Established in 1991, UCC serves as the representative voice for state legislative advocacy for high-population counties in California. Initially composed of seven counties, the association has grown to 14 today. Just over 80 percent of the state's population reside in UCC counties. Consequently, urban counties carry out critical programs and services to the state's most vulnerable populations. For more information, including details on our Board of Directors, please visit our website.

May 5, 2023

Legislature Sends Early Action Budget Package to the Governor, Including Vehicle to Address Distressed Hospitals

The Legislature took early budget action this week, approving one budget bill and four trailer bills that now await the Governor's action (see the bill list and our summary of the main provisions **here**). The full budget committees in both houses met this week to discuss, and the package subsequently was approved in yesterday's floor sessions.

We highlight in particular **AB 112** (Ting), which creates a new Distressed Hospital Loan (DHL) Fund and, among other provisions, authorizes the Department of Finance to transfer up to $150 million from the state General Fund into the DHL Fund over the remainder of fiscal year and into 2023-24. In lengthy public discussions in the Senate Budget and Fiscal Review Committee hearing and on the Senate floor, legislators acknowledged that $150 million is not sufficient to address all distressed hospital needs in the state; it is anticipated that more discussion about increasing the loan funding will take place in June.

Members noted that one in five California hospitals are at risk of closure. Based on the legislative discussion, legislators are interested in further exploration of issues including transparency, the methodology to determine if a hospital is distressed, and the size of the loan an individual hospital can obtain through the fund. Senator Grove noted some hospitals have secured bond payments against future Medi-Cal revenue, which is the mechanism used in AB 112 to secure the loan. There is concern that this feature may disqualify some distressed facilities

from accessing the DHL loan. The distressed hospital conversation will likely continue through the summer.

In other budget news, we expect the Governor will release his 2023-24 May Revision late next week – likely Friday, May 12. We will prepare a detailed summary by the end of the day of its release.

Legislature Holds First Hearing on Mental Health Services Act Modernization

The Assembly Budget Subcommittee No. 1 on HHS issues held a special order of business on Monday evening to hear about the Governor's Mental Health Services Act (MHSA) modernization proposals (**agenda**). The MHSA portion of the hearing was arranged around five panels focusing on: 1) history and overview of the MHSA, 2) the movement of the Oversight and Accountability Commission (OAC) under the California Health and Human Services Agency (CalHHS), 3) the proposed MHSA reforms, 4) accountability and access proposals, and 5) the proposed bond to fund behavioral health residential treatment settings. Subcommittee members engaged in discussion with panelists for more than four hours on MHSA. The Administration acknowledged that their MHSA proposals are works in progress, although they did not specify when additional details would be available, nor did they confirm whether they will be pursuing a legislative proposal or budget proposal this year. Given the fiscal and operational consequences that likely would result from the MHSA reforms being discussed, we are providing a very detailed summary of each panel discussion below.

PANEL #1: History and Overview Panel Key Takeaways

- The panel included remarks from Sacramento Mayor Darrell Steinberg and Toby Ewing, the Executive Director of the Mental Health Services OAC.
- Mayor Steinberg argued that it's time for a modernization or refresh of the MHSA – not an overhaul. He wants the Full Service Partnerships (FSPs) to focus on street homelessness.
- Toby Ewing talked about what the mental health system was like prior to enactment of the MHSA: "California rationed access to care through Medi-Cal to only the most ill, sickest Californians. MHSA was designed around a future where everyone who has a mental health need is met." He argued that prevention and early intervention (PEI) and innovation are foundational pieces to the Act and that this type of funding is unavailable in any other funding stream. There are no restrictions on PEI and innovation beyond the concept of engaging the community. He went on to say that – as a result of the Governor's proposed changes – there is a "likelihood that we may return to how we organized and delivered services prior to MHSA."

- Assembly Member Ramos asked Mayor Steinberg about collaboration between cities and counties and whether funding should be provided directly to cities. Mayor Steinberg responded that providing help to the homeless should be a mandatory legal obligation for cities, counties, and the state. He thinks the state should require cities and counties to develop similar partnerships to what occurred in Sacramento, which includes legally binding partnership agreements as well as specifically assigned roles and responsibilities. He thinks it would be appropriate to provide funding to cities but went on to say that he does not think cities are equipped to become health and human services or mental health agencies. Counties are the appropriate body of government to do this work and that they do a good job and are good partners. Counties are just not prioritizing street homelessness.

