CHCF

Beyond Realignment:
Options for Modernizing California's Behavioral Health System

FEBRUARY 2026

AUTHOR
Jacey Cooper

About the Author

Jacey Cooper is a nationally recognized health policy leader with more than two decades of experience in Medicaid, behavioral health, and health system reform. She previously served as California's Medicaid director and chief deputy director at the Department of Health Care Services, where she led major initiatives, including Medi-Cal benefit and coverage expansion, CalAIM, and behavioral health delivery system reforms. She also served as the director of the State Demonstrations Group at the Centers for Medicare & Medicaid Services, overseeing Medicaid and CHIP Section 1115 demonstrations across the country.

Cooper is the founder of Precision Health Strategies LLC, where she advises states, counties, foundations, and health organizations on Medicaid policy, behavioral health financing and policy, and system transformation. Her work focuses on aligning financing, governance, and accountability to improve access, equity, and outcomes in complex public health systems.

About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Contents

Editor's note: Jacey Cooper was contracted to write this paper before the creation of the Future of Medi-Cal Commission and her subsequent appointment as a commissioner.

Californians living with behavioral health conditions deserve care that is accessible, timely, equitable, and delivered with compassion. The counties, Medi-Cal managed care plans (MCPs), clinicians, and community providers who serve these Californians share the same commitment, to help people heal and communities thrive. Whether those aspirations can be realized depends on how California finances, governs, and oversees its behavioral health system, and how well funding, accountability, and partnership align to support both access and sustainability.

For more than three decades, California's publicly funded behavioral health financing system, anchored in the 1991 and 2011 Realignments, successfully stabilized mental health and substance use disorder (SUD) services during multiple fiscal downturns, and it solidified counties as the backbone of the state's behavioral health safety net. These realignments created dedicated revenue streams and protected local behavioral health funding from state budget fluctuations, ensuring continuity of essential services.

Yet the same mechanisms that once ensured stability now constrain the system's ability to advance equity, integration, and accountability. Over time, state and county policy decisions and fiscal compromises have eroded Realignment's original intent to preserve and strengthen behavioral health. The result is a model that works reliably in some regions but inconsistently across the state, where authority is diffused, accountability is unclear, and fiscal capacity varies widely.[1]

Successive reforms — including the Affordable Care Act (ACA), CalAIM (California Advancing and Innovating Medi-Cal), Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), the Children and Youth Behavioral Health Initiative, and the Behavioral Health Services Act (BHSA) — have layered new mandates and entitlements onto this legacy framework. Each reform sought to expand access and integration but often exposed the underlying fragmentation of California's system, dividing responsibilities among state agencies, counties, and Medi-Cal MCPs. As a result, behavioral health delivery remains complex and uneven, with overlapping mandates, divergent data systems, and inconsistent outcomes.

California now faces an inflection point. Fiscal volatility, workforce shortages, and rising public expectations for transparency and outcomes are straining a system that was built for an earlier era. This brief outlines the fiscal structure underpinning publicly funded behavioral health services, traces the system's evolution through major reforms, and presents options to modernize California's behavioral health financing and governance. The goal is not to assign blame but to build a system that is equitable, integrated, and accountable — one capable of meeting the needs of Californians today and for the next generation.

Why Reform Is Urgent Now

California's behavioral health system is being asked to do more than ever. It is expected to respond to a youth mental health crisis; to address homelessness and the overdose epidemic, which have intensified public and policy expectations for behavioral health systems; and to expand crisis response and housing coordination. The system also must meet federal parity and payment reform mandates and align with CalAIM's integrated-care goals — all within a financing structure that was designed for 1991's realities.

Realignment, once a stabilizing innovation, now limits the system's ability to adapt to changing needs. Its reliance on sales-tax and vehicle-license-fee growth ties funding to the economy rather than to service demand, creating inequities that widen

during economic downturns. Counties are required to maintain mandated services even when revenues stagnate, forcing reductions in prevention, innovation, and workforce investment. These pressures are particularly acute for county behavioral health programs, where long-term treatment obligations and reliance on Mental Health Services Act (MHSA)/ Behavioral Health Services Act (BHSA) funding amplify the effects of economic volatility and complicated multiyear planning.[2]

Funding methodologies for growth allocation do not reflect population growth, the cost of living, or the prevalence of behavioral health conditions. This perpetuates regional inequities, and it leaves smaller and rural counties increasingly unable to meet demand and, often, underfunded. Meanwhile, shared state-county governance has evolved without a clear framework for joint accountability: The state controls policy and regulation, while counties bear operational and fiscal responsibility but lack some flexibility to manage risk or reinvest savings, depending on the funding stream and requirements tied to it.

Together, these pressures have created a system that is resilient but uneven — one that protects safety-net functions but cannot fully meet twenty-first-century expectations for access, data transparency, and equity. Reform is urgent not simply to adjust funding levels, but also to align fiscal policy, governance, and accountability so that California's behavioral health system can function as a true partner in health, housing, and community well-being.

Background and Fiscal Context

Origins and Purpose of Realignments

Prior to the 1991 Realignment, county mental health services were largely financed and governed through the Short-Doyle Act, a state-county program that supported community-based mental health care but relied on federal funds and annual General Fund appropriations.[3] Funding was discretionary, and counties contributed financially and served as the primary providers of mental health services, leaving local systems vulnerable to state budget cuts during fiscal downturns. California's Realignment framework emerged as a fiscal and governance strategy to improve funding stability for critical public services in the context of persistent state budget deficits. The 1991 Realignment formally assigned specific program and fiscal responsibilities to counties, designating dedicated revenue sales tax and vehicle license fees to fund these responsibilities. This shift aimed to create predictable funding for safety-net programs while promoting local flexibility and aligning service delivery with community-level decision-making.[4]

The 2011 Public Safety Realignment expanded this framework during another economic downturn and prison-overcrowding crisis. It shifted full financial responsibility to counties for the non-federal share of major Medi-Cal behavioral health programs — Drug Medi-Cal; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); and Specialty Mental Health — along with responsibilities for justice-involved individuals and social services for children and seniors.[5] These expansions cemented counties as the operational backbone of the behavioral health safety net, but without commensurate tools for fiscal or organizational performance accountability.

