

Honoring the Vision of the MHSAs through Transformation

August 3, 2023



Executive Summary

It has been nearly twenty years since the landmark Mental Health Services Act (MHSA) – co-authored by Steinberg Institute founder Darrell Steinberg was passed. In the time since, we have learned many lessons and seen a changing behavioral health — encompassing both mental health and substance use disorder — funding landscape warranting a reexamination of the MHSA.

The framework for the MHSA can be traced back to legislation intended to provide much-needed funding to county mental health systems that did not have adequate resources to care for people living with serious mental illness or experiencing homelessness. The bills served as the inspiration and foundation for the MHSA, which has a “whatever it takes” approach to providing care for people living with serious mental illness and experiencing homelessness at its core.

Without proper state oversight and guidance, spending has strayed from the MHSA’s original intent of focusing on serious mental illness and homelessness. At the same time, the state has failed to account for recent changes to the behavioral health funding landscape and awareness of substance use disorder treatment needs has grown. In March, Governor Gavin Newsom proposed a major overhaul of the state’s behavioral health system to address these challenges. In this paper, we offer our key takeaways and recommendations on this effort — which we refer to as the Behavioral Health Modernization Proposal.

Some have asserted that the Governor’s proposal unwisely shifts money away from prevention and early intervention services and undermines oversight of behavioral health. However, the history of the MHSA and our assessment of how the Governor’s proposal fits within the broader behavioral health system finds these claims unfounded. The Governor’s proposal makes necessary changes to align funding priorities with the original intent of the MHSA — including by taking a more inclusive approach to expand the use of funding to substance use disorder treatment services — and, most importantly, best serve Californians living with the most serious behavioral health conditions.

Background

The Original Vision of the MHSA

It has been nearly twenty years since voters approved the landmark MHSA in 2004. In the time since the MHSA has transformed California’s mental health systems by infusing unprecedented funding into mental health programs. As California determines the path forward for its behavioral health continuum of care, it is essential to understand the origins of the MHSA. These insights can provide important lessons for current efforts to reform and modernize the act, utilizing clear and thoughtful state policy direction paired with sensible priorities for funding from the state that are aligned with the original vision of the MHSA. Below, we provide the history of the MHSA to inform this discussion.

The MHSA Was Inspired by Legislation to Address Serious Mental Illness and Homelessness. The framework for the MHSA can be traced back to two pieces of legislation that Steinberg Institute founder, Darrell Steinberg, authored when he was in the State Legislature. These bills, described below, were

authored to provide much-needed funding to county mental health systems that did not have adequate resources to care for people living with serious mental illness and experiencing homelessness. These bills also served as the foundation for the “whatever it takes” approach to providing care, which is at the core of the MHSA today (described later in further detail).

- ***Assembly Bill 34 (Steinberg, 1999).*** In response to rising numbers of people experiencing homelessness and frequent involvement with the criminal justice system and hospitalization for people with serious mental illness, Assembly Bill 34 provided demonstration grants to three counties - Los Angeles, Stanislaus, and Sacramento - for pilot programs, providing comprehensive and integrated services for adults with serious mental illness.
- ***Assembly Bill 2034 (Steinberg and Baugh, 2000).*** Assembly Bill 2034 expanded the pilot programs established in AB 34 (Steinberg, 1999) to include comprehensive and integrated services for transitional-age youth and families experiencing serious mental illness and to expand the number of participating counties. *The successes of these programs laid the foundation for what would become the MHSA.*

In 2003, a California Department of Mental Health report found that 83 percent of individuals enrolled in Assembly Bill 2034 programs were housed and that criminal justice involvement and hospitalization rates for individuals in these programs declined dramatically. In addition, the report also quantified an estimated cost savings of \$27.4 million annually by operating these programs as a result of reduced incarceration and hospitalization days¹.

Proposition 63 (2004): The MHSA. In response to underfunded mental health programs across the state (a principal finding of a 2000 report from the California Little Hoover Commission²) and building upon the framework for care and the demonstrated successes of the above pilot programs, California voters approved Proposition 63 — the MHSA — in 2004. The MHSA explicitly referenced the Assembly Bill 34 and Assembly Bill 2034 pilot programs as effective models to expand upon with the additional funding raised by the act.

Proposition 63 levied a 1 percent tax surcharge on all incomes in California over \$1 million and dedicated the vast majority of revenues to county mental health programs (with a relatively small amount reserved for state use). The statutory allocations for county mental health programs are broken down below.

