California State Assembly

Assembly Budget Agenda

Assembly Budget Subcommittee No. 1 on Health

Assemblymember Dawn Addis, Chair

Monday, April 7, 2025

2:30 P.M. – State Capitol, Room 127

Items To Be Heard

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4440 Department of State Hospitals

Issue 1: Budget Overview, Budget Change Proposals & Trailer Bill

Background on the Department of State Hospitals

The Department of State Hospitals (DSH) manages California's inpatient forensic mental health hospital system. Most patients admitted to DSH are court-mandated for treatment, with over 90 percent classified as forensic commitments. These individuals have been accused or convicted of crimes related to their mental illness and are referred to DSH through the criminal court system.

In addition to forensic commitments, DSH also treats individuals designated by a judge or jury as Sexually Violent Predators. These patients have completed prison sentences for crimes specified under the Sexually Violent Predator Act and are committed to DSH for continued treatment until a judge determines they no longer pose a threat to the community. The remaining DSH population includes civil commitments – individuals deemed by a court to be a danger to themselves or others, commonly known as Lanterman-Petris-Short (LPS) commitments.

DSH operates five state hospitals located in Atascadero, Coalinga, Metropolitan-Los Angeles, Napa, and Patton. Its administrative offices are based in Sacramento. Beyond its state hospital services, DSH also oversees programs in jail-based competency treatment (JBCT), community-based restoration (CBR), community inpatient facilities, pre-trial felony mental health diversion, and the Conditional Release Program (CONREP).

The next page provides a chart describing patients under DSH jurisdiction and information on population census.

DSH Population	Population Description	7/1/2024 Actual Census	6/30/2025 Projected Census
Coleman	Patients transferred from the California Department of Corrections and Rehabilitation under *Coleman v. Brown* requiring mental health care in state hospitals.	159	270
Incompetent to Stand Trial (IST)	Individuals found incompetent to stand trial due to a mental disorder, requiring restoration of competency.	1,659	1,741
Lanterman-Petris-Short (LPS)	Lanterman-Petris-Short Act civil commitments for individuals gravely disabled due to mental illness.	547	556
Not Guilty by Reason of Insanity (NGI)	Individuals found Not Guilty by Reason of Insanity and committed for treatment to a state hospital.	1,208	1,212
Offenders with a Mental Health Disorder (OMD)	Offenders with a Mental Health Disorder committed following prison sentences.	1,027	1,033
Sexually Violent Predators	Individuals designated as Sexually Violent Predators under state laws and requiring secure treatment.	950	950
Contracted Programs	Includes Jail-Based Competency Treatment (JBCT), Community-Based Restoration (CBR), and Community Inpatient Facilities (CIF).	1,163	1,545
Conditional Release (CONREP) Programs	Outpatient treatment programs including CONREP, Forensic Assertive Community Treatment (FACT), and Step Down Facilities.	701	1,016
TOTAL		**7,414**	**8,323**

Budget Overview

The 2025-26 Governor's budget proposes **$3.3 billion and 13,484** staff positions for the Department of State Hospitals. Compared to the 2024 Budget Act, this represents an approximate 1.6% budget increase. A high-level breakdown of the DSH budget is included below:

Funding Source	2024 Budget Act	2025-26 Governor's Budget	Percentage Change
General Fund	$3,138,663	$3,192,563	+1.72%
Other Funds	$165,446	$165,446	0.00%
TOTAL	**$3,304,109**	**$3,358,009**	**+1.63%**
Staff Positions	*13,437*	*13,484*	+0.35%

**dollars in thousands*
***includes non-budget act items (Medicare, Lottery, Re-Appropriations)*
****excludes Capital Outlay funding*

Budget Change Proposals

The Governor's budget includes two budget change proposals, outlined below:

1- Statewide Project Management

DSH requests 12 positions for 2025-26 and ongoing to address the sustained increase in workload with the number of design and construction projects managed by its Facility Planning, Construction & Management (FPCM) section. According to the Department, **this proposal is cost neutral**, as the positions will replace contracted project managers and shift contract expenditures to personnel services. These positions will have oversight and authority for all DSH information technology infrastructure, Capital Outlay and Deferred Maintenance/Special Repair projects. The Department notes that FPCM is currently responsible for 100+ active projects including Technology Services Division IT infrastructure, Energy Savings Company efficiency upgrade, solar photovoltaic, and Electric Vehicle charger projects that are recent additions to FPCM's portfolio.

2- Napa Hospital: Electrical Infrastructure Upgrade

The Department requests **$2,844,000 General Fund for the preliminary plans phase** of an electrical infrastructure upgrade project at the DSH Napa Hospital. According to the Department, this project will eventually support the electrical demands necessary to maintain existing critical services at a 24/7 patient care facility and upgrade the electrical distribution

infrastructure by replacing the existing transformer, substation, utility feeder lines, facility transformers, and switch gear. In addition, emergency generators will be installed to provide auxiliary power. DSH notes that the electrical power infrastructure at the Napa facility was originally installed in the 1970s and is time consuming and costly to maintain. Many of the replacement parts are no longer manufactured and must be specially recreated.

Of note, this budget change proposal only covers the costs of the preliminary plan phase of this capital outlay project. Total project costs are currently estimated at $89,267,000.

The current project schedule estimates the following timeline:

- July 2025: Begin preliminary plans
- October 2026: Completion of preliminary plans
- November 2026: Begin working drawings
- August 2028: Completion of working drawings
- September 2028: Construction starts
- March 2032: Construction completion

Budget Trailer Bill: Enhanced Treatment Program

The Department proposes a trailer bill that would extend the statutory authority for its Enhanced Treatment Program (ETP) through January 1, 2030. According to DSH, this change is required to provide adequate time to support the completion and operation of remaining ETP units that experienced delays due to the COVID-19 pandemic.

The ETP was created through AB 1340 (Achadjian, Chapter 718, Statutes of 2014) as a pilot initiative to treat patients who are at the highest risk of committing violence by providing enhanced treatment, staffing, and security measures as well as implementing an admissions and treatment planning process. For example, ETP maintains a 1:5 staff-to-patient ratio, limits each room to one patient, allows visual access by staff 24 hours per day, provides an independent patients' rights advocate, and establishes reviews for gradual transition back to standard units. ETP currently operates at the DSH-Atascadero hospital and is anticipated to open at the DSH-Patton hospital June 2025.

