Behavioral Health Concepts, Inc.
info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2023-24
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

COLUSA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 3, 2023

TABLE OF CONTENTS

EXECUTIVE SUMMARY ... 6

MHP INFORMATION ... 6

SUMMARY OF FINDINGS ... 6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS ... 7

INTRODUCTION ... 9

BASIS OF THE EXTERNAL QUALITY REVIEW ... 9

REVIEW METHODOLOGY ... 9

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE ... 11

MHP CHANGES AND INITIATIVES ... 12

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS ... 12

SIGNIFICANT CHANGES AND INITIATIVES ... 12

RESPONSE TO FY 2022-23 RECOMMENDATIONS ... 13

ACCESS TO CARE ... 16

ACCESSING SERVICES FROM THE MHP ... 16

NETWORK ADEQUACY ... 17

ACCESS KEY COMPONENTS ... 17

ACCESS PERFORMANCE MEASURES ... 18

IMPACT OF ACCESS FINDINGS ... 30

TIMELINESS OF CARE ... 31

TIMELINESS KEY COMPONENTS ... 31

TIMELINESS PERFORMANCE MEASURES ... 32

IMPACT OF TIMELINESS FINDINGS ... 36

QUALITY OF CARE ... 37

QUALITY IN THE MHP ... 37

QUALITY KEY COMPONENTS ... 37

QUALITY PERFORMANCE MEASURES ... 39

IMPACT OF QUALITY FINDINGS ... 46

PERFORMANCE IMPROVEMENT PROJECT VALIDATION ... 47

CLINICAL PIP ... 47

NON-CLINICAL PIP ... 48

INFORMATION SYSTEMS ... 51

INFORMATION SYSTEMS IN THE MHP ... 51

INFORMATION SYSTEMS KEY COMPONENTS 52
INFORMATION SYSTEMS PERFORMANCE MEASURES 53
IMPACT OF INFORMATION SYSTEMS FINDINGS 54
VALIDATION OF MEMBER PERCEPTIONS OF CARE 56
CONSUMER PERCEPTION SURVEYS 56
PLAN MEMBER/FAMILY FOCUS GROUP 56
SUMMARY OF MEMBER FEEDBACK FINDINGS 57
CONCLUSIONS 58
STRENGTHS 58
OPPORTUNITIES FOR IMPROVEMENT 58
RECOMMENDATIONS 59
EXTERNAL QUALITY REVIEW BARRIERS 60
ATTACHMENTS 61
ATTACHMENT A: REVIEW AGENDA 62
ATTACHMENT B: REVIEW PARTICIPANTS 63
ATTACHMENT C: PIP VALIDATION TOOL SUMMARY 65
ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE 71
ATTACHMENT E: CALEQRO CLAIMS DATA DEFINITIONS 72
ATTACHMENT F: LETTER FROM THE MHP DIRECTOR 77

LIST OF FIGURES

Figure 1: Race/Ethnicity for Colusa MHP Compared to State CY 2022 21
Figure 2: MHP PR by Race/Ethnicity CY 2020-22 22
Figure 3: MHP AACM by Race/Ethnicity CY 2020-22 23
Figure 4: Overall PR CY 2020-22 23
Figure 5: Overall AACM CY 2020-22 24
Figure 6: Hispanic/Latino PR CY 2020-22 24
Figure 7: Hispanic/Latino AACM CY 2020-22 25
Figure 8: Asian/Pacific Islander PR CY 2020-22 25
Figure 9: Asian/Pacific Islander AACM CY 2020-22 26
Figure 10: Foster Care PR CY 2020-22 26
Figure 11: Foster Care AACM CY 2020-22 27
Figure 12: Wait Times to First Service and First Psychiatry Service 34
Figure 13: Wait Times for Urgent Services 34
Figure 14: Percent of Services that Met Timeliness Standards 35
Figure 15: Retention of Members Served CY 2022 40
Figure 16: Diagnostic Categories by Percentage of Members Served CY 2022 41
Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2022 42
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2020-22 43
Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2020-22 44
Figure 20: Members and Approved Claims by Claim Category CY 2022 46

LIST OF TABLES

Table A: Summary of Response to Recommendations 6
Table B: Summary of Key Components 6
Table C: Summary of PIP Submissions 7
Table D: Summary of Plan Member/Family Focus Groups 7
Table 1A: Colusa MHP Alternative Access Standards, FY 2022-23 17
Table 1B: Colusa MHP Out-of-Network Access, FY 2022-23 17
Table 2: Access Key Components 18
Table 3: Colusa MHP Annual Members Served and Total Approved Claims CY 2020-22 19
Table 4: Colusa MHP Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022 19
Table 5: Threshold Language of Colusa MHP Medi-Cal Members Served in CY 2022 20
Table 6: Colusa MHP Medi-Cal Expansion (ACA) PR and AACM CY 2022 20
Table 7: Colusa MHP PR of Members Served by Race/Ethnicity CY 2022 21
Table 8: Services Delivered by the Colusa MHP to Adults 28
Table 9: Services Delivered by the Colusa MHP to Youth in Foster Care 29
Table 10: Timeliness Key Components 31
Table 11: FY 2023-24 Colusa MHP Assessment of Timely Access 33
Table 12: Quality Key Components 38
Table 13: Colusa MHP Psychiatric Inpatient Utilization CY 2020-22 42
Table 14: Colusa MHP High-Cost Members (Greater than $30,000) CY 2020-22 45

Table 15: Colusa MHP Medium- and Low-Cost Members CY 2022 45
Table 16: Contract Provider Transmission of Information to Colusa MHP EHR............ 52
Table 17: IS Infrastructure Key Components 53
Table 18: Summary of Colusa MHP Short-Doyle/Medi-Cal Claims CY 2022 54
Table 19: Summary of Colusa MHP Denied Claims by Reason Code CY 2022 54
Table A1: CalEQRO Review Agenda 62
Table B1: Participants Representing the MHP and its Partners 64
Table C1: Overall Validation and Reporting of Clinical PIP Results 65
Table C2: Overall Validation and Reporting of Non-Clinical PIP Results 68

EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — August 3, 2023

MHP Size — Small-rural

MHP Region — Superior

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	1	2	2

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	3	3	4
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**18**	**4**	**4**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Psychosis Identification and Treatment	Clinical	02/2023	Implementation	Moderate
Follow-up After Emergency Department (ED) Visit for Mental Health Condition (FUM)	Non-Clinical	03/2023	Implementation	Moderate

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP implemented SmartCare by Streamline as its new Electronic Health Record (EHR) in July 2023.
- Colusa has a strong bilingual clinical staff, and the MHP places emphasis on building up the workforce with this skillset as Hispanic/Latino members account for a majority of members served.
- The open access process where members can receive assessments as walk-ins two days per week has been a positive step toward improving PR and access to the system.
- The MHP increased outreach efforts and has strong partnerships, particularly with law enforcement, jail, and probation to link inmates to services.
- The MHP has dashboards for the Child and Adolescent Needs Assessment (CANS-50), Milestones of Recovery Scale (MORS), and Pediatric Symptom Checklist-35 (PSC-35) outcome tools.

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

- Transportation can be difficult in Colusa, especially for members relying on the local bus system.
- The MHP lacks an analyst with Structured Query Language (SQL) skills that would help maximize the reporting capabilities of the new EHR.

- While Colusa has made efforts to complete medication monitoring, the process has not yet been implemented.
- The MHP has not yet been able to implement a medication monitoring system for foster care (FC) youth as required by Welfare and Institutions Code (WIC) Section 14197 and Senate Bill (SB) 1291.
- While the open access model is reported as an MHP strength, it can also present a challenge as staff who cover the days may need to delay seeing members who are their established clients.

Recommendations for improvement based upon this review include:

- Review the transportation system within the county and agency and investigate alternative options.
- Review the need to hire a data analyst with skill in SQL who can assist with complex data projects that the new EHR will allow.
- Continue efforts and implement a formal process for psychiatrist review and monitoring of MHP medication prescribing practices.
  (This recommendation was continued from FY 2021-22.)
- Implement a medication monitoring system for FC youth as required by WIC Section 14197 and SB 1291.
  (This recommendation was continued from FY 2021-22.)
- Evaluate staffing needs for open access days and ensure that staff are comfortably able to maintain their current workload in addition to covering walk-in appointments.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

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

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in FC as per California SB 1291 (Section 14717.5 of the California WIC). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2023-24 findings of the EQR for Colusa County MHP by BHC, conducted as a virtual review on August 3, 2023.

REVIEW METHODOLOGY

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

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

CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (CY) 2022 and FY 2022-23, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – summary of the validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5 and also as outlined DHCS's Comprehensive Quality Strategy. Data definitions are included as Attachment E.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding penetration rate (PR) percentages.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

There was no environmental impact during the review.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP transitioned from Cerner Community Behavioral Health (CCBH) EHR and implemented the California Mental Health Services Authority (CalMHSA) semi-statewide EHR, SmartCare by Streamline in July 2023.
- The MHP reported an improved relationship with law enforcement, jail, and probation to link inmates with services.
- The MHP has initiatives to meet MHP staffing needs including employing extra-help therapists to fill gaps in staffing, contracting with CalMHSA for the Palo Alto master's program, and potentially offering hiring bonuses. The MHP is expanding its workforce to have additional fiscal, EHR, Quality Assurance (QA), and clinical providers.
- Colusa executed a memorandum of understanding with University of California (UC) Davis for the Early Psychosis Intervention program.
- Colusa selected a provider for the adult residential facility (Cypress House).
- The MHP is continuing to move forward with No Place Like Home project (Rancho Colusa) – tentatively breaking ground in Spring 2024.
- Colusa reported the MHSA Innovation project (Practical Actions Towards Health) was expanded from three to five years.
- The MHP was awarded a $1.5 million Behavioral Health Bridge Housing grant.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2022-23

Recommendation 1: Research and implement ways to increase access given the MHP's PR remains at 6.08 percent while the number of eligible members and number served has increased.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Overall PR in Colusa decreased again slightly in CY 2022, but there has been a statewide downward trend in PR over the past three CYs, as well as in small-rural counties.
- In the past year, the MHP has increased outreach efforts through community events, advertising in the local newspaper and social media, while also expanding MHSA programs.
- The MHP also implemented a new open access model where prospective members can access walk-in appointments two days per week and receive same day assessments. The MHP believes these efforts will improve PR.

Recommendation 2: Continue to track effectiveness of the performance improvement activities to increase timeliness for urgent appointments, with a goal of 80 percent or more.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Colusa reworked the access to intake appointments by increasing staff and hours that are available for open access intake. The MHP's crisis team is also available to respond to urgent requests.
- The MHP reported issues with data collection. A front office supervisor unexpectedly passed away and as a result, there was disruption in the process and the time of urgent requests was not always recorded. Colusa is training staff members that the time must be recorded.
- Colusa has made efforts to improve this measure. While this item is rated partially addressed, it is not carried over in a recommendation for this year's review due to other priority recommendations identified. Colusa's PR remains above the statewide average.

Recommendation 3: Continue to support EHR vendor (Kings View) in implementing a psychiatrist review that provides medication monitoring. Follow-up with request to second provider of psychiatrists, Traditions Behavioral Health, to do the same.

(This recommendation was continued from FY 2021-22.)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Colusa reported that the MHP did not create a finalized process for this recommendation due to unexpected staffing changes.
- Current psychiatric staff have vetted a medication monitoring tool for adults; however, the MHP is still working on contracting with Traditions Behavioral Health for a youth psychiatrist who can peer review youth charts.
- With the transition away from CCBH to SmartCare by Streamline, the MHP's relationship with Kings View will cease as it transitions to CalMHSA for data analytics support for this project.
- This recommendation will be carried over.

Recommendation 4: Investigate best practices and implement a medication monitoring system for FC system as required by WIC Section 14197 and SB 1291.

(This recommendation was continued from FY 2021-22.)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP did not address this recommendation and included a barrier of being short staffed of Licensed Psychiatric Technicians.
- Colusa hopes that once the position is filled, it will be able to implement a medication monitoring system for FC youth.
- This recommendation will be continued.

