Transformation of California's Behavioral Health System

Housing with Accountability. Reform with Results.

June 2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

CalHHS
California Health & Human Services Agency

Background

- In 2022, one in 20 adults in California is living with a serious mental illness (SMI), representing a nearly 50-percent increase in the last decade.
- Nearly one-quarter of California's homeless population have an SMI and are at higher risk of justice involvement.
- Among recently incarcerated individuals, data suggests that close to one in three people experiencing homelessness are living with an SMI.
- Black, indigenous, and communities of color, younger and older individuals, people who are LGBTQ+, victims of domestic violence or sexual abuse, veterans, people involved with the justice system, and people who are experiencing homelessness, among others, are the most impacted.
- Meeting the growing demand for behavioral health care and housing has our strained infrastructure.

“We are facing a confluence of crises: mental health, opioids, housing, and homelessness – and this transformative effort will ensure California is tackling these head-on in a comprehensive and inclusive way.

Over the last few years, California has led the nation in expanding access to affordable and quality mental health services – especially for children, teens, and people with untreated mental illness. The historic legislative effort announced today will supercharge these efforts to ensure California continues to lead the way in the decades to come.”

Governor Gavin Newsom

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"Governor Newsom & Legislative Partners Unveil Transformation of California's Mental Health Services Act"

Context

- Since 2019, California has embarked on massive investments and policy reforms to re-envision the state's mental health and substance use system and tackle housing and homelessness.
- Behavioral Health Services: We have invested more than $10 billion in a range of efforts that begin to build up the community-based care the sickest Californians desperately need. This includes investments in prevention and early intervention programs for kids, to investments in programs like the CARE Act and system improvements in Medi-Cal through CalAIM.
- Housing and Homelessness: We have invested more than $21.5 billion in housing solutions and $17.5 billion in strategies to prevent and end homelessness. The state continues to deploy a comprehensive set of strategies – improving state financing programs, targeting housing and homelessness investments, and providing technical assistance.
- Veterans Behavioral Health: We have invested $75 million dollars to address veteran behavioral health challenges and suicide prevention. This includes $50 million for the California Veterans Health Initiative (CVHI), which provides a comprehensive statewide approach to ending veteran suicide and strengthens the behavioral health infrastructure by focusing on prevention, early intervention, and direct services, and $25 million for the Veterans Support to Self-Reliance (VSSR) pilot program, which provides a higher level of on-site supportive services for veterans aged 55+ with high-acuity and who reside in permanent supportive housing (PSH) projects throughout California.

Context

- But more can and must be done. Now it's time to take the next step and build upon what we have already put in place – continuing the transformation of how California treats mental illness and substance use disorders.

Update Since March

- In March, the Governor released his proposal to Modernize California's Behavioral Health System.
- Since then, we have engaged in multiple webinars, listening sessions, hearings, and meetings to receive comments on this proposal.
- We have updated this proposal to reflect feedback received.
- The updated proposal is reflected in
  - SB 326 (Eggman) – MHSA Modernization
  - AB 531 (Irwin) – Behavioral Health Infrastructure Bond Act of 2023

Key Elements

1. Authorize a general obligation bond to fund:
   - unlocked community behavioral health residential settings
   - permanent supportive housing for people experiencing or at risk of homelessness who have behavioral health conditions
   - housing for veterans experiencing or at risk of homelessness who have behavioral health conditions
2. Modernize the Mental Health Services Act (MHSA)
3. Improve statewide accountability, transparency, and access to behavioral health services

Authorize General Obligation Bond

Authorize a General Obligation Bond

- Build thousands of new unlocked community behavioral health beds in residential settings for Californians with mental illness and substance use disorders
- Build permanent supportive housing for people experiencing or at risk of homelessness who have behavioral health conditions
- Build housing for veterans experiencing or at risk of homelessness who have behavioral health conditions
- $4.7 billion bond on 2024 ballot

Build Behavioral Health Treatment and Residential Settings Over 6,000 Beds/Units

Multi-Property Settings

Residential campus-style settings where multiple individuals can live, attend groups, recover, and further stabilize with a number of onsite supportive services.

