

# California State Assembly



## Assembly Budget Agenda

### Assembly Budget Subcommittee No. 1 on Health

Assemblymember Dawn Addis, Chair

Monday, May 4, 2026

2:30 P.M. – State Capitol, Room 126

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## Items To Be Heard

### 4260 Department of Health Care Services

#### Issue 1: Through the Lens of Anosognosia: HR1 and the Future of Behavioral Health Services

*This section draws from materials produced by the Legislative Analyst's Office, the California Budget & Policy Center, the California Health Care Foundation, and the National Alliance on Mental Illness.*

This Subcommittee has engaged with several families whose members have been impacted by Anosognosia and have cycled repeatedly through California's behavioral health system, including state hospital programs, county behavioral health, incarceration, hospitalization, diversion, and CARE Court, without achieving lasting stability. This issue examines how those experiences highlight existing structural gaps in California's behavioral health system that can leave California's most vulnerable without support, and how those gaps are anticipated to significantly deepen under the changes enacted under H.R. 1.

#### Background on Anosognosia

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Anosognosia is a symptom of a neurological condition that prevents a person from recognizing their own impairment. Individuals with anosognosia may truly believe nothing is wrong, even when symptoms are obvious to others. Anosognosia is generally caused by changes in the brain that affect a person's ability to recognize they are ill, similar to how someone who has had a stroke might not realize they have lost movement on one side of their body. Experts often describe it as "denial of deficit" or "lack of insight." The condition falls under the family of agnosias, all of which happen when the brain is unable to recognize or process what its senses tell it.

Anosognosia is common among individuals with serious mental illness. According to the National Alliance on Mental Illness, early studies indicated that approximately 30 percent of people with schizophrenia and 20 percent of people with bipolar disorder experience severe lack of awareness of their diagnosis. This has profound implications for treatment engagement: individuals with anosognosia consistently resist voluntary treatment, disengage from services once external oversight ends, and cycle repeatedly through crisis, hospitalization, and incarceration, often at enormous cost to themselves, their families, and the system.

The families whose testimony informs this issue describe the same pattern: a loved one stabilizes under court-ordered treatment, completes a diversion program or CARE Court plan, and then, without the neurological capacity to understand why medication matters, stops

treatment within weeks. As one family described it, when a person with anosognosia completes a treatment program, the system deems it the end of the illness, and families are unable to obtain additional support. In some instances, families recount that after completion of a treatment, county behavioral health systems were unable to conduct outpatient follow-up, hand-off, or sustained case management, prompting the cycle of decompensation and incarceration to begin again.

### **Financing Constraints on County Behavioral Health Systems**

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California's publicly funded behavioral health system is organized around county administration, with counties and their contracted behavioral health providers together serving as the frontline of specialty mental health services and substance use disorder treatment. Counties set program priorities, manage funding, and bear fiscal and administrative responsibility under a complex web of state and federal mandates, while providers translate those resources into direct care for the individuals and families the system is designed to serve. The system's funding rests on several distinct streams, each with its own constraints:

#### **Realignment (1991 and 2011)**

Prior to 1991, county mental health services were largely financed through federal funds and annual state General Fund appropriations. Funding was discretionary, and counties contributed financially and served as the primary providers of mental health services, leaving local systems vulnerable to state budget cuts and reductions.

In 1991, the state faced a \$14 billion budget deficit, which left counties vulnerable to significant potential loss in funding for mental health services. In order to protect California's mental health and other safety net services system from harm, the state transferred several fiscal responsibilities to counties, including community-based mental health services. This 1991 "realignment" replaced state General Fund support with dedicated sales tax and vehicle license fee revenues. This shift aimed to create predictable funding for safety-net programs while promoting local flexibility.

In 2011, the state significantly expanded this realignment, making counties fully responsible for the nonfederal share of major Medi-Cal behavioral health programs, including Drug Medi-Cal, Medi-Cal Specialty Mental Health Managed Care, and the Early and Periodic Screening, Diagnosis, and Treatment program. The 2011 realignment was funded by redirecting a portion of the state's existing sales tax and vehicle license fees revenues to counties, without raising taxes.

A critical constraint of realignment funding is that revenues grow with the economy, not with service demand. And because growth is tied to economic performance rather than to service demand or caseload, behavioral health revenues tend to rise slowly in strong years and to

stagnate, and even decline, during recessions. This financing mechanism can limit the counties' ability to expand services when behavioral health services needs increase.

It is also important to note that counties are not reimbursed for their actual costs or caseload for realigned programs. Instead, counties receive dedicated revenue that is intended to cover their costs over time. Revenue that counties lose during recession years is not made up in future years and generally do not catch up to growing cost of services.

**The Mental Health Services Act / Behavioral Health Services Act (MHSA/BHSA).**

Proposition 63 (2004) established a 1 percent tax on personal income above \$1 million, creating a voter-approved dedicated stream of revenues to expand county mental health programs. Subsequently, Proposition 1 (2024) restructured this as the Behavioral Health Services Act, expanded the uses to include substance use disorders, changed mandated spending categories and added a housing component. MHSA/BHSA constitutes roughly one-third of county behavioral health funding and is similarly subject to economic fluctuation. As discussed in more detail in Issue #4 of this agenda, BHSA revenues are subject to significant volatility; at times three times larger than changes in the Personal Income Tax overall, and nearly five times more volatile than the state's sales and use tax.

In more recent years, counties have typically leveraged half of their MHSA funding as a source of non-federal share for Medi-Cal services given that their realignment funding sources have not kept pace with caseload demands and greater federal and state oversight of Medi-Cal health plans. Although BHSA recast existing dollars to address current state behavioral needs -- including addressing housing and homelessness -- challenging fiscal constraints remain in terms of addressing increased service demand and accounting for volatile revenue streams.

**Medi-Cal**

Medi-Cal federal financial participation is the dominant funding stream for county behavioral health services. While counties receive significant funding from Medi-Cal federal financial participation, they are also primarily responsible for the nonfederal share of costs. In 2025-26, Medi-Cal federal financial participation for county specialty mental health services and drug programs was approximately \$5.6 billion. In the event that Medi-Cal funding shrinks, which is anticipated under HR1, county services and budgets would absorb the fiscal shock.

Existing law requires counties to provide physical health services to individuals with no other health care options through county indigent care programs. In a similar vein, existing law requires counties to provide mental health services to all Californians in need, "to the extent resources are available." When individuals lose Medi-Cal and fall below specialty mental health eligibility thresholds, counties also lose the federal financial participation that makes up their largest funding stream.

