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

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

TEHAMA FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

November 16, 2022

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — November 16, 2022

MHP Size — Small

MHP Region — Superior

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	3	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	2	1	1
Timeliness of Care	6	0	3	3
Quality of Care	10	0	2	8
Information Systems (IS)	6	2	3	1
TOTAL	**26**	**4**	**9**	**13**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
No PIP submitted	Clinical	n/a	n/a	n/a
No PIP submitted	Non-Clinical	n/a	n/a	n/a

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☒Transition Aged Youth (TAY) ☒Family Members ☐Other	5

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP migrated to an electronic health record.
- The MHP co-located medication services support psychiatry staff at the rural health clinic, leveraging available resources.
- The MHP increased contracted services.
- The MHP is piloting ways to expedite recruitment and hiring.

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

- Staffing vacancies create insufficient capacity to meet service demand.
- The MHP lacks leadership staffing including QI and clinical supervision which impact organizational quality.
- The MHP does not conduct medication monitoring.
- The MHP did not conduct PIPs.
- The MHP's foster care (FC) penetration rate continues to decline and there is no alternate monitoring of access for this high-risk group.
- The MHP does not use a level of care tool to identify high-need beneficiaries.
- Routine reports with key timeliness and QI indicators are not available.

Recommendations for improvement based upon this review include:

- Include contract providers in planning strategies to address the workforce crisis to strengthen the workforce across the service continuum.

- Consult with similar size and geographically nearby MHPs and collect various strategies and resources for hiring QI consultants and/or expanding other administrative functions needed.
- Conduct medication monitoring, which may require outside consulting.
- Design and implement two PIPs this year.
- Examine processes to service FC beneficiaries. Measure access and identify and address barriers to service.
- Implement a level of care tool to identify high-risk and high-need beneficiaries.
- Develop and use Avatar reporting for timeliness and QI indicators.

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, representing 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 Tehama County MHP by BHC, conducted as a virtual review on November 16, 2022.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Review and validation of each MHP's network adequacy 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 "≤10" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP is operating under the impact of the workforce crisis with loss of staff at the county-operated programs, contract providers, and other community-based partner agencies. The MHP has undertaken "drastic restructuring" to provide the most core services for beneficiaries.

The MHP Assistant Director who leads quality management (QM) and California Advancing and Innovating Medi-Cal (CalAIM) implementation was on an emergency leave during the review. In addition, because of illness, three other key staff did not participate in the review as had been planned by the MHP. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. Tehama County Health Services leadership planned and completed the review with CalEQRO.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP reports the staff vacancy rate at over fifty percent at the highest point last year. Historical barriers to filling vacancies persist and increased due to staff burnout associated with the pandemic. Tehama County completed a county wide salary comparability analysis and increased salaries in the spring of 2022. Because other counties raised salaries July 1, the MHP is falling lower than the average again. Lack of candidates living in the area and long commutes add more challenges. Review discussions indicate throughout that workloads are "overwhelming." The MHP's priority focus is to keep the staff healthy and prevent burnout to support staff retention. Staffing changes and challenges include:
    - The former MHP Director began in November 2021 and left the MHP in September 2022.
    - The MHP does not have any supervisors, including any licensed clinical supervisors or managers.
    - Fiscal staff are all relatively new this last year and thus not fully experienced yet, which has impacted billing capacity.
    - The MHP increased contracted services, including two licensed clinical social workers via telehealth. The MHP is considering contracting a third clinician.

    - Although the MHP increased contracted services, the MHP reports that there is not a net increase in clinicians due to other departures.
    - The MHP recently hired former MHP leadership staff to provide consultation on PIPs and other administration functions.
- The MHP's performance measure data presented in this report were likely incomplete, impacted by severe fiscal/billing staffing shortages resulting in delayed claiming. The MHP also appears to be providing fewer units of service as a result of clinical staff shortages.
- In November 2022, the Sheriff's department discontinued daytime patrols due to staffing shortages, and this will impact crisis services and transports. The MHP reports that the California Highway Patrol staff will respond to calls instead. However, that had not started at the time of the review, so the impact for MHP beneficiaries is not clear.
- The MHP plans to change their managed care plan to Partnership Health in January 2024. Because of extremely reduced staffing, in addition to increased demand for acute services, the MHP reports that CalAIM implementation demands are further risking the viability of MHP operations. Collaboration thus far with the managed care plan has been inconsistent because the MCP has had high turnover, making sustained progress difficult.

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.

FY 2021-22

Recommendation 1: Allocate more staffing resources to the implementation and ongoing support for the myAvatar system.

(This recommendation is a carry-over from FY 2020-21.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Tehama implemented the myAvatar system in June 2022, including the implementation of the EHR, performance management, and managed services organization modules.
- The MHP migrated from a paper record to the myAvatar EHR; this move has been a significant change for staff who continue to adjust to the new electronic environment. While the MHP continues to be short-staffed overall, the MHP dedicated adequate staffing resources to ensure that staff received an initial myAvatar training and could receive ongoing support. The MHP Business Operations Supervisor holds myAvatar office hours for one hour twice weekly. During this time staff can receive myAvatar clarifications and one-on-one refresher training. The myAvatar office hours will continue to be offered and promoted to staff for the foreseeable future.
- While the MHP increased staffing resources for the initial implementation and to provide ongoing support of the myAvatar system, delays from the vendor for additional functionality continue. The MHP contracted with Netsmart Technologies, Inc. to provide billing support; however, the June claim has not

been submitted from the myAvatar system at the time of this November review. The MHP is working to transition billing functions to Netsmart.

Recommendation 2: Continue to identify barriers, develop a strategic plan, and initiate steadfast solutions related to both filling vacant positions and improving staff retention to increase capacity to provide SMHS to beneficiaries.

(This recommendation is a carry-over from FY 2020-21.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- MHP vacancies increased in the last year. In addition to salary increases noted earlier, the MHP is piloting a county expedient hiring process to assist recruitment. The process being replicated had reduced the hiring period from 120 to 45 days.
- While the MHP increased contracting services, contract providers are also experiencing high staff turnover and vacancies.
- While the MHP did not develop a strategic plan, the MHP reports exploring alternate models of service delivery and administration.

Recommendation 3: Continue to identify barriers, develop a strategic plan, and initiate steadfast solutions to improve the timely provision of SMHS to beneficiaries; this includes tracking, trending, and reporting on timeliness metrics to understand how the MHP is serving beneficiaries.

(This recommendation is a carry-over from FY 2020-21.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has focused on reinstating capacity by increasing contract providers.
- The MHP anticipates having increased reporting capabilities with its new myAvatar and an internal electronic information exchange, DUCHESS. The MHP launched DUCHESS in August 2022. Routine measurement and performance improvement activities toward improving timeliness of services were not evident.
- The MHP does not measure timeliness to several key service points including first offered non-urgent psychiatry appointment and urgent appointments. Similarly, the MHP does not examine any timeliness metrics by adult, youth and FC. This lack of information hinders resource management and quality improvement.

Recommendation 4: Indicate FC status of youth beneficiaries in records such that timeliness and other performance measures (e.g., per SB 1291) are specifically and actively monitored.

(This recommendation is a carry-over from FY 2020-21.)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- No activity was conducted to address this recommendation. The MHP does not measure any timeliness data for services associated with FC youth, including follow-up after hospitalization and no-show rates. Additional information follows in this report.
- The MHP anticipates increased capability with its new EHR.

Recommendation 5: Provide dedicated oversight for psychiatry and medication support services, to include communication of standards and MHP expectations; training; routine meetings with psychiatric providers; and coordination of annual peer review or other review of prescribing practice and psychiatric care.

(This recommendation is a carry-over from FY 2020-21.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP located medication support services at the Tehama County Health Services Agency Rural Health Clinic in September 2022 to provide medication support services oversight.
- The MHP has conducted no medication monitoring, but reports plans to contract for this service.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 60 percent of services were delivered by county-operated/staffed clinics and sites, and 40 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 85 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: telephone calls, referrals from outside providers, crisis unit transfers, and requests from the MHP's web-based referral form. The MHP operates a decentralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. After a beneficiary requests service, they are scheduled for an appointment with a contract provider. Once a beneficiary completes an assessment, the case is reviewed for medical necessity and assigned to a clinician.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults but did not provide data as to how many clients received telehealth versus in-person services.

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

[1] CMS Data Navigator Glossary of Terms

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

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

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

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

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

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Partially Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Not Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- The MHP has continued to expand contracted resources to improve clinical and administrative capacity.
- The MHP continues to provide the 24-hour Community Crisis Response Unit in Red Bluff for beneficiaries with acute needs.
- Activities and evaluation of the MHP's Cultural Competence Plan were not evident.
- The MHP does not monitor system demand, caseloads and flow through system services. EQR review of CY 2021 data show that the MHP's rate of beneficiaries receiving one to three services (51.8 percent) is more than double the state average rate (22.56 percent). This warrants close examination to understand access, engagement, capacity management and outcomes.
- The MHP has eight bilingual staff positions; four are filled. Clerical staff provide interpreter assistance.
- The MHP reports that the transportation vendor had not been responding to requests and thus, the MHP changed vendors. Anecdotally the MHP reports improvement.

ACCESS PERFORMANCE MEASURES

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

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median

differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, the MHP's penetration rate of 2.57 percent was 33.2 percent lower than the statewide average. Tehama's penetration rate ranks 52nd of 56 MHPs.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	30,245	778	2.57%	$2,820,267	$3,625
CY 2020	28,022	960	3.43%	$3,968,476	$4,134
CY 2019	26,878	1,233	4.59%	$5,315,081	$4,311

- Penetration rate declined each year from CY 2019 to CY 2021. While total eligibles increased 7.9 percent from CY 2020 to CY 2021 (28,022 vs. 30,245), beneficiaries served decreased 19 percent (960 vs. 778). The AACB decreased each year from CY2019 to CY 2021.

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

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	3,416	14	0.41%	1.03%	1.59%
Ages 6-17	7,861	207	2.63%	5.00%	5.20%
Ages 18-20	1,532	38	2.48%	4.29%	4.02%
Ages 21-64	14,855	490	3.30%	4.15%	4.07%
Ages 65+	2,582	29	1.12%	2.09%	1.77%
TOTAL	**30,245**	**778**	**2.57%**	**3.83%**	**3.85%**

- Tehama's penetration rates were significantly lower than the comparably sized counties and statewide averages for all age groups.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percent of Beneficiaries Served
Spanish	44	6.11%
Threshold language source: Open Data per BHIN 20-070		

- Tehama had one threshold language, Spanish, and served 44 beneficiaries who identified Spanish as a preferred language.

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

Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	7,272	164	2.26%	$536,584	$3,272
Small	199,673	6,647	3.33%	$36,223,622	$5,450
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The CY 2021 ACA penetration rate was 31.7 percent lower than the statewide average (2.26 percent vs. 3.31 percent), and the AACB was 42.4 percent less than the statewide average ($3,272 vs. $5,677).

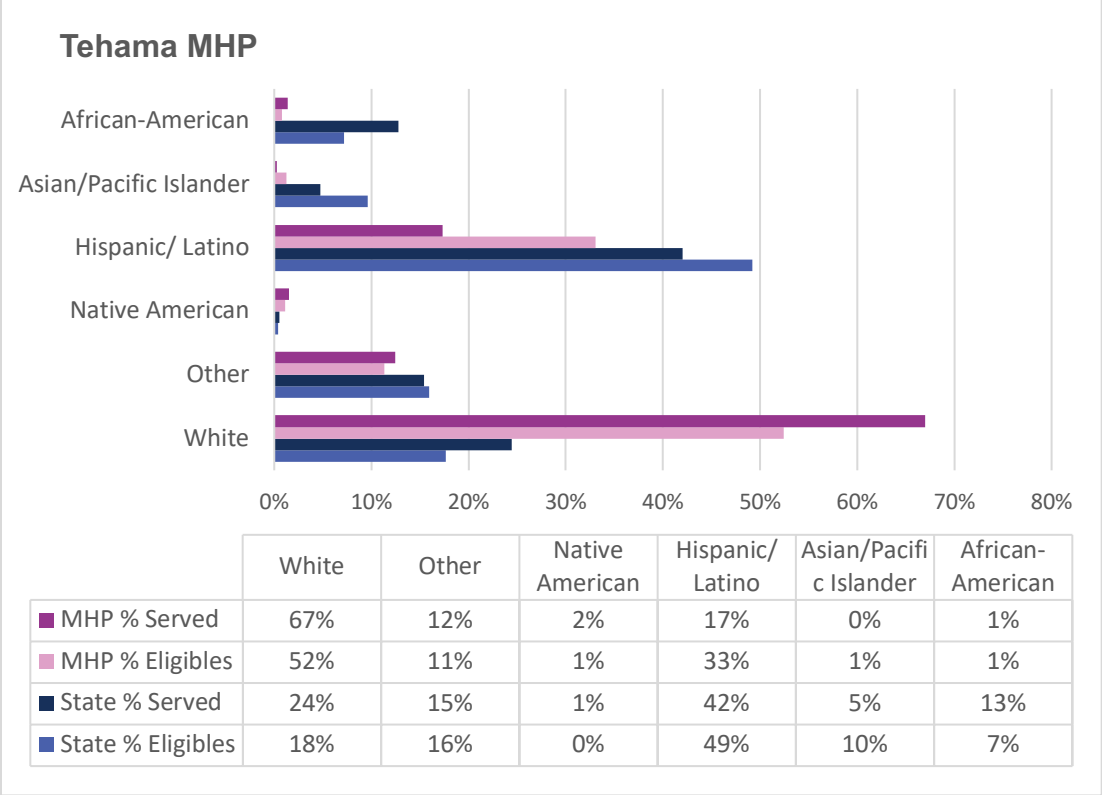
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	# MHP Eligibles	# MHP Served	MHP PR	Statewide PR
African-American	231	-	-	6.83%
Asian/Pacific Islander	380	≤10	-	1.90%
Hispanic/Latino	9,999	135	1.35%	3.29%
Native American	336	12	3.57%	5.58%
Other	3,434	97	2.82%	3.72%
White	15,868	521	3.28%	5.32%
Total	**30,248**	**778**	**2.57%**	**3.85%**

- Tehama served 778 unique beneficiaries in CY 2021 with 521 White beneficiaries served and 135 Hispanic/Latino beneficiaries served. The MHP's White penetration rate was 38.3 percent lower than the statewide average (3.28 percent vs. 5.32 percent) and, similarly the Hispanic/Latino penetration rate was 59 percent lower than the statewide average (1.35 percent vs. 3.29 percent). Tehama's Hispanic/Latino penetration rate was the second lowest in the State, ranking 55th of 56 MHPs.

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

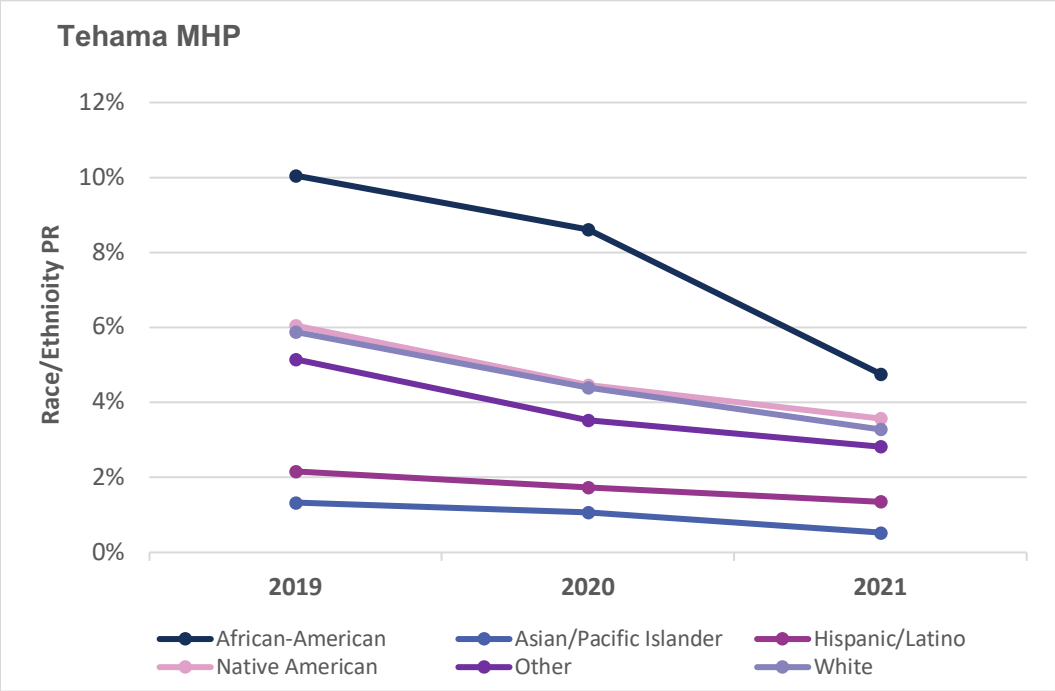


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	67%	12%	2%	17%	0%	1%
MHP % Eligibles	52%	11%	1%	33%	1%	1%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- Tehama's eligible population was largely comprised of White beneficiaries at 52 percent of the eligible population and 67 percent of those served. Hispanic/Latino beneficiaries comprised the next largest race/ethnicity group compromising 33 percent of the eligible population and 17 percent of those served. These two subpopulations comprised 85 percent of total eligibles and 84 percent of those served by the MHP.