The Budget Act of 2017 provided funding and positions for the ETP pilot to operate two 13-bed units at Atascadero State Hospital. The Budget Act of 2018 provided funding for one additional 13-bed unit at Atascadero State Hospital and a 10-bed unit at Patton State Hospital. The Budget Act of 2022 included a scope change and reduced DSH's appropriation for this project. This was due to DSH indefinitely postponing construction of two ETP units at DSH-Atascadero to meet bed capacity needs associated with serving the felony Incompetent to Stand Trial (IST) patient population.

Under existing law, each ETP pilot site is authorized to operate for five calendar years following its first patient admission. However, construction and activation of the DSH-Patton ETP unit was significantly delayed due to pandemic-related interruptions. Without statutory changes, the DSH-Atascadero ETP unit's pilot would expire, DSH-Patton would lose statutory authority before becoming operational, and DSH would not be able to fully assess the impact of the ETP across both program locations.

This trailer bill:

1- Extends the statutory repeal date to January 1, 2030 for all ETP pilot sites.

2- Removes the five-year clock tied to each site's first admission.

3- Retains all existing requirements related to staffing, patient rights, and treatment planning.

Incompetent to Stand Trial (IST) Update

The Incompetent to Stand Trial (IST) population, which consists of individuals found unfit to proceed with felony charges due to mental illness, is the largest and fastest growing DSH population category. In recent years, the state has taken action to reduce waitlists, expand treatment capacity, and meet legal mandates related to IST care.

In 2021, the Alameda Superior Court, in the case of Stiavetti v. Clendenin, ruled that DSH must begin substantive treatment within 28 days of transfer of responsibility for a felony IST patient. To reach that goal, the court established an initial phased compliance timeline. In 2023, the compliance timeline was adjusted as follows:

- March 1, 2024 – provide substantive treatment services within 60 days
- July 1, 2024 – within 45 days
- November 1, 2024 – within 33 days
- March 1, 2025 – within 28 days

Also in 2021, California enacted AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) which tasked the California Health and Human Services Agency and DSH to convene an IST Solutions Workgroup to identify short, medium, and long-term solutions to address the increasing number of individuals deemed IST on felony charges. The group identified over 40 strategies to address the growing IST population and reduce reliance on state hospitals for competency restoration.

The Budget Acts of 2022 and 2023 appropriated funding to implement many of the IST solutions identified by the workgroup. These included providing early stabilization to increase diversion opportunities and care coordination, expanding community-based treatment and diversion options for felony ISTs, improving IST discharge planning and coordination, implementing a pilot for Independent Placement Panels, and improving alienist training. These resources were combined with previously funded IST programs, including IST Re-evaluation services, Jail-Based Competency Treatment, and Community Inpatient Facilities to expand the DSH continuum of care for IST individuals. Additionally, statutory changes aimed at solving the IST demand for services have been implemented to streamline and improve IST processes, target growth in IST determinations.

Prior to the COVID-19 pandemic, as of February 2020, there were about 850 individuals waiting for IST placement. The pandemic disrupted admissions, and the waitlist surged to a peak of 1,953 in January 2022. By January 2025, the IST waitlist had dropped to 359, which represents an 82% reduction from the peak.

Workforce Development Update

DSH continues to implement various efforts to address workforce challenges by expanding and developing psychiatric programs, fellowships and residency rotations. The following provides a high-level update of those efforts:

- Psychiatric Technician Programs: The Budget Act of 2019 included ongoing resources to attract and retain a sufficient workforce of trained medical professionals, primarily focused on recruitment for registered nurses and psychiatric technicians. In March 2020, DSH-Atascadero, in collaboration with Cuesta College, increased the program class size from 30 to 45 students, with two cohorts per year. However, plans were significantly impacted during the COVID-19 pandemic, with class sizes reduced to accommodate spacing restrictions. DSH-Napa continues to contract with Napa Valley College which holds two cohorts per year, with an additional six students each, for a total size of 36 students per cohort.

- DSH-Napa Psychiatric Residency Program: The Psychiatric Residency Program at St. Joseph's Medical Center (SJMC) was approved for ongoing accreditation in February 2023, and the first cohort of seven residents began their training in July 2021. Effective July 1, 2024, the cohort size for the DSH-Napa Residency Program increased from seven to ten. This expansion of three additional residents per year, with three cohorts, yields a total of 30 residents participating annually.

- DSH-Patton Psychiatric Residency Program: DSH received resources in the Budget Act of 2023 to add a second residency program at DSH-Patton. DSH-Patton received a 4-year accreditation for the DSH-Patton residency program, through June 2028. As of the 2025-26 Governor's Budget, DSH-Patton is in discussions with a prospective university partner to begin a Southern California residency program starting in July 2025.

- Psychiatric Fellowships: The Budget Act of 2023 included resources to expand or develop psychiatric fellowship programs across all five State Hospitals, with the objective of providing new psychiatrists with specialized training focused on the unique needs of state hospital patients. In 2024, DSH was working to implement fellowship expansions and fellowship rotation offerings with three universities: Stanford, the University of California Los Angeles, and the University of California San Francisco.

- Resident rotations: The Budget Act of 2023 included resources to increase the amount of rotation opportunities to post-graduate residents. In May 2024, DSH executed an agreement with Kaiser Permanent for resident rotations. DSH notes that the program has been well received by the rotating residents and DSH-Napa faculty, with interest being expressed to increase this rotation from once-a-week to two consecutive full-weeks. As of the 2025-26 Governor's Budget, a contract for a psychiatry resident rotation through June 2027 is in development, with DSH-Patton as the primary location. Additionally, a statewide psychiatry residency rotation contract through June 2027, with DSH-Atascadero as the primary location, has an anticipated execution date of early 2025.

