WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Teleconference Meeting
April 27, 2023
Presentations and Handouts

Miscellaneous:	•Handout	Information Notice: Priorities for the Prevention and Early Intervention Component of the Mental Health Services Act
Agenda Item 6:	•Presentation:	Back to the Future
	•Presentation:	Full Service Partnerships in a Rural Setting
	•Presentation:	Multi-County Full Service Partnership (FSP) Innovation Project
Agenda Item 7:	•Presentation:	Modernizing California's Behavioral Health System

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

MHSOAC INFORMATION NOTICE #23-001

DATE: April 26, 2023

TO: County Mental Health Directors
County Behavioral Health Directors
County MHSA Coordinators
Interested Parties

SUBJECT: Priorities for the Prevention and Early Intervention Component of the Mental Health Services Act.

PURPOSE: To Provide Guidance to Counties Regarding PEI Priorities and the use of PEI Funds.

REFERENCE: Welfare and Institutions Code Section 5840.7; Welfare and Institutions Code Section 5840.8; MHSOAC January 30, 2020 Guidance on Priorities for Prevention and Early Intervention Component of the Mental Health Services Act.

BACKGROUND

This Mental Health Services Oversight & Accountability Commission Information Notice provides guidance to Counties regarding the implementation of Welfare and Institutions Code section 5840.7 enacted by Senate Bill 1004 (Statutes 2018 Chapter 843). The Commission is issuing this Notice pursuant to Welfare and Institutions Code section 5840.8, which authorizes the Commission to implement this law through an information notice or related communication without taking regulatory action.

Section 5840.7 also authorizes the Commission to adopt additional programs that the Commission identifies, with community partner participation, "that are proven effective in achieving, and are reflective of, the goals stated in Section 5840."

On January 30, 2020, the Commission issued a communication that stated "[t]he Commission has not at this time established priorities additional to those specifically enumerated in WIC Section 5840.7(a)." This Information Notice supersedes the Commission's January 30, 2020 Guidance on PEI Priorities.

On March 23, 2023, through formal action, the Commission directed Staff to prepare an information notice indicating that the Commission has adopted additional priorities, regarding transition age youth not in college, and community defined evidence practices (CDEPs).

GUIDANCE

Pursuant to Welfare and Institutions Code sections 5840.7 and 5840.8, the Mental Health Oversight & Accountability Commission has adopted the following priorities for the use of prevention and early intervention funds, including two additional priorities that are identified in *italics* below:

> (1) Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
>
> (2) Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
>
> (3) Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs *and transition age youth not in college*.
>
> (4) Culturally competent and linguistically appropriate prevention and intervention*, including community defined evidence practices (CDEPs).*
>
> (5) Strategies targeting the mental health needs of older adults.

Section 5840.7(d)(1) requires that counties shall, through their MHSA Three-Year Program and Expenditure Plans and Annual Updates, focus use of their PEI funds on the Commission-established priorities or other priorities as determined through their respective, local community partner processes. If a County chooses to focus on priorities other than or in addition to those established by the Commission, "the plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured."

In order to meet the requirements of Section 5840.7(d)(1), each County shall show in the PEI Component of its Fiscal Year 2024-2027 Three-Year Program and Expenditure Plan, the following:

1. Which specific PEI priorities the County's plan addresses, an estimate of the share of PEI funding allocated to each priority, and an explanation of how community partner input contribute to those allocations.

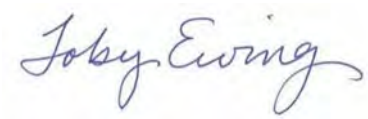
2. If the County has determined to pursue alternative or additional priorities to those listed in Section 5840.7(a), how the County made these determinations through its community partner process.

3. For any alternative or additional priority identified by the County, what metric or metrics relating to assessment of the effectiveness of programs intended to address that priority the County will measure, collect, analyze, and report to the Commission, in order to support statewide learning.

For any alternative or additional priority identified by a County in its plan, the County shall specify at least one metric through which it will assess the effectiveness of the program(s) intended to address that alternative priority. The County shall provide an explanation with supporting evidence as to the validity of the specified metric for its intended purpose.

If you have any questions or concerns regarding this Information Notice, please contact Sharmil Shah, Chief of Program Operations at Sharmil.Shal@mhsoac.ca.gov.

Respectfully,



Toby Ewing
Executive Director

A Presentation to the MHSOAC

Dave Pilon, Ph.D.

April 27, 2023

Village Integrated Service Agency ("The Village")

- Assembly Bill 3777 (Bronsan - 1989): Creates three pilot projects (one urban, one rural, one county-wide) to demonstrate a case rate approach to mental health financing **($15,000 per person per year in advance – NO MINUTE-BY-MINUTE MEDICAID BILLING)**
- The Mental Health Association of Greater Los Angeles (a private, non-profit 501(c)3 agency) wins the grant for the urban project
- We open our doors to 120 randomly assigned members (consumers) on July 1, 1990. 120 other consumers are assigned to a control group. An independent evaluator conducts an ongoing evaluation from July 1, 1990 through June 30, 1993.

VILLAGE STRUCTURAL FEATURES

- A “hybrid” model primarily combining elements of intensive case management (ACT) and **psychosocial rehabilitation (Fountain House Clubhouse)**
- Full risk capitated model: Initially responsible for both inpatient and medication costs in addition to usual and customary outpatient services
- Employs licensed staff (including psychiatrists) as well as unlicensed staff **(including job developers and community integration specialists)**
- Services are designed to address all aspects of the member’s life, not just the symptoms of their mental illness