Recommendation 5: Increase the perception of members and family members that their input is valued by creating opportunities for improved transparency and communication, including involving them in committees and volunteer positions within the MHP.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Colusa added information to its website including a calendar which has all meetings that are open to the public, the Behavioral Health Advisory Board meeting minutes, QI, Cultural Competency, and MHSA plans. The MHP should ensure that members are aware of and know how to use the website.
- The MHP started a quality department bulletin and added a new position, a marketing administration specialist, for more outreach and transparency in the community.
- The MHP has volunteer positions available for community members interested in mental health.
- While this item is rated partially addressed, it is not carried over in a recommendation for this year’s review due to other priority recommendations identified.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 90 percent of services were delivered by county-operated/staffed clinics and sites, and 10 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 93.9 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county provider staff; members may request services through the Access Line during the normal business hours and by contractor-operated staff during the after-hours and weekends, as well as through walk-ins and telephone requests through the MHP clinic. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. The assessment process begins with a member requesting an appointment with the MHP, a standardized screening tool being provided to determine appropriateness of delivery system, being offered an initial appointment date and time if screening-in for SMHS, and attending the initial appointment where medical necessity is determined. If the member does not meet medical necessity for SMHS, the MHP provides referrals and links the member to their Medi-Cal managed care plan (MCP) for services. If the member does meet medical necessity for SMHS, their assessment is completed at the initial appointment, the Access Team ensures that all Medi-Cal documents are completed and approves the chart. A clinical program manager receives the chart and assigns the member to a clinician or treatment team, then the assigned clinician or team contacts the member to schedule the next service appointment.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided

---

[1] CMS Data Navigator Glossary of Terms

telehealth services to 282 adult members, 60 youth members, and 40 older adult members across its only county-operated site with no contracted providers. Among those served, 56 members received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

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

In December 2022, DHCS issued its FY 2022-23 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Colusa County, the time and distance requirements are 60 miles and 90 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: Colusa MHP Alternative Access Standards, FY 2022-23

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

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

Table 1B: Colusa MHP Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No

ACCESS KEY COMPONENTS

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

the foundation of access to quality services that ultimately lead to improved member outcomes.

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

Table 2: Access Key Components

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

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

- The MHP implemented an open access process which allows prospective members the opportunity to attend walk-in appointments on Tuesday and Thursday every week.
- The MHP has strong community partnerships to help meet the needs of its members and increased member and community outreach efforts.
- Based on information received during the EQR, it appears that there is an opportunity for the MHP to ensure that transportation resources are available to members for mental health services. It was stated that many agricultural workers have difficulty getting their children into youth services due to transportation. Unreliable bus schedules and areas of the county where the bus does not travel are barriers to access.

ACCESS PERFORMANCE MEASURES

Members Served, Penetration Rates, and Average Approved Claims per Member Served

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

The PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per

member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The statewide PR is 3.96 percent, with an average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, Colusa demonstrates greater access to care than was seen statewide.

Table 3: Colusa MHP Annual Members Served and Total Approved Claims CY 2020-22

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	11,720	699	5.96%	$4,592,510	$6,570
CY 2021	11,132	706	6.34%	$7,552,815	$10,698
CY 2020	10,404	633	6.08%	$6,530,029	$10,316

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

- The total number of Medi-Cal eligibles in Colusa has increased 12.65 percent since CY 2020, while members served has increased 10.43 percent.
- Total approved claims increased from CY 2020-21 but decreased 39.19 percent in CY 2022 from the prior year. The AACM decreased similarly. The MHP is unsure of causes associated with the significant changes in approved claims over the three-year period.

Table 4: Colusa MHP Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	1,271	<11	-	1.63%	1.82%
Ages 6-17	3,348	249	7.44%	8.62%	5.65%
Ages 18-20	741	-	-	6.55%	3.97%
Ages 21-64	5,330	366	6.87%	7.37%	4.03%
Ages 65+	1,030	41	3.98%	3.60%	1.86%
Total	**11,720**	**699**	**5.96%**	**6.67%**	**3.96%**

- MHP PR for each unsuppressed age group in Table 4 is higher than statewide PR.
- PR in Colusa is lower than similar size counties for ages 6-17 and 21-64, but higher for ages 65+.

Table 5: Threshold Language of Colusa MHP Medi-Cal Members Served in CY 2022

Threshold Language	# Members Served	% of Members Served
Spanish	204	29.18%
Threshold language source: Open Data per BHIN 20-070		

- Colusa has a threshold language of Spanish, with 29.18 percent of members served indicating this as their primary language in CY 2022.

Table 6: Colusa MHP Medi-Cal Expansion (ACA) PR and AACM CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	2,775	169	6.09%	$734,305	$4,345
Small-Rural	38,250	2,337	6.11%	$11,818,209	$5,057
Statewide	4,830,000	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This holds true in Colusa for AACM as ACA members averaged $4,345 in claims compared to $6,570 for all members. However, PR for ACA members was slightly higher than the MHP's overall PR by 0.13 percentage points.

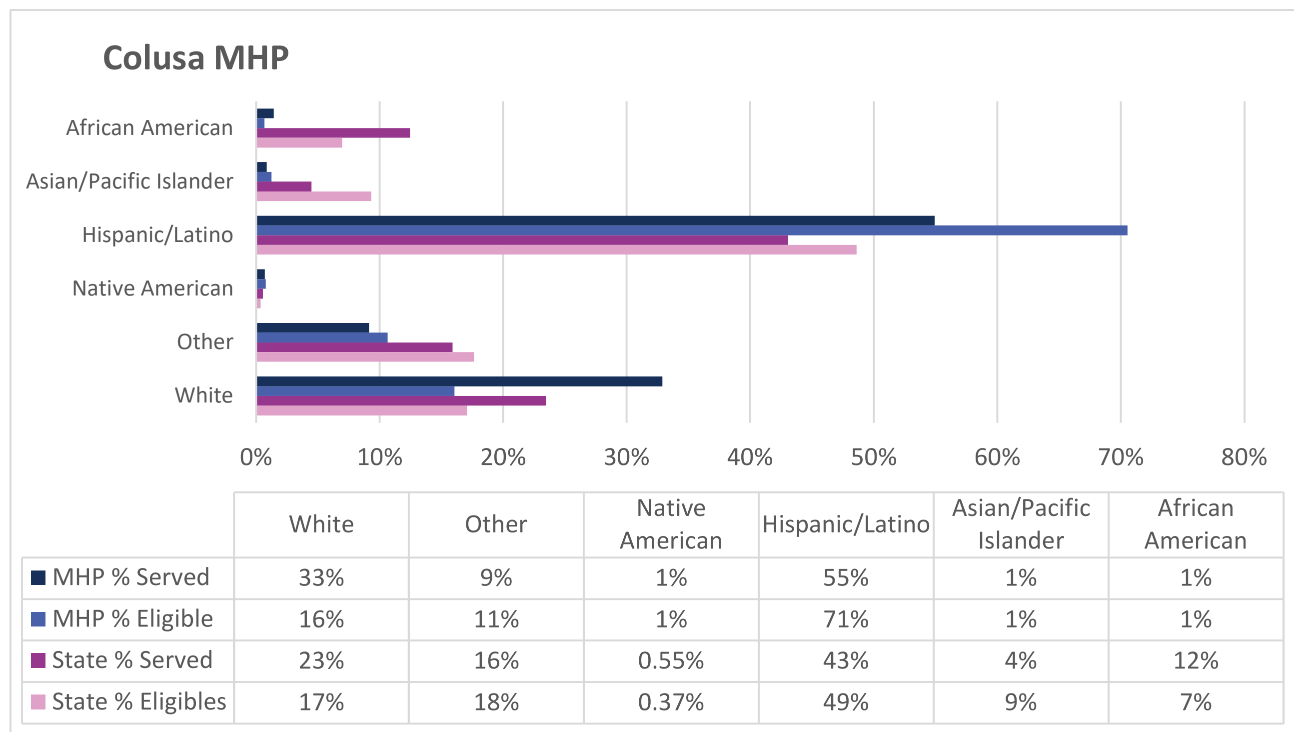
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they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

Table 7: Colusa MHP PR of Members Served by Race/Ethnicity CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	82	<11	-	7.08%
Asian/Pacific Islander	147	<11	-	1.91%
Hispanic/Latino	8,268	384	4.64%	3.51%
Native American	94	<11	-	5.94%
Other	1,249	64	5.12%	3.57%
White	1,882	230	12.22%	5.45%
Total*	**11,722**	**699**	**5.96%**	**3.96%**

- PR is higher in the MHP compared to the state overall, and for Hispanic/Latino, Other, and White members. All other groups in Table 7 are suppressed due to the low number of members served.

Figure 1: Race/Ethnicity for Colusa MHP Compared to State CY 2022



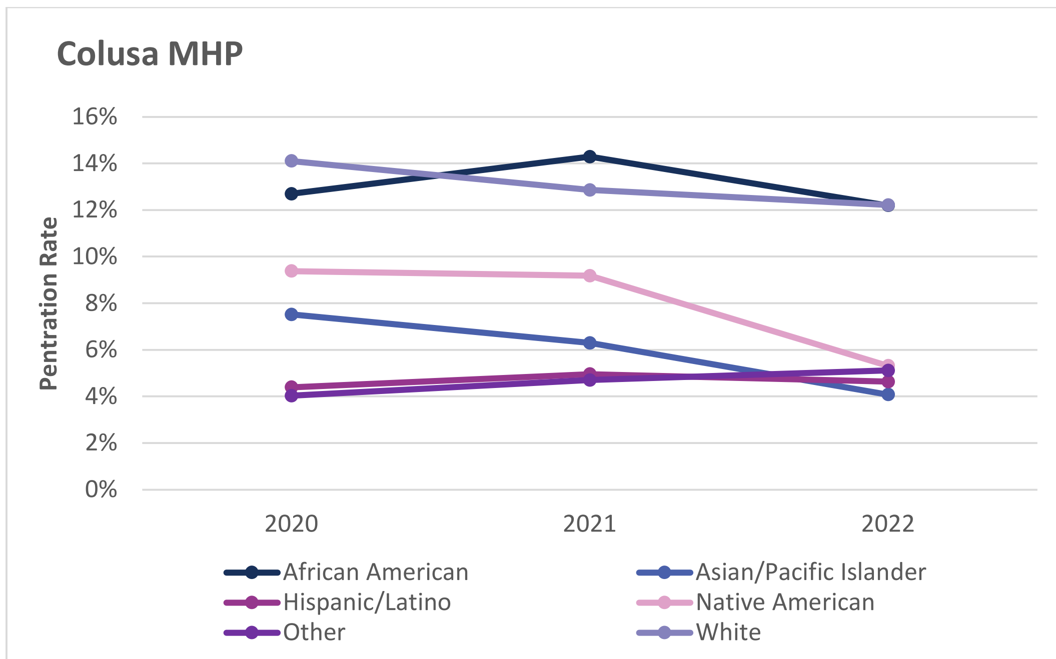
	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	33%	9%	1%	55%	1%	1%
MHP % Eligible	16%	11%	1%	71%	1%	1%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- Among the racial/ethnic groups listed in Figure 1, the Hispanic/Latino group has the largest incongruence between Medi-Cal eligibles and members served (71 percent versus 55 percent), indicating this group is underrepresented in the MHP.

- White members account for the largest overrepresentation of those served as this group accounts for 33 percent of all members served, but only 16 percent of Medi-Cal eligibles in the county.

