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

IMPERIAL FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 19, 2023

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — January 19, 2023

MHP Size — Small

MHP Region — Southern

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
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	4	-	-
Timeliness of Care	6	3	3	-
Quality of Care	10	4	4	2
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**15**	**9**	**2**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
"Reducing Psychiatric Emergencies-HOPE Program"	Clinical	07/2022	First remeasurement	Low
"BHQIP-PIP Follow-up after ED visit for Mental Illness (FUM)"	Non-Clinical	06/2022	First remeasurement	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	7

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP continues to trend low inpatient rates.
- The MHP hand-counted Foster Care (FC) data to report an accurate number of rendered services.
- The MHP is participating as a pilot county for SmartCare Electronic Health Record (EHR).
- The Wellness Center reopened, offering in-person support groups, volunteer opportunities, and clinical services.
- The MHP reallocated staff resources and created more intake slots to promote easier access.

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

- The MHP did not involve youth and families in discussion involving the new children and family outpatient clinic.
- The MHP does not currently have Peer-based employment with opportunities for upward mobility.
- Inaccurate methods for tracking data lead to the inability to track and trend data and inform system-wide improvements.
- High staff vacancy rates can lead to stagnation in services when beneficiaries cannot move fluidly throughout the continuum of care.

- The MHP does not identify impacts to beneficiaries within their Quality Improvement work plan (QIWP.)

Recommendations for improvement based upon this review include:

- Engage youth and families to actively participate in the design and functionality of the upcoming youth and family outpatient clinic remodel.
- Identify and implement paid peer employment opportunities within the department and contracted services.
- Optimize the MHP's leadership reorganization to produce service data on a routine basis so that the leadership team can review services across the continuum of care.
- Examine step-down procedures for medication only beneficiaries and identify a Level of Care (LOC) tool that will allow clinicians to move beneficiaries to lower levels of care to reduce lengthy wait times, high caseloads, and staffing burnout.
- Expand on outcome goals within the QIWP by identifying impact goals that coincide with achieved compliance goals.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2022-23 findings of the EQR for Imperial County MHP by BHC, conducted as a virtual review on January 19, 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 analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

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

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

Findings in this report include:

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

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during/after the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP is impacted by a vacancy rate of 70.37 percent psychiatrist and 52.75 percent clinicians. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP is one of three counties selected to be part of the pilot phase for the California Mental Health Services Authority's (CalMHSA) Semi-Statewide EHR, Smartcare by Streamline. The county is on target for the pilot go live date of February 01, 2023.
- The MHP contracted with Merced Behavioral Health Center, a locked skilled nursing facility, for four dedicated beds.
- The MHP is expanding its Short Term Residential Therapeutic Program within the county.
- Twenty-five staff were trained in the Assertive Community Treatment Model to provide an intensive care team approach for Serious Emotionally Disturbed Adults.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: Engage non-supervisory line level staff employees in an anonymous way to express work retention challenges and propose solutions within the MHP. Document steps taken to address workload exhaustion, discrepancies in hybrid work from home plans, and staffing turnover.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- An Anonymous Survey was completed in July 2022, with 347 responses. Staff were presented with the results during a full Staff Meeting on October 5, 2022.
- The management team will discuss next steps. Due to county specific requirements, staff is allowed to telework two days a week, returning to the office for three of the five-day work week.
- The MHP did not identify proposed solutions to the high caseloads and continued staff burnout.

Recommendation 2: Identify challenges to identifying FC youth entering the behavioral health system and appropriately track and trend data to report accurate FC outcomes.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- As the MHP is currently in the process of implementing a new EHR, efforts to determine the best way to create reports from the EHR on FC youth have been temporarily halted. The MHP intends to identify ways to track and trend FC youth data in the new EHR.

- In the interim, the MHP's Quality Management (QM) unit compiled a Foster Youth Annual Report that included information about the total number of referrals from the Department of Social Services, the number of beneficiaries that met criteria for Katie A. services, timeliness of service delivery, and outcomes.

Recommendation 3: Investigate how to re-engage peer staff within the Wellness Centers and assist clinicians with beneficiary caseloads. Communicate plan and timeline to re-engage peers with both Wellness Center and clinical staff.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The Wellness Center was reopened for in-person services.
- Key informants report lack of ability to obtain paid peer staffing positions.
- The MHP reports limited paid peer positions instead recruiting for volunteer peer positions.
- Key informants reported lack of communication for peer staff, on availability to staff Wellness Centers.

Recommendation 4: Examine the ways to improve psychiatry offered appointment and rendered services, including conducting beneficiary surveys on reducing psychiatry no-show rates.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Quality Management staff conducted analysis and case reviews to evaluate reasons for no shows. It was identified that data was not being properly entered to capture first psychiatric appointment. No other trends were identified. QM conducted surveys for beneficiaries who had not shown to psychiatry appointments. The results noted high rates requesting reminder calls.
- The MHP reported providing regular reminder calls, and key informants acknowledged this effort was taking place.

Recommendation 5: Investigate reasons for decline in services to the older adult, age 65 and older. Formulate outreach and engagement activities to decrease barriers and increase service participation of this population.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP reported the decline in the older adult population seeking treatment may be related to the precautions taken during the Covid19 pandemic, as the older adult population was noted to be at risk of severe Covid-19 complications if infected.
- Once the MHP opened for in-person appointments, many clients declined to attend appointments and/or did not have option for zoom. This too may have

alienated many older adults who were not actively engaged or did not have the supports to continue or seek services.

- The MHP began training in the Program to Encourage Active, Rewarding Lives (PEARLS), in the current FY 2022-23. Training will be completed by February 2023.
- Though the MHP did not increase the participation by this population, this recommendation will not be carried forward as the MHP is implementing the PEARLS program.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 92 percent of services were delivered by county-operated/staffed clinics and sites, and 8 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 79 percent of services provided were claimed to Medi-Cal.

The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Once a request for services is received, the MHP determines eligibility and conducts a brief assessment to determine the appropriate clinic and schedules the individual for initial services. As of January 1, 2023, the access team is responsible for also conducting the initial screening utilizing the screening tool required by DHCS as part of CalAIM. In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth videoconferencing and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 1,293 adult beneficiaries, 1,596 youth beneficiaries, and 381 older adult beneficiaries across 22 county-operated sites and 12 contractor-operated sites. Among those served, 905 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

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

[1] CMS Data Navigator Glossary of Terms

informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

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

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

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

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

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

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

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

- Because the MHP can provide necessary services to a beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries 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 beneficiaries and family members. Examining service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

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

Table 2: Access Key Components

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

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

- The MHP relocated staff which aided in creating more intake slots for easier access across all age groups.
- The MHP reports a 48 percent bilingual rate, which offers the ability to provide services in an individual's preferred language.
- The Wellness Center offers Spanish speaking beneficiaries English learning classes.
- English only speaking key informants have reported at times Spanish is the only language spoken and they cannot participate in the conversation.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, Imperial demonstrates better access to care than was seen statewide, with a total PR of 6.70 percent in the MHP.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	99,540	6,665	6.70%	$36,620,443	$5,494
CY 2020	94,552	6,753	7.14%	$39,318,393	$5,822
CY 2019	94,138	7,808	8.29%	$43,073,043	$5,517

- The number of total eligibles increased in CY 2021, while the number of beneficiaries served, total PR, total approved claims, and AACB decreased from CY 2020 to CY 2021. Trends in eligibles, beneficiaries served, and PR are similar to those seen statewide.

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	10,836	238	2.20%	1.03%	1.59%
Ages 6-17	24,924	2,514	10.09%	5.00%	5.20%
Ages 18-20	5,291	365	6.90%	4.29%	4.02%
Ages 21-64	45,582	3,191	7.00%	4.15%	4.07%
Ages 65+	12,909	357	2.77%	2.09%	1.77%
Total	99,540	6,665	6.70%	3.83%	3.85%

- The MHP's PR exceeded the statewide PRs, as well as those of similarly sized counties, for every age group. The age group with the highest PR was 6 to 17 years old.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	2,662	39.98%
Threshold language source: Open Data per BHIN 20-070		

- The only threshold language in Imperial was Spanish, with nearly 40 percent of beneficiaries identified as being Spanish speakers.

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

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	25,456	1,632	6.41%	$8,017,585	$4,913
Small	199,673	6,647	3.33%	$36,223,622	$5,450
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries. This trend held true in Imperial, with both PR and AACB for the ACA population being slightly lower for CY 2021 as compared to all beneficiaries.
- The PR for this population in the MHP was higher than in other small counties and statewide, whereas AACB was comparatively slightly lower.

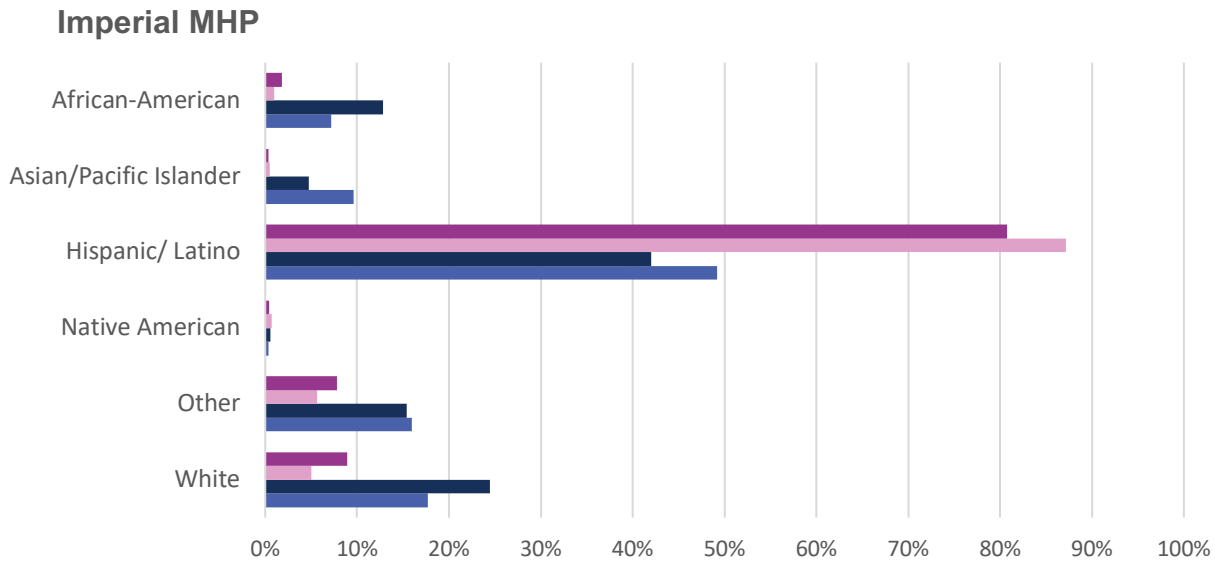
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	984	123	12.50%	6.83%
Asian/Pacific Islander	464	23	4.96%	1.90%
Hispanic/Latino	86,781	5,382	6.20%	3.29%
Native American	697	26	3.73%	5.58%
Other	5,625	518	9.21%	3.72%
White	4,991	593	11.88%	5.32%
Total	**99,542**	**6,665**	**6.70%**	**3.85%**

- PRs in the MHP were higher than the statewide PRs for all racial/ethnic groups with the exception of Native Americans. African-Americans had the highest PR, whereas Native Americans had the lowest PR in Imperial.

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

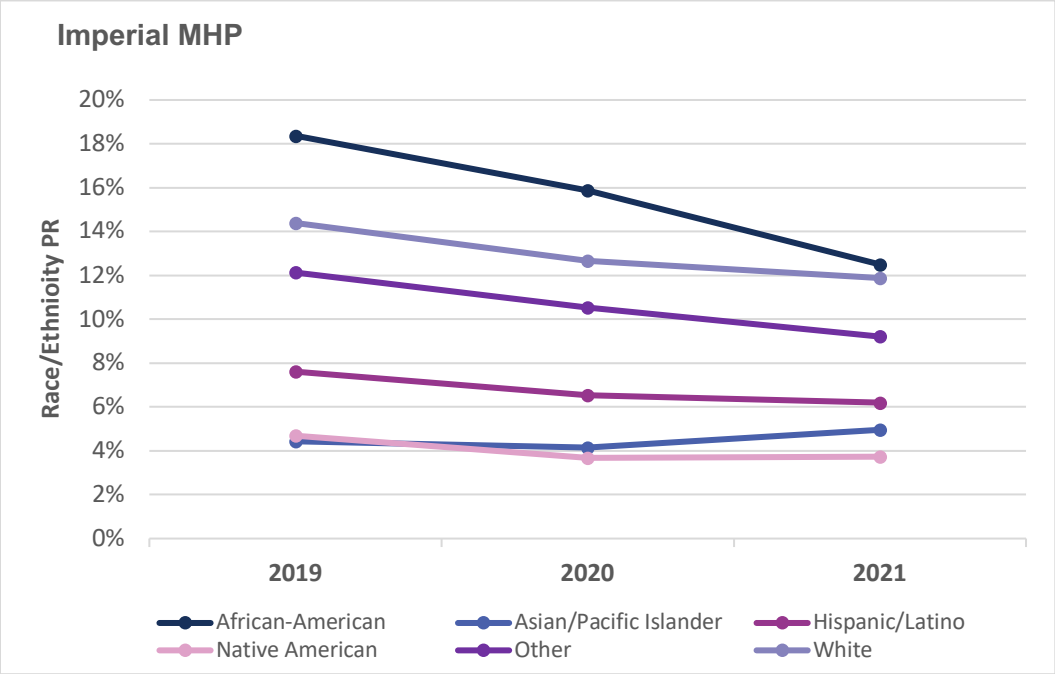


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	9%	8%	0%	81%	0%	2%
MHP % Eligibles	5%	6%	1%	87%	0%	1%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- The most proportionally overrepresented racial/ethnic group in the MHP was Whites, and the most proportionally underrepresented group was Hispanics/Latinos.

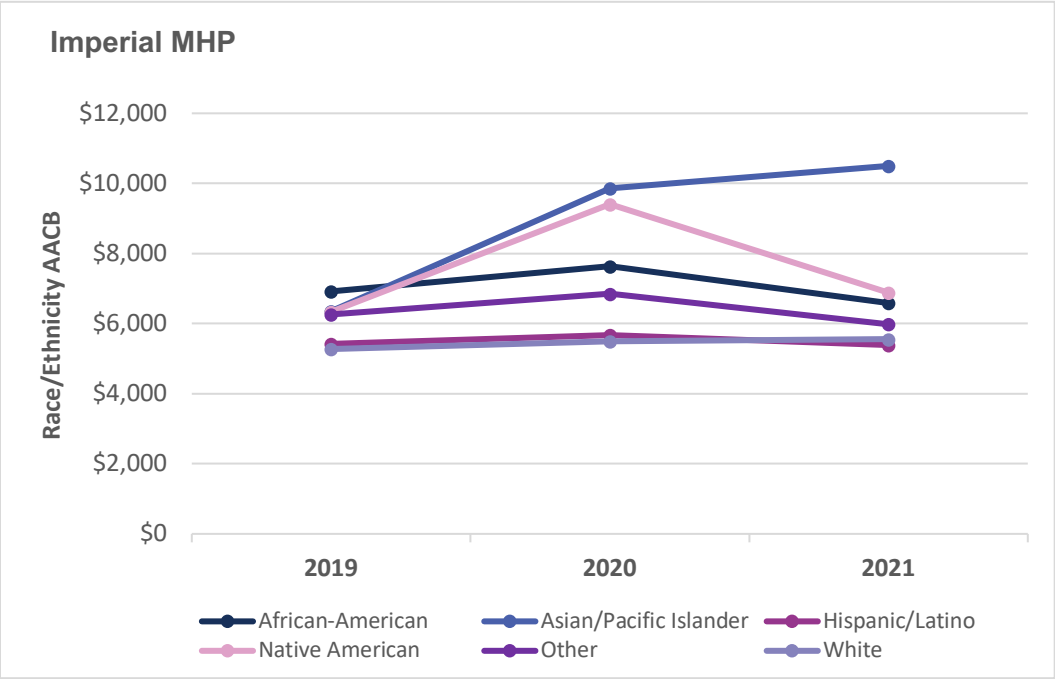
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



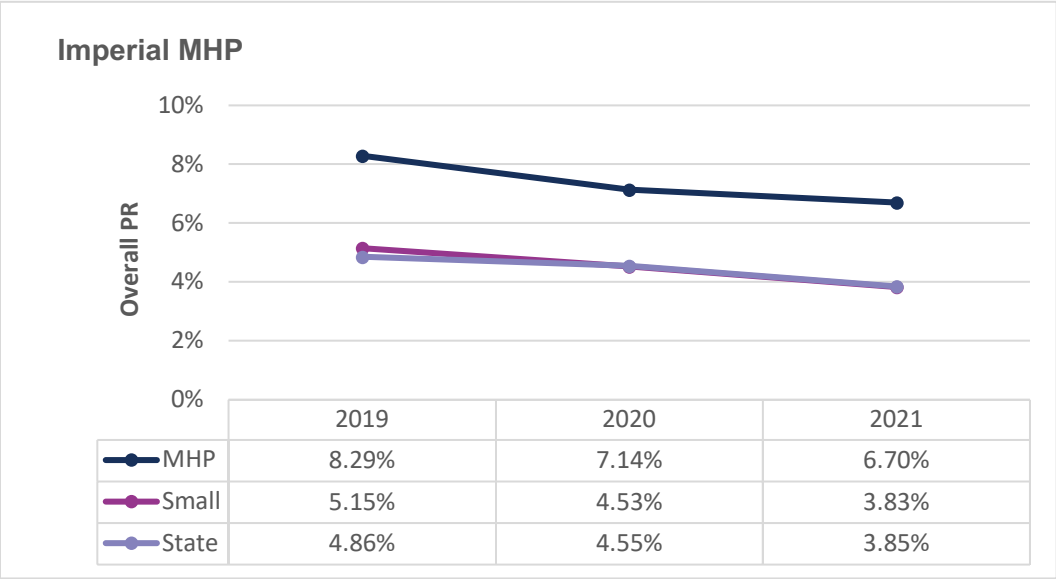
- PRs for most racial/ethnic groups have been trending downwards over the past three years.
- PRs for African-American's and Whites have consistently been the highest in the MHP, whereas PRs for Native Americans and Asians/Pacific Islanders have consistently been the lowest. The PR for the Asian/Pacific Islander populations has increased slightly from CY 2020 to CY 2021.

