, counties have the option to use their MHSA funds to support workforce, education, and training programs as part of their three-year MHSA expenditure plan, but there is no specific funding set aside for that purpose. The Governor's proposal would shift three percent of total funds from counties to the state for workforce purposes.

- Reforms to the MHSA are intended to be integrated with a range of related initiatives designed to draw down more federal funding for mental health and substance use disorder services, improve crisis response and enhance prevention and early intervention strategies.

  The Governor also is proposing a $4.7 billion bond 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 for veterans.

  These reforms would be subject to voter approval through a ballot measure scheduled for a public vote in March 2024.

Issues for Consideration

The Governor's Behavioral Health reform proposal is aligned with the Commission's work in several areas, and it creates opportunities the Commission may wish to consider that would strengthen the proposal.

1. Recognizing Complexity – Reserve the Ability to Modify Provisions Over Time

Background. The Governor's proposed reforms are complex and will take considerable time to implement, particularly as reforms established through the ballot interact with new waivers under Medicaid, other statutory changes, and new operational approaches.

Concerns. The proposed reforms will have unintended consequences and unanticipated challenges. The Commission may wish to encourage the Governor and Legislature to:

- Use the ballot only for those reforms that require a public vote, and

- Affirm the ability of the Governor and Legislature to modify the language adopted at the ballot on an as needed basis without returning to the ballot.

The initial MHSA includes a provision allowing legislative modifications consistent with the Act. That provision is in place because the MHSA was established as an initiative measure, not a legislative ballot measure. The proposed reforms are being put on the ballot by the Legislature. The Commission may wish to encourage the Governor and Legislature to retain reform authority for ballot language, even when reforms are not consistent with the initial intent of the ballot, ensuring their ability to act when additional reforms are needed.

2. Substance Use Disorder – Enhancing Access to Services

Background. The Governor's proposal is intended to improve the integration of mental health and substance use disorder services, consistent with the concept of behavioral health. The proposal would clarify that BHSA funding can be used to support SUD services and

require counties to include substance use disorder services in their three-year comprehensive planning. Substance use disorders are mental health disorders but California's mental health system has not integrated SUD services into mental health care. Recognizing that SUD needs are mental health needs, the Commission has sponsored and supported legislation to clarify that MHSA funding can be used to support SUD needs, including for prevention and early intervention. While substance use disorder services are included under established definitions of mental health needs, the Governor's proposal would clarify that funding established under the BHSA can be used for the full range of SUD services and calls for more integrated planning and service delivery.

Concerns. The state and local behavioral health partners have struggled to fully integrate mental health and substance use services. While the proposal would clarify that BHSA funds could be used to support SUD services, and the reform proposal requires integrated planning, the proposal is unclear on how it would improve the integration of mental health care with substance use programs at the local level. The State is working through a range of initiatives, including administrative integration under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, yet it is not clear that community providers are positioned to integrate services and the reform proposal does not include an implementation plan to ensure that care delivery is integrated in alignment with the proposed policy changes.

Mental health advocates have suggested that the proposed reforms would place greater demands on limited mental health funding, with existing dollars being newly tasked to address workforce and housing needs related to substance use disorders where there is no co-occurring mental health need. It is unclear if the proposal envisions the integration of current SUD funding along with BHSA funding, which could result in improved efficiencies through stronger care integration.

While the proposal calls for robust community engagement, planning, transparency and accountability at the local level, the Commission may wish to explore whether statutory reforms authorizing expanded use of BHSA funding for SUD services will be accompanied by a robust community engagement and strategic planning process at the state level to promote the full integration of mental health and SUD services over time, including fiscal, workforce, licensing, technical assistance, data collection, research, oversight, and outcome reporting.

The behavioral health integration vision of the proposal is consistent with the Commission's priorities and the Commission may wish to encourage a robust state-level planning process – with substantial technical assistance and support for mandatory local integrated planning efforts – and offer to support those efforts.

3. Full Service Partnerships– Increasing Emphasis

Background. Full-Service Partnerships (FSP) were initially designed to support mental health clients who were served in state hospitals under civil commitments. The "whatever it takes" approach that characterizes FSPs has been demonstrated to be an effective model for

reducing homelessness, justice involvement and hospitalizations. The MHSA currently requires 76 percent of MHSA funding to be dedicated to Community Services and Supports, with state regulations requiring a “majority” of those funds, or a minimum of 38 percent of overall MHSA funding, to support Full-Service Partnerships.

The Governor’s proposal requires counties to dedicate 35 percent of ongoing BHSA revenues for FSPs, which amounts to a minimum three percent reduction in FSP investments. As outlined in the box below, almost all counties fall short of meeting the majority threshold for FSP investments today. As a result, for some counties, the new spending rules would result in additional investments in FSPs, for others it may result in lower FSP spending.*

The Commission has sponsored legislation to strengthen state attention on the operations and impact that FSPs have on state-level outcomes, namely homelessness among persons with serious and persistent mental health needs, justice involvement and hospitalizations.

