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

NAPA FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

December 1, 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, "Napa" may be used to identify the Napa County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — December 1, 2022

MHP Size —Small

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
6	5	1	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	2	4	0
Quality of Care	10	4	5	1
Information Systems (IS)	6	2	4	0
TOTAL	**26**	**12**	**13**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Promoting Outpatient Mental Health Service Engagement and Treatment Completion for Hispanic/Latino Adults	Clinical	12/20	Other: Completed	Moderate
Reducing the Average Length of Time from First Assessment Visit to First Offered Adult Psychiatry Appointment	Non-Clinical	11/20	Other: Completed	High

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	10

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has a new Mobile Response unit, which increases its capacity to respond to crises in the community.
- The Mental Health Division (MHD) has contracted with a psychiatric provider vendor, which provides much needed stability in psychiatric coverage and for medication management and monitoring.
- The MHP has made progress in its Electronic Health Record (EHR) replacement project.
- The PIP team used a Plan-Do-Study-Act (PDSA) cycle in conducting its PIP.
- MHD staff are able to telework two days per week.

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

- The MHP reports a vacancy rate of approximately 25 percent, which affects beneficiary access, timeliness, and quality of services as well as implementation of many initiatives.
- Per several stakeholder groups, the change to a centralized access process has purportedly contributed to a protracted process for beneficiaries to begin services delivered through contract providers.
- In its report of timeliness metrics, the MHP cited data integrity issues and challenges in capturing/reporting reliable timeliness data for youth in Foster Care (FC).

- Clinical staff reported pressure to close cases earlier than they otherwise would in order to serve new beneficiaries waiting for services.
- The MHP did not formally monitor the Healthcare Effectiveness Data and Information Set (HEDIS) measures related to medication utilization for youth in FC.

Recommendations for improvement based upon this review include:

- Continue to research and then implement strategies to recruit and retain staff, including leveraging regional partnership participation, loan repayment programs, and internship opportunities. (Access, Timeliness, Quality).
- Investigate reasons and develop and implement strategies to improve the time to initiation of services delivered through contract providers. Ensure that the process facilitates as timely of a service initiation as possible for each beneficiary. (Access, Timeliness)
- Review timeliness metrics on a monthly basis for data completeness and accuracy. On a quarterly basis, review timeliness for all beneficiary groups. This requires changes in the EHR to record FC status). (Timeliness) *(This recommendation is a follow-up from FY 2021-22.)*
- Investigate case closures and develop and implement strategies to appropriately close and transition beneficiaries to lower levels of care. (Quality, Access)
- Monitor and conduct quarterly reviews of the four HEDIS measures related to medication utilization for youth in FC. (Quality)

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 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 Napa County MHP by BHC, conducted as a virtual review on December 1, 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 (IPC).

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 MHP's implementation of several mandates, including emergency department diversion, Enhanced Care Management (ECM), and California Advancing and Integrating Medi-Cal (CalAIM), and some of its own initiatives (e.g., Care Courts and Mental Health Diversion). These initiatives have demanded additional time and responsibilities of clinical and administrative staff, for training, coordination of services with other service providers, screening and referral of beneficiaries, and monitoring and implementing Behavioral Health Information Notices (BHINs). 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.

- Napa County's Health and Human Services (HHS) MHD has adopted an integrated approach to services, combining mental health and substance use treatment, which facilitates coordinated access and a holistic approach to care.
- The MHD has issued a request for proposals for a medication clinic contract that will include five full-time psychiatrists and a medical director.
- The MHP selected and began implementation of a new EHR, Credible.
- The MHP experienced staff turnover and workforce shortages during the pandemic. While there have been more hires over the past year, the MHP reports a vacancy rate of approximately 25 percent.
- The MHP and other divisions of HHS permit staff to telework two days per week.

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: Investigate the disproportionate penetration rate and number of Latino/Hispanic beneficiaries served, relative to the overall Medi-Cal population, and identify potential barriers to service access. Implement related interventions as indicated.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP identified potential barriers to access for Latino/Hispanic eligibles, including stigma around mental health treatment, transportation and mobility challenges, the transient nature of some Latino eligibles (as agricultural workers) which may preclude requests for time off for health care treatment.
- The MHP reported strategies that have been implemented to improve outreach to this population, including school-based mental health services, partnership with Latino-serving organizations (e.g., Puertas Abiertas), and internships and recruitment of Spanish-speaking staff. The MHP hosts programs and advertisements on Spanish-speaking radio stations.
- The outcome of these efforts was not reported and tracking of referral sources was not consistent.

Recommendation 2: Evaluate and correct reporting errors related to First Offered Non-Urgent Appointment and Urgent Services Offered and include the full system of care when reporting First Offered/First Kept Psychiatry Appointment and No-show rates.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP reported that it updated its Central Access and Authorization Team (CAAT) Log to include a drop-down menu to distinguish urgent and non-urgent appointments.
- However, the MHP reported that it is reviewing its data collection and tracking methodology for urgent response after noting errors in the FY 2021-22 CAAT log.
- For the MHP Assessment of Timely Access, the MHP reported only the time to psychiatry for county-operated services. Some contracted providers do provide psychiatry, which the MHP did not capture in the MHP Assessment of Timely Access (ATA).
- This recommendation will not be continued as the MHP addresses new errors are resolved.

Recommendation 3: Expedite the EHR replacement project, incorporating a plan to include contracted provider data. Simultaneously develop contingency plans for support of the Cerner/Anasazi EHR beginning in 2023 and access to the Cerner/Anasazi data once the system is no longer in use.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has selected and is in contract with Qualifacts, Inc. to implement the Credible EHR. Implementation efforts began in November 2022 with a go-live target of July 1, 2023.
- Following implementation, access to the current Cerner system will remain for archival and record-keeping purposes.

Recommendation 4: Research and implement strategies to recruit and retain staff.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has implemented several strategies to increase recruitment of new staff and retention of existing staff.
- The recruitment efforts have included a partnership with California Mental Health Services Authority for an internship program, participation in the Greater Bay Area Regional Partnership Workforce Education and Training program to grow the workforce in mental health profession, and loan repayment programs for new hires.
- The retention efforts include scholarships for interns and recent graduates that have further educational pursuits or repayment for academic loans and an employment engagement committee for staff to provide input on systemic changes and opportunities that increase staff retention.
- The MHP staff endorsed an increase or stability in staff of some programs over the past year but that more recruitment is needed, as is suggested by a 25 percent staff vacancy rate.

Recommendation 5: Explore reasons for the 42 percent clinician no-show rate and implement solutions to improve capacity and timely access to care for beneficiaries.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- For FY 2021-22, the MHP reported a no-show rate of clinician appointments of 15 percent. The improvement is attributed to a refinement in the methodology of capturing no-shows. The appointments that are logged for show/no-show rate are assessments and therapy.
- The MHP reinforced the utilization of reminder calls by clerical staff as the strategy to further decrease the no-show rate.

Recommendation 6: Research and analyze the services provided to the high-cost beneficiaries (HCBs) and determine if there are strategies to provide lower levels of care while still improving outcomes.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP analyzed utilization of services by HCB and found that HCBs utilize more crisis services than routine, outpatient services.
- The MHP is implementing a new model, described as a hub-and-spoke, to better serve HCBs. The MHD is the center and hub of the service delivery and multiple community partners will serve as access points and the spokes. One part of the spoke is a clinician embedded at the federally qualified health clinic; the clinician has been in place for over one year. The MHP intends to lease space for services in other parts of Napa County, (i.e., Calistoga) to add to the spokes of the model.

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 64 percent of services were delivered by county-operated/staffed clinics and sites, and 36 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 and contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: clinic walk-ins, primary care referrals, and school referrals. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. An initial screening is conducted by the Access team within 24 hours typically. After the screening, a clinician conducts a comprehensive assessment and refers to either county, contracted programs, or allied providers.

In addition to clinic-based MH services, the MHP provides psychiatry and mental health services via telehealth video/phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 672 adult beneficiaries, 210 youth beneficiaries, and 112 older adult beneficiaries across two county-operated sites and six contractor-operated sites. Among those served, 86 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

[1] CMS Data Navigator Glossary of Terms

and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information 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 BHINs.

For Napa County, the time and distance requirements are 45 miles and 75 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

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

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The Behavioral Health Integration and CalAIM measures have contributed to an increase in requests for services. The MHP has met this demand by adapting its capacity at Access; clinical staff and managers provided support to the Access Team to screen and assess prospective beneficiaries.
- With a reduction in the number of clinical staff, the rotation for officer/responder of the day has occurred more frequently, reportedly, two or three times a month. To be able to fulfill this duty, clinicians are cancelling and rescheduling routine appointments more often than before.
- The staffing shortage has most affected beneficiary access to therapy services. Case management and medication support services are being used to fill this gap.
- The MHP made changes that centralize access to services including those delivered through contract providers. This change has purportedly led to multiple inquiries and requests for services from the beneficiary before the beneficiary is given a first appointment at/through contract provider.
- The option to work remotely is a benefit that serves the MHP well as it faces competition from other mental health organizations/employers that permit telework.

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.

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, the PR has decreased over the last three years, and is below the small-county average and statewide PR.

The MHP CY 2021 claims data appears to be incomplete due to a significant claims lag beginning in July 2021; this is discussed further in the IS section of the report. The MHP reports that its claiming is current through November 2022, and the claims lag is not reflective of its business practices. Nevertheless, it is important to note this limitation in the PM analyses contained within this report. The impact of incomplete claims data for half of CY 2021 significantly impacts the PR as well as AACB.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	36,154	992	2.74%	$6,646,174	$6,700
CY 2020	32,960	1,259	3.82%	$12,211,292	$9,699
CY 2019	31,665	1,477	4.66%	$13,061,413	$8,843

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	3,631	19	0.52%	1.03%	1.59%
Ages 6-17	8,965	320	3.57%	5.00%	5.20%
Ages 18-20	2,055	57	2.77%	4.29%	4.02%
Ages 21-64	17,527	529	3.02%	4.15%	4.07%
Ages 65+	3,979	67	1.68%	2.09%	1.77%
TOTAL	**36,154**	**992**	**2.74%**	**3.83%**	**3.85%**

- The PR is below similar size county and statewide averages for all age groups.

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	188	19.28%
Threshold language source: Open Data per BHIN 20-070		

- The unduplicated count of Spanish-speaking beneficiaries decreased by 18 percent from the prior review period.

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	10,088	236	2.34%	$1,266,320	$5,366
Small	199,673	6,647	3.33%	$36,223,622	$5,450
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligibles that qualify under the ACA, the overall PR and AACB were lower than non-ACA beneficiaries.
- The MHP has a lower percentage of ACA beneficiaries served compared to small county and statewide.

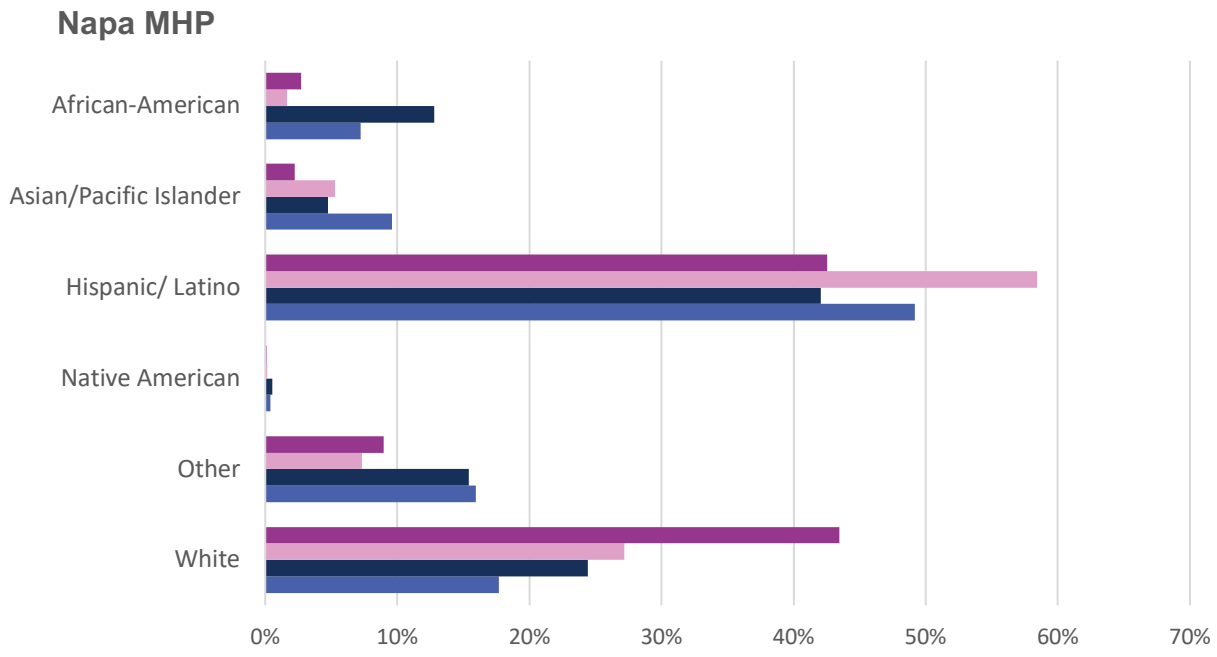
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS comparatively through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions 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 Served	# MHP Eligibles	MHP PR	Statewide PR
African-American	594	27	4.55%	6.83%
Asian/Pacific Islander	1,918	-	-	1.90%
Hispanic/Latino	21,127	422	2.00%	3.29%
Native American	47	≤11	-	5.58%
Other	2,643	89	3.37%	3.72%
White	9,828	431	4.39%	5.32%
Total	**36,157**	**992**	**2.74%**	**3.85%**

- The MHP's PR is lower than the statewide PR for all race/ethnicity groups.

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

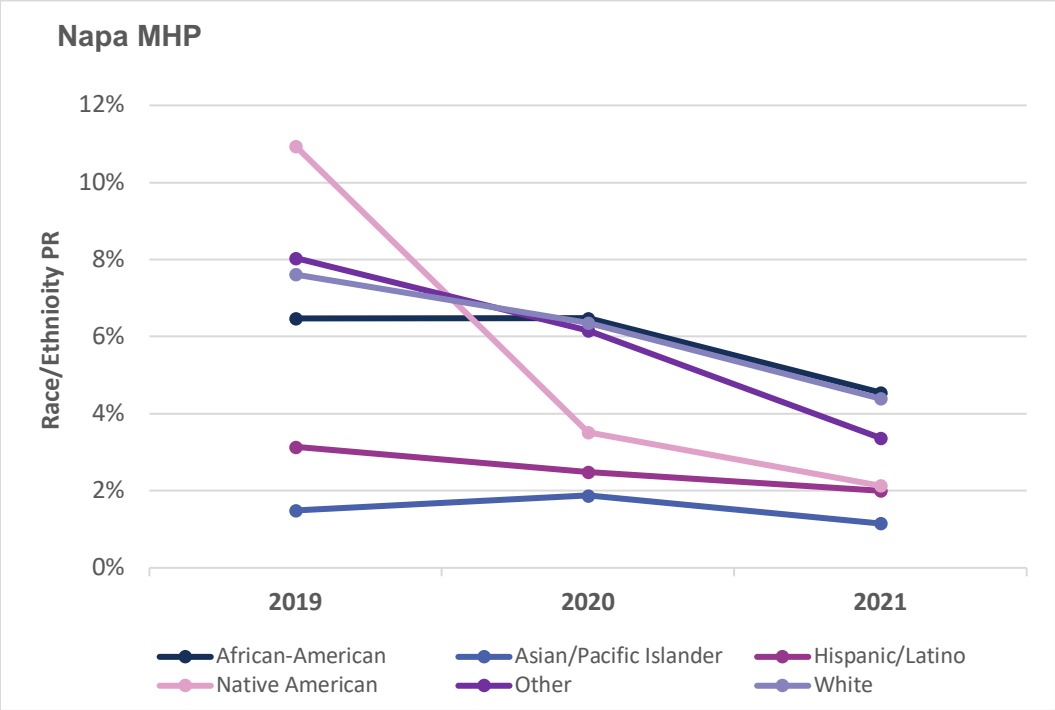


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	43%	9%	0%	43%	2%	3%
MHP % Eligibles	27%	7%	0%	58%	5%	2%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- The most notable gap between eligibles and beneficiaries served is seen in the Latino/Hispanic and Asian/Pacific Islander populations.

