2020-2021 Statewide Annual Report

EXTERNAL QUALITY REVIEW REPORT

MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW REPORT

Prepared for the California Department of Health Care Services (DHCS)

By Behavioral Health Concepts, Inc. (BHC)

BHC | Behavioral Health Concepts, Inc

Acknowledgements

Behavioral Health Concepts, Inc. (BHC) would like to acknowledge the many people who worked tirelessly to serve the people of California who experience mental health conditions and provide support to their families, the providers of care, the County Mental Health and Behavioral Health Directors, the Public Health Officers, and the Department of Health Care Services.

The COVID-19 pandemic and related stressors have contributed to a substantial rise in depression, anxiety, suicidal ideation, and stress-related symptoms, as well as a disproportionate impact on people with schizophrenia and serious mental illness. To that end, it is even more important that the access, quality, and timeliness of the Mental Health Plan (MHP) services be available and continue to thrive. BHC would thus like to acknowledge the work of the 56 MHPs and that took part in the California External Quality Review Organization (CalEQRO) reviews, including staff, volunteers, contract providers, key stakeholders, and many others. BHC extends special thanks to all of the beneficiaries and family members who shared their experiences with us.

In addition, BHC would like to acknowledge the collaborative efforts in trainings and support of quality development statewide with California's Behavioral Health Directors Association (CBHDA) and the California Mental Health Services Association (CalMHSA). Both organizations worked to support efforts to foster quality of care and best practices for mental health services, working on models that optimize success for different beneficiary groups and families.

Also, the guidance of and collaboration with the Department of Health Care Services (DHCS) divisions responsible for quality and evaluation of the 1915(b) Waiver, Network Adequacy, and Behavioral Health Medi-Cal programs have been instrumental in the successful completion of the reviews and reports this year.

It is our goal that the findings and recommendations for enhancement of mental health treatment outcomes from this report may be used to improve the care of people with mental health conditions and provide helpful direction for the next chapter in California's public behavioral health evolution. It is also important to foster a statewide system of service delivery that changes lives in creating positive health and wellness for the Medi-Cal members who depend on these services.

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List of Commonly Used CalEQRO Acronyms

CalEQRO Acronyms	
AAS	Alternative Access Standard
AB	Assembly Bill
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
ACT	Assertive Community Treatment
AHRQ	Agency for Healthcare Research and Quality
ANSA	Adult Needs and Strengths Assessment
API	Asian/Pacific Islander
ASP	Application Service Provider
BHC	Behavioral Health Concepts
BHIN	Behavioral Health Information Notice
CalEQRO	California External Quality Review Organization
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organizations
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
COVID-19	Corona Virus Disease-2019
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CY	Calendar Year
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System

CalEQRO Acronyms	
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FFP	Federal Financial Participation
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FTE	Full Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health & Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
ICC	Intensive Care Coordination
ICD-10	International Statistical Classification of Diseases, 10th Revision
IHBS	Intensive Home-Based Services
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care
LOS	Length of Stay
MCO	Managed Care Organization
MEDS	Medi-Cal Eligibility Data System
MHP	Mental Health Plan

CalEQRO Acronyms	
MHSA	Mental Health Services Act
MHSIP	Mental Health Statistics Improvement Program
MMEF	MEDS Monthly Extract File
MOU	Memorandum of Understanding
NA	Network Adequacy
N/A	Not Applicable
NACT	Network Adequacy Certification Tool
NCQA	National Committee for Quality Assurance
NP	Nurse Practitioner
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OON	Out-of-Network
PHF	Psychiatric Health Facility
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PSC-35	Pediatric Symptoms Checklist (35 items)
QA	Quality Assurance
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QIC	Quality Improvement Committee
RFP	Request for Proposal
SB	Senate Bill
SD/MC	Short-Doyle Medi-Cal
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SUD	Substance Use Disorders
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
42 CFR	42 Code of Federal Regulations

2020-2021 BHC-CalEQRO Specialty Mental Health Statewide Annual Report

Executive Summary

Executive Summary

Introduction

The State of California Department of Health Care Services (DHCS) contracts with 56 Medi-Cal Mental Health Plans (MHPs), representing all 58 California counties, to provide specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. Federal law requires an annual, independent review of each MHP by an External Quality Review Organization (EQRO). The EQRO reviews and evaluates components of access, timeliness, quality, network adequacy (NA), beneficiary perceptions of care, and information systems. Behavioral Health Concepts is the designated EQRO, also referred to as the California EQRO (CalEQRO).

This report summarizes the review findings of CalEQRO for fiscal year 2020-21. For additional information and resources, including individual MHP reports and summaries, presentations and materials, and archived materials, please visit the organization's website, www.caleqro.com.

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Data sources, findings, and recommendations are detailed in nine chapters, highlighted in this summary:

1. **Introduction**
2. **Methods**
3. **Netwok Adequacy**
4. **Access**
5. **Timeliness**
6. **Quality**
7. **Validation of Beneficiary Perceptions of Care**
8. **Performance Improvement Projects**
9. **Information Systems**
10. **Conclusions and Recommendations**
11. **Appendices**

Access

A summary of access findings for MHPs in FY 2020-21 must first acknowledge the unique circumstances and stress to the system that was brought on by the COVID-19 pandemic. As subsequent chapters will describe in more detail, the COVID-19 emergency increased the need for mental health services, while limiting many in-person avenues for services delivery. This required MHPs to shift how services were delivered and monitored to ensure beneficiaries still had access to critical services. In addition, in order to respond to the public health crisis, counties experienced significant staffing challenges, including redeployment, quarantines, and family leaves. These challenges were addressed in innovative ways that were responsive to beneficiary needs, an extraordinary testament to the commitment that staff have to beneficiaries and the communities that are served by the MHPs.

One of the hallmarks of the MHP's response to the COVID-19 emergency was the pivot to expanded telehealth services. Many critical services, such as crisis response and residential care, remained in-person; where possible, other services were delivered through telehealth, ensuring that children, youth, transitional age youth, adults, and older adults continued to meet with psychiatrists, clinicians, case managers, and others.

Due to the complexity of the data and the need to look retrospectively for completeness of the data, all the performance measures reviewed use CY 2019 as the time period. Thus, while the review cycle coincided with the COVID-19 pandemic, the data predates the pandemic and will not reflect changes and trends that emerged as a result.

California experienced further decline in its Medi-Cal eligible population in CY 2019. While the decrease is significant, it mirrors a nationwide trend of a decline in Medicaid eligibles. At the same time, there was an overall increase in the number of beneficiaries served, resulting in a general increase in penetration rates in all regions of California. Overall, MHPs did well to facilitate access to SMHS in CY 2019.

However, among certain racial/ethnic groups, there are disparities indicating both over-representation and under-representation in access to services among historically underserved populations. While there has been a slow but steady increase in the penetration rate of Latino/Hispanic beneficiaries over time, data demonstrate that Latino/Hispanic beneficiaries and Asian/Pacific Islander (API) beneficiaries, especially, remain under-served. Despite constituting 10 percent of total Medi-Cal eligibles, API beneficiaries accounted for only 5 percent of the beneficiaries served statewide. In fact, API eligibles are the least likely racial/ethnic group to receive SMHS. Data further suggests that African-American beneficiaries are over-represented in services. Clearly, there are differences in access to SMHS of eligible Medi-Cal beneficiaries, and these differences are explored in more detail in this report.

NA is another aspect of access. Since the inception of NA standards MHPs have trended toward compliance. All 56 MHPs met time and distance standards directly or through an approved AAS; the majority (48 of 56) met all time and distance standards directly.

Timeliness

Timeliness metrics help determine whether the system is equipped with appropriate levels of care, staffing, and administrative infrastructure to get an individual into services in a timely manner. MHPs have demonstrated improved ability to track and report these metrics. From FY 2017-18 to FY 2020-21, the percentage of counties able to report on timeliness measures has increased such that over

90 percent of counties are able to track six out of the seven metrics. Timeliness to urgent appointment lags slightly behind with only 82 percent of MHPs able to track.

Some timeliness performance has shown an improvement, such as timeliness to first offered appointment. Among MHPs that reported this measure, statewide wait times have decreased by 33 percent from FY 2018-19 (9 days) to FY 2020-21 (6 days).

Timeliness to initial appointment is also impressive. Overall, 96 percent of California's MHPs can offer a non-urgent initial mental health appointment within the statewide standard of 10 business days. Large and small MHPs report meeting the standard 100 percent of the time, while medium and small-rural MHPs report meeting this standard 93 percent of the time. In FY 2020-21, MHPs reported an average wait time to first offered mental health appointments that was at least 30 percent lower than the state-defined standard of 10 business days.

While improvements have been made, there are still challenges that MHPs face in how they gather timeliness information. Because of information system challenges and technical complexities of collecting these metrics from all providers in the system, MHPs often use manual tracking of the data elements, such as spreadsheets.

For some MHPs, the limitations for tracking timeliness are related to EHR interoperability constraints, while for others it is related more to unestablished protocols between entities. Sometimes both factors are at play. DHCS is encouraged to work with MHPs to determine the root causes of the barriers. Solutions must address the underlying systemic challenges that to improve and sustain the timeliness of care to SMHS for California's Medi-Cal beneficiaries.

Quality

Many quality management (QM) programs emphasized Quality Assurance (QA) and DHCS-MHP contract compliance, and considerably fewer QM programs were positioned to engage in continuous quality improvement (CQI). To achieve a QM system that also meets beneficiary needs, MHPs need to adopt a CQI approach. CalEQRO noted considerable variability in the thoroughness and integrity of the data. MHPs did not have access to sufficient or appropriate data to guide decision-making. MHPs need training in quality improvement principles, staff to manage quality improvement projects, and tools and technology to evaluate quality.

All MHPs were rated as implementing strategies to address the needs of diverse communities/populations seeking SMHS, an increase from the previous year. While MHPs can demonstrate efforts to provide culturally responsive services, some could not provide the results or outcomes of this effort.

MHPs endorse the benefit of peer employees in SMHS, although MHPs have not invested fully or consistently in peer employee positions. At the onset of COVID-19, with the closure of wellness centers, peer employees subsequently lost their positions, whereas other mental health positions were retained and moved to virtual or remote service delivery. Peer integration remains a work in progress for MHPs. The recently signed peer certification bill, SB 803, provides additional guidance on how MHPs can better integrate lived experience through peer employees to improve the quality of SMHS.

For medication monitoring, MHPs continue to lack sufficient capacity to monitor medication utilization for children in foster care (FC), as per SB 1291. MHPs experience challenges that can be both technical and pharmacy related.

If SB 1291 monitoring is to be fully implemented by CalEQRO, DHCS will need to provide MHPs a gateway for such specific information and provide periodic and ongoing training for MHPs, accounting for frequent staff turnover.

All MHPs use the two standardized tools for measuring progress for children/youth: the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptoms Checklist 35-Item (PSC-35). Despite no mandate, most MHPs (86 percent) also used standardized measures to determine progress for adults. However, in contrast to almost full adoption of outcome measures, MHPs were less adept at demonstrating their consistent use. Without regular use, MHPs are challenged to demonstrate progress of beneficiaries. Furthermore, without routine use and monitoring, MHPs are less able to detect unsatisfactory response to treatment.

MHPs were also challenged in evaluating and reporting progress systemically. MHPs did not routinely (at least annually) share reports of aggregated beneficiary outcomes. Both findings suggest that MHPs are not positioned to identify and address gaps in overall services. MHPs need to invest more in monitoring and improving the system through which mental health services are delivered.

Recommendations

Despite a growing mental health workforce shortage, MHPs were nimble, innovative, and responsive to beneficiary needs—in ways stakeholders described as heroic. Nevertheless, MHPs experienced periodic staff absences, difficulty filling vacancies, and staff who are profoundly exhausted. If not addressed, the mental health workforce shortage is expected to compound and worsen, negatively impacting the beneficiaries MHPs are committed to serve.

All MHPs have a Quality Assessment and Performance Improvement (QAPI) program, yet there is considerable variation in how the programs are structured. MHPs often reported an insufficient number of QM clinicians or data analysts, leading to difficulty meeting the administrative requirements that accompany recent and ongoing policy changes. MHPs need to direct more resources towards continuous quality improvement, separate and distinct from QA and compliance activities. MHPs need training in quality improvement principles, staff to manage quality improvement projects, and tools and technology to evaluate quality.

The reasons for differences in beneficiary access across racial and ethnic populations are varied and complex, including lack of access to culturally and linguistically competent services and providers; language and cultural barriers; stigma; fears about psychotropic medications; mistrust of treatment; or a combination of factors. MHPs must continue the critical task to identify these differences and address potential inequities in access.

While MHPs demonstrate efforts to provide culturally responsive services, utilize level of care tools, and implement outcome measures, many still struggle to track and trend data, conduct robust analysis, and monitor key quality metrics that measure beneficiary and systemic outcomes. DHCS is encouraged to define established, standardized outcome tools for MHPs to monitor progress for adult and older adult beneficiaries.

Although there was an increase in and more consistent use of Healthcare Effectiveness Data and Information Set (HEDIS) measures among MHPs that had previously incorporated them to some degree, less than half of all MHPs track and trend HEDIS mental health indicators routinely. Overall, MHPs continue to lack sufficient capacity to monitor medication utilization for children in FC. To assist

MHPs in addressing the SB 1291 mandates, DHCS will need to provide MHPs targeted information, training, and clear expectations.

MHPs have demonstrated improved ability to track and report timeliness metrics, and performance has improved across some key measures. However, there are still challenges that MHPs face in how they gather timeliness information, making it difficult to assess true statewide capacity to provide timely access to SMHS. DHCS is encouraged to work with MHPs to determine the root causes of the barriers. Solutions must address the underlying systemic challenges to improve timeliness of care for California's Medi-Cal beneficiaries in need of SMHS.

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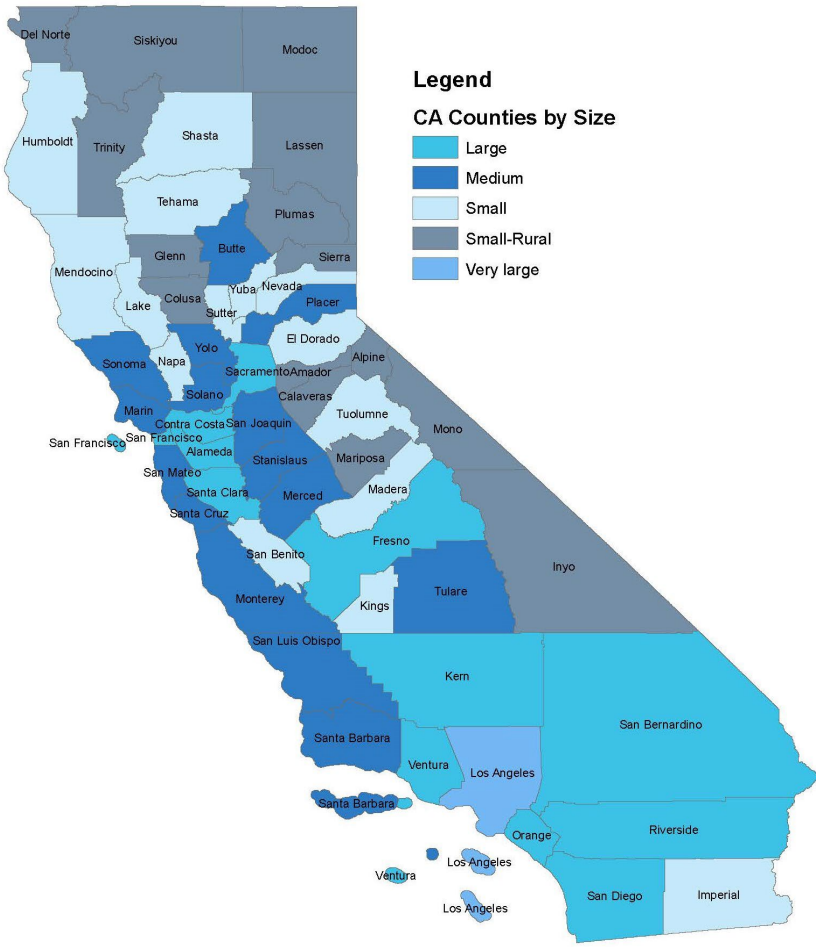
Chapter 1

Introduction

Introduction

Overview

Figure 1-1: California Counties by MHP Size



The U.S. Department of Health and Human Services Centers for Medicare Services (CMS) requires an annual, independent external evaluation of state Medicaid managed care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of state Medicaid managed care services. CMS rules (42 Code of Federal Regulations [CFR] §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) specify the requirements for evaluation of Medicaid (Medi-Cal in California) managed care programs. These rules require an annual EQR of each Medi-Cal Mental Health Plan (MHP) and each Drug Medi-Cal Organized Delivery System (DMC--ODS).

At the conclusion of each EQR, CalEQRO generates a comprehensive report that evaluates the MHP's activities in response to the prior year's recommendations, and identifies system strengths, opportunities for improvement, and recommendations to improve the overall quality of care provided to Medi-Cal beneficiaries served by each MHP. The State of California DHCS contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the statewide aggregate findings of all 56 MHP EQRs conducted in fiscal year (FY) 2020-21. The findings are the result of data collection and analyses by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC). Additional information, including CalEQRO resources, MHP reports and summaries, presentations, data analyses, and archived materials, can be found on the organization's website, www.caleqro.com.

Structure of the MHP EQRO 2020-21 Statewide Annual Report

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6. Quality
7. Validation of Beneficiary Perceptions of Care
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10. Conclusions and Recommendations

Meeting Federal EQRO Requirements

CMS requires that external reviews be conducted by an independent, external contractor (CFR 42, Part 438). As the California EQRO, BHC is required to conduct a review of each county on an annual basis to review access, timeliness, and quality. Reviews are retrospective for the prior year of services and thus the data being reviewed are from Calendar Year (CY) 2017 through CY 2019, unless otherwise specified. The review criteria are based on CMS 42 CFR Part 438, subpart E, which outlines four major requirements:

- Performance Measures (PMs) to evaluate clinical effectiveness and service activity.
- Performance Improvement Projects (PIPs) that focus on clinical and administrative processes.
- Information System Capacity Assessments (ISCAs) to focus on billing integrity, care management, and delivery systems.
- Client satisfaction with the services received, measured through a survey and other mechanisms.

Additionally, DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code).

CalEQRO also considers the State of California requirements pertaining to NA as set forth in California Assembly Bill (AB) 205.

Trends in Mental Health

Either directly or indirectly, the following trends and conditions affect access, timeliness, and quality across all MHPs and throughout California. To the extent possible, the EQR takes these trends into consideration in its methods and analyses.

COVID-19's impact on behavioral health needs and the delivery of behavioral health services in California is a microcosm of its impact nationwide. Behavioral health providers, including county MHPs, had to contend with service delivery to more individuals and in more areas (including mountains, deserts, rural, and metropolitan areas), but made more remote by the pandemic. Many counties activated disaster response systems in which behavioral health departments played significant roles in the overall county response. In addition to COVID-19, several communities in California faced further challenges from more frequent and devastating fires, which also activated county disaster response. The need and scope of behavioral health services over the past year was extraordinary. From disaster response, grief response, civil unrest, violence, and trauma, behavioral health services were at the forefront.

Throughout the year, MHPs continued to shift how they delivered and monitored services, working continuously to ensure services were delivered to beneficiaries. In the face of significant staffing challenges, including redeployment, quarantines, and family leaves, counties were nimble, innovative, and responsive to beneficiary needs—in ways previously unforeseen.

COVID-19

Research has shown that the need for mental health services has increased due to the stress COVID-19 has placed on the population. The need has disproportionately affected certain vulnerable population and has created an unfortunate reality of demand exceeding supply. Lower-income regions have higher rates of self-reported mental distress, suicidality, and substance use-related hospitalizations. Further, in California, there are shortages of behavioral health professionals, particularly in rural areas.[1]

A report by the National Institutes of Mental Health (NIMH) noted that while more adults across the county are reporting symptoms of anxiety and depression, communities of color have borne more of the economic impacts of COVID-19 such as job loss, housing instability, food insecurity, and other risk factors for poor mental health outcomes.[2]

Young adults have also been disproportionately impacted by COVID-19. The Kaiser Family Foundation found that during the pandemic, a larger share of young adults, ages 18-24, reported symptoms of

[1] Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions (2021). Blue Sky Consulting Group. Available at: https://www.chcf.org/publication/medi-cal-behavioral-health-services-demand-exceeds-supply-despite-expansions/

[2] Gordon, J. (2021). One Year In: COVID-19 and Mental Health. Available at: https://www.nimh.nih.gov/about/director/messages/2021/one-year-in-covid-19-and-mental-health

anxiety and/or depressive symptoms (56 percent) and were more likely to report substance use and suicidal thoughts compared to all adults.[3]

Finally, children and adolescents experienced a significant disruption to their routines and social contact with school closures in the last year. Schools are also primary locations where many children and adolescents receive mental health services. Many educators and behavioral health professionals are concerned that the impact of this disruption to routines and social life, in conjunction with losing access to services with school closures, has exacerbated mental health issues for this population.[4]

Rapid Expansion of Telehealth

County behavioral health departments worked closely with the DHCS and California Behavioral Health Directors Association (CBHDA) to adopt new rules on service delivery, HIPAA compliant communication, and beneficiary and staff safety. California's county based SMHS for children, youth, transitional age youth, adults, and older adults never closed during the pandemic. MHPs pivoted to telehealth services while maintaining vital in-person psychiatric, crisis, emergency, and residential care. MHPs adopted both video and telephonic telehealth services.

California Trends

California Advancing and Innovating Medi-Cal (CalAIM)

DHCS formally proposed the version of the 1115 Waiver known as CalAIM in October 2019. DHCS identified the following three primary goals:

(1) Identify and manage member risk and need through Whole Person Care approaches and addressing Social Determinants of Health.

(2) Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.

(3) Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.[5]

In the CalAIM proposal, DHCS outlines a plan for integrating mental health services and SUD into one behavioral health managed care program. The goal is to improve beneficiary outcomes and to reduce administrative burdens on the counties. In addition, the proposal outlines the desire to combine the EQR process and have one EQRO report for each county. Approved in December 2021, there are many phases to the implementation which also includes physical health and aligns quality to benefit clients with multiple disorders in as wholistic a manner as possible with coordinated care.

[3] Panchal, N., Kamal, R., Cox, C, and Garfield, R. (2021). The Implications of COVID-19 for Mental Health and Substance Use. Available at: https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[4] Ibid.

[5] DHCS Comprehensive Quality Strategy. Available from: https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx

Network Adequacy (Assembly Bill 205)

In April 2016, CMS issued the Medicaid and CHIP (Children's Health Insurance Program) Managed Care Final Rule, which aligned the Medicaid managed care program with other health insurance programs. Included in the Final Rule was the requirement for states to establish NA standards and annual certification. On October 13, 2017, Assembly Bill (AB) 205 was signed into law and codified California's NA standards, effective July 2018 (Chapter 738, Statutes of 2017). The NA standards, based on the population of each county, specify timely access as well as time and distance standards. The three parts of the Managed Care Rule set forth in Title 42 are: NA standards (438.68); availability of services (438.206); and assurance of adequate capacity and services (438.207).

DHCS, in consultation with CalEQRO, developed and provided guidelines for the NA areas that CalEQRO will validate and for which technical assistance will be provided. FY 2020-21 is the first year that NA data were reviewed during the annual MHP EQR, and findings regarding the following areas are addressed in the NA chapter in this report: Alternative Access Standards, Out-of-Network Access, and National Provider Identification (NPI) taxonomy codes.

The EQRO Environment in FY 2020-21

The process and content of this year's reviews continued to be affected by the ongoing COVID-19 public health emergency. As the pandemic progressed, California implemented additional requirements for mitigating the pandemic. Reviews were conducted under safety precautions that included phone, virtual, and material reviews that, in most instances, were able to maintain inclusion of staff and beneficiaries to validate the quality of services provided. During the height of the surge in the winter months, DHCS issued an unprecedented cessation of all audit and review activities for a three-month period and extended flexibilities when needed for the remainder of the FY.

In response to the continued public health emergency, nearly all (47) FY 2020-21 EQRs were conducted virtually. Nine MHPs were so impacted by the pandemic response that CalEQRO completed the EQR activities solely based on document review and data analysis. This flexibility required a balance to obtain sufficient information to complete the EQR protocols without unduly burdening MHP systems, practitioners, and beneficiaries, who were each navigating COVID-19 and resulting impact on mental health services.

Despite extensive and successful effort to conduct the EQR virtually, there were some limitations in the review process. The inability to conduct in-person beneficiary and family member focus groups resulted in reduced direct feedback from beneficiaries this year. It is hoped that in-person review activity can resume in late 2021; however, with new variants and local outbreaks still a concern, uncertainty remains regarding how in-person reviews would take place.

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Chapter 2

Methods

Methods

Introduction

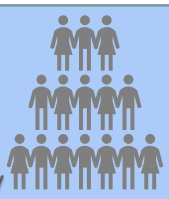
CalEQRO evaluations are mandated by federal law and associated regulations; CMS rules (42 Code of Federal Regulations [CFR] §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) specify the requirements for evaluation of Medicaid managed care programs. These rules require an annual EQR of each Medi-Cal DMC-ODS and each Medi-Cal MHP. Recently updated protocols focused on the core themes of the annual report: access, timeliness, and quality. These protocols for evaluation are applied to all managed Medicaid MHP and DMC-ODS plans to ensure the value of these services funded by state and federal governments.

CalEQRO carefully reviewed and analyzed both quantitative and qualitative data based on these protocols to support and shape the themes and findings for the following chapters: NA, Access, Timeliness, Quality, Performance Improvement Projects (PIPs), Beneficiary Perceptions, Information Systems, and Recommendations. Each chapter includes tables and figures that capture the most relevant and important aggregate findings. Additional tables and figures can be found in the companion report, Validation of Performance Measures, which describes the methods for each of the sources of data in greater detail.

Medi-Cal Population

California counties serve many populations in need of mental health services. The focus of the EQRO evaluation is the Medi-Cal population, which includes California residents who are elderly, disabled, adults, and youth who fall below the federal poverty level and need SMHS services. To be included in this population, a person must meet the criteria for Medi-Cal benefits. The term "eligible" is used to describe a person who is eligible to receive services funded through Medi-Cal. Eligibles are counted even if they have not received MHP services. The term "beneficiary" is used to describe a person who is Medi-Cal eligible *and* has received one or more MHP services. DHCS has assigned specific aid codes to identify the types of recipients eligible under Medi-Cal. These aid codes provide guidance on the types of services for which beneficiaries are eligible. Benefits may be full or restricted, depending on the aid code.

Eligible: a person who is **eligible to receive services funded through Medi-Cal.** Eligibles are counted even if they have not received MHP services.



Beneficiary: a person who is **Medi-Cal eligible *and* has received one or more MHP services.**

CalEQRO Review Activities

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 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.

CalEQRO uses a variety of data sources for the evaluation analyses, including Monthly Medi-Cal Eligibility Data System Eligibility Files (MMEF), Short-Doyle/Medi-Cal (SDMC) approved claims, Inpatient Consolidation File (IPC), Consumer Perception Survey (CPS) annual survey files, Medi-Cal provider files, NA files, and county submission documents. Reviews are retrospective for the prior year of services and thus the data being reviewed is from Calendar Year (CY) 2017 through CY 2019, unless otherwise indicated. An MMEF is requested during the same time period and covers 15 months of eligibility. PMs are calculated on a CY basis. 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–overall, FC, transitional age youth, and Affordable Care Act (ACA). CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

CalEQRO used data from 10 unique sources in compiling this report, summarized in Table 2-1 and described in greater detail below.

Table 2-1: Summary of Annual Report Data Sources

Data Collector	Data Source	Description
DHCS	Consumer Perception Surveys	Surveys distributed to beneficiaries and family members by MHPs and returned to DHCS for tabulation
Medi-Cal approved claims data	Performance Measures	Calculations based on approved claims data
CalEQRO-developed based on CMS Protocol; MHP completed	Information Systems Capabilities Assessment	Mix of quantitative and qualitative data
Cal EQRO-developed; MHP completed	MHP Assessment of Timely Access	Primarily quantitative
CalEQRO-developed; MHP completed	Pathways to Well-Being	Mix of quantitative and qualitative data regarding children and youth in foster care or at risk of foster care placement
CalEQRO-developed based on CMS Protocol; MHP completed	Performance Improvement Projects	Primarily quantitative
CalEQRO	Performance and Quality Management Key Components	Quantitative scores with qualitative comments; intended to summarize all other data and experiences from the review
CalEQRO	Stakeholder Focus Groups	Qualitative focus groups conducted with beneficiaries and family members (including those serving as

Data Collector	Data Source	Description
		employees), line staff, contractors, and clinical supervisors
CalEQRO	MHP Documentation	Qualitative and quantitative reports developed by the MHP that provide evidence of quality activities throughout the review period
CalEQRO	Strengths, Opportunities, and Recommendations	Qualitative data developed as part of the MHP-level reports intended to summarize the results of the review

Consumer Perception Surveys

CalEQRO presents the analyses and findings from the Consumer Perception Survey (CPS) conducted by the DHCS through its contractor, California Institute for Behavioral Health Solutions (CIBHS). CalEQRO's analysis and reporting on CPS is mandated by CA DHCS through its EQRO contract with BHC, as per CMS EQR Protocol 6.[6] Implementation of the surveys including data collection and data entry is performed by CIBHS.

The CPS consists of four different surveys used statewide for collecting consumer perceptions of care, quality and outcomes. Three of the surveys are age-specific and the fourth is used to obtain youth's family member feedback. These are the only instruments used statewide and provide comparable data across different MHPs for each age group and family members of children.

Table 2-2: CPS Domains

Mental Health Statistics Improvement Project	Youth Satisfaction Survey
General Satisfaction	General Satisfaction
Perception of Access	Perception of Access
Perception of Participation in Treatment Planning	Perception of Participation in Treatment Planning
Perception of Outcomes of Services	Perception of Outcomes of Services
Perception of Functioning	Perception of Functioning
Perception of Social Connectedness	Perception of Social Connectedness
Perception of Quality and Appropriateness	Perception of Cultural Sensitivity

[6] Centers for Medicare and Medicaid Services. (2019). CMS External Quality Review (EQR) Protocols October 2019. Department of Health and Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf

Data Sources

CalEQRO obtains the CPS data from DHCS, which in turn obtains the dataset from CIBHS. The files are transferred within HIPAA compliant environments using industry standard encryption protocols. CalEQRO received and reviewed surveys conducted in 2020. Prior to analysis, CalEQRO prepared/cleaned each data file in SAS. This software was used to input, re-code, and analyze the data. The data cleaning consisted of many iterations of identifying invalid identifiers, eliminating invalid county identifiers, re-coding invalid client identification numbers, checking all data variables, and writing analysis statements.

Instruments

DHCS administers four surveys each year tailored for the following categories of beneficiaries – Adult, Older Adult, Youth, and Families of Children and Youth. Adult and Older Adult beneficiaries receive the Mental Health Statistics Improvement Project (MHSIP) survey while the Youth beneficiaries and/or their family members receive the Youth Satisfaction Survey (YSS) and the Family version of the same survey (YSS-F). All consumer perception items are rated on a 5-point scale with “Not Applicable” and “Missing” as additional coding options as follows: 1 = Strongly Disagree, 2 = Disagree, 3 = I am Neutral, 4 = Agree, 5 = Strongly Agree, 8 = Not Applicable, 9 = Missing.

Data Collection

California chose a unique survey methodology to ensure uniformity across all 56 MHPs. In CY 2020, due to COVD-19 pandemic, the MHSIP survey was conducted once in the spring. Each MHP was asked to administer the surveys to the beneficiaries who received services during a pre-specified 2-week period each time. The administration of the surveys was limited to the non-24-hour service locations. Each MHP is required to make sure that the beneficiary identification number is written on the survey as the beneficiary of a family member receives the survey, and then provide means for the beneficiary to submit the survey anonymously to the MHP. The MHPs have an option to scan the data into their own systems and submit them to the State or its designated contractor electronically in a batch mode, or they enter the data using an online system.

In CY 2020, beneficiaries had the option of completing the survey on paper or electronically via an online survey. The paper version was available in six threshold languages and the online survey was available in all twelve-threshold languages of California, including English. Approximately 38,878 surveys were completed during the CY 2020 data collection period. CIBHS coordinated the data collection by counties for DHCS.

Performance Measures

The purpose of PMs is to foster timely access to quality services that yield positive outcomes by measuring indicators with solid scientific links to health and wellness. CalEQRO uses administrative claims data to validate Performance Measures (PMs) defined by DHCS, as well as additional PMs specific to the provision of services to minor and nonminor dependents per Senate Bill (SB) 1291. CalEQRO validates PMs using data from DHCS, beneficiary interviews, staff and community-based provider interviews, observations from program reviews, and documentation of key deliverables. PMs incorporated in this report include:

- Total beneficiaries served by each county MHP
- Penetration rates in each county MHP
- Total costs per beneficiary served by each county MHP
- Penetration rates for vulnerable and underserved populations

- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a calendar year (CY)
- Total psychiatric inpatient hospital episodes, costs, and average length of stay
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates
- Post psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

The statewide Validation of Performance Measures report is the companion to this report and presents findings on these and other key PMs for California's Medi-Cal-funded SMHS delivered by the county MHPs.

Information Systems Capability Assessment

As part of 42 CFR §438.242, MHPs are required to maintain a health information system (HIS) that collects, analyzes, integrates, and reports data for purposes including utilization, claims, grievances and appeals, disenrollment for reasons other than loss of Medicaid or CHIP eligibility, rate setting, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development. CalEQRO assesses this capacity using the ISCA tool, which CalEQRO developed based on CMS protocol in cooperation with California stakeholders and DHCS. The purpose of this assessment is to specify the desired capabilities of the MHP's information systems (IS) and to pose standard questions to assess an MHP's strengths with respect to these capabilities.

CalEQRO reviews and analyzes the extent to which the MHPs meet federal data integrity requirements for HIS, as identified in Appendix A.[7] This evaluation includes a review of the MHPs' reporting systems and methodologies for calculating PMs.

MHP Assessment of Timely Access

CalEQRO developed the MHP Assessment of Timely Access (ATA) tool to capture MHPs' processes for monitoring timeliness to care as well as their performance on key timeliness indicators. MHPs report on technical and analytical capabilities to capture the data elements and report on them. MHPs are asked to report timeliness data stratified by age and foster care status for the entire service delivery system, inclusive of county-operated and contractor-operated services. The six timeliness performance measures on which MHPs are asked to report include metrics identified by DHCS, HEDIS, and CalEQRO as key indicators to evaluate timely access to quality care:

- Initial non-urgent outpatient mental health appointment
- Initial non-urgent outpatient psychiatry appointment
- Urgent services, including mental health and psychiatry
- Outpatient no-show rates
- Follow-up post psychiatric inpatient discharge
- Psychiatric inpatient readmission

Each MHP completes its ATA prior to the EQR. During the review, CalEQRO validates the information provided by the MHPs through focus groups with beneficiaries and family members, line staff,

[7] Centers for Medicare and Medicaid Services. (2019). CMS External Quality Review (EQR) Protocols October 2019. Department of Health and Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf

supervisors, contract providers, and quality improvement (QI) staff. The validation process is additionally informed by the PMs and any timeliness-related Performance Improvement Projects (PIPs).

Pathways to Well-Being

As part of the annual EQR of the MHPs, DHCS requires CalEQRO to collect information on the implementation status of Pathways to Well-Being activities, also known as Katie A. As a result of the Settlement Agreement in *Katie A. v. Bonta*, the State of California agreed to take a series of actions that transformed the way California children and youth in foster care, or who are at imminent risk of foster care placement, access and receive mental health services. Pursuant to the settlement, subclass members were entitled to receive an array of services, including Intensive Care Coordination (ICC), Intensive Home-based Services (IHBS), and Therapeutic Foster Care (TFC) services when medically necessary, consistent with the Core Practice Model.

Performance Improvement Projects

Each MHP is required to conduct two PIPs, per 42 CFR §438.330, for validation during the 12 months preceding the CalEQRO review.

The CMS *Validation of Performance Improvement Projects* protocol specifies that the EQRO validate two PIPs (one clinical and one non-clinical) for each MHP that have been initiated, are underway, or were completed during the reporting year; each is expected to produce beneficiary-focused outcomes.[8] Accordingly, for this Annual Report, CalEQRO examined projects that were underway at some time during the 12 months preceding the FY 2020-21 reviews.

The PIP Development Tool is a template provided by CalEQRO for the MHPs to use when drafting their PIP narratives.[9] CalEQRO reviews and validates any resubmitted PIPs in accordance with the requirements of CMS Protocol 1. All PIPs are rated based on their completeness and compliance with the standards. Each of the nine PIP steps includes subsections containing standards that are rated according to the PIP Validation Tool.[10]

Performance and Quality Management Key Components

A central focus of the EQR process is the validation of key performance and quality management indicators, referred to as Key Components. Collectively, these factors comprise the key performance and quality management indicators of access, timeliness, quality, beneficiary outcomes, and structure and operations.

[8] Centers for Medicare and Medicaid Services. (2019). CMS External Quality Review (EQR) Protocols October 2019. Department of Health and Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf

[9] To view the PIP Development Tool, visit CalEQRO's website: www.caleqro.com. The tool is found under Notification Materials/MHP Notification Materials__Review Preparation Materials.

[10] The PIP Validation Tool is available from CalEQRO's Website, www.caleqro.com

Each key component has three to seven corresponding subcomponents, and each subcomponent has its own set of 2 to 15 individual items. CalEQRO review teams assess the Key Components throughout the EQR process for each MHP and summarize findings in individual MHP reports.

MHP Documentation

In addition to the data sources described above, MHPs are asked to submit quantitative and qualitative documentation in advance of the review that provide information about their current structure, programming, capacity, and performance. These documents reflect performance management and quality improvement activities which occurred during the review period; CalEQRO validates this information during the review process. Examples include:

- Response to prior-year recommendations
- Key changes and new initiatives
- Quality Assessment and Performance Improvement (QAPI) Work Plan
- Quality Improvement Committee (QIC) meeting minutes
- QAPI Work Plan evaluation
- Cultural Competency Plan (CCP)
- Cultural Competency Committee meeting minutes
- Organizational chart(s)
- Managed Care Plans MOUs

The CalEQRO team assigned to each review conducts a document review and analysis prior to the onsite or virtual review activities taking place. During the review, and as part of the validation process, CalEQRO reviewers conduct key informant interviews with MHP staff, beneficiaries, family members, line staff, contract providers, and supervisors to learn more about their experiences and perspectives.

Strengths, Opportunities, and Recommendations

The review of MHP strengths, opportunities, and recommendations is part of federal guidelines governing EQRO. Strengths are those characteristics that enabled or enhanced an MHP's ability to provide SMHS to its beneficiary population. They also reflect industry best practices in mental health, HIS, and program operations. Opportunities are those areas where the MHP was underperforming, did not meet DHCS requirements/standards, and/or showed need for improvement. Recommendations are derived from the opportunities and identify the areas in which MHPs should focus improvement efforts in the upcoming year. Some recommendations also were designated as carry-over recommendations from the previous review year. A recommendation was carried over if it had not been resolved and the need to address the issue continued. The strengths, opportunities, and FY 2020-21 recommendations were drawn directly from the FY 2020-21 MHP final reports.

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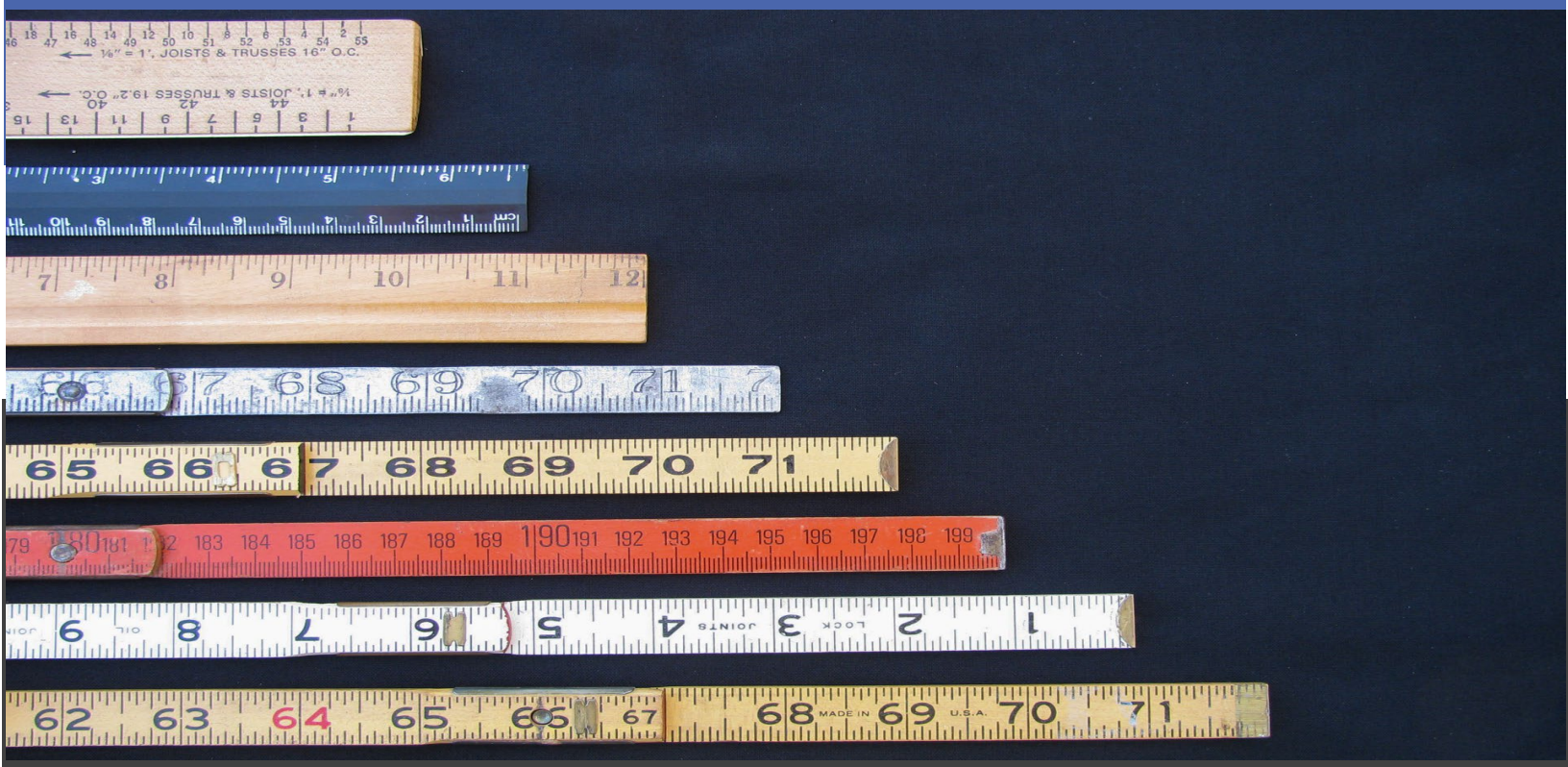

Chapter 3

Network Adequacy

Network Adequacy

Background

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to 42 CFR §438.68. In the October 2019 Protocols, CMS identified Protocol 4: Validation of Network Adequacy; however, the specific components of Protocol 4 have not been released. States will be required to implement activities related to the new EQR protocol within one year of issuance. In the meantime, DHCS tasked CalEQRO with evaluating and validating three related elements of an MHP's NA commencing with the FY 2020-21 EQR cycle: Alternative Access Standards (AAS), Out-of-Network (OON) access, and NPI/Taxonomy Codes. This report represents the first year in which NA was a required component of the MHP EQR.

On February 13, 2018, DHCS issued the first NA policy guidance, Behavioral Health Information Notice (BHIN) 18-011[11], that introduced time, distance, and timely access standards for adult and pediatric behavioral health providers to which MHPs must adhere. In this context, time refers to the number of minutes it takes a beneficiary to travel from the beneficiary's residence to the nearest provider site. Distance refers to the number of miles a beneficiary must travel from the beneficiary's residence to the nearest provider site. The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas.

BHIN 18-011 also summarized the requirements of AB 205[12], which codified several federal Medicaid managed care regulations in State statute in October 2017. Subsequently, updated NA policy guidelines were issued to provide additional clarification on Network Certification Requirements for MHPs; OON requirements for MHPs; and Network Certification Requirements for MHPs and DMC-ODS.[13]

Established time and distance standards for outpatient Mental Health Services, including Targeted Case Management, Crisis Intervention, and Psychiatrist Services are identified in Table 3-1 below.

[11] Department of Health Care Services. Federal Network Adequacy Standards for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties. February 2018. Available from: https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-%20Network%20Adequacy/MHSUDS_IN_18-011_Network_Adequacy.pdf

[12] AB 205 Medi-Cal Managed Care Plans. October 2017. Available from: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB205

[13] Department of Health Care Services. 2021 Federal Network Certification Requirements for County Mental Health Plans and DMC-ODS. May 2021. https://www.dhcs.ca.gov/Documents/BHIN-21-023-2021-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf

Table 3-1: NA Time and Distance Access Standards for MHP Counties[14]

Time and Distance Standards	Counties
15 miles/30 minutes	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara
30 miles/60 minutes	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura
45 miles/75 minutes	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba
60 miles/90 minutes	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne

In addition to time and distance standards outlined above, MHPs are also required to adhere to timely access to care standards, ensuring that the network of available providers is able to offer beneficiaries appointments for outpatient Mental Health Services, including Targeted Case Management, Crisis Intervention, and Psychiatrist Services (Table 3-2). In this context, timely access or "appointment wait time" means the time from the initial request for behavioral health care services, by a beneficiary or the beneficiary's treating provider, to the earliest offered appointment date. When it is necessary for a provider or beneficiary to reschedule an appointment, the appointment must be promptly rescheduled in a manner that is appropriate for the beneficiary's behavioral health care needs and ensures continuity of care consistent with good professional practice.

Table 3-2: NA Timely Access Standards for MHP Counties

Timely Access Standards for Service Request to First Offered Appointment	
Service Type, all ages	**Timeliness Standard**
Non-Urgent Appointment Offered with a Non-Physician Mental Health Care Provider	10 Business Days
Non-Urgent Appointment Offered with a Specialist Physician (i.e., psychiatrist)	15 Business Days
Urgent Care Appointments Offered – Prior Authorization not Required	48 Hours
Urgent Care Appointments Offered – Prior Authorization Required	96 Hours

[14] Department of Health Care Services. 2020 Federal Network Certification Requirements for County Mental Health Plans. April 2020. https://www.dhcs.ca.gov/Documents/Behavioral-Health-Information-Notice-20-012-2020-NA-Certification-4-3-20.pdf

All MHPs submitted detailed information on their provider networks in spring 2020 for the reporting period of December 1, 2019 through February 29, 2020, utilizing the Network Adequacy Certification Tool (NACT) form, per DHCS BHIN 20-012. The NACT outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's NPI number as well as the professional taxonomy code used to describe the individual providing the service. To determine whether the MHP's network allows adequate access to all covered services for all beneficiaries, DHCS maps all provider locations for outpatient mental health and psychiatry services for adults and children/youth relative to all coverage areas where Medi-Cal beneficiaries reside.

Alternative Access Standards

Effective for contract periods commencing on or after July 1, 2020, an MHP that is unable to meet the time or distance standards must submit a description for how it intends to arrange for beneficiaries to access covered services where providers are located outside of the time or distance standards. Referred to as an AAS request, DHCS may honor this request for a dispensation in access, provided the MHP substantiates the request as described in BHIN 20-012 and BHIN 21-023.