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



- AACBs across racial/ethnic groups have been fairly steady over the past three years, with no extreme disparities across groups with a couple of exceptions: The AACB for Native Americans and Asians/Pacific Islanders rose more distinctly in CY 2020 than for other groups. While the Native American AACB has decreased in CY 2021, bringing it more in line with the AACBs of other groups, the AACB for Asians/Pacific Islanders remains noticeably higher. However, this could be due to a small number of outliers within that group with particularly high AACBs, because the total n for this group is quite small (23 beneficiaries).

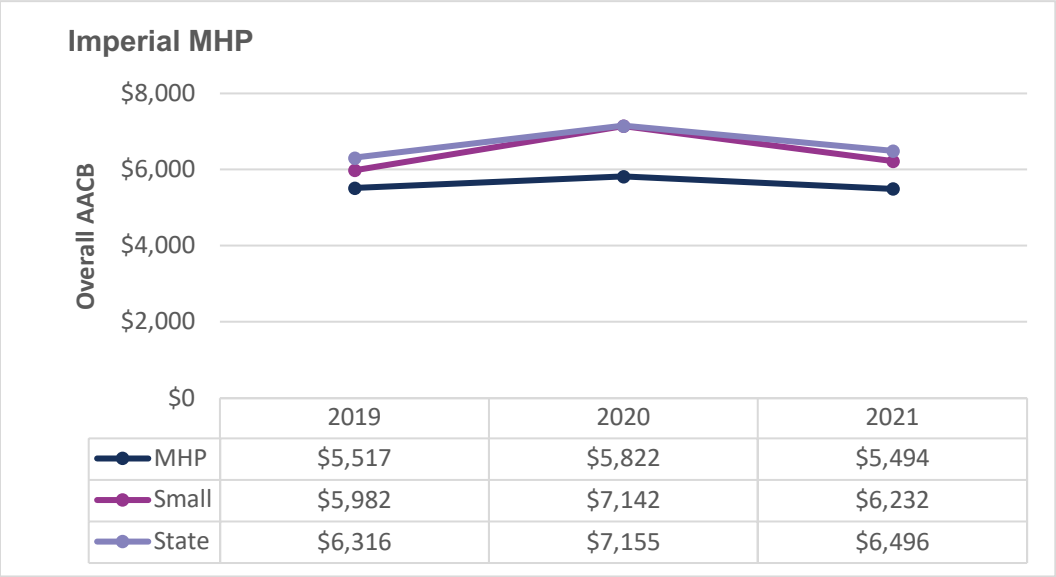
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	8.29%	7.14%	6.70%
Small	5.15%	4.53%	3.83%
State	4.86%	4.55%	3.85%

- Over the past three years PR has been trending downward in the MHP, as well as in other small counties and statewide. However, Imperial has consistently had a higher total PR than those seen in other small counties and statewide.

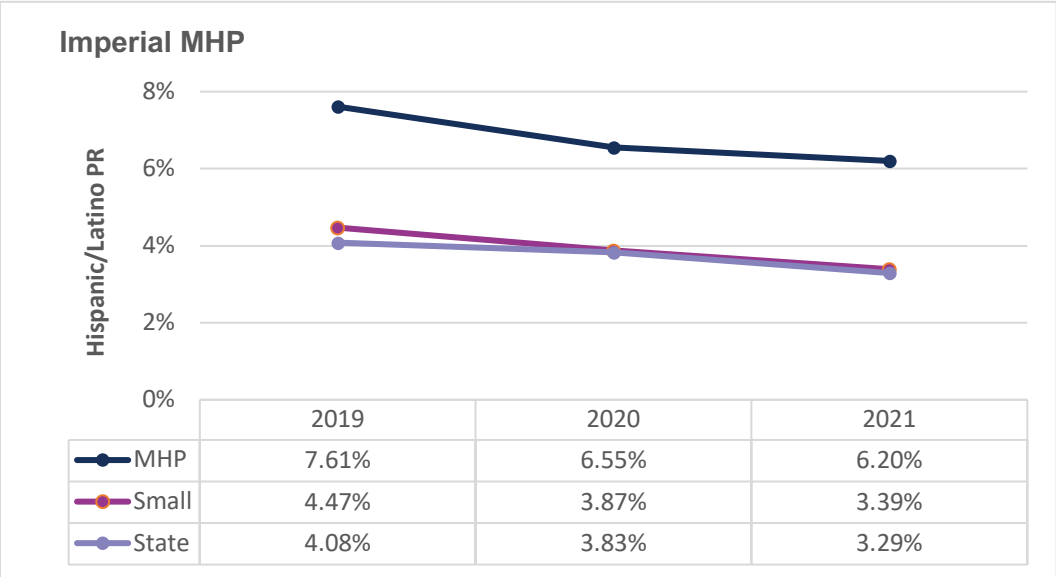
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$5,517	$5,822	$5,494
Small	$5,982	$7,142	$6,232
State	$6,316	$7,155	$6,496

- AACB trended up slightly from CY 2019 to CY 2020, but decreased to just below the CY 2019 level in CY 2021. AACB has been consistently lower in Imperial than in other small counties and statewide.

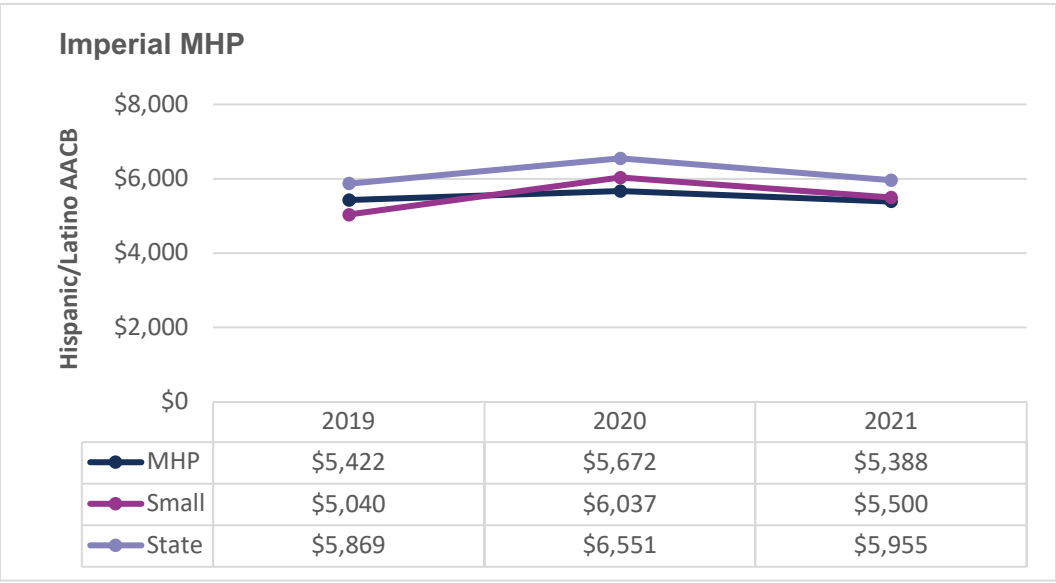
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	7.61%	6.55%	6.20%
Small	4.47%	3.87%	3.39%
State	4.08%	3.83%	3.29%

- The PR for Hispanic/Latino eligibles has been consistently higher in Imperial than in other small counties and statewide over the past three years, though it has been trending downwards slightly. This trend is similar to the trend seen statewide and in other small counties.

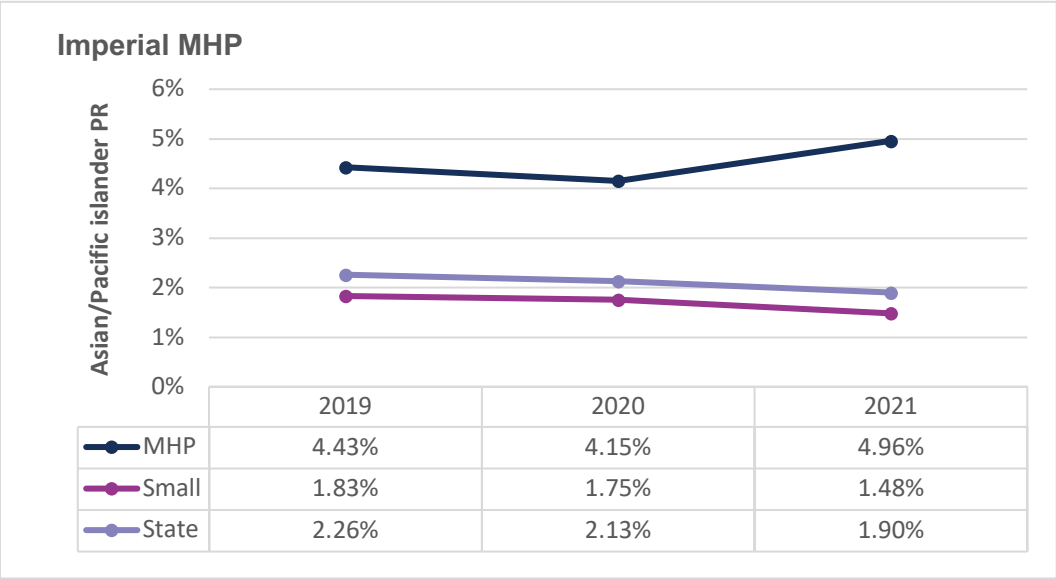
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$5,422	$5,672	$5,388
Small	$5,040	$6,037	$5,500
State	$5,869	$6,551	$5,955

- AACB for Hispanic/Latino beneficiaries has been fairly consistent over time and has been slightly lower than in other counties and statewide over the past two years.

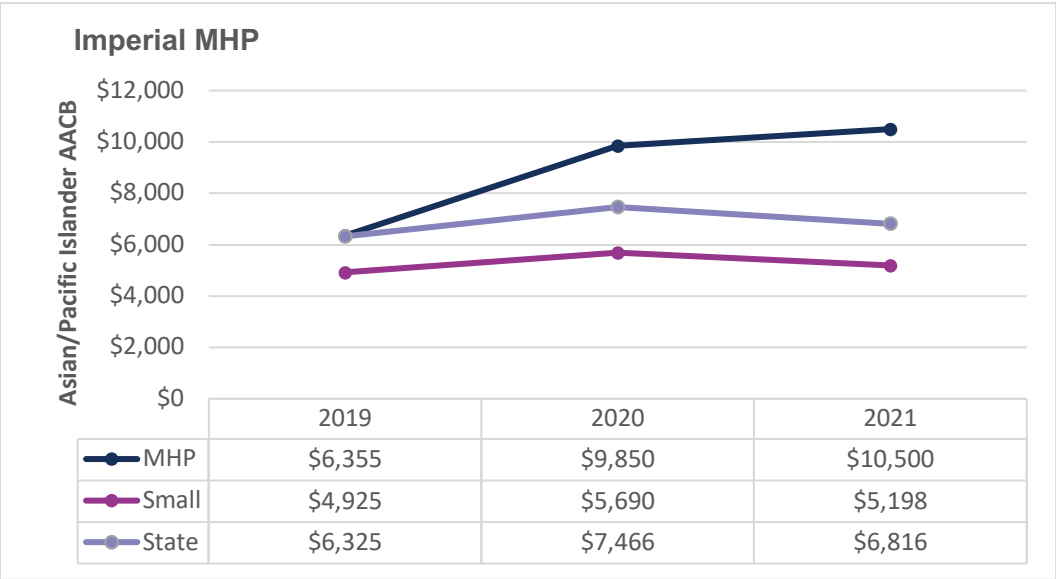
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	4.43%	4.15%	4.96%
Small	1.83%	1.75%	1.48%
State	2.26%	2.13%	1.90%

- The PR for Asian/Pacific Islander eligibles has been consistently higher than in other small counties and statewide over the past three years, and trended upward between CY 2020 and CY 2021, contrary to statewide trends.

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

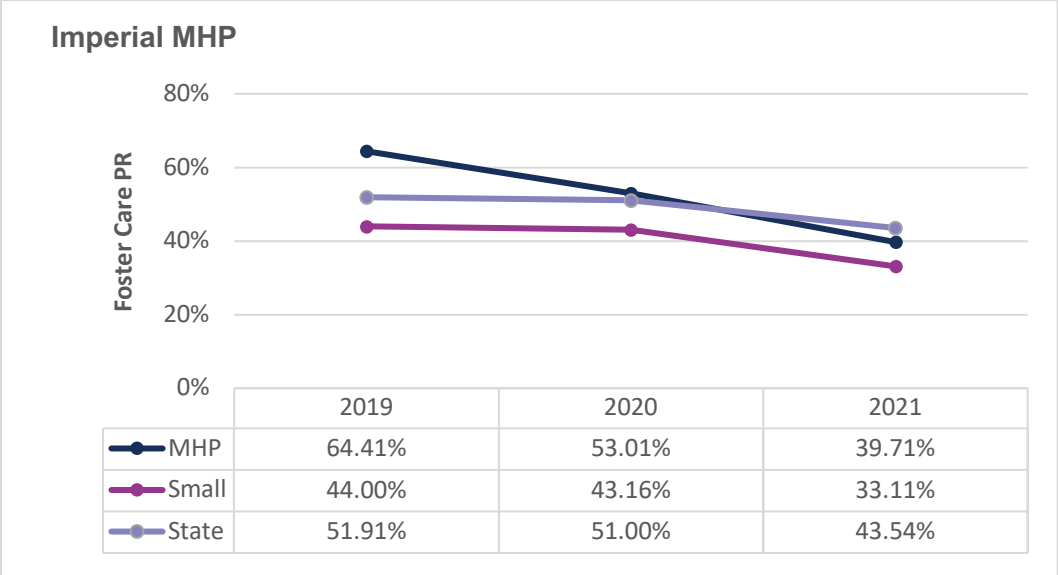


	2019	2020	2021
MHP	$6,355	$9,850	$10,500
Small	$4,925	$5,690	$5,198
State	$6,325	$7,466	$6,816

- AACB for Asian/Pacific Islander beneficiaries has been trending upward since CY 2019 and has been higher than the statewide AACB for this population for the past three years, with the gap widening over time. However, the n for this population is quite small in Imperial, so this could be due to a small number of

beneficiaries with particularly high approved claims skewing the average (mean) upwards.

