BEHAVIORAL HEALTH & RECOVERY SERVICES

Specialty Mental Health

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SPECIALTY MENTAL HEALTH

The California Department of Health Care Services (DHCS) administers Managed Mental Health Care for Medi-Cal eligible beneficiaries with serious mental illness (SMI).

Specialty Mental Health Services are "carved out" of other California Medi-Cal services through what is known as a Federal Medicaid Waiver.

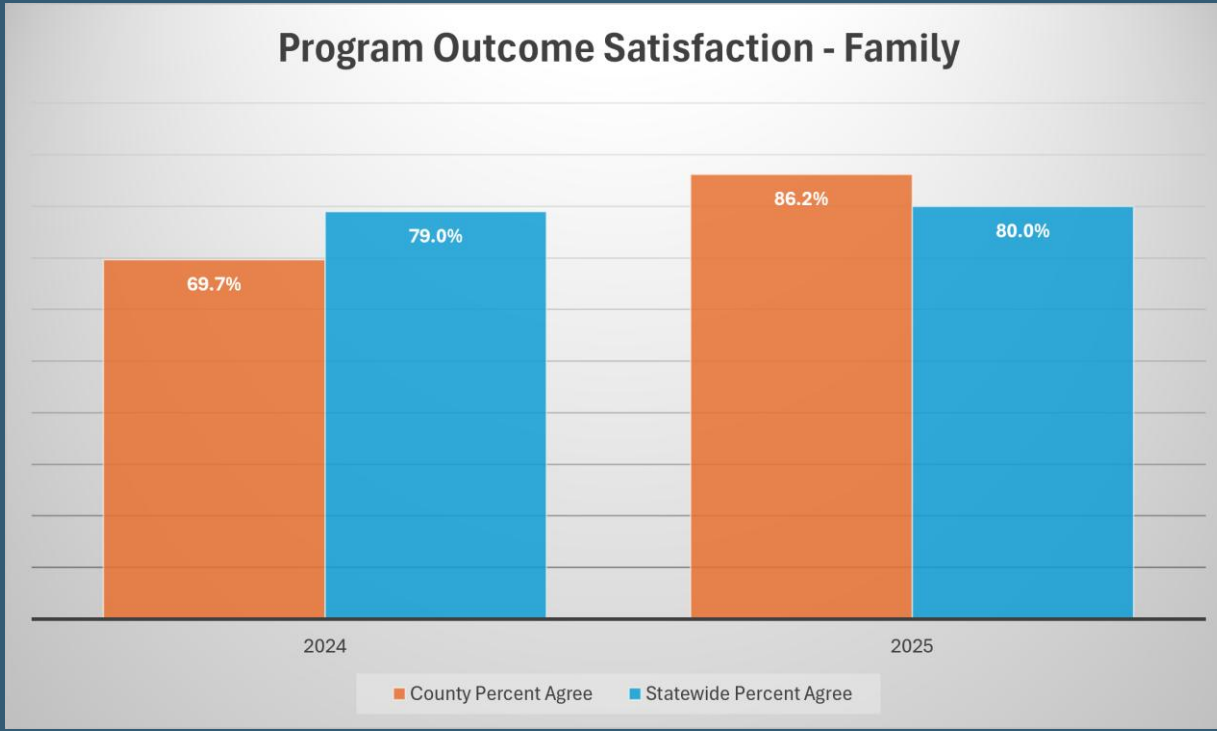
SPECIALTY MENTAL HEALTH

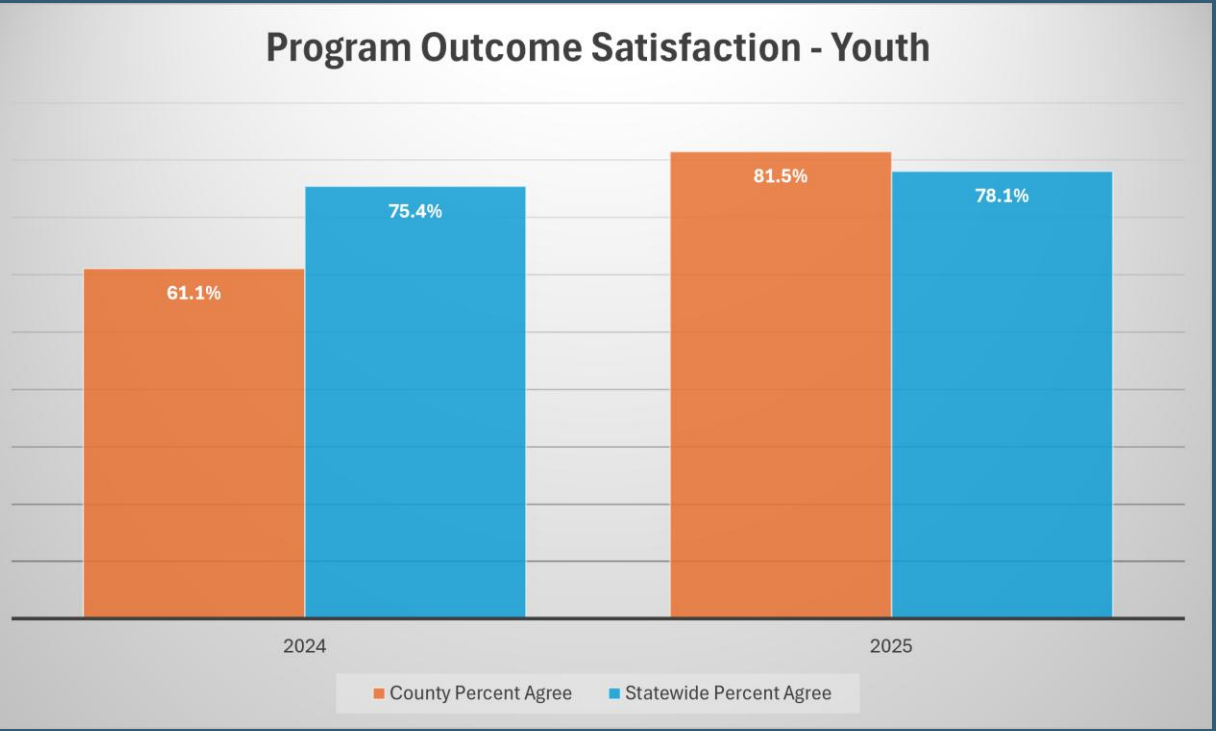
- **Funding**
  - County Funding:
    - General Fund Mandated Maintenance of Effort - $28,840
  - Federal Funding:
    - Federal Financial Participation (FFP) through Medicaid billing (aka Medi-Cal)
  - State Funding:
    - 1991 Realignment Funding
    - 2011 Realignment Funding
    - Behavioral Health Services Act (BHSA)

