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FY 2022-23
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

MERCED FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 25-26, 2022

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Merced" may be used to identify the Merced County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — January 25-26, 2022

MHP Size — Medium

MHP Region — Central

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
4	2	2	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	3	3	0
Quality of Care	10	10	0	0
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**21**	**3**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Trauma Identification and Treatment	Clinical	06/21	Baseline Year	Low
Improving the 7-day follow-up rate post-inpatient discharge.	Non-Clinical	07/21	Second Remeasurement	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	15
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	[redacted]

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has developed a strong quality improvement (QI) structure with emphasis on data analysis, reporting, and data-driven decision making.
- The MHP has established a culturally competent system of care focusing on cultural humility, justice, and equity.
- There are several peer support and mental health worker positions for individuals with lived experience.
- The newly created Justice and Community Integration Division has enabled the MHP to bring more coordinated efforts to provide behavioral health care to the justice and law enforcement involved beneficiaries.
- In the past year, the MHP has strengthened its crisis response capacity to provide more timely and mobile response to crisis episodes.

The MHP was found to have notable opportunities for improvement in the following areas:

- The MHP's first offered psychiatry appointments can take over a month.
- The MHP reported a time period of six days to address urgent requests for service based on a very low number of requests. The reporting of this data appears to have methodological flaws.
- The MHP is unable to utilize its data analytic capabilities fully due to the lack of a database or data warehouse system with its current Electronic Health Record (EHR).

- The MHP's Latino/Hispanic penetration rate (PR) continues to be much lower than the statewide average. The results of the MHP's efforts in addressing this issue are not evidenced in the available data at this time.
- Despite the MHP's strengths in promoting cultural humility, equity, and justice, the Spanish-speaking beneficiaries and family members reported negative experience at the front desk.

Recommendations for improvement based upon this review include:

- Monitor any impact of increasing the telehealth capacity for psychiatry on initial psychiatry appointment timeliness at least on a monthly basis and develop or refine strategies as needed to meet the 15-day standard.
- Investigate the methodology of tracking urgent appointments and strategies to meet the urgent appointment timeliness standards.
- To fully access the increased data that will be available in the Credible system and to increase in-house analytic and reporting capacity, develop a database that mirrors the Credible system.
- Continue efforts to improve access to services for Latino/Hispanic beneficiaries and monitor barriers to access through specific beneficiary surveys tailored to this need.
- Train front desk staff in creating a welcoming environment for Spanish-speaking beneficiaries. Utilize the existing available cultural competency committee expertise to develop such training for the front desk staff.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs, comprised of 58 counties, to provide specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal MHP. DHCS contracts with Behavioral Health Concepts, Inc. (BHC), the CalEQRO to review and evaluate the care provided to the Medi-Cal beneficiaries.

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section14197.05).

This report presents the FY 2022-23 findings of the EQR for Merced County MHP by BHC, conducted as a virtual review on January 25-26, 2022.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File.

CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (CY) 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Review and validation of each MHP's NA as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Beneficiary perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, then "<11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding PR percentages, or dollar amounts.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the third year of the Coronavirus Disease 2019 (COVID-19) pandemic and following significant weather events, including floods, just before the review. At the time of the review, the MHP was under federal emergency alert. The MHP reported high staff turnover and vacancy rates during the past year. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

- At the time of the review, the MHP was operating without a permanent behavioral health director. A new director has been appointed and was slated to start a week after the EQR.
- In June 2022, the children's division received seven new positions to establish the Advancing Support and Enriching Tomorrow Team through the Mental Health Student Services Act. This team operates in collaboration with the Merced County Office of Education.
- The MHP has started a mobile crisis program for children and a mobile youth clinic in the North County.
- The certification process for a new youth crisis stabilization program was underway at the time of the EQR.
- The MHP has consolidated its programs for justice-involved beneficiaries under a new Justice and Community Integration Division.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2021-22

Recommendation 1: Investigate and identify causes of low PR for service delivery for the Latino/Hispanic population. Implement initiatives which address and are designed to improve service numbers for the Latino/Hispanic population.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The Latino/Hispanic PR for the MHP continues to be much lower than the statewide average.
- In its 2022-23 QI Plan, the MHP has set a target to bring the Latino/Hispanic PR to its pre-COVID-19 level which will make it closer to the statewide PR.
- The MHP has undertaken several initiatives including outreach, radio campaigns, school-based mobile crisis and mobile clinic in pre-dominantly Latino/Hispanic areas, and coordination with stakeholder groups to bring more awareness to Latino/Hispanic access issues to the forefront.

Recommendation 2: Improve reliability of timeliness data and bring timeliness PMs into alignment with DHCS, HEDIS and MHP established standards.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has taken steps to improve timeliness of services and the reliability of the timeliness data. The non-clinical PIP focuses on improving the 7-day follow-up rate post-hospitalization. The Navigation and Engagement Team works

on follow-up and engagement. School-based mobile crisis and community co-response team (CCRT) are other initiatives to improve access to services and crisis response times.

- The MHP has also added new telepsychiatry capacity to address psychiatry timeliness issues. However, from the latest available data provided by the MHP through its timeliness self-assessment, first offered psychiatry timeliness and urgent request timeless are significantly above the standards set by DHCS.
- This recommendation has been continued in this year's EQR report in a modified manner specifying psychiatry and urgent request timeliness metrics in two separate recommendations.

Recommendation 3: Consider the feasibility of an outside contractor to assess current systemwide communication methods with an aim to improve and expand staff inclusion, throughout all levels of the system (leadership, managerial, peer and direct service staff, and contractors). Demonstrate a shift in communicative and decision-making approach that is reflective of stakeholder feedback.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The previous MHP director started a "coffee with the director" meeting at all MHP clinic locations so staff could provide feedback.
- The MHP also has several staff-run committees that provide staff the opportunities to participate and provide feedback on many areas of concern. For the documentation redesign portion of CalAIM, a system wide implementation plan occurred including all MHP staff and contract providers.
- The MHP has made its Quality Improvement Committee (QIC) meetings are open to all stakeholders including the line staff and contract providers.

Recommendation 4: Monitor project timelines and human resources during the implementation of the new EHR. Assure robust funding for the project and prioritization to complete implementation in a timely manner.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- There is ongoing project monitoring and collaboration between the MHP, Qualifacts (Credible vendor), and Kings View. The MHP and Kings View have biweekly meetings to discuss implementation and project target dates. The MHP allocated $2.7 million from Mental Health Services Act funds to implement the Credible system. The system will be operated in an application service provider (ASP) environment. Credible will host the system and Kings View will provide ongoing operational support. The anticipated go-live date is April 1, 2023.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or beneficiaries) are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which beneficiaries live, equity, as well as accessibility—the ability to obtain medical care and services when needed.[1] The cornerstone of MHP services must be access, without which beneficiaries are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and PMs addressed below.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 57.39 percent of services were delivered by county-operated/staffed clinics and sites, and 42.61 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 89.93 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: 24/7 crisis services division and walk-ins at clinic sites. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The Access team is primarily responsible for most screening and appropriate referrals for non-urgent service requests regardless of the source of referral. The states that the beneficiaries can also walk into clinic sites and request services, but that is not common.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 2,785 adult beneficiaries, 1,170 youth beneficiaries, and 408 older adult beneficiaries across 12 county-operated sites and 3 contractor-operated sites. Among those served, 571 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Merced County, the time and distance requirements are 45 miles and 75 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 2021-22

Alternative Access Standards	
The MHP was required to submit an AAS request due to time or distance requirements	☐ Yes ☒ No

- The MHP met all time and distance standards and was not required to submit an AAS request.

Table 1B: MHP Out-of-Network Access, FY 2021-22

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☒ Yes ☐ No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☒ Yes ☐ No
OON Access for Beneficiaries	
The MHP ensures OON access for beneficiaries in the following manner:	☒ The MHP has existing contracts with OON providers. ☐ Other: Click or tap here to enter text.

- When a beneficiary needs services that are provided out of county, the MHP staff can assist with coordinating transportation either through the managed care plans or using their own staff. For day treatment intensive or day rehab, services

that are not provided in county, the MHP staff assist with referral and linkage to services.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members. Examining service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population, and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

Each access component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

Strengths and opportunities associated with the access components identified above include:

- The MHP thoroughly evaluates the access and service needs in its QI plan and the cultural competency plan.
- It has established strong collaboration and coordination with partner agencies including school districts, law enforcement, probation, housing, and child welfare.
- The MHP has developed an all-round crisis response network with a 24/7 crisis response division that includes mobile crisis units.
- In August 2020, the MHP changed its cultural competency committee's name to cultural humility, health equity, and social justice committee. Through this committee's work, the MHP has tried to improve access and reduce stigma through billboards, public service announcements in local radio stations, and digital marketing and social media presence.
- The MHP's FC and Latino/Hispanic PRs remain much lower than the statewide average. In its cultural competency plan, the MHP identified Latino/Hispanic, Hmong speakers, and African Americans as underserved communities.

- Although the MHP has made cultural humility as a centerpiece of its service delivery system that is valued by its beneficiaries and their family members, one gap appears to be at the front desk for the monolingual Spanish speakers as was reported by the focus group participants.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rates, and Average Approved Claims per Beneficiary Served

The following information provides details on Medi-Cal eligibles, and beneficiaries served by age, race/ethnicity, and threshold language.

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, the MHP's PR of 2.91 percent was 24 percent less than the statewide average, and the average claim amount of $7,960 was 23 percent greater than the statewide average.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	146,632	4,273	2.91%	$34,014,743	$7,960
CY 2020	135,916	4,422	3.25%	$33,506,647	$7,577
CY 2019	132,391	4,822	3.64%	$22,872,007	$4,743

- While annual eligibles increased each year from CY 2019-21, beneficiaries served, and PR declined each year during this period.
- Between CY 2019 and CY 2020, the total approved claims increased by 50 percent as did the AACB.

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	18,547	49	0.26%	0.89%	1.59%
Ages 6-17	41,423	1,183	2.86%	3.93%	5.20%
Ages 18-20	8,842	253	2.86%	3.42%	4.02%
Ages 21-64	67,442	2,615	3.88%	3.75%	4.07%
Ages 65+	10,379	173	1.67%	2.13%	1.77%
Total	**146,632**	**4,273**	**2.91%**	**3.33%**	**3.85%**

- The MHP's PRs were less than statewide PRs for all age groups. The PR for adults aged 21 to 64 was the highest and closest to the statewide PR.

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	504	11.02%
Threshold language source: Open Data per BHIN 20-070		

- Merced had one threshold language other than English in CY 2021, Spanish. There were 504 beneficiaries served by the MHP who identified Spanish as a preferred language, 11.02 percent of the beneficiaries served by the MHP.

Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	36,859	1,117	3.03%	$6,896,712	$6,174
Medium	613,796	18,023	2.94%	$122,713,843	$6,809
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries. However, in Merced, the ACA PR exceeds the overall PR (3.03 percent vs. 2.91 percent).
- The ACA PR is greater than the medium county average (3.03 percent vs. 2.94 percent) and less than the statewide average (3.03 percent vs. 3.31 percent).

- The AACB is less than the medium county average ($6,174 vs $6,809) and greater than the statewide average ($6,174 vs. $5,677).

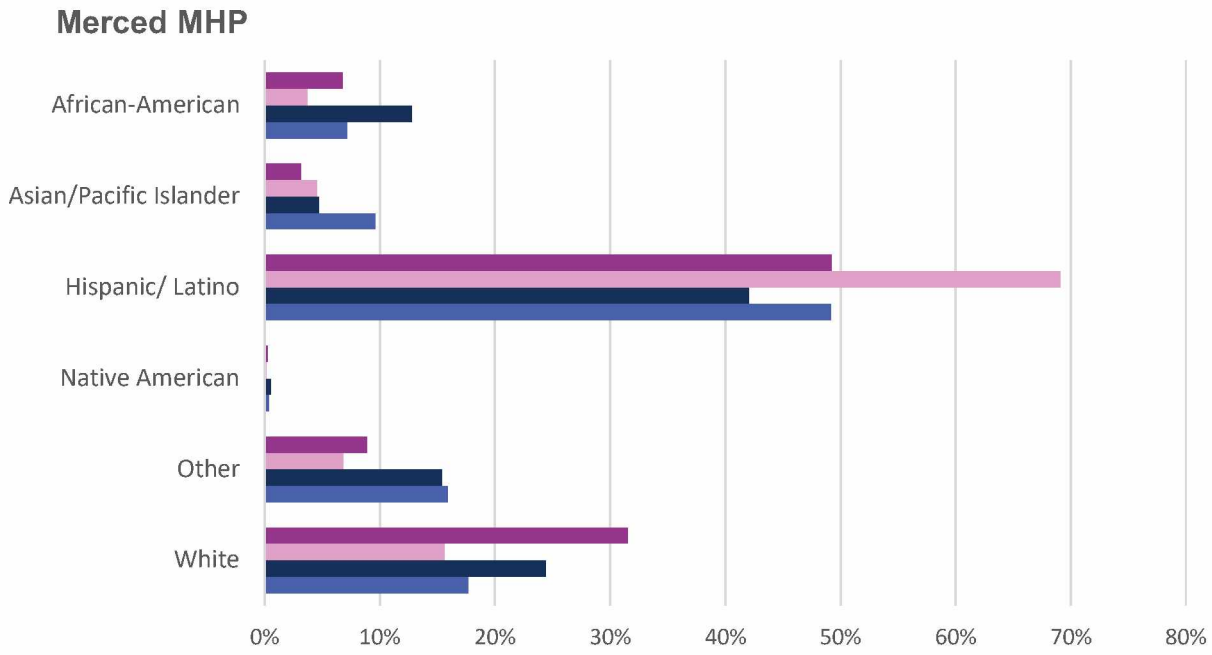
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served. Table 7 and Figures 1–9 compare the MHP's data with MHPs of similar size and the statewide average.

Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	5,468	291	5.32%	6.83%
Asian/Pacific Islander	6,669	135	2.02%	1.90%
Hispanic/Latino	101,318	2,105	2.08%	3.29%
Native American	270	13	4.81%	5.58%
Other	10,018	381	3.80%	3.72%
White	22,890	1,348	5.89%	5.32%
Total	**146,633**	**4,273**	**2.91%**	**3.85%**

- Merced served 4,273 beneficiaries in CY 2021. The eligible population was largely comprised of Hispanic/Latinos, 69 percent of the eligible population. With the exception of Other, PRs for all race/ethnicity groups were lower than corresponding statewide averages.

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021

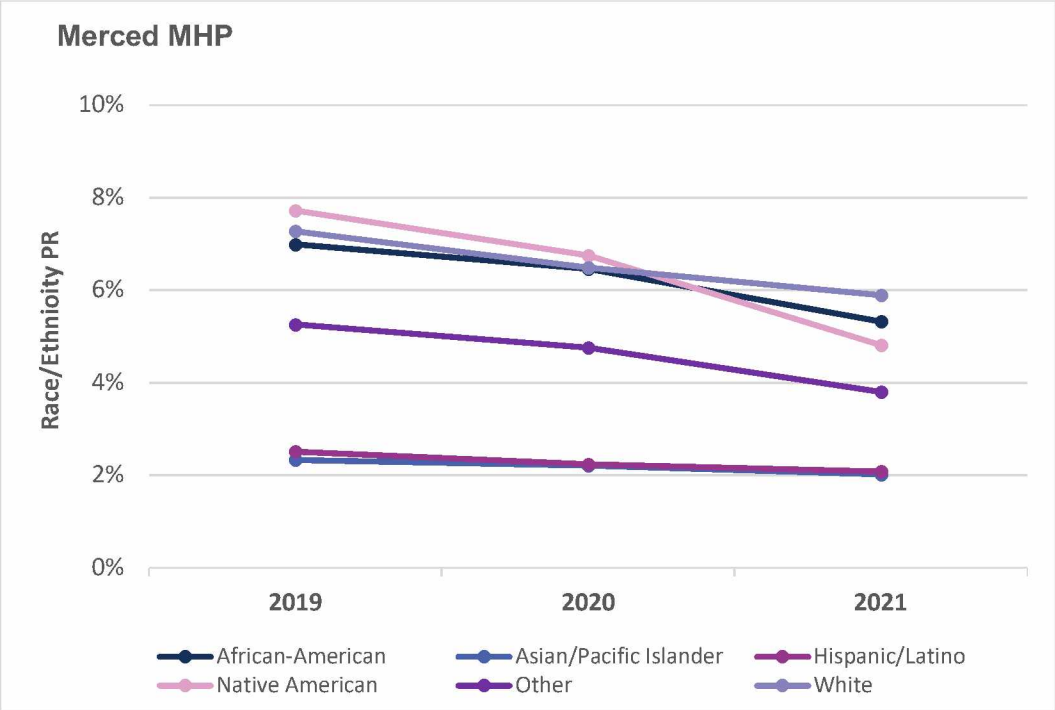


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	32%	9%	0%	49%	3%	7%
MHP % Eligibles	16%	7%	0%	69%	5%	4%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- While the Hispanic/Latino population comprised 69 percent of the eligible population, 49 percent of those served were Hispanic/Latino. Whites comprised the next largest race/ethnicity group, compromising 16 percent of the eligible population and 32 percent of those served. The lower percent of Hispanic/Latinos served compared to the eligible population indicates that this population may be underserved.

