

CALIFORNIA STATE ASSOCIATION OF COUNTIES
SPECIAL EXECUTIVE COMMITTEE MEETING
November 14, 2023 | 5pm – 5:30pm
Oakland Convention Center | Oakland Room

AGENDA

Presiding: Chuck Washington, President

TUESDAY, NOVEMBER 14

5:00 PM

PROCEDURAL ITEM

1. Roll Call

ACTION ITEM

2. Approval of 2023-24 Board of Directors Nominations
 - *Graham Knaus, CEO*

INFORMATIONAL ITEM

3. Proposition 1: MHSA
 - *Graham Knaus, CEO*
 - *Jacqueline Wong-Hernandez, Chief Policy Officer*
 - *Jolie Onodera, Senior Legislative Advocate*

DISCUSSION ITEM

4. Open Issues

5:30 PM

ADJOURN



OFFICERS

President

Chuck Washington
Riverside County

1st Vice President

Bruce Gibson
San Luis Obispo County

2nd Vice President

Jeff Griffiths
Inyo County

Past President

Ed Valenzuela
Siskiyou County



CEO

Graham Knaus

November 14, 2023

TO: CSAC Executive Committee

FROM: Graham Knaus, Chief Executive Officer
Jacqueline Wong-Hernandez, Chief Policy Officer
Chastity Benson, Chief Operating Officer

SUBJECT: Approval of Nominations for the CSAC 2023 – 2024 Board of Directors

Background: The CSAC Constitution indicates that each county board shall nominate one or more directors to serve on the CSAC Board of Directors for a one-year term commencing with the Annual Meeting. The CSAC Executive Committee appoints one director for each member county from the nominations received.

For counties that do not submit nominations, the appointed supervisor from the preceding year will continue to serve until such county board nominates, and the Executive Committee appoints, a supervisor to serve on the CSAC Board.

The highlighted names denote responses received for 2023-2024.

2023 - 2024 CSAC BOARD OF DIRECTORS + ALTERNATES				
COUNTY	CAUCUS	DIRECTOR	ALTERNATE(S)	CHANGE FROM 2023
Alameda	U	Keith Carson	David Haubert	NO
Alpine	R	Terry Woodrow	Ron Hames	
Amador	R	Richard Forster	Jeff Brown	NO
Butte	S	Tod Kimmelshue	Tami Ritter	
Calaveras	R	Benjamin Stopper	Amanda Folendorf	NO
Colusa	R	Kent Boes	Daurice Kalfsbeek-Smith	NO
Contra Costa	U	John Gioia	Diane Burgis	NO
Del Norte	R	Chris Howard	Darrin Short	NO
El Dorado	R	John Hidahl	Brooke Laine	NO
Fresno	U	Buddy Mendes	Nathan Magsig	NO
Glenn	R	Grant Carmon	Monica Rossman	
Humboldt	R	Michelle Bushnell	Natalie Arroyo	NO
Imperial	S	Jesus Eduardo Escobar	Luis A. Plancante	
Inyo	R	Trina Orrill	Jeff Griffiths	NO
Kern	S	Leticia Perez	Phillip Peters	NEW BOARD MEMBER
Kings	R	Rusty Robinson	Doug Verboon	NEW BOARD MEMBER and ALT
Lake	R	Bruno Sabatier	Jessica Pyska	NO

Lassen	R	Gary Bridges	Chris Gallagher	NEW BOARD MEMBER and ALT	*
Los Angeles	U	Kathryn Barger	Holly J. Mitchell		
Madera	R	Leticia Gonzalez	Robert Poythress		
Marin	S	Mary Sackett	Eric Lucan	NEW ALTERNATE	
Mariposa	R	Rosemarie Smallcombe	Miles Menetrey	NEW BOARD MEMBER and ALT	*
Mendocino	R	John Haschak	Maureen "Mo" Mulheren		
Merced	S	Scott Silveira	Josh Pedrozo		
Modoc	R	Ned Coe	Elizabeth Cavasso	NO	
Mono	R	John Peters	Jennifer Kreitz	NO	
Monterey	S	Luis Alejo	Wendy Root Askew	NO	
Napa	S	Ryan Gregory	Anne Cottrell		
Nevada	R	Heidi Hall	Hardy Bullock		
Orange	U	Doug Chaffee	Vicente Sarmiento		
Placer	S	Bonnie Gore		NO	
Plumas	R	Tom McGowan	Jeff Engel		
Riverside	U	V. Manuel Perez	Karen Spiegel		
Sacramento	U	Rich Desmond	Sue Frost		
San Benito	R	Bea Gonzales	Angela Curro		
San Bernardino	U	Jesse Armendarez	Curt Hagman		
San Diego	U	Nora Vargas	Joel Anderson	NO	
San Francisco	U	Rafael Mandelman		NO	
San Joaquin	U	Robert Rickman	Tom Patti	NO	
San Luis Obispo	S	Bruce Gibson	Jimmy Paulding		
San Mateo	U	David Canepa	Dave Pine		
Santa Barbara	S	Das Williams	Gregg Hart		
Santa Clara	U	Susan Ellenberg	Otto Lee	NEW ALTERNATE	
Santa Cruz	S	Bruce McPherson	Zach Friend	NO	
Shasta	S	Tim Garman	Kevin Crye		
Sierra	R	Lee Adams	Sharon Dyrden	NO	
Siskiyou	R	Ed Valenzuela	Brandon Criss	NO	
Solano	S	Erin Hannigan	Wanda Williams	NO	
Sonoma	S	James Gore	Susan Gorin		

* Board Member and Alternate switched positions.