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## Demand for Behavioral Health Services Rising In a Strained System

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According to the Legislative Analyst's Office, the share of California adults with serious mental illness increased by approximately 50 percent between 2008-2010 and 2017-2019, with the share of young adults with serious mental illness nearly doubling over that period. In 2021-2022, 22 percent of California adults had a mental illness, but fewer than 80 percent of those received treatment. For young adults aged 18 to 25, less than two-thirds of those with mental illness received services.

Administrative barriers can influence this unmet need, partly driven by how California divides behavioral health responsibility. Medi-Cal managed care plans are responsible for individuals with mild-to-moderate behavioral health conditions, while county behavioral health departments serve those with the most serious and complex needs. While this division enables each system to specialize, in practice it can create administrative seams where individuals can fall through or bounce between systems depending on how their condition is assessed at given point in time.

For individuals with anosognosia, this seam is particularly consequential. Because anosognosia causes the brain to ignore its own illness, individuals may present themselves differently depending on the day. A person who is partially stabilized may appear mild-to-moderate on paper, routing them to a managed care plan, while their underlying condition remains severe. When that stability collapses, they may suddenly require county-level specialty services. Families interviewed by this subcommittee have described this dynamic several times, recounting family members described as "not bad enough" to receive behavioral health county services, only for impacted individuals to later deteriorate to the point of psychiatric hospitalization, arrest, and homelessness.

This unmet need for behavioral health is also compounded by geographic disparities. In looking at State External Quality Review Organization data, the California Health Care Foundation notes wide county-to-county variation in basic access: the average wait for a first psychiatry visit ranges from 5 to more than 50 business days depending on the county, with adult waits spanning 0 to 152 days and youth waits of up to 252 days. Seven- and 30-day follow-ups after psychiatric hospitalization exceed 80 to 90 percent in some counties but remain below 40 to 50 percent in others.

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### H.R. 1 Impact on Behavioral Health

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Throughout multiple hearings, this subcommittee examined the impacts of HR1 on state programs, including the implementation of work & community engagement requirements, the shift to six-month eligibility redeterminations, and the elimination of full-scope Medi-Cal benefits for certain populations. These changes would reduce Medi-Cal enrollment and, with it, reduce federal financial participation that supports county behavioral health services. As noted

previously, federal financial participation is a significant share of county resources, but counties are primarily responsible for the nonfederal share of costs for drawing those federal resources.

As people lose eligibility for Medi-Cal, counties project that some of those individuals may seek care for their behavioral health needs from counties. Counties note that to the extent that resources are available, counties would be required to provide services to individuals with no alternative options.

According to the counties, using estimates on the number of people projected to lose Medi-Cal coverage due to HR1, approximately 27,000 people are projected to seek behavioral health services in 2026-27 and 89,000 individuals in 2027-28. Assuming a statewide average cost to provide services at about \$10,000 per enrollee per year, counties estimate needing \$224 million in 2026-27 and \$828 million in 2027-28 and ongoing to continue providing services to those who lose Medi-Cal coverage and seek services.

**Panel**

- Dawn Marie Anderson, on behalf of several families impacted by Anosognosia
- Antonette "Toni" Navarro, Director of Behavioral Health Wellness, County of Santa Barbara
- Dr. LeOndra Clark Harvey, Chief Executive Officer, California Behavioral Health Association
- Michelle Doty Cabrera, Executive Director, County Behavioral Health Directors Association

Available for Questions & Technical Support:

- Department of Health Care Services
- Department of Finance
- Will Owens, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- Min Lee, Economist, Legislative Analyst's Office

**Staff Comments**

This Subcommittee has engaged directly with several families whose members have been impacted by anosognosia, a neurological condition that prevents individuals from recognizing their own serious mental illness. Through interviews and testimony, these families highlighted persistent structural gaps in California's behavioral health system. While these gaps are not new, they are at risk of being significantly compounded by the effect of HR1, precisely at a moment where demand for behavioral health services is increasing. Counties estimate that up to 89,000 individuals may seek behavioral health services by 2027-28 as a result of coverage losses.

In addition, counties explain that they are required to provide behavioral health services “to the extent resources are available.” If those resource are unavailable and county services are not provided, the practical reality is that these individuals will not disappear from the system, and will likely reappear in emergency departments, psychiatric holds, jails, and crisis settings that are more expensive and less proactive than the sustained community-based care that might have prevented the crisis.

The Subcommittee may wish to ask:

- 1- The families whose testimony informs this issue describe a recurring cycle: stabilization or program completion, loss of services, and decompensation. What specific behavioral health services exist for individuals who may need long term behavioral health support? If none exist, what would it take to build that continuum?
- 2- Anosognosia presents a significant challenge for behavioral health treatment. What tools are currently available to counties and providers to sustain engagement with individuals who cannot recognize their own illness?
- 3- The division between mild-to-moderate behavioral health services provided by managed care plans vs. specialty services provided by county behavioral health appears to create an administrative seam that individuals with fluctuating conditions can fall through repeatedly. How are eligibility determinations for services made when an individual's behavioral health shifts over time? Does this structure delay intervention until crisis?
- 4- CalAIM's No Wrong Door policy was intended to ensure that individuals receive timely behavioral health services regardless of where they first seek care, and that treatment relationships are not interrupted at system transitions. Has this policy meaningfully reduced the administrative friction that families describe? What implementation gaps remain, and what would full realization of that policy require?
- 5- Counties project that approximately 89,000 individuals will seek behavioral health services by 2027-28 as a result of H.R. 1 coverage losses, at an estimated cost of to \$828 million. Can counties walk the subcommittee through the methodology underlying that estimate, and does it account for the secondary wave of individuals with mild-to-moderate conditions who may decompensate after losing managed care coverage before reaching the county eligibility threshold?
- 6- Access to behavioral health services varies dramatically by geography, with data indicating that first psychiatry appointment wait times ranging from 5 to more than 150 days depending on the county. What is driving that variation, and what does H.R. 1 do to counties that are already at the far end of that range?

7- As individuals with mild-to-moderate behavioral health needs lose Medi-Cal managed care coverage under H.R. 1, what are suggested state's plans to prevent decompensation, support counties and providers in absorbing increased demand, and track cost shifts as they materialize? Is there a mechanism to monitor whether individuals are deteriorating in the gap before reaching the county eligibility threshold?

**Staff Recommendation:**

This item is informational only.

**Issue 2: Children and Youth Behavioral Health Initiative: Update on the Fee Schedule and Behavioral Health Services Online Apps & Supports Platforms**

**CYBHI: Background on the Fee Schedule**

First established in 2021, the Children and Youth Behavioral Health Initiative (CYBHI) is a multiyear, 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.