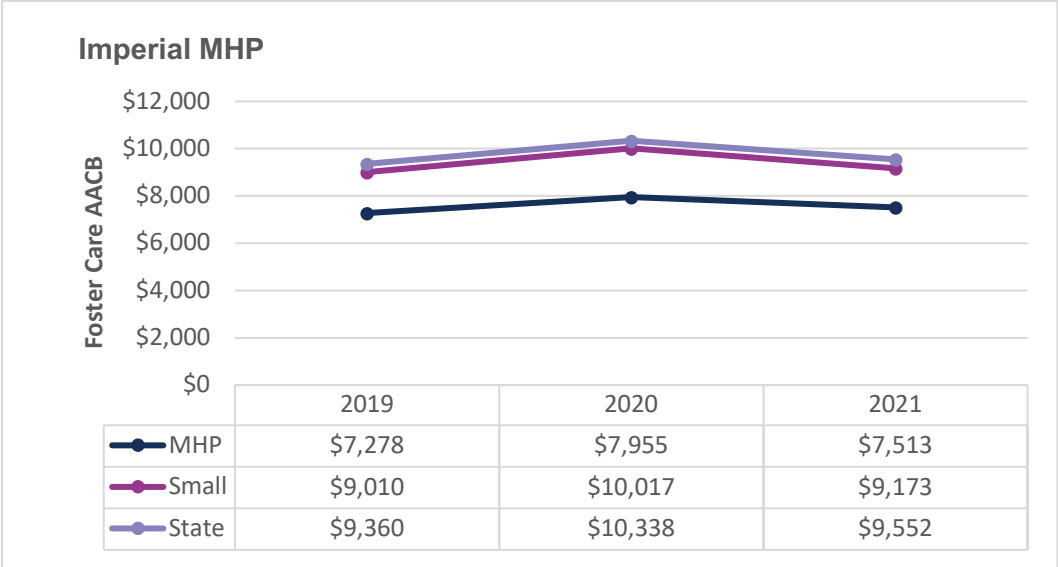
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	64.41%	53.01%	39.71%
Small	44.00%	43.16%	33.11%
State	51.91%	51.00%	43.54%

- The FC PR has decreased over the past three years at a higher rate than that seen statewide. Whereas the MHP's FC PR was much higher than that seen statewide in CY 2019 it was slightly lower than the statewide PR for this group in CY 2021. The PR for this population does, however, remain higher than the FC PR in other small counties.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$7,278	$7,955	$7,513
Small	$9,010	$10,017	$9,173
State	$9,360	$10,338	$9,552

- The MHP's FC AACB has been relatively stable over the past three years and has been consistently lower than the AACB seen statewide and in other small counties for this population.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 3,913				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	47	1.2%	8	7	10.8%	14	8
Inpatient Admin	<11	-	-	-	0.4%	16	7
Psychiatric Health Facility	<11	-	-	-	1.0%	16	8
Residential	<11	-	-	-	0.3%	93	73
Crisis Residential	90	2.3%	2	2	1.9%	20	14
Per Minute Services							
Crisis Stabilization	19	0.5%	1,639	1,200	9.7%	1,463	1,200
Crisis Intervention	418	10.7%	497	212	11.1%	240	150
Medication Support	2,990	76.4%	342	290	60.4%	255	165
Mental Health Services	2,994	76.5%	553	252	62.9%	763	334
Targeted Case Management	456	11.7%	246	131	35.7%	377	128

- Mental Health Services (MHS) and Medication Support were, by far, the most utilized services in the MHP. This is congruent with statewide utilization patterns, though rates of utilization for these services in Imperial were higher than statewide.
- Crisis Residential (CR) and Inpatient were the most utilized per day services. While CR was utilized at a slightly higher rate than that seen statewide, Inpatient was utilized at a much lower rate. Average units (days) billed were lower for both services than those seen statewide. The comparatively low utilization of Inpatient may be due to a lack of Inpatient service providers located within the county and beneficiary resistance to leaving the county to receive those services.
- Targeted Case Management (TCM) and Crisis Stabilization were utilized at much lower rates than statewide.

- Both average (mean) and median units billed for MHS were lower than statewide, whereas they were higher for Medication Support and Crisis Intervention.

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

Service Category	MHP N = 216				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	0	0	0	0	4.5%	13	8
Inpatient Admin	0	0	0	0	n <11	6	4
Psychiatric Health Facility	0	0	0	0	0.2%	25	9
Residential	0	0	0	0	n <11	140	140
Crisis Residential	0	0	0	0	0.1%	16	12
Full Day Intensive	0	0	0	0	0.2%	452	360
Full Day Rehab	0	0	0	0	0.4%	451	540
Per Minute Services							
Crisis Stabilization	<11	-	-	-	2.3%	1,354	1,200
Crisis Intervention	15	6.9%	237	130	6.7%	388	195
Medication Support	120	55.6%	512	485	28.5%	338	232
Therapeutic Behavioral Services	<11	-	-	-	3.8%	3,648	2,095
Therapeutic FC	0	0	0	0	0.1%	1,056	585
Intensive Care Coordination (ICC)	18	8.3%	873	405	38.6%	1,193	445
Intensive Home Based Services (IHBS)	36	16.7%	1,431	967	19.9%	1,996	1,146
Katie-A-Like	0	0	0	0	0.2%	837	435
Mental Health Services	213	98.6%	1,063	620	95.7%	1,583	987
Targeted Case Management	19	8.8%	119	40	32.7%	308	114

- There was no utilization of any per day service among FC youth in the MHP.
- Similar to statewide, the most-used services by far for FC youth were MHS, though average billed units were about 500 minutes less than the statewide average. The second most-used service was Medication Support, which had far

greater utilization in the MHP than seen statewide, as well as higher average and median units billed for that service. More than half of FC youth who received SMHS in the MHP received Medication Support services.

- Both ICC and TCM were utilized at significantly lower rates (78 percent and 73 percent, respectively), also with fewer average units than statewide. IHBS was slightly lower than statewide utilization (16.7 percent versus 19.9 percent), also showing fewer average units of service. The MHP reported an issue with billing both IHBS and ICC services, which may account for some of this disparity.

IMPACT OF ACCESS FINDINGS

- The MHP served nearly as many youth and young adult beneficiaries (3,117 beneficiaries under the age of 20) as adult and older adult beneficiaries (3,548 beneficiaries 21 and older).
- Medication Support was utilized at much higher rates, and with more average billed units, than those seen statewide for both adult and FC youth populations. The MHP may want to examine its step-down processes and further investigate whether all those receiving Medication Support services continue to need SMHS.
- There may be some limitations to the full continuum of care for FC youth, with lower-than-expected utilization of IHBS and TCM in particular as compared to statewide, though the IHBS claims may be somewhat artificially low due to a billing issue for that service.
- Key Informants have requested Spanish classes be offered to non-Spanish speaking beneficiaries.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	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	Partially Met

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

- The MHP collects and reports Access to Timeliness metrics, though several metrics rely on questionable or incomplete data. The MHP is moving to a new EHR that is slated to more accurately collect and report required data metrics.

- The MHP demonstrated excellent outcomes on both 7- and 30-day follow-up services, and psychiatric readmission rates remain low.
- The MHP does not have a set standard to measure no-show data. The percentage rate standard fluctuates each year, offering inconsistent outcome when looking at systemic change.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care for most variables, with the exception of no-show rates which reflect only county-operated services. The county does not have a timeliness standard for first delivered non-urgent service, and only beneficiaries who call the Access Line and request psychiatry services are included in the MHP's tracking of first offered non-urgent psychiatry appointments, resulting in a very small n for that measure. Likewise, only urgent services initiated through the Access Line are included in the county tracking of timeliness to urgent services, resulting in a small n.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	4 Business Days	10 Business Days*	97%
First Non-Urgent Service Rendered	6 Business Days	None**	n/a
First Non-Urgent Psychiatry Appointment Offered	5 Business Days	15 Business Days*	100%
First Non-Urgent Psychiatry Service Rendered	21 Business Days	30 Business Days**	38%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	14.83 Hours	48 Hours**	100%
Follow-Up Appointments after Psychiatric Hospitalization	4 Days	7 Days**	90%
No-Show Rate – Psychiatry	19%	18-23%***	n/a
No-Show Rate – Clinicians	20%	18-25%****	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP-defined standard for Children's Services is 18%, Youth and Young Adult (YAYA) Services is 22%, and Adult Services is 23% **** The MHP-defined standard for Children's Services is 20%, Youth and Young Adult (YAYA) Services is 25%, and Adult Services is 18%			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

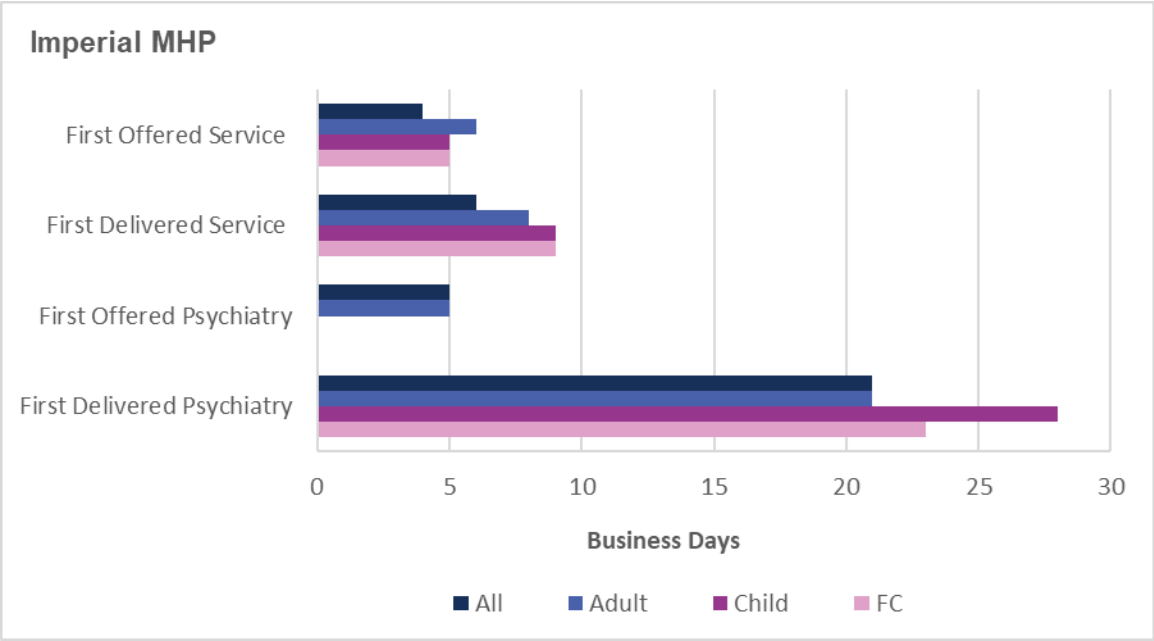


Figure 13: Wait Times for Urgent Services

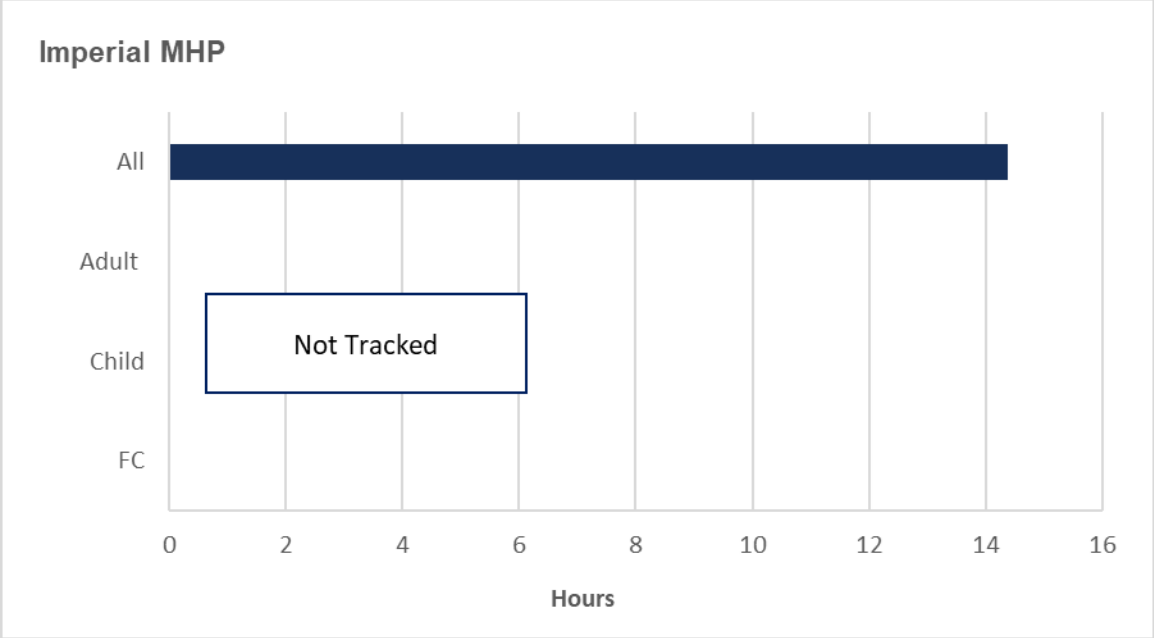
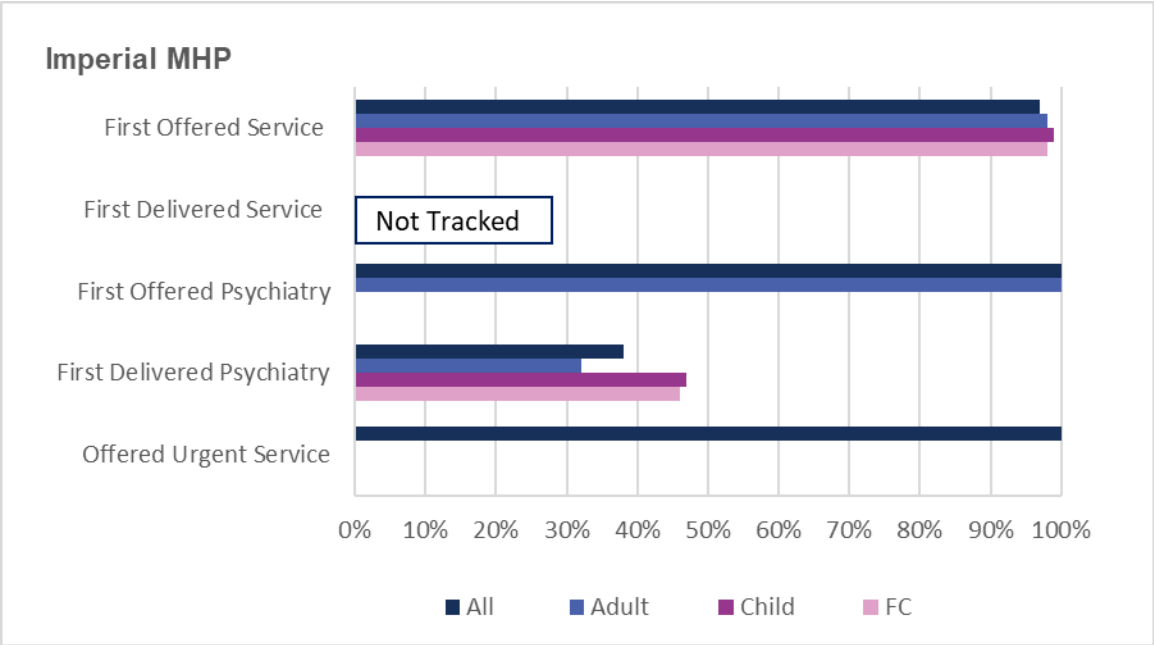


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent intake appointments provided to beneficiaries who request a routine mental health service via the Access Unit.
- Definitions of "urgent services" vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined "urgent services" for purposes of the ATA as services provided in response to an urgent condition. An "urgent condition" is defined by the MHP as "a condition where the individual faces an imminent and serious threat to his or her health and the normal timeframe for a non-urgent appointment would be detrimental to the individual's life or health or could jeopardize the individual's ability to regain maximum function." There were reportedly three urgent service requests with a reported actual wait time to services for the overall population at 14.83 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines first offered non-urgent psychiatry appointment access as those beneficiaries who are in the initial Access Log requesting psychiatry appointments. For first delivered non-urgent psychiatry appointments, timeliness is tracked from when a determination of need has been made by an assessing clinician.

- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked for County-operated services. The MHP reports a no-show rate of 19 percent overall for appointments with psychiatrists and 20 percent overall for appointments with other clinical staff. The MHP sets its standard for no-shows based on identifying the prior year's no-show rate for a given age group and subtracting one percentage point from that rate. This has resulted in different standards for different groups (see Table 11 key for specific standards).

IMPACT OF TIMELINESS FINDINGS

- The MHP has struggled with providing timely access to non-urgent psychiatry appointments (only 38 percent of those referred are seen within 30 days), as well as no-show rates in psychiatry of nearly one in five (19 percent overall). This may provide further reason for the MHP to identify beneficiaries who may be receiving Medication Support services only who could potentially step down from SMHS to be monitored in a mild or moderate setting, possibly freeing up additional appointments and improving timeliness to these services. Prior efforts to improve no-show rates have been largely unsuccessful.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is under the heading of QM, who oversee quality improvements throughout the department, which differs from QA and compliance responsibilities. The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QIWP, and the annual evaluation of the QIWP, included in the annual plan. The QIC, comprised of stakeholders in the MHP and shall include a licensed mental health professional, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met nine times. The MHP does not identify the percentage of goals met as related to their plan. The MHP does offer a summary of the steps taken to verify information and provides updates to QIC. The MHP did not utilize any LOC tools during CY 2021.

The MHP utilizes the following outcomes tools: Behavior and Symptom Identification Scale (BASIS-24), Center for Epidemiologic Studies Depression Scale – Mood Questionnaire (CES-D), Child and Adolescent Needs and Strengths (CANS), Eyberg Child Behavior Inventory (ECBI), Generalized Anxiety Disorder Assessment (GAD-7), Illness Management and Recovery Scale: Client Self-Rating (IMRS), Parenting Stress Index (PSI), Pediatric System Checklist 35 (PSC-35), Patient Health Questionnaire (PHQ-9), Revised Child Anxiety and Depression Scale (RCADS) - Parent, RCADS- Self-Report, UCLA Post Traumatic Stress Reaction Index - Parent (PTSD-RI-Parent), Vanderbilt ADHD Diagnostic Parent Rating Scale and Follow-Up Scale, Vanderbilt ADHD Diagnostic Teacher Rating Scale and Follow-Up Scale, Youth Outcomes Questionnaire Parent (YOQ-Parent), Youth Outcomes Questionnaire Self-Report (YOQ-SR).

The MHP monitors completion of outcome measures, but is still developing capacity to aggregate and analyze outcome data more fully after struggling to get staff sufficiently trained in the use of an analytic dashboard provided by Netsmart. An initial round of reports have been provided to analysts, supervisors, and managers, and MHP leaders hope to continue to expand the use of data once Smartcare has been fully implemented.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	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	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Not met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Not met

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

- Key informants report a collaborative relationship between clinical and medical staff as it pertains to their whole person care.
- The MHP reports on compliance and improvement goals within the QIWP but does not report impact outcomes for beneficiaries.
- The MHP reviews data and is understandably hesitant to make changes to data collection when the new EHR will be onboard and fully functioning within FY 2022-23. This leads to a gap in identifying solutions to ongoing data collection and reporting challenges.
- Key informants reported participating in the QIC, but do not know of other opportunities to participate or have their voice heard. The MHP did not clearly

identify how beneficiaries or family members participate in decisions or discussions throughout the continuum of care.

- Key informants report high caseloads, high probably of burn-out and lack of client movement. There is an absence of understanding within the key informants on how to use the Multi-Disciplinary Team as a tool to move a beneficiary to a lower level of care.
- The MHP tracks and trends data for reporting, but does not aggregate data for identification of QI activities and systemic change.
- The MHP tracks and trends the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)

QUALITY PERFORMANCE MEASURES

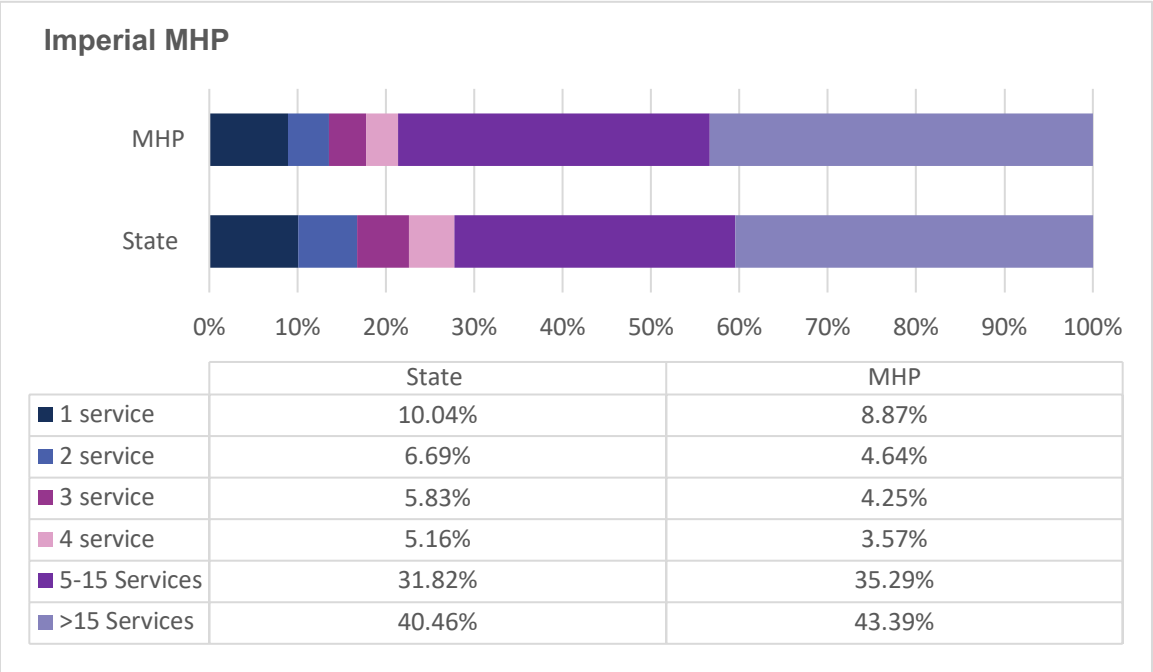
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.04%	8.87%
2 service	6.69%	4.64%
3 service	5.83%	4.25%
4 service	5.16%	3.57%
5-15 Services	31.82%	35.29%
>15 Services	40.46%	43.39%

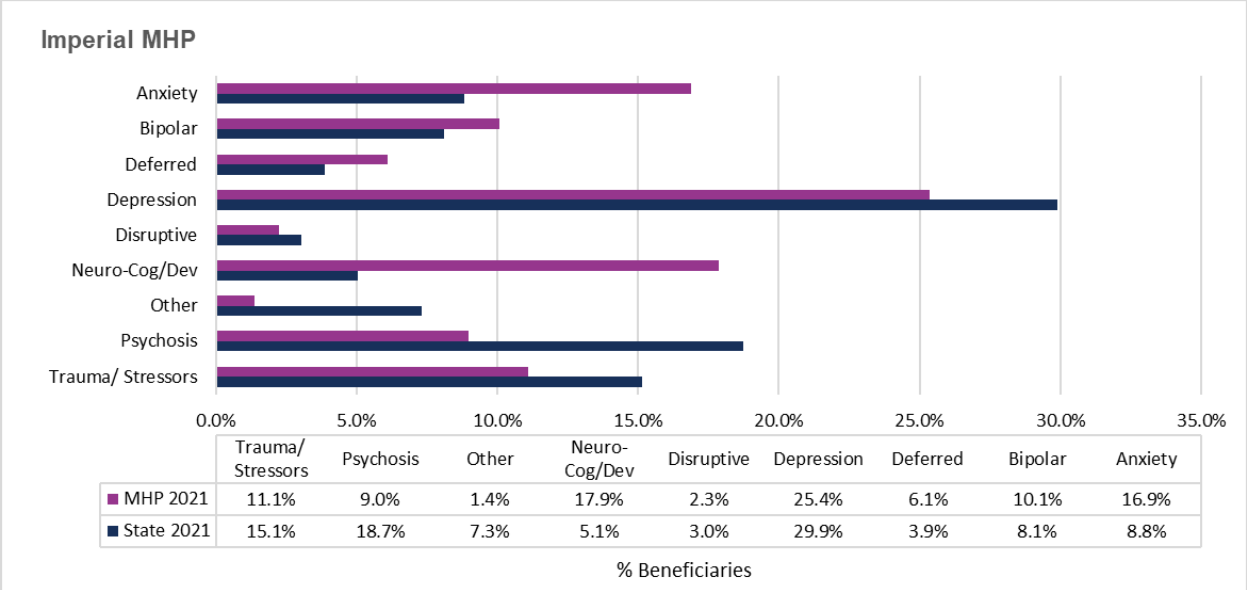
- The MHP had strong retention in services, with over 78 percent of beneficiaries receiving five or more services as compared with 72 percent statewide.

Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment.

Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

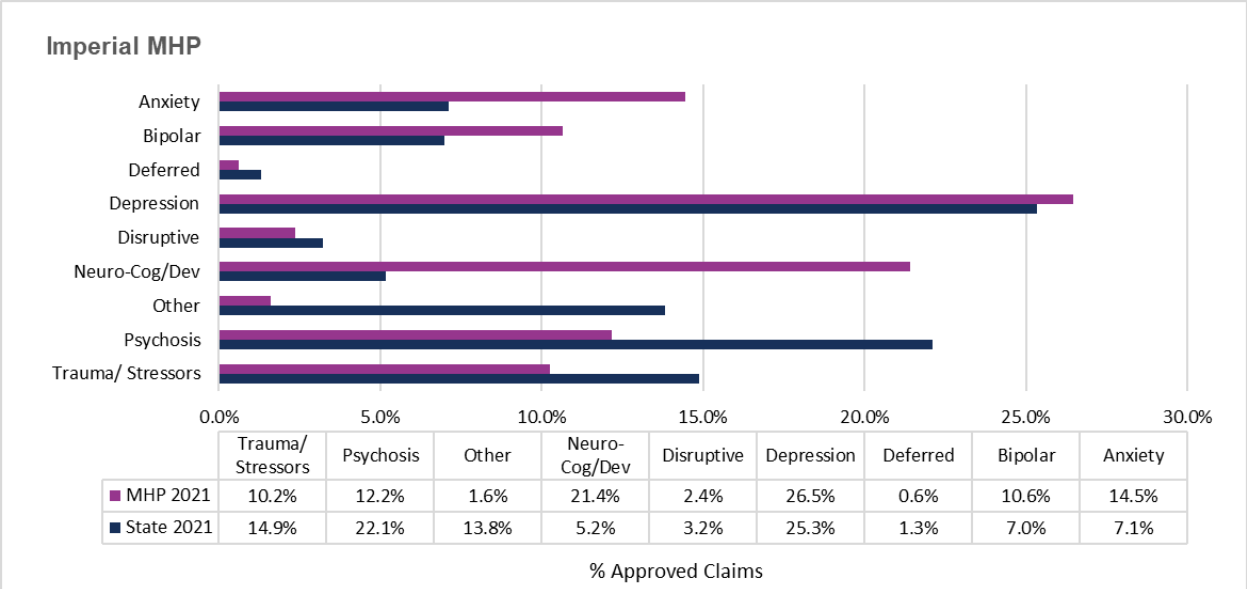
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	11.1%	9.0%	1.4%	17.9%	2.3%	25.4%	6.1%	10.1%	16.9%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- Neurocognitive and Developmental disorders and Anxiety disorders were the most disproportionately overrepresented diagnostic groupings as compared to statewide rates, and Psychosis was the most comparatively underrepresented. These differences may be related to the comparatively high PR for youth ages 6 to 17.

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



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	10.2%	12.2%	1.6%	21.4%	2.4%	26.5%	0.6%	10.6%	14.5%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- Overall, claims were roughly proportionate to diagnostic rates in the MHP.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	63	85	8.96	8.79	$9,579	$12,052	$603,466
CY 2020	62	64	9.35	8.68	$6,789	$11,814	$420,925
CY 2019	82	107	7.84	7.80	$5,848	$10,535	$479,535

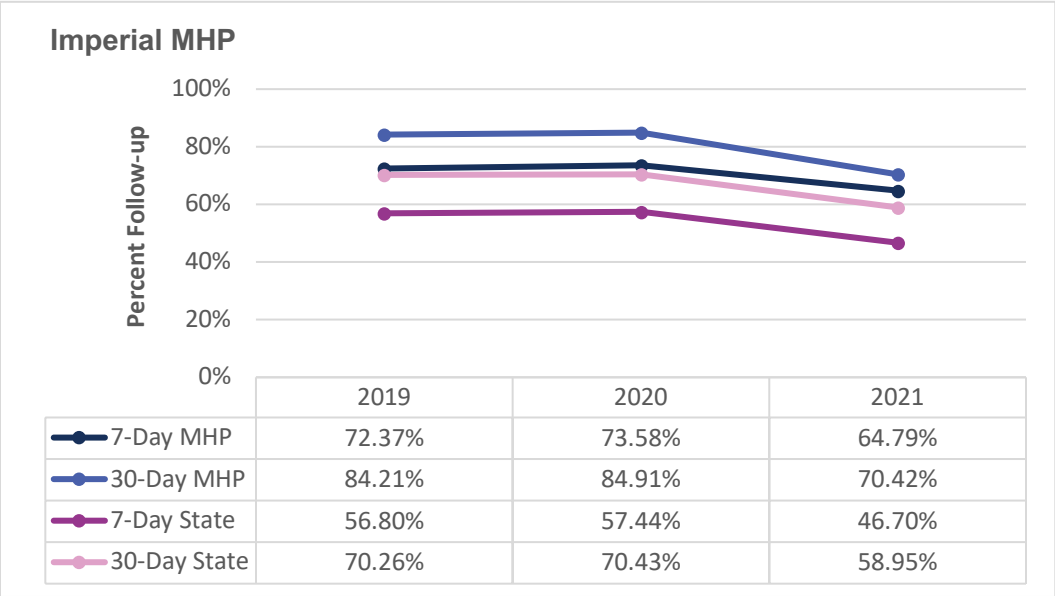
- The number of unique beneficiaries utilizing psychiatric inpatient services was stable from CY 2020 to CY 2021, but the total number of admissions increased. The average number of admissions per beneficiary was 1.35 for CY 2021.
- The average LOS was down slightly from the prior year and was comparable to the statewide average LOS.
- The MHP's AACB for psychiatric inpatient services has increased yearly over the past three years but remains lower than the statewide AACB. The increase in total approved claims from CY 2020 to CY 2021 is roughly commensurate with the increase in total admissions.

Follow-Up Post Hospital Discharge and Readmission Rates

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

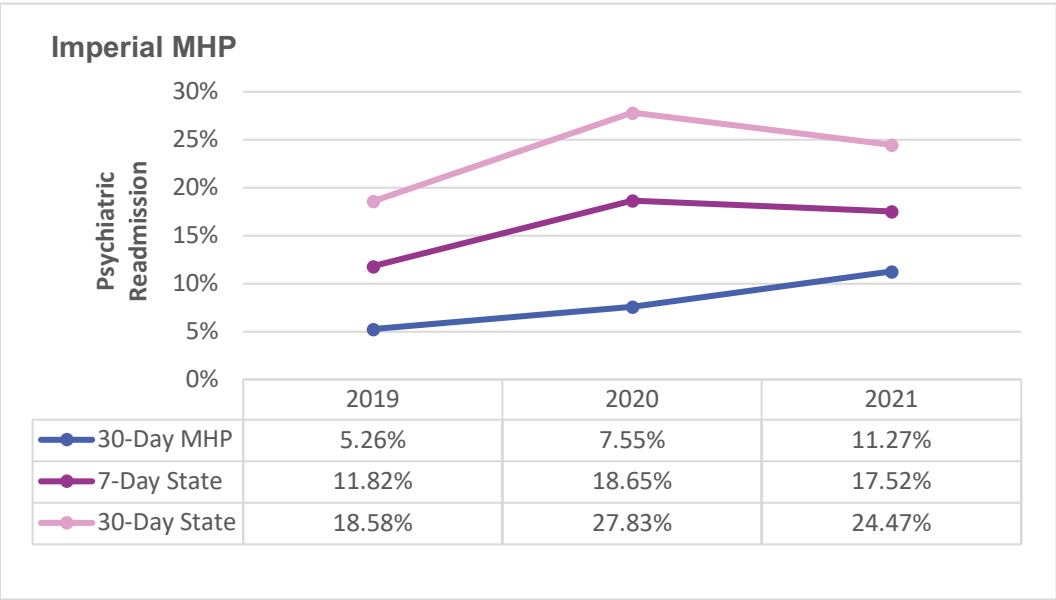
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	72.37%	73.58%	64.79%
30-Day MHP	84.21%	84.91%	70.42%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

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



	2019	2020	2021
30-Day MHP	5.26%	7.55%	11.27%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- Both 7- and 30-day post psychiatric follow-up rates were much higher in the MHP than statewide, despite decreases in rates for both points in time in CY 2021.
- The MHP's 7-day readmission rate is suppressed in Figure 19 due to the small number of beneficiaries readmitted within that timeframe. However, it did increase in CY 2021 after remaining fairly stable, and extremely low, in CY 2019 and CY 2020. 30-day readmissions increased as well, but to a lesser degree.