- ***Community Services and Supports (CSS).*** 76 percent of county MHSA funding is intended for CSS, the primary source of MHSA funding for direct services (including outreach and engagement). CSS funding is designed to serve individuals with serious mental illness and who experience homelessness, and the majority of CSS funding is intended for programs known as Full Service Partnerships (FSPs) that serve this population. (We describe FSP programs in further detail in a later section.) However, in practice, the state has limited ability to verify whether this funding is targeted toward these intended purposes.
- ***Prevention and Early Intervention (PEI).*** 19 percent of county MHSA funding is intended for prevention and early intervention activities to prevent mental illnesses before they become severe, such as early psychosis intervention and suicide prevention programs.
- ***Innovation.*** 5 percent of county MHSA funding must be used for innovative programs to pilot new mental health service delivery approaches.

¹ https://hpmh.semel.ucla.edu/wp-content/uploads/2021/02/8a7e9bff_AB2034_may2003.pdf

² <https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/157/Report157.PDF>

Proposition 63 also established a joint oversight structure for the MHSA, with responsibility shared between the Department of Mental Health — since dissolved with its responsibilities absorbed by the Department of Health Care Services (DHCS) — and a newly created Mental Health Services Oversight and Accountability Commission (MHSOAC). Today, DHCS oversees the CSS funding category and is also the state entity that counties report data to, while the MHSOAC oversees the PEI and Innovation funding categories, overall MHSA spending, and administers state grant programs funded by the MHSA revenues reserved for state use.

The MHSA Took a Comprehensive Approach to Care While Elevating the Issue of Reducing Serious Mental Illness and Homelessness. The MHSA sought to provide a key source of ongoing funding for a comprehensive suite of mental health services and programs to address mental health challenges. The act provided dedicated funding for prevention and early intervention activities, innovation programs, integrated services for individuals with serious mental illness, and homelessness reduction.

The success of MHSA-funded programs across the spectrum of mental health services has been demonstrated in some cases. For example, a recent University of Southern California study found that passage of the MHSA (which funds suicide prevention activities) has resulted in 5,600 avoided deaths from suicide statewide³. However, despite clearly stated outcomes within the MHSA, the state has not reported on progress to meet these outcomes, which hampers its ability to comprehensively demonstrate the MHSA's successes.

At the core of the MHSA was reducing serious mental illness and homelessness by providing life-saving care to individuals struggling with the most acute needs. This intention is demonstrated by the clear influence that the Assembly Bill 34 and Assembly Bill 2034 pilot programs had on the design of the MHSA and by the fact that the plurality of county MHSA funding under Proposition 63 is reserved for a model of care to address serious mental illness and homelessness. We describe this model of care below.

FSPs. FSP programs are integrated and comprehensive services providing mental health and wraparound support — such as housing and employment — to individuals with the most serious mental health needs. The specific structure of FSP programs varies by county, but they are often targeted at individuals experiencing homelessness, excessive hospitalizations, and/or involvement with the criminal justice system.

Full Service Partnership (FSP) programs are designed for individuals with severe mental illness who would benefit from an intensive service program. Full Service Partnerships embrace client-driven services and supports, with each client choosing services based on individual needs. Unique to FSP programs are a low staff-to-client ratio, a 24/7 crisis availability, and a team approach that is a partnership between mental health staff and consumers.

FSP programs assist with everything from housing to employment and education in addition to providing mental health services and integrated treatment for individuals with a co-occurring mental health and substance abuse disorder. Services can be provided to individuals in their homes, the community, and other locations. Peer and caregiver support groups are available. Embedded in Full Service Partnerships is a commitment to deliver services in culturally and linguistically competent and appropriate ways.

Source: Los Angeles Department of Mental Health

The hallmark of FSP programs is the “*whatever it takes*” approach to care driven by the individual receiving services. Research has shown that enrollment in FSP programs leads to reductions in homelessness, criminal justice involvement, and hospitalizations, as well as increases in access to primary care and employment. Together, these effects also result in cost savings for local governments⁴.

