Department of Health Care Services

# Behavioral Health Services Act County Policy Manual

February 2025

FINAL

# 1. Policy Manual Introduction

This policy manual provides counties and two city-operated mental health authorities with guidance necessary to implement Behavioral Health Transformation (BHT),[1] a package of behavioral health policy reforms enacted by California voters through Proposition 1 (2024) and will take effect according to statutory timelines. Counties, providers, and other behavioral health stakeholders will find information on county planning, reporting, and fiscal requirements in this policy manual. The manual also contains information about the Behavioral Health Services Act (BHSA) service and program implementation requirements. Per Welfare and Institutions Code section 5963.05, DHCS has the authority to implement, interpret, or make specific amendments to the Behavioral Health Transformation through county letters, information notices, plan or provider bulletins, and other similar instructions, including this manual. The guidance in this manual will serve as regulations. Throughout the manual, there are footnote references to relevant Department of Health Care Services webpages, Behavioral Health Information Notices, the Welfare & Institutions Code, and the California Code of Regulations for more information. The policy manual will be updated on a continual basis and will include a summary of changes between each version.

[1]1 W&I Code § 5963.05, subdivision (a)

# 2. Behavioral Health Transformation

## A. Introduction to Behavioral Health Transformation

In recent years, California has undertaken historic efforts to re-envision the state's publicly funded mental health and substance use disorder (SUD) services, with a special focus on county-administered specialty mental health and substance use disorder services. In March 2024, voters approved Proposition 1 to reform the Mental Health Services Act (MHSA) and fund needed behavioral health facility infrastructure through a general obligation bond. The efforts to implement Proposition 1 are referred to as Behavioral Health Transformation (BHT).

The primary goals of BHT are to improve access to care, increase accountability and transparency for publicly funded, county-administered behavioral health services, and expand the capacity of behavioral health care facilities across California. Under BHT, county reporting will be uniform to allow for comprehensive and transparent reporting of the Behavioral Health Services Act (BHSA) funding in relation to all public local, state, and federal behavioral health funding.

BHT builds upon and aligns with other major behavioral health initiatives in California including the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT) initiative, the Children and Youth Behavioral Health Initiative (CYBHI), Medi-Cal Mobile Crisis services, the Behavioral Health Bridge Housing program, the Community Assistance, Recovery, and Empowerment (CARE) Act, Lanterman-Petris-Short Conservatorship reforms, 988 expansion, and the Behavioral Health Continuum Infrastructure Program (BHCIP).

California continues to face behavioral health challenges impacted by many factors, including but not limited to the lack of affordable housing and increasing homelessness,[1] the behavioral health workforce shortage,[2] a youth mental health crisis,[3]

[1] California Budget and Policy Center. "The Rise of Homelessness Among California's Older Adults."(May 2024).
[2] Cal Matters. "Mental health workers: Why California faces a shortage." (September 2022).
[3] Xiang, A., Martinez, M., & Chow, T. "Depression and anxiety among US children and young adults." *Journal of American Medical Association Open*." (2024).

an older adult mental health crisis,[4] and a shortage of culturally-responsive and diverse care.[5] Many of these challenges make it difficult for individuals to navigate California's behavioral health care delivery systems and access services at the right time and in the right place. For example, 2022 survey research suggests that 23.5 percent of adult Californians across all payers living with a mental illness reported they did not receive the treatment they needed.[6]

## A.1 Bond

In addition to reforming the MHSA, Proposition 1 includes the Behavioral Health Infrastructure Bond Act of 2023. This bond authorizes $6.38 billion to build new behavioral health treatment beds and supportive housing units to help serve more than 100,000 people annually. This investment creates new, dedicated housing for people experiencing or at risk of homelessness who have behavioral health needs, with a dedicated investment to serve veterans. These settings will provide Californians experiencing behavioral health conditions with places to stay while safely stabilizing, healing, and receiving ongoing support.

- Department of Health Care Services (DHCS) will administer $4.4 billion of these funds to provide grants to public and private entities for behavioral health treatment and residential settings. $1.5 billion of the funds administered by DHCS will be awarded only to counties, cities, and tribal entities (with $30 million set aside for tribes).
- The California Department of Housing and Community Development (HCD) will administer up to $2 billion to support permanent supportive housing for individuals, including veterans, at risk of or experiencing homelessness and behavioral health challenges.

[4] UCLA Health. "California must build workforce to serve older adults' behavioral health needs, UCLA report says." (January 2019).
[5] Kaiser Family Foundation."Racial and Ethnic Disparities in Mental Health Care: Findings from the KFF Survey of Racism, Discrimination and Health." (May 2024).
[6] Mental Health America. "The State of Mental Health in America." (2022).

## A.2 Behavioral Health Continuum Infrastructure Program

In 2021, DHCS was authorized to establish the Behavioral Health Continuum Infrastructure Program (BHCIP) and award $2.1 billion in funding to construct, acquire, and expand properties and invest in mobile crisis infrastructure related to behavioral health. DHCS has been releasing these funds through multiple grant rounds targeting various gaps in the state's behavioral health facility infrastructure.

The Behavioral Health Bond Act of 2023 leverages the success of BHCIP and authorizes DHCS to award up to $4.4 billion for BHCIP competitive grants.[7] Please refer to the BHCIP webpage for the latest information.

# B. Overview of the Behavioral Health Services Act

## B.1 Behavioral Health Services Act Goals

The Behavioral Health Services Act (BHSA) is the first major structural reform of the Mental Health Services Act (MHSA) since it was passed in 2004. The MHSA imposed a 1 percent tax on personal income over $1 million. Counties and two city-operated mental health authorities receive these funds monthly to provide community-based mental health services. The MHSA was designed to serve individuals with serious mental illness (SMI) and individuals that may be at risk of developing serious mental health conditions.[8] The MHSA created a broad continuum of prevention, early intervention, innovative programs, services, and infrastructure, technology, and training elements. MHSA has been a crucial resource to increase access to mental health services for all eligible populations.

The reforms within the BHSA expand the types of behavioral health supports available to Californians who are eligible for services and are in need by focusing on historical gaps and emerging policy priorities. The key opportunities for transformational change within the BHSA include:

1. **Reaching and Serving High Need Priority Populations**

[7] BHCIP Request for Applications
[8] W&I Code § 5600.3

- Restructures funding allocations for the BHSA program components by focusing allocations on the areas of most significant need among Californians, including individuals across the lifespan at risk of or experiencing justice and system involvement, homelessness, and institutionalization.
- Prioritizes early intervention, especially for children and families, youth, and young adults, to provide early linkage to services and prevent mental health conditions, co-occurring disorders, and substance use disorders from becoming severe and/or disabling.
- Prioritizes serving individuals experiencing homelessness or at risk of homelessness, especially individuals and families experiencing long-term homelessness. The BHSA dedicates revenue for counties to assist those with severe behavioral health needs to be housed and provides a path to long-term recovery, including one-time and allowable ongoing capital to build more housing options.
- Updates Full Service Partnerships (FSP) requirements to better serve individuals with the most significant needs by requiring FSP programs to include specified, evidence-based delivery models, community-defined evidence practices, and standardized levels of care.
- Aligns with initiatives aimed at improving care for Medi-Cal members living with significant behavioral health needs such as the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT) initiative, the Children and Youth Behavioral Health Initiative (CYBHI), Medi-Cal Mobile Crisis Services, the Behavioral Health Bridge Housing program, the Community Assistance, Recovery, and Empowerment (CARE) Act, Lanterman-Petris-Short Conservatorship reforms, 988 expansion, and the Behavioral Health Continuum Infrastructure Program (BHCIP).

2. **Increasing Access to Substance Use Disorder Services, Housing Interventions, and Evidence-Based and Community-Defined Practices, and Building the Behavioral Health Workforce**

- Expands the categories of services that may be funded with BHSA dollars to include treatment for substance use disorders, regardless of the presence of a co-occurring mental health condition.
- Provides ongoing funding for counties to assist people living with significant mental health conditions, substance use disorder needs and co-occurring behavioral health needs with housing and provides a path to long-term recovery, including one-time and allowable ongoing capital to build more housing options.
- Increases investments in the behavioral health workforce including efforts to support more culturally, linguistically, and age-appropriate care by building a more representative workforce.
- Requires implementation of specified evidence-based and community-defined evidence practices to improve outcomes for youth and adults with complex behavioral health conditions.

**3. Focusing on Outcomes, Transparency, Accountability, and Equity**

- Requires counties to complete a county Integrated Plan for behavioral health services and outcomes, which will include information on all local behavioral health funding and services, including Medi-Cal and non-Medi-Cal specialty behavioral health programs and funding streams.
- Requires counties to complete an annual county Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) to provide public visibility into county spending, disparities, and results.
- Utilizes data through the lens of health equity to identify racial, ethnic, age, gender, and other demographic disparities and inform disparity reduction efforts.
- County BHSA programs must include culturally responsive and linguistically appropriate interventions. These interventions must be able to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health and substance use disorder treatment services access, quality, and outcomes.

## B.2 Timeline for Implementation

**Table B.2.1. Timeline for Implementation**

| Requirement | Effective Date |
|---|---|
| County Board of Supervisors Approve Fiscal Year (FY) 2026-2029 County Integrated Plan | June 30, 2026 |
| Counties Submit FY 2026-2029 County Integrated Plan to the Department of Health Care Services for Review and Approval | No later than June 30, 2026 |
| County Integrated Plans Are Effective | July 1, 2026 |
| County Board of Supervisors Approve FY 2027-2028 County Annual Update | June 30, 2027 |
| Submit Draft FY 2026-2027 County Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) | January 30, 2028 |
| Submit Final FY 2026-2027 County Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) | January 30, 2029 |

## B.3 Eligible Populations

Eligible populations are those that may receive services funded by the Behavioral Health Services Act (BHSA) and include children and youth, adults, and older adults who meet BHSA eligibility criteria.

Eligibility criteria for BHSA services are aligned with Medi-Cal specialty mental health services (SMHS) access criteria,[9] and include individuals with substance use disorders as described below. However, it is important to note that BHSA eligible populations are not required to be enrolled in the Medi-Cal program.[10]

[9] BHIN 21-073
[10] W&I Code § 5892, subdivision (k)

Eligible children and youth means persons who are 25 years of age or under who meet either of the following:

- Meet SMHS access criteria specified in subdivision (d) of W&I Code section 14184.402 and implemented in SMHS guidance[11] (includes individuals 21-25 years of age who meet this criteria) OR
- Have at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders.[12]

Eligible adults and older adults means persons who are 26 years of age or older who meet either of the following:

- Meet SMHS access criteria specified in W&I Code section 14184.402, subdivision (c) and implemented in DHCS guidance[13] (only applies to individuals 26 years of age and older) OR
- Have at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders.[14]

**Priority Populations**

In addition to defining the populations eligible for services, the BHSA also requires counties to prioritize BHSA services for the populations listed below.[15] While counties must prioritize BHSA services for the priority populations listed below, access to BHSA services is not limited to these priority populations. At-risk populations should be identified by counties based on local need and local planning processes, except for the

[11] BHIN 21-073
[12] W&I Code § 5891.5, subdivision (c)
[13] BHIN 21-073
[14] W&I Code § 5891.5, subdivision (c)
[15] W&I Code §5892, subdivision (d)

criteria for at-risk of homelessness which can be found in the Housing Interventions chapter and below.

Eligible children and youth who satisfy one of the following:

- Are chronically homeless or experiencing homelessness or at risk of homelessness[16]
- Are in, or at risk of being in, the juvenile justice system[17]
- Are reentering the community from a youth correctional facility
- Are in the child welfare system pursuant to W&I Code sections 300, 601, or 602
- Are at risk of institutionalization[18]

Eligible adults and older adults who satisfy one of the following:

- Are chronically homeless or experiencing homelessness or at risk of homelessness[19]
- Are in, or at risk of being in, the justice system
- Are reentering the community from state prison or county jail
- Are at risk of conservatorship[20]
- Are at risk of institutionalization[21]

For additional information about criteria or priority populations for Full Service Partnerships and Housing Interventions, including the definition for "chronically homeless", please refer to the corresponding sections within this manual.

[16] Additional information and definitions should be referenced in the Housing chapter below. Chapter 7.C.
[17] BHIN-21-073
[18] The DHCS ECM Guide defines institutionalization as "broad and means any type of inpatient, Skilled Nursing Facility, long-term, or emergency department setting."
[19] Additional information and definitions should be referenced in the Housing chapter below. Chapter 7.C.
[20] W&I Code § 5350
[21] The DHCS ECM Guide defines institutionalization as "broad and means any type of inpatient, Skilled Nursing Facility, long-term, or emergency department setting."

# C. Statewide Vision for Behavioral Health Quality and Equity

The state is committed to boldly taking action to provide Californians with quality, culturally responsive behavioral health services when, how, and where they need them.[22]It will take cross-system collaboration and partnership across service delivery systems to address the statewide behavioral health goals discussed in this Policy Manual. DHCS, county behavioral health, Medi-Cal Managed Care Plans (MCPs), commercial plans, commercial plan regulators, and other key delivery system partners such as child welfare, public health, schools and others will share responsibility for improving the well-being of Californians in need of behavioral health services.

## C.1 A Population Health Approach to Behavioral Health

The Behavioral Health Transformation presents a historic opportunity to transform behavioral health service delivery by:

- Taking a population health approach to align expectations across California's behavioral health delivery system.
- Establishing a vision for quality and equity and setting statewide goals to drive progress across the behavioral health delivery system.
- Using data to support continuous quality improvement.

A population health[23] approach aims to address these gaps in access to care and connect individuals to the right services, in the right place, and at the right time.

A population health approach for the behavioral health delivery system[24]:

[22] California Health and Human Services. "Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts." (March 2023).

[23] Population health is defined as the health of all individuals in a defined group, and the interdisciplinary, cross-sector approach that brings health-related resources together with medical care to achieve positive health outcomes for a defined group. This definition is derived from the American Journal of Public Health's article, "What is Population Health?".

[24] The population health approach for behavioral health is adapted from the population health strategy for DHCS' Population Health Management.

- Considers the entire population eligible for public behavioral health services, not just those currently receiving behavioral health services and those seeking care (shown in Figure 2.C.3).
- Deploys whole-person care[25] interventions, including addressing social drivers of health, which are the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning and quality of life outcomes and risk factors.[26]
- Coordinates across service delivery systems, including cross-system collaboration and partnership across county behavioral health, Medi-Cal MCPs, commercial plans, commercial regulators, public health, and other key service delivery partners.
- Uses data to:
    - Identify underserved and unserved population groups for targeted interventions.
    - Improve quality[27] across the behavioral health care continuum.
    - Monitor effectiveness of interventions across populations.
    - Support continuous improvement.
    - Identify and track racial and ethnic disparities[28] in behavioral health outcomes.

[25] Whole-person care is an approach that coordinates physical, behavioral, and social services in a patient-centered manner to address needs comprehensively and improve the overall health and wellbeing of individuals. This definition is derived from DHCS' Whole Person Care Pilots.
[26] SDOH definition is derived from the DHCS Population Health Management Policy Guide.
[27] The Agency for Healthcare Research and Quality (AHRQ) defines "quality [in healthcare]" as "providing the right care at the right time in the right way for the right person and having the best results possible": Best Practices in Public Reporting No. 2: Maximizing Consumer Understanding of Public Comparative Quality Reports: Effective Use of Explanatory Information.
[28] "Disparities" is defined as the preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes that are experienced by underserved populations. Source: Center for Medicare and Medicaid Services, adapted from CDC.


**Figure 2.C.3. Population Health Approach to Behavioral Health Quality and Equity**

Like the Population Health Management (PHM) Program[29] for Medi-Cal MCPs implemented in January 2023, a population health approach to behavioral health will reorganize and strengthen existing contract requirements, particularly requirements related to collaboration across the delivery system,[30] and is targeted to the delivery system that DHCS oversees.

DHCS will work to align priorities and desired outcomes across the behavioral health delivery system, payers (e.g., Medi-Cal MCP Non-Specialty Mental Health Services (NSMHS) and Medi-Cal Specialty Mental Health Services (SMHS)), initiatives and funding

[29] DHCS' Population Health Management (PHM) Program is a cornerstone of CalAIM.
[30] See for example the Memorandum of Understanding between [Medi-Cal Managed Care Plan] and [Mental Health Plan] template

sources (e.g., BHSA,[31] BH-CONNECT, and Realignment and Block Grants), while still allowing for initiative-specific goals.

As outlined in W&I Code section 5963.02, subdivision (c)(3)(A), each county shall develop an Integrated Plan (IP) and annual update (AU) aligned with statewide behavioral health goals and their associated measures. DHCS will begin by defining statewide population behavioral health goals to define the improvements that counties and the state should be working towards together across the behavioral health delivery system. Measures associated with these goals will be developed in phases.

Phase 1 will use population-level behavioral health measures, which are defined as measures of community health and wellbeing associated with the statewide behavioral health goals. Phase 1 measures must be used in the county BHSA planning process and should inform resource planning and implementation of targeted interventions to improve outcomes. They are statewide indicators for which counties are not exclusively responsible; it will take cross-service delivery system collaboration and partnership to move the needle on Phase 1 measures. As part of the 2025 PHM strategy (guidance forthcoming), Medi-Cal MCPs will also be working towards the statewide behavioral health goals and measures.

In Phase 2, measures will be used for monitoring and accountability purposes and will focus on performance of county behavioral health and Medi-Cal MCPs, respectively. The BHSA-funded interventions (e.g., Housing Interventions, Behavioral Health Services and Supports, Full Service Partnerships), as well as county behavioral health SMHS and Medi-Cal MCP NSMHS, should impact the goals outlined in C.3. and their associated measures.

In both phases, counties should utilize the Community Planning Process detailed in the Policy Manual to work with key stakeholders to address the statewide population behavioral health goals.