A key component of CYBHI is the **Fee Schedule Program**, which aims to create a sustainable funding source for behavioral health services in schools and school-linked settings.

State law requires DHCS to develop and maintain a multi-payer, school-linked statewide fee schedule for medically necessary outpatient mental health and substance use disorder services provided to students 25 years of age or younger at or near a school site. Additionally, Medi-Cal managed care plans and commercial insurers must reimburse for these school-based services at or above the established fee schedule rate, regardless of whether the school-site provider is in-network. These services cannot be subjected to prior authorization, copayments, coinsurance, or deductibles.

The CYBHI Fee Schedule ensures that Local Educational Agencies (LEAs) and Institutions of Higher Education (IHEs) are reimbursed for behavioral health services delivered on school sites. LEAs may either provide these services directly using their own staff or partner with community-based providers to serve students. Key design details of the CYBHI Fee Schedule are in the following chart:

Category	Description
Services	Outpatient mental health and substance use disorder services identified by in the reimbursement schedule published by DHCS, under four separate categories: <ul style="list-style-type: none"> <li>• Psychoeducation</li> <li>• Screening and Assessment</li> <li>• Therapy</li> <li>• Case Management</li> </ul>
Eligibility	Student 25 years of age or younger at a schoolsite*.
Providers	Local educational agencies or institutions of higher education
Payers	Applies to: <ul style="list-style-type: none"> <li>• State-regulated commercial health plans and insurers**</li> <li>• Medi-Cal managed care plans</li> <li>• Medi-Cal county behavioral health plans</li> </ul>

\* “School site” means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. It also includes a community-based facility or location, if the school or school district provides or

arranges for the provision of services to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

\*\* Applies to plans and insurers to the extent the plan or insurer is required to provide coverage for medically necessary treatment of mental health and substance use disorders.

To implement the fee schedule, DHCS must develop and maintain a school-linked statewide provider network of behavioral health counselors. Each LEA and IHE must submit a roster of their behavioral health providers to be approved prior to being able to bill. LEAs and IHEs are onboarded in implementation “cohorts”, with each cohort selected based on operational readiness. The selection process considers factors such as Medi-Cal enrollment, service delivery infrastructure and capacity, data collection and documentation, and billing infrastructure

### **CYBHI: Fee Schedule Implementation Challenges**

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Previous hearings held by this subcommittee have identified several and ongoing challenges implementing the necessary infrastructure to deliver behavioral health services in a school setting and process the appropriate reimbursements to participating LEAs and IHEs. The process has been described by stakeholders as complex and hindered by technical, operational, and administrative barriers. Examples include:

- **Collection of Student Health Plan Information:** LEAs have struggled to gather accurate and complete health plan data from students, making it difficult to process reimbursement claims. This issue is exacerbated by inconsistent data-sharing practices across schools and health plans.
- **Delay in Receiving Technical Guidance from DHCS and Its Third-Party Administrator:** Many LEAs and IHEs had noted issues obtaining the necessary technical guidance to implement the program, such as receiving policy and technical manuals outlining billing instructions and program compliance requirements.
- **Navigating Complex Health and Education Regulations:** Health and education systems operate under different regulatory frameworks, creating disconnects between schools, health plans, and administrators. For example, the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) govern health data privacy and educational records, respectively. These regulations were designed for separate sectors, making data-sharing and reimbursement coordination between schools and health plans difficult. Other compliance challenges include state Medicaid policies, provider credentialing rules, and administrative billing processes that do not align easily with educational settings.

In response to these challenges, the Legislature proposed a number of statutory changes to assist with keeping program implementation on track. These changes were adopted in AB 144 (Committee on Budget, Chapter 105, Statutes of 2025) and required DHCS to (1) convene a working group to discuss the status of, and receive feedback regarding, the implementation of the school fee schedule; (2) required a contracted administrator to automate the matching of student records with health plan enrollment information and to (3) reimburse claims pursuant to claim payment deadlines for the CYBHI school fee schedule, as specified.

**CYBHI: Fee Schedule Program Implementation Update**

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The Department of Health Care Services has published the following implementation data, updated as of March 30, 2026:

- Approximately 700 Local Educational Agencies and public Institutions of Higher Education enrolled in the CYBHI Fee Schedule program.
- Approximately 3.6 million students are enrolled across participating school-sites.
- 98% of counties in California are represented in the program.
- 169 LEAs/IHEs (including 8 school-linked providers) have submitted claims.
- \$7.35 million in unique clean claims (includes all in-process and approved claims) have been submitted to the Third-Party Administrator for reimbursement.
- 121,397 claims have been reimbursed, totaling \$6.84 million in new revenue for LEAs and IHEs.
- 31,567 unique students have received services submitted for reimbursement.
- 36 Managed Care Plans/Insurers are represented in the claims data.

**CYBHI: Behavioral Health Services Online Apps & Supports Platforms**

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As part of CYBHI, the Administration launched two digital behavioral health platforms to support children, youth, and caregivers. These mental health apps are BrightLife Kids for parents, caregivers, and children (aged 0-12), and Soluna for teens and young adults (aged 13-25). According to the Administration, these apps provide free digital tools, resources, and virtual services to support behavioral health and emotional well-being. The Department of Health Care Services has partnered with two digital health companies, Brightline and Kooth US, respectively, to operate the apps.

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 following chart outlines funding history for the CYBHI Behavioral Services Online Apps and Supports Platform. Of note, in addition to the BrightLife Kids and Soluna applications, these amounts are also inclusive of other platforms and related activities, including a partnership with the University of California, San Francisco Child and Adolescent Psychiatry Program (USCF CAPP); a statewide behavioral health eConsult service called the California Child and Adolescent Mental Health Access Portal (Cal-MAP); provider education and technical assistance campaigns; and promotional and advertising campaigns.

The Subcommittee has requested a more detailed breakdown of funding history by platforms and activities, but the Administration has not provided this information in time for publication.