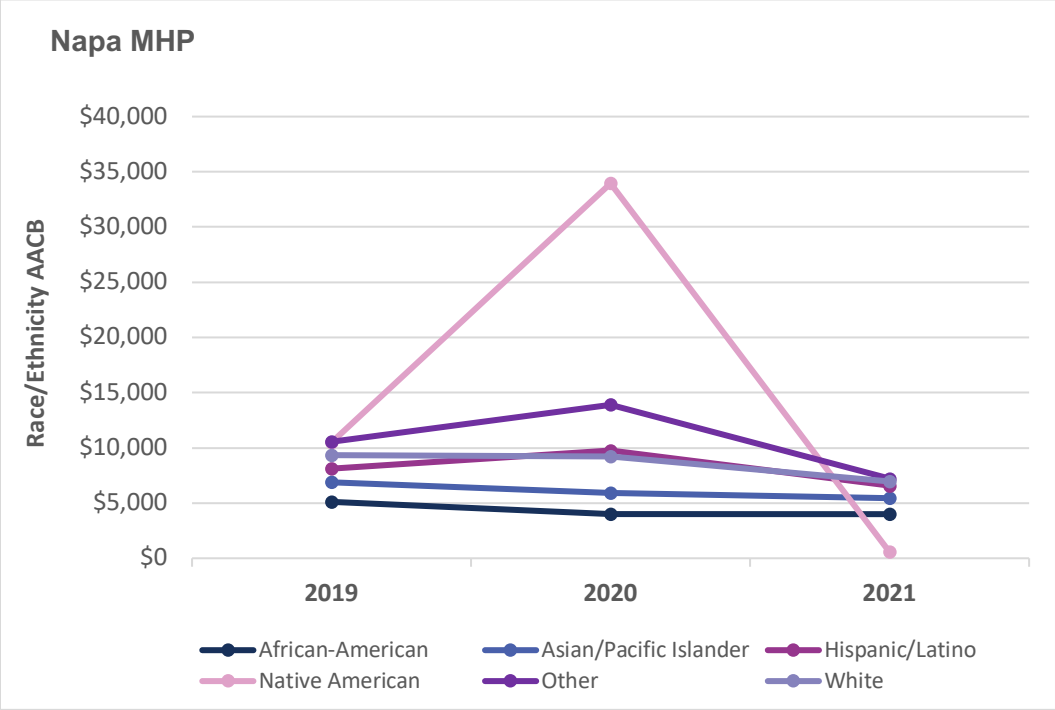
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Latino/Hispanic and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data are compared to similar size MHPs and the statewide for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

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



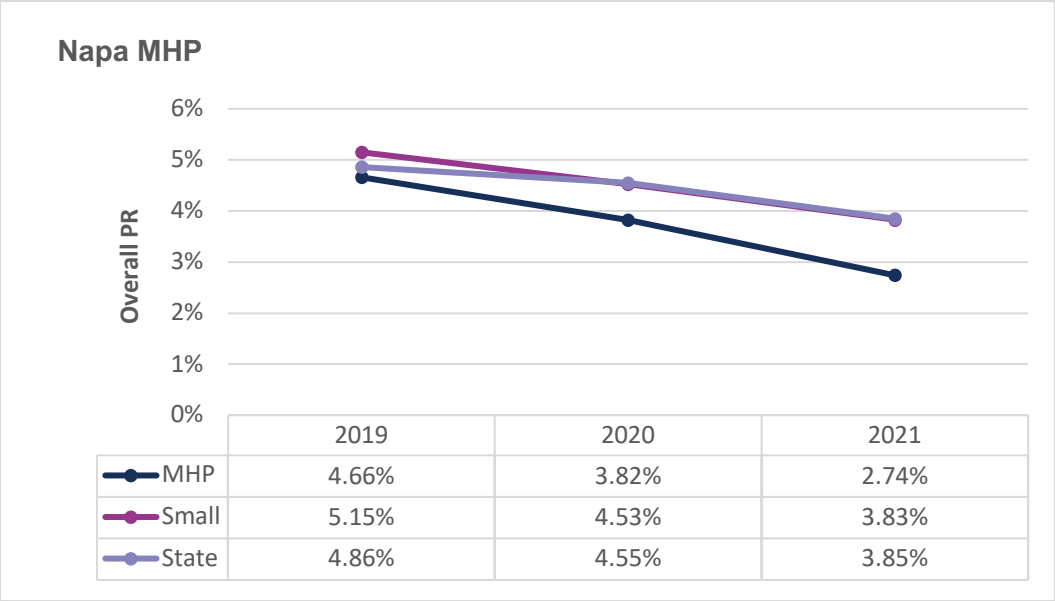
- The MHP's PR by race/ethnicity has declined over the last two years.

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



- The AACB has decreased slightly over the last two years. The Native American AACB increased in 2020 and then fell below the 2019 AACB. The large fluctuation is likely due to a low number of Native American beneficiaries.

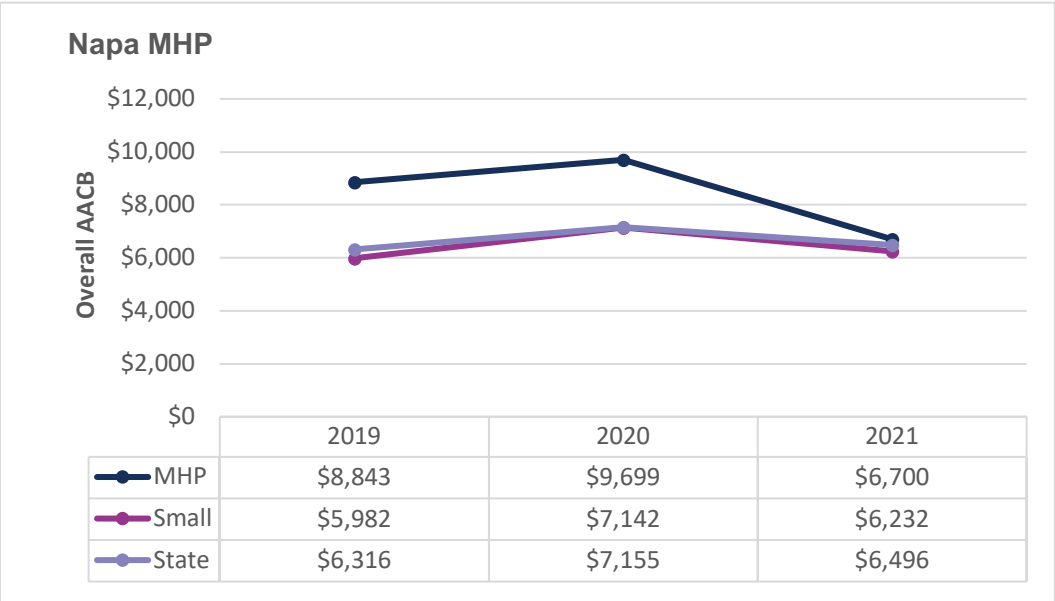
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.66%	3.82%	2.74%
Small	5.15%	4.53%	3.83%
State	4.86%	4.55%	3.85%

- The overall PR has decreased over the last two years while remaining lower than the small MHP and statewide PR.

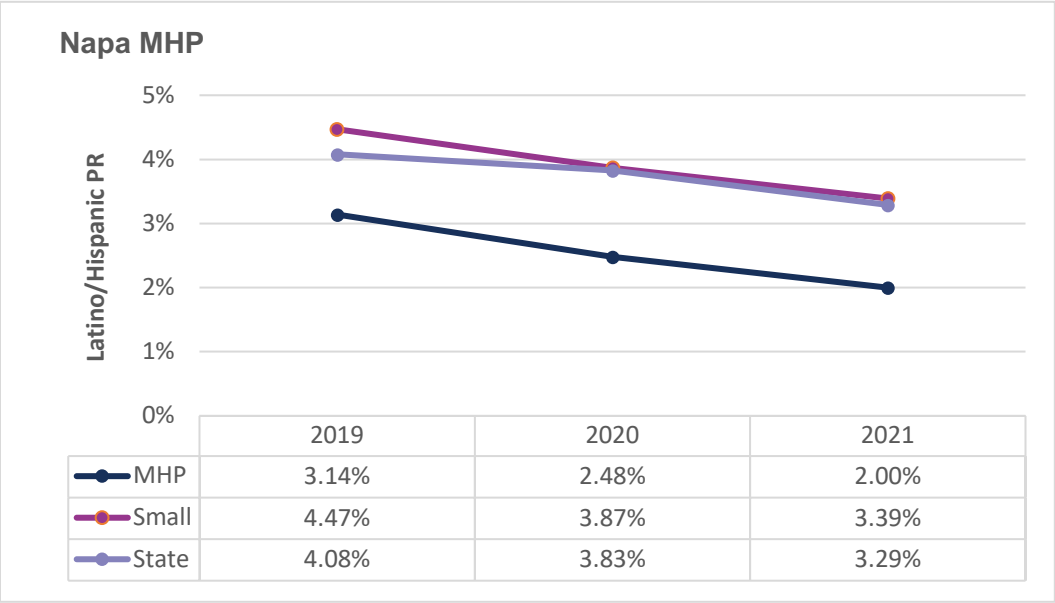
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$8,843	$9,699	$6,700
Small	$5,982	$7,142	$6,232
State	$6,316	$7,155	$6,496

- The overall AACB is higher than that of small MHPs and the statewide AACB.

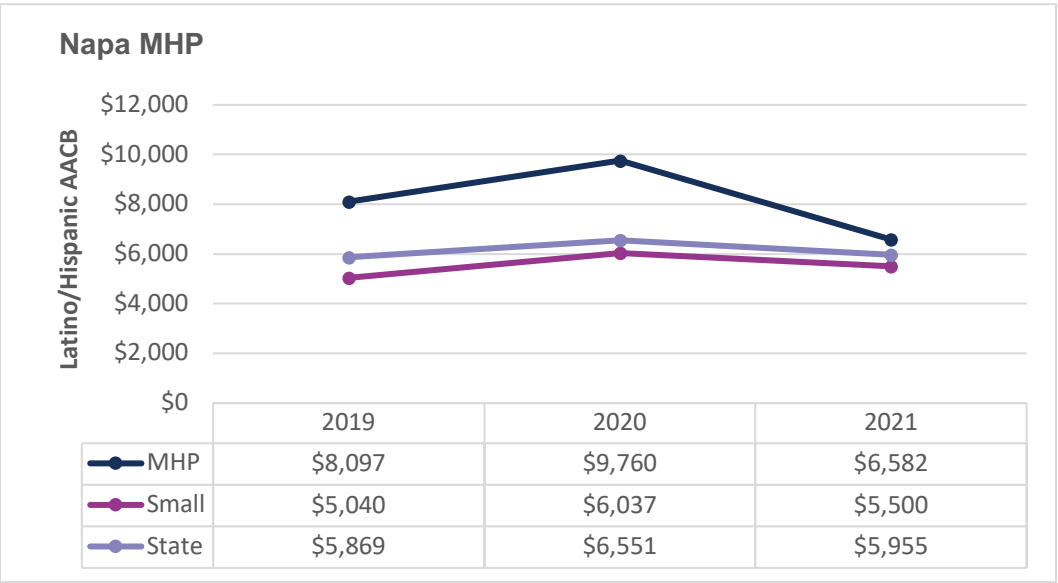
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	3.14%	2.48%	2.00%
Small	4.47%	3.87%	3.39%
State	4.08%	3.83%	3.29%

- The Latino/Hispanic PR decreased across the state as well as in the MHP; however, the MHP PR still remains lower than the small MHP and statewide average.

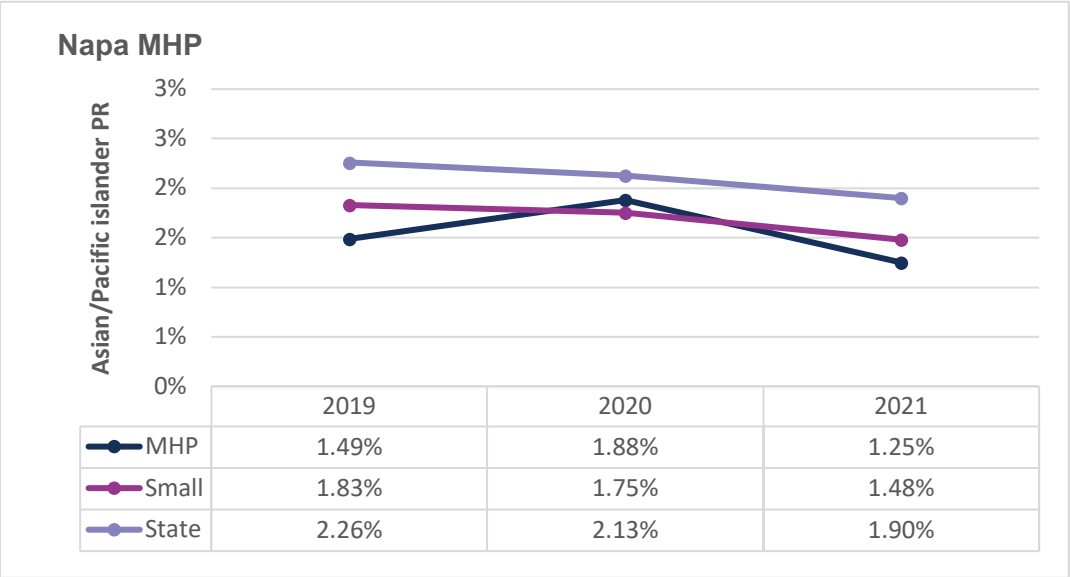
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$8,097	$9,760	$6,582
Small	$5,040	$6,037	$5,500
State	$5,869	$6,551	$5,955

- The AACB for Latino/Hispanic population has decreased in CY 2021 and is now ten percent higher than the statewide average.

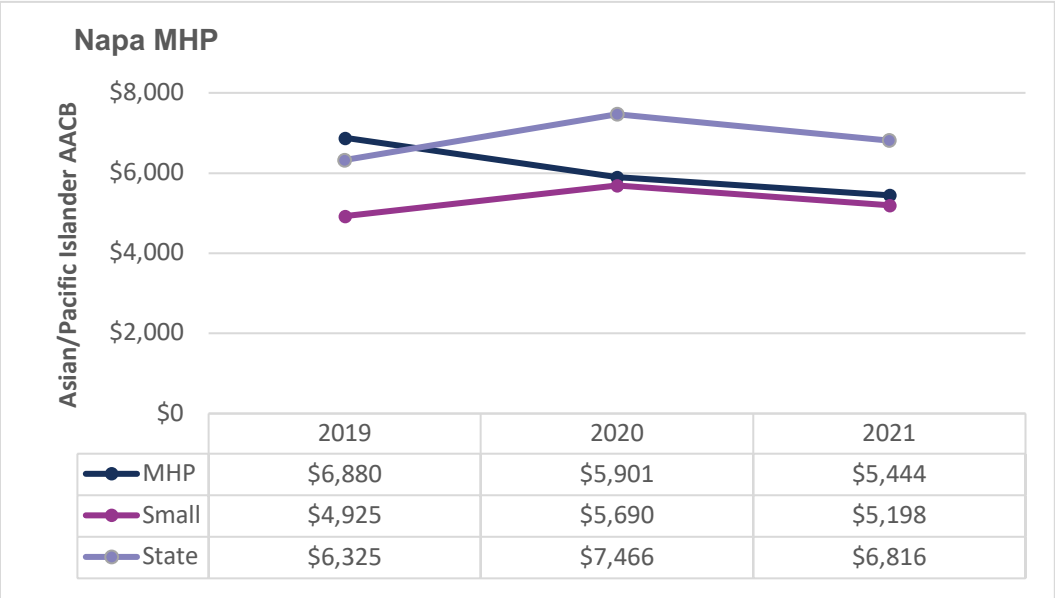
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	1.49%	1.88%	1.25%
Small	1.83%	1.75%	1.48%
State	2.26%	2.13%	1.90%

- Due to small numbers of Asian/Pacific Islander beneficiaries served, the 2021 PR for this group is rounded (up) to prevent calculation based upon other numbers available.
- The Asian/Pacific Islander PR decreased in CY 2021 and is lower than similar sized counties and the statewide average.

