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

MADERA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 8, 2023

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EXECUTIVE SUMMARY

Highlights from the fiscal year (FY) 2023-24 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, "Madera" may be used to identify the Madera County MHP.

MHP INFORMATION

Review Type — Virtual

Date of Review — September 8, 2023

MHP Size — Small

MHP Region — Central

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	2	3	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	3	3	0
Quality of Care	10	3	6	1
Information Systems (IS)	6	3	3	0
TOTAL	**26**	**12**	**13**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Crisis Mobile Unit Implementation	Clinical	08/2022	Implementation	Moderate confidence
Centralized Appointment Scheduling Process	Non-Clinical	05/2023	Implementation	Low confidence

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	4

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The first offered non-urgent appointment (county-operated) tracked and reported is an average of 6 days and meets the 10-day standard 97 percent of the time.
- The MHP has excellent integration and collaboration with partner stakeholders and other public and private agencies in outreach to increase culturally appropriate access to services.
- Crisis Care Mobile Units (CCMU) are implemented county-wide and serve both adults and youth.
- The MHP has substantially increased their telehealth use compared to the prior year.
- The MHP reduced denied claims compared to the prior year.

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

- The MHP has the highest single service-only rate (25.32 percent) in the state, more than twice compared with statewide (11.21 percent).
- The California Advancing and Medi-Cal (CalAIM) Behavioral Health Quality Improvement Program (BHQIP) was not utilized as one of the PIPs submitted to EQRO.
- The MHP does not report timeliness data for contractor-operated services. This prevents understanding of an accurate picture of systemwide service delivery.

- The MHP's highest reason for claims denial is other healthcare or Medicare Part B needing to be billed first.
- The MHP's lack of aggregate data by program outcomes significantly impacts quality management (QM) processes.

Recommendations for improvement based upon this review include:

- Implement a barrier analysis, create strategies and interventions, track and report improvements in engagement as measured by decrease in one service only rate. Evaluate the impact of engagement after field-based crisis intervention.
- Work with DHCS to find how to create a successful BHQIP PIP FUM and consider using it as next year's MHP non-clinical PIP, to reduce the impact of the PIP requirements. Engage in PIP technical assistance (TA) from EQRO on a regular (at least every three months) basis.
- Begin to collect and trend timeliness data for contractor services for the first offered and first delivered non-urgent clinical appointments; first offered and first delivered non-urgent psychiatry appointments; and, first offered urgent appointments. Include this data in assessments of timeliness for systemwide service delivery.
- Investigate the reasons, develop strategies, and implement solutions to improve the MHP's highest reasons for claims denials.
- Develop a plan for the implementation of the new Electronic Health Record (EHR), SmartCare, to ensure that it includes capability to track aggregated data by program outcomes.

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 foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2023-24 findings of the EQR for Madera County MHP by BHC, conducted as a virtual review on September 8, 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.

CalEQRO reviews are retrospective; therefore, county documentation that is requested for this review covers the time frame since the prior review. Additionally, the Medi-Cal approved claims data used to generate Performance Measures (PM) tables and graphs throughout this report 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. PMs calculated by CalEQRO cover services for approved claims for calendar year (CY) 2022 as adjudicated by DHCS by April 2023. Several measures display a three-year trend from CY 2020 to CY 2022.

As part of the pre-review process, each MHP is provided a description of the source of the Medi-Cal approved claims data and four summary reports of this data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; transition aged 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

The MHP has been impacted by the loss of staff during and following the COVID-19 pandemic. Staff shortages continue for both bilingual and non-bilingual, to include clinical line staff, key management positions, fiscal/contract areas, as well administrative staff.

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.

- Madera was awarded funds to establish bridge housing.
- The MHP implemented the community-based mobile crisis county-wide after receiving DHCS CCMU grant award.
- Planning for crisis stabilization unit (CSU) sobering center is underway following the DHCS Behavioral Health Continuum Infrastructure Program award.
- Additional positions to add infrastructure were approved in the current budget.
- The CalAIM BHQIP deliverables have been met and continue to be developed and implemented.
- Modification of records in preparation for the CalAIM documentation standard changes is in process.
- The MHP implemented centralized appointments following initial assessment in clinics.
- The MHP has increased their telehealth use compared to last year.

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 as signed 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 not addressed may be presented as a recommendation again for this review. However, if the MHP has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 1: Investigate the reasons, develop strategies, and implement solutions to improve access for Hispanic/Latino members and retention for members once they've accessed services.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has implemented six activities to reach the Hispanic/Latinx community:
  - Printed materials now include Spanish.
  - The agency name at the main clinic also now appears in Spanish on signage.
  - Transportation has been centralized for more efficiency in accessing services.
  - The MHP's social media has been revitalized and includes posts about initiatives and community events.
  - An increased focus has been placed on hiring bi-cultural/bi-lingual staff.
  - The MHP formed a cultural competency advisory committee.

- The PR has increased by 0.22 percentage points from last year for Hispanics/Latinos, which may reflect the efforts described above yielding results.

- PR is still lower than statewide (2.84 vs 3.51 percent). Further outreach and engagement activities would be useful to increase access.

This recommendation will not be carried forward as the MHP is continuing to work on solutions to the issue.

Recommendation 2: Investigate the reasons, develop strategies, and improve the performance of tracking, trending, analyzing, and performing data driven process improvement on most timeliness metrics.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- A learning curve due to implementation of a new EHR, InSync, in December 2020, and the nuances of how data was to be interpreted in this new environment, created a delay in data reporting activities.
- The MHP developed strategies to learn how data was to be utilized and prepared in a meaningful way across the MHP system of care and developed training materials to assist in data interpretation and report preparation.
- Reports necessary to develop a data driven decision-making process were set to be released on a recurring schedule. These reports are reviewed on a weekly and/or monthly basis to make changes as needed to ensure timely access to services as well as during the provider evaluation process, addressing productivity as applicable.
- The MHP reports its priority is to hire a Business Systems Analyst based on fiscal needs relating to implementation of CalAIM and the new EHR system implementation to begin January 2024.

- This recommendation is partially addressed at this time. It will not be carried forward as the new EHR will offer the MHP the opportunity to address the issues as the new system is implemented.

Recommendation 3: Investigate reasons and develop and implement strategies to improve the QAPI, the Quality Improvement Committee (QIC) and PIP development participation from members in data review, discussions, or decision making.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- In FY 2022-23, the QIC met on a quarterly basis and included agency management staff as well as partner agency key staff.

- Efforts to include MHP members as participants in the QIC which touches on QAPI and PIP related activities is ongoing.
- A QIC brochure and survey link have been developed and recently launched as part of the QAPI, and additional efforts will be made in the coming year to reach this goal.
- This recommendation will not be carried forward as it is expected that the efforts in place at this time will result in a successful improvement in members being part of the QIC and PIP development teams.

Recommendation 4: Investigate reasons and develop and implement strategies to improve the non-clinical PIP alignment and with the PIP requirements as outlined in the PIP Development Tool.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Trained team members have been assigned to understand and align with PIP requirements. It is the MHP's goal to improve as needed in this area to the extent possible with the resources available.
- A clinical and a non-clinical PIP are currently in place and will be reworked as needed per feedback from the EQRO.

Recommendation 5: Investigate reasons and develop and implement strategies to improve the MHP claiming processes and reduce claim denials.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Madera County identified staff with specific billing knowledge and allocated them to the billing unit.
- The approved budget for FY 2023-24 included the addition of enough staff to complete the creation of a dedicated billing unit.
- The MHP partnered with its EHR vendor to add missing billing elements into the software, which enabled the MHP to generate new billing reports. This allows for data entry related to billing to be reviewed, modified, and corrected prior to billing. Additionally, approval and denial reports are now generated to review monthly revenue.
- A system was developed to increase communication and collaboration between billing staff and clinical staff with a focus on how to make accurate entries into the EHR in order to reduce denied claims.

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 86 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 staff during the workday and contractor staff after hours and weekends; members may request services through the Access Line as well as through the MHP website or in-person any of the four outpatient clinics. The MHP operates a decentralized access team that is responsible for linking members to appropriate, medically necessary services. Members may receive screening and assessment directly through the closest outpatient clinic to their residence or the clinic of their choice. Given the population distribution, the MHP provides youth, adult, and older adult outpatient services in two MHP clinics, located in Chowchilla and Oakhurst.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth, adults, and older adults. In FY 2022-23, the MHP reports having provided telehealth services to 2,122 adults, 995 youth, and 261 older adults across 4 county operated sites and 16 contractor-operated sites. Among those served, 162 members received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

An adequate network of providers is necessary for 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 Madera County, the time and distance requirements are 45 miles and 75 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: 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: 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

Because the MHP can provide necessary services to a member within time and distance standards using a network provider, the MHP was not required to allow members to access services via OON providers.

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	Partially 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 provided evidence of excellent integration and access with partner stakeholders and other public and private agencies in outreach to increase culturally appropriate access to services. Faith-Based organizations stood out as noteworthy in collaboration and integration with the MHP. This included collaboration with the Tribal communities.

The MHP did not provide evidence of the evaluation of strategies they had employed to meet the capacity needs of its members.

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.

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 a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, Madera demonstrates more challenges to accessing services than was seen statewide.

Table 3: Madera 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	84,484	2,962	3.51%	$14,961,827	$5,051
CY 2021	79,220	2,733	3.45%	$11,994,882	$4,389
CY 2020	73,626	2,598	3.53%	$15,399,561	$5,927

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

- The total eligibles, members served, total approved claims, and AACM all increased from CY 2021.

Table 4: Madera County 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	10,063	141	1.40%	1.31%	1.82%
Ages 6-17	23,518	945	4.02%	5.83%	5.65%
Ages 18-20	5,133	208	4.05%	4.72%	3.97%
Ages 21-64	40,248	1,568	3.90%	4.53%	4.03%
Ages 65+	5,523	100	1.81%	2.25%	1.86%
Total	**84,484**	**2,962**	**3.51%**	**4.30%**	**3.96%**

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

- PRs were lower in the MHP than statewide for all age groups except for ages 18-20.
- The total PR in the MHP was lower than the statewide and small sized county PRs.

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

Threshold Language	# Members Served	% of Members Served
Spanish	561	19.55%
Threshold language source: Open Data per BHIN 20-070		

- Spanish was the only threshold language in the MHP, with nearly 20 percent of members reporting Spanish as their primary language.

Table 6: Madera 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	22,836	757	3.31%	$3,611,647	$4,771
Small	218,086	8,382	3.84%	$44,131,230	$5,265
Statewide	4,831,118	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 pattern held true in Madera.
- The ACA PR and AACM are lower than the statewide and small county PRs and AACMs for this group.

