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# FY 2020-21
# MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

## MADERA MHP FINAL REPORT

Prepared for:

**California Department of Health Care Services (DHCS)**

Review Dates:

**August 20-21, 2020**

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# INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). External Quality Review (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. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review, or a desk review, of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also considers the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Madera MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

## MHP Information

MHP Size — Small

MHP Region — Central

MHP Location — Madera

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 3,125

MHP Threshold Language(s) — Spanish

CalEQRO obtained the MHP threshold language information from the DHCS Information Notice (IN) 13-09.

## Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

## Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

## MHP Health Information System Capabilities[3]

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

## Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed AB 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and INs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard (AAS) and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS IN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS will review these forms to determine if the provider networks met required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services to youth and adults. If these standards are not met, DHCS will require the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, these will be reviewed by CalEQRO as part of their annual quality review process with a structured protocol to assess access, timeliness, and validation of the AAS and any plan of correction or improvement of the services to Medi-Cal recipients living in the zip codes requiring an AAS.

CalEQRO reviews the NACT provider files, maps of clinics closest to the AAS zip codes, and distances to the closest providers by type and population. If there is no provider within the time or distance standard, the MHP shall develop and propose an AAS plan, and access to any alternative providers who might become Medi-Cal certified for the MHP. The MHP shall submit a plan of correction addressing the needs to meet the AAS.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO will review grievance and complaint log reports, facilitate beneficiary focus groups, review claims and other performance data, and review DHCS-approved corrective action plans.

## Validation of State and MHP Beneficiary Satisfaction Surveys

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

## Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

# PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

## Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations with the MHP. The findings are summarized below.

### Assignment of Ratings

**Met** is assigned when the identified issue has been resolved.

**Partially Met** is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

**Not Met** is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

## Recommendations from FY 2019-20

### PIP Recommendations

**Recommendation 1:** Take steps to launch the second, non-clinical, PIP which remains concept only at this point in accordance with Title 42, CFR, Section 438.330. Seek regular consultation from CalEQRO in the development of both new and ongoing PIPs. (This is a carry-over or follow-up recommendation from FY 2018-19.)

Status: Partially Met

- The MHP launched a pilot of the non-clinical PIP on text reminders to reduce no-show rates with one psychiatrist's appointments.
- Due to COVID-19, the MHP's intervention roll-out had slowed, but it is gradually being activated again.

## Access Recommendations

**Recommendation 2:** The MHP should evaluate the use of its language line and identify solutions for increasing usage or finding alternative solutions for language needs of non-English speaking beneficiaries.

Status: Partially Met

- Although the MHP tracks its use of the language line as part of the NA Standard requirement, it has not as of this date had the time or staffing to find alternative solutions for usage increase.
- The MHP line staff focus group participants noted that the language line works well.
- CalEQRO did not have any monolingual beneficiaries in its beneficiary focus group this year to determine their perspectives on the language line.

**Recommendation 3:** Identify the root cause for the low retention rate for beneficiaries receiving greater than 15 services.

Status: Partially Met

- The MHP investigated this matter and found that a high number of single service cases was arising from the MHP's discontinuance of its pre-screening process. This had resulted in a large number of assessments for individuals who did not meet the medical necessity criteria and were primarily in need of other services, not SMHS.
- The MHP has now reinstated the pre-screening process without impacting timely access to SMHS for those who need it. This was verified in the beneficiary and line staff focus groups.
- The MHP did not provide quantitative data to demonstrate the anecdotal observations listed above, and improvements are not reflected in CalEQRO's CY 2019 claims data. CalEQRO anticipates the impact will be reflected in the CY 2020 claims data and will reevaluate the retention rate at that time. The MHP is encouraged to monitor the issue for sustained improvement.

**Recommendation 4:** The MHP should prioritize filling vacant positions to ensure there are enough staff to provide timely services to beneficiaries. Use of part-time, interim, or temporary staff may be necessary to fulfill its service delivery obligations.

Status: Met

- Since October 2018, the MHP has hired a total of 11 case workers, six of them being bilingual; ten pre-licensed clinicians, four of them being bilingual; and two English monolingual licensed clinicians.
- The MHP realizes that given the lack of availability of qualified candidates, and the recruitment needs of other neighboring MHPs, it needs to pursue other avenues to fill the workforce needs. To that end, the MHP is trying to recruit retired clinicians at least temporarily and has already hired back one retired clinician through this effort.

## Timeliness Recommendations

**Recommendation 5:** The MHP should use data analytics to evaluate frequency of beneficiary contact and timely service. This should include tracking and adjusting to address any timeliness to service issues for mono-lingual Spanish speaking beneficiaries.

Status: Partially Met

- The MHP stated that this will be incorporated in the FY 2020-21 Quality Improvement (QI) work plan. However, the draft plan submitted for review did not explicitly contain any planned analysis by language in the timeliness section.
- This recommendation will be carried forward to the FY 2020-21 EQR report.

**Recommendation 6:** The MHP needs to comply with requests for urgent care appointments including those requiring authorization as per IN 18-010.

Status: Met

- The MHP submitted urgent appointment timeliness data by 48- and 96-hour standards separately and reported meeting the timeliness 80 percent of the time.

**Recommendation 7:** The MHP should initiate performance improvement activities to identify solutions based on root causes of its inability to consistently meet the Healthcare Effectiveness Data and Information Set (HEDIS) 7-day post hospitalization appointment standard.