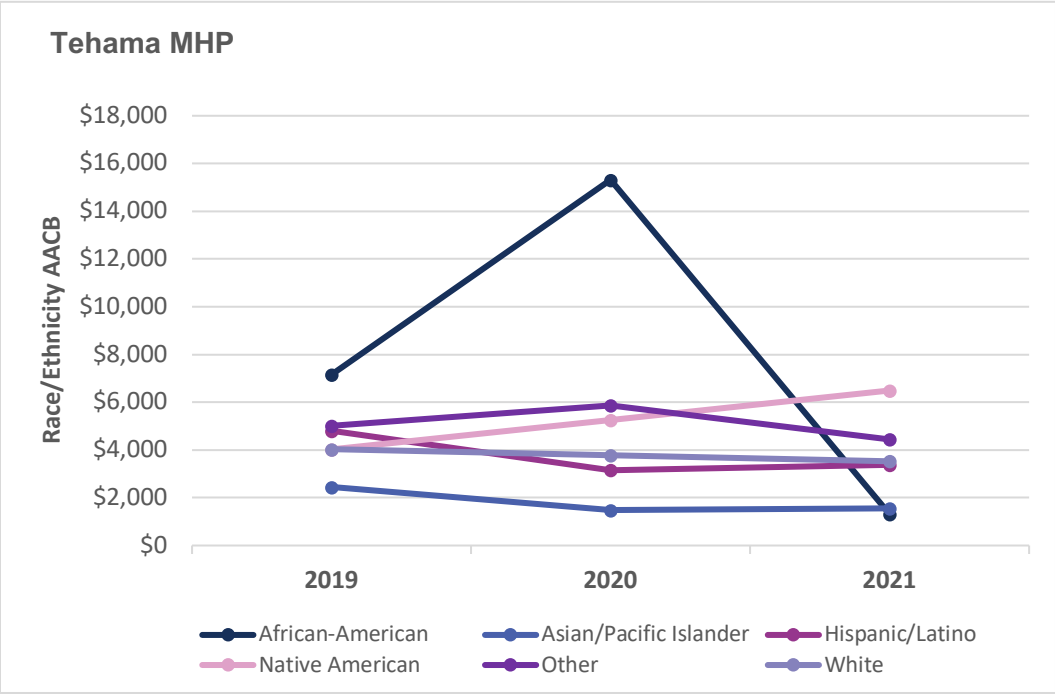
Figures 2 – 11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



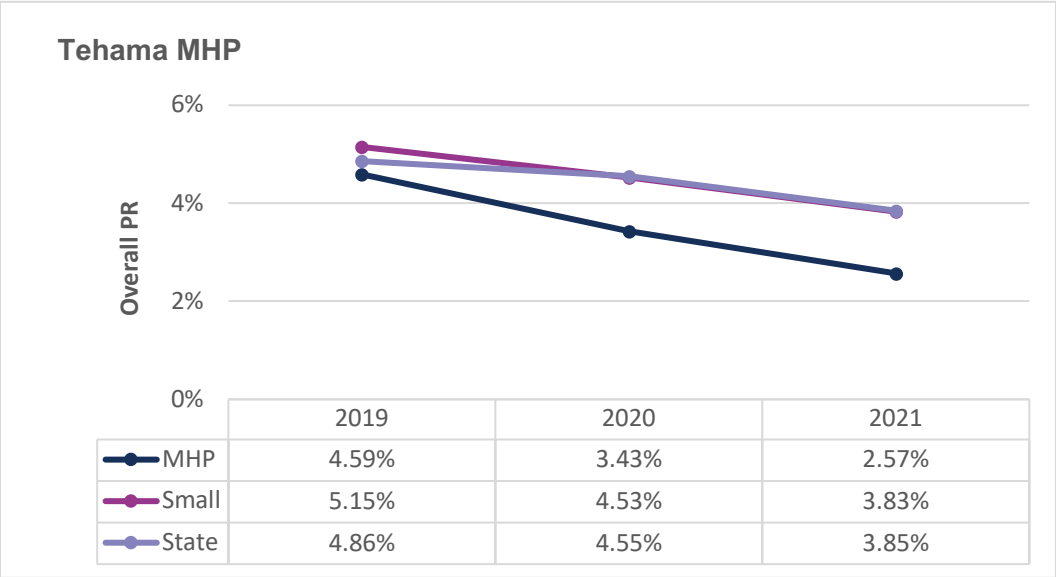
- Penetration rates for all subpopulations declined each year from CY 2019 to CY 2021. Though a small proportion of its eligibles, African Americans had the highest penetration rate from CY 2019 to CY 2021 (the numbers served are not displayed to prevent calculation of the small number of Asian-Americans served in CY 2021). Asian/Pacific Islanders and Hispanic/Latinos had the lowest penetration rates in the three-year period presented.

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



- While Native American beneficiaries had the highest AACB in CY 2021, 12 beneficiaries were served; this small count can contribute to more significant year-over-year data fluctuations. The African American subpopulation displayed the greatest AACB variability from CY 2019 to CY 2021, but also having served few beneficiaries served in CY 2021, the small numbers will impact the data. Asian Pacific Islander beneficiaries had the lowest AACB during this three-year period.

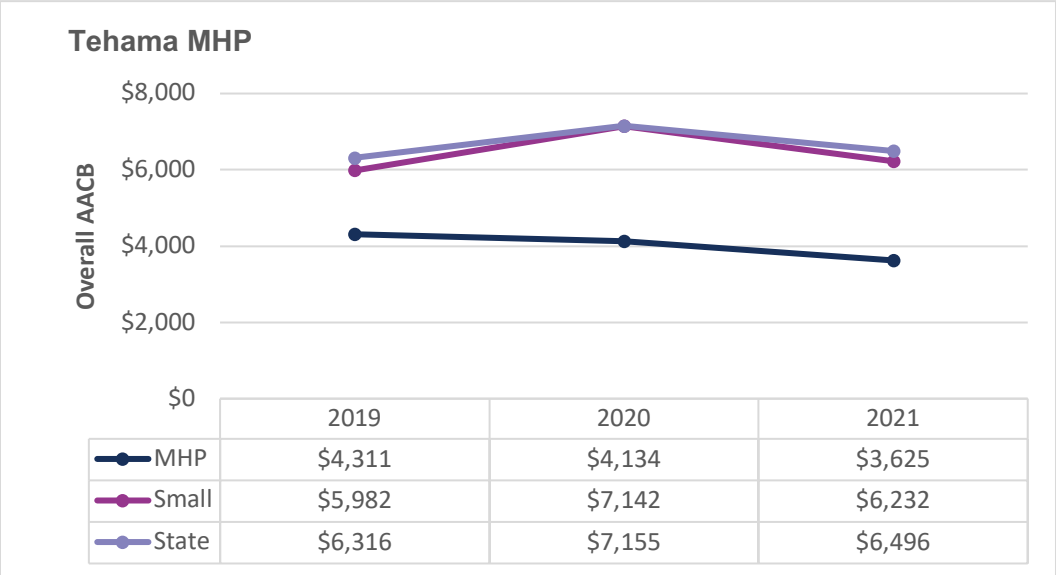
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.59%	3.43%	2.57%
Small	5.15%	4.53%	3.83%
State	4.86%	4.55%	3.85%

- While penetration rates for statewide, small counties, and Tehama declined each year from CY 2019 to CY 2021, Tehama's penetration rate was notably below both small county and statewide averages in CY 2021 (2.57 vs. 3.83 vs. 3.85).

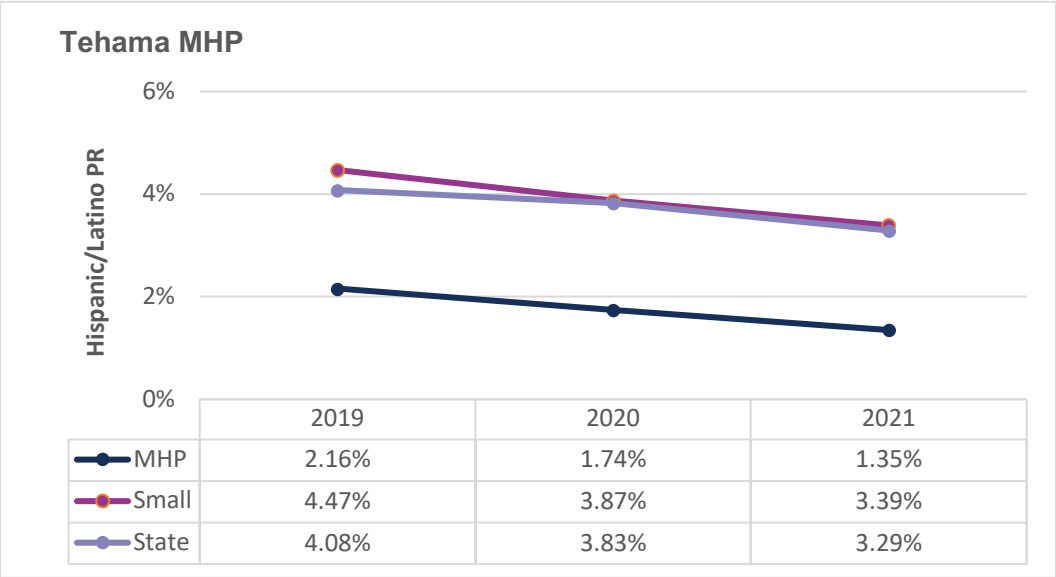
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,311	$4,134	$3,625
Small	$5,982	$7,142	$6,232
State	$6,316	$7,155	$6,496

- Tehama's AACB was significantly less than small county and statewide averages from CY 2019 to CY 2021. In CY 2021, Tehama's AACB was 41.8 percent less than the small county average ($3,625 vs. $6,232) and 44.2 percent less than the statewide average ($3,625 vs. $6,496).

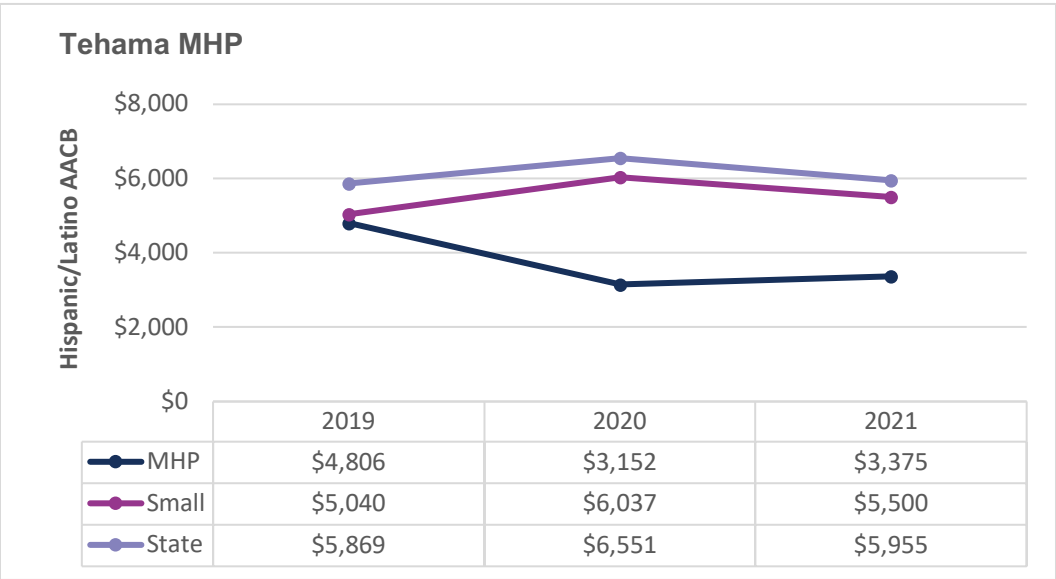
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	2.16%	1.74%	1.35%
Small	4.47%	3.87%	3.39%
State	4.08%	3.83%	3.29%

- Latino/Hispanic penetration rates for statewide and comparative county averages and Tehama declined each year from CY 2019 to CY 2021, with Tehama having the lowest penetration rates during this period. In CY 2021, Tehama's Latino/Hispanic penetration rate ranking was 55th of 56 MHPs.

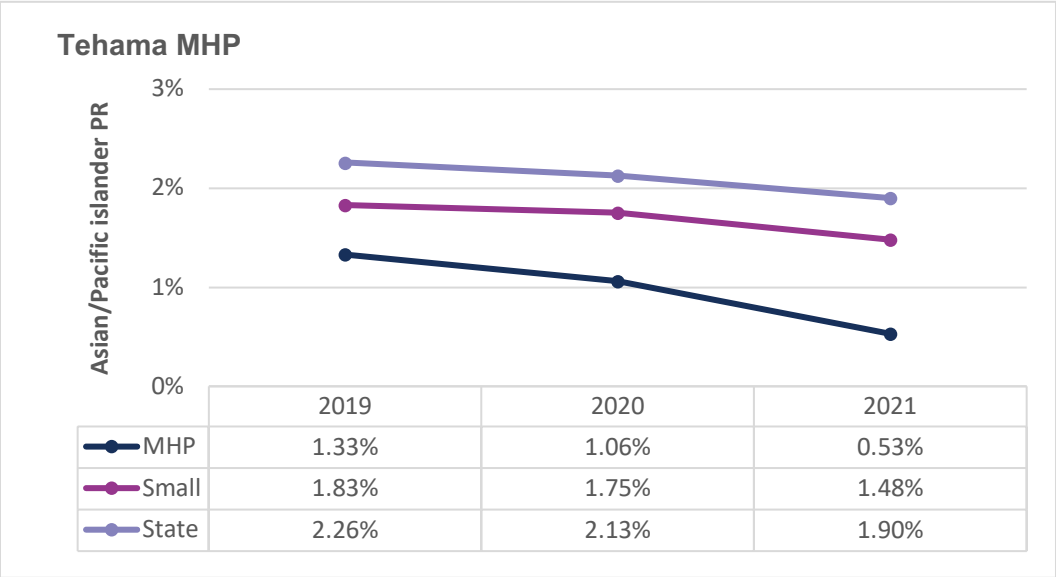
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,806	$3,152	$3,375
Small	$5,040	$6,037	$5,500
State	$5,869	$6,551	$5,955

- While comparable to the small county average in CY 2019, Tehama's AACB declined in CY 2020, and in CY 2021 it was 38.6 percent less than the small county average ($3,375 vs. $5,500) and 43.3 percent less than the statewide average ($3,375 vs. $5,955).

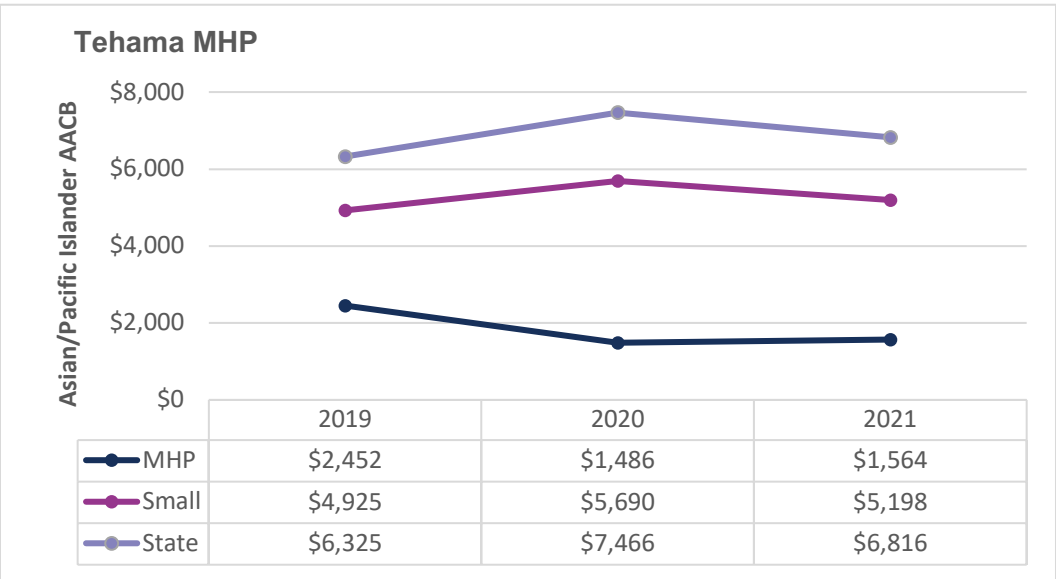
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	1.33%	1.06%	0.53%
Small	1.83%	1.75%	1.48%
State	2.26%	2.13%	1.90%

- Asian/Pacific Islander penetration rates for statewide and small county averages and Tehama declined from CY 2019 to CY 2021, with Tehama's having the steepest decline from CY 2020 to CY 2021. Asian/Pacific Islanders comprise one percent of Tehama's eligibles and fewer than 11 Asian/Pacific Islander beneficiaries were served in CY 2021.