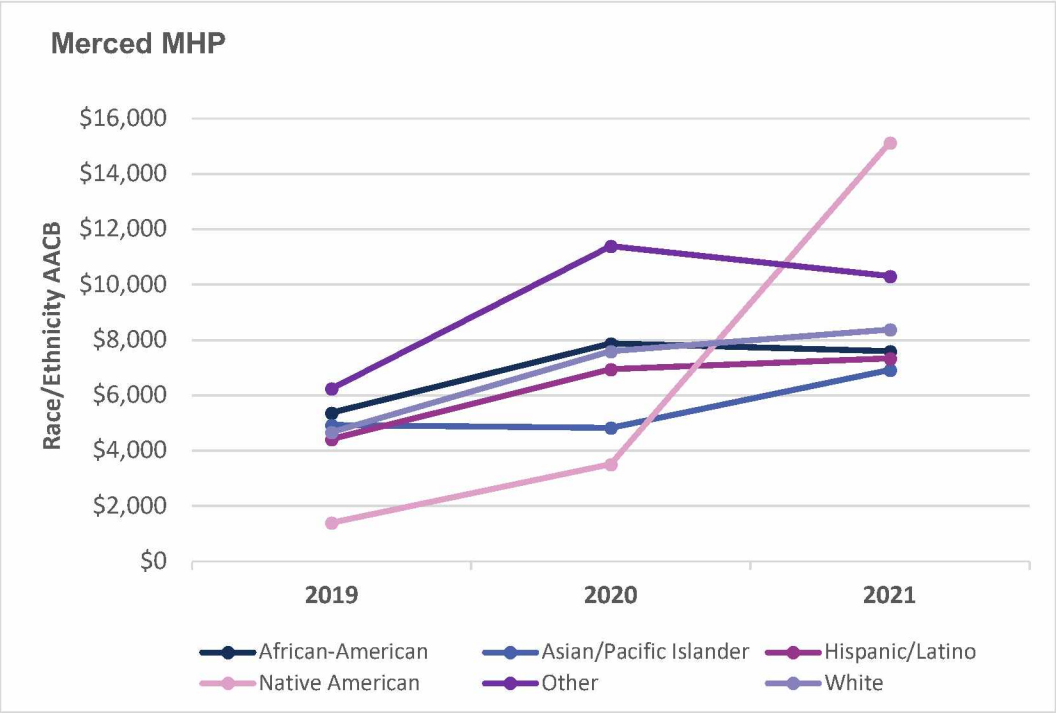
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year trend.

Figure 2: MHP PR by Race/Ethnicity CY 2019-21



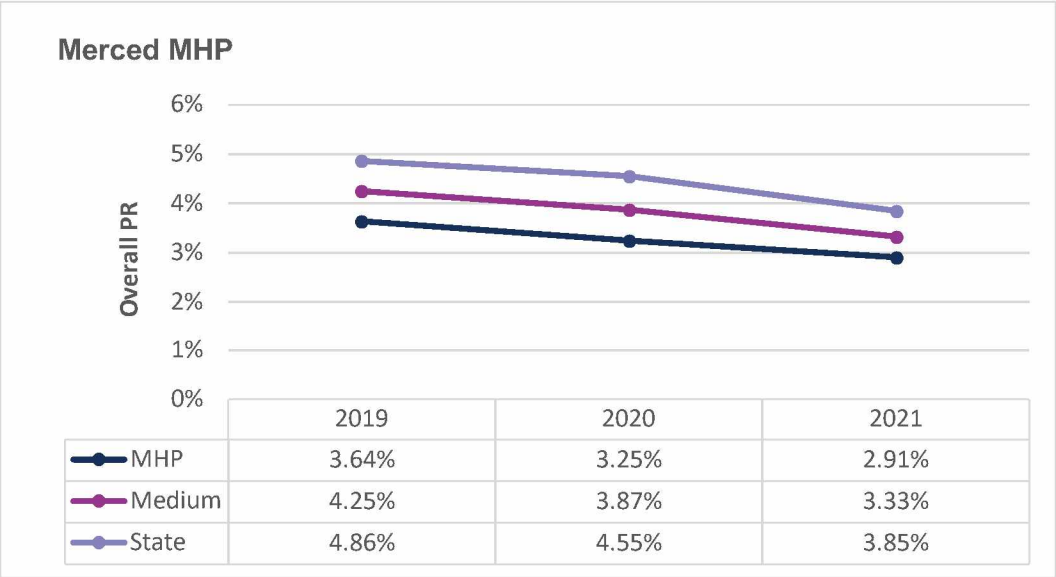
- From CY 2019-21, Hispanic/Latino and Asian/Pacific Islander PRs were the lowest while White, Native American, and African American had the highest PRs. PRs declined for all race/ethnicity groups from CY 2019-21.

Figure 3: MHP AACB by Race/Ethnicity CY 2019-21



- Billing rates impacted by the COVID-19 pandemic likely contributed to the CY 2019 to CY 2020 increase in AACBs for the overall data and all subpopulation data.
- Apart from African-American and Other, AACB increased each year from CY 2020 to CY 2021. Native American and Other had the highest AACBs in CY 2021. Fewer than one percent of those served in CY 2021 were Native American and small beneficiary counts can cause increased variability in year over year data.

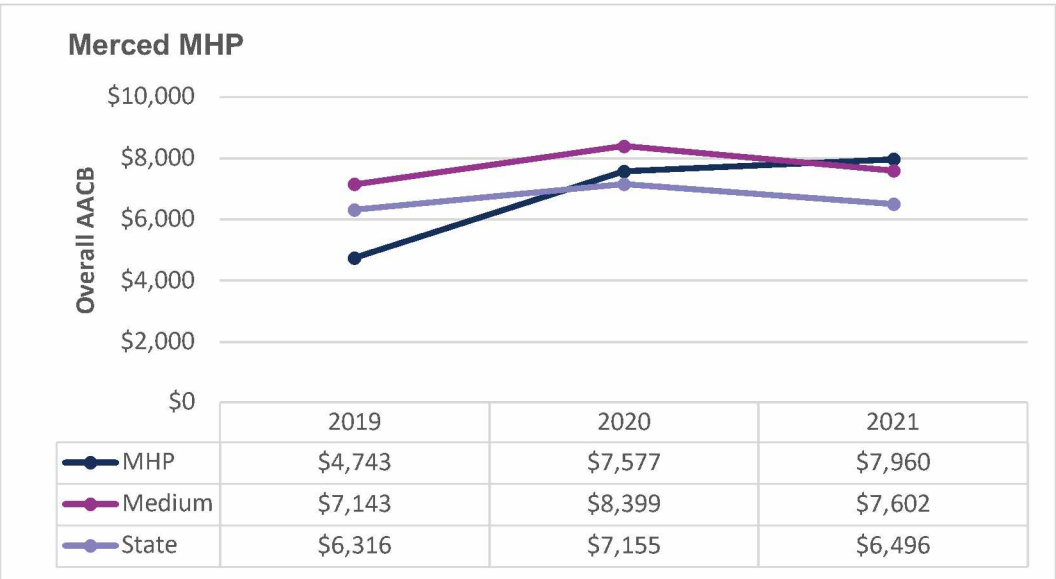
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	3.64%	3.25%	2.91%
Medium	4.25%	3.87%	3.33%
State	4.86%	4.55%	3.85%

- The MHP's PR declined each year from CY 2019 to CY 2021, mirroring the medium county and statewide trends for this time period. In CY 2021, the overall PR was 13 percent less than in medium counties (2.91 percent vs. 3.33 percent) and 24 percent less than statewide (2.91 percent vs. 3.85 percent), ranking 47th of 56 MHPs.

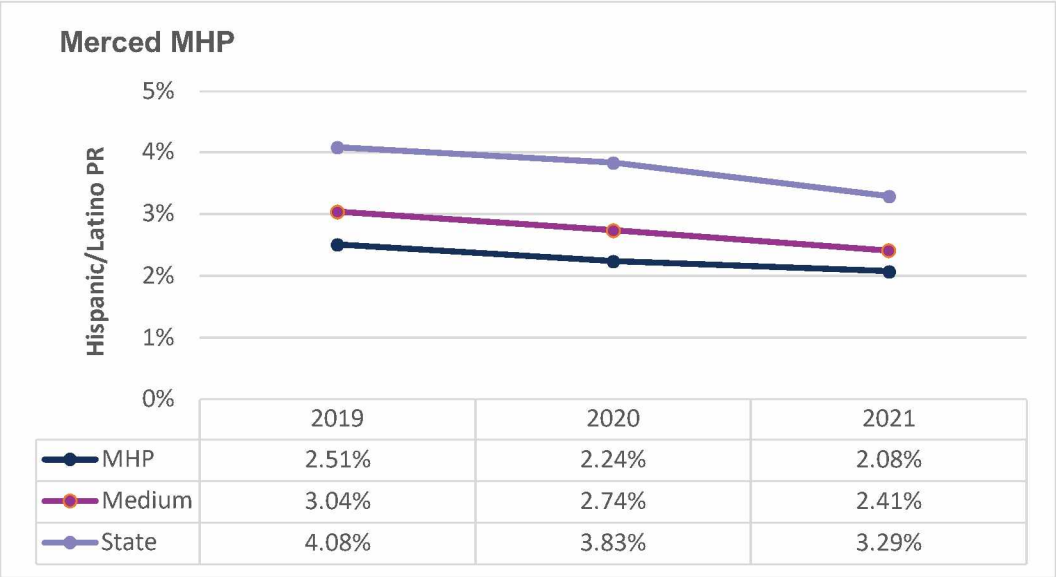
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,743	$7,577	$7,960
Medium	$7,143	$8,399	$7,602
State	$6,316	$7,155	$6,496

- The MHP's AACB increased each year from CY 2019 to CY 2021, rising from 25 percent less than the statewide average in CY 2019 ($4,743 vs. $6,316) to 23 percent more than the statewide average in CY 2021 ($7,960 vs. $6,496).

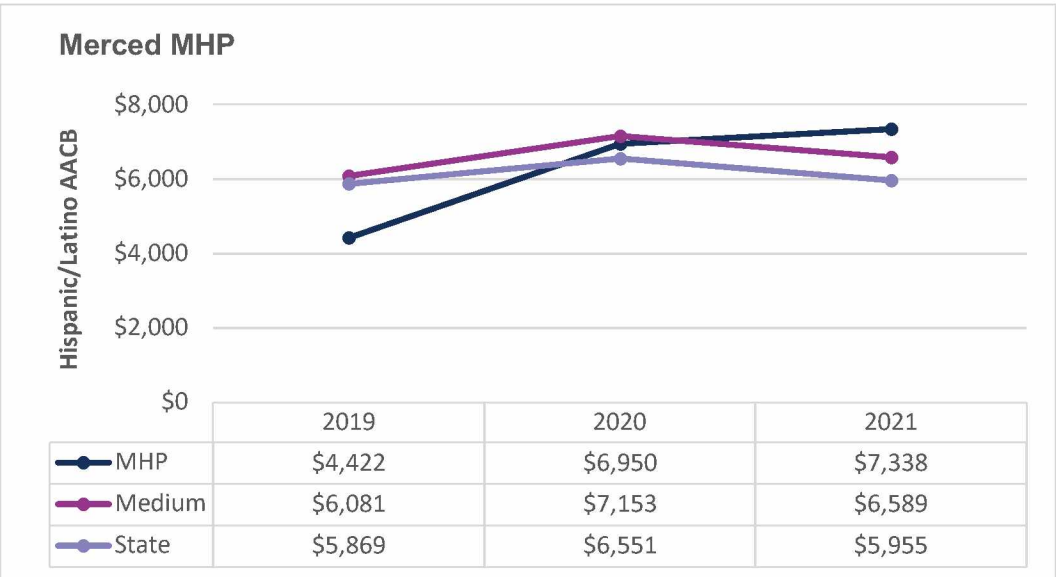
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	2.51%	2.24%	2.08%
Medium	3.04%	2.74%	2.41%
State	4.08%	3.83%	3.29%

- The MHP's Hispanic/Latino PR declined each year from CY 2019 to CY 2021, mirroring the medium county and statewide trends for this time period. In CY 2021, the PR was 14 percent less than in medium counties (2.08 percent vs. 2.41 percent) and 37 percent less than statewide (2.08 percent vs. 3.29 percent), ranking 45th of 56 MHPs.

Figure 7: Hispanic/Latino AACB CY 2019-21

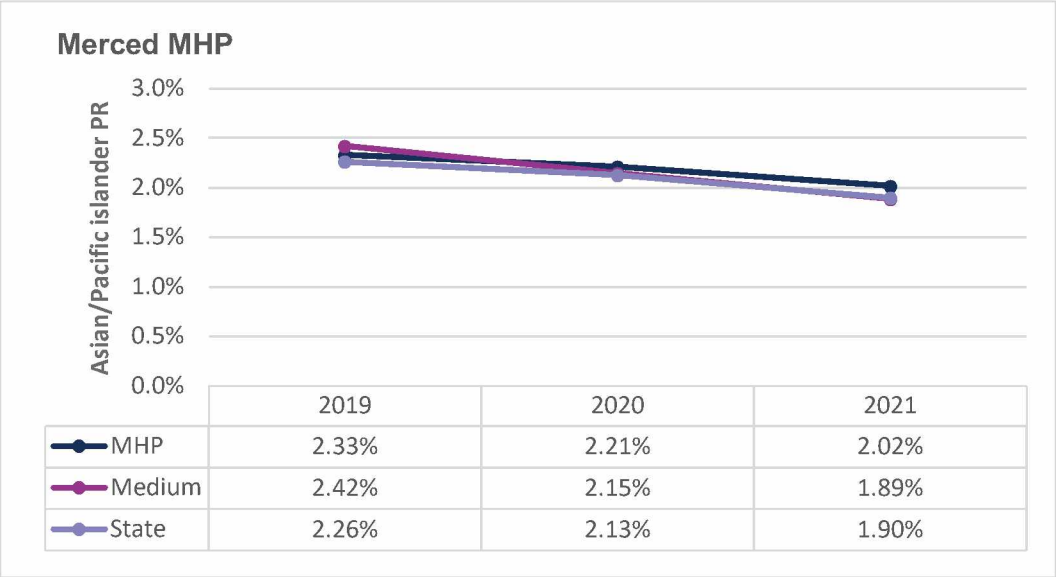


	2019	2020	2021
MHP	$4,422	$6,950	$7,338
Medium	$6,081	$7,153	$6,589
State	$5,869	$6,551	$5,955

- The MHP's Hispanic/Latino AACB increased each year from CY 2019 to CY 2021, rising from 25 percent less than the statewide average in CY 2019 ($4,422

vs. $5,869) to 23 percent more than the statewide average in CY 2021 ($7,338 vs. $5,955).

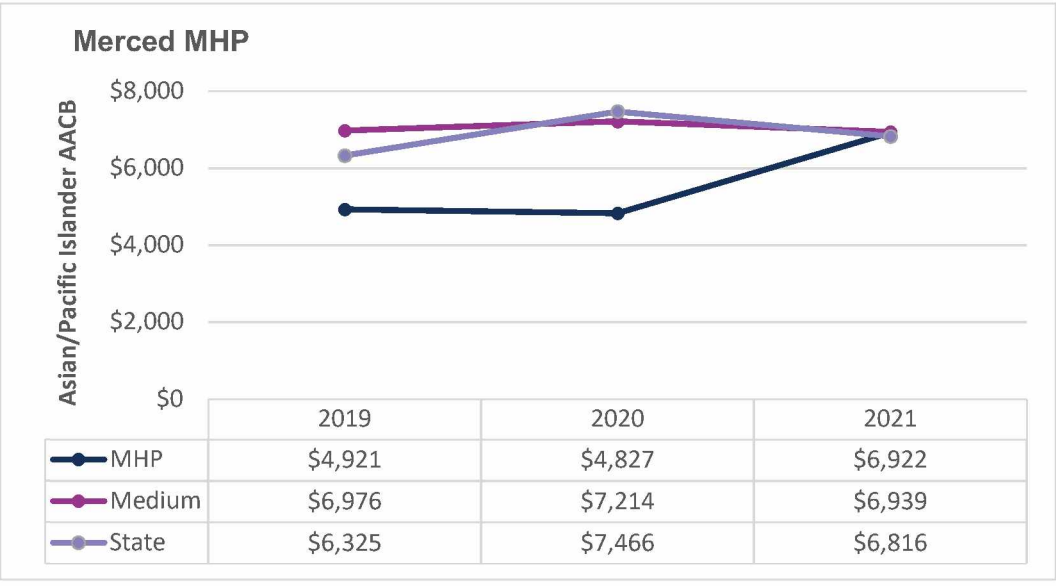
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.33%	2.21%	2.02%
Medium	2.42%	2.15%	1.89%
State	2.26%	2.13%	1.90%

- Asian/Pacific Islander PRs for statewide, medium county and Merced declined each year from CY 2019 to CY 2021. The MHP's PR being just above medium county and statewide rates in CY 2021 and ranking 26th of 56 MHPs.

