



FY 2021-2022 Statewide Technical EXTERNAL QUALITY REVIEW REPORT

MEDI-CAL SPECIALTY MENTAL HEALTH

Prepared for the California Department of Health Care Services (DHCS)
by Behavioral Health Concepts, Inc. (BHC)

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Acknowledgements

Behavioral Health Concepts, Inc. (BHC) would like to foremost acknowledge the behavioral health workforce that has continued to serve the people of California who experience mental health conditions. Despite great adversity over the last two years, County Behavioral Health staff and their contracted providers, in outpatient and inpatient settings, have continued to be of service amidst a diminishing and depleted workforce and increased community need. As we anticipate that need will continue to increase, maintaining and replenishing the workforce is a critical challenge for leaders statewide.

Well into the third year of the Coronavirus Disease-2019 (COVID-19) pandemic and related stressors, communities continue to see increases in depression, anxiety, suicidal ideation, overdose deaths, and increased use of alcohol and other drugs. The effects of prolonged community trauma have also illuminated longstanding disparities in access to healthcare among historically underserved populations and a disproportionate impact on people with serious mental illness, and notably, our youth. To that end, it is even more important that Mental Health Plan (MHP) services be available and continue to thrive.

BHC would thus like to acknowledge the work of the 56 individual MHPs that took part in the California External Quality Review Organization (CalEQRO) reviews. Having conducted the reviews this year via video conferencing, we would especially like to thank county staff and leadership, their partner agencies, stakeholders, beneficiaries, and family members for participating in “yet another Zoom meeting.” Notably, BHC appreciates all the beneficiaries and family members who shared their experiences with us – essential to evaluating client-centered care. Collectively, this flexibility and responsiveness enabled BHC to continue its charge to evaluate MHPs for access, timeliness, and quality of the healthcare services they furnish.

As the External Quality Review (EQR) process evolves alongside other requirements, BHC has enjoyed a collaborative relationship with the California Department of Health Care Services (DHCS), particularly the Quality Assessment and Performance Improvement Section and the Network Adequacy Oversight Section of the Quality and Network Adequacy Oversight Branch. BHC would also like to acknowledge the continued collaboration with the California Behavioral Health Directors Association (CBHDA) and the California Mental Health Services Association (CalMHSA). Both organizations foster quality of care and best practices for mental health services, working on models that optimize success for different beneficiary groups and families.

It is our goal that the findings, best practices, and opportunities for enhancement of specialty mental health services (SMHS) systems may be used to improve the care of people with mental health conditions and provide some helpful direction for the next chapter of the 1915(b) waiver and the successful implementation of California Advancing and Innovating Medi-Cal (CalAIM). We remain optimistic for the systemic changes that CalAIM intends to bring and look forward to seeing these changes over the next few years.

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List of Commonly Used CalEQRO Acronyms

CalEQRO Acronyms	
AACB	Average Approved Claims per Beneficiary
AAS	Alternative Access Standard
ACA	Affordable Care Act
ASP	Application Service Provider
ATA	Assessment of Timely Access
BCP	Business Continuity Plan
BHC	Behavioral Health Concepts, Inc.
BHIN	Behavioral Health Information Notice
CalAIM	California Advancing and Innovating Medi-Cal
CalEQRO	California External Quality Review Organization
CalMHSA	California Mental Health Services Authority
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organization
CFI	Cultural Formulation Interview
CFM	Consumer/Family Member
CFR	Code of Federal Regulations
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare and Medicaid Services
COVID-19	Corona Virus Disease-2019
CPS	Consumer Perception Survey
CQI	Continuous Quality Improvement
CSU	Crisis Stabilization Unit
DEI	Diversity, equity, and inclusion
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
DO	Directly Operated
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FTE	Full Time Equivalent
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set®

CalEQRO Acronyms	
HIE	Health Information Exchange
HIS	Health Information System
IMD	Institutes for Mental Disease
IPC	Inpatient Consolidation File
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
JPA	Joint Powers Authority
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning
LOC	Level of Care
LOS	Length of Stay
MCP	Managed Care Plan
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MMEF	Monthly Medi-Cal Eligibility File
NA	Network Adequacy
NACT	Network Adequacy Certification Tool
OON	Out-of-Network
PHF	Psychiatric Health Facility
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PR	Penetration Rate
PSC-35	Pediatric Symptoms Checklist (35 items)
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QIC	Quality Improvement Committee
QM	Quality Management
QMB	Qualified Medicare Beneficiary
RR	Reaching Recovery
SDMC	Short-Doyle Medi-Cal
SMHS	Specialty Mental Health Services
SUD	Substance Use Disorders
TA	Technical Assistance
WIC	Welfare and Institutions Code

Executive Summary

INTRODUCTION

This report represents the statewide findings from External Quality Reviews (EQRs) conducted in California during Fiscal Year (FY) 2021-22. In response to continuing impacts of the Coronavirus Disease-2019 (COVID-19) public health emergency, as well as recurrent wildfires that devastated many counties, all EQRs were conducted via video conferencing. Behavioral Health Concepts (BHC), Inc., under contract with the State of California Department of Health Care Services (DHCS), conducted an analysis and evaluation of the access, timeliness, and quality of specialty mental health services (SMHS) provided to Medicaid beneficiaries across all 56 of California's Mental Health Plans (MHPs).

By design, EQRs are retrospective for the prior year of services. The validation of performance measures (PMs) for reviews conducted in FY 2021-22 primarily emphasizes claims data from Calendar Year (CY) 2020, as the most current, complete data set available at the beginning of the review year. CY 2020 data reflects impacts from the early stages of the pandemic and related stay-at-home orders, program closures, and social distancing. The data shows some concerning findings that are detailed in this report, including: decreased numbers of beneficiaries served; reduced penetration rates (PR); longer average lengths of stay in psychiatric hospitals; and increased hospital readmissions. Despite these findings, many notable examples of clinical and programmatic improvements were seen and documented across MHPs in FY 2021-22.

FINDINGS

Access

MHPs, aware of the impact that COVID-19 was having on historically under-served populations, renewed efforts to address disparities in service utilization and promote equitable access to services. They were keenly interested in how PRs and service patterns varied by race/ethnicity and other demographic variables. They remained alert to recruiting a workforce more reflective of the populations they serve. At a time when workforce recruitment is more challenging than ever before, counties identified both short- and long-term goals to increase access and provide services that meet the needs of under-served groups.

With workforce deficits comes gaps in service capacity, and as a result, potentially longer waits for the proper level of care (LOC). It is even more important in this environment that high-risk individuals are prioritized and that service systems shift their resources to complex populations. Strong relationships for two-way referral between the MHPs and the managed care systems are especially important when considering LOC needs, as are standardized LOC assignment tools.

While the expansion of telehealth services helped to increase access for many, it has not been without challenges. Rural regions, with weak or no internet, struggled, as did beneficiaries who do not own or know how to operate computers, tablets, or smart phones. Simultaneously, many employees enjoyed the flexibility of working from home with no commute and a generally less pressured environment. Telehealth – and telework – contributed to new challenges for MHPs.

As they struggled to adopt workplace flexibilities to retain a dwindling workforce, MHPs also worked tirelessly to address complex, high-need clients, who often require service delivery in a clinic setting, their homes, elsewhere in the community, or a combination of all three.

Timeliness

Whether an initial service is offered in a timely manner can impact whether a service will be delivered at all. Most individuals initiate mental health care during one of the worst periods of their lives; being told that they need to wait days, weeks, or months can be so discouraging that individuals withdraw from care. MHPs see considerable attrition between the initial call for service and the first service provided – as high as 50 percent in some counties.

While MHPs are quite successful at offering an initial outpatient mental health service, usually an intake assessment, providing a timely psychiatry service is impeded by a longstanding workforce shortage in psychiatry. Additionally, detailed timeliness tracking related to these requirements remains difficult for many counties; some are on the verge of implementing new electronic health records (EHRs), which may help address this problem. However, complex EHR implementation and competing priorities could lead to further delays in tracking critical timeliness measures.

Quality

Management and oversight of the quality of care delivered throughout a system requires a particular set of skills, as well as the support of technology and analytic staff – all of which are in short supply. MHPs are required to develop a Quality Assessment and Performance Improvement (QAPI) Plan, which should include baselines and goals to determine whether priority metrics are improving. An annual evaluation of that plan enables the MHP to re-prioritize or deepen the resolve to improve.

A required element for any of the above to be successful is commitment and meaningful participation by MHP leadership in all areas. For many, this may require building skills in interpreting analytic reports, conducting root cause analysis, and identifying and implementing strategies for improvement. This approach is critical for designing and implementing Performance Improvement Projects (PIPs) and should serve as a foundation for all program management and performance improvement.

Over the past year, while the number of consumer/family focus groups was limited in number, participants were especially appreciative of the care they were receiving. Well aware of the challenges their providers were facing – perhaps too aware of the shrinking workforce and increasing caseloads – they valued the services that were being delivered either in-person or via telehealth.

Information Systems

This last year saw new EHR vendors in California, bringing renewed hope for a comprehensive mental health/substance use disorder record, health information exchange (HIE), interoperability, and personal health record implementation. Some of the historical systems based on older technology took several years to implement, and even then, not fully. The collaborative effort of many counties participating with the California Mental Health Services Authority (CalMHSA) Joint Powers Authority (JPA) to implement a single EHR that meets California Advancing and Innovating Medi-Cal (CalAIM) requirements will hopefully bring more

technology with less demand on the local workforce. Other counties that are adapting their existing EHRs for CalAIM may be challenged if they do not have sufficient technology and analytic staff for local analysis or required reporting. Ultimately, a system that can be more informed by its data can target its improvements and obtain results.

RECOMMENDATIONS

Substantial variation in MHPs exists across the state – including size, region, demographic composition, service delivery system, and EHR functionality. Local and statewide factors affect both the strengths and weaknesses of a system. Challenges are often statewide, affecting many if not all MHPs, while strengths tend to be very MHP-specific. Examples of both are provided throughout this report, followed by a list of recommendations to address the identified challenges, found in the Conclusions chapter of this report.

Included recommendations are intended for California’s SMHS delivery system, inclusive of DHCS and the 56 MHPs. They align with the DHCS 2022 Comprehensive Quality Strategy¹ and are consistent with the vision of the CalAIM² waiver. Some are broadly applicable statewide, though not all recommendations are suited to every county. It will be important for DHCS and MHPs to work together to improve the access, timeliness, and quality of care provided by counties and their contracted providers to Medi-Cal beneficiaries throughout California.

¹ <https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf>

² <https://www.dhcs.ca.gov/calaim>

Introduction

OVERVIEW OF THE EQR AUTHORITY

The U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of state Medicaid managed care programs by an External Quality Review Organization (EQRO). EQR is the analysis and evaluation by an approved EQRO of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of state Medicaid 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 MHP and each Drug Medi-Cal Organized Delivery System (DMC-ODS). The California DHCS contracts with all 56 county Medi-Cal MHPs, comprised of 58 counties, to provide Medi-Cal covered SMHS to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

At the conclusion of each fiscal year's EQR cycle, the California External Quality Review Organization (CalEQRO) generates a comprehensive aggregate technical report of the ERQs conducted in FY 2021-22, summarizing findings from a statewide perspective – generating themes and applicable recommendations, which are outlined in the Conclusion at the end of this report. Developing those recommendations are based upon the individual MHP reviews, how MHPs responded to recommendations made in the prior year's EQR report; an evaluation of how the MHPs are managing to timeliness, access, and quality, and using their information systems (IS); and MHP specific strengths, opportunities for improvement, and recommendations that the EQRO will evaluate at the next year's review.

The findings are the result of data collection and analyses and qualitative review of MHP documentation by CalEQRO. Additional information, including CalEQRO resources, the individual MHP reports and summaries, presentations, data analyses, and archived materials, can be found on the organization's website, www.caleqro.com.

Reviews are retrospective for the prior year of services and the review criteria are based predominantly on CMS 42 CFR Part 438, subpart E, which outlines four major requirements:

- PMs to evaluate clinical effectiveness and service activity.
- 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 (through MHP surveys and EQR focus groups), and a focused review of 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 network adequacy (NA) as set forth in California Assembly Bill 205.

BHC'S EQR APPROACH

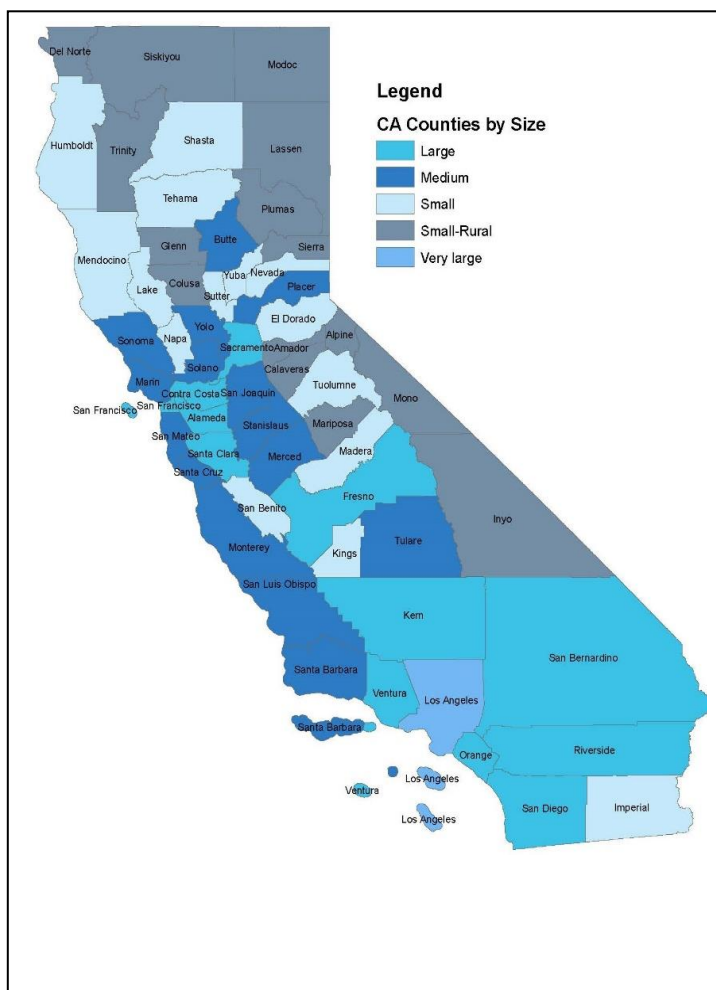
As the California EQRO, BHC is required to conduct a review of each county on an annual basis to review access, timeliness, and quality. PMs are based upon the most recent 12-month set of approved claims available at the beginning of the review cycle – for this report, CY 2020 approved claims data. Most measures are also shown as part of a three-year trend from CY 2018 through CY 2020 claims.

THE MHP ENVIRONMENT

Either directly or indirectly, the environment in which the MHPs operates will affect access, timeliness, and quality of MHP services. This requires viewing the MHP within the context of its local systems and as a part of the larger statewide systems. Local and statewide factors will affect both the strengths and weaknesses of a system. Challenges are often statewide, affecting many if not most or all MHPs; strengths tend to be very MHP-specific. The EQR seeks to take MHP strengths into account when making recommendations for improvement. Additionally, when evaluating the MHPs' activities completed in response to those recommendations, the MHP's environmental context serves as a basis for that evaluation.

COVID-19's impact on behavioral health needs and the MHP systems cannot be overstated. In the first year of the pandemic, MHPs changed how they operated and offered services. In the second year of the pandemic, the year largely addressed through this report, this continued – except by year two, the workforce was worn and depleted. Significant vacancies resulting in a smaller workforce – even if it meets the minimum expectations associated with NA – has made providing and managing quality care even more of a challenge in the State's historically under-resourced SMHS system.

Even so, MHPs have managed to offer services in a timely manner. Many have benefitted from federal funding and developed new programs, expanded existing programs, and built or are planning to build new facilities. They have collaborated with partner agencies in yet new ways,



all to meet the needs of the beneficiaries at their doors and on their video screens. While staffing Quality Management (QM) programs has often been sacrificed for service delivery, the focus on CalAIM implementation may result in a stronger focus on MHP QM programs. Implementation of CalAIM began in January 2022 and will continue over the five-year period of the 1915(b) waiver which encompasses all Medi-Cal services, both SMHS and substance use disorder (SUD), among physical and dental healthcare. It seeks to expand service availability and accessibility through collaborative, whole person care across the Medi-Cal benefit.

The EQRs are focused on obtaining qualitative and quantitative information to understand a system's operations and ways in which the MHPs' processes positively or negatively affect the quality of care. This report will detail statewide themes, findings, and recommendations that CalEQRO hopes will be meaningful to the State, the MHPs, the beneficiaries served – and the unserved individuals that MHPs strive to serve.

A background image of a forest with tall trees and a path leading through them, overlaid with a semi-transparent grey box containing the title.

Methods

OVERVIEW

CalEQRO reviews emphasize the MHPs' 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 (CFM) served by SMHS systems of care. Collectively, the review teams utilize quantitative and qualitative 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 for each MHP, CalEQRO produces a technical report of findings which synthesizes information, draws upon the 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 Files (MMEF), Short-Doyle/Medi-Cal (SDMC) approved claims, Inpatient Consolidation File (IPC), Consumer Perception Survey (CPS) data, NA files, and county submission documents. Reviews are retrospective for the prior year of services. Reviews conducted in FY 2021-22 emphasize CY 2020 data and three-year trends cover CY 2018 to 2020, unless otherwise indicated. An MMEF data set is requested for the same 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 with 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.

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 enrolled in Medi-Cal and entitled to receive services funded through Medi-Cal, whether they received SMHS or not. The term “beneficiary” is used to describe a person who is Medi-Cal eligible and has received one or more MHP service. 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. While MHPs are mandated to serve those who meet medical necessity criteria and have Medi-Cal, they may also provide services to individuals who are uninsured, have Medicare, or both Medicare and Medi-Cal.

PERFORMANCE MEASURES

Data used to generate the Approved Claims Summaries and PM tables and graphs throughout this report, unless otherwise specified, are derived from three source files: MMEF data, SDMC approved claims, and IPC files.

The PMs provided to the MHP prior to the review, and discussed during the review include:

- Numbers Served, PR and Average Approved Claims per Beneficiary Served (AACB) (Overall, Hispanic/Latino, Asian/Pacific Islander, and Foster Care) – three-year trend 2018-2020, compared to similar size MHPs and State
- Beneficiaries with a Threshold Language served by the MHPs
- Beneficiaries Served and Approved Claims by Diagnostic Category, compared to State
- High-Cost Beneficiaries – % of beneficiaries served, % of claims, compared to State
- Inpatient Utilization – beneficiaries served, number of admissions, average length of stay, average and total claims for inpatient – three-year trend 2018-2020, compared to State
- Follow-up from Inpatient Discharge and Readmission Rates at 7-day and 30-day – 2019 and 2020, compared to similar size MHPs and State
- Affordable Care Act summary of beneficiaries served, eligibles, PR, average approved and total claims – compared to similar size MHPs and State
- Rates of denied claims and reason codes compared to State

REVIEW PREPARATION

CalEQRO issues a Notification packet to each MHP via email 60 days prior to the date of the scheduled review. In that letter, BHC identifies demographics or service patterns for requested CFM focus groups. The MHP is also referred to the BHC website for documents that the MHP completes (or updates), including:

- Response to prior-year report recommendations
- Key changes and new initiatives since the last review
- ISCA
- Pathways to Well-Being Survey
- NA Survey
- Assessment of Timely Access, which should be submitted with the source data used to complete the form
- Two PIP submissions – one clinical and one non-clinical

The MHPs are instructed to submit those documents along with other key documents they generally maintain throughout the year to a shared County/BHC secured website folder. These additional documents include:

- QAPI Work Plan

- QAPI Work Plan evaluation
- Quality Improvement Committee (QIC) meeting minutes
- Cultural Competency Plan
- Cultural Competency Committee meeting minutes
- Organizational chart(s)
- MCP memoranda of understanding
- Strategic Plans, if applicable
- Examples of data analysis conducted
- Any other documents that demonstrate the MHP's management of access, timeliness, quality, IS, or outcomes of care

MHPs are advised to contact the Quality Reviewer by a specified date to begin review preparation discussions and to upload all review documentation described above within four weeks prior to the review.

The review agenda is prepared in consultation with each MHP to emphasize CMS protocols, MHP areas noted as requiring improvement in the prior year's EQR report, and to provide the MHP an opportunity to showcase some additional accomplishments since the previous review. MHP EQRs are conducted over the course of one to three days depending upon the size of the MHP. Generally larger MHPs are the most complex and require the longest reviews to gather information from key informants; for example, the Los Angeles review usually involves two full review teams across four days.

In finalizing the agenda and preparing for the review discussions, the review team examines all of the PM data and documents submitted. This preparation enables the review team to identify areas in which further questions or discussion appear necessary to complete the understanding of the MHP's processes or operations. The review team meets prior to the review to discuss the priority areas based upon the prior year's report, the totality of the documents reviewed, and any other MHP-specific information.

CONDUCTING THE REVIEW

During the review, up to three sessions might be conducted at the same time. Each CalEQRO review team contains at least one person in each of the following roles: Quality Reviewer, IS Reviewer, CFM Reviewer. MHP participants vary depending on the focus of each session and the informants in that county that can address the session topic – preferably both leadership and the line staff involved in implementation. Participation range includes MHP leadership and staff, contract agency leadership and staff, beneficiaries and families, partner agencies, and various community stakeholders. During the review, MHPs may realize that they did not submit all relevant documentation or would like to provide additional written information; in these cases, MHPs are allowed to submit additional documentation up to one week after the review.

Throughout the course of the review process the CalEQRO teams are rating, based upon their review of the PMs, documents submitted, and discussion sessions, the items and sub-items that form the Key Components. There are a total of 26 Key Components, categorized by Access,

Timeliness, Quality, and IS³. The totality of the ratings of the Key Components, analysis of the PMs, and other quantitative and qualitative information obtained during the review are further consolidated into a set of Strengths and Opportunities for each broad category. Where there are Opportunities for improvement, recommendations are provided.

REPORT OF MHP-SPECIFIC FINDINGS

CalEQRO is expected to produce a draft report within 30 days of the conclusion of the MHP review; both DHCS and the MHP are invited to provide feedback requesting additional clarification or information prior to delivery of the Final Report, within 90 days of the review.

The Final Report includes:

- A summary of the changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system.
- Rating of the Response to Recommendations as Fully Addressed, Partially Addressed, or Not Addressed, along with a summary of the related MHP activities.
- Review and validation of each MHP's NA as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California Welfare and Institutions Code (WIC) Section 14197.05, detailed in the Access section of this report.
- Ratings of Met, Partially Met, or Not Met for each of the four Key Components categories: Access, Timeliness, Quality, and IS. Document review and review session discussions are essential to this process. Any ratings of "Not Met" are provided a brief explanation.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4).
- Beneficiary perception of the MHP's service delivery system based upon focus groups with beneficiaries and family members.
- Assessment of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS).
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year. These findings are maintained in a database for the statewide analysis.

STATEWIDE REPORT METHODS

CalEQRO maintains several databases used to collect key information included in the MHP reports. These databases serve to develop this statewide aggregate report summarizing the MHP-level review findings from a statewide perspective.

³ www.calegro.com

The report which follows includes comparable information contained within each MHP Final Report, aggregated to provide a comprehensive view of Access, Timeliness, and Quality across California's MHPs, and is organized by the major categories of the EQR scope of work:

- Access, including NA
- Timeliness
- Quality
- PIPs and TA
- Beneficiary Perception
- Information Systems
- Conclusions

This statewide aggregate report is accompanied by a report comprised entirely of the PMs embedded throughout this report. PMs are presented in a combination of tables or figures, with a variety of stratifications (e.g., age, race/ethnicity, MHP size, and MHP region), with narrative descriptions of meaningful trends or other conclusions based upon the data.



Access

INTRODUCTION

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or beneficiaries) can obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient numbers of providers and facilities in the areas where beneficiaries live, socio-cultural factors, and geography— all important for a beneficiary to ultimately obtain the appropriate care and services when needed.⁴ An MHP can offer exemplary services, but if they are not readily accessible, then the system falls short.

ACCESSING MHP SERVICES STATEWIDE

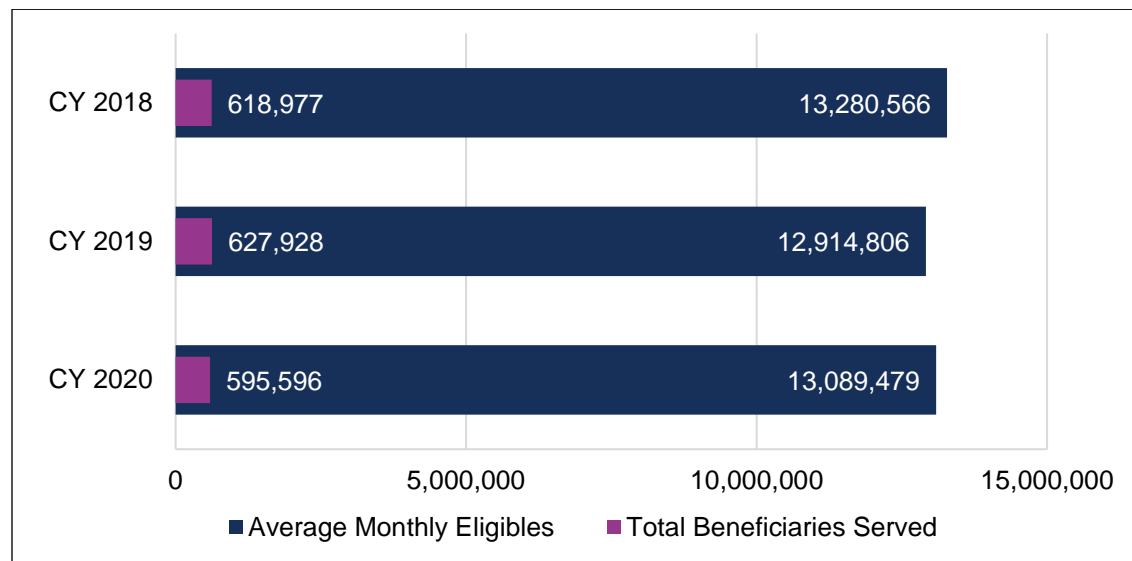
In California, 56 MHPs serve 58 counties – two sets of counties function as a single MHP, Sutter/Yuba and Placer/Sierra. As required, all counties advertise and maintain an 800 # Access Line which beneficiaries primarily use to initiate access to SMHS. The next step toward ongoing care can vary greatly across counties, depending upon the depth of the screening and assessment process that occurs during the initial phone call and the MHP's protocols for an initial comprehensive clinical assessment and treatment plan. The initial assessment may be conducted by county-operated or contracted provider MHP clinicians, and counties have different points of system access, where some are more centralized, and others are very decentralized in terms of geography and providers. Generally, after an initial assessment, beneficiaries are referred to an appropriate service that is geographically most accessible. With the flexibility afforded to systems and beneficiaries in CalAIM, service entry is expected to become more varied, based upon beneficiary needs – services can be provided prior to an assessment and diagnosis, and a formal treatment plan is being replaced with a targeted problem list.

PRs are used by the EQR as a measure of access to care, calculated as the number of beneficiaries served annually divided by the annual average number of Medi-Cal eligibles. This chapter describes access performance across the state and some of the differences that may contribute to varied performance. Figure 4-1 shows the three-year statewide trend of eligibles and beneficiaries served.

⁴ https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf

Medi-Cal Beneficiaries Served Statewide by MHPs

Figure 4-1: Medi-Cal Eligibles and Beneficiaries Served Statewide, CY 2018-20

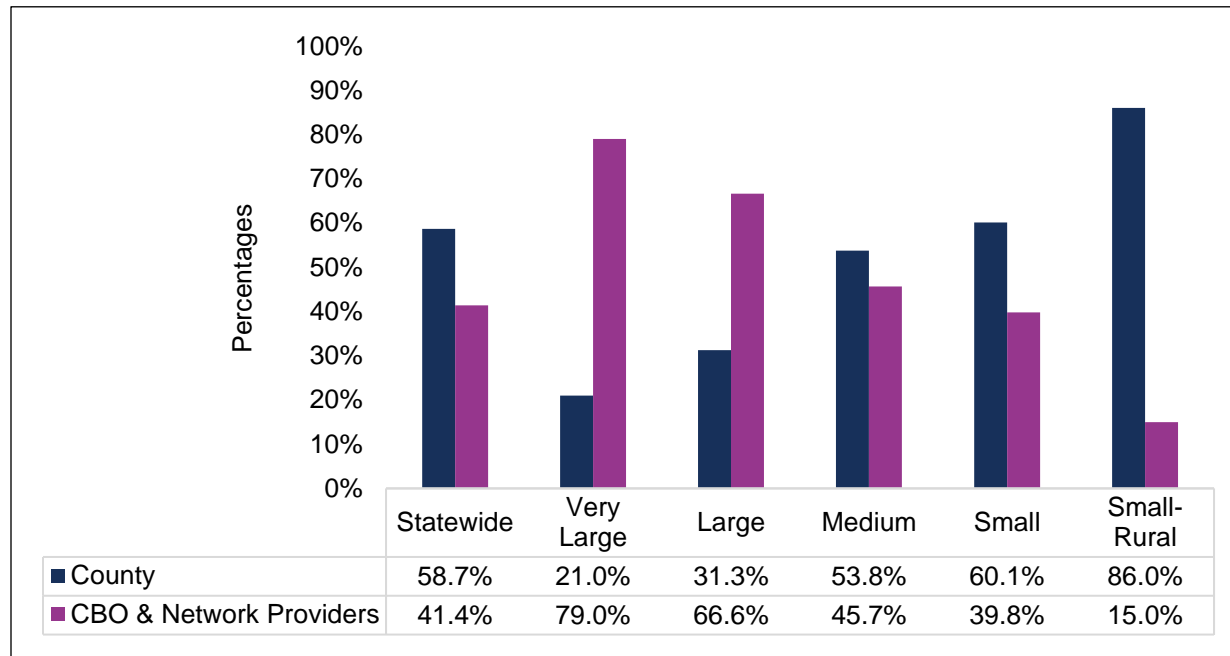


In 2020, the state saw the fewest number of beneficiaries in services for the three-year period. Despite a slight increase in eligibles from 2019 to 2020, the number of beneficiaries served decreased by 5.15 percent (33,332). The decrease in numbers served likely reflects less access to care as opposed to less need for care, given that the COVID-19 pandemic appears to have triggered increases in mental health symptoms nationally.⁵

Service Delivery by Provider Type

SMHS are delivered by both county-operated and contractor-operated providers throughout California; collectively, these providers form the MHP's network. Figure 4-2 shows a correlation between the size of an MHP and the relative percentage of services delivered by county or contractor staff.

⁵ <https://www.cdc.gov/mmwr/volumes/70/wr/mm7013e2.htm>

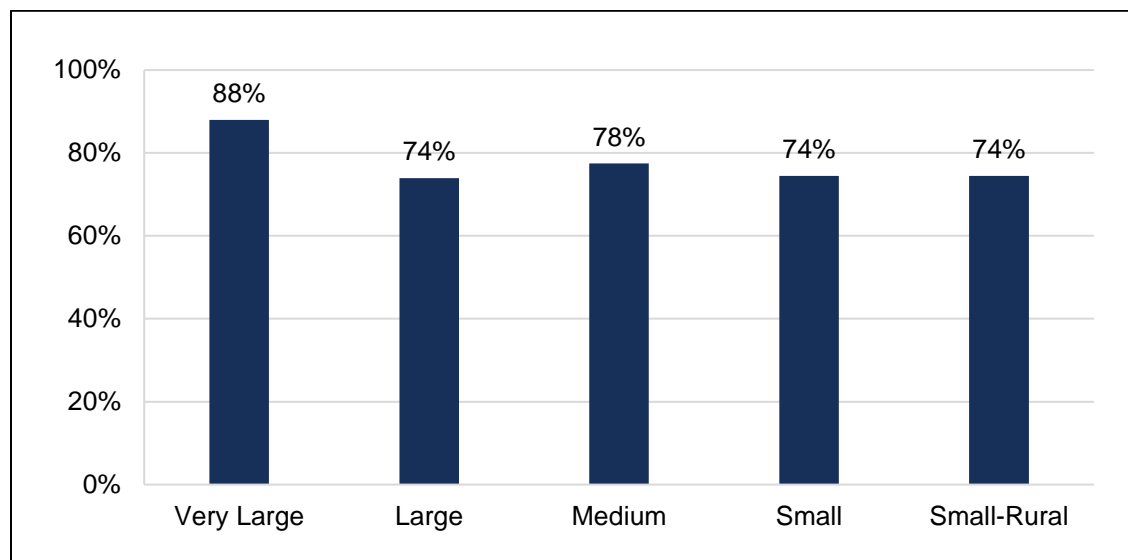
Figure 4-2: SMHS Delivery Provider Type, by County Size, FY 2021-22

According to data reported by the MHPs in the ISCA, approximately 58.7 percent of services statewide were delivered by county-operated programs and 41.4 percent were delivered by contracted providers. Los Angeles (very large) has 79 percent of its services delivered by contract. As the MHP sizes get smaller, the percentage that is contracted decreases. On average, two-thirds of services provided in large MHPs were delivered by contracted providers, and only 15 percent for the small-rural MHPs. Medium MHPs were fairly evenly distributed between county-operated and contracted programs. (Figure 4-2)

As would be expected, over 70 percent of beneficiaries statewide are served in large and medium MHPs. While small and small-rural MHPs represent half of the MHPs in the state, they serve less than 30 percent of the beneficiaries in California.

Percentage of County Mental Health Services Delivered as SMHS

The extent to which counties rely upon Medi-Cal as a major source of funding for their service systems also varies by county. This is impacted by the degree to which counties seek and obtain grants, receive local contributions from the County's general fund, and the methods used to allocate Mental Health Services Act (MHSA) funds and State Realignment funds. Additionally, given staffing demands, some MHPs note that grant applications and the subsequent implementation and often rigorous reporting requirements can be locally prohibitive. As the state experiences an ongoing workforce crisis, the ability to seek grants and other opportunities to develop more innovative strategies and services throughout the service systems will likely be impacted.

Figure 4-3: Services Claimed to Medi-Cal, CY 2020

Among California counties, ISCA submissions show that approximately 76.27 percent of the mental health services provided were claimed to Medi-Cal in 2020 – apart from Los Angeles at 88 percent, counties claim 74 to 78 percent of mental health services to Medi-Cal (Figure 4-3). This represents the extent to which county services are drawing federal dollars for SMHS. Other services are funded by County general funds, grants, or the MHSA. While ACA has nearly eliminated the population of adults that are completely uninsured, regions of the state that have large undocumented residents may have more notable uninsured populations.

The percentage of services that are billed to Medi-Cal are impacted by several policy and local factors, namely: 1) services that are not Medi-Cal billable such as facilities subject to the Institutes for Mental Disease (IMD) exclusion, 2) services that are not billable to Medi-Cal because they are not closely tied to a SMHS treatment plan objective, 3) smaller programs that may not have the infrastructure to support the rigorous compliance protocols associated with Medi-Cal claiming, 4) the availability of local or MHSA resources to fully fund programs when Medi-Cal claiming is deemed to be more burdensome than beneficial, and 5) local “disallowances” where internal MHP audit processes determine that the documentation of a service is not strong enough to support a given claim.

There are many potential opportunities on the horizon to anticipate an increase in Medi-Cal service delivery. CalAIM promises to bring improved ease of clinical documentation with its Documentation Redesign initiative. Less time required for documentation would result in more time available for clinical staff to provide billable services. This policy change may also allow non-participating programs more opportunity to manage Medi-Cal requirements and begin to provide services billed through the MHP rather than MHSA or other funding sources. Further, it is expected that global problem lists will provide the opportunity to deliver more psychosocial interventions that yield increased outcomes in mental health functioning. Additionally, if the State is successful in obtaining a waiver from the IMD exclusion for shorter-term stays, this will allow for more Medi-Cal billing of inpatient care.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the SMHS most appropriate to their needs. CMS requires all states with managed care organizations and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, California further specifies NA implementation requirements, codifying several federal Medicaid managed care regulations in State statute in WIC Section 14197⁶. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of specific data collected and processed by DHCS related to NA.

On February 13, 2018, DHCS issued the first NA policy guidance, BHIN 18-011⁷, that introduced time, distance, and timely access standards for adult and pediatric mental health providers to which MHPs must adhere. Subsequently, DHCS has issued updated NA policy guidelines to provide additional clarification on Network Certification Requirements. BHIN 21-023⁸ was the most current at the time of the FY 2021-22 review year.

MHPs submitted detailed information on their provider networks to DHCS in spring 2021 for the reporting period of December 1, 2020, through February 28, 2021, utilizing the Network Adequacy Certification Tool (NACT) form, per DHCS BHIN 21-023. 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 National Provider Identifier 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.

In the context of NA, time refers to the number of minutes it takes a beneficiary to travel (in a personal vehicle) 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 maximum 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. Established time and distance standards for outpatient Mental Health Services and Psychiatry Services are identified in Table 4-1⁹.

⁶ California Welfare and Institutions Code § 14197

⁷ 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

⁸ <https://www.dhcs.ca.gov/Documents/BHIN-21-023-2021-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf>

⁹ 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>

Table 4-1: NA Time and Distance Access Standards for MHP Counties

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

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. DHCS may honor AAS requests for a dispensation in access requirements, provided the MHP substantiates the request as described in BHIN 20-012¹⁰ and BHIN 21-023¹¹.

In addition to time and distance standards, MHPs are also required to offer timely access to outpatient SMHS. In this context, timely access or “appointment wait time” means the time from the initial request for behavioral health care services by a beneficiary, their caregiver, or their 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 mental health care needs and ensures continuity of care consistent with good professional practice. (Table 4-2)

Table 4-2: NA 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

Policy guidance contained in BHIN 21-008 stipulates that when an MHP is unable to provide all covered services within the time or distance, and timely access standards, the MHP must allow

¹⁰ <https://www.dhcs.ca.gov/Documents/Behavioral-Health-Information-Notice-20-012-2020-NA-Certification-4-3-20.pdf>

¹¹ <https://www.dhcs.ca.gov/Documents/BHIN-21-023-2021-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf>

beneficiaries to access services through an out-of-network (OON) provider within the same time or distance standards. 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.

MHPs with Approved AAS

In FY 2021-22, nearly all (52 of 56) MHPs met all time or distance standards and were not required to submit an AAS request; four MHPs, representing 12 of the 2,703 zip codes in California, required an AAS. Three of the four MHPs resolved the issue with the addition or expansion of telehealth to provide access to SMHS for their beneficiaries. (Table 4-3)

Table 4-3: Approved Alternative Access Standards for MHP Counties

Provider Type	Zip Code	Approved Max Distance (miles)	Approved Max Time (minutes)	Justification for Approval
Alpine				
Psychiatry – Adult	96120	22.6	29	Telepsychiatry services are being administered within the County
	95223	109	47	
Psychiatry – Children/Youth	96120	25.3	34	
	95223	55.4	76	
Mono				
Psychiatry – Adult and Children/Youth	96133	9.3	10	Telepsychiatry services are being administered within the County
	96107	3	4	
	93517	31	35	
	93541	29	33	
	93529	19	24	
	93546	0.3	2	
	93514	18	21	
	93512	46	46	
Trinity				
Psychiatry – Adult and Children/Youth	95595	N/A	N/A	Implementation of a telehealth unit at Southern Trinity High School and a mobile crisis unit that will visit the outlying areas of the County
	95527	N/A	N/A	

Many MHPs identified additional strategies implemented to enhance network access to beneficiaries who continued to experience barriers to access. For example, **Santa Barbara** MHP established telehealth therapy services at New Cuyama High School in August 2021 due to geographical challenges accessing services; **San Luis Obispo** expanded telehealth services

and has collaborated with its MCP to arrange for transportation to in-person services as needed; and **Siskiyou** provides consultation to rural tribal clinics to improve access to medication services as it continues contracting efforts with a local American Indian Health Facility.

MHPs Requiring OON

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 or distance standards. In these circumstances, MHPs are required to arrange for telehealth or transportation to an in-person visit; MHPs may coordinate with MCPs for transportation to SMHS as well. Further, as stipulated by DHCS' Telehealth Policy¹², 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 to ensure 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. In FY 2021-22, 53 of 56 MHPs demonstrated compliance with the timely access standards at the time of the NACT submission; one MHP remained on a Corrective Action Plan for timely access at the end of FY 2021-22¹³.

In zip codes for which approved AAS apply and a beneficiary requests psychiatry services, the MHP must respond in one of two ways: 1) arrange for an appointment with a provider within the applicable time or distance standards and within 15 business days or 2) make its best effort to establish a beneficiary-specific case agreement with an OON psychiatrist located within the required time and distance standards who has availability 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 MCP to arrange non-emergency transportation for the beneficiary to attend an appointment outside the coverage area.

When an MHP is unable to arrange an appointment for a beneficiary with a network provider (for the appropriate LOC, 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.

MHPs report several methods to ensure OON access for beneficiaries. For example, **Alameda** utilizes single case agreements, and **Alpine**, **El Dorado**, **Kern**, and **Sacramento**, and **Tuolumne** report the ability to enter into single case agreements should the need arise. Some MHPs, including **San Diego**, contract with an Administrative Services Organization for the execution of OON agreements.

¹² Department of Health Care Services. Telehealth policy. August 2020. Available from: <https://files.medical.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf>

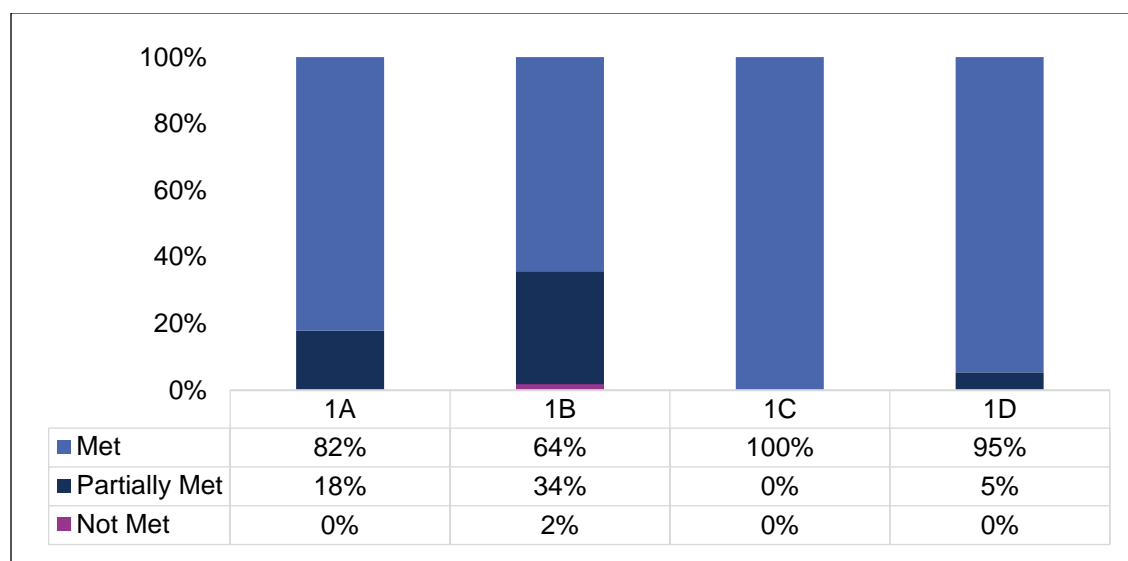
¹³ 2021 Annual Network Certification CAP Report: <https://www.dhcs.ca.gov/Documents/MHP-2021-Annual-Network-Certification-CAP-Report.pdf>

ACCESS KEY COMPONENTS

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

Each of the six access components, comprised of individual subcomponents, are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met. A summary of statewide performance is depicted in Figure 4-4, and a summary of each component follows in Tables 4-4 through 4-7 below.

Figure 4-4: Summary of Access Key Components, Statewide



Many individuals who need mental health services do not reach out and engage in those services. The Access Key Components are intended to measure the MHP's analysis of beneficiary access to care, the identification of areas for improvement, and the implementation of strategies to continuously improve access to Medi-Cal beneficiaries who require SMHS. Therefore, MHPs may show high ratings for their quality improvement (QI) activities yet still have systems that require additional interventions to improve accessibility. (Figure 4-4) Analysis of the six Access Key Components follows.

Cultural Competence

Table 4-4: Access Key Component 1A – Statewide Ratings

KC #	Key Component – Access	Met	Partially Met	Not Met
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	46	10	0

Many MHPs conveyed a renewed emphasis on their Cultural Competence Plan and committees, emphasizing disparities, being trauma informed, and embracing diversity, equity, and inclusion (DEI). For example, **Alameda** was noted as having a robust cultural plan that is evident in outreach, service delivery, and training, with plans to host a statewide cultural training on mental health, the development of an African American Wellness Hub, and providing special outreach to the Afghan population. Stakeholders indicated that the County and Community Based Organizations (CBO) hire diverse staff and utilize the language line when staff language capacity is insufficient.

In response to successful interventions as part of its clinical PIP, **Napa** began using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Cultural Formulation Interview (CFI) to obtain information during a mental health assessment about the impact of culture on key aspects of an individual's clinical presentation and care. As of January 1, 2021, all comprehensive assessments for new beneficiaries meeting SMHS criteria include the CFI to assist clinicians in making person-centered, culturally competent assessments.

Prioritizing the need for beneficiaries to receive services in their preferred language, nearly half (48 percent) of **Tulare's** county and contracted provider staff speak Spanish; 24 percent of beneficiaries served by **Tulare** receive services in Spanish.