State hospitalization trends are of particular concern, as the state has seen dramatic increases in the clients served and state spending on programs for persons deemed Incompetent to Stand Trail (IST). In Fiscal Year (FY) 2017-18, there were 1,827 persons deemed incompetent to stand trial; it is estimated that in FY 2023-24, there will be 4,298. Generally, persons deemed IST with felony charges are directed to state hospitals for competency restoration before their felony charges are pursued through the judicial system. Research from the Department of State Hospitals indicates that nearly half of mental health clients have an average of 16 arrests before the felony charge that led to their placement in a state hospital. The Department also reports that fewer than half of those clients received community based mental health care in the six months prior to their state hospital placement.

The Commission’s work to fortify Full Service Programs began with the state’s $5 million investment in an Innovation Incubator, that focused on reducing Justice involvement, and

*As outlined in the Commission’s 2023 report on Full-Service Partnerships, in 2012 the then Department of Mental Health issued an Information Notice allowing counties to reduce their MHSA allocation for FSPs as long as they met the “majority” funding threshold with other sources of funding, namely federal Medicaid reimbursements. The Information Notice stated that the exemption from the minimum funding standard applies only to the 2011/12 Fiscal Year. In 2021 the Commission notified the Department of Health Care Services that counties were not meeting minimum funding thresholds as required by state regulations. The counties countered that the exemption in the Information Notice remained in effect because the Department of Health Care Services never issued a subsequent Information Notice ending the exemption, despite the clear language in the original Notice. Additionally, counties have expressed confusion over whether the “majority” threshold reflects a majority of revenues or expenditures, which can vary widely in some counties.

reducing state hospital utilization and costs. Nine counties participated in that work and the Commission continues its work to strengthen FSPs in partnership with diverse counties.

Concerns. While the Governor's proposal elevates the significance of FSPs, the fiscal set-aside for these programs will be reduced in some counties. Additionally, although the reform proposal calls for the Department of Health Care Services to ensure a minimum set of standards for FSP programs, the Department has not consistently enforced mandatory minimum spending requirements or developed the technical assistance and training capacity to support local FSP providers. The Commission has alerted the Department to deficiencies in county spending on FSPs, without substantive response. It is unclear how the Department intends to enforce both spending and service requirements for FSPs under the Governor's proposed reforms.

Given the extraordinary investment the state is making in Full Service Partnerships, which would be approximately $1-$2 billion annually under current MHSA revenue projections, the Commission may wish to explore with the Governor and Legislature whether the state should invest in sustained technical assistance, training, return on investment analyses, and related evaluations to ensure that the mandatory investments in FSPs have the desired results. Increased state attention on the operations and impact of Full Service Partnerships should be intended to result in improved client outcomes, reductions in homelessness, incarceration, and hospitalizations, with the long-term goal of reducing state and local costs in these arenas. The most ambitious goals for FSP programs are to move mental health clients into independent employment that generates sufficient income to achieve self-reliance, avoid homelessness and secure health insurance.

The Commission may wish to consider how best to fortify the Governor's proposal to strengthen the capacity of the state and local behavioral health agencies and their community partners to ensure FSPs achieve their intended outcomes: 1) reduce homelessness, 2) reduce justice involvement, and 3) reduce hospitalizations, with a secondary goal of supporting client employment.

4. Homelessness – Establishing Mandatory Spending

Background. The Governor's proposal will require counties to dedicate thirty percent of BHSA spending on homelessness, including rental subsidies, and related strategies. The MHSA currently authorizes counties to use existing revenues to address housing needs, with a specific mandate to reduce homelessness. Under the MHSA, counties have considerable discretion in how to use these funds, including supporting a range of housing strategies, particularly for, but not exclusively for, those served through FSPs.

Despite the statutory goal of preventing homelessness, county behavioral health agencies may be ill equipped to address the factors that result in mental health clients being unhoused.

A recent survey by UC San Francisco reported high housing costs, more than addiction and unmet mental health needs, as the primary driver of California's homelessness crisis: https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf

Concerns. Inadequate access to mental health and SUD services, combined with frequent justice involvement clearly contributes to homelessness, while a large percentage of unhoused people say they face repeated barriers to care.
It is unclear how the Governor's proposal will result in improved interventions for unhoused persons outside of the expansion of Full-Service Partnerships or direct housing supports, and more significantly for the prevention of homelessness.

For example, the Governor's proposal includes 30 percent of MHSA revenues for Behavioral Health Supports, with a majority of those funds supporting early intervention. It is unclear if those funds would be used to support early interventions to address risks for homelessness, particularly for vulnerable populations such as youth and young adults exiting from the child welfare system.

The recent UCSF report indicates that few people experiencing homelessness are able to access prevention services before they lose their housing, and many leaving institutional settings, such as jails or prisons, should be receiving housing support as they transition out of institutional settings. It is unclear whether the funds set aside for housing can be used for prevention strategies.

Additionally, the state has not invested in understanding the link between improved access to behavioral health services and housing access and housing stability. As a result, it is unclear if establishing mandatory funding levels for housing supports will result in measurable and sustained reductions in the number of mental health clients who are unhoused. One challenge to that analysis is limited data on how counties are using MHSA funds today to support housing, and how the shift of these funds from existing programs to housing supports may undermine the success of the initiative as fewer funds are available to support the services needed to support clients to retain their housing.