In FY 2019-20, the majority (48 of 56) of MHPs met all time and distance standards and were not required to submit an AAS request. Although located in different areas in the State, 23 of the 25 zip codes that did not meet time and distance standards are in sparsely populated mountain and forest geography and/or are seasonally impacted by weather. The other two zip codes are in a county where, due to population density and transportation time limitations, the MHP was approved to extend the standards to be slightly longer than the shortest standard but lower than the two longer standards. Of the eight counties that did not meet time and distance standards, four included the use of telehealth as part of their response plan. (Table 3-3)

Table 3-3: Approved Alternative Access Standards for MHP Counties

Alternative Access Standard				
County MHP	**Service Type**	**Zip Code(s)**	**Approved Standard**	**Justification for Approval**
Mono	Adult and Children/Youth Psychiatry Adult and Children/Youth Outpatient SMHS	93512, 93514, 93517, 93529, 93541, 93546, 96107, 96133	90 miles / 120 minutes	Seasonal
San Luis Obispo	Adult and Child/Youth Psychiatry	93453	20 miles / 40 minutes	Proposed Time/Distance standard
San Mateo	Adult and Child/Youth Psychiatry	94020	23 miles / 45 minutes	Telepsychiatry Services
		94021	25 miles / 40 minutes	Telepsychiatry Services
		94060	25 miles / 40 minutes	Telepsychiatry Services

Alternative Access Standard				
County MHP	**Service Type**	**Zip Code(s)**	**Approved Standard**	**Justification for Approval**
	Adult and Child/Youth Outpatient SMHS	94020	25 miles / 45 minutes	Telepsychiatry Services
		94021	25 miles / 45 minutes	Telepsychiatry Services
		94060	25 miles / 40 minutes	Telepsychiatry Services
Shasta	Child/Youth Psychiatry	96025, 96028, 96056, 96076	90 miles / 90 minutes	Telepsychiatry Services
Siskiyou	Adult and Child/Youth Psychiatry	95568	115 miles / 155 minutes	Telepsychiatry and Transportation assistance
		96031	66 miles / 120 minutes	Telepsychiatry and Transportation assistance
		96039	73 miles / 115 minutes	Telepsychiatry and Transportation assistance
		96134	87 miles / 115 minutes	Telepsychiatry and Transportation assistance
Sonoma	Adult and Child/Youth Psychiatry	95412	60 miles / 105 minutes	Proposed Time/Distance standards
	Adult and Child/Youth Psychiatry	95497	60 miles / 90 minutes	Proposed Time/Distance standards
	Adult and Child/Youth Outpatient SMHS	95412	60 miles / 105 minutes	Proposed Time/Distance standards
	Adult and Child/Youth Outpatient SMHS	95497	60 miles / 90 minutes	Proposed Time/Distance standards
Trinity	Adult and Children/Youth PsychiatryAdult and Children/Youth Outpatient SMHS	95595	64 miles / 104 minutes	Telepsychiatry; Seasonal
Ventura	Adult and Children/Youth Psychiatry	93225, 93252	Telehealth	Proposed Time/Distance standards

Out-of-Network Access

Policy guidance contained in BHIN 21-008 stipulates that when an MHP is unable to provide all covered services within the time, distance, and timely access standards, the MHP must allow beneficiaries to access services out of network. In this context, an OON provider refers to an individual provider or provider group that does not have a network provider or subcontractor agreement with the MHP responsible for ensuring covered services. A provider may be "out-of-network" for one MHP but in the network of another MHP.

When an MHP is unable to provide SMHS with an in-network provider that meets time and distance standards, the MHP must refer the beneficiary to an OON provider within the same time and distance standards. Due to the vast geography and population density found throughout California, there are areas where an OON provider is also not available within these time and distance standards. In these circumstances, MHPs are required to arrange for telehealth or transportation to an in-person visit. Further, as stipulated by DHCS' Telehealth Policy[15], beneficiaries have the right to an in-person visit if they do not want to receive services via telehealth.

Regardless of whether a SMHS is rendered by an in-network or OON provider, including those within an approved AAS, services must adhere to timely access standards. MHPs are further required to notify DHCS within 10 business days of any significant change to their operations that would result in the MHP not meeting NA standards.

In zip codes for which approved AAS apply and a beneficiary requests psychiatry services, the MHP must either arrange for an appointment with a provider within the applicable time and distance standards and within 15 business days or make its best effort to establish a beneficiary-specific case agreement with an OON psychiatrist located within the required time and distance standards and available within 15 business days. When there is no available psychiatrist within the time and distance standards, or if the MHP has been unable to enter into a beneficiary-specific case agreement, then the MHP must coordinate with the beneficiary's managed care plan to arrange non-emergency transportation for the beneficiary to attend an appointment outside the coverage area.

When a MHP is unable to arrange an appointment for a beneficiary with a network provider (for the appropriate level of care, as determined by an assessment) that meets the timely access standards, the MHP must arrange an appointment for the beneficiary with an OON provider that meets those standards, either in-person or by telehealth. This applied to only one MHP during the FY 2020-21 EQR cycle, as 55 MHPs met the timely access standards threshold of 70 percent.

Provider NPI and Taxonomy Codes

DHCS provided CalEQRO all of the MHPs' Spring 2020 NACT Exhibit A.3 worksheets. CalEQRO reviewed this source data for accuracy and completeness to validate the NPI numbers and taxonomy codes submitted by MHPs. NPI are assigned by the National Plan and Provider Enumeration System (NPPES). NPPES also maintains and updates information about health care providers with NPIs. Analysis revealed six different categories of discrepancy, referred to as outlier conditions. Of the 29,600 unique NPI numbers submitted by MHPs, there was a discrepancy found among 998 (3.4 percent) of them, as seen in Table 3-4.

[15] Department of Health Care Services. Telehealth policy. August 2020. Available from: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

Table 3-4: NPI and Taxonomy Outlier Conditions

NPI Type 1, NPI Type 2, and Taxonomy Code Conditions			
NPI and Taxonomy Codes		**#**	**%**
Unique (unduplicated) NPI #s – all MHPs		29,600	-
Unique NPI #s – with any Condition		998	3.4%
Unique NPI #s – with Condition 3		415	1.4%
Outlier Conditions		**#**	**%**
All	All conditions – may reflect duplicated NPIs	1,419	-
1	NPI Type 1 number not found in NPPES	116	8.2%
2	NPI Type 1 and 2 numbers are the same	249	17.5%
3	NPI Type 1 number was reported by two or more MHPs and combined FTE percentage is greater than 100 percent	835*	58.9%
4	NPI Type 1 number reported is associated with two or more providers	45	3.2%
5	NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	43	3.0%
6	NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	131	9.2%

CalEQRO supplied each MHP with a report containing rendering provider level detail, background information for each condition, and suggested guidance to resolve each condition. This information was provided in the spirit of technical assistance and was not identified as a deficiency. Ten MHPs accounted for 61 percent of the conditions, and seven MHPs had no outliers.

Background information included education and technical assistance about the NPPES NPI Registry, Type 1 and Type 2 NPI numbers, fatal errors, and taxonomy codes, descriptions, and types. CalEQRO suggested guidance to address these conditions included:

- Investigate and correct fatal errors linked to Conditions 1, 2, 4, and 5 to mitigate possible denied claims.
- Confirm NPI Type 1 numbers, taxonomy codes, and the spelling of rendering provider's last and first name with provider's document of record provided at the time of new employee onboarding or change of license status.
- Confirm Type 1 rendering provider last and first name, and NPI number when validating local information.
- Validate NPI number and confirm Active status on NPPES website.
- Confirm NPI Type 2 number using DHCS - Provider Application and Validation Enrollment (PAVE) system. Link: https://pave.dhcs.ca.gov/sso/login.do
- Validate Exhibit A.3 worksheet to confirm that NPI Type 1 and Type 2 numbers were inputted correctly; transposition of numbers is a possibility, as each NPI is a 10-digit length number.

- Validate Exhibit A.3 worksheet to confirm that rendering providers' last and first names were inputted correctly.
- Confirm FTE percentage calculation for Condition 3.

By the end of the FY, Condition 3 was determined to be largely a reflection of workforce shortages rather than an error which required resolution; therefore, it will not be analyzed in subsequent EQR cycles.

Summary

Since the inception of NA standards MHPs have trended toward compliance. All 56 MHPs met time and distance standards directly or through an approved AAS; the majority (48 of 56) met all time and distance standards directly. Eight MHPs submitted AAS requests for 25 zip codes: all 25 zip codes were approved. 23 of the 25 zip codes are in sparsely populated mountain or forest geography and/or are seasonally impacted by weather. The other two zip codes requested a slight increase from 15 miles or 30 minutes to 20-23 miles to 40-45 minutes, due to overly congested population centers. One MHP was required to arrange beneficiary appointments with an OON provider due to an inability to meet timely access standards. NPI discrepancies were unremarkable.

The COVID-19 pandemic impact on MHPs delivery systems resulted in an unprecedented acceleration in the use of telehealth services. Rapid changes in DHCS and CMS regulatory guidance assisted MHPs as telehealth use increased. In 2020, phone telehealth dominated over video telehealth. Many MHPs expanded use of hardware, virtual platforms, and media platforms to provide initial and ongoing access and timely service delivery. Telehealth services are expected to continue to expand and play a pivotal role in meeting time and distance standards as well as timely access to services. Next steps in the progression of teleservices would benefit from the development and implementation of standardized best practices and systematic beneficiary feedback and preferences.

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Chapter 4

Access

Access

Introduction

Access is the timely use of health services to achieve the best health outcomes. Healthy People, a government initiative to improve access to comprehensive, quality health care services, identifies three steps to access: coverage, accessibility, and provider relationship.[16] Coverage is gaining entry to the health care system, often through insurance coverage. Accessibility refers to the location where health care services are provided and/or its geographic availability. Provider relationship reflects having a trusted health care provider with whom the beneficiary can communicate.

CalEQRO reviewed coverage and accessibility in the evaluation of access to SMHS for Medi-Cal beneficiaries. (Provider dynamics are discussed as part of quality of services, Chapter 6). Under coverage, SMHS utilization data is presented, including beneficiaries served and penetration rate. For accessibility, CalEQRO reviews the services that beneficiaries were provided. CalEQRO examines the MHP's ability to provide the type(s) of care that addresses specific mental health needs of beneficiaries, be those for preventative or therapeutic care. As part of accessibility, CalEQRO discusses the modality of service provision, which took on a significant role after the onset of COVID-19.

The overarching backdrop of access during the review year was COVID-19. The pandemic—the need for physical distancing, its impact on staffing, and other factors—required further accommodations and added new stressors to what can already be a challenging pursuit for users of mental health services. It is important to note that while the timing of the review coincided with the pandemic, the data during this review period predates the pandemic and is from CY 2019.

Coverage

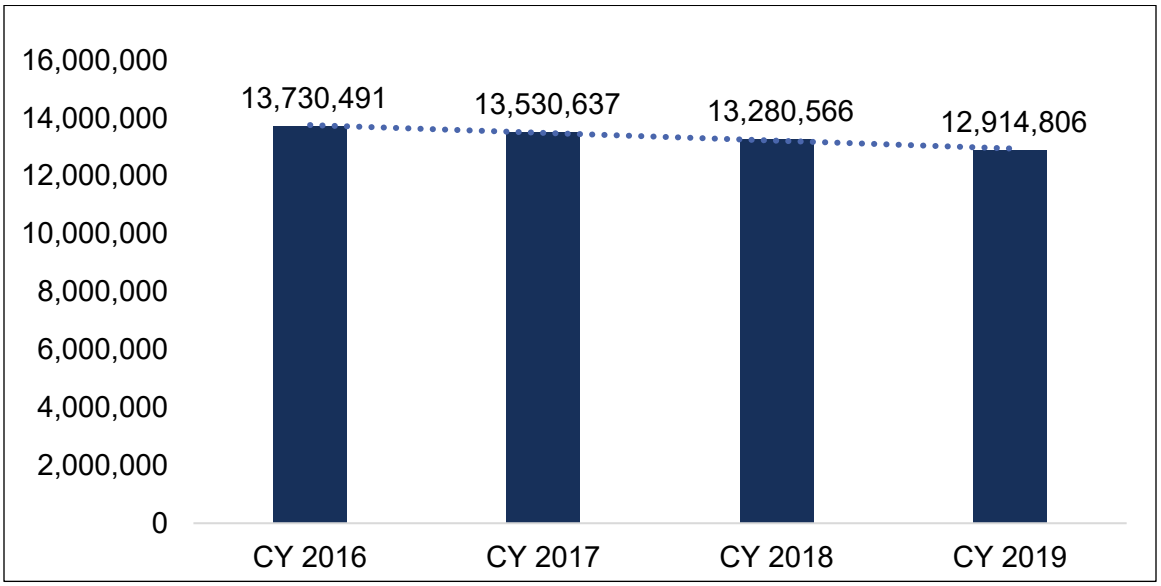
Increase in Beneficiaries Served

As in the previous three years (CY 2016 – CY 2018), California experienced further decline in its Medi-Cal eligible population in CY 2019 (Figure 4-1). There was a 2.75 percent decrease in eligibles for SMHS, despite a population increase by over 100,000 individuals in the state. While the decrease is significant, it mirrors a nationwide trend of a decline in Medicaid eligibles.[17]

[16] Healthy People 2020. Access to Health Services. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services.

[17] Artiga, S. and Pham, O. (2019, September). Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage. Issue Brief. Kaiser Family Foundation. https://files.kff.org/attachment/Issue-Brief-Recent-Medicaid-CHIP-Enrollment-Declines-and-Barriers-to-Maintaining-Coverage

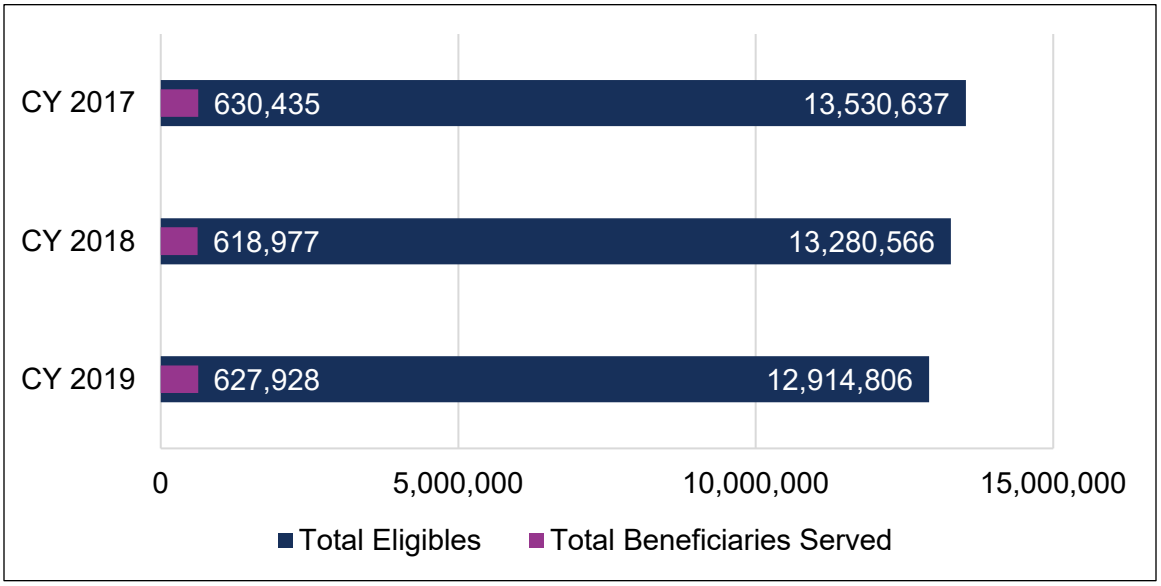
Figure 4-1: Medi-Cal Eligibles Statewide, CY 2016-19



The greatest loss of Medi-Cal eligibles was in Los Angeles and the Southern regions, but proportionately the greatest decline was in Bay Area MHPs, where 3.61 percent fewer individuals were eligible for Medi-Cal in CY 2019 than in CY 2018. Several factors are thought to contribute to the decrease, including laws and guidelines that discourage or disenfranchise individuals, but what is clear is that many Californians are not receiving a safety net service for which they were once eligible and likely, still need.

While there was a decrease in the number of Medi-Cal eligibles, there was an overall increase in the number of beneficiaries served (Figure 4-2). MHPs served 1.46 percent more beneficiaries in CY 2019 than in CY 2018 and almost returned to the CY 2017 levels.

Figure 4-2: Medi-Cal Eligibles and Beneficiaries Served Statewide, Three-Year Trend



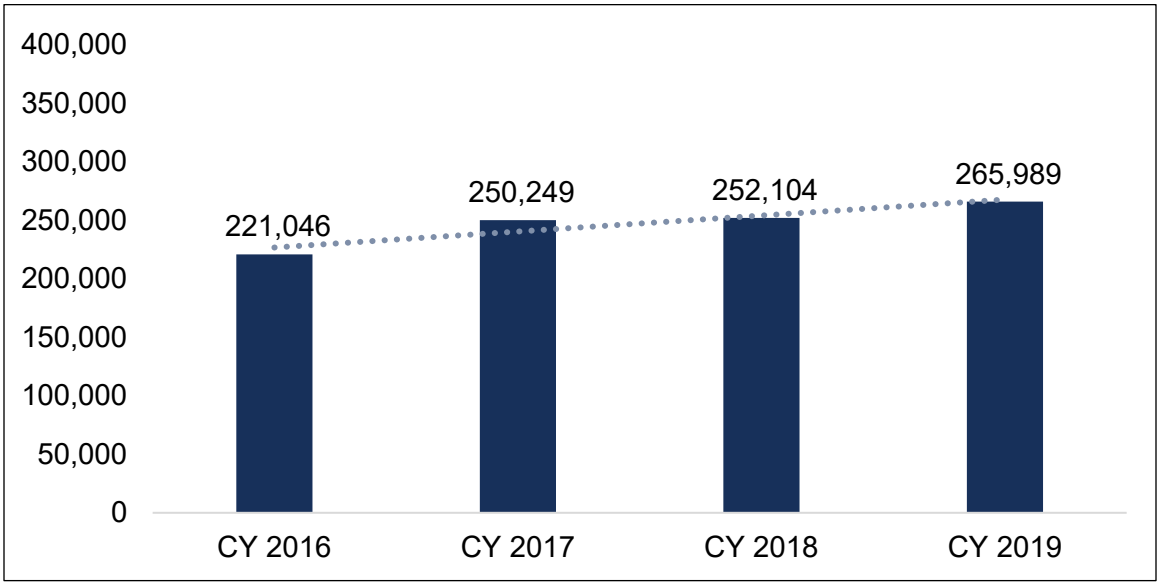
From the review, several factors were underscored as contributing to the increase in beneficiaries served in CY 2019. CalEQRO presents three observations.

1. MHPs increased their capacity to provide services. They expanded services and programs with, and leveraged the expertise of, contract providers (e.g., criminal justice partners). MHPs established new contracts and new partnerships with community organizations (e.g., new MOUs with schools). Also, MHPs expanded or modified their operations including the addition of evening and weekend services, establishment of open access or walk-in clinics, and geographic expansion of existing programs.

2. MHPs focused on unserved and underserved populations. While the definitions and criteria for unserved and underserved populations varied from MHP to MHP, all identified at least one population for whom more services were warranted. There were several efforts to reach at-risk or 'difficult-to-engage' populations, usually described as those experiencing homelessness and those living at home but resistant to treatment. Several MHPs leveraged available funds from initiatives such as No Place Like Home, Project Roomkey, and Emergency Solutions Grant Program to develop programs for at-risk populations. Several MHPs focused on services for incarcerated populations who were Medi-Cal eligible or were soon-to-be released. The jail mental health programs facilitate continuity of care and promote beneficiary stability in the community.

3. MHPs continued Latino/Hispanic outreach. MHPs increased or developed new contracts with promotoras, community health workers who are connected to Spanish-speaking communities. MHPs prioritized both written (e.g., of program material, flyers, and announcements) and verbal communication in Spanish. MHPs increased contracts for translation services and certified more staff as Spanish-speakers, capable of providing services and interpretation in Spanish. MHPs collaborated with other county departments to hire/provide navigators to educate communities about Medi-Cal and to enroll Hispanic/Latino individuals in SMHS. Because of this ongoing Hispanic/Latino outreach, MHPs realized an increase in access for Latino/Hispanic beneficiaries. (Figure 4-3)

Figure 4-3: Latino/Hispanic Beneficiaries Served, CY 2016-19



Differential Increase in Beneficiaries Served

Access by MHP Region and Size

While there was an overall increase in the number of beneficiaries served in CY 2019, not all MHPs experienced an increase. MHPs in the Superior region and Los Angeles had an increase, while the Southern and Central regions showed a decrease. The Bay Area MHPs had a small increase from CY 2018, but it was still well below the CY 2017 figure. Los Angeles region alone showed an increase of 5.13 percent, which was greater than the overall statewide increase in the number of beneficiaries served.

There was also differential increase in the number of beneficiaries served by MHP size. Small, small-rural, and very large (i.e., Los Angeles) MHPs experienced an increase, but large and medium-sized MHPs did not. Los Angeles' MHP accounts for almost one-third of the state's Medi-Cal beneficiaries. As a result, Los Angeles being able to serve a significantly increasing number of beneficiaries was the biggest driver in the statewide increase, and more than made up for the near static or decreasing trends in the other MHP regions or sizes.

Table 4-1: Beneficiaries Served by Region and Size, CY 2017-2019

Region / CY	Total Beneficiaries Served
Bay Area	
CY 2017	112,851
CY 2018	107,905
CY 2019	108,028
Central	
CY 2017	97,208
CY 2018	96,284
CY 2019	95,006
Los Angeles	
CY 2017	212,478
CY 2018	210,337
CY 2019	221,136
Southern	
CY 2017	180,408
CY 2018	177,370
CY 2019	176,209
Superior	
CY 2017	25,527
CY 2018	25,165
CY 2019	25,754

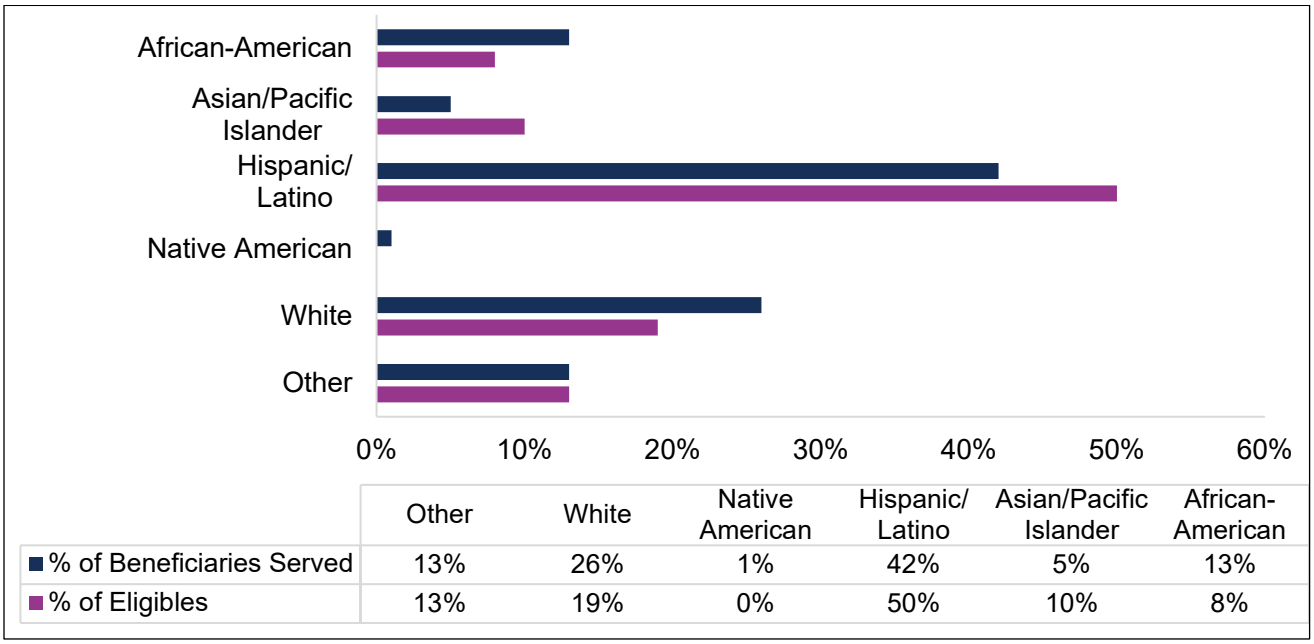
Size / CY	Total Beneficiaries Served
Very Large	
CY 2017	212,478
CY 2018	210,337
CY 2019	221,136
Large	
CY 2017	287,010
CY 2018	280,189
CY 2019	278,182
Medium	
CY 2017	87,684
CY 2018	85,397
CY 2019	84,704
Small	
CY 2017	32,598
CY 2018	32,502
CY 2019	33,219
Small-Rural	
CY 2017	8,688
CY 2018	8,628
CY 2019	8,877

Beneficiaries Served by Race/Ethnicity

Californians of diverse backgrounds access SMHS. In CY 2019, Latino/Hispanic beneficiaries constituted the largest racial/ethnic group served, at 42 percent. At the other end, Native Americans constituted less than 1 percent of beneficiaries served (Figure 4-4). Whites were the second largest group served at 26 percent, followed by Other, African American, and API. The Other group consists of those who identify as mixed-race or whose race/ethnicity was unknown.

Hispanic/Latino individuals constituted the largest proportion of Medi-Cal eligibles (at 50 percent) but were underrepresented in the numbers served (at only 42 percent) (Figure 4-4). As in previous years (i.e., since EQROs started tracking penetration rates for SMHS in California) access for Latino/Hispanic beneficiaries is lower than expected. Many reasons contribute to underuse of SMHS by Latino/Hispanic eligibles, including stigma and negative perceptions of mental illness, minimization of symptoms of mental illness and focus on somatic conditions, obstacles to communication with health care providers, and insufficient access to culturally competent providers.

Figure 4-4: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2019



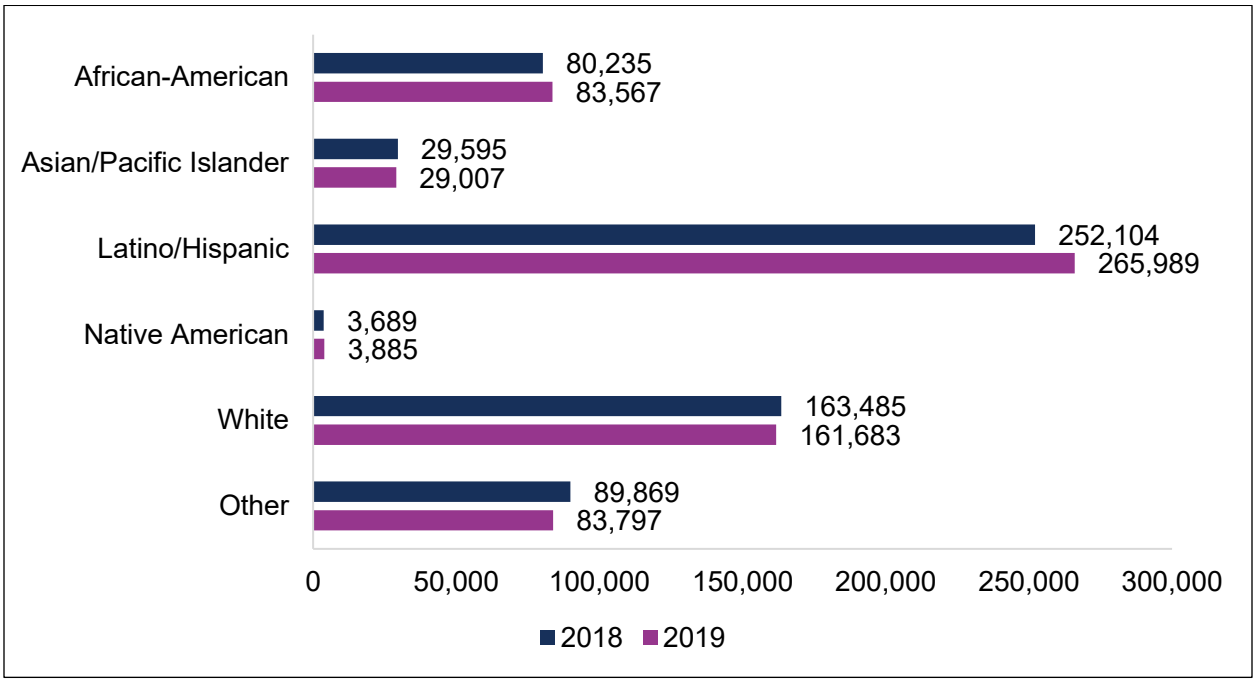
	Other	White	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
% of Beneficiaries Served	13%	26%	1%	42%	5%	13%
% of Eligibles	13%	19%	0%	50%	10%	8%

There was a differential increase in the number of beneficiaries served by race/ethnicity. There was an increase in the number of African-American, Latino/Hispanic, and Native American beneficiaries, but a decrease among APIs, Whites, and Other racial/ethnic group (Figure 4-5). The largest change was in the Other racial/ethnic group, where there was a 7.25 percent decrease in the numbers served. The decrease in beneficiaries who are identified as Other is significant and warrants investigation since they constitute the third highest number of beneficiaries served. It is not clear if the change reflects a decreased ability of MHPs to meet the needs of multi-racial, multi-ethnic individuals, or simply reflects a change in how Other beneficiaries are being identified. Research shows that racial identity is fluid and that change in identity is higher among those who are multi-racial.[18,19] CalEQRO primarily uses the categories from the Medi-Cal eligibility files, which means that the race and ethnicity determination is made by the individual county social services agency, not the MHPs. Any further research into race/ethnicity distribution will require collaboration with the social services agencies at the county and state levels.

[18] Doyle, J. M. and Kao, G. (2007). Are racial identities of multiracial stable? Changing self-identification among single and multiple race individuals. Soc Psychol Q. 70(4):405-423. nihms111096.pdf

[19] Parker, K., Horowitz, J. M., Morin, R. and Lopez, M. H. (2015, June 11). Multiracial in America. Pew Research Center. Proud, Diverse and Growing in Numbers. https://www.pewresearch.org/social-trends/2015/06/11/multiracial-in-america/

Figure 4-5: Beneficiaries Served Statewide by Race/Ethnicity, CY 2018-19

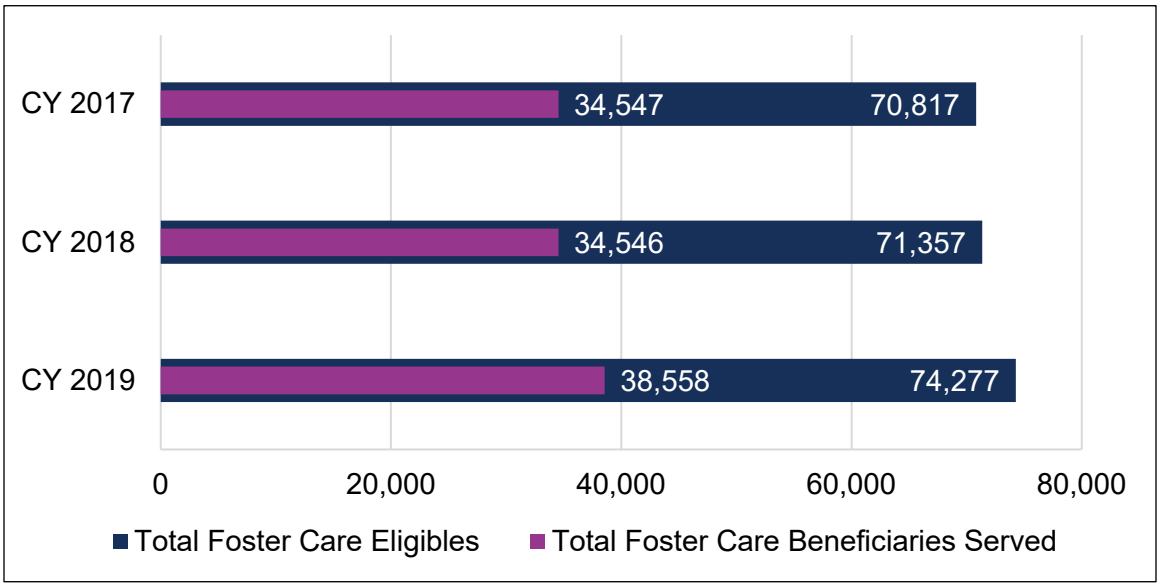


Foster Care

Youth, and youth in FC, represent an ever-increasing segment of users of mental health services. Unlike the overall downward trend in Medi-Cal eligibles, the number of FC eligibles has increased over the past three years. The number of youth who are in FC and eligible for Medi-Cal has increased by nearly 5 percent between CY 2017 to CY 2019, from 70,817 to 74,277 individuals (Figure 4-6). The number of youth in FC who received SMHS also increased, by 11.6 percent. The increase in use of SMHS among youth in FC is aligned with national trends showing increase in mental health issues among adolescents and young adults.[20] In California, the increase in the number of beneficiaries accessing SMHS is also influenced by the statewide settlement of two major lawsuits, Emily Q. v Bontá and Katie A. v Bontá in the past 15 years; the former influenced increased access to Therapeutic Behavioral Services (TBS), while the latter led to the Pathways to Well-Being for FC youth and an increased array of services including Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC).

[20] Rosenberg, J. (2019, March 19). Mental health issues on the rise among adolescents, young adults. https://www.ajmc.com/view/mental-health-issues-on-the-rise-among-adolescents-young-adults

Figure 4-6: Medi-Cal Eligibles and Beneficiaries Served, Foster Care, Three-Year Trend

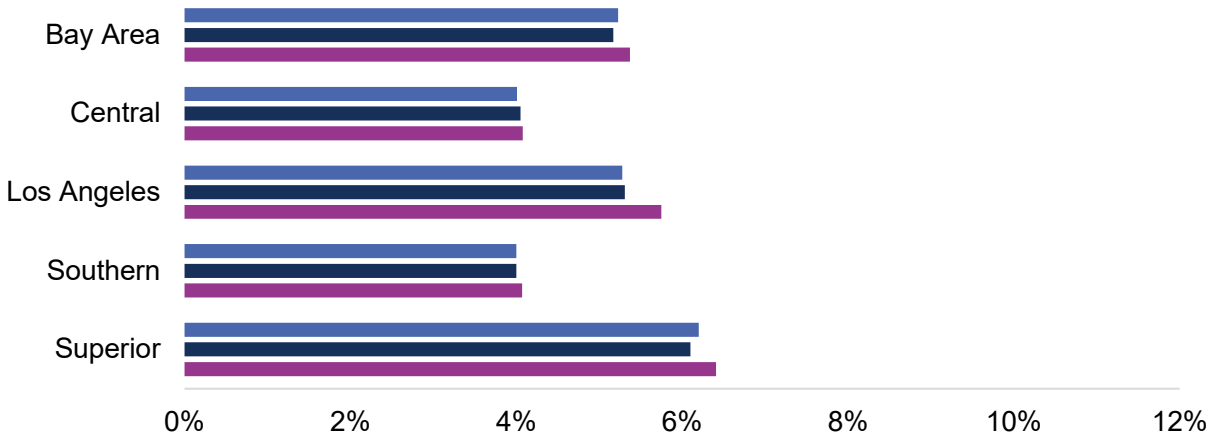


Relative Access to SMHS

Penetration rate, the percentage of Medi-Cal beneficiaries that used SMHS at least once in CY 2019, is another way to evaluate access to SMHS. Penetration rate is a measure of relative access that considers who is eligible for services compared to who received them. Because of the declining number of Medi-Cal eligible beneficiaries, relative to the number of beneficiaries served, the penetration rate increased in CY 2019, from 4.66 percent to 4.86 percent. Unlike the overall statewide penetration rate which increased, primarily, because of a decrease in Medi-Cal beneficiaries, the FC penetration rate increase was driven by an increase in the beneficiaries served that outpaced the growth in FC beneficiaries.

The penetration rate for SMHS increased in all regions, despite MHPs in the Southern and Central regions serving fewer beneficiaries than in the previous year (Figure 4-7). The Los Angeles region had the highest increase in penetration rate and maintained the second highest penetration rate in the state after the Superior region. Los Angeles had both a significant increase in the number of beneficiaries served and a decline in the number of Medi-Cal eligible beneficiaries.

Figure 4-7: Overall Penetration Rate by MHP Region, CY 2017-2019



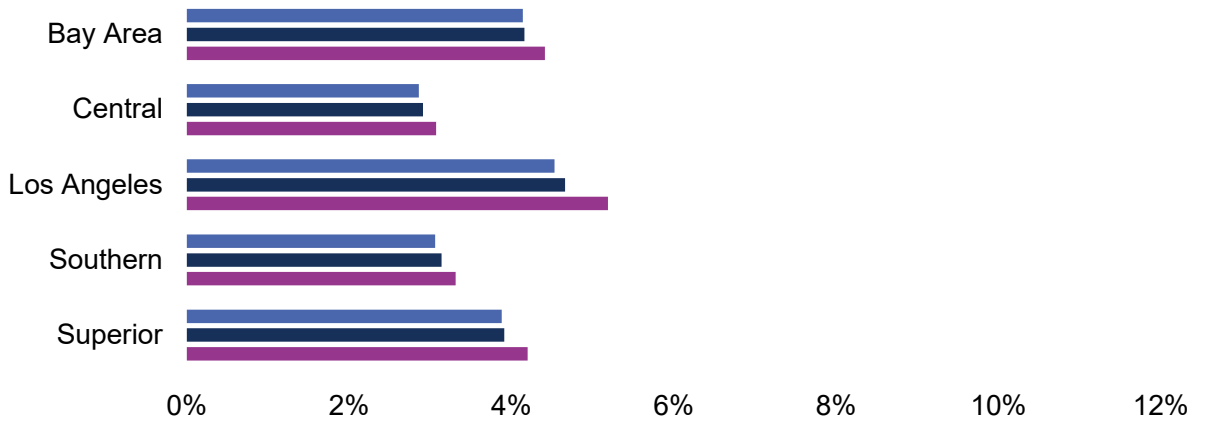
	Superior	Southern	Los Angeles	Central	Bay Area
CY 2017	6.20%	4.00%	5.28%	4.01%	5.23%
CY 2018	6.10%	4.00%	5.31%	4.05%	5.17%
CY 2019	6.41%	4.07%	5.75%	4.08%	5.37%

Disparities

Healthcare disparities are variations in access to care, quality of care, health outcomes, and among other variables between populations or groups. Disparities may be based on age, gender, race/ethnicity, income, disability status, sexual orientation, language, geographic location, and other characteristics. While disparities simply point to differences, they can be associated with inequities, which have consequences for access to health care among other factors (e.g., type of treatment received; the appropriateness and thoroughness of treatment; and provider's perceptions of treatment adherence). Penetration rate provides one measure of disparities in access to SMHS.

With the increase in the number of Latino/Hispanic beneficiaries served in CY 2019, there was a corresponding increase in the penetration rate. A slow but steady increase in the penetration rate of Latino/Hispanic beneficiaries is evident across all MHPs, by region (Figure 4-8). This increase is particularly evident in Los Angeles, which had a 5.13 percent (10,799) increase in Hispanic/Latino beneficiaries than in the previous year. A strategy that MHPs have used to facilitate access has been through collaboration with key informant or stakeholder groups and mental health advocates. MHPs participated in gatherings, community forums, health fairs, and the like to reach Latino/Hispanic beneficiaries.

Figure 4-8: Latino/Hispanic Penetration Rate by MHP Region, CY 2017-19

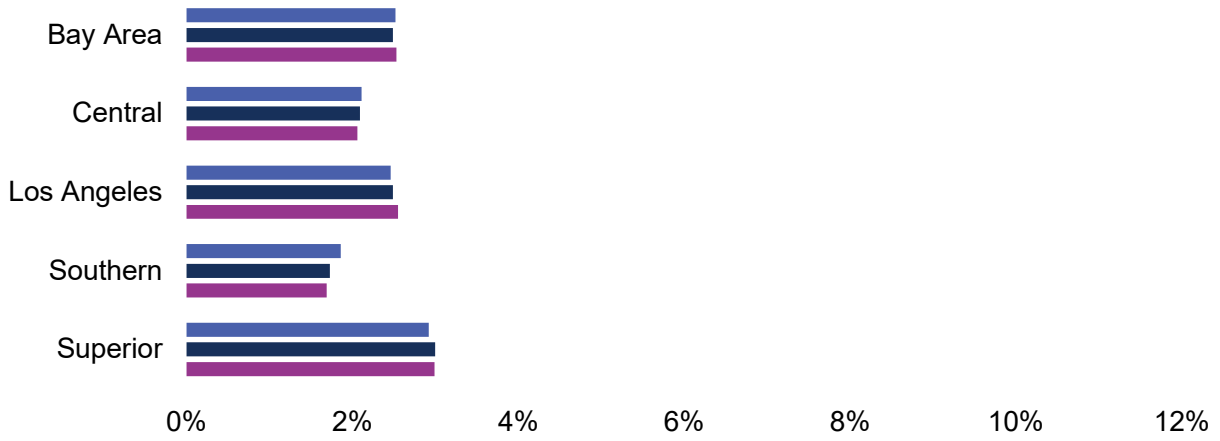


	Superior	Southern	Los Angeles	Central	Bay Area
CY 2017	3.88%	3.06%	4.53%	2.86%	4.14%
CY 2018	3.91%	3.14%	4.66%	2.91%	4.16%
CY 2019	4.20%	3.31%	5.19%	3.07%	4.41%

The API population is the other racial/ethnic group that has historically had less access to SMHS than beneficiaries of other racial/ethnic groups. Like the Latino/Hispanic beneficiaries, the number of API that access SMHS is lower than expected based on their proportion in the population. Despite constituting 10 percent of total Medi-Cal eligibles, they accounted for only 5 percent of the beneficiaries who received SMHS. In fact, API eligibles are the racial/ethnic group least likely to receive SMHS. A three-year trend of API penetration rate shows mostly stagnant or even declining access to SMHS depending on the MHP region (Figure 4-9). The Southern and Central region MHPs witnessed steadily declining penetration rates among API beneficiaries. The API penetration rate in MHPs in the Southern region, most of which are large MHPs, has been historically the lowest and merits further examination for identification of the underlying factors and potential remedies.

API eligibles are the least likely racial/ethnic group to receive SMHS

Figure 4-9: Asian/Pacific Islander Penetration Rate by MHP Region, CY 2017-19

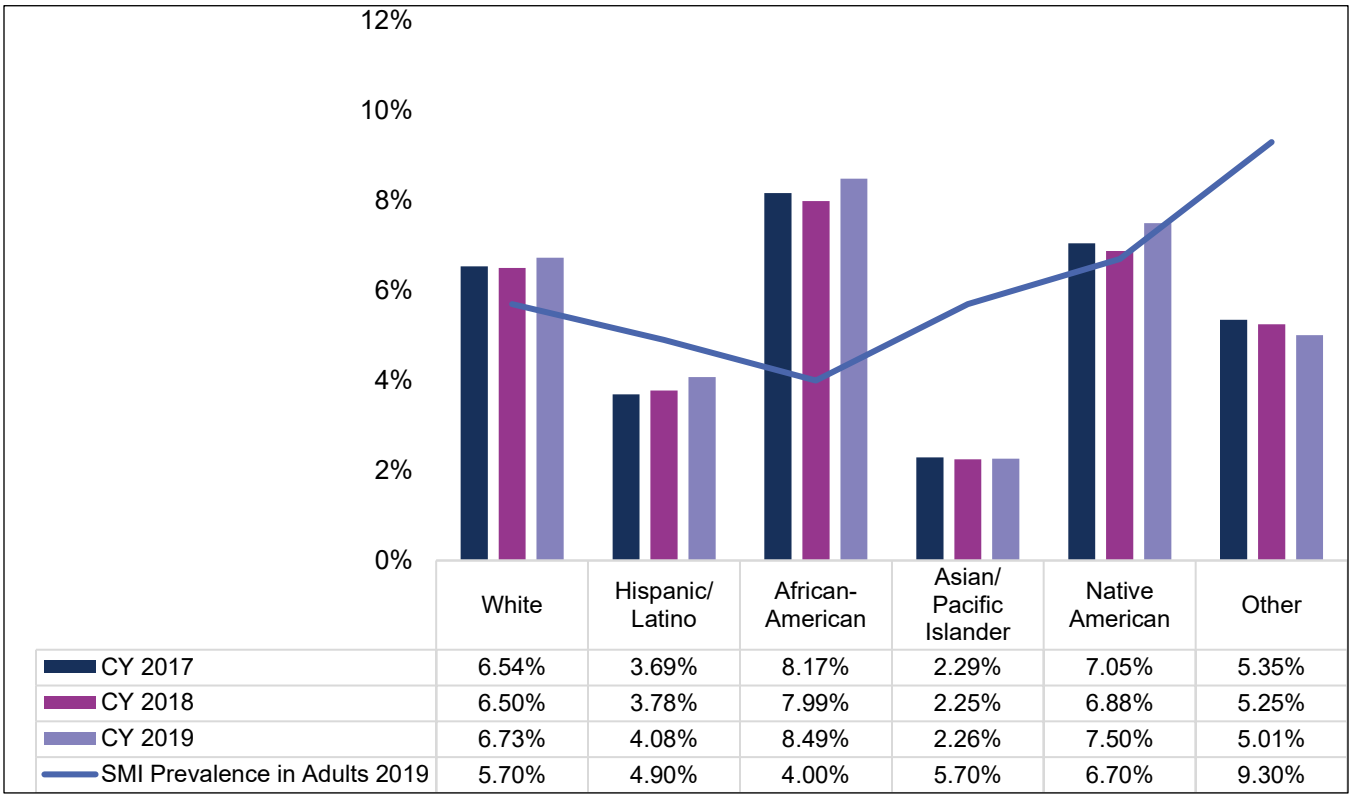


	Superior	Southern	Los Angeles	Central	Bay Area
CY 2017	2.92%	1.86%	2.46%	2.11%	2.52%
CY 2018	3.00%	1.73%	2.49%	2.09%	2.49%
CY 2019	2.99%	1.69%	2.55%	2.06%	2.53%

Another way to frame disparities in access to SMHS is to compare against benchmarks of utilization of mental health services. The National Institute of Mental Health's (NIMH) prevalence rates for mental illness for adults show rates between 4 and 9 percent and differences among racial/ethnic groups.[21] California's SMHS penetration rate is comparable to the SMI prevalence rates for Whites and Native Americans (Figure 4-10). However, for all other races, there are disparities suggesting both over-representation and under-representation of access to services. This comparison provides evidence that Latino/Hispanic and API beneficiaries, in particular, may be under-served. There is also a notable disparity in the Other racial/ethnic group, who show a much lower rate of access to SMHS. This comparison also suggests that African-Americans are over-represented in services. Possible reasons for over-representation include clinical (and implicit) bias, misdiagnosis, and over-diagnosis of mental illness of African-Americans. Another possible disparity points toward utilization of more acute or crisis services by African-Americans due to a lack of timely access to lower levels of care.

[21] National Institute of Mental Health. (n.d.) Mental Illness https://www.nimh.nih.gov/health/statistics/mental-illness

Figure 4-10: Penetration Rates Statewide and SMI Prevalence Rates Nationwide by Race/Ethnicity, CY 2017-19



	White	Hispanic/ Latino	African-American	Asian/ Pacific Islander	Native American	Other
CY 2017	6.54%	3.69%	8.17%	2.29%	7.05%	5.35%
CY 2018	6.50%	3.78%	7.99%	2.25%	6.88%	5.25%
CY 2019	6.73%	4.08%	8.49%	2.26%	7.50%	5.01%
SMI Prevalence in Adults 2019	5.70%	4.90%	4.00%	5.70%	6.70%	9.30%

Clearly, there are differences in access to SMHS of eligible Medi-Cal beneficiaries. The Hispanic/Latino and API access has persistently lagged the other racial/ethnic groups. The reasons for these differences are varied and complex, including lack of access to culturally and linguistically competent services and providers; language and cultural barriers; stigma; fears about psychotropic medications; mistrust of treatment; or some combination thereof. It should be an ongoing task of MHPs to identify these differences and address potential inequities in access.