Realignment's Fiscal Structure

The 1991 Realignment solidified counties' responsibility for community mental health, indigent health care, social services, and public health programs, funded by dedicated but non-cost-tied revenue streams. Under the 1991 Realignment, counties receive a fixed base allocation for services from historical spending levels – if there is sufficient revenue to fund the base. This base distribution across counties is locked in perpetuity and provides predictable revenue. However, it does not automatically adjust for population growth, inflation, or service demand, and it may decline if revenues are insufficient. After base allocations are met, any additional statewide sales-tax or vehicle-license-fee revenue flows into growth accounts, and it is allocated in proportion to the county's share of the base. Because growth is tied to economic performance rather than to service demand or caseload, behavioral health revenues tend to rise slowly in strong years and to stagnate, or even to decline, during recessions, limiting the counties' ability to expand services when needs increase.

The 2011 Realignment broadened these responsibilities for specialty mental health services (SMHS), substance use disorders, child welfare, and lower-level offender supervision. The 2011 Realignment base and growth framework mirrors the 1991 model. The growth is non-entitlement and nonformulaic, meaning that there is no direct link between service demand and revenue growth for behavioral health programs; however, 2011 Realignment does use prevalence and population in the formulas. Counties must use these funds to meet their non-federal share of Medi-Cal behavioral health services. The 1991 and 2011 Realignments provide counties with a stable but inflexible funding base: Revenues grow with the economy rather than with service demand. This approach is atypical for entitlement programs, and it creates structural inequities and widens gaps over time. Essentially, the Realignment funding structure operates counter to needs-based financing. During economic downturns, when Medi-Cal enrollment, uninsured rates, and behavioral health needs increase, the sales-tax- and income-dependent revenues that support county behavioral health through Realignment and MHSA/BHSA contract or reduce, compounding resource scarcity precisely when demand is highest.

Realignment revenues are protected by constitutional and statutory provisions intended to promote fiscal stability for counties. The so-called "poison pill" provisions, established under the 2011 Realignment framework and later constitutionalized by Proposition 30 (2012), generally require the state to reimburse counties for any state-imposed programmatic or funding changes that increase local costs or reduce revenues within realigned programs. These protections have provided a reliable fiscal floor through multiple economic downturns, shielding county behavioral health programs from midyear cuts or state budget actions. However, they also limit some flexibility because revenues are constitutionally earmarked and are tied to specific subaccounts. The state and counties have little ability to adjust allocations in response to changing needs, to integrate funding streams, or to modernize the fiscal structure without a statutory or voter-approved change.

Outside of behavioral health, in 2013, Assembly Bill 85 redirected a portion of 1991 Health Realignment funding to help offset the state's General Fund obligations for CalWORKs. This decision was based on estimates that counties would realize savings under the Affordable Care Act's Medicaid expansion. These redirected dollars were used to support core CalWORKs costs, including cash assistance grants, employment services, and childcare; thereby reducing the state's share of program funding. This demonstrated how state fiscal strategies can reallocate funding, permanently reducing critical health and behavioral health dollars within constitutional bounds.

County Roles and Obligations

Counties are the frontline administrators of California's public behavioral health system. Realignments formalized their authority under the principle that local governments are best positioned to integrate behavioral health with other county-managed services, such as public health, justice, and social services.[6]

Despite this local control, counties operate under state and federal mandates, using allocations derived from tax-based formulas that fluctuate with the economy. Smaller and rural jurisdictions often lack reserves or discretionary funds to absorb volatility. As a result, counties bear the responsibility to deliver mandated services regardless of revenue performance. This long-standing arrangement underscores the importance of understanding that county behavioral health obligations are not discretionary or optional; they are embedded statutory responsibilities that are central to California's safety net and public health infrastructure.

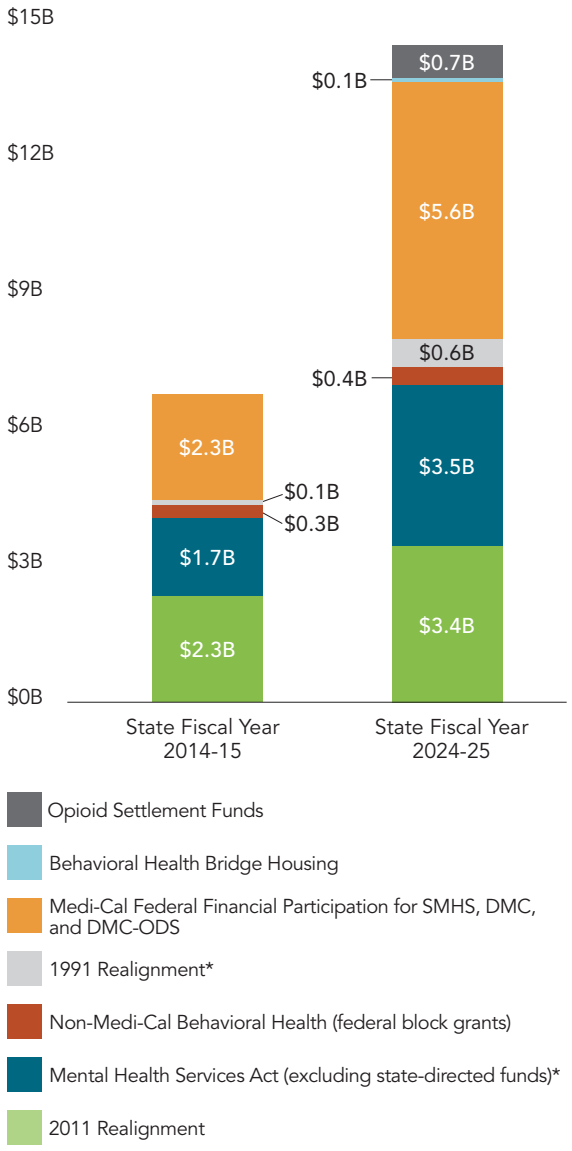
To balance the budget during fiscal downturns, the state has repeatedly reduced or delayed Medi-Cal benefits funded through the General Fund. However, other than 2011 Assembly Bill 97 rate reductions, the state has not cut county-administered SMHS or Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) benefits — an outcome rooted in the Realignment framework.[7] While this stability protects essential behavioral health services, it also means that counties lack the authority that the state exercises to scale back programs or costs during fiscal downturns. Counties therefore must shoulder rising obligations and mandates with finite Realignment and braided funding streams. This lack of authority makes counties inherently risk-averse when they are considering service expansions or new models of care. Counties know that they cannot adjust benefits if costs outpace revenues — leaving them responsible for ongoing obligations without the fiscal levers that the state can use to manage risk. This dynamic, in turn, can dampen innovation and scale, because counties must weigh every new investment against the possibility of long-term, unrecoverable fiscal commitments.

