

POLICY WHITE PAPER

Continuing to serve the
under-served: Leveraging
Proposition 1 for housing
and mental health
services

2025

**MENTAL
HEALTH
FOR
ALL**



I. Abstract

For forty years, the California Behavioral Health Association (CBHA) has represented community-based organizations and businesses that deliver behavioral health services to Californians across the lifespan. CBHA's founder, Rusty Selix, played an instrumental role in drafting and leading advocacy for the Mental Health Services Act (MHSA) which passed as Proposition 63 in 2004.

CBHA has continued to lead advocacy for the continued expansion and innovation of the behavioral health delivery system. In 2024, Proposition 1, the Behavioral Health Services Act (BHSA), was passed, expanding funding for services including housing supports and full-service partnerships.

This document was designed as a resource for behavioral health providers to navigate the major changes as part of BHSA implementation. This resource is intended to offer insights for county contracts and providing behavioral health services under Proposition 1/Behavioral Health Services Act.

II. Executive Summary

The Behavioral Health Services Act (BHSA) provides counties and providers with new opportunities to pay for housing and services for homeless people with serious mental illnesses. Under current conditions, counties use one-time state funds or local general funds to pay for this critical support.

The BHSA creates new requirements, which come into effect in 2026, that counties dedicate a significant portion of funding to housing and services. This funding stream can and should replace one-time state and local sources. This allows counties and their provider networks to significantly expand the amount of intensive housing and services they provide residents with serious and complex mental health needs who are experiencing homelessness – and it provides a stable, predictable funding source every year, moving forward.

This Policy White Paper shares a case study showing that even the most intensive and comprehensive service model for the most challenging dual and triple diagnosis clients - costing \$300 per client, per day — can be fully supported through Medi-Cal and BHSA funding, greatly reducing the need for counties to rely on their general funds.





III. Summary of BHSA Requirements (MHSF Spending)

Background: In March 2024, California voters approved Proposition 1, which updated the 2004 Mental Health Services Act (MHSA) and renamed it the Behavioral Health Services Act (BHSA). The BHSA shifts county mental health funding (the Mental Health Services Fund, or MHSF) to focus more directly on addressing homelessness and serious mental illness—without raising taxes. Counties will still receive 90% of MHSF revenues, but new rules now determine how these funds must be allocated.

HOUSING INTERVENTIONS (30%)

Starting in **FY 2026–27**, counties must dedicate **30% of their BHSA funding** to housing supports for people with serious behavioral health conditions who are homeless or at risk of homelessness.

- **What counts as housing supports?**
 - Rental assistance
 - Operating subsidies for housing units
 - Transitional housing
 - Certain supportive services to help stabilize housing
- **Key requirements:**
 - **50%** of this housing allocation must go to people experiencing chronic homelessness
 - **Up to 25%** can be used for capital costs (e.g., building or renovating housing)

Impact

This creates a significant and reliable funding stream - projected at about **\$950 million statewide by FY 2026–27** - dedicated to housing individuals with serious mental illness or substance use disorders.

FULL-SERVICE PARTNERSHIPS (35%)

Counties must dedicate 35% of MHSF dollars to Full-Service Partnership (FSP) programs. These programs follow a “whatever it takes” model of comprehensive care for people with the most complex behavioral health needs.

- **Who FSPs serve:**
 - Individuals with serious mental illness (SMI)
 - People experiencing homelessness
 - Frequent hospital or emergency service users
 - Individuals involved in the justice system

- **What FSPs provide:**
 - Clinical treatment and psychiatric care
 - Intensive case management
 - Benefits advocacy and support
 - Limited housing supports or subsidies

Why it matters:

This **35% set-aside** ensures counties expand evidence-based, wraparound programs for high-need clients with SMI and co-occurring disorders, strengthening the safety net for people who require the most intensive care.

CORE BEHAVIORAL HEALTH SERVICES AND SUPPORTS (35%)

The remaining **35% of county MHSF funds** support a broad range of behavioral health services, with a strong emphasis on prevention and early intervention.

