Overview of Integrated Plan Requirements and Submission Process

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

August 2025

Housekeeping

- You may type your comments into the chat box throughout the presentation.
- Once we reach the discussion portion of our workgroup meeting, please raise your hand to speak and we will go in the order of raised hands.

Webinar Focus

- Please note this webinar will focus only on instructing counties how to complete the Integrated Plan template, not the policy behind the questions included in the Integrated Plan.
- All policy information can be found in the County Behavioral Health Services Act Policy Manual.

Webinar Agenda

- Integrated Plan Submission Timeline
- Community Planning Process
- Overview of Data in the Integrated Plan
- Statewide Behavioral Health Goals
- County Provider Monitoring and Oversight
- Next Steps

Integrated Plan Submission Timeline

Integrated Plan Submission Timeline

2025 – March 2026

Community Planning & Preparation

- Stakeholder engagement
- Collaboration with LHJ/MCPs

March 31

Draft IP Due

- Completed IP and Budget
- Funding Transfer and Exemption Requests
- CAO & BH Director approvals

April 30

IP Review Process

- DHCS will accept or request revisions within 30 days of receiving draft IP

June 30

Final IP Due

- Comment Period
- Public Hearing
- Completed IP and Budget, with requested revisions
- Approved Funding and Transfer Requests
- CAO, BH Director, & Board of Supervisors approvals

Integrated Plan Submission Timeline - Revisions

April 30

IP Review Process

- DHCS will accept or request revisions within 30 calendar days of receiving draft IP.

May 15

County revises and resubmits in 15 calendar days.

May 30

DHCS reviews and responds in 15 calendar days.

June 30

Final IP Due

- Comment Period
- Public Hearing
- Completed IP and Budget, with requested revisions
- Approved Funding and Transfer Requests
- CAO, BH Director, & Board of Supervisors approvals

Draft IP Submission

- Draft IPs will provide counties with feedback from DHCS and make revisions prior to submitting the final IP.
- Counties are encouraged to submit the draft IP prior to the deadline.
- Submitted draft IPs must include answers to each question in the IP and a budget that is as close to final as possible.
- DHCS will notify the county, through the County Portal, if revisions to the draft IP are needed and whether any exemption or funding transfer requests are approved or denied.
  - If DHCS requests revisions to the draft, the county must address those before submitting their final IP.

Final IP Submission

- Counties do not need to complete another IP for the final submission. Any changes made to the accepted draft IP will be tracked through portal functionality.
- There are additional requirements before submitting the Final IP:
  - Counties must circulate the IP for a 30-day comment period. Counties may choose to meet this requirement prior to submitting the draft IP or prior to submitting the final IP.
  - The Local Behavioral Health Board must:
    - Conduct a public hearing; and,
    - Review the draft and make recommendations
  - Counties must include substantive written recommendations and summary of revisions made as a result of stakeholder feedback.

Requirements for Draft and Final IP

	Draft	Final
Deadline	March 31, 2026	June 30, 2026
Activities Required Prior to Submission	» Engage stakeholders through Community Planning Process	» Circulate draft IP for 30-day comment period » Conduct public hearing » Behavioral Health Board reviews IP, makes revisions » Revise draft IP, if requested by DHCS
Items Required to be Included with Submission	Responses to each required item in the Integrated Plan and Budget	Responses to each required item in the Integrated Plan and Budget
	Funding Transfers and Exemption Requests	DHCS-approved Funding Transfer and Exemption Requests
	Certification from: » County Administrative Office, Chief Executive Officer, or designee » Behavioral Health Director	Certification from: » County Administrative Office, Chief Executive Officer, or designee » Behavioral Health Director » Board of Supervisors

Questions?

Community Planning Process

Community Planning Process Overview

- BHSA builds on the MHSA planning process to develop a broader assessment of community needs and strengthen cross-system collaboration for more efficient resource planning.
- The required stakeholders list helps ensure broad representation from the community, including populations at greatest risk for experiencing behavioral health disparities.
- CalMHSA has developed a guidebook to support counties through the Community Planning Process. The Meaningful Engagement guidebook and supporting webinar are available on CalMHSA's website.

