A Blueprint for California's Behavioral Health Future – Strategic Actions for the Governor's Final Year

November 2025

California is in the midst of the most consequential transformation of its behavioral health system in state history. Under Governor Newsom's leadership, California has launched and advanced a sweeping set of reforms — from modernizing the continuum of care through Proposition 1, to expanding crisis response, to reshaping how care is financed and delivered through CalAIM. These reforms have come with an astounding $14+ billion in behavioral health investments. The scope of this work is unparalleled nationwide. These reforms represent not only a generational investment, but a fundamental rethinking of how the state supports people living with mental illness and substance use disorders.

As these initiatives have taken root, the Steinberg Institute has closely followed their implementation and the remarkable progress already underway. At the same time, we have identified areas where additional focus, alignment, or reinforcement in the Governor's final year would ensure that these historic changes are fully realized and sustained long after this Administration concludes. Many of the gaps that remain are not policy failures — they are simply the natural challenges of executing such an ambitious, multi-year restructuring of systems that have long been fragmented or under-resourced.

This Blueprint offers a focused set of administrative, budgetary, and legislative recommendations designed to build on the Governor's extraordinary legacy. The proposals do not introduce new paradigms; rather, they strengthen, clarify, and complete the transformational work already set in motion. Taken together, they represent strategic actions that can secure the durability of these reforms, maximize their impact, and leave California with a modern, cohesive, and person-centered behavioral health system capable of serving communities for decades.

Policy Area 1: Ensuring Sustainable Funding for Prevention and Early Intervention

The changes championed under the Behavioral Health Services Act (BHSA) were critical to ensure the original intent of the Mental Health Services Act and the obligation of county specialty mental health – to serve the sickest of the sick who are experiencing system involvement in addition to a serious mental illness and/or substance use disorder – is carried out. While opposition to the BHSA have misrepresented that the changes would defund our prevention and early intervention services, the administration has rightfully shifted these

services into school settings and shifted the financial responsibilities to the health plans where they belong. Our policy changes outside of the BHSA should support a holistic funding landscape that can pay for the full continuum of services needed.

Policy Recommendation 1A: Mandate Participation in the Children and Youth Behavioral Health Initiative (CYBHI) Master Fee Schedule

The CYBHI Master Fee Schedule has transformed where and how we pay for behavioral health services for our young people. The CYBHI Master Fee Schedule, as a result, plays an important role in the funding landscape to offset changes in the BHSA. However, adoption of and participation in the Master Fee Schedule is optional. To ensure robust statewide coverage of prevention and early intervention services for our young people, all local education agencies and institutions of higher education should be required to participate in the CYBHI Master Fee Schedule. It is the health plans responsibility to cover mild to moderate services, while county specialty mental health's mission is to support those with serious mental illness and substance use disorders.

Additionally, please see our Policy Area 2 recommendations for Parity enforcement, which will similarly help ensure prevention and early intervention services are covered by commercial insurance, freeing up county staff and financial resources to focus on the priority populations and services under the BHSA and their obligations as specialty mental health plans.

Policy Area 2: Fully Realizing the Promise of Parity for Behavioral Health Care

In 2020, Governor Newsom signed into law the most comprehensive behavioral health parity law in the nation, SB 855 (Wiener), which requires California health plans to cover all medically necessary behavioral health care. Enforcing SB 855 can, much like mandating the adoption of the Master Fee Schedule, eases the financial burden on counties and ensures that prevention services are still robustly covered amidst the funding changes under the Behavioral Health Services Act.

Policy Recommendation 2A: Investigate Individual Level Compliance

We recommend that the DMHC track Help Center complaints to identify trends in parity violations and elevate complaints for investigation. When trends in parity violations are identified, the DMHC should increase fines and utilize corrective action plans. Additionally, consumers should be offered recourse when the DMHC has overturned an appeal through the Independent Meical Review (IMR) process.

