



August 14, 2023

The Honorable Jim Wood, Chair
Assembly Committee on Health
1020 N Street, Room 390
Sacramento, California 95814

Re: SB 326 (Eggman) The Behavioral Health Services Act (BHSA)
As amended July 13, 2023
Set for Hearing: August 22, 2023

Dear Chair Wood,

On behalf of the California State Association of Counties (CSAC), Urban Counties of California (UCC), Rural County Representatives of California (RCRC), County Behavioral Health Directors Association (CBHDA), County Welfare Directors Association (CWDA), County Health Executives Association of California (CHEAC), and the County Probation Officers of California (CPOC), we write to share the county perspective on the Governor's proposal introduced in SB 326 (Eggman), which proposes to significantly reform the Mental Health Services Act (MHSA) and makes additional changes beyond the MHSA to the behavioral health system more broadly.

Counties appreciate the engagement to date with your Committee and seek continued collaboration with the Legislature and the Administration to strengthen the proposal, in the spirit of improving the behavioral health system together in a manner that provides counties the opportunity to implement these significant programmatic and operational changes through a phased-in approach to bring about real and sustainable change. To that end, our organizations request consideration of three critical county priorities and the adoption of associated changes as outlined below as the proposal continues to be reviewed and developed through the legislative process.

Counties collectively agree that MHSA funding reform is needed to assist more Californians with serious mental illness and substance use disorders receive the care and supports they need. In 2020, CSAC convened a working group consisting of county organizations and representatives to develop proposed improvements to the MHSA. A set of county priorities was adopted 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. SB 326 does broaden MHSA's eligible uses to include substance use disorder services but, as currently drafted, it also reduces county flexibility, creates new mandates for higher levels of service with no new funding, and makes it more difficult to manage this volatile funding source by further lowering reserve caps.

In the absence of addressing the critical areas outlined below, the bill as currently drafted will reduce MHSAs funding at the local level currently being used to support core mental health services, including services for children and youth, such as outpatient, crisis services, outreach, and recovery services. Our organizations have identified the following priorities necessary to enable counties to realize the potential opportunities afforded through behavioral health system modernization changes:

- **Maintain MHSAs funding for core mental health services** – MHSAs is a highly volatile fund source, subject to significant year-to-year fluctuations that are largely driven by the stock market. This volatility, which poses particularly acute challenges for small counties, necessitates providing flexibility within the broader framework of the program for counties to meet the unique needs of their communities. Further, a one-size-fits-all approach to program design creates challenges for counties that vary greatly across the state. Providing flexibility from strict percentage requirements for each program category, making considerations for the unique needs of small counties, restoring higher reserve caps, and removing the strict subcategory requirements within the categorical funding allocations are just a few examples that will help support sustainable program and service delivery.
- **Add fiscal protections** – the proposed language may create new mandates or require increased services that require additional funding from the state under Proposition 30. These issues are legally complex because Medi-Cal is a federal entitlement. Added fiscal protections ensuring counties' obligations under the renamed Behavioral Health Services Act are limited to available funding (as under the Bronzan-McCorquodale Act) must be included in recognition that no new funding is being allocated to counties to serve the added target population of those with substance use disorders or for counties to engage in additional planning and administrative activities.
- **Narrow the proposal to MHSAs reform** – this proposal has been presented as reforms to MHSAs to be presented to the voters for consideration. However, SB 326 amends several sections of existing law beyond the MHSAs, including sections of the Bronzan-McCorquodale Act (1991 Realignment), and a new section aligning contract terms for managed care plans and Medi-Cal behavioral health delivery systems, that would become law once the bill is signed, and without voter approval. Additional sections of law proposed to be amended beyond MHSAs include the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. We request that SB 326 be limited to the proposed changes to MHSAs to go before the voters. The other provisions merit more robust discussion and analysis, and should be considered separately through the legislative process.

MAINTAIN MHSAs FUNDING FOR CORE MENTAL HEALTH SERVICES

The highly volatile nature of the MHSAs as a fund source cannot be understated. As reported by the Legislative Analyst's Office, the "MHSAs tax is an extremely volatile revenue source... the year-over-year percentage change in MHSAs revenue is in many years two to three times as large as the change in personal income tax."

This volatility necessitates providing greater flexibility within the structure of the BHSAs to enable counties to adequately plan for the multi-year expenditure of these funds while maintaining critical services, including services for children and youth. It will be extremely difficult if not impossible for counties to hit the specific percentage expenditure requirements for each program category given the unpredictability of MHSAs tax revenue from year to year. The rigidity created by specific percentage targets for each

program category is further intensified by the added subcategory percentage requirements. Further, if all future changes to the BHSA require voter approval, it will be imperative to build in even greater flexibility into the Act's provisions. Additional flexibilities within the new BHSA that will help counties mitigate the challenges created by this revenue volatility include the following:

- Instead of specifying rigid program category percentage requirements, provide more flexibility within the funding categories by establishing target percentage ranges or minimum percentage floors, or allow fund transfers between program categories, to allow counties to respond to economic fluctuations and better meet local needs and priorities.
- Provide additional flexibilities for small counties (population less than 200,000), including authorization to transfer funds between program components, streamlined reporting requirements, and/or exemptions from program requirements (such as the limitation to 2 percent for plan operations) where appropriate.
- Provide more flexibility in the provision of substance use disorder (SUD) services as an allowable, versus a required, use of BHSA funds. By adding SUD as a requirement rather than a flexibility, the new BHSA would add new service levels without added funding. SUD is required under Medicaid law, but this change is overly prescriptive and does not give counties flexibility if other funding sources are available.
- Broaden eligible uses under the housing interventions program to include support services and expand authorization for capital expenditures.
- Remove the strict subcategory percentage requirements to allow counties to provide consistent/stable funding for programs and successfully meet the unique needs of their communities. These requirements include:
 - Fifty percent of the housing interventions component must be used for the chronically homeless.
 - A majority of Behavioral Health Services and Support (BHSS) Funding must be utilized for early intervention programs.
 - Under the BHSS component (30 percent of BHSA funds), counties are required to comply with "other funding allocations specified by the DHCS." This creates additional uncertainty regarding new prescriptive requirements.
- Increase flexibility in the Full-Service Partnership (FSP) component proposed to be added in statute. As currently drafted, the FSP component for all counties must include specified services, including SUD, Assertive Community Treatment (ACT) and Forensic Community Treatment (FACT) to fidelity, "and other evidence-based services and treatment models as specified by DHCS."
- Expand the definition of "chronically homeless," which is currently limited under the federal definition, to reach a broader population.
- Provide time/phase-in for transition to the new category requirements, the revised planning process, and enhanced reporting requirements – which will require additional staffing, training, technical assistance, and system changes.

ADD FISCAL PROTECTIONS

SB 326 proposes major programmatic and administrative changes that will create significant workload and necessitate a transition phase to implementation for counties. Additionally, the proposal may create new responsibilities and increased services that require additional funding from the state. Further, SB 326 proposes amendments well beyond the MHSAsA statutory changes included in Proposition 63, including but not limited to amendments to the Bronzan-McCorquodale Act (1991 Realignment). To the extent SB 326 creates new responsibilities, counties are exploring over which provisions of this complicated proposal Proposition 30 protections will apply. Counties urge consideration of the following revisions to the proposal:

- Add fiscal protections ensuring counties' obligations under the renamed Behavioral Health Services Act (BHSA) are limited to available funding (as under the Bronzan-McCorquodale Act and the CARE Act).
- Ensure sanctions/penalties are reasonable and equitable – the measure gives the state broad authority to impose penalties on counties related to failing to meet outcome measures (that have not yet been established), failing to report timely, and if the state disagrees with a county's plan for spending behavioral health funds. Sanctions should be reserved for deliberate and chronic deficiencies and should be imposed only after meaningful engagement with the responsible state agency with appropriate procedural safeguards and due process. Any resulting withholdings or penalties should be returned to the county of origin for direct behavioral health services for individuals being served by the BHSA.
- Consider having counties develop their MHSAsA planning budgets based on a multi-year rolling average of revenues. Developing plans and requiring spending percentages based on a three- or five-year rolling average will have the effect of significantly smoothing the inherent volatility of this revenue source.
- Eliminate or restore a higher reserve cap to help support sustainable management of this volatile fund source. The reduced flexibility embedded in SB 326 coupled with a lower reserve cap will make it difficult for counties to sustain funding for programs ongoing even when the state is not experiencing a recession.
- In the absence of narrowing the proposal to amendments to MHSAsA statutes as requested below, adhere to the principles of realignment by fully funding all new requirements outside of any proposed MHSAsA reforms.

NARROW THE PROPOSAL TO MHSAsA REFORM ONLY

Finally, as referenced above, this proposal has been presented as reforms to MHSAsA to be presented to the voters for consideration. However, SB 326 amends several sections of existing law beyond the MHSAsA, including sections of the Bronzan-McCorquodale Act (1991 Realignment), and a new section aligning contract terms for managed care plans and Medi-Cal behavioral health delivery systems, that would appear to become law once the bill is signed, and without voter approval. Additional sections of law proposed to be amended beyond MHSAsA include the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. Further complicating matters, SB 326 is not clear as to which sections of the

bill will be placed before the voters for approval. We request that SB 326 be clarified and limited to the proposed changes to MHSA to go before the voters. The other provisions merit more robust discussion and analysis, and should be considered separately through the legislative process.

Thank you for your consideration of these important county priorities and suggested improvements to SB 326. We understand this proposal is still under development and request the provisions outlined above be incorporated into any future amendments.

Counties look forward to working collaboratively to strengthen this proposal to realize the opportunities it presents to improve the behavioral health system, and most importantly, best support the people it intends to serve. Should you have any questions regarding the information outlined above, please do not hesitate to contact our organizations.

Sincerely,



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