[31] The Behavioral Health Services Act replaces the Mental Health Services Act of 2004. It reforms behavioral health care funding to prioritize services for people with the most significant mental health needs while adding the treatment of substance use disorders (SUD), expanding housing interventions, and increasing the behavioral health workforce. It also enhances oversight, transparency, and accountability at the state and local levels Behavioral Health Services Act.

## C.2 Statewide Population Behavioral Health Goals

DHCS, in consultation with behavioral health stakeholders and subject matter experts, has identified 14 statewide behavioral health goals[32] focused on improving wellbeing (e.g., quality of life, social connection) and decreasing adverse outcomes (e.g., suicides, overdoses). These behavioral health goals (shown in Figure 2.C.4) will inform state and county planning and prioritization of BHSA resources, and DHCS will continuously assess statewide and county progress toward these goals under BHT.

Note that health equity, defined as the "reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations",[33] will be incorporated in each of the statewide behavioral health goals. DHCS will endeavor to provide measures that can be stratified (e.g., by demographics such as age group and race/ethnicity, etc.) to enable visibility into disparities. In addition to identifying disparities, DHCS will ask counties and Medi-Cal Managed Care Plans (MCPs) to address disparities and DHCS will consider disparities when developing accountability measures.

[32] W&I Code § 5963.02(c)(3)(A).
[33] Sourced from DHCS MCP Boilerplate Contract.


**Figure 2.C.4. Statewide Population Behavioral Health Goals**

DHCS selected these goals based on their strong indication of the health and wellbeing of Californians living with significant behavioral health needs. In alignment with the mission of BHT to improve behavioral health for Californians, the statewide population behavioral health goals lay out the vision that the state, counties, MCPs, and other key stakeholders must work towards to improve the overall well-being of Californians who are living with behavioral health needs (see Tables 2.C.1 and 2.C.2 for the goals' definitions and rationale for inclusion).

Measures associated with each goal are forthcoming.

**Table 2.C.1. Statewide Population Behavioral Health Goals: Goals for Improvement – Definition and Rationale**

| Goals for Improvement | Definition and Rationale |
|---|---|
| **Care experience** | Care experience refers to the range of interactions and quality of care that patients have and receive from the healthcare system |

| Goals for Improvement | Definition and Rationale |
|---|---|
| | that can impact level of engagement and length of treatment.[34] Improving the care experience (e.g., care is culturally congruent and responsive, trauma-informed, etc.) in California's behavioral health delivery system is important; positive experiences with care can lead to greater treatment engagement, adherence, and remaining in treatment longer, leading to positive health outcomes. |
| **Access to care** | Access to care is defined as the timely and appropriate use of health services to achieve the best possible health outcomes, inclusive of all modalities.[35] Improving Californians' access to care is necessary for improving outcomes. Compliance with provider availability as outlined in network adequacy requirements, strategies for navigating the complex care delivery system, and improving wait times for appointments will enable Californians to better access the right care at the right time. |
| **Prevention and treatment of co-occurring physical health conditions** | Co-occurrence in this goal refers to the prevention or treatment of a physical health condition in an individual with an existing BH condition. An integrated care approach that addresses both behavioral and physical health needs of individuals can lead to earlier treatment of uncontrolled chronic physical health conditions. |
| **Quality of life** | Quality of life is defined as an individual's "perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, |

[34] Definition derived from "Patient Experience" definition from the Agency for Healthcare Research and Quality, from the Consumer Assessment of Healthcare Providers and Systems (CAHPS).
[35] Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services. Access to Health Services - Healthy People 2030.

| Goals for Improvement | Definition and Rationale |
|---|---|
| | standards, and concerns."[36] Individuals living with behavioral health conditions face challenges from symptoms and associated stigma, which can negatively impact daily functioning, wellbeing, and overall quality of life. |
| **Social connection** | Social connection refers to the degree to which an individual has the number, quality, and variety of relationships that they want to feel and have belonging, support, and care.[37] Establishing and maintaining supportive relationships is vital for preventing and managing significant behavioral health needs along with other behavioral health conditions associated with loneliness and isolation. |
| **Engagement in school** | In this context, engagement refers to the degree of attention, curiosity, interest, passion, and optimism that an individual has towards school and related activities, including their enrollment and participation in as well as graduation from school.[38] Enhancing engagement through prevention and treatment of behavioral health conditions can enable individuals to participate actively and meaningfully, leading to improvements in quality of life, independence, and wellbeing. |
| **Engagement in work** | Similar to above, engagement refers to the degree of attention, curiosity, interest, passion, and optimism that an individual has towards work and related activities. Enhancing engagement in the workplace as part of paid employment or unpaid work through prevention and treatment of behavioral health conditions can enable individuals to participate actively and |

[36] World Health Organization. WHOQOL - Measuring Quality of Life. Division of Mental Health and Prevention of Substance Abuse. World Health Organization. March 2012.
[37] Center for Disease Control and Prevention. Social Connection.
[38] Derived from "Student Engagement" definition on The Glossary of Education Reform.

| Goals for Improvement | Definition and Rationale |
|---|---|
| | meaningfully, leading to improvements in job performance, productivity, job satisfaction, and overall personal wellbeing. |

**Table 2.C.2. Statewide Population Behavioral Health Goals: Goals for Reduction – Definition and Rationale**

| Goals for Reduction | Definition and Rationale |
|---|---|
| **Suicides** | Suicide, including suicide attempts is defined as death or non-fatal, potentially injurious harm caused by self-directed injurious behavior with the intent to die as a result of the behavior.[39,40] Strengthening California's behavioral health delivery system and providing targeted and tailored suicide prevention efforts is critical for reducing California's suicide rate. |
| **Overdoses** | A drug-related overdose can occur when a toxic amount of a drug, or combination of drugs, including prescription, illicit, or alcohol, overwhelms the body.[41] In California, drug-related overdose deaths have doubled since 2017, reaching 10,898 in 2021,[42] with the greatest impact among racial and ethnic |

[39] Definition sourced from the National Institute of Mental Health. In relation, "suicide attempt" refers to the non-fatal, self-directed, potentially injurious behavior with intent to die as a result of behavior, and "suicidal ideation" refers to thinking about, considering, or planning suicide.
[40] DHCS does not have a formal definition for "suicide," but acknowledges it as a complex public health challenge involving many biological, psychological, social, and cultural determinants. More on its program can be found in the DHCS Suicide Prevention Fact Sheet.
[41] Referenced from the California Department of Public Health.
[42] Referenced from the California Department of Public Health. Statistic is sourced from the California Overdose Surveillance Dashboard.

| Goals for Reduction | Definition and Rationale |
|---|---|
| | minorities, and individuals experiencing homelessness, unemployment, and incarceration. |
| **Untreated behavioral health conditions** | Untreated behavioral health conditions refer to an individual's behavioral health condition that has not been diagnosed or attended to with appropriate and timely care. Living with untreated behavioral health conditions can lead to worsening symptoms, diminished quality of life, unemployment, reduced educational attainment, homelessness, and higher risk of severe outcomes such as suicide or self-harm. |
| **Institutionalization** | Minimize time in institutional settings by ensuring timely access to community-based services across the care continuum and in a clinically appropriate setting that is least restrictive. Reducing institutionalization entails maximizing community integration and making supportive housing options with intensive, flexible, voluntary supports and services available to all individuals who would benefit. Stays in institutional settings are sometimes clinically appropriate and therefore the goal is not to reduce institutionalization to zero. |
| **Homelessness** | Homelessness is defined below in Section 7.C.4.1.1 of the Housing Interventions chapter. Addressing the increase in statewide homelessness is crucial to ensuring unhoused individuals living with significant behavioral health needs receive regular access to behavioral health treatment and safe and stable housing where they can recover. |
| **Justice-Involvement** | Reducing justice involvement refers to reducing adults and youth living with behavioral health needs who are involved in the justice system - including those who have been arrested, are living in, who are under community supervision, or who have transitioned from a state prison, county jail, youth |

| Goals for Reduction | Definition and Rationale |
|---|---|
| | correctional facility, or other state, local, or federal carcel settings where they have been in custody of law enforcement authorities. More than 50 percent of incarcerated individuals living with a behavioral health condition.[43] While incarcerated, justice-involved individuals living with behavioral health needs have limited access to treatment. Formerly incarcerated individuals are more likely to experience poor health outcomes, including higher risk for injury and death due to violence, overdose, and suicide.[44] Promoting coordinated systems of care between the legal system and behavioral health plans and providers can have an impact on reducing justice involvement and improving outcomes for those who are justice-involved. |
| **Removal of children from home** | Removal of children from home, specifically those with an open child welfare status, refers to when children may be removed from their home due to abuse and/or neglect. Providing early intervention and intensive BH services to parents and additional members of the family unit living with a behavioral health condition can prevent family disruption and improve child welfare outcomes, as children are less likely to be placed in foster care and exposed to early childhood trauma. |

## C.3 Population Behavioral Health Framework

Under BHT, DHCS will partner with counties to participate in a cycle of continuous improvement to drive progress on the statewide behavioral health goals (shown in Figure 2.C.5):

[43] Substance Abuse and Mental Health Services Administration. About Criminal and Juvenile Justice.
[44] Ingrid A. Binswanger, Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. "Release from Prison — A High Risk of Death for Former Inmates." New England Journal of Medicine, January 2007.

1. Establish statewide behavioral health goals.
2. In consultation with behavioral health stakeholders and subject matter experts, identify at least one measure for each behavioral health goal.
3. Deliver measures to counties describing their performance on the statewide behavioral health goals.

DHCS recognizes that shifting to a coordinated, data-driven, population behavioral health approach will take time. As with the PHM Program, DHCS will phase in requirements and provide technical assistance to counties and other key stakeholders.

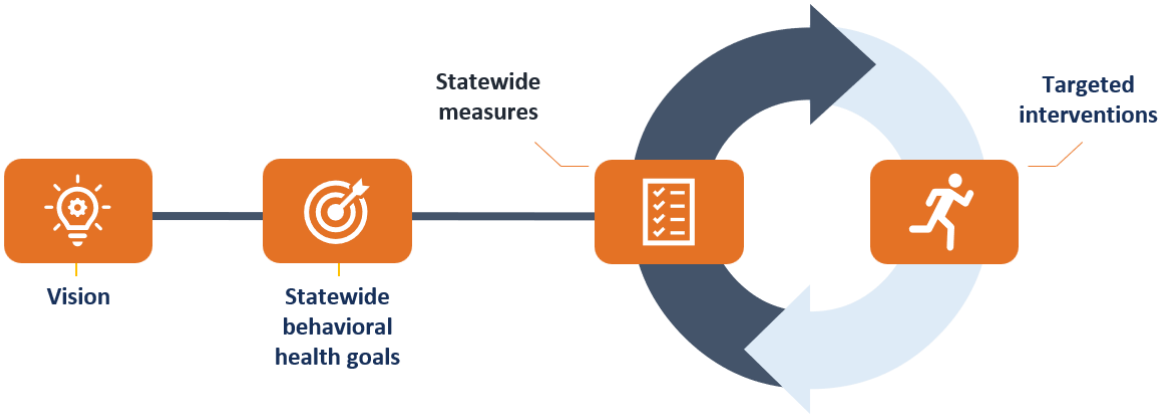


**Figure 2.C.5. Population Behavioral Health Framework**

# 3. Integrated Plan

## A. Purpose of the Integrated Plan

The Behavioral Health Services Act (BHSA) requires counties[1] to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. Whereas the Three-Year Program and Expenditure Plan required under the Mental Health Services Act (MHSA) focused exclusively on MHSA dollars, the BHSA establishes the IP to serve as a three-year prospective global spending plan that describes how county behavioral health departments plan to use all available behavioral health funding, including BHSA, 1991 and 2011 Realignment, federal grant programs, federal financial participation from Medi-Cal, opioid settlement funds, local funding, and other funding to meet statewide and local outcome measures, reduce disparities, and address the unmet need in their community. In accordance with the BHSA, the IP provides a description of how counties will plan expenditures across a range of behavioral health funding sources and deliver high-quality, culturally responsive, and timely care along the Behavioral Health Care Continuum for the plan period.[2] The Department of Health Care Services (DHCS) is developing an IP Template which will include the required elements for each county to submit in their IPs. A copy of the IP Template will be released in this policy manual to inform county planning. Counties will submit the IP through a DHCS web-based county portal.

IPs require counties to conduct a thorough data-informed local service planning process and provide transparency into county planning for expending BHSA funding and all other behavioral health funding sources overseen by counties. All BHSA services and programming must be planned in accordance with local data. In particular W&I Code section 5963.02, subdivision (b)(2) requires the county to use local SUD prevalence data and unmet SUD needs data. IPs will also facilitate local and statewide data collection by providing baseline data on services and planned expenditures and supporting analysis of county goals and outcomes.

[1] W&I Code §§ 5963, subdivision (a); 5963.02, subdivision (a)
[2] W&I Code § 5963, subdivision (a)(1)

## A.1 Reporting Period

The first IP will cover Fiscal Years 2026-2029 and will be due on June 30, 2026.[3] County board of supervisor approval is required for submission. The board of supervisors is also required to confirm in each IP that the county will meet their realignment obligations.[4] The board of supervisors will attest that the county is meeting their realignment obligations, including but not limited to time and distance standards and appointment time standards as set forth W&I Code section 14197.7 without utilizing waitlists, through the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) (see Chapter 4 of this policy manual for BHOATR requirements). DHCS will post each county's IP on the DHCS website.

## A.2 Contents of Integrated Plan

The Integrated Plan (IP) Template requires counties to report planned activities and projected expenditures for all county behavioral health department services provided under the following funding sources, services, and programs[5]:

- Bronzan-McCorquodale Act (1991 Realignment)
- 2011 Realignment
- Medi-Cal behavioral health programs, including:
    - Specialty Mental Health Services (SMHS)
    - Drug Medi-Cal (DMC)
    - Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Federal block grants, including:
    - Community Mental Health Services Block Grant (MHBG)
    - Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)
    - Projects for Assistance in Transition from Homelessness (PATH) grant
- BHSA funds
- Any other federal, state, or local funding directed towards county behavioral health department services, including:
    - Commercial/private insurance

[3] W&I Code § 5963.02, subdivision (a)(3)
[4] W&I Code § 14197.71, subdivision (c)(2)
[5] W&I Code § 5963.02, subdivision (c)(1-2)

- Opioid settlement funding (only funds received by the County Behavioral Health Department)
- County general fund
- Grant revenue
- Other

The IP Template will include required sections on the following topics:

- County Demographics and Behavioral Health Needs
- Plan Goals and Objectives
- Community Planning Process
- Comment Period and Public Hearing
- County Behavioral Health Care Continuum Capacity
- Services by Total Funding Source
- Behavioral Health Services Fund Programs
- Workforce Strategy
- Budget and Prudent Reserve

## A.3 Function of Annual Updates and Intermittent Updates

Counties will be required to update their Integrated Plan (IP) through annual updates in the second and third years of the IP cycle. Annual updates will require the county to complete and submit all sections of the IP. Counties may prepare intermittent updates to their IP at any time during the IP cycle. For intermittent updates, counties must notify DHCS in advance of submission. Annual and intermittent updates will allow counties to be responsive to changes at the local level during the plan period.

Annual and intermittent updates are not subject to the stakeholder engagement requirements for the IP that are outlined in section 3.B.1 of this policy manual. However, DHCS encourages stakeholder engagement on the annual and intermittent updates. Counties are required to post the annual updates and intermittent updates to their IP with a summary and justification of the changes made by the updates for a 30-day comment period prior to the effective date of the updates. Counties maintaining their local stakeholder engagement in developing the annual or intermittent updates must continue to comply with the local behavioral health board public hearing requirements outlined in section 3.B.3 of this policy manual.

## A.3.1 Reporting Period

Counties are required to submit annual updates for the second and third year of the IP period. Annual updates will be submitted by June 30 prior to the fiscal year the update will cover. Counties may submit intermittent updates to their IP as needed.

**Table A.3.1 Reporting Periods for Integrated Plans, Annual Updates, and Intermittent Updates**

| | Integrated Plan | Annual Updates | Intermittent Updates |
|---|---|---|---|
| **Counties are Required to Complete and Submit[6]** | Yes | Yes | If changes are requested |
| **Submission Timeframe** | Every 3 years | Second and third years of IP cycle | Counties may submit at any time |
| **Submission Deadline[7]** | June 30 of year prior to fiscal years IP covers | June 30 of year prior to fiscal year annual update covers | Counties may submit at any time during the 3-year IP cycle |
| **Community Planning Process Required[8]** | Yes | No, but encouraged | No, but encouraged |
| **30-day Public Comment Period Required[9]** | Yes | Yes | Yes |

[6] W&I Code § 5963.02, subdivision (a)(1)
[7] W&I Code § 5963.02, subdivision (a)(3)
[8] W&I Code § 5963.03, subdivision (a)
[9] W&I Code § 5963.03, subdivision (c)(B)

| | | | |
|---|---|---|---|
| **Behavioral Health Board Hearing Required[10]** | Yes | If county engages stakeholders | If county engages stakeholders |
| **Board of Supervisors Approval[11]** | Yes | Yes | Yes |

### A.3.2 Required Contents

Annual updates will include all sections required in the Integrated Plan (IP) template. If there are no changes to a given section of the county's IP at the time of the annual update, the county may resubmit the information provided in the original IP as part of the update. Counties may update information in any section of the IP as needed through an intermittent update.