Stanislaus	S	Vito Chiesa	Mani Grewal	NO
Sutter	R	Dan Flores	Karm Bains	NEW ALTERNATE
Tehama	R	Candy Carlson	Dennis Garton	NO
Trinity	R	Ric Leutwyler	Heidi Carpenter-Harris	
Tulare	S	Amy Shuklian	Pete Vander Poel	NO
Tuolumne	R	Ryan Campbell	Jaron Brandon	NEW ALTERNATE
Ventura	U	Kelly Long	Jeff Gorell	
Yolo	S	Lucas Frerichs	Oscar Villegas	NO
Yuba	R	Don Blaser	John Messick	NO



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CEO

Graham Knaus

November 14, 2023

To: CSAC Executive Committee

From: Jolie Onodera, Senior Legislative Advocate, Health & Behavioral Health
Danielle Bradley, Legislative Analyst, Health, Human Services & Homelessness

RE: March 2024 Ballot Initiative: Proposition 1 – INFORMATIONAL ITEM

Memo sections:

- [HHS Policy Committee Action](#)
- [Issue Overview](#)
- [Proposition 1 Summary](#)
- [Small County Exemptions and Special Considerations](#)
- [Policy/Fiscal Considerations](#)
- [CSAC Ballot/Initiative Review Process](#)

HHS Policy Committee Action. The HHS Policy Committee voted unanimously on October 30 to take “no position” on Proposition 1. As a result, the recommendation is being forwarded to the Executive Committee and Board of Directors as an informational item.

Issue Overview. On October 12, the Governor signed into law both [Assembly Bill \(AB\) 531](#) (Chapter 789, Statutes of 2023) and [Senate Bill \(SB\) 326](#) (Chapter 790, Statutes of 2023). The following sections of AB 531, the Behavioral Health Infrastructure Bond Act of 2024, and SB 326, the Behavioral Health Services Act, will be submitted together to the voters as a single measure to be placed first on the March 5, 2024, statewide primary election ballot and designated as Proposition 1:

- AB 531 – Section 4
- SB 326 – Sections 1, 2, 14, 15, 18 to 23, 28 to 30, 35 to 40, 42 to 44, 49 to 59, 62 to 64, 73 to 81, 86 to 95, 98 to 100, 103 to 112, 116, and 117

Proposition 1 will appear on the ballot as a legislatively referred state statute consisting of two main components that propose statutory changes to reform the state’s behavioral health system and create more supportive housing and behavioral health treatment resources:

- Authorizes \$6.38 billion in general obligation bonds to finance the conversion, rehabilitation, and construction of supportive housing and behavioral health housing and treatment settings. Of the total, \$1.5 billion is to be awarded through grants exclusively to counties, cities, and tribal entities; and local jurisdictions are not precluded from applying for additional funds.

- Amends the Mental Health Services Act (MHSA) which was approved by the voters as Proposition 63 in 2004 and makes other statutory changes to update the state’s behavioral health system. Among its provisions, Proposition 1 renames the MHSA to the Behavioral Health Services Act (BHSA), broadens the eligible uses of funds to include the provision of substance use disorder treatment services, revises the funding categories to include a prioritization for housing interventions for those with the most severe needs, including the chronically homeless, and establishes additional oversight and accountability measures.

NOTE: Several sections of SB 326 not included in Proposition 1 are contingent on approval by the voters of amendments to the MHSA at the March 2024 statewide primary election, and therefore, will only become operative upon the approval of Proposition 1. Most provisions are technical and conforming in nature. One issue of note is the repeal of the Mental Health Services Fund (MHSF) and establishment of the new Behavioral Health Services Fund (BHSF). Any funds remaining in the MHSF on January 1, 2025, are to be transferred to the BHSF. Amounts owed or encumbered at the time of transfer are to be used in the manner required by MHSA. Any funds not owed or encumbered at the time of transfer are to be used in the same manner as any other funds in the BHSF.

Proposition 1 Summary. The Behavioral Health Infrastructure Bond Act of 2024 – authorizes \$6.38 billion in General Obligation bonds for supportive housing and behavioral health treatment beds:

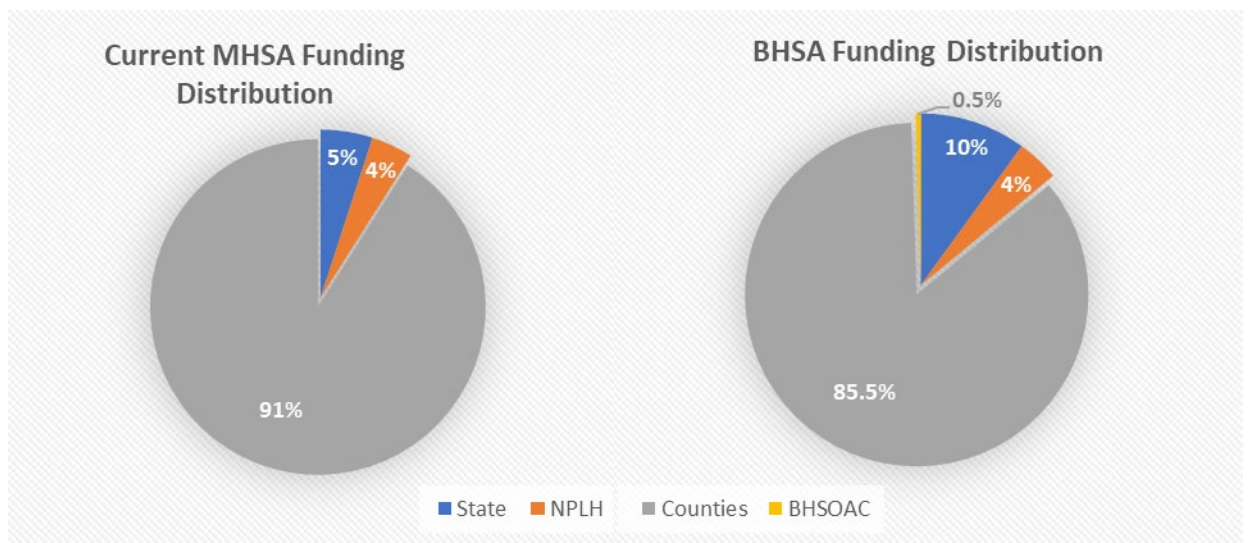
- **\$1.99 billion** in loans/grants for permanent supportive housing for homeless populations:
 - \$1.065 billion for loans or grants for veterans or their households who are homeless, chronically homeless or at risk of homelessness.
 - \$922 million for loans or grants (not specifically for veterans) for people who are homeless, chronically homeless, or at risk of homelessness AND are living with a “behavioral health challenge” (includes, but is not limited to, serious mental illness or substance use disorder (SUD)).
 - Allows for conversion, rehabilitation, or new construction of facilities.
- **\$4.39 billion** as grants for the continuum of behavioral health (BH) treatment resources:
 - **\$1.5 billion to be awarded to cities, counties, and tribal entities** as grants under the Behavioral Health Continuum Infrastructure Program (BHCIP) – specifies \$30 million to be designated to tribal entities.
 - Up to \$2.89 billion for additional grants under BHCIP, without specifying awardees – cities, counties, and tribes are not precluded from applying for these grants.
 - Grants to be administered by the California Department of Health Care Services (DHCS), as specified under BHCIP “to eligible entities to construct, acquire, and rehabilitate real estate assets or to invest in needed infrastructure to expand the continuum of BH treatment resources to build new capacity or expand existing capacity for short-term crisis stabilization, acute and subacute care, crisis residential, community-based mental health residential, SUD residential,

