



CSAC Legislative Conference  
Workshop Panel  
Wednesday, April 17, 2024; 1:00 PM – 2:30 PM  
SAFE Credit Union Convention Center, Classrooms 9-10-11  
1401 K St, Sacramento, CA 95814

## **PROPOSITION 1: WHAT COUNTIES SHOULD EXPECT AND PLAN FOR**

**Issue Overview.** [Proposition 1](#) appeared on the March 5 statewide primary election ballot as a legislatively referred state statute consisting of two main components providing for statutory changes to reform the state’s behavioral health system and create more supportive housing and behavioral health treatment resources. On April 12, 2024, the California Secretary of State [certified](#) the passage of Proposition 1 by the voters.

In October 2023, Governor Newsom signed into law both [Assembly Bill \(AB\) 531](#) and [Senate Bill \(SB\) 326](#). Specified sections of AB 531, the Behavioral Health Infrastructure Bond Act of 2024, and SB 326, the Behavioral Health Services Act, were submitted to the voters as a single measure designated as Proposition 1, which:

- 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.

The passage of Proposition 1 is just the beginning of a multi-year process of intensive planning, as well as stakeholder engagement at the state and local level, to fully implement these significant reforms in the best interests of California’s most vulnerable populations while preserving core services. In fact, counties have already initiated evaluation and planning efforts.

CSAC and our member counties stand ready to work collaboratively with the Administration and other stakeholders in the development of various standards and metrics, evaluation of needed resources, and development of recommended solutions to reduce the Behavioral Health Services Fund’s revenue volatility to better support the sustainability of county programs. Counties are committed to fully implementing these reforms to bring about the needed changes to improve the behavioral health system and reach our shared goals of a comprehensive continuum of care through the development of a thoughtful, robust, and sustainable system that best supports all Californians.



No one disputes that the need for urgency is great. With the acknowledgement that transformational change and infrastructure expansion takes time, counties are seeking a process and distribution of the resources authorized under Proposition 1 for county administration and the critically needed behavioral health infrastructure and permanent supportive housing be undertaken as swiftly and expediently as possible. It will be crucial to expedite these funding allocations to ensure the intended impacts of these significant efforts are realized.

**Speakers.** We have invited the following representatives from the Administration to provide an outline of the major provisions of Proposition 1, as well as an update on upcoming planning activities and implementation timelines, including next steps:

- **Stephanie Welch**, Deputy Secretary of Behavioral Health, California Health and Human Services Agency
  - **Marlies Perez**, Division Chief, Department of Health Care Services (DHCS)
  - **Jennifer Seeger**, Deputy Director, Division of State Financial Assistance, California Department of Housing and Community Development (HCD)
  - **Roberto Herrera**, Deputy Secretary, Veterans Services Division, California Department of Veterans Affairs (CalVet)
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### 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.
  - Specifies the Department of Housing and Community Development (HCD), in coordination with the California Department of Veterans Affairs (CalVet) for the grants for veterans, shall determine the methodology and distribution of the funds.
- **\$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