Cottage Settings

Smaller residential settings, where many services will be available but will also allow individuals to access existing services in the community.

Transitions from these settings will support community living, independence, and long-term housing stability. Depending on need of individuals, it could be returning home, Permanent Supportive Housing, Scattered Site or Shared Housing may be appropriate settings, for example.

Build Permanent Supportive Housing

- Build permanent supportive housing for people experiencing or at risk of homelessness or those transitioning from residential settings who have behavioral health conditions.
  - Estimated 1,800 units

- Build interim, transitional and permanent supportive housing options for veterans experiencing or at risk of homelessness who have behavioral health conditions.
  - Estimated 1,800 units

Modernize the Mental Health Services Act

Modernize the Mental Health Services Act

- Rename to Behavioral Health Services Act
- Update local categorical funding buckets
- Broaden the target population to include those with debilitating substance use disorders
- Focus on the most vulnerable
- Fiscal accountability, updates to county spending and revise county processes
- Many components will require March 2024 Ballot initiative
- Multi-year implementation starting in 2025

No change to current structure of Mental Health Services Oversight and Accountability Commission.

Update Local Categorical Funding Buckets

- **30% for Housing Interventions** for individuals with serious mental illness/serious emotional disturbance and/or substance use disorder.
  - Counties will manage and direct the funds toward local priorities that meet designated purposes including but not limited to rental subsidies, operating subsidies, capital investments and nonfederal share for transitional rent.
- **35% for Full Service Partnerships** which should be optimized to leverage Medicaid as much as is allowable.
- **30% for Behavioral Health Services and Supports** (Behavioral Health Services and Supports (non FSP), Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, innovative pilots, and prudent reserve).
  - A majority of the Behavioral Health Services and Supports allocation must be spent on Early Intervention.
- **5% for Population-Based Prevention** for mental health and substance use disorder prevention programming.
- Counties may pilot and test behavioral health models of care programs, community defined practices or promising practices for the programs specified in all the above. The goal is to build the evidence base for the effectiveness of new statewide strategies to implement an equitable behavioral system.

Housing Interventions

- Dedicate 30% in local BHSA funding for housing interventions for people living with serious mental illness/serious emotional disturbance and/or substance use disorder who are experiencing homelessness. 30% is approximately $1 billion but will vary year to year.
  - 50% of these funds must be used for housing interventions for individuals who are chronically homeless with a focus on those in encampments
  - No more than 25% of these funds may be used for capital with specified conditions
- Funding could be used for rental subsidies, operating subsidies (including for BH settings built through the general obligation bond), shared and family housing, capital and non-federal share for transitional rent.
- Housing interventions are not limited to persons in Full Service Partnerships

Full Service Partnerships

- Dedicate 35% in local BHSA funding for Full Service Partnerships (FSPs). Counties will not report federal financial participation in the FSP bucket, only BHSA expenditures.
- Define FSPs to include mental health and substance use disorder services, Assertive Community Treatment and Forensic Community Treatment, housing interventions, and supportive services.
  - Housing interventions for FSP enrollees will be reported to the 30% Housing Intervention funding bucket
- FSPs will support the individual in the recovery process, reduce health disparities, be trauma informed and in partnership with families or an individual's natural supports.
- FSPs will have an established standard of care with levels based on an individual's acuity and criteria for step-down to an FSP level that provides the greatest degree of independence and self-determination.

Blending FSP & Housing Intervention Funds

- **Example 1**: A consumer in an FSP is ready to move from a residential setting to an independent one-bedroom apartment in the community. The client and her FSP team have identified a unit but to make monthly rent the client needs an ongoing rental subsidy. The Housing Intervention Funds can provide this monthly subsidy. For the earliest months, the Housing Intervention Funds can serve as the non-federal share for transitional rent through BH-CONNECT, so long as the individual is eligible for the transitional rent program.

- **Example 2**: A consumer in an FSP is placed in an adult residential facility uniquely designed for complex co-occurring disorders which requires lower staffing ratios and enhanced services for rehabilitation and recovery. The cost of the placement exceeds the rate provided by the SSI/SSP Non-Medical Out of Home Care Rate (NMOHC). BHSA funds can be a “patch” to fully cover costs. This use of funding can be scored as part of the overall 30% requirement for housing.