Status: Met

- The MHP has initiated a new clinical PIP to reduce 30-day rehospitalizations. One of the aims of this PIP is to improve the 7-day follow-up rate after inpatient discharge.
- The MHP has designated one clinician to ensure that timely assessment and outpatient treatment appointments are in place following inpatient discharge.

**Recommendation 8:** The MHP should move to generalize its appointment reminder performance improvement strategies across the system to remediate the high level of appointment no-shows.

Status: Partially Met

- The MHP's current non-clinical PIP, after resolving privacy and confidentiality issues that took longer than expected, went through a pilot phase involving appointments with a single psychiatrist.
- The MHP indicated that the intervention has been rolled out systemwide beginning January 2020. However, due to COVID-19, the MHP had to modify the workflow temporarily and could not provide any follow-up data at the time of the EQR.

## Quality Recommendations

**Recommendation 9:** The MHP should include contractors and beneficiaries in the Quality Improvement Committee (QIC) to increase stakeholder input.

Status: Partially Met

- The MHP invited its contractors to join its Quality Monitoring Team (QMT) meetings and they have been attending these meetings now.
- The MHP has not found similar success in regular attendance by its beneficiaries or their family members. The QMT meetings were cancelled due to COVID-19 from March to May of 2020.

**Recommendation 10:** The MHP should take steps to amend the current QI Work Plan and establish both baseline and initiative goals that contain measurable objectives to determine progress more objectively.

Status: Met

- The MHP has made these changes in its FY 2020-21 QI work plan for applicable indicators.

**Recommendation 11:** The MHP should provide specific in-person trainings for staff, including front desk and support staff, around trauma informed care

and evidence-based practices for improving beneficiary interaction skills.

Status: Met

- The MHP has provided trauma-focused trainings throughout the year to its administrative, clinical, and clerical staff.

**Recommendation 12:** The MHP should take steps to separate child and adult beneficiaries as they wait for service appointments.

Status: Not Met

- At the time of the EQR, the MHP had just begun reinstating face-to-face appointments post-COVID-19 and was in the planning stages of staggering the adult and child appointments so they will not need to be in a common waiting area at the same time.

## Beneficiary Outcomes Recommendations

**Recommendation 13:** The MHP should refine its Performance Outcomes and Quality Improvement (POQI) analysis to show year over year comparisons and determine an appropriate format for sharing with its beneficiaries such as a printed summary or post on website.

Status: Not Met

- The MHP is planning to do this in its FY 2020-21 QI work plan.
- The MHP did not provide any plans for sharing this information with the relevant stakeholders although it provided limited summaries, not year-over-year comparisons, to CalEQRO; and uses this information in its QI work.
- It should be noted that the MHP's website is transparent with many useful resources and information including the DHCS compliance findings and plan of correction. Adding POQI trends and findings will be a logical step to enhance the website.

**Recommendation 14:** The MHP needs to take meaningful steps to outline clinical output expectations and monitor staff's consistent use of its adult outcome tool.

Status: Not Met

- The MHP is awaiting the implementation of its new EHR which is expected to provide the needed capabilities for greater utilization of adult level of care and outcome tools.

**Recommendation 15:** The MHP should add a training calendar and clinical learning collaborative to obtain improved fidelity in the use of outcome tools.

Status: Partially Met

- The MHP provides an annual documentation training as well as ongoing training during supervision sessions with staff. In addition to trainings provided during group supervision, the MHP also coordinates and provides agency wide trainings throughout the year which are made available to all outside collaborative partner agencies.
- The outcome tools fidelity training will become more relevant after the new EHR is implemented.

**Recommendation 16:** The MHP should take steps to establish level of care (LOC) determinations with clinical protocols and secure information system support to track and report on them across the system of care.

Status: Not Met

- The MHP plans to work on this once the new EHR is implemented.

## Foster Care Recommendations

**Recommendation 17:** The MHP should take steps within its Children's System of Care (CSOC) to prioritize workload expectations and adjust caseload levels allowing staff to be more clinically effective and available to beneficiary service needs.

Status: Met

- The MHP acknowledges that the caseload adjustment is an ongoing effort along with its recruitment efforts.
- The line staff reported there being efforts by the supervisors in this respect, but the ongoing staff shortage makes it a challenging task.

**Recommendation 18:** The MHP should explore and develop processes for monitoring use of the Core Practice Model (CPM) which might include content in utilization review, designated self-attestation that identify CPM in progress notes, or other fidelity checks.

Status: Met

- The MHP is in the process of improving the current QI chart review process and form. This will include additional areas to monitor consistency of FC service delivery and support with the integrated CPM.

- At present, this occurs during scheduled supervision meetings and individual chart reviews. Chart reviews include reviews of Intensive Care Coordination (ICC) services and Child Family Team (CFT) meetings and plans when indicated.

**Recommendation 19:** The MHP should continue to explore and develop a process for electronically monitoring all components of SB 1291.

Status: Not Met

- This is an item pending the implementation of the new EHR.
- The MHP did not present any evidence of monitoring the available measures for which the data is available from the state websites.

## Information Systems Recommendations

**Recommendation 20:** Assure eLab functionality is included in the Cerner Millennium implementation plan.

Status: Not Met

- The MHP chose not to implement Cerner Millennium and signed a contract for alternate EHR/performance management software, InSync, in May 2020.
- The MHP states that eLab functionality will be available in their new EHR, InSync. However, the MHP states they are in the initial discovery phase of exploring eLab options and there is currently no eLab implementation timeline.