<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0271063>

⁴ https://www.rand.org/pubs/research_briefs/RB10041.html

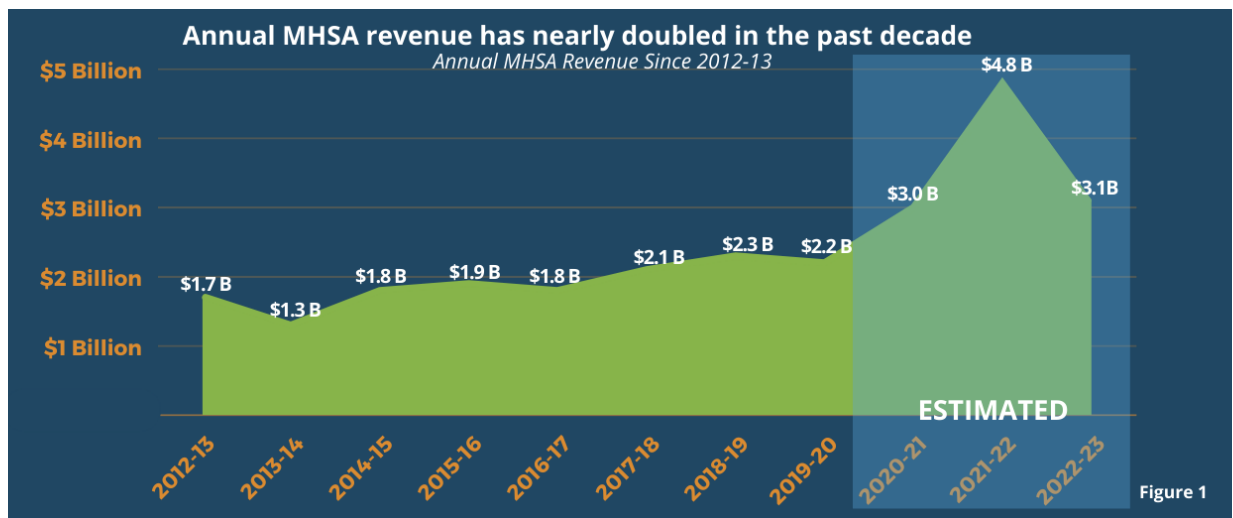
Under current state regulations, counties are required to use the majority of their CSS funding for FSP programs. However, a recent report from the MHSOAC indicates that less than a quarter of counties are meeting this requirement. Furthermore, of the ten counties with the largest populations of people experiencing homelessness, just one is meeting this requirement⁵. FSP programs are the cornerstone of the MHSA’s focus on reducing serious mental illness and homelessness. Inadequate oversight and accountability of MHSA funding for FSP programs throughout the state does a disservice to the original intent of the MHSA and to Californians living with serious mental illnesses at a time when the number of people experiencing homelessness is skyrocketing.

Funding for Behavioral Health

The MHSA was intended to be a funding source of last resort — providing resources for mental health services that other funding sources would not pay for — in the behavioral health system. Accordingly, reforms to behavioral health funding sources other than the MHSA significantly impact how MHSA funding is used. In California, counties have the primary role of financing and providing public behavioral health services, specifically Medi-Cal specialty mental health services for adults with serious mental illness and youth with severe emotional disturbance. However, Medi-Cal managed care plans are responsible for funding and providing a subset of services for individuals with less severe needs. Furthermore, commercial insurance plans also fund behavioral health services for individuals with private coverage. In this section, we provide critical context for the current and future state of funding for behavioral health in California, which is necessary to properly assess the merits of efforts to reform and modernize the MHSA.

Dedicated Revenues for County Behavioral Health Have Generally Grown Over the Past Decade. The dedicated revenues counties receive to fund their behavioral health activities are vital to behavioral health funding in California. (These revenues are over 80 percent of non-federal funding for public behavioral health statewide.) Below, we describe how these funding sources have increased over time.

- ***MHSA Revenues:*** While MHSA revenues can fluctuate annually, from state fiscal year 2012-13 to estimates for 2022-23 MHSA revenues have grown substantially. We display this growth in Figure 1 below.



⁵ https://mhsoac.ca.gov/wp-content/uploads/SB-465-Report-to-the-Legislature_approved_ADA.pdf

- **Realignment Revenues:** In 1991 and 2011, the state dedicated a portion of sales and use tax and vehicle license fee revenue to counties to fund their behavioral health activities. Together, these sources of funding are known as “realignment revenues.” Over the past decade, realignment revenues have generally grown, as shown in Figure 2 below.

