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

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

MARIN FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

December 6-7, 2022

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — December 6-7, 2022

MHP Size — Medium

MHP Region — Bay Area

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	2	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	4	2	0
Quality of Care	10	5	3	2
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**16**	**8**	**2**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Clinical	09/2022	Planning & Implementation	Moderate
Timeliness between Assessment and First Treatment Services	Non-Clinical	03/2021	Sixth remeasurement period	Low

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	4
2	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	3

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Improving time from assessment to treatment through the use of a non-clinical PIP.
- Detailed policies and procedures for the claiming process, including denied claims follow-up, utilized for training staff.
- Beneficiaries are aware and have used MHP website information, which also has an easy to locate translation function.
- Adult beneficiaries reported the offer of transportation assistance in the form of bus passes and gas vouchers.
- Overall, post-hospital discharge follow-up averages 3.0 days, with 74.2 percent within 7-days.

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

- The MHP continues to experience difficulties with the recruitment and retention of needed licensed personnel.
- Staffing losses prevented the implementation of quarterly timeliness data review.
- The MHP was unable to implement comprehensive Senate Bill 1291 medication monitoring of children and youth in foster care (FC) due to staffing issues.

- The MHP's claiming denial rate was 1.24 percent higher than the statewide average.
- The MHP experienced a significant drop in the accurate logging of Access calls during FY 2021-22 and a high volume of unrecorded text calls.

Recommendations for improvement based upon this review include:

- Expedite implementation of the strategies developed to improve recruitment and retention of needed personnel categories.
- Implement the quarterly review of timeliness data.
- Begin the quarterly SB1291 medication monitoring of FC youth.
- Enhance pre-claim review and error correction to reduce the claim denial rate.
- Begin the quarterly review of Access call log entries and development of strategies to improve low-performing areas.

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 Marin County MHP by BHC, conducted as a virtual review on December 6-7, 2022.

REVIEW METHODOLOGY

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

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

CalEQRO reviews are retrospective; therefore, data evaluated represent 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 12, 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 the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP experienced a loss of staff, and difficulties in recruiting, supporting, and retaining behavioral health staff. The most significant impacts occurred in West Marin, with bilingual and crisis specialists for 24-hour programs. 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.

- CalAIM changes implemented, including no wrong door, and significant alterations of clinical documentation.
- At the Access program, a high-priority client assessment waitlist process shortened assessment wait times.
- Added peer support specialist positions to the children's system of care to better serve children and families.
- Added a yearlong course of family therapy training for staff to improve care for families.
- Changes in senior leadership with the departure of Behavioral Health and Recovery System (BHRS) Director and the hiring of the new BHRS Director of Operations.
- BHRS developed over ten new community relationships, including with Marin's Native and Indigenous community and with a disability advisory group.

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: Expedite the process of hiring qualified staff to enable timely services to beneficiaries.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has continued to experience higher vacancy rates, with a Health and Human Services (HHS) overall average of 15.5 percent for the past year. In common with other regional counties, recruitment and retention remain challenging. The MHP is particularly aware of staffing of the hard to fill vacancies within the Marin Crisis Stabilization Unit (CSU), Mobile Crisis Response Team (MCRT), and Jail Mental Health.
- The MHP is aggressively pursuing alternative work schedules (ASW) for clinical teams, with variations that work for both staff and the beneficiaries served. A work group composed of clinical team staff have been involved in the design of alternative work schedules. The ASW pilot will be tested in addition to the existing hybrid work schedules, and aligned with the larger HHS strategy for other HHS departmental divisions.
- Marin BHRS has worked with the County's Central Human Resources Department to pursue changes in the image of county employment. This, including the evolution of county employment to become both competitive and fulfilling, includes recruitment and retention incentives for hard to recruit and retain positions. BHRS has also managed to utilize Mental Health Services Act

(MHSA) funding to help create a Human Resources Analyst to assist in expediting county workflow processes for BHRS positions.

- The MHP engaged in a number of efforts in this last year, but has yet to see substantial reduction in vacancies. Therefore, this topic will remain a recommendation for the current year, which will hopefully show concrete results from all of the areas that are receiving attention.

Recommendation 2: Review eligibility criteria for SMHS and develop a process for staff to present for review individuals that would be better served by another health care provider, thus enabling more time and access for qualified beneficiaries.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The introduction of the CalAIM access criteria for both adults and children has expanded specialty mental health criteria and added a new level of complexity to this recommendation. With the formal screening tools being released by DHCS in January of 2023, there is likely to be more learning to be done regarding the proper assignment of eligibles to MHP versus MCP service providers. The MHP is also exploring level of care (LOC) tools for assisting in the determination of placement within the MHP system of care.
- Internally, the MHP's Access Team has focused on a new initiative to guide in determining diagnosis, which will include reviews of assessments, clinical consultation and training, and review of complex diagnostic pictures. The addition of psychiatry time to Access also will enable early medication intervention when indicated during completion of the assessment process. The early involvement of psychiatry is likely to improve diagnostic accuracy and placement recommendations.
- While the full force of these changes has yet to have a significant impact, the MHP's structural changes to the Access and assessment process appears to meet the recommendation described above. Therefore, this recommendation will not be continued for the current review period.

Recommendation 3: Review timeliness on at least a quarterly basis with documentation of review and improvement strategies as needed.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- During CY 2022, the MHP planned to track and review non-urgent, non-psychiatric services for beneficiaries 18 years of age and older on a quarterly basis. The loss of staff and analytic capacity within the Quality Management (QM) unit limited the ability of this project to twice during the year – March and June 2022.
- The MHP has a non-clinical PIP that targeted this topic, and will continue to monitor data and make adjustments to the interventions to see enduring

improvements. The MHP plans to continue efforts to improve upon and solidify the positive gains, and as well is seeking to develop a system that will support more frequent reporting and analysis of this data element, targeting a monthly frequency goal.

- The MHP's success in this area remains limited, and is considered partially addressed for that reason. However, the PIP has put into place processes which will create the needed changes. Therefore, this recommendation will not be continued for the coming year.

Recommendation 4: Develop a process and begin medication monitoring for youth in FC on a quarterly basis.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP initiated efforts to work with Child Welfare in identifying Foster Care (FC) youth and implement medication monitoring of SB 1291 Healthcare Effectiveness and Data Information Set (HEDIS) measures. Staffing changes prevented this initiative from continuing during CY 2022. The MHP plans to renew efforts in this area during CY 2023.
- This recommendation will be continued in the coming year.

Recommendation 5: Review templates for in clinical documentation in Clinician's Gateway and develop drop-down lists, check boxes, or other features that would reduce writing and expedite documentation completion.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has entered into an agreement with CalMHSA for implementation of the semi-statewide EHR, with a planned July 1, 2023, conversion date. In light of this change, spending the human and financial resources to make the changes indicated in a system that will soon be a legacy system is not reasonable.

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 31.8 percent of services were delivered by county-operated/staffed clinics and sites, and 68.2 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 80 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: schools, social services/child welfare, and juvenile or adult detention. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Individuals are assessed by the Access Team and then referred to the appropriate treatment team.

In addition to clinic-based MH services, the MHP provides psychiatry and/or MH services via telehealth video/phone to youth and/or adults. In FY 2021-22, the MHP reports having provided telehealth services to 1,138 adult beneficiaries, 305 youth beneficiaries, and 253 older adult beneficiaries across six county-operated sites and six contractor-operated sites. Among those served, 349 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

[1] CMS Data Navigator Glossary of Terms

addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

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

For Marin County, the time and distance requirements are 30 miles and 60 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
The MHP ensures OON access for beneficiaries in the following manner:	☐ The MHP has existing contracts with OON providers ☐ Other: Click or tap here to enter text.

- 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	Partially 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 has formed a Hispanic/Latino committee with the goal of improving outreach to this underserved population. This committee is referencing the Latinx Outreach Report published in 2021 to inform the group on potential actions to improve access for this group. During this current review, stakeholders provided information regarding the need for more bilingual staff, and also mentioned some programs that have higher proportions of bilingual staff have low caseloads of Spanish-speaking beneficiaries.
- Consensus was that improved outreach efforts and greater tailoring of behavioral health services still needs to occur to engage those Hispanic/Latino individuals who have a traditional orientation and reluctance towards mental health services. Those with American Sign Language (ASL) needs may have difficulties receiving adequate interpreting from the existing providers. Stakeholders also mentioned that the translations of MHP forms utilized a more formal and academic approach rather than a less formal, common usage approach, which could impact their utility in providing information to the target community.
- The MHP uses a monthly report update to inform system participants of the changes to the provider network, so as to minimize wait times for service access. To support reduced position vacancy time, the MHP utilized MHSA funding to create a dedicated Human Resources position which is devoted solely to support Behavioral Health and Recovery Services division needs. The MHP is also working on tracking the preferred languages of its beneficiaries. Monthly dashboard reports tend to be program-oriented, presenting data on race/ethnicity, sexual orientation and gender identity status distribution and other relevant data elements.

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, is slightly higher than the Statewide PR.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	52,490	2,049	3.90%	$26,851,871	$13,105
CY 2020	47,274	2,171	4.59%	$30,789,855	$14,182
CY 2019	45,335	2,202	4.86%	$30,869,798	$14,019

- This chart reflects a downward trend in Penetration Rate for the MHP.

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

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	4,554	25	0.55%	0.89%	1.59%
Ages 6-17	10,835	350	3.23%	3.93%	5.20%
Ages 18-20	2,853	90	3.15%	3.42%	4.02%
Ages 21-64	29,279	1,308	4.47%	3.75%	4.07%
Ages 65+	4,970	276	5.55%	2.13%	1.77%
TOTAL	**52,490**	**2,049**	**3.90%**	**3.33%**	**3.85%**

- The MHP PR in the 0-5, 6-17 and 18-20 age groups are lower than both other Medium Counties and the Statewide PRs, while the PRs for the MHP in the 21-64 and 65+ age groups are higher than Medium Counties and Statewide PRs.
- The average number of eligibles increased from the prior year, however the number of beneficiaries served by the MHP decreased.

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	Percent of Beneficiaries Served
Spanish	286	14.15%
Threshold language source: Open Data per BHIN 20-070		

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

Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	18,120	543	3.00%	$7,337,932	$13,514
Medium	613,796	18,023	2.94%	$122,713,843	$6,809
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The ACA PR is in line with the Medium Counties total and is lower than the Statewide average. The AACB for the MHP is higher than the Medium and Statewide AACB, at about or more than double the other AACBs.

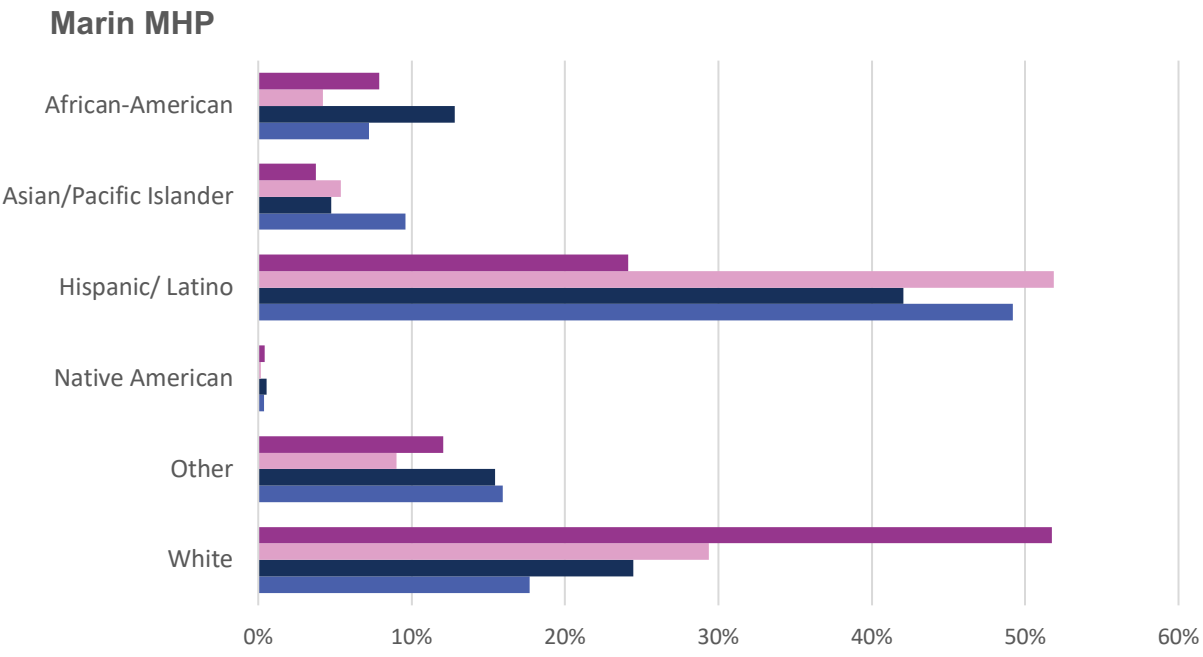
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions 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	# MHP Eligibles	# MHP Served	MHP PR	Statewide PR
African-American	2,213	162	7.32%	6.83%
Asian/Pacific Islander	2,823	77	2.73%	1.90%
Hispanic/Latino	27,220	494	1.81%	3.29%
Native American	89	≤11	-	5.58%
Other	4,721	247	5.23%	3.72%
White	15,426	1,060	6.87%	5.32%
Total	**52,492**	**2,049**	**3.90%**	**3.85%**

- The Hispanic/Latino PR is lower than the Statewide PR, while the MHP PR for the African-American, Other and White populations is higher than the Statewide PR.

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

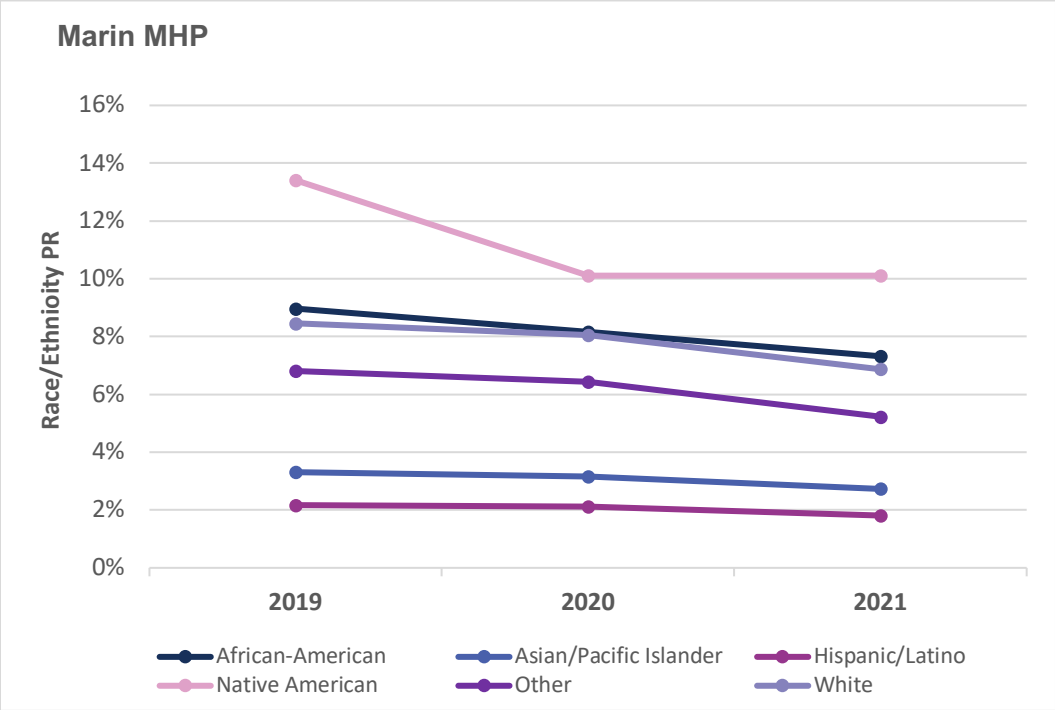


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	52%	12%	0%	24%	4%	8%
MHP % Eligibles	29%	9%	0%	52%	5%	4%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- The African-American, Other and White populations are receiving services above their representative amount among the eligible population, while the Hispanic/Latino population is served at a lower rate than their portion of the eligible population.

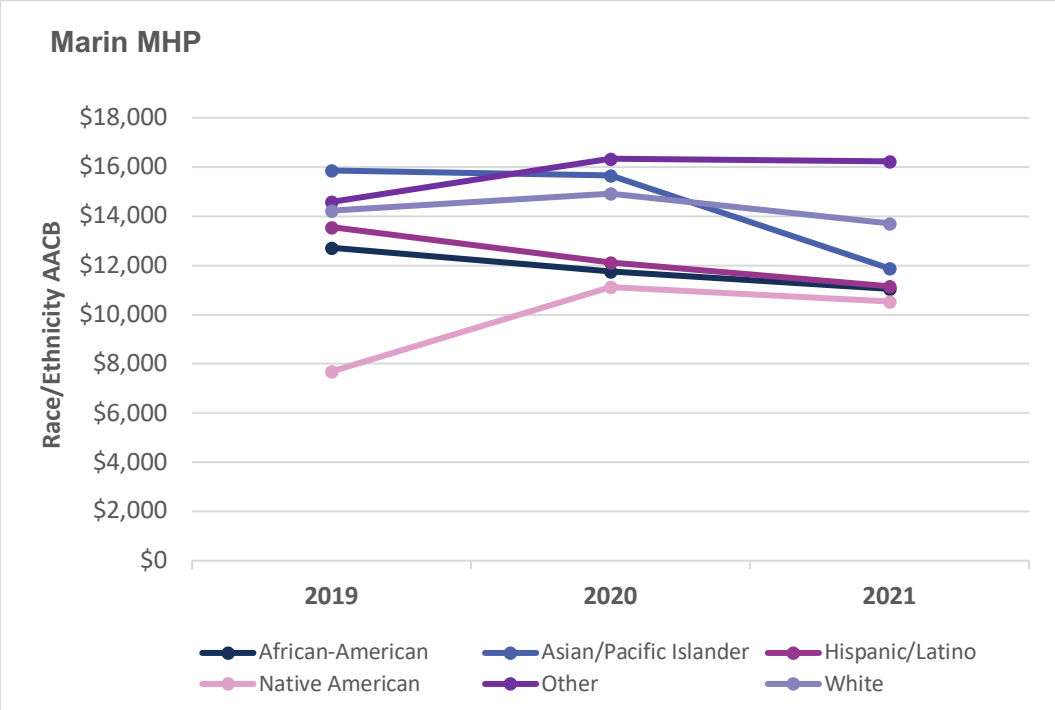
Figures 2-11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



- A visual representation of PR by ethnicity.