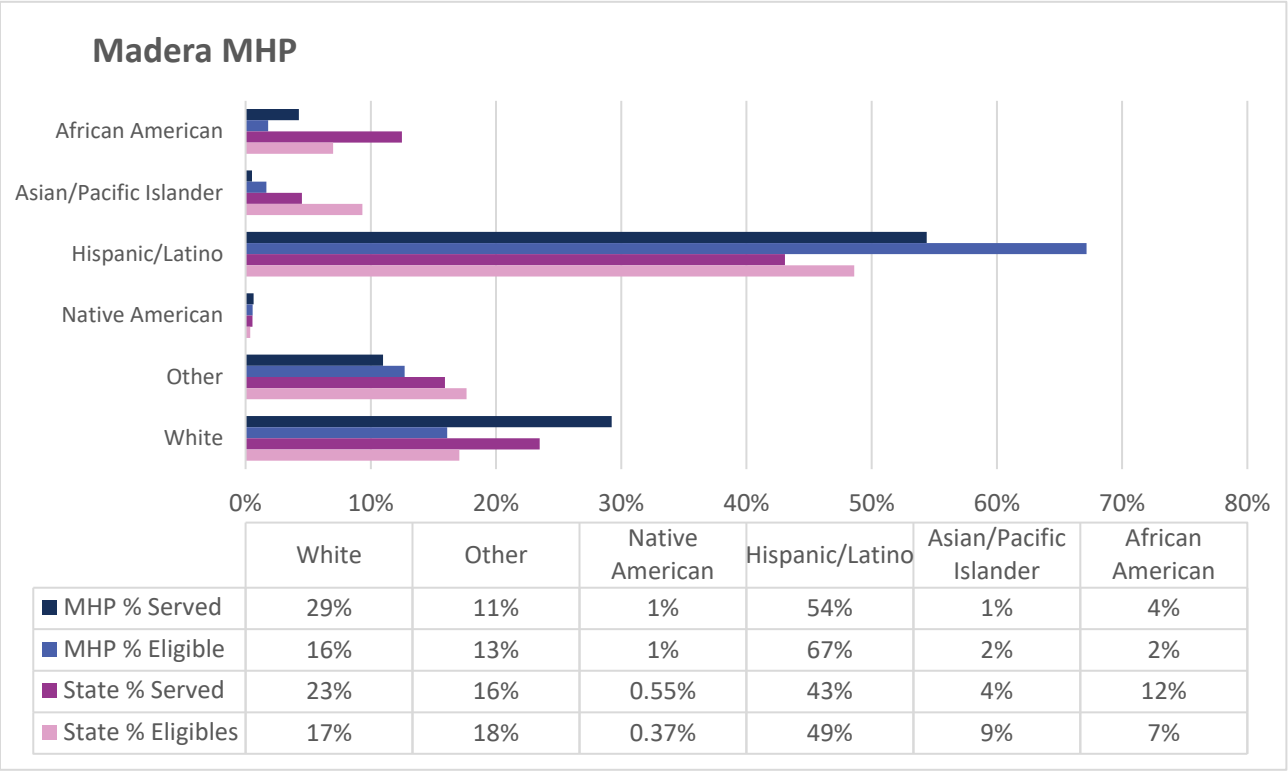
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they 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: Madera MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	1,528	126	8.25%	7.08%
Asian/Pacific Islander	1,402	15	1.07%	1.91%
Hispanic/Latino	56,741	1,611	2.84%	3.51%
Native American	479	19	3.97%	5.94%
Other	10,731	325	3.03%	3.57%
White	13,606	866	6.36%	5.45%

- The PR is highest for African American members, followed by the PR for White members. The PRs for both of these groups are higher than the statewide PRs; whereas, PRs for all other racial/ethnic groups in the MHP were lower than statewide PRs.
- The largest population of eligibles and members served were Hispanic/Latino, though the PR for this group is lower than the statewide PR.

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

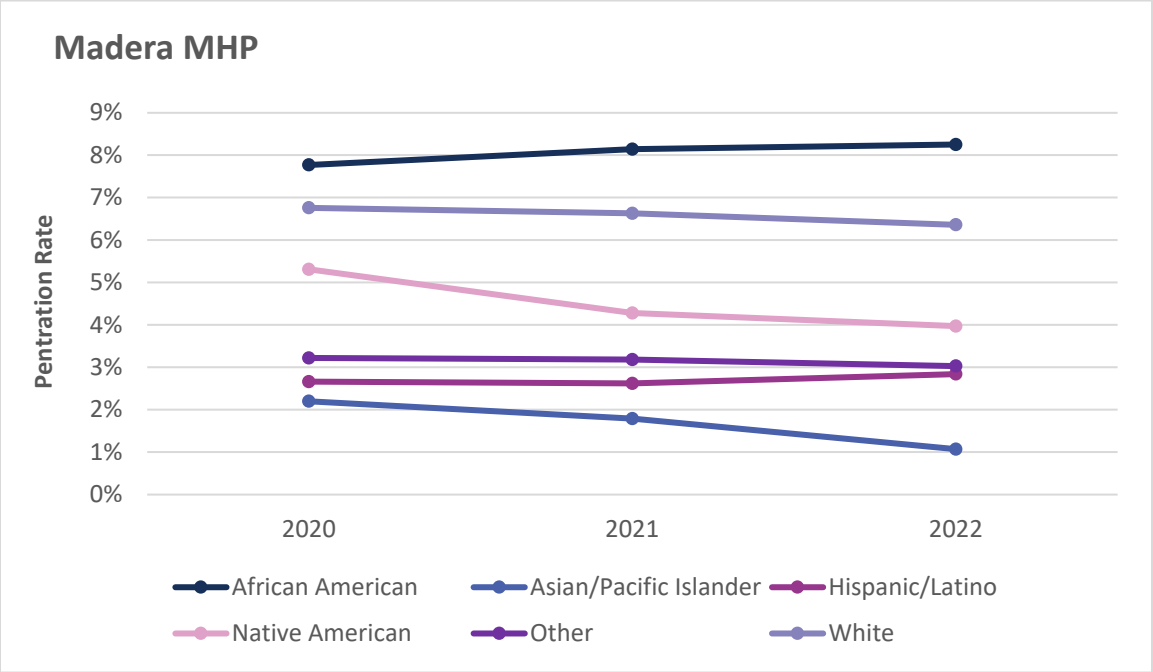


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	29%	11%	1%	54%	1%	4%
MHP % Eligible	16%	13%	1%	67%	2%	2%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- The proportion of Hispanic/Latino eligibles in the MHP is much higher than statewide.
- White members are the most overrepresented in the MHP, while Hispanic/Latino members are the most underrepresented.

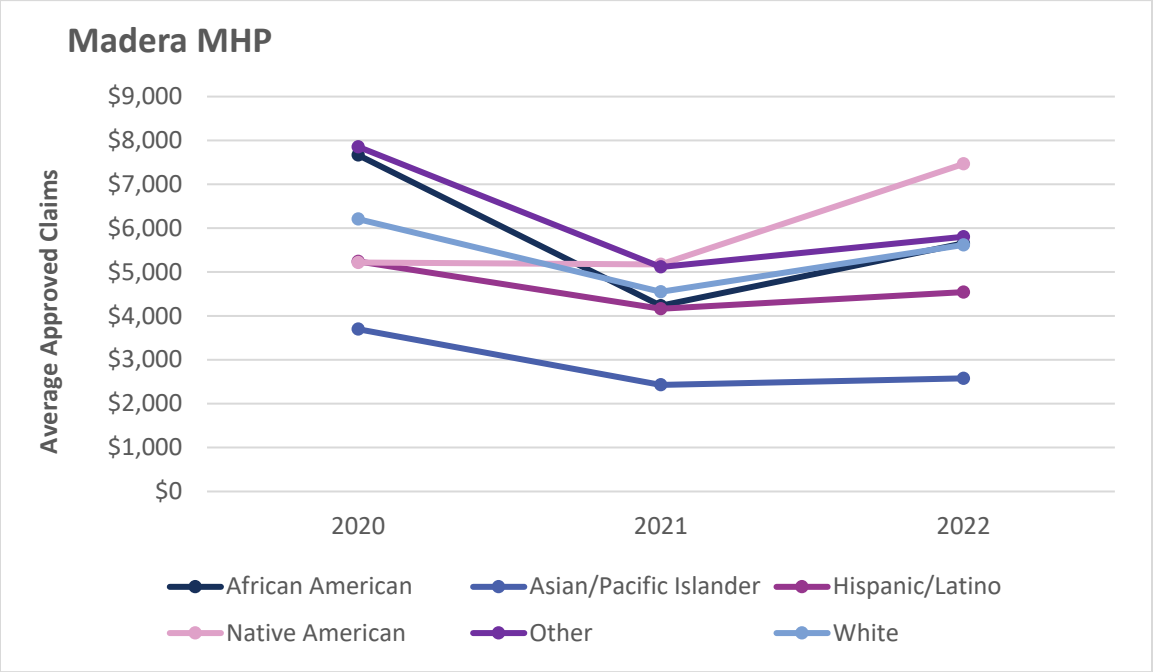
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



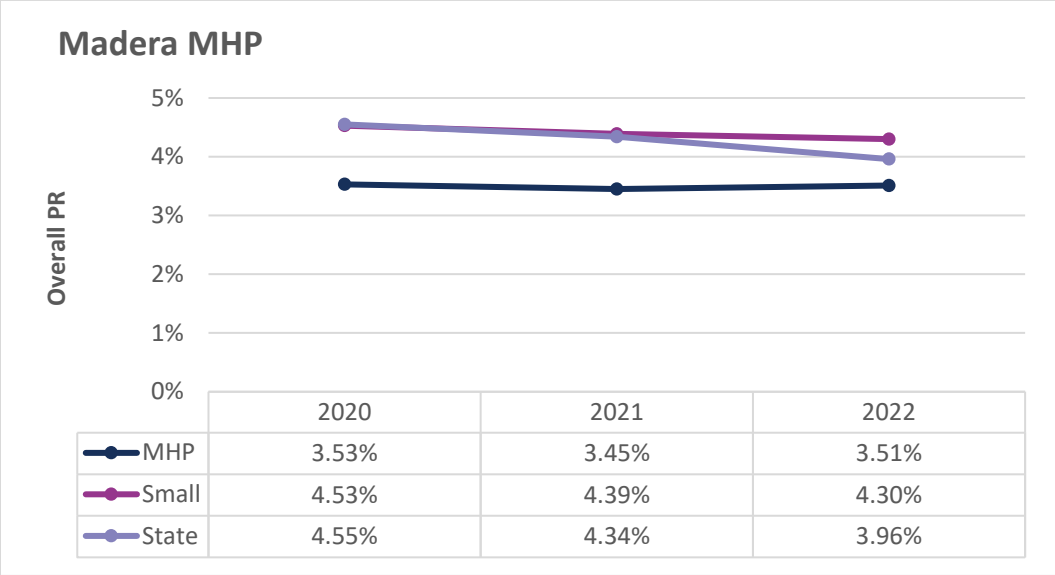
- Two racial/ethnic groups, White and African American, have consistently had the highest PRs in the MHP over the past three years, while Asians/Pacific Islanders have consistently had the lowest PRs.

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



- All groups had higher AACMs in CY 2022 than in CY 2021, with the most dramatic increase in AACM in the Native American population. This is likely due to the small number of Native American members served, as averages are more likely to be impacted by outliers in small samples.
- The Asian/Pacific Islander population consistently had the lowest AACMs across all three years.