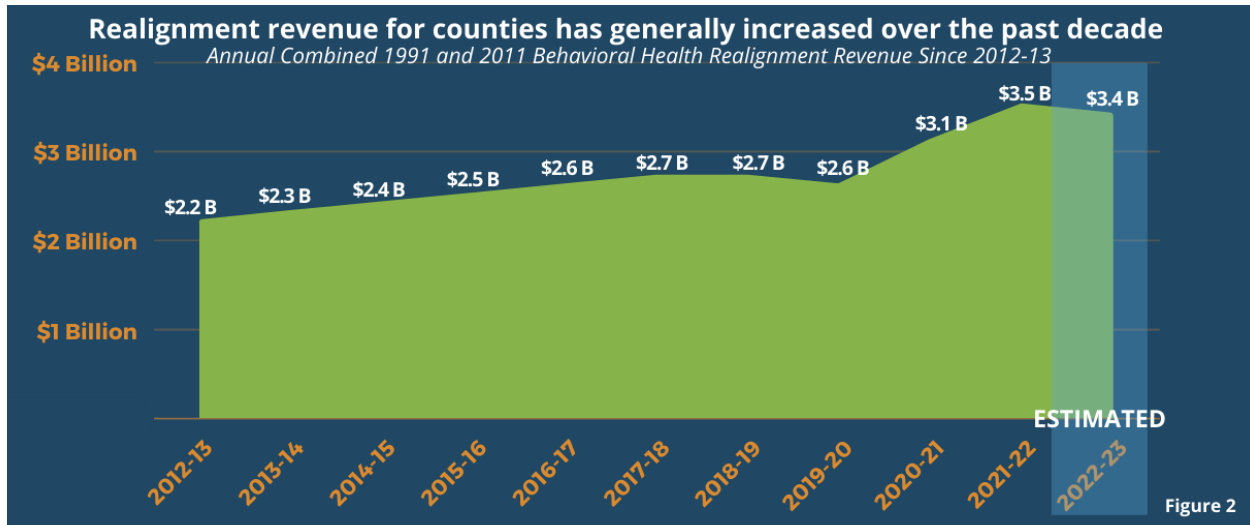


Figure 2

Behavioral Health Funding Landscape Has Shifted Dramatically Since the MHSA Passed. Since Proposition 63 was approved by voters, several significant behavioral health policy changes have had major implications for MHSA funding.

Generally, these policy changes — past, present, and future — infused or will infuse considerable additional funding (from the state, federal government, and commercial insurance payors) into the state behavioral health system on both a one-time and ongoing basis. Below, we briefly describe these policy changes (we discuss their impacts in more detail later in Figure 3). The fiscal impacts of several of these reforms are difficult to quantify; in these cases, we describe their effects qualitatively.

- **Affordable Care Act (ACA) Medi-Cal Expansion.** Implementation of the ACA dramatically increased healthcare coverage in California. Most notably, it expanded Medi-Cal coverage (including for behavioral health services) to single, childless adults at an enhanced federal match for funding of 90 percent.
- **Drug-Medi-Cal Organized Delivery System (DMC-ODS).** Under the DMC-ODS, counties (which opt-in) receive federal funding for services provided in residential substance use disorder treatment settings that were historically not eligible for federal funding through Medi-Cal. Under the DMC-ODS, Medi-Cal also provides funding (including federal funding) for a more comprehensive set of services.
- **Senate Bill 855 (Wiener, 2020).** SB 855 requires commercial insurance plans in California to use standards for behavioral health coverage backed by leading nonprofit professional associations rather than alternative standards that lead to excessive denials of coverage.
- **Children and Youth Behavioral Health Initiative (CYBHI).** The CYBHI is a \$4.7 billion package of both one-time and ongoing funding focused on building capacity to provide prevention and early intervention services for children and youth, including through policy changes to ensure additional funding from commercial insurance payors and Medi-Cal managed care plans for behavioral health services.

- **California Advancing and Innovating Medi-Cal (CalAIM).** Under CalAIM, the state is currently implementing new Medi-Cal benefits (which result in additional federal funding for services that did not receive federal funding before) aimed at the social determinants of health (such as housing status) for individuals with behavioral health challenges. CalAIM also includes several policy changes — such as reforms to payment methods — to ensure additional funding from the federal government, and Medi-Cal managed care plans for behavioral health services.
- **Behavioral Health Continuum Infrastructure Program (BH-CIP) and Behavioral Health Bridge Housing (BHBH).** BH-CIP and BHBH are a combined package of \$3.7 billion in one-time funding for facilities that support individuals with serious behavioral health needs.
- **Community Assistance, Recovery, and Empowerment (CARE) Act.** The CARE Act provides a new framework to ensure that individuals with certain serious mental illnesses receive behavioral health services through a county-developed plan.
- **AB 988 (Bauer-Kahan, 2022) and Medi-Cal Mobile Crisis Services Benefit.** AB 988 provides ongoing funding to implement California's 988 crisis lifeline and mobile crisis services. The state will also shortly begin implementing a new Medi-Cal benefit to receive additional federal funding for mobile crisis response teams.
- **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT).** BH-CONNECT is a \$6.1 billion initiative under which counties — that opt-in — would receive federal funding for mental health services provided in facilities that were not previously eligible for federal funding and reinvest the resulting savings into community-based services. BH-CONNECT also includes a \$2.4 billion behavioral health workforce initiative.

