Assembly
California Legislature
ASSEMBLY COMMITTEE ON HEALTH
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Informational Hearing
Assembly Health Committee
The State's Behavioral Health Transformation: Implementation and Planning Updates
Tuesday, March 4, 2025 — 1:30 p.m.
1021 O Street, Room 1100

INTRODUCTION

Behavioral health (BH) disorders (both mental health disorders and substance use disorders (SUDs)) have come to represent a very complex challenge for California, the enormity of which is evidenced on our streets, in our schools, in our smallest of rural communities, and in our largest cities. Accelerating rates of BH disorders coupled with a shortage of available services have made improving California's BH system a priority for the state's policymakers.

The state is now undertaking a multi-pronged "Behavioral Health Transformation." Core to this effort is the implementation of Proposition 1, which was approved by California voters in the 2024 statewide primary election. Proposition 1 contained two major components related to mental health and SUD treatment. Specifically, Proposition 1:

- Revised and recast the Mental Health Services Act (MHSA) as the Behavioral Health Services Act (BHSA), with a focus on expanding access to SUD treatment, updating how the money from the act is used to include housing interventions, and increasing accountability and transparency with new reporting requirements; and

- Approved a $6.4 billion bond to fund BH treatment facilities and supportive housing for veterans and individuals at risk of or experiencing homelessness with BH challenges.

Proposition 1 aims to complement and build upon the state's other major BH initiatives including, but not limited to, the Behavioral Health Continuum Infrastructure Program (BHCIP), which was established and funded in the 2021-22 state budget. Through BHCIP, the Department of Health Care Services (DHCS) has awarded $1.8 billion in competitive grants to construct, acquire, and expand properties and invest in BH infrastructure.

The purpose of this hearing is to provide the Assembly with updates on how the Behavioral Health Transformation is progressing, focusing on Proposition 1 and BHCIP implementation. This hearing will include representatives from the California Health and Human Services Agency (CHHSA), DHCS, the Legislative Analyst's Office (LAO), counties, and providers who

will share insights on the progress of these initiatives. The hearing will also allow for stakeholder comment.

BH DISORDERS IN CALIFORNIA

SUD. A 2022 publication from the California Health Care Foundation (CHCF), entitled *Substance Use in California: Prevalence and Treatment* reported that substance use in California is widespread with over half of Californians over age 12 reporting using alcohol in the past month and 20% reporting using marijuana in the past year. According to the report, 9% of Californians have met the criteria for a SUD within the last year. Overdose deaths from both opioids and psychostimulants (such as amphetamines), are soaring. This issue, compounded by the increased availability of fentanyl, has resulted in a 10-fold increase in fentanyl related deaths between 2015 and 2019. This epidemic is disproportionately impacting American Indian and Alaskan Native Californians who have the highest rate of opioid overdose deaths, followed by White and Black Californians. According to the California Department of Public Health's Overdose Prevention Initiative, 7,847 opioid-related overdose deaths occurred in California in 2023. In the first two quarters of 2024, 2,975 opioid-related overdose deaths were recorded in California. In August 2024, Health Management Associates, with support of the CHCF published *Substance Use Disorder in California — a Focused Landscape Analysis* found that a key barrier to accessing care for people with substance use disorders is the lack of access to housing and residential services.

Mental Health Disorders. A 2022 publication from CHCF, entitled *Mental Health in California* reported that nearly 1 in 7 California adults experience a mental illness, and 1 in 26 has a serious mental health condition that makes it difficult to carry out daily activities. One in 14 children has an emotional disturbance that limits functioning in family, school, or community activities. According to the report, the prevalence of serious mental illness varies by income, with the highest rates in adults and children in families with incomes below 100% of the federal poverty level.

A 2019 survey by the Substance Abuse and Mental Health Services Administration found nearly five million, or 16%, of Black Americans reported having a mental illness. However, only 1 in 3 Black adults who needs mental health care receives it. Similarly, a 2021 study by the University of California Los Angeles Center for Health Policy Research found that almost half of Latino adults who had a perceived need for mental health services experienced an unmet need for care.

UNMET DEMAND FOR BH SERVICES

National survey data indicates that more Californians need behavioral health services than are receiving them. In 2022 fewer than 20% of those needing SUD treatment received it and fewer than 80% of those with a mental illness received treatment. The shortage of mental health services is more severe for young adults, with 34% of individuals aged 18 through 25 having a mental illness in 2021-2022 and less than two-thirds of young adults with mental illness receiving services in 2022.