In summary, Realignments began as a fiscal mechanism to stabilize local behavioral health services, but, through successive state and county decisions, it has come to define how the system operates. Beyond allocating dollars, Realignments institutionalized the delegation of behavioral health responsibility to counties and embedded the fiscal and administrative rules that shape service delivery, accountability, and system performance. The resulting framework has ensured stability and local control, but it has also hardened inequities across counties and has limited adaptability, constraining the system's capacity to evolve with changing needs. Understanding Realignment's dual legacy — as both the foundation and the constraint of California's behavioral health system — is essential to charting a path toward modernization.

Evolution of Behavioral Health Scope and Complexity

California's publicly funded behavioral health system is organized around county administration. This approach results in a segmented framework where the state sets policy and oversight, counties manage delivery and financing, and Medi-Cal managed care plans operate parallel systems for physical and non-specialty mental health care. Counties operate specialty mental health and SUD programs funded through Realignment (1991 and 2011), federal Medicaid match, the Mental Health Services Act (now Behavioral Health Services Act), and Substance Abuse and Mental Health Services Administration (SAMHSA) block grants. Figure 1 depicts the funding sources that are available to counties for behavioral health.

Figure 1. Public Community Behavioral Health Funding Available to Counties, in Billions



Notes: Funding sources are listed in the order in which they are displayed in the chart. Behavioral Health Bridge Housing and Opioid Settlement Funds were not available in SFY 2014–15. This chart does not include the $1.7 billion in behavioral health infrastructure funding through the Behavioral Health Continuum Infrastructure Program (BHCIP) in 2021 or the $4.4 billion in Bond BHCIP funding in March 2024.

* Funding sources that contribute to Medi-Cal non-federal share.

Source: "Understanding the Behavioral Health Services Act: Myths vs. Reality," California Department of Health Care Services (DHCS), accessed January 16, 2026.

Prior to 1991 Realignment, California's state mental health systems were structurally oriented toward institutional care, particularly state hospitals and Institutions for Mental Disease (IMDs), which provided short-term nursing-level care and were primarily state funded. Beginning in state FY 1992–93, Realignment granted counties new flexibility to adjust state hospital bed use, to redirect IMD funds to community-based services, and to prioritize care for people with the most serious mental illnesses. This shifted resource allocation toward locally determined needs and program effectiveness.[8] However, even after Realignment created the authority to redirect IMD funds, some counties remained structurally tethered to long-standing IMD bed purchase contracts, and fixed Realignment revenues made it risky to rapidly unwind institutional placements without dedicated transition funding to smaller facilities and alternative community-based capacity.

In 2012, California dissolved its stand-alone Department of Mental Health and Department of Alcohol and Drug Programs and transferred these responsibilities to the Department of Health Care Services (DHCS) in an effort to align behavioral health oversight with Medi-Cal administration.[9] Proponents viewed this as a step toward integration, enabling greater fiscal coordination and consistency across Medicaid-funded programs. However, critics contend that the transition diminished behavioral health's dedicated policy voice and reinforced a Medicaid-centric governance structure. County behavioral health departments must manage responsibilities that extend well beyond Medi-Cal, including crisis response, housing supports, conservatorships, prevention, and services for uninsured or justice-involved populations. Therefore, these county departments argue that DHCS's focus on Medi-Cal does not fully reflect the scope, complexity, or cost of their local obligations. The result is a persistent gap between federal and state oversight, centering on Medi-Cal compliance and county systems that are tasked with delivering

comprehensive behavioral health care for all residents, which contributes to ongoing misalignment in priorities, financing, and accountability.

Successive reforms, such as the ACA, parity, the 2016 and 2024 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rules, CalAIM, BH-CONNECT, and Propositions 1 and 36, layered new mandates atop this legacy framework.[10] The result is a bifurcated structure: Counties manage SMHS, DMC and DMC-ODS carve-outs, and a multitude of non-Medi-Cal related mandates, while MCPs cover non-specialty mental health, behavioral health treatment, and behavioral health integration in primary care and emergency room coverage.[11] This segmentation clarifies clinical roles but creates administrative friction at the points of referral and care transition.

California's goals under CalAIM and BH-CONNECT aim to reduce some of the friction of this bifurcated system: misaligned incentives, incompatible data systems, and divergent medical-necessity rules. Two patients with the same symptoms may be treated in different systems depending on how "severity" or diagnostic codes are interpreted, leading providers to navigate inconsistent documentation and approval requirements. Members also experience delays or are ping-ponged between county behavioral health plans and MCPs. Sustained integration will require aligned payment models and interoperable data that allow counties and MCPs to comanage members rather than to operate in silos.