The policy changes described above each have significant implications for using MHSA funding. Efforts to braid these funding changes while aligning the use of MHSA funding with the act's original intent — such as a current proposal from Governor Newsom, which we discuss later in this report — have merit. In addition, many of these policy changes include funding for substance use disorder treatment, reflecting increased need for these services.

Outcomes and Accountability Challenges

Behavioral health programs have been funded and operated by both the state and counties for decades. Furthermore, the state has also historically directed billions of dollars in revenues — and the federal government has provided billions of dollars in additional funding, primarily through Medi-Cal — for behavioral health services in California. However, despite these investments, the state has struggled to assess whether programs are working. (The California Little Hoover Commission noted the state's challenges with evaluating MHSA-funded programs in reports from 2015⁶ and 2016.⁷) In this section, we discuss factors that contribute to this long-standing challenge.

A Historical Lack of State Direction Has Resulted In Difficulty Assessing California's Behavioral Health System. Although counties have the primary role in funding and providing behavioral health services in California (acting as the state's contractors), the state has the responsibility to provide thoughtful and clear policy direction and sensible priorities for funding. In addition, the state is responsible for developing a practical framework for collecting information on behavioral health programs from counties and using this information to accurately assess how well the state is meeting its goals for behavioral health care and communicate the results to the public. However, the state has failed to fulfill its duty to provide adequate guidance, proper accountability, and valuable technical assistance to

⁶ <https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/225/Report225.pdf>

⁷ <https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/233/Report233.pdf>

counties to meet this responsibility. In particular, fragmented state oversight of behavioral health programs — including the DHCS and MHSOAC sharing responsibility for oversight of the MHSA — is a crucial reason why the state cannot properly assess the system. Below, we discuss issues with evaluating the state behavioral health system in further detail.

Clear and Measurable Outcomes, Comprehensive Planning, and Meaningful Data Reporting Are Missing from the System. Historically, the state has not established clear and measurable outcomes to assess the behavioral health system. In addition, as discussed earlier, the behavioral health system in California is composed of several different entities — each with distinct responsibilities for providing care for distinct groups of people — and counties receive several dedicated sources of funding to support their behavioral health activities. These funding sources for counties also have specific spending and data reporting requirements.

As a result, systems planning for behavioral health care and data reporting on programs and spending is conducted piecemeal, and data is missing for certain system components. For example, counties in California are required to (1) develop three-year plans for use of the MHSA funding they receive and (2) submit annual revenue and expenditure reports on MHSA-funded programs. These MHSA plans and reports do not provide a comprehensive look at the behavioral health system as a whole because they exclude programs and services supported by funding other than the MHSA. Notably, the state does not have a clear way to identify what specific programs and services counties fund with their dedicated realignment revenues or what proportion of these revenues are used as the non-federal share for Medi-Cal services.

The Behavioral Health Modernization Proposal

In March, Governor Newsom proposed a major overhaul of the state’s behavioral health system. In this section, we provide a brief description of the proposal.

Governor Newsom Proposes Modernizing and Reforming the MHSA. Governor Newsom is proposing a package of major changes to modernize and reform the state behavioral health system. The flagship elements of this package of reforms — effective July 1, 2026, pending voter approval on the March 2024 ballot — are significant changes to how counties allocate MHSA revenues and strengthening the state’s apparatus to measure behavioral health outcomes and accountability with an equity focus. Senate Bill 326 (Eggman) is the legislative vehicle to enact these changes.

In addition, Governor Newsom is proposing a \$4.68 billion general obligation bond for voter approval on the March 2024 ballot to construct community-based behavioral health and residential care settings that would add 10,000 beds to the state continuum of care. Assembly Bill 531 (Irwin) is the legislative vehicle to enact this proposal.

For the remainder of this report, we refer to the combined legislative package of Senate Bill 326 and Assembly Bill 531 as the “Behavioral Health Modernization Proposal.”