CONTRACTED PROVIDERS

- **Contract terms: July 1, 2026 – June 30, 2027**
  - Anchor Health Management, Inc - $2,200,000
  - Mendocino Coast Hospitality Center - $640,000
  - Mendocino County Youth Project - $750,000
  - Redwood Community Services - $10,664,056
  - Tapestry Family Services - $4,952,300
- **Estimated number of clients to be served: 3,845**
- **Total cost per beneficiary: $4,995.15**

CONSUMER PERCEPTION SURVEY RESULT 2025 – ANALYZED BY UCLA





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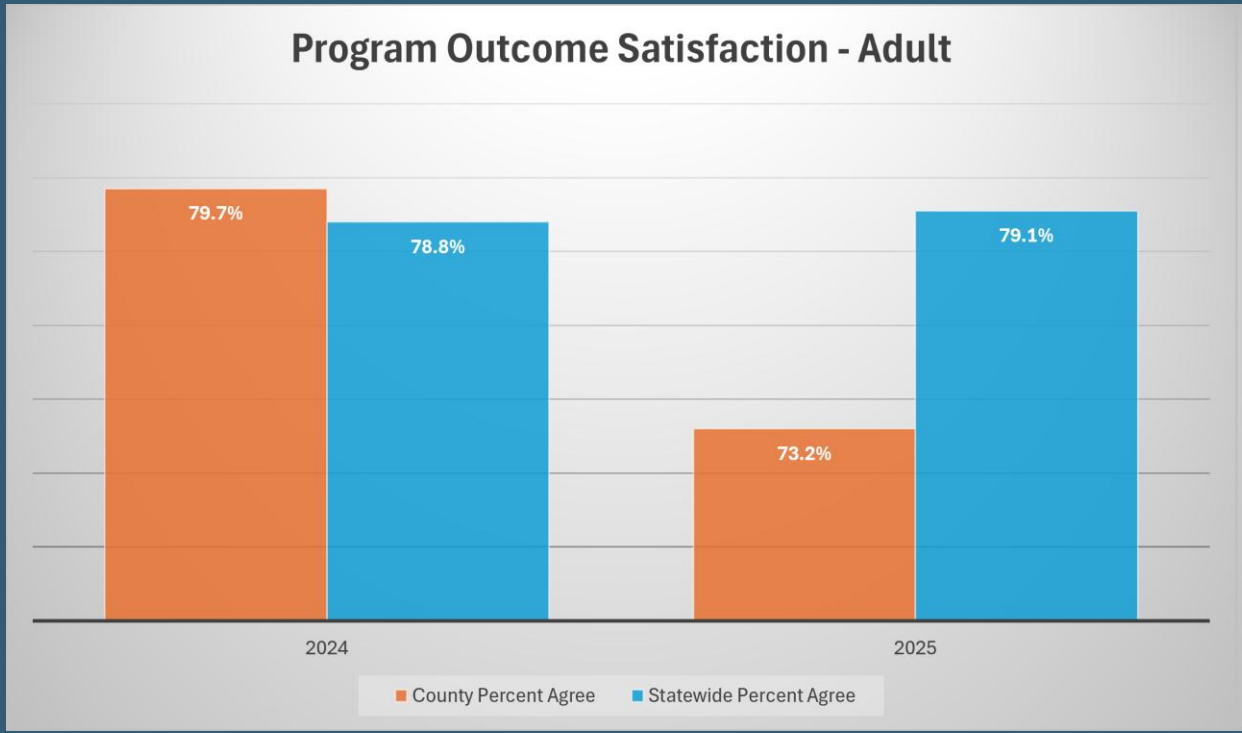