<b>Appropriation Year</b>	<b>Funding History (General Fund)</b>
2022-23	\$230,000,000
2023-24	\$124,900,000
2025-26	\$175,900,000
2026-27	\$109,900,000
<b>TOTAL</b>	<b>\$640,700,000</b>

In their 2025 Impact Report, DHCS, Brightline and Kooth US reported the following information:

- 350,309 children registered since launch;
- 262,633 parents and caregivers registered since launch;
- 1.4 days average wait time for a coaching session;
- 500,000+ children, youth and families supported with BrightLife Kids and Soluna since launch;
- 112,370 completed coaching sessions on BrightLife Kids and Soluna since launch;

**Panel**

- Department of Health Care Services
- Department of Finance
- Will Owens, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- Min Lee, Economist, Legislative Analyst's Office

**Staff Comments**

Note: Prior to this hearing, the Subcommittee requested information in writing from the Administration regarding both the CYBHI Fee Schedule and the Behavioral Health Services Online Apps and Supports Platforms. That information had not been provided at the time this agenda was published. Additionally, the subcommittee requested several specific data points to assess the overall implementation status of the fee schedule. That data request remains pending, with no timeline provided by the Administration for a response. The subcommittee may wish to request that DHCS provide this information at the hearing and establish a timeline for the delivery of the data request.

Regarding the Behavioral Health Services Online Apps and Supports Platforms, the Subcommittee notes that investments have reached \$640 million to date, making the platforms one of the single largest line items within the entire CYBHI initiative. The subcommittee has not received a breakdown of expenditures by platform or activity, despite requesting this information, and the Administration has not provided exact contract amounts for BrightLife Kids or Soluna in writing. However, it is estimated that the contract for these two platforms are valued at an approximate maximum of \$120 million per year combined, which warrants additional questions regarding outcomes and cost-effectiveness.

Given the current fiscal environment and the Administration's caution regarding the fragility of the state's General Fund, the subcommittee recommends that the Administration apply rigorous scrutiny to the return on investment of each major expenditure, including for the Behavioral Health Services Online Apps. At \$640 million in total investment to date, these represent a significant and ongoing commitment of public resources. If the evidence indicates that returns have been modest relative to that investment, regardless of the program's intent, the subcommittee would welcome the Administration's honest assessment of that reality, and would expect the May Revision to reflect it accordingly through a reduction or elimination of funding.

The Subcommittee may wish to ask:

*Regarding the Behavioral Health Services Online Apps & Supports Platforms:*

- 1- Total investments in these platforms have reached \$640 million. Can DHCS provide a breakdown of expenditures by items, and the specific contract values and expenditures to date for BrightLife Kids and Soluna separately, by fiscal year?
- 2- What is the cost per active user and cost per completed coaching session for BrightLife Kids and Soluna based on actual expenditures? How do these figures compare to the cost of delivering equivalent services through traditional behavioral health providers?
- 3- The 2025 Impact Report references 500,000 children, youth, and families "supported" since launch. How is "supported" defined, and how does it translate into clinical outcomes?
- 4- The proposed 2026-27 expenditure is \$109.9 million. What specific activities and deliverables does that funding support, and how much of it is committed to the BrightLife Kids and Soluna contracts specifically?
- 5- What are the contractual terms for BrightLife Kids and Soluna, including contract length, renewal options and performance benchmarks?
- 6- Are these platforms proposed to be funded on an ongoing basis? If so, what is the projected annual cost in future years?

*Regarding the CYBHI Fee Schedule:*

- 1- DHCS reports approximately 700 LEAs and IHEs enrolled in the fee schedule program. What is the total universe of eligible LEAs and IHEs statewide, and how many remain unenrolled? Of those unenrolled, what are the primary barriers to participation, and what is DHCS doing to address them?
- 2- Of the 700 enrolled LEAs and IHEs, 169 have submitted claims. What is driving the gap between enrollment and claims submission?
- 3- Approximately 31,567 unique students have received services submitted for reimbursement, with 3.6 million enrolled students across participating sites. Are these numbers in line with the Administration implementation objectives? If not, what are the targets and the timeline to reach it?
- 4- The subcommittee requested LEA-level data including amounts billed, amounts reimbursed, denial rates, and LEA size. When will this information be made available?

**Staff Recommendation:**

Hold Open

**Issue 3: Behavioral Health Proposals: 988 Call Center Oversight and Community-Based Mobile Crisis Response Services****988 Call Center Oversight Proposals**

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**Background on 988**

The National Suicide Hotline Designation Act of 2020 (NSHD Act) designated 988 as the three-digit dialing code for the national Suicide and Crisis Lifeline and authorized states to impose fees on telecommunication access lines to fund 988-related services.

California implemented the 988 Lifeline through AB 988 (Bauer-Kahan, Chapter 747, Statutes of 2022), also known as the Miles Hall Lifeline and Suicide Prevention Act. Key provisions of AB 988 included:

- **Establishing 988-Crisis Policy Advisory Group (PAG).** CalHHS was mandated to establish the PAG, comprising state, county, and local government representatives, service providers, advocates, and community members. The PAG advises CalHHS on developing a Five-Year Implementation Plan for a comprehensive 988 crisis system.
- **988 Fund and Surcharge.** 988 State Suicide and Behavioral Health Crisis Services Fund, financed through a surcharge on telecommunication access lines. By statute, surcharge revenue must be prioritized for: (1) the 988 centers, including the efficient and effective routing of telephone calls, personnel, and the provision of acute behavioral health services through telephone call, text, and chat to the 988 number; and (2) the operation of mobile crisis teams accessed via telephone calls, texts, or chats made to or routed through 988.

The surcharge was capped at \$0.08 per access line per month for calendar years 2023 and 2024. Beginning January 1, 2025, the fee may be adjusted pursuant to a statutory formula, up to a maximum of \$0.30 per access line per month. The surcharge is currently set at \$0.05. Cal OES oversees the Fund and administers the surcharge calculation process.

- **988 System Director and Technical Advisory Board (TAB).** AB 988 requires Cal OES to appoint a 988 System Director and convene a TAB to guide technical and operational standards, including interoperability requirements between 988, 9-1-1, and other emergency and behavioral health crisis services.

DHCS contracts with Advocates for Human Potential as an administrative entity to subcontract with California's eleven 988 Crisis Centers and distribute funding from the 988 Fund. The current centers are:

- Buckelew Programs (Novato)
- Kings View (Fresno)
- Contra Costa Crisis Center (Walnut Creek)
- Crisis Support Services of Alameda County (Oakland)
- Didi Hirsch Mental Health Services (Century City)
- Kern Behavioral and Recovery Services (Bakersfield)
- United Behavioral Health/Optum (San Diego)
- San Francisco Suicide Prevention – Felton Institute (San Francisco)
- County of Santa Clara Behavioral Health Services (San Jose)
- Family Service Agency of the Central Coast (Santa Cruz)
- Wellspace Health (Sacramento)

### **Five-Year Implementation Plan**

In December 2024, the Administration published its Five-Year Implementation Plan for building a comprehensive 988 crisis system. The plan is organized around four goals:

- **Goal A:** Increase public awareness of and trust in 988 and behavioral health crisis services.
- **Goal B:** Establish systems — including technology, policies, and practices — to connect help seekers to appropriate call, chat, and text takers.
- **Goal C:** Support the 988 system in delivering a high-quality response.
- **Goal D:** Increase coordination of behavioral health crisis services.