Panel

- Stephanie Clendenin, Director, Department of State Hospitals
- Chris Edens, Chief Deputy Director, Program Services, Department of State Hospitals
- Brent Houser, Chief Deputy Director, Operations, Department of State Hospitals
- Victoria Rappleye, Department of Finance
- Joseph Donaldson, Department of Finance
- Will Owens, Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

Incompetent to Stand Trial (IST) Population

Staff notes that the Department has made remarkable progress in reducing the IST waitlist, coming from a high of 1,953 in January 2022, down to 359 by January 2025 – representing an 82% reduction from the peak. This decline appears to reflect positive success in the combined impact of increased community capacity, legal reforms, and recovery from pandemic-related

slowdowns. However, DSH data also indicates that felony IST referrals continue to rise year over year, presenting a risk of future strain on the Department's IST treatment capacity.

The Subcommittee may wish to ask the following questions:

1- What is the Department's long-term strategy to maintain a low waitlist while addressing rising referral volumes?

2- What specific investments or programs have contributed most to the IST decline? Are these efforts sustainable long-term?

3- Has the Department met the final compliance deadline set in Stiavetti v. Clendenin to provide substantive treatment within 28 days by March 2025?

Workforce Development

In prior hearings, the Subcommittee has discussed the state's broader investments in workforce development. The Department of State Hospitals' workforce development efforts – particularly in launching and expanding psychiatric residency and fellowship programs – represent an important opportunity for both DSH and the state's behavioral health workforce strategy.

The Subcommittee may wish to ask the following questions:

1- What proportion of residency or fellowship participants are choosing to remain in the state hospital system post-training? Are there strategies or mechanisms in place to ensure trainees want to stay as long-term employees?

2- What is the current status of the psychiatric technician program class sizes, particularly those affected by COVID-19 spacing restrictions? Are those cohorts now back to pre-pandemic size?

3- What is the nature of DSH's partnerships with institutions of higher education like Stanford, UCLA, and UCSF? Are there opportunities to formalize or expand these types of partnerships to create long-term training pipelines?

Staff Recommendation: HOLD OPEN

0530 California Health and Human Services Agency
4260 Department of Health Care Services

Issue 2: Overview of Proposition 1 (2024)

The content of this background is adapted from materials provided by the Legislative Analyst's Office.

Proposition 1, approved by California voters in March of 2024, made several changes to the Mental Health Services Act originally established through Proposition 63 in 2004. These changes are outlined below and aim to provide context for the subsequent issues covered in this agenda.

Proposition 1 Provides BHCIP with Additional $4.4 Billion in Grant Funding

In 2021, California enacted AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) which provided $2.2 billion (later reduced to $1.7 billion) to build new behavioral health infrastructure. This program, called the Behavioral Health Continuum Infrastructure Program (BHCIP), issued grant funding to build a variety of new inpatient and outpatient capacity in mental health and Substance Use Disorder (SUD) treatment facilities. BHCIP grants are available to cities, counties, tribes, nonprofits, and corporations. Funding for BHCIP was provided in five rounds, described in the next issue, with nearly 90 percent of dollars awarded in three main competitive and themed rounds.

Proposition 1, approved by California voters in 2024, authorized the state to sell an additional $4.4 billion in general obligation bonds for BHCIP. This brings total funding for the program to over $6 billion. At least $1.5 billion of the Proposition 1 bond dollars must be allocated to local governments, including $30 million for tribes. DHCS is working quickly to implement the bond, with a goal to award up to the first $3.3 billion in May 2025 and a stated commitment to award all funding by 2026.

Proposition 1 Changes How Counties Provide Services Using "Millionaire's Tax"

Counties provide mental health care and drug or alcohol treatment to those with the highest service needs. Counties have the primary role in the funding and delivery of mental health care and SUD services to individuals with low income and severe mental illnesses. These services are primarily provided through the Medi-Cal program to eligible individuals. (In contrast, mild-to-moderate outpatient mental health services for low-income individuals are funded by the state and delivered primarily through Medi-Cal managed care plans.)

Funding for counties comes from various sources, including a tax on people with high incomes (the “Millionaire’s Tax”). Counties receive roughly $10 billion to $13 billion per year in statewide taxes (largely local realignment revenues) and federal money to provide mental health care and SUD treatment. Roughly one-third of the money received comes from a tax levied on people with incomes over $1 million per year that has been collected since 2005 following voter approval of Proposition 63. This tax typically raises between $2 billion and $3.5 billion annually that is deposited into a special fund and to be spent on behavioral health services.

Counties have some choices about how to provide services using millionaire’s tax revenues. Most of the money from the millionaire’s tax goes directly to counties, with the balance going to the state. Up until 2024 under Proposition 63, counties received millionaire’s tax revenues that were allocated across three broadly defined funding “buckets.” Counties had significant flexibility in how to provide services within the parameters of the funding buckets. Proposition 1 makes changes to the uses of the millionaire’s tax revenues (the tax itself was not changed) by providing the state with a somewhat greater share of the tax and revising the funding buckets that apply to counties. While the degree of flexibility afforded counties was lessened somewhat by the funding bucket revisions, how much counties spend on different behavioral health services continues to depend on future county decisions. The next chart details the changes in funding allocations for counties under Proposition 1.

Allocation of Funding Categories[a] Under Proposition 63 (2004)

Funding Category	Examples of Types of Services/ Activities	Revenue Allocation
Community Services and Supports	• Full-Service Partnerships • Outpatient Treatment • Crisis Intervention • Wellness Centers • Housing Services • Capital Facilities • Workforce and Training • Deposits Into Prudent Reserves	76 percent
Prevention and Early Intervention	• School-based Services • Outreach to Older Adults • Suicide Prevention	19 percent
Innovation Programs	• Technology Integration • Holistic Care	5 percent

Allocation of Funding Categories[a] Under Proposition 1 (2024)

Funding Category	Examples of Types of Services/ Activities	Revenue Allocation
Housing Interventions	• Rental and Operating Subsidies • Family Housing for Children and Youth	30 percent
Full Service Partnership Services	• Wrap-Around Services • Assertive Community Treatment	35 percent
Behavioral Health Services and Supports	• Early Intervention • Outreach and Engagement • Outpatient Treatment • Wellness Centers • Capital Facilities	35 percent

[a] Refers to the allocation of millionaire's tax revenues distributed to counties across various specified funding categories.

Additional Changes Under Proposition 1

- Increase in the state's share of millionaire's tax revenues: Prior to Proposition 1, the state could use up to 5 percent of total revenues from the millionaire's tax (the remaining 95 percent went to counties) to administer the act. Under Proposition 1, the state share of total funding increased to 10 percent, but only 3 percent can be used for administration.