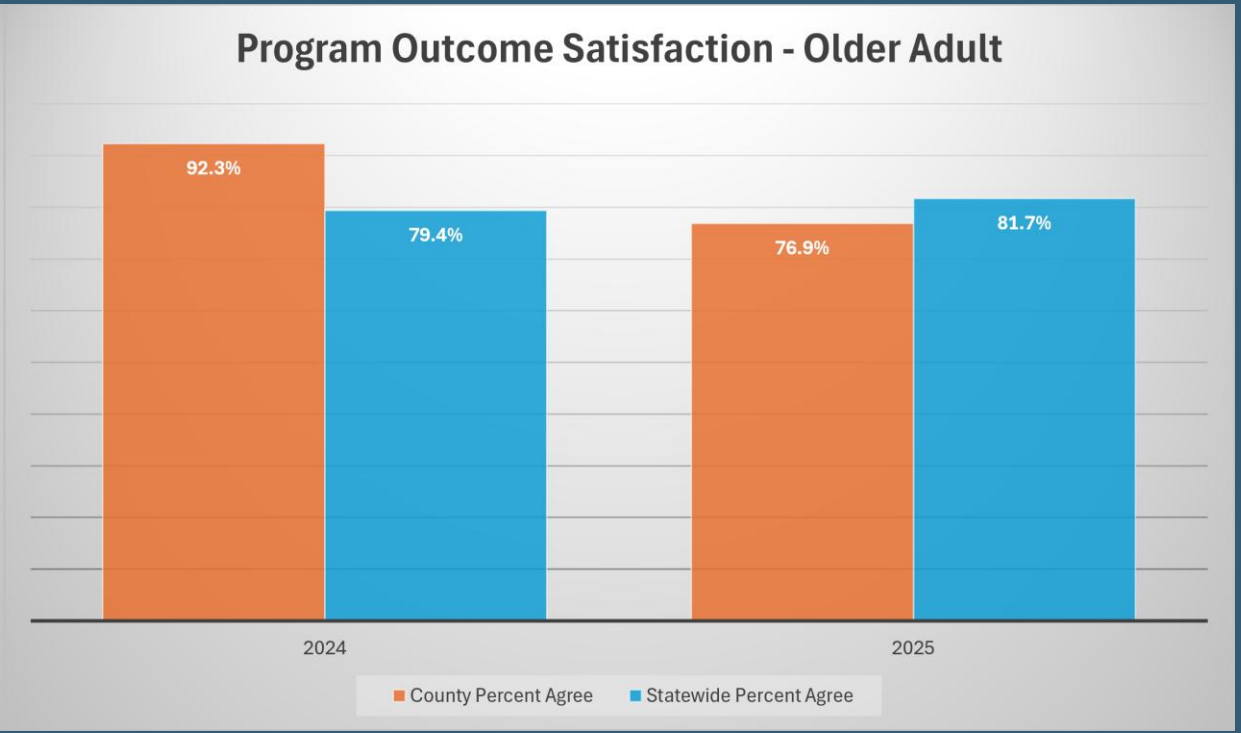

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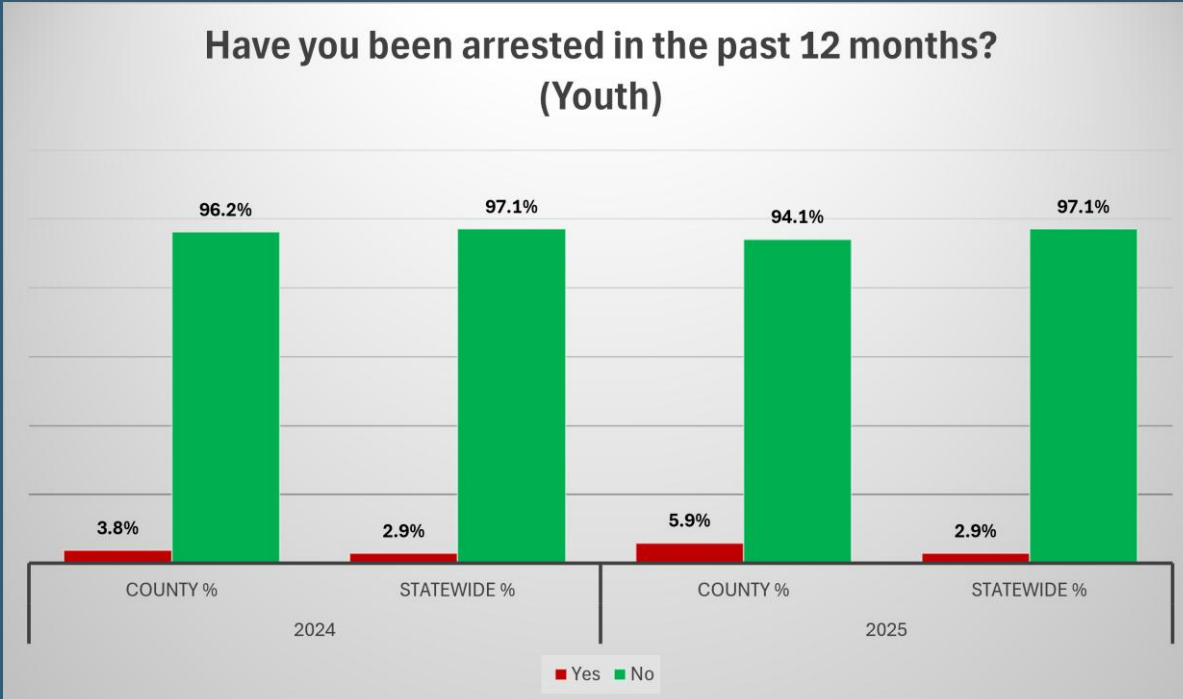