## Structure and Operations Recommendations

**Recommendation 21:** The MHP should examine the benefits of establishing an enhanced career ladder for peer employees.

Status: Partially Met

- The MHP is exploring the possibility of including experience acquired as a Community Service Liaison (CSL) or Vocational Aid Driver (VAD), the two current positions that exist for individuals with lived experience, in the job descriptions of office assistant, program assistant, and case manager.
- The MHP reports that it tries to expose CSL and VADs to a variety of workplace skills so they can then qualify for other county employment following the established county process.

# PERFORMANCE MEASURES

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards: http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures: http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to: screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (q) measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).

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- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

## Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

# Total Beneficiaries Served

Table 1 provides details on beneficiaries served by race/ethnicity.

### Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

| Madera MHP | | | | |
|---|---|---|---|---|
| **Race/Ethnicity** | **Average Monthly Unduplicated Medi-Cal Beneficiaries** | **Percentage of Medi-Cal Beneficiaries** | **Unduplicated Annual Count of Beneficiaries Served by the MHP** | **Percentage of Beneficiaries Served by the MHP** |
| White | 12,279 | 17.2% | 1,009 | 32.3% |
| Latino/Hispanic | 48,080 | 67.3% | 1,558 | 49.9% |
| African-American | 1,467 | 2.1% | 143 | 4.6% |
| Asian/Pacific Islander | 1,140 | 1.6% | 35 | 1.1% |
| Native American | 428 | 0.6% | 31 | 1.0% |
| Other | 8,064 | 11.3% | 349 | 11.2% |
| **Total** | **71,456** | **100%** | **3,125** | **100%** |

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

During CY 2019, the MHP experienced claims submission delays that resulted in a number of claim transactions for December not being included in the analysis for CY 2019 results which could result in under reporting of Figures 1-6 results.

Table 2 provides details on beneficiaries served by threshold language.

**Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language**

| Madera MHP | | |
|---|---|---|
| **Threshold Language** | **Unduplicated Annual Count of Beneficiaries Served by the MHP** | **Percentage of Beneficiaries Served by the MHP** |
| Spanish | 557 | 17.8% |
| Other Languages | 2,568 | 82.2% |
| **Total** | **3,125** | **100%** |
| Threshold language source: DHCS Information Notice 13-09. | | |
| Other Languages include English | | |

## Penetration Rates and Approved Claims per Beneficiary

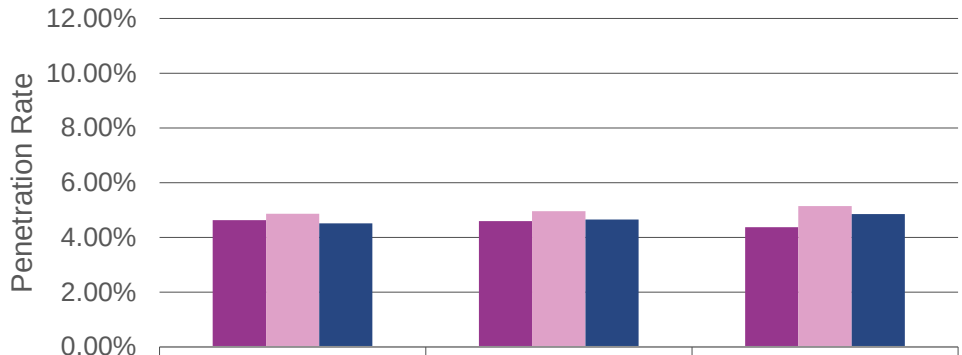
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2019. See Table C1 for the CY 2019 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Madera MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

## Figure 1: Overall Penetration Rates CY 2017-19

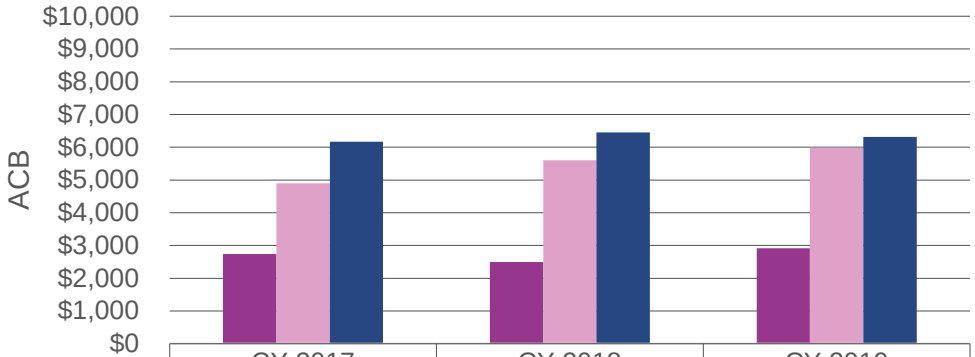
### Madera MHP




| | CY 2017 | CY 2018 | CY 2019 |
|---|---|---|---|
| MHP | 4.63% | 4.60% | 4.37% |
| Small | 4.87% | 4.96% | 5.15% |
| State | 4.52% | 4.66% | 4.86% |