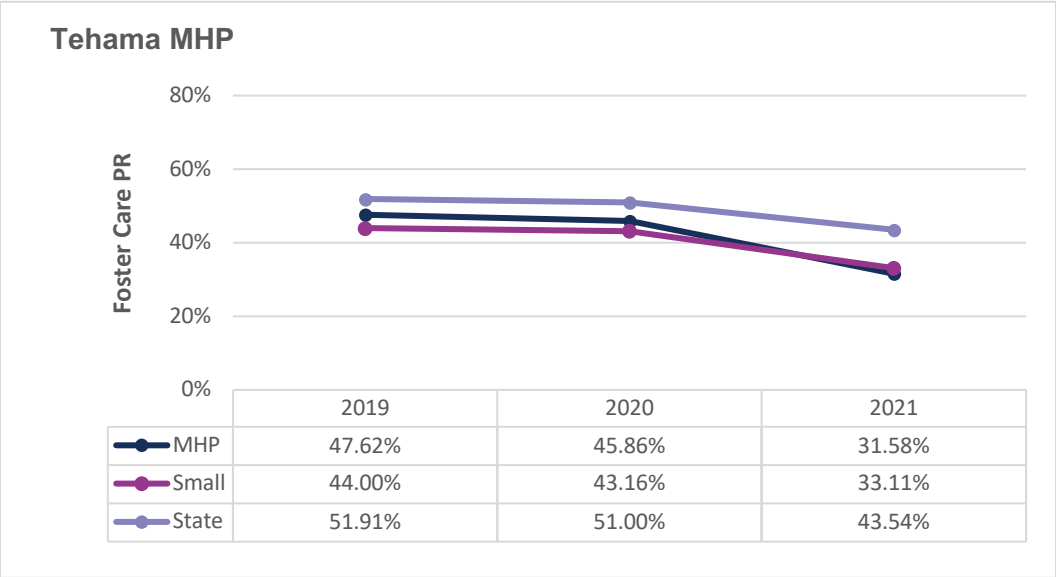
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$2,452	$1,486	$1,564
Small	$4,925	$5,690	$5,198
State	$6,325	$7,466	$6,816

- Asian/Pacific Islander AACB was well below the small county and statewide averages from CY 2019 to CY 2021, though as stated earlier, small numbers were served.

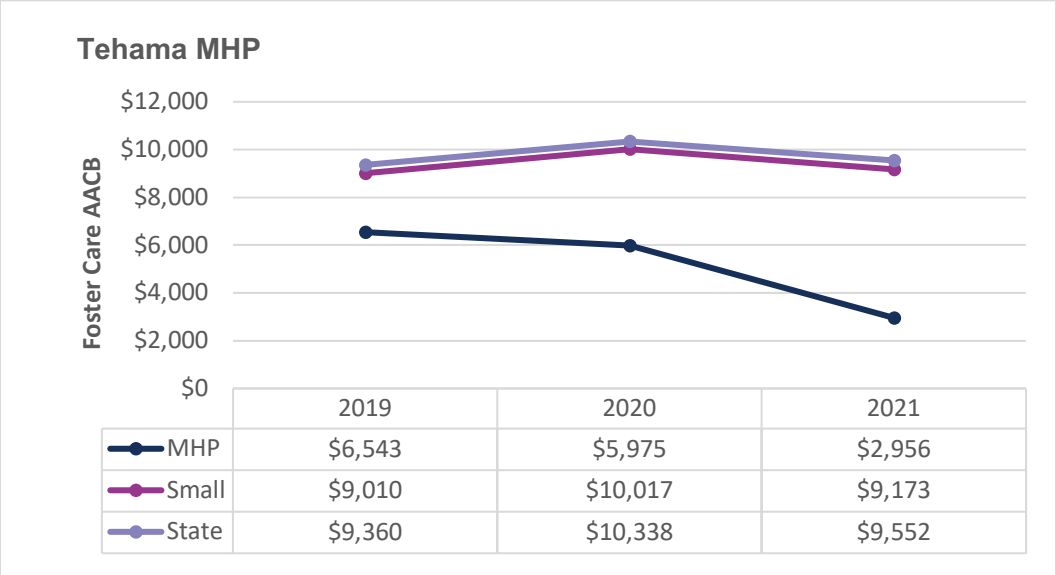
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	47.62%	45.86%	31.58%
Small	44.00%	43.16%	33.11%
State	51.91%	51.00%	43.54%

- FC penetration rates for small county, statewide averages, and Tehama declined from CY 2019 to CY 2021. Tehama's penetration rate is just below the small county average in CY 2021 (31.58 percent vs. 33.11 percent) but was 27.5 percent less than the statewide average (31.58 percent vs. 43.54 percent) and ranked 43rd of 56 MHPs. While there was a 5.52 percent decrease in FC eligibles from CY 2020 (181) to CY 2021 (171), the MHP served 34.94 percent fewer FC beneficiaries (83 vs. 54)

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$6,543	$5,975	$2,956
Small	$9,010	$10,017	$9,173
State	$9,360	$10,338	$9,552

- FC AACB decreased each year from CY2019 to CY 2021 and in CY 2021 was 69 percent less than the statewide average percent ($2,956 vs. $9,552). In CY 2021, FC AACB ranked 54th of 56 MHPs.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 557				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	14	2.5%	12	6	10.8%	14	8
Inpatient Admin	≤ 10	-	-	-	0.4%	16	7
Psychiatric Health Facility	36	6.5%	22	8	1.0%	16	8
Residential	≤ 10	-	-	-	0.3%	93	73
Crisis Residential	≤ 10	-	8	8	1.9%	20	14
Per Minute Services							
Crisis Stabilization	74	13.3%	1,105	990	9.7%	1,463	1,200
Crisis Intervention	64	11.5%	237	136	11.1%	240	150
Medication Support	270	48.5%	140	60	60.4%	255	165
Mental Health Services	278	49.9%	330	203	62.9%	763	334
Targeted Case Management	136	24.4%	709	261	35.7%	377	128

- Relatively fewer adults received planned SMHS: medication support, mental health services, and targeted case management. For those who received these services, the average and median units were significantly below statewide averages.
- Crisis stabilization services were provided at a higher rate than statewide, though for shorter periods of time. Increased use of crisis stabilization services may be associated with fewer proactively planned SMHS.
- Beneficiaries receiving Inpatient and psychiatric health facility (PHF) services were lower than statewide, but the PHF average length of stay was significantly longer than statewide (22 days vs. 16 days). Admissions to non-PHF inpatient hospitals had slightly shorter lengths of stay (12 days vs. 14 days).
- Data is suppressed if beneficiaries were ≤10.

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

Service Category	MHP N = 54				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	≤ 10	-	9	7	4.5%	13	8
Inpatient Admin	≤ 10	-	-	-	n ≤11	6	4
Psychiatric Health Facility	≤ 10	-	-	-	0.2%	25	9
Residential	≤ 10	-	-	-	n ≤11	140	140
Crisis Residential	≤ 10	-	-	-	0.1%	16	12
Full Day Intensive	≤ 10	-	-	-	0.2%	452	360
Full Day Rehab	≤ 10	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	≤ 10	-	2,124	1,200	2.3%	1,354	1,200
Crisis Intervention	≤ 10	-	282	282	6.7%	388	195
Medication Support	20	37.0%	215	145	28.5%	338	232
Therapeutic Behavioral Services	≤ 10	-	-	-	3.8%	3,648	2,095
Therapeutic FC	≤ 10	-	-	-	0.1%	1,056	585
Intensive Home Based Services	≤ 10	-	162	135	38.6%	1,193	445
Intensive Care Coordination	≤ 10	-	853	853	19.9%	1,996	1,146
Katie-A-Like	≤ 10	-	-	-	0.2%	837	435
Mental Health Services	42	77.8%	415	203	95.7%	1,583	987
Targeted Case Management	13	24.1%	96	70	32.7%	308	114

- Compared to statewide, FC youth had lower penetration rates for mental health services and targeted case management but a higher penetration rate for medication support.
- FC received fewer median units of service compared to statewide averages for the following service types: medication support, intensive home-based services, Intensive care coordination, mental health services and targeted case

management. Median units of service for crisis intervention exceeded comparable statewide data, but was delivered to a small number of beneficiaries.

- A significant amount of data was suppressed due to beneficiaries served being fewer than 11.

IMPACT OF ACCESS FINDINGS

- Consistent with the MHP's insufficient capacity, Tehama's penetration rate of 2.57 percent was 33.2 percent lower than the statewide average. Penetration rates were lower than corresponding statewide averages for all age groups. Tehama's AACB was significantly less than small county and statewide averages from CY 2019 to CY 2021. In CY 2021, Tehama's AACB was 44.2 percent less than the statewide average.
- In CY 2021, Tehama's Latino/Hispanic penetration rate ranking was the second lowest in the State, ranking 55th of 56 MHPs. AACB was 43.3 percent less than the statewide average.
- FC penetration rates declined statewide from CY 2020 to CY 2021. In CY 2021, Tehama's penetration rate was 27.5 percent less than the statewide average and ranked 43rd of 56 MHPs. FC AACB decreased each year from CY 2019 to CY 2021, and in CY 2021 it was 69 percent less than the statewide average. In CY 2021, FC AACB ranked 54th of 56 MHPs.

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	Not Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Not 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	Partially Met

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

- Mechanisms to routinely measure, extract, and examine time to key service points are not present in the MHP system. While the MHP has set timeliness standards, timeliness is not known, performance meeting the standards are not

known, and the EQR was not able to validate some of the calculations reported by the MHP.

- Review discussions indicate the timeliness and capacity for FC beneficiary requests are unmet. Child Welfare often directly refers beneficiaries to the contract providers and the time frames are not tracked. Reports for FC utilization and referral tracking were not provided.
- Capacity for psychiatry service appears insufficient. The MHP met its goal to first delivered psychiatry service in 15 business days 34 percent of the time. The no-show rate for psychiatry appointments is reported at 22 percent. The MHP did not conduct performance improvement activities; the MHP reports plans to start QI in this area. The MHP could consider developing a PIP in this area. Additional information follows in the report.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12 – 14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care for some access points and for only county-operated services for other access points. The MHP does not have the ability to separate out the data by age for some indicators and by type of service (psychiatry vs non-psychiatry).

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	9 Days	10 Business Days*	87%
First Non-Urgent Service Rendered	13 Days	10 days**	60%
First Non-Urgent Psychiatry Appointment Offered	***	15 Business Days*	***
First Non-Urgent Psychiatry Service Rendered	29 Days	15 Days**	34%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	***	48 Hours*	***
Follow-Up Appointments after Psychiatric Hospitalization	8 Days	7 Days**	18%
No-Show Rate – Psychiatry	22%	10%**	n/a
No-Show Rate – Clinicians	11%	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

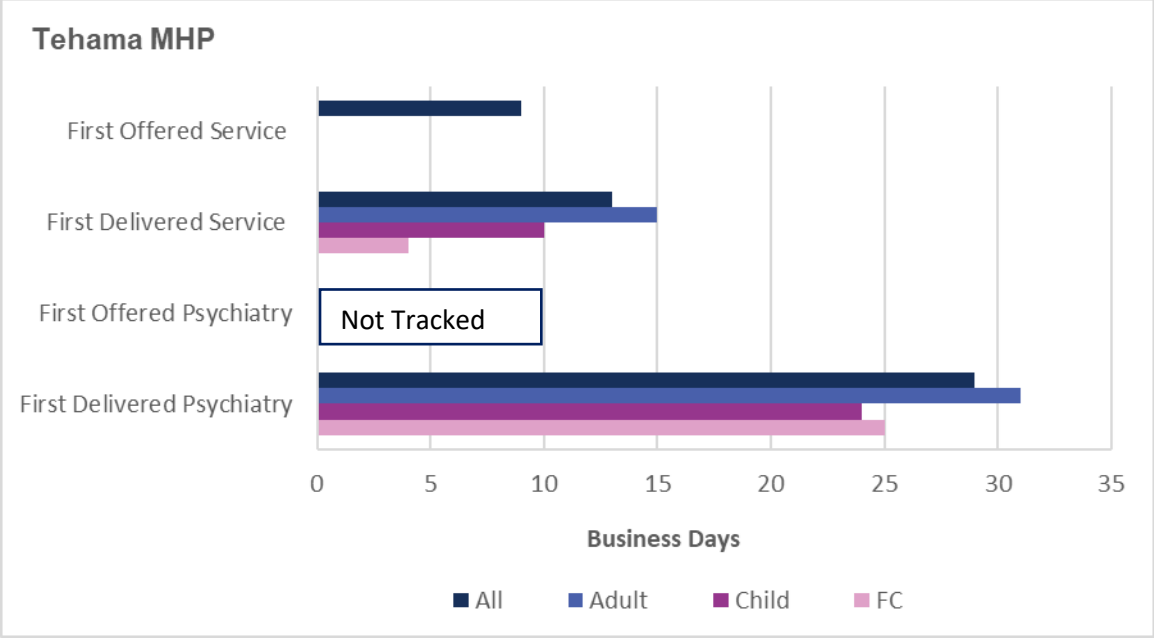


Figure 13: Wait Times for Urgent Services

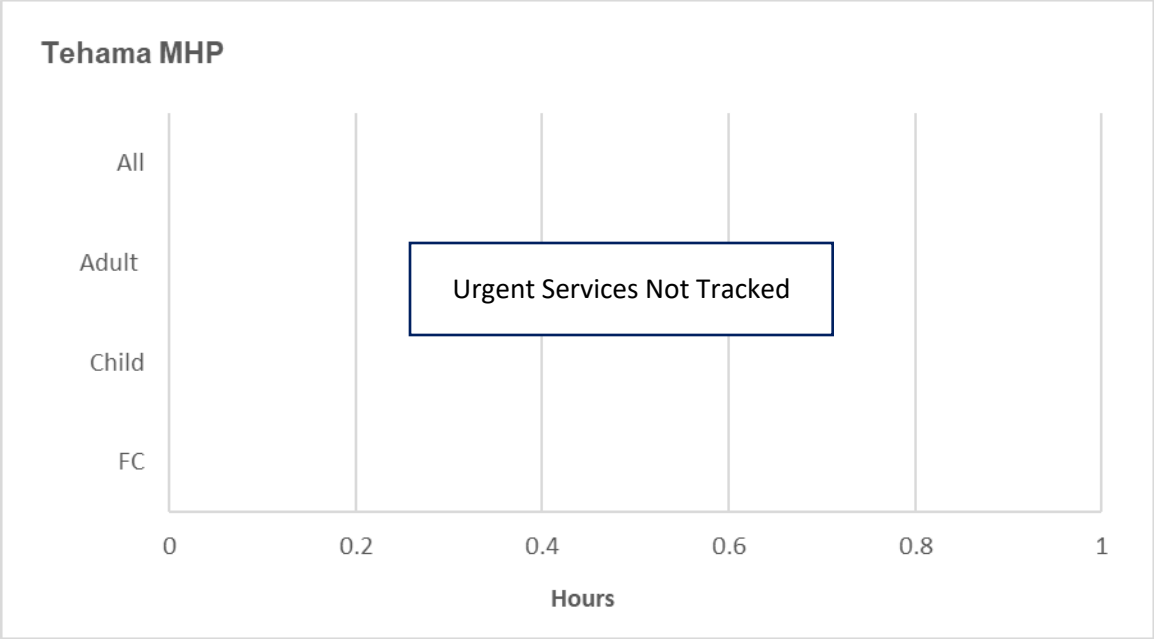
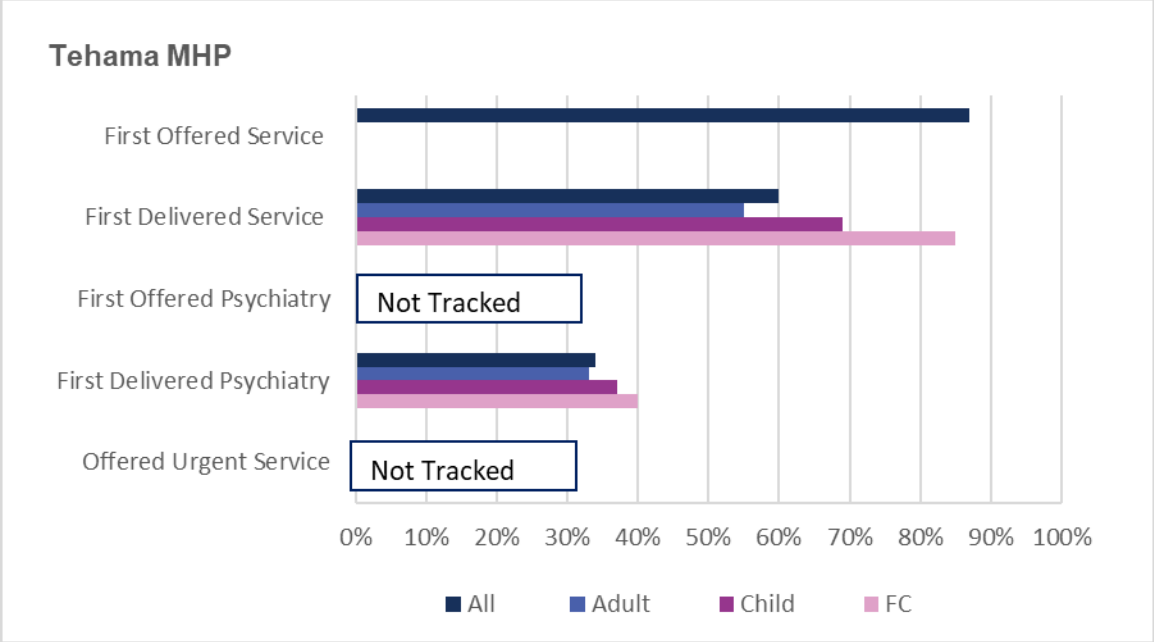