peer respite, community and outpatient BH services, and other clinically enriched longer-term treatment and rehabilitation options for persons with BH disorders in the least restrictive and least costly setting.”

- Specifies DHCS to determine the methodology and distribution of the funds.

The Behavioral Health Services Act – amends the MHSA and makes other statutory changes to update the state’s behavioral health system:

- Recasts/renames the MHSA as the Behavioral Health Services Act (BHSA) and makes numerous amendments to the MHSA (Proposition 63, 2004), which must be placed on the ballot as a voter-approved initiative, and other statutory changes. Changes are effective January 1, 2025, unless otherwise specified.
- Redirects additional BHSA funds to the state and the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) – eff. July 1, 2026:
 - Statewide BH workforce initiative (HCAI): minimum of 3% of BHSA funds
 - Population-based prevention programs (CDPH): minimum of 4% of BHSA funds
 - At least 51% of funding to serve the population 25 years of age or younger.
 - State administration: up to 3% of BHSA funds
 - **Total state-directed funding: up to 10% of annual BHSA revenues** (compared to the current state maximum of 5%)
 - Establishes the BHSA Innovation Partnership Fund, which takes up to a maximum of \$20 million annually (2026-27 to 2030-31) off the top of total BHSA funds towards a grant program to be administered by BHSOAC, with future funding to be determined through the annual budget act.
 - After accounting for funds reserved for No Place Like Home bonds (~4%), **total county allocation estimated to decrease from 91% under MHSA to 85.5% of total BHSA revenues.**

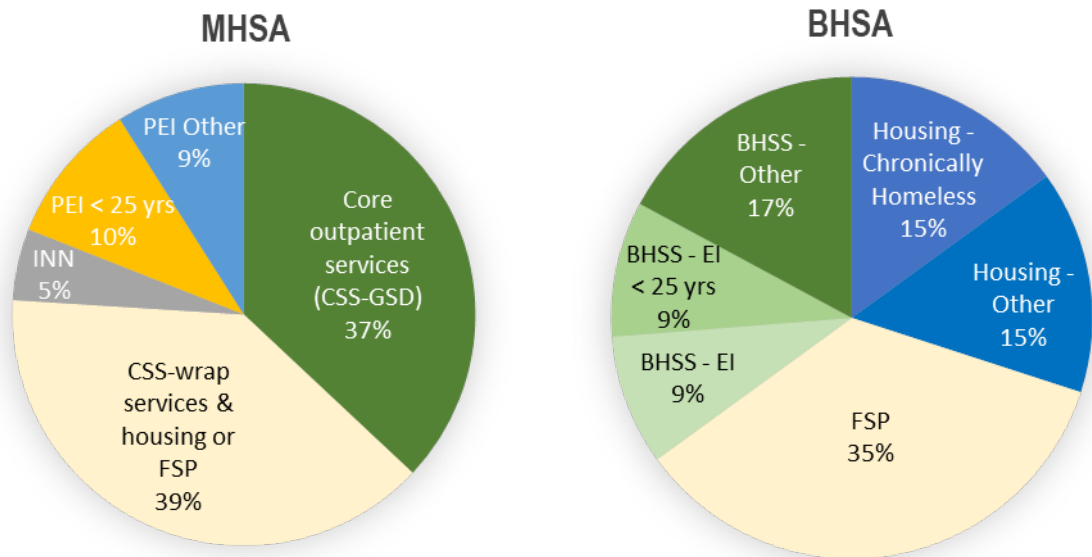


- Revises the distribution of BHSA funding into the following categories (eff. July 1, 2026):

- 30% Housing Interventions
- 35% Full-Service Partnerships (FSP)
- 35% Behavioral Health Services and Supports (BHSS)

Specifies the programs established for all components are to include services to address the needs of eligible children and youth, 0 to 5 years of age, inclusive, transition age youth, and foster youth.