## Figure 2: Overall ACB CY 2017-19

### Madera MHP

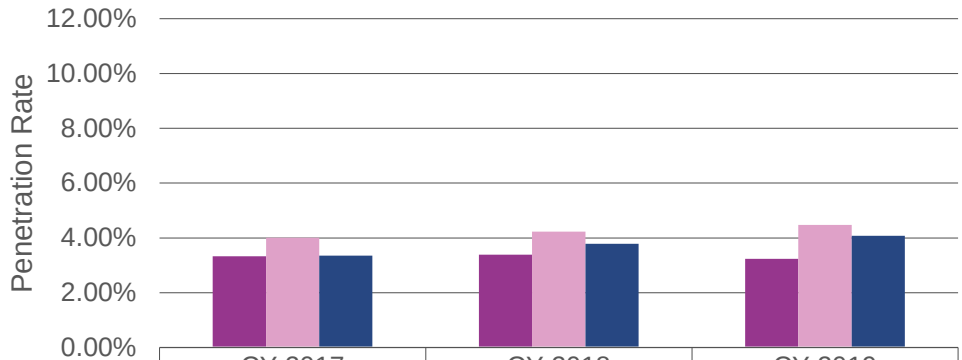



| | CY 2017 | CY 2018 | CY 2019 |
|---|---|---|---|
| MHP | $2,738 | $2,493 | $2,916 |
| Small | $4,895 | $5,602 | $5,982 |
| State | $6,170 | $6,454 | $6,316 |

Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

**Figure 3: Latino/Hispanic Penetration Rates CY 2017-19**

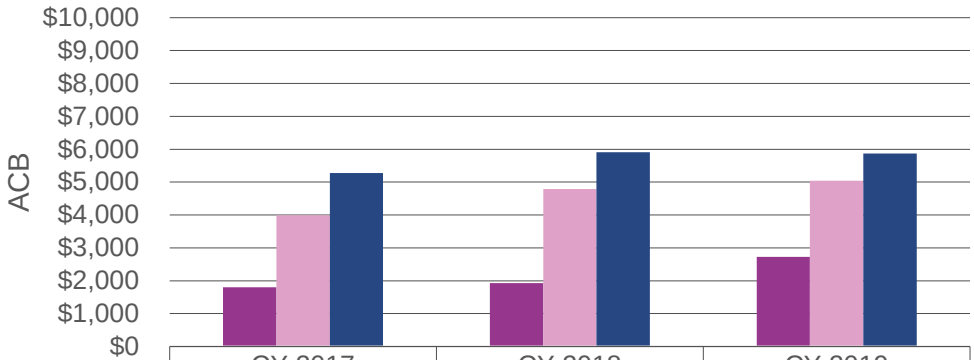
**Madera MHP**




| | CY 2017 | CY 2018 | CY 2019 |
|---|---|---|---|
| MHP | 3.33% | 3.39% | 3.24% |
| Small | 4.01% | 4.23% | 4.47% |
| State | 3.35% | 3.78% | 4.08% |

**Figure 4: Latino/Hispanic ACB CY 2017-19**

**Madera MHP**

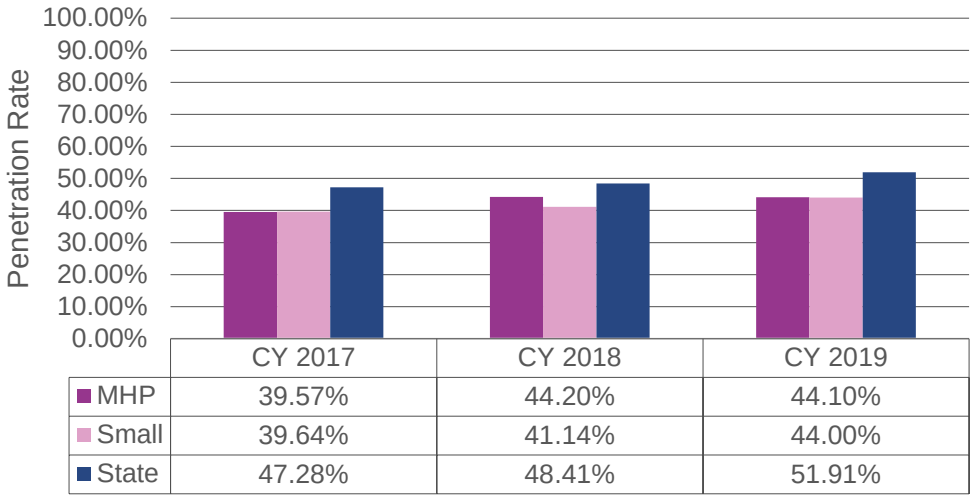



| | CY 2017 | CY 2018 | CY 2019 |
|---|---|---|---|
| MHP | $1,799 | $1,929 | $2,728 |
| Small | $3,993 | $4,788 | $5,040 |
| State | $5,278 | $5,904 | $5,869 |

Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

**Figure 5: FC Penetration Rates CY 2017-19**

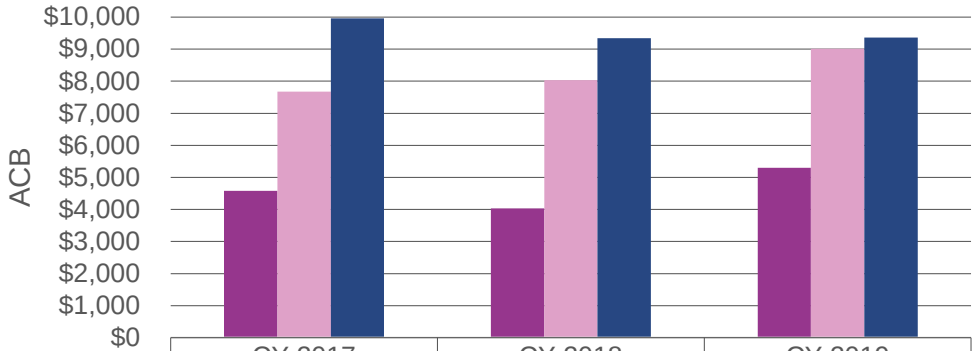
**Madera MHP**




| | CY 2017 | CY 2018 | CY 2019 |
|---|---|---|---|
| MHP | 39.57% | 44.20% | 44.10% |
| Small | 39.64% | 41.14% | 44.00% |
| State | 47.28% | 48.41% | 51.91% |