The remaining state share of funding will be used for behavioral health workforce development programs (3 percent) and statewide prevention services (4 percent).

- Expanded eligibility to individuals with SUD: Prior to Proposition 1, individuals with SUD challenges had to have a co-occuring mental health challenge to receive services funded from the millionaire's tax. Proposition 1 changed the law so that people with only SUD challenges could receive such services.

- Additional county reporting requirements: Prior to Proposition 1, counties were required to submit three-year plans on how they intended to use revenues collected from the millionaire's tax on behavioral health services. Proposition 1 updated the requirements of the three-year plan so that counties are required to report how all available behavioral health funding will be used for the provision of behavioral health services.

Panel

- Will Owens, Fiscal and Policy Analyst, Legislative Analyst's Office
- Marlies Perez, Chief, Community Services Division, Department of Health Care Services
- Sabrina Adams, Department of Finance
- Lizbeth Castillo-Monterrosa, Department of Finance

Staff Comments

Staff Recommendation: This item is informational only.

Issue 3: Behavioral Health Continuum Infrastructure Program (BHCIP), Bond BHCIP and Behavioral Health Bridge Housing Program Updates

Portions of this background were adapted from materials provided by the Legislative Analyst's Office.

BHCIP: Funding Details

As noted in the previous issue, the Legislature provided $2.2 billion (later reduced to $1.7 billion) in 2021 to create BHCIP. The program provides grants to construct, acquire, or rehabilitate facilities in which to provide behavioral health services. BHCIP can be used to fund a variety of facility types to treat individuals with varying levels of behavioral health needs. Eligible entities include counties, tribes, nonprofits, and corporations. DHCS was granted broad authority to implement the program, including discretion to determine how to allocate the funding. DHCS estimates that BHCIP-funded facilities will offer inpatient treatment to more than 2,600 people at any time and outpatient treatment to over 280,000 people annually.

Trailer bill legislation creating the program detailed several conditions for an applicant to meet in order to receive assistance. These conditions include providing matching funds or real property, supplementing and not supplanting existing funds for facility expansion, certain reporting requirements, and a commitment to operate services in the financed facility for the intended purpose for at least 30 years. Statute, however, also provided DHCS discretion in the extent to which some of these conditions are required in order to receive grant funding. In practice, these conditions of assistance have been applied throughout the program.

As the next table shows, DHCS awarded BHCIP grants in five rounds in 2022 and 2023. The focus of Round 1 was expanding mobile behavioral health services, mostly in the form of mobile crisis teams. Round 2 supported county and tribal planning efforts. Specifically, awardees used funding to engage with the community, counties, and providers in producing an action plan with goals, objectives, and strategies for building behavioral health infrastructure. Round 3, for launch-ready projects, was initially funded with federal funds from the American Rescue Plan Act of 2021. As such, the projects funded in this round were required to comply with certain federal reporting and other requirements. (Importantly, projects funded in Round 3 had to have all funds obligated by June 2024 and liquidated by December 2026 to meet federal spending time lines.) The focus of Round 4 was children and youth ages 25 and younger, including pregnant and postpartum individuals and their children, and transition-age youth, along with their families. Round 5 included a wide variety of eligible facility types, but was focused on crisis care.

BHCIP Awards Made in Five Funding Rounds
(In Millions)

Round 1: Mobile Crisis Services[a]	$206
Round 2: County and Tribal Planning	7
Round 3: Launch Ready	522
Round 4: Children and Youth	471
Round 5: Crisis and Behavioral Health Continuum	445
Total[b]	**$1,651**

[a] Includes $56 million in federal grant funding that was in addition to state funding.
[b] Excludes $30 million that was to be distributed in a planned sixth round. Excludes $4.4 billion in general obligation bond authority provided by Proposition 1 (2024).

BHCIP = Behavioral Health Continuum Infrastructure Program.

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.

BHCIP: Implementation Details

Rounds 3 through 5 of BHCIP awarded the bulk of grant dollars and funded a wide variety of behavioral health facility types. These rounds are generally referred to as the three main infrastructure rounds. The grant administration approach for these rounds was broadly similar.

Key grant features include:

1- *Regional Funding Approach.* BHCIP is a competitive grant program. To "ensure the equitable and fair distribution of funds," BHCIP employs a regional funding approach that designates portions of overall funding for seven regions of the state. Applicants within each of these regions compete amongst themselves rather than competing statewide. Seventy-five percent of funding in the main infrastructure rounds was set aside in this manner, with another 5 percent designated for tribal entities. The remaining 20 percent was available on a statewide basis for DHCS to award to projects at its discretion. Amounts set aside for the seven regions were based on the methodology used to allocate 2011 realignment funding.

2- *Matching Requirements.* BHCIP awardees are required to match state dollars, with the amount of match varying depending upon the entity type. Specifically, applicants provide matching funds as follows: 5 percent for tribal entities; 10 percent for cities, counties, and nonprofits; and 25 percent for for-profit providers and/or private organizations. A wide

variety of state and local funding sources can be used for the match, with the notable exception of state General Fund and realignment funding. The match also can also be met in the form of land or existing structures.

3- *Thirty Year Commitment to Operate Facilities.* State statute that established BHCIP requires awardees to commit to operate funded facilities for at least 30 years.

4- *Letters of Support.* Applicants are required to submit letters of support with their applications that vary depending upon the entity type. For example, city, nonprofit, and private applicants are required to include a letter of support from their county behavioral health agency. These letters of support are one factor used by DHCS in making award decisions.

5- *Scoring Preferences for Project Readiness.* Generally, as proposed projects are closer to being shovel ready, they are scored higher.

DHCS reports that Round 3 through 5 awarded funds for 130 projects. 16 projects (23 facilities) have been completed for construction and 8 project (11 facilities) are open and providing services.

Proposition 1: Bond BHCIP Funding to Be Issued in 2025 and 2026

As explained in the previous issue, Proposition 1 infused an additional $4.4 billion in general obligations bonds for BHCIP, bringing total funding for the program to over $6 billion. DHCS currently plans to issue Proposition 1 BHCIP funding through two rounds: Round 1 “Launch Ready” and Round 2 “Unmet Needs.” These rounds are modeled after the current BHCIP structure, with all grant funding awarded on a competitive basis. DHCS anticipates that the BHCIP portion of the bond is estimated to fund 6,800 residential treatment beds and 26,700 outpatient treatment slots for behavioral health.