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



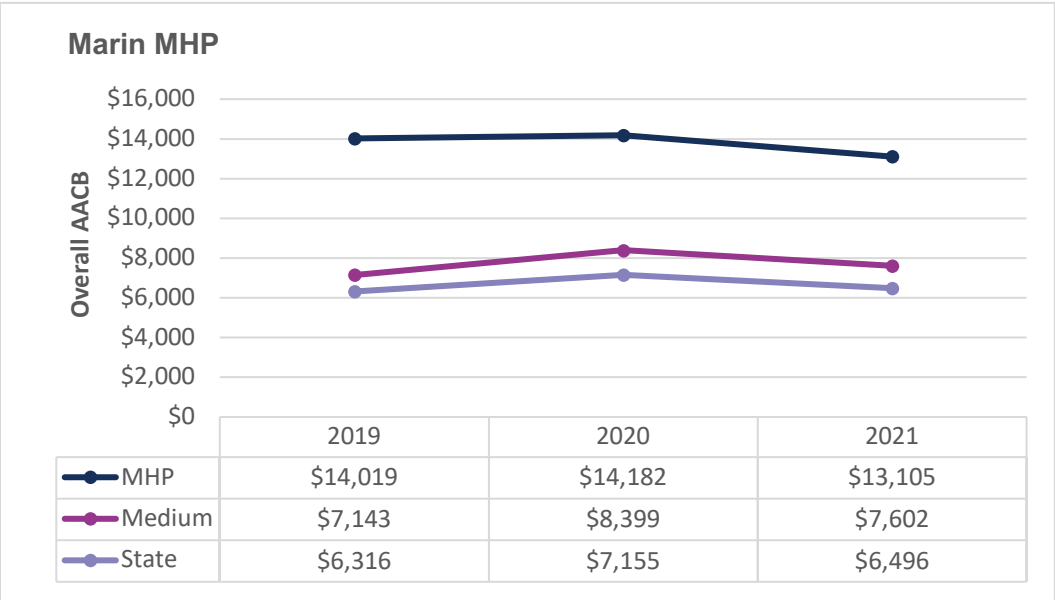
- The AACB for the Other population is the highest, while Native American, Hispanic/Latino and African-American populations are the lowest at the MHP.

Figure 4: Overall PR CY 2019-21

	2019	2020	2021
MHP	4.86%	4.59%	3.90%
Medium	4.25%	3.87%	3.33%
State	4.86%	4.55%	3.85%

- All sectors have experienced a decrease in overall PR over the last three years.
- The MHP's PR is higher than the Medium Counties total and in line with the Statewide total for 2021.

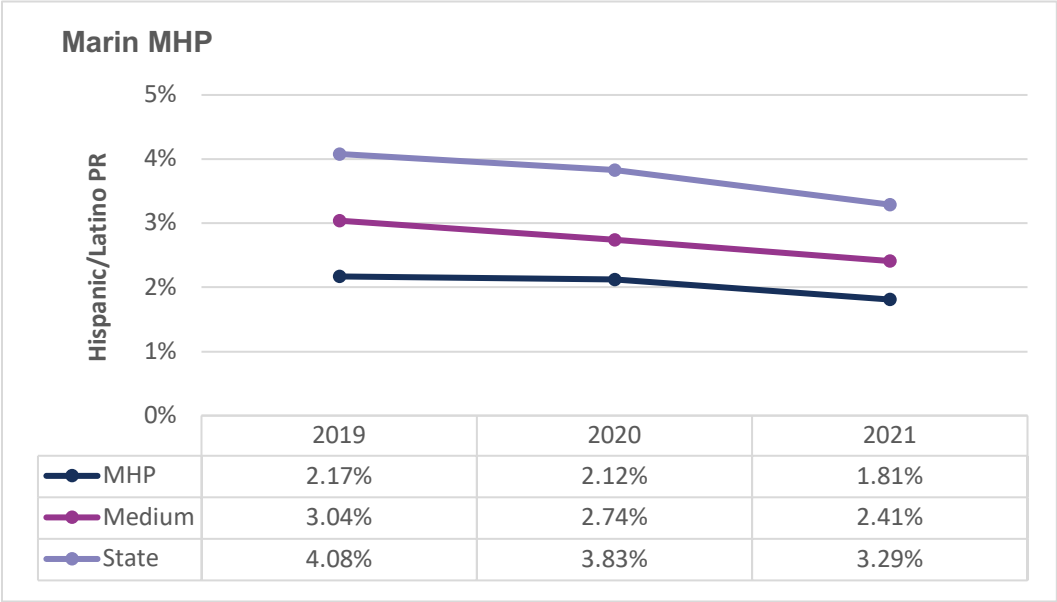
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$14,019	$14,182	$13,105
Medium	$7,143	$8,399	$7,602
State	$6,316	$7,155	$6,496

- The AACB for the MHP has been, and remains higher that the Medium Counties and Statewide totals.
- All sectors have experienced a reduction in AACB from 2020 to 2021.

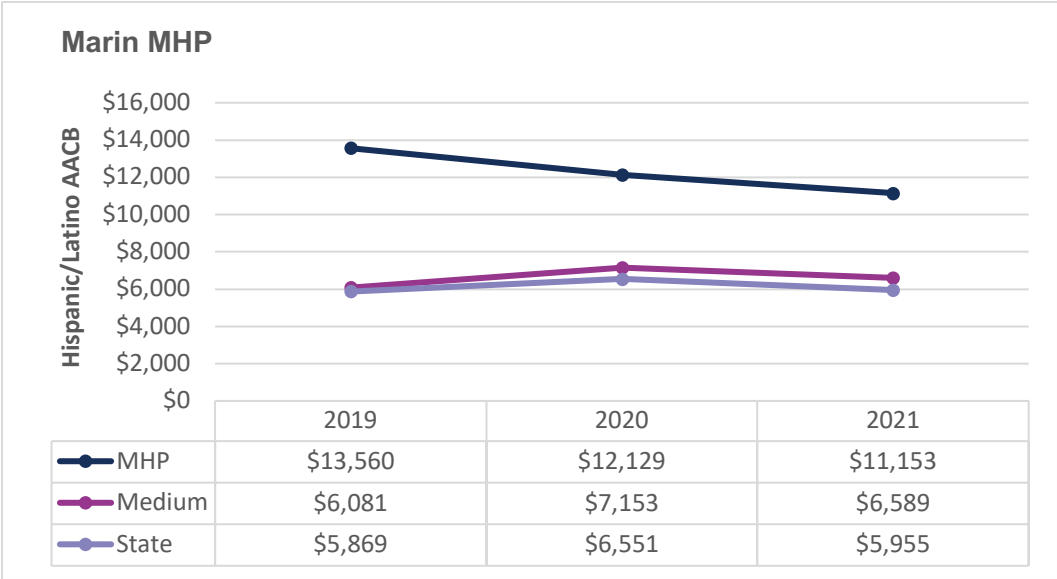
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	2.17%	2.12%	1.81%
Medium	3.04%	2.74%	2.41%
State	4.08%	3.83%	3.29%

- The Hispanic/Latino PR for the MHP has been and remains the lowest when compared to Medium Counties and Statewide totals.
- All sectors have experienced reductions in PR over the last three years.

Figure 7: Hispanic/Latino AACB CY 2019-21

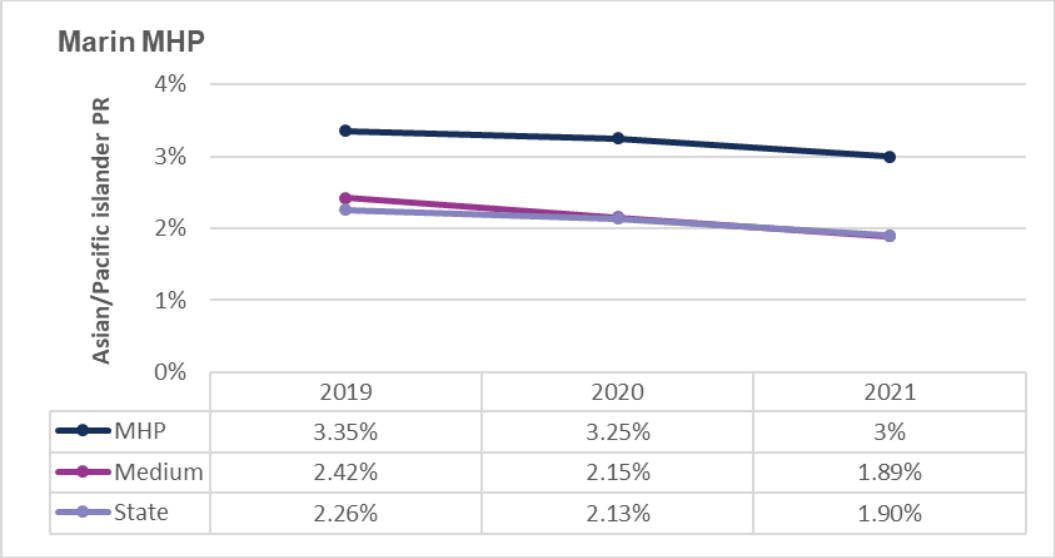


	2019	2020	2021
MHP	$13,560	$12,129	$11,153
Medium	$6,081	$7,153	$6,589
State	$5,869	$6,551	$5,955

- The MHP AACB has experienced a downward trend in recent years, it remains higher than the other sectors, and is almost double the Statewide total.

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

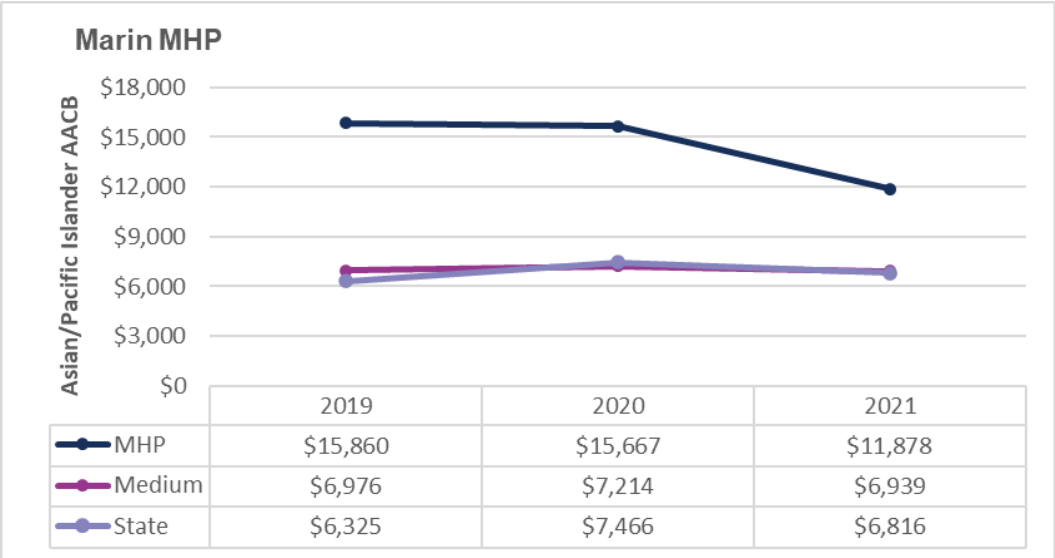
Due to small numbers of beneficiaries in the Native American category, the MHP rate for API in 2021 is rounded to prevent calculation based upon other numbers available.



	2019	2020	2021
MHP	3.35%	3.25%	3%
Medium	2.42%	2.15%	1.89%
State	2.26%	2.13%	1.90%

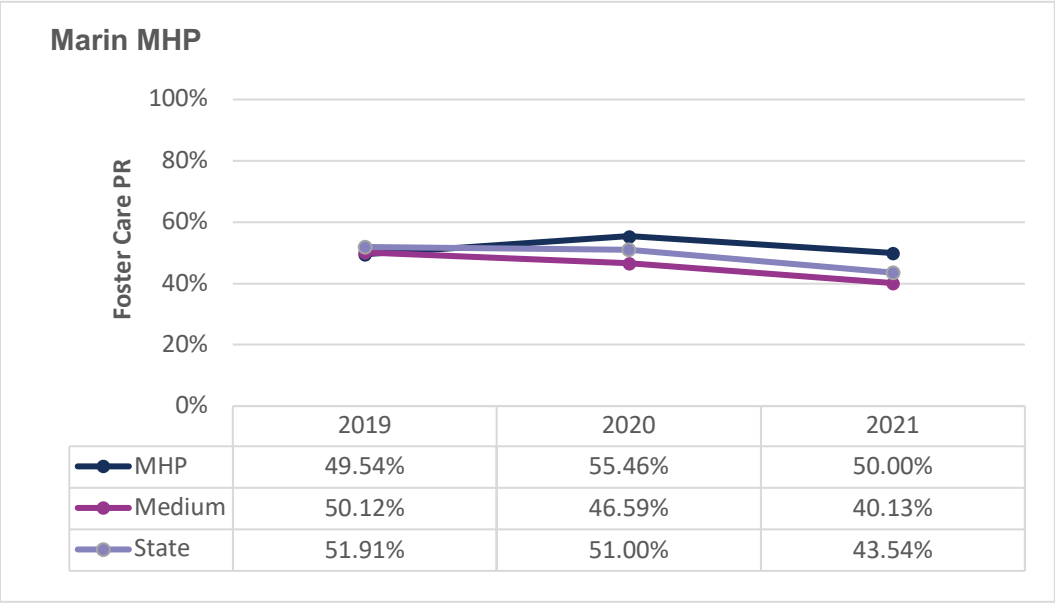
- All sectors experienced a decline in AACB from 2020 to 2021.
- The MHP AACB for the API population is 87 percent higher than the Statewide average.

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



	2019	2020	2021
MHP	$15,860	$15,667	$11,878
Medium	$6,976	$7,214	$6,939
State	$6,325	$7,466	$6,816

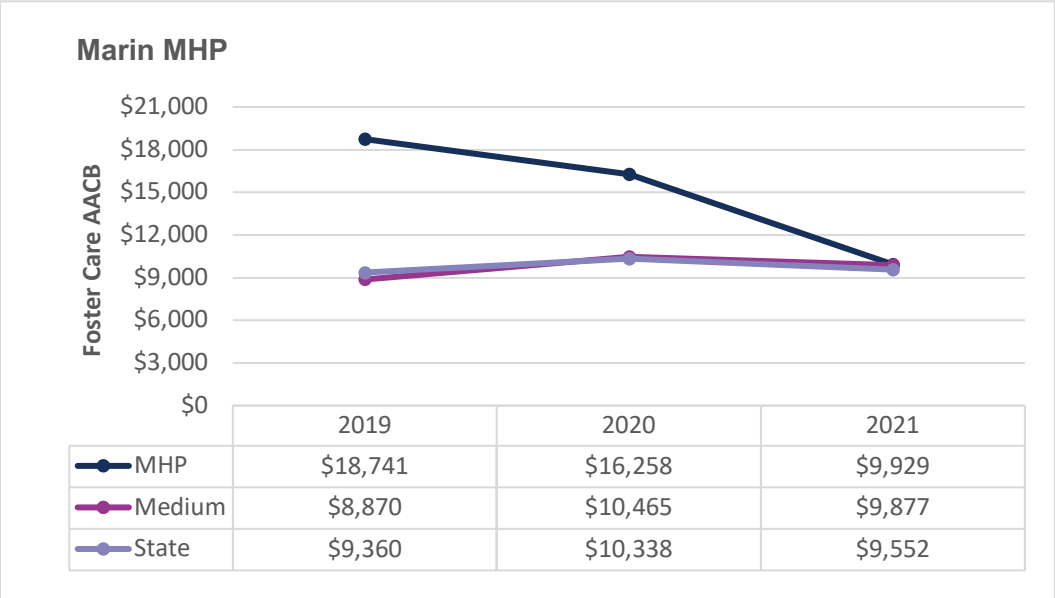
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	49.54%	55.46%	50.00%
Medium	50.12%	46.59%	40.13%
State	51.91%	51.00%	43.54%

- All sectors experienced a decline in PR over the three years represented.
- The MHP's PR is higher than both Medium, by 9.87 percent, and Statewide, by 6.46 percent.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$18,741	$16,258	$9,929
Medium	$8,870	$10,465	$9,877
State	$9,360	$10,338	$9,552

- The Foster Care AACB for the MHP declined by approximately 38.9 percent from 2020 to 2021.
- All sectors experienced a reduction in AACB from 2020 to 2021

- The AACB for all sectors are in close alignment.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 1,675				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	233	13.9%	19	12	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	122	7.3%	17	16	1.9%	20	14
Per Minute Services							
Crisis Stabilization	338	20.2%	1,414	1,200	9.7%	1,463	1,200
Crisis Intervention	89	5.3%	156	113	11.1%	240	150
Medication Support	1,190	71.0%	459	375	60.4%	255	165
Mental Health Services	990	59.1%	914	508	62.9%	763	334
Targeted Case Management	783	46.7%	813	395	35.7%	377	128

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

Service Category	MHP N = 55				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	≤11	-	-	-	4.5%	13	8
Inpatient Admin	≤11	-	-	-	≤11	6	4
Psychiatric Health Facility	≤11	-	-	-	0.2%	25	9
Residential	≤11	-	-	-	≤11	140	140
Crisis Residential	≤11	-	-	-	0.1%	16	12
Full Day Intensive	≤11	-	-	-	0.2%	452	360
Full Day Rehab	≤11	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	≤11	-	-	-	2.3%	1,354	1,200
Crisis Intervention	≤11	-	-	-	6.7%	388	195
Medication Support	13	23.6%	465	468	28.5%	338	232
Therapeutic Behavioral Services	≤11	-	-	-	3.8%	3,648	2,095
Therapeutic FC	≤11	-	-	-	0.1%	1,056	585
Intensive Home Based Services	31	56.4%	780	388	38.6%	1,193	445
Intensive Care Coordination	12	21.8%	1,533	836	19.9%	1,996	1,146
Katie-A-Like	≤11	-	-	-	0.2%	837	435
Mental Health Services	54	98.2%	1,029	827	95.7%	1,583	987
Targeted Case Management	23	41.8%	161	70	32.7%	308	114

IMPACT OF ACCESS FINDINGS

- The MHP's PR access by age indicates lower rates for those 20 and under and much increased access for those 21-64 and 65-plus.
- The MHP may wish to consider the deployment of bilingual/bicultural staff to ensure they are assigned to programs that have the highest demand, particularly considering the Hispanic/Latino group is the only race/ethnicity segment which has a lower PR than the statewide average.

