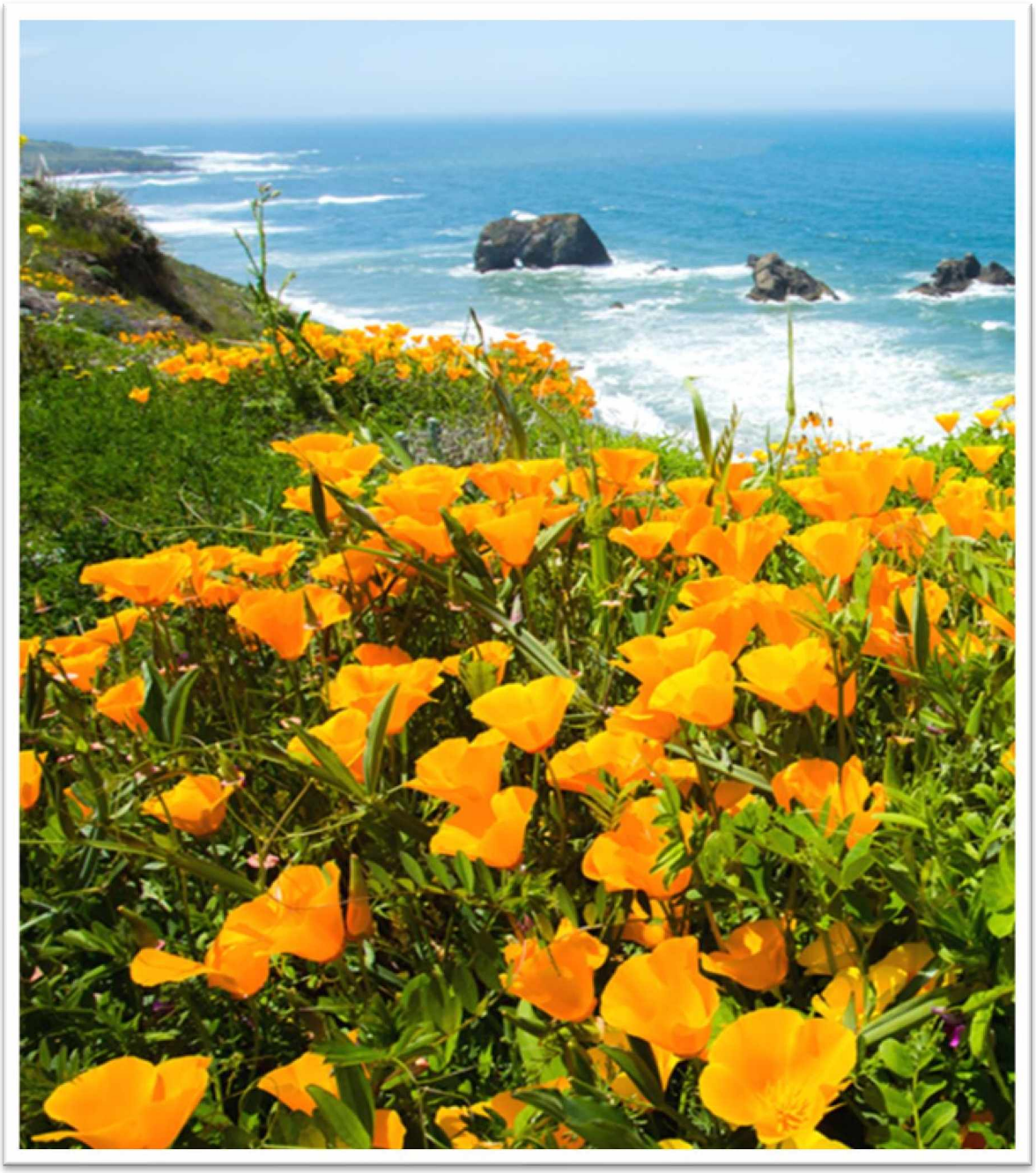

FY 2023-24 Statewide Annual Technical

EXTERNAL QUALITY REVIEW REPORT

MEDI-CAL SPECIALTY MENTAL HEALTH

Prepared for the California Department of Health Care Services
by Behavioral Health Concepts, Inc.
November 22, 2024

BHC | Behavioral Health Concepts, Inc

Acknowledgments

Behavioral Health Concepts, Inc. (BHC) offers this report as our final deliverable as California External Quality Review Organization (CalEQRO).

We want to acknowledge the work of California's 56 Mental Health Plans (MHPs) – along with the many stakeholders – that took part in the reviews over our 10 years as the EQRO for specialty mental health services. This includes leadership, direct service staff, volunteers, contract providers, key stakeholders, and many others. We are especially grateful to the consumers of mental health services who shared their experiences with us in focus groups; personal experiences were especially impactful to our MHP-level recommendations for improvement.

We have also appreciated our partnership with the California Mental Health Services Authority (CalMHSA) and California Behavioral Health Directors Association (CBHDA). We also want to thank the State of California Department of Health Care Services (DHCS) leaders and staff who have overseen our contract for 10 years; thank you for your partnership in delivering the highest quality reports to Centers for Medicare and Medicaid Services (CMS), MHPs, and the public.

Finally, we want to recognize the efforts of our own staff, the reviewers who have been responsible for facilitating the evaluation of MHPs each year – in-person and over email, phone, and video. Their subject matter expertise enabled us to understand the systems we reviewed, and they conducted reviews through a strength-based lens, meeting systems where they were, and promoting quality improvement. As they move on to their next chapters, we extend this heartfelt gratitude to our staff – Quality Reviewers, Information Systems Reviewers, and Consumer/Family Member Reviewers (and our essential BHC colleagues behind the scenes who supported the work). They were instrumental in not only carrying out our charge to evaluate, but also to share in the efforts toward improved member care.

As always, BHC's goal is that our final statewide annual technical report both acknowledges the good work being done and also informs improvements that would result in better care and outcomes for people experiencing severe mental health conditions – and helping them to thrive and enjoy meaningful lives.

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Acronyms

CalEQRO Acronyms	
AACM	Average Approved Claims per Member
AAS	Alternative Access Standard
ACA	Affordable Care Act
ASP	Application Service Provider
ATA	Assessment of Timely Access
BH	Behavioral Health
BHAS	Behavioral Health Accountability Set
BHC	Behavioral Health Concepts, Inc.
BHIN	Behavioral Health Information Notice
BHP	Behavioral Health Plan
BHQIP	Behavioral Health Quality Improvement Program
CalAIM	California Advancing and Innovating Medi-Cal
CalEQRO	California External Quality Review Organization
CalMHSA	California Mental Health Services Authority
CANS	Child and Adolescent Needs and Strengths
CAP	Corrective Action Plan
CARE	Community Assistance, Recovery and Empowerment Court
CBT	Cognitive Behavioral Therapy
CCBH	Cerner Community Behavioral Health
CCC	Cultural Competence Committee
CCP	Cultural Competence Plan
CFM	Consumer/Family Member
CFR	Code of Federal Regulations
CIN	Client Index Number
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease-2019
CPS	Consumer Perception Survey
CQS	Comprehensive Quality Strategy
CY	Calendar Year
DHCS	Department of Health Care Services

CalEQRO Acronyms	
DMC-ODS	Drug Medi-Cal Organized Delivery System
ED	Emergency Department
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FSP	Full-Service Partnership
FTE	Full-Time Equivalent
FUH	Follow-Up After Hospitalization for Mental Illness
FUM	Follow-up after Emergency Department Visit for Mental Illness
FY	Fiscal Year
HCM	High-Cost Member
HEDIS®	Healthcare Effectiveness Data and Information Set[1]
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
ICC	Intensive Care Coordination
IHBS	Intensive Home-Based Services
IPC	Inpatient Consolidation
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer or Questioning
LOC	Level of Care
LOS	Length of Stay
MCP	Managed Care Plan
MHP	Mental Health Plan
MMEF	MEDS (Medi-Cal Eligibility Data System) Monthly Extract File
MY	Measurement Year

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

CalEQRO Acronyms	
NA	Network Adequacy
OCP	Operations Continuity Plans
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PMF	Plan Member/Family
PR	Penetration Rate
PSC-35	Pediatric Symptoms Checklist (35 items)
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QIC	Quality Improvement Committee
QM	Quality Management
SAS	Statistical Analysis Software
SDMC	Short-Doyle Medi-Cal
SMHS	Specialty Mental Health Services
SUD	Substance Use Disorders
TA	Technical Assistance
TADT	Timely Access Data Tool
TAY	Transitional Age Youth
UCLA	University of California Los Angeles
WIC	Welfare and Institutions Code

Executive Summary

INTRODUCTION

Behavioral Health Concepts (BHC), Inc., under contract with the State of California Department of Health Care Services (DHCS), evaluated the access, timeliness, and quality of specialty mental health services (SMHS) provided to Medicaid members by all 56 of the state's Mental Health Plans (MHPs).

This report presents statewide findings from External Quality Reviews (EQR) conducted in California during fiscal year (FY) 2023-24, marking BHC's tenth year and final year as the External Quality Review Organization (EQRO) for SMHS.

EQRs are intentionally retrospective, reviewing the MHPs' work accomplished in the prior 12 months and the prior years' service data. The performance measures (PMs) for FY 2023-24 reviews primarily focus on claims data from calendar year (CY) 2022, calculated by the California External Quality Review Organization (CalEQRO), as the most current and complete 12-month data set available at the beginning of the review year. Additionally, prior to each review, MHPs submitted data on service timeliness, which was validated and reported in the Timeliness chapter of this report. This year's statewide report also includes more tables with Plan-specific data.

MHP review findings are derived from a combination of PM analysis, documents submitted by the Plans, and qualitative information gathered from group discussions. MHPs submit a significant number of documents prior to reviews, demonstrating work accomplished, challenges faced, and improvements made in the prior 12 months. Each MHP's Final Report is posted online.[2]

This report presents findings from reviews of MHPs, conducted over 1 to 3 days, mostly via video conference, though some were in-person visits. Using Centers for Medicare and Medicaid Services (CMS) EQRO Protocols and involving key stakeholders, CalEQRO facilitated discussions on access, timeliness, and quality of care, including performance improvement projects (PIPs) and review of a current Information Systems Capability Assessment (ISCA). In addition, an attachment follows this report, containing the Executive Summaries from each MHP Final Report. The data extracted from the MHP Final Reports provided the basis for the statewide findings, themes, and recommendations. This statewide report includes both qualitative and quantitative findings based upon aggregated statewide information.

FINDINGS

Access

CY 2020 data, reflecting the pandemic's peak, showed a significant drop in members receiving SMHS. CY 2021 saw a rebound in access, but the gains did not persist into CY 2022, although the

[2] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

decreases did not return to CY 2020 levels. As in the previous year, the penetration rate (PR) fell due to both fewer members served and a larger number of eligibles. Southern (3.26 percent) and Central MHPs (3.53 percent) have lower PRs. Consistent with historical patterns, Superior region MHPs had the highest PRs, at 5.19 percent in CY 2022.

Additionally, the number of foster youth served decreased again in CY 2022, at a statewide PR of 46.0 percent. Los Angeles had a PR (51.23%) higher than the statewide average, while all other county sizes were below the statewide rate. This was particularly evident in small MHPs, which had a PR of 36.14 percent. With the California Advancing and Innovating Medi-Cal (CalAIM)[3] initiative targeting to increase services to foster youth in the SMHS system, this trend may reverse in CY 2023 data, although CalAIM-related criteria were implemented in CY 2022.

The reduction in members served was observed across all racial/ethnic groups. At the same time, the number and percentage of members served in a threshold language decreased only slightly from CY 2021. Spanish is a threshold language in 44 MHPs and was the preferred language for 17.34 percent of members served in CY 2022. California has 11 other threshold languages, listed in decreasing order of frequency: Vietnamese, Cantonese, Armenian, Arabic, Mandarin, Farsi, Russian, Korean, Cambodian, Hmong, and Tagalog. These languages were represented by a total of 2 percent of members in MHP services.

Telehealth, critical during the public health emergency, remained prominent, with approximately 60 percent of youth, 39 percent of adults, and 33 percent of older adults receiving at least one telehealth service, according to MHP reports. CalEQRO defines telehealth as two-way, interactive treatment sessions between a member and a healthcare professional at a distant site, using interactive telecommunication equipment and/or software that includes, at a minimum, audio and video equipment.

Challenges with access are likely linked to difficulties in maintaining a sufficient MHP workforce in both county-operated and contractor-operated programs. Many MHPs have made significant progress in replacing some of the workforce lost over the past 3 to 4 years, but vacancy rates, particularly for licensed clinical staff, often exceeded 25 percent.

Despite workforce challenges, improving access to care remained a priority for MHPs. They continued to excel in coordinating with entities such as schools, courts, law enforcement, and other community organizations. Cultural competence and equity were prioritized, with 93 percent demonstrating specific actions to improve access and services for the diversity in their local communities. MHPs continued to face challenges in managing and adapting capacity to meet members' needs, primarily due to limited mechanisms and analytic reports for assistance, as well as the workforce limitations.

Timeliness

This chapter provides a detailed analysis and validation of the timeliness of services provided by the MHPs. MHPs submitted the Assessment of Timely Access (ATA) form and were also expected to provide the source data used for the calculation. Plan-level results are presented for key points in care, with data representing the vast majority of Plans. The timeliness of an initial service can impact whether the service will be delivered at all. Most individuals seek mental health care during some of their most challenging times; being told they must wait days, weeks, or even months can be so discouraging that they may withdraw or miss appointments. MHPs

[3] https://calaim.dhcs.ca.gov/pages/behavioral-health

experienced significant attrition between the initial call for service and the first service provided, with nearly 60 percent statewide, according to the data analysis. The average wait time for the first delivered service statewide was 10.4 business days, with faster times in Superior region MHPs and slower times in Southern MHPs. There were also variations within given MHPs, with some showing longer initial wait times for youth and others for adults. In several MHPs, the difference in wait times between the adult and youth systems was as much as 8 to 10 business days, with youth most often experiencing a longer waiting period.

For the initial offered psychiatry visit, the statewide average wait time reported to CalEQRO was 11.3 business days, with three-quarters of the visits occurring within the 15 business-day standard. Receiving the initial psychiatry service required an additional wait of 4.7 business days statewide, compared to the initial offered appointment. MHP wait times varied widely, from 2.5 business days to 72 business days (an outlier). Several MHPs reported average wait periods of 20 to 30 business days.

In DHCS's 2023 Timely Access Data Tool (TADT), MHPs also reported wait times for the next non-psychiatry service offered and delivered after the initial non-psychiatry visit.[4] CalEQRO was tasked with validating the follow-up service dates when compared to the service date expressed in the Short Doyle Medi Cal (SDMC) approved claims. Due to the degree of incomplete data in many of the MHPs' submissions, DHCS ultimately determined that this data was not sufficient for the validation; therefore, the results are not presented in this report. DHCS notified all MHPs to resubmit the 2023 TADT for April 1, 2023 – June 30, 2023. This was due to DHCS in June 2024. The timing for completion of this report did not enable validation of the resubmitted 2023 TADT data.

Quality

Managing and overseeing the quality of care throughout a system requires specific skills and support from technology and analytic staff, all of which are in short supply. MHPs are required to develop a Quality Assessment and Performance Improvement (QAPI) Work Plan (WP), which should include baselines and goals to assess whether priority metrics are improving. Plans should also implement improvement strategies when performance falls below identified standards. Additionally, an annual evaluation of the plan allows the MHP to re-prioritize or reinforce efforts to improve. In fact, nearly all MHPs had at least one quality-related strength identified in their MHP Final Report.

A crucial element for success in any of the above areas is the commitment and meaningful participation of MHP leadership. For many, this may involve developing skills in interpreting analytic reports, conducting root cause analysis, and identifying and implementing strategies for improvement. This approach is critical for designing and implementing PIPs and should serve as the foundation for all program management and performance improvement efforts.

Data analytics are essential for measuring the quality of care. Although the use of data has generally improved over time, this year it faced additional challenges due to electronic health record (EHR) implementations prompted by CalAIM's payment reform. Additionally, results were mixed regarding the strength of MHP communication, including two-way communication between leadership and stakeholders.

[4] https://www.dhcs.ca.gov/Documents/BHIN-23-041-Network-Cert-Req-for-MHP-DMC-ODS.pdf

Medication monitoring, particularly for youth, was a challenged area for at least 52 percent (n=29) of MHPs. Medication monitoring was especially impacted by insufficient or unstable psychiatry staffing. Nearly all MHPs (n=51) employed peer support specialists in some capacity and typically had at least one peer employee in a key role within the system.

Information Systems

This past year introduced a new EHR vendor in California, as MHPs continue to work towards implementing comprehensive mental health and substance use disorder (SUD) clinical records, health information exchange (HIE), interoperability, and personal health record (PHR) systems. Some historical systems based on older technology took several years to implement, and even then, they were not necessarily fully realized. Many MHPs prioritized the collaborative effort with the California Mental Health Services Authority (CalMHSA) Joint Powers Authority to implement a single EHR system that meets CalAIM requirements. Other MHPs were independently implementing new EHR systems, which required substantial staff resources. Other MHPs adapted their existing EHR systems to meet CalAIM requirements for payment reform and interoperability. Ultimately, a system that leverages its data effectively can target improvements more precisely and achieve better results.

CONCLUSIONS

There is substantial variation among MHPs across the state, including in size, region, demographic composition, service delivery systems, and EHR functionality. Local and statewide factors influence both the strengths and weaknesses of a system. Challenges are often statewide, impacting many or all MHPs, while strengths tend to be specific to MHPs. Examples of both challenges and strengths are provided throughout this report. The Conclusions chapter includes a list of recommendations directed to MHPs as well as to DHCS for addressing the themes identified as challenges.

DHCS and MHPs should monitor service utilization to return to or exceed pre-pandemic CY 2019 levels, aiming for improvements in access across all racial and ethnic groups. Additionally, timeliness requires improvement in tracking methods, reporting, and actual performance. Although some MHPs reduced wait times this year, others experienced setbacks due to workforce shortages and EHR implementations that are not yet adequately set up for sufficient tracking and reporting.

Level of care (LOC) management is lacking, though more MHPs have started to identify and implement LOC tools, such as the Level of Care Utilization System[5] for adults. The Child and Adolescent Needs and Strengths (CANS) is often used to guide LOC placement, though it frequently lacks documented guidance based on ratings. Appropriate LOC determinations are especially valuable for assessing whether high-cost members (HCMs) are receiving the right range of services. Analyzing inpatient utilization for HCMs is recommended. Comprehensive analysis of member outcomes is also significantly lacking.

[5] American Association for Community Psychiatry. (n.d.). *LOCUS + CALOCUS.* https://www.communitypsychiatry.org/locus

To achieve the vision of CalAIM and the Comprehensive Quality Strategy[6] (CQS), MHPs need to further strengthen their quality management (QM) efforts and improvement initiatives, grounded in local data. Reporting from EHRs, along with interoperability with other systems and HIE, is essential for routine monitoring. This ensures that areas needing improvement can be identified and examined in near real time. Many MHPs need to analyze root causes in areas such as timely access to care, engagement rates, service patterns of HCMs, and inpatient utilization. All of these factors are connected to ensuring that members receive care at the appropriate LOC, whether through telehealth, in-person services, or a combination of both.

PIPs represent structured approaches to analyzing and improving care outcomes. They require more resource allocation to address high-volume topics and high-risk conditions. This is a challenging task when MHP workforces are already struggling to meet basic requirements amid increased regulatory reporting demands. Addressing the behavioral health (BH) workforce crisis will require multi- level efforts, including State leadership and collaboration with educational institutions.

The universal screening tool, transition tools, and Behavioral Health Quality Improvement Program (BHQIP)[7] projects that develop data exchange are crucial for better integration between SMHS and managed care plans (MCPs). This involves ensuring that members with SMHS needs are served within MHP systems and transition to the MCP LOC when appropriate. Ultimately, with the goal of better integration across systems of care, the transformation initiated through CalAIM is expected to improve health and BH outcomes for all populations served by California's Medi-Cal systems.

These recommendations are based upon apparent themes throughout the report and are further detailed in the Conclusions chapter, divided into two sections: one for MHPs and the other for DHCS. The Plan-level recommendations are broadly applicable, though not all recommendations are suited to every Plan. Recommendations to DHCS are made to further and operationalize the goals set forth in the CQS, build upon the policy framework of CalAIM, and promote Plan-level improvements.

[6] https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx

[7] https://www.dhcs.ca.gov/bhqip

OVERVIEW OF THE EQR AUTHORITY

CMS under the U.S. Department of Health and Human Services mandates an annual independent evaluation of state Medicaid managed care programs by an EQRO. EQR involves an approved EQRO analyzing and evaluating aggregate data on access, timeliness, and quality of health care services provided by prepaid inpatient health plans (PIHPs) and their contractors to Medicaid managed care recipients. CMS rules (42 Code of Federal Regulations (CFR) §438; Medicaid Program, EQR of Medicaid Managed Care Organizations) outline the evaluation requirements for Medicaid managed care programs, known as "Medi-Cal" in California. These rules mandate an annual EQR for each MHP. The California DHCS contracts with all 56 county Medi-Cal MHPs, covering 58 counties, to provide Medi-Cal covered SMHS to members under Title XIX of the federal Social Security Act.

This report covers the statewide aggregate results for FY 2023-24, highlighting common themes and applicable recommendations outlined in the Conclusion. CalEQRO's recommendations are derived from the findings in individual MHP reports. These reports evaluate how each MHP addressed recommendations from the previous year's EQR, managed timeliness, access, and quality, utilized information systems (IS) to produce valid data, and highlight each MHP's strengths, opportunities for improvement, and recommendations to be assessed in the next year's review.

The findings result from the CalEQRO's review of data, analysis, and both quantitative and qualitative review of MHP documentation. Additional information, including CalEQRO resources, individual Final MHP Reports, as well as presentations, data analyses, and archived materials, have historically been made available on CalEQRO's website, which is no longer available. Historical material will be posted on DHCS's website.[8]

Reviews are retrospective for the previous year of services, and the criteria are based primarily on CMS 42 CFR Part 438, subpart E, which outlines the major requirements of the CMS EQR Protocol, updated in February 2023:

- Protocol 1 – PIPs both clinical and non-clinical
- Protocol 2 – PM validation – applied to the timeliness measures
- Protocol 4 – Network adequacy (NA) validation
- Protocol 6 – Survey results
- Protocol 7 – PM calculation
- Appendix A – ISCA

Additionally, BHC's contract with DHCS requires CalEQRO to evaluate MHPs on: the delivery of SMHS addressing diversity, equity, and inclusion; coordination of care to improve outcomes and address social determinants of health; member satisfaction, and participation through focus

[8] https://www.dhcs.ca.gov/services/MH

groups; and provision of Pathways to Well-Being (formerly Katie A), including a focused review of services for Medi-Cal eligible minors and non-minor dependents in foster care (FC) per California Welfare and Institutions Code (WIC) Section 14717.5. CalEQRO also reports on the DHCS audit of MHP compliance with Medicaid rules, Protocol 3, in the statewide annual technical report, but not in the MHP-specific reports. Additionally, the most recent DHCS NA Findings Reports and their submitted CalEQRO NA Form were reviewed with each MHP.

BHC'S EQR APPROACH

As the California EQRO, BHC was required to conduct an annual review of each Plan to assess access, timeliness, and quality. This was grounded in significant document review prior to the on-site or virtual review, which entails questions tailored to the specific Plan. To promote data-driven approaches, BHC produced PMs based on the most recent 12 months of approved claims data available at the start of the review cycle – for this review year, CY 2022. Review of the PM data, as well as data produced by the Plans, launched discussions regarding quality of care to evaluate a Plan's progress, improvements, setbacks, and goals related to access, timeliness, and quality. While adhering to the CMS EQRO Protocols, BHC's approach was one of curious questions and meaningful group discussions to better understand each MHP. Interviews with stakeholders, including groups of members in care and their families, as well as MHP leaders and staff (county and contract providers) representing a variety of perspectives and focused areas throughout the system, which helps round out understanding of the systems and improvements. The document review and discussions enabled CalEQRO to identify improvements compared to the prior year and the strengths demonstrated in a Plan, as well as recommendations to address opportunities identified through the review. BHC's approach is further detailed in the Methods chapter of this report.

The CQS guiding principles align with CalEQRO's review priorities: eliminating health disparities, data-driven improvements, transparency and accountability, community partnerships, and member involvement. These CQS principles have been foundational to CalEQRO's work.

THE MHP ENVIRONMENT

The environment in which MHPs operate will directly or indirectly affect access, timeliness, and quality of MHP services. This required evaluating the MHP within the context of its local systems and as part of the larger statewide system. Local and statewide factors influence both the strengths and weaknesses of a system. Challenges are often statewide, impacting many or all MHPs, while strengths tend to be specific to individual MHPs. The EQR aims to consider MHP strengths when making recommendations for improvement. Additionally, when evaluating MHPs' activities in response to recommendations, their environmental context is considered as a basis for the evaluation.

Post-pandemic impacts remain evident statewide as MHPs adapt to meet community behavioral health needs amid an ongoing workforce shortage[9]. High employee turnover and workforce

[9] Coffman, J. & Fix, M. (February 2023). *Building the future behavioral health workforce*: *Needs assessment*. County Behavioral Health Directors Association of California. https://static1.squarespace.com/static/5b1065c375f9ee699734d898/t/63e695d3ce73ca3e44824cf8/1676056025905/CBHDA_Needs_Assessment_FINAL_Report_2-23.pdf

shortages are near catastrophic for many MHPs. Policies on attracting quality staff, increasing pay, offering remote work options, enhancing diversity, training new staff after high turnover, and retaining long-term staff vary across MHPs. Given that the SMHS system was already under-resourced before the pandemic, there is significant strain on the system to implement state initiatives and collect quality data while managing ongoing processes due to both vacancies and newly hired staff. The greatest strain is likely on the smallest MHPs, where a limited number of clinical staff must cover ongoing services across the continuum and lead expansion efforts.

Similarly, as in recent review cycles, MHPs faced various adverse impacts in their local communities or regions, including rain, flooding, widespread electrical outages, and large catastrophic wildfires. Like the pandemic, these events directly impacted the service delivery system, staff, and communities, often diverting Plan employees and resources from their regular duties to assist with emergency and recovery activities. Such ad hoc assignments strained resources, both clinical and administrative, prioritizing routine service delivery tasks and leaving non-clinical tasks unattended or deprioritized. One review had to be rescheduled on the morning of the review because of a county-wide disruption of the internet and county telephone systems, and even had the 911 dispatch offline. MHP staff were needed to respond to the community, and the CalEQRO review team accommodated this by holding the review later in the week.

As CalAIM documentation and billing reforms have been implemented statewide, MHPs have faced challenges this year in shifting access policies, adjusting staffing ratios, maintaining positive relationships with contractors, rolling out new EHRs for updated billing and improved data collection, and establishing community relationships to address justice system initiatives, youth care, integration with substance use treatment services, and the development or expansion of mobile crisis units. For example, Riverside MHP, an integrated system with the Drug Medi-Cal Organized Delivery System (DMC-ODS) and public health, has made significant efforts to attract clinical staff, but the large system could only affect a reduction in its vacancy rate from 30 percent to 25 percent. Despite most MHPs reporting only marginal improvements to the clinical workforce since the previous year's review, they have largely been successful in addressing the CalAIM changes systemwide, generally prioritizing it above all else. Regarding MHPs' contractors, there was evident uncertainty around payment reform's fee-for-service contract negotiations and the passing of Proposition 1, now referred to as DHCS's Behavioral Health Transformation[10]. The restructuring of Mental Health Services Act (MHSA) funds to support housing needs poses concerns for reductions in funding available for MHP service providers. Additionally, many MHPs reported improvements to how they coordinated with and supported contract providers, especially as partners in new CalAIM practices.

This year, administrative functions and reporting responsibilities for MHPs notably increased due to CalAIM, other state initiatives, and the decision by most MHPs to switch their EHR systems rather than work with vendors on multiple upgrades to meet new requirements. Additionally, doing so would entail delays as the EHR software is quite tailored to each MHP, and vendors are challenged to make significant changes for multiple Plans at once. QM staff were frequently redirected to support these functions, resulting in neglect of ongoing tasks. Additional impacts included the resignation of many experienced staff, the onboarding of new staff and leadership teams, slow growth of analytic staff, and shortages and turnover in supportive units such as human resources.

Continuing the trend from last year, MHPs prioritized timely initial access for high-need members. However, focus group members often reported longer waits for ongoing care with a

[10] https://www.dhcs.ca.gov/BHT/Pages/home.aspx

therapist. Many MHPs still need to improve data accuracy for this issue, which was a focus of technical assistance (TA) during several reviews. Many PIPs addressed timely access, outreach and engagement, and retention for high-need members.

The EQRs focused on gathering qualitative and quantitative information to understand a system's operations and how MHP processes positively or negatively impact the quality of care provided to members experiencing severe mental illness. This report will detail statewide themes, findings, and recommendations that CalEQRO hopes will be meaningful to DHCS, MHPs, current members, and unserved individuals who may become members through efforts to reduce stigma and engage underserved and high-risk populations.

Methods

BACKGROUND

The core elements of EQRO evaluations are mandated by federal law and associated regulations and are operationalized by CMS (42 CFR §438.350; Medicaid Program, EQR of Medicaid Managed Care Organizations), which specifies the requirements for the evaluation of Medicaid managed care programs and prepaid inpatient health plans. The 2023 CMS protocols for EQRs focus on the core themes of access, timeliness, and quality.[11] These protocols for evaluation assist states in the oversight of the programs as funded by state and federal governments.

In doing so, CalEQRO reviews emphasized the MHPs' data use in alignment with the CQS, ensuring accurate data-driven decisions across the BH continuum of care for Medi-Cal members. The objective of all technical data collection and analysis was to assess and validate the performance of the MHPs in service to Medi-Cal members. This chapter provides detailed information on data collection and analysis methods, including the entities responsible for validation. Further details, including the validated data and conclusions, are available in the specific chapter dedicated to each EQR activity.

BHC review teams were composed of three distinct roles – Lead Quality Reviewer, IS Reviewer, and Consumer/Family Member (CFM) Reviewer. Depending on the size and complexity of the MHP, additional BHC staff may also have been required. BHC's staff have public mental health expertise in their respective areas, some having served in MHPs in leadership, including former directors, IS administrators, and CFM'S served by SMHS systems of care. All team members are subject matter experts, fully qualified to validate their respective aspects of the review.

The review teams used both quantitative and qualitative techniques to analyze data, review MHP-submitted documentation, and conduct interviews with county leadership and staff, contract providers, advisory groups, members, family members, and other stakeholders. At the conclusion of the EQR process for each MHP, CalEQRO produced a technical report that synthesizes information, builds on the previous year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations across four domains: access, timeliness, quality, and IS. Although there is overlap and dually qualified staff, the Lead Quality Reviewer validated PIPs using Protocol 1, while PMs were validated by the IS Reviewer using Protocol 2.

EQR Protocol 3, compliance with Medicaid regulations, is formally conducted by DHCS staff through its triennial compliance review. The relevant compliance topics were considered throughout the annual MHP review process, MHP-level reports, and are discussed throughout the chapters of this aggregate report. More specifically, Protocol 3 topics – including the availability of services, assurances of adequate capacity, coordination and continuity of care, grievances, subcontracted relationships, health information systems (HIS), and the MHPs' QAPI

[11] Department of Health and Human Services & Centers for Medicare and Medicaid Services. (February 2023). *CMS external quality review (EQR) protocols.* https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

programs – were evaluated during the pre-review, the review, and post-review periods. In accordance with 42 CFR 438.360, DHCS provided the Triennial Audit summary level results for the prior 3 years for inclusion in the Compliance chapter of this report.

Protocol 4, the validation of NA, has been historically conducted by DHCS staff through the review of significant documentation submitted by MHPs, with CalEQRO responsible for evaluating the MHPs' adherence to time or distance as well as alternative access standards (AAS). These NA findings are detailed in the MHP reports. DHCS's NA Findings and Corrective Action Plan (CAP) reports can be found on DHCS's NA webpage.[12] At the time of this report, DHCS had posted 2022 results, provided CalEQRO and MHPs with the 2023 results (and resubmission requirements), and MHPs recently submitted the 2024 data. requirements where needed), and Plans recently submitted the 2024 data. For this report, DHCS provided CalEQRO with Plans' 2023 TADT with the intent to validate the timeliness for the first non-urgent, non-psychiatric follow-up visit, based upon the extent to which service dates were substantiated in the claims data. As DHCS ultimately determined that the Plans' data as submitted was insufficient for validation, this analysis is not presented in this report.

CalEQRO used various data sources to create PMs and other analyses, including the MEDS (Medi-Cal Eligibility Data System) Monthly Extract File (MMEF), SDMC approved claims, Inpatient Consolidation (IPC) File, Consumer Perception Survey (CPS) data, NA Findings Reports, and Plan submission documents. Plan documents included materials already maintained by the MHP and those specifically prepared for the review. Reviews conducted in FY 2023-24 used local data provided by MHPs, while PM data produced by CalEQRO focused on CY 2022 approved claims data, often with a 3-year trend starting from CY 2020. The MMEF data set covered 15 months of eligibility for the same period and forms the denominators for the PMs created. CalEQRO received these large data files through secure file transfer and stores them on BHC's secure network. Only BHC's Statistical Analysis Software (SAS) programmers and the Information Technology (IT) Director can access these servers.

As part of the pre-review process, each MHP received a description of the data sources and five summary reports of Medi-Cal approved claims data: total, FC, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), transitional age youth (TAY), and Affordable Care Act (ACA). Although not required by the contract, CalEQRO developed the EPSDT summary to help review teams and MHPs better understand the differences between child and adult systems of care and to compare care patterns for FC youth versus all youth. Data compiled by the MHPs and submitted to CalEQRO was also reviewed. This data often provided a more comprehensive reflection of the entire system, including services not billed to SDMC or that were funded by other resources such as grants, the Mental Health Block Grant, or MHSA funds.

Reviews are retrospective, covering the prior year of services since the last review. Five to six MHP reviews were conducted monthly, typically 10 to 12 months after the prior review. The schedule for FY 2023-24, developed with input from the MHPs, was produced and published in March 2023. When MHPs identified conflicts with planned review dates, such as key staff vacations or other audits, CalEQRO worked to find mutually acceptable alternative dates.

Additionally, CalEQRO provided individualized TA to MHPs. Guidance on developing PIPs was the most common subject of TA, but MHPs also requested TA regarding the approved claims data and PMs compiled by CalEQRO to better understand what the data reflected and what it did not. CalEQRO's goal is that MHPs would produce these measures independently and in

[12] https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx

real-time. Therefore, it is important to note that nearly all PMs (except for the ATA timeliness data) were produced by CalEQRO.

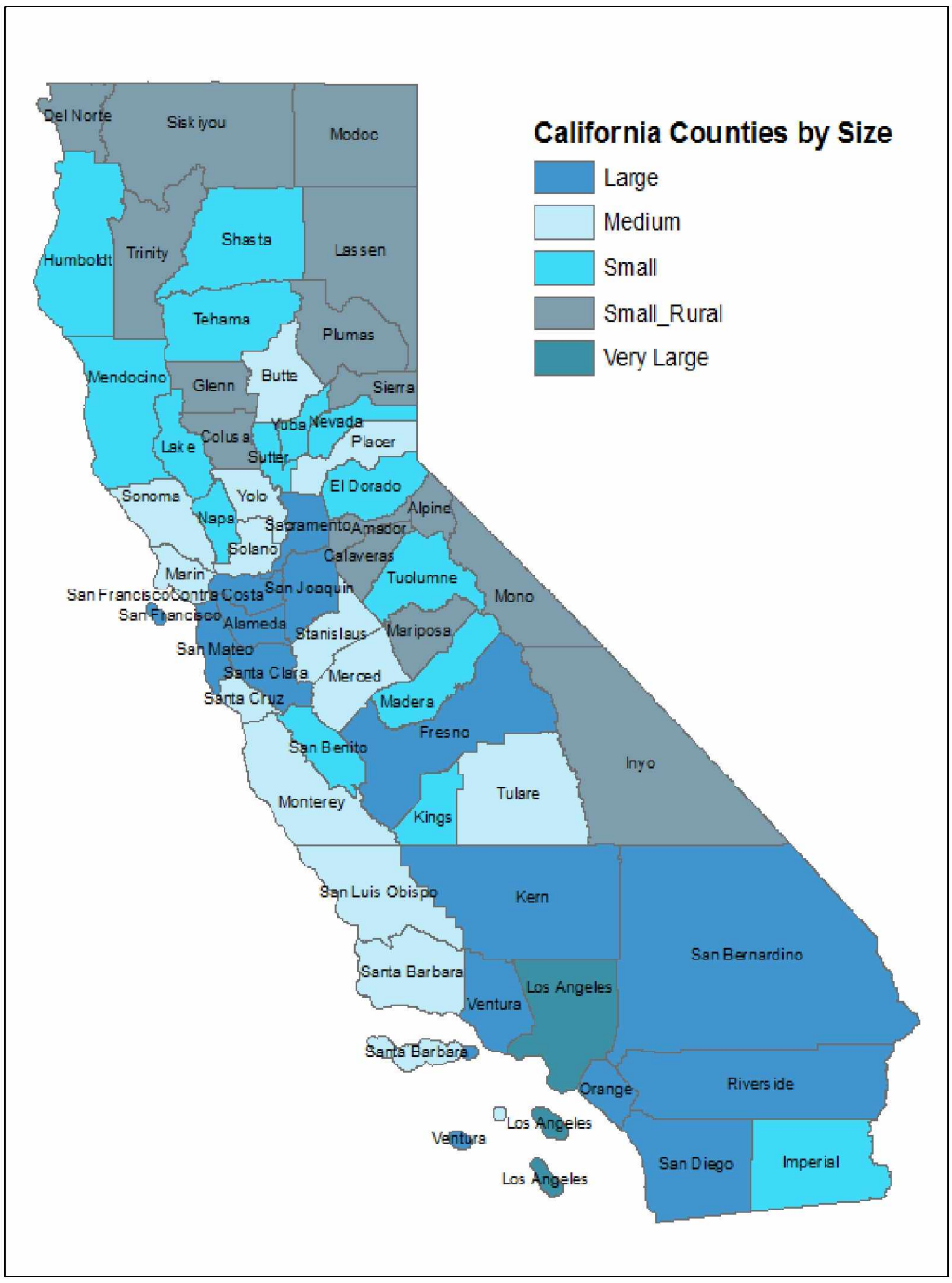
MEDI-CAL POPULATION

California MHPs serve diverse populations in need of mental health services. The EQR evaluation focuses on the Medicaid population – Medi-Cal in California – including elderly, disabled, and financially eligible residents. The term "eligible" describes a person enrolled in Medi-Cal and eligible to receive services funded through Medi-Cal, irrespective of whether they needed or received SMHS. The term "member" describes a person who is enrolled in Medi-Cal and has received one or more MHP service – referred to as "beneficiary" in previously published EQR reports.

DHCS has assigned specific aid codes to identify the types of recipients eligible under Medi-Cal. These aid codes indicate the types of services for which members are eligible. Benefits may be full or restricted, depending on the aid code. They also indicate certain groups with special needs such as foster care, disabled, ACA, and enable analysis by aid code. While MHPs are required to serve those who meet access criteria and have Medi-Cal, they may also provide services to individuals who are uninsured, have Medicare, or have both Medicare and Medi-Cal. Some Plans serve individuals with private insurance, though this is typically limited to crisis services and other services not covered by insurance plans, such as therapeutic behavioral services, full-service partnership (FSP), intensive care coordination (ICC), or intensive home-based services (IHBS).

Figure 3-1 below displays the California counties as represented by size. This information is also listed in Appendix 2.

Figure 3-1: California Counties by Size



PERFORMANCE MEASURES

The data sources used in the analyses for this report are described below. Medi-Cal claims data involves a lag time between service delivery by providers, claims submission by the Plans to DHCS, and final claim approval by DHCS. To report on the most recent period with relatively complete data, FY 2023-24 reviews used CY 2022 data for tables and figures of calculated PMs, with most measures displayed over a 3-year period (CYs 2020-22).

Data used to generate the Approved Claims Summaries and PM tables and graphs throughout individual Plan reports and this statewide report, unless otherwise specified, are derived from three source files:

- MMEF – includes eligibility, demographic, and aid code data for all individuals enrolled in Medi-Cal at any point in CY 2022; generates most denominators for PMs.
- SDMC approved claims file – all MHP SMHS claims that were submitted by MHPs and approved for services delivered in CY 2022; generates most numerators for PMs.
- IPC file – includes all acute hospitalizations claimed to Medi-Cal for care delivered in CY 2022, excluding SDMC claims for psychiatric health facility care and private hospitals larger than 16 beds directly reimbursed by the MHP (outside the Medi-Cal system and not included in PM data). These inpatient data are included in numerators.

It is important to note that MHPs reported that, on average, 79 percent of their services are billed to Medi-Cal. Therefore, the PMs represent the vast majority, but not the entirety, of services provided by MHPs.

Additionally, this statewide annual technical report includes an analysis of the CPS data submitted by MHPs to the University of California Los Angeles (UCLA), and then transferred to BHC through DHCS's secure transfer protocol.

MHPs provided a required report for the EQR called the ATA. The ATA provided an overview of timely access to care, and included specific population counts, averages, ranges, and means for timeliness data, covering first non-urgent service, first delivered service, first non-urgent psychiatry appointment, first non-urgent psychiatry service delivered, urgent services, follow-up after inpatient discharge, psychiatric readmission rates, and no-show rates for psychiatry and other clinicians. This comprehensive form was to be submitted with de-identified source data, which is then validated by CalEQRO. An IS Reviewer familiar with these data conducted the ATA validation, as described later in the Timeliness chapter. The ATA also requested the definitions and methods used to calculate these measures, which can vary across MHPs and with the analytic staff who populate the form. This is why this technical report references "follow-up after inpatient discharge" rather than the Healthcare Effectiveness Data and Information Set (HEDIS®) measure Follow-Up After Hospitalization for Mental Illness (FUH); MHPs may not follow those specific guidelines, and historically, it was not required. To review these results and learn more about the ATA measures, please refer to the Timeliness chapter of this report.

CalEQRO calculated the remaining PMs throughout all chapters of this report, as required by DHCS, using the data sources mentioned above, and provided a copy to the MHPs prior to the review. Additionally, a Health Insurance Portability and Accountability Act (HIPAA)-compliant version was provided to the MHP and included in the published MHP report. All PMs were discussed during the review in the context of the main domains: access, timeliness, and quality of care. Points of underperformance identified during calculation or discovered in the prior year often drove specific discussions during the review sessions. Numerator and denominators are defined in each section where a new PM is introduced.

Except for the Plan-submitted ATA data, all measures calculated by CalEQRO are compared to statewide data, and most are also compared to subgroups of counties in the same size category. Size categories are defined by DHCS. Los Angeles is in a size category of its own ("very large" and its own region) but is compared to large county numbers for most PM analyses, unless otherwise specified. Where Los Angeles' large numbers will unduly skew the large MHPs' data, it is separated into its own size category. Large MHPs have a population of 750,000 or more; medium MHPs have 200,000 to 749,999; small have 50,000 to 199,999; and

small-rural have less than 50,000 individuals in the county's population. Fifty percent of California's counties are small or small-rural.

CalEQRO produced the following measures in each MHP report and from a statewide perspective for this report:

- Numbers served, PR, eligibles, and average approved claims per member (AACM) by age group and racial/ethnic group
- Numbers Served, PR and AACM (Overall, Hispanic/Latino, Asian/Pacific Islander, and FC)
- ACA summary of members served, eligibles, PR, average approved and total claims
- Members with a Threshold Language served by the MHPs.
- Utilization of and units of service (mean and median) for adults and FC who received SMHS
- Retention in services – the percentage of members who received 1, 2, 3, 4, 5-15 or 15+ services
- Diagnosis of members – the percentage of members served and the percentage of claims accounted for by each diagnostic group
- HCMs – percent of members served whose claims exceed $30,000 in the CY
- Inpatient utilization – members served, number of admissions, average length of stay (LOS), average and total claims for inpatient
- Follow-up from inpatient discharge and inpatient readmission rates at 7 days and 30 days

The PMs that present data by Plan are outlined in Table 3-1, with reference to its table number and page number in this report.

Table 3-1: PMs with Plan-level Data, Table Numbers and Page Location

PM	Number of Table	Page(s)
PR by Race/Ethnicity by MHP	Table 4-8	50
Wait Time to Initial Non-urgent, Non-psychiatry Appointment Offered	Table 5-3, Table 5-4	69, 71
Wait Time to Initial Non-urgent, Non-psychiatry Appointment Delivered	Table 5-5, Table 5-6	76, 79
Wait Time to First Offered Non-Urgent Psychiatry	Table 5-7, Table 5-8	84, 86
Wait Time to First Delivered Non-Urgent Psychiatry	Table 5-9, Table 5-10	90, 94
Wait Time to Urgent Services	Table 5-11	98
Post-Inpatient Discharge Follow-up	Table 5-12	102
Psychiatric Inpatient Readmission Rates	Table 5-13	105
Average No-show Rates	Table 5-14	108
Adult/Older Adult Surveys by MHP	Table 8-3	161
Youth/Families of Youth Surveys by MHP	Table 8-4	164
Compliance System Review Results	Table 10-3	201
Compliance Outpatient Chart Review Results	Table 10-4	202

ANALYSIS TOOLS

The quantitative approved claims data were compiled and analyzed with SAS. Graphs were created using Microsoft Excel, generated to highlight key findings. Data in the annual report are largely presented in a statewide aggregate form, with some measures comparing similar-sized counties or region, and provided with comparisons over time.

Analytic staff manually extracted key themes from the extensive qualitative data to highlight the most salient ones. Discussions with key informants during the review, along with MHP documentation, provided programmatic context for understanding the PMs.

Collecting member feedback was a cornerstone of the reviews, providing significant qualitative data about services across the continuum. The Plan member/family (PMF) focus groups were interviews that engaged members in discussing their nuanced experiences of receiving services from the MHP. The focus groups were designed to include members from various service locations or treatment programs, ages, and ethnic groups, including those for whom English is not the preferred language and who require translators.

This mixed-methods approach is used to generate highlights, key findings, noteworthy practices, and areas for improvement.

PRE-SITE ACTIVITIES: REVIEW PREPARATION

CalEQRO issued a notification packet to each MHP via email 60 days prior to the date of the scheduled review. This letter identified the requested PMF focus groups based on a review of PM data or concerns from the prior year's review, or determined in collaboration with the MHP if a particular population was of interest to the MHP.

The MHP was also referred to the CalEQRO website for documents that the MHP completes or updates, including the following CalEQRO forms:

- Response to prior-year report recommendations
- Key changes and new initiatives
- ISCA
- Pathways to Well-Being Form
- NA Form
- ATA
- Two PIP Development Tool submissions – one clinical and one non-clinical

The MHPs were instructed to submit those documents, along with other key documents they maintain throughout the year, to a shared, secure website folder. These additional documents include:

- QAPI Work Plan
- Prior year QAPI Work Plan Evaluation
- Quality Improvement Committee (QIC) meeting minutes
- Cultural Competency Plan (CCP)
- Cultural Competency Committee meeting minutes

- Current organizational chart(s) of the MHP
- MCP memoranda of understanding
- Strategic Plans, if applicable
- Examples of data analysis conducted since the last review

In addition, MHPs were encouraged to provide examples of activities conducted to enhance the provider network, expand the continuum of care, build community partnerships, and any other documents that demonstrated the MHP's management of access, timeliness, quality, IS, or outcomes of care.

MHPs were advised to contact the Lead Quality Reviewer by a specified date to begin review preparation discussions and to upload all review documentation to CalEQRO's HIPAA-compliant web-based platform 4 weeks before the review for comprehensive review by the assigned team.

During the Coronavirus Disease-2019 (COVID-19) pandemic, reviews transitioned to being conducted via video conference due to safety protocols, with only two MHPs receiving on-site reviews in FY 2022-23. It became clear that virtual reviews offered the advantage of allowing for a more robust agenda within the allotted time frame, as there was no need to move between conference rooms or travel between sites. For FY 2023-24, MHPs were given the option to choose between an on-site or virtual review format. Of the 56 MHPs, 52 opted for a virtual review and 4 chose on-site. One of the MHPs that preferred on-site was instead conducted in a hybrid approach, due to changes that occurred in EQRO staffing. It was most often the larger Plans that opted for on-site reviews; no small or small-rural MHPs preferred on-site reviews.

If a given county also participated in a DMC-ODS review, the option to combine the EQRs was provided. The seven counties participating in the DMC-ODS regional plan model did not have the option of combining agendas for the MHP and DMC-ODS reviews due to logistical reasons. Although the review preparation and final reports remained distinct, and integration has been embraced to varying degrees across the behavioral health plans (BHPs), providing the option to combine reviews was intended to reduce duplication and encourage integration, or, at the very least, promote discussion regarding integration opportunities. The 21 MHPs that opted for an integrated review accounted for all three on-site reviews (Fresno, Santa Cruz, Ventura) and the one hybrid review (Riverside). The other reviews that were conducted jointly with the DMC-ODS were Contra Costa, El Dorado, Kern, Marin, Merced, Monterey, Napa, Nevada, Placer, Orange, San Benito, San Bernardino, San Luis Obispo, San Mateo, Santa Barbara, Stanislaus, and Tulare. For integrated EQRs, additional days were usually not required when the MHP and DMC-ODS teams worked concurrently or collaboratively, depending on the session topic, the degree of Plan integration, and BHP staff preference and availability. Sometimes, what would have been two separate 2-day reviews was conducted as a comprehensive 3-day review.

The review agenda was prepared in consultation with each MHP, following CMS protocols. Discussions were planned to address improvements in areas identified in the prior year's EQR report and to provide the MHP an opportunity to showcase additional accomplishments since the previous review, particularly those impacting access, timeliness, and quality of care. MHP EQR agendas were tailored to specific topic areas or key informant groups (e.g., contract provider management, clinical line staff, peer providers), with sessions typically lasting between 1 and 2 hours. For those that opted to combine the MHP with the DMC-ODS EQRs, sessions were more frequently 2 hours long to ensure comprehensive collection and clarification of review materials for each distinct report. However, PMF focus groups remained specific to either MHP or DMC-ODS and occurred concurrently. It was discovered that integrated reviews allowed for additional input about the MHP that might not have been gathered by an MHP-only

review. For example, integrated reviews provided a more comprehensive look at the extent of SUD treatment integration, its impact on services for co-occurring populations, prevention services, and justice system collaboration.

MHPs were asked to invite members to participate in focus groups where they shared their experiences with care and offered recommendations for improvement. The MHP was usually asked to focus on members who have initiated care within the past 12 months. Depending upon the MHP, a particular member demographic or service type may have been requested. Virtual reviews can present challenges for member focus groups, though many members are familiar with telehealth services. For members in rural areas, virtual reviews have been beneficial for reducing transportation barriers but challenging due to limited internet bandwidth. In some cases, a few members who had confirmed their attendance did not participate in the focus groups. Additional member feedback results are detailed in the Perceptions of Care chapter.

Reviews were conducted over 1 to 3 days, depending on the size of the MHP. Larger MHPs, being more complex, typically required an additional Quality Reviewer and 3 days to gather and validate information through interviews with key informants. Small and small-rural reviews were conducted in 1 to 1.5 days, while medium MHP reviews took 2 days. The Los Angeles review is unique in typically requiring 4 days and an expanded review team, focusing each year on two of the eight service areas in addition to the overall system operation. Although the Los Angeles MHP review focused on two geographic service areas, most submitted documents represented the entire MHP system.

In finalizing the agenda and preparing for the review discussions, the review team examined all CalEQRO-created PM data and the MHP documents submitted. This preparation allowed the review team to identify areas where additional questions or discussion were needed to fully understand the MHP's processes or operations. Before the review, the team held a pre-site meeting to discuss priority areas based on the previous year's report, the MHP's documents, and any other MHP-specific information. For integrated reviews, both review teams held a meeting to coordinate and discuss the extent of BHP integration as it applied to the joint agenda, as well as to find ways to minimize duplication for reviewers and Plan participants.

CONDUCTING THE MHP REVIEW

During the review, up to three sessions, but usually two, were held concurrently, depending on county size, system complexity, participant roles, and review team size. An integrated review included as many integrated sessions as necessary based on the BHP's structure, operating concurrently with both the MHP and DMC-ODS review teams. Each CalEQRO review team included at least one Quality Reviewer, IS Reviewer, and CFM Reviewer, with each potentially conducting review discussions simultaneously. MHP participants varied based on the session focus and the availability of informants who could address the topic, ideally including both leadership and line staff involved in implementation. Participation included leadership and staff, contract agency leadership and staff, members and families, partner agencies, and various community stakeholders. Additional documents could be submitted during the review, and CalEQRO permitted the submission of relevant information up to 2 weeks after the review, "post-site."

Throughout the review process, the CalEQRO teams rated the items and sub-items that form the Key Components based on their review of PMs, submitted documents, and discussion sessions used to validate impressions and conclusions. This document, historically available on the CalEQRO website, outlines the number of items that must be met to achieve a Partially Met or

Met rating.[13] There are 26 Key Components, categorized into Access, Timeliness, Quality, and IS. The ratings of the Key Components, analysis of the PMs, and other quantitative and qualitative information from the review were consolidated into a set of strengths and opportunities for each broad category. Tailored recommendations were provided where opportunities for improvement were identified.

CalEQRO focused on how MHPs used data to promote quality and improve performance. Critical elements of successful performance management include a focused organizational culture with strong leadership and stakeholder involvement, effective use of data for QM and QI, a comprehensive service delivery system, and workforce development strategies that support system needs. These issues aligned with the CQS's broad view of quality and its goal of using data-driven analytics to represent care and outcomes. Analyzing PMs by race/ethnicity and making recommendations on access to care was intended to help advance equity goals and identify care gaps, which are key priorities in the CQS. The CalEQRO review used data analyses from MHP reviews to identify strengths, opportunities for improvement, and recommendations for addressing areas needing enhancement. Each review also assessed the work done in response to the prior year's recommendations, evaluating whether those items were fully, partially, or not addressed.

POST-SITE: REPORT OF MHP-SPECIFIC FINDINGS

The Plan-level report consolidated quantitative and qualitative data into an initial draft report. Preliminary drafts were reviewed and edited iteratively by internal staff and leadership. The core report template followed the general CMS protocol, incorporated areas of interest to DHCS within the CalEQRO scope of work, and aligned with the DHCS 2022 CQS.

CalEQRO was expected to produce a draft report within 30 days of the MHP review conclusion. DHCS and the MHP were then invited to provide feedback or request additional clarification or information be included before the Final Report was delivered within 90 days of the review. MHPs were requested to provide feedback within 2 to 3 weeks, while DHCS provided its feedback within 30 days. If MHPs requested additional time due to competing demands, a new deadline was negotiated and approved. As this is the last year BHC will serve as the state as its BH EQRO, historical BHP reports will be posted on a DHCS web page.[14]

The MHP Final Report included:

- A summary of the changes and initiatives identified by the MHP that significantly impacted access, timeliness, and the quality of the service delivery system. Additionally, a section identifying external events outside the MHP's control that may have impacted services, such as wildfires or mudslides affecting staff or members, was included.
- Ratings of the Responses to Recommendations as Fully Addressed, Partially Addressed, or Not Addressed, with a summary of related MHP activities. It also indicated whether the same recommendation would be repeated based on the relative need. When a partially or not addressed recommendation was not repeated, reasons were

[13] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

[14] Ibid.

provided, such as other more important recommendations or a substantive plan from the MHP for addressing the issues.

- Review and validation of each MHP's NA per 42 CFR Section 438.68, including data related to DHCS AAS as specified in California WIC Section 14197.05, detailed in the Access section of this report.
- Ratings of Met, Partially Met, or Not Met for each of the four Key Component categories: Access, Timeliness, Quality, and IS. Document review and review session discussions to validate the documentation were essential to this process. At a minimum, any ratings of Not Met included a brief explanation.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs per 42 CFR 438.358(b)(1)(ii). PMs included the examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, per California WIC Section 14717.5.
- Evaluation and validation of the MHP's two contractually required PIPs per Title 42 CFR Section 438.330 (d)(1)-(4).
- Member perception of the MHP's service delivery system based on focus groups with members and family members. The report included a brief overview of the feedback and specific recommendations made by the participants.
- Assessment of the extent to which the MHP and its subcontracting providers met Federal data integrity requirements for HIS.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year. These findings were maintained in a database for statewide analysis.

STATEWIDE AGGREGATE TECHNICAL REPORT

This statewide aggregate technical report includes comparable information from each MHP Final Report, aggregated at a statewide level to provide a comprehensive view of access, timeliness, and quality across California's MHPs. The chapters are organized by the major categories of the EQR scope of work:

- Methods
- Access
- Timeliness
- Quality
- PIPs
- Member Perceptions of Care
- IS
- Compliance

The PMs, focused on CY 2022, are embedded throughout this report. They are often presented as part of a three-year trend using tables or figures, with various stratifications (e.g., age, race/ethnicity, MHP size, MHP region), accompanied by narrative descriptions of meaningful trends or conclusions based on the data.

To facilitate the analysis of information from 56 MHPs, CalEQRO maintains several databases that correspond with CalEQRO forms, MHP submissions, and information extracted from the MHP final reports. The following databases of information collected from documents and the reviews enabled analysis from a statewide perspective:

- NA
- Pathways to Well-Being
- ISCA
- Timeliness
- PMF Focus Groups
- PIPs
- Strengths, opportunities, and recommendations from each MHP final report.

The report includes four Appendices. The first is a comprehensive list of definitions used in the programming and calculations of the PMs from the approved claims data. The second appendix defines each MHP by size and region, as both categories are used for comparative purposes in the PM analysis. The third appendix shows each county on a California map, by size and by region. The fourth appendix details the DHCS EQR Protocol 3 Compliance results, provided by DHCS to include in this report to remedy DHCS's ongoing deficiencies identified by CMS.

An additional attachment includes the Executive Summaries from all 56 MHP reports. This provides the reader with summary information at the MHP level. The Executive Summaries include the MHPs' Response to Recommendations, detailing how many were Fully Addressed, Partially Addressed, or Not Addressed. They provide a summary of the 26 Key Component ratings by domain, details regarding the PIP topic, phase, and confidence validation ratings, as well as the types of member focus groups held and the number of participants. Additionally, the summaries conclude with descriptions of strengths, opportunities for improvement, and recommendations based on the review finding.

This report was submitted to DHCS first in draft form. After a 45-day period for DHCS to review and submit feedback, the finalized version was submitted to DHCS 30 days thereafter. Ultimately, DHCS submits it to CMS via public posting on its website in April 2025.

INTRODUCTION

CMS defines access as the ability to receive essential health care and services. Access encompasses a broad range of concerns regarding the extent to which eligible individuals (or members) can obtain necessary health care services from a health care system. It includes various factors such as insurance/plan coverage, the availability of providers and facilities in members' areas, sociocultural considerations, and geography – all crucial for members to access appropriate care when needed.[15] An MHP provide exemplary services, but if they are not readily accessible, the system fails to meet its mandate and the needs of the community.

ACCESSING MHP SERVICES STATEWIDE

In California, 56 MHPs serve 58 counties, with two pairs of counties – Sutter-Yuba and Placer-Sierra – operating as single MHPs. All MHPs are required to advertise and maintain a toll-free access line, which members primarily use to initiate access to SMHS. The implementation of the Adult and Youth Screening Tools effective January 1, 2023, made this step more consistent. After screening, members are typically referred to a clinical assessment, but this no longer must be completed before treatment can begin, as long as that service is medically necessary and matched to an identified problem. The initial assessment may be conducted by county-operated or contracted MHP clinicians. MHPs vary in their points of system access, with some being more centralized and others highly decentralized in terms of geography and providers. Although not required to start services, a diagnosis – or provisional diagnosis – early in care is relevant for guiding the treatment provided. Except for certain services, also under CalAIM, treatment plans have largely been replaced by problem lists and progress notes.

PRs are used by the EQR to measure access to care, calculated as the number of members served annually divided by the average annual monthly number of Medi-Cal eligibles. This chapter describes access performance across the state and explores factors that may contribute to variations in performance.

Medi-Cal Members Served Statewide by MHPs

Figure 4-1 illustrates the three-year statewide trend of eligibles and members served.

[15] Centers for Medicare and Medicaid Services. (n.d.) *CMS Data Navigator Glossary of Terms*. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf

Figure 4-1: Medi-Cal Eligibles and Members Served Statewide, CY 2020-22

Although the average monthly number of eligibles has steadily increased from CY 2020 to CY 2022, the number of members served rose significantly in CY 2021, but then declined in CY 2022. This was preceded by a marked decline in members served in CY 2020 due to the COVID-19 pandemic, with numbers served not yet returning to pre-pandemic levels.

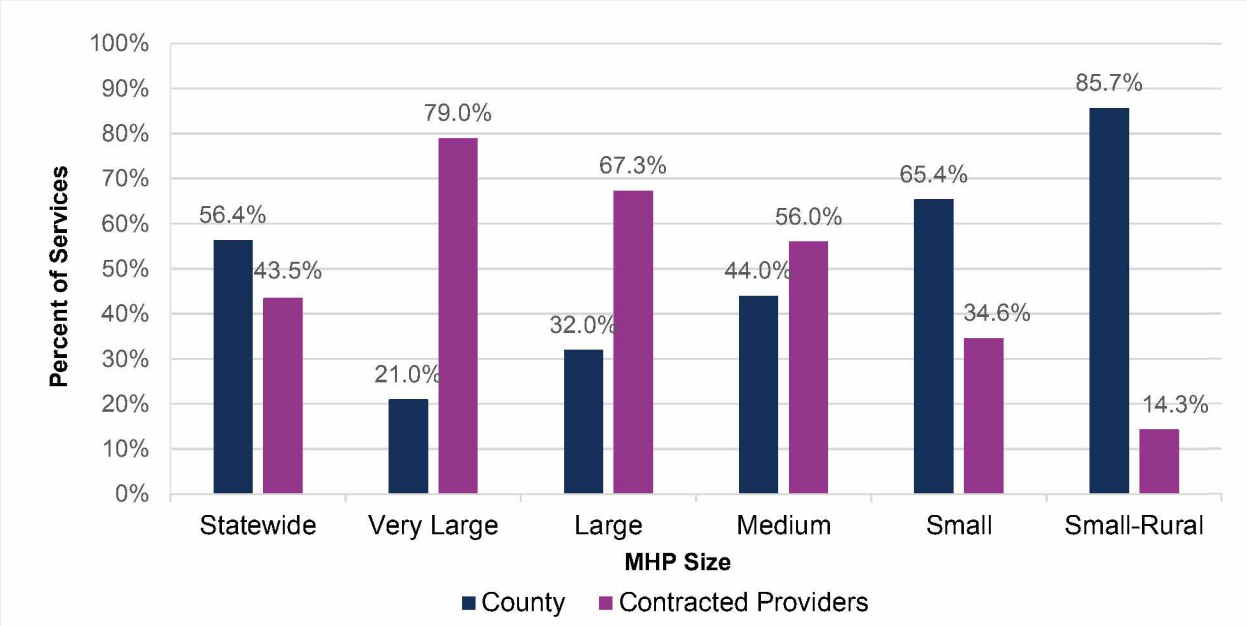
The average monthly eligible population grew by 15.9 percent between CY 2020 and CY 2022, while the number of members served increased by just 0.9 percent over the same period and decreased by 2.4 percent in CY 2022 compared to CY 2021.

In CY 2022, the annual number of Medi-Cal eligibles, based on a monthly average from the MMEF file, was 15,168,280. In CY 2021, as shown in the SDMC and IPC claims, the state experienced a decrease in the number of members in services compared to the previous year, with numbers served in CY 2022 only slightly higher than those in CY 2020. Following a substantial increase in eligibles from 2020 to 2021, the average monthly eligibles increased in CY 2022 by nearly one million (7 percent) increase from the previous year, as individuals were not discontinued from Medi-Cal enrollment during the COVID-19 pandemic. Medi-Cal. Redeterminations began on April 1, 2023, and a decrease in eligibles is anticipated starting in CY 2023.

Service Delivery by County vs Contract Provider

SMHS are delivered by both county-operated and contractor-operated providers throughout California, collectively forming the MHP's network. Figure 4-2 shows a correlation between the size of an MHP, and the percentage of services delivered by MHP staff.

Figure 4-2: SMHS Delivery Provider Type, by County Size, FY 2023-24



According to data reported by the MHPs in the ISCA, approximately 56.4 percent of services statewide were delivered by county-operated programs, while 43.5 percent were delivered by contract providers. To some extent, services provided by contractors represent smaller agencies scattered throughout communities, potentially offering better access to care compared to county-operated services, which are often centralized in a few locations.

Los Angeles, the only “very large” MHP, has 79 percent of its services delivered by contract providers. As MHP sizes decrease, the average percentage of services provided by contractors also decreases. On average, two-thirds of services in large MHPs were delivered by contract providers, compared to just 14.3 percent in small-rural MHPs. Medium MHPs had a fairly even distribution between county-operated and contracted programs. County-operated programs provide the majority of services in small and small-rural MHPs (Figure 4-2).

Figure 4-3 shows the percentage of services reported by MHPs as claimed to Medi-Cal.

Figure 4-3: Services Claimed to Medi-Cal, CY 2022

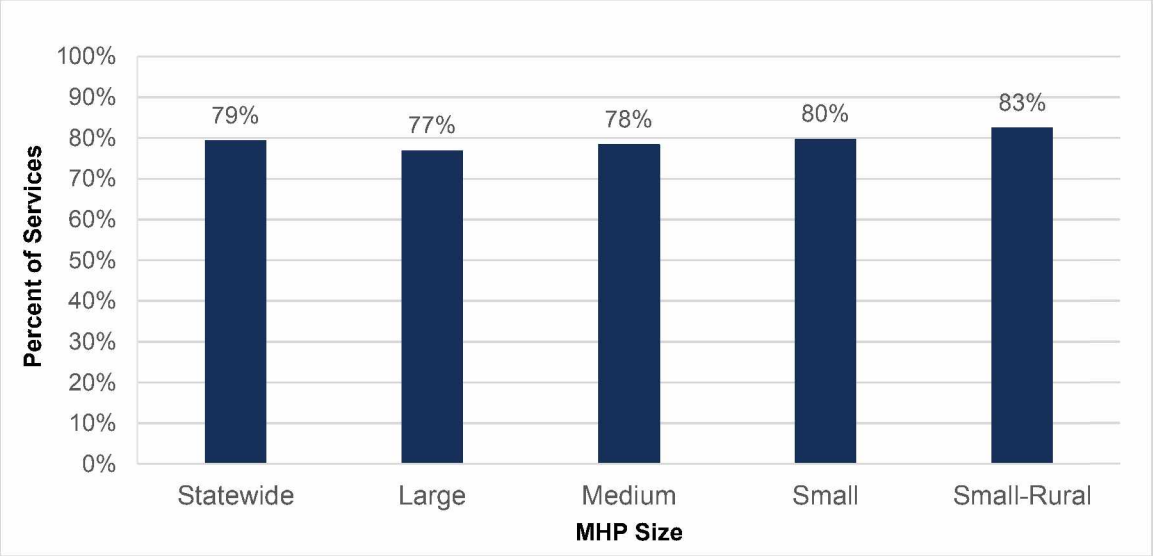


Figure 4-3 indicates that MHPs claim the vast majority, but not all, of their services to Medi-Cal. Therefore, some parts of the MHPs' service systems are not represented in the PMs throughout this report. Some services are funded entirely by the Mental Health Services Act, other grants, 1991/2011 Realignment, or local funds.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system that improves member outcomes: culturally appropriate service accessibility and availability; system capacity; integration and collaboration with other providers; and the extent to which an MHP informs the Medi-Cal eligible population and monitors service access and availability.

Each of the six access components, consisting of individual subcomponents, is collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met.[16] A summary of statewide performance is shown in Table 4-1, followed by a summary of each component.

[16] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

Table 4-1: Summary of Access Key Components – Statewide, FY 2023-24

KC #	Key Component – Access	Met	Partially Met	Not Met
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	52	4	0
1B	Manages and Adapts Capacity to Meet Member Needs	41	14	1
1C	Collaboration and Coordination of Care to Improve Access	56	0	0
1D	Service Access and Availability	54	2	0

Each Access component (1A through 1D) is rated based on its subcomponents. Components 1A and 1B include 5 items each. A rating of Met is achieved by meeting four or five items, while Partially Met is assigned for meeting two or three items. Meeting only one subcomponent results in a Not Met rating, which, for Access, occurred in only one MHP. Component 1C involves collaboration with 11 systems to improve access to care; collaborating with six to eleven systems results in a Met rating, and collaborating with three to five systems results in a Partially Met rating. Component 1D includes eight elements related to service access. Meeting six to eight elements results in a Met rating, while meeting three to five elements results in a Partially Met rating.

For the Access components, 37 MHPs (66 percent) received a Met rating on all four items. Because CalEQRO uses a quality improvement (QI) framework, this means that MHPs either demonstrated strength in all four areas, or, where they did not, had distinct efforts aimed at achieving improvement. Monterey, a medium MHP, received the only Not Met rating in this area due to a lack of mechanisms to monitor system demand and available service capacity.

The ratings indicate that MHPs recognize the importance of prioritizing access to care. Improving access to mental health services remains an ongoing challenge for many MHPs, as numerous individuals in need of SMHS do not seek or engage with these services. The Access Key Components are designed to assess an MHP's analysis of member access to care, identify areas for improvement, and implement strategies to continuously enhance access for Medi-Cal members requiring SMHS. This includes their commitment to diversity, equity, and inclusion, capacity management, care coordination, and the overall accessibility and availability of services.

Table 4-2 shows the rating for each Key Component by Plan.*

Table 4-2: Access Key Components by Plan, FY 2023-24

MHP	1A	1B	1C	1D
Alameda	M	M	M	M
Alpine	PM	M	M	M
Amador	M	M	M	M
Butte	M	M	M	M
Calaveras	M	M	M	M
Colusa	M	M	M	M
Contra Costa	M	M	M	M
El Dorado	M	M	M	M
Fresno	M	PM	M	M

MHP	1A	1B	1C	1D
Del Norte	M	M	M	M
Glenn	M	M	M	M
Humboldt	M	M	M	M
Imperial	M	M	M	M
Inyo	M	PM	M	M
Kern	M	M	M	M
Kings	M	M	M	M
Lake	M	M	M	M
Lassen	M	PM	M	M
Los Angeles	M	M	M	M
Madera	M	PM	M	M
Marin	PM	M	M	M
Mariposa	M	PM	M	M
Mendocino	M	M	M	M
Merced	M	M	M	M
Modoc	M	M	M	M
Mono	M	M	M	M
Monterey	M	NM	M	M
Napa	M	PM	M	M
Nevada	M	M	M	M
Orange	M	M	M	M
Placer - Sierra	M	M	M	M
Plumas	M	M	M	M
Riverside	M	PM	M	M
Sacramento	M	M	M	M
San Benito	M	M	M	M
San Bernardino	M	PM	M	M
San Diego	M	M	M	M
San Francisco	M	M	M	PM
San Joaquin	M	M	M	M
San Luis Obispo	M	PM	M	M
San Mateo	M	M	M	M
Santa Barbara	M	PM	M	PM
Santa Clara	M	M	M	M
Santa Cruz	M	M	M	M
Shasta	M	M	M	M
Siskiyou	M	M	M	M
Solano	M	M	M	M
Sonoma	M	M	M	M
Stanislaus	M	M	M	M
Sutter-Yuba	M	PM	M	M
Tehama	M	PM	M	M
Trinity	PM	M	M	M
Tulare	M	PM	M	M

MHP	1A	1B	1C	1D
Tuolumne	M	M	M	M
Ventura	M	M	M	M
Yolo	PM	PM	M	M

*Note: M = Met, PM = Partially Met, NM = Not Met

Cultural Competence

Key Component 1A focuses on evaluating MHPs' approaches to cultural competence and efforts to reduce disparities in access and care. Diversity, equity, and inclusion are prominent issues from both a state perspective and across MHPs. In this category, 52 MHPs (93 percent) received a Met rating, reflecting improvement over the FY 2022-23 review, where 49 MHPs received a Met rating. This is a priority issue across MHPs; access for underserved populations was noted as a strength in 18 MHPs and as an opportunity for improvement in 11 MHPs. When cited as an opportunity, it was most often related to low PRs for the Hispanic/Latino population or the need for more bilingual staff. This year, many MHPs discussed active efforts to improve representation of all prevalent ethnic and racial groups, not only in the PRs for members served but also within the clinical staff. For example, during the Solano review, members requested greater representation of African Americans within the clinical staff, leading to plans to integrate these efforts into their internship program.

MHPs generally maintain current CCPs and have a separate cultural competence committee (CCC) responsible for implementing the goals of the CCP. MHPs often struggle to engage representatives from underserved populations in these work groups to develop meaningful improvements. Participation by members, their families, and community-based organizations embedded in these communities is crucial for creating and sustaining change. Nevertheless, there are many strong examples of MHPs improving access for underserved populations and striving for equity in access – a consistent theme also in the CQS. **Los Angeles**, for instance, has addressed this issue with a robust "anti-racism, diversity, and inclusion" initiative aimed at combating all forms of structural racism. **Merced** demonstrated a notable focus on the deaf/hard of hearing and Lesbian, Gay, Bisexual, Trans, Queer or Questioning (LGBTQ+) populations. **Tuolumne** engages in accessible outreach events like "family night" and "coffee talk" to introduce families to services. **Colusa** added a full-time position dedicated to community outreach.