Community Planning Process Funds

REMINDER: Counties may allocate up to 5% of BHSF revenue to support stakeholder engagement. Use of funds may include:

Staffing & Training

- Train designated staff managing the CPP
- Training for stakeholders to be meaningfully involved

Planning Cost

- Infrastructure and technology
- Laptops, web-based meeting platforms, accessibility tools

Stakeholder Support

- Stipends/wages for participating consumers and family members
- Travel and transportation
- Childcare/eldercare

Community Planning Process – Collaboration with Local Planning

- As part of the Community Planning Process, the BHSA establishes **local planning requirements** to align County IP community planning with local health jurisdiction (LHJ) Community Health Assessments (CHAs) and/or Community Health Improvement Plans (CHIPs) processes.
- **Local Planning Requirements**
  - Starting January 2025, Counties must engage with their LHJ, along with MCPs, to develop the CHA/CHIP.
  - ***Required Areas of Engagement:*** Collaboration, data-sharing, and stakeholder activities.
  - Counties are encouraged to work with their LHJ to streamline processes and reduce community fatigue.
- **For 2026 IP submissions,** counties may consider the most recent LHJ CHA, CHIP or strategic plan when developing its IP. Counties will not be penalized for early engagement with LHJs on CHA and CHIP development.
- Forthcoming: DHCS will release a **BHSA Local Planning Process Collaboration Tool** to support counties in meeting these requirements; use of the tool is optional.

Questions?

Overview of Data in the Integrated Plan

DHCS

Data in the Integrated Plan

- The IP is a prospective, global planning tool.
- The required data reporting should be used to inform county planning and spending decisions to address community needs, reduce disparities, and meet statewide and local outcome measures.
- The data should also be leveraged to facilitate stakeholder engagement by providing stakeholders with an assessment of the county's current behavioral health gaps.
- Data will not be pre-populated in the FY 2026-29 IP.

Data in the Integrated Plan

- Counties may use any relevant local data in their IP – but ideally data should be from the fiscal year prior to the year that IP planning begins.
- This allows the county and stakeholders to have recent data to begin developing the IP in 2025 to prepare for submission by the March 31, 2026 due date.

Data for Cities and Counties Submitting Jointly

- Counties are expected to report local data in the Integrated Plan.
- Counties submitting joint IPs must use data reflecting all counties included.
- Cities are expected to submit data corresponding to the county in which they are located.

County Behavioral Health System Overview Section

- This section is intended to provide a broad overview of the populations served, current tech infrastructure, and services provided in the county to help inform conversations with stakeholders and program planning to assess where gaps in the system exist.
- Data is stratified by age group:
  - Children and Youth under age 21
  - Adults and Older Adults
- Please Note: Although BHSA defines children and youth under age 25 as a priority population, counties will use Medi-Cal data for some reporting in the IP and report on children and youth under age 21 where appropriate.

Data Sharing Strategy

- Overarching, long-term goal of the Behavioral Health Transformation and other DHCS initiatives is to strengthen data sharing between typically siloed entities.
  - Improves care and outcomes
  - Supports data-driven, value-based health care approach
- To complete the Integrated Plan, counties are expected to provide information on housing availability and service utilization and justice involvement data.
  - REMINDER: Counties must make a good faith effort to obtain updated information from other county partners that may own this data.

Questions?

Statewide Behavioral Health Goals

Statewide Behavioral Health Goals

DHCS has identified 14 statewide behavioral health goals aimed at improving well-being and reducing adverse outcomes. To support these goals and data-informed planning, DHCS has identified population-level behavioral health measures. Counties will be required to review and address these measures in the IP.

Planning and progress on these goals in Phase 1 will require coordination across multiple service delivery systems.

↑ Goals for Improvement
Care experience
Access to care
Prevention and treatment of co-occurring physical health conditions
Quality of life
Social connection
Engagement in school
Engagement in work

↓ Goals for Reduction
Suicides
Overdoses
Untreated behavioral health conditions
Institutionalization
Homelessness
Justice-Involvement
Removal of children from home

Health equity will be incorporated in each of the BH Goals

Approach to Data-Informed County Planning

- To support the BHSA Planning Process, each county is required to review the population-level behavioral health measures associated with each statewide behavioral health goal and compare their status to the statewide rate or average.
- Counties will address the six priority goals and select one additional goal to work towards. The self-selected goal should reflect an area where the county does not meet the statewide rate and should be chosen based on community needs and stakeholder input.
- Counties will be asked to identify disparities and choose data-informed strategies to improve community health and well-being for the six priority goals and the additional self-selected goal.