Solano concluded its five-year innovation project with University of California at Davis Center for Reducing Healthcare Disparities, which focused on improving engagement with the historically underserved Latino, Filipino-American and Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ+) communities, anchored in the Culturally and Linguistically Appropriate Services (CLAS) Standards. This project's continued impact is reflected through replication in other MHPs and locally in the creation of access and equity dashboards for ongoing monitoring the Diversity and Equity Committee. Related efforts include the recent development of a non-clinical PIP which aims to improve identification of Sexual Orientation and Gender Identity status and increase access for the LGBTQ+ population.

Another way in which MHPs demonstrated commitment to DEI was through staff training. For example, **Imperial** provided valuable training to many levels of staff and peers. Of note is the LGBTQ+ training, "Working with Lesbian/Gay/Bisexual/Transgender + Clients: Gender Identity and Sexual Orientation Issues in Mental Health and Social Work Practice," which trained 524 of 573 clinical and non-clinical staff.

While many MHPs demonstrated strong DEI, the theme was noted as an opportunity for improvement as often as it was identified as a strength. MHPs were identified as having insufficient numbers of bilingual staff relative to the number of beneficiaries with a preferred language other than English. Additionally, some MHPs have continued to serve a disproportionately low percentage of specific beneficiary groups relative to the Medi-Cal eligible population. Others struggled to gather and report outreach activity data necessary to identify and target unserved and underserved populations. Feedback from stakeholders highlighted

opportunities for improved outreach, services in preferred languages, and reduction of mental health stigma within cultural communities.

Workforce

Table 4-5: Access Key Component 1B – Statewide Ratings

KC #	Key Component – Access	Met	Partially Met	Not Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	36	19	1

Counties have been losing staff in numbers never seen before. Staff at all levels are leaving for “less stressful” positions, private practice, positions that are entirely telehealth, private healthcare companies with higher salaries, school districts with summer vacation, and MCPs with lower acuity clientele, as well as retiring or transitioning out of the mental health field. In addition to staff departures, other workforce challenges include delayed recruitments, slow onboarding, lack of competitive salaries, staff burnout, and staff personal or family-related medical leave. Over the course of the year, workforce issues became essentially universal – impacting access to care and timeliness of care.

An overall reduced clinical workforce has led to higher caseloads (and fueled a cycle of additional resignations) and results in concerns about inability to provide appropriate services and adequately engage clients. This may correspond with the increase in rehospitalizations noted statewide (and the corresponding increase in the number of high-cost beneficiaries [HCB], discussed later in this report).

Capacity management strategies are not necessarily rigorously applied in those counties that had the most significant access problems, as indicated by long wait times and/or wait lists. With a reduced workforce, larger caseloads, and potentially longer wait times in between services, it is even more important that MHPs utilize objective measures, such as LOC tools, to manage transitions in care and identify and prioritize beneficiaries with the highest needs.

Recognizing the significance of the behavioral health workforce crisis, DHCS sponsored the 2021 California Behavioral Health Workforce Assessment, wherein 1,602 mental health and substance use professionals and paraprofessionals participated; the report contains valuable information, insights, and recommendations to address this crisis.¹⁴ MHPs across the state also recognized that retention of employees has become critical and cited loan repayment programs, work-from-home, salary adjustments, and other efforts to improve communication to/from employees as strategies to improve morale and retention. Such efforts to improve recruitment and retention in **San Bernardino** were noted by line staff who described a picture of flexible and supportive supervisors who convey a genuine sense of caring about the health and mental health of staff. Among small MHPs, **Tehama** increased salaries in hard to fill positions by 5 percent; **San Benito** began participating in a loan repayment program.

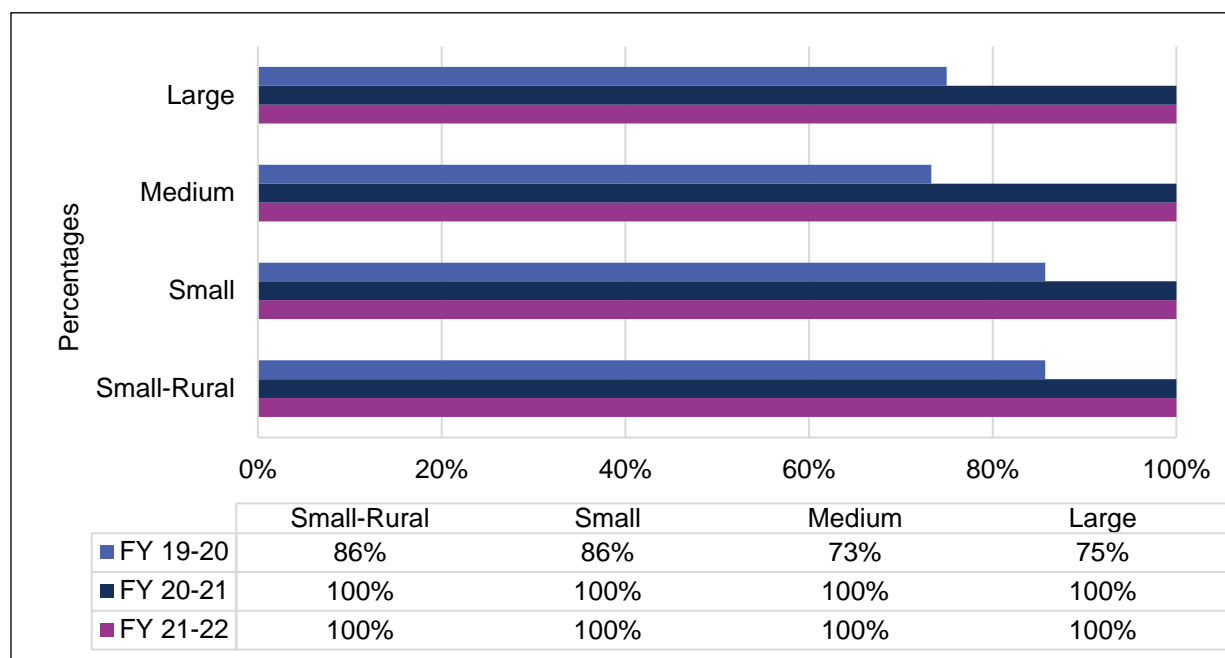
¹⁴ 2021 California Behavioral Health Workforce Assessment, Center for Applied Research Solutions

Telehealth

Telehealth has been an essential service modality, available among all MHPs since the beginning of the COVID-19 pandemic. While in some cases, beneficiaries are seen over video at a clinic site, telehealth with the beneficiary at home can eliminate the time and financial impact of traveling via car or bus to a clinic. In many rural regions where transportation may pose a barrier to access, telehealth sometimes is not a complete solution because of weak or absent internet services, and beneficiaries who do not have computers or smart phones or the familiarity with using them. To address this, several counties installed telehealth equipment at satellite sites; but sometimes these were difficult for beneficiaries to use if staff were not available to assist—especially for older adults who are less familiar with video communications. Despite some challenges, staff and clients alike express interest in continuing to have options for telehealth when appropriate. This flexibility may be a component of workforce retention, in addition to the added convenience for beneficiaries who have the necessary equipment and internet bandwidth.

Nearly two-thirds (62.5 percent) of beneficiaries are reported to have received at least one service through telehealth after MHPs quickly implemented telehealth at the beginning of the COVID-19 pandemic. In FY 2021-22, MHPs provided telehealth services to 160,071 adult beneficiaries, 160,063 youth beneficiaries, and 14,703 older adult beneficiaries. Among those served, 37,538 beneficiaries received telehealth services in a language other than English – from a provider speaking the beneficiary’s language or with an interpreter joining as a third party via phone or video.

Telehealth practices in three MHPs stand out as particularly noteworthy. **San Diego** provides beneficiary hardware and usage assistance; captures video telehealth as separate and distinct from telephonic services for purposes of analysis; prioritizes beneficiary empowerment and choice in deciding face-to-face or telehealth options; and uses a safety and clinical decision-making framework to determine use and frequency of telehealth utilization. In **Los Angeles**, telehealth expansion, inclusive of video and telephonic services became a useful choice in the redistribution of key services which have limited capacity, such as psychiatry. Furthermore, it became a resource for families and individuals whose circumstances make travel to a clinic difficult. **Lassen** offers portable telehealth units for beneficiaries with access barriers; the units are available for beneficiaries to use in their homes, one-stop-centers, and the local emergency room.

Figure 4-5: Telehealth Services Availability, FY 2019-22

All 56 MHPs report in the ISCA having sustained telehealth service capability for the past two fiscal years. (Figure 4-5)

Integration and/or Collaboration to Improve Access

Table 4-6: Access Key Component 1C – Statewide Ratings

KC #	Key Component – Access	Met	Partially Met	Not Met
1C	Integration and/or Collaboration to Improve Access	56	0	0

The challenges that service systems faced throughout the pandemic appeared to trigger more collaborative efforts to reach and serve beneficiaries. This included increased or improved partnerships between county and contract providers as well as reaching across County departments, especially criminal justice partners, to improve and coordinate connections with high-risk beneficiaries. All MHPs received a Met rating based upon multiple strategies for collaborating and coordinating with partner agencies.

Counties have focused on improving their collaboration with other agencies and county departments in the past year. **Merced** collaborates with several CBOs and other agencies, allowing for targeted outreach and service to specific populations, i.e., Latino/Hispanic, Hmong, Laotian, and justice-connected individuals. Relationships with law enforcement and criminal justice were noted as particularly strong in many counties, including **Imperial**, **San Luis Obispo**, **San Mateo**, and **Santa Clara**; partnerships around mobile crisis teams in these counties are evidence of the supportive collaboration. Additionally, **Nevada** actively participates in several multi-county initiatives which allows them to engage in several projects with a minimum number of staff.

Statewide efforts focused on improving access to the crisis end of the behavioral health continuum include three contracts intended to support preparation for and implementation of the state's 988 Suicide and Crisis Lifeline network, as well as a DHCS initiative to develop and implement a Medi-Cal Mobile Crisis benefit. The 988 Suicide and Crisis Lifeline went live on July 1, 2022, and DHCS invested approximately \$53 million in the state's 12 separate 988 call centers from November 2021 through June 2025 to improve call center capacity, training standards, and infrastructure. Assembly Bill (AB) 988¹⁵ (Bauer-Kahan, Chapter 747, Statutes of 2022) is expected to provide additional resources to 988 call centers, mobile crisis teams, and other providers of behavioral health crisis services by requiring health care service plans to reimburse medically necessary treatment of a mental health disorder or SUD. AB 988 additionally established the 988 State Suicide and Behavioral Health Crisis Services Fund, which will support 988 centers and the operation of mobile crisis teams.

The Behavioral Health Continuum Infrastructure Program (BHCIP) has provided unprecedented state funding opportunities to counties, cities, tribal entities, nonprofits, and for-profit organizations allowing the expansion of behavioral health infrastructure around the entire continuum of care for individuals. In 2021, AB 133 authorized DHCS to award \$2.2 billion to support entities to construct, acquire, and expand properties related to behavioral health and invest in mobile crisis infrastructure. BHCIP Round 1 funding was awarded to California county, city, and tribal entity behavioral health authorities to implement or expand mobile crisis infrastructure and limited direct services. DHCS awarded more than \$163 million to 49 entities to fund 245 new or enhanced mobile crisis response teams throughout California.

The new Medi-Cal Mobile Crisis benefit, effective January 1, 2023, is designed to provide qualifying community-based mobile crisis intervention services to eligible Medi-Cal beneficiaries experiencing a mental health and/or SUD crisis. DHCS' policy for this benefit (BHIN 22-064¹⁶) requires Medi-Cal behavioral health delivery systems in each county to collaborate with each other to implement the mobile crisis services benefit, and that all mobile crisis teams, regardless of delivery system, meet the same requirements. Counties are encouraged to implement a fully integrated approach across mental health and SUD delivery systems in which a single mobile crisis services infrastructure serves the entire county.

Collaboration with law enforcement and criminal justice has also served to increase collaboration on homeless outreach and access to housing resources. In **Butte**, for example, the MHP prioritizes housing for beneficiaries as part of its service delivery, recognizing its role as social determinant of health in this county – this is the case in many counties in the state as well.

Strengthening relationships with schools was often cited as a mechanism to better access youth needing mental health services, often due to grant funding made available through the Mental Health Student Services Act.¹⁷ In **Modoc**, the MHP implemented the “Handle with Care” model in local schools to promote whole-school trauma informed care to youth experiencing trauma, and in **Fresno**, the MHP strengthened its partnership with school districts through the All 4 Youth collaborative.

¹⁵ https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB988

¹⁶ <https://www.dhcs.ca.gov/Documents/BHIN-22-064-Medi-Cal-Mobile-Crisis-Services-Benefit-Implementation.pdf>

¹⁷ <https://mhsoac.ca.gov/initiatives/school-mental-health/>

With youth mental health particularly impacted by the pandemic response, enhanced strategies to outreach and provide services to youth is increasingly becoming a priority, and related initiatives will be supported through the Children and Youth Behavioral Health Initiative (CYBHI); MHPs are eligible to apply for this funding. Established as part of the California Budget Act of 2021, the CYBHI is a multiyear, multi-department package of investments that seeks to reimagine the systems, regardless of payer, that support behavioral health for all California's children, youth, and their families. Efforts will focus on promoting social and emotional well-being, preventing behavioral health challenges, and providing equitable, appropriate, timely, and accessible services for emerging and existing behavioral health needs for children and youth ages 0-25. CYBHI is grounded in focusing on equity; centering efforts around children and youth voices, strengths, needs, priorities, and experiences; driving transformative systems change; and using ongoing learning as the basis for change and improvement in outcomes for children and youth.

Service Access and Availability

Table 4-7: Access Key Component 1D – Statewide Ratings

KC #	Key Component – Access	Met	Partially Met	Not Met
1D	Service Access and Availability	53	3	0

Nearly half of all MHPs (25) added new programs and additional positions to strengthen the continuum of services available, even during a pandemic and prolonged workforce shortage. Many new programs were implemented as part of a collaborative and often targeted toward underserved and high-risk populations.

One of the ways in which MHPs enhance access to care is through improvements to their intake processes. **Lake** expanded its access team and redesigned the intake process, while **Glenn** and **Riverside** developed PIPs to formalize intake improvement efforts. **Del Norte** created a new access and screening process and a Same Day Service Team to respond to immediate needs.

Counties have expanded and strengthened the crisis continuum of care, with a significant emphasis on community-based crisis intervention. For example: **Mendocino** implemented its first mobile crisis program with the Sheriff's Office; **Tuolumne** secured a grant to create a crisis response team; **Solano** implemented community crisis response and school-based crisis programs; **Yolo** is participating in a crisis system redesign based on the Crisis Now Model which bridges 24/7 access for both mental health and SUD crisis; **Calaveras**, **San Joaquin**, and **El Dorado** implemented Family Urgent Response System programs; **Shasta** collaborated with a local hospital to create a six bed Crisis Stabilization Unit (CSU) in the emergency department; **Contra Costa** is developing an eight bed children's CSU; and **San Luis Obispo** incorporated a walk-in model for services at its CSU.

On the other hand, some County websites are not necessarily user friendly for a person seeking mental health services. In at least 8 counties the review team found it difficult to locate a phone number to call for service access or a hotline for individuals in crisis.

ACCESS PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect access to care in the MHP:

- Total beneficiaries served, stratified by MHP size, region, race/ethnicity, and threshold language
- PR of beneficiaries served
- AACB served

The following information provides details on Medi-Cal eligibles and beneficiaries served by county size, region, race/ethnicity, and threshold language, first in a table showing numbers served.

The race/ethnicity data can be viewed as a representation of how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served. This is shown in Table 4-8 below when comparing “% eligibles.”

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligibles. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count.

The average eligible count is used because enrollment may vary greatly from month to month; therefore, the annual total and PR account for the monthly fluctuations in Medi-Cal enrollment. The AACB per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

Table 4-8: Statewide PR and AACB, CY 2018-20

	Average Monthly Eligibles	Total Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2018	13,280,566	618,977	4.66%	\$3,994,630,000	\$6,454
CY 2019	12,914,806	627,928	4.86%	\$3,966,010,000	\$6,316
CY 2020	13,089,479	595,596	4.55%	\$4,261,350,000	\$7,155

The number of Medi-Cal eligibles and the AACB increased in 2020, whereas the number of beneficiaries served and the PR decreased. Overall, PRs were highest in 2019 (4.86 percent) and decreased by 6.38 percent in 2020 (to 4.55 percent). AACB increased across all size counties in 2020, on average 13 percent statewide. This is likely due to federal approvals to increase interim rates during the pandemic and longer lengths of stay for inpatient care. (Table 4-8)

Tables 4-9 through 4-11 stratify this information by county size, region, and race/ethnicity. In addition to PR, these tables display the percentage each category represents in the total eligible or total beneficiary population, (e.g., for each year, the total eligibles will equal 100 percent and the total beneficiaries served will equal 100 percent). Noting the difference in the proportion of beneficiaries served compared to the proportion of eligible provides another perspective of where disparities may exist.

Table 4-9: Eligibles and Beneficiaries Served by County Size, CY 2018-20

Category	# of Beneficiaries Served	# of Eligibles	% of Beneficiaries Served	% of Eligibles	PR	AACB
Very Large						
CY 2018	210,337	3,964,272	34.09%	29.85%	5.31%	\$6,176
CY 2019	221,136	3,843,353	35.32%	29.76%	5.75%	\$6,256
CY 2020	212,272	3,866,435	35.74%	29.54%	5.49%	\$6,748
Large						
CY 2018	280,189	6,494,707	45.41%	48.90%	4.31%	\$6,750
CY 2019	278,182	6,323,746	44.43%	48.97%	4.40%	\$6,219
CY 2020	265,801	6,434,454	44.75%	49.16%	4.13%	\$7,156
Medium						
CY 2018	85,397	2,053,900	13.84%	15.47%	4.16%	\$6,785
CY 2019	84,704	1,993,115	13.53%	15.43%	4.25%	\$7,143
CY 2020	78,220	2,021,916	13.17%	15.45%	3.87%	\$8,399
Small						
CY 2018	32,502	655,800	5.27%	4.94%	4.96%	\$5,602
CY 2019	33,219	644,702	5.31%	4.99%	5.15%	\$5,982
CY 2020	29,631	654,201	4.99%	5.00%	4.53%	\$7,142
Small-Rural						
CY 2018	8,628	111,888	1.40%	0.84%	7.71%	\$3,794
CY 2019	8,877	109,891	1.42%	0.85%	8.08%	\$4,310
CY 2020	8,002	112,476	1.35%	0.86%	7.11%	\$6,238

All sized MHPs showed lower overall PRs in CY 2020 compared to CY 2019. Across the three-year period, over one-third of the California beneficiaries served received services in the Very Large County, Los Angeles, where less than 30 percent of the eligibles reside; therefore, Los Angeles has a significant impact on the statewide data.

Los Angeles showed a smaller decrease of 4.5 percent in its PR (from 5.75 percent to 5.49 percent). Large and medium MHPs serve fewer beneficiaries compared to the eligibles that reside in those counties, with medium MHPs showing the lowest PR at 3.87 percent. Small-rural MHPs continue to demonstrate relatively high PR compared to statewide averages, but they showed the most significant decrease (12 percent) from 2019 to 2020. Furthermore, across the years, 6 to 7 percent of the state's beneficiaries are served in small/small-rural MHPs, and 5 to 6 percent of the state's eligibles live in those counties. (Table 4-9)

Table 4-10: Eligibles and Beneficiaries Served by County Region, CY 2018-20

Category	# of Beneficiaries Served	# of Eligibles	% of Beneficiaries Served	% of Eligibles	PR	AACB
Bay Area						
CY 2018	107,905	2,087,709	17.49%	15.72%	5.17%	\$10,211
CY 2019	108,028	2,012,246	17.25%	15.58%	5.37%	\$9,352
CY 2020	101,477	2,041,248	17.09%	15.59%	4.97%	\$11,056
Central						
CY 2018	96,284	2,378,549	15.60%	17.91%	4.05%	\$5,156
CY 2019	95,006	2,327,951	15.17%	18.03%	4.08%	\$5,071
CY 2020	89,987	2,365,670	15.15%	18.07%	3.80%	\$6,237
Los Angeles						
CY 2018	210,337	3,964,272	34.09%	29.85%	5.31%	\$6,176
CY 2019	221,136	3,843,353	35.32%	29.76%	5.75%	\$6,256
CY 2020	212,272	3,866,435	35.74%	29.54%	5.49%	\$6,748
Southern						
CY 2018	177,370	4,437,502	28.74%	33.41%	4.00%	\$5,314
CY 2019	176,209	4,329,683	28.14%	33.52%	4.07%	\$5,195
CY 2020	167,130	4,413,347	28.14%	33.72%	3.79%	\$5,785
Superior						
CY 2018	25,165	412,535	4.08%	3.11%	6.10%	\$5,753
CY 2019	25,754	401,573	4.11%	3.11%	6.41%	\$6,388
CY 2020	23,077	402,780	3.89%	3.08%	5.73%	\$7,391

Showing a pattern similar to prior years, in 2020, the Bay Area held 15.59 percent of the state's eligibles and 17.09 percent of the state's beneficiaries served. An inverse relationship is seen in the central valley and southern regions where more eligibles are represented but proportionately fewer beneficiaries are served. (Table 4-10)

As noted earlier, the increase in average approved claims occurred broadly across the state, increasing the averages by MHP size and by MHP region. Notably, the largest increase in average claims occurred in the Bay Area. Already the highest region for AACB, the Bay Area increased by 18.22 percent between 2019 and 2020.

San Francisco appears to have initiated this trend early in the pandemic response; it increased rates for community-based providers whose fiscal viability depended upon delivering units of service to cover expenses. San Francisco assured its contracted agencies fiscal stability by funding 1/12 of their annual contracts monthly despite an expected decrease in units of service provided. Many other counties, though not all, followed similarly or used other methodologies to help offset anticipated financial losses in contract agencies due to fewer units of services delivered.

Table 4-11: Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2018-20

Category	# of Beneficiaries Served	# of Eligibles	% of Beneficiaries Served	% of Eligibles	PR	AACB
African American						
CY 2018	80,235	1,004,291	13.01%	7.56%	7.99%	\$6,916
CY 2019	83,567	984,839	13.31%	7.63%	8.49%	\$6,726
CY 2020	77,980	976,616	13.09%	7.46%	7.98%	\$7,393
Asian/Pacific Islander						
CY 2018	29,595	1,316,629	4.80%	9.91%	2.25%	\$6,557
CY 2019	29,007	1,284,330	4.62%	9.94%	2.26%	\$6,325
CY 2020	27,310	1,285,115	4.59%	9.82%	2.13%	\$7,466
Hispanic/Latino						
CY 2018	252,104	6,677,877	40.89%	50.28%	3.78%	\$5,904
CY 2019	265,989	6,519,605	42.36%	50.48%	4.08%	\$5,869
CY 2020	250,391	6,531,536	42.04%	49.90%	3.83%	\$6,551
Native American						
CY 2018	3,689	53,655	0.60%	0.40%	6.88%	\$7,149
CY 2019	3,885	51,789	0.62%	0.40%	7.50%	\$6,769
CY 2020	3,435	50,821	0.58%	0.39%	6.76%	\$7,908
White						
CY 2018	163,485	2,514,792	26.52%	18.94%	6.50%	\$6,093
CY 2019	161,683	2,401,489	25.75%	18.59%	6.73%	\$6,167
CY 2020	149,074	2,379,061	25.03%	18.18%	6.27%	\$7,137
Other						
CY 2018	87,406	1,713,326	14.18%	12.90%	5.25%	\$8,175
CY 2019	83,797	1,672,756	13.35%	12.95%	5.01%	\$7,588
CY 2020	87,406	1,866,332	14.68%	14.26%	4.68%	\$8,575

The decrease in numbers served and PR, along with an increase in AACB, seen in all regions and county sizes, is also seen in all race/ethnicity groups – also at varying rates of change. (Table 4-11)

The Asian/Pacific Islander population, long showing the lowest PR, experienced the smallest PR decrease, but the largest AACB increase (18.40 percent). The Asian/Pacific Islander population is relatively small, representing just under 10 percent of Medi-Cal eligibles and 4.59 percent of the beneficiaries served. The A/PI population had the lowest PR in all three years displayed, suggesting unmet need is most significant among this group.

The most significant PR decreases were in the Hispanic/Latino, Native American, and White populations, decreasing by 6.13 percent, 9.87 percent, and 6.84 percent, respectively. The Native American population also showed a significant increase in AACB by 16.83 percent, but it is a very small proportion of beneficiaries and represents less than a half percent of all Medi-Cal eligibles. The Hispanic/Latino population represents 50 percent of the Medi-Cal population and

is under-represented in the beneficiary population served, at about 42 percent. Their AACB increase of 11.62 percent to \$6,551 contributes significantly to the statewide average increase but remains 8.21 percent below the White AACB at \$7,137. The White population is over-represented in the beneficiaries served (25 percent) and is only 18 percent of the eligible population. African Americans showed the smallest increase in AACB at 9.91 percent; they continue to be over-represented in the service population at about 7.5 percent of the eligibles and 13 percent of the beneficiaries served.

Table 4-12: Threshold Language of Medi-Cal Beneficiaries Served, CY 2020

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by MHPs	Percentage of Medi-Cal Beneficiaries Served by MHPs
Spanish	98,036	15.72%
Vietnamese	3,486	0.56%
Cantonese	2,152	0.35%
Armenian	1,423	0.23%
Arabic	999	0.16%
Mandarin	757	0.12%
Korean	731	0.12%
Farsi	719	0.12%
Russian	660	0.11%
Hmong	615	0.10%
Cambodian	531	0.09%
Tagalog	294	0.05%
TOTAL	110,403	17.71%
Threshold language source: Open Data per BHIN 20-070		

Over 110,000 beneficiaries speaking threshold languages were served across the state. This represented 17.71 percent of all beneficiaries served by MHPs. Many other languages are spoken across counties that are not included in the above table because those languages did not meet the threshold criteria in that county. Some counties have languages that hover at the threshold and may become threshold one year and not the next; often these counties operate as if those languages are threshold languages given their significant prevalence locally. (Table 4-12)

Table 4-13: Medi-Cal Expansion (ACA) Penetration Rate and AACB, CY 2020

	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2018	3,807,829	152,568	4.01%	\$832,986,475	\$5,460
CY 2019	3,719,952	159,904	4.30%	\$824,153,538	\$5,154
CY 2020	3,835,638	155,154	4.05%	\$934,903,862	\$6,026

ACA beneficiaries represent 29 percent of the eligibles and 26 percent of the beneficiaries served, with a PR of 4.05 percent compared to the overall PR of 4.55 percent. Their lower PR and lower AACB align with the population qualifying for Medi-Cal due to family size and income level rather than significant disability. (Table 4-13)

Table 4-14: ACA Eligibles, Beneficiaries Served, and Penetration Rates by Region, CY 2020

Region	Average Number of Medi-Cal Beneficiaries per Month	ACA Percentage of Overall Medi-Cal Eligibles	Number of ACA Beneficiaries Served per Year	ACA Percentage of Beneficiaries Served per Year	ACA Penetration Rate
Statewide	3,835,638	29%	155,154	26%	4.05%
Bay Area	610,800	30%	25,402	25%	4.16%
Central	605,069	26%	20,755	23%	3.43%
Los Angeles	1,235,310	32%	57,934	27%	4.69%
Southern	1,269,042	29%	45,027	27%	3.55%
Superior	115,418	29%	5,649	24%	4.89%

While ACA eligibles represent 29 percent of the total Medi-Cal enrollment, they represent 26 percent of the MHP beneficiaries served.

The ACA pattern in PR and claims varies slightly when viewing the state's regions. Fewer ACA beneficiaries receive SMHS in the central and southern regions. (Table 4-14)

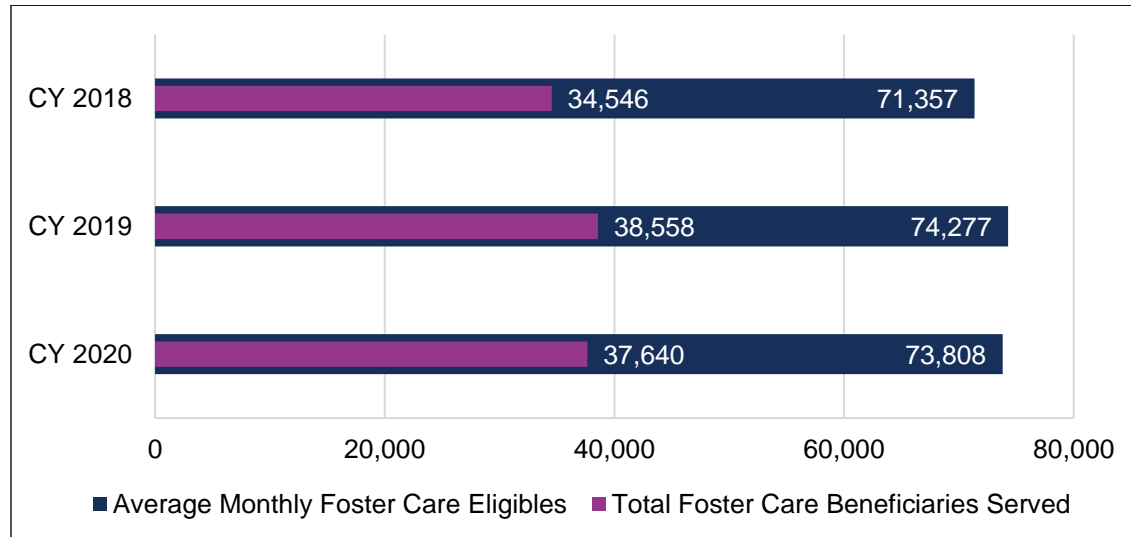
Table 4-15: ACA Approved Claims by MHP Region, CY 2020

Region	ACA Total Approved Claims	ACA AACB
Statewide	\$934,903,862	\$6,026
Bay Area	\$222,723,081	\$8,768
Central	\$119,527,634	\$5,759
Los Angeles	\$315,468,609	\$5,445
Southern	\$244,751,614	\$5,436
Superior	\$31,102,790	\$5,506

All regions show lower AACB for the ACA beneficiaries than the overall Medi-Cal AACB. As is the case overall, the Bay Area shows much higher claims for the CA population at \$8,768 where all other regions are over \$3,000 lower. (Table 4-15)

Foster Care

Figure 4-6: Medi-Cal Eligibles and Beneficiaries Served, Foster Care, CY 2018-20



Services to foster youth have fluctuated over the last three years. In 2019, the state had the largest number of foster youth and the largest number served. In the following year, the first year of the COVID-19 pandemic, the number of foster youth in services decreased by 918 youth. Given the complex needs of foster youth, the decrease in access to services to this population warrants significant attention if this trend continues. (Figure 4-6)

Figure 4-7: Foster Care Penetration Rate by MHP Size, CY 2018-20

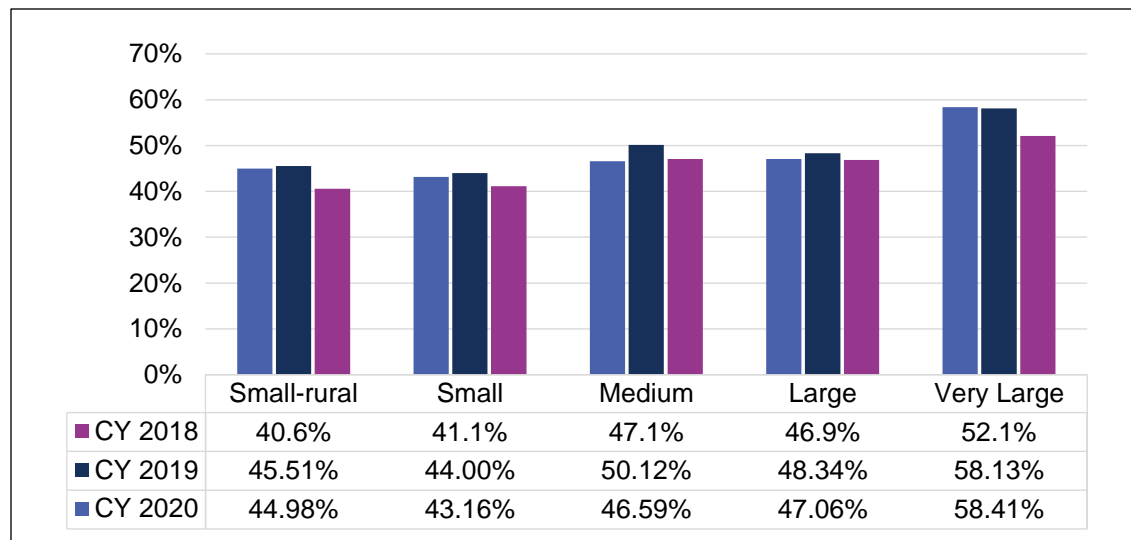
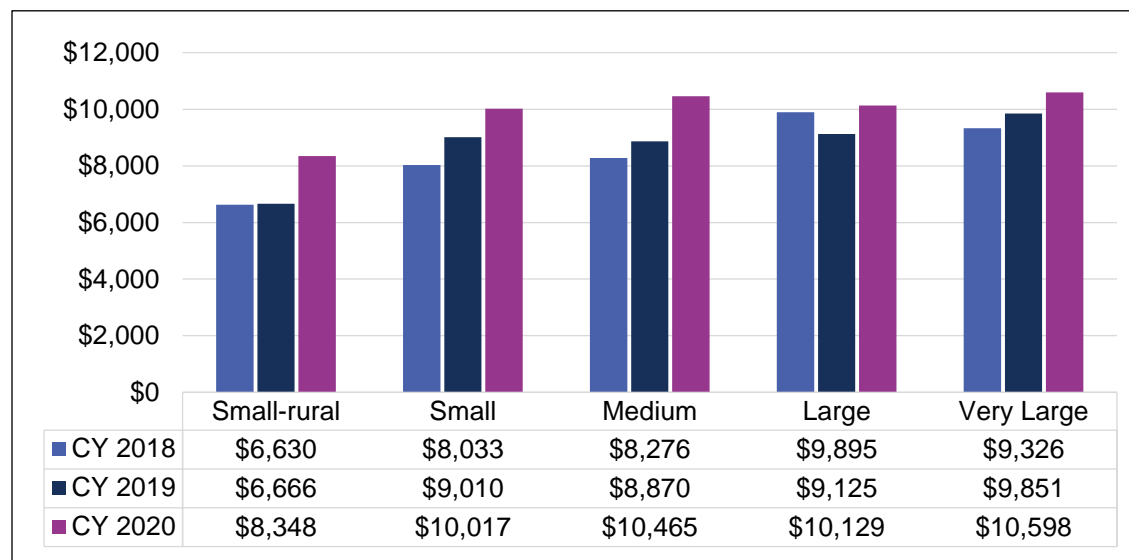


Figure 4-7 shows the FC PR decreased by 6.74 percent across the three years, a little more than the overall statewide PR decrease seen in Table 4-8. Small-rural MHPs showed the lowest PR for FC in the three-year period.

Figure 4-8: Foster Care AACB by MHP Size, CY 2018-20

The 10.45 percent increase in AACB for FC is a smaller increase than is seen statewide. Medium-sized MHP AACB for FC increased by 18 percent in 2020. Previously the lowest AACB, in 2020 it was on par with the statewide average. As with PR, small-rural MHPs showed the lowest AACB for FC in all three years. (Figure 4-8)

SUMMARY OF ACCESS FINDINGS

Access to care decreased in CY 2020 compared to the two previous years, measured by both numbers served and PR. This trend was observed across all regions, county sizes, and demographic groups analyzed. This decrease is likely a result of the pandemic and related “stay at home orders” followed by personal decisions to isolate to avoid COVID-19 exposure. Given the lower PRs, outreach and engagement to underserved populations remains an important statewide priority. It will be important to monitor a return to pre-pandemic access patterns, when numbers served and PR were at their highest, in CY 2019.

From CY 2019 to CY 2020, the overall decrease in PR by 6.38 percent impacted all race/ethnicity groups. Hispanic/Latino (at 3.83 percent) and A/PI (at 2.13 percent) continue to have the lowest PRs of the race/ethnicity groups. Nevertheless, Hispanic/Latino beneficiaries are a predominant population served, representing half of the eligible population and 42 percent of beneficiaries served statewide. Conversely, the A/PI population has represented just under 10 percent of the Medi-Cal eligibles and between 4.59 percent (in CY 2020) and 4.80 percent (in CY 2018) of the beneficiaries served statewide over the three-year period. The A/PI population is proportionately most underserved.

Since the inception of NA standards, MHPs have trended toward compliance. All but one MHP met time or distance standards directly or through an approved AAS. The majority (52 of 56) met all time or distance standards directly, and three MHPs resolved the issue by providing telehealth services.

In CY 2020, the overall AACB increased across all regions, sizes, and demographic groups analyzed. This may represent more services or more high-cost services, but it is also likely to be impacted by rate adjustments in claiming, as fewer units of service result in higher costs per

unit. Additionally, the increase in inpatient care, namely longer lengths of stay, mostly in large MHPs, is also a factor in this statewide increase and is discussed later in this report.

MHPs remain alert to access challenges that beneficiaries face, especially when access is shown to be disproportionate by race/ethnicity or other factors related to diversity and equity. While telehealth bridges the gap for many, it is a barrier for others. Providing telehealth to those beneficiaries who benefit from it and maintaining a workforce that desires at least some time working from home requires careful matching of the proper service modality for beneficiaries.



Timeliness

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is an important component of beneficiary engagement, retention, and the 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 MHP 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 to ensure timely entry into care at all possible points of access to the service delivery systems. Further, if overall access, or access through a particular point of entry, is not meeting State and or local expected time frames, improvement activities are necessary to improve access to medically necessary services.

CalEQRO developed the MHP Assessment of Timely Access (ATA) to provide a systematic approach to gather information from MHPs to evaluate how MHPs track and report timeliness data and evaluate their system performance on key timeliness metrics. MHPs are asked to submit the raw data as well as average wait times and percentage of appointments and services that met either DHCS or self-defined standards, at key points in care. This data should be viewed as two categories: 1) reliable and valid tracking of timeliness data elements, and the comprehensiveness of that data and reporting, and 2) timeliness performance, the actual wait time for service, and the responsiveness of the MHP when performance does not meet expected standards of care.

The six timeliness PMs on which MHPs are asked to report in the ATA include compliance metrics identified by DHCS (timeliness to first offered appointments), Healthcare Effectiveness Data and Information Set (HEDIS®) metrics (timeliness related to inpatient hospitalization), and additional quality metrics identified by CalEQRO (timeliness to delivered services and no-show rates) as key indicators to evaluate systemwide timely access to quality care.

In the ATA, MHPs are asked to report timeliness data stratified by age (adults and youth) and FC status for the entire service delivery system, inclusive of county-operated and contractor-operated services. Reporting on the three identified demographics for all metrics for the entire service delivery system at all points of entry is a complex task for MHPs. Timeliness reporting is often limited to an incomplete data set of those who initiate care (e.g., not inclusive of all entry points such as directly through contracted agencies, or co-located programming Child Welfare, schools, jails, or other access locations that may not be well connected to the MHP's Access Line and/or the access records maintained in the EHR), and therefore may not present a true reflection of how quickly a typical beneficiary can be served. The vast majority of MHPs reported in FY 21-22 on the prior FY in their ATA, but some reported on CY 21 and a few reported partial years such as 9-month periods based upon the timing of their EQR.

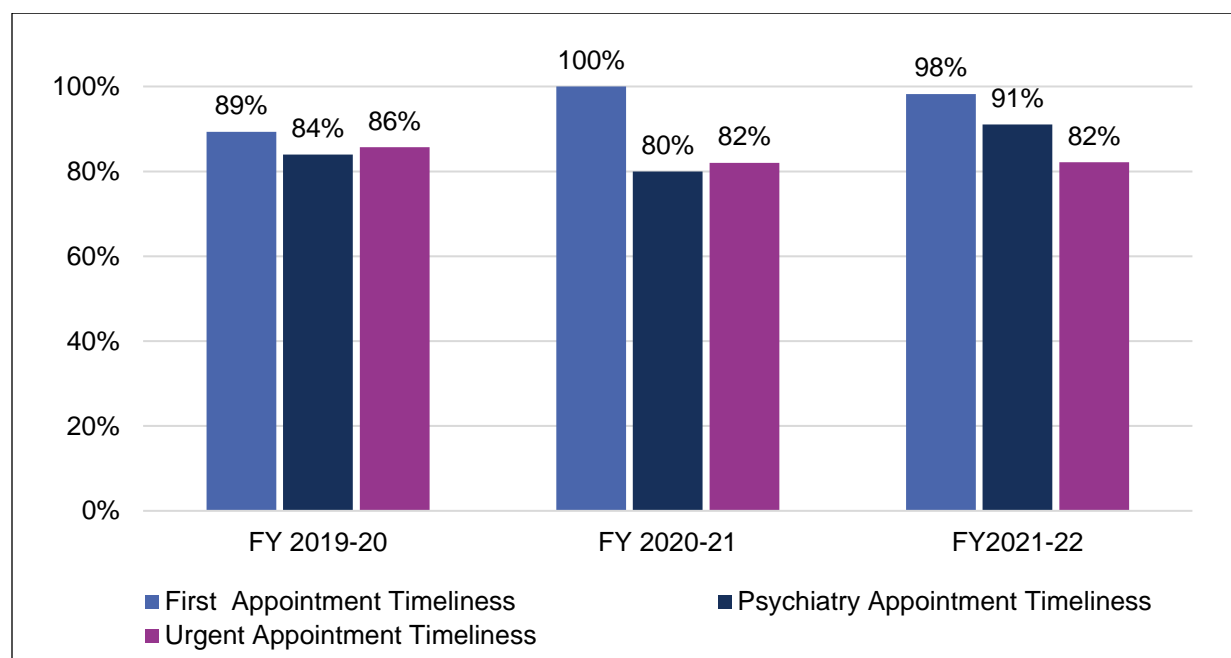
Routine monitoring is essential because timeliness can vary tremendously quarter to quarter, or month to month, due to variation in service demand and fluctuations in the available workforce. Variability of beneficiary service requests; unanticipated workforce retirements, resignations, and medical leaves of absence; and a statewide shortage of behavioral health workforce have impacted the quantity of services provided and the timeliness in which those services are

offered. At many times across the State, demand for services has exceeded the capacity to provide those services in a timely manner. To provide timely access to care, many MHPs have had to sacrifice care in other areas of the system. This creates a nearly insurmountable challenge for MHPs that strive to provide the “right service at the right time” for ongoing care. With the unprecedented workforce shortage, never has this struggle been so significant.

TIMELINESS REPORTING CAPABILITIES

The overall capabilities for MHPs to collect and report data associated with the required timeliness metrics are largely unchanged, shown below in Figure 5-1. The exception is a marked increase in the tracking of psychiatry services, which increased from 80 percent of MHPs to 91 percent of MHPs. Variation from year to year within given MHPs may be impacted by implementation of new EHRs and turnover in responsible staff – especially in smaller MHPs, where often only one staff person is trained for particular tasks, and absent documented procedure for new staff.

Figure 5-1: Capability to Report Timeliness Metrics, FY 2019-22



In addition to reporting on overall timeliness metrics, most MHPs report the ability to capture detailed aspects, such as timeliness by race/ethnicity, referral source, and point of entry. However, while they collect this data, few analyze it to identify variations in ease of access.

Smaller MHPs still rely quite heavily on manual spreadsheets that are outside of their EHR for timeliness tracking. Some of this is likely improving due to the mandated timeliness reporting that is required by DHCS. It also appears that the data reported to DHCS through electronic upload may differ from the data being reported in the ATA document; this may be due to different reporting periods or the inclusion of payor sources other than Medi-Cal in the ATA data. Additionally, as many MHPs look to transition to a new EHR over the next year, it will

require time to ensure that the proper data elements are collected so that the necessary timeliness reports can be extracted.

Completeness of Timeliness Data

The degree to which the timeliness data submitted in the ATA is “complete” as a reflection of all points of service access varies across MHPs. The degree to which contract providers serve as points of entry, and whether there is electronic data exchange or comprehensive tracking, impacts whether the MHP is submitting data which includes all beneficiaries who entered services. Additionally, MHPs may be able to evaluate one metric but not another. The following charts indicate the extent to which each measure reflects the entire service system, only the county-operated services, a nuanced subset, or if it is not tracked. Within each timeliness metric is a description of how many MHPs and what sizes are reporting on the entire service delivery system.

This data provides a context for the actual timeliness reported by MHPs, where “county-operated” reporting only is likely to reflect an incomplete data set, unless MHP procedures require entry to care through county-operated assessment.

In Figure 5-2, 39 MHPs (70 percent) reported tracking the first non-urgent service offered for the entire service delivery system. Fifteen MHPs reported only for county-operated programming. This performance drops by one MHP to “not tracked” when reporting on the actual first service delivered, in Figure 5-3. MHPs where “other” describes their dataset generally reflects an incomplete data set of County, contractor, or both.