Meeting attendance and participation have suffered in some MHPs due to staff turnover and vacancies. Additionally, the CCC, as reflected in meeting minutes, sometimes focuses on cultural celebrations, training opportunities, and idea exchanges rather than addressing key issues that act as barriers to engagement in SMHS. Some MHPs noted that they included mandatory attendance at the CCC, often a subcommittee of the QIC, in their providers' contracts. Attendance at both groups could facilitate a stronger connection between CCC discussions and QI actions, potentially improving member access.

Language capacity is crucial for serving the state's diverse populations effectively. MHPs often find that they lack sufficient Spanish-speaking capacity, even in those with 25 percent or more of their staff speaking Spanish. Some MHPs have bilingual staff who are verbally fluent but cannot pass a written fluency exam, which can prevent them from receiving a salary differential for their language skills. This situation often leads to union-related tensions about whether staff should be expected to use their alternate language without additional compensation. Staff typically continue to offer services in the language they speak, but they often cite it as a negative factor affecting their morale.

Despite the challenges, many MHPs are actively working toward improved language access and cultural representation. Small-rural MHP **Colusa** was recognized for having a strong contingent of bilingual staff and serving 29 percent of its members in Spanish. Nearly all of **Imperial**'s workforce speaks Spanish, and 41 percent of their members were served in Spanish – the highest proportion of Spanish-speaking clientele in the state. **Santa Clara** serves over 24 percent of its members in Spanish, as well as five other threshold languages: Vietnamese, Farsi, Mandarin, Tagalog, and Cantonese. **San Luis Obispo**, with a long history of analyzing data specific to Spanish-speaking members, hired a new public information specialist to launch a monolingual media campaign aimed at outreach to this population.

Some MHPs do not have all their written materials translated into all threshold languages on their public-facing websites. Therefore, while MHP staff may be engaged in robust outreach activities targeting underserved communities, the systems to serve these members may not be fully developed to effectively engage them once identified.

Capacity Management and Workforce

Maintaining and managing adequate service capacity has long been a challenge for MHPs. However, 41 MHPs (73 percent) achieved a Met rating for the capacity management Key Component. This improved from 37 MHPs in FY 2022-23. This does not indicate that MHPs have sufficient workforce but that they are consistently monitoring service demand and making efforts to align their workforce with member needs.

Managing capacity has long been a challenge for MHPs, with staff recruitment and retention becoming increasingly difficult. During validation sessions, many clinical staff acknowledged that although CalAIM has introduced some flexibility with updated documentation processes, clinical positions in the private sector or outside the SMHS system still require significantly less administrative work than those in the Medi-Cal system of care. Staff at all levels have left for "less stressful" positions in private practice, telehealth roles, private healthcare companies offering higher salaries, school districts with summer vacations, MCPs with lower acuity clientele, or have retired or exited the mental health field entirely. New master-level graduates seeking clinical licenses now have the option to gain their clinical hours under private practitioners or within MCP systems, rather than fast-tracking into MHPs. Other workforce challenges include delayed recruitment, slow onboarding, lack of competitive salaries, staff burnout, insufficient training for new employees, and personal or family-related medical leave. Recruitment and retention challenges often leave many MHPs unable to maintain a stable workforce, with vacancy rates frequently reported at around 20 to 40 percent.

Some MHPs have effectively directed their workforce and staffing efforts toward revamping their internship programs. Others have successfully hired and employed new graduates before they obtain their associate clinician number. These MHPs aim to mitigate the negative impact of turnover by hiring staff early in their careers with the hope of retaining them long-term. Workforce issues are nearly universal, impacting access to care, timeliness of care, and the frequency of service delivery.

Simultaneously, MHPs have expanded their capacity creatively, reinforcing and redesigning existing staffing resources. **Los Angeles** implemented collaborative charting. (This is a practice where the progress note is produced at the end of the session and is discussed with the member in its draft form, and is intended to eliminate progress note documentation outside of the session time.) **Humboldt** and other MHPs have utilized non-clinical staff to administer the Adult and Youth Screening Tools. **Lake** hired a vendor for clinical supervision to allow their clinical supervisors to dedicate more time to direct services. **Mono** embraced teleworking,

expanding telehealth services and hiring remote providers from outside the area. Telehealth with remotely located psychiatrists has been crucial for psychiatric capacity, as seen in **Butte**, where a remote medical director was sought when necessary.

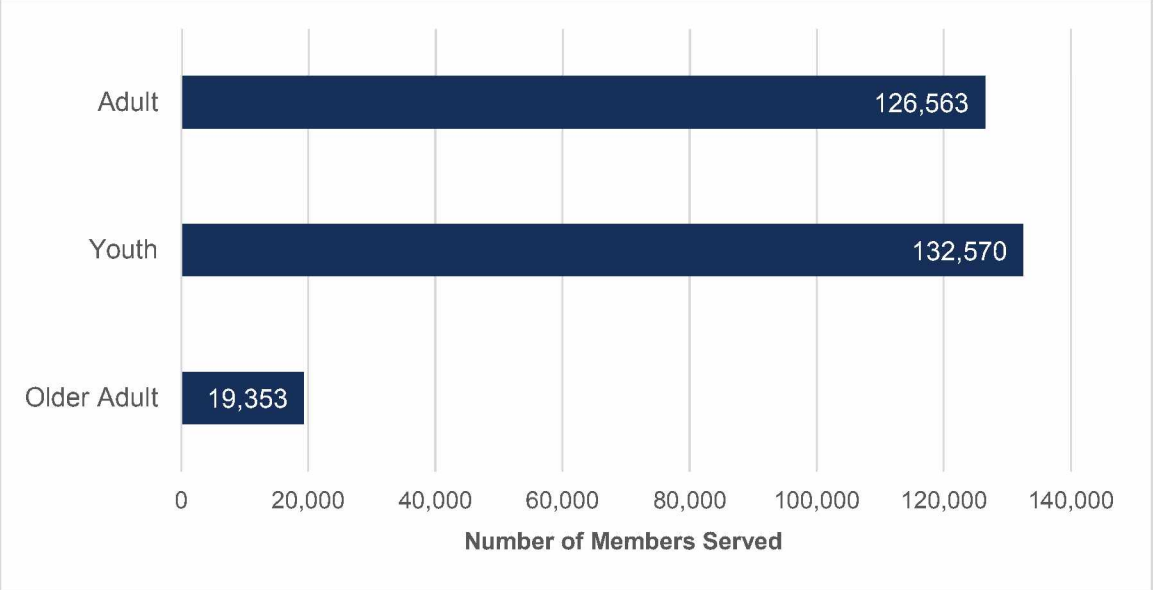
Telehealth and Telework

Telehealth, saw a major launch during the COVID-19 pandemic, has become a mainstay in service provision, particularly amid the workforce crisis. Most MHPs have adopted a "hybrid" workforce model, combining telehealth with partial remote work, typically having staff work 2 to 3 days on-site and 2 to 3 days from home. **Madera** significantly expanded their telehealth services by contracting with a new provider.

As before, telehealth services offered by staff working remotely helped MHPs retain employees. However, this effect varied by MHP and role. MHPs found that some roles were less suited to telework, such as FSPs that involve community-based services or outreach and engagement programs. A few MHPs were implementing policies, sometimes instituted at the county-level and beyond the MHP's control, that aimed to reduce telework. Even if telehealth was permitted, staff were required to conduct it from the office. Further, in staff validation sessions, many expressed a strong preference for in-person interactions with members, despite a prevalent desire for increased telework to enhance job satisfaction and maintain service capacity.

All 56 MHPs report in the ISCA that they have sustained telehealth service capabilities over the past three FYs. Figure 4-4 shows members served with telehealth by age groups.

Figure 4-4: Members Served via Telehealth Reported by MHPs, FY 2023-24



Almost half (46.3 percent) of members were reported in the ISCA as having received at least one service through telehealth in the prior year. In FY 2023-24, MHPs reported providing telehealth services to 126,563 adult members, 132,570 youth members, and 19,353 older adult members. Compared to the previous year, MHPs reported a decrease in telehealth services for adults and youth, with a reduction of 11.8 percent for adults and 21.1 percent for youth. However, there was an increase of 6.5 percent in the number of older adults receiving telehealth compared to the previous year. While some adults and many youth have returned to more in-person care, a growing number of older adults are gradually participating in telehealth.

Using CalEQRO approved claims data for members served by age group (displayed later in this chapter), approximately 60 percent of youth, 39 percent of adults, and 33 percent of older adults received telehealth services. (Note that as telehealth utilization data was provided in the ISCA by MHPs, there may be variations in how MHPs defined telehealth as well as each age group, so these percentages should be viewed as approximate rates of telehealth utilization.)

Integration and/or Collaboration to Improve Access

This included enhanced partnerships between MHPs and contract providers, and improved coordination across county departments to connect with high-risk members. MHPs have prioritized collaborations with criminal justice systems, MCPs, hospitals, school districts, and county offices of education. All MHPs received a Met rating for their multiple strategies in collaborating and coordinating with partner agencies, reflecting an improvement of one MHP from the previous year. Collaboration across systems was noted as a strength for 30 MHPs.

Mendocino, Marin, and Humboldt were noted for their collaborative suicide prevention initiatives. Collaboration with MCPs is crucial for coordinating care with medical providers and transitioning members between service systems. It was noted as a strength only in Mono and Monterey, with recommendations involving MCPs given to seven MHPs. Since the Transition Tool's implementation in January 2023, MHPs have reported mixed results, frequently encountered challenges when transitioning members to a non-SMHS LOC. In some counties, the MCPs did not seem to have a sufficient network to accept these referrals, but also there may have been challenges with members being reluctant to transition to a new system and provider.

MHPs frequently expanded collaboration with criminal justice partners to enhance access to mental health courts, diversion programs, and Community Assistance, Recovery and Empowerment (CARE) Court. Tuolumne, Yolo, Riverside, and San Bernardino were recognized for their strengths in this area. For example, **Riverside** has established 17 collaborative courts fully integrated with the DMC-ODS. The goal was to be member-centered and ultimately prevent further justice involvement for members with mental health conditions. An increasing number of MHPs have collaborated with social services to address challenges in transitioning from jail to outpatient care, emphasizing the importance of quickly restoring Medi-Cal benefits upon release for member success.

Service Access and Availability

This Key Component demonstrated very high performance, with all but two MHPs receiving a Met rating. San Francisco and Santa Barbara were the MHPs that received a Partially Met rating.

This year, five MHPs were noted for lacking important access information on their public-facing websites. Given that the internet is a primary source of information, it is that access and crisis numbers are easily accessible. Several counties and MHPs were in the process of updating their websites. This meant that until the new infrastructure was ready, County policies often led to neglecting maintenance of the current website while awaiting the new one. MHPs often delayed posting new or updated materials on a website slated for discontinuation, even though the transition could take months or even years.

Transportation continues to be a crucial factor in ensuring service accessibility. To address this, MHPs worked with MCPs to enhance their transportation benefits. Complaints about inconsistent transportation benefits were common, often leading MHP staff to provide transportation themselves. Telehealth services partially offset transportation needs, but some

members still preferred in-person services or had mixed preferences for telehealth and in-person care. Some MHPs aimed to return services "back to the clinics," rather than relying on field-based services or telehealth, as deemed appropriate. Payment reform, which did not allow billing for transportation time, often led to an increase in providing services at clinics rather than in the community or members' homes.

The mobile crisis benefit was scheduled to be implemented by December 31, 2023, in most counties, with 12 – primarily small-rural counties – having until June 30, 2024, to complete implementation.[17] MHPs appeared to be at various stages of implementation throughout the year. Many struggled with having enough staff, county or contract, to implement this 24/7 service. Implementation was sometimes coordinated with law enforcement, depending on local needs, geography, and community expectations. Many MHPs have expanded their staffing options through the allowable use of peer counselors and SUD counselors.

Several MHPs celebrated the colocation of services, which eased transit and access barriers for members. They reported improved efficiencies from collocating with child welfare, adult protective services, contracted pharmacy services, as well as within jails, schools, and shelters. For example, **Siskiyou**'s "Yreka Base Camp" will be located in the same building as the wellness center and will offer a 32-bed, low-barrier shelter for the justice-involved population. The building will include showers, laundry facilities, and a confidential telehealth-equipped space for direct services.

ACCESS PERFORMANCE MEASURES

In addition to the Key Components mentioned, the following PMs further reflect access to care in the MHP:

- Total members served, stratified by MHP size, region, race/ethnicity, and threshold language.
- PR of members served, which is calculated by including a member in the numerator if they receive at least one service in the time frame, with the denominator being the total of the average monthly eligibles throughout the year.
- AACM, which is determined by dividing the total average approved claims by the unduplicated number of members served.

The following information details Medi-Cal eligibles and members served, categorized by county size, region, race/ethnicity, and threshold language.

The average eligible count is used to account for significant monthly enrollment variations, so the annual total and PR accurately reflect fluctuations in Medi-Cal enrollment. The AACM is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated Medi-Cal members served each year.

Table 4-3 provides a statewide overview of eligible and served members, PR, total approved claims and AACM. The numerator for the PR is the unduplicated number of members served, and the denominator is the total eligibles. The AACM is calculated by dividing the total approved claims by the number of members served.

[17] https://www.dhcs.ca.gov/Documents/BHIN-23-025-Medi-Cal-Mobile-Crisis-Services-Benefit-Implementation.pdf

Table 4-3: Statewide PR and AACM, CY 2020-22

	Total Eligibles	Total Members Served	Penetration Rate	Total Approved Claims	AACM
CY 2020	13,089,479	595,596	4.55%	$4,261,350,000	$7,155
CY 2021	14,173,747	615,562	4.34%	$4,602,990,000	$7,478
CY 2022	15,168,280	600,959	3.96%	$4,472,180,000	$7,442

The number of members served has lagged behind the increase in eligibles, leading to decreased PRs in CYs 2021 and 2022. Medi-Cal eligibles remained enrolled throughout the pandemic. With an increase in eligibles and a decrease in members served, the PR dropped to 3.96 percent, an 8.76 percent decline from CY 2021's 4.34 percent. PRs peaked at 4.55 percent in 2020 and decreased by 8.76 percent to 3.96 percent in 2022.

Total approved claims peaked in CY 2021, while the AACM in CY 2022 was similar to the previous year.

Tables 4-4 through 4-7 break down this information by county size, region, age, and race/ethnicity. Los Angeles is the only very large county. These tables also show the percentage each category represents of the total eligible or total member population., i.e., each year, "total eligibles" and "total members served" each total100 percent of their respective groups). Comparing the proportion of members served to the proportion of eligibles provides insight into potential disparities.

Table 4-4 presents data categorized by MHP size.

Table 4-4: Eligibles and Members Served by MHP Size, CY 2020-22

Category	# of Eligibles	# of Members Served	% of Eligibles	% of Members Served	PR	AACM
Very Large						
CY 2020	3,866,435	212,272	29.54%	35.74%	5.49%	$6,748
CY 2021	4,156,251	214,658	29.32%	34.96%	5.16%	$6,625
CY 2022	4,473,021	207,203	29.49%	34.58%	4.63%	$6,927
Large						
CY 2020	6,434,454	265,801	49.16%	44.75%	4.13%	$7,156
CY 2021	7,010,128	279,674	49.46%	45.55%	3.99%	$7,910
CY 2022	7,995,344	287,504	52.71%	47.99%	3.60%	$7,838
Medium						
CY 2020	2,021,916	78,220	15.45%	13.17%	3.87%	$8,399
CY 2021	2,185,555	80,234	15.42%	13.07%	3.67%	$8,601
CY 2022	1,827,011	63,837	12.04%	10.66%	3.49%	$8,084
Small						
CY 2020	654,201	29,631	5.00%	4.99%	4.53%	$7,142
CY 2021	700,711	30,794	4.94%	5.02%	4.39%	$7,010
CY 2022	745,228	32,050	4.91%	5.35%	4.30%	$6,505
Small-Rural						
CY 2020	112,476	8,002	0.86%	1.35%	7.11%	$6,238
CY 2021	121,103	8,570	0.85%	1.40%	7.08%	$6,230
CY 2022	127,678	8,522	0.84%	1.42%	6.67%	$5,494

In CY 2022, the majority of members served were in large county MHPs (47.99 percent), followed by very large (34.58 percent), medium (10.66 percent), small (5.35 percent), and small-rural (1.42 percent).

PRs have declined each year since CY 2020 across all county size groups. Los Angeles, as the sole very large MHP, has consistently served over one-third of members statewide. However, its PR decreased by 15.66 percent over the displayed period, despite housing nearly 30 percent of statewide eligibles. No county size groups showed increases in PRs, although small and large MHPs served more members in CY 2022 than in CY 2021.

PRs have been highest in small-rural MHPs over the past three CYs, reaching 6.67 percent in CY 2022. In CY 2022, Los Angeles had the next highest PR at 4.63 percent, followed by small (4.30 percent), large (3.60 percent), and medium (3.49 percent) MHPs.

From CY 2020 to CY 2022, all size groups except medium saw an increase in eligibles. Medium-sized MHPs experienced a 9.6 percent decrease in eligibles during this period. The medium group also experienced the largest drop in numbers of members served (18.38 percent since CY 2020) and a decrease in AACM in compared to CY 2021. Los Angeles showed an increase in AACM in CY 2022, while all other categories experienced a decrease. The most significant decrease occurred in small-rural MHPs, with a reduction of 11.81 percent.

Table 4-5 presents this information stratified by region.

Table 4-5: Eligibles and Members Served by MHP Region, CY 2020-22

Category	# of Eligibles	# of Members Served	% of Eligibles	% of Members Served	PR	AACM
Bay Area						
CY 2020	2,041,248	101,477	15.59%	17.09%	4.97%	$11,056
CY 2021	2,232,173	105,074	15.75%	17.11%	4.71%	$12,301
CY 2022	2,388,267	104,878	15.75%	17.50%	4.39%	$11,840
Central						
CY 2020	2,365,670	89,987	18.07%	15.15%	3.80%	$6,237
CY 2021	2,539,218	97,287	17.91%	15.85%	3.83%	$6,257
CY 2022	2,697,762	95,324	17.79%	15.91%	3.53%	$5,965
Los Angeles						
CY 2020	3,866,435	212,272	29.54%	35.74%	5.49%	$6,748
CY 2021	4,156,251	214,658	29.32%	34.96%	5.16%	$6,625
CY 2022	4,473,021	207,203	29.49%	34.58%	4.63%	$6,927
Southern						
CY 2020	4,413,347	167,130	33.72%	28.14%	3.79%	$5,785
CY 2021	4,816,881	173,349	33.98%	28.24%	3.60%	$6,297
CY 2022	5,157,371	168,344	34.00%	28.09%	3.26%	$6,200
Superior						
CY 2020	402,780	23,077	3.08%	3.89%	5.73%	$7,391
CY 2021	429,225	23,573	3.03%	3.84%	5.49%	$7,576
CY 2022	451,861	23,454	2.98%	3.91%	5.19%	$7,290

In CY 2022, the Southern region accounted for 34.00 percent of California's eligibles, followed by Los Angeles (29.49 percent), Central (17.79 percent), Bay Area (15.75 percent), and Superior (2.98 percent). However, the Central region saw proportionally fewer members (15.91 percent) and the Southern region saw 28.09 percent. The three other regions showed proportions of members served comparable or higher than the proportion of eligibles.

Since CY 2020, the number of eligibles has increased in all regions. However, while the numbers of members served rose in all regions in CY 2021, they declined in CY 2022. In CY 2022, PRs in all regions were lower compared to both CY 2020 and CY 2021.

Table 4-6 presents this data categorized by age group. The PR numerator is an unduplicated count of members in that age category who received at least one service and the denominator is the unduplicated count of eligibles in that age category. The age of the members and eligibles are determined from their birthdate and age on January 1 of the year represented according to the MMEF for that year.

Table 4-6: Eligibles and Members Served by Age Group, CY 2020-22

Category	# of Eligibles	# of Members Served	% of Eligibles	% of Members Served	PR	AACM
0-5						
CY 2020	1,454,817	29,057	11.11%	4.88%	2.00%	$4,911
CY 2021	1,422,857	27,956	10.04%	4.54%	1.96%	$5,427
CY 2022	1,418,405	25,758	9.35%	4.29%	1.82%	$5,391
6-17						
CY 2020	3,148,820	195,978	24.06%	32.90%	6.22%	$8,342
CY 2021	3,300,692	195,768	23.29%	31.80%	5.93%	$8,668
CY 2022	3,420,454	193,297	22.55%	32.16%	5.65%	$8,663
18-59						
CY 2020	6,545,115	315,368	50.00%	52.95%	4.82%	$6,829
CY 2021	7,366,285	332,823	51.97%	54.07%	4.52%	$7,181
CY 2022	8,065,639	322,424	53.17%	53.65%	4.00%	$7,115
60+						
CY 2020	1,940,728	55,193	14.83%	9.27%	2.84%	$5,985
CY 2021	2,083,914	59,015	14.70%	9.59%	2.83%	$6,176
CY 2022	2,263,783	59,480	14.92%	9.90%	2.63%	$6,131

Despite the overall trend, older adults experienced an increase in numbers served each year. Although the increase in the number of older adults served (n=465) from CY 2021 to CY 2022 was modest, it was the only age group that did not experience a decrease during that period, though PR did decrease slightly due to increases in older adult members served not keeping pace with increases in eligibles. In CY 2022, 10,399 fewer adults were served, reflecting a 3.1 percent decrease. In CY 2022, youth in age groups 0-5 and 6-17 decreased by a total of 4,669, representing a 2.1 percent decrease in youth served. All age groups experienced an increase in eligibles, and the PR decreased for each age group in CY 2022 compared to CY 2021.

Table 4-7 displays this data by race/ethnicity. The numerator is an unduplicated count of members in that race/ethnicity category (according to the MMEF) who received at least one service and the denominator is the average unduplicated count of eligibles in that race/ethnicity category. It is also important to note that MHPs collect this race/ethnicity demographic information and MHP-generated data may differ from the MMEF.

Table 4-7: Eligibles and Members Served by Race/Ethnicity, CY 2020-22

Category	# of Eligibles	# of Members Served	% of Eligibles	% of Members Served	PR	AACM
African American						
CY 2020	976,616	77,980	7.46%	13.09%	7.98%	$7,393
CY 2021	1,020,844	77,961	7.20%	12.67%	7.64%	$7,786
CY 2022	1,059,802	74,995	6.99%	12.48%	7.08%	$8,149
Asian/Pacific Islander						
CY 2020	1,285,115	27,310	9.82%	4.59%	2.13%	$7,466
CY 2021	1,361,786	28,330	9.61%	4.60%	2.08%	$7,990
CY 2022	1,414,953	27,021	9.33%	4.50%	1.91%	$7,928
Hispanic/Latino						
CY 2020	6,531,536	250,391	49.90%	42.04%	3.83%	$6,551
CY 2021	6,972,105	260,551	49.19%	42.33%	3.74%	$6,733
CY 2022	7,371,266	258,856	48.60%	43.07%	3.51%	$6,731
Native American						
CY 2020	50,821	3,435	0.39%	0.58%	6.76%	$7,908
CY 2021	53,360	3,378	0.38%	0.55%	6.33%	$7,891
CY 2022	55,800	3,314	0.37%	0.55%	5.94%	$7,624
White						
CY 2020	2,379,061	149,074	18.18%	25.03%	6.27%	$7,137
CY 2021	2,506,373	149,398	17.68%	24.27%	5.96%	$7,599
CY 2022	2,589,245	141,105	17.07%	23.48%	5.45%	$7,457
Other						
CY 2020	1,866,332	87,406	14.26%	14.68%	4.68%	$8,575
CY 2021	2,259,282	95,944	15.94%	15.59%	4.25%	$8,894
CY 2022	2,677,216	95,668	17.65%	15.92%	3.57%	$8,645

Over the three-year period, the number of eligibles increased for all racial/ethnic groups except for Asian/Pacific Islander. The largest racial/ethnic group statewide for both eligibles and members served was Hispanic/Latino. Only the Hispanic/Latino and Other racial/ethnic groups saw more members served in CY 2022 compared to CY 2020. All groups had the highest numbers served in CY 2021. Between CY 2020 and CY 2022, the Other group had the largest increase in members served (9.5 percent), followed by Hispanic/Latino with a 3.4 percent increase. All racial/ethnic groups, except Asian/Pacific Islander, experienced a decrease in the number of members served in CY 2022 compared to CY 2020, with White showing the largest decrease at 5.3 percent. Asian/Pacific Islander saw a slight increase in CY 2021 but experienced a decrease in PRs, as did all other racial/ethnic groups, in both CY 2021 and CY 2022.

In CY 2022, African American was the most proportionally overrepresented group, with 6.99 percent of eligibles and 12.48 percent of members served, followed by White, with 17.07 percent of eligibles and 23.48 percent of members served. In CY 2022, Hispanic/Latino

and Asian/Pacific Islander groups were the most proportionally underrepresented racial/ethnic groups. In CY 2022, Hispanic/Latino members Made up 48.60 percent of eligibles and 43.07 percent of members served, while Asian/Pacific Islander members comprised 9.33 percent of eligibles, and 4.50 percent of members served.

In CY 2022, AACMs were higher than in CY 2020 for all racial/ethnic groups except Native American. In CY 2022, the Other category had the highest AACM, and Hispanic/Latino had the lowest, which was 9.74 percent lower than that for White members.

Plan-level data for PR by race/ethnicity in CY 2022 is displayed in Table 4-8 below. This data is calculated by CalEQRO and is not reported by the MHPs.

Table 4-8: PR by Race/Ethnicity versus Plan PR, CY 2022

MHP	African American	Asian/Pacific Islander	Hispanic/ Latino	Native American	White	Other	Plan PR
Alameda	6.98%	1.44%	3.63%	6.94%	5.55%	3.93%	3.93%
Alpine	0.00%	50.00%	0.00%	6.94%	6.40%	6.38%	6.45%
Amador	16.67%	7.83%	6.83%	2.70%	9.34%	7.04%	8.62%
Butte	8.45%	2.25%	4.94%	4.73%	7.40%	5.26%	6.30%
Calaveras	5.98%	5.63%	6.21%	3.89%	7.63%	6.59%	7.23%
Colusa	12.20%	4.08%	4.64%	5.32%	12.22%	5.12%	5.96%
Contra Costa	7.17%	2.22%	3.63%	9.65%	7.55%	5.05%	4.92%
Del Norte	6.74%	0.79%	3.53%	5.89%	6.23%	4.72%	5.48%
El Dorado	5.44%	1.78%	2.29%	6.42%	4.15%	3.69%	3.67%
Fresno	7.00%	2.11%	3.34%	7.59%	7.02%	3.84%	4.01%
Glenn	14.14%	2.96%	5.51%	5.88%	10.57%	7.19%	7.32%
Humboldt	6.83%	1.92%	3.87%	4.40%	6.12%	4.12%	5.21%
Imperial	13.42%	3.67%	6.79%	3.37%	12.31%	6.55%	7.07%
Inyo	4.88%	3.70%	4.13%	3.64%	7.62%	4.74%	5.52%
Kern	5.97%	1.49%	3.60%	6.81%	6.82%	3.32%	4.23%
Kings	6.27%	2.77%	3.14%	9.81%	7.23%	2.83%	3.81%
Lake	5.38%	2.51%	1.94%	3.31%	4.84%	4.21%	3.90%
Lassen	4.46%	0.39%	4.82%	5.35%	7.70%	4.03%	6.44%
Los Angeles	8.66%	2.27%	4.35%	8.61%	5.60%	3.39%	4.63%
Madera	8.25%	1.07%	2.84%	3.97%	6.36%	3.03%	3.51%
Marin	7.49%	2.64%	1.54%	11.96%	6.47%	5.29%	3.58%
Mariposa	8.00%	1.37%	6.64%	6.47%	10.04%	5.55%	8.86%
Mendocino	10.11%	2.73%	3.39%	5.97%	7.13%	4.66%	5.50%
Merced	5.96%	2.08%	2.62%	7.80%	6.48%	3.62%	3.38%
Modoc	8.57%	0.00%	5.95%	8.75%	12.78%	7.32%	10.43%
Mono	23.53%	0.00%	3.04%	0.99%	8.09%	6.24%	5.29%
Monterey	9.98%	2.84%	3.57%	13.71%	8.32%	2.43%	3.86%
Napa	5.31%	1.50%	2.12%	3.85%	5.22%	4.15%	3.12%

MHP	African American	Asian/Pacific Islander	Hispanic/ Latino	Native American	White	Other	Plan PR
Nevada	8.05%	2.62%	4.35%	4.97%	5.45%	5.07%	5.23%
Orange	4.77%	0.96%	2.48%	4.68%	3.19%	2.07%	2.27%
Placer/Sierra	6.03%	1.21%	2.35%	8.03%	4.61%	2.90%	3.54%
Plumas	9.28%	3.33%	7.26%	4.38%	8.06%	5.26%	7.54%
Riverside	5.43%	1.55%	2.72%	4.84%	4.88%	2.29%	3.18%
Sacramento	4.96%	1.43%	2.93%	5.63%	4.73%	3.11%	3.44%
San Benito	6.10%	3.44%	4.55%	10.34%	8.32%	3.66%	4.97%
San Bernardino	5.06%	1.24%	2.60%	4.35%	4.65%	3.09%	3.18%
San Diego	5.26%	1.97%	2.42%	4.62%	4.74%	3.37%	3.25%
San Francisco	10.47%	2.72%	4.25%	14.29%	9.02%	6.96%	5.53%
San Joaquin	5.21%	1.85%	2.53%	5.71%	5.84%	3.10%	3.26%
San Luis Obispo	7.04%	2.18%	2.79%	5.69%	6.01%	6.70%	5.21%
San Mateo	11.98%	2.48%	3.55%	13.33%	9.82%	5.44%	4.70%
Santa Barbara	7.77%	2.13%	2.06%	4.80%	2.95%	4.53%	3.03%
Santa Clara	9.40%	2.49%	5.77%	9.80%	9.21%	5.79%	5.40%
Santa Cruz	7.81%	2.48%	2.47%	8.03%	4.72%	3.63%	3.34%
Shasta	6.17%	2.35%	3.04%	3.72%	4.29%	3.52%	3.97%
Siskiyou	6.67%	2.19%	3.58%	5.22%	6.38%	4.02%	5.52%
Solano	4.33%	1.76%	1.95%	7.58%	5.19%	3.69%	3.32%
Sonoma	4.17%	1.14%	1.20%	2.32%	3.49%	2.38%	2.20%
Stanislaus	4.67%	1.24%	1.78%	4.61%	3.82%	2.75%	2.46%
Sutter-Yuba	5.66%	1.61%	2.56%	5.56%	6.11%	4.37%	3.98%
Tehama	2.78%	1.51%	1.47%	4.96%	3.35%	2.44%	2.60%
Trinity	8.70%	0.60%	4.02%	8.43%	6.00%	3.26%	5.34%
Tulare	6.67%	2.58%	3.48%	5.71%	6.63%	4.57%	4.08%
Tuolumne	2.44%	3.14%	4.70%	5.33%	6.11%	4.40%	5.65%
Ventura	7.58%	2.08%	3.29%	6.46%	6.01%	4.71%	4.14%
Yolo	7.15%	1.35%	2.29%	8.58%	5.09%	3.00%	3.22%
Statewide	**7.08%**	**1.91%**	**3.51%**	**5.94%**	**5.45%**	**3.57%**	**3.96%**

MHPs with PRs over 6 percent were all small and small-rural MHPs. They also showed high PRs across all racial/ethnic groups, though less so for Asian/Pacific Islander and Native American, and often driven by high PRs for the White population. Among large MHPs, San Francisco showed the highest overall PR, but it was also impacted by PRs that were comparatively lower for Asian/Pacific Islander and Hispanic/Latino that were lower than the other groups. Despite this, among large MHPs, the highest Hispanic/Latino and Asian Pacific Islander PRs, respectively, were among San Francisco (4.25 percent, 2.72 percent), Contra Costa (3.63 percent, 2.2 percent), and Los Angeles (4.35 percent, 2.72 percent) – all of which also have relatively significant proportions of these populations. An important consideration is that smaller MHPs may have higher rates in some racial/ethnic groups but a small proportion of eligibles in that group.

The MHP PR ranges from a low of 2.20 percent (Sonoma) to a high of 10.43 percent (Modoc). The ranges for each racial/ethnic group are as follows:

- African American – 0 percent to 23.53 percent
- Asian/Pacific Islander – 0 percent to 50 percent
- Hispanic/Latino – 0 percent to 7.26 percent
- Native American – 0.99 percent to 14.29 percent
- White – 2.95 percent to 12.78 percent
- Other – 2.07 percent to 7.32 percent

Table 4-9 displays the statewide threshold languages spoken by MHP members served. The numerator for each language is the unduplicated number of members served based upon the threshold language identified in the MMEF, summed across MHPs. The denominator is the unduplicated number of members served, summed across MHPs.

Table 4-9: Threshold Language of Medi-Cal Members Served, CY 2022

Threshold Language[18]	Unduplicated Annual Count of Medi-Cal Members Served by MHPs	Percentage of Medi-Cal Members Served by MHPs	Number of MHPs with Threshold Language
Spanish	104,215	17.34%	44
Vietnamese	2,994	0.50%	8
Cantonese	2,126	0.35%	6
Armenian	1,302	0.22%	1
Arabic	970	0.16%	5
Mandarin	983	0.16%	6
Farsi	869	0.14%	5
Russian	748	0.12%	3
Korean	681	0.11%	2
Cambodian	505	0.08%	1
Hmong	482	0.08%	2
Tagalog	325	0.05%	4
Total	**116,200**	**19.34%**	**N/A**

Nearly one in five members served in MHPs preferred a language other than English. Spanish was the most prevalent threshold language spoken by members. In CY 2022, over 17 percent of members, as reported in the MMEF, identified Spanish as their preferred language. Spanish is a threshold language in 44 MHPs, while the remaining 12 MHPs reported no threshold language. Each of the other 11 threshold languages was spoken by 0.5 percent of members served. Ten MHPs had multiple threshold languages. At the high end, Los Angeles has all 12 threshold languages listed in Table 4-9. Sacramento has seven threshold languages: Spanish, Russian, Hmong, Vietnamese, Arabic, Cantonese, and Farsi. Alameda (Spanish, Cantonese,

[18] Open Data per BHIN 20-070 www.dhcs.ca.gov/Documents/BHIN-20-070-Threshold-Languages.pdf

Vietnamese, Mandarin, Arabic, and Tagalog) and Orange (Spanish, Vietnamese, Korean, Farsi, Arabic, and Mandarin) have six. San Diego (Spanish, Arabic, Vietnamese, Tagalog, Farsi) and San Francisco (Spanish, Cantonese, Vietnamese, Russian, Mandarin) have five. In addition, Fresno (Spanish and Hmong) and San Mateo (Spanish and Cantonese) each have two threshold languages, while San Bernardino has three (Spanish, Vietnamese, and Mandarin).

Threshold language is a data element in the MMEF. In CY 2022, 116,200 members preferring non-English languages were served, a decrease from 117,522 in CY 2021. With a smaller total number of members served, the percentage of those speaking threshold languages decreased slightly from 19.73 percent to 19.34 percent, meaning nearly one in five members spoke a threshold language.

In 2022, 539 fewer individuals with Spanish as a threshold language were served compared to 2021, representing 17.34 percent of members served statewide. Many other languages spoken across counties are not included in the table because they did not meet the threshold criteria for those counties. For example, some Spanish-speakers were served in MHPs where Spanish was not designated as a threshold language.

Table 4-10 shows the subset of Medi-Cal eligibles who qualified under ACA. The numerator for the ACA PR is the statewide number of members served with an ACA aid code in the MMEF. The denominator is the total number of eligibles with an ACA aid code.

Table 4-10: Medi-Cal Expansion (ACA) Penetration Rate and AACM, CY 2020-22

	Average Monthly ACA Eligibles	Total ACA Members Served	ACA Penetration Rate	Total Approved Claims	ACA AACM
CY 2020	3,835,638	155,252	4.05%	$934,908,584	$6,022
CY 2021	4,385,188	167,033	3.81%	$1,066,170,000	$6,383
CY 2022	4,831,118	164,980	3.41%	$1,051,010,722	$6,371

In 2022, ACA PR and ACA AACM were lower than the overall statewide figures. Since the ACA eligibility group generally has lower acuity, this pattern is expected. However, some MHPs have PRs for the ACA population well above 6 percent. This is often due to the limited number of mental health providers in the area, with all 12 of these MHPs being small or small-rural. Modoc and Mariposa are outliers, each with PRs over 8 percent for the ACA group.

ACA PRs declined in both CY 2021 and CY 2022, whereas ACA AACMs increased in CY 2021 and remained stable (a $12 decrease) in CY 2022.

Although the number of members served decreased in 2022, the number of ACA members served was highest in 2021. Their PR declined each year due to the increasing size of the eligible population. The ACA AACM of $6,371 increased in CY 2021 and slightly decreased in CY 2022, remaining 14.4 percent lower than the overall AACM of $7,442.

Table 4-11 shows the number and percentage of ACA members served by region. The “ACA percentage of overall Medi-Cal eligibles” numerator is the total number of ACA eligibles and the denominator is the total number of eligibles regardless of aid code. The “ACA percentage of members served per year” numerator is the total number of Medi-Cal members with the ACA aid code served, and the denominator is the total number of Medi-Cal eligibles with the ACA aid code.

Table 4-11: ACA Eligibles, Members Served, and Penetration Rates by Region, CY 2022

Region	Average Number of Medi-Cal Members per Month	ACA Percentage of Overall Medi-Cal Eligibles	Number of ACA Members Served per Year	ACA Percentage of Members Served per Year	ACA Penetration Rate
Statewide	4,831,118	32%	164,980	28%	3.41%
Bay Area	790,550	33%	28,221	27%	3.57%
Central	762,293	28%	23,476	25%	3.08%
Los Angeles	1,511,808	34%	61,461	30%	4.07%
Southern	1,626,722	32%	45,542	27%	2.80%
Superior	139,748	31%	5,878	25%	4.21%

ACA PRs in all regions were lower than the total PRs for those regions. Regions varied slightly in the proportion of members served with ACA eligibility, ranging from 25 percent in the Central and Superior regions to 30 percent in Los Angeles.

Although ACA eligibles comprised 32 percent of total Medi-Cal enrollment, they represented 28 percent of MHP members served with both percentages increasing by 1 percentage point from CY 2021.

The ACA PR and claims patterns vary slightly by region within the state. Relatively fewer ACA members receive SMHS in the Central and Southern regions, reflecting a similar trend in overall PR.

Table 4-12 shows ACA claims data by region. The “ACA AACM” is calculated by dividing the total number of approved claims dollars for members with an ACA aid code by the number of members served who have the ACA aid code.

Table 4-12: ACA Approved Claims by MHP Region, CY 2022

Region	ACA Total Approved Claims	ACA AACM
Statewide	$1,051,010,722	$6,371
Bay Area	$279,092,615	$9,890
Central	$125,447,628	$5,344
Los Angeles	$346,861,385	$5,644
Southern	$265,226,814	$5,824
Superior	$32,146,581	$5,469

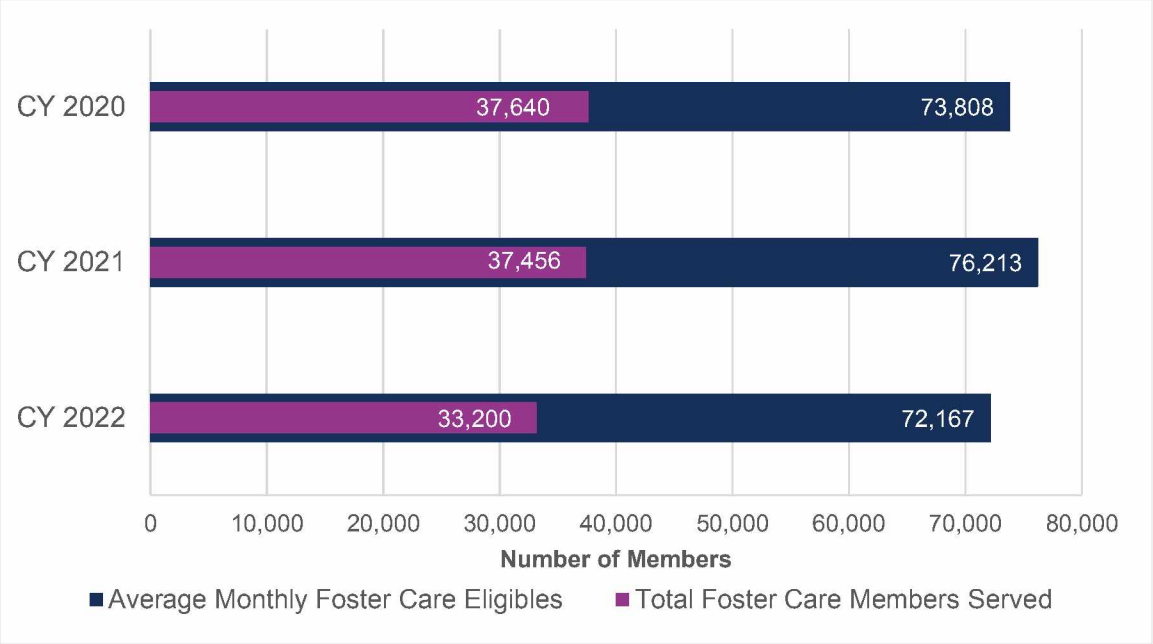
ACA AACMs were lower than the statewide ACA AACM in all regions except the Bay Area. The Bay Area’s ACA AACM was 55 percent higher than the statewide ACA AACM and 70 percent higher than the ACA AACM of the next-highest region, Southern.

All regions reported lower ACA AACM compared to the overall Medi-Cal AACM. As with the overall AACM comparison, the Bay Area has a significantly higher ACA AACM of $9,890, while all other regions’ AACMs are more than $4,000 lower.

Foster Care

Figure 4-5 shows the number of FC eligibles and members served CY 2020-22.

Figure 4-5: Medi-Cal Eligibles and Members Served, Foster Care, CY 2020-22

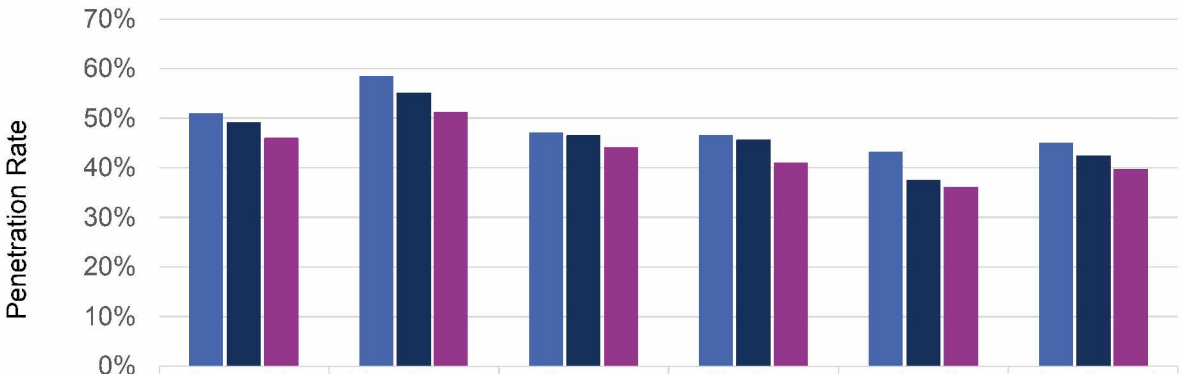


In CY 2022, the fewest number of FC youth were served, and the number of youth in FC was also the lowest, resulting in a PR of 46.0 percent. After a 3.3 percent increase in FC eligibles from CY 2020 to CY 2021, the number decreased in CY 2022. In CY 2022, the number of FC eligibles was 2.2 percent lower than in CY 2020 and 5.3 percent lower than in CY 2021. The number of FC members served decreased slightly by 0.5 percent in CY 2021 compared to CY 2020), and more significantly by 11.4 percent in CY 2022 compared to CY 2021.

Given the complex needs of foster youth, the ongoing decrease in PR for this population requires significant attention.

Figure 4-6 shows FC PR by size. The FC PR numerator is the unduplicated number of members with the FC aid code who were served and the denominator is the total number of eligibles with the FC aid code. The FC AACM is calculated by dividing the total amount of approved claims associated with the FC aid code divided by the number of FC served.

Figure 4-6: Foster Care Penetration Rate by MHP Size, CY 2020-22



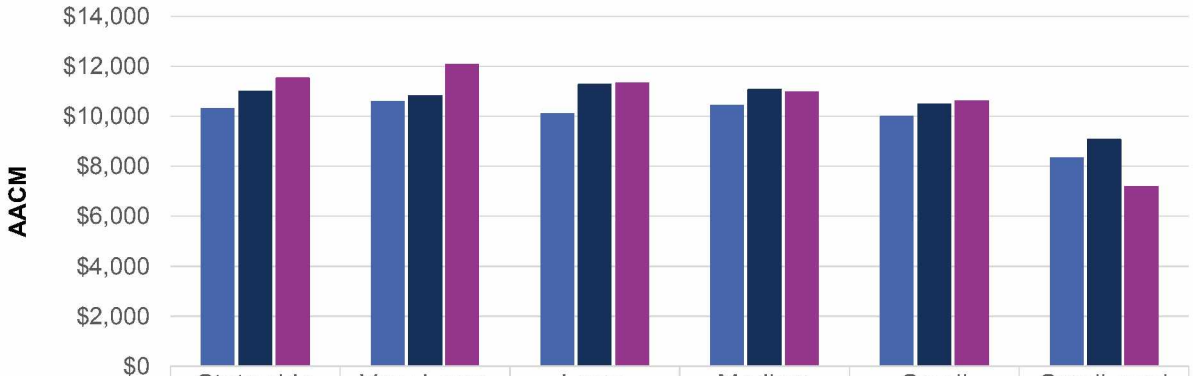
	Statewide	Very Large	Large	Medium	Small	Small-rural
CY 2020	51.00%	58.41%	47.06%	46.59%	43.16%	44.98%
CY 2021	49.15%	55.10%	46.53%	45.62%	37.49%	42.49%
CY 2022	46.00%	51.23%	44.06%	41.00%	36.14%	39.76%

Statewide, FC PRs decreased slightly across all MHP sizes from CY 2020 to CY 2022.

Los Angeles (very large MHP) had the highest FC PR across all three CYs, with a PR in CY 2022 over 7 percentage points higher than the next-highest size group (large), representing a 16.27 percent difference. Over the three-year period, small MHPs consistently had the lowest FC PR, followed by small-rural MHPs.

Figure 4-7 shows FC AACM by size.

Figure 4-7: Foster Care AACM by MHP Size, CY 2020-22



	Statewide	Very Large	Large	Medium	Small	Small-rural
CY 2020	$10,338	$10,598	$10,129	$10,465	$10,017	$8,348
CY 2021	$11,020	$10,843	$11,288	$11,092	$10,517	$9,089
CY 2022	$11,542	$12,103	$11,343	$10,981	$10,638	$7,202

FC AACMs have been rising over the past three CY both statewide and in most county size groups. Los Angeles (very large) had the largest FC AACMs from CYs 2020 to CY 2022, while the small-rural group consistently had the lowest.

The statewide FC AACM has increased by 11.65 percent since CY 2020. In 2022, Los Angeles' FC AACM increased by 11.62 percent, surpassing the statewide FC AACM. In CY 2022, small-rural MHPs saw a decrease in FC AACM in CY 2022 and maintained the lowest AACM for FC across all 3 years.

SUMMARY OF ACCESS FINDINGS

After a significant increase in numbers served from CY 2020 to CY 2021, CY 2022 saw a decrease in total members served and an increase in eligibles, resulting in a decline in the statewide PR each year. Numbers served have not returned to pre-pandemic levels; in 2019, nearly 628,000 members were served, with a statewide PR of 4.86 percent. In CY 2022, the statewide PR was 3.96 percent. The gains made in CY 2021 were not sustained, and the PR decrease in CY 2022, down 18.5 percent from pre-pandemic 2019, reflects both an increase in eligibles and a decrease in members served. Medium and small MHPs showed a net increase in members served in CY 2022, despite a decrease in PRs.

Consistent with the CQS, health equity is widely prioritized in MHPs, with statewide efforts focused on enhancing access to care for the SMHS population and underserved groups, as emphasized by CalAIM. Expanded access necessitates significant efforts to strengthen the MHP workforce, which faces a highly competitive environment and a shortage of mental health professionals relative to the overall need in both private and public sectors. MHPs persist in creatively utilizing their resources and enhancing collaboration and integration to maximize their impact. Statewide initiatives such as mobile crisis and CARE Court depend on collaborative relationships and approaches for successful implementation and achieving intended outcomes.

Timeliness

BACKGROUND

The ability to secure timely access to care is a critical factor that contributes to members' overall initiation and engagement in treatment, retention in services, and attainment of desired outcomes. The collection, evaluation, and consistent monitoring of relevant timeliness data, at regular intervals, throughout systems of care is an essential process that MHPs have been developing. To successfully promote timely access to treatment, Plans must establish the necessary infrastructure to track the elapsed time from initial requests for services to first-offered appointments and rendered services. This requires a requisite number of IS staff or contracted application service providers (ASPs), who possess the necessary technical skills to support the ongoing development of Plans' EHRs to ensure that they have the capacity and functionality (e.g., modeled forms and data entry screens) to collect all appropriate member and service information. Further, they must train clinical staff to ensure accurate entry of data and monitor those processes, and maintain dedicated data analytics staff to perform effective extraction, analysis, and reporting of collected timeliness data.

It is important that Plans invest energy and resources toward becoming and sustaining data-driven organizations to ensure valid and reliable processes are established for reviewing timeliness metrics on a regular basis – and evaluating timely access to care through all points of entry. Monitoring fluctuations in workforce, capacity, and service demands are key to providing timely entrée into care. Thus, summary reports that illustrate patterns and trends in the captured data need to be disseminated, at routine intervals, to supervisors and members of leadership for meaningful assessment and application. This approach gives rise to continuous quality feedback loops which support Plans in the perpetual use of data to inform and shape decisions and improvements to systems of care. When situations are discovered in which expected thresholds of timeliness are not being met, strategies can be crafted to remediate these challenges. Conversely, MHPs can isolate and define what activities are likely contributing to the delivery of smooth and timely care for members.

CalEQRO utilizes the Key Components as tools to evaluate the extent to which MHPs are routinely collecting, reviewing, and applying data within articulated timeliness metrics. More precisely, CalEQRO utilizes its MHP ATA form to gather information from Plans to determine how they track and report timeliness data, as well as the methods they employ to assess the performance of their systems. In addition to providing frequencies pertaining to the total number of requests for services that occur within a given time frame, MHPs are asked to submit the raw data associated with the activity in question as well as average wait times and the percentage of appointments and services that met either DHCS (offered appointments) or MHP-defined standards (delivered services). Additionally, Plans are asked to submit the equations they applied to perform any calculations from which reported counts were derived. The resultant ATA-related counts and raw data sets provided by MHPs not only offer evidence of their processes for timeliness data elements, but also the extent to which this information is used to support and improve overall timeliness performance.

DHCS sets the following standards for timely access to care:

- First non-urgent, non-psychiatry appointment offered – 10 business days

- First non-urgent psychiatry appointment offered – 15 business days
- First urgent appointment offered – 48 hours (or 96 hours if pre-authorization is required)

The six timeliness measures on which MHPs are asked to report in the ATA encompass: DHCS-defined compliance metrics (timeliness to first offered appointments); HEDIS metrics (timeliness related to inpatient hospitalization); and additional quality metrics identified by CalEQRO (timeliness to delivered services and no-show rates). The six measures function broadly as key indicators that demonstrate, in a quantifiable fashion, systemwide timely access to quality care.

In the ATA, MHPs are asked to report each metric stratified by age (adults and youth) and FC status for the entire service delivery system, inclusive of county-operated and contractor-operated services. Reporting on these three identified demographics for all metrics across the entire service delivery systems, at all points of entry, is a complex task for MHPs. Moreover, considering that some transactions relating to members who initiate treatment directly through contracted agencies, or co-located programming at Child Welfare, schools, jails, or other locations may not be captured or documented within a Plan's EHR due to challenges relating to interoperability or connectivity, timeliness reporting is often truncated or incomplete. As a result, counts provided in the ATA may not present a comprehensive representation of how quickly typical members are served.

Due to the year-long occurrence of MHP reviews, ATA data are expected to embrace the most recent 12-month period. Accordingly, more than 91 percent of Plans (n=51) submitted timeliness findings submitted data representing a 12-month period, though it may not have been current (e.g., a review in December 2023 submitting FY 2022-23 data). Of this group, 41 Plans extracted data from FY 2022-23, whereas the other 10 Plans reported information from CYs 2022 or 2023, or from self-defined, 12-month intervals. The five remaining MHPs offered frequencies that covered time frames that were less than 1 year, but greater than or equal to 6 months.

The two methods of CalEQRO evaluation: 1) Key Components for QI oversight and evaluation, and 2) ATA for actual wait times reported. These two methods may result in seemingly different findings associated with the same point in care. For example, a Plan may submit its ATA containing data that shows compliance with timeliness standards; however, this same MHP may have provided no evidence that it routinely tracks and trends this data or initiates necessary performance improvement processes at any point outside of the EQR preparation. In that scenario, because of the lack of routine monitoring and improvement activities, the Key Component rating may be Partially Met or Not Met despite the submission of data that retrospectively demonstrates timely access to care. Conversely, a Plan may not have met the timeliness standard as reflected in the ATA, but it demonstrated robust tracking mechanisms, routine data review, and rigorous performance improvement processes to bolster timely access, thereby potentially earning a Key Component rating of Partially Met or Met.

DHCS also reviews timely access to care for initial offered appointments through annual submission of the TADT. This represents a specific 9-month time frame, and for this reason, DHCS reviews a separate data set than is included in this report which may result in findings that do not coincide with those displayed in this report, derived from the MHPs' ATA submissions to CalEQRO.

This chapter begins with summarized findings associated with the Key Components for timely access to care. It is followed by the timeliness findings reported by MHPs in the ATA. Indications are also made as to whether CalEQRO's review of the raw data submitted by various validated their submissions.

TIMELINESS KEY COMPONENTS

To summarize the information presented earlier in this chapter, CalEQRO evaluates timeliness performance based upon two main data sources: 1) the MHP report of actual wait times through the ATA, and 2) Key Components 2A through 2F, which also correspond with the metrics submitted in the ATA. The number of subcomponent items are included for each:

- Initial non-urgent outpatient mental health service (of seven items, six or seven rate Met, and three to five rate Partially Met)
- Initial non-urgent outpatient psychiatry service (of seven items, six or seven rate Met, and three to five rate Partially Met)
- Urgent services, including SMHS and psychiatry (of eight items, six to eight rate Met, and three to five rate Partially Met)
- Follow-up post psychiatric inpatient discharge (of six items, five or six rate Met, and three or four rate Partially Met)
- Psychiatric inpatient readmission (of three items, three rate Met, and two rate Partially Met)
- Outpatient no-show rates (of three items, three rate Met, and one or two rate Partially Met)

Based upon processes in place as defined in the Key Components document,[19] CalEQRO evaluates MHPs' oversight of timely access to care. Specifically, the Key Components serve as mechanisms to evaluate whether the Plans set a standard, regularly track and trend the data, assess its performance through routine data analysis, and initiate performance improvement processes.

A summary of statewide performance on the Key Components for timeliness is depicted in Table 5-1.[20]

Table 5-1: Key Components: Summary of Oversight of Timeliness– Statewide FY 2023-24

KC #	Key Component – Timeliness	Met	Partially Met	Not Met
2A	First Non-Urgent Request to First Offered Appointment	40	15	1
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	34	17	5
2C	Urgent Appointments	31	17	8
2D	Follow-Up Appointments after Psychiatric Hospitalization	45	8	3
2E	Psychiatric Readmission Rates	50	5	1
2F	No-Shows/Cancellations	37	17	2

[19] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

[20] Meeting Key Components is not the same as the DHCS Network Adequacy ratings for achieving "Pass" for timely access to care.

In contrast to findings expressed in last year's annual report, 18 MHPs (32 percent) were assigned a rating of Met for all six Timeliness Key Components: Butte, Colusa, Kern, Kings, Lake, Lassen, Los Angeles, Mariposa, Mendocino, Merced, Nevada, San Diego, San Joaquin, Santa Clara, Santa Cruz, Siskiyou, Sonoma, and Stanislaus. This change represents a 38.46 percent increase over the 13 MHPs that secured a rating of Met in the prior review cycle. Interestingly, however, when considering both Met and Partially Met results on all Timeliness Key Components, 41 MHPs (73 percent) – as opposed to 46 in FY 2022-23 – showed 10.87 percent decrease in the overall number of MHPs that received a Met or Partially Met rating on all items.

There were 32 Not Met ratings in the timeliness domain that occurred over 15 MHPs. In comparison to the distributions of Key Component ratings in FY 2022-23, there was a 100 percent increase in the number of Not Met ratings that were assigned this year (32 vs. 16), and a 50 percent increase in number of Plans that were represented in this group (15 vs. 10). No MHP had more than three Not Met ratings. Timeliness to urgent service appointments (2C) had the fewest Met ratings, slightly less than the first offered psychiatric appointment component (2B). Conversely, the component dedicated to monitoring psychiatric readmissions (2E) evidenced the highest percentage of MHPs (89 percent) obtaining a rating of Met. This performance was closely followed by the observation that 80 percent of Plans received a rating of Met on the Key Component relating to the monitoring of follow-up appointments after psychiatric hospitalizations (2D). Similar to the finding last year, the Key Component for no-show monitoring (2F) was in the middle, with 66 percent of MHPs being assigned a rating of Met.

Table 5-2 shows the rating for each Key Component by Plan.*

Table 5-2: Timeliness Key Components by Plan, FY 2023-24

MHP	2A	2B	2C	2D	2E	2F
Alameda	M	M	M	M	M	PM
Alpine	PM	PM	PM	PM	PM	PM
Amador	M	M	PM	M	PM	M
Butte	M	M	M	M	M	M
Calaveras	M	M	M	M	M	PM
Colusa	M	M	M	M	M	M
Contra Costa	M	PM	PM	M	M	M
El Dorado	PM	PM	PM	NM	NM	PM
Fresno	M	M	M	M	M	NM
Del Norte	PM	M	NM	M	M	M
Glenn	M	M	M	M	M	PM
Humboldt	M	PM	M	M	M	M
Imperial	NM	PM	M	M	M	NM
Inyo	PM	NM	NM	NM	M	PM
Kern	M	M	M	M	M	M
Kings	M	M	M	M	M	M
Lake	M	M	M	M	M	M
Lassen	M	M	M	M	M	M
Los Angeles	M	M	M	M	M	M
Madera	PM	PM	PM	M	M	M
Marin	PM	PM	PM	M	M	M
Mariposa	M	M	M	M	M	M

MHP	2A	2B	2C	2D	2E	2F
Mendocino	M	M	M	M	M	M
Merced	M	M	M	M	M	M
Modoc	M	M	PM	M	M	M
Mono	M	M	M	M	M	PM
Monterey	PM	NM	PM	M	M	M
Napa	M	PM	PM	PM	M	PM
Nevada	M	M	M	M	M	M
Orange	M	PM	M	M	M	PM
Placer - Sierra	PM	PM	M	M	M	PM
Plumas	M	M	PM	M	M	M
Riverside	M	M	PM	M	M	M
Sacramento	M	NM	PM	PM	M	PM
San Benito	M	M	NM	PM	M	M
San Bernardino	M	PM	M	M	M	PM
San Diego	M	M	M	M	M	M
San Francisco	M	M	M	M	M	PM
San Joaquin	M	M	M	M	M	M
San Luis Obispo	PM	PM	PM	PM	PM	PM
San Mateo	M	NM	PM	PM	PM	M
Santa Barbara	PM	PM	M	M	M	M
Santa Clara	M	M	M	M	M	M
Santa Cruz	M	M	M	M	M	M
Shasta	PM	M	NM	M	M	M
Siskiyou	M	M	M	M	M	M
Solano	PM	PM	PM	M	M	M
Sonoma	M	M	M	M	M	M
Stanislaus	M	M	M	M	M	M
Sutter - Yuba	PM	PM	NM	M	M	M
Tehama	PM	NM	NM	PM	PM	PM
Trinity	M	M	PM	PM	M	PM
Tulare	PM	PM	M	NM	M	PM
Tuolumne	M	M	NM	M	M	M
Ventura	M	PM	PM	M	M	M
Yolo	M	M	NM	M	M	M

*Note: M = Met, PM = Partially Met, NM = Not Met

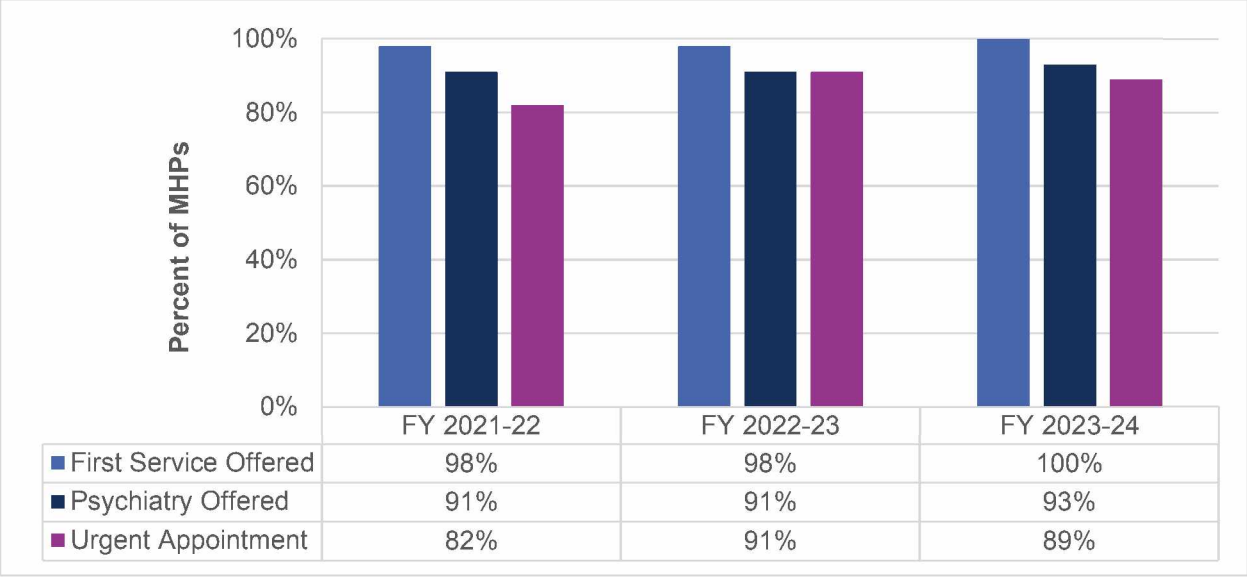
Timeliness Reporting Capabilities

The overall capabilities of MHPs to collect and report data associated with the required timeliness metrics is shown below in Figure 5-1.

It offers a comparative illustration of the extent to which MHPs had the requisite tools to track and evaluate activities relating to the monitoring of first offered, non-urgent appointments; first offered, non-urgent psychiatric appointments; and urgent appointments. The number of MHPs that were able to provide frequencies on all three of these metrics showed modest increases over the three-year period. Variation from year to year within given MHPs may be impacted by

factors such as the implementation of new EHRs and fluctuations in the availability of staff who possess the necessary data analytics skills to perform this type of task.

Figure 5-1: Timeliness Metrics Reported by MHPs in FY 2021-24



	FY 2021-22	FY 2022-23	FY 2023-24
First Service Offered	98%	98%	100%
Psychiatry Offered	91%	91%	93%
Urgent Appointment	82%	91%	89%

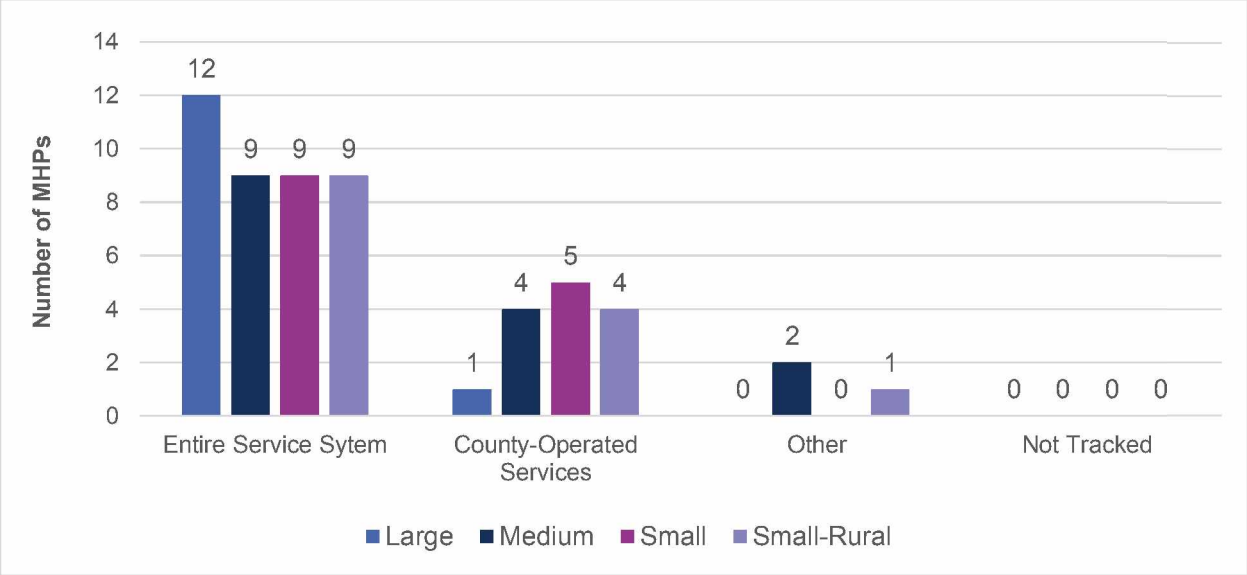
Completeness of Timeliness Data

The degree to which the timeliness data submitted in the ATA is "complete" as a reflection of all points of service access varies across MHPs. For example, in situations where contract providers serve as points of entry and there is a lack of mechanisms to support data collection and reporting for contractor-operated programs, information relating to members obtaining timely access would likely not be tracked in an efficient manner or, perhaps, not tracked at all. As a result, MHPs may be able to track and evaluate one metric well but experience challenges with another. The following charts indicate the extent to which each measure reflects the entire service system, only county-operated services, a nuanced subset, or if it was not tracked.

Some of the decrease in MHPs reporting on these metrics is attributable to a new EHR implementation. However, most MHPs reported a time frame prior to their launch of the new system, and so the implementation status did not significantly impact the delivery of results this review year. MHPs often reported for CY 2022 or FY 2022-23 from their former EHR.

Also enumerated within each timeliness metric is a count of MHPs that reported as designated by size as shown in Figure 5-2.

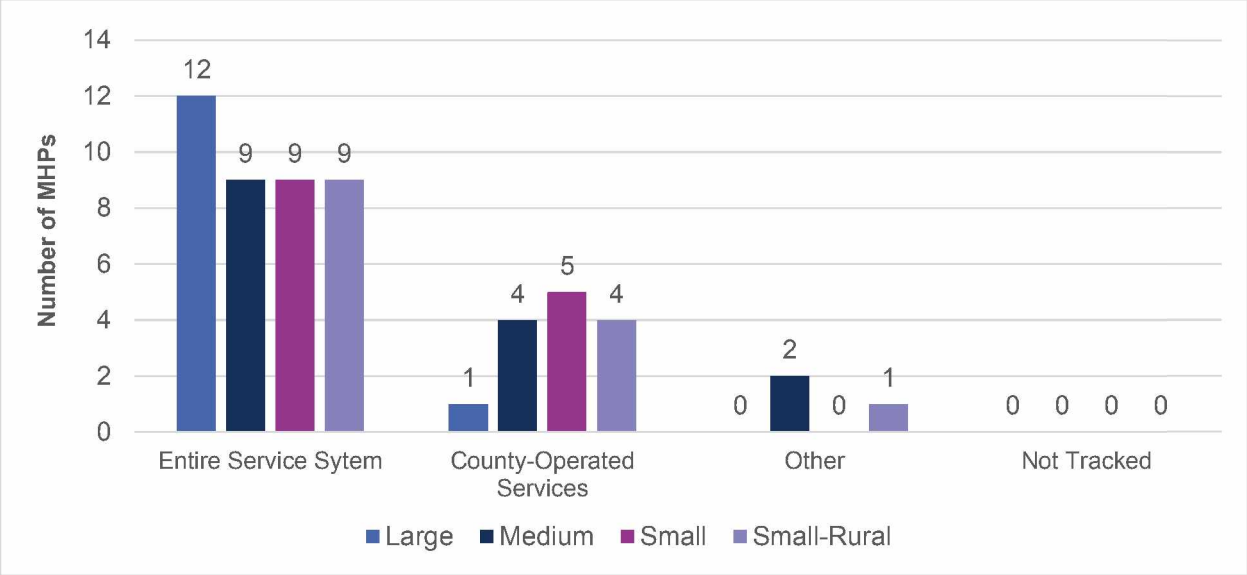
Figure 5-2: Data Set for Initial Non-Urgent, Non-Psychiatry Appointments Offered, Reported by MHPs in FY 2023-24



In Figure 5-2, 39 MHPs reported tracking the offering of first non-urgent appointments for the entire service system, which represented an increase of 21.88 percent over the number that were counted in this category last year (32 vs. 39). There were 14 MHPs that tracked initial entry into care only through county-operated programs. Three MHPs tracked this metric through environments that were not defined as the entire service system or all of the county-operated services; instead, they were nuanced subsets that were broadly identified as Other. It is also possible that MHPs did not disclose if aspects of the system of care were not captured in the data set.

Figure 5-3 shows that the patterns of distribution for the counts of MHPs that tracked first delivered services were precisely the same as for first offered appointments, as seen in Figure 5-2.

Figure 5-3: Data Set for Initial Non-Urgent, Non-Psychiatry Services Delivered, Reported by MHPs in FY 2023-24

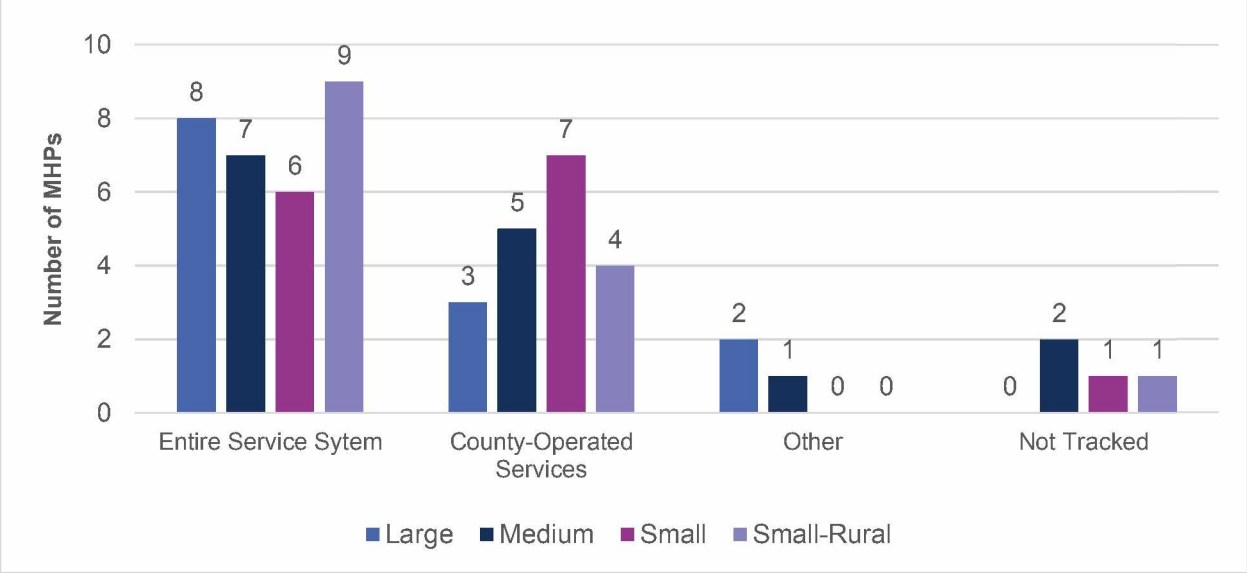


All MHPs submitted some form of tracking for first delivered service and most reported that they tracked the entire service system.

Small MHPs were more likely to only report on county-operated services. It is unclear the degree to which contractor-operated services represent points of entry in these MHPs, as small MHPs tend to be predominantly county-operated.

Figure 5-4 shows the tracking of the first offered psychiatry appointment.