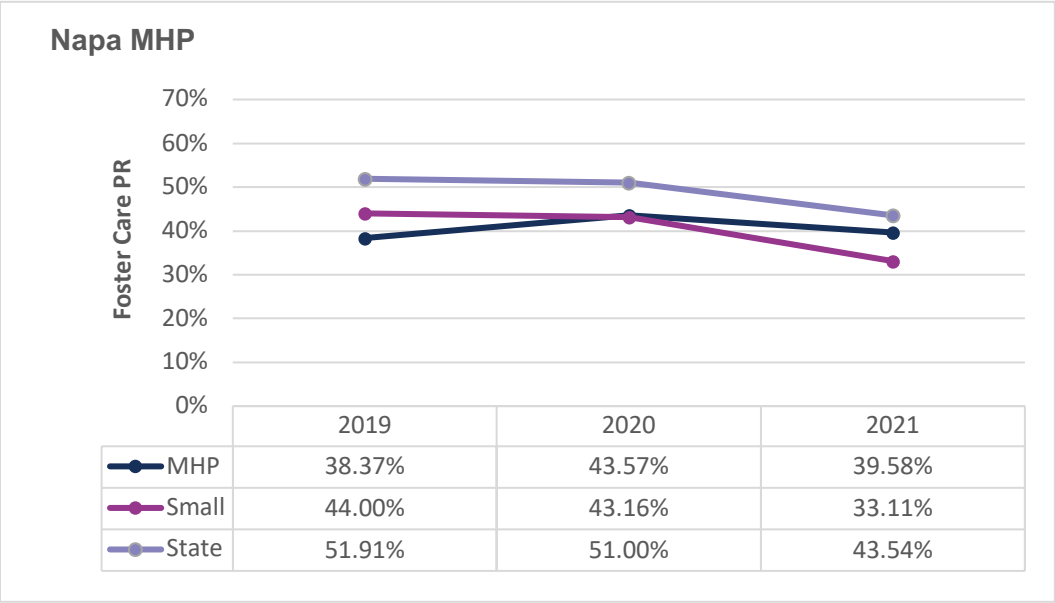
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$6,880	$5,901	$5,444
Small	$4,925	$5,690	$5,198
State	$6,325	$7,466	$6,816

- The Asian/Pacific Islander AACB decreased in CY 2021 and remains lower than the statewide average and slightly higher than similar sized MHPs.

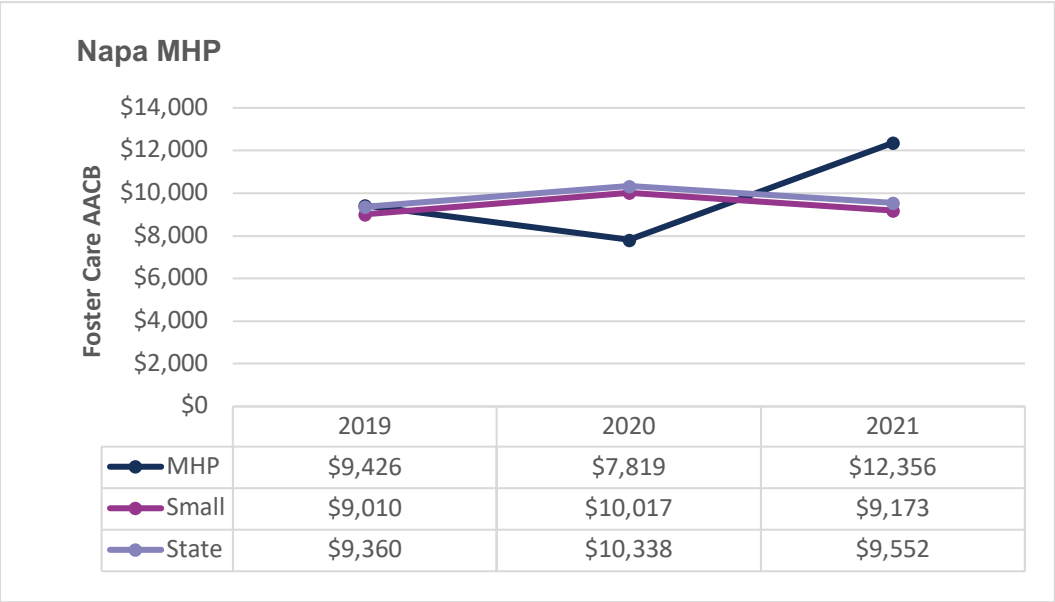
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	38.37%	43.57%	39.58%
Small	44.00%	43.16%	33.11%
State	51.91%	51.00%	43.54%

- The FC PR has decreased across the state over the prior two years, while the MHP's PR slightly decreased in CY 2021 and is now higher than similar sized MHPs and below the statewide average.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$9,426	$7,819	$12,356
Small	$9,010	$10,017	$9,173
State	$9,360	$10,338	$9,552

- The FC AACB increased significantly in the MHP and is 29 percent higher than the statewide AACB.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 653				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	34	5.2%	12	8	10.8%	14	8
Inpatient Admin	≤11	-	-	-	0.4%	16	7
Psychiatric Health Facility	≤11	-	-	-	1.0%	16	8
Residential	16	2.5%	49	41	0.3%	93	73
Crisis Residential	13	2.0%	15	14	1.9%	20	14
Per Minute Services							
Crisis Stabilization	81	12.4%	1,372	1,200	9.7%	1,463	1,200
Crisis Intervention	≤11	-	-	-	11.1%	240	150
Medication Support	340	52.1%	141	105	60.4%	255	165
Mental Health Services	365	55.9%	667	373	62.9%	763	334
Targeted Case Management	166	25.4%	202	107	35.7%	377	128

- The MHP has a lower percentage of adult beneficiaries accessing mental health services (52 percent) compared to the statewide average (62 percent) and case management (25 percent) compared to the statewide average (35 percent).

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

Service Category	MHP N = 57				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	-	-	-	n ≤11	6	4
Psychiatric Health Facility	<11	-	-	-	0.2%	25	9
Residential	<11	-	-	-	n ≤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	19	33.3%	557	222	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	22	38.6%	755	388	38.6%	1,193	445
Intensive Care Coordination	≤11	-	-	-	19.9%	1,996	1,146
Katie-A-Like	≤11	-	-	-	0.2%	837	435
Mental Health Services	53	93.0%	1,990	1,085	95.7%	1,583	987
Targeted Case Management	34	59.6%	260	96	32.7%	308	114

- The MHP's service delivery to youth in FC is consistent with the statewide averages for Mental Health Services and Intensive Home-based Services, while the MHP has a higher percentage of youth in FC receiving Medication Support (33 percent compared to 28 percent statewide).

IMPACT OF ACCESS FINDINGS

- Historically, the MHP has had lower PRs than the state and comparable sized MHPs. Also, the MHP has had lower PR by race/ethnicity than the state and comparable sized MHPs, especially for Latino/Hispanic. Both of these trends continued in CY 2021.
- The MHP is implementing a hub and spoke model for service delivery that is meant to facilitate increased access, particularly 'up county.' The MHP might also direct resources in this model to increasing outreach and service to Latino/Hispanic and Asian/Pacific Islander beneficiaries who also have low PRs.
- Lower utilization of adult mental health services in the MHP compared to statewide is consistent with stakeholder feedback of limited clinicians to provide therapy. Conversely, improved coordination and collaboration with child welfare services may contribute to comparable use of mental health services and Intensive Home-Based Services.
- Stakeholders reported an increase in beneficiaries requesting services, which was attributed to the integrated behavioral health services and CalAIM's No Wrong Door policy. To meet this increased demand for services, the MHP must increase its clinical capacity. The MHP is already doing so with psychiatry. The new psychiatry contract should provide more stability with psychiatric coverage and regular access beneficiary access for medication management.
- The workforce shortage also affects new initiatives, like the ECM that requires Spanish-speaking staff.
- The new Mobile Response Team may alleviate some of the pressure that staff experience when they are assigned the officer/responder of the day role and concurrently have routine appointments for scheduled beneficiaries.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The MHP reports that its EHR makes it difficult to identify youth in FC. Several of the timeliness indicators, such as time to first non-urgent psychiatry appointment, time to urgent services, and post-hospitalization follow-up appointments, could not be determined for this population.

- Stakeholders across several groups reported that missed appointments may take one to two months to be rescheduled.
- For several years, the MHP has reported high rates (above 65 percent) for 7-day post-hospitalization follow-up.
- The timeliness log is reviewed weekly, by the Access Supervisor. Timeliness summary reports are produced monthly, and are reviewed annually and semi-annually by the quality improvement committee (QIC) and the MHP leadership, respectively.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, MHPs complete and submit the ATA 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 ATA, representing access to care during the 12month period of FY 2021-22. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care. Timeliness to psychiatry and urgent services offered was only reported for county-operated programs. The no-show rates reported did not include no-shows for contracted providers, with the exception of one contract provider who furnished data for the clinician no-show rate.

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	9.0 Days	10 Business Days*	70.2%
First Non-Urgent Service Rendered	15 Days	10 Days**	46.0%
First Non-Urgent Psychiatry Appointment Offered	7.0 Days	15 Business Days*	94.2%
First Non-Urgent Psychiatry Service Rendered	9.0 Days	15 Days**	83.7%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	7.8 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization	5.1 Days	7 Days**	80.2%
No-Show Rate – Psychiatry	18%	12%**	n/a
No-Show Rate – Clinicians	15%	***	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: FY 2021-22			

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

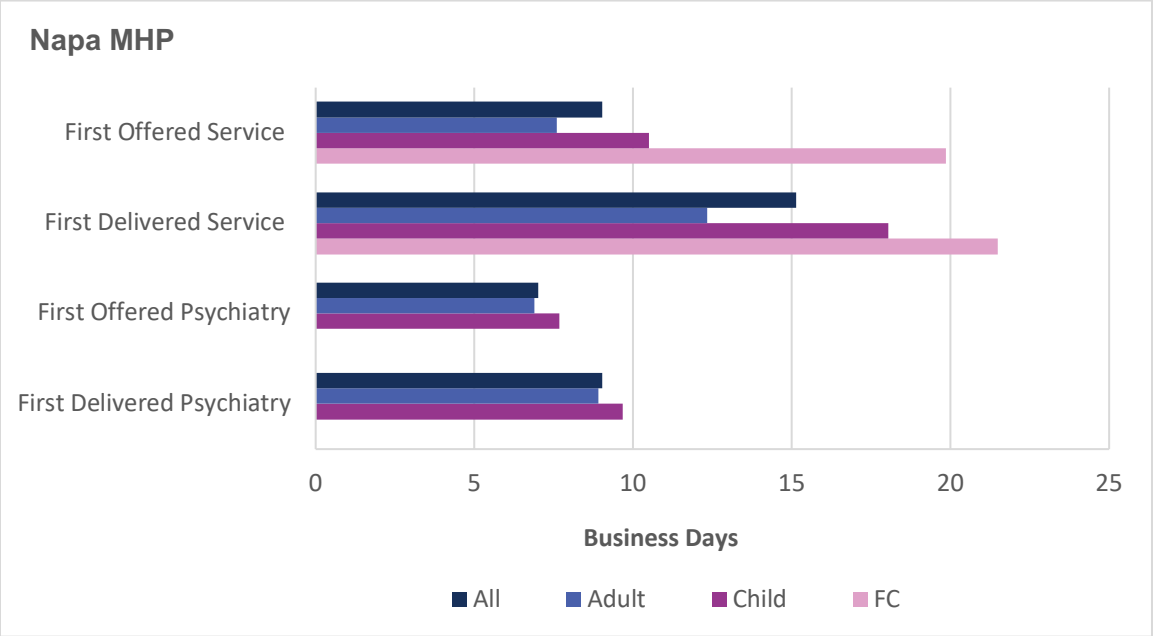


Figure 13: Wait Times for Urgent Services

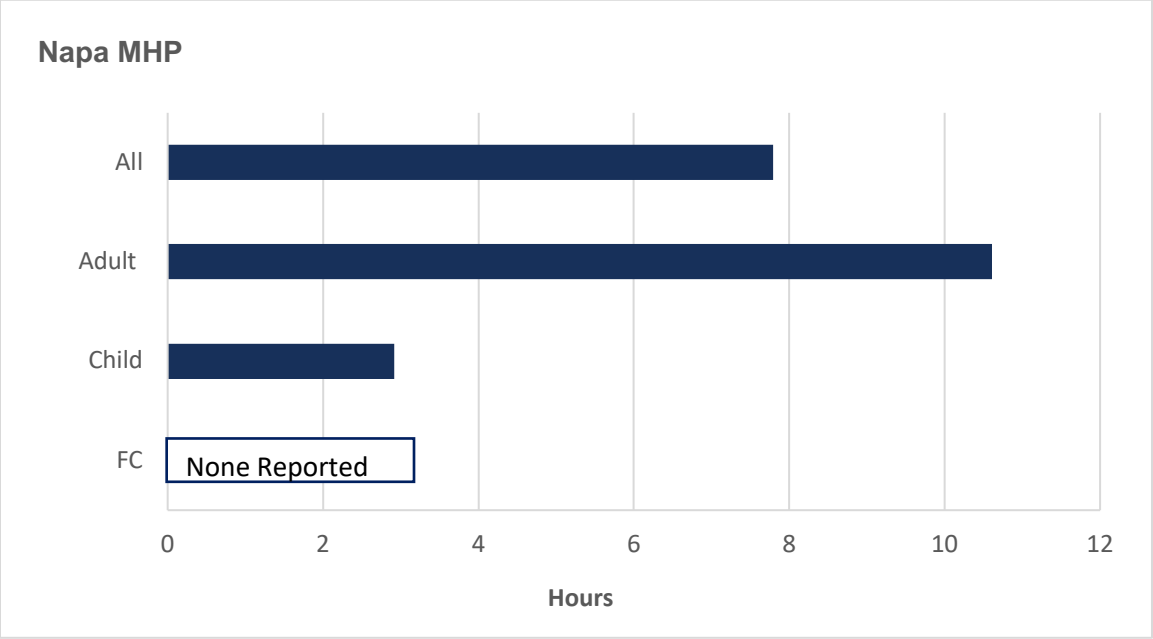
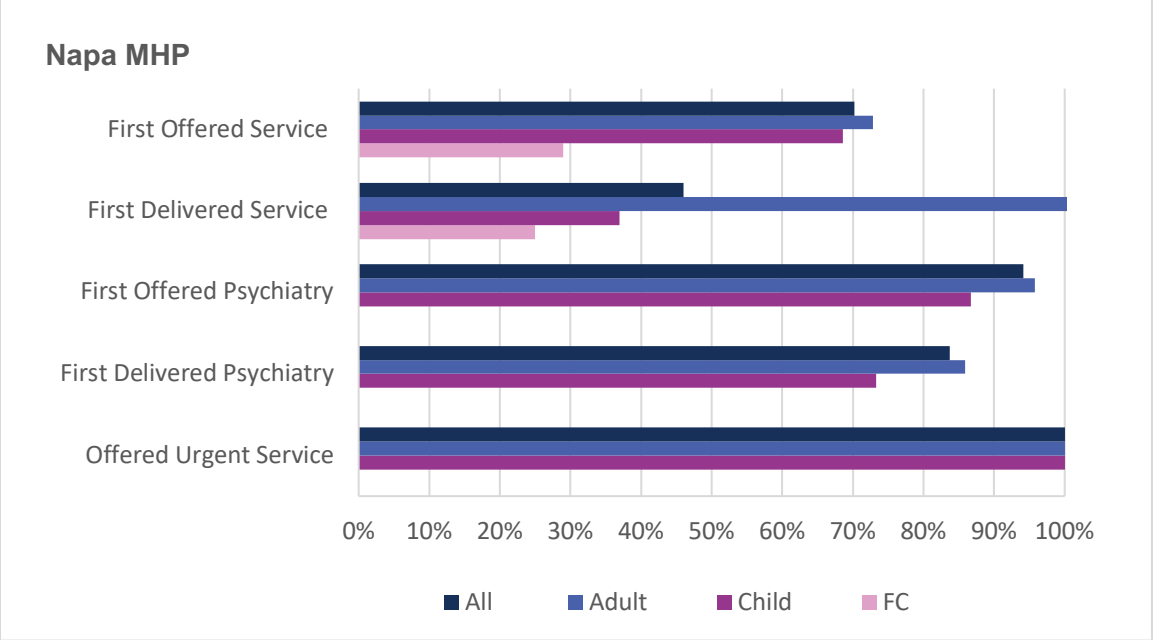


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled 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 crisis stabilization unit. The MHP defined “urgent services” for purposes of the ATA as services provided when an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function. There were reportedly 30 urgent service requests with a reported overall actual wait time to services of 7.8 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 clinical determination of need.
- 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 the system-wide data as it does not include no-shows for all contracted providers. The MHP reports a no-show rate for psychiatric services of 18 percent for adults, 22 percent for children, and 5 percent for youth in FC. The MHP no-show rate for non-psychiatric clinical staff is 15 percent for adults, 16 percent for children, and 33 percent for youth in FC.

