SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Board of Supervisors Study Session on BHRS

September 2025

Welcome – Behavioral Health Context

- California's behavioral health system is undergoing major shifts driven by state reforms and a turbulent federal funding outlook—all of which will impact county programs, priorities and vulnerable communities.
- Ongoing challenges include addressing workforce shortages, adapting to changing federal Medicaid rules, and ensuring equity for diverse local communities.
- Having a strong network of providers, whole-person approach to care and partnerships across county departments and with local leaders and community-based organizations will be critical.

Agenda

- About BHRS
- Services & Staffing Overview
- Clients Served
- Fiscal Landscape
- Contracted Services
- Service Utilization by Program Type
- Performance Outcomes

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Glossary of Key Terms – for reference

- **Behavioral Health Plan** is California's managed care program for delivering mental health and substance use disorder services to Medicaid enrollees
- **Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC)** are intensive mental health and SUD services provided to clients that meet medical necessity criteria.
- **Serious mental illness (SMI)** mental health challenges resulting in serious functional impairment, which substantially interferes with major life activities.
- **Substance use disorder (SUD)** recurrent use of alcohol and/or drugs causes clinically significant impairment and failure to meet major life responsibilities.
- **Continuum of care** is a comprehensive range of health and support services to individuals ensuring seamless transitions between different levels of need.
- **Co-occurring capacity** focuses on the ability of providers to address mental health and substance use disorders; integrated services provides care concurrently, rather than being referred to separate programs or services.
- **Evidence-based practices (EBPs)** have documented (e.g., peer-reviewed studies, and publications) effectiveness on improving behavioral health.
- **Patient Care Revenue** is revenue received from payors including private insurance, Medicare, Medicaid, and patient self-pay for healthcare services.

ABOUT BHRS

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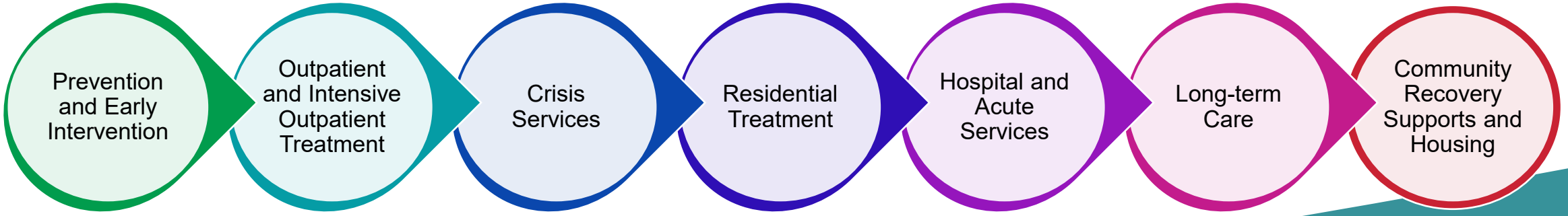
Behavioral Health Continuum of Care

- BHRS provides mental health and substance use services across the behavioral health continuum to children, youth, transition age youth, families, adults and older adults living with mental health challenges and/or substance use disorders.



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BHRS Responsibilities Under Managed Care

- **Behavioral Health Plans** (BHRS) provide all specialty mental health services and substance use disorder treatment services for Medi-Cal beneficiaries.
- Behavioral Health Plans will shift their focus to primarily serving the most vulnerable individuals living with serious mental illness and substance use disorders, requiring increase collaboration with:
    - **Managed Care Plans** (Kaiser, Health Plan of San Mateo) provide mild-to-moderate mental health services to Medi-Cal enrolled members.
    - **Public Health Departments** (PHPP) address the full scope of population-health prevention, which includes behavioral health prevention, through the development of a county Community Health Improvement Plan (CHIP).
    - **Public Hospitals** (SMMC) support acute medical and psychiatric needs of behavioral health clients.

Collaboration and Partnerships

BHRS partners with many county departments and entities to support clients across the behavioral health continuum of care – Human Services Agency Children and Family Services, First 5, San Mateo County Office of Education, Department of Housing, Probation, Law Enforcement, Public Health Policy and Planning, etc. Following is a few highlights from our collaborative work with the Health Plan of San Mateo (HPSM) and the San Mateo Medical Center (SMMC) to serve specialty behavioral health clients.

HPSM Collaborations

- Access Call Center ⇨
  - shared line for all behavioral health needs
- Children and Youth Behavioral Health Initiative ⇨
  - reimbursement model to increase access to mental health services on school sites + infrastructure incentive funding for schools
- Flex Pool Academy ⇨
  - transitional rent for SMI/SUD population
- Institute for Healthcare Improvement (IHI) Behavioral Health Collaborative ⇨
  - mental health and substance use follow-up after ED visit

SMMC Collaborations

- Acute Psychiatry ⇨
  - SB 43 standing committees
  - Weekly discharge planning meetings
  - PES Youth Crisis Stabilization project
  - SMC suicide prevention committee
  - Daily, manager and higher-level discussions on placement for individuals on both PES and 3AB
- Ambulatory/Outpatient Psychiatry⇨
  - Primary Care Interface
  - Integrated Medication Assisted Tx (IMAT)
  - Placement / conservatorship – Senior Care
  - Primary care support to Cordilleras

Network Adequacy & Timely Access: BHP Obligations

Sufficient Number of Providers	•Health plans must contract with enough providers, including psychiatrists, therapists, and SUD treatment centers
Appropriate Geographic Distribution	•Providers should be within a reasonable distance or travel time from where enrollees live
Timely Access to Care	•Enrollees must receive care without unreasonable delays, including appropriate appointment wait times.
Continuum of Care	•Networks must support a full range of services, from outpatient therapy to inpatient and residential treatment.
Essential Community Providers	•Plans must include providers who primarily serve low-income and medically underserved populations.
Specialty Providers	•Networks should include child/adolescent psychiatry, addiction medicine, and geriatric psychiatry specialists
Cultural Competency and Language Access	•Services must be culturally responsive and accessible to individuals with limited English proficiency or communication needs.
Accurate Provider Directories	•Provider listings must be current, accurate, and publicly available.
Telehealth Access	•Especially important for improving access in rural or underserved areas.
Monitoring and Enforcement	•State and federal agencies regularly assess compliance with network adequacy standards.

Network adequacy ensures enrollees have sufficient and timely access to covered mental health and substance use disorder (SUD) services.

- Medi-Cal managed care plans in SMC shall maintain a network of providers that are located up to 15 miles or 30 minutes from beneficiary's place of residence (for MH and SUD Outpatient service and Opioid Treatment Programs).
- Timely access or "appointment waiting time" means the time from initial request to earliest offered appointment. Urgent Appointment timely access is 48 hours, non-urgent outpatient service is 10 business days, follow-up appointments are 10 business days, Medication for Addition Treatment appointments are within 72 hours, and psychiatric service is 15 business days.

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Changing Behavioral Health Landscape

Over the past several years, BHRS has been responding to a series of state legislative and policy initiatives

State Initiative	Year Launched	Description
BHCIP - Behavioral Health Continuum Infrastructure Program	Sep 2021	$2.2B funded program for expanding/renovating behavioral health treatment facilities, launched with first grant awards in 2021.
CalAIM - California Advancing and Innovating Medi-Cal	Dec 2021	Comprehensive overhaul of Medi-Cal including behavioral health, focusing on integration, equity, prevention, and population health.
CYBHI - Children and Youth Behavioral Health Initiative	Jan 2022	Broad "whole child" approach under a multi-year plan to boost youth behavioral health, services, and infrastructure.
CARE Court - Community Assistance, Recovery, and Empowerment Act	Sep 2022	Provides court-ordered treatment, housing, and services for people with certain severe mental illnesses.
BHBH - Behavioral Health Bridge Housing	Sep 2022	Program to provide temporary housing and services for homeless people with behavioral health needs; funded through June 2027.
CalAIM Justice-Involved Initiative	Jan 2023 (pre-release) Oct 2024 (linkages)	Improves reentry via behavioral health, medical, and social services coordination; aims to reduce health disparities, recidivism, and support continuity of care
Mobile Crisis Services – MediCal Benefit	Jan 2023	Requires mobile crisis services to eligible Medi-Cal members ensuring 24/7 community-based crisis services led by licensed professionals for behavioral health and substance use crises.
Senate Bill 43 - Grave Disability Reform	Oct 2023	Expanded definition for grave disability effective Jan 1, 2024.
BH-CONNECT - Behavioral Health Community Based Organized Networks of Equitable Care & Treatment	Jan 2024	Five-year Medicaid demonstration, workforce, incentives, evidence-based practices for Medi-Cal members with significant behavioral health needs.
Prop. 1 - Behavioral Health Services Act (BHSA) + Bond	Mar 2024	$6.4B bond for treatment settings and supportive housing and amended the Mental Health Services Act funding allocations to prioritize housing for those with serious mental health and/or substance use disorders.
Prop. 36 - Homelessness, Drug Addiction, and Theft Reduction	Dec 2024	New law for drug and theft offenses, introduces "wobbler" sentencing, expands treatment as alternative to incarceration.

Behavioral Health Transformation Journey

Nov 2024 - Organizational Capacity Assessment

Validates the need for a strategic vision to align across increased demands from the State, local and organizational priorities.

Apr 2025 - Priorities and Outcomes

Based on the aspirational themes, and aligning across state and county requirements **established 5-year organizational priorities and anticipated outcomes.**

Jul 2025 - Activities and Milestones

Defined key activities and milestones for each priority.

Aug 2025 - Key Performance Indicators

Detail allocation of key activities and milestones to **specific owners, along with associated KPIs and timelines**

Aug 2025 - Staff & Community Input

Validating Strategic Vision with staff and community, and updating mission, vision statements

We are here

Oct 2025 – Five Year Road Map

Map identified future activities to current work and develop a road map and communication plan

Outcomes

- **Culture of Excellence & Continuous Improvement**
- **Financial Stewardship**
- **Coordinated & Collaborative Behavioral Health Ecosystem**
- **Transformed Client & Staff Experience**

SERVICES & STAFFING OVERVIEW

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BHRS Services

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BHRS Operated Treatment Services

Most county-operated services focus on early intervention and outpatient treatment. BHRS contracts with a network of about 85 community-based providers to provide services across the continuum.

Prevention and Early Intervention	Outpatient and Intensive Outpatient Treatment	Crisis Services	Residential Treatment	Hospital and Acute Services	Long-term Care	Community Recovery Supports and Housing
• Primary Care Interface • Health Care for the Homeless • Homeless Engagement Assessment and Linkage (HEAL) • Office of Diversity and Equity (ODE) • Community Health Promotion Unit • Opioid Community Response • Deferred Entry of Judgment	• 6 Regional Clinics • Access Call Center • Adult Resource Management • Collaborative Care Team • Assisted Outpatient Treatment (AOT) • Pathways, Service Connect • Older Adult System of Integrated Services (OASIS) • Youth Services Center • School Based Mental Health • Youth to Adult Transition • Prenatal to Three (Pre-to-3) • Puente Clinic	• Youth to Adult Transition Youth Case Management • Psychiatric Emergency Response Team (PERT)	• Canyon Oaks Youth Center (COYC) • SUD Residential Treatment Team	• Temporary Conservatorship Investigation Unit	N/A	• Office of Consumer and Family Affairs • Supported Housing Case Management

- Collaborative Courts – Multiple DUI and Drug Court
- Correctional Health SUD assessment, treatment, and re-entry
- Integrated Medication Assisted Treatment (IMAT)
- Prop. 36 – Homelessness, Drug Addiction, and Theft Reduction

Other BHRS-Operated Services

- Workforce Education and Training (WET) Team – mandated trainings, continuing education, evidence-based practices
- Clinical Internship and Psychiatry Residency Training Programs
- Other administrative teams (fiscal, contracts, payroll, etc.)

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Integrated Approach to Care

Adopting an integrated approach to care—especially by expanding capacity for co-occurring mental health and substance use services across the behavioral health continuum—has been a key BHRS priority for many years and will continue with even greater focus.

Clinical and Program Integration

- Co-occurring Consult Group
- Programs: Mobile Crisis, Primary Care Interface, Service Connect, Access Call Center
- Office of Consumer and Family Affairs and Peer Specialist Services
- No Wrong Door
- Member Handbook
- Alignment of clinical documentation requirements

Administrative Integration

- Cultural Competency Plans
- Credentialing
- Payment reform: CPT code and fee for service payment by practitioner category
- BHRS administrative teams: Quality Management, Contracts, Management Information Systems, Office of Diversity and Equity, Workforce Education and Training

State Oversight Integration

- Quality Improvement Plans
- External Quality Review Organization
- Performance Improvement Plans
- Network Adequacy
- Single DHCS Contract
- Compliance Reviews
- MOU with the Managed Care Health Plan

24/7 Access Call Center

Mild to Moderate Needs

- Client referred to HPSM or Kaiser

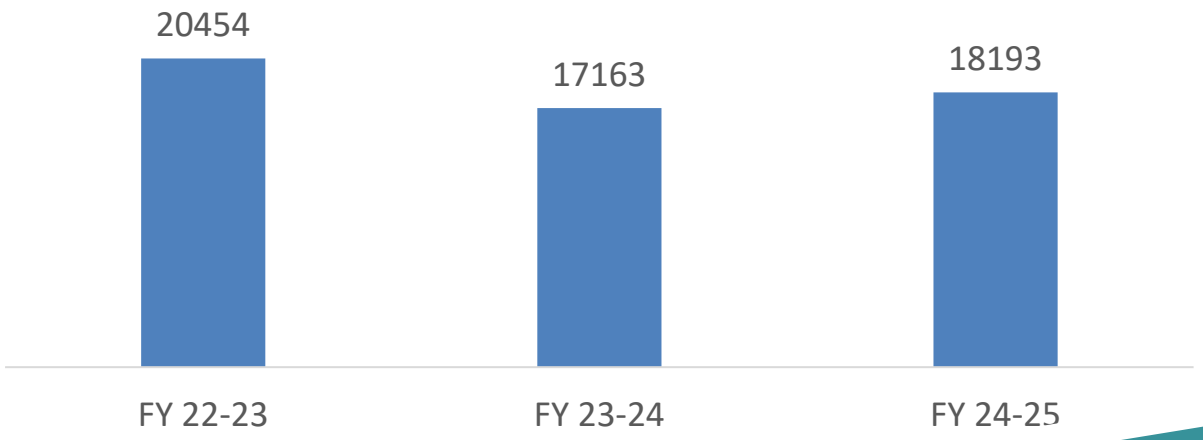
Severe Mental Health Needs

- Client referred within BHRS

Substance Use Needs

- Client referred to BHRS staff or contracted providers

Total Access Call Center Calls



- Upon confirmation of health insurance, BHRS uses a state provided screening tool to determine referral (about 70% about go to HPSM)
- Moderate clients can go back-and-forth between BHRS and HPSM/Kaiser
- Staff speak English, Spanish, and Chinese; other languages are provided through a free telephone interpreter service.

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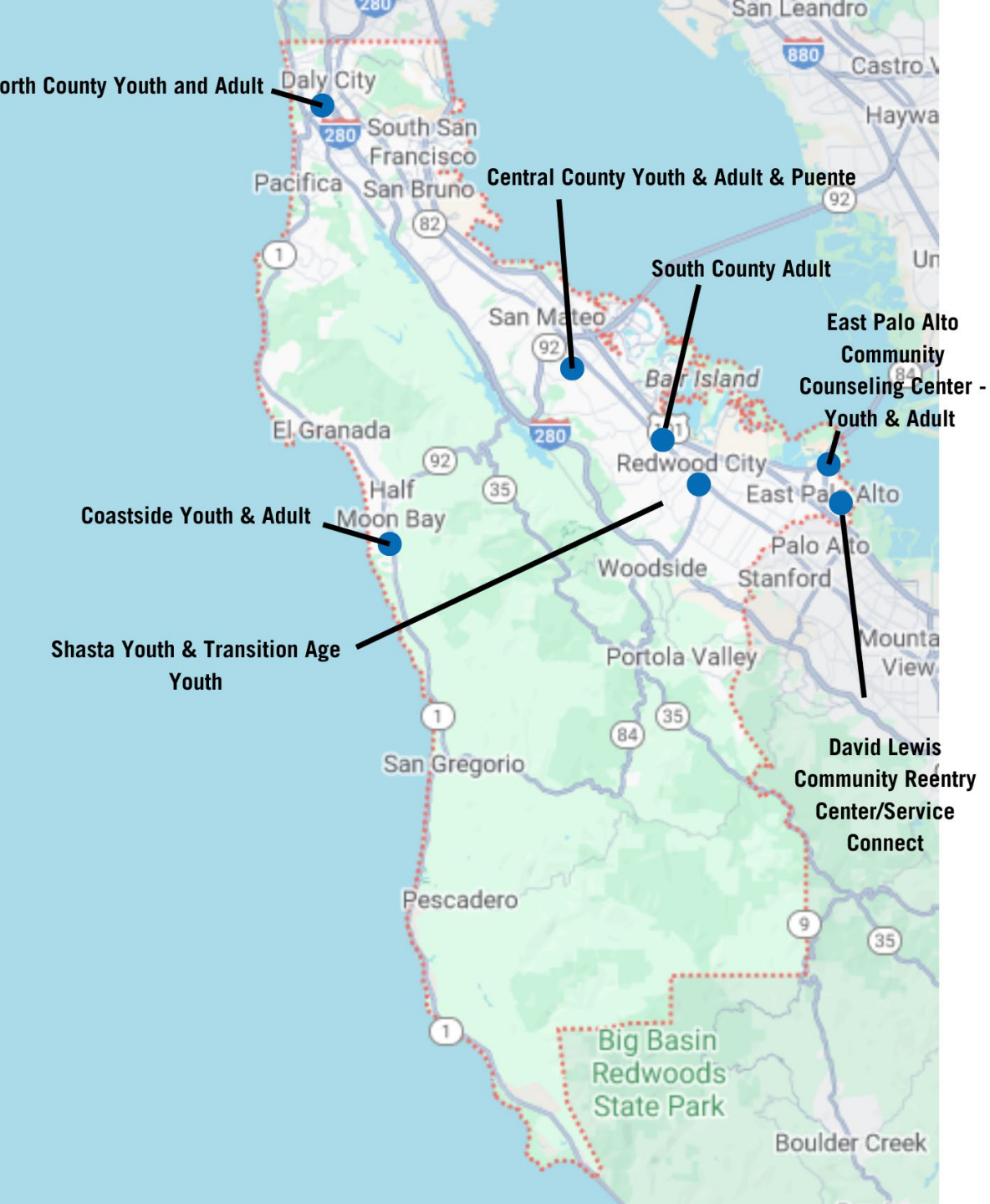

