The Budget included:

- **$7.5 Billion in direct investments in Behavioral Health; and**
- **An additional $6.7 Billion in investments in housing, social services and other supports etc.**

Funding Allocated in FY 2021-22 Budget	Description of the Program and Brief Updates
Behavioral Health Continuum Infrastructure Program	
$2.2B	Behavioral Health Continuum Infrastructure Program: The Budget includes $755.7 million in 2021-22 and $1.4 billion in 2022-23 and $2.1 million General Fund in 2023-24 for competitive grants to qualified entities including county behavioral health agencies and city mental health authorities to construct, acquire, and rehabilitate real estate assets or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. DHCS has a new website on this program: The Behavioral Health Continuum Infrastructure Program
Children and Youth Behavioral Health Initiative	
$205M	Mental Health Student Services Act (MHSSA): MHSSA funds grants to school and county mental health partnerships that support the mental health and emotional needs of children and youth as they return to schools and everyday life.
$550M	School-Linked Behavioral Health Services: $100,000,000 is available in FY 2021-22 to support school-linked partnership, capacity, and infrastructure grants to qualified entities, including county/city behavioral health agencies to support implementation of the initiative for behavioral health services in schools and school-linked settings. Of this amount, $70,000,000 is available for grants focused on individuals in preschool through secondary educational institutions and $30,000,000 is available for grants focused on individuals in institutions of higher education.
$429M	Develop & Scale-up EBPs & Community Defined Evidence: DHCS will develop and select evidence-based interventions and community-defined promising practices, to improve outcomes for children and youth with or at high risk for behavioral health conditions. Prior to selecting the evidence-based interventions, DHCS will establish a workgroup comprised of subject matter experts and affected stakeholders to consider evidence-based interventions based on robust evidence for effectiveness, impact on racial equity, and sustainability. DHCS, or its contracted vendor, will provide competitive grants to entities it deems qualified (including county behavioral health agencies and city mental health authorities) to support the implementation of the evidence-based interventions and community-defined promising practices developed through the workgroup process.

$305M	Building Crisis Continuum Infrastructure: Funds to support mobile crisis support teams to assist youth and adults experiencing a behavioral health crisis. County behavioral health agencies have already applied for these funds. Part of this funding comes from the larger infrastructure grant funding listed above.
$430M	Broad BH Workforce Capacity: Approves the allocation to be spent over five years on workforce capacity, including: • Psychiatry and social workers • Substance use disorder services providers • Behavioral health workforce pipeline • "Earn to Learn" apprenticeship models • Training to serve justice- and system-involved youth • Train New Trainers Psychiatry Fellowship for Primary Care Providers • Peer Training and Placement Programs • Existing Loan Repayment, Scholarship, and Stipend Programs for Behavioral Health This includes $75 million to address the recognized need to develop a SUD workforce which provides age-appropriate treatment. In FY 2021-22, OSHPD will develop a new SUD workforce framework and plan focused on youth and families. The plan will focus on several components, including but not limited to the following: • Expand knowledge of existing licensed behavioral health clinicians through Train New Trainer models. • Develop a SUD career ladder for existing certified SUD counselors. This can include tuition assistance, stipends, etc. • Establish and support programs to help registered SUD counselors become certified and train in age-appropriate treatment.
$352M	School BH Counselor and BH Coach Workforce: OSHPD will award competitive grants to entities and individuals it deems qualified to expand the supply of behavioral health counselors, coaches, peer supports, community health workers, and other allied health care providers serving children and youth, including those at schoolsites. "Behavioral health coach" means a new category of behavioral health provider trained specifically to help address the unmet mental health and substance use needs of children and youth.
$400M	Medi-Cal Incentive Program: DHCS will allocate one-time funds, available over three years, for incentive payments paid through Medi-Cal managed care plans to build infrastructure, partnerships, and capacity, statewide for school behavioral health services. The program would begin January 1, 2022. A portion of this funding will allow the state to provide technical assistance to Local Education Agencies, Medi-Cal Managed Care plans, and Mental Health Plans to implement the program, including facilitation of partnerships. Incentives cannot be used for treatment.
$750M	Behavioral Health Service Virtual Platform: DHCS will oversee a vendor to establish and maintain a behavioral health services and supports virtual platform that integrates behavioral health screenings, application-based supports, and direct behavioral health services to children and youth 25 years of age and younger, regardless of payer. The virtual platform will include access in all Medi-Cal threshold languages and will be culturally appropriate to accommodate the diversity of the population and will be accessible by telephone.
$800M	Enhance Medi-Cal Benefits (*Dyadic services, ACEs*): Commencing no sooner than July 1, 2022, dyadic behavioral health visits will be a covered benefit under the Medi-Cal program, subject to utilization controls. The dyadic services benefit is a family- and caregiver-focused model of care

	intended to address developmental and behavioral health conditions of children as soon as they are identified, and that fosters access to preventive care for children, rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health.
$125M	Public Education and Change Campaign/ACES: To fund public education campaigns for behavioral health literacy, adverse childhood experiences, and trauma-informed training that is comprehensive, and culturally and linguistically proficient.
$50M + $50M	Coordination, Subject Matter Expertise and Evaluation and Pediatric, Primary Care and Other Healthcare Providers
Behavioral Health Housing and Homelessness	
$805M	Community Care Expansion Program: Funds for the construction, acquisition and/or rehabilitation of projects to preserve or expand adult and senior care facilities to serve people experiencing homelessness or who are at risk of becoming homeless. $55 million of this funding is available for Capitalized Operating Subsidy Reserve to assist with operational costs.
No Allocation	Housing Support Services: Adopts trailer bill that requires DHCS to conduct an evaluation of Medi-Cal managed care network adequacy for housing support services, in order to determine readiness to request federal approval of housing support services as a statewide Medi-Cal benefit. Requires DHCS to report the evaluation findings to the Legislature by January 1, 2024.
988 Crisis Line	
$20M	988 Hotline: To invest in California's network of emergency call centers to support the launch of a new 988 hotline, an alternative to 911 for people seeking help during a mental health crisis. This federal grant funding will bolster call centers that will support 988.
CalAIM	
$1.6B FYs 21-23 $1.5B FY 23-24 $900M FY 24-25 Ongoing	California Advancing and Innovating Medi-Cal (CalAIM) Initiative: to implement CalAIM, including, but not limited to, the following components: 1. Reforms the reimbursement system for County Mental Health Plans. 2. Requires continuation of the Drug Medi-Cal Organized Delivery System and Specialty Mental Health Services programs, including a placeholder requirement to design an intergovernmental transfer claiming methodology to replace the current claiming process and a Behavioral Health Quality Improvement Program for grants to counties and contracting entities to implement. 3. Establishes an incentive payment program for Medi-Cal managed care (MCMC) plans that meet certain milestones and metrics, including In Lieu of Services (ILOS) and Enhanced Care Management (ECM). 4. Authorizes the continuation of the Health Homes Program using General Fund and sunsets the program January 1, 2022. 5. Requires county Boards of Supervisors to designate entities to assist county jail and juvenile inmates with submitting Medi-Cal applications. 6. Authorizes funding for the Population Health Management Service.
$21.8M FY 21-22 $32.1M FY 22-23	Behavioral Health Quality Improvement Program: To assist county Mental Health Plans and county Drug Medi-Cal programs prepare for opportunities through CalAIM. This includes payment