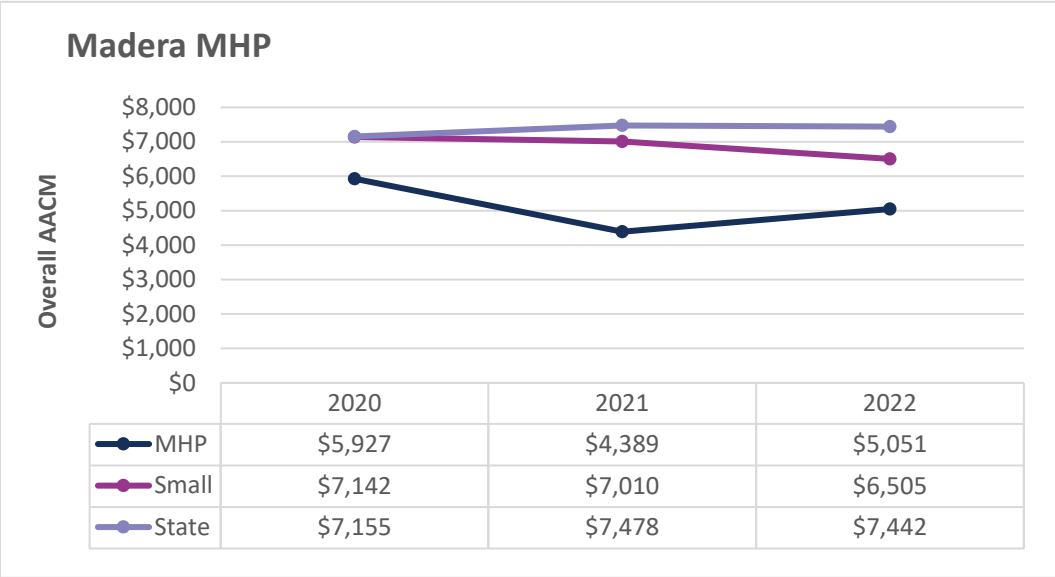
Figure 4: Overall PR, CY 2020-22



	2020	2021	2022
MHP	3.53%	3.45%	3.51%
Small	4.53%	4.39%	4.30%
State	4.55%	4.34%	3.96%

- Madera's overall PR has consistently been lower than PRs in similar sized counties and statewide, despite a slight uptick in the MHP PR in CY 2022 and decreasing PRs in small counties and statewide.

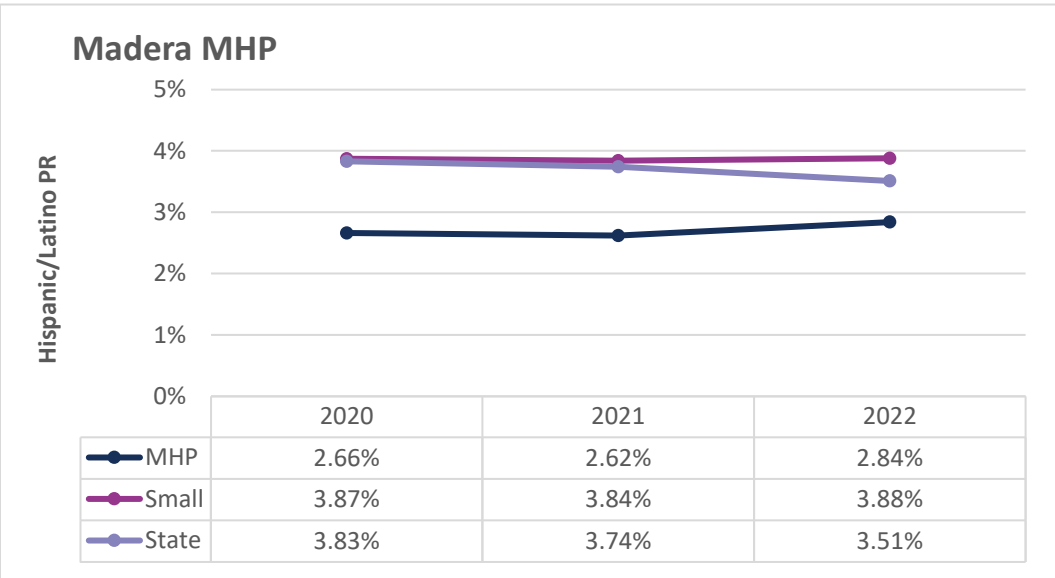
Figure 5: Overall AACM CY, 2020-22



	2020	2021	2022
MHP	$5,927	$4,389	$5,051
Small	$7,142	$7,010	$6,505
State	$7,155	$7,478	$7,442

- The MHP's AACM has been lower than AACMs in both small counties and statewide for the past three years.
- In CY 2020 Madera's AACM was a little more than $1,000 lower than both the counties and the state, and in CY 2021 the gap grew to $2,621, lower than the small counties and $3,089 lower than the state. In CY 2022 the difference was close to $1,500 and $2,500 lower, respectively, than the AACMs in small counties and the state.

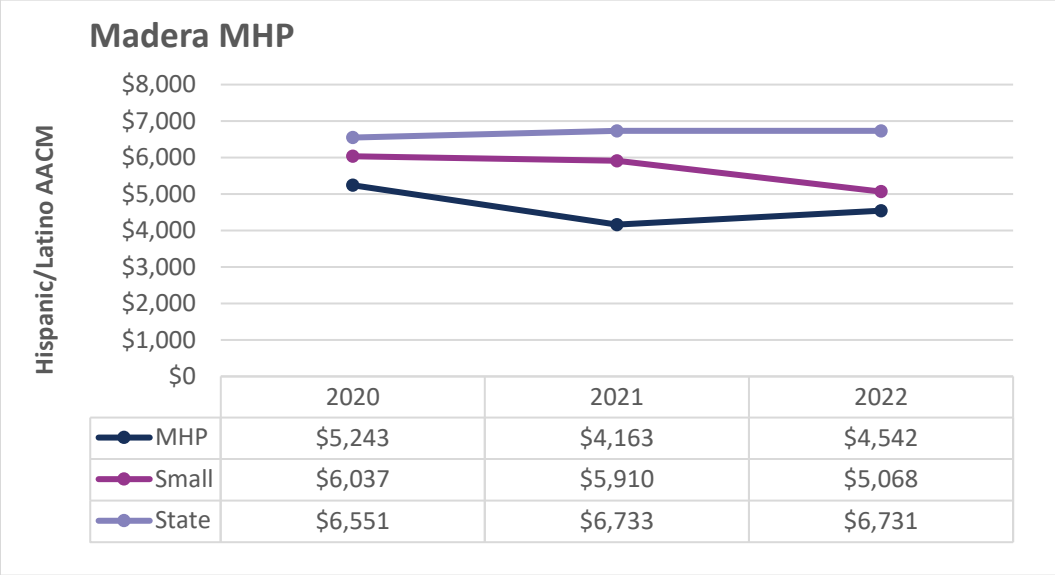
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	2.66%	2.62%	2.84%
Small	3.87%	3.84%	3.88%
State	3.83%	3.74%	3.51%

- The PR for the Hispanic/Latino population is consistently lower in Madera than in small counties and statewide, though it did increase slightly in the MHP in CY 2022.

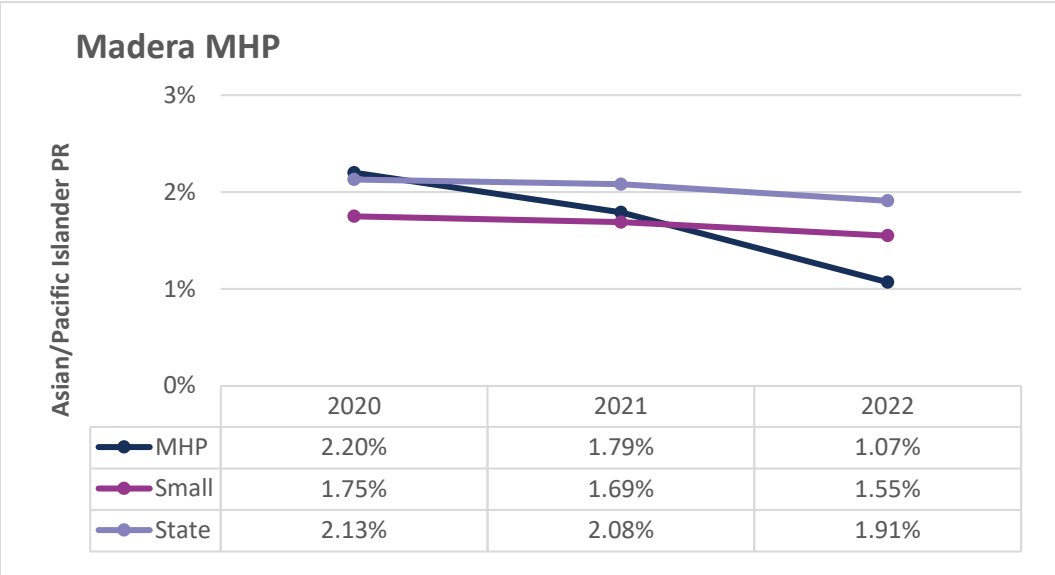
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$5,243	$4,163	$4,542
Small	$6,037	$5,910	$5,068
State	$6,551	$6,733	$6,731

- Madera's Hispanic/Latino AACM was lower than the AACMs in small counties and statewide across the past three years, with CY 2021 having the largest gap.

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

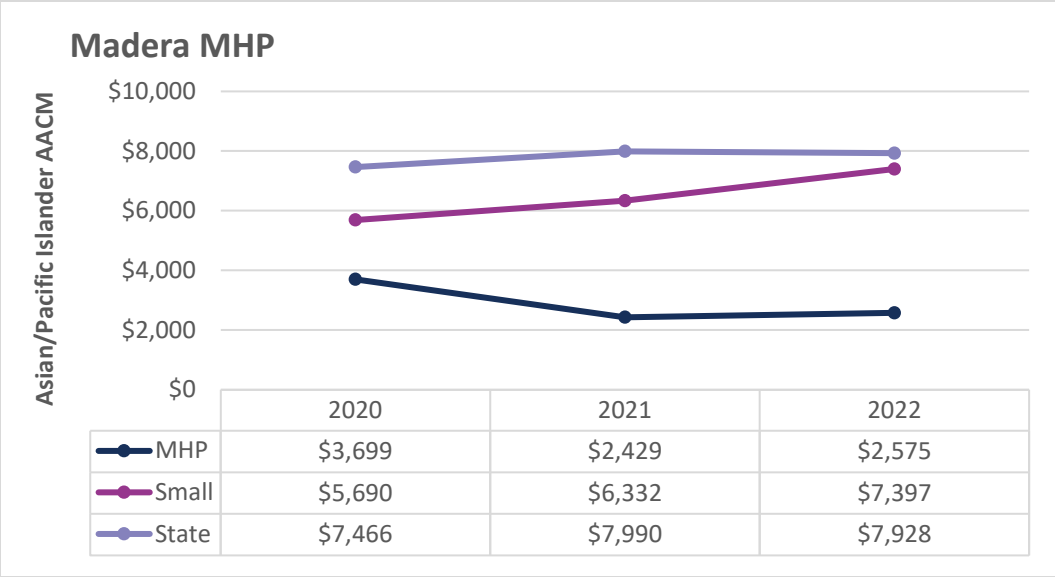


	2020	2021	2022
MHP	2.20%	1.79%	1.07%
Small	1.75%	1.69%	1.55%
State	2.13%	2.08%	1.91%

- In CY 2020 Madera's Asian/Pacific Islander PR was slightly higher than statewide and in small counties. Asian/Pacific Islander PRs have decreased each year since CY 2020, with the MHP having more dramatic decreases, ultimately having a