It also is unclear how the new funding mandates will impact the ability of counties to sustain their long-term commitments to supportive services associated with the state's No Place Like Home (NPLH) program. In 2018, California voters passed a ballot measure authorizing the sale of $2 billion in bonds to enact a supportive housing program for mental health consumers, with MHSA revenues repaying those bonds at an annual cost of approximately $140 million.

According to the most recent NPLH Annual Report issued by the California Department of Housing and Community Development (HCD), the state has distributed approximately $1.9 billion in NPLH bond funds, has housed 523 Individuals in 498 housing units. HCD estimates that NPLH will result in 7,852 NPLH-assisted units.

It is unclear if HCD has calculated the ongoing fiscal commitment the counties have made to offer supportive services for those units when fully built and whether counties will have sufficient funding or fiscal flexibility to maintain their NPLH commitments and meet the fiscal requirements of the proposed BHSA.

It also is unclear what impact counties will face when they are required to shift 30 percent of their existing expenditures from current uses toward housing. Such a fundamental change could be disruptive to their ability to not only respond to this new mandate, but also to continue to provide the other services called for under the MHSA/BHSA. A more gradual implementation of this commitment to spending on homelessness could make it much more manageable for local communities.

The Commission may wish to consider:

- Whether the Administration has developed an operational plan to guide county use of the 30 percent housing set-aside being proposed.
- Whether the state will provide technical assistance and support to counties to ensure the best use of those funds and how anticipated reporting requirements will allow the state, counties, and service providers to understand the most cost-effective approaches to housing, resulting in long-term sustainable housing stability.
- How the state can best support homelessness prevention and early intervention strategies, such as direct cash assistance, for both transition age youth at high risk, and older adults who face similar risks for being unhoused, but also for Californians leaving institutional settings, such as hospitals, jails, and prisons.
- Whether the state is exploring the use of fiscal incentives for prevention and intervention strategies that reduce the number of unhoused persons, such as improved child welfare investments, childcare, and job training to improve income opportunities or income supports, such as universal basic income initiatives for high-risk groups.
- Whether the state is exploring enhanced access to early psychosis interventions, improved criminal justice diversion and related strategies that reduce barriers to employment – paired with greater investments in affordable housing – as a way to reduce costs and improve housing outcomes.

The Commission may wish to explore opportunities to strengthen the Governor's proposal by recommending the development of an operational strategy to ensure the proposed statutory reforms are matched with technical assistance, research, evaluation, collaborative learning opportunities and outcome reporting to support sustained success.

The Commission also may wish to explore the following approaches to easing the transition to the new housing requirements:

- Establish a baseline for MHSA/BHSA spending (not funding) beginning with the 2021-22 fiscal year and require counties to dedicate a majority of revenue growth above that spending base to address housing needs for clients with serious and persistent behavioral health needs. Based on Department of Finance estimates, this proposal would generate $1.5 billion - $3 billion in immediate funding to support housing. The state could support that investment with robust research and technical assistance on best practices and outcome reporting.

- Establish a 3-year transition approach to shift 30 percent of existing mental health funding to support housing. The first year following enactment of the BHSA, counties could be required to increase their housing investments by a minimum of 10 percent to support housing, 20 percent in the second year, with the goal of reaching the 30 percent funding level within three years – and maintain that investment until such time as the county has substantially met the housing needs of mental health clients, at which point investments could be reduced.

These two approaches would enable the state to accelerate new investments in housing while allowing counties three years to learn how to best invest limited funds to address housing needs and how to evolve their spending programs to adhere to the new fiscal requirements.

5. Early Intervention – Elevation

Background. Consistent with the comments above, the Governor's reform proposal calls for the "majority" of the 30 percent set aside for Behavioral Health Services and Supports funding to be dedicated to early intervention efforts. The Commission has been working to promote early intervention, namely for persons in the early stages of psychosis, through youth drop-in programs and through the development of robust school mental health partnerships between local education agencies and county behavioral health agencies. The Governor's proposal is consistent with the Commission's work in these areas.

Concerns. It is unclear how the establishment of new fiscal requirements will result in greater attention on early intervention strategies. Under existing fiscal rules, counties are required to invest 19 percent of MHSA funds in prevention and early intervention strategies with half of those funds supporting programs for children and youth. The state requires the counties to invest in stigma reduction activities, access to care services and care linkages programs to better connect people to services. Despite those limited requirements, fiscal rules allow counties to invest based on the priorities determined through a local community planning process, including what portion of the 19 percent is used for population or individual prevention efforts and what portion is used for early intervention. It also is important to recognize that the distinctions between prevention and early intervention are not always clear.

The Governor's reform proposal would require counties to invest a minimum of 15 percent of BHSA funds in early prevention and 5 percent in population level prevention. The reform proposal, from a fiscal perspective is substantially similar to existing law – 20 percent under the reform versus 19 percent currently.

For some counties, depending on how they are using existing funding, there may be no difference between existing uses of MHSA funding and funding uses under the proposed BHSA. Under current reporting rules, counties are not required to differentiate between prevention and early intervention spending, and as above, the distinction between those two efforts is not always clear, so we are unable to document whether the reform will result in the establishment of new funding priorities.