INDEPENDENT EVALUATOR'S FINDINGS: MAJOR HIGHLIGHTS

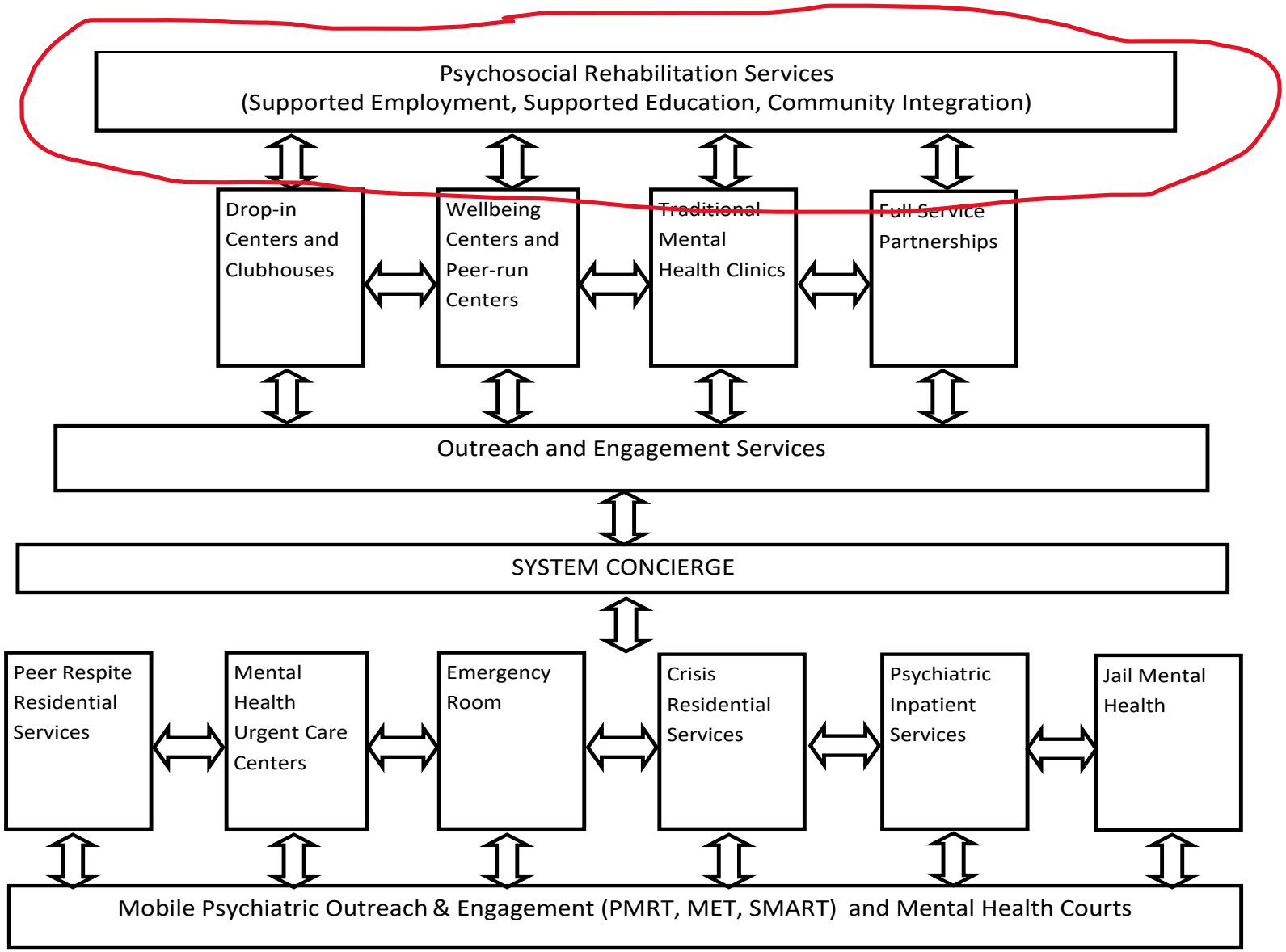
- Village members had significantly fewer hospital days than the comparison members. Village members also had significantly lower costs for inpatient care.
- **At the Village, 72.6% of members tried paid employment over a three-year period, compared to 14.6% of the comparison group.**
- The percentage of Village members living in group and institutional settings declined from 15.8% at baseline to 10.8% after three years. Among the comparison members, the percentage remained fairly constant from 23.7% at baseline to 23.2% after 3 years.
- Village members reported more solitary leisure activities and more activities with others during the week before the interview than did comparison members. Village members reported significantly more support at each of the three annual interviews.
- Families of Village members reported significantly less burden and less stress from burden than did family members of the comparison group. Families of Village members also were much more positive about the member's hopes for the future than families of the comparison group.
- Members at the Village were significantly more satisfied with mental health services than members in the comparison group.

In Lewin-VHI, Inc., with Meisel, J., & Chandler, D. The Integrated Service Agency Model: A Summary Report to the California Department of Mental Health, June, 1995.

SERVICE EXPENDITURE PATTERNS: VILLAGE vs. COMPARISON GROUP

Type of Service	Village Percent of Total	Comparison Percent of Total
Case Management	40.6	10.1
Day Treatment	0.2	1.0
Medications	11.2	10.2
Residential	0.3	2.1
Socialization	**11.6**	**1.2**
Outpatient Therapy	4.7	23.2
Vocational	**25.1**	**1.3**
Acute Hospital	5.1	27.9
Long Term Care	1.3	23.1

In Lewin-VHI, Inc., with Meisel, J., & Chandler, D. The Integrated Service Agency Model: A Summary Report to the California Department of Mental Health, June, 1995.


Psychosocial Rehabilitation Services
(Supported Employment, Supported Education, Community Integration)
Drop-in Centers and Clubhouses
Wellbeing Centers and Peer-run Centers
Traditional Mental Health Clinics
Full Service Partnerships
Outreach and Engagement Services
SYSTEM CONCIERGE
Peer Respite Residential Services
Mental Health Urgent Care Centers
Emergency Room
Crisis Residential Services
Psychiatric Inpatient Services
Jail Mental Health
Mobile Psychiatric Outreach & Engagement (PMRT, MET, SMART) and Mental Health Courts

So why aren't we providing psychosocial rehabilitation services?

It's very hard to focus on the banality of day-to-day needs (work, school, socializing) when crises (evictions, suicidal ideation) are happening all around us.

Our current billing system Medicaid) puts up significant barriers to billing for employment services

There is an underlying unspoken assumption to our work that the job of our staff is to address "clinical" issues (i.e., medication and therapy) and those services should be the limit of our interventions.

Clinical staff are not trained to provide "downstream services" like job development and job coaching

Three Recommendations

1) Explore a true pay-for-value system that holds providers accountable for their outcomes
   - Reduces the documentation and billing burdens that our staff experience under Medicaid
2) Provide separate funding streams (de-coupled from FSPs) for psychosocial rehabilitation services like supported employment, supported education, and community integration services
3) Increase hiring of and reliance on non-licensed B.A. level staff to provide the aforementioned psychosocial rehabilitation services.