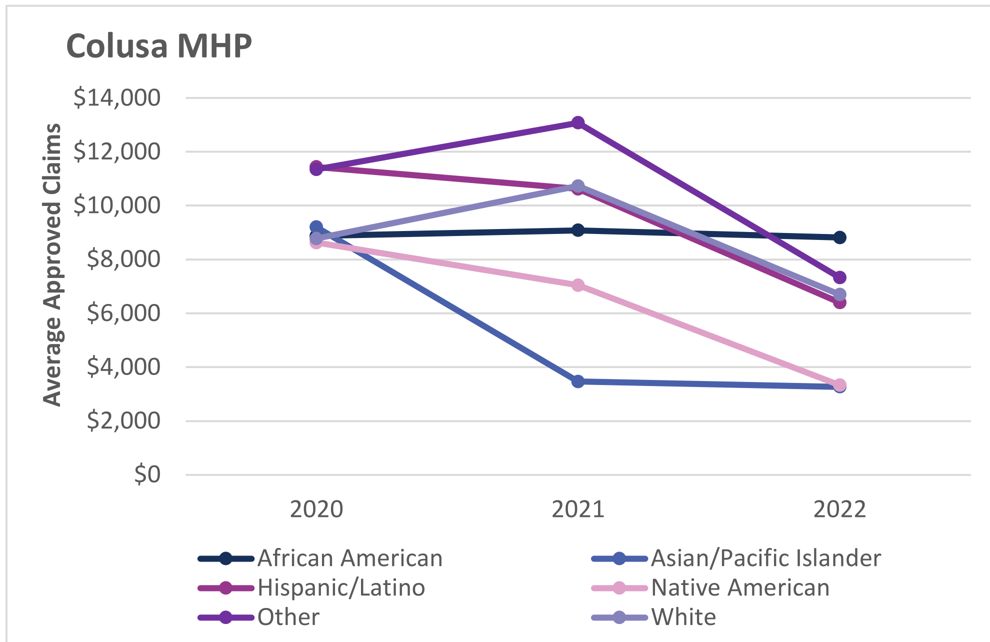
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

Figure 2: MHP PR by Race/Ethnicity CY 2020-22



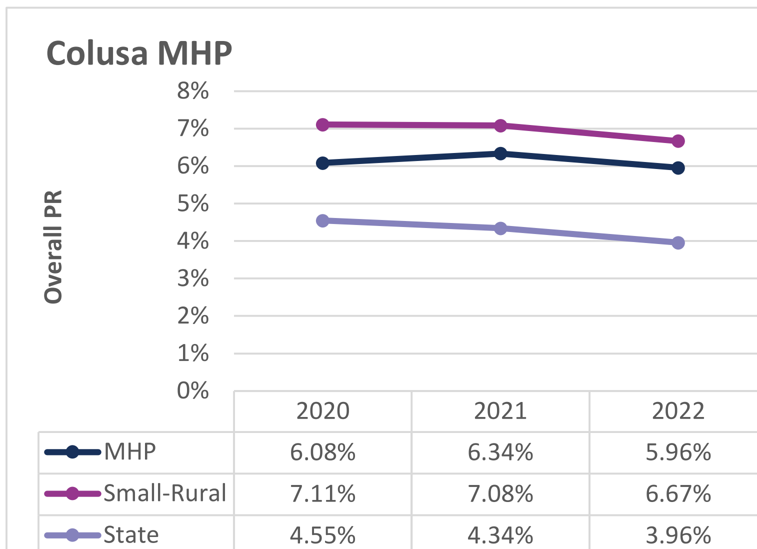
- Since CY 2020, only the Hispanic/Latino and Other racial/ethnic groups have seen an increase in PR. All other groups have seen a decrease in PR during the same timeframe.
- African American and White populations have consistently had the highest PRs in the MHP. PRs for all other racial/ethnic groups were comparable to each other in CY 2022.

Figure 3: MHP AACM by Race/Ethnicity CY 2020-22



- Similar to the overall trend displayed in Table 3, AACM decreased for all racial/ethnic groups between CYs 2021-22, with the exception of African Americans and Asian/Pacific Islanders whose AACM has remained fairly stable over the past two years.

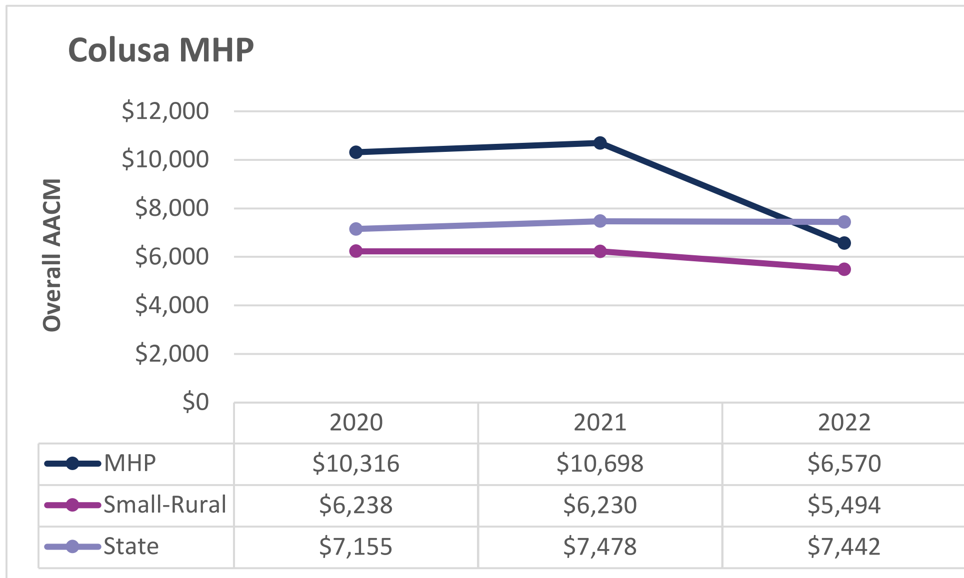
Figure 4: Overall PR CY 2020-22



	2020	2021	2022
MHP	6.08%	6.34%	5.96%
Small-Rural	7.11%	7.08%	6.67%
State	4.55%	4.34%	3.96%

- Overall statewide PR has decreased each year since CY 2020, while PR in Colusa increased in CY 2021, but decreased below CY 2020 levels in CY 2022.
- The MHP's overall PR has consistently been higher than that seen statewide.

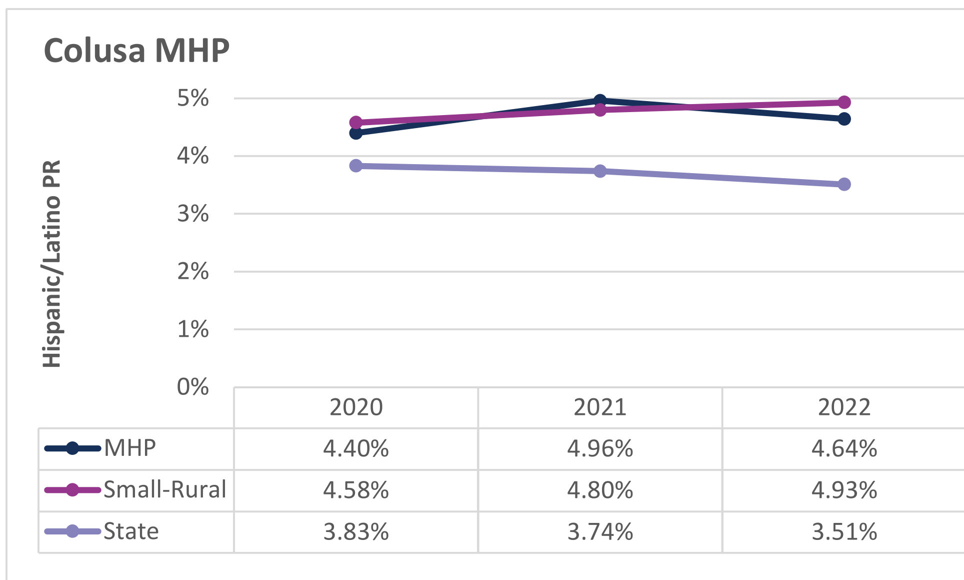
Figure 5: Overall AACM CY 2020-22



	2020	2021	2022
MHP	$10,316	$10,698	$6,570
Small-Rural	$6,238	$6,230	$5,494
State	$7,155	$7,478	$7,442

- AACM in Colusa was considerably higher than in similar sized counties and the state as a whole in both CYs 2020 and 2021 but decreased by more than $4,000 in CY 2022. AACM is still higher than in similar sized counties but is now much more comparable to small-rural county AACMs from the past three years.

Figure 6: Hispanic/Latino PR CY 2020-22

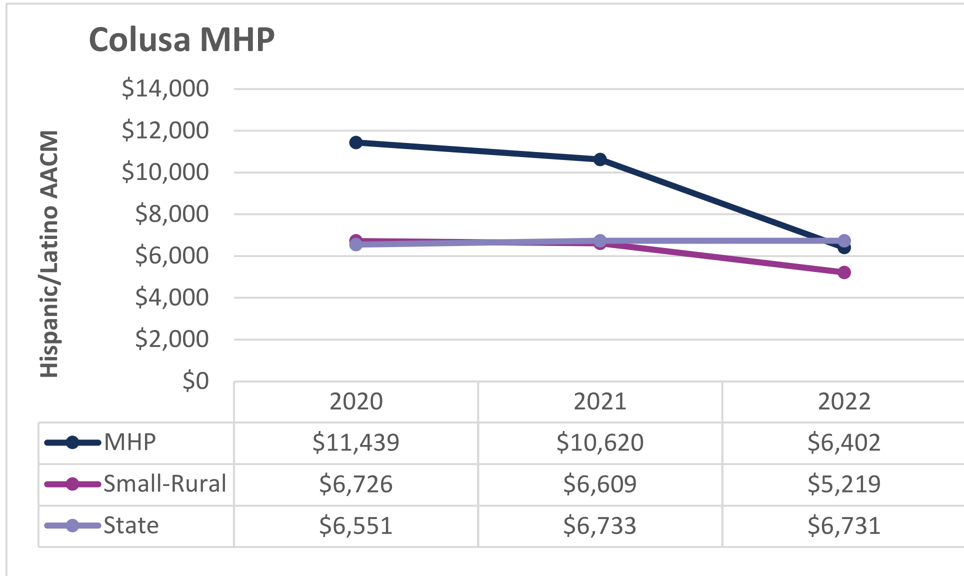


	2020	2021	2022
MHP	4.40%	4.96%	4.64%
Small-Rural	4.58%	4.80%	4.93%
State	3.83%	3.74%	3.51%

- PRs for Hispanic/Latino members in Colusa have followed a similar trend as seen in Figure 4, where this group saw an increase in CY 2021, but a decrease in CY 2022.

- PRs for this population have consistently been higher than those seen statewide and are comparable to trends in small-rural counties overall.

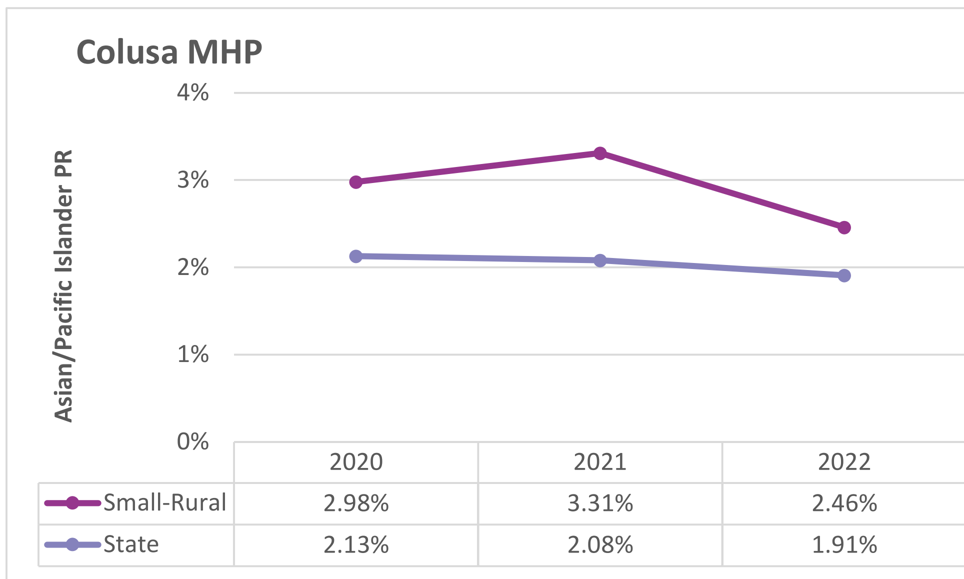
Figure 7: Hispanic/Latino AACM CY 2020-22



	2020	2021	2022
MHP	$11,439	$10,620	$6,402
Small-Rural	$6,726	$6,609	$5,219
State	$6,551	$6,733	$6,731

- Hispanic/Latino AACM decreased by 39.72 percent in CY 2022 compared to the prior year.
- PR for this group is higher in the MHP than similar sized counties, but lower than statewide.