Early Intervention

- Define Early Intervention to include programs designed to recognize the early signs of potentially severe and disabling mental illnesses and substance use disorders and prevent them from becoming severe and disabling.

- A majority of the Behavioral Health Services and Supports allocation must be spent on Early Intervention.

- Prevention and early intervention remains a key component and a priority within the proposal. Under the BHSA prevention and early intervention programs will maintain at least 20% of local MHSA funding:
  - 5% for Population-Based Prevention, and
  - At least 15% for Early Intervention, since a majority of the 30% Behavioral Health Services and Supports component must go to Early Intervention

- Require the Department of Health Care Services to biennially establish a list of evidence-based practices that focuses on addressing the needs of those who decompensate into severe behavioral health conditions. The Department may require counties to implement certain evidence-based practices.

Workforce

- Expand the use of local BHSA funds under the Workforce Education and Training (WET) component to include:
  - Workforce recruitment, development, training, and retention
  - Professional licensing and/or certification testing and fees
  - Loan repayment
  - Retention incentives and stipends
  - Internship and apprenticeship programs
  - Continuing education
  - Efforts to increase the racial, ethnic and geographic diversity of the behavioral health workforce
- In addition to expanding the local BHSA funds under WET, allocate BHSA **state** directed funds:
  - 3% to the California Health and Human Services Agency for statewide behavioral health initiatives. This 3% is in addition to the existing 5% of BHSA revenues that are used for state directed purposes. Of this, $36 million to the Department of Health Care Services for BH-CONNECT (1115 demonstration waiver) for workforce investments of $480 million annually and $2.4 billion total for the five-year demonstration period, pending federal approval.

Population-Based Prevention

- Dedicates 5% in local BHSA funding for Population-Based Prevention.
- Defines Population-Based Prevention as activities designed to reduce the prevalence of mental health and substance use disorders and resulting conditions.
- Population-Based Prevention must incorporate evidence-based or community-defined practices.
- Does not include individual based prevention services.

Broaden Target Population

- Authorizes BHSA funding to provide treatment and services to individuals who have a debilitating substance use disorder (SUD) but do not have a co-occurring mental health disorder.

- Increases access to SUD services for individuals with moderate and severe SUD.

- Requires counties to incorporate SUD prevalence and local unmet need data into spending plans. Uses data to inform and develop accountability to improve the balance of funding for SUD.

Focus on Most Vulnerable and Most At-Risk

Adults and Older Adults

- Adults with serious mental illness (SMI) or substance use disorder (SUD) who are or at risk of experiencing homelessness or are or are at risk of being justice-involved, at risk of institutionalization, and/or meet the criteria for behavioral health linkages under the CalAIM Justice-Involved Initiative
- Adults with SMI at-risk of conservatorship

Children and Youth

- Children and youth with serious emotional disturbance or SUD, who are experiencing homelessness, are involved or at risk of being justice-involved, at risk of institutionalization, and/or meet the criteria for behavioral health linkages under the CalAIM Justice-Involved Initiative or are in or transitioning out of the child welfare system

Fiscal Accountability and County Spending

- Require counties to bill Medi-Cal for all reimbursable services in accordance with Medicaid State Plan and applicable waivers, to further stretch scarce dollars and leverage BHSA to maximize federal funding for services.
- Require counties to maximize funding from other sources, such as private insurance, and require counties to make a good faith effort to contract with commercial health plans.
- Provide that counties may report to regulators complaints about a health plan's failure to work in good faith and/or failure to timely reimburse.
- Reduce allowable prudent reserve amounts from 33% to 15% for large counties and 20% for small counties. Reassess prudent reserve more frequently from every 5 years to every 3 years.
- Authorize up to 2 percent of local BHSA revenue to be used for administrative resources to assist counties in improving plan operations, quality outcomes, reporting fiscal and programmatic data and monitoring subcontractor compliance for all county behavioral health funding.

