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

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

SUTTER-YUBA FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 11, 2023

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — January 11, 2023

MHP Size — Small

MHP Region — Central

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	1	2	2

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	1	4	1
Quality of Care	10	0	7	3
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**8**	**14**	**4**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Improving Rates of Post-Psychiatric Hospitalization Follow-up	Clinical	01/23	Planning	Low
Follow-up After Emergency Department (ED) Visit for Mental Health (FUM)	Non-Clinical	12/22	Planning	Low

Table D: Summary of Consumer/Family Focus Groups

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

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Sutter-Yuba Behavioral Health (SYBH) maintains collaborative relationship with its contract providers. Together, they present a united front, which enables coordination of services.
- The MHP has a full complement of psychiatric providers.
- Beneficiary documents are available in Spanish and Hmong, through links on the SYBH website.
- The Quality Assurance (QA) staff and program have buy-in and positive regard from both internal and external staff.
- The MHP's claim review processes are effective and have resulted in a low Medi-Cal denial rate, at 1.21 percent, which can contribute to stable cash flow for the MHP.

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

- Timeliness to services is infrequently monitored for the MHP to have a clear picture of the extent of delays and to be able to implement strategies to improve it.
- The links (on the SYBH website) that direct beneficiaries to documentation in Spanish and Hmong are in English, which may make it difficult for those with limited English proficiency who are seeking those very documents.
- The MHP did not track or trend the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5, despite

having a full complement of psychiatric providers and a medical director to oversee this area.

- The MHP's QA program prioritizes compliance, leaving fewer resources for quality improvement (QI).
- There has not been cross-training in the Billing Unit. Although there is only one billing position in the unit, it would be beneficial for others in the Finance/Billing area to be cross-trained to preserve processes and history.

Recommendations for improvement based upon this review include:

- Monitor timeliness on a quarterly basis, with documented evidence of review and analysis of four areas needing improvement.
- Include instructions or graphics on the SYBH website in Spanish and Hmong to direct individuals to documents in those languages.
- Develop a SYBH process for reviewing medication utilization of youth in foster care (FC) with quarterly review by the medical director or another assigned psychiatric provider.
- Review the QAPI and incorporate QI goals that directly benefit beneficiary experience as versus compliance. Develop and provide cross-training in the Finance/Billing unit to ensure preservation of processes and relevant history within the unit.

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 Sutter-Yuba County MHP by BHC, conducted as a virtual review on January 11, 2023.

REVIEW METHODOLOGY

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

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

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age youth (TAY); 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 QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Review and validation of each MHP's network adequacy (NA) as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19). The MHP has been transitioning to providing more in-person services and managing what this requires to ensure safety for beneficiaries and staff. Otherwise, there were no environmental impacts during the review.

SIGNIFICANT CHANGES AND INITIATIVES

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

- SYBH and its contract providers continue to face staff shortages and workforce turnover. In an effort to retain and recruit staff, the MHP:
    - Is developing an internship program with Sacramento State University, through contract provider, Youth For Change.
    - Has increased salaries and has negotiated additional increases over the next four years.
    - Offers flexible work schedules and remote or hybrid work.
    - Is developing a process for peer staff to provide billable services.
- While the MHP continues to endeavor to meet new service demands, rebuild its capacity, and resume in-person services, aging facilities and space limitations of county buildings have become more apparent.
- Implementing California Advancing and Innovating Medi-Cal (CalAIM) has demanded more of the MHP and especially from staff who facilitate access to services and QA staff who disseminate and apply regulations.
- The MHP has invested in a few mobile programs that bring services directly to beneficiaries who (may) face challenges in accessing services themselves. The MHP launched iCare, for individuals who are frequent utilizers of acute services and infrequent users of outpatient services and the Mobile Access Hub that provides services to students in crisis. The MHP is developing the Crisis Care Mobile Unit that will behavioral health crisis services to youth and adults aged 24 years and younger.
- The MHP is preparing to implement a new Electronic Health Record (EHR) system with a go-live date of April 1, 2023.

- The Board of Supervisors (of Sutter County) prioritizes services for individuals experiencing homelessness, accordingly the Health and Human Services agency and the MHP has expanded the number of positions for programs that serve the homeless.

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: Conduct two PIPs and submit them for review, as federally required. (This recommendation is a carry-over from FY 2020-21.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP submitted two projects to be considered for the non-clinical PIP. One project was the Behavioral Health Quality Improvement Program (BHQIP) FUM and the other was a project to improve communication with families regarding hospital transfers. As the former had more data and clearer objectives, it was selected and validated as the non-clinical PIP.
- The MHP's clinical and non-clinical PIPs are both in the planning, if not conceptual, phases. They were only recently started. SYBH reports staff turnover in QA and delayed start on its projects.
- In addition to limited staff to guide PIPs and other quality projects, the MHP does not appear to give itself sufficient time to collect preliminary data, plan and implement a project, and analyze data, in time for its next EQR.

Recommendation 2: Complete the development of key dashboards, especially those related to timeliness reporting.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP did make some progress on this issue, conducting fact-finding meetings with Medical Records, identifying gaps in current processes and

consulting with Kings View Professional Services (Kings View), its Application Service Provider (ASP).

- In October 2022, the MHP onboarded new QA staff, one of whom will be responsible for timeliness tracking. It is anticipated that this staff member will move the project forward.
- This recommendation will be continued for next year.

Recommendation 3: Consult with Kings View to gain a better understanding of data elements available to complete the dashboard report and begin implementing strategies to better support analysis and decision making.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Two senior analysts left their positions making moving forward on this item impractical. New staff have been hired but require training and familiarity with the data and processes at the MHP.
- The MHP did not approach Kings View on this issue.
- This recommendation will not be continued as the MHP is implementing a new EHR and will not be working on this item.

Recommendation 4: Review the QI programs and QAPI work plans of other MHPs (as suggested by CalEQRO) and begin to make appreciable changes to the QI program (e.g., increase stakeholder participation and accountability at QI Council meetings; establish regular frequency of review of timeliness and other performance measures; develop a work plan with measurable goals; conduct a full evaluation of the preceding year's QI plan; etc.). (This recommendation is a carry-over from FY 2019-20 and FY 2020-21.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has made some changes to its QA program including a revision of its QAPI workplan (adding more measurable goals); increased the frequency of QI committee (QIC) meetings; and completed an evaluation of the preceding year's QI efforts.
- There are other areas that still need attention, including stakeholder engagement, especially of contract providers; increased or comparable focus on quality monitoring as compliance monitoring; and more substantive evaluation of indicators of access, timeliness, and quality of its services.
- The QA program lacks depth to evaluate its programs and affect change. It is unclear if this is a staffing or training issue.

Recommendation 5: Monitor and document the review of the indicators from California Child Welfare Indicators Project and the EPSDT Performance Outcome System, regarding medication utilization of youth in FC. (This recommendation is a carry-over from FY 2019-20 and FY 2020-21.)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP has not made progress in monitoring and documenting review of medication utilization of youth in FC for itself. The MHP continues to rely on the individual/case-by-case review that is conducted by the public health nurse and monitoring that psychiatric providers are meant to do.
- The MHP reports that it does not have the capability to automatically track this through its EHR or other electronic system. It would need to be done manually, to which the MHP has not allocated resources.

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 and contracted providers in the MHP. Regardless of payment source, approximately 72 percent of services were delivered by county-operated/staffed clinics and sites, and 28 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 87.94 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: open access clinics, Sutter County Probation, crisis services, and schools. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries are assessed at the open access clinics and then referred to programs/services operated by the MHP or referred externally to managed care plan 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 282 adult beneficiaries, 457 youth beneficiaries, and 17 older adult beneficiaries across 9 county-operated sites and 8 contractor-operated sites, which is an increase from available sites in the prior year. Among those served, 25 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

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

For Sutter-Yuba 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	Partially Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- Despite challenges that the MHP faces with staffing, SYBH and its contract providers present a united front, which enables coordination of services. The multi-disciplinary teams and meetings were reported as a means by which this coordination takes place.
- The MHP has a full complement of psychiatric providers, all but one holds a permanent position within the MHP.
- The MHP is challenged in providing the services and numbers of practitioners and providers necessary to meet the beneficiary needs. Stakeholders reported an insufficient number of clinicians to provide therapy and waitlists for this service, in excess of eight months. Purportedly, even the interim group (e.g., Early Explorers) to facilitate earlier access has a protracted wait.
- Cultural Competence Committee meeting minutes referenced the need to build the committee infrastructure and have two co-chairs, a QA staff analyst and another MHP staff member. This approach shares responsibility and can facilitate continuity of meetings, activities, and projects, if one co-chair is not available. This program structure is needed throughout the MHP and especially in QA program.

ACCESS PERFORMANCE MEASURES

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

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served

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

The statewide PR is 3.85 percent, with an AACB of $6,496. Using PR as an indicator of access for the MHP, at 3.80 percent, the MHP's PR is close to the statewide PR. The MHP's PR has decreased each year for the last two CY.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	79,919	3,038	3.80%	$16,198,886	$5,332
CY 2020	75,136	3,325	4.43%	$17,767,203	$5,344
CY 2019	73,653	3,628	4.93%	$20,301,809	$5,596

- Although total eligibles have increased over the past three years, beneficiaries served and the overall penetration rate have been trending downward.

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	9,409	40	0.43%	1.03%	1.59%
Ages 6-17	19,927	783	3.93%	5.00%	5.20%
Ages 18-20	4,152	157	3.78%	4.29%	4.02%
Ages 21-64	39,334	1,884	4.79%	4.15%	4.07%
Ages 65+	7,100	174	2.45%	2.09%	1.77%
Total	79,919	3,038	3.80%	3.83%	3.85%

- PRs for the 21-64 and 65+ age groups are higher than the similar size MHPs and the statewide PR.
- PR rates for beneficiaries aged 0-20 are lower than the similar size MHPs and the statewide PRs.
- The MHP PR is closely aligned with that of similar size MHPs and the statewide average, albeit slightly lower than them.

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	194	6.66%
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	20,687	698	3.37%	$2,468,111	$3,536
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 for Medi-Cal under the ACA, the overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The ACA PR is in line with that of small MHPs and the statewide PR, while the AACB is approximately $2,000 below that of small MHPs and statewide amounts.

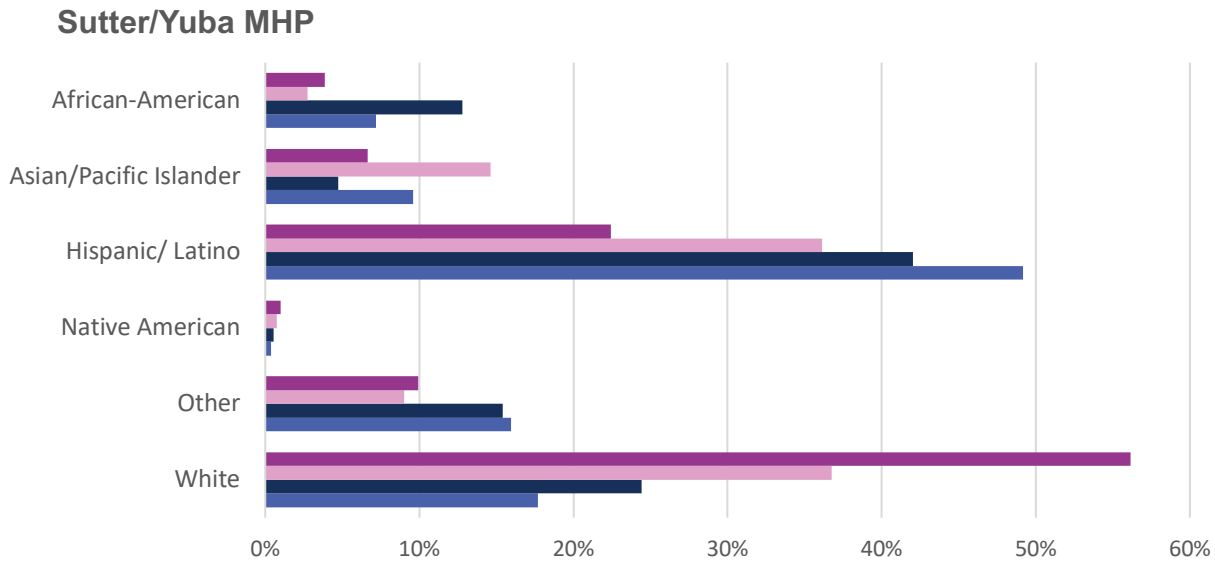
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	2,204	117	5.31%	6.83%
Asian/Pacific Islander	11,690	202	1.73%	1.90%
Hispanic/Latino	28,871	681	2.36%	3.29%
Native American	588	30	5.10%	5.58%
Other	7,188	302	4.20%	3.72%
White	29,380	1,706	5.81%	5.32%
Total	**79,921**	**3,038**	**3.80%**	**3.85%**

- The MHP's PRs for African-American, Asian/Pacific Islander (API), Hispanic/Latino, and Native American populations are lower than the statewide PR.
- Among all the race/ethnic groups, the PR for API is the lowest for both the MHP and statewide.
- The PRs for Other and White beneficiaries are higher than the statewide PR.

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

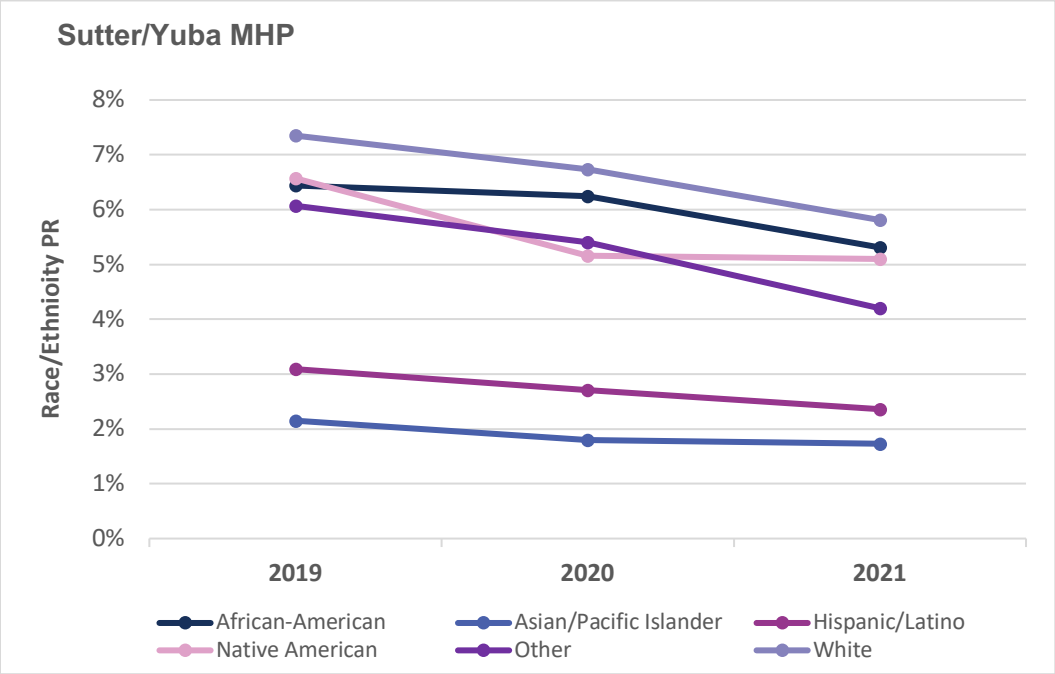


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	56%	10%	1%	22%	7%	4%
MHP % Eligibles	37%	9%	1%	36%	15%	3%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- The largest race/ethnicity served by the MHP is White, followed by Hispanic/Latino. Although the Hispanic/Latino population is 22 percent of the population served, they represent 36.12 percent of the eligible population. While Hispanic/Latino beneficiaries are underrepresented, White beneficiaries tend to be overrepresented.
- The White population served by the MHP is notably higher than the statewide percentage. Some of this variance may be due to the White population being a higher proportion of Eligibles than is seen statewide.