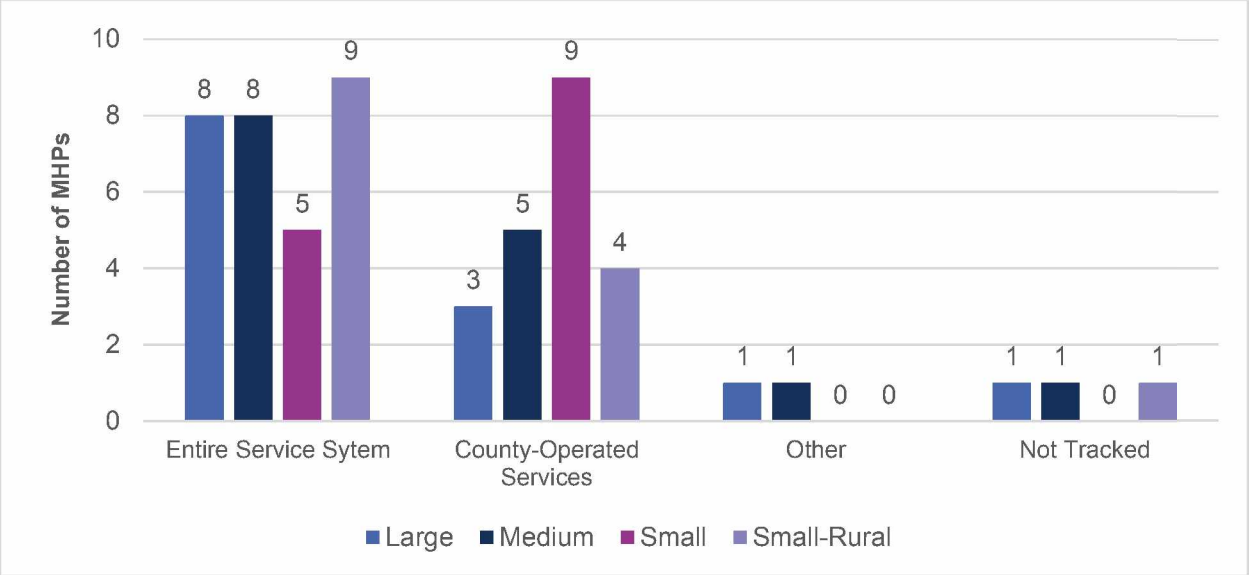
Figure 5-4: Data Set for Initial Non-Urgent Psychiatry Appointment Offered, Reported by MHPs in FY 2023-24



There were four MHPs (Inyo, San Luis Obispo, San Mateo, Tehama) that did not track the offering of first non-urgent psychiatry appointments, which was one less than was last year.

Only three MHPs (Inyo, Los Angeles, and San Luis Obispo) did not report on initial psychiatry services that were delivered, as seen in Figure 5-5 below.

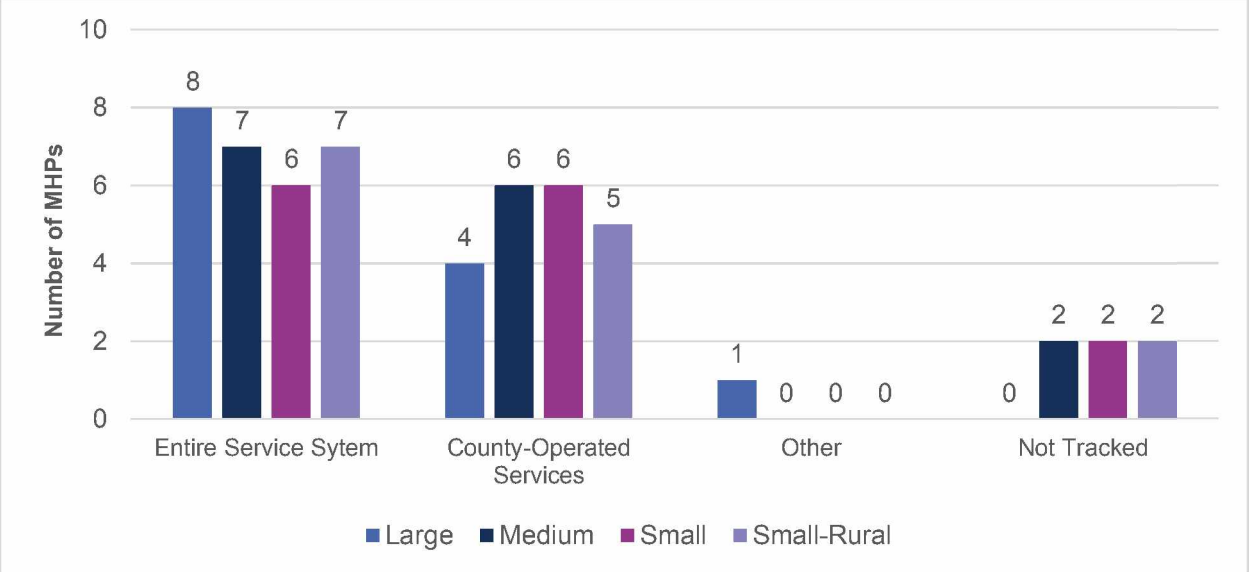
Figure 5-5: Data Set for Initial, Non-Urgent Psychiatry Service Delivered, Reported by MHPs in FY 2023-24



Reporting psychiatry wait times can be challenging since the point of request may be unknown if it does not correspond to the date of the initial service request. This process can also be impeded if an MHP has not identified a mechanism for capturing the date of psychiatry referral or if the MHP established a process but staff do not conform to it in all circumstances.

Figure 5-6 shows the tracking for urgent services.

Figure 5-6: Data Set for Urgent Services, Reported by MHPs in FY 2023-24



As illustrated in Figure 5-6, MHPs continue to have challenges reporting urgent service wait times. Six MHPs (Del Norte, Inyo, Madera, Solano, Sutter-Yuba, Tehama, and Yolo) – one more

than last year – did not report on this measure. Although three of these Plans did not report last year as well (Del Norte, Sutter-Yuba, and Tehama), three other MHPs (Inyo, Solano, and Yolo) that were able to address this metric during the previous reporting cycle, were not able to do so in the current review year.

While MHPs must deliver urgent services that do not require pre-authorization within 48 hours, the lack of an adequate definition of what constitutes a clinically "urgent" presentation by a member is a problematic factor that needs to be resolved before it can meaningfully track the offering of urgent appointments – especially to compare across MHPs. Another issue that has impeded the process of collecting data for this metric is MHPs that implemented new EHRs and may not yet have had the necessary functionality to capture this information. MHPs should perform ongoing reviews of EHRs to not only determine whether appropriate data-entry screens or forms have been modeled into the system, but that it is being entered and reported accurately. These challenges infused a significant degree of unreliability into the comparison of urgent wait times across MHPs, which are presented later in this chapter.

Initial Non-Urgent, Non-Psychiatry Service

This section is organized as follows:

- Initial non-urgent, non-psychiatry service offered – 10 business-day standard
  - Average percentages meeting the standard
    - By county MHP size
    - Table of each MHP's percentages that met the standard.
  - Average wait times reported by MHPs
    - By county MHP size
    - Table of each MHP's reported average wait times.
- Initial non-urgent, non-psychiatry service delivered – MHP-defined standards
  - Average percentages meeting the standard
    - By county MHP size
    - By county region
    - Table of each MHP's percentages that met the standard.
  - Average wait times reported by MHPs
    - By county MHP size
    - By county region
    - Table of each MHP's reported average wait times.

For ease of display, although Los Angeles is a "very large" MHP and its own "Los Angeles" region, reporting in this chapter incorporates Los Angeles with large MHPs and the Southern region. The calculations presented in this chapter are not influenced by the larger volume of services delivered in Los Angeles, and so displaying Los Angeles separately is not needed.

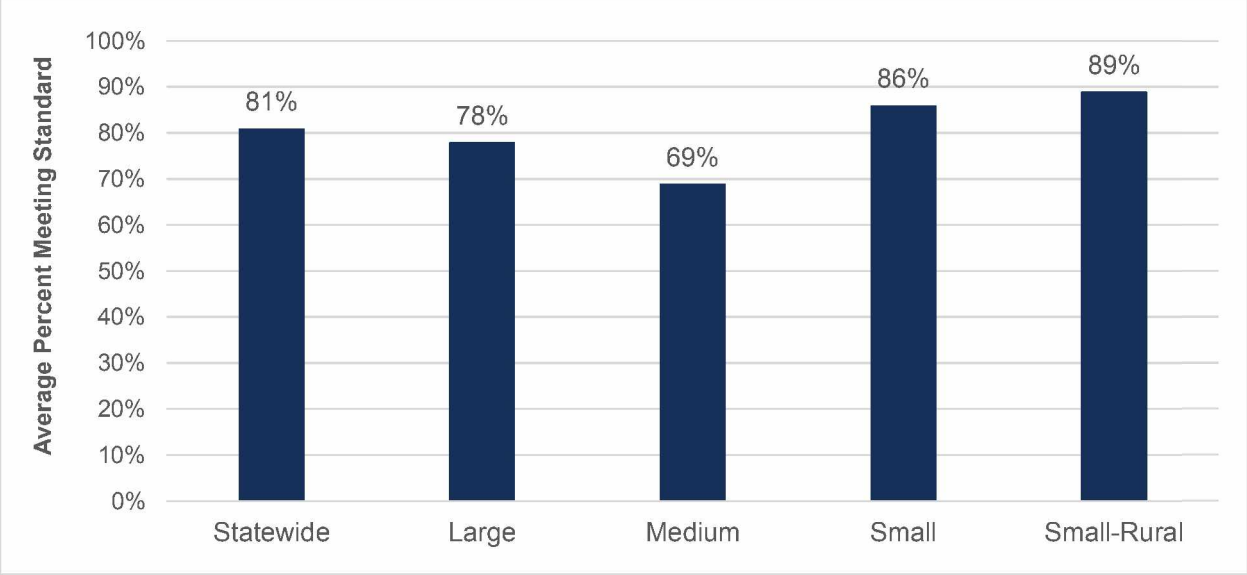
Initial Non-Urgent Mental Health Services – Offered Appointments

Percentage Meeting DHCS 10 business-day Standard

The Key Component performance for 2A showed 50 MHPs achieving a Met rating and 15 a Partially Met rating. Only one MHP (Imperial) received a Not Met rating, a result of the implementation of the new EHR that could not yet report this data.

MHPs are expected to meet the timeliness standard for 80 percent of the offered initial, non-urgent appointments. The actual percentage meeting this standard is first displayed in aggregate by county size (Figure 5-7).

Figure 5-7: Initial Appointment Offered, Average Percent Meeting DHCS Standard, by MHP Size, Reported by MHPs in FY 2023-24



In contrast to the findings from the previous EQR review cycle, all 56 MHPs were able to successfully report counts relating to the first offered, non-urgent appointments. As a result, the overall statewide average (calculated as an average of the MHP percentage meeting 10 business-day standards) was 81 percent, which showed a one percentage point increase over what was observed last year. The averages for large[21] and medium MHPs were not only below the statewide average, but also, in comparison to FY 2022-23 numbers, show slight decreases. Conversely, each of the averages for small (86 percent) and small-rural (89 percent) MHPs exceeded the statewide average, respectively, by 5 and 9 percentage points. Furthermore, both evidenced increases over the averages that were reported last year. While small-rural MHPs showed a 1 percentage point increase, small MHPs evidenced a 7.50 percent increase, from 80 percent to 86 percent for this measure.

Table 5-3 outlines by MHP the percentage of initial offered appointments meeting the 10 business-day for each population – adults, youth, and foster youth. These rates (percentage meeting the standard) are alphabetized into three categories:

[21] Los Angeles is included in the large MHPs. The calculations presented in this chapter are not influenced by the larger volume of services delivered in Los Angeles, and separating Los Angeles is not needed.

- MHPs that met at least 80 percent performance with the overall 10 business-day expectation (with validated data).
- MHPs that met the 80 percent standard for one age group (with validated data).
- MHPs that did not meet the 80 percent standard for any age group or results could not be validated.

Table 5-3: MHP Initial Non-Urgent, Non-Psychiatry Appointment Offered – Percent Meeting DHCS Standard, Reported by MHPs in FY 2023-24

MHP	Overall % Meeting Standard	Adult % Meeting Standard	Youth % Meeting Standard	Foster Youth % Meeting Standard
80% Overall met 10 business days and results were validated				
Alameda	80%	68%	84%	90%
Amador	98%	98%	98%	95%
Colusa	100%	100%	100%	N/A
Contra Costa	97%	99%	94%	84%
Del Norte	83%	98%	54%	50%
El Dorado	88%	88%	89%	76%
Fresno	83%	83%	83%	85%
Glenn	85%	88%	83%	86%
Imperial	92%	91%	93%	95%
Kern	96%	95%	96%	91%
Lake	84%	82%	81%	40%
Lassen	98%	98%	98%	100%
Madera	97%	97%	97%	87%
Mariposa	99%	98%	99%	100%
Mendocino	95%	94%	89%	100%
Modoc	99%	100%	99%	90%
Nevada	86%	99%	68%	100%
Plumas	96%	100%	97%	100%
San Benito	99%	100%	99%	100%
San Diego	80%	86%	75%	79%
San Francisco	82%	84%	79%	91%
San Joaquin	85%	73%	98%	100%
San Mateo	80%	79%	83%	80%
Shasta	96%	99%	92%	98%
Siskiyou	81%	83%	77%	84%
Sutter-Yuba	93%	97%	85%	78%
Ventura	84%	84%	83%	82%
80% met standard for one or more age groups (not Overall) and results were validated				
Santa Cruz	71%	89%	63%	100%
No age groups met 80% performance – or – Results could not be validated or no data was submitted for validation				
Alpine	95%	94%	100%	50%

MHP	Overall % Meeting Standard	Adult % Meeting Standard	Youth % Meeting Standard	Foster Youth % Meeting Standard
Butte	74%	69%	79%	78%
Calaveras	74%	77%	71%	83%
Humboldt	94%	96%	88%	88%
Inyo	98%	99%	96%	100%
Kings	46%	48%	45%	35%
Los Angeles	70%	79%	56%	60%
Marin	66%	70%	53%	71%
Merced	54%	59%	46%	37%
Mono	98%	98%	95%	100%
Monterey	76%	75%	80%	100%
Napa	88%	89%	87%	92%
Orange	73%	99%	54%	60%
Placer-Sierra	96%	100%	94%	89%
Riverside	78%	79%	75%	77%
Sacramento	51%	72%	42%	40%
San Bernardino	77%	85%	73%	76%
San Luis Obispo	44%	41%	44%	17%
Santa Barbara	52%	54%	46%	81%
Santa Clara	61%	60%	61%	63%
Solano	61%	54%	72%	78%
Sonoma	42%	47%	39%	81%
Stanislaus	87%	80%	91%	96%
Tehama	58%	56%	75%	N/A
Trinity	48%	48%	48%	0%
Tulare	74%	75%	74%	58%
Tuolumne	89%	88%	92%	100%
Yolo	71%	69%	69%	94%

In Table 5-3 above, all 56 MHPs reported on this measure for offered appointments. Of this group, 27 (48 percent) met the 10 business-day standard for the overall population – combining all adult and youth members – at least 80 percent of the time. This count represents a 12.5 percent increase over the 24 MHPs that met this expectation last year. Furthermore, CalEQRO was able to validate the findings against their submitted source material.

One MHP (Santa Cruz) did not meet 80 percent of the overall population; however, their data was validated and they satisfied the 80 percent standard for an age population (adult).

Of the remaining 28 MHPs, 8 reported results exceeding 80 percent but did not submit data for validation. However, 20 MHPs did not meet the 80 percent threshold, irrespective of whether they submitted source material for assessment. Additionally, one MHP reported on this measure that it did not track foster youth separately.

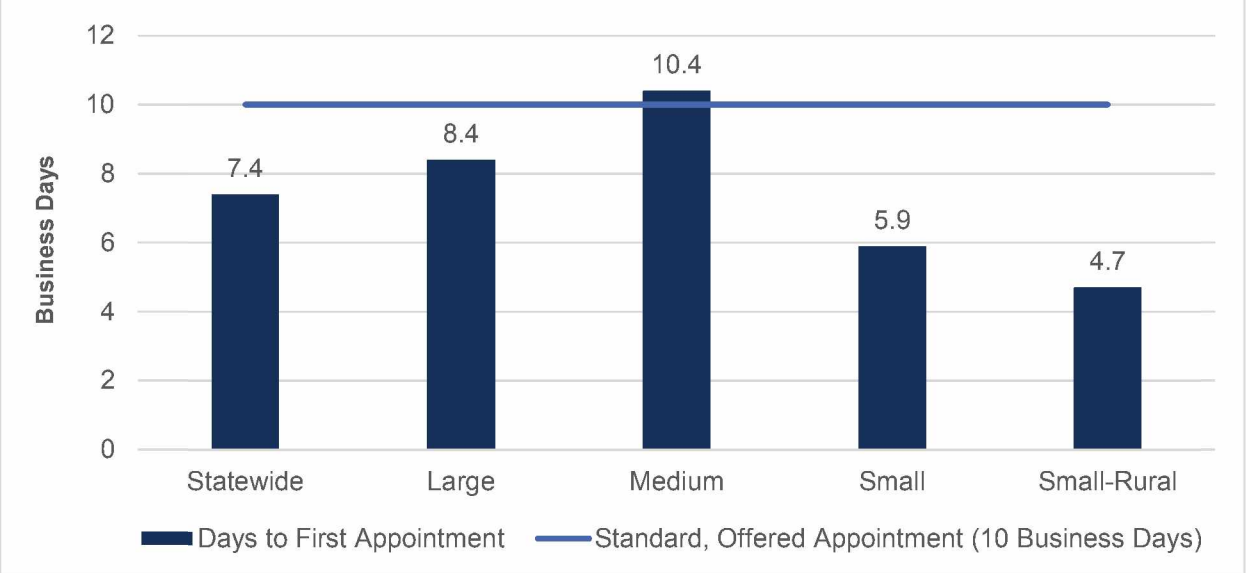
The range of performance for the MHPs on this metric extended from a minimum of 42 percent to a maximum of 100 percent of offered appointments meeting the 10 business-day standard.

Four MHPs reported performance of less than 50 percent, which was a 33.33 percent reduction from last year's six MHPs.

Average Wait Time for Initial Offered Non-Urgent Appointment

In addition to the percentage meeting the expectations displayed earlier, Figure 5-8 below shows the average wait times, by MHP size, for the initial offered non-urgent appointment.

Figure 5-8: First Non-Urgent Appointment Offered, Average Wait by MHP Size, Reported by MHPs in FY 2023-24



Evaluating the average number of business days that elapsed between dates of requests and first offered, non-urgent appointments, stratified by MHP size, reveals that small-rural MHPs demonstrated the shortest wait times with an average of 4.7 business days. Medium MHPs slightly exceeded the standard at 10.4 business days. In comparison to the findings reported last year, average wait times to first offered, non-urgent appointments among large and medium Plans increased by 9.09 percent and 6.12 percent, respectively. However, average wait times for small and small-rural MHPs decreased by 20.27 percent and 16.07 percent, respectively. In addition, the overall statewide average wait time of 7.4 business days in FY 2023-24 represented a slight improvement (2.63 percent) in performance from what was reported last year (7.6 business days).

MHP-specific wait times are displayed below in Table 5-4. The MHPs' data are presented alphabetized in the same categories that reflect their percentage performance for this metric.

Table 5-4: MHP Wait to First Non-Urgent Appointment in Average Business Days, Reported by MHPs in FY 2023-24

MHP	Overall Average Wait Time	Adult Average Wait Time	Youth Average Wait Time	Foster Youth Average Wait Time
80% Overall met 10 business-day standard and results were validated				
Alameda	6.8	9.1	6.2	4.9
Amador	2.3	1.9	2.9	6.2
Colusa	1.6	1.8	1.3	N/A

MHP	Overall Average Wait Time	Adult Average Wait Time	Youth Average Wait Time	Foster Youth Average Wait Time
Contra Costa	5.3	4.9	6.1	6.2
Del Norte	6.0	1.0	15.0	18.0
El Dorado	5.0	5.0	5.1	7.0
Fresno	6.8	6.0	7.0	7.0
Glenn	6.3	6.0	6.7	4.8
Imperial	6.0	7.0	8.0	7.0
Kern	4.2	4.2	4.2	5.6
Lake	6.3	6.6	6.6	11.4
Lassen	1.7	1.7	1.8	3.2
Madera	6.0	6.0	7.0	7.0
Mariposa	5.8	5.8	6.0	4.3
Mendocino	4.1	4.3	3.7	4.2
Modoc	1.2	1.2	0.9	2.5
Nevada	6.7	4.3	10.0	6.8
Plumas	2.1	2.2	2.1	2.1
San Benito	2.1	2.1	2.1	1.0
San Diego	10.4	4.8	14.9	9.3
San Francisco	8.7	7.9	10.4	4.6
San Joaquin	7.3	8.8	5.6	5.5
San Mateo	6.3	6.3	6.4	6.5
Shasta	3.3	1.5	5.5	4.0
Siskiyou	6.0	6.0	7.0	8.0
Sutter-Yuba	1.7	0.2	4.8	4.8
Ventura	5.6	5.4	5.9	6.7
80% met standard for one or more age groups (not Overall) and results were validated				
Santa Cruz	10.6	6.2	12.7	4.6
No age groups met 80% performance – or – Results could not be validated or no data was submitted for validation				
Alpine	5.1	5.0	5.5	8.0
Butte	8.6	9.6	7.3	8.1
Calaveras	8.3	7.6	9.1	7.0
Humboldt	5.0	4.0	7.0	6.0
Inyo	1.6	1.4	2.2	1.5
Kings	14.7	11.7	17.5	20.9
Los Angeles	11.7	8.6	16.4	14.3
Marin	8.6	8.2	9.5	8.6
Merced	16.7	14.6	20.1	16.0
Mono	3.2	2.9	3.9	2.0
Monterey	6.0	6.0	6.0	17.0
Napa	5.3	5.1	5.6	5.1
Orange	9.3	1.6	18.2	14.5
Placer-Sierra	2.3	1.6	3.6	2.2
Riverside	6.9	6.1	8.6	8.3

MHP	Overall Average Wait Time	Adult Average Wait Time	Youth Average Wait Time	Foster Youth Average Wait Time
Sacramento	13.9	9.0	16.0	15.2
San Bernardino	7.4	5.9	8.1	6.6
San Luis Obispo	24.0	23.0	24.0	56.0
Santa Barbara	15.0	11.0	21.0	9.0
Santa Clara	12.0	11.9	12.0	9.9
Solano	9.2	9.3	9.0	9.6
Sonoma	16.4	10.7	20.6	7.4
Stanislaus	7.0	7.0	7.0	7.0
Tehama	10.0	10.0	10.0	N/A
Trinity	14.0	14.0	13.0	16.0
Tulare	8.1	7.3	8.5	13.9
Tuolumne	7.0	7.0	7.0	7.0
Yolo	10.0	9.0	12.0	5.0

With an overall average of 7.4 business days, the statewide averages for this metric by age group were quite similar to last year. The average wait for adults was slightly shorter at 6.4 business days, and it was 0.3 business days faster than last year. The range of wait times for adults was 0.2 to 23 business days, which also showed a reduction in comparison to last year's high of 36 business days. Conversely, youth wait times this year increased slightly (by 1.29 percent) to 8.65 business days. Average wait times for foster youth increased by 5.64 percent, with a corresponding increase to a high of 56 business days compared to 27 business days last year.

There were 11 MHPs (20 percent), one fewer than last year, that showed overall wait times of longer than 10 business days. Of this group, three MHPs had average wait times of 16 business days or longer (greater than 3 weeks).

As in FY 2022-23, there were seven MHPs in FY 2023-24 that reported wait times of 5 business days or less across all three demographic groups, and with submitted source data that permitted CalEQRO to validate their results (**Colusa**, **Lassen**, **Mendocino**, **Modoc**, **Plumas**, **San Benito**, and **Sutter-Yuba**).

Initial Outpatient Mental Health Services – Delivered Services – Percent Meeting Standards

Percentage Meeting the MHP-Defined Standard

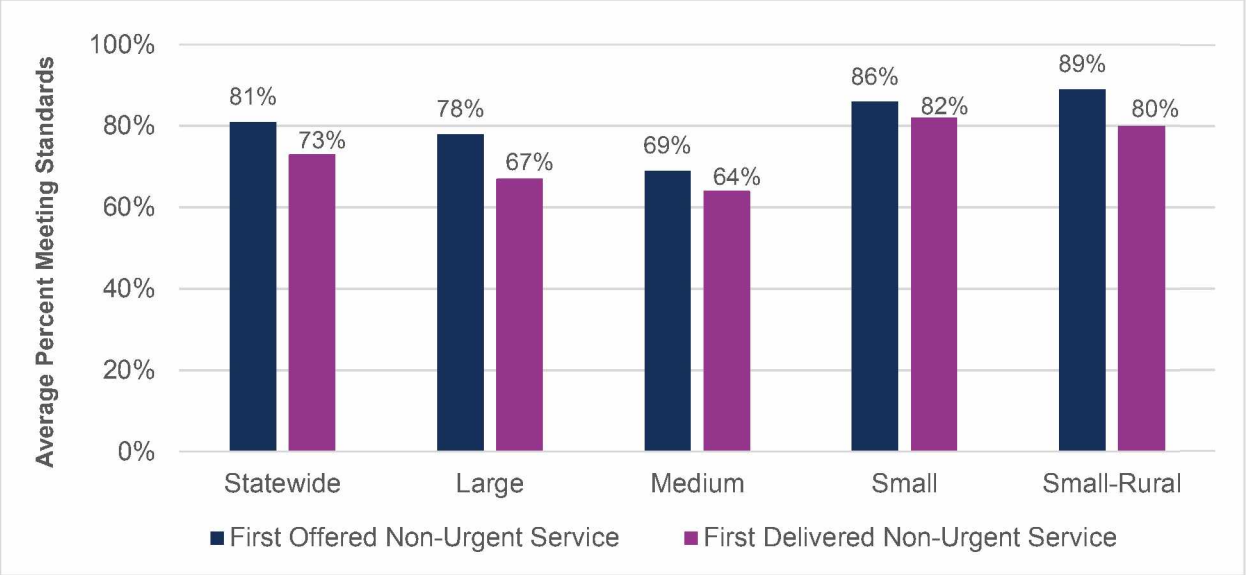
This section of the report compares the percentage of initial services delivered within the context of MHP-defined standards. DHCS does not set a performance target for the wait time for delivering the initial service. This section also compares both metrics for offered versus delivered initial non-urgent service, as expressed by county size and county region, to provide a comparative delineation of performance. All 56 MHPs reported this measure during the FY 2023-24 review cycle.

Regarding MHPs that self-defined benchmarks for first delivered, non-urgent services, 44 Plans applied a 10 business-day standard, but 10 Plans articulated a longer standard (Colusa, Contra Costa, Mono, Solano, Tehama, and Yolo at 15 business days; Nevada and San Luis Obispo at 20 and 21 business days, respectively; and San Joaquin and Tuolumne at 30 business days).

Imperial and Los Angeles had not operationally defined a standard and, therefore, did not provide compliance frequencies for this metric but did report overall average wait times.

Figure 5-9 provides a comparative view broken down by MHP size for the reported performance of MHPs for both offering and delivering first non-urgent services.

Figure 5-9: Initial Offered and Delivered Services, Average Percent Meeting Standards by MHP Size, Reported by MHPs in FY 2023-24



The percentage of Plans meeting the MHP-defined standards decreased when compared to the average percentage of appointments that satisfied the DHCS 10 business-day standard. The more protracted wait times to the first delivered service may be ascribed to the reality that members might not have accepted the initially offered appointment; or, perhaps, they accepted the appointment, but then either the member or the MHP had to cancel and/or reschedule, and ultimately the service was delivered later than initially intended.

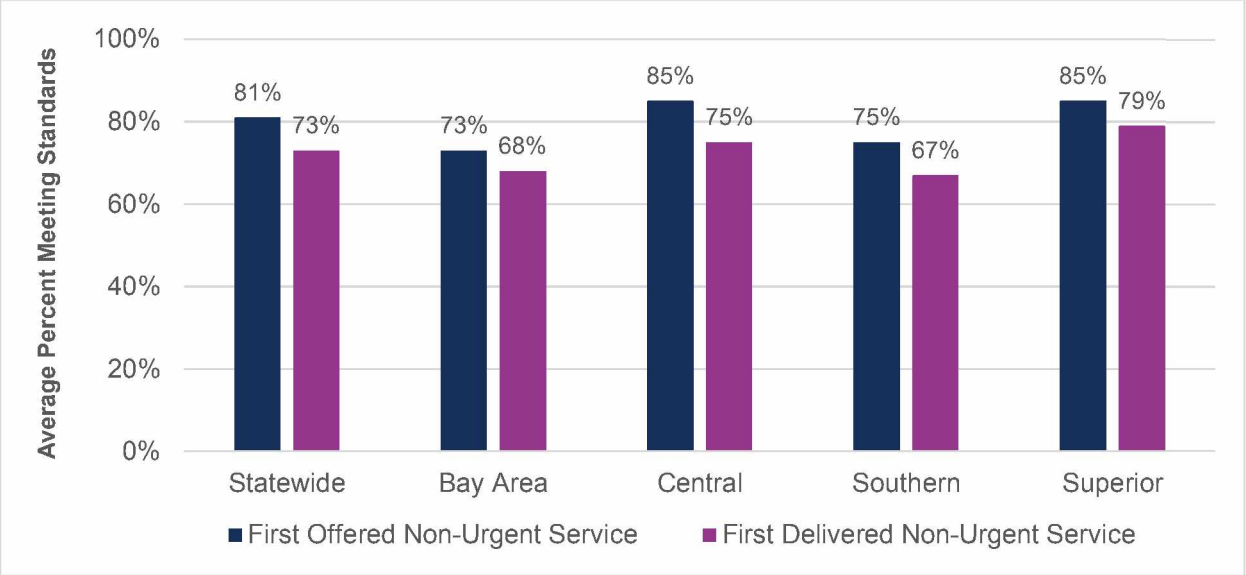
Statewide, Plans averaged 73 percent, similar to last year's 72 percent. The calculation of compliance for this metric; however, is confounded by the fact that ten MHPs do not employ the 10 business-day standard. Nonetheless, the MHPs met their standards for delivered services with overall performance 8 percentage points lower than performance for the offered appointment.

At 89 percent, small-rural MHPs reported on average the best performance for offering members timely access to first non-urgent appointments while small MHPs did the most effective job of delivering these services (82 percent). The rates associated with the delivery of services by small MHPs increased by 26.15 percent (82 percent vs. 65 percent).

Large and medium MHPs not only showed the lowest performance in contrast to the other groups, but also when comparing percentages from the last FY, it is evident that they experienced small decreases in the rates of performance for both offered and delivered services. In short, it appears that during FY 2023-24, small and small-rural MHPs outperformed their medium and large counterparts in the process of providing members timely access to non-urgent offered appointments and delivered services.

Figure 5-10, below, displays timeliness performance for the initial non-urgent appointment (offered and delivered) by region.

Figure 5-10: Initial Offered and Delivered Services, Percent Meeting Standards by MHP Size, Reported by MHPs in FY 2023-24



The Superior region, which comprises more than half of all small-rural MHPs (n=8), collectively manifested the strongest performance for both the offered and delivered metrics. The MHPs included in the Central region demonstrated the next best rates of performance. In comparison to last year, the average percentage of offered appointments that met the DHCS 10 business-day standard in the Superior region decreased by 3 percentage points, while the average percentage of delivered services that satisfied the MHP standards in this group evidenced a 7-percentage point increase. Conversely, during the same period, the average percentage of appointments that were offered within 10 business days (85 percent) in the Superior region was greater than last year (77 percent).

Between FY 2022-23 and FY 2023-24, overall efforts by MHPs in the Bay Area region to offer and deliver services decreased in the performance rates for both metrics. While the average percentage of non-urgent appointments that were offered within 10 business days among Southern region MHPs[22] was like last year, the average percentage of delivered services that conformed to MHP standards increased by 7 percentage points to 67 percent. Interestingly, the average statewide percentages of offered appointments and delivered services that met standards this FY as opposed to those disclosed in the previous FY were invariant.

In general, it appears that appointments offered in the Superior and Central regions were most likely to have been completed within the 10 business-day standard. Members in the Bay Area and Southern regions, however, seemed to be offered appointments that had average wait times that were greater than those of the other two groupings. Furthermore, the average percentage of appointments in the Bay Area and Southern regions that met the DHCS 10 business-day standard experienced decreases over the percentages reported for the MHPs in

[22] Los Angeles is included in the large MHPs. The calculations presented in this chapter are not influenced by the larger volume of services delivered in Los Angeles, and separating Los Angeles is not needed.

these categories last year. Similarly, the percentages of services that were delivered within MHP-defined benchmarks by Plans in the Superior and Central regions exceeded the corresponding percentages in the Bay Area and Southern regions. From a geographic perspective in FY 2023-24, MHPs in the Superior and Central regions seemed to offer and deliver non-urgent services in a manner that was on average timelier than was witnessed in either the Bay Area or Southern regions.

Table 5-5 provides an account by MHP of the percentages meeting the standard for the first non-urgent service delivered within MHP-defined standards. Aside from each Plan's overall performance being shown, performance is stratified by adults, youth, and foster youth.

Table 5-5: First Non-Urgent Services Delivered by MHPs – Percent Meeting MHP Standard, Reported by MHPs in FY 2023-24

MHP	Overall % Meeting Standard	Adult % Meeting Standard	Youth % Meeting Standard	Foster Youth % Meeting Standard
80% Overall met 10 business-day standard and results were validated				
Amador	94%	94%	93%	74%
Colusa	94%	94%	94%	N/A
Contra Costa	95%	99%	90%	89%
Del Norte	84%	99%	50%	50%
El Dorado	85%	84%	85%	71%
Kern	84%	90%	79%	71%
Lake	80%	81%	76%	40%
Lassen	91%	92%	89%	88%
Mendocino	92%	93%	90%	97%
Modoc	95%	97%	93%	90%
Mono	97%	96%	100%	100%
Nevada	88%	99%	78%	100%
Plumas	84%	79%	87%	100%
San Benito	98%	98%	99%	100%
San Joaquin	91%	88%	93%	86%
Shasta	95%	99%	89%	90%
Sutter-Yuba	90%	95%	80%	50%
Ventura	82%	83%	81%	72%
Met 80% for one or more age groups (not overall) and results were validated – or – Met 80% with a local standard and results were validated				
Madera	74%	84%	66%	48%
Santa Cruz	66%	86%	55%	100%
No age groups met 80% performance – or – Results could not be validated or no data was submitted for validation				
Alameda	68%	56%	71%	79%
Alpine	75%	75%	N/A	50%
Butte	58%	56%	63%	61%
Calaveras	70%	74%	66%	83%
Fresno	61%	66%	59%	41%

MHP	Overall % Meeting Standard	Adult % Meeting Standard	Youth % Meeting Standard	Foster Youth % Meeting Standard
Glenn	75%	79%	72%	83%
Humboldt	77%	79%	74%	89%
Inyo	99%	99%	100%	100%
Kings	39%	48%	33%	19%
Marin	56%	64%	36%	43%
Mariposa	62%	67%	55%	60%
Merced	42%	46%	37%	23%
Monterey	92%	94%	89%	100%
Napa	74%	75%	73%	80%
Orange	64%	87%	46%	50%
Placer-Sierra	80%	68%	94%	89%
Riverside	70%	75%	55%	62%
Sacramento	37%	45%	31%	0%
San Bernardino	64%	69%	62%	66%
San Diego	52%	66%	44%	59%
San Francisco	68%	69%	66%	75%
San Luis Obispo	59%	59%	60%	20%
San Mateo	72%	71%	74%	64%
Santa Barbara	59%	65%	48%	76%
Santa Clara	54%	58%	51%	57%
Siskiyou	55%	60%	45%	35%
Solano	66%	64%	70%	72%
Sonoma	37%	42%	34%	67%
Stanislaus	81%	81%	81%	91%
Tehama	71%	70%	86%	N/A
Trinity	46%	45%	49%	0%
Tulare	42%	59%	32%	20%
Tuolumne	97%	98%	96%	100%
Yolo	62%	67%	59%	60%
No Standard Set for this Metric				
Imperial	Not Reported			
Los Angeles	Not Reported			

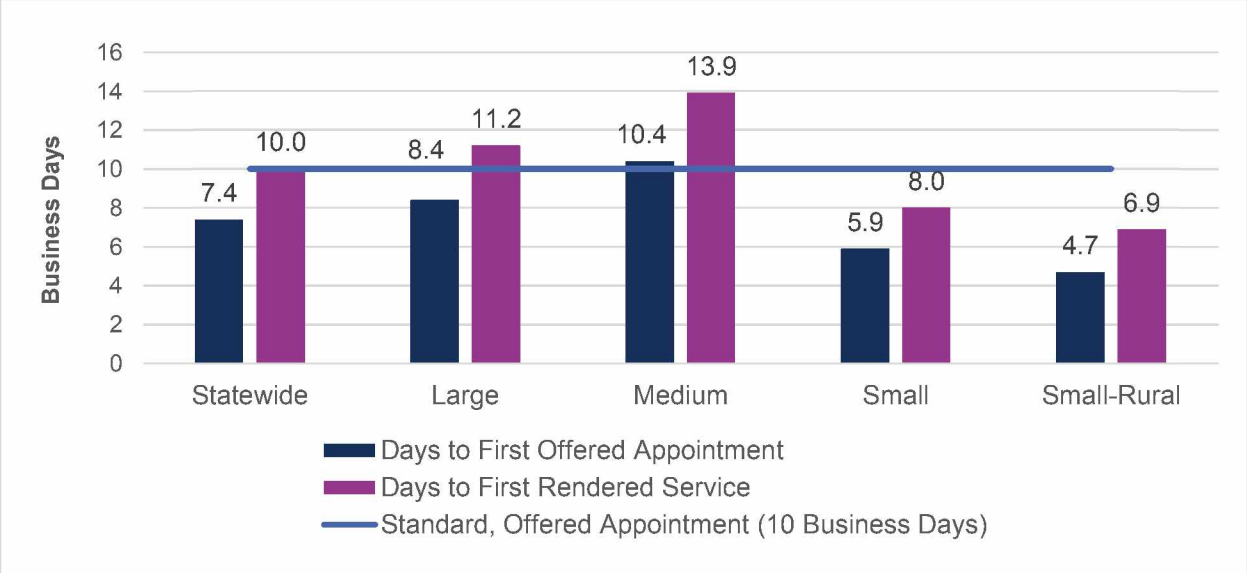
There were 18 MHPs that met the 10 business-day standard for delivering the initial service at least 80 percent of the time and their data was validated by CalEQRO, compared to 10 MHPs last year. Two MHPs also submitted validated data but either only met the 80 percent 10 business-day standard for one or more age groups, but not for the overall population, or maintained a local standard longer than 10 business days (as did the ten MHPs named earlier in this chapter). Of the remaining MHPs, 34 were within the third category, where performance was below 80 percent for any standard, or the numbers could not be validated against source material. The last two MHPs (Imperial and Los Angeles) were sequestered as they did not set standards against which performance can be measured or evaluated.

Initial Outpatient Mental Health Services – Delivered Services – Average Wait Times

Wait Times for the First Delivered Service

The figures below illustrate the differences in wait times from the points of the initial offered appointment to the delivery of service. These comparative frequencies are expressed first by MHP size (Figure 5-11) and then by MHP region (Figure 5-12).

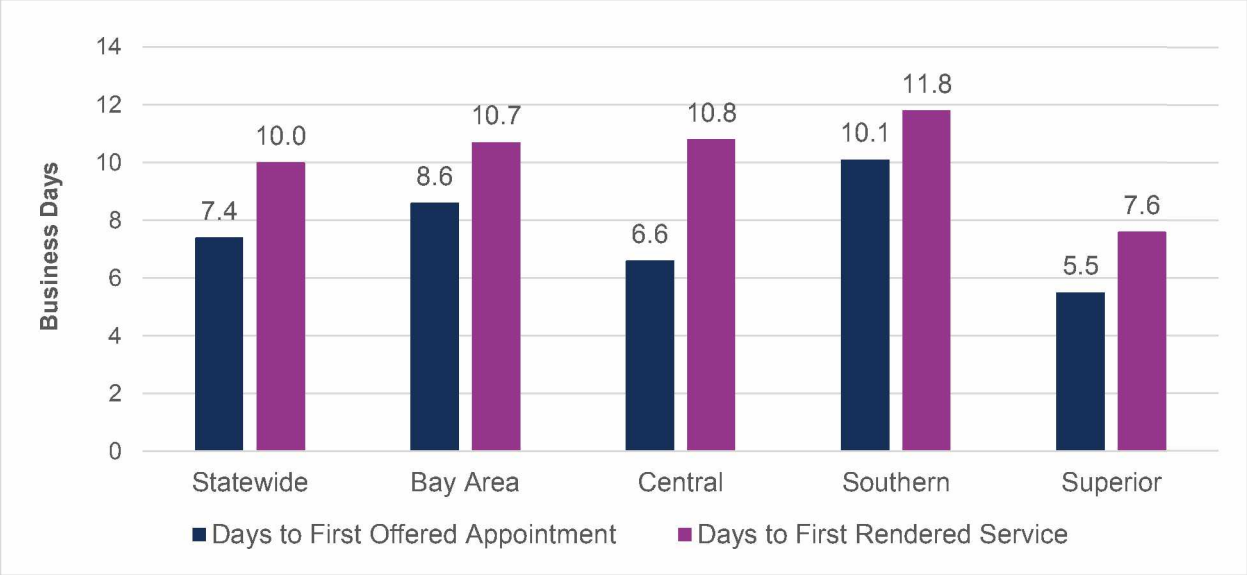
Figure 5-11: Initial Appointment Offered and Delivered, Average Wait by MHP Size, Reported by MHPs in FY 2023-24



The statewide average for first delivered services, calculated as the average wait time across MHPs, was 10.0 business days, which was only 2.6 days longer than the average wait time for initial offered appointments. In comparison to findings in FY 2022-23, the statewide average for first rendered services decreased by 2 business days (from 12 to 10 days). The wait time gap between offered appointments and delivered services narrowed.

While small-rural MHPs had the shortest wait times for first offered appointments and first delivered services, small Plans showed the smallest difference (2.1 business days) between these two measures. Compared to last FY, even though the average wait time for the first offered appointments increased by 0.6 business days among medium MHPs, the average wait time for the first delivered services for this group decreased by 1 business day. This change generated a reduction in the difference between wait times for the two measures that was 1.6 business days shorter than was reported in FY 2022-23 (3.5 vs. 5.1). In contrast, large MHPs, during the same time frame, showed respective increases of 0.7 and 0.6 business days; however, the wait time difference between them remained almost the same (2.8 vs. 2.9 business days). From a macro-level vantage point, it is evident that members are being afforded more timely access to care than was observed during the previous FY, especially in small and small-rural MHPs.

Figure 5-12: Initial Offered and Delivered Services, Average Wait by MHP Region, Reported by MHPs in FY 2023-24



The delivery of services was most prompt in the Superior region, while the longest wait times occurred in the Southern and Central regions. As for appointments, members in the Southern and Bay Area regions experienced, on average, wait times that exceeded what was seen statewide. The statewide difference between wait times for first offered appointments and first rendered services was 2.6 business days, which was 1.8 days shorter than the gap that was reported between these two metrics in FY 2022-23. In comparison to last year's findings, the most salient decrease in average wait times for initially offered appointments and delivered services was observed in the Superior region, where the average times to the first appointment delivered service fell, respectively, by 0.4 and 3.1 business days. During the same period, average wait times for appointments in the Southern region decreased by 1.3 business days, whereas wait times for delivered services increased by 1.0 business days. MHPs in the Bay Area experienced a modest increase in average wait times for appointments, less than 1 day, while average wait times related to delivered services fell by 1.0 business day. Members in the Central region encountered on average a decrease in wait times for both metrics of 1.8 and 2.4 business days, respectively.

MHP-level results for wait times to the first non-urgent service delivered are outlined below in Table 5-6. The MHPs are categorized in the same groupings as defined in Table 5-3 (initial non-urgent, non-psychiatry service offered).

Table 5-6: First Non-Urgent Services Delivered by MHPs – Average Wait Time, Reported by MHPs in FY 2023-24

MHP	Overall Business Days Wait	Adult Business Days Wait	Youth Business Days Wait	Foster Youth Business Days Wait
80% Overall that met 10 business days and results were validated				
Amador	3.3	2.9	4.1	8.3
Colusa	3.1	3.2	2.8	N/A
Contra Costa	6.9	5.5	9.1	8.2

MHP	Overall Business Days Wait	Adult Business Days Wait	Youth Business Days Wait	Foster Youth Business Days Wait
Del Norte	6.0	1.0	15.0	18.0
El Dorado	5.6	5.5	5.8	7.8
Kern	6.1	4.9	7.1	8.5
Lake	7.2	7.2	7.2	14.6
Lassen	3.5	3.5	3.6	4.8
Mendocino	5.3	4.3	3.9	4.3
Modoc	1.7	1.5	2.2	3.0
Mono	4.9	4.9	5.1	2.0
Nevada	9.4	4.9	13.8	9.5
Plumas	3.6	6.0	7.0	8.0
San Benito	2.1	2.1	1.9	1.3
San Joaquin	15.0	18	11.9	14.7
Shasta	3.4	1.6	5.7	5.3
Sutter-Yuba	4.9	3.3	7.8	16.1
Ventura	6.1	5.9	6.2	8.2
80% met 15 business days for one or more age groups (not Overall) and results were validated				
Madera	8.7	8.0	10.0	13.0
Santa Cruz	10.7	4.3	14.2	2.8
No age groups met 80% performance - or – Results could not be validated or no data was submitted for validation				
Alameda	9.2	11.2	8.8	6.3
Alpine	6.3	6.3	N/A	8.0
Butte	15.2	16.4	12.3	17.2
Calaveras	9.3	7.9	10.8	8.0
Fresno	13.9	14.0	14.0	18.0
Glenn	7.5	6.9	8.1	5.1
Humboldt	7.0	6.0	8.0	6.0
Inyo	10.0	10.0	7.0	N/A
Kings	18.7	12.2	23.4	33.7
Marin	11.7	10.0	15.0	13.0
Mariposa	10.7	10.0	9.6	11.1
Merced	25.4	17.0	21.0	22.0
Monterey	2.0	2.0	3.0	0.0
Napa	7.4	7.2	7.8	6.3
Orange	10.7	5.5	15.0	13.7
Placer	2.3	11.4	3.6	2.2
Riverside	7.2	5.9	10.0	9.6
Sacramento	18.8	15.9	20.5	23.8
San Bernardino	12.2	12.4	12.1	10.8
San Diego	19.7	9.9	25.4	15.2
San Francisco	10.5	10.3	10.6	7.8

MHP	Overall Business Days Wait	Adult Business Days Wait	Youth Business Days Wait	Foster Youth Business Days Wait
San Luis Obispo	24.0	23.0	24.0	56.0
San Mateo	9.4	9.6	8.7	11.1
Santa Barbara	12.0	9.0	19.0	8.0
Santa Clara	14.8	13.6	14.9	12.2
Siskiyou	11.8	11.0	14.0	15.0
Solano	15.0	14.7	15.0	14.0
Sonoma	20.4	14.7	23.9	11.3
Stanislaus	9.0	9.0	8.0	8.0
Tehama	14.0	14.0	10.0	N/A
Trinity	15.0	16.0	14.0	16.0
Tulare	17.4	12.0	20.3	27.3
Tuolumne	10.0	9.0	11.0	10.0
Yolo	19.0	18.0	19.0	22.0
No Standard				
Imperial	8.0	9.0	8.0	13.0
Los Angeles	9.5	9.0	10.2	9.5

The average wait times for delivered services varied tremendously across MHPs and by populations. Average wait times across the MHPs for the first delivered service ranged from 1.7 to 25.4 business days – an improved high end that was 44 business days last year. Statewide adults averaged shorter wait times at 8.9 business days, with a range of 1.0 to 23.0 business days. Youth waits were about 2.2 days longer than adults, averaging 11.1 business days, ranging from 1.9 to 25.4 business days, also a shorter high end of the range which was 48 business days last year. Foster youth averaged 11.9 business days, with a range of 0.0 to 56.0 business days. The average wait time for foster youth was a bit higher than last year.

For the delivery of the initial service, 23 MHPs (41 percent) disclosed wait times of longer than 10.0 business days. Of that group, 14 had average wait times ranging from 10.5 to 15.0 business days and 4 reported average wait times ranging from 15.2 to 18.8 business days. The remaining five Plans (9 percent) had a wait time range of 19.0 to 25.4 (4 to 5 weeks). During the reporting cycle last year, however, there were two MHPs that reported average wait times that were greater than 40 business days (roughly 2 months). Given that the upper range of average wait times extends only a few days beyond 1 month (25.4 business days), coupled with the observation that all MHPs submitted their findings in business days for FY 2023-24, the Plans are demonstrating improvement with respect to members accessing treatment faster.

It is notable to mention that **Lassen, Mendocino, Modoc, Monterey,** and **San Benito** all reported to have delivered the initial service in less than a week across all three demographic groups.

Overall, in the ATA submissions, MHPs reported 319,971 requests for service, constituting a small increase (0.76 percent) over the number reported last year (N=317,557). Of those requests, 54 percent (n=172,121) were translated into a delivered SMHS; however, only 37 percent of those rendered services (n=63,556) were compliant with MHP-defined standards, bearing in mind that some MHPs had longer standard time frames as well.

Initial Non-Urgent Psychiatry Service

This section is organized as follows:

- Initial non-urgent psychiatry service offered – 15 business-day standard
  - Average percentages meeting the standard
    - By county MHP size
    - Table of each MHP's percentages that met the standard.
  - Average wait times reported by MHPs
    - By county MHP size
    - Table of each MHP's reported average wait times.
- Initial non-urgent psychiatry service delivered – MHP-defined standards
  - Average percentages meeting the standard
    - By county MHP size
    - By county region
    - Table of each MHP's percentages that met the standard.
  - Average wait times reported by MHPs
    - By county MHP size
    - By county region
    - Table of each MHP's reported average wait times.

Initial Non-urgent Psychiatry Service – Offered

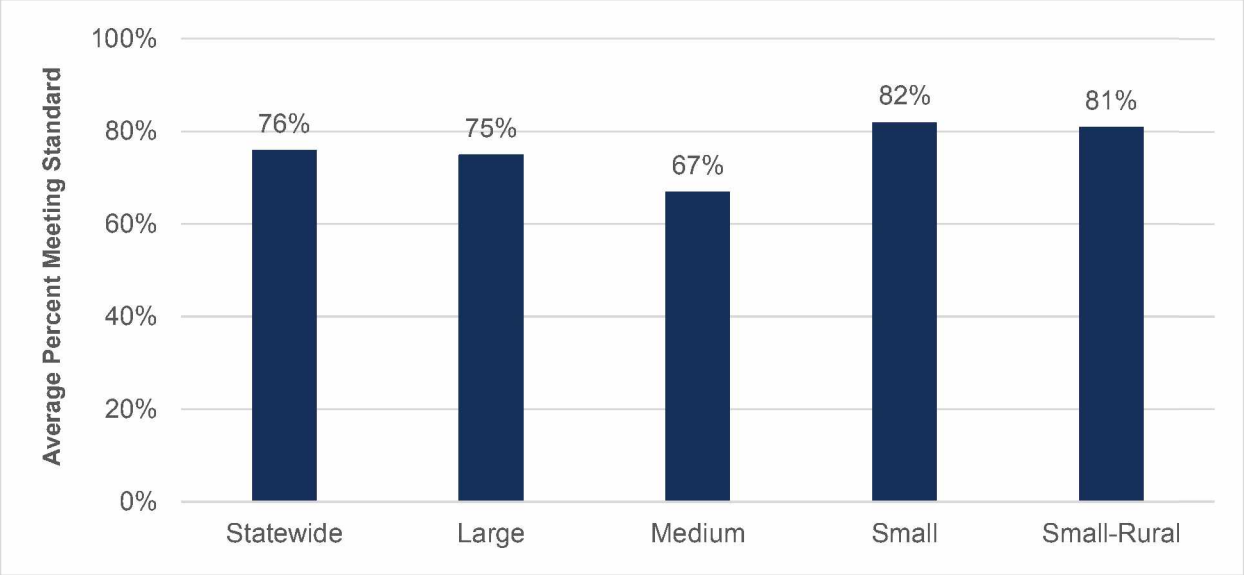
Percentage Meeting DHCS 15 business-day Standard

Delays in accessing psychiatric services can lead to medication non-adherence, lost engagement opportunities, increased emergency room encounters, and rising psychiatric inpatient hospitalizations for members. Due to these challenges, monitoring timeliness to initial psychiatry encounter is a critical element of the EQR process. Furthermore, DHCS established a 15 business-day standard for timeliness to first offered non-urgent psychiatry appointment.

For Key Component 2B for this measure, 34 MHPs received Met and 17 received Partially Met ratings. Five MHPs (Inyo, Monterey, Sacramento, San Mateo, and Tehama) received Not Met ratings for this measure.

Figure 5-13, below, comparatively illustrates the average percentage of offered psychiatry appointments that met the 15 business-day standard by MHP size.

Figure 5-13: Initial Offered Non-Urgent Psychiatry, Average Percent Meeting DHCS Standard, by MHP Size, Reported by MHPs in FY 2023-24



In FY 2023-24, three MHPs (Inyo, San Mateo, and Tehama) did not track the initial offered psychiatry appointments and one (San Luis Obispo) did not provide information for this activity utilizing the DHCS 15 business-day standard. Consequently, only 52 MHPs provided frequencies for this metric during this review cycle. Of this group, one Plan (Placer-Sierra) did not track this measure for adult members, but it submitted rates and average wait times for the youth demographics. Also, Monterey did not offer rates in connection with youth psychiatry encounters and Alpine had no youth referred to psychiatry. That said, based on the 49 (87.5 percent) MHPs that provided data for the "overall" population (compared to 47 MHPs last year), the average percentage of first offered psychiatry appointments that met the DHCS timeliness standard on a statewide level was 76 percent. The aggregate performance of individual MHPs, as reflected through the various demographic categories, ranged from 20 to 100 percent. There were 16 Plans that reported performance rates between 90 to 100 percent and seven MHPs that reported rates less than 50 percent.

In considering the average percentage of initial offered psychiatry appointments that satisfied the DHCS standard by size, small MHPs showed the greatest level performance with a rate of 82 percent (last year was 81 percent). Immediately following this group was small-rural MHPs with a rate of 81 percent (last year was 77 percent). During this same time frame, the percentages associated with large and medium MHPs, as well as the statewide rate, all increased by 1 percentage point. Thus, the positive changes in the rates of performance evidenced by all MHP size groups were modest but, coupled with the fact that a larger number of MHPs fully participated in the process of providing counts for this measure in FY 2023-24, it appears that Plans are making quantifiable strides toward ensuring that members are being offered an initial psychiatry appointments within the 15 business-day window.

Table 5-7 presents the percentage of the initial offered psychiatry appointments meeting the DHCS standard for each population surveyed (adults, youth, and foster youth). These results are then broken into the following four categories and alphabetized, similar to the initial non-psychiatry appointment metrics were displayed:

- MHPs that met 80 percent compliance with the overall 15 business-day expectation (with validated data).

- MHPs that did not meet the 80 percent standard overall but did so for one age group (with validated data).
- MHPs that did not meet the 80 percent standard for any age group or results could not be validated
- MHPs that did not track or did not report this metric.

Table 5-7: Initial Offered Non-Urgent Psychiatry, Percent Meeting 15 Business Day Wait – Reported by MHPs in FY 2023-24

MHP	Overall % Meeting Standard	Adult % Meeting Standard	Youth % Meeting Standard	Foster Youth % Meeting Standard
80% Overall met 15 business-day standard and results were validated				
Amador	87%	86%	85%	100%
Colusa	86%	97%	52%	N/A
El Dorado	83%	83%	89%	100%
Imperial	88%	86%	100%	N/A
Kings	89%	99%	55%	46%
Lake	89%	49%	91%	N/A
Lassen	98%	99%	98%	89%
Madera	99%	99%	99%	100%
Mariposa	100%	100%	100%	100%
Mendocino	93%	94%	89%	100%
Modoc	85%	84%	89%	100%
Napa	96%	97%	100%	80%
Plumas	100%	100%	100%	N/A
Riverside	85%	98%	77%	78%
San Benito	100%	100%	100%	N/A
San Diego	87%	88%	84%	83%
San Francisco	90%	91%	82%	67%
San Joaquin	81%	69%	99%	100%
Shasta	80%	95%	78%	46%
Siskiyou	97%	97%	98%	92%
Sutter-Yuba	93%	97%	68%	43%
Yolo	94%	91%	100%	100%
80% met standard for one or more age groups (not Overall) and results were validated				
Contra Costa	58%	53%	93%	92%
Kern	79%	76%	88%	97%
Nevada	79%	76%	88%	N/A
Santa Cruz	77%	96%	55%	60%
No age groups met 80% performance – or – Results could not be validated or no data was submitted for validation				
Alameda	53%	53%	44%	17%
Alpine	100%	100%	N/A	N/A
Butte	73%	75%	66%	71%

MHP	Overall % Meeting Standard	Adult % Meeting Standard	Youth % Meeting Standard	Foster Youth % Meeting Standard
Calaveras	77%	77%	77%	N/A
Del Norte	20%	27%	7%	50%
Fresno	57%	66%	49%	54%
Glenn	63%	70%	48%	60%
Humboldt	49%	48%	63%	100%
Los Angeles	66%	67%	62%	71%
Marin	52%	58%	32%	33%
Merced	21%	16%	36%	41%
Mono	95%	97%	88%	100%
Monterey	30%	100%	N/A	N/A
Orange	94%	93%	99%	91%
Placer-Sierra	51%	N/A	52%	44%
Sacramento	100%	100%	100%	100%
San Bernardino	90%	95%	74%	63%
Santa Barbara	69%	71%	65%	44%
Santa Clara	36%	36%	37%	54%
Solano	90%	90%	46%	47%
Sonoma	38%	18%	56%	36%
Stanislaus	88%	83%	91%	90%
Trinity	63%	60%	70%	50%
Tulare	58%	50%	74%	85%
Tuolumne	24%	24%	29%	0%
Ventura	77%	87%	49%	77%
Not Reported				
Inyo	N/A			
San Luis Obispo	N/A			
San Mateo	N/A			
Tehama	N/A			

Performance for adult and child psychiatry in the current FY was comparable to last year. Adult psychiatry averaged 78 percent and child psychiatry averaged 74 percent. The performance rates for both of these demographics increased, respectively, by 6.85 percent and 5.71 percent over last year. Although performance for foster youth (71 percent) was lower than the other two groups, the rate for this demographic was 16.39 percent higher than was observed last year. Moreover, there were 22 MHPs that had 80 percent of their appointments meeting the 15 business-day standard and submitted data that supported their calculations. This finding of 22 MHPs constitutes a 29.41 percent increase in MHPs over the previous year.

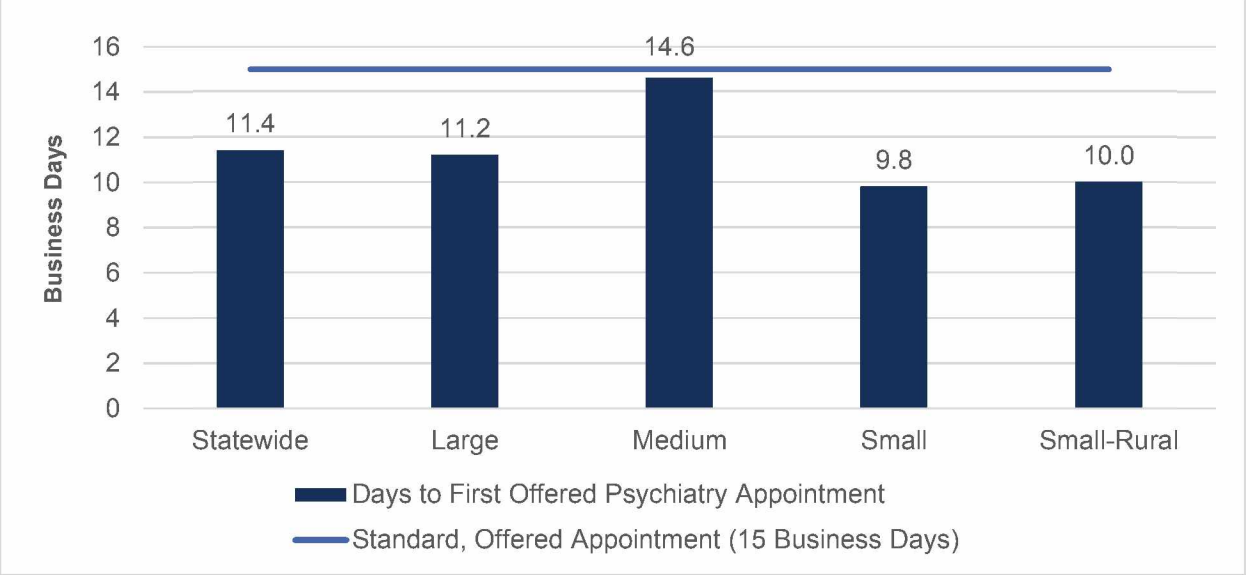
Four MHPs (Contra Costa, Kern, Nevada, and Santa Cruz) did not meet the 80 percent standard overall, but met it for one or more of the demographics, and the source data submitted enabled validation by CalEQRO.

There were 26 Plans that either did not meet the 80 percent threshold for any age group and/or their submission could not be validated. Lastly, four MHPs did not track or report this metric, which represents one fewer MHP than last year.

Figure 5-14, below, comparatively illustrates the average wait times for initial offered psychiatry appointments by MHP size.

Average Wait Times for the Initial Offered Psychiatry Service

Figure 5-14: Initial Offered Psychiatry, Average Wait by MHP Size, Reported by MHPs in FY 2023-24



As demonstrated in Figure 5-14, the overall average wait time for initial psychiatry appointments statewide was 11.4 business days, indicating that the aggregate mean of time between referral and appointment was almost 1.0 full day shorter than last year. In fact, the averages across all MHP sizes showed performances better than the 15 business-day threshold. Small and small-rural MHPs showed the shortest average wait times at 9.8 and 10.0, respectively. From an overarching perspective, it seems that Plans are performing well in terms of helping link from an initial SMHS to a timely psychiatrist appointment.

Table 5-8 below outlines MHP-specific wait time averages for the initial offered non-urgent psychiatry appointment in business days. The MHPs' data are presented in the same categories that reflect their percentage performance for this metric.

Table 5-8: Average Wait Time for Initial Offered Non-Urgent Psychiatry, Reported by MHPs in FY 2023-24

MHP	Overall Average Wait Time	Adult Average Wait Time	Youth Average Wait Time	Foster Youth Average Wait Time
80% Overall met 10 business days and results were validated				
Amador	9.9	9.7	10.5	5.0
Colusa	8.5	5.5	17.3	N/A
El Dorado	9.9	10.2	7.1	4.5
Imperial	11.0	11.0	9.0	N/A
Kings	8.7	6.5	16.9	14.8
Lake	6.9	6.9	7.4	N/A

MHP	Overall Average Wait Time	Adult Average Wait Time	Youth Average Wait Time	Foster Youth Average Wait Time
Lassen	4.8	4.6	5.2	6.9
Madera	8.7	9.0	7.0	7.0
Mariposa	8.8	9.0	8.5	8.7
Mendocino	3.1	2.2	6.9	7.8
Modoc	9.8	9.9	9.4	9.0
Napa	7.3	6.9	9.1	10.5
Plumas	2.6	3.0	2.0	0.0
Riverside	17.0	6.0	23.0	26.0
San Benito	2.5	2.4	2.7	N/A
San Diego	6.4	5.7	8.0	8.8
San Francisco	7.0	6.2	12.5	11.3
San Joaquin	11.0	13.1	8.1	7.6
Shasta	9.9	4.3	12.0	18.8
Siskiyou	7.0	7.0	7.0	8.0
Sutter-Yuba	7.1	5.2	31.8	N/A
Yolo	7.0	8.0	6.0	2.0
80% met standard for one or more age groups (not Overall) and results were validated				
Contra Costa	16.5	17.3	11.4	11.8
Kern	11.8	12.7	10.0	7.6
Nevada	10.3	10.3	9.0	N/A
Santa Cruz	10.4	6.6	15.0	12.0
No age groups met 80% performance – or – Results could not be validated or no data was submitted for validation				
Alameda	14.5	14.0	15.0	19.0
Alpine	3.0	3.0	N/A	N/A
Butte	13.5	11.9	17.1	14.0
Calaveras	12.3	11.9	12.8	N/A
Del Norte	32.1	33.0	30.0	16.0
Fresno	16.7	15.0	18.0	15.0
Glenn	13.9	11.5	18.8	10.9
Humboldt	20.0	22.0	14.0	9.0
Los Angeles	15.1	14.3	18.6	12.9
Marin	18.2	15.2	29.4	19.6
Merced	36.3	41.1	22.0	24.3
Mono	5.1	4.7	6.4	6.0
Monterey	4.0	4.0	N/A	N/A
Orange	6.2	6.4	3.6	6.0
Placer-Sierra	10.0	N/A	8.2	8.8
Sacramento	0.0	0.0	0.0	0.0
San Bernardino	6.7	5.2	10.0	14.8
Santa Barbara	11.6	10.4	12.9	17.1

MHP	Overall Average Wait Time	Adult Average Wait Time	Youth Average Wait Time	Foster Youth Average Wait Time
Santa Clara	20.8	22.6	16.0	13.8
Solano	4.7	4.7	17.6	16.0
Sonoma	20.6	22.1	19.2	27.2
Stanislaus	8.0	9.0	8.0	14.0
Trinity	12.8	13.0	12.0	13.0
Tulare	19.7	23.3	11.9	8.7
Tuolumne	22.0	22.0	24.0	22.0
Ventura	6.7	6.7	20.7	12.2
Not Reported				
Inyo	N/A			
San Luis Obispo	N/A			
San Mateo	N/A			
Tehama	N/A			

For the MHPs to which at least 80 percent met the psychiatry standard and submitted data that was validated, the range of average wait times extended from 2.5 (San Benito) to 17.0 (Riverside) business days. While three MHPs (Kern, Nevada, and Santa Cruz) did not meet the 80 percent threshold overall, their overall average wait time was shorter than 15 business days, and they met 80 percent for one or more age groups.

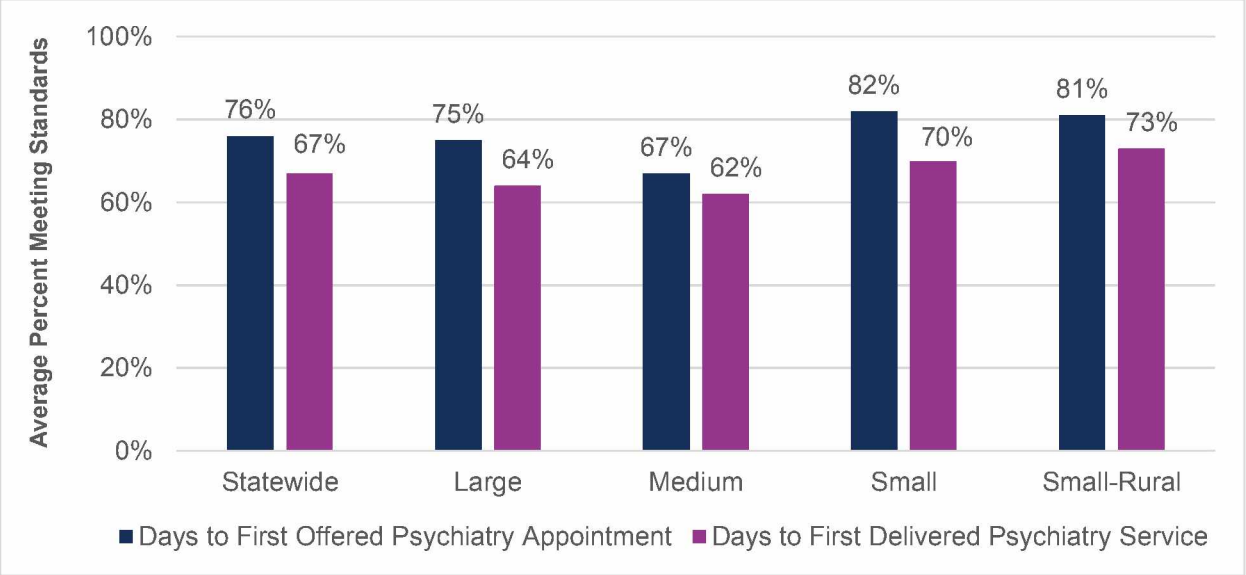
Initial Outpatient Psychiatry Service – Delivered

Percentage Meeting MHP-Defined Standard

This section displays the actual wait times for the first delivered psychiatry service. It also compares both metrics for the initial psychiatry service (offered and delivered), displaying performance by both MHP size and region. Because DHCS does not require a time frame for this metric, MHPs are asked to identify their own standards. Most but not all MHPs identified a 15 business-day standard.

Figure 5-15 below illustrates the average percentages of offered and delivered initial psychiatry appointments that met timeliness standards by size category.

Figure 5-15: First Offered and Delivered Psychiatry, Average Percent Meeting Standards by MHP Size, Reported by MHPs in FY 2023-24

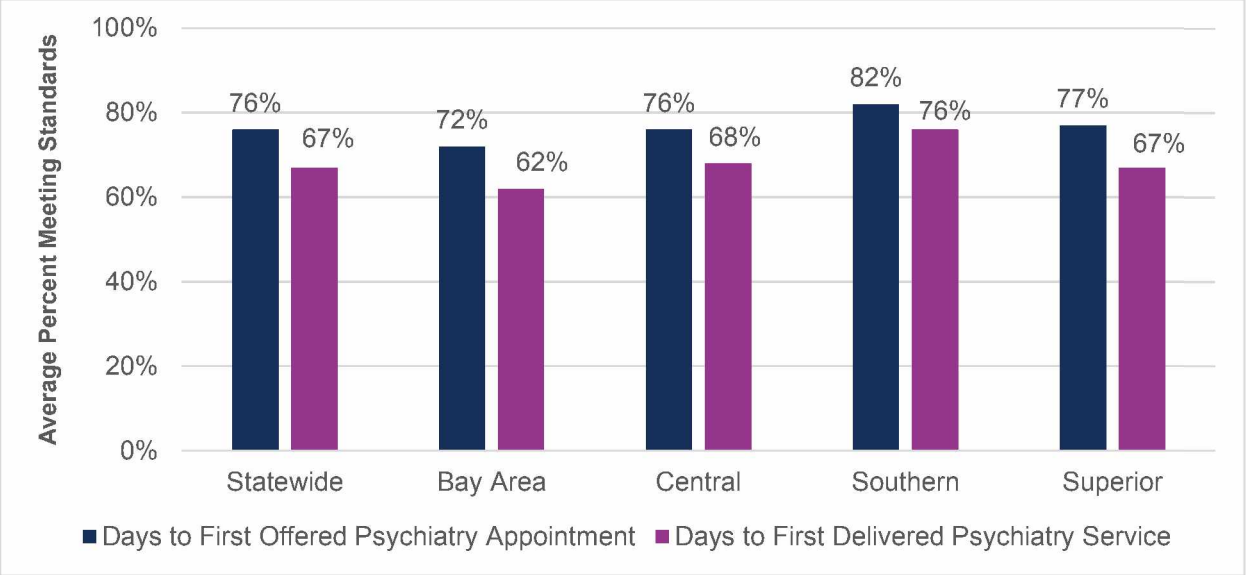


Percentages that met MHP-defined standards across all size categories and statewide drop when comparing delivered services to offered appointments – a statewide gap of 9 percentage points. Furthermore, performance rates for large (64 percent) and medium (62 percent) MHPs were both below the statewide number. Rates for small and small-rural Plans were higher than statewide by 3 and 6 percentage points, respectively. When comparing the change in performance between the first offered psychiatry appointment and the delivered service, the most prominent differences were exhibited in small and large MHPs. In the former group, 82 percent of offered psychiatry appointments met the standard but only 70 percent of delivered services achieved this objective. In the latter category, 75 percent of offered appointments satisfied the benchmark as opposed to only 64 percent of rendered services meeting the MHP standard. The smallest decrease in performance between the offered appointment and the delivered service occurred in medium-sized Plans (67 percent to 62 percent).

In comparison to last year, medium-sized MHPs showed the greatest improvement of rendered psychiatry services that met standards, resulting in a 12.73 percent increase over the rate in the prior year (55 percent vs. 62 percent). Additionally, statewide as well as small and small-rural MHPs also improved performance this year, and large MHP performance was invariant.

Figure 5-16 below illustrates the average percentages of offered and delivered initial psychiatry appointments that met timeliness standards by region.

Figure 5-16: Initial Offered and Delivered Psychiatry, Average Percent Meeting Standards by MHP Region, Reported by MHPs in FY 2023-24



Reviewing the regional distribution, rates for Central and Superior Plans approximated the statewide rates, and Southern MHPs performed better than the statewide average. However, Bay Area (62 percent) MHPs, followed immediately by MHPs in the Superior (67 percent) region, showed the lowest performance for delivered psychiatry services, and the largest decrease from the prior year for the offered psychiatry service.