Revise County Process

- Create the **Integrated Plan for Behavioral Health Services and Outcomes**.
- Transform the BHSA planning process into a broader county/region behavioral health planning process. Require counties to work with Medi-Cal Managed Care Plans in the development of their Population Needs Assessments and with Local Health Jurisdictions in the development of their Community Health Improvement Plans and to ensure strategic alignment.
- Specify state behavioral health goals/outcomes and local goals/outcomes.
- Require counties to identify behavioral health disparities and consider approaches to eliminate disparities, including, but not limited to, promising practices, models of care, community-defined evidence-based practices, workforce diversity, and cultural responsiveness.
- Include workforce strategy for ensuring behavioral health workforce are well supported.
- Specify that counties collaborate with cities, managed care plans, and Continuums of Care to outline responsibilities and coordination of services related to Housing Interventions.
- Require plans be approved by boards of supervisors by June 30th, prior to the year of implementation.

Improve Statewide Accountability and Access to Behavioral Health Services

Improved Transparency and Accountability for BH Funding and Outcomes

- Today we have poorly defined and articulated expectations around what should be achieved with taxpayer funds.

- We do not have systems to collect information at the county level nor do we have systems to analyze this information at the state level to determine if our goals and aspirations are being met.

- Californians want to know how their government programs are performing. The information collected and assessed must be presented publicly to demonstrate a commitment to transparency and accountability to the voters on the value of these critical resources.

- BH Modernization recognizes this fundamental challenge and moves to:
  - Set clear expectations as to what the funds are to be used for and who they are intended to serve.
  - Set specific data measures that are made public so that taxpayers can track impact and progress.
  - Set clear actions that the state will take against counties that are not delivering.

Outcomes, Accountability, and Transparency Report

» Create the **County Behavioral Health Outcomes, Accountability, and Transparency Report**, which includes:

- Annual allocation of BHSA, Realignment, and all federal block grants
- Annual spend on non-federal match payments including BHSA, Realignment or other county sources
- BHSA, Realignment and Block Grant only spend
- Any other behavioral health investments using local General Fund or other funds
- Any unspent BHSA, Realignment or block grant funds for that fiscal year
- Cumulative unspent BHSA, Realignment or block grant funds, inclusive of reserves
- Administrative costs
- Data and information on workforce
- Quality metrics
- Stratified data to identify behavioral health disparities and outcomes
- Information on services provided to persons not covered by Medi-Cal, including commercial insurance, Medicare, and uninsured.

County Accountability and Infrastructure

- Develop outcome measures, not just process measures, to drive toward meaningful and measurable system change.
- Align county Behavioral Health (BH) plans (including MHPs and DMC-ODS) and Medi-Cal Managed Care Plan contract requirements when the same requirements exist across programs. This includes, but is not limited to:
  - Organization and administration of the plan, including key administrative staffing requirements;
  - Financial information;
  - Information systems;
  - Quality improvement systems;
  - Utilization management;
  - Provider network;
  - Provider compensation arrangements;
  - Provider oversight and monitoring;
  - Access and availability of services, including but not limited to reporting of any waitlists for any behavioral health services or attesting to no waitlists;
  - Care coordination and data sharing;
  - Member services;
  - Member grievances and appeals data;
  - Reporting requirements.
  - Any other contractual requirements determined by the department.