Figure 9: Asian/Pacific Islander AACB CY 2019-21

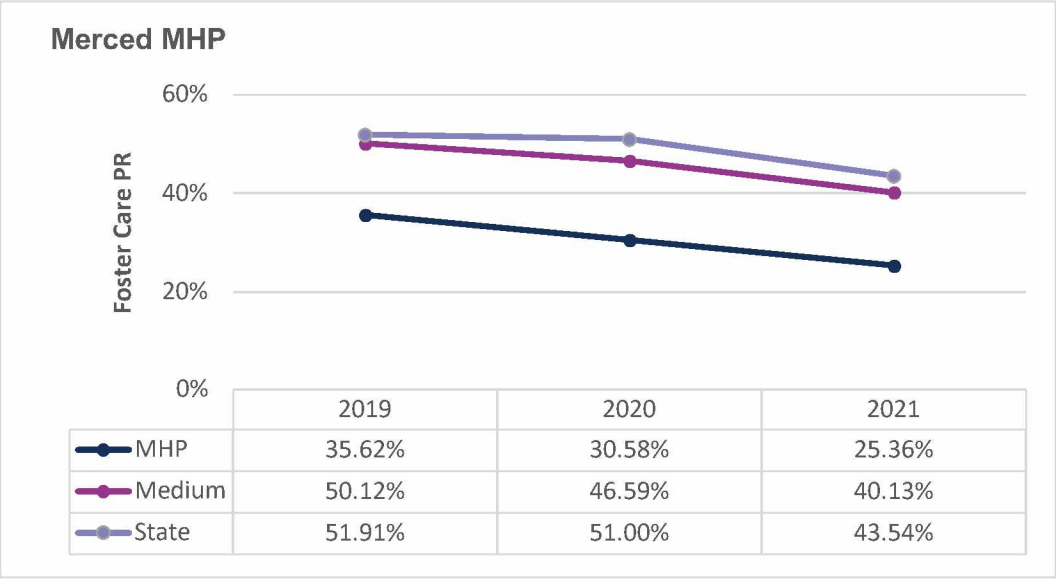


	2019	2020	2021
MHP	$4,921	$4,827	$6,922
Medium	$6,976	$7,214	$6,939
State	$6,325	$7,466	$6,816

- The MHP's AACB increased notably from CY 2020 to CY 2021, rising from 35 percent less than the statewide average in CY 2020 ($4,827 vs. $7,466) to being

just above the statewide average in CY 2021 ($6,922 vs. $6,816). The MHP served 135 Asian Pacific Islander beneficiaries in CY 2021.

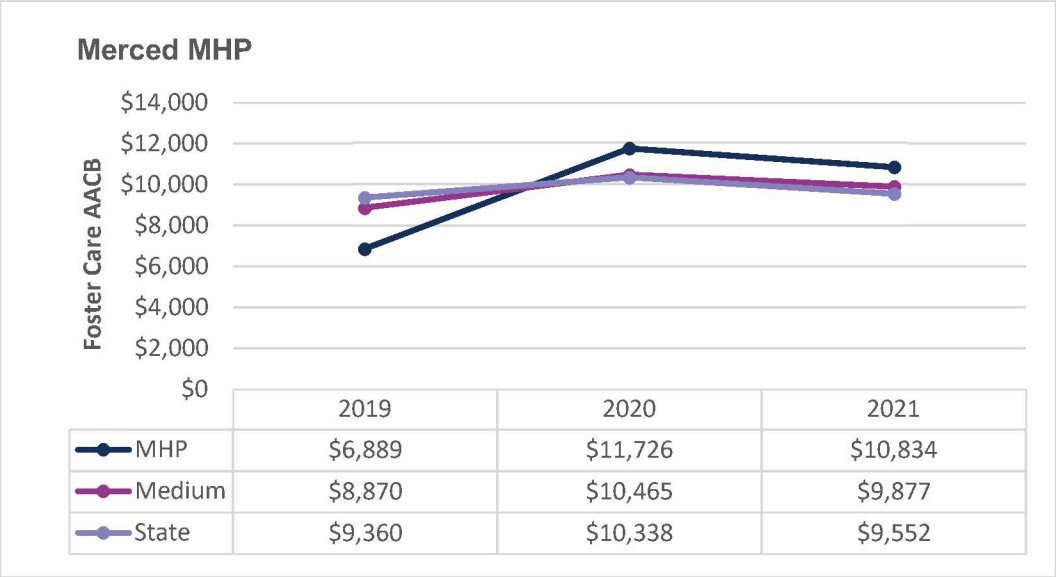
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	35.62%	30.58%	25.36%
Medium	50.12%	46.59%	40.13%
State	51.91%	51.00%	43.54%

- The MHP's foster care PR declined each year from CY 2019 to CY 2021, mirroring medium county and statewide trends for this time period. In CY 2021, the PR was 37 percent less than in medium countries (25.36 percent vs. 40.13 percent) and 42 percent less than the statewide rate (25.36 percent vs. 43.54 percent), ranking 52nd of 56 MHPs.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$6,889	$11,726	$10,834
Medium	$8,870	$10,465	$9,877
State	$9,360	$10,338	$9,552

- The MHP's foster care AACB increased from 26 percent less than the statewide average in CY 2019 ($6,889 vs. $9,360) to 13 percent more than the statewide average in CY 2021 ($10,834 vs. $9,552).

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 3,041				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	125	4.1%	8	6	10.8%	14	8
Inpatient Admin	<11	-			0.4%	16	7
Psychiatric Health Facility	138	4.5%	11	7	1.0%	16	8
Residential	<11	-			0.3%	93	73
Crisis Residential	23	0.8%	24	18	1.9%	20	14
Per Minute Services							
Crisis Stabilization	213	7.0%	3,613	1,800	9.7%	1,463	1,200
Crisis Intervention	589	19.4%	259	165	11.1%	240	150
Medication Support	1,622	53.3%	222	171	60.4%	255	165
Mental Health Services	1,877	61.7%	622	275	62.9%	763	334
Targeted Case Management	1,041	34.2%	384	116	35.7%	377	128

- Merced had a notably lower percentage of beneficiaries served compared to statewide averages for inpatient and crisis residential intervention and a greater percentage of beneficiaries served in the following service categories: psychiatric health facility and crisis intervention.

Table 9: Services Delivered by the MHP to Youth in Foster Care

Service Category	MHP N = 220				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-			4.5%	13	8
Inpatient Admin	0	0%	0	0	<11	6	4
Psychiatric Health Facility	0	0%	0	0	0.2%	25	9
Residential	0	0%	0	0	<11	140	140
Crisis Residential	0	0%	0	0	0.1%	16	12
Full Day Intensive	0	0%	0	0	0.2%	452	360
Full Day Rehab	0	0%	0	0	0.4%	451	540
Per Minute Services							
Crisis Stabilization	<11	-			2.3%	1,354	1,200
Crisis Intervention	27	12.3%	251	150	6.7%	388	195
Medication Support	82	37.3%	266	210	28.5%	338	232
Therapeutic Behavioral Services	<11	-			3.8%	3,648	2,095
Therapeutic FC	0	0%	0	0	0.1%	1,056	585
Intensive Care Coordination	81	36.8%	345	156	38.6%	1,193	445
Intensive Home Based Services	32	14.5%	1,820	1,382	19.9%	1,996	1,146
Katie-A-Like	0	0%	0	0	0.2%	837	435
Mental Health Services	204	92.7%	1,289	521	95.7%	1,583	987
Targeted Case Management	134	60.9%	392	152	32.7%	308	114

- Merced foster youth had a notably greater percentage of beneficiaries served in the following service categories as compared to statewide utilization rates: crisis intervention, medication support, and targeted case management. Data is suppressed if the number of beneficiaries served is <11.

IMPACT OF ACCESS FINDINGS

- Merced MHP has put in place several initiatives to improve access to mental health services. It has developed a number of collaborative efforts with other agencies and community organizations to facilitate access and intake into the services.
- These efforts are yet to show positive results in terms of PR as an access measure. Two simultaneous developments have contributed to these challenges:
    - High staff turnover and vacancy rates have limited any growth in the number of beneficiaries served.
    - At the same time, the county has experienced a strong growth in the number of Medi-Cal beneficiaries.
- Two underserved or vulnerable populations have continued to have low or declining PRs that include the Latino/Hispanic and FC beneficiaries.

TIMELINESS OF CARE

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

Each Timeliness Component is comprised of individual subcomponents, which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Partially Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

Strengths and opportunities associated with the timeliness components identified above include:

- The MHP has started a school-based mobile crisis team for quick response to children and youth crisis episodes. CCRT provides crisis response for all age groups in the field.

- The Navigation and Engagement Team (NET) and Innovative Strategies Network (ISN) ensures timely follow-up services post-inpatient discharge. The MHP's current non-clinical PIP aims to improve the 7-day inpatient follow-up rates.
- The MHP's average timeliness for the first offered appointment is 12.2 days and longer than the 10-day standard. Less than 50 percent of these appointments meet the timeliness standard. For FC beneficiaries, the MHP meets the standard for less than a quarter of the new requests or referrals.
- The MHP has instituted an "all hands on deck" approach to improve its first offered appointment timeliness whereby clinicians outside of the intake pool and clinical supervisors have started offering intake appointments.
- Beneficiaries experience excessive delays in the initial psychiatry appointment and urgent care timeliness metrics. The MHP meets the standard for less than a third of the beneficiaries for each of these two metrics.
- The MHP has increased its telepsychiatry slots to address the delays in initial psychiatry appointments.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Counties are also expected to submit the source data used to prepare these calculations. This is particularly relevant to data validation for the additional statewide focused study on timeliness that BHC is conducting.

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented county-operated services. However, the MHP also provided additional worksheets detailing timeliness data for the contract providers.

Claims data for timely access to post-hospital care and readmissions are discussed in the Quality of Care section.

Table 11: FY 2021-22 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	12.2 Business Days	10 Business Days*	46%
First Non-Urgent Service Rendered	21.7 Business Days	10 Days**	49%
First Non-Urgent Psychiatry Appointment Offered	27 Business Days	15 Business Days*	30%
First Non-Urgent Psychiatry Service Rendered	34 Business Days	15 Days**	31%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	143.5 Hours	48 Hours**	40%
Follow-Up Appointments after Psychiatric Hospitalization	22 Days	7 Days**	48%
No-Show Rate – Psychiatry	17.53%	10%**	n/a
No-Show Rate – Clinicians	9.34%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-2022			

Figure 12: Wait Times to First Service and First Psychiatry Service

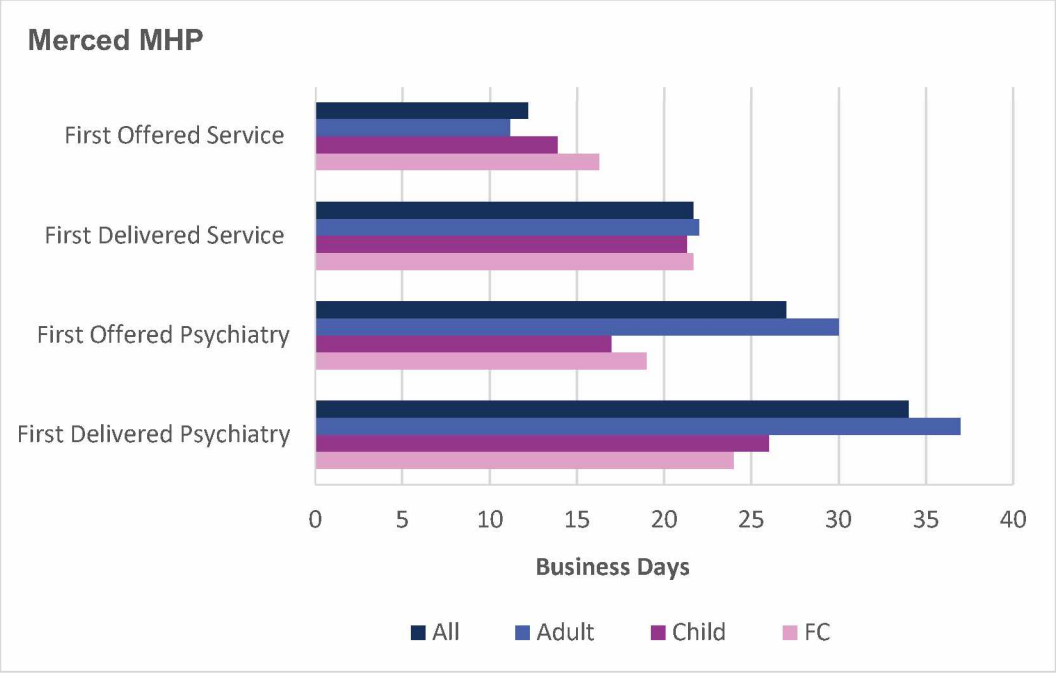


Figure 13: Wait Times for Urgent Services

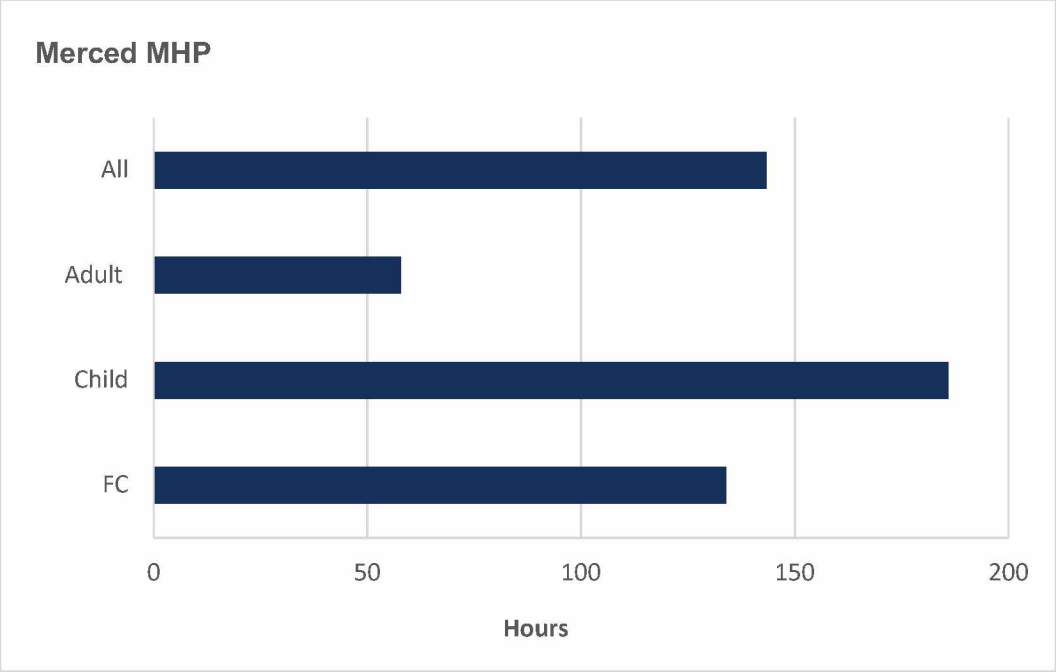
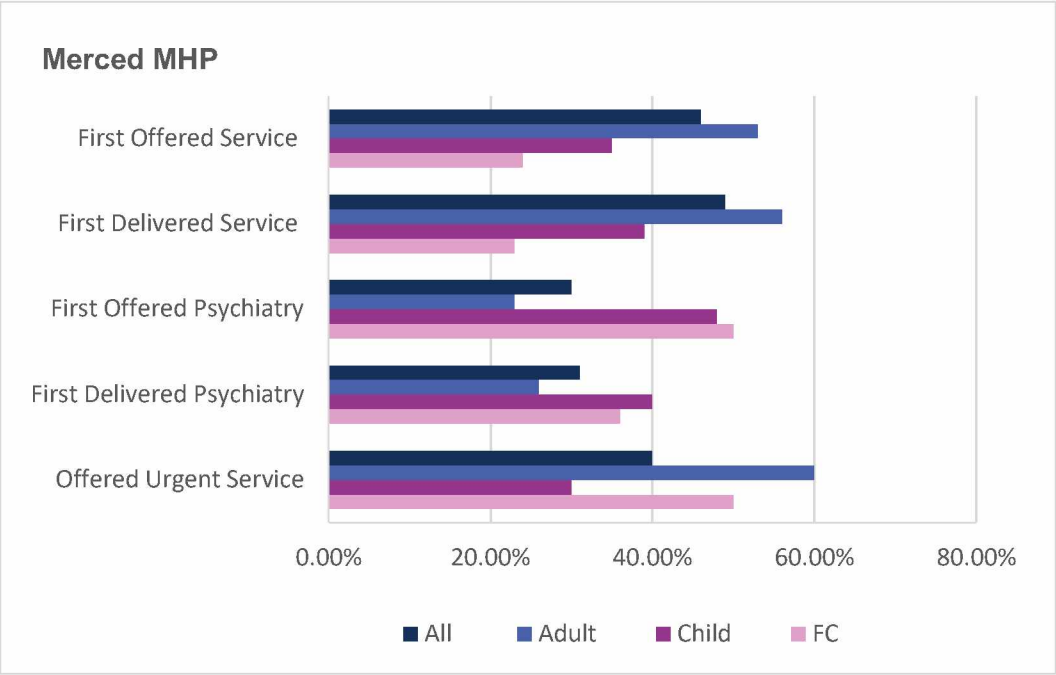


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments in most cases.
- Definitions of "urgent services" vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined "urgent services" for purposes of the ATA as those provided to avoid psychiatric emergencies or hospitalization. There were reportedly 15 urgent service requests with a reported actual wait time for services for the overall population at 143.5 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access timeliness from the point of first clinical determination of need.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked for both clinicians and psychiatrists. The MHP reports a no-show rate of 9.3 percent for clinicians and 17.5 percent for psychiatrists.