The Behavioral Health Modernization Proposal Aligns With the Original Intent of the MHSA: Addressing Serious Behavioral Health Needs and Homelessness... The Behavioral Health Modernization Proposal proposes to rename the MHSA the Behavioral Health Services Act (BHSA) and bring the BHSA into alignment with the original vision of the MHSA by elevating the issue of serious behavioral health needs and homelessness as a primary state behavioral health priority.

Specifically, the Behavioral Health Modernization Proposal adjusts the proportion of BHSA revenues reserved for county use to 92 percent and requires that counties use 30 percent of this amount for housing interventions (such as rental or operational subsidies) for individuals with serious behavioral health needs who are experiencing homelessness. In addition, of this amount, 50 percent is reserved for individuals

who are chronically homeless. Furthermore, the proposal requires that 35 percent of BHSAs funding reserved for counties be used to increase the number of individuals in FSP programs statewide, making this a statutory requirement.

...While Also Maintaining a Protected, Dedicated Portion of Funding for PEI. In keeping with the MHSA's original vision for a comprehensive approach to care, under the Behavioral Health Modernization Proposal, 30 percent of county BHSAs revenues would be reserved for a broad range of community-based behavioral health services, including innovative projects. Of this amount, a majority of funding would be reserved for early intervention activities. In addition, under the proposal, 5 percent of county BHSAs funding would be reserved for population-based prevention programs. Combined, the two portions of funding earmarked for early intervention and population-based prevention programs mean there is no change to the share of county BHSAs revenues for PEI funding.

The Proposal Expands Use of Funding for Substance Use Disorder Treatment... As discussed earlier, the MHSA would be renamed to the BHSAs under the Behavioral Health Modernization Proposal. This name change reflects the expanded use of BHSAs funding for substance use disorder treatment services (which are currently only eligible for MHSA funding in limited cases).

...And Reflects a Focus on Addressing the Behavioral Health Workforce Crisis. In response to the current behavioral health workforce shortage, the Behavioral Health Modernization Proposal reserves up to 3 percent of total BHSAs revenues for the state to implement a statewide workforce initiative focused on both pipeline investments and recruitment and retention efforts. This funding is intended to support the BH-CONNECT initiative's workforce component (discussed earlier).

The Proposal Also Reforms the Framework for Behavioral Health Outcomes and Accountability. The Behavioral Health Modernization Proposal includes several outcomes and accountability reforms to address the outcomes and accountability challenges discussed earlier. Specifically, the proposal consolidates state responsibility for oversight and (1) allows the state to establish measurable outcome metrics, (2) replaces existing county three-year MHSA plans and data reporting requirements with new frameworks that appropriately account for the multiple entities and funding streams that make up the behavioral health system, and (3) authorizes up to 2 percent of county BHSAs funding for systems improvements to meet these requirements.

Key Takeaways

In this section, we provide our key takeaways from the Behavioral Health Modernization Proposal and a recommendation to strengthen a key component of the proposal.

An Increased Focus on Serious Behavioral Health Needs and Homelessness Is Absolutely Warranted.

As mentioned earlier, California is facing an unprecedented serious behavioral health and homelessness crisis. A recent UCSF report found that more than 171,000 individuals are experiencing homelessness statewide, more than double the amount in the next highest state. In addition, 82 percent of the report's study participants reported having experienced a serious mental health condition, and 65 percent reported substance use⁸. Failure to elevate this issue to the highest level of state priority does a disservice to the original intent of the MHSA.

Furthermore, as discussed earlier, the state is responsible for providing clear direction and sensible priorities for funding that address California's most critical behavioral health issues. This state oversight obligation is especially relevant because most counties are not spending the required proportion of MHSA funding they receive on FSPs. The state also has an obligation to deploy the necessary resources to provide lifesaving care for people experiencing serious behavioral health needs and homelessness.

⁸ https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf

Therefore, efforts to ensure the state can fulfill its obligations — such as the Behavioral Health Modernization Proposal — are vital.

The Behavioral Health Modernization Proposal May Require Counties to Shift Current MHSA Spending... As discussed earlier, the Behavioral Health Modernization Proposal makes several changes to the current funding categories of the MHSA. Accordingly, it is possible that under the proposal, counties would need to shift current MHSA spending toward different types of programs and services to meet the proposal's new requirements for funding. However, ensuring that MHSA funding is used in a targeted way ensures that funding has an impact on the lives of individuals living with mental illnesses and substance use disorders experiencing the greatest need.