Regional Clinics

6 Clinics for Youth and Adults

- North County (Daly City)
- Central County (San Mateo)
- South County Adult (Redwood City)
- Shasta Youth (Redwood City)
- East Bayshore (East Palo Alto)
- Coastside Mental Health (Half Moon Bay)

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Crisis Services

Crisis Response

- Youth Case Management Team
- Psychiatric Emergency Response Team (PERT)
- San Mateo Assessment and Referral Team (SMART)
- Family Assertive Support Team (FAST)
- 24/7 Crisis Hotline - 988
- 24/7 Mobile Crisis Response Team (MCRT) + Family Urgent Response Services (FURS)
- Community Wellness and Crisis Response Teams (CWCRT)

Crisis Stabilization

- Psychiatric Emergency Services at SMMC (Adults & Youth)
- Serenity House (Adults)

Acute Psychiatric Inpatient

- San Mateo Medical Center Psychiatric Inpatient Unit
- Mills-Peninsula Inpatient Unit
- Seton Medical Center Geriatric Inpatient Unit
- Psychiatric Health Facility – San Jose
- Fremont Hospital
- John Muir Behavioral Health Hospital

BHRS Staffing

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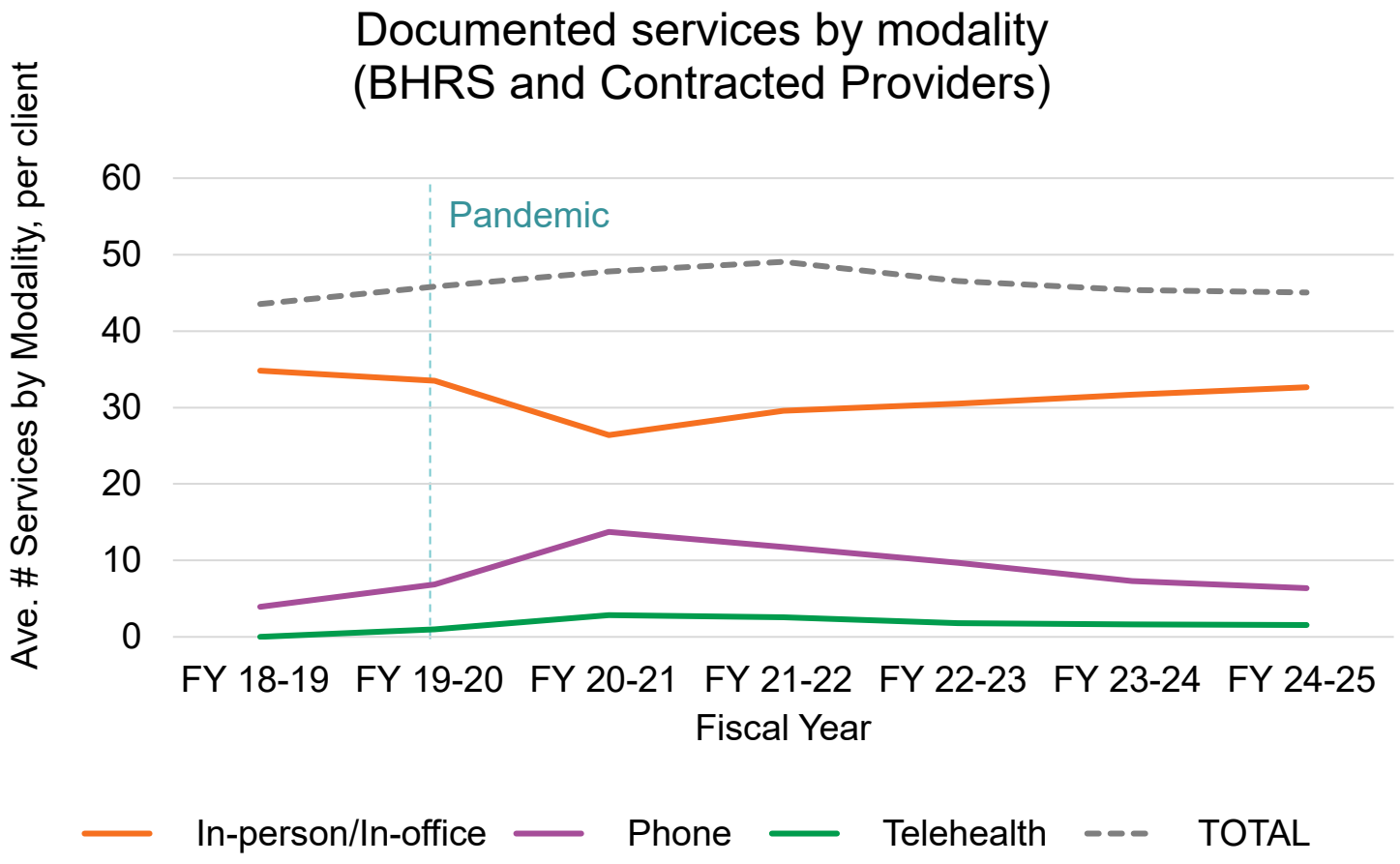
BHRS Staffing and Service Model

BHRS and contracted providers have a hybrid model of in-person/in-office, over-the-phone and telehealth services, based on client need and/or preference.



- 73% of BHRS staff are clinical and 27% non-clinical (7% management level).
- Telehealth and phone services rapidly surged starting FY 19-20 due to the pandemic, to maintain care while ensuring safety.
- Peak usage occurred around FY 20-21 and gradually began shifting back as in-person services resumed.
- Telehealth and phone use has now stabilized reflecting an integrated, hybrid approach that leverages both remote and in-person care to optimize accessibility and patient preference.
- This hybrid service model environment has not inhibited BHRS's ability to adjust to changing State demands.

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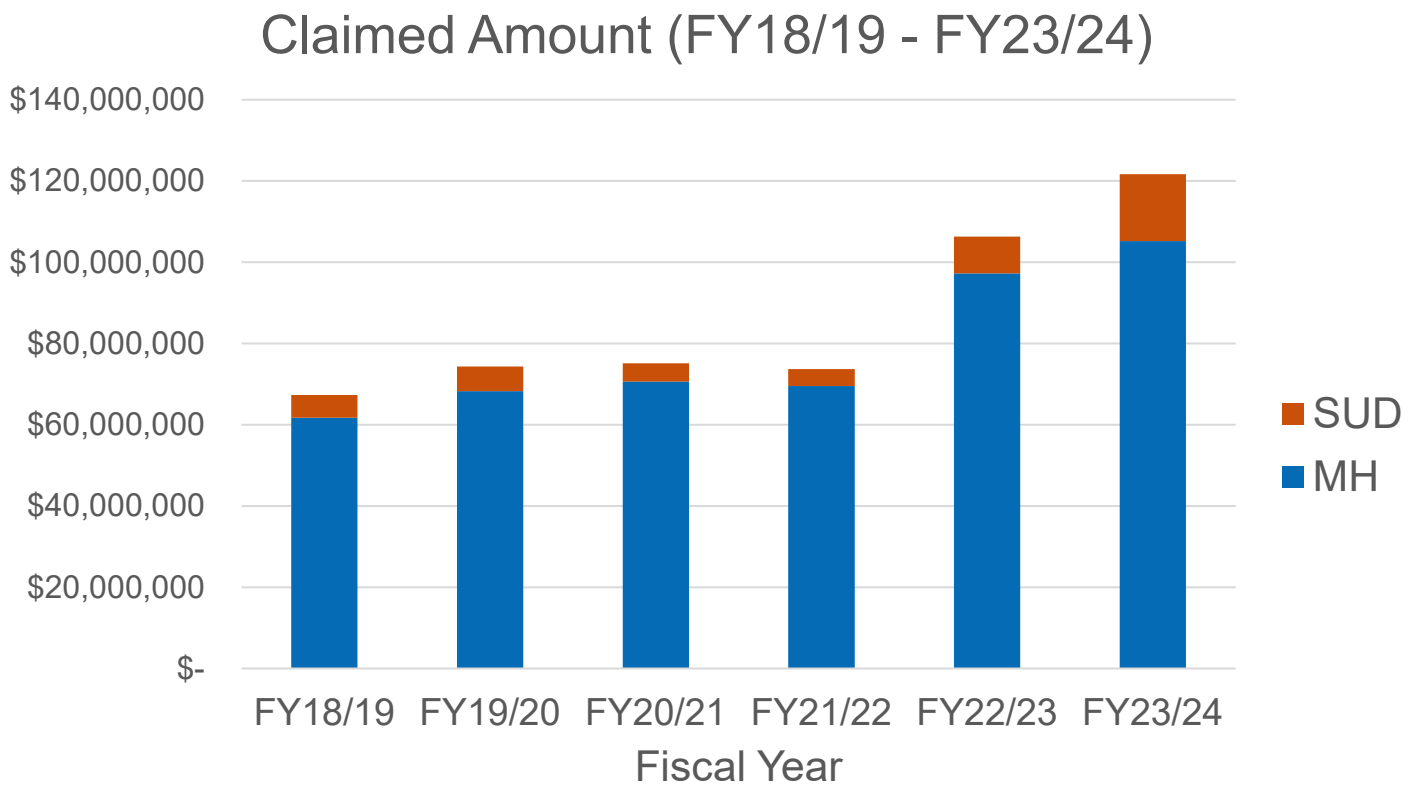
BHRS Claims

Telework has not hindered BHRS staff productivity and there is no correlation between telework time and claimable time.



- Claimed amounts have increased over time and partially impacted by CalAIM payment reform. Although, these numbers are not a reliable measure of staff productivity.
- Telework has not limited staff member's ability to claim services.

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CLIENTS SERVED

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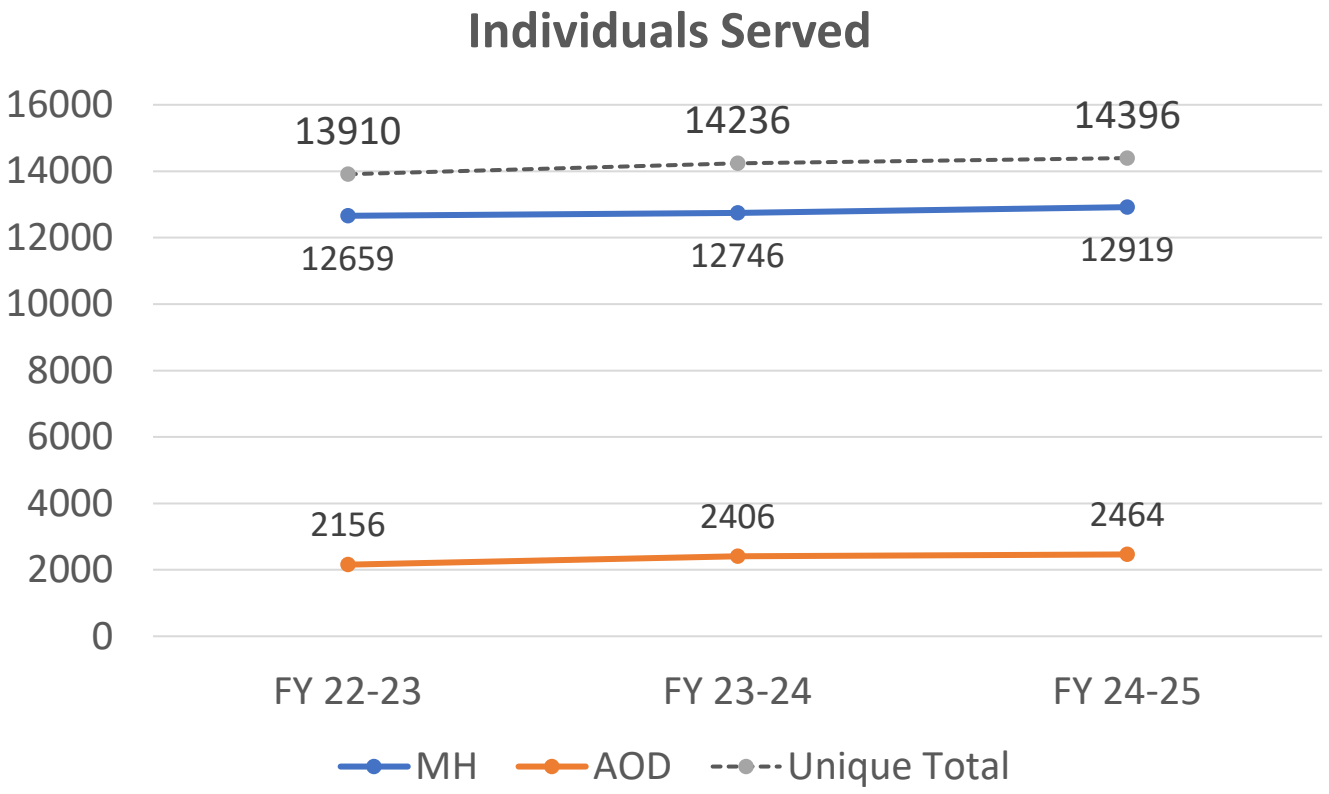
BHRS Clients Served

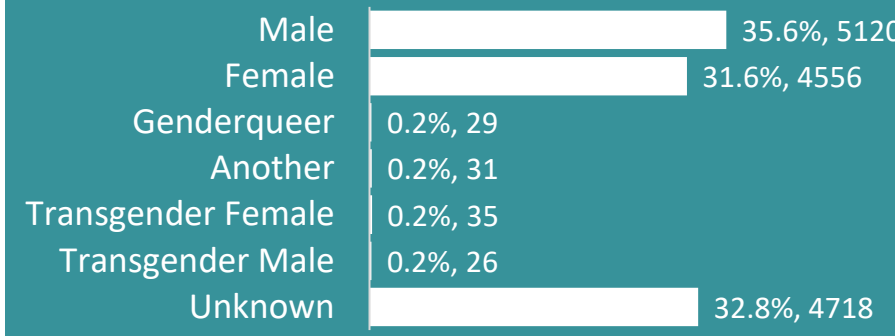
BHRS has experienced a steady 3.5% growth in the number of individuals served over the past three years. This increase is aligned with Medi-Cal enrollment trends.



Client Age and Gender Identity FY 24-25*

BHRS' client population demographics have remained consistent across age and gender identity over the years.

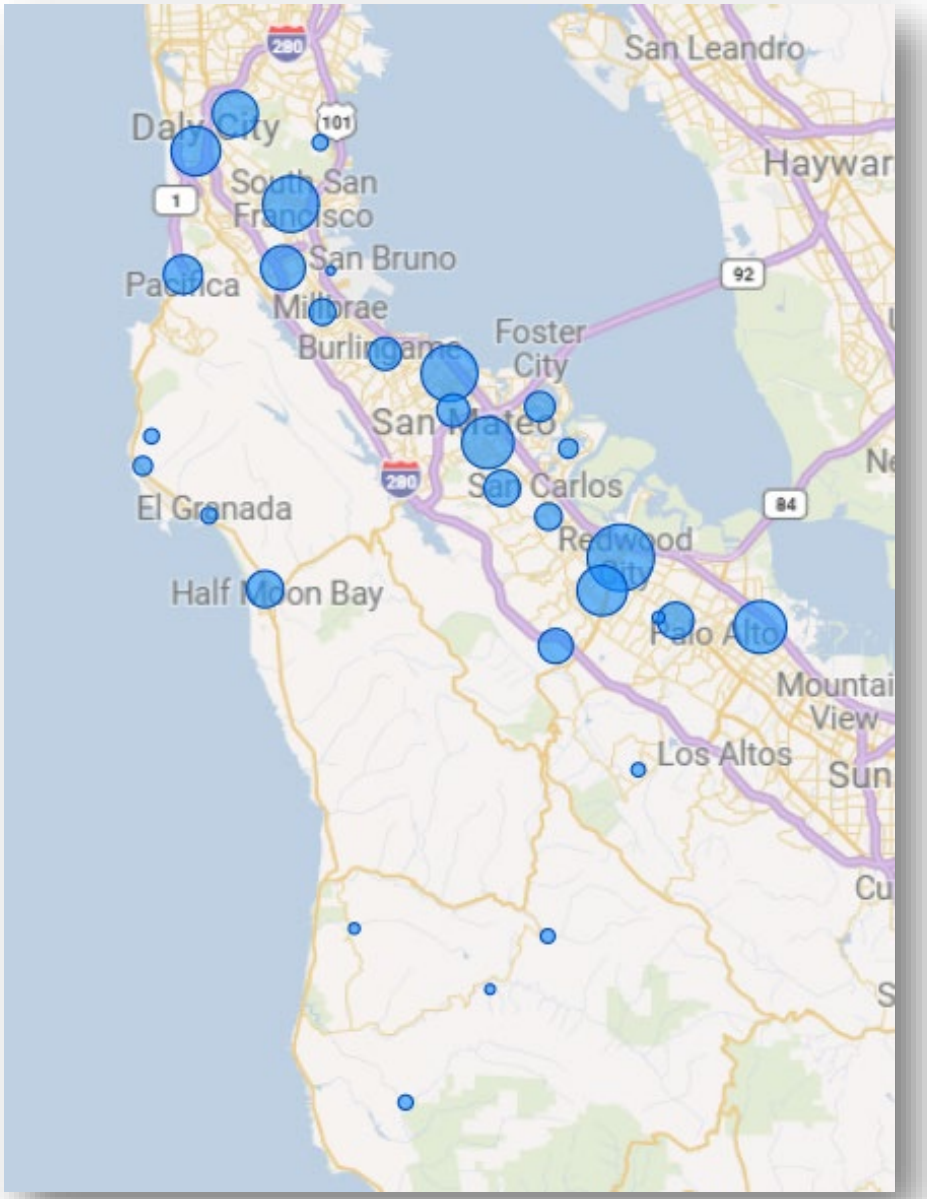
- Age Groups: primarily adults ages 18-59 (53%) followed by transition age youth ages 16-25 (17%); older adults ages 60+ (16%) and children ages 6-15 (12%).
- Gender Identity:



Nearly one third (32.8%) of clients have unknown gender identity due to non-disclosure and/or lack of documentation underscoring the importance of implementing culturally informed data collection practices and understanding barriers to documentation.