PANEL #2: Mental Health Services Oversight and Accountability Commission Transfer to Administration Panel Key Takeaways

- Stephanie Welch and Kim Chen from the CalHHS Agency kicked off the panel by explaining the rationale for moving the OAC under the Agency. Currently, the majority of the Commission is appointed by the Governor, but it functions as an independent body with the Executive Director appointed by the Commission, not the Governor. The Administration's proposal would also require the Governor to appoint the Executive Director. As for the rationale for the governance change, the Administration shared that they are striving for better integration between state agencies and real-time collaboration.
- Assembly Member Ting, Chair of the Assembly Budget, was present for the first two panels and was very focused on the proposed changes to the independence of the Commission. He engaged in a tense exchange with the CalHHS representatives asking about independence, data collection, and bond oversight. He asked them to provide examples of the problems they are trying to solve and, when they were unable to provide one, he questioned the need for this aspect of the proposal.
- The rest of the panel included current and former OAC commissioners, including Santa Barbara County Sheriff Bill Brown, youth being served by an Imperial County-funded MHSA program, individuals with lived experience, SEIU, and providers.
- Nearly all the panelists spoke in opposition to the proposal to take away the independence of the Commission. One of the panelists told the committee that during the CARE Court discussions last year, the Administration did not meet with consumers to discuss their

concerns. As a result, having a dependent commission heightens concerns about whether consumer voices will be heard.

- SEIU noted that there was a political reason there was an oversight commission: polling undertaken when MHSA was being prepared for the ballot indicated that the Act would not have passed without an independent oversight commission.
- Assembly Members Arambula and Jackson both expressed concerns with this aspect of the proposal.

PANEL #3: MHSA Reform Panel Takeaways

- The Administration anticipates that counties will continue to invest in PEI but, under their proposal, counties will have more flexibility to invest. They anticipate managed care plans will provide services to children with mild to moderate needs. Many of the panelists included on panel three focused their comments on the impacts of the proposed changes on services provided to children.
- Department of Health Care Services (DHCS) Director Michelle Baass reiterated that the proposal is a work in progress.
- The Administration does not believe their proposal will result in lost services and would like specific examples about where losses are anticipated.
- SEIU is pleased with the inclusion of substance use disorders in the MHSA reforms.
- The representative from Children Now made clear they do not want MHSA to be used to pay for substance use disorders services. They also have concerns about the flexibility provided in the community supports and services bucket – particularly as it relates to spending on children's services. Additionally, there is no plan to support long-term investments in community defined models. Children Now noted that no one tracks good outcomes; MHSA is NOT unique, and a ballot initiative is not necessary to track outcomes. Children Now recommends requiring a set percentage be spent on PEI for children and youth, a set percentage be spent on community supports and services for children, and a set percentage be spent on FSPs for children and youth. All of these recommendations go beyond what is currently required in the MHSA.
- The California Alliance of Child and Family Services noted that moving PEI into the community supports and services funding bucket puts children and youth funding at risk. They urged the Legislature to preserve a set aside of PEI for children and youth. The Alliance also recommended that MHSA changes include a focus on youth not in school and the 0 to 5 population.

- Toby Ewing raised questions about the incentives that the Medi-Cal maximization proposal would create. He used the early psychosis program as an example, which is funded 80% by Medi-Cal and 20% by MHSA. If we change incentives to require Medi-Cal be spent first, does it create an incentive to provide 80% toward Medi-Cal matchable services and ignore the 20% that are not eligible for Medi-Cal match, thereby changing the efficacy for the early psychosis program? Fiscal incentives are a huge driver of decision making. Ewing reminded the subcommittee that MHSA was envisioned as balance to Medi-Cal. He went on to say that it is a false choice between PEI and treatment.
- CBHDA noted that MHSA is the lifeblood of the community mental health safety net. MHSA pays for culturally aligned services that are not insurance reimbursable. MHSA was used to build suicide prevention call centers and mobile crisis centers before 9-8-8 was created. Counties leverage approximately half of MHSA as a match for the non-federal share of Medi-Cal. MHSA is by far county behavioral health's most complex and volatile funding stream. CBHDA is working to understand how the state's proposal lines up with local community priorities and what tradeoffs may occur with the proposal.
- While the Legislative Analyst's Office (LAO) thinks it is reasonable for the Legislature to reconsider priorities of MHSA nearly 20 years post-implementation, they also acknowledged that funding category changes could disrupt services at the county level. The LAO suggested the Legislature consider: 1) delays in implementation to allow time for better evaluation of how changes will impact current service levels, as well as 2) provisions that would allow changes in the MHSA allocations without going back to the voters.
- The LAO noted that the MHSA funding source is among the most volatile in the state's budget that fluctuates a large degree year over year. To manage the volatility, the Legislature should either allow for prudent reserves or propose changes in the tax structure. The LAO cautioned about decreasing prudent reserves along the lines of what the Administration is proposing.
- In his comments, Assembly Member Jackson struggled with the stakeholder suggestions to allocate fixed percentages to certain services (PEI) or populations (children), given that this approach may be overly rigid and won't allow for community needs and differences.
- Assembly Member Arambula asked whether community defined practices are a covered benefit. Director Baass responded that they

are not covered now but they would like them to become statewide strategies and covered Medi-Cal benefits in the future.