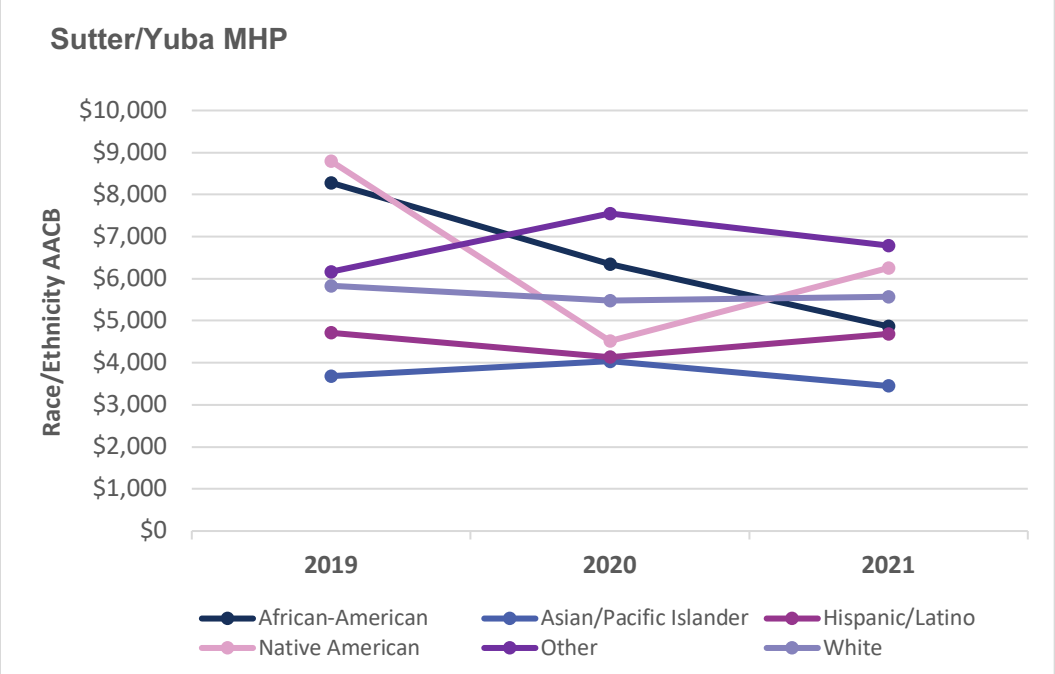
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino and API), and the FC population. For each of these measures, the MHP's data are compared to the similar sized MHPs and the statewide for a three-year trend.

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



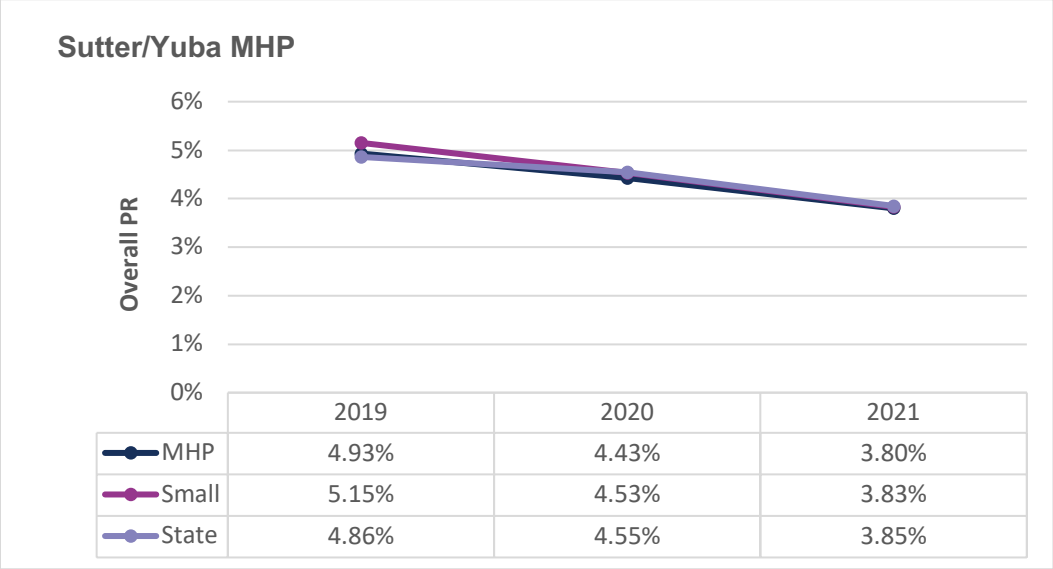
- All the PRs are trending downward since 2020.
- The PRs for both API and Hispanic/Latino have been consistently the lowest over time.

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



- The AACB for White beneficiaries has been steady across the three years.
- There has been a sharp decline in the AACB of Native Americans from 2019 to 2020 and an increase from 2020 to 2021.
- African-Americans are the only population whose AACB has steadily decreased over the past three years.
- Hispanic/Latino AACBs show a decrease from 2019 to 2020, with an increase from 2020 to 2021.
- Other shows a fair increase from 2019 to 2020 and a slight decrease in 2021.

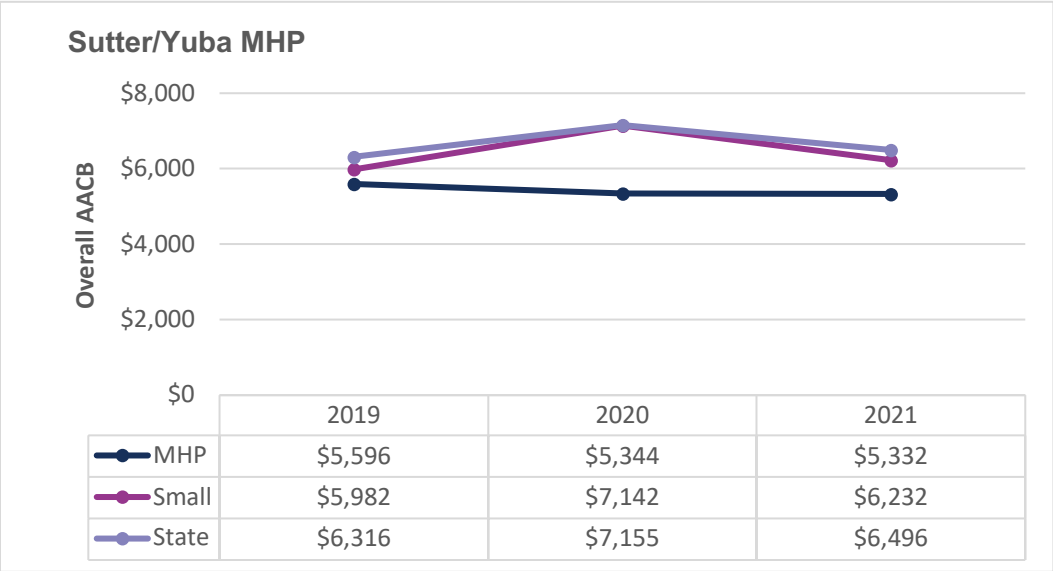
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.93%	4.43%	3.80%
Small	5.15%	4.53%	3.83%
State	4.86%	4.55%	3.85%

- Figure 4 shows that the PRs of the MHP, Small Counties, and the State have been closely aligned for the last three years and are all trending downward.

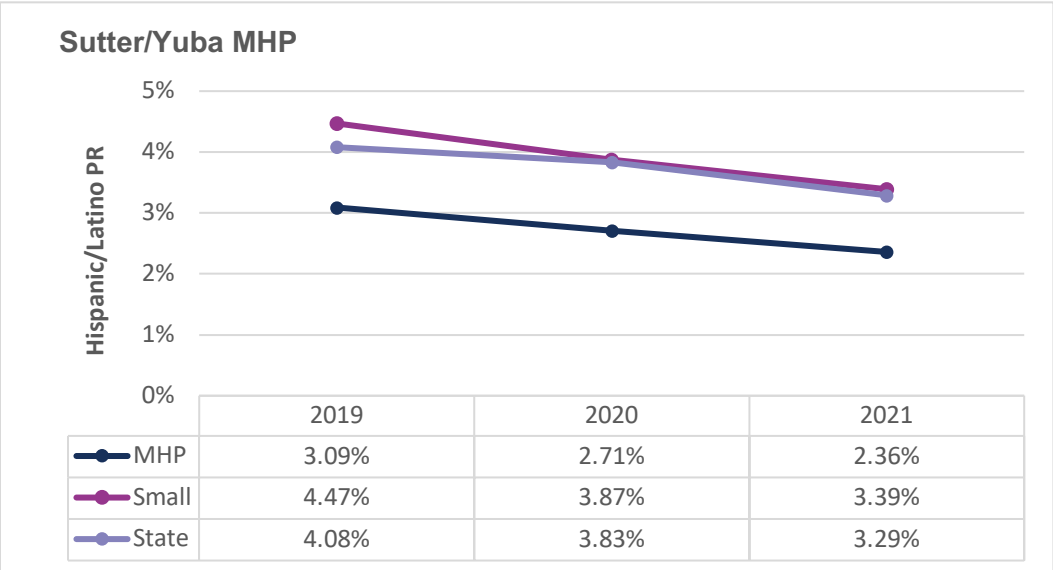
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$5,596	$5,344	$5,332
Small	$5,982	$7,142	$6,232
State	$6,316	$7,155	$6,496

- Overall, the AACB of the MHP has been consistently lower than that of other small MHPs and statewide totals.

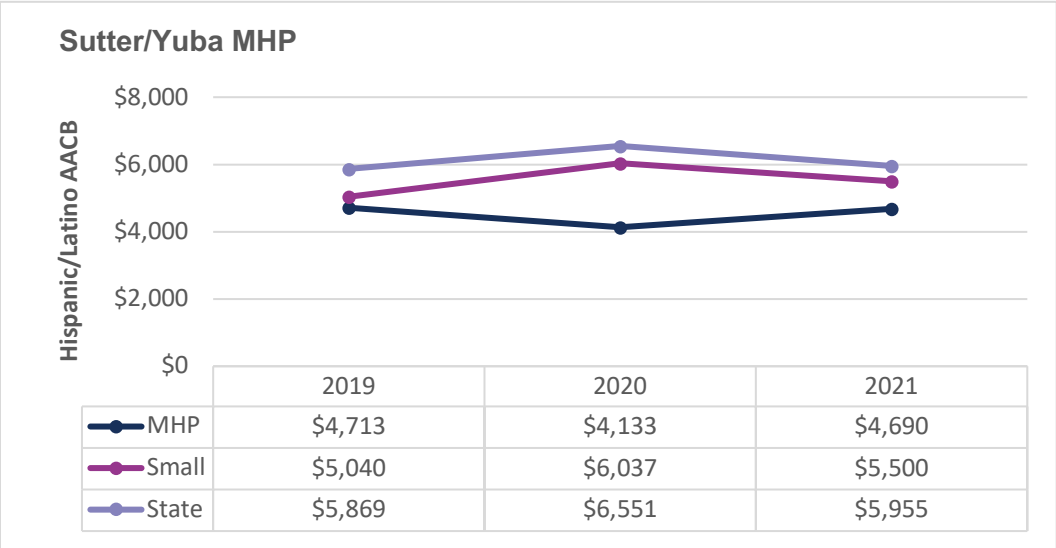
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	3.09%	2.71%	2.36%
Small	4.47%	3.87%	3.39%
State	4.08%	3.83%	3.29%

- Figure 6 shows that the Hispanic/Latino PR has decreased for all sectors over the last three years.
- The MHP's PR has consistently been lower than the small MHPs and statewide totals.

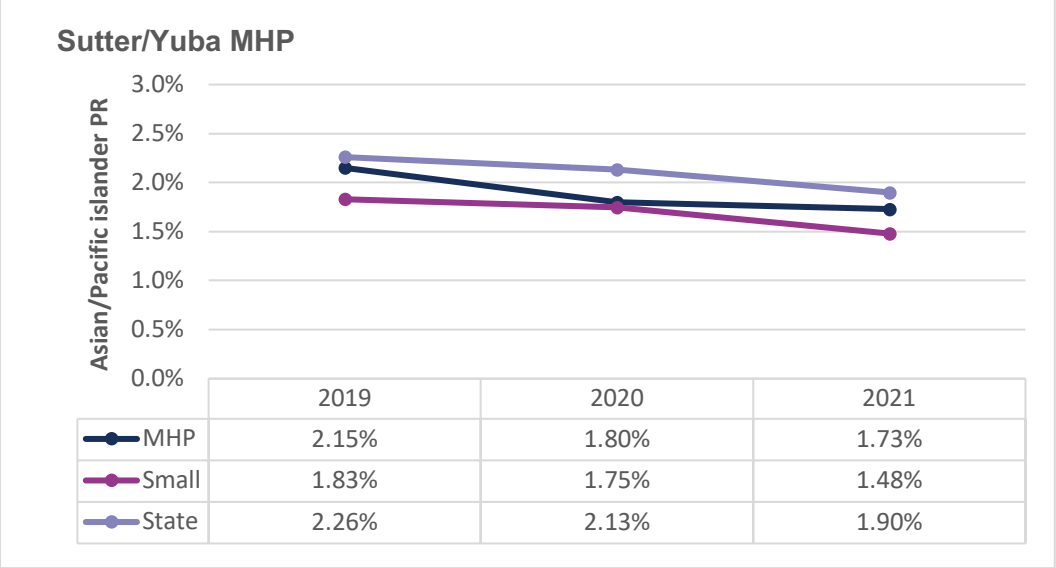
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,713	$4,133	$4,690
Small	$5,040	$6,037	$5,500
State	$5,869	$6,551	$5,955

- The MHP's Hispanic/Latino AACB has been lower than the small MHPs and State totals across the three years. This AACB is trending upward and was closer to that of others in 2021.

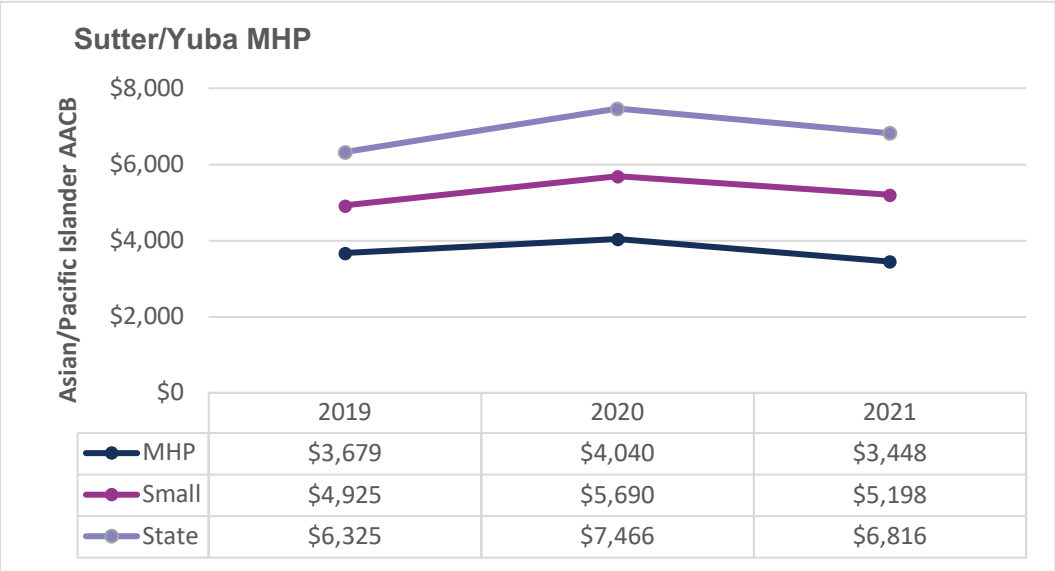
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.15%	1.80%	1.73%
Small	1.83%	1.75%	1.48%
State	2.26%	2.13%	1.90%

- The API PR has trended downward over the three years represented here. In 2021, the MHP's total was greater than the small counties total, and slightly lower than the statewide total.

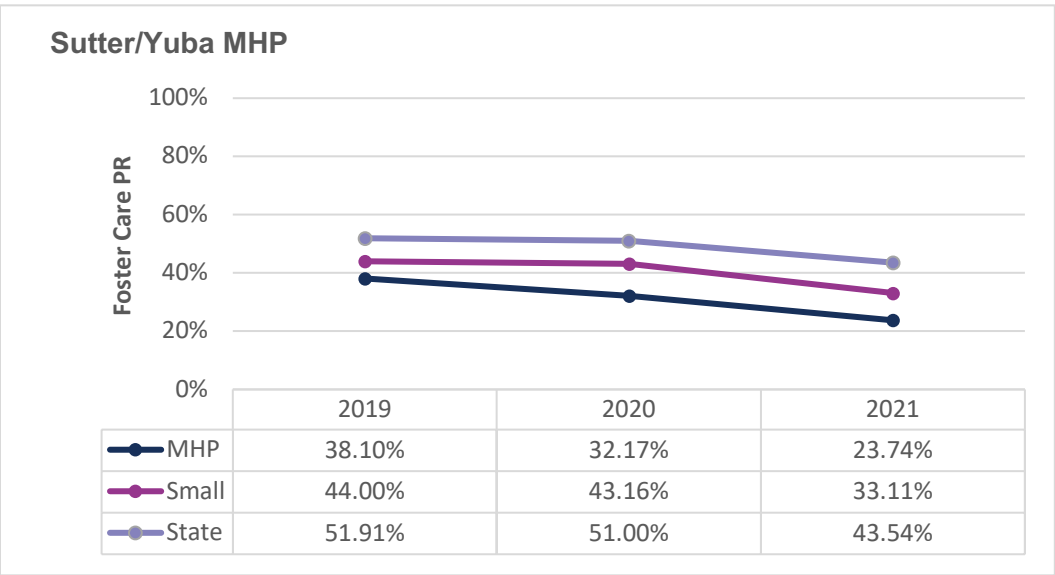
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$3,679	$4,040	$3,448
Small	$4,925	$5,690	$5,198
State	$6,325	$7,466	$6,816

- The API AACB has trended downward from 2020 to 2021 with reduction of 14.6 percent at the MHP, 8.6 percent for small MHPs and 8.7 percent for the State.