Questions and Discussion

Full Service Partnerships in a Rural Setting

Phebe Bell, Nevada County

Behavioral Health

NEVADA COUNTY
CALIFORNIA

A little context setting:

- Population of 103,000
- Three population centers
- Mountain pass in the middle

Nevada County Behavioral Health Department

- Three clinic sites
- Staff of 58 FTEs
- Budget of $45m
- Contract out 69% of services

Full Services Partnership Programs

- Turning Point Community Programs
- Victor Community Support Services
- Stanford Sierra Youth and Families

By the numbers:

Turning Point Community Programs:	• Serve 75~ people at a time • Comprehensive array of services • 40+ people on daily med delivery • Manage 42 beds of housing
Victor Community Support Services:	• Serve 80~ youth at a time • Parent partners key
Stanford Sierra Youth and Families:	• Smaller program – up to 10 families

Unique aspects of FSP in a rural area

- Clients are well known across the system and care can be personalized
- Co-located with county services; fluid movement back and forth between our programs
- Flexibility is critical – “fidelity lite”

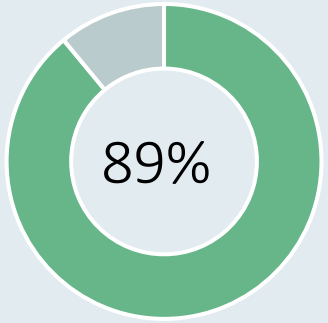
ADULT FULL SERVICE PARTNERSHIP OUTCOMES

July 2021 - June 2022

80 individuals served

18% gained or maintained employment

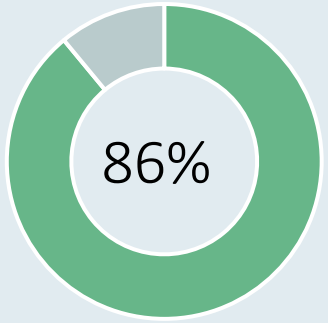
HOUSING & HOMELESSNESS



SUCCESFULLY REMAINED HOUSED

71 INDIVIDUALS

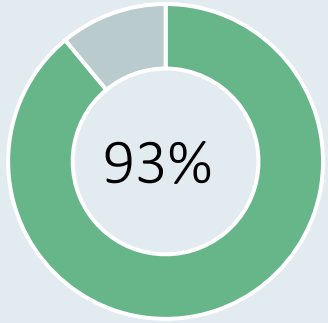
PSYCHIATRIC HOSPITALIZATION



AVOIDED PSYCHIATRIC HOSPITALIZATION

69 INDIVIDUALS

CRIMINAL JUSTICE



AVOIDED ARREST OR INCARCERATION

74 INDIVIDUALS

CHILDREN'S FULL SERVICE PARTNERSHIP

Performance Outcomes July 2021 - June 2022

131 youth served

4% increase in youth served from previous year

96%
SUCCESSFULLY REMAINED HOUSED

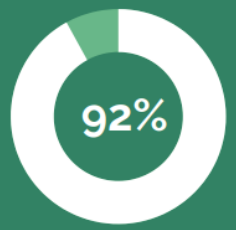
96%
AVOIDED PSYCHIATRIC HOSPITALIZATION

98%
AVOIDED NEW LEGAL INVOLVEMENT

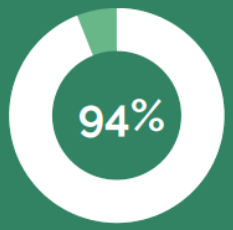
ACADEMIC PERFORMANCE

- **80%** maintained a C average or improved their academic performance
- **95%** did not experience a suspension or expulsion
- **91%** of discharged youth reported regular school attendance or improvement in school attendance