Component Comparison – MHSA vs. BHSA



Housing Interventions (30%)

- A 30% set-aside for housing is estimated at about \$1 billion annually to serve the chronically homeless and those experiencing or at risk of homelessness.
- 50% of the housing component (15% of total BHSA funds) is required to be used for interventions for persons who are chronically homeless, with a focus on those in encampments.
- No more than 25% may be used for capital development projects, and the units funded must be available in a reasonable timeframe and meet a cost-per-unit threshold, as specified by DHCS. Capital projects funded in whole or in part with BHSA funds shall be a use by right and subject to a streamlined, ministerial review process if the project meets specified criteria.
- **Small County Exemption** (population less than 200,000):
 - Starting with FYs 2026-2029 integrated plan and ongoing, DHCS is required to establish criteria and a process for approving county requests for an exemption that considers factors including a county’s homeless population, the number of individuals receiving Medi-Cal specialty BH services or SUD treatment services in another county, and other factors as determined by DHCS.
 - DHCS is required to collaborate with CSAC and the County Behavioral Health Directors Association of California (CBHDA) on “reasonable criteria” for those requests and a timely and efficient exemption process.

- Requests for approval of an exemption shall be responded to, approved, or denied within 30 days of receipt by DHCS, or shall otherwise be deemed approved by DHCS.
- **Additional county exemptions:**
 - Starting with FYs 2032-2035 integrated plan and ongoing, DHCS *may* establish criteria and a process for approving requests for county exemption from the 30% housing requirement, *regardless of county population size*.
 - DHCS is required to collaborate with CSAC and CBHDA on “reasonable criteria” for those requests and a timely and efficient exemption process.
- County programs for housing interventions may include rental subsidies, operating subsidies, shared housing, family housing for eligible children and youth, nonfederal share for transitional rent, other housing supports, as defined by DHCS, including, but not limited to, the community supports policy guide, and capital development projects, including affordable housing, project-based housing assistance, including master leasing of project-based housing.
- Specifies funds for housing interventions shall not be used for mental health and SUD treatment services.
- Specifies housing interventions shall not be limited to those enrolled in Medi-Cal or FSP programs.
- Housing interventions are required to comply with the core components of Housing First, as defined, and may include recovery housing as defined by federal HUD.

Full-Service Partnerships (35%)

- Each county is required to establish and administer a FSP program that includes but is not limited to MH services, supportive services, and SUD treatment services; outpatient BH services; ongoing engagement services; other evidence-based services and treatment models, as specified by DHCS; housing interventions; as well as:
 - Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) fidelity, Individual Placement and Support model of Supported Employment, high fidelity wraparound, or other evidence-based services and treatment models, as specified by DHCS.
 - **Small County Exemption from ACT/FACT:** small counties may request an exemption from the ACT/FACT requirements. Exemption requests are subject to approval by DHCS. DHCS is required to collaborate with CSAC and CBHDA on reasonable criteria for those requests and a timely and efficient exemption process.
 - FSP programs are required to employ community-defined evidence practices (CDEP), as specified by DHCS.
- **County exemption from 35% FSP requirement:**
 - Starting with FYs 2032–2035 integrated plan and ongoing, DHCS *may* establish criteria and a process for approving requests for an exemption that considers factors such as county population, client counts, and other factors as determined by DHCS.

- DHCS is required to collaborate with CSAC and CBHDA on reasonable criteria for those requests and a timely and efficient exemption process.

Behavioral Health Services and Supports (35%) for services for the children’s and adult/older adult’s systems of care, early intervention programs, outreach and engagement, workforce education and training, capital facilities and technological needs, and innovative BH pilots and projects.

- At least 51% of BHSS funding must be for early intervention (EI) programs:
 - At least 51% of EI funding must be used to serve individuals who are 25 years of age and younger.
 - Each county is required to establish/administer an EI program to include specified components, as well as “additional components developed by DHCS.”
 - DHCS “may require a county to implement specific evidence-based and community-defined evidence practices.”
- Also requires a county to comply with other funding allocations specified by DHCS for the other categories (i.e., WET, CF/TN, INN, but are unspecified in statute).
- Substance use disorder provisions:
 - “Notwithstanding any other law,” specifies the programs and services/supports in the Housing, FSP, and BHSS categories **may** include SUD treatment services (no longer requires a co-occurring mental health diagnosis) for children, youth, adults, and older adults. (WIC section 5891.5(a)(1))
 - With regard to serving individuals with SUD in the various programs, WIC section 5891.5(a)(2) states “the provision of housing interventions to individuals with a SUD shall be optional for counties.” There are no similar optional provisions in the FSP and BHSS categories.
 - **Note:** the FSP program statutes (WIC section 5887) specify each county is required to establish and administer a FSP program that includes SUD treatment services.
 - **Note:** the Early Intervention program statutes (WIC section 5840) require EI programs to include specified components, including but not limited to MH and SUD treatment services.
 - In both the child/youth and adult system of care statutes, these sections are updated to add the provision of SUD services.
- Allowable planning expenditures:
 - Annual planning costs are capped at 5% of total annual revenues received for the Local BH Services Fund.
 - May include funding to improve plan operations, quality outcomes, fiscal and programmatic data reporting, and monitoring of subcontractor compliance for all county BH programs, capped at 2% (4% for small counties) of total annual revenues received for the Local BH Services Fund. Counties may commence use of funding for these purposes on July 1, 2025.
- Ability to transfer funds between program categories, subject to DHCS approval:

- Authorizes counties to transfer up to 14% of total funds (up to 7% per program category) allocated to counties per year, ongoing.
 - County requests for changes to the allocation percentages are subject to DHCS approval.
 - Requires DHCS to collaborate with CSAC and CBHDA on “reasonable criteria” for requests and a timely/efficient approval process. Specifies an application is deemed approved if not responded to, approved, or denied within 30 days by DHCS.
 - Allows changes to approved transfer requests through counties’ annual plan updates, subject to similar application/approval process noted above by DHCS in collaboration with CSAC and CBHDA, with applications deemed approved if not responded to, approved, or denied by DHCS within 30 days of receipt.
- Changes to prudent reserves:
 - Flexibility added by allowing counties to fund its prudent reserve from any or all funding buckets (Housing Interventions, FSP, and/or BHSS). Under MHSA, the prudent reserve may only be funded from the Community Services and Supports (CSS) category.
 - Revises the prudent reserve allowance level:
 - Effective July 1, 2026, the prudent reserve is not to exceed 20% (25% for small counties) of the preceding five-year average of BHSA funds received.
 - For one-year period from July 1, 2025, to July 1, 2026, prudent reserve not to exceed 33% (25% for small counties) of the preceding five-year average of BHSA funds received.
 - Under MHSA, prudent reserves are capped at 33% of the average CSS revenue (76% of total MHSA funding) received in the preceding five years. This equates to a county prudent reserve level of approximately 25% of total MHSA funds.
 - Does not allow counties to spend prudent reserve funds on capital development projects under the housing interventions category.
- Creates the BHSA Revenue Stability Workgroup to assess revenue volatility:
 - Jointly led by the California Health and Human Services Agency (CalHHS) and DHCS to commence no later than June 30, 2024.
 - Workgroup membership:
 - BHSOAC, the Legislative Analyst’s Office (LAO), CBHDA, and CSAC, including both urban and rural county representatives.
 - The Department of Finance may consult with the workgroup to provide technical assistance.
 - Workgroup to develop and recommend solutions to reduce BHSA revenue volatility and to propose appropriate prudent reserve levels to support the sustainability of county programs and services.
 - On or before June 30, 2025, CalHHS and DHCS to submit a report that includes its recommendations to the Legislature and the Governor’s Office.

- Recasts local mental health advisory boards as behavioral health (BH) boards and requires these boards to additionally review and evaluate their local public SUD treatment systems.
 - Adds requirement that BH board membership to include at least one member who is 25 years of age or younger and at least one member who is an employee of a local education agency.
- DHCS-established service standards for children and youth specify each child/youth to have a clearly designated “personal services coordinator” or case manager responsible for providing case management services and specifies the coordinator shall perform an enumerated list of activities. (eff. July 1, 2026). Similar requirement for a designated personal services coordinator for adults/older adults currently exists under MHSA and is extended under BHSA.

New Accountability/Oversight Provisions

- BH Planning and Reporting Requirements:
 - Makes changes to the county planning process, requiring **county integrated plans** to be developed every three years with over 20 local stakeholder groups including managed care plans (MCPs), labor representative organizations, and continuums of care, among others.
 - Requires a county to work with each Medi-Cal MCP that covers residents of the county on development of the MCP’s population needs assessment. (eff. July 1, 2026)
 - Requires a county to work with its local health jurisdiction on development of its community health improvement plan. (eff. July 1, 2026)
 - Annual updates to the integrated plan are also required.
 - Requires the draft integrated plan and updates to be prepared for review and comment by stakeholders and interested parties for at least 30 days.
 - Requires BH boards to conduct a public hearing on the draft integrated plan after the 30-day comment period.
 - Integrated plans and annual updates are required to have specified sections, including a budget that includes the county planned expenditures and reserves for the county distributions from the BH Service Fund and any other funds allocated to the county to provide community mental health services/programs and a description of its workforce strategy.
 - Requires a county to consider relevant data sources, including local data, to guide addressing local needs, including the prevalence of mental health and SUD, the unmet need for mental health and SUD treatment in the county, behavioral health disparities, and the homelessness point-in-time count, in preparing each integrated plan and annual update, and should use the data to demonstrate how the plan appropriately allocates funding between mental health and SUD treatment services.
 - Requires counties to stratify data to identify BH disparities and consider approaches to eliminate disparities, including, but not limited to, promising practices, models of care, community-defined evidence practices, workforce diversity, and cultural responsiveness in preparing each integrated plan and annual update.

- Requires counties with population greater than 200,000 to collaborate with the 5 most populous cities in the county, MCPs, and continuums of care to outline respective responsibilities and coordination of services related to housing interventions.
- Integrated plans and annual updates must be approved by a county's board of supervisors and submitted to the BHSOAC and DHCS.
- Requires a set of measures to track progress and hold counties accountable in meeting specific outcome goals.
- Requires counties to annually submit a County BH Outcomes, Accountability, and Transparency Report to DHCS, including but not limited to the following data (eff. July 1, 2026):
 - County's annual allocation and expenditure of state and federal BH funds, by category.
 - County's annual expenditure of county general funds and other funds (assume this includes 1991 and 2011 Realignment funds), by category, on MH or SUD treatment services.
 - Sources and amounts spent annually as the nonfederal share for Medi-Cal specialty MH services and Medi-Cal SUD treatment services, by category.
 - All contracted services, and the cost of those contracted services, by category.
 - Data and information on workforce measures and metrics.
- Sanction Provisions:
 - Authorizes DHCS to impose a corrective action plan, monetary sanctions, or temporarily withhold payment to counties that fail to submit data and information by the required deadline, fail to allocate funding as required, or fail to follow the planning process.
 - DHCS may require a county to revise its integrated plan or annual update if DHCS determines the plan or update fails to adequately address local needs, as specified.
 - DHCS may impose a corrective action plan or require a county to revise its integrated plan or annual update if DHCS determines that the county fails to make adequate progress in meeting the metrics established by DHCS.
 - If a county's actual expenditures of its allocations from the BH Services Fund "significantly varies" from its budget, DHCS may impose a corrective action plan, monetary sanctions, or temporarily withhold payments to the county.
 - Monetary sanctions collected to be deposited in the BHSOAC Accountability Fund.
 - All monies in the Fund to be allocated and distributed to the county that paid the monetary sanction upon DHCS' determination that the county has come into compliance.
 - DHCS to temporarily withhold amounts it deems necessary to ensure the county comes into compliance and will release the temporarily withheld funds when it determines the county has come into compliance.
 - Revises the contracting process for mental health services, including authorizing DHCS to temporarily withhold funds or impose monetary sanctions on a county

BH department that is not in compliance with the contract (under MHSA, only plans of correction are authorized).