Figure 5-2: Data Set Reported in FY 2021-22 for Offered Appointments

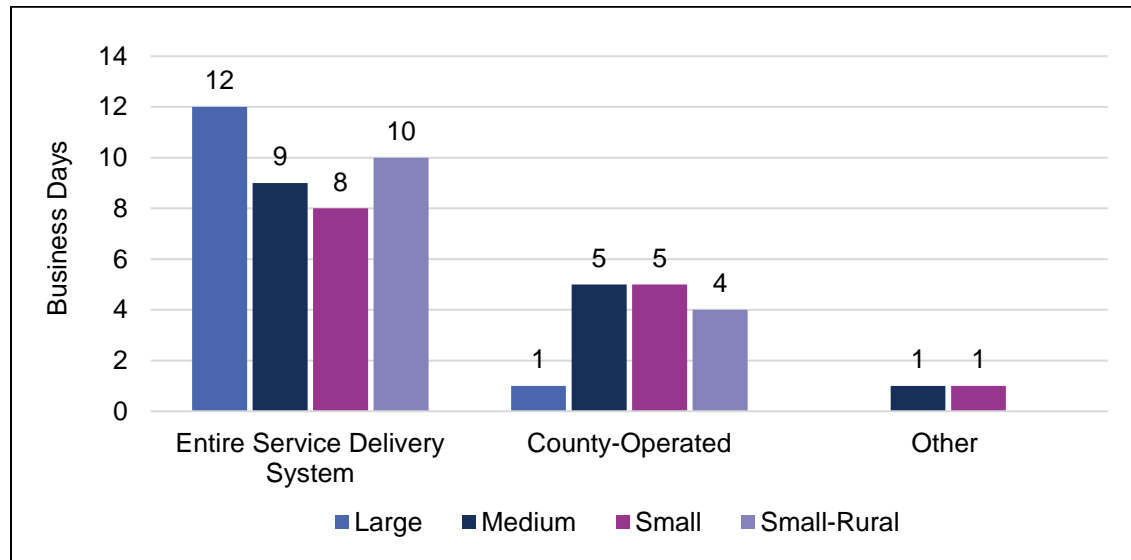


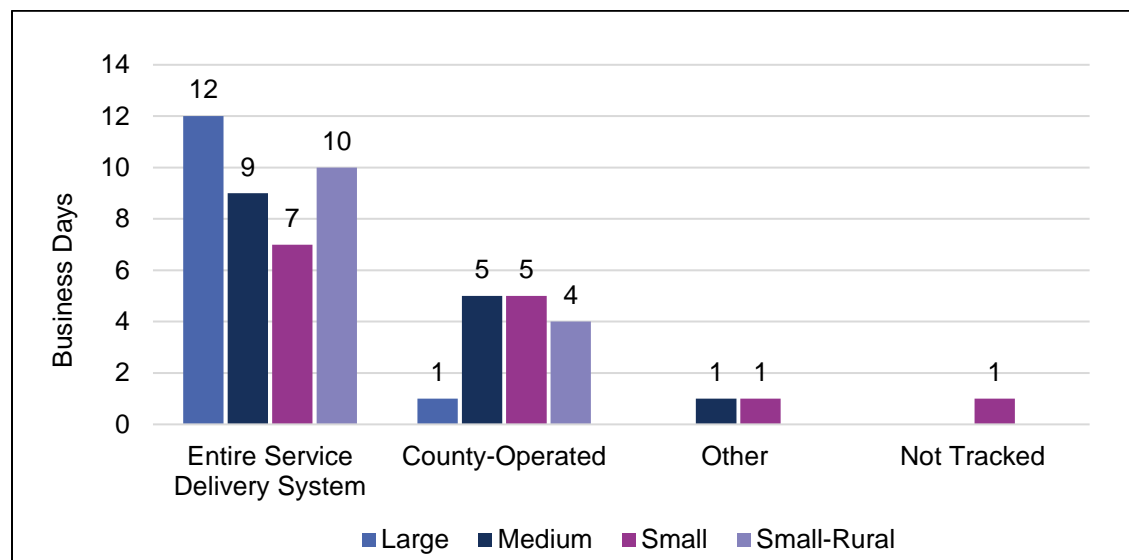
Figure 5-3: Data Set Reported in FY 2021-22 for First Delivered Service

Figure 5-4 shows MHP ability to track and report on psychiatry access. MHPs are somewhat less comprehensive in reporting timely access to psychiatry, with fewer reporting entire system wait time (county-operated only) for the first offered non-urgent psychiatry service, and two MHPs not able to report at all. Figure 5-5 shows a reduction in entire system reporting for first delivered non-urgent psychiatry services, and four MHPs are not able to report on this wait time at all. It is a challenge for many MHPs to report on psychiatry if they do not track the date of referral, especially in children's services where psychiatry is often considered weeks to months into outpatient care.

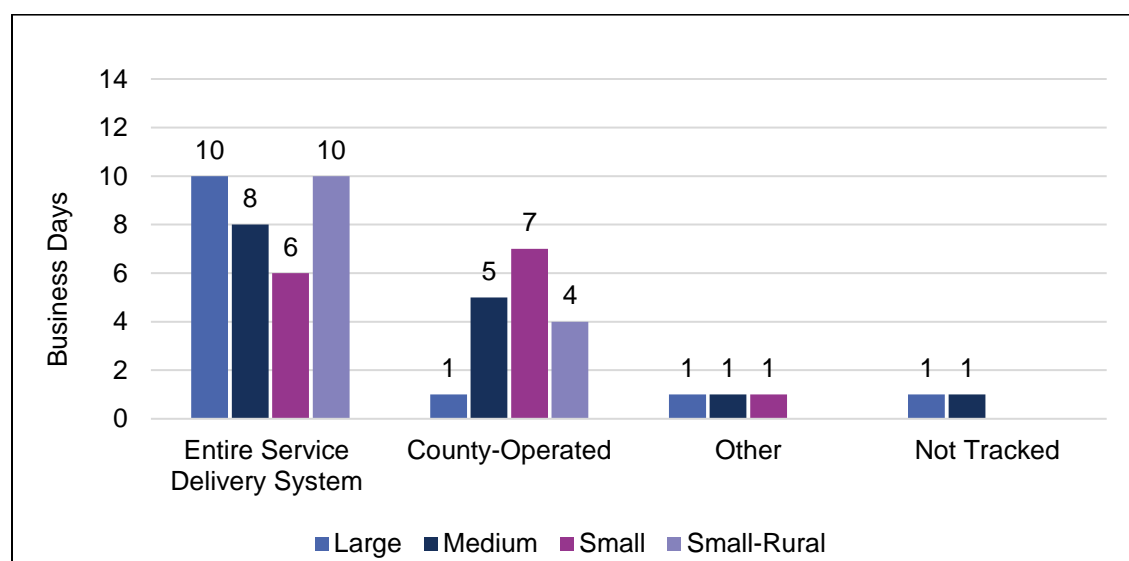
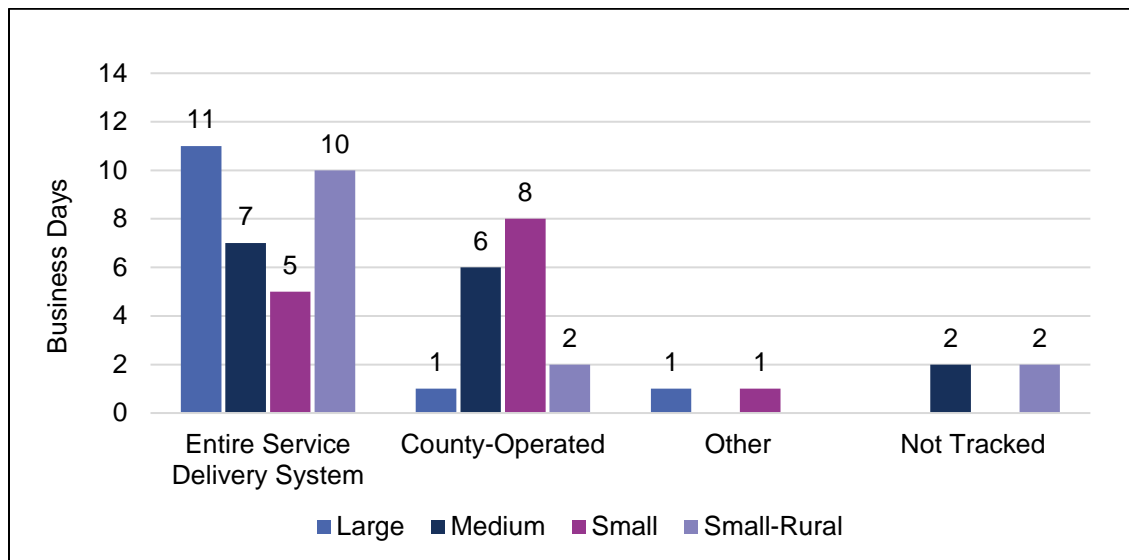
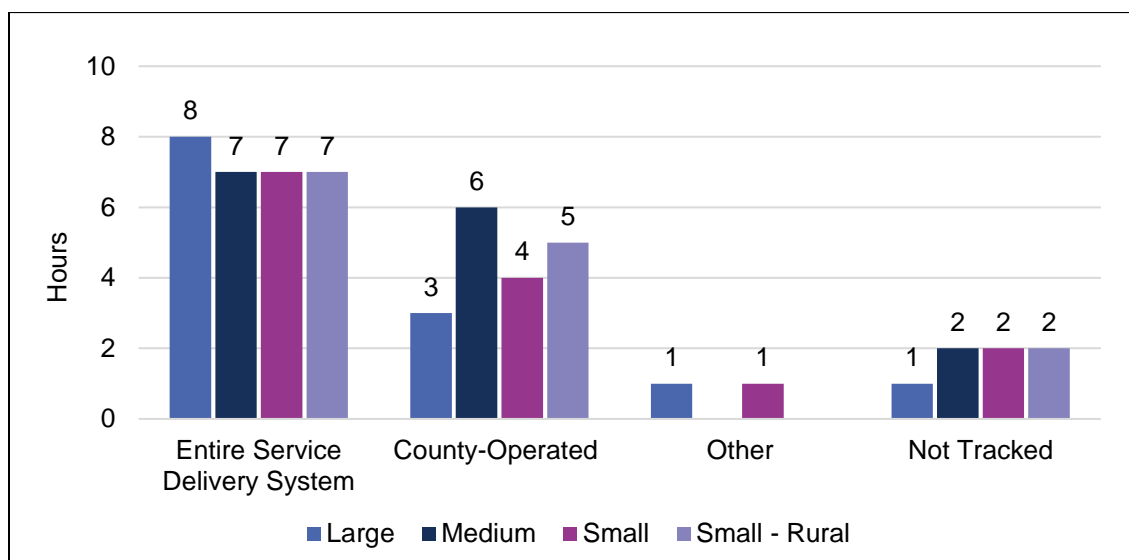
Figure 5-4: Data Set Reported in FY 2021-22 for First Psychiatry Appointment Offered

Figure 5-5: Data Set Reported in FY 2021-22 for First Psychiatry Service Delivered

Shown below in Figure 5-6, MHPs are least successful at reporting urgent services. This metric has the fewest counties reporting on the entire service delivery system, and the greatest number of counties (n=7) that cannot report on this metric at all.

Additionally, while MHPs must deliver urgent services that do not require pre-authorization within 48 hours, the definition of what is an “urgent” presentation by a beneficiary (clinical criteria), and what is a type of “urgent service” delivered (a responsive phone call, an outpatient SMHS, or an admission to a CSU), varies tremendously. This adds a significant degree of unreliability to comparing urgent wait times across MHPs presented later in this chapter.

Figure 5-6: Data Set Reported in FY 2021-22 for Urgent Services

TIMELINESS KEY COMPONENTS AND PERFORMANCE

In addition to the data reported by MHPs presented earlier in this chapter, CalEQRO also evaluates timeliness performance based upon two main sources: 1) the MHP-report of actual wait times through the ATA, and 2) Key Component 2A through 2F, which also correspond with the metrics submitted in the ATA:

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

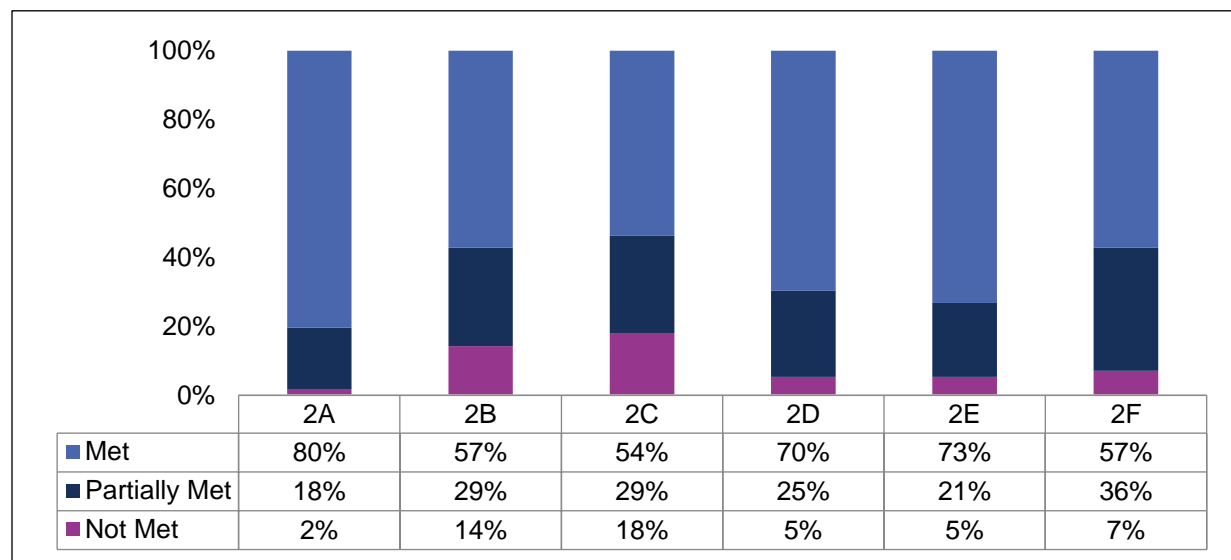
Based upon processes in place as defined in the Key Components document¹⁸, CalEQRO evaluates the MHP's oversight of timely access to care. Specifically, the Key Components evaluate whether the MHP sets a standard, routinely tracks and trends the data, evaluates its performance through routine data analysis, and initiates performance improvement processes.

The two methods of evaluation may result in different findings associated with the same timeliness metric. For example, a county may submit its ATA with data that shows compliance with the DHCS timeliness standard, yet the county provided no evidence that it routinely tracks and trends this data or initiates necessary performance improvement processes at any point outside of the EQR preparation. In that scenario, the Key Component rating may be Not Met despite the annual reporting showing timely service access. Conversely, a county may not have met the timeliness standard, but it demonstrated robust tracking mechanisms, routine data review, and rigorous performance improvement processes to improve timely access. In that scenario, the Key Component rating may be Met, despite not meeting timely access standards.

Overall, MHPs have prioritized reporting on at least some of the timeliness metrics, as this has been an expectation of the EQRO review for several years. The quality of this reporting, and the activities that follow upon review of poor timeliness results, varies tremendously and is a key factor in the Key Component ratings.

A summary of statewide performance is depicted in Figure 5-7 below, and a summary of each component follows in Tables 5-1 through 5-6.

¹⁸ Detailed definitions for each of the review criteria in the Key Components form can be found on the CalEQRO website, www.caleqro.com

Figure 5-7: Summary of Timeliness Oversight Key Components, Statewide

Thirteen MHPs (23 percent) Met all Timeliness Key Components: **Alameda, Alpine, Colusa, Kings, Mariposa, Mendocino, Modoc, San Diego, San Joaquin, Stanislaus, Tulare, Tuolumne, and Ventura**. When considering both Met and Partially Met results on all Timeliness, 39 MHPs (70 percent) showed strong Timeliness results. Only one small MHP rated “Not Met” on all but one Key Component.

Initial Outpatient Mental Health Services

Table 5-1: Timeliness Key Component 2A – Statewide Ratings

KC #	Key Component – Timeliness Oversight	Met	Partially Met	Not Met
2A	First Non-Urgent Request to First Offered Appointment	45	10	1

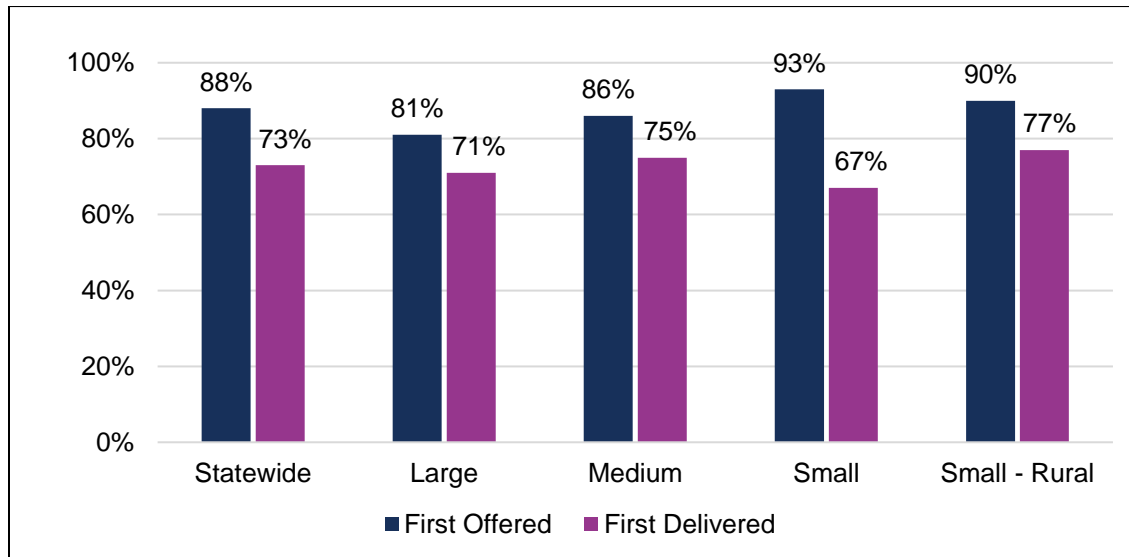
This component is defined as “the MHP has a methodology to collect data related to first offered appointment. The MHP tracks and trends the data routinely and establishes performance improvement processes when warranted.”

Of the 6 timeliness components, MHP performance was strongest on Key Component 2A, with 45 MHPs earning Met ratings and only 1 MHP failing to meet the Key Component at all. For this item, setting the appropriate standard and measuring at least two of the three demographic groups (adults, youth, foster youth) earns a Partially Met rating. To be fully met, if the MHP is measuring for all groups, then two of the following three must be met: the entire system is reported (unless there are no contract providers), the data is routinely reviewed and evaluated, and if there is poor performance, the MHP initiates improvement activities. As is the case across the Key Components, MHPs must demonstrate a coherent strategy aimed at improving timeliness of care to warrant a Met rating.

Using the ATA, CalEQRO reviews two metrics associated with accessing initial outpatient mental health services: the first offered appointment (also tracked by DHCS), and the first delivered service, which are detailed in the figures below. MHPs provide information regarding the average wait time and the percent of appointments that met the timeliness standards. For

the initial offered appointment, DHCS expected a minimum of 70 percent of offered appointments to meet the 10-business day standard in FY 2021-22.

Figure 5-8: Average Percent Meeting 10-day Timeliness Standard for First Service, Reported in FY 2021-22



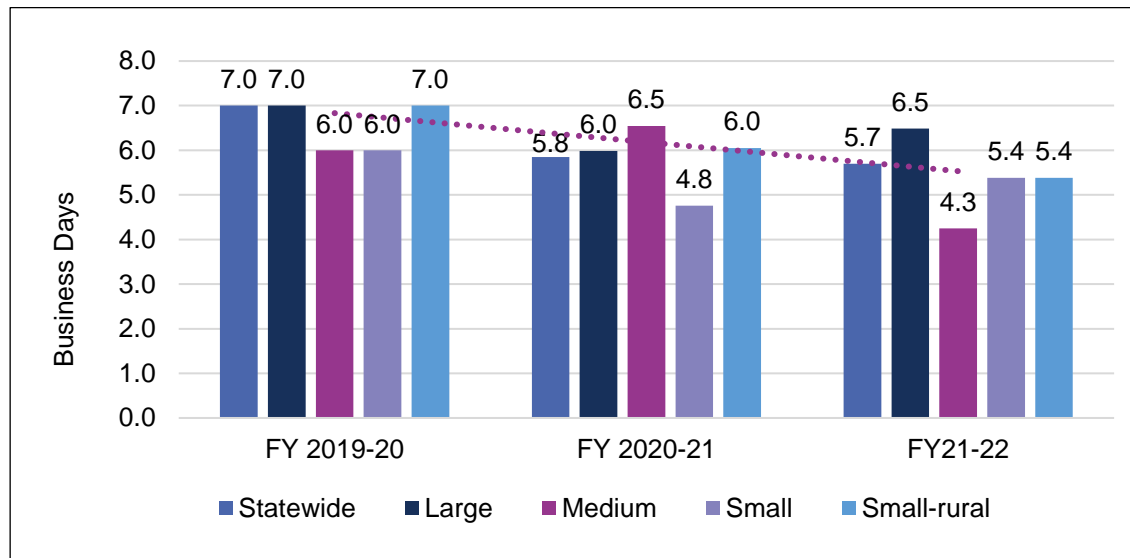
Overall, the statewide average (calculated using counties' percent meeting standards) shows that services were offered timely 88 percent of the time, when averaging each MHP's percentage meeting the standard for the total population. Small-rural and small MHPs offered appointments within 10-business days an average of 90 and 93 percent of the time, respectively. The lowest performance was seen in large counties that met the standard for 81 percent of services offered. (Figure 5-8)

Of the 55 MHPs that reported on this measure, 45 met the 10-business day standard for the overall population (combining adults and youth), at least 70 percent of the time (the threshold established in BHIN 21-023).

Some MHPs met the standards overall but not for all populations and vice versa. Despite meeting the overall standard, one of the largest MHPs did not meet the minimum for children, and four (medium and large MHPs) did not meet it specifically for the foster youth population. Conversely, of the 11 MHPs that did not meet standard for their combined populations, four MHPs met it for adults and another six met it for children. Of the 50 MHPs reporting this measure for the foster youth population, 42 reported meeting the threshold; 6 MHPs did not stratify FC timeliness data.

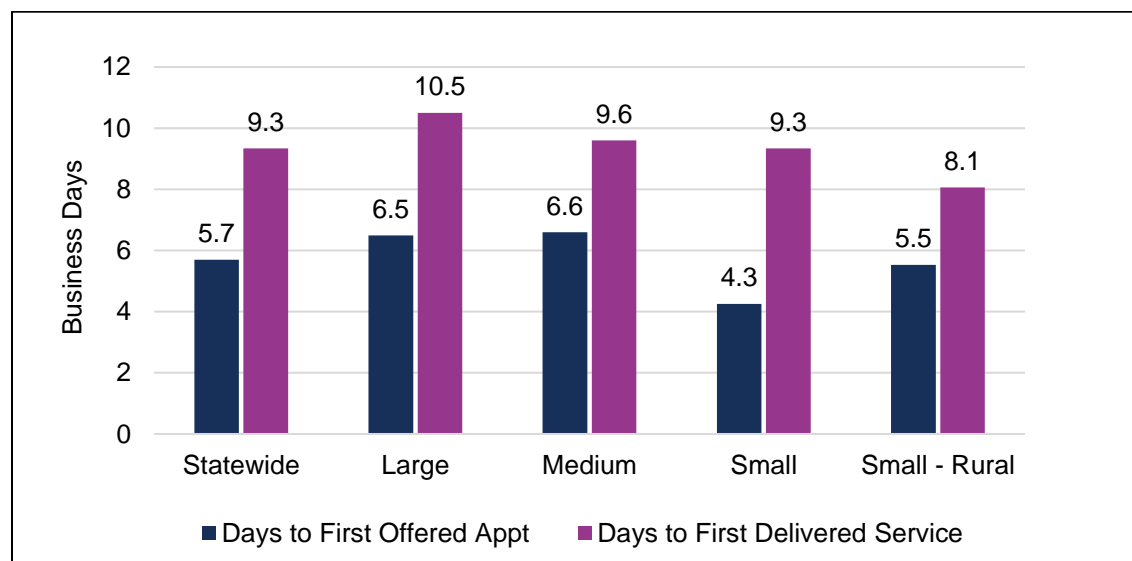
Though not required, most counties have also adopted a 10-business day standard for when the service is actually delivered; the statewide average (a calculated average of MHP performance) for meeting this standard is 73 percent. While small MHPs show the highest average for an offered appointment (93 percent), they show the lowest average for a service received (67 percent). This is discussed further following Table 5-10, which depicts wait times in business days by MHP size.

Figure 5-9: Business Days to First Offered Appointment by MHP Size, Reported in FY 2019-22



Despite the many challenges MHPs have been facing, the three-year trend for wait time for the first offered, non-urgent appointment showed overall performance similar to or better than the year prior. (Figure 5-9)

Figure 5-10: Business Days to First Mental Health Appointment Offered and Rendered Service by MHP Size, Reported in FY 2021-22



The average across all counties showed a 6-business day wait for the first offered appointment and a 9-business day wait for the first delivered service. The averages varied by county size, with small counties showing the strongest performance in offering a first service in four days on average but delivering it in nine days on average. Small-rural MHPs showed the strongest performance in delivery of the first service at 8 days on average. (Figure 5-10)

The wait time for an offered appointment in a large MHP averaged one day longer than the state average, and subsequently a day longer wait for the first delivered service. Small MHPs showed the largest difference between the offered and received service at 5 days (4.3 days offered to 9.3 days received). Regardless, the average first service is offered in 4 to 6 days and provided in 8 to 10 business days. The gap between the offered appointment and delivered service may be impacted by the MHPs' ability to have an array of appointments to offer when the first offered appointment is declined by the beneficiary; workforce shortages may be impacting appointment flexibility.

With the offered average wait time fairly steady or even improved in the last year, despite workforce shortages, it appears that counties have adjusted their workforce more toward the access function. The downstream impacts of emphasizing timely access to the first service is not known but could be resulting in longer wait times for ongoing care or less frequent service delivery after assessment.

Initial Outpatient Psychiatry Service

Delays in accessing psychiatric services can lead to medication non-adherence, lost engagement opportunities, increased emergency room encounters, and rising psychiatric inpatient hospitalizations for beneficiaries. Because of this, monitoring 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.

Table 5-2: Timeliness Key Component 2B – Statewide Results

KC #	Key Component – Timeliness Oversight	Met	Partially Met	Not Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	32	16	8

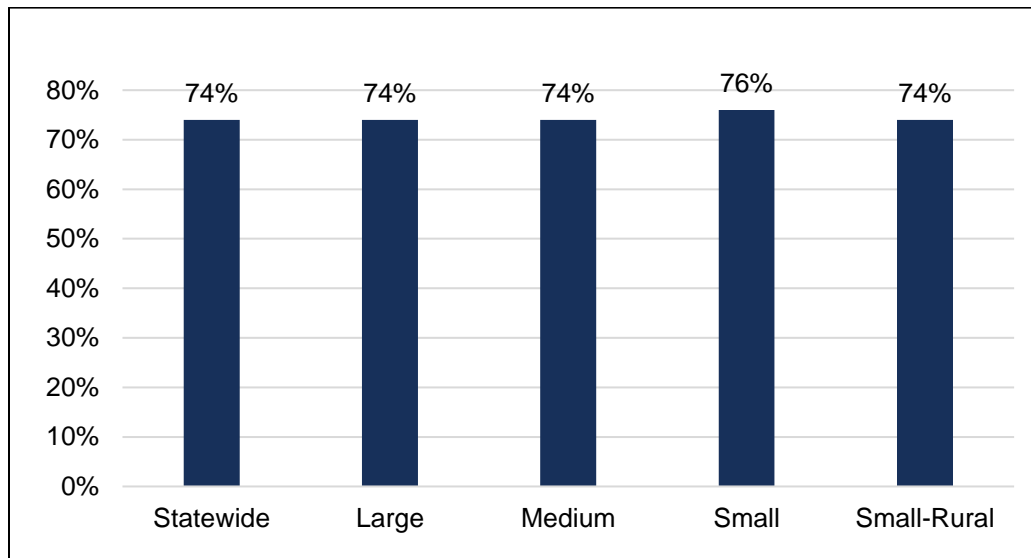
This component is defined as: “the MHP has a methodology to collect data related to first offered psychiatric appointment. The MHP tracks and trends the data routinely and establishes performance improvement processes when warranted.”

Similar to the earlier Key Component 2A, to receive a Met rating the MHP must collect the relevant data points, review the data routinely, and if applicable, initiate improvement activities toward improved timeliness. A partial rating indicates that the MHP may not be collecting for all age groups, analyzing the data routinely, or initiating improvement activities when necessary.

The DHCS expectation for psychiatric access requires meeting the 15-business day wait time 70 percent of the time. It is important to recognize that MHPs are often measuring this 15-business day period from what can be very different starting points, either the date of the first service request or the date of the first assessment and/or determination of clinical need for a psychiatry appointment. Therefore, these findings should be viewed with those limitations in mind.

Figure 5-11 shows the averages of the percent of offered psychiatry appointments that met the 15-day standard by county size.

Figure 5-11: Average Percent Meeting First Offered Psychiatry Appointment Standard by MHP Size, Reported in FY 2021-22



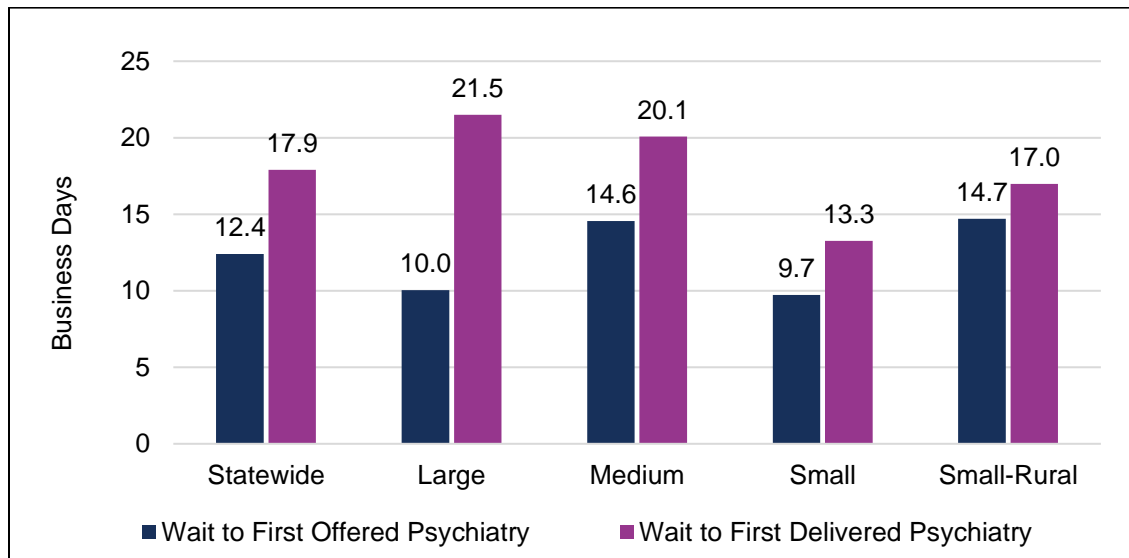
Statewide, for the 50 MHPs that reported on this metric, timeliness to adult psychiatry exceeded that of child psychiatry. Large MHPs are the only group that showed better performance in child psychiatry.

Thirty-six of the reporting MHPs met the 70 percent standard. Of 14 MHPs that reported on this metric and did not meet the 70 percent standard overall, two of the MHPs did meet it for adults only, and one MHP met it for children/youth. For foster youth specifically, 25 MHPs met the standard, including 4 MHPs that reported they had no foster youth referred to psychiatry; notably 15 MHPs did not report on this metric for FC but reported for the entire youth population.

While there is a well-known dearth of psychiatry workforce, it is even more dire in the field of child psychiatry, which will naturally impact the ability to provide timely services.

The wait time to the first offered psychiatry appointment and the first actual psychiatry service delivered is shown below in Figure 5-12.

Figure 5-12: Average Business Days to First Offered Psychiatry and First Delivered Psychiatry, Reported in FY 2021-22



While several MHPs do not meet the 70 percent expectation for a timely offered psychiatry appointment, statewide average wait times fall within the expected time frame. The average across counties is 12.4 days for an offered psychiatry appointment with the delivered appointment in 18 days. However, the significant difference in some cases between the offered appointment and the actual appointment received warrants additional inquiry at the local level, particularly in large counties where the average service is delivered in 22 business days, 12 business days after the first offered appointment. Medium MHPs also deliver the first psychiatry service in 20 business days. Given that the median wait times reported tended not to vary significantly from the averages, about half of the beneficiaries received an earlier service and the other half received a later service – later than one month's time.

Wait time for psychiatry can result in disruption in medication care or lack of engagement in psychiatric care. When MHPs show significant differences between the first psychiatry service offered versus actually delivered, root cause analysis and efforts toward improvement are warranted.

Urgent Services

Table 5-3: Timeliness Key Component 2C – Statewide Results

KC #	Key Component – Timeliness Oversight	Met	Partially Met	Not Met
2C	Urgent Appointments	30	16	10

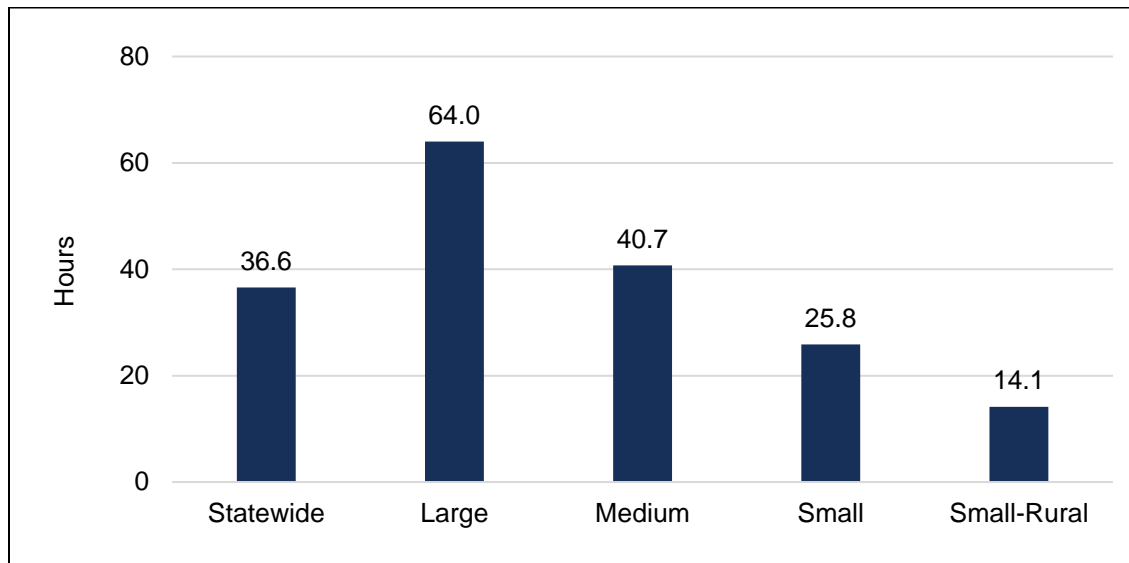
The component which rates MHP performance on measurement of timely access to urgent services had the weakest performance of all the Timeliness components.

Most MHPs (49) provided some data (generally small data sets) regarding urgent service delivery. As noted earlier, definitions of urgent conditions and the services that get delivered vary greatly across MHPs, as the State allows MHPs to apply their own definitions. Some MHPs reported the data in days rather than hours due to limitations with the EHR. In these instances,

CalEQRO converted days to hours for comparative purposes. Additionally, some MHPs had wait times that were significant outliers – for what kinds of services are unknown – thus, negatively impacting averages.

Given the great variability in definitions and measurements in this category, this information is limited in its usefulness for drawing conclusions or comparing across counties, and any interpretation should be made with awareness of these significant limitations.

Figure 5-13: Hours Wait for Urgent Services, Reported in FY 2021-22



For urgent services, large MHPs show the longest wait times (64 hours on average), driven by longer wait times in Los Angeles. Smaller MHPs show shorter wait times but appear to have more narrow definitions of urgent conditions, as discussed above. (Figure 5-13)

Follow-up Post Psychiatric Inpatient Discharge

Key Component 2D indicates that “the MHP has a methodology to collect data related to timeliness for follow-up appointments within seven days after a discharge from a psychiatric facility. The MHP tracks and trends the data routinely and establishes performance improvement activities when warranted.”

Table 5-4: Timeliness Key Component 2D – Statewide Results

KC #	Key Component – Timeliness Oversight	Met	Partially Met	Not Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	39	14	3

On this measure, most MHPs track this data fairly closely, given its correlation with hospital readmission and other high-cost services.

Only three MHPs (small and small-rural) received a Not Met rating for lack of tracking of this important clinical service. Despite this, small and small-rural MHPs also performed the strongest with 71 percent and 79 percent, respectively, rating Met.

At 69 percent, 9 of the 13 large counties (including LA) rated Met on this item. Medium MHPs had the weakest performance on this component, with 60 percent rating Met and 40 percent of them rating Partially Met. Other MHPs of all sizes rated Partially Met as well.

Performance on post-hospitalization follow-up based upon approved claims analysis is presented in the Quality chapter of this report.

Psychiatric Inpatient Readmission Rates

Key Component 2E focuses on the MHP's "methodology to collect data related to rehospitalizations. The MHP tracks and trends the data routinely and establishes performance improvement activities when warranted."

Table 5-5: Timeliness Key Component 2E – Statewide Results

KC #	Key Component – Timeliness Oversight	Met	Partially Met	Not Met
2E	Psychiatric Readmission Rates	41	12	3

82 percent of the MHPs that rated a Met on the post-hospital item also rated Met on this item for monitoring psychiatric readmissions. While medium MHPs rated lowest on Key Component 2D above, medium MHPs were most likely to rate Met in this area, with 87 percent (n=13) successfully Met, and the other two MHPs rating Partially Met. Similarly, 86 percent of small-rural MHPs similarly rated Met. The 3 MHPs that rated Not Met were small or small-rural MHPs.

Just over half of the large MHPs (n=7, including Los Angeles) rated Met on this item and the other six large MHPs rated Partially Met. MHPs of all sizes except small-rural are represented in the Partially Met category.

Eleven MHPs had their work on hospital readmissions cited as a Strength and four MHPs as an Opportunity.

MHP performance on readmission rates using approved claims analysis follows in the Quality chapter of this report.

Outpatient No-Show Rates

Key Component 2F indicates that the "MHP has a methodology to collect data related to no-shows and cancellations for psychiatry and mental health services. The MHP tracks and trends the data routinely and establishes performance improvement activities when warranted."

Table 5-6: Timeliness Key Component 2F – Statewide Results

KC #	Key Component – Timeliness Oversight	Met	Partially Met	Not Met
2F	No-Shows/Cancellations	32	20	4

Most MHPs monitor no-show rates, to some extent. However, there appears to largely be an incomplete data set across most MHPs – mostly reporting for psychiatry services at county-operated sites. Additionally, the methodology used can have great impact on the accuracy of the MHP's reported rate. For example, if an MHP records its no-shows from

progress notes, it relies upon all staff to write a progress note indicating that a beneficiary did not show for service. Or, if an MHP records its no-shows through a calendar mechanism, it relies upon staff to “check in” the beneficiary electronically; this became more of a challenge with telehealth and more services delivered off-site without an official “front desk” function that records the attendance information.

No-show tracking is clinically significant, particularly for psychiatry, where a no-show will generally result in a gap in psychiatric medications. Engagement efforts at the time of the no-show could help mitigate that impact and maintain continuous care in services.

From a systems perspective, no-show monitoring is important as it reflects unused service capacity that is in great need for other individuals in service. While some MHPs may reduce the impact of no-shows by over-booking a provider (psychiatry in particular) or assertively calling other beneficiaries when someone cancels, most MHPs tend to be reluctant to overbook provider schedules, despite fairly predictable overall no-show rates and long wait times to services. More creative strategies, including same-day access, to optimally use unscheduled psychiatry time is necessary to actively manage available capacity.

SUMMARY OF TIMELINESS FINDINGS

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 LOC, staffing, and administrative infrastructure to get an individual into services in a timely manner. Whether a service is delivered in a timely manner can impact whether a beneficiary chooses to enter into treatment at all. Ultimately, delays in entry to care can result in detrimental outcomes.

More counties are reporting timeliness data for both county and contracted providers (i.e., “the entire system”) than in the prior year, but it is unclear whether counties are capturing all points of possible entry to the system (e.g., walk-ins, school-based sites, community outreach). For counties that only provided data on county-operated program timeliness, they vary in whether beneficiaries enter the system through contract providers. In instances where only county-operated access is reported, it may represent a largely complete data set in terms of systemwide access.

While most MHPs are meeting metrics for “offering” appointments within a timely manner, the difference between the offered appointment and the actual service delivered – especially when greater than a few days – warrants further investigation. When beneficiaries decline the initial service offered, they may not have many other appointment choices, resulting in a lengthy wait time. Other systemic barriers to care and NA should be examined. Additionally, wait times may have an impact on show-rates and overall engagement in care, and ultimately on the desired outcomes.



Quality

INTRODUCTION

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

QUALITY MHP SYSTEMS STATEWIDE

Quality is naturally the cornerstone of the EQR process, representing the MHPs' ability to conduct oversight of its systems using data, and using best practices to promote optimal outcomes. While MHPs acknowledge that QM and improvement are priorities, delivering on this stated priority is more of a challenge. At a time when the workforce is smaller and strained with the demands of service delivery, MHPs find it difficult to assign staff to quality issues when staff are needed for service delivery. At best it is a balancing act; at worst, QM can get pared back to dealing with only the contractual obligations and audit preparation.

CalAIM will bring an era that MHPs have long awaited, one in which quality of care is expected to be the priority over the compliance of the documentation. With this, MHPs will be implementing a new financial model using intergovernmental transfers as opposed to certified public expenditure of fee for service reimbursement. The anticipation of CalAIM will bring new demands, and it remains to be seen whether MHPs will be able to dedicate the necessary staff to prepare the technology to manage programs more efficiently and driven by outcomes. Leadership in many MHPs began preparing for these changes when the CalAIM document was submitted to CMS and posted for review. Its importance is further strengthened by the DHCS Comprehensive Quality Strategy¹⁹, upon which DHCS enhanced its own quality infrastructure to conduct CQI.

QUALITY KEY COMPONENTS

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

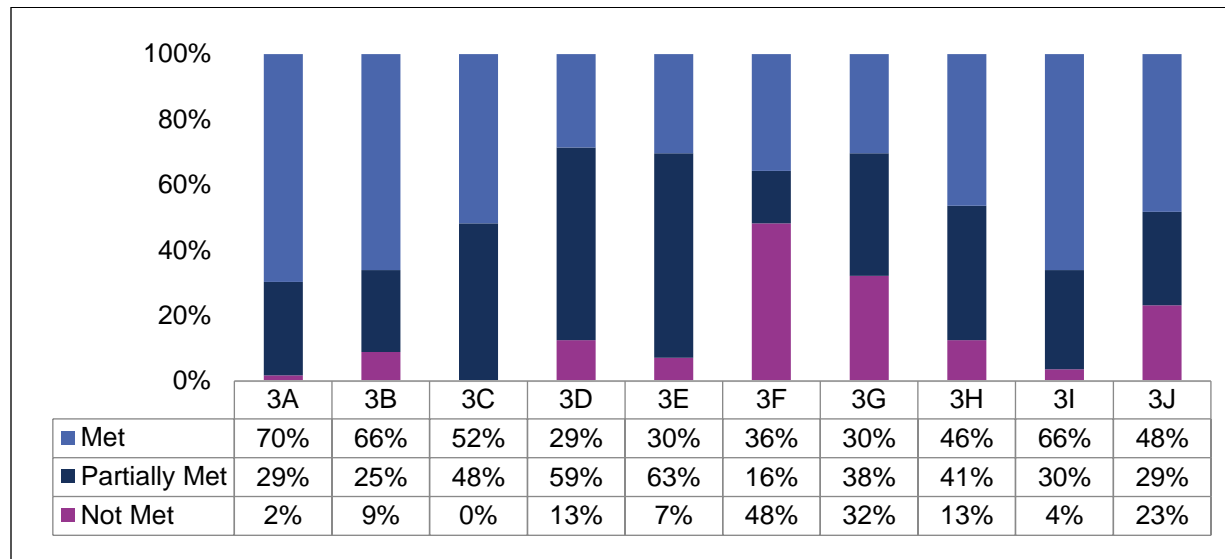
Each of the ten Quality Components, comprised of individual subcomponents, are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI. A summary of statewide

¹⁹ <https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf>

performance is depicted in Figure 6-1 below, and a summary of each component follows in Tables 6-1 through 6-10.

The overall statewide performance in Quality is displayed in Figure 6-1, below.

Figure 6-1: Summary of Quality Key Components, Statewide



Three MHPs (5 percent) – **Sonoma**, **Alameda**, and **Mendocino** – evidenced all ten of the Quality Key Components, and an additional 19 MHPs (34 percent) either Met or Partially Met all ten. The individual components and related findings are described below.

Quality as an Organizational Priority

Table 6-1: Quality Key Component 3A – Statewide Ratings

KC #	Key Component – Quality	Met	Partially Met	Not Met
3A	Quality Assessment and Performance Improvement are Organizational Priorities	39	16	1

The degree to which a CQI philosophy, framework, and related activities permeate an organization’s management and practices defines and impacts an MHP’s overall QI performance. This is best demonstrated through an ongoing comprehensive QAPI program; a current QAPI Work Plan that establishes baselines and time-bound goals for tracking of measurable progress to work plan goals and organizational strategic initiatives; an annual evaluation of the effectiveness of QAPI activities; a functional QIC that allows the goals of the QAPI Work Plan to be accomplished; an organizational structure in which executive management is accountable for the QAPI function and a direct line of communication exists between QAPI staff and administrative leaders; and a QAPI team that interfaces with other MHP divisions/units/departments to achieve quality related goals throughout service delivery.