**Figure 6: FC ACB CY 2017-19**

**Madera MHP**



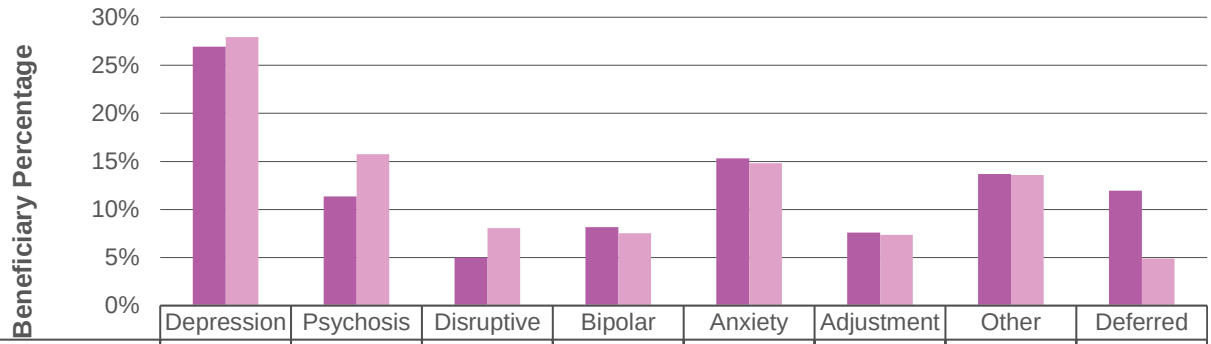

| | CY 2017 | CY 2018 | CY 2019 |
|---|---|---|---|
| MHP | $4,585 | $4,029 | $5,296 |
| Small | $7,671 | $8,033 | $9,010 |
| State | $9,962 | $9,340 | $9,360 |

# Diagnostic Categories

Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

## Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019

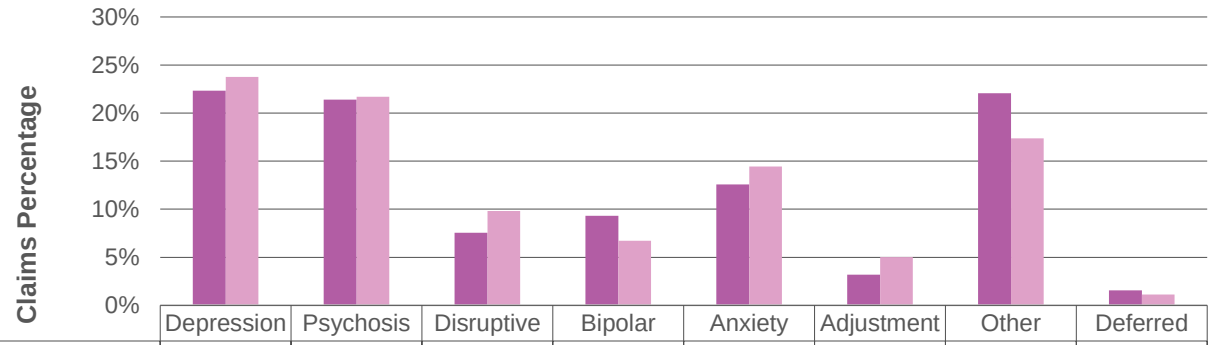
### Madera MHP




| | Depression | Psychosis | Disruptive | Bipolar | Anxiety | Adjustment | Other | Deferred |
|---|---|---|---|---|---|---|---|---|
| MHP CY 2019 | 27% | 11% | 5% | 8% | 15% | 8% | 14% | 12% |
| State CY 2019 | 28% | 16% | 8% | 8% | 15% | 7% | 14% | 5% |

## Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019

### Madera MHP




| | Depression | Psychosis | Disruptive | Bipolar | Anxiety | Adjustment | Other | Deferred |
|---|---|---|---|---|---|---|---|---|
| MHP CY 2019 | 22% | 21% | 8% | 9% | 13% | 3% | 22% | 2% |
| State CY 2019 | 24% | 22% | 10% | 7% | 14% | 5% | 17% | 1% |

## High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

### Table 3: High-Cost Beneficiaries CY 2017-19

| Madera MHP | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Year | HCB Count | Total Beneficiary Count | HCB % by Count | Average Approved Claims per HCB | HCB Total Claims | HCB % by Total Claims |
| Statewide | CY 2019 | 21,904 | 627,928 | 3.49% | $51,883 | $1,136,453,763 | 28.65% |
| MHP | CY 2019 | 40 | 3,125 | 1.28% | $43,806 | $1,752,241 | 19.23% |
| | CY 2018 | 34 | 3,279 | 1.04% | $57,112 | $1,941,821 | 23.75% |
| | CY 2017 | 32 | 3,283 | 0.97% | $51,005 | $1,632,163 | 18.16% |