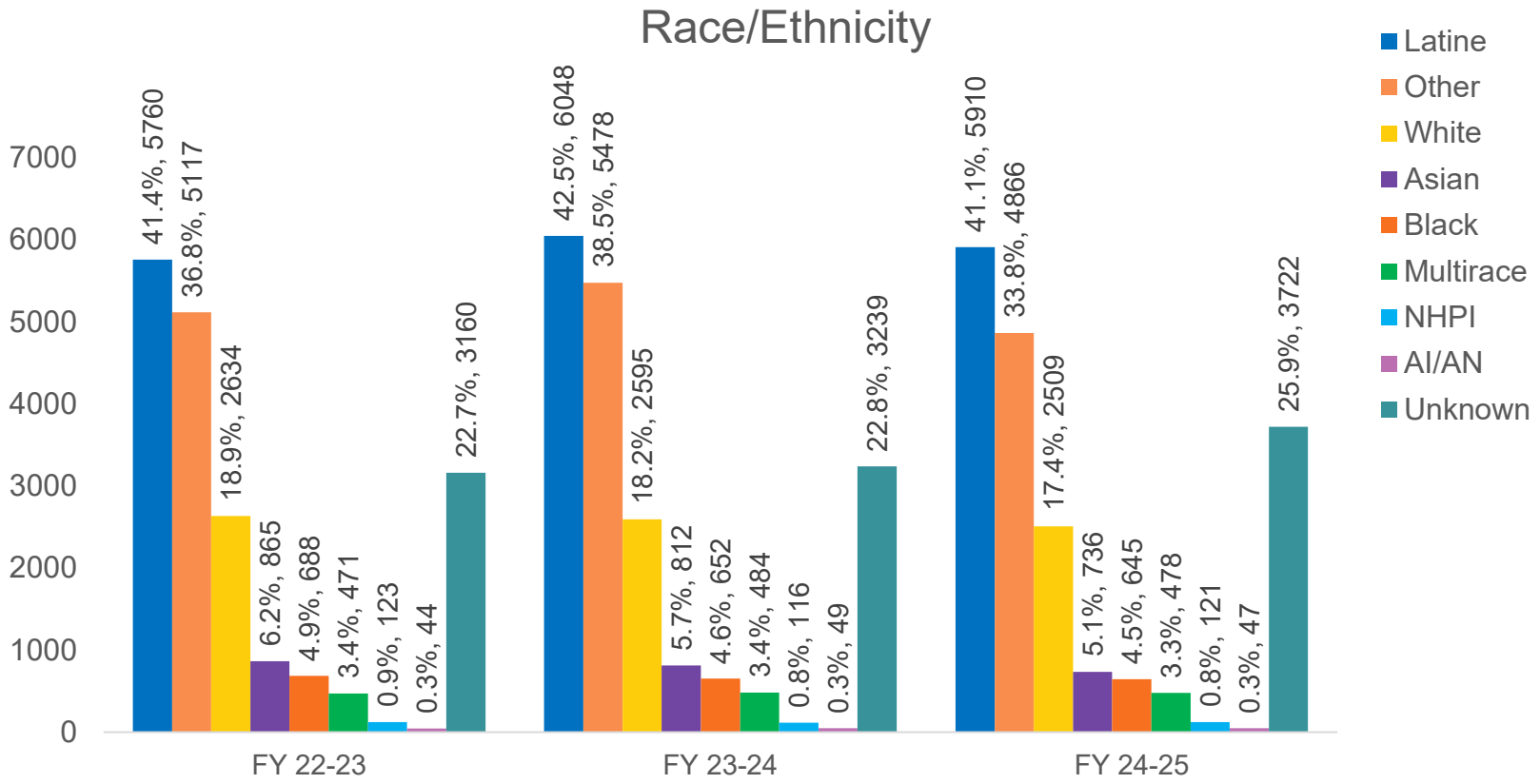
Location of Clients

Region	# Clients	% of Total
South County	4608	32%
North County	4278	30%
Mid-County	3853	27%
Coastside	671	5%
Outside of SMC/Unknown	988	7%
Total	**14398**	**100%**



Client Race/Ethnicity and Sexual Orientation

BHRS client race/ethnicity and sexual orientation demographics have also remained consistent over the years and represent San Mateo County's diverse communities.



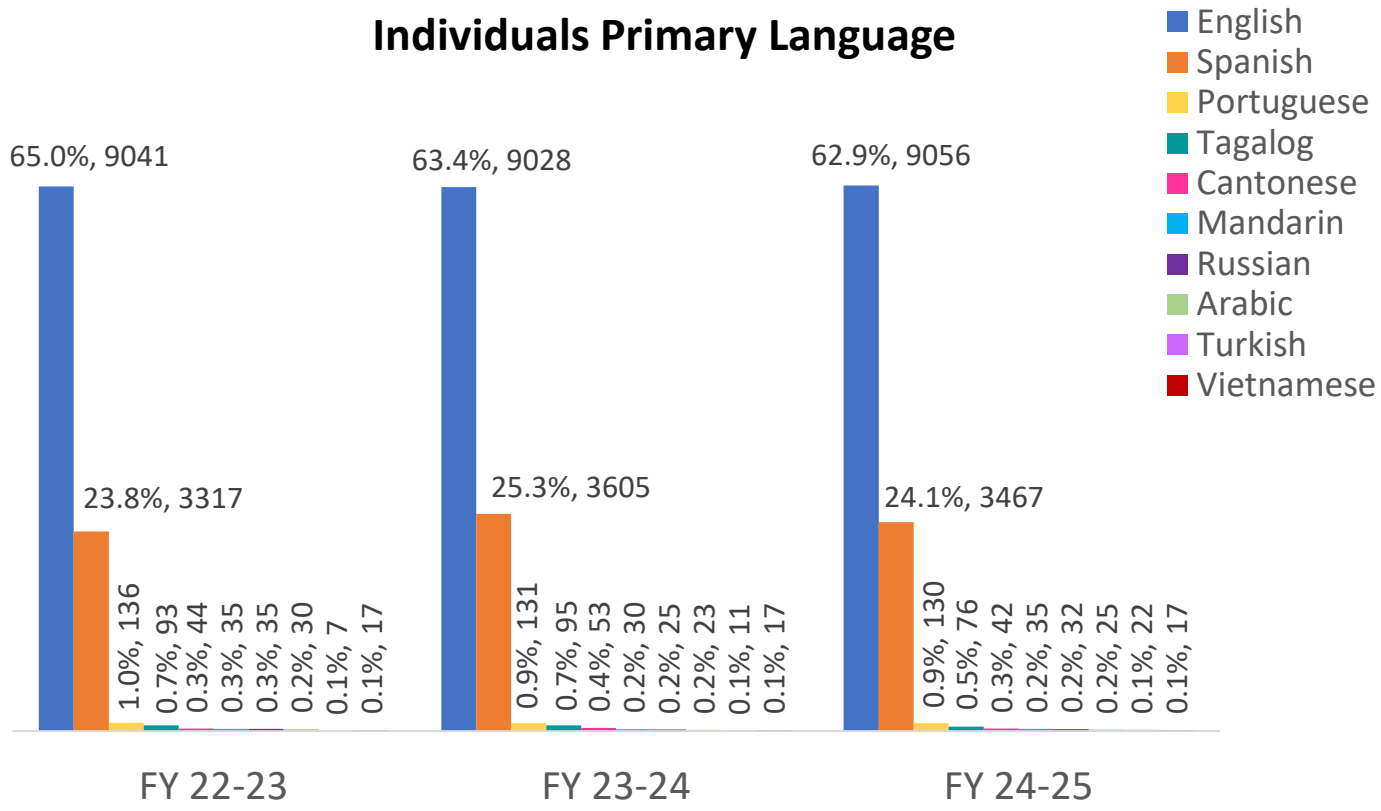
Data includes individuals who identified with a particular race or ethnicity category, either solely by itself or in combination with another race or ethnicity category.

Sexual Orientation FY 2024-25*:

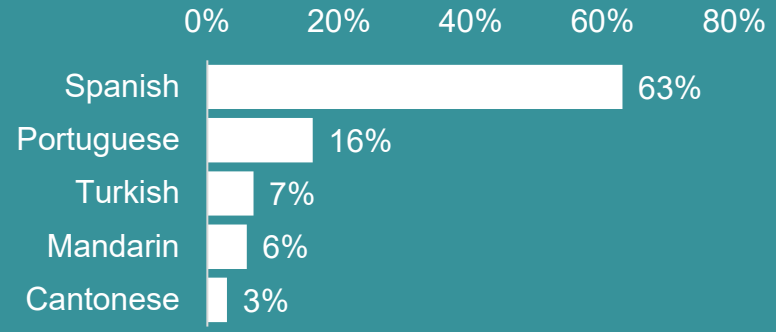
BHRS clients served primarily identify as straight or heterosexual (28.2%). Smaller but meaningful populations identify as bisexual (1.6%), lesbian, gay, or homosexual (.9%) other orientations (.6%), queer (.2%) and asexual (.1%), underscoring the importance of culturally competent, inclusive behavioral health services that address the unique experiences and needs of LGBTQ+ clients.

Top 10 Primary Languages

BHRS clients' primary languages reported have remained consistent over the past 3 years. Threshold language requirements continue for Spanish, Tagalog and Chinese languages.



Top 5 Languages for Interpretation Service Requests FY 24-25



- In FY 24-25, Turkish was the 3rd highest language requested for interpretation and only that year came up on the Top 5 languages requested and top 10 primary languages reported by clients.

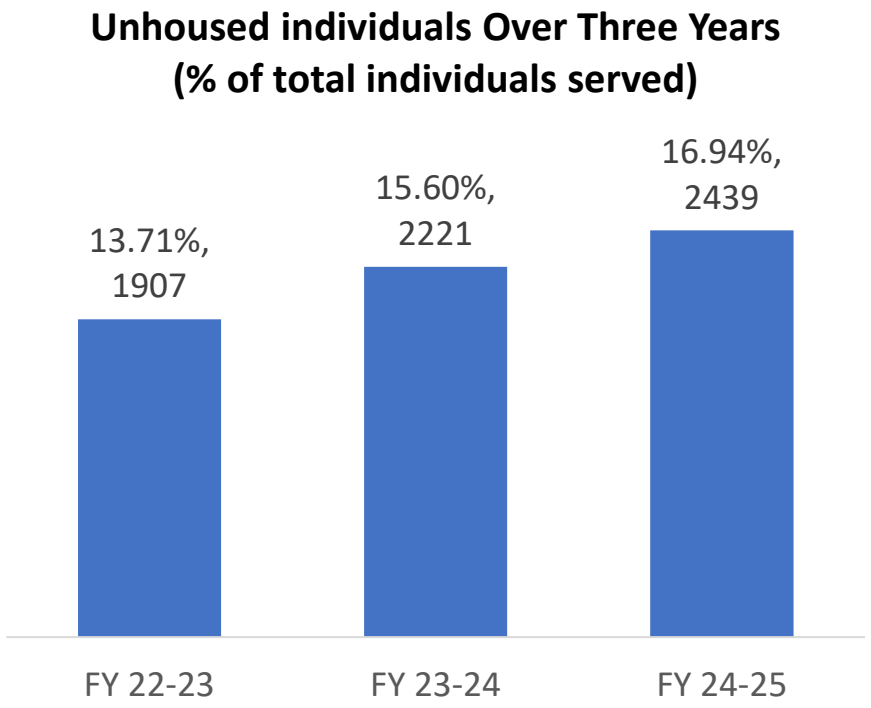
**BHRS continues efforts to understand the impact of matching clients to bilingual providers and additional barriers for people who speak other languages.*

Complex Client Needs

Behavioral health clients present with complex needs leading to increased demands, requiring specialized training, increased resources, and multi-disciplinary coordinated care.

FY 24-25

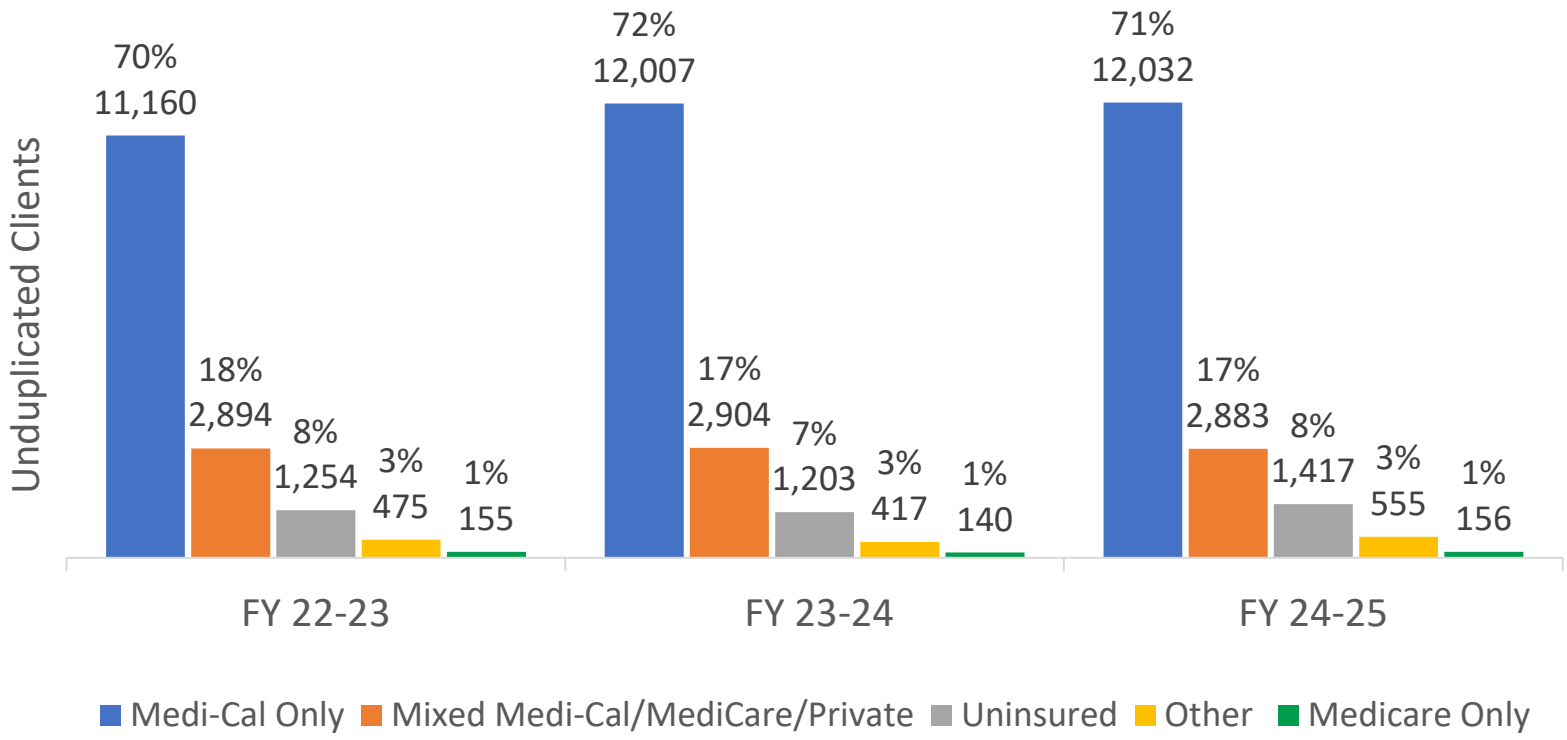
- **Homelessness:**
  - 17% (2439/14396) of BHRS clients experienced homelessness. 14% of mental health clients and 45% of substance use clients.
- **Co-occurring mental health and substance use services:**
  - 1 in 4 behavioral health clients experience both mental health and substance use challenges.*
  - 7% (987/14396) of BHRS clients received both mental health and substance use disorder services. 8% of mental health clients and 40% of substance use clients.
- **Multi-substance use:**
  - 63% (676/1069) of clients who accessed substance use services reported having both a primary and secondary drug or alcohol problem.
- **Criminal justice involvement and substance use:**
  - 43% (458/1065) of clients who accessed substance use services reported justice involvement (e.g., AB109 Post-release Community Service or on probation).