- Both 7- and 30-day readmission rates in the MHP are much lower than those seen statewide.

High-Cost Beneficiaries

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

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

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	3.46%	28.46%	$1,007,853,748	$53,476	$43,231
MHP	CY 2021	99	1.49%	12.34%	$4,519,423	$45,651	$39,901
	CY 2020	125	1.85%	13.61%	$5,351,167	$42,809	$37,424
	CY 2019	136	1.74%	13.80%	$5,944,191	$43,707	$37,619

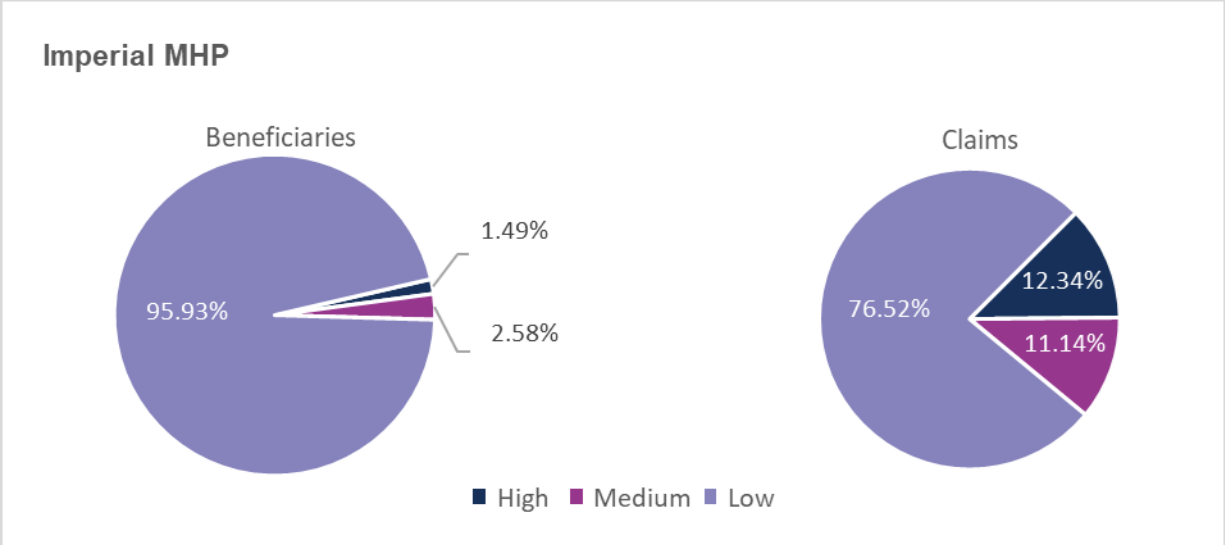
- The total count of HCBs was down from the prior two years and represents a smaller percentage of beneficiaries than statewide. HCBs represented 12.34 percent of claims in the MHP as compared to 28.46 percent statewide.
- Both average and median approved claims per HCB were lower in the MHP than statewide, despite increasing over the past three years.

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	172	2.58%	11.14%	$4,078,484	$23,712	$23,365
Low Cost (Less than $20K)	6,394	95.93%	76.52%	$28,022,536	$4,383	$3,126

- Almost 96 percent of beneficiaries fell into the Low-Cost category, and the median approved claims per beneficiary in that category was $3,126. Less than 3 percent of beneficiaries fell into the Medium Cost category, with a median approved claims per beneficiary of $23,365.

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



- Low-Cost beneficiaries made up almost 96 percent of beneficiaries served and represented almost 77 percent of claims.
- Medium Cost beneficiaries represented almost 3 percent of beneficiaries and about 11 percent of claims.
- HCBs represented about 1.5 percent of beneficiaries served and about 12 percent of claims.

IMPACT OF QUALITY FINDINGS

- While the average number of psychiatric inpatient admissions per beneficiary receiving those services increased from CY 2020 to CY 2021, it was comparable to the CY 2019 average and the unique beneficiary count remains lower than CY 2019. The MHP has consistently excelled in providing follow-up services to those exiting psychiatric inpatient services and its readmission rates, which are consistently lower than statewide rates, appear to reflect these efforts.
- Without management intervention in identifying a movement of beneficiaries to a lower level of care, key informants report a high probability of continued workforce decline.
- Key informants have reported a desire to participate in stakeholder meetings within the MHP, and to access paid peer work opportunities.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: "Reducing Psychiatric Emergencies-HOPE Program"

Date Started: 07/2022

Aim Statement: "Will youth aged 13 to 25 years old receiving intensive after care services through the Holistic Outreach Prevention and Engagement (HOPE) program decrease psychiatric emergency admissions by 5 percentage points by one year of the PIP?"

Target Population: "This PIP will focus on individuals ages 13 to 25 years old, active and inactive with the MHP, who experience a psychiatric emergency (5150 or inpatient psychiatric hospitalization) and are referred to the HOPE program for intensive after care services."

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

[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

Summary

The PIP proposes to decrease the number of psychiatric emergencies for youth by coordinating care and providing support utilizing the HOPE Program, as an intervention to focus on holistic specialized services focused on wellness activities to assist emotional, physical, spiritual and mental health needs.

The interventions consists of community service workers, peer supporters and mental health professional staff from the youth and young adult division providing supportive services to youth who have experienced a psychiatric emergency. The activity depends on the youth's interests regarding the available wellness activities

First remeasurement results are pending and have not yet been analyzed.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: based on the PIP presentation, there are no clinical interactions or tools that would identify a change in readmission rate. The PIP uses the HOPE program which focuses on wellness activities based on the client's interest.

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

- The MHP is recommended to look at CANS scores of the youth entering the HOPE program and identify changes in the CANS scores that directly correlate with the wellness activities the youth choose in the program.
- The MHP is recommended to aggregate and trend youth CANS scores for those entering the HOPE program. The MHP can then identify specific trends in clinical care needs and tailor outpatient treatment to this population.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: "Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)"

Date Started: 09/2022

Aim Statement: "For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7- and 30-days by five percentage points by June 30, 2023."

Target Population: "The target population for this project will be operationalized within the parameters of the HEDIS FUM metric. The MHP will focus on beneficiaries with a

qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm."

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

Summary

For individuals with mental illness, care coordination practices and related data exchange processes can cause delays in receiving services after leaving the ED. In efforts to "aim for excellence" and meet the 90th percentile national benchmark of client follow-up after ED visits for mental illness, the MHP seeks to enhance its relationship with the two local hospitals and streamline the process of screening and referral at the ED. The MHP and local ED lack a protocol that addresses the need for comprehensive screening for individuals accessing local EDs that identifies when MH treatment is required.

The MHP and local EDs lack a sufficient system and processes to initiate, track, and close referrals loops which results in a service gap for individuals visiting the ED that are not experiencing a psychiatric emergency. This creates gaps in identifying client's treatment needs.

The MHP plans on assigning a referral liaison, to monitor and provide care coordination for referrals received through local EDs. The referral liaison will provide reminders, scheduling and rescheduling follow-up appointments and update clinical teams regarding status of case.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the validation rating of moderate confidence has to do with the condition and ability of local hospital participation and has little to do with the MHP. The MHP has set bi-monthly meetings; however, one of the two accessible hospitals is unable to accommodate meetings, as the hospital itself is going through a major transition and is at risk of closing. The other hospital has agreed to email information through the Access Email.

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

- The MHP sought TA throughout the year while formulating the PIP.
- The MHP is recommended to create a Memorandum of Understanding with both hospitals.
- Through discussion the MHP relayed a possible work around by identifying gap individuals through their triage unit.
- It is recommended to continue brokering the lines of communication with the local hospitals as the best course of action towards shared data exchange.

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 NetSmart/MyAvatar, which has been in use for 19 years. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 5 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). This represents a slight increase in the budgetary allocation from the prior year. The budget determination process for IS operations is under MHP control.

The MHP has 497 named users with log-on authority to the EHR, including approximately 476 county staff and 21 contractor staff. Support for the users is provided by 11 full-time equivalent (FTE) IS technology positions. This is the same number of positions dedicated to IS as the prior year, though one previously vacant position has been filled since the prior EQR. Currently all positions are filled.

As of the FY 2022-23 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 beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☒ Weekly ☒ Monthly	75%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☒ Weekly ☒ Monthly	25%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP currently provides beneficiaries with PHR access which allows beneficiaries to view upcoming appointments, receive appointment reminders, view active prescriptions, and send and receive secure messages.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Federally Qualified Health Center, contracted mental health providers, and hospitals.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- While the county does not currently have a Data Warehouse, this is something that will be implemented as part of the new EHR system.
- The MHP has a low claims denial rate of 1.23 percent, as compared to the statewide rate of 2.78 percent. This reflects the staff's attention to putting strong policies, procedures, and cross-training strategies in place to support accurate claiming.
- There are some opportunities for improvement in the MHP's security measures. For example, the MHP could implement two-factor authentication for increased security when changing passwords, and identify a standard timeline to restore the EHR in the event continuity is disrupted.
- While interoperability with CBOs is currently sufficient to meet the Interoperability Key Component, not all contracted providers have access to the EHR, and not all of those that do have access to the same functions. The move to Smartcare presents an opportunity to improve interoperability.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

For the MHP, it appears that significant claims lag begins in October 2021 and likely represents about $4,399,300 in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through the period under review.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	12,302	$3,131,726	$16,591	0.53%	$3,115,135
Feb	13,149	$3,331,480	$63,188	1.90%	$3,268,292
Mar	14,559	$3,718,365	$162,531	4.37%	$3,555,834
April	15,286	$4,014,697	$160,716	4.00%	$3,853,981
May	13,693	$3,531,415	$9,624	0.27%	$3,521,791
June	13,509	$3,436,798	$7,776	0.23%	$3,429,022
July	12,219	$3,297,670	$4,672	0.14%	$3,292,998
Aug	13,049	$3,340,924	$3,358	0.10%	$3,337,566
Sept	12,202	$3,106,305	$6,072	0.20%	$3,100,233
Oct	11,608	$3,103,050	$13,849	0.45%	$3,089,201
Nov	9,811	$2,670,867	$1,117	0.04%	$2,669,750
Dec	0	$0	$0	0.00%	$0
Total	**141,387**	**$36,683,297**	**$449,494**	**1.23%**	**$36,233,803**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
NPI related	1,049	$206,405	45.92%
Service line is a duplicate and a repeat service procedure code modifier not present	421	$151,105	33.62%
Beneficiary not eligible or non-covered charges	119	$38,997	8.68%
Claim/service lacks information which is needed for adjudication	81	$29,182	6.49%
Medicare Part B or Other Health Coverage must be billed before submission of claim	62	$22,657	5.04%
Other	3	$1,146	0.25%
Total Denied Claims	1,735	$449,492	100.00%
Overall Denied Claims Rate	**1.23%**		
Statewide Overall Denied Claims Rate	**2.78%**		

- The majority of denied claims, and denied claimed dollars, were denied for NPI related reasons.
- The MHP's overall denied claims rate of 1.23 percent is lower than the statewide average of 2.78 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP is executing a well-supported transition to Smartcare as a pilot county working with CalMHSA. The last round of data conversion has been completed and the county is currently working on training staff in conjunction with CalMHSA, with whom they have a robust partnership on this project.
- The MHP has moved forward with a number of other important IS initiatives, including redesigning progress notes as part of CalAIM documentation reform, working with DHCS to ensure they can send the 274 record transaction file, and working to identify a suitable HIE to support interoperability.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP provided the required CPS to all beneficiaries. Key informants reported filling out the survey but have not received the results nor do they know where they can find the results of the survey. The MHP did not identify improvements based on the CPS findings.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held in-person for participants at the MHP Wellness Center which provided a virtual environment for CalEQRO staff and included seven participants. All consumers participating receive clinical services from the MHP.

Key informants are overall pleased with the services they receive and are satisfied with timeliness of those services. If a clinician is needed prior to a scheduled appointment, they felt that service was available to them.

Key informants expressed how elated they were to be once again using the Wellness Centers. Wellness Centers are back to being fully opened and having access to support groups or activities in-person rather than a virtual experience.

A few English-speaking key informants mentioned not feeling welcomed when attending support groups at the clinics because most people attending those groups were

speaking Spanish with no English interpretation, making them feel unwelcomed or uncomfortable, which they stated negatively impacted their mental health.

Recommendations from focus group participants included:

- “Having someone interpret Spanish for English speaking support group participants.”
- “Bring back field trip/social type activities to the Wellness Centers.”
- “Hold group discussions on Bi-polar and Depression.”
- “How to use resources available, practical workshops, such as completing applications and advocacy.”

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall, the beneficiaries were pleased with services received. Of note, most participants were receiving medication only and outpatient clinical service approximately every two months. Some participants did not know the difference between a clinician or a psychiatrist. The group actively participates in Wellness Center activities and would like more opportunities for employment verses unpaid volunteers.

CONCLUSIONS

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

STRENGTHS

1. Due to the vast array of mental health services offered, the MHP continues to trend low inpatient rates. (Access, Timeliness, Quality)
2. The MHP partnered with Child Welfare System, and Probation to hand-count FC data and report an accurate number of rendered services. (Access, Timeliness, Quality)
3. The MHP is participating as a pilot county for SmartCare EHR. This opportunity will allow the county to contribute to the design and implementation of the EHR. (IS)
4. The Wellness Center reopened, offering in-person support groups, volunteer opportunities, and clinical services. (Quality)
5. The MHP reallocated staff resources and created more intake slots to promote easier access; this has been shown to improve access across all demographic groups. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP will be renovating the youth and family outpatient clinic, which would allow for the engagement of youth and families to have a say in what they feel would be a beneficial and welcoming environment for treatment. (Quality)
2. The county identifies Community Service Workers or Mental Health Associates as individuals that may have lived experience, but these positions are not directly peer-based employment with opportunities for upward mobility. Beneficiaries would like to see more opportunities for paid employment. (Quality)
3. The MHP does not report a standard percentage to identify no-show rates for psychiatrists and clinicians; beneficiaries reported that wait times to psychiatry are lengthy with no other method to obtain an urgent appointment. Inaccurate tracking may lead to the inability to trend data for system-wide improvements. (Timeliness)
4. High staff vacancy rates and high caseloads make utilizing a LOC tool difficult to enforce and leads to stagnation in services when beneficiaries cannot move fluidly throughout the continuum of care. (Timeliness, Quality)

5. The MHP identifies compliance goals and expectations on their QIWP; however, it is unclear if the obtained outcome impacted the beneficiary experience, treatment, and recovery, based on the outcomes presented. (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 beneficiary outcomes:

1. Engage youth and families to actively participate in the design and functionality of the upcoming youth and family outpatient clinic remodel. (Quality)
2. Identify and implement paid peer employment opportunities within contracted services and engage the HR department in peer employment discussions that include peer billing. (Quality)
3. Provide training opportunities to IS staff to identify the best use of the analytic functionalities in the new EHR. Produce, review, and make recommendations for service data on a routine basis that tracks and trends Access and Timeliness data across the continuum. (Access, Timeliness, IS, Quality)
4. Examine step-down procedures for beneficiaries who receive only Medication Support services to determine whether this may impact non-urgent psychiatry capacity in the MHP. Identify a LOC tool that will allow clinicians to move beneficiaries to lower levels of care to reduce lengthy wait times, high caseloads, and staffing burnout. (Timeliness, Quality)
5. Expand on outcome goals within the QIWP by identifying impact goals that coincide with achieved compliance goals. Utilize information about the beneficiary experience, including goal-specific surveys, LOC tools, and/or client perception survey results. (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 2022-23 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT F: PM Data CY 2021 Refresh