- Fiscal provisions for counties:
 - Specifies new and ongoing county and BH agency administrative costs to implement the article (planning and reporting) and WIC section 14197.71 (aligning county BH plans and MCP contract requirements), any costs for plan development required under this article that exceed the 5% cap, and any costs for reporting required by this article that exceed the 2% (4% for small counties) for improving plan operations, shall be included in the Governor's 2024–25 May Revision.
 - DHCS is required to consult with CSAC and CBHDA no later than March 15, 2024, to estimate the resources needed to implement this article and WIC section 14197.71.
 - New FSP and Housing Interventions categories – statutory language added stating implementation of those sections only to the extent BHSA funds are allocated for those purposes, and counties are not obligated to use funds from any other source for services for those sections.
 - Amendments to WIC section 5892 similarly add a provision to evaluate costs for inclusion in 2024-25 May Revision for the section, in consultation with counties.

- Authorizes DHCS to align county BH plans and Medi-Cal MCP contract terms when the same requirements exist across programs. This would be a new requirement that counties comply/align with Medi-Cal MCP contract requirements in 13 different areas, and potentially more, as determined by DHCS.
 - Requires each county Medi-Cal BH delivery system to report annually to the county board of supervisors on utilization, quality, patient care expenditures, and other data as determined by DHCS.
 - Requires the board of supervisors to annually submit an attestation to DHCS that the county is meeting its obligations to provide realigned programs and services, as specified.
 - Requires DHCS to implement no later than January 1, 2027.

- Requires a county, for BH services or supportive services eligible for Medi-Cal reimbursement, to submit the claims for reimbursement to DHCS when using BHSA funds.

- Requires counties to pursue reimbursement through other fund sources for a BH service, supportive service, housing intervention, prevention service, or other related activity that is covered by or can be paid from another available funding source, including other mental health funds, SUD funds, public and private insurance, and other local, state, and federal funds.

- Requires counties to make a good faith effort to enter into contracts, single case agreements, or other agreements to obtain reimbursement with health care service plans and disability insurance plans.

- Requires counties to also submit requests for prior authorization for services, request letters of agreement for payment as an out-of-network provider and pursue other means to obtain reimbursement in accordance with state and federal laws.
- Authorizes counties to submit complaints to the Department of Managed Health Care or the Department of Insurance about a health plan's or a health insurer's failure to make a good faith effort to contract or enter into a single case agreement or other agreement with the county. Counties may also submit complaints for a failure by a health plan or insurer to timely reimburse the county for services the plan or insurer must cover as required by state or federal law.
- Changes to the BH Services and Oversight Commission:
 - Shifts more authority to the state/DHCS – revises statutory description of Commission's role to specify "advise the Governor and the Legislature, pursuant to the BHSA and related components of CA's BH system. For this purpose, the Commission shall collaborate with the CalHHS Agency, its departments and other state entities."
 - Increases the Commission's membership from 16 to 27 voting members, to add:
 - Family members of, and individuals, with lived experience in BH/SUD.
 - A person with knowledge/experience in CDEP and reducing BH disparities.
 - A representative of a children and youth organization.
 - A veteran or a representative of a veterans' organization.
 - A current or former BH director.
 - Authorizes the Commission to "make reasonable requests for data and information to DHCS, HCAI, DPH, or other state and local entities that receive BHSA funds." Requires entities to respond in a timely manner and provide info and data in their possession that the Commission deems necessary for the purposes of carrying out its responsibilities.
 - No longer provides BHSOAC with the authority to establish priorities for the use of early intervention funds, and instead shifts this authority to DHCS, who will consult with BHSOAC (eff. July 1, 2026).
 - The funds in a county plan relating to early intervention are required to focus on the DHCS-established priorities and are to be allocated as determined by the county with stakeholder input.
 - A county may include other priorities, as determined through the stakeholder process, in addition to the established priorities.
- Audit Requirements
 - CA State Auditor is required to conduct audits and submit reports on progress and effectiveness of the BHSA.
 - First report to be submitted no later than December 31, 2029, to the Governor and Legislature. Audit to be conducted every three years thereafter, with the final audit report due December 31, 2035.
 - Audits to assess various issues including but not limited to:

- Implementation of the BHSa by each of the primary entities involved in the transition and implementation, including but not limited to state entities, the BHSOAC, **counties**, and county BH directors.
- How **counties** demonstrate progress towards meeting the statewide BH goals and outcome measures developed.
- The effectiveness and compliance by the **counties** with the revised BHSa reporting requirements.
- The degree to which the inclusion of SUD, SUD treatment services, and SUD personnel into the BHSa has impacted the system of BH care and the degree to which inclusion has been initially successful.

Summary of Small County Exemptions and Special Considerations

- **Which counties are impacted?** Proposition 1 provides for potential exemptions and special considerations for counties “with a population of less than 200,000.” Based on population data as of January 2023 from the Department of Finance, **30 counties** meet this threshold:

Alpine	El Dorado	Kings	Mendocino	Plumas	Sutter
Amador	Glenn	Lake	Modoc	San Benito	Tehama
Calaveras	Humboldt	Lassen	Mono	Shasta	Trinity
Colusa	Imperial	Madera	Napa	Sierra	Tuolumne
Del Norte	Inyo	Mariposa	Nevada	Siskiyou	Yuba