Together, these policy, fiscal, and administrative shifts have produced the complex system that California manages today — one shaped by decades of layered reforms, from Realignments and the Mental Health Services Act to the ACA and CalAIM. Each reform aimed to strengthen access, accountability, and integration. However, without constitutional change, these reforms necessarily built upon rather than replaced existing structures, resulting in overlapping mandates and uneven capacity across counties. The following timeline traces these key milestones, illustrating how successive reforms have incrementally reshaped California's behavioral health financing, governance, and delivery systems.

Key Behavioral Health Financing Milestones in California (1991–2029)

- **1991, Realignment I.** The state formalized community mental health and indigent health as a county responsibility, funded by dedicated sales tax and vehicle license fees.
- **2004, Proposition 63 (MHSA).** This millionaire's tax created a dedicated county mental health expansion fund layered on top of Realignment.
- **2010–2014, ACA and parity implementation.** Medi-Cal expanded under the ACA to include coverage for the Medicaid expansion adult population and essential health benefits. Responsibility for non-specialty mental health services was carved out to the managed care plans (MCPs), while counties retained responsibility for specialty mental health services (SMHS) and core substance use disorder (SUD) services.
- **2011, Realignment II (Public Safety Realignment).** Counties assumed the non-federal share of SMHS; Early and Periodic Screening, Diagnostic and Treatment; and Drug Medi-Cal.
- **2012, Integration of Department of Mental Health and Department of Alcohol and Drug Programs into the California Department of Health Care Services and Department of State Hospitals.**
- **2013, AB 85.** Redirected a portion of 1991 Health Realignment revenues to support the CalWORKs Maintenance of Effort requirement, reducing discretionary health realignment funding available to counties.

- **Mid-2015 DMC-ODS.** The Drug Medi-Cal Organized Delivery System was launched as a voluntary, county opt-in model, expanding county-administered SUD benefits under Medi-Cal.
- **2016–2018, CMS Medicaid Managed Care and Parity Final Rule implementation.** The US Centers for Medicare & Medicaid Services (CMS) issued sweeping managed care regulations in 2016, modernizing standards for network adequacy, quality, parity, encounter data, and rate setting.
- **2021–2022, CalAIM behavioral health reforms.** Behavioral health payment and policy modernization began — the No Wrong Door policy, updated medical necessity, and a shift toward rate-based reimbursement.
- **2022–2024, CARE Court.** A new civil court framework was established for certain adults with serious mental illness, creating a court-supervised process to connect people to county-based behavioral health services and care plans.
- **2024, Proposition 1 (BHSA and bonds).** MHSA became the Behavioral Health Services Act. New bonds finance behavioral health and housing infrastructure with a stronger link between housing and treatment.
- **2025–2029, BH-CONNECT and BHSA implementation.** Federal 1115 demonstration and BHSA reshape community behavioral health, payment incentives, and housing-linked care statewide.

Impact of the ACA

The Affordable Care Act fundamentally reshaped California's behavioral health landscape by expanding coverage, standardizing benefits, and redefining payer responsibilities. When the ACA expanded Medi-Cal and required mental health and substance use disorder benefits as essential health benefits, California made a pivotal structural decision: to preserve county responsibility for specialty behavioral health services while carving out responsibility for non-specialty mental health care to MCPs. Counties strongly advocated for this division, arguing that their long-standing infrastructure, safety-net role, and expertise in serving high-acuity populations were essential to maintain.[12] This compromise became a defining feature of California's behavioral health system, one that continues to shape its fragmentation, financing, and governance today.

Furthermore, the ACA transformed specialty mental health and SUD services into entitlements by expanding Medi-Cal coverage, establishing parity, and defining behavioral health as an essential health benefit. The expansion also enabled the launch of the Drug Medi-Cal Organized Delivery System. DMC-ODS strengthened the state's SUD Continuum of Care by expanding access to evidence-based treatment, improving care coordination, and establishing consistent standards and accountability across counties.

The ACA also brought millions of newly insured adults into the system, increasing demand for care and the administrative work of coordination, quality assurance, and compliance. Realignment revenues and other flexible county funding streams did not grow in parallel, leaving counties responsible for the non-federal share of what had become an entitlement program.[13] Meanwhile, Medicaid parity and Managed Care Final Rule requirements improved consumer protections but further elevated demand and compliance costs. The result is a more insured population with broader behavioral health entitlements layered onto a financing structure that predates modern Medi-Cal.

Integration, Financing, and System Structure

Carve-Out Structure and Growth of Behavioral Health Services

California's behavioral health delivery system remains defined by a long-standing carve-out that separates responsibility for specialty mental health and SUD treatment from broader Medi-Cal managed care. Counties act as mental health plans (MHPs) for SMHS and operate DMC and DMC-ODS, while MCPs cover non-specialty mental health services, primary care, and physical health benefits.[14]

This carve-out preserved local control and clinical specialization for high-acuity populations but embedded fragmentation in eligibility, medical-necessity criteria, and payment systems. Over the past decade, initiatives such as CalAIM, BH-CONNECT, and now BHSA have sought to bridge these divides through integration and unified accountability. MCPs increasingly serve as the entry point for screening and early intervention, while counties remain responsible for crisis response, intensive treatment, and recovery supports.

Despite shared objectives, data silos, incompatible billing systems, and differing rules continue to impede seamless transitions between MCPs and county behavioral health plans and systems. Workforce shortages and divergent financial incentives further limit coordination, particularly for people whose care spans both systems.

Since 2010, coverage and benefit expansions have broadened California's behavioral health portfolio, adding evidence-based SUD treatments under DMC-ODS, peer-support certification, enhanced children's behavioral health services, and new crisis-continuum requirements. Each expansion advanced parity and access but also introduced new administrative complexity, because to sustain operations, counties must braid categorical funds from Realignments, Medi-Cal match, BHSA, and federal block grants. Federal and state obligations also require coordination across schools, MCPs, and family-support networks, intensifying the administrative load on counties. The result is a comprehensive but brittle system.