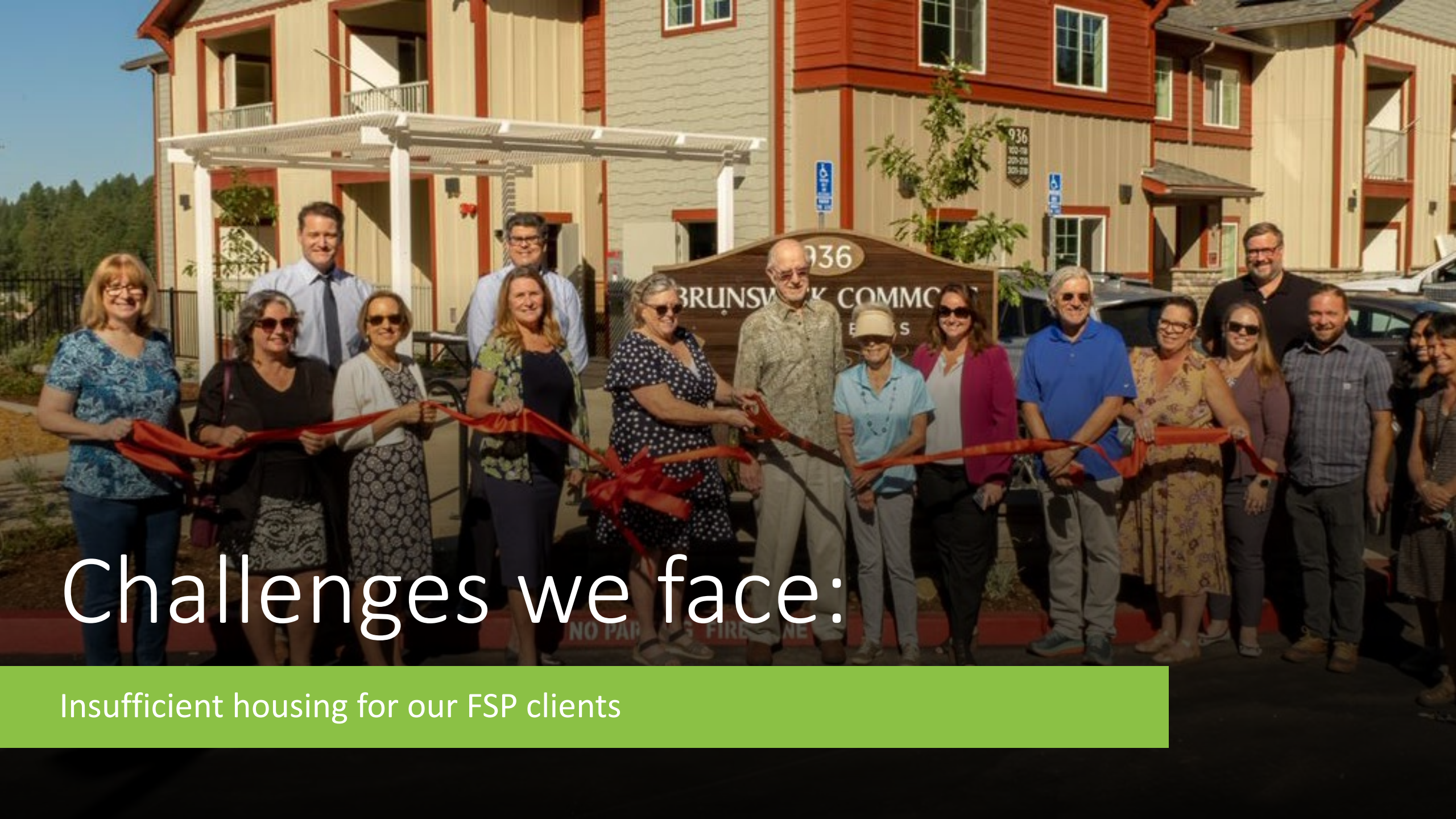
CAREGIVERS



of caregivers reported increased connections in the community



of caregivers reported their parenting skills increased or improved



Challenges we face:

Insufficient housing for our FSP clients

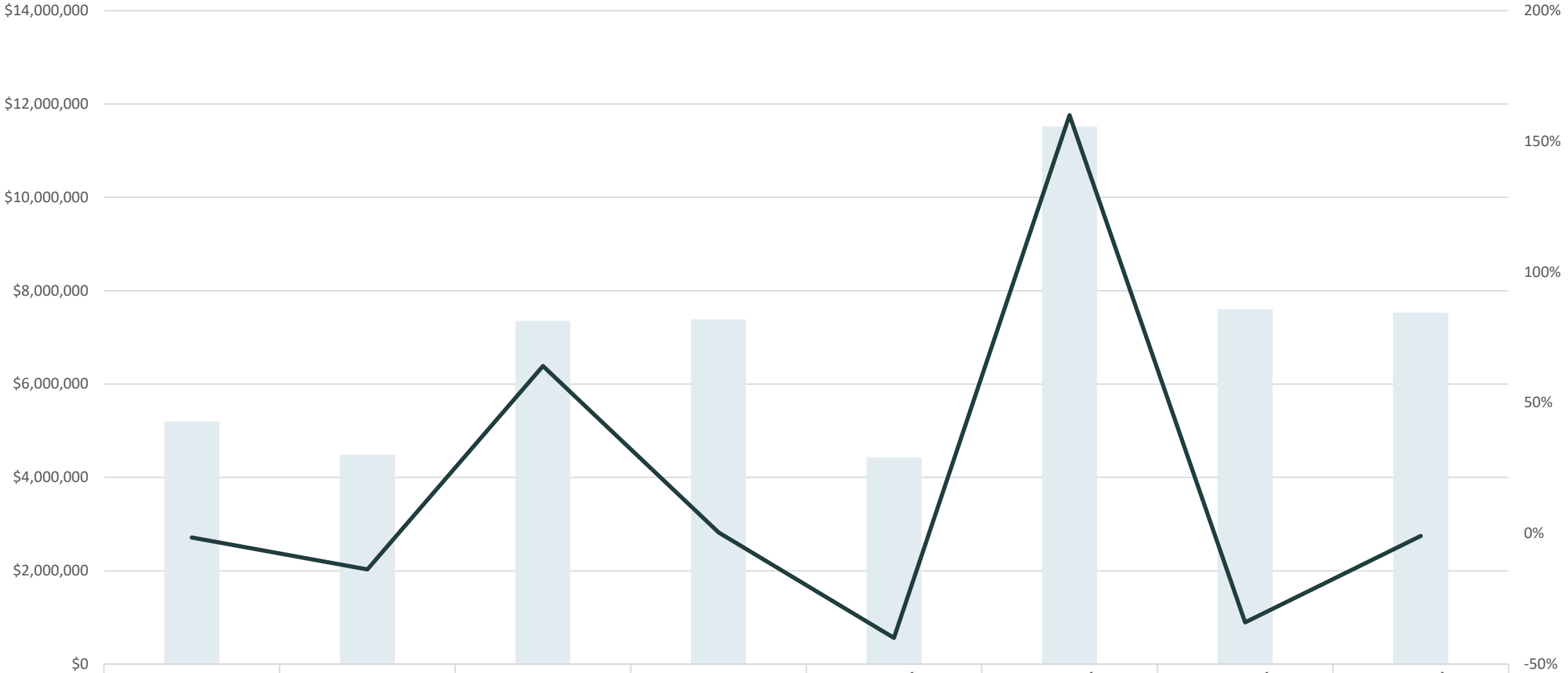
Workforce Crisis

- Vacancies
- Recruitment challenges
- Level of experience

Quality of life concerns

- Sense of purpose or meaning
- Adding evidence based employment program
- Trying to nurture social connections

Nevada County MHSA Revenue Trends



	FY18/19	FY19/20	FY20/21	FY21/22	FY22/23 (Projected)	FY 23/24 (Projected)	FY 24/25 (Projected)	FY 25/26 (Projected)
MHSA Revenue	$5,197,441	$4,483,778	$7,354,433	$7,383,573	$4,430,144	$11,518,374	$7,602,127	$7,526,106
% YoY Change	-2%	-14%	64%	0%	-40%	160%	-34%	-1%

Fund Balance – Three Year Plan FY 23/24 – 25/26

Community Services and Supports (CSS)	**FY 23/24**	**FY 24/25**	**FY 25/26**
CSS Revenue	8,753,964	5,777,616	5,719,840
CSS Expenditure	7,767,583	7,767,583	7,767,583
CSS Fund Balance	3,401,384	1,302,835	(853,490)
Prevention and Early Intervention (PEI)	**FY 23/24**	**FY 24/25**	**FY 25/26**
PEI Revenue	2,188,491	1,444,404	1,429,960
PEI Expenditure	2,160,014	2,160,014	2,160,014
PEI Fund Balance	1,211,521	495,911	(234,143)