Round 1 “Launch Ready” will total up to $3.3 billion, making 75% of the Bond BHCIP funds for the behavioral health treatment facilities available in 2025. Of this funding up to $1.5 billion is open only to counties, cities, and tribal entities; up to $1.8 billion open to counties, cities, and tribal entities, as well as nonprofit and for-profit organizations; and $30 million is the minimum to be awarded to tribal entities. At the time of writing, applications for Round 1 funding have been received, and award announcements are expected in May 2025.

Round 2 “Unmet Needs” will issue the remaining $1.1 billion. DHCS plans to release Round 2 Request for Application in May 2025, and have all bond funds be awarded in communities no later than 2026.

Behavioral Health Bridge Housing: Funding Reduction

The Behavioral Health Bridge Housing (BHBH) Program is another significant component of the state's investments in behavioral health. BHBH aims to provide over $1.25 billion dollars in funding to county behavioral health agencies and Tribal entities to operate bridge housing settings to address the immediate housing needs of people experiencing homelessness who have serious behavioral health conditions, including serious mental illness and/or substance use disorder. The program, which was signed into law in September 2022 under AB 179 (Ting, Chapter 249, Statutes of 2022), provides funding through June 30, 2027.

BHBH funding is administered through four rounds of funding, as outlined in the following table:

Behavioral Health Bridge Housing Funding Rounds		
Round	**Eligibility**	**Award Amount**
1	County behavioral health agencies	$907.9 million
2	Tribal entities	$50 million
3	County behavioral health agencies	$132.5 million
4	County behavioral health agencies and tribal entities	Not Awarded

The Governor's budget proposes to **fully eliminate Round 4** of funding for the BHBH program. This funding would have made approximately $117.5 million available to both county behavioral health agencies and tribal entities.

LAO Comments

In February 2025, the Legislative Analyst's Office released its publication "Progress Update and Opportunities for the Proposition 1 Bond," providing oversight recommendations of the Proposition 1 BHCIP Bond funding. Because the bond funding has not yet been awarded, the LAO's assessment covers the $1.7 billion in BHCIP funding allocated prior to the bond's approval**.**

Below are a few of the LAO's suggested questions for legislative oversight:

1- About 5 percent of program dollars have gone to projects estimated to serve less than 20 percent Medi-Cal enrollees. While a small share of BHCIP dollars, in general, what does DHCS see as the benefit to the state from funding projects with such low concentrations of Medi-Cal enrollees?

2- How much BHCIP funding has been allocated to for-profit entities?

3- Should a more thorough needs assessment be conducted to inform awards made in the second planned round of bond funding?

4- What is DHCS doing to ensure that future awards address geographic inequities in adult inpatient mental health beds?

5- With 19 small counties and one larger county not receiving awards in the three main infrastructure rounds, should a different funding approach for a portion of the $4.4 billion bond be considered in order to ensure that progress is made in building out behavioral health infrastructure in all counties?

Panel

- Marlies Perez, Chief, Community Services Division, Department of Health Care Services
- Lizbeth Castillo Monterrosa, Department of Finance
- Mark Newton, Deputy Legislative Analyst, Legislative Analyst's Office

Staff Comments

As noted in the background, the Governor's budget proposes eliminating the final round of funding for the **Behavioral Health Bridge Housing Program**, which was intended to provide $117.5 million in competitive grants to county behavioral health agencies and tribal entities. These funds would have supported the housing needs of individuals experiencing homelessness who also have serious behavioral health conditions.

It is not immediately clear why the Administration is proposing to eliminate this funding – whether to address broader cost pressures or to reallocate resources to other priorities. The Subcommittee may wish to ask for clarification on the rationale behind this reduction and whether any alternative funding for the BHBH program is being considered.

Staff Recommendation: HOLD OPEN

Issue 4: Children and Youth Behavioral Health Initiative (CYBHI) Program Updates

Background on CYBHI

First established in 2021, the Children and Youth Behavioral Health Initiative (CYBHI) is a multi-year, approximately $4.1 billion investment aimed at transforming California's behavioral health system to ensure that all children and youth aged 25 and under – regardless of payer –are screened, supported, and served for both emerging and existing behavioral health needs.

To achieve this goal, the Administration emphasizes that CYBHI is implementing 20 distinct workstreams guided by four core strategies:

- Centering children, youth, and families, and grounding efforts in equity
- Investing in promotion, prevention, and public awareness
- Developing workforce capacity to support behavioral health
- Investing in infrastructure to improve service delivery

The table below outlines some of the major CYBHI investments, organized into six categories: (1) Homes and Communities; (2) Education Settings; (3) Digital Spaces; (4) Health Care Settings; (5) Workforce Development; and (6) Public Awareness Campaigns.

Program Component	Funding ($ in Millions)	Description
Homes and Communities		
Evidence-Based Practices and Community-Defined Evidence Practices Grant Program	$305	Prevention, early intervention, and resiliency grant program providing behavioral health care and supports to children, youth, family, and caregivers.
Youth Suicide Reporting and Crisis Response	$35	Pilot program to report and respond to youth suicides and suicide attempts in school and community settings.
Education Settings		
Safe Spaces Trauma-Informed Training	$1	Free, online training designed to help individuals working with children and youth recognize and respond to signs of trauma and stress.
CalHOPE Mindfulness, Resilience, and Well-being Supports	$75	Promotes local wellness, mindfulness, resilience and well-being programs supporting teachers and students in TK-12 schools.