# B. Community Planning Process

## B.1 Stakeholder Involvement

Stakeholder engagement requirements for the Integrated Plan (IP) are effective January 1, 2025.[12] Counties must engage with local stakeholders to develop each element of their IP.[13] The stakeholders that must be engaged include, but are not limited to[14]:

- Eligible adults and older adults[15] (individuals with lived experience)
- Families of eligible children and youth, eligible adults, and eligible older adults[16] (families with lived experience)

[10] W&I Code § 5963.03, subdivision (b)
[11] W&I Code §§ 5963.03, subdivision (c)(10)-(11)
[12] W&I Code §5963.03, subdivision (e)
[13] W&I Code §5963.02, subdivision (c)
[14] W&I Code §5963.03, subdivision (a)(1)
[15] W&I Code § 5892, subdivision (d)(1)
[16] W&I Code § 5892, subdivision (d)

- Youths (individuals with lived experience) or youth mental health or substance use disorder organizations
- Providers of mental health services and substance use disorder treatment services
- Public safety partners, including county juvenile justice agencies
- Local education agencies
- Higher education partners
- Early childhood organizations
- Local public health jurisdictions
- County social services and child welfare agencies
- Labor representative organizations
- Veterans
- Representatives from veterans' organizations
- Health care organizations, including hospitals
- Health care service plans, including Medi-Cal Managed Care Plans (MCPs)[17]
- Disability insurers (a commercial disability insurer that covers hospital, medical or surgical benefits as defined in Insurance Code section 106, subdivision (b))
- Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- The five most populous cities in counties with a population greater than 200,000
- Area agencies on aging
- Independent living centers
- Continuums of care, including representatives from the homeless service provider community
- Regional centers
- Emergency medical services
- Community-based organizations serving culturally and linguistically diverse constituents

In addition to the required stakeholders listed above, stakeholders shall include participation of individuals representing diverse viewpoints,[18] including, but not limited to:

- Representatives from youth from historically marginalized communities

[17] W&I Code § 14184.101, subdivision (j)
[18] W&I Code § 5963.03, subdivision (a)(2)(A)(ii)

- Representatives from organizations specializing in working with underserved racially and ethnically diverse communities
- Representatives from LGBTQ+ communities
- Victims of domestic violence and sexual abuse
- People with lived experience of homelessness

Counties are required to demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health and substance use disorder policy, program planning and implementation, monitoring, workforce, quality improvement, evaluation, health equity, evaluation, and budget allocations.[19] Meaningful stakeholder engagement requires that counties conduct a community planning process that is open to all interested stakeholders and that stakeholders have opportunities to provide feedback on key planning decisions. Stakeholder engagement should not be limited to individuals who belong to organizations or advocacy groups.

Counties must demonstrate a partnership with constituents and stakeholders[20] as part of their community planning processes. Examples of meaningful partnership with stakeholders may include, but are not limited to, the following types of stakeholder engagement:

- Education and engagement to support meaningful involvement, including on policies that govern the behavioral health delivery system
- Listening sessions
- Conference calls
- Client advisory meetings
- Consumer and family group meetings
- Town hall meetings
- Video conferences
- Media announcements
- Targeted Outreach
- Public comment
- Public hearings

[19] W&I Code § 5963.03(a)(2)(A)(i)
[20] W&I Code § 5963.03, subdivision (a)(2)(A)(i)

- Stakeholder workgroups and committees
- Focus groups
- Surveys
- Key informant interviews or engaging with subject matter experts
- Training, education, and outreach related to community planning
- Other strategies that demonstrate meaningful partnerships with stakeholders

To ensure that the community planning process is adequately staffed, the county may designate positions and/or units responsible for:

- The overall community planning process.
- Coordination and management of the community planning process.
- Ensuring that stakeholders have the opportunity to meaningfully and sufficiently participate in the community planning process.[21]

Training should be provided by the county as needed to their staff designated responsible for any of the functions that will enable staff to establish and sustain a community planning process.

A county may also provide supports, including, but not limited to, training and technical assistance, to ensure stakeholders, including peers and families, receive sufficient information and data to meaningfully participate in the development of Integrated Plans and annual updates.

Counties may allocate up to 5 percent of the total annual revenue received from the local Behavioral Health Services Fund (BHSF) to fund planning costs.[22] For additional information on how counties can fund the community planning process, please refer to the County Planning Funds Chapter B.4.

## B.2 Considerations of Other Local Program Planning Processes

This section focuses on the requirements for Integrated Plan (IP) development related to collaboration with Medi-Cal Managed Care Plans (MCPs) and local health jurisdictions

[21] W&I Code §5963.03, subdivisions (a)(2)(A)(i) and (ii)
[22] W&I Code §5892, subdivision (e)(1)

(LHJs).[23] Specifically, the Behavioral Health Services Act (BHSA) requires that each county must:

- Work with its LHJ on the development of its Community Health Improvement Plan (CHIP) (W&I Code section 5963.01, subdivision (b)).
- Consider the CHIP of each LHJ that covers residents of the county in preparing their IP and annual update (W&I Code section 5963.02, subdivision (b)(4)).
- Work with each MCP that covers residents of the county on the development of the MCP's Population Needs Assessment (PNA) (W&I Code section 5963.01, subdivision (a)).
    - The BHSA was written prior to the 2024 DHCS redesign of PNA requirements. MCPs no longer develop and submit a PNA to the Department of Health Care Services (DHCS). MCPs now fulfill their PNA requirement by meaningfully participating in the Community Health Assessments (CHA) and CHIPs conducted by LHJs.[24]
- Consider the PNA of each MCP that covers residents of the county in preparing their IP and annual update (W&I Code section 5963.02, subdivision (b)(3)).

DHCS is focused on building bridges across public health, MCPs, and behavioral health delivery systems. The BHSA transforms the Mental Health Services Act (MHSA) planning process into a broader county and regional planning process. The targeted points of integrations of BHSA community planning processes with the community- and population-level assessment and planning efforts led by public health with MCPs and other stakeholders will reduce siloes and increase cross-system collaboration to enable strategic alignment of funding for coordinated and complementary approaches. DHCS' goal is to improve upstream interventions[25] and health outcomes for, and thus more effectively improve the lives of, community members. While perspectives and focus areas may vary, local public health, MCPs, and counties serve common communities,

[23] Per HSC Section 124030, subdivision (f) a "Local health jurisdiction" means county health department or combined health department in the case of counties acting jointly or city health department within the meaning of HSC §101185.

[24] CalAIM: Population Health Management Policy Guide (May 2024)

[25] Upstream interventions include those that link to public health and social services and support members staying healthy through wellness and prevention services. For further details and additional context, see the PHM Policy Guide (p.4) and CalAIM Population Health Management Initiative webpage.

and local integration and partnerships are essential to paving a path toward better understanding the needs of local communities, strategizing appropriate interventions, addressing social determinants of health, and advancing health equity. With this goal in mind, in January 2024, DHCS coordinated with the California Department of Public Health (CDPH) and issued a new policy requiring the MCP PNA to be more closely aligned with LHJ local planning processes, as detailed further below. As the BHSA was written prior to the 2024 DHCS PNA policy change, this guidance explains the BHSA IP requirements in the context of these other recent policy developments.

This guidance addresses requirements for counties' IP submissions, specific to collaboration with MCPs and LHJs on Community Health Assessments (CHAs) and CHIPs, to promote greater alignment among public health, managed care, and behavioral health.

## B.2.1. Local Planning Overview

This section provides background on MCP and LHJ local planning processes.

### B.2.1.1 Background: LHJ, CHA and CHIP

As part of its local planning processes, most LHJs develop both a CHA and a CHIP, which emphasize participatory and collaborative practices centered on the community.[26]

- The CHA describes the status of population health within a jurisdiction.[27]
- Informed by the CHA, the CHIP identifies how the public health entity will work with community partners to address key issues elevated in the CHA.

An array of tools and processes may be used to conduct a CHA and develop a CHIP; the essential feature is that these processes are informed by community collaboration and participation. Since the CHA and CHIP processes are tailored to address local

[26] For further details and additional context, see the California Department of Public Health December 26, 2023 Memo to All Local Health Jurisdictions and the CalAIM PHM Policy Guide (p. 8-10)

[27] Although the BHSA does not specifically reference the CHA and only the CHIP, the CHA and CHIP are part of the same local LHJ planning process, and the CHA is the essential precursor step to developing the CHIP.

community needs, there is no requirement to include prescribed topic areas such as specialty or non-specialty mental health, or other content areas.

At present, most LHJs complete or update their CHAs and CHIPs every five years when seeking to obtain and maintain voluntary Public Health Accreditation Board (PHAB) accreditation. Some LHJs are on a three-year submission cycle to align with local processes, such as non-profit hospital community health needs assessments. Currently, non-accredited LHJs can choose not to formally conduct CHAs and CHIPs.

Starting in 2028, as a part of the collaborative state efforts to improve local integration in community planning, the CHA and CHIP will be mandatory for all LHJs, and all LHJs will implement the same three-year submission cycle, as described below in Figure 3.B.2.1. This timeline is intentionally designed to align with and inform BHT IP planning processes as well as simplify the new PNA-CHA policy for MCPs operating in multiple local health jurisdiction areas.

#### B.2.1.2 Background: MCP PNA

The PNA is the mechanism that MCPs use to identify (1) priority needs of their local communities and members and (2) health disparities. Under the CalAIM Population Health Management (PHM) Program, since January 1, 2024, MCPs have fulfilled their PNA requirement by meaningfully participating in the development of LHJ CHAs and CHIPs in the service areas where MCPs operate.

MCP meaningful participation includes[28]:

- **Collaboration.** MCPs must participate in every LHJ CHA and CHIP in their service area and collaborate with other MCPs within the same service areas to foster a unified planning process.
- **Data-Sharing.** MCPs are expected to share data with LHJs in ways that support the CHA and CHIP process.
- **Stakeholder Engagement.** MCPs must attend key CHA and CHIP meetings and serve on CHA and CHIP governance structures, as requested by LHJs.

[28] See the CalAIM PHM Policy Guide for additional details on MCP PNA Requirements (p. 7-10)

- **Funding and/or In-Kind Staffing.** Starting on January 1, 2025, MCPs are required to contribute funding and/or in-kind staffing to support LHJ CHA and CHIP processes.

MCPs are required to complete an "MCP-LHJ Collaboration Worksheet" to demonstrate that they are meeting their PNA requirement.[29]

DHCS and CDPH collaborated to create a regulatory environment that supports effective and efficient joint work on CHAs and CHIPs between LHJs and MCPs. Thus, aligned with CDPH guidance, the cycles for LHJs' CHA and CHIP development will become standardized across California starting in 2028, as previously noted, and as displayed in the timeline below.

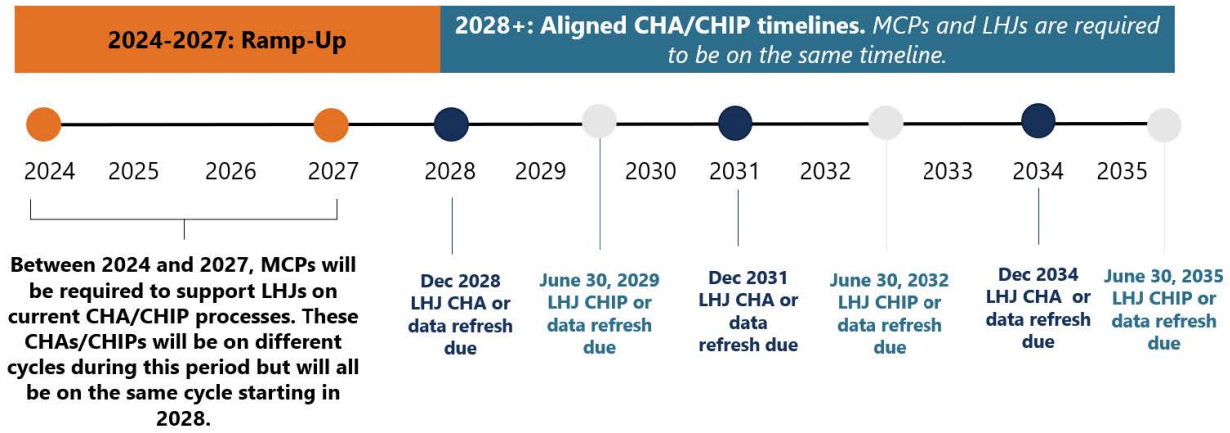


**Figure 3.B.2.1. LHJ CHA and CHIP Submission Cycle Alignment Timeline**

## B.2.2 Overlap and Alignment with Other Local Program Planning Processes

County behavioral health departments (counties), LHJs, and MCPs share a common interest in identifying the needs of the populations and communities they serve. Points of integration existed before SB 326 and its IP mandate, and some counties, LHJs, and MCPs have been collaborating on CHA/CHIP processes for many years.

[29] MCPs are not required to submit MCP-LHJ Collaboration Worksheet unless requested by DHCS. In addition, all MCPs are required to submit a PHM Strategy which provides details on MCPs' meaningful participation on LHJs' CHA and CHIP.

Specific to BHSA mandates that counties work with and consider LHJ CHAs and CHIPs, and MCP PNAs, DHCS has established the following guiding principles to work toward the achievement of common goals:

- Counties, LHJs, and MCPs serve overlapping local communities and should collectively be aware of key, population-level needs and challenges.
- There is an opportunity to employ complementary and coordinated strategies and interventions across delivery systems.
- As counties begin to engage in the PNA, CHA, and CHIP processes, alignment should lead to more integrated, *upstream*, and effective community health initiatives and prevention strategies to improve population health.
- Given the distinct focus areas and different populations that LHJs, MCPs, and counties serve, DHCS intends for this alignment to supplement the broader county IP requirements.

Figure 3.B.2.2 depicts the initial level of overlap anticipated as counties and LHJs embark on, or in some cases continue, collaborative efforts related to the development and alignment of community needs assessments and planning processes. Additionally, it demonstrates that the IP has numerous requirements unrelated to the LHJ CHA and CHIP. However, over time, as relationships advance, collaboration strengthens, and timelines align, county, MCP, and LHJ overlap on CHAs and CHIPs will likely increase, and the overlap in these circles will expand.

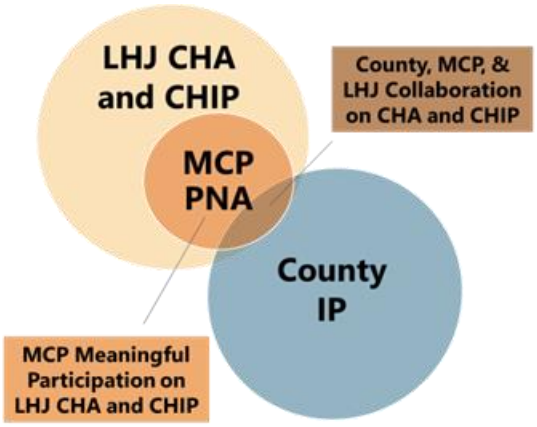


**Figure 3.B.2.2 LHJ CHA and CHIP, MCP PNA, and County IP Overlap**

## B.2.3 County Requirements

This section provides county requirements, effective January 2025, for alignment with LHJs and MCPs in support of the IP submissions due in June 2026.

### 1. Engagement with Other Local Program Planning Processes

Counties are required to engage with LHJs and MCPs on CHAs and CHIPs, across the three areas described below. However, given that counties' IPs and LHJs' CHAs and CHIPs are driven by unique local needs, DHCS will allow for flexibility in how counties may work with LHJs and MCPs. For example, specific behavioral health topics and focus areas may vary from county to county.

**Area 1: Collaboration.** Over time, counties, LHJs, and MCPs can partner to focus on coordinated strategies for upstream interventions that can improve population health. To advance meaningful collaboration, counties are required to:

- Work with LHJs on the development of the CHA and CHIP in that county (or city, recognizing three city LHJs),[30] along with MCPs, in fulfillment of their meaningful participation requirements. If multiple MCPs are present in the county or city, they will already be aligned in support of the LHJ in accordance with DHCS PHM Policy Guide mandates.

[30] For a complete list of LHJs, see CDPH's listing of local health services/offices.

- Attend key CHA and CHIP meetings and serve on CHA and CHIP governance structures, including CHA and CHIP subcommittees, at the request of LHJs when discussions are relevant to behavioral health issues.

**Area 2: Data-Sharing.** Counties, LHJs, and MCPs all have access to their own siloed data. When this data is shared among these partners, it can be used to improve population health by creating a more holistic picture of the multiple factors contributing to a community's health. Counties are expected to work with LHJs and MCPs to determine the types of relevant data to be shared, taking into consideration the specific nature of CHAs and CHIPs, the needs of the counties, and how data should be de-identified/disaggregated, if needed. Counties are required to begin to identify priority areas to:

- Share data to support behavioral health-related focus areas of the CHA and CHIP.[31]
- Utilize and stratify data from LHJs and MCPs to inform IP development.

Counties are subject to various and specific mandates regarding data sources, uses, and stratification for IP development that exceed the integration of LHJs' and MCPs' data. DHCS expects that counties must continue to meet any broader data requirements required by the IP that may not be fulfilled through the LHJ CHA and CHIP processes.

**Area 3: Stakeholder Engagement.** Given that BHSA identifies more than twenty specific populations and stakeholder groups that counties must engage in the development of the IP, counties should work with LHJs to look for opportunities where IP stakeholder engagement could be combined or integrated with CHA/CHIP processes to reduce duplication and community fatigue. LHJs generally involve a wide array of community stakeholders in the CHA and CHIP development processes. In order to streamline community input and reduce redundancy, counties are required to:

[31] Counties will need to adhere to applicable federal and state privacy laws and regulations (e.g., consent requirements) and relevant frameworks (e.g. the California Health and Human Services Agency Data Exchange Framework if county is a signatory) while fulfilling the BHSA requirements to share and utilize data, as will MCPs and LHJs. BHSA includes broader data sharing and utilization requirements that counties must fulfill for their IP submissions.