The behavioral health reform proposal also highlights the potential for counties to invest in best practices for early intervention for psychosis, but it does not make it a requirement. Research suggests that California has the capacity to support just 10 percent of the residents who develop psychosis within 12 months of their first psychotic episode. Despite evidence that unmet needs associated with psychosis are fueling dramatic state cost increases, the state has not consistently leveraged its available funding, including federal block grants dedicated to early psychosis and publicly funded premiums for health coverage, to promote the expansion of best practices in responding to early psychosis needs.

Through the CYBHI, the Department of Health Care Services and the Commission are partnering to release Evidence Based Practice and Community Defined Evidence Practice funding for early interventions, including for early psychosis and youth drop-in programs.

The state's investment in the allcove™ youth drop-in program is intended to improve access to care during the vulnerable "transition age" period when research suggests mental health needs are mostly likely to develop. Allcove™ youth drop-in centers may be a loss-leader, and should be considered as such. Although the programs may not be fully supported with reimbursement funding, as youth-centric programs they can address stigma, meet immediate needs, engage youth in program planning and build a foundation of understanding and trust to support access to services during the early stages of mental health needs. Currently, a limited range of allcove™ services can be billed under MediCal. The reform proposal, because of its emphasis on MediCal billing, may undermine efforts to expand the adoption of this globally recognized early intervention program – as well as others.

Although the Governor's reform proposal highlights the opportunity for early intervention, it is unclear if the administration is planning to provide guidance on which early intervention opportunities offer the greatest potential for return on investment, how best to align population-based prevention opportunities with early intervention strategies, how to develop a research, evaluation and data analysis strategy to identify new early intervention approaches that target vulnerable populations such as veterans, child welfare participants,

older adults, persons exiting from correctional institutions, state hospitals or other locked settings, or others.

The Commission may wish to explore these opportunities with the Administration, as well as whether the state is proposing to expand technical assistance and training programs, capacity-building investments, the availability of incentive funds to encourage counties to put greater emphasis on early intervention using local funds and how the state will document the impact of these policy changes. For example, the state has an opportunity to replicate the Child and Youth Behavioral Health Initiative – with its emphasis on digital strategies, improved program integration and incentive funding –yet with a focus on reducing disparities and/or adults and older adults.

The Commission may also wish to explore with the administration whether the BHSA would retain the requirement to invest a majority of early intervention funding in children and youth, as is currently required. Children's advocates have raised alarms that the proposed reforms may undermine the progress that has been made in child and youth focused initiatives, especially when recognizing that the majority of mental health needs occur early in life.

6. Prevention – A Core Behavioral Health Strategy

Background. As mentioned above, the Governor's proposal would set aside five percent of BHSA revenues for population-based prevention strategies that focus prevention efforts on an entire population or sub-population within a community. Under current law counties are required to dedicate 19 percent of their MHSA revenues for prevention and early intervention, including support for stigma reduction, outreach, and awareness. As with early intervention funds, current law does not determine how counties should allocate funding across prevention or early intervention strategies. The proposed legislation indicates that prevention funds could not be used for individual level prevention efforts, although it is unclear in the legislation what constitutes an individual prevention effort as compared to a population-level prevention effort.

Under current law, the Commission is authorized to issue regulations on the uses of prevention and early intervention funding under the MHSA and the Commission and the Department of Health Care Services each have a role in promoting effective strategies. Recognizing the Commission's authority, and building upon robust community engagement efforts, the Commission has issued Prevention and Early Intervention regulations that call for improved data reporting and monitoring of disparities and has recommended that the Department implement those reporting standards across the entire mental health system.

The Commission also has long championed stronger prevention and early intervention efforts and recently released a report on leveraging a public health model to support prevention and early intervention. The Commission has issued reports and policy recommendations on criminal justice prevention, suicide prevention, school mental health, and workplace mental

health. Each of these efforts provides a foundation, strategies, and priorities for population-based prevention strategies.

As the Governor's proposal moves prevention strategies from county-driven, local initiatives, to population-only initiatives, it is unclear how individual county investments will differ from existing efforts. The Commission may wish to explore if population-level strategies are better suited to state-level investment and leadership instead of 59 unique county-level, population-based prevention strategies.

For example, at the start of the COVID pandemic, the Department of Health Care Services and the Commission partnered to develop the CalHOPE initiative and the Wellness Together component that focuses on mental health. In the current budget year, state MHSA funds are dedicated to sustaining the CalHOPE program and the Children and Youth Behavioral Health Initiative includes funding to support an on-line mental health information and screening platform and stigma reduction efforts.

These initiatives suggest that population-level prevention opportunities may be better suited to state-level investments.

Under the Governor's reform proposal, regulatory authority over prevention and early intervention would shift from the Commission to the Department. The Legislative Analyst has raised concerns that limiting the Commission's role in this way will, in effect, undermine its independence and value.