Table 5-9 shows MHP-specific percentages relating to the delivery of first psychiatry services that met MHP-defined standards for each population surveyed (adults, youth, and foster youth). CalEQRO encouraged a 15 business-day standard for this measure. The wait times are presented in the categories associated with percentage performance for this metric, with those MHPs that reported based on a standard greater than 15 business days included in the second section of the table below.

Table 5-9: First Delivered Non-Urgent Psychiatry, Percent Meeting Standard – Reported by MHPs in FY 2023-24

MHP	Overall % Meeting Standard	Adult % Meeting Standard	Youth % Meeting Standard	Foster Youth % Meeting Standard
Met 80% overall with 15 business-day standards and results were validated				
Colusa	89%	97%	62%	N/A
Contra Costa	85%	84%	89%	75%
El Dorado	80%	79%	96%	100%
Lake	81%	81%	82%	N/A
Lassen	90%	91%	88%	78%
Madera	81%	79%	88%	90%
Mariposa	88%	87%	92%	80%
Mendocino	91%	93%	84%	100%
Napa	83%	82%	90%	80%

MHP	Overall % Meeting Standard	Adult % Meeting Standard	Youth % Meeting Standard	Foster Youth % Meeting Standard
Nevada	91%	94%	84%	N/A
Plumas	95%	95%	91%	N/A
Riverside	89%	97%	81%	0%
San Benito	100%	100%	100%	N/A
San Francisco	84%	85%	73%	33%
80% met 15 business days for one or more age groups (not Overall) and results were validated – or – 80% Overall met a local standard that exceeded 15 business days and results were validated				
Kings	75%	81%	56%	75%
Modoc	75%	73%	82%	100%
Mono	76%	80%	50%	100%
San Diego	78%	84%	71%	72%
San Joaquin	93%	93%	95%	82%
Santa Cruz	71%	88%	49%	70%
Shasta	75%	95%	71%	32%
Siskiyou	78%	76%	86%	63%
No age groups met 80% performance – or – Results could not be validated or no data was submitted for validation				
Alameda	37%	38%	20%	0%
Alpine	100%	100%	N/A	N/A
Amador	64%	69%	50%	100%
Butte	58%	60%	53%	57%
Calaveras	75%	73%	77%	N/A
Del Norte	24%	32%	10%	50%
Fresno	44%	44%	43%	37%
Glenn	62%	62%	56%	0%
Humboldt	51%	56%	41%	75%
Kern	75%	74%	75%	95%
Marin	51%	55%	17%	50%
Merced	25%	23%	29%	32%
Monterey	100%	100%	100%	N/A
Orange	89%	87%	98%	87%
Placer-Sierra	66%	72%	38%	33%
Sacramento	26%	28%	6%	33%
San Bernardino	62%	63%	63%	88%
San Mateo	39%	37%	47%	67%
Santa Barbara	64%	68%	56%	35%
Santa Clara	21%	22%	18%	38%
Solano	68%	60%	81%	84%
Sonoma	40%	24%	55%	27%
Stanislaus	86%	79%	89%	88%

MHP	Overall % Meeting Standard	Adult % Meeting Standard	Youth % Meeting Standard	Foster Youth % Meeting Standard
Sutter-Yuba	71%	74%	33%	N/A
Tehama	4%	2%	25%	N/A
Trinity	37%	36%	41%	25%
Tulare	54%	49%	66%	76%
Tuolumne	21%	20%	25%	0%
Ventura	74%	86%	40%	64%
Yolo*	54%	51%	42%	40%
Not Tracked or Not Reported				
Imperial	N/A			
Inyo	N/A			
Los Angeles	N/A			
San Luis Obispo	N/A			

* Indicates wait times reported in calendar days.
N/A in the foster youth category = reportedly no foster youth were referred to psychiatry.

Regarding MHPs' operationally defining standards to evaluate timeliness for the first delivered psychiatry services, 45 Plans (80.36 percent) established benchmarks based on 15 business days. Six MHPs, however, applied different benchmarks that were measured in business days (Contra Costa, San Joaquin, and Solano at 30 business days; Colusa and Nevada at 20 business days, and Lake at 10 business days). Of the remaining five Plans, one set forth a standard of 30 calendar days (Yolo). Three MHPs did not track this metric (Inyo, Los Angeles, and San Luis Obispo), and one had not set a benchmark for this measure and, therefore, did not provide frequencies in a context that could be reported (Imperial).

Fourteen MHPs (six more than last year) delivered 80 percent or more of their initial psychiatry services within 15 business days, and submitted data that was validated, four more MHPs than last year.

Additionally, 11 more MHPs (3 more than last year) secured at least 80 percent performance for a standard that was longer than 15 business days, and the results were validated. Lastly, aside from the four MHPs that did not track or report for this metric, there were 30 Plans that either 1) failed to deliver 80 percent of their initial psychiatry services in a time frame that conformed with an internally established standard, or 2) CalEQRO was unable to validate their findings, either based upon the source data submitted, or because no source data was submitted.

Average Wait Times for Initial Delivered Psychiatry Service

The following figure (6-17) compares the offered wait time compared to the wait time for the delivered psychiatry service, statewide and by MHP size.

Figure 5-17: First Offered and Delivered Psychiatry, Average Wait by MHP Size, Reported by MHPs in FY 2023-24

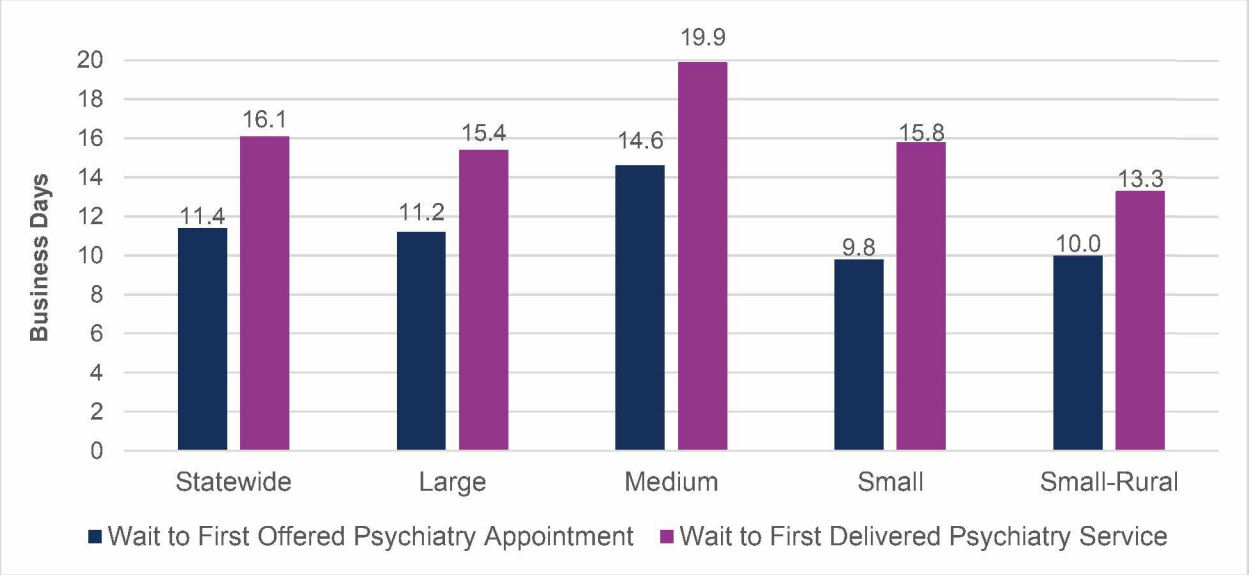
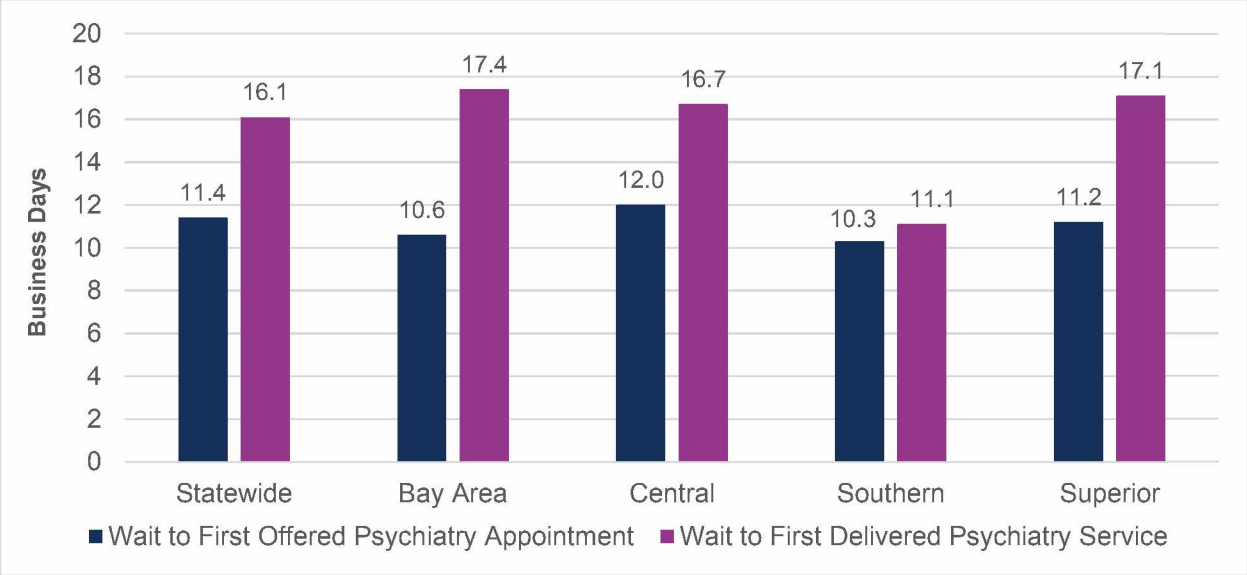


Figure 5-17 shows that the overall average wait time for the delivery of the initial psychiatry services statewide was 16.1 business days, shorter than last year's 18.8 business days. Statewide, the time gap between the first offered psychiatry appointment and first rendered psychiatry service averaged 4.7 business days, which is almost 2.0 business days less than last year's 6.6 business days. Even though small-rural Plans demonstrated the only wait time average for first rendered psychiatry service that was less than 15 business days, averages across all the MHP size groupings improved compared to last year.

The greatest percentage decrease in the average wait time to first delivered services as well as the largest reduction in the wait time gap between appointment and service was seen in large MHPs. Clearly, from the point of referral to the delivery of an initial psychiatry service – including the ensuing gap between the first offered appointment and the first rendered service itself – MHPs have made substantial progress toward the goal of getting members into psychiatry services in a timely manner.

Figure 5-18 illustrates average wait times for both offered and delivered first psychiatry appointments by region.

Figure 5-18: Initial Offered and Initial Delivered Psychiatry, Average Wait by MHP Region, Reported by MHPs in FY 2023-24



This year Southern MHPs showed the shortest wait times for both offered and delivered psychiatry services. The average wait times for appointments in the Bay Area and Superior regions were also both below the statewide mean.

Table 5-10, below, outlines MHP-level wait times for the first delivery of initial non-urgent psychiatry services (adults, youth, and foster youth) in business days. The MHPs' data are presented in the same categories that reflect their percentage performance for this metric in Table 5-9.

Table 5-10: Average Wait Times to First Delivered Non-Urgent Psychiatry Service, Reported by MHPs in FY 2023-24

MHP	Overall Wait Time	Adult Wait Time	Youth Wait Time	Foster Youth Wait Time
Met 80% overall with 15 business-day standards and results were validated				
Colusa	9.4	5.8	20.3	N/A
Contra Costa	19.9	19.7	21.4	63.5
El Dorado	10.5	11.0	6.3	5.0
Lake	7.6	7.6	8.1	0.0
Lassen	6.9	6.2	8.6	9.6
Madera	10.8	11.0	9.0	10.0
Mariposa	11.4	11.0	11.9	14.8
Mendocino	3.7	2.5	6.8	6.0
Napa	11.4	11.8	9.7	10.8
Nevada	11.2	10.2	13.2	N/A
Plumas	7.6	8.0	7.0	0.0
Riverside	15.0	6.0	18.0	23.0
San Benito	2.5	2.6	2.4	N/A
San Francisco	8.9	8.0	15.4	25.0

MHP	Overall Wait Time	Adult Wait Time	Youth Wait Time	Foster Youth Wait Time
80% met 15 business days for one or more age groups (not Overall) and results were validated – or – 80% Overall met a local standard that exceeded 15 business days and results were validated				
Kings	12.2	11.2	16.4	19.8
Modoc	13.4	14.3	10.6	9.0
Mono	10.5	9.8	14.7	6.0
San Diego	10.7	8.8	12.8	12.6
San Joaquin	26.4	28.3	23.5	30.5
Santa Cruz	13.0	8.6	19.0	12.6
Shasta	10.9	3.5	14.9	22.2
Siskiyou	11.4	12.0	9.0	15.0
Did not meet 80% for any age group – or – Results could not be validated or no data was submitted for validation				
Alameda	17.9	17.8	19.5	21.5
Alpine	5.0	5.0	N/A	N/A
Amador	14.1	13.3	16.2	5.0
Butte	17.8	16.8	19.8	15.8
Calaveras	12.6	12.6	13.0	N/A
Del Norte	30.6	32.0	28.0	23.0
Fresno	22.3	22.0	22.0	26.0
Glenn	18.5	15.6	24.4	9.0
Humboldt	15.0	14.0	16.0	12.0
Kern	12.0	12.2	11.7	8.8
Marin	16.9	16.1	26.1	13.5
Merced	39.9	42.6	33.4	32.8
Monterey	8.0	8.0	N/A	N/A
Orange	7.9	8.8	3.0	6.1
Placer-Sierra	10.0	8.7	8.2	7.7
Sacramento	30.2	28.9	39.7	23.2
San Bernardino	6.7	5.9	9.3	14.8
San Mateo	30.1	30.3	29.4	31.2
Santa Barbara	12.7	11.2	15.8	20.7
Santa Clara	26.3	27.2	23.9	12.5
Solano	17.7	30.7	17.0	9.0
Sonoma	23.5	25.6	21.6	28.7
Stanislaus	9.0	11.0	8.0	10.0
Sutter-Yuba	12.5	12.5	N/A	N/A
Tehama	72.0	74.0	40.0	N/A
Trinity	21.0	22.0	18.0	20.0
Tulare	22.2	25.0	16.1	11.2
Tuolumne	25.0	26.0	24.0	22.0
Ventura	6.9	6.9	25.1	16.1

MHP	Overall Wait Time	Adult Wait Time	Youth Wait Time	Foster Youth Wait Time
Yolo*	30.0	21.0	37.0	44.0
Not Reported				
Imperial	N/A			
Inyo	N/A			
Los Angeles	N/A			
San Luis Obispo	N/A			

* Indicates wait times reported in calendar days.

The overall average wait time for the first delivered psychiatry service was 16.1 business days statewide, which was, as referenced above, a 14.36 percent improvement over last year. Across the MHPs, the wait times ranged from 2.5 to 72.0 business days. For adults, the range extended from 2.5 to 74.0 business days and 2.4 to 40.0 business days for youth. Eight of the 52 MHPs that provided data for this metric did not supply information on the delivery of initial psychiatry services for foster youth. Of the 44 Plans that did track this measure, average wait times for foster youth ranged from no wait to 63.5 business days.

Four MHPs did not track or report on the delivery of first psychiatry services (Imperial, Inyo, Los Angeles, and San Luis Obispo), where Inyo also did not track the initial offered psychiatry appointment.

Urgent Services

Measuring timely access to urgent services continues to present challenges for many of the MHPs. From developing and revising the clinical and operational definitions of this activity to making certain that the requisite tools to capture, monitor, and evaluate this metric are in the context of hours, many MHPs are struggling to report findings with that level of precision. As a result, it is difficult to determine the extent to which improvements or changes in definitions and/or the system responsiveness to address members' needs for urgent services are yielding the desired 48-hour threshold.[23] (While DHCS allows for a 96-hour wait time for urgent services requiring a pre-authorization, the MHPs that tracked urgent services did not track that separately and used the 48-hour standard for measuring performance).

Plans reported urgent wait times in either hours or days. Therefore, CalEQRO converted findings reported in days as hours (multiplying total days by 24 hours) to facilitate comparative evaluation across Plans and the assessment of performance on the 48-hour model. Additionally, some Plans reported that they performed this calculation prior to submission. This introduces some inaccuracy compared to actual wait times members experienced (i.e., a wait time reported as 1 calendar day, depending upon actual times, may have been anywhere from a few hours to 24 hours, but was calculated as 24 hours).

For this metric, 31 MHPs had a rating of Met on Key Component 2C for urgent appointments, 17 received a Partially Met, and 8 were assigned a Not Met. Also, given that only four MHPs submitted information regarding timeliness to urgent services that require prior authorization, the focus below will be placed exclusively on the delivery of urgent services that do not require prior

[23] https://www.dhcs.ca.gov/Documents/BHIN-22-033-2022-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf

authorization. (Both can be submitted separately on the ATA.) The MHPs generally reported that they did not require prior authorization for any urgent services.

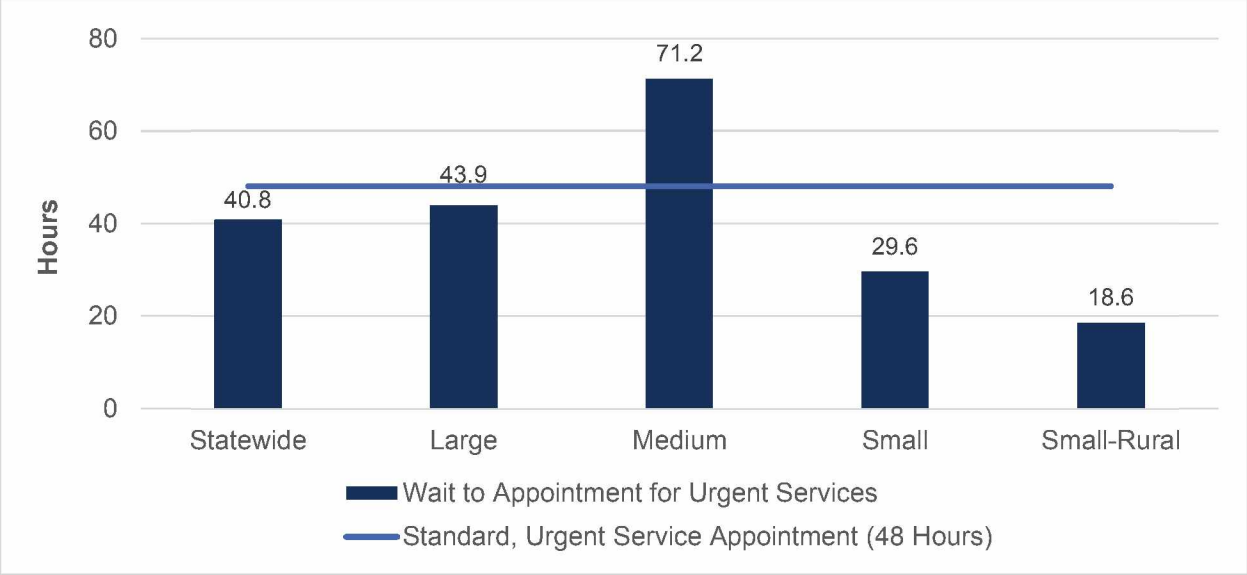
There were 50 MHPs (89 percent) that provided some data in connection with the delivery of urgent services that did not require prior authorization. Of this group, four Plans initially presented findings for this metric in days (which were converted by CalEQRO) due to the absence of mechanisms (e.g., timestamps) in their EHRs to promote the collection of this information in hours. Further, only 27 (54 percent) of the 50 reporting MHPs provided source-level data that were amenable to validation. The remaining six Plans (Del Norte, Inyo, Solano, Sutter-Yuba, Tehama, and Yolo) did not track this metric.

As a caveat, given that definitions of urgent conditions (e.g., a responsive phone call, an outpatient SMHS, or an admission to a crisis stabilization unit), and the associated services that get delivered to address them, vary greatly among MHPs, it is important to recognize that this information has limited utility for drawing conclusions regarding clinical performance or comparing wait time performances across Plans. Therefore, any interpretation should be made with an awareness of this dynamic.

According to information offered by the 50 reporting MHPs in the ATA form, 49 disclosed overall average wait times (Modoc did not report frequencies for this data element). Of this group, 47 Plans provided average wait times for adults, 44 included it for youth, and 34 submitted frequencies for foster youth as well. The overall mean wait time range extended from no wait (an immediate crisis response) to 335.0 hours, with a high of 183.4 hours for adults, 363.2 hours for youth, and 203.0 hours for foster youth. While 36 MHPs indicated that their overall average wait time interval occurred within the 48-hour threshold, 13 Plans reported longer average wait times for this metric.

Figure 5-19 below shows average wait times for urgent services as expressed by MHP size.

Figure 5-19: Urgent Services, Average Wait by MHP Size, Reported in FY 2023-24



With the exception of medium Plans at 3 business days (71.2 hours), the performance of all other MHP size groups had average wait times that were below the DHCS standard of 48 hours. Additionally, the statewide average was 7.2 hours shorter than the benchmark. The shortest

average time intervals between a request for urgent services and the offering of an appointment to address this need were seen in small-rural and small MHPs.

Compared to the prior year, the average wait times improved for large and small MHPs but increased in medium and small-rural MHPs. While small-rural Plans had a 36.76 percent increase in this measure from 13.6 hours to 18.6 hours, the change in the wait times for medium Plans was more than doubled from 30.4 to 71.2 hours, averaging essentially 3 full days.

Fluctuations in wait time outcomes across MHPs may be impacted by multiple factors ranging from the operational definitions regarding urgent conditions to the development of infrastructural tools in EHRs and precise methodologies for accuracy in the capture and tracking of data for this metric. Even where solid definitions and tools are in place, clinical staff may assess cases as either crisis or routine and neglect identifying those that fall in-between as urgent. Therefore, until this process stabilizes and evolves into a structured form that is more conducive to comparative analysis over time, any attempt to evaluate this measure – either between FYs or across MHP-group designations – should be approached with caution.

Table 5-11, below, shows MHP-level wait times relating to appointments for urgent services that met the DHCS standard for each population surveyed (adults, youth, and foster youth). The MHP results are alphabetized in the following categories:

- Average overall wait less than or equal to 24 hours with source data that supported validation of findings.
- Average overall wait greater than 24 hours with source data that supported validation of findings.
- MHPs did not supply source data or findings could not be validated.
- MHPs that did not track or report this metric.

Table 5-11: Average Wait Times for Urgent Services, Reported by MHPs in FY 2023-24

MHP	Overall Wait Time	Adult Wait Time	Youth Wait Time	Foster Youth Wait Time
Overall average ≤ 48 hours validated by source data				
Glenn	24.2	0.06	0.05	0.11
Mendocino	0.06	0.06	0.06	0.06
Lassen	32.4	0.17	0.18	0.13
Santa Cruz	1.0	0.51	0.89	0.14
Siskiyou	39.4	0.63	0.63	N/A
San Joaquin	38.2	0.80	0.90	0.50
Calaveras	12.0	1.0	1.1	0.72
Lake	96.0	1.0	1.1	0.97
Marin	0.06	1.9	2.0	1.4
Shasta	29.5	5.4	5.5	5.1
Plumas	42.2	5.5	0.25	N/A
San Francisco	1.0	6.8	13.0	3.4
El Dorado	0.17	12.0	14.4	0.0
Alameda	1.9	24.2	3.2	102.7

MHP	Overall Wait Time	Adult Wait Time	Youth Wait Time	Foster Youth Wait Time
Overall average >48 hours validated by source data				
Santa Barbara	26.4	26.4	9.6	184.8
Imperial	29.5	29.5	26.6	31.7
Mono	29.8	29.8	16.6	96.0
Butte	32.4	32.4	31.0	40.5
Contra Costa	38.2	38.2	30.2	57.1
Tulare	38.4	38.4	38.6	38.2
Colusa	39.4	39.4	45.0	24.8
Kern	42.2	42.2	48.4	35.0
Ventura	52.4	52.4	37.5	74.2
Fresno	96.0	96.0	3.0	4.0
Nevada	102.0	102.0	10.2	N/A
San Diego	137.8	137.8	127.7	227.7
Sonoma	335.0	335.0	183.4	363.2
Findings not validated by source data submitted or no source data submitted				
Alpine	114.0	114.0	N/A	N/A
Amador	0.02	N/A	N/A	N/A
Humboldt	18.0	0.0	19.0	16.0
Kings	89.5	38.8	136.7	40.0
Los Angeles	42.2	32.1	60.7	69.0
Madera	96.0	72.0	96.0	72.0
Mariposa	10.5	19.0	2.0	N/A
Merced	195.3	170.9	206.8	203.0
Monterey	153.5	166.5	120.0	N/A
Napa	2.1	2.5	0.90	0.40
Orange	33.6	24.0	45.6	24.0
Placer-Sierra	0.40	0.40	0.30	0.30
Riverside	91.0	153.0	70.0	0.0
Sacramento	0.70	0.70	0.50	3.0
San Benito	0.06	N/A	N/A	N/A
San Bernardino	5.8	3.6	36.8	0.0
San Luis Obispo	72.0	96.0	24.0	N/A
San Mateo	0.10	0.10	N/A	0.0
Santa Clara	0.40	0.39	0.42	0.30
Stanislaus	69.1	106.3	10.6	4.0
Trinity	4.0	4.0	1.0	3.0
Tuolumne	0.0	0.0	48.0	0.0
Not Reported				
Del Norte	N/A			
Inyo	N/A			
Modoc	N/A			
Solano	N/A			

MHP	Overall Wait Time	Adult Wait Time	Youth Wait Time	Foster Youth Wait Time
Sutter-Yuba	N/A			
Tehama	N/A			
Yolo	N/A			

Note: Numbers are listed to the hundredth when values are less than one.

As displayed in Table 5-11 above, there were 27 MHPs that provided source data that supported validation and supplied, at a minimum, overall average wait times for urgent-service appointments. Fourteen of the 27 showed wait times averaging 48 hours or less.

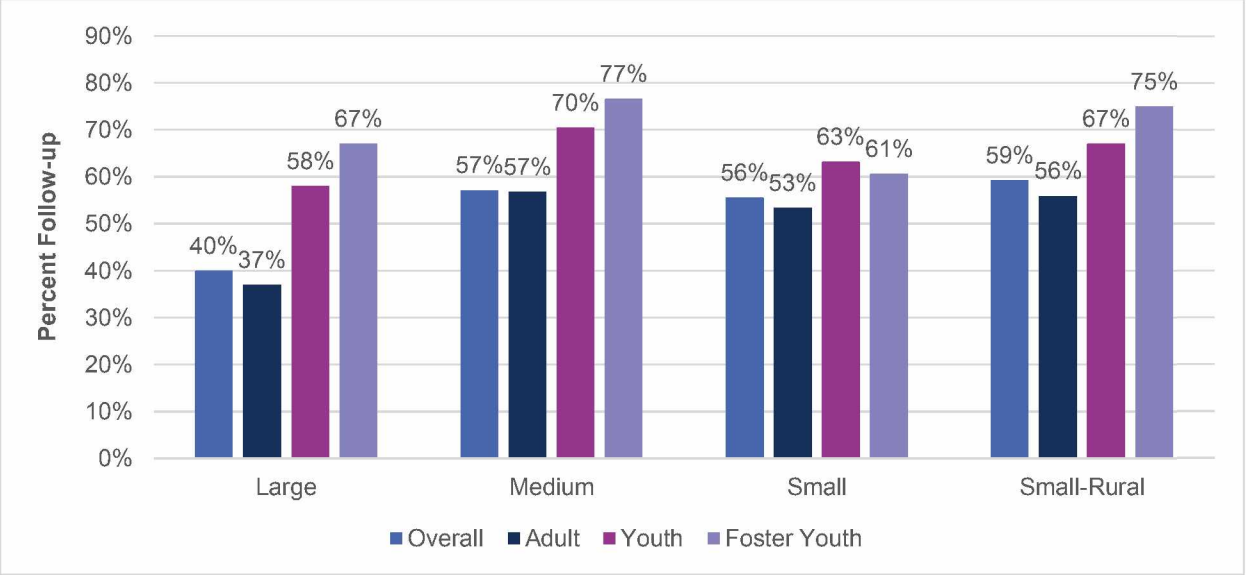
There were 22 Plans that generated wait time averages in their submitted ATA, but either did not provide source data or submitted macro-level, summary reports that were not amenable to validation. Of the remaining seven MHPs, one did not report any wait time averages (Modoc), and six did not track this metric (Del Norte, Inyo, Solano, Sutter-Yuba, Tehama, and Yolo).

Follow-up Post Psychiatric Inpatient Discharge

Provision of timely transitions from psychiatric hospitals to the appropriate level of outpatient care is essential in promoting continuity of care and treatment success, especially to maintain any gains made while hospitalized. The process of engaging members from highly structured, intensive settings (almost always involuntary) to engaging them in voluntary outpatient treatment in the community can be challenging. The Key Component (2D) ratings on MHP processes for follow-up after inpatient discharge that 80 percent (n=45) of MHPs were assigned a rating of Met, and 14 percent (n=8) received a Partially Met. Only 5 percent of MHPs (El Dorado, Inyo and Tulare) were given a Not Met rating in this area.

Figure 5-20 illustrates the average percentages of follow-ups delivered within 7 days overall and to different member groups by size group.

Figure 5-20: Follow-up within 7 Days by MHP Size, Reported by MHPs in FY 2023-24

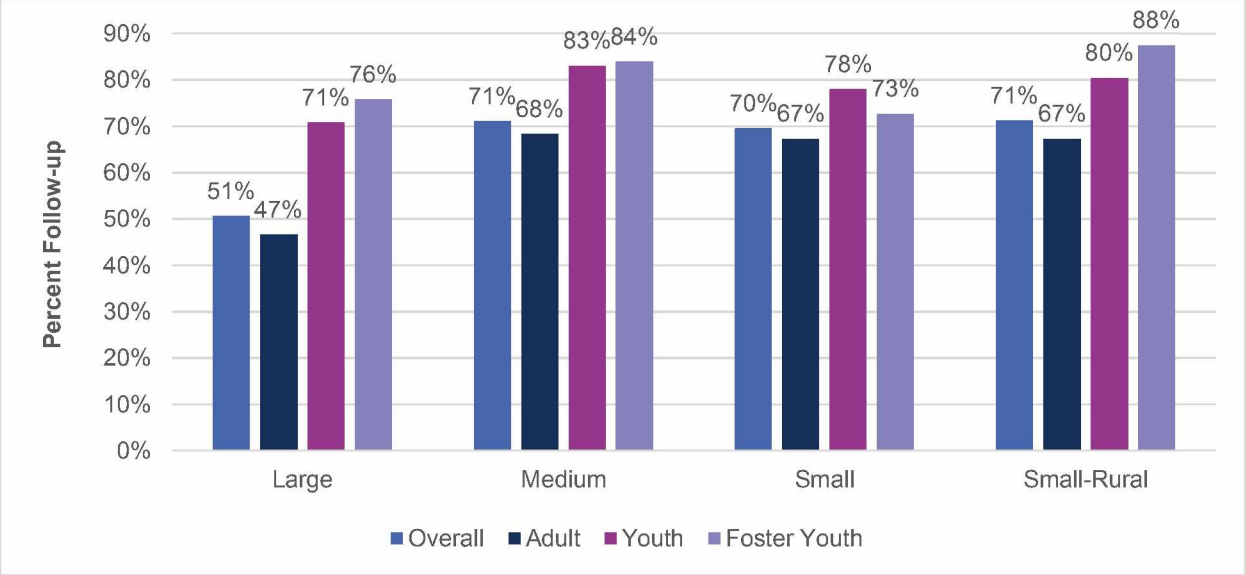


Upon discharge, MHPs reported a total of 42.63 percent that received a service within 7 days and 53.84 percent that received a service within 30 days. If follow-up services were delivered, then it was most likely within 7 days. All but one MHP reported this metric in the ATA, and statewide there was a reported total of 91,840 hospital discharges, of which 36.14 percent (n=33,188) occurred in Los Angeles MHP. MHPs tend to track and monitor closely hospitalizations, especially those not claimed to Medi-Cal (due to cost implications), the frequencies generated in this exercise are likely derived from data sets that are more comprehensive than those associated with SDMC approved claims (presented later in the Quality chapter of this report).

The follow-up rates for youth were higher than those related to adults. More specifically, 59.62 percent of youth discharges from inpatient hospital stays resulted in the delivery of an outpatient follow-up service within 7 days and 72.78 percent of these discharges received follow-up services within 30 days. In contrast, 39.49 percent of adult discharges had a service within 7 days and 49.96 percent of these events were within 30 days. The highest follow-up rates were observed in the foster youth population, wherein 67.91 percent and 76.52 percent of these discharges resulted in an outpatient service within 7 and 30 days, respectively. Some MHPs included the foster youth in the youth counts and some did not.

6-21 below presents the average percentages of follow-ups delivered within 30 days overall and to different member groups by size group.

Figure 5-21: Follow-up within 30 Days by MHP Size, Reported by MHPs in FY 2023-24



As illustrated above in Figures 5-20 and 5-21, small-rural and medium MHPs demonstrated the most robust performances in this metric. For example, while the highest follow-up rate at 7 days after discharge from an inpatient hospitalization was observed in small-rural MHPs (59 percent), small-rural and medium Plans were highest at the 30-day juncture (each at 71 percent). Further, the largest percentage of discharges for adult and youth members that resulted in a follow-up outpatient service being delivered within both the 7-day and 30-day periods was seen among medium-sized Plans. In addition, medium Plans collectively rendered the highest percentage of follow-up services (77 percent) to this demographic, whereas small-rural MHPs occupied this position (88 percent) at the point of 30 days post discharge.

Table 5-12 outlines the MHP-level percentages of inpatient discharges that had an outpatient follow-up service within 7 and 30 days. Outcomes are broken down by the populations surveyed (adults, youth, and foster youth). This information is then sorted into the following three categories:

- MHPs that connected 80 percent of their overall inpatient discharges to an outpatient service within 30 days (with validated data).
- MHPs that connected 80 percent of their inpatient discharges to an outpatient service within 30 days for one or more age groups (with validated data).
- MHPs that did not connect 80 percent of inpatient discharges to an outpatient service for any group or did not submit data for validation.
- MHPs that did not track this measure.

Table 5-12: Percentage with Post-Discharge Follow-up, Reported by MHPs in FY 2023-24

MHP	Overall		Adult		Youth		Foster Youth	
	7 Days	30 Days	7 Days	30 Days	7 days	30 Days	7 Days	30 Days
80 percent of discharges received follow-up within 30 days and results were validated								
Alpine	50%	100%	N/A	N/A	50%	100%	N/A	N/A
Butte	77%	80%	74%	78%	96%	96%	85%	85%
Calaveras	54%	91%	46%	86%	70%	98%	N/A	N/A
Imperial	78%	97%	76%	96%	87%	100%	N/A	N/A
Modoc	94%	100%	93%	100%	100%	100%	100%	100%
Mono	100%	100%	100%	100%	N/A	N/A	N/A	N/A
Plumas	82%	100%	83%	100%	82%	100%	N/A	N/A
San Joaquin	72%	84%	70%	82%	82%	94%	81%	100%
Shasta	61%	97%	55%	97%	81%	98%	83%	100%
Siskiyou	95%	100%	94%	100%	100%	100%	N/A	N/A
Yolo	62%	84%	62%	82%	58%	60%	25%	50%
80 percent of discharges for one or more age groups (not Overall) received follow-up within 30 days and results were validated								
Fresno	62%	79%	57%	70%	69%	83%	82%	91%
Lassen	64%	71%	64%	67%	67%	83%	0%	100%
Madera	72%	73%	68%	68%	81%	83%	100%	100%
Mariposa	62%	64%	46%	50%	100%	100%	100%	100%
Merced	55%	75%	54%	73%	59%	83%	57%	77%
San Francisco	42%	51%	38%	46%	82%	88%	73%	80%
Santa Barbara	60%	70%	55%	65%	82%	93%	90%	90%
Trinity	41%	47%	31%	31%	60%	80%	50%	100%
Tulare	64%	79%	62%	79%	75%	81%	N/A	N/A
Ventura	52%	68%	47%	64%	71%	87%	87%	97%
No age group achieved 80 percent follow-up within 30 days or results could not be validated								
Alameda	45%	56%	42%	52%	59%	72%	59%	64%
Amador	77%	85%	82%	85%	68%	84%	N/A	N/A

MHP	Overall		Adult		Youth		Foster Youth	
	7 Days	30 Days	7 Days	30 Days	7 days	30 Days	7 Days	30 Days
Colusa	79%	79%	79%	79%	78%	78%	N/A	N/A
Contra Costa	53%	64%	49%	61%	78%	85%	86%	86%
Del Norte	48%	55%	42%	49%	68%	72%	N/A	N/A
El Dorado	27%	37%	27%	37%	N/A	N/A	N/A	N/A
Glenn	61%	68%	60%	67%	67%	73%	50%	50%
Humboldt	52%	74%	49%	74%	68%	77%	36%	43%
Kern	62%	74%	60%	72%	70%	82%	75%	87%
Kings	85%	95%	83%	94%	92%	98%	100%	100%
Lake	69%	75%	66%	74%	79%	82%	N/A	N/A
Los Angeles	45%	54%	41%	50%	63%	76%	83%	90%
Marin	71%	77%	72%	77%	61%	77%	100%	100%
Mendocino	97%	100%	99%	100%	85%	100%	100%	100%
Monterey	63%	76%	58%	71%	90%	100%	50%	50%
Napa	56%	68%	57%	67%	52%	76%	N/A	N/A
Nevada	55%	68%	56%	68%	51%	68%	N/A	N/A
Orange	34%	47%	27%	40%	29%	74%	77%	83%
Placer-Sierra	60%	65%	62%	67%	50%	58%	100%	100%
Riverside	28%	41%	27%	40%	29%	45%	28%	40%
Sacramento	25%	36%	24%	34%	36%	49%	27%	34%
San Benito	43%	54%	48%	60%	36%	44%	N/A	N/A
San Bernardino	38%	47%	30%	38%	71%	82%	62%	70%
San Diego	36%	50%	35%	48%	43%	61%	48%	61%
San Luis Obispo	87%	96%	85%	96%	89%	94%	N/A	N/A
San Mateo	42%	55%	37%	43%	53%	76%	N/A	N/A
Santa Clara	33%	42%	27%	36%	52%	65%	66%	81%
Santa Cruz	46%	61%	47%	59%	45%	66%	50%	50%
Solano	17%	29%	13%	23%	48%	70%	61%	78%
Sonoma	42%	61%	35%	53%	58%	79%	83%	92%
Stanislaus	77%	94%	77%	93%	77%	98%	75%	90%
Sutter-Yuba	34%	59%	26%	50%	50%	75%	33%	100%
Tehama	33%	48%	36%	44%	28%	53%	N/A	N/A
Tuolumne	74%	83%	72%	81%	79%	90%	100%	100%
Not Reported								
Inyo	N/A							

As shown in Table 5-12 above, 11 MHPs not only were able to connect 80 percent of their overall inpatient discharges to an outpatient service within 30 days, but also submitted source data that validated their findings. There were ten MHPs that did not connect 80 percent of their overall discharges to a follow-up service within 30 days, but they did meet that level of performance for youth discharges and submitted raw data to support their reported counts. There were also 34 Plans that either were not able to transition at least 80 percent of these discharges to an outpatient service for any group within 30 days, or they did not provide source

material that could be validated. Lastly, one Plan (Inyo) did not track this metric. Although the MHPs continue to make palpable advances toward reducing the amount of time it takes to move members discharged from psychiatric hospitals to outpatient services, it appears that these transitions in care still present opportunities for improvement.

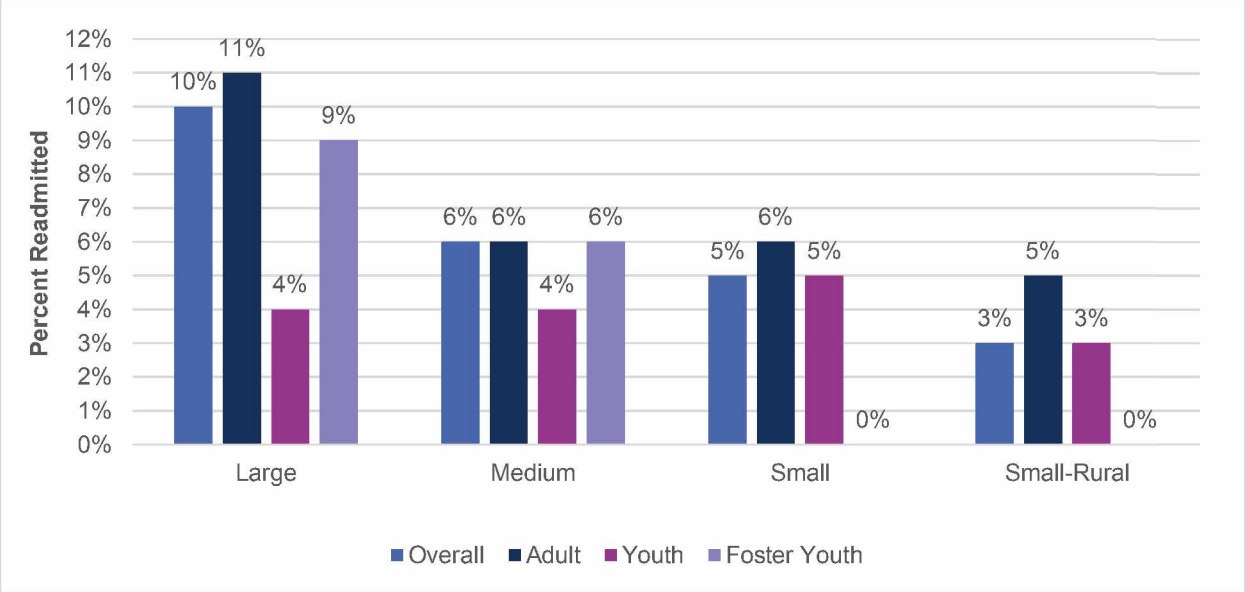
Psychiatric Inpatient Readmission Rates

Tracking admissions, discharges, and subsequent readmissions to psychiatric hospitals allows MHPs to better evaluate and coordinate LOC transitions within their systems of care. On a program-specific level, this type of monitoring can assist Plans in identifying members who may require more intensive outpatient care to avoid future hospitalizations. For FY 2023-24, all but one MHP (Mono) reported findings for psychiatric inpatient readmission rates – although not stated on Mono's submitted ATA, the report of N/A may have referenced a lack of readmissions.

On the Key Component for this measure (2E), 50 MHPs received a Met rating. Only five MHPs received a Partially Met rating (Alpine, Amador, San Luis Obispo, San Mateo, and Tehama), and only one MHP received a Not Met rating (El Dorado)

Figure 5-22 below illustrates inpatient readmissions within 7 days overall and to different member groups by MHP size.

Figure 5-22: Inpatient Readmission within 7 Days by MHP Size, Reported in FY 2023-24

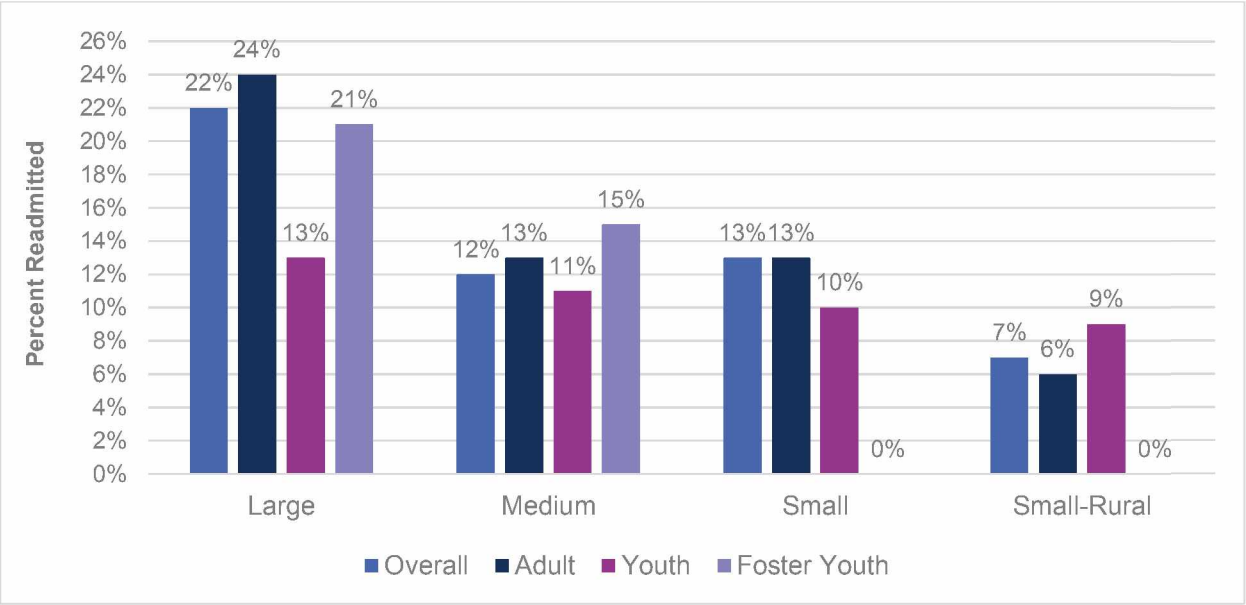


Overall, rates were fairly similar to the prior reporting year, indicating 9 percent within 7 days and 20 percent within 30 days; this was essentially unchanged from last year's 9 percent and 21 percent, respectively. The rates this year for youth, also 1 percentage point lower than what was reported in the prior review cycle, were reported at 4 percent for 7 days and 12 percent 30 days. Foster youth rates increased by 1 percentage point to 8 percent at 7 days and decreased by 1 percentage point to 20 percent at 30 days.

Large MHPs reported higher 7-day readmission rates at 10 percent overall. Rates were similar for Plans of all other sizes, with adults at 5 or 6 percent and youth at 3 to 5 percent.

Figure 5-23 below illustrates inpatient readmissions within 30 days overall and to different member groups by MHP size.

Figure 5-23: Inpatient Readmission within 30 Days by MHP Size, Reported in FY 2023-24



Readmission rates ranged from a low of 6 percent (small-rural MHP adults) to 24 percent (large MHP results). Overall rates ranged from 7 percent in small-rural MHPs to 22 percent in large MHPs. Medium and small MHPs' overall readmission rates were 12 percent and 13 percent, respectively. Large MHPs also showed the highest overall inpatient readmission rates within 30 days. Small-rural MHPs reported the lowest rate of readmissions within both time frames. These rates are favorable when comparing to the 2022 Substance Abuse Mental Health Services Administration's Uniform Reporting System that indicates a national rate for the 30-day period of 16.3 percent.

Table 5-13, below, shows MHP-level readmission rates for the 7-day and 30-day periods as reported by MHPs.

Table 5-13: Inpatient Readmission Rates, Reported by MHPs in FY 2023-24

MHP	7-Day Readmission Rate	30-Day Readmission Rate
Alameda	7%	17%
Alpine	0%	0%
Amador	6%	8%
Butte	2%	8%
Calaveras	4%	9%
Colusa	0%	3%
Contra Costa	3%	12%
Del Norte	1%	7%
El Dorado	5%	10%
Fresno	2%	9%
Glenn	5%	13%
Humboldt	5%	13%
Imperial	8%	16%
Inyo	0%	0%

MHP	7-Day Readmission Rate	30-Day Readmission Rate
Kern	5%	12%
Kings	4%	9%
Lake	2%	6%
Lassen	2%	4%
Los Angeles	14%	28%
Madera	14%	23%
Marin	6%	15%
Mariposa	3%	3%
Mendocino	4%	8%
Merced	5%	14%
Modoc	0%	0%
Mono	N/A	N/A
Monterey	13%	17%
Napa	4%	10%
Nevada	4%	12%
Orange	8%	20%
Placer	7%	14%
Plumas	7%	7%
Riverside	11%	21%
Sacramento	8%	20%
San Benito	6%	15%
San Bernardino	9%	21%
San Diego	9%	20%
San Francisco	6%	15%
San Joaquin	3%	10%
San Luis Obispo	N/A	7%
San Mateo	2%	6%
Santa Barbara	5%	14%
Santa Clara	5%	12%
Santa Cruz	4%	11%
Shasta	6%	15%
Siskiyou	0%	50%
Solano	3%	11%
Sonoma	4%	12%
Stanislaus	8%	10%
Sutter-Yuba	5%	12%
Tehama	2%	2%
Trinity	12%	12%
Tulare	5%	14%
Tuolumne	3%	13%
Ventura	8%	17%
Yolo	5%	16%

Alpine, **Inyo** and **Modoc** had no readmissions at either the 7- or 30-day points. Additionally, **Colusa** and **Siskiyou** reported no readmissions within 7 days. (All five of these MHPs have small numbers of members hospitalized annually.) Mono did not track this metric, and San Luis Obispo only collected this metric at 30 days, but not 7 days.

Within 7 days, the highest readmission rates were reported by Los Angeles and Madera, each at 14 percent. Monterey, Trinity, and Riverside also reported rates between 11 and 13 percent. Within 30 days, Siskiyou reported a readmission rate of 50 percent (this appears to be an error in reporting but the actual rate could not be discerned through the source data submitted). Removing Siskiyou, Los Angeles and Madera showed the highest rates within 30 days at 28 percent and 23 percent, respectively. Riverside and San Bernardino's rates were next highest at 21 percent for each.

No-Show Tracking

The tracking of no-show events by MHPs seemed to have little consistency in the various approaches used to address this metric. For this Key Component (2F) results showed 37 MHPs rating Met and 17 Partially Met. Only two MHPs received a Not Met rating (Imperial and Fresno).

There were 50 Plans in FY 2023-24 that reported on this measure and six MHPs that did not track this activity (Inyo, Los Angeles, Plumas, Sacramento, San Luis Obispo, and Solano). Further, one Plan captured and evaluated no-show data that related exclusively to psychiatrists (Napa) and another (Imperial) collected no-show information but had no set standard against which it could be measured. Further, in reviewing materials submitted by the 50 reporting MHPs to support their ATA findings, 30 Plans (60 percent) provided data that CalEQRO was able to validate and 20 Plans (40 percent) either did not offer any information – aside from macro-level, summary reports – or provided data sets that were missing elements critical to validation efforts.

The extent to which MHPs were attempting to collect and monitor no-show data, patterns, and trends varied. While 27 Plans (54 percent) performed this exercise for their entire service systems, 20 Plans (40 percent) placed an emphasis on county-operated services only, one (2 percent) focused exclusively on contractor-operated services, and two (4 percent) created hybrid strategies that only covered targeted areas of operation. Also, in terms of the time frames embraced by the reported frequencies, 45 MHPs derived their counts from 12-month periods (37 Plans used FY 2022-23, six extracted data from CYs 2022 or 2023, and two used another 12-month interval), while the remaining five used data sets that were between 6 and 11 months in length. The extent to which the data submitted is a complete data set is difficult to determine.

Table 5-14 below discloses MHP-level average no-show rates and associated standards for psychiatrists and non-psychiatry clinical staff. The results are separated into the following categories:

- MHPs that met Plan-defined standards for both psychiatrists and non-psychiatry clinical staff (with validated data).
- MHPs that met Plan-defined standards for either psychiatrists or non-psychiatry clinical staff but not both (with validated data).
- MHPs that did not meet Plan-defined standards for either staff category or did not submit data to validate the findings.
- MHPs that did not track or did not report this measure.

Table 5-14: Average No-Show Rates and Standards, Reported by MHPs in FY 2023-24

MHP	Psychiatrists: Average No-Show Rate	Psychiatrists: No-Show Standard	Non-Psychiatrists Clinical Staff: Average No-Show Rate	Non-Psychiatrists Clinical Staff: Standard
MHPs that met Plan-defined standards for both psychiatrists and non-psychiatry clinical staff, validated by source data				
Alameda	7%	15%	9%	15%
Fresno	8%	20%	15%	20%
Lake	19%	20%	17%	20%
Lassen	21%	30%	30%	30%
Orange	14%	15%	7%	10%
San Francisco	12%	Age-Based	6%	10%
San Mateo	1%	5%	2%	5%
Santa Clara	6%	10%	2%	10%
Sonoma	8%	10%	1%	10%
Trinity	18%	25%	14%	25%
Tulare	15%	20%	13%	20%
Met Plan-defined standards for either psychiatrists or non-psychiatry clinical staff (not both), validated by source data				
Amador	13%	15%	14%	10%
Butte	19%	15%	8%	15%
Calaveras	18%	10%	6%	10%
Colusa	12%	10%	9%	10%
El Dorado	13%	10%	3%	15%
Kern	24%	18%	11%	15%
Marin	13%	10%	3%	10%
Mariposa	23%	10%	10%	10%
Modoc	17%	10%	5%	10%
Mono	28%	25%	14%	25%
Sutter-Yuba	16%	15%	9%	10%
Yolo	14%	5%	2%	5%
Did not meet Plan-defined standards for either staff category or did not submit data for validation				
Alpine	11%	10%	0%	10%
Contra Costa	15%	10%	12%	10%
Del Norte	10%	15%	8%	15%
Glenn	19%	10%	13%	10%
Humboldt	7%	10%	2%	10%
Imperial	15%	N/A	15%	N/A
Kings	21%	25%	18%	25%
Madera	19%	10%	19%	10%
Mendocino	6%	10%	5%	10%
Merced	20%	10%	16%	10%

MHP	Psychiatrists: Average No-Show Rate	Psychiatrists: No-Show Standard	Non-Psychiatrists Clinical Staff: Average No-Show Rate	Non-Psychiatrists Clinical Staff: Standard
Monterey	16%	15%	9%	15%
Napa	27%	12%	N/A	N/A
Nevada	8%	10%	2%	10%
Placer-Sierra	16%	25%	4%	25%
Riverside	19%	10%	10%	5%
San Benito	9%	8%	12%	10%
San Bernardino	14%	25%	6%	15%
San Diego	18%	20%	8%	15%
San Joaquin	14%	15%	13%	15%
Santa Barbara	10%	10%	6%	10%
Santa Cruz	7%	5%	4%	5%
Shasta	15%	15%	13%	15%
Siskiyou	16%	10%	11%	10%
Stanislaus	9%	20%	8%	20%
Tehama	19%	10%	20%	10%
Tuolumne	18%	15%	16%	20%
Ventura	16%	10%	12%	5%
Not Reported				
Inyo	N/A			
Los Angeles	N/A			
Plumas	N/A			
Sacramento	N/A			
San Luis Obispo	N/A			
Solano	N/A			

Eleven MHPs (22 percent) satisfied Plan-defined standards for both psychiatrists and non-psychiatry clinical staff, and CalEQRO was able to validate these findings based upon the MHPs' source data. Average no-show percentages for this group ranged from 1 percent to 21 percent for psychiatrists and from 1 percent to 30 percent for non-psychiatry clinical staff.

There were 12 Plans (24 percent) that met the standard for psychiatry or non-psychiatry staff, but not for both, and provided raw data that were validated.

In addition, 27 Plans (54 percent) either did not provide data for validation, lacked any defined standard (Imperial), or did not meet Plan-defined standards for either staff type. Finally, as referenced above, there were six MHPs that did not track this metric, and Napa did not track this metric for non-psychiatric clinical staff. Imperial did not set a no-show standard but tracked the no-show events. San Francisco has separate standards for adults and youth within each provider category.

Effective no-show tracking is a critical process. It not only serves to enable the MHP to implement interventions to minimize the probability of these events, but it also promotes more successful treatment engagement and outcomes among members. It also represents service capacity that could be redirected and made available to other members in need. Based on

interactions with county and contracted staff during review sessions, there are clearly many MHPs that struggle to model tools into their EHRs to collect this information in a systematic and universal fashion. MHPs need to endorse the creation of more data-driven environments wherein functional quality feedback loops are established in ways that support the monitoring of this information at regular intervals, enabling its use to inform positive change within the system of care. Given that more than half of the reporting Plans (54 percent) did not meet their own standards for psychiatrists and non-psychiatry clinical staff – coupled with the reality that some of the no-show data collected by these Plans was not representative of the entire service system and, therefore, may have had limited utility – this metric constitutes an area that warrants further attention and improvement.

SUMMARY OF TIMELINESS FINDINGS

Timeliness metrics are employed to evaluate the extent to which members are able to receive access to care in reasonable times frame that conform to established standards. From a macro perspective, these metrics help assure that systems of care are equipped with the appropriate LOCs, clinical and administrative staffing, and functional infrastructure to promote the objective of getting members into services in a timely manner. Whether services are delivered in a timely fashion can severely impact member engagement in treatment. Delays or impediments to the expedient time between the point of their initial requests for help and their corresponding entry into care can create outcomes that are not only poor but also potentially detrimental.

Table 5-15 below presents average wait times for various timeliness measures, as well as the percentage of appointments that met the timeliness standards.

Table 5-15: Summary of Overall Average Wait Times per MHP Report in FY 2023-24

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	7.4 Business Days	10 business days*	80%
First Non-Urgent Service Rendered	10.4 Business Days	**	74%
First Non-Urgent Psychiatry Appointment Offered	11.3 Business Days	15 Business Days*	76%
First Non-Urgent Psychiatry Service Rendered	16.1 Business Days	**	68%
Urgent Services Offered	41.8 Hours	48 Hours***	81%
Follow-up Appointments after Psychiatric Hospitalization – 7 Days	9.6 Calendar Days	7 Calendar Days	43%
Follow-up Appointments after Psychiatric Hospitalization – 30 Days	9.6 Calendar Days	30 Calendar Days	54%

* DHCS-defined timeliness standards per BHIN 22-033[24]

** MHP-defined timeliness standards varied

*** DHCS standard is 48 hours if no pre-authorization is required and 96 hours for urgent services requiring pre-authorization. No MHPs tracked this separately.

[24] https://www.dhcs.ca.gov/Documents/BHIN-22-033-2022-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf

As illustrated above in Table 5-15, the overall initial wait time for the first offered non-urgent appointment was less than 2 weeks, at 7.4 business days, slightly shorter than 7.6 the prior year. Statewide the initial non-urgent psychiatry averaged 11.3 business days and 76 percent of appointments met the 15 business-day standard. DHCS also monitors Plans for their offered non-urgent initial appointment and non-urgent psychiatry appointment. As indicated earlier, results displayed in this report may differ from DHCS findings based upon different time frames that are collected in DHCS's TADT.

With respect to the rendering of non-urgent services, Plans were able to effectuate their delivery within an average of 10.4 business days, yielding a 13.33 percent improvement over the prior year reported. Psychiatry services rendered showed a reported average of 16.1 business days, with 68 percent meeting local standards, an improvement over the prior year's 64 percent.

Overall, performance on timeliness is shaped and influenced by the lack of complete and consistent reporting by all MHPs. Additionally, the absence of the requisite number of data analytic staff and existence of EHR tools to support the processes relating to the collection, evaluation, and reporting of timeliness data can adversely impact timeliness performance. Improvements shown in timeliness may be ascribed to a combination of having adequate data analytic support, effective tracking mechanisms, and/or appropriate quality feedback loops that promote the review of this information at regular intervals to encourage informed decisions, all of which translate into enhanced performance. Considering that some Plans did not report on all measures – especially for the first offered and first delivered psychiatry services, offered urgent appointments, and no-show tracking – attempts to obtain a macro-level, statewide perspective on timeliness by inferring from MHP-level performance should be undertaken with a clear understanding of the limitations inherent in the information provided. Some MHPs cite that interoperability concerns pertaining to contractors not being able to transmit member and service data to them at timely and regular intervals was an obstacle that militated against their ability to secure complete and accurate data sets. Despite these challenges, however, the majority of Plans are meeting timeliness standards for new members entering into care.

INTRODUCTION

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

QUALITY IN MHP SYSTEMS STATEWIDE

Quality is naturally the cornerstone of the EQR process, representing the ability of the MHPs to conduct oversight for the system using data and best practices to promote optimal outcomes. While MHPs acknowledge that QM and improvement are priorities, delivering on this stated priority is more of a challenge. At a time when the workforce is often smaller and strained, MHPs have found it difficult to assign staff to quality issues when staff are needed for service delivery. Further, QM staff have been pulled from ongoing quality and compliance efforts to support reforms under CalAIM and other initiatives. For many MHPs, thin staffing and payment reform impacted the ability to provide consistent support and guidance to their contract providers who also needed to navigate the reforms. With increasing needs for reporting capacity and implementation of new EHRs, many MHPs have also been challenged to expand the IS/analytic supportive structures for QM. Continued staffing turnover, challenges in the hiring of new staff, ongoing environmental disasters and pandemic recovery, and the related limitations of other county departments, such as human resources, intensified the difficulties faced by MHPs to update operations, expand the continuums, and integrate care in FY 2023-24.

QUALITY KEY COMPONENTS

CalEQRO identifies components of healthcare quality in SMHS that are essential to achieve the underlying purpose of the service delivery system – improved outcomes for members. These 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. Measured as ten Quality Key Components, comprising individual subcomponents, are collectively evaluated during the review to determine an overall Key Component rating for each item – Met, Partially Met, or Not Met.

A summary of the overall statewide performance is depicted in Table 6-1 below.

Table 6-1: Quality Key Components – Statewide, FY 2023-24

KC #	Key Component – Quality	Met	Partially Met	Not Met
3A	QAPI are Organizational Priorities	48	6	2
3B	Data are Used to Inform Management and Guide Decisions	45	9	2
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	33	22	1
3D	Evidence of a Systematic Clinical Continuum of Care	19	32	5
3E	Medication Monitoring	32	15	9
3F	Psychotropic Medication Monitoring for Youth	29	6	21
3G	Measures Clinical and/or Functional Outcomes of Members Served	17	24	15
3H	Utilizes Information from Member Satisfaction Surveys	26	22	8
3I	Consumer Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	32	19	5
3J	Consumer and Family Member Employment in Key Roles throughout the System	23	27	6

In all except one quality Key Component, Consumer and Family Member Employment in Key Roles, more MHPs were rated as Met when compared to FY 2022-23. Accordingly, fewer MHPs were rated as Partially Met in all categories except for that item. There were only small changes in the numbers who were found Not Met in each. Further, the first component, QAPI are Organizational Priorities, had the greatest number of MHPs rated as Met again this year, with an increase from 70 percent to 86 percent of MHPs across the state. Also, again this year, the component Psychotropic Medication Monitoring for Youth was the item most frequently rated as Not Met; however, the percentage of MHPs with a Not Met rating improved from 41 to 38 percent. Of the MHPs found to be Not Met on this item, most were MHPs sized at small (n=8) or small-rural (n=9).

Across the last three years, three MHPs rated Met on all ten Quality components in FY 2021-22 (**Sonoma**, **Alameda**, **Mendocino**), only one MHP (**Merced**) did so in FY 2022-23, and none did this year. Of those, four met nine of the ten components (**Butte, Mendocino, Merced, Stanislaus**), and they were all Partially Met on Consumer and Family Member Employment in Key Roles. This year, the 74 instances of Not Met ratings across the ten Quality items; 31 MHPs had at least one Not Met rating.

Almost all Plans (98 percent) had at least one activity associated with Quality cited as a strength in their EQRO report. At the same time, 98 percent had at least one QI activity cited as an opportunity for improvement. This is indicative of the continuous nature of QI; the MHPs have many strengths as it relates to their quality practices yet there is constant room for improvement.

Table 6-2 shows the rating for each Key Component by Plan.*

Table 6-2: Quality Key Components by Plan, FY 2023-24

MHP	3A	3B	3C	3D	3E	3F	3G	3H	3I	3J
Alameda	M	M	M	M	M	M	PM	M	M	M
Alpine	NM	PM	M	PM	NM	NM	NM	NM	NM	NM
Amador	M	M	PM	M	M	PM	PM	PM	M	PM
Butte	M	M	M	M	M	M	M	M	M	PM
Calaveras	M	M	PM	NM	PM	NM	NM	NM	M	PM
Colusa	M	M	M	PM	NM	NM	PM	NM	PM	NM
Contra Costa	M	M	PM	PM	PM	M	M	M	M	PM
El Dorado	M	PM	PM	PM	NM	NM	NM	PM	NM	NM
Fresno	M	M	PM	M	M	M	NM	M	NM	NM
Del Norte	PM	M	M	NM	M	NM	M	PM	NM	PM
Glenn	M	M	PM	PM	M	NM	PM	NM	PM	M
Humboldt	M	M	M	PM	NM	NM	NM	M	M	PM
Imperial	M	PM	M	PM	M	M	NM	PM	PM	PM
Inyo	NM	NM	M	NM	NM	NM	NM	NM	PM	PM
Kern	M	M	PM	M	PM	NM	M	M	M	PM
Kings	M	M	M	PM	M	M	M	PM	PM	PM
Lake	PM	M	M	PM	M	NM	NM	PM	M	M
Lassen	M	M	M	M	M	PM	PM	M	M	M
Los Angeles	M	M	M	M	PM	M	M	M	M	M
Madera	M	PM	PM	PM	M	NM	PM	PM	M	PM
Marin	M	M	M	M	PM	PM	NM	M	M	M
Mariposa	M	M	PM	PM	NM	NM	PM	PM	PM	PM
Mendocino	M	M	M	M	M	M	M	M	M	PM
Merced	M	M	M	M	M	M	M	M	M	PM
Modoc	M	M	M	PM	PM	M	NM	PM	M	PM
Mono	M	M	M	PM	M	M	PM	M	PM	M
Monterey	M	NM	PM	PM	PM	M	NM	PM	M	M
Napa	M	M	PM	PM	NM	NM	PM	PM	M	PM
Nevada	M	M	M	PM	M	M	NM	M	M	M
Orange	M	M	PM	PM	PM	NM	PM	M	PM	M
Placer - Sierra	M	M	PM	M	M	M	PM	PM	M	M
Plumas	M	M	M	PM	NM	NM	PM	M	NM	NM
Riverside	PM	M	M	PM	PM	PM	M	PM	M	M
Sacramento	M	M	M	PM	PM	PM	M	M	M	PM
San Benito	PM	PM	PM	PM	M	M	PM	NM	PM	NM
San Bernardino	M	M	M	M	M	M	M	PM	M	M
San Diego	M	M	PM	M	M	M	M	PM	M	M
San Francisco	M	M	PM	PM	M	M	PM	PM	PM	M
San Joaquin	M	M	M	PM	M	M	PM	M	M	M
San Luis Obispo	M	PM	PM	PM	PM	M	PM	M	M	PM
San Mateo	M	M	M	PM	M	M	PM	NM	M	M
Santa Barbara	M	M	PM	M	M	NM	PM	PM	PM	M
Santa Clara	M	M	NM	NM	M	M	PM	PM	PM	PM

MHP	3A	3B	3C	3D	3E	3F	3G	3H	3I	3J
Santa Cruz	M	M	M	PM	M	NM	M	PM	PM	M
Shasta	M	M	M	PM	M	M	PM	M	M	M
Siskiyou	M	M	M	PM	M	M	NM	NM	PM	PM
Solano	M	M	M	PM	M	PM	PM	M	PM	PM
Sonoma	PM	M	M	M	M	M	M	M	M	M
Stanislaus	M	M	M	M	M	M	M	M	M	PM
Sutter - Yuba	M	PM	PM	PM	PM	NM	PM	PM	PM	PM
Tehama	M	PM	PM	PM	PM	NM	NM	PM	PM	PM
Trinity	PM	PM	PM	NM	NM	NM	NM	PM	PM	PM
Tulare	M	M	M	PM	M	M	PM	M	PM	M
Tuolumne	M	M	M	M	PM	NM	M	M	M	PM
Ventura	M	M	PM	M	M	M	M	M	M	M
Yolo	M	M	M	M	PM	M	PM	M	M	PM

*Note: M = Met, PM = Partially Met, NM = Not Met

Quality as an Organizational Priority

The degree to which a continuous QI philosophy, framework, and related activities permeate an organization's management and practices defines and impacts an MHP's overall QI performance.

Quality as an organizational priority is best demonstrated through an ongoing comprehensive QAPI program; a current QAPI Work Plan that establishes baselines and time-bound goals for tracking of measurable progress to goals and organizational strategic initiatives; an annual evaluation of the effectiveness of QAPI activities; a functional QIC that allows the goals of the QAPI Work Plan to be accomplished; an organizational structure in which executive management is accountable for the QAPI function and a direct line of communication exists between QAPI staff and administrative leaders; and a QAPI team that interfaces with other MHP divisions/units/departments to achieve quality related goals throughout service delivery. These characteristics are described in this Key Component's six subcomponents, where a Met rating requires satisfying five or six items and a Partially Met rating requires three or four items.

A functional QIC has the following characteristics:

- Meets on a consistent basis as scheduled.
- Includes participation by necessary subject matter experts (stakeholders), including executive leadership, program staff inclusive of contract providers, and service recipients.
- The QAPI Work Plan is routinely reviewed and data informing members of progress toward goals are shared. When progress is not occurring, discussion regarding possible causes informs course correction toward improvement.
- Meeting minutes reflect input from subject matter experts for prioritizing goals and activities.
- Executive management sponsorship and participation can be called upon to remove systemic barriers to success.

- In the case of MHP/DMC-ODS integrated QICs, both BHPs are appropriately represented and supported.

One barrier that many MHPs had to address this year in order to expand the use of national quality measures and redesign existing quality reporting tools after the implementation of new EHRs was the necessary IS/analytic staff to allow consistent tracking, reporting, and aggregate analysis. Most Plans that reported a new EHR also had significant disruption to ongoing QIC processes, compounded by the demands of CalAIM's payment reform. Those MHPs with leadership who endorsed and empowered updated quality tracking and the analytical support it requires seemed to do better on all quality Key Components. For example, **Merced,** which has rated highly on quality Key Components across the last three reporting years, notably has a comprehensive QAPI that tracks and trends key metrics, including HEDIS measures, and reported surpassing the overall compliance rate goal.

Several MHPs were noted as having strong QM teams that delivered action for quality initiatives. **Santa Cruz** exhibited a widely inclusive quality feedback system where members reported being invited to QIC and line staff reported regular education about recent Behavioral Health Information Notices (BHIN). Further, despite staff shortages and the work toward payment reform, it participated in the Authorization to Share Confidential Medi-Cal Information pilot, linking multiple agencies for member care coordination across county departments. This served as a powerful and effective tool during outreach and engagement efforts. **Tulare** has been successful in using the PIP process to structure its mental health outreach and crisis response systems. **Kern** was noted for its unique QI structure which ensures data-driven decision making, prompt identification of needs for performance improvement, and participation by various stakeholders including the Plan members and the line staff.

Data-Informed Decision Making

A key element of QI is the collection and analysis of reliable and valid data, the ability to interpret quantitative data and provide systems with qualitative insights, and the identification of critical trends and meaningful information. Collectively, these activities help determine areas for improvement to member outcomes. This item contains four subcomponents; a Met rating requires demonstration of all four elements while Partially Met requires three elements.

MHPs of all sizes rated Met and Partially Met in this area, and only two, one medium and one small-rural, MHPs rated as Not Met. An increasing number of MHPs were rated as Met for this item this year with an almost 18 percent jump, representing the MHPs growth in this area. Data analytics was cited as a strength 16 times in 16 MHPs and cited as an opportunity 27 times in 20 MHPs. This is double the ten MHPs that received an opportunity and recommendation in this area last year, reflective of the EHR implementation progress at the time.

As mentioned earlier in this chapter, data analytics is increasingly leveraged in MHPs to meet modern quality metrics. For example, **Lassen**, which rated as Met for eight out of the ten quality Key Components, has notably surpassed the maximum number of data dashboards in its new EHR contract and has contracted for additional dashboards to be created and continues to grow analytic staff positions each year. **Alameda** has a strong validation protocol to ensure data demands are met accurately and with integrity. **Stanislaus** has placed an emphasis on becoming a data-driven agency, and to achieve this, it created a new Outcome, Evaluation, and Management unit to address internal data analytic needs. Additionally, this MHP has expanded its contract with Kings View to promote the development of more interactive dashboards.

MHP Communication and Stakeholder Involvement

Another critical element to quality, as also reflected in the CQS, is a consistent and formal process whereby stakeholders receive regular communication about and can provide input into system planning and the delivery of services. This Key Component looks at the extent of successful inclusion and participation by members and their families, contract providers, line staff and supervisors, and community partners or other stakeholders. This component has six subcomponents and requires five or six to be Met and three or four to be Partially Met.

While many MHPs utilize a variety of communication strategies, key informants frequently indicated communication was top-down and there were insufficient opportunities to provide feedback or participate in a bidirectional communication process. More specific to this year's stakeholder interviews, there was frequently a need to repair relationships with contract providers after multiple, rapid and significant changes (e.g., new EHRs, new access tracking tools, increased contract monitoring and oversight, payment reform and requisite contract negotiations). Communication was the focus of a recommendation for improvement nine times, four of which were carried over from the previous review year; all those intended to address opportunities to improve communication with contract providers were new for this year.