IMPACT OF TIMELINESS FINDINGS

- The MHP performed better on time to offered service than time to rendered service, and attributes the difference to beneficiary cancelling, rescheduling, or no-shows of appointments. However, the difference between offered psychiatry and rendered psychiatry appointment was much less. If the MHP has available analytic capacity, this may be an area for further investigation. The MHP reported an 80 percent rate for post-hospitalization follow-up in 7 days, which is consistent with its performance in previous years. However, this performance rate differs sharply from that shown in the claims data (to be presented in the Quality). That missed appointments take one to two months to reschedule is consistent with feedback from focus group participants that routine appointments occur every one to two months. Both of these speak to potential limitations in capacity to provide ongoing, routine services. One consequence of reduced capacity to provide routine services is increased use of acute services, which requires close monitoring.
- For many of the above timeliness metrics, the MHP cited data integrity issues related to tracking methodologies and staff turnover. Also, the MHP did not have a way to capture reliable timeliness data for youth in FC. The limitations in timeliness data capture and reporting likely affects the MHP’s review of timeliness; timeliness metrics were infrequently or inconsistently reviewed to affect change.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is the Quality Coordinator that reports to the Assistant Mental health Director-Administration. Compliance is the responsibility of the Utilization Review Coordinator. HHS has a Quality Management Division that provides additional support and consultation to the MHP's quality program.

The MHP monitors its quality processes through the Quality Improvement/Utilization Review Committee (QI/URC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QI/URC is comprised of the quality coordinator, utilization review coordinator, staff service analysts, line staff, supervisors, division managers, patient's rights advocate, mental health board representative, beneficiaries, and family members. The committee is scheduled to meet monthly. Since the previous EQR, the MHP QIC met eight of ten times. The MHP provided the evaluation of its FY 2020-21 QAPI workplan goals. CalEQRO did not review this document for attainment goals or summary of findings.

The MHP does not utilize standardized level of care (LOC) tools; however, the MHP makes placement decisions based on outcome measures (see below), clinical assessments, beneficiary needs, and program capacity.

The MHP utilizes the following outcomes tools: the Child and Adolescent Needs and Strengths, the Pediatric Symptom Checklist, the Milestones of Recovery Scale (MORS), and the Adult Needs and Strengths Assessment (ANSA). The MHP provided an example of a MORS dashboard that shows proportion of beneficiaries whose scores improved or remained the same over the course of treatment. Staff reported that ANSA is used for older adults, but some sections (e.g., work/employment) were less applicable to this population.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These key components include an organizational culture

that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

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

Table 12: Quality Key Components

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

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

- HHS has contracted with Transitions for psychiatric and medication support services. This contract provides more consistency with psychiatric coverage, obviating the need for locums, and positions the MHP to monitor medications and prescriptions more intentionally for adults and children.
- The MHP's processes for data extraction and analysis rely on manual tracking (i.e., vial Excel and Access databases) and only include county-operated services. Review of data was not regularly noted in QI/URC meeting minutes. The MHP has a Data Committee that has been on hiatus for a few months.
- Clinical staff reported pressure to "turn over" or close cases earlier than they otherwise would in order to serve new beneficiaries waiting for services. The MHP did not provide evidence of how it evaluates transitions in care.
- The MHP uses several outcome measures to assess progress for adults and youth beneficiaries alike. The MHP has at least one aggregate report (MORS) for adults, but none yet for youth. There was no evidence of the use of

aggregate-level beneficiary outcomes to improve or adapt services at the program or system level.

- The MHP participated in the CY 2022 CPS survey and is awaiting the results. The MHP has posted the findings from CY 2021 on its website; however, the findings do not compare results to previous survey for the MHP to ascertain if there have been any changes in perceptions of care and areas needing improvement.
- The MHP has designated positions for beneficiary/family members; those positions are few in number and none appeared to be supervisory or part of an executive or management team.
- The MHP does not track the following HEDIS measures as required by WIC Section 14717.5
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

QUALITY PERFORMANCE MEASURES

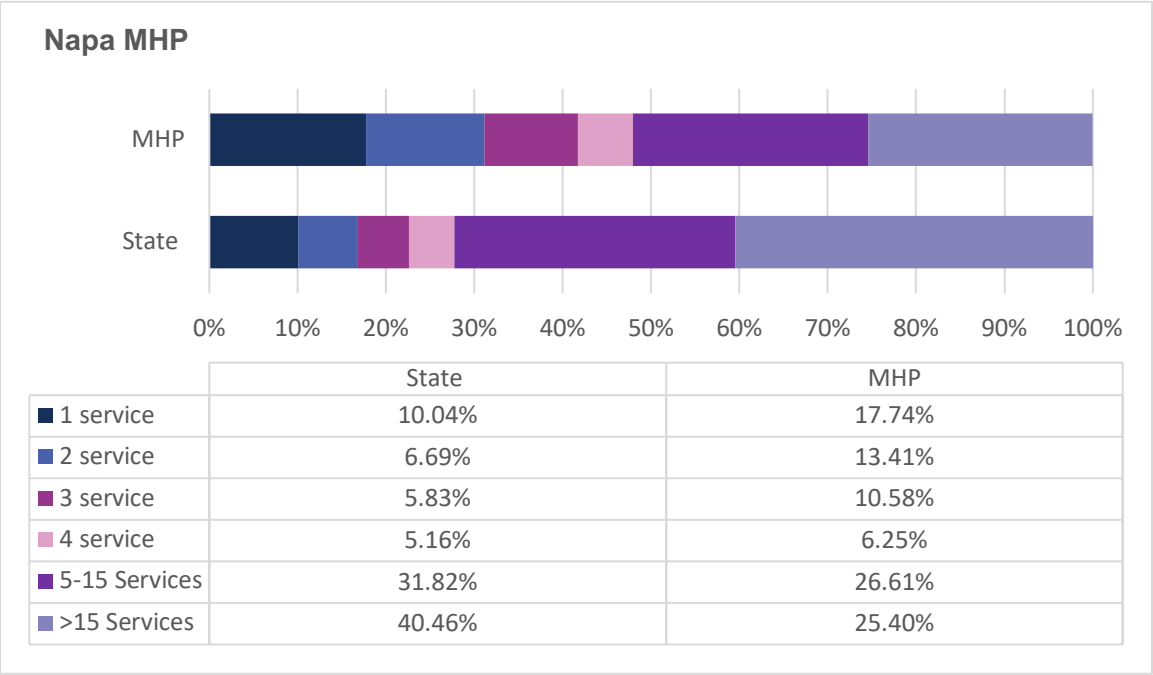
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

- Retention in Services
- Diagnosis of Beneficiaries Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- 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



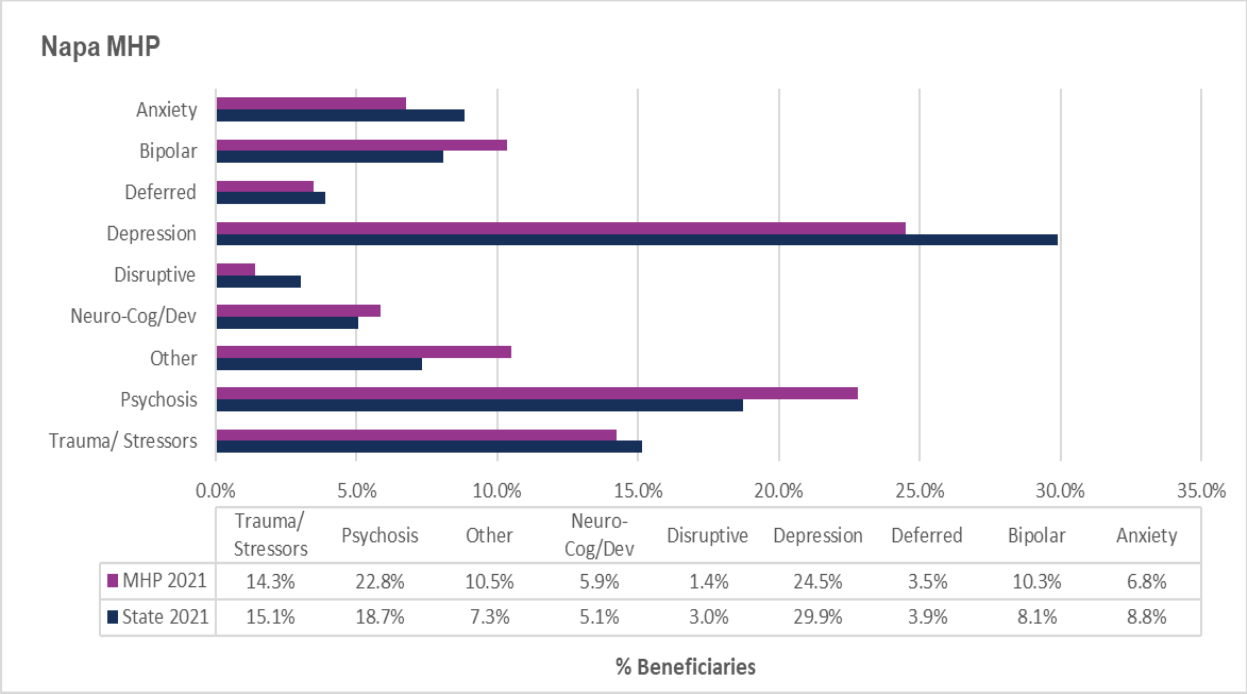
	State	MHP
1 service	10.04%	17.74%
2 service	6.69%	13.41%
3 service	5.83%	10.58%
4 service	5.16%	6.25%
5-15 Services	31.82%	26.61%
>15 Services	40.46%	25.40%

- Initial service and ongoing retention rates are higher in the MHP for beneficiaries receiving up to four services in a year. For those beneficiaries receiving greater than five services in CY 2021, the MHP was lower than the statewide average, although the percentages would likely increase for the MHP with complete claims data for CY 2021.

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. Figures 16 and 17 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.

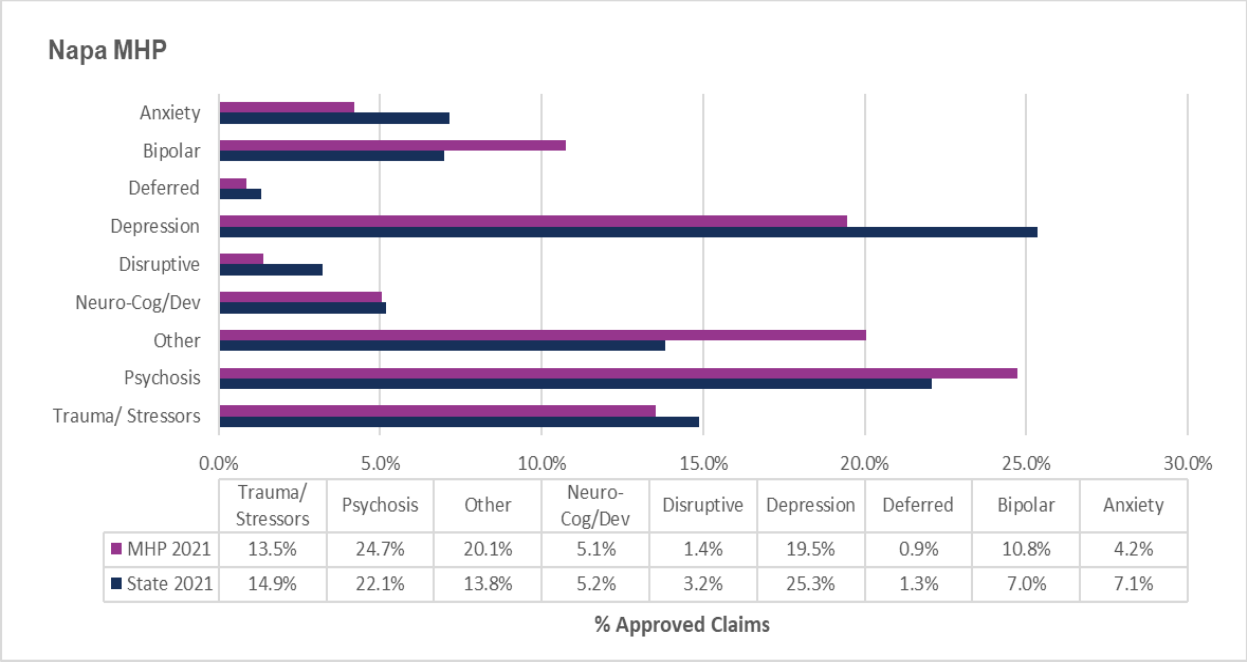
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	14.3%	22.8%	10.5%	5.9%	1.4%	24.5%	3.5%	10.3%	6.8%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- The MHP's diagnosis prevalence of depressive disorder, followed by psychotic disorder, and trauma/stress-related disorder follows the statewide diagnosis prevalence.

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	13.5%	24.7%	20.1%	5.1%	1.4%	19.5%	0.9%	10.8%	4.2%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- The highest AACB by diagnostic category is for psychotic disorder, while depressive disorder accounted for the highest AACB statewide average.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	81	126	8.88	8.79	$12,054	$12,052	$976,354
CY 2020	70	97	8.56	8.68	$13,350	$11,814	$934,484
CY 2019	108	167	7.20	7.80	$9,212	$10,535	$994,881

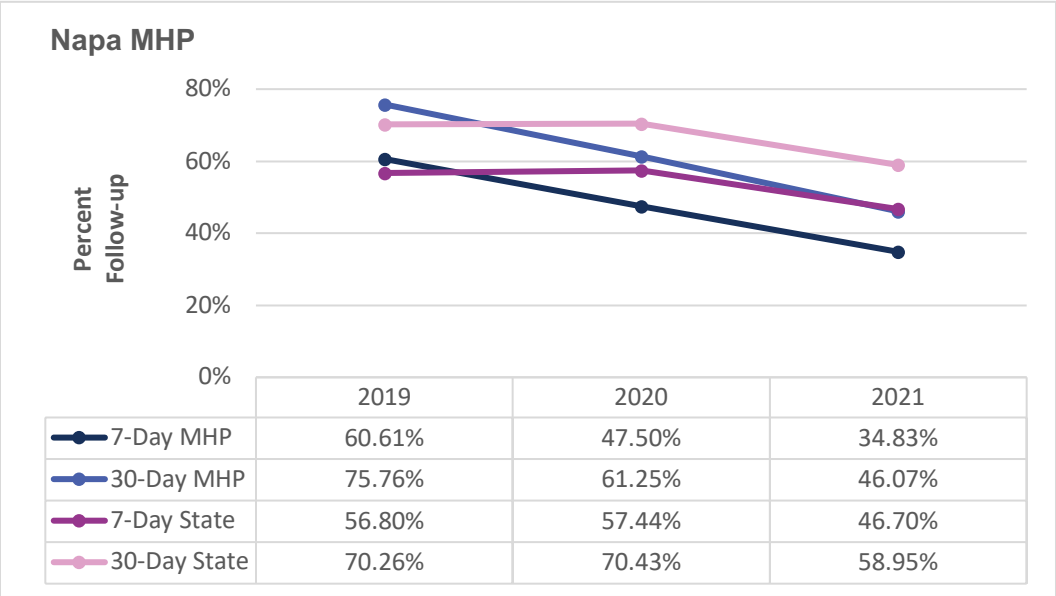
- Inpatient admissions increased by 30 percent with a slight increase in average LOS.

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.