Most counties evidenced strengths in this area, with one small MHP rating “Not Met” and six others rating “Partially Met.” Large MHPs were most likely to rate “Met” in this category, though all sizes are represented.

While all MHPs have a QAPI program or function, there is considerable variation in how the requirements are met, whether from a minimum compliance expectation or with a robust CQI framework. Medium- and large-sized MHPs had designated teams assigned to QI. The teams generally consisted of a manager/director, clinicians, and analysts to facilitate both compliance and quality activities. For example, **Orange** has a well-staffed Authority and Quality Improvement Services department, inclusive of data analysts that provide relevant, detailed information about services and utilization that inform access and timeliness. **Santa Barbara** has a robust quality team, inclusive of a Research and Evaluation team. By contrast, in small and small-rural MHPs, the responsibility for QI tended to spread among various staff whose positions were not expressly quality focused, or there was one designated QM position often responsible for all QM and compliance activities; in some MHPs, that position also supported the entire health agency. Challenges with this structure include diffusion of responsibilities; inconsistent implementation of CQI projects that are labor intensive and subject matter specific (e.g., PIPs); and lack of evaluation of QAPI goals and objectives based upon the prior year's results. Nevertheless, **Plumas**, redesigned its QAPI workplan in response to previous EQRO recommendations, and **Mariposa** demonstrated strong collaboration among teams regarding QAPI functions.

Many QAPI programs emphasized quality assurance and DHCS-MHP contract compliance, and considerably fewer were positioned to consistently review, evaluate, and apply the principles of QI to affect change and improvement in the MHP. For example, most QM programs have the DHCS-requisite components: QAPI work plans; test call monitoring of the 24-hour toll-free telephone line; grievance and appeals monitoring; and an identified utilization review process. While meeting the minimum requirements, CalEQRO noted that the degree to which these mandated activities truly functioned to support continuous QI was often lacking: inconsistently held or attended QIC meetings; work plans that emphasized compliance and lacked system level, clearly defined, measurable goals associated with quality of care; lack of evaluation of workplan goals and indicators to ensure quality and progress over time toward MHP priorities; and lack of attention to PIPs. Where counties did not submit two PIPs, lack of staff to dedicate to QAPI functions was generally the stated reason. For example, with a 55 percent vacancy rate overall, one MHP's QI Coordinator position had been vacant for two years. MHPs generally found it near impossible to implement a PIP without dedicated staff who could engage the program subject matter experts; PIP-related activities were cited as an Opportunity in 32 percent of MHPs (n=18).

QICs provide MHPs an opportunity to engage stakeholders' input and perspectives into the QAPI activities. Many MHPs, however, displayed ongoing challenges with broad stakeholder representation. While QIC membership often consisted of MHP leadership, program managers, and QI staff – though not necessarily consistently – there was less membership or attendance among beneficiaries, family members, line staff, and community members.

There were some notable exceptions to the above listed challenges, where MHPs were found to have exemplary QAPI programs that embraced CQI. For example, **Solano's** workplan had numerous quantifiable metrics, baseline or prior year data included, and an evaluation of the extent of success. **Santa Cruz** effectively utilized its robust QIC meetings to incorporate QI workplan and evaluation analysis, actively and positively impacting management decisions to address service gaps across the continuum of care.

Data-Informed Decision Making

Table 6-2: Quality Key Component 3B – Statewide Ratings

KC #	Key Component – Quality	Met	Partially Met	Not Met
3B	Data is Used to Inform Management and Guide Decisions	37	14	5

A key element of QI is the collection and analysis of reliable and valid data, the ability to interpret quantitative data and provide systems with qualitative insights, and the identification of critical trends and meaningful information. Collectively, these activities help determine areas for improvement to improve beneficiary outcomes.

MHPs of all sizes rated “Met” and “Partially Met” in this area, and only four small and one small-rural MHP rated “Not Met.” Data analytics was cited as a Strength in 20 counties, representing all county sizes. Despite this, issues related to data analytics were also cited as an Opportunity in 75 percent of MHPs (n=42). Of note, it was both a Strength and an Opportunity in several counties.

Most MHPs demonstrated some capacity to report and trend data and draw conclusions about SMHS provided, and several excelled at this. For example, **Napa** routinely uses data and surveys to guide decisions and manage their operations. **Kings** relies on and makes strategic use of available data in their assessment and decision-making process; overarching trend analysis is performed to respond to system gaps and needs. In the very large county of **Los Angeles**, multiple data points are reviewed during monthly Service Area (SA) reviews of directly operated (DO) programs; discussions include financial, direct service percentages, access to care data, documentation timeliness, time to service finalization, telehealth video vs. telephone/other, total DO beneficiaries served, monthly total assessments, and other information. SA leadership in collaboration with program leadership, identify strategies to remedy underperformance and share success stories of changes improving access and care.

Increasingly, MHPs are relying on data dashboards to report key performance indicators. **Alameda’s** use of dashboards was noted to be exemplary, and **San Joaquin** built a data warehouse and created several departmental dashboards that trend capacity and utilization data. Recognized for its extensive use of data, **Solano** includes an adult and a children’s service dashboard that also support monitoring of services through an equity lens. Other dashboards include a CLAS dashboard, homeless outreach, facility admissions, and a subacute flow tracker, among others. During the preceding year, **Ventura** updated its public-facing dashboard in coordination with County IT to report on services at geographic locations, demographics, and clients served. **Modoc** worked with its IS vendor to create several dashboards, including demographics served and aggregated reports for beneficiary outcomes, medication management, and metabolic monitoring.

While these and other MHPs illustrated effective data analytics, the use of data was identified as a challenge for MHPs twice as often as it was identified as a systemwide strength. The most frequently observed difficulties included reliability and validity related to challenges with IS and consistent business processes; insufficient access to data; limited ability to sufficiently analyze data to present implications of findings and to drive decision-making; and lack of aggregated data to reflect the entirety of beneficiary services. Some MHPs had access to and made use of some metrics but could not access a comprehensive set of data, and as a result, have limited ability to identify good practices, explain patterns of care within and across service programs, identify issues in the provision of care, and determine areas requiring review and improvement.

MHP Communication and Stateholder Involvement

Table 6-3: Quality Key Component 3C – Statewide Ratings

KC #	Key Component – Quality	Met	Partially Met	Not Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	29	27	0

Another critical element to quality is a consistent and formal process whereby stakeholders receive regular communication about and can provide input into system planning and the delivery of services. Small and small-rural MHPs were more likely to receive a “Met,” with large and medium MHPs more likely to rate “Partially Met.” Given the complexity of communication in larger organizations, these findings suggest that successful communication and stakeholder involvement is more challenging when the MHP is larger. Similarly, communication issues were cited as an Opportunity only in large and medium MHPs (n=7).

While many MHPs utilize a variety of communication strategies, key informants frequently indicated communication was top-down and there were insufficient opportunities to provide feedback or participate in a bidirectional communication process. The need for improved communication was noted across many MHPs, where key stakeholders report the need for a consistent and formal process whereby regular communication is received regarding QI activity updates and beneficiary outcome data.

There were some notable exceptions to this lack of robust communication processes. Bi-directional communication within **Colusa** has drastically improved from previous EQRs, contributing to a positive shift in MHP culture. Key stakeholder feedback in **Modoc** suggests positive bidirectional communication and staff involvement in MHP committees.

Continuum of Care and Level of Care Assignment

Table 6-4: Quality Key Component 3D – Statewide Ratings

KC #	Key Component – Quality	Met	Partially Met	Not Met
3D	Evidence of a Systematic Clinical Continuum of Care	16	33	7

Critical to ensuring beneficiaries receive clinically appropriate care is the degree to which an MHP offers a comprehensive range of services, from least- to most-restrictive, and utilizes LOC tools to measure, monitor, and guide treatment. The seven MHPs that were rated “Not Met” were small and small-rural counties, which are more likely to have less funding to strengthen gaps in the systems of care. Large MHPs rated highest in this measure.

LOC tools were cited as a strength in eight MHPs, primarily large and medium. While tools have been implemented in many counties – in some, aggregate reporting is used for capacity management and outcomes review – but more often counties have not yet begun to aggregate this data for analysis. Instead, MHPs that use LOC tools use them to individualize treatment, and sometimes to evaluate treatment progress compared to an earlier administration. Among the tools used in MHPs were: Adult Needs and Strengths Assessment, Child and Adolescent Needs and Strengths Assessment (CANS), Level of Care Utilization System, Reaching

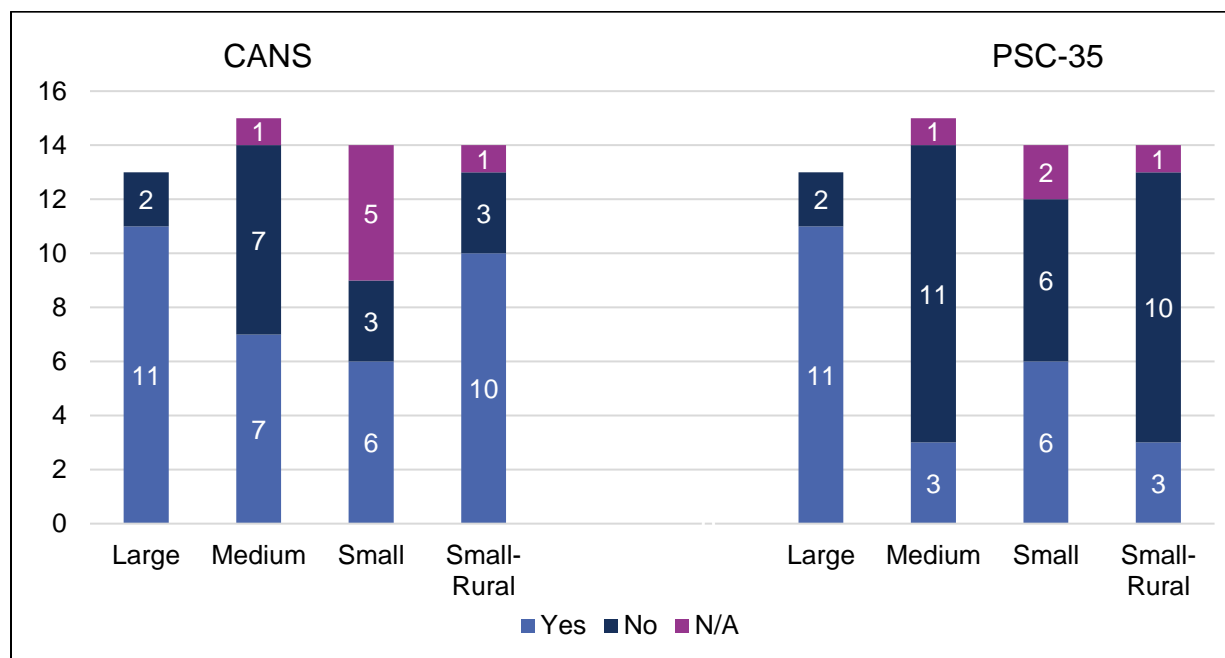
Recovery (RR), and Level of Care and Recovery Index. Notably, more MHPs, including **Solano**, **Fresno**, and **Monterey** have adopted RR, a three-part beneficiary/client and clinician assessment tool that identifies five treatment levels as their adult LOC tool. **Placer-Sierra** and **Mendocino** are two of many MHPs that regularly use the CANS in care planning to identify priority items when discussing treatment options with youth and family.

Currently, there is no required LOC instrument for adults, and most MHPs do not use one systemwide. And while MHPs have been required to utilize the CANS and Pediatric Symptoms Checklist (PSC-35) for its children's/youth systems of care since 2018, and many began using the CANS in the years prior, most have yet to develop aggregate reporting for them. Decisions regarding program placements were often reportedly based on clinical judgment, program and provider capacity, and clinician/staffing availability. Stakeholders reported inconsistent use among staff and held a perception that findings from a LOC tool, when used, did not accurately reflect beneficiaries' true level of functioning, or need.

LOC instruments can be supplemented by qualitative input through multidisciplinary teams. Staff and providers in **Marin** regularly communicate regarding changing presentation and greater needs of beneficiaries. Stakeholders spoke to the use of a team-based approach to care in **Santa Barbara**, demonstrated through multidisciplinary meetings to address beneficiary care, needs, and other updates. Particularly during a time of limited resources, these approaches facilitate continuity of care.

MHPs submitted to CalEQRO a survey which asked whether they "tracked and trended" data associated with the CANS and the PSC-35 (questionnaire for caregivers) and how that data is used to inform care and systems decisions. Results are displayed in Figure 6-2.

Figure 6-2: Tracking and Trending Aggregate Data from the CANS and PSC-35, Reported in FY 2021-22



Overall, 34 MHPs indicated that they did so with the CANS and 23 indicated the same for the PSC-35. Large counties mostly indicated that they did so for both tools. Smaller counties were least likely to use the data associated with the PSC-35, even if they reported doing so for the

CANS. This may be because many counties were already using the CANS when it became a requirement, but the PSC-35 was generally a new tool across the state. (Figure 6-2)

It should also be noted that it appears that counties answered “yes” to this question when they “collected” the data but did not necessarily aggregate and analyze it. Additionally, seven MHPs did not answer the question about the CANS and four did not answer the question about the PSC-35.

Medication Monitoring

Table 6-5: Quality Key Component 3E – Statewide Ratings

KC #	Key Component – Quality	Met	Partially Met	Not Met
3E	Medication Monitoring	17	35	4

Medication monitoring is conducted to assess whether psychiatric practices follow standard practices of care and include collaboration with primary care providers as well as collaboration and communication with other non-prescribing members serving the beneficiaries. For this component to be fully met, MHPs must establish related policies and procedures and use aggregate findings for performance improvement. This may include comparing findings across programs or psychiatric providers. Because many psychotropic medications can have side effects impacting physical health and ultimately mortality, a comprehensive approach to medication monitoring is necessary to assure that both mental health and physical health outcomes are considered as part of psychiatric practice.

This component had the least number of counties with a “Met” rating, most frequently Met in large MHPs. Two small and two small-rural MHPs rated “Not Met.” The lack of strength in this area is often attributed to turnover in psychiatric leadership as well as psychiatric providers. As this area is outside of the scope of practice for staff generally assigned QI functions, it may not get addressed because psychiatric provider time is focused on providing direct patient care. Medication monitoring was cited as a strength in only four large and medium MHPs and as an opportunity in seven MHPs of all sizes.

There are some counties demonstrating best practices in this area. **San Francisco** shows a high level of collaboration between prescribers, pharmacy, executive management, and data reporting teams to improve prescribing practices that support positive beneficiary outcomes. In **Los Angeles**, the medication monitoring of DO programs has made progress this past year through a combination of peer and pharmacy review of prescribing. **San Mateo’s** Pharmacy Therapeutics Committee is comprised of medical providers that peer review one another’s work. It covers all prescribers, compiles trends, and gives feedback to providers. The committee tracks and reports outcomes, with an emphasis on developing guidelines and educating prescribers where results show the need.

Medication Monitoring for Youth

Table 6-6: Quality Key Component 3F – Statewide Ratings

KC #	Key Component – Quality	Met	Partially Met	Not Met
3F	Psychotropic Medication Monitoring for Youth	20	9	27

CalEQRO reviews whether MHPs conduct medication monitoring consistent with the child welfare psychotropic medication measures outlined in W&I Code 14717.5 and seeks to validate any aggregate report findings and improvement activities that resulted from the findings. Specifically, CalEQRO evaluates whether the MHP performs the following six activities:

- Tracks and trends Attention Deficit Hyperactivity Disorder medication (HEDIS ADD)
- Tracks and trends the use of multiple concurrent antipsychotics in children and adolescents (HEDIS APC)
- Tracks and trends metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)
- Tracks and trends the use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)
- Tabulates and reports findings to management bodies for decision-making
- Initiates performance improvement activities when indicated

This is a relatively new Key Component, and it is the Quality component with the greatest number of counties rated as “Not Met.” Medium-sized MHPs were most likely represented in the “Met” category followed by large MHPs. Seventeen of the 28 (61 percent) small and small-rural counties rated “Not Met.” To receive a rating of “Met,” MHPs must conduct five or six of the related activities; a “partially met” rating indicates that the MHP conducted three or four of those activities, and a “not met” rating indicates the MHP conducted two or fewer.

Overall, MHPs report difficulty calculating the related HEDIS measures, as the data may require interface with other healthcare systems, pharmacy data, and more complex reporting (multiple variables) from within the MHP’s EHR. Twenty MHPs were rated Met and an additional nine rated partially met. **Merced** stood out as a medium-sized MHP that used a comprehensive and proactive approach to implementing data tracking and monitoring for medications and HEDIS measures for youth, FC, and adults.

Outcomes Measurement

Table 6-7: Quality Key Component 3G – Statewide Ratings

KC #	Key Component – Quality	Met	Partially Met	Not Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	17	21	18

Ratings for using a standardized outcome tool and analyzing aggregated data was nearly equally distributed across MHPs in terms of their ratings, but MHPs receiving a “Met” rating were more likely to be Large MHPs. Medium MHPs dominated the “Partially Met” rating and small and small/rural MHPs were most likely to be rated “Not Met,” though MHPs of all sizes are represented in “Not Met.” MHPs often reported that their LOC tools also function as outcome measures, if pre/post data is properly analyzed over time. As noted earlier, data is collected from a variety of tools, and aggregated reporting significantly lags behind.

Management of HCBs and high cost/high acuity services is often an outcome area that MHPs monitor, and this data is reflected in part in the MHPs’ ATA submissions regarding psychiatric inpatient utilization and readmission rates. **Kern** showed readmission rates following a psychiatric inpatient admission that are much lower than the those of the State, both for 7 days and 30 days – a slightly longer length of stay may contribute to reduced readmissions. **Madera** initiated a clinical PIP to reduce adult readmissions, with findings showing 30-day readmissions decreased from 17.58 percent to 11.16 percent; this may be linked to their successful intervention in which beneficiaries who received post-discharge follow-up within 7-days increased from 42.5 percent to 74.7 percent. Additionally, **Alameda** has managed its high-cost beneficiaries by increasing crisis services and resulted in decreased inpatient admissions.

As an overall approach to managing by outcomes, **Solano** reassigned positions to a Performance Improvement Team, with focus on a broad swath of performance topics including clinical outcomes across directly operated and contracted programs, fidelity of evidence-based practices, implementation of the RR instrument suite, analysis of adverse outcome data, adult and children’s service dashboards, and other topics.

MHPs are adopting more symptom checklists and measures associated with evidence-based practices, but a systemwide understanding of outcomes remains lacking. Especially during this workforce crisis, when there are not sufficient staff to extract meaningful data from electronic records and perform these analyses, it is simultaneously even more important to focus limited personnel to those services that provide the most benefit to the high-need, high-risk beneficiaries.

Beneficiary Satisfaction Surveys

Table 6-8: Quality Key Component 3H – Statewide Ratings

KC #	Key Component – Quality	Met	Partially Met	Not Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	26	23	7

Large and medium counties were equally successful in achieving a “Met” rating. Again, small and small-rural counties comprised the seven MHPs that rated “Not Met.” All sizes of MHPs were represented in the “Partially Met” category. Nine MHPs representing all size categories were cited for a Strength in utilizing beneficiary feedback in the form of surveys or other methods of input; similarly, ten MHPs of all sizes were identified as having an Opportunity in this category.

Santa Cruz was noted for developing and implementing surveys to reach staff and beneficiaries for input into QI processes. **San Bernardino’s** consumer advisory committee started in August 2020 and has been an ongoing forum for providing departmental leadership on matters including the clinical PIP which focused on improving the physical health by targeting issues

related to cardio-metabolic health. The forum also developed a feedback tool for the department that improved the capture of key topics that are important to service recipients.

Using the statewide survey, discussed in detail later in this report, **Ventura** demonstrated improvement in beneficiary participation in treatment planning, and CalEQRO beneficiary focus groups supported this perception of engagement. As a small-rural MHP, **Amador** leadership reviews the survey findings for each administration cycle and incorporates the beneficiary feedback into tangible changes cited by stakeholders.

Consumer Involvement

Table 6-9: Quality Key Component 3I – Statewide Ratings

KC #	Key Component – Quality	Met	Partially Met	Not Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	37	17	2

Strong performance was shown in MHPs of all sizes, with only two small-rural MHPs rating “Not Met.” Large counties were mostly rated as “Met” in this area.

Wellness Centers to varying degrees are led or managed by their beneficiary members and largely have become part of the service continuum in MHPs. Generally, they are not sufficient in number to meet demand nor located so that they are geographically accessible across the entire MHP’s population. Often, services at the Wellness Centers are cited by beneficiaries as the most impactful in their recovery. **Merced**, **Humboldt**, and **Lake** were all noted for having robust wellness centers that are recovery oriented and incorporate input from the participants. While some wellness centers were temporarily closed in the beginning of the pandemic, many began re-opening over the last year. Wellness Centers can be utilized as an entry to or an exit from SMHS and are therefore an important component of the service delivery system. As Wellness Centers are also locations where beneficiaries can develop peer support systems and identify access points for other resources, the benefits of Wellness Centers are many and are slated for expansion in many MHPs.

Peer Employment

Table 6-10: Quality Key Component 3J – Statewide Ratings

KC #	Key Component – Quality	Met	Partially Met	Not Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	27	16	13

Results in this measure, as in 3I, showed Large MHPs largely rating “Met,” and MHPs of other sizes are represented in “Partially Met” and “Not Met,” though small-rural MHPs dominated the “Not Met” rating.

Peer workers were cited as a Strength in 11 MHPs, more often large MHPs, and an Opportunity in 8 MHPs of all sizes. Peer workers continue to be added across counties or their contractors, serving in roles that inspire hope among service recipients and their families. Implementation of peer workers requires targeted strategies, and there is great inconsistency across MHPs in

clarity of role, appropriate training and supervision, inclusion as part of a clinical service program, and longer-term career growth.

With the recent inclusion of peer support as a Medi-Cal billable service, and a simultaneous professional workforce crisis, this workforce population is ripe for expansion. **Sonoma** has created its own peer certification process, a component necessary for Medi-Cal billing. **Tulare** is noted for peer positions with advancement opportunities in county and contractor programs. **Sacramento** has long supported peer employment in its contracted agencies and soon expects to implement a peer classification for county employment. **Riverside**, also with a strong history of peer employment, expanded its peer roles during the pandemic with a peer “chat” service available during work hours.

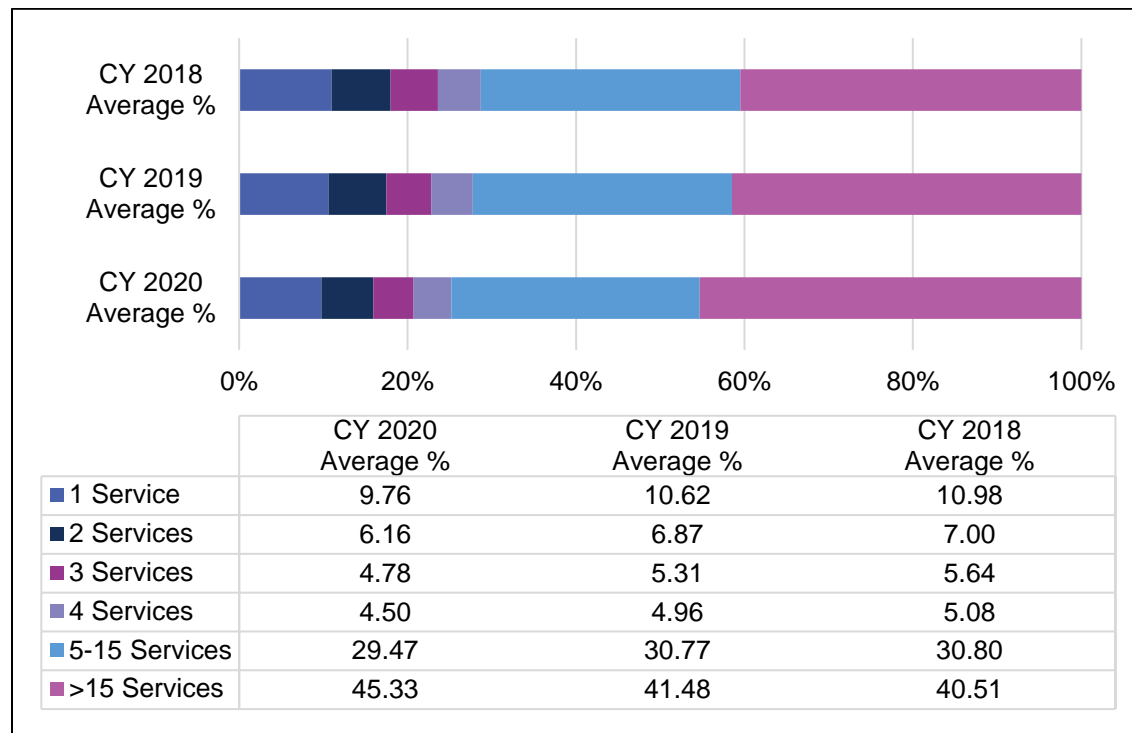
QUALITY PERFORMANCE MEASURES

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

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

Retention in Services

Retention in services is an important measure of beneficiary engagement to receive appropriate care and intended outcomes. It is important to note that this table does not account for the length of stay, as individuals enter and exit care during a 12-month period.

Figure 6-7: Retention of Beneficiaries Statewide, CY 2018-20

CY 2020 showed an increase in the percentage of beneficiaries receiving more than 15 services, suggesting improved retention in care. (Figure 6-7)

Retention varies significantly across counties. The following Table 6-11 shows the minimum and maximum for each of the above categories.

Table 6-11: Retention by Number of Services, MHP Minimum and Maximum, CY 2020

# Services	MHP Minimum %	MHP Maximum %
1 service	5.69%	21.86%
2 services	4.39%	17.07%
3 services	2.44%	9.17%
4 services	2.44%	7.78%
5–15 services	19.96%	42.46%
>15 services	23.02%	57.54%

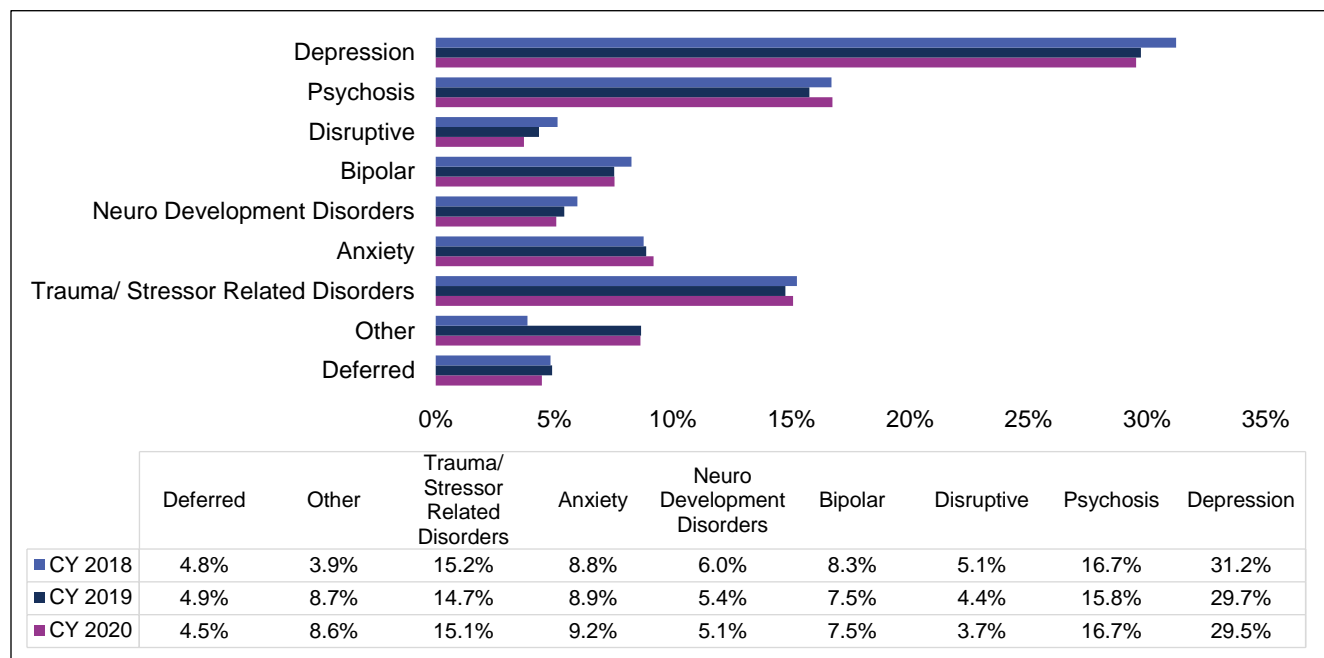
Where MHPs show very high numbers of beneficiaries receiving a low number of services, and vice versa, MHPs should examine the types of services delivered and the populations most affected for engagement issues, disparities, or inappropriate LOC placement.

Diagnosis of Beneficiaries Served

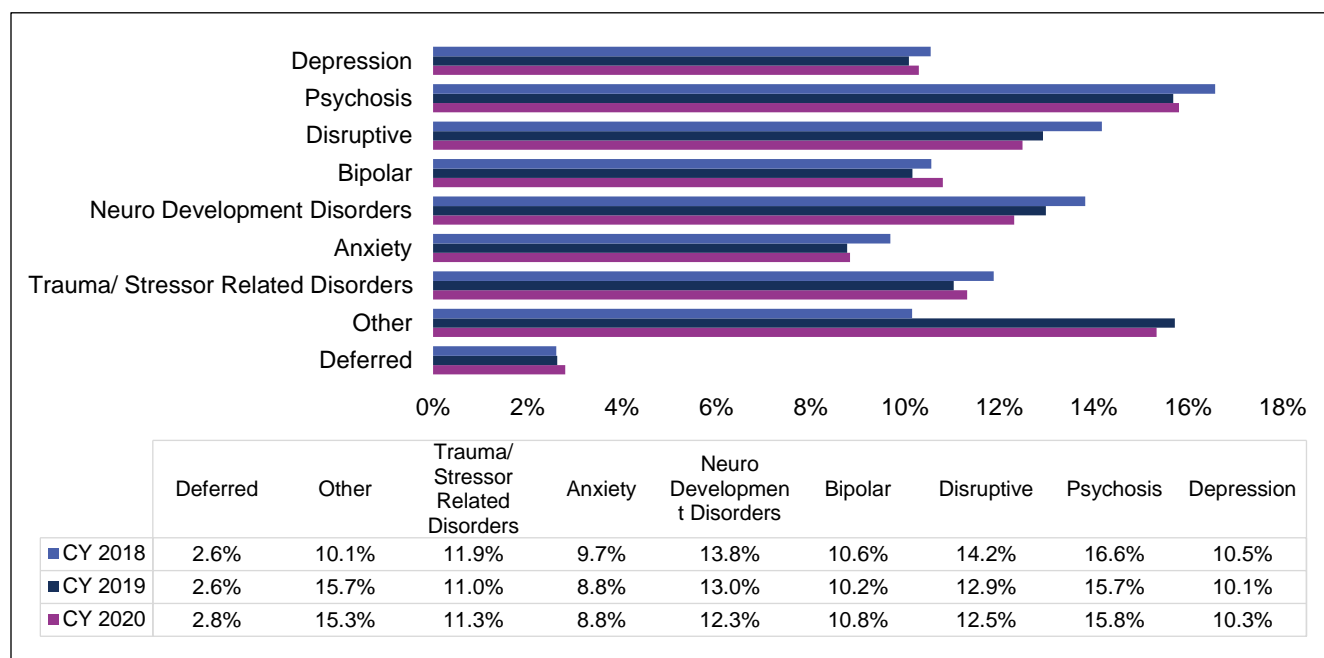
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The tables below represent the primary diagnosis as submitted with the

MHP's claims for treatment. Figure 6-8 shows the number of beneficiaries in a diagnostic category in CY 2020. This is not an unduplicated count, as a beneficiary may have claims submitted with different diagnoses crossing categories over time and at the same time in different programs. Figure 6-9 shows the average approved claims by diagnostic category.

Figure 6-8: Statewide Distribution of Beneficiaries Served by Diagnoses, CY 2020



CY 2020 showed an overall decrease in beneficiaries served, but Psychotic Disorders, Anxiety, and Trauma related disorders showed a slight proportional increase. It is fortunate that despite decreased PR statewide, there was no measured decrease in access to individuals with psychotic disorders, generally accepted as the most functionally impaired category of SMHS. The decrease in Disruptive Disorders may be attributed to fewer referrals from school systems during COVID-19 closures. (Figure 6-8)

Figure 6-9: Statewide Approved Claims by Diagnoses, CY 2020

The figure above shows the representation of diagnostic categories within the total approved claims (Figure 6-9). In the three-year period, individuals with Psychotic Disorders received the highest proportion of approved claims, followed closely by the “Other” category. The “Other” category also showed the most variability over the three-year period.

Psychiatric Inpatient Services

Table 6-12 provides a three-year summary (CY 2018-20) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay (LOS).

Table 6-12: Psychiatric Inpatient Utilization, CY 2018-20

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	Statewide Average LOS in Days	Statewide AACB	Total Approved Claims
CY 2018	157,102	308,742	7.63	\$9,772	\$852,000,172
CY 2019	171,740	344,758	7.80	\$10,535	\$977,885,680
CY 2020	151,566	293,346	8.68	\$11,814	\$1,027,874,950

In 2020, fewer beneficiaries were admitted to Medi-Cal reimbursable facilities but averaged almost a day longer LOS. From 2019 to 2020, there was a 11.75 percent decrease in the number of beneficiaries who received inpatient services; there were also 14.91 percent fewer admissions. In 2019 hospitalized beneficiaries received an average of 2.0 hospitalizations, and the average decreased slightly in 2020 to 1.94 admissions per beneficiary receiving inpatient services.

Especially in the earlier months of the COVID-19 pandemic, there were days to weeks in which facilities could not admit or transfer patients due to an outbreak in their facility. This may have resulted in more admissions to IMD-excluded facilities that are not represented in the Medi-Cal claims, rather than an actual reduction in hospitalizations. Anecdotal reports from MHP staff indicated that hospitalizations increased and finding placement was particularly challenging. This included longer un-reimbursed stays in crisis units and hospital EDs, sometimes for days or even weeks for complex clinical admissions.

Figure 6-10: Average Inpatient Length of Stay by MHP Region, CY 2018-20

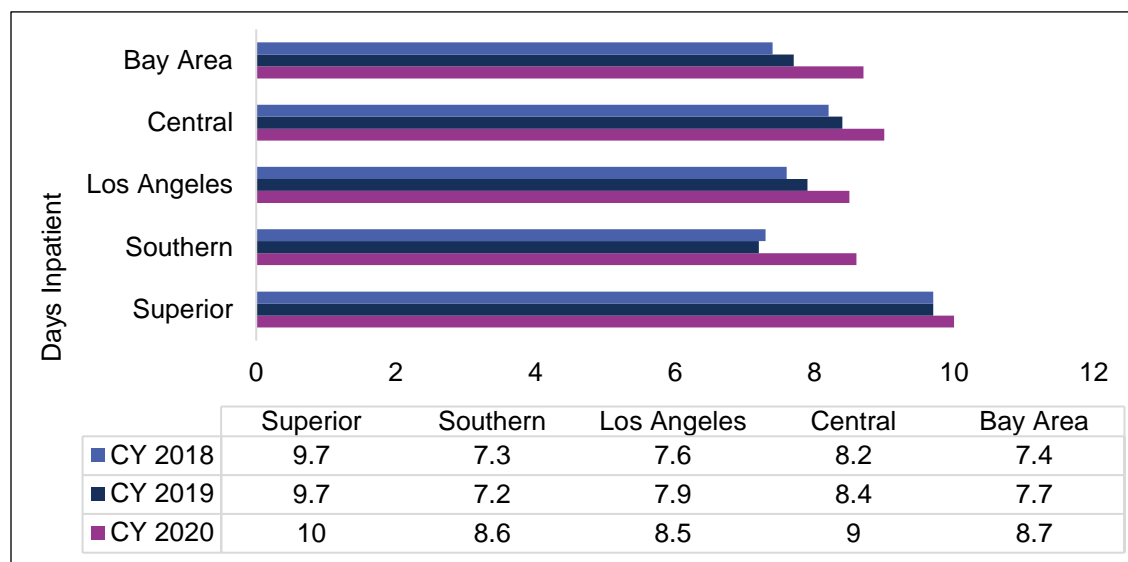
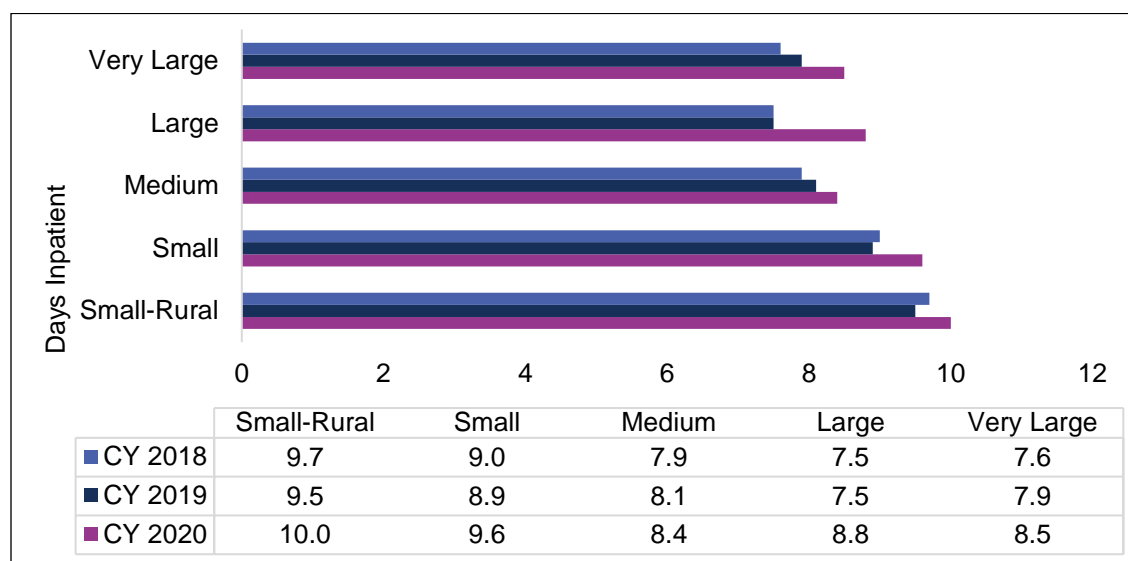


Figure 6-11: Average Inpatient Length of Stay by MHP Size, CY 2018-20



In all regions and county sizes, 2020 showed slight increases in lengths of stay inpatient. Small and small-rural, largely the superior region counties, showed longer lengths of stay over the three-year period and in 2020. The most significant increase in 2020 is in southern MHPs in

which the average admission was 1.4 days longer than in 2019. Bay Area MHPs experienced a 1-day increase. (Figures 6-10 and 6-11)

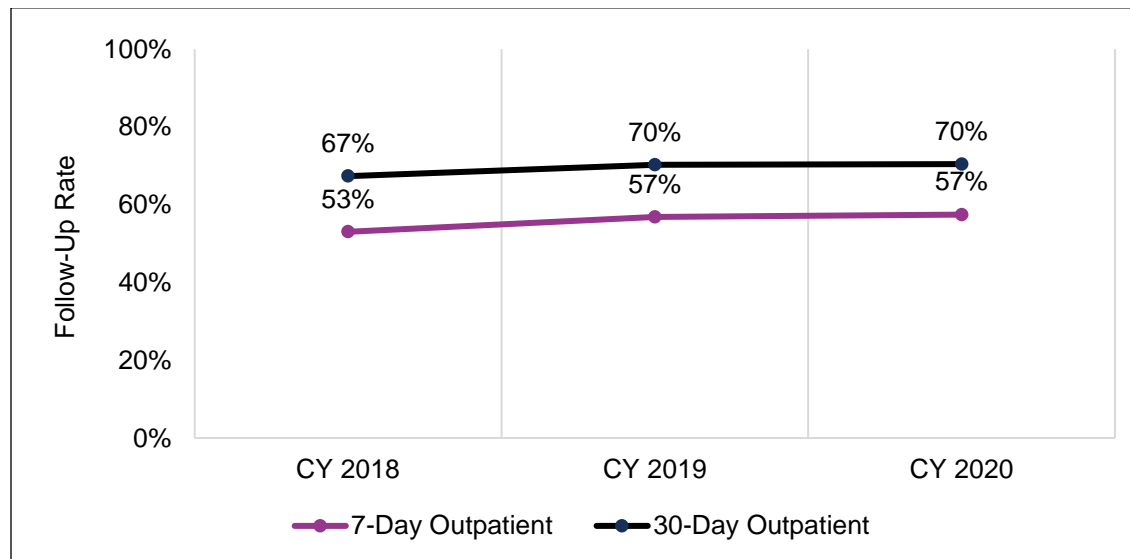
Longer lengths of stay in 2020 may be attributed to difficulties in discharges, as COVID-19 cases in facilities impacted whether individuals could be discharged or admitted in accordance with Public Health protocols for facilities, as described earlier.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained mental health professionals is critically important.

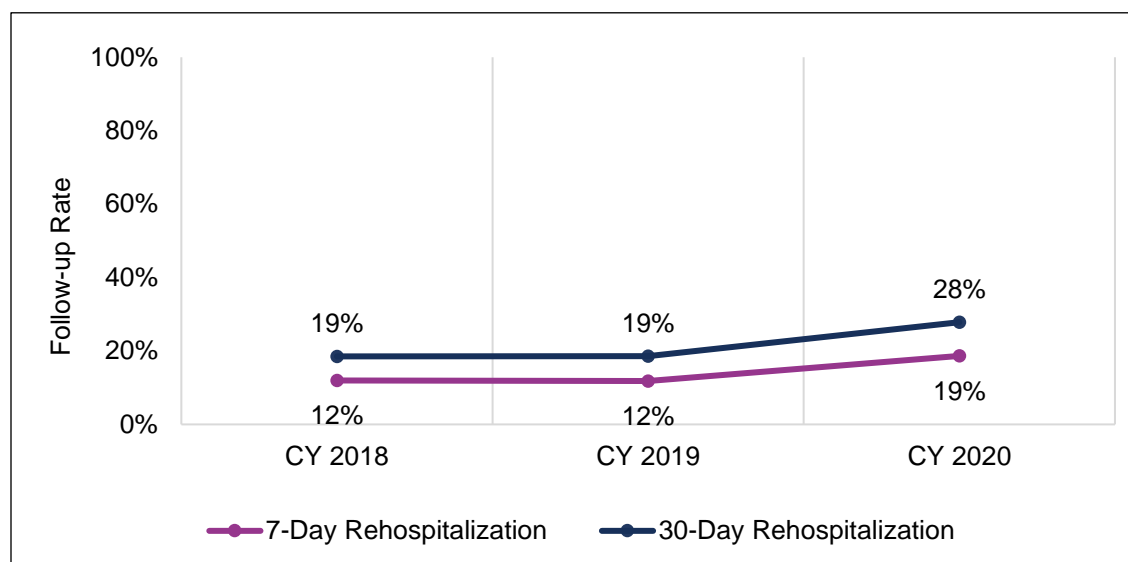
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and may be reflected in the rate to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

Figure 6-12: Follow-up Rates post Hospital Discharge Statewide, CY 2018-20



In CY 2020, there was no change overall in the 7-day or 30-day follow-up service after hospital discharge. This may be viewed as improved service coordination, given the somewhat unpredictable nature of service delivery throughout much of 2020. (Figure 6-12)

Eight MHPs (three medium MHPs and the balance small or small-rural) had 30-day follow-up rates exceeding 80 percent. However, seven MHPs – mostly small/small-rural, and one large, one medium MHP – demonstrated 30-day follow-up rates of less than 60 percent. Most MHPs' follow-up rates therefore are near the averages shown.

Figure 6-13: Rehospitalization Rates Statewide, CY 2018-20

Despite stable performance from a statewide perspective in follow-up care, readmissions showed a significant overall increase in 2020 (Figure 6-13). This appears to be a driver for the increase in high-cost beneficiaries described below. However, it is important to note that the increase in readmissions was not universal, and this statewide increase appears to be associated with large counties, including Los Angeles, showing increased readmission rates.

The 7-day readmission rate increase from 12 percent to 19 percent represents a 58 percent increase. The top ten readmission rates were in one medium MHPs and nine large MHPs, including Los Angeles. Despite the 7-day average at 19 percent, only nine MHPs had rates at 19 percent or higher. Some MHPs had no readmissions within 7-days – mostly smaller MHPs – but also **Sonoma**, a medium MHP.

The 30-day readmission rate increase from 19 percent to 28 percent represented a 47 percent increase, again highly influenced by large MHPs.

A high readmission rate might be viewed as an expected outcome during the COVID-19 pandemic, where upon discharge individuals were less likely to be able to return home to an extended support network, which is so critical to mental wellness. Unable to reach out to friends and family, beneficiaries may have instead found themselves quickly in a poor mental state, requiring rehospitalization. Given the critical outcome that hospitalization and rehospitalization represents, as well as the high cost to service systems, this is an important measure for MHPs to closely monitor and identify strategies for improvement when warranted.

High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. HCB percentage of total claims, when compared with the HCB count percentage, provides a subset of the beneficiary population that warrants close utilization review, both for appropriateness of LOC and expected outcomes.

Table 6-13 provides a three-year summary (CY 2018-20) of statewide HCB trends for the MHP. HCBs in this table are identified as those with approved claims of more than \$30,000 in a year. High-cost outliers drive the average claims across the state. While the overall AACB is \$6,496, the statewide median amount is just \$2,928.