*Substance Abuse and Mental Health Services Administration (SAMHSA) 2024 National Survey

Insurance Type

BHRS serves the most vulnerable San Mateo County residents regardless of insurance.



Counties are a safety net provider and will at times serve privately insured clients (avg 431 clients) for crisis needs (75%), specialty/early psychosis or school-based needs (14%), continuity of care – insurance status changes (11%), and other (11%) temporary reasons - underinsurance, limited provider networks, prior authorization requirements or coverage limits.

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Undocumented Clients

As a safety net provider, BHRS has served undocumented clients with federal, state and Net County Cost funding. Federal changes will lead to a decrease in federal and state funding to continue serving this vulnerable population.

- By design, BHRS does NOT know which of our clients are undocumented. Rough estimates indicate 10% of BHRS clients may be undocumented.
- July 10, 2025 – US Department of Health and Human Services announced an expanded list of public benefits that will no longer be available to undocumented individuals.
- California is instituting strict new limits for undocumented adults in Medi-Cal and other benefit cuts starting January 1, 2026.

Ongoing assessment of unmet needs

Prop. 1 introduced new requirements for measuring need and planning for resource allocations for county behavioral health departments. A Three-Year Integrated Plan is due June 30, 2026.

State Mandates

- Unhoused
- Criminal Justice Involved
- Co-Occurring SUD/MH

Population Data

- Penetration Rates
- Suicide Rates
- Opioid Use Rates

Organization Performance

- Network Adequacy
- Grievances
- Client Perception Surveys
- Service Utilization

Client Outcomes

- Emergency Service Utilization
- Housing Status
- Criminal Justice Involvement
- Social Connection

Community Program Planning (CPP)

- Input Sessions
- Focus Groups
- Key Interviews
- Surveys

FISCAL LANDSCAPE

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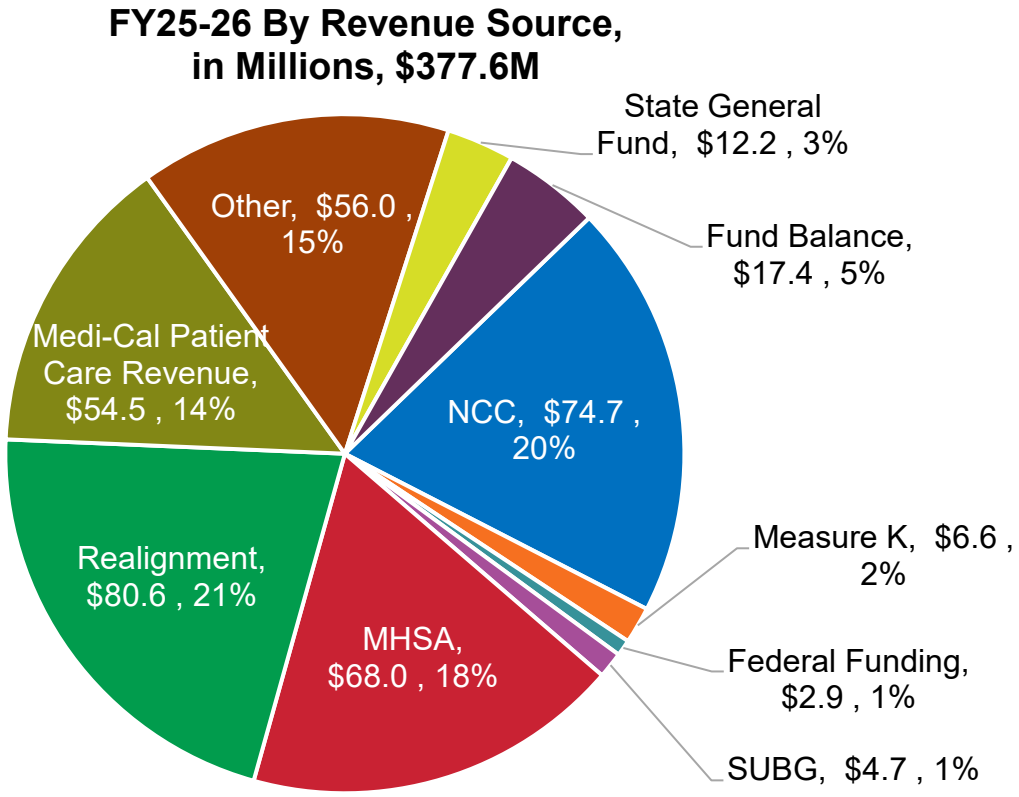
BHRS Revenue Sources

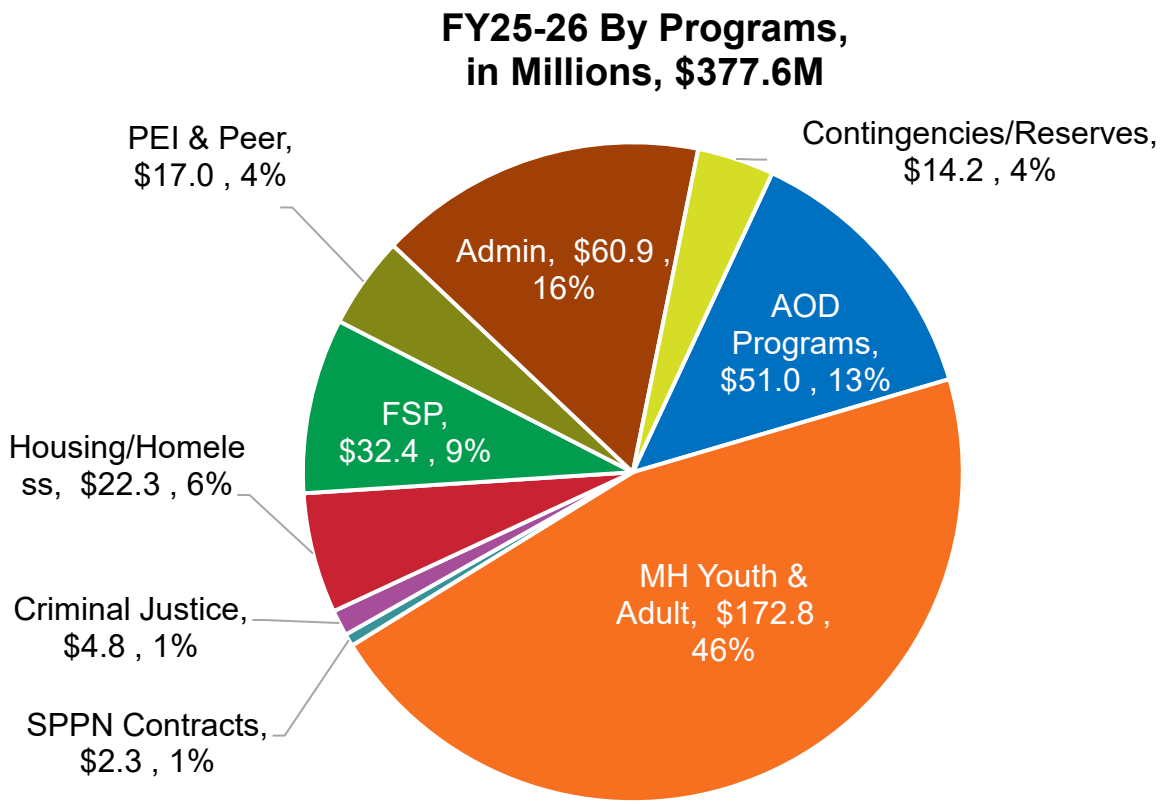
BHRS relies on local, state and federal-level allocations to help ensure federal requirements related to maintenance of effort and match contributions are met and to support the sustainability of critical services despite fluctuating funding streams.



- The "One Big Beautiful Bill Act" reduced federal Medicaid funding by about 15% to key SAMHSA block grants, Medicaid cuts, federal restructuring and other changes.
- Responsibility for vulnerable communities are shifting to states and private insurers.
- Additionally, federal funding comes with specific prescribed uses and regulatory requirements, often requiring a maintenance of effort (MOE) and/or matching contributions.
  - State required MOE is $5.1M
  - Local NCC overmatch is $39.9M
  - Mandated services funded with local NCC is $55.9M
  - Non-mandated services make up 10% of the total BHRS budget, $37.4M

BHRS Funding Allocations by Service Type

BHRS funds services across the continuum of care and for core initiatives and populations such as the unhoused, criminal justice involved and wraparound supports.



- Mental Health Youth and Adult treatment services include all Regional Clinics and Access Call Center staff, outpatient treatment programs and other County operated and contracted services.
- Prop. 1 reallocation of MHSA funds starting FY 2026-27 will lead to decreased population-based prevention program allocations and increase to housing interventions, full-service partnerships, peers supports and early intervention strategies.

BHRS Budget Increases

The largest contributors to the BHRS budget increases over the past three years include mandated services such as Mental Health Rehabilitation Centers (MHRC) and Full Service Partnerships (FSPs), as well as capital projects and staff Salaries and Benefits (S&B).

Largest Budget Increases	3-Year Amount Increase
1. Cordilleras MHRC – ongoing	↑ $30.1 M (+$10.6M debt service)
2. S&B COLA + FTEs – ongoing	↑ $28.0 M
3. Capital Projects – one-time	↑ $39.0 M
4. FSPs – ongoing	↑ $9.6 M

- S&B increases were due to COLA increases and new FTEs, with no Net County Cost supporting these new positions

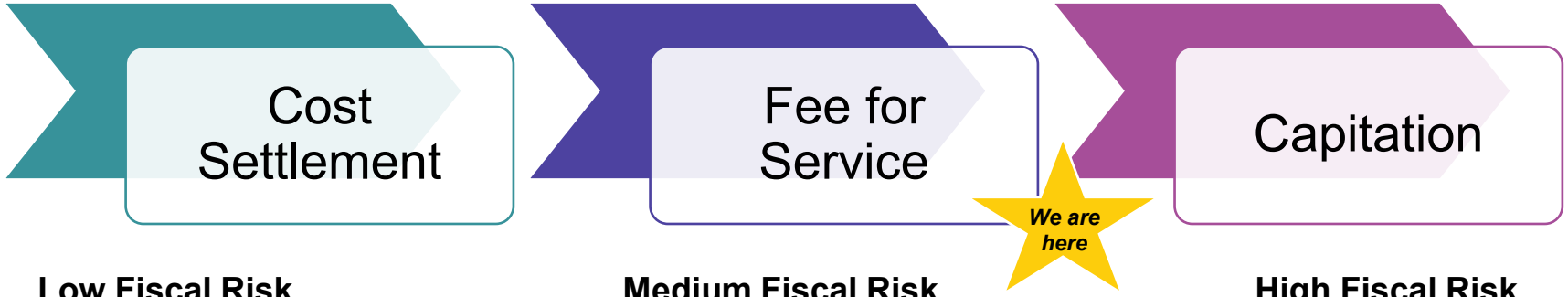
	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26
S&B	$ 90,452,661	$102,497,610	$101,703,536	$118,627,700
FTEs	475	505	526	532

Capital Projects

- The budget for capital purchases has increased by one-time $39M starting FY 2023-24.
  - $15M – Permanent Housing Development: $5M towards each of three Department of Housing Affordable Housing Fund NOFAs, FYs 2023-26
  - $6.3M - South County Clinic Purchase
    - ~3.5M - Renovations
  - $2.3M – Board & Care Facility Purchase; 12-14 beds; (278 Hudson in Redwood City)
    - +$500K – Renovations
  - $1.7M Renovations: 46 new Board & Care beds (Hopkins Manor)
  - $5-6M Purchase of Adult Crisis Residential facility (TBD)

Changing Fiscal Landscape

To responsibly manage a fiscal shift to fee-for-service and capitation models, counties must invest in infrastructure to support fiscal rate setting, network and contract management, data utilization for quality improvement and increased care coordination.



Low Fiscal Risk

- **Counties** first pay for services, then claim reimbursement based on actual costs.
- **Contractors** received a predictable 1/12th payment term.

➢ Requires auditing, cost reconciliation, and settlements, leading to administrative complexity and delayed final payments.

Medium Fiscal Risk

- **Counties** submit claims for each service rendered based on a state-established fee schedule.
- **Contractors** now receive a variable month-to-month reimbursement for actual services delivered.

➢ Reduces burden of audits and settlements to actual costs but shifts risk to counties if fee schedules do not adequately cover services. Insufficient rates risk provider withdrawal.

High Fiscal Risk

- **Counties** receive a fixed payment, predetermined amount per member (per unit of time, e.g., monthly) and will determine methodology for contractors
- **Contractors** may receive predictable upfront fixed payments, regardless of the number of services provided.

➢ Encourages cost control, care coordination and creates increased need for quality oversight, data infrastructure, contracting, fiscal and network management. County assumes significant risk. Insufficient rates risk provider withdrawal.

CONTRACTED SERVICES

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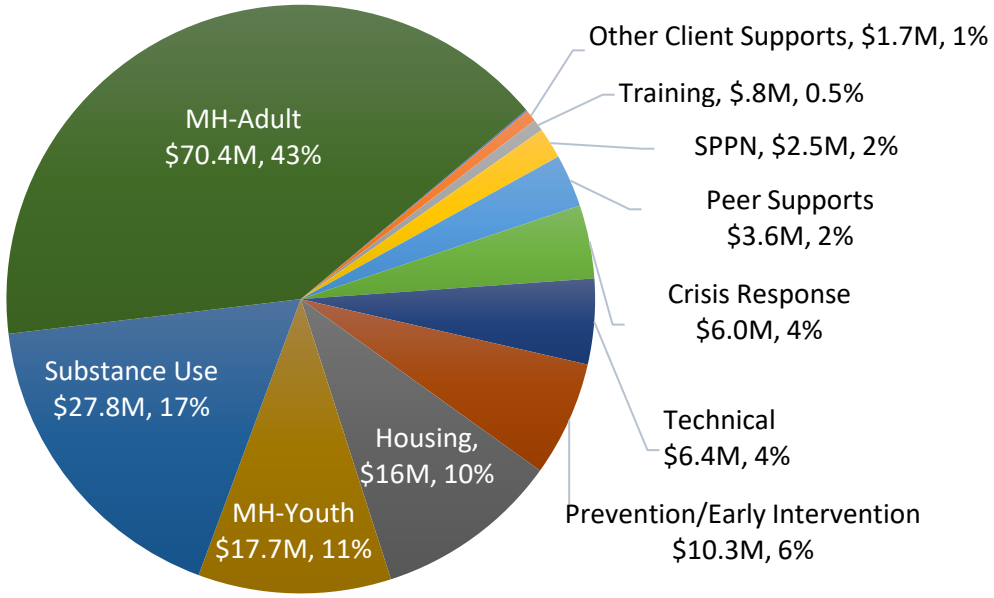
Contract Allocations, FY 2025-26

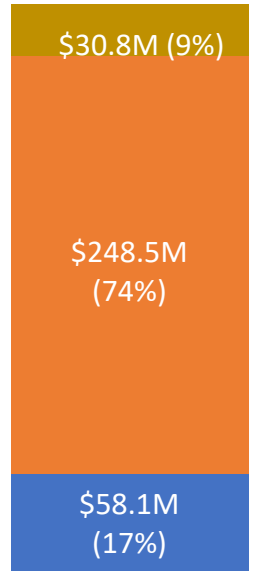
The majority of BHRS contracted services (86%) provide direct client services and supports, represent mandated services (74%) and are provided by non-profit organizations (60%).

- Contracted services represent $163.1M (48%) of the FY 2025-26 BHRS Budget
- 5,173 unduplicated clients served by contracted direct treatment service providers; and an estimated10,638 duplicated through community engagement, prevention and early intervention services.

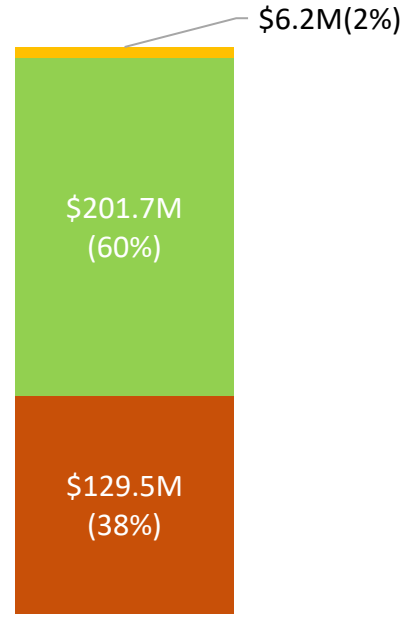
Contract Allocations by Service Type



Contract Allocations by Mandated/Non-Mandated



Contract Allocations by Vendor Type



both mandated non-mandated individual non-profit for-profit

Contract Revenue Sources

59% ($97M) of **BHRS contracted services** are funded with federal revenue, followed by 27% ($44M) with state revenue, 11% ($19M) local revenues and 3% ($3M) other revenues.