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

## Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

### Table 4: Psychiatric Inpatient Utilization CY 2017-19

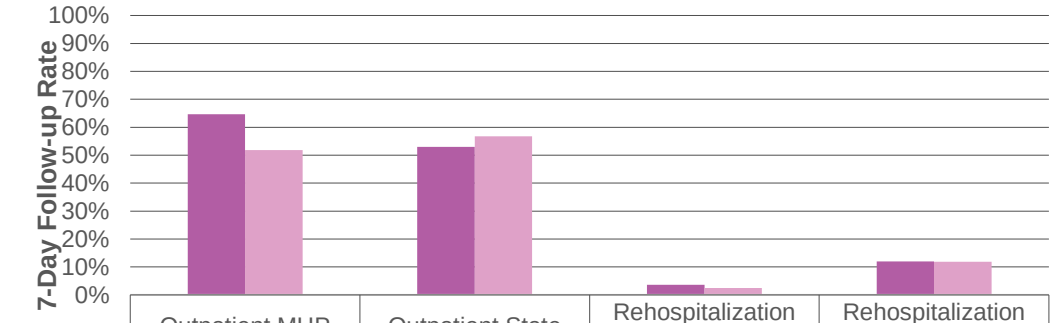
| Madera MHP | | | | | | | |
|---|---|---|---|---|---|---|---|
| Year | Unique Beneficiary Count | Total Inpatient Admissions | MHP Average LOS in Days | Statewide Average LOS in Days | MHP ACB | Statewide ACB | Total Approved Claims |
| CY 2019 | 146 | 221 | 7.96 | 7.80 | $9,595 | $10,535 | $1,400,906 |
| CY 2018 | 140 | 300 | 8.14 | 7.63 | $15,394 | $9,772 | $2,155,171 |
| CY 2017 | 163 | 281 | 10.12 | 7.36 | $11,707 | $9,737 | $1,908,212 |

# Post-Psychiatric Inpatient Follow-Up and Rehospitalization

Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

## Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19

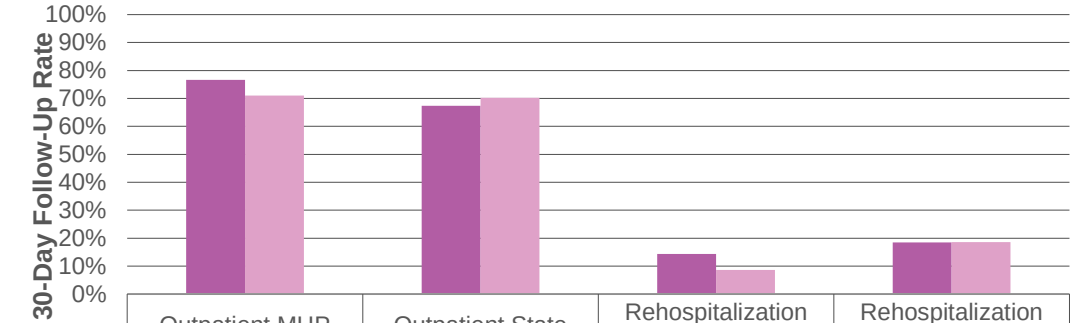
### Madera MHP




| | Outpatient MHP | Outpatient State | Rehospitalization MHP | Rehospitalization State |
|---|---|---|---|---|
| CY 2018 | 65% | 53% | 4% | 12% |
| CY 2019 | 52% | 57% | 2% | 12% |

## Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19

### Madera MHP




| | Outpatient MHP | Outpatient State | Rehospitalization MHP | Rehospitalization State |
|---|---|---|---|---|
| CY 2018 | 77% | 67% | 14% | 19% |
| CY 2019 | 71% | 70% | 9% | 19% |

# PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

## Madera MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed three PIPs and validated 2 PIPs, as shown below.

**Table 5 : PIPs Submitted by Madera MHP**

| PIPs for Validation | Number of PIPs | PIP Titles |
|---|---|---|
| Clinical | 1 | Identifying Post-Traumatic Stress Disorder (PTSD) Among Outpatient MH Youth |
| Non-Clinical | 1 | Text and/or Email Appointment Reminder System (TEARS) |

## Clinical PIP

**Table 6: General PIP Information – Clinical PIP**

| MHP Name | Madera |
|---|---|
| PIP Title | Identifying Post-Traumatic Stress Disorder (PTSD) Among Outpatient MH Youth |
| PIP Aim Statement | "Will the number of Post-Traumatic Stress Disorder related diagnosis in 7th Street Children's Program increase by 5% when the Screen for Child Anxiety Related Disorders measuring tool is administered?" |
| Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply)<br><br>☐ State-mandated (state required MHP to conduct PIP on this specific topic) | |

| MHP Name | Madera |
|---|---|
| ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases)<br>☒ MHP choice (state allowed MHP to identify the PIP topic) | |
| Target age group (check one):<br><br>☒ Children only (ages 0-17)*<br>☐ Adults only (age 18 and above)<br>☐ Both Adults and Children<br>*If PIP uses different age threshold for children, specify age range here: 8-18 years | |
| Target population description, such as specific diagnosis (please specify):<br><br>Youth beneficiaries between the ages of 8-18 who are receiving outpatient mental health services through the 7th Street children's program. | |