Figure 8: Asian/Pacific Islander PR CY 2020-22

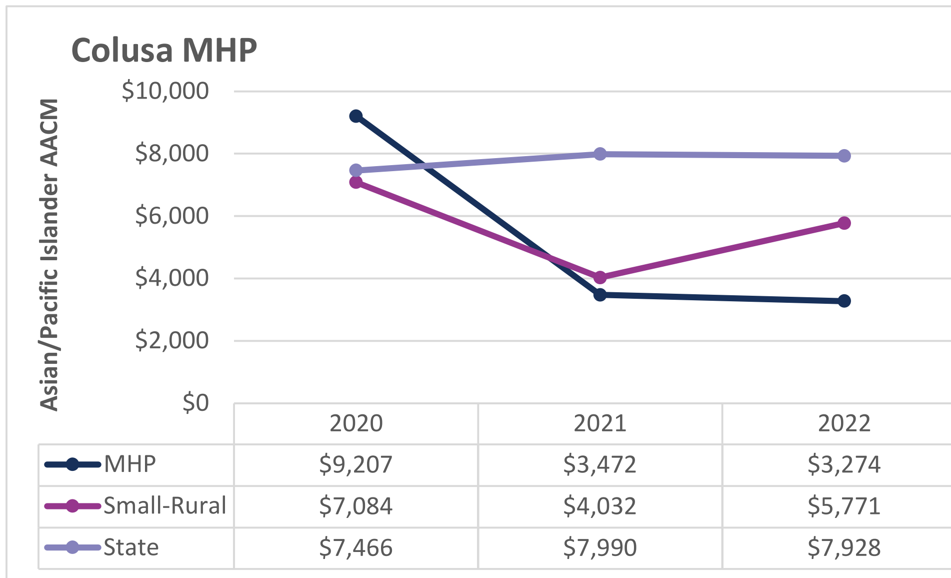


	2020	2021	2022
Small-Rural	2.98%	3.31%	2.46%
State	2.13%	2.08%	1.91%

*The MHP's data is not displayed above due to the small number of members represented.

- Colusa served less than 11 Asian/Pacific Islanders in CY 2022 so the MHP data in Figure 8 has been suppressed. While the MHP's PR for this population has been higher than PRs in other Small-Rural MHPs and statewide for the past three years, it has been decreasing each year since CY 2020.

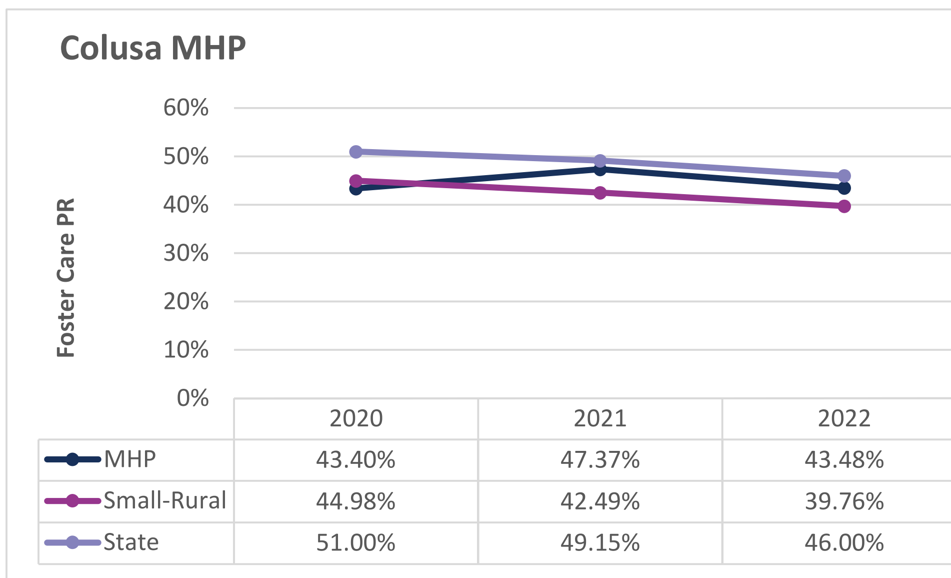
Figure 9: Asian/Pacific Islander AACM CY 2020-22



	2020	2021	2022
MHP	$9,207	$3,472	$3,274
Small-Rural	$7,084	$4,032	$5,771
State	$7,466	$7,990	$7,928

- AACM for Asian/Pacific Islanders remained fairly stable between CY 2021 and CY 2022.

Figure 10: Foster Care PR CY 2020-22

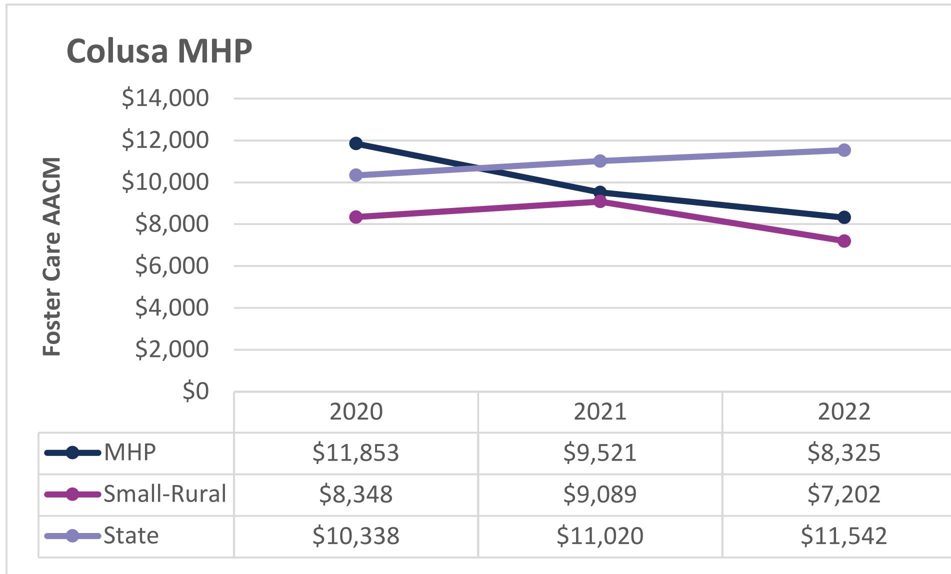


	2020	2021	2022
MHP	43.40%	47.37%	43.48%
Small-Rural	44.98%	42.49%	39.76%
State	51.00%	49.15%	46.00%

- Statewide FC PR has declined each year since CY 2020.

- Similar to statewide trends, FC PR for small-rural counties has decreased each year since CY 2020. However, PR in Colusa increased in CY 2021, followed by a decrease in CY 2022. The MHP's FC PR in CY 2022 was more than three percentage points higher than the small-rural county PR but remains slightly lower than statewide.

Figure 11: Foster Care AACM CY 2020-22



	2020	2021	2022
MHP	$11,853	$9,521	$8,325
Small-Rural	$8,348	$9,089	$7,202
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years, while small-rural county FC AACM increased 8.88 percent in CY 2021 but decreased 20.76 percent in CY 2022. In Colusa, FC AACM has decreased each of the past three years, and was 29.77 percent lower in CY 2022 compared to CY 2020.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Colusa MHP to Adults

Service Category	MHP N = 443				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	2.0	2.0	10.29%	14	8
Inpatient Admin	0	0.0%	0.0	0.0	0.41%	26	10
Psychiatric Health Facility	<11	-	9.3	6.5	1.19%	16	8
Residential	0	0.0%	0.0	0.0	0.33%	114	84
Crisis Residential	0	0.0%	0.0	0.0	1.92%	23	15
Per Minute Services							
Crisis Stabilization	<11	-	689	689	13.36%	1,449	1,200
Crisis Intervention	65	14.7%	194	131	12.21%	236	144
Medication Support	218	49.2%	273	170	59.75%	298	190
Mental Health Services	327	73.8%	835	471	62.71%	832	329
Targeted Case Management	173	39.1%	650	240	36.95%	445	135

- Per day services were minimally utilized by adults in the MHP, and average units were considerably lower than the state for Inpatient and Psychiatric Health Facility services.
- Adult utilization of Mental Health Services was 11 percentage points higher than statewide, while Medication Support had a 10-percentage point lower utilization rate than statewide.

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

Service Category	MHP N = 20				Statewide N = 33,243		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	0	0.0%	0.0	0.0	4.5%	11.8	8.0
Inpatient Admin	0	0.0%	0.0	0.0	0.0%	4.7	3.0
Psychiatric Health Facility	0	0.0%	0.0	0.0	0.2%	18.6	8.0
Residential	0	0.0%	0.0	0.0	0.0%	56.0	39.0
Crisis Residential	0	0.0%	0.0	0.0	0.1%	23.7	22.0
Full Day Intensive	0	0.0%	0.0	0.0	0.2%	673.5	435.0
Full Day Rehab	0	0.0%	0.0	0.0	0.2%	110.8	84.0
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	3.1%	1,166	1,095
Crisis Intervention	0	0.0%	0	0	8.5%	371	182
Medication Support	<11	-	411	295	27.6%	364	257
TBS	0	0.0%	0	0	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Home-Based Services	<11	-	956	1,144	40.8%	1,458	441
Intensive Care Coordination	<11	-	1,837	1,837	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	20	100.0%	1,221	1,161	95.4%	1,846	1,053
Targeted Case Management	<11	-	212	74	35.8%	307	118

- Colusa FC youth members did not utilize any per day services in CY 2022.
- Very few FC youth received per minute services in CY 2022, although 100 percent received Mental Health Services.
- Utilization of both Intensive Home-Based Services and Intensive Care Coordination were lower in the MHP than statewide.

IMPACT OF ACCESS FINDINGS

- Overall PR increased slightly in CY 2021, then decreased slightly in CY 2022.
- Medication Support is utilized more than ten percentage points less than the state.
- Colusa has implemented several outreach efforts with the goal of increasing PR.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The MHP reported the creation of a crisis team that decreased wait times for urgent appointments. For the FY 2023-24 EQR, Colusa reported the result for an urgent appointment offered within 48 hours (all services category) as 66.67, improved over last year's 50 percent.

- Colusa reported that 100 percent of first offered appointments are within 10 business days.
- The MHP indicated that it reviews timeliness data quarterly at the Quality Improvement Committee (QIC) meetings.
- Colusa reported challenges with completing timely follow-up appointments after hospitalization because of not always being notified of member discharges.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of ATA, representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12 – 14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care. It should be noted that timeliness data for FC was not included by the MHP in the ATA. The MHP indicated during the EQR that it did not have any data for FC youth to report in the ATA for the specified measurement period.

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

Table 11: FY 2023-24 Colusa MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	1.59 Business Days	10 Business Days*	100%
First Non-Urgent Service Rendered	3.09 Business Days	15 Business Days**	94.17%
First Non-Urgent Psychiatry Appointment Offered	8.48 Business Days	15 Business Days*	85.71%
First Non-Urgent Psychiatry Service Rendered	9.40 Business Days	20 Business Days**	89.29%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	39.36 Hours	48 Hours*	66.67%
Urgent Services Offered (including all outpatient services) – Prior Authorization Required	***	96 Hours*	***
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	2.5 Days	7 Calendar Days**	78.95%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	2.5 Days	30 Calendar Days	78.95%
No-Show Rate – Psychiatry	11.84%	10%**	n/a
No-Show Rate – Clinicians	9.30%	10%**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033

** MHP-defined timeliness standards

*** The MHP does not separately report urgent timeliness for services requiring prior authorization

For the FY 2023-24 EQR, the MHP reported its performance for the following time period:

FY 2022-2023

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

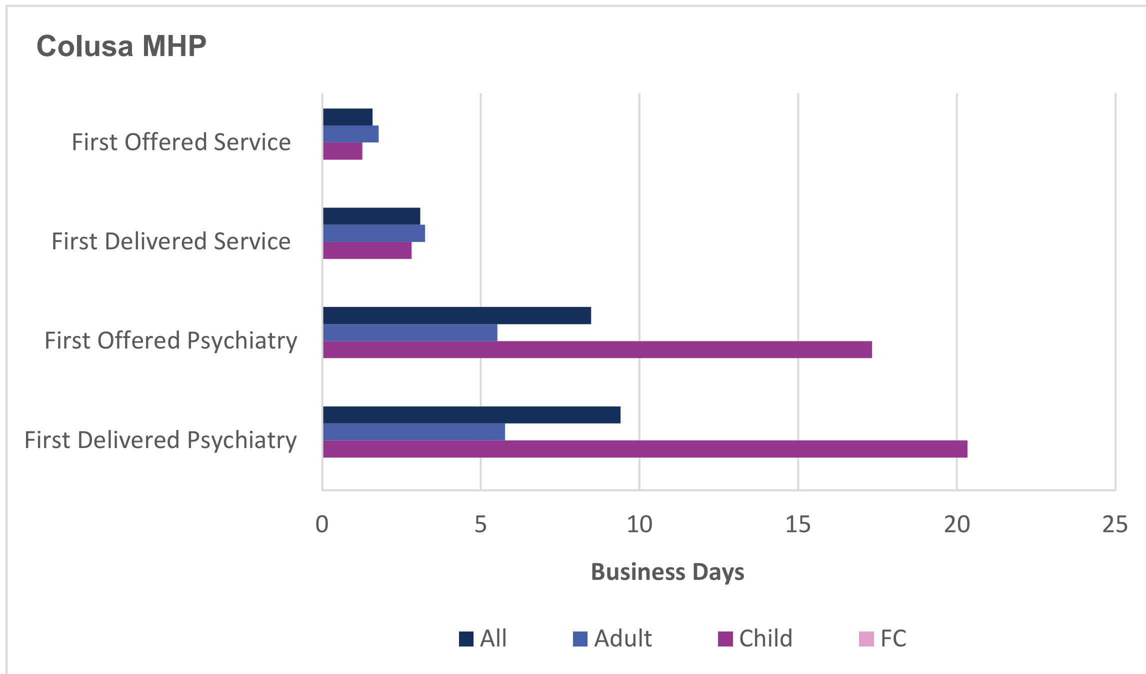


Figure 13: Wait Times for Urgent Services

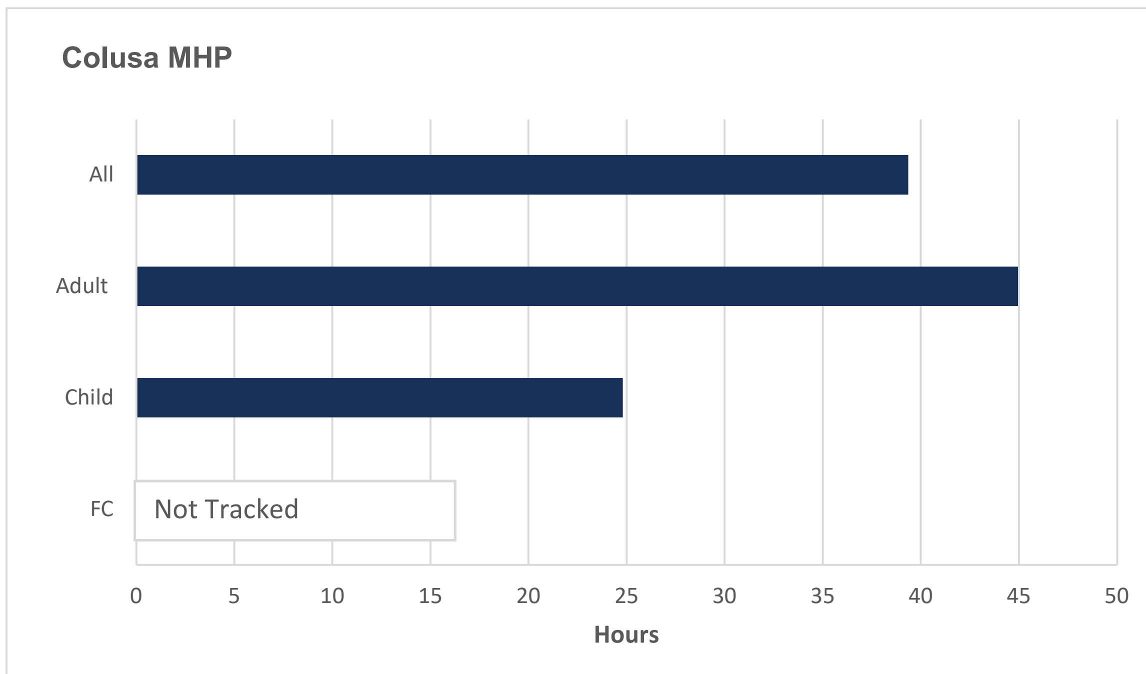
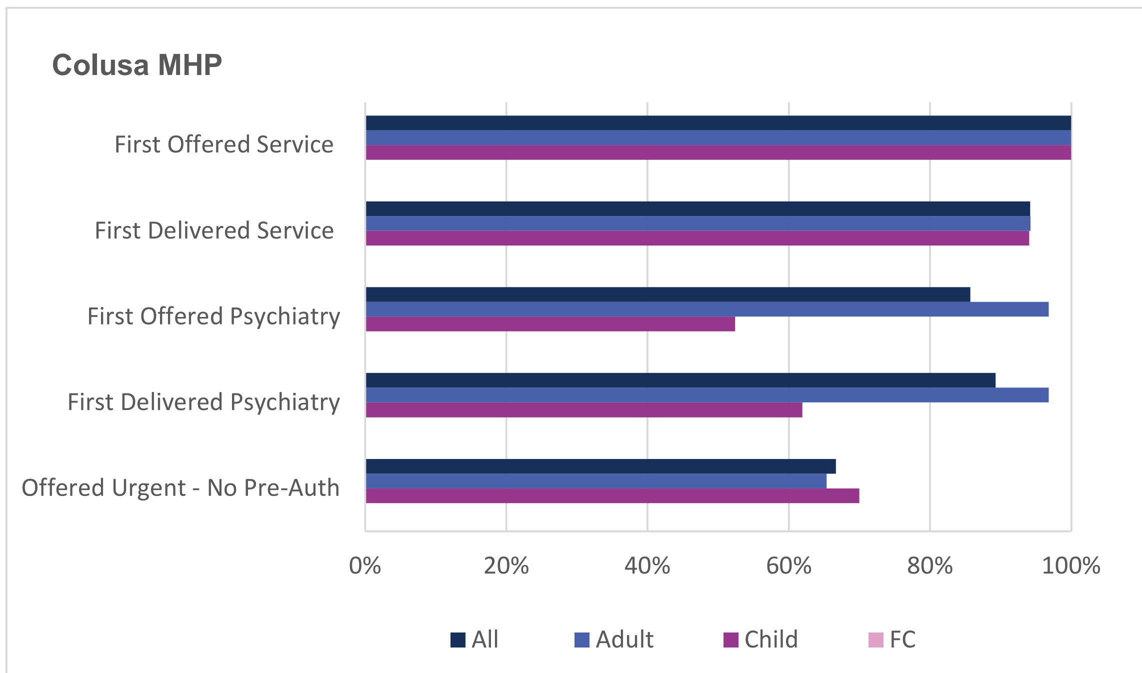


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent any mental health appointment request made by members.
- The MHP defined "urgent services" for purposes of the ATA as "an imminent and serious threat to the member's health where the normal timeframe to access services could jeopardize their ability to regain maximum function. Some examples of urgent needs are a discharge from an inpatient hospital, a member who was recently seen in crisis at the clinic, a member who just moved to Colusa County who is low on psychotropic medication, a recent [Child Protective Services] removal from the home, and other conditions that may pose a risk of decompensation if the member is not seen as soon as possible." There were reportedly 36 urgent service requests with a reported actual wait time to services for the overall population of 39.36 hours. The MHP does not track urgent services that require pre-authorization separately.
- A 15-business day standard is expected for initial access to psychiatry, though the MHP may define when and how this is measured, and often MHP processes, definitions, and tracking may differ for adults and children. The MHP defines timeliness to first delivered/rendered psychiatry services as from the point of first clinical determination of need for all new clients to psychiatry.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 11.84 percent for psychiatrists and 9.30 percent for clinical staff.

- The MHP did not report data for FC services.

IMPACT OF TIMELINESS FINDINGS

- The MHP averages 1.59 days between the date of first contact and first offered appointment. This number is well below the 10-business day DHCS standard. This is likely due to the open access process where the MHP schedules two days per week that prospective clients can come in and receive instant assessments.
- Colusa reported that only 52.38 percent of children received a first offered non-urgent psychiatry service within 15 business days. The MHP is looking to expand its number of providers.
- Since the MHP did not have any timeliness data for FC youth for the measurement period, it is unclear whether these members are receiving timely care and services.

QUALITY OF CARE

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 the intervention for performance improvement.

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is an agency responsibility undertaken by the QA Clinical Program Manager who is supported by a full-time QA Coordinator. Quality is viewed as a continuous process across systems, with QI embedded in each program.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of executive-level staff, program managers, program supervisors, clinical line staff, peer support specialists, and members, is scheduled to meet quarterly. Progress towards the work plan goals is evaluated quarterly in QIC meetings. Annually, the work plan is evaluated to assure the success of the Quality Management program. Since the previous EQR, the MHP provided notes for four QIC meetings. Colusa reviewed its QI workplan goals in July 2023 and approximately 54 percent of the goals were indicated as being met.

The MHP indicated use of the following screening/assessment tools: Screening Tool for Medi-Cal Mental Health Services (Adult and Youth) and Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth). Colusa reported that it does not utilize other level of care (LOC) tools for mental health services.

The MHP reported that the following tools are used to measure member outcomes: California Outcomes Measurement System (CalOMS), Generalized Anxiety Disorder-7, MORS, Adult Needs and Strengths Assessment, PSC-35, CANS-50, and Patient Health Questionnaire-9.

Colusa provided dashboards for the CANS-50, MORS, and PSC-35. It was not evident that the MHP uses aggregate member-level outcomes to improve or adapt services at the program or system level. Colusa plans to begin tracking and trending aggregate data once mechanisms for monitoring via the SmartCare EHR have been put in place.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve

outcomes for members. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Not Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Partially Met
3H	Utilizes Information from Member Satisfaction Surveys	Not Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Member and Member Employment in Key Roles throughout the System	Not Met

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

- The MHP demonstrated a systematic approach for improving overall access, timeliness, and quality of care and utilizing data to identify issues to improve the service delivery system. Colusa reported that it reviews the entire work plan at each QIC.
- The MHP provided screening and outcomes tools and three dashboards for the outcome tools. Colusa reported that it does not utilize other LOC tools.
- Although Colusa administers the Consumer Perception Survey (CPS), it is not evident that the MHP shares the findings with stakeholders or uses the results to improve access, timeliness, or quality.
- Colusa reported that receiving services for members living in Williams presents challenges due to transportation issues and there is lack of peer-based support in Williams. In its MHSA Three-Year Plan, the MHP included construction of a new building for a wellness center in Williams.

- There may be opportunities for the MHP prescribers to coordinate medication management with primary care providers, for Colusa to use aggregate member-level outcomes data to improve services at the program or system level, and offer career advancement opportunities for peer support staff.
- The MHP does not track and trend any of the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.

QUALITY PERFORMANCE MEASURES

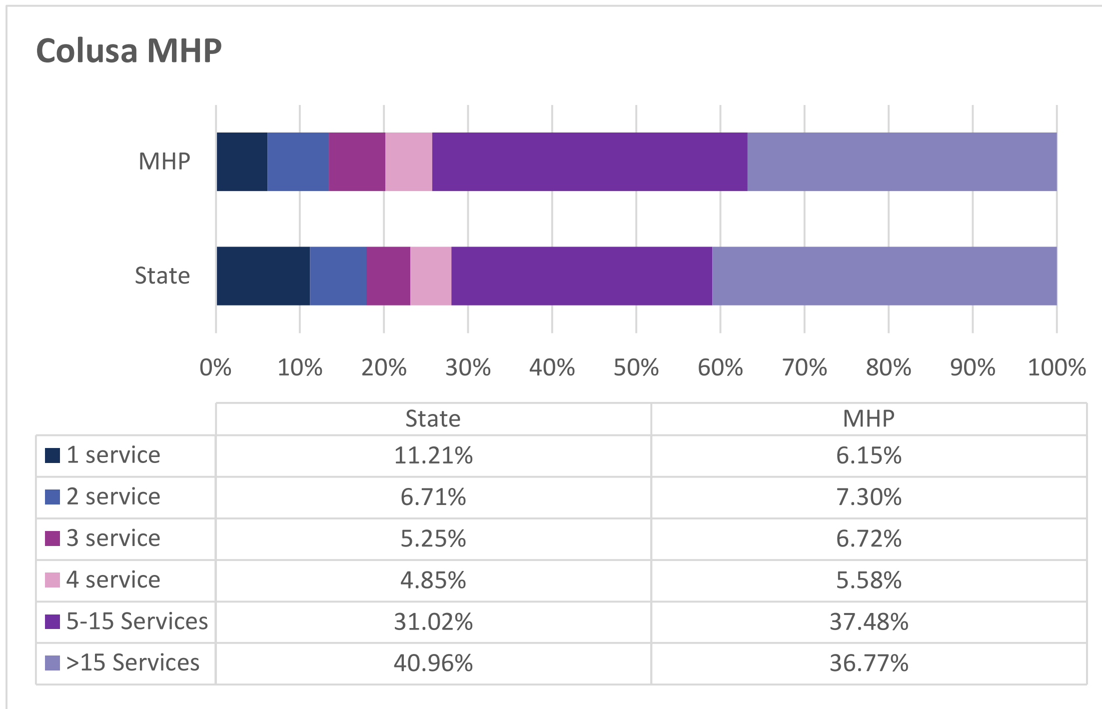
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Members Served CY 2022