	Local Revenue (NCC, Meas K)	**Federal Revenue** (Medi-Cal FFP, SAMHSA, SUBG)	**State Revenue** (Realignment, MHSA, State General Fund)	**Other** (HPSM, MediCare, Third Party, OSF)	**Totals**
Client Services (treatment, housing, supports)	$18,258,947	$92,335,173	$42,446,793	$2,874,677	$155,915,590
Administrative (IT, facilities, consultation, trainings)	$490,425	$4,675,282	$1,676,606	$377,743	$7,220,057
Totals	**$18,749,372**	**$97,010,455**	**$44,123,400**	**$3,252,420**	**$163,135,647**

Contractor Infrastructure

Initiatives	Outcomes
Workforce Education and Training • *Annual MHSA-Funds*	FY 24-25: • 386 contracted provider staff from 30+ organizations completed trainings, a 275% increase. • Contracted provider staff received 136 continuing education units.
Contractors Association Grants • *Annual MHSA-Funds*	FY 24-25:18 contractors received small grants totaling $186,761 to support staff development • 29% Staff recruitment and retention activities • 65% Staff training and capacity building • 6% Therapeutic supplies • 6% Peer support incentives
Post-Covid Infrastructure • *One-Time American Rescue Plan Act (ARPA) of 2021 funds*	FY 23/24: 43 contractors received one-time funds totaling $3,857,411 • 35% Staff recruitment and retention incentives • 29% Tenant improvements • 10% Staff trainings and capacity building • 14% Equipment and supplies • 12% Vehicles to support client transportation needs
Cal AIM Contractor Quality Improvement Incentive Program • *One-time MHSA Funds*	FY24/25: one-time funding totaling $464,100 awarded • 11 contractors met deliverables and received awards to implement payment reform, documentation and policy changes, and client outreach activities. FY25/26: one-time funding totaling $2,035,900 available • Contractors will be required to meet deliverables related to maximizing revenue, workforce development, client engagement outreach, and/or BH-CONNECT evidence-based practices

Contract Monitoring & Ongoing Supports

Contract Requirements

- County 3-5 Year RFP term and performance metrics.
- Emergency and contingency plans.
- Regular contract monitoring by BHRS Managers and Contract Analysts.
- Reconciliation and invoice tracking against contract amounts.
- Annual reports are requested and sent to accounting.

Trainings and Support

- Ongoing trainings and technical assistance provided for billing and service codes, documentation, mandated services, use of Avatar and required assessment tools, etc.
- Onsite chart reviews conducted for SUD contracts.
- Mandated annual training with service verification for audits.

Meetings and Resources

- BHRS Director attends Contractor Association monthly meetings.
- BHRS staff facilitate regular ongoing meetings with treatment providers.
- Contractors receive Quality Management supports and resources to implement Culturally and Linguistically Appropriate Services (CLAS) requirements.

BHRS Contract Administration

BHRS is navigating an increase in procurement and contract administration needs, a trend that is expected to continue as counties take on more administrative roles as the designated managed care plan and expand their network of contracted direct service providers.

- Currently, BHRS holds close to 300 contracts.
- In FY24/25, BHRS completed:
  - 150 renewals: 50 Board-level and 100 Director-level
  - 10 RFPs
  - 20 Single Case Agreements
  - 30 MOUs
  - 30 Small Dollar Waivers
  - 15 CalAIM Incentive Contracts
  - 20 SELPA School District Contracts

B-1 Waiver

With the new B-1 Memo, contracts are being reviewed - anticipated increase of over 50 new RFPs and/or B-1 waiver requests and an increase in RFP process to 3-6 months.

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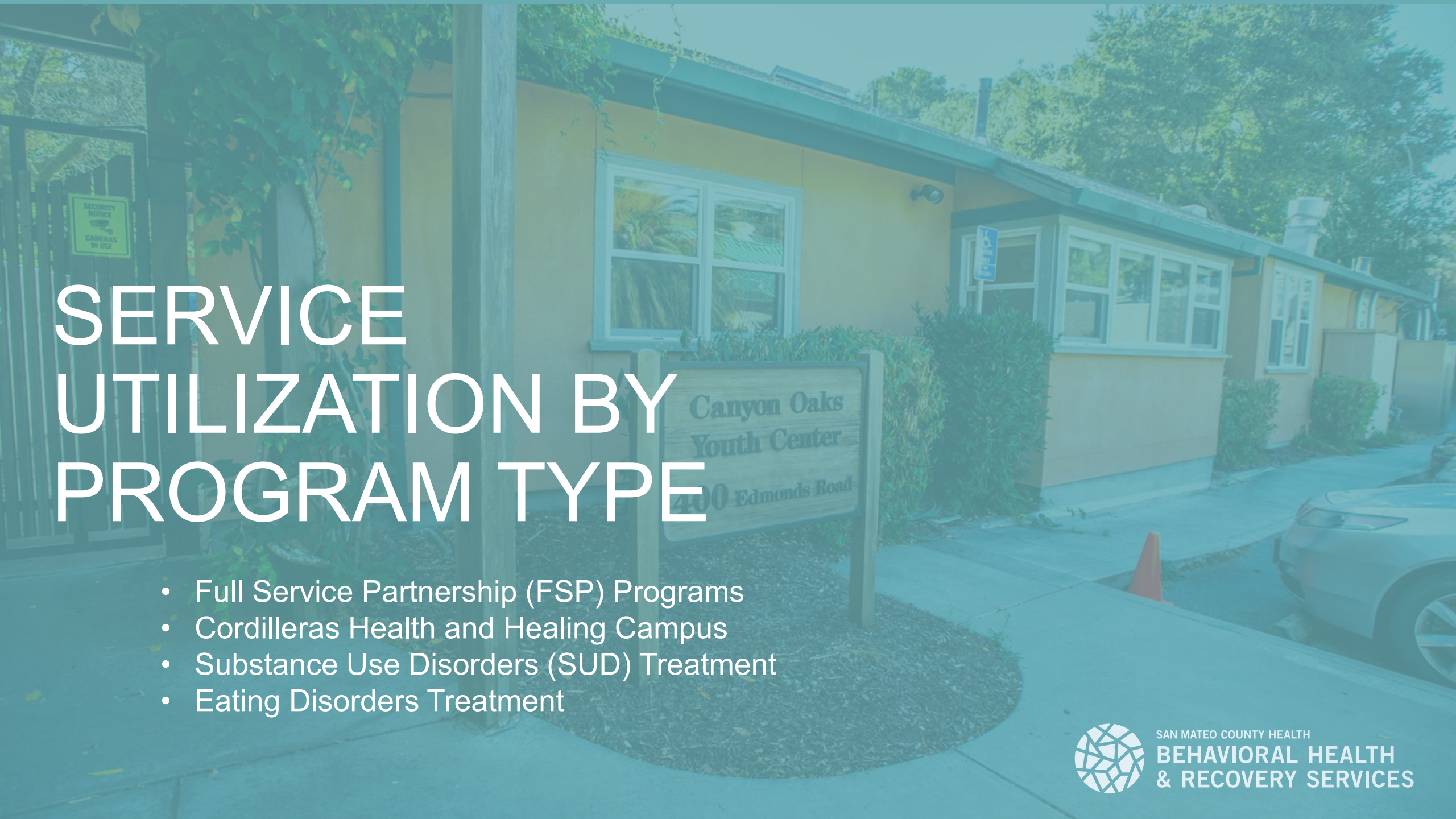
StarVista Update

20 BHRS programs were impacted: BHRS staff worked quickly to determine whether programs would close or are actively being transitioned to new providers.

- Programs in process of transitioning to other providers
  - Pride Center identified fiscal sponsor San Francisco Public Health Foundation
  - Crisis Hotline and Mobile Crisis Response dispatch will transition to Telecare
  - Early Childhood Community Team and Early Childhood Consultation will be contracted out to a new CBO
  - First Chance Sobering Station – staff continue to engage other partners to reopen
  - CWCRT dependent on 5 cities – hiring clinician or contracting with Felton Institute
- 8 programs ended and/or clients transitioned to other providers
  - Insights, Women's Enrichment Center, detox center, DUI program, and Mindfulness-Based Substance Abuse Treatment program – numbers were low and there are other providers that could absorb clients
  - Health Ambassador Program for Youth, Parent Project – MHSA prevention funding is ending June 30, 2026
- Suicide Prevention Committee and Diversity and Equity Council will be supported in-house



SERVICE UTILIZATION BY PROGRAM TYPE

- Full Service Partnership (FSP) Programs
- Cordilleras Health and Healing Campus
- Substance Use Disorders (SUD) Treatment
- Eating Disorders Treatment

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Full Service Partnership (FSP)

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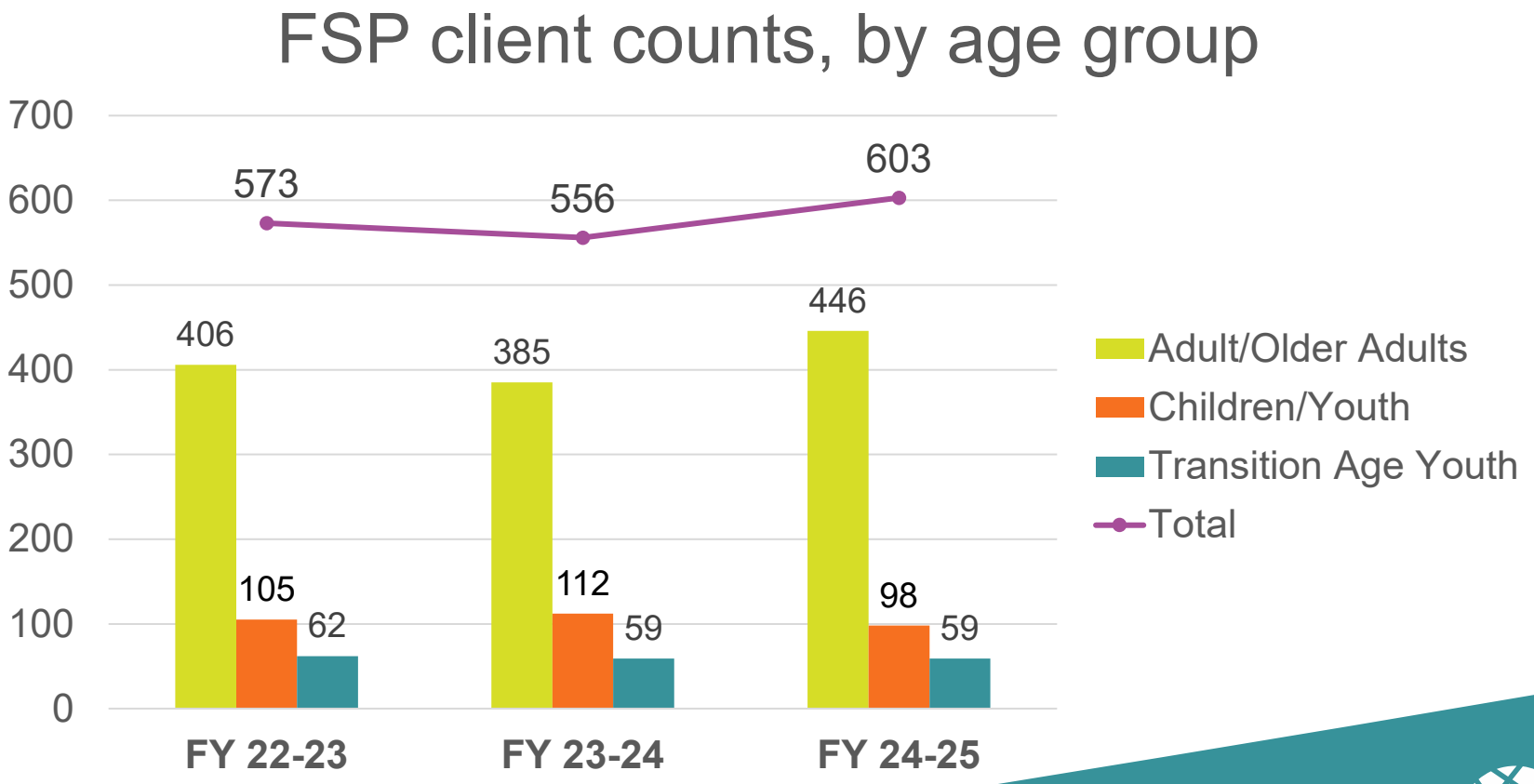
FSP Services

- Funded by the Mental Health Services Act (MHSA)
- “Whatever it takes” approach is personalized and comprehensive care model serving:
  - Children and youth ages 0 to 15 and their families
  - Transition-age youth, adults, and older adults
  - Individuals who are unhoused or at risk of homelessness
  - Criminal justice involved or clients with repeat hospitalizations
- Individualized care plans include:
  - Behavioral health treatment
  - Crisis intervention
  - Housing, employment, education, transportation and family supports
- Aims to reduce hospitalization and incarceration, support long-term community integration through natural supports and connections, prevent out-of-home placement for youth, support school and vocational success, address trauma and family needs.

FSP Clients Served Over 3 Years

Total FSP clients served across all age groups has increased by 5.2% from FY22-23 to FY24-25.



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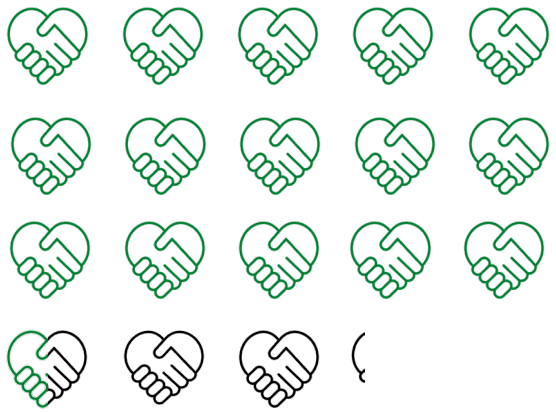
FSP Capacity vs. Utilization, FY 24-25

We can use utilization and program monitoring to determine appropriate slots per year and adjust contracts as needed. For example, Children and Youth FSP experienced significant staffing turnovers and could not accept referrals for a period of time. They are now fully staffed and able to accept all referrals sent.

Adults/Older Adults

Total = 361 Slots

86% Average Occupancy



Transition Age Youth

Total = 40 Slots

92% Average Occupancy

Children/Youth

Total = 80 Slots

76% Average Occupancy

 = 20 contracted client slots

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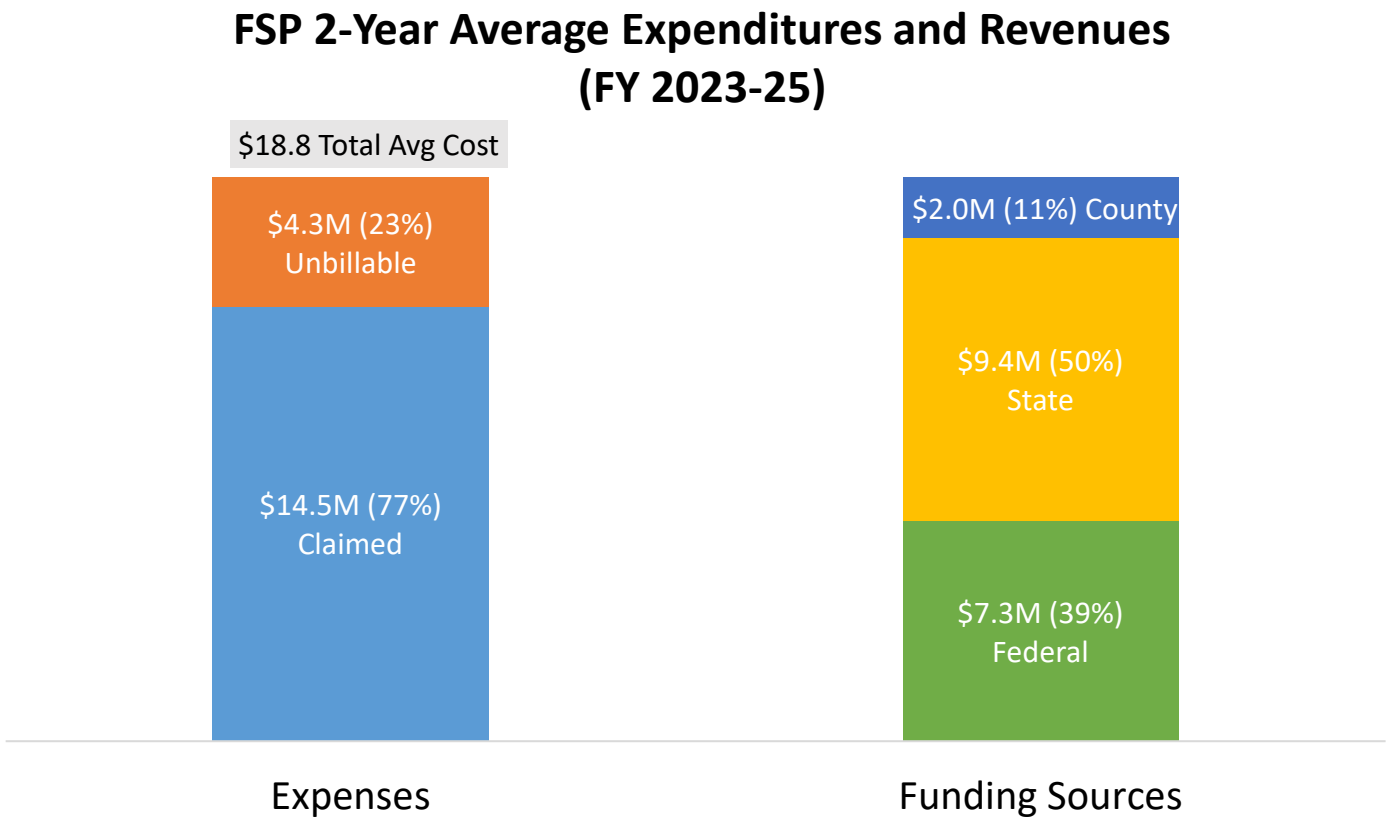
FSP Claims and Revenue Sources

The “Whatever It Takes” mandated approach requires individualized wraparound services aimed at meeting all the needs of individuals and their families. Unbillable services including transportation, administrative, and non-clinical interventions and activities are funded by MHSA state and local funds.



In FY 2025-26 we anticipate an FSP increase of $8.5M due to:

- Cost increases for FSP housing and COLAs
- Added 36 new adult slots
- Added new staffing ratio requirements.