Availability and Accessibility

Types of Services

Access includes providing services to meet beneficiary needs across the lifespan and through different experiences. MHPs provide four main categories of SMHS: inpatient, outpatient, residential, and urgent. Therein MHPs have provided a broad range of services including therapy services, crisis stabilization, medication support, inpatient services, and targeted case management, among others.

Typically, the majority of SMHS are delivered through outpatient services. MHPs either provide these through county-operated clinics or arrange for the provision of those outpatient services through contract providers and network providers. Other partners in the delivery of outpatient services included primary care providers and clinics, such as the federally qualified health facilities (FQHCs), Community Health Centers, Rural Health Centers, Indian Health Clinics, child welfare/human services, educational systems (K-12, vocational, community college, higher education), law enforcement/criminal justice,

SUD programs, and public health/health departments. Public health collaboration was particularly prominent after the onset of COVID-19. CalEQRO noted increased collaborations with community-based organizations (CBOs), housing authority/affordable housing programs, and managed care plans.

Youth have access to specialized services that provide individualized and trauma-informed care, inclusive of ICC, IHBS, TFC, and TBS.

Therapeutic Behavioral Services

CalEQRO tracks the utilization of TBS by the EPSDT beneficiaries, on a statewide basis. Per the settlement of the Emily Q. v. Bontá class action lawsuit, the state agreed to maintain a 4 percent or higher TBS penetration rate.[22] The TBS penetration rate in CY 2019 was 4.68 percent.

Table 4-2: EPSDT Beneficiaries Receiving TBS, CY 2019

	EPSDT Beneficiary Count	Beneficiaries Receiving TBS	TBS Penetration Rate
Statewide	265,401	12,124	4.57%
Non-Emily Q. FC Beneficiaries	31,018	1,145	3.69%
Emily Q. FC Beneficiaries	234,383	10,979	4.68%

Therapeutic Foster Care

TFC was developed to provide short-term, intensive treatment for youth in FC through placement with trained, intensely supervised, and supported parents. TFC prioritizes family-based setting to address serious emotional, behavioral, and mental health needs of children. Of the 50 MHPs that completed the FY 2020-21 CalEQRO Pathways to Well-Being form, only 15 (30 percent) were providing TFC in FY 2019-20, with an additional five MHPs (10 percent) in the process of providing TFC. Most MHPs were not providing this service, had not conducted a needs assessment (70 percent), and had not issued an RFP for TFC services (62 percent).

The overall consensus among MHPs, including those that are currently providing TFC, is that TFC is difficult to provide with few foster family agencies (FFAs) interested in facilitating this service and too few parents/families willing to take on the responsibilities and risks. MHPs shared that the level of training, the amount of oversight, and grueling requirements make for unfavorable cost-benefit ratio.

[22] The former Department of Mental Health and DHCS, with local county MHP agencies, have agreed to increase utilization of TBS and ensure accessible, effective, and sustained services for children and their families in the Emily Q. class in California. https://www.dhcs.ca.gov/services/MH/Pages/Court_Documentation.aspx

30%

MHPs that provided TFC in FY 2019-2020

To fill the gap created by TFC services, some MHPs are meeting the need through intensive services foster care (ISFC). ISFC provides minor and non-minor dependents who have intensive needs (medical, therapeutic, and/or behavioral) with trained, trauma-informed families and a supportive system. While recruitment for families for ISFC can also be challenging, FFAs find families more willing to accept this level of commitment than TFC. Many MHPs also provide TBS to eligible EPSDT beneficiaries in situations where they are not able to provide TFC.

No Wrong Door

As in previous year, MHPs focused on the front door—getting beneficiaries to SMHS. MHPs focused on public-facing communication and raising awareness of services. There were improvements in county websites making them easier to navigate, with ready links for Spanish and other translations. However, continued improvements were needed; information regarding transportation and wellness centers were still difficult to locate. There were a number of impressive media outlets, including interactive, informative websites, Facebook Live discussions and videos, and several engaging community newsletters. One MHP sent regular communication through an email distribution list maintained by peer employees. Following the onset of COVID-19, communication also included measures to maintain the health and safety of the community as well Medi-Cal beneficiaries. Many MHPs partnered with public health and other county agencies to produce public service announcements and to communicate ongoing availability of mental health services.

Efforts to streamline access to services was also evident. County mental health staff were embedded, integrated, and/or co-located with schools, law enforcement, social services, probation, and juvenile-serving agencies. One MHP effectively eliminated the emergency room visits prior to a crisis stabilization unit (CSU) through its acquisition of equipment to conduct medical clearance onsite and requisite staff training. Several other strategies to enhance entry into services were documented through performance improvement projects (PIPs) (see Chapter 8). MHPs conducted projects on implementing email/text reminders; same-day access; reduction in intake paperwork; and increased intake assessment slots.

Beyond the Front Door

Following the onset of COVID-19, a new paradigm in service delivery was needed. Maintenance of services was paramount. MHPs' focus was not just on the front door, but keeping beneficiaries engaged and still connected to services. The MHPs relied on the following strategies, including fiscal and technical adaptations, to achieve this:

- Enhancement of pre-existing telehealth capabilities.
- Adaptation of new service and billing modality (field-based, telehealth, telephone).
- Utilization of new resources and grants.
- Board of supervisor support.
- Financial reserves including advances to the CBOs.
- Business continuity plan.
- Activating and repurposing the existing communication channels.
- Information on MHP websites.

One collateral damage to the access and service delivery system due to the onset of the COVID-19 pandemic was the suspension of certain services by many MHPs such as the wellness centers and group therapy programs. Only during the reviews conducted in the last quarter of FY 2020-21, CalEQRO found these services slowly coming back up with careful planning of safety procedures or alternative means utilizing secure teleconferencing technologies.

A greater number of beneficiaries are receiving multiple services and remaining in care with a corresponding reduction in the lower frequency of service encounters. Ultimately, greater retention in services bodes well for treatment outcomes and achievement of goals.

Table 4-3: Retention of Beneficiaries

Number of Services Approved per Beneficiary Served	CY 2017 Average Percentage	CY 2018 Average Percentage	CY 2019 Average Percentage
1 Service	11.13	10.98	10.62
2 Services	6.67	7.00	6.87
3 Services	5.39	5.64	5.31
4 Services	4.93	5.08	4.96
5-15 Services	31.11	30.80	30.77
>15 Services	40.76	40.51	41.48

Evaluating Access

MHPs implemented strategies to enable and improve access, but the evaluation of those strategies was not evident. Few MHPs could clearly link strategies to improve access with outcomes. MHPs would do well to adopt a more comprehensive and analytic view of disparities in access that emphasizes such evaluation through both PIPs and other evaluative efforts. Without gaining such knowledge, any improvements and continuous quality improvement efforts are unlikely to be sustained long-term.

Summary

Overall, MHPs did well to facilitate access to SMHS in CY 2019. A combination of internal and external factors influenced access to and provision of SMHS. There are various factors—financial, political, technological, and environmental, including workplace and organizational dynamics—that were strengths that enabled an increase in the number of beneficiaries served in CY 2019. There are also weaknesses that limit MHP's ability to provide access, particularly to underserved communities, API, and Latino/Hispanic eligibles. COVID-19 shed a particular light on the strengths and weaknesses of MHPs in delivering SMHS, many of which were reflected nationwide. The pandemic presented extraordinary challenges, which the MHPs rose to the occasion to address. Many of the adaptations to the access and service delivery system are likely to continue beyond the pandemic, and perhaps even become permanent service access modalities.

2020-2021 BHC-CalEQRO Specialty Mental Health Statewide Annual Report

Chapter 5

Timeliness

Timeliness

Background

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. 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 the time between an initial request for service to an offered appointment and a rendered service, and a valid and reliable process to review the metrics on a regular basis. Counties then need to analyze the data and adjust service delivery systems based on these findings to ensure that beneficiaries receive timely care.

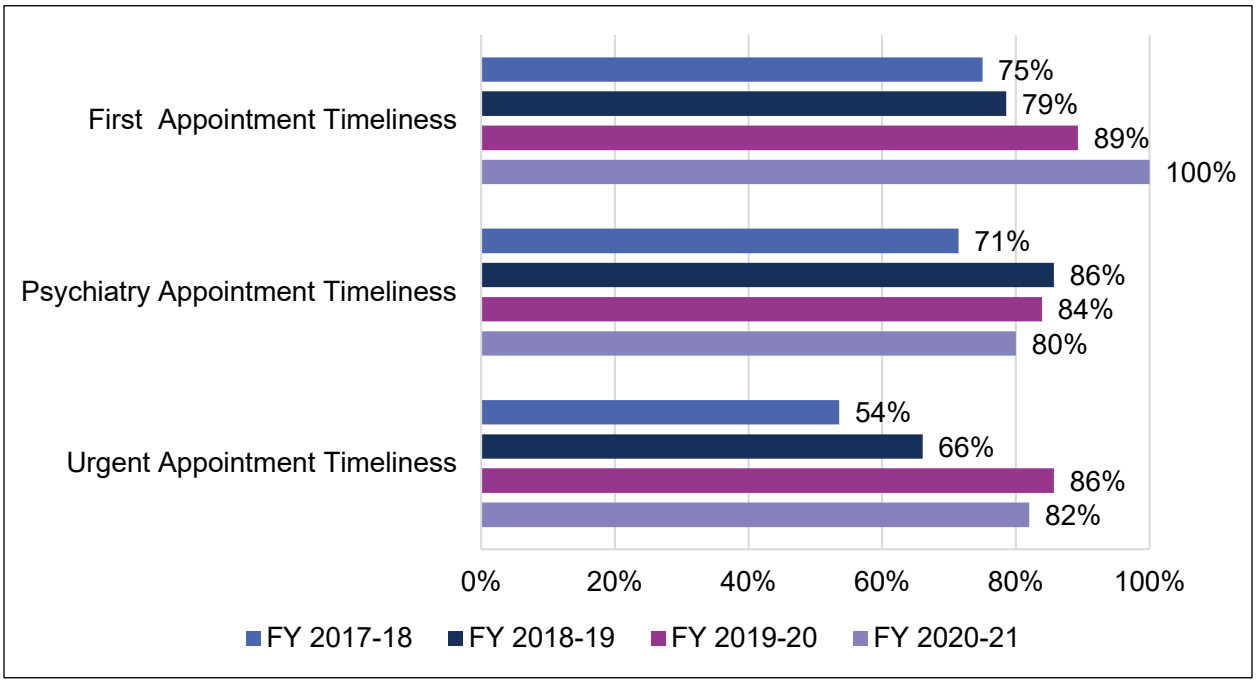
CalEQRO developed the MHP Assessment of Timely Access (ATA) to provide a systematic approach to evaluate how MHPs track and report timeliness information and to evaluate performance on key timeliness metrics. MHPs are asked to report timeliness data stratified by age and foster care status for the entire service delivery system, inclusive of county-operated and contractor-operated services. MHPs also report on technical and analytical capabilities to capture the data elements and report on them. The six timeliness performance measures on which MHPs are asked to report include metrics identified by DHCS, HEDIS, and CalEQRO as key indicators to evaluate timely access to quality care:

- Initial non-urgent outpatient mental health appointment
- Initial non-urgent outpatient psychiatry appointment
- Urgent services, including mental health and psychiatry
- Outpatient no-show rates
- Follow-up post psychiatric inpatient discharge
- Psychiatric inpatient readmission

Timeliness Reporting Capabilities

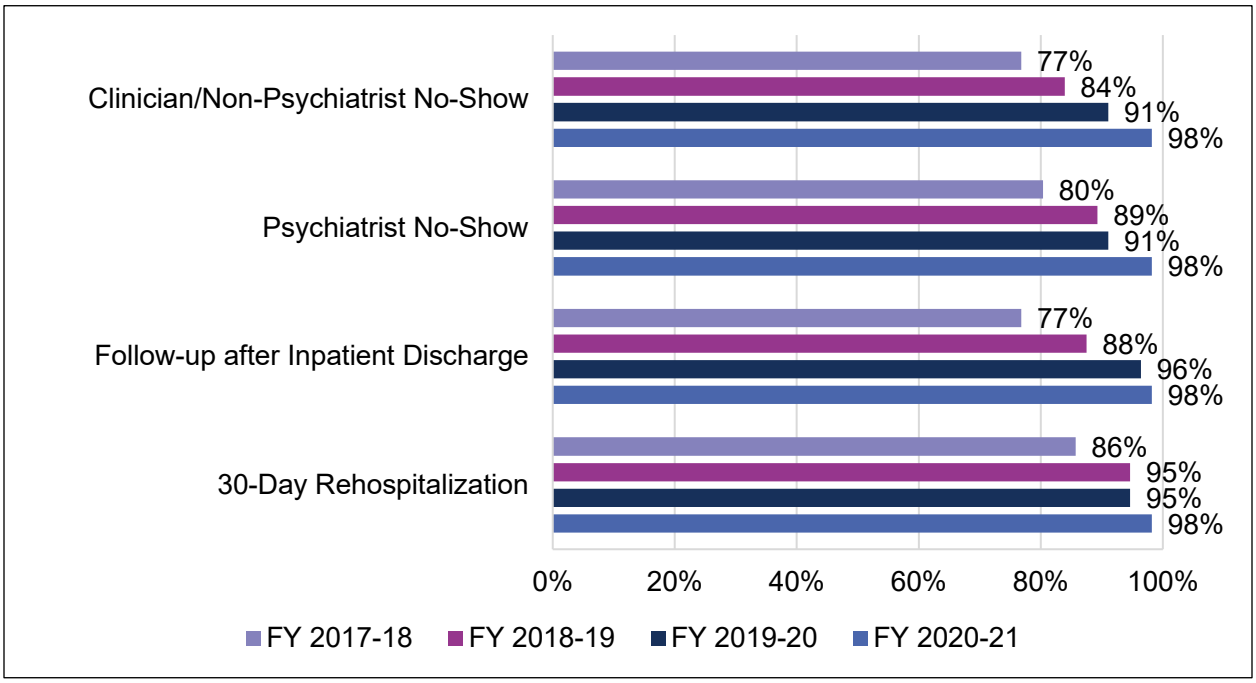
With the implementation of NA reporting requirements, MHPs' timeliness reporting rates have improved for most metrics that CalEQRO examines. Between FY 2017-18 and FY 2020-21, MHPs increased their reporting rates on the three timeliness metrics mandated by BHIN 18-011: 100 percent of MHPs now report on first offered non-urgent mental health appointment (a 33 percent improvement), 80 percent of MHPs report on first non-urgent psychiatry appointment (a 13 percent improvement), and 82 percent of MHPs report on timeliness to urgent appointment, inclusive of mental health and psychiatry services, reflecting a 52 percent increase. (Figure 5-1)

Figure 5-1: Timeliness Reporting Rates Statewide, Mandatory Metrics, FY 2017-18 to FY 2020-21



Although not required by regulation, tracking additional timeliness metrics provides MHPs with even more information that potentially impacts beneficiary outcomes. No-show rates have significant beneficiary care, fiscal, and operational impacts. Follow-up after inpatient discharge and inpatient readmission rates have important quality of care implications and are discussed in more detail in the accompanying Validation of Performance Measures report. MHPs have increased their tracking of these measures since FY 2017-18, with 55 MHPs now reporting on them. (Figure 5-2)

Figure 5-2: Timeliness Reporting Rates Statewide, Additional Metrics, FY 2017-18 to FY 2020-21



While most MHPs have adopted the state-mandated timeliness standards for metrics required by DHCS, many MHPs do not have the infrastructure to disaggregate timeliness data by age group and foster care status or the necessary interoperability to exchange data across multiple providers who use different EHRs.

Despite the improvement in timeliness reporting rates, some MHPs face challenges in how they gather information for timeliness metrics. Because of technical challenges, the MHPs often resort to manual tracking of the data elements needed to compute the actual metrics. This particularly impacts the first offered appointment categories.

The lack of widespread electronic information exchange also necessitates some manual tracking for MHPs who have significant contract-provided services. This issue varies from MHP to MHP, and even within the same MHP depending on the contract providers' own IS and information exchange capabilities.

These varying nuances provide important context when evaluating MHP performance on timeliness measures. Data reported may reflect only those MHPs that are able to report on the measures, and then, the data may only reflect a portion of the service delivery system.

Timeliness Performance

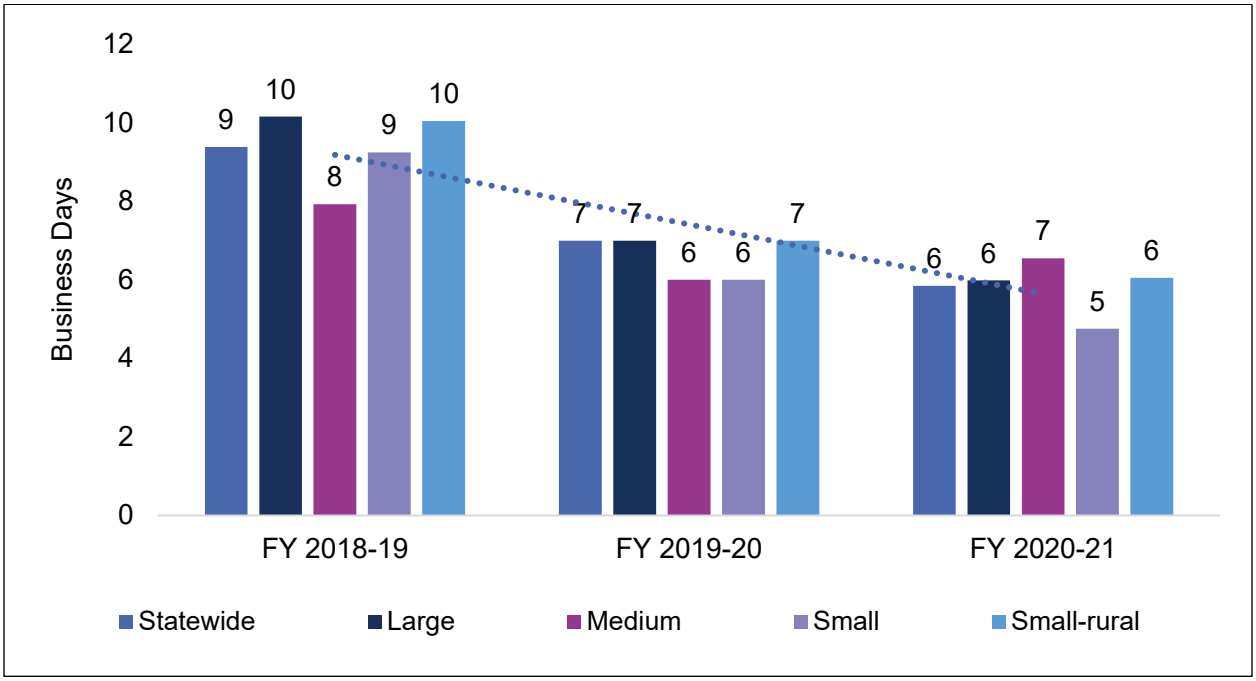
Initial Outpatient Mental Health Services

One measure of an MHPs' ability to provide timely services to beneficiaries is the average wait time between an initial service request and the first offered appointment. DHCS has set a 10-business day

standard for this measure, which reflects system capacity. By comparison, timeliness to the first non-urgent mental health service rendered more closely reflects the beneficiary's experience and may be a more reliable measure to track, due to the functionality of many IS. MHPs set their own standards for this measure, although 75 percent of the MHPs reported establishing the same 10-day standard for this measure as that for the first offered appointment.

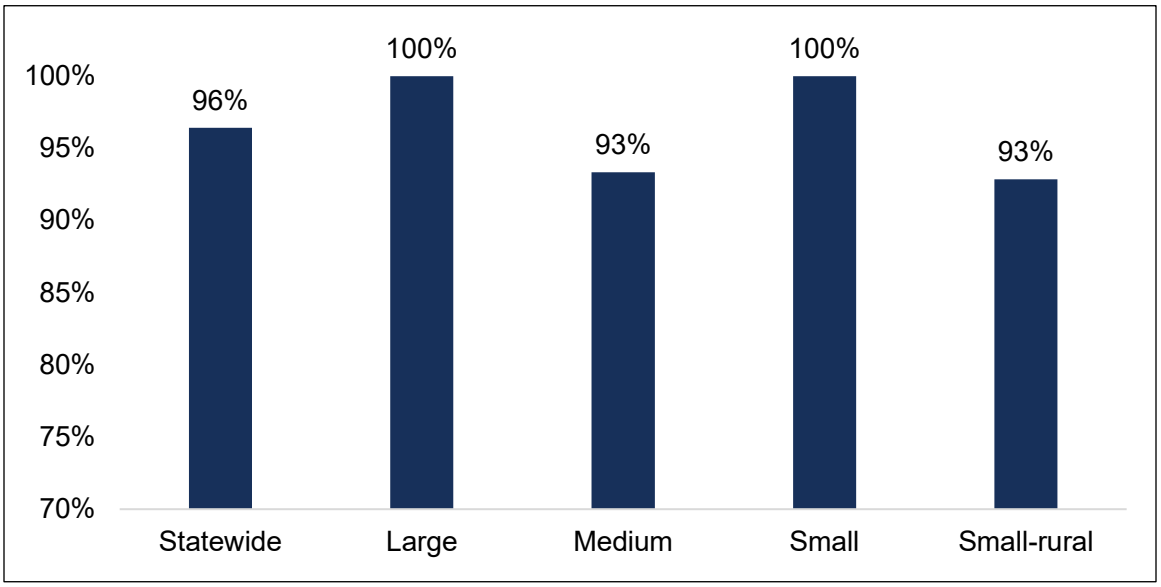
Over time, the performance on timeliness to first offered appointment has improved (Figure 5-3). Among MHPs that reported this measure, statewide wait times have decreased by 33 percent from FY 2018-19 (9-days) to FY 2020-21 (6-days). Similar decreases are seen across MHPs of all sizes, with the slightest improvement (12.5 percent) seen in medium-sized MHPs.

Figure 5-3: Business Days to First Offered Appointment, Statewide and by MHP Size, Three Year Trend



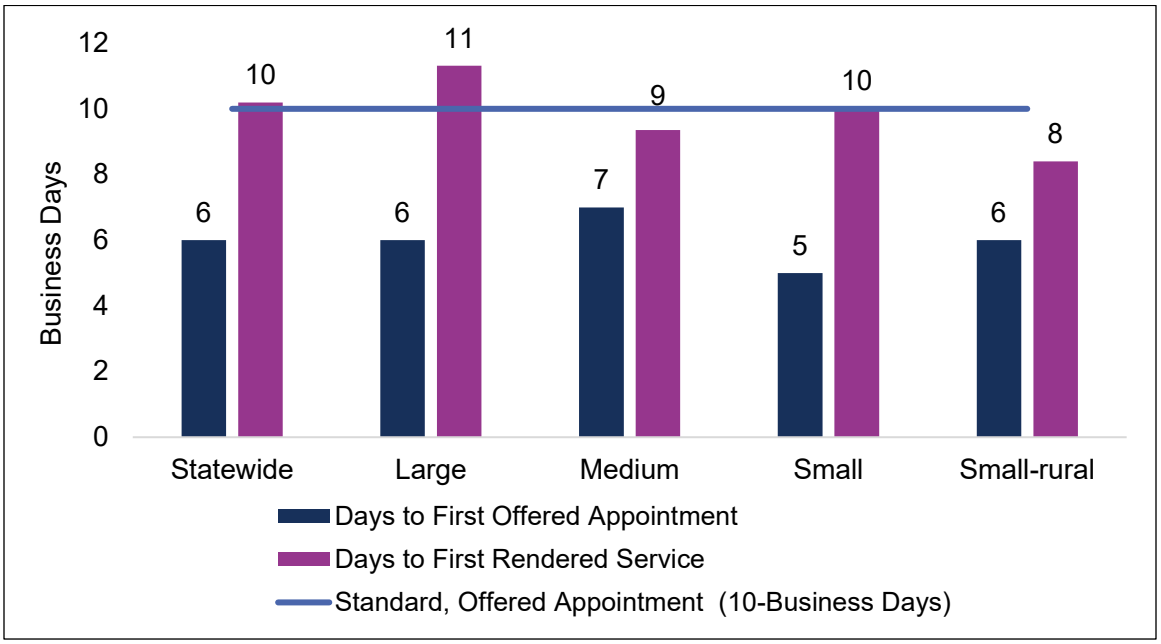
Overall, 96 percent of California's MHPs can offer a non-urgent initial mental health appointment within the statewide standard of 10-business days. Large and small MHPs report meeting the standard 100 percent of the time, while medium and small-rural MHPs report meeting this standard 93 percent of the time. (Figure 5-4)

Figure 5-4: Percentage Meeting First Offered Appointment Standard, Statewide and by MHP Size, FY 2020-21



In FY 2020-21, MHPs reported an average wait time to first offered mental health appointments that was at least 30 percent lower than the state-defined standard of 10 business days (Figure 5-5). In all but the large MHPs, average wait times to first mental health service rendered were also at or below the MHP-defined offered timeliness standards; large MHPs averaged 11 days to first service rendered.

Figure 5-5: Business Days to First Offered Mental Health Appointment and Rendered Service, Statewide and by MHP Size, FY 2020-21

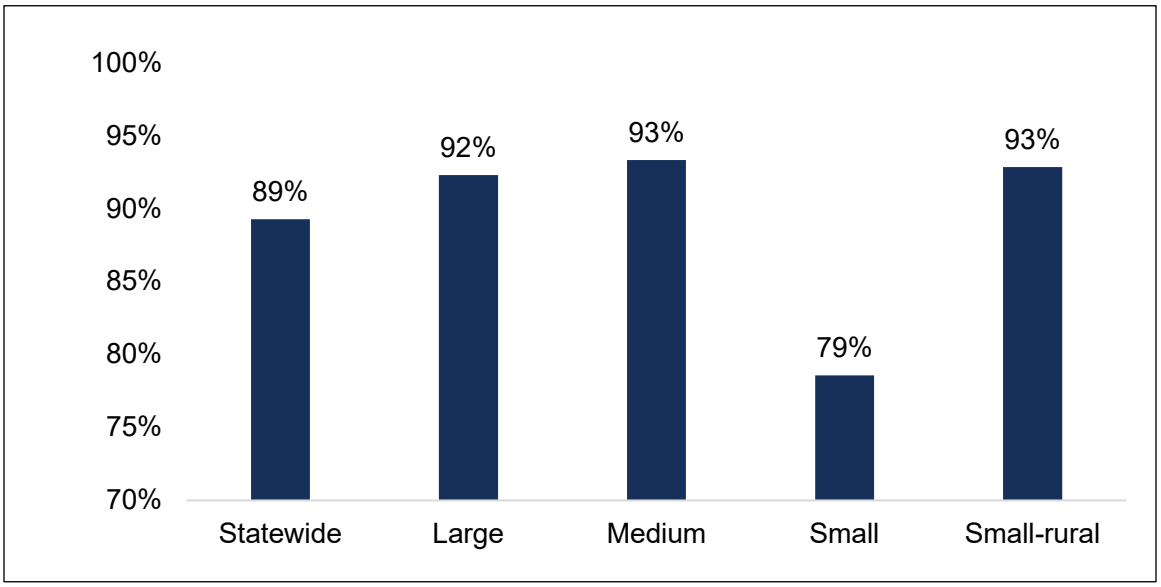


Initial Outpatient Psychiatry Service

Delays in accessing psychiatric services can lead to lost engagement opportunities, increased emergency room encounters, and rising psychiatric inpatient hospitalizations for beneficiaries. Because of this, timeliness to initial psychiatry encounter is a critical element of the EQR process. Further, DHCS has established a 15-business day standard for timeliness to first offered non-urgent psychiatry appointment.

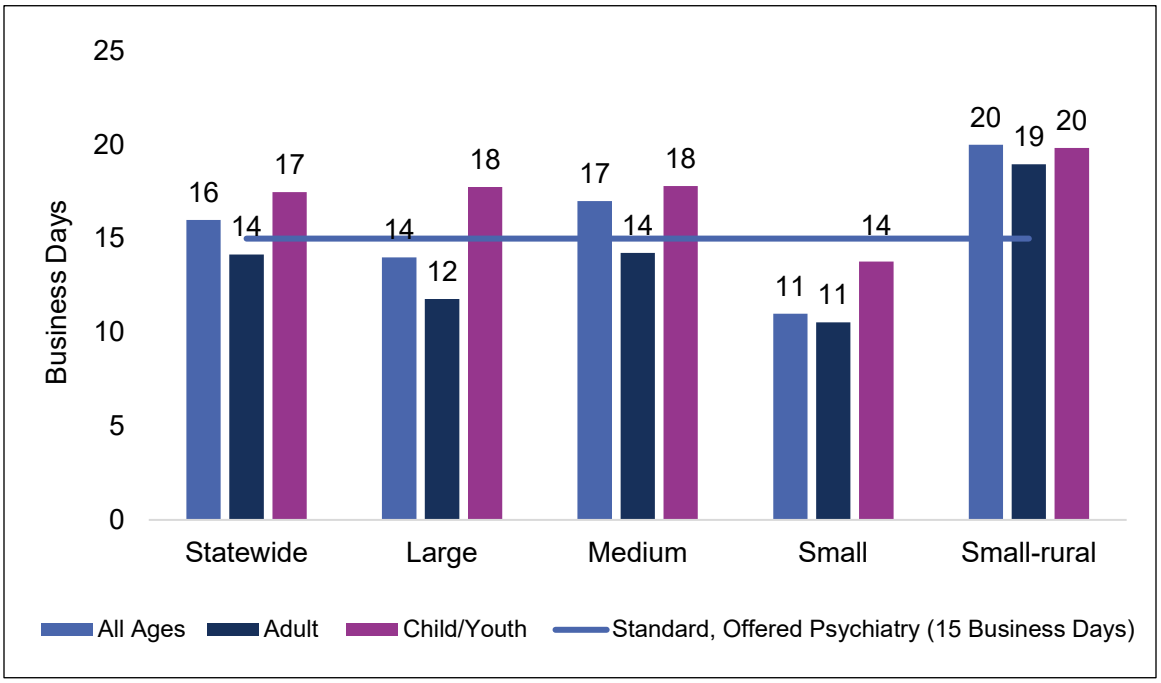
Among the 52 MHPs that reported timeliness to first psychiatry in FY 2020-21, MHPs of all sizes report they meet the 15-business day standard overall at least 79 percent of the time. (Figure 5-6)

Figure 5-6: Percentage Meeting First Offered Psychiatry Appointment Standard, Statewide and by MHP Size, FY 2020-21



On average, wait times to first psychiatry appointment ranges between 11 and 20 business days. In all but small-rural MHPs, the average wait time for adults is less than the 15-business day standard; conversely, average wait times for children/youth exceed the statewide standard in all but small MHPs (Figure 5-7). Although children access psychiatry appointments less often, their wait time is higher than the adults, mostly likely reflecting the relative shortage of child psychiatrists across the state.

Figure 5-7: Business Days to First Offered Psychiatry by Age, Statewide and by MHP Size, FY 2020-21



Urgent Services

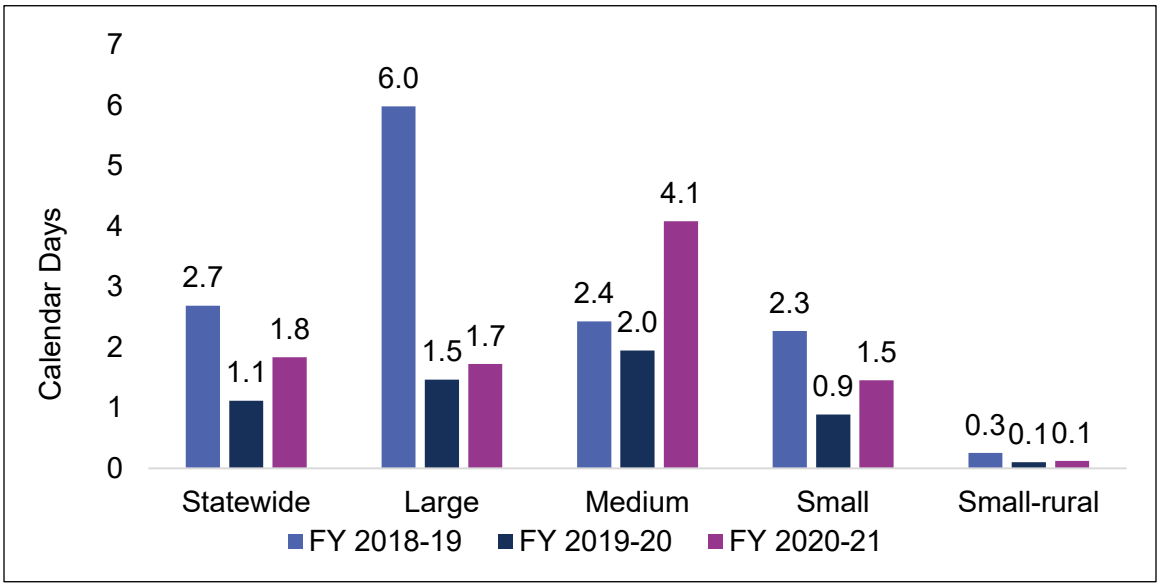
CalEQRO evaluates whether the MHP has a methodology to collect data related to timeliness for urgent conditions and whether it adheres to the statewide standards of 48-hours for urgent conditions that do not require prior approval and 96-hours for those that do require prior authorization.

In FY 2020-21, all MHPs report that they have adopted the statewide urgent timeliness standards. Many hold all urgent conditions to the more restrictive 48-hour standard – both reflecting difficulty in tracking the metric and the commitment to meeting the needs of the beneficiary.

A common methodological challenge reported by MHPs, some EHRs are only able to report timeliness on a daily basis, rather than the required hourly increments. As such, to allow for statewide analysis, CalEQRO converted all reported timeliness data to daily increments for the FY 2020-21 Medi-Cal SMHS Statewide Annual Report. An additional methodological issue is that one MHP's data can skew the results, making the average look higher than is truly reflective of most of the MHPs. For example, in FY 2018-19, one large MHP reported an average of 25 days, which skewed the average for large counties to 6.0 days. If that outlier county were removed from the analysis, the average would be in line with FY 2019-20 and FY 2020-21.

Statewide, the 48-hour standard for an urgent appointment is being met with a 1.8-day average. While all MHP size categories, except for medium, meet the 48-hour standard in FY 2020-21, small-rural MHPs average a time to service of less than one day. (Figure 5-8)

Figure 5-8: Calendar Days to Urgent Appointment, Statewide and by MHP Size, FY 2018-19 to FY 2020-21

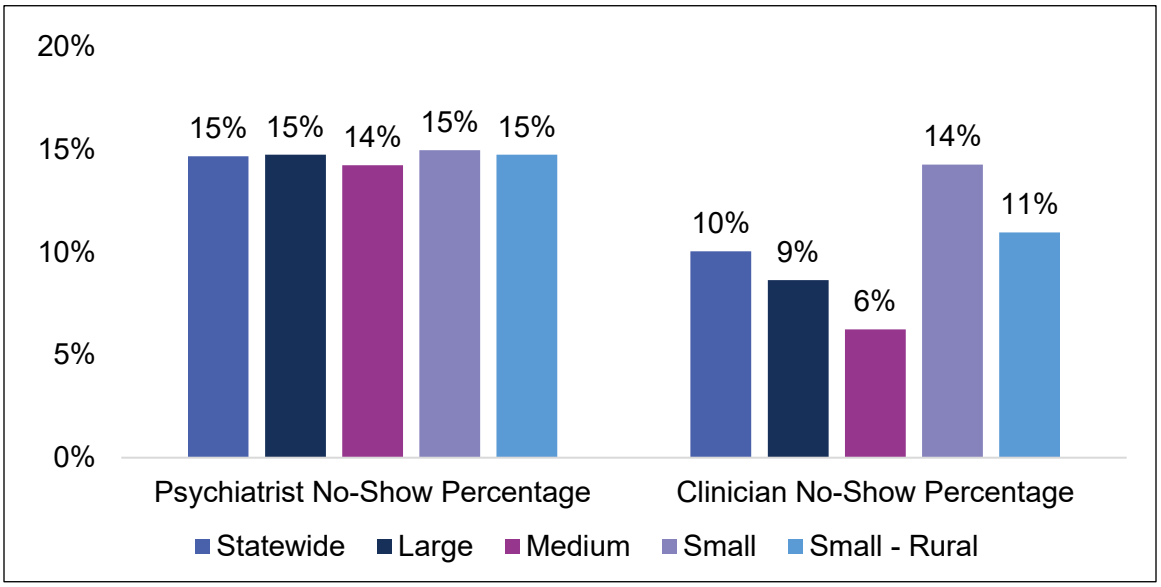


Outpatient No-Show Rates

No-show rates have significant impact on access to and timeliness of services that, in turn, affect the quality of care for the beneficiaries, and ultimately outcomes of care. These also have significant fiscal and operation impacts on the MHP resources. Some counties do not have clear standards to define a no-show, and therefore there may be inconsistencies with the data.

Psychiatry no-show rates are consistently and significantly higher than those for clinicians/non-psychiatrists. Although the no-show rates vary by MHP size, the psychiatrist no-show rates are consistently higher than their corresponding similarly sized MHP clinician no-show rates, except for small MHPs (Figure 5-9). It should be noted that the no-show rates are tracked for the individual beneficiary who may miss an appointment, and therefore represent a high figure; in reality, many MHPs schedule extra appointments so as not to lose the available psychiatrist time slots. Also, MHPs often provide reminder calls, transportation, and other adjunct beneficiary support services to reduce the no-show rates. Some MHPs also formally address this through their PIPs.

Figure 5-9: No-Show Rates for Psychiatrists and Other Clinicians, Statewide and by MHP Size, FY 2020-21

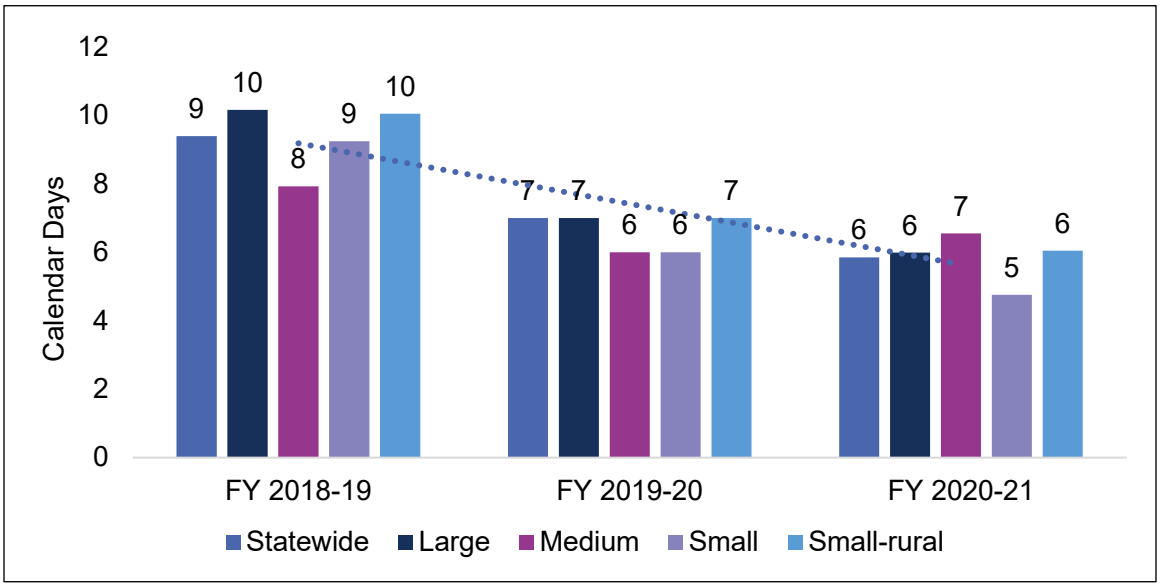


Follow-up Post Psychiatric Inpatient Discharge

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 mental health professionals is critically important for beneficiary outcomes. Performance on this metric is indicative both of timeliness to care as well as quality of care. Data reported by MHPs on the ATA is reflected here; corresponding Medi-Cal claims data is presented in the Quality chapter.

Over time, MHPs have provided outpatient follow-up services to beneficiaries following discharge from an inpatient psychiatric hospitalization more quickly than seen just a few years prior. Among MHPs that reported this measure, statewide wait times have decreased by 33 percent from FY 2018-19 (9 days) to FY 2020-21 (6 days). Similar decreases are seen across MHPs of all sizes, except for medium MHPs. (Figure 10)

Figure 5-10: Calendar Days to First Outpatient Service after Inpatient Discharge, Statewide and by MHP Size, Three Year Trend

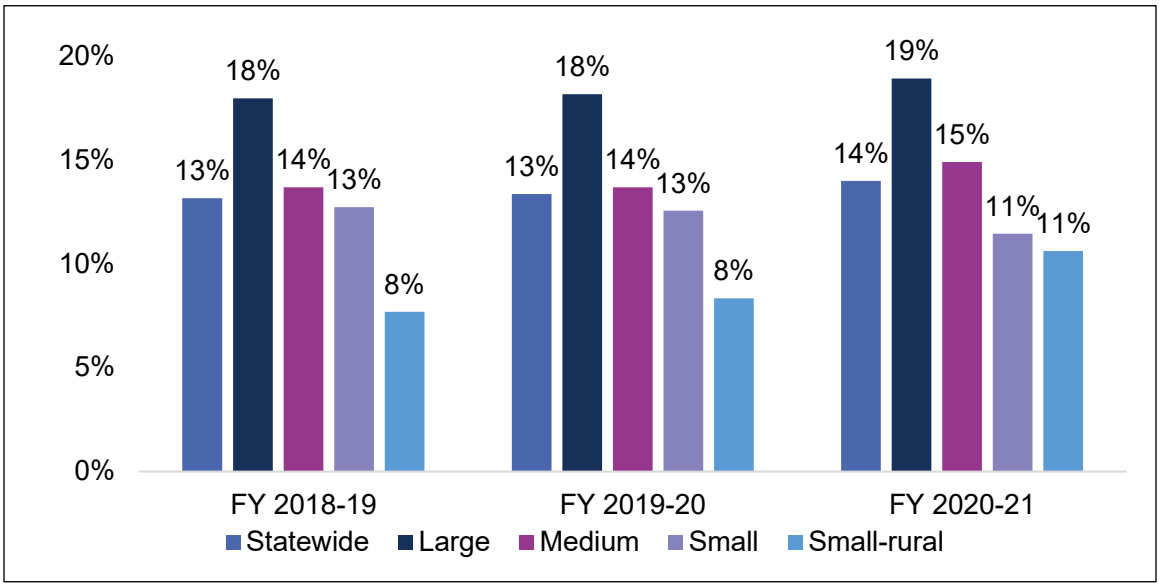


Psychiatric Inpatient Readmission Rates

CalEQRO asks MHPs to report on psychiatric readmission rates as an important proximate indicator of outcomes. As with follow-up after discharge, readmission rates relate to both timeliness and quality of care. Data reported by MHPs on the ATA is reflected here; corresponding Medi-Cal claims data is presented in the Quality chapter.

Thirty-day readmission rates as reported by MHPs have remained relatively stable across the past three reporting periods (Figure 5-11). FY 2020-21 reporting for small MHPs shows a two-percentage point decrease to 11 percent, while small-rural MHPs report an increase of three percentage points to 11 percent.

Figure 5-11: 30-Day Psychiatric Readmission Rates, Statewide and by MHP Size, Three Year Trend



Summary

Timeliness metrics assess whether the beneficiary was able to receive help when they requested it. From a macro perspective, these metrics help determine whether the system is equipped with appropriate levels of care, staffing, and administrative infrastructure to get an individual into services in a timely manner.

The NA reporting in the last three years has resulted in an improvement in MHP's ability to track and report these metrics. The timeliness metrics required for NA reporting include first offered appointment, first offered psychiatry appointment, and urgent appointments. Additional metrics, such as no-show rates and follow-up from inpatient services have also been more consistently tracked. From FY 2017-18 to FY 2020-21, the percentage of counties able to report on timeliness measures has increased such that over 90 percent of counties are able to track five of the seven CalEQRO metrics. Timeliness to initial psychiatry and urgent appointments lags slightly behind, with 80 and 82 percent of MHPs, respectively, able to track these metrics.

While some improvements in tracking timeliness have been made, there are still challenges the MHPs face. Due to multiple factors, MHPs often end up using manual tracking or "workarounds", such as spreadsheets, to gather information on timeliness. Another challenge is in reporting inpatient follow-up rates, particularly when the MHP and admitting psychiatric inpatient units do not always have a set protocol for communicating discharge information, even for in-county facilities.

As more MHPs have disaggregated their reporting of timeliness by age group, delays in access to services for children and youth have been discovered to be an issue. An area of particular concern is timeliness to psychiatry appointment, which is in part explained by the statewide shortage in child psychiatrist availability—there are not enough psychiatrists in the pipeline who specialize in children's psychiatry who also want to work in the public sector. An additional challenge is the relatively high no-show rate for psychiatry appointments, sometimes as high as 20 percent. Many MHPs have designed their PIPs around addressing no-shows.

Some timeliness reporting continues to be challenging for counties while others have figured out how to incorporate it into the practice management workflow. MHPs should collaborate and seek technical assistance from one another to problem-solve barriers and spread the adoption of best practices. CalEQRO can be a facilitator of that MHP to MHP problem-solving and provide introductions to counties who have found solutions to tracking and reporting on timeliness.

For some MHPs, the limitations for tracking timeliness are related to EHR interoperability constraints while for others it is related more to unestablished protocols between entities. Sometimes both factors are at play. MHPs should determine the root causes of the barriers so that the solutions can address the root of the problem rather than creating workarounds that put a temporary bandage on the problem.

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Chapter 6

Quality

Quality

Introduction

Quality in health care reflects the degree to which services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Quality encompasses different aspects of a health care system and is often assessed through indicators that provide information about constructs (e.g., like quality) that are difficult to measure directly.

Typically, quality indicators reflect three aspects of the health care systems: its structures, its processes, and user outcomes. Structures refer to the characteristics of the health care organization and environment; they include personnel, quality management, cost/spending on health care, information systems, and policies. Processes refer to the extent to which the health care system performs activities that are typically associated with a good outcome; they include the use of standards of practice. Outcomes refer to the ability of the health care system to make a difference to the health of the user.

CalEQRO used all three aspects—structures, processes, and outcomes—in the evaluation of the quality of SMHS provided by the MHPs. For structures, CalEQRO presents a review of MHP personnel, wellness and recovery frameworks, QAPI programs, and cultural competency. For processes, CalEQRO presents level of care (LOC) utilization, medication monitoring, and data analytic capacity of MHPs. For outcomes, CalEQRO presents findings on MHP use of outcome measures and beneficiary feedback. (A comprehensive review of beneficiary input is given in the next chapter on the Consumer Perception Survey).

In addition to a qualitative evaluation, CalEQRO conducts a quantitative review of quality using performance measures. The performance measures are drawn from federal guidelines (e.g., CMS, AHRQ), industry best practices (e.g., HEDIS, NCQA), and state mandates (i.e., from DHCS). The performance measures provide another means to validate MHP performance at a point in time, over time, and across MHPs. The performance measures cut across structures, processes, and outcomes, and are meant to inform selection and evaluation of quality improvement activities, per Protocol 2.[23]

Quality Structures

Investment in Mental Health Workforce

There are shortages of health care providers, including mental health professionals, nationwide. An estimated 130 million Americans live in health professional shortage areas (HPSA), lacking sufficient

[23] Centers for Medicare and Medicaid Services. (2019). CMS External Quality Review (EQR) Protocols October 2019. Department of Health and Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf

numbers of licensed clinical social workers (LCSWs), licensed marriage and family and therapists (LMFTs), psychiatrists, psychologists, licensed professional clinical counselors (LPCCs), and others.[24]

The State of California is not immune to the mental health workforce shortages. According to the California Health Care Foundation, approximately one-third of Californians live in HPSAs.[25] Furthermore, mental health professionals are unevenly distributed in the state. Urban communities and larger cities have greater access to and options for recruiting mental health professionals than rural communities.[26]

While most MHPs are not in HPSAs, many had shortages in their workforce. Vacancy rates for clinical positions in MHPs ranged from 30 percent to 74 percent. Across the 56 MHPs, 21 had shortages, vacancies, and turnover worth noting. Most MHPs had overall shortages of mental health professionals as well as scarcities in specific regions in the county. The most frequently identified staffing deficit was in Spanish-speaking and bilingual mental health professionals.