- **Key focus:**
 - At least 51% of these funds must be directed to youth (age 25 and under) for early intervention services.
 - This requirement reflects California’s continued investment in upstream care—catching problems early before they escalate into crises.

- **Flexibility:**
 - Counties with populations under 200,000 may have some flexibility in meeting the exact percentages.
 - During the first two years of implementation, counties may request limited adjustments, shifting up to **7% between categories** (no more than **14% total**).

Why it matters:

This allocation balances the system, ensuring that while housing and intensive treatment are prioritized, counties still invest in prevention and youth-focused services to reduce long-term demand on the system.

Implications

The BHSA changes significantly reshape how counties **must invest behavioral health dollars, with a strong emphasis on housing and intensive services (FSPs) for people with serious mental illness (SMI).**

- **Shift in Priorities**
 - Counties are now required by law to dedicate **30% of funds to housing supports and 35% to Full-Service Partnerships (FSPs)**.
 - This marks a major change from earlier MHSA spending. For example, housing supports were previously optional and totaled about **\$286 million statewide in FY 2022–23**—now they represent a guaranteed statewide investment of nearly **\$1 billion annually by FY 2026–27**.
- **County Integrated Plans**
 - Counties must replace their former three-year MHSA plans with new County Integrated Plans, aligned with BHSA categories and outcome tracking requirements.
 - Each plan must be developed through a **Community Planning Process**, involving:
 - Local providers
 - Government agencies
 - Community-based organizations
 - Individuals with lived experience
- **Goal of the Reform**
 - Direct existing mental health dollars **to homeless or at-risk individuals with SMI or substance use disorders**.
 - Pair **stable housing** with **robust treatment and supports**, ensuring better long-term outcomes.
- **One-Time State Bond (Prop 1)**
 - Proposition 1 also authorized a **\$6.38 billion state bond** for behavioral health facilities and housing.
 - Funds will be distributed through programs like **BHCIP** (Behavioral Health Continuum Infrastructure Program) and **Homekey Plus**, supporting capital projects.



IV. CASE STUDY: 150-BED FACILITY COST STRUCTURE

To show how BHSa funding can support large-scale residential treatment, consider a 150-bed mental health residential facility (ARF), providing the highest level of care allowed under the ARF licensure (on-site, comprehensive wraparound services and programming), serving persons who have been homeless, institutionalized and/or incarcerated, who have multiple and complex conditions relating to their physical health, mental health, and substance abuse.

In this example estimated annual operating costs would be approximately \$16.5 million, or roughly **\$300 per bed, per night**.

- **Room & Board** – \$135/day
 - Covers rent or lease, insurance, operations and maintenance, meals, transportation, toiletries, clothing, security, and management overhead.
- **FSP-Level Clinical Support Services** – \$165/day
 - Includes staffing and treatment by psychiatrists, social workers, registered nurses, licensed vocational nurses, pharmacists, medication technicians, as well as pharmaceuticals.

HOW TO PAY FOR IT:

MHSA Community Services & Supports (CSS): ~\$5.5–6.5 million (33–39%)

- A large share of funding came from MHSA (now BHSa) dollars, specifically the CSS category, which included Full-Service Partnerships (FSPs).
- These funds supported:
 - Clinical staff and treatment services
 - Flexible “whatever-it-takes” supports for client needs
 - Peer support
 - Recovery-oriented services
- Essentially, CSS/FSP funds covered the **treatment and recovery services** that paired with housing supports.





Behavioral Health Bridge Housing (BHBH) Grant: ~\$2.5–3 million (15–18%)

- A **state one-time grant** designed to expand short-term housing for people experiencing homelessness with behavioral health needs.
- In the pro forma, BHBH dollars were used to help pay for:
 - Rent and facility operating expenses
 - Supportive services tied to housing stability

While helpful in closing the funding gap, BHBH is **temporary** - funding is only authorized through 2026, making it an *unsustainable long-term solution*.