FSPs will be required to deliver ACT/FACT evidence-based practice and will switch from billing for each individual service to claiming one monthly bundled rate per eligible client. Bundled rates are county-specific, calculated to cover staffing, benefits, 24/7 crisis response, administrative overhead, and other indirect costs.

Cordilleras Health and Healing Campus

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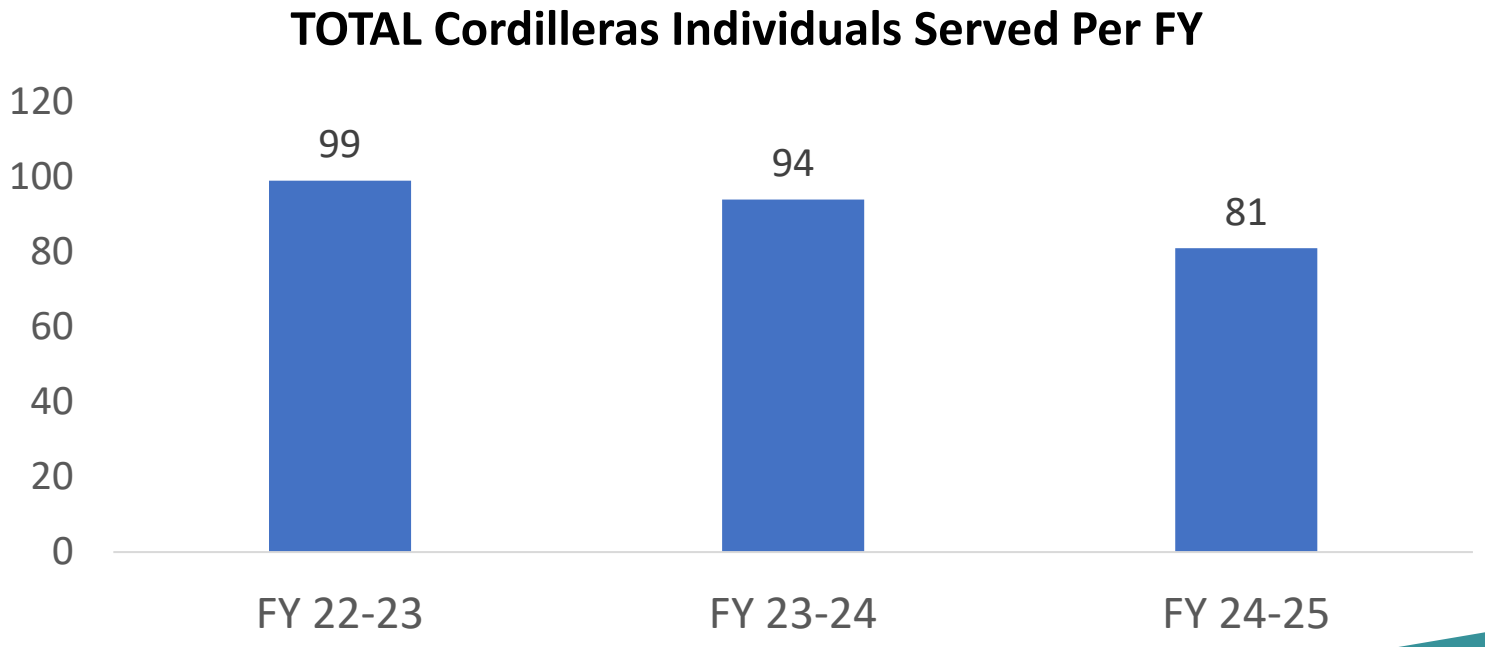
Cordilleras Services

- Cordilleras Health and Healing Campus is county-owned and located in Redwood City.
- The campus serves adults with serious mental illness, many with histories of repeated psychiatric hospitalizations.
- Consists of four 16-bed Mental Health Rehabilitation Centers (MHRCs) and 57-bed Canyon Vista co-housing development.
- MHRCs are operated by Telecare Corporation, Stars, Crestwood and Caminar and provide case management support, medication management, and crisis management and stabilization.
- Includes a multidisciplinary care team of psychiatrists, therapists, nurses, peer support specialists, and social workers.
- Telecare provides 24/7 onsite support at Canyon Vista and Abode oversees property management for Canyon Vista
- Cordilleras is focused on improving client recovery and independence, reducing acute hospitalizations, providing stable, supportive housing and community connection.

Cordilleras Clients Served Over 3 Years

Total clients served at Cordilleras shows a slight decrease over the past three years likely due to the transition of clients to the new center between December 2024 through January 2025 – stopped taking new admits as we got close to the transition time.



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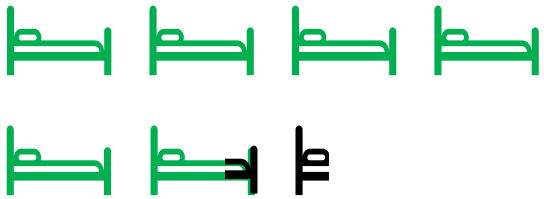
Cordilleras Capacity vs. Utilization, FY 24-25

Cordilleras MHRC maintains a high 91% occupancy rate, demonstrating robust demand and efficient use of critical mental health resources—well above the typical occupancy benchmark of 85% for psychiatric and residential care facilities.

Cordilleras MHRC

Total = 64 beds

91% Average Occupancy



= 10 beds

Focused Population	Facility	# of Beds
SMI and self harming behaviors	Caminar – Willow House	16
SMI and medical fragility/older adults	Crestwood – Ponderosa House	16
SMI and violence towards others	Star Inc. – Acacia House	16
SMI	Telecare – Sage House	16

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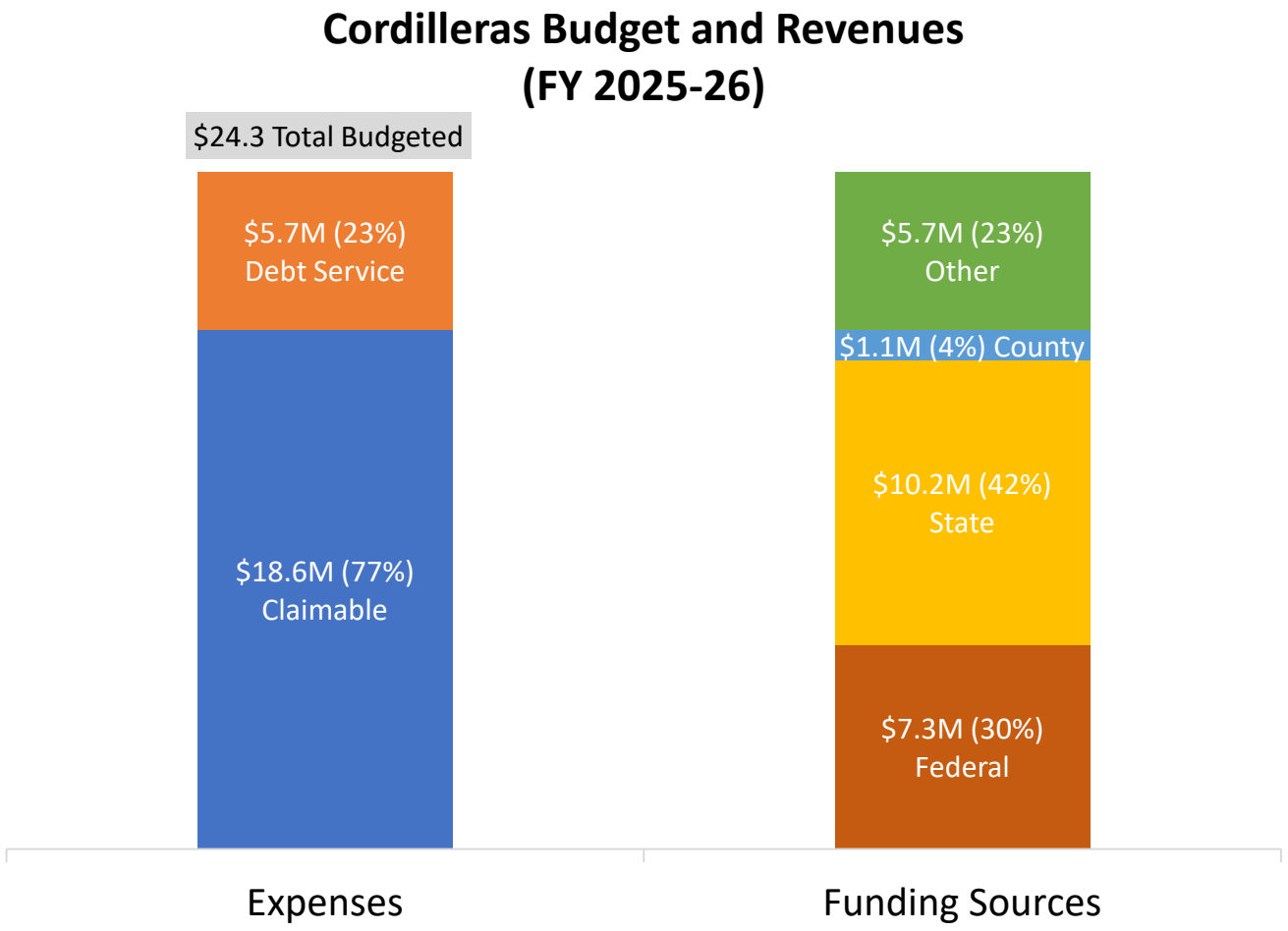
Cordilleras Claims and Revenue Sources

While the new Cordilleras MHRC is the largest contributor to the BHRS budget increase, all 4 MHRC's will now be billable.



- Clients were transferred to the new Cordilleras MHRC in December 2024 and January 2025.
- FY 2025-26 will be the first full year of claimable services.
- Other revenues for Cordilleras include one-time sources.

Substance Use Disorder (SUD) Treatment

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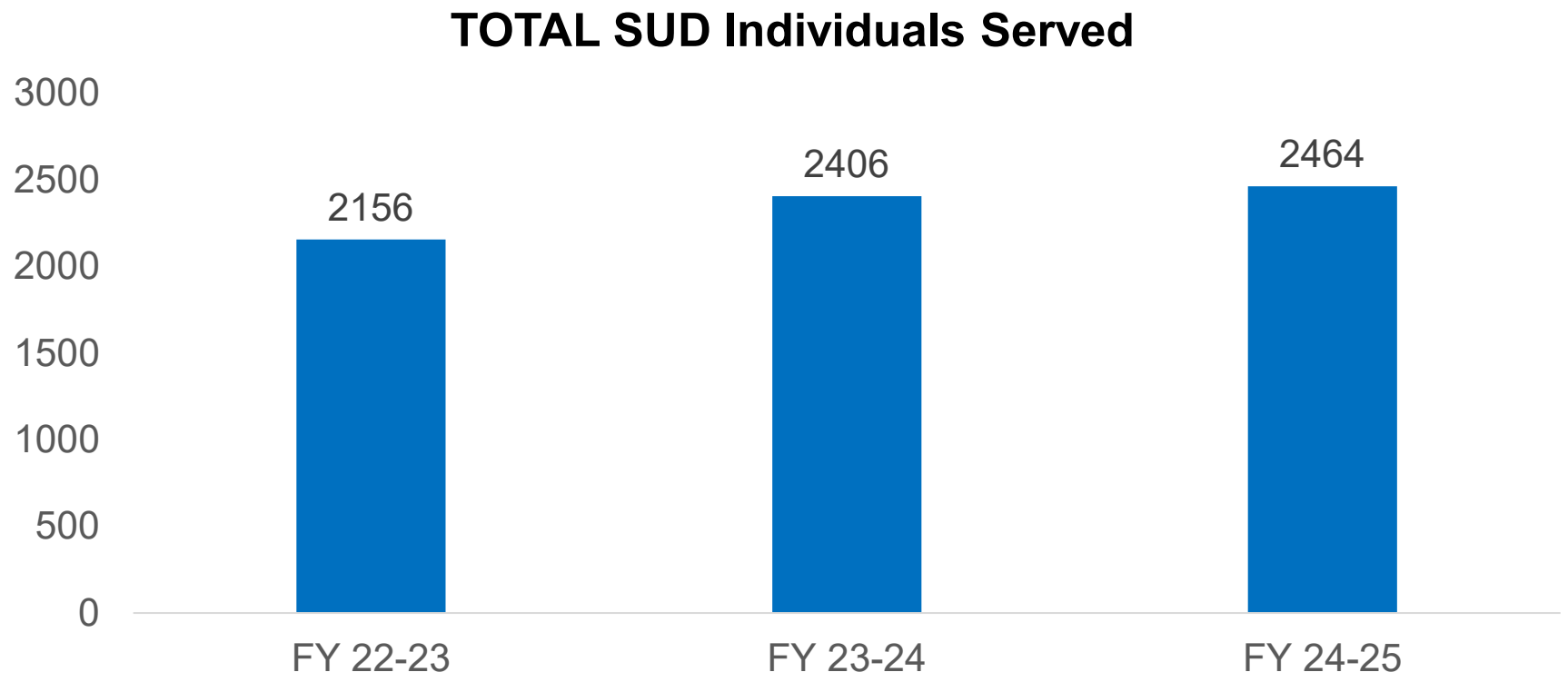
SUD Services

- Supports individuals of all ages and their family members, who may be affected by substance use conditions.
- Highly individualized and aimed at reducing substance use and related harms, increasing retention in treatment, preventing relapse and supporting long-term recovery.
- Includes services for various levels of care and special populations – infants and their mothers, youth transitioning to adults, foster youth, older adults.

SUD Clients Served Over 3 Years

SUD clients served across the spectrum of treatment services has increased by 14% over the past three years.



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SUD Residential Capacity & Utilization (FY 24-25)

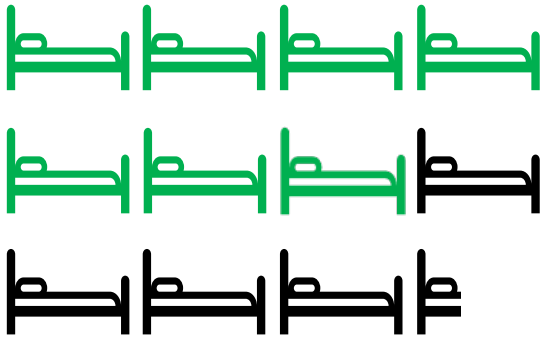
These services are a critical part of the substance use treatment continuum. Often unhoused individuals begin their recovery journey in Residential Detox and Residential Treatment services then transition to Recovery Residences where they can rebuild life skills—while simultaneously engaging in outpatient care.

Residential Treatment

Total = 113 Facility Licensed Beds

63% Average Occupancy

Range: Lows of 39% | Highs of 77%



Residential Detox

Total = 28 Facility Licensed Beds

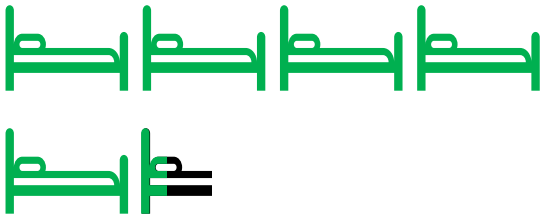
60%* Average Occupancy

= 10 beds

Recovery Residence

Total = 56 Facility Licensed Beds

93% Average Occupancy



*Excess capacity is required for Network adequacy; fee-for-services shifts model ensures BHRS only pays for residential beds used.

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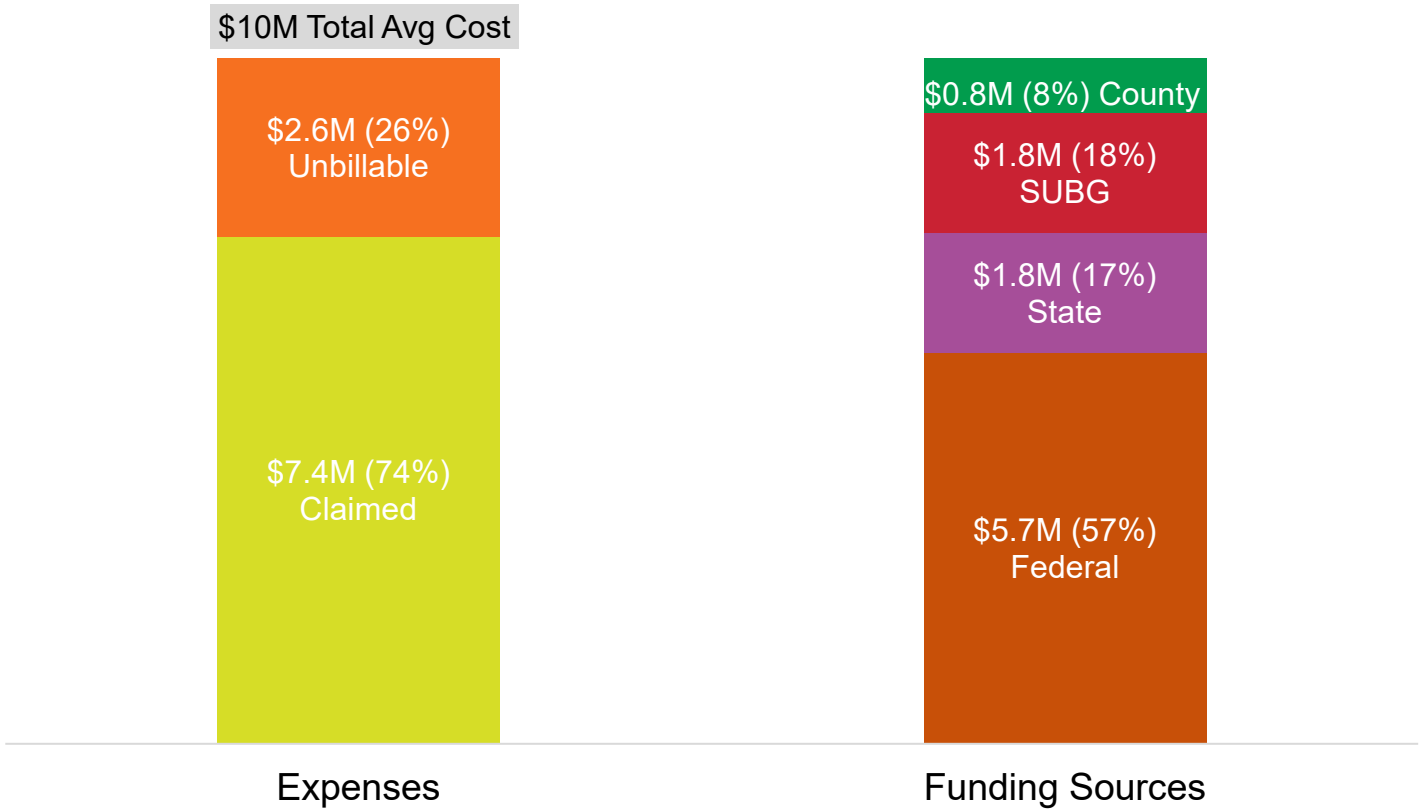
SUD Residential Treatment Claims and Revenue Sources

Costs for SUD Residential Treatment have consistently increased over the past three years in response to increased provider costs and increased utilization.