Policy Recommendation 2B: Increase Transparency, Data Collection, and Public Oversight

Specific enforcement timelines and public reporting structures should be implemented to ease DMHC's administrative burden, provide needed clarity to plans, and better support consumers. We do not recommend *more* procedures but rather more transparent, measurable processes that align with existing law. Specifically, we recommend:

- The DMHC utilize federal parity reporting templates available for oversight. The DMHC can utilize these recommended templates and worksheets. States that have done so have found widespread noncompliance.
- The DMHC establish internal process standards including agency-wide enforcement priorities as well as expectations and timelines for plans in routine reporting, special investigations, and corrective action plans.
- The DMHC prioritize the collection of outcomes and report outcomes publicly on its website. We would recommend the collection and reporting of the following outcomes:
    - The number and percentage of claims denials, disaggregated by category or service type (for example, mental health separated from substance use disorder care)
    - In-network and out-of-network utilization rates (including data related to provider claim submissions)
    - Network adequacy metrics (including time and distance data and data on providers accepting new patients)
    - Provider reimbursement rates (for comparable services and as benchmarked to a reference standard)
    - Other relevant outcomes data as specified under federal comparative analyses on nonquantitative treatment limitations (45 C.F.R. § 146.137)

Policy Recommendation 2C: Automate Enforcement Actions

The scale of parity violations is so widespread that commercial health plans benefit from and bank on the DMHC being unable to keep up and adequately enforce parity violations. This could be addressed by automating some enforcement actions. We would recommend mandating automatic fines for systemic violations, for example exceeding a defined threshold of IMR overturns.

Policy Recommendation 2D: Strengthen Provider Reimbursement Incentives

DMHC should be required to address payment disparities that drive provider shortages and network adequacy issues.

Policy Area 3: Building Out a Robust Crisis Care Continuum

In 2022, the Governor signed AB 988 (Bauer-Kahan) into law establishing the 988-crisis line and response system implementation issue. Our crisis system has been bolstered by the creation of a statewide mobile crisis team benefit, investments in mobile crisis teams and crisis facilities via the Behavioral Health Continuum Infrastructure Program (BHCIP), and authorizing statute that ensures commercial coverage for crisis services. Even still, California's crisis response system is struggling. Without bold leadership to shape the system as it is built, it will crumble resulting in a return to the status quo of the criminalization of mental illness.

Policy Recommendation 3A: Establish a 988 Governance Structure that Facilitates Fast and Fair Collaboration Between State Entities

Authority over California's 988 system is split between the Health and Human Services Agency and the Office of Emergency Services. Each has critical expertise and must be part of the solution in building out a high-functioning 988 system. But in the years following the passage of AB 988, it has become clear that there are not enough structures in place to facilitate productive collaboration between the two entities. A governance structure must be put in place that leverages each entity's strengths without slowing down decision making or preferencing one entity over the other.

Policy Recommendation 3B: Establish a Process for Annual Budgeting to Draw Down on the 988 Surcharge for Authorized Expenses

A mechanism needs to be developed for 988 call centers and mobile crisis team operators to submit their budgets and have them approved via an administrative process. The current process in unclear and opaque for non-governmental entities and local governments. Additionally, there have been concerning reports that the budgeting process has become political rather than administrative. The result of both dynamics is that our crisis service providers are underfunded, and our crisis system's growth has been stunted despite a dedicated funding source

Policy Recommendation 3C: Fully and Sustainably Fund Mobile Crisis Teams

Under the Governor's leadership, California established statewide 24/7 mobile crisis teams. These teams were stood up with support from a three-year enhanced Federal Medical Assistance Percentage (FMAP) of 85%. That enhanced FMAP is set to expire in Spring 2027. The enhanced FMAP is unlikely to be renewed. Counties are already struggling to cover the cost of mobile crisis teams even with enhanced federal support. Should the FMAP drop to the standard 50%, California must backfill those dollars to preserve the statewide benefit. Failure to do so will stunt the growth of our fledgling crisis response system. After fully

funding 988 call centers, 988 surcharge revenue should be prioritized for stabilizing mobile crisis teams during this transition.

Policy Recommendation 3D: Clarify 911 Operating Guidance

Local jurisdictions have begun to transform our behavioral health crisis response system by adding one simple question to their 911 script, "Is your emergency police, fire, EMS, or **behavioral health**?" When this question is asked 911 operators are empowered to connect people in crisis with more appropriate systems, such as 988, reducing reliance on our first responders. The state should mandate the incorporation of this question into our 911 system statewide to connect people to the most appropriate care while relieving pressure on our law enforcement, fire, and EMS providers.