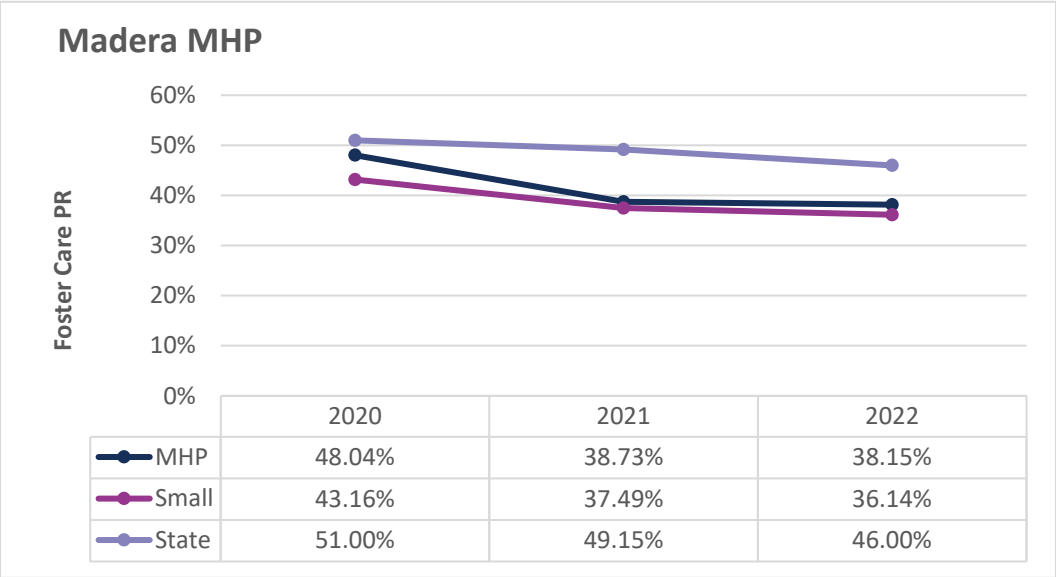
lower PR for this population than in small counties and statewide in CY 2022. It should be noted that this is a county with a small Asian/Pacific Islander population, which means relatively small changes in the number of members served can have a more dramatic impact on PRs than it would in larger groups.

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



- Madera's AACMs are consistently lower than AACMs in small counties and statewide for Asians/Pacific Islanders.
- While Asian/Pacific Islander AACMs were higher in CY 2022 than CY 2020 in small counties and statewide, the CY 2022 AACM in the MHP is lower, widening the gap between the MHP and the comparisons. There were very few Asian/Pacific Islander members served in CY 2022, and this likely reflects that at least some of those members received lower intensity or fewer services.

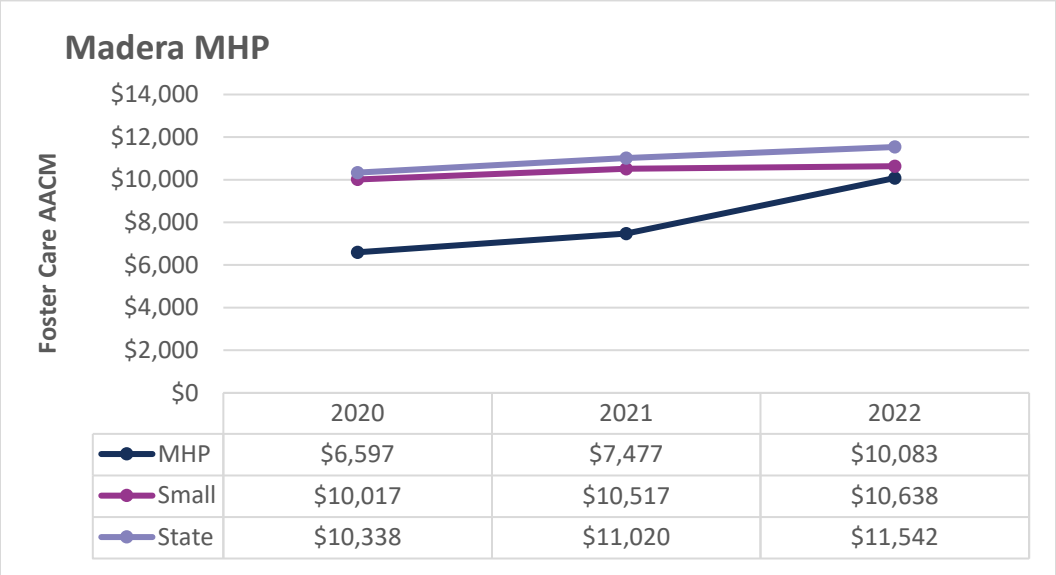
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	48.04%	38.73%	38.15%
Small	43.16%	37.49%	36.14%
State	51.00%	49.15%	46.00%

- Madera's FC PRs are very comparable to small counties as a whole, and both the MHP and small county PRs are lower than statewide.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$6,597	$7,477	$10,083
Small	$10,017	$10,517	$10,638
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years.
- Statewide FC AACM has increased each year for the past three years, and that pattern is in Madera and small counties overall as well. Madera's FC AACM increased each of the past two years, closing the gap with small counties and increasing from about $3,700 less than statewide in CY 2020 to a little under $1,500 less than statewide in CY 2022.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Madera MHP to Adults, CY 2022

Service Category	MHP N = 1,876				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	181	9.6%	4	3	10.3%	14	8
Inpatient Admin	<11	-	8	8	0.4%	26	10
Psychiatric Health Facility	<11	-	22	5	1.2%	16	8
Residential	0	0.0%	0	0	0.3%	114	84
Crisis Residential	<11	-	12	12	1.9%	23	15
Per Minute Services							
Crisis Stabilization	43	2.3%	1,693	1,200	13.4%	1,449	1,200
Crisis Intervention	288	15.4%	200	107	12.2%	236	144
Medication Support	838	44.7%	179	150	59.7%	298	190
Mental Health Services	1,366	72.8%	335	165	62.7%	832	329
Targeted Case Management	771	41.1%	463	135	36.9%	445	135

- The MHP data for day services only had one category with enough stays to display. The MHP inpatient percentage of members served was less than one percent lower than the state. The average and median length of stay was considerably less than the state.
- Crisis intervention was provided more frequently than statewide, likely a representation of the CCMU implementation.
- Mental health services had a noticeably higher percentage of members served but the average and median units were much less.

Table 9: Services Delivered by the MHP to Madera MHP Youth in Foster Care, CY 2022

Service Category	MHP N = 164				Statewide N =33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	20	15	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	101	101	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	<11	-	1,791	1,200	3.1%	1,166	1,095
Crisis Intervention	14	8.5%	560	409	8.5%	371	182
Medication Support	45	27.4%	328	270	27.6%	364	257
TBS	<11	-	3,538	3,475	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Home-Based Services	30	18.3%	578	300	40.8%	1,458	441
Intensive Care Coordination	<11	-	1,890	482	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	162	98.8%	966	400	95.4%	1,846	1,053
Targeted Case Management	109	66.5%	320	135	35.8%	307	118

- The per day services, inpatient and psychiatric health facility had fewer than 11 members served. All other services had zero members served, which likely means those services are not available locally.
- Crisis intervention, medication support, intensive home-based services (IHBS), mental health services, and targeted case management (TCM) are serving more than 10 members. The crisis intervention and medication support are the same or very close to the statewide percentages. The crisis intervention average units are 189 more than the state. The medication support average is 36 units less than the state.

- Intensive Care Coordination (ICC) and IHBS had much lower utilization than the state, and the average units is also much lower.
- While the MHP and the state show high percentages for mental health services, the MHP average units is much lower than the state.
- For TCM, the MHP serves a much higher percentage than statewide and the average units per FC member served is similar to statewide.

IMPACT OF ACCESS FINDINGS

- The MHP did not provide evidence of the evaluation of strategies they had employed to meet the capacity needs of its members. The high percentage members who received only one service, and the average and median length of stay being considerably less than the state suggest a lack of engagement issue.
- The largest population of eligibles and members served were Hispanic/Latino The proportion of Hispanic/Latino eligibles in the MHP is much higher than statewide; however, despite outreach efforts, the PR for this group is lower than the statewide (2.84 vs 3.51 percent).
- The MHP's PR for the 6-17 age group was 4.02 percent, less than both same size counties (5.83 percent) and the state (5.65 percent). FC PRs have remained static from last year. Madera's FC AACM increased each of the past two years, suggesting that more services have been provided for FC members.

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	Partially Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

The first offered non-urgent appointment tracked and reported is an average of 6 days, meeting the 10-day standard 97 percent of the time.

While the MHP has a methodology to collect and track data for county operated services, they did not provide contractor operated services data for KC items 2A, 2B, or 2C above.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (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 for follow-up services after psychiatric hospitalization, and county-operated services only for all other variables.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	6 Business Days	10 Business Days*	97%
First Non-Urgent Service Rendered	9 Business Days	10 Business Days**	74%
First Non-Urgent Psychiatry Appointment Offered	9 Business Days	15 Business Days*	99%
First Non-Urgent Psychiatry Service Rendered	11 Business Days	15 Business Days**	81%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required or Required	96 Hours	48 Hours*	46%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	9 Calendar Days	7 Calendar Days**	72%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	9 Calendar Days	30 Calendar Days	73%
No-Show Rate – Psychiatry	19%	10%**	n/a
No-Show Rate – Clinicians	19%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23			