Student Behavioral Health Incentive Program (SBHIP)	$389	Funds incentive payments to Medi-Cal plans to implement school-based behavioral health services.
School-Linked Partnership and Capacity Grants	$400	Provides County Offices of Education, Local Education Agencies, and Institutes of Higher Education with resources to build infrastructure related to the CYBHI fee schedule.
CYBHI Fee Schedule Program	$10	Creates a statewide billing system for school-linked behavioral health services.
Transforming Together	$3.5	Cross-sector working group supported by the San Bernardino County Superintendent of Schools to align and integrate behavioral health systems.
Digital Spaces		
Behavioral Health Virtual Services Platforms (Soluna, BrightLife Kids)	$532.7	Free online digital applications providing behavioral health coaching and tools for children, teens, and young adults.
Next-Generation Digital Therapeutics	$75	Research initiative focused on developing digital tools focused on behavioral health services and supports for children, youth, families, and clinicians.
Positive Parenting, Thriving Kids	$0	Free videos and tools for parenting and youth development support.
Health Care Settings		
Behavioral Health Continuum Infrastructure Program (BHCIP Round 4 targeting children and youth)	$480.5	Builds new treatment and crisis facilities for children and youth.
California Child and Adolescent Mental Health Access Portal	$60.1	Training and consultation for pediatric and primary care providers on providing behavioral health care to children and youth ages 0-25
Dyadic Services Benefit	$511.2	Family-and-caregiver-focused model of care intended to address developmental and behavioral health conditions of children and includes services provided to parents / caregivers (known as a “dyad”).
Workforce Development		
Youth Peer-to-Peer Support Program	$10	Supports student-led peer mental health programs in high schools.
Youth Mental Health Academy	$25	Trains high school students for careers in behavioral health.

Peer Personnel Training and Placement Program	$8.5	Grant program to train, place, and support individuals who have lived behavioral health experience as Peer Support Specialists.
Health Professions Pathways Program	$16	Grants for pipeline programs, internships, fellowships, and scholarships to underrepresented individuals pursuing health careers
Certified Wellness Coach Program	$278	Establishes a new job class to support student mental wellness.
Community-Based Org Behavioral Health Workforce Grants	$116.6	Supports Community-Based Organizations to recruit and retain behavioral health personnel and provide loan repayments, scholarships, and stipends to staff.
Scholarships and Loan Repayment Programs	$27	Provides behavioral health students with financial support in exchange for direct patient service upon completion of their education.
Public Behavioral Health Social Work Training and Fellowship Program	$33.7	Provides funding to support MSW students and graduates prepared to work in the public sector.
Justice System Involved Youth Training	$9	Trains non-medical, non-clinical personnel to identify and respond to substance use and behavioral health concerns in justice-involved youth
Substance Use Disorder Earn and Learn Grant Program	$23	Provides funding to organizations who provide education and paid job experience for students earning their Substance Use Disorder Counselor certification
Social Work Education Capacity Expansion	$20	Provides funding to expand Master of Social Work programs, increasing student slots for those pursuing behavioral health careers
Psychiatric Education Capacity Expansion	$55	Expands psychiatry residency and fellowship slots and provides education, clinical training, and curriculum development for psychiatric mental health nurse practitioner
Train New Trainers: Primary Care Psychiatry & Addiction Medicine	$28.6	Provides year-long fellowship training for primary care providers to improve expertise, knowledge, and comfort-level in specialized primary care psychiatry and addiction medicine.
Public Awareness Campaigns		
Live Beyond: ACEs and Toxi Stress Awareness Campaign	$24	Awareness and understanding of Adverse Childhood Experiences (ACEs), toxic stress, and their potential negative impacts.
Never a Bother: Youth Suicide Prevention Campaign	$40	Reminds youth and young adults experiencing thoughts of suicide that they're never a bother when reaching out to friends, trusted adults, counselors, and other types of support.

Take Space to Pause: Public Education Campaign	$74.6	Mental health stigma-reduction campaign that motivates California teens to take help-seeking actions before mental health challenges become more serious

CYBHI Reports

In addition to publishing its 2024 CYBHI Annual Report, the Administration also contracted with Mathematica to evaluate the initiative on behalf of CalHHS in partnership with Health Management Associates, James Bell Associates, and the University of California, Los Angeles (UCLA) Prevention Center of Excellence. The evaluation started in November 2022 and will continue through June 2026. As part of the evaluation, the Administration issued an interim report providing an outline of the strategies being leveraged by the initiative, the investments made, the progress achieved to date, the potential for future impact, and lessons learned for implementation of large, complex initiatives.

The report notes that, while it is too soon to assess whether CYBHI implementation has accomplished the significant systems-level transformation the initiative hopes to achieve, interim findings support the assessment that the CYBHI has the potential to contribute significantly to strengthening the behavioral health ecosystem across multiple environments of care. **The report highlights the following strengths** in CYBHI implementation:

- Workforce investments have infused funding across the state for expanding and training the behavioral health workforce. Key approaches include the development of the Certified Wellness Coach position, substantial investments in training and educating future behavioral health professionals, and investments in strengthening and retaining the existing behavioral health workforce. The investments are designed to bear positive results in both the short and long-term, providing an encouraging sign that California's workforce investments can alleviate near-term workforce capacity constraints while building toward a more diverse and sustainable workforce in the long-term.

- New, sustainable funding mechanisms for behavioral health services are intended to facilitate the provision of behavioral health services in convenient, familiar settings, such as educational and primary care settings. The CYBHI has developed two such sustainable mechanisms: the CYBHI Fee Schedule and the Dyadic Services Benefit. Service providers making use of these mechanisms will require ongoing support to strengthen uptake and utilization.

The interim reports outline the **following opportunities to improve CYBHI:**

- Reduce complexity and administrative burden for state and local actors. In interviews, leaders across the state indicated that the complexity of the CYBHI, along with parallel behavioral health initiatives, posed risks for the effective and efficient use of resources. The complexity also poses challenges to sustainability in the future, as there is likely a need for ongoing coordination across and within departments for successful implementation.

- Identify and pursue opportunities to align communications and cross-promote resources. With 20 workstreams, 15 outcome objectives, and 5 implementing departments, the CYBHI is complex, posing challenges for clear communications and alignment.

- Streamline and ease data sharing within the CYBHI. The complex organizational structure of CYBHI results in fragmented information and data about workstream activities. Each of the 20 workstreams gather and track data about their programs, often with support from external partners and under the purview of a department with data stewardship responsibilities. The CYBHI does not have a central warehouse or process for tracking and sharing those data among partners; as such, gathering comprehensive data about CYBHI activities and beneficiaries requires complex administrative processes and data use agreements with external partners, resulting in significant administrative burden. This results in data delays which pose challenges for ongoing monitoring of progress and evaluation efforts for the initiative as a whole as well as across its workstreams.