When communication was mentioned as a strength, it was rare, in just four MHPs across the state; most were small or small-rural and none were large. Furthermore, half had to do with the ability to maintain communication while navigating staffing shortages. Smaller MHPs were more likely to report communication, both with internal stakeholders and external community partners, as being more direct, naturally due to being a smaller entity. Larger MHPs tended to have more formalized structures for internal communication, but the outcome was not viewed as positively as in smaller MHPs. As it was last year, communication was cited as an opportunity twice as often as it was identified as a strength.

When looking at the Key Components, a positive shift can be seen. Like the jump in ratings for being data-driven, the MHPs made significant strides in this area with six more found as Met compared to last year, a 22 percent increase. Like last year, just one MHP ranked as Not Met, but was large-sized this year rather than small-rural.

Yolo stakeholders noted improved transparency and bidirectional communication with leadership that invites them to the table for planning of programs and services. For example, current crisis staff were invited to participate in the development of the new mobile crisis benefit program. **Del Norte** overcame staffing challenges and navigated the roll out of a new EHR while the remaining staff remained active and dedicated, reporting a positive work culture that includes bidirectional communication and a "whatever it takes" approach to serving members.

Continuum of Care and LOC Assignment

Critical to ensuring members receive clinically appropriate care is the degree to which an MHP offers a comprehensive range of services, from least- to most-restrictive, and utilizes LOC tools to measure, monitor, and guide treatment. Across the state MHPs are using grants and collaborative efforts to not only fill gaps but expand the continuums of care through the addition of needed programs. This includes ease for members to enter the most appropriate LOC, then step-up or step-down with an efficient flow between LOCs.

This component has seven subcomponents and requires the satisfying of six or seven to be rated Met and three to five to be rated as Partially Met. This category references having a range of treatment options; using a LOC tool to measure and monitor treatment for adults and for

youth; monitoring fidelity to best practice or evidence-based practices; tracking and trending transitions in care on an aggregate basis; implementing strategies to facilitate LOC transitions; evaluating performance data and implementing QI activities where warranted.

The distribution of ratings has been comparable across the last 3 years, with the majority this year receiving a Partially Met rating on this item (57 percent). Of the five MHPs that rated Not Met, four were small-rural. Smaller counties are less likely to have the funding and staff to strengthen gaps in the systems of care and are more likely to be left with few options other than a heavy reliance upon contracted telehealth providers for clinical staffing. Further, they are less likely to have the funding or analytic capacity to implement LOC tools; some felt that data was less useful for their small member populations with a history of making individualized clinical decisions regarding which services are appropriate. Most MHPs (32 this year and 37 last year) rated Partially Met on this item due to a lack of LOC tools and aggregate systemic review of whether members are served at the appropriate LOC. Small and small-rural comprised 63 percent of the MHPs that received a Partially Met.

Some MHPs have historically used their outcome measures to crosswalk to a LOC tool or generally inform clinicians about the appropriate LOC, but increasingly the larger systems have dedicated and separate LOC tools. For example, **San Francisco** developed, tested, and validated its own LOC tool. **Ventura** provides findings reports for LOC that are aggregate and systemwide.

Other MHPs do well to manage the flow between LOCs, including step-down from SMHS. Mentioned in last year's report, **Solano's** transition team has had continued success and expansion. This team reviews readiness for step-down based upon outcome scores, and clinical staff ensure seamless transition to MCP-level services, with follow-up as needed. Further, their adoption of the Netsmart Reaching Recovery tools provided a LOC tool. Resultant data are reported on a dashboard, aggregated data are compiled, and a summary of the system is generated. The data are then disaggregated by program where staff can view the dispersion of Recovery Needs Level scores within their programs and compare that to target levels based on acuity.

Medication Monitoring

Medication monitoring is conducted to assess whether psychiatric practices follow standard practices of care and include collaboration with primary care providers as well as collaboration and communication with other non-prescribing providers serving the members. For this component to be fully Met, MHPs must establish related policies and procedures and use aggregate findings for performance improvement. This may include comparing findings across programs or psychiatric providers. Because many psychotropic medications can have side effects impacting physical health and ultimately mortality, a comprehensive approach to medication monitoring is necessary to assure that both mental health and physical health outcomes are considered as part of psychiatric practice.

This component contains seven items, where satisfying six to seven rates Met, and three to five rates Partially Met:

- Tracks and trends HEDIS and other quality measures related to diagnoses, medication practices, and care standards
- Tracks and trends prescribing practices for county and contract providers.

- Coordinates medication management in collaboration with primary care (one item for adults and one for youth).
- Demonstrates routine communication between prescribers and clinicians.
- Uses findings from medication monitoring for performance improvement.
- Establishes policies, procedures, and programmatic changes to ensure appropriate medication management.

This component was rated Met in 57 percent (n=32) MHPs, with an increasing trend across the last 3 years from 17 in FY 2021-22 and 22 in FY 2022-23. Three small and six small-rural MHPs rated Not Met. The lack of strength in this area is often attributed to turnover in psychiatric leadership as well as psychiatric providers – both in terms of service delivery and for medication monitoring. As this area is outside of the scope of practice for staff generally assigned QI functions, it may not get addressed because psychiatric provider time is focused on providing direct patient care. Those MHPs with a strong medication monitoring process this year generally had less turnover and vacancies in their psychiatric staff and medical directors.

While medication monitoring was not cited as a strength last year in any MHP, it was cited in three this year. **San Joaquin** has a robust medication monitoring program that includes a monthly discussion at the Pharmacy and Therapeutics Committee. Further, it monitors data regarding medications and labs, and as a result, improved the lab ordering process for youth. **San Diego** created a new medication monitoring committee for both adult and youth prescribing.

Medication Monitoring for Youth

CalEQRO reviews whether MHPs conduct medication monitoring consistent with the child welfare psychotropic medication measures outlined in WIC Code 14717.5 and seeks to validate any aggregate report findings and improvement activities that resulted from the findings. Specifically, CalEQRO evaluates whether the MHP performs the following six activities, where meeting five to six rates as Met and three to four rates as Partially Met:

- Tracks and trends follow-up care for children prescribed attention deficit hyperactivity disorder medications (HEDIS ADD)
- Tracks and trends the use of multiple concurrent antipsychotics in children and adolescents (HEDIS APC)
- Tracks and trends metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)
- Tracks and trends the use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)
- Tabulates and reports findings to management bodies for decision-making
- Initiates performance improvement activities when indicated

This is a relatively new Key Component and state requirement; it is the quality component with the greatest number of Plans rated as Not Met again this year. However, the number of MHPs that are not doing this activity at all decreased across the last 3 years from 27 in FY 2021-22 to 23 in FY 2022-23 to 21 this year. At the same time, the number that Met this item trended up to 29 MHPs for this year.

Many MHPs that elected to change EHRs seemed optimistic that their new system will be able to supply or support the tools necessary to meet these quality monitoring standards, not just for tracking, but the ability to easily review the aggregate information and draw conclusions regarding care and any improvements needed. Of note, **Yolo** successfully initiated their EHR's Business Intelligence analytic solution to support the monitoring and analysis of HEDIS measures.

Outcomes Measurement

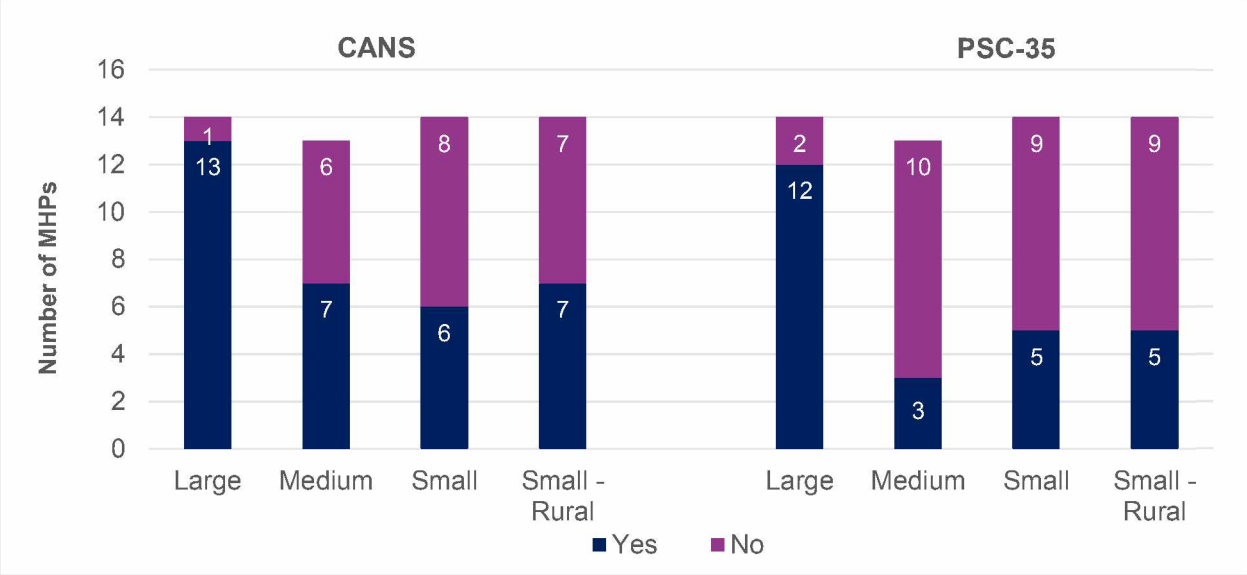
This component seeks to measure the extent to which the MHP tracks and analyzes data related to system wide member outcomes. The subcomponents look at whether the MHP has a standardized outcome tool for adults and for youth populations, that the results are tracked and trended in reports for both populations, and that these data are used to improve or adapt services at the system level. It requires satisfying all five subcomponents to achieve Met and three to four to achieve Partially Met.

The majority of MHPs were Partially Met on this practice (n=24), with limited contrast between the size of the MHP across the ratings. Further, there is not much variation between the last 3 review years. Most often MHPs were uniformly utilizing the CANS as an outcome tool for youth, but they were less likely to be aggregating the data for analysis at a program or systemwide level. The use of CANS results on an individualized member level, comparing results to a prior administration, was variable by the clinical staff involved. Most inconsistent was the adoption of an adult outcome tool; usually various tools were used across the MHPs' clinics, depending on the populations they served, and most frequently for members served in FSP. What is then tracked is the completion rate or the number of the tool submissions due/missing, rather than the outcomes as reported or analyzed from the data provided.

Line staff interviews frequently conveyed that, while these practices are in place, making them meaningful both systematically and in direct care is more difficult. Some MHPs, however, were able to bridge this sense of utility, broadly using the results to inform the system while also making them functional in treatment. Noted last year and continued strong into this review year, **Fresno** uses software which leverages artificial intelligence to provide detailed reports and visualization of data, enabling the MHP to use data to drive services and outcomes. **Solano** continued to expand the use of Netsmart's Reaching Recovery tools with the roll-out of the two outcome measures – one completed by the member, and one completed by the clinician.

Figure 6-1 displays the MHPs' report of whether they tracked and trended the data from the CANS and Pediatric Symptoms Checklist – 35 items (PSC-35).

Figure 6-1: Tracking and Trending Aggregate Data from the CANS and PSC-35, Reported by MHPs in FY 2023-24



Overall, 33 MHPs indicated that they utilized the outcomes data with the CANS and 25 indicated the same for the PSC-35. There is no significant change in these counts from last year. Large MHPs mostly indicated that they did so for both tools. Medium counties were least likely to use the data associated with the PSC-35, even if they reported doing so for the CANS. Small MHPs were the only size group where greater than 50 percent of them did not track and trend CANS data. The PSC-35 has only been in place for a few years and large MHPs are likely to have the staffing and skillset to create reporting for a new data set.

This figure over-represents the utilization of results from these two tools. It appears that Plans answered "yes" to this question on the Pathways to Well-Being form regarding tracking and trending data from these two tools, while often MHPs did not aggregate and analyze the collected data (and did not submit examples). This is supported by the finding that while many reported that they did so, only 17 MHPs demonstrated a Met rating for the Key Component on using data for outcomes or analysis – for these tools or any others.

Member Satisfaction Surveys

Although all MHPs are required to conduct the CPS each year for an identified week in May, the practice of applying the results for continuous QI or reporting the results to key stakeholders varied widely. These efforts are described in this Key Component's four subcomponents where a Met rating requires satisfying all four items and a Partially Met rating requires two or three. The subcomponent most often not exhibited was the application of findings to improve access, timeliness, and/or quality. This is the presumed reason why while 26 MHPs were found to be Met on this item (46 percent), almost as many were found to be Partially Met (22 MHPs). This year, 8 MHPs were found Not Met. The ratios have not varied significantly over the last 3 review years.

Those MHPs with well-developed analytic teams were able to tabulate the results prior to submission to the state were better able to note subtle trends across years and incorporate improvement goals into their QAPI or Diversity, Equity, and Inclusion Work Plans. Supporting this idea, large and medium counties composed 69 percent of those MHPs that achieved a Met

rating. Small-rural MHPs comprised six of the eight rated as Not Met. Also, this year, all sizes of MHPs were represented in the Partially Met category.

Given that most MHPs claim the limited usefulness of the CPS survey results (e.g., too latent results, little variability on measures year to year, highly positive feedback), more localized and shorter surveys would be beneficial for obtaining member feedback. Some MHPs have been notably successful in using the CPS; for example, **Sonoma** took a new approach to increase transparency by assigning a third party to assimilate the comments for presentation to the executive team. Also, additional questions were added to the CPS to more deeply understand the impact of telehealth services. **Merced** developed local surveys to evaluate participant demand for group services; this input resulted in the increased duration of one population-specific group and an increase in the number of the Wellness Recovery Action Plan group sessions.

Member Involvement

This Key Component seeks to measure member participation to enhance wellness and recovery, that peer-run or peer-driven programs exist throughout the system, are well-supported by the MHP, and members are educated about their availability. There are five subcomponents where a Met rating requires satisfying all five items and a Partially Met rating requires three or four items.

In FY 2023-24 the number of MHPs receiving Met (n=32) was slightly more than last year (n=30). The reasons for this are likely complex given the impact of the pandemic on wellness center activity, the advent of peer certification, and the involvement of peers to support new programs such as mobile crisis or act as resource liaisons. Most MHPs have progressed on this item with 51 rated Met or Partially Met. Further, all sizes except small-rural were more often rated Met than Partially Met.

Involving members in their care is a priority strategy in the 2022 CQS. MHPs have a history of engaging members in their care and in systemwide improvement activities, but the system participation is a challenge for MHPs to sustain. With the growth of peer leadership models, where peers are then part of the system's leadership, this seems to be improving slowly. Increasingly, and especially as billing for peer activities has become possible, peer-involvement is not mostly relegated to wellness centers and parent partners, but it is becoming more decentralized to support the whole continuum.

Some MHPs have embraced the clubhouse model and have an expansive and functional system of wellness centers well-managed by a peer structure. For example, **San Diego** received the National Association of Counties Achievement award for its clubhouse system which included three programs that have added new capacity responsive to community need. With a total of ten, the clubhouses are an essential part of the MHP's continuum of care. Three specialize in the populations of TAY, deaf and hard of hearing, and homeless. Six of them offer Social Security Insurance advocacy services. **San Bernardino** also has an impressive system of nine clubhouses and five one-stop TAY centers. All employ peers and family advocates who are culturally and linguistically representative of the clients served throughout the system of care. With the approval of a $12.5 million contract, the MHP will be renewing and expanding the peer programs' clubhouses to a total of 11 locations. An example in a small MHP would be **Nevada** whose Empowerment Center and Day Resource Center offer a wide array of services and peer support for members. There is also a five-bedroom house for adults, providing peer support as part of a crisis continuum of care to prevent hospitalization or provide step-down, with stays of up to 2 weeks.

Peer Employment

This item evaluated the MHPs' demonstrations that paid positions are available specifically for individuals hired based upon their lived experience who are considered an integral part of the service delivery system, including direct services and system planning activities. This Key Component has five subcomponents where a Met rating requires four or five items and a Partially Met requires two or three. It was a major discussion during the reviews this year, as indicated by it being the most cited strength (n=20), while it was also one of the most frequently cited recommendations (n=16). The implementation of the certified Medi-Cal peer support services by DHCS brought the topic to the forefront, though CalEQRO did not collect a measure of the implementation of the specific benefit.[25]

Results in this measure showed large and medium MHPs were more likely rated Met, but all size Plans were represented within the Met rating. Small and small-rural MHPs dominated in Partially Met and Not Met ratings. Over the previous two review years, there had been an increase from 27 to 31 MHPs rated as Met. This year, however, there is a further drop to 23 MHPs that were rated as Met and 27 were rated as Partially Met. The decrease this year may be attributed to the systemic changes that must occur as peers are certified and increasingly able to bill their services, but also at a time when leadership is pulled toward many other initiatives. As more MHPs moved toward a decentralized placement of peer staff, more integrated into programs, this will take more time and planning to implement.

Peer employment can come with challenges in MHPs. These staff often reported inequity in pay structures, poor definitions between volunteers and paid peer workers, and shifting leadership while MHPs experienced large turnovers in staff. Sometimes they reported that their new manager had taken the appropriate training, yet they still did not seem to know best practices for managing and utilizing peer staff effectively. Further, they noted lack of upward mobility as MHPs worked with their human resources departments to define these roles, add positions, and seek models for peer leadership structures. This feedback and the different implementation across MHPs make clear why this topic was so frequently a recommendation to MHPs.

Many Plans had encouraged and supported the peer staff in obtaining certification; however, some were still slow to use these positions and the associated billing potential to the benefit of the system and its members. The ability to bill prior to diagnosis under CalAIM is a good example of an opportunity for the MHPs to expand the roles for peers and set them apart from case managers. Furthermore, the MHPs have been challenged in a civil service environment to define advancement based on lived experience and work in a peer role, rather than through advancing education. A concept that, although many contract providers were already strong in, has not been as widely applied within county-operated programs.

Amador is an example of a small-rural MHP where there is significant and notable progress in this area. While there were only two peers at the time of the review, the supervisory job description had been created and was pending budgeting. These peers had been certified and participated in a wide range of community stakeholder meetings, including the QIC. They also utilized the PIP process to see if peer-run groups could improve hope for recovery and reduce psychiatric hospitalization. Even **Los Angeles** continues to advance in this area and was able to add the Chief of Peers position last year to oversee its robust peer specialist system with over 400 peers in the system. **Alameda** has over 100 peer employees and volunteers throughout the

[25] https://www.dhcs.ca.gov/services/Pages/Peer-Support-Services.aspx

system and achieved an increase in peer certification last year. This MHP's peer staff reported advancement through committees and a sense of support to advance by supervisors.

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:

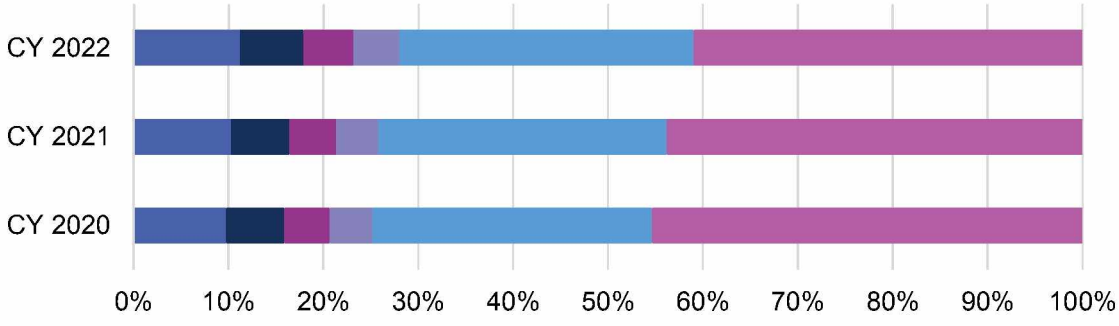
- Retention in services
- Diagnosis of members served
- Psychiatric inpatient services
- Follow-Up post hospital discharge and readmission rates
- HCMs

Retention in Services

Retention in services is an important measure of member engagement to receive appropriate care and intended outcomes. It is important to note that the results below do not account for the LOS, as individuals enter and exit care during a 12-month period. All services regardless of service type are included in this measure.

Figure 6-2 below shows retention of members from CY 2020-22. Each category shows the percentage of members who received that number of SDMC services in the CY identified.

Figure 6-2: Retention of Members Statewide, CY 2020-22



	CY 2020	CY 2021	CY 2022
1 Service	9.76%	10.25%	11.21%
2 Services	6.16%	6.20%	6.71%
3 Services	4.78%	4.88%	5.25%
4 Services	4.50%	4.47%	4.85%
5-15 Services	29.47%	30.41%	31.02%
>15 Services	45.33%	43.78%	40.96%

Statewide, the plurality of members (40.96 percent) was retained for greater than 15 services in CY 2022, and the majority (71.98 percent) of members were retained for 5 or more services. It is important to note that the type of service delivered is not distinguished nor is the length of stay in care.

Overall, member retention has trended downward between CYs 2020 and 2022. A greater proportion of members received only one service in CY 2022 (11.21 percent) than in CY 2020 (9.76 percent). The proportion of members receiving greater than 15 services decreased over the past three CYs.

There is wide variation in retention across MHPs. The following Table 6-3 shows the MHP minimum and maximum for each of the above categories.

Table 6-3: Retention by Number of Services, MHP Minimum and Maximum, CY 2022

# Services	MHP Minimum %	MHP Maximum %
1 service	6.15%	25.98%
2 services	4.48%	12.87%
3 services	2.87%	9.65%
4 services	0.00%	8.92%
5–15 services	21.55%	40.91%
>15 services	16.21%	53.80%

The El Dorado MHP showed the lowest retention of members beyond one initial service, seeing more than one-quarter of members for only one service. Six other MHPs (Tehama, Madera, Sutter-Yuba, Stanislaus, San Benito, and Tuolumne) showed over 20 percent of their members receiving only one service in CY 2022. At the other end of the spectrum, the Colusa MHP showed the highest retention of members retained, with only 6.15 percent receiving only a single service.

In CY 2022, **Santa Clara** had the greatest retention of members past 15 services, with over half of its members (53.80 percent) in that category. In addition, six other MHPs (Marin, Sonoma, Alameda, Nevada, Sacramento, and Butte) had greater than 50 percent of members served receiving 15 or more services. Conversely, the Tehama MHP had the lowest proportion of members retained for greater than 15 services and only retained 16.21 percent of members for that many services. Three additional MHPs (Madera, Amador, and Merced) had rates below 25 percent of members receiving more than 15 services.

While it is important for MHPs to engage with and retain members in services, it is also important that they move members toward recovery, only being retained until it is appropriate to transition to the next lower LOC. There is an increasing need for deep collaboration with the MCPs, with careful processes to identify members for transition and ensure that connections are made; flow through the SMHS system with planned discharges and transitions is necessary to maintain sufficient capacity. As discussed in the Key Component Continuum of Care and LOC Assignment section, it is frequently small-rural MHPs that struggle the most to step members into non-SMHS, as these resources may be severely limited or unwilling to assume MHP-transitioned members who they deem too complex. Further, DHCS's implementation of the Transition Tool sets some guidelines between the two systems to facilitate communication

and identify the appropriate LOC to support this process.[26] Whether there is substantive improvement in ability to transition between systems is an area that warrants future review.

Where MHPs show very high numbers of members receiving a low number of services, and vice versa, MHPs should examine the types of services delivered and the populations most affected for engagement issues, disparities, or inappropriate LOC placement.

Diagnosis of Members Served

The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. The diagnostic groupings are outlined in Appendix 1. It should be noted that all diagnosis data presented represent only the primary MH diagnosis reported and does not include secondary or tertiary diagnoses that may be clinically relevant.

This is not an unduplicated count, as a member may have claims submitted with different diagnoses crossing categories over time and at the same time in different programs. A member and their claims may be represented in more than one category, but within a category it is an unduplicated member count. For example, a member may be listed as "deferred" and then in another category, or a member may be diagnosed in claim with bipolar disorder and another with a psychosis disorder. Additionally, secondary or tertiary diagnoses may be applied, and those are not included in this analysis.

CY 2022 saw two very important changes to the diagnostic system for outpatient SMHS which may impact this data in the coming years. First, is the revised definitions and criteria for SMHS which include the ability to provide services without a diagnosis.[27] The second is billing using Z codes.[28] These suggested a shift in the entire intake flow, who could initially welcome a member to the MHP as well as how they could be served during transition to the non-SMHS system. These changes took place in CY 2022 and are represented by a slight increase in deferred diagnoses in Figure 6-3. However, many MHPs are still adjusting to what it looks like in their system. The most frequently cited reason for slowly rolling out these changes was lack of a sufficient capacity of direct service staff and, second, the lack of QM staffing to manage the adjustments, training, and implementation.

Figure 6-3 shows the relative proportion of members in each diagnostic category in CY 2022.

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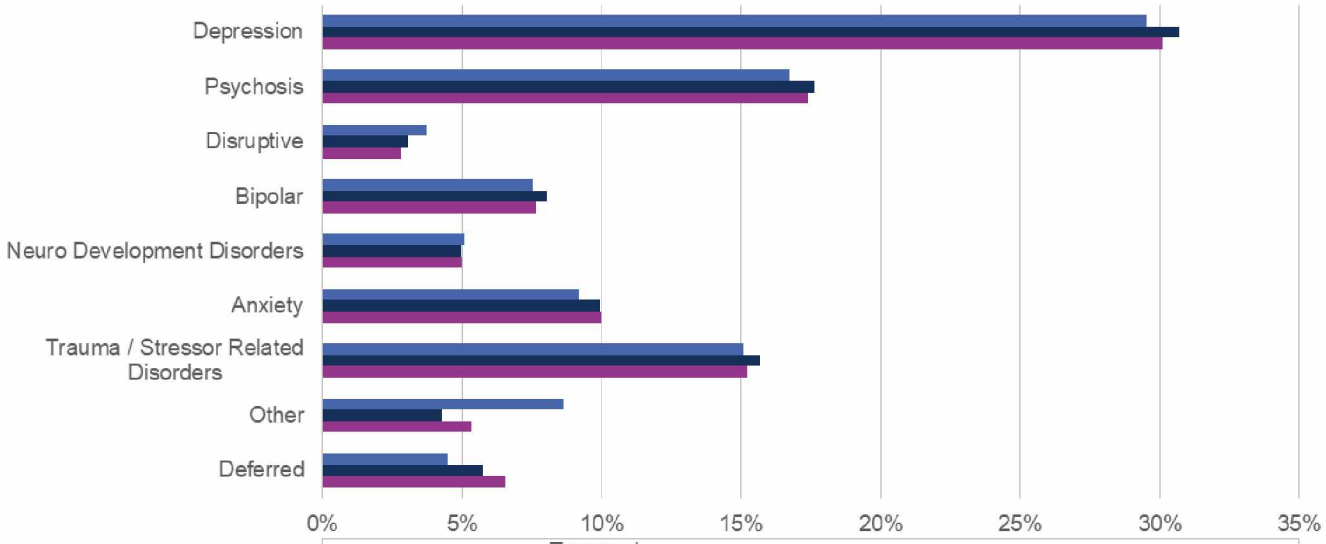
[26] https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx

[27] SMHS/NSMHS designation leading into 2022: BHIN 21-073 came out Dec 2021. Assembly Bill (AB) 133 implements various components of the CalAIM initiative. As specified in Welfare and Institutions Code section 14184.402, the revised definitions and criteria below are effective January 1, 2022. AB 133 gives DHCS authority to implement the criteria for access to SMHS and medical necessity through this Behavioral Health Information Notice (BHIN) until DHCS implements new regulations by July 1, 2024.

[28] BHIN 22-013, California Welfare & Institutions Code § 14184.402, subd. (f)

Figure 6-3: Statewide Distribution of Members Served by Diagnoses, CY 2020-22



	Deferred	Other	Trauma / Stressor Related Disorders	Anxiety	Neuro Development Disorders	Bipolar	Disruptive	Psychosis	Depression
CY 2020	4.5%	8.6%	15.1%	9.2%	5.1%	7.5%	3.7%	16.7%	29.5%
CY 2021	5.8%	4.3%	15.7%	10.0%	5.0%	8.0%	3.1%	17.6%	30.7%
CY 2022	6.6%	5.3%	15.2%	10.0%	5.0%	7.6%	2.8%	17.4%	30.1%

Where diagnostic categories showed increases in CY 2021, CY 2022 data generally showed those numbers returning closer to the CY 2020 pattern. Overall, depression, psychosis, and trauma-related disorders remain the top three diagnostic categories. There was an overall increase in members served, with slight increases seen in trauma/stressor related disorders, anxiety, and depression diagnoses.

CY 2022 saw two very important changes to the diagnostic system for outpatient SMHS which may impact this data in the coming years. First, is the revised definitions and criteria for SMHS which include the ability to provide services without a diagnosis.[29] The second is billing using Z codes.[30] These suggested a shift in the entire intake flow, who could initially welcome a member to the MHP as well as how they could be served during transition to the non-SMHS system. These changes took place in CY 2022 and are represented by a slight increase in deferred diagnoses in Figure 6-3. However, many MHPs are still adjusting to what it looks like in their system. The most frequently cited reason for slowly rolling out these changes was lack of a sufficient capacity of direct service staff and, second, the lack of QM staffing to manage the adjustments, training, and implementation.

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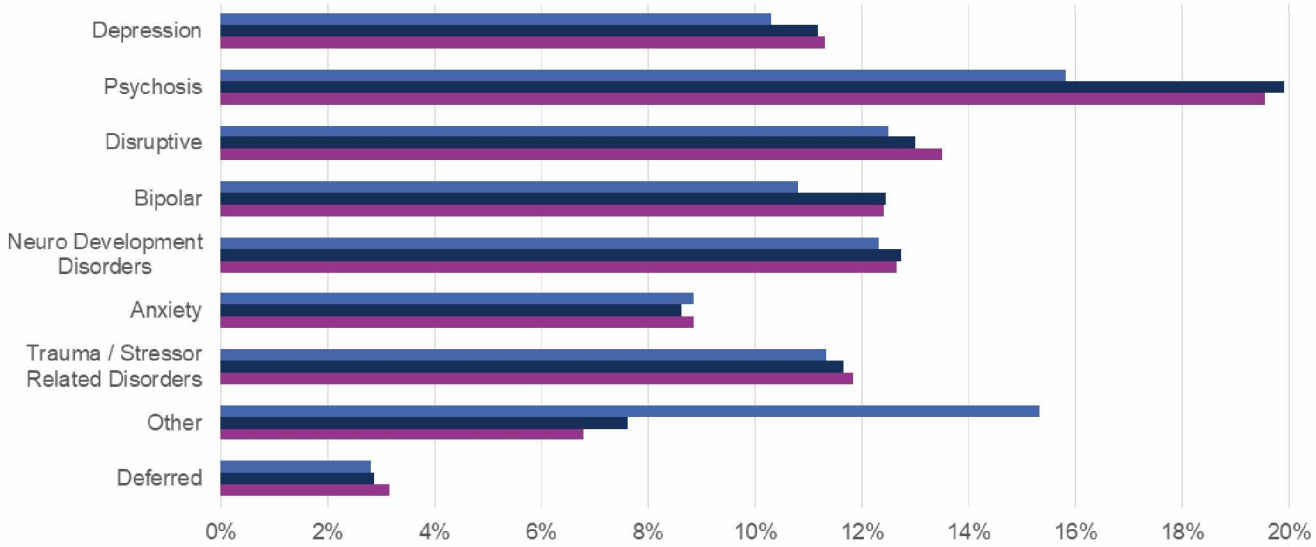
[30] Use of Z codes, and billing before dx: BHIN 22-013 California Welfare & Institutions Code § 14184.402, subd. (f)

Figure 6-4 shows the proportion of claims per diagnostic category, in accordance with the SDMC claims for the members represented in Figure 6-3.

Figure 6-4: Statewide Approved Claims by Diagnoses, CY 2020-22



	Deferred	Other	Trauma / Stressor Related Disorders	Anxiety	Neuro Development Disorders	Bipolar	Disruptive	Psychosis	Depression
CY 2020	2.8%	15.3%	11.3%	8.8%	12.3%	10.8%	12.5%	15.8%	10.3%
CY 2021	2.9%	7.6%	11.7%	8.6%	12.7%	12.4%	13.0%	19.9%	11.2%
CY 2022	3.2%	6.8%	11.8%	8.8%	12.6%	12.4%	13.5%	19.5%	11.3%

In general, CY 2022 claiming patterns were quite similar to CY 2021. They tend to generally align with the percent of members with those diagnoses (as seen in Figure 6-3), except for proportionately more dollars spent on psychotic, disruptive, disorders, bipolar, and neurodevelopmental disorders. In the three-year period, individuals with psychotic disorders, disruptive, and neurodevelopment disorders largely received the highest proportion of approved claims – an exception was CY 2020 which had an unusual amount of claims in the Other category.

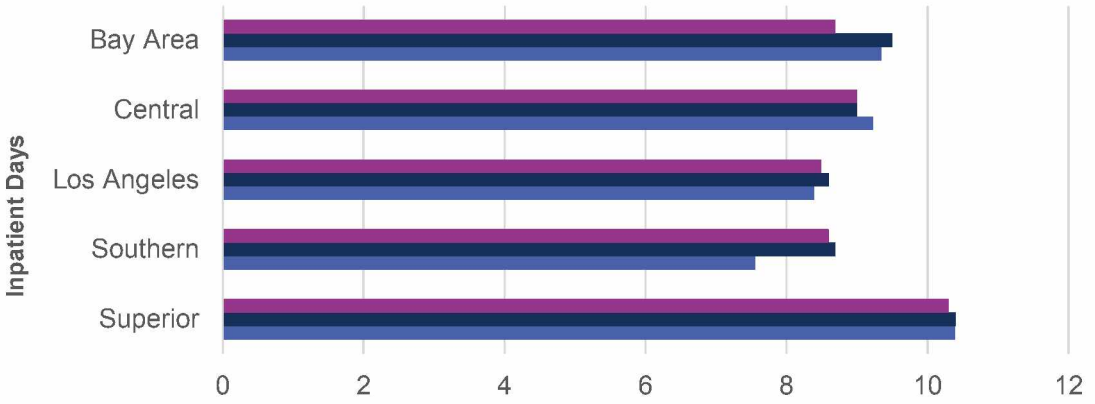
When claims appear disproportionate to the prevalence of a diagnosis, it may be due to the cost associated with the LOC appropriate to a given diagnosis, the acuity of symptoms associated with the diagnosis, or the chronic nature of a disorder that may require longer treatment periods or multiple episodes of treatment. This is the reason psychosis commonly receives a greater portion of claims dollars, as these members tend to be served by more intensive, higher cost outpatient programs (e.g., FSP) and may receive more inpatient services that are more costly.

Psychiatric Inpatient Services

Psychiatric inpatient claim PMs are calculated by combining hospital claims from both SDMC and IPC for numerators. The average LOS is calculated by dividing the total inpatient days by the unduplicated members served in inpatient care. A given member may have multiple admissions represented in this LOS, and episodes of inpatient care are not reflected.

Figure 6-5 shows the LOS by region for CY 2020-22.

Figure 6-5: Average Inpatient Length of Stay by MHP Region, CY 2020-22



	Superior	Southern	Los Angeles	Central	Bay Area
CY 2020	10.3	8.6	8.5	9.0	8.7
CY 2021	10.4	8.7	8.6	9.0	9.5
CY 2022	10.4	7.6	8.4	9.2	9.4

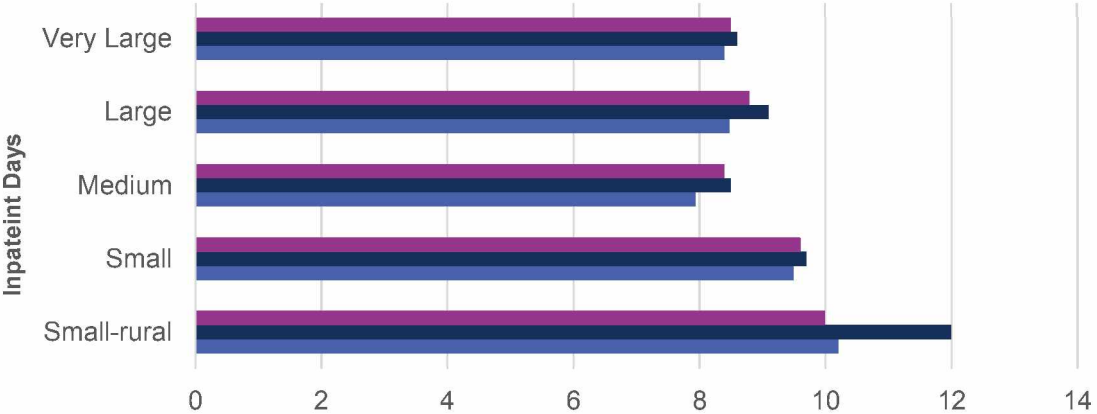
Inpatient LOS was largely stable except in the Southern region which showed a decrease by 1.1 days from CY 2021.

The Superior region has consistently had the longest inpatient LOS. This may be due to a lack of in-county inpatient services in this region, and challenges in coordinating transitions in care from inpatient settings in other geographic areas.

As MHPs expand their continuum of care to include more crisis services and comprehensive post-hospitalization follow-up services, presumably there will be a LOS decrease achieved.

Figure 6-6 shows LOS by MHP size for CY 2020-22.

Figure 6-6: Average Inpatient Length of Stay by MHP Size, CY 2020-22



	Small-rural	Small	Medium	Large	Very Large
CY 2020	10.0	9.6	8.4	8.8	8.5
CY 2021	12.0	9.7	8.5	9.1	8.6
CY 2022	10.2	9.5	7.9	8.5	8.4

All MHP size groups experienced increases in LOS in CY 2021 compared to CY 2020, followed by a decrease in CY 2022. In all size groups except small-rural MHPs, CY 2022's decrease resulted in a LOS that was slightly shorter than in CY 2020. Further, the small-rural MHP group has consistently had the longest LOS over the past three CYs, followed by the small-size MHPs. This is likely due to smaller MHPs (many in the Superior region) having fewer in-county inpatient services and available step-down options.

Longer LOS in CY 2021 may be attributed to difficulties in discharges, as COVID-19 cases in facilities impacted whether individuals could be discharged or transferred to other facilities in accordance with Public Health protocols for facilities. Further, outpatient services were disrupted and eventually suffered from turnover and shortages, impacting follow-up and readmissions.

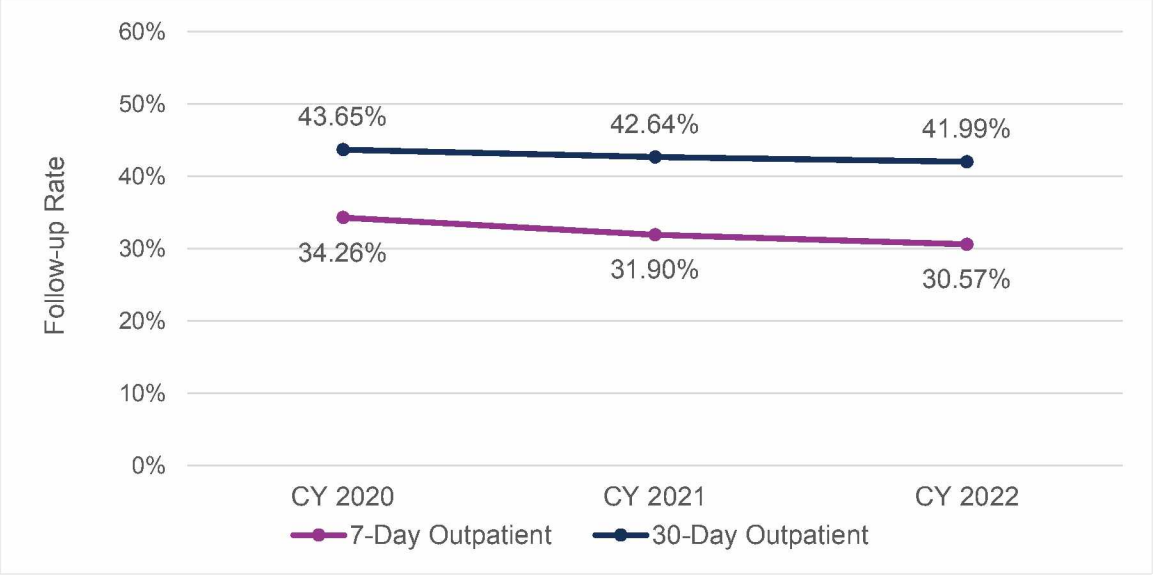
Follow-Up Post Hospital Discharge and Readmission Rates

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 mental health professionals is critically important. All services that are not provided in an inpatient setting are counted in the numerator for inpatient follow-up. All readmissions are based upon the 7-day or 30-day period after discharge.

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge 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 member outcomes and may be reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge.

Figure 6-7 represents statewide performance related to outpatient follow-up post hospital discharge. The numerator is the number of members with an SDMC services within the 7- or 30-day time frame after a SDMC inpatient discharge, and the denominator is the number of inpatient discharges.

Figure 6-7: Follow-up Rates Post Hospital Discharge Statewide, CY 2020-22



Statewide follow-up rates after discharge from a hospital have been decreasing slightly over the past three CYs at both 7 and 30 days. The 7-day follow-up rates have decreased by 3.69

percentage points, and 30-day follow-up rates have decreased by 1.66 percentage points. This represents a 10.77 percent decrease at 7 days and a 3.80 percent decrease at 30 days.

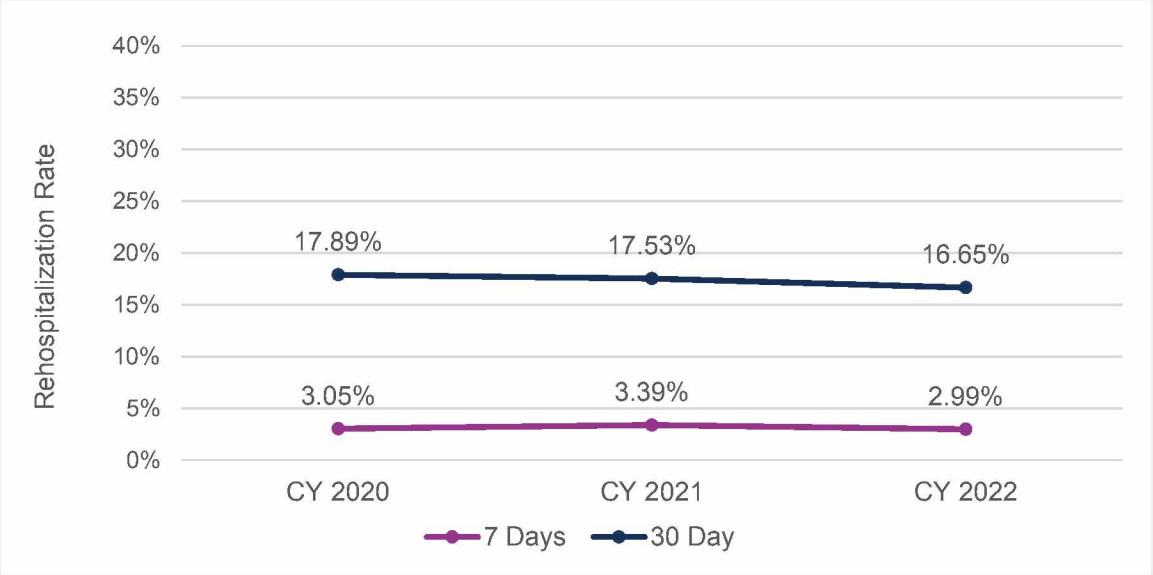
In CY 2022, the majority of the members (69.43 percent) discharging from inpatient stays did not receive a follow-up service within 7 days, 58.01 percent did not receive a follow-up service within 30 days.

Follow-up services are crucial in re-engaging members in outpatient services and preventing rehospitalizations. There are some reasons why members would not follow-up, including their choice not to enter care, incarceration, and moving out of the area.

In 2022, four MHPs (**Modoc**, **Mono**, **Tulare**, and **Sonoma**) showed 7-day follow-up rates exceeding 60 percent, and two MHPs (**Modoc** and **Mono**) had 30-day follow-up rates exceeding 80 percent. On the other end of the continuum, nine MHPs showed performance at less than 30 percent at 7 days and seven MHPs with very small numbers had follow-up rates below 40 percent at 30 days.

Figure 6-8 shows the rehospitalization rates at 7 and 30 days after inpatient discharge for CY 2020-22. The numerator is the number of inpatient admissions occurring within the 7- or 30-day period after an inpatient discharge. The denominator is the number of inpatient discharges.

Figure 6-8: Rehospitalization Rates Statewide, CY 2020-22



Statewide rehospitalization rates were very stable over the time frame displayed, but showed a small reduction in CY 2022, reaching 2.99 percent at 7 days and 16.65 percent at 30 days. Several small and small-rural MHPs had few hospitalizations and no readmissions in 7 or 30 days.

Rehospitalization rates can be impacted by MHPs' follow-up care, but there are also factors which extend beyond the MHP's influence, such as psychosocial factors (e.g., housing, employment, and interpersonal stressors, etc.) that impact mental health conditions.

High-Cost Members

Tracking the HCMs 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. HCM percentage of total claims, when compared with the HCM count percentage, provides a subset of the member population that warrants close utilization review, both for appropriateness of LOC and expected outcomes.

Table 6-4 provides a summary of statewide HCM trends for the MHPs. HCMs in this table are identified as those with SDMC total approved claims of more than $30,000 in a year, regardless of service type.

Table 6-4: HCM (Greater than $30,000), CY 2020-22

Year	Member Count by Cost Category	Statewide Member Count	% of Members Served	Average Approved Claims per Member by Cost Category	Total Approved Claims by Cost Category	% of Total Approved Claims
	Members Served			Member Claims		
High-Cost Members (payment ≥ $30,000)						
CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
CY 2021	27,729	615,562	4.50%	$55,523	$1,539,601,175	33.45%
CY 2022	27,277	600,959	4.54%	$55,518	$1,514,353,866	33.86%
Medium-Cost Members (payment between $20,000 and $30,000)						
CY 2020	22,110	595,596	3.71%	$24,274	$536,694,163	12.59%
CY 2021	23,655	615,562	3.84%	$24,286	$574,488,408	12.48%
CY 2022	22,794	600,959	3.79%	$24,298	$553,853,510	12.38%
Low-Cost Members (payment < $20,000)						
CY 2020	549,244	595,596	92.22%	$4,399	$2,416,340,502	56.70%
CY 2021	564,178	615,562	91.65%	$4,412	$2,488,904,944	54.07%
CY 2022	550,888	600,959	91.67%	$4,364	$2,403,975,935	53.75%

The proportion of members considered to be high-cost increased in both CY 2021 and CY 2022. High-cost outliers drive the average claims up across the state, and one-third of claims were attributed to HCMs in CY 2022. While the overall AACM is $7,478, the statewide median amount is just $3,200, showing that the average is not representative of most members' treatment.

The proportion of members in the medium-cost category has consistently been near 4 percent for the past three CYs, and the proportion of claims attributed to this cost category has also consistently been just over 12 percent.

On the other end of the spectrum, statewide, almost 92 percent of the statewide members are "low cost" (less than $20,000 annually) and receive just over half of the Medi-Cal resources, with an AACM of $4,364 but a much lower median of $2,761. Given the median value, about

46 percent of members served are associated with less than $2,761 in average approved claims. Compared to CY 2020, the proportion of members in the low-cost category in CY 2022 has decreased very slightly, and the proportion of claims attributed to the low-cost group decreased by about 3 percentage points over this period.

AACMs for each category have been relatively static over the past three CYs.

2022 CQS Behavioral Health Accountability Set

The 2022 CQS introduced five priority HEDIS quality measures, later named the Behavioral Health Accountability Set (BHAS) measures that reflect the improvement intended through CalAIM implementation. These measures are expected to become part of routine tracking and reporting by the MHPs. For the first year of reporting (measurement year [MY] 2022) DHCS calculated the rates to enable MHPs more time to develop the infrastructure to collect and report on the measures directly. BHC's report of analysis of these results, MY 2022 Quality Measure Report, is available on DHCS's website.[31]

Accurate measurement requires MHPs to conduct data exchange with MCPs in order to have accurate results for elements such as emergency department (ED) visits, medications prescribed, and relevant visits that occur in the MCP medical system. DHCS encouraged data exchange through the CalAIM BHQIP, Milestone 3d, which provided financial incentives for MHPs to work on the Follow-Up After ED Visit for Mental Illness (FUM) measure. Most MHPs opted to work on this project with templates provided by DHCS, and many have also submitted them to CalEQRO to also meet one of the PIP requirements, detailed further in the PIP chapter of this report.

BHIN 24-004 was issued in January 2024, outlining expectations and intended time frames for data submissions, data review and validation, and data publication.[32] MY 2022 was identified as the baseline year, with the expectation that in subsequent years MHPs will target the 50th percentile nationally for each measure, increasing by 5 percent annually, if below this target. The BHAS measures are:

1. FUM
2. FUH
3. Antidepressant medication management (AMM)
4. Use of first-line psychosocial care for children and adolescents on antipsychotic medication (APP)
5. Adherence to antipsychotic medications for individuals with schizophrenia (SAA)

SUMMARY OF QUALITY FINDINGS

As the MHPs adjust to national quality measures, embrace CalAIM, and expand the complexity of their QI efforts, there is an increasing demand for data analytics to support QM and skilled QI

[31] https://www.dhcs.ca.gov/services/MH

[32] https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-24-004-Quality-Measures-and-Performance-Improvement-Requirements.pdf

staff who must monitor and interpret the analyses. Further, executive leadership must value and invest in these processes, while designing member feedback and involvement as inherent to the system. In fact, when looking at all the strengths listed in MHP EQR reports, the most often cited strength categories were peer staff and data analytics. At the same time, the most frequently cited recommendations were associated with QI efforts, peer staff, and use of a LOC tool, which shows the focus and energy MHPs have placed on these quality-related tasks in the past review year.

As MHPs use the available grants and initiatives to close gaps in their services and struggle to maintain adequate staffing, there is an increasing need to understand the flow of members through the system, to measure capacity ratios in new ways, and to address inequities. The demand for effective LOC tools is paramount while improvement efforts geared at equity and other QI efforts have become more important to the context of CalAIM and the CQS. Many MHPs are still using dated, compliance- and timeliness-focused QAPI, but have not had the staffing resources to make needed adjustments to this approach. Many have stated a need for increased guidance and coaching from the state in balancing older processes with updated requirements and seeing the big picture of reform as it specifically applies to SMHS.

Those MHPs that changed their EHRs seemed to express hope and anxiety that their new systems will help launch or improve truly QI efforts as opposed to compliance, particularly aggregate calculations and the collection of HEDIS measures. For many MHPs, measures continue to be a mix of manual entry and electronic tracking, producing data that is not readily available, sufficiently accurate, and adequately displayed to inform the system. Even where data, such as outcome measures, have been collected for many years, the results have not necessarily been used aggregately for systemic decision making. CalMHSA also plays a role in supporting these efforts in reporting the BHAS measures for the Plans which contract to do so.

As routinely stated in the Key Components discussion, larger MHPs generally have the resources to adapt much quicker with less reliance on ready-made tools. Small and small-rural MHPs continue to have the biggest shortages in the staff knowledge base, usually less financial support from county governance, more difficulty collaborating with local healthcare services, and shortages of in-county psychiatric facilities and non-SMHS providers for step-downs. It may benefit some of these MHPs to collaborate with their resources to develop viable strategies.

The MHPs show many improvements and advancements toward the goals in the CQS which are noted throughout this chapter. Not surprisingly though, fluctuations in the PMs between CY 2020 and 2022 are observed, resulting in significant room for improvement. For example, in CY 2022 only 42 percent of members discharged from a Medi-Cal billable inpatient facility received a mental health service within 30 days, and 16.65 percent experienced a rehospitalization within 30 days. These data must be understood in context where factors are acknowledged such as the negative impacts of the pandemic from 2020 through 2022 on hospitalization rates, facility transfers, MHP staff availability, emergency safety protocols, the deleterious impact on mental health for members and the health care workers attempting to serve them. Lastly, California communities have dealt with the impacts of devastating environmental and weather-related disasters each year, and this is ongoing with record-breaking fires displacing many Medi-Cal members and MHP staff.

Lastly, the MHPs have demonstrated vast efforts toward supporting their workforce, which deserves mention when talking about quality. Retaining knowledgeable staff long-term improves consistent and quality care; reducing onboarding and retraining efforts can consume significant resources in a smaller MHP. Improving wages, updating classifications and job descriptions, recruiting and improving the ease of the application process, and attracting recent behavioral sciences graduates, psychiatry residents, and well-educated analysts were substantial points of

discussion during reviews this year. Efforts to expand and improve the skillset of the workforce, including but not limited to, recruitment, training and onboarding, working with county-level human resources (and labor unions), and improving leadership skills were cited as strengths but also warranted 25 recommendations, included nine recommendations to expand QM, IS, and data analytic staff. For all of these quality of care issues, expanding and strengthening the skillset among the workforce are critical issues.

Performance Improvement Projects

INTRODUCTION

A PIP is "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner."[33] Each PIP is expected to produce member-focused outcomes. The CMS Protocol 1 and the *Validating Performance Improvement Prcjects* protocol require the EQRO to validate two PIPs at each MHP that were initiated, are in progress, or completed during the reporting year.[34] For this Annual Report, CalEQRO reviewed projects that were active at any point during the 12 months leading up to the FY 2023-24 reviews. Each MHP report includes detailed descriptions of the PIPs and a summary of their performance based on the PIP Validation Tool.[35]

Each MHP must have two PIPs: one clinical and one non-clinical. A clinical PIP should focus on treatment interventions to enhance outcomes and member experiences, while the non-clinical PIP should target processes that improve access and the overall member experience of care. The goal of both PIPs is to address problems or barriers in care, with the aim of achieving outcomes that positively impact members.

A clinical PIP might target the following types of issues:

- Prevention and treatment of a specific condition
- High-volume services
- High-risk procedures and services
- Transitions in care from 24-hour settings to community settings
- Enhancing treatment for special needs populations

A non-clinical PIP might target the following types of issues:

- Coordination of care with hospital EDs, other providers, or county departments
- Timeliness and convenience of service improvements
- Improvements in customer service and initial engagement in care
- Improvement in access or authorization processes
- Member services and processes that hinder optimal outcomes and satisfaction

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[33] Department of Health and Human Services & Centers for Medicare and Medicaid Services. (February 2023). *CMS external quality review (EQR) protocols.* https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

[34] Ibid.

[35] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

The CalAIM BHQIP was a DHCS incentive project that enabled each MHP Plan to earn incentive payments by meeting deliverables linked to program milestones.[36] "Leverage improved data exchange capabilities to improve quality and coordination of care, Milestone 3d," created PIP opportunities for Plans to earn incentive funding from DHCS and receive credit as a PIP from CalEQRO, using the DHCS format. The MHP option was based on the National Committee for Quality Assurance measure, FUM. This is a valuable PIP topic, as it addresses high-risk issues and can be either clinical or non-clinical, depending on the analysis and the identified interventions. The last submission to DHCS was in September 2023, but CalEQRO reviewed these PIPs throughout the review year.

METHODS

The PIP Development Tool is a template provided by CalEQRO for MHPs to use in drafting their PIP narratives.[37] Using the tool helps ensure that MHPs addresses all essential PIP components required for validation. MHPs are expected to submit both PIPs 4 weeks before the EQR, but they are submitted the week or even the day before the review. The designated CalEQRO Quality Reviewer and PIP Consultant assess all submitted PIPs for clarity, applicability, and relevance to the MHP's population, methodology, data findings, and other features outlined in the PIP Validation Tool.

During the EQR, the CalEQRO team reviews the documentation provided by the MHP and seeks any necessary clarification. During these sessions, the team discusses each PIP submission with MHP staff, often gaining valuable context and understanding that enhances the written submission. CalEQRO provides feedback and TA, when applicable, to strengthen the submitted PIPs. After the review, MHP staff can resubmit their PIPs within 1 week with any changes or additions discussed. This is particularly valuable when the MHP conducted activities or analyses that were not adequately described in their initial submission. CalEQRO reviews and validates any resubmitted PIPS using the PIP Validation Tool, in accordance with CMS Protocol 1 requirements.[38] When MHPs did not submit any PIPs, validation was not possible.

Each of the nine PIP steps includes subsections with standards rated according to the PIP Validation Tool, as detailed in Table 7-1.

Table 7-1: PIP Validation Steps

Step	PIP Section
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population

[36] https://www.dhcs.ca.gov/Documents/DHCS-8761-CalAIM-BHQIP-Program-Implementation-Plan-and-Instructions-Enclosure-2.pdf

[37] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

[38] Department of Health and Human Services & Centers for Medicare and Medicaid Services. (February 2023). *CMS external quality review (EQR) protocols.* https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

Step	PIP Section
4	Review the Sampling Method (if applicable)
5	Review the Selected PIP Variables and PMs
6	Review the Data Collection Procedures
7	Review Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

All PIPs are rated based on progress, completeness, and adherence to CMS protocol standards, and are assigned both a status and a confidence rating.[39] In addition to rating each PIP's status, CalEQRO assesses its relative validity. Validity ratings are based on how well the PIP adheres to acceptable methodology in study design, data collection, analysis, and interpretation of results. Based on performance as indicated in the PIP Validation Tool, each PIP is assigned a rating of High, Moderate, Low, or No Confidence, with each rating described as follows:

- High confidence – The PIP documented credible, reliable, and valid methods.
- Moderate confidence – The PIP implied or established credible, reliable, or valid methods for part of the process.
- Low confidence – Errors in logic, contradictory information, or incorrect interpretation were noted, which may include a lack of demonstrated outcome data.
- No confidence – The PIP lacked sufficient documentation to determine if credible, reliable, and valid methods were used.

Table 7-2 defines each status assigned based on the progress of the PIP.

Table 7-2: PIP Status Definitions

PIP Validation Phase per CMS Protocol Terminology	Definition
PIP Submitted for Approval	The MHP submitted the PIP concept for CalEQRO review.
Planning Phase	The MHP is preparing to implement the PIP.
Implementation Phase	The MHP has established baseline data on some indicators, and at least some strategies for improvement have begun. Any combination of these is acceptable.
Baseline Year	A strategy for improvement has begun, and the MHP is establishing or refining a baseline measurement.
First Remeasurement	Baseline data has been established, and one or more strategies are being remeasured for the first year/period.
Second Remeasurement	The success of the intervention strategy is being measured for the second year/measurement period.

[39] Ibid.

PIP Validation Phase per CMS Protocol Terminology	Definition
Other – Multiple Remeasurements	The strategy is being measured beyond the second remeasurement.
Other – Completed	In the past 12 months (since the previous EQR), the work on the PIP has been completed.
Other – Developed in a Prior Year	Rated last year but not this year due to a lack of activities in the past year.

To be considered in the Implementation phase, a PIP must have (1) baseline data on some indicators or PIP variables and (2) some improvement strategies must have started. During the Baseline year, a strategy has begun, and refinements to the baseline measurements may be occurring, but a First Measurement has not yet taken place. A PIP in the First Remeasurement phase will measure the impact of the improvement strategy using key indicators and then prepare for the Second Remeasurement. Some PIPs have additional remeasurement periods, placing them in the Other phase. Additionally, PIPs that have been completed at some point since the prior review are also placed in the Other phase.

PIP SUBMISSIONS

Detailed PIP findings from the past 3 years' submissions are reflected in Table 7-3 below.

Table 7-3: PIP Submission Status Summary, FY 2021-22 to FY 2023-24

Submission Status	FY 2021-22		FY 2022-23		FY 2023-24	
	#	%	#	%	#	%
PIP Submitted for Approval	1	1%	1	1%	0	0%
Planning	13	13%	16	14%	11	10%
Implementation	23	21%	33	29%	42	38%
Baseline Year	1	1%	4	4%	6	5%
Remeasurement	39	35%	23	21%	31	28%
Developed in a Prior Review Year	6	5%	0	0%	1	1%
Completed	17	15%	27	24%	10	9%
Total PIPs Submitted	**100**	**89%**	**104**	**93%**	**101**	**90%**
No PIP Submitted	12	11%	8	7%	11	10%
Total Possible PIPs	**112**	**100%**	**112**	**100%**	**112**	**100%**

Note: Percentages for Submission Status uses Total Possible PIPs (112) as the denominator. Percentages may not add up to 100% due to rounding of percentages.

Note: Data for FY 2021-22 PIPs does not reflect prior report publications as this year two PIPs were re-categorized to align with current practices.

- In FY 2023-24, the 56 MHPs submitted a total of 101 PIPs, meeting 90 percent of the required 112. This is a decrease from FY 2022-23, when 104 PIPs (93 percent) were submitted, but an increase from FY 2021-22, when the fewest number of PIPs, 100 (89 percent), were submitted for validation.

- Ninety of the PIPs had implemented at least one intervention – comparing favorably to 88 PIPs in FY 2022-23 and 84 PIPs in FY 2021-22. Sixty-six percent of the PIPs were in the implementation (38 percent) or remeasurement phases (28 percent), higher than last year's 50 percent and FY 2021-22 at 56 percent. Additionally, fewer PIPs were still in the planning phase at 10 percent, compared to 14 percent in FY 2022-23.
- Ten PIPs were considered completed by the MHP at the time of the review, compared to 27 the previous year.
- The 11 PIPs not submitted represent eight MHPs: three submitted no PIPs (Alpine, Del Norte, and Tehama) and five submitted one PIP each, the BHQIP FUM (Inyo, Lake, Modoc, Plumas, and Yolo).

Validity ratings are based on the PIP Validation Tool, developed in alignment with EQR Protocol 3, which assesses how well the PIP adheres to acceptable methodology in study design, data collection, analysis, and interpretation of results. Each PIP is subsequently assigned a rating of high, moderate, low, or no confidence.[40]

Table 7-4 compares the confidence ratings between FY 2021-22, FY 2022-23, and FY 2023-24.

Table 7-4: PIP Validity Ratings Summary, FY 2021-22 to FY 2023-24

Validation Rating	FY 2021-22		FY 2022-23		FY 2023-24	
	#	%	#	%	#	%
High confidence	13	13%	15	14%	9	9%
Moderate confidence	40	41%	58	56%	41	41%
Low confidence	26	27%	25	24%	39	39%
No confidence	21	19%	6	6%	12	12%
Total PIPs Submitted	**100**	**100%**	**104**	**100%**	**101**	**100%**

Note: Percentages for Submission Status uses Total PIPs Submitted (varies per year) as the denominator. Percentages may not add up to 100% due to rounding of percentages.

Note: Data for FY 2021-22 PIPs does not reflect prior report publications as this year two PIPs were re-categorized to align with current practices.

- Each year, a Moderate confidence rating was the most common finding, at 41 percent in FY 2023-24. A PIP with a validation rating of Moderate confidence implies that credible, reliable, or valid methods were used for at least part of the PIP.
- The number of PIPs with a High confidence rating (9 percent) decreased from 14 percent in FY 2022-23 and 13 percent in FY 2021-22. A PIP with a High confidence rating demonstrates documented credible, reliable, and valid methods.
- The number of PIPs receiving Low or No confidence ratings in FY 2023-24 increased to 51 percent, up from 30 percent in FY 2022-23. When validating these PIPs, CalEQRO identified errors in logic, contradictory information, improper interpretation, or insufficient documentation to determine if credible, reliable, and valid methods were used. Many

[40] Department of Health and Human Services & Centers for Medicare and Medicaid Services. (February 2023). *CMS external quality review (EQR) protocols.* https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

lacked sufficient evidence of applied interventions and had poor documentation of results.

PIP TOPIC DOMAINS

In addition to submission and validation statuses, the clinical and non-clinical PIPs can be categorized into four domains: access to care, timeliness of care, quality of care, and outcomes of care. The domains relate to the MHP's operation as an effective Managed Care Organization, encompassing processes for ensuring access to and timeliness of services, enhancing the quality of care, and improving functioning and outcomes as a result of care.

Table 7-5 categorizes PIPs into one of four domains – access, timeliness, quality, or outcomes – for the three FYs.

Table 7-5: PIP Domain by Category and Type, FY 2021-22 to FY 2023-24

Domain	FY 2021-22			FY 2022-23			FY 2023-24		
	% by Domain	# Clinical	# Non-Clinical	% by Domain	# Clinical	# Non-Clinical	% by Domain	# Clinical	# Non-Clinical
Access to Care	23%	6	17	26%	13	14	16%	8	8
Timeliness of Care	20%	4	16	11%	0	11	13%	2	11
Quality of Care	18%	8	10	29%	10	20	53%	21	32
Outcomes of Care	39%	33	6	35%	28	8	19%	18	1

Note: Percentages for Submission Status uses Total PIPs Submitted (varies per year) as the denominator. Percentages may not add up to 100% due to rounding of percentages.

Access to Care

The Access to Care PIPs accounted for 16 percent of all PIPs submitted in FY 2023-24, marking a decline in submissions within this domain compared to previous years. These PIPs covered a range of themes, many of which were related to initial engagement, the screening phase, linkage, and access call center functions. The clinical topics centered on enhancing assessment and intake processes, improving access to telehealth, implementing collaborative documentation, and addressing enrollment issues. The non-clinical PIPs focused on reducing no-show rates, enhancing attendance across various LOCs, improving access or linkage to services both within the MHP and in the community, and expanding the use of telehealth services.

Timeliness of Care

The 13 Timeliness of Care PIPs submitted (13 percent) in FY 2023-24 was slightly higher than the 11 PIPs (11 percent) submitted in FY 2022-23. This was a decrease from FY 2021-22 when 20 Timeliness of Care PIPs were submitted. These PIPs focused on specific challenges such as timely access to assessments and psychiatric treatment, appointment reminders, and referrals. Many of the PIPs aimed to improve the time between an initial assessment and the first offered appointment. MHPs continue to explore ways to deliver services more quickly to enhance engagement for various populations and member groups.

Quality of Care

For FY 2023-24, the largest domain for PIPs was Quality of Care, representing 53 percent of all PIPs. This included 21 clinical and 32 non-clinical PIPs. This is a marked increase from the 30 PIPs (29 percent) submitted in FY 2022-23 and the 18 PIPs (18 percent) in FY 2021-22. Much of this increase is attributable to CalAIM BHQIP projects identifying this domain. These PIPs focus on improving the rate of FUM, targeting individuals with an ED visit for a mental health condition, including the identification of these individuals and arranging follow-up appointments for improved engagement in care.

Outcomes of Care

Outcomes of Care PIPs accounted for a total of 19 PIPs (19 percent) in FY 2023-24, with 18 clinical and 1 non-clinical. This was a marked decrease from the 36 PIPs (35 percent) in this category during FY 2022-23 and the 39 PIPs (39 percent) in FY 2021-22. The clinical PIPs examined outcomes for individuals with depression and anxiety, recidivism or rehospitalization, community, social, and family functioning, engagement in treatment, and linkage to other services. The non-clinical PIP focused on the impact of engagement and integration of services on members. All Outcomes of Care PIPs have the potential to provide valuable insights into treatment and best practices, if conducted consistently and designed well.

PIP VALIDATION

Table 7-6 below provides a comprehensive description of the PIPs submitted by each Plan. It includes each PIP's type, title, domain, primary intervention, status or phase of PIP at submission, and validation rating. Again, more detailed information about each PIP, including implementation challenges and CalEQRO recommendations for improvement, is provided in the Plan-level reports.