- Coordinate stakeholder activities for IP development with LHJ engagement on the CHA and CHIP to the extent possible.
- Consider input from diverse populations and a wide range of community stakeholders.

DHCS expects that counties must continue to meet any broader stakeholder engagement requirements that may not be fulfilled through the LHJ CHA and CHIP processes.

Because LHJ stakeholder engagement on CHAs and CHIPs is uniquely focused on the individual needs of each community, there are no prescribed topics or mandated focus areas. However, behavioral health may be a key focus area identified by communities. Counties are expected to participate in the CHA and CHIP as described above, and where behavioral health-specific needs arise through the progress, work with LHJs and MCPs to incorporate addressing such needs in its IP.

The county requirements across all three areas noted mirror MCP requirements for meaningful participation on LHJs' CHAs and CHIPs.[32]

As mentioned previously, due to the current disparate submission cycles for LHJ CHAs and CHIPs, counties should consider the most recent CHA and CHIP on record, which could be up to four years old (depending on the submission cycle) and/or may not be available in all LHJs, when preparing their 2026 IP submissions. For the LHJs without CHAs or CHIPs available, counties should reach out to their respective LHJ to determine if a Strategic Plan is available for their review.

### 2. Monitoring and Oversight

In alignment with MCP PNA requirements and to support successful partnerships among counties, LHJs, and MCPs, DHCS has developed, and will require submission of, a "County-LHJ-MCP Collaboration Worksheet" (see Appendix; *placeholder- Worksheet to be added when finalized*). This Worksheet will require input from all three partners attesting to their efforts across the three areas of collaboration, data sharing, and

[32] DHCS does not require or expect counties to provide funding and/or in-kind staffing to support the LHJ CHA and CHIP processes. Per the PHM Policy Guide, however, MCPs are required to work with LHJs to determine what combination of funding and/or in-kind staffing the MCP will contribute to the LHJ CHA/CHIP process.

stakeholder engagement. Completion of the Worksheet will offer insight into these cross-sector partners' experiences as they build relationships and begin working together towards shared goals.

Additionally, LHJs will be separately surveyed to provide their insight on the collaboration with counties.

### 3. Iterative Approach for Overlap and Alignment

Figure 3.B.2.3 below details the timeline for implementation of the county, LHJ, and MCP collaboration requirements for the first IP submission in 2026 through the June 2029 IP submission.

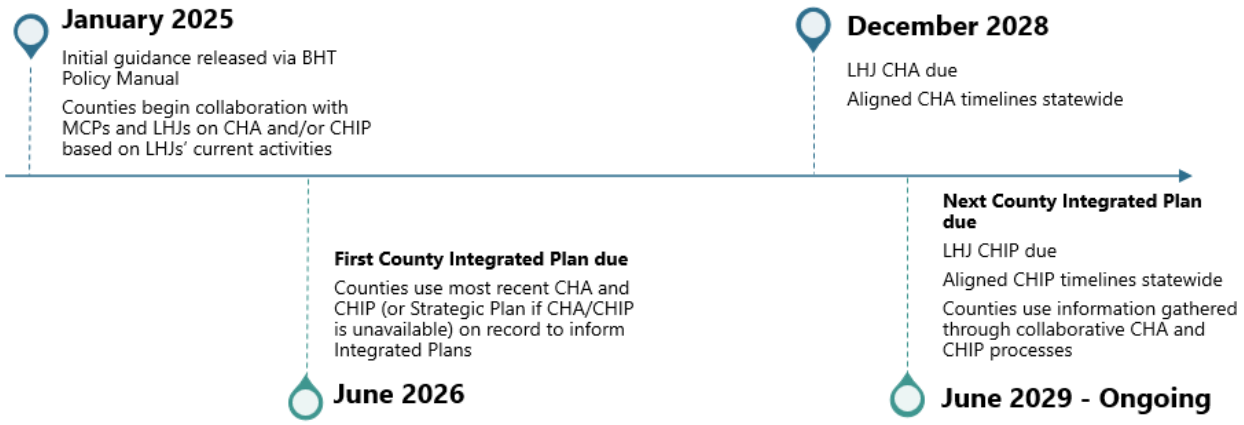


**Figure 3.B.2.3 Timeline for Implementation of County, LHJ, and MCP Collaboration**

Counties, LHJs, and MCPs should take time in 2025 to come to a common understanding of the respective key facts, goals, and language in each system.

- Opportunities should be identified for each entity to share background on their respective requirements and processes (relative to the IP, the PNA, and the CHAs and CHIPs) and how they utilize these tools.
- Counties, MCPs, and LHJs should ensure all parties are aligned on one another's roles and responsibilities, the populations they serve, and the services they are responsible for providing.

## B.3 Public Comment and Updates to the Integrated Plan

**Comment Period**

Counties are required to provide 30 days for stakeholder comment on each draft IP. A draft IP and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.[33]

**Local Behavioral Health Board**

The local behavioral health board shall conduct a public hearing on the draft IP at the close of the 30-day comment period.[34]

Once an IP has been drafted and is ready for public comment, the local behavioral health board is required to review the draft plan and make recommendations to the local behavioral health agency for revisions. The local behavioral health board is not required to approve county Integrated Plans.[35]

The local behavioral health agency is also required to provide an annual report to the local governing body, which is the local Board of Supervisors or city council, and DHCS that includes written explanations in response to any substantive recommendations[36] made by the local behavioral health board that are not included in the final IP or update.[37]

**Revisions to the Integrated Plan**

After the 30-day comment period and public hearing are complete, counties are required to make the following revisions to the IP:

- Each draft IP should include a summary of substantive written recommendations.[38]
- The draft IP should also include a summary and analysis of the revisions made as a result of stakeholder feedback.[39]

**Annual Updates and Intermittent Updates**

Counties must prepare annual updates to their IP and may prepare intermittent updates, although intermittent updates are not required. When preparing Annual and

[33] W&I Code § 5963.03, subdivision (a)(2)(B)
[34] W&I Code § 5963.03, subdivision (b)(1)
[35] W&I Code § 5963.03, subdivision (b)
[36] W&I Code § 5963.03, subdivision (d)
[37] W&I Code §5963.03, subdivision (b)(5)
[38] W&I Code § 5963.04, subdivision (d)
[39] W&I Code § 5963.03, subdivision (b)(3)

Intermittent Updates, counties are not required to comply with the stakeholder process outlined in W&I Code section 5963.03, subdivision (a) and W&I Code section 5963.03, subdivision (b). Counties may choose to elicit participation from stakeholders when preparing annual and intermittent updates. If counties choose to request stakeholder feedback, the county must comply with the local behavioral health board public hearing requirements outlined above.[40]

Counties must post Annual and Intermittent Updates to their IP and a summary and justification of changes to their website for a 30-day comment period prior to the effective date of the updates.[41] Counties will submit annual and intermittent updates to DHCS through the county portal. Counties can download their completed IP from the county portal and submit to the Behavioral Health Services Oversight and Accountability Commission (BHSOAC).

## B.4 County Planning Funds

### B.4.1 Planning Costs

Counties may allocate up to 5 percent of the total annual revenue received from the local Behavioral Health Services Fund (BHSF) to fund planning costs. All allocations and expenditures for planning costs must be included in the county IP and Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). These planning costs shall include funds for county mental health and substance use disorder programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process.[42]

Planning costs may be used to help pay for infrastructure and technologies that will support robust stakeholder engagement. Examples may include but are not limited to:

- Laptops and other technologies to help stakeholders participate in the planning process
- Web-based meeting platforms
- Virtual engagement tools
- Accessibility services

[40] W&I Code § 5963.03, subdivision (b)(1)
[41] W&I Code § 5963.03, subdivision (c)(2)(B)
[42] W&I Code § 5892, subdivision (e)(1)(B)-(C)

- Stipends, wages, and contracts to be paid to consumers and family members
- Translation/interpretation services
- Travel and transportation for stakeholders
- Childcare
- Eldercare
- Training and technical assistance (TTA) for stakeholders to be meaningfully involved including TTA on fiscal policies
- Other supports to help with stakeholder engagement

Counties may use planning funds to assess public behavioral health workforce needs required as part of the IP, including the number of providers and vacancies in the county, the county's ability to develop and maintain a robust workforce that provides adequate access to services and supports, and address statewide behavioral health goals described in Section 2.C of this policy manual. Counties will no longer be required to submit a separate Workforce Needs Assessment beyond what is included in the IP.

Planning costs do not include costs incurred as administrative costs or program expenditures. Additional information on administrative costs, including direct and indirect costs, can be found in Chapter 6.B.

# C. Behavioral Health Care Continuum

## C.1 Background

Each county's Integrated Plan (IP) and its associated budget template is required to describe how it will spend behavioral health dollars across a care continuum. Specifically, each county is required to demonstrate, per Welfare and Institutions (W&I) Code section 5963, subdivision (a)(1), how it will:

> "utilize various funds for behavioral health services to deliver high quality, culturally responsive, and timely care along the continuum of services in the least restrictive setting from prevention and wellness in schools and other settings to community-based outpatient care, residential care, crisis care, acute care, and housing services and supports."

To provide counties with more specificity as to what it means to provide care along "the continuum of services," the California Department of Health Care Services (DHCS) has defined a Behavioral Health Care Continuum. The Behavioral Health Care Continuum is

composed of two distinct frameworks for substance use disorder (SUD) and mental health (MH) services. These frameworks will allow counties to describe their expenditures across key service categories, identify gaps in their service continuum, and articulate the investments they will make to expand access, close identified gaps, and improve performance as indicated through statewide behavioral health goals. The use of a standardized Behavioral Health Care Continuum also enables state-level analysis and comparison over time and across counties.[43] The information that counties provide through the Behavioral Health Care Continuum in the IP will not be used to evaluate compliance with expenditure requirements for Behavioral Health Service Act (BHSA) funds.

## C.2 Behavioral Health Care Continuum

Counties will report on *planned* service delivery and expenditures in the IP and budget template, and *actual* service delivery and expenditures in the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) and expenditure template, disaggregated by child/youth under age 21 and adults aged 21 and older, within the Behavioral Health Care Continuum service categories outlined below. Counties will plan expenditures in the IP by *totaling* the dollar amount *across all* behavioral health funding streams for each Behavioral Health Care Continuum service category and will report actual expenditures in the BHOATR by *listing* the dollar amount from *each* behavioral health funding stream for each Behavioral Health Care Continuum service category.

The Behavioral Health Care Continuum (shown in Figure 3.C.1) has eight service categories across discrete SUD and MH frameworks, which capture behavioral health programs and services delivered by county behavioral health agencies.[44] One category, Housing Intervention Services, will be reported as a single total across the SUD and MH

[43] While informed by national behavioral health frameworks, the Behavioral Health Care Continuum is tailored to California's specific landscape and adjusted to reflect input from California stakeholders. The Continuum is also informed by DHCS's previous assessment of California's Medi-Cal behavioral health service delivery system.

[44] The Behavioral Health Care Continuum includes services provided in facilities designated as Institutions for Mental Disease (IMD) and services in non-IMD facilities. The IMD exclusion is only applicable to billing for Medi-Cal services.

frameworks within the IP. For the BHOATR, DHCS will ask counties to report actual spending on Housing Intervention Services distinctly in each of the SUD and MH frameworks.


**Figure 3.C.1 Behavioral Health Care Continuum**

The Behavioral Health Care Continuum does not include county expenditures on: 1) workforce investment activities; 2) capital infrastructure activities; 3) quality and accountability, data analytics, plan management, and administrative activities; and 4) other *non-clinical service* county behavioral health agency activities (e.g. Public Guardian, forensic activities, Community Assistance, Recovery and Empowerment (CARE) Act). Counties will report these expenditures in the IP and BHOATR distinctly from the Behavioral Health Care Continuum. These non-Continuum expenditure categories will be described in forthcoming guidance on IP and BHOATR reporting.

Tables 3.C.1 and 3.C.2 below describe each of the categories that span the SUD and MH frameworks. The tables below offer descriptions of each service category as well as examples of the specific services that should be reported under the SUD and MH frameworks. A more detailed inventory cataloguing DHCS's recommended approach to reporting service expenditures across categories in the Behavioral Health Care Continuum will be provided with the release of the IP and BHOATR. Some services, like peer supports, medication services, and case management, may cut across several categories in the Behavioral Health Care Continuum; the funding for these services should be allocated according to the setting in which services are delivered (i.e., peer support services delivered within an outpatient setting should be categorized within "outpatient services").

SUD and MH frameworks include county reporting on population prevention services. While DHCS recognizes BHSA funds for population prevention are exclusively with the

California Department of Public Health (CDPH), counties have other funds that they may use for population prevention (e.g., Substance Abuse and Mental Health Administration (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), opioid settlement, Realignment, etc.) which DHCS anticipates this category will capture.

**Table 3.C.1 Substance Use Disorder Care Continuum Service Categories, Definitions,[45] and Example Services**

| Service Categories | Service Category Definition | Example SUD Services[46] |
|---|---|---|
| Population Prevention Services[47] | Includes services and activities that educate and support individuals to prevent substance misuse and substance use disorders from developing. These services/activities offer communities support in identifying and addressing issues, tools for coping with stressors and information on ways to promote resiliency. They may also include services and public health campaigns focused on overdose prevention. | • Substance use disorder education, such as paid media campaigns regarding "fentapills"<br>• Targeted prevention, such as SUBG-funded prevention screenings and referrals |

[45]Definitions are informed by DHCS's previous assessment of California's Medi-Cal behavioral health service delivery system and tailored to the county landscape.
[46] Services referenced reflect the ASAM 3rd edition. Medi-Cal guidance on the ASAM 4th edition is forthcoming. Available here.
[47] While BHSA funds for population prevention are exclusively with the California Department of Public Health (CDPH), counties have other funds that they may use for population prevention (e.g., SAMHSA SUBG block grant, opioid settlement, Realignment, etc.) which this category will capture.

| Service Categories | Service Category Definition | Example SUD Services[46] |
|---|---|---|
| Early Intervention Services[48] | Includes interventions that take a proactive approach to identifying and addressing substance use issues among individuals who are showing early signs, or are at risk, of a substance use disorder. These interventions, such as outreach, access and linkage, and treatment services, help avert the development of a severe and disabling condition, discourage risky behaviors and support individuals in maintaining healthy lifestyles. | • Screenings<br>• Brief intervention, American Society of Addiction Medicine (ASAM) level 0.5<br>• Evidence-based practices, like motivational interviewing |
| Outpatient Services[49] | Includes a variety of therapeutic substance use disorder services that can be provided anywhere an individual is located, such as in school, home, clinic, office, or other outpatient settings. These services may help avert the need for, or be provided after, crisis care, inpatient, or residential treatment. These services are provided, if necessary, as part of stabilization and continued recovery/ongoing evaluation. | • ASAM level 1.0, including individual and group therapy<br>• Contingency Management<br>• Narcotic/Opioid Treatment Programs |
| Intensive Outpatient Services | Includes services to support individuals living with higher acuity SUD needs who may require assistance at a higher frequency and/or intensity, sometimes via a team-based | • ASAM levels 2.1-2.5 |

[48] W&I Code § 5840, subdivisions (b)(1)-(3)

[49] W&I Code § 5887, subdivision (a)(4)

| Service Categories | Service Category Definition | Example SUD Services[46] |
|---|---|---|
| | approach. These services offer structure and monitoring when more support than routine outpatient visits is necessary. | |
| Crisis and Field-Based Services | Includes a range of services that engage, assess, stabilize, treat, and/or coordinate care for individuals in need of substance use disorder services in field settings (e.g., homeless encampments, shelters, or syringe service programs). Services may be delivered in non-traditional settings where individuals work or reside. | • Mobile crisis<br>• Assertive field-based initiation for substance use disorder treatment services[50]<br>• Post overdose follow up |
| Residential Treatment Services | Includes low- to high-intensity clinically managed residential treatment. Services may be delivered in short-term residential settings of any size. | • ASAM level 3.1-3.5 care |
| Inpatient Services | Includes 24-hour, intensive treatment services to individuals who require medical management or medical monitoring for substance use disorder needs. | • ASAM levels 3.7-4.0<br>• SUD services within a general acute care hospital (GACH), acute psychiatric hospital (APH), psychiatric health facility (PHF), or mental |

[50] W&I Code § 5887, subdivision (a)(3)

| Service Categories | Service Category Definition | Example SUD Services[46] |
|---|---|---|
| | | health rehabilitation center (MHRC) |
| Housing Intervention Services *(reporting is aggregated with the mental health framework)* | Includes services and supports designed to enable individuals to remain in their homes or obtain housing to support recovery and improved health outcomes. Services help individuals find and retain housing, support recovery and resiliency, and/or maximize the ability to live in the community. | • Permanent supportive housing<br>• Housing tenancy and sustaining services<br>• Recovery residences and sober living homes<br>• Rent<br>• Interim Settings |

**Table 3.C.2 Mental Health Care Continuum Service Categories, Definitions,[51] and Example Services**

| Service Categories | Service Category Definition | Example MH Services |
|---|---|---|
| Population Prevention Services | Includes services and activities that educate and support individuals to prevent acute or chronic conditions related to mental health from ever developing. These services/activities may offer communities support in identifying and addressing issues before they turn into | • Mental health education, such as public health campaigns for suicide prevention or adverse |

[51] Definitions are informed by DHCS's previous assessment of California's Medi-Cal behavioral health service delivery system and tailored to the county landscape.