- Anecdotally, increases in caseload particularly among children and youth were discussed during the review related to CalAIM changes in access criteria; however, the MHP related that this impact is minimally reflected in data submitted for the EQR process. Interaction with local MCP and their mental provider panel are increasing, but the full effect is expected to occur the start of 2023.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- As of December 2021, the Marin MHP began collecting timeliness data from both directly operated programs and contract providers. Prior to that, as of November 2020 the MHP used a spreadsheet to collect timeliness of directly operated programs. Due to the small numbers of participants starting services during the

last year, validation of this data was compromised. However, it should be noted that a number of caregivers who did have recent experience reported barriers and delays to initial access.

- First non-urgent psychiatry/prescriber appointment utilized spreadsheet data from January through December 2021. The data does not include those individuals who were determined to need psychiatry after the assessment was completed. Child psychiatry services were provided by out of county practitioners for most of the past year, primarily via telehealth.
- The urgent service data does not include contract providers, and reflects data limited to directly-operated programs.
- With the post-hospital discharge 7- and 30-day follow-up data, the MHP utilizes a higher initial 3-day standard, and includes all admissions regardless of payor source, and does not remove those who might not qualify for follow-up.
- No-show data is of questionable accuracy as it is based on the use of an Outlook calendar, from which missed appointments may be deleted by staff. There is also no policy and procedure on no-show follow-up by clinical staff.

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 CY 2021. Table 11 and Figures 12-14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care.

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	8.5 Days	10 Business Days*	74.2%
First Non-Urgent Service Rendered	12.4 Days	10 Business Days**	56.2%
First Non-Urgent Psychiatry Appointment Offered	16.9 Days	15 Business Days*	44.5%
First Non-Urgent Psychiatry Service Rendered	18.1 Days	15 Business Days**	43.1%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	1.28 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization	3.0 Days	7 Days**	80.3%
No-Show Rate – Psychiatry	12.7%	10%**	n/a
No-Show Rate – Clinicians	3.3%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: January through December 2021.			

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

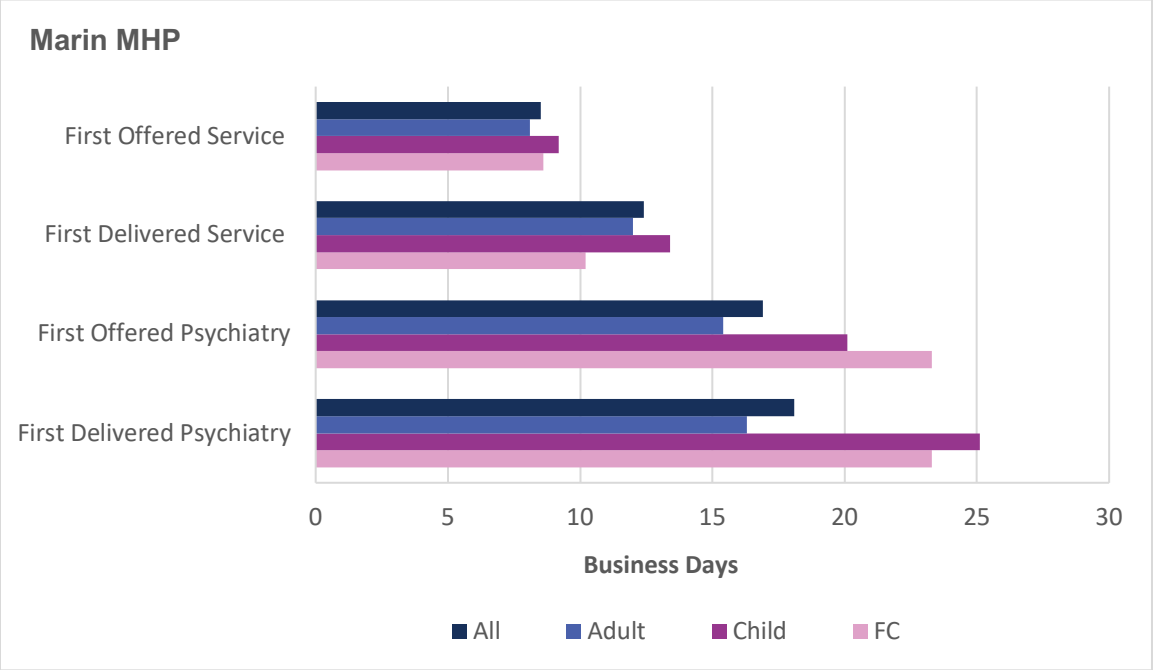


Figure 13: Wait Times for Urgent Services

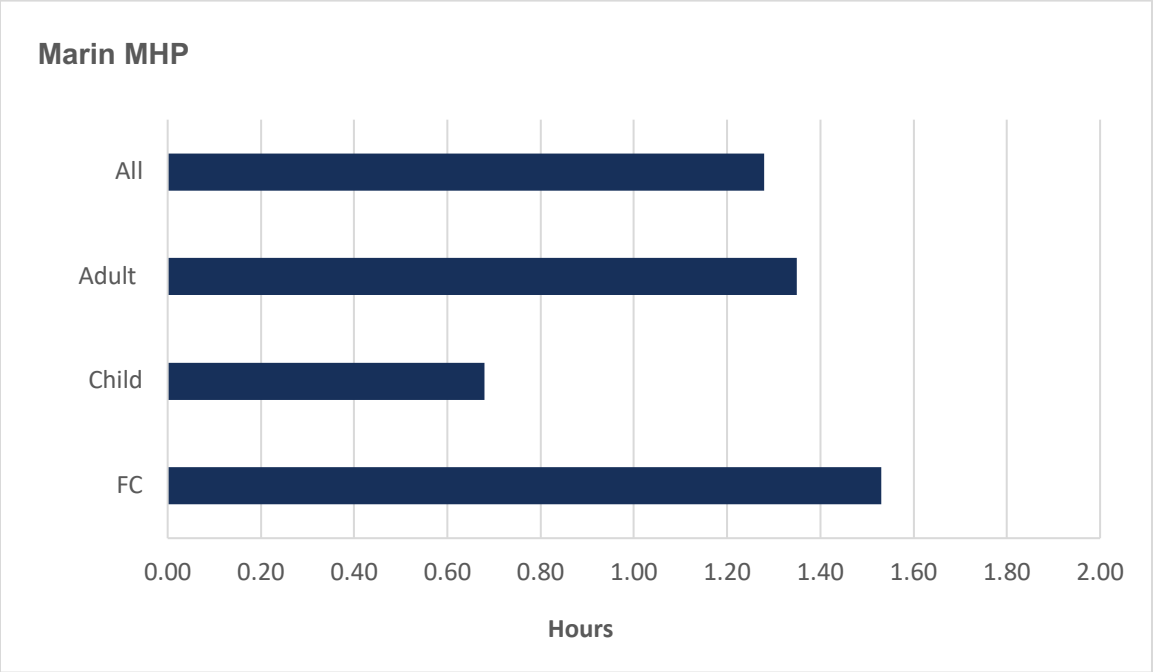
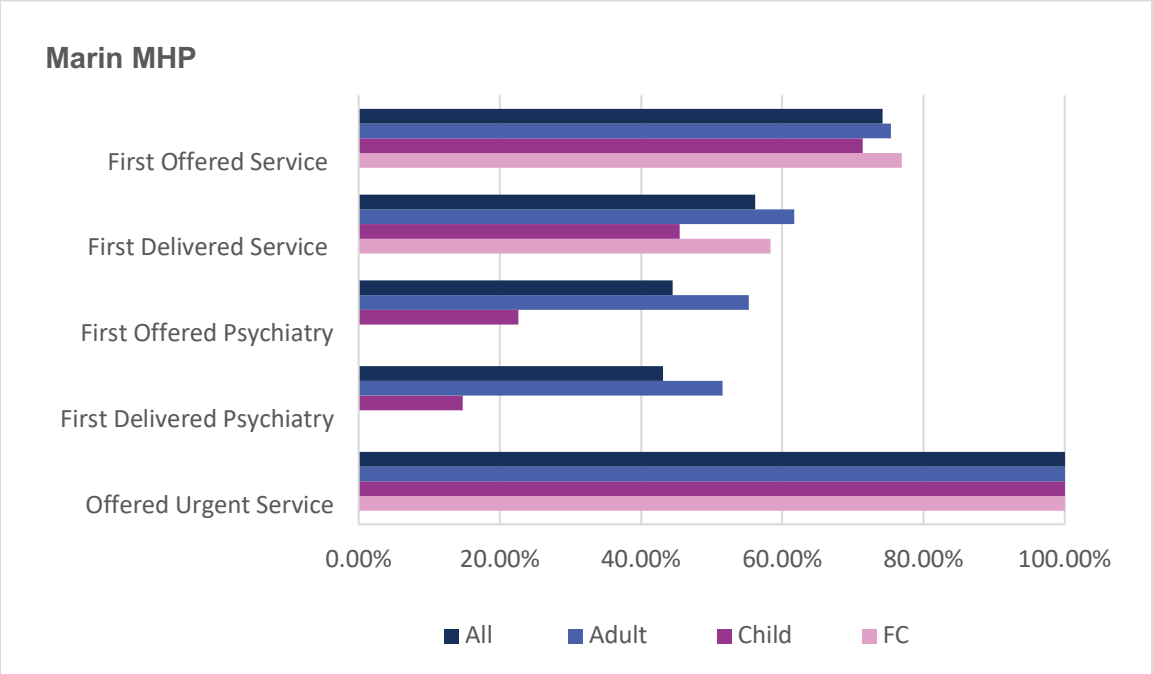


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary.

According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments and unscheduled assessments.

- 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 CSU. The MHP defined “urgent services” for purposes of the ATA as derived from the MCRT log. There were reportedly 493 of urgent service requests with a reported actual wait time to services for the overall population at 1.28 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as from the first request for service or at the time of assessment.
- 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 represent a subset of county operated programs. The MHP reports a no-show rate of 12.7 percent for psychiatry services overall, and a 3.3 percent rate for clinicians overall.

IMPACT OF TIMELINESS FINDINGS

- With an overall first non-urgent appointment offered of 8.5 days and a rendered for the same of 12.4, time to first assessment is rapid.
- The MHP currently supports improvements in time from assessment to first rendered treatment service by the efforts of a non-clinical PIP, which has unfortunately experienced limited success and setbacks related to staffing.

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 and QA are under Quality Management (BHRS specific) but the separate from the Compliance division which is an HHS wide division. QI is under Quality Management, but separate from QA/Compliance. The Access Team is overseen by the Division Director who also oversees the Quality Management division. This Division Director reports to the Operations Director.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of contract providers, MHP staff, QI staff, and substance use services staff, is scheduled to meet once per quarter. Since the previous EQR, the MHP QIC met four times. Of the 49 identified FY 2021-22 QAPI workplan goals, the MHP found 21 Met, 15 Partially Met, 13 Not Met, and 47 Continued for the next plan period.

The MHP utilizes the following level of care (LOC) tool: The MHP is considering the Level of Care Utilization System (LOCUS) for service intensity determination and the Adult Needs and Strengths (ANSA) for outcome tracking with the implementation of the Streamline SmartCare EHR.

The MHP utilizes the following outcomes tools: Pediatric Symptom Checklist-35, Child and Adolescent Needs and Strengths-90, Patient Health Questionnaire-9.

The MHP experienced a set-back in its plans to select and implement a universal outcome instrument for adults. This related to loss of leadership staff in the adult division, and loss of analytic staff. In addition, the change to the semi-statewide Streamline SmartCare EHR will bring to the MHP an application that already has the capability to incorporate the instruments under consideration. The MHP considers it wise to await the implementation of this new system in the summer of 2023 to bring online an adult outcome instruments, and potentially the LOCUS level of care tool.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- The MHP's transition to a new primary provider that employs peer support specialists resulted in a brief pause in their participation while the transition between employing entities was navigated. The new provider has a career ladder built into the contract, with three program manager positions, a peer coordinator, with a total of 17.75 FTEs. Lived experience employees report that there is room to improve the understanding that clinical staff have of the contributions that peer specialists and parent partners can make to services, which would improve their utilization in treatment.
- As mentioned, the MHP has paused its implementation of an adult outcome instrument and level of care tool until the Streamline SmartCare EHR comes

online, resulted in the MHP pausing efforts in this area until summer of 2023. The new system has built-in capabilities for the ANSA and the LOCUS tool.

- The MHP has a placeholder for policy and procedure postings to its website, currently without any content. It should consider developing and posting prescribing protocols and/or guidelines, such as for benzodiazepines, to that location when it begins to add policies and procedures. This would also be a useful location to post the medication monitoring tool utilized when reviewing prescribing practitioners.
- The MHP utilizes the CANS-90 and PSC-35 with children and youth, but has not developed a mechanism for aggregation and analysis of results by program. There were plans to select an adult outcome instrument and a level of care tool, but these actions were paused due to personnel changes and the move to a new EHR in the summer of 2023.
- Consumer-run/driven programs such as the Enterprise Resource Center and the Empowerment Clubhouse have experienced significant losses of participation due to COVID-19 restrictions. While shifting to Zoom virtual sessions did occur, communicating the existence of these programs to the community posed a challenge. In addition, changes in staff have taken a toll on participation. Beneficiaries providing feedback during this review were not aware of any consistent formal process to notify individuals starting treatment of the existence of these programs. Outreach and flyers do periodically furnish information, but not on a routine or regular basis.
- The MHP does not comprehensively track SB 1291 Healthcare Effectiveness Data and Information Set (HEDIS) measures for FC. Several starts have occurred in this area, but loss of personnel and other priorities paused this effort. There is a registered nurse assigned to the JV-220 review process, who reviews with the team medications prescribed and also reviews available lab work. Also, obtaining lab results is not currently an automated process, which in some cases presents challenges. Hopefully, during the FY 2022-23 period the MHP will regain the bandwidth required to comprehensively review this area.
    - 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

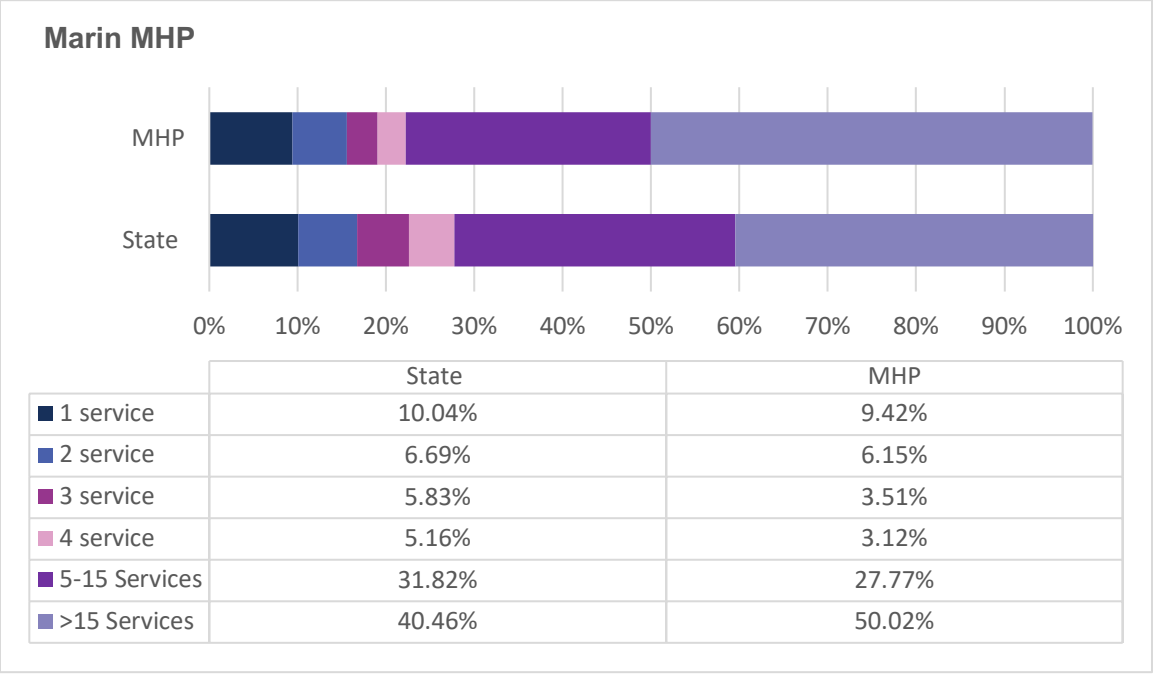
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