As we look ahead:

areas we are watching that may impact our FSP work

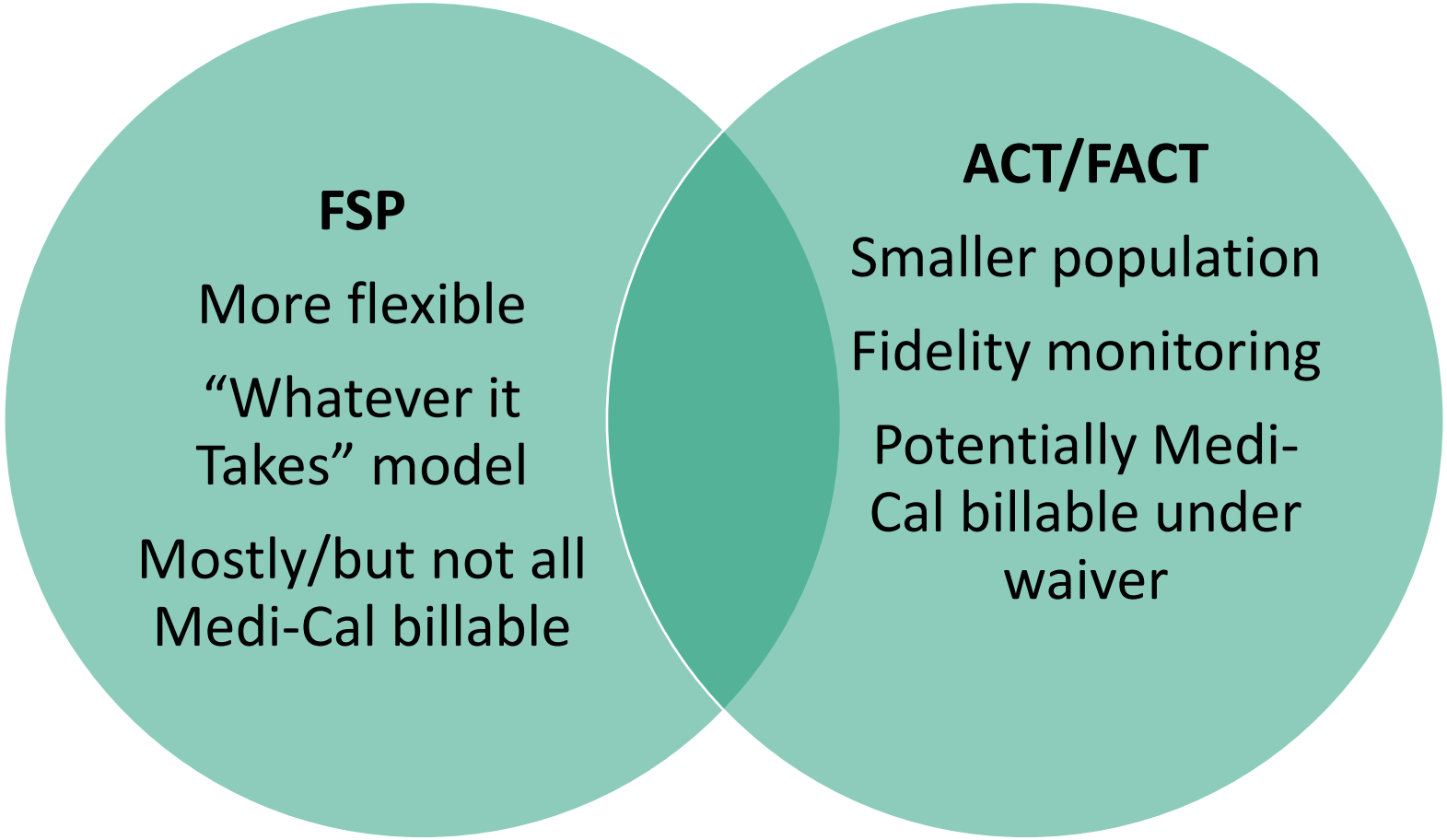
- Multiple state reform initiatives
- Impacts of payment reform
- Growing demand for FSP services

Behavioral Health Reform Proposal

Governor's Proposal:

- New requirement to spend 30% of MHSA funding on Housing/Housing Services
- New requirement to spend 35% on FSPs
  - Equates to a 10% decrease in FSP required spending
- Delinking housing stability from FSPs could be a positive
- Could also introduce concept of SUD only or SUD primary FSPs
- Impact on services/funding uncertain

DHCS CalBH-CBC Proposal:
Establish ACT/FACT as new Medi-Cal benefits



Thank you!