IMPACT OF TIMELINESS FINDINGS

- Excessive delays in initial psychiatry appointments and urgent care services call into question whether the MHP needs to take further remedial actions in addition to the steps it has already taken.
- A high no-show rate for psychiatry appointments provides an opportunity for the MHP to utilize any last-minute availability through higher number of offered appointments per day.
- Further, the urgent care timeliness metric listed a very low number of beneficiaries for whom the metric was reported. This calls into question to what extent the MHP is classifying urgent requests as crisis episodes. The PM data (Table 8) shows that the MHP provided crisis intervention at a 75 percent higher rate than the statewide average. Although classifying these as crises ensures quick response time, this metric may be reported for only those who experience significant delays.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, and the intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI Program for the services furnished to beneficiaries. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN THE MHP

In the MHP, the responsibility for QI is with the Quality and Performance Management (QPM) division. In addition to QI, QPM is also responsible for quality assurance and utilization management activities. The MHP supports the activities of QPM through planned communication of its findings to different units within the agency as well as to outside stakeholders including the Behavioral Health Board (BHB).

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of the MHP leadership, beneficiaries and family members, BHB members, community service providers, wellness center consumer advisory board members, and the patients' rights advocate, is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met three times. In addition, the QAPI listed 16 subcommittees and workgroups whose work informs the QI plan and evaluation. These subcommittees and workgroups meet at varying frequencies throughout the year. Of the 17 identified FY 2021-22 QAPI workplan goals, the MHP met or partially met 71 percent of the goals. The timeliness goals were adversely impacted by serious staffing shortage in the past two years.

The MHP utilizes the following level of care (LOC) tools: Child and Adolescent Needs and Strengths (CANS), 35-item Pediatric Symptoms Checklist (PSC-35) and Adult Needs and Strengths Assessment (ANSA).

The MHP utilizes the following outcomes tools: CANS, PSC-35, Pediatric ACES (Adverse Childhood Experiences) and Related Life Events Screener (PEARLS), Child PTSD (Post-Traumatic Stress Disorders) Symptoms Scale (CPSS-V), and ANSA.

The MHP produces reports on the LOC tools at individual level in spreadsheet or dashboard format. It expects to be able to summarize the LOC tools at the system level once the new EHR becomes operational. The MHP has instituted PEARLS for all child intakes to capture ACES and use CPSS-V as needed based on the PEARLS findings as part of its clinical PIP.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

Each Quality Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

Strengths and opportunities associated with the quality components identified above include:

- The MHP's QI plan goals are data-driven. QPM division produces numerous data reports and summaries including those on timeliness, access, beneficiary satisfaction, and outcomes to inform the management, the QIC, and other stakeholders.
- The QIC has representation from all levels of the system including beneficiaries, BHB members, community service agencies, and wellness center representatives. The QIC meeting is open to all.
- In the past year, communication between the management and various stakeholders has improved. The previous director instituted a "coffee with the director" session that was open to all line staff and supervisors. In addition, the

MHP conducted several focus groups with staff from county and contracted programs.

- The MHP has a robust peer support specialist (PSS) and mental health worker (MHW) workforce. While the PSS job classification requires lived experience and MHW does not, many MHWs have lived experience.
- The wellness centers including one specifically for the TAY youth provide important adjunct services and are well attended since their reopening after COVID-19.
- During the past two years, staff turnover and shortage have been a contributing factor to issues with access, timeliness, and quality of care. Change in telepsychiatrists and clinical line staff has been disruptive to continuity of care and had negatively impacted beneficiary experience. The MHP has utilized the MHWs and PSSs to the extent possible to provide navigation and service linkage during this ongoing staff shortage.
- The MHP tracks the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): 85.7 percent.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): The MHP stated that it tracks this measure but did not provide the findings in the medication monitoring report.
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): 0 percent of a very small count of FC beneficiaries who were on antipsychotics had blood glucose or cholesterol tests recorded.
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): 50 percent.

QUALITY PERFORMANCE MEASURES

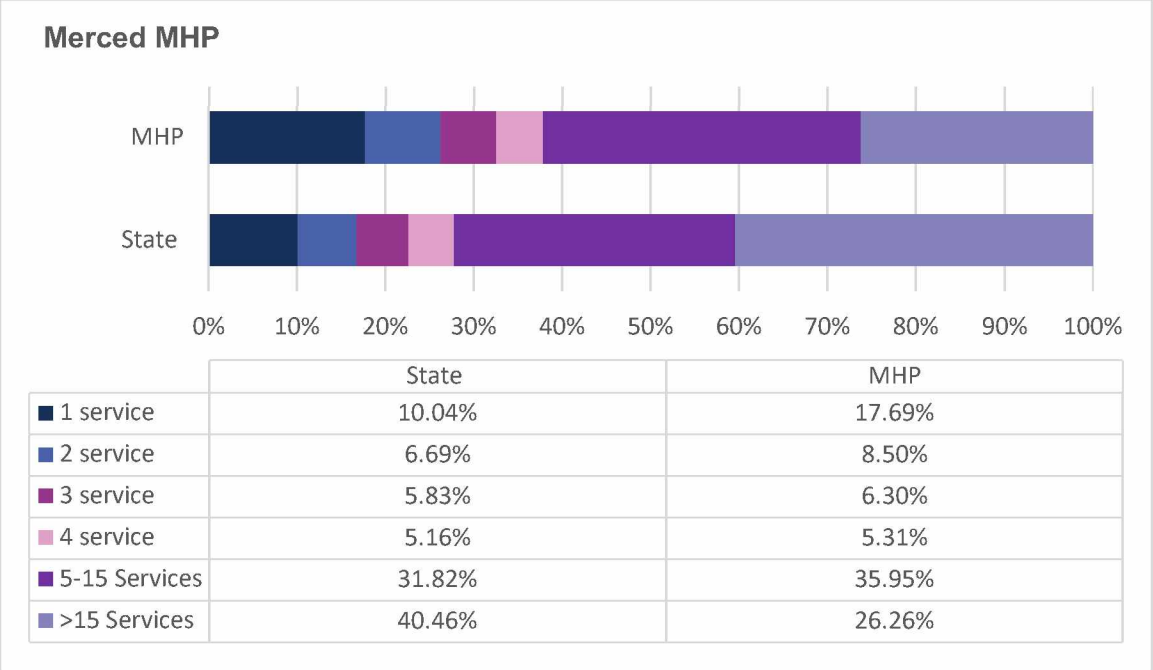
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented in the approved claims:

- Retention in Services
- Diagnosis of Beneficiaries Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Beneficiaries (HCB)

Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries served by the MHP to require 5 or more services during a 12-month period. However, this table does not account for the length of stay, as individuals enter and exit care throughout the 12-month period.

Figure 15: Retention of Beneficiaries CY 2021



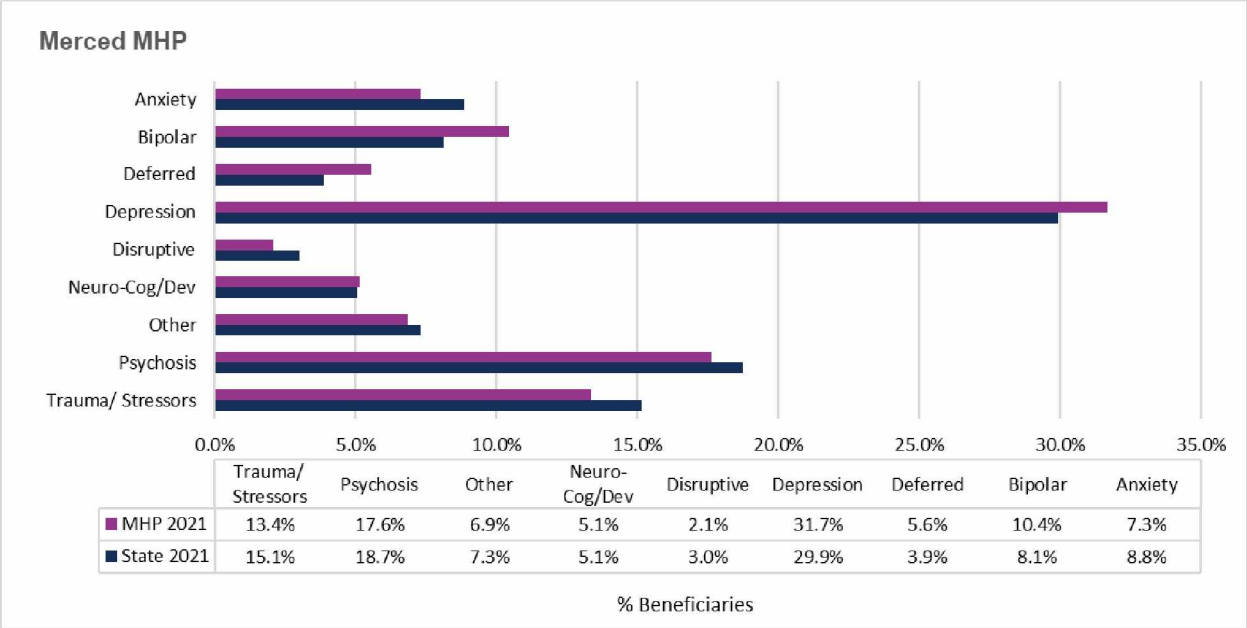
	State	MHP
1 service	10.04%	17.69%
2 service	6.69%	8.50%
3 service	5.83%	6.30%
4 service	5.16%	5.31%
5-15 Services	31.82%	35.95%
>15 Services	40.46%	26.26%

- In CY 2021, the MHP had 70 percent higher number of beneficiaries who received only one service. Conversely, the MHP had 35 percent less beneficiaries who received more than 15 services. The other service frequency categories had comparable percentages.

Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

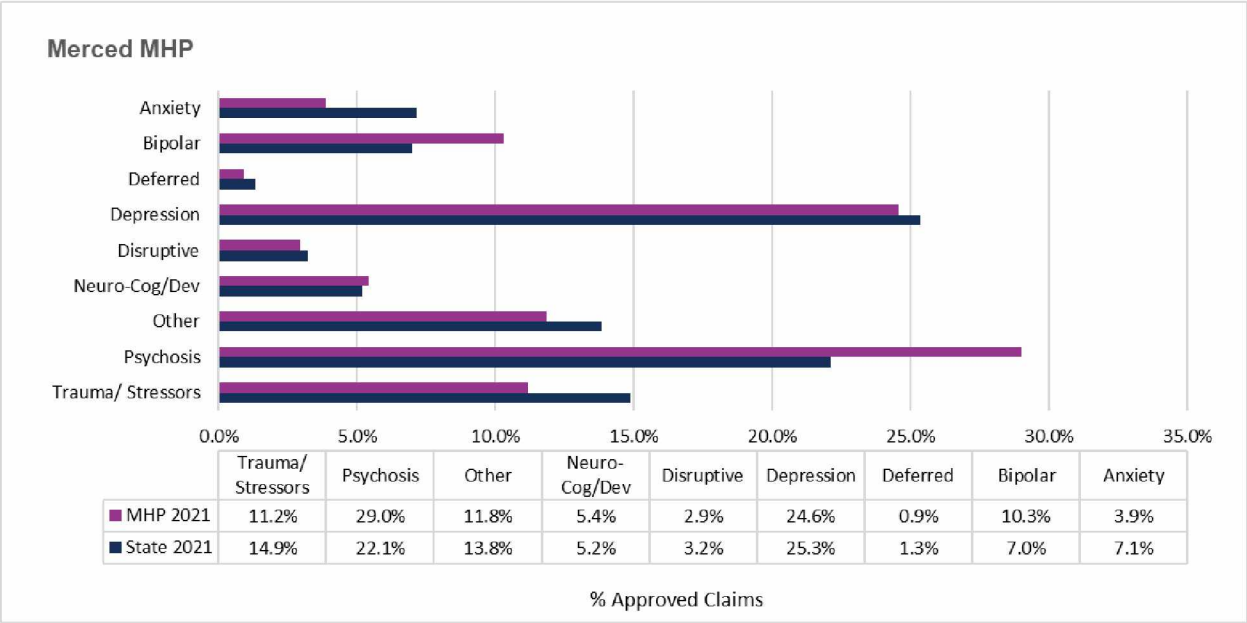
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	13.4%	17.6%	6.9%	5.1%	2.1%	31.7%	5.6%	10.4%	7.3%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- In CY 2021, the distribution of the MHP's diagnostic categories closely mirrored the statewide distribution.

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	11.2%	29.0%	11.8%	5.4%	2.9%	24.6%	0.9%	10.3%	3.9%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- Although the diagnostic distribution was similar to statewide, the AACBs for psychosis and bipolar disorders were considerably higher than the corresponding statewide AACBs.

- The AACBs for anxiety and trauma/stressors-related disorders were correspondingly lower than statewide.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay (LOS).

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	423	834	8.69	8.79	$19,203	$12,052	$8,122,745
CY 2020	386	710	9.28	8.68	$21,517	$11,814	$8,305,650
CY 2019	445	831	7.86	7.80	$16,060	$10,535	$7,146,824

- The MHP had more beneficiaries hospitalized in CY 2021 than the previous year, but it was lower than CY 2019.
- Although the average LOS is similar to the statewide average, the AACB for the MHP was 59 percent higher than statewide indicating most likely higher unit rates.

Follow-Up Post Hospital Discharge and Readmission Rates

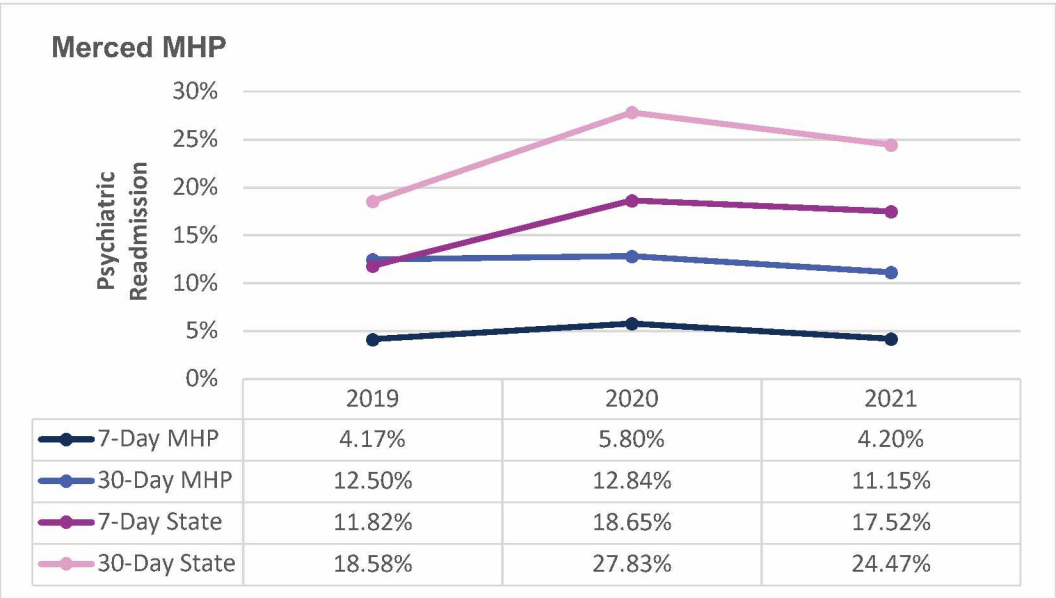
The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2021 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis.

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21

	2019	2020	2021
7-Day MHP	49.43%	51.97%	45.16%
30-Day MHP	70.45%	69.57%	65.08%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	4.17%	5.80%	4.20%
30-Day MHP	12.50%	12.84%	11.15%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The MHP's 7-day follow-up rate post-inpatient discharge was similar to statewide, but its 30-day follow-up rate was 10.4 percent higher than the state. The MHP's reported rates for FY 2021-22 closely match CalEQRO's CY 2021 rates for both 7- and 30-day follow-up.
- The 7- and 30-day rehospitalization rates for the MHP were significantly lower than the corresponding statewide rates. The 7-day rehospitalization was less than a quarter of the state, and the 30-day rate was less than half that of the state.