County General Fund / Philanthropy / Other: ~\$0.5–1 million (3–6%)

- The final gap in the financing plan was assumed to come from a mix of:
 - County general funds (local discretionary revenue)
 - Philanthropic grants
 - Partnerships with hospitals or federally qualified health centers (FQHCs)
 - No Place Like Home (NPLH) operating subsidies
- These sources function as **gap-fillers**, covering costs not addressed by dedicated state funding streams.
- Counties are generally **reluctant to rely on general funds** for behavioral health housing, since local dollars are scarce and cannot sustainably support ongoing operating costs.

Contextualizing Costs

An annual cost of \$16.5 million for 150 beds underscores the intensity of resources required to stably house and treat chronically homeless individuals with serious mental illness (SMI). At roughly \$300 per person per day, this model goes far beyond basic shelter - it also includes:

- Comprehensive mental health treatment
- Intensive case management
- A safe and supportive living environment

Why \$300/day is reasonable

At first glance, \$300 per day may seem high, however the alternatives are both more expensive and less effective:

- **Jail or acute hospital stays** cost significantly more per bed (with worse health outcomes), especially when individuals no longer need high-acuity care but cannot be discharged because of a lack of step-down housing options.
- **Street homelessness** often leads to repeated and costly emergency room visits, psychiatric hospitalizations, and justice system involvement.

Long-term benefits

Integrated housing-treatment facilities are cost-effective over time because they:

- Reduce emergency department use
- Prevent psychiatric hospital readmissions
- Lower incarceration rates

V. Why BHSA matters

The pro forma's reliance on multiple temporary and local funding sources highlights why BHSA's dedicated allocations are critical.

Pre-BHSA: Counties patched together one-time grants (like BHBH), Realignment, MHSA CSS, and local general funds—often without long-term stability.

Post-BHSA: Counties now have ongoing state funding earmarked for housing and Full-Service Partnership (FSP) services, making it far more feasible to operate intensive residential programs like this 150-bed facility on a sustainable basis.

Leveraging BHSA: Replacing One-Time Funds with Housing & FSP Dollars

The Behavioral Health Services Act (BHSA) gives counties a new opportunity to replace unstable or one-time funds with dedicated Mental Health Services Fund (MHSF) dollars.

By targeting housing supports and Full-Service Partnerships (FSPs), counties now have sustainable financing structures for high-intensity programs, like the one depicted in the Alamo Health Management model with counties **substituting Prop 1 funds for several of the original funding sources** as summarized below:

Pre-BHSA vs. Post-BHSA Funding for a 150-Bed Facility

Original Funding Source	Annual Amount (Example)	Prop 1 Replacement Fund	Role of Prop 1 Funds
1991 Realignment (Mental Health)	\$6.5–7M (≈40%)	Retain Realignment (no change)	Continue covering core non-Medi-Cal costs (operations, IMDs, basic care, room & board). Realignment remains the flexible base funding.
MHSA (CSS) – e.g., FSP Services	\$5.5–6.5M (≈35%)	BHSA – Full-Service Partnerships (35%)	Covers intensive clinical services and wraparound supports formerly funded by MHSA/CSS: psychiatric staff, case management, peer support, “whatever-it-takes” client support.
State Bridge Housing (BHBH)	\$2.5–3M (≈15%)	BHSA – Housing Supports (30%)	Replaces expiring bridge housing grants with a permanent housing carve-out. Can fund rent subsidies, operating costs, and housing-related services, ensuring stability once BHBH sunsets in 2026.
Local Gap Funding (County General Fund, philanthropy, private grants)	\$0.5–1M (≈5%)	BHSA – Housing or FSP (as eligible)	Reduces or eliminates reliance on local gap-fillers. Prop 1 dollars can be flexibly applied to either housing costs or service enhancements, lessening the burden on counties and donors.
NPLH Operating Subsidy (if applicable)	\$0.5M (≈3%)	BHSA – Housing Supports (30%)	If absent, Prop 1 housing funds can backfill operating subsidies for units serving chronically homeless SMI individuals. If present, Prop 1 funds add to NPLH, creating more stability.