Priority Statewide Behavioral Health Goals

Goals for Improvement
Care experience
Access to care *
Prevention and treatment of co-occurring physical health conditions
Quality of life
Social connection
Engagement in school
Engagement in work

Goals for Reduction
Suicides
Overdoses
Untreated behavioral health conditions *
Institutionalization *
Homelessness *
Justice-Involvement *
Removal of children from home *

Health equity will be incorporated in each of the BH Goals

* Indicates a priority goal

Phase 1 Population-Level Behavioral Health Measures

- Counties will review the Phase 1 Population-Level Behavioral Health Measures associated with each goal to complete the first IP (June 2025 – June 2026).
- The Phase 1 Measures are publicly available and focused on population-level behavioral health measurement.
- Each goal has ~1 primary measure and 2-3 supplemental measures. Primary measures reflect the community's status and well-being, and supplemental measures provide additional context to inform planning.
- Counties can assess their status on all Phase 1 Measures using the County Population-Level Behavioral Health Measure Workbook and the Measure Access Instructions and Notes Document.

Priority Goal Example: Access to Care

- Here is an example of a Primary Measure associated with the priority goal Access to Care.

Access To Care

Primary Measures

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

1. How does your county status compare to the statewide rate?
    a. For adults/older adults [above/below/same]
    b. For children/youth [above/below/same]
2. What disparities did you identify across demographic groups or special populations? [Multi-select]
    a. Age
    b. Gender
    c. Race or Ethnicity
    d. Sex
    e. Spoken Language
    f. None Identified
    g. No Disparities Data Available
    h. Other [narrative box]

Priority Goal Example: Access to Care

- Use the Measure Access Instructions Document to locate the source data and review the measure description, as well as any related notes or guidance.

Primary Measure* – Non-Specialty Mental Health Service (NSMHS) Penetration Rates for Adults & Children & Youth, FY 2023

Links:

- (Adult) Adult MHS Demographic Dashboard (AB470) | Behavioral Health Reporting
- (Children and Youth) Children and Youth MHS Demographic Dashboard (AB470) | Behavioral Health Reporting

Measure Description:

Penetration rates of Adults (age 21 and over) and Children & Youth (under 21 years) enrolled in a Medi-Cal managed care plan (MCP) that received one or more NSMHS by State Fiscal Year.

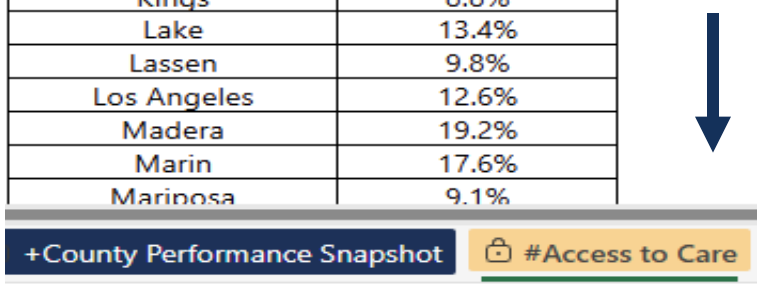
Access Instructions:

- Access the dashboards with the links provided (note: there are two dashboards, one for Adults and one for Children and Youth). Repeat the following steps for each dashboard.
- Scroll to the "Demographic Data" report tool section.
- Click on the filter arrow on the right and select desired demographic and year filters (note: you have to complete each filter).