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Imperial MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
EHR Deployment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Kiran Sahota, Lead Quality Reviewer
Leah Hanzlicek, Information Systems Reviewer
Gloria Marin, 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.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Aramburo	Rosalva	Program Supervisor	ICBHS
Astorga	Alan	Mental Health Rehabilitation Specialist	ICBHS
Barker	Andrea	Behavioral Health Manager	ICBHS
Bazan	Sylvia	Behavioral Health Manager	ICBHS
Cardoza	Joaquin	Mental Health Rehabilitation Technician	ICBHS
Castillo	Julius	Psychiatric Technician	ICBHS
Contreras	Sonia	Behavioral Health Manager	ICBHS
DeChenne	Jessica	Administrative Analyst	ICBHS
Del Real	Nancy	Deputy Director	ICBHS
Esquer	Mary	Behavioral Health Manager	ICBHS
Esquer	Ramona	Therapist	Center for Family Solutions
Estrada	Adolfo	Behavioral Health Manager	ICBHS
Flores	Arely	Program Supervisor	ICBHS
Jimenez	Gabriela	Assistant Director	ICBHS
Jurado	Andrea	Program Supervisor	ICBHS
Lepe	Jose	Deputy Director	ICBHS
Lopez	Anais	Program Supervisor	ICBHS
Lopez	Jacqueline	Psychiatric Technician	ICBHS

Last Name	First Name	Position	County or Contracted Agency
Lozano	Nicole	Mental Health Rehabilitation Technician	ICBHS
Madrigal	Cinthia	Administrative Analyst	ICBHS
Magana	Mariana	Behavioral Health Therapist	ICBHS
Manriquez	Victor	Behavioral Health Manager	ICBHS
Martinez	Nicole	Administrative Analyst	ICBHS
Mata	Melissa	Office Supervisor	ICBHS
Moore	Sarah	Behavioral Health Manager	ICBHS
Patino	Priscilla	Behavioral Health Manager	ICBHS
Pesqueira	Dalia	Behavioral Health Manager	ICBHS
Pineda	Jessica	Behavioral Health Manager	ICBHS
Plancarte	Leticia	Director	ICBHS
Quezada	Victor	Mental Health Rehabilitation Technician	ICBHS
Rosas	Jonathan	Behavioral Health Therapist	ICBHS
Ruiz	Alex	Behavioral Health Therapist	ICBHS
Ruiz	Alfonso	Behavioral Health Manager	ICBHS
Sanchez	Brenda	Deputy Director	ICBHS
Smith	Matthew	Program Supervisor	ICBHS
Soto	Stephanie	Mental Health Rehabilitation Technician	ICBHS
Taylor	Ryan	Administrative Analyst	ICBHS

Last Name	First Name	Position	County or Contracted Agency
Torres	Victor	Behavioral Health Manager	ICBHS
Uribe	Stephanie	Psychiatric Technician	ICBHS
Welzein	Anna	Behavioral Health Manager	ICBHS
Wyatt	Maria	Behavioral Health Manager	ICBHS
Zarate	Francisco	Behavioral Health Manager	ICBHS

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The PIP as submitted uses the Holistic Outreach Prevention and Engagement (HOPE) program which focuses on wellness activities based on the youth's interest. Based on how the PIP is currently presented there are no clinical interactions or tools that would identify a change in readmission rate.
General PIP Information	
MHP/DMC-ODS Name: Imperial	
PIP Title: "Reducing Psychiatric Emergencies-HOPE Program"	
PIP Aim Statement: "Will youth aged 13 to 25 years old receiving intensive after care services through the HOPE program decrease psychiatric emergency admissions by 5 percentage points by one year of the PIP?".	
Date Started: 07/2022	
Date Completed: n/a	
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): "This PIP will focus on individuals ages 13 to 25 years old, active and inactive with the MHP, who experience a psychiatric emergency (5150 or inpatient psychiatric hospitalization) and are referred to the HOPE program for intensive after care 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): Beneficiaries will participate in the HOPE program.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Youth will be referred to the HOPE program. The MHP will provide A mental health rehabilitation technician and peer supporter.

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
PM 1. Decrease psychiatric emergencies for Youth & Young Adults receiving the HOPE Program Services	7/1/2022	Youth & Young Adults Age Group (Active/Inactive) 429/184=43% psychiatric emergencies admissions rate	☐ Not applicable—PIP is in Planning or implementation phase, results not available	Q1- FY 2022-23 7/22-9/22 132/56=42% 132 total psychiatric admissions/56 admissions for YAYA age group (active/inactive)	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☒ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • The MHP is recommended to look at CANS scores of the youth entering the HOPE program and identify changes in the CANS scores that directly correlate with the wellness activities the youth choose in the program. • The MHP is recommended to aggregate and trend youth CANS scores for those entering the HOPE program. The MHP can then identify any specific trends in clinical care needs and tailor outpatient treatment to this population of youth.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The validation rating of moderate confidence has to do with the condition and ability of local hospital participation and has little to do with the MHP. The MHP has set bi-monthly meetings; however, one of the two accessible hospitals is unable to accommodate meetings, as the hospital itself is going through a major transition and is at risk of closing. The MHP does utilize a workaround by reviewing referrals through their triage unit to identify individuals that may have a referral from the local hospital. The MHP is hopeful to continue to work towards a collaborative relationship with hospital staff and will continue this PIP for another year.

General PIP Information
MHP/DMC-ODS Name: Imperial
PIP Title: BHQIP-PIP Follow-up after ED visit for Mental Illness (FUM)
PIP Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percentage points by June 30, 2023.
Date Started: 9/2022
Date Completed: n/a
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): "The target population for this project will be operationalized within the parameters of the HEDIS FUM metric. The MHP will focus on beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm."
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Provide the MHP with follow-up referrals for individuals that enter the hospital ED with a MH condition.
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): Work with local hospitals to receive information on individuals who enter the hospital ED but are not referred for MH services to the MHP. Identify a referral system for interoperability.

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
For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP	CY 2021	Within 7 days: 184/277=66% Within 30 days: 202/277=73%	☒ Not applicable—PIP is in Planning or implementation phase, results not available	158 Emergency Department- Mental Health Count: 158	☐ Yes ☐ No **n/a**	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☒ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • The MHP sought TA throughout the year while formulating the PIP. • The MHP is recommended to create a Memorandum of Understanding with both hospitals. • Through discussion the MHP relayed a possible work around by identifying individuals through their triage unit. It is recommended to continue to broker the lines of communication with the local hospitals as the best course of action towards shared data exchange.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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

ATTACHMENT F: PM DATA CY 2021 REFRESH

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

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

BHC | Behavioral Health Concepts, Inc

Imperial MHP Performance Measures

REFRESHED

FY22-23

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	99,540	7,072	7.10%	$40,890,167	$5,782
CY 2020	94,552	6,753	7.14%	$39,318,393	$5,822
CY 2019	94,138	7,808	8.29%	$43,073,044	$5,517

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

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	10,836	258	2.38%	1.27%	1.96%
Ages 6-17	24,924	2,656	10.66%	5.74%	5.93%
Ages 18-20	5,291	388	7.33%	4.89%	4.41%
Ages 21-64	45,582	3,371	7.40%	4.73%	4.56%
Ages 65+	12,909	399	3.09%	2.45%	1.95%
Total	**99,540**	**7,072**	**7.10%**	**4.39%**	**4.34%**

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	2,824	39.93%
Threshold language source: Open Data per BHIN 20-070		

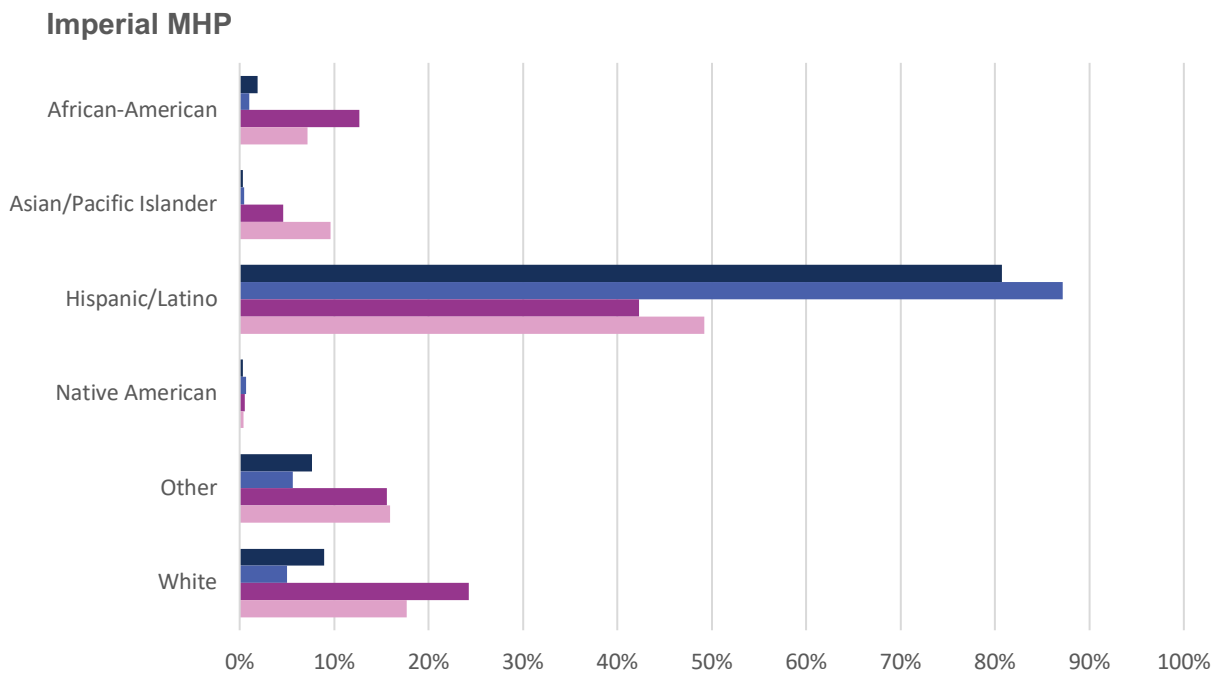
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	25,456	1,712	6.73%	$8,868,160	$5,180
Small	199,673	7,709	3.86%	$45,313,502	$5,878
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	984	136	13.82%	7.64%
Asian/Pacific Islander	464	23	4.96%	2.08%
Hispanic/Latino	86,781	5,711	6.58%	3.74%
Native American	697	26	3.73%	6.33%
Other	5,625	543	9.65%	4.25%
White	4,991	633	12.68%	5.96%
Total	**99,542**	**7,072**	**7.10%**	**4.34%**

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



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	9%	8%	0%	81%	0%	2%
MHP % Eligible	5%	6%	1%	87%	0%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