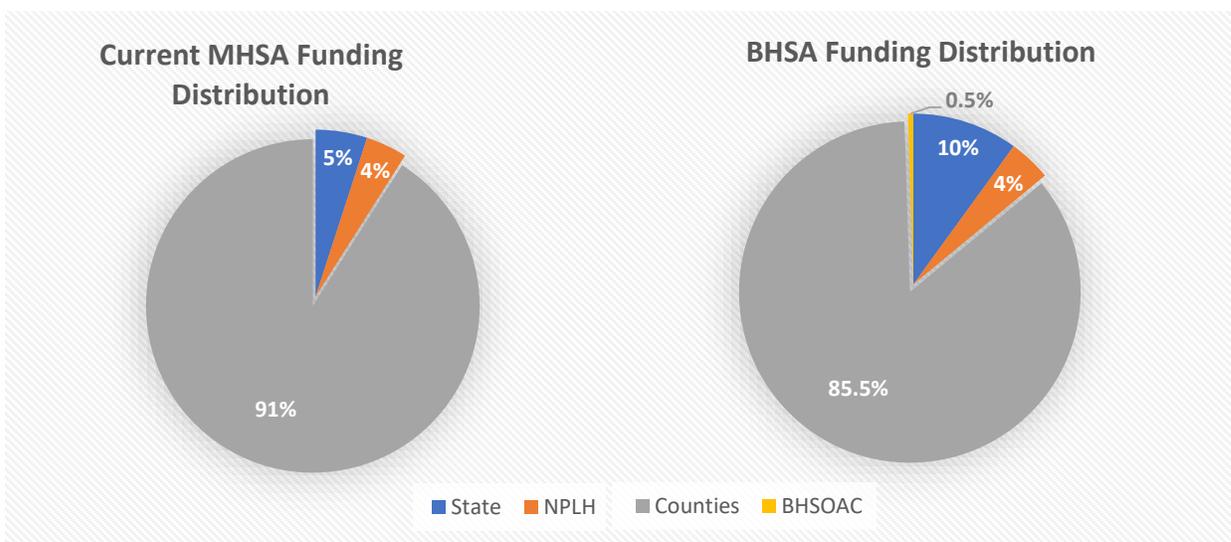


assets or to invest in needed infrastructure to expand the continuum of BH treatment resources to build new capacity or expand existing capacity for short-term crisis stabilization, acute and subacute care, crisis residential, community-based mental health residential, SUD residential, peer respite, 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 MHSAs and makes other statutory changes to update the state’s behavioral health system:

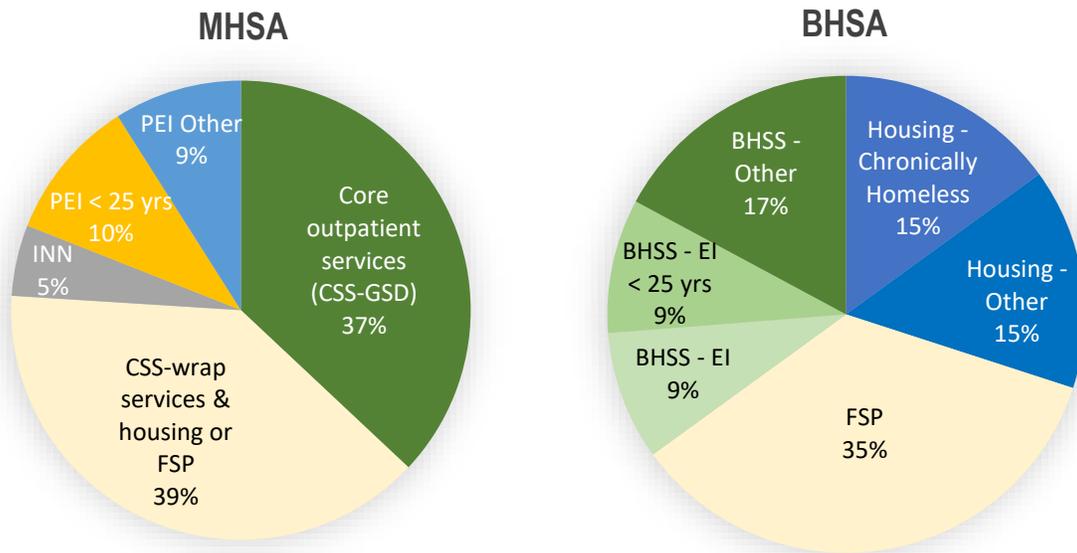
- Recasts/renames the MHSAs as the Behavioral Health Services Act (BHSA) and makes numerous amendments to the MHSAs (Proposition 63, 2004), which must be placed on the ballot as a voter-approved initiative, and other statutory changes. Changes are effective January 1, 2025, unless otherwise specified.
- 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 MHSAs 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.



### Housing Interventions (30%) - continued

- 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 BHSAs 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 BHSAs 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 BHSAs 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 BHSAs 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 BHSAs.



## 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 BHSA 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.
- Fiscal provisions for counties (continued):
  - 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 BHSOAC.
  - 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 BHSOAC 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 BHSOAC reporting requirements.
    - The degree to which the inclusion of SUD, SUD treatment services, and SUD personnel into the BHSOAC 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     |



## Summary of Small County Exemptions and Special Considerations (continued)

- **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 BHTA funds 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, BHTA funds 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 MHTA, 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 MHTSOAC 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



## Summary of Small County Exemptions and Special Considerations (continued)

- 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 MHSA was 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 BHSA 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 BHSA 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 BHSA 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 BHSA 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, the first eight counties have launched implementation of the Community Assistance, Recovery and Empowerment (CARE) Act, with full statewide implementation of this new program across all 58 counties 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 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, counties, plans, providers, and community partners 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.



With the passage of Proposition 1, CSAC and our member counties are committed to working collaboratively with the Administration and other stakeholders to fully implement these reforms to bring about the needed changes to improve the behavioral health system and reach our shared goals of a comprehensive continuum of care through the development of a thoughtful, robust, and sustainable system that best supports all Californians.

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