Priority Goal Example: Access to Care

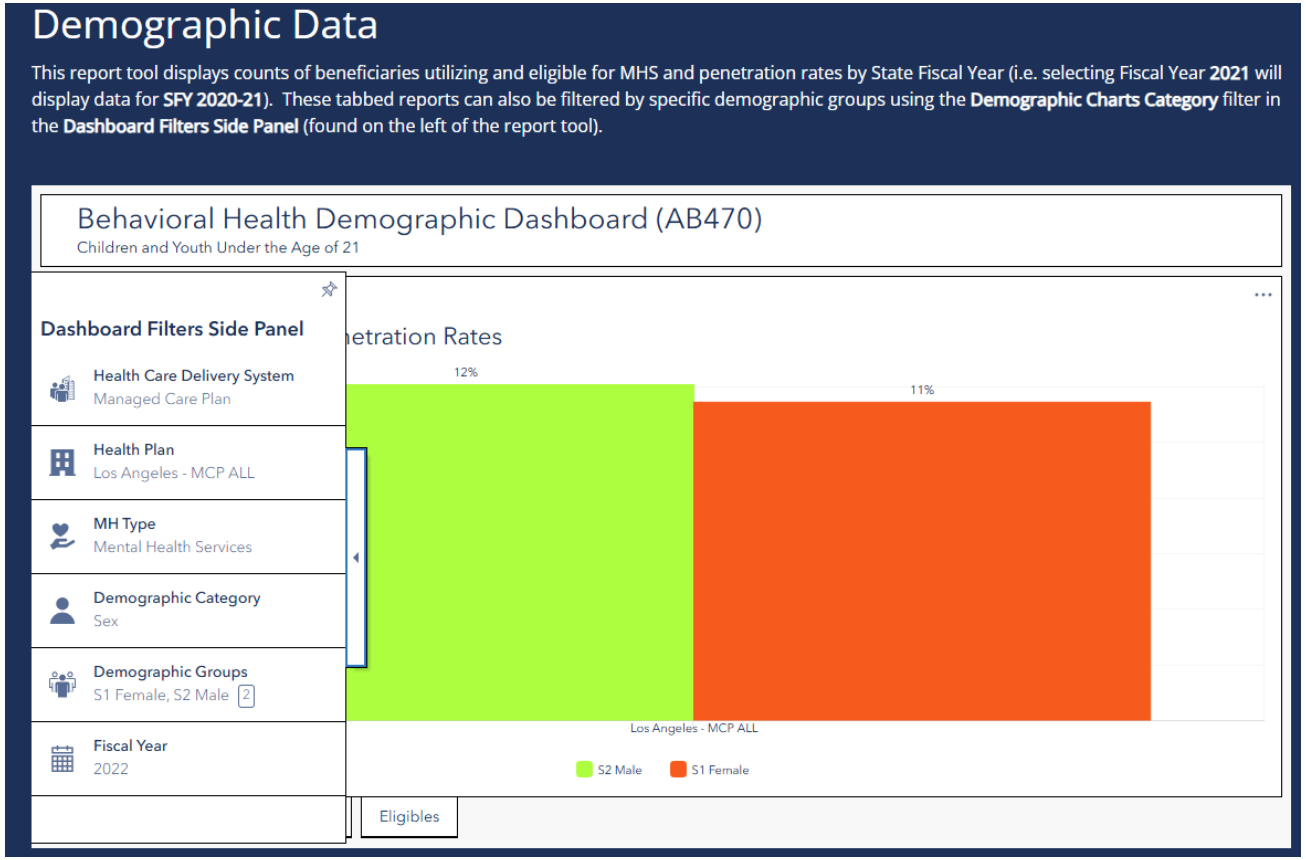
- Open the County Population-Level Behavioral Health Workbook and navigate to the Access to Care tab.
- Find your county's rate for the corresponding measure and compare it to the statewide rate (15.5%).

Primary Measure	
County Name	NSMHS Penetration Rates for Children & Youth
Statewide Rate	15.5%
Statewide Median	15.1%
Alameda	14.0%
Alpine	8.9%
Amador	15.9%
Butte	17.1%
Calaveras	9.4%
Colusa	16.0%
Contra Costa	14.0%
Del Norte	15.1%
El Dorado	15.1%
Fresno	13.0%
Glenn	14.5%
Humboldt	16.5%
Imperial	15.8%
Inyo	18.1%
Kern	12.0%
Kings	8.8%
Lake	13.4%
Lassen	9.8%
Los Angeles	12.6%
Madera	19.2%
Marin	17.6%
Mariposa	9.1%



Assessing Disparities

- Counties must identify and evaluate disparities for the six priority goals and the additional self-selected goal.
- To evaluate and identify disparities, counties should review the demographic data available from the public dashboard for each measure.
- Please note that the level of demographic detail may vary by dashboard.
- Counties are encouraged to supplement this analysis with local data, as available, and should use existing processes to conduct this assessment.