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

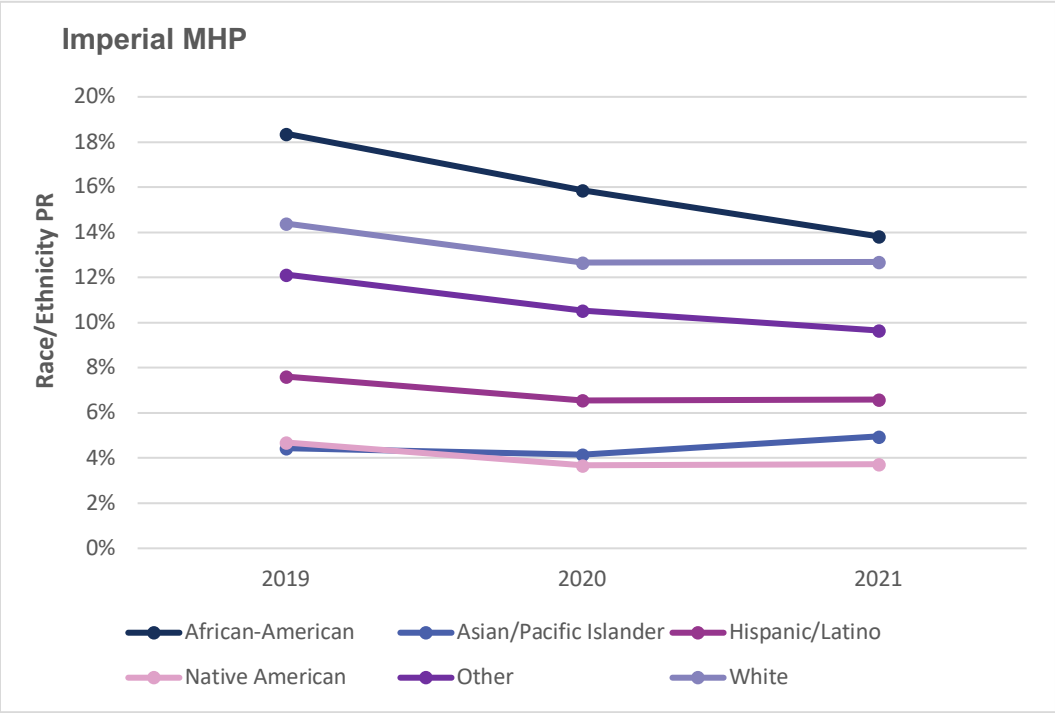


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

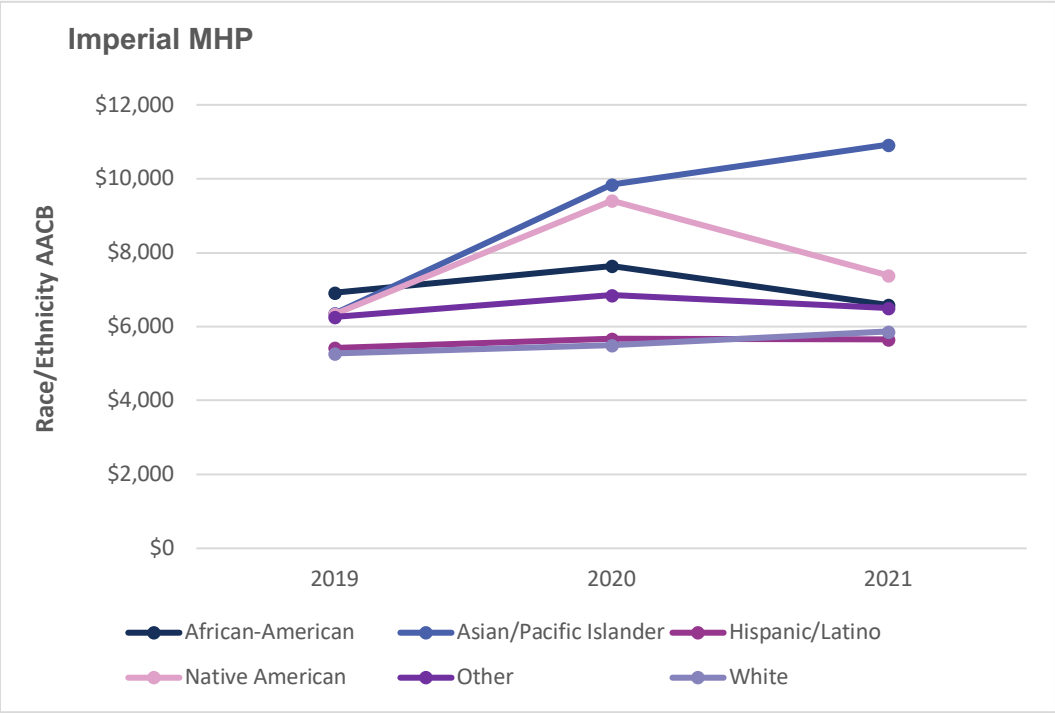
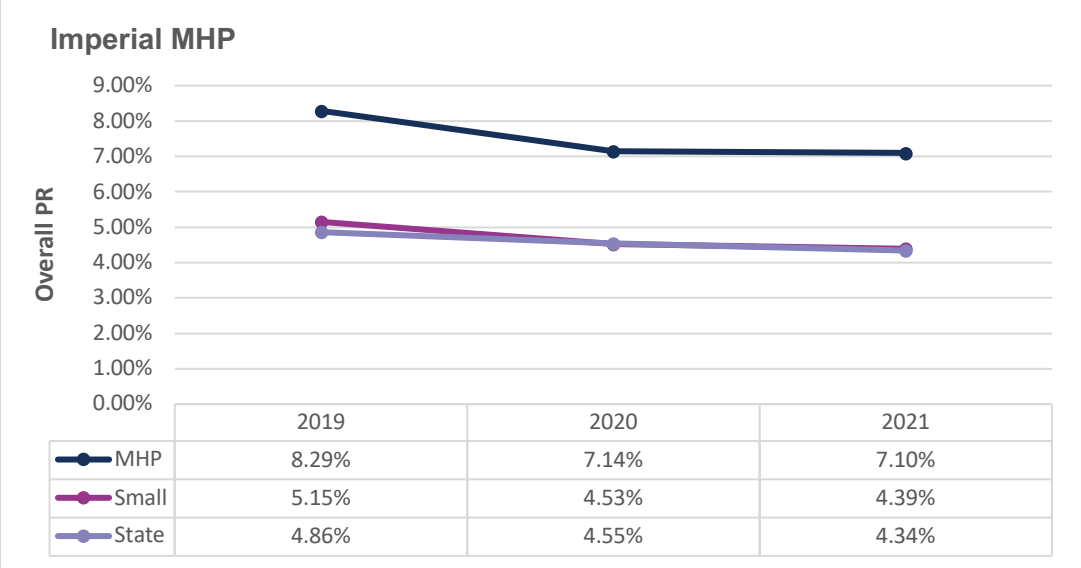
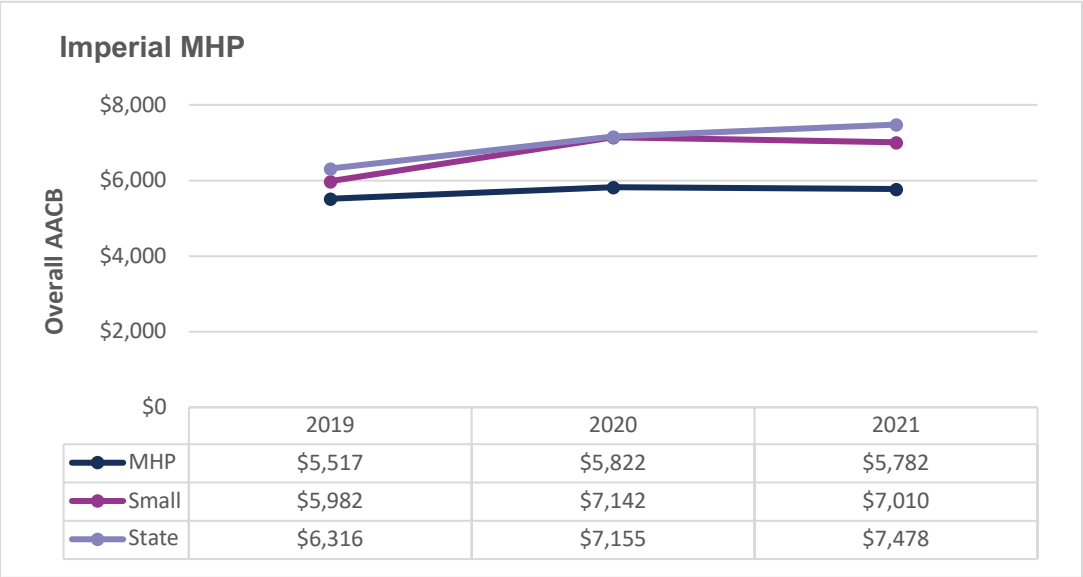


Figure 4: Overall PR CY 2019-21



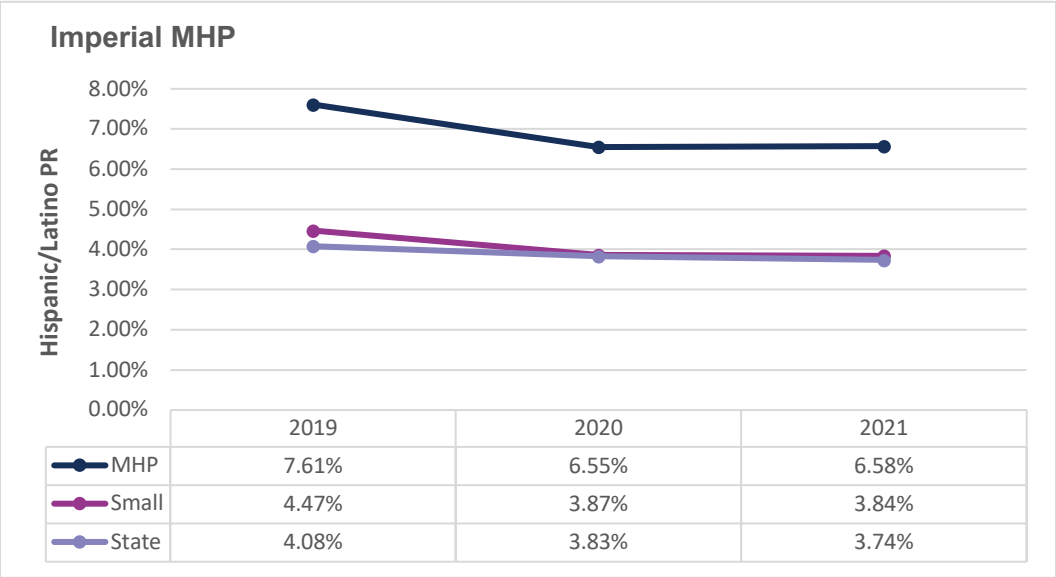
	2019	2020	2021
MHP	8.29%	7.14%	7.10%
Small	5.15%	4.53%	4.39%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



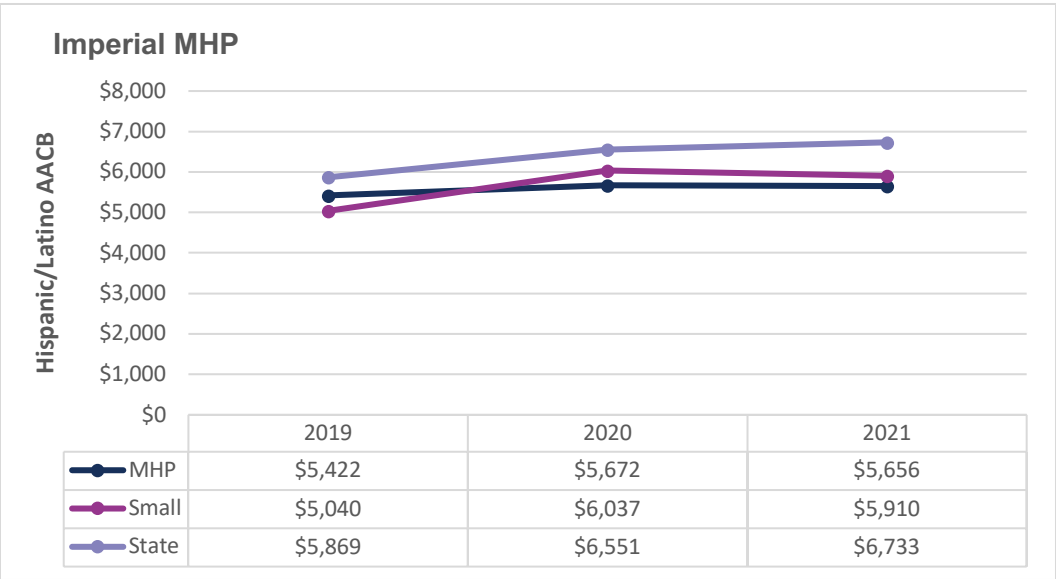
	2019	2020	2021
MHP	$5,517	$5,822	$5,782
Small	$5,982	$7,142	$7,010
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21



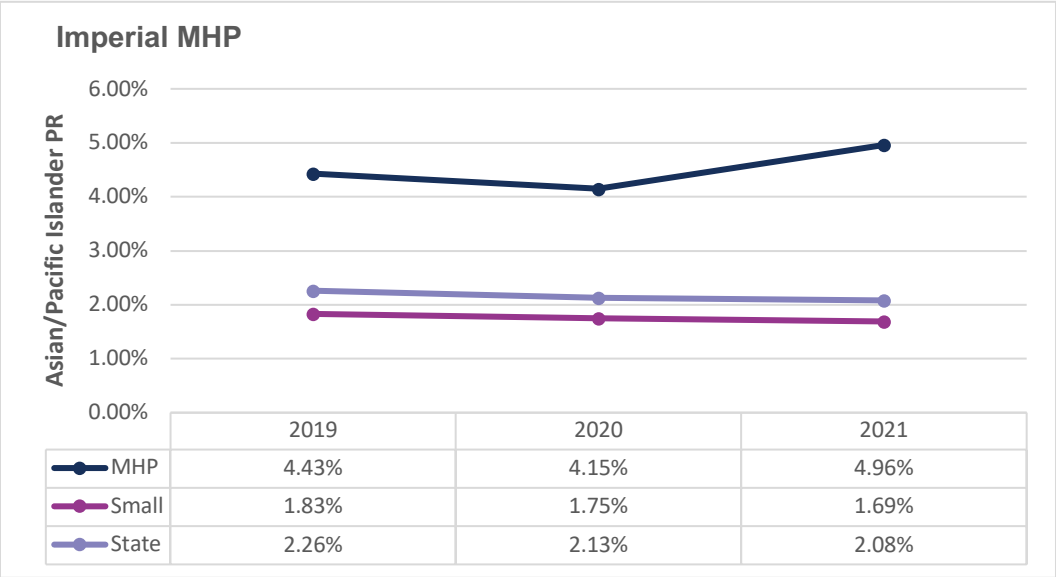
	2019	2020	2021
MHP	7.61%	6.55%	6.58%
Small	4.47%	3.87%	3.84%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21



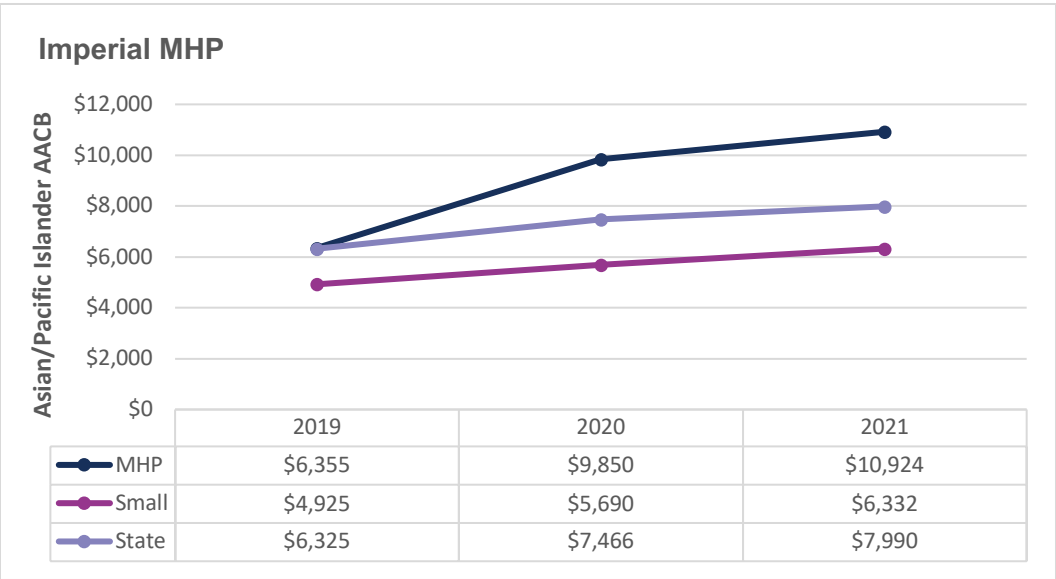
	2019	2020	2021
MHP	$5,422	$5,672	$5,656
Small	$5,040	$6,037	$5,910
State	$5,869	$6,551	$6,733

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



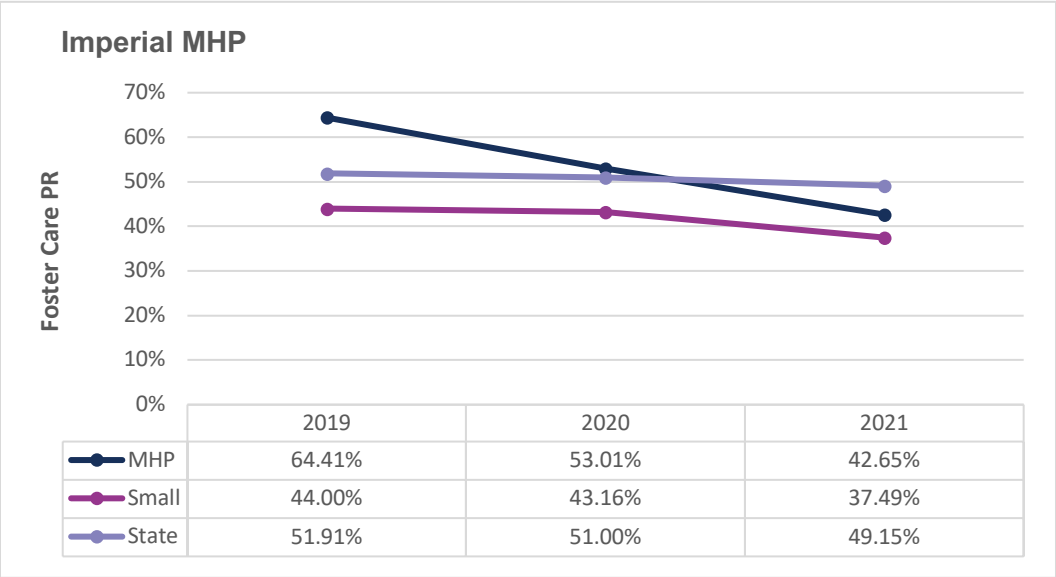
	2019	2020	2021
MHP	4.43%	4.15%	4.96%
Small	1.83%	1.75%	1.69%
State	2.26%	2.13%	2.08%

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



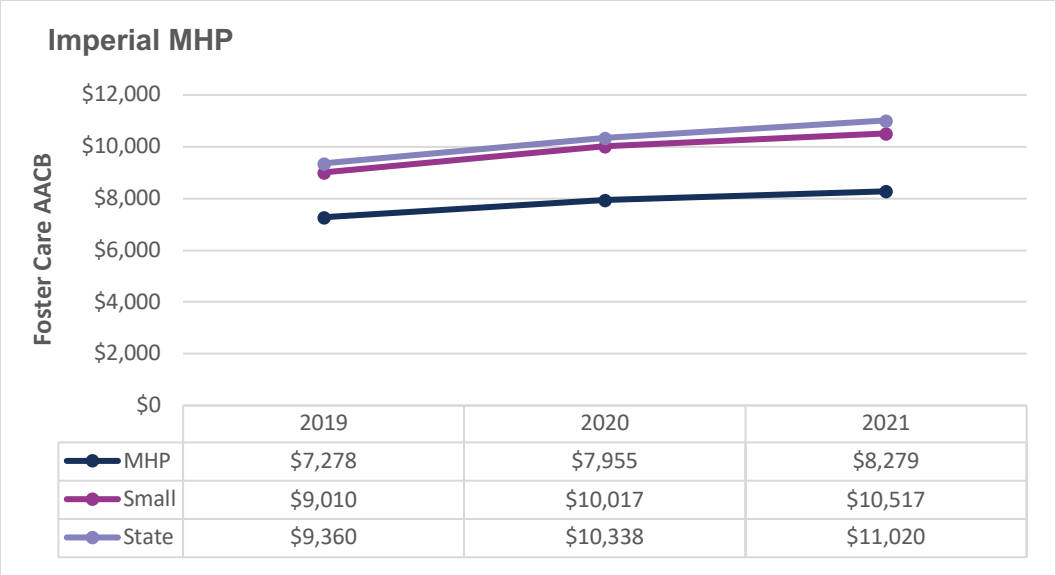
	2019	2020	2021
MHP	$6,355	$9,850	$10,924
Small	$4,925	$5,690	$6,332
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	64.41%	53.01%	42.65%
Small	44.00%	43.16%	37.49%
State	51.91%	51.00%	49.15%

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$7,278	$7,955	$8,279
Small	$9,010	$10,017	$10,517
State	$9,360	$10,338	$11,020