- **What exemptions/special considerations are provided?** Proposition 1 provides for the following exemptions and special considerations for small counties:
 - **30% Housing Interventions**
 - Starting with the 2026-2029 integrated plan and ongoing, small counties may apply for an exemption from the 30% housing interventions requirement.
 - Reasonable criteria and timely/efficient process to be developed by DHCS in consultation with CSAC and CBHDA.
 - Approval not automatic – subject to DHCS approval, but exemption requests must be responded to, approved, or denied within 30 days of receipt by DHCS, or shall otherwise be deemed approved by DHCS.
 - **ACT/FACT Requirements for FSP**
 - Small counties may request an exemption from the ACT/FACT requirements for the FSP program.
 - Reasonable criteria and timely/efficient process to be developed by DHCS in consultation with CSAC and CBHDA.
 - Approval not automatic – subject to DHCS approval. No 30-day timeline for response/action specified in statute.
 - **Note:** all counties may potentially apply for an exemption from the 35% FSP requirement starting with the 2032–2035 integrated plan and ongoing. DHCS *may* establish criteria and a process for approving

- requests for an exemption that considers factors such as county population, client counts, and other factors as determined by DHCS.
- **Allowable Prudent Reserve Levels**
 - Starting July 1, 2026, small counties are allowed to carry a prudent reserve level not to exceed 25% (larger counties cannot exceed 20%) of the average of total BHSAs distributed to the county in the preceding five years.
 - For one year starting on July 1, 2025, until July 1, 2026, small counties are allowed to carry a prudent reserve level not to exceed 25% (larger counties cannot exceed 33%) of the average of total funds distributed to the county in the preceding five years.
- **Expenditures for Plan Operations, Quality Outcomes, Data Reporting, Contractor Monitoring**
 - For small counties, these costs shall not exceed 4% of total annual revenues received. For larger counties, these costs are not to exceed 2%.
- **Reversion Periods**
 - Other than funds placed in a reserve, BHSAs allocated to a small county that have not been spent for their authorized purpose within 5 years shall revert to the state for deposit in the Reversion Account for use by other counties in future years. Larger counties must spend funds within 3 years before reversion to the state.
 - Consistent with MHSAs, funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the Reversion Account.
 - For one year starting on July 1, 2025, until July 1, 2026, allows small counties that have approval from the MHSOAC of a plan for innovative programs, the county's funds identified in that plan for innovative programs shall not revert to the state so long as they are encumbered under the terms of the approved project plan, including any subsequent amendments approved by the Commission, or until five years after the date of approval, whichever is later.
- **Integrated Plan Process Requirements**
 - Each county's integrated plan is to be developed with numerous local stakeholders. For counties with a population greater than 200,000, the integrated plan must be developed with the 5 most populous cities in the county. Small counties are not subject to this requirement.
 - As part of the planning process, counties with a population greater than 200,000 are required to collaborate with the 5 most populous cities in the county, managed care plans, and continuums of care to outline respective responsibilities and coordination of services related to housing interventions. Small counties are not subject to this requirement.

Policy/Fiscal Considerations. The MHSAs were approved by the voters nearly 20 years ago, and the short- and long-term impacts of Proposition 1 are largely unknown at this time and will depend on numerous factors, some of which are outside of county control. Numerous sections of Proposition 1 require county adherence to policy or funding allocation requirements that

are unspecified but will be developed via future regulations or plan letters/notices, shifting the discretion in setting policy and funding priorities away from counties to the state. Proposition 1 not only amends the MHSA but also adds new statutory provisions related to the state's behavioral health system seeking to improve coordination across multiple systems and provides for greater planning, oversight, and accountability measures.

Since 2020, the CSAC platform has called for reforms to MHSA. Specifically, the CSAC Board adopted a [set of county priorities](#) in May 2020 supporting changes to the MHSA funding silos that would allow for greater funding flexibility tied to outcomes and its usage for individuals living with a substance use disorder. Proposition 1 broadens the eligible uses of funding to include the provision of services to those with substance use disorders, but also dedicates 30 percent of BHSAs revenues to a new housing interventions category to support the ongoing housing needs of those who are chronically homeless, or who are experiencing or are at risk of homelessness. Under Proposition 1, these expansions to prioritize a broader population of the most vulnerable in our communities will not be supported with new ongoing revenues.

Dedicating nearly one-third of annual BHSAs funding for housing, coupled with the diversion of an additional five percent of annual revenues for state-directed purposes, is estimated to result in significantly less funding from the millionaire's tax (over \$1 billion less statewide) for core mental health and prevention services.

It is unknown to what extent this prioritization and redirection of BHSAs funding may impact existing contracts with community-based organizations, programs serving local communities, and county staffing given the severe workforce shortage. Additionally, counties have a significant and growing obligation to fund behavioral health services under the Medi-Cal entitlement and use these funds to support that obligation. Reducing available BHSAs revenues means less funding available to use as Medi-Cal match to draw down additional federal dollars.

Counties recognize that expanding voluntary housing placements is integral to meeting the needs of many Californians experiencing behavioral health issues, including individuals experiencing homelessness. Proposition 1 directs counties to prioritize those with the most acute behavioral health needs and provides \$6.38 billion, of which \$1.5 billion is to be awarded exclusively to counties, cities, and tribal entities, to build critically needed supportive housing and behavioral health treatment facilities at all levels of care, including investment in treatment facilities for individuals with the highest needs.

Proposition 1 presents counties with both opportunities and challenges. The behavioral health crisis requires thoughtful and immediate action at all levels of government, but making up for decades of inadequate resources and policy focus cannot be addressed overnight. The meaningful changes that Proposition 1 seeks to realize in the state's behavioral health system that is supported in part by an inherently volatile fund source will take time and resources to build capacity and recruit/retain the workforce necessary to implement these reforms.

Counties are simultaneously planning and implementing significant policy and operational changes such as the multi-year CalAIM initiative, which seeks to implement broad delivery system, program, and payment reform across the Medi-Cal program. Further, earlier this month, the first cohort of seven counties launched implementation of the Community

Assistance, Recovery and Empowerment (CARE) Act, with full statewide implementation of this new program required by December 2024.