Interpreting Your County's Data

- Counties are expected to review and reflect on their community's status where data is available.
- If data is not available for a specific measure, the county is not expected to evaluate or address it in their planning process.
- To support planning and address local needs, counties may use other local or publicly available data sources.

Data-Informed County Planning

- Based on this review, counties will:
  - Select and describe data-informed initiatives aimed at improving their status on the goal.
  - Identify both BHSA and non-BHSA funding sources that will support these initiatives.

Questions?

County Provider Monitoring and Oversight Section

DHCS

BHSA Provider Locations

- The IP requires counties to report the total number of contracted BHSA provider locations, as well as the subset that participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS):

Table 8. Contracted BHSA Provider Locations Offering Non-Housing Services

Services Provided	Number of Contracted BHSA Provider Locations
Mental Health (MH) services only	[numeric response]
Substance Use Disorder (SUD) services only	[numeric response]
Both MH and SUD services	[numeric response]

Table 9. Contracted BHSA Provider Locations that Participate in Medi-Cal BHDS

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	[numeric response]
DMC/DMC-ODS only	[numeric response]
Both SMHS and DMC/DMC-ODS systems	[numeric response]

- Counties will count each physical location for each provider *(in alignment with Medi-Cal network adequacy and provider site certification)*.
  - For a multi-site provider, count each site as a separate provider location.
  - For different programs in the same building, count each as a separate provider location.

SMHS/NSMHS Overlap

- Among all BHSA Provider locations, counties must report the percentage of BHSA-funded SMHS provider locations that contract with at least one Managed Care Plan (MCP) to deliver non-specialty mental health services (NSMHS).
- If the percentage is under 60%, then counties must explain how they will enhance their rate of MCP contracting.
  - DHCS will provide each county with the % of SMHS/NSMHS overlap based on network adequacy reports, as well as the list of overlapping providers. (Fall 2025)
  - Counties may report the percentage prepared by DHCS or adjust it by removing SMHS provider locations that do not offer NSMHS services.

Example	Prepared by DHCS	Prepared by County
Numerator: No. SMHS locations that contract with MCP for NSMHS	5	5
Denominator: No. SMHS locations that offer NSMHS	10	8
Percentage: % of SMHS locations offering NSMHS that contract with MCPs	50%	63%

County Monitoring of BHSA Providers

- Counties are encouraged to adopt the Medi-Cal provider monitoring schedule (annual monitoring with a site visit at least once every 3 years).
- Alternatively, counties can describe their own BHSA provider monitoring schedule in the IP, as long as it includes periodic site visits.

Questions?

Next Steps

Upcoming Webinars

- Behavioral Health Services Act Components
  - August 14, 10:30am – 12:00pm
- Integrated Plan Budget, Funding Transfers, Exemptions, and Integrated Plan Review
  - August 26, 1:00pm – 2:30pm

Appendix

BHSA and non-BHSA Reporting Requirements

BHSA-specific Reporting	Non BHSA Reporting
Adjustments to BHSA components from funding transfers and exemptions	Care Continuum Expenditures & Total Count of Individuals Served
Allocation of unspent MHSA funds	Capital Infrastructure
Transfers to & from Prudent Reserve	Workforce Investment
Planned expenditures for Housing, FSP, and BHSS from BHSA funding	Quality, Accountability, Data Analytics, Administration
Projected individuals served through BHSA services	Other County BH Services
Projected improvement, monitoring, and community planning expenditures	Realignment, State General Fund, FFP, PATH, SUBG, MHBG, commercial insurance, county general fund, OSF, other federal grants, state, county, and foundation funding
	Planned expenditures for Housing, FSP, and BHSS services from non-BHSA funding
	Supplemental funding for improvement, monitoring, and community planning

Links

- County Behavioral Health Services Act Policy Manual
  - County Integrated Plan
  - Community Planning Process
  - Behavioral Health Transformation Fiscal Policies
  - BHSA Components and Requirements
- Integrated Plan Budget Template
- County Population-Level Behavioral Health Measure Workbook
  - Instructions and Notes
- Data Share Authorization Resources for Community Planning:
  - Med-Cal Housing Support Services Toolkit
  - Reentry Initiative Toolkit