On the other end of the spectrum, statewide, over 92 percent of the statewide beneficiaries are “low cost” (less than \$20,000 annually) and receive just over half of the Medi-Cal resources, with an AACB of \$4,399 but a much lower median of \$2,800. Given the median value, about 46 percent of beneficiaries served are associated with less than \$2,800 in approved claims.

Table 6-13: HCB (Greater than \$30,000), CY 2018-20

Year	Beneficiaries Served			Beneficiary Claims		
	Beneficiary Count by Cost Category	Statewide Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per Beneficiary by Cost Category	Total Approved Claims by Cost Category	% of Total Approved Claims
High-Cost Beneficiaries (payment ≥ \$30,000)						
CY 2018	23,164	618,977	3.74%	\$57,725	\$1,337,141,530	33.47%
CY 2019	21,904	627,928	3.49%	\$51,883	\$1,136,453,763	28.65%
CY 2020	24,242	595,596	4.07%	\$53,969	\$1,308,318,589	30.70%
Medium-Cost Beneficiaries (payment between \$20,000 and \$30,000)						
CY 2018	19,171	618,977	3.10%	\$24,272	\$465,327,504	11.65%
CY 2019	20,094	627,928	3.20%	\$24,251	\$487,296,714	12.29%
CY 2020	22,110	595,596	3.71%	\$24,274	\$536,694,163	12.59%
Low-Cost Beneficiaries (payment < \$20,000)						
CY 2018	576,642	618,977	93.16%	\$3,802	\$2,192,160,320	54.88%
CY 2019	585,930	627,928	93.31%	\$3,998	\$2,342,261,916	59.06%
CY 2020	549,244	595,596	92.22%	\$4,399	\$2,416,340,502	56.70%

Despite a decrease in numbers served in 2020, the number of HCBs increased from 2019 to 2020 by 10.67 percent, with an additional 2,338 beneficiaries in this category. When factoring in the overall decreased number of beneficiaries served, the rate of 4.07 percent of beneficiaries qualifying as HCB reflects a proportional increase of 16.62 percent increase in HCBs. At the same time, the total amount of approved claims dollars in this category increased by 15 percent. In 2019, HCBs represented 28.65 percent of all approved claims, and in 2020, this increased by 7 percent to 30.70 percent of all approved claims.

This large increase in HCBs in 2020 followed a year where HCBs decreased by 6.68 percent (representing 3.74 percent of beneficiaries served in 2018 and 3.49 percent in 2019), and the total approved claims decreased more so at 15 percent.

Each year a similar number of beneficiaries is considered “medium cost,” at greater than \$20,000 but less than \$30,000. Together, the medium and high-cost beneficiaries comprise less than 7 to 8 percent of the population each year.

The vast majority of beneficiaries each year (over 92 percent) are considered “low cost,” averaging \$4,399 in 2020, a 10 percent increase over the average of \$3,998. Therefore, when considering the statewide averages (\$7,155 in 2020), it is important to consider the impact that the small number of high-cost beneficiaries have on the average; the statewide average in claims does not represent the average beneficiary.

SUMMARY OF QUALITY FINDINGS

Service patterns in 2020 suggest an even greater need to analyze local findings and conduct improvement activities when necessary. For counties that are experiencing lower PR, increased hospital readmissions, and increases in the numbers of HCBs, examination of root causes is especially important. This must also be done with Access and Timeliness issues as part of the context. With a limited workforce, MHPs must delicately balance service delivery priorities with oversight of the quality of those services provided.

Additionally, with the implementation of CalAIM, strong QM must become foundational for MHPs. However, MHPs show great variation in the availability of IT and data analytic staff to conduct the analyses necessary, and few staff skilled in QI strategies that must follow the analyses. With new EHRs on the horizon – referenced later in this report – many of these functions may be automated. Results then require routine review by MHP leadership and their endorsement and support of true improvement, with staff and stakeholder participation; such attention is labor intensive, yet essential to healthcare quality. With fewer counties successfully submitting PIPs, this suggests it may continue to be a challenge for MHPs, with large MHPs being the anticipated exception.

With the claims data showing that 30 percent of beneficiaries discharged from a Medi-Cal billable inpatient facility do not receive any mental health service within 30 days, greater analysis of the population that is not engaged in outpatient care after an acute admission, and interventions to remedy this are needed.

Validation of Beneficiaries' Perceptions of Care

INTRODUCTION

CFM voices are an integral part of the CalEQRO review process and arguably the ultimate indicator of the success of any mental health system. Feedback from those who receive services and their family members provides important information regarding access, timeliness, quality, and outcomes. Consumer, or beneficiary, and family member involvement in the EQR process elevates CalEQRO's findings and has the potential to infuse firsthand knowledge in a meaningful way into the success of the local mental health system.

Consumer/Family Member Focus Groups

The CFM focus group is an EQR evaluation method that brings together a small group of people, with predefined demographic traits or service experiences, to answer questions in a moderated setting. At least one CFM focus group is planned as part of every EQR, although COVID-19, staffing, and video challenges made this not feasible in all counties in FY 2021-22.

The CFM focus group is facilitated by a CalEQRO reviewer who is either a consumer or a family member and includes another CalEQRO staff person who can take notes during the session. The group is designed to shed light on the MHP services over the past year. Specifically, the focus group questions and discussion emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and peer involvement and integration. To thank CFMs for their time and input, CalEQRO provides gift cards to group participants.

CalEQRO recommends that MHP staff recruit 12 to 16 participants for the focus group, anticipating some attrition of prospective participants, resulting in the preferred focus group size of 6 to 12 participants. This provides sufficient variation in experiences and allows for some contrasting or differing opinions on services. With fewer numbers, there may be less diversity and richness of experiences and feedback, as well as concerns about confidentiality by participants. Nevertheless, CalEQRO uses less stringent criteria for the number of participants; at least three CFMs are required to conduct the focus group, and the written report is expected to eliminate any identifying characteristics.

Consumer Perception Surveys

The statewide CPS is another evaluation method to obtain stakeholder perceptions of care. The CPS is the DHCS-required survey on quality and satisfaction with services, historically held twice annually but once annually since 2021, per BHIN 21-015 and 22-010. The CPS is conducted through convenience sampling of beneficiaries who receive outpatient services during the week identified by DHCS. The CPS includes three age-specific consumer surveys and one family member survey for youth beneficiaries. All the survey types assess: General Satisfaction, Quality and Appropriateness, Access and Participation in Treatment Planning,

Improved Functioning, Outcomes, and Social Connectedness. Because the same surveys are used statewide, the CPS provides one uniform metric of beneficiary perception of care across different MHPs.

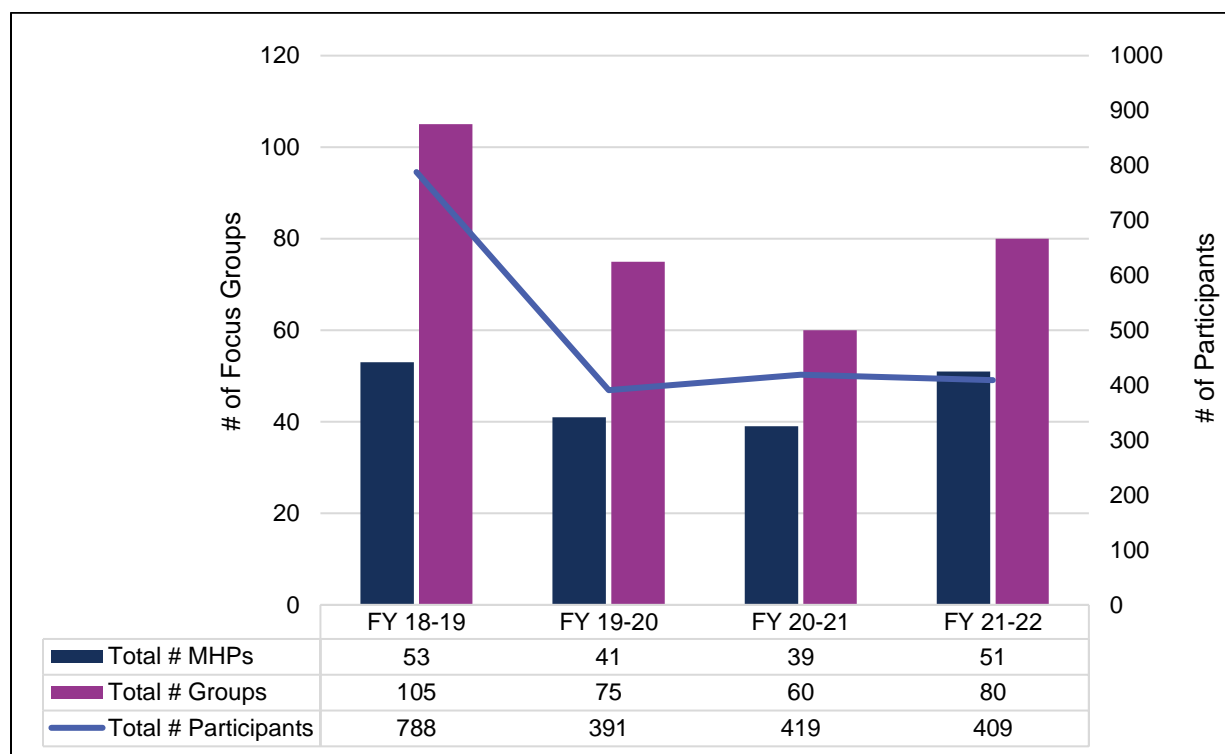
In 2021 the CPS was conducted in June 2021. Beneficiaries had the option of completing the survey on paper or electronically via an online survey portal. The paper survey and the online survey were available in all eleven threshold languages and English. The 2021 CPS data were collected by California Institute for Behavioral Health Solutions, a DHCS contractor. The surveys were approved by DHCS and then analyzed by CalEQRO, through its partnership with the University of California Los Angeles-Integrated Substance Abuse Programs.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

Results

For FY 2021-22, there were 80 focus groups conducted across 51 MHPs. The focus groups (78) were conducted by video conference (either Zoom or Teams), one consisted of four telephone calls/conversation with four individual CFMs, and another one was conducted in-person at an MHP drop-in center. In general, after two years of video conference communication prompted by COVID-19, participants were comfortable with the video conference and most opted to be visible on-screen during the focus group.

The focus groups were attended by 409 participants, predominantly adult beneficiaries and then parents/caregivers of youth beneficiaries. Most participants were not new to services, having received care over several years. CalEQRO did not capture the race/ethnicity, gender, preferred language, and age of the participants due to the video format. Race/ethnicity and preferred language were only captured in as far as the focus group was specifically for that population (e.g., Latino beneficiaries as requested in [Fresno](#), Spanish-speaking adults as requested in [Kern](#)). Eighteen (18) focus groups included an Interpreter for the following languages: Spanish, Vietnamese, Cantonese, another Chinese dialect, and Dari. CalEQRO notes that the language diversity in the focus groups is only a small fraction of the diversity in languages in which MHPs are prepared to deliver services, in accordance with Threshold Language discussed in the Access Chapter.

Figure 7-1: CFM Focus Group Participation, FY 2018-22

Since the pandemic, the numbers of focus group participants have decreased. FY 2018-19 had 788 participants, almost double the participation in FY 2021-22. (Figure 7-1)

In FY 2021-22, MHPs averaged 5 individuals per focus group compared to 7 participants pre-COVID-19. More frequently this year, the groups had fewer than three in attendance and therefore the focus group could not be held. Nevertheless, the numbers of MHPs hosting focus groups (51) have nearly returned to pre-pandemic levels (53).

Five MHPs did not host any CFM focus groups. There were two reasons that focus groups did not occur: (1) due to staffing issues, the MHP was not in a position to organize a focus group (i.e., advertising, recruiting participants, securing an interpreter) and in advance of the review opted out of the CFM focus group; (2) a focus group was planned, but no participants or fewer than three participants attended.

Themes

Beneficiaries and family members who participated in the CFM focus groups reported general satisfaction with MHP services. Participants' positive perceptions were based on feeling supported in care, having a voice during their treatment, and working with caring and committed staff. The modality of service delivery also played a factor in the positive perception of services. Resumption of in-person services was recounted by most, if not all participants, but the availability for telehealth was distinctly emphasized and appreciated. Beneficiaries and family members noted the options and flexibility in service: in-person, telephone, telehealth (video), or appointments either in the community or at home.

Beneficiaries who were new to services and/or their family members had overwhelmingly positive perceptions of entry into services. Initial access was described as timely, within one to

two weeks, and with a variety of treatment services available. If there were delays in access, psychiatric services and children's services were mentioned most often. This is consistent with MHP report of their timeliness data. Participants were concerned about the lack of availability of psychiatric providers and lack of experienced clinicians providing services to children.

MHPs continue to experience staff shortages, and beneficiaries and family members were well aware of the staffing challenges that MHPs were facing. Focus group participants reflected on the current challenges and shared the implications for them. Staff shortages and turnover affected the service options (e.g., suspension of psychotherapy due to loss of practitioner). Multiple changes in and turnover of staff were related to sharing their history and reasons for care repeatedly, which diminished the rapport that beneficiaries and family members had established with MHP staff. The staff viewed as "overburdened" were also thought to be less engaged and perceived as rushing through sessions. These perceptions were connected to their experience of reduced access to services, delays in services, and reduced quality of care.

In the CFM focus group, beneficiaries and family members are typically asked about their involvement in system planning and opportunities to give input on the beneficiary experience to inform SMHS. Few focus group participants were aware of such opportunities and even fewer endorsed involvement – this is a long-standing theme and not unexpected during the pandemic. If participants recalled an opportunity to give feedback, it was the CPS. Those who were aware or were involved tended to be already interested in advocacy work and community engagement; they sought out the opportunity at the MHP. Upon hearing about giving their input, most participants expressed interest.

Consumer and Family Member Recommendations

Focus group participants had few recommendations to improve SMHS, but those offered emphasized staffing. Beneficiaries and family members felt that there were too few staff to serve them or provide the type of services needed. The recommendations were to: increase staff, stabilize staffing, add more peer specialists and case managers, reduce the use of temporary doctors, and hire more psychiatrists.

Their recommendations were also to resume certain services that may have been discontinued during the pandemic (e.g., group rehabilitation or group therapy, wellness center offerings) or types of care (e.g., in Dialectal Behavioral Therapy), and more services for demographic populations (e.g., older adults). Participants also recommended providing or increasing the opportunities for community-based supportive services and information about public services (e.g., housing). These included more social outings; mentors or peer partners; support and assistance with seeking employment; nutrition classes; and others. Ironically, these are some of the services and supports provided through wellness centers, but few focus group participants were aware of wellness centers or had been to one in their county. Finally, they recommended increasing information about and assistance with transportation to SMHS service sites.

CONSUMER PERCEPTION SURVEYS

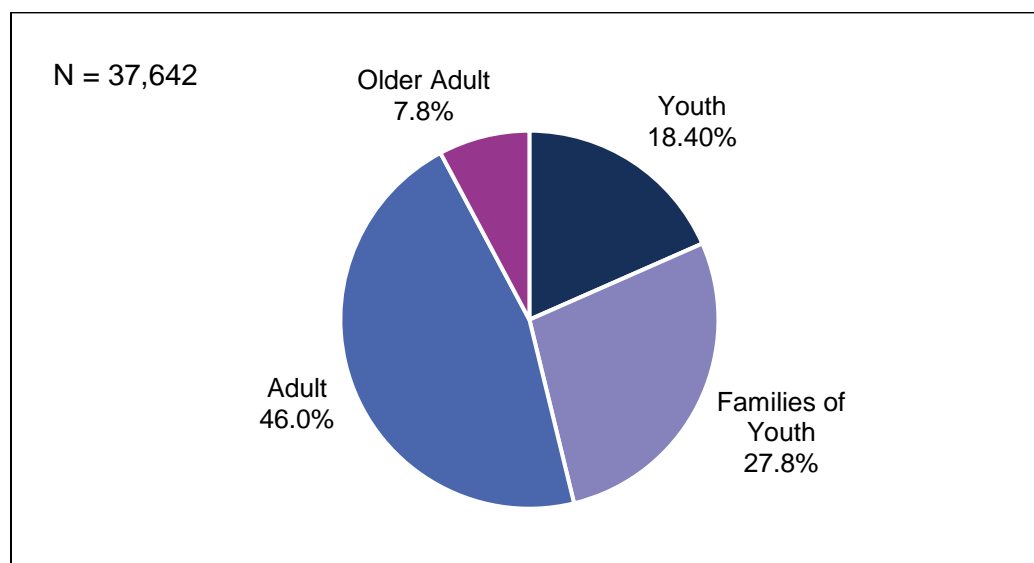
Instruments

DHCS administers four surveys for the following categories of beneficiaries – Adult, Older Adult, Youth, and Families of Children and Youth.²⁰ Adult and Older Adult beneficiaries receive the Mental Health Statistics Improvement Project survey while the Youth beneficiaries receive the Youth Satisfaction Survey and the Families of Children and Youth receive the family version of the survey. 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, and 9 = Missing.

Results

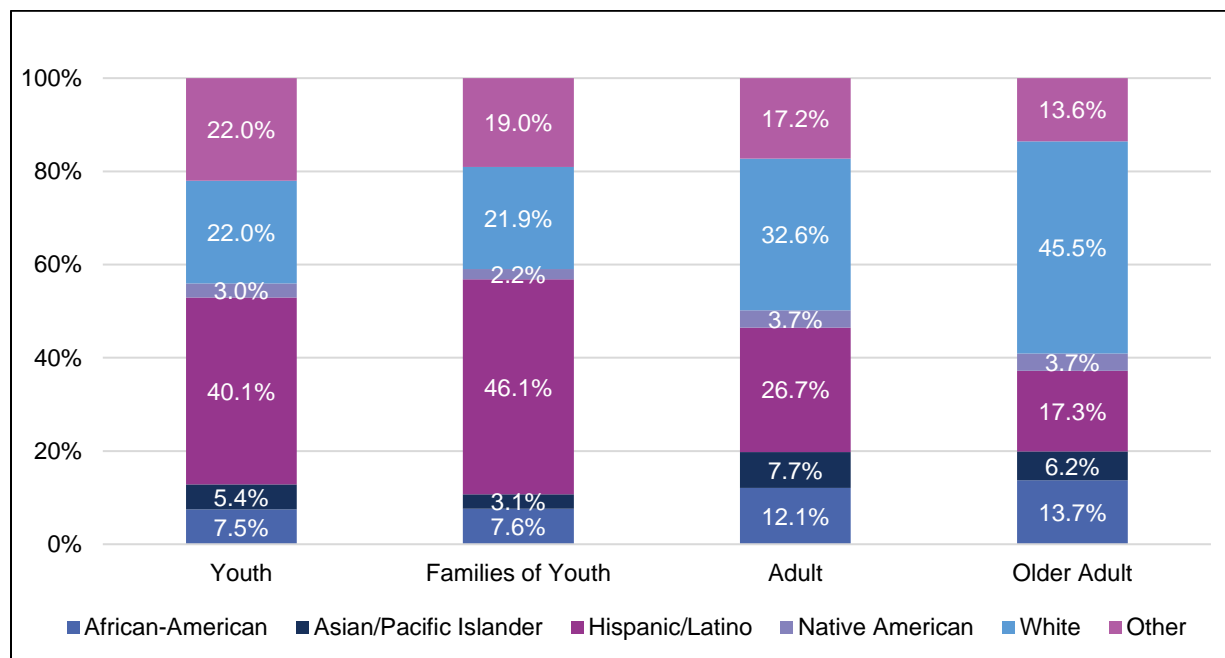
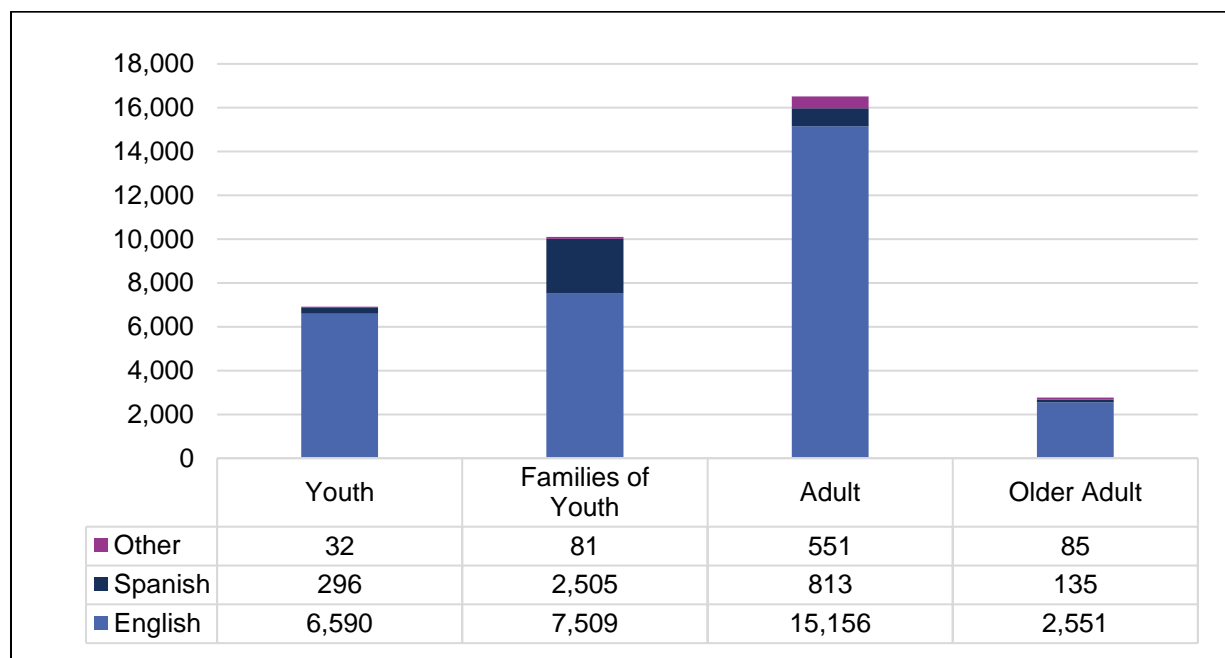
In CY 2021, DHCS received 37,642 surveys from 57 (98 percent) counties. The majority of the submitted surveys were from adults, followed by family members of children and youth (Figure 7-2).

Figure 7-2: Surveys Received by Survey Type, CY 2021



The surveys featured a cross-section of beneficiaries and family members by race/ethnicity. The survey responses by race/ethnicity are not comparable to the distribution by race/ethnicity of beneficiaries served. Those who identified as “Other,” Asian/Pacific Islanders, and Native American are overrepresented in surveys, and African Americans and Latinos are underrepresented in the surveys relative to their use of SMHS. Latino respondents submitted the most surveys, accounting for approximately 30 percent, followed closely by White respondents at approximately 28 percent (Figure 7-3).

²⁰ <https://www.uclaisap.org/mh-consumer-perception-survey.html>

Figure 7-3: Race/Ethnicity by Survey Type, CY 2021**Figure 7-4: Surveys Received in Primary Threshold Language, CY 2021**

The CPS were mostly completed in English (84.5 percent) followed by Spanish (9.9 percent). The remaining 5.6 percent of surveys were received in other languages such as Armenian, Chinese, Farsi, Hmong, Korean, Russian, Tagalog and Vietnamese. There is a 4 percent increase in the number of non-English and non-Spanish surveys in CY 2021 compared to CY 2020. For 2021, both the paper and online surveys were available in all eleven threshold

languages (statewide) as compared to only six threshold languages on the paper survey in CY 2020. (Figure 7-4)

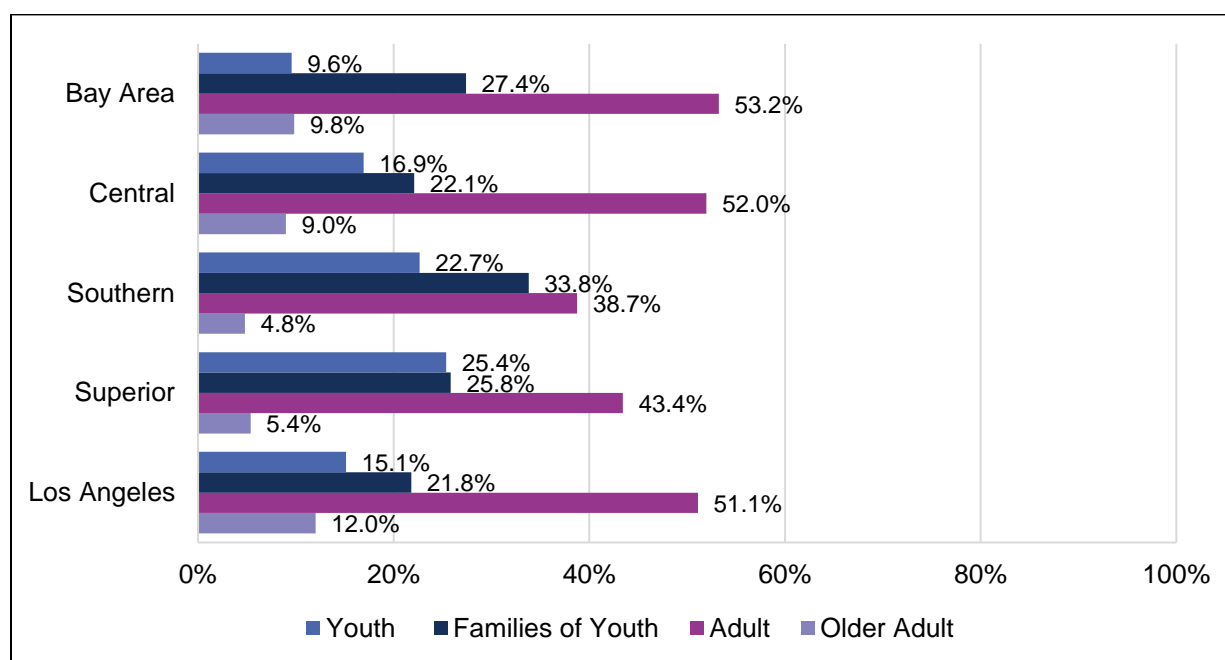
Response Rate

In 2020 and 2021, due to the COVID-19 pandemic, DHCS permanently changed the requirement for collecting CPS data to once a year in Spring as compared with twice a year in Spring and Fall, thus reducing the total number of surveys possible for analysis by half. Additionally, during the pandemic years, the response rate was also lower than pre-pandemic. The response rate is defined as the percent of surveys submitted compared to the number of individuals receiving services and eligible to complete a survey during the survey period. Among Families of Youth, the response rate decreased from 20.0 percent in 2019 to 10.0 percent in 2020. The largest decrease in survey response in that time frame was among Youth, decreasing from 23.9 percent to 5.9 percent. The response rate among Adults decreased from 26.7 percent to 13.2 percent, and among Older Adults from 31.9 percent to 8.2 percent.

In 2021, the Older Adult response rate increased slightly to 10.0 percent. Older Adults are less likely to complete an online survey, and in 2021 they were likely to have returned to some in-person services, and therefore completed more surveys than in 2020. The Response Rates among the other three survey age groups remained similar in 2020 and 2021.

It appears that telehealth and the online survey resulted in a lower response rate compared to the in-person paper survey used prior to the pandemic. Likely a combination of both workforce and client reluctance to participate may have influenced survey participation. Staff are less able to influence – and perhaps less motivated to encourage – participation in on-line surveys upon completion of a telehealth service. Previously in-person surveys, which were often completed in the waiting room with assistance of a peer or other staff if needed, allowed for staff to encourage client participation – especially if the clinical provider dedicated time before or during the scheduled appointment for the client to complete the survey.

Figure 7-5: Surveys Received by Region, CY 2021



As in the previous years, there were regional differences in the types and numbers of surveys completed (Figure 7-5). MHPs in the Central and Southern region had the highest proportion of youth surveys submitted, at 25.4 percent and 22.7 percent respectively. MHPs in the Southern region also had the highest submission of Families of Youth surveys. Bay Area MHPs returned the highest percent of Older Adult surveys (12 percent) and Southern MHPs returned the lowest percent of Older Adult surveys (4.8 percent).

Themes

Beneficiaries and family members who completed the CPS had overall favorable ratings of SMHS, as is consistent with the findings from the surveys in prior years. Respondents had higher ratings for General Satisfaction, Quality and Appropriateness, Access, and Participation in Treatment Planning than for Improved Functioning, Outcomes, and Social Connectedness (Table 7-1). Among youth and families of youth, the highest rated domain was Quality and Appropriateness of care. For adults and older adult surveys, the highest rated domain was General Satisfaction. Across all survey types, respondents were least satisfied with Outcomes, Improved Functioning, and Social Connectedness.

Table 7-1: Mean Score for Satisfaction Domains by Survey Type, CY 2021

Mean Score	Youth	Families of Youth	Adult	Older Adult
General Satisfaction	4.17	4.36	4.53	4.51
Access	4.16	4.44	4.43	4.37
Quality and Appropriateness	4.31	4.56	4.46	4.38
Participation in Treatment Planning	4.08	4.31	4.45	4.36
Outcomes	3.79	3.93	4.14	4.11
Improved Functioning	3.84	3.95	4.13	4.07
Social Connectedness	4.08	4.22	4.12	4.06

Overall, families of youth tend to be more satisfied with the services than the youth receiving services. Adults provided ratings slightly higher than older adults across all categories as well. The Outcomes category rates the lowest among youth and families of youth. While comparatively low ratings were also provided by adults and older adults for Outcomes, their lowest ratings were in social connectedness – not surprising during a period of pandemic isolation. (Table 7-1)

Access

Scores on Access were highest among families of youth, followed by adult survey respondents. Youth had the lowest rating of Access (at 4.16). In terms of satisfaction, again, families of youth were most satisfied with access. Youth, adults, and older adults had similar ratings of access, approximately 90 percent of them were satisfied with access to SMHS. Satisfaction with services were also comparable across race/ethnicity, with the exception of those who were identified as “Unknown.” It appears that less satisfied respondents were less likely to identify their race/ethnicity on the survey. Respondents who were “Unknown” older adults were the least satisfied with access to services.

Table 7-2: Mean Score and Positive Perception of Access, CY 2021

Access	Youth	Families of Youth	Adult	Older Adult
Mean Score for Satisfaction of Access	4.16	4.44	4.43	4.37
Respondents Positive Perception of Access	90%	95%	91%	90%

Overall, Families of Youth showed the highest satisfaction with Access, followed by adults. Youth showed lowest average Access rating at 4.16, but 90 percent rated positively. Older Adults showed the same 90 percent positive rating but their average (4.37) is higher than the Youth. (Table 7-2)

Table 7-3: Positive Perception of Access by Race/Ethnicity, CY 2021

Access by Race/Ethnicity	Youth	Families of Youth	Adult	Older Adult
African American	85%	96%	92%	91%
Asian/Pacific Islander	91%	95%	92%	90%
Hispanic/Latino	91%	96%	92%	93%
Native American	85%	95%	89%	89%
Other	91%	97%	92%	91%
Unknown	89%	94%	89%	79%
White	90%	96%	90%	90%

Youth were least satisfied with Access, especially youth identifying as African American and Native American. The families of youth identifying as same reported satisfaction with Access in line with other groups. For adults, Unknown and White adults showed lower satisfaction. Unknown Older Adults rated Access least favorably of all groups and ages. (Table 7-3)

Table 7-4: Positive Perception of Access by Region, CY 2021

Access	Youth	Families of Youth	Adult	Older Adult
Bay Area	92%	96%	91%	89%
Central	85%	95%	92%	89%
Los Angeles	90%	94%	91%	93%
Southern	91%	95%	90%	90%
Superior	92%	95%	91%	87%

By region alone, there were no notable differences in perception of Access. Across all regions, 90 percent of respondents were satisfied with Access. There was, however, a region and respondent (i.e., survey type) interaction. Compared with 90 percent of youth in other regions, only 85 percent of youth in the Central region reported satisfaction with Access. Conversely, older adults in most regions had the same rating of satisfaction (at approximately 88 percent),

but more of the older adult respondents in Los Angeles and Southern MHPs (90 percent and above) were satisfied with Access. (Table 7-4)

Figure 7-6: Perceptions of Access, CY 2019-21

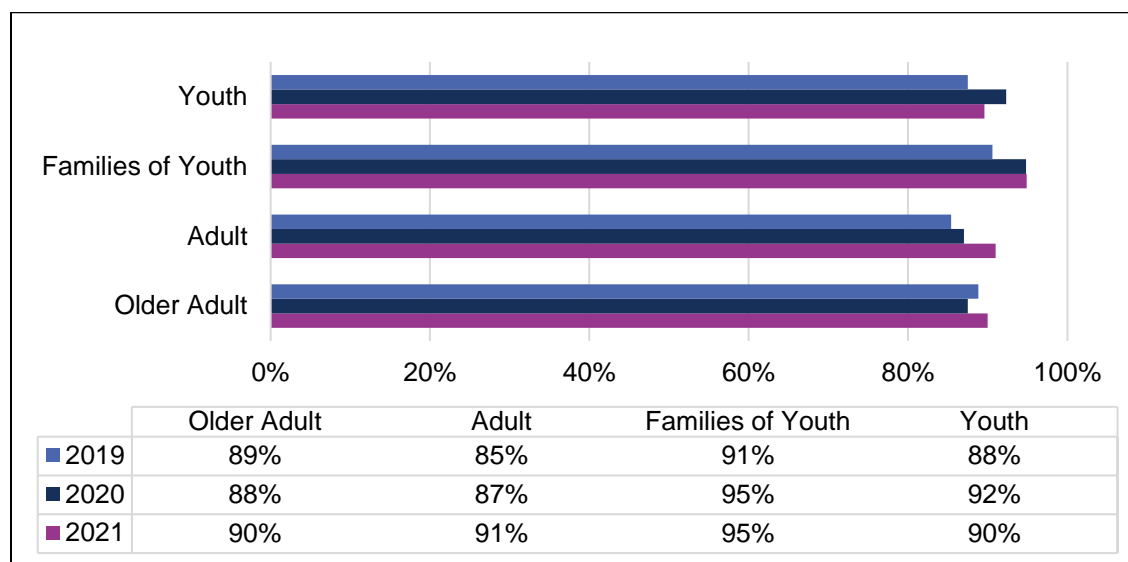


Figure 7-6 shows an average increase of 2 percentage points in satisfaction with Access among survey respondents from 2019 to 2021. Adults however showed a greater increase from 85 percent to 91 percent satisfied.

Timeliness

While the CPS does not have a satisfaction domain specifically addressing timeliness of services, CalEQRO identified three questions in the Adult and Older Adult surveys that relate to satisfaction with timeliness of services. These are “Staff were willing to see me as often as was necessary,” “Staff returned my calls within 24 hours,” and “Services were available at times that were good for me.” A Cronbach’s alpha was tested for internal consistency and analysis of these three items. The resulting Cronbach’s alpha of 0.87 allows for creating a sub-scale related to satisfaction with services that relate to timeliness of services. Among Youth and Families of Youth survey, there is one question that relates to timeliness, “Services were available at times that were good for me”. This question was used as a single item. The data on timeliness was analyzed by race/ethnicity. See Table 7-5 below.

Table 7-5: Positive Perception of Timeliness of Services by Race/Ethnicity, CY 2021

Access by Race/Ethnicity	Youth	Families of Youth	Adult	Older Adult
African American	83%	96%	91%	92%
Asian/Pacific Islander	88%	92%	90%	91%
Hispanic/Latino	89%	95%	91%	92%
Native American	80%	94%	87%	83%
Other	88%	94%	89%	88%
White	88%	96%	90%	90%

Data shows that overall, 90 percent or more survey respondents were satisfied with timeliness of services. However, among African American and Native American Youth and Native American Older Adults, between 80 percent and 83 percent reported satisfaction with this indicator. (Table 7-5)

Quality

Mean scores on perception of Quality and Appropriateness of care was high among families of youth and adults and lower among older adults and youth.

Table 7-6: Mean Score and Positive Perception of Quality and Appropriateness, CY 2021

Access	Youth	Families of Youth	Adult	Older Adult
Mean Score for Quality and Appropriateness	4.31	4.56	4.46	4.38
Respondents Positive Perception of Quality and Appropriateness	93%	97%	91%	90%

More families of youth (approximately 97 percent) had positive perceptions of the Quality and Appropriateness of care compared to other respondents, where 92 percent had positive perceptions. (Table 7-6)

Table 7-7: Positive Perception of Quality and Appropriateness by Race/Ethnicity, CY 2021

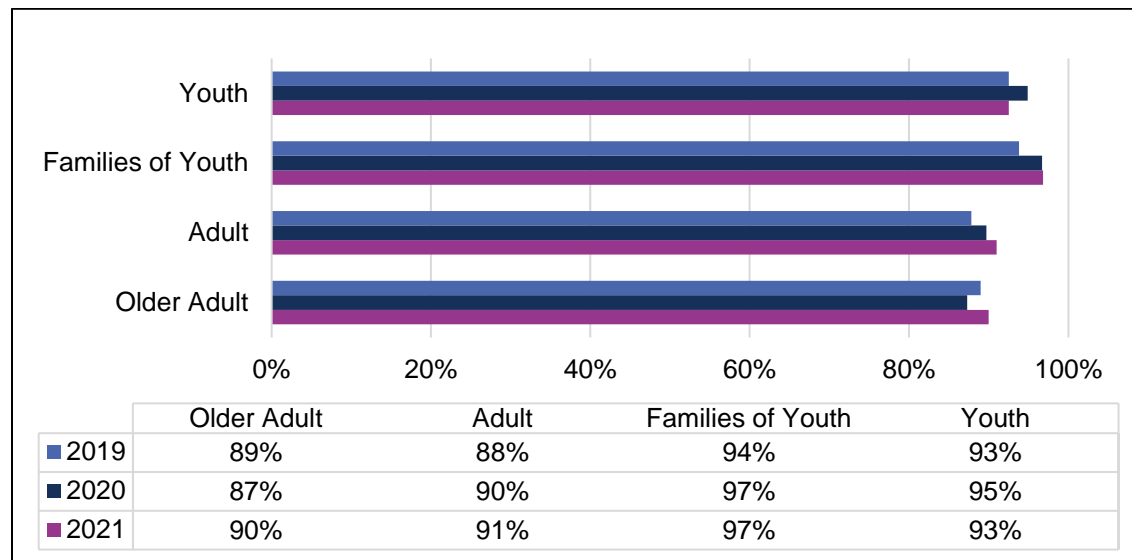
Quality by Race/Ethnicity	Youth	Families of Youth	Adult	Older Adult
African American	89%	98%	93%	91%
Asian/Pacific Islander	93%	98%	91%	90%
Hispanic/Latino	94%	97%	92%	94%
Native American	83%	97%	90%	89%
Other	94%	98%	91%	93%
Unknown	94%	99%	87%	86%
White	92%	98%	91%	90%

Satisfaction with the Quality and Appropriateness of services were comparable across race/ethnic groups, with the exception of Native Americans. Fewer Native American respondents (89 percent) were satisfied with the Quality and Appropriateness of services than other groups (averaging 92 percent), followed by those identified as Unknown. (Table 7-7)

Table 7-8: Positive Perception of Quality and Appropriateness by Region, CY 2021

Quality	Youth	Families of Youth	Adult	Older Adult
Bay Area	96%	97%	90%	88%
Central	87%	98%	92%	88%
Los Angeles	92%	95%	92%	95%
Southern	94%	97%	91%	91%
Superior	96%	97%	93%	84%

There were no regional differences in respondents' satisfaction with the Quality and Appropriateness of services, but there was a region and respondent interaction. Fewer youth respondents from Central region MHPs (87 percent) were satisfied with the Quality and Appropriateness of SMHS as compared to 92 percent or higher in other regions. For older adults, again, more respondents receiving services in Los Angeles and MHPs in the Southern region had positive perceptions of the Quality and Appropriateness of services. (Table 7-8)

Figure 7-7: Perceptions of Quality and Appropriateness, CY 2019-21

Over the three-year period, the pattern of responses for Quality and Appropriateness showed higher rates of satisfaction than the three-year responses to Access, with the exception of older adults that showed the same rates of satisfaction in the three years in both categories. In all three years, adults were the least satisfied in this category. (Figure 7-7)

Outcomes

Outcomes of care are captured in three CPS metrics: Outcomes, Improved Functioning, and Social Connectedness.

Table 7-9: Mean Score and Positive Perception of Outcome Measures, CY 2021

Outcomes	Youth	Families of Youth	Adult	Older Adult
Mean Score for Outcomes	3.79	3.93	4.14	4.11
Respondents Positive Perception of Outcomes	73%	78%	80%	81%
Mean Score for Improved Functioning	3.84	3.95	4.13	4.07
Respondents Positive Perception of Improved Functioning	73%	76%	78%	77%
Mean Score for Social Connectedness	4.08	4.22	4.12	4.06
Respondents Positive Perception of Social Connectedness	88%	91%	80%	81%

Collectively, the mean rating is 4.03 across all respondents. Of the three metrics, Social Connectedness is rated higher than Outcomes and Improved Functioning for youth and their families. (Table 7-9)

There are differences in the perception of outcomes across survey types/age groups. Across all age groups, the least (number or) proportion of respondents had positive perceptions of improved functioning as a result of the SMHS. More adults and older adults reported positive

perceptions of outcomes compared to youth themselves or their family members. More youth and family members recognized social connectedness as a positive outcome of care than either outcomes (presumably, treatment) or improved functioning.

Table 7-10: Positive Perception of Outcome Measures by Race/Ethnicity, CY 2021

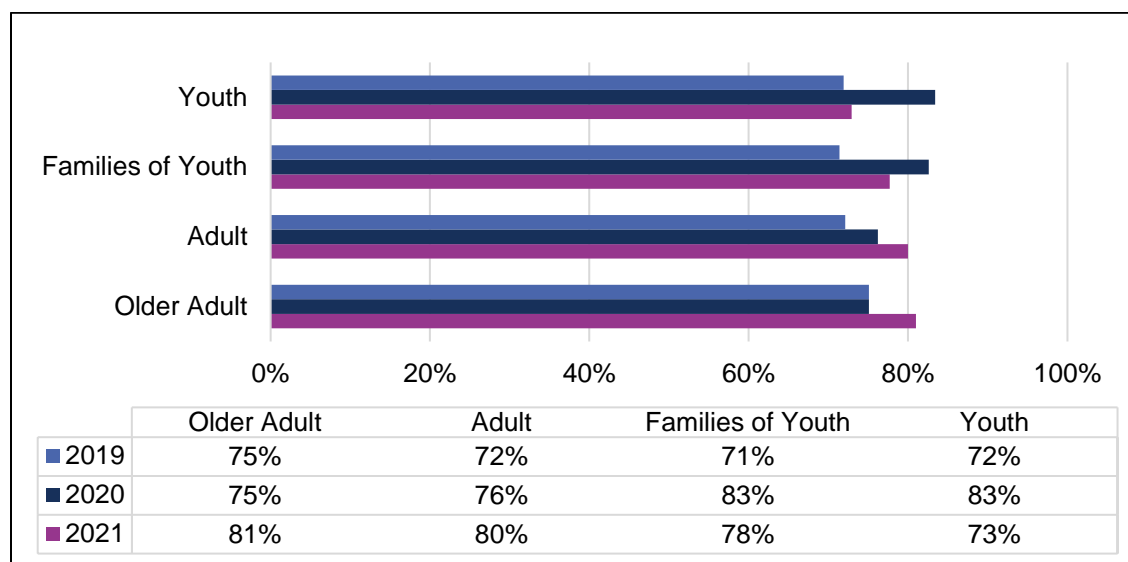
Outcomes by Race/Ethnicity	Youth	Families of Youth	Adult	Older Adult
African American	70%	72%	79%	82%
Asian/Pacific Islander	69%	74%	81%	81%
Hispanic/Latino	75%	81%	83%	86%
Native American	64%	74%	79%	76%
Other	74%	84%	82%	88%
Unknown	82%	82%	79%	75%
White	71%	74%	80%	80%

The Outcome category was analyzed by race/ethnicity. Fewer Native American respondents, approximately 73 percent, had positive perceptions of outcomes of care compared to respondents of other racial/ethnic groups, where 75 percent or higher had positive perceptions of outcomes, with the highest for the 'Other' racial/ethnic group (at 82 percent). (Table 7-10)

Table 7-11: Positive Perception of Outcomes by Region, CY 2021

Outcomes	Youth	Families of Youth	Adult	Older Adult
Bay Area	72%	81%	82%	80%
Central	69%	74%	81%	80%
Los Angeles	81%	83%	79%	85%
Southern	73%	75%	79%	82%
Superior	76%	74%	79%	69%

There were no marked regional differences in respondents' perception of Outcomes of care. However, the least proportion of respondents from MHPs in the Central region (at 76 percent) had positive perceptions of Outcomes of care. The Los Angeles MHP had the highest proportion of respondents (82 percent) who were satisfied with Outcomes of care. There is one region and age group interaction of note. Older adults receiving services through MHPs in the Superior region were among the least satisfied with Outcomes. Only 69 percent of respondents had positive perceptions of their Outcomes, compared to at least 80 percent in all the other regions and Los Angeles. (Table 7-11)

Figure 7-8: Perceptions of Outcome Measures, CY 2019-21

Beneficiary and family member perceptions of Outcomes of care have changed over the past three years. Across all age groups, more respondents (79 percent) had positive perceptions of care in CY 2020 compared to CY 2019 (72 percent). Likely, COVID-19 had some effect. Beneficiaries may have viewed Outcomes in care relative to the unprecedented time — increased isolation, youth depression, and social anxiety, amongst other adverse consequences of the pandemic. The effort that MHPs made to continue services, maintain communication, and facilitate interaction may have been viewed more positively by survey respondents, especially youth beneficiaries and their family members. One year later, a comparable proportion of respondents (79 percent) had a positive perception of Outcomes. There was however an appreciable decrease in the proportion of youth who had positive perceptions of Outcomes. (Figure 7-8)

SUMMARY OF PERCEPTIONS OF CARE

The FY 2021-22 CFM focus groups and the CY 2021 CPS continued to be affected by COVID-19, both in obtaining beneficiaries perceptions of care and in the information gleaned from them. As in the previous two years, the numbers of focus group participants and CPS respondents have decreased. Ironically, while the means to facilitate participation have expanded (i.e., through telephone, teleconference, and online), the numbers of participants/respondents have decreased. Likely with remote services, MHP staff have less influence (e.g., reminders, on the spot encouragement, provision of transportation) on beneficiary and family member participation.