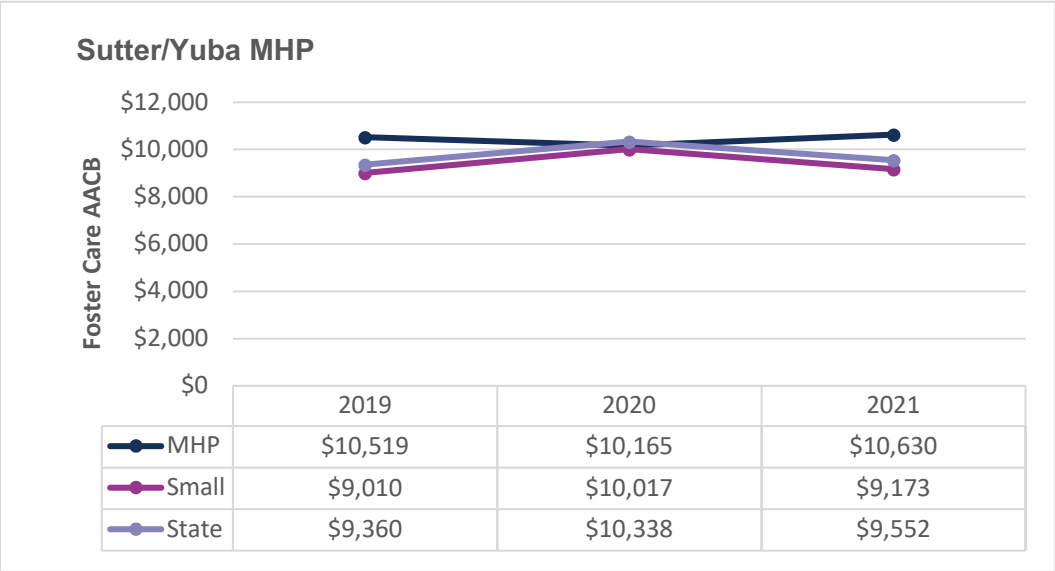
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	38.10%	32.17%	23.74%
Small	44.00%	43.16%	33.11%
State	51.91%	51.00%	43.54%

- The FC PR reflects a downward trend in all sectors for the three years represented here, with the MHP consistently having the lowest PR.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$10,519	$10,165	$10,630
Small	$9,010	$10,017	$9,173
State	$9,360	$10,338	$9,552

- The AACBs for youth in FC across the state are in close alignment, particularly in CY 2020 when the largest variance was $321.00.
- For 2021, the MHP had a higher AACB for FC than other similar sized MHPs and the State.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 2,215				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	38	1.7%	7	6	10.8%	14	8
Inpatient Admin	<11	-	5	5	0.4%	16	7
Psychiatric Health Facility	171	7.7%	15	6	1.0%	16	8
Residential	<11	-	58	75	0.3%	93	73
Crisis Residential	<11	-	7	7	1.9%	20	14
Per Minute Services							
Crisis Stabilization	25	1.1%	1,530	1,200	9.7%	1,463	1,200
Crisis Intervention	515	23.3%	205	137	11.1%	240	150
Medication Support	1,362	61.5%	210	131	60.4%	255	165
Mental Health Services	1,274	57.5%	207	83	62.9%	763	334
Targeted Case Management	210	9.5%	279	124	35.7%	377	128

- The largest proportion of services received by beneficiaries in the MHP were Medication Support (61.5 percent) and Mental Health Services (57.5 percent).
- The MHP has a higher percent of Crisis Intervention than the statewide total and this service was provided to 23.3 percent of beneficiaries, while the statewide percent of beneficiaries served is 11.1 percent.
- For Mental Health Services, the MHP's average units (at 207 minutes) are notably lower than the State average of 763 minutes. Additionally, the MHP median units (at 83 minutes) are also notably lower than the State median of 334 minutes.
- Targeted Case Management was provided by the MHP at a lower rate (9.5 percent) than statewide (35.7 percent).

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

Service Category	MHP N = 85				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	-	16	10	4.5%	13	8
Inpatient Admin	0	0.0%	0	0	n ≤11	6	4
Psychiatric Health Facility	<11	-	28	28	0.2%	25	9
Residential	0	0.0%	0	0	n ≤11	140	140
Crisis Residential	0	0.0%	0	0	0.1%	16	12
Full Day Intensive	<11	-	600	600	0.2%	452	360
Full Day Rehab	0	0.0%	0	0	0.4%	451	540
Per Minute Services							
Crisis Stabilization	<11	-	1,488	1,200	2.3%	1,354	1,200
Crisis Intervention	13	15.3%	356	276	6.7%	388	195
Medication Support	44	51.8%	248	173	28.5%	338	232
Therapeutic Behavioral Services	<11	-	4,772	5,773	3.8%	3,648	2,095
Therapeutic FC	0	0.0%	0	0	0.1%	1,056	585
Intensive Care Coordination (ICC)	47	55.3%	467	308	38.6%	1,193	445
Intensive Home-Based Services (IHBS)	<11	-	1,313	1,021	19.9%	1,996	1,146
Katie-A-Like	0	0.0%	0	0	0.2%	837	435
Mental Health Services	78	91.8%	1,698	1,025	95.7%	1,583	987
Targeted Case Management	54	63.5%	239	180	32.7%	308	114

- The MHP has higher utilization of per minute services in the Crisis Intervention, Medication Support, ICC, and Targeted Case Management categories than statewide.

IMPACT OF ACCESS FINDINGS

- The number of beneficiaries served in the last three years has decreased, while the number of Medi-Cal beneficiaries has increased, causing a decrease in the PR for CY 2021. However, this decrease mirrors a statewide decrease in PR.
- The MHP has implemented CalAIM documentation, No Wrong Door, and other changes. These changes have resulted in beneficiaries being able to begin services sooner, as they do not have to wait for a completed treatment plan. No Wrong Door has resulted in an increase in the number of individuals qualifying for services, but without any increase in clinical staff.
- Overall, the MHP provided lower average and median units of service, which is consistent with fewer staff to provide services over the past two years.
- Conversely, the MHP tends to provide more services to youth in FC than what is seen statewide. While the higher utilization of services like IHBS and targeted case management may be warranted, greater use of crisis and medications should be examined.
- The MHP continues to have a low Hispanic/Latino penetration rate. The MHP has a Hispanic/Latino Outreach Center that specifically service Hispanic/Latino beneficiaries and provides a variety of services. A challenge for the MHP is that the two therapists who provide services are also the staff who must conduct outreach to the community. At the time of the review, the MHP indicated that they were hesitant to allow any additional beneficiaries into the program, as the therapists' caseloads were full, which reflects overall limitations in the MHP's capacity.

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	Not Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Partially Met
2E	Psychiatric Readmission Rates	Partially Met
2F	No-Shows/Cancellations	Met

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

- The open access clinic is a strength for the MHP; it facilitates timely first offered and first delivered service to adults.

- Conversely, the MHP is not able to offer and provide the same level of timely services to youth, including those in FC. The MHP's self-reported time to first offered and delivered service within 10 days was 61.47 percent and 32.97 percent, respectively.
- Timeliness to services is infrequently monitored for the MHP to have a clear picture of the extent of the delays and challenges with timeliness. Additionally, a twice-annual review is insufficient monitoring for a process that is prone to errors and delays.
- Stakeholders reported delays in subsequent services, especially for TAY, some of whom aged out of the services while waiting for availability.
- The MHP does not track urgent appointments and did not provide data on time to urgent appointments.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented county-operated services.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	4 Days	10 Business Days*	83.56%
First Non-Urgent Service Rendered	9 Days	10 Business Days**	68.76%
First Non-Urgent Psychiatry Appointment Offered	11 Days	15 Business Days*	67.44%
First Non-Urgent Psychiatry Service Rendered	13.78 Days	15**	70.73%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	***	48 Hours*	***
Follow-Up Appointments after Psychiatric Hospitalization	7 Days	7 days**	32.29%
No-Show Rate – Psychiatry	18.13%	15%**	n/a
No-Show Rate – Clinicians	8.82%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22.			

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

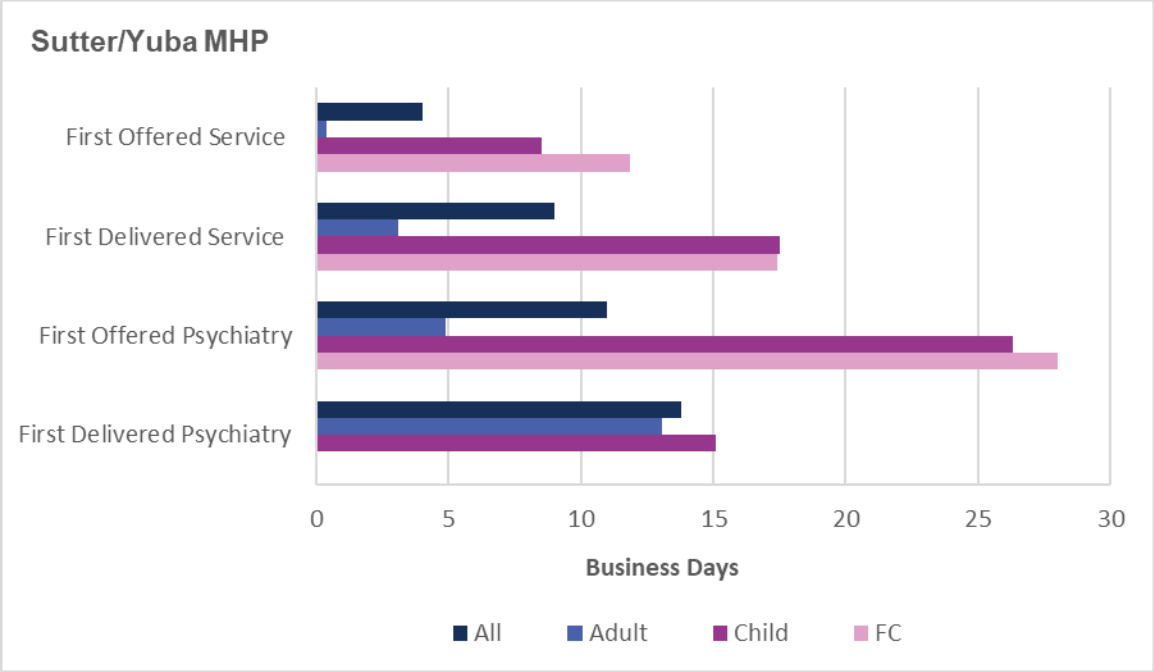


Figure 13: Wait Times for Urgent Services

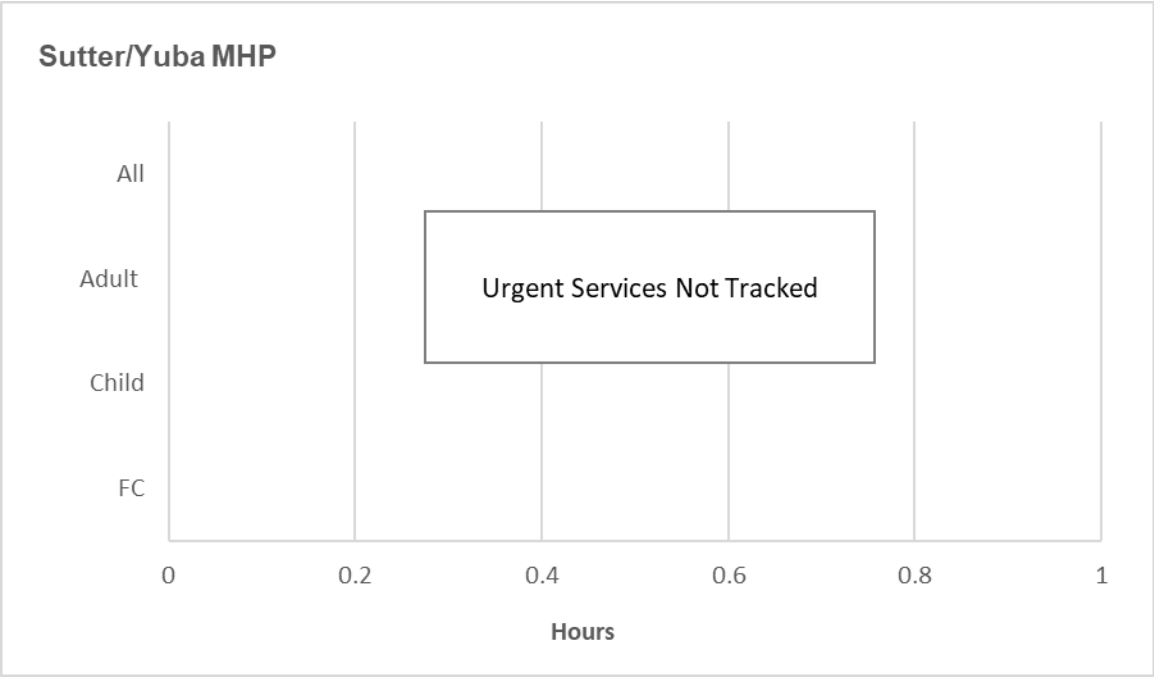
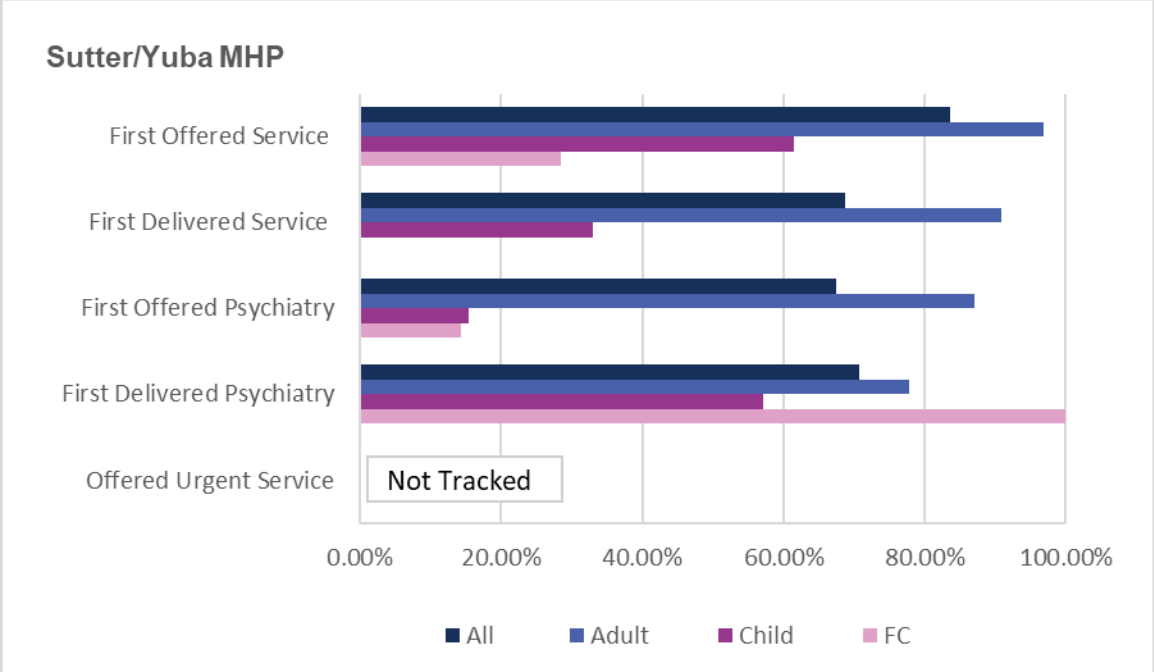


Figure 14: Percent of Services that Met Timeliness Standards



- 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 unscheduled assessments and other first appointments provided.