Approximately 1/3 of Californians live in a designated a Mental Health Professional Shortage Area

Unless significant changes are made in how MHPs recruit, shortages are expected to continue, if not worsen. Several strategies have been proposed to increase the size and diversity of California's mental health workforce.[27, 28, 29] MHPs have adopted a number of these strategies. Many MHPs prioritized staffing by creating a pipeline of mental health professionals. They focused on recruitment at colleges and raising awareness of careers in mental health in high schools. MHPs (or county behavioral health departments) partnered with academic institutions to provide graduate-level health professional training opportunities (internships for therapists) or residency opportunities for new physicians. Some MHPs offered loan repayment programs to incentivize new professional development, and others integrated mid-level practitioners (e.g., clinical nurse specialists and nurse practitioners) into their provider pool.

In addition to recruitment, there was a considerable emphasis on staff retention during the past review year. All providers, from county behavioral health departments, contract providers, and community partners, felt the impact of COVID-19 on their workforce. There were periodic staff absences (i.e., from confirmed infections, self-quarantining, and family leave), redeployments to disaster response roles, and vacancies created by accelerated retirements and more lucrative work offers. Systems also experienced difficulties filling vacant positions due to locally imposed budgetary restraints. These factors then increased the responsibility, demands on time, and caseloads of remaining staff. In response, MHPs underscored self-care—conscious effort (of staff) to prioritize their own health, actively

[24] Health Resources and Services Administration. (October 2021). Shortage Areas. https://data.hrsa.gov/topics/health-workforce/shortage-areas

[25] California Health Care Foundation. (July 2020). Shortchanged: Health Workforce Gaps in California. https://www.chcf.org/wp-content/uploads/2020/07/ShortchangedHealthWorkforceGapsCalifornia.pdf

[26] Coffman, J., Bates, T., Geyn, I., and Spetz, J. (2018). California's Current and Future Behavioral Health Workforce. Healthforce Center at UCSF. https://healthforce.ucsf.edu/publications/california-s-current-and-future-behavioral-health-workforce

[27] Rittenhouse, D., Ament, A., Genevro, J., and Contreary, K. (April 2021). Health Workforce Strategies for California: A review of the evidence. California Health Care Foundation. https://www.chcf.org/publication/health-workforce-strategies-california/

[28] California Health Policy Strategies (October 2020). California's Health Workforce Crisis: The Pipeline for new psychiatrists falls short. https://stateofreform.com/wp-content/uploads/2020/10/psychiatric-pipeline.pdf

[29] Baum, N. and King, J. (February 2020). The Behavioral Health Workforce in Rural America: Developing a National Recruitment Strategy. Center for Health and Research Transformation.

manage illnesses, and cope with challenges. MHPs made available to their staff workplace self-care sessions and support phone lines. Other strategies to support staff included transparent and effective communication, flexible work schedules, increased training opportunities and supervision, and streamlined onboarding process for new staff.

100%
MHPs with peer employees

MHPs were not at a loss of strategies to recruit, retain, and stabilize their workforce; however, the efficacy of the strategies was seldom presented. MHPs could not or did not present the outcomes relative to the implemented strategies. Investing in the mental health workforce remains an area for improvement in most MHPs, which will have an impact on quality.

Wellness-Focused Service Delivery

As public spending on health care is projected to increase, concerns are raised about the ability of states to manage costs (e.g., claims per beneficiary); increasing Medicaid commitments may undermine state's ability to invest in other, important priorities such as education and infrastructure.[30] As such, a dramatic restructuring of Medicaid programs is proposed, of which CalAIM is a part.

In advance of CalAIM, MHPs have been incorporating strategies that balance costs and still maintain quality. One of the strategies is the promotion of wellness services that motivate healthy behaviors and focus on preventative care. While MHPs do not incentivize participation in wellness activities (e.g., through vouchers, reduced premiums, gift cards), they do make wellness and recovery a focus of services. All MHPs had at least one wellness center, a site for non-clinical programming to advance and supplement mental health treatment. Wellness centers offered a variety of programs and services that facilitate beneficiary empowerment, personal responsibility, and health advocacy as well as recreational and social activities. The centers provided resources to help beneficiaries secure employment and housing. The wellness centers also served as a community resource on mental health and wellness. Most centers were open to the public, but targeted individuals who have had experience with mental health services. The majority of MHPs had wellness centers that served adults exclusively, and 10 MHPs had wellness centers that served youth/young adults.

Another strategy to restructure SMHS and retain quality of services is through health homes. Health homes are service providers that integrate primary health, acute services behavioral health, and long-term services. As well, health homes provide linkages to community and social supports. Health homes are person-centered and are meant to empower participants to manage and prevent chronic conditions to improve health outcomes. Twenty-two MHPs (39 percent) had or were part of a health home. Another means to integrated services was through the Whole Person Care Pilot, which has similar objectives to a health home model. The Whole Person Care is meant to coordinate physical health, behavioral health, and social services in a patient-centered manner. According to DHCS, 25 Whole Person Care programs exist in California, and many MHPs are part of this effort.[31]

2.4
Average number of wellness centers in MHPs

[30] Wiener, J. M., Romaire, M., Thach, N. Collins, A., Kim, K., Pan, H., Chiri, G., Sommers, A., Haber, S., Musemeci, MB., and Paradise, J. (2017, June 21). Strategies to Reduce Medicaid Spending: Findings from a Literature Review. Issue Brief. https://files.kff.org/attachment/Issue-Brief-Strategies-to-Reduce-Medicaid-Spending-Findings-from-a-Literature-Review

[31] Department of Health Care Services. (2021b, September 7). Whole Person Care Pilots. https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

Winding Path to Peer Integration

Per DHCS, "peers personally understand the experiences of the individuals they serve and can help clarify the most effective set of services for each individual's recovery needs."[32] Peer employees bring unique perspectives to service delivery and lend their experience to improve the quality of SMHS.

Peer employees were a fixture of all MHPs. Peer employees held differing titles, including peer support specialists, peer specialists, mental health aides, mental health workers, and peer advocates. They performed various functions including facilitating groups, coaching employment readiness, assisting with entitlements and benefits, operating warm lines, providing transportation, and managing supplies and resources at wellness centers. Before COVID-19, peer employees served as greeters at clinics and wellness centers, and during the pandemic, some peer employees assisted with technology and telehealth services. While some peer employees were integrated within treatments teams including those at crisis services, residential programs, assertive community treatment, full-service partnership programs, and forensic services, most peer employees were employed at wellness centers or designated peer programs.

MHPs endorse the benefit of peer employees in SMHS, although MHPs have not invested fully or consistently in peer employee positions. At the onset of COVID-19, with the closure of wellness centers, peer employees subsequently lost their positions, whereas other mental health positions were retained and moved to virtual or remote service delivery. As in previous reviews, peer employees continue to experience stigma and report disparities in treatment, some of which were amplified by COVID-19. While clinicians could work remotely, peer employees had to perform some job duties onsite and without adequate personal protective equipment. Lack of clarity of roles, differences in responsibilities across programs or clinics (i.e., despite the same position) and insufficient funding for peer employees were identified as other weakness of peer integration efforts in MHPs.

MHPs with well-integrated peer structures had a peer employee classification system. The MHPs had multiple levels of peer employee positions, with clear job duties and increasing responsibilities. There were opportunities for advancement within the organization, which enabled greater integration of peer employees throughout the system. These MHPs made training opportunities available to peer employees, including for leadership development.

Peer integration remains a work in progress for MHPs. The recently signed peer certification bill, SB 803, creates a new Medi-Cal provider, the Peer Support Specialist, and a new benefit, peer support services. SB 803 also creates a statewide certification pathway, which professionalizes the field. Counties can choose to opt-in to provide the peer benefit.

Improving Quality of SMHS

The contract between each MHP and DHCS requires an ongoing comprehensive QAPI program to review services furnished to beneficiaries. The contract further requires that the MHP's quality management (QM) 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".

[32] Department of Health Care Services. (2021a, June 23). Peer Support Specialists for Medi-Cal Behavioral Health presented by M. Perez. Community Services Division.

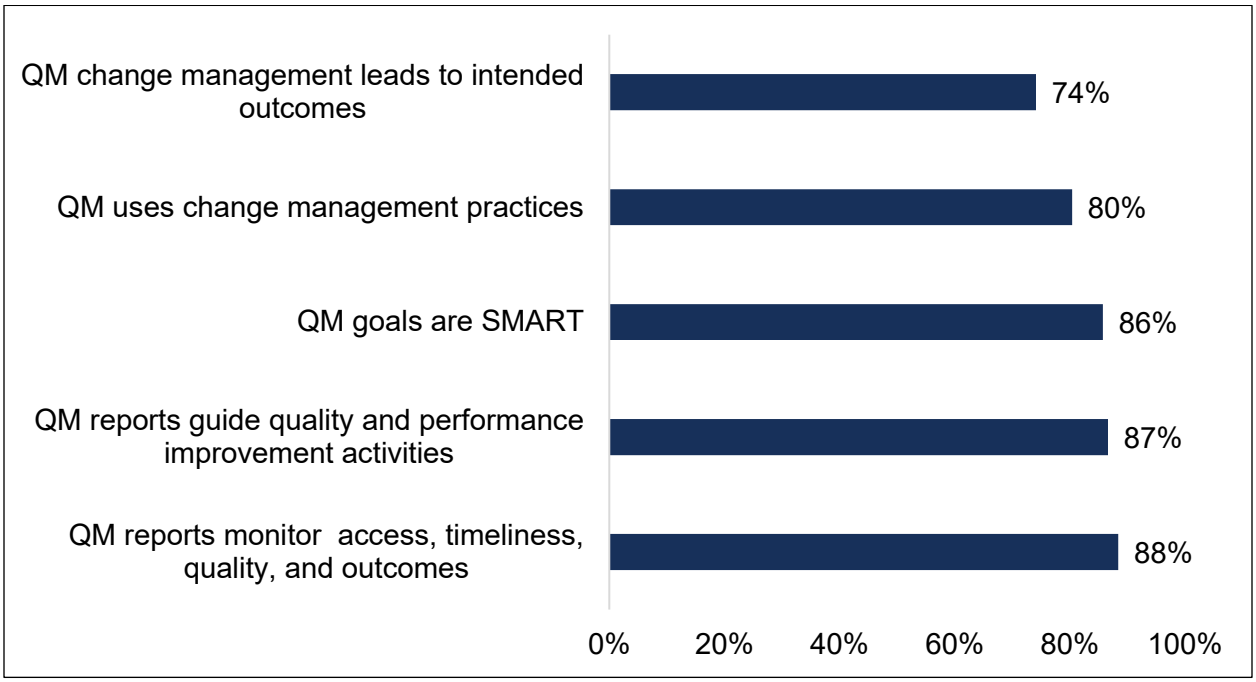
While all MHPs have a QAPI program, there is considerable variation in how the programs are structured. In small and small rural MHPs, there was usually one designated QM position and in some MHPs, that position also supported the entire health agency. In medium and large MHPs, there were several QM positions, including a QM director and subordinate staff who supported quality efforts across various programs. QM leadership included licensed clinical staff, public health officers, public administration staff, and certified quality professionals. QM staff were primarily clinicians and data analysts; an insufficient number of one or the other was often identified. The QM programs interfaced with other units of the behavioral health department including information systems/technology, cultural committees, fiscal department, contracts units, service delivery programs, contracted providers, and if present, the research and evaluation team.

The American Society for Quality highlights two benefits of a QM system: (1) meeting the customer needs, which help to instill confidence in the organization and (2) meeting the organization's requirements, which ensures compliance with regulations and provisions of products and services. MHP's QM programs do well on the latter goal. Many QM programs emphasized Quality Assurance (QA) and DHCS-MHP contract compliance and considerably fewer QM programs were positioned to engage in CQI. All QM programs have: QAPI work plans; annual evaluations of their QAPI work plan and activities; test call monitoring of the 24-hour toll-free telephone line; grievance and appeals monitoring; and utilization review—as required.

> Many QAPI programs emphasize quality assurance and compliance, with considerably fewer resources directed toward continuous quality improvement

To achieve a QM system that also meets beneficiary needs, MHPs need to adopt a CQI approach. One element of CQI that MHPs demonstrated well was reporting and monitoring of services (Figure 6-1). Most MHPs produced reports that enabled review of access, timeliness, and quality. QM reports were used to guide improvement activities, and QM goals were guided by specific, measurable, attainable, realistic, and time-bound (SMART) principles. As well, QM programs use change management practices (e.g., assessing readiness; shaping a vision; mobilizing commitment and buy-in; rules and policies). However, relative to the QM effort, MHPs were not as successful in achieving intended improvement outcomes. CalEQRO noted considerable variability in the thoroughness and integrity of the data. MHPs did not have access to sufficient or appropriate data to guide decision-making. Ostensibly, programs were modified, and new services were established, for which many MHPs did not have empirical data to substantiate the need for change.

Figure 6-1: Quality Management Program Characteristics



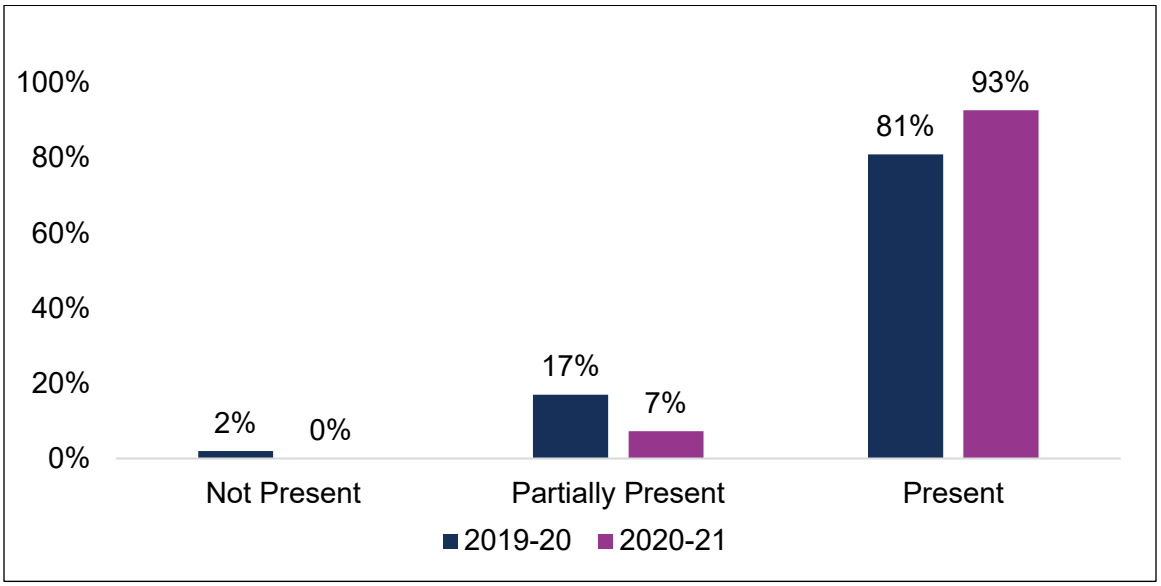
MHPs need training in quality improvement principles, staff to manage quality improvement projects, and tools and technology to evaluate quality. A critical component of an effective QM system is MHP leadership endorsement of QM efforts. In addition to being present at QM meetings, which demonstrates commitment to quality, the leadership must also establish direct communication lines with the QM staff and hold itself accountable for QM findings and recommendations. The QM manager and staff need to feel empowered to make objective assessments and communicate quality findings to MHP leadership regularly and freely.

Reflecting Diversity

Cultural competency reflects a health care system's ability to interact with, attend to, and meet the needs of its population that differ by culture, ethnicity, race, religion, language, and other characteristics (e.g., gender identity and age). It is the responsiveness of a system to the unique needs of bicultural/bilingual and culturally distinct populations.

All MHPs were rated as implementing strategies and using resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its beneficiary population (Figure 6-2). Examples of strategies employed by MHPs included faith-based outreach to educate the Filipino community on mental health; micro-innovation grants to CBOs that have established relationships with underserved Latino populations; advertisements and articles in Latino publications and media; development of specific programs to target specific underserved populations (e.g., the Asian/Pacific Islander Team); and specific teams to outreach to farmworkers.

Figure 6-2: Implementation of Cultural Competence Strategies

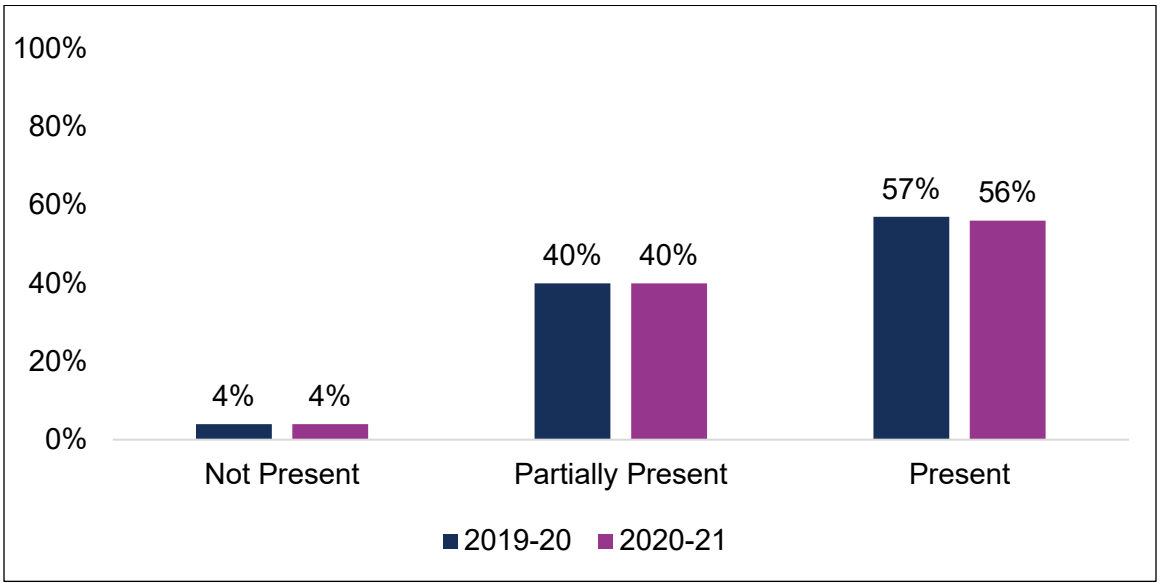


One component of cultural competence efforts was through a bilingual workforce. MHPs sought, recruited, and employed bilingual staff. In addition to Spanish, which was the dominant non-English language, some MHPs employed staff who spoke Hmong and Vietnamese. In some MHPs, there was also an effort to recruit bicultural staff who, in addition to speaking the beneficiary's language (often Spanish), are also of the same culture as the beneficiary population (e.g., Mixteco).

Training was another means through which MHPs delivered culturally competent services. Training to cultural competency often addressed three areas: awareness, knowledge, and skill development. MHPs provided training on increasing staff's awareness of their own attitudes and beliefs about other cultures; education on the populations in their communities and the help-seeking behavior and view of mental health of these populations; and training to increase staff's clinical (and social) skills in delivering culturally appropriate treatment. One such example of clinical training was on increased use of screenings for children that incorporated an assessment of adverse childhood experience (ACEs). Training on cultural competency was often the purview of the cultural competence committee and the committee coordinator/director who recruited expert trainers and convened key informants.

While MHPs can demonstrate efforts to provide culturally responsive services, the majority of MHPs could not provide the results or outcomes of this effort (Figure 6-3). There has been no change in MHPs' evaluation of their cultural competency strategies. Only 56 percent of MHPs evaluated the implementation of strategies to address cultural needs of beneficiaries. Few had evidence of the impact of cultural competency approach on, for example, beneficiary engagement in services, therapeutic relationships/alliance, and treatment retention. As well, a cultural competency approach is associated with reducing disparities in mental health care, but MHPs could neither demonstrate a reduction in disparities nor link it to their cultural competency strategies. In part to address this need, DHCS hired a contractor in 2021 to work with counties on their cultural competency plans, with the goal to improve their diversity, equity, and inclusion efforts.

Figure 6-3: Evaluation of Cultural Competence Strategies



Despite the effort to diversify the MHP workforce, the need continues to outpace the number and capacity of bilingual/bicultural staff that MHPs have, as reported by numerous stakeholder groups.

Quality Processes

Resource Intensity and Beneficiary Needs

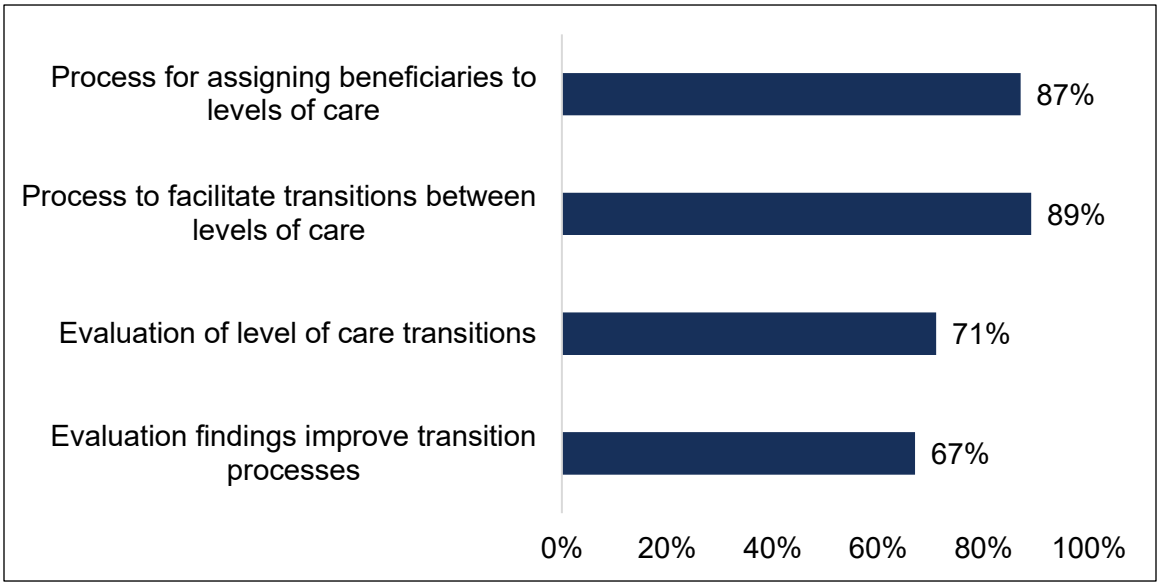
How MHPs match resource intensity to beneficiary needs or determine level of care is quite variable. A process for assigning beneficiaries *to* levels of care exists in most MHPs. The process tends to be informal and is based on clinical judgement. MHPs also have a process to transition beneficiaries *between* levels of care, for example from inpatient to outpatient services or between SMHS and mild-to-moderate services. However, the transition *within* outpatient services, that is between different intensity of services, was less evident, unless MHPs had a formal levels of care process.

MHPs that endorsed a formal level of care process either used a tool/standardized instrument or conducted some sort of formal review. The most commonly used tools were: Reaching Recovery, the World Health Organization Disability Assessment Schedule, the Level of Care and Recovery Index (LOCRI), the Level of Care Utilization System (LOCUS), and the Child and Adolescent Level of Care Utilization System (CALOCUS). A few MHPs had developed their own level of care indexes, including Clinical Practice Guidelines and an integrated CANS- and ANSA-derived tool, the CANSA. The level of care tools were often used for one part of the system or beneficiary population, but not the entire system.

MHPs that conducted a formal review convened treatment team members in weekly or biweekly meetings. The level of care review would incorporate chart reviews and discipline-specific review of clinical decisions (e.g., Transitions in Care meeting, multi-disciplinary treatment team review; and level of care coordination meetings).

Matching resource intensity with beneficiary need is incomplete without a regular review of level of care, which prompts a decision about treatment. MHPs were less adept at evaluating level of care within their system of care (Figure 6-4). Less than 75 percent of MHPs evaluated beneficiary movement in outpatient services or in other parts of the continuum of care. Even fewer consistently used the findings from the level of care to inform the quality of care delivered to beneficiaries.

Figure 6-4: Meeting Beneficiary Needs and Evaluating Level of Care

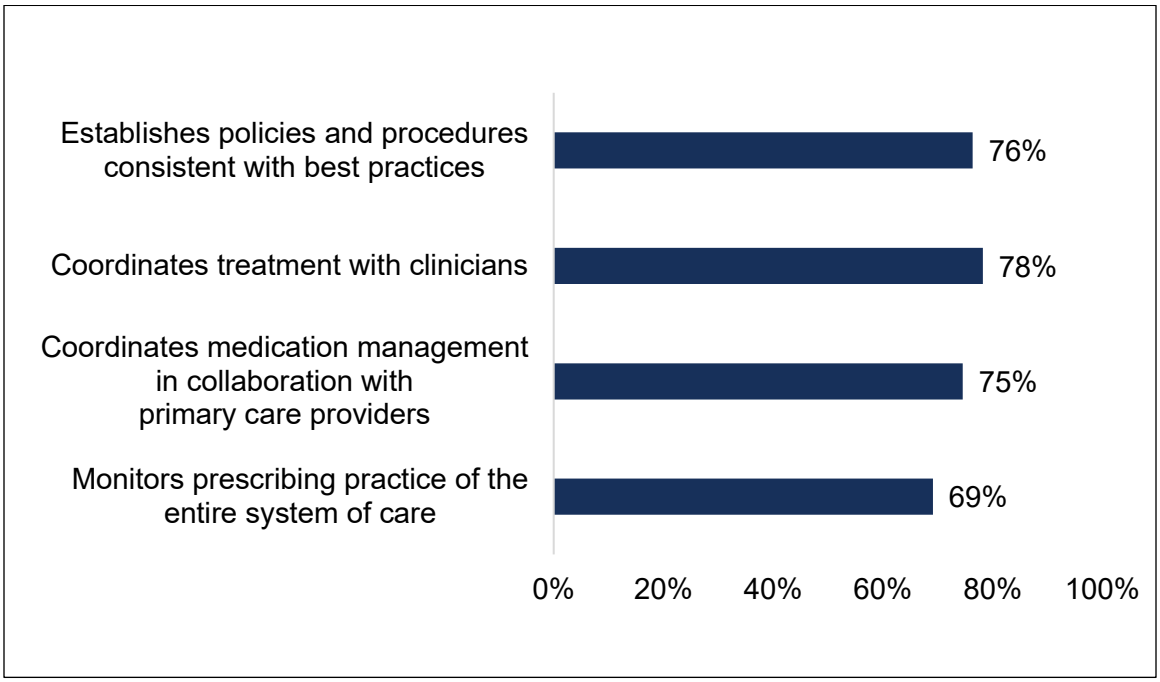


Medication Monitoring

For many beneficiaries, SMHS requires psychiatry services in addition to other mental health services. Management and monitoring of medication services are a critical process in delivering quality care. Medication management encompasses a number of activities, including periodic review of laboratory results, evidence of collaboration with clinicians and other treatment providers; monitoring of side effects, monitoring of medication adherence, peer review, systemic review of prescribing practice, and development of policies and procedures related to medication.

There is considerable variability in medication management activities of MHPs. Part of the variability in medication monitoring relates to who is responsible for the medication management. In many MHPs, medication management and associated monitoring activities are the purview of a medical director. However, the medical director was not always an integral part of the QM program or team. Given the responsibilities of medical directors, especially in filling psychiatry positions, these activities become secondary. Additionally, many QM programs, which are largely responsible for system monitoring, do not have staff for whom medication monitoring falls within their professional scope of practice.

Figure 6-5: Medication Monitoring Activities



HEDIS Monitoring

In addition to medication monitoring activities, HEDIS provides some guidance and standards for medication management in mental health. These indicators provide MHPs with further tools to assess the quality of medication support services. MHPs can gauge their performance relative to national standards and identify opportunities for improvement.

There has been no change in the use of HEDIS measures by MHPs from the previous review to the current review, including no increase in tracking. Less than half of MHPs track and trend HEDIS mental health indicators routinely. However, among MHPs that had partially incorporated HEDIS measures, there has been an increase in use and more consistent use of the measures to inform quality improvement.

Figure 6-6: Tracks and Trends HEDIS Related Diagnoses, Medication Practice, and Care Standards

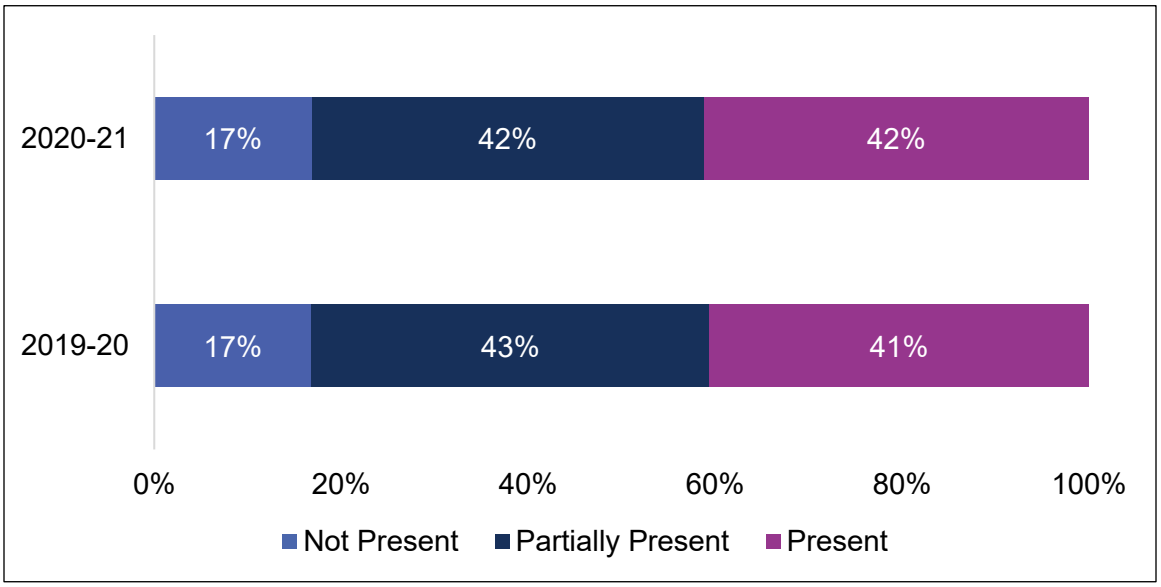
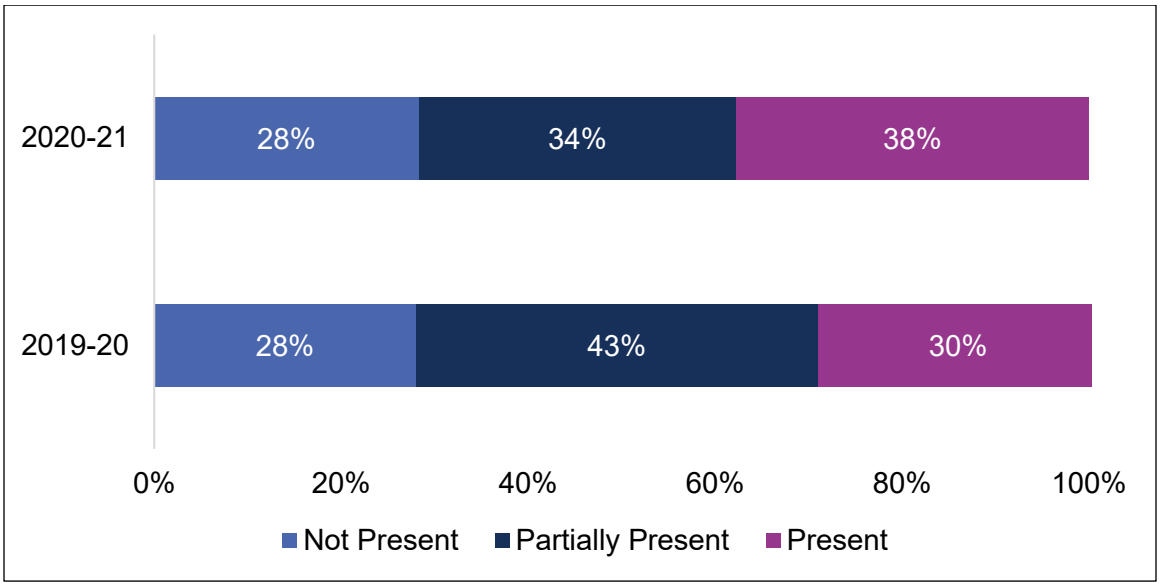


Figure 6-7: Uses Finding from HEDIS for Performance Improvement



Utilization of HEDIS measures relative to youth in FC may account for some of the increase seen in the past year. More MHPs have incorporated youth specific HEDIS indicators and FC indicators, such as those suggested by the California Department of Social Services and monitored by the University of California, Berkeley, Center for Social Science Research. In lieu of direct monitoring of these measures, MHPs have co-opted some of the monitoring required by JV-220 in the FC medication monitoring protocol. This approach should be considered as an interim or intermediary step only, as it does not provide the full HEDIS information which are consistent with best practice and that are required by DHCS.

Medication Monitoring of Youth in Foster Care

Overall, MHPs continue to lack sufficient capacity to monitor medication utilization for children in FC, as per SB 1291. MHPs experience challenges that can be both technical and pharmacy related. The technical challenges arise when an FC youth receives medications in another setting, such as primary care, and the MHP does not have access to that information for proper monitoring. As well, many MHPs have not utilized fully the new data capabilities of the EPSDT Performance Outcome System website. The pharmacy-related challenges arise from disparate health information systems and interoperability and multiple and varied processes for reporting relevant beneficiary prescription data.

If SB 1291 monitoring is to be fully implemented by CalEQRO, DHCS will need to provide MHPs a gateway for such specific information, and provide ongoing training for MHP staff, keeping in mind frequent staff turnover at the MHPs, which necessitates periodic training and redundancy.

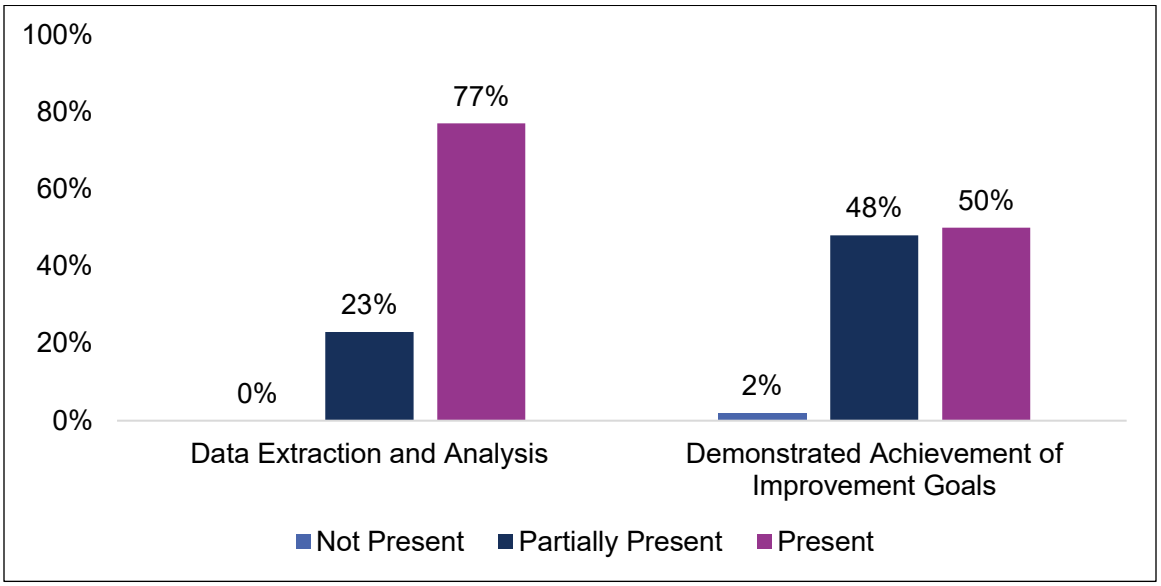
Data Analytic Capacity

A key to performance or quality improvement impact is the collection of meaningful data and the communication of useful information. The QM program must be able to sort through vast amounts of data, determine what is relevant and meaningful, and present it in a way that informs a course of action.[33] A QM program per se is not sufficient for delivering quality health care; the QM program must have a data analytic component. Data analytic capacity is the process of interpreting quantitative data to provide qualitative insights, identify trends, and answer questions about services or beneficiaries.

By nature of participating in and providing data for the EQR (e.g., the MHP Assessment of Timely Access; penetration rates), MHPs demonstrated some capacity to report and trend data and draw some conclusions about SMHS provided (Figure 6-8). However, despite scoring highly on data extraction and analyses, MHPs could not demonstrate well a consistent and comprehensive analysis and interpretation of data (Figure 6-8). While MHPs incorporated data in cultural competency plans and QAPI work plans in addition to CalEQRO requested data, few were successful in achieving improvement goals and project outcomes. The MHP or its QM program lacked (1) data or information systems/technology from which they could obtain substantive information, (2) staff with expertise in data analysis, and (3) sufficient numbers of data analytic staff. Most MHPs were able to present descriptive analyses, but more robust analysis (e.g., predictive and diagnostic) were not evidenced. MHP completion of performance improvement projects (PIPs) (discussed in detail in Chapter 8) demonstrate some of the challenges in data analytics (e.g., only 6 percent of PIPs were rated as 'High Confidence').

[33] Rosati, R. J. (2018). Section 4, Health Data Analytics. In L. R. Pelletier and C. L. Beaudin (Eds). HQ Solutions, Resource for the Healthcare Quality Professional (Fourth Edition, 199-242). National Association for Healthcare Quality.

Figure 6-8: Data Extraction/Analysis Functions and Achieving Improvement Goals



A few MHPs were adept in health data analytics, and one of the distinguishing features of these MHPs was that they deployed working groups. Working groups, an organized group of experts or informed staff and stakeholders, were convened to bring focus and offer solutions to identified areas for improvement. Working groups brought the appropriate stakeholders to the table, many of whom were often outside of QM. The working groups were deliberate and allocated time to examining data. Examples of working groups in MHPs included a data-focused committee, a documentation empowerment group, medication monitoring committee, and polypharmacy committees.

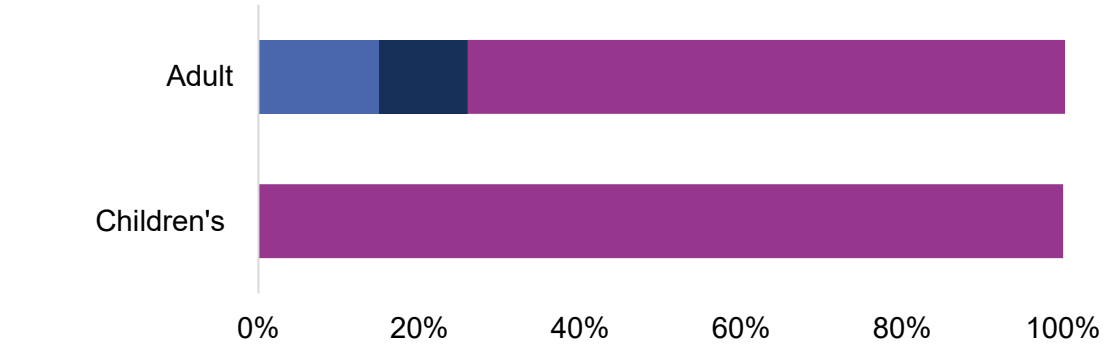
Quality Outcomes

Making a Difference

Outcomes refer to change in the health of an individual, which is attributable to the health services or some interventions. Outcome measures in mental health have a tenuous infrastructure and lag behind somatic health. However, there is a burgeoning body of measurement-based outcomes, systematic administration of symptom rating scales or other beneficiary-data, collected through the course of treatment, to drive clinical decision making, some of which are used by MHPs.

Following the DHCS mandate in FY 2018-19 on adoption of outcome measures for children receiving SMHS (BHIN 17-052 and 18-048), there has been a steady increase in use of measurement-based outcomes for both children and adults. The standardized tools measure four main constructs: symptom management, functioning, quality of life, and emotional experience. All MHPs use the two standardized tools for measuring progress for children/youth: the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptoms Checklist 35-Item (PSC-35). Despite no mandate, most MHPs (86 percent) used standardized measures to determine progress for adults. The MHPs reported use of the following outcome measures: Milestones of Recovery Scale (MORS), ANSA, PHQ-9, Behavior and Symptom Identification Scale 24 (BASIS-24), and the Generalized Anxiety Disorder 7-Item (GAD-7). MHPs also used program-specific outcomes (e.g., FSP programs).

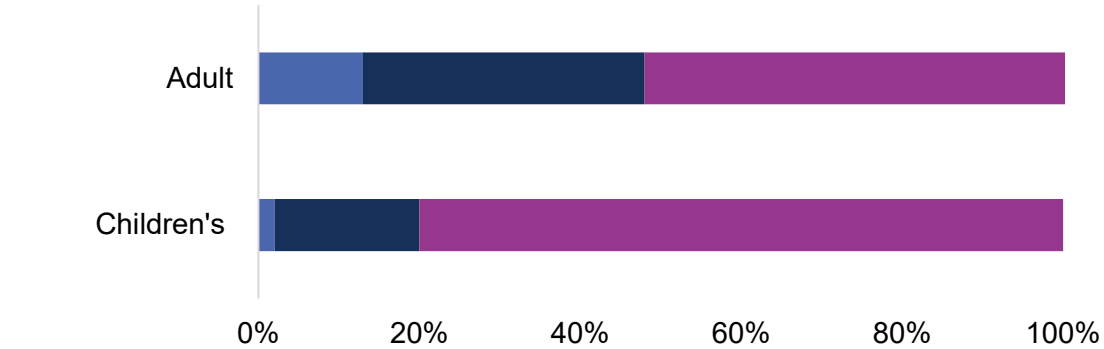
Figure 6-9: Adoption of Outcome Measures



	Children's	Adult
Not Present	0%	15%
Partially Present	0%	11%
Present	100%	75%

In contrast to almost full adoption of outcome measures, MHPs were less adept at demonstrating consistent use of the outcome measures (Figure 6-10). That is, integration of the measurement-based outcomes in clinical practice was inconsistent. While use of measurement-based outcomes is greater in children's system of care than adult (98 percent overall versus 88 percent) both are substantially lower than the rate of adoption. Without regular use, MHPs are challenged to demonstrate progress of beneficiaries. Even more, without routine use and monitoring, MHPs are less able to detect unsatisfactory response to treatment, and when there is stagnant progress in care, MHPs are not positioned to address it.[34]

Figure 6-10: Use of Outcome Measures

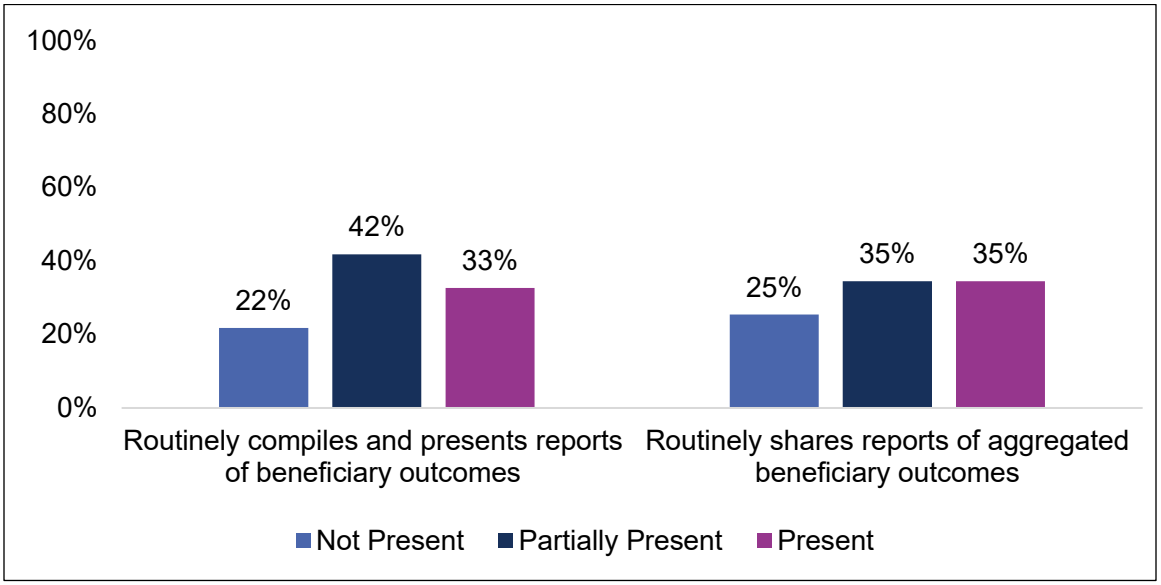


	Children's	Adult
Not Present	2%	13%
Partially Present	18%	35%
Present	80%	53%

[34] Fortney, J., Sladek, R., and Unutzer, J. (2015). Fixing Behavioral Health Care in America, Issue Brief. Kennedy Forum.

MHPs were also challenged in evaluating and reporting progress systemically (Figure 6-11). Beyond outcomes for individual users, health care systems should strive to make a difference systemically, and outcome measures enable this assessment of broader impact. Few MHPs compiled and reviewed aggregate reports of beneficiary outcomes. As well, MHPs did not routinely (at least annually) share reports of aggregated beneficiary outcomes. Both findings point to a larger issue that MHPs are not positioned to identify and address gaps in overall services. MHPs need to invest more in monitoring and improving the system through which mental health services are delivered.

Figure 6-11 Systemic Progress



There are a few barriers that stand out as limiting MHP ability to measure beneficiary and systemic outcomes. Outcome measures were not embedded in the electronic or information systems, preventing comprehensive collection (i.e., from all providers) and aggregation of data. Staff did not feel sufficiently confident or supported in using the standardized measures. MHPs had not researched and selected from among available outcome measures. In some MHPs, there were cultural barriers, with some staff resistant or reluctant to integrate mental health outcome measures. Whatever the reasons, as above, it reinforces that MHPs "cannot improve what [they] cannot measure." [35]

Beneficiary Input

MHPs can also incorporate beneficiary feedback of their own progress and beneficiary perception of services in the assessment of outcomes. Many MHPs conduct their own surveys and questionnaires, of varying degrees of detail and specificity. While the survey analyses tend to be shallow, MHPs reported that beneficiaries were satisfied with services and endorsed improved functioning for themselves or a family member.

MHPs have the opportunity for a more in-depth assessment of beneficiary perception of outcomes through the CPS. The findings of the DHCS-sponsored CPS are presented in the next chapter.

[35] Kilbourne, A. M., Beck, K., Spaeth-Rublee, B., Ramanuj, P., O'Brien, R. W., Tomoyasu, N., and Pincus, H. A. (2018). Measuring and improving the quality of mental health care: a global perspective. World Psychiatry. 17(1): 30-38. 10.1002/wps.20482.