- Assembly Member Arambula expressed concerns about potential impacts of having capital improvement, technology, and workforce investments in the same spending bucket as PEI. CBHDA encouraged the subcommittee to think about the proposed MHSA changes as a table for four that needs to make room for seven – SUD, housing and more FSPs will require three additional chairs.
- CBHDA also reminded the subcommittee about the rest of community supports and services that are not FSPs, much of which is used to fund outpatient care. The key will be to figure out how to make this all work together.
- Assembly Member Arambula asked about the notion that counties are not investing in housing. Toby Ewing responded that some counties are using MHSA for housing. CBHDA noted that close to $1 billion of MHSA currently gets put to housing and services for people who are unhoused.

PANEL #4: Statewide Accountability and Access to Behavioral Health Services Panel Key Takeaways

- The Administration's proposals for accountability and access are broader than MHSA; they are interested in reporting and transparency on realignment funds, federal block grant funds, how match is spent, Medi-Cal expenditures, services to people not covered by Medi-Cal unspent funds and reserves.
- The Administration wants to develop statewide behavioral metrics to track across the state.
- The Administration is proposing that counties develop behavioral health plans for a county or for a region – not just an MHSA plan.
- Finally, the Administration is proposing to align behavioral health benefits across all health plans, including Medi-Cal managed care plans and commercial payers.
- CBHDA noted that although county behavioral health reports a lot of data currently, as a state we don't have the kind of data and analysis that policy makers, counties, and advocates currently desire.
- CBHDA also expressed concerns that if mild to moderate services are not getting to underserved communities, individuals' conditions will worsen, and some will access services in the public system. They also noted that the Administration's focus on the commercial parity issue is just beginning. Part of the Administration's proposal – that counties can spend less on PEI because counties provide services to people who are the responsibility of Medi-Cal managed care plans or commercial insurance – is predicated on counties being confident

that other sectors will step up and provide behavioral health services.

- Toby Ewing acknowledged the vast amount of data that the state has available, but noted the state lacks the technology needed to link, analyze, and synthesize the data timely. He commented that it is inappropriate to simply talk about more reporting without also talking about eliminating some of reporting and being more efficient. He suggested moving away from legacy data requirements and focusing on what data the states need to inform its decisions.
- The California Pan Ethnic Health Network (CPEHN) noted that communities of color face barriers to accessing behavioral health services. Only a small fraction of individuals receives mild to moderate services, and commercially insured individuals have similar levels of unmet need. Disparities grow with race and language data.
- CPEHN offered several recommendations, including: 1) adding community defined evidence-based practices as a Medi-Cal benefit and to the commercial market; 2) conducting more rigorous oversight of delegated behavioral health plans; 3) implementing equity metrics; 4) evaluating efforts to build sufficient networks with appropriate cultural diversity and/or linguistic providers; 5) including in MHSA reforms statewide policy on workforce and PEI expenditures (set a percentage instead of in a flexible pot); 6) including in MHSA reforms an ongoing fund to invest in cultural diversity/linguistically diverse providers; 7) shifting the focus on how MHSA dollars are spent to outcomes achieved, including metrics that demonstrate that plans are serving communities of color adequately.
- The LAO recommended that more data reporting is not necessarily needed but a more narrowly defined focus on data could be beneficial, specifically around areas that would help the Legislature make decisions.
- In response to a question from Assembly Member Arambula, Director Baass indicated that the Administration's proposal will create state and local processes for developing metrics, but not establish the metrics.
- Assembly Member Arambula asked how to make sure the commercial plans are not cost shifting to the public sector.

PANEL #5: Bond Measure to Fund Behavioral Health Residential Treatment Settings Panel Key Takeaways:

- The bond proposal is being designed around the documented need for additional subacute and residential treatment beds. A RAND

study shows California needs 6,000 subacute beds and residential treatment beds (8,000 if acute beds are included).
- The proposed general obligation bond of $3 to 5 billion would develop appropriate short- and long-term services, including subacute and residential care facilities. The Administration is proposing to build unlocked community-based treatment facilities.
- The LAO recommends a more in-depth analysis on how beds would fit with recent ongoing investments.
- Further, the LAO estimates $275 million of annual debt service for a $5 billion bond – making the total cost of the bond $7 billion. The percentage of General Fund revenue currently being used for general obligation bond debt service is low as compared to historical averages.
- The portion of the bond to be used for veterans' housing has yet to be identified.
- In response to a question from Assembly Member Arambula, the Administration indicated the disbursement of bond funds will factor in geographic disparities.
- Assembly Member Arambula commented that since the state's debt limit is low, it seems appropriate to consider this type of bond.