Additionally, the CalAIM Behavioral Health Payment Reform initiative represents a fundamental shift for county behavioral health systems, moving from cost-based reimbursement to standardized, rate-based payment for both specialty mental health services and Drug Medi-Cal Organized Delivery System programs. This transition is intended to simplify claiming, to improve transparency, and to align with Medi-Cal managed care payment principles, while creating a platform for future value-based models. For counties, it brings greater fiscal predictability and flexibility but also new administrative complexity and tighter accountability, marking a major structural change in how behavioral health services are financed and managed statewide. Many behavioral health providers are struggling to transition from cost-based reimbursement to fee-for-service operations, prompting counties to use scarce local dollars to bridge payment gaps and to sustain providers — resources that could otherwise be directed toward expanding services or innovation. And because counties remain responsible for the non-federal share, their ability to adapt to the new rate environment is constrained, underscoring the tension between modernized payment policy and an outdated financing structure.

Evolving and Varying Financing: From MHSA/BHSA to Federal Block Grants

California's Mental Health Services Act (Proposition 63, approved in 2004) established a 1% tax on personal income of more than $1 million to expand county behavioral health programs. In 2024, voters approved Proposition 1, transforming MHSA into the Behavioral Health Services Act, effective in 2026. BHSA rebalances local flexibility with statewide priorities by linking behavioral health

treatment to housing stability and by codifying outcome-oriented spending categories. Counties continue to receive the majority of funds, but allocations now require 30% for housing interventions for people with significant behavioral health needs, half of which must support those who are experiencing chronic homelessness. Designated shares also support interventions like Full Service Partnerships, Coordinated Specialty Care, and early intervention.[15]

This reform reinforces the state's drive to centralize oversight and to enforce results-based accountability, strengthening alignment with housing and recovery outcomes. However, it also significantly narrows local discretion. Counties are required to use Medi-Cal and other payers whenever possible and to demonstrate measurable impact. This requirement signals a clear shift from flexibility toward state-directed performance management while also aiming to address funding gaps by drawing down additional federal and nonpublic dollars.

Federal block grants from the SAMHSA remain vital complements to state and local funds. The Mental Health Services Block Grant dedicates 10% to first-episode psychosis and 5% to crisis services; the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) reserves 20% for prevention. Recent federal supplements like COVID-19 relief and crisis response initiatives have expanded capacity but remain time-limited and categorical.

Community prevention sits at the intersection of county public health, behavioral health, MCPs, and local coalitions. Counties blend SUBG prevention dollars, BHSA early-intervention resources, public health funds, and philanthropy to support school-based programs, stigma reduction, overdose prevention, and early-childhood interventions. These local innovations, while impactful, remain fragile without sustained, flexible financing. Long-term prevention success depends on multiyear, cross-sector partnerships that extend beyond the limits of current categorical funding.

BHSA: A Step Forward, but Structural Issues Remain

BHSA modernizes MHSA by realigning dollars to today's needs, explicitly linking treatment with the need to address homelessness and housing stability, sharpening focus on youth and Full Service Partnerships, and requiring more coherent county planning and reporting. Paired with Proposition 1's capital investments, BHSA can relieve critical bottlenecks in crisis and residential capacity; accelerate community placements; and move counties toward clearer, outcome-oriented use of funds.[16] In short, BHSA aims to strengthen alignment with CalAIM and BH-CONNECT goals, and it attempts to provide a more purposeful, equity-minded framework for spending — not just the process compliance that existed in MHSA. However, achieving the BHSA promise will depend on implementation that truly aligns with CalAIM and other state initiatives, translating coordination and equity goals from design into practice, and overcoming the long-standing fragmentation that has often limited statewide consistency and impact.

BHSA does not resolve the structural issues that are outlined in this brief, however. It retargets existing dollars, but it does not address behavioral health funding volatility or bring new dollars into the system. It leaves unchanged the state-county accountability gap, the division of fiscal responsibility for the non-federal share of specialty behavioral health, and the carve-out fragmentation between MCPs and county systems. It also does not guarantee sustained operating support or data interoperability. BHSA is a valuable enabler — particularly for housing-linked recovery and capital build-out, but achieving equitable, stable, and accountable behavioral health financing still requires modernizing the behavioral health fiscal and governance foundation.

Behavioral Health System Composition

Across the country, states have adopted a range of Medicaid behavioral health financing and governance models that balance integration, accountability, and local control in different ways. Some, like Arizona and Washington, have mostly integrated behavioral health into Medicaid managed care, creating a single statewide or regional plan that is responsible for physical and behavioral health. Others, such as Pennsylvania, retain strong county roles, allowing counties to purchase services through contracted behavioral health managed care organizations. Michigan and Colorado operate regional public entities, Prepaid Inpatient Health Plans or Regional Accountable Entities, that manage specialty behavioral health benefits and coordinate care across counties. States like Oregon and North Carolina have pursued hybrid approaches, integrating behavioral health within broader coordinated care models or through specialized, "tailored" plans for high-need populations. Together, these examples illustrate a continuum of options — from fully state-managed integration to regionally anchored, county-partnered structures.

Although behavioral health represents less than 6% of total US health spending, it accounts for a disproportionate share of unmet need.[17] Because of high prevalence, persistent workforce shortages, fragmented financing, and long-standing separation from the general medical system, behavioral health access and coordination are more complex than in other areas of care. Nationally, most behavioral health care is delivered by private nonprofit or for-profit organizations; only about 10% of mental health facilities and 9% of substance use treatment facilities are publicly operated.[18] California's system is an outlier: Through Realignments, the state assigned fiscal, programmatic, and service provision responsibilities to counties, creating a uniquely public infrastructure that anchors behavioral health financing and oversight in local government. California's county behavioral health plans operate as public entities responsible for oversight, accountability, and system management, and some counties directly provide clinical services. However, it is important to note that most counties also contract with private and nonprofit organizations to deliver mental health and substance use disorder care within their local networks.