The Commission may wish to consider ways to strengthen the Governor's proposal, including:

- Whether to encourage the state to develop a strategic approach to population-based prevention, that leverages federal, state and county investments, taps into the private sector, leverages education, workplace, and related venues, and is integrated into similar public health-informed prevention campaigns, such as smoking cessation, addiction, healthy eating, healthy sleep habits and other related health and mental health prevention initiatives.
- Whether to delay one or more components of the reform to allow time to analyze how the changes in fiscal support for prevention and early intervention will be implemented by counties, the services that will be reduced or eliminated, how population-based prevention efforts will be defined and implemented and the anticipated improved outcomes.
- How the state can best support population based prevention strategies, including the respective roles of the Department of Health Care Services, with its expertise and staff dedicated to mental health finance and oversight, and the Department of Public Health, which currently administers a range of prevention-oriented programs that target many of the communities at risk for mental health needs, and the Commission,

recognizing its independence, ability to engage diverse communities, distribute grant funds and monitor outcomes.

- Exploring the value of allowing flexibility across the proposed BHSA components, including prevention and early intervention, particularly for small and medium-sized counties, to maximize resources and meet the diverse needs of communities across the state.

7. Fiscal Rigidity – New Challenges

Background. The Governor's proposal establishes new, discrete funding allocations that call for very specific levels of funding based on percentages of revenue received. Under existing law, the MHSA has three primary funding components, Community Services and Supports, Prevention and Early Intervention, and Innovation, with the option of moving funds into components for workforce, capital needs and a prudent reserve.

Overlap between the existing MHSA components allows counties to make funding decisions based on local needs with guidance from a community planning process. Counties have considerable discretion in how existing MHSA funds are used because there is functional overlap between the three core components of the Act. For example, Prevention and Early Intervention funds can be used to provide treatment for up to four years, in some instances, including services that also can be funded with Community Services and Support dollars. While this flexibility makes it difficult to track spending in each component, it supports dynamic decision-making and allows counties to determine how to best use limited funds based on diverse and evolving needs.

Concerns. While the proposed reforms suggest the California Department of Health Care Services will have discretion to allow counties to propose alternative funding allocations in limited instances, it is unclear how the four discrete spending categories under the BHSA will work for the state's diverse counties. For example, it is unclear how California's smallest counties, which may have no FSP providers, or in the case of Alpine, do not have clients qualifying for FSP services, will be disparately impacted by these new rules. It also is unclear to what extent the Department will be able to exempt individual counties from a mandatory expenditure percentage.

To strengthen the Governor's reform proposal, the Commission may wish to explore an alternative approach that would provide counties with greater flexibility on how they use BHSA funding. The Commission may wish to explore ways to authorize the Department of Health Care Services to grant an exemption from the mandatory BHSA funding allocations. Exemptions could be limited to counties that can demonstrate that deviation from the statutory funding levels is more likely to result in improved outcomes, with an emphasis on reducing homelessness among mental health clients.

Alternatively, the Commission might explore the value of authorizing counties to spend BHSA funds across a range of percentages for each component, such as 20-30 percent for housing,

25-35 percent for Full Service Partnerships, 20-40 percent for Behavioral Health Services and Supports and 5-10 percent for Population-level Prevention.

8. Accountability – Focus

Background. The Governor's reform proposal re-establishes existing law in Welfare and Institutions Code (WIC) Sections 5610-5613, and Section 14707.5, that require the Department of Health Care Services to establish performance measures, data systems, quality improvement strategies and ensure that county mental health programs are meeting minimum standards. These reporting strategies were supposed to be developed in consultation with diverse communities, work to reduce disparities and be updated as needed. County mental health programs also are required to submit data to the state as required by the Department of Health Care Services to support public accountability (WIC § 5610).

Under current law, state agencies also are required to provide data to the Commission upon request. Under proposed reforms, state agencies would not be required to submit such data to the Commission but would have the discretion to determine whether the Commission should receive this data.

Similarly, under current law, the Commission is charged with overseeing California's children's system of care, the adult system of care, and the older adult system of care, which collectively make up the entire California public mental health system (WIC § 5845(a)). The Commission also has regulatory and oversight authority for prevention, early intervention, and innovation (WIC § 5845(a)). Moreover, the prevention and early intervention language of the MHSA calls for reducing school failure, criminal justice involvement, unemployment, suicide, child welfare involvement, homelessness, and prolonged suffering.

Those broad goals extend beyond the traditional roles of local behavioral health departments and have authorized the Commission to explore school mental health, workplace mental health, the impacts of firearm violence, criminal justice diversion, suicide prevention and other topics that are key to supporting broad individual and community wellbeing, consistent with the language of the MHSA.

The Governor's reform proposal would remove statutory references to the Commission's oversight of California's three systems of care, it would eliminate the Commission's direct role in supporting prevention and early innovation initiatives, and it would eliminate the mandate for innovation spending and thus the need for Commission review and approval of innovation projects.

Concerns. Despite clear and compelling statutory requirements, the Commission and other mental health partners have raised concerns that the Department has not assertively pursued its accountability mandate. In 2017, the Commission alerted the Department of Health Care Services that counties are not consistently reporting MHSA revenues, expenditures, and

unspent funds, were not utilizing MHSA funds under statutory deadlines, and that reversion requirements were not being enforced. A subsequent audit revealed more than $2.5 billion in unspent and unreverted MHSA funding.