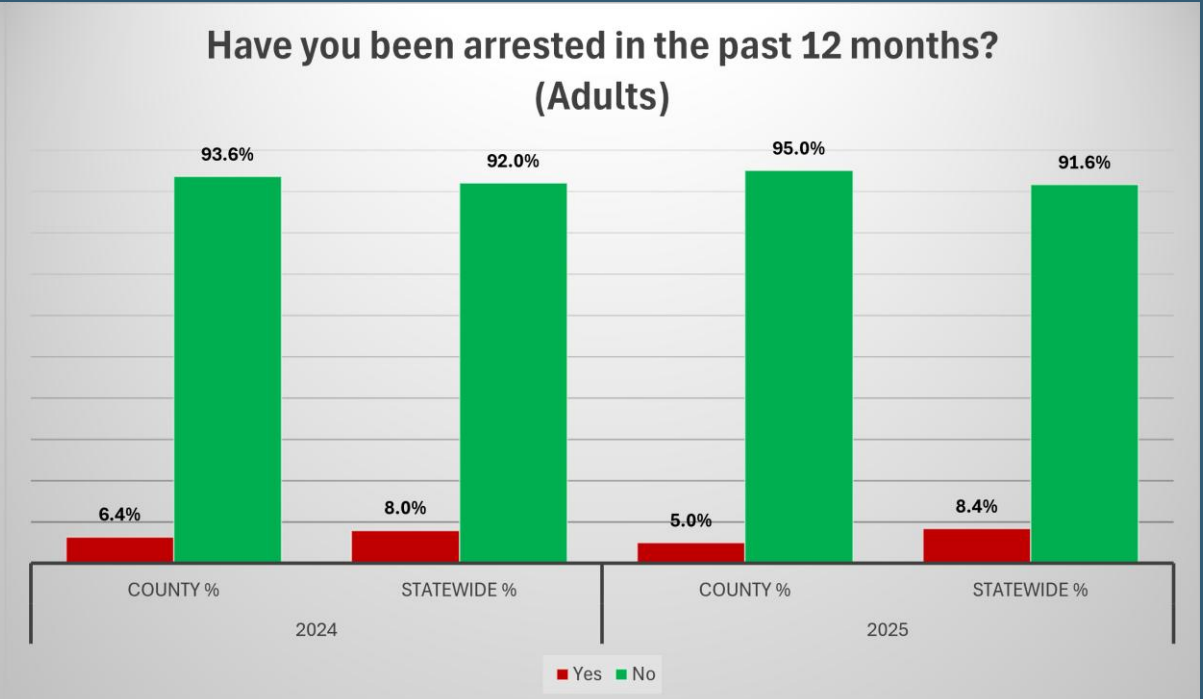

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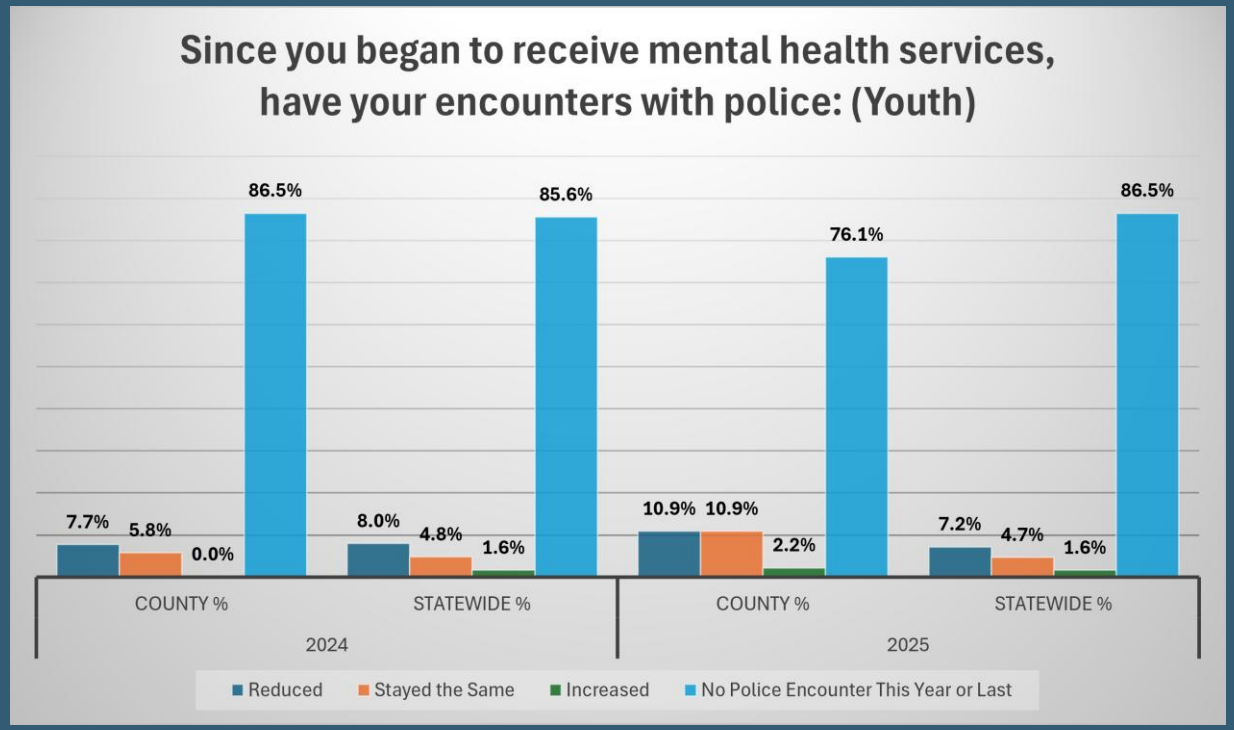
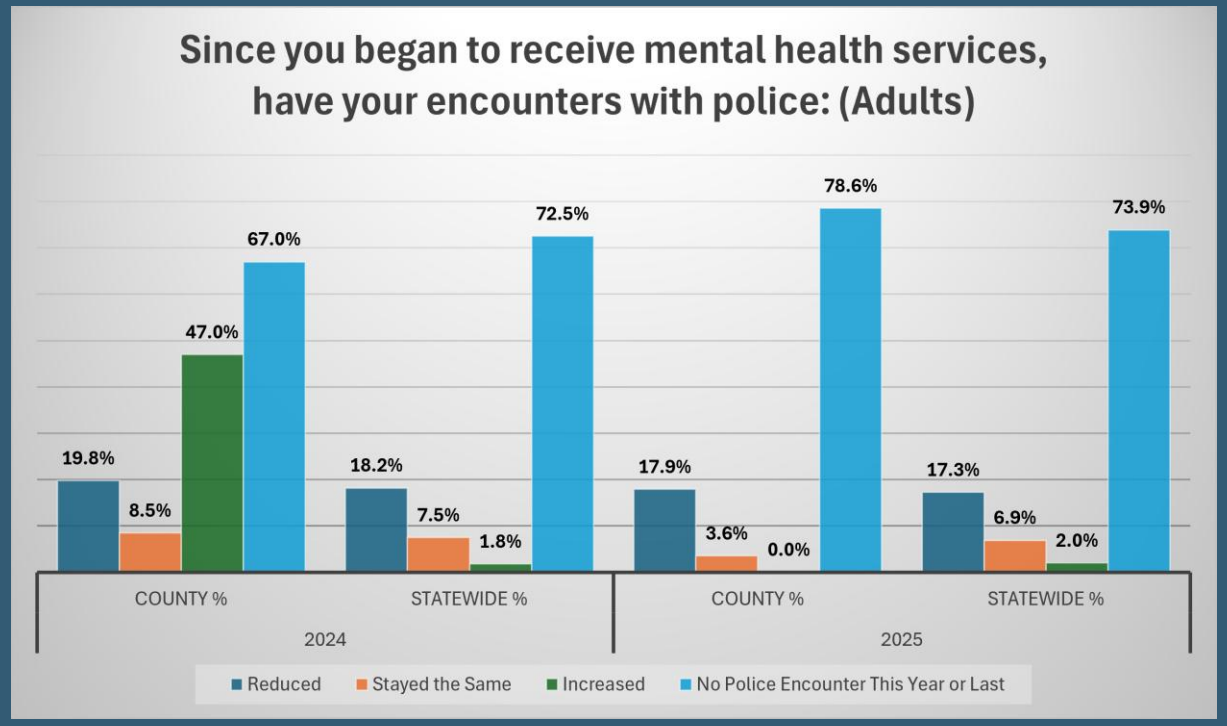




DATA REPORTING

- All contracted providers shall provide:
  - Number of individuals housed during services,
  - Number of individuals unhoused vs housed in services,
  - Number of new beneficiaries' accessing services,
  - Number of services provided,
  - Number of services provided by provider type, type of services provided by provider type
  - Number of beneficiaries who completed treatment and have not returned,
  - Number of beneficiaries currently in services accessing crisis services,
  - Improvement in beneficiary outcome measures including but not limited to, based on client's age, the Adult Needs and Strengths Assessment (ANSA), Child Assessment of Needs and Strengths IP (CANS-IP), Client Satisfaction Questionnaire (CSQ-4) General Anxiety Disorder-7 (GAD7) Pediatric Symptom Checklist (PSC-35) and Adverse Childhood Experiences, to measure clients' functioning and/or satisfaction, and
  - Number of beneficiaries accessing services that need a higher level of care, ie LPS.