Figure 14: Percent of Services that Met Timeliness Standards



- 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 first scheduled mental health service. The MHP does not capture which type of first service is delivered and includes first assessment or psychiatry services.

- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” as an attempt to access services outside normal business hours or an emergent behavioral health need that required immediate intervention. However, the MHP did not report data for urgent services.
- Timely access to psychiatry may be defined by the County MHP. The process as well as the definitions and tracking may differ for adults and children. The MHP has defined psychiatry access in the submission as from the point of the beneficiary’s initial service request but does not track this measure and did not provide any related data.
- No-show tracking varies across MHPs and is often incomplete data due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 11 percent for clinicians and 22 percent for psychiatry in county operated services. The MHP does not track no-shows for contract provided services.

IMPACT OF TIMELINESS FINDINGS

- While the MHP’s measures are not complete, the MHP’s timeliness data are consistent with the severe workforce challenges it is navigating. The MHP’s ability to meet its timeliness standards are impacted by clinical and management staffing. Psychiatry services appear to be an area significantly challenged with delays.

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 an agency responsibility under the QA Manager, which has been vacant for three years. The MHP Deputy Director fills this responsibility in the interim and had been out on leave at the time of the review. The MHP recently hired consultants to help with PIPs and other QI areas.

The MHP reports that it monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. However, while the QIC, comprised of MHP staff, is scheduled to meet quarterly, it has only met once since the last EQR. Additionally, the MHP has not had a current QIWP since 2019; the MHP reports this is a long-term goal as extreme staffing shortages and clinical service provision are priority.

The MHP utilizes no level of care (LOC) tools.

The MHP utilizes the following outcomes tools: Child and Adolescent Needs and Strengths (CANS) Assessment Tool-50, Patient Health Questionnaire-9, Pediatric Symptom Checklist (PSC), and the Posttraumatic Stress Disorder Checklist. Document review shows that the MHP examined the number of completed CANS and PSC since FY 2018-19. Analysis of the results from CANS and PSC data on an individual or an aggregate level was not evident.

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	Not 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	Not Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Not Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Not Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Not Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Not Met

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

- A systematic organization-wide approach for measuring and improving access, timeliness and outcomes continues to be absent. Data-driven management is not established.
- The MHP collects outcome tool information but does not use the information for QM. The MHP plans to incorporate the information in the EHR which may increase its accessibility and use.
- The MHP offers a continuum of services but does use a level of care system or examine transitions in level of care. This is particularly important in times of workforce shortages.
- As reported earlier, the MHP does not conduct medication monitoring.
- The MHP does not use the beneficiary feedback data such as the Consumer Perception Survey (CPS) data.
- The MHP does not track or trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)

    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)
- The MHP offers a peer-run program through a contract provider for beneficiaries who are referred by a clinician. There is not a peer-run program in all the key geographic areas, and its staffing is by a majority of peer staff.
- While the MHP employs peer staff at a wellness center through a contract provider, a career ladder is not present.

QUALITY PERFORMANCE MEASURES

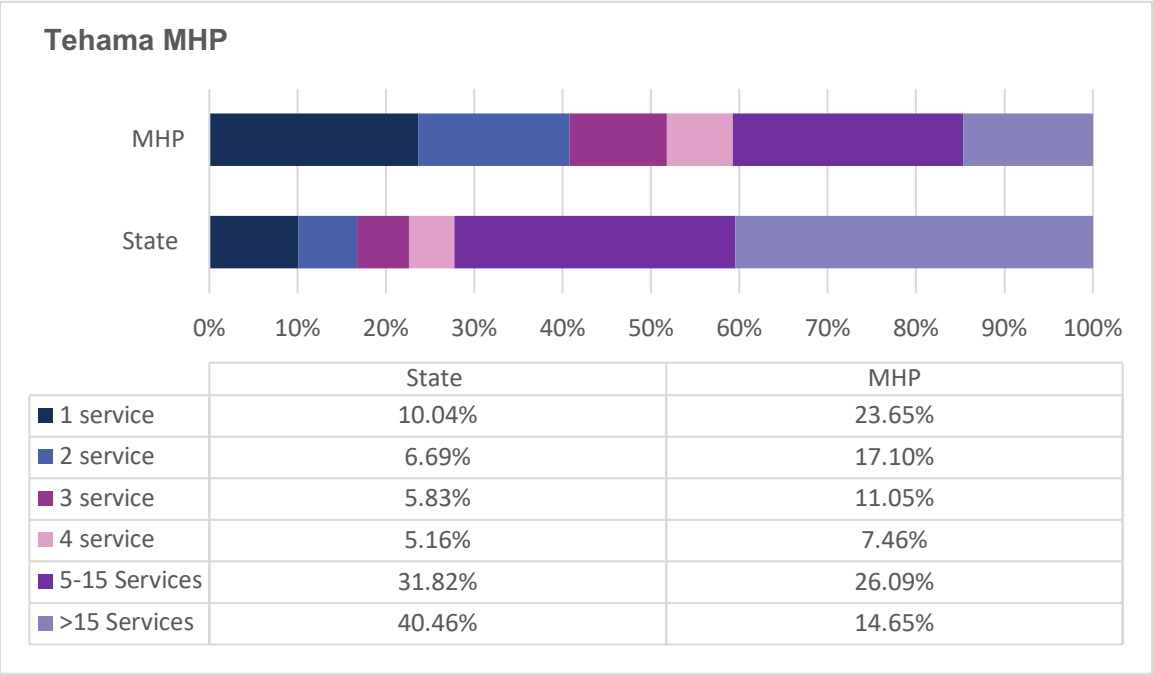
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



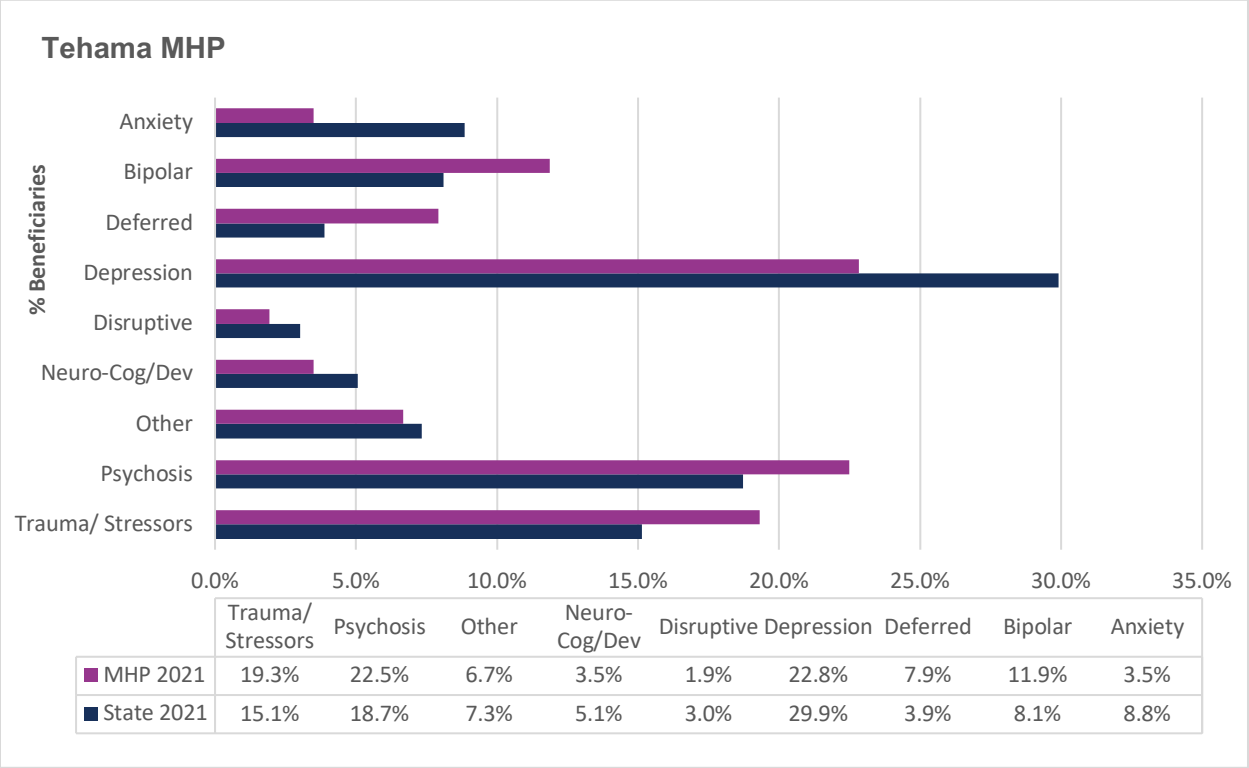
	State	MHP
1 service	10.04%	23.65%
2 service	6.69%	17.10%
3 service	5.83%	11.05%
4 service	5.16%	7.46%
5-15 Services	31.82%	26.09%
>15 Services	40.46%	14.65%

- A single service was provided to 23.65 percent of beneficiaries, more than twice the statewide average of 10.04 percent.
- One to three services were received by 51.8 percent of beneficiaries compared to 22.56 percent of beneficiaries statewide.
- More than 15 services were provided to 14.65 percent of beneficiaries, 63.8 percent lower than the 40.46 percent statewide average.
- More than 15 services were provided to 14.07 percent of Latino/Hispanic beneficiaries and 13.05 percent of White beneficiaries. FC youth had a comparable percentage of greater than 15 services, 14.81 percent.

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

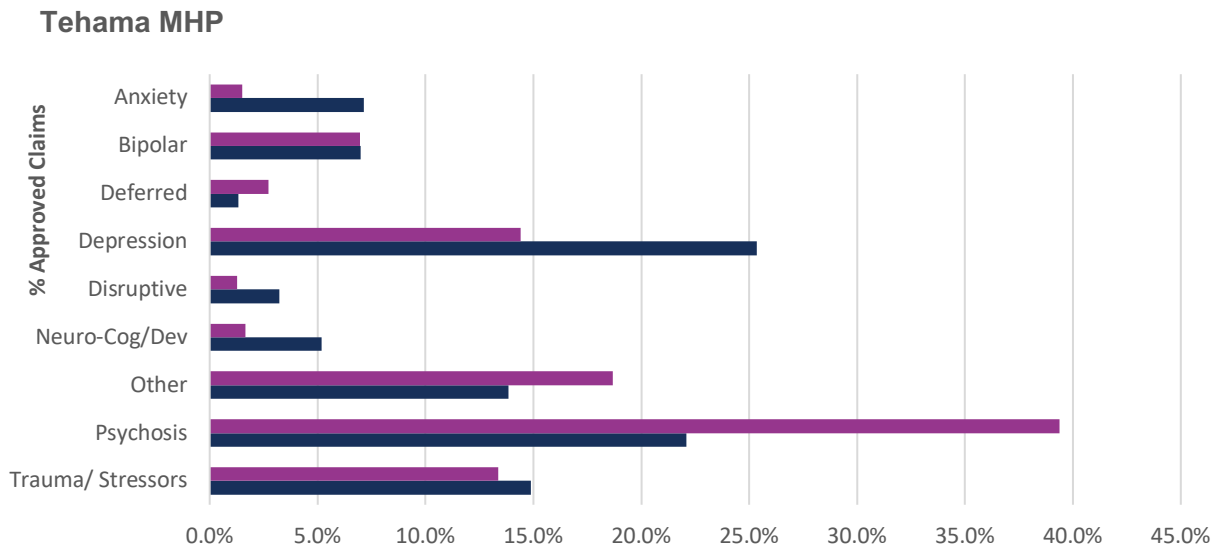
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	19.3%	22.5%	6.7%	3.5%	1.9%	22.8%	7.9%	11.9%	3.5%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- Approximately 65 percent of beneficiaries had one of three diagnoses: Depression (22.8 percent), psychosis (22.5 percent), and trauma/stressor (19.3 percent). The MHP shows relatively more psychotic disorders, bipolar disorders, and trauma disorders than statewide.

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



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	13.4%	39.4%	18.7%	1.7%	1.3%	14.4%	2.7%	7.0%	1.5%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- While serving 20.3 percent more beneficiaries with psychosis compared to the statewide average (22.5 percent vs. 18.7 percent), Tehama's spending for this group was 78.3 percent greater than the statewide average (39.4 percent vs. 22.1 percent). In a system with strained resources, allocating to those with the most severe conditions is likely necessary.

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.

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	73	129	10.11	8.79	$14,033	$12,052	$1,024,413
CY 2020	62	100	14.06	8.68	$17,563	$11,814	$1,088,935
CY 2019	83	131	9.88	7.80	$12,058	$10,535	$1,000,787

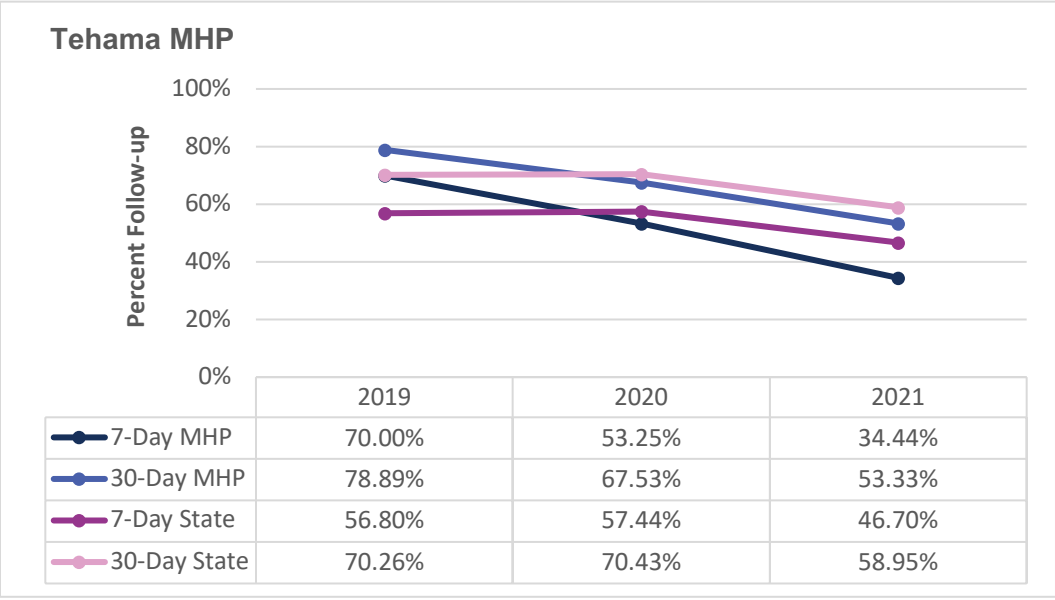
- While unique beneficiary count and total admissions increased from CY 2020 to CY 2021, LOS decreased and remains above the statewide average in CY 2021 (10.11 days vs. 8.79 days).