- 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 ED, or a referral to a Crisis Stabilization Unit. The MHP did not define “urgent services” and did not provide any data on its delivery of urgent services. The MHP has not set up a system to track urgent services.
- 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 beneficiaries’ initial service request.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked for all appointments that a beneficiary does not attend or cancel prior to appointment. The MHP reports no-show rates for psychiatry and non-psychiatry clinical staff, disaggregated by system of care.
- While the MHP provides the majority of first service and psychiatry appointments, contract providers also provide these services to some beneficiaries but the MHP’s tracking only included county-operated services for these two measures.

IMPACT OF TIMELINESS FINDINGS

- Key informants in the MHP confirm significant delays for initiating services, with some individuals aging out of the programs for which they are waiting to enter (e.g., birth to 5 and TAY programs)
- Through Kings View, the MHP produces some reports on timeliness to services. Ongoing collaboration with Kings View is encouraged to ensure that reports meet the MHP’s current and upcoming needs (i.e., can trend, identify changes, track beyond first appointments).
- Several of the MHP’s self-reported timeliness measures show areas needing improvement (e.g., adult psychiatry no-shows and first rendered service for children and youth in FC) and would make for viable and timely PIPs.
- The MHP reported the ability to stratify timeliness reports by race/ethnicity and preferred language. The MHP should consider an analysis of timeliness to services for Hispanic/Latino beneficiaries, to determine if/how current capacity may affect this population.
- The MHP is directed to consult with DHCS and refer to the ATA form instructions for how to define urgent services.

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 QIC that is composed of SYBH leadership, managers, and analyst staff. There is a QA Officer who manages and coordinates QI activities. The QA Officer also oversees compliance for the MHP and SYBH. Overall, there is an emphasis on compliance, termed 'quality monitoring,' more so than QI.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC is meant to be comprised of directors, program managers, practitioners and providers, beneficiaries, family members, and other stakeholders; however, the membership lists only included SYBH directors, program managers, and QA staff. As of the past five months, the QIC is scheduled to meet monthly. Previously, the committee met every other month. Since the prior EQR, the MHP QIC met seven out of eight possible times. The MHP had 21 objectives identified in the FY 2021-22 QAPI workplan. As the QIC is implementing a new strategy for its QAPI, it is updating its goals and objectives and determining which to continue, revise, or monitor differently.

The MHP utilizes the following level of care (LOC) tools: Level Of Care Utilization System (LOCUS) and Milestones of Recovery Scale (MORS) for adults and the Child and Adolescent LOCUS (CALOCUS) and Child and Adolescent Needs and Strength (CANS) assessment for youth. For TAY, the MHP utilizes the CALOCUS and MORS.

The MHP utilizes the following outcomes tools: MORS, CANS, and the Pediatric Symptom Checklist-35 as outcome tools.

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	Partially Met
3B	Data is Used to Inform Management and Guide Decisions	Not Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	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	Not 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:

- The MHP has a dedicated individual and a clear process for coordinating post-hospitalization services for its beneficiaries. This coordination enables consistent post-hospitalization follow-up at or above the statewide rate.
- To their credit, the QA staff and program have buy-in and positive regard from both internal and external staff. The QA unit was viewed as responsive and informative. The MHP has something that it can leverage to engage those stakeholders and make them more accountable for QI of MHP services.
- The MHP's QA program prioritizes compliance—interpreting regulations, applying mandates, and developing corresponding policy. While compliance is important, it is not a substitute for quality of services that relates to the beneficiary experience.
- The MHP is dependent on Kings View to provide data and reports. As such, key staff do not have a full understanding of the specific data that may be needed for monitoring and effective evaluation.
- The MHP does not track or trend 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).
- Given that there are only a few youth in FC who are prescribed psychotropic medications (and that the MHP has a full complement of psychiatric providers and a medical director) not monitoring this area of care is an oversight.
- The MHP has a Work Wellness program that includes six weeks training on resume-writing and other job readiness skills and concludes with a job placement.

QUALITY PERFORMANCE MEASURES

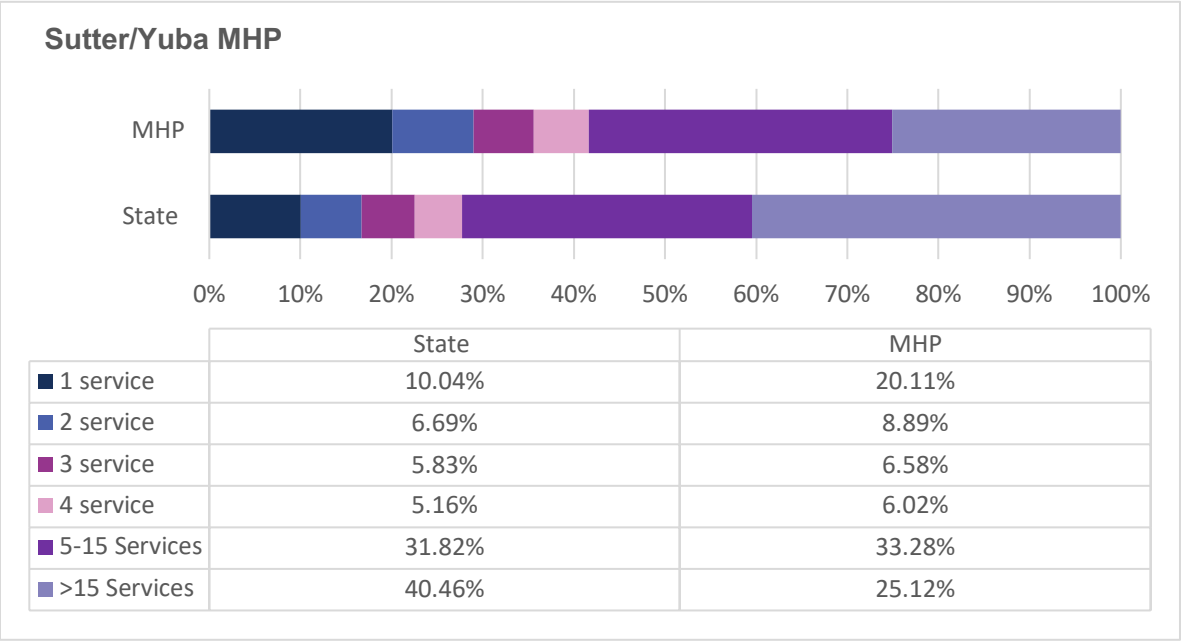
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries served by the MHP to require five 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



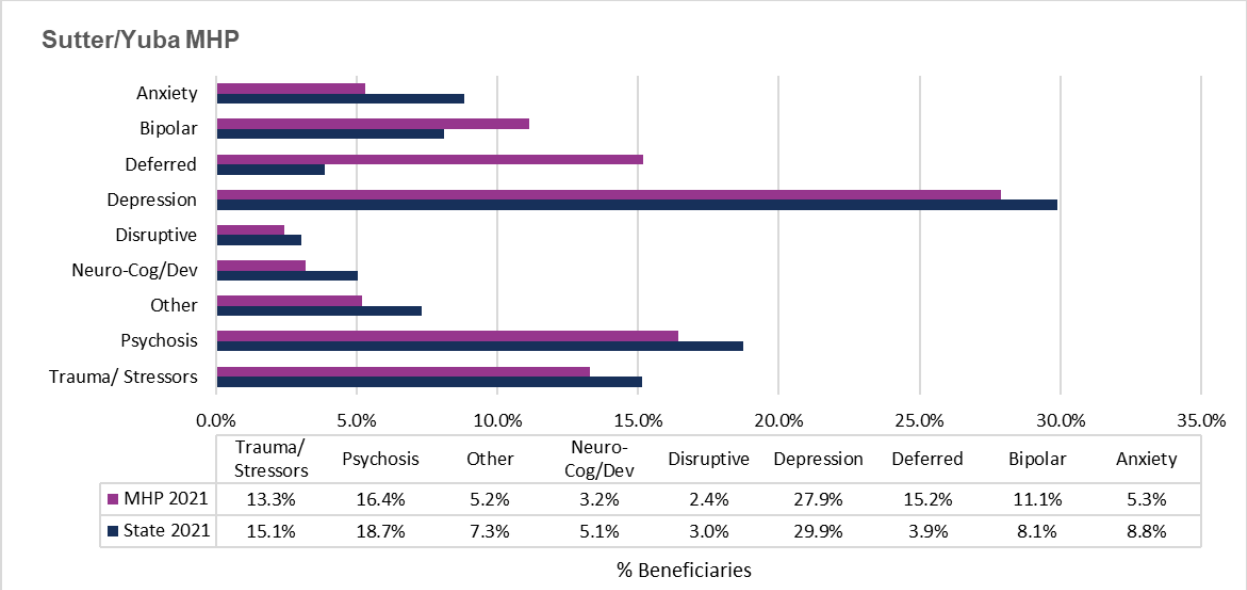
	State	MHP
1 service	10.04%	20.11%
2 service	6.69%	8.89%
3 service	5.83%	6.58%
4 service	5.16%	6.02%
5-15 Services	31.82%	33.28%
>15 Services	40.46%	25.12%

- The MHP's one-service percentage is double that of the State. This is due to the MHP's open access policy of screening all beneficiaries who present for services. Many of those who are screened may be referred to an MCO or other providers.
- The MHP has a higher percent of beneficiaries with 5-15 services, at 33.28 percent, than the State (31.82). The MHP's 15-services, at 25.12 percent, is 37.91 percent lower than the state total of 40.46 percent.
- There are 58.40 percent of beneficiaries at the MHP with five or more services.

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.

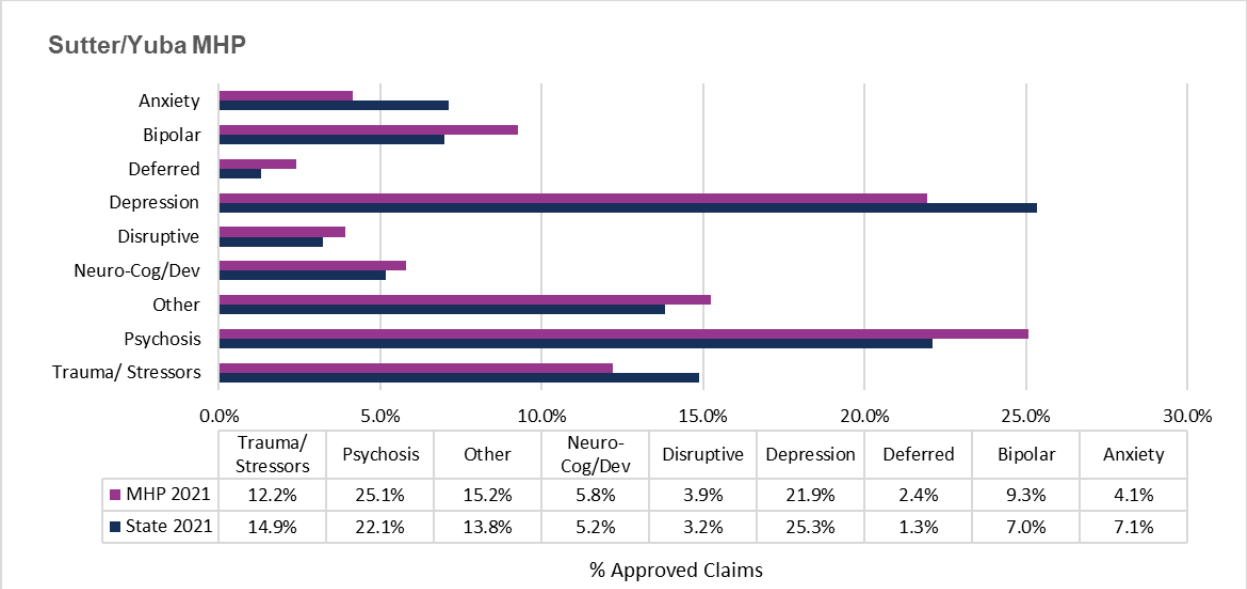
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	13.3%	16.4%	5.2%	3.2%	2.4%	27.9%	15.2%	11.1%	5.3%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- Depression, Psychosis and Deferred are the top three diagnosis at the MHP for pre-claim services compared to the top three for the State, which are Depression, Psychosis, and Trauma/Stressors.
- Diagnostic categories for the MHP and State are mostly aligned, with a two-to-three-point variance, with the exception of Deferred diagnosis, with the State showing 3.9 percent and the MHP with 15.2 percent. MHP staff enter initial diagnoses as 'Deferred' until full assessments are completed.

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	12.2%	25.1%	15.2%	5.8%	3.9%	21.9%	2.4%	9.3%	4.1%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- Psychosis, Depression, and Other are the top three diagnoses for the MHP on approved claims. Their percentages are closely aligned with State percentages.

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	325	640	11.05	8.79	$16,223	$12,052	$5,272,332
CY 2020	330	660	11.45	8.68	$17,000	$11,814	$5,610,125
CY 2019	376	693	10.97	7.8	$15,756	$10,535	$5,924,296

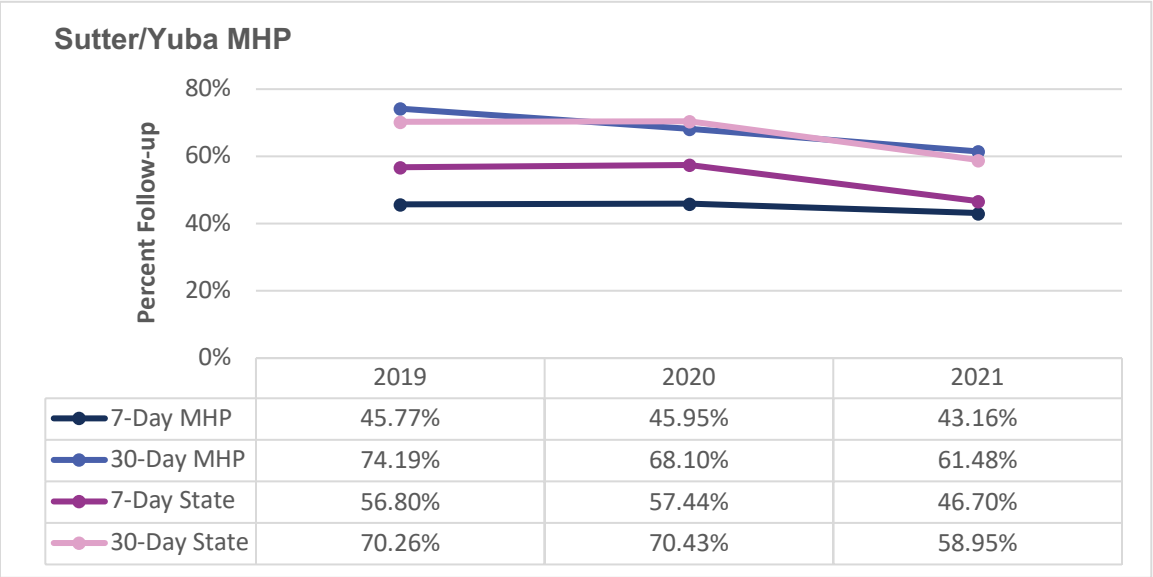
- While the unique beneficiary count, total Medi-Cal admissions, and average LOS decreased in 2021, the average LOS and AACB remain above the statewide totals.

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 is reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis.

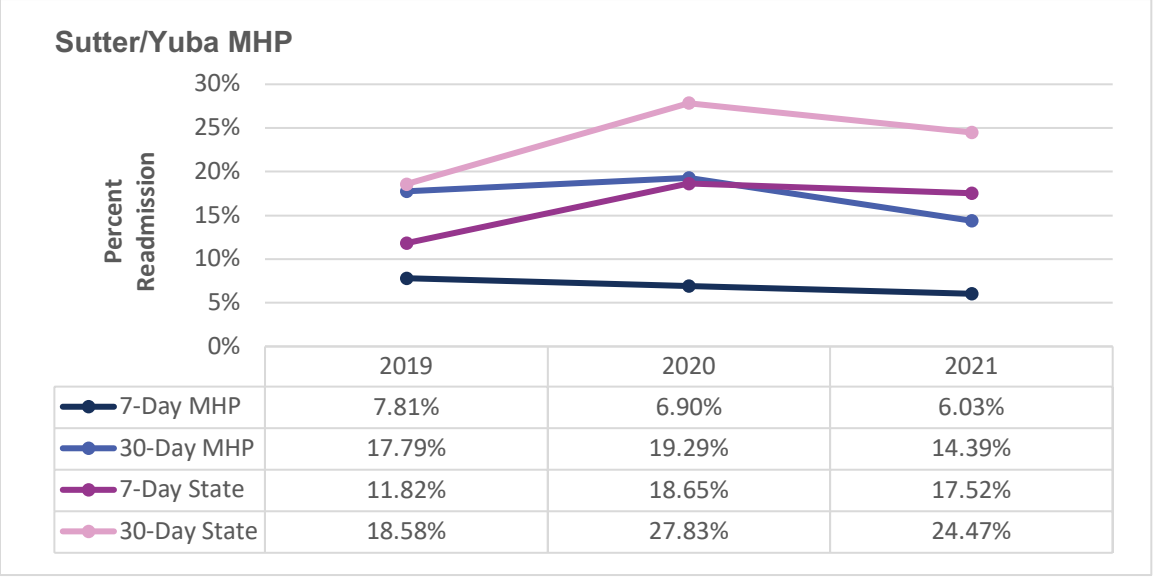
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	45.77%	45.95%	43.16%
30-Day MHP	74.19%	68.10%	61.48%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

- The MHP's 7-day follow-up rates are lower than the State totals, indicating that that the MHP is providing follow-up at a lower rate than statewide.
- For 30-day follow-up, the MHP's rates are closer to and, at times, exceed the State averages.
- There is a downward trend in the MHPs 30-day inpatient follow-up totals.