**Table 7: Improvement Strategies or Interventions – Clinical PIP**

| PIP Interventions (Changes tested in the PIP) |
|---|
| Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br><br>• Administration of Screen for Child Anxiety Related Disorders (SCARED) tool at admission and at six months. |
| Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br><br>• Training of clinicians in using SCARED. |
| MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): |

| PIP Interventions (Changes tested in the PIP) |
|---|
| • Setting up a system recording, analyzing, and reporting on SCARED. (Note: CalEQRO inferred this, the MHP did not explicitly present this except for mentioning it in passing in data collection challenges.) |

### Table 8: Performance Measures and Results – Clinical PIP

| Performance Measures | Baseline Year | Baseline Sample Size and Rate | Most Recent Remeasurement Year | Most Recent Remeasurement Sample Size and Rate (if applicable) | Demonstrated Performance Improvement | Statistically Significant Change in Performance |
|---|---|---|---|---|---|---|
| Percentage of PTSD Diagnosis | 2019* | N=110<br>Rate =22% | 2020<br>☐ n/a** | N=77<br>Rate =19% | ☐ Yes<br>☒ No | ☐ Yes<br>☐ No<br>p-value:<br>☐ <.01<br>☐ <.05<br>Other (specify): n/a |
| Percentage of ADHD Diagnosis | | N=110<br>Rate =36% | 2020<br>☐ n/a** | N=77<br>Rate =8% | ☒ Yes<br>☐ No | ☐ Yes<br>☐ No<br>p-value:<br>☐ <.01<br>☐ <.05<br>Other (specify): n/a |
| Percentage of Anxiety Diagnosis | | N=110 | 2020 | N=77 | ☒ Yes<br>☐ No | ☐ Yes<br>☐ No |

| Performance Measures | Baseline Year | Baseline Sample Size and Rate | Most Recent Remeasurement Year | Most Recent Remeasurement Sample Size and Rate (if applicable) | Demonstrated Performance Improvement | Statistically Significant Change in Performance |
|---|---|---|---|---|---|---|
| | | Rate =20% | ☐ n/a** | Rate =30% | | p-value: ☐ <.01 ☐ <.05 Other (specify): n/a |
| Percentage of Depression Diagnosis | | N=110<br>Rate =22% | 2020<br>☐ n/a** | N=77<br>Rate =43% | ☒ Yes ☐ No | ☐ Yes ☐ No<br>p-value: ☐ <.01 ☐ <.05 Other (specify): n/a |
| Was the PIP validated? | | | | ☒ Yes | ☐ No | |
| Validation phase:<br><br>☐ PIP submitted for approval<br>☐ Planning phase<br>☐ Implementation phase<br>☐ Baseline year<br>☒ First remeasurement<br>☐ Second remeasurement<br>☐ Other (specify): | | | | | | |
| Validation rating:<br><br>☐ High confidence | | | | | | |

| Performance Measures | Baseline Year | Baseline Sample Size and Rate | Most Recent Remeasurement Year | Most Recent Remeasurement Sample Size and Rate (if applicable) | Demonstrated Performance Improvement | Statistically Significant Change in Performance |
|---|---|---|---|---|---|---|
| ☒ Moderate confidence<br>☐ Low confidence<br>☐ No confidence<br><br>"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. | | | | | | |
| EQRO recommendations for improvement of PIP:<br>• Provide more detailed data collection plan that explains how data integrity is maintained. It was not clear how the SCARED scores were collected and tabulated.<br>• As the MHP has itself noted, the data collection at specific markers should happen in order to have greater confidence in results.<br>• Consider a two-sample t-test for significance testing of pre- and post-intervention scores. | | | | | | |
| The technical assistance (TA) provided to the MHP by CalEQRO consisted of:<br>• Necessity of maintaining treatment fidelity.<br>• Ensuring consistent and reliable data collection. | | | | | | |

* For all indicators, the MHP discarded its 2018 baseline data due to other changes that may have affected the change between 2018 and 2019.

**PIP is in planning and implementation phase if n/a is checked.

## Non-clinical PIP

### Table 9: General PIP Information – Non-Clinical PIP

| MHP Name | Madera |
|---|---|
| PIP Title | TEARS |
| PIP Aim Statement | "Will the implementation of Text and/or Email Appointment Reminder System decrease the percentage of client |

| MHP Name | Madera |
|---|---|
| | absenteeism for medication services by 5%, from FY1617 no-show rate of 20% to 15% within twelve (12) months after implementation?” |
| Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply)<br><br>☐ State-mandated (state required MHP to conduct PIP on this specific topic)<br>☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases)<br>☒ MHP choice (state allowed MHP to identify the PIP topic) | |
| Target age group (check one):<br><br>☐ Children only (ages 0-17)*<br>☒ Adults only (age 18 and above)<br>☐ Both Adults and Children<br>*If PIP uses different age threshold for children, specify age range here: | |
| Target population description, such as specific diagnosis (please specify):<br>The target population is not well-defined. From the PIP submission, it appears that the initial target population was limited to adults only. | |