Policy Recommendation 3E: Expand the Role of EMS in Behavioral Health Crisis Response

California has made great strides to build a compassionate in-person crisis response system. But a fledgling mobile crisis network and recent decisions by law enforcement to disengage from behavioral health calls have left a gap. The state should support our EMS providers to be properly funded, trained, and resourced to be part of the solution, because a health crisis always deserves a health response. Specifically, we'd recommend:

- Adopting a policy of first response where fire or EMS are the default responders to behavioral health crisis calls and are accompanied by law enforcement as necessary. This policy would apply when an in-person response is necessary, but mobile crisis teams are unavailable and there is no crime in process.
- Supporting local governments in opting into California's Triage to Alternate Destination (TAD) program by easing expensive, time consuming, and excessive statutory and regulatory requirements that prevent Local Emergency Medical Services Agencies (LEMSAs) from doing so. For example, the state could create a statewide training curriculum for paramedics participating in the TAD program rather than requiring each LEMSA to create their own curriculum – an expensive and time-consuming endeavor for a local government.
- Funding the Medi-Cal benefit for community paramedicine and TAD programs established by SB 1180 (Ashby, 2024).
- Authorize emergency medical technicians and paramedics to be statewide Lanterman Petris Short-designated professionals to reduce our reliance on law enforcement for behavioral health crisis response.

Policy Area 4: Ensure Federal Waivers Are Successful

Policy Recommendation 4A: Extend Technical Assistance for CalAIM

CalAIM is one of the most critical reforms currently being implemented in California. Its transformational nature makes it particularly complicated for implementors to rollout. Initial technical assistance and funding support through Providing Access and Transforming Health (PATH) was critical, but insufficient to support the work. County behavioral health, providers, justice partners, and managed care plans among others need additional hands-on guidance from the state and additional PATH funds to ensure success. Failure to continue this programmatic and financial support risks the failure of key components of CalAIM.

Policy Recommendation 4B: Expand CalAIM to Double Down on Success

CalAIM's transformational vision for the Medi-Cal program is spectacular. Even so, there remains room for improvement. To the extent California is able to partner with Centers for Medicare and Medicaid Services to renew and expand CalAIM, we recommend the following policy enhancements:

- **Expand access to all community supports statewide.** DHCS should require all counties to offer the full suite of 14 Community Supports. Consistent access across counties is critical to equity and to ensuring that Medi-Cal members do not face geographic disparities in access to lifesaving supports. Recognizing the capacity limitations of small counties (under 200,000 residents in alignment with carveouts in Proposition 1), we support a modified requirement that at minimum includes: Transitional Rent, Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Short-Term Post-Hospitalization Housing, and Day Habilitation Programs. These services are core to Behavioral Health Transformation and the implementation of Proposition 1's vision of housing that heals.
- **Make contingency management a statewide benefit.** Contingency Management is a proven, cost-effective intervention for stimulant use disorders, already showing success in participating counties. Limiting it to only some geographies creates inequities in access to evidence-based treatment. DHCS should mandate availability statewide to ensure all Medi-Cal members can benefit.
- **Expand the Use of Standard Templates to Ease Cross-System Collaboration.** The MOU templates provided for managed care plans have been invaluable in standardizing relationships with counties and community partners. DHCS should build on this model by developing additional templates for partnerships with homelessness response systems, criminal justice agencies, and social service providers to streamline coordination statewide and ensure that templates (beyond MOUs) are a staple implementation tool provided to counties and partners.
- **Improve Data Sharing Across Homelessness and Criminal Justice Systems.** Breaking the cycle of homelessness, incarceration, and hospitalization requires that systems communicate effectively. We encourage DHCS to require Medi-Cal plans and counties to share data with local homelessness systems (e.g., Homeless Coordinated Community Plans, Continuums of Care) and criminal justice partners.

- **Raise Reimbursement Rates and Continue the Conversation on Payment Reform.** Medi-Cal reimbursement rates remain too low to support a stable behavioral health workforce and robust provider networks. DHCS should prioritize targeted rate increases while continuing the broader conversation around payment reform to ensure sustainability for providers.
- **Strengthen Accountability and Public Transparency.** We urge DHCS to ensure that data on access, outcomes, finances, and equity is made publicly available in a clear and accessible manner to members of the public in addition to DHCS staff. Transparent reporting will build trust with members, advocates, policymakers, and the public and ensure that program investments are driving measurable improvements.