This public model enables integration with housing, justice, and social service systems but also concentrates financial risk and operational burden at the county level. Counties must comply with state and federal Medicaid requirements as well as public governance processes — board approvals, open meetings, and procurement rules — which slow adaptation and innovation. Unlike private providers or managed care plans, counties cannot easily adjust networks, modify rates, or quickly pursue private capital for facility investments. Modernization often depends on state grants or bond measures, which are episodic and competitive. And many counties have not been able to invest in proper managed care infrastructure like utilization management, encounter data and analytics, network adequacy, access and quality monitoring, and performance-based contracting. The result is a public-sector behavioral health infrastructure that fosters cross-sector coordination but struggles with flexibility, capacity, appropriate management resources, and long-term capital investment.

Lessons Learned over Three Decades of Realignment

California's behavioral health financing system was designed to solve twentieth-century fiscal crises, not to manage a twenty-first-century, parity, and data-driven health system. Interviews with former

state finance and health officials, county leaders, and external experts reveal a consistent narrative: While Realignments stabilized budgets, they also contributed to fragmentation and uneven capacity across counties. The following lessons summarize those insights and their implications for reform.

1. Braided Funding: Complexity as a Survival Strategy

Counties sustain services by combining Realignment revenues, BHSA funds, Medi-Cal match, SAMHSA block grants, and local dollars. This braiding ensures continuity, but it consumes administrative capacity and deters innovation. Many counties lack the data infrastructure and fiscal sophistication to maximize federal matching funds, leaving potential resources untapped. Because reimbursable services dominate, prevention, housing, and recovery supports are chronically underfunded. Financial survival has replaced system strategy.

2. The Unintended Consequences of Fiscal Protections

Constitutional protections like Proposition 30 preserve county stability, but they freeze outdated base and growth allocations and shift the risk of policy changes to local governments. Reimbursement for new mandates is often administratively complex, relying on preliminary cost estimates that may be incomplete, one-time, or without future adjustments. To avoid triggering a formal mandate, the state makes new programs voluntary, forcing counties to choose between unfunded participation and declining innovation. Fiscal stability achieved through protection has become a barrier to modernization, access, and statewide policy.

3. A System That Works Locally — but Unevenly

The county-centric model rewards strong local leadership and integrated governance structures, enabling innovation in some areas but leaving others behind. Counties with robust General Funds or with dedicated local measures and infrastructure have developed value-based DMC-ODS models, early-psychosis networks, and harm-reduction initiatives. Smaller or resource-limited counties struggle with workforce shortages, limited analytics, and constrained budgets. Geographic inequities in access and outcomes are widening, undermining statewide quality and outcome goals.

4. Governance and Accountability: The Missing Center

The partnership between the state and counties has weakened over time. What was once a collaborative partnership has become largely transactional, with counties viewing the state as a regulator and check-writer, and the state viewing counties as administrative agents tasked with executing state-defined priorities rather than codesigning policy or system strategy. The result is a diffuse governance environment that is marked by overlapping responsibilities and limited accountability. Because counties administer, finance, and deliver many of the same services that they are supposed to oversee and manage, the lines between payer, regulator, and provider are blurred. This makes it difficult to determine where authority truly sits — the state's oversight is increasingly defined and active; counties' accountability is internal; and when counties are also the provider, performance often folds into county operations themselves. As a result, many view counties as functioning primarily as providers, rather than fully embracing their parallel role as payers.

The state often treats county behavioral health directors as the functional equivalent of plan

CEOs, responsible for outcomes, fiscal stewardship, and system performance. Yet these county directors lack comparable authority or autonomy. Unlike health plan executives, county behavioral health directors operate within county government structures, where boards of supervisors and county administrative offices dominantly control budgets, staffing, and policy priorities, creating a disconnect between state expectations and local decision-making power.

Potential Solutions to Modernize California's Behavioral Health System

California has several viable pathways to reform behavioral health. Each option seeks to simplify funding, to strengthen accountability, and to promote fiscal equity, but they differ in how they balance local autonomy and statewide oversight. Also, more than one solution can be implemented.

Equity-Weighted Growth Allocation Reset with New State General Fund Contribution

A one-time equity recalibration of Realignment growth allocations could address long-standing disparities while preserving the stability that counties depend on through maintaining their base funding levels. Rather than reopening the entire Realignment structure, the state could modernize the growth allocation methodology — using indicators such as population, prevalence, service utilization, and rural access — to create a more equitable and transparent distribution formula.[19] Policymakers could also plan for future investment by adding new state funds into the growth pool, effectively "rightsizing" behavioral health financing to reflect current demand and cost pressures. While current fiscal constraints limit immediate action, establishing a revised growth allocation framework now would position California to advance additional state General Fund dollars when budget conditions improve.

Performance- and Outcome-Based Growth Allocation Reset

Under this approach, the state would distribute behavioral health funds through performance-based allocations tied to shared statewide metrics, such as access, timeliness, engagement, crisis diversion, and recovery outcomes. Incremental or incentive-based funding could be layered on top of existing Realignment growth allocation methodologies and Medi-Cal structures, creating an outcome-based overlay that rewards measurable improvement. This structure could preserve local flexibility and innovation while strengthening accountability and transparency. To be effective, performance expectations would need to be realistic and adjusted for regional variation in population health, cost of living, and workforce capacity.

Performance- and outcome-based overlays could improve accountability. However, if not designed carefully, they absolutely could widen inequities, because counties would still start from very different baselines in workforce, infrastructure, housing availability, IT capacity, and population needs.

Budget permitting, new state General Fund dollars could be added to this concept as well, as described in the preceding option.