### **Trailer Bill Proposal: 988 Call Center Oversight Proposal**

The Governor's budget includes a trailer bill that broadly proposes the following:

- 1- Establish a process and standard criteria for entities to apply for designation as 988 crisis centers.
- 2- Authorize DHCS to set and enforce performance standards for designated 988 centers, including staffing and training requirements, clinical and triage protocols, quality measures, and performance requirements.
- 3- Authorize DHCS to oversee funding to 988 centers and mobile crisis teams for staffing necessary to provide 988 and mobile crisis services.

- 4- Allow 988 surcharge revenue to be used for state operations expenditures, including personnel and administrative costs.
  
- 5- Require Cal OES, in consultation with DHCS, to allocate and distribute funds to 988 centers for the acquisition of technology and equipment, as appropriated by the Legislature.

### **988 Budget Change Proposal**

In addition to the trailer bill described above, DHCS additionally requests 8 permanent positions and expenditure authority of \$25,906,000 from the 988 State Suicide and Behavioral Health Crisis Services Fund in 2026-27, \$25,834,000 in 2027-28 through 2029-30, and \$4,373,000 in 2030-31 and ongoing to manage the increasingly complex and growing workload, and to support the 988 Crisis Centers. The expenditure authority requested is a combination of state operations, and local assistance.

Specifically, on local assistance for the 988 call centers, the proposal would bring an additional \$19.4 million annually in addition to an existing \$12.5 million in existing authority, for a total of \$31.9 million per year. Of note, the 2025-26 budget included an additional, one-time \$17,500,000 investment to support 988 crisis center operations.

### **Community-Based Mobile Crisis Response Services**

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#### **Background on Mobile Crisis Response**

Mobile crisis services are community-based interventions that provide rapid, in-person behavioral health support to individuals wherever a crisis occurs; whether at home, work, school, or in the community. Services are delivered by multidisciplinary teams of trained behavioral health professionals and are designed to:

- Assess and stabilize individuals experiencing a behavioral health crisis;
- Reduce the immediate risk of danger and subsequent harm through de-escalation and stabilization techniques; and
- Avoid unnecessary emergency department visits, psychiatric hospitalizations, and law enforcement involvement.

## **Federal Authorization for Mobile Crisis and Enhanced Federal Funding**

Federal law authorizes state Medicaid programs to offer qualifying community-based mobile crisis response services for a five-year period running April 1, 2022 through March 31, 2027. To encourage states to stand up this benefit, federal law also provides an enhanced 85 percent Federal Medical Assistance Percentage (FMAP), significantly above the standard match rate, for the first 12 fiscal quarters in which qualifying services are offered. For California, the enhanced FMAP period covers dates of service January 1, 2024 through December 31, 2026.

### **Enhanced Federal Funding Expiration**

The enhanced 85 percent FMAP expires at the end of 2026. At that point, the state would revert to its standard FMAP rate for any remaining claims, with the underlying federal authorization for the benefit continuing through March 31, 2027. The Governor's budget proposes \$431.5 million total funds, (\$50.7 million in Proposition 35 funds, \$347 million in federal funds, \$28.2 million in 988 funds, and \$5.6 million in General Fund) to continue the benefit through both the enhanced and standard FMAP periods, covering 2025–26 and 2026–27.

### **Budget Proposal to Make Mobile Crisis an Optional Benefit**

Effective April 1, 2027, DHCS proposes to recast mobile crisis response services as an optional Medi-Cal benefit available in counties that elect to participate and provide the necessary nonfederal share funding with local fund sources. DHCS has indicated it will consult with counties and stakeholders on revisions to current program requirements, including modifications to address operational challenges, with the goal of supporting sustainable mobile crisis delivery in counties that opt in.

#### **Panel**

#### 988 Call Center Oversight:

- Department of Health Care Services
- Department of Finance
- Narges Dillon, 988 California President, 988 California Crisis Center Consortium
- Elise Jones, County Behavioral Health Director, Lake County
- Dr. LeOndra Clark Harvey, Chief Executive Officer, California Behavioral Health Association
- Will Owens, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- Min Lee, Economist, Legislative Analyst's Office

Community-Based Mobile Crisis Response Services:

- Department of Health Care Services
- Department of Finance
- Elise Jones, County Behavioral Health Director, Lake County
- Mae Sampani, Executive Director, Crisis Services, Pacific Clinics
- Dr. LeOndra Clark Harvey, Chief Executive Officer, California Behavioral Health Association

**Staff Comments***Related to 988 Call Center Oversight:*

- The 988 Lifeline represents a meaningful shift in how California approaches behavioral health crisis response, moving towards a dedicated, non-law-enforcement pathway for individuals in acute mental health crisis. As the system continues to mature and evolve, the subcommittee may wish to examine whether the current funding structure, governance framework, and performance standards are adequate to sustain and scale it.
- On funding, the Governor's budget proposes approximately \$31.9 million in annual local assistance for the state's 11 crisis centers. In discussion with the 988 centers, the 988 California Crisis Center Consortium has outlined a resource need of approximately \$105 million to adequately support those centers; a gap of more than \$73 million annually. The Subcommittee may wish to better understand what level of service the proposed funding actually supports, what goes unfunded, and whether unmet demand is being tracked.
- The 988 surcharge is the primary revenue source for the system, currently set at \$0.05 per access line per month, and well below the statutory maximum of \$0.30. Staff notes that the process for setting the surcharge involves two departments, DHCS and Office of Emergency Services (CalOES). Currently, it is unclear which entity would have the final surcharge-setting authority. The Administration's trailer bill proposal appears to give DHCS a more explicit programmatic role, including authority to determine what constitutes sufficient funding for 988 center operations and to specify the staffing and cost categories for which 988 funds are allocated. However, CalOES remains the entity that can determine the annual surcharge. The subcommittee may wish to examine whether this governance structure provides sufficient transparency and accountability, and whether the division of responsibility between DHCS and CalOES is workable in practice.
- The Subcommittee has received stakeholder concerns regarding the trailer bill proposal, including specific provisions that would restrict 988 surcharge revenue to center operations only until December 31, 2029, after which the allowable uses would broaden.

Stakeholders have raised concerns that this sunset creates significant uncertainty about the long-term stability and dedicated purpose of the surcharge fund. The subcommittee may wish to understand the Administration's rationale for this provision and whether adequate protections exist to ensure surcharge revenue continues to support its intended purpose beyond 2029.