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

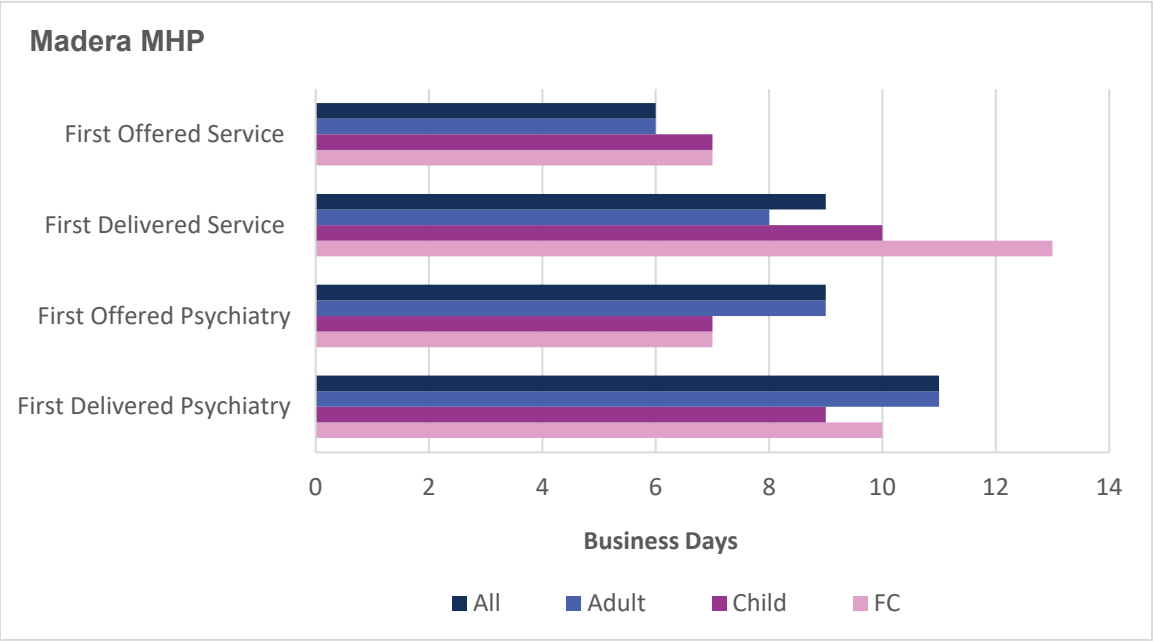


Figure 13: Wait Times for Urgent Services

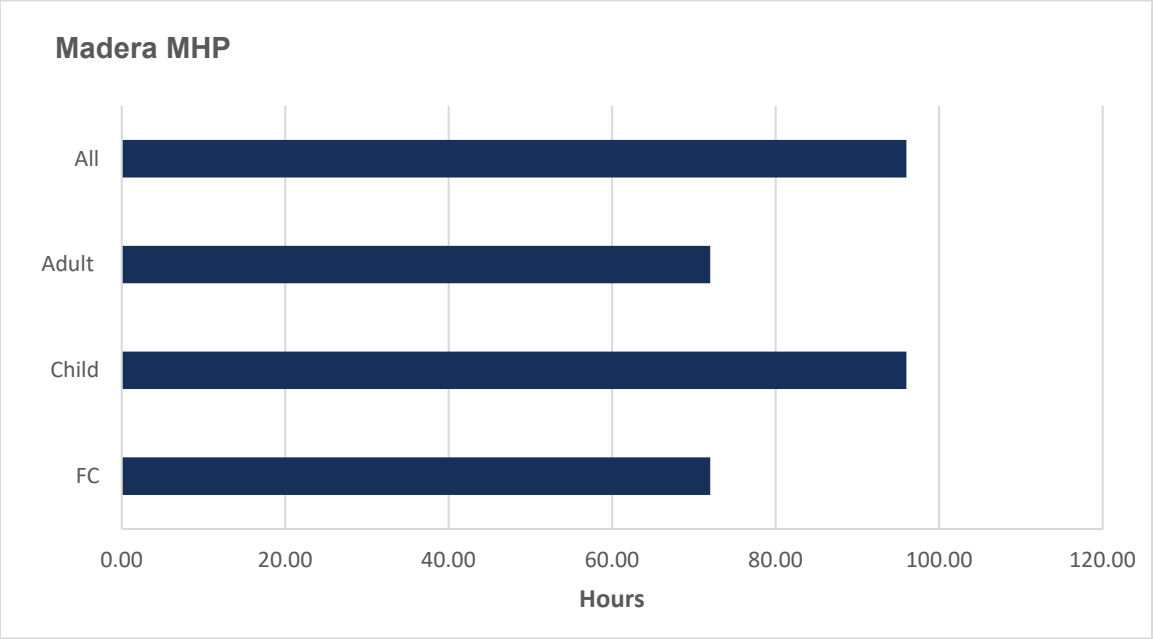
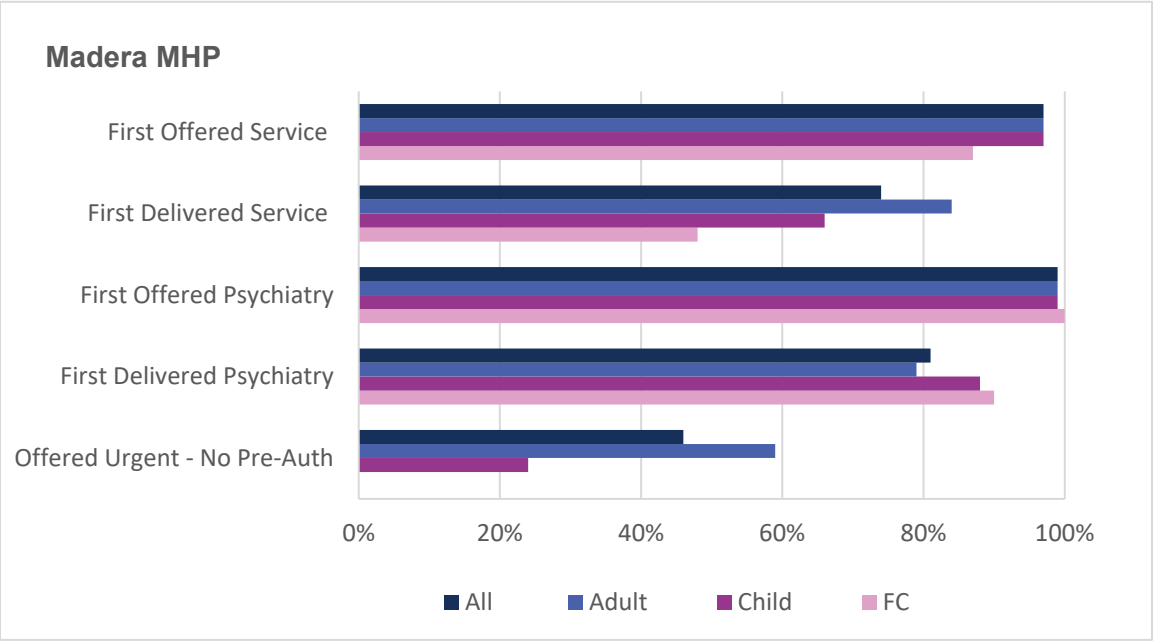


Figure 14: Percent of Services that Met Timeliness Standards



- 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 scheduled assessments.
- The MHP defined “urgent services” for purposes of the ATA as “a situation experienced by a Medi-Cal member that, without timely intervention, is certain to result in an immediate emergency psychiatric condition.” There were reportedly 45 urgent service requests with a reported average wait time for services for the overall population of 96 hours. The MHP does not require pre-authorization for urgent services.
- The MHP defines timeliness to first delivered/rendered psychiatry services as from the point of internal psychiatric referral to first delivered psychiatric appointment, reporting a nine business day average for the first offered appointment and an eleven business day average for the first delivered psychiatry service.
- The MHP reports a no-show rate of 19 percent overall for both psychiatrists and non-psychiatry clinical staff. Psychiatrists’ no-show rates were reported as: Adult services 22 percent; Children 13 percent; and FC 8 percent. Non-psychiatry clinical staff no-show rates were reported as: Adult services at 18 percent; Children 21 percent; and FC 16 percent. The MHP does not track or did not report data for contractor-operated services for: outpatient first offered or first delivered appointments; first offered or first delivered non-urgent psychiatry appointments; or first offered urgent appointments.

IMPACT OF TIMELINESS FINDINGS

- The MHP reports that retrieving timeliness data remains labor intensive with the current EHR. The new EHR system (SmartCare) is expected to be more efficient. This may make the data for contactor-operated services more available.
- The MHP may want to investigate why their retention in services is lower than statewide retention – and the impact of crisis intervention services – to ensure members are getting appropriately referred to and engaged in necessary services. Stakeholders reported large caseloads that have resulted in gaps between member appointments, which may be a factor contributing to lower engagement in 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 Quality Improvement QI is organized under a division manager who oversees compliance, quality management, and administrative support services inclusive of medical records.

The MHP monitors its quality processes through QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of leadership, line staff, members, and the MHP director, is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met four times. Of the 18 identified FY 2022-23 QAPI workplan goals, approximately 55 percent were met, 17 percent were partially met and/or in progress, and 28 percent were not met. The primary barriers discussed were EHR difficulties and staffing priorities/shortages. The MHP reported that although the brochure for the QIC has been designed, approved, and is available at all Madera County Department of Behavioral Health Services (MCDBHS) sites, they have yet to recruit a client or family member to serve on the QIC. Recruitment of a client or family member continues as an ongoing effort.

The MHP does not use a LOC tool within the MHP SOC.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths Assessment (ANSA), California Child and Adolescent Needs and Strengths-50 (CANS-50), Pediatric Symptoms Checklist (PSC-35), Generalized Anxiety Disorder-7 (GAD-7), Patient Health Questionnaire-9 (PHQ-9), Ages and Stages Questionnaire (ASQ), and Post Trauma Symptoms Disorder Checklist-5 (PTSD PCL-5).

However, the MHP does not aggregate the data captured in any of the outcome tools. Tools are utilized in the development of both formal and informal support systems that may assist both members and families with continued progress during and after treatment.

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	Partially Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	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	Partially Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Member and Member Employment in Key Roles throughout the System	Partially Met

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

- The MHP presented evidence of the efforts in place to improve both quality and performance across the system of care.
- The MHP does not aggregate data by program in order to evaluate good practices and determine areas for improvement. It is expected that when the next EHR is implemented that this will be something that can be produced, analyzed and utilized to continue their quality improvement of services.
- Stakeholders reported that they were not aware of a consistent and formal process whereby they would receive regular communication from the MHP administration. They did endorse that they can provide input into system planning thought their providers and case managers.

- Stakeholders are not informed or aware of results of surveys they participate in concerning their perception of services.
- The MHP is invested in growing a cadre of peer support workers and in making them an integral part of the MHP. However, currently there are no lived experience positions in the MHP executive management team or reporting directly to that team. Peers do not have supervisory roles/positions within the MHP.
- The MHP does not collect information regarding the four Healthcare Effectiveness Data and Information Set (HEDIS) measures for FC youth as required by WIC Section 14717.5

QUALITY PERFORMANCE MEASURES

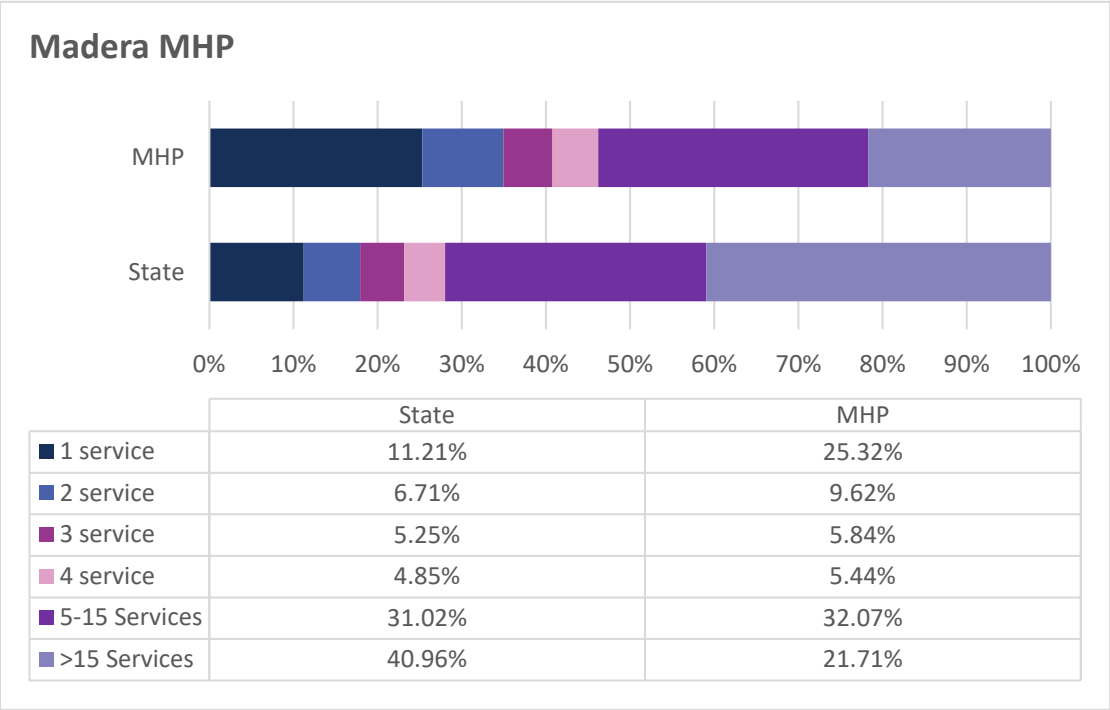
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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 five 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