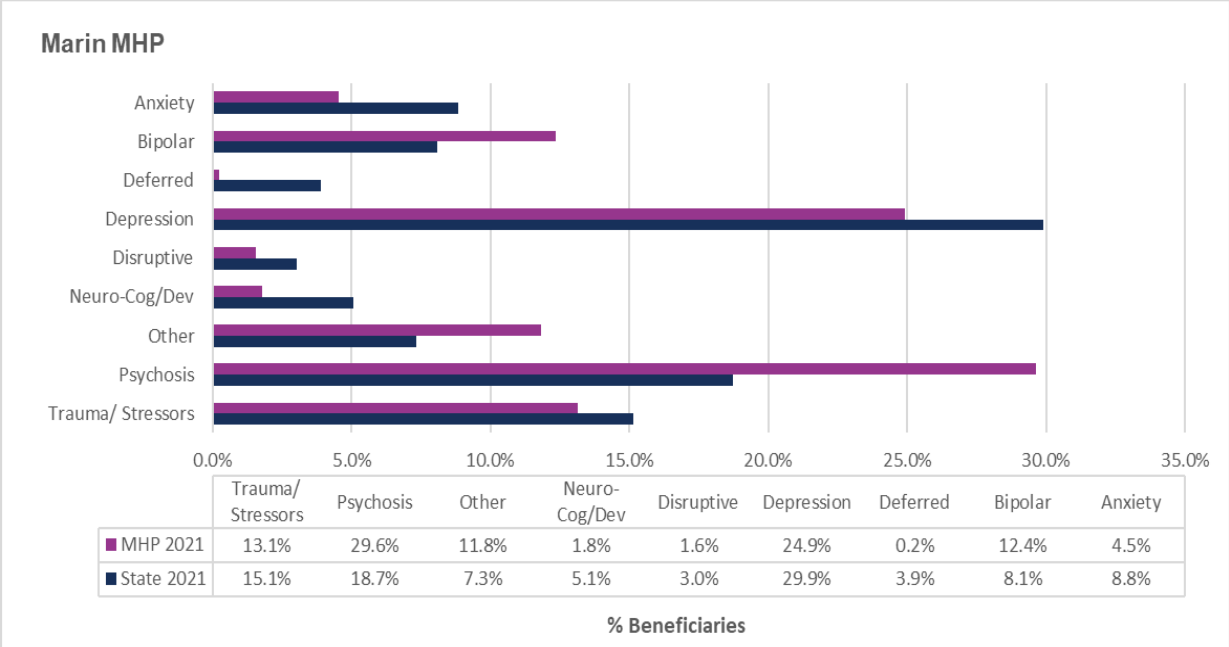
	State	MHP
1 service	10.04%	9.42%
2 service	6.69%	6.15%
3 service	5.83%	3.51%
4 service	5.16%	3.12%
5-15 Services	31.82%	27.77%
>15 Services	40.46%	50.02%

- The MHP's retention rate for beneficiaries receiving more than 15 services is over 9 percent higher than the Statewide total, and represents slightly more than 50 percent of the beneficiaries served.

Diagnosis of Beneficiaries Served

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

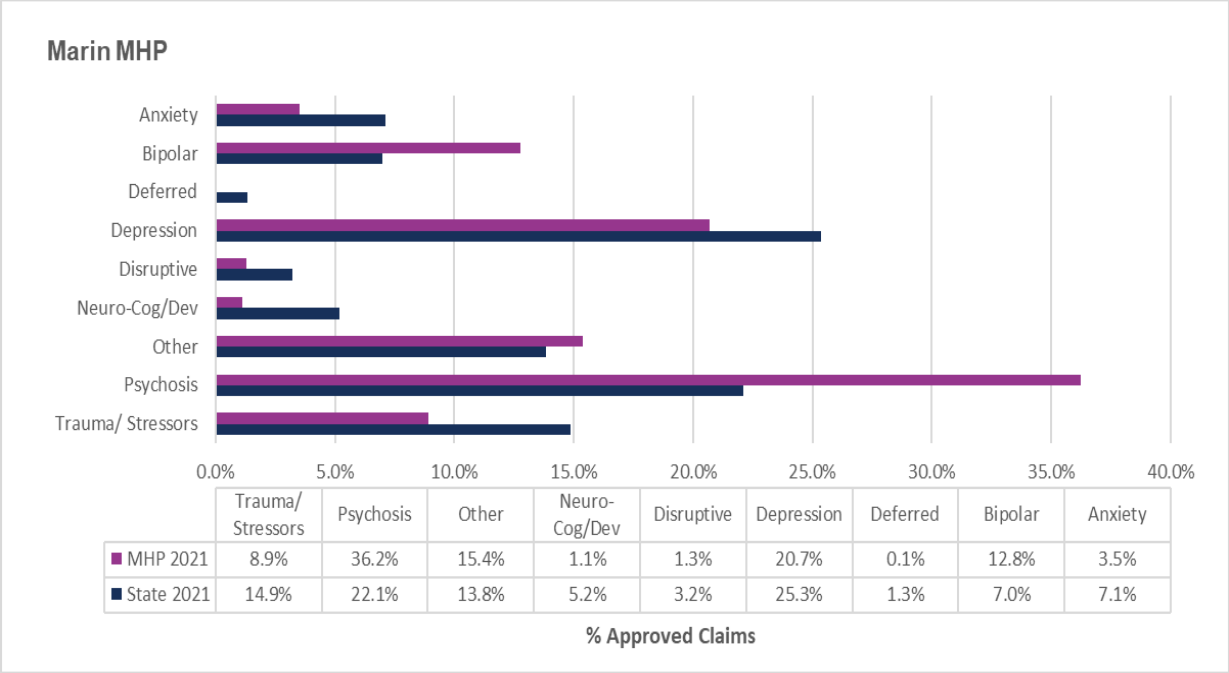
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	13.1%	29.6%	11.8%	1.8%	1.6%	24.9%	0.2%	12.4%	4.5%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- The MHP's Psychosis disorder is higher than the Statewide percentage.
- The MHP's diagnoses of Trauma/Stressors and Depression are in line with the State percentages, in all other categories the MHP is at variance to the State totals.

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	8.9%	36.2%	15.4%	1.1%	1.3%	20.7%	0.1%	12.8%	3.5%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

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 (ALOS).

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	223	420	9.77	8.79	$16,470	$12,052	$3,672,804
CY 2020	211	322	9.71	8.68	$14,042	$11,814	$2,962,773
CY 2019	231	377	9.38	7.80	$13,262	$10,535	$3,063,456

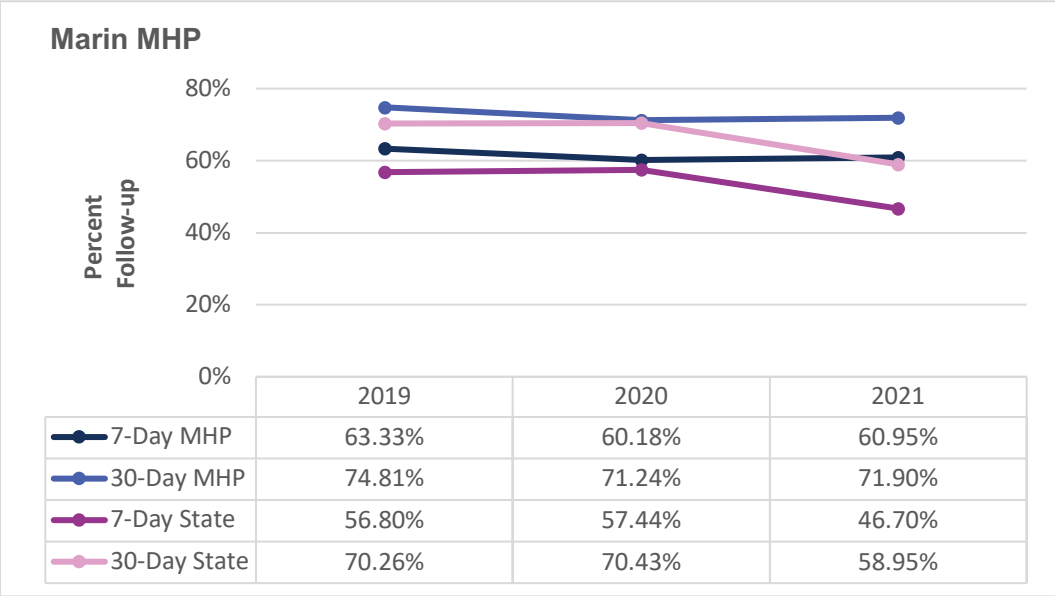
- Inpatient admissions in CY 2021 increased by 31 percent from the prior year while the ALOS remained close to the same.
- The MHP's ALOS is almost 1.0 day greater than the Statewide ALOS and the AACB is over 4k higher than the Statewide amount.

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.

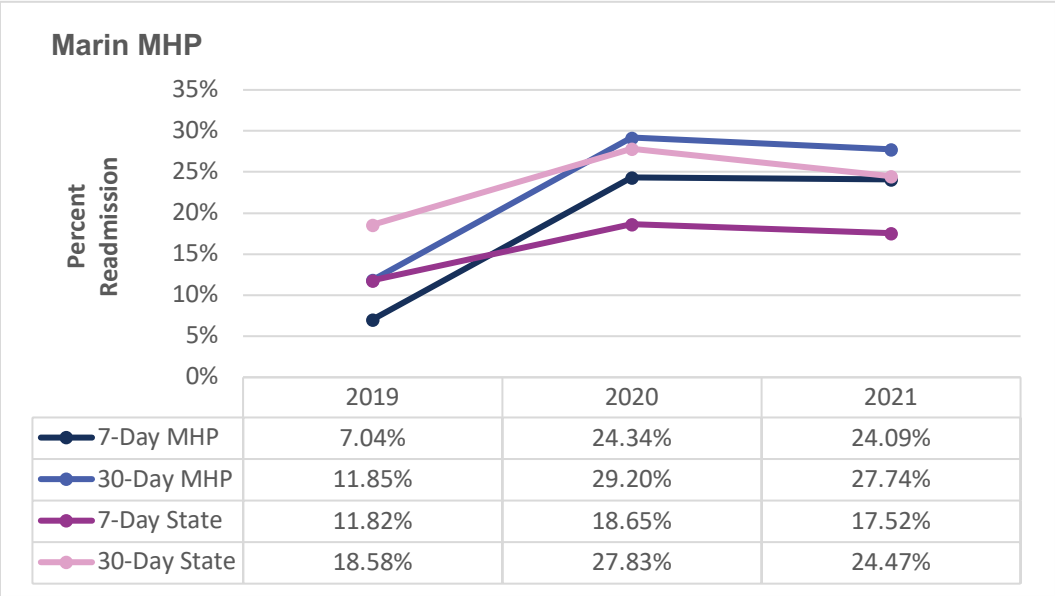
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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	63.33%	60.18%	60.95%
30-Day MHP	74.81%	71.24%	71.90%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

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



	2019	2020	2021
7-Day MHP	7.04%	24.34%	24.09%
30-Day MHP	11.85%	29.20%	27.74%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- Inpatient admissions and ALOS increased at the MHP in CY 2021.
- Inpatient approved claims represent approximately 14.13 percent of total approved claims in CY 2021.
- The 7 and 30 day post psychiatric inpatient follow up care percentages have consistently remained above the state percent.
- The MHP's readmission rates at 7- and 30-days have increased in CY 2020 and 2021.
- The MHP's data for inpatient readmission varies from the EQRO data. It reflects 4.1 percent readmission within 7 days and 15 percent readmission rate within 30 days. This issue is currently being researched.

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.

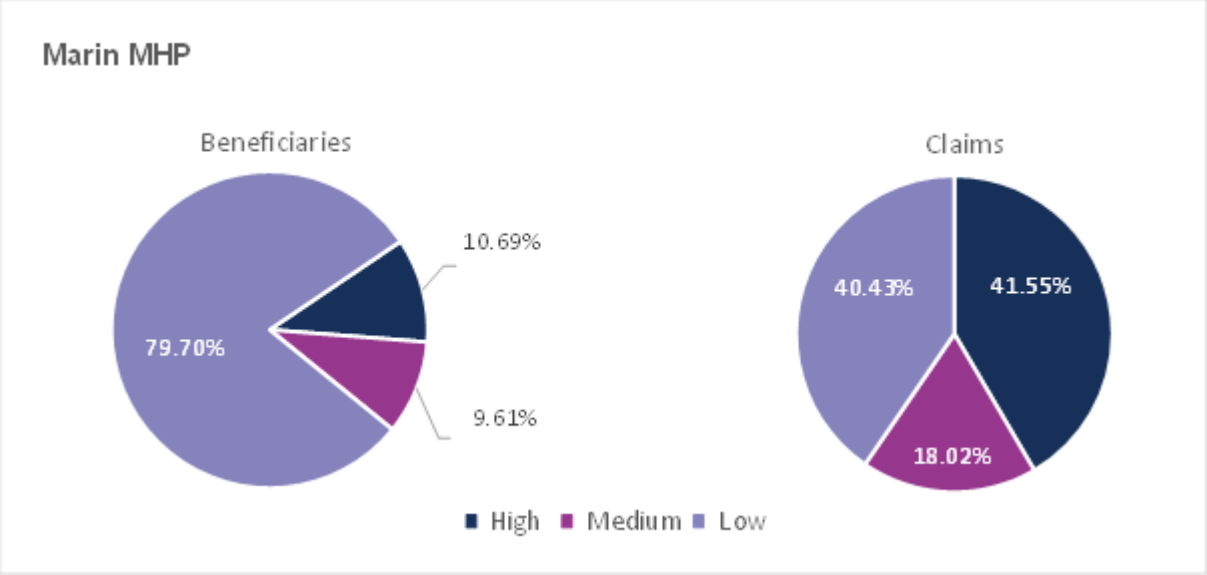
Table 14: HCB (Greater than $30,000) CY 2019-21

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	219	10.69%	41.55%	$11,158,191	$50,951	$43,787
	CY 2020	272	12.53%	44.58%	$13,725,491	$50,461	$42,219
	CY 2019	300	13.62%	50.60%	$15,620,859	$52,070	$44,394

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	197	9.61%	$4,837,5811	8.02%	$24,556	$24,317
Low Cost (Less than $20K)	1,633	79.70%	$10,856,099	40.43%	$6,648	$5,317

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



- HCB, while only 10.69 percent of the beneficiaries, represent the highest portion of all claims at 41.55 percent.

IMPACT OF QUALITY FINDINGS

- With a retention rate for >15 services nearly 10 percent higher than the statewide average, the MHP may expect to experience capacity challenges with new beneficiaries, as well as difficulties providing services at the frequency commonly associated with achieving symptomatic and functional improvements for those currently in treatment, a problem that is likely compounded by the loss of staff and difficulties with recruitment and retention.
- In a number of areas, the MHP cited staffing issues with programmatic leadership and analytic staff producing postponements of important quality efforts. This was particularly notable with improvements to medication monitoring efforts and implementation of adult outcome instruments.

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: BHQIP-PIP Milestone 3d – FUM 7/30

Date Started: 9/2022

Date Completed: 6/2023 (projected)

Aim Statement: The MHP intends to increase by 5 percent those Medi-Cal beneficiaries who receive a follow-up appointment within 7 & 30 days of an ED visit, from the CY 2021 FUM7 62 percent and FUM30 69 percent baseline for these measures.

Target Population: All Medi-Cal individuals who receive an ED visit for a mental health condition.

Status of PIP: The MHP's clinical PIP is in the planning and implementation phase following the July 2022 receipt of baseline data.

[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 BHQIP PIP seeks to improve the follow-up of Medi-Cal individuals who have received a recent emergency department visit focused on a mental health problem. There are quite a few aspects to sort through, including the data exchange process, as well as identification of staff assigned to perform the follow-up. The MHP has outlined the various aspects of this PIP, and is focused on achieving an overall 5 percent improvement by the summer of 2023. While numerous aspects are yet unresolved, the basic outline for the follow-up initiative appears well thought-out, and likely to produce the desired result.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: While resolution of some issues, such as data sharing initiatives is still in process, the basic concept and intervention strategies of outreach and utilizing trained peers to follow-up appear likely to create an improvement. More challenging is the development of data sharing agreements and interfaces, particularly with the MHP onboarding the new Streamline SmartCare EHR system in July. Typically, this type of change may create temporary obstacles to the implementation of electronic initiatives.