DATA REPORTING

Specialty Mental Health Services Measurement	FY 22/23 Outcome (# of Individuals)	FY 23/24 Outcome (# of Individuals)	FY 24/25 Outcome (# of Individuals)	FY 25/26 Outcome (# of Individuals)
Number of people that entered services this year	899	1,118	1,337	1,229
Number of people currently served who utilized crisis services this year	388 (21%)	491 (22%)	593 (23%)	435 (20%)
Number of people currently served who utilized crisis services last year, but not this year	104	112	212	277
Number of people currently served who have not needed to utilize crisis services this year	1,463 (79%)	1,745 (78%)	2,027 (77%)	2,137 (80%)
Number of people that needed to be conserved	29	9	9	13
Number of people who got off conservatorship and have stayed off	10	6	6	13
Number of people housed during fiscal year	46	46	56	60

HEALTHCARE EFFECTIVE DATA AND INFORMATION SET (HEDIS)

- Follow-Up After Emergency Department Visit for Mental Illness - FUM
  - How well the system ensures timely continuity of care post-crisis. Strong FUM rates indicate effective transitions from emergency care to outpatient mental health services, reducing relapse and readmission risk.
- Follow-Up After Hospitalization for Mental Illness - FUH
  - Measures the system's ability to engage individuals in outpatient mental health care after inpatient treatment. High FUH rates reflect strong discharge planning, community provider coordination, and client engagement.
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - APP
  - Assesses the percentage of individuals 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. Strong adherence indicates that individuals 1-17 years are receiving evidence-based, clinically appropriate care by attempting psychosocial interventions before initiating antipsychotic medication when appropriate.
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia - SSA
  - Reflects how well individuals with schizophrenia are supported in maintaining antipsychotic treatment. Strong adherence indicates effective medication management and support for a high-need population.

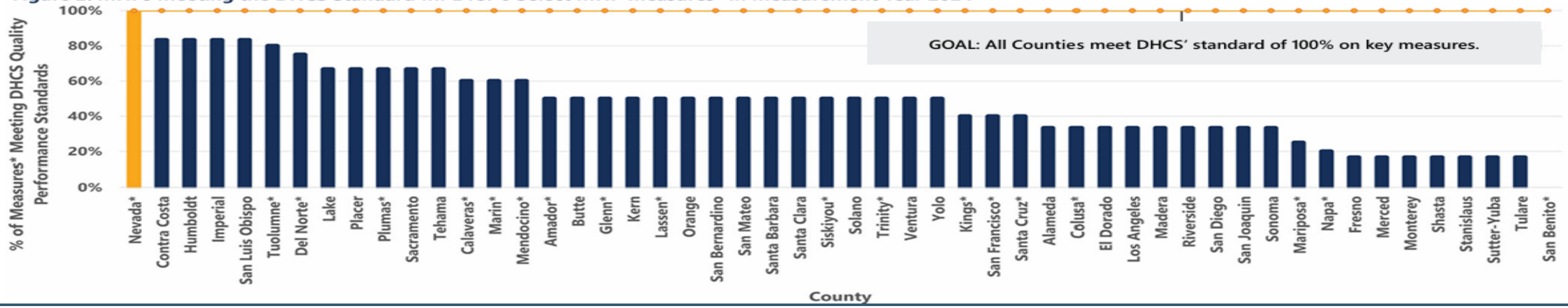
MENDOCINO COUNTY 2025 HEDIS MEASURES

Measure	Description	Mendo Compliance Rate	Mean State Compliance Rate
FUM	Follow-Up After Emergency Department Visit for Mental Illness (30-Day)	65%	65.90%
FUH	Follow-Up After Hospitalization for Mental Illness (30-Day)	69.31%	68.87%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	54.70%	69.55%
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	75.11%	71.97%

HEDIS MEASURES – DHCS CLINICAL QUALITY PERFORMANCE MEASUREMENTS

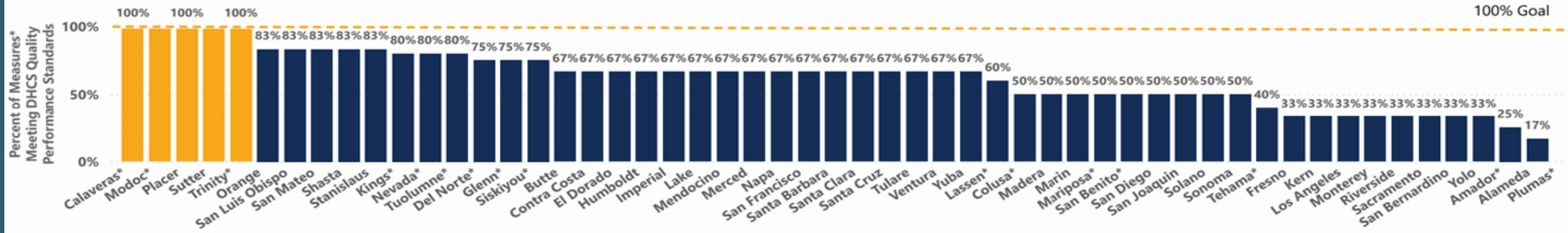
- FUH-30 Days
  (Follow-up After Hospitalization for Mental Illness)
- FUM- 30 days
  (Follow-up After Emergency Department (ED) Visit for Mental Illness)
- APP
  (Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics)
- SAA
  (Adherence to Antipsychotic Medications for Individuals with Schizophrenia)
- AMM
  (Antidepressant Medication Management Effective Acute Phase Treatment)
- AMM
  (Antidepressant Medication Management Effective Continuation Phase Treatment)

Figure 2: MHPs Meeting the DHCS Standard MPL for 6 Select MHP Measures* in Measurement Year 2024



- AMM-Acute
  (Antidepressant Medication Management, Acute)
- AMM-Continuation
  (Antidepressant Medication Management, Chronic)
- FUH-30 Days
  (Follow-up After Hospitalization for Mental Illness)
- FUM-30 Days
  (Follow-up After Emergency Department (ED) Visit for Mental Illness)
- APP
  (Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics)
- SAA
  (Adherence to Antipsychotic Medications for Individuals with Schizophrenia)