The Subcommittee may wish to ask:

- 1- What are the current performance standards for 988 centers, and are the centers meeting those standards?
- 2- What is the projected demand for 988 services in the coming years?
- 3- The 988 Consortium has identified a resource need of approximately \$105 million annually to adequately support the state's 11 crisis centers. The Governor's budget proposes \$31.9 million. What level of service does the proposed funding actually support, and what demand, staffing, or quality standards go unmet at that funding level?
- 4- Can DHCS describe how call center funding needs are evaluated, what coordination exists with CalOES in that process?
- 5- What data is publicly available on how funding is disbursed to each center and what outcomes are being achieved?
- 6- What process will be used to govern decisions regarding telecommunication surcharge?
- 7- Existing law requires that surcharge revenue be prioritized for 988 center operations and for mobile crisis teams accessed through 988. Has that mobile crisis priority been funded to date? If not, what is the plan and timeline to fulfill that statutory priority?
- 8- The trailer bill would restrict surcharge revenue to center operations until December 31, 2029, after which allowable uses broaden. What is the Administration's rationale for this sunset date?

*Related to Community-Based Mobile Crisis Response Services*

- Mobile crisis response services represent one of the more promising developments in California's behavioral health continuum by providing rapid, in-person behavioral health support as an alternative to law enforcement response and emergency department diversion. The program has been described to be associated with meaningful reductions in involuntary psychiatric holds, emergency department visits, and law enforcement involvement. As federal support for the benefit is scheduled to end, the Administration

proposes to recast mobile crisis as an optional county benefit beginning April 1, 2027. This proposal has generated significant opposition from counties, providers, and advocates.

- The transition from mandatory to optional benefit creates a structural risk of geographic inequity, as discussed in Issue #1 of this agenda. Counties with stronger local revenue sources may be able to sustain the benefit; smaller and lower-resourced counties may not.

The Subcommittee may wish to ask:

- 1- Mobile crisis services have been associated with reductions in involuntary psychiatric holds, emergency department visits, and law enforcement involvement. Prior to advancing the proposal to make this benefit optional, did the Administration conduct a formal impact assessment?
- 2- What engagement has the Administration conducted with counties regarding this proposal, and what has that feedback indicated about which counties are likely to opt in versus opt out?
- 3- Under the optional model, counties must provide the nonfederal share from local fund sources. Given that H.R. 1 is simultaneously projected to reduce Medi-Cal revenues and increase demand for behavioral health services, what is the counties assessment of fiscal capacity to absorb the costs of providing mobile crisis services?
- 4- For counties that opt out, what alternative crisis response pathways will be available to individuals in need of services?

**Staff Recommendation:**

Hold Open

**Issue 4: Behavioral Health Proposals: Behavioral Health Services Fund Revenue and Stability and Other Proposals****Behavioral Health Services Act Revenue and Stability Trailer Bill**

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**Background**

The Mental Health Services Act (MHSA), passed as Proposition 63 in 2004, established the Mental Health Services Fund (MHSF), financed through a one percent tax surcharge on personal income over \$1 million. In March 2024, California voters passed Proposition 1, implementing the statutory changes in SB 326 (Eggman, Chapter 790, Statutes of 2023), which renamed the MHSA to the Behavioral Health Services Act (BHSA) and modernized the state's public behavioral health system.

The vast majority of BHSA funding flows to counties, which are subject to statutory parameters governing how funds may be spent, including prescribed allocation percentages across program components such as Full-Service Partnerships, housing interventions, and behavioral health services and supports.

**Revenue Volatility**

The BHSA tax is an exceptionally volatile revenue source. In a 2023 analysis, the Legislative Analyst's Office found that year-over-year changes in MHSA revenue were in many years two to three times larger than changes in the Personal Income Tax overall -- and nearly five times more volatile than the sales and use tax. This volatility stems from the narrow, high-income tax base: revenue is concentrated among a small number of filers whose income is heavily weighted toward capital gains and other market-sensitive sources.

Because the BHSA predominantly funds ongoing mental health services, this revenue volatility poses a significant challenge for counties trying to maintain consistent service levels year to year.

**Prudent Reserves**

To manage this volatility, counties are authorized to maintain local prudent reserves, which are set-aside funds accumulated during high-revenue years that can be drawn down when revenues decline. MHSA originally required counties to establish prudent reserves and capped annual deposit amounts, but did not limit the cumulative balance a county could hold. In 2018, the Legislature enacted SB 192 (Beall, Chapter 328, Statutes of 2018), establishing a cumulative caps on county prudent reserves using specific formulas.

## **BHSA Revenue Stability Workgroup and Trailer Bill Proposal**

To address this structural volatility, the BHSA required DHCS to convene a Revenue Stability Workgroup to assess year-over-year revenue fluctuations, develop recommendations to reduce volatility, and propose appropriate prudent reserve levels to support the sustainability of county programs and services. DHCS and CalHHS convened the Workgroup between July and October 2024. In May 2025, the Administration released its recommendations. Key recommendations include:

- 1- *Minimum Expenditure Level.* Each county would be required to maintain an annual minimum expenditure level calculated using historical BHSA revenue distribution data and a three-year trailing weighted average (weighting the most recent year at 60 percent, the prior year at 25 percent, and the year before that at 15 percent) with an annual inflationary adjustment of four percent to account for a two-year lag in available revenue data. Counties would be required to spend at least this minimum annually on BHSA programs, consistent with their local Integrated Plan or Annual Update. If forecasted local assistance revenue falls more than 10 percent below the calculated minimum, counties may revise the minimum downward through a budget revision process.
- 2- *Reduction in Prudent Reserves.* Counties would be required to set their local prudent reserves up to a maximum of 10 percent for medium and large counties (population over 200,000) and 15 percent for small counties (population 200,000 or below), calculated as a share of the average total BHSA or MHSA funds distributed to the county over the preceding five years. Counties would implement a one-time drawdown of reserves exceeding these new caps during the FY 2026–29 Integrated Plan cycle, with local discretion over how excess funds are allocated across BHSA program components.
- 3- *Reserve Access During Downturns.* During an economic downturn, counties would be permitted to access their prudent reserves at local discretion to support BHSA programs and services consistent with statutory requirements and their approved Integrated Plan.

The Governor's budget includes trailer bill language that would implement the workgroup recommendations.