- Improving the 7-day follow-up rate post-inpatient discharge is the topic of the MHP's non-clinical PIP.

High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCBs may disproportionately occupy treatment slots that may prevent access to levels of care by other beneficiaries. HCB percentage of total claims, when compared with the HCB count percentage, provides a subset of the beneficiary population that warrants close utilization review, both for appropriateness of level of care and expected outcomes.

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the statewide overall AACB is $6,496, the median amount is just $2,928.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $3,779 and median of $2,256.

Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	3.46%	28.46%	$1,007,853,748	$53,476	$43,231
MHP	CY 2021	251	5.87%	48.07%	$16,352,062	$65,148	$53,986
	CY 2020	237	5.36%	46.35%	$15,529,262	$65,524	$55,304
	CY 2019	152	3.15%	36.65%	$8,381,976	$55,145	$44,883

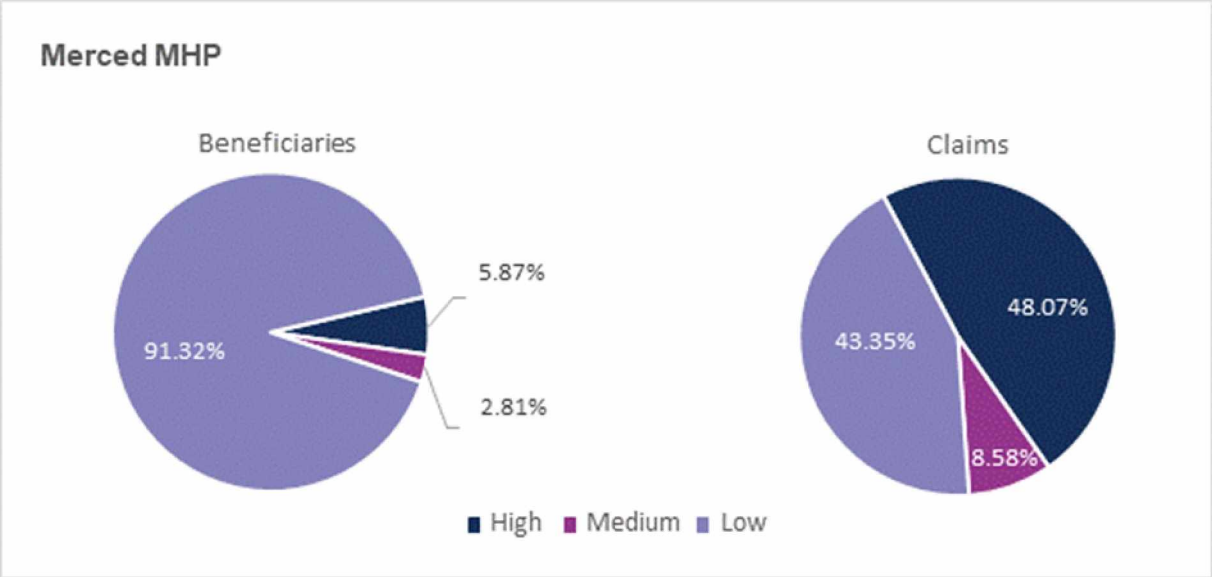
- During CY 2019-21, the MHP's percentage of HCBs has increased as well as the volume of claims that HCBs account for. In CY 2021, the MHP's HCB percentage and claim volume percentages were 70 percent higher than statewide. The increase in the MHP's HCB claims was concurrent with its increase in AACB.

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
MHP Med. Cost ($20K to $30K)	120	2.81%	8.58%	$2,918,208	$24,318	$24,165
MHP Low Cost (Less than $20K)	3,902	91.32%	43.35%	$14,744,473	$3,779	$2,256

- More than 91 percent of the MHP's beneficiaries fall in the low-cost category with an average AACB of $3,779. This is only 5.8 percent of the AACB of $65,148 for the HCBs.

Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021



- Less than six percent of the beneficiaries accounted for nearly half of the MHP's total claims.

IMPACT OF QUALITY FINDINGS

- A major strength of the MHP lies in its data analytical capabilities and the reports the QPM produces. While the findings are not always positive, especially in the timeliness metrics, regular tracking of these metrics and evaluation of its QI actions to address any issues keep them in the forefront and allow the MHP to continually refine its remedial actions.

- Although staff shortages have been a challenge for the MHP at a time of significant changes taking place due to the implementation of CalAIM, the MHP reported being on-time for all CalAIM requirements including no wrong door policy, access criteria, standardized assessment, problem lists, and targeted case management care plan.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.caleqro.com.

Validation tools for each PIP are located in Attachment C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Trauma Identification and Treatment

Date Started: 06/2021

Date Completed: N/A

Aim Statement: By the end of 2023, will the following interventions:

1. Universal screening of ACES using PEARLS.
2. Application of CPSS-V to measure trauma severity.
3. Use of short-term interventions, including Community Resiliency Model (CRM) training and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

(a) increase recognition of child and adolescent traumatic stress upon intake from an improbably low rate of 14 percent to a more likely rate of 28 percent (a 100 percent increase) and

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[2] https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf

[3] https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf

(b) increase the proportion of children and adolescents who demonstrate a reduction in traumatic stress between their two most recent assessments from 22 percent - 35 percent (a 60 percent increase)?

Target Population: Children and youth 6-20 years of age.

Status of PIP: The MHP's clinical PIP is in the baseline year.

Summary

This PIP has a two-fold aim of improving the detection rate of ACES and resulting trauma, and then using CRM and TF-CBT to reduce the severity of trauma symptoms. The MHP used peer review study findings to set its phase 1 goal for improving the detection rate of moderate to very severe trauma-related stress to 28 percent. In phase 2, using the interventions above, the MHP is trying to reduce the trauma scores. Part of the interventions include thorough training of the staff involved in detecting and treating trauma in the universal screening ACES, CRM, and TF-CBT.

The MHP started with CANS as the primary tool for identifying trauma among the PIP population. In its phase 1 findings, it showed a 20-percent improvement in the trauma detection rate. However, it has found CPSS-V to be a more sensitive tool to detect trauma and moving to make CPSS-V to be the primary measurement instrument. At the time of the review. First remeasurement post-intervention was in progress at the time of the review.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: It is a well-designed PIP; however, no post-intervention results are available yet to assess the success of the PIP. While the CANS results show that the trauma detection rate is improving, it is far from the target set by the MHP and will take longer to accomplish the goal.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this clinical PIP including:

- Since the MHP has found CPSS-V to be a more reliable measure and implementing its use, another PIP variable specifically with CPSS-V needs to be added to determine the PIP's success.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Improving the 7-day follow-up rate post-inpatient discharge.

Date Started: 07/2021

Date Completed: 06/2023 (expected)

Aim Statement: By improving communications between hospitals and the outpatient system of care and establishing a twice-weekly post-hospitalization outpatient clinic, Behavioral Health and Rehabilitation Services (BHRS) will increase the percentage of adult beneficiaries who receive follow-up care within 7 days of psychiatric hospital discharge—from a FY 20-21 baseline of 36 percent to a national standard of 46 percent—and increase the percentage who have 7-day medication management follow-ups—from 10 percent to 30 percent—by the second quarter of 2023.

Target Population: Adult beneficiaries aged 21 and over who are discharged from a psychiatric hospital.

Status of PIP: The MHP's non-clinical PIP is in the second remeasurement phase.

Summary

This PIP aims to improve the MHP's 7-day post-inpatient follow-up rate from 36 percent to a national standard of 46 percent and improve the medication management follow-up rate from 10 to 30 percent. In order to achieve its goals, the MHP identified improving communication processes with the discharging hospitals, pre-discharge contacts using the NET and ISN, and establishing a twice-weekly post-hospitalization outpatient clinic that can provide assessment of urgent needs, care coordination, and medication management bridge support.

The results from the second remeasurement show slight improvements in the 7-day follow-up rates, but it is not statistically significant. In contrast, the MHP accomplished significant improvements in the medication support follow-up rates. The MHP has conducted more analyses of the reasons why the regular follow-up rates may not have yet accomplished the goal. For the past year, email communication lagged behind and the follow-up appointments had been affected by COVID-19. The MHP was not certain if there were communication emails that may not have been tracked.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: Although this PIP has not produced the intended results yet, the MHP has tracked the results and conducted significance tests rigorously.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this non-clinical PIP including:

- This PIP would benefit from adding another indicator tracking the 30-day post-discharge follow-up rate. This will determine the success of the PIP for those beneficiaries whose follow-up time falls outside of the 7-day window.

INFORMATION SYSTEMS

Using the Information Systems Capabilities Assessment protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the MHP's EHR, Information Technology (IT), claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an ASP where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner Community Behavioral Health (CCBH), which has been in use for 12 years. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 3.6 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency, County IT. The current year's budget of 3.6 percent is a reduction from 4.11 percent reported in the previous year. The higher budget in the previous year was due to the costs associated with the addition of a clinic.

The MHP has 513 named users with log-on authority to the EHR, including approximately 373 county staff and 140 contractor staff. Support for the users is provided by 2.5 full-time equivalent (FTE) IS technology positions. Currently, all positions are filled.

As of the FY 2022-23 EQR, most contract providers have access to directly enter clinical data into the MHP's EHR. However, while most contract providers have system access, most contract providers have chosen to continue to utilize and maintain their own EHRs and not utilize CCBH. Contractor staff having direct access to and utilizing the MHP's EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	57%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	41%
Paper documents delivered to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	2%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not have a PHR. This functionality is expected to be implemented within the next two years.

Interoperability Support

The MHP is a member or participant in the San Joaquin Health Information Exchange (SJHIE) with a staff on the Board of Directors. SJHIE participants include San Joaquin County, Stanislaus County, Merced County, San Joaquin General Hospital, Golden Valley Health Centers, Community Medical Centers (CMC), Health Net, and the Health Plan of San Joaquin. Healthcare professional staff also use secure information exchange directly with service partners through secure email. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

Each IS Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 17: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Partially Met
4C	Integrity of Medi-Cal Claims Process	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Met

Strengths and opportunities associated with the IS components identified above include:

- The CCBH system is hosted by the MHP with Cerner having access to the system. Kings View operationally supports the system with the implementation of upgrades and patches.
- While most contract providers have full access to CCBH, they have chosen to utilize and maintain individual EHRs and not utilize CCBH. In addition, while 57 percent of providers enter services directly into CCBH, 41 percent email/fax service data, and 2 percent hand deliver service data to the MHP. This increases MHP staff time required for service entry into CCBH.
- The Credible system from Qualifacts is expected to be implemented April 1, 2023. The cloud-based system will be hosted by Qualifacts and operationally supported by Kings View. To enhance timeliness to service reporting, the access log will be implemented in the Credible system.
- Internal analytic support to BHRS is provided by 15 FTEs with additional analytic support provided by Praxis Associates (1.5 FTEs), Intrepid Ascent (1.1 FTEs) and Kings View (one FTE)
- Security training is included in the employee onboarding process. Email security tips and warnings, in the event of an identified risk, are utilized to maintain and enhance staff security knowledge. Bitdefender software is to detect and rapidly respond to cyber-attacks.
- There is an Operations Continuity Plan for critical business functions that maintained in readiness for use in the event of a cyber-attack, disaster, or other emergency and it is reviewed annually.
- The MHP does not maintain a data warehouse that replicates the CCBH system to support data analytics.
- The MHP's CY 2021 denied claims rate of 3.58 percent exceeds the CY 2021 statewide average of 2.78 percent. Sixty five percent of claim denials were due to two denial reasons: claim/service lacks information which is needed for adjudication and Medicare Part B or other health coverage must be billed prior to the submission of this claim.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

For the MHP, it appears that significant claims lag begins in November and likely represents approximately $4,000,000 in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through December 2022.

Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	6,019	$3,220,500	$94,569	2.94%	$3,125,931
Feb	5,819	$3,362,668	$159,076	4.73%	$3,203,592
Mar	6,981	$4,260,684	$115,200	2.70%	$4,145,484
April	6,612	$3,831,775	$152,703	3.99%	$3,679,072
May	7,172	$3,886,068	$123,970	3.19%	$3,762,098
June	7,634	$4,014,025	$205,349	5.12%	$3,808,676
July	6,882	$2,332,496	$79,101	3.39%	$2,253,395
Aug	7,035	$2,394,169	$80,250	3.35%	$2,313,919
Sept	6,700	$2,058,415	$65,136	3.16%	$1,993,279
Oct	6,254	$2,148,119	$54,221	2.52%	$2,093,898
Nov	35	$15,726	$0	0.00%	$15,726
Dec	0	$0	$0	0.00%	$0
Total	**67,143**	**$31,524,643**	**$1,129,575**	**3.58%**	**$30,395,068**

- It was reported the MHP did not experience a delay in claiming during CY 2021. Therefore, Table 18 may reflect an incomplete claims data set for November to December 2021.

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	584	$507,956	44.97%
Medicare Part B or Other Health Coverage must be billed before submission of claim	933	$228,736	20.25%
Beneficiary not eligible or non-covered charges	105	$217,855	19.29%
NPI related	225	$169,245	14.98%
Service line is a duplicate and a repeat service procedure code modifier not present	[redacted]		
Other			
Total Denied Claims	**1,870**	**$1,129,574**	**100.00%**
Overall Denied Claims Rate	**3.58%**		
Statewide Overall Denied Claims Rate	**2.78%**		

- Claims with denial codes claim/service lacks information which is needed for adjudication, Medicare Part B or other health coverage must be billed prior to the submission of this claim and NPI related are generally rebillable within State guidelines upon successful remediation of the reason for denial.
- The claim denial rate for CY 2021 of 3.58 percent is higher than the statewide average of 2.78 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The support provided by the operation of Credible in an ASP environment, with Qualifacts hosting the system and Kings View providing additional operational support, is a strength for the MHP.
- Without contractor provider use of the MHPs EHR, a significant amount of beneficiary health information is maintained in disparate electronic health records which limits 24/7 access to a beneficiary's complete health information. In addition, the disaster recovery and operations continuity plans for individual contract provider EHR systems are not standardized which may provide varied access times to beneficiary data in the event of a disaster or data compromising event.
- While the MHP has developed robust analytic capacity, the absence of a database that mirrors the CCBH system has prevented full use of this capacity for internal data extraction and reporting.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of beneficiaries: adult, older adult, youth, and family members. MHPs administer these surveys to beneficiaries receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS and provides a comprehensive analysis in the annual statewide aggregate report.

The MHP uses the CPS data to evaluate beneficiary satisfaction and sets goals in its annual QI plan. The findings are presented to several internal committees, as well as to other stakeholders including the Board of Supervisors.

CONSUMER FAMILY MEMBER FOCUS GROUPS

Consumer and family member (CFM) focus groups are an important component of the CalEQRO review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-review planning process, CalEQRO requested two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held by videoconference and included 15 participants; no language interpreter was used for this focus group. All consumers participating receive clinical services from the MHP.

The participants who started receiving services from the MHP in the past 12 months described delays of up to 2 months to get a therapist and psychiatrist appointments. However, once the services started, all beneficiaries reported having benefitted from the services and according to some of the participants, the quality of care exceeded their expectations – "they give me a better quality of life. I don't have to struggle." Most beneficiaries reported receiving reminder calls for appointments.

Although psychiatry appointments take long to get, the participants noted that the MHP always ensures that their medications are refilled promptly between appointments. The participants also noted that they receive transportation for appointments and wellness center visits. All participants except one reported that they go to the wellness center.

Very few of the participants are enrolled in any vocational or job training. A few of them had heard about the options from another beneficiary, but not directly from the MHP or the wellness center. The beneficiaries who have looked for housing options did not have a good experience with the housing staff.

Recommendations from focus group participants included:

- Increase timely access to appointments with psychiatrists.
- Hire more clinicians.
- Restore wellness centers back to services that were available before Covid-19.
- Need a new crisis unit. ("Do not want to be shipped out of county.")

Consumer Family Member Focus Group Two

CalEQRO requested a group of parents and caregivers of child beneficiaries who initiated services in the preceding 12 months. The focus group was held by videoconference and included [redacted]; a Spanish language interpreter was used for this focus group. All family members participating have a family member who receives clinical services from the MHP.

All participants reported that their children have been receiving services for more than year. They highlighted staff turnover and resulting service disruptions to be very hard on their children. The participants described services provided by their mental health workers to be very good. The Spanish-speaking parents felt rudely treated by the front desk staff. They reported a lack of understanding and compassion among the front desk staff.