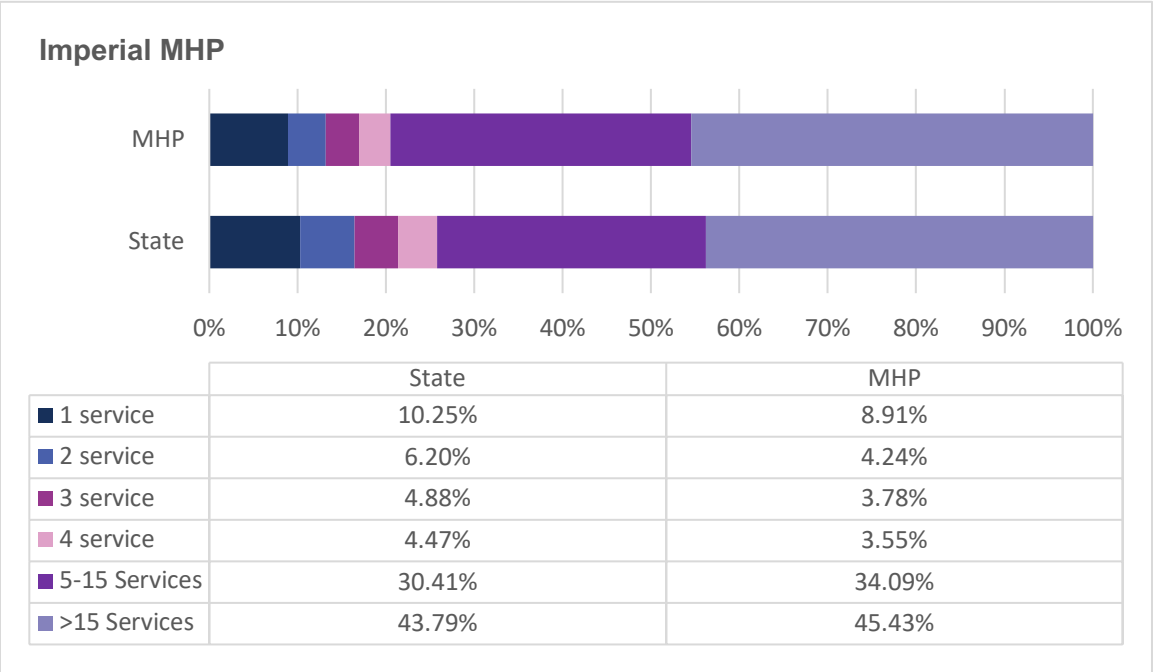
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 4,158				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	52	1.3%	8	6	11.6%	16	8
Inpatient Admin	<11	-	13	13	0.5%	23	7
Psychiatric Health Facility	<11	-	10	10	1.3%	15	7
Residential	11	0.3%	29	41	0.4%	107	79
Crisis Residential	98	2.4%	3	2	2.2%	21	14
Per Minute Services							
Crisis Stabilization	28	0.7%	1,384	1,200	13.0%	1,546	1,200
Crisis Intervention	452	10.9%	501	211	12.8%	248	150
Medication Support	3,138	75.5%	367	305	60.1%	311	204
Mental Health Services	3,243	78.0%	576	259	65.1%	868	353
Targeted Case Management	509	12.2%	247	132	36.5%	434	137

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

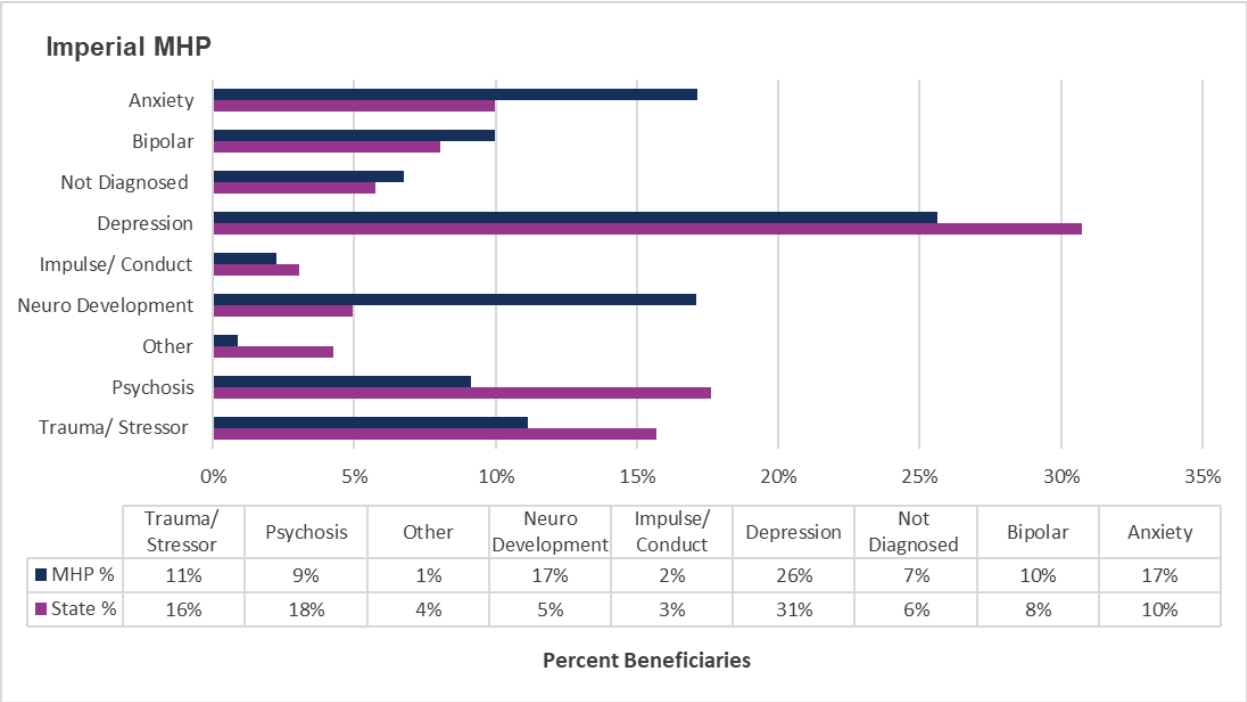
Service Category	MHP N = 230				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	0	0	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	<11	-	18	18	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	1,200	1,200	3.1%	1,404	1,200
Crisis Intervention	18	7.8%	245	163	7.5%	406	199
Medication Support	131	57.0%	527	490	28.2%	396	273
TBS	<11	-	4,193	2,687	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	26	11.3%	856	310	40.2%	1,354	473
Intensive Home Based Services	44	19.1%	1,458	967	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	226	98.3%	1,186	743	96.3%	1,854	1,108
Targeted Case Management	28	12.2%	126	50	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	8.91%
2 service	6.20%	4.24%
3 service	4.88%	3.78%
4 service	4.47%	3.55%
5-15 Services	30.41%	34.09%
>15 Services	43.79%	45.43%

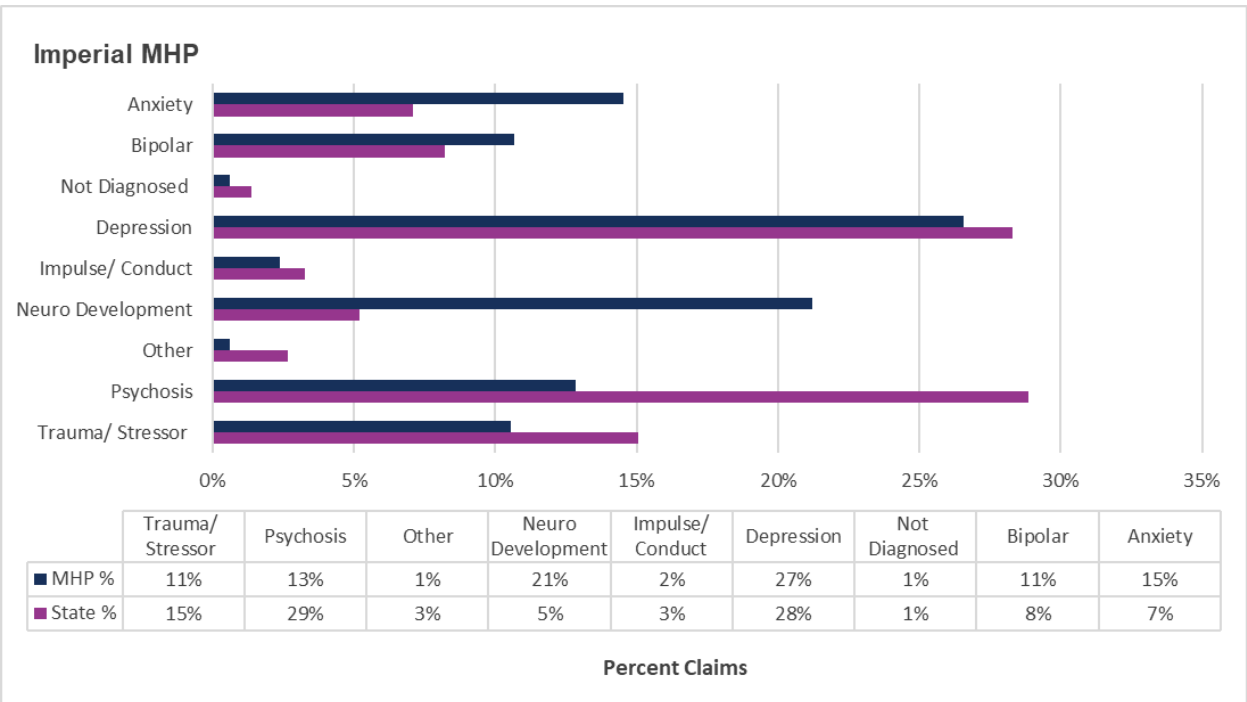
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	11%	9%	1%	17%	2%	26%	7%	10%	17%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Percent Beneficiaries

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	11%	13%	1%	21%	2%	27%	1%	11%	15%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Percent Claims

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	66	85	8.96	8.86	$9,234	$12,052	$609,426
CY 2020	62	64	9.35	8.68	$6,789	$11,814	$420,925
CY 2019	82	107	7.84	7.80	$5,848	$10,535	$479,535

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

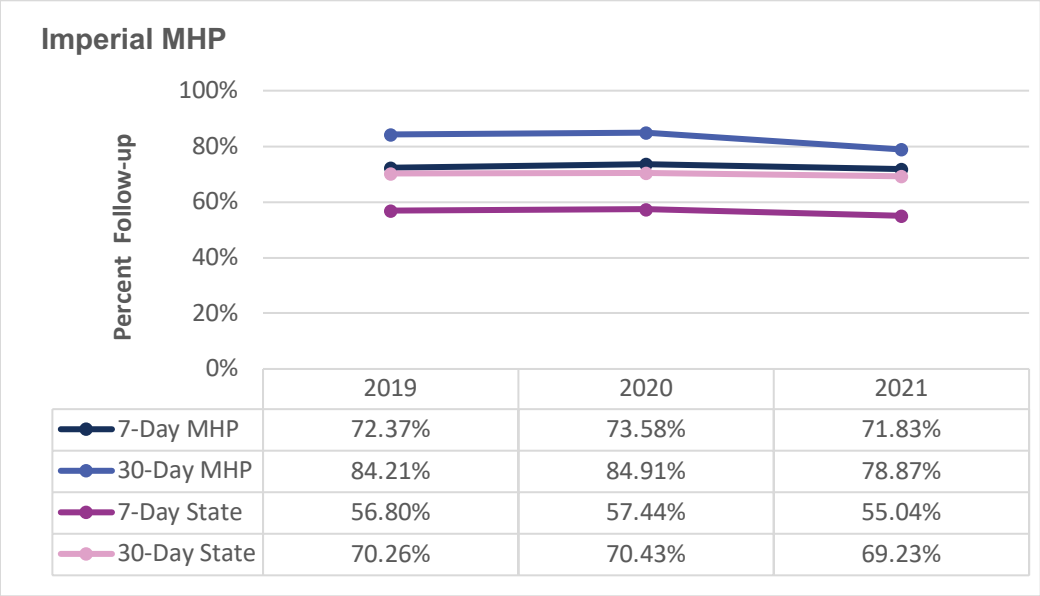


Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21

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

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	122	1.73%	13.90%	$5,681,880	$46,573	$40,059
	CY 2020	125	1.85%	13.61%	$5,351,167	$42,809	$37,424
	CY 2019	136	1.74%	13.80%	$5,944,191	$43,707	$37,619

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	184	2.60%	10.86%	$4,440,890	$24,135	$23,885
Low Cost (Less than $20K)	6,766	95.67%	75.24%	$30,767,397	$4,547	$3,286

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

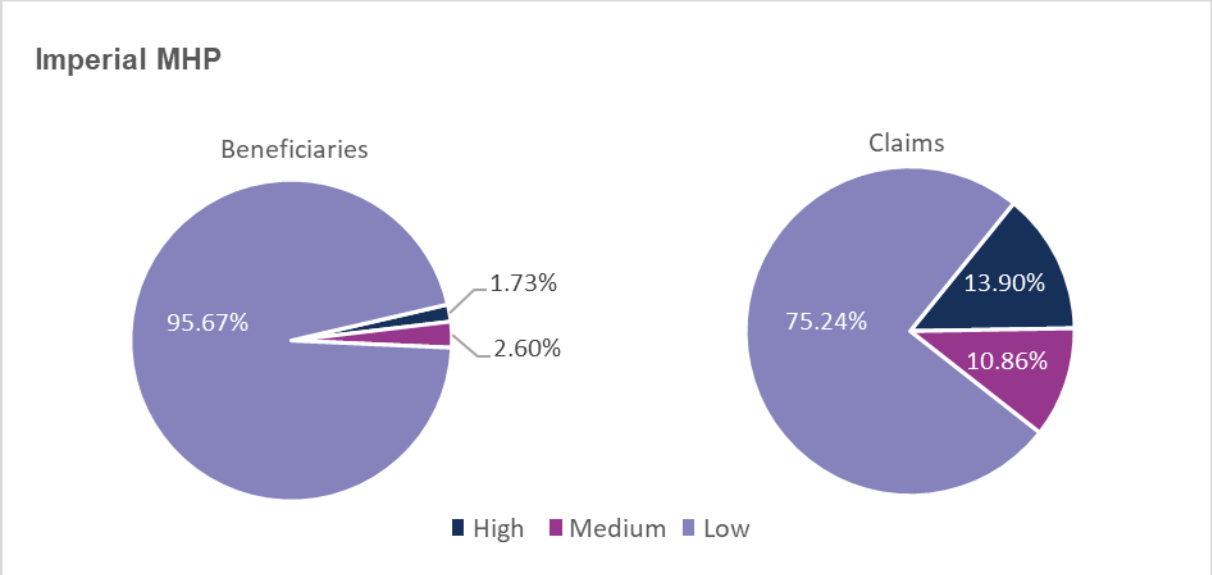


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	12,317	$3,159,495	$0	0.00%	$3,119,031
Feb	13,232	$3,371,244	$0	0.00%	$3,287,692
Mar	14,995	$3,850,823	$916	0.02%	$3,650,493
April	15,671	$4,197,058	$1,621	0.04%	$3,938,971
May	14,065	$3,833,394	$1,222	0.03%	$3,613,696
June	13,943	$3,583,117	$2,751	0.08%	$3,533,278
July	12,673	$3,442,536	$1,030	0.03%	$3,403,081
Aug	13,463	$3,466,590	$3,340	0.10%	$3,434,632
Sept	12,914	$3,303,989	$1,601	0.05%	$3,264,235
Oct	12,653	$3,343,374	$1,856	0.06%	$3,303,798
Nov	11,556	$3,103,123	$3,651	0.12%	$3,073,595
Dec	11,018	$2,909,633	$6,406	0.22%	$2,880,702
Total	**158,500**	**$41,564,376**	**$24,394**	**0.06%**	**$40,503,204**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B must be billed before submission of claim	49	$13,040	53.46%
Service line is a duplicate and a repeat service procedure code modifier not present	20	$5,140	21.07%
Other healthcare coverage must be billed before submission of claim	10	$3,501	14.35%
Beneficiary not eligible or non-covered charges	10	$2,412	9.89%
Late claim	2	$301	1.23%
Total Denied Claims	**91**	**$24,394**	**100.00%**
Overall Denied Claims Rate	**0.06%**		
Statewide Overall Denied Claims Rate	**1.43%**		