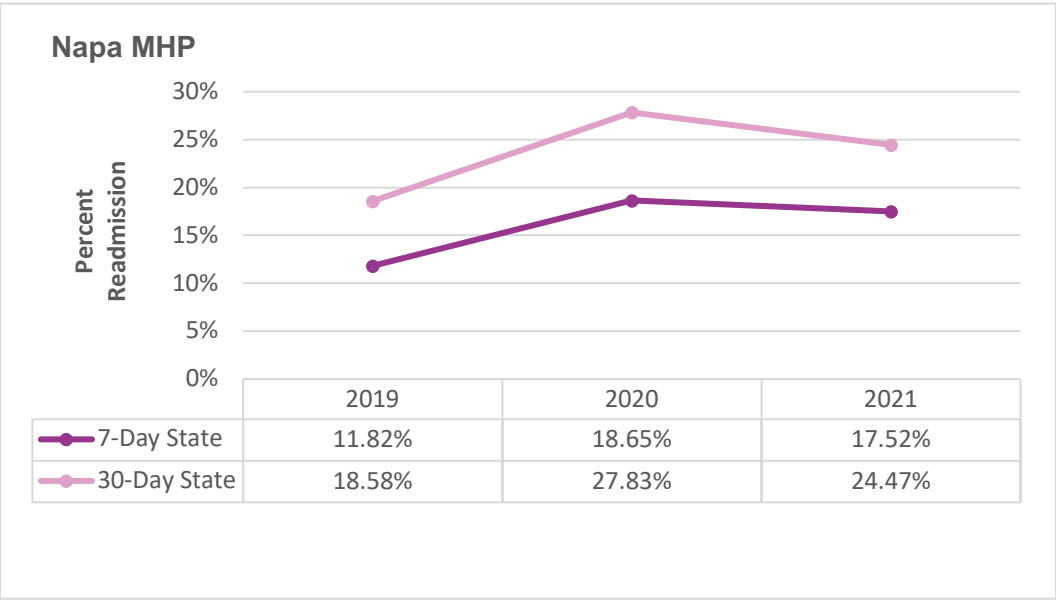
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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	60.61%	47.50%	34.83%
30-Day MHP	75.76%	61.25%	46.07%
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 State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The MHP trend for follow-up care following psychiatric hospitalization is below the statewide average in both measured time periods.
- The rate of psychiatric readmissions is suppressed for the MHP due to a small number of readmissions, while the statewide averages decreased slightly in CY 2021.

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 beneficiaries, 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 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, approximately 92 percent of the statewide beneficiaries who 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

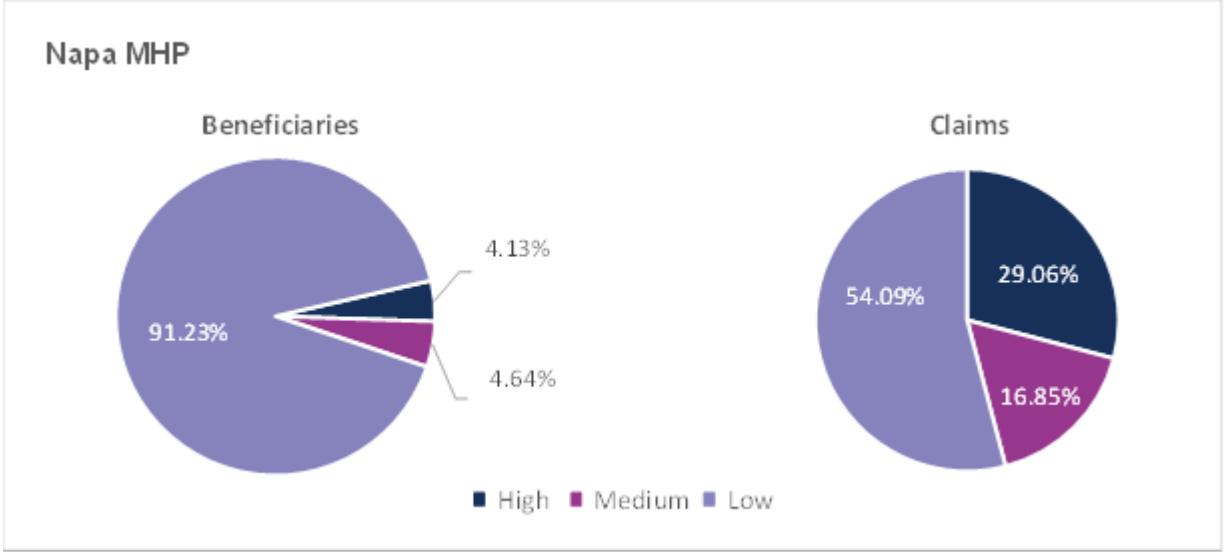
Entity	Year	HCB Count	Total Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	545,147	3.46%	$53,476	$43,231
MHP	CY 2021	41	4.13%	29.06%	$1,931,658	$47,114
	CY 2020	88	6.99%	46.18%	$5,638,998	$64,080
	CY 2019	90	6.09%	37.40%	$4,884,659	$54,274

- The number of HCBs decreased in CY 2021 by 53 percent, and accounted for 4 percent of beneficiaries and 29 percent of approved claims.

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)	46	4.64%	16.85%	$1,119,825	$24,344	$23,894
Low Cost (Less than $20K)	905	91.23%	54.09%	$3,594,691	$3,972	$2,421

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



IMPACT OF QUALITY FINDINGS

- A consequence of decreased capacity for routine services is increased beneficiary use of acute services; for FY 2021, the MHP inpatient admissions increased by 30 percent. Ironically, the HCB decreased in CY 2021 (by 53 percent); the numbers are half of what they have been in the previous two years. All the variables related to HCB are less than in the previous years, and rather may be a byproduct of incomplete claims data. The MHP's 7-day follow-up rate for CY 2021 is uncharacteristically low and even lower than the statewide rate. The MHP's rate has decreased for the past three years and a review of the process for post-hospitalization follow-up is warranted.
- The MHP did not formally monitor medication utilization for youth in FC. Vacancy in the medical director position was cited as the reason for the lack of monitoring. The new psychiatry contract that includes a medical director and psychiatric providers is expected to provide consistency in coverage and routine monitoring.

- There were a small number of peer employees employed at the wellness center. Stakeholders did not endorse a career ladder and other positions that peer employees could hold in the MHP. CalEQRO notes that for many plans, peer employees or trusted community members can fill a gap in service providers and can be a means to engage hard-to-reach populations.

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: Promoting Outpatient Mental Health Service Engagement and Treatment Completion for Latino/Hispanic Adults

Date Started: 12/2020

Date Completed: 06/2022

Aim Statement: Will the use of the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) Cultural Formulation Interview (CFI) increase outpatient treatment engagement and completion by a rate of 5 percent for Hispanic/Latino Adults with a severe mental illness over the next two years, while decreasing the dropout rate by 5 percent?

Target Population: Adults who apply for and meet SMHS criteria or are currently enrolled in NCMH outpatient services who require an assessment.

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

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[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

A review of the MHP's service disposition for FY 2018-20 showed that the majority of Latino/Hispanic beneficiaries were not satisfactorily completing services; 61 percent of cases were closed due to beneficiary drop out. The team hypothesized that a culturally-sensitive assessment would allay concerns about the MHP to meet their health needs. The assessment was meant to increase engagement of Latino/Hispanic beneficiaries. Clinicians were trained to conduct the CFI and obtain periodic training throughout the year. The assessment was used for all adult beneficiaries who required an assessment. The MHP compared outcomes of Latino/Hispanic adults to all adults. While there was improvement in the outcome measures (decreased case closure, increased treatment completion, and increased number of outpatients services), the improvement was greater for all adults and not Latino/Hispanic adults per se.

The outcomes suggest that the CFI has a positive impact on engaging adults and may speak to the MHP's cultural sensitivity more generally. The team may consider strategies that might increase retention for Latino/Hispanic beneficiaries specifically. One area that the team might investigate is the timing of drop-out; most drop-out (approximately 60 percent) occurred after the assessment and before routine services.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: The MHP presented a problem and some potential root causes. The team implemented an intervention and applied it to its target population. The team analyzed data on a yearly basis; however, more frequent analysis was advised. There was some improvement in the performance measures, but the primary outcome only had minor change for the target population.

CalEQRO provided TA to the MHP in the form of recommendations for improvements to be applied to future PIPs:

- Provide MHP-specific reasons for the cause(s) of the problem.
- Increase the frequency of data review and analysis from annually to quarterly.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Reducing the average length of time from first assessment visit to first offered adult psychiatry appointment

Date Started: 11/2020

Date Completed: 06/2022

Aim Statement: The aim of this PIP is to "reduce from 19 days to 15 days the average length of time from first assessment date to first offered psychiatry appointment through the introduction of timeline standards for Access assessment completion and referral submission and for Medication Clinic triage and processing adult psychiatry referral."

Target Population: Adults who request or are referred for psychiatry services.

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

Summary

In reviewing the timeliness to psychiatry over the past three years, the MHP was not meeting the 15-business day standard for appointments. In FY 2018-19 and FY 2019-20 the rates were 44 percent and 70 percent, respectively. The PIP team determined that there was variability in the process for psychiatry referrals from Access unit to the Medication Clinic. There were inconsistencies in the time to referral and inconsistencies in triage once at the Medication Clinic. The intervention was to standardize the timeline for completing intake assessments and processing referrals for adult psychiatry: three days for Access unit to refer to the Medication Clinic and five days for the Medication Clinic to triage, contact beneficiary, and schedule the appointment. In the second year of the project, the time to referral to the Medication Clinic was increased to five days, based on feedback from Access unit staff.

The PIP team reported an improvement in the proportion of appointments scheduled in 15-business days, from 55 percent at the start of the project to 81 percent at the end of the study period. The team also intended to decrease the average time to appointment, from 19 days, but did not report this measure. The team reported that even with staff changes at the Access unit and Medication Clinic the process has continued.

TA and Recommendations

As submitted, this non-clinical PIP was found to have high confidence. The MHP presented a problem with two potential root causes. The team implemented an intervention to improve the process at the Access Unit and the Medication Clinic. The team used a PDSA process to assess its strategy and subsequently revised part of the process. The team analyzed data on a yearly basis; however, more frequent analysis was advised. The team reported an improvement, which was sustained even with staff changes in both units.

CalEQRO provided TA to the MHP in the form of recommendations for improvements to be applied to future PIPs:

- Include the average time to psychiatry appointment as a performance measure.
- Increase frequency of data analysis from annually to quarterly.
- Aggregate results over one year, not two years.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner Anasazi, which has been in use for 15 years. Currently, the MHP has selected a new EHR (Qualifacts/Credible), and began the implementation phase in November 2022 with a target go-live date of July 1, 2023.

Approximately 2 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is allocated to the MHP but managed by another county department.

The MHP has 305 named users with log-on authority to the EHR, including approximately 139 county staff and 166 contractor staff. Support for the users is provided by two full-time equivalent (FTE) IS technology positions. Currently all positions are filled.

As of the FY 2022-23 EQR, one contract provider has 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	0.14%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	99.86%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not currently have a PHR. This functionality is expected to be implemented within the next year with the new EHR implementation.

Interoperability Support

The MHP is not a member or participant in an HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email. The MHP engages in electronic exchange of information with internal staff 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	Partially Met
4F	Interoperability	Partially Met

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

- The MHP has set aside resources for IS and data analytic positions to support the system of care, and is contracting for ancillary system support as it implements the Credible EHR.
- The MHP has not granted access for all contract providers to have full access for data entry into the EHR.
- The MHP's claim denial rate exceeds the statewide average denial rate.
- The current EHR lacks multiple components including: care coordination module, referral management, and a PHR.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

For the MHP, it appears that significant claims lag begins in July and likely represents $5 million in services not yet shown in the approved claims. The MHP reports that its claiming is current through November 2022.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	1,877	$1,046,772	$4,133	0.39%	$1,042,639
Feb	1,852	$962,227	$14,515	1.51%	$947,712
Mar	2,244	$1,228,117	$35,030	2.85%	$1,193,087
April	1,698	$821,930	$77,022	9.37%	$744,908
May	1,447	$747,663	$11,541	1.54%	$736,122
June	1,484	$788,219	$28,430	3.61%	$759,789
July	297	$83,597	$1,513	1.81%	$82,084
Aug	279	$85,643	$3,049	3.56%	$82,594
Sept	399	$97,737	$8,410	8.60%	$89,327
Oct	289	$81,204	$34,986	43.08%	$46,218
Nov	69	$31,248	$603	1.93%	$30,645
Dec	1	$270	$0	0.00%	$270
Total	**11,936**	**$5,974,626**	**$219,232**	**3.67%**	**$5,755,394**

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	275	$120,820	55.11%
Medicare Part B or Other Health Coverage must be billed before submission of claim	61	$43,338	19.77%
NPI related	70	$24,764	11.30%
Service line is a duplicate and a repeat service procedure code modifier not present	70	$22,919	10.45%
Beneficiary not eligible or non-covered charges	19	$7,391	3.37%
Claim/service lacks information which is needed for adjudication	275	$120,820	55.11%
Total Denied Claims	495	$219,232	100.00%
Overall Denied Claims Rate	3.67%		
Statewide Overall Denied Claims Rate	2.78%		

- The MHP's CY 2021 claim denial rate of 3.67 percent is higher than the statewide average of 2.78 percent.
- Claims with denial codes: claim/service lacks information which is needed for adjudication, Medicare Part B or other health coverage must be billed prior to the

submission of this claim, and NPI related are generally rebillable within State guidelines following claim corrections and resubmission.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Strong collaboration with the contracted providers and ongoing communication will assist the MHP in its efforts to implement a new EHR. The MHP would benefit from increasing the contract provider involvement and input on the implementation process, including the implementation phase as the MHP confirms functionality within the Credible EHR.
- The base of two FTEs supporting the overall health agency IS functionality and 3.4 FTE data analytics staff will provide a foundation during the EHR transition. The ancillary contract for system development support will be vital to a successful EHR transition, if the MHP does not increase support staff to address the increased resources needed for transitioning EHRs.
- The continued system limitations within the current EHR will prohibit efficient and fully reliable data collection efforts due to the current manual and workaround processes in place. Timeliness data, in particular, is significantly impacted by these limitations.

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 presented CPS results from FY 2021 that included response rate for various survey questions, the total number of survey respondents per survey, and survey comments, when provided. The MHP did not provide a summary of the results, a conclusion, or any follow-up action from the survey. From previous surveys and grievances regarding psychiatric provider coverage, the MHP recognized a need to change its psychiatric provider coverage, which it has with the new contract.

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 one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members, containing ten participants.

Consumer Family Member Focus Group One

CalEQRO requested a culturally diverse group of 8-10 adult beneficiaries, including Latino beneficiaries, who have initiated/utilized services in the preceding 12 months. The focus group was held via videoconference and included ten participants; a language interpreter was not needed for this focus group. All consumers participating receive clinical services from the MHP.

Participants reported that, with decreasing COVID-19 restrictions, there has been more engagement of beneficiaries in services and programs at the wellness center. All the participants were clients of the Innovations Wellness Center. They found the wellness center to be a reliable source of support. Participants described a protracted process for initiation of clinical services. For the participants who had initiated services in the preceding 12 months, the time that they reported for start of their services averaged two months; one participant recounted that it took four months to begin therapy. Participants

reported frequency of ongoing appointments as one to two months. They were dissatisfied with the inconsistency in the psychiatric provider coverage. Participants were not all aware of the options available to beneficiaries, including to have family members/close friends be involved in their care, to participate in stakeholder groups or committees, or to participate in surveys to give their input on mental health services.

Recommendations from focus group participants included:

- Improve speed of seeing beneficiaries.
- Stabilize psychiatric coverage.
- Provide or facilitate supportive housing programs for beneficiaries experiencing homelessness.
- Increase staff sensitivity and cultural awareness.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Beneficiaries have a variety of means to provide input of MHP services, including the CPS, grievances, program surveys, and participation in stakeholder/planning meetings. Some of the latter opportunities were not widely known to beneficiaries. Feedback from the beneficiary focus group—that the frequency of appointments was every two months and that therapy could take up to four months to initiate—is consistent with line staff feedback that the MHP has challenges in providing routine ongoing services. The new psychiatry contract will be a welcome change for beneficiaries, as frequent change in psychiatric provider coverage was presented as an ongoing concern.