MHPs Meeting the DHCS Quality Performance Standards for 6 Select MHP Measures* in Measurement Year 2023



HEDIS MEASURES – DHCS CLINICAL QUALITY PERFORMANCE MEASUREMENTS

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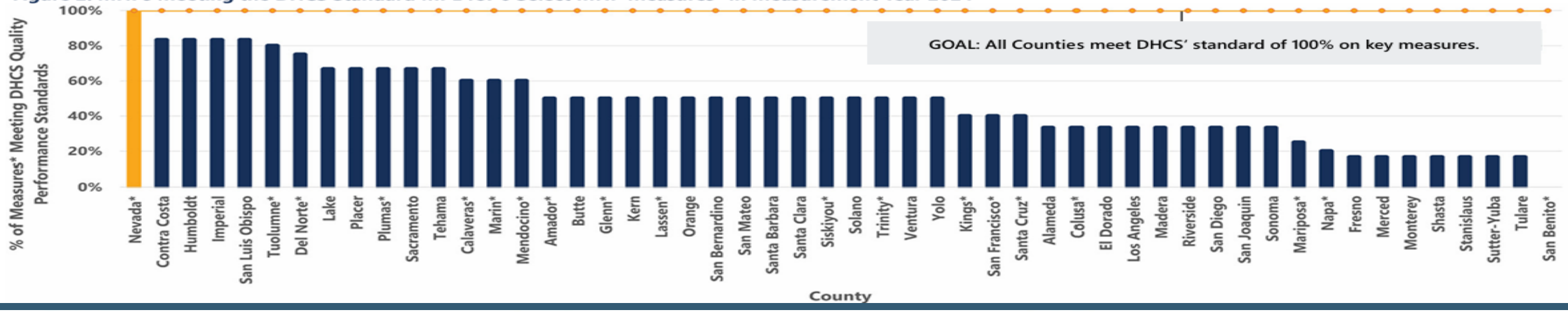
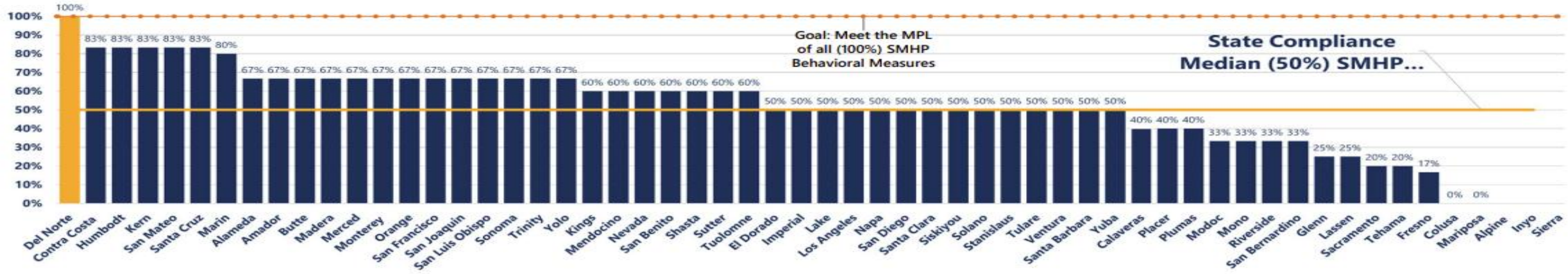


- AMM-Acute
  (Antidepressant Medication Management, Acute)
- AMM-Continuation
  (Antidepressant Medication Management, Chronic)
- FUH-30*
  (Follow-up After Hospitalization for Mental Illness)
- FUM-30
  (Follow-up after Hospitalization for Mental Illness)
- APP*
  (Use of First Line Psychosocial care for Children and Adolescents on Antipsychotics)
- SAA
  (Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia)

SMHPs Meeting the DHCS Standard (MPL) for 6 Select Behavioral Measures in Measurement Year 2022