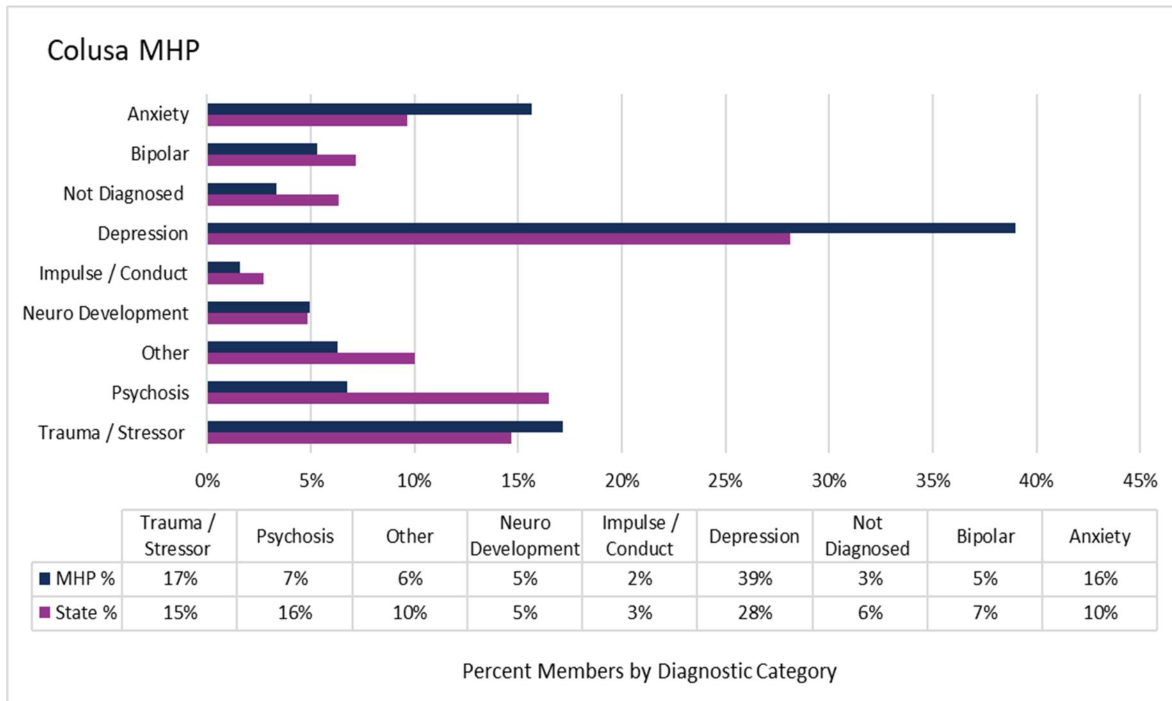
	State	MHP
1 service	11.21%	6.15%
2 service	6.71%	7.30%
3 service	5.25%	6.72%
4 service	4.85%	5.58%
5-15 Services	31.02%	37.48%
>15 Services	40.96%	36.77%

- Colusa has had success in retaining members, with 74.25 percent of members receiving five or more services. The statewide retention rate for five or more services is 71.98 percent. The MHP also shows rate of one-service only much lower than statewide.

Diagnosis of Members Served

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

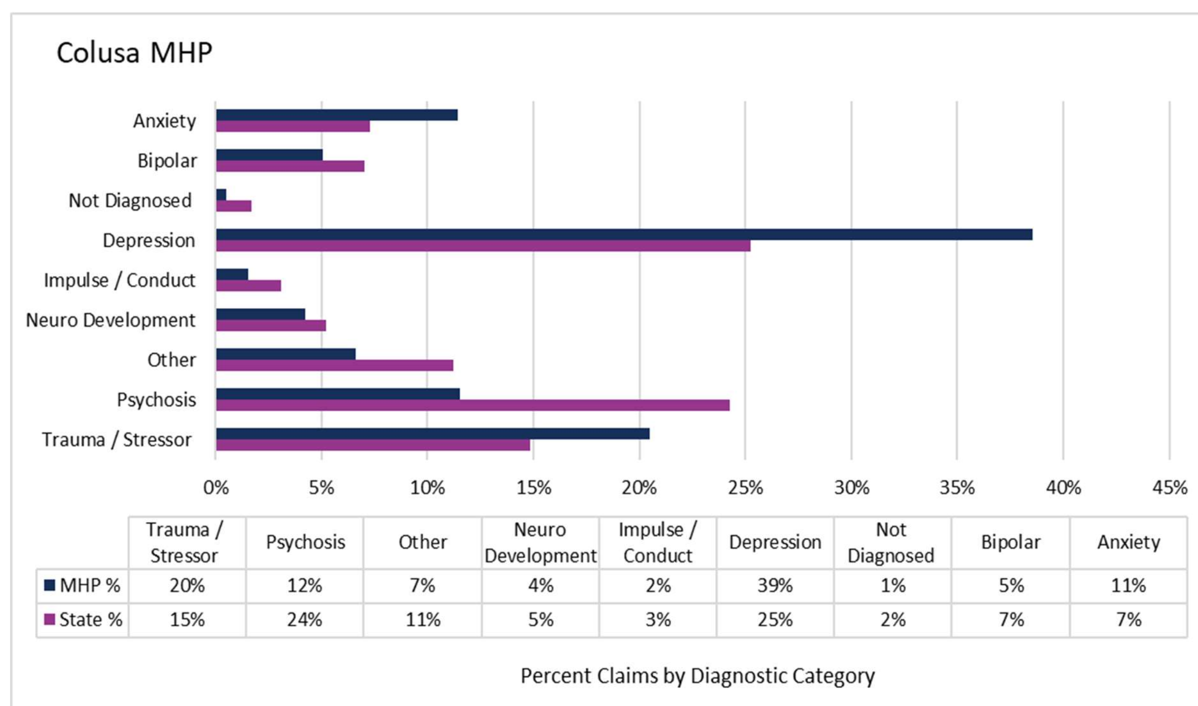
Figure 16: Diagnostic Categories by Percentage of Members Served CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	17%	7%	6%	5%	2%	39%	3%	5%	16%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- The top three diagnostic categories in Colusa are Depression, Trauma/Stressor, and Anxiety. Depression rates are 11 percentage points higher than the statewide rate for this diagnostic category. Anxiety is also more prevalent in the MHP than statewide.
- Psychosis, on the other hand, is seen far less in the MHP than across the state (7 percent versus 16 percent). Colusa has implemented a PIP to address this issue.

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	20%	12%	7%	4%	2%	39%	1%	5%	11%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- Depression is the leading diagnostic category by percentage of approved claims at 39 percent, while Trauma/Stressor is the second highest at 20 percent.
- Although Psychosis is the fourth most prevalent diagnosis in the MHP, it accounts for the third highest percentage of approved claims at 12 percent.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average length of stay (ALOS).

Table 13: Colusa MHP Psychiatric Inpatient Utilization CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	MHP ALOS in Days	Statewide ALOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	13	15	8.93	8.45	$9,100	$12,763	$118,300
CY 2021	16	18	15.35	8.86	$13,695	$12,696	$219,127
CY 2020	16	16	11.94	8.68	$11,154	$11,814	$178,464

- Colusa has seen a stable number of unique Medi-Cal members utilizing psychiatric inpatient care over the past three years, and total inpatient admissions have remained consistent as well.

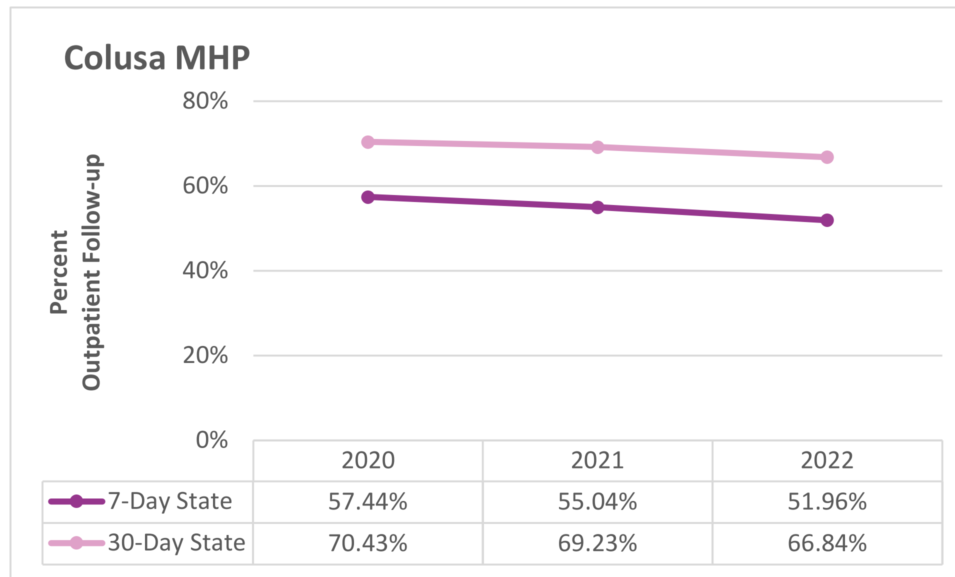
- In CY 2022, ALOS decreased 41.82 percent to 8.93 days, and was much more in line with the statewide ALOS of 8.45 days. Similarly, the Inpatient AACM for the MHP decreased by 33.55 percent in CY 2022 from the prior year and is now more than $3,000 less than the statewide AACM ($9,100 versus $12,763). Furthermore, total inpatient claims decreased by 46.01 percent compared to CY 2021.
- Small numbers of members utilizing inpatient services may be reflected in large swings in totals and averages from year to year.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

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

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2020-22



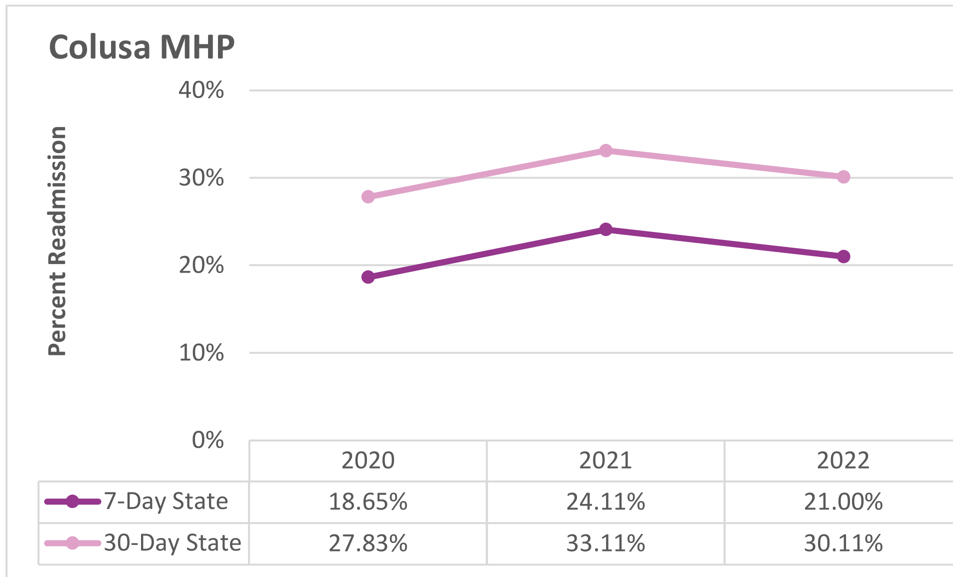
	2020	2021	2022
7-Day State	57.44%	55.04%	51.96%
30-Day State	70.43%	69.23%	66.84%

- The number of members with psychiatric inpatient follow-up services was less than 11 in CY 2022, so the data has been suppressed in Figure 18. Colusa's 7-Day follow-up rate improved between CY 2021 and CY 2022 and remains higher

than the statewide rate, whereas there was a decrease in 30-day follow-ups which decreased their rate below the statewide rate for the first time in the past three years.

- Colusa reported that hospitals do not always notify the MHP of member discharges. Colusa tracks inpatient admissions, discharges, and readmissions manually and enters the results into an Excel spreadsheet.

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2020-22



	2020	2021	2022
7-Day State	18.65%	24.11%	21.00%
30-Day State	27.83%	33.11%	30.11%

- There were fewer than 11 members with psychiatric readmissions within 7 or 30 days of discharge in CY 2022, so the data has been suppressed in Figure 19. Readmission rates at both 7- and 30-days remain lower than statewide rates, as they have been for the past three years.