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 inpatient consolidated data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

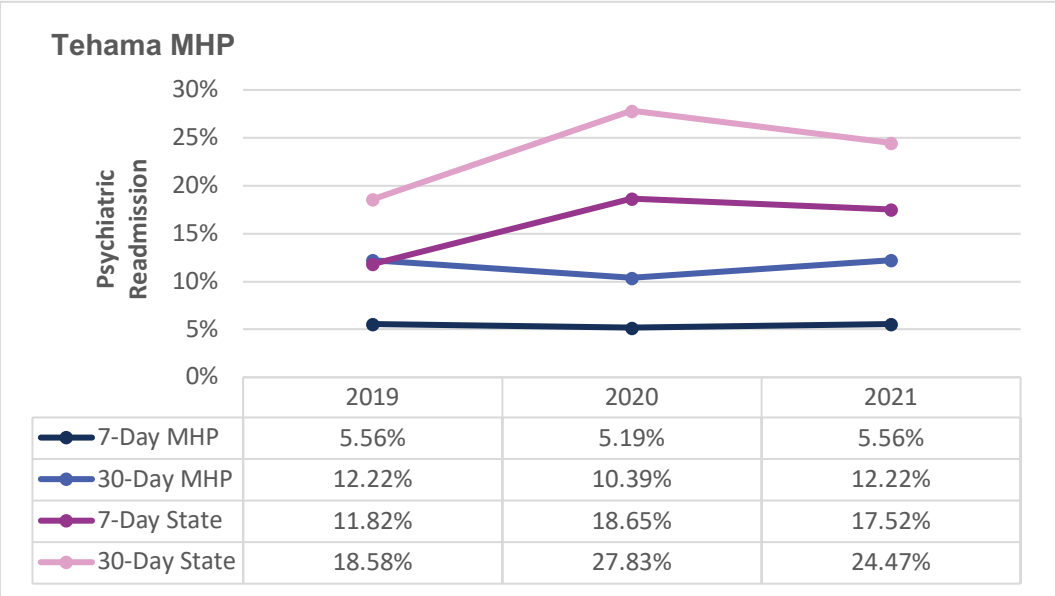
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	70.00%	53.25%	34.44%
30-Day MHP	78.89%	67.53%	53.33%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

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



	2019	2020	2021
7-Day MHP	5.56%	5.19%	5.56%
30-Day MHP	12.22%	10.39%	12.22%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The 7-day post psychiatric inpatient follow-up rate declined each year from CY 2019 to CY 2021 (70.00 percent vs. 53.25 percent vs. 34.44 percent) and was below the statewide average in CY 2021 (34.44 percent vs. 46.70 percent).
- The 30-day post psychiatric inpatient follow-up rate declined each year from CY 2019 to CY 2021 (78.89 percent vs. 67.53 percent vs. 53.33 percent) and was below the statewide average in CY 2021 (53.33 percent vs. 58.95 percent).
- The 7-day psychiatric readmission was stable from CY 2019 to CY 2021 (5.56 percent vs. 5.19 percent vs 5.56 percent) and was 68.3 percent lower than the CY 2021 statewide average (5.56 percent vs. 17.52 percent).
- The 30-day psychiatric readmission rate increased from CY 2020 to CY 2021 (10.39 percent vs 12.22 percent) but was 50 percent lower than the CY 2021 statewide average (12.22 percent vs. 24.47 percent).

High-Cost Beneficiaries

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

the beneficiary population that warrants close utilization review, both for appropriateness of level of care and expected outcomes.

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

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

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	3.46%	28.46%	$1,007,853,748	$53,476	$43,231
MHP	CY 2021	14	1.80%	27.05%	$762,884	$54,492	$46,452
	CY 2020	14	1.46%	23.57%	$935,198	$66,800	$57,302
	CY 2019	29	2.35%	25.16%	$1,337,127	$46,108	$40,142

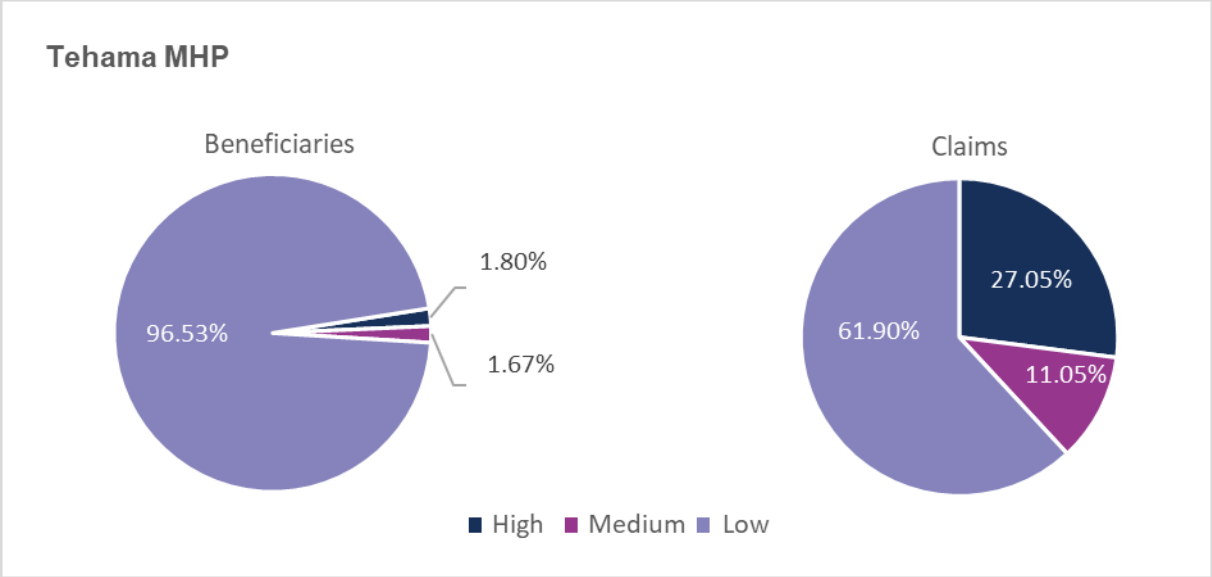
- While the number of high-cost beneficiaries was stable from CY 2020 to CY 2021 2021 (14), the percent of high-cost beneficiaries increased (from 1.46 percent to 1.80 percent) due to a decline in total beneficiaries served (960 vs. 778).
- The percent of high-cost beneficiaries in CY 2021 was 48 percent less than the statewide average (1.80 percent vs. 3.46 percent) and the average approved claim amount per high-cost beneficiary was comparable to the statewide average ($54,492 vs. $53,476) with 27.05 percent of claims vs. 28.46 percent of claims statewide.

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	13	1.67%	$311,743	11.05%	$23,980	$24,762
Low Cost (Less than $20K)	751	96.53%	$1,745,640	61.90%	$2,324	$991

- While low-cost beneficiaries comprised 96.53 percent of those served, 61.90 percent of approved claims dollars were spent on this subpopulation.

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



- While high-cost beneficiaries were 1.80 percent of those served, 27.05 percent of approved claims dollars were spent on this subpopulation.

IMPACT OF QUALITY FINDINGS

- MHP beneficiaries receive a low number of services (one to three services) compared to the statewide average performance. It is likely that the MHP's fiscal/billing and clinical staffing shortages are somewhat impacting claim submission timeliness as well as the number of services that can be delivered to beneficiaries.
- The CY 2021 percent of high-cost beneficiaries was significantly lower than the statewide average (1.80 percent vs. 3.46 percent). This figure may also be impacted by delayed claiming and fewer services provided per beneficiary.

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: No PIP submitted.

TA and Recommendations

Review discussions included suggesting the MHP develop PIPs in areas they already plan to conduct quality improvement activities in such as reducing no-shows to appointments.

BHC recommends the MHP seek TA early and often during the design and implementation of the PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: No PIP submitted.

[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

TA and Recommendations

Review discussions included suggesting the MHP develop PIPs in areas they already plan to conduct quality improvement activities in

BHC recommends the MHP seek TA early and often during the design and implementation of the PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart/myAvatar, which has been in use for less than one year. Currently, the MHP is actively implementing and conducting post implementation fine tuning the active modules which requires heavy staff involvement to fully develop.

Approximately 5.15 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). This is an increase from the prior year budget of 3.9 percent. The budget determination process for IS operations is under MHP control.

The MHP has 51 named users with log-on authority to the EHR, including approximately 46 county staff and 5 contracted medical staff. This is a significant decline from 91 named users noted in the prior year. The percent of services provided by MHP staff declined from 77 percent to 60 percent in the past year. Support for mental health users is provided by one full-time equivalent (FTE) IS technology position. Currently, this position is filled.

As of the FY 2022-23 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	0%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☒ Monthly	70%
Paper documents delivered to MHP IS	☒ Daily ☐ Weekly ☒ Monthly	30%
		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. Tehama has no plans to implement a PHR in the next two years.

Interoperability Support

The MHP is not a member or participant in an HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email and electronic consult. The MHP engages in electronic exchange of information with its contract provider organizations.

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	Not Met
4D	EHR Functionality	Partially Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

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

- The MHP migrated from a paper to electronic client chart with the implementation of myAvatar on June 1, 2022. The MHP is hosting the myAvatar system.
- As described earlier, the implementation of an EHR is a significant adjustment for staff. While the MHP continues to be short-staffed overall, staffing resources have been dedicated to ensuring that staff can receive ongoing myAvatar support. The MHP Business Operations Supervisor holds myAvatar office hours for one hour twice weekly and during this time staff can receive myAvatar clarifications and one on one refresher training. The myAvatar office hours will continue to be offered and promoted to staff for the foreseeable future.
- Avatar reporting will be done with Crystal Reports. To support additional data analytic needs, three Tehama County Health Services Agency analysts have been trained in the use of Microsoft's Power BI.
- The IT budget was reported to be 5.15 percent, reflecting a change from 3.9 percent in FY 2021-22.
- Telehealth services are available at the Red Bluff and Corning clinics.
- While 40 percent of services are provided by contract providers, no contract providers have full access to CCBH.
- To support coordination of care, utilization reviews, and data analysis, DUCHESS was implemented to permit outside provider data exchange.
- While contract providers currently do dual data entry into their EHR and myAvatar, the MHP is planning to achieve the capability to import contract providers 837 forms directly into myAvatar. A timeline for the availability of this functionality is not yet available.
- The MHP's CY 2021 denied claims rate of 13.36% significantly exceeds the CY 2021 statewide average of 2.78%.
- Due to significant fiscal/billing staff vacancies and turnover in CY 2021, the MHP experienced delayed claiming. The May 2022 claim was submitted in November

2022. The June 2022 claim had not been submitted at the time of the review in November.

- CSI submissions are current through May 2022. The MHP is working collaboratively with Netsmart on the availability of this functionality.
- While two-factor authentication to authorize user password change is not supported, the MHP is planning to implement this functionality in the next year.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

For the MHP, it appears that significant claims lag begins in July and likely represents approximately $950,000 in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through May 2022.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	1,054	$319,497	$26,653	8.34%	$292,844
Feb	1,014	$321,018	$42,631	13.28%	$278,387
Mar	829	$335,048	$54,906	16.39%	$280,142
April	822	$443,979	$113,486	25.56%	$330,493
May	789	$402,946	$106,290	26.38%	$296,656
June	697	$312,243	$2,961	0.95%	$309,282
July	528	$199,747	$2,033	1.02%	$197,714
Aug	541	$187,465	$7,688	4.10%	$179,777
Sept	198	$70,184	$4,286	6.11%	$65,898
Oct	169	$97,517	$1,739	1.78%	$95,778
Nov	44	$25,698	$0	0.00%	$25,698
Dec	0	$0	$0	0.00%	$0
Total	**6,685**	**$2,715,340**	**$362,673**	**13.36%**	**$2,352,667**

- Fiscal/billing vacancies and turnover resulted in delayed claiming beginning in July 2021. It was also noted that clinical vacancies began to impact service delivery more significantly at this time. Considering increased clinical vacancies and the impact this had on service delivery, the MHP is unsure of the complete

impact of the claims lag seen in the BHC data from July through December 2021. It is estimated that at least 35 percent of 2021 claims may be missing due to delayed claiming, and it is unknown what percentage of these claims may be submitted and approved for reimbursement.

- Due to ongoing fiscal/billing vacancies, the MHP has contracted with Netsmart to provide claims processing support. They are currently working collaboratively with Netsmart to prepare for the June 2022 claim submission. There is no estimate as to when this claim will be submitted.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	403	$321,052	88.52%
Service line is a duplicate and a repeat service procedure code modifier not present	17	$20,206	5.57%
Medicare Part B or Other Health Coverage must be billed before submission of claim	40	$14,073	3.88%
Beneficiary not eligible or non-covered charges	11	$5,084	1.40%
Other	1	$1,600	0.44%
NPI related	1	$658	0.18%
Total Denied Claims	473	$362,673	100.00%
Overall Denied Claims Rate	13.36%		
Statewide Overall Denied Claims Rate	2.78%		

- Tehama's claim denial rate for CY 2021 of 13.36 percent is significantly higher than the statewide average of 2.78 percent.

- Claims with denial codes claim/service lacks information which is needed for adjudication, Medicare Part B or other health coverage must be billed prior to the submission of this claim, and NPI related are generally rebillable within State guidelines upon successful remediation of the reason for denial.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- After previously maintaining a paper client chart, myAvatar was implemented on June 1, 20222. This was a significant achievement for the MHP.
- The migration from a paper to electronic chart is a significant undertaking and culture shift. MHP clinical staff is continuing to adjust to the new electronic environment and receive support from the MHP Business Operations Supervisor.

- The MHP experienced delayed claiming in CY 2021 due to fiscal/billing staff vacancies and turnover. Recognizing that their staffing issues are ongoing, the MHP has contracted with Netsmart for claiming support beginning with the June 2022 claim, but the timing was not yet known.
- Without contractor provider access to myAvatar, beneficiary health information is maintained in disparate electronic health records which limits 24/7 access to beneficiary health information.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The 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 did not provide information on CPS surveys.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

As part of the pre-review planning process, CalEQRO requested one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members, containing 8 to 10 participants each.

Consumer Family Member Focus Group One

CalEQRO requested consumers and family members of child/youth services at least half who initiated services in the preceding 12 months. The focus group was held virtually and included five participants; a Spanish language interpreter was used for this focus group. All consumers/family members participating receive and/or have a family member who receives clinical services from the MHP.

Participants had received services between one month to seven years. Services received include therapy, case management, and medication service. Two participants had begun services in the last year. Participants who started services this last year described access as difficult. One beneficiary waited six months for services and is now waiting for case management services. A parent of a child beneficiary reported waiting one month to begin services. The participant however felt confused because the child began therapy, and then the MHP referred the child to First Five and was informed that the child did not qualify for MHP services because "it was not big issues" and was referred to services at school. However, the parent does not understand why her child no longer qualifies for services.

Participants generally found services helpful once accessed. Some participants report receiving help whenever they need it, while some report that services are helpful but "not enough." All participants report feeling welcomed and respected, and felt a sense of hope. One participant received transportation assistance. All felt comfortable to request a change in provider if wanted.

Experience with crisis services was mixed. Some accessed services at the crisis stabilization unit and experienced "no help at all." One participant had been referred to the wellness center. No participants had been asked to provide input to the MHP.

Recommendations from focus group participants included:

- Build housing for individuals who are homeless.
- Provide more services to those who need them.
- Provide more clear information why beneficiaries do not quality for services.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The MHP reported that increasing the ways to collect consumer and family member input is a QI goal. Anecdotally, the MHP reported receiving some feedback through grievances requesting a higher intensity of services. Beneficiary input from this review aligns with the MHP's observation.

CONCLUSIONS

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

STRENGTHS

1. The MHP migrated from a paper to an electronic client chart with the implementation of myAvatar.
2. The MHP partnered with a rural health clinic and co-located MHP medication services at the clinic in order to provide oversight of psychiatry and medication support services.
3. The MHP continues to increase contract provider services improving access to services for Medi-Cal beneficiaries.
4. The MHP is piloting an expedient hiring process to assist recruitment.
5. Representing more approved claims, intensive service delivery appears available to those beneficiaries with psychotic disorders.