**Table 10: Improvement Strategies or Interventions – Non-Clinical PIP**

| PIP Interventions (Changes tested in the PIP) |
|---|
| Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>• Authorizations from beneficiaries who are interested in receiving text appointment reminders and verify/update phone number information on demographic in EHR at time of check-in for any appointment.<br>• Assigned front desk staff will use Teletask dashboard to send text appointment reminders to beneficiaries in the pilot group who authorized such communication exchange.<br>• Assigned front desk staff will identify those beneficiaries who did not respond to the text and follow up with a reminder call. |

| PIP Interventions (Changes tested in the PIP) |
|---|
| • Assigned front desk staff will use Teletask dashboard to send text appointment reminders to all medication services beneficiaries who authorized such communication exchange. |
| Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>• PIP lead will need to become familiar with the Teletask software and ensure front desk staff is trained on its use and functionality. |
| MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):<br>• Teletask, a health messenger dashboard software with which the MHP has contracted, will be utilized to complete and coordinate appointment reminders.<br>• All data related to beneficiary and staff surveys was captured with the use of Survey Monkey internet collector tool. |

### Table 11: Performance Measures and Results – Non-Clinical PIP

| Performance Measures | Baseline Year | Baseline Sample Size and Rate | Most Recent Remeasurement Year | Most Recent Remeasurement Sample Size and Rate (if applicable) | Demonstrated Performance Improvement | Statistically Significant Change in Performance |
|---|---|---|---|---|---|---|
| Percentage of beneficiaries who kept their scheduled medication appointments. | FY 2018-19 | N = 876<br><br>Rate = 80 percent | Starting January 2020<br><br>☒ n/a* | None collected or reported due to COVID-19. | ☐ Yes<br>☒ No | ☐ Yes<br>☒ No<br><br>p-value:<br>☐ <.01<br>☐ <.05<br>Other (specify): |
| Percentage of beneficiaries who missed their scheduled | FY 2018-19 | N = 876 | Starting January 2020 | None collected or reported | ☐ Yes<br>☒ No | ☐ Yes<br>☒ No |

| Performance Measures | Baseline Year | Baseline Sample Size and Rate | Most Recent Remeasurement Year | Most Recent Remeasurement Sample Size and Rate (if applicable) | Demonstrated Performance Improvement | Statistically Significant Change in Performance |
|---|---|---|---|---|---|---|
| medication appointments | | Rate = 80 percent | ☒ n/a* | due to COVID-19. | | p-value:<br>☐ <.01<br>☐ <.05<br>Other (specify): |
| Was the PIP validated? | | | | ☒ Yes | ☐ No | |
| Validation phase:<br><br>☐ PIP submitted for approval<br>☐ Planning phase<br>☐ Implementation phase<br>☐ Baseline year<br>☒ First remeasurement<br>☐ Second remeasurement<br>☐ Other (specify): | | | | | | |
| Validation rating:<br><br>☐ High confidence<br>☐ Moderate confidence<br>☐ Low confidence<br>☒ No confidence<br><br>"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. | | | | | | |
| EQRO recommendations for improvement of PIP: | | | | | | |

| Performance Measures | Baseline Year | Baseline Sample Size and Rate | Most Recent Remeasurement Year | Most Recent Remeasurement Sample Size and Rate (if applicable) | Demonstrated Performance Improvement | Statistically Significant Change in Performance |
|---|---|---|---|---|---|---|
| • These indicators constitute one single one, just the flip side of each other. It would be useful for QI purposes, to measure the actual performance indicator as written, i.e., percentage of unique clients who miss appointments. | | | | | | |
| The TA provided to the MHP by CalEQRO consisted of:<br>• The TA consisted of advising the MHP that the suggested additional performance indicator can be easily obtained from the EHR and administrative data.<br>• Combined with the percentage of missed appointment, this will provide the MHP with better information on whether some individuals need more or different types of help/reminder in keeping appointments. | | | | | | |

*PIP is in planning and implementation phase if n/a is checked.

# INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

## Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site review.

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

**Table 12: Budget Dedicated to Supporting IT Operations**

| Entity | FY 2020-21 | FY 2019-20 | FY 2018-19 | FY 2017-18 |
|---|---|---|---|---|
| Madera MHP | 9.13% | 4.30% | 4.40% | 3.25% |
| Small MHP Group | n/a | 2.95% | 3.25% | 3.54% |
| Statewide | n/a | 3.58% | 3.35% | 3.34% |

- The MHP's FY 2020-21 budget increase over prior years is due to the purchase of EHR/performance management software, InSync from InSync Healthcare Solutions.

The budget determination process for information system operations is:

☐ Under MHP control
☐ Allocated to or managed by another County department
☒ Combination of MHP control and another County department or Agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

### Table 13: Business Operations

| Business Operations | Status | |
|---|---|---|
| There is a written business strategic plan for IS. | ☐ Yes | ☒ No |
| There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster. | ☒ Yes | ☐ No |
| If no BCP was selected above; the MHP uses an Application Service Provider (ASP) model to host EHR system which provides 24-hour operational support. | ☒ Yes | ☐ No |
| The BCP (if the MHP has one) is tested at least annually. | ☒ Yes | ☐ No |
| There is at least one person within the MHP organization clearly identified as having responsibility for Information Security. | ☐ Yes | ☒ No |
| If no one within the MHP organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security? | ☒ Yes | ☐ No |
| The MHP performs cyber resiliency staff training on potential compromise situations. | ☒ Yes | ☐ No |

- In addition to having a BCP, the MHP receives additional critical business function EHR support from their ASP, Kings View Behavioral Health Systems (Kings View).

Table 14 shows the percentage of services provided by type of service provider.

### Table 14: Distribution of Services by Type of Provider

| Type of Provider | Distribution |
|---|---|
| County-operated/staffed clinics | 89.20% |
| Contract providers | 2.80% |
| