Pre 1957 – 1966: Foundations of Current Mental Health Systems

- The State had sole responsibility for care for people with mental illness and developmental disabilities within State Hospitals.

- Department of Mental Hygiene, later the Department of Mental Health, established in 1943.

- Short-Doyle Act enacted in 1957, with 50% State match for county mental health programs, increased to 75% in 1962.

- Federal Community Mental Health Act of 1963 offered grants for creation of community-based mental health centers.

- 1965-6 enactment of Medicaid, known as Medi-Cal in California.
1968: Lanterman-Petris-Short Act (LPS)

- LPS Act made major changes to the legal process for involuntary treatment for mental health conditions, requiring a judicial hearing procedure, and establishing criteria and timelines for involuntary holds and conservatorship

- State share of funding for county Short-Doyle programs increased to 90%

- LPS Act remains current law governing involuntary treatment and conservatorships for mental health conditions

- State hospitals began to close in 1969 subsequent to LPS enactment
1970s: Knox-Keene Act

- 1975: Knox-Keene Act passed to regulate health plans, promote the delivery and quality of health care, protect consumers, and support a stable health insurance market and cost-effective delivery system

The Department of Alcohol and Drug Programs

- 1978: Department of Drug and Alcohol Programs established to coordinate State’s prevention, treatment, and recovery services
1980s: Development of Systems of Care for Youth

- 1984: Transfer of mental health services for special education from schools to counties
- 1987: Creation of the Children’s System of Care, which expanded to 42 counties to serve children with a serious emotional disturbance
1991: Realignment

- In an economic downturn, mental health programs faced reductions
- 1991 Realignment shifted funding from the State General Fund to a new Local Revenue Fund
- Financing from a new ½ cent sales tax and a change in the Vehicle License Fee depreciation schedule
- Funding was for community mental health, State Hospital services for county clients, and funding for Institutions for Mental Disease (IMDs)
- General Fund retained appropriations for Children’s System of Care
1995-6: Specialty Mental Health Managed Care

- State Implemented Medi-Cal Mental Health Managed Care

- Mental health services to be administered as a carve-out from broader Medi-Cal managed care delivered by health plans

- State received a federal Medicaid waiver to establish managed care plans with county delivery systems as the sole providers of specialty mental health services
1996-9: Mental Health Parity

- 1996: Federal Mental Health Parity Act establishes parity in lifetime and annual dollar limits for large group health plans offering mental health benefits

- 1999: AB 88 establishes within the Knox-Keene Act parity in benefit limits and cost sharing in coverage for 9 mental illnesses
2000: 
Department of Managed Health Care

• Department of Managed Health Care established to enforce Knox-Keene Act

2002: 
Laura’s Law

• 2002: Laura’s Law established new court-ordered outpatient treatment option for people with mental illness who do not meet criteria for involuntary inpatient treatment

• Eligibility included history of mental illness, county option to implement
2004: Mental Health Services Act (MHSA or Prop 63)

• 2004: California voters pass Proposition 63

• Established a 1% tax on income above $1 million to broadly support counties’ community mental health programs

• 80% for community treatment and 20% for prevention and early intervention

• Funding also used for Innovation, Capital Facilities and Technology Needs, and Workforce Education and Training

• Full Service Partnerships model adopts a “whatever it takes” approach to treatment
2000s: Federal Expansion of Coverage and Consumer Protections

- 2008: Mental Health Parity and Addiction Equity Act (MHPAEA)

- MHPAEA expands parity to include SUD services and established new protections for treatment limitations and financial requirements for large group plans that offer behavioral health benefits

- 2010: Affordable Care Act (ACA) expands Medicaid and establishes new health insurance exchanges with subsidies for households with lower and middle incomes

- ACA establishes new federal health insurance rules, Essential Health Benefits package includes mental health and SUD services, and applies to individual and small group plans, and Medicaid benefits
2011: Realignment

- 2011 Realignment: Funding for mental health services in 1991 Realignment transferred to 2011 Realignment with constitutional protections under Prop 30, and mental health EPSDT funding

- Drug Medi-Cal and all SUD services realigned from General Fund to counties within Behavioral Health Subaccount

- Public Safety Realignment (AB 109) transfers responsibility for supervision of non-violent, non-serious, non-sexual offenders to counties with sales tax and VLF revenue

- AB 109 provides flexibility for counties to use funding for mental health and SUD services for people newly within counties’ supervision
2010s: State Administrative Integration and Behavioral Health Treatment Expansion

• 2010: AB 108 returns responsibility of education-related mental health services to schools from counties

• 2012: Department of Mental Health and Department of Alcohol and Drug Programs transfer to Department of Health Care Services, State Hospitals become a separate department

• 2014: Medi-Cal expansion launches

• 2014: Medi-Cal managed care plans launch new coverage of mental health services for people with needs that fall below threshold of specialty mental health services
2010s: Focus on Housing and SUD Treatment Expansion

• 2015: Federal approval of the Drug Medi-Cal Organized Delivery System (DMC-ODS), 1115 Medicaid waiver amendment to expand and improve SUD treatment

• 2016: No Place Like Home; voters approve bond program for permanent supportive housing for people with mental illness, funded with MHSA revenue

• 2017: First group of counties launch DMC-ODS, implementation is ongoing (up to 27 counties in 2019, 40 intend to opt in)
2019: CalAIM

• Administrative integration of county specialty mental health and SUD services and regional contracting

• Payment reform: reduce paperwork burden and move toward value-based payment

• Medical necessity revisions to focus more on acuity rather than diagnosis

• SUD Managed Care

• Enhanced Care Management coordinates services across full Medi-Cal benefit

• “In Lieu Of Services” offer supports not traditionally reimbursable through Medi-Cal to prevent avoidable hospitalization, institutional care
A Summary: Public Funding for Community Behavioral Health Services

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Realignment Revenue</td>
<td>$3.1 billion</td>
</tr>
<tr>
<td>MHSA/Prop 63:</td>
<td>$2.1 billion</td>
</tr>
<tr>
<td>State General Fund: (Medi-Cal Managed Care, DMC-ODS)</td>
<td>$0.8 billion</td>
</tr>
<tr>
<td>Federal Matching Funds:</td>
<td>$5.0 billion</td>
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<tr>
<td>Federal SAPT Block Grant</td>
<td>$0.23 billion</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$11.23 billion</strong></td>
</tr>
</tbody>
</table>

Other funding sources include:

- State and local criminal justice funding
- State and local education funding

Note: 2017-18 LAO and 2019 CHCF Estimates. Includes SUD services. Does not include counties general funding spending, community clinic services, or Medi-Cal FFS spending due to data limitations.