Performance Measures

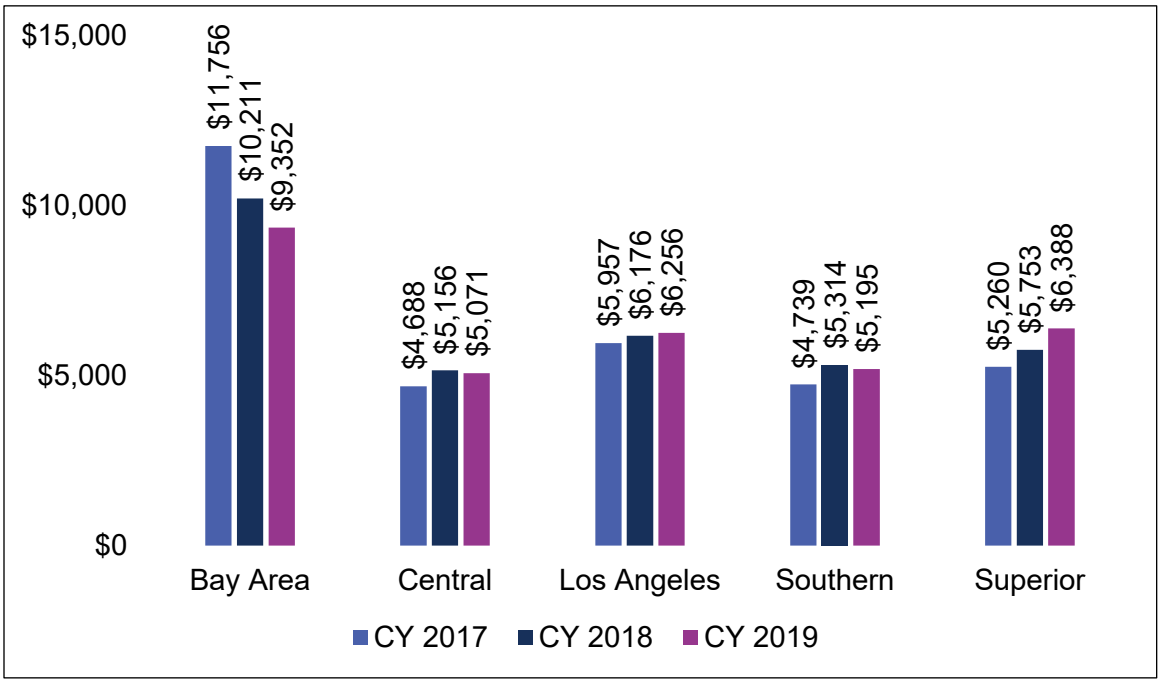
In addition to the quality structures, processes, and outcomes discussed above, CalEQRO also looks to Medi-Cal claims data to analyze performance measures related to quality of care. Overall trends regarding approved claims per beneficiary served (ACB), high-cost beneficiaries (HCB), and psychiatric inpatient utilization are discussed here. Additional detailed analysis of ACB, diagnosis, and quality of care for populations with historical disparities is contained within the companion report, Validation of Performance Measures.

Approved Claims per Beneficiary

ACB serves is a proxy for the scope and intensity of SMHS that beneficiaries receive from MHPs, and thus as a proxy for the quality of care received. CalEQRO underscores that in a large and diverse state like California, ACB may depend on contextual and historical factors of individual MHPs, MHP regions, and MHP sizes. Such factors may include the type and mix of county and contract providers, general cost-of-living, service types utilized, distribution of Medi-Cal eligible population by age group, race/ethnicity, and other demographic characteristics, as well as individual MHP's ability to set their reimbursement rates. Despite such variation, ACB can illustrate patterns and distributions that are essential to quality improvement efforts at a statewide level.

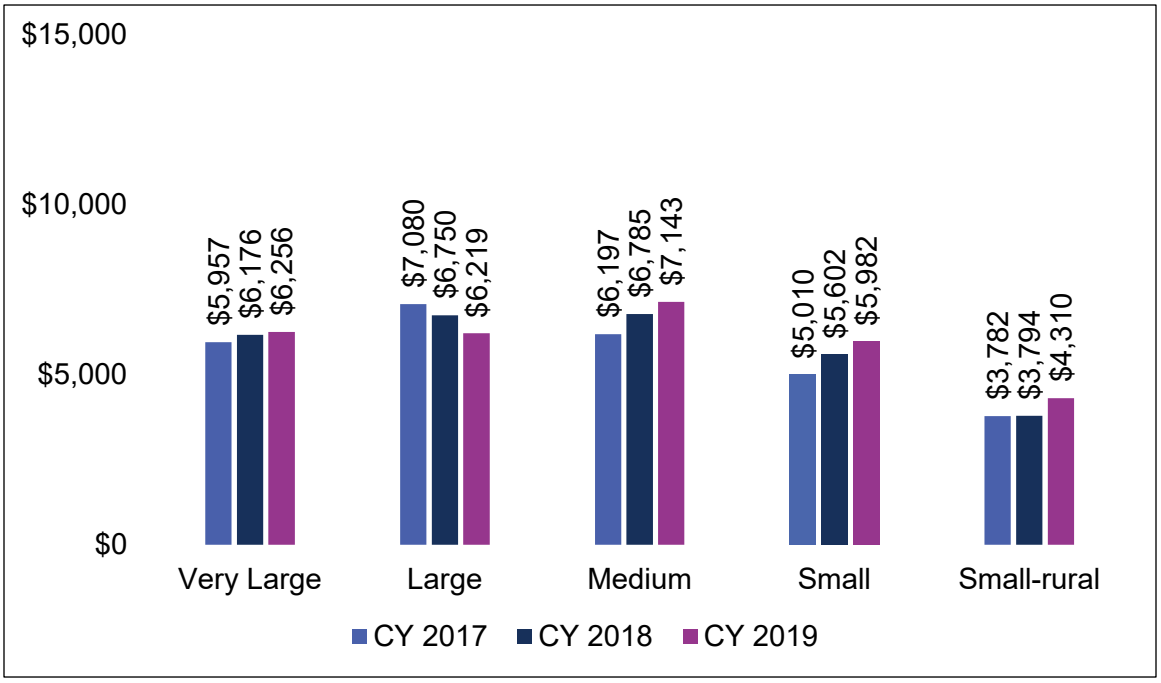
The Bay Area continues to have the highest ACB among all regions (Figure 6-12). However, it is also the only region showing a consistent declining trend for three years from CY 2017 to CY 2019. Despite the decline and the modest increases in ACB in the next highest regions, Los Angeles and Superior, the Bay Area's ACB was still nearly 50 percent higher than those regions. In addition to being the regions with the lowest ACBs, the Southern and Central regions both showed a slight decline in ACB from CY 2018 to CY 2019.

Figure 6-12: Approved Claims per Beneficiary Served by MHP Region, CY 2017-19



By MHP size, the small-rural MHPs' ACB continue to be the lowest of all MHP sizes despite a 13.6 percent increase from CY 2018 to CY 2019 (Figure 6-13). Except for the large MHPs, MHPs of all sizes show an average ACB that has been increasing for three years, from CY 2017 to CY 2019. The average ACB for large MHPs has declined for three years in a row. Large MHPs no longer have the highest ACB in the state, being surpassed by the medium-sized MHPs.

Figure 6-13: Approved Claims per Beneficiary Served by MHP Size, CY 2017-19



High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. High cost of care typically occurs when a beneficiary requires more intensive care at a greater frequency than the rest of the beneficiaries receiving SMHS. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves.

CalEQRO defines HCBs as those with ACBs of $30K and more in a year; however, as Table 6-1 shows, the average ACB per HCB has been consistently over $50K for at least three years. A large number of HCBs had much higher ACBs than the $30K threshold. After a spike in CY 2018 in HCB count, HCB percentage, and HCB ACB, all three decreased in CY 2019. Although neither the HCB count nor the HCB percentage by count were below the CY 2017 levels, the ACB was lower than the CY 2017 level by 5 percent.

HCB percentage of total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by HCBs. Although in each of the three years between CY 2017 and CY 2019 the percentage of HCB beneficiaries was below 4 percent, they accounted for well over a quarter of the percentage of total claims, including a spike to a third of the total claims in CY 2018.

Table 6-1: High-Cost Beneficiaries, CY 2017-19

Year	HCB Count	Total Beneficiary Count	HCB Percent by Count	Average Approved Claims per HCB	HCB Percentage of Total Claims
CY 2017	19,962	626,334	3.19%	$54,777	29.61%
CY 2018	23,164	618,977	3.74%	$57,725	33.47%
CY 2019	21,904	627,928	3.49%	$51,883	28.65%

Psychiatric Inpatient Utilization

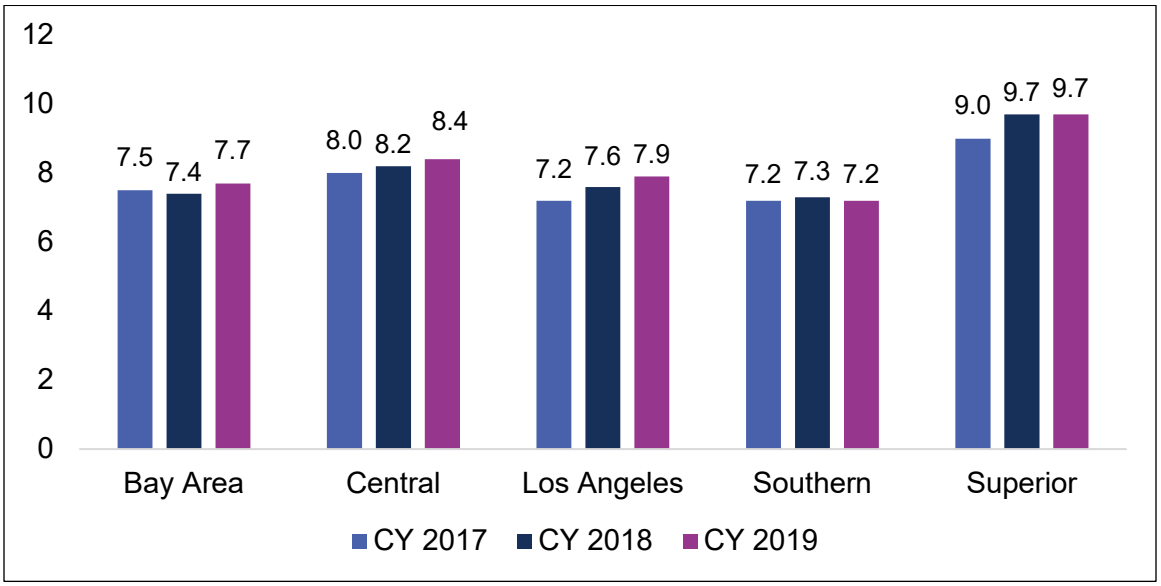
Length of Stay

The inpatient LOS varies from region to region. Although the Superior region has much fewer beneficiaries who are hospitalized for psychiatric reasons, it has the highest inpatient length of stay (LOS) (Figure 6-14). The Southern region has the lowest inpatient LOS, and the other MHP regions have LOS between these two, with the Central region having the second highest LOS.

In addition, all regions except the Southern region showed increases in the average LOS in CY 2019 compared to the previous two years. The average LOS stayed mostly the same in the Southern region. The increase in LOS was most pronounced in Los Angeles and the Superior regions, both increasing by 0.7 percentage points.

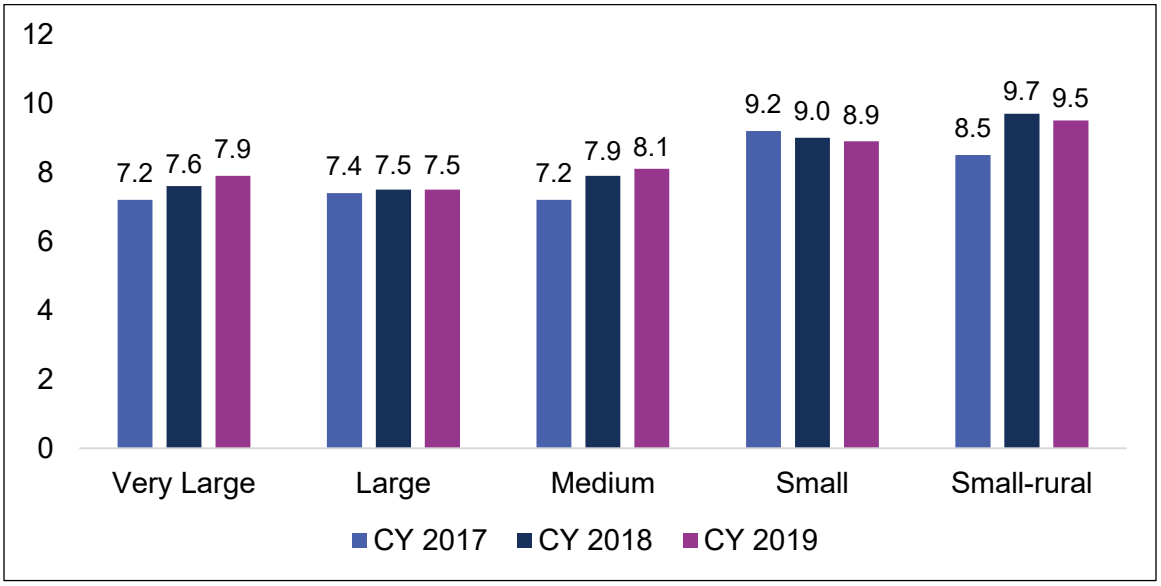
The longer LOS for the Superior region MHPs may be associated with the relatively low hospitalization rate. Most Superior region MHPs do not have psychiatric inpatient units in their own counties, and the beneficiaries need to be transported long distances for hospitalization. Consequently, most Superior region MHPs utilize local crisis intervention or crisis residential modalities of services to keep their beneficiaries from getting hospitalized. In other words, those who get hospitalized from the Superior region require longer hospital stays, which in turn, drives up the average LOS. However, this does not explain the relatively sharp increases in average LOS for the Superior or Los Angeles region between CY 2017 and CY 2019.

Figure 6-14: Average Inpatient Length of Stay by MHP Region, CY 2017-19



By MHP size, the small-rural size MHPs have the highest average inpatient LOS, followed by the small and medium-sized MHPs (Figure 6-15). Large and very large MHPs have the shortest LOS. The three-year trend between CY 2017 and CY 2019 shows that along with the very large, which is Los Angeles, the medium and small-rural sized MHPs' average LOS increased significantly, 0.9 and 1 percentage points, respectively. The large MHP average stayed the same, while the small MHP average declined slightly. Small-rural and small MHPs' average LOS were the two highest, which perhaps reflects a strong overlap between the small-rural and small MHPs and those in the Superior region.

Figure 6-15: Average Inpatient Length of Stay by MHP Size, CY 2017-19



Follow-up after Hospitalization and Readmission

Both the 7- and 30-day outpatient follow-up rates after inpatient discharges have been increasing statewide between CY 2017 and CY 2019. The 7-day follow-up rate increased by 22.6 percent, while the 30-day follow-up rate went up by 17.8 percent during the same period (Figure 6-16). However, the outpatient follow-up rate seems to have little or no impact on the 7- and 30-day rehospitalization rates. (Figures 6-16 and 6-17)

Figure 6-16: Follow-up Rates post Hospital Discharge Statewide, CY 2017-19

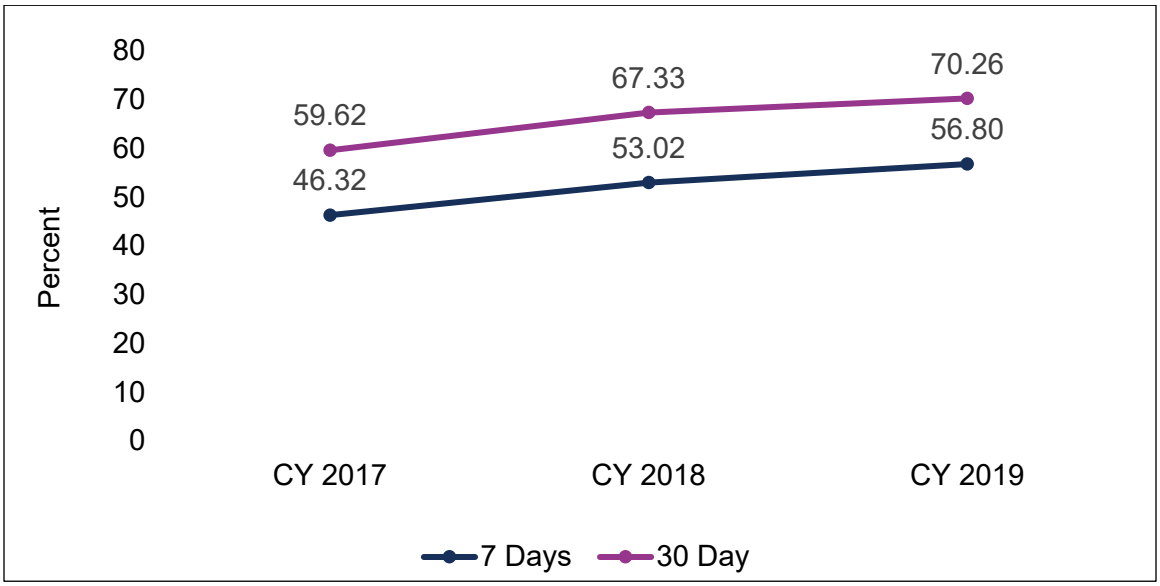
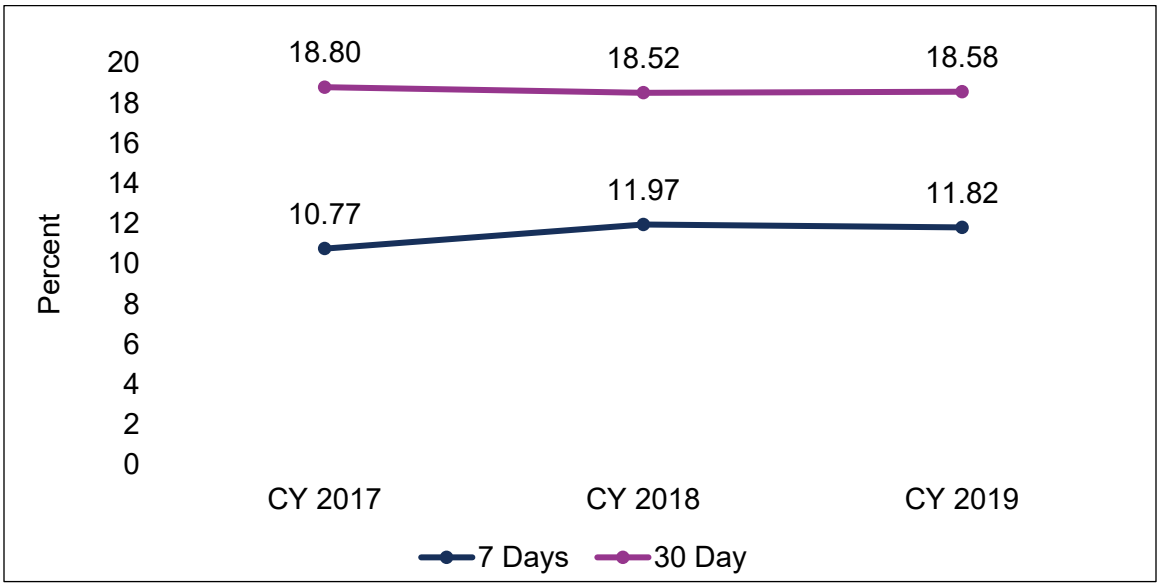


Figure 6-17: Rehospitalization Rates Statewide, CY 2017-19*



* Beginning with CY 2019 data, CalEQRO changed its methodology to fully align with the corresponding HEDIS measure. This was retroactively done for CY 2017 and CY 2018 as well. Therefore, those figures will not match the corresponding ones in the FY 2019-20 statewide annual report.

Summary

Healthcare quality encompasses multiple elements, including structures, processes, and performance measures, which reflect the degree to which services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. MHPs in FY 2020-21 demonstrated definitive strengths in this area and experienced challenges that create opportunities for improvement. MHPs also identified strategies to address many of the challenges, and continued efforts are warranted.

Despite a growing mental health workforce shortage, MHP were nimble, innovative, and responsive to beneficiary needs—in ways stakeholders described as heroic. Nevertheless, MHPs experienced periodic staff absences, difficulty filling vacancies, and staff who are profoundly exhausted. If not addressed, the mental health workforce shortage is expected to compound and worsen, negatively impacting the beneficiaries MHPs are committed to serve.

While MHPs demonstrate efforts to provide culturally responsive services, utilize level of care tools, and implement outcome measures, many still struggle to track and trend data, conduct robust analysis, and monitor key quality metrics that measure beneficiary and systemic outcomes. DHCS is encouraged to define established, standardized outcome tools for MHPs to monitor progress for adult and older adult beneficiaries.

Although there was an increase in and more consistent use of HEDIS measures among MHPs that had previously incorporated them to some degree, less than half of all MHPs track and trend HEDIS mental health indicators routinely. Overall, MHPs continue to lack sufficient capacity to monitor medication utilization for children in FC. MHPs would benefit from targeted information, training, and clear expectations pertaining to SB 1291 mandates.

All MHPs have a QAPI program, yet there is considerable variation in how the programs are structured. MHPs often reported an insufficient number of QM clinicians or data analysts, leading to difficulty meeting the administrative requirements that accompany recent and ongoing policy changes. Several report an ability to allocate few resources to true continuous quality improvement. MHPs need to direct more resources towards continuous quality improvement, separate and distinct from QA and compliance activities.

Chapter 7

Validation of Beneficiary Perceptions of Care

Validation of Beneficiary Perceptions of Care

Introduction

Consumer and Family Member (CFM) and stakeholder voices are an integral part of the CalEQRO review process and arguably the ultimate indicator of the success of any mental health system. Stakeholder involvement in the EQR process elevates CalEQRO's findings and infuses firsthand knowledge in a meaningful way into the success of the local mental health system. For the purposes of EQR, stakeholder refers to an individual of any age or family member whose life is affected by serious mental illness (SMI).

CFM Focus Groups

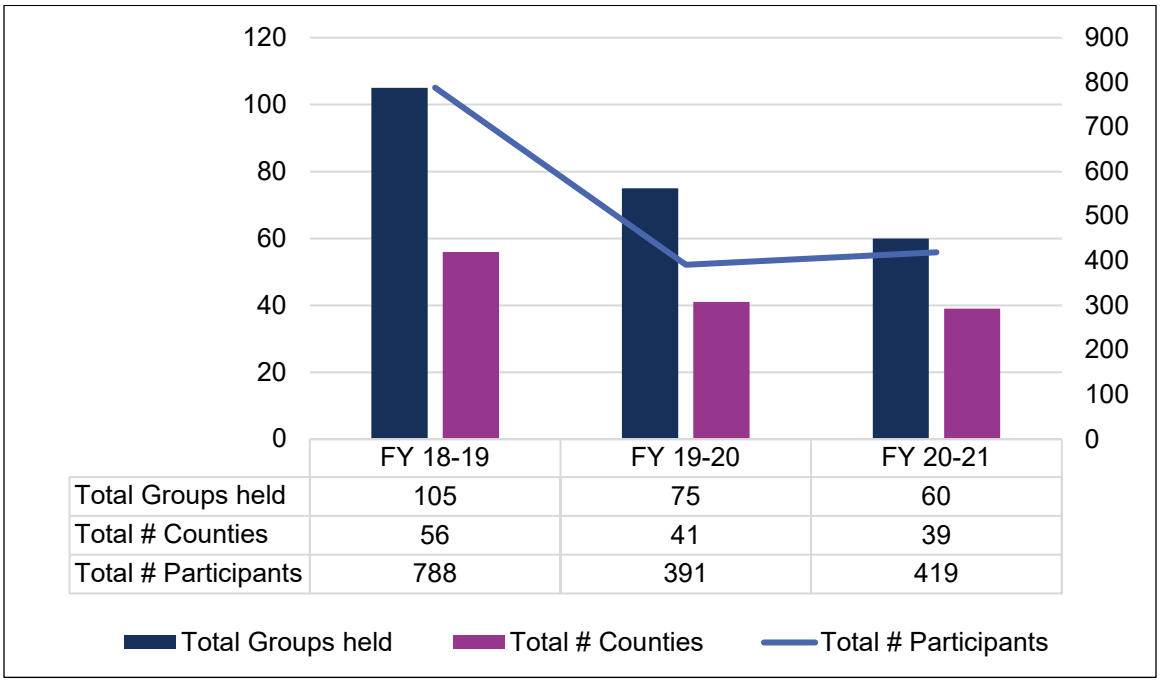
CFM focus groups are an important component of the CalEQRO site review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support,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

Obstacles

Due to the numerous impacts of COVID-19, far fewer beneficiaries and family members were able to provide direct feedback during the past two EQR cycles compared to previous years. Due to stay-at-home orders, social distancing requirements, technical barriers, and staffing vacancies due to illness and redeployment to assist in the Public Health emergency response, it was simply not possible to conduct CFM focus groups as per typical CalEQRO practice.

In FY 2018-19, the year prior to COVID-19, CalEQRO conducted 105 CFM focus groups across all 56 MHPs, with a total of 788 beneficiaries or family members interviewed in person. By contrast, only 60 CFM focus groups occurred in FY 2020-21 across 39 MHPs; CalEQRO directly interviewed 419 beneficiaries, representing a 47 percent reduction in beneficiary participation (Figure 7-1). Further, all CFM Focus Groups conducted in FY 2020-21 occurred remotely via telephone or videoconferencing.

Figure 7-1: CFM Focus Group Participation, FY 2018-19 to FY 2020-21



	FY 18-19	FY 19-20	FY 20-21
Total Groups held	105	75	60
Total # Counties	56	41	39
Total # Participants	788	391	419

CalEQRO developed a virtual focus group protocol that included questions to guide group discussion in the areas of access to services, timeliness, quality, and outcomes. Logistical limitations resulted in unreliable and invalid quantitative data collection, and as a result, detailed demographic information is not available for this year's annual aggregate statewide report. Nevertheless, CalEQRO employed nine CFM consultants who leveraged their own lived experience and EQR training to effectively gather qualitative data reflective of beneficiaries' experiences within the MHP system. Key findings, including comments and recommendations from each focus group were included in the individual MHP reports; aggregated results follow.

Themes

For MHPs, shelter-in-place orders, off-site care, and closed wellness centers resulted in less frequent contact with beneficiaries. Additionally, ongoing staffing issues, shifting work priorities, and illness hindered the communication needed to successfully orchestrate group logistics. For focus group participants, not having the needed technology, i.e., smart phones or computer access, and an unreliable internet connection prevented participation. Not only did technology issues hinder participation, but it also posed a barrier to completing surveys related to demographics and service experience.

Beneficiaries reported that counties demonstrated flexibility and worked to meet beneficiaries where they were located, in the community and in their homes. MHPs also worked hard to keep people safe and provide socially distanced services and masking supplies when needed. Overall, beneficiaries had a variety of service delivery options – through video, phone, or in-person. More families reported engaging in services with their children due to computer access at home. Focus group participants reported accessing more telehealth services and describing telehealth experiences as positive, and many expressed hopes that telehealth would continue after the pandemic. Some beneficiaries reported that wellness centers went beyond expectations by providing virtual groups and increased outreach to

make connections with beneficiaries while closed. Increased outreach and services were also made with persons experiencing homelessness to connect them to services and housing.

Beneficiaries raised several concerns related to transportation, the widespread closing of wellness centers, and a decline in peer employment opportunities. Some peer jobs were eliminated altogether or had hours significantly reduced. Transportation was often mentioned in conjunction with the wellness centers; moreover, many wellness center closures reduced the availability of rides and group services. Many CFMs reported that they missed having peer support persons to assist with bus navigation and other needs, i.e., getting prescriptions filled. Transportation issues and center closures also reduced peer representation on committees such as quality cultural competence and program planning committees. Lastly, a key COVID-19 impact related to telehealth services was the lack of privacy for beneficiaries when participating in telehealth services if they did not have a private space available to them.

Consumer Perception Surveys

In this section, CalEQRO presents the findings from the statewide Consumer Perception Survey (CPS), which consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes. Three of the surveys are age-specific and the fourth is used to obtain youth's family member feedback. These are the only instruments used statewide and provide comparable data across different MHPs for each age group and family members of children.

MHPs typically administer these surveys to beneficiaries receiving outpatient services during two prespecified one-week periods. Data collection and data entry are then performed by DHCS contractor, CIBHS; CIBHS then submits the dataset to DHCS who in turn provides the data to CalEQRO. CalEQRO's analysis and reporting on CPS is mandated by CA DHCS through its EQRO contract with BHC.

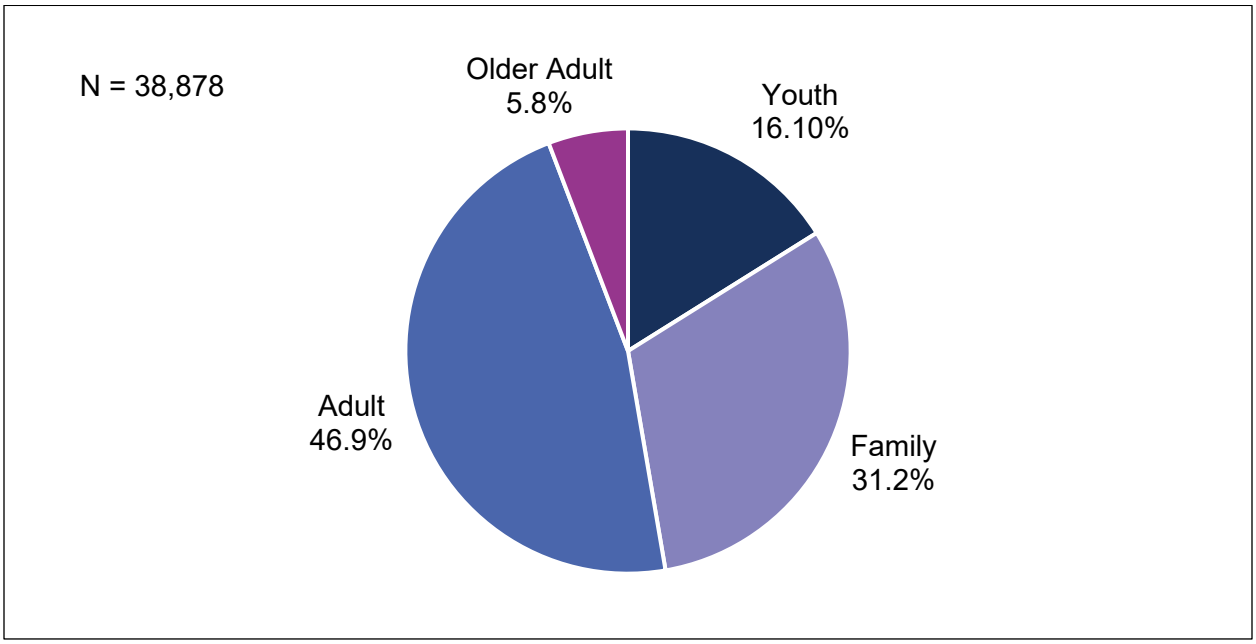
As with CFM focus groups conducted during the EQRs, participation in the CPS was significantly impacted by COVID-19. Specifically, due to the public health emergency and related restrictions, the CPS was only administered once during CY 2020. This resulted in only 38,878 surveys received from publicly funded MHPs in CY 2020, compared to 95,482 surveys in CY 2019 and over 100,000 in CY 2018; this represents a roughly 60 percent reduction in the number of individuals whose feedback is reflected in these findings.

Results

Survey Distribution

The distribution of surveys among the four types of survey was 46.9 percent Adults, 31.2 percent Families of Youth (YSS-F), 16.1 percent Youth and 5.8 percent Older Adults. (Figure 7-2)

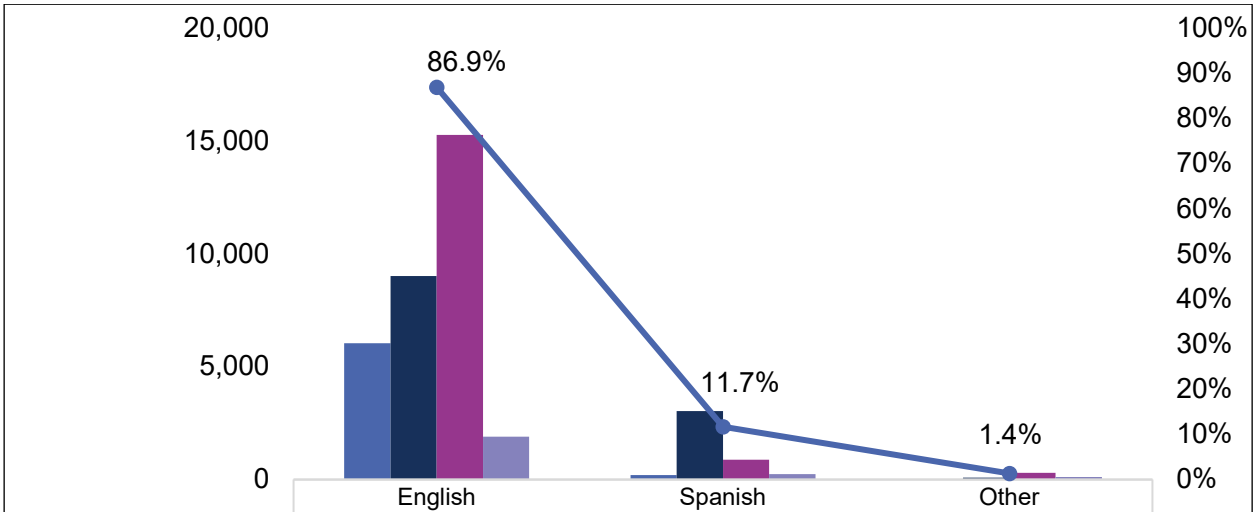
Figure 7-2: Surveys Received by Survey Type, CY 2020



Language of Surveys Received

The majority of surveys (86.9 percent) were received in English followed by surveys in Spanish at 11.7 percent. The remaining 1.4 percent of the surveys were received in other threshold languages such as Armenian, Chinese, Hmong, Korean, Russian, and Vietnamese. (Figure 7-3)

Figure 7-3: Surveys Received in Primary Threshold Language, CY 2020



	English	Spanish	Other
Youth	6,044	196	18
Families of Youth	9,021	3,032	88
Adult	15,275	880	292
Older Adult	1,906	240	108
Percent	86.9%	11.7%	1.4%

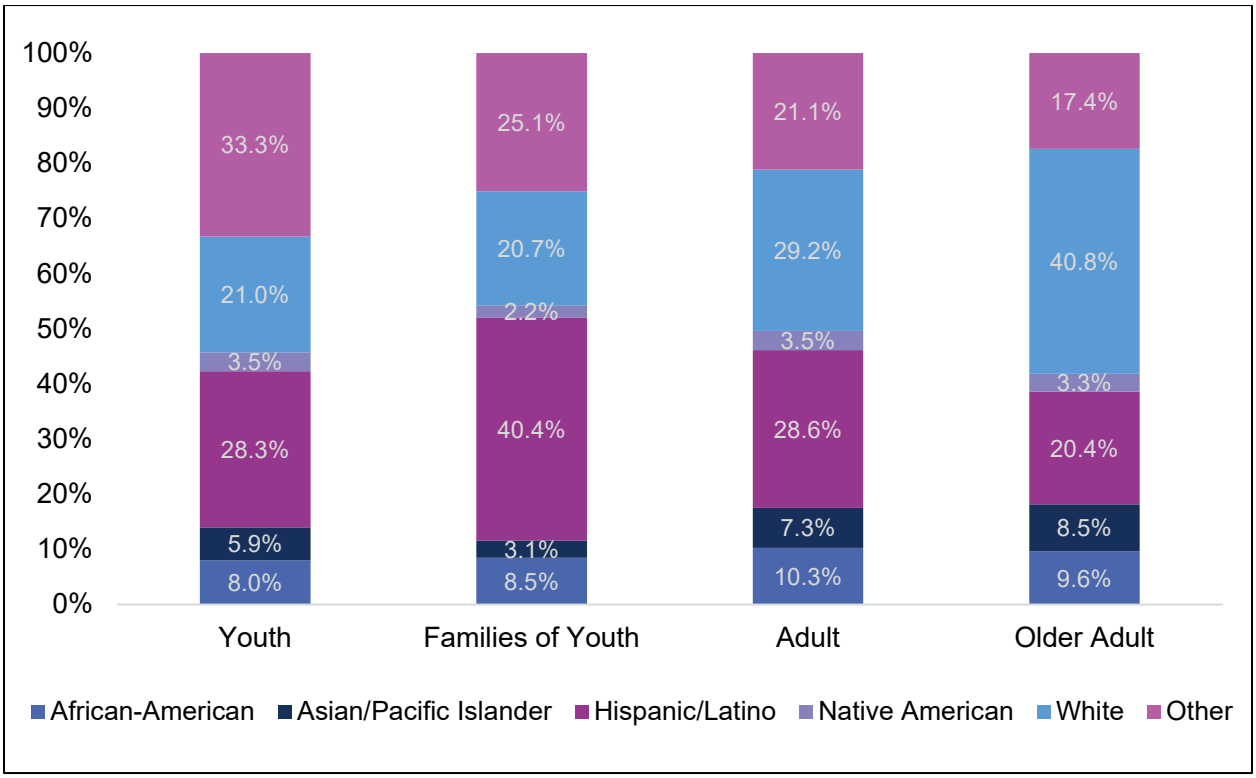
Surveys Received by Race/Ethnicity

The highest percent of Youth and Families of Youth surveys were from Hispanic/Latino at 28.3 percent and 40.4 percent, respectively. (Figure 7-4)

A higher percent of APIs completed Adult and Older Adult surveys at 7.3 percent and 8.5 percent, respectively, as compared with 5.9 percent of Asian Youth and 3.1 percent of Families of Youth.

A higher percent of Youth at 33.3 percent and Families of Youth at 25.1 percent reported their ethnicity as "Other Race" as compared with Adults and Older Adults at 21.1 percent and 17.4 percent respectively.

Figure 7-4: Percentage of Surveys Received Statewide by Race/Ethnicity and Survey Type



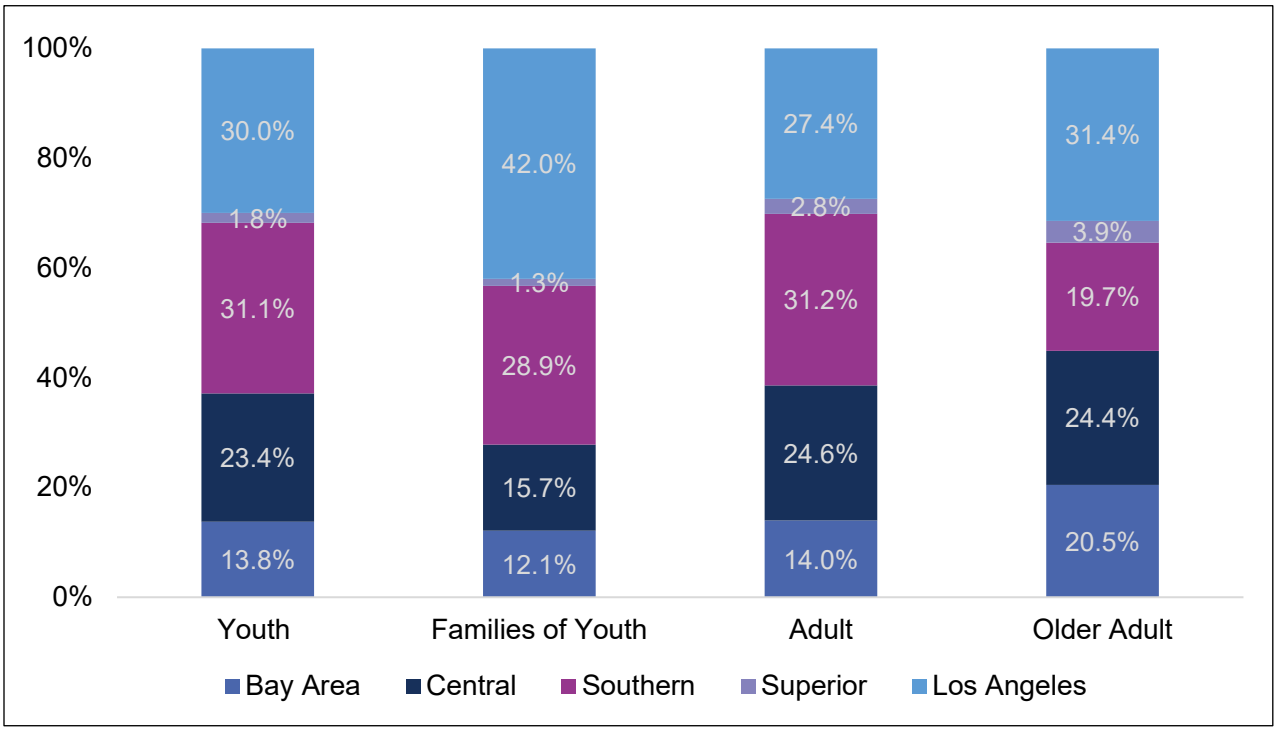
Surveys Received by Region

Approximately one third or more of the surveys from Youth, Families of Youth, and Older Adult clients were from Los Angeles County. In addition, between 29 percent and 31 percent of Youth, Families of Youth and Adult surveys were from the southern region. As a result, approximately 60 percent of the Youth, Families of Youth and Adult surveys were from Southern California and 55 percent of the Older Adult surveys were from Southern California region. (Figure 7-5)

Between 12 and 14 percent of Youth, Families of Youth, and Adult surveys were from the Bay Area and 20.5 percent of Older Adult surveys were from the Bay Area.

Nearly a quarter (between 23.4 percent and 24.6 percent) of the Youth, Adult and Older Adult surveys were from the Central region.

Figure 7-5: Percentage of Surveys Received Statewide by MHP Region and Survey Type, CY 2020



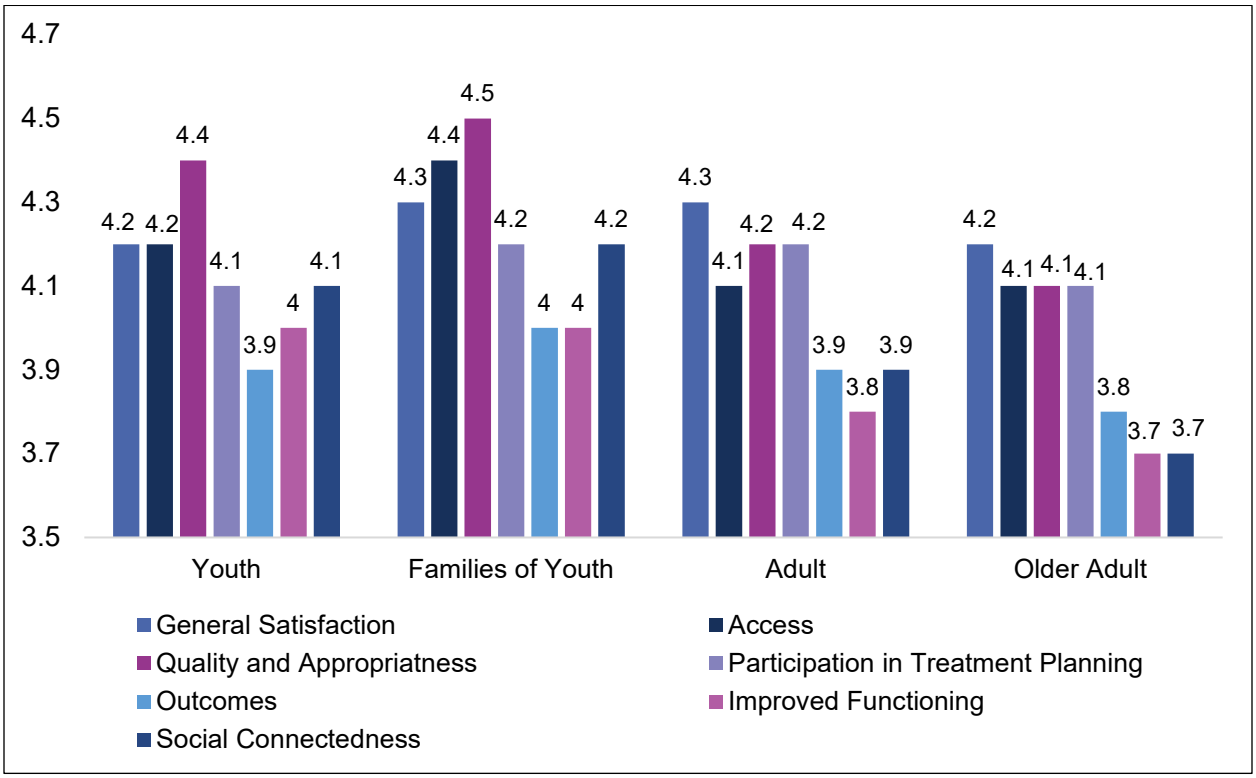
Mean Score by Satisfaction Domains and Survey Type

In general, across the four survey types, survey respondents rated General Satisfaction, Quality and Appropriateness, Access, and Participation in Treatment Planning higher than Outcome measures such as Improved Functioning, Outcomes, and Social Connectedness. (Figure 7-6)

Among the Youth and Families of Youth, the highest rated satisfaction domain was for Quality and Appropriateness at 4.4 and 4.5 respectively on a 5-point scale and the lowest rated satisfaction domain was for Outcomes and Improved Functioning at 3.9 and 4.0.

However, among Adult and Older Adult surveys, the highest rated satisfaction domain was for General Satisfaction at 4.3 and 4.2 respectively and the lowest rated satisfaction domain was for Improved Functioning, Social Connectedness, and Outcomes.

Figure 7-6: Mean Score for Satisfaction Domains by Survey Type, FY 2020-21

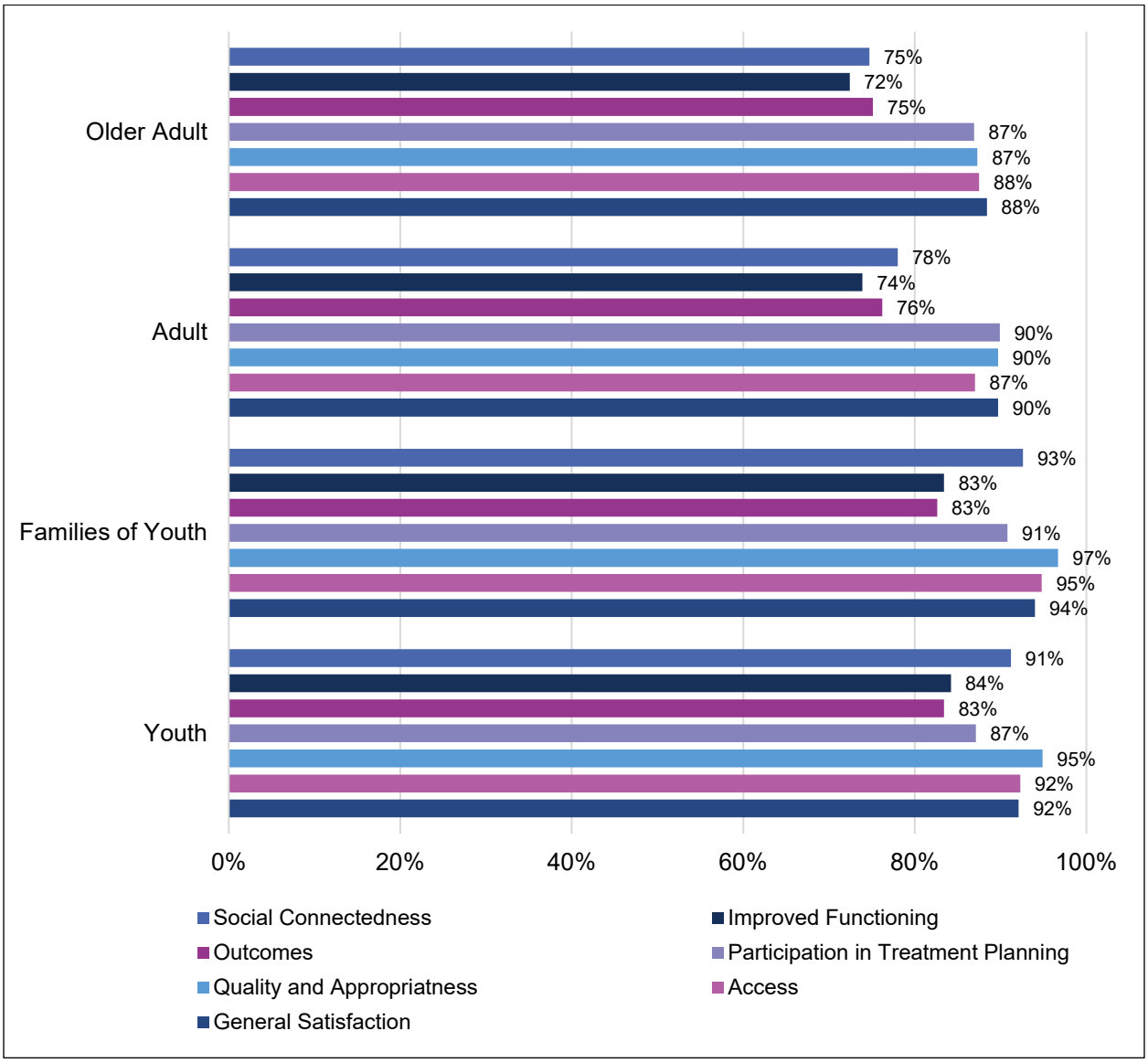


Percent Satisfied by Satisfaction Domain and Survey Type

More than 90 percent of Youth and Families of Youth had a positive rating for General Satisfaction, Access, and Quality and Appropriateness related to their treatment. Whereas between 83 percent and 84 percent had a positive rating for satisfaction with Outcomes and Improved Functioning. (Figure 7-7)

Approximately 90 percent of Adult and Older Adults had a positive rating for Quality Measures such as satisfaction with Access, Quality and Appropriateness, and Participation in Treatment Planning and between 72 percent and 75 percent had a positive rating for Outcome Measures such as Improved Functioning and Social Connectedness.