While the Department has strengthened its monitoring of funding reversion requirements, it has not improved its attention to other fiscal concerns. In 2022 the Commission alerted the Department that counties are not consistently meeting expenditure requirements for Full Service Partnerships. The Department also has failed to enforce county spending rules that require Commission approval for the use of MHSA innovation funds. Similarly, the Department has not consistently made data available on county mental health outcomes, such as disparities. Despite its statutory authority to receive data from the Department of Health Care Services, the Commission faces significant delays in receiving data or data are incomplete, despite state laws requiring counties to report such data. It is not clear that the Department has consistently updated its data reporting requirements and systems as envisioned in the Welfare and Institutions Code, undermining the value of existing accountability systems.

The reform proposal calls for the Commission to administer grants, identify key policy issues and emerging best practices, and promote high-quality programs implemented through the examination of data and outcomes, leaving it unclear what the role of the Commission would be as an independent "oversight and accountability" entity.

The proposal calls for the Commission to advise the Department and Agency on their accountability initiatives, but it is unclear if the reform proposal would result in fundamental changes to Commission staffing, research and evaluation functions, its authority to sustain its fiscal, programmatic and outcome transparency work and other strategies for fortifying broad public accountability for transformational change in our mental health system.

It also is unclear if the proposal would result in expanded investments in the Department of Health Care Services and its capacity to stand up more robust accountability systems.

The changes proposed by the Administration have raised concerns among some mental health partners that the reforms would weaken existing accountability efforts, particularly independent accountability and hinder the ability of the public and policy makers to understand how well California's mental health system is working and what investments or reforms may be warranted.

The Commission may wish to consider strategies to fortify the Governor's reform proposal, consistent with his calls for improved accountability, including:

- How the Commission can best support the Administration to outline explicit steps to strengthen the Department's oversight of mental health spending, uses of unspent funds, including investments to address homelessness, child welfare involvement, criminal justice involvement, educational failure and the other key outcomes that are the target of prevention and early intervention initiatives as outlined in the BHSA.

- How the Commission, and other entities such as local behavioral boards and the California Behavioral Health Planning Council, the Council on Criminal Justice and Behavioral Health, the Child Welfare Council, external quality review organizations, and other entities can fortify the oversight and accountability championed by the Department of Health Care Services, while emphasizing the work of independent oversight entities.
- How the Administration is proposing to support community engagement – and how the Commission can support that work – to develop new and relevant outcome reporting strategies, the replacement of legacy data systems and improve transparency strategies to ensure that performance and outcome data are relevant, timely, responsive to community needs and used to inform fiscal, programmatic, and related decisions at the state and local levels.
- Why the Administration is proposing to reduce the Commission's access to relevant mental health related data and what policies and procedures the Administration is proposing to ensure the Commission can continue to play an essential advisory and oversight role.
- How the reform proposal could be modified to enhance the oversight opportunities of the Commission and of local behavioral health boards to encourage public understanding of mental health outcomes and enhance public trust that limited behavioral health dollars are being well spent.

9. Minimum Standards – to be Established

Background. The Governor's reform proposal calls for minimum standards for Full-Service Partnerships, MediCal and commercial insurance billing, and may result in new minimum standards under new authorities granted to the Department of Health Care Services to establish program responsibilities or priorities. As stated above, under current law, counties have considerable discretion on how to organize services and where to prioritize investments. For example, fiscal rules require counties to spend a "majority" of community services and support funds on FSPs, and to spend at least 51 percent of prevention and early intervention funding on children and youth. But counties retain authority to spend more than the minimum in these areas and they are also required to pursue a robust community planning process to determine spending priorities.

Concerns. The reform proposal may result in conflict between statewide requirements for specific programs – at the discretion of the Department of Health Care Services – and county needs and priorities as determined by community members. The reform proposal is intended to ensure that counties respond more effectively to unmet mental health needs, but it is not clear how new fiscal mandates – with minimum standards – will result in better outcomes, particularly in response to diverse needs across 59 local behavioral health agencies.

Prior to the MHSA, state fiscal rules often resulted in what became known as "one size fits all" decisions that were difficult to implement across diverse counties, poorly aligned with the

needs of diverse communities, and undermined efforts to both integrate care and tailor responses to individuals.

Critics also have raised concerns that minimum standards create incentives for compliance, rather than creating support for continuous improvement and annual enhancement of outcomes.

To strengthen the Governor's proposal, the Commission may wish to explore whether establishing minimum standards is the most effective strategy for promoting system improvement and achieving better outcomes. The Commission may wish to explore if there are other strategies, particularly creating fiscal incentives, establishing multi-county learning collaboratives, enhancing data analysis and the calculation of returns on investment or cost avoidance for specific programs, or expanding investments such as the child and youth behavioral health initiative with a focus on disparities and/or adults and older adults, or other approaches that can improve outcomes, in addition to or in place of minimum standards.

10. Workforce – Opportunity Prioritization

Background. The behavioral health reform proposal would expand investments in workforce opportunities by setting aside three percent of total revenues for workforce to be administered by the state. Under current requirements, the state allocates funding for workforce on an annual basis using the state's portion of MHSA revenues or other funding. Counties also are allowed to fund workforce, education, and training efforts with local resources and can shift up to 20 percent of their MHSA community services and supports funding those and other efforts.