Table 7-6: PIPs, FY 2023-24

PIPs				
MHP	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating**
Alameda	Clinical	BHQIP FUM		
		In-person outreach at the hospital, a data dashboard, and sharing discharge data		
		Quality	Implementation	Low Confidence
	Non-Clinical	Adult Access to Psychiatric Care		
		A warm handoff from Access to the medication services provider to immediately receive an appointment		
		Access	Implementation	Low Confidence
Alpine	Clinical	No PIP Submitted*		
	Non-Clinical	No PIP Submitted*		

PIPs				
MHP	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating**
Amador	Clinical	Peer-Led Support Group after a Crisis Event		
		A peer support group for those who received crisis contacts; use of the Hope Scale		
		Quality	Completed	Moderate Confidence
	Non-Clinical	Timely Access		
		Increase frequency of utilization review team meetings; the CalAIM Youth and Adult Screening Tools		
		Timeliness	Implementation	Moderate Confidence
Butte	Clinical	Youth LOC Intervention Standards		
		Implementation of a CANS algorithm for triage and LOC placements		
		Outcomes	Planning Phase	No Confidence
	Non-Clinical	Youth LOC of Dashboard		
		A CANS dashboard that enables the use of CANS data in real time		
		Outcomes	Planning	No Confidence
Calaveras	Clinical	BHQIP FUM		
		A referral tracking system and follow-up reminder calls to members		
		Quality	First Remeasurement	Moderate Confidence
	Non-Clinical	Improving the Quality of 24/7 Access to Care Telephone Line Responses and Information		
		Provision of regular feedback and Continuous Quality Improvement on the 24/7 line test calls; an updated resource directory		
		Access	Baseline Year	Low Confidence
Colusa	Clinical	Psychosis Identification and Treatment		
		Implement the Prodromal Questionnaire, Brief Version		
		Outcomes	Implementation	Moderate Confidence
	Non-Clinical	BHQIP FUM		
		Referral form for the ED; meetings with MCPs to discuss data sharing		
		Quality	Implementation	Moderate Confidence
Contra Costa	Clinical	BHQIP FUM		
		Referral system for ED social workers including expedited access to follow-up appointments		
		Quality	Implementation	Moderate Confidence
	Non-Clinical	Gain-framed Provider Reminder Calls to Reduce No-Shows to Initial Assessment Appointments		
		Reminder calls from therapist and the automated system; offer on-demand clinical assessments		
		Timeliness	Second Remeasurement	High Confidence
Del Norte	Clinical	No PIP Submitted*		
	Non-Clinical	No PIP Submitted*		

PIPs				
MHP	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating**
El Dorado	Clinical	BHQIP FUM		
		Embed MHP staff in two EDs to make referrals for follow-up care		
		Quality	Second Remeasurement	Moderate Confidence
	Non-Clinical	Ensuring Members are Involved in Medication Management Services as Evidenced by Signed Medication Consent Forms		
		A new medication consent form and tracking members who need a new or updated consent		
		Access	First Remeasurement	Moderate Confidence
Fresno	Clinical	Children's FSP Progress Review		
		Periodic clinical progress reviews in children's FSPs programs		
		Outcomes	First Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP FUM		
		Real-time, centralized referrals from the ED, including alerts for high risk, urgent needs, and social determinants of health		
		Quality	Developed in a Prior Year	No Confidence
Glenn	Clinical	P.A.W.S: Pets Advocacy Wellness and Support Group		
		Animals to engage FSP youth in group rehabilitation services		
		Outcomes	First Remeasurement	Low Confidence
	Non-Clinical	BHQIP FUM		
		Work with MCPs for data sharing and conducting real time referral coordination with the local ED		
		Quality	Baseline Year	Moderate Confidence
Humboldt	Clinical	Improving Family Engagement and Functioning for Children and Youth through Family Therapy		
		A three-part training series was provided to clinicians to increase family engagement		
		Quality	Second Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP FUM		
		Expanded the existing HIE with local hospitals to eliminate fax of ED summaries		
		Quality	Implementation	Moderate Confidence
Imperial	Clinical	Increasing Access to Mental Health Services to 65+ Older Adult Population		
		Outreach and engagement services to older adults		
		Access	First Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP FUM		
		Enhance relationship with the two local hospitals; streamline the referral process; established a liaison		
		Quality	Second Remeasurement	Moderate Confidence
Inyo	Clinical	No PIP Submitted		
	Non-Clinical	BHQIP FUM		
		Increased multi-disciplinary team meetings		
		Quality	Implementation	Low Confidence

PIPs				
MHP	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating**
Kern	Clinical	Cognitive Behavioral Therapy (CBT) for Psychosis for Youth with Enhanced Outpatient Program (EOP) Symptoms		
		CBT for Psychosis for youth with early onset psychosis		
		Outcomes	Implementation	Low Confidence
	Non-Clinical	Quarterly Engagement Self-Care Raffle Basket		
		A raffle to incentivize members who keep three successive appointments		
		Access	Baseline Year	Low Confidence
Kings	Clinical	BHQIP FUM		
		Data exchange; referral management system with local EDs		
		Quality	Implementation	Low Confidence
	Non-Clinical	Urgent Conditions (at Intake)		
		An urgent care triage tool to ensure a standardized process		
		Timeliness	Completed	Moderate Confidence
Lake	Clinical	No PIP Submitted*		
	Non-Clinical	BHQIP FUM		
		A referral process from the ED that includes consent for automated text appointment reminders		
		Quality	Planning	Low Confidence
Lassen	Clinical	Institution of Educational Curriculum Prior to First Prescription of Medication to Improve Reported Understanding of Benefits and Side-Effects and Necessity for Ongoing Therapy		
		Increase medication education prior to prescription		
		Outcomes	Implementation	Low Confidence
	Non-Clinical	BHQIP FUM		
		A referral/screening tool to be used by ED staff		
		Quality	Implementation	Low Confidence
Los Angeles	Clinical	Improving Treatment Services for Individuals with Eating Disorders		
		Eating disorder training; consultation; best practice toolkit; integrated practice network		
		Quality	Completed	High Confidence
	Non-Clinical	BHQIP FUM		
		A mechanism for collaboration with the two EDs, including the HIE		
		Quality	Implementation	Low Confidence
Madera	Clinical	Crisis Mobile Unit Implementation		
		A new 24/7 crisis care mobile unit		
		Timeliness	Implementation	Moderate Confidence
	Non-Clinical	Centralized Appointment Scheduling Process		
		A centralized appointment scheduling process for members		
		Timeliness	Implementation	Low Confidence

PIPs				
MHP	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating**
Marin	Clinical	BHQIP FUM		
		Assertive outreach by peer staff; warm handoffs from the hospital social workers; plan for HIE		
		Quality	Implementation	Low Confidence
	Non-Clinical	Timeliness between Assessment and First Treatment Services		
		Clarify roles and expected timelines; conferencing between teams; eventual LOC tool		
		Timeliness	Second Remeasurement	Low Confidence
Mariposa	Clinical	Psychiatry Appointment No Shows		
		Provide case management to link clients to transportation resources		
		Access	Completed	Low Confidence
	Non-Clinical	Phone Services		
		Virtual meeting rooms embedded in the EHR		
		Quality	Planning	No Confidence
Mendocino	Clinical	Youth LOC		
		Additional time to discuss identification of symptoms and strategies during family sessions		
		Outcomes	Implementation	Low Confidence
	Non-Clinical	BHQIP FUM		
		Resumed meetings with the ED, wellness centers, and crisis team to improve the follow-up referral process		
		Quality	Implementation	Low Confidence
Merced	Clinical	Post Hospitalization PIP		
		Improve communications with hospitals; twice-weekly post-hospitalization clinic		
		Quality	Completed	High Confidence
	Non-Clinical	BHQIP FUM		
		Standardize procedures for referrals via closed loop platform; use of an HIE		
		Quality	First Remeasurement	Moderate Confidence
Modoc	Clinical	BHQIP FUM		
		Care coordination via appointment reminder, data exchange, and referral tracking system		
		Quality	Baseline Year	Moderate Confidence
	Non-Clinical	No PIP Submitted*		
Mono	Clinical	Vitamin D Deficiency Case Management Linkage		
		Education on the benefits of vitamin D supplements		
		Outcomes	Implementation	Moderate Confidence
	Non-Clinical	BHQIP FUM		
		Referral process and coordination, including alerts for high-risk clients		
		Quality	First Remeasurement	Moderate Confidence

PIPs				
MHP	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating**
Monterey	Clinical	Stanley Brown Safety Plan		
		Implement the Stanley Brown Safety Plan		
		Outcomes	Implementation	No Confidence
	Non-Clinical	BHQIP FUM		
		Communication; referral process and tracking; formed a dedicated care team		
		Quality	Second Remeasurement	Low Confidence
Napa	Clinical	Enhancing Engagement in Psychosocial Care for Children/Youth on Psychotropic Medication		
		An educational sheet focused on youth psychosocial care concurrent with psychotropic medication		
		Outcomes	First Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP FUM		
		In-person linkage at the ED for referral procedure from the MCP; tracking system		
		Quality	Implementation	Moderate Confidence
Nevada	Clinical	BHQIP FUM		
		A FUM tracking tool and outreach efforts		
		Quality	First Remeasurement	Low Confidence
	Non-Clinical	Increasing Service Capacity Through Clinical Intern Staffing		
		An intern program for youth services		
		Access	Second Remeasurement	High Confidence
Orange	Clinical	Rehospitalization Reduction in Children/Youth After First Hospitalization		
		An FSP service referral option for new youth members after discharge from their first inpatient episode		
		Quality	Second Remeasurement	Low Confidence
	Non-Clinical	Improving Adults' Timely Access to Mobile Crisis Support		
		Standardized assessment tool for safety concerns; co-response from law enforcement		
		Timeliness	Implementation	No Confidence
Placer/ Sierra	Clinical	BHQIP FUM		
		Information exchange with the ED; referrals and follow-up scheduling		
		Quality	Planning	No Confidence
	Non-Clinical	Sexual Orientation Gender Identity and the Beneficiary Experience in Adult System of Care Mental Health Clinics		
		Asking and using member sexual orientation, gender identity, and preferred pronouns		
		Quality	Second Remeasurement	Moderate Confidence
Plumas	Clinical	No PIP Submitted*		
	Non-Clinical	BHQIP FUM		
		A simplified referral tool		
		Quality	Implementation	Low Confidence

PIPs				
MHP	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating**
Riverside	Clinical	Responding to the Whole Person by Assessing Social Determinants of Health		
		Assessing social determinants of health in an adult clinic		
		Access	Baseline Year	Moderate Confidence
	Non-Clinical	BHQIP FUM		
		Data exchange; welcoming packets at inpatient discharge		
		Quality	Second Remeasurement	Moderate Confidence
Sacramento	Clinical	Racial Equity Action Plans		
		A new training on racial inequities in treatment		
		Outcomes	Completed	Low Confidence
	Non-Clinical	Admissions at Provider Site		
		Weekly assessment clinics including assignment to a clinician		
		Timeliness	Completed	Low Confidence
San Benito	Clinical	Improve Engagement and Retention of Clients for Continued Treatment		
		An orientation to services group facilitated by case managers		
		Outcomes	Planning	Low Confidence
	Non-Clinical	BHQIP FUM		
		A referral tracking system that allows for real-time referral coordination from the ED and care coordinators		
		Quality	Second Remeasurement	High Confidence
San Bernardino	Clinical	Improving the attitudes of Department of Behavioral Health Mental Health Providers towards Metabolic Syndrome Management among Serious Mental Illness Patients		
		Continuing education for prescribers on metabolic monitoring		
		Outcomes	Planning	No Confidence
	Non-Clinical	BHQIP FUM		
		Data sharing; embedded navigators; Enhanced Care Management		
		Quality	Implementation	Moderate Confidence
San Diego	Clinical	Improved Therapeutic Support for Youth Members who Identify as LGBTQ+		
		Resource website improvement; systemwide clinical training on LGBTQ+		
		Quality	Implementation	Moderate Confidence
	Non-Clinical	Improving the Experience of Teletherapy for Older Adults		
		In-person training for older adult members on the use of telehealth		
		Quality	Implementation	Moderate Confidence
San Francisco	Clinical	Adapt a LOC Tool to Support Clients Getting to the Right LOC		
		A workgroup to develop a LOC tool		
		Timeliness	Planning	Moderate Confidence
	Non-Clinical	Hiring a Culturally Congruent Workforce		
		A job description that was specifically inclusive of African American lived experience		
		Quality	Implementation	Moderate Confidence

PIPs				
MHP	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating**
San Joaquin	Clinical	BHQIP FUM		
		Education and promotion; closed-loop referrals; centralized follow-up		
		Quality	Implementation	High Confidence
	Non-Clinical	Intensive Home-Based Services Expansion		
		Prioritize IHBS services; more effective family engagement practices; automated screening/referrals		
		Access	Completed	High Confidence
San Luis Obispo	Clinical	Martha's Place Fast Improved Access		
		Centralized access; CalAIM Youth Screening Tool; early case management with dedicated clinician		
		Access	First Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP FUM		
		Coordination with two EDs via clinician notifications; member outreach		
		Quality	First Remeasurement	Low Confidence
San Mateo	Clinical	Improving Clinically Focused Demographic Data Collection		
		Updated assessment and intake forms; new clinical trainings		
		Outcomes	Implementation	No Confidence
	Non-Clinical	BHQIP FUM		
		ED data exchange with automated alerts to notify clinicians		
		Quality	Implementation	Low Confidence
Santa Barbara	Clinical	Mental Health Treatment Court		
		Group therapy sessions; more member participation in treatment planning		
		Outcomes	Implementation	Low Confidence
	Non-Clinical	BHQIP FUM		
		Bilingual access line cards and referral tracking system		
		Quality	Second Remeasurement	High Confidence
Santa Clara	Clinical	BHQIP FUM		
		Peer Navigator outreach and provide informational materials		
		Quality	Implementation	Moderate Confidence
	Non-Clinical	Improving the 24/7 Access Call Line Efficiency		
		An updated 24/7 line procedure with supervisor oversight		
		Timeliness	Second Remeasurement	Moderate Confidence
Santa Cruz	Clinical	No-Show PIP		
		An operational definition and universal protocol established and clinical care teams trained		
		Access	Planning	Moderate Confidence
	Non-Clinical	BHQIP FUM		
		An HIE with processes for clinician alerts, daily discharge reports, and closed-loop referrals		
		Quality	Implementation	Moderate Confidence

PIPs				
MHP	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating**
Shasta	Clinical	Applied Behavioral Analysis: Improving Functioning of Youth Experiencing Anxiety		
		Application of applied behavioral analysis for anxiety		
		Outcomes	Second Remeasurement	Low Confidence
	Non-Clinical	Decreasing No-Show Rates for Adult Services Outpatient Psychiatric Provider Appointments		
		Educating members about adherence to psychiatric appointments and transportation options		
		Access	Second Remeasurement	Moderate Confidence
Siskiyou	Clinical	CBT Diversion Group		
		CBT in conjunction with SUD treatment		
		Outcomes	First Remeasurement	Low Confidence
	Non-Clinical	BHQIP FUM		
		Collaboration with the MCP		
		Quality	First Remeasurement	No Confidence
Solano	Clinical	BHQIP FUM		
		Data exchange and dedicated referrals team		
		Quality	Implementation	Moderate Confidence
	Non-Clinical	Youth Psychiatry Timeliness		
		Increased psychiatry staff and holding intake slots		
		Timeliness	Implementation	Low Confidence
Sonoma	Clinical	Enhancing Community Connection and Living Skills for High-Cost Beneficiaries		
		The Strengths Model case management approach		
		Outcomes	First Remeasurement	Low Confidence
	Non-Clinical	BHQIP FUM		
		A system for referrals and follow-up from the EDs, including care navigators and trainings for ED staff		
		Quality	First Remeasurement	Low Confidence
Stanislaus	Clinical	BHQIP FUM		
		Coordination with the ED and utilizing the crisis team for outreach and case management		
		Quality	Implementation	Moderate Confidence
	Non-Clinical	Timeliness of Initial Psychiatric Medication Appointments		
		A standardized questionnaire for referrals to youth psychiatry services		
		Timeliness	Implementation	Moderate Confidence

Sutter-Yuba	Clinical	Improving Rates of Post-psychiatric hospitalization follow-up		
		A referrals process; training staff; monitoring new dashboards		
		Quality	Implementation	Low Confidence
	Non-Clinical	Follow-up After Psychiatric Emergency Services		
		Improved tracking and referral system; assertive outreach after crisis contact		
		Quality	Implementation	Low Confidence
Tehama	Clinical	No PIP Submitted*		
	Non-Clinical	No PIP Submitted*		
Trinity	Clinical	BHQIP FUM		
		Relationship with the local ED; HIE		
		Quality	Implementation	Low Confidence
	Non-Clinical	Reducing Wait Time to First Offered Appointment		
		Introducing care prior to assessment		
		Timeliness	Implementation	Low Confidence
Tulare	Clinical	Field-Based Backup Crisis Response for Young People		
		Field-based mobile crisis unit for youth		
		Access	Completed	High Confidence
	Non-Clinical	Mental Health Outreach to and Engagement with the Homeless		
		Increased outreach and engagement for the homeless		
		Access	Completed	Moderate Confidence
Tuolumne	Clinical	Supportive Housing		
		House case managers, a process to submit concerns, and collaboration meeting		
		Access	Implementation	Moderate Confidence
	Non-Clinical	BHQIP FUM		
		Increased ED data exchange; case management; updated training and policies		
		Quality	First Remeasurement	Low Confidence
Ventura	Clinical	Screening and Identification of Psychosis Symptoms in TAY		
		A psychosis screening checklist at the point of referral		
		Access	Planning	No Confidence
	Non-Clinical	BHQIP FUM		
		Coordination with the ED; trainings about mental health services for hospital staff		
		Quality	Baseline Year	Low Confidence
Yolo	Clinical	No PIP Submitted		
	Non-Clinical	BHQIP FUM		
		Establishing an HIE; assign staff to engage and screen members seen at ED		
		Quality	Planning	No Confidence

* No PIP was submitted; no validation could be conducted.

TRENDS IN PIP SUBMISSIONS

Eight MHPs did not meet the requirement to submit two PIPs for validation. Five MHPs (Inyo, Lake, Modoc, Plumas, and Yolo) submitted one PIP (the BHQIP), and no PIPs were submitted by Alpine, Del Norte, and Tehama. When MHPs did not submit two PIPs, the MHP Director was requested to provide a letter acknowledging the lack of submission and explaining the

associated reasons. This letter is included as Attachment E in the Plan level reports. MHPs cited competing priorities with reduced staff available to oversee or implement PIPs. There were also environmental issues (e.g., fire or flood response) that required prioritization and repurposing of staff over the PIP submissions. Additionally, with a limited workforce due to vacancy rates, MHPs often lack the technical expertise required for thorough analysis and may face difficulties extracting critical information from EHRs, particularly when QM staff are either vacant or diverted to other tasks. Further, PIPs that depended on staff entering information into spreadsheets were hindered by staff departures and inconsistent attention from those involved.

Most MHPs (73 percent) submitted the BHQIP PIP, representing a 59 percent increase compared to the 46 percent of MHPs that submitted it for FY 2022-23.

Overall, CalEQRO experienced decreased levels of confidence in the PIPs that were submitted. During the FY 2023-24 review year, only nine PIPs received a High Confidence rating; 50 percent of all PIPs submitted received a confidence rating of Moderate or High Confidence, a decrease from 60 percent in the prior year. Lower confidence rates, it is important to note, may be for a number of reasons: an incomplete or inadequate PIP plan (or its documentation), poor results indicating that the interventions did not result in improvement, or the stage of implementation such that there is no way to tell yet if the intervention(s) planned will have an improvement effect. Nevertheless, some technical challenges persist, particularly in obtaining sufficient baseline data and linking project outcomes to the interventions. However, MHPs reported a greater understanding of and ability to implement PIPs.

PIP TECHNICAL ASSISTANCE

CalEQRO provides TA to all MHPs through various channels, including during reviews, via e-mail, telephone, video, and webinars. The purpose of the TA is to assist MHPs in producing qualified PIPs. This support ranges from helping to develop measurable aim statements to providing a comprehensive evaluation of all PIP validation steps.

In FY 2023-24, 35 MHPs (63 percent) utilized TA from CalEQRO for developing and implementing their PIPs. This represents a decrease from 41 MHPs (73 percent) in FY 2022-23 and 40 MHPs (71 percent) in FY 2021-22. Many MHPs submitting BHQIP relied on the CalMHSA team for data and analysis, and therefore sought related TA from them. This largely explains the decrease in MHPs requesting PIP TA, but there may also have been gaps in staff tracking their TA time.

CalEQRO provided a total of 63 hours of individual TA to the 35 MHPs in FY2023-24, averaging 1.8 hours of TA per MHP. Common areas for TA included root cause analysis, baseline determination, and providing feedback on proposed topics or study questions. Many MHPs struggled to design and implement PIPs that integrate with their overall QM practices. Instead, they often created stand-alone projects that were difficult to prioritize and sustain. Additionally, substantial TA was provided to help MHPs collect and use data to design PIPs targeting specific problems within their Plans or communities.

In addition to the TA described, CalEQRO supplemented its support with PIP clinic webinars and an in-person presentation. The subjects and presentation formats of each PIP TA provided are shown in Table 7-7.

Table 7-7: TA Provided via PIP Presentations by CalEQRO, FY 2023-24

Title of Presentation	Format	Date
PIPs – Opportunities and Lessons to Date	Webinar	September 28, 2023
PIP Designs to Emulate	Webinar	December 18, 2023
Annual Technical Report – MHP Strengths and Recommendations	In-person	March 13, 2024

CalEQRO conducted three TA sessions as presentations with opportunities for questions. Two PIP webinars focused on assisting MHPs with developing PIPs related to the DHCS BHQIP initiative. A third presentation was delivered at the annual QI Coordinator's conference, discussing common PIP challenges and solutions based on findings from the FY 2022-23 Annual Technical Report.

SUMMARY OF PIP VALIDATION

In summary, MHPs submitted a total of 101 PIPs for the FY 2023-24. The vast majority of PIPs had entered the implementation phase, with nearly 80 percent having either begun at least one intervention with results or started measuring post-intervention outcomes. In FY 2023-24, the most common domain for PIPs was quality of care, accounting for 53 percent of all submitted PIPs. Fewer PIPs were considered completed by the MHPs at the time of the review compared to prior years.

Despite an increase in the number of PIPs in the implementation and remeasurement phases, the number of PIPs receiving Low or No Confidence ratings rose to 51 in FY 2023-24, compared to 30 in FY 2022-23 and 47 in FY 2021-22. Similarly, only 9 PIPs received a High Confidence rating.

CalEQRO received 41 PIP submissions in response to the CalAIM BHQIP initiative. Receiving credit from both DHCS for the CalAIM incentive and CalEQRO for the PIP was highly motivating for participation. Despite being in the second year of implementation, many of these PIPs were still in the early stages of their execution. Meaningful interventions being applied included the use of peer navigators in the EDs, improved coordination between MHPs and EDs, and assertive follow-up after the ED visit. Plans were actively working to navigate the inherent complexities of establishing necessary collaborations and eventually data exchanges with EDs and MCPs.

Nine MHPs (Alpine, Del Norte, Fresno, Inyo, Lake, Modoc, Plumas, Tehama, and Yolo) did not meet the requirement of submitting two PIPs for validation. This is an increase from prior years. MHPs reported that the shortfall in PIP submissions was due to workforce shortages and the simultaneous demands of addressing various aspects of CalAIM.

Some technical aspects of PIPs continue to present challenges, particularly in data collection and analysis, and in allocating sufficient resources to conduct all required components of a PIP. These underlying obstacles related to fundamental staffing infrastructure are similarly noted throughout this report. Despite these barriers, MHPs worked hard to implement projects that positively impact access, timeliness, quality, and outcomes of SMHS for members.

Validation of Members' Perceptions of Care

INTRODUCTION

The voices of members and their families are a crucial component of the CalEQRO review process and arguably the ultimate measure of a mental health system's success. Feedback on services provides crucial insights into access, timeliness, quality, and outcomes. Member and family involvement in the EQR process enhances CalEQRO's findings and brings valuable firsthand knowledge that can significantly impact the success of the local mental health system. This feedback can greatly inform service performance assessments, highlight areas for further analysis, and influence QI efforts. Focus groups are used in every MHP review to gather detailed feedback on members' treatment experiences, including their entry into care, assessing timeliness and overall access.

This chapter also includes member perspectives from the annual CPS data compiled by DHCS's contractor, UCLA's Integrated Substance Abuse Programs, as well as from the member focus groups conducted by CalEQRO during the reviews. The CPS consists of standardized questions administered annually to all members in treatment during the survey week, as required by Section 3530.40 of Title 9 of the California Code of Regulations due to California's receipt of mental health block grant funding.

This chapter aims to present member feedback by highlighting the strengths and areas for improvement of the MHPs from the members' perspectives. A set of recommendations based upon the overall findings is included.

PLAN MEMBER AND FAMILY FOCUS GROUPS

The PMF focus group is an EQR evaluation method that gathers a small group with specified demographic traits or service experiences to answer questions in a moderated setting. At least one PMF focus group is requested for every EQR, with participants invited to join either virtually or in person during on-site reviews. To thank participants for their time and input, CalEQRO offers gift cards to those in the focus groups.

The PMF focus group is facilitated by a CalEQRO reviewer who is either a recipient of mental health services or a family member and includes another CalEQRO staff member who takes notes during the session. The group is designed to evaluate MHP services over the past year, focusing on timely access to care, recovery, cultural competence, improved outcomes, peer involvement and integration, as well as addressing any issues identified in the previous year's EQR report.

CalEQRO recommends that MHP staff recruit 12 to 16 participants for the focus group to account for potential attrition, aiming for a final group size of 6 to 12 participants. This approach ensures sufficient variation in experiences and allows for diverse or contrasting opinions on services. Fewer participants may result in less diversity and richness of experiences and feedback. To ensure confidentiality, a minimum of three participants are required for the focus group, and the written report must omit any identifying characteristics.

Focus Group Results

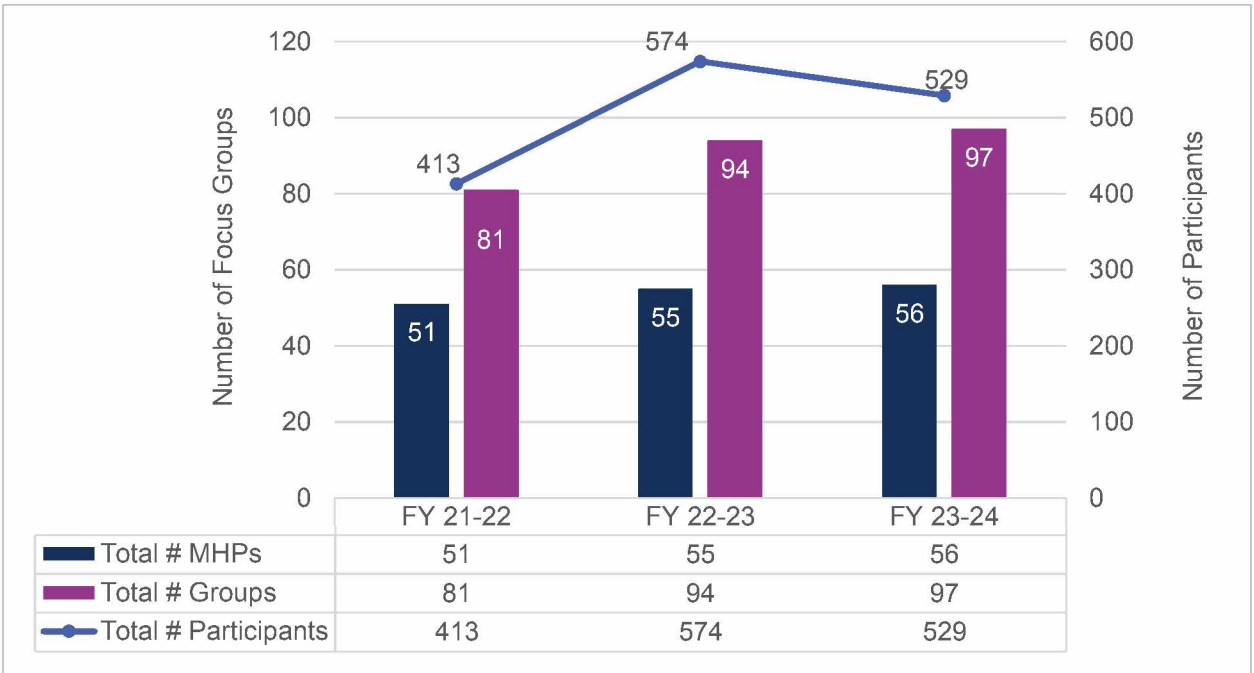
For FY 2023-24, 97 focus groups were conducted across 56 MHPs. Three more groups were held than last year. Nearly 85 percent (n=82) were conducted by videoconference, twelve were conducted on-site, and three used a hybrid model with both on-site and videoconference participants. After more than 4 years of videoconference communication due to COVID-19, participants were generally comfortable with the format, and most members opted to be visible on screen during the focus group.

Small and small-rural counties held one focus group each, medium counties held two, large counties held three, and Los Angeles held four. The focus groups were attended by 529 participants. The most frequently requested group was adults (n=53), followed by parents/caregivers of youth members (n=23). The largest group requested was a diverse set of primarily adult participants who had started services within the past year. Fifty-four such groups were held across 51 MHPs, including four in two service areas in Los Angeles. This was followed by 22 groups of parents of youth receiving services in 21 MHPs, primarily involving those who had started services in the past year or so. Additional groups included seven with family members of adults in treatment, six with TAY members, three Spanish-speaking adult groups, one group for Vietnamese speakers in Orange, and one group for Khmer speakers in Los Angeles. CalEQRO did not capture demographic data such as race/ethnicity, gender, preferred language, and age of participants due to the videoconferencing format.

Although only eight groups specifically requested Latino and Asian/Pacific Islander participants, the broader request for diverse groups led to a total of 20 groups requiring interpreters for Spanish, Khmer, and Vietnamese. CalEQRO notes that the language diversity in the focus groups represents only a small fraction of the languages in which MHPs are prepared to deliver services, as outlined in the Access Chapter.

Figure 8-1 illustrates focus group participation over the past 3 FYs.

Figure 8-1: Plan Member/Family Focus Group Participation, FY 2021-24



During the height of the pandemic, focus group participation numbers decreased, as shown in Figure 8-1. However, FY 2022-23 saw a noticeable increase in both the number of groups held and the number of member participants. In FY 2023-24, the picture is mixed, with 8 percent fewer participants (n=529) but three more groups (n=97) compared to the previous year.

In FY 2023-24, MHPs averaged just under six individuals per focus group, with numbers ranging from one to thirteen participants. A total of 20 focus groups had fewer than three participants in attendance. The number of MHPs hosting focus groups returned to pre-pandemic levels, with all 56 MHPs hosting at least one focus group this review cycle. This is a notable improvement compared to FY 2021-22, when five MHPs did not host any focus groups.

Themes

Members and families who participated in the focus groups generally reported satisfaction with MHP services. Participants' positive perceptions were based on feeling supported in their care, having a voice in their treatment, and working with caring and committed staff.

Members new to services and/or their families generally had positive perceptions of the initial entry into services. They typically received a timely assessment within 1 or 2 weeks, though longer wait times for psychiatry or ongoing services with a clinical provider were not uncommon. In a few MHPs, there were complaints about long wait times for initial services. Participants continued to note staff turnover in many MHPs, feeling it contributed to increased wait times and reduced frequency of services. Members frequently expressed concerns about staff burnout and the need to hire more staff to "lower caseloads". Members in several MHPs also specifically mentioned concerns about psychiatry staffing. At the same time, many praised their providers, saying things like "our therapist has gone above and beyond," and "services have been a godsend. I can't thank them enough."

Wellness centers were generally referenced positively, especially those that employed peer providers. Members in one MHP requested more activities and extended hours at the wellness center. Overall, feedback on peer staff was positive, with members expressing a desire for more opportunities to be hired in peer roles or to participate on committees. Responses regarding crisis care were mixed; while most participants knew what to do or who to call in a crisis, some were unsure or lacked clear guidance. In several MHPs where the mobile crisis benefit was already implemented, members expressed great satisfaction, noting significantly improved experiences compared to previous crisis interventions.

The importance of transportation was frequently discussed; in many MHPs, some group members discovered during the focus group that the MCP provides a transportation benefit. Telehealth was generally seen as positive and helpful in overcoming transportation barriers. However, some members reported that their telehealth sessions were shorter than in-person ones, and there were mixed preferences, with some members wanting more in-person services while others preferred telehealth. Additionally, members frequently cited the need for more support and assistance in obtaining stable, affordable housing.

Many members recalled completing satisfaction surveys, but most were unaware of other opportunities to participate in system planning or provide feedback. They generally enjoyed providing feedback to CalEQRO, appreciated being asked for their input, and often expressed a desire to participate again in the future.

Plan Member and Family Recommendations

Participants highlighted the need for additional staff in several roles, including bilingual workers, case managers, psychiatrists and peer specialists. Members and their families recognized the staffing challenges and supported enhanced recruitment and employee wellness initiatives to improve retention.

Participants requested an increase in the following services:

- Group therapy sessions and support groups
- Family-oriented treatment, especially services provided at schools
- Case managers to assist with system navigation
- Outreach and education efforts targeting the homeless, teachers, and social media platforms
- Parent Partners
- Wellness centers, with a focus on services for youth
- Housing for individuals with mental health conditions
- Flexible scheduling
- Employment assistance
- In-home services instead of clinic-based services
- In-person psychiatry rather than telehealth
- Enhanced collaboration with Child Welfare
- Increased training for law enforcement
- Information about other available services

CONSUMER PERCEPTION SURVEYS

The statewide CPS is an evaluation method used to gather stakeholder perceptions of care and is required by CMS for states receiving block grant funding. To meet this requirement, DHCS mandates that the CPS survey assess satisfaction with various service elements, using convenience sampling of members who receive outpatient services during the week specified by DHCS. The CPS comprises three age-specific surveys (youth, adult, older adult) and one family survey for parents or caregivers of youth members. All survey types assess the following domains: General Satisfaction, Quality and Appropriateness, Access and Participation in Treatment Planning, Improved Functioning, Outcomes, and Social Connectedness. By using the same surveys statewide, the CPS offers a consistent metric for evaluating member perceptions of care across various MHPs.

In 2023, the CPS was conducted from May 15 to May19, 2023. Members could complete the survey either on paper, before or after receiving mental health services in a clinic or elsewhere, or electronically through an online survey portal. Both the paper and online surveys were available in English and all twelve threshold languages: Spanish, Chinese, Tagalog, Farsi, Arabic, Russian, Hmong, Korean, Eastern Armenian, Western Armenian, Vietnamese, and

Cambodian. The 2023 CPS data were collected and analyzed by DHCS's contractor, UCLA's Integrated Substance Abuse Programs.

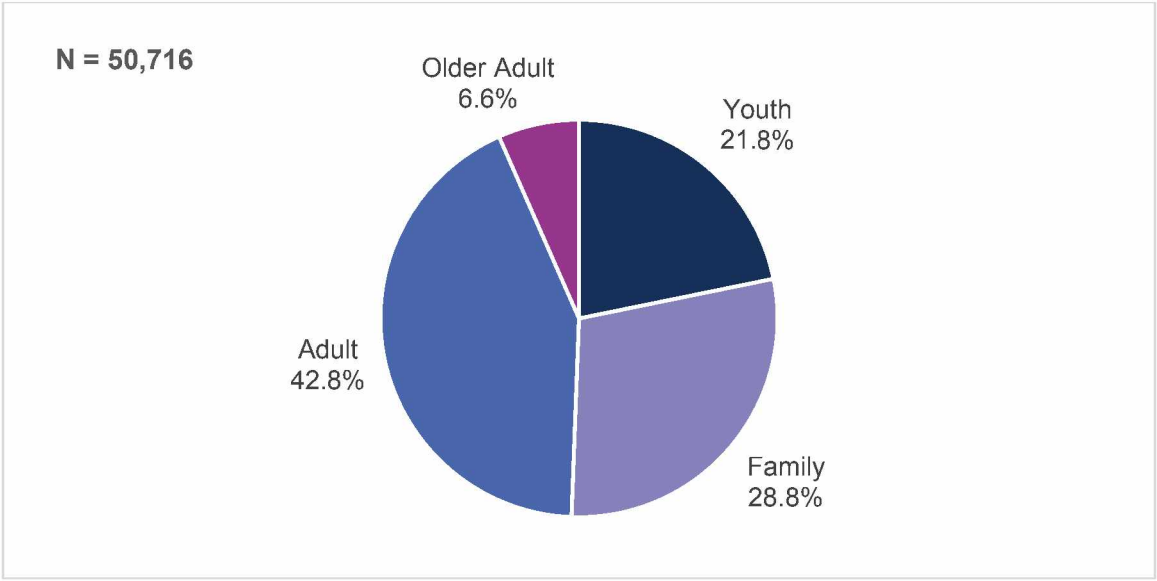
MHPs administer four surveys for the following member categories: Adult, Older Adult, Youth, and Families of Children and Youth.[41] Adult and Older Adult members receive the Mental Health Statistics Improvement Project survey. Youth members receive the Youth Satisfaction Survey, while Families of Children and Youth receive the family version of the survey.

All member perception items are rated on a 5-point Likert scale with additional coding options for "Not Applicable" and "Missing". The scale is as follows: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree.

Survey Participation

In CY 2023, DHCS received 50,716 surveys from all MHPs, representing a 27.2 percent increase (n=39,860) from the previous year. The majority of the submitted surveys were completed by adults, followed by families of children and youth, as shown below in Figure 8-2. The full UCLA report on the 2023 survey results is available online.[42]

Figure 8-2: Surveys Received by Survey Type, CY 2023

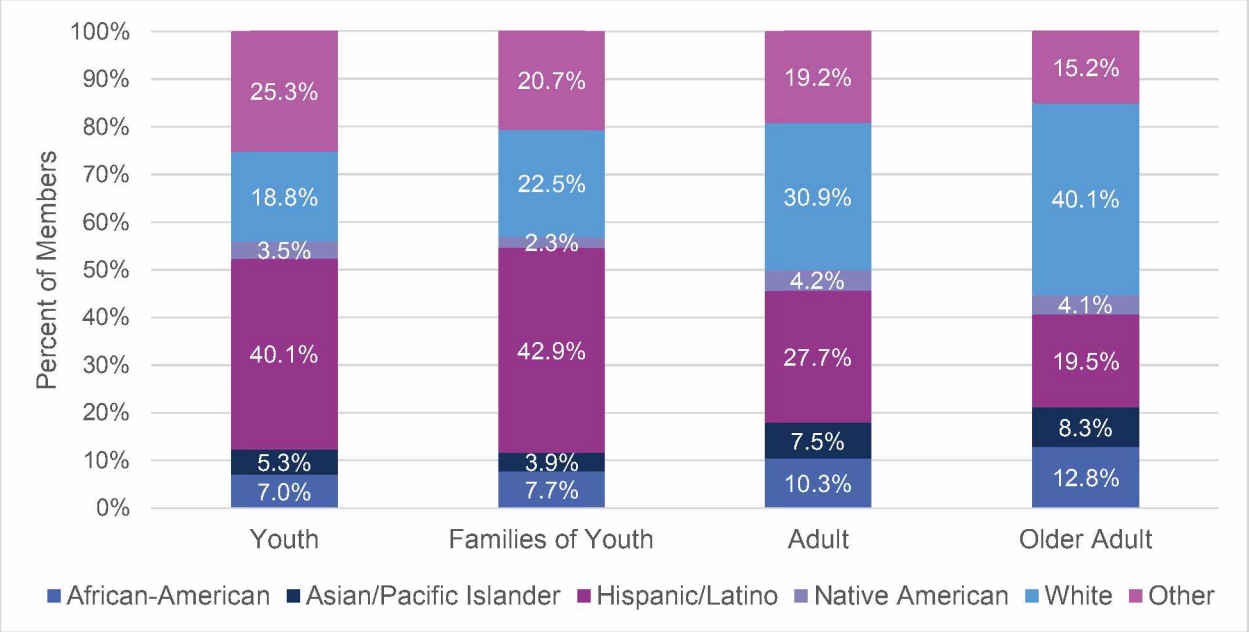


[41] UCLA Integrated Substance Abuse Programs. (2024). *CA consumer perception survey (CPS) - Mental health (MHSIP)*. https://www.uclaisap.org/mh-consumer-perception-survey.html

[42] Ibid.

Figure 8-3 displays the percentage of each survey type by the racial/ethnic category identified by the participant.

Figure 8-3: Race/Ethnicity by Survey Type, CY 2023

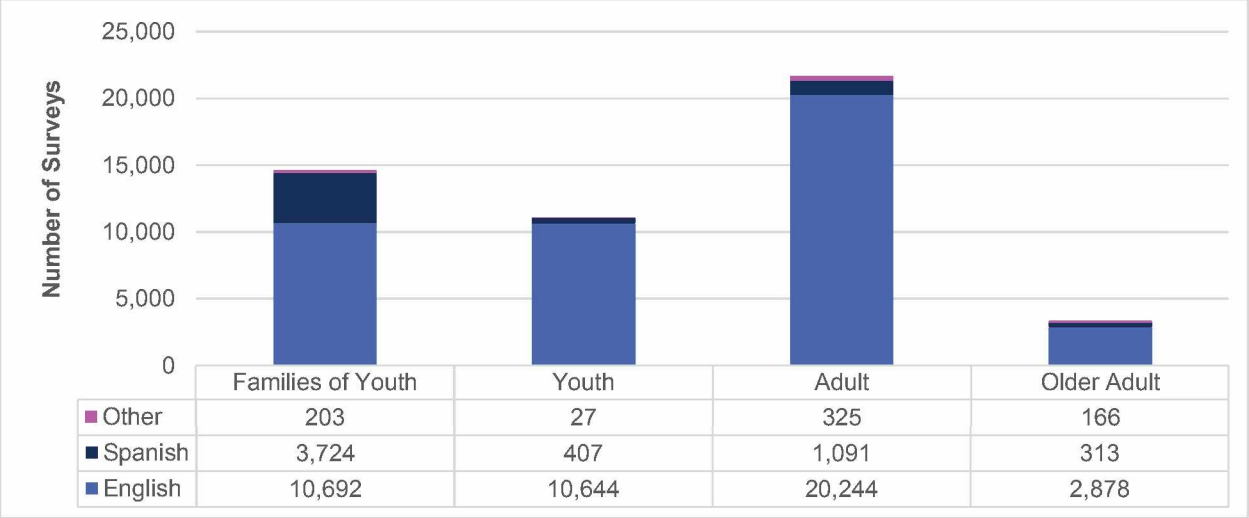


The surveys included a cross-section of members and families from various racial/ethnic groups. For Youth and Families of Youth, the highest percent of surveys received was from the Hispanic/Latino population. For Adults and Older Adults, the highest percentage of surveys received was from the White population, followed by Hispanic/Latino. For all surveys, the lowest percentage of responses came from the Native American population, followed by the Asian/Pacific Islander population.

Across all surveys, 40.1 percent of responses were from Hispanic/Latino respondents, though this is not displayed. This is followed by Other (25.2 percent), White (18.8 percent), African American (7.0 percent), Asian/Pacific Islander (5.3 percent), and Native American (3.5 percent).

Figure 8-4 shows the number of surveys completed in English, Spanish, and other threshold languages.

Figure 8-4: Surveys Received in Primary Threshold Language, CY 2023



	Families of Youth	Youth	Adult	Older Adult
Other	203	27	325	166
Spanish	3,724	407	1,091	313
English	10,692	10,644	20,244	2,878

The CPS were predominantly completed in English (87.6 percent), followed by Spanish (10.9 percent). The remaining 1.5 percent of surveys were completed in other languages, including Armenian, Chinese, Hmong, Korean, Tagalog and Vietnamese. There was a 1.0 percentage point decline in the number of non-English and non-Spanish surveys in CY 2023 compared to CY 2022. For survey administration, both the paper and online surveys were available in all twelve threshold languages in the state.

Response Rate

The response rate was calculated by first counting the number of survey types submitted. Secondly, the denominator was created by analysis of approved claims for the week the survey was conducted. Each member served that week was counted once regardless of how many times they were served that week.

The response rate for each survey type for each year is shown in Table 8-1.

Table 8-1: CPS Response Rates, CY 2021-23

	Youth	Families of Youth	Adult	Older Adult
2021	19.4%	16.1%	25.6%	21.7%
2022	20.8%	17.6%	27.0%	20.0%
2023	26.8%	20.4%	31.9%	23.2%

In 2023, the response rate for all four survey types increased, especially for youth which showed a 6-percentage point (26.8 percent) increase over the 2022 response rate. The other survey types increased between 2.8 percentage points (families of youth) and 4.9 percentage points (adults). Adults had the highest response rate with nearly one in three members served during the survey week submitting a survey. The next highest were youth followed by older adults, both of which had roughly one in four members served completing the survey. Families

of youth had one in five families participating; a lower family response rate is to be expected because families are not always present at appointments, especially for services conducted in schools – but participation by families of youth was greatest in 2023.

The 2023 response rates by MHP size are displayed below in Table 8-2.

Table 8-2: CPS Response Rates by MHP Size, CY 2023

	Youth	Families of Youth	Adult	Older Adult
Very Large	14.0%	15.3%	21.5%	19.3%
Large	35.3%	25.3%	35.7%	23.2%
Medium	32.0%	18.2%	41.5%	32.4%
Small	25.6%	17.2%	42.8%	32.7%
Small-rural	28.6%	17.5%	45.0%	28.6%

Los Angeles showed a much lower rate for all surveys than other size MHPs; except for older adults, it was half or less than the other size MHPs' response rates. Its low response rate is particularly apparent when examining youth and families of youth. Even though Los Angeles' response rates were low, one in four surveys was from Los Angeles.

Medium MHPs had a high rate of 41.5 percent for adults and a little lower at 32 percent for all other survey types. Small and small-rural MHPs had fairly similar rates, with the highest for adults at 42.8 percent and 45 percent, respectively.

The highest response rate was in small-rural MHPs for adults at 45 percent. The lowest was for youth at 14 percent in Los Angeles.

Adult and Older Adult Surveys

Table 8-3 presents the response rates for the 2023 administration of the CPS by MHP. The denominator is the number of possible surveys (unduplicated count of members served), calculated by CalEQRO from approved claims for outpatient services during the week of the survey.

Table 8-3: CPS Response Rates by MHP, CY 2023

2023 CPS Response Rates						
MHP	Adults			Older Adult		
	Surveys Completed	Members Served	Response Rate	Surveys Completed	Members Served	Response Rate
Alameda	823	2,565	32.1%	105	529	17.4%
Alpine	0	[redacted]	0.0%	0	16	0.0%
Amador	23	75	30.7%	[redacted]	0	[redacted]
Butte	497	605	82.1%	78	146	53.4%
Calaveras	56	99	56.6%	14	17	82.4%
Colusa	24	67	35.8%	[redacted]	-	[redacted]
Contra Costa	242	1,892	12.8%	61	500	12.2%

2023 CPS Response Rates						
MHP	Adults			Older Adult		
	Surveys Completed	Members Served	Response Rate	Surveys Completed	Members Served	Response Rate
Del Norte	[redacted]	-	[redacted]	0	11	0.0%
El Dorado	55	165	33.3%	[redacted]	22	[redacted]
Fresno	196	2,321	8.4%	58	309	18.8%
Glenn	57	95	60.0%	[redacted]	[redacted]	[redacted]
Humboldt	77	350	22.0%	[redacted]	77	[redacted]
Imperial	128	566	22.6%	46	69	66.7%
Inyo*	25	19	131.6%	[redacted]	6	[redacted]
Kern	283	2,172	13.0%	0	340	0.0%
Kings	102	288	35.4%	[redacted]	-	[redacted]
Lake	103	107	96.3%	13	-	72.2%
Lassen	53	79	67.1%	[redacted]	-	[redacted]
Los Angeles	5,002	23,271	21.5%	986	5,099	19.3%
Madera	170	188	90.4%	[redacted]	-	[redacted]
Marin	204	379	53.8%	61	185	33.0%
Mariposa	34	68	50.0%	[redacted]	-	[redacted]
Mendocino	165	393	42.0%	21	89	23.6%
Merced	287	554	51.8%	13	90	14.4%
Modoc	[redacted]	-	[redacted]	0	16	0.0%
Mono*	-	[redacted]	[redacted]	[redacted]	0	0.0%
Monterey	90	1,111	8.1%	31	193	16.1%
Napa	112	128	87.5%	13	25	52.0%
Nevada	80	231	34.6%	25	73	34.2%
Orange	1,133	2,200	51.5%	[redacted]	331	3.3%
Placer-Sierra	201	402	50.0%	45	64	48.4%
Plumas	30	45	66.7%	[redacted]	-	[redacted]
Riverside	687	3,267	21.0%	102	677	15.1%
Sacramento	986	2,404	41.0%	187	523	35.8%
San Benito	22	98	22.4%	[redacted]	[redacted]	[redacted]
San Bernardino	1,204	2,203	54.7%	255	399	63.9%
San Diego	2,415	4,149	58.2%	212	752	28.2%
San Francisco	1,485	2,082	71.3%	295	855	34.5%
San Joaquin	470	1,160	40.5%	55	195	28.2%
San Luis Obispo	178	510	34.9%	49	75	65.3%
San Mateo	177	1,185	14.9%	61	459	13.3%
Santa Barbara	204	666	30.6%	68	206	33.0%
Santa Clara	1,243	3,950	31.5%	149	734	20.3%

2023 CPS Response Rates						
MHP	Adults			Older Adult		
	Surveys Completed	Members Served	Response Rate	Surveys Completed	Members Served	Response Rate
Santa Cruz*	329	328	100.3%	33	116	28.4%
Shasta	80	223	35.9%	26	52	50.0%
Siskiyou	54	141	38.3%	[redacted]	-	[redacted]
Solano	212	499	42.5%	38	110	34.5%
Sonoma	217	451	48.1%	31	110	28.2%
Stanislaus	246	680	36.2%	31	119	26.1%
Sutter-Yuba	179	261	68.6%	29	52	55.8%
Tehama	31	90	34.4%	[redacted]	-	[redacted]
Trinity	16	40	40.0%	0	14	0.0%
Tulare	342	1,026	33.3%	21	94	22.3%
Tuolumne	64	107	59.8%	0	31	0.0%
Ventura	455	1,527	29.8%	63	346	18.2%
Yolo	84	229	36.7%	17	40	42.5%
Total	**21,654**	**67,833**	**31.9%**	**3,357**	**14,381**	**17.4%**

* When response rates are higher than 100 percent, MHPs either had denied claims for a member who completed a survey, or surveys were submitted by individuals who are not Medi-Cal eligible.

Note: --Due to HIPAA-related considerations, counts less than 11 (<11) and associated numbers that can be used to identify those counts through calculation (-) were suppressed.

Adult Surveys

Represented above in Table 8-3, adults submitted 21,654 surveys with a statewide response rate of 31.9 percent. The median MHP response rate was 37.5 percent. Large MHPs were represented by 54.5 percent of the surveys, in addition to 23.1 percent from Los Angeles. After Los Angeles, the largest numbers of surveys were from large MHPs in descending order: San Diego, San Francisco, Santa Clara, San Bernardino, Orange, Sacramento, Alameda, and Riverside. In addition, large MHPs, Kern, Contra Costa, and Fresno submitted numbers more aligned with much smaller, medium MHPs. However, overall, nearly three-quarters of all adult surveys were from Los Angeles and other large MHPs.

Small and small-rural MHPs were represented by 8.1 percent of the surveys and medium MHPs delivered 14.3 percent of the adult surveys. Lake and Madera, both small MHPs, had response rates greater than 90 percent. Alpine, Modoc, and Del Norte had response rates lower than 10 percent. As a small MHP, Sutter-Yuba submitted the highest number of surveys among small MHPs. Glenn was most successful among small-rural MHPs with a 60 percent response rate. Also small-rural, Inyo and Mono's response rates are much greater than 100 percent, likely due to submitting surveys for individuals who are not Medi-Cal eligibles. However, several small-rural MHPs had very low response rates, but their number of possible surveys was also comparatively small. The number of surveys and members served cannot be displayed for some of the smaller Plans, though their response rate is included.

San Francisco had the highest response rate of all large MHPs at 71.3 percent, followed by San Diego at 58.2 percent. The lowest large MHP response rate was Fresno (8.4 percent). Additionally, Kern and Contra Costa had response rates between 10 and 15 percent. The large MHP response rate was 35.7 percent and the median was 31.78 percent.

For medium MHPs, the response rate was 41.5 percent and the median rate was 42.5 percent. Santa Cruz had a response rate of 100 percent, and also very successful was Butte at 82.2 percent – Butte also submitted the most adult surveys of any medium MHP. The lowest response rate was 8.1 percent in Monterey.

Older Adult Surveys

The statewide response rate for the older adult survey was 23.3 percent. The median rate for MHPs was 18.4 percent. As shown earlier in Table 8-2, when considering MHPs by their sizes, older adult response rates ranged from 19.3 percent in Los Angeles to 32 percent in medium and small MHPs.

Large MHPs represented 48 percent of the adult surveys, and Los Angeles represented 29.3 percent. Small and small-rural represented only 7.4 percent and medium represented 15.1 percent of all older adult surveys.

The highest response rates were among small-rural MHPs – Amador, Glenn, and Inyo all at 100 percent (though a very small number of surveys). Seven MHPs had 0 percent response rates for the older adult survey, including large MHP Kern; the balance of MHPs were small and small-rural. Orange also had a very low response rate of 3.3 percent.

San Bernardino (63.9 percent) had the strongest response rate, by far, of large MHPs. All other large MHPs had rates of 36 percent or lower now. San Luis Obispo had the highest response rate of medium MHPs at 65.3 percent, followed by Butte at 53.4 percent.

Youth and Families of Youth Surveys

Table 8-4 presents the same information as Table 8-3 above for the youth surveys and families of youth. Again, the denominator for calculating the response rate is based upon the possible number of surveys which was calculated from the approved claims for the week of the survey.

Table 8-4: CPS Response Rates by MHP, Youth and Families of Youth, CY 2023

2023 CPS Response Rates						
MHP	Youth			Families of Youth		
	Surveys Completed	Members Served	Response Rate	Surveys Completed	Members Served	Response Rate
Alameda	392	1,501	26.1%	491	2,912	16.9%
Alpine	-	[redacted]	[redacted]	-	[redacted]	[redacted]
Amador	[redacted]	-	[redacted]	[redacted]	46	23.9%
Butte	150	407	36.9%	143	700	20.4%
Calaveras	12	43	27.9%	[redacted]	78	12.8%
Colusa	[redacted]	40	10.0%	13	67	19.4%
Contra Costa	257	1,121	22.9%	326	2,005	16.3%
Del Norte	[redacted]	44	2.3%	[redacted]	69	2.9%

2023 CPS Response Rates						
MHP	Youth			Families of Youth		
	Surveys Completed	Members Served	Response Rate	Surveys Completed	Members Served	Response Rate
El Dorado	47	111	42.3%	43	205	21.0%
Fresno	481	1,822	26.4%	218	3,237	6.7%
Glenn	34	78	43.6%	21	126	16.7%
Humboldt	33	197	16.8%	21	359	5.8%
Imperial	67	352	19.0%	156	638	24.5%
Inyo	[redacted]	-	[redacted]	[redacted]	32	25.0%
Kern	72	1,415	5.1%	164	2,316	7.1%
Kings	84	187	44.9%	96	296	32.4%
Lake	12	75	16.0%	[redacted]	127	[redacted]
Lassen	13	27	48.1%	[redacted]	47	[redacted]
Los Angeles	2,087	14,925	14.0%	4,104	26,783	15.3%
Madera	46	87	52.9%	50	131	38.2%
Marin	20	84	23.8%	20	137	14.6%
Mariposa	[redacted]	21	[redacted]	[redacted]	37	[redacted]
Mendocino	34	160	21.3%	24	281	8.5%
Merced	83	230	36.1%	97	344	28.2%
Modoc	0	19	0.0%	0	32	0.0%
Mono	[redacted]	[redacted]	[redacted]	0	0	0.0%
Monterey	56	543	10.3%	56	856	6.5%
Napa	26	91	28.6%	27	116	23.3%
Nevada	22	111	19.8%	41	181	22.7%
Orange	980	2,173	45.1%	1,021	3,066	33.3%
Placer-Sierra	12	80	15.0%	46	134	34.3%
Plumas	[redacted]	28	[redacted]	[redacted]	51	[redacted]
Riverside	847	2,231	38.0%	1,445	3,723	38.8%
Sacramento	486	1,627	29.9%	551	2,675	20.6%
San Benito	[redacted]	25	[redacted]	[redacted]	42	[redacted]
San Bernardino	1,005	2,092	48.0%	996	4,082	24.4%
San Diego	961	1,695	56.7%	1,501	2,978	50.4%
San Francisco	471	612	77.0%	588	1,077	54.6%
San Joaquin	83	442	18.8%	110	729	15.1%
San Luis Obispo	64	191	33.5%	74	311	23.8%
San Mateo	42	311	13.5%	11	449	2.4%
Santa Barbara	61	281	21.7%	66	513	12.9%
Santa Clara	683	1,820	37.5%	868	3,262	26.6%
Santa Cruz	103	264	39.0%	80	378	21.2%

2023 CPS Response Rates						
MHP	Youth			Families of Youth		
	Surveys Completed	Members Served	Response Rate	Surveys Completed	Members Served	Response Rate
Shasta	54	196	27.6%	35	351	10.0%
Siskiyou	[redacted]	36	[redacted]	[redacted]	65	[redacted]
Solano	79	235	33.6%	85	403	21.1%
Sonoma	66	243	27.2%	90	338	26.6%
Stanislaus	249	462	53.9%	276	744	37.1%
Sutter-Yuba	21	154	13.6%	12	255	4.7%
Tehama	[redacted]	57	[redacted]	[redacted]	94	[redacted]
Trinity	0	18	0.0%	0	24	0.0%
Tulare	451	1,271	35.5%	224	1,983	11.3%
Tuolumne	[redacted]	-	[redacted]	[redacted]	30	[redacted]
Ventura	236	969	24.4%	280	1,392	20.1%
Yolo	22	132	16.7%	37	256	14.5%
Total	**11,078**	**41,396**	**26.8%**	**14,619**	**71,565**	**20.4%**

Note: Due to HIPAA considerations, counts less than 11 (<11) and associated numbers that can be used to identify those counts through calculation (-) were suppressed.

Youth Surveys

The statewide response rate for the youth survey was 26.8 percent. The median rate for MHPs was 27.9 percent. As shown earlier in Table 8-2, when considering MHPs by their sizes, youth response rates ranged from 14.0 percent in Los Angeles to 35.3 percent in large MHPs. Small and small-rural MHPs together represented only 5.2 percent of youth surveys.

Large MHPs and Los Angeles represented 82 percent of all youth surveys. Of large MHPs, San Francisco had a highest response rate of 77.0 percent, followed by San Diego at 56.7 percent. San Joaquin, Kern, Los Angeles, and San Mateo had response rates less than 15 percent. Among medium MHPs Stanislaus had the highest rate of 53.9 percent, followed by Santa Cruz at 39 percent. Monterey had a response rate for youth that was less than 15 percent.

The highest response rates of 100 percent were from small-rural MHPs Alpine and Mono. However, their numbers are too small to display. Small-rural MHPs with response rates below 15 percent are Sutter-Yuba, Colusa, Amador, [redacted], Trinity, Del Norte, and Modoc.

Families of Youth Surveys

Families of youth receiving SMHS represented the lowest response rate and the smallest number of surveys. The overall response rate for this survey was 20.4 percent, and the MHP median was 19.3 percent. Large MHPs had the highest response rate (25.3 percent) and the lowest in Los Angeles (15.3 percent). Small and small-rural response rates were 17.2 percent and 17.5 percent, respectively. Medium MHPs' rate was 18.2 percent.

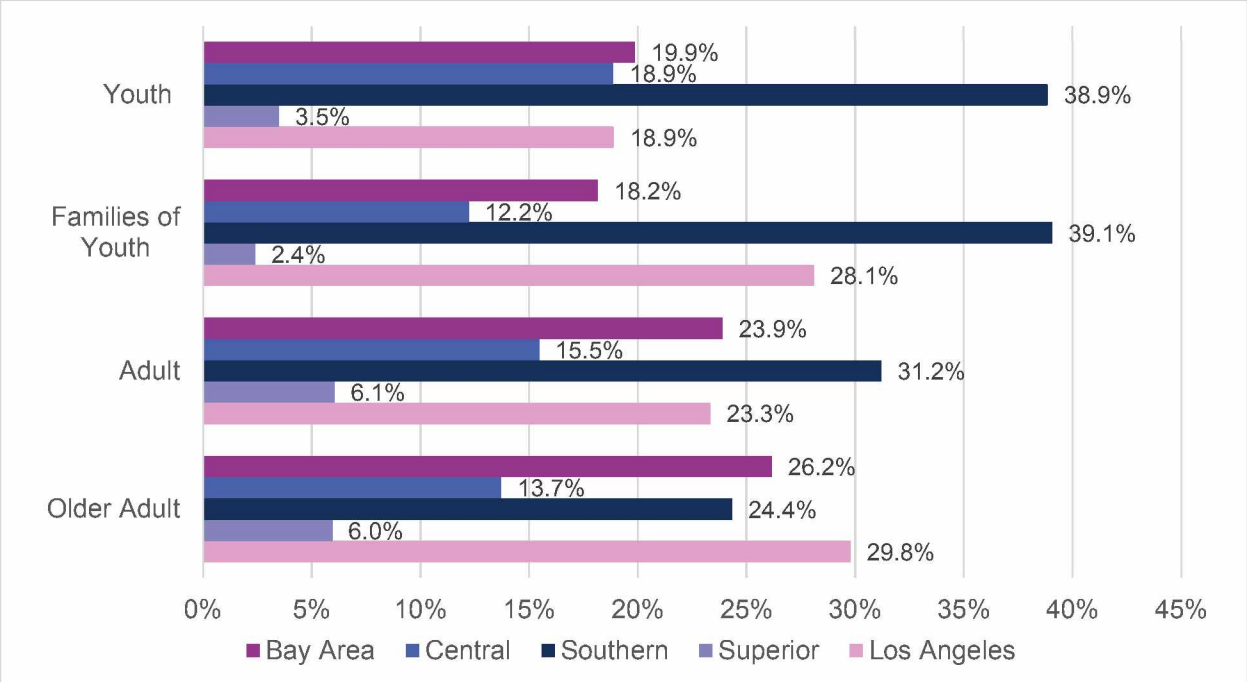
Los Angeles (28.1 percent) and large MHPs (58.6 percent) represent 86.7 percent of all family surveys. Medium MHPs submitted 8.9 percent and small/small-rural comprised 4.2 percent.

Among large MHPs, San Francisco had the highest response rate of 54.6 percent, followed by San Diego at 50.4 percent. All other large MHPs had response rates less than 40 percent. The highest response rates among medium MHPs were Stanislaus (37.1 percent) and Placer-Sierra (34.3 percent). Of the small/small-rural MHPs, only three MHPs had a response rate greater than 25 percent: Alpine (100 percent), Madera (38.2 percent), and Kings (32.4 percent). Three MHPs (Modoc, Mono, and Trinity) submitted no surveys in this category. Three MHPs had response rates below 5 percent: Sutter-Yuba, San Mateo, and Del Norte.

Regional Survey Participation

Figure 8-5 illustrates the proportion of survey types submitted by each region.

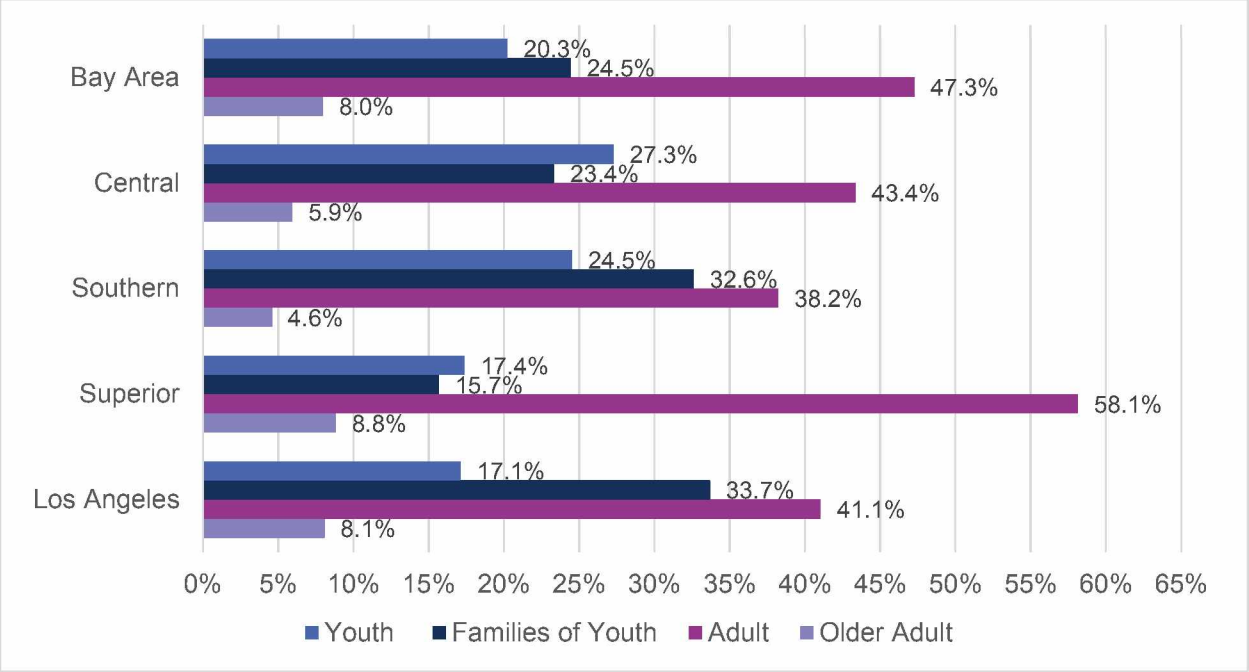
Figure 8-5: Survey Type by Region, CY 2023



The Southern region is most represented in youth, families of youth, and adult surveys. However, the largest proportion of older adult surveys were submitted by Los Angeles, followed by the Bay Area, and then the Southern Region. Due to its smaller population, the Superior region MHPs represent a small proportion of all surveys delivered.

Figure 8-6 displays the breakdown of survey types submitted by each region, with each region totaling 100 percent.

Figure 8-6: Region by Survey Type, CY 2023



Across all regions, the majority of surveys were from adults, which is expected given that more adults receive SMHS. In all regions except Superior, the next most populous survey was the families of youth survey. In the Superior region, more youth than their families submitted surveys. The Superior region also submitted the highest proportion of surveys from older adults (8.8 percent), while the Southern region had the lowest proportion, with less than 5 percent of their surveys coming from older adults.

CPS Findings

Members and families who completed the CPS gave overall favorable ratings of SMHS. Consistent with previous years' findings, respondents rated General Satisfaction, Quality and Appropriateness, Access, and Participation in Treatment Planning higher than Improved Functioning, Outcomes, and Social Connectedness. Table 8-5 shows a summary of the findings for CY 2023.

Table 8-5: Mean Score for Satisfaction Domains by Survey Type, CY 2023

Mean Score	Youth	Families of Youth	Adult	Older Adult
General Satisfaction	4.21	4.38	4.43	4.48
Access	4.21	4.44	4.33	4.31
Quality and Appropriateness	4.38	4.58	4.34	4.33
Participation in Treatment Planning	4.07	4.32	4.33	4.32
Outcomes	3.82	3.94	4.00	4.01
Improved Functioning	3.87	3.96	3.98	3.97
Social Connectedness	4.10	4.27	3.98	3.97

Among youth and families of youth, the highest rated domain was Quality and Appropriateness of care. For adults and older adult surveys, the highest rated domain was General Satisfaction. Youth, families of youth, and adults were least satisfied with Outcomes and Improved Functioning. Older Adults were least satisfied with Improved Functioning and Social Connectedness. For Youth, performance was the highest at 4.21 for both General Satisfaction and Access. Families most strongly endorsed Quality and Appropriateness of care, with a rating of 4.58. Adults and older adults most strongly endorsed the General Satisfaction domain, with ratings of 4.43 and 4.48, respectively.

Overall, families of youth tend to be more satisfied with the services than the youth receiving them. Families' ratings ranged from 0.10 to 0.25 points higher than those of the youth.

There was little difference in ratings between adults and older adults, except in General Satisfaction, where older adults were slightly more satisfied than adults. Compared to 2022, youth were slightly more satisfied in most categories, while their families' ratings remained similar between 2022 and 2023. Adults were more satisfied in 2023 compared to 2022, and older adults' responses were also slightly more satisfied in 2023.

Access

Table 8-6 displays the average rating for questions in the Access domain and the percentage of positive endorsements.

Table 8-6: Mean Score and Positive Perception of Access, CY 2023

Access	Youth	Families of Youth	Adult	Older Adult
Mean Score for Satisfaction of Access	4.21	4.44	4.33	4.31
Respondents Positive Perception of Access	91%	95%	91%	91%

Overall, the percentage with positive perceptions in Access was very similar, with 95 percent of families of youth and 91 percent of youth, adults, and older adults. Average scores on Access were highest among families of youth (4.44) with 95 percent positive endorsement, followed by adult survey respondents (4.33). Youth reported the lowest ratings for Access at 4.21.

Table 8-7 shows positive perceptions of Access for each survey, comparing different race/ethnicity groups.

Table 8-7: Positive Perception of Access by Race/Ethnicity, CY 2023

Access by Race/Ethnicity	Youth	Families of Youth	Adult	Older Adult
African American	90%	96%	91%	91%
Asian/Pacific Islander	91%	94%	92%	95%
Hispanic/Latino	93%	95%	93%	94%
Native American	90%	95%	88%	84%
Other	92%	95%	92%	90%
White	91%	95%	91%	89%

Youth identifying as African American and Native American were the least satisfied with Access, though both still had high positive perceptions at 90 percent. Families of youth identifying as Asian/Pacific Islander reported the lowest satisfaction for Access. Additionally, for adults and older adults, those identifying as Native American showed lower satisfaction compared to all other racial/ethnic groups.

Table 8-8 below displays the percentage of respondents with positive perceptions of Access. Positive perceptions include responses of three, four, or five on the Likert scale.

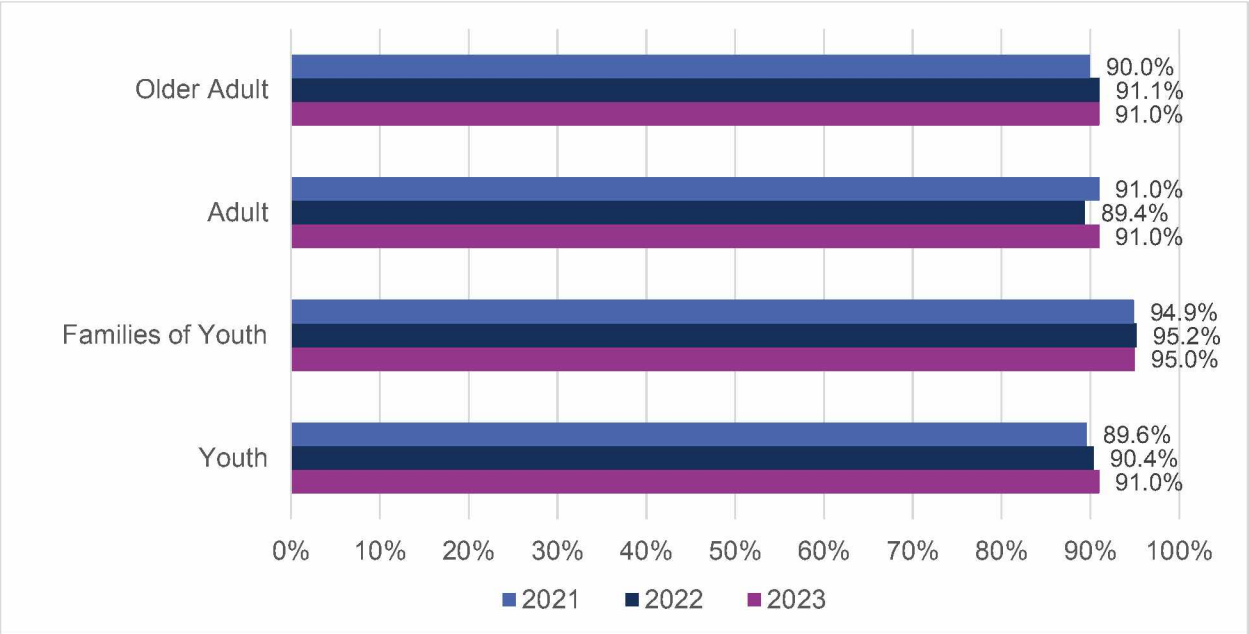
Table 8-8: Positive Perception of Access by Region, CY 2023

Access	Youth	Families of Youth	Adult	Older Adult
Bay Area	92%	95%	90%	90%
Central	90%	93%	91%	90%
Los Angeles	93%	95%	92%	91%
Southern	91%	95%	91%	90%
Superior	92%	95%	91%	94%

By region, youth in Los Angeles were slightly more positive about Access compared to other regions. Families in all regions except Central (93 percent) were equally positive about Access, with a 95 percent endorsement. Bay Area adults were slightly less positive about Access (90 percent) compared to other regions, which had positive endorsements of 91 percent and 92 percent. Older adults in the Superior region were most positive about Access at 94 percent, compared to 90 percent and 91 percent positive in the other regions.

Figure 8-7 shows the three-year trend for questions related to Access across the four survey types.

Figure 8-7: Perceptions of Access, CY 2021-23



Responses from older adults and families of youth remained fairly stable over the three-year period. Adults showed a lower positive Access rating in 2022 but rebounded to the 2021 rating of 91.0 percent in 2023. Youth perceptions of Access increased slightly each year, reaching 91.0 percent in 2023, the same as adults and older adults.

Quality

Table 8-9 shows the average rating for questions in the Quality domain for each survey type, along with the percentage of positive endorsements.

Table 8-9: Mean Score and Positive Perception of Quality and Appropriateness, CY 2023

Quality	Youth	Families of Youth	Adult	Older Adult
Mean Score for Quality and Appropriateness	4.38	4.58	4.34	4.33
Respondents' Positive Perception of Quality and Appropriateness	95%	98%	91%	91%

Mean scores for the positive perception of Quality and Appropriateness of Care were highest among families of youth (4.58) with 98 percent positive endorsement, followed by youth at 4.38 and 95 percent. Adults and older adults rated similarly, with 91 percent positive perceptions.

Table 8-10 displays positive perception of Quality and Appropriateness for each survey type and racial/ethnic group.

Table 8-10: Positive Perception of Quality and Appropriateness by Race/Ethnicity, CY 2023

Quality by Race/Ethnicity	Youth	Families of Youth	Adult	Older Adult
African American	93%	98%	90%	91%
Asian/Pacific Islander	95%	99%	91%	92%
Hispanic/Latino	97%	98%	93%	94%
Native American	96%	98%	87%	84%
Other	96%	98%	90%	91%
White	95%	98%	91%	91%

Among youth, Hispanic/Latino respondents reported the highest satisfaction with Quality and Appropriateness of services, at 97 percent. Families of youth reported the highest satisfaction, with Asian/Pacific Islander families at 99 percent; all other groups rated 98 percent. Among adults, those with the highest satisfaction were Hispanic/Latino (93 percent), while the Native American population reported the lowest satisfaction at 87 percent. For older adults, Hispanic/Latino respondents had the highest positive perception of this domain at 94 percent, while Native American older adults rated it is the least positive at 84 percent.

Table 8-11 shows Quality and Appropriateness of Care ratings for each survey type by region.

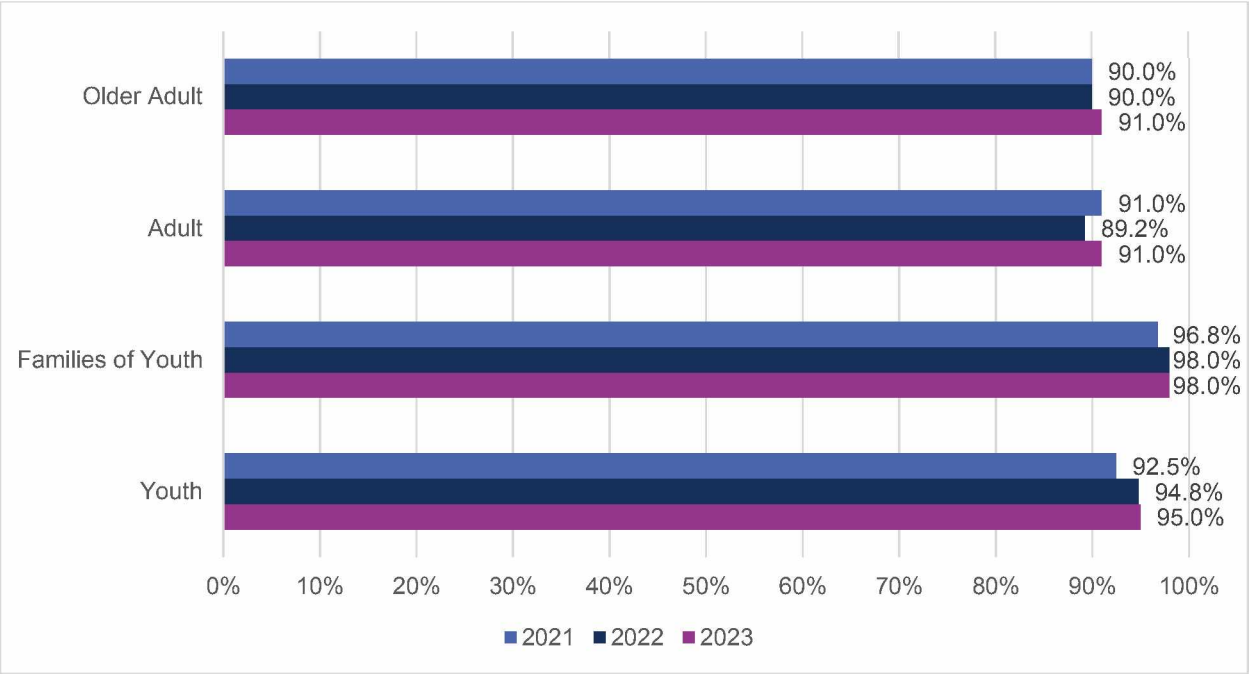
Table 8-11: Positive Perception of Quality and Appropriateness by Region, CY 2023

Quality	Youth	Families of Youth	Adult	Older Adult
Bay Area	96%	98%	90%	89%
Central	93%	98%	90%	91%
Los Angeles	97%	98%	91%	93%
Southern	95%	98%	91%	91%
Superior	96%	98%	91%	91%

Youth in Los Angeles reported the highest satisfaction at 97 percent, followed by the Bay Area and Superior regions at 96 percent. For families of youth, the results were consistently high across all regions at 98 percent. Adults rated 90 to 91 percent across the five regions. Older adults showed more variation, with Los Angeles most satisfied at 93 percent and the Bay Area having the lowest positive perception at 89 percent.