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



	2019	2020	2021
7-Day MHP	7.81%	6.90%	6.03%
30-Day MHP	17.79%	19.29%	14.39%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The MHP's 7-day readmission rates reflect a downward trend over the past three years.

- 7- and 30-day readmission rates for the MHP are lower than that State rate.
- The MHP employees a Resource Specialist who is responsible for tracking all hospital discharges. This individual makes follow-up appointments for all those being discharged. If the beneficiary is currently open to MHP services, the follow-up appointment is with a psychiatrist. If the beneficiary is new, an appointment for assessment is scheduled at access.

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 amount is just $2,928.

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

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	3.46%	28.46%	$1,007,853,748	$53,476	$43,231
MHP	CY 2021	83	2.73%	30.29%	$4,907,362	$59,125	$43,448
	CY 2020	90	2.71%	29.49%	$5,240,263	$58,225	$46,163
	CY 2019	118	3.25%	30.02%	$6,095,549	$51,657	$43,274

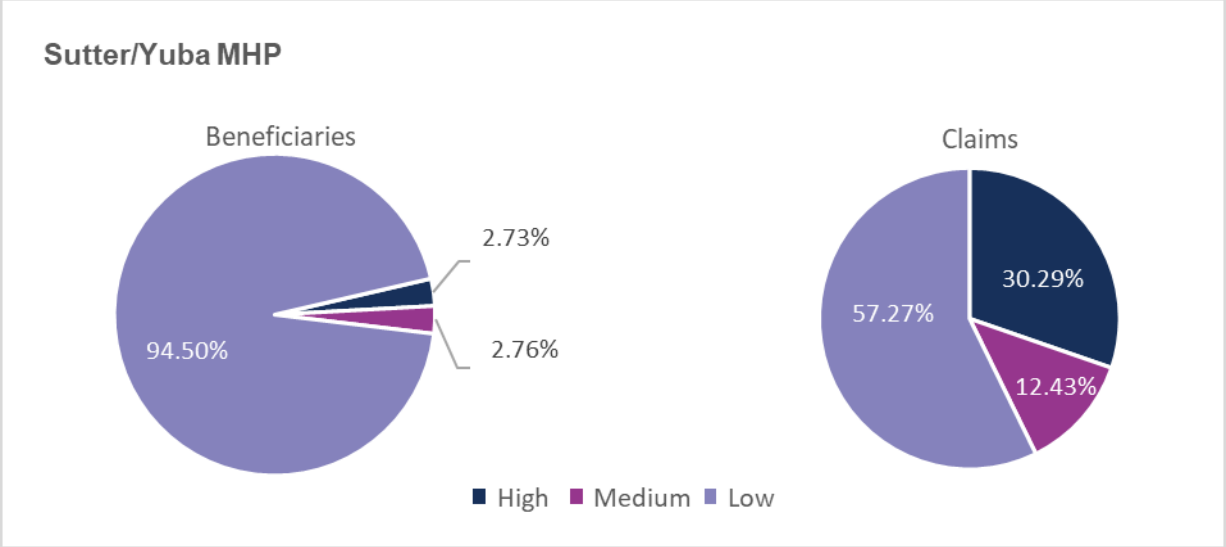
- The percent of HCBs in the MHP is lower than the statewide total, while the percent of HCB claims is higher than the statewide total.
- While the HCBs are only 2.73 percent of the beneficiaries served, they represent 30.29 percent of claims.

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)	84	2.76%	12.43%	$2,014,064	$23,977	$23,431
Low Cost (Less than $20K)	2,871	94.50%	57.27%	$9,277,460	$3,231	$1,558

- Low-cost beneficiaries account for 94.5 percent of beneficiaries served and represent 57.27 percent of the claims.

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



- Low-cost beneficiaries account for 94.5 percent of beneficiaries served and represent 57.27 percent of the claims, with an average claim of $3,231.

IMPACT OF QUALITY FINDINGS

- The MHP is adept at implementing and meeting QA and compliance. Stakeholders remarked on open communication and being apprised of mandates, changes in practice and policy, and new initiatives (e.g., BHQIP). CalAIM, in particular, has been a focus of the QA program, with much of analysts' time and attention towards meeting regulations, policy changes, documentation reform, and information exchange and EHR updates.

- While the compliance areas are necessary and important, these alone do not give the MHP a measure of the quality of the services delivered to beneficiaries.
- More investment is needed in data review, analysis, and interpretation to align with the beneficiary experience. Areas that reflect well on the beneficiary experience are low rehospitalization rates, assessing many beneficiaries and then referring to appropriate programs, and serving the majority of beneficiaries in low-cost services. However, other areas need improving and it behooves the MHP to use its reports and data to drive decision-making for QI. For example, the new FC report includes the medications that youth are prescribed; this report should be leveraged to track the necessary HEDIS measures related to psychotropic medication utilization.

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: Improving Rates of Post-Psychiatric Hospitalization Follow-up

Date Started: 01/2023

Aim Statement: Will the use of a follow-up program increase the rate of beneficiaries who are receiving follow-up services within 7 days after psychiatric hospitalization by 10 percent over a 12-month period?

Target Population: The team did not provide details on the target population, except that they would have been hospitalized and discharged.

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

Summary

The PIP team reported an MHP 7-day post-hospitalization follow-up rate of 21 percent; per the Medi-Cal Claims (in this report), the MHP's rate was 43.16 percent for 2021 and

[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

45.95 percent for 2020. The team has identified a target improvement of 10 percent. The strategy for improvement is convening a follow-up care team and instituting a protocol; however, the details of these strategies were not provided (e.g., what the team would do and what the protocol would entail). The follow-up care team will focus on communication during the hospital stay, during the discharge process, and immediately after discharge into the community. The team referenced a few evidenced-based and effective models, presumably, around which it will model its transition care.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence. While the team has identified an area needing improvement, it has not investigated thoroughly the potential causes of the problem. There may be beneficiary variables and/or process variables that contribute to reduced follow-up, but the strategy implemented assumes a process issue. The strategy for improvement lacks the detail necessary to ensure consistent implementation.

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

- Providing a baseline and target for improvement, both of which the PIP team did.
- Reducing the timeframe from two years to one year, which the PIP team did.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: FUM

Date Started: 12/2022

Aim Statement: For Medi-Cal beneficiaries with ED visits for mental health conditions, implemented interventions will increase the percentage of follow-up mental health services within 7 and 30 days by 5 percent by June 2023?

Target Population: Beneficiaries who have an ED visit with a primary diagnosis of a mental illness or intentional self-harm.

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

Summary

The MHP presented the BHQIP FUM as its non-clinical PIP. The PIP team reported 66 percent and 74 percent rates for 7-day and 30-day follow-up after ED visit, respectively. The PIP team reported further that both rates were above the national benchmarks but did not explain further the need for improvement. The team's strategies for improvement include safety planning, peer support services, care coordination, and check-ups. The

strategies were not well articulated. (It would be difficult for other or future staff to know how to continue the project). Part of the difficulty the team may have in the specificity of its strategy is that a root cause was not identified; several causes were mentioned from lack of understanding, client disengagement, repetitive and lengthy triage assessments, lack of information sharing between EDs and providers, and others. Accordingly, multiple interventions would be needed to address these varied causes.

Ironically, the PIP team presented that there are disparities in follow-up rates by race and ethnicity; Black/African American and Asian/Pacific Islanders have the lowest rates of both 7- and 30-day ED visit follow-up. This disparity would merit further review and would likely help the PIP team focus on a particular issue and then pinpoint interventions.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence. The project requires more analysis to enable precise interventions that staff would implement. The team indicates a target date of June 2023, but the project does not seem to have begun. The team is not giving itself sufficient time to plan, implement, collect data, and analyze.

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

- Focus on the area that needs obvious improvement.
- Provide details on the strategies.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an ASP where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner Community Behavioral Health, which has been in use for 10 years. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 5 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control. This budget is a 1.40 percent increase over the prior year's budget, which is attributable to the increased costs of implementing a new EHR and maintaining two systems for a period of time.

The MHP has 237 named users with log-on authority to the EHR, including approximately 197 county staff and 40 contractor staff. Support for the users is provided by 3 full-time equivalent (FTE) IS technology positions. Currently all positions are filled.

As of the FY 2022-23 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit beneficiary practice management and service data through direct entry into the EHR.

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	100%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
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, but indicates they plan to implement one within the next year.

Interoperability Support

The MHP is a member or participant in a HIE. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: SacValley Medshare, Mental Health contract providers, and Alcohol and Drug contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP's Medi-Cal claiming is timely, consistent, and accurate. Its denial percent is 1.21 and is below the statewide average of 2.78, pointing to a thorough pre- and post-claiming review process.
- The MHP does not have a data warehouse.
- The MHP does not do any cross-training in the Fiscal/Billing area. While the MHP only has one billing position, it could cross-train others in the business office.
- The crisis phone number on the MHP's home page does not stand out in any way. It would be more noticeable if it were more prominently featured at the top of the page and in a contrasting or easily discernible color.
- There are several links to forms and documents in both Spanish and Hmong on SYBH's website. However, the website is in English, which may make it difficult for those with limited English proficiency to identify the necessary links to access those documents.
- In its current location, under the QI heading, the Provider Directory on the MHP's website is difficult for beneficiaries and/or the public to locate.
- Contract provider key informants indicated that pulling data from the existing EHR is difficult at times and impacts their ability to receive certain reports.

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 November and likely represents $2.5 million in services not yet shown in the approved claims provided. The MHP reports that its claiming is current through CY 2021.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	3,814	$1,249,319	$17,910	1.43%	$1,231,409
Feb	3,771	$1,338,954	$34,934	2.61%	$1,304,020
Mar	4,508	$1,666,856	$11,735	0.70%	$1,655,121
April	3,936	$1,531,714	$13,631	0.89%	$1,518,083
May	3,829	$1,443,474	$14,118	0.98%	$1,429,356
June	3,675	$1,313,111	$6,327	0.48%	$1,306,784
July	3,240	$1,260,738	$2,543	0.20%	$1,258,195
Aug	3,245	$1,330,583	$5,239	0.39%	$1,325,344
Sept	3,504	$1,277,476	$16,172	1.27%	$1,261,304
Oct	3,041	$1,085,893	$37,448	3.45%	$1,048,445
Nov	1,569	$561,655	$9,890	1.76%	$551,765
Dec	0	$0	$0	0.00%	$0
Total	**38,132**	**$14,059,773**	**$169,947**	**1.21%**	**$13,889,826**

- The November claims appear to be incomplete and there should be claims data reported for December.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible or non-covered charges	28	$46,617	27.43%
Medicare Part B or Other Health Coverage must be billed before submission of claim	104	$43,177	25.41%
Claim/service lacks information which is needed for adjudication	39	$30,141	17.74%
Service line is a duplicate and a repeat service procedure code modifier not present	55	$22,859	13.45%
NPI related	44	$20,983	12.35%
Other	17	$6,169	3.63%
Total Denied Claims	**287**	**$169,946**	**100.00%**
Overall Denied Claims Rate	**1.21%**		
Statewide Overall Denied Claims Rate	**2.78%**		

- The MHP's Medi-Cal claim denial rate at 1.21 percent is well below the State average of 2.78 percent, indicating that the MHP has a thorough pre- and post-claim review process.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP has added the new coding requirements to the existing EHR and will be available in the new system when they go live.
- The MHP is in the process of implementing a new EHR, Credible, from the Qualifacts vendor. Currently MHP staff, in conjunction with Kings View are cleaning up the existing EHR and preparing it for export. The implementation team at the MHP meets routinely with Kings View to determine how to best organize the new system.
- There has not been cross-training in the Billing Unit. Although there is only one billing position in the unit, it would be beneficial for others in the Finance/Billing area to be cross-trained to preserve processes and history.
- SYBH has some updates to do to its website to enable access to documentation and to improve visibility of crisis information.
- The MHP has been able to meet all BHQIP deadlines to date and is on track to meet the March 2023 deadlines.

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 administered the CPS in 2022 but had yet to compare the findings to previous survey years. Per the QIC meeting minutes, there was a plan to disseminate the results, but then no further mention of the survey appeared in subsequent minutes. The survey results were not shared because of a vacancy in the QA analysts, which has since been filled.

CONSUMER FAMILY MEMBER FOCUS GROUP(S)

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

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

Consumer Family Member Focus Group One

CalEQRO requested "a diverse group of adult beneficiaries, including Latino and adult TAY beneficiaries, who initiated services in the preceding 12 months". The focus group was held via videoconference and included seven participants. The focus group was conducted in English. All consumers participating receive clinical services from the MHP.

Focus group participants noted the return to (more) in-person services, which they all appreciated. The participants added that telehealth was still an option. The frequency of appointments was anywhere between two to six weeks, and the consensus was that more frequent appointments were wanted. The TAY participant waited one month before starting the TAY program. Most of the participants had been to the wellness center and liked the services and the ability to connect with others. They noted that the wellness center offered field trips, groups, and other social activities. The participants did not recall completion of any surveys or other MHP efforts to obtain their input on

services. Nevertheless, the focus group participants were satisfied with services and were especially pleased with the care and concern displayed by the staff, including psychiatric providers.

The focus group participants did not have recommendations related to MHP services.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Despite some delays in timeliness of services, beneficiary experiences with mental health services are positive. MHP staff are a key part of beneficiaries' satisfaction with services. Focus group participants felt supported and cared for and that services were making a difference to their health. There were no concerns regarding culturally responsive services and language capacity. They recognized the MHP's efforts to provide services in preferred language, either directly or through interpretation services for English and Chinese. All participants welcome in-person services.