USING HOUSING VS. FSP ALLOCATIONS

Under Prop 1, county finance teams - working with community stakeholders - must determine what portion of a project's costs count as housing supports versus service/FSP costs. While these costs are often intertwined in practice, Prop 1's framework encourages thinking in these two buckets:

Housing (30% allocation):

- Eligible costs include rent, utilities, property management, and basic living supports.
- Funds can also cover a wide range of housing needs such as:
 - Master leasing
 - Shared housing
 - Temporary housing
 - Long-term housing subsidies

Full-Service Partnerships (35% allocation):

- Covers intensive, client-centered services for residents enrolled in FSPs, such as:
 - Clinical staff salaries
 - Case management
 - Rehabilitation and recovery groups
 - "Whatever-it-takes" personal services

Realignment (as needed):

- Any costs that don't fit neatly into either housing or FSP categories (e.g., certain non-Medi-Cal expenses) can continue to be funded through **1991 Realignment** as a flexible backstop.

Why this matters:

Prop 1 allows counties to **maximize flexibility** by drawing from the most appropriate category for each expense. The result is a **more stable funding model**: ongoing BHSA revenues—though variable year to year—can reliably support both housing and services, dramatically reducing reliance on unpredictable grants or county general funds.





BRAIDING OTHER NON-BHSA FUNDING: MANAGED MEDI-CAL, CALAIM, AND BH-CONNECT

Counties can **further leverage resources** by collaborating with **Medi-Cal managed care plans (MCPs)**, tapping into the “medical side” of funding for individuals who are dual beneficiaries of medical and behavioral health services.

- **Transitional Rent Benefits:**
 - Individuals receiving BHSA-supported services may also qualify for 6 months of rental subsidy, with the federal government covering 50% of the cost.
- **Community Supports:**
 - Additional benefits can include move-in assistance, tenancy support, and other services that help stabilize housing and maintain treatment engagement.
- **CalAIM and BH-Connect:**
 - Portions of FSP services may qualify for **Federal Financial Participation (FFP)**, allowing **federal funding to cover part of the expenses** for intensive behavioral health services.

Why this matters:

By braiding BHSA funding with Medi-Cal resources, counties can:

- Stretch BHSA dollars further
- Reduce reliance on local or one-time funding
- Maximize support for residents in integrated housing-treatment programs

This approach creates a **more sustainable, multi-source financing** model for high-need populations, ensuring that both housing and clinical services are consistently funded.

VI. Recommendations for Implementation of BHSA Funds

(Fiscal Years 2025-26 & 2026-27)

To effectively deploy Behavioral Health Services Act (BHSA) funds beginning FY 2026, counties are encouraged to begin planning and coordination **now**. The following recommendations provide guidance for county leadership and contracting providers involved in implementation planning:

1. ALIGN AND UPDATE COUNTY PLANS

- **Proactive Integrated Planning:** Counties are encouraged to begin **now** the work required under BHSA for FY 2026. This includes creating comprehensive Integrated Plans that clearly articulate how BHSA funds will be allocated, ensuring alignment with proportional spend requirements established under BHSA reforms.
- **Stakeholder Engagement:** Meaningful involvement of community stakeholders - particularly providers - is critical to ensure that planning reflects local needs and practical service delivery considerations.
- **Fiscal Braiding:** Counties should develop explicit strategies for **coordinating BHSA funds with County Realignment and leveraged Medi-Cal managed care resources**. This approach enables a holistic response that addresses both clinical and housing needs for the target populations.
- **Multi-Section Integration:** The fiscal braiding strategy can be included in multiple sections of the BHSA Integrated Plan, demonstrating compliance with all three spending categories and supporting transparency in funding allocation.