Figure 8-8 displays the three-year trend for positive perceptions of Quality and Appropriateness for each survey type.

Figure 8-8: Perceptions of Quality and Appropriateness, CY 2021-23



Older adults' positive perception was slightly higher in 2023 at 91 percent, compared to 90 percent in 2022. Adult ratings dipped slightly in 2022 but returned to 91 percent in 2023. Youth ratings were highest in 2023 at 95 percent. Families of youth showed slightly lower ratings in 2021 but maintained stable ratings at 98 percent in 2022 and 2023.

Outcomes

Table 8-12 shows the average rating for questions in the Outcomes domain for each survey type, along with the percentage of positive endorsements. This domain includes three areas: Outcomes, Improved Functioning, and Social Connectedness.

Table 8-12: Mean Score and Positive Perception of Outcome Measures, CY 2023

Outcomes	Youth	Families of Youth	Adult	Older Adult
Mean Score for Outcomes	3.82	3.94	4.00	4.01
Respondents Positive Perception of Outcomes	74%	78%	77%	79%
Mean Score for Improved Functioning	3.87	3.96	3.98	3.97
Respondents Positive Perception of Improved Functioning	74%	78%	74%	76%
Mean Score for Social Connectedness	4.10	4.27	3.98	3.97
Respondents Positive Perception of Social Connectedness	89%	93%	77%	79%

In the outcomes categories, youth and families of youth rated Social Connectedness most favorably. Adults rated all three outcome areas similarly, with Outcomes of care slightly higher at 4.00, compared to the other two areas, which averaged 3.98.

Older adults rated Outcomes of care higher than Improved Functioning and Social Connectedness, both averaging 3.97. Social Connectedness had slightly higher positive perceptions at 79 percent, compared to Improved Functioning at 76 percent.

Table 8-13 shows the percentage of positive endorsement for Outcomes items by racial/ethnic group for each survey type.

Table 8-13: Positive Perception of Outcome Measures by Race/Ethnicity, CY 2023

Outcomes by Race/Ethnicity	Youth	Families of Youth	Adult	Older Adult
African American	73%	71%	78%	81%
Asian/Pacific Islander	71%	77%	78%	83%
Hispanic/Latino	75%	81%	80%	85%
Native American	74%	74%	76%	81%
Other	76%	81%	78%	80%
White	73%	74%	77%	76%

The rate of positive perception regarding Outcomes was largely below 80 percent for all age groups except older adults. For youth, positive perception ratings for all racial/ethnic groups ranged between 71 percent and 76 percent. The Asian/Pacific Islander group had the lowest positive perception at 71 percent, while the Other group had the highest at 76 percent. For families of youth, the lowest positive perception scoring was among African American respondents at 71 percent, while Hispanic/Latino and Other groups had the highest at 81 percent. Adults had lower scores for Native American respondents at 76 percent. For older adults, White respondents had the lowest score at 76 percent, while other racial/ethnic groups scored 80 percent or higher. Overall, Hispanic older adults were the most positive regarding outcomes, with a rating of 85 percent.

Table 8-14 shows the percentage of positive endorsement for Outcomes items by region.

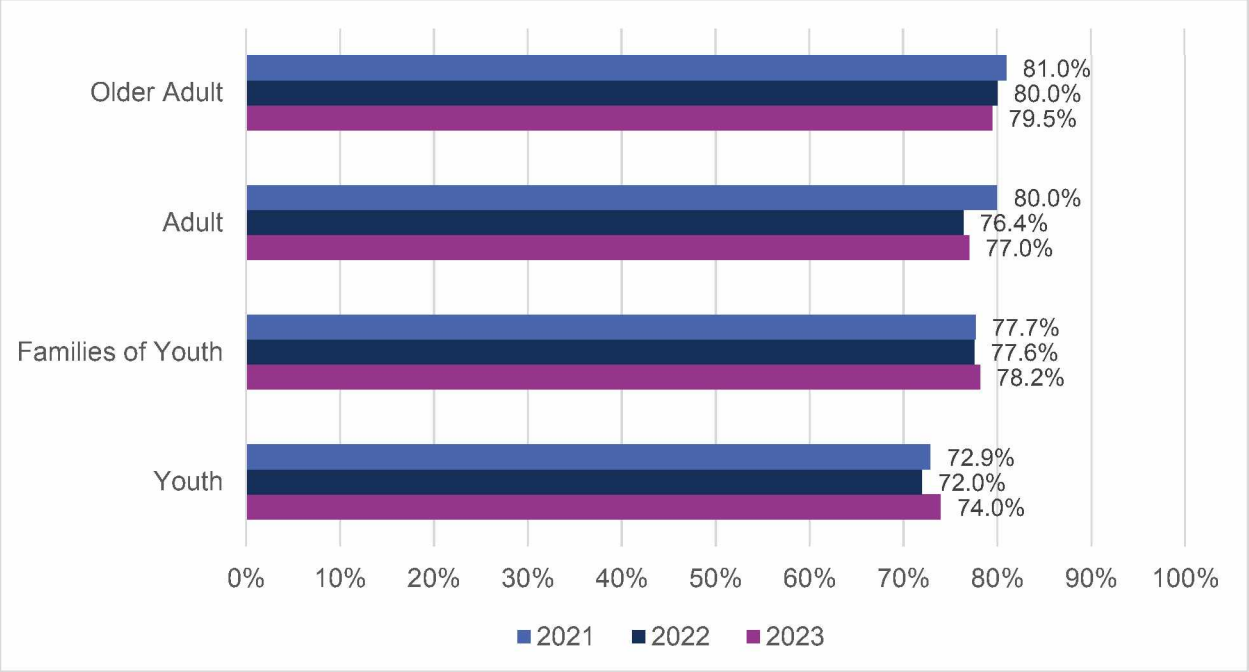
Table 8-14: Positive Perception of Outcomes by Region, CY 2023

Outcomes	Youth	Families of Youth	Adult	Older Adult
Bay Area	76%	79%	78%	79%
Central	70%	71%	74%	77%
Los Angeles	79%	84%	79%	82%
Southern	73%	77%	77%	78%
Superior	68%	72%	77%	81%

Youth in the Superior region had the lowest positive perception of outcomes at 68 percent, though this was an improvement from 61 percent in 2022. For families of youth, the lowest rating was 71 percent for the Central region. For adults, scores ranged from a low of 74 percent in the Central region to a high of 79 percent in Los Angeles. Older adults had similar scores, with a low of 77 percent in the Central region and a high of 82 percent in the Los Angeles region. Los Angeles had the highest positive perceptions, while members in the Central region showed the least positive perceptions in the Outcomes domain.

Figure 8-9 displays the positive perceptions in the Outcome domain over the three-year period for each survey type.

Figure 8-9: Perceptions of Outcome Measures, CY 2021-23



In positive perceptions of outcomes older adults showed slight annual decreases, adults showed a drop of 3.6 percentage points in 2022 but increased slightly in 2023. Youth responses have ranged from 72 to 74 percent, which is the highest over the 3 years. Families of youth responses were close each year, from 77.6 percent to 78.2 percent.

SUMMARY OF PERCEPTIONS OF CARE

In 2023, the number of focus groups increased, and for the first time, all 56 MHPs conducted at least one focus group. However, participation dropped to 529 individuals, a decrease of 7.84 percent compared to 2022. The members and families' participation greatly informed the recommendations provided to the individual MHPs.

Participants in the PMF focus groups reported general satisfaction with MHP services. Participants' positive perceptions were based on feeling supported by caring and committed staff. Initial access was generally viewed favorably, though wait times often occurred after the initial visit. Recommendations from members included increasing staff, expanding group services, improving system navigation, and enhancing support in areas such as housing and employment.

The CPS survey saw a notable increase in participation; response rates increased each year, with over 27 percent more surveys submitted compared to 2022. Adults and older adults accounted for 42.8 percent and 6.6 percent of all surveys administered, respectively. Youth services were well-represented, with youth completing 21.8 percent of the surveys and families of youth submitting 28.8 percent. Surveys from Los Angeles and the Southern region accounted for over half of the respondents across all survey types – Los Angeles itself represented one-fourth of all surveys.

The statewide response rates showed that surveys were submitted by nearly one in three adults, roughly one in four youth and older adults, and one in five families of youth. MHPs showed great variation in their response rates, from no surveys submitted to 100 percent of all possible surveys – 100 percent response rates occurred in small-rural MHPs, but also in Santa Cruz. Some larger MHPs submitted very few surveys and should be encouraged to strengthen their efforts.

In 2023, 65.0 percent of completed surveys were on paper, down from 67.7 percent in 2022. This decrease suggests that while paper surveys remain an integral component of CPS data collection, there was an increase in in-person services. At the same time, online surveys played a crucial role in the overall response.

The survey was available in twelve threshold languages statewide. Spanish surveys represented 10.9 percent of all submissions. In 2023, non-English, non-Spanish surveys declined to 1.5 percent, down from 1.7 percent in 2022 and significantly lower than 5.6 percent in 2021. More efforts are needed to increase survey participation from members who speak non-Spanish threshold languages.

Families of youth generally reported more positive perceptions of care. Families and youth were most positive about the Quality and Appropriateness of Care, whereas adults and older adults were most satisfied with General Satisfaction. Youth, families of youth, and adults were least satisfied with Outcomes and Improved Functioning. Older Adults were least satisfied with Improved Functioning and Social Connectedness.

Overall, in Quality and Appropriateness of Care, Hispanic/Latino respondents had the most positive perceptions, with no survey rating below 93 percent satisfaction. However, while Native American youth and families of youth respondents also evidenced high levels of satisfaction at 96 percent and 98 percent, respectively, ratings for older adults (84 percent) and adults (88 percent) demonstrated that they were the least satisfied among the racial/ethnic groups surveyed. Furthermore, of all age-related demographic categories measured, families of youth collectively registered the highest levels of satisfaction, with Asian/Pacific Islanders at 99 percent and all other racial/ethnic communities at 98 percent. Also, while positive perceptions of outcomes of care slightly declined across all age groups between CYs 2021 and 2022, they modestly increased in CY 2023 among adults, youth, and families of youth respondents. However, satisfaction ratings for older adults in this domain consistently fell during this three-year period.

Members and families provide invaluable insights into SMHS delivered through MHPs and should be considered when designing or improving services. Although MHPs tend to struggle to gather member input in committees and work groups, many focus group participants expressed a strong interest in contributing. Personalized outreach may be effective, as it is often the method MHPs use to secure focus group participation. Although neither the focus groups nor the CPS are a representative sample of all members served, they provide general insights into services from a diverse group of members and families on issues related to access, timeliness, and quality. Feedback from members and their families at the MHP level serves as a starting point for assessing trends, identifying areas needing improvement, and initiating system enhancements.

INTRODUCTION

CalEQRO assesses the extent to which the MHP and its contract providers meet the Federal data integrity requirements for HIS, as identified in 42 CFR §438.242. To facilitate review of this topic, MHPs submit a completed ISCA prior to the EQR. The ISCA commonly requires input from multiple areas of the organization, such as IT, Finance, Operations, and QM. Specifically, CalEQRO utilizes the ISCA protocol to review the MHP's EHR, IT, claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs, and whether the MHP and its contract providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the QAPI program.

INFORMATION SYSTEMS STATEWIDE

In this chapter, CalEQRO examines the functionalities of the EHR systems that were in place during FY 2023-24, along with IT budgets, staffing, and other planned IS changes. There was considerable variation in how SMHS services were delivered by MHPs, ranging from 98 percent contract provider-operated in Kings and 94 percent contract provider-operated in Sacramento, to 100 percent county-operated in Lassen and Mono. On average, 43 percent of SMHS were delivered by contract providers, which makes it vital to examine contract providers' access to the Plan EHR systems, data submittal methods, and utilization of the Plans' EHR functionalities. The results presented are based on the status at the time of each Plan's review and may have changed since that time.

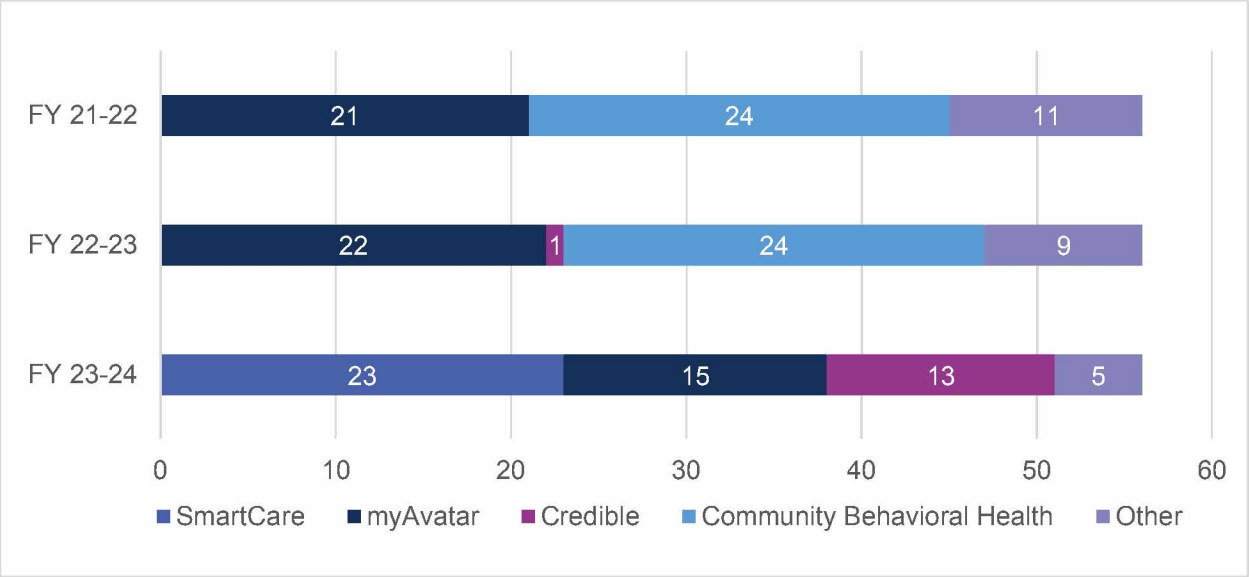
The past year has been particularly notable in terms of the HIS landscape due to the entry of a new EHR vendor (Streamline Healthcare Solutions ["Streamline"]) that offers a product that was intended to enhance MHPs' capabilities to meet CalAIM requirements, including payment reform, as well as providing more seamless coordination of care for Medi-Cal members. Additionally, Cerner was acquired by Oracle Health, who is now the vendor for the Cerner Millennium EHR product, and the Cerner Community Behavioral Health (CCBH) EHR is no longer supported. This change resulted in massive shifts in EHR system and vendor utilization statewide. CalEQRO found that 39 of the 56 MHPs implemented a new EHR within the past FY, with a second smaller group of MHPs exploring options anticipating a change in the next 2 years. The majority of MHPs with a new EHR were participants in the CalMHSA's multi-county EHR initiative and had implemented, or were in the process of implementing, the SmartCare EHR by Streamline. In other words, 70 percent of MHPs have been devoting resources to transitioning to a new EHR, which is a major undertaking.

HIS Systems and Vendors

In recent years, California MHPs primarily relied on two technology vendors to support HIS: Netsmart Technologies ("Netsmart") and Cerner Corporation ("Cerner"). In a shift seen in FY 2023-24, Streamline, Netsmart, and Qualifacts are now the most prevalent vendors in the MHP EHR landscape, with Streamline dominating. Their products, SmartCare, myAvatar, and Credible, respectively, were the EHRs for 91 percent of Plans.

Figure 9-1 summarizes MHP EHR systems in place over the past three FYs.

Figure 9-1: MHP EHR Systems, FY 2021-22 to FY 2023-24

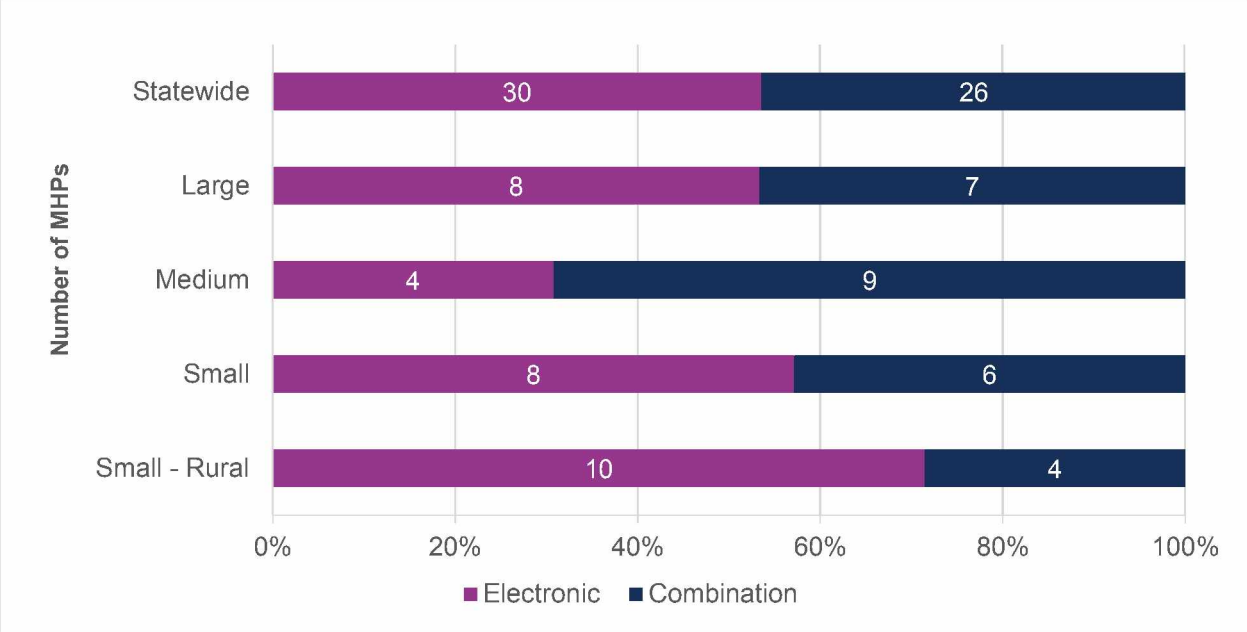


FY 2023-24 saw substantial changes in the EHRs used by individual MHPs. There were several factors influencing EHR transitions. First, as previously mentioned, Cerner discontinued support for the CCBH EHR at the end of 2023, necessitating the 24 MHPs who had been utilizing CCBH to seek new systems. Updated system requirements due to CalAIM was another primary driver for MHPs transitioning to new EHRs. Additionally, the opportunity to participate in the CalMHSA's multi-county EHR initiative, which uses SmartCare, enticed many Plans to transition due to the availability of implementation and post-implementation support from CalMHSA.

In FY 2023-24, 23 Plans (41 percent) used SmartCare, 15 Plans (27 percent) used myAvatar, and 13 Plans (23 percent) used Credible by Qualifacts. The current vendors continue to modify legacy systems to conform to state and federal data collection and reporting standards or, in the case of Streamline, continue to build out the product to do so.

Figure 9-2 illustrates the aggregated FY 2023-24 health record types across Plans, both statewide and by county size group, as reported in the ISCA.

Figure 9-2: Type of Mental Health Records, FY 2023-24

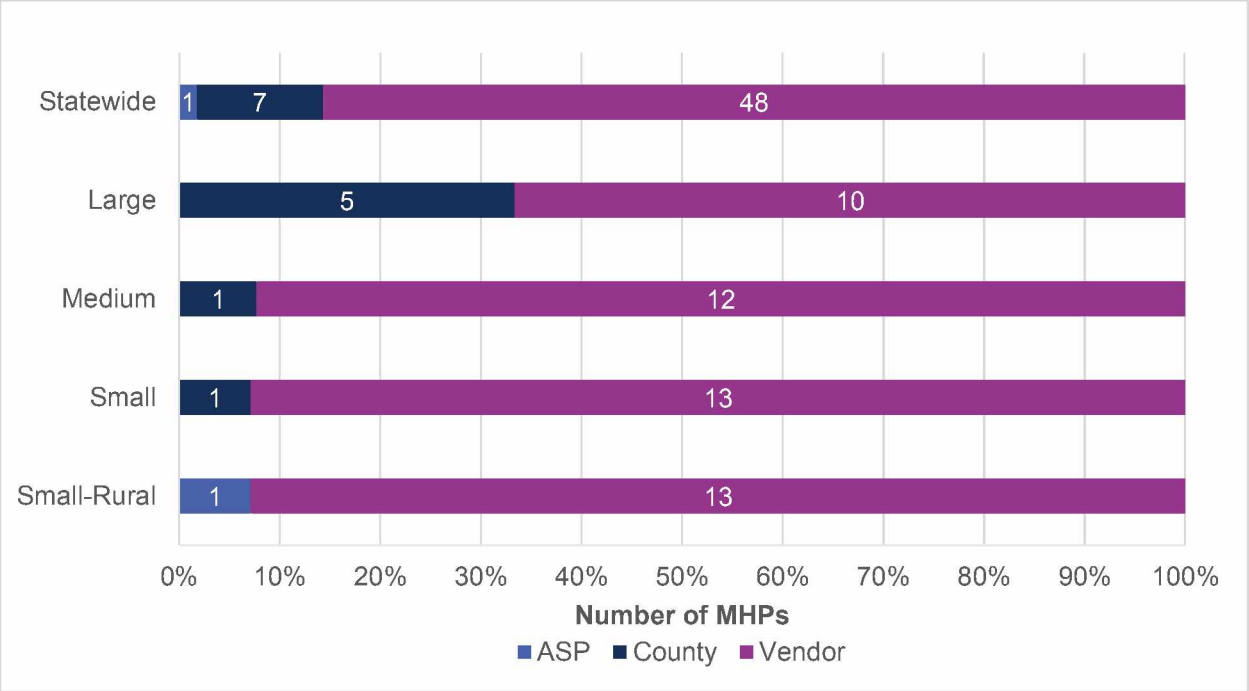


Statewide, 30 out of 56 MHPs (54 percent) maintained member health records fully electronically, and the rest embraced hybrid systems comprising both electronic and paper records. While MHPs of all sizes have maintained health records in both paper and electronic formats, medium-size county MHPs were more likely to have a combination. Furthermore, the majority of large, small, and small-rural county MHPs reported fully electronic member health records, thereby marking the first time that a majority of small county MHPs were utilizing fully electronic records.

California MHP EHRs are either self-hosted by county IT, county health agency IT, BH IT, or are hosted by the vendor or another third party such as an ASP. A number of factors, including perspectives informed by cost-benefit and risk-management considerations, help collectively to shape and influence the decision regarding the best hosting arrangements for EHRs. Historically, Plans in larger counties with more robust staffing and infrastructure were able to host their own systems at the behavioral health IT, health IT, or county IT levels. Conversely, Plans ranging from small to medium counties, with more limited IT staff, were more likely to employ the EHR vendor or an ASP to host and manage their EHR.

Figure 9-3 illustrates the breakdown of MHPs' EHR hosting as reported in the ISCA, displayed by county size group and statewide.

Figure 9-3: Hosting of MHP EHR Systems by MHP Size, FY 2023-24

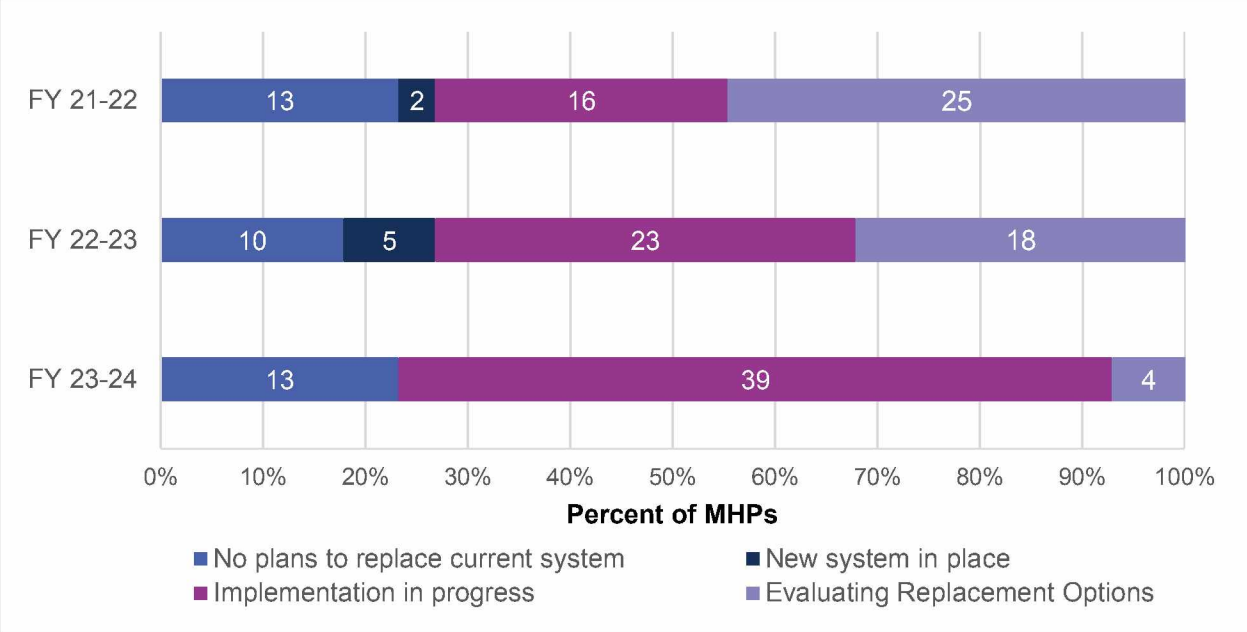


In FY 2023-24, the number of MHPs that relied on their vendor to host their EHRs increased substantially from 64 percent to 86 percent of all MHPs. The substantial increase in vendor-hosted systems that occurred over the past year is largely due to many Plans opting in to the CalMHSA SmartCare EHR project, which provides cloud-based hosting via the vendor, Streamline. The number of MHPs with county-hosted systems statewide decreased to seven (12.5 percent), with the majority of these being large MHPs that have greater staffing resources, and only one Plan reported being hosted by their ASP. Even among the large MHPs, two-thirds had vendor-hosted systems.

Regardless of EHR host-type, 89 percent of MHPs in FY 2023-24 reported having an ASP providing maintenance and support on the Plan EHR or were receiving ASP-like support and TA from CalMHSA (CalMHSA SmartCare MHPs only).

Figure 9-4 represents the EHR replacement status of the 56 MHPs over the past three FYs, as reported by MHPs in the ISCA.

Figure 9-4: MHP EHR Replacement Status, FY 2021-24



In FY 2023-24, 39 MHPs (70 percent) reported implementation of a new EHR was in progress, and the majority (59 percent) of those MHPs were participating in the CalMHSA multi-county EHR initiative, implementing the SmartCare EHR. Those Plans that previously used the CCBH EHR, including those whose EHR was hosted by Kings View, transitioned to new EHRs (50 percent of which went to Credible, 42 percent to SmartCare, and 4 percent each to Cerner Millennium and myAvatar). An additional four Plans were evaluating their options for replacement of their current EHR, while 13 MHPs had no plans to replace their current systems.

Indeed, the current FY represents an important transition year as MHPs simultaneously implemented payment reform updates as well as changes in billing procedures that became effective July 1, 2023. The number of MHPs actively implementing new systems was the highest it has been over the past three FYs, and these implementations required the dedication of substantial resources to effectuate changes in Medi-Cal claiming, contractual updates related to updated rates, staff workflow and processes, and overall training for clinical and administrative staff and contract providers, on the new EHR systems.

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 member outcomes. This section reviews the extent to which MHPs are fully using their EHR technology, both in executing accurate Medi-Cal claiming and to utilize EHR data to inform their understanding of service delivery within their respective systems of care. Optimal use of an EHR includes interoperability and use of the EHR as the medical record across the entire service delivery system. This includes use by not only the county-operated programs, but also any contracted agencies providing services. If the EHR does not include all services provided to

members, then analytics based on these services will have limited utility. Technology, effective business processes, and staff skills in the extraction, analysis, and reporting of data must be present to stimulate the creation of ongoing quality feedback loops that will promote the rendering of data-informed decisions – ensuring the overall quality of the SMHS delivery system and organizational operations. It also requires that the technology and program leadership collaborate strategically to mutually identify and define data needs and accurately determine what information needs to be captured, tracked, and evaluated to address stated programmatic purposes.

Each of the six IS Key Components, composed of individual subcomponents, are collectively assessed to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated on to promote opportunities for QI.[43]

A summary of statewide performance is depicted in Table 9-1 below.

Table 9-1: IS Key Components – Statewide, FY 2023-24

KC #	Key Component – IS	Met	Partially Met	Not Met
4A	Investment in IT Infrastructure and Resources is a Priority	53	3	0
4B	Integrity of Data Collection and Processing	21	34	1
4C	Integrity of Medi-Cal Claims Process	36	20	0
4D	EHR Functionality	49	7	0
4E	Security and Controls	40	15	1
4F	Interoperability	34	20	2

Five MHPs (9 percent) – **Alameda**, **Fresno**, **Nevada**, **San Francisco**, and **San Joaquin** – Met all six of the IS Key Components, and an additional 48 MHPs (86 percent) either Met or Partially Met all six. These MHPs' ratings indicate they make optimal use of their EHR functionalities. Investment in IT Infrastructure and Resources is a Priority was the Key Component with the largest number of Plans receiving a Met rating (53 Plans total). Integrity of Data Collection and Processing was the Key Component that was rated Met for the smallest number of MHPs (21 Plans, equating to 38 percent), with the majority (34 MHPs) receiving a rating of Partially Met (61 percent) and one MHP with a rating of Not Met. Three MHPs received one or two Not Met ratings, and fewer Not Met ratings were issued than in the previous FY (i.e., four in FY 2023-24 vs. eight in FY 2022-23).

Compared to the previous FY, more Plans were rated Met on the Investment in IT Infrastructure and Resources is a Priority, EHR Functionality, and Security and Controls Key Components, whereas fewer MHPs were rated Met on the Integrity of Medi-Cal Claims Process and Interoperability Key Components (due to implementation). While the number of MHPs rated Met for the Integrity of Data Collection and Processing Key Component remained the same as in the prior year, Security and Controls, followed by EHR Functionality, were the Key Components with the greatest increases in the number of Plans rated Met. The Interoperability Key Component, however, had the greatest decrease in the number of Plans rated Met.

[43] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

Table 9-2 shows the rating for each Key Component by Plan.*

Table 9-2: IS Key Components by Plan, FY 2023-24

MHP	4A	4B	4C	4D	4E	4F
Alameda	M	M	M	M	M	M
Alpine	M	PM	PM	M	M	PM
Amador	M	M	M	PM	PM	M
Butte	M	M	M	M	M	PM
Calaveras	M	PM	PM	PM	PM	PM
Colusa	M	PM	M	M	M	M
Contra Costa	M	M	M	M	M	PM
El Dorado	M	PM	M	M	M	M
Fresno	M	M	M	M	M	M
Del Norte	M	M	M	M	PM	PM
Glenn	M	PM	M	M	PM	M
Humboldt	M	PM	M	M	PM	PM
Imperial	M	PM	M	M	M	PM
Inyo	M	PM	M	PM	PM	M
Kern	M	PM	M	M	M	M
Kings	M	PM	M	M	M	M
Lake	M	NM	PM	M	M	PM
Lassen	M	M	PM	PM	PM	PM
Los Angeles	M	PM	M	M	M	PM
Madera	M	PM	PM	M	M	PM
Marin	M	PM	PM	M	M	M
Mariposa	M	PM	PM	M	M	M
Mendocino	M	PM	M	PM	M	PM
Merced	M	PM	M	M	M	PM
Modoc	M	PM	M	M	M	M
Mono	M	PM	PM	M	M	M
Monterey	M	PM	M	M	M	PM
Napa	M	PM	M	M	PM	M
Nevada	M	M	M	M	M	M
Orange	M	PM	M	M	M	PM
Placer - Sierra	M	PM	PM	M	M	M
Plumas	M	PM	M	M	M	M
Riverside	M	M	M	M	PM	M
Sacramento	M	PM	M	M	M	M
San Benito	PM	PM	M	M	M	NM
San Bernardino	M	M	PM	M	M	PM
San Diego	M	PM	M	PM	M	M
San Francisco	M	M	M	M	M	M
San Joaquin	M	M	M	M	M	M
San Luis Obispo	M	PM	PM	M	PM	M
San Mateo	PM	M	M	M	M	M

MHP	4A	4B	4C	4D	4E	4F
Santa Barbara	M	PM	PM	M	M	M
Santa Clara	M	M	PM	M	PM	PM
Santa Cruz	PM	M	M	M	PM	M
Shasta	M	PM	M	M	M	M
Siskiyou	M	M	M	M	NM	NM
Solano	M	M	PM	M	PM	M
Sonoma	M	M	PM	M	M	M
Stanislaus	M	PM	M	M	M	M
Sutter - Yuba	M	PM	PM	M	M	M
Tehama	M	PM	M	M	M	PM
Trinity	M	M	M	PM	PM	M
Tulare	M	PM	PM	M	PM	M
Tuolumne	M	M	PM	M	M	PM
Ventura	M	M	PM	M	M	M
Yolo	M	PM	PM	M	M	PM

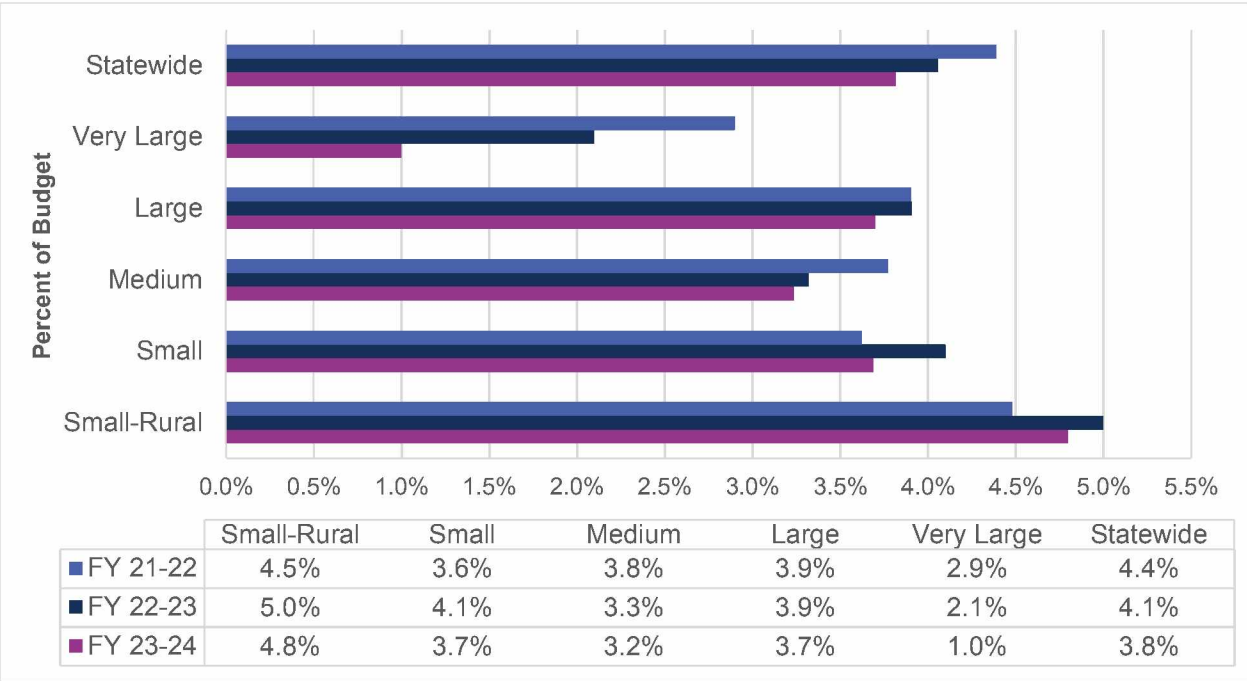
*Note: M = Met, PM = Partially Met, NM = Not Met

Investment in IT Infrastructure

This component evaluates the degree to which MHPs are dedicating resources, including appropriate staffing resources, to the acquisition and maintenance of IT, which, in turn, influences their ability to meet strategic and operational needs. Most Plans (95 percent) evidenced strengths in this area, with 53 MHPs being rated Met, and 3 MHPs rated Partially Met. This likely reflects the necessity of investment required to transition EHRs and the large number of Plans undergoing that process, as well as the resources needed to comply with CalAIM requirements such as payment reform. Furthermore, since the beginning of the pandemic, all MHPs have invested in telehealth technology and provided staff with the equipment needed for remote operation.

Figure 9-5 below illustrates MHPs' IT budgets as a percentage of their total budgets across the past three FYs, as reported by MHPs in the ISCA, displayed by county size and statewide. Please note that Los Angeles is the only MHP represented in the "very large" county size group, which serves over one-third of members statewide. Los Angeles may be included in large MHPs in this chapter when the numbers would not skew the results.

Figure 9-5: MHP IT Budget by County Size, FY 2021-22 to FY 2023-24



	Small-Rural	Small	Medium	Large	Very Large	Statewide
FY 21-22	4.5%	3.6%	3.8%	3.9%	2.9%	4.4%
FY 22-23	5.0%	4.1%	3.3%	3.9%	2.1%	4.1%
FY 23-24	4.8%	3.7%	3.2%	3.7%	1.0%	3.8%

Statewide, MHPs spent an average of 3.8 percent of their total budgets on IS, a decrease from the prior year (4.1 percent). Small-rural county MHPs dedicated the highest percentage of their budget to IS (4.8 percent); however, Los Angeles dedicated the smallest proportion of its budget to this objective (1.0 percent). Small and large Plans spent 3.7 percent of their total budgets on IS, which were the closest averages to the overall statewide mean, and medium Plans dedicated 3.2 percent of their budgets to IS on average.

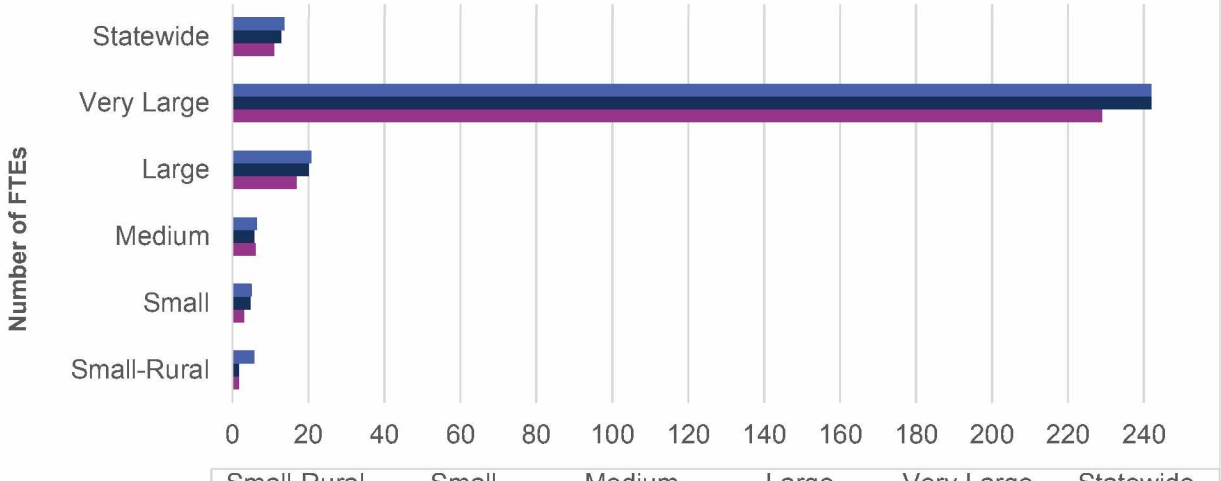
IT budget averages for small and small-rural Plans increased in FY 2022-23, with a subsequent decrease in FY 2023-24, though they remained higher than the FY 2021-22 averages. Compared to the previous two FYs, the average budget for Medium MHPs decreased in FY 2023-24, while the average for Large MHPs decreased compared to the previous FY after remaining steady from FY 2021-22 to FY 2022-23. Los Angeles had the largest percentage decrease in spending on IT over the past three FYs and has consistently had the lowest IT budget allocation across MHP-size groups. It should be noted that the total Los Angeles MHP budget is also much larger than any other MHP. Therefore, while the actual dollar amount that they are allocating to this sphere of activity is greater than the comparisons, proportionally it translates into a smaller percentage of their overall IT budget than is reflected in other county size designations. Smaller MHPs with smaller budgets require a greater proportion of their budget allocated to IT to maintain similar systems, and still may not have the necessary staff to fully utilize the technology they have acquired. Continued investment for IT will be crucial in supporting the systems of care, especially in those MHPs who are implementing and developing a new EHR.

The percentage of the MHP budget devoted to IS represents just one simple indicator of the level of IT resources and capabilities available to support the administration and delivery of SMHS within the MHP framework. Although there are no standards for the percentage of budget devoted to IT, there are industry references to between 3 and 6 percent as the average in health

care organizations with a full-featured EHR.[44] [45] Regardless of the scale of operation and the number of members served by a given Plan, the reality is that IS costs must exceed a minimum baseline in order to maintain operations. Further, with all the new demands on HIS and reporting requirements, the existing funding levels for the HIS that may have worked with the legacy systems and historical reporting requirements may be inadequate moving forward.

Figure 9-6 illustrates the FY 2023-24 average authorized technology resources in MHP Plans, measured in full time equivalent (FTE) positions reported by MHPs, both statewide and by county size group, across the last three FYs.

Figure 9-6: MHP Average Technology Staffing by County Size, FY 2021-24



	Small-Rural	Small	Medium	Large	Very Large	Statewide
FY 21-22	5.7	5.0	6.4	20.8	242.0	13.8
FY 22-23	1.8	4.8	5.8	20.0	242.0	12.8
FY 23-24	1.8	3.1	6.1	17.0	229.0	11.0

Figure 9-6 demonstrates that a shift in staffing has occurred over the last several FYs. Average IS FTEs have decreased both statewide and for Plans in all county size groups with the exceptions of small-rural (no change from previous FY) and medium (small increase). The average number of IS FTEs statewide decreased by 14 percent compared to the previous FY, and by just over 20 percent compared to FY 2021-22. Many Plans acknowledged executing a recalculation of their FTEs (both technology and analytical) in FY 2023-24 in order to more accurately report staffing allocations than in prior EQRs; therefore, not all shifts in the data necessarily reflect changes to the actual dedicated MHP resources.

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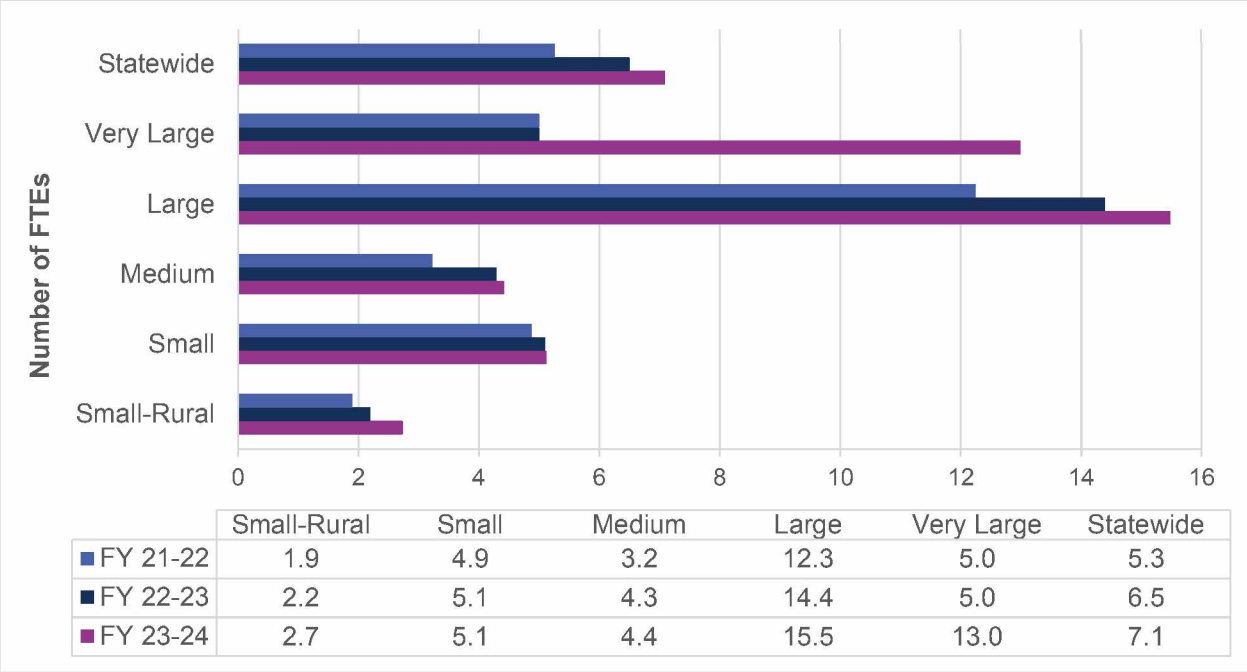
[44] Definitive Healthcare. (July 24, 2024). *Hospitals with the highest IT expenses.* https://www.definitivehc.com/resources/healthcare-insights/25-hospitals-highest-operating-budget#:~:text=The%20average%20IT%20operating%20expense,highest%20estimated%20IT%20operating%20budgets

[45] Medicus IT. (January 30, 2023). *How much should my healthcare organization spend on IT in 2023?* https://knowledge.medicusit.com/how-much-should-my-healthcare-organization-spend-on-it-in-2023#:~:text=While%20there%20is%20no%20exact,total%20revenue%20on%20business%20IT

While large MHPs averaged 17 FTE positions, Los Angeles had over ten times that many staff, with 229 FTE positions. Further comparison shows that Large MHPs have many more IT staff than MHPs of all smaller-size categories. The demands in a larger system require more staff, and it is more likely that medium MHPs (often with similarly complex service systems) are under-resourced as opposed to over-resourcing in large MHPs. In FY 2022-23, and now again in FY 2023-24, small-rural MHPs were operating with a dearth of staff. This need appeared to have been addressed in FY 2021-22; however, small-rural Plan staffing has now decreased to the lowest recorded levels since FY 2018-19, and small-rural MHPs are operating with slightly more than half the small MHP staffing average. Of the five Plans with the smallest reported IS staffing levels, four were small-rural and one was small. The numbers alone, however, may not tell the full story. Some small-rural and small Plans have long-term legacy staff, and while their staff may be limited in number, those highly experienced staff carry added value due to their experience and expertise.

Figure 9-7 illustrates the FY 2023-24 average allocated analytical resources in MHP Plan budgets, measured in FTE positions, both statewide and by county size group across the last three FYs.

Figure 9-7: MHP Average Data Analytics Staffing by County Size, FY 2021-24



	Small-Rural	Small	Medium	Large	Very Large	Statewide
FY 21-22	1.9	4.9	3.2	12.3	5.0	5.3
FY 22-23	2.2	5.1	4.3	14.4	5.0	6.5
FY 23-24	2.7	5.1	4.4	15.5	13.0	7.1

Figure 9-7 reflects the trend in analytical staffing levels in recent FYs. Average data shows that analytical FTEs increased in each of the past two FYs for Plans in all MHPs of all size except for small MHPs, which slightly increased in FY 2022-23 and did not change in FY 2023-24. Statewide, MHPs averaged just over seven FTE analytical staff in the current FY, which was also the highest level in the past the three FYs. While Plans generally continued to have more technology personnel than analytic staff, the small and small-rural MHP averages reflect higher staffing levels for analytic staff than IT staff. All MHPs have the same DHCS reporting requirements; consequently, while the size of the data sets may differ by MHP size, the process for reporting is nevertheless the same. This is why FTE disparities across county size groups are less pronounced for analytic FTEs than technology FTEs. MHPs also vary tremendously in the amount and type of routine reporting they do for internal operations and public-facing reports.

Additionally, some Plans may include analytic staff in other technology or quality divisions or units. If the MHP is part of a larger county agency, it is common for some analytic and technology staff resources to be employed at the agency level, rather than dedicated to the MHP. This means these staff can be tapped to provide necessary support as needed but may not be reflected in reported staffing allocations.

Small MHPs, on average, reported having more analytic staff than the medium Plans, although the latter group's number has been steadily rising for 3 years by 0.85 FTE positions per year on average – it was still 0.7 FTE positions less than small MHPs for FY 2023-24. Small-rural MHPs continued to increase data analytic staffing by 0.4 FTE positions per year on average. Similar to IT staffing levels, large/very large MHPs also have a much higher number of data analytic staff on average compared to other Plans. The influence of large/very large MHPs on the statewide average is apparent, with all other county size groups demonstrating lower numbers of analytic staff than the statewide average, and large/very large MHPs being the only county size group with average staffing levels higher than statewide.

Overall, limited data analytic staff embedded in QI may mean that MHPs, especially in medium and small-rural MHPs, may only have enough staff to fulfill mandated reporting requirements – and that too may be tested following the full implementation of CalAIM and initiation of other new reporting requirements. As a result, many MHPs report an inability to do analytic reporting that would benefit the oversight and management of the system and successfully implement data-demanding projects, such as PIPs and, more recently, the quality measure reporting associated with CalAIM. Notably, the transition to new EHRs for so many MHPs has reset progress in the development of initiatives including data collection efforts to aggregate county-operated and contract provider-rendered services, implementation of PHRs for members, and interoperability efforts tied to data sharing through HIEs.

Data Integrity

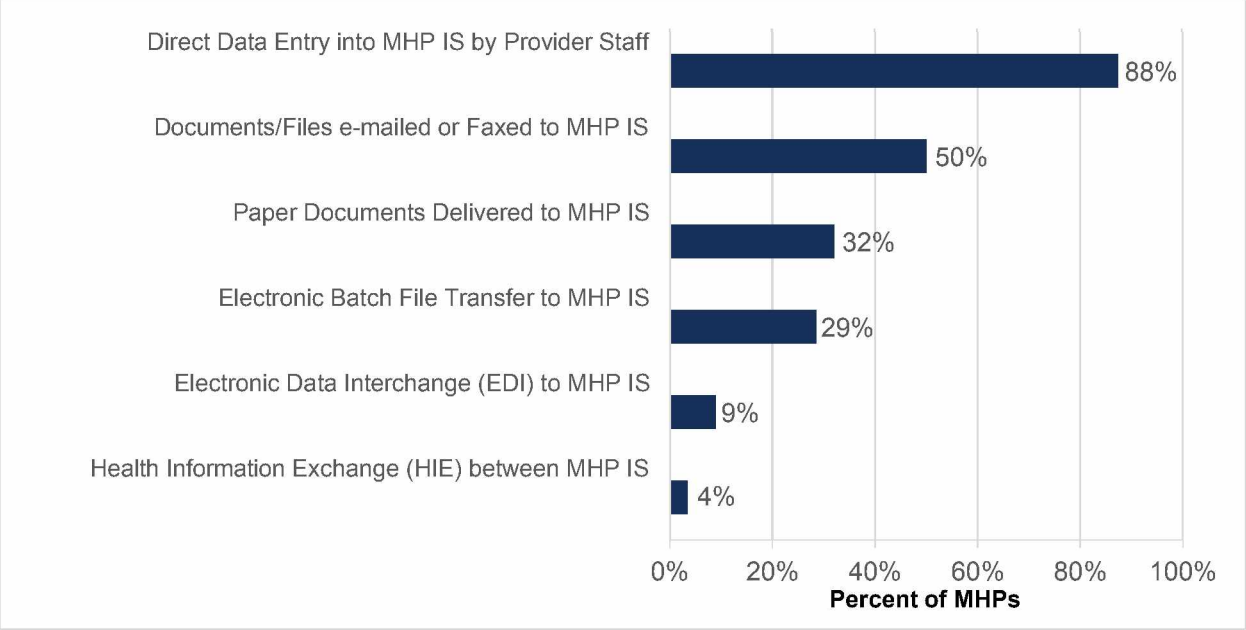
Data integrity refers to the overall accuracy, completeness, and consistency of data. It is maintained by a collection of processes, rules, and standards implemented to support core EHR functionality. When the integrity of data is secure, the information stored in a database will remain complete, accurate, and reliable no matter how long it is stored or how often it is accessed.

MHPs of all sizes were rated Met (37.5 percent) or Partially Met (61 percent), with only one MHP being rated Not Met. Large MHPs were more likely to receive a Met rating, with small and medium Plans more likely to receive a Partially Met rating.

Multiple issues contributed to the high proportion of MHPs receiving a rating of Partially Met for this Key Component. While most MHPs have strong data collection and processing faculties for county-operated programs, the data collection and transmittal processes for the contract providers varied widely. For many small and small-rural MHPs with very few, or even no contract providers, this is not an issue. For large and medium MHPs with a significant proportion of services being delivered by contract providers, there are many different data transmission practices in use. These range from hardcopy paper and e-mail transmissions of information to having fully automated and integrated data transfer processes in place. When the data transfer processes are not fully automated, this often leads to manual solutions to data submission, extraction, and analytics for fulfilling reporting requirements which, in turn, allows for increased errors throughout the manual process. NA, timeliness, and EPSDT outcomes reporting are prime examples of such practices that warrant electronic integration, but often require that the MHP compile data from multiple disparate sources, including manually maintained spreadsheets, for reporting to DHCS.

Figure 9-8 illustrates the modes of data submission utilized by contract providers across MHP Plans, as reported by MHPs in the ISCA.

Figure 9-8: Contract Provider Data Submission Modalities, FY 2023-24



Note: Percentages add up to greater than 100 percent because many MHPs employ multiple modalities of data submission. Each bar represents the percentage of MHPs that utilize that particular modality of data submission.

Data submission methods varied, influenced by both the Plans' preferences and the contract providers' technological and staffing capabilities. Of MHPs that reported, 88 percent indicated in the ISCA that direct data entry into the MHP EHR for at least some of their contract providers was functional; however, this does not mean that all or even most of the contracted services are directly entered into an MHP's EHR. Many contract providers managed their own EHRs and preferred to perform electronic batch file transfers to the MHP EHR (29 percent of Plans used electronic batch file transfers), but this would be for claiming purposes and would not contain the clinical information present in progress notes that direct use of the same EHR would offer. Half of the MHPs reported that some of their contract providers submit member information using fax or email to transmit files, and almost one-third of MHPs reported receiving paper documentation from contract providers. These modalities typically represent the methods with the highest risk of data entry errors into the MHP's system, as it requires staff to manually enter data through a separate process. Any electronic transfer type lowers the burden of double data entry, as well as errors associated with that process. Electronic Data Interchange and HIE were the least commonly used data transmission methods.

An encouraging trend the EQRO identified was that many MHPs used the transition to new EHRs as an opportunity to integrate contract providers more fully into the MHP EHR in FY 2023-24. MHPs, including **Placer-Sierra**, **Stanislaus**, **Napa**, **Monterey**, and **Trinity**, onboarded contract providers as primary users of the new EHRs alongside MHP staff, providing contract providers user licenses. **Napa** even offered incentive payments to contract providers for joining the EHR. In some cases, contract providers are using the MHP EHR as their primary system, which not only removes the added burden of entering data into two systems, but also ensures more accurate and complete data sets. This, in turn, supports reporting, NA analysis, and enhances MHPs' abilities to make data-informed decisions.

Medi-Cal Claiming Integrity

The integrity of the Medi-Cal claims requires data integrity and further examines that Plans' claims processes include the presence of policies and procedures to administer the Medi-Cal claims processing effectively, eligibility verification procedures in place to ensure appropriate Medi-Cal services are claimed, and that claims are submitted in a timely and accurate manner. The claims denial rate is an objective measure of the integrity of an MHP's claims processing. A well-managed claims system with proper documentation lowers the risk of denied claims from the state, as well as that associated with any future audits. Based on rates reported in the ISCA, the statewide average proportion of services claimed to Medi-Cal was 79 percent, which was fairly consistent across MHP sizes.

All MHPs Met (64 percent) or Partially Met (36 percent) this component. Overall, while MHPs generally had low claims denial rates, they were higher than in years past at almost 6 percent statewide. CalEQRO made recommendations to multiple MHPs to address the rate of Medi-Cal denied claims. One recurring issue in MHPs with higher claim denials was the absence of Medicare certification and claiming.

CalEQRO found that many Plans had difficulties submitting claims after the implementation of payment reform, and those Plans that had implemented the SmartCare EHR in partnership with CalMHSA were particularly challenged by an inability to submit claims at all for a period of time. Ratings reflect Plans' situations at the time of their review, and it is likely that most Plans have resolved claiming issues related to payment reform and EHR transitions since their reviews occurred, particularly for those Plans whose reviews occurred shortly after the go-live of a new EHR.

For the MHPs in the process of new EHR implementation, and those planning to do so soon, maintaining a strong process for the integrity of the Medi-Cal claims is critical for generating accurate and timely revenue production throughout implementation – and provides for more valid administrative data for analytic purposes. In this last year, all MHPs updated Medi-Cal claiming processes due to payment reform updates, which required updating policies, procedures, and EHR development to implement the changes.

EHR Functionality

The EHR Functionality Key Component addresses the ability to store clinical data electronically as all or part of a member's medical record, accessible by providers and others involved in clinical care. MHPs of all sizes were rated Met (88 percent) in this category, and seven MHPs were rated Partially Met (12 percent), with small and small-rural MHPs as the majority, and one large MHP also receiving a Partially Met rating.

Figure 9-9 presents the EHR functionalities in place across the Plans.

Figure 9-9: EHR Functionality, FY 2023-24

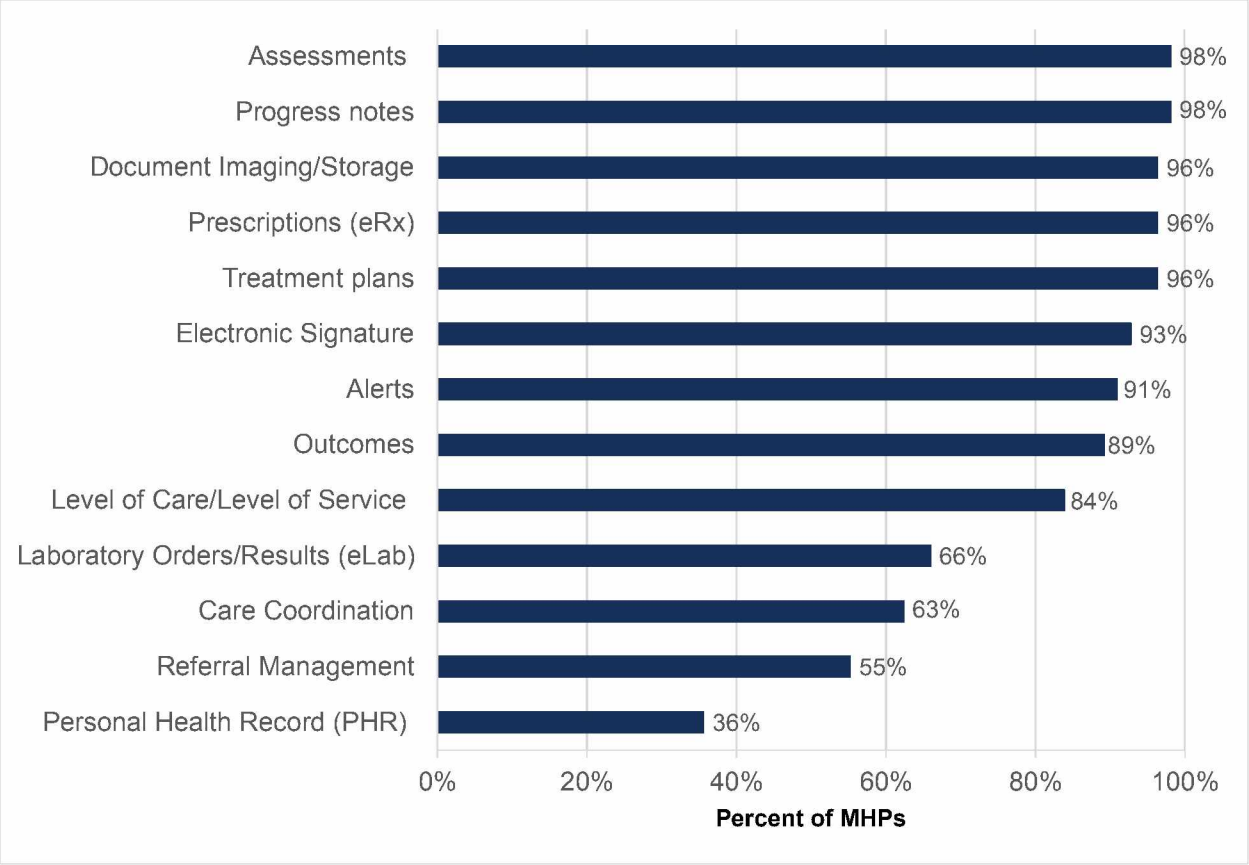


Figure 9-9 shows that in FY 2023-24, nearly all MHPs had core operational functionalities such as assessments, progress notes, document storage, prescriptions, and treatment plans built into their EHRs. All but one of the functionalities included in Figure 9-9 were in place in the majority of MHPs' EHRs. The least common functionalities available in MHP EHRs were PHR, referral management, care coordination, and eLab, all of which were implemented in two-thirds or less of all MHPs.

In some instances, MHPs relied on adjunct or add-on systems for functionalities such as outcomes, e-prescription, LOC, care coordination, and referral management. MHPs that lacked the care coordination and referral management functionalities continued to rely on proactive communication from providers and other manual processes to assist in coordination of services as members transitioned between LOCs. Embedding referral management and care coordination alerts into an EHR creates efficiencies and improved quality of care. The lack of eLab implementation statewide also poses a noteworthy challenge for prescribing providers. Plans continue to require a lot of work in this area. Notably, many of these areas of functionality were in development in prior EHRs used by Plans, and with the transition to new EHRs for so many MHPs, the timeline for development has effectively been reset due to the focus on clinical documentation and claiming as the initial priorities.

It should be noted that the presence of any given functionality does not necessarily equal the utilization of that functionality or the data it provides. While 84 percent of MHPs indicated that their EHR included LOC or Level-of-Service functionality, there were very few examples across the state of this data being analyzed and matched to the members' LOC provided. While 20 MHPs reported having a PHR function in their EHR, only 10 Plans reported members having

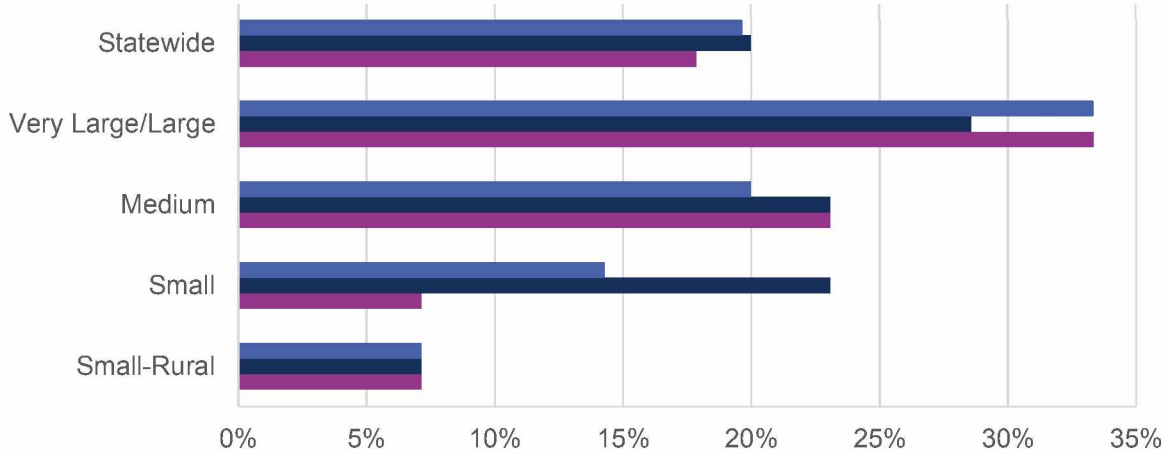
been allowed access to it in the prior year. Two of those Plans were unable to report the number of members who had accessed the PHR. Of the remaining eight MHPs with a PHR, one reported no members having accessed it, and five reported that only 1 percent or less of their members had accessed it in the past year.

The PHR is a portal into the EHR that enables members and their authorized representatives to access key aspects of their record: assessments and notes written by service providers; current and past medication prescriptions; next scheduled appointment; and, in some cases, signed Releases of Information, lab results, and other information. If this functionality is fully implemented, it can be a mechanism for online scheduling or rescheduling of appointments and enables two-way communication with providers.

For medium and large MHPs that had greater reliance on contract provider-operated services, however, access to these functionalities remained varied. While in some MHPs most contract providers have full, two-way, look-up, and data entry privileges, many contract providers in other MHPs lack such access. In some instances, the contract providers have only look-up access to certain functionalities, whereas many others rely on paper, fax, or e-mail documents from the Plan's EHR to learn about any past diagnoses, treatment plans, medication histories, and other related treatment information. Given that many contract providers work with multiple MHPs, many of which are using different systems, a solution in which an MHP requires contracted agencies to use its EHR to have a complete clinical view can also create additional complications if a contracted agency must learn and interface with multiple, completely different, systems. In this case, a strong HIE becomes a more viable solution.

Figure 9-10 reflects the availability of PHR for members to access by county size group and statewide over the past three FYs.

Figure 9-10: MHP Member Access to Online Personal Health Record by MHP Size, FY 2021-24



	Small-Rural	Small	Medium	Very Large/Large	Statewide
FY 21-22	7%	14%	20%	33%	20%
FY 22-23	7%	23%	23%	29%	20%
FY 23-24	7%	7%	23%	33%	18%

The availability of member online access varies by MHP size and shows few changes outside of the small MHPs over the past three FYs. Larger Plans were more likely to have this functionality than smaller ones. All MHPs without a member-accessible PHR reported in the ISCA that implementation of a PHR is anticipated within the next 2 years. Statewide, 18 percent of MHPs reported having a PHR that was accessible by members in FY 2023-24, which was a decrease from the previous year. Six of the ten MHPs with PHRs used by members were using the myAvatar EHR.

As noted previously, while some MHPs indicated on the ISCA that a PHR was in place, there were proportionally low counts of members using the PHR in most cases. **Contra Costa** had, by far, the most effective implementation of PHR, reporting that 44 percent of their Medi-Cal members had accessed their PHR in the past year. **Mariposa** was the only small-rural Plan to have PHR available to members, and 19 percent of Medi-Cal members had accessed their health records via the PHR function, making them the MHP with the second-most accessed PHR in the state proportional to their number of members served.

Security

CalEQRO evaluates the safeguards and counter measures present in MHP IS to avoid, detect, counteract, or minimize security risks to physical property, information, computer systems, or other assets. In general, the MHPs have strong security and controls over their systems. MHPs of all sizes Met (71 percent) or Partially Met (27 percent) this component, with the exception of one small-rural MHP that received a Not Met rating. For many MHPs, this is a bifurcated function reliant on both the EHR vendor or the ASP, and the operations at the MHP, agency, or county levels. Often the EHR back-up and restoration process after any maintenance or interruption events are the responsibilities of the vendor or the ASP. The MHP, parent agency, or the county is often responsible for the maintenance of other critical functionalities including internet security, network connections, e-mail, and other communications.

During the FY 2023-24 reviews, the EQRO found that MHP IT departments did not always maintain their own operations continuity plans (OCPs) to use in the event of a natural disaster or cybersecurity issues. The EQRO made recommendations to several MHPs pertaining to this issue, although many MHPs have adopted new OCPs in the past 2 years. Given the state's experiences with catastrophic wildfires and floods that have interrupted power transmission and internet capabilities in affected areas, as well as cyber-attacks that have targeted BHPs, the need for an OCP appears to have been prioritized for most MHPs.

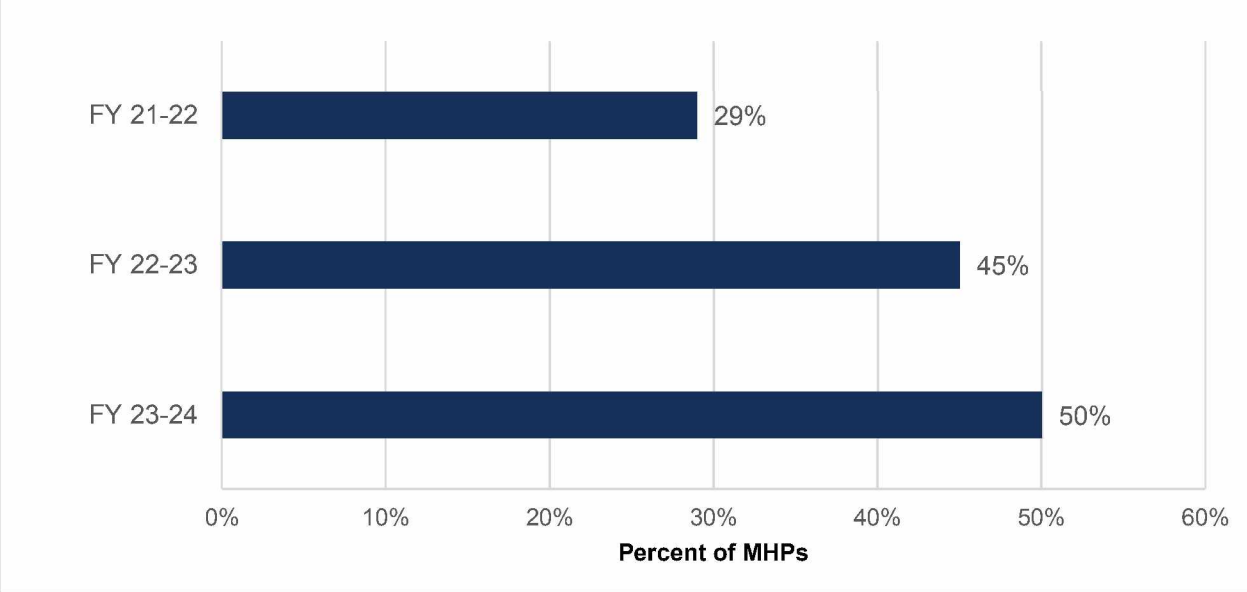
Interoperability

CalEQRO examines both internal interoperability issues with the MHPs' contract providers and external capabilities through participation in an established HIE with other agencies, such as hospitals or primary care providers. An overarching issue associated with utilizing EHRs within BHPs has been the integration of service-level data from contract providers who use separate systems. Generally, Plans communicate with contract providers via two or more submittal methods to exchange member information. Most MHPs received a rating of Met (61 percent) or Partially Met (35 percent), and the distribution was fairly equal across sizes; however, there were two small MHPs that received a Not Met rating (4 percent). Given that data exchange is a priority within the CalAIM framework, this is an important issue for MHPs to implement, particularly for data exchange with their local MCPs.

There is quite a bit of momentum surrounding increasing interoperability capabilities in California's landscape at this time. In FY 2021-22, DHCS implemented the CalAIM BHQIP,[46] an incentive program available to Plans until FY 2023-24 that provided an opportunity to MHPs that successfully met certain CalAIM implementation milestones, including CMS Interoperability and Patient Access requirements specified in BHIN 22-068.[47] BHPs were presented with the opportunity to earn incentive payments by completing specific deliverables tied to program milestones,[48] including technology and infrastructure milestones. DHCS encouraged and financially incentivized BHPs to pursue this opportunity, although participation was not required. Relatedly, California has established a data-exchange framework[49] that is intended to foster interoperability between a variety of health care systems and increase and enhance the electronic exchange of health information. Finally, calculation of several of the CalAIM quality measures[50] requires BHPs to have access to MCP data. All three of these initiatives are contributing to additional attention being paid by Plans to how they can improve interoperability.

Figure 9-11 illustrates HIE participation among MHPs across the last three FYs.