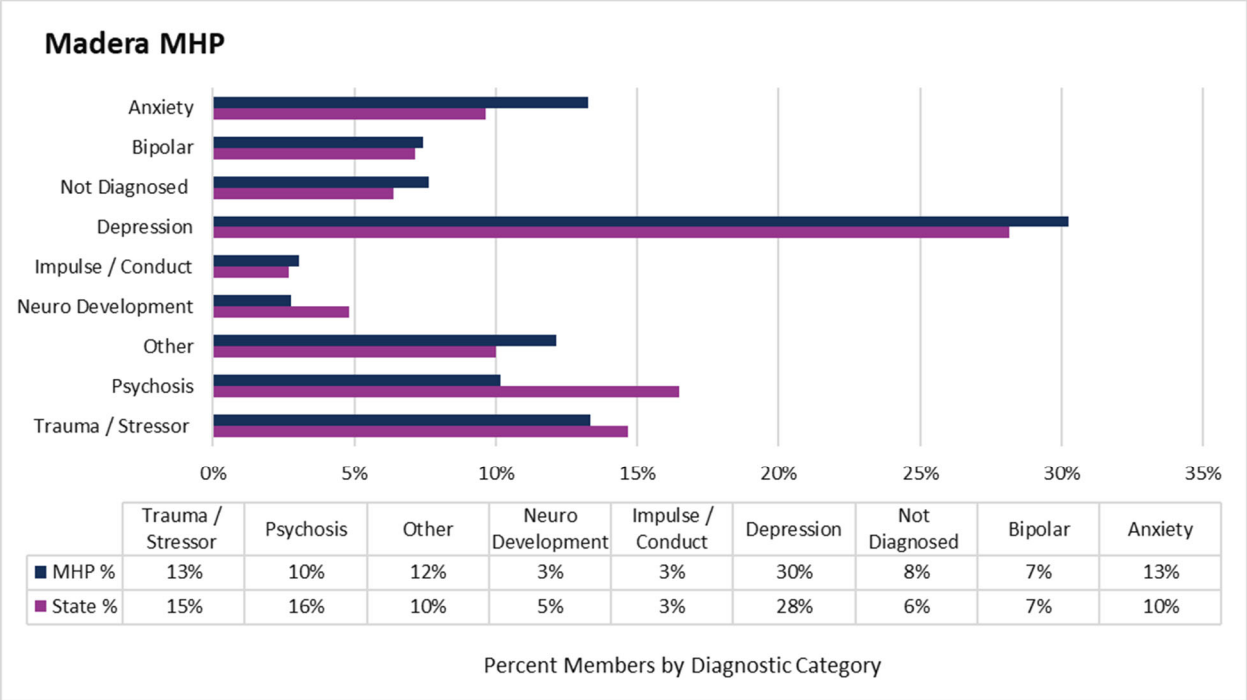
	State	MHP
1 service	11.21%	25.32%
2 service	6.71%	9.62%
3 service	5.25%	5.84%
4 service	4.85%	5.44%
5-15 Services	31.02%	32.07%
>15 Services	40.96%	21.71%

- The proportion of members receiving a single service in the MHP is more than double compared to statewide (25.32 percent compared to 11.21 percent). This may be related to mobile crisis implementation and members receiving a single crisis intervention service.
- On the other end of the spectrum, the proportion of members receiving more than 15 services (21.71 percent) is about half the statewide proportion (40.96 percent).

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.

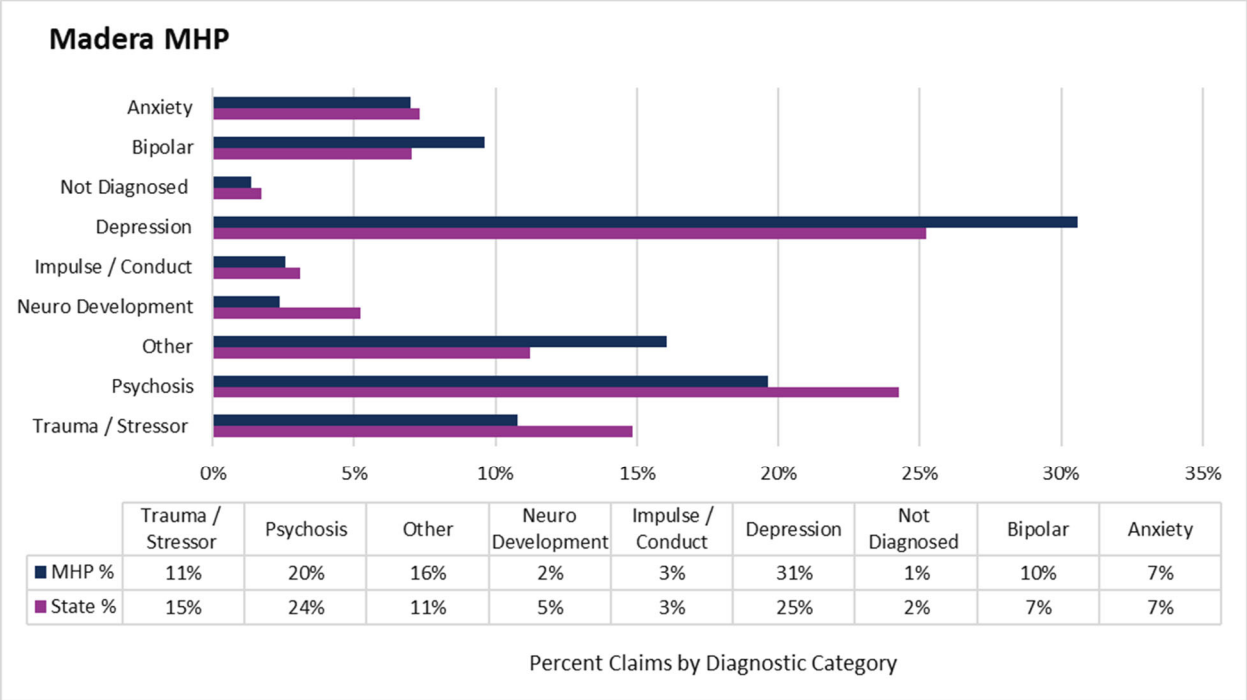
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	13%	10%	12%	3%	3%	30%	8%	7%	13%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- Depression is the leading diagnostic category in the MHP and represents 30 percent of members. Other prevalent diagnostic categories include Trauma/Stressor and Anxiety.
- Psychosis was less prevalent in the MHP than statewide, 6 percentage points lower than the state.

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 %	11%	20%	16%	2%	3%	31%	1%	10%	7%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- The patterns of claims by diagnostic categories were generally congruent with diagnostic patterns in the MHP and claiming patterns statewide, though claims associated with diagnoses that are grouped into the “Other” category are perhaps slightly higher than would be expected.

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 (LOS). CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

Table 13: Madera MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	247	452	1.83	3.91	8.45	$7,286	$12,763	$1,799,584
CY 2021	195	435	2.23	4.14	8.86	$9,962	$12,696	$1,942,618
CY 2020	166	198	1.19	8.58	8.68	$11,489	$11,814	$1,907,115

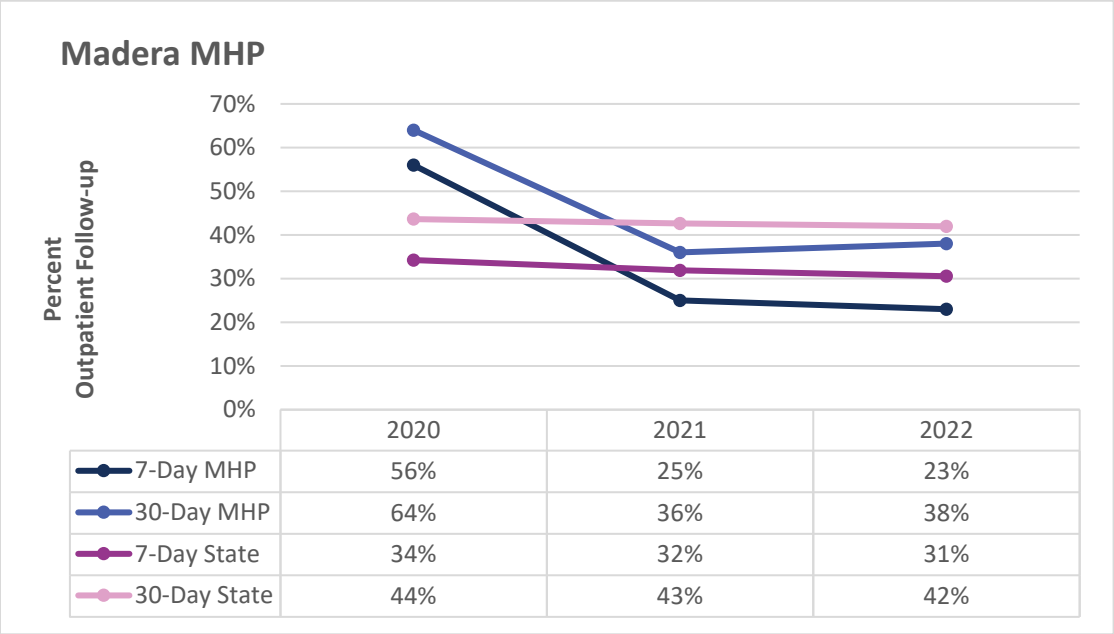
- While inpatient total approved claims have decreased in dollar amount, unique inpatient Medi-Cal members have increased by 81 members in 3 years.

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 is 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. As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the current methodology.

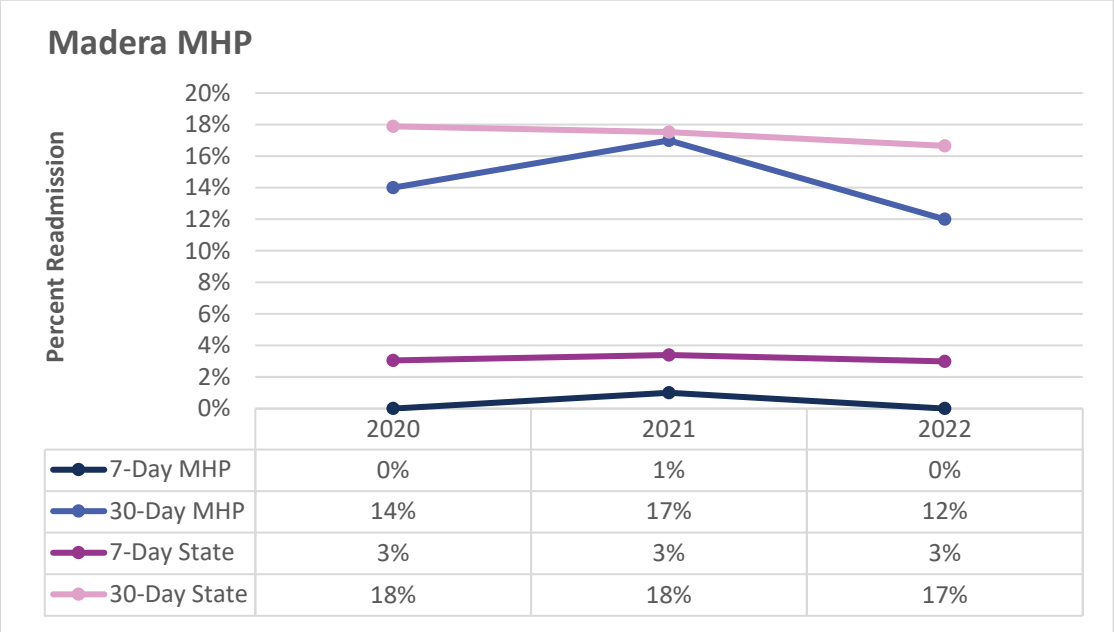
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	56%	25%	23%
30-Day MHP	64%	36%	38%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- The MHP's 7-day follow-up rate performance decreased by 59 percent and the 30-day rate decreased by 41 percent in the time frame displayed.