Policy Recommendation 4C: Adopt a Standardized Level of Care Tool

The changes under way with CalAIM and BH-CONNECT coupled with the BHSA create an exciting, but complex new universe of services and populations of focus. To ensure equal access to care across the state, California should mandate the use of standardized level of care tool, for example the Level of Care Utilization System (LOCUS), to ensure eligible individuals receive the appropriate care.

Policy Area 5: Monitoring Our Infrastructure Investments

Policy Proposal 5A: Establish a Comprehensive and Public Facing BHCIP Tracking System

California has made historic investments through the Behavioral Health Continuum Infrastructure Program (BHCIP), yet the state lacks a comprehensive, centralized understanding of what services have been created, expanded, or strengthened as a result.

To ensure these investments fulfill their intended purpose — building a robust, equitable continuum of care — we propose establishing a public-facing statewide tracking and reporting framework for all BHCIP-funded projects. This effort would identify what infrastructure and service capacity now exists, highlight geographic or population-specific gaps that persist, and inform future budget and policy decisions. By systematically cataloging outcomes and ongoing needs, the state can maximize the impact of prior investments, avoid duplication, and target remaining resources where they will do the most good.

Policy Area 6: Building a Workforce to Support Behavioral Health Transformation

California's behavioral health reforms currently underway have the potential to fundamentally change the way people receive mental health and substance use disorder care in our state – setting a national model for innovative care. However, Behavioral Health Transformation will only be as successful as our workforce allows.

The Steinberg Institute estimates that California will need to add roughly 375,000 behavioral health workers by 2030 to meet the demand for care. This would effectively require doubling positions across the entire continuum of care. Behavioral Health Transformation success depends on a workforce ready, willing, and able to usher in the change. We do not currently have the workforce in place to guarantee success.

Policy Recommendation 6A: Develop a Stronger Peer Network

In 2020, Governor Newsom signed SB 803 (Beall) into law establishing Certified Medi-Cal Peer Support Specialists in California. While the ability to bill Medi-Cal for peer services is a huge advancement, SB 803 faces serious limitations that have prevented full access to peer services to all who would benefit. We recommend the following changes to expand access to these life-saving services:

- California should establish a statewide benefit, rather than an optional benefit, for Medi-Cal Peer Support Specialists.
- California should eliminate the requirement that Peer Support Specialists have a high school diploma as it unnecessarily excludes peers with valuable experience from offering critical services.
- California should expand authorized employers of Peer Support Specialists beyond County Specialty Mental Health. All entities with the ability to bill Medi-Cal – jails, prisons, hospitals, shelters, permanent supportive housing sites – should be able to employ and bill for Medi-Cal Peer Support Specialists directly. Failure to do so prevents access to peers for many individuals who would benefit from their services.
- California should adopt a "No Good Cause" policy for Peer Support Specialist hiring. Peers are hired because of their lived experience. Allowing background checks for peers without limitations on how that information can be used undermines the unique value of the peer workforce and deprives individuals with serious mental illness and/or substance use disorders engaged in the criminal legal system from benefitting peers who share their lived experience.

Policy Recommendation 6B: Restore Workforce Funding Cuts

In 2022, Governor Newsom championed a historic $1.7 billion investment in health workforce development, of which approximately half was set aside for developing the behavioral health workforce. In the face of a looming multi-year budget deficit, the vast majority of these workforce dollars were subsequently eliminated. While this was a reasonable choice to protect core services, the reality is that without workforce development programs we will not have the capacity to implement the full array of programs and policy changes included in the state's Behavioral Health Transformation. We recommend, at minimum, restoring the eliminated dollars, but would strongly encourage the state to invest in permanent recruitment and retention programs across the spectrum of behavioral health workers. Failure to do so will result in the failure of Behavioral Health Transformation.

Policy Recommendation 6C: Backfill Lost Federal Workforce Dollars

With the federal government phasing out Designated State Health Program (DSHP) matching funds, which is used to fund the workforce investments through BH-CONNECT, the state must backfill these dollars.