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 new Mobile Response Team increases the MHP's capacity to respond to crises in the community and will likely reduce the clinician rotation of officer/responder of the day, which decreases their ability to see scheduled appointments. (Access)
2. HHS has contracted with a provider for full-time psychiatrists and a medical director, which will provide much needed stability with psychiatric coverage and medication management and monitoring. (Access, Quality)
3. The MHP has made progress in moving the EHR replacement project forward with Qualifacts/Credible and is investing in additional contracted development support. (IS)
4. The PIP team used a PDSA cycle in conducting the PIPs and demonstrated understanding of continuous quality improvement. (Quality)
5. Staff of the MHD are able to telework two days per week, which gives the department an incentive in retaining current staff. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP reports a vacancy rate of approximately 25 percent, which affects beneficiary access, timeliness, and quality of services and affects the MHP's ability to implement and sustain current initiatives, including but not limited to, the Credible EHR implementation, integration of mental health and substance use disorder systems of care, and CalAIM (Access, Timeliness, Quality, IS)
2. Per several stakeholder groups, the change to a centralized access process has purportedly contributed to a protracted process for beneficiaries to begin services delivered through contract providers. (Access, Timeliness)
3. In its report of timeliness metrics, the MHP cited data integrity issues and challenges in capturing/reporting reliable timeliness data for youth in FC. (Quality)
4. Clinical staff reported pressure to close cases earlier than they otherwise would in order to serve new beneficiaries waiting for services. (Quality, Access)
5. The MHP did not formally monitor the HEDIS measures related to medication utilization for youth in FC. (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. Continue to research and implement strategies to recruit and retain staff including the leveraging of regional partnership participation, loan repayment programs, and internship opportunities. (Access, Timeliness, Quality)
2. Investigate reasons and develop and implement strategies to improve the time to initiation of services delivered through contract providers. Ensure that the process facilitates as timely of a service initiation as possible for each beneficiary. (Access, Timeliness)
3. Review timeliness metrics on a monthly basis, for data completeness and accuracy. On a quarterly basis, review timeliness for all beneficiary groups. (This requires changes in the EHR to be able to record FC status). (Timeliness) *This recommendation is a follow-up from FY 2021-22.*)
4. Investigate case closures and develop and implement strategies to appropriately close and transition beneficiaries to lower levels of care. (Quality, Access)
5. Monitor and conduct quarterly reviews of the four HEDIS measures related to medication utilization for youth in FC. (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.

All participants for the consumer/family member focus group were from the Innovations program, as it was last year. Recruiting participants from one program/service provider may not provide a broad perspective of beneficiary experience.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT F: PM Data CY 2021 Refresh

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Napa MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs Validation and Analysis
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Consumer and Family Member Focus Group(s)
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Forensics and Law Enforcement Group Interview
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

Ewurama Shaw-Taylor, PhD, CPHQ, Lead Quality Reviewer
Joel Chain, Lead Information Systems Reviewer
Brian Deen, Information Systems Reviewer
Walter Shwe, 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.

MHP County Sites

All sessions were held via video conference.

MHP Contract Provider Sites

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	Adrian	Senior Mental Health Worker, Pathways to Well Being	Health and Human Services Agency - Mental Health (HHSA MH)
Ahearn	Kerry	Chief Executive Officer	Aldea
Akil	Latoya	Deputy Director, Compliance and Privacy Officer	HHSA MH
Angel	Yesenia	Mental Health Worker	HHSA MH
Bedolla	Felix	Project Manager, MHSA Coordinator	HHSA
Bhambra	John	Assistant County Compliance and Privacy Officer	HHSA MH
Cahill	Valerie	Assistant Deputy Director, Behavioral Health Adult	HHSA MH
Castro	Roxana	Quality Assurance/Utilization Review Clinician	HHSA MH
Chavez-Duarte	Erika	Mental Health Counselor	HHSA MH
Curletto	Jason	Senior Systems Support Analyst	HHSA MH
Diel	James	Assistant Director	HHSA
Eslami	Cassandra	Behavioral Health Director, Deputy Director HHSA	HHSA MH
Figueiras-Davidson	Betty	Mental Health Counselor	HHSA
Forrester	Kelli	Mental Health Counselor	HHSA MH
Harry	Carolina	Staff Services Manager/Application Support Team Manager	HHSA

Last Name	First Name	Position	County or Contracted Agency
Hernandez	Elizabeth	Director of Operations and Clinical Services	Progress Foundation
Jones	Amanda	Manager – ADS	HHSA ADS
Kyle	Clay	Supervising Mental Health Counselor II	HHSA MH
Lawrence	Lynette	Providers Services Coordinator	HHSA MH
Mahler, PhD	Catherine	Mental Health Counselor	HHSA MH
McClanahan	Mandy	Staff Services Analyst	HHSA
Menges	Jennifer	Quality Coordinator	HHSA MH
Michael	Jacquenette	Program Director	Stanford Sierra Youth & Families
Mills	Mike	Manager – Mental Health Administration	HHSA MH
Nesbitt	Will	Director of Programs	Mentis
Paramo	Sulema	Mental Health Counselor	HHSA MH
Rodriguez-Garcia	Graciela	Supervising Mental Health Counselor II	HHSA MH
Roy	Brian	Mental Health Counselor	HHSA MH
Sanchez	Blanca	Mental Health Utilization Review Coordinator	HHSA MH
Schmidt	Sandra	Staff Services Analyst	HHSA MH
Simonsen	Eric	Program Director	Buckelew Programs

Last Name	First Name	Position	County or Contracted Agency
Stoner	Chelsea	Supervising Mental Health Counselor II	HHSA MH
Thompson	Gianna	Supervisor, Adult Case Management Unit	HHSA MH
Torres	Jessica	Supervising Office Assistant	HHSA MH
Zamora	Erin	Compliance Manager	Aldea

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP presented a problem, related to beneficiary access, and some potential root causes. The team implemented an intervention and applied it to its target population, Latino/Hispanic beneficiaries. The team analyzed data on a yearly basis; however, more frequent analysis was advised. There was some improvement in the three performance measures assessed. However, for the primary outcome, the change was not appreciable.

General PIP Information
MHP/DMC-ODS Name: Napa County
PIP Title: Promoting Outpatient Mental Health Service Engagement and Treatment Completion for Hispanic/Latino Adults
PIP Aim Statement: Will the use of the DSM-5 Cultural Formulation Interview (CFI) increase outpatient treatment engagement and completion by a rate of 5 percent for Hispanic/Latino Adults with a severe mental illness over the next two years, while decreasing the dropout rate by 5 percent?
Date Started: 12/2020
Date Completed: 06/2022
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Adults who apply for and meet criteria for SMHS or who are currently enrolled in MHD outpatient services who require an assessment.

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Integrate the DSM-5 Cultural Formulation Interview into the comprehensive intake/assessment and annual reassessment processes. 2. Deliver three booster training sessions for clinicians on applying CFI responses to inform engagement, treatment planning, and clinical intervention.
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): 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
Percentage of Latino/Hispanic adult cases closed as a result of completing treatment	FY 2018-20	N = 44, 13.5%	FY 2021-22	N = 21, 20%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of Latino/Hispanic adult outpatient cases where the CFI was administered that are closed as a result of dropping out of treatment	FY 2018-20	N = 44, 61%	FY 2021-22	N = 21, 57%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Average number of outpatient services received by Hispanic/Latino adults to whom the CFI was administered before dropping out of treatment	FY 2018-20	N = 27, Average = 5	FY 2021-22	N = 12, Average = 8.4	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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:

- Increase the frequency of data review and analysis from quarterly to annually.
- Provide MHP-specific reasons for the cause of the problem.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP presented a problem with two potential root causes. The team implemented an intervention to improve the process at the Access Unit and the Medication Clinic. The team used a PDSA process to assess its strategy and subsequently revised part of the process. The team analyzed data on a yearly basis; however, more frequent analysis was advised. The team reported improvement, which was sustained even with staff changes in both units.

General PIP Information
MHP/DMC-ODS Name: Napa County
PIP Title: Reducing the average length of time from first assessment visit to first offered adult psychiatry appointment
PIP Aim Statement: The aim of this PIP is to reduce from 19 days to 15 days the average length of time from first assessment date to first offered psychiatry appointment through the introduction of timeline standards for Access assessment completion and referral submission and for Medication Clinic triage and processing adult psychiatry referral.
Date Started: 11/2020
Date Completed: 06/2022
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): Adults who meet SMHS criteria and who are request/are referred for psychiatry services.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Implement/standardize the timeline for completing intake assessments and processing referrals for adult psychiatry.

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 first offered psychiatry appointments offered within 15 business days	FY 2019-20	30%	FY 2021-22	N = 123, 81%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): Completed 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: • Include the average time to psychiatry appointment as a performance measure. • Increase frequency of data analysis from annually to quarterly. • Aggregate results over one year, not two years.

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

Napa 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	36,154	1,356	3.75%	$15,061,363	$11,107
CY 2020	32,960	1,259	3.82%	$12,211,292	$9,699
CY 2019	31,665	1,477	4.66%	$13,061,412	$8,843

*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	3,631	32	0.88%	1.27%	1.96%
Ages 6-17	8,965	455	5.08%	5.74%	5.93%
Ages 18-20	2,055	73	3.55%	4.89%	4.41%
Ages 21-64	17,527	708	4.04%	4.73%	4.56%
Ages 65+	3,979	88	2.21%	2.45%	1.95%
Total	**36,154**	**1,356**	**3.75%**	**4.39%**	**4.34%**

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	277	20.43%
Threshold language source: Open Data per BHIN 20-070		

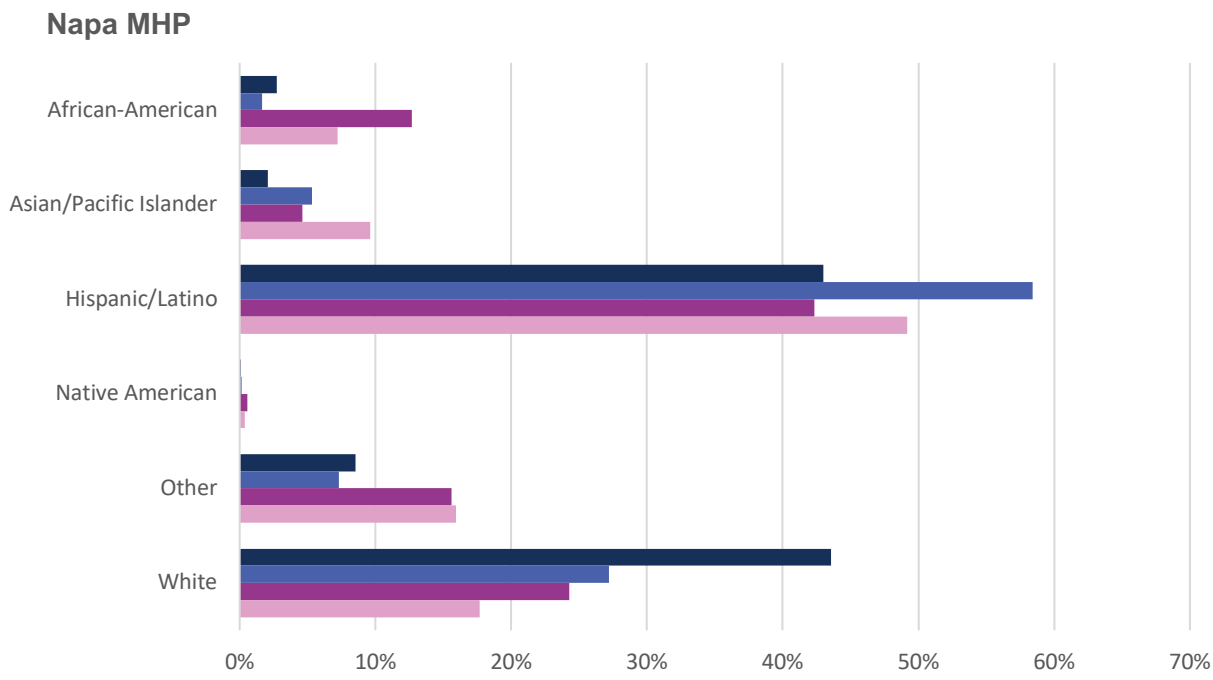
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	10,088	329	3.26%	$2,823,807	$8,583
Small	199,673	7,709	3.86%	$45,313,502	$5,878
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	594	-	-	7.64%
Asian/Pacific Islander	1,918	28	1.46%	2.08%
Hispanic/Latino	21,127	583	2.76%	3.74%
Native American	47	<11	-	6.33%
Other	2,643	116	4.39%	4.25%
White	9,828	591	6.01%	5.96%
Total	**36,157**	**1,356**	**3.75%**	**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	44%	9%	0%	43%	2%	3%
MHP % Eligible	27%	7%	0%	58%	5%	2%
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