Happy to answer any questions

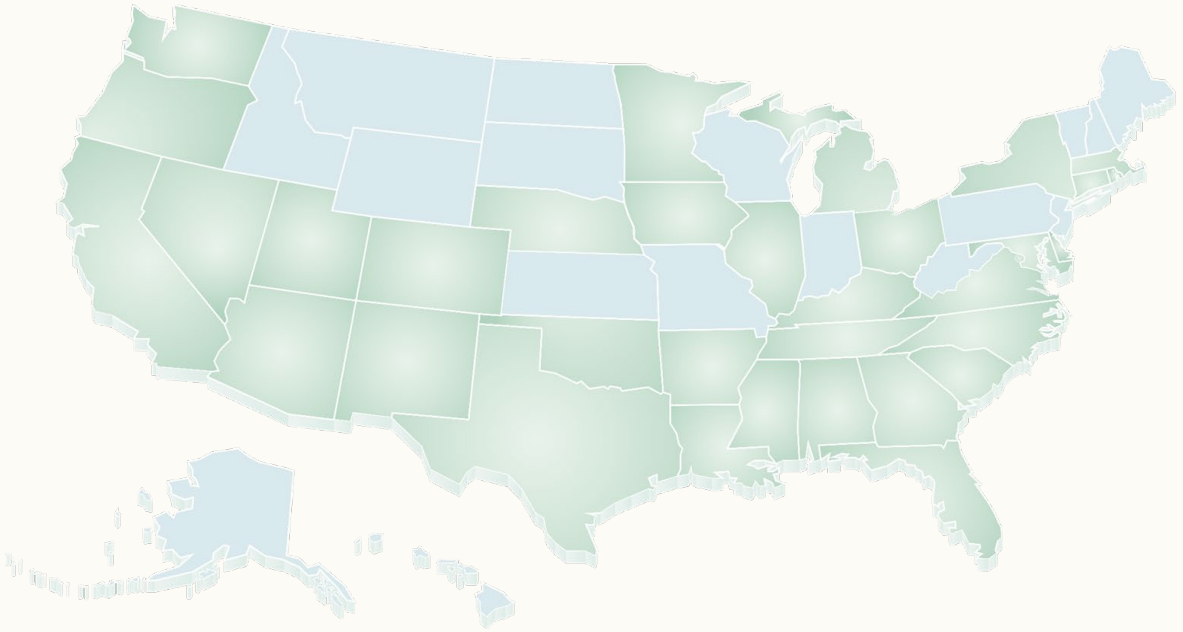
THIRD SECTOR

Multi-County Full Service Partnership (FSP) Innovation Project

FSP Panel

April 27, 2023

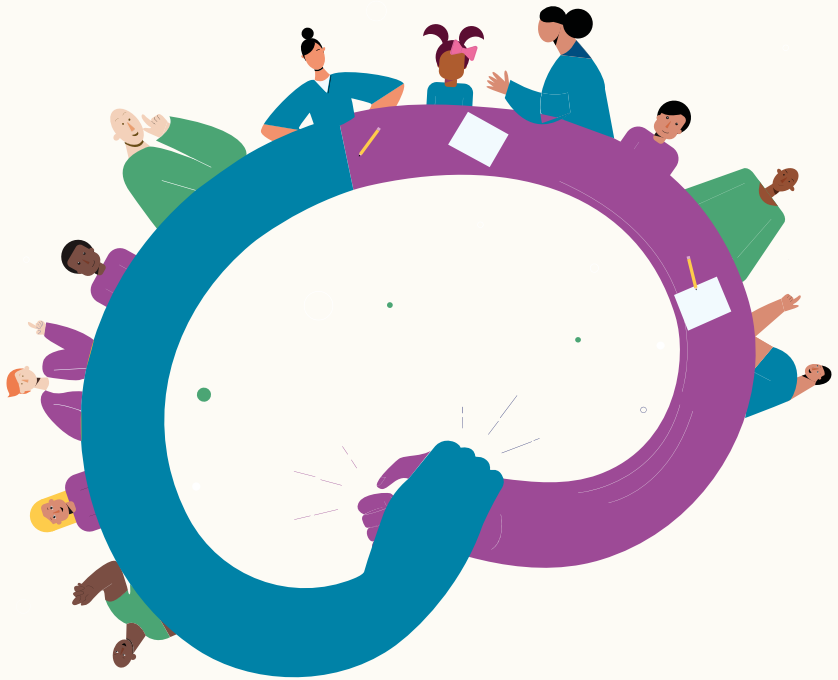
Third Sector advises government and their partners on effective ways to reshape policies, systems, and services toward better outcomes



75+ Consulting Engagements

Since 2011, Third Sector has worked with **50+ communities** to deploy more than **$1.2 billion** in government resources toward improved outcomes

Objectives



01

Provide overview of the Multi-County Full Service Partnership Innovation Project

02

Outline differences in program elements across counties, including definitions of target populations, graduation and transition processes, and metrics of success

03

Share key takeaways from the innovation project around capacity building and technical assistance opportunities for counties and FSP providers

Origins of the Multi-County FSP Innovation Project

The Opportunity for Improvement

Counties are provided substantial flexibility in FSP operations, data collection, and approaches. While this local control has supported innovative, community-responsive services, counties have different operational definitions and inconsistent data processes, making it challenging to understand and tell a statewide impact story.

An Initial County Pilot

From 2018 – 2021, the Los Angeles County Department of Mental Health partnered with Third Sector to transform FSPs into more outcomes-oriented and data-informed programs that reflect the spirit of doing "whatever it takes."

The Multi-County FSP Collaboration

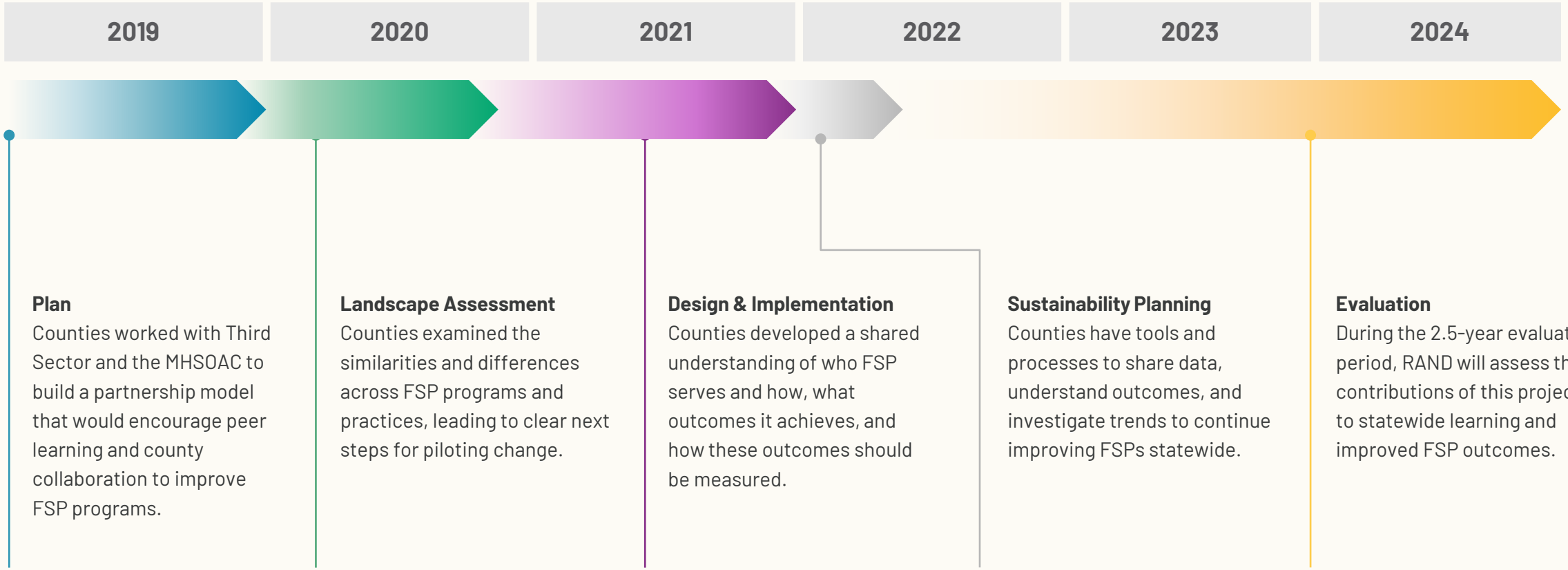
In 2020, six counties – Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura – in partnership with the MHSOAC and CalMHSA, launched the Multi-County FSP Innovation Project to leverage their collective resources and experiences to transform how data is used to continuously innovate and improve FSPs across California. In the fall of 2021, Lake and Stanislaus counties joined the project. In the summer of 2022, Napa County joined the project.

Project Vision and Shared Goals

When the Multi-County FSP Innovation Project is complete, counties will have an improved ability to collect and use data that illuminates **who FSP is serving, what services they receive, and what outcomes are achieved**. Findings from each county will contribute to **statewide recommendations to create more consistent FSPs** that deliver on FSP's "whatever it takes" promise.

1. **Develop a shared understanding** and more consistent interpretation of FSP's core components across counties, creating a common FSP framework
2. **Increase the clarity and consistency** of enrollment criteria, referral, and graduation processes through developing and disseminating clear tools and guidelines across stakeholders
3. Improve how counties define, track, and **apply priority outcomes across FSP programs**
4. **Develop a clear strategy** for tracking outcomes and performance measures through various state-level and county-specific reporting tools
5. **Develop new and/or strengthen existing processes** for continuous improvement that leverage data to foster learning, accountability, and meaningful performance feedback

Project Overview and Timeline*



*Project timeline for original six counties. Lake, Stanislaus, and Napa counties will follow a similar process along a different timeline.

Landscape Assessment: Counties began by gathering context within and across their FSP programs, then prioritized changes

225

Individual interviews
with current or former FSP clients or their caregivers

"Success looks like stable housing in an environment where I feel comfortable."

"[My primary goal] is to start relationships with people and maintain them."

Clients

50

Provider focus groups
with participation from over 200 FSP staff

"This process has revealed that each [program] operates in a unique way. The lack of an overall framework caused inconsistency. To more effectively provide these services, **the provider community needs to learn from each other, in collaboration with the county and state**. The ideas are out there."

Providers

123

Survey responses
from county and provider staff

"A data-driven approach is important: instinct may not always be reliable.""

County Staff

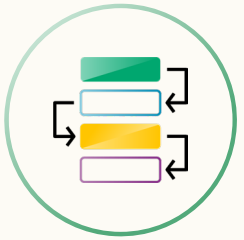
Design & Implementation: Counties created shared definitions and metrics as a cross-county cohort

FSP Population Definitions*

Standardize definitions of FSP populations (e.g., homeless, justice-involved, high utilizer of psychiatric facilities, etc.)

Outcome & Process Metrics*

Identify priority outcomes and process measures to track what services FSP clients receive and the success of those services



Statewide Data Recommendations

Develop recommendations for revising Data Collection & Reporting (DCR) forms, metrics, and/or data reports to increase the utility of state data

*Links with additional information on FSP population definitions and outcome and process metrics can be found here and here

Design & Implementation: Counties also pursued their own local implementation activities*

Implementation Activity	Participating Counties			
Stepdown (Graduation) Guidelines	Sacramento	San Mateo	Ventura	Lake
	San Bernardino	Siskiyou	Stanislaus	
Service Requirements	San Mateo	Ventura	Siskiyou	
Eligibility Guidelines	San Mateo	Ventura	Lake	
Reauthorization Process	Fresno	Sacramento		
Improved Data Collection Processes	Fresno	San Bernardino		
Referral Guidelines	San Bernardino			
Referral and Enrollment Process	Fresno			
Workforce Recruitment / Retention	Stanislaus			

*Napa County is still deciding on their local implementation activities

Sustainability Planning & Evaluation: Once solutions are implemented, counties focus on continuous improvement processes and evaluating success

Continuous Improvement Planning
Develop an ongoing cadence across counties to share outcomes data, identify best practices, and strategize operational improvements to pilot

Evaluation Preparation
Confirm evaluation plan and data-sharing format for RAND's ongoing analysis, in order to understand client and project impact

Lessons Learned: Project insights on multi-county collaborations

Pursue a shared vision with flexible approaches tailored to individual county needs

State collaborations inevitably draw counties of varying sizes, structures, and resources. Recognizing and responding to these differences in work planning, meeting cadence, communication, and process implementation can help mitigate challenges.

Consider which activities are best suited for statewide standardization vs. local adaptation

Some activities are more appropriate for consistency while others should include local county nuance. Both can create efficiencies through shared resources and learnings while honoring counties' distinct geographies, populations, and histories.

Value informal learning as highly as formal meetings and project structures

In addition to structured forums for designing and delivering on project activities, the counties had the opportunity to compare notes and exchange informal learnings about best practices on topics ranging from flex funding to data reporting practices.

Creating a statewide vision for Full Service Partnerships

Expand Community Engagement for Decision Making

Counties and providers can expand roles for community members, particularly FSP clients, to iterate and improve upon program elements and outcome measures and ensure that they are recovery oriented and client-centered.

Grow Statewide Learning Community

Counties can utilize forums developed during the project to continue to understand program variations, share learnings, evaluate results, and collaborate across the state more broadly.

Save the date for the next Learning Community on May 25th, 2023!

Explore Opportunities for Statewide Capacity Building

Counties and providers can expand roles for community members, particularly FSP clients, to iterate and improve upon program elements and outcome measures and ensure that they are recovery oriented and client-centered.

Thank you!