County Behavioral Health Plan Modernization

The state could pursue a county behavioral health plan modernization strategy that funds counties to operate more like managed care plans, with clear expectations and resources to match. Under this approach, counties would remain the specialty behavioral health plans but would receive dedicated plan-administration funding and technical

support to build core managed care functions: actuarially informed rate development, utilization management, care management, network development, quality improvement, and robust data and analytics.

The state could establish a per-member per-month administrative payment or other dedicated plan-support funding stream, separate from Realignment, tied to defined capabilities and performance benchmarks. In exchange, counties would be expected to hire key leadership positions, such as a CFO, COO, or quality director; to enter into performance-based provider contracting; and/or to share quality measures with Medi-Cal MCPs. Over time, the state could introduce value-based payment incentives for counties that demonstrate improved access, continuity, and outcomes for high-need populations.

This model would preserve the counties' roles as specialty behavioral health plans and safety-net providers. It would also move them closer to "real" managed care entities in function — backed by explicit plan funding, clearer expectations, and shared accountability — without immediately requiring full-risk capitation or structural carve-in.

Shared Services for Small Counties

A shared-services model could establish regional hubs for claims processing, data analytics, IT infrastructure, and quality assurance, giving small and midsize counties access to specialized expertise and modern systems that they could not sustain alone.[20] These hubs would create economies of scale, reduce administrative burden, and bolster compliance and fiscal management, while allowing counties to retain local governance and programmatic control. Shared services would also offer a path to strengthen workforce capacity, provider contracting, and performance monitoring across regions without the complexity of new legal entities. Each of these structural approaches presents trade-offs; the immediate priorities should be to stabilize the fiscal foundation, to ensure equitable access across counties, and to strengthen joint accountability before pursuing constitutional or statutory overhaul.

Regional Public Authorities

Counties could establish regional public authorities or joint powers entities to formally pool resources, to centralize administrative functions, and to strengthen regional bargaining power. This model would go beyond shared services by creating a unified governance structure capable of managing fiscal, contractual, and workforce functions collectively. It would be particularly valuable for small counties that struggle to sustain stand-alone operations. Regionalization could promote efficiencies, improve rate standardization, and enhance data and performance oversight across counties.

However, this model would require careful design to reconcile labor agreements, governance representation, and fiscal accountability, as well as to ensure equitable participation and resource distribution across member counties. Implementation would depend on standardized data systems, transparent allocation formulas, and clear state authorization, making it a longer-term reform best pursued after Realignment funding and growth methodologies had been stabilized.

Joint State-County Governance Model

This approach would renew shared accountability through the creation of a State-County Behavioral Health Governance Council or a Fiscal Oversight Board. This new entity would be responsible for coordinating financing, performance, and system oversight. Rather than fully centralizing authority or maintaining fragmented local control, this model would formalize joint decision-making between state and county leaders on fiscal policy, quality metrics, and system outcomes. The governing body

could oversee rate methodologies, Realignment allocations, Medi-Cal performance targets, and transparency dashboards to ensure consistent statewide standards while preserving local flexibility. By reestablishing shared responsibility, this structure could strengthen alignment between fiscal policy and system performance, improve transparency, and rebuild trust across state and county partners. This option could be layered onto many of the other potential solutions.

MCP-Managed Behavioral Health Model (Carve-In)

In this approach, the state would hold fiscal responsibility for behavioral health services, and Medi-Cal managed care plans would administer the benefit under unified rules for specialty mental health and substance use disorder services. Realignment revenues, supplemented by the General Fund as needed, would fund the integrated benefit. Counties who also serve as providers could voluntarily choose to continue as core specialty mental health and SUD providers, contracting with MCPs alongside other behavioral health providers. Additionally, some counties could maintain a full behavioral health plan structure that subcontracts to the MCPs.

This model would promote statewide consistency, integrated care and financing, and clearer accountability while preserving county expertise and service capacity. Transition would require careful planning to prevent service disruption and to safeguard critical local functions in crisis response, housing, and justice coordination. Success would depend on adequate funding, equitable rates, and joint governance structures that balanced state oversight with local implementation experience. This concept may require changes to state statutes or the California Constitution.

Conclusion

California's Realignment financing framework has anchored the state's behavioral health system, ensuring stability through economic volatility and enabling counties to build deep community-based networks of care. Its success in ensuring stability and local control is undeniable. Yet those same features now constrain progress toward equity across counties, toward integration, and toward statewide accountability.

The cumulative impact of decades of incremental reforms — spanning Realignment, the Mental Health Services Act, the Affordable Care Act, and CalAIM — has created a complex but resilient foundation. What California needs now is not another wholesale overhaul, but a purposeful modernization: updating fiscal formulas, aligning incentives, and clarifying governance so that the system can meet contemporary demands for transparency, access, and outcomes.

Modernization can build on Realignment's strengths, which are local innovation, community connection, and the partnership between the state and counties, while addressing its structural limits. A recalibrated Realignment, paired with aligned payment reform and shared accountability, would position California to deliver on the vision that has guided its behavioral health system for more than three decades: care that is equitable, integrated, and centered on the people it serves.