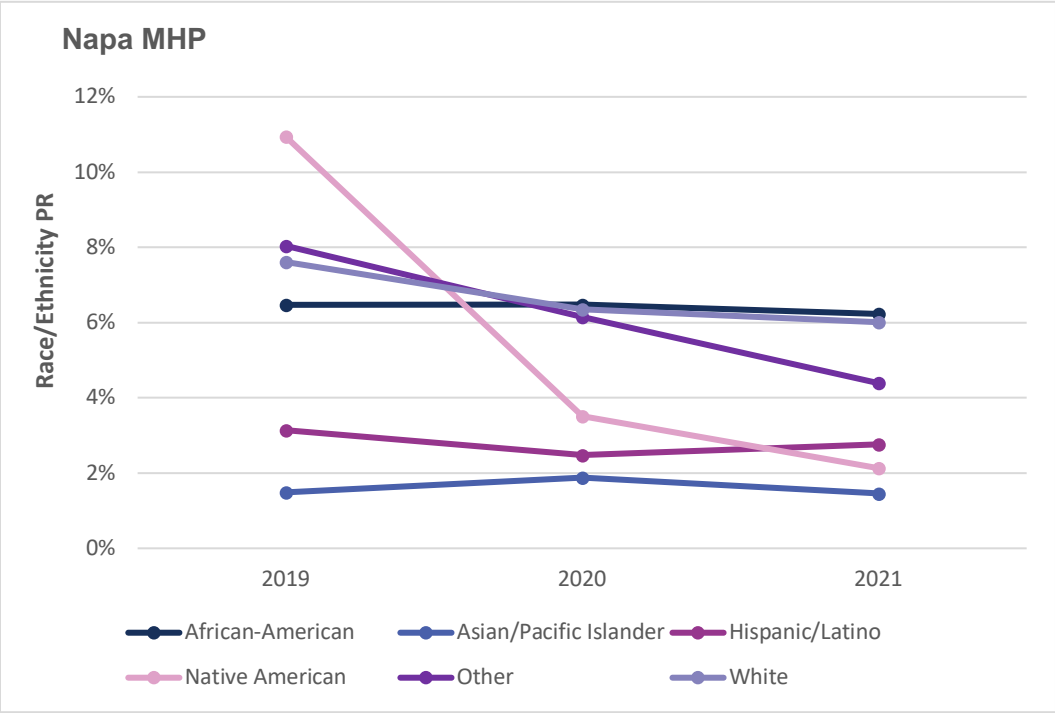


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

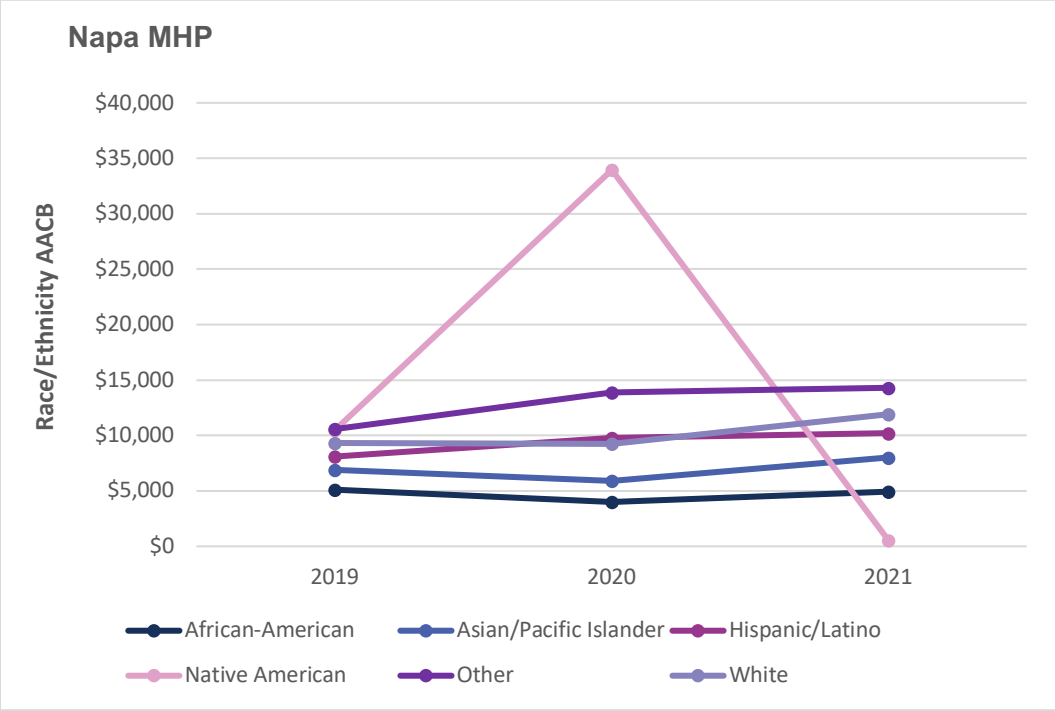
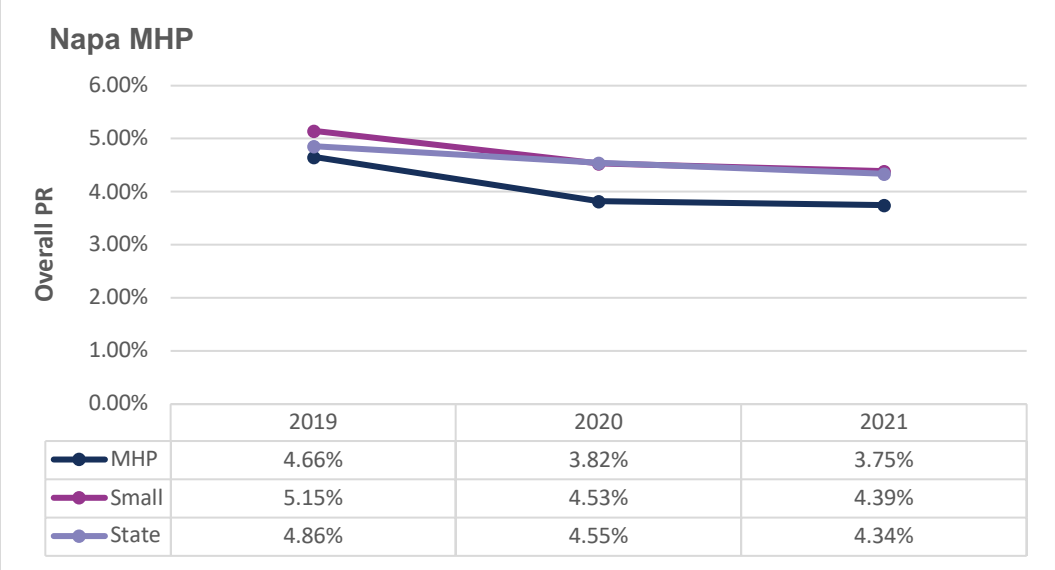
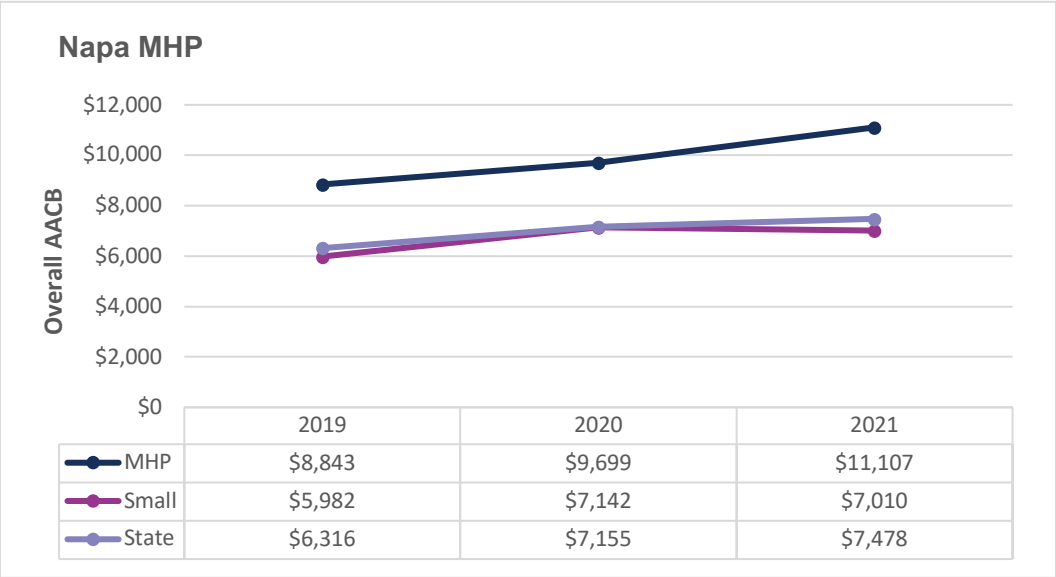


Figure 4: Overall PR CY 2019-21



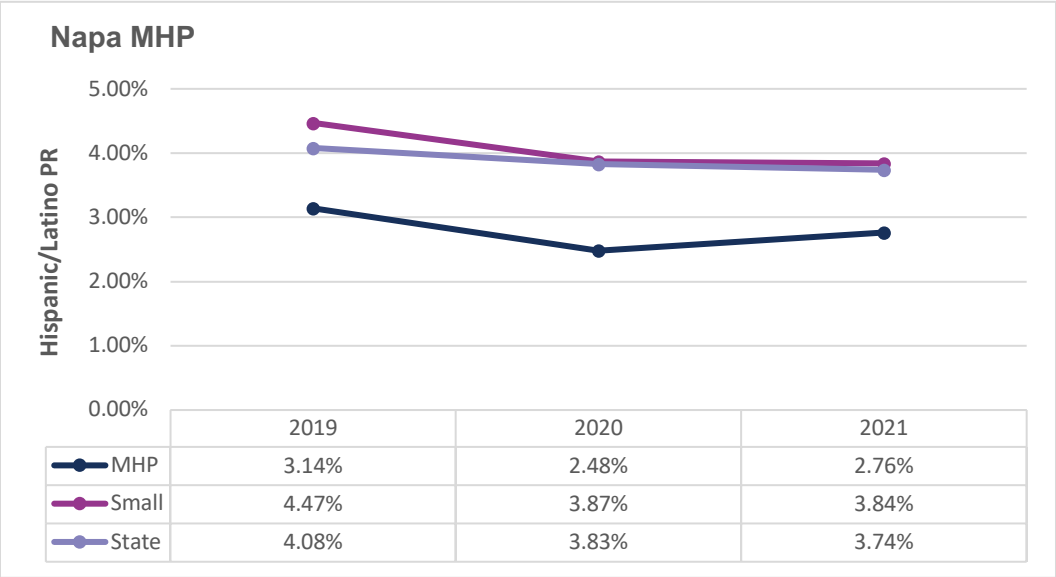
	2019	2020	2021
MHP	4.66%	3.82%	3.75%
Small	5.15%	4.53%	4.39%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



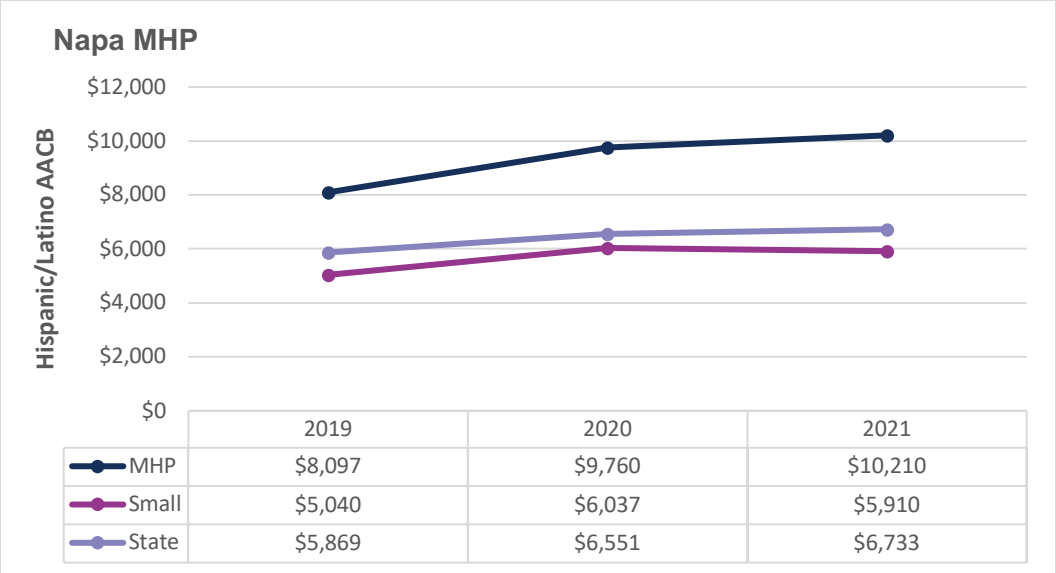
	2019	2020	2021
MHP	$8,843	$9,699	$11,107
Small	$5,982	$7,142	$7,010
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21



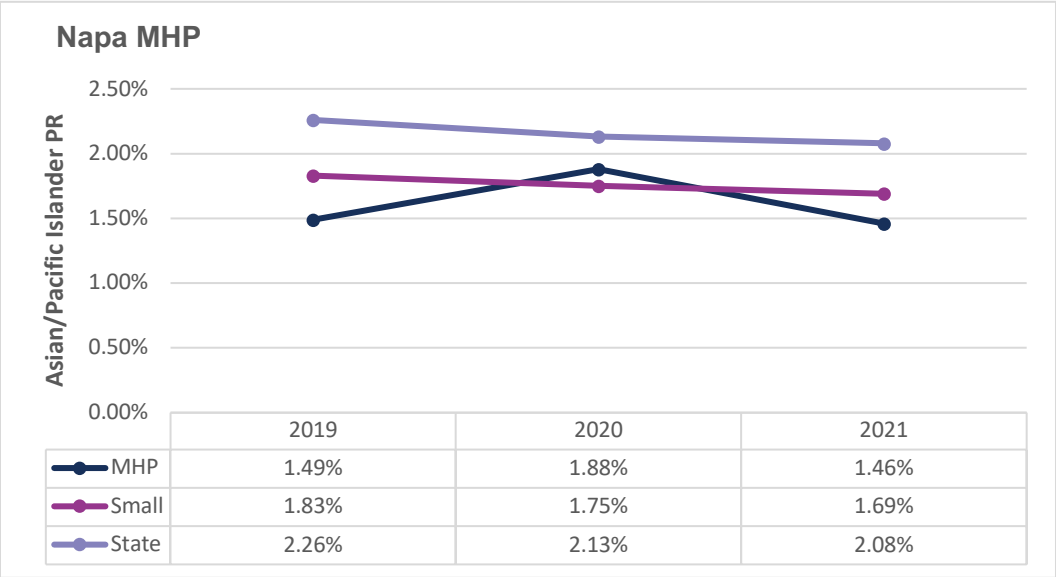
	2019	2020	2021
MHP	3.14%	2.48%	2.76%
Small	4.47%	3.87%	3.84%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21



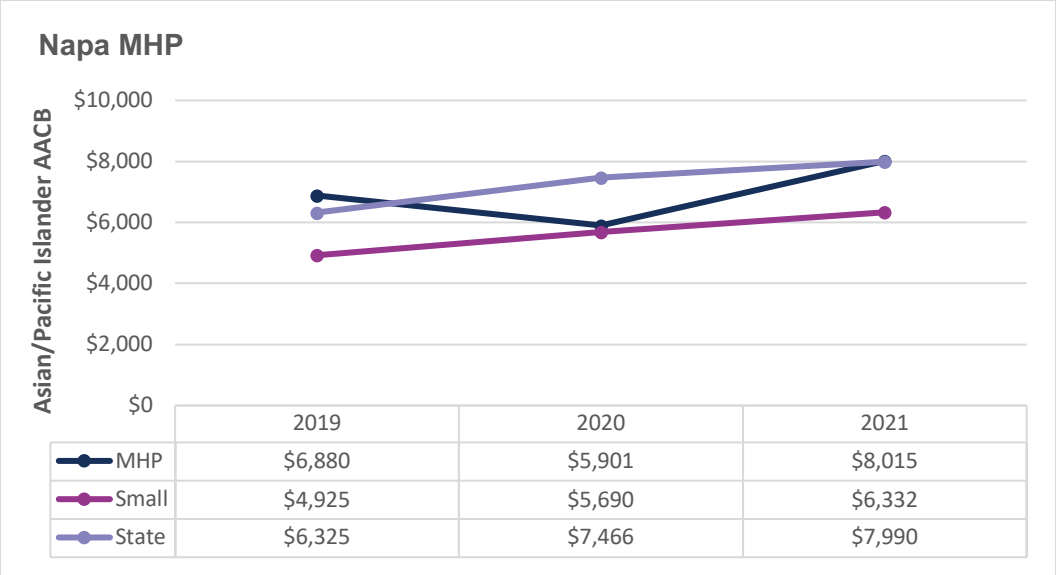
	2019	2020	2021
MHP	$8,097	$9,760	$10,210
Small	$5,040	$6,037	$5,910
State	$5,869	$6,551	$6,733

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



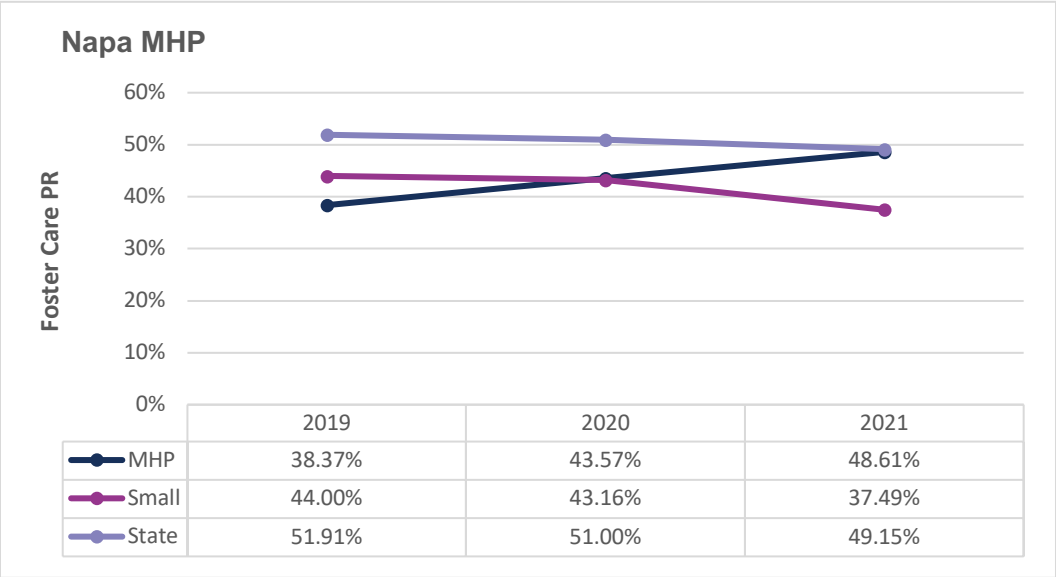
	2019	2020	2021
MHP	1.49%	1.88%	1.46%
Small	1.83%	1.75%	1.69%
State	2.26%	2.13%	2.08%