	reform, updating county information technology systems to meet changes in medical necessity determinations, incorporate managed care and other utilization data from DHCS into county information technology systems of care and automate data reporting and/or electronic health record systems as needed.
$315M	Population Health Management Service: As part of the CalAIM initiative, these funds are to provide population health management services that would centralize administrative and clinical data from the Department, health plans, and providers. Access to this information would allow all parties to better identify and stratify member risks and inform quality and value delivery across the continuum of care while implementing the CalAIM Initiative. The service will also facilitate the connection between important health data and critical human service data for a given beneficiary.
$200M	Medi-Cal Providing Access and Transforming Health Payments (PATH): As part of the CalAIM Initiative, to build capacity for effective pre-release care for justice-involved populations to enable coordination with justice agencies and Medi-Cal coverage of services 90 days prior to release.
Families First Prevention Services Act (FFPSA) and Foster Youth	
Medi-Cal Estimates $19.2M Total Funds $10M FFP $4.6M State Funds $4.6M County BH	Qualified Individual (QI): DHCS and DSS have identified the QI role as a MHP role and QI activity as primarily a Medi-Cal specialty mental health service. To comply with federal law, the QI must begin conducting assessments for a children in county child welfare or probation systems by October 1, 2021 for any placement in a STRTP or Out-of-State (OOS) facility. A QI will conduct an assessment to determine if a referred child would best be served in a home-based placement or a STRTP. This new role triggers Proposition 30 protections. Because it is a federal requirement and intended to be a SMHS, federal financial participation will be available and counties will be responsible for half of the nonfederal share with state general funds covering the other half of the nonfederal share.
Medi-Cal Estimates $26.2M Total Funds $13.1M FFP $6.3M State Funds $6.3M County Funds (45% Child Welfare & 55% County BH)	Aftercare: Family-based Aftercare Services are defined by federal law as an array of integrated services and supports that are required to be provided to a child for at least 6 months post discharge from an STRTP (or OOS facility). On and after October 1, 2021, each county child welfare agency, probation department, and mental health plan, in consultation with the local interagency leadership team shall jointly provide, arrange for, or ensure the provision of, at least six months of aftercare services for the youth. Eventually, the state will require Aftercare to be High Fidelity Wraparound services. CDSS and DHCS, in consultation with county representatives and other stakeholders, shall develop recommendations for implementing and expanding high-fidelity wraparound services statewide.
$5M Total Funds in FY 2020-21 and $18M total Funds in FY 2021-22	DHCS - Funding to Support Mental Health Services for Out-of-State Foster Youth. To provide specialty mental health services to foster youth returning from out-of-state placements and other youth with similar, higher levels of need that otherwise would have been placed out-of-state. Claiming Instructions can be found in BHIN No. 21-038
$18.1M annually	Child Specific Requests for Exceptional Needs: To fund identified exceptional supports needed to support individual children in foster care within California within the least restrictive setting. CBHDA is exploring whether county behavioral health can access these funds directly or if these funds must be secured through Child Welfare. Of the annual allocation for counties for this purpose, approximately 5% is available for immediate use by the counties. Counties may use these funds flexibly to support children with high acuity needs such as those children who are in need of intensive specialty mental health services, for services that are not billable to Medi-Cal, and for youth with co-occurring treatment needs.

$43.2M	<u>County Capacity Building</u>: To support counties and ensure the provision of a high-quality continuum of care that is designed to support foster children in the least restrictive setting, consistent with a child's permanency plan. Funding requests must include completion of a self-assessment of the county's or tribe's capacity to provide placement options to children with complex needs at every level of placement setting, including emergency homes, relative caregivers and foster family homes, and the capacity to meet the needs of children with complex needs across the continuum of placement options through services and supports. A self-assessment for a high-quality continuum of care will include consideration of the services and supports needed to identify home based caregivers for every child, including children with complex or specialized needs, and to meet the needs of children with highly complex needs or specialized needs in those family settings. Funds may be used to lift up the following models or other interventions: • Specialized models of professional foster care, including therapeutic foster care, intensive services foster care, or other models, in collaboration with counties, including CBHDA. • Specialized models of integrated care and support for family-based settings, including high-fidelity wraparound, and community-based treatment models that create alternatives to out-of-home or residential placement. • Highly individualized STRTPs designed to serve children with complex needs who otherwise may have been placed in an OOS residential facility. • A Children's Crisis Continuum Pilot Program • Highly specialized STRTPs designed to serve children with cooccurring intellectual or developmental disabilities and behavioral health needs. In addition to completion of the self-assessment, funding requests must include a county or tribe spending plan that identifies the specific investments that will address the capacity gaps identified by the county or tribe and how the funding will assure the establishment of a high-quality continuum of care that is designed to support foster children in the least restrictive setting, consistent with the child's permanency plan.
~$60M	<u>Children's Crisis Continuum Pilot Program</u>: CDSS and DHCS with input from relevant stakeholders will establish the Children's Crisis Continuum Pilot Program, including guidelines for foster youth eligibility and the selection, operation, and evaluation of the pilots, for the purpose of developing treatment options that are needed to support California's commitment to keep youth in families and to eliminate the placement of foster youth with complex needs in OOS facilities whenever possible. The pilot program shall be implemented for 5 years from the date of the appropriation.
No Allocation	<u>Prohibit Placement of Foster Youth, Nonminor Dependents and Wards of the Court in Out-Of-State Facilities</u>: On July 1, 2021, foster care placements by county child welfare agencies or probation departments into out-of-state (OOS) residential facilities shall not be made, except in the limited circumstances. On July 1, 2022, new placements shall not be made in OOS residential facilities. The state shall decertify all OOS residential facilities on January 1, 2023, and ensure that all children and youth placed in OOS facilities have been returned to California by that date.
$7.5M	<u>STRTPs Determined to be IMDs</u>: For DHCS to support short-term residential therapeutic programs (STRTPs) with more than 16 beds that become ineligible for federal funding due to the federal exclusion on funding for Institutes for Mental Disease (IMDs). These funds will be given to county behavioral health agencies in a grant though the BH-QIP to reimburse for the lost federal financial participation for SMHS provided in STRTPs determined to be IMDs as they transition to non IMD entities.