SUD Residential Treatment 2-Year Average Expenditures and Revenues (FY 2023-25)



- In FY 2025-26, we anticipate an increase of $1.6M for residential treatment costs driven by:
  - Increased rates to reflect provider and practitioner costs.
  - CalAIM fee-for-service shift has resulted in increased facility utilization.
  - CalAIM Justice Initiative and Proposition 36 are expected to increase demand for residential care.
  - Residential Room and Board is not billable but required for every residential treatment episode.
  - Other unbillable costs are associated with clients whose Medi-Cal has lapsed, are undocumented, or other coverage gaps.

Eating Disorder Treatment

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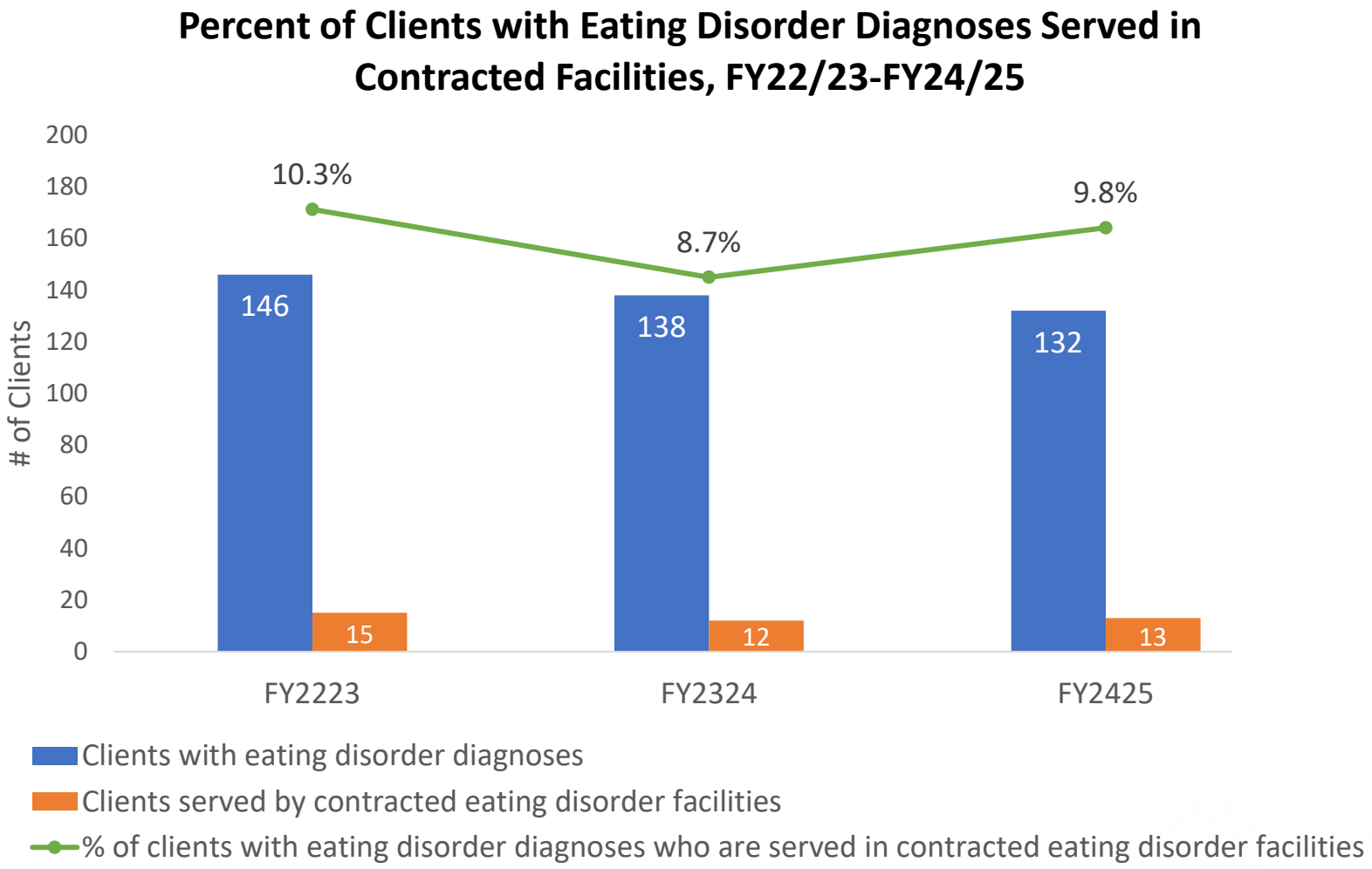
Eating Disorders

- Eating disorders are severe, life-threatening illnesses requiring complex, long-term care.
- Effective treatment involves sustained and resource-intensive, multidisciplinary approaches, including medical monitoring, nutritional support, and specialized therapy.
- Many individuals require long-term care such as residential treatment, partial hospitalization, or intensive outpatient programs.
- While treatment is expensive, neglecting eating disorders leads to higher long-term healthcare costs due to severe medical complications and psychiatric comorbidities.

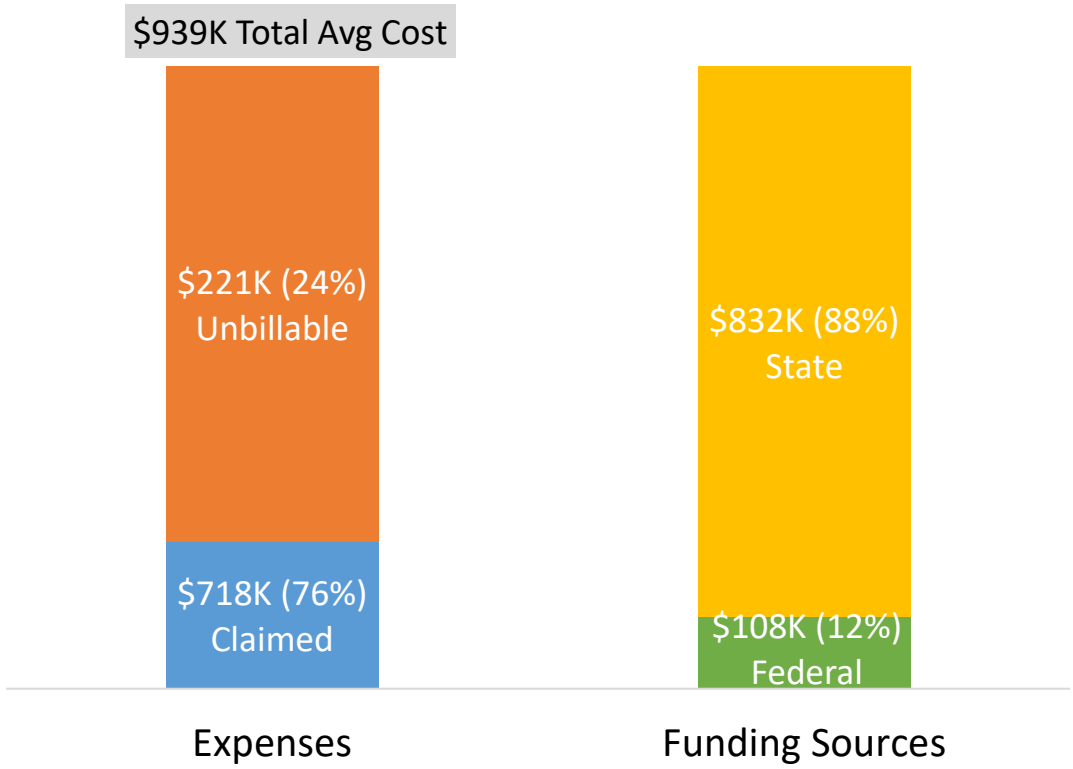
Eating Disorders Clients Served Over 3 Years



Eating Disorder Claims

While services are costly, the average cost per client in higher levels of care is $109,000, there is anticipated growth in federal reimbursement for eating disorder treatment services.

Eating Disorders 2-Year Average Expenditures and Revenues (FY 2023-25)



- In FY 2025-26 we anticipate a cost increase of $861K for eating disorder treatment due to provider expansion to meet network adequacy.
- Unbillable costs:
  - State realignment covers nonbillable costs.
  - Agreements are now in place with the Health Plan of San Mateo and Kaiser to reimburse costs.
  - In FY 2025-26 the largest contractor will be Medi-Cal Certified increasing federal reimbursement.
- Billable services:
  - Most of the lower level of care provided by county clinicians is billable and reimbursed at 50%.
  - Some of the higher level of care services will also be billable.

PERFORMANCE OUTCOMES

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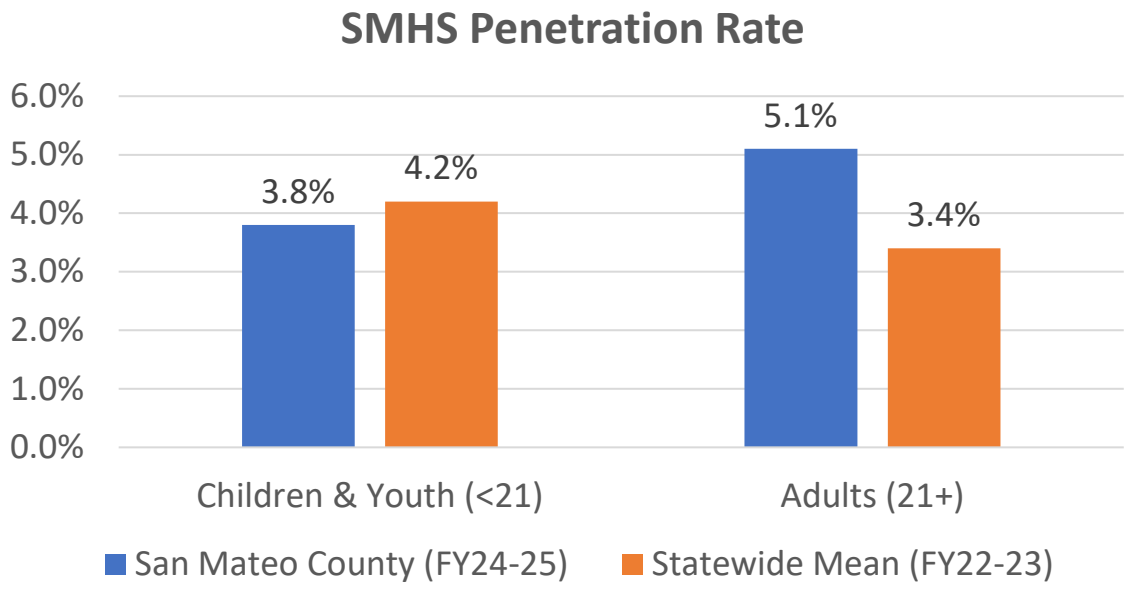
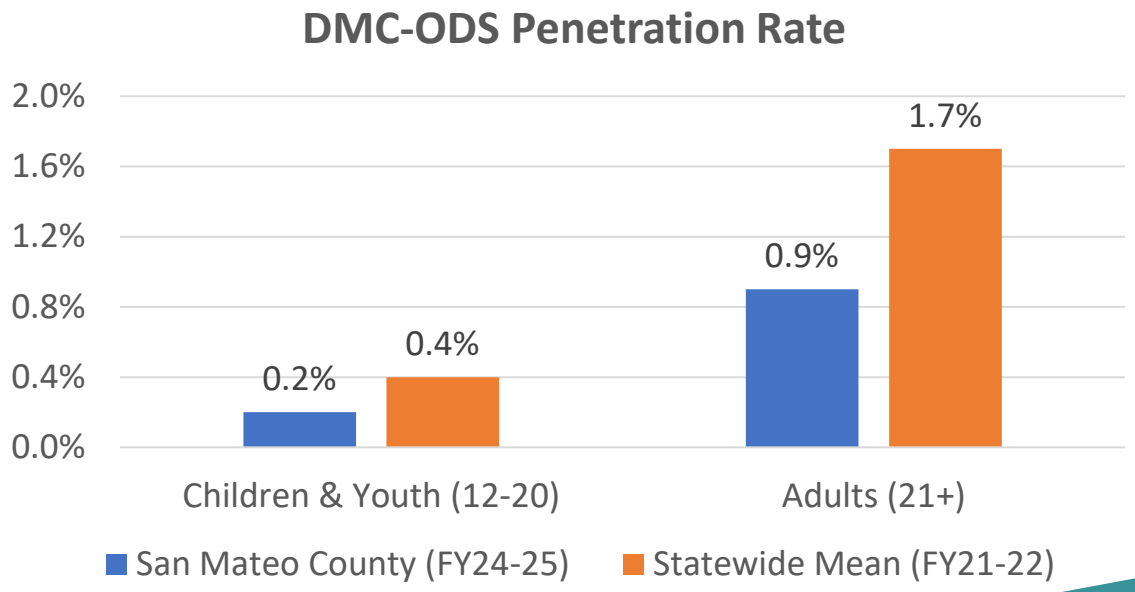
Penetration Rates

Penetration Rates are the percentage of Medi-Cal eligible individuals who receive behavioral health services – these rates can indicate how effectively BHRS is reaching its intended population.