Alignment between Medi-Cal and Commercial Coverage of Behavioral Health Services

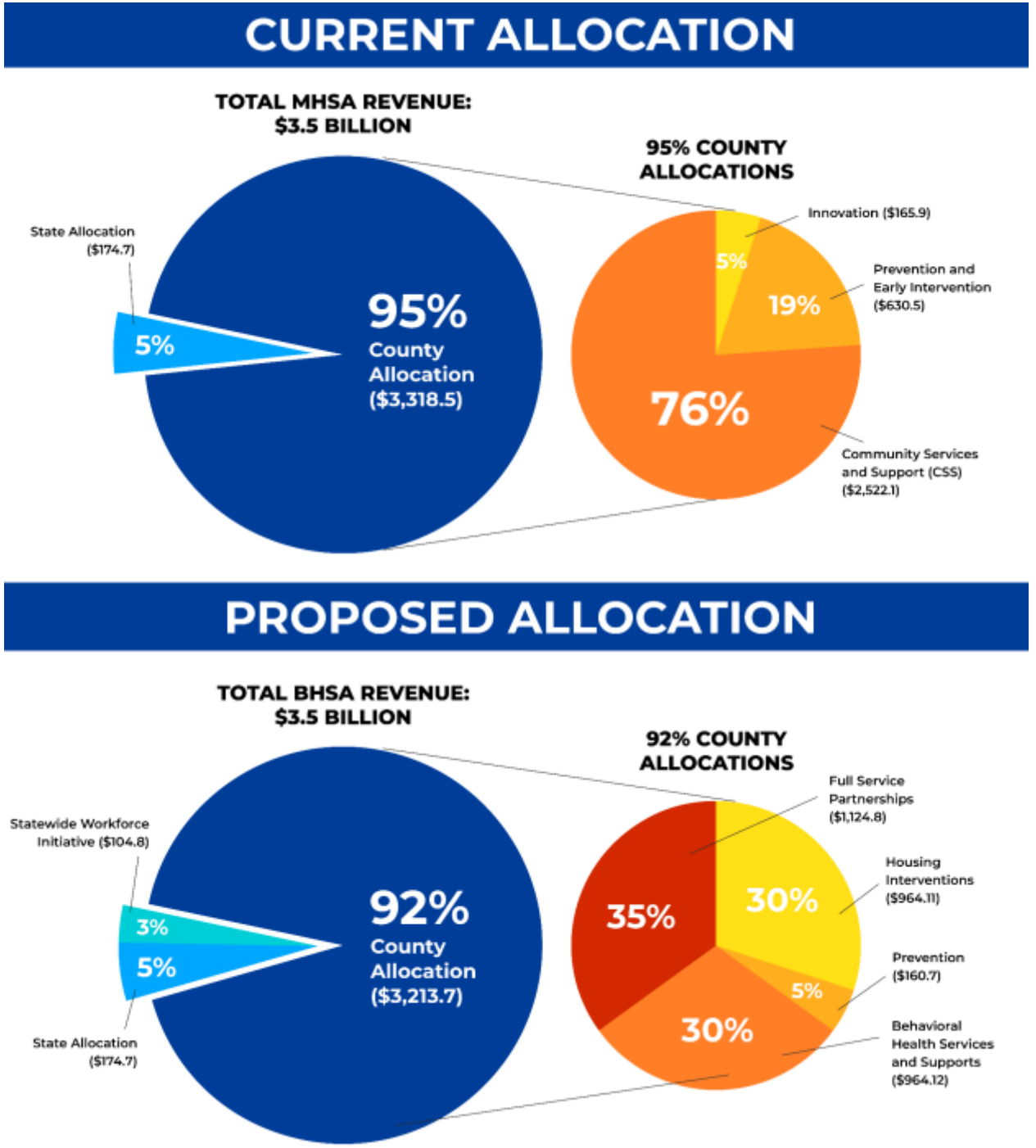
- Over the next year, DMHC and DHCS will develop a plan for achieving parity between commercial and Medi-Cal mental health and substance use disorder benefits. This may include, but is not limited to, phasing in alignment of utilization management, benefit standardization, and covered services.

- DMHC and DHCS will establish a stakeholder process that will include health plans, and other system partners to develop framework.

FACT SHEET

Frequently Asked Questions

How do the proposed BHSA funding allocations differ from existing MHSA funding allocations?



Why does the proposal expand the BHSA to include SUD-only?

- Expanding eligibility to include SUD-only provides additional flexibility for locals depending on their community needs.

- The number of Californians living with SUDs continues to rise – nearly one in ten Californians met the criteria for a SUD in the past year. Emergency department visits and overdose deaths are at record-setting levels, with American Indian and Black communities experiencing the largest increases in overdose death rates. Early identification and treatment of SUDs can also prevent the onset of comorbid mental health conditions.