This week's hearing was the first opportunity for the Legislature to engage with the Administration on its multi-part proposal. The Administration's timeline for releasing more details and, as noted above, for how it intends to pursue these policy changes (via legislative bill vs. through the budget process) both remain unknown. We will continue to provide updates as we learn more.

New Economic Analysis Finds SB 525 Would Increase Health Care Costs by $8 Billion Annually

The coalition opposing **SB 525** (Durazo) released an **economic analysis** this week that found that the health care worker pay measure would increase costs for public and private health care providers by $8 billion annually. The amount will increase every year, growing to more than $11.3 billion by 2030. The report found that SB 525 would increase costs to state and local governments by $4.8 billion each year. The report was compiled by California's former Director of the Department of Finance and the former Chief Economist for the California State Legislative Analyst's Office. The key findings include:

Total public and private health care expenses will increase by $8 billion annually, increasing to $11.3 billion annually by 2030.

- $4.9 billion related to wage increases for workers currently making between $15.50 (the statewide minimum wage) and $25 per hour.

- $920 million related to increased employer payments for benefits such as social security contributions, retirement, and overtime differentials.
- $300 million due to provisions raising the "manager exemption" from California's overtime requirements from $31 per hour to $50 per hour.
- $380 million for the increase in minimum wages paid to on-site contractors, such as those providing building and grounds maintenance, security services, and temporary employment services.
- $1.5 billion due to employers offsetting wage compression by raising pay rates for employees earning up to double the new $25 per hour minimum wage.

Costs to state and local governments will be $4.8 billion annually. All levels of government would be directly affected by the minimum wage increase: first, as employers of workers in state and county hospitals and correctional facilities; and second, as major purchasers of health care services – through county health care programs, the state's Medi-Cal program, and as purchasers of health insurance for their active and retired employees. The following are anticipated costs for state and local governments:

Total Local Government Costs: $770.9 million

- County Health Program Costs: $406 million
- County, City, Special District (including School District) Employee Health Insurance Costs: $364.9 million

Total State Government Costs: $4.01 billion

- Medi-Cal: $3.6 billion
- State Employee Health Insurance: $112.9 million
- Dept of Corrections: $53.4 million
- Department of State Hospitals: $19.7 million
- State Retiree Health Insurance: $78.5 million
- CSU Retiree Health Insurance: $11.8 million
- UC Employee Health Benefits: $74.6 million
- UC Retiree Health Benefits: $10.3 million

The Senate Appropriations Committee heard SB 525 on May 1 and placed the bill on the Suspense File. The Committee **analysis** notes potential state costs including:

- The California Department of Human Resources (CalHR) indicates that the bill would result in increased personnel costs across multiple departments and job classifications. CalHR's detailed

costing has yet to be completed. However, based on preliminary information, the Department estimates that the bill would result in increased state employee payroll costs, minimally in the high hundreds of millions of dollars annually. Depending on how broadly the State defines the indirect support functions covered by the bill, annual personnel costs could reach billions of dollars. The majority of these costs would come from the General Fund.

- The magnitude to Medi-Cal is unknown, but minimally would be in the hundreds of millions of dollars annually (General Fund and other funds).
- The bill would result in General Fund cost pressures to increase wages for state employees who at present earn slightly more than the current minimum wage to avoid salary compaction.

We will report on the disposition of SB 525 and a range of other high-profile measures when the Appropriations Committees in both houses hold their suspense file hearings late in the week of May 15.

Assembly Speaker-Elect Robert Rivas Shares Insights Two Months Prior to Taking Helm

Former San Benito County Supervisor and now-Assembly Member Robert Rivas, who has been selected to succeed Assembly Speaker Anthony Rendon on July 1, joined Scott Shafer and Marisa Lagos of KQED for a wide-ranging **interview**. The 30-minute conversation covers topics ranging from his family history, challenges in his district, and his policy priorities – the primary of which is affordability. Assembly Speaker-elect Rivas shared that his staff is meeting regularly with Speaker Rendon's staff to prepare for a smooth transition at the end of next month. He plans to be a results-driven unifier who will work to bring the best out of his colleagues in service of the people in the state of California.