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP is providing fewer services to fewer beneficiaries as a result of its severe staffing shortages at both county and contracted agencies. Capacity does not meet beneficiary demand for services. Despite increases in contract services, service delivery gaps persist and impact quality and access. (Access)
2. The MHP does not have an executive management team or clinical supervision in place. These are critical areas to address to establish the quality management structure and ensure appropriate care delivery. (Quality, Business Operations)
3. Mechanisms to measure, monitor,ensure, and communicatestandards, MHP expectations, training, coordination of annual peer review or other reviews of prescribing practices, and psychiatric care, are absent. (Quality)
4. The MHP continues to not have any active PIPs. An ongoing structure to improve quality priorities is not present. (Quality)
5. The MHP's FC penetration rates continue to decline. Mechanisms to monitor, ensure, and manage access and outcomes are not established. (Access, Quality, IS)
6. The MHP does not use a level of care tool to assist identifying high-need or high-risk beneficiaries.

7. The MHP does not yet have Avatar reporting for key timeliness and other QI indicators. (Quality)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the MHP in its QI efforts and ultimately to improve beneficiary outcomes:

1. Ensure active contract provider participation as the MHP continues to identify barriers, develop a strategic plan, and initiate solutions to both filling vacant positions and improving staff retention to increase capacity across the MHP continuum to provide SMHS to beneficiaries. (Access)

   (This recommendation is a carry-over from FY 2021-22.)
2. Consult with similar size and geographically nearby MHPs and collect strategies, experiences, and resources for hiring QI consultants and/or expanding other administrative resources needed. (Quality)
3. Prioritize a detailed and assertive plan for quality oversight functions including clinical oversight as steps to stabilize the MHP and focus on clinical oversight and access management. (Quality)
4. Implement oversight of psychiatry services, including medication monitoring. (Access, Quality)

   (This recommendation is a carry-over from FY 2018-19, FY 2019-20, FY 2020-21, and FY 2021-22.)
5. Implement two PIPs in priority quality areas. Review the MHP's current priorities for improvement as potential projects to implement within the PIP structure. (Quality)
6. Complete an assessment of mechanisms to monitor all FC referrals, access, and course of treatment. Identify barriers and implement routine processes to monitor and ensure timely access and appropriate level of care. (Access, Timeliness, Outcomes)
7. Given delays at entry, rely upon a level of care tool to identify high-need and high-risk beneficiaries who need to be prioritized for care. (Access, Quality)
8. Develop Avatar reporting for key timeliness measures and other critical quality indicators. (Timeliness, Quality)

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

EXTERNAL QUALITY REVIEW BARRIERS

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

The EQR completed a limited review. The MHP lacks leadership and key staff did not participate in the review. Informants to fully represent the MHP were not present because of either vacancies or not participating in the review for a variety of reasons.

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, either individually or in combination with other sessions.

Table A1: CalEQRO Review Agenda

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

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rowena Nery, Lead Reviewer
Lisa Farrell, Information Systems Reviewer
MaryEllen Collins, Consumer/Family Member Consultant

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
Barwick	Curtis	Behavioral Health Clinician III	Tehama County Behavioral Health
Bottke	Jayme	Executive Director	Tehama County Health Services Agency
Burton	Stephanie	Psychiatric Aide II	Tehama County Behavioral Health
Garcia	Jovita	Behavioral Health Clinician II	Tehama County Behavioral Health
Gee	Deanna	Asst. Executive Director, Administration	Tehama County Behavioral Health
Hyde	Kaare	Behavior Health Clinician I	Tehama County Behavioral Health
Lyon	Jennifer	Executive Director	Victor Community Support Services
Osgood-Cooper	Isobel	Behavioral Health Director & Clinical Supervisor	Lassen Counseling @ Children First Counseling Center
Ross	Alexis	Asst. Executive Director, Program	Tehama County Health Services Agency
Shugars	Troy	Clinical Supervisor	Remi Vista, Inc.

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 did not submit a Clinical PIP.

General PIP Information
MHP/DMC-ODS Name:
PIP Title:
PIP Aim Statement:
Date Started:
Date Completed:
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):

General PIP Information
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
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): Click or tap here to enter text.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☐ Yes ☐ No

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

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:

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 did not submit a Non-Clinical PIP.
General PIP Information	
MHP/DMC-ODS Name:	
PIP Title:	
PIP Aim Statement:	
Date Started:	
Date Completed:	
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):	
Improvement Strategies or Interventions (Changes in the PIP)	

General PIP Information
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
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): Click or tap here to enter text.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☐ Yes ☐ No

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

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:

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

TEHAMA COUNTY HEALTH SERVICES AGENCY

JAYME BOTTKE
EXECUTIVE DIRECTOR

DEANNA GEE
ASSISTANT EXECUTIVE DIRECTOR, ADMINISTRATION

ALEXIS ROSS, MPH, MSDA
ASSISTANT EXECUTIVE DIRECTOR, PROGRAM

BEHAVIORAL HEALTH
1860 WALNUT STREET, BUILDING A
MAILING ADDRESS: PO BOX 400, RED BLUFF, CA 96080

(530) 527-5631
FAX (530) 527-0232
24-HOUR CRISIS UNIT
(530) 527-5637

January 24, 2023

Samantha Fusselman, LCSW, CPHQ
Executive Director, CalEQRO
Behavioral Health Concepts, Inc.
2340 Powell St. #334
Emeryville, CA 94608

Dear Samantha,

On December 22, 2020 and in response to a surge in COVID-19 cases in the state, the Department of Health Care Services (DHCS) approved a pause on EQRO review activities through March 1, 2021. DHCS further approved flexibilities beyond March 1, 2021, as the COVID pandemic continued to impact county operations.

Accordingly, Tehama County requested flexibility during the November 2022 EQRO review. Specifically, Tehama requested additional and ongoing Technical Assistance from BHC in order to design and implement Performance Improvement Projects (PIPs) in preparation for next EQRO (2023) as staffing challenges have led to a lack of active PIPs since 2019. The Quality Assurance Manager (QAM) position was recently filled in December, 2022 after being vacant since January, 2020. Tehama County is therefore requesting flexibility because of one or more of the following related challenges:

- X Lack of staff/resources
- ☐ Staff have been reassigned to other departments
- ☐ Lack of infrastructure
- ☐ Additional factors:_____

Please attach this letter to our FY2022-2023 annual report.

Sincerely,

Alexis Ross
Assistant Executive Director, Program
Tehama County Health Services Agency

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

Tehama 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	30,245	999	3.30%	$2,809,797	$2,813
CY 2020	28,022	960	3.43%	$3,968,476	$4,134
CY 2019	26,878	1,233	4.59%	$5,315,081	$4,311

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

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	3,416	19	0.56%	1.27%	1.96%
Ages 6-17	7,861	265	3.37%	5.74%	5.93%
Ages 18-20	1,532	43	2.81%	4.89%	4.41%
Ages 21-64	14,855	632	4.25%	4.73%	4.56%
Ages 65+	2,582	40	1.55%	2.45%	1.95%
Total	**30,245**	**999**	**3.30%**	**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	56	5.61%
Threshold language source: Open Data per BHIN 20-070		

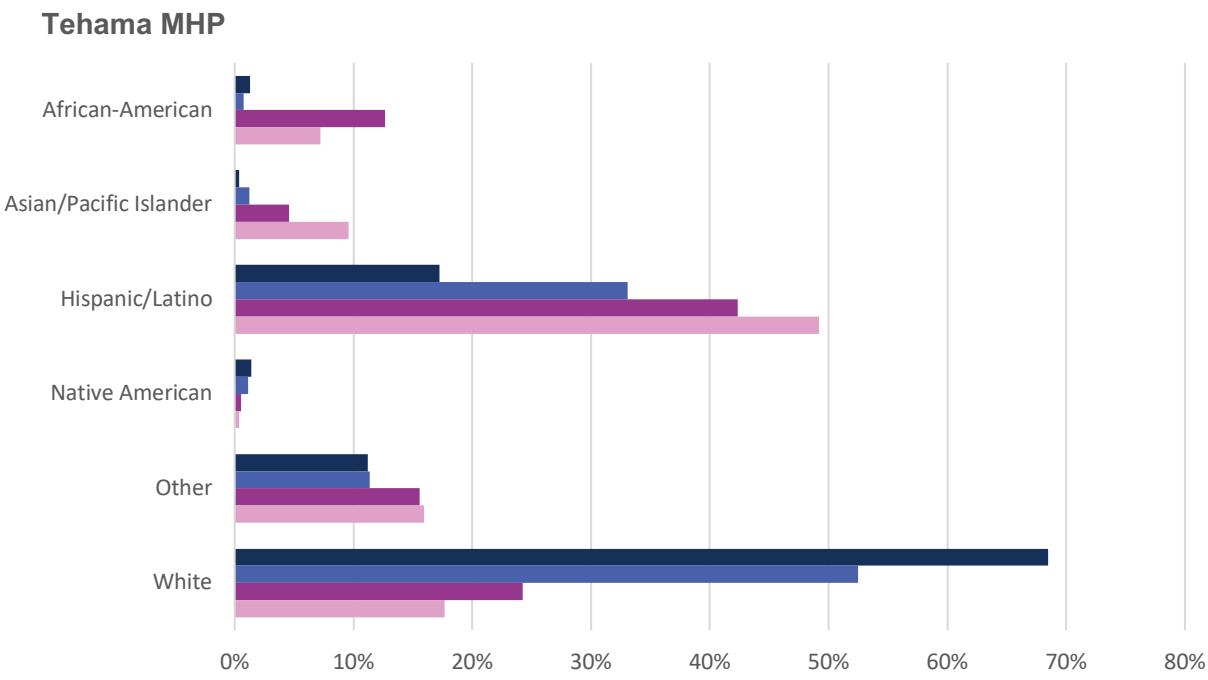
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	7,272	227	3.12%	$428,803	$1,889
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	231	-	-	7.64%
Asian/Pacific Islander	380	<11	-	2.08%
Hispanic/Latino	9,999	172	1.72%	3.74%
Native American	336	14	4.17%	6.33%
Other	3,434	112	3.26%	4.25%
White	15,868	684	4.31%	5.96%
Total	**30,248**	**999**	**3.30%**	**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	68%	11%	1%	17%	0%	1%
MHP % Eligible	52%	11%	1%	33%	1%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

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

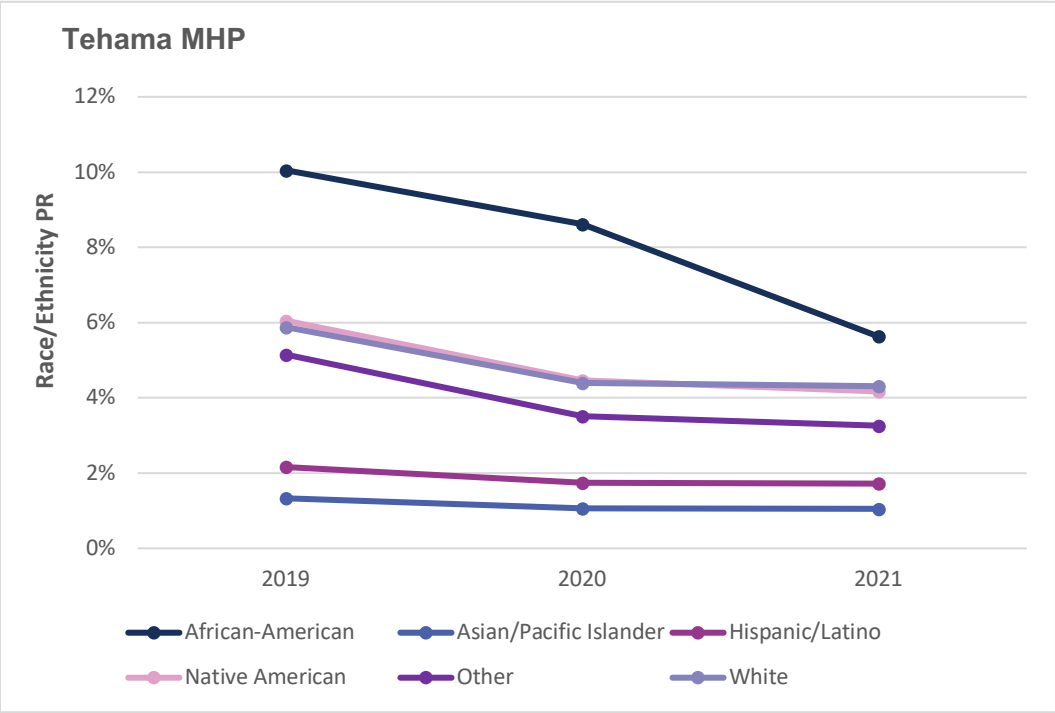


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

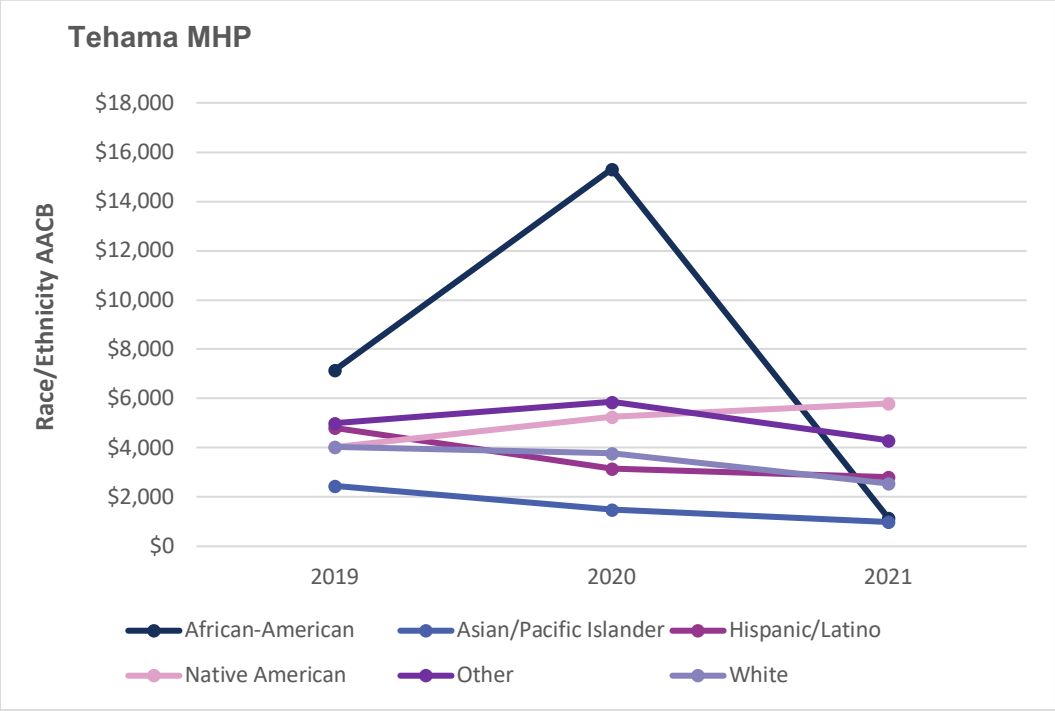
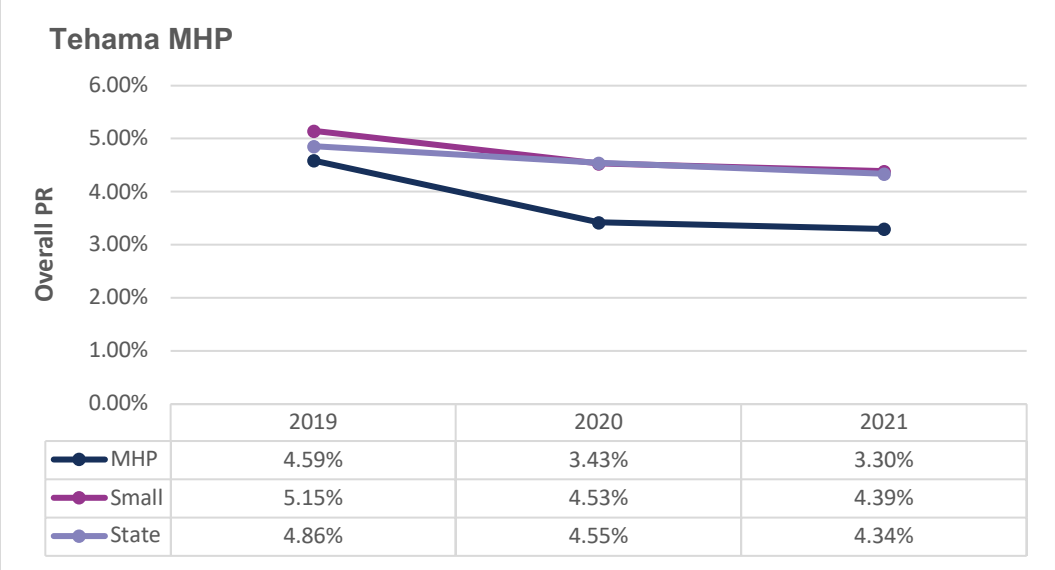
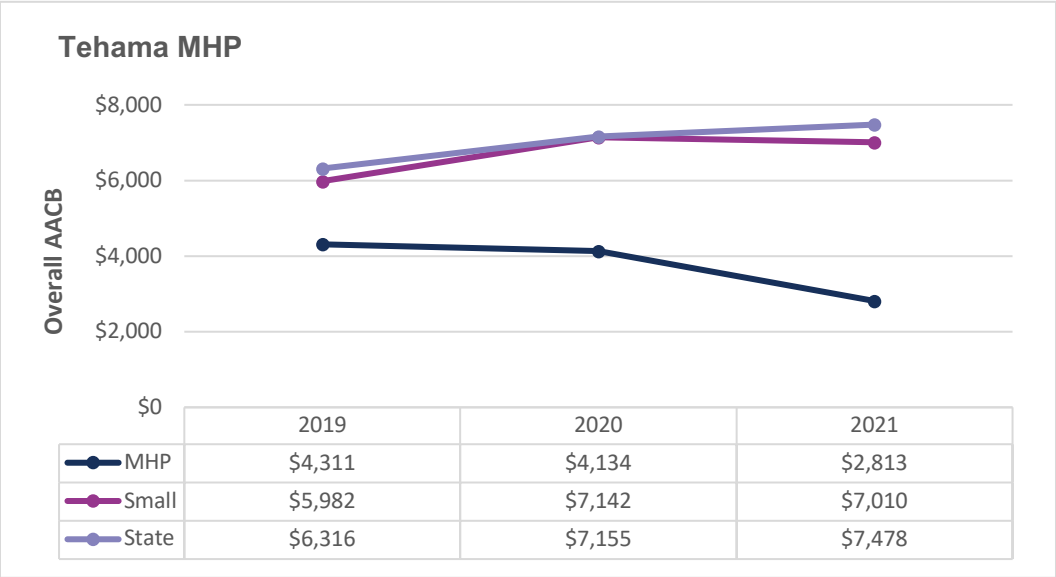