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

- The MHP may seek to identify and address the cultural barriers to the Black/African-American (BAA) population willingness to engage in mental health care, and then track the timeliness between assessment and first treatment services resultant outcomes separately for this group.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Timeliness between Assessment and First Treatment Services

Date Started: 03/2021

Aim Statement: Can the MHP increase the percent of clients assessed as appropriate for treatment who have their first treatment encounter within ten days of their assessment to 80 percent by defining roles, implementing new protocols, case conferencing, and changing the diagnosis process? (Baseline is 55.1 percent for youth and adult combined)

Target Population: Adults

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

Summary

The MHP reviewed the data on time from assessment to actual beginning of treatment and found a concerning long interval that exceeded the ten-day expectation. The MHP developed a set of interventions that included a flow chart from the centralized access and assessment program to the treatment programs, review and revision of protocols, cases conferences, and a changed perspective on diagnosis – with the assessment diagnosis considered a provisional one which the treatment teams are expected to update. The performance measures include: 1) assessment notes completed within 3 days of assessment, goal 90 percent of assessments; 2) average days between assessment and first treatment appointment, goal ten days or less; 3) client contacted by program with five business days of assessment, goal of 85 percent within 5 business days; 4) clients offered a treatment appointment within ten days of assessment, goal of 90 percent within 10 business days; 5) clients have their first treatment appointment within 10 business days of assessment, goal of 80 percent within 10 business day.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because: the critical metrics are not improving. There are likely a number of factors that contribute to this lack of change, but it is notable that other MHPs using the same model of centralized assessment frequently find challenges in the timeliness of transfer to a treatment program. This PIP may take further efforts and modification to see substantial and sustained improvement.

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

- The MHP noted that turnover in staff within the Access/Assessment team and within treatment teams has comprised both capacity and knowledge of the protocols. In addition, the MHP has a nearly 10 percent higher retention rate for individuals receiving more than 15 services than the statewide average. Both factors likely are involved with the reluctance of programs to accept new referrals.
- The MHP needs to develop a structured case review system, informed by an adult outcome instrument and level of care tool. The latter elements are delayed until the new EHR is implemented. However, it still remains possible for the MHP to develop clear step-down criteria, and perhaps broad implementation of group treatment modalities other protocols so that individuals can move to a less intensive form of treatment but still continue to receive care.

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 Electronic Health Records (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 a hybrid of Clinician's Gateway from Krassons, which has been in use for 16 years and ShareCare from the ECHO group, which have been in use for 11 years. Currently, the MHP has chosen the new semi-statewide new system SmartCare from Streamline in conjunction with CalMHSA and is preparing for active implementation which requires heavy staff involvement to fully develop.

Approximately 3 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency. This is a reduction of 0.49 percent from the prior year's budget.

The MHP has 310 named users with log-on authority to the EHR, including approximately 204 county staff and 106 contractor staff. Support for the users is provided by 3 full-time equivalent (FTE) IS technology positions. Currently all positions are filled.

As of the FY 2022-23 EQR, all 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	50%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐Monthly	50%
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. Currently the MHP does not have a PHR but plan to implement within the next two years.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: MH community-based organizations/Contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP has policies and procedures in place detailing the claiming process, including denied claims follow up. These procedures are utilized in training new staff and cross training existing staff.
- Key Component 4B is partially met as the MHP does not have a Data Warehouse.
- Key Component 4C is partially met as the MHP's denial rate at 4.02 percent is above the Statewide overall rate.

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in the table below, 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.

This chart appears to reflect a largely complete or very substantially complete claims data set for the time frame claimed, with only December 2021 claims data absent from the information available for the EQR to review for this period. There was no indication the MHP had experienced a claims submission delay.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	5,451	$2,346,375	$105,909	4.51%	$2,240,466
Feb	5,448	$2,358,190	$95,366	4.04%	$2,262,824
Mar	6,325	$2,753,260	$107,188	3.89%	$2,646,072
April	4,859	$2,114,515	$97,207	4.60%	$2,017,308
May	4,868	$2,267,190	$91,225	4.02%	$2,175,965
June	5,347	$2,375,665	$96,341	4.06%	$2,279,324
July	4,494	$2,211,662	$69,867	3.16%	$2,141,795
Aug	4,320	$2,121,010	$88,159	4.16%	$2,032,851
Sept	4,257	$2,149,641	$71,719	3.34%	$2,077,922
Oct	4,012	$2,046,985	$95,407	4.66%	$1,951,578
Nov	3,284	$1,740,317	$66,400	3.82%	$1,673,917
Dec	0	$0	$0	0.00%	$0
Total	**52,665**	**$24,484,809**	**$984,788**	**4.02%**	**$23,500,021**

- Overall, claims data is consistent and timely, with the exception of December 2021.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	716	$397,273	40.34%
Medicare Part B or Other Health Coverage must be billed before submission of claim	307	$176,977	17.97%
NPI related	828	$153,022	15.54%
Beneficiary not eligible or non-covered charges	251	$137,172	13.93%
Other	750	$105,270	10.69%
Service line is a duplicate and a repeat service procedure code modifier not present	28	$15,075	1.53%
Total Denied Claims	**2,880**	**$984,789**	**100.00%**
Overall Denied Claims Rate	**4.02%**		
Statewide Overall Denied Claims Rate	**2.78%**		

- The MHP overall denied claims rate is higher than the Statewide average.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP's 4.02 percent denial rate is 1.24 percent higher than the Statewide average, indicating that additional pre-claim screening and correction is necessary. Denials in CY 2021 represented close to 1 million dollars of funding. Decreasing the denials impact would improve cash flow.
- With current systems on MH side producing data and reports is a challenge. The MHP strives to use the data available. Every manager gets a client services report, monthly dashboards including a Crisis Services Unit dashboard, monthly no-show reports, weekly pending reports (notes) and draft reports (notes) as well.
- No show tracking relies on staff to enter a procedure code and notes, as such it is not reliable. There is not a standardized policy/procedure for no show events which likely results in under-reporting.
- The MHP does not currently have a Data Warehouse which contributes to inhibiting the ability to test and produce reports.
- The MHP has chosen the semi-Statewide EHR, through CalMHSA, SmartCare from StreamLine. The conversion is scheduled to ramp up in January 2023, with full implementation in July 2023. It is anticipated that this conversion will result, along with CalAIM changes, in business process and record keeping changes which may impact beneficiaries. The new system will include a Data Warehouse.
- A contract has been established with XPIO Health consulting who will help guide the customization of SmartCare.
- Document redesign for CalAIM was implemented in July 2022. Leaner progress notes have been well received. No wrong door policy was also implemented in July 2022. These changes allow beneficiaries a more expedient entry into services. The changes allow staff to spend more time with clients.
- MHP does not currently have LOC tools.
- MHP does not currently have an exercise or learning management system (LMS)
- Webpage comments:
    - Crisis Services banner needs to be in a bright color to draw attention.
    - Location of items on the website is not intuitive.
    - Provider Directory was last updated in August 2022.

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's goal is to report CPS results data back to programs twice yearly for use in selecting improvement goals, with plans to pilot an improvement process with the adult system of care (SOC) and the children's SOC. The MHP states that it has not yet received the results of the June 2021 administration, and thus has not implemented improvement activities that were planned.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of parents and caregivers of children and youth, the majority of whom initiated services in the preceding 12 months. The focus group was held at virtually and included four participants; a Spanish language interpreter was used for this focus group. All family members participating have a family member who receives clinical services from the MHP.

Of those who initiated services within the last year, for some it took approximately one month, and required two calls to follow-up and have services initiated. None receive appointment reminder calls. For those parents/caregivers who prefer Spanish, there are no difficulties with language. The children often have English as preferred language and bilingual clinicians seem available to assist parents who are Spanish speakers.

Participants did not need transportation help, but did not recall that type of assistance was offered. Also, if there are challenges with reaching an appointment, telehealth is an

option using telephone or Zoom. Some were surprised to learn that transportation help was available.

Family participation in treatment is offered and for most has occurred, contingent upon the child's approval. Physical health status is a topic of discussion, which includes nutrition and general healthcare. For those receiving medication, communication with other psychiatrists and primary care does occasionally occur.

Knowledge of the option to change clinicians was possessed by some of the group members, but not utilized as it was not needed. Most reported exclusively receiving services through Zoom, but offers to make home visits have been made by clinicians. Psychiatry has been available only through Zoom sessions. Participants are aware that recently the option of in-person care has been made for non-psychiatry services.

All caregivers mentioned receiving services initially through the school system, with several of the children having an individual education plan. But referrals to the MHP were made due to the need for more intensive care and psychiatry.

The frequency of services varies widely among these participants. Prior to the pandemic some had robust care that included a child mentor and a parent partner. Currently, the frequency of services varies from weekly to monthly or every three months. Psychiatry frequency also varies, following medication changes it can be as often as every two weeks.

Therapist contact is often weekly for an hour. Case manager support varies from person to person and needs of the family. Case management support is missed when it is no longer available. One of the participants continues to have a parent partner's support.

Appointment scheduling is reportedly quite flexible and adaptive. If an appointment is missed, a quick reschedule for the next week is possible. Most report this is very infrequent.

If a crisis arises, crisis phone numbers can be utilized, as can the Access number. The crisis unit is also available. Some are able to text the clinician who will make time to talk outside of a routine appointment.

Communication about changes in services was obtained during in-person appointments. But emails and other communication vehicles are not utilized by the MHP. The MHP website has been utilized by some, but generally it is not needed. Information can be gained by contacting the therapist or using Google. Family Partners also have resource information. All participants feel their cultural needs are understood and met by the MHP and its staff.

The majority have not felt negative impacts from the COVID adjustments in care. However, associated with the resignation of a clinician, one participant felt the need to file a grievance because there was no follow-up or bridge services when the clinician

departed. However, the grievance response referred the caregiver to a robust program and there have been no further problems.

At this point all participants feel positive about the care received and feel hopeful about the future. However, this positive response follows, for several members, a frustrating initial experience with treatment wherein it took as long as eight months to finally receive care. For these participants, it seemed that their children entered into services after significant delays and upon engaging in self-harm behaviors.

Recommendations from focus group participants included:

- Several of the participants were completely satisfied and had no recommendations to offer.
- Expedite initial assessments, so that early treatment is provided.
- Offer family therapy to all early in treatment.
- Provide support in navigating the nexus between private insurance and MHP services.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of adult consumers, the majority of whom initiated services in the preceding 12 months. The focus group was held virtually, via a Zoom session, and included three participants; an ASL language interpreter was used for this focus group. All consumers participating receive clinical services from the MHP.

None of the participants initiated services within the last year. Beyond that one-year period, participants reported wait times for services ranging between two weeks to one year. The longest wait time occurred at the onset of the COVID-19 pandemic.

The majority of these participants receive appointment reminders. In regards to linguistic needs, ASL interpreting is difficult to obtain and reportedly of limited quality. Transportation support involves bus rides to appointments, but requests for taxi to return home when not feeling well are denied. Individuals with more prominent and permanent health issues do receive taxi ride approval. Others mentioned Whistle Stop for medical transport, and gas cards provided by Project Hope as additional means of transportation support.

Family involvement in treatment is not desired by some, and considered not needed by another. All members consider that clinicians and psychiatrists discuss physical health issues with them, and coordinate with primary care providers on an as-needed basis. Telehealth varies among these focus group beneficiaries. Some usually receive in-person psychiatry services, but currently have a choice of telehealth if desired. Another was informed that therapy may continue via telehealth, but psychiatry needs to revert to in-person care. This individual is concerned due to preference for virtual/telehealth services.

Urgent or crisis needs result in those with Kaiser coverage going to that hospital's emergency room, calling 911, or turning to the MCRT or family members. Others are aware of the myriad of resources, but typically personally manages these matters. The Enterprise Resource Center was identified as another resource.

Satisfaction surveys, or the CPS, has been completed by the majority of participants, with half receiving the results, and the other half who has not been provided with the results.

Information about service changes in the system has been received by the majority of these participants, with information provided by a case manager or the MHP's website. The website was cited as well-designed by several members, and provides new information.

Participation in MHP committees has not occurred for any of these focus group members. One has thoughts about joining or attending the mental health advisory board. Several are consistently using the wellness center program and its services. The Enterprise Resource Center is cited as a positive program that provides activities, groups and other functions.

In regards to progress from services, all members cite positive changes that have occurred, including cessation of drug and alcohol use, finding housing, absence of jail episodes, and more.

One member stated: "Not doing this alone," attributing progress to the assistance received from staff at all levels.

Recommendations from focus group participants included:

- Greater access to transportation. Respect requests for individual transportation (taxi, Uber), instead of evaluating the individual's need which may result in denial of the request.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Caregivers of children and youth and adult beneficiaries both report significant positive results from services. The quality of ASL interpretation may be worthy of exploration by the MHP with beneficiaries who use it. The caregiver experience of delays in access to care, in which self-harm acts occurred before intake to the services occurred is also worthy of exploration by the MHP. Perhaps this could be addressed with the MHP seeking feedback about the intake process from all of those who have entered services. Beneficiaries seem to be receiving mixed messages about the availability of psychiatry through telehealth, even when preferred. Finally, the approval of individual transportation support (i.e., taxi, Uber) merits exploration to determine what criteria are currently in use for approval or denial of these requests.

CONCLUSIONS

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

STRENGTHS

1. The MHP continues to work on improving the time to first treatment service with a non-clinical PIP, a common problematic area for many MHPs and infrequently the focus of formal improvement efforts. (Access, Timeliness)
2. The MHP has policies and procedures in place detailing the claiming process including denied claims follow up. These procedures are utilized in training new staff and cross training existing staff. (IS)
3. MHP focus group beneficiaries reported awareness and use of the MHP website than is usual, with positive comments about the design and usefulness of information provided. A translation tab is easily located at the top of the page. (Access, Quality)
4. Adult beneficiaries reported they were offered bus vouchers and gas cards for transportation. (Access)
5. The MHP reports an overall post-hospital discharge follow-up average of 3.0 days, with 73.2 percent delivered within 7-days of discharge and 80.3 percent delivered within 30-days. (Access, Timeliness)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP continues to experience difficulties in recruitment and retention of needed licensed personnel, including psychiatrists, resulting in continuation of capacity challenges. (Access, Quality)
2. Due to staffing issues, the MHP was unable to implement the review of timeliness on at least a quarterly basis, with documentation of review and development of improvement strategies as needed. (Timeliness, Quality)
3. Staffing changes prevented the MHP from implementing SB 1291 medication monitoring of FC youth. (Quality)
4. The MHP's denial percent at 4.02 percent is 1.24 percent higher than the Statewide average. Denials in CY 2021 represented close to 1 million dollars of funding. (Quality, IS)
5. The MHP identified 14 percent of access calls appropriately logged in FY 2021-22, contrasted with 81 percent during FY 2020-21. In addition, a high

volume of test calls went unanswered during the FY 2021-22 period. (Access, 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. Expedite the process of implementing strategies for improving recruitment and retention efforts that result in the hiring of qualified individuals through mechanisms such as alternative work schedules, as well as improving the image of MHP employment. (Access, Quality)

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

2. Review timeliness on at least a quarterly basis with documentation of review and development of improvement strategies as needed. (Timeliness, Quality)

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

3. Develop a process and begin medication monitoring for youth SB1291 HEDIS measures in FC on a quarterly basis. (Quality)

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

4. Enhance pre-claim review increasing completion of necessary corrections, thereby decreasing unnecessary denials and negative impact to department cash flow. (Quality, IS)

5. Implement a regular, at least quarterly, review of Access call logging, and develop intervention strategies to improve those areas falling short of standards. (Access, Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a public health emergency (PHE) exists. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT F: PM Data CY 2021 Refresh

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Marin MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Access to Care
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Validation and Analysis of Beneficiary Satisfaction
PIP Validation and Analysis
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Performance Measure Validation and Analysis
Validation and Analysis of the MHP's Network Adequacy
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Clinical Management and Supervision
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

Rob Walton, Quality Reviewer
Leda Frediani, Information Systems Reviewer
Pamela Roach, Consumer-Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Aguilar Miramontes	Sinead	Mental Health Practitioner	Marin County BHRS
Averbach	Rachelle	Mental Health Practitioner	Marin County BHRS
Ballard	Lisa	Unit Supervisor - Crisis	Marin County BHRS
Berry	Christel	Mental Health Practitioner	Marin County BHRS
Cain	Sarah	Utilization Review Specialist	Marin County BHRS
Carter	Matthew	CSOC Program Manager	Marin County BHRS
Clarke Rio	Kasey	Admin Services Manager	Marin County BHRS
Condon	Cat	SA Division Director	Marin County BHRS
Corkum	Freeman “Sam”	Technology Systems Specialist III	Marin County BHRS
Dang	Alex	Mental Health Unit Supervisor – ASOC/AOSOC	Marin County BHRS
De Nieva	Mo	Sr. Program Coordinator SUD	Marin County BHRS
DeBusk	Mike	Office Assistant III	Marin County BHRS
Diaz	Jessica	ASOC/AOSOC Program Manager	Marin County BHRS
Flores	Marta	Clinical Psychologist II	Marin County BHRS
Funez Arteaga	Michelle	Forensics Division Director	Marin County BHRS
Gibson	Jeanene	Administrative Services Associate	Marin County BHRS
Gill	Shammi	Asst Tech Finance	Marin County BHRS
Gordiejew	Kristin	Utilization Review Specialist	Marin County BHRS
Hall	Jordan	SUD Program Manager	Marin County BHRS