Compared to FY 2020-21, there was an increase in the number of MHPs that were able to organize participants for a focus group and an increase in the numbers of participants. Nevertheless, there were still groups that did not have three or more participants sufficient to conduct the planned focus group. Also, the focus groups did not include the degree of beneficiaries who were new to services, as requested by CalEQRO, and therefore less information was obtained regarding personal experiences associated with access and timeliness of initial services.

There was an increase in CPS respondents in 2021 that included a 4 percent increase in the number of non-English and non-Spanish surveys. In CY 2021, the paper survey was available in the eleven threshold languages (statewide) whereas in CY 2020, the paper survey only included six threshold languages, suggesting that paper surveys are still an integral part of the CPS data collection, particularly for non-English speaking beneficiaries. Adult beneficiaries submitted the most surveys and older adults the least.

Overall, beneficiaries had positive perceptions of care and were grateful for the care and support that they and their family members received. Beneficiaries had high ratings for Quality and Appropriateness of care, Access to services, General Satisfaction with services, and Participation in Treatment Planning. Resumption of in-person services, with continued access to/use of telehealth, was appreciated. Telehealth offered flexibility in service delivery and reduced transportation challenges for some beneficiaries.

Beneficiaries and family members noted opportunities for improvement in staffing, competency and skill of children's providers, and access to supportive services. They noted specific areas for improvement (e.g., Cantonese-speaking participants noted the need for more Asian psychiatrists; a group of parents/caregivers recommending more clinicians skilled in childhood trauma). By contrast, the CPS showed that youth beneficiaries were generally more critical of care than other beneficiary/age groups. Youth had the lowest positive perceptions on all the variables related to access and quality of care, except (MHP efforts around) Social Connectedness. The differences in ratings and perceptions among youth respondents were typically on the order of 0.2-0.3 points or 4-5 percentage points. Although these are small differences, they were consistent. There is an opportunity, here, for all MHPs to review services to youth to understand their perceptions and to determine if there are real differences in access, timeliness, and quality of their care.

Not as stark as the difference in the perceptions of youth, there was a slight regional difference in that fewer respondents from MHPs in the Central region had positive perceptions of services.

While there was a general positive perception of services that MHPs provide, beneficiaries and family members had mixed perceptions of the effect and efficacy of those services. Beneficiaries and family members rated Outcomes, Improved Functioning, and Social Connectedness the lowest of the survey metrics. Youth beneficiaries as well as the family members of youth beneficiaries had the lowest positive perception of outcomes of care. It appears that youth and family members may have certain expectations for outcomes, which are not realized. Just as with the youth's general perception of services, there is an opportunity for further review and understanding. There is a need for more dialogue with clinical staff to understand and, perhaps, manage expectations for outcomes for youth beneficiaries – or better understand where treatment may be adjusted to improve the outcomes.

Neither the CFM focus groups nor the CPS highlighted striking or particular differences in perceptions of care by race/ethnicity. However, for three metrics, Access, Quality and Appropriateness, and Outcomes, fewer Native American respondents compared to respondents from other racial/ethnic groups had positive perceptions. Respondents in the 'Unknown' racial/ethnic group tended to have lower positive perceptions of MHP services, but without knowing who they are, it will be difficult for MHPs to address their needs in care. Unknown was differentiated from 'Other' racial/ethnic group, making it further difficult to statistically evaluate.

Beneficiaries and family members have invaluable perspectives on SMHS delivered through MHPs, and it is vital to capture perceptions of care that is meant for *them*. When given the opportunity, as per the CFM focus groups and the CPS, beneficiaries and family members provide keen and nuanced insight on services. While neither the CFM focus group nor the CPS

approximate a representative sample of beneficiaries served, they enabled general perceptions of services from a cross-section of beneficiaries and family members and focused discussion on particular topics or exigent issues affecting access, timeliness, and quality of services. The feedback from CFM focus groups and CPS, as presented here, provides a springboard from which MHPs can further assess topics identified, services and outcomes of care.

Performance Improvement Projects

INTRODUCTION

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.”²¹ 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.²² Accordingly, for this Annual Report, CalEQRO examined projects that were underway at some time during the 12 months preceding the FY 2021-22 reviews.

Each MHP is required to have two 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 non-clinical 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

²¹ 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>

²² Ibid.

METHODS

The PIP Development Tool is a template provided by CalEQRO for the MHPs to use when drafting their PIP narratives.²³ Prior to the EQR, the MHPs are expected 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 data findings, among other features.

During the EQR, the CalEQRO team discusses the documentation provided by the MHP. During these sessions, the team discusses the PIP submission with the MHP staff, often gaining a better understanding of and context for the PIP's goals that enhance the written submission. CalEQRO provides feedback and TA when applicable 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 1.²⁴

All PIPs are rated based on their completeness and adherence to 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;²⁵ the steps are shown in Table 8-1, below:

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

²³ To view the PIP Development Tool, visit CalEQRO's website: http://calegro.com/#!california_egro_resources/. The tool is found under Notification Materials/DMC Notification Materials Review Preparation Materials.

²⁴ Ibid.

²⁵ The PIP Validation Tool and PIP Submission Tool are available from CalEQRO's Website, www.calegro.com

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.

Table 8-2: PIP Status Defined

PIP Status – DHCS Contract Terminology	PIP Validation Phase – CMS Protocol Terminology 2020-21	Definition
Concept Only, Not Yet Active	PIP Submitted for Approval	The MHP submitted the PIP concept for review by CalEQRO.
Not an Active PIP	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	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.²⁶

²⁶ CMS Protocol 1

FINDINGS

In FY 2021-22, the 56 MHPs submitted a total of 98 (88 percent) of the required 112 PIPs. This is a decrease from FY 2020-21, wherein MHPs submitted 107 PIPs for validation. Detailed PIP findings across the past three years are reflected in Table 8-3 below.

Table 8-3: PIP Submission Status, FY 2019-22

Submission Status	FY 2019-20		FY 2020-21		FY 2021-22	
	#	%	#	%	#	%
Total PIPs submitted	104	93%	107	96%	98	88%
Active/Ongoing	67	60%	74	66%	63	56%
Completed	19	17%	15	13%	17	15%
Concept Only, Not Yet Active	12	11%	14	13%	13	12%
Determined not to be a PIP	7	6%	3	3%	2	2%
Inactive, developed in a prior year	6	5%	1	1%	5	4%
No PIP submitted	1	1%	5	5%	12	11%
Total Possible PIPs	112	100%	112	100%	112	100%

There was an 8.4 percent reduction in the number of PIPs submitted in FY 2021-22 (98), compared to FY 2020-21 (107). The fewest number of PIPs were submitted this year; the number of no PIPs submitted more than doubled. Of the 98 PIPs submitted, 80 received credit by either being active or active and completed during the prior 12 months.

There continues to be a consistent number of Concept Only, Not Yet Active PIPs submitted year over year.

In response to the 2019 CMS Validating Performance Improvement Projects protocol,²⁷ CalEQRO began reporting validity ratings for each submitted PIP effective FY 2020-21. Table 8-4 compares the confidence ratings between FY 2020-21 and FY 2021-22.

²⁷ Centers for Medicare and Medicaid Services. (2019). CMS External Quality Review (EQR) Protocols October 2019. Department of Health and Human Services. <https://www.medicare.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>

Table 8-4: PIP Validity Ratings, FY 2020-22

Validation Rating	FY 2020-21		FY 2021-22	
	#	%	#	%
No Confidence	27	25%	19	19%
Low Confidence	21	20%	26	27%
Moderate Confidence	52	49%	40	41%
High Confidence	7	6%	13	13%
Total PIPs Submitted	107	100%	98	100%

For FY 2021-22, the most common validation rating for the PIPs submitted was Moderate Confidence (41 percent). It was also the largest category the prior year at 49 percent. (Table 8-4)

The number of PIPs with a high confidence rating doubled from the prior year, but it is still the lowest category at 13 percent.

The number of PIPs to receive ratings of Low or No Confidence was consistent with 45 percent in FY 2020-21 and 46 percent in FY 2021-22.

TRENDS IN PIP SUBMISSIONS

Many MHPs cited competing priorities when they were asked about the lack of PIP submissions during this review year. There were staffing challenges and environmental issues that required prioritization over the PIP submissions.

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 PMs, 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. MHPs continue to deal with these challenges.

PIP TOPICS

The clinical and non-clinical PIPs can be categorized into four domains: access, timeliness, quality, and outcomes.

Table 8-5: PIP Domain by Category and Type, FY 2020-22

Domain	FY 2020-21			FY 2021-22		
	% by Domain	# Clinical	# Non-Clinical	% by Domain	# Clinical	# Non-Clinical
Access to Care	37%	12	28	23%	6	17
Timeliness of Care	16%	1	16	20%	4	16
Quality of Care	17%	12	6	16%	8	8
Outcomes of Care	30%	29	3	39%	33	6

Note: Percentages may not add up to 100% due to rounding of whole number percentages.

The number of PIPs addressing access to care decreased by nearly half in FY 2021-22 (23) from FY 2020-21 (40). The number of PIPs addressing outcomes of care increased by nearly 22 percent in FY 2021-22 (39) from FY 2020-21 (32). (Table 8-5)

Access to Care

The Access to Care PIPs, representing 23 percent of all PIPs submitted in FY 2021-22, had a variety of themes, many of which are linked to initial engagement, screening phase or linkage, and Access Call Center functions. The clinical topics focused on improvements in assessment and intake, access to telehealth, collaborative documentation, and enrollment issues. The non-clinical PIPs addressed topics that included improving attendance at different LOC, 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 8-6 and 8-7)

Table 8-6 Access to Care PIPs – Clinical

Access to Care Clinical PIP Titles	MHP
Beneficiary Enrollment Issues	Alpine
Services During COVID-19 Pandemic	Amador
Use of Collaborative Documentation to Improve No Show/Cancellation Rates and Positive Change Within the Person Served	Fresno
Improving Access, Engagement and Satisfaction Through Telehealth Services	Sacramento
Increasing Youth Engagement in Remote Services	San Mateo
Improving Screening of Co-Occurring Disorders for Beneficiaries	Yolo

Table 8-7: Access to Care PIPs – Non-Clinical

Access to Care Non-Clinical PIP Titles	MHP
Care Coordination with Primary Care	Alameda
Native American Support Group	Alpine
Gain-framed Provider Reminder Calls to Reduce No Shows to Initial Assessment Appointments	Contra Costa
Engagement PIP	Imperial
Increasing Client Access to Homeless Adult Team Appointments Via Specific Bus Route Flyers	Kern
Post-Hospitalization PIP	Merced
Improving Client Retention Rates via Service Process Improvements	Mono
Improve Client Engagement in Rehabilitation Services	Nevada
Text Appointment Reminders	San Benito
Utilizing the Youth Screening, Brief Intervention, and Referral to Treatment evidence-based approach to Increase the Number of SUD Screens, Brief Interventions, and referrals to SUD Treatment for Adolescents in Success First Early Wrap Programs	San Bernardino
Increase Client's Ability to Utilize Telehealth Services	San Mateo
Referral to SUD Services for Dual-Diagnosis Clients	Siskiyou
Creating Culturally Inclusive Care Sites	Solano
Improving Access Equity for Latin(x) Beneficiaries	Sonoma
Effectiveness of Telehealth Kiosks	Trinity
Mental Health Outreach to and Engagement with the Homeless	Tulare
Client Engagement after Intake Assessment	Ventura

Timeliness of Care

The number of Timeliness of Care PIPs that were submitted is larger than previous years, with 20 in total (20 percent), including 4 clinical and 16 non-clinical. The clinical PIPs focused on meeting specific timeliness requirements related to case management and same-day assessments. The non-clinical PIPs are focused on specific challenges in timely access to assessments and psychiatric treatment, appointment reminders, and referrals from mental health to 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. (Tables 8-8 and 8-9)

Table 8-8: Timeliness of Care PIPs – Clinical

Timeliness of Care Clinical PIP Titles	MHP
Improve Continuity of Care and Engagement in Community Outpatient Services for Detention Mental Health Consumers when they are Released	Riverside
Beneficiary Engagement Post-Discharge from the Psychiatric Health Facility (PHF)	Santa Barbara
Same-Day Assessment for Adults/Older Adults Pilot	Santa Clara
Case Management Services	Tuolumne

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

Timeliness of Care Non-Clinical PIP Titles	MHP
Timely Documentation	Amador
Reducing Wait Time Between Intake Assessment and Offered Therapy Appointment	Colusa
Improving Timeliness of Psychiatry Appointments for Adult Beneficiaries Requesting Initial Medication Support Services	Del Norte
Early SMHS Engagement Enhancement Pilot	El Dorado
Text Appointment Reminders	Glenn
Improving Timeliness to Appointments for Urgent Requests	Humboldt
Urgent Conditions	Kings
Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected	Los Angeles
Timeliness Between Assessment and First Treatment Services	Marin
Automated Reminder Calls	Mariposa
Reducing the Average Length of Time from First Assessment Visit to First Offered Adult Psychiatry appointment	Napa
Utilizing Direct Booking to Increase Timely Access to Services	Riverside
Timeliness to First Outpatient Assessment after Inpatient Discharge	Sacramento
Connections after a Psychiatric Emergency Response Team Contact	San Diego
Children's Psychiatric Timeliness	San Joaquin
Beneficiaries' Timeliness to Access and Treatment Services	Santa Clara

Quality of Care

Quality of Care PIPs accounted for a total of 16 PIPs (16 percent), with 8 clinical PIPs and 8 non-clinical PIPs. The clinical PIPs had the stated goal of improving co-occurring disorder

identification, specifically for SUD, improving community connections, assuring accurate LOC determination, and emergency and crisis support. The non-clinical PIPs focused on improving beneficiary engagement, identifying SUDs, and managing transitions of care. (Tables 8-10 and 8-11)

Table 8-10: Quality of Care PIPs – Clinical

Quality of Care Clinical PIP Titles	MHP
Decreasing the Number of Crisis Intervention Services for Beneficiaries Between the Ages of 6 and 17 Years	Del Norte
Improving the Use of Medication-Assisted Treatment for Consumers with Co-Occurring Mental Health Disorders and Substance Use	Los Angeles
Improving Services to Clients in IMDs and Similar Settings	Marin
Trauma Identification and Treatment	Merced
Using CANS to Identify SUD Needs	Nevada
Responding to People Experiencing Crisis in Public Spaces with a Behavioral Health Model	San Francisco
Hospital Emergency Department Consults	San Luis Obispo
Fields Based Backup Crisis Response for Young People	Tulare

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

Quality of Care Non-Clinical PIP Titles	MHP
Level of Care	Butte
Implementation of New SUD Screening Tool	Lassen
Lesbian Gay Bi-sexual Transgender Queer + Network of Affirmative Care	Monterey
Sexual Orientation and Gender Identity and the Beneficiary Experience in Adult System of Care Mental Health Clinics	Placer/Sierra
Child and Family Team	Santa Barbara
Improve Service Provider Response Practices when Consumers Cancel or miss SMHS Appointments	Santa Cruz
Milestones of Recovery Scales 2	Shasta
Dual Diagnosis	Tuolumne

Outcomes of Care

The largest domain for PIPs (39 percent), Outcomes of Care included 33 clinical and 6 non-clinical PIPs. 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 8-12 and 8-13)

Table 8-12: Outcomes of Care PIPs – Clinical

Outcomes of Care Clinical PIP Titles	MHP
Reducing Psychiatric Emergency Services Recidivism through Pre-Discharge Visits/Follow-up Texts	Alameda
High Utilizers	Butte
Enhancing the Journey to Wellness	Calaveras
Collateral Support	Colusa
Addressing Depression and Anxiety Among Youth	Contra Costa
Improving Individual's Community Functioning with Full-Service Partnership Targeted Assessment and On-going Evaluation of Treatment	El Dorado
Impact of Wellness Recovery Action Plans on Crisis and Psychiatric Inpatient Utilization	Glenn
Client Engagement after discharge from Sempervirens Psychiatric Health Facility	Humboldt
Multi-Disciplinary Team Meeting Clinical PIP	Imperial
Eye Movement Desensitization and Reprocessing for Trauma	Kern
Assertive Community Treatment	Kings
Use of Motivational Interviewing in Discharge Planning from Long Term Psychiatric Placement to the Community	Lake
Integration of Clinical Contact between Registration and Assessment to Improve Retention Rate	Lassen
Reducing Psychiatric Hospitalizations	Madera
Dialectical Behavior Therapy Group	Mariposa
Social Skill Development for Clients Transitioning to Adulthood from Transitional Aged Youth status	Mendocino
Integrated Health for Individuals with Severe Mental Illness	Modoc
Increasing Youth Resiliency: Connectedness and Feelings of Sadness and Hopelessness	Mono
Youth Mobile Crisis Support	Monterey
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
Wraparound Fidelity	Placer/Sierra

Outcomes of Care Clinical PIP Titles	MHP
Coordination of Care to Reduce Crisis and Inpatient Services	San Benito
Utilizing Psychoeducation and Pharmacotherapy to Address Cardiometabolic Risk Factors in Seriously Mentally Ill Population on Antipsychotic Medication During a 12-month period	San Bernardino
Preventing Crisis Service and Inpatient Utilization among Youth with Depression	San Diego
Reentry Rehab	San Joaquin
Increase of Outpatient Mental Health Therapeutic Engagement through Face-to-Face Services for SMHS clients enrolled in Federally Qualified Therapy Services	Santa Cruz
Applied Behavioral Analysis: Improve Functioning of Youth Experiencing Anxiety	Shasta
Moral Recognition Therapy Diversion Group	Siskiyou
Solano County Mobile Crisis	Solano
Enhancing Community Connection and Living Skills for High-Cost Beneficiaries	Sonoma
Measuring Social Functioning Progress	Trinity
Post Hospitalization Performance Improvement Project	Ventura

Table 8-13: Outcomes of Care PIPs – Non-Clinical

Outcomes of Care Non-Clinical PIP Titles	MHP
Emergency Department Care Coordination with Outpatient Specialty Mental Health	Fresno
Reducing Recurrent Inpatient Hospitalization in the Community	Mendocino
Integrated Health for Individuals with Severe Mental Illness	Modoc
Increasing Crisis Assessment Team Client Linkage to Outpatient Services	Orange
Decrease 30-day Readmissions to Psychiatric Emergency Services Through Prescribing Discharge Medication and Linkages to Outpatient Clinics	San Francisco
Connecting Beneficiaries from the PHF to their Post-PHF Appointments	San Luis Obispo

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.

Forty MHPs (71 percent) utilized TA from CalEQRO in the development and support of their PIPs in FY 2021-22, down from 50 MHPs (89 percent) in FY 2020-21. This is however 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 404 hours of individual TA to those 40 MHPs in FY 2021-22, averaging roughly 10 hours of TA per MHP; this is an increase compared to the 373 hours of individual TA provided to 50 MHPs in FY 2020-21. 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 collecting and using data to design PIPs that target a specific problem in a particular geographical area.

In addition to TA provided throughout the FY 2021-22 year, CalEQRO conducted quarterly PIP clinic webinars that focused on PIP development. The subject of each webinar is presented in Table 8-14.

Table 8-14: TA Provided via PIP Webinars by CalEQRO, FY 2021-22

Title of Webinar	Date
PIP Tools: PIP Development and Validation Tools	September 24, 2021
PIP Library Updates	December 14, 2021
Establishing a Problem; Conducting a Barrier Analysis; and Utilizing Stakeholder Input	March 8, 2022
Behavioral Health Quality Improvement Program (BHQIP) PIP Opportunities	June 29, 2022

SUMMARY

In summary, 98 PIPs were submitted: 80 are currently active and 13 were in the planning phase and are expected to be active within the year – the other 5 were inactive over the year. The most common topic of PIPs in FY 2021-22 was outcomes of care, reflecting 39 percent of all submitted PIPs.

CalEQRO heard consistently throughout the year that COVID-19 continued to impact many 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 8.3 percent increase in the number of hours spent on TA, though to fewer MHPs.

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.

With the onset of CalAIM, CalEQRO will encourage MHPs to take advantage of the opportunity to join in the statewide effort to improve CalAIM BHQIP Milestone 3d. “Leverage improved data exchange capabilities to improve quality and coordination of care” by developing PIPs that target the three HEDIS measures identified in this CalAIM Milestone: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence; Follow-up After Emergency

Department Visit for Mental Illness; and Pharmacotherapy for Opioid Use Disorder. CalEQRO is working with DHCS to allow MHPs to implement PIPs for these measures. This ongoing project will allow for collaboration as counties across the state embark on this new concept.

Information Systems

INTRODUCTION

CalEQRO assesses the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for HIS, as identified in 42 CFR §438.242. MHPs submit a completed ISCA, available at www.calegro.com, prior to the EQR. The ISCA commonly requires input from multiple areas of the organization, such as IT/IS, Finance, Operations, and QM. Specifically, CalEQRO utilizes the ISCA protocol to review the MHP's EHR, IT, claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the QAPI program.

INFORMATION SYSTEMS STATEWIDE

EHRs have become an integral part of ensuring the highest quality of care for beneficiaries receiving behavioral healthcare. Most county MHPs implemented newer EHRs with the MHSA technology funds that became available between 2008 and 2013. During this time, the MHPs were able to transition from the traditional practice management systems focusing primarily on Medi-Cal claims and billing. Treatment plans, progress notes, electronic prescription systems are among the newer functionalities that were added during this time. More than a decade later, CalEQRO found that MHPs have again started to consider new EHRs with newer functionalities, flexibility to connect to HIE, and greater capabilities in terms of interoperability with other systems in primary care and health and human services.

For the past ten years, the California public mental health EHR landscape has been dominated by three legacy vendors. This new spate of EHR selection and implementation is marked by the entry of several new vendors who offer updated products that promise to enhance MHP capabilities to meet CalAIM requirements and more seamless care for Medi-Cal beneficiaries. CalEQRO found an increasing number of MHPs indicating that they are looking for a new EHR in this past year, and a majority are slated to start implementation in the next two fiscal years.

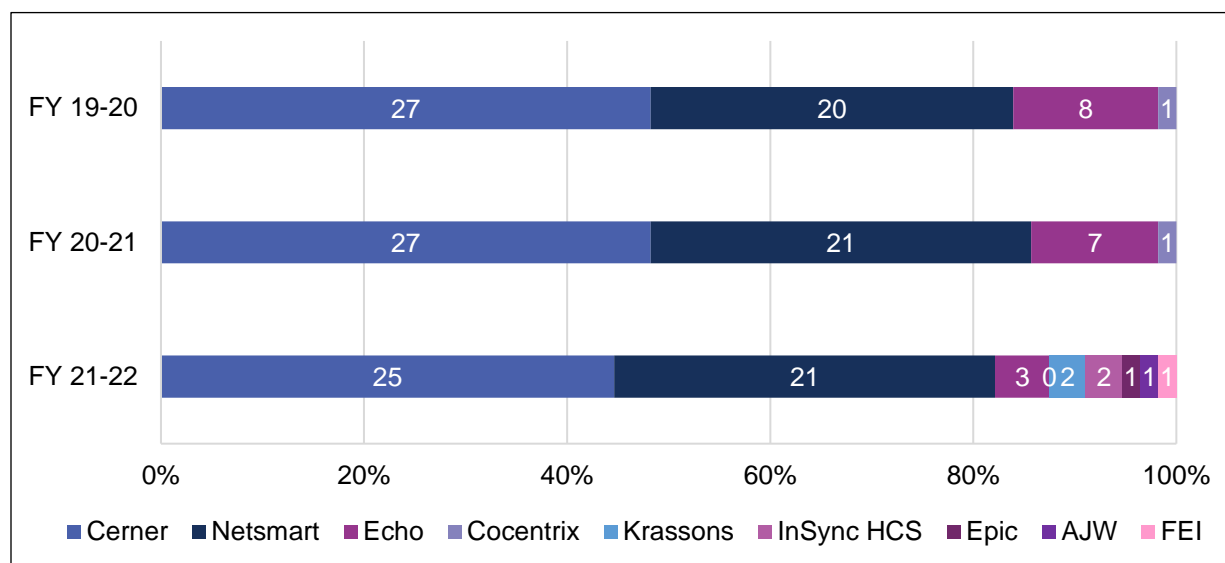
In FY 2021-22, DHCS implemented the CalAIM Behavioral Health Quality Improvement Program (BHQIP), an incentive program available to counties until FY 2023-24, that provides an opportunity for MHPs to meet interoperability requirements specified in BHIN 22-068²⁸. MHPs and DMC-ODS Plans may earn incentive payment by completing specific deliverables tied to program milestones, including technology and infrastructure. DHCS encourages and financially incentivizes MHPs to pursue this opportunity, although participation is not required.

In this chapter, CalEQRO examines the functionalities of the EHR systems that were in place during FY 2021-22, along with IT budget, staffing, and other planned IS changes. In many counties, especially in medium and large MHPs, contract or organizational providers play a

²⁸ <https://www.dhcs.ca.gov/Documents/BHIN-22-068-Interoperability-and-Patient-Access-Final-Rule.pdf>

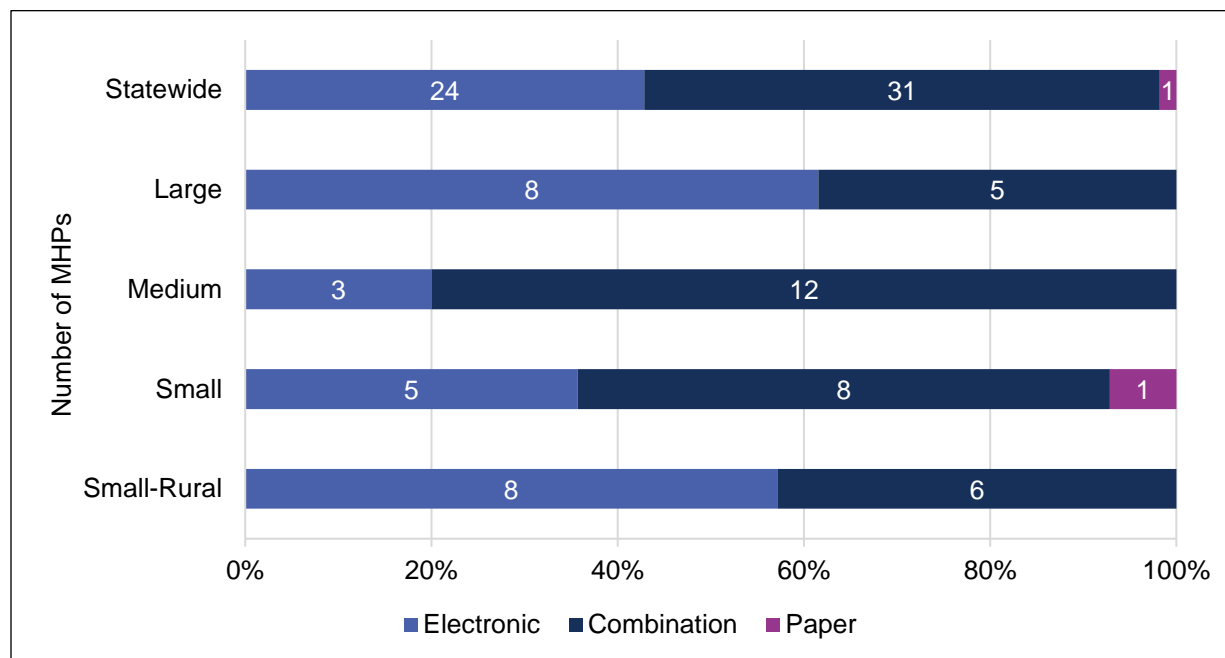
critical role in mental health service delivery; because of this, CalEQRO also looked at their ease of access to the MHP EHRs.

Figure 9-1: County EHR Vendors, FY 2019-22



FY 2021-22 saw some initial changes in the EHRs used by MHPs after more than five years of static vendor utilization. For years, the MHP EHR landscape was dominated by Cerner, Netsmart, and Echo. In FY 2021-22, MHPs reported full deployment of a few newer EHR vendors not seen in prior year reviews. (Figure 9-1)

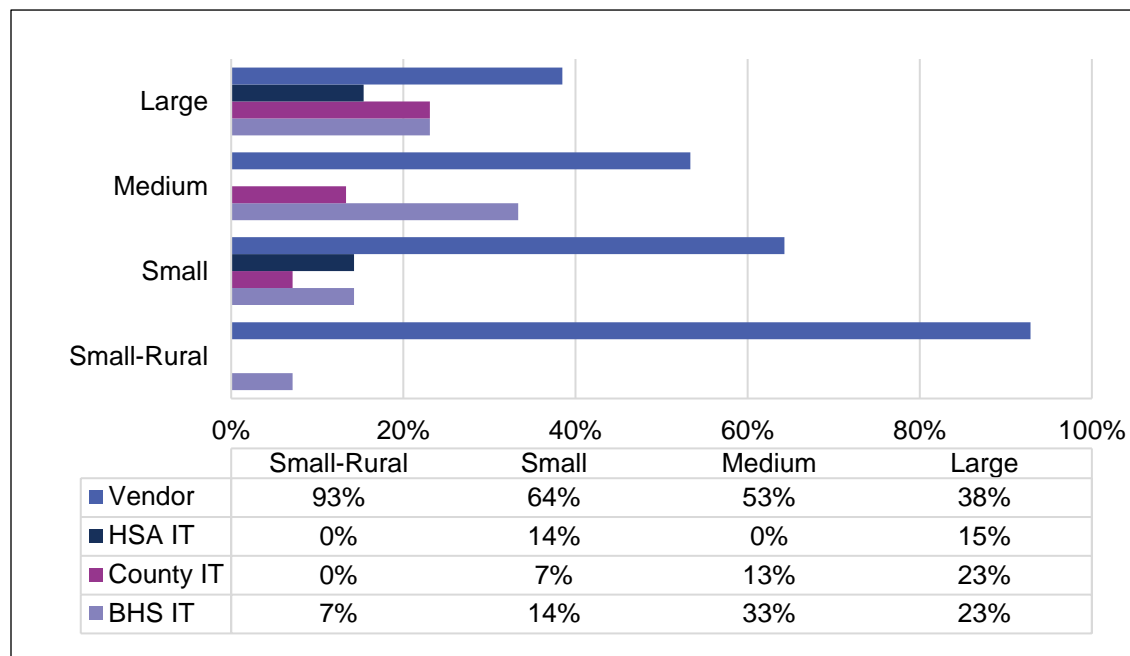
Figure 9-2: Beneficiary Health Records, FY 2021-22



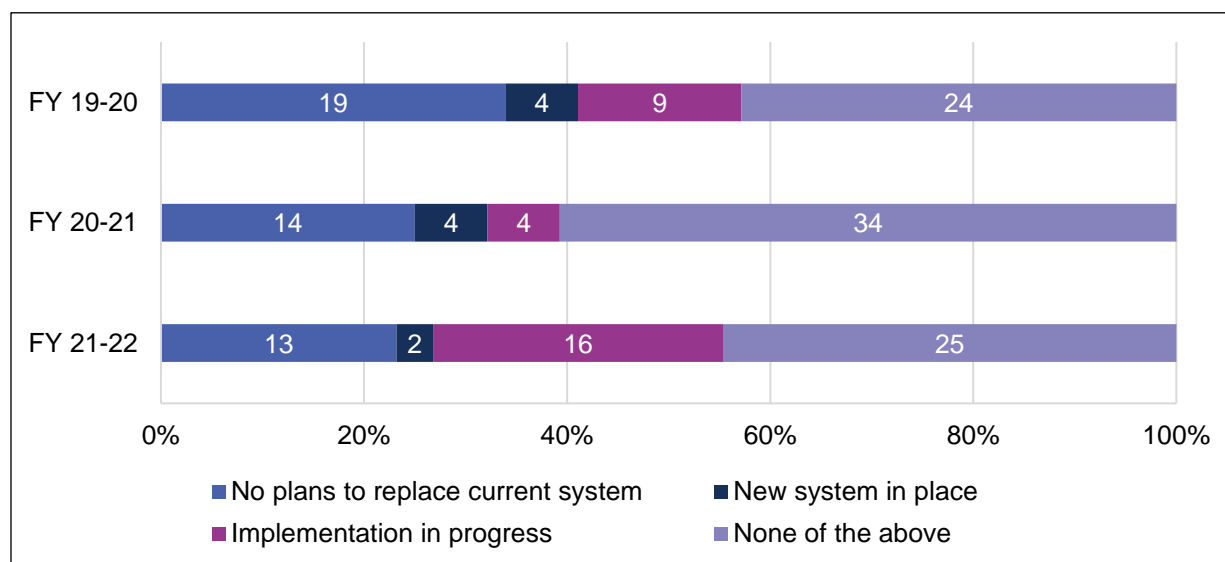
Statewide, 24 out of 56 MHPs (43 percent) maintain beneficiary health records fully electronically, 1 MHP had not yet implemented its EHR at the time of the review, and the rest

maintain a combination of both electronic and paper records. Medium and small MHPs were most likely to have a combination while large and small-rural MHPs reported fully electronic beneficiary health records. One small MHP continues to utilize a paper beneficiary chart despite efforts to implement an EHR; all others have some EHR functionality. (Figure 9-2)

Figure 9-3: Hosting of County EHR Systems by MHP Size, FY 2021-22



California MHP EHRs are managed by county or MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. More than half of the MHPs rely on their vendor or a third-party ASP to host their EHRs. The percentage of MHPs that utilize an ASP increases as the MHP size and staffing resource capacity decreases. Among the small-rural MHPs, 93 percent reported using an ASP and two-thirds of the small MHPs reported the same. Even among the large MHPs, more than one-third had vendor-hosted systems. (Figure 9-3)

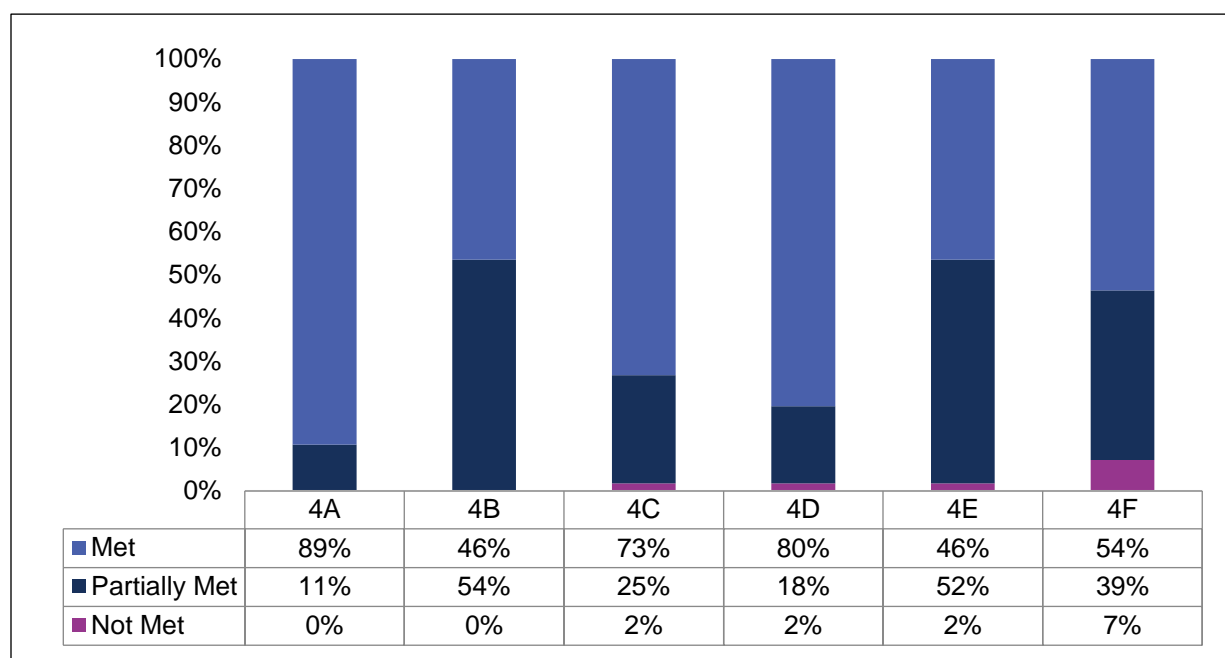
Figure 9-4: County EHR Replacement Status, FY 2019-22

An increasing number of MHPs report planning or being in the Implementation in Progress status. The biggest shift came from a reduction in the number of MHPs who had reported None of the Above in FY 2020-21; of those, most indicated that they were considering a new system in FY 2021-22. (Figure 9-4)

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. This section reviews the extent to which MHPs are fully using their EHR technology, both for accurate Medi-Cal claiming and for using that data to inform understanding of the service delivery. Optimal use of an EHR includes interoperability and use of the EHR as the medical record across the entire service delivery system – not just the County-operated programs when there are also contracted agencies providing services. If the EHR does not include all services provided to a beneficiary, treatment planning and analytics based on services are limited in usefulness. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations. It also requires that the technology and program leadership work closely to mutually understand the data needs and accurately define what data needs to be extracted for the stated programmatic purpose.

Each of the six IS Key Components, comprised of individual subcomponents, are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI. A summary of statewide performance is depicted in Figure 9-5 below, and a summary of each component follows in Tables 9-1 through 9-6.

Figure 9-5: Summary of IS Key Components, Statewide

Five MHPs (9 percent) – **Alameda, Los Angeles, Mendocino, San Francisco, and Stanislaus** – evidenced all six of the IS Key Components, and an additional 46 MHPs (82 percent) either Met or Partially Met all six. These MHPs are rated to optimally make use of their EHR functionality. With the exception of the first component, the Partially Met rating is quite dominant in this area. This further aligns with review conclusions that cited EHR issues as a Strength and an Opportunity an equal number of times, 16 in each. (Figure 9-5)

Investment in IT Infrastructure

Table 9-1: IS Key Component 4A – Statewide Ratings

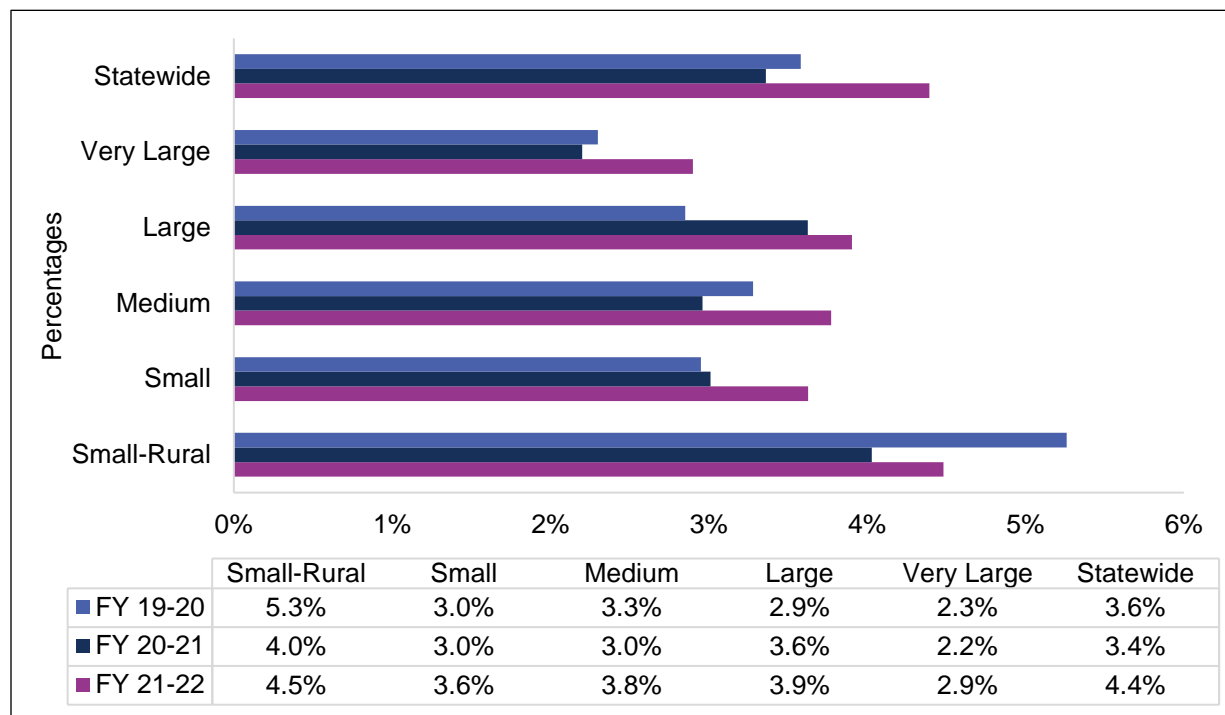
KC #	Key Component – IS	Met	Partially Met	Not Met
4A	Investment in IT Infrastructure and Resources is a Priority	50	6	0

This component evaluates the degree to which an organization’s budget is devoted to the acquisition and maintenance of IT, which in turn influences the MHP’s ability to meet its strategic and operational needs.

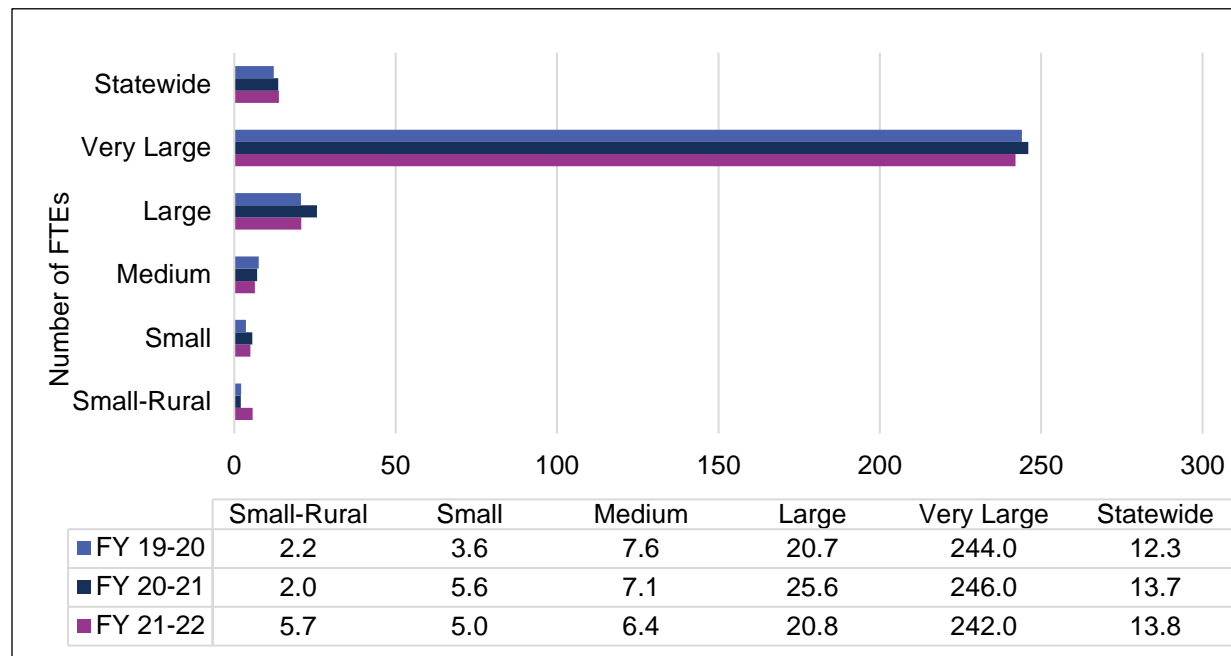
Most counties evidenced strengths in this area, with 50 MHPs rating “Met” and 6 rating “Partially Met.” Since the beginning of the pandemic, all MHPs have invested in telehealth technology and provided staff with the equipment needed for remote operation. Nonetheless, with all the new demands on HIS and reporting requirements, the existing funding levels for the HIS that may have worked with the legacy systems and historical reporting requirements may be inadequate. Increased resources are likely needed to meet the expectations for successful CalAIM implementation, which will require entirely redesigned Medi-Cal billing and more rigorous reporting of clinical service delivery and outcomes. In active preparation, **Mendocino** has already increased its IT budget to 7 percent, a significant increase from 1.57 percent reported in FY 2020-21.

The following three figures show the percentage of IT budget by MHP size (Figure 9-6), technology staffing average (Figure 9-7), and data analytics staffing average (Figure 9-8) across MHPs of all sizes for the past three FYs.