Figure 4: Overall PR CY 2019-21



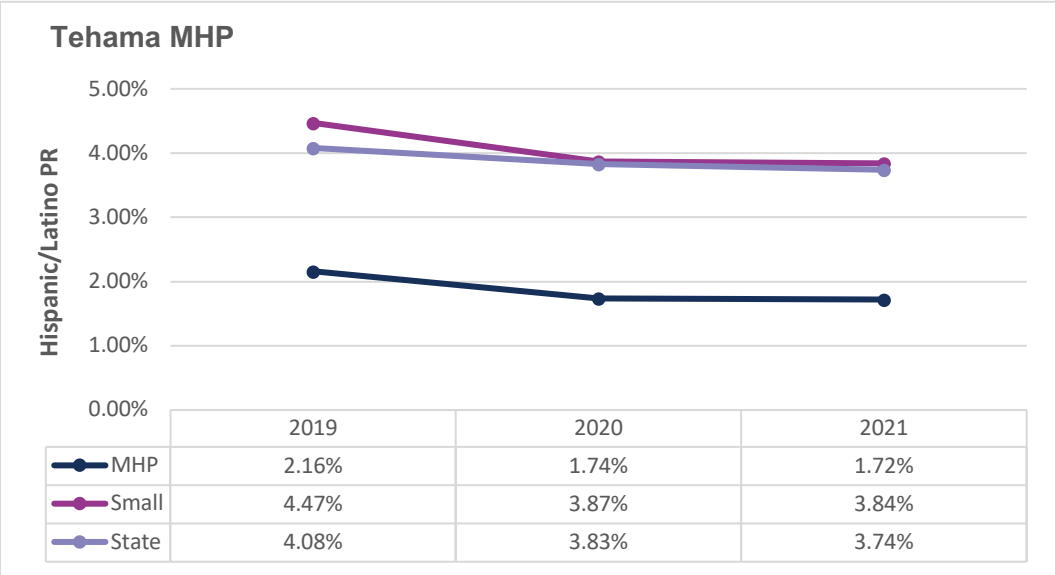
	2019	2020	2021
MHP	4.59%	3.43%	3.30%
Small	5.15%	4.53%	4.39%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



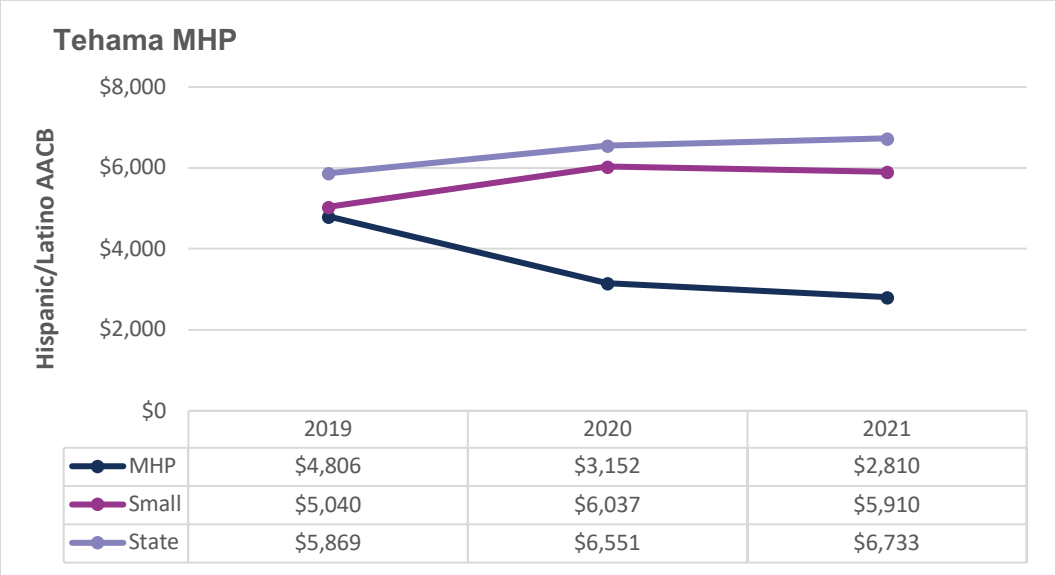
	2019	2020	2021
MHP	$4,311	$4,134	$2,813
Small	$5,982	$7,142	$7,010
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21



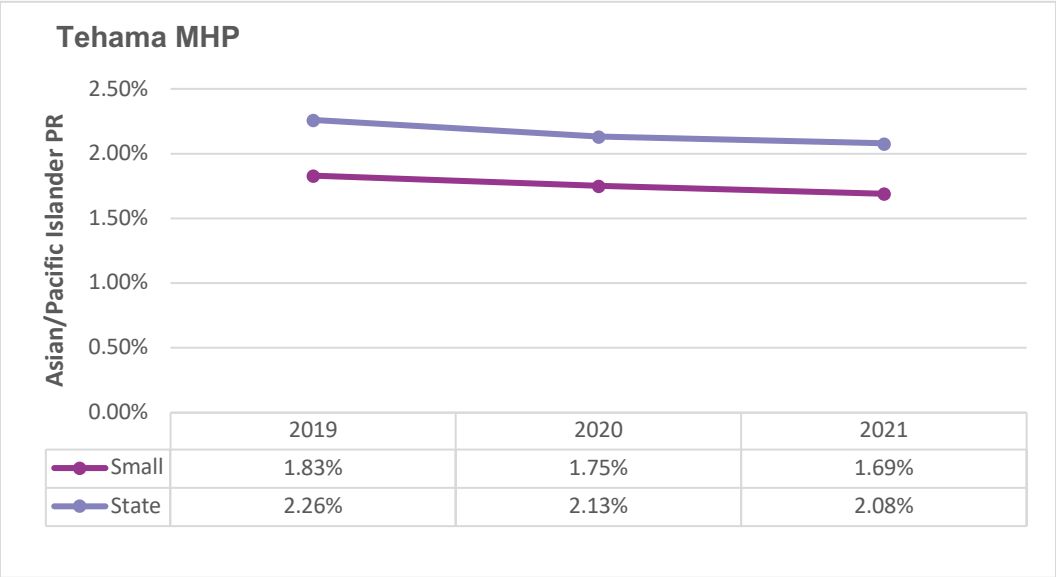
	2019	2020	2021
MHP	2.16%	1.74%	1.72%
Small	4.47%	3.87%	3.84%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,806	$3,152	$2,810
Small	$5,040	$6,037	$5,910
State	$5,869	$6,551	$6,733

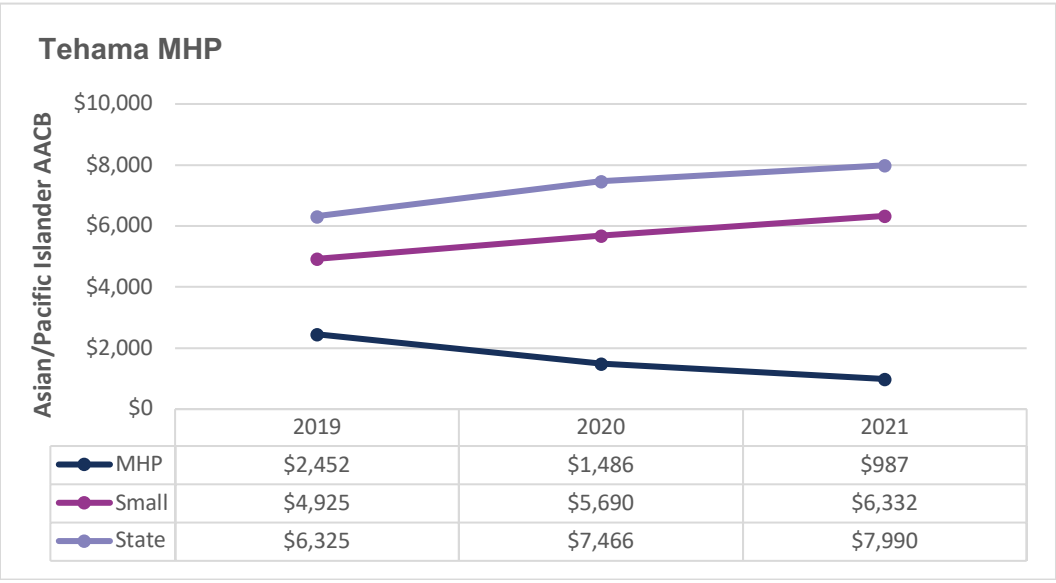
Figure 8: Asian/Pacific Islander PR CY 2019-21



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

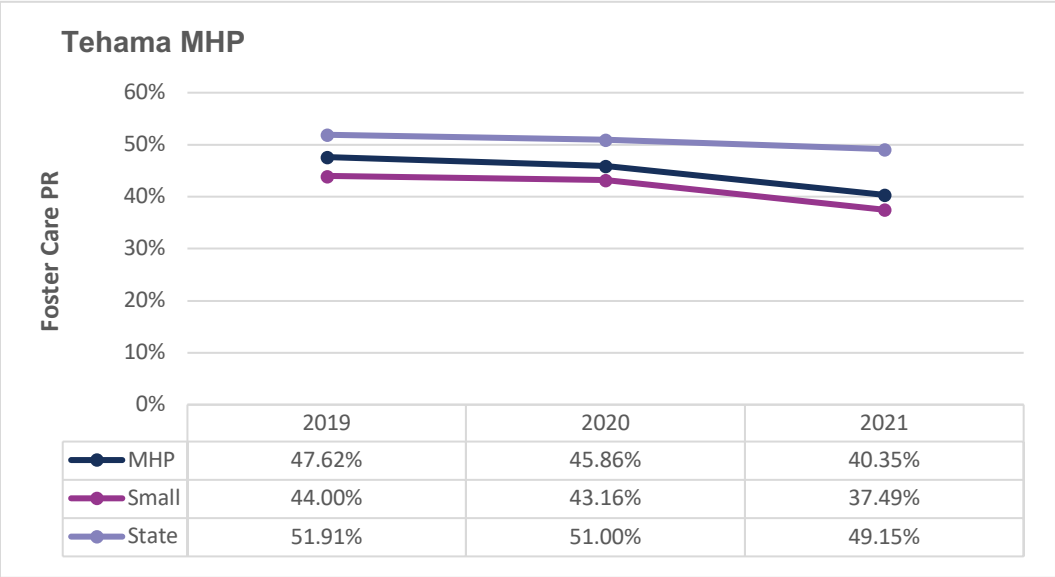
*The MHP's data is not displayed above due to the small number of beneficiaries represented.

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



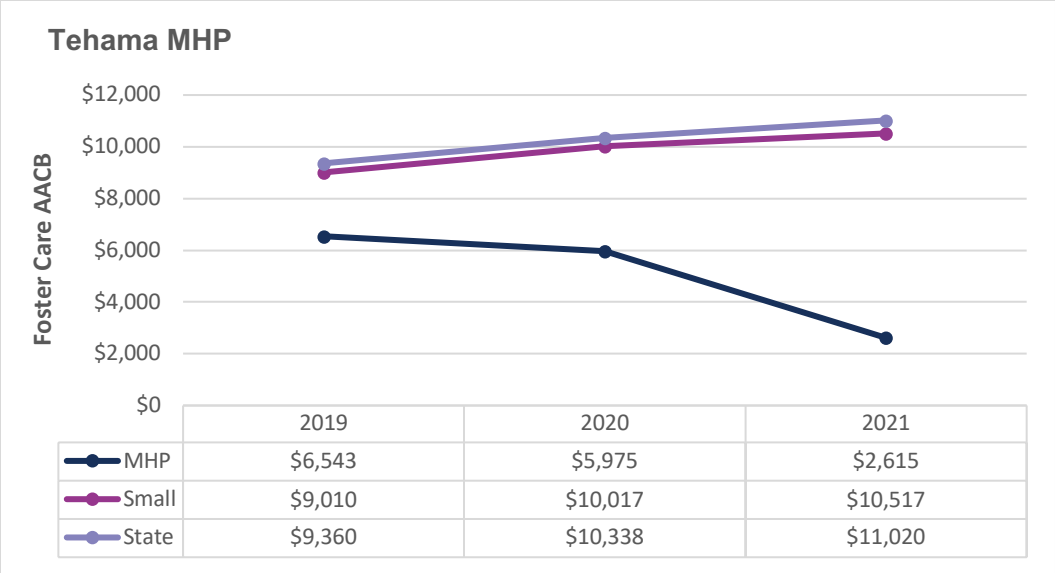
	2019	2020	2021
MHP	$2,452	$1,486	$987
Small	$4,925	$5,690	$6,332
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	47.62%	45.86%	40.35%
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	$6,543	$5,975	$2,615
Small	$9,010	$10,017	$10,517
State	$9,360	$10,338	$11,020