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



	2020	2021	2022
7-Day MHP	0%	1%	0%
30-Day MHP	14%	17%	12%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

The MHP's readmission rates at both 7 and 30 days were lower than statewide rates in CY 2022.

- Madera's 7-day readmission trendlines is suppressed in Figure 19 due to small numbers and is well below the statewide rate.

- Madera's 30-day readmission rate increased in 2021 but decreased to below 2020's rate in 2022.

High-Cost Members

Tracking the HCMs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. 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 and 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: Madera 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	70	2.36%	25.42%	$3,803,183	$54,331	$44,457
	CY 2021	47	1.72%	21.84%	$2,620,193	$55,749	$47,384
	CY 2020	87	3.35%	27.87%	$4,292,436	$49,338	$43,556

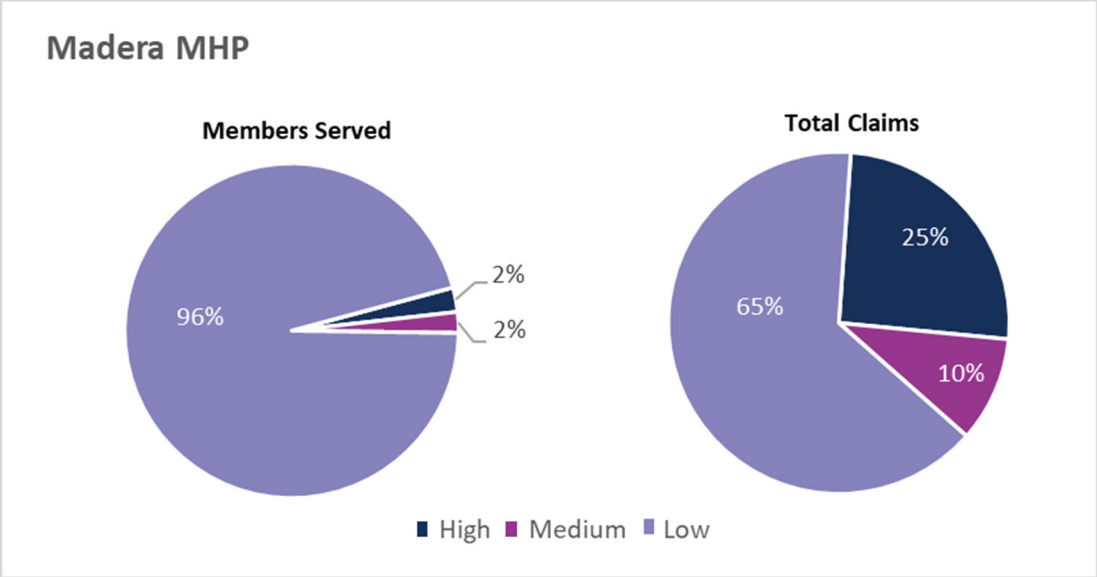
- The MHP saw a decrease in HCM count, the percentage of members considered HCMs, and HCM approved claims dollars in CY 2021, followed by an increase in CY 2022, though all remain below CY 2020 levels.
- The proportion of HCMs in the MHP, percentage of claims billed on behalf of HCMs, and average approved claims per HCM were all lower than statewide.
- The average and median approved claims per HCM are very similar between MHP and statewide.

Table 15: Madera 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)	60	2.03%	10.00%	$1,495,522	$24,925	$24,838
Low-Cost (Less than $20K)	2,832	95.61%	64.59%	$9,663,122	$3,412	$1,844

- Nearly 96 percent of members fell into the low-cost category, and just about 2 percent were considered medium-cost.

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



- Low-cost members represented 96 percent of members served and 65 percent of claims, medium-cost members represented 2 percent of members served and 10 percent of claims, and HCMs represented 2 percent of members served and 25 percent of claims.

IMPACT OF QUALITY FINDINGS

- The proportion of members receiving a single service being double the statewide average, coupled with the proportion of members receiving more than 15 services being approximately half of the statewide average, warrants investigation into service engagement.
- As reported last year, the MHP would benefit from strategically linking the QAPI, Cultural Competency Plan (CCP), medication monitoring, HEDIS measures and CalAIM goals to the QIC so that goals can be tracked, trended, and process improvements implemented from the plans to the QIC. The QIC would benefit from analysis and improvement plan documenting progress.
- The MHP has centralized scheduling (see non-clinical PIP) after assessment and for ongoing appointments within each clinic. This change was initiated to make access easier and timelier for the members. However, stakeholders reported that not having a personal connection with members in scheduling was at times a barrier to rapport and retention.
- The MHP's lack of aggregate data by program outcomes significantly impacts quality management processes. This is especially true where Evidence-Based Treatment (EBT) is being used. EBT requires measurement to fidelity and is most useful when aggregate outcomes are tracked and trended program wide.

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: Crisis Mobile Unit Implementation

Date Started: 08/2022

Aim Statement: "The aim of this PIP is to establish a crisis mobile unit providing timely services to anyone, anywhere, anytime within the boundaries of Madera County to deescalate crisis situations in the community and therefore decrease the number of individuals who are placed on a 5150 or 5585 hold beginning 08/01/2022 through 08/01/2024."

Target Population: The population affected by this PIP will be anyone, anywhere, anytime within Madera County boundaries who calls the Crisis Mobile Unit requesting services.

[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 PIP was designed in response to the need to address the growing number of mental health and substance use disorder emergency department visits reported over the last several years. The goal is to implement a MCDBHS Crisis Care Mobile Unit available 24/7 to respond during crisis situations within Madera County with the purpose of decreasing the crisis in the community, resulting in a decrease in the necessity of 5150/5585 holds. The MHP will be evaluating the goal of responding to all crises call contacts within one hour.

The interventions for this PIP are as follows:

- The crisis mobile unit will respond to anyone who requests services, anywhere, anytime in real time and in person.
- For every contact, the crisis mobile unit will have a goal of deescalating the situation at the individual's location to remove the need of a 5150 or 5585 hold.
- For every contact, the crisis mobile unit will have a goal of responding to all calls within one hour in Madera County.

The interventions began in September 2022. However, due to circumstances that required adjusting the PIP process, the MHP is now beginning to track and trend the data for this PIP. There was no data available at the time of the review.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because although credible, reliable, or valid methods were implied or able to be established for part of the PIP, there is not yet any results/data available to review the methodology in use.

No TA was requested/provided prior to the review. The MHP has agreed to accept TA for this PIP through the coming year. CalEQRO recommends regular (at least quarterly) TA as this PIP continues.

Recommendations to improve the PIP include:

- Rewrite the aim statement to be succinct and quantifiable.
- Begin to collect and track data and provide information in Table 8.1 as it becomes available. Since the mobile crisis response is new, there is no baseline prior to the beginning of the PIP. This year will provide a baseline.
- Use percentage increase or decrease from baseline rather than just numbers to better evaluate PIP results.

The number of calls to the mobile crisis unit could be captured and reviewed to see any discrepancy in after-hours versus business hours requests. It would also be useful to track any canceled calls.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Centralized Appointment Scheduling Process

Date Started: 05/2023

Aim Statement: "Will the implementation of a centralized appointment scheduling process decrease scheduling/appointment related grievances by 10 percentage points by FY 2024-25 from 33 percent in FY2022-23 to 13 percent and scheduling appointment related change of provider requests by 10 percentage points by FY2024-25 from 18 percent in FY2022-23 to 8 percent?"

Target Population: The study population is all clients, new and ongoing, who require appointment scheduling.

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

Summary

This PIP is designed to improve the process clients follow to schedule and/or reschedule, cancel, or any other change to appointments in general. The lack of a centralized scheduling process post-assessment creates a delay in appointment scheduling, thereby delaying necessary treatment for members and impacting their health. The current process of routing calls to the provider to coordinate scheduling has added administrative duties to providers, impeding much needed direct service time. Client dissatisfaction is clearly reflected in the analysis of member complaints and concerns data regarding their appointment scheduling and rescheduling process.

The interventions for this PIP are as follows:

- Initiate centralized appointment scheduling process with front desk staff.
- Initiate centralized appointment scheduling responsibilities with front desk staff post assessment.

TA and Recommendations

The MHP did not request TA on this PIP during the year. CalEQRO recommends regular (at least quarterly) TA as this PIP continues this year.

As submitted, this non-clinical PIP was found to have low confidence, because while the intervention began May 2023, there is no information available at the time of this review showing performance rate, year to date baseline, or other data to assess the PIP.

CalEQRO recommendations for improvement of this non-clinical PIP:

- The change of provider data shows a drop in requests from FY 2021-22 (21 percent) to FY 2022-23 (18 percent). However, grievances filed and change of provider requests increase from 13 percent in FY 2021-22 to 33 percent in FY 2022-23. Consider this might be an appropriate measure to illustrate the problem defined in the PIP.
- Ensure that a process indicator is in place to measure that the interventions occur as intended.
- Determine whether outcome indicators are aligned with the goal of this project.

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 InSync, which has been in use since 2020. Currently, the MHP is actively preparing to implement a new system, SmartCare by Streamline. The implementation will start in July 2024 and will again be another huge effort for the MHP.

Approximately 10 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 152 named users with log-on authority to the EHR, including approximately 137 county staff and 15 contractor staff. Support for the users is provided by two full-time equivalent (FTE) IS technology positions. Currently one of those FTE positions is vacant.

As of the FY 2023-24 EQR, 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 Madera 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	50%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	25%
Paper documents delivered to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	25%
		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 have a PHR and has no plans at this time to implement one as they will be on their current EHR for less than one more year and are not making major changes to it at this time.

Interoperability Support

The MHP is not a member or participant in a HIE. Care coordination activities occur within the EHR. The MHP engages in electronic exchange of information with its contract providers and the managed care plan.

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	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

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

- The MHP has appropriate IS protocols in place to protect itself against cyberattacks or other situations that could result in compromised security.
- The MHP does not utilize a data warehouse, which would support analytic functions and quality improvement efforts.
- The MHP has had challenges making timely claims submissions, which they attribute to not having enough staff. This may have been remedied with the development of its billing unit.
- The MHP is not a member or participant in an HIE, which would support information exchange with partner organizations, and CBOs cannot enter data directly into the EHR unless they are working on-site from a county clinic.

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 Madera MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	2,673	$935,305	$72,971	7.80%	$862,334
Feb	2,766	$1,018,725	$67,037	6.58%	$951,688
Mar	3,231	$1,300,368	$72,373	5.57%	$1,227,995
April	3,046	$1,239,590	$63,137	5.09%	$1,176,453
May	2,995	$1,277,015	$61,471	4.81%	$1,215,544
June	3,186	$1,351,611	$59,579	4.41%	$1,292,032
July	2,705	$1,102,296	$65,450	5.94%	$1,036,846
Aug	3,416	$1,392,268	$74,179	5.33%	$1,318,089
Sept	2,636	$1,100,502	$41,857	3.80%	$1,058,645
Oct	2,443	$1,021,064	$39,666	3.88%	$981,398
Nov	2,752	$1,176,192	$55,561	4.72%	$1,120,631
Dec	2,734	$737,179	$54,843	7.44%	$682,336
Total	**34,583**	**$13,652,115**	**$728,124**	**5.33%**	**$12,923,991**

- The claims volume and billed amounts are largely stable across CY 2022, with some more substantial fluctuations in the percent of claims dollars denied from month to month.