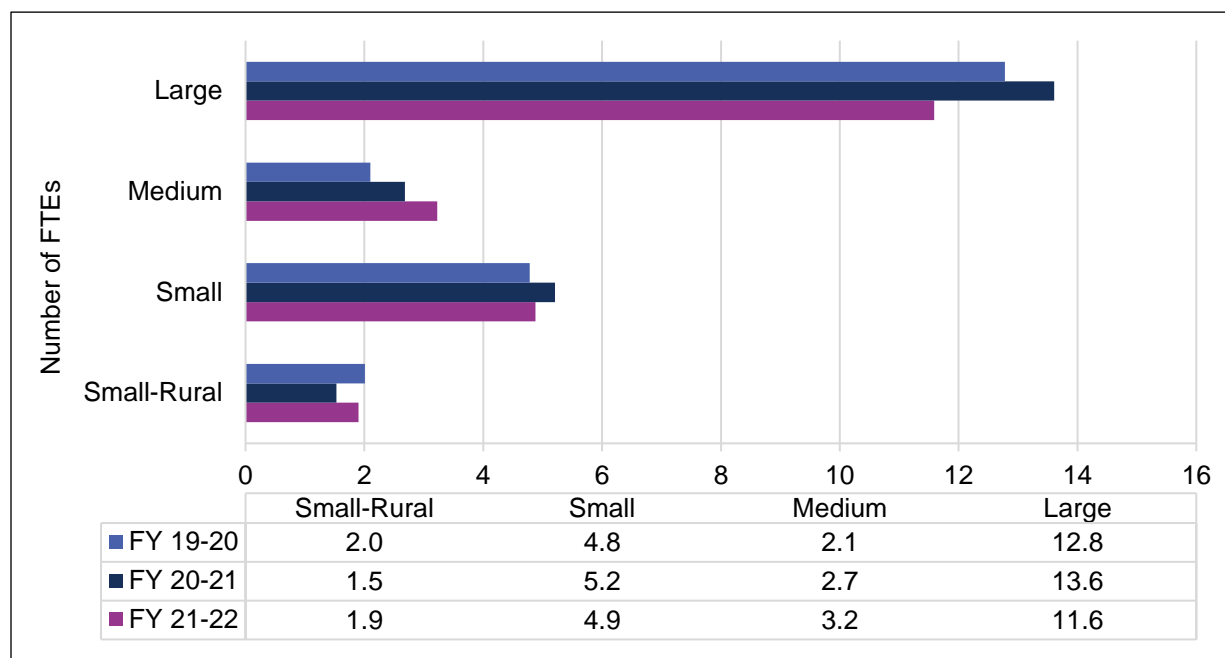
Figure 9-6: IT Budget by MHP Size, FY 2019-22



Displayed above in Figure 9-6, MHPs of all sizes reported an increase in their IT budget in FY 2021-22 compared to the previous FY – though small-rural MHPs were still below their percentage reported in FY 2019-20. Large MHPs averaged the largest percentage increase in spending on IT, more than doubling in three years. With larger budgets and more investment in technology needs, large MHPs are positioned with robust IT resources. Smaller MHPs with smaller budgets will require a greater percentage of their budget allocated to IT to maintain similar systems and still may not have the necessary staff to fully utilize the technology they maintain.

Figure 9-7: Technology Average Staffing by MHP Size, FY 2019-22

While large MHPs averaged 20.8 FTE, Los Angeles had over ten times that many staff at 242 FTE. Further comparison shows that Large MHPs have many more IT staff than MHPs of all other sizes. There remains a sizable disparity in average IT staffing between large MHPs and those of all other sizes. The demands in a larger system require more staff, and it is more likely that medium MHPs (often with similarly complex service systems) are under-resourced as opposed to over-resourcing in large MHPs. In FY 2019-20 and FY 2020-21, small-rural MHPs were clearly operating with a dearth of staff. This was remedied in FY 2021-22, and small-rural staffing is now comparable – a little larger – than small MHP staffing. (Figure 9-7)

Figure 9-8: Data Analytics Average Staffing by MHP Size, FY 2019-22

Like IT staffing shown earlier, large MHPs also have a significantly higher number of data analytical staff on average compared to other MHPs (Figure 9-8).

All MHPs have the same required reporting to DHCS. While the size of the data sets may differ, the process is nevertheless the same. Small MHPs, on average, reported having more analytical staff than the medium MHPs, although the latter group's number was steadily rising for three years at 0.5 full time equivalent (FTE) per year on average – still 1.7 FTE fewer than small MHPs. Small-rural MHP **Trinity** was able to add an analyst to its QI team. But overall, limited data analytic staff embedded in QI may mean that MHPs, especially medium and small-rural, may only have enough staff to fulfill mandated reporting requirements. As a result, many MHPs report an inability to do analytic reporting that would benefit the oversight and management of the system and successfully implement data-demanding projects, like PIPs.

An example of a large MHP investing in data analytical staffing is **Santa Clara**. The MHP created an Analytics and Reporting Division that positions it to address future EHR implementation and reporting development needs. The centralized team supports consistent processes as the MHP aims to further integrate between the mental health and SUD systems of care. Additionally, strengthening its data management, **Contra Costa** created an Office of Informatics led by a Chief of Informatics – again, this kind of significant expansion predominantly occurs in large MHPs.

Data Integrity

Table 9-2: IS Key Component 4B – Statewide Ratings

KC #	Key Component – IS Infrastructure	Met	Partially Met	Not Met
4B	Integrity of Data Collection and Processing	26	30	0

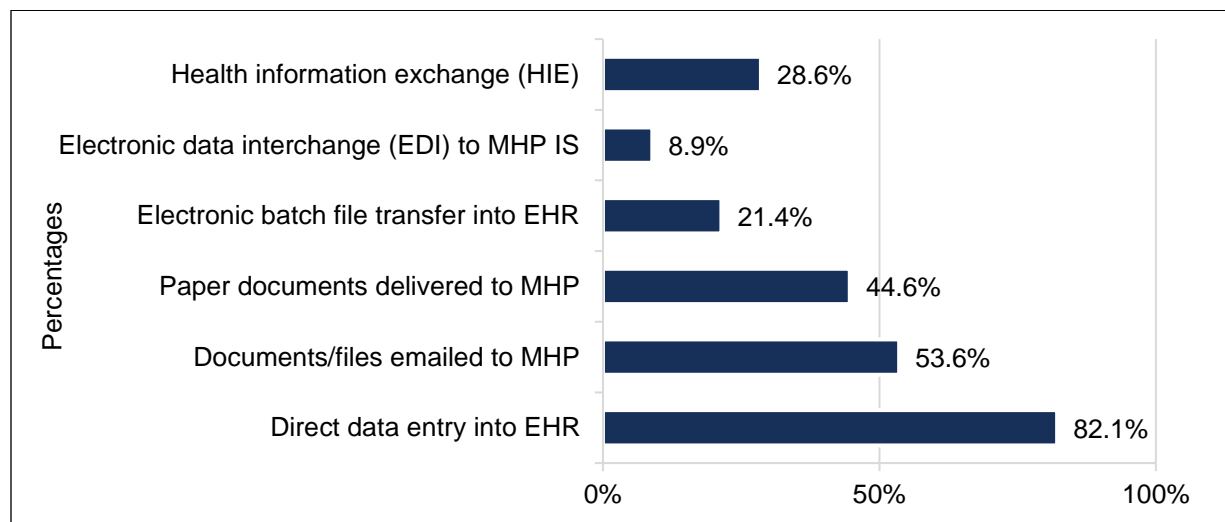
Data integrity refers to the overall accuracy, completeness, and consistency of data. It is maintained by a collection of processes, rules, and standards implemented to support core EHR functionality. When the integrity of data is secure, the information stored in a database will remain complete, accurate, and reliable no matter how long it is stored or how often it is accessed.

MHPs of all sizes rated “Met” or “Partially Met”. Large MHPs were more likely to receive a “Met” rating with small MHPs likely to receive a “Partially Met” rating.

Multiple issues contribute to the high rating of Partially Met in this category. While most MHPs have strong data collection and processing facilities for county-operated programs, the data collection and transmittal processes for the contract providers vary widely across the state. For many small and small-rural MHPs with very few or no contract providers, this is not an issue. For large and medium MHPs with a significant amount contract-provided services, there are many practices from paper and e-mail delivery of information, up to fully automated and integrated data transfer processes. When the data transfer processes are not fully automated, this often leads to manual solutions to data submission, extraction, and analytics for fulfilling reporting requirements. NA, timeliness, and Early and Periodic Screening, Diagnostic and Treatment outcomes reporting are prime examples of such practices that warrant electronic integration but often require that the MHP compiles data from multiple disparate sources for reporting to DHCS.

During FY 2021-22 reviews, CalEQRO found that many MHPs were implementing the necessary processes for Healthcare Provider Information Transaction Set (274 transactions) as part of their NA data submission. Preparation efforts were focused on identifying and mapping data previously held in separate databases to consolidate for future testing with DHCS. This is expected to implement over the course of the next FY.

Figure 9-9: Contract Provider Data Submission Modalities, FY 2021-22



Note: Percentages do not add up to 100 percent because many MHPs employ multiple modalities of data submission. Rather, each bar represents the percentage of MHPs that utilize that particular modality of data submission.

Four out of every five MHPs reported direct data entry capabilities into the MHP EHR for at least some of their contract providers – this does not mean that all or even most of the contracted services are directly entered into the county’s EHR. Many contract providers manage their own EHRs and prefer to electronic batch file transfer to the EHR, but this would be for claiming

purposes and would not contain the clinical information present in progress notes that direct use of the same EHR would offer. A notable exception in a small-rural MHP, **Inyo** has interoperability with its contracted providers. Regardless, any electronic transfer type lowers the burden of double data entry and errors associated with that. (Figure 9-9)

Half of MHPs report that some of their contract providers submit beneficiary information using paper documents or email. These two modalities typically represent the highest probability of data entry errors into the county's system.

Medi-Cal Claiming Integrity

Table 9-3: IS Key Component 4C – Statewide Ratings

KC #	Key Component – IS	Met	Partially Met	Not Met
4C	Integrity of Medi-Cal Claims Process	41	14	1

Evaluating the integrity of the Medi-Cal claims processing further examines: the presence of policies and procedures to administer the Medi-Cal claims process effectively; eligibility verification procedures in place to ensure appropriate Medi-Cal services are claimed; and that claims are submitted in a timely and accurate manner. The claims denial rate is an objective measure of the integrity of an MHP's claims processing.

All but one small MHP “Met” or “Partially Met” this component. A well-managed claims system with proper documentation lowers the risk of denied claims from the state, as well as that associated with any future audits. Overall, the MHPs generally **have** low denial rates, less than 5 percent statewide, which points to good Medi-Cal claims processing practices overall. The claiming processes in **Merced**, **Mono**, and **Sutter-Yuba** were specifically identified as Strengths, with denial rates well below the statewide average.

For the MHPs in the process of new EHR implementation, and those planning to do so soon, maintaining a strong process for the integrity of the Medi-Cal claims is critical for generating accurate and timely revenue production throughout implementation.

EHR Functionality

Table 9-4: IS Key Component 4D – Statewide Ratings

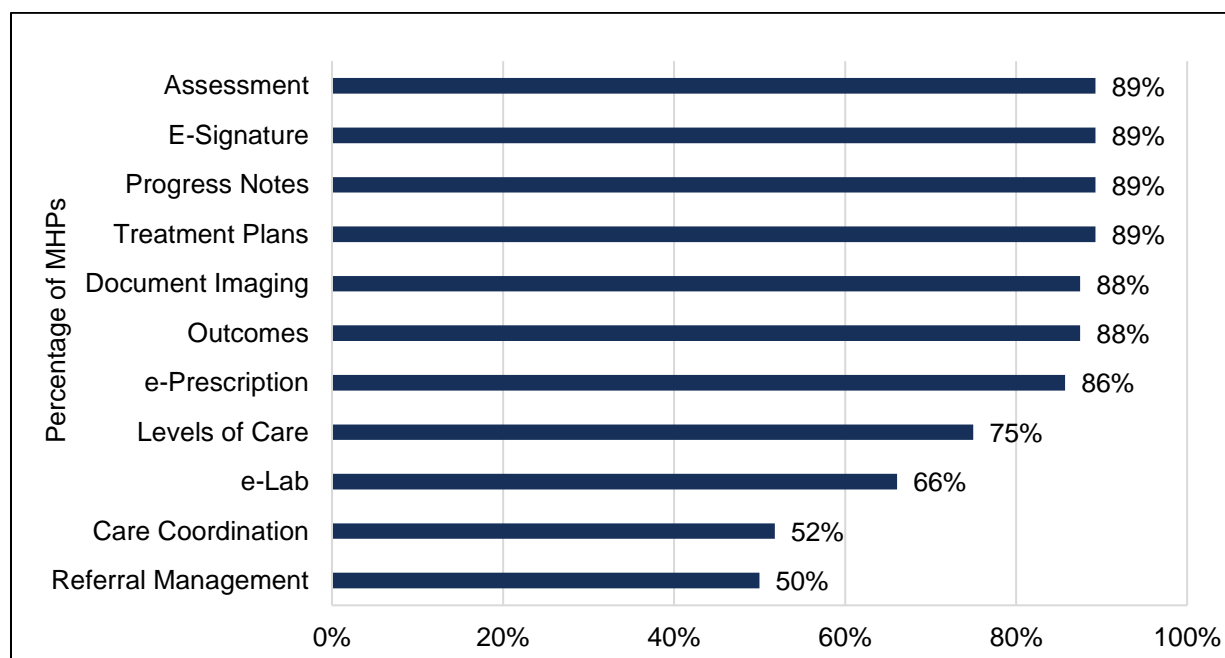
KC #	Key Component – IS	Met	Partially Met	Not Met
4D	EHR Functionality	45	10	1

EHR Functionality addresses the ability to store clinical data in electronic form as all or part of a beneficiary's medical record, with access by providers and others involved in clinical care. All but two of the medium and large MHPs rated “Met” in this category, eight of the small/small-rural MHPs “Partially Met” the elements, and only one small MHP received a “Not Met” rating.

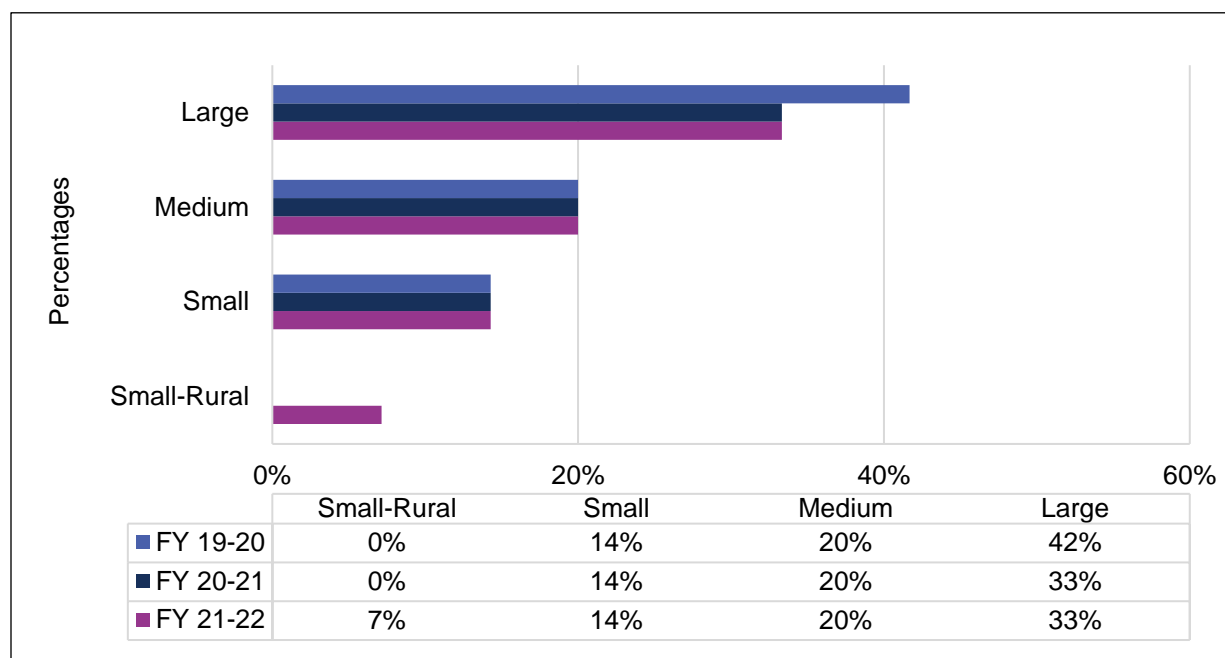
As seen in Figure 9-10, most MHPs have the core functionalities in their EHR systems such as assessments, treatment plans, and progress notes. However, for medium to large MHPs with significant contractor-operated services, the access to these functionalities remains varied. While most contract providers for some MHPs have full, two-way, look-up and data entry

privileges, many contract providers for other MHPs lack such access. In some instances, the contract providers have only look-up access to certain functionalities, many others rely on paper, fax, or e-mail documents from the county's EHR to learn about any past diagnoses, treatment plans, medication histories, and other related treatment information. This is a result of primarily two factors: Contract providers having their own EHRs with no HIE capabilities for communicating with the county EHRs and varying interpretations about privacy laws and regulations from county to county. Given that many contract providers work with multiple MHPs, many of them using different systems, a solution in which an MHP requires contract agencies to use its EHR to have a complete clinical view can also create additional complications if a contract agency must learn and interface with multiple completely different systems. In this case, a strong HIE becomes a more viable solution.

Figure 9-10: EHR Functionality, FY 2021-22



In FY 2021-22, most MHPs had operational core EHR functionalities such as assessment, treatment plans, and progress notes in place within their EHRs. In some instances, MHPs relied on adjunct or add-on systems for additional functionality such as outcomes, e-prescription, LOC, care coordination, and referral management. Half the MHPs lacked the care coordination and referral management functionalities and continued to rely on proactive communication from providers and other manual processes to assist in coordination of services as beneficiaries transition between LOC. Embedding referral management and care coordination alerts into an EHR creates efficiencies and improved care. Additionally, one-third lacked e-Lab, a significant gap for prescribing providers. And one-quarter also did not include LOC functionalities; while 75 percent of MHPs indicated that their EHR did this, there were very few examples across the state of this data being analyzed and matched to the beneficiaries' LOC provided. (Figure 9-10)

Figure 9-11: Online Personal Health Record by MHP Size, FY 2019-22

The personal health record is a portal into the EHR that enables the beneficiary and their authorized representatives to access key aspects of their record: assessments and notes written by service providers; current and past medication prescriptions; next scheduled appointment; and in some cases, signed Releases of Information, lab results and other information. If fully implemented, it can be a mechanism for online scheduling or rescheduling of appointments and two-way communication with one's providers. (Figure 9-11)

The availability of beneficiary online access varies by MHP size and showed little change in the past three FYs. Larger MHPs were more likely to have this functionality than the smaller ones. **Mariposa** was the first small-rural MHP to offer this functionality as it implemented a new EHR.

Security

Table 9-5: IS Key Component 4E – Statewide Ratings

KC #	Key Component – IS Infrastructure	Met	Partially Met	Not Met
4E	Security and Controls	26	29	1

CalEQRO evaluates the safeguards or counter measures present in MHP IS to avoid, detect, counteract, or minimize security risks to physical property, information, computer systems, or other assets. MHPs of all sizes “Met” or “Partially” met this component, with the exception of one small-rural MHP that did not.

In general, the MHPs have strong security and controls over their systems. For many MHPs, this is a bifurcated function reliant on both the EHR vendor or the ASP, and the county operations at the MHP, agency, or county levels. Often the EHR back-up and restoration process after any maintenance or interruption events are the responsibilities of the vendor or the ASP. The MHP, parent agency, or the county is often responsible for the maintenance of other

critical functionalities including internet security, network connections, e-mails, and other communications.

During the FY 2021-22 reviews, CalEQRO found that MHP IT departments do not always maintain their own business continuity plans (BCPs) in the event of a natural disaster or cybersecurity issues. In some instances, the MHP was unaware of current BCPs maintained by the county IT departments that may be called upon in the event of such untoward events. CalEQRO made several recommendations on this issue to several MHPs. This landscape explains a large percentage of partially met ratings for this Key Component. Given the state's experiences with fires that have interrupted internet capabilities in affected areas, the need for a BCP has become clearer to MHP leaders over the last few years.

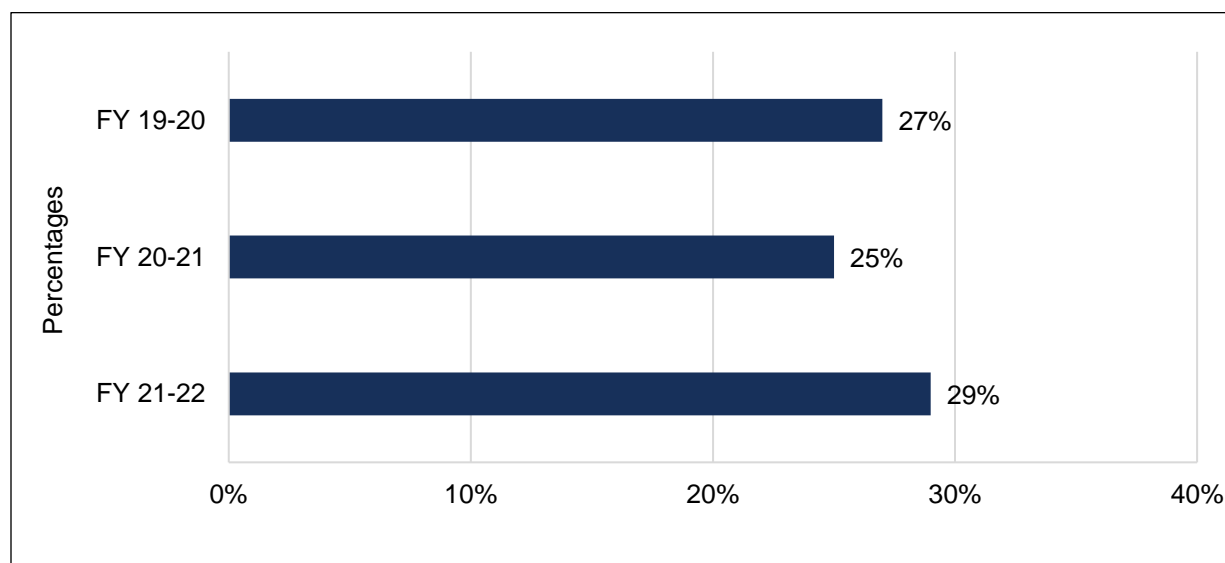
Interoperability

Table 9-6: IS Key Component 4F – Statewide Ratings

KC #	Key Component – IS	Met	Partially Met	Not Met
4F	Interoperability	30	22	4

CalEQRO examines both internal interoperability issues with the MHPs' contract providers and external capabilities through participation in an established HIE with other agencies such as the hospitals or primary care providers. Most MHPs received a rating of "Met" or "Partially Met," and the distribution was fairly equal across sizes; however, there were three medium and one small MHP that received a "Not Met" rating.

Figure 9-12: Health Information Exchange Participation, FY 2019-22



Participation in HIE continued to stagnate in FY 2021-22. Slightly more than one-quarter of MHPs participated in a HIE; within that group, the type of HIE varied widely. Some MHPs only had a HIE with their contract providers. Many MHPs cite legal or regulatory restrictions, while others cite technological challenges as reasons for their non-participation in a HIE. Some communities also lack viable HIEs. (Figure 9-12)

In FY 2021-22 reviews, CalEQRO noted that many MHPs have initiated consideration and discussion with local partners about participating in local HIEs; some are exploring or actively participating in exchanging some data elements with specific entities. HIE participation will be essential during CalAIM implementation, especially between hospital emergency departments, MCPs, and MHPs. With many MHPs beginning to learn the existing HIE landscape, they will soon need to begin participating – especially given data exchange requirements with hospital emergency departments and MCPs under CalAIM. Data exchange is necessary to obtain the appropriate data set for numerous HEDIS measures. **Alameda** has established interoperability by participating in the local HIE and has subsequently established a community health record.

INFORMATION SYSTEMS SUMMARY

As the CalAIM waiver brings forth fundamental changes in the behavioral healthcare delivery system in California, the MHPs will need significant changes in its IT infrastructure to effectively implement the requirements of this waiver. In FY 2021-22, CalEQRO found the MHPs to be in various stages of implementing changes to their information systems.

As the MHPs implement new systems or significantly enhance the capacity of their existing systems, interoperability and contract provider access to the EHRs will continue to be at the forefront of the challenges. The less access the contract providers have to the MHP EHRs, the quality of care is likely to suffer due to lack of information while making assessments and treatment plans. In addition, in some instances, double data entry will continue to be a source of errors and unnecessary workforce demands.

Another challenge in meeting the demands of the CalAIM waiver will be either a lack of HIEs in some counties, or a lack of MHP participation in the existing HIEs. For the MHPs to be able to track outcomes and PMs that require data from hospitals, primary care, and pharmacies, there will need to be statewide standardized guidelines and protocols. This will facilitate the MHPs successfully overcoming technical, technological, and legal barriers for meaningful participation in HIEs.

For the past two years, the COVID-19 pandemic created significant challenges for the behavioral health service delivery systems across California. Prior to the onset of the pandemic, only a handful of MHPs had limited capacity for delivering psychiatric services through telehealth. During the pandemic, the MHPs rose to the challenge and were able to rapidly deploy telehealth for most outpatient services. Based on the FY 2021-22 reviews, it appears that the MHPs will continue to offer telehealth services throughout their system as an alternative or adjunct to traditional, face-to-face services based on beneficiary preferences and workforce capacity.

Conclusions

OVERALL

As a result of the continued consequences of the COVID-19 pandemic, as well as recurrent wildfires profoundly impacting some counties, all FY 2021-22 EQR activities were conducted via video conferencing. The virtual reviews allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions having limited impact on the review process.

The CY 2020 Medi-Cal claims data used to validate PMs reflects the first year of COVID-19 impacts on the public SMHS system, and the data reflected some concerning findings. Statewide, fewer beneficiaries were served, PRs decreased, average lengths of hospital stays increased, and hospital readmissions increased (mostly driven by several large MHPs). Anecdotal reports from EQRs indicate that maintaining and improving access to care throughout the pandemic era has been a priority to MHPs. Review of CY 2021 data throughout the next review year will shed light onto the impact of local strategies on these important indicators of access and care.

ACCESS

Access to care decreased in CY 2020 compared to the two previous years, measured by both numbers served and PR. This trend was observed across all regions, county sizes, and demographic groups analyzed. Over 33,000 fewer beneficiaries received services in CY 2020, representing a 6.38 percent decline in PR from CY 2019.

While the overall decrease in PR impacted all race/ethnicity groups, historically underserved populations continued to have the lowest PRs statewide. The PRs for Hispanic/Latino beneficiaries (3.83 percent) and Asian/Pacific Islander beneficiaries (2.13 percent) are significantly lower than White beneficiaries (6.27 percent). MHPs remained alert to the importance of recruiting a workforce more reflective of the populations they serve or seek to serve, recognizing that both short-term and long-term strategies are necessary to meet the needs of under-served groups.

Telehealth became a standard of care during the pandemic, and with it came an emerging challenge for MHPs to incorporate telework as a workforce recruitment strategy with the demands of service delivery. At a time when recruiting any workforce has been challenging in ways previously unforeseen, it has become increasingly important to balance the retention of a dwindling workforce with the needs of complex, high-need clients.

TIMELINESS

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 LOC, staffing, and administrative infrastructure to get an individual into services in a timely manner. Whether a service is delivered in a timely manner can impact whether a beneficiary chooses to enter treatment at all. Ultimately, delays in entry to care can result in detrimental outcomes.

While most MHPs are meeting metrics for “offering” appointments within a timely manner, the difference between the offered appointment and the actual service delivered – especially when greater than a few days – warrants further investigation. When beneficiaries decline the initial service offered, they may not have many other appointment choices, resulting in a lengthy wait time. Other systemic barriers to care and NA should be examined, as wait times also impact show-rates, overall engagement in care, and ultimately the desired outcomes. MHPs with longer wait times, especially, must prioritize this aspect of care delivery.

QUALITY

Service patterns in CY 2020 suggest an increased need to analyze local findings and conduct improvement activities when necessary. For counties that are experiencing lower PR, increased hospital readmissions, and increases in the numbers of HCBs, examination of root causes is especially important. This must also be done with Access and Timeliness issues as part of the context. With a limited workforce, MHPs must delicately balance service delivery priorities with oversight of the quality of those services provided.

Currently, there is no required LOC instrument for adults. MHPs are required to utilize the CANS and PSC-35 for their children’s/youth systems of care, however. While a few utilize aggregate reporting for capacity management and outcomes review, most have not yet begun to aggregate this data for analysis. More commonly, decisions regarding program placements were often reportedly based on clinical judgment, program and provider capacity, and clinician/staffing availability.

Claims data shows that 30 percent of beneficiaries discharged from a Medi-Cal billable inpatient facility do not receive any mental health service within 30 days. Greater analysis of the population that is not engaged in outpatient care after an acute admission is warranted, and interventions to remedy this are needed.

The implementation of CalAIM is intended to bring an era where quality of care is prioritized over burdensome documentation, but managing care based upon quality of services and outcomes of care will require strong technical expertise within QM. Currently MHPs show great variation in the availability of IT and data analytic staff who can extract data and conduct the analyses necessary, as well as few staff skilled in QI strategies that must follow the analyses. With new EHRs on the horizon, easier report output should enable MHPs to focus on planning and implementing improvements based upon their data in near real time, and should also include MHP leadership, relevant stakeholders, and subject matter experts. Challenges evident in successfully designing and implementing PIPs suggest that the paradigm shifts associated with CalAIM may be challenging for many MHPs.

INFORMATION SYSTEMS

For the past two years, the COVID-19 pandemic created significant challenges for the behavioral health service delivery systems across California. Prior to the onset of the pandemic, only a handful of MHPs had limited capacity for delivering psychiatric services through telehealth. During the pandemic, the MHPs rose to the challenge and were able to rapidly

deploy telehealth for most outpatient services. Based on the FY 2021-22 reviews, it appears that the MHPs will continue to offer telehealth services throughout their system as an alternative or adjunct to traditional, face-to-face services based on beneficiary preferences and workforce capacity. Clear procedures to guide these decisions are warranted.

To effectively implement the requirements of the CalAIM waiver and the associated changes to the behavioral healthcare delivery system in California, MHPs will need significant changes in their IT infrastructure. Barriers to interoperability and contract provider access to the EHRs must be addressed. Statewide standardized guidelines and protocols for HIE participation are needed so that MHPs can track outcomes and PMs that require data from hospitals, primary care, and pharmacies. Such standardization will facilitate the MHPs successfully overcoming technical, technological, and legal barriers for meaningful participation in HIEs.

RECOMMENDATIONS

The following recommendations are intended for California's SMHS delivery system, inclusive of DHCS and the 56 MHPs. Some are broadly applicable statewide, though not all recommendations are suited to every county. To improve the access, timeliness, and quality of care provided to Medi-Cal beneficiaries throughout California, CalEQRO encourages DHCS and MHPs to work together toward these recommendations as they advance the implementation of CalAIM and the 2022 Comprehensive Quality Strategy:

1. Develop, strengthen, and prioritize the knowledge and skills necessary for continuous QI throughout the SMHS service delivery system. This includes interpretation of analytic reports, root cause analysis, and identification and implementation of improvement strategies to respond to system needs or gaps in a timely manner.
2. Prioritize the development and execution of meaningful PIPs based on local needs that will improve beneficiary outcomes of care.
3. Analyze service patterns of high-cost beneficiaries who may be receiving a high quantity of service, but not necessarily the right ones for them. This includes implementation of clinical tools to assure that individuals are served at the most appropriate LOC to achieve the best outcomes, and using the results on an individual, clinical basis as well as from an aggregate, program, or systemwide perspective. With a reduced workforce, delivering services at the wrong LOC, or providing services not shown to deliver outcomes, is not feasible.
4. Prioritize the development, recruitment, and retention of the behavioral health workforce. Incorporate lessons learned from the 2021 California Behavioral Health Workforce Assessment and seek input from the local, existing workforce to maintain their employment and prevent or mitigate burnout.
5. Monitor service utilization and examine ways to increase numbers served to pre-pandemic levels – or higher – given that mental health needs have been severely exacerbated by the pandemic and its consequences. Analysis of existing disparities in access will be key to increasing access in areas where it is especially warranted.
6. Continue to improve data collection that captures wait times at all access points so that timeliness of care can be adequately monitored and improved when necessary. Timely access to services should also bring improved engagement after the service request; this warrants local root cause analysis and ongoing monitoring. Focused attention

should be paid to individuals identified with urgent service requests who do not follow through with care.

7. Prioritize IT infrastructure development, including interoperability, care management, and referral coordination functionality to better manage linkages, coordinate care, and effectively implement the requirements of CalAIM.
8. Collaborate with MCPs for transitioning beneficiaries out of the SMHS system when clinically appropriate. This will aid in capacity management, facilitate care coordination, and promote improved systems and beneficiary outcomes.
9. Continue to provide telehealth for those beneficiaries who benefit from it and provide in-person services for those who need it. Analyze service patterns by race/ethnicity and geographic regions to assess for improvement opportunities related to availability of preferred service modality.
10. Balance the retention of a dwindling workforce with the needs of complex, high-need clients, who often need to receive services in a clinic setting, their homes, elsewhere in the community, or a combination of all three.

OTHER CONSIDERATIONS

CMS issued a letter to DHCS 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 amended the current Behavioral Health EQRO contract with an effective date of July 1, 2022. The new contract requirements are tailored to remediate some of the CMS findings and achieve full compliance with federal statutory references related to quality assessment and performance improvement standards.

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, H0032 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, 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, 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	<p>Expanded eligibility for children under 19, who are eligible with full scope Medi-Cal benefits regardless of immigration status, as long as all other eligibility requirements are met. To be identified as “SB75 Eligible” beneficiary status (SB75 flag = “1”) is met AND one of the following aid codes.</p> <p>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.</p> <p>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.</p>
EPSDT Eligible Aid Codes	<p>Beneficiary age is less than 21 AND identified with SB-75 status (SB-75 flag = “0”) AND one of the following aid codes:</p> <p>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.</p>
Excluded aid codes - not SDMC funded or inactive in MEDS.	<p>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.</p>
Eligibility Status	<p>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.</p>
	<p>1st Digit =Medi-Cal/CMSP/Other Eligible Status</p> <p>0 Eligible with no conditions (includes zero SOC)</p> <p>1 Share of Cost to be met by LTC claim</p> <p>2 LTC/SOC plus other conditions (i.e., 1+3)</p> <p>3 Other conditions Certified SOC, Restricted Service, Minor Consent or Partial Health Care Plan</p> <p>4 Medi-Cal eligible with Full Service Medi-Cal Health Care Plan Coverage</p> <p>5 Unmet Share of Cost Obligation (Uncertified SOC)</p> <p>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)</p> <p>7 Hold</p> <p>8 QMB pending Medicare part A & B confirmation</p> <p>9 Ineligible</p> <p>2nd Digit =Normal/Exception Eligibility</p> <p>0 Normal Eligible</p> <p>1 Unconfirmed Immediate Need eligible reported more than 1 month prior</p> <p>2 Unconfirmed Immediate Need Eligible reported 1 month prior</p> <p>3 Unconfirmed Immediate Need Eligible reported in current month</p> <p>4 Forced eligible due to late termination</p> <p>5 Partial Month Eligibility (Healthy Families, etc.)</p> <p>7 Exception eligible</p> <p>8 Forced eligible from MEDS hold</p> <p>9 Full Month Eligibility (Healthy Families, etc.)</p> <p>3rd Digit=Timeliness /Misc. Information</p> <p>1 Regular eligible reported timely</p> <p>2 Regular eligible reported retroactively</p>

	3 3 months 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	

APPENDIX

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

APPENDIX 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

MHP County	MHP Size	MHP Region
Riverside	Large	Southern
Sacramento	Large	Central
San Benito	Small	Bay Area
San Bernardino	Large	Southern
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





APPENDIX 3: FY 2021-22 PERFORMANCE MEASURES

Figure PM-1: Medi-Cal Eligibles and Beneficiaries Served Statewide, CY 2018-20

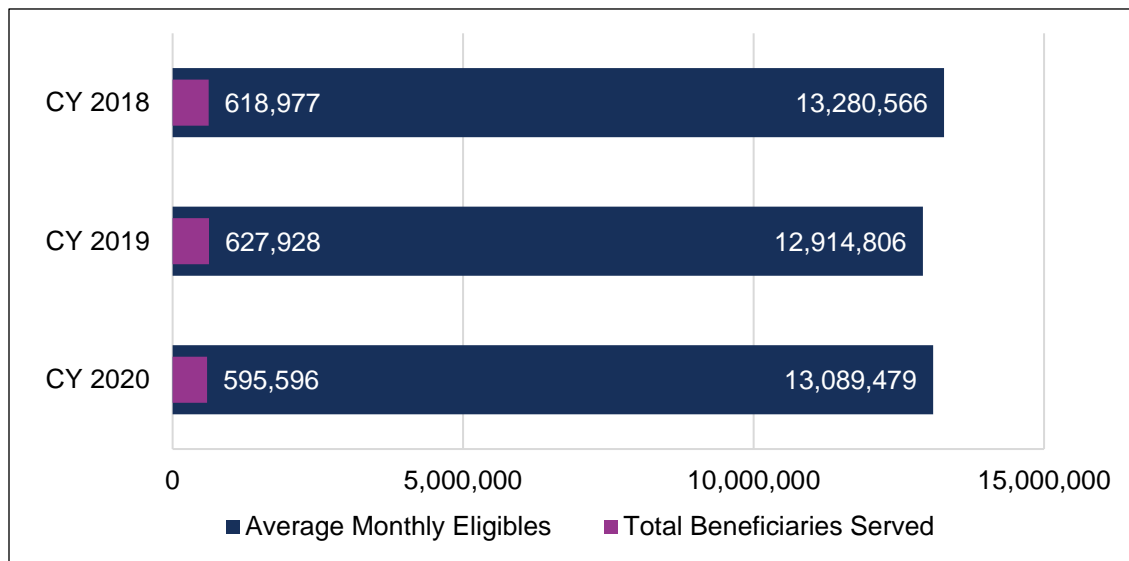


Table PM-1: Statewide PR and AACB Three Year Trend, CY 2018-20

	Average Monthly Eligibles	Total Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2018	13,280,566	618,977	4.66%	\$3,994,630,000	\$6,454
CY 2019	12,914,806	627,928	4.86%	\$3,966,010,000	\$6,316
CY 2020	13,089,479	595,596	4.55%	\$4,261,350,000	\$7,155

Table PM-2: Eligibles and Beneficiaries Served by County Size, CY 2018-20

Category	# of Beneficiaries Served	# of Eligibles	% of Beneficiaries Served	% of Eligibles	PR	AACB
Very Large						
CY 2018	210,337	3,964,272	34.09%	29.85%	5.31%	\$6,176
CY 2019	221,136	3,843,353	35.32%	29.76%	5.75%	\$6,256
CY 2020	212,272	3,866,435	35.74%	29.54%	5.49%	\$6,748
Large						
CY 2018	280,189	6,494,707	45.41%	48.90%	4.31%	\$6,750
CY 2019	278,182	6,323,746	44.43%	48.97%	4.40%	\$6,219
CY 2020	265,801	6,434,454	44.75%	49.16%	4.13%	\$7,156
Medium						
CY 2018	85,397	2,053,900	13.84%	15.47%	4.16%	\$6,785
CY 2019	84,704	1,993,115	13.53%	15.43%	4.25%	\$7,143
CY 2020	78,220	2,021,916	13.17%	15.45%	3.87%	\$8,399
Small						
CY 2018	32,502	655,800	5.27%	4.94%	4.96%	\$5,602
CY 2019	33,219	644,702	5.31%	4.99%	5.15%	\$5,982
CY 2020	29,631	654,201	4.99%	5.00%	4.53%	\$7,142
Small-Rural						
CY 2018	8,628	111,888	1.40%	0.84%	7.71%	\$3,794
CY 2019	8,877	109,891	1.42%	0.85%	8.08%	\$4,310
CY 2020	8,002	112,476	1.35%	0.86%	7.11%	\$6,238

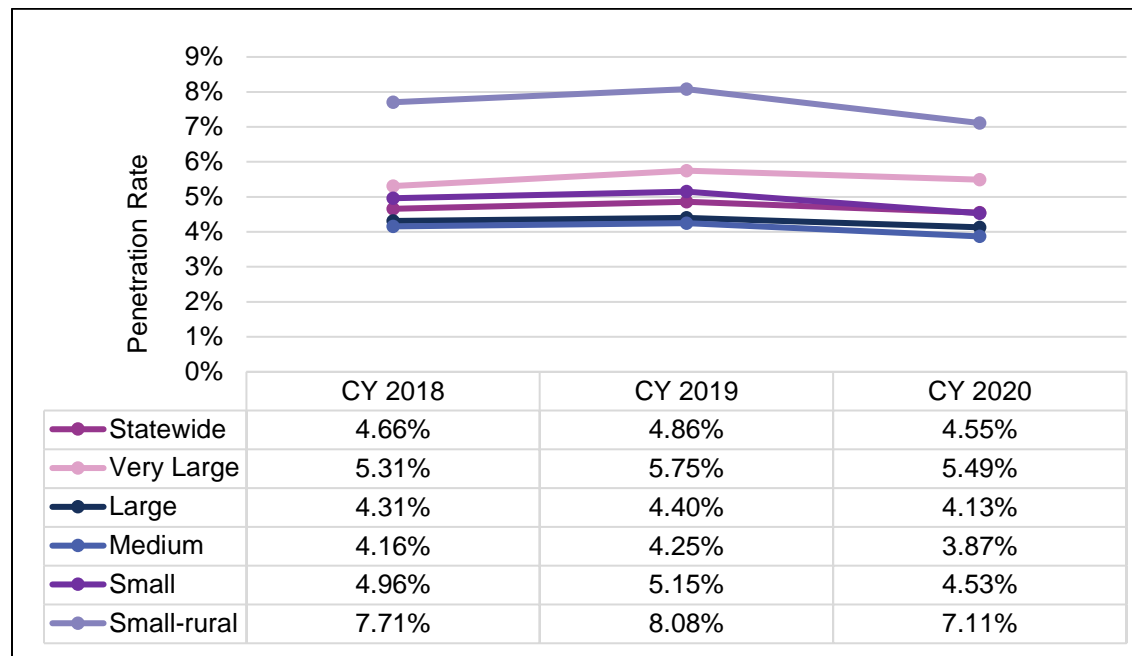
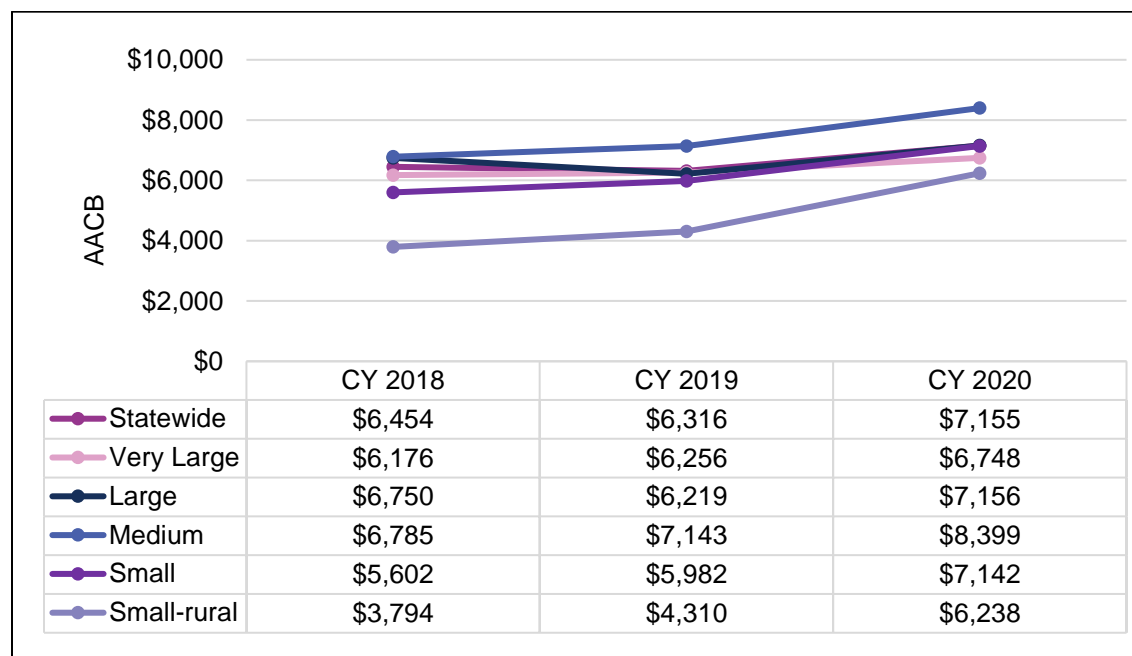
Figure PM-2: Overall Penetration Rates by MHP Size, CY 2018-20**Figure PM-3: Approved Claims per Beneficiary Served by MHP Size, CY 2018-20**

Table PM-3: Eligibles and Beneficiaries Served by County Region, CY 2018-20

Category	# of Beneficiaries Served	# of Eligibles	% of Beneficiaries Served	% of Eligibles	PR	AACB
Bay Area						
CY 2018	107,905	2,087,709	17.49%	15.72%	5.17%	\$10,211
CY 2019	108,028	2,012,246	17.25%	15.58%	5.37%	\$9,352
CY 2020	101,477	2,041,248	17.09%	15.59%	4.97%	\$11,056
Central						
CY 2018	96,284	2,378,549	15.60%	17.91%	4.05%	\$5,156
CY 2019	95,006	2,327,951	15.17%	18.03%	4.08%	\$5,071
CY 2020	89,987	2,365,670	15.15%	18.07%	3.80%	\$6,237
Los Angeles						
CY 2018	210,337	3,964,272	34.09%	29.85%	5.31%	\$6,176
CY 2019	221,136	3,843,353	35.32%	29.76%	5.75%	\$6,256
CY 2020	212,272	3,866,435	35.74%	29.54%	5.49%	\$6,748
Southern						
CY 2018	177,370	4,437,502	28.74%	33.41%	4.00%	\$5,314
CY 2019	176,209	4,329,683	28.14%	33.52%	4.07%	\$5,195
CY 2020	167,130	4,413,347	28.14%	33.72%	3.79%	\$5,785
Superior						
CY 2018	25,165	412,535	4.08%	3.11%	6.10%	\$5,753
CY 2019	25,754	401,573	4.11%	3.11%	6.41%	\$6,388
CY 2020	23,077	402,780	3.89%	3.08%	5.73%	\$7,391