| Service Categories | Service Category Definition | Example MH Services |
|---|---|---|
| | problems, tools for coping with stressors and information on ways to promote resiliency. | childhood experiences (ACEs) awareness<br>• Community Health Workers |
| Early Intervention Services[52] | Includes interventions that take a proactive approach to identifying and addressing mental health issues among individuals who are showing early signs, or are at risk, of a mental health disorder. These interventions, such as outreach, access and linkage, and treatment services, help avert the development of a severe and disabling condition, discourage risky behaviors and support individuals in maintaining healthy lifestyles. | • Screenings<br>• Evidence-based practices, such as coordinated specialty care for first episode psychosis |
| Outpatient[53] & Intensive Outpatient Services | Includes a variety of therapeutic mental health services that can be provided anywhere an individual is located, such as in school, home, clinic, office, field settings (e.g. homeless encampments, shelters, etc.) or other outpatient settings. Also includes services to support individuals living with higher acuity mental health needs who may require assistance at a higher frequency and/or intensity, sometimes via a team-based approach. These services may help avert the | • Individual therapy<br>• Group therapy<br>• Assertive Community Treatment/ Forensic Assertive Community Treatment (ACT/FACT) |

[52] W&I Code § 5840, subdivisions (b)(1)-(3)
[53] W&I Code § 5887, subdivision (a)(4)

| Service Categories | Service Category Definition | Example MH Services |
|---|---|---|
| | need for, or be provided after, crisis care, inpatient or residential treatment and are provided, if necessary, as part of stabilization and continued recovery/ongoing evaluation. They may also offer structure and monitoring when more support than routine outpatient visits is necessary. | • High Fidelity Wraparound (HFW)<br>• Intensive Outpatient Treatment/Day Treatment Intensive |
| Crisis Services | Includes a range of services and supports that assess, stabilize, and treat individuals experiencing acute distress. Services are designed to provide relief to individuals experiencing a mental health crisis, including through de-escalation and stabilization techniques, and may be delivered in clinical and non-clinical settings. | • Crisis call centers<br>• Crisis stabilization<br>• Crisis residential services<br>• Mobile Crisis |
| Residential Treatment Services | Includes intensive treatment services that are provided in a structured, facility-based setting to individuals who require consistent monitoring for mental health needs on a longer-term basis. Services may be delivered in short-term residential settings to divert individuals from or as a step-down from hospital and acute services. | • Adult residential treatment services |
| Hospital and Acute Services | Includes treatment services that are provided in structured, hospital settings to individuals who require consistent monitoring and stabilization. These services may include comprehensive | • Services within a psychiatric health facility (PHF), acute psychiatric hospital (APH), or |

| Service Categories | Service Category Definition | Example MH Services |
|---|---|---|
| | psychiatric treatment, including medication adjustments, and acute withdrawal services. | psychiatric unit within a general acute care hospital (GACH). |
| Subacute and Long-Term Care Services | Includes intensive licensed skilled nursing care provided to patients with mental health needs, most frequently delivered in a skilled nursing facility (SNF) and special treatment programs (STPs). | • Services within a SNF & SNF-STP<br>• Services within a MHRC |
| Housing Intervention Services *(reporting is aggregated with the substance use disorder framework)* | Includes services and supports designed to enable individuals to remain in their homes or obtain housing to support recovery and improved health outcomes. Services help individuals find and retain housing, support recovery and resiliency, and/or maximize the ability to live in the community. | • Permanent supportive housing<br>• Housing tenancy and sustaining services<br>• Residential Care Facilities for the Elderly (RCFE) and Adult Residential Care Facilities (ARF)<br>• Rent<br>• Interim Settings |

## D. County Integrated Plan Alignment with Statewide Population Behavioral Health Goals

As outlined in W&I Code section 5963.02, subdivision (c)(3)(A), each county shall develop an Integrated Plan (IP) and annual update (AU) aligned with their associated measures. DHCS will identify and provide counties with measures of their performance relative to the statewide behavioral health goals. Counties will use those measures to inform resource planning in their IPs and AUs, as well as their approach to population health management and implementation of targeted interventions to drive progress on statewide behavioral health goals. In forthcoming guidance, DHCS will describe its approach to calculating performance measures and delineate expectations for counties, MCPs, and other stakeholders as part of a monitoring and accountability framework. See Section 2.C for more detailed information.

# 4. Behavioral Health Outcomes, Accountability, and Transparency Report

## A. Purpose of the Behavioral Health Outcomes, Accountability, and Transparency Report

The Behavioral Health Services Act (BHSA) requires counties[1] to submit Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) to the Department of Health Care Services (DHCS) on an annual basis. Whereas limited information is publicly available regarding the provision of services that are funded with federal grant programs and other county-administered behavioral health funding sources outside of Medi-Cal, the BHSA establishes the BHOATR to provide California with greater transparency into how counties spend behavioral health dollars and administer behavioral health care. Counties will use the BHOATR Template to report on implementation of the county Integrated Plan (IP) and the related annual and intermittent updates. Counties are required to report on behavioral health spending, service utilization, and achievement of goals and outcomes outlined for the reporting period. County boards of supervisors are required to attest that the BHOATR is complete and accurate before it is submitted to DHCS.[2] Additionally, in accordance with Welfare and Institutions (W&I) Code section 14197.71, subdivision (c)(2), county boards of supervisors are required to attest that the county is meeting its realignment obligations, including but not limited to time and distance standards and appointment time standards set forth in W&I Code section 14197.7 without utilizing waitlists, and will do so through the BHOATR.

DHCS will review county BHOATRs. After DHCS approves the county BHOATR, DHCS will develop a statewide BHOATR describing activities and opportunities in behavioral health delivery across California. DHCS will post each county's BHOATR and an aggregated statewide BHOATR on the DHCS website.[3]

[1] W&I Code § 5963.04, subdivision (a)(1)
[2] W&I Code § 5963.04, subdivision (c)
[3] W&I Code § 5964.04, subdivision (d)

## A.1 Reporting Period

The first BHOATR will cover fiscal year (FY) 2026-27. The due date for the first BHOATR will be January 30, 2029. Counties will submit a draft BHOATR for FY 2026-27 due January 30, 2028. This one-time draft submission will allow DHCS to provide technical assistance.

## A.2 Required Contents

The BHOATR template will mirror the reporting requirements within the IP template. A detailed list of sections required for inclusion in the BHOATR template is forthcoming.

# 5. County Portal

Department of Health Care Services (DHCS) has developed an online county portal for each county to submit their Integrated Plans (IP), Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATR), and annual and intermittent updates. To facilitate county reporting and ensure comparability between county reports, data from publicly available sources will be pre-populated into each county's IP county portal where possible. Detailed information on how to use the county portal will be available in the DHCS Integrated Plan County Portal User Manual.

# 6. BHT Fiscal Policies

## B. BHSA Fiscal Policies

### B.4 Funding Transfer Requests

Starting with the fiscal year (FY) 2026-2029 Integrated Plan (IP), all counties can request changes to the funding allocation percentages outlined in Table B.5.1 below. Counties may ask to transfer funds between these three components to change their funding allocation percentages. However, these changes in funding allocation percentages cannot exceed 7 percent of total funds allocated to the county in one fiscal year from any one component. Counties may only request a maximum of 14 percent of total funds allocated to the county to transfer in any given fiscal year.[1] Adjusting the distribution of funds within a county according to these guidelines does not exempt the county from adhering to any additional applicable laws or to the sub-allocation requirements.[2]

In a fiscal year, a county may transfer from its housing intervention funds up to 7 percent of its total BHSA allocation for that fiscal year. However, if a county uses housing intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the housing intervention component must be decreased by a corresponding amount.[3] For example, if County A chooses to use 3 percent of its annual Housing Intervention funds for outreach and engagement, then County A would be able to transfer no more than 4 percent out of its Housing Interventions component into another funding component. Counties are not required to utilize Housing Interventions funding for outreach and engagement. Counties are also not required to transfer funds out of Housing Interventions. Counties shall retain discretion to transfer up to a total of 14 percent of its total BHSA allocation in a fiscal year.

All transfer requests between Housing Interventions, Full Service Partnerships (FSP), and/or Behavioral Health Services and Supports (BHSS) components must be submitted to DHCS through the county portal and include all required information and

[1] W&I Code § 5892, subdivision (c)(1)
[2] W&I Code § 5892, subdivision (c)(2)
[3] W&I Code § 5892, subdivision (c)(4)

documentation.[4] This includes details and rationale for the funding allocation transfer request. The rationale must specify how the transfer request is responsive to community needs and include local data and community input in the planning process. For instance, a county might demonstrate significant need within a particular component by showing that programs are unable to meet the demand of their community. Or, if a county is interested in decreasing a funding allocation percentage for a component, a county should demonstrate that there is limited need or show where there is sufficient funding from other sources.

Counties may submit their funding transfer request within the county portal prior to developing their IP in order to support planning efforts.

DHCS will review transfer requests based on compliance with statutory requirements, evidence of alignment with local priorities, and community input.[5] For transfer requests, counties are also required to adhere to local stakeholder consultation requirements.[6] Additional information about the community planning process can be found in Chapter 3.B.1 of this policy manual.

## B.5 Funding Component Allowances

The table below lays out the funding allocations and their corresponding sub-allocations for each Behavioral Health Services Act component, beginning July 1, 2026.[7]

**Table B.5.1 Overview of Funding Allowances**

| Statute | Allocation | Sub-Allocations | Special Considerations |
|---|---|---|---|
| | Housing Intervention | 50% of these funds shall be directed | These housing interventions are focused on the chronically |

[4] W&I Code § 5892, subdivision(c)(4)
[5] W&I Code § 5892, subdivision (c)(4)(A)
[6] W&I Code §§ 5963.02 and 5963.03
[7] W&I Code § 5892, subdivision (l)

| Statute | Allocation | Sub-Allocations | Special Considerations |
|---|---|---|---|
| W&I Code section 5892, subdivision (a)(1)(A) | Programs (30%) | towards housing interventions for persons who are chronically homeless. | homeless, with a focus on encampments. |
| | | No more than 25% shall be used for capital development projects. | Housing Intervention funds may be used for capital development, under the provisions of W&I Code section 5831, and only for eligible populations under W&I Code section 5830, subdivision (a). If a county elects to use housing intervention funds for capital development, the units shall be available in a reasonable timeframe as specified by DHCS (W&I Code section 5830, subdivision (b)(2)(B)). |
| W&I Code section 5892, subdivision (a)(2)(A) | Full Service Partnership Program (FSP) (35%) | N/A | The sub-allocations of Housing Intervention services may be used towards individuals enrolled in a FSP program. |

| Statute | Allocation | Sub-Allocations | Special Considerations |
|---|---|---|---|
| W&I Code section 5892, subdivision (a)(3)(A)<br>W&I Code section 5892, subdivision (a)(3)(B)(i-ii) | Behavioral Health Services and Supports (BHSS) (35%) | At least 51% of BHSS services shall be used exclusively for early intervention programs. | Of the BHSS funds allocated for early intervention programs, at least 51% shall be used for early intervention programs to serve individuals aged 25 years and younger. |

### B.5.1 Adjusting a Previously Approved Funding Allocation Percentage Change

Approved funding allocation percentage changes are final and cannot be adjusted again for the duration of the three-year plan, unless an annual change is approved by DHCS due to a state or local emergency.[8] To be granted an annual change, a county shall demonstrate to DHCS that it is experiencing a state[9] or local[10] emergency, and the change is necessary because of the emergency. Counties may only request an annual change in funding allocations percentages for previously approved funding allocation percentage changes.[11] If a county seeks to adjust the percentage allocations that were previously approved by DHCS as part of the IP, the county will submit the funding allocation percentage change request in the county portal. Counties are required to adhere to local stakeholder consultation requirements to adjust funding allocations.[12]

### B.5.2 Process for Approval and Denial

DHCS has 30 calendar days to approve or deny funding allocation transfer requests following receipt of the request. The approval and/or denial of the transfer request will

[8] W&I Code § 5892, subdivision (c)(4)(C)
[9] Gov. Code, § 8625
[10] Gov. Code, § 8630
[11] W&I Code § 5892, subdivision (c)(4)(C)
[12] W&I Code § 5963.03(c)(1)

be completed through the county portal. If DHCS does not respond within 30 calendar days, the funding allocation transfer request will be considered approved.[13]

If the transfer request is approved, funding allocation adjustments cannot be changed during the three-year IP period, unless an annual change is approved by DHCS.[14] If the transfer request is denied, justification will be included with the decision. The county will be required to update their Integrated Plan (IP) to reflect the denial. Counties should be transparent with stakeholders throughout the community planning process and acknowledge where the IP will need to be adjusted if the exemption request is not approved.

If the county does not agree with DHCS's decision to deny the transfer request, the county may submit an appeal to DHCS within 30 calendar days of receipt of the denial. The appeal must include an explanation stating the basis of the appeal and supporting documentation. Appeals must be submitted through the county portal. DHCS has 30 calendar days to approve and/or deny the appeal, starting with the date that DHCS confirmed receipt of the appeal.

DHCS will have 10 calendar days from confirming receipt of the appeal to request additional documentation from the county. Counties will supply additional documentation within 10 calendar days of confirming receipt of the request.

If the appeal is denied, justification will be included with the decision. If an appeal is submitted after 30 calendar days from receipt of the denial, the appeal will be automatically denied.

If the county already submitted their IP and budget and the county receives notice that their funding transfer request was denied, the county is required to update the IP and budget to reflect the correct allocation amounts within 90 days of receipt of the denial from DHCS, unless the county receives approval for an extension to this timeframe.

### B.5.3 Reporting Requirements

Transfers between components will change the required allocation of BHSA funds dedicated to Housing Interventions (30 percent), FSP (35 percent), and BHSS (35 percent). As a result, counties are required to report approved transfers and updated

[13] W&I Code § 5892, subdivision(c)(4)
[14] W&I Code § 5892, subdivision (c)(4)(C)

BHSA allocations on the BHOATR, consistent with the transfers approved as part of the IP.[15]

Funds transferred between FSP, Housing Interventions, and BHSS components are subject to the same reversion requirements as before the transfer. Transferring funds does not alter the reversion period associated with those funds. The reversion period is the length of time a county has to spend its local Behavioral Health Services Fund (BHSF) money; the reversion period begins the fiscal year in which funds are transferred from the state BHSF to the local BHSF. For more information on reversion, please see the Reversion Section of this policy manual in Chapter 6.B.

[15] W&I Code § 5963.04, subdivision (a)

# 7. BHSA Components and Requirements

## C. Housing Interventions

### C.1 Housing Interventions Funding

Counties are required to use 30 percent of the funds distributed by the State Controller's Office into their Behavioral Health Services Fund (BHSF) for Housing Interventions.

Of the funding distributed to counties for Housing Interventions:

- 50 percent must be used to support the housing needs of individuals who are chronically homeless, with a focus on those in encampments.
- Up to 25 percent may be used for capital development projects.
    - If a capital development project identifies chronically homeless individuals as a priority population, the project funding will contribute toward the 50 percent requirement.

### C.2 Introduction and Background

Using the Behavioral Health Services Act (BHSA) Housing Interventions funding, counties can develop an ongoing behavioral health housing program to increase access to permanent supportive housing for people meeting BHSA eligibility who are chronically homeless, experiencing homelessness, or are at risk of homelessness.

These policies have been developed to give counties flexibility so that each community can develop a program that is reflective of its needs. The flexibilities of Housing Interventions are also intended to build upon other housing initiatives, including but not limited to Homekey+, Behavioral Health Bridge Housing (BHBH), No Place Like Home (NPLH), Homekey, Project Roomkey, the Community Care Expansion (CCE) Program, the Housing and Homelessness Incentive Program (HHIP), the Encampment Resolution Fund (ERF), and the Homeless Housing Assistance and Prevention Grant Program (HHAP). Housing Interventions are also intended to complement CalAIM Community Supports and Transitional Rent available through Medi-Cal Managed Care Plans (MCPs). The Transitional Rent benefit available through MCPs specifically to seamlessly connect

BHSA eligible individuals receiving Transitional Rent to BHSA-funded Housing Interventions.

In the following sections, the Department of Health Care Services (DHCS) identifies a number of policies and procedures that counties must develop to support the implementation of Housing Interventions. Those policies and procedures are not subject to approval by DHCS but must be provided to DHCS upon request.

## C.3 Program Priorities

The development of Housing Interventions has been driven by the following priorities:

- Reduce homelessness among BHSA eligible individuals experiencing homelessness with a behavioral health condition, focusing efforts on the chronically homeless, with a focus on those in encampments.
- To the extent possible, provide individuals with permanent supportive housing, including voluntary, flexible, and intensive supports and services available such as Assertive Community Treatment, Intensive Case Management, and other supports funded under the BHSA and Medi-Cal consistent with best practice.
- Provide flexibility for counties to respond to local conditions and needs, and to innovate.
- Provide individuals receiving Housing Interventions access to clinical and supportive behavioral health services.
- Support the provision of low-barrier, harm reduction, and Housing First principles.
- Complement ongoing state, county, city, Continuum of Care, and tribal efforts to address homelessness, including but not limited to those provided through Medi-Cal.

# C.4 Eligible and Priority Populations

## C.4.1 Eligible Populations for Housing Interventions[1]

Individuals must meet the BHSA eligibility requirements, identified in this policy manual[2] and meet the definition of:

- At-Risk of Homelessness, or
- Experiencing Homelessness, or
- Chronically Homeless, with a focus on those in encampments.

### C.4.1.1 Experiencing Homelessness and At Risk of Homelessness

W&I Code section 5892, subdivision (k)(3) provides that for purposes of the BHSA, "experiencing homelessness or at risk of homelessness" means people who are homeless or at risk of homelessness as defined by 24 CFR section 91.5 or as otherwise defined by the State Department of Health Care Services for purposes of the Medi-Cal program.

For purposes of the BHSA, DHCS is adopting the definitions of experiencing homelessness and at risk of homelessness consistent with CalAIM Community Supports, which are the same as the definitions provided at 24 CFR section 91.5 with three modifications, as follows:

- Individuals exiting an institution or carceral setting are considered homeless if they were homeless immediately prior to entering that institutional or carceral stay or become homeless during that stay, regardless of the length of the institutionalization or incarceration.
- The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness to 30 days.