Endnotes

1. State External Quality Review Organization (EQRO) and California Department of Health Care Services (DHCS) quality reports show wide county-to-county variation in basic access and quality metrics. For example, the average wait for a first psychiatry visit ranges from 5 to more than 50 business days depending on the county, with adult waits spanning 0 to 152 days and youth waits of up to 252 days. Only a small subset of mental health plans (MHPs) meet statewide timeliness standards, and others fall far short. Similarly, 7- and 30-day follow-ups after psychiatric hospitalization exceed 80%–90% in some counties but remain below 40%–50% in others, and 30-day readmission rates range from 0% in a few small counties to 30% in Los Angeles. These numbers led the state's own EQRO to conclude that "MHP readmission rates varied tremendously across the state." On the SUD side, Drug Medi-Cal Organized Delivery System (DMC-ODS) plans show waits ranging from same-day access to multiple business days, and only a minority of plans meet timeliness standards consistently. DHCS's Healthcare Effectiveness Data and Information Set–based ratings similarly show that while a handful of counties meet most benchmarks, the median county meets only about half of them.
2. MHSA/BHSA funds constitute one-third of county behavioral health funding and are also subject to economic fluctuations.
3. For information about the Short-Doyle Act, see "Medi-Cal Mental Health Policy (MCMHP): Background" by DHCS. Prior to the 1991 Realignment, California's public mental health system relied heavily on state hospitals and inpatient care in Institutions for Mental Disease, supplemented by limited community-based safety-net services where available. The 1991 Realignment expanded and formalized counties' responsibility for community mental health services, authorizing funding, subject to available resources, for a comprehensive Continuum of Care. This Continuum of Care included prevention and crisis services, comprehensive evaluation and assessment, individualized service planning, medication education and management, case management, 24-hour treatment services, rehabilitation and support services, vocational rehabilitation, residential services, services for people experiencing homelessness, and group services.
4. Scott Graves and Nishi Nair, *Understanding Realignment: California's Shifts in State and County Responsibilities*, California Budget & Policy Center, July 2025.
5. EPSDT is a federal Medicaid entitlement that requires states to provide comprehensive and preventive health care services for members under age 21 who are enrolled in Medicaid. EPSDT ensures that children and youth receive all medically necessary services to correct or ameliorate physical and behavioral health conditions — whether or not those services are covered under the state's Medicaid plan.
6. "Community Mental Health in California: A County Business Plan for the Future" (PDF), March 14, 2012, included in the California Mental Health Services Authority, County Behavioral Health Directors Association of California, and California Institute for Behavioral Health Solutions Strategic Planning Session on March 13, 2015. This document explains a county "business plan" for mental health in the ACA era and reaffirms the county role as administrator of specialty behavioral health under Medi-Cal."
7. In 2011, Assembly Bill 97 authorized 10% Medi-Cal rate reductions across a range of services, including many core behavioral health providers — such as psychiatrists, clinics, and Drug Medi-Cal providers — with some reductions applied retroactively. Although litigation and subsequent policy changes narrowed the scope and duration of certain cuts, the episode highlighted the vulnerability of behavioral health rates funded through the state General Fund. In contrast, county-administered specialty behavioral health services financed through Realignment were not reduced in the same way.
8. Elizabeth Hill, *The 1991–92 State and Local Program Realignment: Overview and Current Issues* (PDF), California Legislative Analyst's Office, February 1992, reprint from The 1992–93 Budget: Perspectives and Issues.
9. IResponsibility for state hospitals was also transferred to the California Department of State Hospitals
10. "Medicaid and CHIP Managed Care Final Rules," US Centers for Medicare & Medicaid Services, accessed January 16, 2026
11. "Behavioral Health Treatment," California Department of Health Services, accessed January 16, 2026.
12. When ACA expanded Medi-Cal coverage and required mental health and substance use disorder services as essential health benefits, California elected to maintain its long-standing county-administered carve-out for specialty behavioral health. State and county leaders cited several reasons: Counties had already established managed systems of care for specialty mental health and SUD services; county behavioral health systems were deeply integrated with crisis response, justice diversion, and housing supports that Medi-Cal managed care plans were not positioned to replicate; carving services into managed care risked destabilizing existing provider networks and financing structures; and other states' carve-in efforts had often resulted in thin networks and diminished specialty capacity. These considerations are reflected in DHCS guidance implementing the ACA, California Mental Health Services Authority, and County Behavioral Health Directors Association of California (CBHDA) strategy papers (2012–14), and RAND analyses commissioned by CBHDA, all of which reaffirmed and advocated for the county role in administering specialty behavioral health under Medi-Cal.
13. The state General Fund covers the non-federal share for the ACA population, but not for DMC-ODS because that program is voluntary.

14. MHPs and DMC-ODS operate as non-risk Prepaid Inpatient Health Plans (PIHPs). A PIHP is a Medicaid managed care arrangement under which a public or private entity receives a prospective payment to provide a defined set of services, such as specialty mental health or SUD treatment. In California, county behavioral health plans operate as non-risk PIHPs for specialty mental health services and DMC-ODS, administering benefits under Medicaid rules. By the end of 2026, all counties must integrate mental health and substance use SUD services into a single behavioral health plan.
15. Full Service Partnerships are intensive, team-based programs that provide comprehensive, "whatever-it-takes" services for people with a serious mental illness or serious emotional disturbance, with the goal of supporting recovery, stability, and community integration.
16. Proposition 1 (2024) authorized billions in capital investment to expand behavioral health treatment and supportive housing infrastructure statewide, including new inpatient, outpatient, and residential treatment, and housing facilities for people with serious mental illness and substance use disorders. These bond funds are intended to address long-standing capacity gaps by financing the physical infrastructure necessary for treatment and recovery, while ongoing services and operations are supported through Medi-Cal and the Behavioral Health Services Act. The Behavioral Health Bridge Housing program serves as a transitional mechanism, providing time-limited funding to expand interim housing and treatment capacity and to help counties bridge the period between emergency and capital investments and the longer-term, housing-linked service funding framework established under BHSA.
17. Nathaniel Counts, "Behavioral Health Care in the United States: How It Works and Where It Falls Short," The Commonwealth Fund, Explainer, September 7, 2022.
18. *National Mental Health Services Survey (N-MHSS): 2020* (PDF), US Department of Health and Human Services, September 2021.
19. The 2011 Realignment does use prevalence and population in the formulas.
20. Alyssa Vicario et al., *Managing California's Behavioral Health System: County Contracting Strategies* (PDF), California Health Care Foundation (CHCF), October 2024.