## **Aligning Evidence-Based Standards for Substance Use Disorder Treatment**

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The Department of Health Care Services proposes statutory updates to align state standards for substance use disorder (SUD) treatment facilities licensed or certified by the Department with current, evidence-based standards of care. To implement the American Society of Addiction Medicine's (ASAM) Criteria, 4<sup>th</sup> Edition, this TBL eliminates detoxification as a standalone licensable service, effective June 30, 2027, and instead integrates non-medical withdrawal management services into standard residential treatment. DHCS further proposes to amend

state licensure and certification statutes for SUD treatment facilities, including Narcotic Treatment Programs (NTPs), to replace references to “detoxification” with the modern, industry-standard term “withdrawal management.”

The Administration notes that approximately 6 facilities will be impacted by the change, who currently have detoxification as a standalone licensable service.

**Panel**

- Department of Health Care Services
- Department of Finance
- Michelle Doty Cabrera, Executive Director, County Behavioral Health Directors Association
- Will Owens, Senior Fiscal and Policy Analyst, Legislative Analyst’s Office
- Min Lee, Economist, Legislative Analyst’s Office

**Staff Comments**

Counties have expressed concerns with the Administration’s proposal to implement the BHSA Revenue and Stability proposal and have proposed amendments that would:

- 1- Maintain existing BHSA prudent reserve levels of 20% instead of dropping them to 10% to ensure greater fiscal stability across revenue changes. In addition, maintain existing BHSA prudent reserve levels for rural counties under 200,000 population at 25% instead of dropping them to 15%.
- 2- Provide greater flexibility for counties to access prudent reserves so that counties can account for unexpected changes in budgeted expenditures,
- 3- Allow counties to adjust funding allocations across BHSA components on a year-to-year basis, rather than every three years given the general economic uncertainty.
- 4- Establish criteria, in partnership with counties, for calculating the county minimum expenditure level.

**Staff Recommendation:**

Hold Open

## 4440 Department of State Hospitals

### Issue 5: Overview of Budget, Estimate, and Budget Change Proposals

#### 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 following table describes the type of patients under DSH jurisdiction and information on population census.

DSH Population	Population Description	7/1/2025 Actual Census	7/1/2026 Projected Census
Coleman	Patients transferred from the California Department of Corrections and Rehabilitation under Coleman v. Brown requiring mental health care in state hospitals.	190	260
Incompetent to Stand Trial (IST)	Individuals found incompetent to stand trial due to a mental disorder, requiring restoration of competency.	1,589	1,630

Lanterman-Petris-Short (LPS)	Lanterman-Petris-Short Act civil commitments for individuals gravely disabled due to mental illness	568	625
Not Guilty by Reason of Insanity (NGI)	Individuals found Not Guilty by Reason of Insanity and committed for treatment to a state hospital.	1,197	1,201
Offenders with a Mental Health Disorder (OMD)	Offenders with a Mental Health Disorder committed following prison sentences.	1,016	1,022
Sexually Violent Predators	Individuals designated as Sexually Violent Predators under state laws and requiring secure treatment	956	956
Contracted Programs	Includes Jail-Based Competency Treatment (JBCT), Community-Based Restoration (CBR), and Community Inpatient Facilities (CIF).	1,359	1,730
Conditional Release (CONREP) Programs	Outpatient treatment programs including CONREP, Forensic Assertive Community Treatment (FACT), and Step Down Facilities.	663	893
<b>TOTAL</b>		<b>7,538</b>	<b>8,317</b>

**DSH Budget Overview**

The 2026-27 Governor’s budget proposes \$3.1 billion and 13,255 staff positions for the Department of State Hospitals. Compared to the 2025 Budget Act, this represents an approximate 1.1% budget increase. A high-level breakdown of the DSH budget is included below:

Funding Source	2025 Budget Act	2026-27 Proposed Governor’s Budget	Percentage Change
General Fund	\$2,931,652	\$2,957,559	+0.9%
Other Fund	\$178,848	\$186,469	+4.2%
<b>TOTAL</b>	<b>\$3,110,500</b>	<b>\$3,144,028</b>	<b>+1.1%</b>
<i>Staff Positions</i>	13,214	13,255	+0.3%

*\*dollars in thousands*

## Budget Change Proposals & April Finance Letters

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The 2026-27 Governor's budget proposes four budget change proposals for the Department of State Hospitals, as summarized below:

- 1- **Dental Care Initiative:** DSH requests \$3.9 million General Fund and 4 permanent positions in 2026-27, \$1.1 million in 2027-28 and ongoing to support dental health services provided to patients at DSH-Metropolitan and DSH-Patton. DSH proposes one trailer to serve as a dental clinic as well as 3 Dental Hygienists and 1 Dentist to improve access to dental services. According to the Administration, adding these positions will allow DSH to provide routine oral health screens and preventive care; reduce dental emergencies and infections; improve patients' ability to eat, speak and maintain self-esteem, which supports psychiatric rehabilitation; establish a consistent oral hygiene education and care plan for patients; and comply with best practices in integrated healthcare models that emphasize complete care.
- 2- **Transitional Housing (SB 380 Implementation).** DSH requests \$469,000 in 2026-27 to conduct an analysis on the feasibility of establishing transitional housing facilities for the Conditional Release Program (CONREP) for Sexually Violent Predators (SVP) and submit a report of results to the Legislature as required by SB 380 (Jones, Chapter 581, Statutes of 2025). DSH also requests two limited-term positions beginning July 1, 2026, and ending June 30, 2027, to support the needs of this analysis.
- 3- **Napa: Electrical Infrastructure Upgrade.** DSH requests \$7,269,000 General Fund for the working drawings phase of the DSH-Napa Electrical Infrastructure Upgrade project. To support the electrical demands necessary to maintain existing critical services at a 24/7 patient care facility, this project upgrades 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. While this project is currently in preliminary plans, total estimated project costs are \$95,073,000 (\$2,844,000 for preliminary plans, \$7,269,000 for working drawings, and \$84,960,000 for construction).
- 4- **Patton: Electrical Infrastructure Upgrade.** DSH requests \$1,757,000 General Fund for the preliminary plans phase of the DSH-Patton Electrical Infrastructure Upgrade project. To support the electrical demands necessary to maintain existing critical services at a 24/7 patient care facility, this project upgrades the medium and high-voltage distribution infrastructure and modernizes low-voltage systems in each building through the replacement of obsolete panels and wiring. In addition, the project will install housed emergency generators with associated fuel systems to provide reliable auxiliary power. Total project costs are estimated at \$61,695,000 which includes preliminary plans (\$1,757,000), working drawings (\$3,441,000) and construction (\$56,497,000).