Figure 7-7: Percent Satisfied by Satisfaction Domains and Survey Type, FY 2020-21

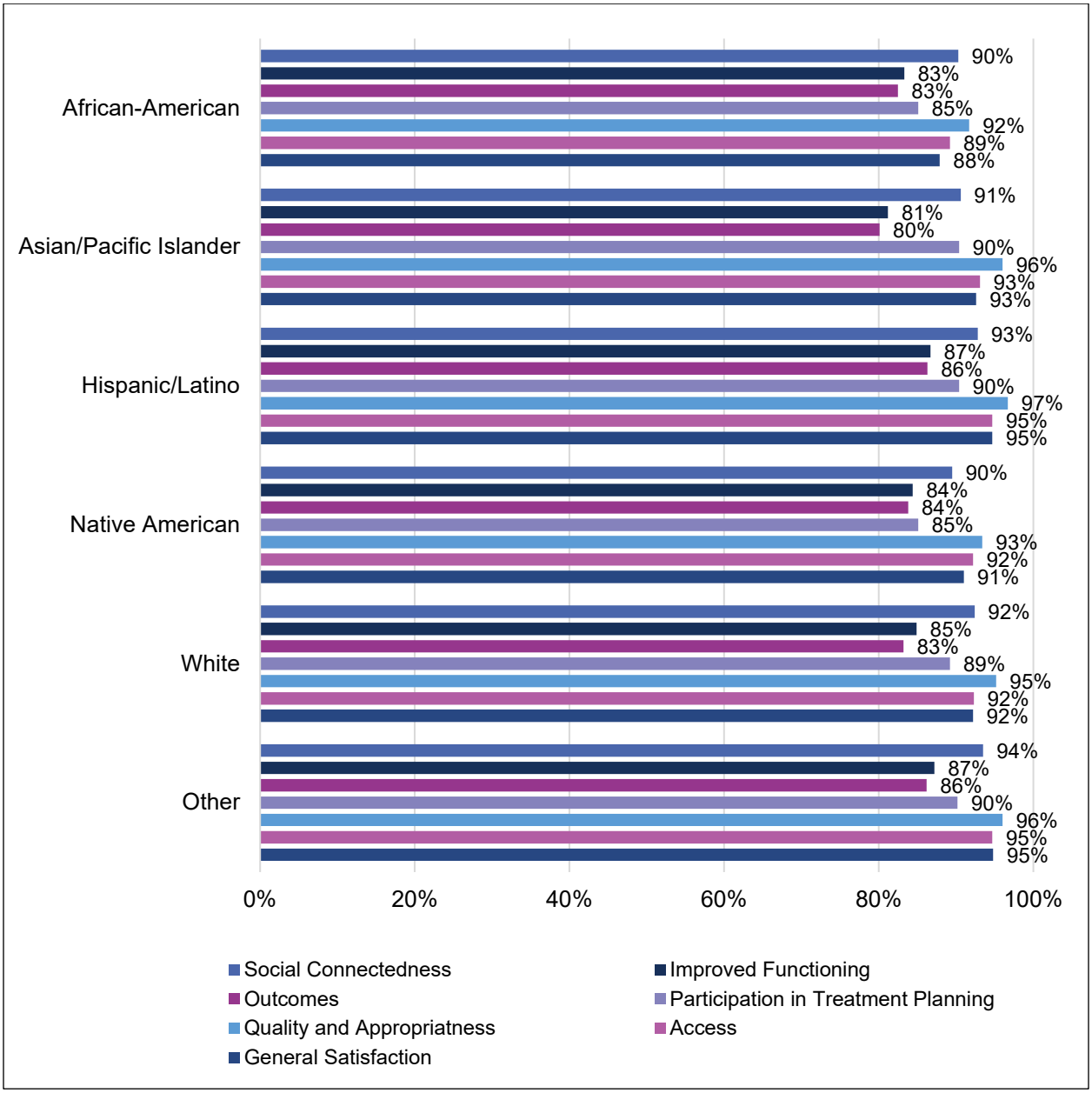


Percent Satisfied by Satisfaction Domain, Survey Type, and Race/Ethnicity

Figures 7-8 through 7-11, show the domains by race/ethnicity with a figure for each survey type. Figures 7-12 through 7-14 display the Satisfaction Domains of Access, Quality, and Outcomes.

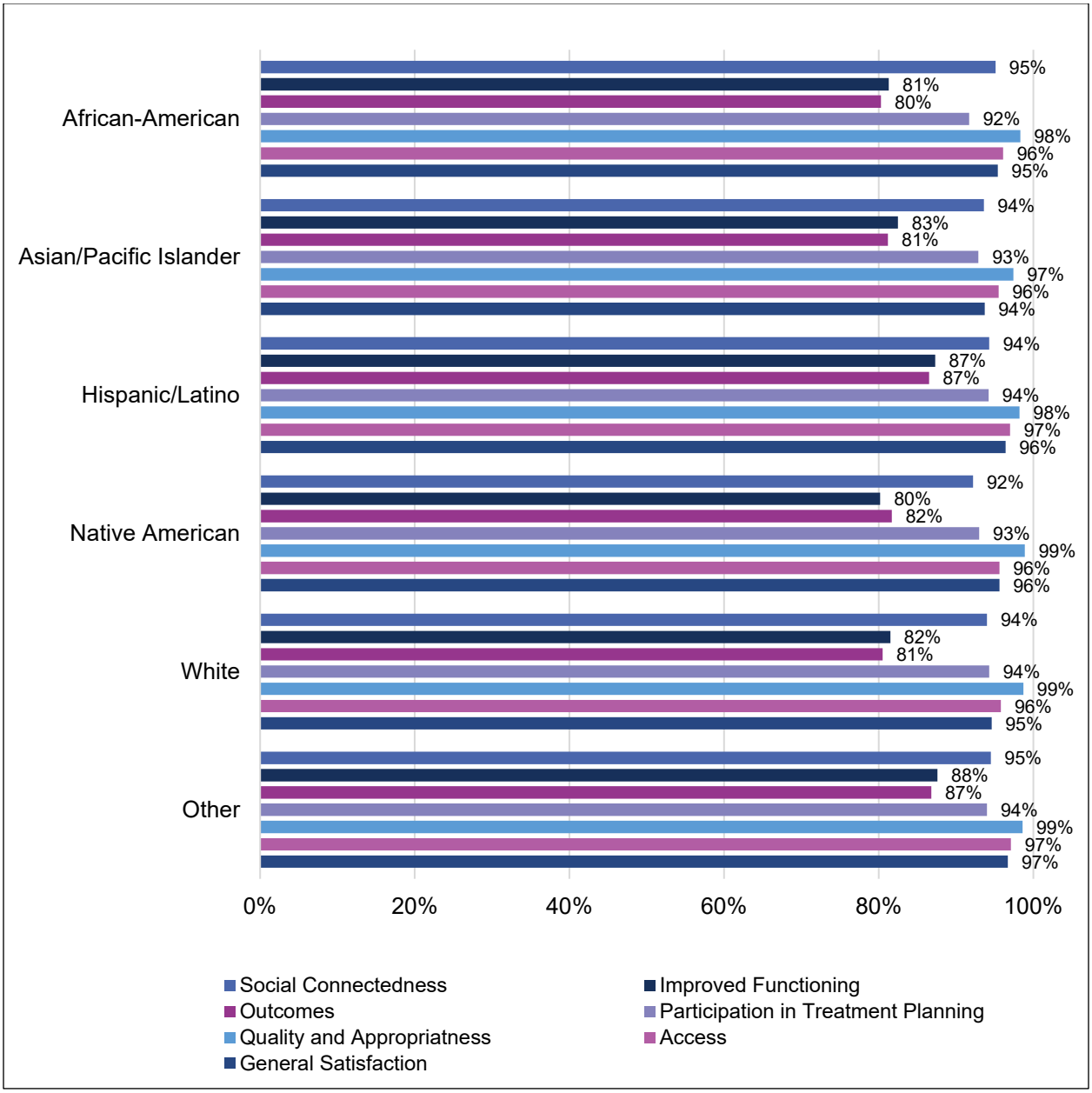
Among Youth, satisfaction with Access and Quality and Appropriateness was greater than 90% among all ethnic groups. However, satisfaction with Participation in Treatment Planning was slightly lower among African-American and Native American respondents. Satisfaction with Outcomes was slightly lower among API, African-American and White youth. (Figure 7-8)

Figure 7-8: Percent Satisfied by Race/Ethnicity and Survey Type – Youth, CY 2020



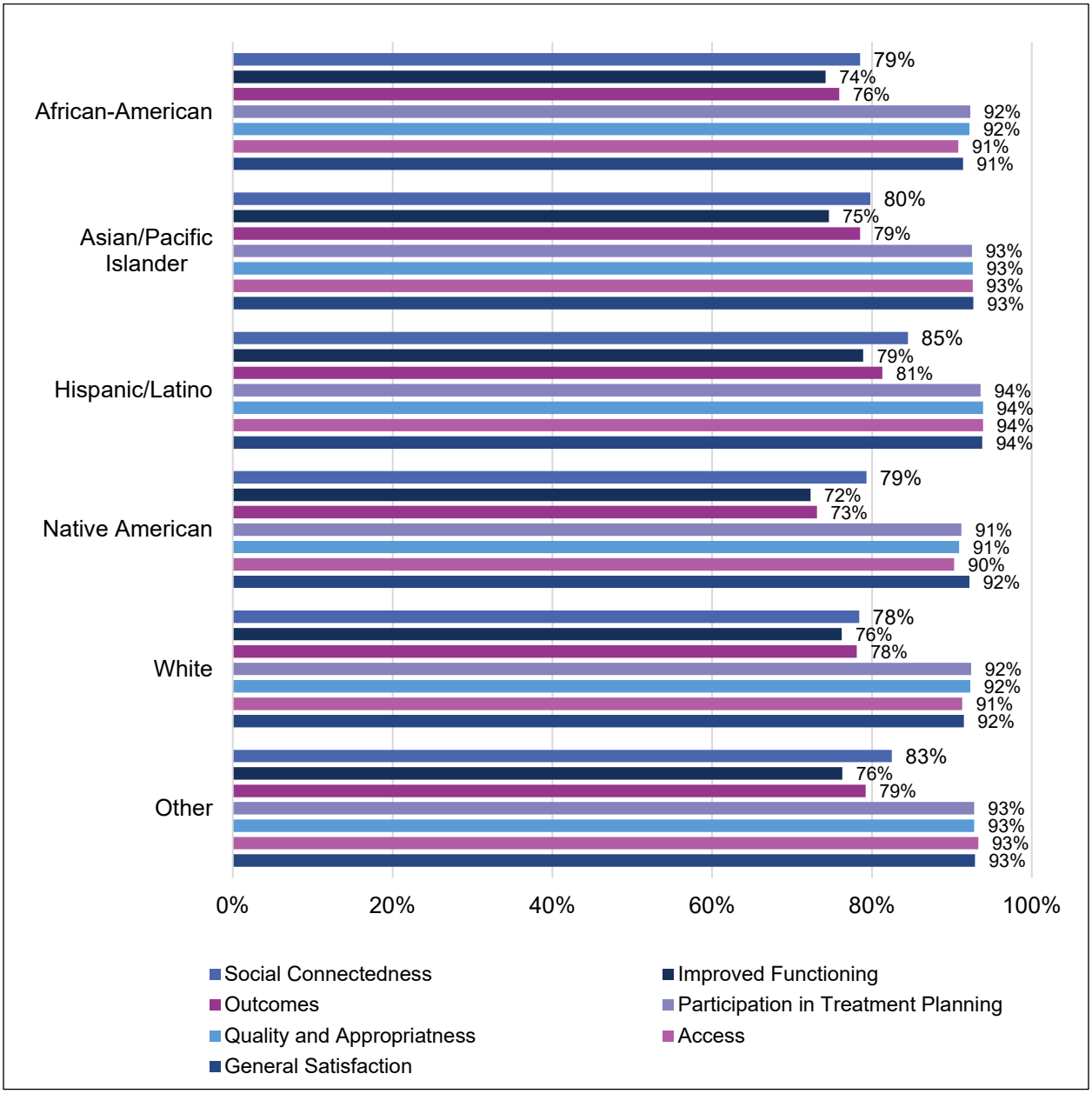
Among Families of Youth surveys, satisfaction with Access, Quality and Appropriateness, and Participation in Treatment Planning was greater than 90% among all ethnic groups. Satisfaction with Outcomes was slightly lower among African-American, API and White. (Figure 7-9)

Figure 7-9: Percent Satisfied by Race/Ethnicity and Survey Type – Families of Youth, CY 2020



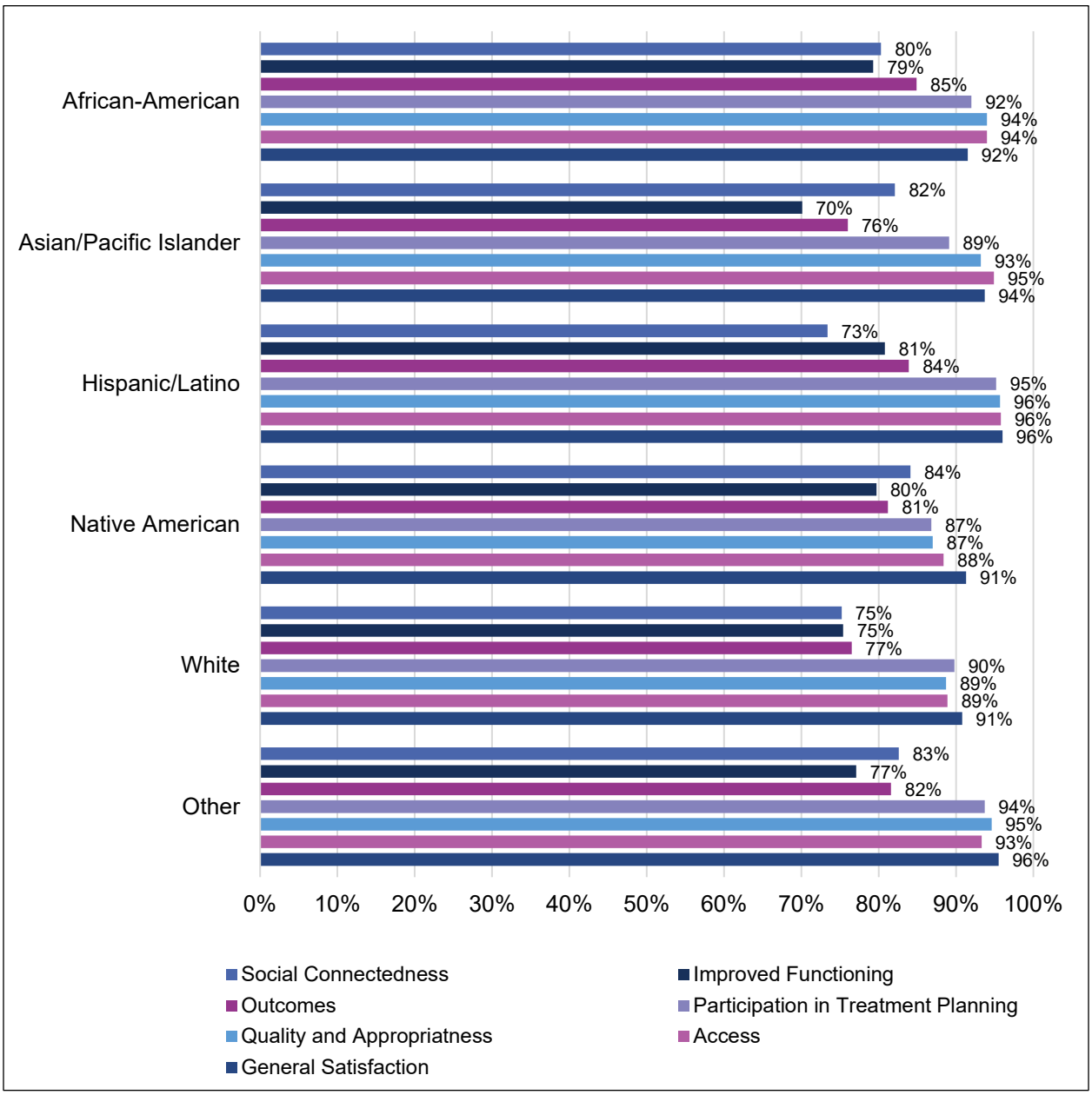
Among Adult surveys, satisfaction with Access, Quality and Appropriateness, and Participation in Treatment Planning was greater than 90% among all ethnic groups. However, satisfaction with Outcome and Improved Functioning was lower among Native American. (Figure 7-10)

Figure 7-10: Percent Satisfied by Race/Ethnicity and Survey Type – Adult, CY 2020



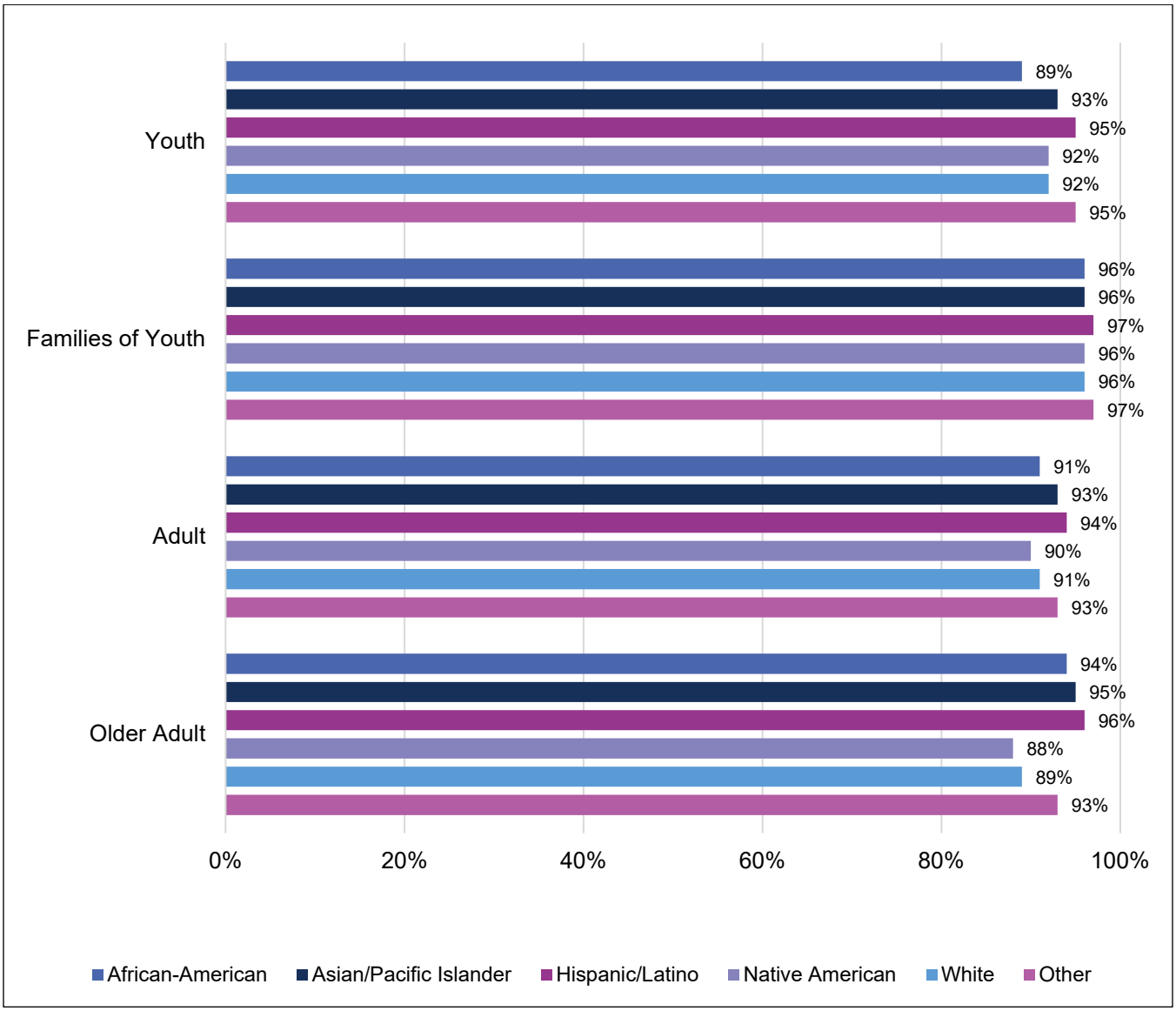
Among Older Adults, satisfaction with Access, Quality and Appropriateness, and Participation in Treatment Planning was lower among Native Americans. Satisfaction with Outcome and Improved Functioning was lower among API and White surveys. Satisfaction with Social Connectedness was lower among Hispanic/Latino and White surveys. (Figure 7-11)

Figure 7-11: Percent Satisfied by Race/Ethnicity and Survey Type – Older Adult, CY 2020



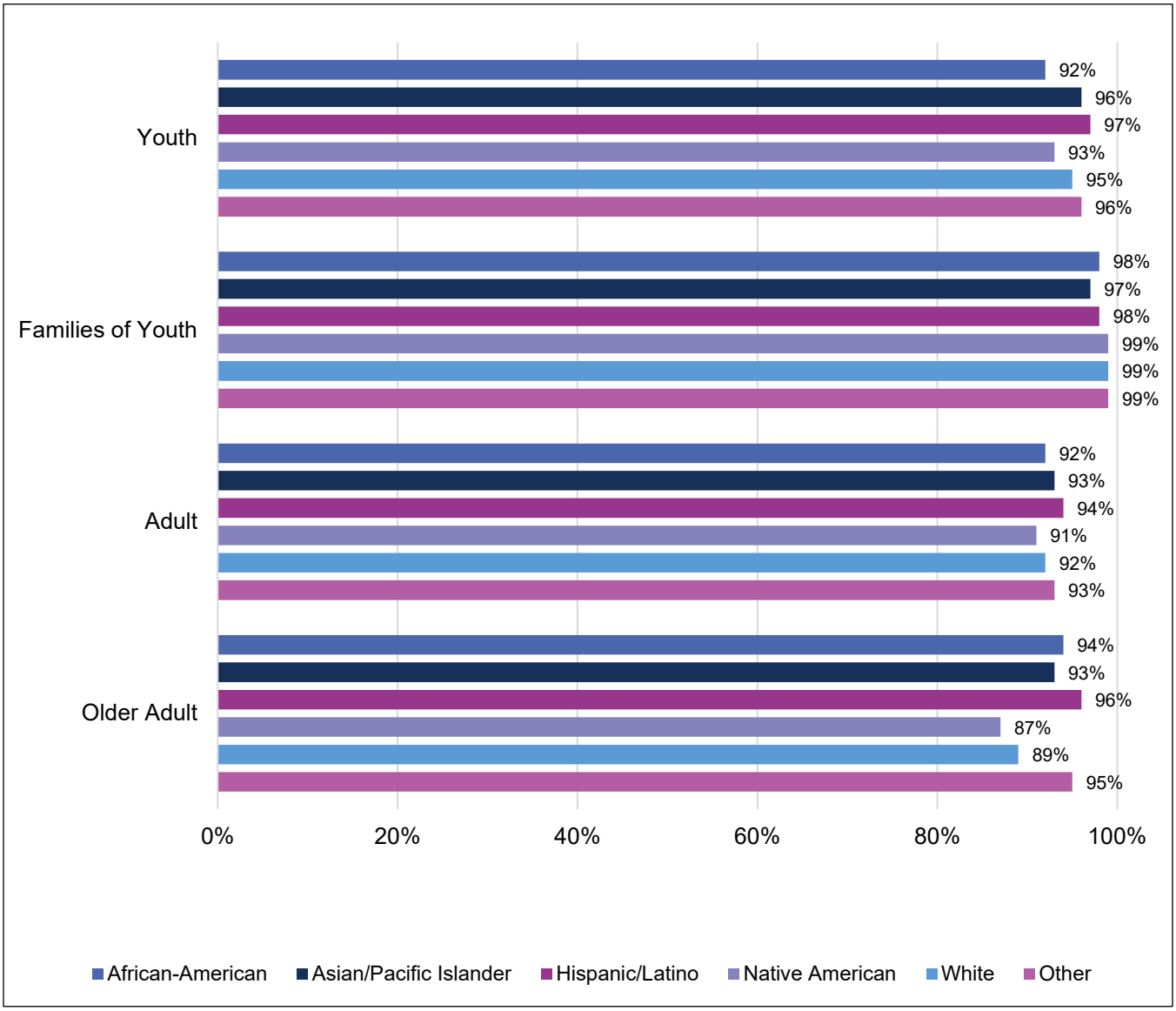
With the Access domain there were differences in satisfaction by race/ethnicity and survey type. Among Youth, African Americans reported the lowest perception of satisfaction with Access. Among Adults, White, African-American, and Native American reported lower satisfaction with Access. Among Older Adults, White and Native Americans reported lower satisfaction with Access. (Figure 7-12)

Figure 7-12: Satisfaction with Access by Race/Ethnicity and Survey Type, CY 2020



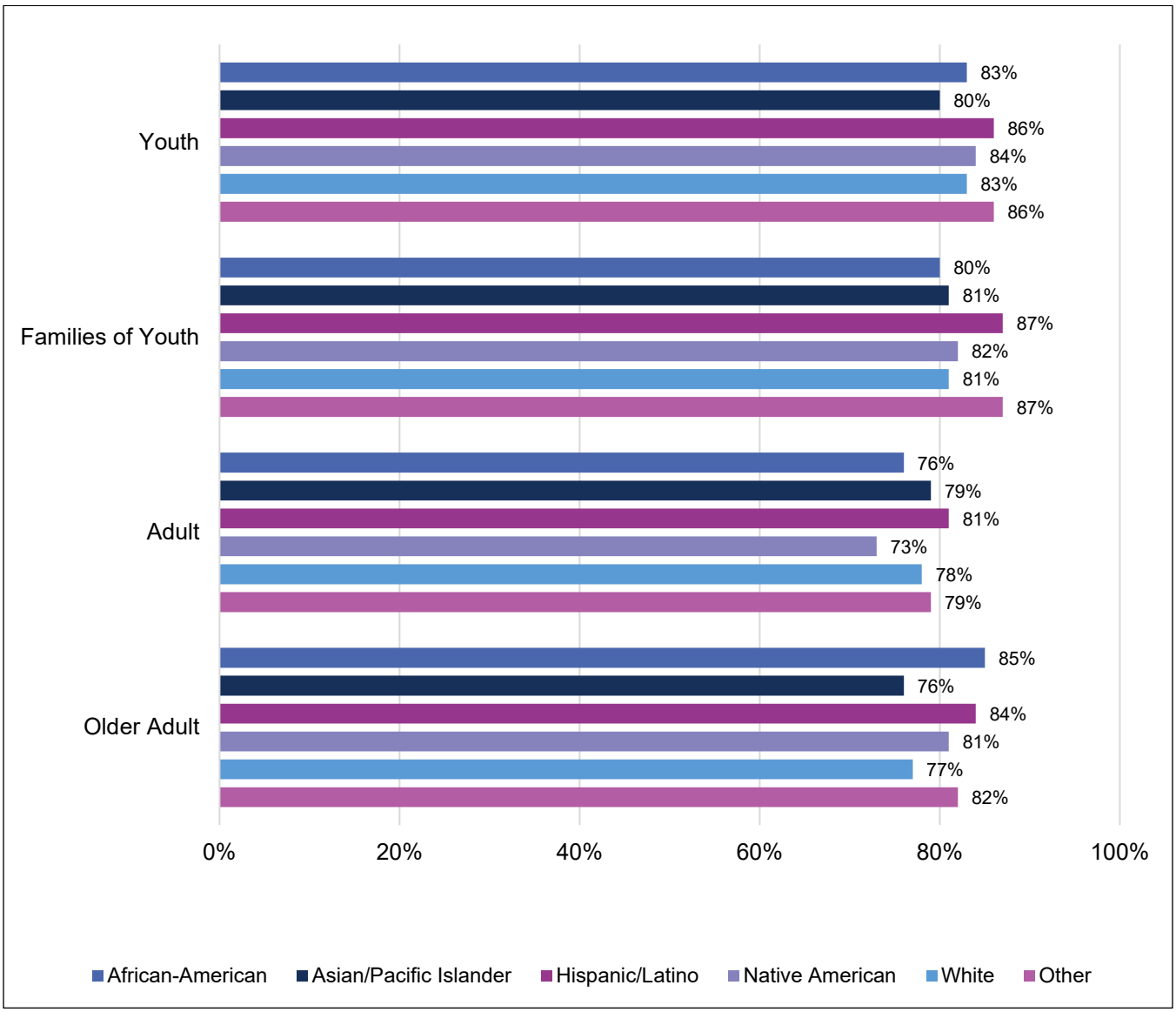
Differences by race/ethnicity and survey types were also found when looking at satisfaction with Quality and Appropriateness. Families of Youth had the highest and Older Adults had the lowest positive rating for satisfaction with Quality and Appropriateness. By ethnicity, satisfaction with Quality and Appropriateness was greater than 90% among all ethnic groups among Youth, Families of Youth, and Adult surveys. However, among Older Adults, a lower percent of White and Native American respondents reported satisfaction with the Quality and Appropriateness domain. (Figure 7-13)

Figure 7-13: Satisfaction with Quality by Race/Ethnicity and Survey Type, CY 2020



With the Outcomes domain, differences in satisfaction were also seen by race/ethnicity and survey type. Youth and Families of Youth had a higher positive rating as compared with Adult and Older Adult survey types. White and API Families of Youth and API Youth reported lower satisfaction with Outcomes. Among Adults, Native American respondents had the lowest positive rating and among Older Adults, White, and API respondents had the lowest positive rating for Outcomes. (Figure 7-14)

Figure 7-14: Satisfaction with Outcomes by Race/Ethnicity and Survey Type, CY 2020

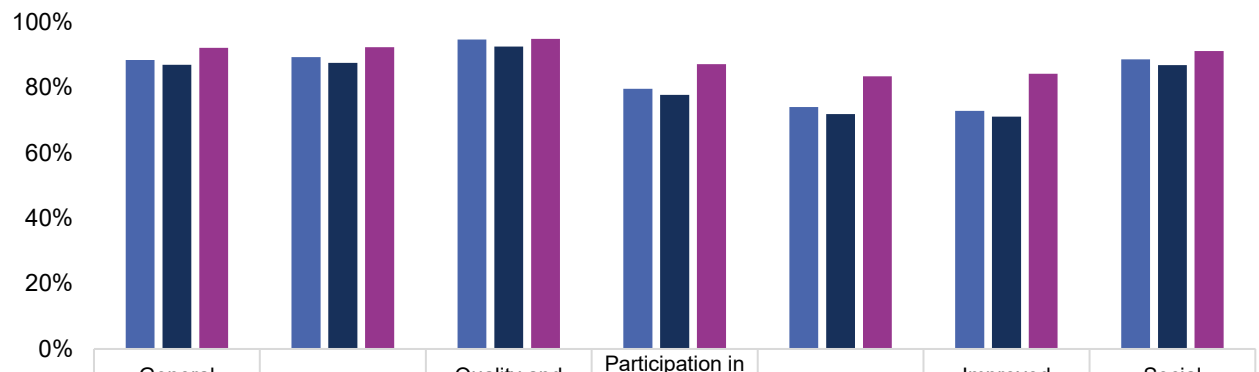


Trend Analysis

Figures 7-15 through 7-18, show the positive ratings of satisfaction domains for each survey type over a three-year period.

Youth surveys show a positive trend and an increase in all seven satisfaction domains between 2018 and 2020. Most notably there is almost a 10-percentage point increase in satisfaction rating for the three Outcome Measures and Participation in Treatment Planning. (Figure 7-15)

Figure 7-15: Positive Rating of Satisfaction Domains among Youth, CY 2018-2020

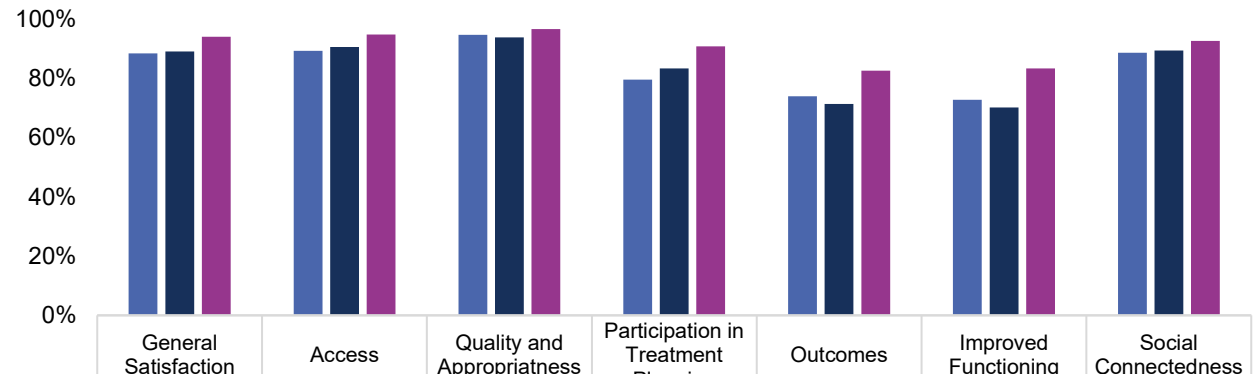


	General Satisfaction	Access	Quality and Appropriatness	Participation in Treatment Planning	Outcomes	Improved Functioning	Social Connectedness
2018	88.4%	89.3%	94.7%	79.6%	74.0%	72.8%	88.6%
2019	86.9%	87.5%	92.5%	77.7%	71.9%	71.1%	86.8%
2020	92.1%	92.3%	94.9%	87.1%	83.4%	84.2%	91.2%

2018 2019 2020

Similar to Youth, Families of Youth also show an increase in positive rating for the seven satisfaction domains between 2018 and 2020. (Figure 7-16)

Figure 7-16: Positive Rating of Satisfaction Domains among Families of Youth, CY 2018-2020

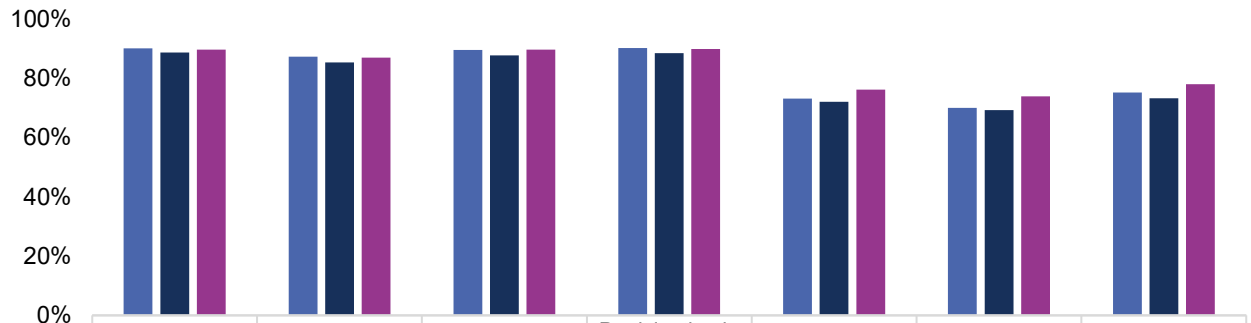


	General Satisfaction	Access	Quality and Appropriatness	Participation in Treatment Planning	Outcomes	Improved Functioning	Social Connectedness
2018	88.4%	89.3%	94.7%	79.6%	74.0%	72.8%	88.6%
2019	89.1%	90.6%	93.8%	83.4%	71.4%	70.2%	89.4%
2020	94.0%	94.8%	96.7%	90.8%	82.6%	83.4%	92.6%

2018 2019 2020

Adult surveys show an increase in positive rating for the three measures of Outcomes, Improved Functioning, and Social Connectedness between 2018 and 2020. (Figure 7-17)

Figure 7-17: Positive Rating of Satisfaction Domains among Adults, 2018-2020

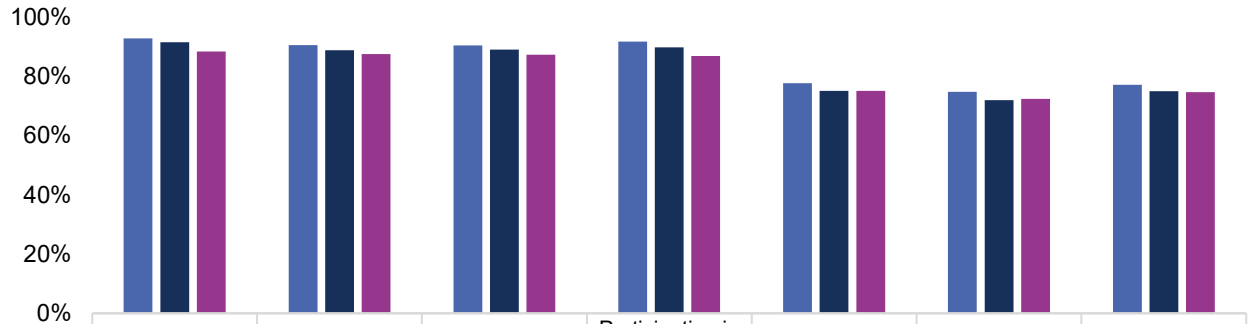


	General Satisfaction	Access	Quality and Appropriatness	Participation in Treatment Planning	Outcomes	Improved Functioning	Social Connectedness
2018	90.1%	87.3%	89.6%	90.3%	73.2%	70.1%	75.2%
2019	88.7%	85.4%	87.8%	88.5%	72.1%	69.3%	73.3%
2020	89.7%	87.0%	89.7%	89.9%	76.2%	73.9%	78.0%

2018 2019 2020

Older Adult surveys show a decrease in positive rating for all the satisfaction domains between 2018 and 2020. (Figure 7-18)

Figure 7-18: Positive Rating of Satisfaction Domains among Older Adults, 2018-2020



	General Satisfaction	Access	Quality and Appropriatness	Participation in Treatment Planning	Outcomes	Improved Functioning	Social Connectedness
2018	92.8%	90.5%	90.4%	91.7%	77.7%	74.8%	77.1%
2019	91.5%	88.8%	89.0%	89.8%	75.1%	72.0%	75.0%
2020	88.4%	87.5%	87.3%	86.9%	75.1%	72.4%	74.7%

2018 2019 2020

Summary

In CY 2020 due to the COVID-19 pandemic, the CPS was conducted only once in the month of June. Approximately 39,000 surveys were completed during this survey period. Nearly 47 percent of the surveys received were from Adults, 31 percent from Families of Youth, 16 percent from Youth, and 5.8 percent were from Older Adults. Nearly 87 percent of the surveys were in English, 12 percent in Spanish, and 1.4 percent in other threshold languages. By race and ethnicity, a higher percent of Youth and Families of Youth surveys were from Hispanic/Latinos, and a higher percent of Older Adults surveys were from Whites. Nearly 60 percent of all surveys received were from Southern California regions, namely Los Angeles County and southern counties.

Mean scores for satisfaction were higher among Youth and Families of Youth as compared with Adult and Older Adults. Among Youth and Families of Youth, Quality and Appropriateness was the highest rated satisfaction domain, and among Adults and Older Adults, General Satisfaction was the highest rated domain. Adults and Older Adults lowest positive rating was for Social Connectedness and Improved Functioning during this survey period.

Given that most counties were under a lockdown during the CY 2020 data collection period, it is not surprising that more Adults and Older Adults reported lower satisfaction scores for Access, Quality, and Outcome measures. Youth, on the other hand, reported a significantly higher rate of satisfaction with nearly all the seven satisfaction domains. This may indicate a greater impact of the lockdown on adults and older adults than on youth services.

Chapter 8

Performance Improvement Projects

Performance Improvement Projects

Introduction

A Performance Improvement Project (PIP) is "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner."[36] Each PIP is expected to produce beneficiary-focused outcomes. The CMS Validating Performance Improvement Projects protocol specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, or were completed during the reporting year.[37] Accordingly, for this Annual Report, CalEQRO examined projects that were underway at some time during the 12 months preceding the FY 2020-21 reviews.

Each MHP is required to have two active and ongoing PIPs: one clinical and one non-clinical. The clinical PIP is expected to focus on treatment interventions to improve outcomes and beneficiary experiences, and the nonclinical PIP is expected to focus on processes that improve access and beneficiary experience of care. The goal of both PIPs is to address problems or barriers in care; if successful, the outcome will positively impact beneficiaries.

A clinical PIP might target some of the following types of issues:

- Prevention and treatment of a specific condition
- High-volume services
- High-risk procedures and services
- Transitions in care from 24-hour settings to community settings
- Enhancing treatment for special needs populations.

A non-clinical PIP might target some of the following types of issues:

- Coordination of care with other providers or county departments
- Timeliness and convenience of service improvements
- Improvements in customer service and initial engagement in care
- Improvement in access or authorization processes
- Member services and processes that are barriers to optimal beneficiary outcomes and satisfaction.

[36] Centers for Medicare and Medicaid Services. (2019). CMS External Quality Review (EQR) Protocols October 2019. Department of Health and Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf

[37] Ibid.

Methods

The PIP Development Tool is a template provided by CalEQRO for the MHPs to use when drafting their PIP narratives.[38] Prior to the review, the MHPs are to submit both PIPs to CalEQRO. The designated CalEQRO Quality Reviewer and the CalEQRO PIP Consultant review all submitted PIPs for clarity, applicability, and relevance to the MHP's population, methodology used, and appropriateness of data and data collection tools, among other features.

During the review, the CalEQRO team conducts at least one PIP session with the MHP to discuss the documentation provided. During these sessions, the team provides feedback and TA for strengthening the submitted PIPs. Following the review, MHP staff are allowed to resubmit their PIPs within one week with any changes or additions discussed during the review. CalEQRO reviews and validates any resubmitted PIPs in accordance with the requirements of CMS Protocol 1. All PIPs are rated based on their completeness and compliance with the standards found in the CMS protocol. Each of the nine PIP steps include subsections containing standards that are rated according to the PIP Validation Tool.[39] The PIP steps are shown in Table 8-1:

Table 8-1: PIP Steps

Step	PIP Section
1	Identify PIP Topic
2	Develop the Aim Statement
3	Define the PIP Population
4	Describe the Sampling Plan
5	Select the PIP Variables (Indicators) and Performance Measures
6	Describe the Improvement Strategy (Interventions) and Implementation Plan
7	Describe Data Collection Procedures
8	Describe Data Analysis and Interpretation of PIP Results
9	Address Likelihood of Significant and Sustained Improvement through the PIP

A PIP will have met the standards set forth in the MHP's contract with DHCS, if the PIP is either Active and Ongoing or Completed (within the 12 months prior to the review). A PIP that has been submitted for approval or is in the planning phase is considered not yet active and does not meet the PIP requirements. To be considered in the Implementation phase, a PIP must have (1) baseline data on some indicators or PIP variables and (2) some improvement strategies must have started. During the Baseline year, a strategy has begun and refinements in the baseline measurements may be occurring, but there will not yet be a first measurement. A PIP in the First Remeasurement phase will be measuring the impact of the improvement strategy per the key indicators and then preparing for the Second Remeasurement. Some PIPs have more remeasurement periods and would fall in the Other phase. Table 8-2 shows the categories of PIP Status and their definitions.

[38] To view the PIP Development Tool, visit CalEQRO's website: http://caleqro.com/#!california_eqro_resources/. The tool is found under Notification Materials/DMC Notification Materials Review Preparation Materials.

[39] The PIP Validation Tool and PIP Submission Tool are available from CalEQRO's Website, www.caleqro.com.

Table 8-2: PIP Status Defined

PIP Status – DHCS Contract Terminology	PIP Validation Phase – CMS Protocol Terminology 2020-2021	Definition
Concept Only, Not Yet Active	PIP Submitted for Approval	The MHP submitted the PIP concept for review by CalEQRO
	Planning Phase	PIP is not yet active; the MHP is preparing to implement the PIP.
Active and Ongoing	Implementation Phase	The MHP has established baseline data on at least some of the indicators, and at least some strategies for improvement have started. Any combination of these is acceptable.
	Baseline Year	A strategy for improvement has begun and the MHP is establishing or refining baseline measurements.
	First Remeasurement	Baseline has been established and one or more strategy(s) is being remeasured for the first year/period.
	Second Remeasurement	The success of strategy(s) is being remeasured for the second year/measurement period.
Completed	Other	The PIP is undergoing three or more remeasurements.
		In the past 12 months or since the prior EQR, the work on the PIP has been completed.
Inactive, Developed in a Prior Year	Other	Rated last year, but not rated this year due to lack of any activities in the past year.

In addition to rating the status of each PIP, CalEQRO assesses its relative validity. Validity ratings are based on the degree to which the PIP adheres to acceptable methodology in study design, data collection, analysis, and interpretation of results. Each PIP is subsequently assigned a rating of high, moderate, low, or no confidence.[40]

Findings

As stated, each MHP is required to submit two PIPs annually, for a total of 112 required PIPs. FY 2020-21, 107 (96 percent) PIPs were submitted, demonstrating a slight improvement in the number

[40] CMS Protocol 1

of Active and Ongoing or Completed PIPs submitted from the previous year. In FY 2019-20, CalEQRO reviewed 104 PIP submissions, of which 86 (83 percent) were Active and Ongoing or Completed.

- 89 PIPs were rated as Active and Ongoing or Completed (79 percent)
    - 9 were in the Baseline Phase
    - 35 were in the Implementation Phase
    - 18 were in the first Remeasurement Phase
    - 10 were in the Second Remeasurement Phase
    - 15 were in the Other Phase – Completed
    - 2 were in the Other Phase – 3 or more remeasurements
- 15 were considered Concept Only, Not Yet Active
    - 1 was rated as Inactive, Developed in a Prior Year (1 percent)
    - 14 were rated in the Planning Phase (13 percent)
- 3 submissions did not meet the criteria for a PIP (3 percent)
- 5 PIPs were not submitted (5 percent).