Key Outcome: Early, inclusive, and strategic planning ensures that counties are ready to deploy BHSA funds efficiently in FY 2026 while meeting regulatory and community needs.

2. COORDINATE WITH DHCS AND STATE PARTNERS

- **Engage Early and Continuously:** BHSA implementation will introduce new state guidelines, reporting forms, and oversight requirements. County leaders should remain closely engaged with the **Department of Health Care Services (DHCS)** and the **State Oversight & Accountability Commission (OAC)** as details are released.
- **Participate in State Learning Opportunities:** Attend DHCS workshops, webinars, and technical assistance sessions to stay informed on evolving requirements and best practices.
- **Leverage Planning Funds:** Utilize the **\$85 million in state funds set aside for county planning** (appropriated in the FY 2024 Budget Act) to support critical preparatory activities such as hiring planners or consultants, training staff, and upgrading data systems to track housing and Full-Service Partnership (FSP) outcomes.
- **Clarify Guidance and Compliance:** Since BHSA represents a major reform, guidance may evolve during implementation. Maintaining open communication with state officials helps ensure counties interpret allowable uses correctly (e.g., what qualifies as a “housing support” expense, or how to document FSP enrollment).
- **Coordinate Fund Allocations:** Confirm anticipated Mental Health Services Fund (MHSF) distributions under the new formula. Early awareness of projected allocations - such as housing-designated funding for FY 26-27 - supports accurate budgeting, contract negotiations, and program scaling.

Key Outcome: Active coordination with DHCS and other state partners ensures counties maximize planning resources, stay compliant with evolving requirements, and align funding allocations with local program needs.

3. BUDGET FOR FACILITIES WITH THE NEW FUND MIX

- **Integrate BHSA Funding Streams into Project Financing:**
 - For new facilities, counties should create a blended funding plan that incorporates each of the three BHSA funding categories, County Realignment contributions, and Medi-Cal managed care resources.
 - Additional gaps may be filled using Realignment or BHSA funds, with philanthropy as a potential - but less consistent - supplemental source.
 - Example: For a 150-bed facility, portions of each funding stream are allocated upfront, ensuring comprehensive coverage of both capital and operational needs.
- **Maintain Realignment Transparency and Plan for Cash Flow:**
 - Ensure that Realignment funds remain budgeted at current levels, clearly labeled in budgets as “County Mental Health (Realignment) Contribution” to signal that BHSA funds are not replacing existing allocations.
 - Plan for cash flow challenges: MHSAs revenues are received quarterly, so counties may need to use reserves or Realignment funds temporarily. Private partners may also provide short-term financing with formal agreements.
 - Blended budgeting institutionalizes Prop 1 funding into base operations for homelessness programs from Day 1 of implementation.
- **Leverage Complementary Funding to Maximize Impact:**
 - Combine BHSA streams with state bond funds for capital development, such as the Behavioral Health Continuum Infrastructure Program (BHCIP) and Homekey Plus grants, to support facility acquisition or construction.
 - Use MHSF dollars to fund ongoing operations, creating a sustainable model that covers both capital and programmatic needs.
 - Coordinate with housing authorities to access federal housing vouchers or subsidies, using BHSA housing funds to fill service gaps not covered by those programs.

Key Outcome: By strategically blending funding sources, counties can maximize resources, ensure operational sustainability, and accelerate the creation of new housing capacity for behavioral health populations.





4. MAINTAIN AND LEVERAGE OTHER FUNDING

- **Continue Existing Funding Streams:**
 - Counties should continue to utilize programs such as **No Place Like Home (NPLH) funds, HUD Continuum of Care grants**, and other existing homeless program funding alongside BHSA resources.
 - The state encourages fund braiding to improve service outcomes and maximize impact.
- **Coordinate Complementary Services:**
 - Example: Use a federal grant to provide on-site employment services at a 150-bed facility, while FSP funds cover mental health services.
 - By strategically coordinating multiple funding sources, counties can **extend the reach of BHSA dollars**, serve more people, and avoid duplication of services.