$10.4M	STRTPs Determined to be IMDs: For DSS to assist Short-Term Residential Treatment Program providers that will be determined to be IMDs so they can reduce capacity or transition to a facility that can continue receiving Medicaid funding.
Department of State Hospitals and Individuals Incompetent to Stand Trial (IST)	
$75M	IST Solutions Workgroup: In the May Revision, the Administration proposed to eliminate LPS contracts with counties over a three-year timeframe, transitioning back 778 high-risk, high-needs conservatees, in order to focus more on the IST population to satisfy the requirements of the *Stiavetti v. Clendenin* case. The case requires State Department of State Hospitals (DSH) to admit individuals into the state hospitals or "substantive treatment" within 28 days of receipt of the commitment packet from the court. As a result of pushback from CBHDA and CSAC on prior proposals to address the waitlist by transitioning the responsibility to counties, the final budget includes a workgroup that will convene between August 2021 and November 2021 to find solutions to the IST crisis. • California Health and Human Services Agency (CHHS) along with the DSH will convene an IST Solutions Workgroup to identify short, medium, and long-term solutions to advance alternatives to placement at the State Department of State Hospitals (DSH) due November 2021. • If insufficient progress is made on the identified solutions, until December 31, 2024, the Secretary of CHHS has the authority to discontinue admissions for LPS conservatees to the state hospital and authority to impose patient reduction targets over the subsequent three years. Reduction targets shall only be to the minimum level needed to achieve timely access to treatment for IST commitments and cannot be reduced lower than 6 months for the first reduction target to be achieved. There is $75 million available for immediate deployment of what the IST Solutions Workgroup recommends and is adopted by the Administration.
$12.7M FY 21-22 $9.2M FY 22-23 Ongoing	IST Reevaluations: DSH will have the authority and sole discretion to consider and conduct reevaluations for IST defendants committed to and awaiting admission to the DSH for 60 days or more. Reevaluations provided by the department clinician or contracted clinician will include (1) Assessments to determine whether the IST defendant should be referred to the county for further evaluation for potential participation in the county diversion program, if one exists; (2) Evaluations on whether the IST defendant is substantially unlikely to be restored to competence in the foreseeable future or has regained competence.
No Allocation	Unrestored ISTs: In the last few years, DSH has experienced county sheriffs not picking up their unrestored ISTs quickly upon an unrestorable determination. Additionally, some counties have kept unrestored ISTs at the state hospital while going through the court process for a LPS conservatorship. When an individual is conserved, the "least restrictive" placement is often determined to be a state hospital. DSH through this trailer bill is discouraging this practice because it has impacted their overall capacity to restore ISTs. Existing law requires ISTs who are found substantially unlikely to regain competence to be referred back to the county of commitment and the individual is returned to the court within 10 days of receipt of the report. For defendants that are determined to have no substantial likelihood that they will regain mental competence in the foreseeable future, as specified, custody will transfer from DSH to the committing county. If a county sheriff does not take custody of a defendant committed to the DSH within 10 calendar days after being notified, the county will be charged the daily rate for a state hospital bed, as established by the DSH.