The impacts of Proposition 1 in conjunction with these and other significant behavioral health policy changes such as the Governor's recent signing of [SB 43](#) (Chapter 637, Statutes of 2023), which expands the definition of "gravely disabled" for purposes of conservatorship eligibility, will likely vary greatly across counties and communities, and will be dependent on numerous factors, some of which are outside a county's control. As noted above, numerous sections of Proposition 1 require county adherence to policy or funding allocation requirements that are unspecified but will be developed via future regulations or plan letters/notices, shifting the discretion in setting policy and funding priorities away from counties to the state. Additionally, critical flexibilities afforded to counties require state approval and are not guaranteed. Lastly, it may be difficult to assess the long-term impacts resulting from the required prioritization of specified populations and the subsequent effects of that prioritization on existing populations and programs.

Proposition 1 may have unknown and long-term impacts on county planning and funding beyond the BHSA. One of the cornerstones of this reform centers on the development of an integrated county plan, annual updates, and submittal of an annual accountability and transparency report, which will require counties to plan and report on the allocation and expenditure of all fund sources. This provides counties with the opportunity to maximize the effective and equitable delivery of behavioral health services in our communities.

However, as summarized earlier, the state will have significant oversight authority to require a county to revise its integrated plan or annual update if the state determines the plan or update fails to adequately address local needs or if the county fails to make adequate progress in meeting state-established metrics. It will be critically important for the state and counties to work together to realize the opportunities Proposition 1 presents to improve the behavioral health system, and most importantly, best support the people it intends to serve.

Current CSAC policy includes a section specific to behavioral health services within [Chapter Six: Health](#), of the CSAC Policy Platform. Relevant passages include:

Counties must have the flexibility to design and implement behavioral health services that best meet the needs of their local communities. The appropriate treatment of people living with substance use and serious mental health disorders should be provided equitably and within the framework of local, state, and federal criteria.

Counties have developed a range of locally designed programs to serve California's diverse population and must retain local authority and flexibility. At the same time, the state must ensure that counties have adequate funding to continue and evaluate such services and are provided with additional funding when new programs are created to ensure existing funds are not redirected, resulting in reduced access or quality of care. The state, counties, and other organizations must collaborate to ensure adequate resources for addressing the complex needs of individuals involved in or at risk of being involved in the criminal justice system who also live with serious mental illness and substance use disorders. The state must acknowledge the critical role of counties in

responding to emergencies, natural disasters and states of emergencies and the need for disaster response trauma-related behavioral health services.

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MHSA funding is also dedicated to meeting the needs of each community via robust stakeholder input to determine spending priorities. The Act is crucial to the stability of the Medi-Cal behavioral health safety net as counties expertly leverage available MHSA funding to provide critical Medi-Cal specialty mental health services annually. Counties value the partnership with local community stakeholders to develop priorities which address local needs, as required by MHSA.

1) Counties oppose additional reductions in state funding for behavioral health services that will result in the shifting of state or federal costs to counties, or require counties to use MHSA funds for that purpose. These cost shifts result in reduced services available at the local level and disrupt treatment capacity and options for behavioral health clients. Any shift in responsibility or funding must hold counties fiscally harmless and provide the authority to tailor behavioral health programs to individual community needs consistent with the Act.

2) Counties also strongly oppose any effort to redirect MHSA funding to new or existing state programs and services, or removing local control over funding decisions as intended by the voters.

3) MHSA funds have been diverted in the past due to economic challenges and the establishment of the No Place Like Home Program in 2016. Any further diversions of MHSA funding will require robust county engagement, keeping the needs of local communities at the forefront without disruption to current programming at the local level.

4) Counties support timely and clear reporting standards, including reversion timelines, for MHSA expenditures and seek guidance from the Department of Health Care Services on all reporting standards, deadlines, and formats. Any development or update to reporting should be clearly established with county stakeholder involvement. Further, updates should be data-driven, measurable, and reassessed for effectiveness at specified intervals.

5) Counties support the fiscal integrity of the MHSA and transparency in stakeholder input, distributions, spending, reporting, and reversions, and seek collaboration with the state on developing tools that accurately report on MHSA programs and expenditures.

6) Counties support the continued evaluation of MHSA funding silos to allow for greater funding flexibility, accountability for outcomes, and its usage for individuals living with a substance use disorder or co-occurring disorders, provided counties are central to the development of reforms and any shift to accountability for outcomes is grounded in sound data science and client and community input.

CSAC Ballot Initiative Review Process. In most instances, CSAC will only take a position on a relevant ballot measure after it qualifies or has been placed on the statewide ballot for a scheduled election. The CSAC Officers referred Proposition 1 to the HHS Policy Committee for review. On October 30, after consideration and discussion, the HHS Policy Committee voted unanimously to recommend “no position” on Proposition 1.

In the absence of a “support” or “oppose” position on the measure, the HHS Policy Committee recommendation was forwarded to the Executive Committee as an informational item only, and is being subsequently forwarded to the Board of Directors as an informational item. Both the Executive Committee and the Board of Directors may accept the HHS Policy Committee’s recommendation or change the recommendation. Upon approval by the Board of Directors, the position is adopted as the Association’s official position.

CSAC Staff Contacts:

Jolie Onodera, Senior Legislative Advocate, Health & Behavioral Health:

jonodera@counties.org, (916) 591-5308

Danielle Bradley, Legislative Analyst, Health, Human Services & Homelessness:

dbradley@counties.org, (916) 224-3137

Materials:

Secretary of State: [Qualified Statewide Ballot Measures: California Secretary of State](#)

Full text of AB 531: [Bill Text - AB-531 The Behavioral Health Infrastructure Bond Act of 2024](#)

Full text of SB 326: [Bill Text - SB-326 The Behavioral Health Services Act](#)