The reform proposal would establish an ongoing revenue stream for workforce needs, shifting three percent of annual funding from the counties to the state. Based on recent MHSA revenue reports for the 2021-22 fiscal year the three percent set aside for workforce would generate approximately $163 million per year in funding. MHSA revenue projections for the 2022-23 and 2023-34 fiscal years would reduce that estimate to some $103 million each year.

Concerns. California is facing a dramatic workforce shortage. It is unclear how those funds would be used and how quickly they would result in improved access to care. The public sector competes with the private sector for mental health professionals. Some research suggests that reimbursement rates under MediCal and burdensome paperwork requirements are significant barriers to existing professionals responding to public sector needs, remaining in the field, or expanding the hours they commit to the profession. In recent years mental health innovators have developed strategies to address these and other challenges.

It also is not clear what impact a $100-$175 million fiscal shift from the counties to the state will have on the ability of counties to sustain their existing behavioral health programs.

The Commission may wish to explore how the newly established workforce funding would be used, the timeframe for developing a proposal for the use of these funds, how the state might leverage private sector investments, and if there is a role for workforce and technology innovation to address workforce needs.

The Commission also might explore how state-level workforce investments differ from existing local workforce investments as currently allowed under the MHSA, if local behavioral health agencies will guide the uses of state workforce funds and if the newly established state funds can be used to sustain efforts that are currently receiving local workforce funding.

11. Department of Healthcare Services – Fortification

Background. In 2013, the state eliminated the California Department of Mental Health and the California Department of Alcohol and Drug Programs and transferred the functions of those departments to other entities, including the Department of Health Care Services, the Department of Social Services, and the Mental Health Commission. Those organizational changes included establishing the new Department of State Hospitals to oversee the operations of California's mental health hospitals which previously had been administered by the Department of Mental Health.

At the time, mental health advocates raised concerns that California would lose statewide leadership and visibility on the issues of mental health and substance use disorders that had been provided by those standalone departments. The reform moved forward with the intent of better integrating mental health and substance use disorder services into the broader purview of the Department of Health Care Services, particularly with regard to Medi-Cal financing of health care services, something that was previously distributed across the three departments.

The BHSA reform proposal transfers a limited number of functions from the Commission to the Department. As mentioned above, under current law, the Commission issues regulations and oversees county use of Prevention and Early Intervention funding, and reviews and approves county innovation spending. The reform proposal transfers the Commission's PEI regulatory function to the Department, and as discussed below, eliminates innovation regulations and approvals as innovation spending is no longer required.

The proposed reforms would enhance the authority of the Department of Health Care Services to promote improved integration of county supported mental health services with services offered through MediCal managed care plans, as well as supporting improved alignment between state-level prevention and early intervention programs and county strategies. The reform proposal also highlights opportunities to enhance the draw-down of federal Medicaid funding and calls for the Department to support improved billing with the inclusion of a Medi-Cal billing mandate for county behavioral health departments.

Concerns. In recent years the Commission has raised concerns regarding where leadership, technical assistance, and administrative oversight would reside on mental health matters, including school mental health, suicide prevention, workplace mental health, prevention and early intervention, criminal justice diversion, and related opportunities. The reform proposal does not address the operational needs of the Department of Health Care Services or offer a transition or change management plan to ensure the Department has the staff, training, tools, and other resources needed to succeed under its enhanced responsibilities.

The Commission may wish to explore opportunities to strengthen the Governor's proposal, including:

- How the Department of Health Care Services intends to expand its technical assistance and other roles to support local behavioral health departments and improve outcomes consistent with the enhanced authorities outlined in the reform proposal.
- Whether the reforms will promote greater clarity on the appropriate state-level leadership on school mental health, workplace mental health, criminal justice diversion, behavioral health innovation, and targeted strategies to prevent homelessness.
- How the Department will work with the Departments of Aging, Education, Housing and Community Development, Rehabilitation, Social Services, Public Health, and Employment Development to support the early intervention goals outlined in the reform and whether the Department envisions establishing a leadership council or related body to undertake that work.
- How the Department will ensure that the concerns and perspectives of clients, family members, child and youth advocates, including youth and underserved populations, such as communities of color, current and former foster youth, immigrants and refugees, veterans, older adults and others who bring essential perspectives on how to effectively respond to behavioral health needs will be engaged in all aspects of the Department's work.
- Whether the proposal will include an implementation plan that outlines needs for staffing, data infrastructure, technical assistance and incentive funding, as well as strategies around collaborative learning, program integration and capacity building across the range of mental health partners who support California, including county behavioral health leaders, managed care and commercial insurance plans, health and hospital systems, county and community based providers, public safety and emergency responders, and most importantly community organizations, client, peer and family organizations that are key to ensuring that public sector strategies are aligned with individual, family and community needs, particularly around the essential work of addressing disparities.
- The impacts these reforms are intended to achieve, what harms or risks these reforms may create and how those harms and risks can be mitigated or minimized.