Recommendations from focus group participants included:

- Parents wanted support in understanding their child's behavior. "They need to contact me and give me directions."
- Provide guidance to the parents and caregivers on how to receive services themselves. They were open to it but thought that their doctor had to refer them.
- Communicate with the family and improve front office communication to provide a welcoming and compassionate feeling.
- Would like the sessions back at the school (only happened once) so the children do not have to be pulled out and miss time out of school.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

According to the CPS findings that the MHP presented in its FY 2021-22 QI plan evaluation, it exceeded the goals in all three domains of access, timeliness, and quality. While the participants in the focus group validated their satisfaction with the quality of care that they had received, both the adult and parents' group participants reported

delays in access to therapists and psychiatrists. The parents' group participants also noted a lack of welcome at the front desk.

Much of the delays in access can be attributed to the staff turnover that the MHP experienced in the past two years. Parents' focus group participants noted this and reported that for children, change in therapists can be very disruptive. As suggested by the parents, the MHP may consider expanding its school-based services that can at least facilitate better attendance at school and for therapy sessions.

The adult focus group participants heavily utilize the wellness center and appreciate the transportation services they receive from the MHP. The MHP may consider greater availability of information on training and job opportunities as most participants appeared unfamiliar with such.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP has developed a strong QI structure with emphasis on data analysis, reporting, and data-driven decision making. (Quality)
2. The MHP has established a culturally competent system of care focusing on cultural humility, justice, and equity. (Access, Quality)
3. There are a number of peer support and mental health worker positions for individuals with lived experience that enhances the services and make them more recovery-oriented. (Quality)
4. The newly created Justice and Community Integration Division has enabled the MHP to bring more coordinated efforts to provide behavioral health care to the justice and law enforcement involved beneficiaries. (Access)
5. In the past year, the MHP has strengthened its crisis response capacity to provide more timely and mobile response to crisis episodes. (Access)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP's first offered psychiatry appointments can take over a month. (Timeliness)
2. The MHP reported a time period of six days on average to address urgent requests for service based on a very low number of requests. The reporting of this data appears to have methodological flaws. (Timeliness)
3. The MHP is unable to utilize its data analytic capabilities fully due to the lack of a database or data warehouse system with its EHR. (IS)
4. The MHP's Latino/Hispanic PR continues to be much lower than the statewide average. The results of the MHP's efforts in addressing this issue are not evidenced in the available data at this time. (Access)
5. Despite the MHP's strengths in promoting cultural humility, equity, and justice, the Spanish-speaking beneficiaries and family members reported negative experience at the front desk. (Access)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the MHP in its QI efforts and ultimately to improve beneficiary outcomes:

1. Monitor any impact of increasing the telehealth capacity for psychiatry on initial psychiatry appointment timeliness at least on a monthly basis and develop or refine strategies as needed to meet the 15-day standard. (Timeliness)

   (This recommendation is a carry-over from FY 2021-22.)

2. Investigate the methodology of tracking urgent appointments and strategies to meet the urgent appointment timeliness standards. (Timeliness)

   (This recommendation is a carry-over from FY 2021-22.)

3. To fully access the increased data that will be available in the Credible system and to increase in-house analytic and reporting capacity, develop a database that mirrors the Credible system. (IS)

4. Continue efforts to improve access to services for Latino/Hispanic beneficiaries and monitor barriers to access through specific beneficiary surveys tailored to this need. (Access)

   (This recommendation is a carry-over from FY 2021-22.)

5. Train front desk staff in creating a welcoming environment for Spanish-speaking beneficiaries. Utilize the existing available cultural competency committee expertise to develop such training for the front desk staff. (Access)

EXTERNAL QUALITY REVIEW BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

There were no barriers to this FY 2022-23 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT F: PM Data CY 2021 Refresh

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Merced MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Satisfaction
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Consumer and Family Member Focus Groups
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision

CalEQRO Review Sessions – Merced MHP
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Forensics and Law Enforcement Group Interview
Community-Based Services Agencies Group Interview
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Saumitra SenGupta, PhD, Lead Quality Reviewer
Lisa Farrell, Lead IS Reviewer
Diane Mintz, Lead CFM Reviewer
Brian Deen, IS Reviewer
Arden Tucker, CFM Reviewer

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-review and the post-review meetings and in preparing the recommendations within this report.

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Anaya	Yanira	Mental Health Clinician	BHRS
Azevedo	Maria	Staff Services Analyst	BHRS
Baptista	Pinky	Mental Health Clinician	BHRS
Barboza	Clovia	Staff Services Analyst	BHRS
Belan	Kate	Mental Health Clinician	BHRS
Bettencourt	Nicole	Program Manager	BHRS
Bolser	Daniel	Staff Services Analyst	BHRS
Bonson	Tyler	Automation Services Manager	BHRS
Castaneda	Cresencio	SUD Counselor	BHRS
Caza-Burdick	Lidia	Division Director	BHRS
Chang	Kit	Program Manager	BHRS
Cornish	Whitney	Mental Health Clinician	BHRS
Danipour	Charlotte	Mental Health Clinician	BHRS
Davis	Tara	Medical Records Supervisor	BHRS
Doradea	Jaime	Mental Health Clinician	BHRS
Dunlap	Genevieve	SUD Counselor	BHRS
Dupont	Christina	Staff Services Analyst	BHRS
Eslinger	Lila	Program Manager	BHRS
Espino	Amy	Mental Health Worker	BHRS
Espinoza	Dee Dee	AOD Prevention Worker	BHRS

Last Name	First Name	Position	County or Contracted Agency
Gallacher	Veronica	Division Director	BHRS
Garibaldi	Michelle	Division Director	BHRS
Green	Joni	Mental Health Director	Aspiranet
Guzman	Francisco	Mental Health Clinician	BRHS
Hall	Maranda	Director of Emergency Services	Mercy Medical Center
Hall	Victoria	Program Manager	BHRS
Haygood	Caitlin	Staff Services Analyst	BHRS
Hernandez	Tabatha	Director of Services	CSMA
Herrington	Jessica	Program Director	Aspiranet
Hickman	Tammy	Dual Diagnosis Specialist	BHRS
Hintz	Melyssa	Staff Services Analyst	BHRS
Johnson	Jennifer	Coordinator of Student and Family Support	Hilmar Unified School District
Jones	Sharon	MHSA Coordinator	BHRS
Kaur	Manjit	Program Manager	BHRS
Keegan	Lori	Mental Health Clinician	BHRS
Lara	Elisa	SUD Counselor	BHRS
Lockerby	Christine	Staff Services Analyst	BHRS
Malough	Samantha	Executive Director	Aegis
Mata	Kristen	Mental Health Clinician	BHRS

Last Name	First Name	Position	County or Contracted Agency
Mendonca	Sharon	Assistant Director	BHRS
McMullen	Rebecca	Division Director	Aspiranet
Murillo	Nancy	Program Director	Aspiranet
Newman	Jason	SUD Counselor	BHRS
Newman	Lori	Executive Director	CSMA
Noble	Roslynn	Program Manager	BHRS
Olvera	Maria	Program Coordinator	BHRS
Orellana	Alyssa	AOD Counselor	BHRS
Orozco	Patricia	Program Manager	BHRS
Parker	Sabrina	Chief Public Guardian	BHRS
Patino	Raymond	SUD Counselor	BHRS
Pulido	Liliana	Mental Health Clinician	BHRS
Reed	Matthew	Division Director	BHRS
Rodriguez	Maria	Staff Services Analyst	BHRS
Rupp	Cara	Program Manager	BHRS
Ryland	Tony	Program Manager	BHRS
Saechao	Sandlin	Deputy Probation Officer	BHRS
Saavadra	Socorro	Program Administrator	Merced County Human Services Agency
Servin	Leticia	Mental Health Clinician	BHRS

Last Name	First Name	Position	County or Contracted Agency
Shaw	Jennifer	Officer	Merced Police Department
Smyth	Lanetta	Division Director	BHRS
Sorisho	Carmen	Mental Health Clinician	BHRS
Susskind	Jennifer	Project Manager	Praxis Associates
Tapia	Iohana	Program Manager	BHRS
Walters	Carolyn	Program Manager	BHRS
Xiong	May-Ci	Program Manager	BHRS
Yang	Nancy	Program Manager	Aspiranet
Yarbrough	Dr. John	Medical Director	BHRS
Zhang	Yiguo	Staff Services Analyst	BHRS

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	It is a well-designed PIP; however, no post-intervention results are available yet to assess the success of the PIP. While the CANS results show that the trauma detection rate is improving, it is far from the target set by the MHP and will take longer to accomplish the goal.

General PIP Information
MHP/DMC-ODS Name: Merced MHP
PIP Title: Trauma Identification and Treatment
PIP Aim Statement: By the end of 2023, will the following interventions: Universal screening of ACES using PEARLS. Application of CPSS-V to measure trauma severity. Use of short-term interventions, including Community Resiliency Model (CRM) training and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). a. increase recognition of child and adolescent traumatic stress upon intake from an improbably low rate of 14 percent to a more likely rate of 28 percent (a 100 percent increase) and b. increase the proportion of children and adolescents who demonstrate a reduction in traumatic stress between their two most recent assessments from 22 percent - 35 percent (a 60 percent increase)?
Date Started: 06/2021
Date Completed: N/A

General PIP Information
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: Children and youth 6-20 years of age.
Target population description, such as specific diagnosis (please specify): Children with trauma history and related symptoms.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1) Improving the detection rate of ACES and resulting trauma. 2) Reducing the trauma scores.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Training in assessment of ACES using PEARLS and trauma severity using CPSS-V and CANS.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): N/A

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of children who are identified has having moderate, severe, or very severe trauma (score a 2+ on CANS or a 31+ on CPSS-5)	FY 2020-21	N=574 13.9%	☐ Not applicable—PIP is in planning or implementation phase, results not available	N=358 16.8% (Based only on CANS scores)	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Percentage of children with actionable trauma (score a 2+ on CANSA or a 31+ on CPSS-5) who demonstrate a reduction in trauma scores	FY 2020-21	N=76 22% (CANS only)	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year

☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP: • Since the MHP has found CPSS-V to be a more reliable measure and implementing its use, another PIP variable specifically with CPSS-V needs to be added to determine the PIP's success.

Non-Clinical PIP

Table C2: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	Although this PIP has not produced the intended results yet, the MHP has tracked the results and conducted significance tests rigorously.
General PIP Information	
MHP/DMC-ODS Name: Merced MHP	
PIP Title: Improving the 7-day follow-up rate post-inpatient discharge	
PIP Aim Statement: By improving communications between hospitals and the outpatient system of care and establishing a twice-weekly post-hospitalization outpatient clinic, BHRS will increase the percentage of adult beneficiaries who receive follow-up care within 7 days of psychiatric hospital discharge—from a FY 20-21 baseline of 36 percent to a national standard of 46 percent—and increase the percentage who have 7-day medication management follow-ups—from 10 percent to 30 percent—by the second quarter of 2023.	
Date Started: 07/2021	
Date Completed: 06/2023 (expected)	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: 21 and over.	

Target population description, such as specific diagnosis (please specify): Adult beneficiaries aged 21 and over who are discharged from a psychiatric hospital.

Improvement Strategies or Interventions (Changes in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):

N/A

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):

N/A

MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):

1) Marie Green Psychiatric Center's communication with the adult system of care outpatient support team. 2) Notification of out-of-county hospitalizations, 3a) NET pre-discharge contact with hospitalized beneficiaries, 3b) ISN pre-discharge contact with hospitalized beneficiaries who are deemed hard-to-reach or homeless, 4) Post-hospitalization clinic.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
7-day follow-up rate	FY 2020-21	672 36%	FY 2022-23 (Quarter1)	179 42%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
7-day follow-up rate for medications	FY 2020-21	672 10%	FY 2022-23 (Quarter1)	179 27%	☒ Yes ☒ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • This PIP would benefit from adding another indicator tracking the 30-day post-discharge follow-up rate. This will determine the success of the PIP for those beneficiaries whose follow-up time falls outside of the 7-day window.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, and PIP Validation Tool, are available on the CalEQRO website.

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required to be included in this report.

ATTACHMENT F: PM DATA CY 2021 REFRESH

At the time of the MHP's review, the data set used for the PMs was incomplete for CY 2021. Across the state, most of the approved claims data November and December 2021 was not included in the original data used for this report.

CalEQRO obtained a refreshed data set for CY2021 in January 2023. The PM data with the refreshed data set follows in this Attachment.

BHC | Behavioral Health Concepts, Inc

Merced MHP Performance Measures

REFRESHED

FY22-23

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	146,632	4,670	3.18%	$39,009,799	$8,353
CY 2020	135,916	4,422	3.25%	$33,506,647	$7,577
CY 2019	132,391	4,822	3.64%	$22,872,006	$4,743

*Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	18,547	69	0.37%	1.08%	1.96%
Ages 6-17	41,423	1,306	3.15%	4.41%	5.93%
Ages 18-20	8,842	271	3.06%	3.73%	4.41%
Ages 21-64	67,442	2,842	4.21%	4.11%	4.56%
Ages 65+	10,379	182	1.75%	2.26%	1.95%
Total	**146,632**	**4,670**	**3.18%**	**3.67%**	**4.34%**

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	504	10.79%
Threshold language source: Open Data per BHIN 20-070		

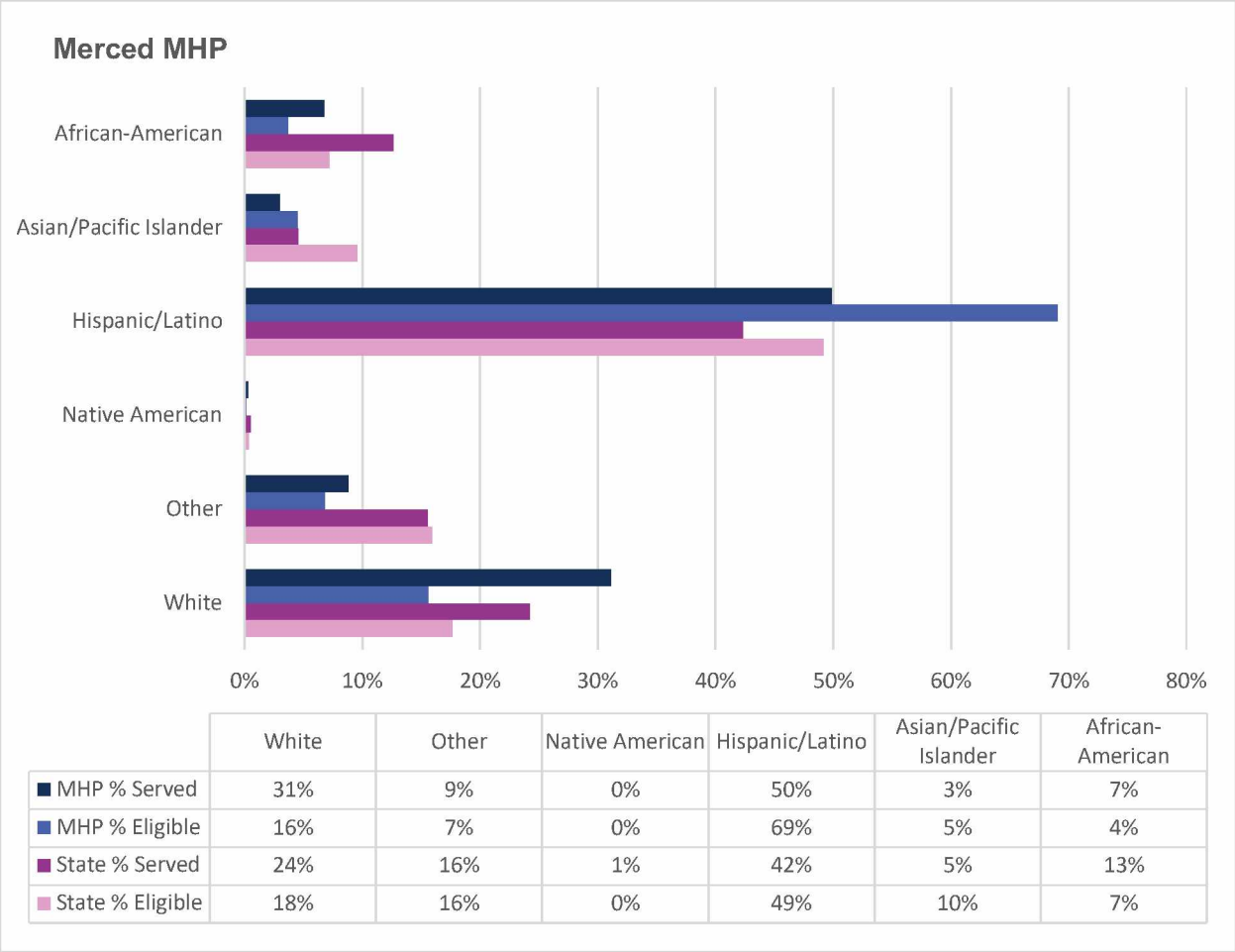
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	36,859	1,247	3.38%	$7,924,685	$6,355
Medium	613,796	20,261	3.30%	$151,430,714	$7,474
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