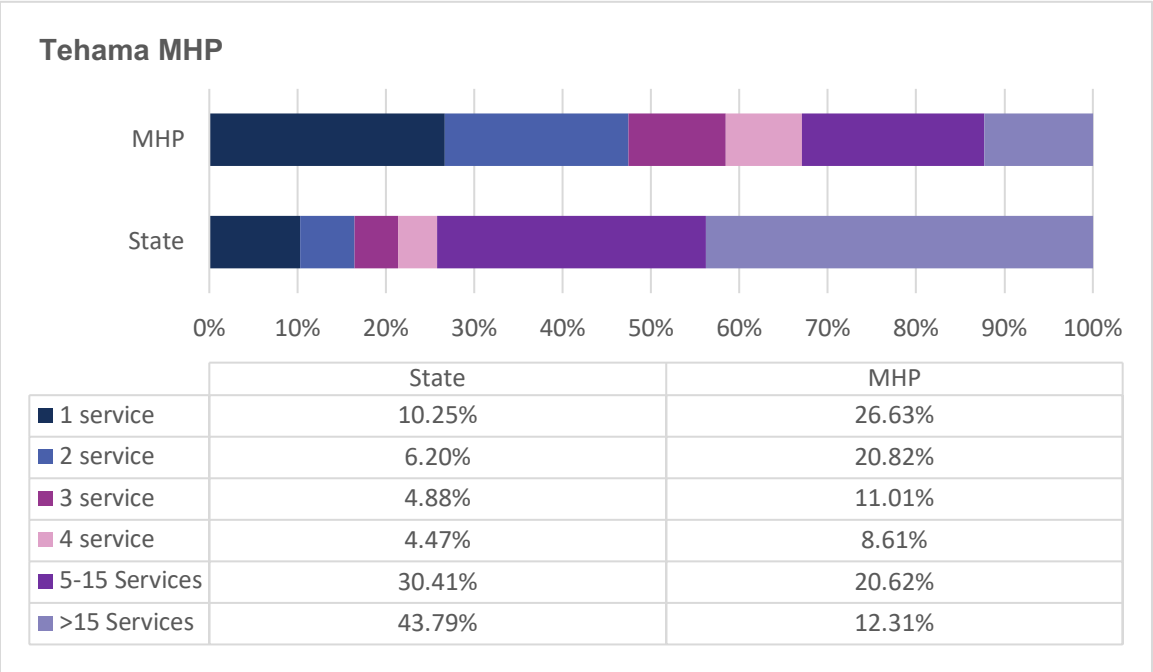
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 715				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	16	2.2%	14	7	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	48	6.7%	2	1	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	<11	-	8	8	2.2%	21	14
Per Minute Services							
Crisis Stabilization	109	15.2%	647	480	13.0%	1,546	1,200
Crisis Intervention	73	10.2%	236	132	12.8%	248	150
Medication Support	340	47.6%	122	60	60.1%	311	204
Mental Health Services	453	63.4%	318	210	65.1%	868	353
Targeted Case Management	160	22.4%	787	291	36.5%	434	137

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

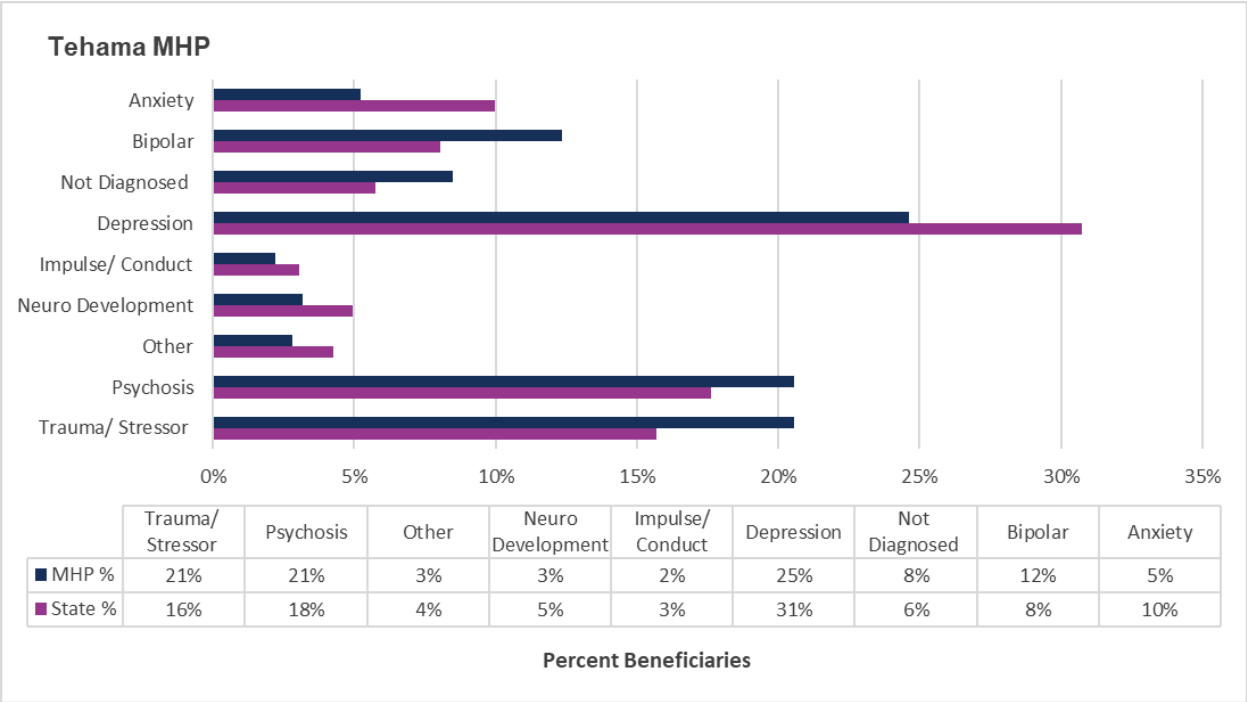
Service Category	MHP N = 68				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	9	7	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	969	960	3.1%	1,404	1,200
Crisis Intervention	<11	-	230	209	7.5%	406	199
Medication Support	20	29.4%	214	122	28.2%	396	273
TBS	<11	-	3,359	3,359	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	<11	-	248	159	40.2%	1,354	473
Intensive Home Based Services	<11	-	2,469	2,469	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	63	92.6%	375	150	96.3%	1,854	1,108
Targeted Case Management	14	20.6%	122	81	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



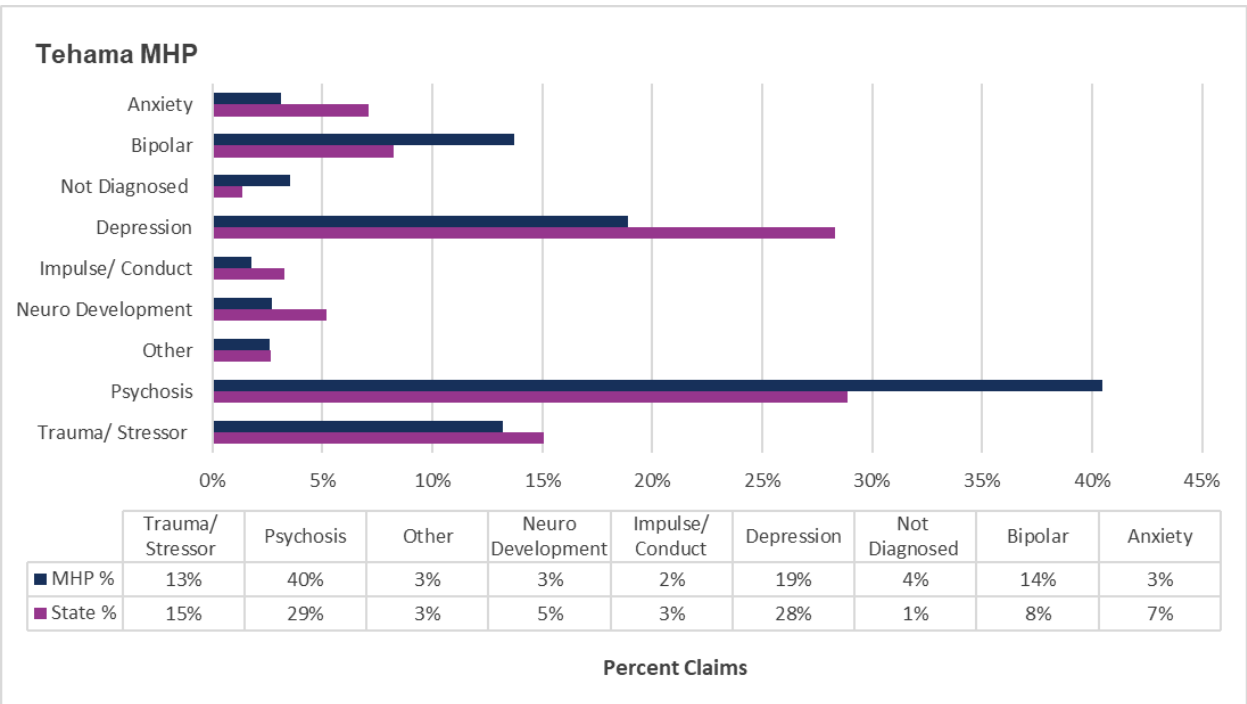
	State	MHP
1 service	10.25%	26.63%
2 service	6.20%	20.82%
3 service	4.88%	11.01%
4 service	4.47%	8.61%
5-15 Services	30.41%	20.62%
>15 Services	43.79%	12.31%

Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	21%	21%	3%	3%	2%	25%	8%	12%	5%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

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

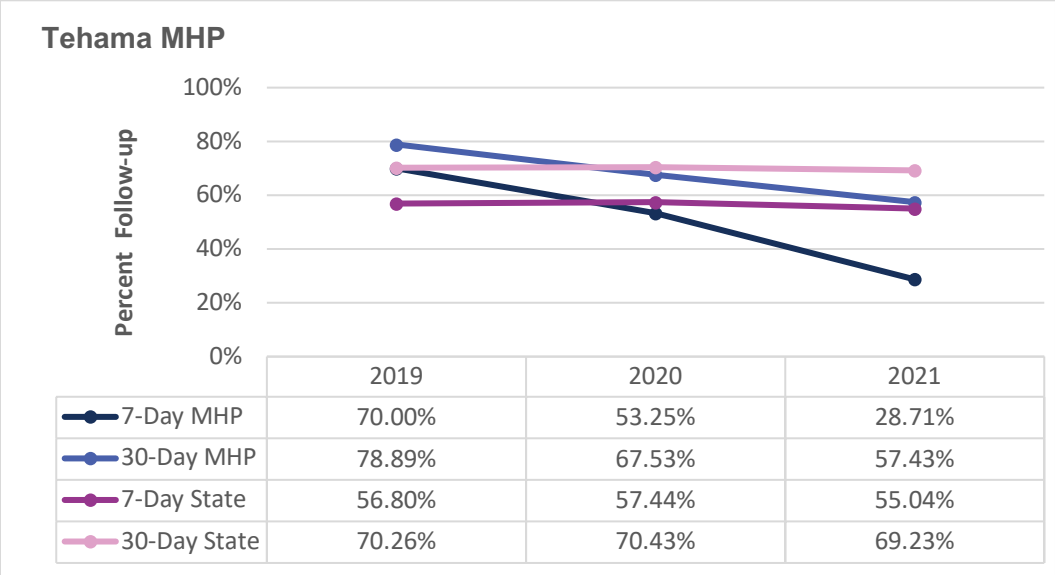


	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	13%	40%	3%	3%	2%	19%	4%	14%	3%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Table 13: Psychiatric Inpatient Utilization CY 2019-21

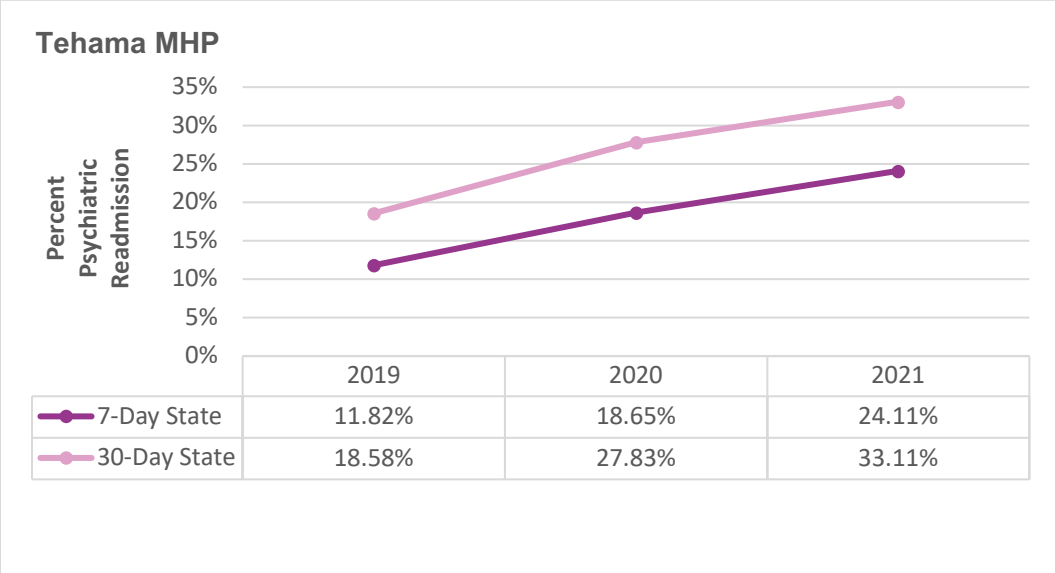
Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	90	151	5.24	8.86	$7,350	$12,052	$661,523
CY 2020	62	100	14.06	8.68	$17,563	$11,814	$1,088,935
CY 2019	83	131	9.88	7.80	$12,058	$10,535	$1,000,787

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



	2019	2020	2021
7-Day MHP	70.00%	53.25%	28.71%
30-Day MHP	78.89%	67.53%	57.43%
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



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

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	<11	-	16.72%	$469,671	$46,967	$39,287
	CY 2020	14	1.46%	23.57%	$935,198	$66,800	$57,302
	CY 2019	29	2.35%	25.16%	$1,337,127	$46,108	$40,142

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)	<11	-	8.88%	$249,401	$24,940	$25,600
Low Cost (Less than $20K)	979	98.00%	74.41%	$2,090,725	$2,136	$943

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

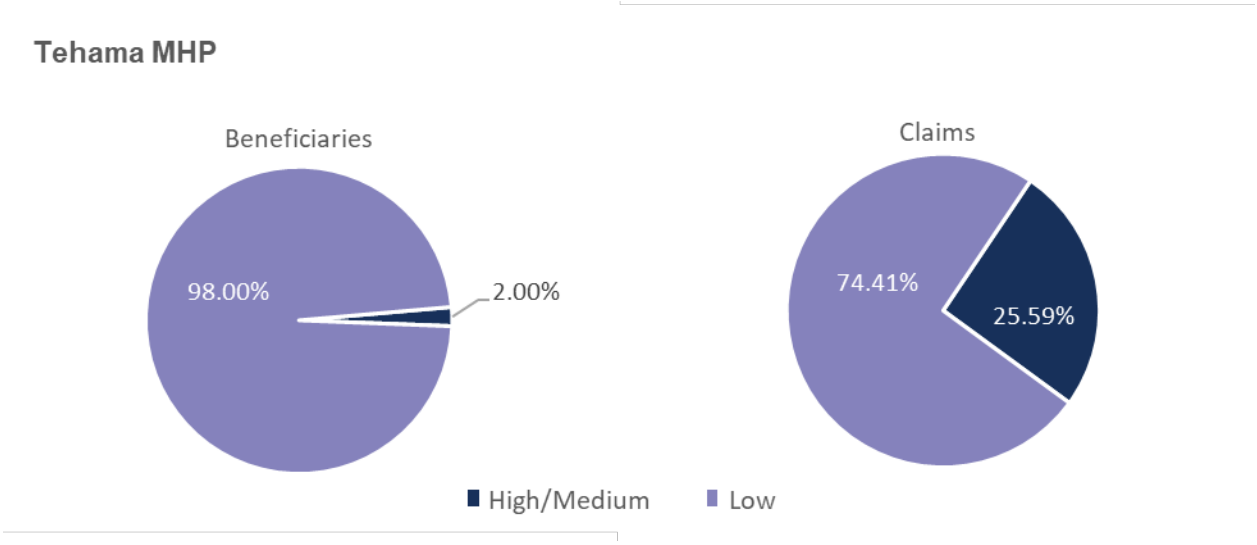


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	821	$245,298	$0	0.00%	$236,830
Feb	742	$216,125	$0	0.00%	$200,778
Mar	748	$235,985	$1,734	0.73%	$227,962
April	589	$232,008	$214	0.09%	$216,981
May	648	$214,664	$1,460	0.68%	$209,395
June	707	$253,961	$3,008	1.18%	$247,239
July	855	$281,560	$52,423	18.62%	$216,043
Aug	468	$168,314	$3,057	1.82%	$156,771
Sept	439	$148,711	$3,107	2.09%	$140,650
Oct	405	$145,695	$7,397	5.08%	$136,024
Nov	370	$138,303	$1,398	1.01%	$135,986
Dec	410	$174,128	$5,667	3.25%	$166,664
Total	**7,202**	**$2,454,752**	**$79,465**	**3.24%**	**$2,291,323**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Deactivated NPI	168	$50,046	62.98%
Other healthcare coverage must be billed before submission of claim	54	$21,616	27.20%
Beneficiary not eligible or non-covered charges	5	$3,818	4.80%
Medicare Part B must be billed before submission of claim	7	$3,521	4.43%
Service line is a duplicate and a repeat service procedure code modifier not present	2	$463	0.58%
Total Denied Claims	**236**	**$79,464**	**100.00%**
Overall Denied Claims Rate	**3.24%**		
Statewide Overall Denied Claims Rate	**1.43%**		