Key Outcome: Maintaining and leveraging existing funding alongside BHSA ensures a comprehensive, coordinated approach to housing and behavioral health services, maximizing efficiency and impact for target populations.

5. IMPLEMENT PROGRAMS AND OVERSIGHT MECHANISMS

- **Develop Programmatic Infrastructure:**
 - Ensure counties have the operational capacity to deploy BHSA funds effectively. For the **housing component**, this may involve expanding housing unit inventory or partnering with housing nonprofits to operate **master-leased units**.
- Identify projects that will utilize the **30% housing allocation**, such as:
 - Converting motels to supported housing
 - Adding beds at board-and-care homes
 - Augmenting rent subsidies for FSP clients
 - Begin procurement or development processes in advance so that funds can be **fully deployed on Day 1 of FY 2026**.
- **Scale Up Full-Service Partnerships (FSPs):**
 - Train existing FSP teams to serve **new clients referred from homelessness service providers**.
 - Consider creating specialized FSP teams focused on **homeless outreach and residential facilities**.
 - For services administered through provider partners, ensure staff receive **adequate training, funding, and technical support** to deliver high-quality care.

- **Integrate Housing and Services:**

- FSPs are the vehicle for delivering mental health and supportive services, so their capacity must **grow in parallel with housing expansions** to ensure comprehensive, coordinated care.

Key Outcome: By establishing robust programmatic and oversight mechanisms, counties can ensure timely, effective deployment of BHSA funds, seamlessly integrating housing and FSP services to serve target populations.

6. CLOSELY MONITOR OUTCOMES AND EXPENDITURES

- **Establish Enhanced Accountability Measures:**

- BHSA requires robust reporting on **housing outcomes, duration of placement, health improvements, and expenditure tracking**, along with adherence to new audit requirements.
- Develop **internal dashboards** to track key metrics, such as:
 - Occupancy rates for facilities (e.g., a 150-bed facility)
 - Hospitalizations or crisis interventions before and after placement
 - Dollars spent per funding category

- Use Data to Inform Adjustments:

- Regularly review metrics to optimize program performance:
 - If housing funds are under-utilized, reallocate to additional rental assistance.
 - If FSP funds are insufficient, consider reallocating a portion of the **“behavioral health services” 35% funds**, where permitted.
- Demonstrate Positive Outcomes:
 - Track stable housing, reduced crisis utilization, and other measurable impacts.
 - Reporting strong outcomes helps build public and political support, reinforcing the sustainability and potential expansion of Prop 1-funded programs.

Key Outcome: Continuous monitoring ensures fiscal responsibility, supports compliance with BHSA accountability requirements, and enables counties to adjust programs dynamically for maximum impact.



VII. CONCLUSION

The **Behavioral Health Services Act (BHSA)** marks a pivotal step in California's efforts to stabilize and expand behavioral health services, particularly for individuals experiencing homelessness with serious mental illness. By establishing clear, ongoing allocations for housing supports and Full-Service Partnerships (FSPs), the BHSA removes the uncertainty of one-time or discretionary funding and provides counties with a durable framework to build and sustain high-impact programs.

The case study presented in this Policy White Paper demonstrates that even resource-intensive service models are now feasible under the BHSA when combined with Medi-Cal and existing County Realignment funding. Counties that act promptly to integrate BHSA allocations into their budgets, update County Integrated Plans, and braid complementary funding streams will be best positioned to deliver on the law's intent: **stable housing, comprehensive care, and measurable outcomes** for the state's most vulnerable residents.

In short, **Proposition 1** and the **BHSA provide California with a predictable, scalable path to serve under-served populations**. Counties and their provider partners now have both the mandate and the means to align housing and behavioral health care—turning policy into programs, and programs into lasting change.

For further information, please reach out to CBHA at info@calbha.org and visit our website at www.calbha.org.