In January 2022, DHCS released a report titled, *Assessing the Continuum of Care for Behavioral Health Services in California*, that examined the state's capacity to provide BH services. DHCS estimated that over 600 facilities provide outpatient mental health services, nearly 800 facilities provide SUD services, and over 100 facilities provide inpatient care. The report identified gaps in the BH continuum of care, including the following:

- Marginalized groups experience higher rates of BH conditions and more difficulties securing care.
- There is a shortage of psychiatrists and other individual practitioners, particularly in the Medi-Cal program.
- Greater shortages of outpatient services, especially mental health clinics, exist in smaller counties.
- Availability of inpatient beds varies by county, with insufficient capacity for children, youth, and people living with complex physical conditions.

A 2022 study released by the RAND Corporation further assessed the state of adult inpatient mental health beds in California by Census Bureau region. The study identified three inpatient beds categories: acute (individuals with the highest level of needs, typically served for days to weeks), subacute (moderate to high level of needs for multiple months), and community residential (lower level of need for up to multiple years). RAND estimated a shortage of: 2,000 acute level beds, 2,800 subacute level beds, and about 3,000 community residential level beds. RAND estimated that across all bed types, the shortage is most severe in the southern San Joaquin Valley, Inland Empire, Central Coast, and San Francisco Bay Area. However, these regional shortages vary considerably across acute, subacute, and community residential facilities. For example in Los Angeles County, the northern San Joaquin Valley, San Diego-Imperial, and the Superior region (Butte, Colusa, El Dorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Yolo, and Yuba counties), RAND estimated a shortage in some bed types but excess capacity in others.

EFFORTS TO BOLSTER CALIFORNIA'S BH INFRASTRUCTURE

BHCIP. To address the facility shortage across the state, the 2021-22 state budget established BHCIP which enabled DHCS to award $2.2 billion (later reduced to $1.8 billion) in competitive grants to counties, tribal entities, and nonprofit and for-profit entities to build or expand the existing capacity of public and private behavioral health facilities, including crisis care mobile units. DHCS was granted broad authority to implement the program and determine how to allocate the funding, except for $150 million for mobile crisis infrastructure and $245 million for facilities targeted at children and youth that were prescribed in the budget plan.

In 2022 and 2023 DHCS released the BHCIP funds through five grant rounds targeting various gaps in the state's BH facility infrastructure. Round 1 focused on expanding mobile BH services. Round 2 supported county and tribal planning efforts. Round 3 focused on launch-ready projects.

Round 4 focused on children and youth ages 25 and younger, including pregnant and postpartum individuals and their children, and transition-age youth (ages 18-25), along with their families. Round 5 included a wide variety of eligible facility types, but focused on crisis care.

According to DHCS, BHCIP has been oversubscribed, with $2 billion in applications for $519 million available in Round 3, $1 billion in applications for $481 million available in Round 4, and $2 billion for $430 million available in Round 5. According to data posted on the BHCIP web page, as of January 29, 2025, the program has funded 2,601 beds of various types through 130 awards and 458 mobile crisis teams in rounds one through five. When all projects are complete, this is expected to increase treatment capacity by 281,000 slots. Prior to Round 6, which would have focused on unmet needs, a gap analysis of BHCIP awards showed that several regions of the state and tribal entities continued to have behavioral health needs unmet by earlier rounds. DHCS stated in a November 2023 update, "Due to ongoing outstanding needs across California, disbursal of grant funds will continue to be available to all eligible applicants across all California regions and counties." However, funding for Round 6 was reallocated as part of budget negotiations in 2024.

DHCS was further authorized to award up to $4.4 billion of Proposition 1 bond funds for BHCIP competitive grants. The department is working to allocate the bond funding quickly, with $3.3 billion in Bond BHCIP Round 1: Launch Ready award announcements expected in May 2025. A second and final round of Bond BHCIP will focus on unmet needs.

Program Outcomes. In February 2025, the LAO released a report that examined outcomes from the $1.8 billion in BHCIP grants awarded so far, what those outcomes indicate about the extent to which BHCIP is building the most needed infrastructure in the places where shortages are most acute, and suggested opportunities for the Bond BHCIP funding and questions for legislative oversight.

The LAO found that BHCIP made awards for about 800 adult inpatient beds, addressing roughly 10% of the state's estimated adult shortage of 8,000 inpatient beds. Thus far, BHCIP has supported mostly inpatient facilities. The LAO estimates, assuming awards are granted proportional to early BHCIP rounds, that Proposition 1 funding would add an additional 3,000 inpatient beds. Consistent with the need across the state, the awards have been evenly split between SUD and mental health inpatient facilities. However, the LAO notes that limited data on capacity poses challenges for assessing whether the mix of facilities being built by BHCIP—both by service type and level of acuity—reflect the highest needs.