...But Shifts In the Behavioral Health Funding Landscape Reduce the Burden on Current MHSA Spending. Since the MHSA passed, dedicated revenues for county behavioral health have doubled, and the behavioral health funding landscape has shifted dramatically. In addition, the state is implementing several major behavioral health policy changes that will significantly affect the funding landscape. These changes infuse additional funding into the behavioral health system (mainly from the state and federal government or commercial insurance payors).

These changes complement and help reduce the burden on MHSA spending by shifting responsibility for programs and services currently paid for by the MHSA to other entities. For example, under several state initiatives, Medi-Cal managed care and commercial insurance plans are required to provide additional funding for school-based services (currently a key component of MHSA PEI funding).

Accordingly, it is time to update the MHSA to more appropriately reflect how the act fits within the broader state architecture for behavioral health funding. We further describe the major policy changes for behavioral health and their impacts on funding in Figure 3 (at the conclusion of this report).

Effective Complementary Reform Implementation Is Critical to Realizing the State's Vision for Behavioral Health. It is an unprecedented time of transformation. Several of the policy changes discussed above are currently being implemented or will be implemented in the future. The state is responsible for ensuring that all of these changes complement one another and, as stewards of the public dollar, that funding is invested wisely and efficiently. In addition, given that these reforms have major implications for using MHSA funding, the state must focus resources on ensuring they are implemented effectively. For example, properly enforcing the CYBHI's statutory requirement that Medi-Cal managed care and commercial insurance plans pay for behavioral health services provided in schools is necessary to ensure that counties do not need to use MHSA funding to cover these services. Enforcement is especially critical if the Behavioral Health Modernization Proposal is enacted and the categories of MHSA funding change. In addition, effective implementation of one-time programs for behavioral health and homelessness housing — such as BH-CIP and BHBH — can provide a solid foundation for the proposal's ongoing funding focused on housing.

The Proposal Continues to Protect, and Appropriately Targets, Funding for PEI... In keeping with the original vision of the MHSA of a comprehensive approach to care, the Behavioral Health Modernization Proposal continues to include a dedicated, protected funding source for PEI. In addition, the proposal improves how prevention and early intervention dollars are spent by ensuring a targeted set aside for highly effective early intervention programs, such as first-episode psychosis programs while maintaining funding broad population-based programming for maximum impact.

...And Its Expansion of Funding for Substance Use Disorders Promotes an Inclusive Approach. Historically, discrimination against those with substance use disorders has resulted in a lack of focus and underfunding substance use disorder treatment. Substance use disorder is a diagnosis recognized by the American Psychiatric Association and should receive funding for services that are in line with resources provided for mental and physical health. The Behavioral Health Modernization Proposal's addition of substance use disorder treatment services as an eligible use of funding corrects discriminatory policy

decisions — such as reimbursement rates that are much lower relative to rates for mental health services — and promotes a more comprehensive and inclusive approach to care, in line with the principles of parity with resources for mental health and physical health.

The Proposal Helps the State Fulfill Its Responsibility to Focus on Behavioral Health Outcomes and Accountability. As discussed earlier, the state is responsible for developing an effective strategy for collecting valuable data and measuring outcomes in the behavioral health system to demonstrate the effectiveness of programs and services. Yet, this strategy is missing from our current behavioral health system. Furthermore, a comprehensive approach to behavioral health planning that accounts for the system's complexity is notably absent.

By allowing the state — through a consolidated approach to oversight — to establish measurable outcome metrics, reforming systems planning and data reporting requirements (including to more accurately assess behavioral health spending), and providing local resources to improve outcomes and accountability efforts, the Behavioral Health Modernization Proposal represents an essential step toward the state fulfilling its responsibility to focus on behavioral health outcomes and accountability. To this end, we suggest changing the proposal's language to explicitly require the DHCS to establish measurable outcome metrics for the behavioral health system. This change would make clear that the state is committed to fulfilling its responsibility to demonstrate how well its behavioral health programs and services are working. This suggested change would also allow for continuous quality improvement efforts to ensure outcomes get better over time and that the state can tell a story of success for the BHSA.