Last Name	First Name	Position	County or Contracted Agency
Henn	Cameron	Prevention Projects	Marin County BHRS
Hornsey	Tamara	Access Unit Supervisor	Marin County BHRS
Jean	Larry	Peer Provider	Mental Health Assoc. of SF (MHASF)
Johnson	Heather	Mental Health Practitioner	Marin County BHRS
Jones	Steve	QM/Access/IT Division Director	Marin County BHRS
Kaufmann	Lynda	Director of Government and Public Affairs	Psynergy
Klein	Irene	Behavioral Health Programs Director	Connect Integrated Community Services (ICS)
Lallana	Rosanna	Compliance Officer	Marin County BHRS
Lucius	Guinevere	Peer Counselor II	Marin County BHRS
Lukas	Brian	Executive Director	Child Therapy Institute of Marin (CTIM)
Main	Galen	MHSA Coordinator	Marin County BHRS
Marquardt	Talita	Quality Assurance Manager	Seneca Family of Agencies
Mena	Cheryllynn	Mental Health Practitioner	Marin County BHRS
Moore	Jennifer	Equity and Inclusion Manager	Marin County BHRS
Murotake	David	Technology Systems Specialist III	Marin County BHRS
N/A	Lucy	Program Manager of Crisis Related Services	Mental Health Assoc. of SF (MHASF)

Last Name	First Name	Position	County or Contracted Agency
Nisbet	Cynthis	Admin Support SUD	Marin County BHRS
Nobori	Michelle	BHRS Operations Director	Marin County BHRS
O'Brien	Nancy	Mental Health Unit Supervisor – ASOC/AOSOC	Marin County BHRS
Ongwongsakul	Walter	Department Analyst II	Marin County BHRS
Paler	Todd	ASOC/AOSOC Program Manager – Crisis Services	Marin County BHRS
Palomo	Alberto	Technology Systems Coordinator	Marin County BHRS
Parra	Yessica	Mental Health Practitioner	Marin County BHRS
Perez	Dana	Peer Provider	Mental Health Assoc. of SF (MHASF)
Rajparia	Amit	BHRS Medical Director	Marin County BHRS
Ramirez-Griggs	Sandra	Mental Health Unit Supervisor – CSOC	Marin County BHRS
Robinson	Brian	CSOC Division Director	Marin County BHRS
Rodriguez-Trujillo	Kenny	PSC - IMPACT	Marin BHRS IMPACT
Saddler	Yazmin	Mental Health Unit Supervisor – ASOC/AOSOC	Marin County BHRS
Sarria	Karen	Mental Health Practitioner	Marin County BHRS
Schirmer	Todd	BHRS Director	Marin County BHRS
Schliesmann	Lauren	Utilization Review Specialist	Marin County BHRS
Silverstein	Jesse	Utilization Review Specialist	Marin County BHRS

Last Name	First Name	Position	County or Contracted Agency
Smedley	Rose	Assistant CFO - BHRS	Marin County BHRS
Smith	Katie	QM Unit Supervisor	Marin County BHRS
Steffy	Leigh	Department Analyst II	Marin County BHRS
Stein	Rebecca	Workforce Education and Training Supervisor	Marin County BHRS
Struzzo	Susanna	Mental Health Practitioner	Marin County BHRS
Tiura	Bailey	Program Director	Homeward Bound of Marin
Tognotti	Angela	Mental Health Unit Supervisor – ASOC/AOSOC	Marin County BHRS
Turner	Martin	Mental Health Practitioner	Marin County BHRS
Wasson	Jennifer	Accounting Technician	Marin County BHRS
Wilbur	Steve	Quality Improvement Coordinator	Marin County BHRS
Wilson	Michael	ASOC/AOSOC Division Director	Marin County BHRS
Yu	Lokyan “Wilsxe”	Mental Health Nurse	Marin County BHRS
Zuniga	Juanita	Clinical Psychologist II	Marin County BHRS

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	In that the MHP currently stands above the FUM7/30 national benchmarks, and in Quartile 2 (second highest) for FUM 7/30, achievement of a 5 percent improvement by June 20, 2023 would appear a reasonable goal, particularly since previously there were no organized efforts to improve results in this area before.

General PIP Information
MHP/DMC-ODS Name: Marin MHP
PIP Title: Follow-Up After Emergency Department 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% by June 30, 2023.
Date Started: 09/2022
Date Completed: 06/30/2023 (projected)
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): Individuals receiving emergency department services for a mental health condition.
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): Use of peer support services – care coordination, assertive outreach, motivational interviewing, advocacy and empowerment to support transitions following emergency department visits.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): MHP work with ED staff to obtain timely reports of beneficiary visits for mental health conditions.
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): EHR improved data-exchange capabilities to obtain timely notification of emergency department visits; bidirectional communication with MCPs. Assertive care coordination strategies.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of emergency department visits that result in a follow-up MH service with 7/30 days (FUM7/FUM30)	CY 2021	N=359 68%	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

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 plans to track overall improvement, not improvement based on race/ethnicity/language. Considering that Black/African Americans have a slightly lower follow-up rate, if may wish to develop strategies to overcome resistance to follow-up and treatment by this group. Should the data be available in a format that includes race/ethnicity/language, it could be useful to track results based on that breakdown. If obtaining data as provided by CalMHSA by these variables will not be available in future data runs, aggregate analysis would be an appropriate fallback approach.

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	This is a very important topic, and one that is rarely addressed. It reflects the challenges of changing cultural and process in organizations that are having significant turnover of staff and at the same time were impacted by COVID restrictions. With only one performance measure of five that remains better than baseline, low confidence is the most appropriate current rating. That said, if staffing and leadership stabilize during the next six months of the PIP, it may begin to produce more positive results.

General PIP Information
MHP/DMC-ODS Name: Marin MHP
PIP Title: Timeliness between Assessment and First Treatment Services
PIP Aim Statement: Can the MHP increase the percent of clients assessed as appropriate for treatment who have their first treatment encounter within ten days of their assessment to 80% by defining roles, implementing new protocols, case conferencing, and changing the diagnosis process? (Baseline is 55.1% for youth and adult combined)
Date Started: 03/2021
Date Completed: 06/30/2023
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): Medi-Cal beneficiaries who have had a emergency department visit for a mental health condition. Medi-Cal eligible adults initially accessing care.
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): Outreach and engagement with individuals who have had a recent emergency department visit – both open to mental health and not.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Training of staff, protocol development, and case conferences.
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): Adoption of the LOCUS for the adult system of care. Changes in protocol, training of staff, and case conferences.

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. Assessment notes completed within 72 hours (3 days) of assessment Goal 90% of assessments	Oct - Dec 2020	N= 132 60.6%	April - June 2022	N= 71 29.6%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2. Average days between Assessment and first treatment appointment Goal Equal to or less than 10 days.	December 2020	N = 54 7.7 days	April - June 2022	N= 12 12.9 days	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
PM 3. Clients contacted by a program within 5 business days of assessment 85% of contacts happening within 5 business days of note completion	December 2020	N= 17 64.7%	April – June 2022	N= 12 41.67%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
PM 4. Clients who are offered an appointment within 10 days of assessment Goal 90% of clients offered an appointment within 10 business days of assessment	December 2020	N= 27 18.5%	April -June 2022	N= 12 33 %	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
PM 5. Clients who have their first appointment within 10 days of assessment Goal 80% of clients complete an appointment within 10 business days of assessment	FY 2019-20	55.1%	April - June 2022	N=12 41.67	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

PIP Validation Information
Validation phase (check all that apply): ☒ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☒ First remeasurement ☒ Second remeasurement ☒ Other (specify): Sixth remeasurement 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: Continued efforts to identify communication strategies that ensure the workforce remains aware of the changes in policy and protocol. More frequent review of the protocol elements, timeliness standards, and quick implementation of the LOCUS instrument may be more effective means of promoting changes this PIP is targeting.

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

Marin 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	52,490	2,137	4.07%	$30,817,427	$14,421
CY 2020	47,274	2,171	4.59%	$30,789,855	$14,182
CY 2019	45,335	2,202	4.86%	$30,869,799	$14,019

*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	4,554	26	0.57%	1.08%	1.96%
Ages 6-17	10,835	367	3.39%	4.41%	5.93%
Ages 18-20	2,853	92	3.22%	3.73%	4.41%
Ages 21-64	29,279	1,366	4.67%	4.11%	4.56%
Ages 65+	4,970	286	5.75%	2.26%	1.95%
Total	**52,490**	**2,137**	**4.07%**	**3.67%**	**4.34%**

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	301	14.09%
Threshold language source: Open Data per BHIN 20-070		

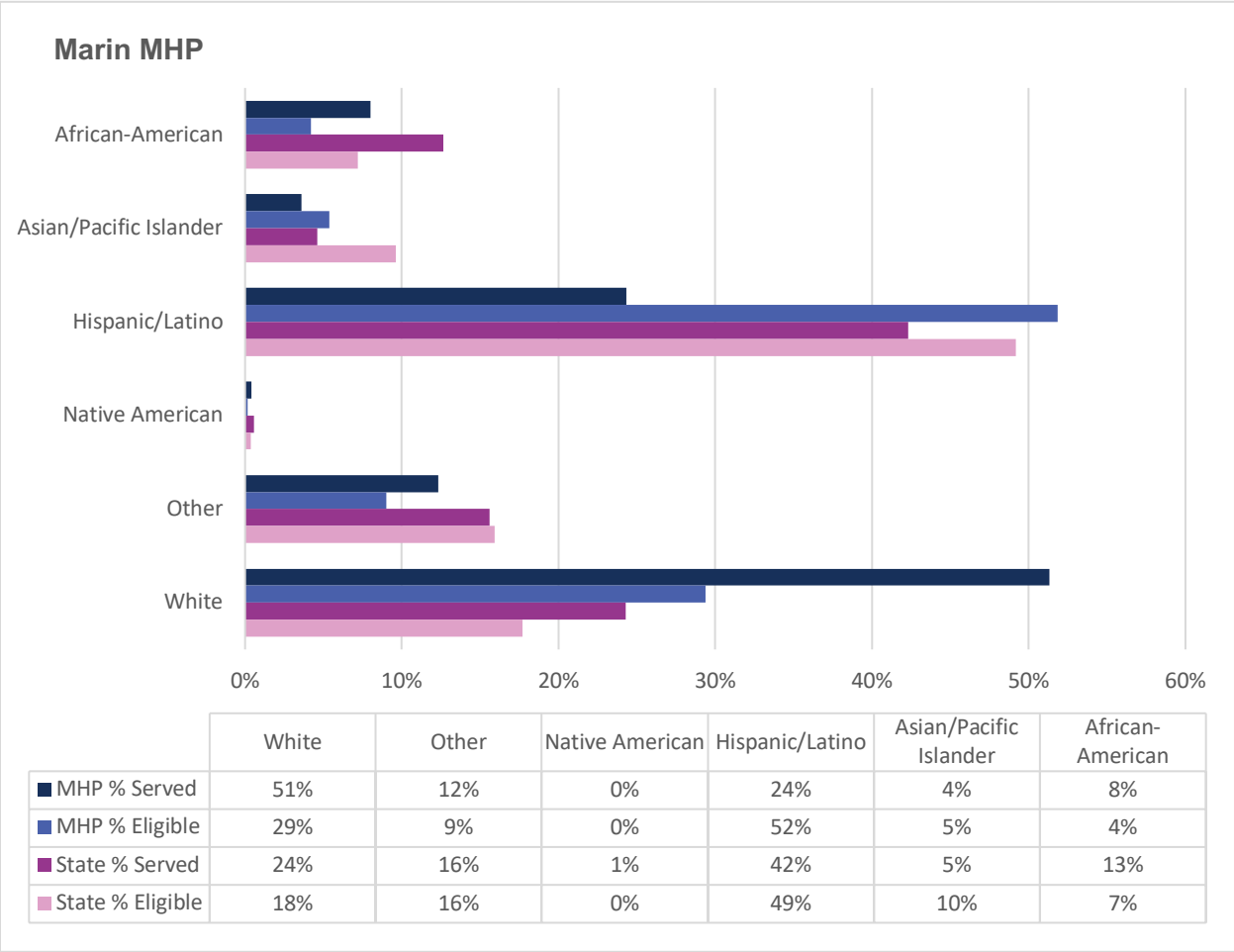
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	18,120	576	3.18%	$8,045,568	$13,968
Medium	613,796	20,261	3.30%	$151,430,714	$7,474
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	2,213	171	7.73%	7.64%
Asian/Pacific Islander	2,823	-	-	2.08%
Hispanic/Latino	27,220	520	1.91%	3.74%
Native American	89	<11	-	6.33%
Other	4,721	263	5.57%	4.25%
White	15,426	1,097	7.11%	5.96%
Total	**52,492**	**2,137**	**4.07%**	**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	51%	12%	0%	24%	4%	8%
MHP % Eligible	29%	9%	0%	52%	5%	4%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