$267M	Increased Sub-Acute Bed Capacity: DSH was allocated $267 million, of which $250 million can be utilized to establish sub-acute capacity for IST, NGI, OMD, or LPS patients who can be served at lower-level capacity within IMDs, MHRCs, Skilled Nursing Facilities, or other treatment options. Financing will be available for providers to be able to expand or renovate existing facilities to serve DSH populations.
$47.5M	Diversion Program: To expand the pre-trial Mental Health Diversion Program to 33 additional counties and to expand capacity within existing counties to divert ISTs out of the criminal justice system and into treatment. For counties willing to expand their existing contracts there are several changes below. Beginning July 1, 2021, DSH may amend contracts with a county to fund the expansion of an existing DSH-funded pretrial diversion for the population that meets both of the following criteria: (A) All participants identified for potential diversion are found incompetent to stand trial on a felony charge. (B) Participants diverted through a program expansion suffer from a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, excluding antisocial personality disorder, borderline personality disorder, and pedophilia. Counties expanding their programs under this section will not be required to meet any additional match funding requirements.
$32.8M	Community Based Restoration Expansion: DSH was allocated funding in order to expand the LA CBR model within LA County and to new counties. DSH plans to expand 300 beds to the LA CBR program and add 252 new beds in 17 additional counties over the next three years.
$13.1M	JBCT New Programs: DSH was allocated $13.1 million to build out the continuum of care to support ISTs in developing new Jail-Based Competency Treatment beds. This funding will allow DSH to add 123 JBCT beds in 11 new counties.
Other FY 2021-22 Allocations	
$67M FY 21-22 growing to $1.5B FY 24-25.	Expand Medi-Cal to Undocumented Older Adults: To expand Medi-Cal to undocumented adults aged 50 and older, effective no sooner than May 1, 2022.
$16.3M FY 21-22 growing to $201M by FY 26-27	Community Health Worker (CHW) Medi-Cal Benefit: To allow community health workers to provide preventive benefits and services to Medi-Cal beneficiaries, effective January 1, 2022.
$16.7M	Afghan Assistance: For DSS to provide assistance to Afghan citizens evacuated from Afghanistan.
$6.9M	COVID Response Activities for SUD Facilities: For DHCS to support testing and other COVID-19 response activities for substance use disorders services providers and organizations, pursuant to a federal grant awarded to the state by the Substance Abuse and Mental Health Services Administration (SAMHSA).
$1.6M	Crisis BH Services: For DHCS to support behavioral health services for individuals impacted by the state's wildfires and the COVID-19 pandemic, pursuant to federal grants awarded to the state by (SAMHSA).
$67M	Community Services Infrastructure Grant Program: For CHFFA to support the Community Services Infrastructure Grant Program, which creates and expands community alternatives to incarceration in the form of mental health treatment, substance use disorder treatment, and trauma-centered services. This is an existing grant program and this is a reappropriation that allows counties additional time to expend the funding provided through CHFFA.

$90.5M FY 21-11 $362.2M FY 22-23 growing to $400M until 4/1/27	Five-Year Medi-Cal Eligibility Extension for Postpartum Individuals: The American Rescue Plan Act of 2021 allows states to receive a federal funding match if they extend Medi-Cal eligibility from 60 days to 12 months for postpartum individuals, effective April 1, 2022 for up to five years.
Budget Trailer Bill Language	Telehealth: Extend the approved waiver or flexibility that are related to the delivery and reimbursement of services via telehealth modalities in the Medi-Cal program through December 31, 2022. DHCS will convene an advisory group to provide recommendations to inform DHCS in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program. The advisory group will analyze the impact of telehealth in increased access for patients, changes in health quality outcomes and utilization, best practices for the appropriate mix of in-person visits and telehealth, and the benefits or liabilities of any practice or care model changes that have resulted from telephonic visits. The advisory group will include representatives of the California Medical Association, the California Primary Care Association, the California Association of Public Hospitals, the County Behavioral Health Directors Association, Medi-Cal managed care plans, Planned Parenthood Affiliates of California, Essential Access Health, and other subject matter experts or other affected stakeholders as identified by the department.
Budget Trailer Bill Language	Statewide Health and Human Services Data Exchange Framework: Developing a single data sharing agreement and common set of policies and procedures that will govern the exchange of health information among health care entities and government agencies beginning in June 2024