The LAO identified various outcomes and issues for the legislature to consider, including but not limited to:

- **Awards could be better aligned with needs.** The LAO found that the majority of adult inpatient capacity is being added in four (out of ten) regions of the state estimated to have the least need. In contrast, no progress has been made in building facilities in the region that was identified as having the greatest need (southern San Joaquin Valley).

- **BHCIP may not be working well in all small counties.** While on a per-person basis small counties overall received disproportionately more BHCIP dollars than larger counties, the funding has been concentrated in 11 out of 30 small counties. The remaining 19 counties didn't receive a single award in Rounds 1-5.

- **Barriers exist for applicants.** Launch-ready projects receive scoring preferences, creating significant challenges for small and disadvantaged applicants and potentially limiting the program's success in siting the hardest-to-build facilities.

- **The bulk of dollars are being used to benefit Medi-Cal enrollees.** Given that Medi-Cal enrollees disproportionately experience serious mental health and SUD challenges, the program has been well targeted in this respect. However, this makes it challenging to assess BHCIP's impact on other populations of concern.

The LAO recommends oversight of BHCIP to address the opportunities for improvement identified in their report and maximize the success of the $4.4 billion of Proposition 1 Bond BHCIP funds.

PROPOSITION 1: TRANSITIONING THE MHSA TO THE BHSA

Approved by voters in 2004, the MHSA placed a 1% tax on personal income over $1 million and dedicated the associated revenues to mental health services. The vast majority of MHSA revenues—at least 95%—went directly to counties to support a variety of services for individuals with or at risk of mental illness. The MHSA established five broad categories for how counties must spend the funding. The categories are as follows:

- **Community Services and Supports (CSS)**. 76% of county MHSA funds to provide direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports. Regulations require counties to direct the majority of its CSS funds to full service partnerships (FSPs). FSPs are county coordinated plans, in collaboration with the client and the family, to provide the full spectrum of community services. These services consist of mental health services and supports, such as peer support and crisis intervention services; and non-mental health services and supports, such as food, clothing, housing, and the cost of medical treatment. Up to 20% of CSS funds can be used for Capital Facilities and Technological Needs, Workforce Education and Training, and/or prudent reserves;

- **Prevention and Early Intervention.** 19% of county MHSA funds to provide services to mental health clients in order to help prevent mental illness from becoming severe and disabling;

- **Innovation.** 5% of county MHSA funds to provide services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community;

- **Capital Facilities and Technological Needs.** Creates additional county infrastructure, such as additional clinics and facilities and/or development of a technological infrastructure for the mental health system, such as electronic health records for mental health services; and,
- **Workforce Education and Training.** Provides training for existing county mental health employees, outreach and recruitment to increase employment in the mental health system, and financial incentives to recruit or retain employees within the public mental health system.

The MHSA requires each county mental health program (CMHP) to prepare and submit a three-year plan to DHCS, after review from a local mental health board and approval from the board of supervisors. The plan must be updated each year and approved by DHCS after review and comment by the Mental Health Services and Oversight Commission (MHSOAC). DHCS is required to provide guidelines to counties related to each component of the MHSA. In the three-year plans, CMHPs are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. The plans are to be completed in collaboration with stakeholders that reflect the diversity of the demographics of the county, through a community planning process. CMHPs also must submit their plans for approval to the MHSOAC before they can spend innovation program funds. Counties generally have three years to spend funds (smaller counties have five years) before DHCS can revert funds back to the Mental Health Services Fund for redistribution to other counties.

Passed by California voters in the 2024 statewide primary election, Proposition 1 revised and recast the MHSA as the BHSA with a focus on expanding access to SUD treatment and changing how the money from the act is used. Major policy changes encompassed in the BHSA are covered below.

Spending Allocations. Counties continue to receive the bulk of BHSA funds (90%). However, the allocation across different spending categories changed without an increase in revenues. Counties have the flexibility to move up to 7% from one of the categories below to another, with a maximum overall shift of 14% between the categories. Unless they are granted this flexibility by DHCS, counties must allocate their BHSA funds as follows:

- 30% of county BHSA funds for housing interventions;
- 35% of county BHSA funds for FSPs; and,
- 35% of county BHSA funds for behavioral health services and supports, including early intervention programs, outreach and engagement, workforce education and training, capital facilities and technological needs, and innovative pilot projects.