- Further support the adoption of key investments such as the Fee Schedule and Dyadic Services. The CYBHI increases the availability of evidence-based and innovative services for children, youth, and families in California. The CYBHI Fee Schedule and the introduction of the Dyadic Services Benefit are innovative investments that have the potential to improve behavioral health outcomes. Promoting uptake will require sustained engagement by CalHHS and its partners.

CYBHI: Online Apps & Digital Services

In partnership with Brightline and Kooth US, California launched two digital behavioral health platforms to support children, youth, and caregivers: BrightLife Kids, designed for parents or caregivers of children aged 0–12, and Soluna, aimed at teens and young adults aged 13–25. Together, these virtual platforms represent CYBHI's single largest line-item investment, with $532.7 million allocated to expand access to behavioral health services through digital solutions.

Both platforms are available as web and app-based tools and offer free, one-on-one support with qualified behavioral health coaches in English and Spanish, regardless of insurance coverage. The platforms also feature a library of multimedia resources, guided wellness exercises, and peer community spaces moderated by trained behavioral health professionals.

The 2024 CYBHI Annual Report notes that Soluna and BrightLife Kids have provided in-app support to more than 132,000 children, youth, and caregivers, including over 24,000 coaching sessions. Users have been recorded in every California county, with over half residing in underserved communities.

Panel

- Autumn Boylan, Deputy Director, Office of Strategic Partnerships, Department of Health Care Services
- Lizbeth Castillo Monterrosa, Department of Finance
- Will Owens, Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

Digital Services: Soluna & BrightLife Kids

As the background indicates, Soluna and BrightLife Kids represent CYBHI's single largest line-item investment, totaling $532.7 million. These platforms were designed to expand access to behavioral health services for youth and caregivers through virtual behavioral coaching, wellness tools, and peer community support. While the Administration reports over 132,000 users statewide and 24,000 coaching sessions in 2024, questions remain about the cost-effectiveness, clinical value, and long-term sustainability of these tools.

The Subcommittee may wish to ask:

1- What evaluation criteria are being used to assess the effectiveness of Soluna and BrightLife Kids? Are there any clinical outcomes, utilization patterns, or user retention metrics available beyond registration counts and coaching sessions?

2- What measures or outcomes are being used to evaluate the return on investment for the $532.7 million allocated to Soluna and BrightLife Kids? Given the current level of user engagement and take-up rate, how is the Administration assessing whether these platforms are delivering value and represent an effective behavioral health investment?

3- How are the platforms integrated with California's broader behavioral health ecosystem? Are users being connected to Medi-Cal, county services, or in-person care when deemed appropriate, or are these platforms functioning in isolation?

4- What is the long-term funding plan for these platforms? Is the state expected to maintain them via General Fund?

5- What contractual obligations exist with Brightline and Kooth US, particularly around performance? For example, are there performance clauses requiring app providers to meet certain milestones or utilization thresholds?

6- How are privacy and information security managed by app providers, particularly in peer community spaces for minors?

CYBHI

As it relates to the broader CYBHI, the Subcommittee may wish to ask the following questions:

1- How is CYBHI ensuring coordination across its 20 workstreams and various implementing state departments?

2- What is the long-term plan for sustaining successful CYBHI programs once one-time funding ends?

3- How is equity being taken into account when implementing CYBHI workstreams? For example, how does the Administration ensures investments are made in rural areas, or reach LGBTQ youth?

4- The interim report identifies challenges in data sharing and fragmentation. Are there solutions being identified, such as central data warehousing, to consolidate data collection?

Staff Recommendation: HOLD OPEN

Issue 5: Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Update

Background on BH-CONNECT Demonstration Waiver

Section 1115 of the federal Social Security Act gives the federal government with authority to approve experimental, pilot, or demonstration projects that are found are likely to assist in promoting the objectives of the joint federal-state Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

On December 16, 2024, the Centers for Medicare & Medicaid Services (CMS) approved California's Section 1115 demonstration, titled Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT). Effective January 1, 2025 through December 31, 2029, BH-CONNECT authorizes the use of federal funding for a series of initiatives aimed at strengthening behavioral health services for Medi-Cal beneficiaries. The demonstration builds on the state's broader CalAIM initiative, heard by this committee in previous hearings, and focuses on improving access, equity, outcomes, and the behavioral health workforce.

Major Components of BH-CONNECT

1- Access, Reform, and Outcomes Incentive Program: This program will provide up to $1.9 billion over five years in incentive payments to Behavioral Health Plans (BHPs) in up to 80% of California counties. Funding is tied to performance improvements in behavioral health access and outcomes, with BHPs eligible for rewards based on achievement of CMS-approved metrics. To the extent participating BHPs implement care delivery and other initiatives that succeed in improving the care that is furnished to Medi-Cal beneficiaries, they are eligible to earn performance-based incentive payments based upon improvements on measures identified jointly by the state and CMS. Participating BHPs will also be rewarded for behavioral health system reforms targeted at driving improvement in health outcomes.

2- Workforce Initiatives: This program will provide up to $1.9 billion over five years to support workforce recruitment and retention to promote the increased availability of behavioral health care providers who serve Medi-Cal beneficiaries. The demonstration will feature five workforce initiatives, including behavioral health scholarship, loan repayment, community-based provider training, residency training, and recruitment and retention programs. All workforce initiatives will require practitioners to fulfill service commitments at safety net settings serving a significant population of Medi-Cal and/or uninsured individuals.

Short-Term Rental Assistance

BH-CONNECT also authorizes the use of federal funding for short-term rental assistance – a health-related social needs benefit aimed at supporting housing stability for vulnerable Medi-Cal beneficiaries. Under the demonstration, California will receive authority to provide short-term rental assistance, defined as room and board without clinical services, for up to six months per household over the demonstration period.

Notably, this is California's second Medicaid demonstration to offer a housing intervention that includes room and board. Episodic interventions that include both clinical services and room and board are currently authorized under CalAIM. As a result, CMS imposed a combined six-month cap for room and board services across both BH-CONNECT and CalAIM.

Short-term rental assistance will be administered through Medi-Cal managed care plans. Initially, the benefit will be optional for plans to offer. However, beginning no sooner than January 1, 2026, the benefit will become mandatory for plans to provide to certain populations, and will be mandatory for all eligible beneficiaries no sooner than January 1, 2027.