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 members, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCMs may disproportionately occupy treatment slots that may prevent access to levels of care by other members. 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 level of care and expected outcomes.

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with

approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

Tables 14-15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

Table 14: Colusa MHP High-Cost Members (Greater than $30,000) CY 2020-22

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	22	3.15%	23.19%	$1,065,093	$48,413	$41,773
	CY 2021	57	8.07%	38.51%	$2,908,752	$51,031	$39,769
	CY 2020	38	6.00%	31.19%	$2,036,440	$53,591	$46,387

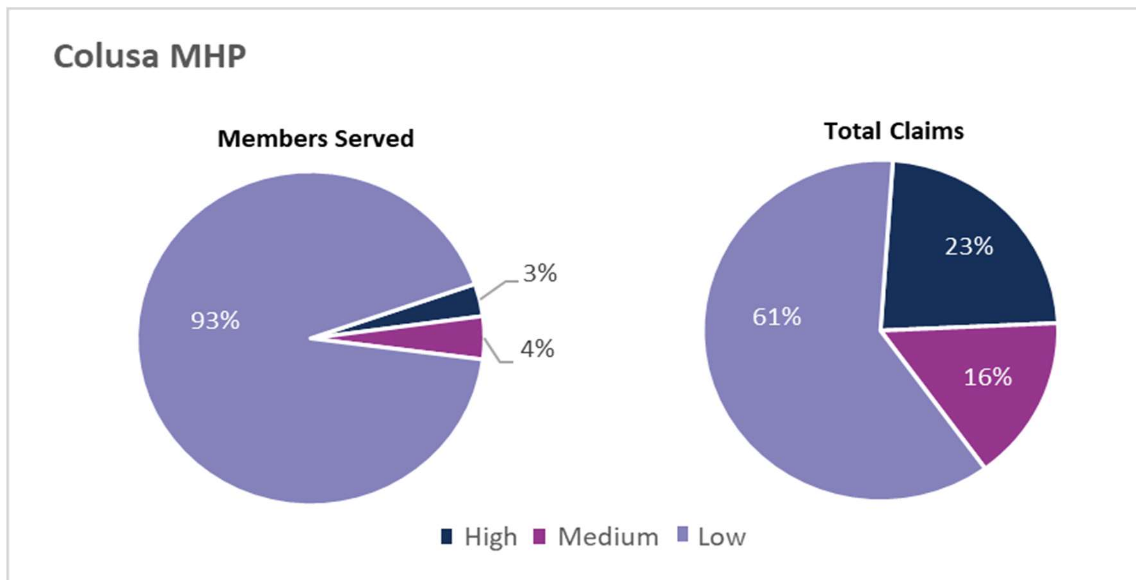
- The number of HCMs in Colusa has fluctuated over the past three years. There was a 50 percent increase in HCMs in CY 2021, followed by a 61.40 percent decrease in CY 2022. The HCM count in CY 2022 is the lowest it has been in the past three years, and now represents a smaller percentage of members served than was seen statewide.
- The HCM percentage of approved claims decreased below the statewide rates in CY 2022 (23.19 percent versus 33.86 percent).

Table 15: Colusa MHP Medium- and Low-Cost Members CY 2022

Claims Range	# of Members Served	% of Members Served	Category Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	29	4.15%	15.68%	$720,104	$24,831	$25,413
Low-Cost (Less than $20K)	648	92.70%	61.13%	$2,807,313	$4,332	$2,612

- Low-cost members make up the majority of the client base in Colusa, and account for 61.13 percent of all approved claims, while medium-cost members total approved claims represent 15.68 percent of all claims.

Figure 20: Members and Approved Claims by Claim Category CY 2022



IMPACT OF QUALITY FINDINGS

- In CY 2022, Colusa was able to retain members with five or more services at a higher rate than the state (74.25 percent versus 71.98 percent), proving the MHP's strong ability to keep members engaged for the long term, and higher engagement from the first service than statewide.
- The top three diagnostic categories in Colusa are Depression, Trauma/Stressor, and Anxiety which account for 72 percent of all diagnoses. Considering the importance of agriculture in the county, these diagnoses align with the environmental and economic challenges faced by many farmers and agricultural workers over the past few years.
- Psychiatric Inpatient ALOS decreased 41.82 percent to 8.93 days.
- The number of HCMs served decreased 61.40 percent in CY 2022 compared to the previous year, which may be an indication that these members are utilizing less intensive services. Although there had been an increase in the number of HCMs served from CY 2020 to CY 2021, in CY 2022 it was notably lower than both.
- Colusa reported that it reviews data at the quarterly QIC meetings, discusses progress, and whether goals are met. Currently the MHP is no longer able to enter data into its old EHR system and is awaiting full functionality of SmartCare for reporting. Meanwhile, Colusa is manually tracking measures.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Psychosis Identification and Treatment

Date Started: 02/2023

Aim Statement: The goal of the Psychosis Identification and Treatment PIP is to increase the amount of treatment and support a member receives to improve their overall functioning. The PIP population includes new members ages 12-30 who endorse psychotic symptoms on the Prodromal Questionnaire, Brief Version (PQ-B) from February 1, 2023, to June 30, 2024. The intervention Colusa is providing allows access to and treatment of psychotic symptoms by partnership with UC Davis Early Diagnosis and Preventive Treatment (EDAPT) from a baseline of 0 members to a goal of 20 members.

Target Population: All new members ages 12 to 30 years of age will be administered the PQ-B as part of intake to screen for symptoms of psychosis.

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

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

Status of PIP: The MHP's clinical PIP is in the implementation phase.

Summary

The MHP initiated the PIP based on the prior year EQR findings that indicated the percentage of members with psychosis was lower than statewide. To improve identification of potential psychotic symptoms, new members ages 12-30 years old will be administered the PQ-B at intake. When a screening indicates a member has symptoms of psychosis, Colusa initiates a referral to UC Davis for specialty treatment, and coordinates care for the member. UC Davis provides specialty treatment for psychosis while Colusa provides outpatient mental health services. MHP staff work as a collaborative support to the member in their UC Davis appointments, which allows the member's learned skills to be reinforced.

The PQ-B will be administered to all new eligible members upon intake, re-administered at bi-annual reassessment, and at any time it has been deemed to be clinically appropriate due to symptoms and functional impairments reported by the member or observed by the treatment team. All clinicians were trained on how to administer and score the PQ-B tool in September 2022. The PIP did not yet include results.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence. The MHP had not yet progressed to reporting outcomes to determine whether the intervention of using the PQ-B assessment for the targeted population addresses root causes of the issue.

CalEQRO provided TA on this PIP during the review. The MHP did not request PIP TA prior to or immediately after the annual EQR.

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

- Provide quantitative/numeric goal in the aim statement. (MHP resubmitted the PIP to address this recommendation.)
- Describe in the data collection process how mutual clients enrolled in the UC Davis EDAPT program and number of crisis services will be collected for the performance measure results. (Colusa's resubmission did not address this recommendation.)

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-up After ED Visit for Mental Health Condition (FUM)

Date Started: 03/2023

Aim Statement: Colusa will increase the percentage of follow-up mental health services to members with an ED visit for a mental health condition within 7 days from a rate of 50 percent to 55 percent and within 30 days from a rate of 75 percent to 80 percent. This PIP will take place until 6/30/2024 unless these goals have not been achieved, which will extend the PIP in FY 2024-2025.

Target Population: All Colusa members who have an ED visit for a mental health symptom.

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

Summary

The MHP initiated a PIP that is the Behavioral Health Quality Improvement Program to improve follow-up in 7 and 30 days for members who have an ED visit for a mental health condition. The MHP reported provider change and system change interventions for the PIP that included collaboration with the ED and MCP.

Colusa reported two interventions. One intervention was a referral form for the ED to utilize when making a referral to the MHP. The referral form is emailed to ED staff, available on the MHP's website, and is a monthly agenda item for the collaborative meetings with the MHP crisis team and ED. This intervention began in May 2023. Another intervention was implementing quarterly meetings with MCPs to discuss data sharing via a secure file transfer protocol (SFTP). The data exchange is monthly and began in March 2023. The PIP did not yet report the results.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence. The MHP had not yet progressed to reporting outcomes to determine whether the intervention for the targeted population addresses root causes of the issue.

CalEQRO provided TA on this PIP during the review. The MHP did not request PIP TA prior to or immediately after the annual EQR.

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

- Solicit member input for the topic and root causes/barriers to the members receiving follow-up care within the specified timeframes.
- Document clearly and consistently variables and performance measures throughout the PIP. It appears the variables would be members with an ED visit for mental health conditions and subsequently members with follow-up visits. Performance measures would be the percentage of members with an ED visit for mental health conditions with follow-up in 7 and 30 days. Intervention evaluation

measures may include percentage of members with an ED visit for a mental health condition that the MHP schedules a follow-up mental health service, and the percentage who receive that follow-up service.

- The aim included what appeared to be baseline rates for 7- and 30-day follow-up (i.e., 50 percent and 75 percent, respectively); however, the MHP did not provide baseline data in this year’s submission. It appears that the MHP could provide baseline data in this year’s submission based on the aim statement.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is SmartCare by Streamline, which has been in use since July 2023 (one month at the time of the EQR). Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 9.2 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control.

The MHP has 72 named users with log-on authority to the EHR, including approximately 65 county staff and 7 contractor staff. Support for the users is provided by three full-time equivalent (FTE) IS technology positions. Currently there is one vacant position.

Some contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to Colusa MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☒ Monthly	10%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	90%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP does not currently utilize a PHR but intends to implement one in their new EHR within the next year.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: MH Community Based Organization (CBO)/Contract Providers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP implemented a new EHR in July 2023, SmartCare by Streamline.
- The MHP's denied claims rate is considerably lower than the statewide rate.
- There is a data warehouse in place that replicates the EHR system to support data analytics.
- It would benefit the MHP to formalize a data integrity validation process where the staff member assigned to a data extraction or report project is not the same person to validate the data before it is released to the rest of the agency. This is to ensure the reliability and internal consistency of data remains complete and accurate, especially with the coming data extraction capabilities of the new EHR.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

Table 18 appears to reflect a largely complete or very substantially complete claims data set for the time frame represented.

Table 18: Summary of Colusa MHP Short-Doyle/Medi-Cal Claims CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	846	510,265	$2,079	0.41%	$508,186
Feb	1,110	365,082	$2,815	0.77%	$362,267
Mar	1,479	453,931	$0	0.00%	$453,931
April	1,237	377,762	$1,417	0.60%	$376,345
May	1,227	379,247	$2,573	0.51%	$376,674
June	1,085	341,327	$2,250	0.13%	$339,077
July	1,184	336,993	$1,935	2.35%	$335,058
Aug	1,377	390,139	$440	0.29%	$389,699
Sept	1,406	406,019	$7,909	0.26%	$398,110
Oct	1,185	333,181	$1,143	0.11%	$332,038
Nov	1,071	343,392	$1,043	0.30%	$342,349
Dec	982	289,895	$372	0.13%	$289,523
Total	**14,189**	**$4,527,233**	**$23,976**	**0.53%**	**$4,503,257**

- Claim lines are consistent and denied claims rates are exceptionally low across CY 2022.

Table 19: Summary of Colusa MHP Denied Claims by Reason Code CY 2022

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B must be billed before submission of claim	35	$14,509	60.52%
Member is not eligible or non-covered charges	14	$7,357	30.69%
Other healthcare coverage must be billed first	3	$1,800	7.51%
Other	2	$309	1.29%
Total Denied Claims	**54**	**$23,975**	**100.00%**
Overall Denied Claims Rate	**0.53%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The MHP's denied claims rate is extremely low compared to the statewide rate (0.53 percent versus 5.92 percent).

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP implemented a new EHR, SmartCare by Streamline, in July 2023. Colusa's executive leadership and line staff all gave positive remarks about the

functionality of the system through the first month of use. The implementation process went smoothly and the main functionalities the MHP is still waiting on from the vendor are full data analytics and reporting capabilities.