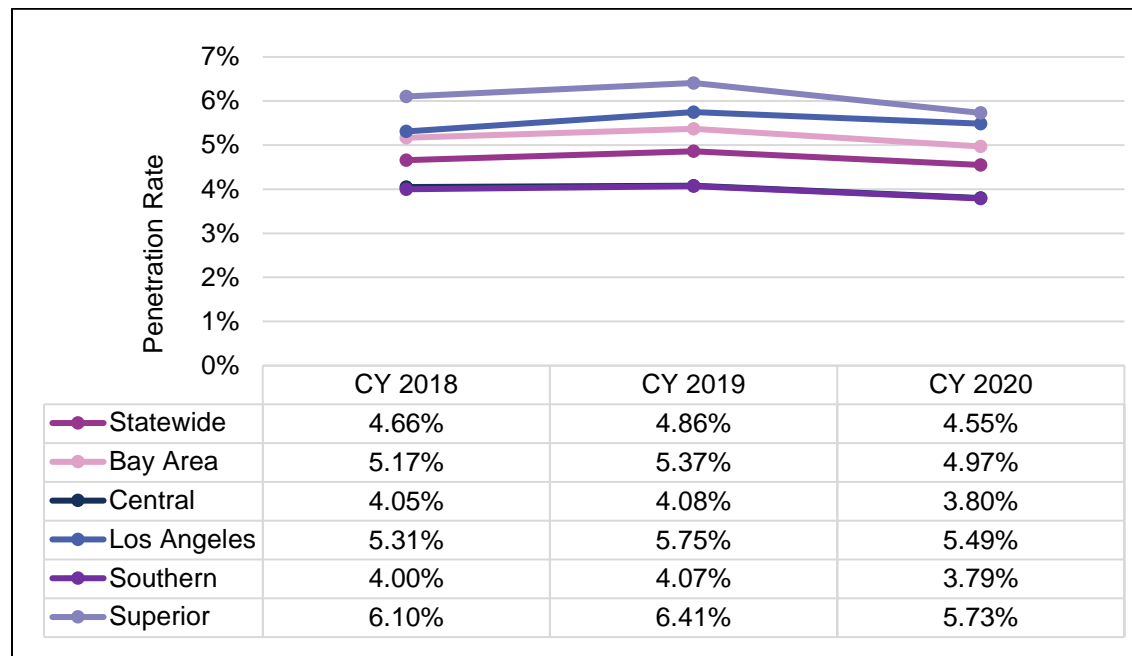
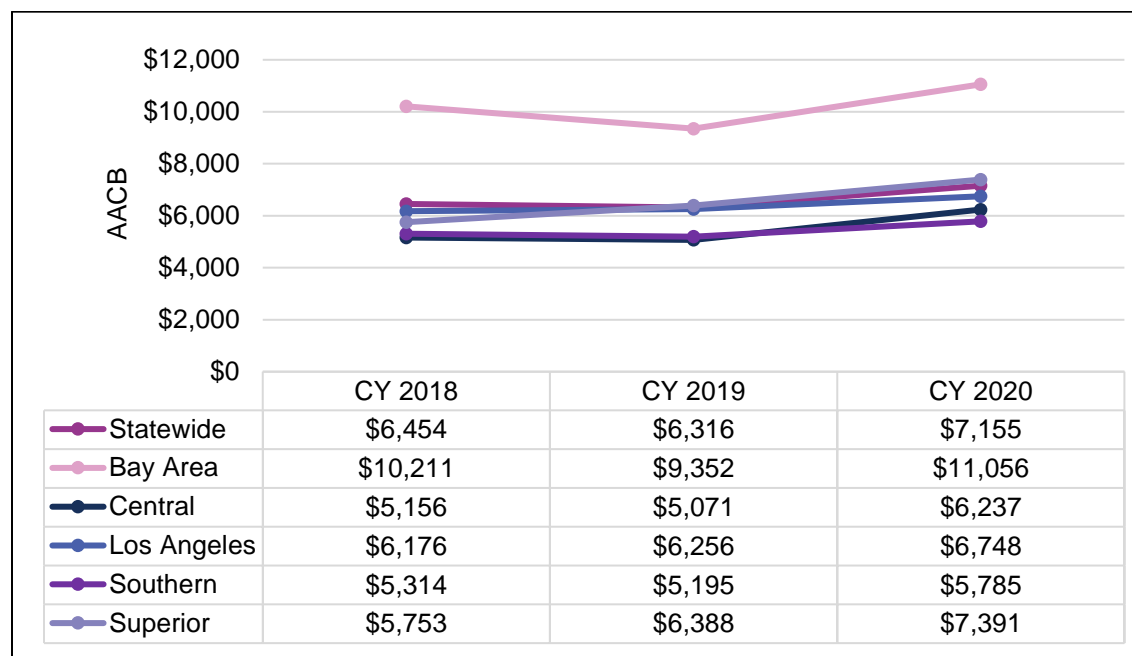
Figure PM-4: Overall Penetration Rate by MHP Region, CY 2018-20**Figure PM-5: Approved Claims per Beneficiary Served by MHP Region, CY 2018-20**

Table PM-4: Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2018-20

Category	# of Beneficiaries Served	# of Eligibles	% of Beneficiaries Served	% of Eligibles	PR	AACB
African American						
CY 2018	80,235	1,004,291	13.01%	7.56%	7.99%	\$6,916
CY 2019	83,567	984,839	13.31%	7.63%	8.49%	\$6,726
CY 2020	77,980	976,616	13.09%	7.46%	7.98%	\$7,393
Asian/Pacific Islander						
CY 2018	29,595	1,316,629	4.80%	9.91%	2.25%	\$6,557
CY 2019	29,007	1,284,330	4.62%	9.94%	2.26%	\$6,325
CY 2020	27,310	1,285,115	4.59%	9.82%	2.13%	\$7,466
Hispanic/Latino						
CY 2018	252,104	6,677,877	40.89%	50.28%	3.78%	\$5,904
CY 2019	265,989	6,519,605	42.36%	50.48%	4.08%	\$5,869
CY 2020	250,391	6,531,536	42.04%	49.90%	3.83%	\$6,551
Native American						
CY 2018	3,689	53,655	0.60%	0.40%	6.88%	\$7,149
CY 2019	3,885	51,789	0.62%	0.40%	7.50%	\$6,769
CY 2020	3,435	50,821	0.58%	0.39%	6.76%	\$7,908
White						
CY 2018	163,485	2,514,792	26.52%	18.94%	6.50%	\$6,093
CY 2019	161,683	2,401,489	25.75%	18.59%	6.73%	\$6,167
CY 2020	149,074	2,379,061	25.03%	18.18%	6.27%	\$7,137
Other						
CY 2018	87,406	1,713,326	14.18%	12.90%	5.25%	\$8,175
CY 2019	83,797	1,672,756	13.35%	12.95%	5.01%	\$7,588
CY 2020	87,406	1,866,332	14.68%	14.26%	4.68%	\$8,575

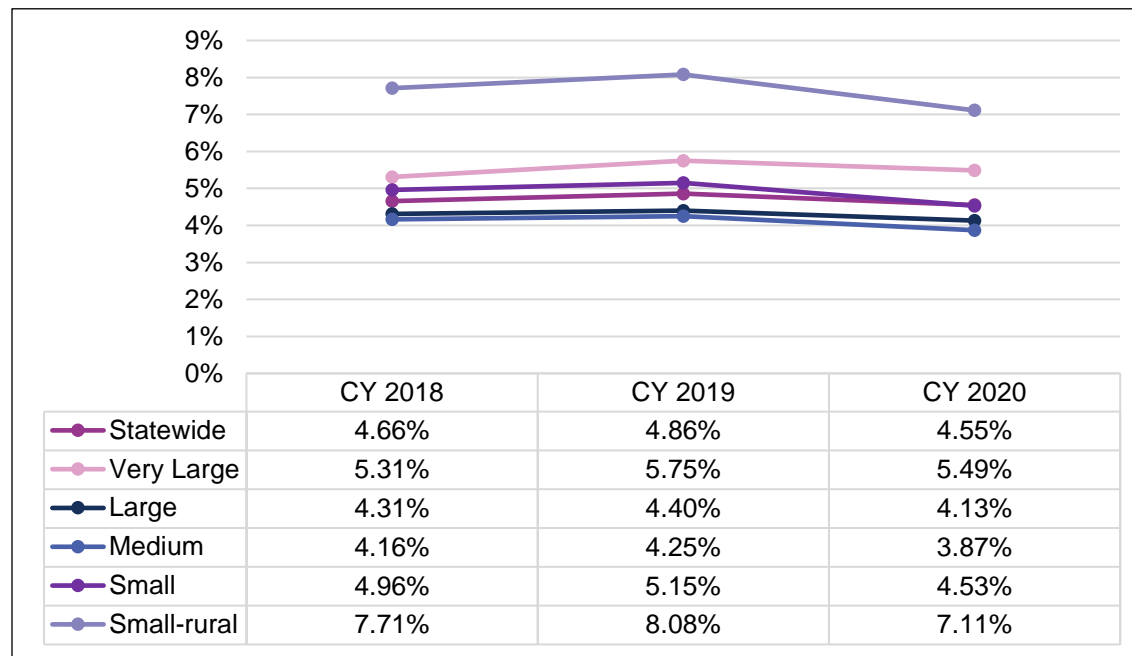
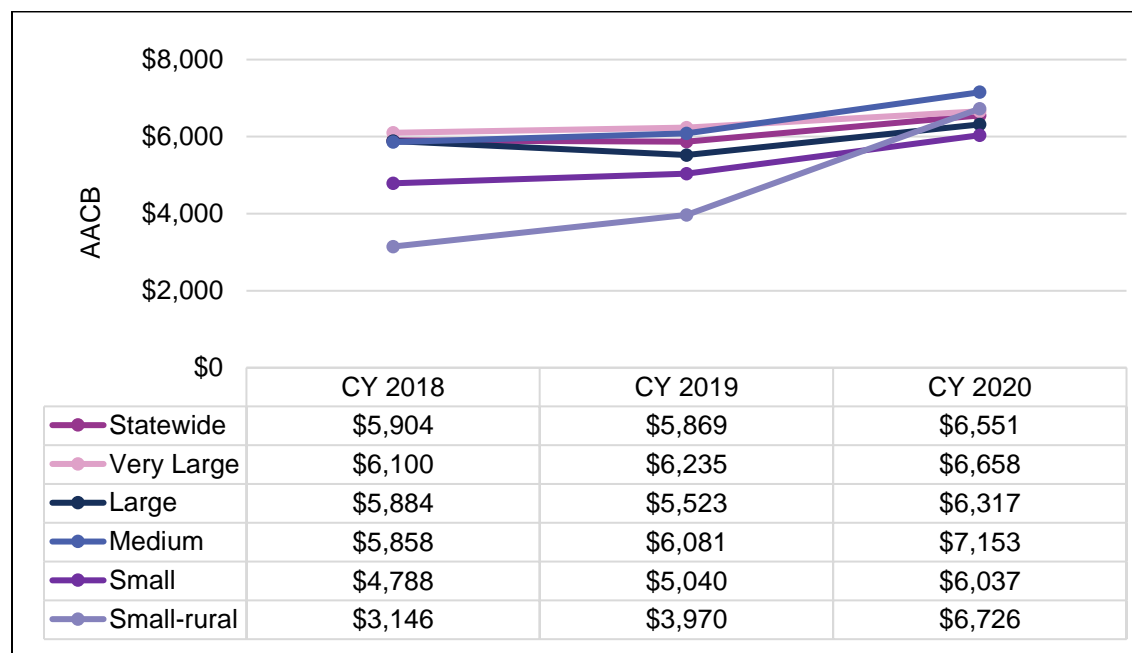
Figure PM-6: Hispanic/Latino Penetration Rate by MHP Region, CY 2018-20**Figure PM-7: Hispanic/Latino Approved Claims per Beneficiary Served by MHP Region, CY 2018-20**

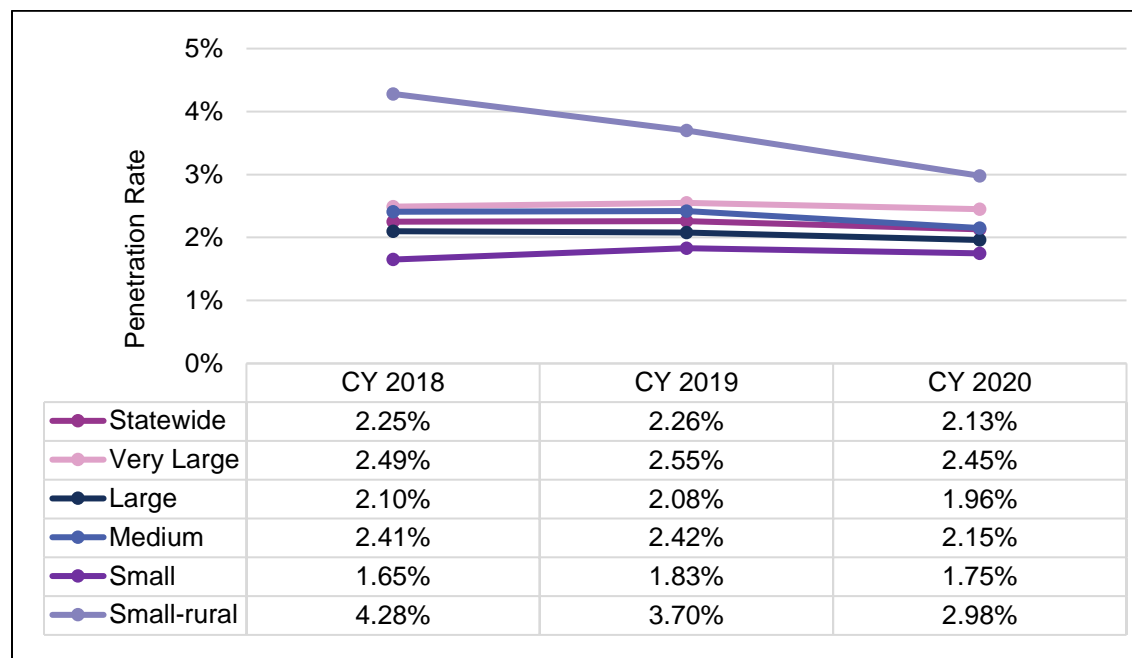
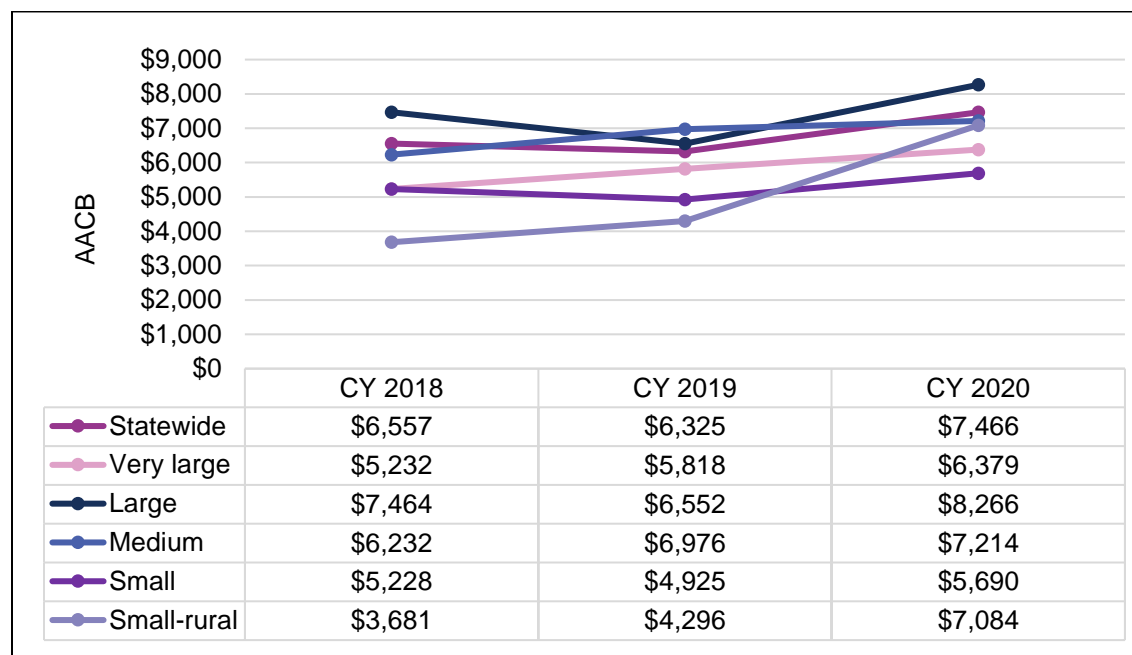
Figure PM-8: Asian/Pacific Islander Penetration Rate by MHP Region, CY 2018-20**Figure PM-9: Asian/Pacific Islander Approved Claims per Beneficiary Served by MHP Region, CY 2018-20**

Table PM-5: Threshold Language of Medi-Cal Beneficiaries Served, CY 2020

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by MHPs	Percentage of Medi-Cal Beneficiaries Served by MHPs
Spanish	98,036	15.72%
Vietnamese	3,486	0.56%
Cantonese	2,152	0.35%
Armenian	1,423	0.23%
Arabic	999	0.16%
Mandarin	757	0.12%
Korean	731	0.12%
Farsi	719	0.12%
Russian	660	0.11%
Hmong	615	0.10%
Cambodian	531	0.09%
Tagalog	294	0.05%
TOTAL	110,403	17.71%
Threshold language source: Open Data per BHIN 20-070		

Table PM-6: Medi-Cal Expansion (ACA) Penetration Rate and AACB, CY 2020

	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2018	3,807,829	152,568	4.01%	\$832,986,475	\$5,460
CY 2019	3,719,952	159,904	4.30%	\$824,153,538	\$5,154
CY 2020	3,835,638	155,154	4.05%	\$934,903,862	\$6,026

Table PM-7: ACA Eligibles, Beneficiaries Served, and Penetration Rates by Region, CY 2020

Region	Average Number of Medi-Cal Beneficiaries per Month	ACA Percentage of Overall Medi- Cal Eligibles	Number of ACA Beneficiaries Served per Year	ACA Percentage of Beneficiaries Served per Year	ACA Penetration Rate
Statewide	3,835,638	29%	155,154	26%	4.05%
Bay Area	610,800	30%	25,402	25%	4.16%
Central	605,069	26%	20,755	23%	3.43%
Los Angeles	1,235,310	32%	57,934	27%	4.69%
Southern	1,269,042	29%	45,027	27%	3.55%
Superior	115,418	29%	5,649	24%	4.89%

Table PM-8: ACA Approved Claims by MHP Region, CY 2020

Region	ACA Total Approved Claims	ACA AACB
Statewide	\$934,903,862	\$6,026
Bay Area	\$222,723,081	\$8,768
Central	\$119,527,634	\$5,759
Los Angeles	\$315,468,609	\$5,445
Southern	\$244,751,614	\$5,436
Superior	\$31,102,790	\$5,506

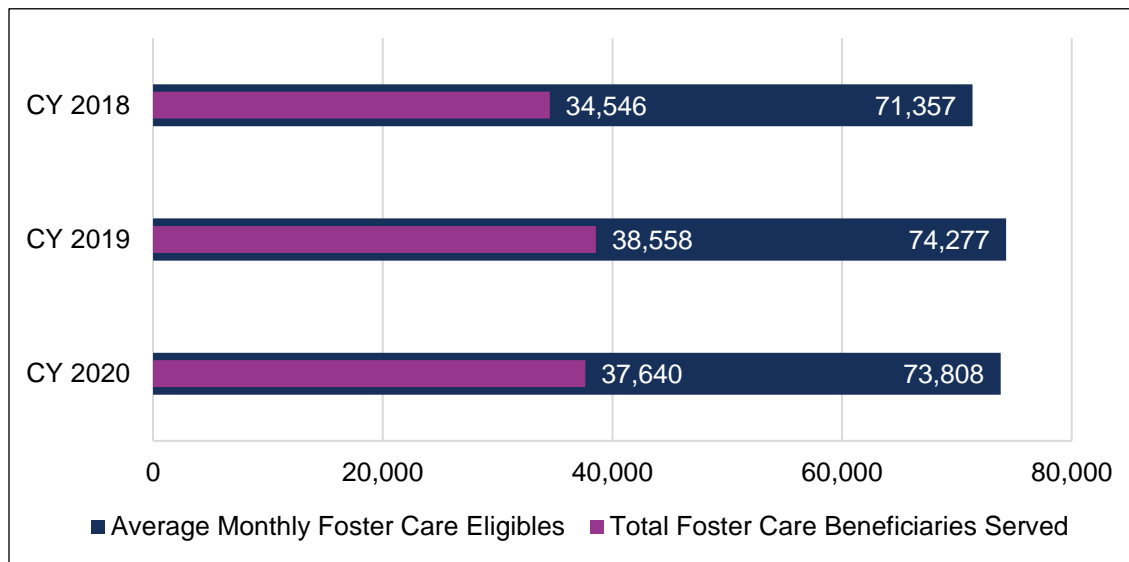
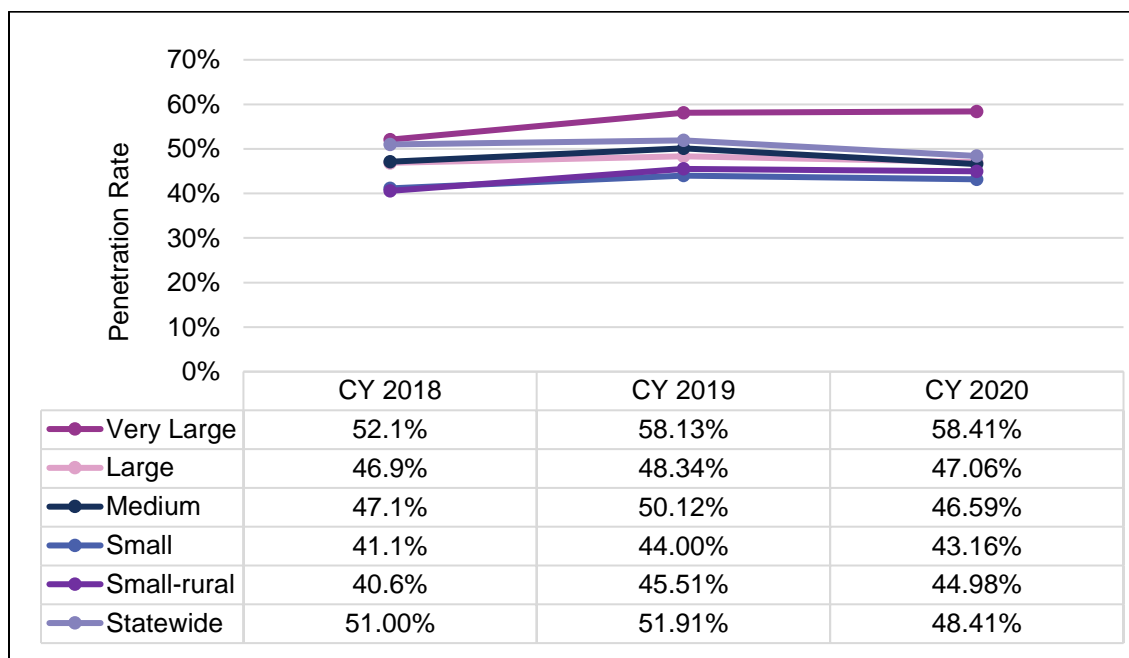
Figure PM-10: Medi-Cal Eligibles and Beneficiaries Served, Foster Care, CY 2018-20**Figure PM-11: Foster Care Penetration Rate by MHP Size, CY 2018-20**

Figure PM-12: Foster Care Approved Claims per Beneficiary Served by MHP Size, CY 2018-20

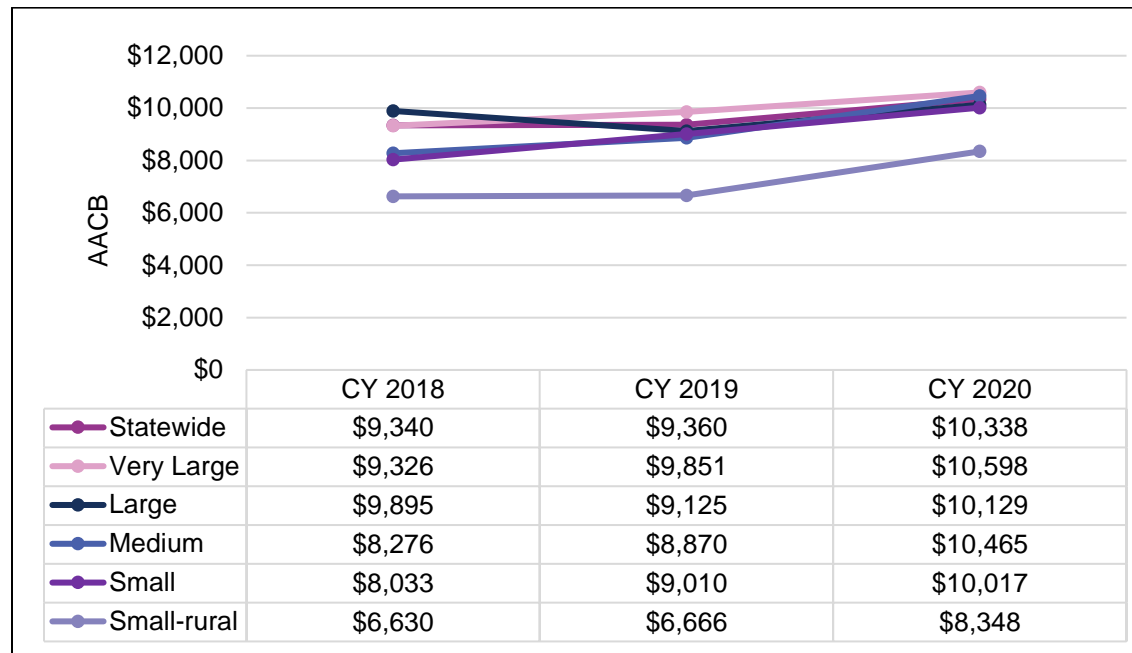
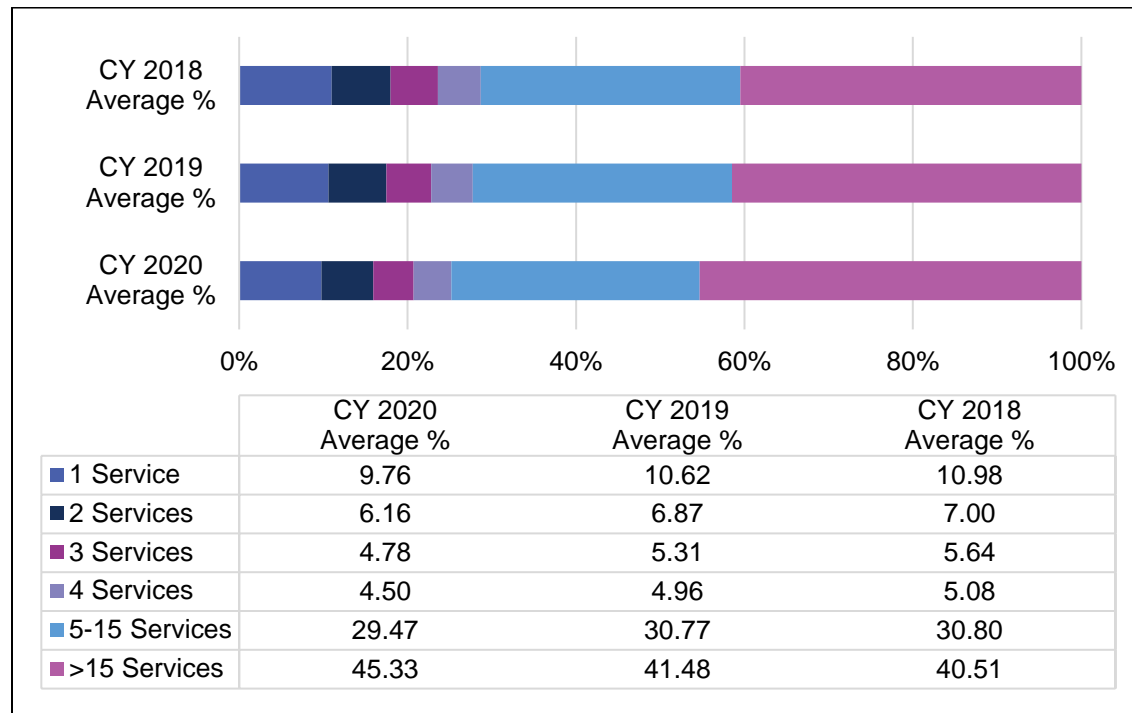


Figure PM-13: Retention of Beneficiaries Statewide, CY 2018-20**Table PM-9: Retention by Number of Services, MHP Minimum and Maximum, CY 2020**

# Services	MHP Minimum %	MHP Maximum %
1 service	5.69%	21.86%
2 services	4.39%	17.07%
3 services	2.44%	9.17%
4 services	2.44%	7.78%
5–15 services	19.96%	42.46%
>15 services	23.02%	57.54%

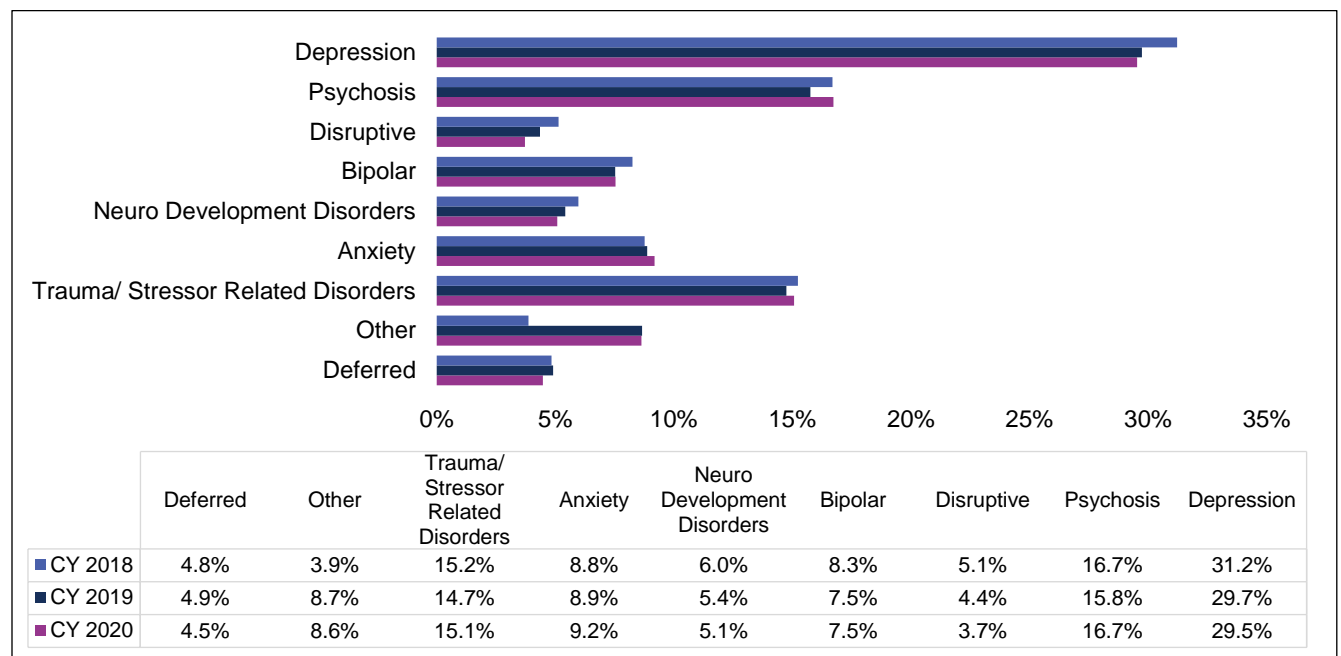
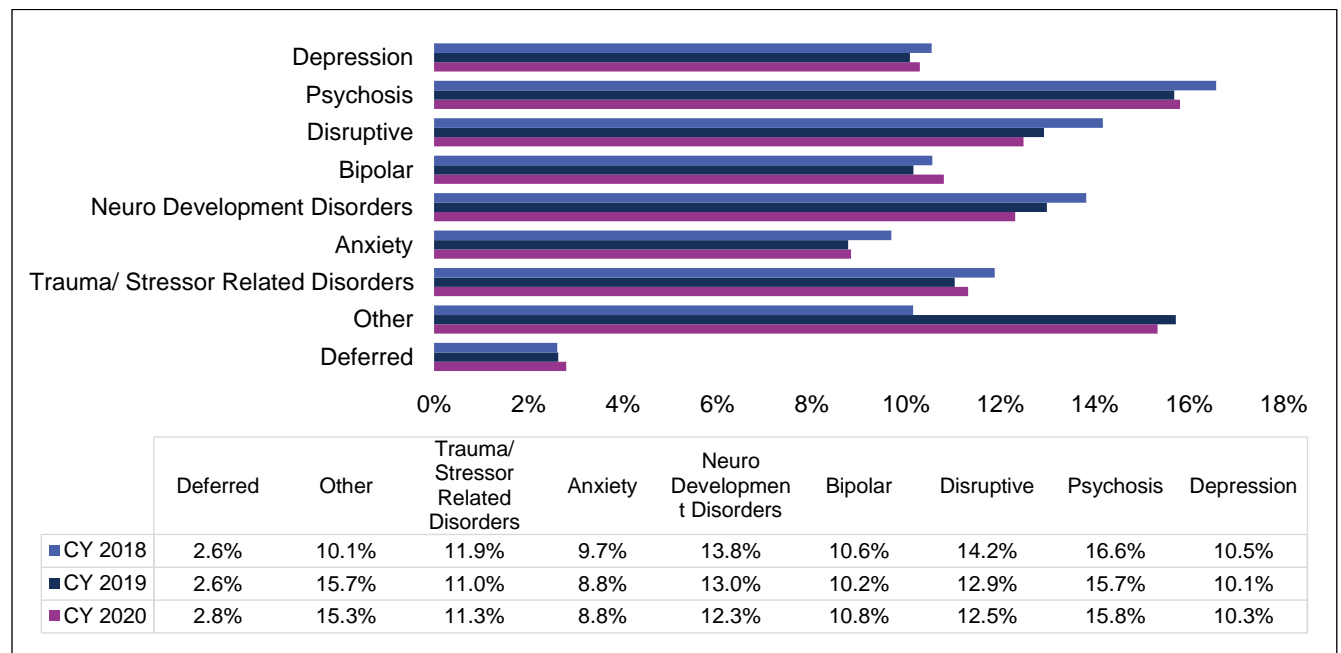
Figure PM-14: Statewide Distribution of Beneficiaries Served by Diagnoses, CY 2020**Figure PM-15: Statewide Approved Claims by Diagnoses, CY 2020**

Table PM-10: Psychiatric Inpatient Utilization, CY 2018-20

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	Statewide Average LOS in Days	Statewide AACB	Total Approved Claims
CY 2018	157,102	308,742	7.63	\$9,772	\$852,000,172
CY 2019	171,740	344,758	7.80	\$10,535	\$977,885,680
CY 2020	151,566	293,346	8.68	\$11,814	\$1,027,874,950

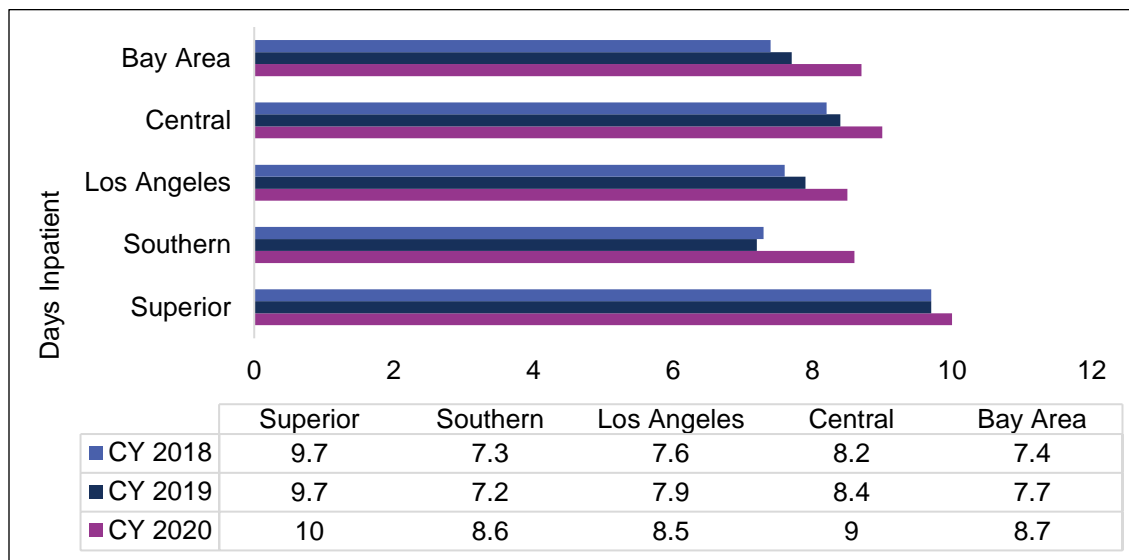
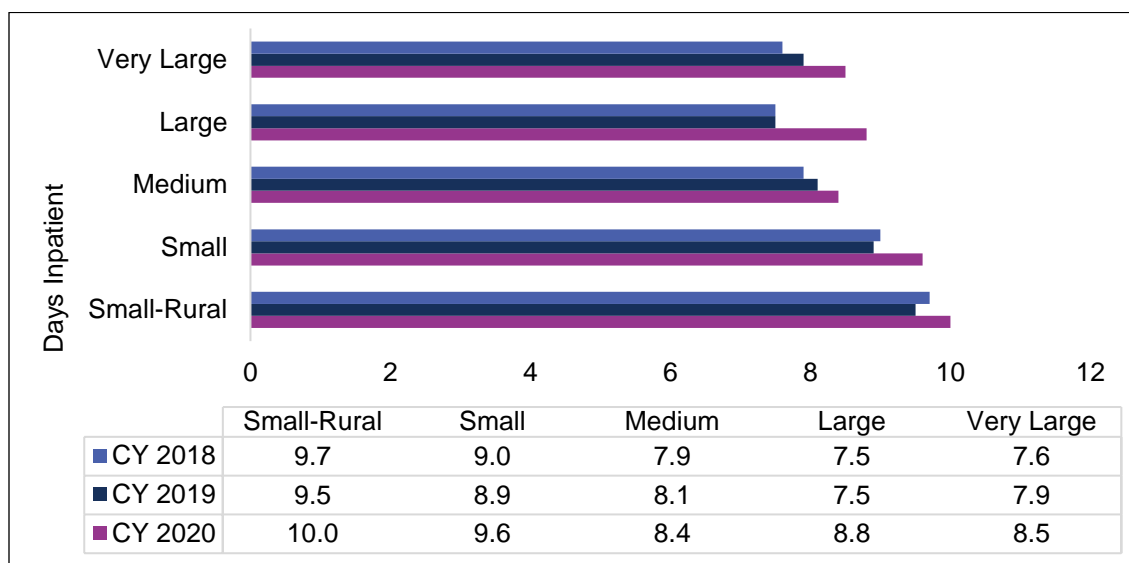
Figure PM-16: Average Inpatient Length of Stay by MHP Region, CY 2018-20**Figure PM-17: Average Inpatient Length of Stay by MHP Size, CY 2018-20**

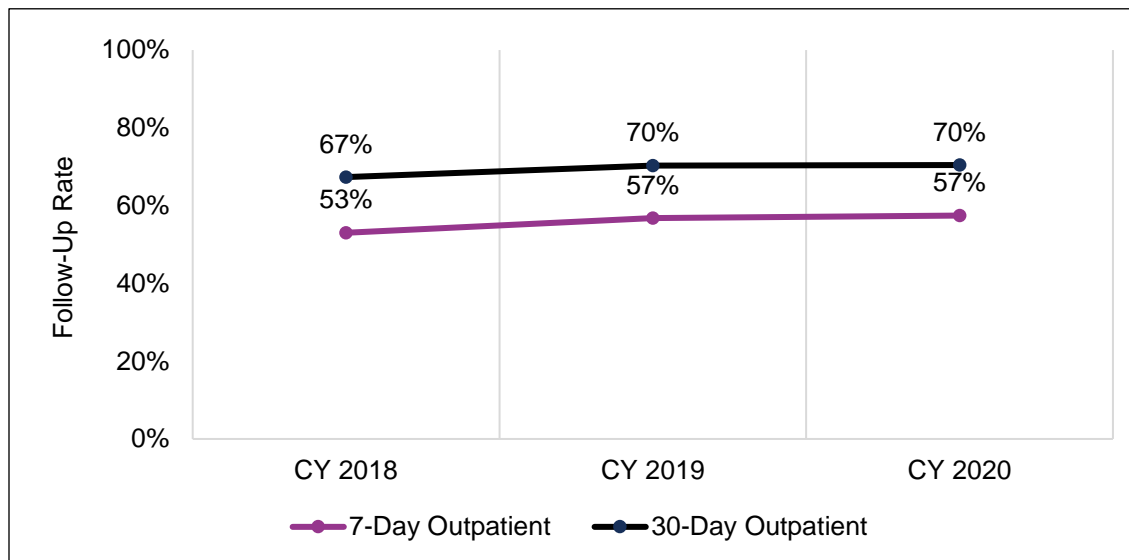
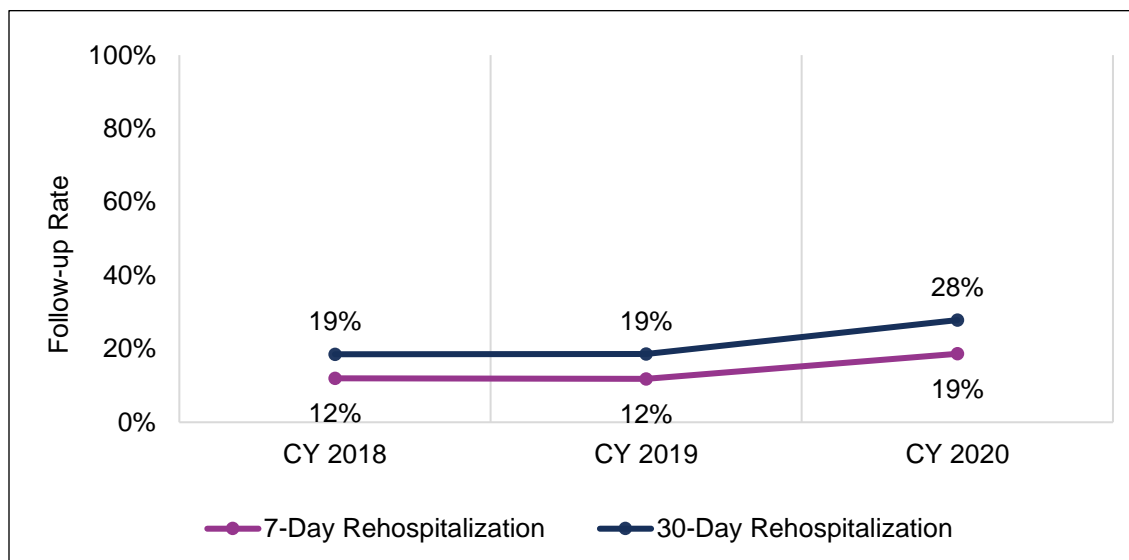
Figure PM-18: Follow-up Rates post Hospital Discharge Statewide, CY 2018-20**Figure PM-19: Rehospitalization Rates Statewide, CY 2018-20**

Table PM-11: HCB (Greater than \$30,000), CY 2018-20

Year	Beneficiaries Served			Beneficiary Claims		
	Beneficiary Count by Cost Category	Statewide Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per Beneficiary by Cost Category	Total Approved Claims by Cost Category	% of Total Approved Claims
High-Cost Beneficiaries (payment ≥ \$30,000)						
CY 2018	23,164	618,977	3.74%	\$57,725	\$1,337,141,530	33.47%
CY 2019	21,904	627,928	3.49%	\$51,883	\$1,136,453,763	28.65%
CY 2020	24,242	595,596	4.07%	\$53,969	\$1,308,318,589	30.70%
Medium-Cost Beneficiaries (payment between \$20,000 and \$30,000)						
CY 2018	19,171	618,977	3.10%	\$24,272	\$465,327,504	11.65%
CY 2019	20,094	627,928	3.20%	\$24,251	\$487,296,714	12.29%
CY 2020	22,110	595,596	3.71%	\$24,274	\$536,694,163	12.59%
Low-Cost Beneficiaries (payment < \$20,000)						
CY 2018	576,642	618,977	93.16%	\$3,802	\$2,192,160,320	54.88%
CY 2019	585,930	627,928	93.31%	\$3,998	\$2,342,261,916	59.06%
CY 2020	549,244	595,596	92.22%	\$4,399	\$2,416,340,502	56.70%