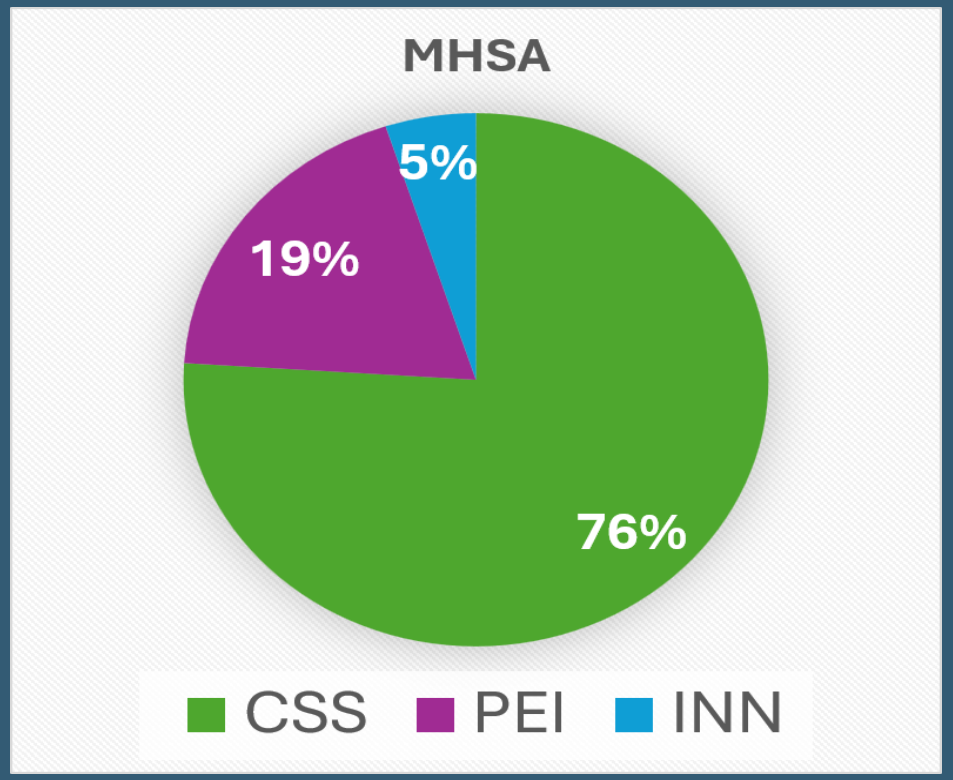


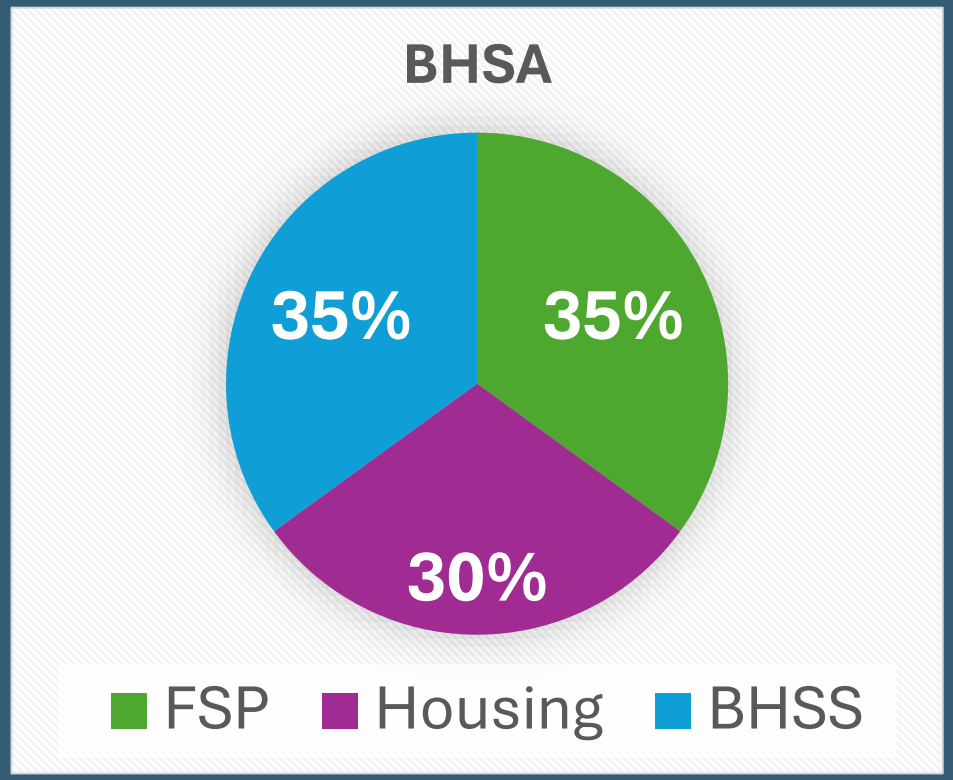
MHSA – BHSA TRANSFORMATION

- Housing Intervention 30%
  - 50% required to be used for individuals with serious mental illnesses or substance use disorder and chronic homelessness; focus on encampment level homeless
  - 25% maximum can be used for capital facilities
- Full Service Partnerships 35%
  - Behavioral health treatment and support services through a "whatever it takes"
- Behavioral Health Services and Supports (BHSS) 35%
  - Early intervention, outreach and engagement, workforce education and training, capital facilities and technology, innovation pilots and projects, and any other qualified BHSA expenditures.
  - 51% for early intervention services for youth under 25 with specialty mental health conditions

MHSA – BHSA TRANSFORMATION

- Funding Distribution





ELECTRONIC HEALTH RECORD

- Department of Health Care Services Requirements
  - The federal interoperability requirements under the Centers for Medicare & Medicaid Services (CMS) interoperability rules for California County Behavioral Health Plans, including County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) plans.
  - Behavioral Health Plans must support standards-based interoperability by implementing a **FHIR-based Patient Access API**.

- The Patient Access API must provide beneficiaries with access to applicable information maintained by the County, including:
  - Adjudicated Claims
  - Encounter Data
  - Payment Information
  - Other required USCDI V3 data elements as applicable

- Department of Health Care Services places the legal responsibility on the Behavioral Health Plan, therefore County Behavioral Health Plans must ensure their contracted providers comply with the requirements necessary for the department to remain in compliance. Counties can not rely on their own systems if contracted providers maintain or generate the required data.

ELECTRONIC HEALTH RECORD

- Netsmart/Avatar
  - The County has been using Avatar since 2006 as the EHR for Specialty Mental Health Services. In 2020, SUDT services was added to Avatar.
  - Over the last two years, the county has worked to expand the use of Avatar within the County and contracted providers.
  - Current utilizers: Specialty Mental Health, Substance Misuse Treatment, Public Health, Juvenile Hall Medical, Mendocino County Hospitality Center, and Mendocino County Youth Project.
  - Working with the Sheriff Department to get full interoperability between Naphcare EHR and Avatar.
  - Currently working with Restpadd and several Drug Medi-Cal providers who are interested in and willing to utilize Avatar.
  - Currently have three specialty mental health providers that are using their own EHR.

ELECTRONIC HEALTH RECORD MANDATES

Department of Health Care Services API Requirements	
Requirement	**County Action**
Patient Access API	Provide members electronic access to their health information.
Provider Access API	Allow authorized providers to electronically retrieve member information for care coordination.
Prior Authorization API	Exchange prior authorization information electronically where applicable.
Interoperability standards	Use CMS-required technical standards (FHIR APIs).
Privacy & Security	Comply with HIPAA, 42 CFR Part 2, and California confidentiality laws.
Public reporting	Publish annual prior authorization metrics.
Governance	Maintain policies, monitoring, testing, and documentation demonstrating compliance.

ELECTRONIC HEALTH RECORD MANDATES

County Responsibility	What Contracted Providers Must Do
Electronic data sharing	Maintain electronic records and share required clinical, encounter, and administrative data with the county.
API support (where applicable)	Work with the county's EHR staff to ensure required information can be made available through the county's Patient Access, Provider Access, Payer-to-Payer, and Prior Authorization APIs.
Timely documentation	Submit complete encounter and authorization data within county-established timeframes so the county can meet CMS interoperability requirements.
Privacy compliance	Follow HIPAA, 42 CFR Part 2, and California confidentiality laws, including obtaining and honoring required consents.
Admission, Discharge, and Transfer (ADT) notifications	If the provider operates an inpatient or residential facility with an electronic record system, participate in real-time ADT notification sharing with the county.
Data quality	Maintain accurate provider, member, claims, authorization, and clinical data needed for county reporting and interoperability.
County monitoring	Cooperate with audits, monitoring, testing, and corrective action plans related to interoperability and data exchange.