[1] W&I Code § 5830

[2] Pursuant to W&I Code § 5891.5, subdivision (a)(2), the provision of Housing Interventions to individuals with a substance use disorder (SUD) is optional for counties in alignment with the requirements in Section 5963.02(b)(2) . However, when Housing Interventions are provided to an individual living with a SUD, all housing intervention requirements in W&I Code § 5830 must be met.

- An individual or family is not required to have an annual income below 30 percent of median family income for the area.

Additionally, anyone who was homeless or at risk of homelessness prior to the receipt of Transitional Rent (as covered by a Medi-Cal managed care plan) or prior to the receipt of housing funded by MHSA is considered homeless for BHSA purposes.

### C.4.1.2 Chronically Homeless

W&I Code section 5892, subdivision (k)(2) provides that for purposes of the BHSA, "chronically homeless" means an individual or family that is chronically homeless as defined in 42 U.S. Code section 11360 or as otherwise modified or expanded by the State Department of Health Care Services.

DHCS is adopting the Department of Housing and Urban Development (HUD) definition of chronic homelessness, identified under 24 CFR section 91.5 with two modifications, as follows:

- The requirement that a discontinuous period of 12 months of homelessness over the last three years occur on at least four separate occasions is eliminated; any number of occasions will suffice so long as the combined duration equals at least 12 months.
- Consistent with the Medi-Cal modification to the definition of "homeless," anyone residing in an institutional care facility, defined according to the HMIS definition of "institutional situations," who was chronically homeless prior to entry retains that status upon discharge, regardless of length of stay.

Additionally, anyone who was chronically homeless prior to the receipt of Transitional Rent or prior to the receipt of housing funded by MHSA and is transitioning from either of these services to Housing Interventions services will be considered chronically homeless under Housing Interventions.

Regarding the requirement that 50 percent of Housing Interventions be directed to individuals experiencing chronic homelessness, the determination that an individual meets the definition of chronically homeless will be made by counties at enrollment and may maintain their status as such for the duration of their enrollment in Housing Interventions services.

### C.4.1.3 People in Encampments

The BHSA requires that 50 percent of a county's Housing Interventions funds be used for Housing Interventions for persons eligible for BHSA funding who are chronically homeless, "with a focus on those in encampments."[3] The BHSA definition for encampments is in alignment with the Department of Housing and Urban Development (HUD)[4] definition. An encampment includes the following:

- A group of people sleeping outside in the same location for a sustained period.
- The presence of some type of physical structures (e.g., tents, tarps, lean-to's).
- The presence of personal belongings (e.g., coolers, bicycles, mattresses, clothes).
- The existence of social support or a sense of community for residents.

Counties are expected to prioritize serving individuals living in encampments with methods consistent with the U.S. Interagency Council on Homelessness' 19 Strategies for Communities to Address Encampments Humanely and Effectively. It is essential that counties provide Housing Interventions services that are relevant and responsive to the needs of individuals in encampments who are chronically homeless and are BHSA eligible, including the provision of housing and behavioral health interventions that will help individuals transition out of encampments and into permanent supportive housing.

## C.4.2 Priority Populations

In addition to specifying the populations who are eligible for Housing Intervention services ("Eligible Populations"), the BHSA identifies a smaller subset of populations who should be prioritized for BHSA services (see BHSA requirements here).

**Priority Populations[5]:**

Children and youth in the Eligible Population who also satisfy one of the following:

- In, or at risk of being in, the juvenile justice system;
- Reentering the community from a youth correctional facility;
- In the child welfare system; or
- At risk of institutionalization.

[3] W&I Code § 5892, subdivision (a)(1)(A)(ii).
[4] Unsheltered Homeless and Homeless Encampments in 2019
[5] W&I Code § 5892, subdivision (d)

Adults or older adults in the Eligible Population who also satisfy one of the following:

- In, or are at risk of being in, the justice system;
- Reentering the community from prison or jail;
- At risk of conservatorship; or
- At risk of institutionalization.

### C.4.3 Individuals Transitioning from MHSA to BHSA

For individuals housed under the MHSA as of June 30, 2026, the following policies apply:

1. Counties may transfer individuals housed in permanent housing directly to BHSA-funded Housing Interventions without eligibility redetermination.
2. Individuals receiving interim housing under the MHSA who are not enrolled in an MCP may also be transferred to BHSA Housing Interventions without eligibility redetermination.
3. For individuals in interim housing who are in an MCP, the county should connect the individual to their MCP for assessment of eligibility for Transitional Rent. The goal is for this to be seamless to the individual being served. This will require the delivery systems to put processes in place for effective coordination.
    - Those determined eligible for Transitional Rent may be transferred to the MCP and may not receive rental assistance or housing under BHSA Housing Interventions until they are no longer eligible for Transitional Rent.
    - Those determined ineligible for Transitional Rent may be transferred directly to BHSA Housing Interventions without eligibility redetermination.
4. Anyone who was chronically homeless when housed under MHSA, and who was transferred from MHSA to BHSA, will be considered chronically homeless for purposes of the requirement to direct 50 percent of Housing Interventions to individuals who are chronically homeless.

## C.5 Program Requirements

In addition to the eligibility requirements, W&I Code section 5830, subdivision (a) specifies the following:

- Housing Interventions shall not be limited to individuals enrolled in either a Full Service Partnership or Medi-Cal.

- Counties shall not discriminate against or deny access to housing for individuals that are utilizing medications for addiction treatment or other authorized medications, or individuals who are justice-involved.
- Housing Interventions shall comply with the core components of Housing First, as defined in subdivision (b) of W&I Code section 8255, and may include recovery housing. See additional information in the C.9.5.1 Housing First section below.
- All Housing Interventions settings must be combined with access to clinical and supportive behavioral health care and housing services that will promote the individual's health and functioning and long-term stability. Access does not necessitate co-location. Housing Interventions may not be used for behavioral health services; however, these activities can be covered under Behavioral Health Services and Supports or other behavioral health funding sources.
- Counties may utilize up to 7 percent of Housing Intervention funds on identified Outreach and Engagement activities. If Housing Intervention funds are used for Outreach and Engagement activities under the Housing Intervention component, counties must adhere to transfer requirements, including required documentation, in section C.6 Transfers and Exemptions.

## C.6 Transfers and Exemptions

### C.6.1 Transfers

Beginning in Fiscal Year 2026, counties may request to transfer funds distributed to the counties Behavioral Health Services Fund to spend more than or less than 30 percent of their local BHSF on Housing Interventions.[6] Please refer to the Funding Transfer Requests section for more information.

Transfer of funds into or out of Housing Interventions funds does not relieve the county from complying with:

- The requirement to use 50 percent of Housing Interventions funds on services for the chronically homeless.
- The requirement to use no more than 25 percent of Housing Interventions funds on capital development projects.

[6] W&I Code § 5892, subdivision (c).

## C.6.2 Exemptions

State law permits counties to request exemptions to Housing Interventions spending requirements. Exemptions are necessary for counties requesting a funding adjustment beyond the seven percent allowed through the transfer process. Counties with a population of less than 200,000 may request exemptions beginning with the 2026-29 Fiscal Years' county Integrated Plan (IP), and all counties regardless of size may do so beginning with the 2032-35 Fiscal Years' county IP. Exemption requests are subject to DHCS approval; counties may request exemptions from one or more of the following requirements[7]:

- 30 percent of the BHSF funds distributed to the county for Housing Interventions services.
- 50 percent of the county's Housing Interventions funds on those who are chronically homeless.
- No more than 25 percent of Housing Interventions funds on capital development projects.

**Table C.6.2.1 Criteria for Housing Exemption Requests**

| Requirement | Exemption Request Criteria |
|---|---|
| **30 percent of BHSF for Housing Interventions** | Criteria for increased/reduced percentage (beyond transfer allowance):<br>• Very significant or very limited need (e.g., small/large eligible population).<br>• Sufficient/insufficient funding from other sources to address housing needs.<br>• Other considerations, subject to evidence requirements and DHCS review.<br><br>Requests for exemptions must include information and data demonstrating that the exemption request criteria provided above are met (e.g., Point in Time Count (PIT), Housing |

[7] W&I Code § 5892, subsections (a)(1)(B)-(C)

| Requirement | Exemption Request Criteria |
|---|---|
| | Inventory Count (HIC), HMIS data, Coordinated Entry System data, Electronic Health Record data, etc.). |
| **50 percent of the county's Housing Intervention funds on persons who are chronically homeless** | Criteria for reduced percentage:<br>• Very limited need (e.g., small number of BHSA eligible individuals experiencing chronic homelessness).<br>• Sufficient funding from other sources to address housing needs.<br>• Other considerations, subject to evidence requirements and DHCS review.<br><br>Requests for exemptions must include information and data demonstrating that the exemption request criteria provided above are met (e.g., PIT, HIC, HMIS data, Coordinated Entry System data, Electronic Health Record data, etc.). |
| **No more than 25 percent of the county's Housing Intervention funds on capital development projects** | Criteria for increased percentage:<br>• Significant capital development required to meet housing needs of eligible population (e.g., demonstrated lack of existing suitable housing facilities within the county).<br>• Other funding sources insufficient to address need<br>• Costs of accessibility improvements exceed 25 percent capital improvement limits.<br>• Other considerations, subject to evidence requirements and DHCS review.<br><br>Requests for capital development exemptions must include documentation demonstrating that the exemption request criteria provided above are met (e.g., a detailed budget with funding breakdown, partnership agreements/letters of support, evidence of need for housing production, and other supporting data). |

## C.7 Relationship to Medi-Cal Funded Housing Services

Per W&I Code section 5830, subdivision (c)(2), Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Accordingly, counties must work closely with MCPs to ensure that Housing Interventions funds are used to complement, not supplant, MCP-covered services. By working closely with MCPs to coordinate the delivery of housing-related Community Supports covered by MCPs prior to expending the Behavioral Health Services Act (BHSA) Housing Interventions funding, counties and MCPs will play a key role in the prudent stewardship of taxpayer dollars and help ensure that funding sources other than the BHSA also contribute to meeting the housing-related needs of BHSA eligible Californians with behavioral health conditions. This statutory requirement will maximize the total amount of the BHSA Housing Interventions funding available to counties, allowing these dollars to go further to improve outcomes for Californians. The close coordination will also facilitate appropriate referrals to additional Community Supports, Enhanced Care Management, and other services delivered by MCPs.

### C.7.1 Prohibition on Housing Interventions Coverage of Managed Care Plan-Covered Services

Housing Interventions "shall not be used for housing interventions covered by a Medi-Cal Managed Care Plan."[8] Under CalAIM, MCPs are authorized to cover five housing-related "Community Supports"[9,10]:

[8] W&I Code § 5830, subdivision (c)(2).

[9] As of September 6, 2024, 100 percent of MCPs cover the Housing Trio and 92 percent cover Recuperative Care and Short-Term Post-Hospitalization Housing. An additional six Medi-Cal managed care plans will offer Recuperative Care and Short-Term Post-Hospitalization Housing by 1/1/25. On 1/1/25, MCPs will have the option to cover Transitional Rent and on 1/1/26, coverage will be mandatory.

[10] DHCS Medi-Cal Community Supports Policy Guide. July 2023.

**Table C.7.1. Coverage of Housing-related Community Supports**

| Service | Coverage[11,12] |
|---|---|
| **Housing Deposits** | Covered by all MCPs in all counties |
| **Housing Transition Navigation Services** | Covered by all MCPs in all counties |
| **Housing Tenancy and Sustaining Services** | Covered by all MCPs in all counties |
| **Recuperative Care** | Varies by MCP |
| **Short-Term Post-Hospitalization Housing** | Varies by MCP |
| **Transitional Rent[13]** | All MCPs required to cover for the behavioral health population beginning January 1, 2026 |

Housing Interventions may not be used to cover any of the services identified above when the individual is eligible for the service through their MCP. BHSA funding can be used if the MCP is not offering the Community Support in a county or if the individual has expended a benefit with a timeline restriction (e.g., the six month aggregate annual cap across Transitional Rent, Short-Term Post-Hospitalization Housing, and Recuperative Care; the limitation of six months per demonstration period for Transitional Rent). Additionally, if a Medi-Cal member is receiving housing services from their MCP, this does not preclude the individual from receiving simultaneous Housing Interventions not covered by the MCP. For example, an individual who is receiving Transitional Rent could also receive utility assistance funded by the BHSA Housing Interventions because

[11] DHCS CalAIM Community Supports – Managed Care Plan Elections. Updated July 2024.
[12] Coverage depicted as of date of publication – please refer to website for current status.
[13] DHCS Transitional Rent Concept Paper. August 2024.

Transitional Rent will only cover landlord-paid utilities that are part of rent, not utilities that the tenant is responsible for paying separately.

### C.7.2 Expectations for Coordination with MCPs

Counties will be expected to coordinate closely with MCPs to:

1. Ensure that Housing Interventions are not used for services that are covered by the MCP.
2. Support seamless connections from the county to the MCP for coverage of housing services and vice versa.
3. Provide whole-person care and integrated housing services for MCP-enrolled members with significant behavioral health needs who meet BHSA eligible criteria.

At a minimum, counties are required to establish detailed policies and procedures for issuing referrals to MCPs for housing-related Community Supports (including Transitional Rent) in alignment with forthcoming DHCS guidance and receiving referrals for BHSA Housing Interventions services (guidance forthcoming). DHCS may provide additional information in the future regarding minimum standards for coordination with MCPs regarding housing-related Community Supports and the BHSA Housing Interventions funding.

In addition, counties are strongly encouraged to participate as providers of housing-related Community Supports covered by MCPs, including but not limited to: Transitional Rent, Housing Deposits, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services in particular. The BHSA Housing Interventions funding is intended to serve as a permanent rental subsidy for housing following MCP-covered Transitional Rent for BHSA eligible individuals, providing seamless continuity and supporting Californians with behavioral health conditions in achieving long-term housing sustainability. As such, it is critical to ensure that counties and MCPs work in full partnership to connect individuals to Transitional Rent and integrate this service with specialty behavioral health services. To that end, DHCS is designing a comprehensive policy approach to standardize processes and streamline requirements for the Transitional Rent benefit with the goal of directly enabling counties to serve as MCP-contracted providers of Transitional Rent and other housing-related Community

Supports. Such arrangements will amplify MCP-county coordination of housing-related services and improve the experience of individuals receiving these supports.

## C.8 Flexible Housing Subsidy Pools

While not required, Flexible Housing Subsidy Pools ("Flex Pools") are a strategy to support local partners, including counties, in braiding complementary funding sources and resources to provide permanent supportive housing. Flex Pools provide a model for administering and coordinating multiple streams of funding for rental subsidies and a model which shows potential for the coordination and administration of housing supports. This model for housing payments could facilitate the centralized deployment of housing location, navigation, and rental subsidy payments and supports administrative billing functions. With a Flex Pool, a centralized administrative entity can efficiently connect individuals to the units that best meet their needs from with collective "housing pool". Flex Pools provide a solution to create economies of scale, reduce the burden of subsidy administration, and braid together resources seamlessly so that members are accessing housing more quickly and efficiently, and ensures individuals who become housed, remain housed.

Technical assistance will be made available on the use of Flex Pools to coordinate the administration of the Behavioral Health Services Act (BHSA) Housing Interventions, housing-related Community Supports (including Transitional Rent), and other sources of housing support funding.

## C.9 Allowable Expenditures and Related Requirements

Housing Interventions may be used for the following expenditures and are subject to the identified program requirements as discussed in the remainder of this chapter, which is organized as follows:

1. Rental Subsidies
2. Operating Subsidies
3. Allowable Settings
4. Other Housing Supports
    a. Landlord Outreach and Mitigation Funds
    b. Participant Assistance Funds

   c. Housing Transition Navigation Services and Tenancy and Sustaining Services
   d. Outreach and Engagement (up to 7 percent)
5. Other Housing Interventions Requirements
6. Capital Development Projects

## C.9.1 Rental Subsidies

The terms rental subsidies and rental assistance as used in the manual are inclusive of multiple, specific types of rental assistance described in detail in this section. The intent of Housing Interventions is to place and sustain individuals in permanent housing settings including permanent supportive housing developed through the Homekey+ program and other state and locally funded supportive housing programs. While counties may establish short and medium-term rental assistance programs, particularly in interim settings as described below, the goal is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. Rental subsidies can be established either as scattered-site (multiple locations) or project-based assistance (one location), including master leasing. Counties are encouraged to work with housing providers in their regions to prioritize the Behavioral Health Services Act (BHSA) Housing Interventions for projects serving BHSA eligible individuals within their regions.

### C.9.1.1 Rental Assistance Requirements

All rental subsidies must be issued directly to property owners, managers, or providers contracted to administer BHSA-funded rental assistance.

Counties opting to provide rental subsidies must develop policies and procedures that, at a minimum, address the following:

- The setting in which the rental subsidy will be used (see Allowable Settings, below).
- The duration of payments (to be determined based on individual need and, to the extent possible, to continue as long as necessary or until an alternative subsidy or arrangement is in place).

- The calculation of rental assistance for permanent settings. The method elected must use either the rent reasonableness methodology or Fair Market Rents[14] (FMRs), to calculate allowable rental rates. Rent Reasonableness assesses rent based on similar unassisted units in the local area, considering factors like location, size, type, quality, and amenities. It adapts to the actual market dynamics and can be more accurate for specific neighborhoods or property types.
- The calculation and types of utilities that are allowed (e.g., electricity, natural gas, water, sewer services, trash collection and internet).
- The calculation of individual contribution towards rent. Counties may establish individual contribution requirements of zero to 30 percent of individual income, and the individual contribution requirements may vary by program or setting.[15] Importantly, BHSA-eligible individuals may not be denied Housing Interventions assistance due to lack of income (i.e., if income is zero, tenant pays zero). DHCS recommends 30 percent of adjusted income for permanent settings to match federal vouchers.
- The housing-related supportive services and resources that will be made available to individuals who are receiving rental subsidies that will remove barriers and help them obtain and/or maintain supportive housing.
- Fraud prevention measures, along with a designated and regular audit process.
- Record-keeping methods, including the process for the documentation of all payments issued.