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. SYBH maintains collaborative relationships with its contract providers. Together, they present a united front, which enables coordination of services. The multi-disciplinary teams and meetings were reported as one of the means by which this coordination takes place. (Quality)
2. As in the previous year, the MHP has a full complement of psychiatric providers. (Access)
3. Beneficiary documents available through links on the website are provided in Spanish and Hmong. (Quality, IS)
4. To their credit, the QA staff and program have buy-in and positive regard from both internal and external staff. The MHP has something that it can leverage to engage stakeholders, making them more accountable for QI of MHP services. (Quality)
5. The MHP demonstrates a thorough and effective pre- and post-claim review process, resulting in a low Medi-Cal claim denial rate, at 1.21 percent, which can contribute to stable cash flow for the MHP. (Quality, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Timeliness to services is infrequently monitored for the MHP to have a clear picture of the extent of delays and for the MHP to implement strategies to improve it; a twice-annual review is insufficient. The MHP's performance in four areas need improving: time to offered and delivered first services for youth; time to Early Explorers (an interim group service); time to rendered psychiatry for youth; and time to second and third appointments. (Timeliness).
2. There are several links to forms and documents on the MHP website available in both Spanish and Hmong. The website, however, is entirely in English making it difficult for those speaking another language to identify the links taking them to materials in an alternative language. (Quality, IS)
3. The MHP did not track or trend the requisite FC HEDIS measures. Given that there are a small number of youth in FC who are prescribed psychotropic medications (and that the MHP has a full complement of psychiatric providers and a medical director) not monitoring the requisite areas of care more formally in-house is an oversight. (Quality)

4. The MHP's QI program prioritizes compliance—meeting regulations, following mandates, and developing corresponding policy. While compliance is important, it is not a substitute for quality of services that relates more directly to the beneficiary experience. (Quality)
5. There has not been cross-training in the Billing Unit. Although there is only one billing position in the unit, it would be beneficial for others in the Finance/Billing area to be cross-trained to preserve processes and history. (IS)

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. Monitor timeliness on a quarterly basis, with documented evidence of review and analysis of MHP performance on:
    - time to offered and delivered first services for youth;
    - time to Early Explorers group;
    - time to rendered psychiatry for youth; and
    - time to second and third appointments for all beneficiaries.
2. Include instructions on the SYBH website in Spanish and Hmong directing individuals to documents in those languages. (Quality, IS)
3. Develop a SYBH process for reviewing medication utilization of youth in FC with quarterly review by the medical director or another assigned psychiatric provider. (Such a process may involve receipt/collection of requisite information from the JV-220 from the public health nurse on a monthly basis, audits of those records, aggregation of that information, and a committee review) (Quality) (This recommendation is a carry-over from FY 2021-22.)
4. Review the QAPI and incorporate QI goals that directly benefit beneficiary experience as versus compliance. (Quality) (This recommendation is a carry-over from FY 2021-22, FY 2020-21, and FY 2019-20.)
5. Develop and provide cross-training in the Finance/Billing unit to ensure preservation of processes and relevant history within the unit. (Quality, IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT F: PM Data CY 2021 Refresh

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Sutter-Yuba MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Satisfaction
Validation of Findings for Pathways to MH Services (Katie A./CCR)
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 Analysis & Validation
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care

CalEQRO Review Sessions – Sutter-Yuba MHP
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
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
Leda Frediani, Information Systems Reviewer
Patricia Rupe, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Aldridge	Chulo	Peer Employee	Youth For Change
Amaya, LCSW	Janet	Supervisor, Children's System of Care	Sutter-Yuba Behavioral Health (SYBH)
Andersen	Tammy	Staff Analyst, Quality Assurance	SYBH
Ayala	Connie	Office Services Supervisor	SYBH
Baker	Melissa	Mental Health Therapist	SYBH
Beebe	Tonya	Program Manager - Community Services	SYBH
Benzel	Janet	Account Clerk III	SYBH
Bingham, LMFT	Rick	Director, Sutter-Yuba Behavioral Health	SYBH
Brown-Wade, LMFT	Jacinta	Supervisor, TAY	SYBH
Bryer	Amy	Staff Analyst, Youth Services	SYBH
Chahotte	Ashley	PSS	Youth for Change
Chambers	Brooke	Director of Quality	Youth for Change
Chambers, LCSW	Lori	Administrator, SHINE FSP	Telecorp
Chase	Lesia	Resource Specialist	SYBH
Chue	Xay	Quality Assurance Therapist	SYBH
Clavel, MPA	Melissa	Quality Assurance Officer	SYBH
Cole	Tara	Administration and Accounting Supervisor	SYBH
Davis	Tia	Mental Health Therapist	SYBH

Last Name	First Name	Position	County or Contracted Agency
Duran	Gina	Program Manager - Hospital & Emergency Services	SYBH
Freeman, LCSW	Quenette	Clinician	Youth For Change
Gowan	Betsy	Branch Director, Adult Services	SYBH
Hallford	Jesse	Staff Analyst, Adult Services	SYBH
Hanson	Scott	Information Technology Supervisor	Sutter County General Services
Heer	Parminder	Supervising Mental Health Therapist	SYBH
Holland	Sharie	Intervention Counselor	SYBH
Hollis	Rachael	Intervention Counselor	SYBH
Hughes, LMFT	Kristine	Therapist, Quality Assurance	SYBH
Johnson	Kelani	Prevention Services Coordinator, Children's System of Care	SYBH
Kearns, MSW	Paula	Branch Director - Children's Services	SYBH
Kurtz	J'Lene	Supervising Psychiatric Technician	SYBH
Lopez Leon	Geisha	Supervisor, Latino Outreach	SYBH
Lopez-Barajas, LCSW	Lisa	Program Manager, CBS	Youth For Change
Marsh, LCSW	Megan	Clinical Supervisor	Youth For Change
Meza	Audrey	EHR/Data Management Supervisor	Kings View Professional Services
Morrison	Don	Peer Support Supervisor	Youth for Change

Last Name	First Name	Position	County or Contracted Agency
Ramos, LCSW	Estela M.	Supervisor, Youth Outpatient	SYBH
Redford, LMFT	Susan	Branch Director - Acute Psychiatric Services	SYBH
Reeb, LMFT	Adam	Program Manager, PHF	SYBH
Rodriguez	Adrian	Supervising Mental Health Therapist	SYBH
Rodriquez	Rachel	Parent Partner	Youth for Change
Rosa	Kitrice	Supervisor, Wellness and Recovery, Adult Outpatient	County
Sales	Jacob	Case Manager II, SHINE FSP	Telecare
Schotte	Ashley	Peer Employee	Youth For Change
Scott	Grace	Team Line, SHINE FSP	Telecare
Shields	Clinton	Business Services Analyst III	Kings View Professional Services
Singh, MD	Hardeep	Medical Director	SYBH
Tate, LMFT	April	Program Manager, Adult Outpatient	SYBH
Teresi	Krishna	Program Manager, FSP	Youth For Change
Thomas	Josh	Program Manager, CSOC/TAY-FSP	SYBH
Tucker	Chandra	Intervention Counselor	SYBH
Utter	Misty	Supervisor, Youth Outpatient Urgent Services	SYBH
Vang	Tony	Staff Services Manager	SYBH

Last Name	First Name	Position	County or Contracted Agency
Whittaker	Darrin M.	Program Manager, Clinical Services	SYBH
Wilson-Baker	Tina	Supervisor, Medical Records	SYBH
Wood	Emily	Intervention Counselor	SYBH

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 reported a 7-day post-hospitalization follow-up rate of 21 percent, with a target for improvement of 10 percent. The strategy for improvement is convening a follow-up care team and instituting a protocol for follow-up. The details of the strategies need to be clarified.

General PIP Information
MHP/DMC-ODS Name: Sutter-Yuba
PIP Title: Improving Rates of Post-Psychiatric Hospitalization Follow-up
PIP Aim Statement: The two-year project will be aimed at ensuring all Sutter-Yuba Medi-Cal beneficiaries who receive psychiatric hospitalization are consistently receiving follow-up services within 7 days through discharge planning and linkage to timely and appropriate aftercare.
Date Started: 01/2023
Date Completed: Ongoing
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Beneficiaries who are discharged from/after a psychiatric hospitalization.

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): Convene a follow-up care team and instituting a protocol.
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
Post-hospitalization follow-up rate 7-day	2021	21%	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Providing a baseline and target for improvement, both of which the PIP team did. • Reducing the timeframe from two years to one year, which the PIP team did.

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 reported 66 percent and 74 percent rates for 7-day and 30-day follow-up appointment respectively after emergency department (ED) visit, both of are above the national benchmark. The MHP did not explain the need for improvement, given the above. The team's strategies for improvement include safety planning, peer support services, care coordination, and check-ups. The strategies need more specificity, which may occur when the team identifies an area needing improvement.

General PIP Information
MHP/DMC-ODS Name: Sutter-Yuba
PIP Title: Follow-Up After ED Visit for Mental Illness (FUM)
PIP Aim Statement: For Medi-Cal beneficiaries with ED visits for mental health conditions, implemented interventions will increase the percentage of follow-up mental health services within 7 and 30 days by 5 percent by June 2023?
Date Started: 12/2022
Date Completed: Ongoing
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Beneficiaries who have reported to an ED for mental illness.

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): Increase care coordination via assertive outreach.
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 mental health visits after ED visit 7-day 30-day	2021	7-day – 66% 30-day – 74%	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Focus on the area that needs obvious improvement. • Provide more details on the strategies.

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

Sutter/Yuba 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	79,919	3,251	4.07%	$19,297,807	$5,936
CY 2020	75,136	3,325	4.43%	$17,767,202	$5,344
CY 2019	73,653	3,628	4.93%	$20,301,809	$5,596

*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	9,409	46	0.49%	1.27%	1.96%
Ages 6-17	19,927	832	4.18%	5.74%	5.93%
Ages 18-20	4,152	166	4.00%	4.89%	4.41%
Ages 21-64	39,334	2,022	5.14%	4.73%	4.56%
Ages 65+	7,100	185	2.61%	2.45%	1.95%
Total	**79,919**	**3,251**	**4.07%**	**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	207	6.37%
Threshold language source: Open Data per BHIN 20-070		

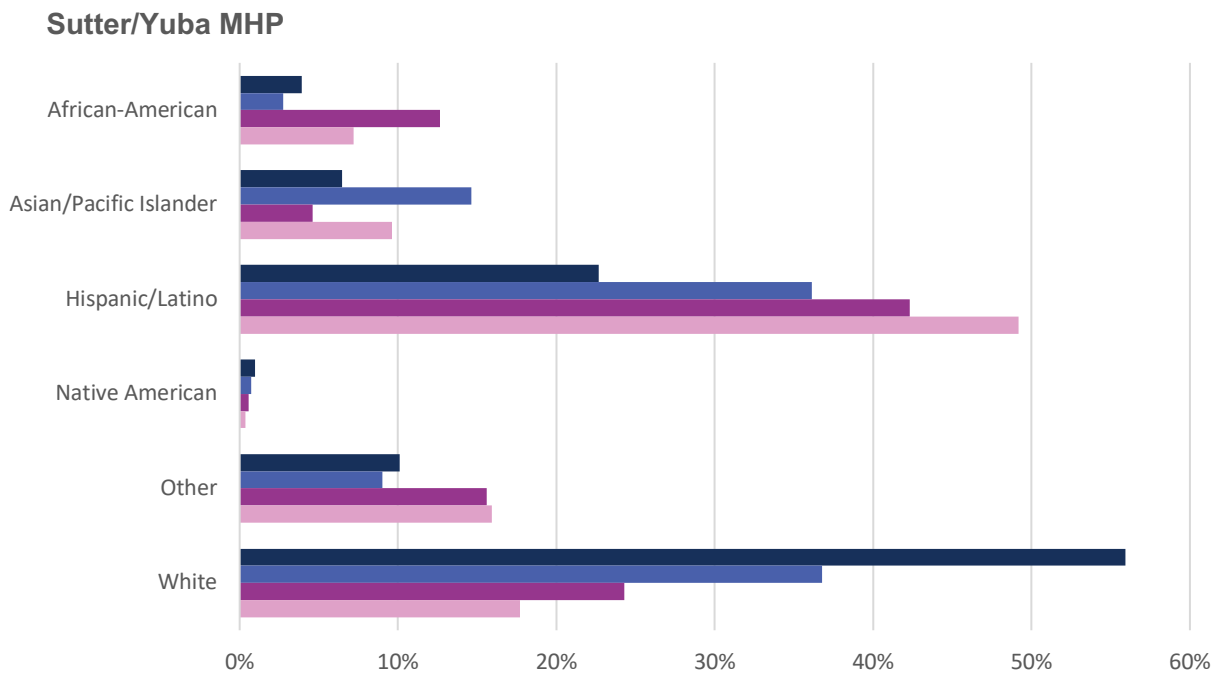
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	20,687	761	3.68%	$2,951,158	$3,878
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	2,204	127	5.76%	7.64%
Asian/Pacific Islander	11,690	210	1.80%	2.08%
Hispanic/Latino	28,871	737	2.55%	3.74%
Native American	588	31	5.27%	6.33%
Other	7,188	328	4.56%	4.25%
White	29,380	1,818	6.19%	5.96%
Total	**79,921**	**3,251**	**4.07%**	**4.34%**

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



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	56%	10%	1%	23%	6%	4%
MHP % Eligible	37%	9%	1%	36%	15%	3%
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