Individuals eligible for short-term rental assistance under BH-CONNECT include those transitioning from institutional settings (e.g., hospitals, nursing facilities), incarceration (e.g., prisons, jails), foster care, homeless shelters, and other qualifying situations.

Additional Demonstration Elements

1- **Serious Mental Illness (SMI) Program:** Federal support for short-term stays in psychiatric institutions with conditions to strengthen crisis stabilization services and community-based care, and reduce utilization and lengths of stays in emergency departments for Medi-Cal beneficiaries with SMI.

2- **Community Transition In-Reach Services:** Transitional care for individuals expected to stay in institutional settings for 120 days or more, to support discharge planning and reentry services.

3- **Activity Funds Initiative:** Provides expenditure authority for services and items to improve behavioral health outcomes of children and youth in the child welfare system.

Panel

- Paula Wilhelm, Deputy Director, Behavioral Health, Department of Health Care Services
- Sabrina Adams, Department of Finance
- Will Owens, Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

Staff notes that the funding plan for BH-CONNECT is understandably not yet available, given that the waiver was approved in December of 2024. The Subcommittee may still wish to ask:

1- When does the Administration plan to release a detailed, multi-year funding plan for BH-CONNECT? Will this include an annualized breakdown of costs and funding sources across all five years of the demonstration?

2- What is the projected total General Fund obligation over the demonstration period?

3- Is there a preliminary timeline for BH-CONNECT implementation? For example, when is DHCS planning to release implementation guidance to counties and Medi-Cal managed care plan?

Staff Recommendation: HOLD OPEN

4170 Commission for Behavioral Health

Issue 6: Commission Transition Under Proposition 1

The Commission for Behavioral Health (Commission), formerly known as the Mental Health Services Oversight and Accountability Commission, is the independent state body charged with promoting transformational change in California's behavioral health system. It does this through research, data analysis, grantmaking, and technical assistance. The Commission plays a key role in advancing evidence-based and community-defined practices while advising the Governor and Legislature on emerging trends in California's behavioral health system.

The 2025-26 Governor's budget allocates $48.7 million and 59 staff positions to support the work of the Commission.

Prior to Proposition 1, the Commission oversaw major components of the Mental Health Services Act originally established under Proposition 63. For example, the Commission then had oversight over the Prevention and Early Intervention Programs; Innovation programs, and system-of-care initiatives for children, adults, and older adults.

The passage of Proposition 1 restructured the Commission and its role, with the following changes taking effect beginning January 1, 2025:

- **Expanded Membership:** The Commission expanded from 16 members to 27 members, adding representatives who have lived experience of substance use disorder, family members of those with SUD, housing and homelessness experts, veterans, youth, and more.

- **Expanded Focus to Include Substance Use Disorder.** Prior to Proposition 1, the Commission primarily focused on mental health services, overseeing programs funded by the Mental Health Services Act. While substance use disorder services were part of the broader behavioral health system, they were not a major focus of the Commission's work. Under Proposition 1, the Commission's scope of work now explicitly includes substance use disorder services. This aligns with the transition from the Mental Health Services Act to the Behavioral Health Services Act, which integrates mental health and substance use treatment under a single framework.

- **Advisory and Technical Assistance Role:** The Commission provides technical assistance to counties on implementation planning, training, and capacity building investments including on innovative behavioral health models of care and innovative promising practices. The Commission consults with DHCS, counties, and stakeholders to establish metrics to measure and evaluate the quality and efficacy of programs and

services. Finally, the Commission advises the Governor and the Legislature on components of the state's behavioral health system.

- **Policy Development:** The Commission has authority to establish technical advisory committees such as a committee of consumers and family members and a reducing disparities committee focusing on demographic, geographic, and other communities. The commission may provide pertinent information gained from those committees to relevant state agencies and departments. In addition, the Commission is tasked with developing several reports, including recommended solutions for long-term financial sustainability of county programs, improving programs, and more.

Innovation Partnership Fund

A key responsibility of the Commission under Proposition 1 is the administration of the Innovation Partnership Fund (IPF). Proposition 1 authorizes up to $20 million annually from the Behavioral Health Services Fund for the IPF, for fiscal years 2026-27 through 2030-31. Funding beyond that period will be subject to the annual state budget process.

The Commission is tasked with using the IPF to award grants to public, private, and nonprofit partners to support the development and evaluation of innovative mental health and substance use disorder programs and practices. Funded projects must aim to improve outcomes for underserved, low-income, or other communities experiencing behavioral health disparities.

To determine allowable uses of the fund, the Commission must consult with the California Health and Human Services Agency, the Department of Health Care Services, the Department of Public Health, and the Department of Health Care Access and Information.

The Commission is required to submit a report to the Legislature on the use and outcomes of the IPF by January 1, 2030, and every three years thereafter.

Panel

- Will Lightbourne, Interim Executive Director, Commission for Behavioral Health
- Lizbeth Castillo Monterrosa, Department of Finance
- Will Owens, Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

With the passage of Proposition 1, the Commission is undergoing a period of transition as it assumes its restructured responsibilities. The Subcommittee may wish to ask the following questions:

Commission Transition:

1- What structural and internal changes, such as staffing, governance, or new advisory committees, have been made or are underway to reflect the Commission's new statutory responsibilities?

2- The Commission is now integrating substance use disorder into its scope of responsibilities. How is the Commission working to integrate SUD its operations, programs, and advisory processes?

3- What are the Commission's short-term and long-term research and data analytic priorities?

Innovation Partnership Fund:

1- What is the Commission's timeline for developing and releasing IPF grantmaking criteria and guidelines? What will be the public engagement process prior to the first funding round in FY 2026-27?

2- What mechanisms will the Commission use to ensure geographic and demographic equity in the distribution of IPF funds?

3- Are there preliminary ideas or strategies is the Commission exploring to support with the IPF? Will the Commission prioritize certain focus areas or populations in the initial rounds of IPF grantmaking (e.g., youth, justice-involved individuals, specific behavioral health projects)?

Staff Recommendation: HOLD OPEN

This agenda and other publications are available on the Assembly Budget Committee's website at: Sub 1 Hearing Agendas | California State Assembly. You may contact the Committee at (916) 319-2099. This agenda was prepared by Patrick Le.