Impact of Major Changes in the Behavioral Health Funding Landscape Since MHSA Passage

Year	Program	Impact	
2014	Affordable Care Act Medi-Cal Expansion The ACA expanded Medicaid eligibility to childless adults for states that chose to opt-in. California opted to expand Medi-Cal eligibility to this population at its first opportunity.	Additional federal funding for behavioral health services at 90 percent federal match, freeing up state and county funding for behavioral health programs and services.	FULLY IMPLEMENTED
	Drug Medi-Cal Organized Delivery System Counties that opt-in to the DMC-ODS can receive federal funding for newly eligible substance use disorder treatment services provided in facilities not previously eligible.	Additional federal funding for substance use disorder treatment services, freeing up county funding for substance use disorder programs and services.	
2020	Senate Bill 855 (Wiener) Landmark behavioral health parity bill, requiring commercial insurance plans in California to base medical necessity determinations on generally accepted standards of care backed by leading nonprofit professional associations rather than alternative standards that lead to excessive denials of coverage.	Additional commercial insurance funding for behavioral health services ranging from prevention and early intervention to services to addressing severe needs, freeing up county funding for behavioral health programs and services.	IMPLEMENTATION UNDERWAY
2021	Child Youth Behavioral Health Initiative The CYBHI includes a large package of roughly \$4.7 billion in state grant programs focused on prevention and early intervention, including funding to develop the behavioral health workforce, improve infrastructure and capacity for school-based services, further evidence-based behavioral health interventions, and implement a virtual platform for behavioral health services statewide. The CYBHI also includes the implementation of a new Medi-Cal benefit for dyadic services (resulting in additional federal funding) and a statutory requirement for commercial and Medi-Cal managed care plans to pay for behavioral health services provided in schools according to a designated fee schedule.	Infusion of one-time funding to develop the infrastructure and capacity to provide prevention and early intervention services statewide. Increased ongoing funding from commercial insurance and Medi-Cal managed care plans to pay for children and youth prevention and early intervention services. These impacts free up county MHSA prevention and early intervention funds for further investment.	
2022	CalAIM Behavioral Health Reforms CalAIM includes a large set of reforms impacting individuals on Medi-Cal with behavioral health needs, including additional federal funding for services and supports not previously eligible for federal funding. These include the new Enhanced Care Management benefit and Community Supports (such as housing support). CalAIM also places the responsibility for paying for these new services on managed care plans rather than counties and includes several policy changes intended to increase Medi-Cal billing and ensure that counties are not paying for services that should be covered by managed care plans.	Additional federal funding for behavioral health services and supports, including through policy changes to streamline Medi-Cal billing, freeing up county funding for behavioral health programs and services. Increase in Medi-Cal behavioral health services paid for by managed care plans rather than counties through policy changes that clarify financial responsibility, freeing up county funding for behavioral health services.	
	Behavioral Health Continuum Infrastructure Program and Behavioral Health Bridge Housing A combined \$3.7 billion in state funding across two grant programs to construct, acquire, or renovate facilities for behavioral health and develop transitional housing for individuals experiencing homelessness who also have serious behavioral health needs.	Infusion of one-time funding for behavioral health facilities and housing, freeing up county MHSA funding used for capital facilities.	
2023	Community Assistance, Recovery, and Empowerment Act (CARE) Act A new framework to ensure that individuals with certain serious mental illnesses receive behavioral health services provided through a county-developed plan. \$715 million in state funding will be provided to participating counties through 2026-27 to implement.	Infusion of both one-time and ongoing state funding to implement the CARE Act, relieving pressure on existing county sources of funding.	IMPLEMENTATION PENDING
	Assembly Bill 988 (Bauer-Kahan) and Medi-Cal Mobile Crisis Services Benefit A landmark bill to implement the 988 crisis lifeline in California, establishing a dedicated source of funding to cover both infrastructure and service costs associated with the lifeline and the addition of a new Medi-Cal benefit for the rapid provision of mobile crisis teams in the community.	Infusion of ongoing funding to implement the federal 988 crisis lifeline and additional federal funding to support county mobile crisis services. Counties may need to use existing sources of funding to build out mobile crisis teams in advance of the new Medi-Cal benefit going live.	
2024	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment A comprehensive \$6.1 billion initiative providing federal funding for mental health services in facilities that were not previously eligible for federal funding. Counties may opt-in to provide a suite of new community-based services (such as up to six months of rent). BH-CONNECT also includes a \$2.4 billion workforce initiative for both pipeline and recruitment and retention efforts.	Additional federal funding for mental health services, which would be re-invested by counties into providing a suite of new community-based services. Additional state and federal funding for workforce development, augmenting (and potentially freeing up) county MHSA funding used for workforce.	