For more resources and information:
Multi-County FSP Project website: https://www.thirdsectorcap.org/behavioral-health/multi-county-ca-fsp-inn/

For additional questions please contact:
Nicole Kristy, Director (nkristy@thirdsectorcap.org)

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Modernizing California's Behavioral Health System

April 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

CalHHS
California Health & Human Services Agency

Context

- Since 2019, California has embarked on massive investments and policy reforms to re-envision the state's mental health and substance use system.

- 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.

- 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 abuse.

Key Elements

1. Authorize a general obligation bond to fund unlocked community behavioral health residential settings
    - The bond would also provide housing for homeless veterans
2. Modernize the Mental Health Services Act (MHSA)
3. Improve statewide accountability 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
- Provide more funding for housing of homeless veterans
- $3-5 billion bond on 2024 ballot

Adding New Behavioral Health Settings

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 and long term housing stability. Depending on need that may be returning home, Permanent Supportive Housing, Scattered Site or Shared Housing, for examples.

Modernize the Mental Health Services Act

Modernize the Mental Health Services Act

- Update local categorical funding buckets – lifting up housing interventions and workforce
- 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
- Restructure role of the Mental Health Services Oversight Accountability Commission
- Many components will require 2024 Ballot initiative
- Multi-year implementation starting in July 2025

Update Local Categorical Funding Buckets

- 30% for housing in residential settings for individuals with serious mental illness/serious emotional disturbance and/or substance use disorder.
  - Counties will manage the funds and direct the funds toward local priorities that meet designated purposes including but not limited to rent subsidies, operating subsidies, shared housing, and non federal share for housing related Medi-Cal services. Capital investments will require authority from DHCS
- A services bucket with two sub-categories:
  - 35% of the local assistance for Full Service Partnership (FSP) which should be optimized to leverage Medicaid as much as is allowable
  - 35% for other services including Community Services and Supports (non FSP), Prevention and Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, and prudent reserve (no required spending per category)
- To reduce overlap with the Children and Youth Behavioral Health Initiative and close the gap in preventive services, Prevention and Early Intervention (PEI) dollars for schools should be focused on schoolwide behavioral health supports and programs and not services and supports for individuals.

Housing Interventions

- Dedicate 30% in local MHSA 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.

- Funding could be used for full spectrum of housing services, rental subsidies, operating subsidies, capital and non-federal share for certain housing-related Medi-Cal covered services. It also could be used to further the California Behavioral Health Community-Based Continuum Demonstration.

- Funding for capital development projects, subject to DHCS limits established through bulletin authority.

Blending FSP & Housing Intervention Funds

Under this proposal, MHSA funding could be used for a wide range of housing options, including:

- Rental subsidies, operating subsidies, shared housing, and the non-federal share for certain Medi-Cal covered housing-related services (e.g., Rent/Temporary Housing covered under the CalBH-CBC demonstration).

This funding is not intended for non-housing services and supports (e.g., Targeted Case Management services or Peer Support Services) that would help keep the individual housed; those services and supports would be funded by either other MHSA buckets of funding or through Medi-Cal, where the other MHSA components could be used for the non-federal share.

- *For example - 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). MHSA 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.*

Workforce

- Expand the use of local MHSA funds under the Workforce Education and Training (WET) component to include activities for workforce recruitment, development, and retention.

- The use of these funds could include professional licensing and/or certification testing and fees, loan repayment, stipends, internship programs, retention incentives, and continuing education and that increase the racial/ ethnic and geographic diversity of the workforce.

- In addition to expanding the local MHSA funds under WET, allocate MHSA funds to create a new Behavioral Health Workforce Initiative, while drawing down additional federal funds for a five-year period.

Broaden Target Population

- Authorize MHSA 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.

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

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

Focus on Most Vulnerable

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, 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, 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 MHSA to maximize federal funding for services.
- Reduce allowable prudent reserve amounts from 33% to 20% for large counties and 25% for small counties.
- Reassess prudent reserve more frequently from every 5 years to every 3 years.
- Authorize up to 2 percent of local MHSA 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

- Pare back the requirements for Three-Year Program and Expenditure Plans, standardize the level of detail and submission process, and provide additional flexibilities for transparent amendment process.

- Provide county behavioral health agencies with more flexibility to adjust spending.

- Transform the MHSA 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 for these reports to inform the MHSA planning process to ensure strategic alignment of funding and local cross-system collaboration.

- Require plans be approved by boards of supervisors by June 30.

Mental Health Services Oversight Accountability Commission

- Move the Mental Health Services Oversight Accountability Commission (MHSOAC) under the California Health and Human Services Agency to ensure their work is connected and coordinated with the State's overall behavioral health system.

- MHSOAC will continue to examine data and outcomes to identify key policy issues and emerging best practices and promote high-quality programs.

- MHSOAC will also continue to report to the Legislature and include representation from the Legislature, and maintain their responsibilities related to stakeholder engagement. Under the proposal, DHCS will provide oversight of the fiscal allocations and counties' use of funding, including accountability for contracted services.

- Require that the Commission would become advisory, and its Executive Director would be a gubernatorial appointee.

Improve Statewide Accountability and Access to Behavioral Health Services

Fiscal Transparency

Require counties to report:

- Annual allocation of MHSA, Realignment, and all federal block grants;
- Annual spend on non-federal match payments including MHSA, Realignment or other county sources;
- MHSA, Realignment and Block Grant only spend;
- Any other behavioral health investments using local General Fund or other funds;
- Any unspent MHSA, Realignment or block grant funds for that fiscal year;
- Cumulative unspent MHSA, Realignment or block grant funds, inclusive of reserves;
- Admin costs, and
- 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:
  - Require key administrative positions (e.g., quality director, chief financial officer, operations director, compliance officer)
  - Compliance oversight and monitoring of subcontractors
  - Post on their website network adequacy filings, annual number of utilizers and utilization by service type
  - Establish a robust set of quality metrics for county BH plans and establish quality thresholds/goals
  - Require county BH plans annually report utilization and quality to Board of Supervisors (BOS) and require the BOS to attest that they are meeting their obligation under Realignment
  - Require county BH plans to form member advisory council to inform policy and programs
  - Implement closed loop referrals

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.

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.

Questions?

For questions and inquiries, contact
BehavioralHealthTaskForce@chhs.ca.gov

DHCS