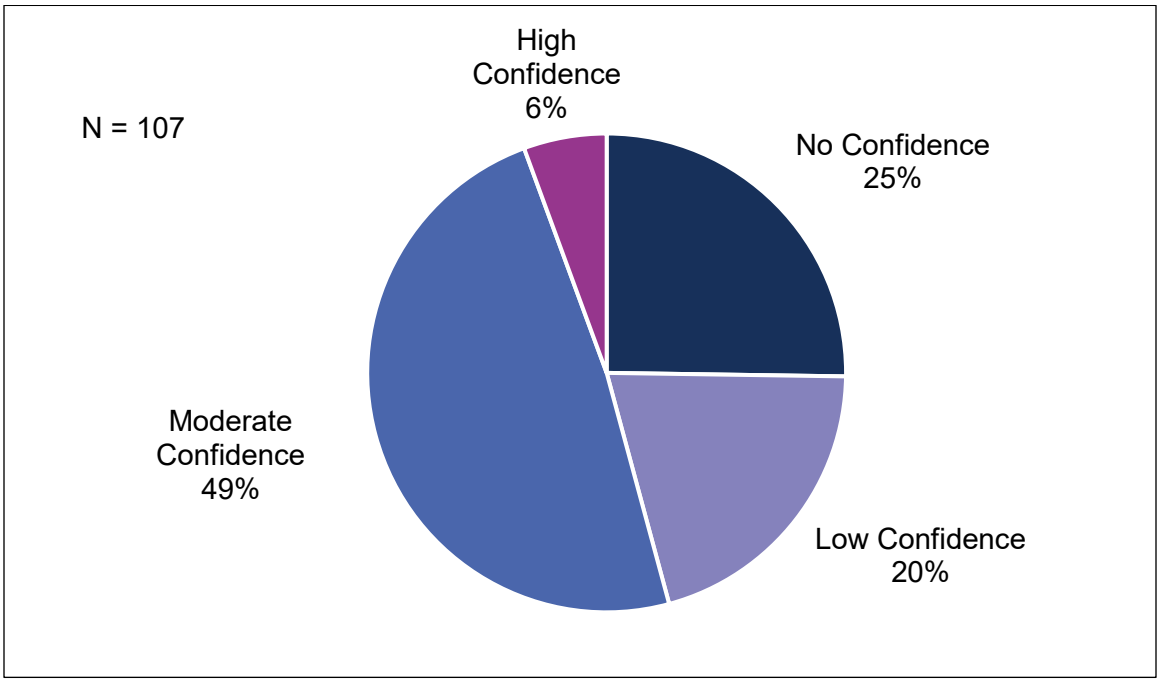
Below is a chart for FY 2020-21 breakdown of the PIPs submitted:

Table 8-3: PIP Submission Status FY 2020-21

Submission Status	FY 2019-20	FY 2019-20 Percent	FY 2020-21	FY 2020-21 Percent
PIPs submitted	104	93%	107	96%
Concept Only, Not Yet Active	12	11%	14	13%
Active and Ongoing or Completed	86	83%	89	79%
Inactive, developed in a prior year	6	5%	1	1%
Submission determined not to be a PIP	7	6%	3	3%
No PIP submitted	1	1%	5	5%
Total possible PIPs	112	100%	112	100%

As illustrated in Figure 8-1, the validity rating for nearly half of all PIPs submitted (49 percent) was Moderate Confidence. The next most frequent ratings were No Confidence (25 percent) and Low Confidence (20 percent). Despite 79 percent of all PIPs having an Active and Ongoing or Completed status, only 6 percent were found to have a High Confidence validity rating.

Figure 8-1: PIP Validity Ratings FY 2020-21



Trends in PIP Submissions

FY 2020-21 saw a slight increase in the number of Active and Ongoing or Completed PIPs submitted and a decrease in the number of Inactive PIPs submitted this year compared to the prior year (Table 8-3); there was also an increase in Active and Ongoing or Completed PIPs versus Concept Only PIPs. In FY 2019-20, there were 12 Concept Only PIPs and 7 that were determined not to be a viable PIPs; in FY 2020-21, there were 14 Concept Only PIPs, but only 3 were determined not to be viable PIPs. In FY 2019-20, 77 percent (86 out of 112 required) of the submitted PIPs were considered Active and Ongoing or Completed; this number increased by 2-percentage points to 79 percent (89 out of 112) in FY 2020-21.

Overall, MHPs report increased levels of confidence in their understanding of and ability to implement PIPs. MHPs have more clarity regarding their data collection and analysis plans, selection of performance measures, and the foundational research of the problems they are attempting to resolve. Nevertheless, some of the technical aspects of PIPs are still presenting challenges, particularly in terms of data collection capabilities and resource allocation to successfully conduct all steps of the PIP. In addition, COVID-19 impacted many PIP interventions and data collection efforts, thereby requiring the redesign of many PIP interventions, and in some cases the suspension of a PIP and/or the start of new short-term COVID-19 related PIPs.

Range of PIP Topics & Themes

The PIP topics submitted in FY 2020-21 are organized by Access to Care, Timeliness of Care, Quality of Care, and Outcomes.

Figure 8-2: PIP Themes, by Category FY 2020-21

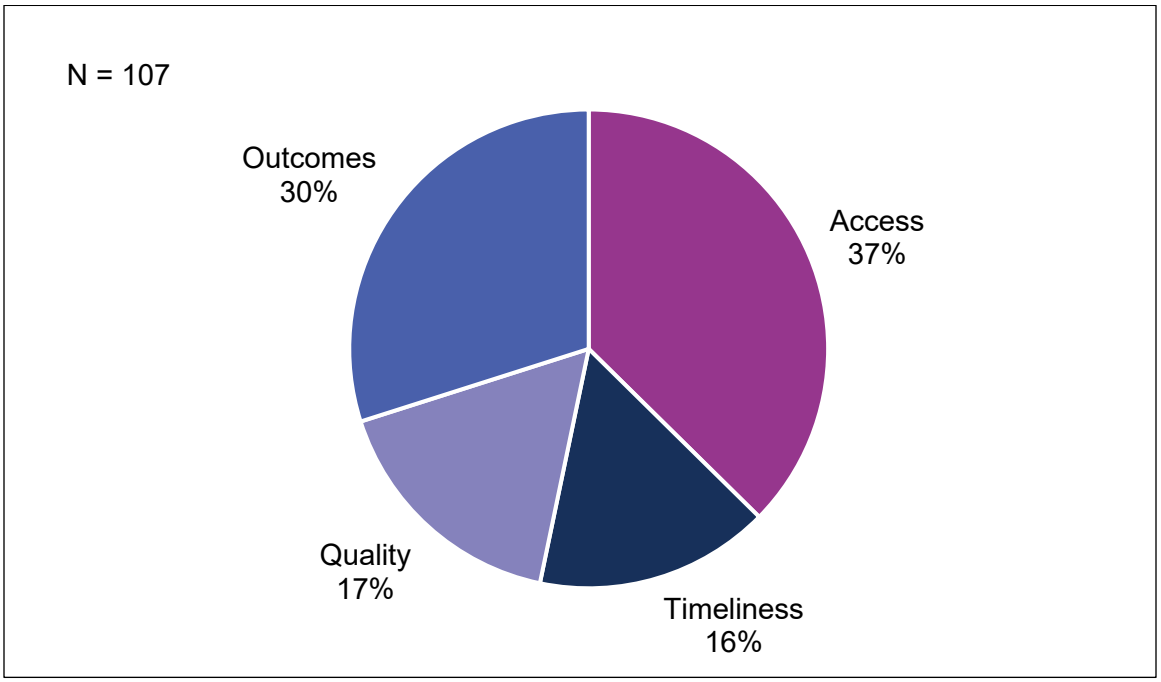
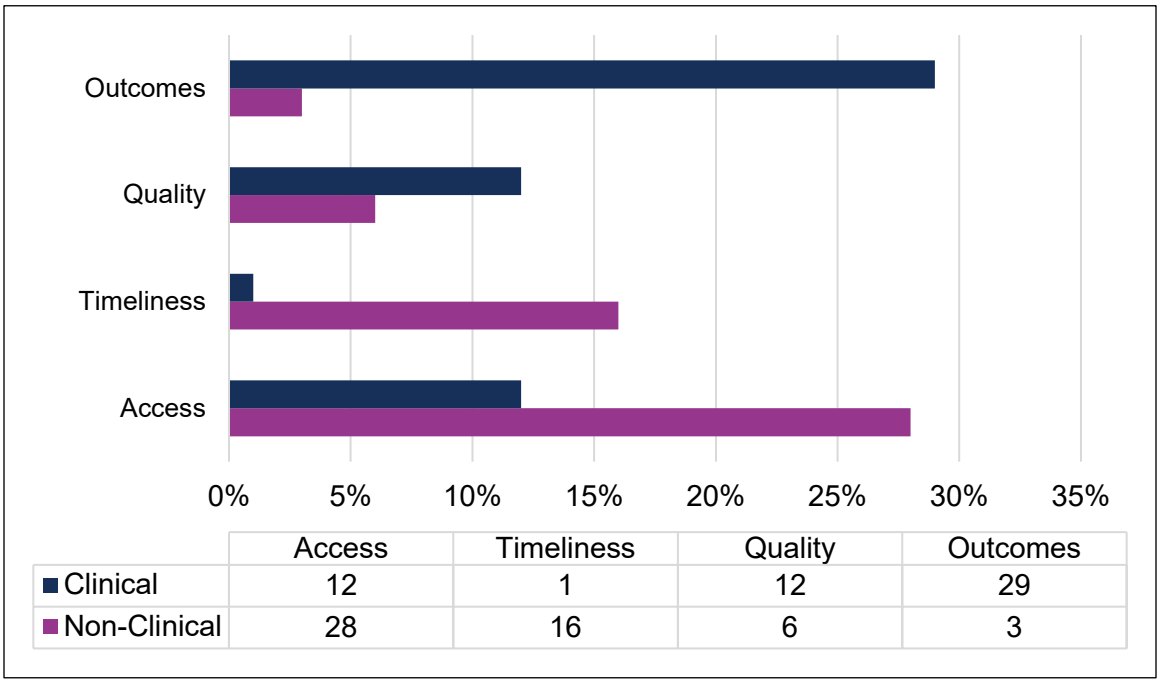


Figure 8-3: PIP Themes, by Type FY 2020-21



	Access	Timeliness	Quality	Outcomes
Clinical	12	1	12	29
Non-Clinical	28	16	6	3

PIPs to Address Access to Care

With 40 PIPs submitted, Access to Care was the most often addressed topic (37.4 percent) by MHPs. This review year, there were 12 clinical and 28 non-clinical Access to Care PIPs. The Access to Care PIPs had a variety of themes, many of which are linked to the initial engagement, screening phase or

linkage, and Access Call Center functions. The 12 clinical topics focused on engagement in services following psychiatric hospitalization, improvements in assessment and intake, access to telehealth, collaborative documentation, and treatment for Post-Traumatic Stress Disorder among youth. The 28 non-clinical PIPs addressed topics that included improving attendance at different levels of care, providing better access or linkage to services in the community or within the MHP, and providing services that utilize telehealth or have changed due to COVID-19. (Tables 8-4 and 8-5)

Table 8-4: Access to Care PIPs - Clinical

Access to Care Clinical PIP Titles	MHP
Services during COVID-19 Pandemic	Amador
Collaborative Documentation	Fresno
Engagement PIP	Imperial
Identifying Post-Traumatic Stress Disorder (PTSD) Among Outpatient Mental Health-Youth	Madera
Improving Access, Engagement and Satisfaction Through Telehealth Services	Sacramento
Children/Youth Assessment & Treatment Access	San Benito
Increasing Youth Engagement in Remote Services	San Mateo
Follow-up Appointment Attendance After Discharge from the Psychiatric Health Facility (PHF)	Santa Barbara
Same Day Assessment for Adult/Older Adult: Pilot	Santa Clara
Beneficiary Engagement with Mental Health Treatment after Discharge from a Psychiatric Hospital or Crisis Stabilization Unit	Solano
Increasing Therapeutic Alliance in Telehealth Services	Tulare
Post-Hospitalization PIP	Ventura

Table 8-5: Access to Care PIPs – Non-Clinical

Access to Care Non-Clinical PIP Titles	MHP
Using Language Line to Improve Penetration Rates	Alameda
Improving Attendance in Mental Health, Substance Use Disorder (SUD), & Psychiatric Appointments	Alpine
Low Service Retention Rate	Amador
Decreasing Psychiatric No-Shows	Calaveras
Improved Intake Attendance	Colusa
Maintaining Client Services During a Pandemic and Shelter-in-Place Orders	Contra Costa

Access to Care Non-Clinical PIP Titles	MHP
Early Specialty Mental Health Services (SMHS) Engagement Enhancement Pilot	El Dorado
Access to Mental Health Services at Harmony House	Glenn
Improving Initial Appointment Requests and Scheduled Appointments to Pre-COVID-19 Level	Imperial
Continuity of Community Care Post Psychiatric Hospitalization	Inyo
Increasing Client Access to Appointments through Telehealth Expansion	Kern
Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected	Los Angeles
Text and/or Email Appointment Reminder System	Madera
Appropriate Engagement for Homeless SMH Clients in Ukiah	Mendocino
Improving Client Retention Rates via Service Process Improvements	Mono
LGBTQ+ Network of Affirmative Care	Monterey
Increasing Crisis Assessment Team Beneficiary Linkage to Outpatient Services	Orange
Aftercare	Placer/Sierra
Text Appointment Reminders	San Benito
Promoting Bright Futures after Adverse Childhood Experiences (ACEs) PIP	San Bernardino
Connections After a Psychiatric Emergency Response Team Contact	San Diego
Facilitating Successful Transitions from Intensive Case Management to Outpatient Care	San Francisco
Same Day Access	San Luis Obispo
Increase Client's Ability to Utilize Telehealth Services	San Mateo
Beneficiaries' Timeliness to Access and Treatment Services	Santa Clara
Benefits of Increased Telehealth Services	Solano
Effectiveness of Telehealth Kiosks	Trinity
Enhanced Access Performance Improvement Project	Ventura

PIPs to Address Timeliness of Care

The number of Timeliness of Care PIPs that were submitted is smaller than previous years, with 17 in total (15.9 percent), including 1 clinical and 16 non-clinical. The clinical PIP is focused on meeting specific timeliness requirements related to assessments for children and youth. The non-clinical PIPs are focused on specific challenges in timely access to assessments and psychiatric treatment, urgent appointments, and referrals from mental health to substance use disorder (SUD) treatment. The MHPs have been exploring ways to overcome social, cultural and emotional barriers to provide engagement to different populations and groups of beneficiaries. As MHPs have refined timeliness issues successfully, this type of PIP has been seen less frequently. (Tables 8-6 and 8-7)

Table 8-6: Timeliness of Care PIPs – Clinical

Timeliness of Care Clinical PIP Titles	MHP
Timely Assessments for Children and Youth	Stanislaus

Table 8-7: Timeliness of Care PIPs – Non-Clinical

Timeliness of Care Non-Clinical PIP Titles	MHP
High Priority Clients	Butte
Improving Timeliness of Psychiatry Appointments for Adult Beneficiaries Requesting Initial Medication Support Services	Del Norte
Intake Process Redesign	Fresno
Improving Timeliness to Appointments for Urgent Requests	Humboldt
Urgent Conditions	Kings
Timely Connections to Services	Lake
Assessment, Placement, and Referral Revamp	Marin
Improving the Timeliness of Psychiatry Referrals	Merced
Promoting Reduction of Average Length of Time from First Request for Adult Psychiatry to First Scheduled Psychiatry Appointment	Napa
Utilizing Direct Booking to Increase Timely Access to Services	Riverside
Timeliness to First Outpatient Assessment After Inpatient Discharge	Sacramento
Children's Psychiatric Timeliness	San Joaquin
Compassion-Focused Therapy Meetings	Santa Barbara
Timely Access to Psychiatry	Siskiyou
Access System Re-Design to Improve Timeliness and Reduce Crisis Episodes	Sonoma
Mental Health to SUD Referrals	Stanislaus

PIPs to Address Quality of Care

Quality of Care PIPs accounted for a total of 18 PIPs (16.8 percent), with 12 clinical PIPs and 6 non-clinical PIPs. Six of the clinical PIPs had the stated goal of improving co-occurring disorder identification, specifically for SUD. Four clinical PIPs focused on improving community connections; one was designed to assure accurate level of care determination, and another was one focused on youth mobile crisis support. The non-clinical PIPs focused on improving beneficiary engagement, identifying SUDs, and managing transitions of care. (Tables 8-8 and 8-9)

Table 8-8: Quality of Care PIPs – Clinical

Quality of Care Clinical PIP Titles	MHP
Level of Care	Butte
Collateral Support	Colusa
Clinical PIP Improving Co-Occurring SUD Identification	El Dorado
Integration of Clinical Contact Between Registration and Assessment to Improve Assessment and Retention Rates	Lassen
Improving Quality of Services for Consumers with Co-Occurring Disorders	Los Angeles
Youth Mobile Crisis Support	Monterey
Using Child and Adolescent Needs and Strengths (CANS) to Identify SUD Needs	Nevada
Improve Continuity of Care and Engagement in Community Outpatient Services for Detention Mental Health Consumers when they are Released	Riverside
Enhancing Community Connection and Living Skills for High-Cost Beneficiaries	Sonoma
Psychiatric Emergency Service Visits and Intensive Care Coordination, Intensive Home-Based Services, and Therapeutic Behavioral Services	Sutter-Yuba
Dual Diagnosis	Tuolumne
Improving Screening and Assessment of Co-occurring Disorders for Beneficiaries	Yolo

Table 8-9: Quality of Care PIPs – Non-Clinical

Quality of Care Non-Clinical PIP Titles	MHP
Implementation of New SUD Screening Tool	Lassen
SUD Screening Tool	Mariposa
Improve Client Engagement in Rehabilitation Services	Nevada
Will Coordinating Care with Referral Sources Improve Engagement and Access to Care?	Plumas
Specialty Mental Health Services to Managed Care Plan Transition	Tehama
Documentation by Peer Specialists	Tuolumne

PIPs to Address Outcomes of Care

Lastly, the remaining 32 PIPs (29.9 percent) related to Outcomes of Care—29 focused on clinical interventions and 3 on non-clinical interventions. The clinical PIPs look at outcomes for individuals with depression and anxiety; recidivism or rehospitalization; community, social, and family functioning; engagement in treatment; and linkage to other services. The non-clinical PIPs focused on the impact of engagement and integration of services on beneficiaries. All of the Outcomes of Care PIPs have the potential for learning new insights about treatment and best practices in care, if done in a consistent and well-designed manner. (Tables 8-10 and 8-11)

Table 8-10: Outcomes of Care PIPs – Clinical

Outcomes of Care Clinical PIP Titles	MHP
Reducing Psychiatric Emergency Services Recidivism Through Mobile Diversion Teams	Alameda
Reducing Symptoms of Depression & Anxiety with a Stress Reduction Group	Alpine
Enhancing the Journey to Wellness	Calaveras
Addressing Depression and Anxiety Among Youth	Contra Costa
Decreasing the Number of Crisis Intervention Services for Beneficiaries Between the Ages of 6 and 17 Years	Del Norte
Family Functioning	Glenn
Client Engagement After Discharge from Sempervirens PHF	Humboldt
Community Life Strengths Domain	Inyo
Eye Movement Desensitization and Reprocessing for Trauma	Kern
Assertive Community Treatment	Kings

Outcomes of Care Clinical PIP Titles	MHP
Use of Motivational Interviewing in Discharge Planning from Long Term Psychiatric Placement to the Community	Lake
Improving Services to Clients in Institutes for Mental Diseases and Similar Settings	Marin
Treatment of Anxiety Disorders in Adults	Mendocino
Reducing the Frequency of Crisis Contacts and Hospitalizations for Adults	Merced
Integrated Health for Individuals with Serious Mental Illness	Modoc
Increasing Youth Resiliency: Connectedness and Feelings of Sadness and Hopelessness	Mono
Promoting Outpatient Mental Health Service Engagement and Treatment Completion for Hispanic/Latinx Adults	Napa
Increasing Rates of Step-down to Ongoing Care Following Hospital Discharge	Orange
Social Security Insurance/Social Security Disability Insurance Outreach, Access, and Recovery and its Effect on Homelessness	Placer/Sierra
Improving Clinical Outcomes and Consumer Perception of Success	Plumas
Metabolic Syndrome and Antipsychotic Medication	San Bernardino
Preventing Crisis Service and Inpatient Utilization Among Youth with Depression	San Diego
Increase Prescribing of Discharge Medications at Zuckerberg San Francisco General Hospital Psychiatric Emergency Services	San Francisco
Timely Rehabilitation Services Post Crisis Stabilization Unit and Hospital Discharge	San Joaquin
Improving Transition of Care of Un-engaged Homeless Individuals from the PHF to Outpatient Care	San Luis Obispo
Increase of Outpatient Mental Health Therapeutic Engagement through Face-to-Face Services for SMHS Beneficiaries Enrolled in Adult Mental Health Therapy Services	Santa Cruz
Post-Hospital Engagement	Siskiyou
Benzodiazepine Reduction	Tehama
Measuring Social Functioning Progress	Trinity

Table 8-11: Outcomes of Care PIPs – Non-Clinical

Outcomes of Care Non-Clinical PIP Titles	MHP
Integrated Health for Individuals with Serious Mental Illness	Modoc
Improving Beneficiary Engagement in Psychiatric Medication Services	Santa Cruz
Clinic Administrators	Tulare

PIP Technical Assistance

CalEQRO offers TA to MHPs in multiple ways—onsite, e-mail, telephone, video, and webinar. The purpose of the TA is to help the MHPs produce qualified PIPs, with TA ranging from helping to develop measurable aim statements to a comprehensive evaluation of all PIP validation steps.

Fifty MHPs (89 percent) took advantage of TA in FY 2020-21, a notable increase from previous years. In FY 2018-19, 39 MHPs (30.4 percent) utilized TA from CalEQRO, followed by 33 MHPs (59 percent) in FY 2019-20. Outside of the review process, CalEQRO provided a total of 373 hours of individual TA to 50 MHPs in FY 2020-21, an average of roughly 7 hours of TA per MHP. Common areas for TA included PIP development and providing feedback on proposed topics or study questions. Many MHPs struggle to design and implement PIPs that are part of or consistent with the MHPs' overall QM practices. Often, MHPs construct PIPs that are stand-alone projects. Additionally, substantial TA was provided to aid MHPs in modifying PIPs in response to COVID-19 and/or converting PIPs from the old to the new CMS format. Some MHPs also had difficulties collecting and using data to design PIPs that target a specific problem in a given geographical area.

In addition to TA provided throughout the FY 2020-21 year, CalEQRO conducted quarterly PIP clinic webinars that focused on PIP development. The subject of each webinar is presented in Table 8-12.

Table 8-12: Technical Assistance Provided via PIP Webinars by CalEQRO, FY 2020-21

Type of TA Provided	Title	Location	Date
PIP Webinar	PIP Development and Implementation Tool	Online	July 30, 2020
PIP Webinar	Using the Tools to Develop a Successful PIP	Online	December 17, 2020
PIP Webinar	How to Address Disparities – Could a PIP Help?	Online	March 17, 2021
PIP Webinar	Foundations of a PIP	Online	June 30, 2021

Summary

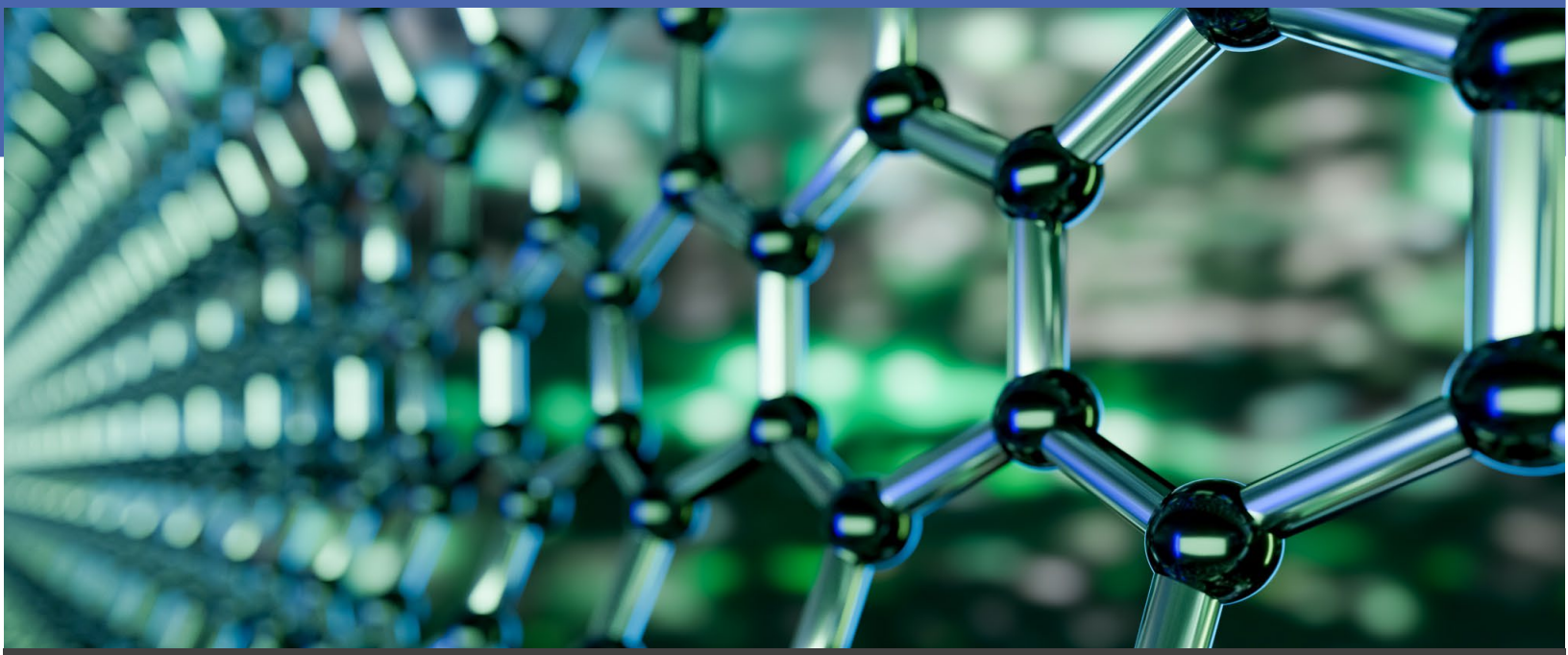
In summary, 107 PIPs were submitted: 89 are currently active and 14 were in the planning phase and are expected to be active within the year. The most common topic of PIPs in FY 2020-21 was access to care, reflecting 37.4 percent of all submitted PIPs.

CalEQRO heard consistently throughout the year that COVID-19 impacted almost all services and was disruptive to previously customary clinical processes. As a result, many PIP strategies had to change; this need may have contributed to the 51.5 percent increase in MHPs requesting TA.

MHPs reported increased levels of confidence in their understanding of and ability to implement PIPs, perhaps in response to the increased TA. However, technical aspects of PIPs continue to present challenges, particularly in terms of data collection capabilities and resource allocation to successfully conduct all required components of a PIP. These underlying obstacles related to fundamental infrastructure are seen throughout this report.

Despite these barriers, MHPs worked hard to implement projects that positively impact access, timeliness, quality, and outcomes of SMHS for beneficiaries.

2020-2021 BHC-CalEQRO Specialty Mental Health Statewide Annual Report



Chapter 9

Information Systems

Information Systems

Structure and Operations to Support Quality

Introduction

The HIS plays an important role in the effectiveness and efficiency of public mental health service systems. CMS regulations require EQRO organizations to examine the role of HIS in behavioral health systems, particularly in operations and the ability to manage quality of care and efficient operations. The HIS has three primary functions: (1) collection and storage of data; (2) analysis of data to support decision making; and (3) assistance with operational business processes. The latter includes quality of care and core operations as a managed care plan and for service delivery when that is also part of the core mission.

CalEQRO developed a tool to gather information from the MHP on various IS-related areas called the ISCA. The ISCA is an evolving document, normally updated yearly to reflect the evolution of MHPs with respect to changes and enhancements, data collection, and regulation changes. Based on CMS federal protocols, the ISCA examines financial, business, and clinical areas as they relate to IS.

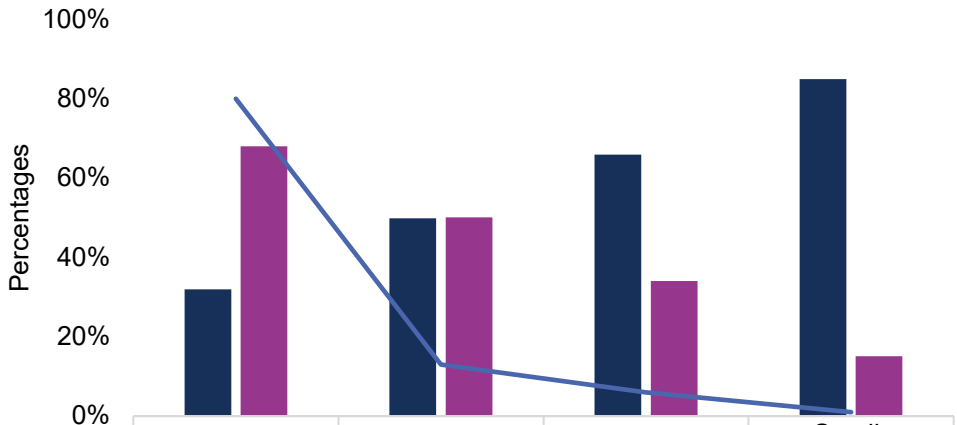
CalEQRO provides an annual assessment of each MHP HIS, using information gathered from the county-specific ISCA and focus groups conducted during reviews. For the statewide annual report, the following major areas are highlighted:

- HIS infrastructure
- EHRs or practice management systems
- Telehealth services
- Use of data for Quality Improvement

MH Services Delivery by County Size

In FY 2020-21, 80.0 percent of beneficiaries received specialty mental health services from large MHPs. Service delivery varied by county size—large counties tend to contract services out to CBOs and network providers, whereas small and small-rural counties relied more on county-operated services. For example, in large counties, CBO and network providers accounted for 68.03 percent of services in contrast to small-rural counties with only 15.09 percent of services provided by CBO and contract providers. (Figure 9-1)

Figure 9-1: SMHS Delivery Provider Type, by County Size



	Large	Medium	Small	Small-rural
County	31.97%	49.90%	65.92%	84.91%
CBO & Network Providers	68.03%	50.10%	34.08%	15.09%
Beneficiaries Served	80.00%	13.00%	6.00%	1.00%

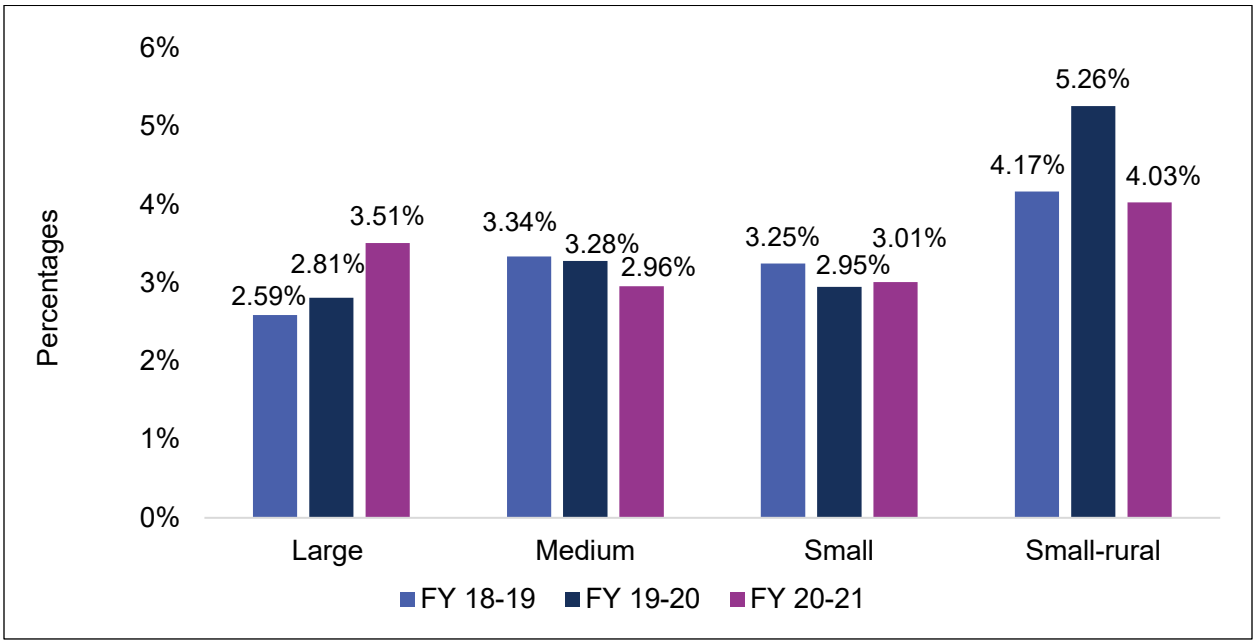
Budget Allocations for Information Systems

The percentage of the MHP's budget devoted to information systems is a rough indicator of the level of IT resources and capacity available to support the administration and delivery of services. Although no benchmark exists for the percentage of budget that should be devoted to IT, the EQRO considers three to five percent to be the minimum necessary for MHPs with a full-fledged EHR.

The range for budget percentages in FY 2020-21 was 2.96 percent (medium counties) to 4.03 percent (small-rural counties). Large counties saw an overall increase in their budgets, increasing to 3.51 percent in FY 2020-21 from 2.81 percent in FY 2019-20. Small counties remained fairly stable—2.95 percent in FY 2019-20 and 3.01 percent in FY 2020-21. Medium counties decreased slightly from 3.28 percent to 2.96 percent and small-rural counties had the most significant decrease from 5.26 percent to 4.03 percent. (Figure 9-2)

While these percentages offer a window into capacity for IS-related functions, context is important. Counties report different methodologies for calculating their budget percentages and factors such as whether the IT department is centralized at the county supporting many departments or is a department within behavioral health impact how the percentages are estimated.

Figure 9-2: IT Budget 3-Year Trend



Technology and Analytics Staffing for Information Systems

Figures 9-3 and 9-4 show the FY 2018-19 to FY 2020-21 average authorized technology and analytical resources for MHPs, measured in FTEs. For technology staffing, it appears these resources are proportional to county size and large MHPs have steadily increased their technology resources from 36.6 in FY 2018-19 to 42.5 in FY 2020-21. For medium, small, and small-rural counties, the technology staffing has been stable with very little fluctuation.

The increase in staffing for large counties on the technology side is offset by the decrease in data analytic staff. The FTEs for data analytics decreased from 16.9 in FY 2018-19 to 13.6 in FY 2020-21. Medium and small counties saw a small increase from FY 2019-20 to FY 2020-21, while small-rural counties had a slight decrease. Data analytic staff are essential for generating reports, analyzing data, and creating dashboards to provide management with information for decision-making. In many cases, opportunities and recommendations identified by the EQRO are rooted less in the limitations of the technology or functionality of the EHR but rather in the staff capacity to fully realize the potential of their EHR and practice management systems.

Figure 9-3: Technology Average Staffing, 3-Year Trend, FTEs

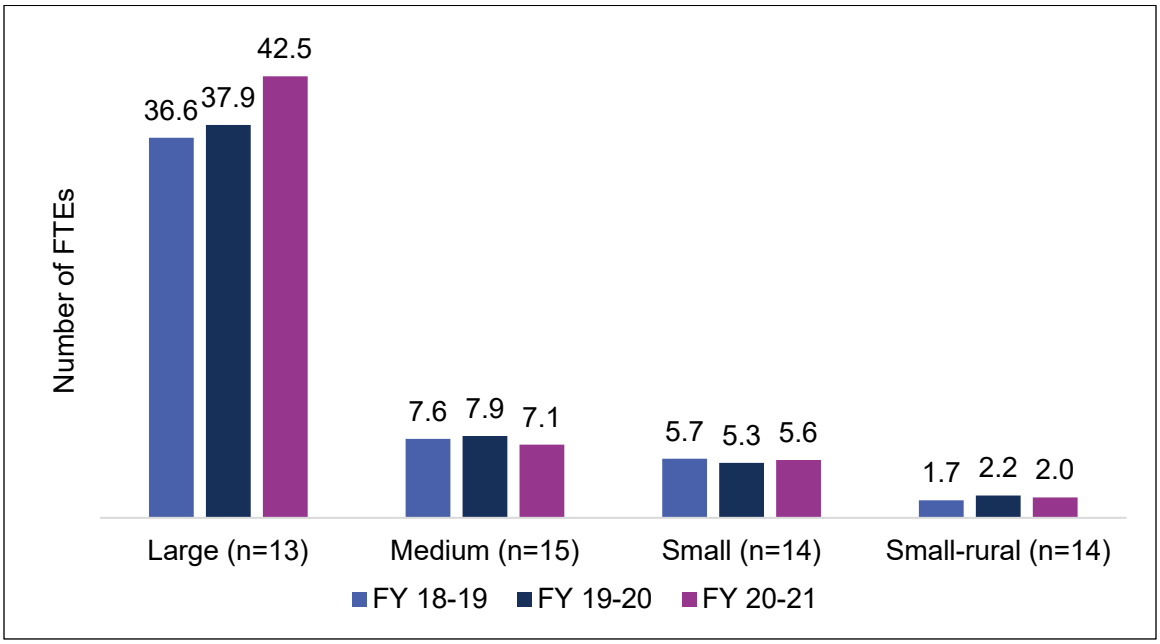
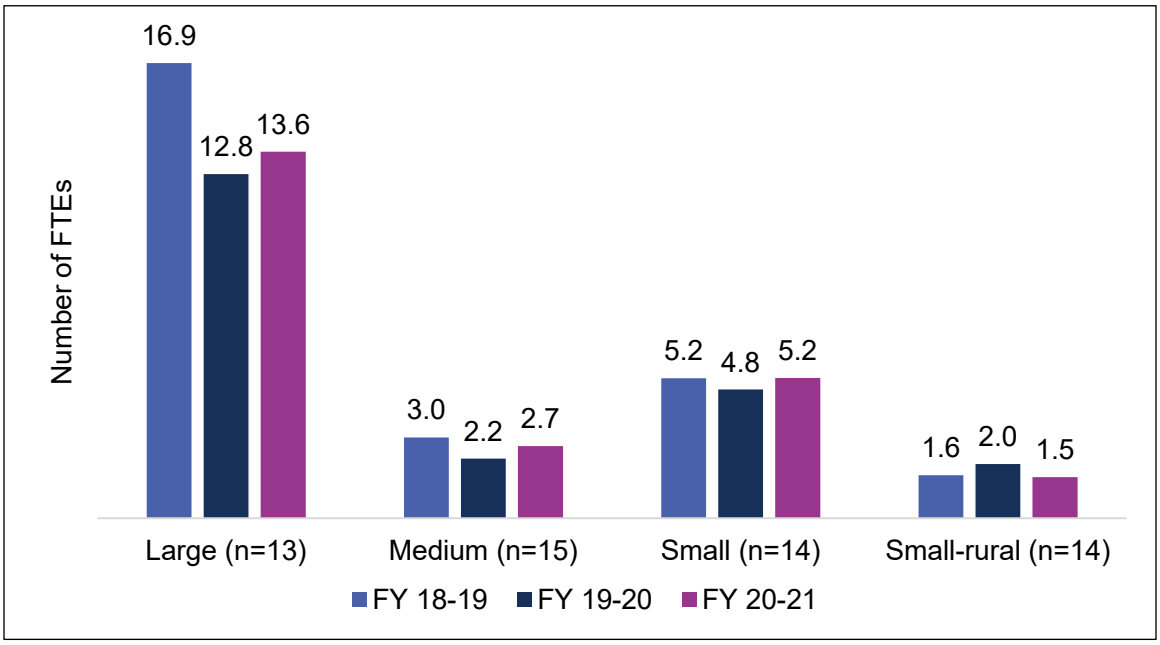


Figure 9-4: Data Analytics Average Staffing, 3-Year Trend, FTEs



Health Information Systems by Vendor

California MHPs have primarily relied on four technology vendors to support HIS in behavioral health: Cerner Corporation, Netsmart Technologies, The Echo Group, and Harris Healthcare Group (Cocentrix), as shown in Figure 9-5. Cerner and Netsmart support 87.5 percent of the counties, a reflection of the complexity and uniqueness of Medicaid claims processing business rules.

Figure 9-5: County EHR Vendors

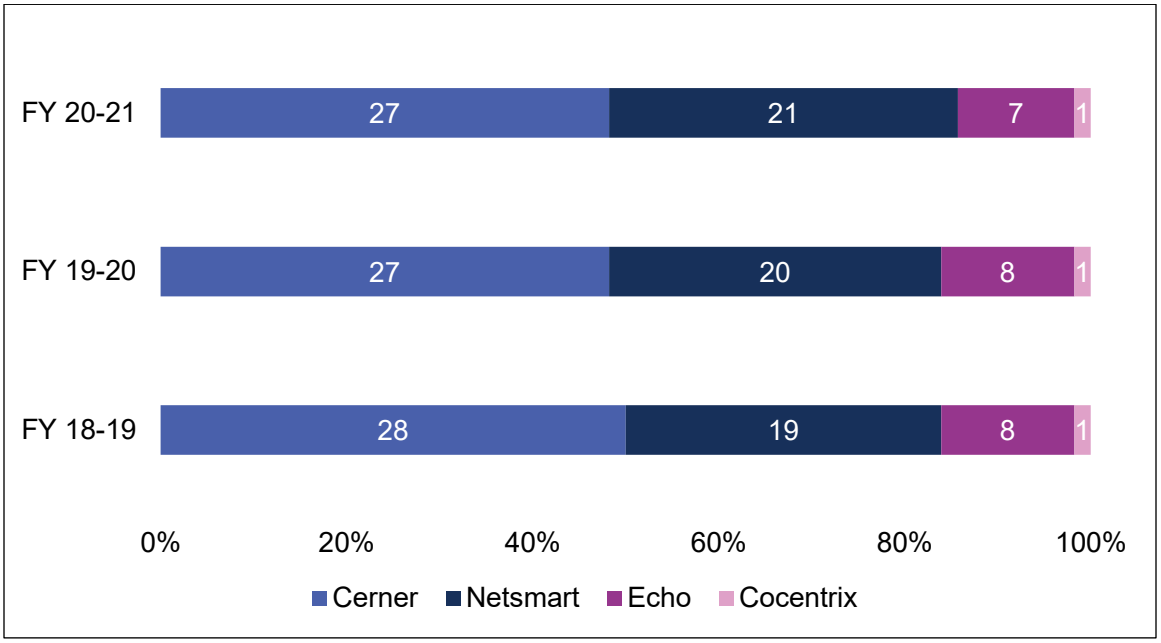
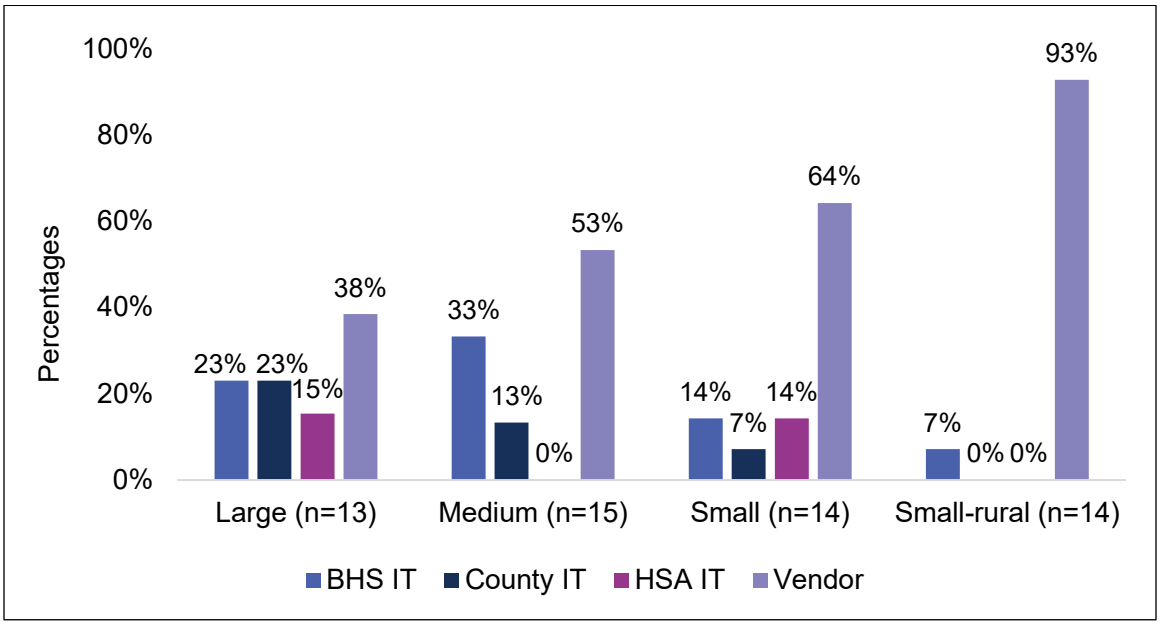


Figure 9-6 illustrates where EHR systems are hosted. Application Service Provider (ASP) hosting usually includes benefits such as heightened system security, business continuity assurances, and 24- hour staffing by qualified technicians. Hosting EHR systems varies by county size with larger counties utilizing ASP far more frequently than smaller counties. For example, 93 percent of small-rural counties host systems at an ASP compared to 38 percent of large counties. Most of the small and small-rural counties contract with Kings View for EHR hosting, whereas large and medium counties have a mix of in-county hosting and out-of-county vendor hosting.