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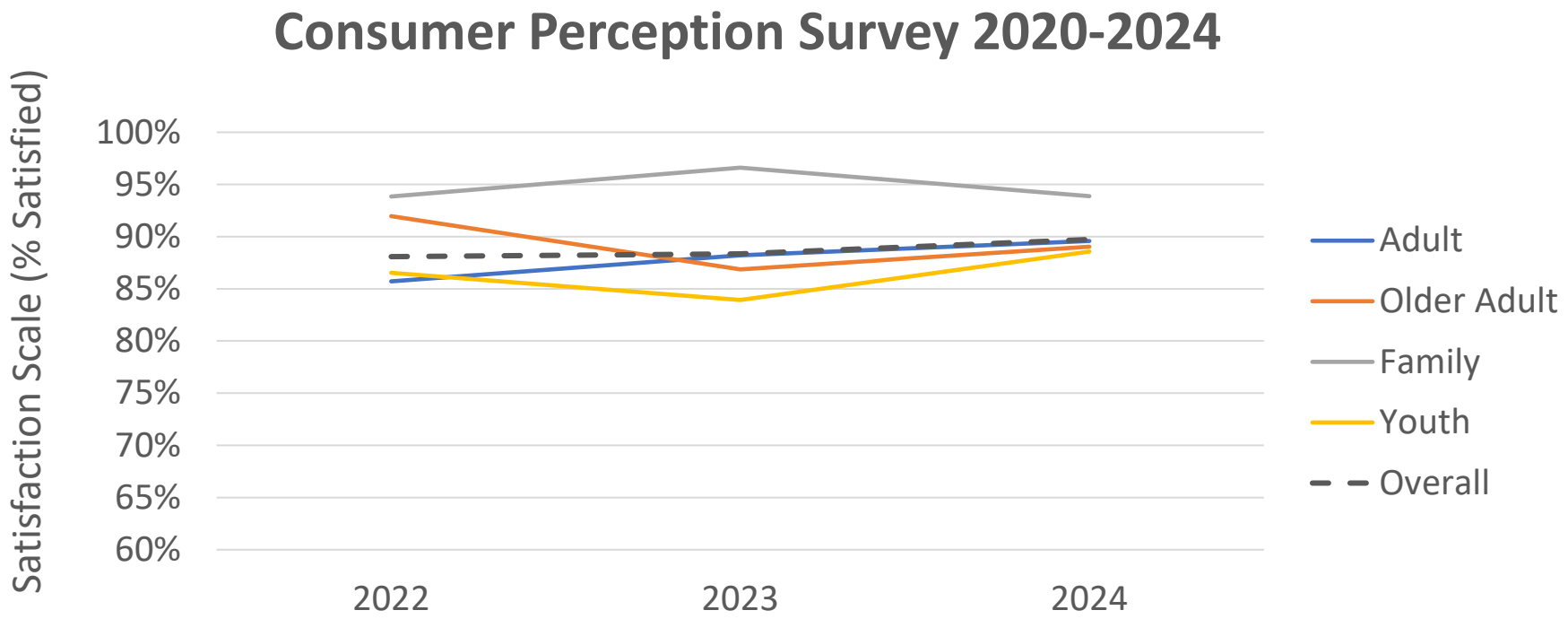
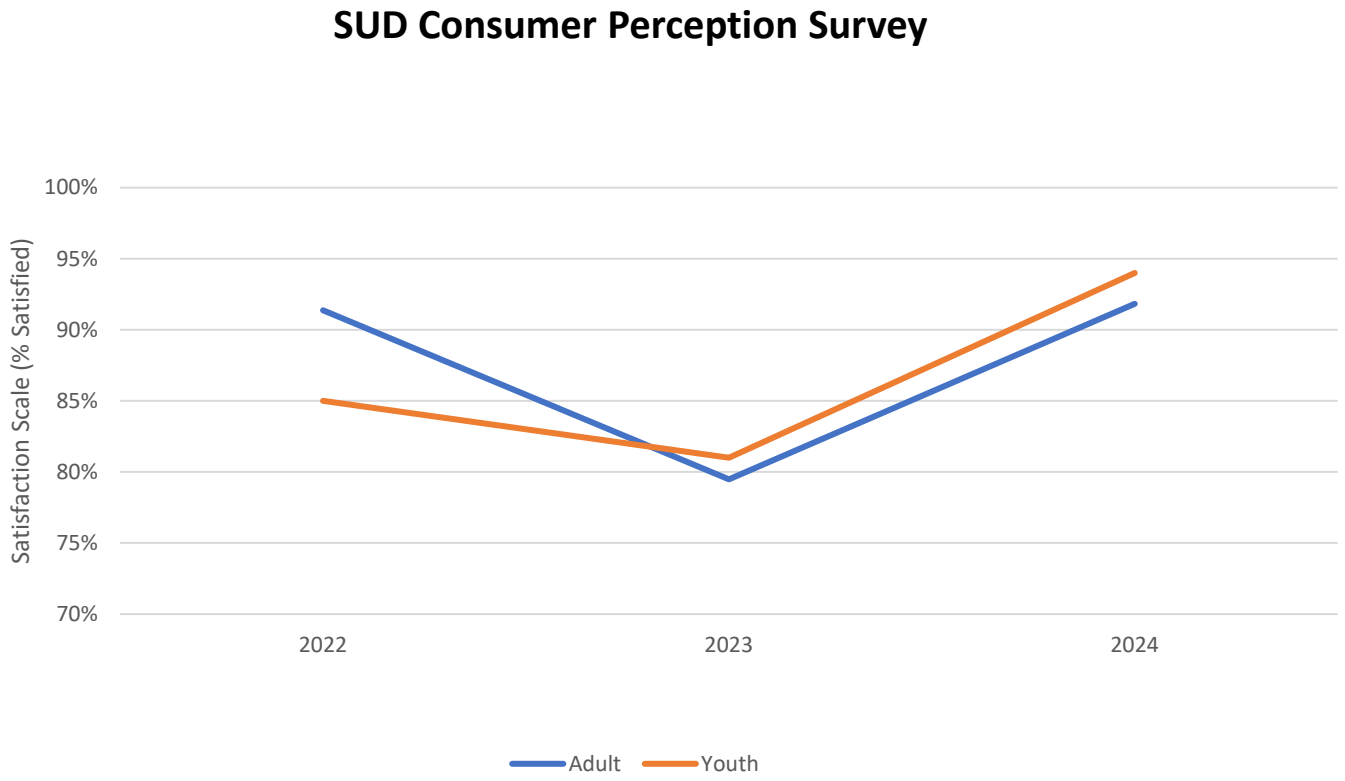
Consumer Perception Surveys

Mental Health Statistics Improvement Program (MHSIP) uses validated surveys to measure clients' perceptions of the quality and efficiency of services they receive. **BHRS clients' overall level of satisfaction with their services has increased over the years and is continuing to climb**.



Substance Use Treatment Perception Survey

Treatment Perception Survey (TPS) for SMC-ODS uses validated surveys to measure Drug Medi-Cal clients' perceptions of the quality and efficiency of services they receive. **BHRS clients' overall level of satisfaction with their SUD treatment services has increased and is on the rise**.



Performance – Time to 1st Appointment

The State has established timely access standards for county BHPs that include urgent and non-urgent appointments for clinicians and psychiatrists, as well as standards for DMC-ODS:

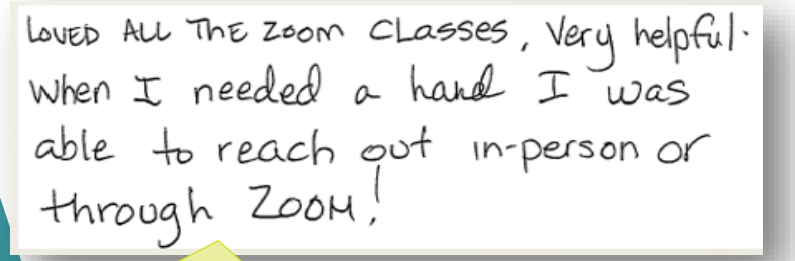
Appointment Type	Standard Met	Standard Not Met
Initial Non-Urgent & Initial Urgent Appointment - Clinician	✓	
Initial Non-Urgent & Initial Urgent Appointment -Psychiatrist		✓ *
Follow Up Appointment - Clinician		✓ *
DMC-ODS (Detox, NTP, Outpatient, Residential)	✓	

*= Lack sufficient data to determine if standard is met.

Work is being done to collect accurate data to show BHRS is meeting the standards, and nearly every county in the state struggles with collecting this data and the most successful counties have implemented expensive, labor-intensive, manual processes.

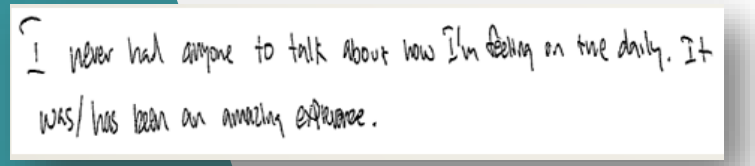
Network Adequacy and Client Feedback

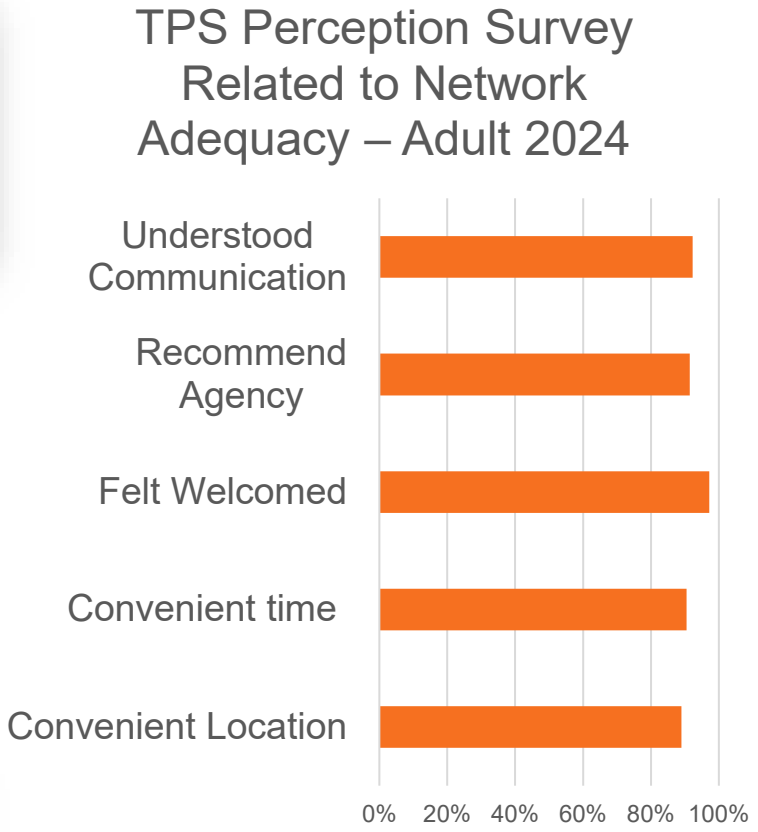
SUD providers receive positive responses to questions related to network adequacy, demonstrating the nuances in response and areas for improvement.

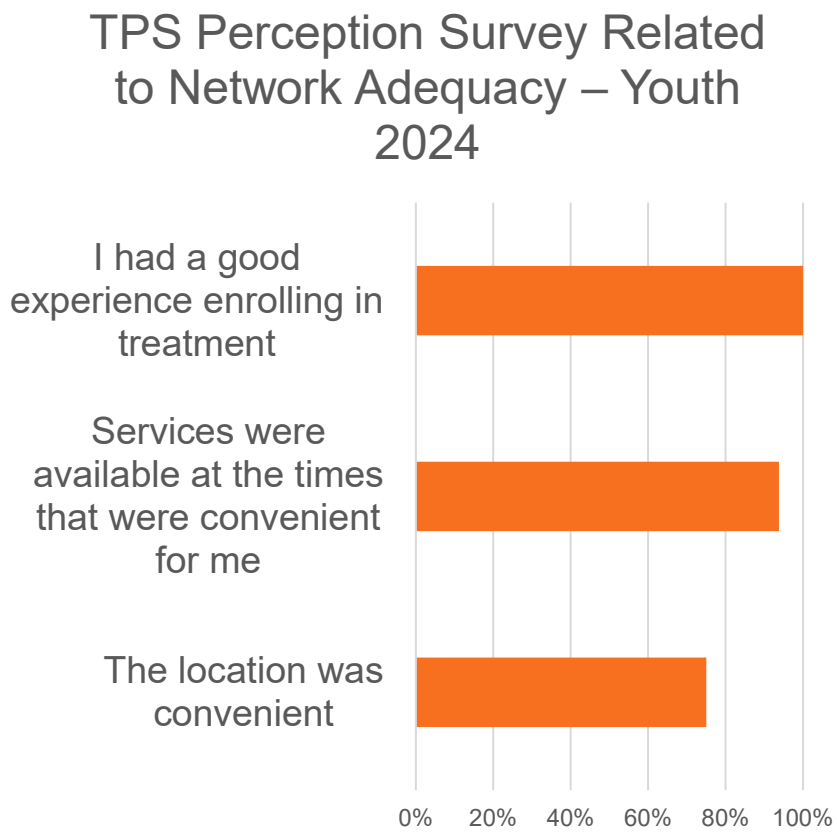


"Loved all the Zoom classes, very helpful. When I needed a hand I was able to reach out in-person or through Zoom!"

"I never had anyone to talk about how I'm feeling on the daily. It was/has been an amazing experience."







Client/Program-Level Outcomes

BHRS is standardizing client outcome data collection across programs and across various client service utilization, improved health and quality of life outcomes.

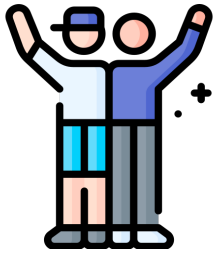
Emergency Utilization

Employment

Goals Met

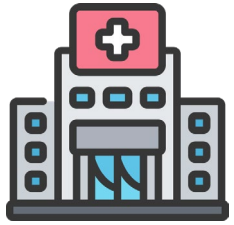
Housing

Connection



Criminal Justice

Hospitalization



Substance Use

Education

Post-Intervention Outcomes

Homelessness	↓	**Caminar Adult and Older Adult FSP:** 35% (n=118) of Adults and 17% (n=24) of Older Adults reported an incident of being unhoused (i.e., homeless or emergency shelter) after the first year enrolled in FSP compared to 41% and 21% prior to enrolling, respectively.
Criminal Justice Involvement	↓	**Pathways Program:** 21.9% (n=33) of clients were taken into custody after being admitted to the program, compared to 93.9% before admission.
Employment - Engagement	↑	**Caminar Enhanced Education:** 5% (n=118) of members reported active employment since joining the program, compared to 1% before enrolling.
Education – School Suspensions	↓	**Edgewood Child and TAY FSP:** 8% (n=238) of Children and 2% (n=284) of TAY reported a school suspension incident after the first year in FSP compared to 20% and 10% after the year prior to enrolling in FSP, respectively.

"I can't ask for better team members for me to recover from being homeless and everything else. And they've been very helpful... and it seems like they know what they're doing and I can reach out to them anytime."

~ Adult FSP Client

"It's made changes with my family, with my daughters in this case, we have had better communication. The change has been that we have a better relationship, more interaction."

~ Parent of a youth FSP Client

Office of Improvement & Innovation (OII)

BHRS recently established the Office of Improvement and Innovation to support standardized data collection, reporting and continuous improvement.

Support BHRS in embodying a spirit of learning, curiosity, growth and utilizing data for continuous improvement.

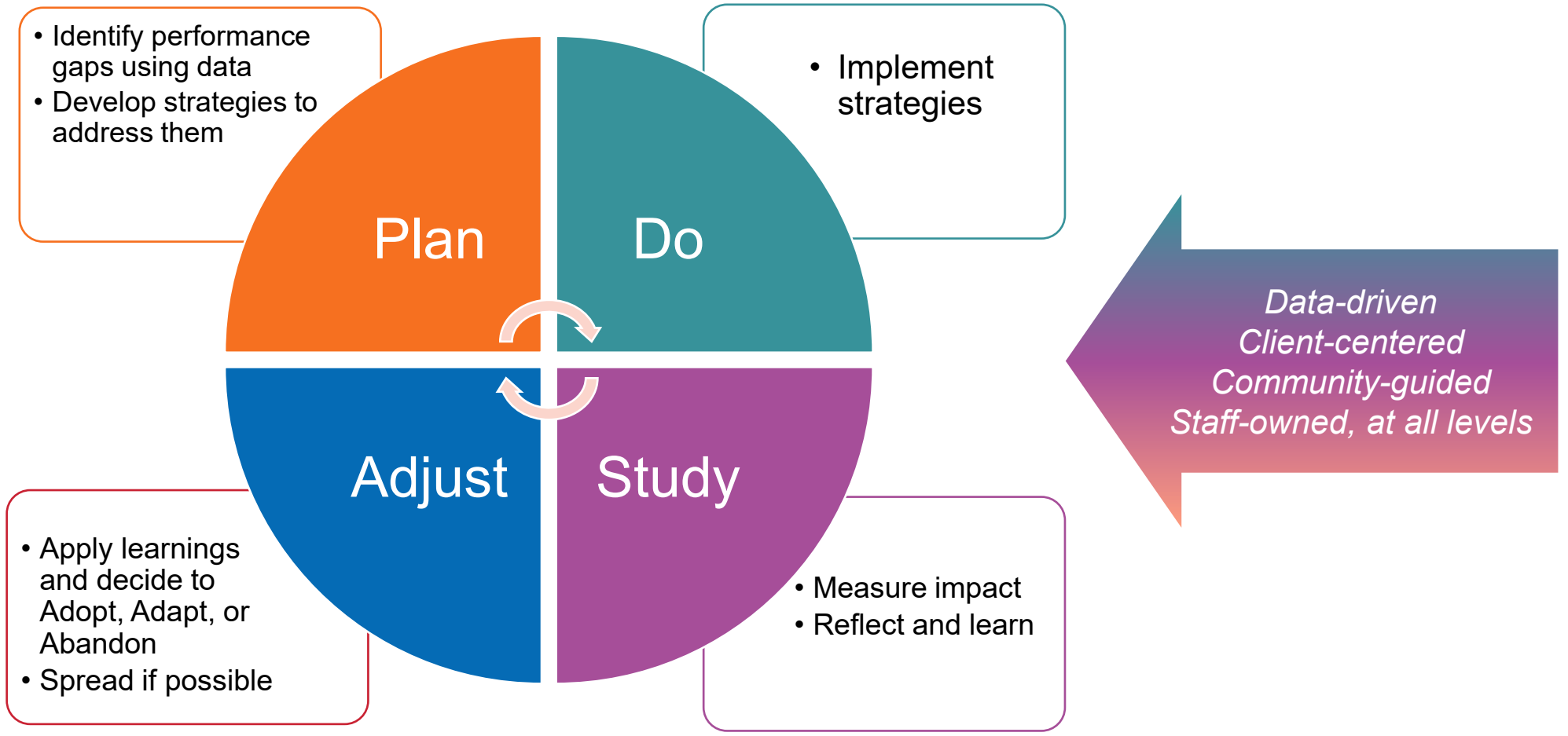
- Guide data reporting, analysis and visualization efforts
- Facilitate improvement activities
- Support the (annual) planning cycle

Support BHRS's journey in attaining that future state

- Cultivate a culture of utilizing data for continuous improvement
- Build a performance management system
- Foster psychological safety and staff wellbeing
- Create structures to drive change in ways that are trauma- and resiliency-informed

BHRS Outcome Reporting

BHRS' vision includes cultivating a culture at every level of the organization where data drives progress, transparency, and action. Data should demonstrate impact, support continuous improvement and meet state requirements for Behavioral Health Plans.



Final Reflections

- **Partnerships:** Given the rapid changes in the behavioral health landscape and with federal funding uncertainties, building strong partnerships and infrastructure will be essential to meet client needs effectively.
- **Infrastructure:** Prop. 1 has been a catalyst for statewide transformation and investments in infrastructure focused on effective data management, fiscal transparency, quality monitoring, and developing and retaining a skilled workforce; these will be critical for compliance and future sustainability.
- **Changing Responsibilities:** BHRS has served as a safety net provider and relied on federal, state and local general funds to serve clients regardless of insurance or documentation status; this is shifting as our Behavioral Health Plan responsibilities focus on serving complex individuals and new federal and state policy affect eligibility for Medi-Cal.
- **Contracted Provider Network:** Contracted services constitute almost half of the BHRS budget and will require ongoing support to address workforce shortages, service coordination and other infrastructure challenges.
- **BHRS will continue to adapt responsively, meeting challenges with innovation and collaboration.**

SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

THANK YOU!