These policies and procedures are not subject to review and approval by DHCS but must be provided to DHCS upon request.

### C.9.1.2 Project-Based Housing Assistance

Project-Based Housing (PBH) assistance is a form of rental assistance that is tied to a particular housing unit. PBH differs from tenant-based rental assistance, which is a subsidy or federal voucher assigned to the program participant, and which may relocate with the participant to another unit if needed.  PBH can occur in unit(s) of an apartment

[14] Fair Market Rent includes Small Area Fair Market Rent or up to 120% Fair Market Rent or Small Area Fair Market Rent.
[15] Time-limited interim settings must not require tenants to pay rent.

complex, duplex, triplex, or other structure that is leased, purchased, and/or otherwise subsidized for the purpose of providing housing to eligible individuals. Counties are encouraged to work with housing providers in their region constructing permanent supportive housing and other affordable housing for the eligible population to assess opportunities for project-based rental subsidies, especially through the Homekey+ program. Counties are also encouraged to assess the full pipeline of permanent supportive housing and affordable housing being built within their region so that this funding can be paired with eligible projects that meet the housing needs of BHSA priority populations.

In addition to the policies required for all rental assistance projects (See "Rental Assistance Requirements" section), counties providing PBH are responsible for ensuring policies and procedures governing such units, such as a property management guide for each property meet the requirements identified under "Program Requirements." The property management guide must also include tenant selection and occupancy procedures (for example, rent contributions, if any; and other core program and fiscal policies to be required by DHCS).

### C.9.1.3 Master Leasing

A master lease is a legal agreement through which a master tenant (the county or its subcontracted provider or county grantee) leases a unit or multiple units from a property owner, and then subleases units to subtenants. Under a master lease strategy, the county or subcontracted provider enters into a lease with the property owner, specifying the county/property owner roles and responsibilities, including tenant selection and responsibility for damage and repair. The county then would serve as a master tenant, and then enter into subleases or occupancy agreements with individual(s) who are eligible for Housing Interventions.

Master leasing can be used by counties to provide scattered-site or PBH. Units can include but shall not be limited to single and multi-family homes, apartments, and other privately owned properties.

## C.9.2 Operating Subsidies

Housing Interventions allows the use of funds for operating subsidies for either new or existing housing on the allowable settings list provided below. Operating costs are those costs associated with the day-to-day physical operation of housing projects and may include utilities (including internet), maintenance and repairs, marketing and leasing costs taxes and insurance, property management, office supplies and expenses, legal and accounting services, security and/or site monitors, cleaning fees, and housing incidentals (refrigerators/appliances, water heater, transportation, furnishings, food, hygiene products etc.). Operating costs may not include costs for behavioral health services; however, these can be covered under Behavioral Health Services and Supports (BHSS) and other behavioral health funding sources. Operating costs may not include costs for housing transition navigation or tenancy sustaining services; however, the costs for these services are included as allowable expenditures in the "other housing supports" component of Housing Interventions (see section C.9.4 below). Counties opting to provide operating subsidies as a Housing Intervention service must develop policies and procedures that, at a minimum, address the types of expenses which may be covered with Housing Interventions.

## C.9.3 Allowable Settings

The aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings.

However, Housing Interventions may also be used in connection with placement in interim settings for a limited time. For BHSA eligible individuals who have exhausted the Transitional Rent benefit, counties may use the BHSA Housing Interventions funding to provide an additional six months of subsidy for placement in an interim setting. For BHSA eligible individuals who are not eligible for Transitional Rent, 12 months of coverage in an interim setting may be provided. After the 6- or 12-month time limit has expired, Housing Interventions funds may only be used for placement in a permanent setting.

Housing Interventions funding will be permissible in the following settings:

Non-Time-Limited Permanent Settings:

- Supportive housing
- Apartments, including master-lease apartments
- Single and multi-family homes
- Housing in mobile home communities
- Single room occupancy units
- Accessory dwelling units, including Junior Accessory Dwelling Units
- Tiny Homes[16]
- Shared housing
- Recovery/Sober Living housing, including recovery-oriented housing[17]
- Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
- License-exempt room and board
- Other settings identified under the Transitional Rent benefit

Time Limited Interim Settings:

- Hotel and motel stays
- Non-congregate interim housing models
- Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[18] (does not include behavioral health residential treatment settings)
- Recuperative Care
- Short-Term Post-Hospitalization housing
- Tiny homes, emergency sleeping cabins, emergency stabilization units
- Peer respite
- Other settings identified under the Transitional Rent benefit

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[16]Tiny homes would only be considered permanent if the settings have the hallmarks of a permanent setting such as requiring a lease, require payment of rent, has reasonable and ease of access to private bathrooms, kitchen areas, and utilities. Additionally, the settings must not have restrictive rules pertaining to curfews or having guests and has sufficient infrastructure to function as a permanent site.

[17] Single Room Occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those who are not eligible for Transitional Rent. Please see Appendix B for a crosswalk of coverage by select programs.

[18] Congregate settings do not include behavioral health residential treatment settings. Housing Interventions may not be used to cover room & board in residential treatment settings.

Counties must ensure that individuals are voluntarily placed in the least restrictive, most community-integrated setting that can accommodate their physical and behavioral health needs.

Individuals should be placed in settings that reflect their preferences and goals, enables them to stay in their "home" communities and provides for community integration in accordance with all applicable federal and state law.

### C.9.3.1 Permanent Supportive Housing

Permanent Supportive Housing (PSH) is a proven and cost-effective model that provides long-term housing coupled with intensive case management services linking individuals with medical, behavioral health, and other services such as income supports. Those supports can be referrals to community-based providers or delivered onsite, depending on the nature of the project or the tenants' needs. When integrated with voluntary, flexible, intensive community-based services, PSH is an evidence-based practice that is nationally recognized as the standard solution for meeting the housing needs of people with serious mental illness. Basic tenets of PSH, including those enumerated in Housing First, include:

- **Permanent:** Tenants may live in their homes as long as they meet the basic obligations of tenancy, such as paying rent.
- **Supportive:** Tenants have access to the supportive services that they need and want to retain housing.
- **Housing:** Tenants have a private or shared and secure place to make their home, just like other members of the community, with the same rights and responsibilities.

PSH programs may be administered through tenant-based rental subsidies, which may be used in the private rental market, or through site-based subsidies or vouchers (rental assistance), that are attached to particular units. PSH requires a rental contract or lease between the tenant/program participant and a property owner/landlord. The tenant may pay a portion of the rent (typically no more than 30 percent of the tenant's adjusted monthly income) and the PSH program covers the remaining portion of rent to the owner/landlord/property.

County-led PSH rental subsidy programs should adopt policies that outline the parameters and procedures of the administration of the subsidies. Among those are

definition of eligible participants, eligible units (i.e., compliance with rent reasonableness and housing quality standards), and rental contribution income calculation methodology. Counties are encouraged to adhere to the Department of Housing and Urban Development (HUD) standards for PSH rental calculations.

Leases are required, and those leases or other occupancy agreements shall comply with state and local laws and not impose additional barriers or behavioral standards not contained in standard lease agreements.

PSH is an effective model even for individuals with significant and complex behavioral health conditions; individuals with frequent and long-term hospitalizations, homelessness, and incarceration succeed in PSH with intensive supports, such as Assertive Community Treatment (ACT) or Intensive Case Management (ICM). An independent evaluation from 2020 using a randomized control trial in Santa Clara County, for example, found that PSH is associated with increases in housing placement, increases in housing retention, increases in outpatient mental health service utilization, and decreases in psychiatric-related emergency department utilization among individuals with the most acute needs. Counties are encouraged to assess the opportunity to leverage BHSA Housing Interventions with other programs providing capital funding for PSH units for BHSA eligible individuals, including Veterans, such as Homekey+, No Place Like Home (NPLH), and Community Care Expansion (CCE).

### C.9.3.2 Shared Housing

Many communities have programs that use rental assistance for shared housing, which is when more than one person or household agrees to share a housing unit. Each person (or couple as they choose) must have their own bed and locked cabinet/bureau. In some cases, programs will offer private bedrooms. In all cases, participants must have access to common areas such as the kitchen, bathroom, and living room. Shared housing is an effective way to make housing more affordable, to maximize available housing stock, and to decrease isolation for people not used to living alone.

Typically, each household has its own lease or sublease, and shares expenses like utilities. Rent is split by the number of bedrooms, and the rent reasonableness standard is applied per tenant/household. The tenant's contribution may be based on percent of income as described above.

Shared Housing is a subset of rental assistance, and counties opting to provide shared housing should develop policies and procedures with specific callouts for best practices for shared housing. Those practices include the following:

- **Participant choice** is one of the hallmarks of success in shared housing programs. Participants should opt into shared housing and feel informed about the logistics and pros and cons of the arrangement as well as feel empowered in the creation of shared household rules and norms.
- **Roommate matching** is key to success; some roommate matches may occur organically, through meetings at shelter or in other programs. Many providers use a roommate matching process, much like those used for college dorms or other roommate situations, to help participants define preferences. For example, individual preferences for roommates may include gender, pets, substance use rules, quiet hours, or cleanliness.
- **Roommate agreements** can help support roommates in living in a shared space; and some programs will have peer or case management facilitation for this process and for dispute resolution.

### C.9.3.3 Recovery Housing

Recovery housing is a housing intervention that is recognized by both Substance Abuse and Mental Health Services Administration (SAMHSA) and HUD as an important housing option for individuals with substance use disorders.[19] Recovery housing, also referred to as sober living or recovery residences, offers shared housing in a milieu that is supportive of recovery and that builds a sense of community and mutual support. Recovery housing, including recovery-oriented housing, can provide valuable support for those in outpatient treatment, leaving residential treatment, or others seeking to live in an alcohol and drug-free environment that supports recovery and wellness. The American Society of Addiction Medicine (ASAM) Criteria, Fourth Edition, includes recovery residences as a part of the continuum of care.

People who want to live in a recovery environment should have access to recovery housing; however, individuals who prefer low-barrier housing must not be limited to

[19] Substance Abuse and Mental Health Services Administration. Best Practices for Recovery Housing. Publication No. PEP23-10-00-002. Rockville, MD: Office of Recovery, Substance Abuse and Mental Health Services Administration, 2023.

recovery housing. In other words, recovery housing should be an option but must never be the only option available to individuals in need of housing interventions.

Recovery housing should be designed to promote community, prosocial behaviors, and mutual support. Additionally, recovery housing providers must ensure the rights of privacy, dignity, and respect of residents and have policies in place that allow for all medications for addiction treatment approved by the FDA to treat substance use disorders. Other requirements include providing a lease or at minimum a participant agreement, supportive services for both relapse prevention and relapse support, and appropriate referrals for an individual who chooses not to stay or must leave. Recovery housing providers are encouraged to meet the National Association of Recovery Residences national standards for recovery housing.

Most recovery housing is transitional with people staying up to one year then moving to permanent housing once they have built their recovery capital and found supportive, affordable housing. There are different levels of recovery housing starting with varying staffing and services and requirements. Some recovery housing providers require participation in outpatient treatment. There is some recovery housing that is permanent housing with no maximum length of stay. There are also some recovery housing options designed for specific populations including transition age youth, families with children, LGBTQIA+ populations, and faith communities.

### C.9.3.4. Assisted Living (Adult Residential Care Facilities, Residential Care Facilities for the Elderly, and Licensed Board and Care Facilities)

Housing Interventions may help to cover stays in Adult Residential Facilities, Residential Care Facilities for the Elderly, Board and Care facilities, and license-exempt room and board facilities. Such facilities provide 24/7 care to people who require it due to cognitive impairment or inability to perform activities of daily living (ADLs), along with room and board. These settings may be appropriate for some people experiencing homelessness who have serious behavioral health conditions, require assistance with ADLs, or have severe cognitive impairment.

Housing Interventions funding for these facility types is not time-limited. However, Title II of the Americans with Disabilities Act, as affirmed by the U.S. Supreme Court in Olmstead v. L.C. (1999), requires states to provide services to individuals with disabilities in the most integrated setting appropriate to their needs. This means that eligible

individuals should only be placed in such settings where medically necessary and only for as long as medically necessary. Eligible individuals who are able to reside in PSH or other more independent settings should be transitioned as soon as possible.

### C.9.3.5 Recuperative Care

Recuperative Care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

Recuperative Care is available as a Medi-Cal Community Support. If Recuperative Care can be covered by a Medi-Cal Managed Care Plan (MCP), the Medi-Cal service must be used before Housing Interventions. Housing Interventions may be used for the costs of room and board in Recuperative Care for BHSA eligible individuals not eligible to receive coverage of this service from their MCP. Behavioral health services provided during Recuperative Care cannot be funded through Housing Interventions.

### C.9.3.6 Short-Term Post-Hospitalization Housing

Short-Term Post-Hospitalization Housing provides BHSA eligible individuals who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient facility (either acute or psychiatric or Chemical Dependency Recovery hospital, or psychiatric health facility), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or Recuperative Care and avoid further utilization of these services.

This setting must make available ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, utilizing case management, and accessing other housing supports. This setting may include an

individual or shared interim housing setting, where residents receive the services described above.

Short-Term Post-Hospitalization Housing is available as a Medi-Cal Community Support. If Short-Term Post-Hospitalization Housing can be covered by an MCP, the Medi-Cal service must be used before Housing Interventions. Housing Interventions funds may be used for the costs of room and board in Short-Term Post-Hospitalization Housing for BHSA eligible individuals not eligible to receive coverage of the service from their MCP. Behavioral health services provided during Short-Term Post-Hospitalization Housing cannot be funded through Housing Interventions.

## C.9.4 Other Housing Supports

Counties may provide other housing supports as identified by DHCS in this guide, in addition to the housing interventions specifically identified in W&I Code section 5830, subdivision (b), including, but not limited to, those listed in the Medi-Cal Community Supports Policy Guide.[20] Pursuant to this authority, counties may provide under the category of "other housing supports": (1) Landlord Outreach and Mitigation Funds, (2) Participant Assistance Funds, (3) Housing Transition Navigation Services and Housing Tenancy and Sustaining Services and (4) Outreach and Engagement (up to 7 percent). However, as described throughout this section, BHSA funds may not be used for Medi-Cal services that can be covered and funded through the individual's Medi-Cal managed care plan (MCP). In other words, BHSA funds can only be used for Community Supports if the MCP has chosen not to administer the service, the individual is not eligible for the service, or the individual's needs exceed service limitations and as such the service cannot be covered as a Community Support.

### C.9.4.1 Landlord Outreach and Mitigation Funds

Landlord Outreach and Mitigation Funds may be used to support outreach to, and engagement of, landlords and property owners, which may include the development of presentations, outreach materials, campaigns, and support to help properties meet the requirements of Housing Interventions. Landlord Outreach and Mitigation Funds may also be used by counties to encourage and incentivize property owners to rent to eligible individuals. Additionally, counties may establish a mitigation fund to offset any

[20] W&I Code § 5830, subdivision (b)(1)(F).

damages caused by a Housing Interventions participant and/or for use in connection with potential or actual evictions as further described below.

Counties opting to provide Landlord Outreach and Mitigation Funds as part of their Housing Interventions must develop policies and procedures that, at a minimum, address the following:

- Enumerate the types of landlord outreach costs that Housing Interventions will cover and the maximum allowable reimbursement, examples include:
    - Development of outreach materials (e.g., graphic design).
    - Costs associated with advertising and campaigns focused on landlord recruitment, including networking events (e.g., attending/presenting at local landlord associations).
    - Landlord incentives (e.g., one-time incentives, signing bonus, referral bonus).
    - Holding fees (short term costs to hold a vacant unit before a tenant moves in).
- Enumerate the types of landlord mitigation costs that Housing Interventions will cover and the maximum allowable reimbursement, examples include:
    - Damage reimbursement outside of usual wear and tear.
    - Unit hold related costs and vacancy payment (if tenant leaves early) or if PBH unit is vacant for a specified number of days after sufficient marketing.
    - Eviction prevention costs which may include financial assistance, back-rent, mediation, tenant education, legal costs and connection to resources (if necessary for someone to maintain their housing or be relocated).
- Identify protocols for approving allowable costs and mechanisms for documenting costs.
- Identify processes for the prevention of fraud, waste, and abuse
- Identify any overlap with other community funds and create procedures to avoid duplication.

These policies and procedures are not subject to review and approval by DHCS but must be provided to DHCS upon request.

### C.9.4.2 Participant Assistance Funds

Counties may use Housing Interventions to establish Participant Assistance Funds that seek to remove barriers to housing and support people in meeting their immediate housing needs. Any support provided should be based on individualized assessment of needs. Examples of services and activities to be covered under a Participant Assistance Fund may include, but would not be limited to:

- Costs associated with obtaining government-issued identification and other vital documents
- Housing application fees
- Fees for credit reports
- Security deposits
- Utility deposits
- Storage fees
- Pet deposits and other pet fees
- Move-in costs, including costs associated with establishing a household such as:
    - Transportation
    - Food
    - Hygiene products
    - Moderate furnishings (including but not limited to items such as a bed, tables and chairs, cleaning tools, and other supplies that people need to settle into housing)
- Rent and utility arrears

The Medi-Cal Housing Deposits Community Support covers many of the expenses identified above.[21] Housing Interventions may not be used to cover expenses that an individual's MCP would cover under the Housing Deposits Community Support (assuming the individual is enrolled in an MCP and eligible for Housing Deposits). However, Housing Interventions may be used for expenses not covered under Medi-Cal Housing Deposits, such as pantry stocking. For individuals not eligible for Housing Deposits or who have exhausted the Housing Deposits covered by their MCP, Housing

[21] See DHCS Medi-Cal Community Supports Policy Guide.