The BHSA increases the state-directed allocation from 5% to 10%. Of the state's BHSA allocation, dollars are dedicated as follows:

- 3% to bolster the public mental health system workforce, overseen by the Department of Health Care Access and Information (HCAI).
- 4% to fund population-based prevention programs through the CDPH. CDPH must use a minimum of 51% of these funds for programs serving Californians who are 25 years or younger.
- 3% to develop statewide outcomes, provide oversight of county outcomes, provide training and technical assistance, and evaluate programs.

The BHSA identifies several "priority populations" for counties to prioritize BHSA services. These priority populations are children and youth who: are chronically homeless, experiencing homelessness, or at risk of experiencing homelessness; are in, or at risk of being in, the juvenile justice system; are reentering the community from a youth correctional facility; are in the child welfare system; or are at risk of institutionalization. Priority populations also include adults and older adults who: are chronically homeless, experiencing homelessness, or at risk of experiencing homelessness; are in, or at risk of being in, the justice system; are reentering the community from a state prison or county jail; are at risk of conservatorship; or are at risk of institutionalization.

In response to stakeholder concerns regarding the volatility in revenues, the BHSA created the Revenue and Stability Workgroup, jointly convened by DHCS and CHHSA. The workgroup will recommend solutions to fund volatility in a report to the Legislature and the Governor by June 30, 2025. In October 2024, the Revenue and Stability Workgroup released a draft proposal containing several recommendations to improve BHSA revenue stability. The proposal recommends establishing base funding levels using historical revenue data rather than expenditure data, implementing a weighted three-year trailing average (giving the highest weight to the most recent year revenue available) to calculate funding levels, and maintaining county prudent reserves while reducing the maximum level of funds that counties can maintain in their local prudent reserve to 10%, among other changes.

Housing Interventions. A significant modification to MHSA funds under the BHSA is the creation of a Housing Intervention allocation that requires each county to establish and administer a housing intervention program to provide housing interventions for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness. As mentioned above, counties are required, except as specified, to spend 30% of their entire BHSA allocation for these new housing interventions, which can cover rental subsidies, operating subsidies, family housing, and shared housing. Half of this funding must be dedicated to housing interventions for those experiencing chronic homelessness and up to 25% may be used for capital development.

Addition of Stand-Alone SUD. The original MHSA made explicit reference to those with co-occurring conditions and permitted the use of funds to treat those with a co-occurring SUD, as long as an individual has a primary mental health condition. The BHSA now permits counties to provide stand-alone SUD treatment services without a mental health diagnosis. The MHSOAC

was also rebranded as the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) to reflect the addition of SUD. Consistent with the rebranding, the BHSOAC now has an explicit advisory role to the Governor and the Legislature on SUD, and 11 members were added to the commission, including two people who have or have had an SUD and a physician specializing in SUD treatment.

County Planning and Outcomes. The BHSA requires counties to submit three-year integrated plans for their total behavioral health funding, including BHSA, 1991 and 2011 Realignment, federal grant programs, federal financial participation from Medi-Cal, opioid settlement funds, and local funding. 1991 realignment refers to the shift of fiscal and programmatic responsibility for many health and human services programs from the state to counties, and 2011 realignment refers to the shift of public safety, mental health services, substance abuse treatment, and more from the state to the counties. The state provides counties dedicated revenues to pay for their share of these costs. The BHSA planning process also specifically requires the consideration of local SUD prevalence and unmet needs data.

The BHSA requires counties to submit Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) annually to improve transparency of how they spend behavioral health dollars and administer behavioral health care. Counties are required to report on all behavioral health spending, not just the dollars provided through the BHSA, and on goal achievement and outcomes for each reporting period. The first BHOATR will be due January 30, 2028 for fiscal year 2026-27.

While the BHSA was passed by voters in 2024, the major policy changes detailed above won't be in effect until July 2026 when the new county plans become effective. Since the passage of the BHSA, DHCS and CHHSA have been collaborating with counties, providers, tribal leaders, and other stakeholders to prepare for implementation. In February of 2025, DHCS released the final version of the Behavioral Health Services Act County Policy Manual Module 1, which reflects feedback received through public listening sessions, comments, and engagement forums. The manual is being released in multiple phases called "modules." Once completed, it will be a comprehensive guide for all involved parties to implement the requirements detailed in the BHSA.

As the implementation Proposition 1 unfolds, the Legislature will need to provide oversight and input into how bond funds are spent to ensure that they are distributed in an equitable manner and that the most impacted communities, counties, and populations receive the support that they need.