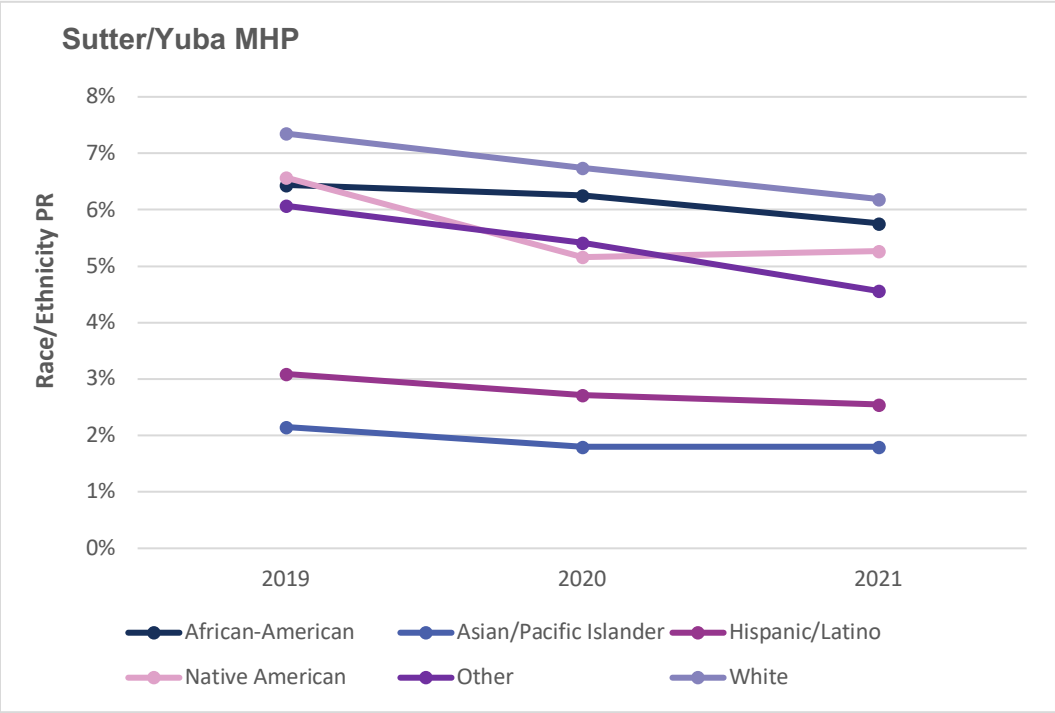


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

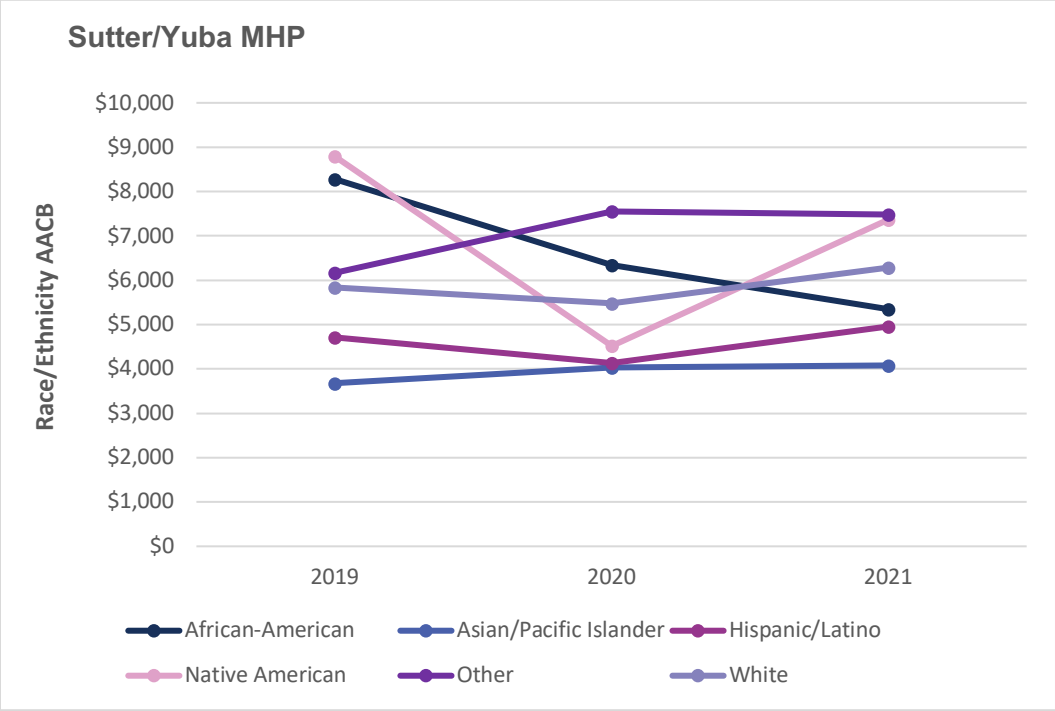
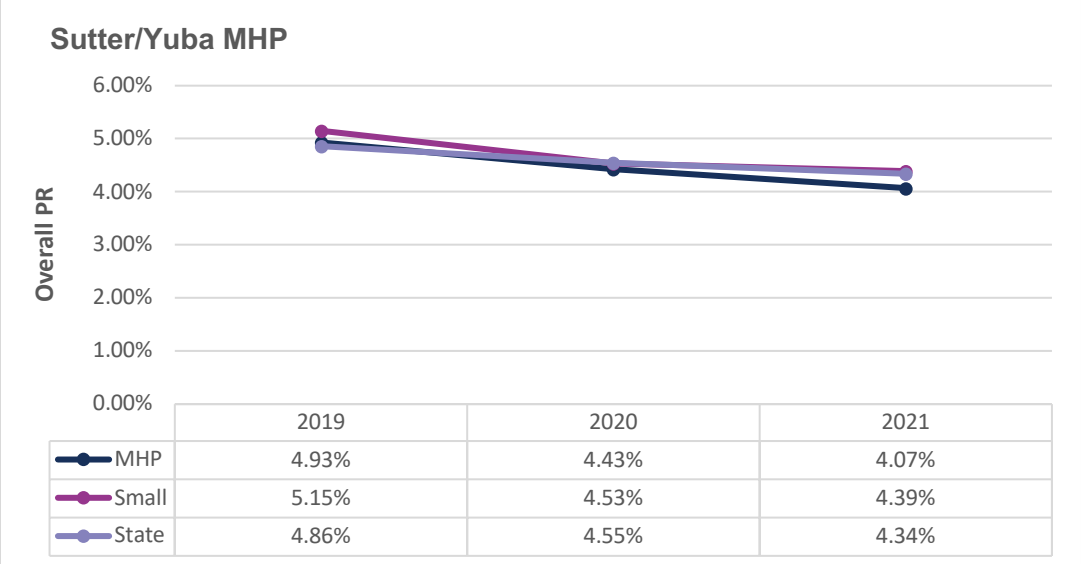
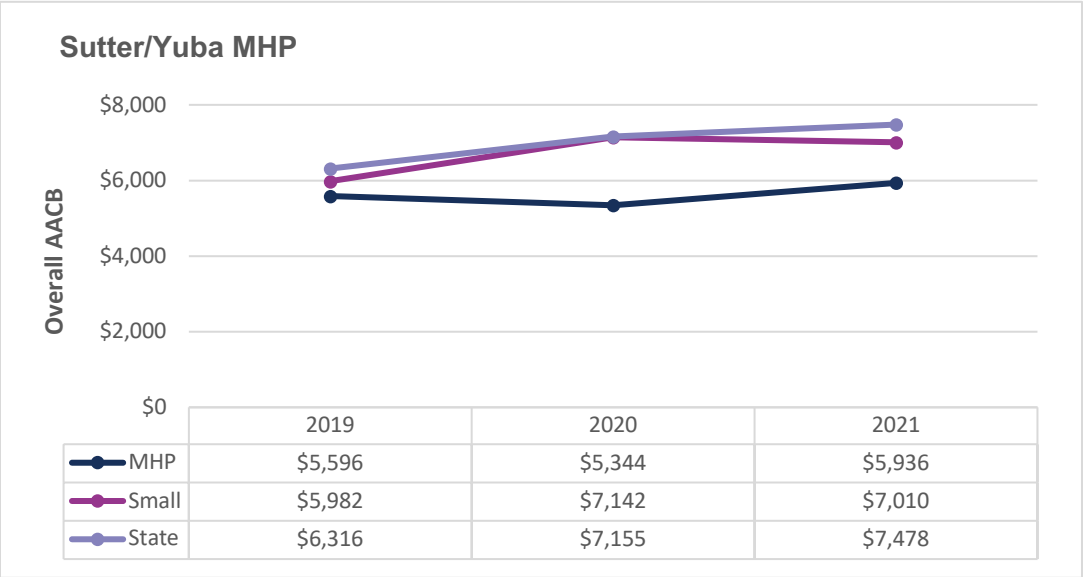


Figure 4: Overall PR CY 2019-21



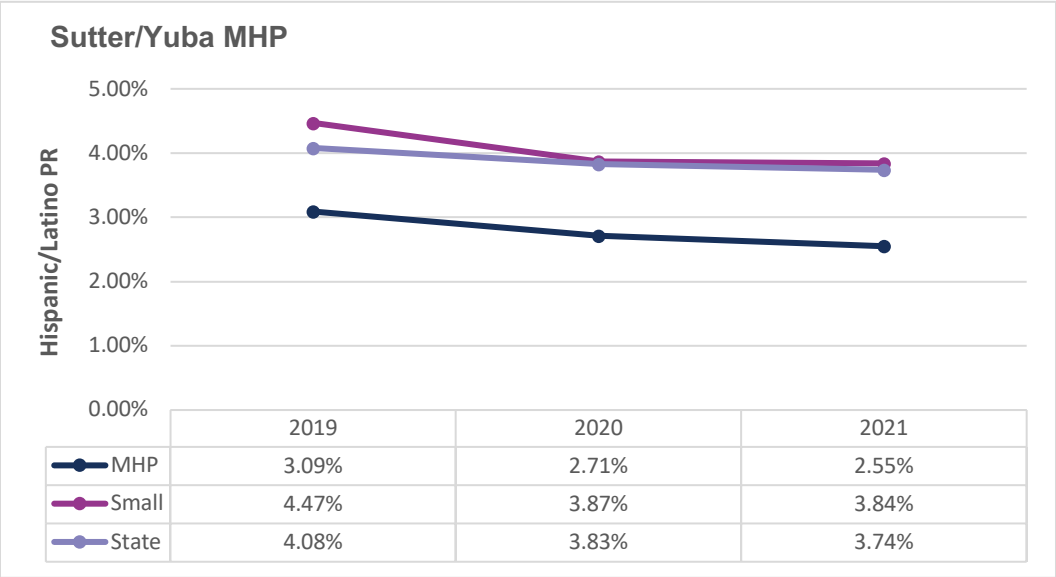
	2019	2020	2021
MHP	4.93%	4.43%	4.07%
Small	5.15%	4.53%	4.39%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



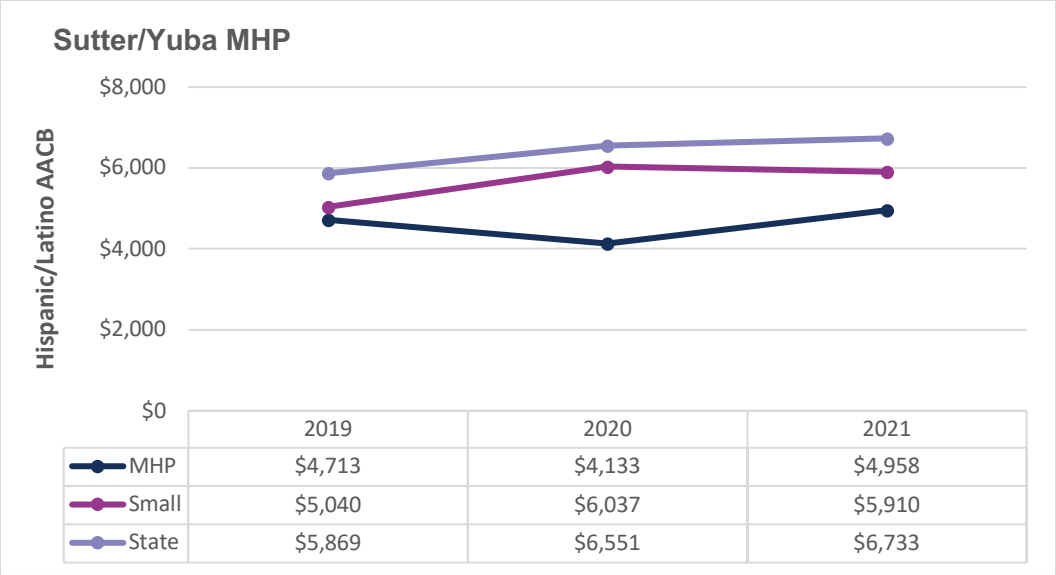
	2019	2020	2021
MHP	$5,596	$5,344	$5,936
Small	$5,982	$7,142	$7,010
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21



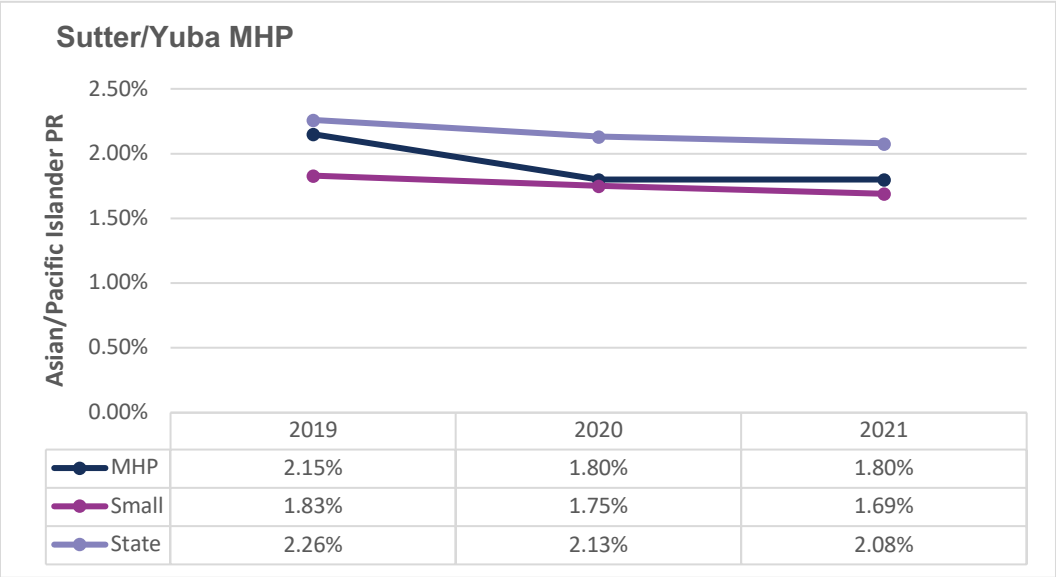
	2019	2020	2021
MHP	3.09%	2.71%	2.55%
Small	4.47%	3.87%	3.84%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21



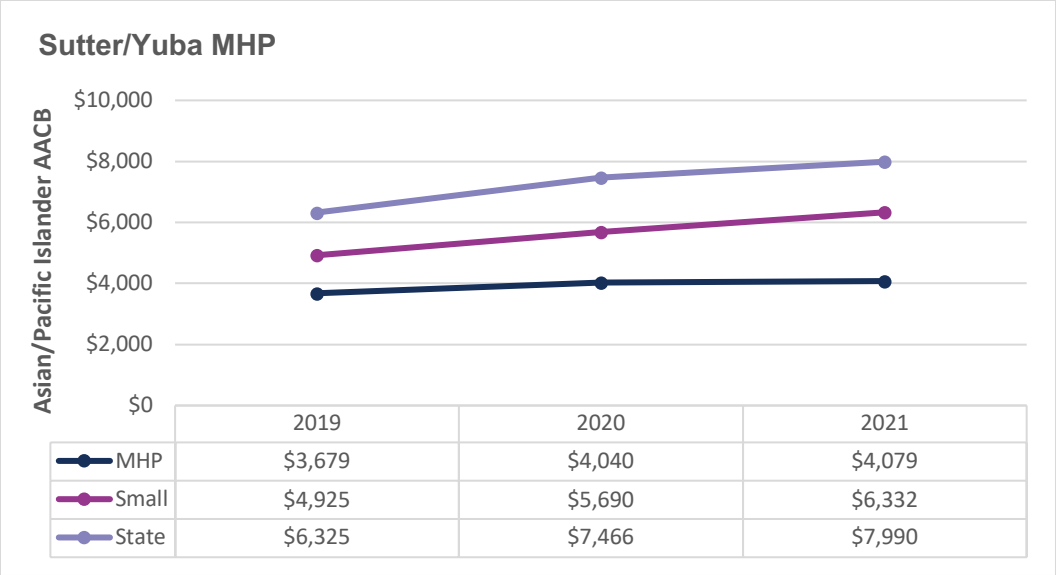
	2019	2020	2021
MHP	$4,713	$4,133	$4,958
Small	$5,040	$6,037	$5,910
State	$5,869	$6,551	$6,733

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



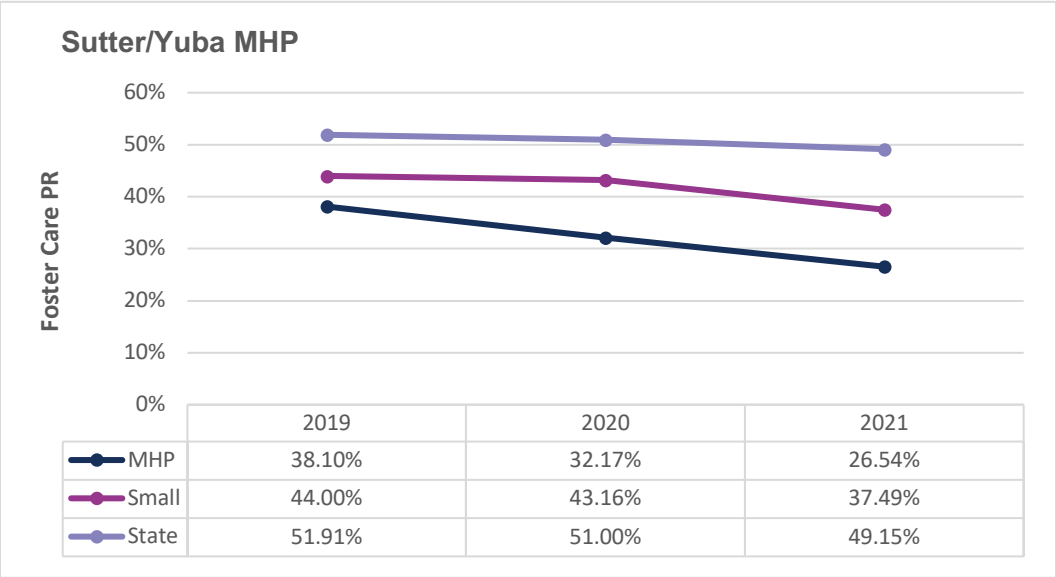
	2019	2020	2021
MHP	2.15%	1.80%	1.80%
Small	1.83%	1.75%	1.69%
State	2.26%	2.13%	2.08%

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



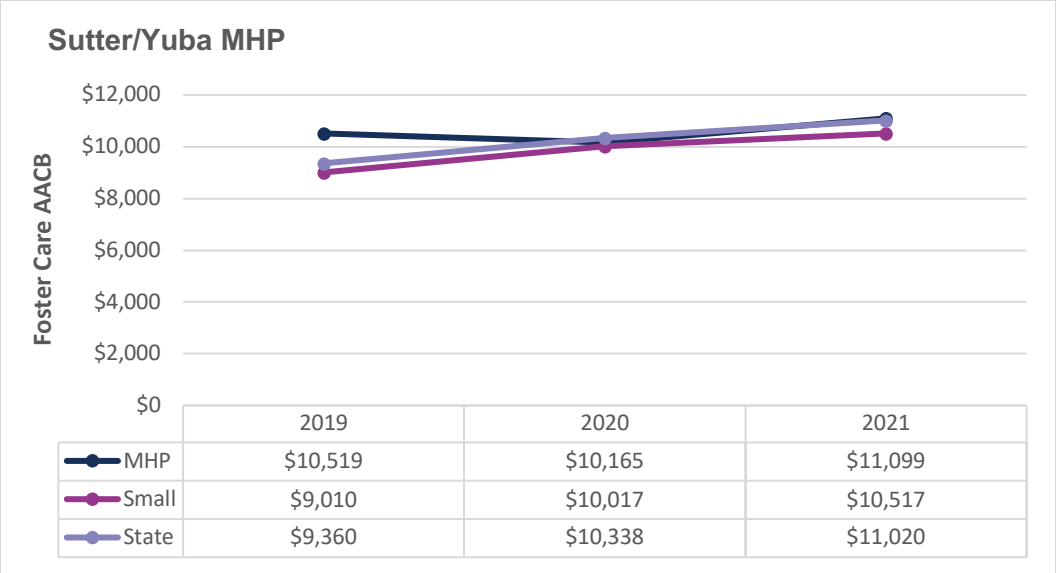
	2019	2020	2021
MHP	$3,679	$4,040	$4,079
Small	$4,925	$5,690	$6,332
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	38.10%	32.17%	26.54%
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	$10,519	$10,165	$11,099
Small	$9,010	$10,017	$10,517
State	$9,360	$10,338	$11,020