ELECTRONIC HEALTH RECORD

Issue	Providers Use Their Own EHR	Providers Use County EHR	Hybrid Model (County EHR + Interoperability Provider EHRs)
DHCS compliance	Most complex	Simplest	Moderate
Interoperability management	County manages every interface	Minimal interfaces	County manages interfaces only for approved external EHRs
Data quality	Variable; mapping and validation required	Standardized	Mostly standardized with some reconciliation
Real-time data availability	May be delayed by interfaces	Immediate	Immediate for county EHR; dependent on interface performance for external EHRs
Care coordination	Fragmented records	Shared longitudinal record	Improved but may require viewing records from multiple sources
Reporting to DHCS	Complex; requires reconciliation	Simplified	Moderate complexity
Quality Improvement and analytics	Difficult to standardize	Standardized dashboards and reporting	Mostly standardized with some additional validation
Patient Access and Provider Access APIs	County must aggregate data from multiple systems	Single source	County aggregates from approved systems
Prior Authorization workflows	May vary by provider	Standardized	Standardized where possible; interfaces support external providers
Provider flexibility	Highest	Lowest	Moderate to High
County operational control	Lowest	Highest	Moderate
Business continuity	Dependent on multiple vendors	Centralized disaster recovery	Mixed depending on interoperability
Future CMS/DHCS changes	Every vendor must update independently	One county-wide implementation	Updates coordinated across county and approved vendors
Overall compliance risk	Highest	Lowest	Moderate

ELECTRONIC HEALTH RECORD

Model	Advantages	Challenges
Providers Use Their Own EHR	Maximum provider autonomy; avoids migration costs; providers retain existing workflows	Increased compliance risk; more difficult reporting and care coordination
County EHR	Standardized documentation; shared patient record; easier interoperability, reporting, audits, quality management, records are maintained in county system should provider's contract terminate	Provider transition and training; less flexibility for contractors
Hybrid Model	Balances provider flexibility with county oversight; reduces the number of interfaces compared with an open environment; allows large providers to retain mature EHRs while smaller providers use the county system	Requires external EHRs to meet the interoperability of the County EHR; ongoing interface management; some data reconciliation; more complex than a single EHR

ELECTRONIC HEALTH RECORD - RECOMMENDATION

- **Department Recommendation**
  - **Preferred Option:**
    - Require all contracted providers to utilize the County's EHR (Avatar) as the primary clinical record.
    - Promotes standardized documentation and workflows.
    - Improves care coordination and data quality.
    - Simplifies compliance with DHCS and federal interoperability requirements.
  - The Department also understands that some contracted providers have requested the flexibility to utilize their own EHR systems while achieving interoperability through a hybrid model.
  - While the Department believes a single County EHR provides the greatest operational efficiencies, reduces administrative complexity, and offers the most sustainable long-term solution, it also recognizes providers' desire to continue using their existing EHR systems. The Department cannot predict future state and federal interoperability, API, and electronic health record requirements. As those requirements continue to evolve, a hybrid model may result in increased implementation costs, additional staff workload, and greater operational complexity for both the County and contracted providers.

ELECTRONIC HEALTH RECORD – HYBRID MODEL

- Three contracted providers have requested a hybrid model. Two utilize the same EHR System. The proposed hybrid model would increase operational responsibilities for the County, including:

- County Impacts
  - Increased staffing to support implementation, validation, and ongoing operations
  - Review and processing of incoming EDI files
  - Validation of encounter documentation submitted by contracted providers
  - Data quality monitoring and exception management
  - Resolution of data discrepancies between County and contracted provider systems
  - Transformation of validated data into API-accessible structures
  - Ongoing monitoring of data completeness, accuracy, and timeliness
  - Increased coordination between Fiscal, QA, EHR, and contracted providers

- Technology & Infrastructure
  - Increased system administration and interface management
  - Additional testing, maintenance, and support for EDI and API integrations
  - Greater dependency on vendor support and third-party system availability
  - Enhanced data governance, audit logging, and monitoring requirements

- Operational & Compliance Risks
  - Duplicate or inconsistent patient records across systems
  - Data exchange failures or interface disruptions between EHR systems
  - Delays in data availability that could impact care coordination and beneficiary access
  - Increased cybersecurity and data privacy exposure due to additional data exchange
  - Increased administrative workload and resource demands
  - Potential compliance findings if interoperability requirements, data quality standards, or reporting timelines are not met

- Strategic Risks
  - Reliance on contracted provider vendor development timelines and product capabilities
  - Reduced flexibility if future federal or state interoperability requirements change
  - Potential delays in implementation if staffing, funding, or technical resources are insufficient

HYBRID RECOMMENDATIONS

- Department Electronic Health Records Recommendations, if the County Board of Supervisors support a hybrid model:
  - To promote compliance with DHCS interoperability requirements, improve care coordination, and reduce long-term administrative, financial and technical complexity, the County should adopt the following approach:
    - **County EHR as the Preferred Standard**
      The majority of contracted providers should utilize the County's Avatar Electronic Health Record (EHR) system as the standard platform for documentation, billing, reporting, and care coordination.
    - **Required Avatar Interface Subsystem**
      All contracted providers, regardless of the EHR they utilize, shall be required to maintain an Avatar Interface Subsystem to support secure data exchange with the County. Providers shall be responsible for all licensing and ongoing costs associated with the required interface subsystem.
    - **Limited Hybrid Model**
      A provider may be permitted to utilize its own EHR only when it demonstrates full interoperability with the County's EHR and all applicable DHCS and CMS interoperability requirements. The provider shall be responsible for all costs associated with developing, implementing, testing, maintaining, and upgrading the necessary interfaces and ensuring continued compliance.
    - **Approval of External EHR Systems**
      The County shall limit the number of approved external EHR systems to reduce operational complexity, interface maintenance, security risks, and compliance costs. Approval of an external EHR shall be based on established technical, operational, security, and interoperability standards and shall be subject to ongoing review and continued compliance with County requirements.
  - This approach establishes the County EHR as the preferred standard while allowing a limited, well-governed hybrid model when it is operationally feasible, fully interoperable, can be completed within a year of approval, and does not create an undue financial or administrative burden on the County.
  - Increase in staffing to meet all the compliance requirements – realignment dollars.