Figure 9-11 Health Information Exchange Participation, FY 2021-24



Participation in an HIE has increased consistently in each of the past two FYs. One-half of MHPs reported in the ISCA that they participated in a HIE, which is a more efficient method for two-way exchange of member data between EHR systems. Within the group of MHPs with an

[46] https://www.dhcs.ca.gov/Documents/BHIN-21-044-Behavioral-Health-Quality-Improvement-Program-Start-Up-Fund.pdf

[47] https://www.dhcs.ca.gov/Documents/BHIN-22-068-Interoperability-and-Patient-Access-Final-Rule.pdf

[48] https://www.dhcs.ca.gov/Documents/BHIN-22-050-Updated-Guidance-for-CalAIM-BHQIP.pdf

[49] State of California Center for Data Insights and Innovation. (2024). *Data exchange framework.* https://www.cdii.ca.gov/committees-and-advisory-groups/data-exchange-framework/

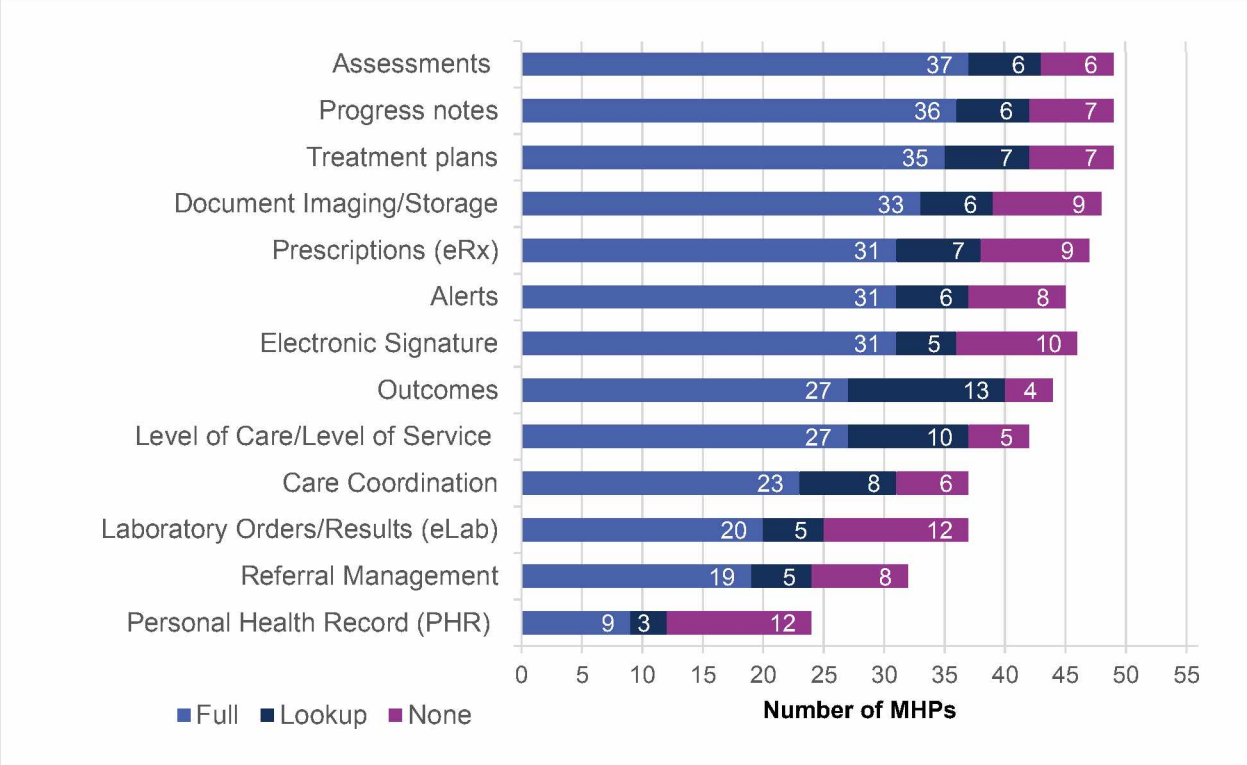
[50] https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-24-004-Quality-Measures-and-Performance-Improvement-Requirements.pdf

HIE, the type of HIE varied widely. Some MHPs only had an HIE with their contract providers, and many that reported being contractual participants in a HIE still did not actively exchange data through the HIE. Barriers to data exchange through an HIE cited by many MHPs included: legal or regulatory restrictions for not exchanging information with other entities via an HIE, local business decisions based on risk analysis, and technological challenges and lack of IS staffing needed to implement the functionality. Joining an HIE is a step in the right direction, however until it is used for the actual exchange of information, membership in these organizations can only be seen as the preliminary act of laying the groundwork for future improvements.

In FY 2023-24 reviews, the EQRO noted that many MHPs had initiated discussions with local partners about participating in local HIEs, and some were exploring or actively participating in exchanging some data elements with specific entities. HIE participation will be essential during continued CalAIM implementation, especially for use in facilitating exchanges of information between hospital emergency departments, MCPs, and MHPs given data-exchange requirements with these entities under CalAIM. Data exchange is necessary to obtain the appropriate data set for numerous quality measures. MHPs reported in the ISCA that the most commonly used mechanism for exchanging required data with MCP this past year was through secure file transfer protocol.

Figure 9-12 illustrates contract provider access to various EHR functionalities statewide.

Figure 9-12: Provider Access to EHR Functionalities, FY 2023-24



Assessments, progress notes, and treatment plans represented the most common functionalities to which Plans provided full access to their contract providers. Outcomes was the most common functionality with lookup access, followed by LOC, and then care coordination. In contrast, PHR, referral management, and eLab were the least common functionalities fully available to contract providers. The lack of contract-provider access to these functionalities points toward more manual transmission of this information, which introduces greater

opportunities for errors as well as being less efficient. As the many MHPs that were transitioning EHRs this FY complete that process, it would be prudent for them to develop and implement additional contract-provider access to their new EHR systems if they have not already undertaken that work.

SUMMARY OF INFORMATION SYSTEMS

As CalAIM has brought fundamental changes in the behavioral healthcare delivery system in California, the MHPs will need to continue to make significant investments in IT infrastructure and data analytic resources to effectively implement the changes required by this waiver. In FY 2023-24, all MHPs were required to implement changes to their EHRs to maintain compliance. The simultaneous transitions to new EHRs for the majority of MHPs created a more significant challenge given the resources needed for developing the systems, planning their implementation, training MHP and contract provider staff on a new EHR, testing functionalities, and finally going live with the new systems. MHPs reported in EQR sessions that a lack of clear information and directions on how to execute CalAIM updates was a challenge in implementing changes. This caused some long-term development of system functionalities such as interoperability, PHR, and data integrity improvements, to be placed on hold as foundational system functionality including clinical documentation, Medi-Cal claiming, and mandated reporting were prioritized.

Most MHPs reported Medi-Cal claiming issues associated with the changes related to payment reform, including vendor readiness, lack of timely directions pertaining to billing updates, and a delay in state claims processing that occurs at the end of a FY. This created a financial strain due to unreimbursed claims that, in many cases, lasted beyond the end of CY 2023, not only for the MHPs, but also the contract provider networks that partner with the Plans. This initial FY of service claims following the payment reform updates are being monitored closely by the MHPs and contract providers alike to assess for any long-term impacts on programs and adjustments that may be needed in order to remain viable.

As MHPs navigate reporting on new quality measures, issues of data integrity related to data extraction and combining data sets will continue to be a challenge that will require additional technical staff resources and training for successful implementation. In particular, many of the CalAIM quality measures (also referred to as BHAS measures) require data exchange with hospitals, pharmacies, and MCPs. Most MHPs did not already have data-exchange capabilities with these providers and have struggled with executing data-sharing agreements and negotiating the complexities inherent in exchanging sensitive health information with outside entities. While DHCS calculated these measures for the MHPs for MY 2022, it is very unlikely that most BHPs are prepared to calculate MY 2023 themselves, and many have had to devote financial resources to outside organizations, including CalMHSA, for assistance with this endeavor.

For the MHPs to be able to track outcomes and PMs that require data from hospitals, primary care, and pharmacies, substantial work is needed to ensure statewide standardized guidelines and protocols are adopted, while navigating the barriers of disparate systems and processes. These challenges may be addressed by MHPs with meaningful participation and effective data-sharing efforts through HIEs, if they are successful in surmounting current technical, technological, and legal barriers, and are able to engage outside entities in facilitating the exchange of information when they do not necessarily have the same incentives to do so. Some may argue that they are disincentivized due to the increased potential for data breaches.

With many MHPs implementing new systems or significantly enhancing the functionality of their existing systems, interoperability and contract-provider access to the EHRs will continue to be at the forefront of both challenges and priorities. When contract providers have less access to the MHP EHRs, there is a greater potential for quality of care to suffer due to a lack of information while making assessments and transitioning members between LOCs. Additionally, in some instances, double data entry will continue to be a source of errors and unnecessary workforce demands, especially during a time of continued widespread staffing shortages being reported by MHPs and contract providers during the EQR sessions.

With 50 percent of MHPs having implemented the SmartCare by Streamline EHR coordinated through CalMHSA, there are unique opportunities in developing interoperability between participating MHPs and the contract providers within each county and statewide. While this initial year of implementation has focused on staff training and the foundational system components of clinical documentation and claiming, substantial vendor and CalMHSA resources are needed to ensure that missing functionalities within the base EHR are implemented as soon as possible. With this focus on the foundational systems, it appears clear that MHPs have acknowledged the need for added IT and data-analytic resources, either internally or contracted, to make progress on customized reporting and system development for each MHPs specific needs. Without the ability to leverage these additional resources, functionality for reporting capabilities and interoperability will be delayed for the foreseeable future, as participant MHPs reported these as lower priorities under the CalMHSA EHR initiative.

Compliance

OBJECTIVE

DHCS conducts triennial reviews of each county MHP to determine compliance with federal and state regulations as well as the terms of the MHP contract. The goal of this process is to ensure compliance and to identify opportunities for improvement. Based upon EQRO Protocol 3, the triennial review has been structured as a two-part process, comprising an assessment of both the compliance of the SMHS system operations and the compliance of individual SMHS charts. Pursuant to WIC Section 5614, DHCS revised the Annual Review Protocol for SMHS and Other Funded Services (Protocol) in collaboration with DHCS's Compliance Advisory Committee, FY 2020-21 (BHIN 20-061[51]), FY 2021-22 (BHIN 21-053[52]), and FY 2022-23 (BHIN 22-063[53]), the 3 years for which summarized audit findings are covered in this chapter. CalEQRO received the summary of audit results from DHCS and details them in this chapter.

TECHNICAL METHODS

In FY 2023-24, DHCS discontinued providing the detailed protocol in advance of the year's audits, aligning more with the process historically utilized in the DMC audits. Additionally, BHIN 23-006 informed Plans of additional monitoring activities to be implemented in addition to the compliance audits, which are supplemented by monthly TA and check-in calls with MHPs.[54]

Compliance audits of MHPs include the quantitative analysis of SDMC claims data, member files, provider files, and a qualitative analysis of policy and procedural documentation to determine each PIHPs compliance with state and federal standards. SDMC data is collected from each PIHP via DHCS' claims submission process whereas member files, provider files, and any associated documentation is provided by each PIHP at the time of each audit. Compliance results are compiled into a findings report which is sent to the PIHP with the associated CAP requirements. In addition, the Department posts each PIHP's findings report on DHCS' website. Upon receiving audit findings, MHPs are expected to submit a Plan of Correction. This plan must be approved by DHCS and subsequently implemented by the MHP.

Due to the triennial schedule, the chart review process for FY 2022-23 was adjusted in response to Assembly Bill 133, which was the trailer bill that outlined regulations for CalAIM implementation. Findings warranting recoupment were to be limited to issues of fraud, waste, and abuse, rather than minor errors in progress notes or explicit linkages between interventions and treatment plans. This approach is reflected in the absence of disallowances in the FY 2022-23 audits. The 2 prior years resulted in financial recoupments, which are represented in this chapter by their percentage of audited dollars disallowed.

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[51] https://www.dhcs.ca.gov/Documents/BHIN-20-061-Annual-Review-Protocol-SMHS-FY20-21.pdf

[52] https://www.dhcs.ca.gov/Documents/BHIN-21-053-Annual-Review-Protocol-for-SMHS-FY-2021-22.pdf

[53] https://www.dhcs.ca.gov/Documents/BHIN-22-063-Annual-Review-Protocol-for-FY-2022-23.pdf

[54] https://www.dhcs.ca.gov/Documents/BHIN-23-006-Ongoing-Monitoring-Activities-Process-for-MHP-and-DMC-ODS-counties.pdf

DHCS issues a comprehensive document submission checklist that includes all the requested documentation for both the SMHS system review and the SMHS outpatient chart review. MHPs are required to submit evidence of compliance for each requirement outlined in the protocol. DHCS provides MHPs with instructions for accessing its secure e-transfer portal, enabling the secure transmission of documents containing Protected Health Information. Before conducting on-site or virtual reviews, DHCS performs a desk review of the documentation submitted by the MHPs. During the on-site or virtual review, DHCS interviews key personnel from the MHPs and reviews a wide variety of documentation.

The audit is structured into the categories outlined in Table 10-1.

Table 10-1: Annual Review Protocol Categories for SMHS

Section	Protocol Sections
Section A	Disenrollment: Requirements and Limitations
Section B	Enrollee Rights
Section C	Emergency and Post-stabilization Services
Section D	Availability of Services
Section E	Assurances of Adequate Capacity and Services
Section F	Coordination and Continuity of Care
Section G	Coverage and Authorization of Services
Section H	Provider Selection
Section I	Confidentiality
Section J	Grievance and Appeal Systems
Section K	Subcontractual Relationships and Delegation
Section L	Practice Guidelines
Section M	Health Information Systems
Section N	Quality Assessment and Performance Improvement Program
Section O	Disenrollment: Requirements and Limitations

After completing a review, DHCS issues notification letters to MHPs describing identified compliance deficiencies, outlining ongoing monitoring activities, and specifying the timeframe for these activities. DHCS then provides MHPs with a resolution letter once the ongoing monitoring activities have been completed. Ongoing monitoring activities to support improved compliance and quality are described in Table 10-2[55]. If MHPs fail to comply with the established ongoing monitoring activities, DHCS will evaluate the situation and may impose administrative and monetary sanctions.

[55] https://www.dhcs.ca.gov/Documents/BHIN-23-006-Ongoing-Monitoring-Activities-Process-for-MHP-and-DMC-ODS-counties.pdf

Table 10-2: MHP Compliance Monitoring Activities

Monitoring Activity	Associated Methodology
Monitoring Calls	Individual monitoring calls/webinars with each MHP. Monthly monitoring calls are conducted by DHCS County Monitoring Liaisons and take place regardless of tier placement or other compliance status.
Statewide/Regional TA and Training	TA or training provided to all MHPs, or groups of MHPs, on specific topics
Focused TA	TA provided, focusing on the MHP's particular area or areas of noncompliance
Focused Training	Training provided, focusing on the MHP's particular area or areas of noncompliance.
Focused Desk/On-site Review of the MHP	Targeted desk or on-site audits are conducted for one or more specific areas identified as out of compliance in the MHP. Focused desk and on-site reviews conducted for ongoing monitoring activities are distinct from and additional to other DHCS compliance reviews. If deficiencies are identified during a focused desk or on-site review, DHCS issues a separate Findings report detailing the deficiencies. A new CAP is then required. If there are no findings, DHCS provides written notification to the MHP stating that no findings were identified. In this case, a CAP is not required.
CAP Process	A CAP is required for findings of non-compliance. MHPs are required to submit a CAP to DHCS within 60 days of receiving the findings report. The CAP must include the following information: • Description of corrective actions, including a timeline for implementation and/or completion of corrective actions. • Proposed (or actual) evidence of correction that will be submitted to DHCS. • Processes for monitoring the effectiveness of corrective actions over time. • Descriptions of corrective actions required of the county's contract providers to address findings. DHCS confirms receipt of the CAP within 15 business days of submission and follows-up with MHPs if the CAP documents are missing required elements and/or need to be resubmitted. After submission of the CAP, if DHCS determines that the CAP is insufficient, the MHP shall propose an alternative CAP to DHCS. County Monitoring Units in the Medi-Cal Behavioral Health Division approve and monitor the county's progress on the MHP findings identified in the CAP every 90 days until the deficiencies are remediated.
Appeals	If MHPs elect to appeal any item within their findings report, they may do so by submitting an appeal, in writing, within 15 business days after the receipt of the findings report. DHCS will grant or deny the appeal, either in whole or in part, within 30 calendar days after receiving the appeal. If an appeal is submitted, and/or the original findings are upheld, the MHP shall send the CAP within 60 calendar days of receipt of the notification from DHCS.

DHCS COMPLIANCE FINDINGS

As previously described, each triennial compliance review is composed of two sections – a system review and a chart review. This chapter displays the three-year set of system review aggregate findings (Table 10-3) followed by the chart review results (Table 10-4).

It should be noted that CalEQRO does not have access to the detailed results for validation, only the summary results as displayed below.

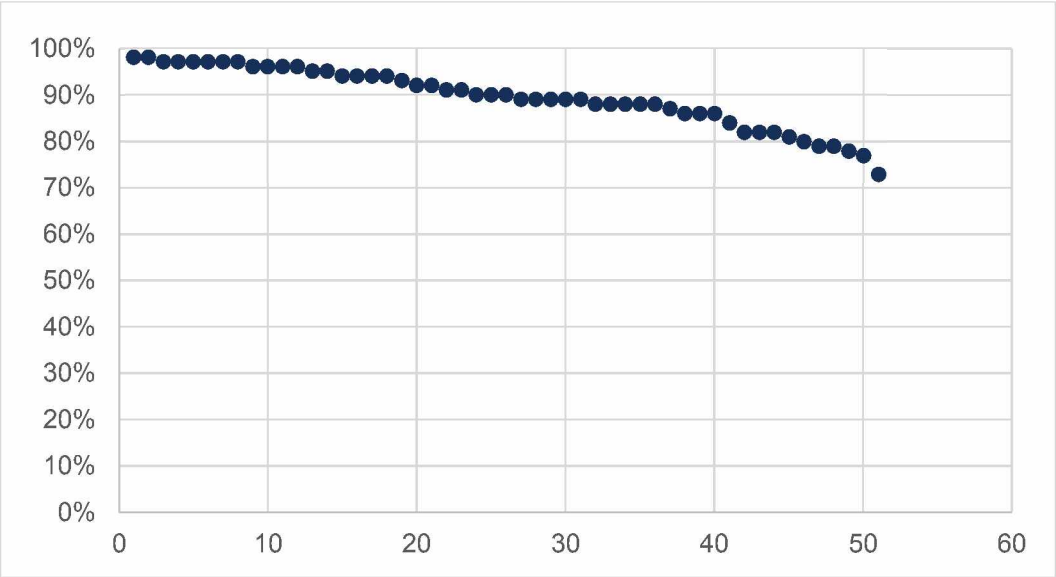
Table 10-3: System Review Triennial Results, FY 2020-23

FY 2020-21: Cycle 1		FY 2021-22: Cycle 2		FY 2022-23: Cycle 3	
MHP	**% Compliance**	**MHP**	**% Compliance**	**MHP**	**% Compliance**
Amador	97%	Alpine	78%	Alameda	90%
Calaveras	94%	Butte	95%	Contra Costa*	*
Colusa	89%	El Dorado	92%	Humboldt	88%
Del Norte	88%	Glenn	98%	Kings	73%
Fresno	95%	Imperial	97%	Marin	90%
Inyo	77%	Kern	89%	Merced*	*
Lake	82%	Los Angeles	82%	Nevada	81%
Lassen	96%	Madera	90%	Orange	89%
Modoc	94%	Mariposa	97%	San Benito	79%
Mono	88%	Mendocino	98%	San Francisco	86%
Monterey	91%	Napa	96%	San Mateo	80%
Sacramento	91%	Placer/Sierra	88%	Santa Barbara	88%
San Diego	97%	Plumas	86%	Shasta	79%
San Joaquin	97%	Riverside	89%	Sonoma	86%
Santa Clara	84%	San Bernardino	93%	Stanislaus	92%
Santa Cruz	97%	San Luis Obispo	96%	Sutter-Yuba*	*
Solano	94%	Siskiyou	94%	Trinity*	*
Tehama	87%			Tuolumne	89%
Tulare	82%			Ventura*	*
Yolo	96%				
Average Rates	**91%**	**Average Rates**	**92%**	**Average Rates**	**85%**

* Moved to FY 2023-24 (Integrated Audit)

Across the three-year review of all 51 MHPs, performance is displayed in Figure 10-1.

Figure 10-1: Distribution of MHP System Compliance Rates, FY 2020-23



- Over the three-year period, 30 MHPs of the 51 MHPs reviewed (58.8 percent) exceeded 90 percent compliance with the system review requirements. The overall average performance was 89 percent and the median performance was 90 percent.
- Only five MHPs (8.9 percent) – Kings, Inyo, Alpine, San Benito, and Shasta – rated less than 80 percent on the system review, ranging from 73 percent to 79 percent.
- Five MHPs representing 8.9 percent of MHPs – Contra Costa, Merced, Sutter/Yuba, Trinity, and Ventura – are not represented with system review findings. They were scheduled for their triennial audit in FY 2022-23, but it was deferred to FY 2023-24. The audit will be integrated with the DMC-ODS or DMC State Plan, as applicable.

The annual results for the chart reviews (rates of disallowances) are outlined in Table 10-4.

Table 10-4: Outpatient Chart Review Triennial Results, FY 2020-21 – FY 2022-23

FY 2020-21		FY 2021-22		FY 2022-23	
MHP	**% Disallowance**	**MHP**	**% Disallowance**	**MHP**	**% Disallowance**
Amador	3.0%	Alpine	5.0%	Alameda	0.0%
Calaveras	3.0%	Butte	0.0%	Contra Costa*	N/A
Colusa	3.0%	El Dorado	31.0%	Humboldt	0.0%
Del Norte	0.0%	Glenn	0.0%	Kings	0.0%
Fresno	4.0%	Imperial	3.0%	Marin	0.0%
Inyo	17.0%	Kern	0.0%	Merced*	N/A
Lake	19.0%	Los Angeles	4.0%	Nevada	0.0%
Lassen	19.0%	Madera	0.0%	Orange	0.0%
Modoc	2.0%	Mariposa	15.0%	San Benito	0.0%

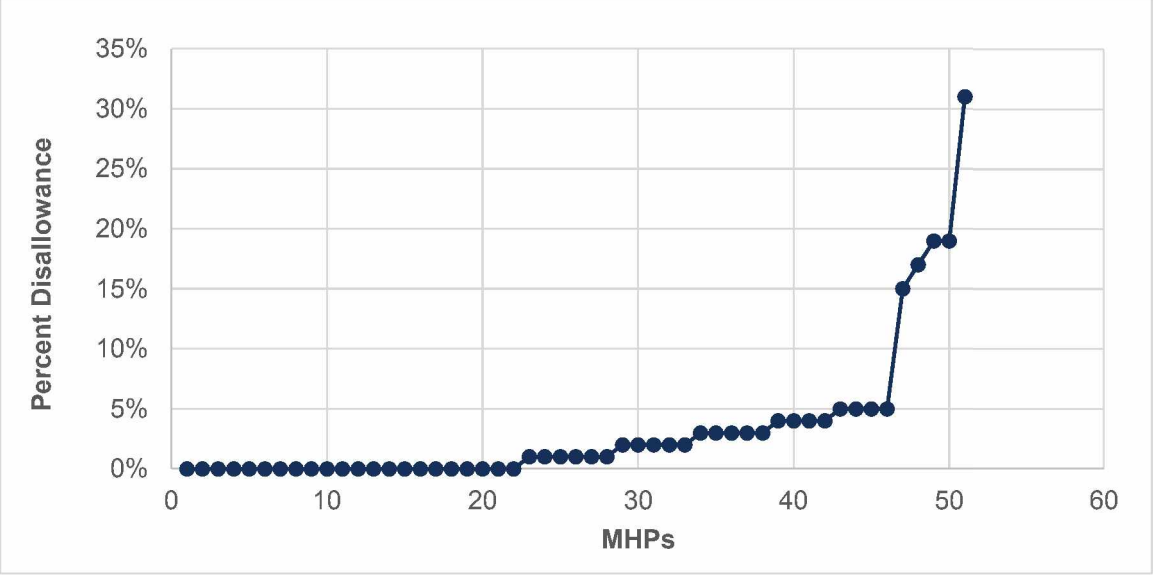
FY 2020-21		FY 2021-22		FY 2022-23	
MHP	**% Disallowance**	**MHP**	**% Disallowance**	**MHP**	**% Disallowance**
Mono	5.0%	Mendocino	1.0%	San Francisco	0.0%
Monterey	2.0%	Napa	2.0%	San Mateo	0.0%
Sacramento	1.0%	Placer/Sierra	1.0%	Santa Barbara	0.0%
San Diego	1.0%	Plumas	2.0%	Shasta	0.0%
San Joaquin	5.0%	Riverside	3.0%	Sonoma	0.0%
Santa Clara	2.0%	San Bernardino	4.0%	Stanislaus	0.0%
Santa Cruz	0.0%	San Luis Obispo	4.0%	Sutter/Yuba*	N/A
Solano	0.0%	Siskiyou	1.0%	Trinity*	N/A
Tehama	1.0%			Tuolumne	0.0%
Tulare	0.0%			Ventura*	N/A
Yolo	5.0%				
Average Rates	**4.60%**	**Average Rates**	**4.47%**	**Average Rates**	**0.00% ****

* Moved to FY 2023-24 (integrated audit)

** There were no chart disallowances for the FY 2022-23 cycle.

The disallowance rates for 56 MHPs are displayed in Figure 10-2.

Figure 10-2: Distribution of MHP Chart Disallowance Rates, FY 2020-23



- Disallowance ratings from chart reviews ranged from 0 percent to 31 percent, with an average of 3 percent and median of 1 percent.

  - Five MHPs had a disallowance rate higher than 5 percent – El Dorado, Lassen, Lake, Inyo, and Mariposa – with rates ranging from 15 percent to 31 percent. Among these, only one MHP had a rate of 20 percent or higher.
  - Twenty-four MHPs' disallowance rates were between 1 percent and 5 percent.
- No MHPs (N=14) had any disallowances in FY 2022-23 reviews, with DHCS applying a new standard as part of CalAIM, only disallowing claims due to reasons of fraud, waste, or abuse.
- Again, five MHPs (Contra Costa, Merced, Sutter-Yuba, Trinity, and Ventura) are not represented with outpatient chart review results. Their review was deferred from FY 2022-23 to FY 2023-24 and will be conducted as an integrated audit with the DMC-ODS or DMC State Plan, as applicable.

CONCLUSIONS AND SUMMARY OF COMPLIANCE FINDINGS

DHCS provided CalEQRO with the summary of system review compliance findings for the three-year period described which included 51 of 56 MHPs.

In FY 2020-21, four MHPs – Santa Cruz, Solano, Del Norte, and Tulare – showed no disallowances, which was prior to the implementation of the new documentation standards. In addition, six MHPs had both system compliance rates of 95 percent or above and chart disallowance rates of less than 5 percent: Amador, San Diego, San Joaquin, Santa Cruz, Yolo, and Fresno.

In FY 2021-22, four MHPs – Glenn, Butte, Madera, and Kern – showed no disallowances. This occurred prior to the implementation of the new documentation standards. Eleven of the 17 MHPs audited that year scored 80 percent or higher in the system review. Nine MHPs had both compliance rates of 95 percent or above and chart disallowance rates of less than 5 percent: Glenn, Butte, Madera, Mendocino, Siskiyou, Napa, Imperial, San Luis Obispo, and San Bernardino.

In FY 2022-23, none of the 14 MHP's reviewed had disallowances. However, only three of them – Stanislaus, Alameda, and Marin – also scored 90 percent or higher in the system review.

This report also contains Compliance information included as Appendix 4, displayed to remedy prior CMS findings. Within those findings, three MHPs (Merced, Mono, and Santa Cruz) received Met ratings for all 14 areas. Strong performance suggests that these MHPs may have some best practices that could benefit other MHPs.

High performance is indicated by a high system compliance rate and a low chart review disallowance rate. The highest performance was observed in FY 2022-23, coinciding with the new chart review audit protocol. At the same time, FY 2022-23 also exhibited the lowest system review performance. Over the 3-year period, 20 MHPs had a system compliance rate of 90 percent or higher and a chart disallowance rate of 5 percent or lower. Additionally, 12 MHPs had a chart disallowance rate of 2 percent or lower: Glenn, Santa Cruz, Butte, Solano, Madera, Mendocino, San Diego, Siskiyou, Sacramento, Modoc, and Monterey.

Conclusions

INTRODUCTION

This chapter highlights some of the salient findings described throughout this report and is followed by recommendations for MHPs and for DHCS.

ACCESS

After an increase in access in CY 2021 compared to CY 2020, during the peak of the pandemic, many of the measures of Access decreased in CY 2022. In CY 2019 pre-pandemic, MHPs served 627,928 members (PR at 4.86 percent) compared to 600,959 in CY 2022 (PR at 3.96 percent). This represented the first year that the statewide PR fell below 4 percent. Although this level of utilization represents an increase over what was seen in CY 2020 (N=595,596), the CY 2022 PR represents an 18.5 percent decrease when compared to 2019 (4.86 percent).

Comparing CY 2021 to CY 2022, older adults showed a slight increase in numbers served in CY 2022, but the number of youth and adults served decreased, as did the numbers served by all racial/ethnic groups analyzed and the number of members served in a threshold language; however, this pattern varies across Plans. Additionally, the continued decrease in FC members served warrants attention, although current data will show whether the expanded approach to FC youth and other high-risk populations prioritized in CalAIM begins to reverse this trend.

MHPs reported that fewer members overall had received services through telehealth, the largest decrease among youth. However, there was an increase in the number and percentage of older adults served who received at least one telehealth service, with data indicating that 30 percent of older adults participated in the MHPs' telehealth.

TIMELINESS

Statewide timeliness metrics reported by MHPs showed similar performance to prior years. The initial offered, non-urgent appointment was scheduled, on average, within 7.4 business days and 81 percent of those appointments met the DHCS standard of 10 business days. In terms of the percentage that met the 10 business-day standard, rates at 95 percent or higher were validated for 12 MHPs with many of them showing average wait times of 4 business days or less. There are others with long initial wait times, and six MHPs showed average wait times approximating 3 or 4 weeks. In light of these long averages, it implies that many members experience longer wait times, exceeding a month, and that is a critical service issue for those MHPs. Additionally, it is important to keep an eye on the gap between the offering of the initial appointment and the subsequent delivery of the associated service, as a system may have an abundance of inconvenient times that are declined (e.g., 8 am).

Timeliness to the offered initial non-urgent psychiatry appointment averaged 11.4 business days, almost a day shorter than last year. The percentage meeting the standard overall still fell short of DHCS's 80 percent expectation, with 76 percent of these appointments meeting the standard of 15 business days. Utilizing the 80 percent standard for 15 business days, 29 MHPs

met this threshold (though only 22 MHPS could be validated). Six MHPs reported overall wait times longer than 20 business days (4 weeks). Three MHPs met the 80 percent standard but reported average wait times that were 11 business days or longer. The average wait time was as brief as 3 business days, but as long as 41 business days (8 weeks) for adults and nearly 32 business days (6 weeks) for youth. Because MHPs still generally require an assessment with a clinician prior to an assessment by a prescriber, the wait-time interval before a member can reach a psychiatric provider can be as short as 2 to 4 weeks or as long as 3 or more months.

Timeliness metrics assess whether the member was able to receive help when they requested it. From a macro perspective, these metrics help determine whether the system is equipped with appropriate LOC, staffing, and administrative infrastructure to get individuals into services in a timely manner. The extent to which services are delivered in a timely manner can impact whether members decide to enter treatment at all.

QUALITY

The Quality area is where MHPs had the most challenges in meeting elements reviewed, but 9 of 10 Key Components had more Met ratings than the prior year. Small and small-rural MHPs are most challenged in this area, generally with insufficient staffing and technical expertise to maintain a robust QM function. Despite challenges based upon the timing of the review and the progress in new EHR implementation, more MHPs received Met ratings than last year, demonstrating more capacity to develop and utilize reporting for system evaluation and improvement. Utilizing tools for LOC placement (especially for adults) and evaluation or for outcomes analysis were the areas in which most MHPs had challenges. Only 19 met the elements for LOC and 17 for outcomes analysis. Despite utilization of the CANS, most MHPs have not utilized this data for systemwide review. Additionally, in an era of increasing requirements of accountability, demonstrating improved outcomes is a significant gap.

Engagement in services after an inpatient hospitalization is a meaningful quality measure. The statewide average showed that 58 percent of members hospitalized did not receive a follow-up service in the 30 days that followed discharge. Local tracking of this metric is important because CalEQRO approved claims only reflect Medi-Cal inpatient services, and to varying degrees across MHPs, non-billable inpatient facilities can represent a significant proportion of inpatient services.

CalEQRO obtained input and feedback from 574 individuals through 94 focus groups conducted in all MHPs. Their feedback at the MHP-level warrants local attention, especially when feedback suggests improvements may be necessary and that further analysis is needed.

While half of all PIPs received a Moderate to High Confidence validation rating, maintaining skilled staffing to oversee and implement PIPs continues to be an ongoing challenge. Nine MHPs, impacted by workforce challenges, did not meet the requirement of two PIPs. The five MHPs that submitted only one PIP utilized the BHQIP PIP. Now that the BHQIP project has concluded, additional MHPs may have more difficulty submitting two PIPs next year. (The BHQIP brought additional resources and a simplified submission document – though simplified sometimes it did not provide enough structure for MHPs to include sufficient detail.)

INFORMATION SYSTEMS

In FY 2023-24, 70 percent of MHPs reported being in the process of implementing a new EHR, and 59 percent of the Plans transitioning EHRs were participating in the CalMHSA multi-county

EHR initiative, implementing the SmartCare EHR by Streamline. Plans dedicated substantial resources to executing payment reform (which involved renegotiating reimbursement rates and updating contracts with providers, training staff, updating workflows and claiming processes) at the beginning of the FY. In many cases, claiming was reportedly delayed, sometimes for many months, due to the need for modifications to Plan EHRs. In some cases, delays in claiming resulted in financial concerns for Plans, due to their not receiving reimbursements from the implementation of payment reform through the beginning of CY 2024. However, CalMHSA worked with the SmartCare Plans to try to resolve these issues and continues to pursue the objective of developing and building out the potential of this new EHR system, especially its reporting functionality.

While IT staffing levels were down statewide this FY, Plans have been investing in additional data analytical staff to try to keep up with expanded data reporting requirements. Plans continue to struggle to collect complete and accurate data, particularly from contract providers. Nonetheless, it is possible that the sheer volume of Plans that decided to implement the SmartCare EHR (50 percent of MHPs) will also prove beneficial in increasing interoperability with contract providers. One of the barriers to contract-provider EHR access has been persuading providers who work across multiple Plans to use a common EHR (as different Plans use different EHRs). If all providers within an MHP's system of care used the same EHR, however, duplication of effort caused by the need for these providers to enter member-related data into divergent systems would be remediated, data-entry errors might be thereby reduced due to streamlining the process of information capture, and the ability to evaluate and maintain overall data integrity would likely be increased.

Interoperability is increasingly important within the CalAIM framework and is necessary in order for Plans to calculate the quality measures (which necessitates information exchange with hospitals, pharmacies, MCPs, and other providers). While the proportion of MHPs reporting membership in an HIE has nearly doubled over the past three FYs, CalEQRO found that very few were using the HIE to exchange information. Becoming a member is an important first step, but Plans must use their HIEs for data exchange in order to leverage their benefits.

RECOMMENDATIONS

The following recommendations are intended for California's SMHS delivery system, inclusive of DHCS and the 56 MHPs. Some are broadly applicable statewide, though not all recommendations are suited to every Plan. Many of the recommendations made in last year's report still apply and some were altered and put forth again this year. Several of the recommendations are new to this report.

Recommendations for MHP Consideration

Access

1. Identify gaps in access to care for metrics that have not improved or returned to pre-pandemic levels. Identify targeted strategies to engage and retain affected populations in care. This is important for achieving the goals of the CQS.
2. Identify member attrition between screening and first appointment, as well as the first and second services. Strengthening early engagement is important, especially in underserved populations.

3. Conduct analysis on how the implementation of the statewide Screening and Transition of Care Tools and CalAIM changes have had on MHP capacity. This is important to anticipate year-to-year growth that may differ from historical numbers, affecting the size and type of the necessary workforce.
4. Assess systems for the full implementation of Pathways to Well-Being by analyzing ICC and IHBS service utilization in both the FC and non-FC youth populations – given that the FC PR statewide has decreased annually since CY 2020, and many MHPs' data showed relatively low utilization of these services in the youth population overall.
5. To strengthen the BH workforce, continue creative solutions for recruitment and retention. Counties that have not initiated recruitment and retention bonuses or other focused strategies should implement them, especially if their vacancy rates exceed 10 to 15 percent or more. As a long-term strategy, consider more outreach to local schools for pipeline programs encouraging careers in BH and psychiatry.

Timeliness

1. Continue to improve data collection to capture wait times at all access points (e.g., schools, Child Welfare Services, Probation, direct at contract providers, etc.) so that timeliness of care can be adequately monitored in real-time and improved when performance indicates the need. Timeliness reporting and review should occur at the executive level and QIC so that changes occurring in demand and capacity are quickly illuminated.
2. Improve timeliness to the follow-up visit after the initial appointment. This may require reviewing the methodology for tracking offered appointments. Tracking the time between the first delivered service and the next delivered service could yield meaningful information in terms of the wait time as well as unintended attrition. This could also be used for equity analysis if there are unintended patterns of care.
3. At the outset of care, identify individuals who have urgent needs – but are not in crisis – to facilitate timeliness monitoring necessary to implement efforts to engage them in care. MHPs that are only tracking the number of minutes or hours for crisis response are missing an important higher-risk population that require faster access to care.

Quality

1. Develop, strengthen, and prioritize the knowledge and skills necessary for analysis critical for continuous monitoring and improvement in care delivery systems. Reporting capacity, especially as it needs to be developed in newly implemented EHRs, requires additional development. Engage consultants to augment this function when there are insufficient positions to support necessary reporting or recruitment is not yet successful.
2. Prioritize the development and execution of meaningful PIPs based on local needs that will improve member outcomes of care. MHPs that have engaged consultants as technical-matter experts have been quite successful, though it is important that key MHP staff are at the table so that the implementation occurs in a way that applies appropriately to the local system.
3. Prioritize LOC review for those members who are HCMs or who are high utilizers of acute services. This undertaking may require focused engagement on members who are served multiple times only by acute and crisis service systems. Follow-up after delivering crisis services is important for engagement in outpatient systems.

4. If this has not yet occurred, implement the hiring of certified Peer Support Specialists to strengthen the overall BH workforce and the available services. Peer Support Specialists are critical conveyors of hope and support.

Information Systems

1. The lack of consistent tracking in the TADT rendered CalEQRO unable to present validation findings for network adequacy. Plans that currently use member identification (ID) numbers other than Client Index Numbers (CIN) should transition to using CINs as their primary IDs. As described in the NA chapter, numerous TADT submissions from Plans were unable to be validated due to using other IDs or using CINs that were truncated or adulterated in other ways. As Plans are increasingly expected to exchange information with outside entities, including hospitals and MCPs, to calculate BHAS measures, it is crucial to use a unique identifier that is not solely recognizable within individual Plans to match datasets to each other.
2. Prioritize IT infrastructure development, including interoperability, care management, and referral coordination, as well as HIE functionality to better manage linkages, coordinate care, and effectively manage care across systems.
3. Strengthen EHR functionality to support routine extraction of data associated with timeliness and other types of reporting and continue to enhance data analytics staffing resources within Plans. Effectuating this objective requires either contract providers' use of the Plan's EHR or electronic interface between disparate systems. Some contract providers work with multiple MHPs – all of which may have different EHRs – and so the MHP's EHR is often not inclusive of all clinical service data. Plans to work with agencies in this position should work to develop strategies that will foster interoperability and data exchange.
4. Work toward developing automated reporting for the CalAIM quality measures being implemented. Engage DHCS staff if there are questions regarding specifications.
5. Implement LOC tools and embed this functionality into EHRs so that service patterns can be analyzed, reported, and monitored in light of LOC results.

Recommendations for DHCS Consideration

These recommendations are intended to align, when possible, with the CQS. They are furnished to identify how the State can target goals and objectives in the CQS under 42 CFR Section 438.40 to support quality, timeliness, and access to health care services furnished to Medi-Cal members, as required in 42 CFR Section 438.364(a)(4).

Access

1. As MHPs report anticipating revised DHCS guidelines for CCPs, consider including in those guidelines the populations that are underserved statewide and ensure that local consideration of underserved populations is also addressed. The Hispanic/Latino population is almost always included in CCPs, but consideration should also be given to Native Americans and Asian/Pacific Islanders in particular. Even though these populations are often rather small in counties, they warrant more attention to culturally relevant outreach, engagement, and services. This should occur in addition to locally defined areas of focus. This aligns with the CQS focus on equity.

2. Continue to support statewide initiatives that strengthen the BH workforce. State-level leadership that encourages expansion of master's programs and other certification programs at California colleges is necessary to increase the number of professionals trained to work in MHPs and the BH field in general.
3. Evaluate whether payment reform has created an unintended consequence of more services being provided in clinics rather than in the community and other more accessible field-based locations. While intended to be accounted for in the payment methodology, the lack of separate transportation billing seems to be impacting (per review discussions) whether MHPs (county and contract providers) are dis-incentivized to deliver SMHS services to complex populations in the community as opposed to a clinic site. This issue could severely limit member engagement and outcomes for members who are most severely impacted by their mental health.

Timeliness

1. To better gauge comparable performance across MHPs, consider defining criteria for which members are considered "new" to an MHP. This can include factors like last date of service, last type of service, and/or date of most recent case closure. Similarly, set a more specific operational definition for urgent service needs so that individuals who are not in crisis but have urgent needs are identified. This is especially important in those MHPs that have longer initial wait times. Adding an urgency determination protocol to the CalAIM Screening Tool may assist in this regard.
2. For those MHPs with excessively long wait times for psychiatry services, work with the MHPs to identify mechanisms to improve access.
3. Encourage monitoring timely access to care beyond initial access. Many MHPs have improved their initial access processes only to have significant bottlenecks elsewhere in service delivery.

Quality

1. As DHCS increases its monitoring and assistance to MHPs, as described in the CQS, identify opportunities to create model tools that will not only assist MHPs in meeting statewide mandates in a consistent way (e.g., medication monitoring, FC HEDIS measures), but also could be used flexibly if MHPs want to include additional elements. Tools that are developed by State staff with subject-matter expertise would be especially useful for small MHPs that have difficulty retaining psychiatry and nursing staff and are unable to develop tools locally as a result.
2. Work with MHPs to develop a universal LOC tool for adults that could be implemented statewide. This is an effort that is being tackled independently in many MHPs; a statewide model could launch the work for many, reduce duplicative efforts, and create some uniformity in the approach across Plans.
3. Identify a mechanism for MHPs to receive detailed service data associated with inpatient care that is billed through the State's vendor so that a comprehensive view of inpatient utilization is more readily achievable.
4. Clarify for MHPs whether the FC HEDIS measures monitoring per WIC Section 14717.5 continue to be required, as is not elucidated in the CQS and other DHCS communications regarding quality monitoring.

APPENDIX 1: SDMC CLAIM DEFINITIONS

Medi-Cal Approved Claims Code Definitions and Data Sources			
Last Modified by: Rachel Phillips – January 2023			Source: Medi-Cal Aid Code Chart Master – November 2022
Source: Data are derived from statewide source files.			
1. Short-Doyle/Medi-Cal approved and denied claims (SD/MC) from DHCS.			
2. In-Patient Consolidation (IPC) approved claims from DHCS			
3. Monthly MEDS Extract File (MMEF) from DHCS			
Selection Criteria:			
Medi-Cal members for whom the MHP is "County of Fiscal Responsibility" are included, even when the member was served by another MHP.			
Medi-Cal members with aid codes eligible for SD/MC program funding are included.			
Process Date: The date DHCS processes files for CalEQRO. The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY 2020 file with a DHCS process date of May 19, 2021, includes claims with service dates between January 1 and December 31, 2020, processed by DHCS through April 2021.			
Most recent MMEF includes Medi-Cal eligibility for April (CY) or October (FY) and 15 prior months.			
Service Activity: Defined by Procedure Code and Modifiers			
Service Category	**Procedure Codes**	**Modifiers**	**Description**
Inpatient Services	H2013, H2015		Local Hospital, Psychiatric Health Facility
Inpatient Services	114, 124, 134, 154, 204		In Patient Consolidation (IPC) claims/134 file
Inpatient Services	H0046, 169		Hospital Administrative Days
Crisis Stabilization	S9484	HE, TG	24hr Crisis Unit
Residential Services	H0018		Adult Crisis Residential
Residential Services	H0019		Adult Residential
Day Treatment	H2012		Day Treatment Programs
Case Management	T1017	HE	Case Management
Mental Health Services	H2015, H2017, H0032	HE	Mental Health Services
Medication Support	H2010, H0034, G8437	(FCV not in 21,51)	Medication Support
Crisis Intervention	H2011	(FCV not in 21,51)	Crisis Intervention
TBS	H2019		Therapeutic Behavioral Services
ICC	T1017	HK	Intensive Care Coordination
IHBS	H2015	HK	Intensive Home-Based Services

Medi-Cal Approved Claims Code Definitions and Data Sources			
Last Modified by: Rachel Phillips – January 2023			Source: Medi-Cal Aid Code Chart Master – November 2022
Look-A-Like		HK and DPI	Intensive Care Coordination Intensive Home-Based Services Demonstration Project Indicator (DPI) = KTA
TFC	S5145		Therapeutic Foster Care
Data Definitions: Selected elements displayed within this report are defined below.			
Penetration rate	The number of Medi-Cal members served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of Medi-Cal eligibles over a 12-month period.		
Approved claims per member per year	The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal members served per year.		
Age Group	Age groups are determined by member's age on January 1 of the reporting calendar or fiscal year.		
Eligibility Categories	Medi-Cal aid codes used to report approved claims by eligibility category.		
Disabled	2H, K6, K7, K8, K9, 36, 60, 63, 64, 66, 67, 68, 6A, 6C, 6E, 6G, 6H, 6N, 6P, 6R,6V, 6W, 6X, 6Y, L6.		
Foster Care	2P, 2R, 2S, 2T, 2U, 40, 42, 43, 46, 49, 4F, 4G, 4H, 4L, 4N, 4S, 4T, 4W, 5K, 5L.		
Other Child	Member age is less than 18 AND one of the following aid codes: 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 2A, 2E, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 44, 45, 47, 4A, 4E, 4M, 5C, 5D, 54, 59, 5E, 5F, 72, 74, 7A, 7C, 7J, 7K, 7S, 7W, 82, 83, 8E, 8G, 8L, 8P, 8R, 8U, 8V, 8W, F3, G5, G7, H7, H8, H9, J1, J2, J5, J7, K1, M3, M7, M9, P1, P2, P3, P4, P7, T1, T2, T3, T4, T5.		
Family Adult	Member age is greater than or equal to 18 AND one of the following aid codes. 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 2A, 2E, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 44, 45, 47, 4A, 4E, 4M, 5C, 5D, 54, 59, 5E, 5F, 72, 74, 7A, 7C, 7J, 7K, 7S, 7W, 82, 83, 8E, 8G, 8L, 8P, 8R, 8U, 8V, 8W, F3, G5, G7, H7, H8, H9, J1, J2, J5, J7, K1, M3, M7, M9, P1, P2, P3, P4, P7, T1, T2, T3, T4, T5.		
Other Adult	Member age is greater than 19 AND one of the following aid codes: 0U, 0V, 1E, 1H, 1U, 1X, 1Y, 10, 13, 14, 16, 17, 3T, 3V, 48, 55, 58, 5F, 5J, 5R, 5S, 5T, 5W, 6J, 6U, 76, 7C, 80, 86, 87, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, G6, G8, J3, J4, J6, J8, M0, M4, M8.		
MCHIP	Expanded eligibility for certain populations of children (under age 20) as defined in federal law as targeted low-income children who would not otherwise qualify for full-scope Medi-Cal benefits AND one of the following aid codes E1, E6, E7, H0, H1, H2, H3, H4, H5, H6, H9, M5, M6, T0, T1, T2, T3, T4, T5, T6, T7, T8, T9, 5C, 5D, 7X, 8N, 8P, 8T, 8R, 8X.		
Affordable Care Act (ACA)	ACA aid codes were effective January 1, 2014. The FFP is 100% from 2014 through 2016. In future years it will step down to 95% for 2017; 94% for 2018; 93% for 2019; 90% for 2020 and thereafter. 7U, L1, M1, M2, N0, N7, N8, N9.		
Eligibility Categories	Medi-Cal aid codes used to report approved claims by eligibility category.		
EPSDT Eligible Aid Codes	Member age is less than 21 one of the following aid codes: 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 20, 23, 24, 26, 27, 2A, 2E, 2H, 2P, 2R, 2S, 2T, 2U, 30, 32, 33, 34, 35, 36, 37, 38, 39, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 40, 42, 43, 44, 45, 46, 47, 49, 4A, 4E, 4F, 4G, 4H, 4L, 4M, 4N, 4P, 4R, 4S, 4T, 4W, 54, 59, 5C, 5D, 5E, 5K, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6N, 6P, 6V, 6W, 6X, 6Y, 72, 7A, 7J, 7S, 7U, 7W, 7X, 82, 83, 8E, 8G, 8L, 8P, 8R, 8U, 8V, 8W, 8X, E6, E7, G5, G7, H0, H1, H2, H3, H4, H5, H6, H7, H8, H9, J1, J2, J7, K1, K8, L1, L6, M1, M3, M5, M7, M9, P1, P2, P3, P5, P7, P9, T1, T2, T3, T4, T5.		

Medi-Cal Approved Claims Code Definitions and Data Sources			
Last Modified by: Rachel Phillips – January 2023		Source: Medi-Cal Aid Code Chart Master – November 2022	
MEDS Race/Ethnicity Codes			
1 = White	2 = Hispanic	3 = Black	4 = Asian/Pacific Islander
5 = Alaska Native or American Indian	7 = Filipino	8 = No valid data reported	9 = Decline to state
A = Amerasian	C = Chinese	H = Cambodian	J = Japanese
K = Korean	M = Samoan	N = Asian Indian	P = Hawaiian
R = Guamanian	T = Laotian	V = Vietnamese	Z = Other
Race/Ethnicity Groups	**MEDS Code**		
White	1		
Hispanic	2		
African-American	3		
Asian/Pacific Islander	4, 7, A, C, H, J, K, M, N, P, R, T, V		
Native American	5		
Other/Decline or Missing Data	8, 9, Z		
Member Primary Languages	**MEDS Code**		
0 = American Sign	1 = Spanish	2 = Cantonese	3 = Japanese
4 = Korean	5 = Tagalog	6 = Other Non-English	7 = English
8 = No Valid Data Reported	9 = No Response, Client Declined	A = Other Sign Language	B = Mandarin
C =Other Chinese Languages	D = Cambodian	E = Armenian	F = Ilocano
G = Mien	H = Hmong	I = Lao	J = Turkish
K = Hebrew	L = French	M = Polish	N = Russian
P = Portuguese	Q = Italian	R = Arabic	S = Samoan
T = Thai	U = Farsi	V = Vietnamese	
Primary Language Groups	**BHIN 20-070**	**Threshold Languages by County**	
English	Code = 7 - Not threshold language		
Spanish	Code = 1 - Threshold language for 46 counties		
Arabic	Code = R - Los Angeles, Orange, Sacramento, San Diego		
Armenian	Code = E - Los Angeles		
Cambodian	Code = D – Los Angeles		
Cantonese	Code = 2 – Alameda, Los Angeles, Sacramento, San Francisco, San Mateo, Santa Clara		
Farsi	Code = U – Los Angeles, Orange, Sacramento, San Diego		
Hmong	Code = H – Fresno, Sacramento		
Korean	Code = 4 – Los Angeles, Orange		
Mandarin	Code = B – Alameda, Los Angeles, Orange, San Bernardino, San Francisco, Santa Clara		
Primary Language Groups	**BHIN 20-070**	**Threshold Languages by County**	
Other Chinese Languages	Code = C – Los Angeles		
Russian	Code = N – Los Angeles, Sacramento, San Francisco		
Tagalog	Code = 5 – Alameda Los Angeles, San Diego, Santa Clara		
Vietnamese	Code = V – Alameda, Los Angeles, Orange, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara		
Non-Threshold Languages	Codes = 3, 6, F, G, I, J, K, L, M, P, Q, S, T (Not threshold languages)		

Medi-Cal Approved Claims Code Definitions and Data Sources			
Last Modified by: Rachel Phillips – January 2023	Source: Medi-Cal Aid Code Chart Master – November 2022		
Sign Languages	Codes = 0, A (Not threshold languages)		
Decline to State/Missing Data	Codes = 8, 9, Undetermined (Not threshold languages)		
County Codes	**MEDS Code**		
01 = Alameda	02 = Alpine	03 = Amador	04 = Butte
05 = Calaveras	06 = Colusa	07 = Contra Costa	08 = Del Norte
09 = El Dorado	10 = Fresno	11 = Glenn	12 = Humboldt
13 = Imperial	14 = Inyo	15 = Kern	16 = Kings
17 = Lake	18 = Lassen	19 = Los Angeles	20 = Madera
21 = Marin	22 = Mariposa	23 = Mendocino	24 = Merced
25 = Modoc	26 = Mono	27 = Monterey	28 = Napa
29 = Nevada	30 = Orange	31 = Placer/Sierra	32 = Plumas
33 = Riverside	34 = Sacramento	35 = San Benito	36 = San Bernardino
37 = San Diego	38 = San Francisco	39 = San Joaquin	40 = San Luis Obispo
41 = San Mateo	42 = Santa Barbara	43 = Santa Clara	44 = Santa Cruz
45 = Shasta	47 = Siskiyou	48 = Solano	49 = Sonoma
50 = Stanislaus	51 = Sutter-Yuba	52 = Tehama	53 = Trinity
54 = Tulare	55 = Tuolumne	56 = Ventura	57 = Yolo
Counties by DHCS Regions	**County Code**		
Bay Area	01, 07, 21, 27, 28, 35, 38, 41, 43, 44, 48, 49		
Central	02, 03, 05, 09, 10, 16, 20, 22, 24, 26, 31, 34, 39, 50, 51, 54, 55, 57		
Los Angeles	19		
Southern	13, 15, 30, 33, 36, 37, 40, 42, 56		
Superior	04, 06, 08, 11, 12, 14, 17, 18, 23, 25, 29, 32, 45, 47, 52, 53		
Counties by DHCS County Sizes	**County Code**		**Population**
Small-Rural	02, 03, 05, 06, 08, 11, 14, 18, 22, 25, 26, 32, 47, 53		<50,000
Small	09, 12, 13, 16, 17, 20, 23, 28, 29, 35, 45, 51, 52, 55		50,000 to 199,999
Medium	04, 21, 24, 27, 31, 39, 40, 41, 42, 44, 48, 49, 50, 54, 57		200,000 to 749,999
Large	01, 07, 10, 15, 30, 33, 34, 36, 37, 38, 43, 56		750,000 to 3,999,999
Very Large	19		>4,000,000
Diagnosis Groups – ICD 10	**BHIN 20-043 Outpatient Diagnosis Codes from SDMC Claims**		
Depressive Disorders	F320, F321, F322, F323, F324, F325, F3281, F3289, F329, F330, F331, F332, F333, F3340, F3341, F3342, F338, F339, F340, F341, F3481, F3489, F349, F39, F530		
Schizophrenia Spectrum and Psychotic Disorders	F200, F201, F202, F203, F205, F2081, F2089, F209, F21, F22, F23, F24, F250, F251, F258, F259, F28, F29, F53.1		
Disruptive, Impulse/Conduct Disorders	F631, F632, F633, F6381, F6389, F639, F910, F911, F912, F913, F918, F919		
Bipolar and Related Disorders	F3010, F3011, F3012, F3013, F302, F303, F304, F308, F309, F310, F3110, F3111, F3112, F3113, F312, F3130, F3131, F3132, F314, F315, F3160, F3161, F3162, F3163, F3164, F3170, F3171, F3172, F3173, F3174, F3175, F3176, F3177, F3178, F3181, F3189, F319		

Medi-Cal Approved Claims Code Definitions and Data Sources	
Last Modified by: Rachel Phillips – January 2023	Source: Medi-Cal Aid Code Chart Master – November 2022
Anxiety Disorders	F4000, F4001, F4002, F4010, F4011, F40210, F40218, F40220, F40228, F40230, F40231, F40232, F40233, F40240, F40241, F40242, F40243, F40248, F40290, F40291, F40298, F408, F409, F410, F411, F413, F418, F419, F930, F488, F4021, F4022, F4023, F4024, F4029
Diagnosis Groups – ICD 10, cont'd	**BHIN 20-043 Outpatient Diagnosis Codes from SDMC Claims**
Neuro Development Disorders	F8082, F809, F840, F842, F843, F845, F848, F849, F900, F901, F902, F908, F909, F950, F951, F952, F958, F959, F984, F0150, F0151, F0280, F0281, F0390, F0391, F04, F05
Trauma/Stressor Related disorders	F430, F4310, F4311, F4312, F4320, F4321, F4322, F4323, F4324, F4325, F4329, F438, F439, F941
Trauma/Stressor Related disorders	F430, F4310, F4311, F4312, F4320, F4321, F4322, F4323, F4324, F4325, F4329, F438, F439, F941
Not Diagnosed	R69, Z0389
Other Diagnosis	Other ICD-10 codes not listed above which were submitted through SDMC claim transactions

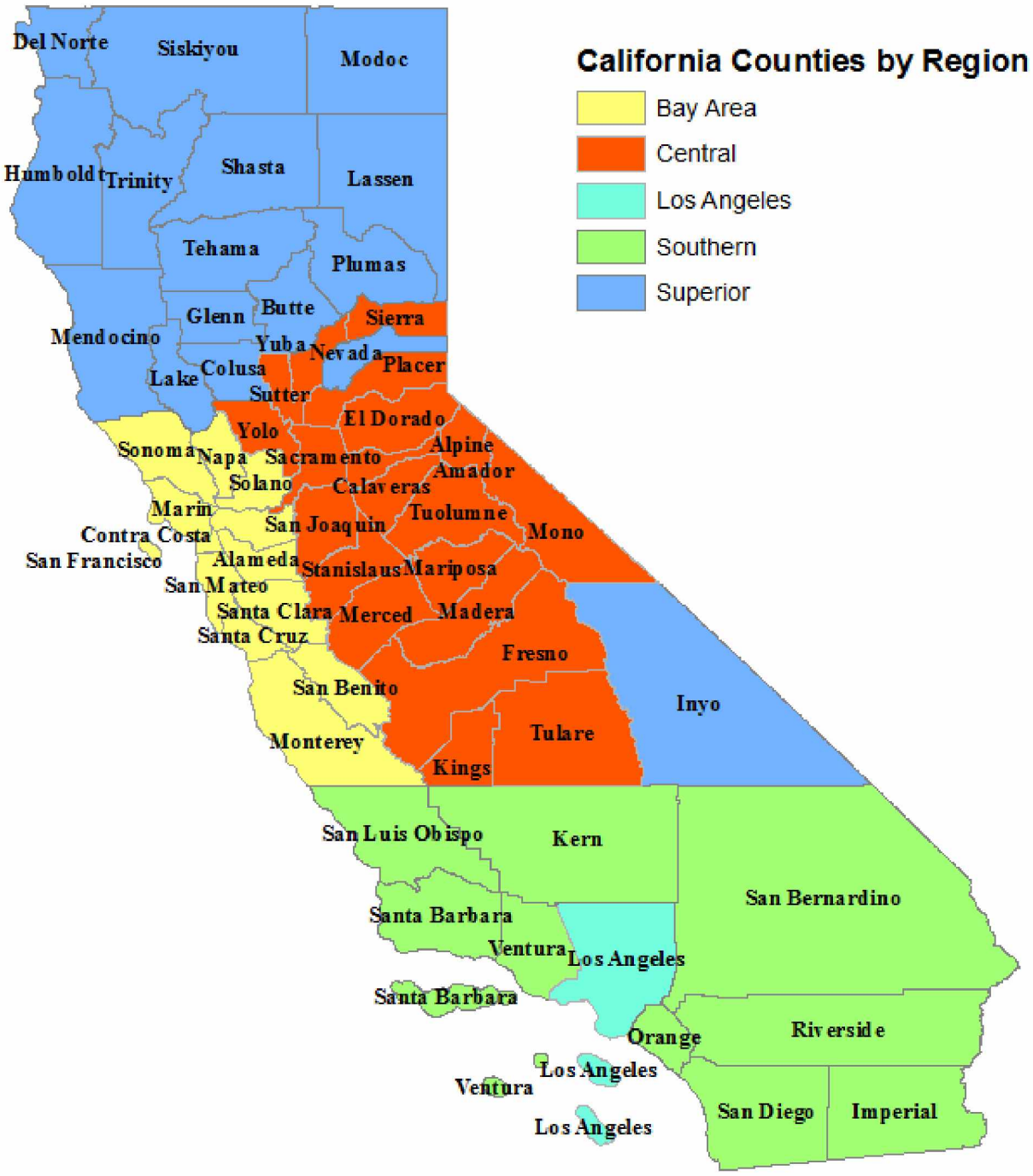
APPENDIX 2: LIST OF MHPS BY SIZE AND REGION

List of MHPs

MHP County	MHP Size	MHP Region
Alameda	Large	Bay Area
Alpine	Small-rural	Central
Amador	Small-rural	Central
Butte	Medium	Superior
Calaveras	Small-rural	Central
Colusa	Small-rural	Superior
Contra Costa	Large	Bay Area
Del Norte	Small-rural	Superior
El Dorado	Small	Central
Fresno	Large	Central
Glenn	Small-rural	Superior
Humboldt	Small	Superior
Imperial	Small	Southern
Inyo	Small-rural	Central
Kern	Large	Southern
Kings	Small	Central
Lake	Small	Superior
Lassen	Small-rural	Superior
Los Angeles	Very Large	Los Angeles
Madera	Small	Central
Marin	Medium	Bay Area
Mariposa	Small-rural	Central
Mendocino	Small	Superior
Merced	Medium	Central
Modoc	Small-rural	Superior
Mono	Small-rural	Central
Monterey	Medium	Bay Area
Napa	Small	Bay Area
Nevada	Small	Superior
Orange	Large	Southern
Placer	Medium	Central
Plumas	Small-rural	Superior

MHP County	MHP Size	MHP Region
Riverside	Large	Southern
Sacramento	Large	Central
San Benito	Small	Bay Area
San Bernardino	Large	Southern
San Diego	Large	Southern
San Francisco	Large	Bay Area
San Joaquin	Large	Central
San Luis Obispo	Medium	Southern
San Mateo	Large	Bay Area
Santa Barbara	Medium	Southern
Santa Clara	Large	Bay Area
Santa Cruz	Medium	Bay Area
Shasta	Small	Superior
Sierra	Medium	Central
Siskiyou	Small-rural	Superior
Solano	Medium	Bay Area
Sonoma	Medium	Bay Area
Stanislaus	Medium	Central
Sutter	Small	Central
Tehama	Small	Superior
Trinity	Small-rural	Superior
Tulare	Medium	Central
Tuolumne	Medium	Central
Ventura	Large	Southern
Yolo	Medium	Central
Yuba	Small	Central

APPENDIX 3: MAPS OF CALIFORNIA COUNTIES


California Counties by Region
Bay Area
Central
Los Angeles
Southern
Superior
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Glenn
Butte
Sierra
Mendocino
Yuba
Nevada
Placer
Lake
Colusa
Sutter
El Dorado
Yolo
Sonoma
Napa
Sacramento
Alpine
Amador
Solano
Calaveras
Marin
Tuolumne
San Joaquin
Mono
Contra Costa
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Madera
Santa Cruz
Fresno
San Benito
Inyo
Monterey
Tulare
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Santa Barbara
Orange
Riverside
Los Angeles
Ventura
San Diego
Imperial
Los Angeles

APPENDIX 4: DHCS EQR PROTOCOL 3 COMPLIANCE REMEDIATION

The following information was provided to BHC by DHCS to be included in the annual reporting to remediate ongoing CMS Protocol 3 Compliance Findings.

Protocol 3 Compliance Review Information		
Requirement	**PIHP**	**EQR Submission**
The objective(s) of the compliance review.	DMC-ODS	DHCS conducts annual reviews to measure compliance with the State-County contract, which includes the terms and conditions of the SABG Block Grant, the DMC-ODS, and other State and Federal statutes and regulations. The goal of this process is to enhance the substance use disorder continuum of care throughout California through compliance oversight and technical assistance.
	MHP (SMHS)	DHCS conducts triennial reviews of each county MHP to determine compliance with federal and state regulations as well as the terms of the MHP contract. The goal of this process is to ensure compliance and to identify opportunities for improvement.
The technical methods of data collection and analysis for the compliance review.	DMC-ODS	Compliance audits of County Specialty Mental Health (SMH) and Drug Medi-Cal Organized Delivery System (DMC-ODS) programs include the quantitative analysis of SDMC claims data, member files, provider files, and a qualitative analysis of policy and procedural documentation to determine each PIHPs compliance with state and federal standards. SDMC data is collected from each PIHP via DHCS' claims submission process whereas member files, provider files, and any associated documentation is provided by each PIHP at the time of each audit. Compliance results are compiled into a findings report which is sent to the PIHP with the associated CAP requirements. In addition, the Department posts each PIHP's findings report on DHCS' website.
	MHP (SMHS)	
The results, a description of the results, and any validation of the compliance review.	DMC-ODS	Results are provided in the pages that follow.
	MHP (SMHS)	
Conclusions drawn from the results of the compliance review.	DMC-ODS	BHC will review the approved A&I Compliance Review Results to write narrative statements documenting the percentage of plans meeting each of the 14 federal standards.
	MHP (SMHS)	

Dates of Compliance Review	Plan Name	Compliance Items ** Met (M) / Partially Met (PM) / Not Met (NM) / Not Reviewed (NR)														Did DHCS impose a corrective action plan (CAP) based on the compliance review findings?	Current Status of the CAP (Open/ Closed/ Not Applicable)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14		
12/13-12/15/22	Alameda	M	M	M	M	M	M	PM	M	M	M	M	PM	M	M	Yes	Closed
07/12-07/13/22	Alpine	M	M	M	PM	M	M	NM	M	M	M	M	PM	M	M	Yes	Closed
12/14-12/16/20	Amador	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
05/03-05/04/22	Butte	M	M	M	M	M	M	M	M	M	M	M	PM	M	M	Yes	Closed
11/30-12/02/20	Calaveras	M	M	M	PM	M	M	M	M	M	M	M	PM	M	M	Yes	Closed
01/08-01/11/18	Colusa	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
10/06-10/08/20	Contra Costa	M	M	M	M	M	PM	M	M	M	M	M	M	M	M	Yes	Closed
10/19-10/21/21	Del Norte	M	M	M	PM	M	M	PM	M	M	M	M	PM	M	M	Yes	Closed
10/11-10/12/22	El Dorado	M	M	M	PM	M	PM	M	M	M	M	M	M	M	M	Yes	Closed
08/10-08/12/21	Fresno	M	M	M	PM	M	M	M	M	M	M	M	M	M	M	Yes	Closed
03/22-03/23/22	Glenn	M	M	M	PM	M	PM	M	M	M	M	M	M	M	M	Yes	Closed
01/10-01/11/23	Humboldt	M	M	M	M	M	M	PM	M	M	M	M	PM	M	PM	Yes	Closed
04/19-04/20/22	Imperial	M	M	M	PM	M	M	M	M	M	M	M	M	M	M	Yes	Closed
08/24-08/26/21	Inyo	M	M	M	PM	M	M	PM	M	M	PM	M	PM	M	PM	Yes	Closed
06/21-06/23/22	Kern	M	M	M	PM	M	M	PM	M	M	PM	M	M	M	M	Yes	Closed
01/24-01/25/23	Kings	M	M	M	PM	M	M	PM	M	M	PM	M	PM	M	M	Yes	Open
11/02-11/03/21	Lake	M	M	M	PM	M	M	M	M	M	M	M	M	M	PM	Yes	Closed
11/08-11/10/21	Lassen	M	M	M	PM	M	M	M	M	M	M	M	M	M	M	Yes	Closed
09/27-09/30/22	Los Angeles	M	M	M	PM	M	PM	PM	M	M	PM	M	PM	M	M	Yes	Closed
03/08-03/10/22	Madera	M	M	M	PM	M	M	M	M	M	M	M	M	M	PM	Yes	Closed
02/07-02/09/23	Marin	M	M	M	M	M	M	M	M	M	PM	M	PM	M	M	Yes	Closed
08/09-08/10/22	Mariposa	M	M	M	PM	M	M	M	M	M	M	M	PM	M	M	Yes	Closed
04/05-04/06/22	Mendocino	M	M	M	M	M	M	M	M	M	PM	M	M	M	M	Yes	Closed
12/03-12/05/19	Merced	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
09/14-09/16/21	Modoc	M	M	M	PM	M	M	M	M	M	M	M	M	M	M	Yes	Closed
09/07-09/09/21	Mono	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
01/12-01/14/21	Monterey	M	M	M	PM	M	M	M	M	M	PM	M	M	M	M	Yes	Closed
01/25-01/26/22	Napa	M	M	M	PM	M	M	PM	M	M	PM	M	M	M	M	Yes	Closed
03/07-03/08/23	Nevada	M	M	M	M	M	M	PM	M	M	PM	M	M	M	M	Yes	Closed

Dates of Compliance Review	Plan Name	Compliance Items ** Met (M) / Partially Met (PM) / Not Met (NM) / Not Reviewed (NR)														Did DHCS impose a corrective action plan (CAP) based on the compliance review findings?	Current Status of the CAP (Open/ Closed/ Not Applicable)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14		
03/21-03/23/23	Orange	M	M	M	PM	M	M	PM	M	M	PM	M	M	M	M	Yes	Closed
02/15-02/17/22	Placer-Sierra	M	M	M	M	M	M	M	M	M	M	M	PM	M	M	Yes	Closed
05/17-05/18/22	Plumas	M	M	M	PM	M	PM	PM	M	M	M	M	M	M	M	Yes	Closed
06/07-06/09/22	Riverside	M	M	M	PM	M	PM	PM	M	M	M	M	M	M	PM	Yes	Closed
07/13-07/15/21	Sacramento	M	M	M	M	M	M	PM	M	M	M	M	M	M	PM	Yes	Closed
04/04-04/05/23	San Benito	M	M	M	M	M	M	PM	M	M	PM	M	PM	M	M	Yes	Closed
08/30-09/01/22	San Bernardino	M	M	M	PM	M	M	PM	M	M	M	M	PM	M	M	Yes	Closed
06/08-06/10/21	San Diego	M	M	M	PM	M	M	M	M	M	M	M	M	M	M	Yes	Closed
04/18-04/20/23	San Francisco	M	M	M	M	M	PM	PM	M	M	M	M	PM	M	M	Yes	Closed
12/14-12/16/21	San Joaquin	M	M	M	M	M	M	M	M	M	PM	M	M	M	M	Yes	Closed
02/01-02/03/22	San Luis Obispo	M	M	M	PM	M	M	M	M	M	M	M	M	M	M	Yes	Closed
05/02-05/04/23	San Mateo	M	M	M	M	M	M	PM	M	M	M	M	PM	M	M	Yes	Closed
05/16-05/18/23	Santa Barbara	M	M	M	M	M	M	PM	M	M	M	M	PM	M	M	Yes	Closed
07/27-07/29/21	Santa Clara	M	M	M	PM	M	M	M	M	M	PM	M	M	M	M	Yes	Closed
05/11-05/13/21	Santa Cruz	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
06/06-06/07/23	Shasta	M	M	M	M	M	M	PM	M	M	PM	M	PM	M	M	Yes	Closed
07/26-07/27/22	Siskiyou	M	M	M	M	M	M	PM	M	M	M	M	M	M	M	Yes	Closed
12/07-12/09/21	Solano	M	M	M	PM	M	M	M	M	M	M	M	PM	M	M	Yes	Closed
06/20-06/22/23	Sonoma	M	M	M	M	M	M	PM	M	M	M	M	PM	M	M	Yes	Closed
06/20-06/23/23	Stanislaus	M	M	M	PM	M	M	PM	M	M	M	M	PM	M	M	Yes	Closed
10/29-10/30/19	Sutter-Yuba	M	M	M	M	PM	M	M	M	M	M	M	M	M	M	Yes	Closed
06/22-06/24/21	Tehama	M	M	M	PM	M	M	PM	PM	M	M	M	PM	M	M	Yes	Closed
08/26-08/27/20	Trinity	M	M	M	PM	M	PM	PM	M	M	M	M	M	M	M	Yes	Closed
10/05-10/07/21	Tulare	M	M	M	PM	M	PM	PM	M	M	M	M	PM	M	PM	Yes	Closed
02/21-02/22/23	Tuolumne	M	M	M	M	M	M	PM	M	M	M	M	PM	M	M	Yes	Closed
08/11-08/13/20	Ventura	M	M	M	M	M	M	M	M	M	M	M	M	M	PM	Yes	Closed
05/25-05/27/21	Yolo	M	M	M	PM	M	M	M	M	M	M	M	M	M	M	Yes	Closed

Compliance items 1-14 referenced above are defined below:

Item	** Code of Federal Regulation Standards - Met/Partially Met/Not Met/Not Reviewed	Reference
1	Disenrollment: Requirements and Limitations	§ 438.56
2	Enrollee Rights	§ 438.100
3	Emergency and Post-stabilization Services	§ 438.114
4	Availability of Services	§ 438.206
5	Assurances of Adequate Capacity and Services	§ 438.207
6	Coordination and Continuity of Care	§ 438.208
7	Coverage and Authorization of Services	§ 438.210
8	Provider Selection	§ 438.214
9	Confidentiality	§ 438.224
10	Grievance and Appeal Systems	§ 438.228
11	Subcontractual Relationships and Delegation	§ 438.230
12	Practice Guidelines	§ 438.236
13	Health Information Systems	§ 438.242
14	Quality Assessment and Performance Improvement Program	§ 438.330