Interventions may be used for the complete list of expenses covered by the county's Housing Interventions under its Participant Assistance Fund. [22]

Counties opting to provide Participant Assistance Funds as a Housing Interventions service must develop policies and procedures that, at a minimum, address the following:

- Enumerate the types of costs that may be covered.
- Identify protocols for approving allowable costs and mechanisms for documenting costs.
- Identify processes for the prevention of fraud, waste, and abuse.
- Identify any overlap with other community resources (for example, the Housing Deposits Community Support or other rental assistance deposit funds) and create procedures to avoid duplication of services.

These policies and procedures are not subject to review and approval by DHCS but must be provided to DHCS upon request.

### C.9.4.3 Housing Transition Navigation Services and Housing Tenancy Sustaining Services

Counties may fund Housing Transition Navigation Services and Housing Tenancy Sustaining Services for individuals not eligible for these services through a Medi-Cal MCP. Counties using Housing Interventions to fund Housing Transition Navigation Services and Housing Tenancy Sustaining Services shall refer to the Community Supports policy guide for a list of allowable activities but are not subject to the eligibility, restrictions/limitations, or licensing/allowable provider requirements set forth in the Medi-Cal guidance or any other requirements established for Medi-Cal, if not additionally specified as applicable to BHSA Housing Interventions. Counties may also become contracted Community Supports providers which enables counties to provide Housing Transition Navigation Services and Housing Tenancy Sustaining Services to individuals enrolled in Medi-Cal.

[22] For example, if an MCP covers the costs of Housing Deposits up to $8,000 and the individual has additional needs related to securing or establishing a home that cannot be met under this amount, additional expenses could be paid by Housing Interventions component. If the individual must pay fees or needs items not covered by the MCP, those too could be covered by Housing Interventions component.

### C.9.4.4 Outreach and Engagement

Outreach and engagement activities may only represent up to 7 percent of the Housing Interventions funding allocation in accordance with the transfer guidelines in C.6 Transfers and Exemptions. Outreach and engagement activities should be tracked and entered into HMIS to inform key metrics such as the number of individuals contacted, the percentage of individuals who received housing assistance, the housing retention rate, the number of new community partnerships formed, and qualitative feedback from participants and community partners.

In alignment with the engagement activities identified as allowable under the United States Department of Housing and Urban Development Emergency Solutions Grant funding, engagement activities may include the activities necessary to locate, identify, and build relationships with individuals or families living in unsheltered settings for the purpose of providing immediate support, intervention, and connections with homeless assistance programs or mainstream social services and housing programs. Outreach and engagement activities shall not duplicate services provided by Medi-Cal MCPs per W&I Code (5830(c)(2)).

Activities may include but not limited to:

- Building relationships either through one-on-one engagement or by conducting regularly-scheduled broad outreach in high-need areas in conjunction with community partners.
- The purchase and distribution of items like food, hygiene products, clothing, blankets, and water to provide immediate support and foster future service engagement.
- Providing immediate, onsite direct navigation to housing resources.
- Coordinating behavioral health service and housing resources for unsheltered individuals in collaboration with other outreach and engagement efforts.
- Travel by outreach workers, social workers, medical professionals, or other service providers during the provision of eligible street outreach services. Also includes the costs of transporting unsheltered people to emergency shelters or other service facilities.
- Harm reduction activities and the distribution of harm reduction supplies.

## C.9.5 Other Housing Interventions Requirements and Policies

This section discusses other requirements and policies that apply to Housing Interventions services.

### C.9.5.1 Housing First

Housing Interventions must be operated in compliance with the core components of Housing First and "may include recovery housing."[23,24] Housing First is defined in statute[25] as "the evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible."

Consistent with the national Housing First model and W&I Code section 8255, subdivision (b), abstinence from alcohol or other substances cannot be a requirement or prerequisite for Housing Interventions services. Additionally, the use of alcohol or other substances in and of itself cannot be grounds for eviction and Housing Interventions services are informed by a harm-reduction philosophy that recognizes drug and alcohol use and substance use disorder (SUD) as a part of tenants' lives, where tenants are engaged in nonjudgmental communication regarding drug and alcohol use; and where tenants are offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if the individual so chooses. However, Housing Interventions may be used to support recovery housing and sober living environments for individuals who request them. Counties must ensure that in their implementation of Housing Interventions, neither they, nor entities that receive the BHSA Housing Interventions dollars, discriminate against or deny access to housing for individuals who are utilizing medications for addiction treatment or other authorized medications.

In alignment with the California Interagency Council on Homelessness "Guide to California's Housing First Law" Housing First law applies to both permanent and interim housing settings. While the requirement of a lease may not be applicable to interim

[23] W&I Code § 8255, subdivision (b).
[24] W&I Code § 5830, subdivision (a)(5).
[25] W&I Code §§ 8255, subdivisions (d)(1)-(2)(A).

settings, they must use Housing First components and principles for screening and selecting participants and in providing services and other engagement with participants.

The Department of Housing and Urban Development (HUD) provides valuable resources on Housing First that a county may look to for guidance on how to apply Housing First principles.

### C.9.5.2 Family Housing

All Housing Interventions, as appropriate, must be available to support Family Housing. As defined by HUD, "Family" includes, but is not limited to, regardless of marital status, actual or perceived sexual orientation, or gender identity, any group of persons presenting for assistance together with or without children and irrespective of age, relationship, or whether or not a member of the household has a disability. A child who is temporarily away from the home because of placement in foster care is considered a member of the family.

Family Housing means housing that prioritizes not separating individuals meeting the definition of family. Family housing includes housing that accommodates the family caregiver of a BHSA eligible child, adult, older adult, or a person living with a disability.

Family housing for children and youth considerations include:

- Design, location, and environmental impacts of the housing interventions provided to the family. Dedicated space for children and youth, including green space, open space, secure play areas and courtyards, as well as indoor space in which children may play and learn are some examples.
- Access to public transportation, walkable neighborhoods or bike path access benefit children and youth and their parents.
- Where a child is eligible for Housing Interventions, the family is eligible for Housing Interventions services, even if the parent or guardian is not independently eligible, provided that the parent or guardian lives with the child. Emancipated minors are eligible to receive Housing Interventions services directly. In the reverse situation (parent or guardian is eligible but child is not), the housing provided should accommodate the whole family living together (including children).

Family housing for adults and older adults considerations include:

- Accommodations that meet the needs of the BHSA eligible individual (e.g., wheelchair ramps) as well as proximity to amenities such as community spaces, public transportation, and clinical care.

### C.9.5.3 Habitability Standards

Housing Interventions may only be used in connection with housing settings that meet minimum standards for habitability. Effective October 1, 2025, all units subject to HUD quality requirements will be required to meet a new set of standards titled the National Standards for the Physical Inspection of Real Estate (NSPIRE).[26] This will replace the HUD Housing Quality Standards. While DHCS expects counties to seek to fund settings that meet NSPIRE standards whenever possible, an attestation that the housing is habitable as defined by state law[27] and meets applicable state and local building standards will meet the minimum requirement for Housing Interventions funding. These standards will be implemented in alignment with the standards identified under Transitional Rent. Inspection costs are an allowable expense under Housing Interventions.

### C.9.5.4 Minimum Quality Standards

Counties must ensure that all settings for which Housing Interventions are expended meet minimum quality standards. Many of the settings eligible for coverage serve populations with significant needs but are unlicensed and have been found to be of widely varying quality. This would include, for example, recovery residences and sober living environments as well as license-exempt room and board facilities. These standards will be implemented in alignment with the standards identified under Transitional Rent.

### C.9.5.5 Homeless Management Information System Requirements

Counties are required to operate Housing Interventions in accordance with the Homeless Management Information System (HMIS) reporting requirements.[28]

Counties are required to enter into the local HMIS the Universal Data Elements (Items 3.01-3.917) and the Common Data Elements (Items 4.02-4.20 and Item W5 of the Individual Federal Partner Program Elements as defined by the HUD HMIS Data

[26] NSPIRE Final Rule.
[27] See, e.g., California Civil Code §§ 1941, 1941.1, 1941.3.
[28] W&I Code § 8256, subdivision (d)(3)(A).

Standards) on the individuals and families served, as required by W&I Code section 8256, subdivision (d)(8).

Every Continuum of Care (CoC) must designate an HMIS lead entity. The HMIS lead is responsible for administering, implementing, and managing the HMIS database as well as training and supporting HMIS users. Counties should work closely with the HMIS lead in their community to complete program setup and ensure data quality is meeting expectations. This list of CoC leads in California includes the HMIS leads for most communities. Coordination with the local Coordinated Entry System (CES) is strongly encouraged but counties are not required to route referrals for housing interventions through the CES.

## C.10 Capital Development Projects

Increasing the supply of Permanent Supportive Housing (PSH) and other affordable housing is critical to addressing California's homelessness crisis. Housing Interventions may include capital development projects that increase the supply of PSH, or affordable units that provide long-term housing stability and supportive services to eligible individuals and their families. For individuals who meet the eligibility and priority populations criteria, maintaining residential stability without greater assistance can be difficult. Many of these individuals and families are challenged by health conditions, social isolation, and deep poverty, and face significant barriers to both work and housing. However, studies have shown that even high-risk individuals can be successfully housed if PSH is available.[29]

Counties will be required to detail their proposed capital development projects in their Integrated Plans (IPs) and annual updates (AUs). The Department of Health Care Services (DHCS) encourages counties to employ and include in their IP innovative practices to develop permanent supportive housing and other affordable housing in the most efficient, timely and cost-effective manner available to the county. This section provides guidance regarding the requirements for capital development projects.

[29] Study finds Permanent Supportive Housing is effective for highest risk chronically homeless people.

## C.10.1 Capital Development Project Funding

Counties may use no more than 25 percent of their Housing Interventions on capital development projects.[30] Counties may use capital development project funds to fully fund a capital development project or to fill gaps in funding within a larger development that includes a set number of units dedicated to PSH for BHSA eligible individuals and their families.

Key elements of capital development funding:

- Counties may accrue their capital development project funding for multiple years to cover the cost of a project provided that the county complies with the rules regarding reversion. See Chapter 6 for more details about the reversion of funding to the state.
- Generally, there is no single funding source for PSH developments. Consequently, counties and project developers may also combine funding from other federal, state, and local sources to develop properties that include PSH units provided that the project meets the requirements for capital development projects. Counties are encouraged to align their capital development funding requirements with other local, state and federal programs that will help braid requirements and funding from multiple programs – this practice can reduce administrative burden and related costs for counties and housing sponsors.
- The maximum amount of capital development funds that a county may use to fund the construction and/or rehabilitation of housing units under this program is $450,000 per unit.

## C.10.2 Eligibility and Access Requirements

Counties may use capital development funding for the construction and/or rehabilitation of housing units provided that the projects meet the following eligibility and access requirements:

1. The housing units must be made available to individuals and families who meet the eligibility and priority populations criteria as defined in Chapter 7.C.4.1 "Eligible Populations".

[30] W&I Code § 5892, subdivision (a)(1)(A)(iii).

2. Access to housing units may not be limited to individuals enrolled in Full Service Partnerships (FSP) or to those enrolled in Medi-Cal.
3. Capital development projects may not discriminate against or deny access to housing for individuals who are utilizing medications for addiction treatment or other authorized medications.
4. Capital development projects must comply with the core components of Housing First.

### C.10.3 Capital Development Project Requirements

The following additional requirements apply to projects receiving capital development project funding:

1. The housing units constructed and/or rehabilitated must be affordable and satisfy the definition of "supportive housing." As provided in California Government Code section 65582, subdivision (g), "supportive housing" means "housing with no limit on length of stay, that is occupied by the target population, and that is linked to onsite or offsite services that assist the supportive housing resident in retaining the housing, improving their health status, and maximizing their ability to live and, when possible, work in the community."
2. The housing units must be available for Eligible individuals and their families within a reasonable timeframe that is consistent with each county's approved Integrated Plan.
3. To constitute a "use by right" the project must meet all of the requirements under W&I Code section 5831, subdivision (a)(1).
4. The project must comply with any other requirements specified by DHCS for purposes of administering county capital development programs.
5. Funding for capital development projects are subject to the three and five-year reversion periods.

### C.10.4 Exemption from the Low Rent Housing Project Requirements

Capital development projects are exempt from the low rent housing project requirements in the California Constitution and related statutes, which require voter approval of such projects. While there are multiple criteria for an exemption, the Behavioral Health Services Act (BHSA) projects are identified as one of the exemption criteria. Specifically, if the capital development project consists of the "acquisition,

rehabilitation, reconstruction, alterations work or new construction or any combination" of these with respect to lodging facilities or dwelling units funded using moneys from the Behavioral Health Services Fund (BHSF), the project is exempt from the low rent housing project requirements in Section 1 of Article XXXIV of the California Constitution.[31]

## C.10.5 Exemptions Available to Projects that Meet "Use by Right" Requirements

To allow for the efficient use of capital development project funds and the timely construction and/or rehabilitation of PSH units, W&I Code section 5831 limits the application of permitting, land use requirements and environmental requirements to capital development projects that satisfy the "use by right" requirements and meet specified criteria. These rules are intended to prevent capital development projects from being delayed by time-consuming subjective and discretionary approval processes and related litigation.

As further specified in the Appendix, the BHSA limits local governmental review of such projects to the application of objective zoning, subdivision, and design standards which must be applied within strictly limited timeframes. It also exempts BHSA-funded projects that meet the "use by right" requirements from the California Environmental Quality Act.

[31] W&I Code § 5830, subdivision (e)(8).

# Appendix

## A: Select Definitions

### 1. Experiencing Homelessness

1. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
    a. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
    b. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or
    c. An individual who is exiting an institution and was considered homeless immediately prior to entering the institution or becomes homeless during the institutional stay, regardless of the length of stay.
2. An individual or family who will imminently lose their primary nighttime residence, provided that:
    a. The primary nighttime residence will be lost within 30 days of the date of application for homeless assistance;
    b. No subsequent residence has been identified; and
    c. The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing.
3. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
    a. Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012),

section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);

b. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;
c. Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
d. Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment.

4. Any individual or family who:
    a. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
    b. Has no other residence; and
    c. Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.

## 2. At-Risk of Homelessness

1. An individual or family who:
   a. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
   b. Meets one of the following conditions:
      i. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
      ii. Is living in the home of another because of economic hardship;
      iii. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 30 days after the date of application for assistance;
      iv. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, state, or local government programs for low-income individuals;
      v. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
      vi. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
      vii. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.
   c. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7

U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

d. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

## 3. Chronically Homeless

1. A homeless individual with a disability as defined in section 401, subdivision (9) of the McKinney-Vento Assistance Act (42 U.S.C. section 11360, subdivision (9)), who:
    a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and
    b. Has been homeless as defined in 7.C.4.1.1 Experiencing Homelessness and At Risk of Homelessness on any number of occasions in the last 3 years, as long as the combined occasions equal at least 12 months; or
2. An individual who is exiting an institution and met all of the criteria in paragraph (1) immediately prior to entering the institution regardless of the length of stay; or
3. A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2), including a family whose composition has fluctuated while the head of household has been homeless.

# B: Coverage of Settings

| | Assisted Living | Community Residential Treatment *(Settings eligible under BHCIP)* | Interim Housing | Housing |
|---|---|---|---|---|
| **Settings** | • Adult Residential Facilities[1]<br>• Residential Care Facilities for the Elderly[2]<br>• Licensed Board and Care[3] | • Adult Residential Substance Use Disorder (SUD) Treatment Facilities[4]<br>• Children's Crisis Residential Programs (CCRP)[5]<br>• Peer Respite<br>• Perinatal Residential SUD Facilities[6] | • Hotels/Motels<br>• Peer Respite<br>• Recovery Housing<br>• Recuperative Care~<br>• Non-congregate interim housing models<br>• Congregate settings with small number of individuals per room (i.e., not larger dormitory sleeping halls)<br>• Short-Term Post-Hospitalization Housing~<br>• Tiny Homes, emergency sleeping cabins, emergency stabilization units<br>• Single room occupancy (SRO) units | • Single-family and multi-family homes (e.g., apartments, duplexes, etc.)<br>• Housing in mobile home communities<br>• Accessory Dwelling Units (ADU) and Junior Accessory Dwelling units (JADUs)<br>• Tiny Homes<br>• Project-Based or Scattered Site Supportive Housing<br>• Recovery/Sober living Housing<br>• Apartments<br>• Shared housing<br>• License-exempt room and board<br>• SRO units |

[1] Licensure: CDSS
[2] Licensure: CDSS
[3] Licensure: CDSS
[4] Licensure: DHCS
[5] Licensure: CDSS
[6] Licensure: DHCS

| | Assisted Living | Community Residential Treatment *(Settings eligible under BHCIP)* | Interim Housing | Housing |
|---|---|---|---|---|
| **BHT Housing Interventions** | Yes | Peer respite only | Yes, can be used for an additional 6 months if member is receiving Transitional Rent under managed care or up to 12 months if member is not eligible for Transitional Rent. **The aim is to transition individuals to permanent housing as quickly as possible.** | Yes[7] |
| **Transitional Rent** | No | Peer respite, when provided as transitional or recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming | Yes (see note)<br>*~Note: Transitional rent is not available for Recuperative Care and Short-Term Post-Hospitalization.* | Yes |

[7] DHCS will seek to align the list of eligible settings under BHT and Transitional Rent to ensure seamless transitions between funding sources.