- The MHP reports CalMHSA has been very helpful during the EHR implementation process and has provided virtual training as well as in-person training in Sacramento. The MHP has also developed training to further aid staff in learning the system.
- A desire to add a data analyst with SQL skills was expressed during the Information Systems Capabilities Assessment session to aid the department in data analytics support with the new EHR.
- Denied claims rates are considerably lower than the statewide denial rate.
- CBOs have been given access to the new EHR, and access will continue to be expanded as the system becomes fully functional.
- With the increased data analytics capabilities of the new EHR, and the demand for reports and data extraction that will come with it, it would benefit the MHP to formalize a data integrity validation process where the staff assigned a data extraction project is not the same person to validate the data before it is released to the rest of the agency.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP reported administering the annual CPS and does not have the most recent results yet. Colusa shares findings with the advisory board; however, it was not evident that the MHP provides the results to other stakeholders or uses the findings to improve access, timeliness, or quality.

PLAN MEMBER/FAMILY FOCUS GROUP

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

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

Consumer Family Member Focus Group

CalEQRO requested a culturally diverse group of six to eight English and Spanish speaking adults who mostly have initiated/utilized services within the past 15 months. The focus group was held virtually and included six participants who receive clinical services from the MHP. All attending members were English speaking and an interpreter was not required.

Members who began services in the past 12 months reported waiting one to three weeks to get an appointment. No members had completed a satisfaction survey or heard of the results. Three members reported that they do not know how to use the MHP's website. One member provided positive feedback regarding the wellness center. Three members who required substance abuse treatment reported being connected to services and the transition was smooth. Three members reported waiting two weeks for an urgent appointment and one member indicated walking in and receiving an urgent appointment right away. Three of six members shared that their mental health provider talks with their primary care provider.

Recommendations from focus group participants included: more therapists, classes, and ability to receive services a little more often. Members would like more resources, including better transportation.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Members provided positive feedback as well as areas for improvement. Three of the six members who attended the focus group began services in 2023 and therefore, may not be as familiar with all the services and resources that the MHP offers. There may be an opportunity to provide additional resources to new members and ensure that they know how to access the website information. Since no members recalled completing the satisfaction survey or seeing the results, this may also be an area for improvement.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP implemented SmartCare by Streamline as its new EHR in July 2023. (IS)
2. Colusa has a strong bilingual clinical staff, and the MHP places an emphasis on building up the workforce with this skillset as Hispanic/Latino members account for a majority of members served. (Access, Quality)
3. The open access process where members can receive assessments as walk-ins two days per week has been a positive step toward increasing access to the system. (Access, Timeliness, Quality)
4. The MHP increased outreach efforts in the community and has strong partnerships, particularly with law enforcement, jail, and probation to link inmates to services. Colusa added a new position (i.e., Marketing Administration Specialist) with the goal of more outreach and transparency. (Access, Quality)
5. The MHP has dashboards for the CANS, MORS, and PSC-35 outcome tools. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Transportation can be difficult in Colusa, especially for those relying upon the local bus system. There are certain areas in the county the bus does not travel to, and line staff and members mentioned inconsistencies in the buses arriving at locations on time. (Access, Timeliness)
2. The MHP lacks an analyst with SQL skills that would help maximize the reporting capabilities of the new EHR. (IS)
3. While Colusa has made efforts to complete medication monitoring, the process has not yet been implemented. (Quality)
4. The MHP has not yet been able to implement a medication monitoring system for FC system as required by WIC Section 14197 and SB 1291. (Quality)
5. While the open access model is reported as an MHP strength, it can also present a challenge as staff who cover the days may need to delay seeing members who are their established clients. (Access, Timeliness)

RECOMMENDATIONS

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

1. The MHP should review the transportation system within the county and agency and investigate alternative options. Colusa should complete an assessment on whether providing members bus passes is an effective strategy to get them into services in a timely fashion. Additionally, transportation for youth should be reviewed as many Hispanic/Latino youth have parents working in agriculture who are unable to get time off from work to drive their children to services. Besides difficulties in taking off work, there are barriers such as not having a driver's license or vehicle to drive their children to appointments. (Access, Timeliness)
2. Review the need to hire a data analyst with skill in SQL who can assist with complex data projects that the new EHR will allow due to its improved functionality and data reporting capabilities. (Quality, IS)
3. Continue efforts and implement a formal process for psychiatrist review and monitoring of MHP provider medication prescribing practices. (Quality)
   (This recommendation was continued from FY 2021-22.)
4. Implement a medication monitoring system for FC youth as required by WIC Section 14197 and SB 1291. (Quality)
   (This recommendation was continued from FY 2021-22.)
5. Evaluate staffing needs for open access days and ensure that staff are comfortably able to maintain their current workload in addition to covering walk-in appointments. (Access, Timeliness)

EXTERNAL QUALITY REVIEW BARRIERS

There were no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: CalEQRO Claims Data Definitions

ATTACHMENT F: Letter from the MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Colusa MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Satisfaction
Validation of Findings for Pathways to MH Services (Katie A./Continuum of Care Reform)
Consumer and Family Member Focus Group: English and Spanish speaking adults
Fiscal/Billing
Clinical Line Staff Group Interview
Information Systems Billing and Fiscal Interview
Cultural Competence / Healthcare Equity
Quality Management, QI and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Christy Hormann, Quality Reviewer
Brian Deen, Information Systems Reviewer
David Czarneck, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Alvernaz	Graciela	Mental Health Specialist	Colusa County Behavioral Health
Amundson	Haley	Marketing and Administrative Specialist	Colusa County Behavioral Health
Arce	Tomika	Medical Billing Specialist	Colusa County Behavioral Health
Bullis-Cruz	Heather	Compliance Officer	Colusa County Behavioral Health
Hobson	Tony	Director	Colusa County Behavioral Health
Leal	June	Therapist	Colusa County Behavioral Health
Maguire	Sharon	Peer Support Specialist	Colusa County Behavioral Health
McCloud	Bill	EHR Manager	Colusa County Behavioral Health
McCutchen	Daisy	Therapist	Colusa County Behavioral Health
McGregor	Mark	Clinical Program Manager, Children	Colusa County Behavioral Health
Nokes	Alicia	Licensed Psychiatric Technician	Colusa County Behavioral Health
Puga	Mayra	MHSA Coordinator	Colusa County Behavioral Health
Rios	Daisy	Therapist	Colusa County Behavioral Health
Rivera	Marcianna	Case Manager	Colusa County Behavioral Health
Rojas	Bessie	Quality Assurance Coordinator	Colusa County Behavioral Health
Rubio	Rocio	Medical Billing Specialist	Colusa County Behavioral Health
Scroggins	Jeannie	Clinical Program Manager, QA & MHSA	Colusa County Behavioral Health
Tafolla Martinez	Brizia	Clinical Program Manager, Crisis	Colusa County Behavioral Health
Triggs	Pamela	Peer Support Specialist	Colusa County Behavioral Health
Vazquez	Wendy	Therapist	Colusa County Behavioral Health
Whiting	Lynn	Electronic Health Record Coordinator	Colusa County Behavioral Health

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP initiated a clinical PIP based on the prior year EQR that indicated the percentage of members with psychosis was lower than statewide. To improve identification of potential psychotic symptoms, new members ages 12-30 years old will be administered the PQ-B at intake. When a screening indicates a member has symptoms of psychosis, a referral is initiated to UC Davis for specialty treatment. The PIP did not yet report the results.

General PIP Information
MHP/DMC-ODS Name: Colusa County Behavioral Health
PIP Title: Psychosis Identification and Treatment
PIP Aim Statement: The goal of the Psychosis Identification and Treatment PIP is to increase the amount of treatment and support a member receives to improve their overall functioning. The PIP population includes new members ages 12 – 30 years who endorse psychotic symptoms on the PQ-B from February 1, 2023, to June 30, 2024. The intervention CCBH is providing allows access to and treatment of psychotic symptoms by partnership with UC Davis EDAPT from a baseline of 0 members to a goal of 20 members.
Date Started: 02/2023
Date Completed: In progress
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:

General PIP Information
Target population description, such as specific diagnosis (please specify): New members will be administered the PQ-B as part of intake.

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): N/A
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): N/A
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): • The PQ-B will be administered to all new members aged 12-30 upon intake, re-administered at bi-annual reassessment, and at any time it has been deemed to be clinically appropriate due to symptoms and functional impairments reported by the member or observed by the treatment team. All clinicians were trained on how to administer and score the PQ-B tool in September 2022.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Mutual clients enrolled in UC Davis EDAPT			☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Crisis services for mutual clients enrolled in UC Davis EDAPT program (inverse measure-lower result indicates improvement)			☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- Provide quantitative/numeric goal in the aim statement. (MHP resubmitted the PIP following the EQR to address this recommendation.)
- Describe in the data collection process how mutual clients enrolled in the UC Davis EDAPT program and number of crisis services will be collected for the performance measure results.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP initiated a PIP to improve follow-up in 7 and 30 days for members who have an ED visit for a mental health condition. The MHP reported provider change and system change interventions for the PIP that included collaboration with the ED and MCP. The PIP did not yet report results.

General PIP Information
MHP/DMC-ODS Name: Colusa County Behavioral Health
PIP Title: Follow-up After ED Visit for Mental Health Condition (FUM)
PIP Aim Statement: Colusa will increase the percentage of follow-up mental health services to members with an ED visit for a mental health condition within 7 days from a rate of 50 percent to 55 percent and within 30 days from a rate of 75 percent to 80 percent. This PIP will take place until 6/30/2024 unless these goals have not been achieved, which will extend the PIP in FY 2024-2025.
Date Started: 03/2023
Date Completed: In progress
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): All Colusa members who have an ED visit for a mental health symptom.

General PIP Information
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): N/A
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Referral form for the ED to utilize when making a referral to the MHP. The referral form is emailed to ED staff, available on the MHP’s website, and a monthly agenda item for the collaborative meetings with the MHP crisis team and ED.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): • Quarterly meetings with MCPs to discuss data sharing via SFTP.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of members who received a follow-up mental health service within 7 days after an ED visit for a mental health condition			☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of members who received a follow-up mental health service within 30 days after an ED visit for a mental health condition			☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Solicit member input for the topic and root causes/barriers to the members receiving follow-up care within the specified timeframes. • Document clearly and consistently variables and performance measures throughout the PIP. It appears the variables would be members with an ED visit for mental health conditions and subsequently members with follow-up visits. Performance measures would be the percentage of members with an ED visit for mental health conditions with follow-up in 7 and 30 days. Intervention evaluation measures may include percentage of members with an ED visit for a mental health condition that the MHP schedules a follow-up mental health service, and the percentage who receive that follow-up service. • The aim included what appeared to be baseline rates for 7- and 30-day follow-up (i.e., 50 percent and 75 percent, respectively); however, the MHP did not provide baseline data in this year's submission. It appears that the MHP could provide baseline data in this year's submission based on the aim statement.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: CALEQRO CLAIMS DATA 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 is derived from statewide source files.			
1. Short-Doyle/Medi-Cal approved and denied claims (SD/MC) from the Department of Health Care Services (DHCS)			
2. In-Patient Consolidation (IPC) approved claims from DHCS			
3. Monthly MEDS Extract File (MMEF) from DHCS			
Selection Criteria:			
Medi-Cal beneficiaries for whom the MHP is "County of Fiscal Responsibility" are included, even when the beneficiary was served by another MHP.			
Medi-Cal beneficiaries with aid codes eligible for SD/MC program funding are included.			
Process Date: The date DHCS processes files for CAEQRO. The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY2020 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
Look-A-Like		HK and DPI	Intensive Care Coordination Intensive Home-Based Services

			Demonstration Project Indicator (DPI) = KTA
TFC	S5145		Therapeutic Foster Care

Medi-Cal Approved Claims Code Definitions and Data Sources

Last Modified by: Rachel Phillips Nov 2022 — Source: Medi-Cal Aid Code Chart Master – December 13, 2020

Data Definitions: Selected elements displayed within this report are defined below.

Penetration rate	The number of Medi-Cal beneficiaries 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 beneficiary per year	The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year.
Age Group	Age groups are determined by beneficiary'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	Beneficiary 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	Beneficiary 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	Beneficiary 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	Beneficiary 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.

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

Beneficiary 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)
Sign Languages	Codes = 0, A (Not threshold languages)
Decline to State/Missing Data	Codes = 8, 9, Undetermined (Not threshold languages)

Medi-Cal Approved Claims Code Definitions and Data Sources

Last Modified by: Rachel Phillips Nov 2022 — Source: Medi-Cal Aid Code Chart Master – December 13, 2020

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, F32A, 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, F1515
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

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
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, F942
Not Diagnosed	R69, Z0389
Other Diagnosis	Other ICD-10 codes not listed above which were submitted through SDMC claim transactions

ATTACHMENT F: LETTER FROM THE MHP DIRECTOR

A letter from the MHP Director was not required as part of this report.