- Expanding the BHSA target population will help address the rising number of Californians living with SUDs, prevent co-occurring mental health conditions, and allow counties to use BHSA funds in combination with federal funds to expand SUD service offerings.

Can you share what the factors led to the decisions on the housing bucket?

- One of the biggest needs facing our communities is housing. Safe, stable housing is critical for individuals with significant behavioral health conditions to receive care, recover, and thrive in their communities. We have prioritized this as an ongoing revenue source for our counties to assist those with severe BH needs to be housed and provided a path to recovery.

- Many counties already use MHSA funds to support housing interventions; the proposed reforms will further support counties in directing resources into these programs.

- The new housing intervention bucket could be used for rental subsidies, operating subsidies, shared housing, family housing for eligible children and youth, capital, transitional rent as included in the BH-CONNECT waiver and other housing supports as defined by DHCS.

Is the Administration deprioritizing prevention and early intervention?

- No. Prevention and early intervention remains a key component and a priority within the proposal. Under the BHSA prevention and early intervention programs will maintain at least 20% of local MHSA funding:
  - 5% for Population-Based Prevention, and
  - At least 15% for Early Intervention, since a majority of the 30% Behavioral Health Services and Supports component must go to Early Intervention

- Further, counties will have more flexibility to adjust MHSA spending to potentially increase funding to support historically under-served and discriminated-against populations. Counties will continue to engage key community partners through an updated planning process to develop an Integrated Plan, inclusive of all funding sources for both mental health and SUD.

Will this proposal cut funding to existing programs or eliminate them entirely?

- This proposal prioritizes funding to services and supports for Californians with the most severe mental health and substance use disorder needs.

- Local communities will determine based on their local needs what programs and services to fund. The state is providing some general parameters but leaves local perspective.

- Counties should test and pilot innovative models of care and promising practices across all BHSA buckets. The goal of these pilots and promising practices, is to build the evidence base for the effectiveness of new statewide strategies to implement an equitable behavioral system.

- Counties will continue to engage key community partners through an updated planning process to develop an Integrated Plan, inclusive of all funding sources for both mental health and SUD.

How does this proposal leverage changes that have occurred in Medi-Cal and state policies since the passage of the MHSA?

- Affordable Care Act and parity
  - Adult expansion in Medi-Cal coverage
  - Non-specialty mental health services and essential health benefits in Covered California marketplace plans
  - Parity compliance for mental health and SUD benefits utilization management

- Medi-Cal benefits (current)
  - Dyadic benefit, Community Health Workers (Medi-Cal managed care plans and FFS), Peer Support Specialists, mobile crisis

- CalAIM and BH-CONNECT benefits (proposed)
  - Community Health Workers (county BH), Transitional Rent (county BH and managed care), Assertive Community Treatment, Forensic ACT, Coordinated Specialty Care for First Episode Psychosis, Supported Employment, short-term IMD stays

- Children and Youth Behavioral Health Initiative (CYBHI)
  - All-payer fee schedule for public TK-12 and higher education to obtain reimbursement from both Medi-Cal managed care and commercial health plans for school-linked behavioral health services.
  - Includes psychoeducation, screening and assessment, parent and family supports, individual, family and group therapy, peer supports, and care coordination and case management.

Next Steps

Next Steps

- We look forward to working with the Legislature, system and implementation partners, and a broad set of stakeholders, including those impacted by behavioral health conditions, to set these reforms into motion to deliver equitable, accessible, and affordable community-based behavioral health care for All Californians.

Behavioral Health Task Force

» The CalHHS Behavioral Health Taskforce (BHTF) will be hosting a workshop via Zoom webinar on **June 27th from 2pm to 4pm** which will be dedicated to **BHTF member discussion** and members of the public may join in to listen. Members of the public who wish to listen can register as attendees using this registration link.

» The BHTF will host a workshop dedicated to **members of the public** on **June 29th 4pm – 6pm**. Here is the public workshop Zoom Meeting registration link.

Questions and Comments?

Stakeholder questions and input should be sent to

BHReform@dhcs.ca.gov

Thank you

DHCS

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