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

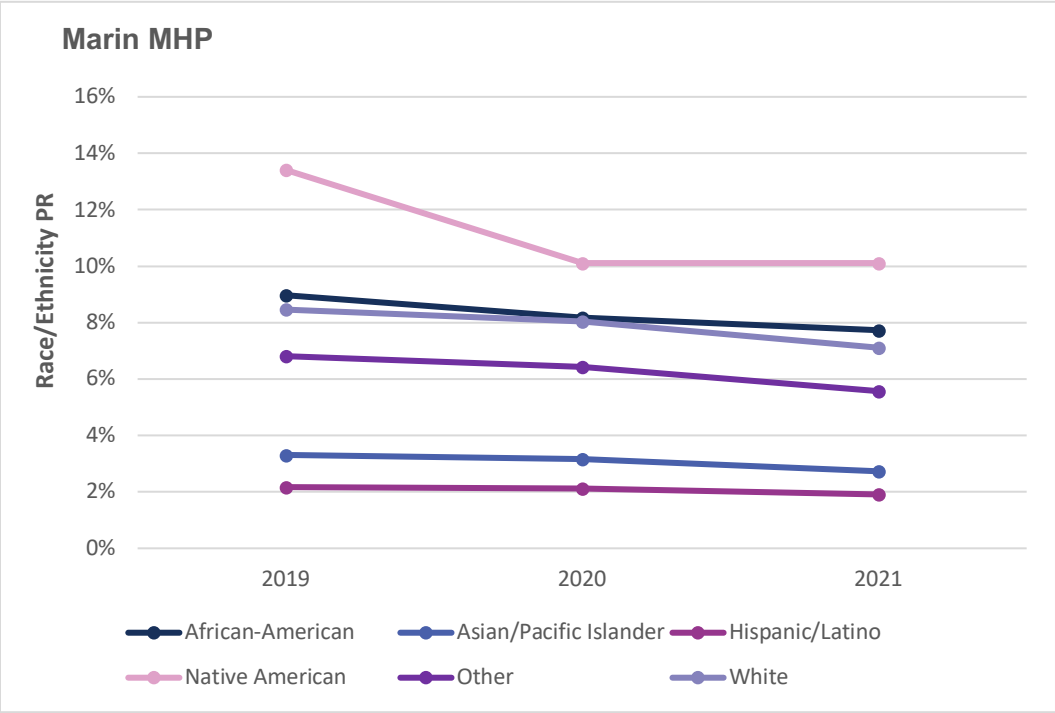


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

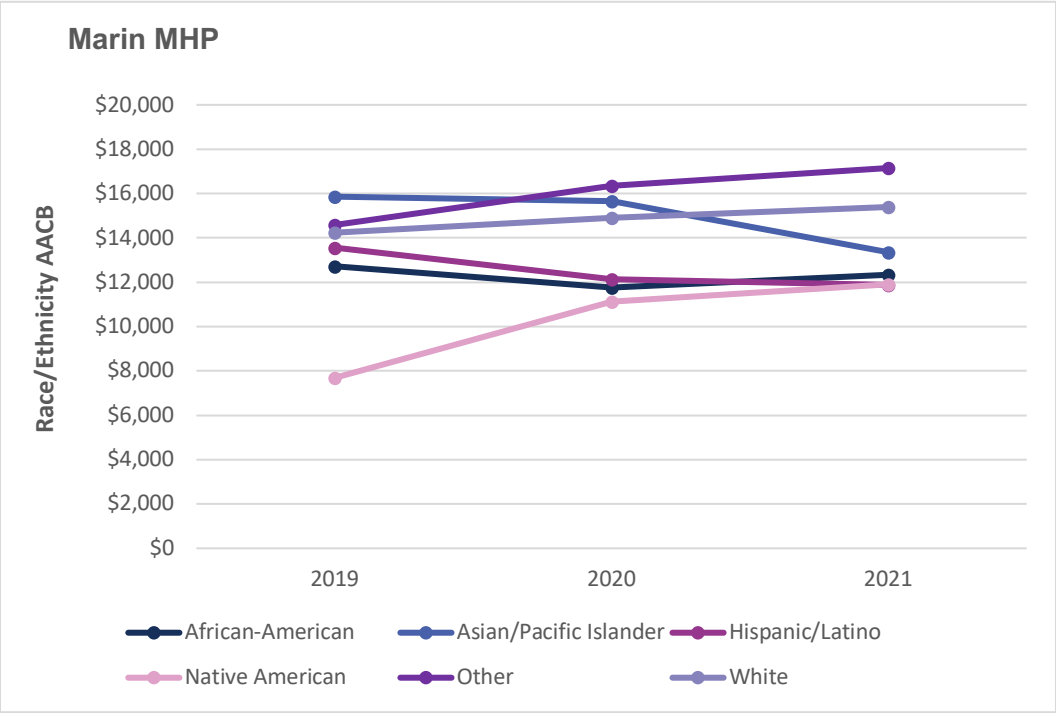
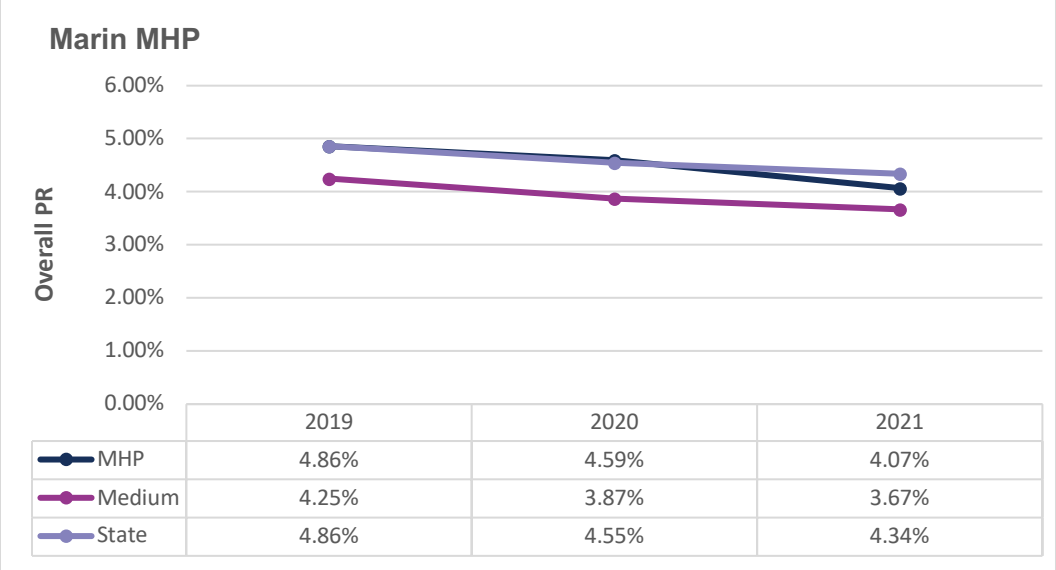
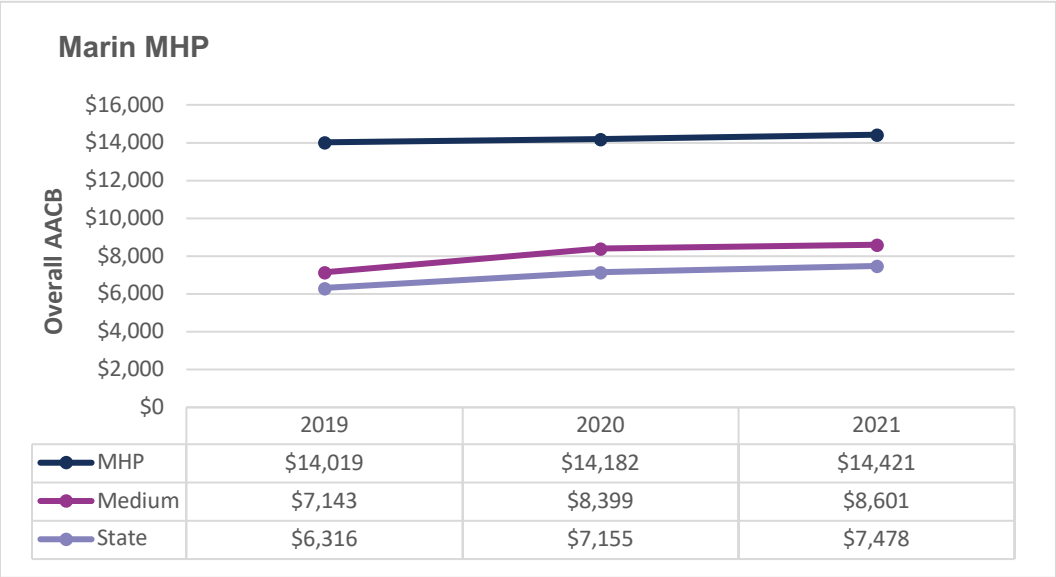


Figure 4: Overall PR CY 2019-21



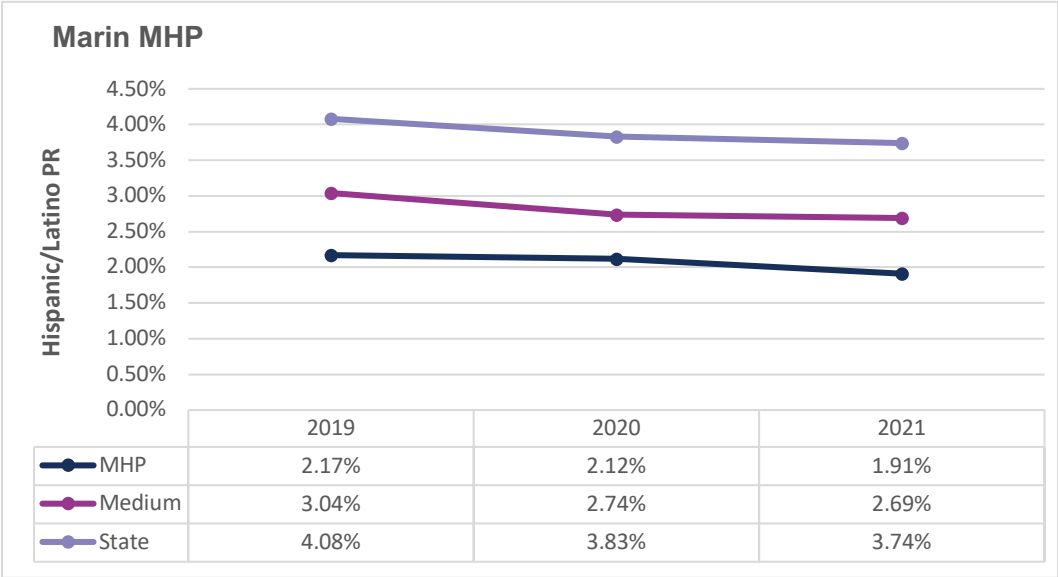
	2019	2020	2021
MHP	4.86%	4.59%	4.07%
Medium	4.25%	3.87%	3.67%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



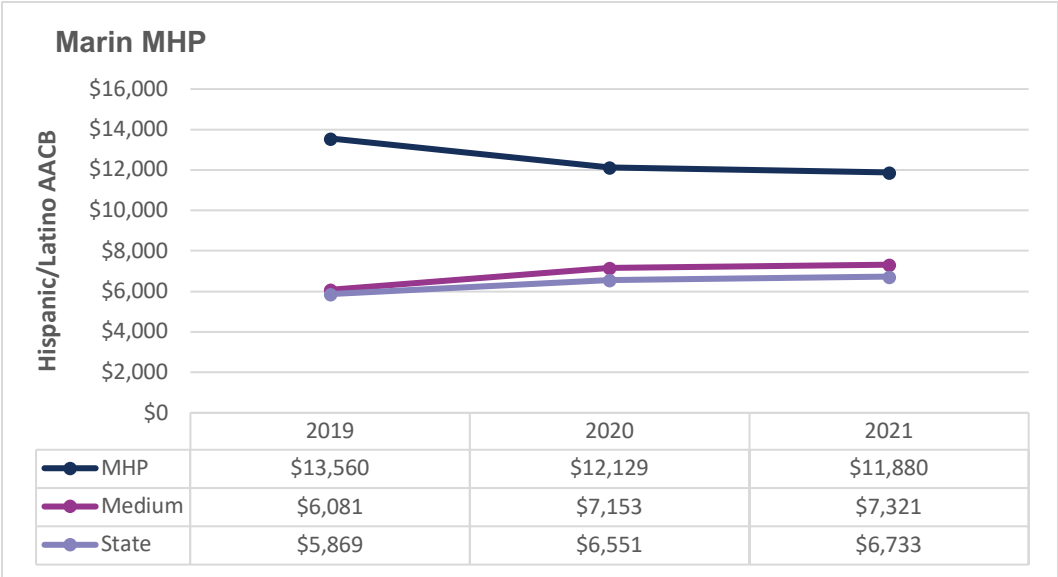
	2019	2020	2021
MHP	$14,019	$14,182	$14,421
Medium	$7,143	$8,399	$8,601
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21



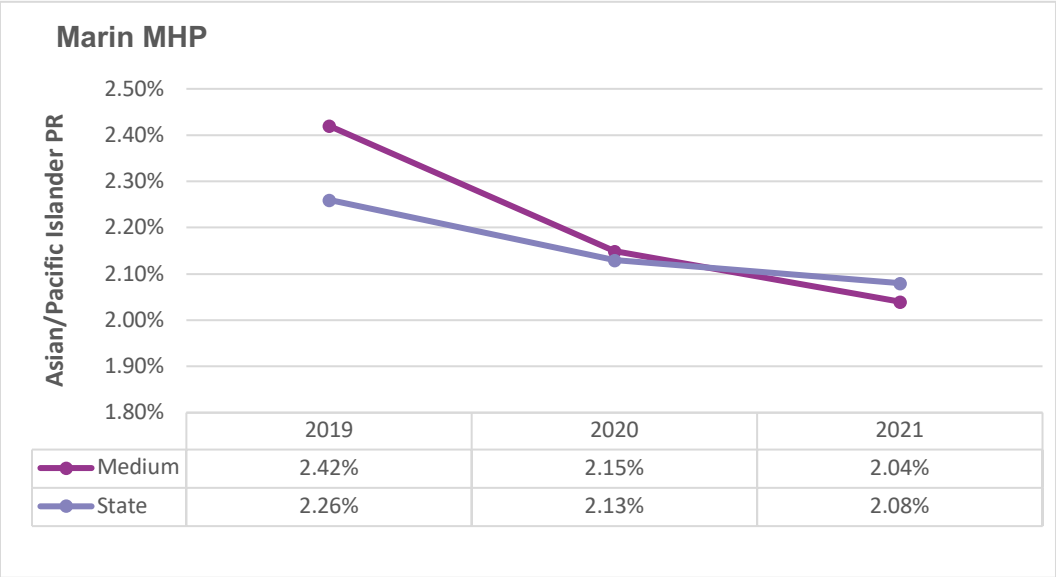
	2019	2020	2021
MHP	2.17%	2.12%	1.91%
Medium	3.04%	2.74%	2.69%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$13,560	$12,129	$11,880
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

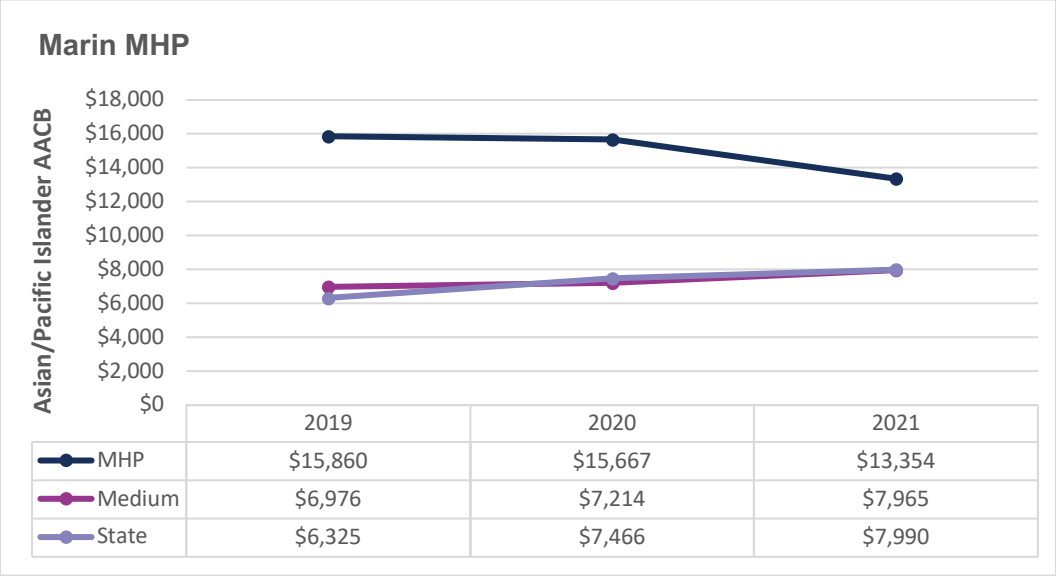
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
Medium	2.42%	2.15%	2.04%
State	2.26%	2.13%	2.08%

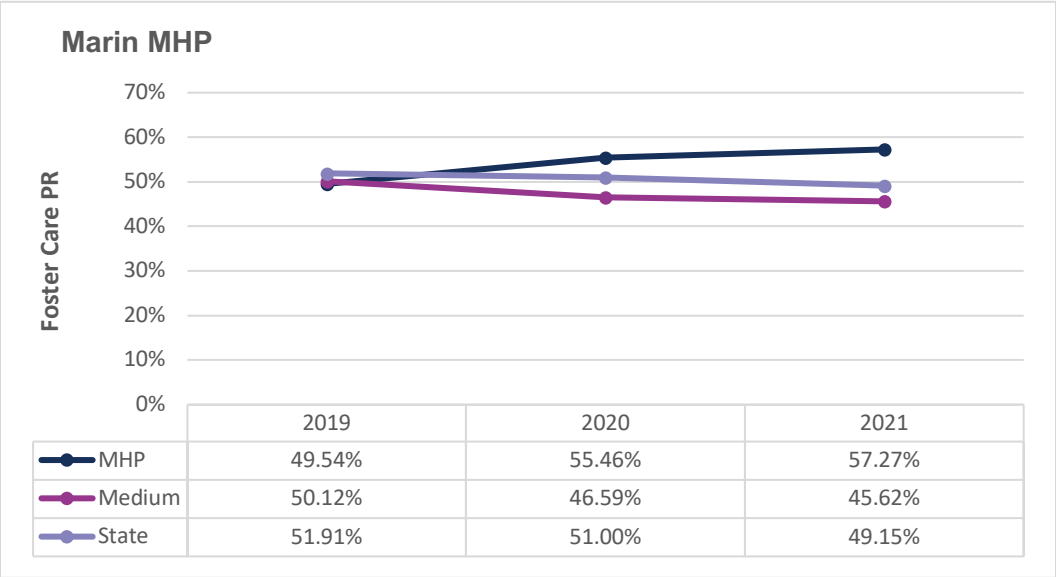
*The MHP's data is not displayed above to prevent calculation of the small number of Native American beneficiaries represented in Table 7.

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



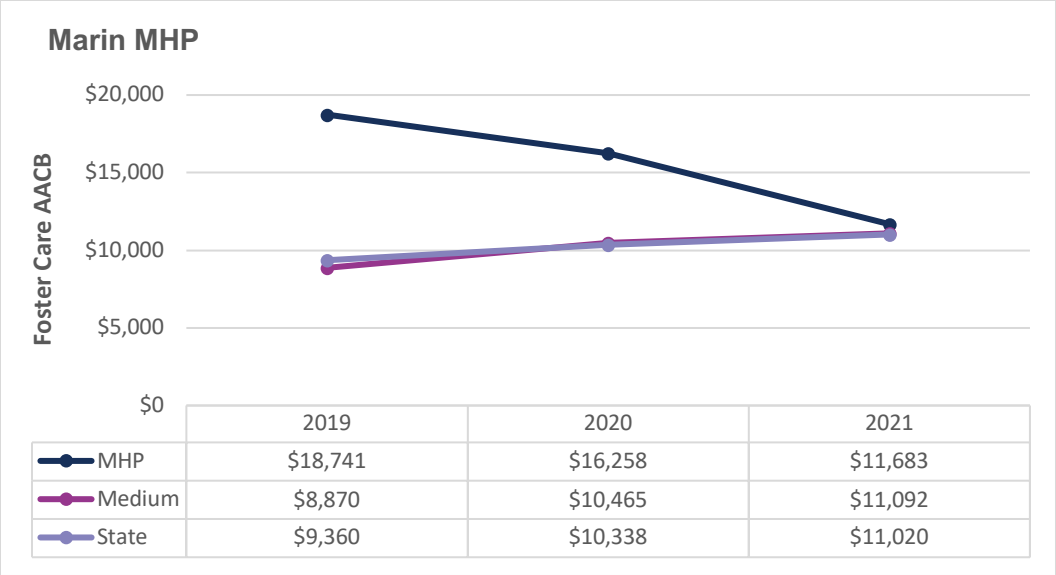
	2019	2020	2021
MHP	$15,860	$15,667	$13,354
Medium	$6,976	$7,214	$7,965
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	49.54%	55.46%	57.27%
Medium	50.12%	46.59%	45.62%
State	51.91%	51.00%	49.15%

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$18,741	$16,258	$11,683
Medium	$8,870	$10,465	$11,092
State	$9,360	$10,338	$11,020