The Administration also requests the addition of provisional language in the budget bill that would:

- 1- Authorize the Department of Finance to shift expenditure authority between funding schedules in order to meet operational needs of the Department of State Hospitals.
- 2- Extend expenditure authority for ligature risk special repair projects from June 30, 2028 to June 30, 2029.

### **Incompetent to Stand Trial (IST) Update**

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The Incompetent to Stand Trial (IST) population, which consists of individuals found unfit to proceed with felony charges due to mental illness, was 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.

DSH reached a high of 1,953 IST patients on the pending placement list as of January 2022 and is now down to 275 as of 2026-27 Governor’s Budget. The Administration notes that this significant reduction is due to the rapid implementation of the IST solutions authorized in the budget, the easing of CDC and CDPH requirements on healthcare facilities in response to the pandemic, no longer having to cohort admissions, and shorter quarantine timelines associated with exposures.

Due to the average monthly referrals, the Administration projects that it is unlikely this current pending placement list trend will change significantly moving forward. In FY 2024-25, DSH received an average of 451 IST referrals per month. The current waitlist reflects real-time monthly referrals, and the number of patients pending admission to a treatment bed is fewer than the number of referrals received per month.

**Panel**

- Stephanie Clendenin, Director, Department of State Hospitals
- Chris Edens, Chief Deputy Director for Program, Department of State Hospitals
- Brandon Price, Chief of Hospital Operations, Department of State Hospitals
- Mark Beckley, Chief Deputy Director for Operations, Department of State Hospitals
- Department of Finance
- Will Owens, Senior Fiscal and Policy Analyst, Legislative Analyst’s Office

**Staff Comments**

Staff do not have concerns with the proposals, but recommend holding the item open until May Revision proposals are presented to the Subcommittee.

**Staff Recommendation:**

Hold Open

## 4560 Commission for Behavioral Health

### Issue 6: Program Updates: Innovation Partnership Fund and Mental Health and Wellness Act

#### Background on the Commission for Behavioral Health

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The Behavioral Health Services Oversight and Accountability Commission, also known as the Commission for Behavioral Health (CBH) and formerly the Mental Health Services Oversight and Accountability Commission, was initially established in 2004 through Proposition 63 to oversee implementation of the Mental Health Services Act and to drive innovation and accountability in California's community-based mental health system.

With the passage of Proposition 1, the Behavioral Health Services Act, in 2024, the Commission is now made up of 27 members selected by the Governor, Attorney General, State Superintendent, Assembly, and Senate. The Commission is tasked with analyzing data, identifying gaps, and advancing solutions to improve services, reduce disparities, and address emerging issues. The Commission also aims to build a more effective and responsive behavioral health system through grant programs, technical assistance, and collaborating with community members and local and state agencies.

#### Program Update: Innovation Partnership Fund (IPF)

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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 for a total of \$100 million. 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.

The Commission released request for application for its first round of funding on March 20, 2026. This first round of IPF will offer two distinct grant categories, each with specific eligibility requirements:

- Category 1: Small Grants (Less than \$500,000): A minimum of 8 grants will be awarded, with a total of \$4 million available. These grants are exclusively open to community-based organizations, non-profit entities, and/or tribal organizations.

- Category 2: Large Grants (\$500,000 to \$5,000,000): A minimum of 3 grants will be awarded, with a total of \$16 million available. These grants are open to all organization and entity types including public, private, and non-profit entities.

Deadline to submit applications is May 8, 2026, with the Commission intending to award in June 2026.

### **Program Update: Mental Health and Wellness Act**

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California's Mental Health Wellness Act (MHWA) grant program provides \$20 million each year to improve community response to people facing behavioral health crises. Grants generally provides funds to California counties to improve access to and capacity for behavioral health crisis services, including crisis intervention, stabilization, treatment, rehabilitative services, and mobile crisis support teams.

The Commission has identified six areas of focus for funding, and grants focus on those priorities. Multiple programs are currently in various stages of development and funding, and are described by the Commission below:

**EmPath:** Emergency Psychiatric Assessment Treatment and Healing (EmPATH) units are ideally located adjacent to regular hospital Emergency Departments, and deliver acute behavioral health care to patients in crisis in a calm, therapeutic setting not always found in a typical emergency room. Most emergency departments are not equipped to handle patients in a behavioral health crisis, which can lead to increased stress in an already stressful situation for both ED workers and patients. The goal of an EmPATH unit is to reduce ED boarding time for those patients and to reduce unnecessary psychiatric hospitalizations.

**PEARLS and Age Wise:** Program to Encourage Active Rewarding Lives (PEARLS) is a brief, time-limited, and participant-driven program developed by the University of Washington that educates older adults about depression and helps them develop the skills they need for self-sufficiency and more active lives. Age Wise is a traditional mental health program for the high-risk and underserved older adult population developed by the County of San Bernardino. Its goal is to help individuals, families, and agencies maintain the best possible behavioral and physical health to promote independent living and wellbeing.

**Maternal Behavioral Health and Children Ages 0-5:** The Commission identified in 2023 children ages zero to five and their parents/caregivers as a priority for MHWA funding. This focus will promote early childhood social-emotional wellbeing and develop local systems of care to identify issues early, while also ensuring connection to culturally relevant services.

**Substance Use Disorder Pilot Program:** California adopted the American Society of Addiction Medicine Criteria as the standard for treating substance use disorders using a holistic, person-centered approach to treatment and co-occurring disorders. The Commission recognizes that counties and their partners are struggling to meet those standards due to a lack of adequately trained medical prescribers available to provide evidence-based medications for addiction treatment (MAT), an underutilized and high-impact intervention for SUD clients.

**Full Service Partnership Technical Assistance:** Full Service Partnerships (FSPs) are recovery-oriented, comprehensive services created to help people with severe, chronic behavioral health challenges who are at risk of becoming or already are unhoused. It provides the “full” spectrum of community services with a “whatever it takes” approach. The Commission’s MHWA grant funding for improving FSPs takes the form of technical assistance and capacity building focused on value-based contracting and performance management and improved service delivery.

**Peer Respite:** A peer respite is a voluntary, short-term program, usually overnight, that provides community-based, non-clinical support to people experiencing or at risk of experiencing a psychiatric crisis. Peer respites are staffed and operated by people with lived experience with behavioral health challenges. Inside a homelike environment, individuals who are struggling with a behavioral health challenges – whether emotional or psychological – can receive support from their peers.

### Panel

- Brenda Grealish, Executive Director, Commission for Behavioral Health
- Department of Finance
- Will Owens, Senior Fiscal and Policy Analyst, Legislative Analyst’s Office

### Staff Recommendation:

This item is informational only.

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