Table 7: PR Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	5,468	318	5.82%	7.64%
Asian/Pacific Islander	6,669	141	2.11%	2.08%
Hispanic/Latino	101,318	2,330	2.30%	3.74%
Native American	270	15	5.56%	6.33%
Other	10,018	412	4.11%	4.25%
White	22,890	1,454	6.35%	5.96%
Total	**146,633**	**4,670**	**3.18%**	**4.34%**

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	31%	9%	0%	50%	3%	7%
MHP % Eligible	16%	7%	0%	69%	5%	4%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

Figure 2: MHP PR by Race/Ethnicity CY 2019-21

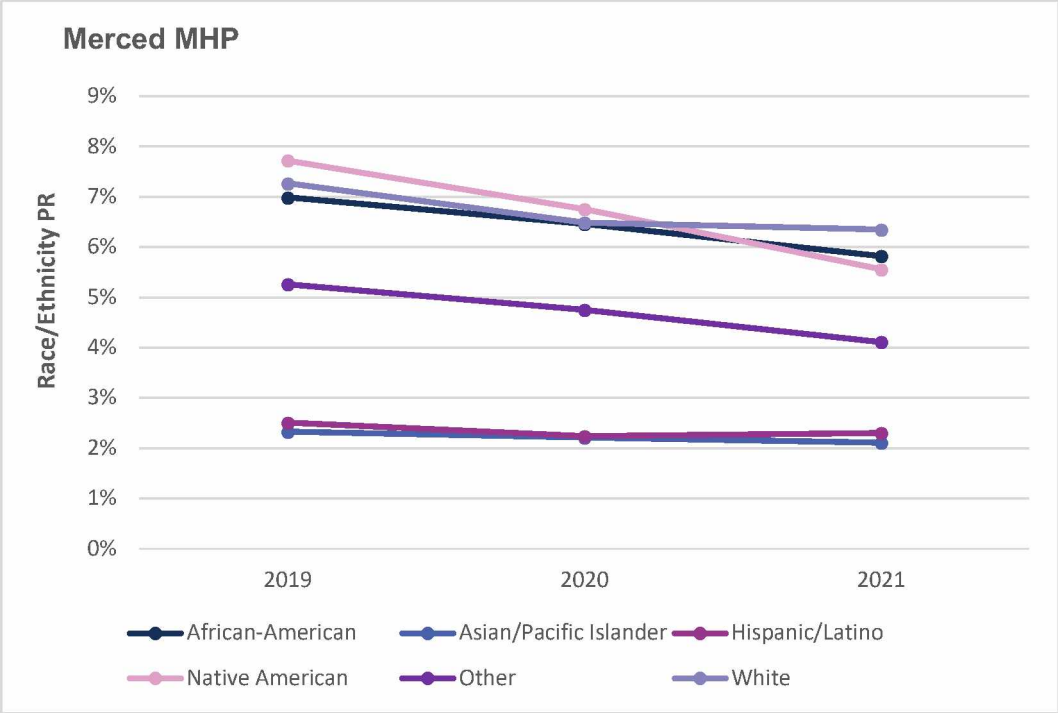


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

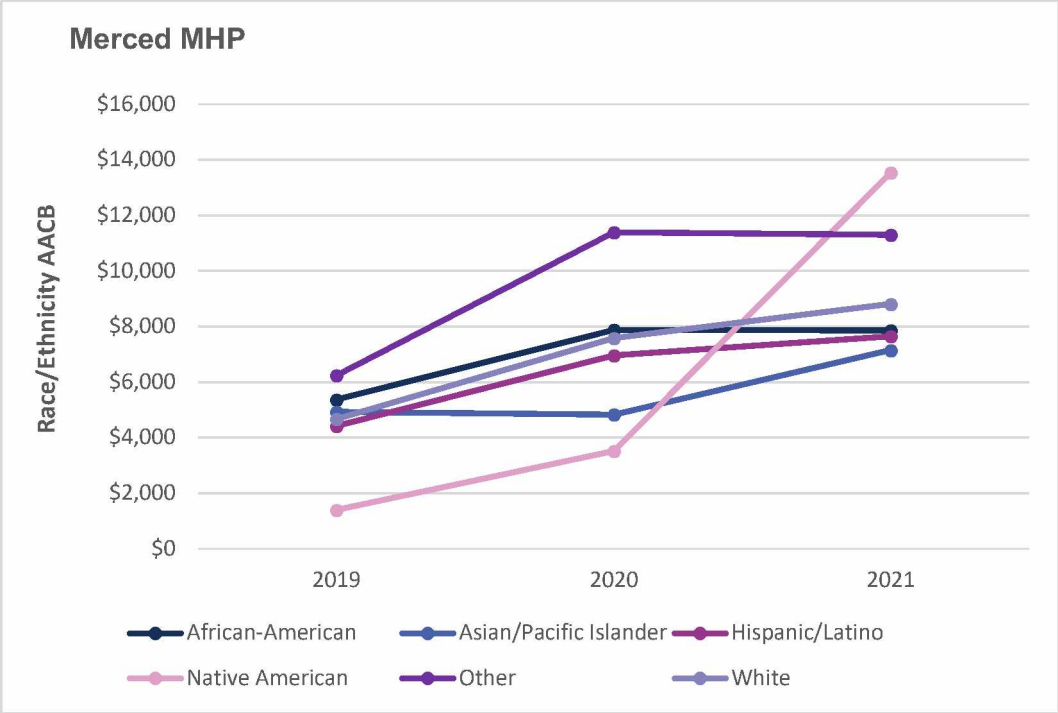
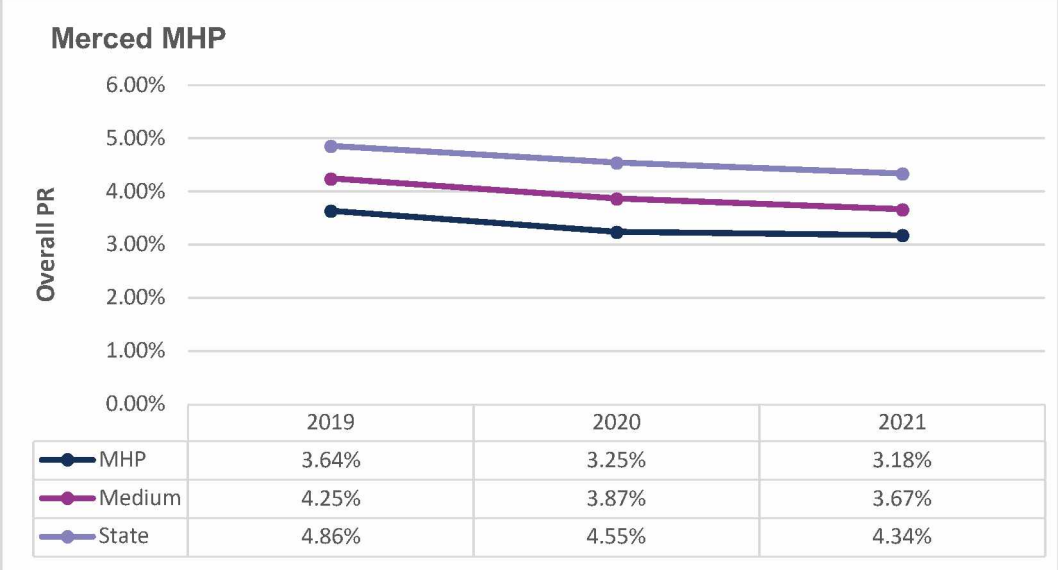
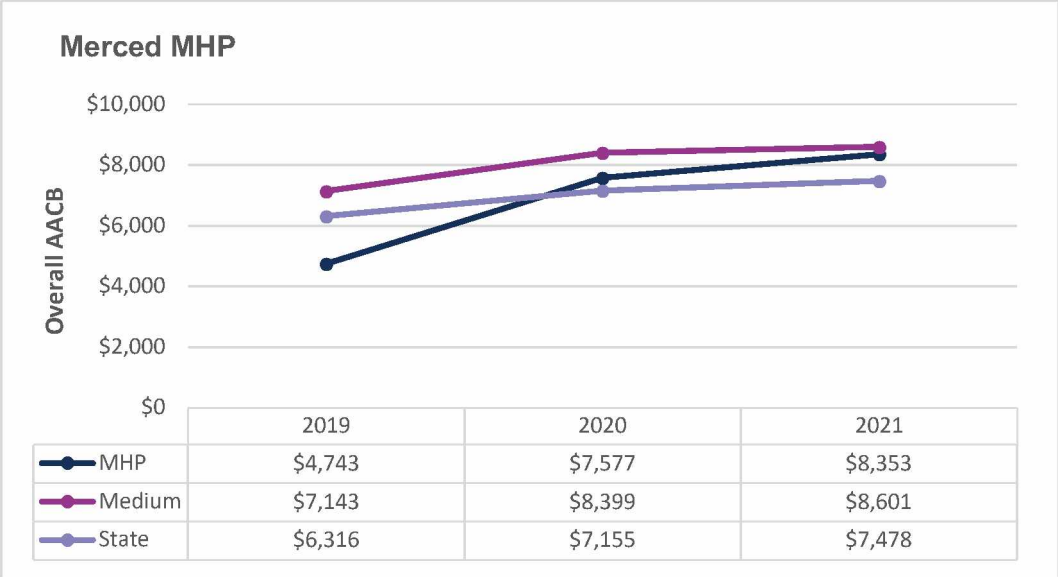


Figure 4: Overall PR CY 2019-21



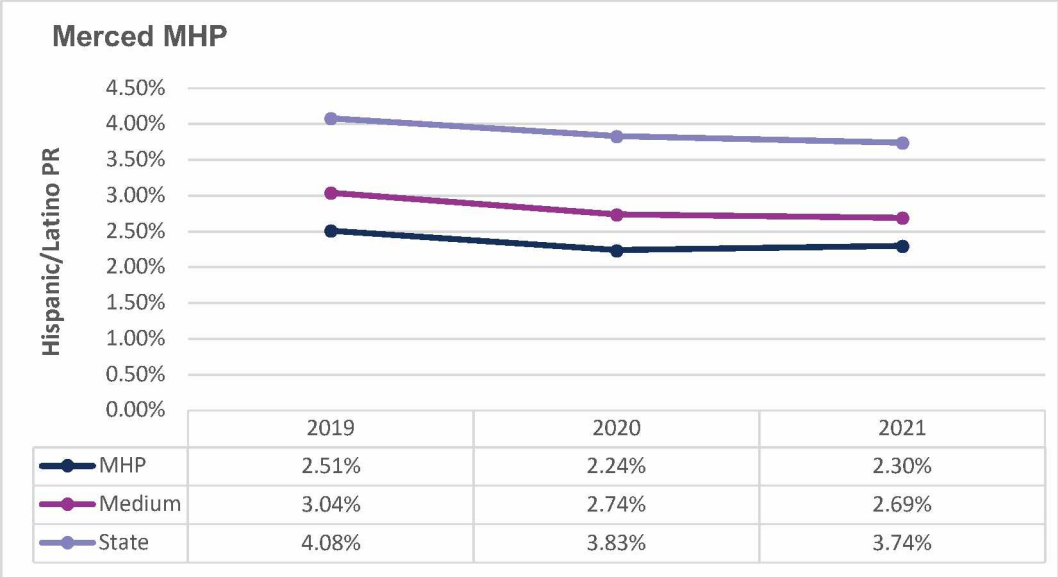
	2019	2020	2021
MHP	3.64%	3.25%	3.18%
Medium	4.25%	3.87%	3.67%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,743	$7,577	$8,353
Medium	$7,143	$8,399	$8,601
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21

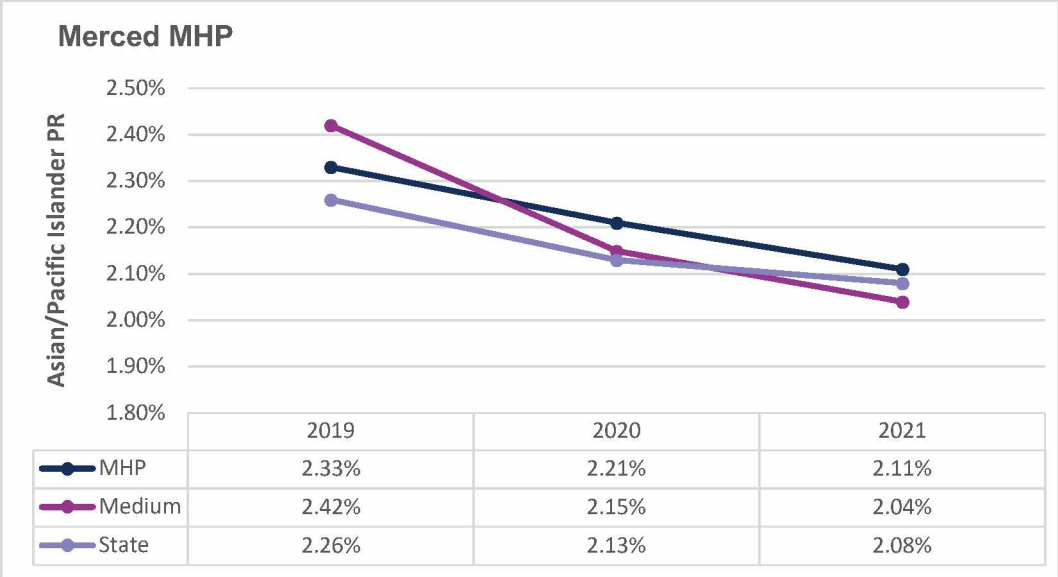


	2019	2020	2021
MHP	2.51%	2.24%	2.30%
Medium	3.04%	2.74%	2.69%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21

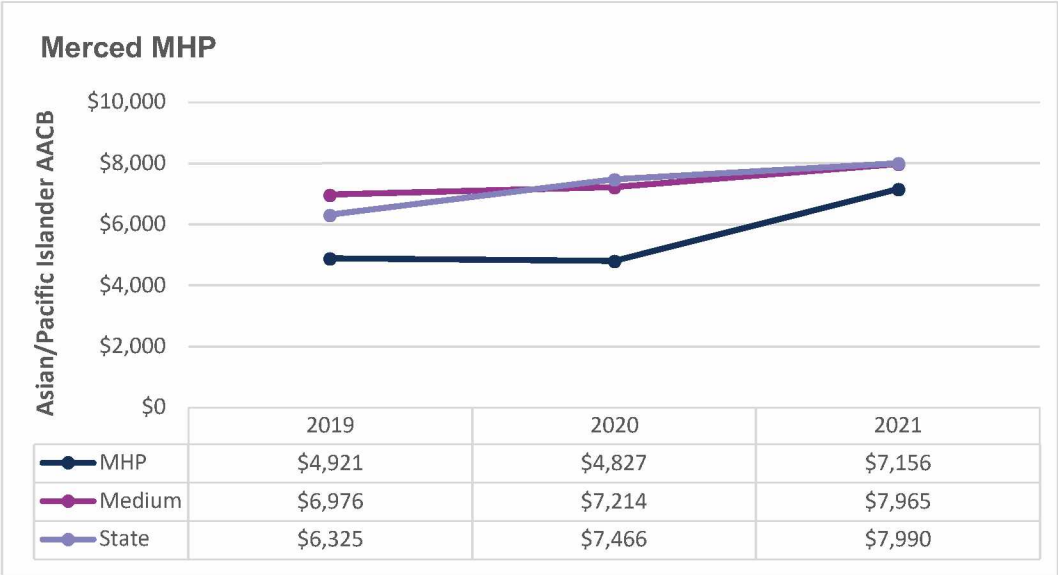
	2019	2020	2021
MHP	$4,422	$6,950	$7,649
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.33%	2.21%	2.11%
Medium	2.42%	2.15%	2.04%
State	2.26%	2.13%	2.08%

Figure 9: Asian/Pacific Islander AACB CY 2019-2021

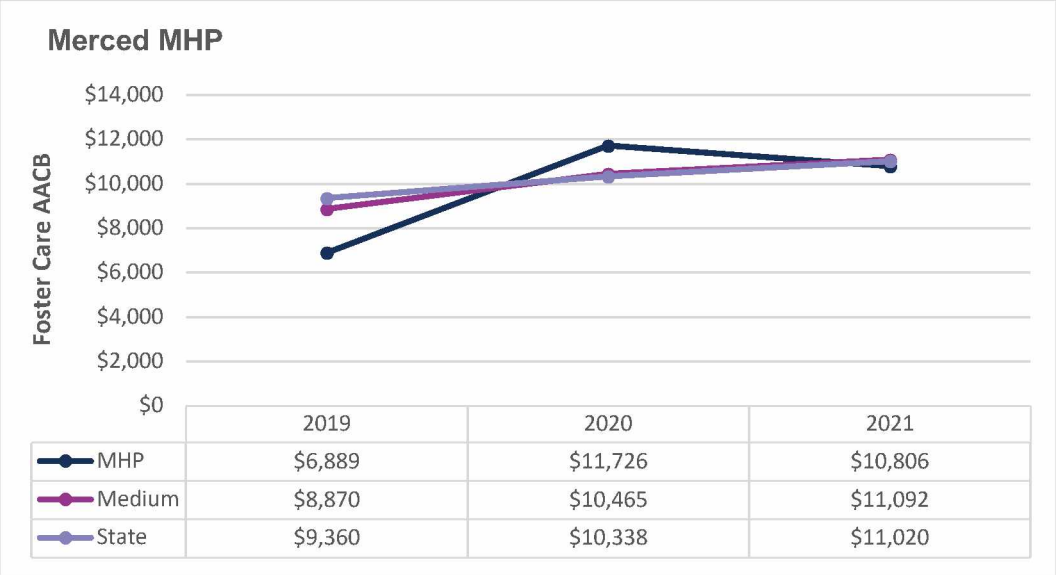


	2019	2020	2021
MHP	$4,921	$4,827	$7,156
Medium	$6,976	$7,214	$7,965
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21