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



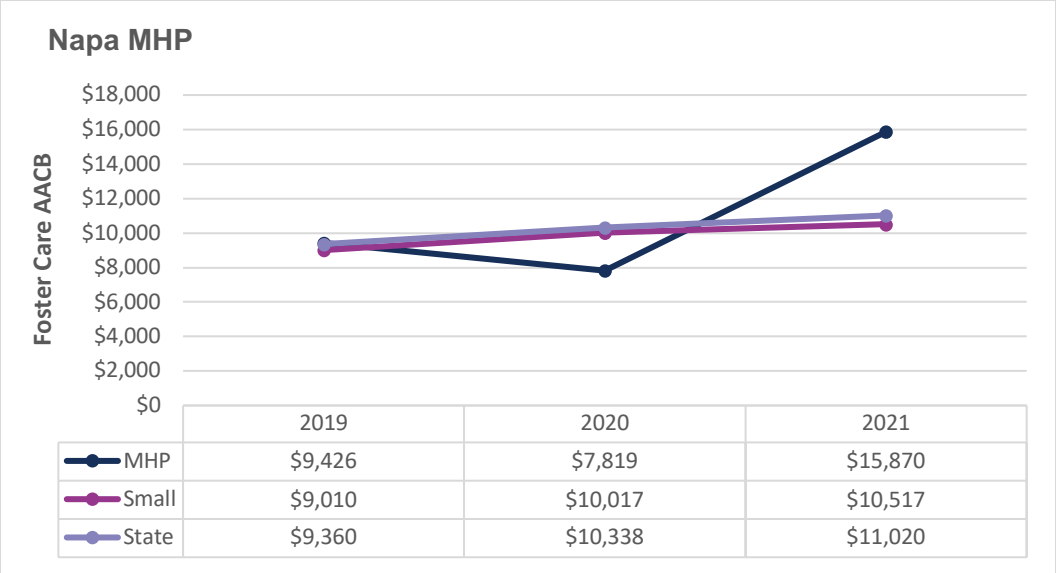
	2019	2020	2021
MHP	$6,880	$5,901	$8,015
Small	$4,925	$5,690	$6,332
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	38.37%	43.57%	48.61%
Small	44.00%	43.16%	37.49%
State	51.91%	51.00%	49.15%

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$9,426	$7,819	$15,870
Small	$9,010	$10,017	$10,517
State	$9,360	$10,338	$11,020

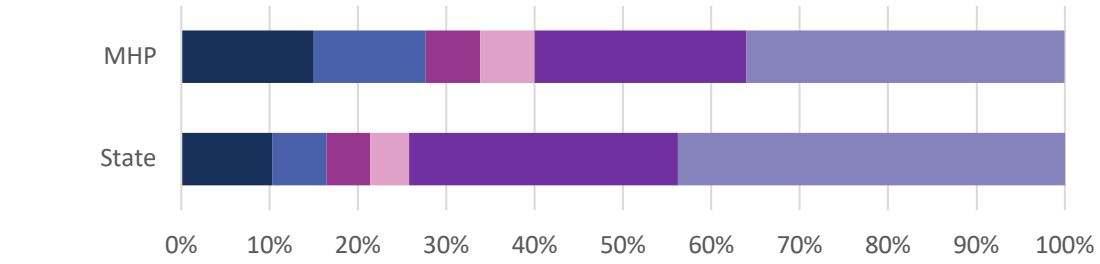
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 869				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	34	3.9%	12	8	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	37	4.3%	14	9	1.3%	15	7
Residential	23	2.6%	128	82	0.4%	107	79
Crisis Residential	64	7.4%	22	20	2.2%	21	14
Per Minute Services							
Crisis Stabilization	197	22.7%	1,780	1,200	13.0%	1,546	1,200
Crisis Intervention	12	1.4%	271	206	12.8%	248	150
Medication Support	479	55.1%	235	178	60.1%	311	204
Mental Health Services	480	55.2%	1,130	424	65.1%	868	353
Targeted Case Management	234	26.9%	264	131	36.5%	434	137

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

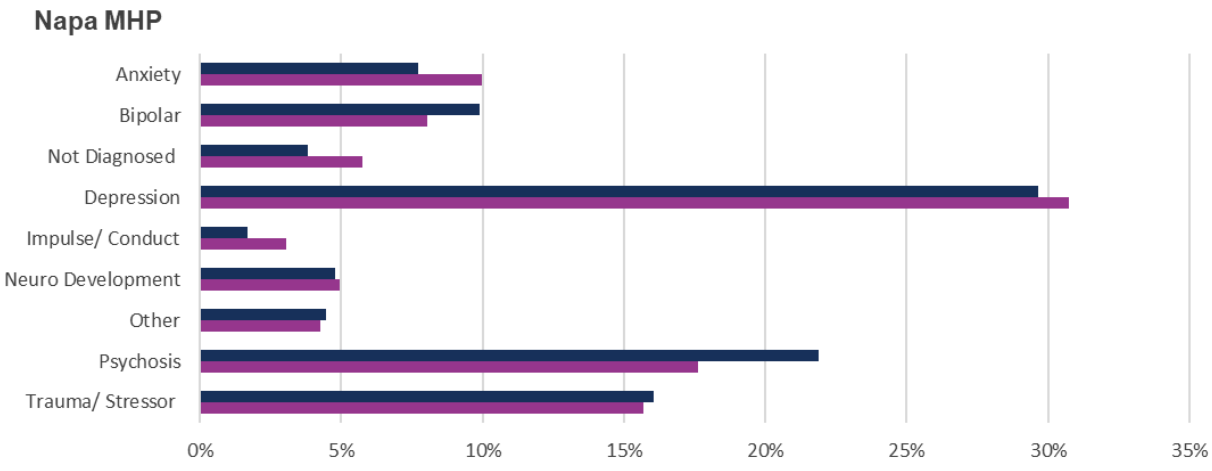
Service Category	MHP N = 70				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	6	6	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	<11	-	3	3	0.2%	22	8
Residential	<11	-	194	194	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	-	1,180	1,200	3.1%	1,404	1,200
Crisis Intervention	<11	-	308	308	7.5%	406	199
Medication Support	22	31.4%	561	320	28.2%	396	273
TBS	<11	-	582	582	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	24	34.3%	967	551	40.2%	1,354	473
Intensive Home Based Services	<11	-	1,825	1,592	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	64	91.4%	2,285	1,098	96.3%	1,854	1,108
Targeted Case Management	38	54.3%	363	170	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	14.97%
2 service	6.20%	12.68%
3 service	4.88%	6.19%
4 service	4.47%	6.12%
5-15 Services	30.41%	23.97%
>15 Services	43.79%	36.06%

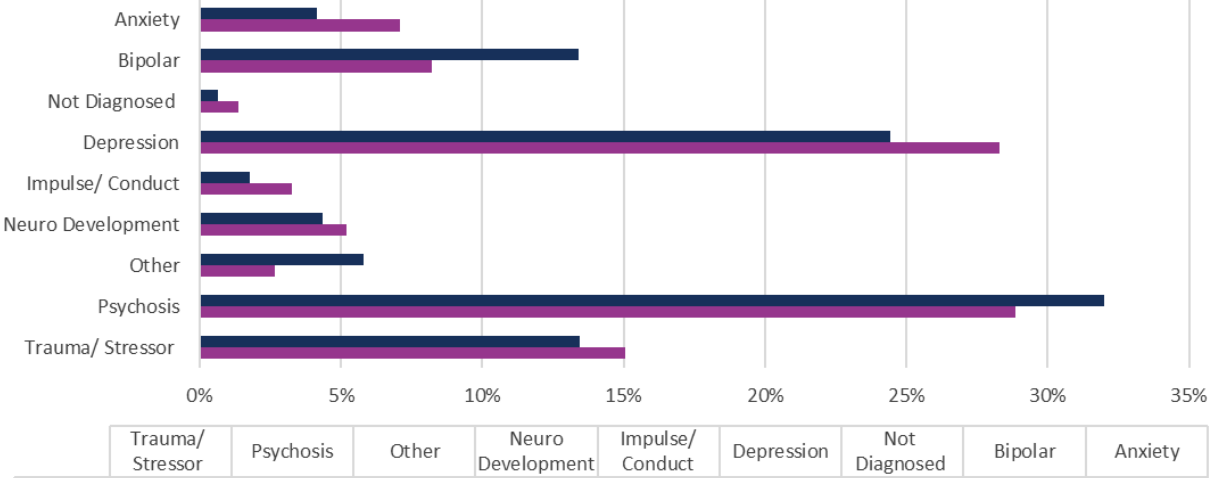
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	16%	22%	4%	5%	2%	30%	4%	10%	8%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Percent Beneficiaries

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	13%	32%	6%	4%	2%	24%	1%	13%	4%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Percent Claims

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	112	180	10.32	8.86	$13,140	$12,052	$1,471,701
CY 2020	70	97	8.56	8.68	$13,350	$11,814	$934,484
CY 2019	108	167	7.20	7.80	$9,212	$10,535	$994,881

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

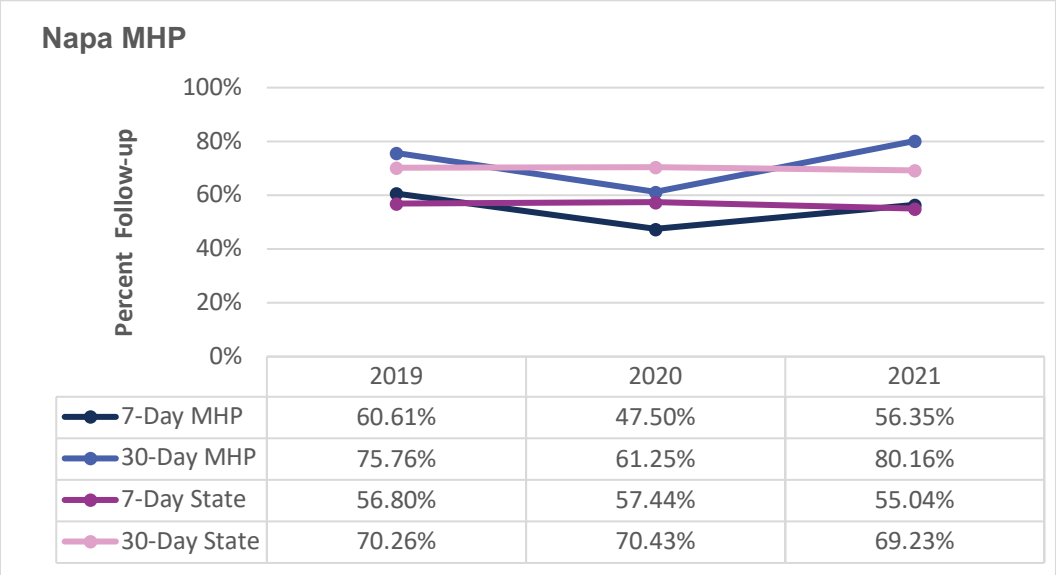
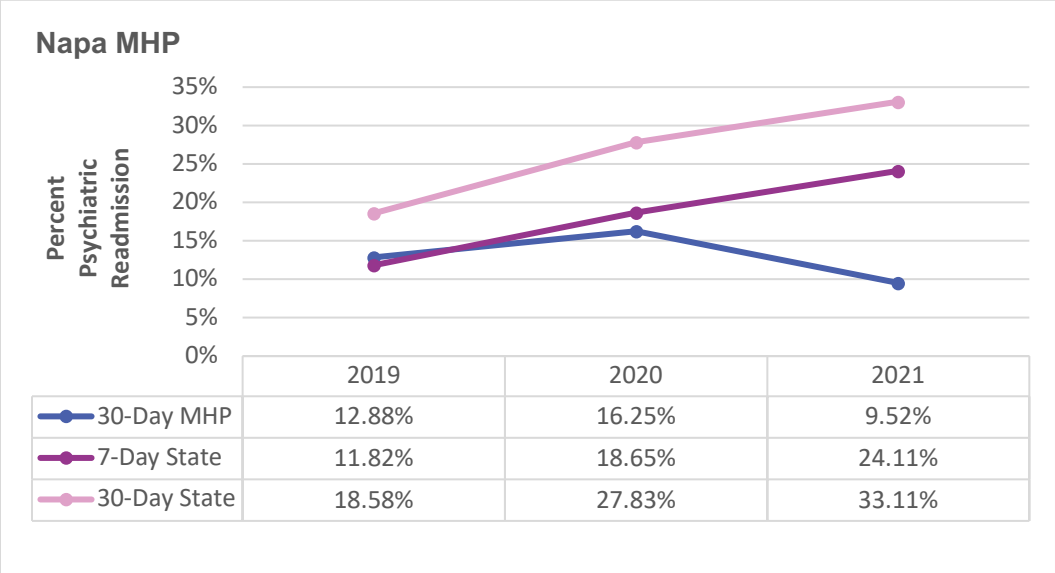


Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



*The MHP's 7-day readmission data is not displayed above due to the small number of beneficiaries represented.

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	132	9.73%	52.67%	$7,932,128	$60,092	$47,575
	CY 2020	88	6.99%	46.18%	$5,638,998	$64,080	$48,494
	CY 2019	90	6.09%	37.40%	$4,884,659	$54,274	$47,987

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)	64	4.72%	10.18%	$1,533,714	$23,964	$23,512
Low Cost (Less than $20K)	1,160	85.55%	37.15%	$5,595,521	$4,824	$2,950

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

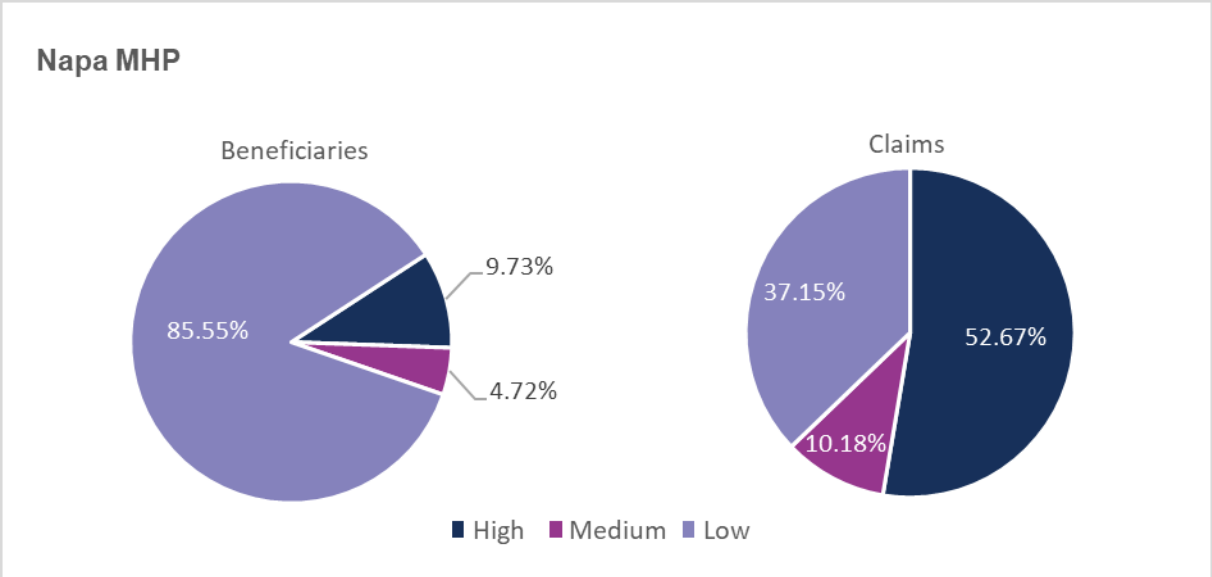


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	2,045	$1,142,777	$768	0.07%	$1,110,224
Feb	2,046	$1,034,626	$0	0.00%	$1,006,662
Mar	2,465	$1,300,847	$0	0.00%	$1,250,087
April	2,586	$1,408,303	$1,726	0.12%	$1,316,634
May	2,156	$1,319,600	$4,868	0.37%	$1,297,790
June	2,259	$1,360,910	$16,797	1.23%	$1,307,954
July	2,054	$1,197,980	$18,401	1.54%	$1,170,739
Aug	2,089	$1,175,538	$6,849	0.58%	$1,156,353
Sept	2,247	$1,293,557	$4,091	0.32%	$1,269,719
Oct	2,278	$1,265,411	$20,321	1.61%	$1,194,358
Nov	2,025	$1,092,322	$5,891	0.54%	$1,076,157
Dec	1,911	$1,022,706	$8,652	0.85%	$1,004,668
Total	**26,161**	**$14,614,577**	**$88,364**	**0.60%**	**$14,161,345**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other healthcare coverage must be billed before submission of claim	56	$43,413	49.13%
Service location NPI issue	21	$19,914	22.54%
Medicare Part B must be billed before submission of claim	26	$18,679	21.14%
Beneficiary not eligible or non-covered charges	8	$4,983	5.64%
Service line is a duplicate and a repeat service procedure code modifier not present	2	$779	0.88%
Deactivated NPI	3	$595	0.67%
Total Denied Claims	**116**	**$88,363**	**100.00%**
Overall Denied Claims Rate	**0.60%**		
Statewide Overall Denied Claims Rate	**1.43%**		