12. Innovation – Funding Mandate Elimination

Background. Under the existing MHSA, county behavioral health departments are required to invest 5 percent of their funding toward innovative approaches to support transformational change. Recognizing uncertainty in what constitutes innovation, state law requires Commission approval for innovation projects before spending can occur.

In the last six years, the Commission has approved more than $1 billion in innovation spending that supports more than 200 innovation projects. The Commission has partnered with counties to support a range of multi-county learning collaboratives, with the Commission often funding initial planning costs on behalf of partnering counties, with counties then electing to opt-in and use their innovation funds to join these collaborative projects based on their relevance to individual county priorities.

The Commission has supported multi-county innovation collaboratives to reduce justice involvement, strengthen approaches to responding to psychosis, fortifying Full-Service Partnership programs, deploying Psychiatric Advanced Directives to accelerate recovery and prevent the escalation of mental health crises, enhancing access to care through robust community engagement, and more.

The MHSA Innovation component was established in response to recommendations from the Little Hoover Commission in 2000 that recognized that California's mental health system did not have a built-in strategy for continuous improvement. Organizers of the initiative elected to require each county to invest their innovation funds in county-level projects so that all counties would benefit from the opportunity for innovation, rather than utilizing a state-level innovation fund that may not be equitably distributed across California's 59 local mental health agencies.

Concerns. The language of the reform proposal is unclear on whether counties are encouraged or required to innovate and how or whether innovation will be implemented or supported, if there is a role for the state in supporting innovations, and how innovations developed in one county can be scaled to additional counties.

The Commission has increasingly recognized that innovation is happening in the behavioral health sector, often in the private sector, but that those innovations are not consistently benefiting public sector clients, nor are they consistently designed and implemented with public sector needs in mind.

The Commission may wish to explore ways to embrace innovation to meet statewide goals, including:

- Whether the proposed reforms should be modified to retain the innovation component and whether to leverage innovation funding to address statewide priories, consistent with the Commission's support for multi-county innovation projects and learning collaboratives. The Commission has informally discussed limiting approval

for county spending of innovation unless projects would reduce homelessness and justice involvement. The Commission has not, as of yet, pursued these proposals.

- In the absence of an innovation mandate and a funding set-aside to support that work, the Commission may wish to seek clarification on what resources would be available under the reform proposal to support the ability of counties to innovate.
- Whether the Department of Health Care Services is proposing to support innovation as allowed under the BHSA, taking over the guidance and technical assistance role for innovation currently performed by the Commission.
- How counties will be asked to wind down innovations as new fiscal requirements take effect, while taking into consideration the need for continuity of service for those participating in those projects.
- How the state can leverage private sector innovation investments, including elevating community voice to support private sector innovation decisions.
- Whether in the absence of local innovation funding, the state should set aside a percentage of state BHSA funding to support statewide innovation investments that can accelerate the transformation of California's mental health system, including public-private partnerships, better understanding of the emerging fields of brain health and brain capital, and leverage the expertise of California's diverse communities, research institutions, communications, technology, and related sectors.

13. The Commission's Role should Guide its Membership

Background. California's mental health Commission was formed to elevate visibility on the need for mental health investments and reforms and to ensure fiscal, programmatic, and outcome-based accountability to the taxpayers. The composition of the Commission reflects the goals of bringing together clients, family members and providers, with leaders in business, labor, public safety, education, and the Legislature to guide policy and build public support for the recovery vision of the MSHA.

As mentioned above, the proposed reforms would retain the Commission's independence and shift some responsibilities from the Commission to the Department of Health Care Services. The proposed reforms state that the Commission:

> "Is established to administer grants, identify key policy issues and emerging best practices, and promote high-quality programs…through the examination of data and outcomes."

Commission membership also is proposed to be modified. The existing 16-member Commission has two mental health consumers, two mental health family members, two business representatives, a physician specializing in addiction medicine, a county Sheriff, a local superintendent, a labor union representative, a representative of a health plan or insurer, a mental health professional, a State Senator, and a State Assembly member. The

California Attorney General and the Superintendent of Public Instruction each serve on the Commission and have the authority to appoint a designee.

Under the proposed reforms, the Commission would increase from 16 members to 20 members, with the addition to two family members of persons with substance use disorders, an expert on housing and homelessness, and a county behavioral health director. Additionally, the Commission's mental health peer membership would be reduced to one member and replaced with a peer who has or has had a substance use disorder.

Concerns. Advocates have pointed out the benefit of adding members with SUD experience, both as peers and family members, but have expressed concerns that the Commission would have two peers and four family members, with just one mental health peer. Additionally, they have expressed concern that county behavioral health directors are in charge of the mental health system, and it is unclear why a seat is being added for a county director.

Similarly, they have pointed out that reforms are not proposing to add youth, a seat for an expert on disparities, one or more veterans, an MHSA taxpayer, persons who have experienced homelessness, or others who would bring robust lived experience to the work of the Commission.

The existing makeup of the Commission is reflective of its mission. The Commission may wish to explore with the Administration:

- The rationale for expanding the membership.
- The rationale for the additional members in the proposed reform and the exclusion of other potential contributors.

The Governor's behavioral health reform proposal, with emphasis on Senate Bill 326 (Eggman), would make substantial and lasting changes to California's behavioral health system.