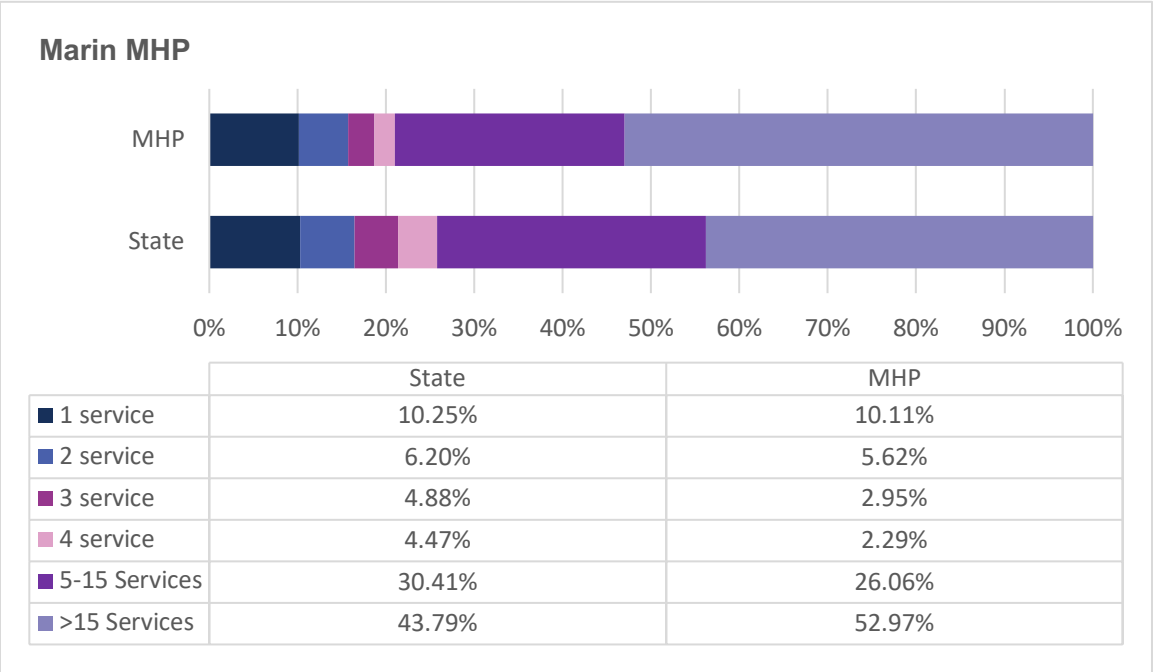
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 1,745				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	262	15.0%	19	12	11.6%	16	8
Inpatient Admin	<11	-	2	2	0.5%	23	7
Psychiatric Health Facility	<11	-	7	6	1.3%	15	7
Residential	<11	-	34	34	0.4%	107	79
Crisis Residential	138	7.9%	18	17	2.2%	21	14
Per Minute Services							
Crisis Stabilization	378	21.7%	1,467	1,200	13.0%	1,546	1,200
Crisis Intervention	100	5.7%	170	121	12.8%	248	150
Medication Support	1,240	71.1%	551	430	60.1%	311	204
Mental Health Services	1,058	60.6%	959	500	65.1%	868	353
Targeted Case Management	813	46.6%	858	419	36.5%	434	137

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

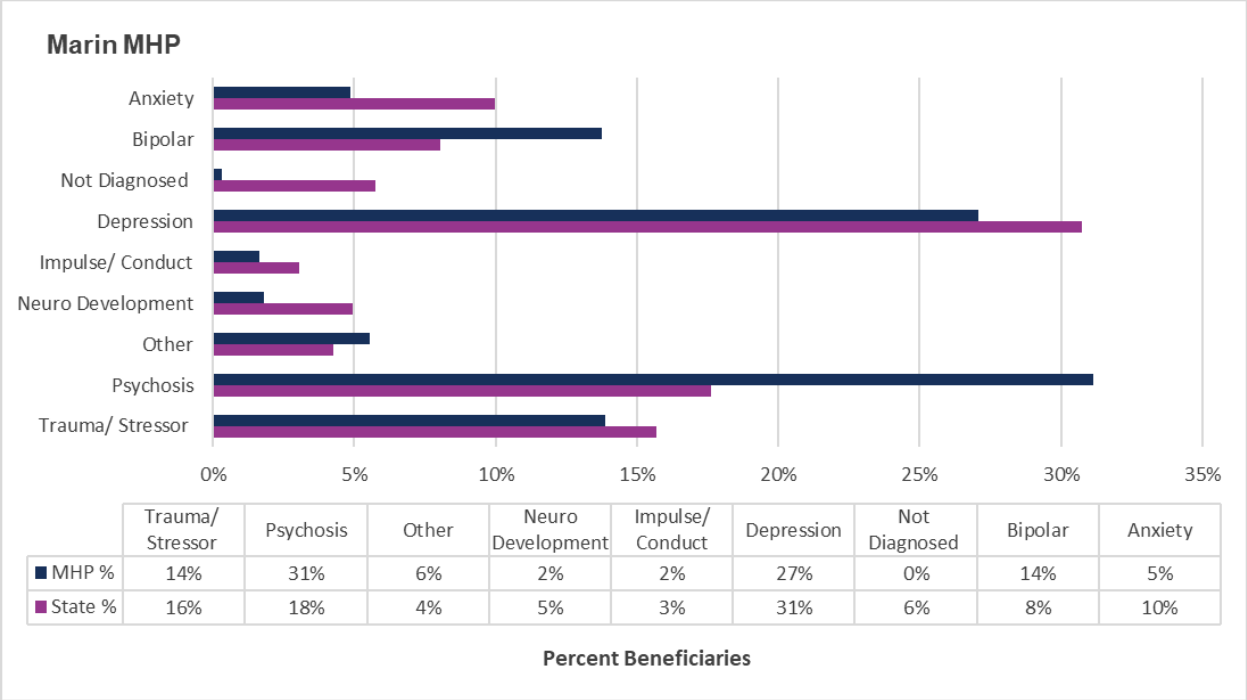
Service Category	MHP N = 63				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	4	4	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	720	720	3.1%	1,404	1,200
Crisis Intervention	<11	-	132	132	7.5%	406	199
Medication Support	17	27.0%	444	406	28.2%	396	273
TBS	0	0.0%	0	0	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	32	50.8%	1,087	388	40.2%	1,354	473
Intensive Home Based Services	12	19.0%	2,400	1,647	20.4%	2,260	1,275
Katie-A-Like	<11	-	1	1	0.2%	640	148
Mental Health Services	62	98.4%	1,549	986	96.3%	1,854	1,108
Targeted Case Management	28	44.4%	229	74	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



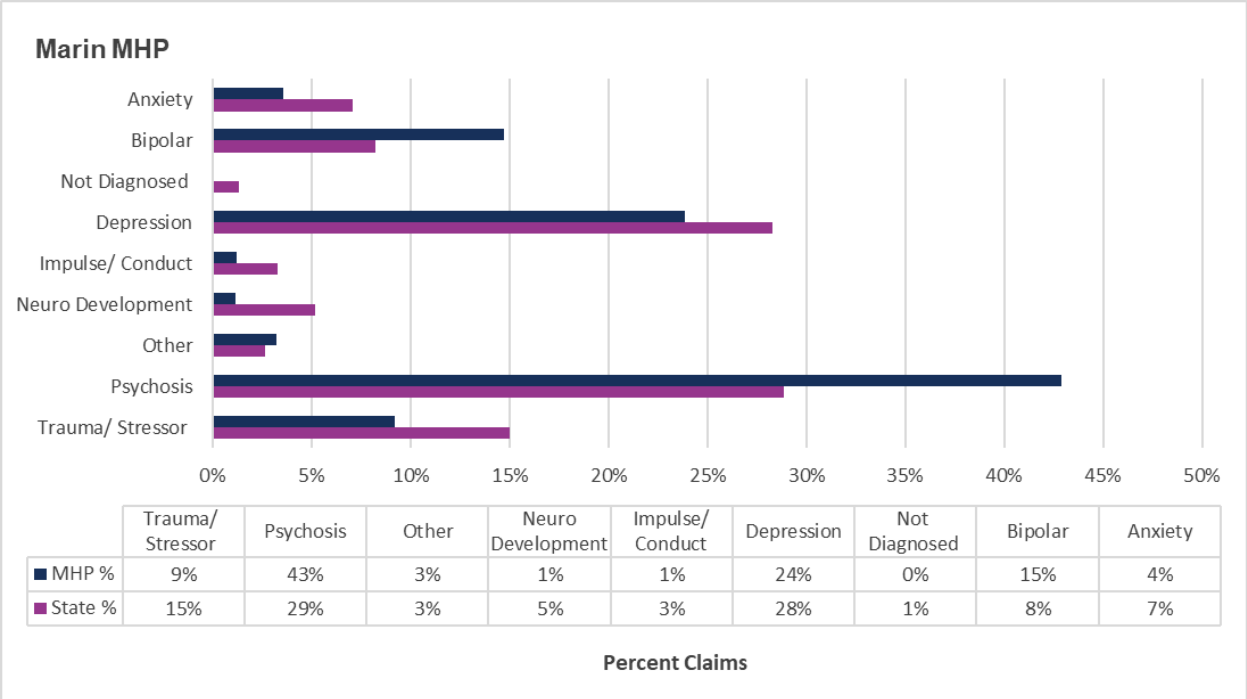
	State	MHP
1 service	10.25%	10.11%
2 service	6.20%	5.62%
3 service	4.88%	2.95%
4 service	4.47%	2.29%
5-15 Services	30.41%	26.06%
>15 Services	43.79%	52.97%

Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	31%	6%	2%	2%	27%	0%	14%	5%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

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

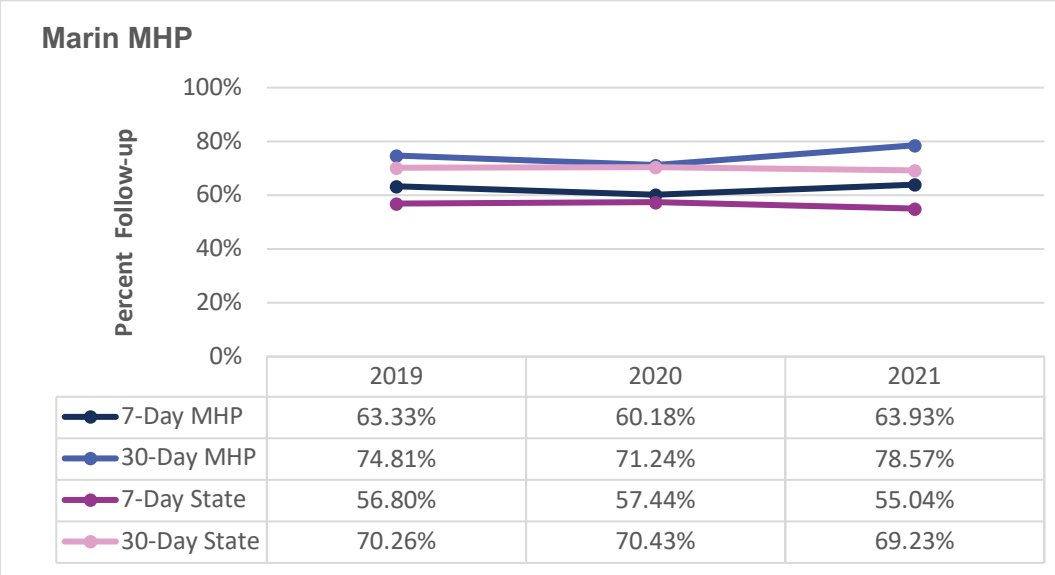


	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	9%	43%	3%	1%	1%	24%	0%	15%	4%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Table 13: Psychiatric Inpatient Utilization CY 2019-21

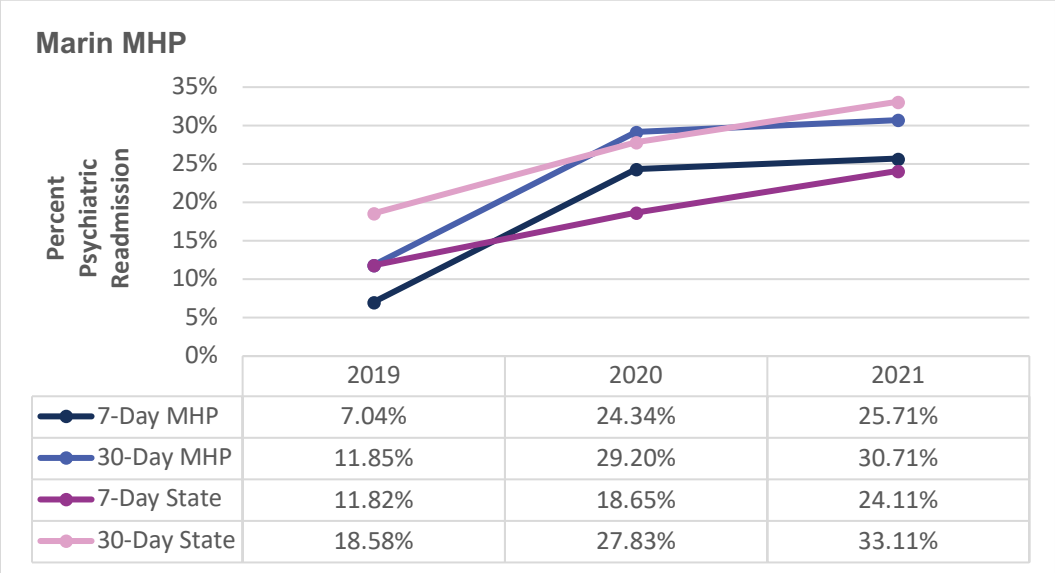
Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	233	428	9.71	8.86	$16,312	$12,052	$3,800,717
CY 2020	211	322	9.71	8.68	$14,042	$11,814	$2,962,773
CY 2019	231	377	9.38	7.80	$13,262	$10,535	$3,063,456

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



	2019	2020	2021
7-Day MHP	63.33%	60.18%	63.93%
30-Day MHP	74.81%	71.24%	78.57%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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



	2019	2020	2021
7-Day MHP	7.04%	24.34%	25.71%
30-Day MHP	11.85%	29.20%	30.71%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	274	12.82%	45.96%	$14,163,147	$51,690	$44,666
	CY 2020	272	12.53%	44.58%	$13,725,491	$50,461	$42,219
	CY 2019	300	13.62%	50.60%	$15,620,859	$52,070	$44,394

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)	216	10.11%	17.26%	$5,317,813	$24,620	$24,397
Low Cost (Less than $20K)	1,647	77.07%	36.79%	$11,336,467	$6,883	$5,341

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

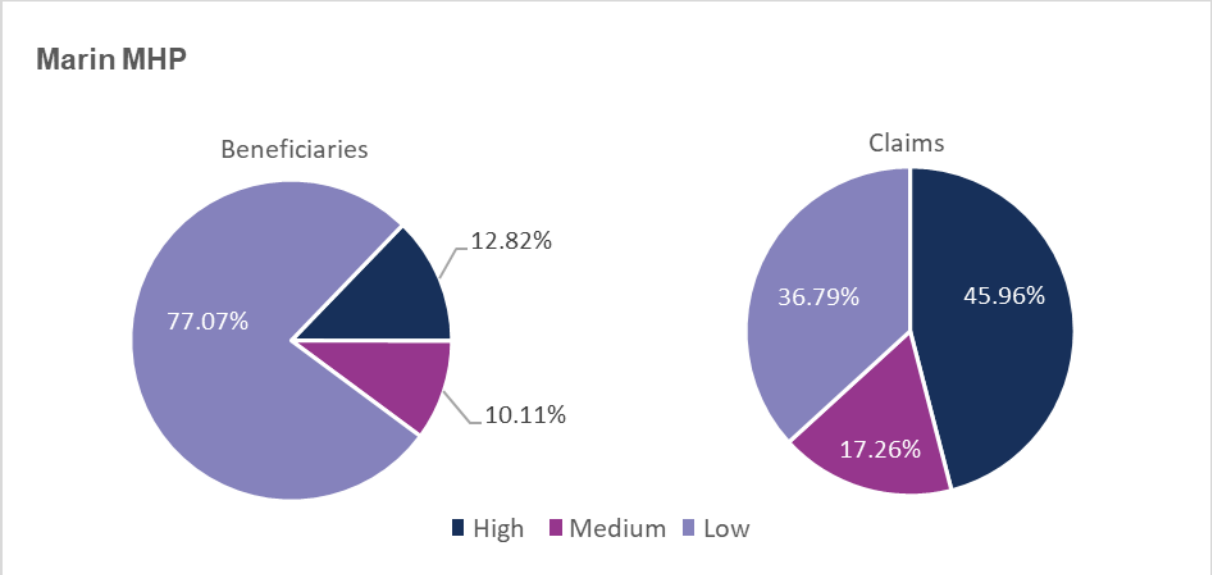


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	5,487	$2,448,334	$18,738	0.77%	$2,246,060
Feb	5,495	$2,452,912	$15,119	0.62%	$2,270,632
Mar	6,361	$2,898,394	$16,983	0.59%	$2,648,424
April	4,909	$2,223,872	$31,138	1.40%	$2,017,415
May	4,945	$2,396,512	$41,341	1.73%	$2,188,801
June	5,436	$2,530,671	$39,623	1.57%	$2,304,898
July	4,961	$2,496,233	$15,615	0.63%	$2,357,075
Aug	5,056	$2,462,043	$9,622	0.39%	$2,311,771
Sept	5,009	$2,517,039	$15,051	0.60%	$2,357,546
Oct	4,942	$2,499,886	$19,557	0.78%	$2,328,198
Nov	4,624	$2,317,730	$25,511	1.10%	$2,176,600
Dec	4,596	$2,364,909	$90,556	3.83%	$2,210,414
Total	**61,821**	**$29,608,535**	**$338,854**	**1.14%**	**$27,417,834**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Late claim	209	$117,843	34.78%
Other healthcare coverage must be billed before submission of claim	136	$82,957	24.48%
Medicare Part B must be billed before submission of claim	68	$46,772	13.80%
Beneficiary not eligible or non-covered charges	35	$31,746	9.37%
Deactivated NPI	68	$17,012	5.02%
Service location NPI issue	55	$16,647	4.91%
Other	65	$15,462	4.56%
Service line is a duplicate and a repeat service procedure code modifier not present	29	$10,415	3.07%
Total Denied Claims	**665**	**$338,854**	**100.00%**
Overall Denied Claims Rate	**1.14%**		
Statewide Overall Denied Claims Rate	**1.43%**		