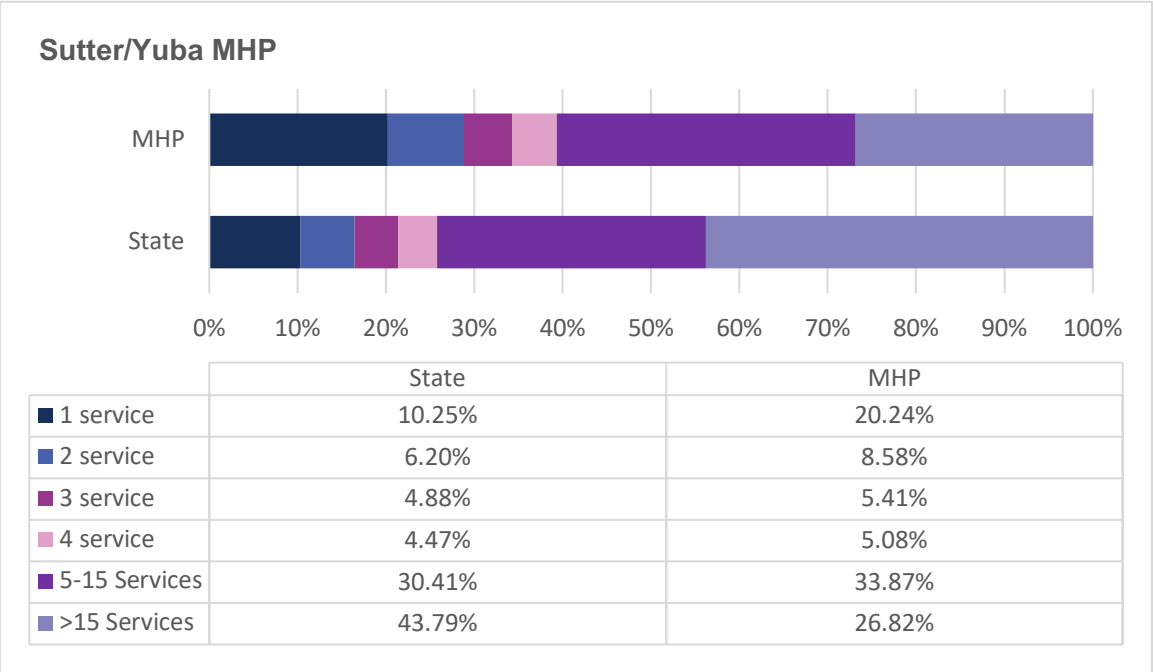
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 2,373				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	40	1.7%	7	6	11.6%	16	8
Inpatient Admin	<11	-	8	8	0.5%	23	7
Psychiatric Health Facility	224	9.4%	15	6	1.3%	15	7
Residential	10	0.4%	49	46	0.4%	107	79
Crisis Residential	<11	-	11	11	2.2%	21	14
Per Minute Services							
Crisis Stabilization	29	1.2%	1,543	1,200	13.0%	1,546	1,200
Crisis Intervention	602	25.4%	219	145	12.8%	248	150
Medication Support	1,433	60.4%	237	149	60.1%	311	204
Mental Health Services	1,465	61.7%	223	85	65.1%	868	353
Targeted Case Management	237	10.0%	307	145	36.5%	434	137

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

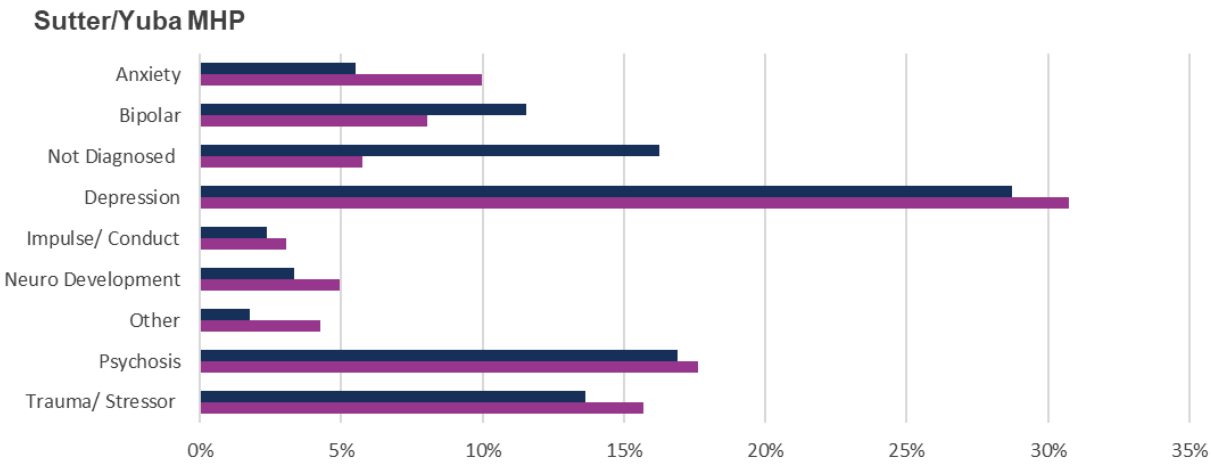
Service Category	MHP N = 93				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	16	10	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	<11	-	28	28	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	<11	-	690	690	0.2%	582	441
Full Day Rehab	<11	-	30	30	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	1,488	1,200	3.1%	1,404	1,200
Crisis Intervention	14	15.1%	341	273	7.5%	406	199
Medication Support	48	51.6%	334	179	28.2%	396	273
TBS	<11	-	3,664	3,820	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	49	52.7%	508	308	40.2%	1,354	473
Intensive Home Based Services	<11	-	1,606	1,021	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	89	95.7%	2,036	1,143	96.3%	1,854	1,108
Targeted Case Management	63	67.7%	251	165	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	20.24%
2 service	6.20%	8.58%
3 service	4.88%	5.41%
4 service	4.47%	5.08%
5-15 Services	30.41%	33.87%
>15 Services	43.79%	26.82%

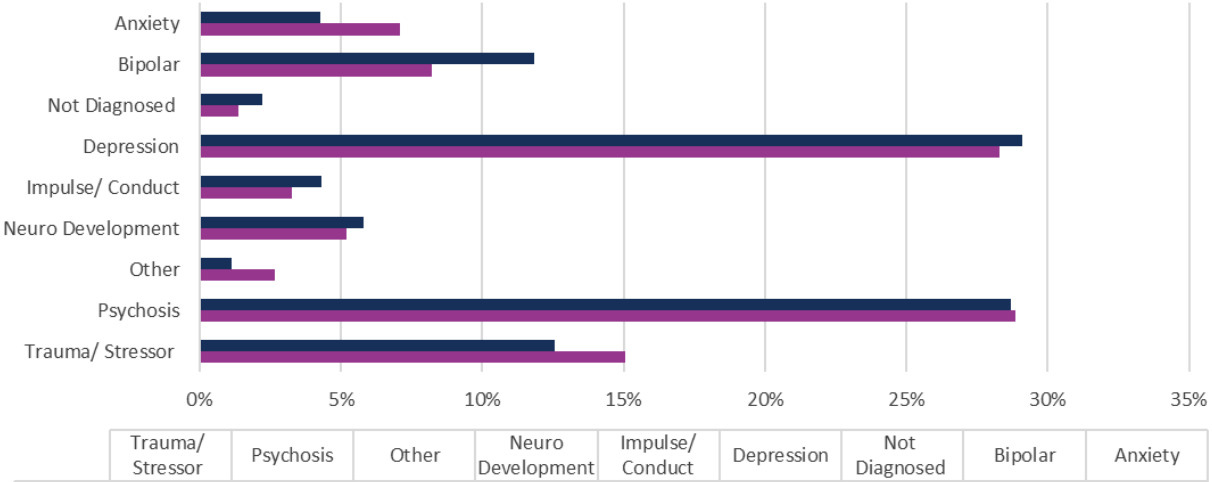
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	17%	2%	3%	2%	29%	16%	12%	6%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Percent Beneficiaries

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



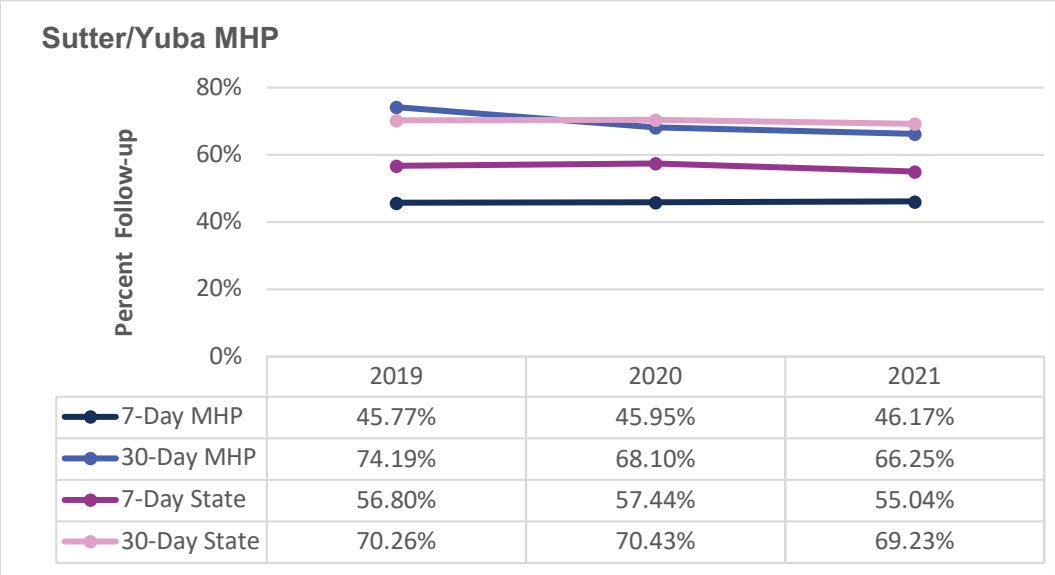
	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	13%	29%	1%	6%	4%	29%	2%	12%	4%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Percent Claims

Table 13: Psychiatric Inpatient Utilization CY 2019-21

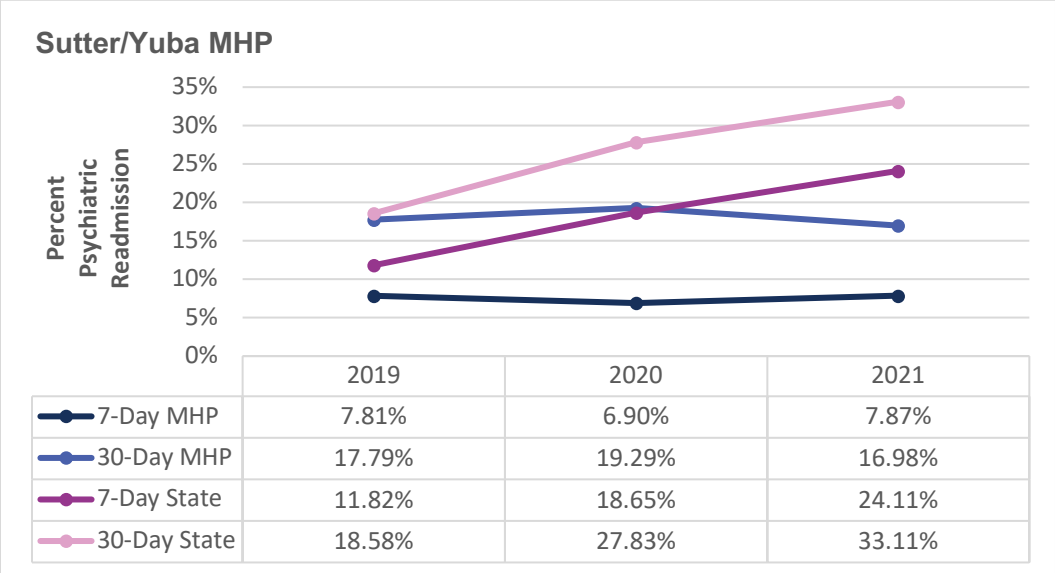
Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	379	789	11.14	8.86	$16,674	$12,052	$6,319,427
CY 2020	330	660	11.45	8.68	$17,000	$11,814	$5,610,125
CY 2019	376	693	10.97	7.80	$15,756	$10,535	$5,924,296

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



	2019	2020	2021
7-Day MHP	45.77%	45.95%	46.17%
30-Day MHP	74.19%	68.10%	66.25%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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



	2019	2020	2021
7-Day MHP	7.81%	6.90%	7.87%
30-Day MHP	17.79%	19.29%	16.98%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	103	3.17%	32.74%	$6,318,046	$61,340	$47,618
	CY 2020	90	2.71%	29.49%	$5,240,263	$58,225	$46,163
	CY 2019	118	3.25%	30.02%	$6,095,549	$51,657	$43,274

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approv	Total Approved Claims	Average Approved Claims	Median Approved Claims

			ed Claims		per Beneficiary	per Beneficiary
Medium Cost ($20K to $30K)	110	3.38%	13.73%	$2,649,588	$24,087	$23,919
Low Cost (Less than $20K)	3,038	93.45%	53.53%	$10,330,173	$3,400	$1,695

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

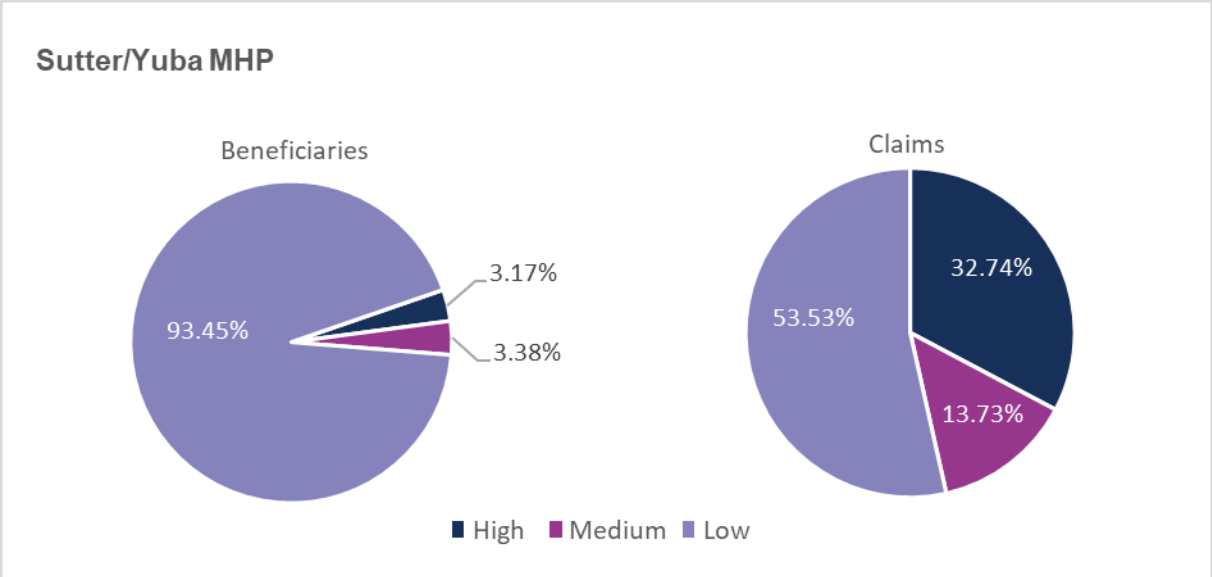


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	3,863	$1,281,979	$1,501	0.12%	$1,244,100
Feb	3,814	$1,373,763	$803	0.06%	$1,320,246
Mar	4,631	$1,712,866	$1,028	0.06%	$1,672,426
April	4,049	$1,579,807	$7,275	0.46%	$1,535,492
May	3,929	$1,510,707	$4,492	0.30%	$1,463,352
June	3,807	$1,411,895	$2,483	0.18%	$1,363,794
July	3,429	$1,384,526	$2,084	0.15%	$1,356,146
Aug	3,591	$1,506,538	$1,097	0.07%	$1,471,990
Sept	3,922	$1,518,759	$443	0.03%	$1,476,136
Oct	3,823	$1,511,646	$5,516	0.36%	$1,424,664
Nov	3,344	$1,327,200	$1,925	0.15%	$1,293,175
Dec	3,276	$1,347,975	$5,267	0.39%	$1,319,352
Total	**45,478**	**$17,467,661**	**$33,914**	**0.19%**	**$16,940,873**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Late claim	65	$17,581	51.84%
Medicare Part B must be billed before submission of claim	23	$7,237	21.34%
Beneficiary not eligible or non-covered charges	2	$3,816	11.25%
Other healthcare coverage must be billed before submission of claim	9	$3,446	10.16%
Service line is a duplicate and a repeat service procedure code modifier not present	10	$1,093	3.22%
Service location NPI issue	1	$743	2.19%
Total Denied Claims	**110**	**$33,916**	**100.00%**
Overall Denied Claims Rate	**0.19%**		
Statewide Overall Denied Claims Rate	**1.43%**		