	2019	2020	2021
MHP	35.62%	30.58%	29.55%
Medium	50.12%	46.59%	45.62%
State	51.91%	51.00%	49.15%

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$6,889	$11,726	$10,806
Medium	$8,870	$10,465	$11,092
State	$9,360	$10,338	$11,020

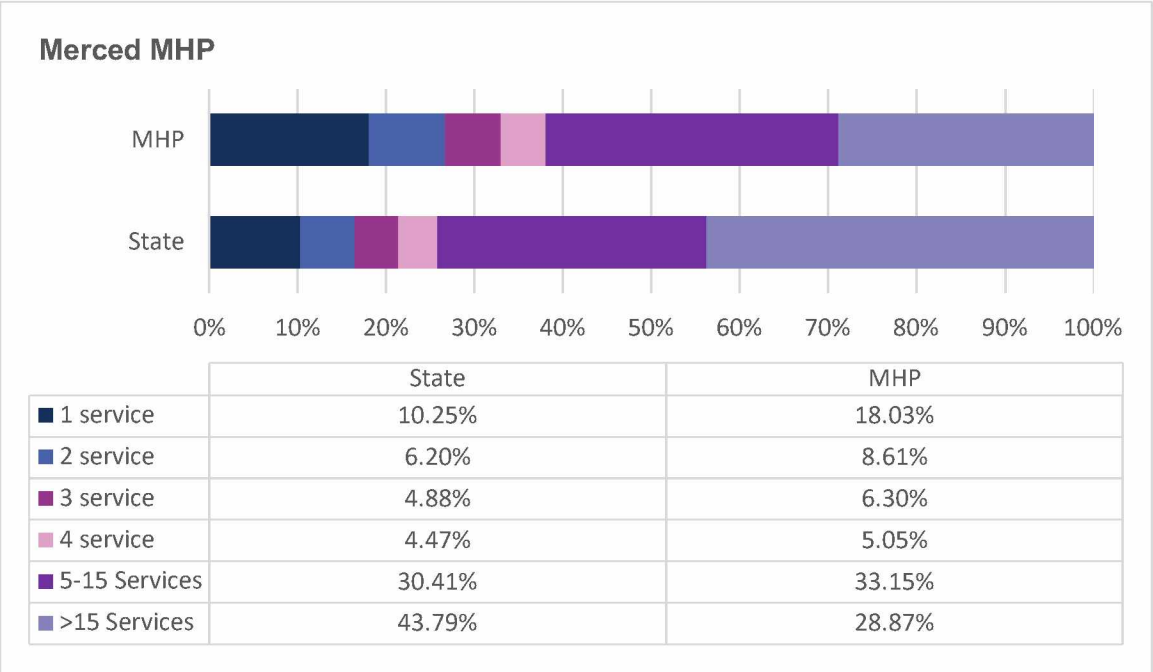
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 3,295				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	128	3.9%	8	6	11.6%	16	8
Inpatient Admin	<11	-			0.5%	23	7
Psychiatric Health Facility	168	5.1%	12	8	1.3%	15	7
Residential	<11	-			0.4%	107	79
Crisis Residential	38	1.2%	28	21	2.2%	21	14
Per Minute Services							
Crisis Stabilization	227	6.9%	3,570	1,920	13.0%	1,546	1,200
Crisis Intervention	681	20.7%	261	165	12.8%	248	150
Medication Support	1,733	52.6%	246	190	60.1%	311	204
Mental Health Services	2,072	62.9%	689	286	65.1%	868	353
Targeted Case Management	1,171	35.5%	426	117	36.5%	434	137

Table 9: Services Delivered by the MHP to Youth in Foster Care

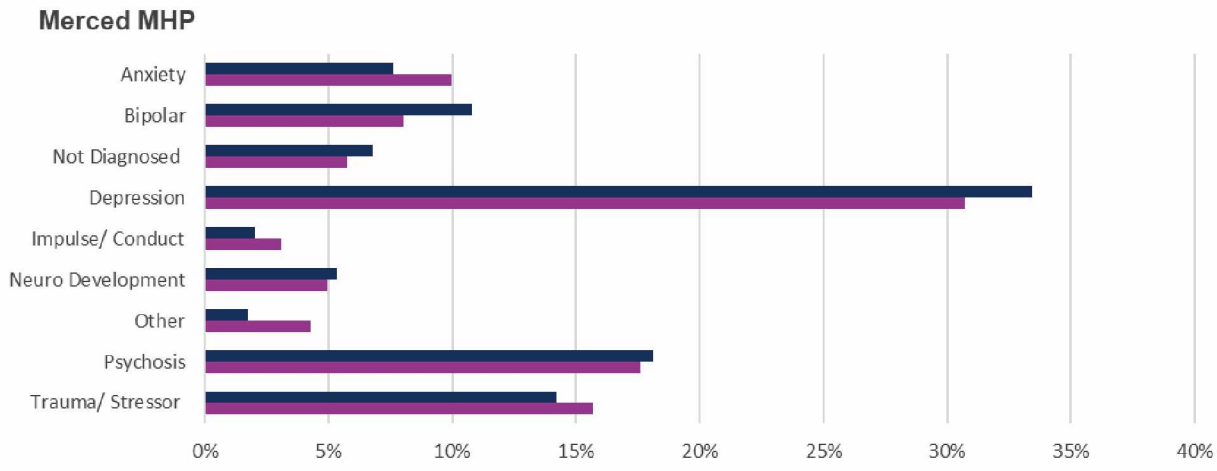
Service Category	MHP N = 253				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-			4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-			3.1%	1,404	1,200
Crisis Intervention	30	11.9%	272	152	7.5%	406	199
Medication Support	87	34.4%	311	246	28.2%	396	273
TBS	<11	-			4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	87	34.4%	387	190	40.2%	1,354	473
Intensive Home Based Services	40	15.8%	1,590	837	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	232	91.7%	1,384	566	96.3%	1,854	1,108
Targeted Case Management	155	61.3%	449	150	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	18.03%
2 service	6.20%	8.61%
3 service	4.88%	6.30%
4 service	4.47%	5.05%
5-15 Services	30.41%	33.15%
>15 Services	43.79%	28.87%

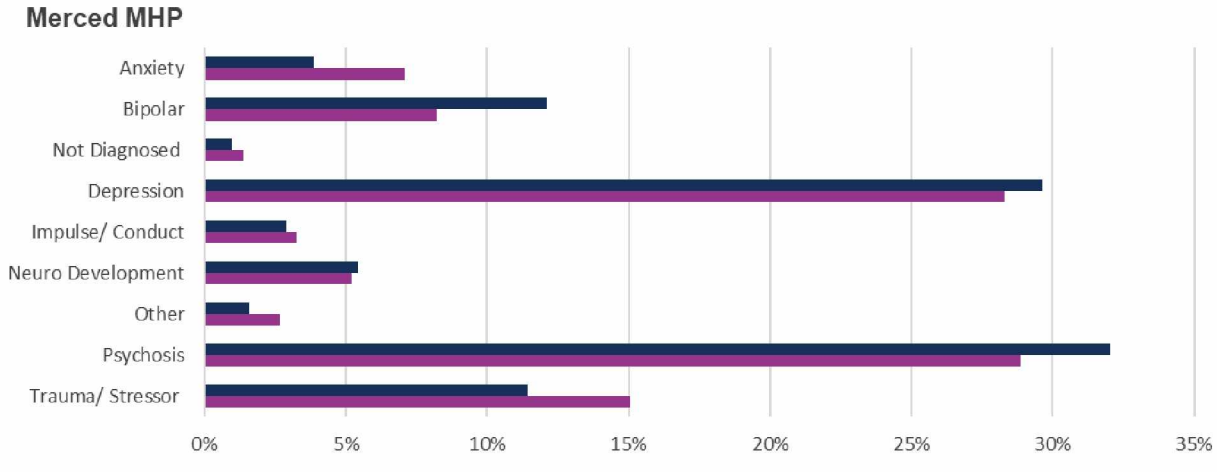
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	18%	2%	5%	2%	33%	7%	11%	8%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Percent Beneficiaries

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



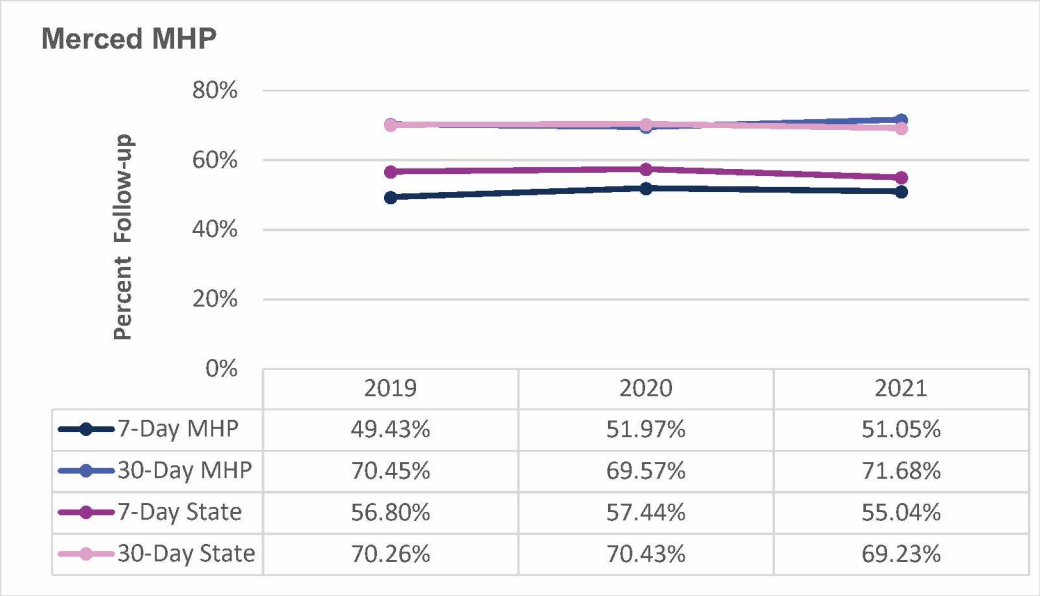
	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	11%	32%	2%	5%	3%	30%	1%	12%	4%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Percent Claims

Table 13: Psychiatric Inpatient Utilization CY 2019-21

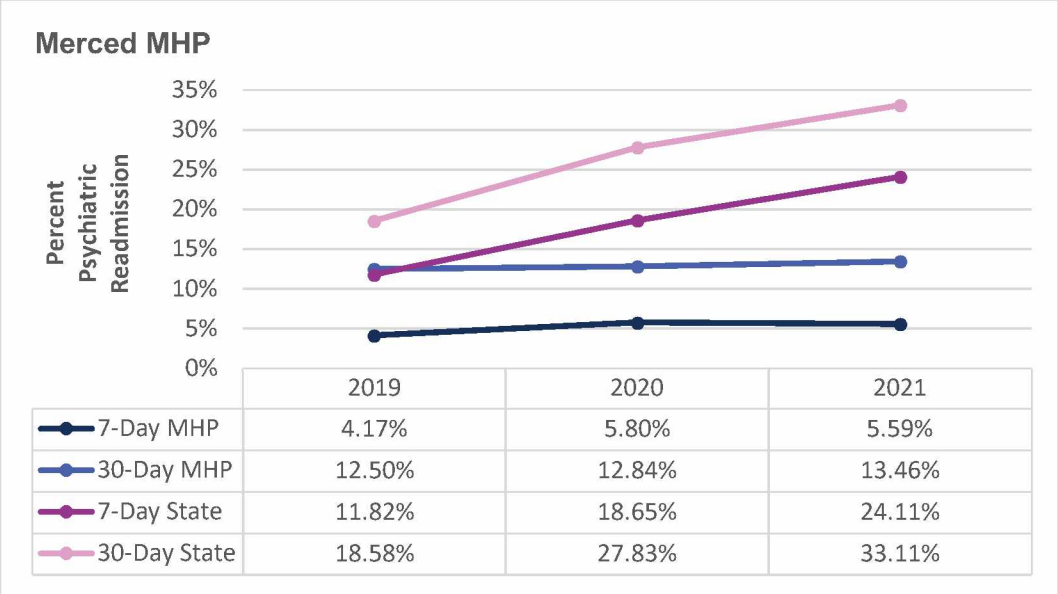
Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	462	928	9.09	8.86	$20,322	$12,052	$9,388,556
CY 2020	386	710	9.28	8.68	$21,517	$11,814	$8,305,650
CY 2019	445	831	7.86	7.80	$16,060	$10,535	$7,146,824

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	49.43%	51.97%	51.05%
30-Day MHP	70.45%	69.57%	71.68%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	4.17%	5.80%	5.59%
30-Day MHP	12.50%	12.84%	13.46%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	283	6.06%	49.36%	$19,255,443	$68,040	$57,047
	CY 2020	237	5.36%	46.35%	$15,529,262	$65,524	$55,304
	CY 2019	152	3.15%	36.65%	$8,381,976	$55,145	$44,883

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	148	3.17%	9.31%	$3,631,069	$24,534	$24,613
Low Cost (Less than $20K)	4,239	90.77%	41.33%	$16,123,287	$3,804	$2,209

Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021

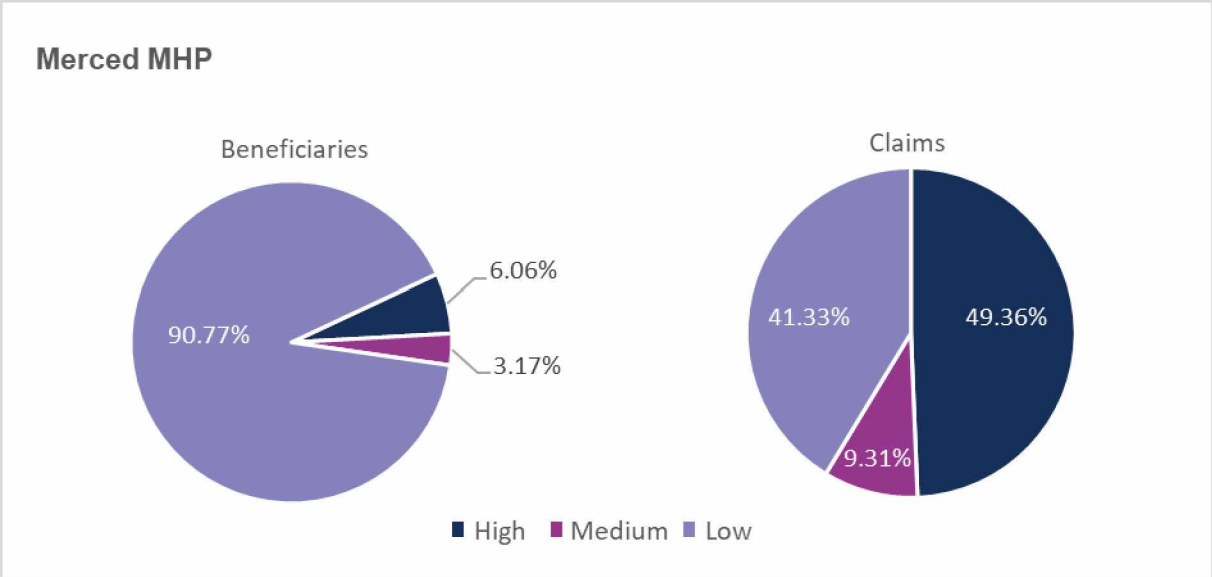


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan					
Feb					
Mar					
April					
May					
June					
July					
Aug					
Sept					
Oct					
Nov	6,495	$2,169,749	$49,071	2.26%	$2,095,686
Dec	6,685	$2,315,491	$52,299	2.26%	$2,214,341
Total	**81,863**				**$35,334,513**

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other healthcare coverage must be billed before submission of claim	105	$66,784	43.22%
Medicare Part B must be billed before submission of claim	230	$49,714	32.17%
Late claim	33	$21,457	13.89%
Beneficiary not eligible or non-covered charges	27	$14,562	9.42%
Service line is a duplicate and a repeat service procedure code modifier not present	11	$2,001	1.29%
Total Denied Claims	**406**	[redacted]	**100.00%**
Overall Denied Claims Rate	[redacted]		
Statewide Overall Denied Claims Rate	**1.43%**		