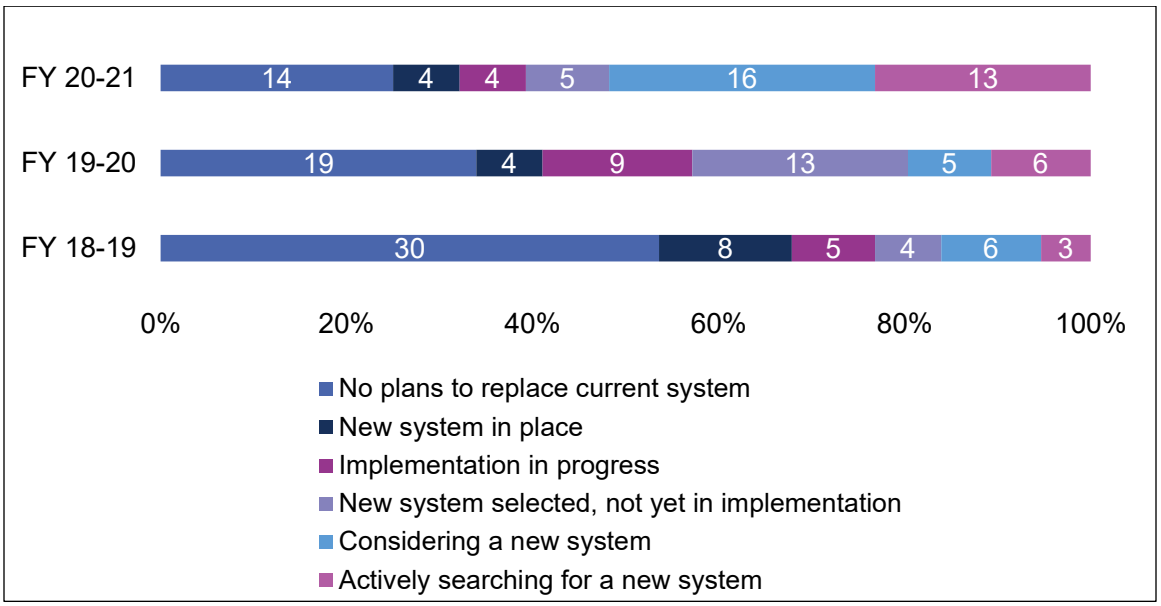
Figure 9-6: Hosting of County EHR Systems



County EHR Replacement Status

In FY 2020-21, over half of all MHPs were considering or actively searching for a new system, compared to 16 percent in FY 2018-19. This could be a reflection of changing state requirements and attempts to align with EHR systems in other parts of the county's health system. Some counties have indicated interest in a forthcoming semi-statewide effort to design and implement an EHR that is aligned with statewide requirements and could be adapted as needed to the changing regulatory landscape. (Figure 9-7)

Figure 9-7: County EHR Replacement Status, 3-Year Trend

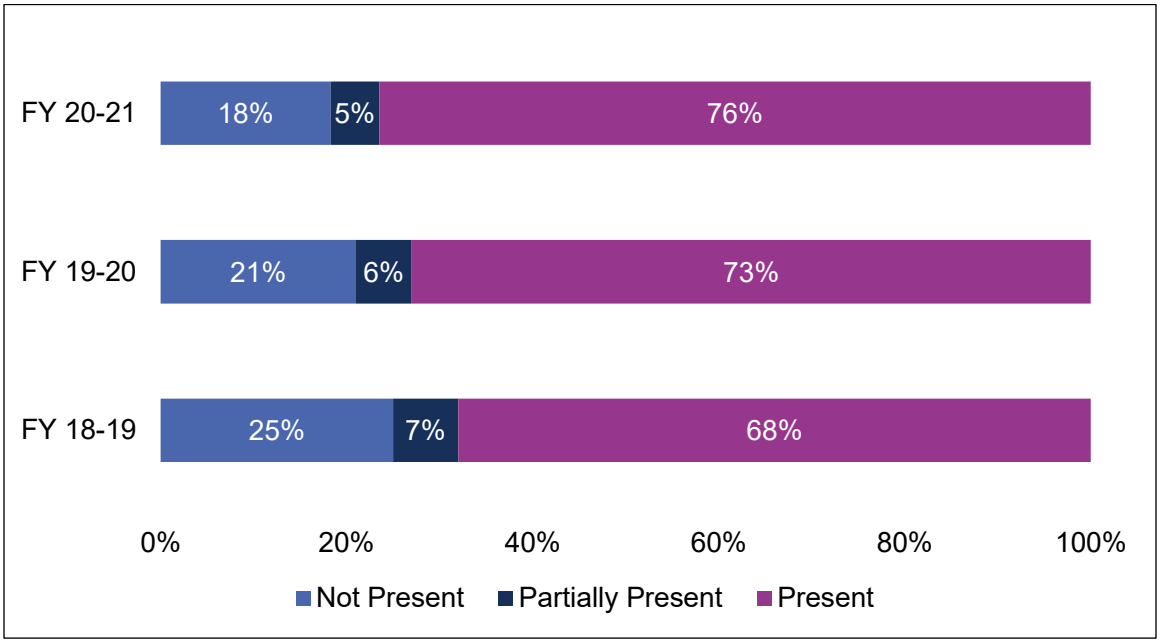


Progress at Implementing EHR Functionality

An information system is a group of integrated hardware and software components designed to collect, organize, store, process, and report information. Information system functionality, from a user perspective, is the ease of use of those integrated components, often in terms of the availability of the software designed to support daily workflow. The following EHR functions are assessed in the ISCA for individual MHP reviews: alerts, assessments, care coordination, document imaging/storage, electronic signature, laboratory orders/results, level of care, outcomes, prescriptions, progress notes, referral management, and treatment plans. All MHPs have some functionality and some have full functionality; however, some MHPs lack functionality of specific components, such as level of care and referral management.

Between FY 2018-19 and FY 2020-21, MHPs have steadily added these EHR functionalities in their core systems. In FY 2018-19, EHR functionalities were present, or partially present, in 75 percent of MHP core systems. In FY 2020-21, the percentage had increased to 81 percent (Figure 9-8). MHPs still have work to do to make sure that the EHRs have full functionality.

Figure 9-8: Progress to Implement EHR Functionality, 3-Year Trend*



*Due to rounding, totals may not equal 100%

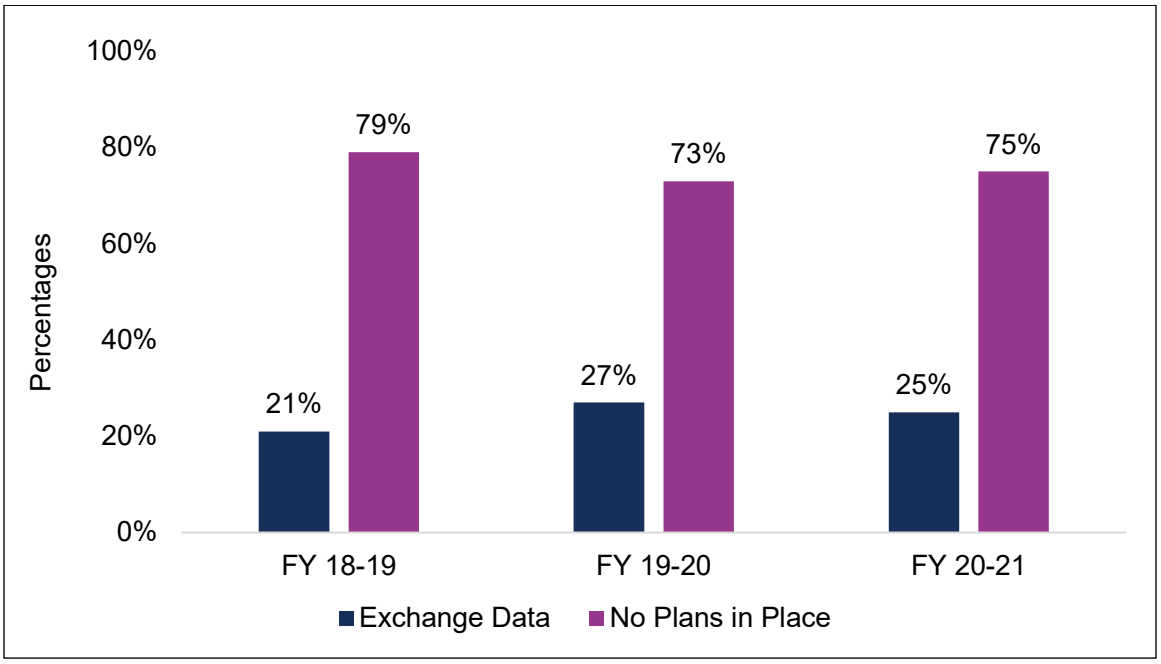
Health Information Exchange Participation

Health Information Exchange (HIE) is the mobilization of health care information electronically across organizations within a region, community, or hospital system. HIEs provide the capability to electronically move clinical information among disparate healthcare information systems and maintain the meaning of the information being exchanged. The goal of health information exchange is to

facilitate access to, and retrieval of, clinical data to provide safe, more timely, efficient, effective, and equitable beneficiary centered care.

The percentage of MHPs that participated in Health Information Exchanges deceased slightly to 25 percent in FY 2020-21 from 27 percent in FY 2019-20, as shown in Figure 9-9.

Figure 9-9: Health Information Exchange Participation, 3-Year Trend



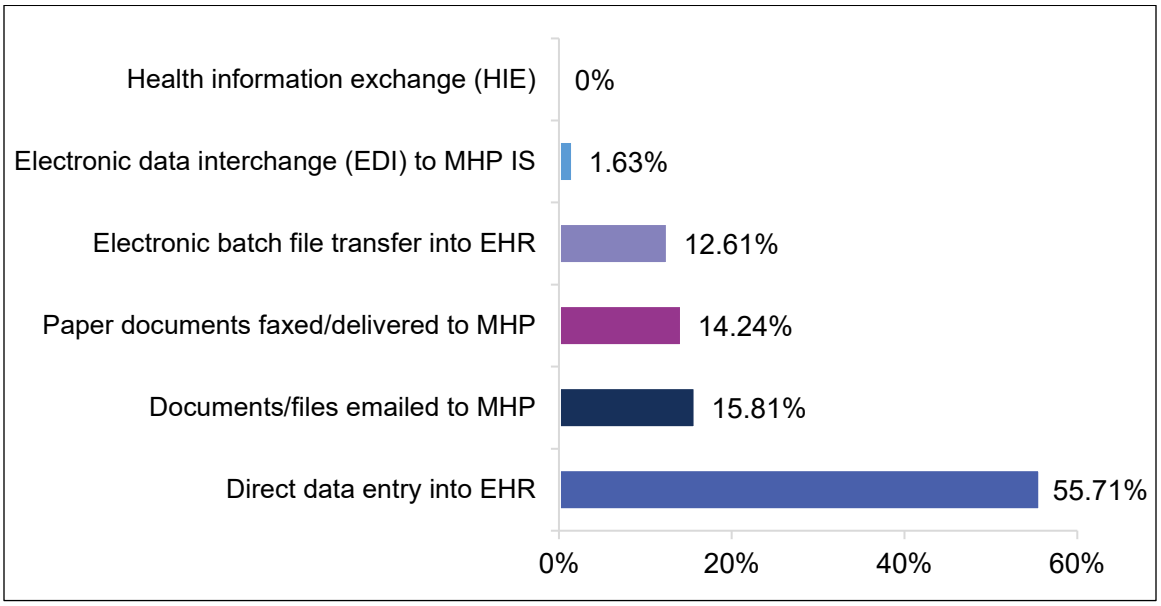
Interoperability

A significant aspect of the MHPs' use of the EHR has been the integration of services provided by contract providers into county systems. Generally, MHPs provide contract providers two or more submittal methods to exchange client information.

There is minimal use of HIE, which is a more efficient method of exchanging client data bilaterally. Special confidentiality requirements make this protocol difficult. Vendors continue to prioritize working with the MHPs to stay up to date with evolving state requirements.

Figure 9-10 shows current data exchange options available to MHP contract providers from electronic data interchange (EDI) transactions to sending documents attached to secured e-mails. Where "Direct data entry to EHR" is noted, it almost always means that contract provider employees are entering the client data into their own EHRs, then logging into the county EHR to enter the same data there. This is inefficient, generally slows down the availability of data, is an ongoing drain on contract provider resources, and is a frequent source of data entry errors. However, direct data entry was the leading data exchange method used in FY 2020-21 at 55.71 percent.

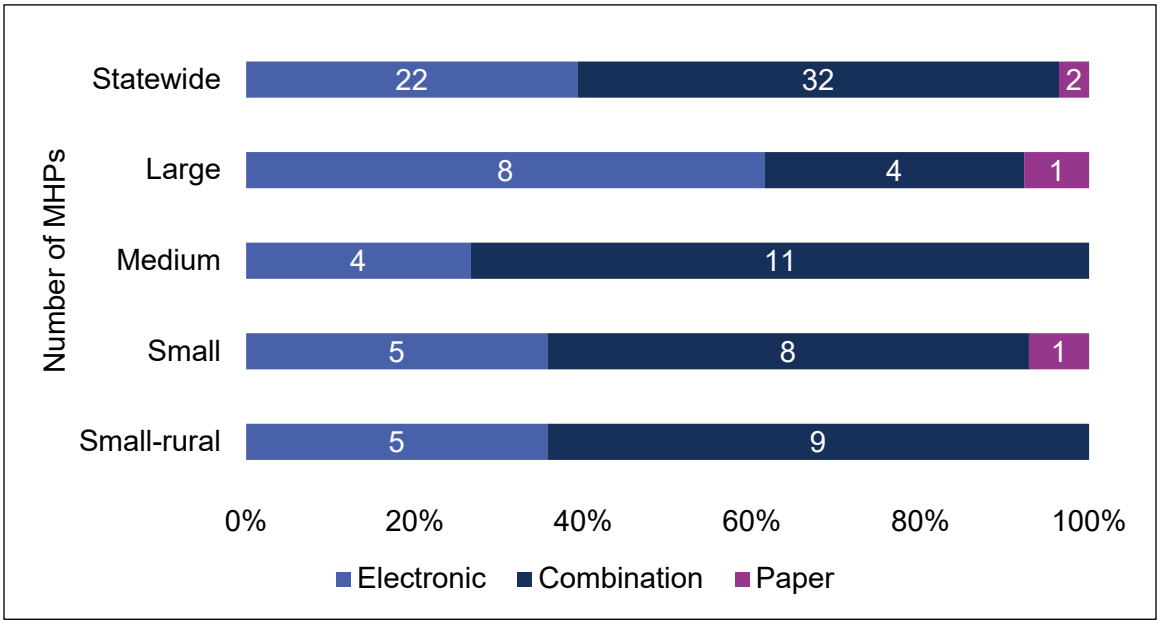
Figure 9-10: Data Exchange Types



Health Records

Health records are rated functionally as electronic, paper, or a combination of electronic and paper. An EHR environment supports better communication and coordination of care among providers, including physical health providers, and facilitates the establishment of client portals to help motivate clients to manage their own health. Almost half of the large MHPs reported having an EHR for beneficiaries while only a quarter of medium-sized MHPs have EHRs, as shown in Figure 9-11. For small and small-rural-sized MHPs, approximately 35 percent have electronic health records, which is also the statewide percentage.

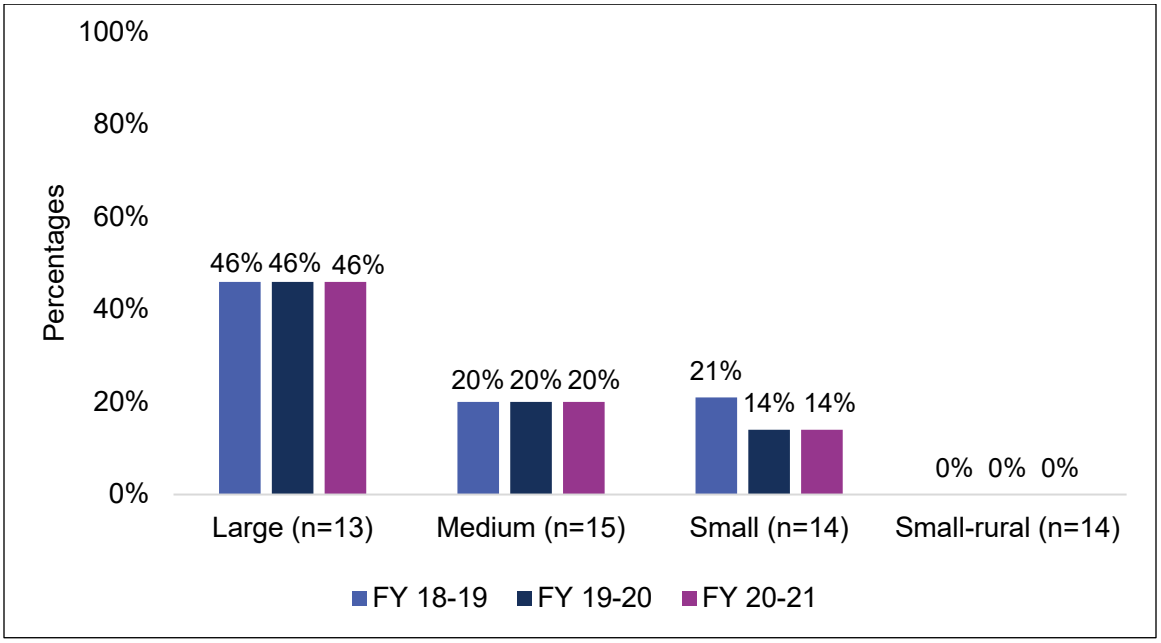
Figure 9-11: Beneficiary Health Records



Internet-Accessible Personal Health Records

Internet-accessible Personal Health Records (PHRs) can improve client engagement by assisting clients in better managing their care through access to health information, such as past and future appointments and lab results. As noted in Figure 9-12, availability of PHR functionality has been challenging to implement in the small-rural MHPs which do not have the resources for a successful implementation. Trends have been stable for the last three years, which could partially be explained by the MHPs having to focus on priorities related to the COVID-19 response, making this a lower priority project to implement.

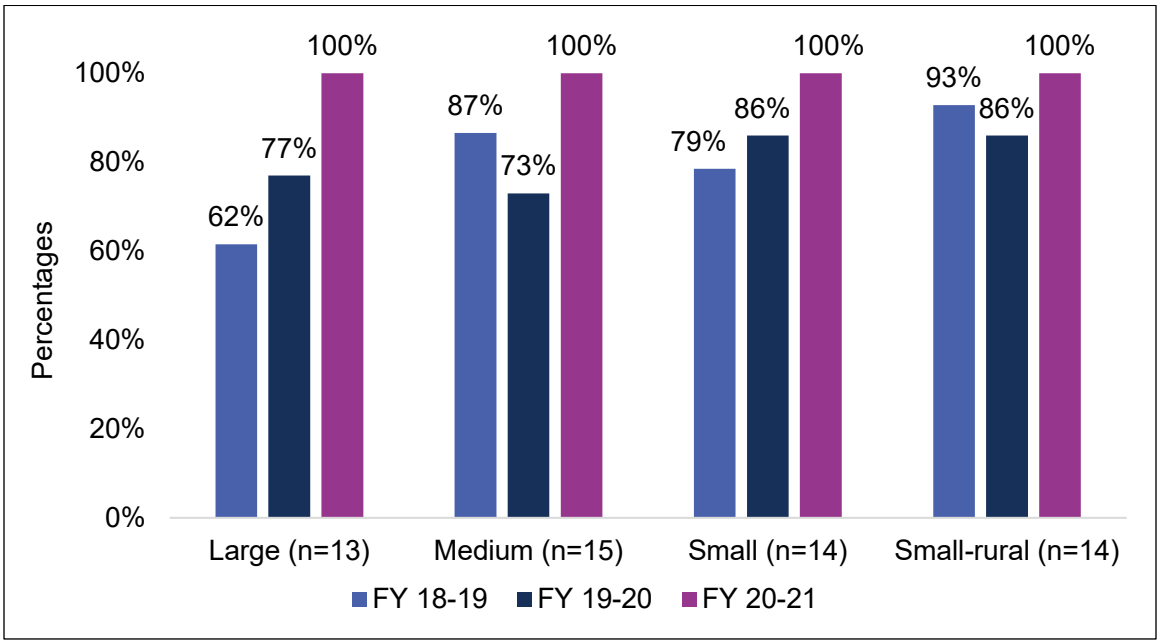
Figure 9-12: Online Personal Health Record Access and Availability, 3-Year Trend



Availability of Telehealth

Service delivery via telehealth benefits both the client and providers. For the client, telehealth expands access to care by overcoming the barrier of distance from established services. For providers, telehealth allows for the convenience of service delivery from their existing locations and may allow them to more efficiently serve clients. It can also help with NA requirements and offers more flexibility to both clients and providers who are in remote areas of California. Certainly, COVID-19 and the subsequent stay-at-home orders necessitated a change in the MHPs service delivery model, moving toward more telehealth services where possible. In FY 2020-21, 100 percent of counties, regardless of county size, had telehealth service availability which speaks to the ability of MHPs to pivot and adjust rather quickly in order to meet beneficiaries' needs. (Figure 9-13)

Figure 9-13: Telehealth Services Availability, 3-Year Trend



Summary

The 56 MHPs reviewed are in various stages of implementing their EHRs; some are considering replacing or updating their systems entirely. These counties vary in size, deliver specialty mental health services through different county/contractor program combinations, and have differing IS budgets and technology/analytics staffing resources.

Telehealth has been an invaluable tool for providing specialty mental health services during the pandemic. Counties are considering ways of continuing to use telehealth to facilitate access to treatment services as some subpopulations of beneficiaries have stated that telehealth removed certain barriers for them. Expanded telehealth can prevent new disparities in health access by making it easier for those who are homebound, disabled, homeless, and/or face transportation challenges in rural and frontier areas.

As reported in prior year reports, interoperability continues to be a common challenge. Interoperability allows for communication, collaboration, and care coordination between county-operated programs, contract, and network providers. At this time, this capacity among contract providers is limited. Counties are required to comply with federal interoperability standards, and many have significant work ahead of them to achieve compliance.

In conclusion, a plan to enhance the core IS infrastructure for the EHRs and practice management systems is crucial. It should include community contract partners and address interoperability and effective communication systems. Timing is important because California will soon be updating its Medicaid Waiver, which will likely change many requirements that affect county IS. Finally, ongoing relaxation of requirements around telehealth will ensure access to treatment services for some of the most vulnerable beneficiaries. With mental health crises on the rise, foundational supports related to IS and EHR are essential for decision-making and ongoing quality improvement efforts.

Chapter 10

Conclusion and Recommendations

Conclusion and Recommendations

The FY 2020-21 review year was overshadowed with worries and concerns related to COVID-19. Since County Behavioral Health Departments were a core part of the pandemic response, this was always impacting the environment, despite noble efforts to keep services operational and address the needs of beneficiaries and families with specialty mental health needs. Even now as MHPs enter the next cycle of reviews, there is heightened anxiety related to new variants, and possible new impacts on services while vaccination efforts are underway. Despite best efforts to maintain services through the pandemic, contractor and county staff have reported a profound level of exhaustion with the extended crisis and its impact on staff and programs. Existing workforce resources are over-tapped; stress and burnout levels are high, as some MHPs are reporting more retirements, leaves due to illness, and obstacles to hiring.

Nevertheless, MHPs addressed challenges in new ways that were responsive to beneficiary needs, reflecting the ongoing commitment that counties and contractors have to beneficiaries and the communities they serve.

As MHPs demonstrated innovative approaches to addressing the challenges they faced and are still facing, they worked together to learn from each other's best practices and techniques. The DHCS strategies promise to help address some other system-wide challenges through policy and programmatic structural changes, revised requirements, and forthcoming initiatives.

Strengths and Opportunities

Access

The COVID-19 emergency increased the need for mental health services, while at the same time, limited many avenues for in-person service delivery. This required MHPs to shift how services were delivered and monitored to ensure beneficiaries still had access to critical services.

One of the hallmarks of the MHPs response to the COVID-19 emergency, despite the growing workforce shortage, was the pivot to expanded telehealth services. Many critical services, such as crisis response and residential care, remained in-person; where possible, other services were delivered through telehealth, ensuring that children, youth, transitional age youth, adults, and older adults continued to meet with psychiatrists, clinicians, case managers, and other service providers. MHPs were nimble, innovative, and responsive to beneficiary needs—in ways previously unforeseen.

Overall, MHPs did well to facilitate access to SMHS in CY 2019. All 56 MHPs met NA time and distance standards directly or through an approved AAS, and 55 of 56 met timely access standards established by DHCS.

However, among certain racial/ethnic groups, disparities exist, indicating both over-representation and under-representation of access to services. While there has been a slow but steady increase in the penetration rate of Latino/Hispanic beneficiaries over time, this population remains underserved, and API beneficiaries are the least likely racial/ethnic group to receive SMHS. Further, African-Americans appear to be over-represented among beneficiaries who receive SMHS. The reasons for differences in beneficiary access across racial and ethnic populations are varied and complex including a lack of access to culturally and linguistically competent services and providers; language and cultural barriers; stigma; fears about psychotropic medications; mistrust of treatment; or some combination thereof. MHPs must continue the critical task of identifying these differences and addressing inequities in access.

Timeliness

Timeliness metrics help determine whether a system has the capacity to serve beneficiaries when needed and thereby increase the likelihood of positive outcomes. Over time, MHPs have demonstrated improvement in their ability to track and report these metrics. Across the past three EQR cycles, the percentage of counties able to track and report timeliness measures has increased such that over 90 percent of counties report on five of the seven CalEQRO metrics. Timeliness to initial psychiatry and urgent appointments lags slightly behind, with 80 and 82 percent of MHPs, respectively, able to track these metrics.

Not only has the reporting of timeliness measures improved, but so has the actual performance. Statewide, wait times have decreased, and overall, 96 percent of California's MHPs offer a non-urgent initial mental health appointment within the statewide standard of 10 business days. Further, average wait times to that first offered appointment are at least 30 percent lower than the state-defined standard of 10 business days.

While improvements have been made, there are still challenges that MHPs face in how they gather timeliness information and meet psychiatry and urgent timeliness performance standards. Because of IS challenges and the technical complexities of collecting these metrics from all providers in the system, MHPs often use manual tools to track data elements, such as spreadsheets. Further, workforce shortages, particularly among psychiatric providers, proves an exceedingly challenging obstacle to providing timely care.

For some MHPs, the limitations for tracking timeliness are related to EHR interoperability constraints, while for others it is related more to unestablished protocols between entities. Sometimes both factors are at play. DHCS is encouraged to work with MHPs to determine the root causes of these barriers.

Quality

While all MHPs have a QAPI program, there is considerable variation in how the programs are structured, and many emphasize QA and compliance activities; considerably fewer were positioned to engage in CQI. CalEQRO noted considerable differences in the thoroughness and integrity of the data, as well. MHPs frequently did not have access to sufficient or appropriate data to guide decision-making.

MHPs demonstrated continued commitment to addressing the needs of diverse communities, and despite efforts to provide culturally responsive services, the majority of MHPs could not provide the results or outcomes of their efforts.

All MHPs have peer employees as part of their workforce, yet not all MHPs have invested fully or consistently in peer employee positions. Nevertheless, peer integration remains a work in progress for MHPs. Many eagerly embrace the recently signed peer certification bill, SB 803, and look forward to additional guidance on how to better integrate lived experience through employment of peer employees.

More MHPs reported using outcome instruments in FY 2020-21 than in previous years. Fully 100 percent report using the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptoms Checklist 35-Item (PSC-35) to measure progress for children and youth, as required. Among adults, 48 of 56 MHPs report using standardized measures to monitor beneficiary progress. However, MHPs are much less proficient in demonstrating consistent use of the measures and therefore less able to demonstrate improvement. And even when MHPs used outcome measures more consistently, use was often limited to the individual, clinical level. Few systems routinely evaluated and reported aggregated beneficiary progress.

Less than half of MHPs routinely track and trend HEDIS measures related to psychotropic medication use, and that number did not increase in FY 2020-21. Among MHPs that had previously partially incorporated HEDIS measures, there was an increase in the use and consistency of the measures for quality improvement. However, MHPs generally report insufficient capacity to monitor medication utilization for children in foster care (FC), as required by SB 1291.

As reported in prior year reports, interoperability continues to be a common challenge. Interoperability allows for communication, collaboration, and care coordination between county-operated programs, contract, and network providers. At this time, this capacity among contract providers is limited. Looking ahead to forthcoming statewide initiatives and the goals of an integrated managed care system, interoperability will remain an important challenge that must be addressed.

Recommendations

Progress continues to be made by MHPs on access, timeliness, and quality of services in pursuit of positive beneficiary and systemic outcomes. Many MHPs demonstrated particularly impressive performance in these areas, and even more extended great effort despite seemingly insurmountable challenges. Training and education on these best practices are needed, along with support for activities to address areas that continue to present challenges. Specific recommendations targeting these improvement opportunities are summarized below:

1. The mental health workforce shortage is expected to compound and worsen, negatively impacting the beneficiaries who MHPs are committed to serve. DHCS and MHPs are encouraged to continue to explore creative solutions and implement strategies to expand the mental health workforce.

2. Telehealth has been an invaluable tool for providing specialty mental health services during the pandemic. Counties are considering ways to continue the use of telehealth to facilitate access to treatment services, as some beneficiary subpopulations have stated that telehealth removed important barriers for them to access care. Maintaining the COVID-19 emergency provisions for the expanded use of telehealth will ensure access to treatment services for some of the most vulnerable beneficiaries.

3. To achieve a service delivery system that fully meets beneficiary needs, MHPs need to adopt a CQI approach. This includes directing more resources towards quality improvement, separate and distinct from quality assurance and compliance activities. MHPs need training in quality improvement principles, staff to manage quality improvement projects, and tools and technology to evaluate quality.

4. The reasons for differences in beneficiary access across racial and ethnic populations are varied and complex, including a lack of access to culturally and linguistically competent services and providers; language and cultural barriers; stigma; fears about psychotropic medications; mistrust of treatment; or some combination thereof. MHPs must continue the critical task of identifying these differences and addressing potential inequities in access.

5. While MHPs demonstrate efforts to provide culturally responsive services, utilize level of care tools, and implement outcome measures, many struggle to track and trend data, conduct robust analysis, and monitor key quality metrics that measure beneficiary and systemic outcomes. DHCS is encouraged to identify established, standardized outcome tools for statewide use to monitor progress for adult and older adult beneficiaries.

6. Although there was an increase in and more consistent use of HEDIS measures among the MHPs that had previously incorporated them to some degree, less than half of all MHPs routinely track and trend HEDIS measures related to psychotropic medication use. Overall, MHPs report insufficient capacity to monitor medication utilization for children in FC. To promote statewide efforts at meaningfully monitoring and reporting on SB 1291 requirements, DHCS will need to provide MHPs targeted information, training, and clear expectations.

7. MHPs have demonstrated improved ability to track and report timeliness metrics, and performance has improved across some key measures. However, there are still challenges that MHPs face in how they gather timeliness information, making it difficult to assess true statewide capacity to provide timely access to SMHS. DHCS is encouraged to work with MHPs to determine the root causes of the barriers. Solutions must address the underlying systemic challenges to improve timeliness of care meaningfully and sustainably for California's Medi-Cal beneficiaries in need of SMHS.

8. A plan to enhance the core IS infrastructure for the EHRs and practice management systems is crucial. Include community contract partners in the plan development, and address interoperability and effective communication systems. With mental health crises on the rise, foundational supports related to IS and EHR are essential for decision-making and ongoing quality improvement efforts.

These recommendations are based on the reviews of the 56 MHPs, their data, their provider networks, stakeholders, and the voices of the beneficiaries and family members who participated in the reviews. CalEQRO appreciates the time, effort, and dedication of the staff and programs who assisted in these reviews, without which we would not have been able to do this work and identify these important findings.

Other Considerations

The Centers for Medicare & Medicaid Services (CMS) issued a letter to the Department of Health Care Services on November 16, 2021, noting areas of non-compliance with 42 CFR Part 438 Subpart D and QAPI standards in the EQRO technical reports. To remedy these deficiencies, DHCS and the BH EQRO have initiated an amendment to the EQRO Contract. The new effective date will be July 1, 2022. The new contract requirements will be tailored to remediate some of the CMS findings in future technical reports. Because of the timing of CMS' feedback and the DHCS' audit cycle, and the necessity for a contract amendment, full compliance with federal statutory references will be achieved over the course of the next few reporting cycles.

2020-2021 BHC CalEQRO Specialty Mental Health Statewide Annual Report

Appendix

Appendix 1: SDMC Claim Definitions

Medi-Cal Approved Claims Code Definitions and Data Sources			
Last Modified by: Rachel Phillips, Bill Ullom – July 2019			Source: Medi-Cal Aid Code Chart Master – October 18, 2017
Source: Data is derived from statewide source files.			
1. Short-Doyle/Medi-Cal approved and denied claims (SD/MC) from the Department of Health Care Services (DHCS)			
2. In-Patient Consolidation (IPC) approved claims from DHCS			
3. Monthly MEDS Extract File (MMEF) from DHCS			
4. State Provider File from DHCS			
Selection Criteria:			
Medi-Cal beneficiaries for whom the MHP is "County of Fiscal Responsibility" are included, even when the beneficiary was served by another MHP.			
Medi-Cal beneficiaries with aid codes eligible for SD/MC program funding are included.			
Process Date: The date DHCS processes files for CAEQRO. The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY2017 file with a DHCS process date of May 19, 2018 includes claims with service dates between January 1 and December 31, 2017 processed by DHCS through April 2018.			
Most recent MMEF includes Medi-Cal eligibility for April (CY) or October (FY) and 15 prior months.			
Service Activity: Defined by Procedure Code and Modifiers.			
Service Category	Procedure Codes	Modifiers	Description
Inpatient Services	H2013, H2015	HE, HA, HC	Local Hospital, Psychiatric Health Facility
Inpatient Services	114, 124, 134, 154, 204	(modifiers not used)	In Patient Consolidation (IPC) claims/134 file
Inpatient Services	H0046, 169	HE, HA, HC	Hospital Administrative Days
Inpatient Services	90792, 99214		Professional Inpatient Visits
Crisis Stabilization	S9484	HE, TG	Emergency Room / Urgent Care
Residential Services	H0018	HE, HB, HC	Adult Crisis Residential
Residential Services	H0019	HE, HB, HC	Adult Residential
Day Treatment	H2012	HE, TG	Intensive Day Treatment and Day Rehabilitative
Case Management	T1017	HE, SC, GT, HQ	Case Management/Brokerage
Mental Health Services	H2015, H2017, H0032	HE, SC, GT, HQ	Mental Health Services
Medication Support	H2010, H0034, G8437	HE, SC, GT, HQ	Medication Support
Crisis Intervention	H2011	HE, SC, GT, HQ	Crisis Intervention
TBS	H2019	HE, SC,GT,HQ	Therapeutic Behavioral Services

ICC, IHBS	T1017, H2015	HK	Intensive Care Coordination Intensive Home-Based Services
ICC, IHBS	H2015, H2017, HOO32 H2010, H0034, G8437 T1017	HE, SC, GT, HQ	Look-alike Services Demonstration Project Indicator (DPI) = KTA
TFC	S5145	HE	Therapeutic Foster Care

Medi-Cal Approved Claims Code Definitions and Data Sources	
Last Modified by: Rachel Phillips, Bill Ullom - June 2018	Source: Medi-Cal Aid Code Chart Master – October 18, 2017
Data Definitions: Selected elements displayed within this report are defined below.	
Penetration rate	The number of Medi-Cal beneficiaries served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of Medi-Cal eligibles over a 12-month period.
Approved claims per beneficiary served per year	The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year.
Age Group	Age groups are determined by beneficiary's age on January 1 of the reporting calendar or fiscal year.
Eligibility Categories	Medi-Cal aid codes used to report approved claims by eligibility category.
Disabled	2H, 36, 60, 63, 64, 66, 67, 68, 6C, 6E, 6G, 6H, 6N, 6P, 6R, 6V, 6W, 6X, 6Y.
Foster Care	40, 42, 43, 46, 49, 4F, 4G, 4H, 4L, 4N, 4S, 4T, 4W, 5K.
Other Child	Beneficiary age is less than 18 AND one of the following aid codes. 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 2A, 2E, 2P, 2R, 2S, 2T, 2U, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 44, 45, 47, 4A, 4E, 4M, 5C, 5D, 54, 59, 5E, 5F, 6A, 72, 74, 7A, 7C, 7J, 7K, 7S, 7W, 82, 83, 8E, 8G, 8L, 8P, 8R, 8U, 8V, 8W, F3, G5, G7, H7, H8, H9, J1, J2, J5, J7, K1, M3, M5, M7, M9, P1, P2, P3, P4, P5, P7, P9, T1, T2, T2, T3, T4, T5.
Family Adult	Beneficiary age is greater than or equal to 18 AND one of the following aid codes. 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 2A, 2E, 2P, 2R, 2S, 2T, 2U, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 44, 45, 47, 4A, 4E, 4M, 5C, 5D, 54, 59, 5E, 5F, 6A, 72, 74, 7A, 7C, 7J, 7K, 7S, 7W, 82, 83, 8E, 8G, 8L, 8P, 8R, 8U, 8V, 8W, F3, G5, G7, H7, H8, H9, J1, J2, J5, J7, K1, M3, M5, M7, M9, P1, P2, P3, P4, P5, P7, P9,T1, T2, T2, T3, T4, T5.
Other Adult	Beneficiary age is greater than 19 AND one of the following aid codes: 0U, 0V, 1E, 1H, 1U, 1X, 1Y, 10, 13, 14, 16, 17, 3T, 3V, 48, 55, 58, 5F, 5J, 5R, 5S, 5T, 5W, 6J, 6U, 76, 7C, 80, 86, 87, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, G6, G8, J3, J4, J6, J8, M0, M4, M8.
MCHIP	Expanded eligibility for certain populations of children (under age 19) as defined in federal law as targeted low-income children who would not otherwise qualify for full-scope Medi-Cal benefits AND one of the following aid codes E6, E7, H0, H1, H2, H3, H4, H5, H9, M5, M6, T0, T1, T2, T3, T4, T5, 5C, 5D, 7X, 8N, 8P, 8T, 8R, 8X.
Affordable Care Act (ACA)	ACA aid codes were effective January 1, 2014. The Federal Financial Participation (FFP) was 100% from 2014 through 2016, 95% in 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and thereafter. 7U, L1, M1, M2, N0, N7, N8.

SB-75	Expanded eligibility for children under 19, who are eligible with full-scope medical benefits regardless of immigration status, as long as all other eligibility requirements are met. To be identified as "SB-75 Eligible" beneficiary status (SB-75 flag = "1") is met AND one of the following aid codes. 2H, 23, 24, 27, 3N, 34, 37, 39, 44, 47, 54, 59, 5C, 5D, 6H, 63, 64, 67, 7A, 7J, 72, 82, 83, 8P, 8R, G5, G7, J1, J2, J7, M3, M5, M7, M9, P5, P7, P9, T1, T2, T3, T4, T5. Beneficiary results are included with one of the following eligibility categories: Disabled, Other Child, Family Adult, or MCHIP that corresponds to a combination of each beneficiary's aid code and age group.
EPSDT Eligible Aid Codes	Beneficiary age is less than 21 AND identified with SB-75 status (SB-75 flag = "0") AND one of the following aid codes: 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 20, 23, 24, 26, 27, 2A, 2E, 2H, 2P, 2R, 2S, 2T, 2U, 30, 32, 33, 34, 35, 36, 37, 38, 39, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 40, 42, 43, 44, 45, 46, 47, 49, 4A, 4E, 4F, 4G, 4H, 4L, 4M, 4N, 4P, 4R, 4S, 4T, 4W, 54, 59, 5C, 5D, 5E, 5K, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6N, 6P, 6V, 6W, 6X, 6Y, 72, 7A, 7J, 7S, 7U, 7W, 8E, 8G, 8L, 8P, 8R, 8U, 8V, 8W, 8X, E6, E7, G5, G7, H0, H1, H2, H3, H4, H5, H6, H7, H8, H9, J1, J2, J7, K1, L1, M1, M3, M5, M7, M9, P1, P2, P3, P5, P7, P9, T1, T2, T3, T4, T5.
Excluded aid codes - not SDMC funded or inactive in MEDS.	0, 00, 0R, 0T, 09, 18, 28, 2G, 31, 3J, 3K, 3X, 3Y, 41, 4C, 4K, 4P, 4R, 50, 51, 53, 56, 5X, 5Y, 61, 62, 65, 68, 69, 6D, 6F, 6K, 6M, 6T, 74, 78, 7K, 7M, 7N, 7P, 7R, 7X, 81, 82, 83, 84, 85, 86, 87, 88, 89, 8A, 8F, 8H, 8Y, 9A, 9C, 9E, 9F, 9G, 9H, 9J, 9K, 9M, 9N, 9R, 9S, 9X, FX, IE, R1, RR, C5, C6, E2, E4, E5, G0, G1, G2, G9, L2, L3, L4, L5, N5, N6, N9, P0, P8.
Eligibility Status	Three-byte code – Byte one reflects beneficiary's eligibility status; Byte two Medi-Cal ID card issuance; Byte three Pre/Post eligibility status information and eligibility established for retroactive months.
	1st Digit =Medi-Cal/CMSP/Other Eligible Status **0** Eligible with no conditions (includes zero SOC) **1** Share of Cost to be met by LTC claim **2** LTC/SOC plus other conditions (i.e.1+3) **3** Other conditions-Certified SOC, Restricted Service, Minor Consent or Partial Health Care Plan **4** Medi-Cal eligible with Full Service Medi-Cal Health Care Plan Coverage **5** Unmet Share of Cost Obligation (Uncertified SOC) **6** Health and Welfare Program other than Medi-Cal/MSP eligible (SLMB, QDWI, Out –of –State Foster Care, Unborn, Healthy Families, County MI, CHDP State Only, MCE State & County, HCCI, AIM Pregnant Mother) **7** Hold **8** QMB pending Medicare part A & B confirmation **9** Ineligible **2nd Digit =Normal/Exception Eligibility** **0** Normal Eligible **1** Unconfirmed Immediate Need eligible reported more than 1 month prior **2** Unconfirmed Immediate Need Eligible reported 1 month prior **3** Unconfirmed Immediate Need Eligible reported in current month **4** Forced eligible due to late termination **5** Partial Month Eligibility (Healthy Families, etc.) **7** Exception eligible **8** Forced eligible from MEDS hold **9** Full Month Eligibility (Healthy Families, etc.) **3rd Digit=Timeliness /Misc. Information** **1** Regular eligible reported timely **2** Regular eligible reported retroactively

	3 3 month retroactive eligible **4** Continuing eligible reported timely **5** Continuing eligible reported retroactively **6** Ramos/Pickle/IHSS/Other Extended eligible **7** Aid Paid Pending Ramos/Myers **8** Hold from LTC/SOC status **9** Ineligible or Regular hold
Share of Cost	Beneficiaries with monthly share of cost are obligated to meet (spent down to $0) before being considered Medi-Cal eligible and claims are approved for payment. Beneficiaries with SOC are not included in "Average Number of Eligibles per Month" count for any month until SOC is zero dollars for any month.

MEDS Race/Ethnicity Codes			
1 = White	2 = Hispanic/Latino	3 = Black	4 = Asian/Pacific Islander
5 = Alaska Native or American Indian	7 = Filipino	8 = No valid data reported	9 = Decline to state
A = Amerasian	C = Chinese	H = Cambodian	J = Japanese
K = Korean	M = Samoan	N = Asian Indian	P = Hawaiian
R = Guamanian	T = Laotian	V = Vietnamese	Z = Other
Race/Ethnicity Groups	**MEDS Code**		
White	1		
Hispanic/Latino	2		
African American	3		
Asian/Pacific Islander	4, 7, A, C, H, J, K, M, N, P, R, T, V		
Native American	5		
Other/Decline or Missing Data	8, 9, Z		
Beneficiary Primary Languages	**MEDS Code**		
0 = American Sign	1 = Spanish	2 = Cantonese	3 = Japanese
4 = Korean	5 = Tagalog	6 = Other Non-English	7 = English
8 = No Valid Data Reported	9 = No Response, Client Declined	A = Other Sign Language	B = Mandarin
C =Other Chinese Languages	D = Cambodian	E = Armenian	F = Ilocano
G = Mien	H = Hmong	I = Lao	J = Turkish
K = Hebrew	L = French	M = Polish	N = Russian
P = Portuguese	Q = Italian	R = Arabic	S = Samoan
T = Thai	U = Farsi	V = Vietnamese	
Primary Language Groups	**MEDS Code**		
English	7		
Spanish	1		
Threshold Languages – exclude Sp.	2, 4, 5, B, C, D, E, H, N, R, U, V		
Non-Threshold Languages	3, 6, F, G, I, J, K, L, M, P, Q, S, T		
Sign Languages	0, A		
Decline to State/Missing Data	8, 9		

County Codes	MEDS Code		
01 = Alameda	02 = Alpine	03 = Amador	04 = Butte
05 = Calaveras	06 = Colusa	07 = Contra Costa	08 = Del Norte
09 = El Dorado	10 = Fresno	11 = Glenn	12 = Humboldt
13 = Imperial	14 = Inyo	15 = Kern	16 = Kings
17 = Lake	18 = Lassen	19 = Los Angeles	20 = Madera
21 = Marin	22 = Mariposa	23 = Mendocino	24 = Merced
25 = Modoc	26 = Mono	27 = Monterey	28 = Napa
29 = Nevada	30 = Orange	31 = Placer/Sierra	32 = Plumas
33 = Riverside	34 = Sacramento	35 = San Benito	36 = San Bernardino
37 = San Diego	38 = San Francisco	39 = San Joaquin	40 = San Luis Obispo
County Codes	**MEDS Code**		
41 = San Mateo	42 = Santa Barbara	43 = Santa Clara	44 = Santa Cruz
45 = Shasta	47 = Siskiyou	48 = Solano	49 = Sonoma
50 = Stanislaus	51 = Sutter/Yuba	52 = Tehama	53 = Trinity
54 = Tulare	55 = Tuolumne	56 = Ventura	57 = Yolo

Counties by DHCS Regions	County Code	
Bay Area	01, 07, 21, 27, 28, 35, 38, 41, 43, 44, 48, 49	
Central	02, 03, 05, 09, 10, 16, 20, 22, 24, 26, 31, 34, 39, 50, 51, 54, 55, 57	
Los Angeles	19	
Southern	13, 15, 30, 33, 36, 37, 40, 42, 56	
Superior	04, 06, 08, 11, 12, 14, 17, 18, 23, 25, 29, 32, 45, 47, 52, 53	
Counties by DHCS County Sizes	**County Code**	**Population**
Small-Rural	02, 03, 05, 06, 08, 11, 14, 18, 22, 25, 26, 32, 47, 53	<50,000
Small	09, 12, 13, 16, 17, 20, 23, 28, 29, 35, 45, 51, 52, 55	50,000 to 199,999
Medium	04, 21, 24, 27, 31, 39, 40, 41, 42, 44, 48, 49, 50, 54, 57	200,000 to 749,999
Large	01, 07, 10, 15, 30, 33, 34, 36, 37, 38, 43, 56	750,000 to 3,999,999
Very Large	19	>4,000,000
Diagnosis Groups – ICD 10	**Diagnosis Codes From SD/MC Claims**	
Depressive Disorders	F39, F348, F338, F349, F341, F329, F320, F321, F322, F323, F324, F325, F3340, F339, F330, F331, F332, F333, F3341, F3342, F328	
Psychotic Disorders	F201, F202, F200, F2081, F205, F250, F251, F258, F259, F203, F209, F22, F24, F23, F28, F29	
Disruptive Disorders	F900, F902, F901, F909, F911, F912, F919, F913	
Bipolar Disorders	F3010, F309, F3011, F3012, F3013, F302, F303, F304, F310, F3189, F3110, F3111, F3112, F3113, F312, F3173, F3174, F3130, F3131, F3132, F39, F338, F348, F349, F314, F315, F3175, F3176, F3160, F3161, F3162, F3163, F3164, F3177, F3178, F319, F319, F308, F3181, F328, F348, F349	

Anxiety Disorders	F430, F419, F410, F411, F413, F418, F42, F4310, F4311, F4312, F4001
Adjustment Disorders	F930, F4321, F4322, F4323, F4324, F4325, F4310, F4311, F4312, F4320
DEFERRED	R69, Z0389
OTHER	Other ICD-10 codes not listed above which were submitted thru SDMC claim transactions

Appedix 2: List of MHPs by Size and Region

List of MHPs

MHP County	MHP Size	MHP Region
Alameda	Large	Bay Area
Alpine	Small-rural	Central
Amador	Small-rural	Central
Butte	Medium	Superior
Calaveras	Small-rural	Central
Colusa	Small-rural	Superior
Contra Costa	Large	Bay Area
Del Norte	Small-rural	Superior
El Dorado	Small	Central
Fresno	Large	Central
Glenn	Small-rural	Superior
Humboldt	Small	Superior
Imperial	Small	Southern
Inyo	Small-rural	Central
Kern	Large	Southern
Kings	Small	Central
Lake	Small	Superior
Lassen	Small-rural	Superior
Los Angeles	Very Large	Los Angeles
Madera	Small	Central
Marin	Medium	Bay Area
Mariposa	Small-rural	Central
Mendocino	Small	Superior
Merced	Medium	Central
Modoc	Small-rural	Superior
Mono	Small-rural	Central
Monterey	Medium	Bay Area
Napa	Small	Bay Area
Nevada	Small	Superior
Orange	Large	Southern
Placer	Medium	Central
Plumas	Small-rural	Superior
Riverside	Large	Southern
Sacramento	Large	Central
San Benito	Small	Bay Area
San Bernardino	Large	Southern

MHP County	MHP Size	MHP Region
San Diego	Large	Southern
San Francisco	Large	Bay Area
San Joaquin	Medium	Central
San Luis Obispo	Medium	Southern
San Mateo	Medium	Bay Area
Santa Barbara	Medium	Southern
Santa Clara	Large	Bay Area
Santa Cruz	Medium	Bay Area
Shasta	Small	Superior
Sierra	Medium	Central
Siskiyou	Small-rural	Superior
Solano	Medium	Bay Area
Sonoma	Medium	Bay Area
Stanislaus	Medium	Central
Sutter	Small	Central
Tehama	Small	Superior
Trinity	Small-rural	Superior
Tulare	Medium	Central
Tuolumne	Medium	Central
Ventura	Large	Southern
Yolo	Medium	Central
Yuba	Small	Central