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

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Other healthcare coverage must be billed first	858	$307,051	42.17%
Medicare Part B must be billed before submission of claim	637	$253,641	34.83%
Member is not eligible or non-covered charges	171	$78,126	10.73%
Other	404	$59,896	8.23%
Late claim submission	56	$15,798	2.17%
Service line is a duplicate and repeat service modifier is not present	41	$12,933	1.78%
Deactivated NPI	4	$570	0.08%
Service location NPI issue	1	$110	0.02%
Total Denied Claims	**2,172**	**$728,125**	**100.00%**
Overall Denied Claims Rate	**5.33%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The MHP's denied claims rate is lower than the state.
- Other healthcare coverage and Medicare Part B needing to be billed first were the two most prevalent denial reasons and, combined, represented 77 percent of denied claims.
- The MHP could reduce the denial rate if they could determine that the member has other coverage and if Medicare Part B should be billed first.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP experienced challenges in working with a new EHR system to gather the information needed to meet reporting requirements mandated by the state. Kings View supported their system previously. When they realized that this company did not support InSync, they had to bring the work in-house and figure out how to make the new system work for them.
- Madera has encountered difficulties in finding appropriate candidates to bring on board, despite having budgeted vacancies that are ready to be filled. Additional staff are needed to complete claim processes in a timely manner while also working to meet CalAIM requirements and deadlines. At the time of the EQR the MHP was preparing to interview candidates for several positions.
- Madera is looking to replace their new EHR system with SmartCare in CY 2024. The EHR transition will have an impact on staff, likely into CY 2025, as they work to fully implement the new EHR and train staff on its functionalities.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (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's CPS report was completed for Spring 2023. The MHP reported difficulties in obtaining the aggregated CPS data from prior survey administrations; thus, the MHP has not been able to compare most recent CPS findings with past results.

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 one 90-minute focus group with MHP members and/or their family, containing 10 to 12 participants.

Member/Family Member Focus Group

CalEQRO requested a diverse group of adult members who initiated services in the preceding 12 months. The focus group was held virtually through Zoom-platform hosted by an EQRO reviewer and included four participants, none of whom had begun services within the past 12 months. No language interpreter was used for this focus group. All members participating receive clinical services from the MHP.

- Missed appointments are rescheduled in a timely manner. Sometimes members receive a call as soon as the next day to reschedule.
- All agree staff are open and engaging and know how to make changes if a staff member is not a good fit. Participants are aware that they may either call clinic office or talk to therapists or case managers.
- Two members mentioned transportation options are available. Rides are provided by case managers, and bus tokens and/or passes are also available. The group agreed that they received information regarding transportation. One participant pointed out that this information was in the member handbook.

- All four members receive and prefer in-person services but are aware they have the option of video and telephone as well.
- No members accessed crisis services within the past year but reported knowing that the mobile crisis unit is new and if a crisis or urgent care need arises, they all acknowledged having the crisis number, 988 crisis line, and warm line access. All had been given a card with the information on how to reach out in a crisis.
- All participants reported that they completed a CPS survey within the past year but have not heard any results from those surveys.
- Members had not been invited or were not aware of opportunities to be a part of any QIC or any other type of committee. They voiced that they would appreciate and welcome the opportunity.
- All members are very grateful for the services they receive from Madera MHP. It has made positive, and life changing impacts to their lives. They noted the services they have received give them skills to help with anxiety, depression, and other personal challenges. All participants agreed they feel the staff gives them a great sense of hope.

Recommendations from focus group participants included:

- “More group support services, especially in Chowchilla.”
- All members who participated in this session were from the Chowchilla area and agreed that a Drop-In Wellness Center in the Chowchilla area would make a huge impact for members in that service area.

SUMMARY OF MEMBER FEEDBACK FINDINGS

All participants in the group found the services they receive to be helpful in their recovery. They report that the staff is giving them hope and being respectful of their cultural and personal beliefs.

The participants mentioned and all agreed how isolated and lonely it can feel in the Chowchilla service area, and a center with social activities, support groups, and classes who are facing similar mental health challenges would be value added.

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 first offered non-urgent appointment (county-operated) tracked and reported is an average of six days, meeting the ten-day standard 97 percent of the time. (Timeliness)
2. The MHP has excellent integration and collaboration with partner stakeholders and other public and private agencies in outreach to increase culturally appropriate access to services. (Access)
3. Crisis Care Mobile Units (CCMU) are implemented county-wide, regardless of payer, and serve both adults and youth. (Access)
4. The MHP has increased their telehealth use substantially. One contract provider site was added, and 1,210 more adults, 314 more children/youth and 129 more older adults used telehealth. (Access)
5. The MHP reduced their medical revenue initial loss, $520,710 from last year, reducing their non-eligible claims from 2,179 members to 171 members. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP has the highest single service only rate in the state, more than twice compared with statewide. (Access)
2. The CalAIM BHQIP was not used as one of the PIPs that was submitted to EQRO due to unforeseen complexity of the work involved for the BHQIP. This meant the MHP was required to submit a clinical and a non-clinical PIP to EQRO as well as complete the BHQIP for DHCS. (Quality)
3. The MHP does not report timeliness data for first offered and first delivered non-urgent clinical appointments; first offered and first delivered non-urgent psychiatry appointments; or, first offered urgent appointments for contractor-operated services. This prevents an accurate picture of system-wide service delivery. (Timeliness)
4. The MHP's highest reason for denial is other healthcare or Medicare Part B needed to be billed first. Reducing this issue would bring in revenue in a timelier fashion and with likely less effort. (IS)

5. The MHP's lack of aggregate data by program outcomes significantly impacts quality management processes. This is especially true where Evidence-Based Treatment (EBT) is utilized. EBT requires measurement to fidelity and is most useful when aggregate outcomes are tracked and trended program wide. (Quality)

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. Implement a barrier analysis, create strategies and interventions, track and report improvements in engagement as measured by decrease in one service only rate. Evaluate the impact of expanded crisis intervention and whether members served are appropriately referred to the MHP for ongoing care if needed. (Access)
2. Work with DHCS to find how Madera might create a successful Behavioral Health Quality Improvement Program (BHQIP) PIP Follow-up After Emergency Department (FUM) and use it as next year's MHP non-clinical PIP to reduce the impact of the PIP requirements. Engage in PIP technical assistance (TA) from EQRO on a regular (at least every three months) basis. (Quality)
3. Begin to collect and trend timeliness data for first offered and first delivered non-urgent clinical appointments; first offered and first delivered non-urgent psychiatry appointments; or, first offered urgent appointments for contractor-operated services. Include this data in assessments of timeliness for system wide service delivery. (Timeliness)
4. Investigate the reasons, develop strategies, and implement solutions to improve the MHP's highest reason for denial – other healthcare or Medicare Part B needing to be billed first. Track and report progress on this issue. (IS)
5. Develop a plan for the implementation of the new EHR (SmartCare) to ensure that it includes capability to track aggregated data by program outcomes. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 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: Letter from 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 – Madera MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and 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 Perceptions of Care
Validation of Findings for Pathways to Well-Being (Katie A./CCR)
Plan Member and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Information Systems Billing and Fiscal Interview
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, LMFT, Lead Quality Reviewer
Naga Kasarabada, PhD, Quality Reviewer
Pamela Springer, Information Systems Reviewer
Leah Hanzlicek, Data and Information Systems Manager
Gloria Marrin, 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
Moreno-Peraza	Connie	Director	County
Galindo	Art	Division Manager - Childrens	County
Garcia	Aaron	Fiscal Manager	County
Hernandez	Kimberlee	Administrative Analyst - Quality	County
Navarro	Miravel	Division Manager – Cultural Competence/MHSA	County
Weikel	Eva	Division Manager – Quality/Compliance/Administrative	County
Yang	Say	Administrative Analyst – Data	County
Bertram	Lynn	Medical Director	Contracted
Herra	Kelsey	Mental Health Aide	County
Diaz	Alisia	Mental Health Aide/Peer Support Specialist	County
Vasquez	Crystal	Mental Health Aide/Peer Support Specialist	County
Yanez	Sulman	Mental Health Aide	County

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	Although credible, reliable, or valid methods were implied or able to be established for part of the PIP, there is not yet any results/data available to review the methodology in use.

General PIP Information
MHP/DMC-ODS Name: Madera MHP
PIP Title: Crisis Mobile Unit Implementation
PIP Aim Statement: The aim of this PIP is to establish a crisis mobile unit providing timely services to anyone, anywhere, anytime within the boundaries of Madera County to deescalate crisis situations in the community and therefore decrease the number of individuals who are placed on a 5150 or 5585 hold beginning 08/01/2022 through 08/01/2024."
Date Started: 08/2022
Date Completed: ongoing
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): Anyone in Madera County who call the Crisis Mobile Unit requesting services.
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): Gives Member option of crisis mobile response in the field rather than needing to go to hospital emergency department for assessment.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Providers can assess in the field with the crisis mobile team interventions.
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): New program to have a crisis mobile team where intervention is no longer bound by client coming into treatment or hospital to be assessed.

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
			☒ 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 parts 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: Rewrite the Aim statement to be succinct and quantifiable. Begin to collect and track data and provide information in Table 8.1 as it becomes available. Since the Mobile Crisis response is new, there is no baseline prior to the beginning of the PIP. This year will provide a baseline. Consider the use of percentage increase or decrease from baseline rather than just numbers to better evaluate PIP results. The number of calls to the Mobile crisis unit could be captured and reviewed to see any discrepancy in afterhours versus business hours requests. It would also be useful to track any canceled calls. Participate in EQRO TA at least quarterly.

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	While the intervention began May 2023, there is no information available at the time of this review showing performance rate, year to date baseline, or other data to assess the PIP.
General PIP Information	
MHP/DMC-ODS Name: Madera MHP	
PIP Title: Centralized Appointment Scheduling Process	
PIP Aim Statement: "Will the implementation of a centralized appointment scheduling process decrease scheduling/appointment related grievances by 10 percentage points by FY 2024-25 from 33 percent in FY2022.-23 to 13 percent and scheduling/appointment related change of provider requests by 10 percentage points by FY2024-25 from 18 percent in FY2022-23 to 8 percent?"	
Date Started: 05/2023	
Date Completed: ongoing	
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 clients, new and ongoing, who require appointment scheduling in the clinic.	

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): Members will now use the front desk of the clinic to schedule appointments vice through their provider.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Providers will no longer be involved in scheduling their clients for appointments.
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 MHP is changing the practice of how members receive appointments in the hope of more timely access to those appointments.

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
			☒ 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.

PIP Validation Information
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: CalEQRO recommends regular (at least quarterly) TA as this PIP continues this year. The change of provider data shows a drop in requests from FY 2021-22 (21 percent) to FY 2022-23 (18 percent). However, grievances filed and change of provider requests increase from 13 percent in FY 2021-22 to 33 percent in FY 2022-23. Consider that this might be a better measure to illustrate the problem defined in the PIP.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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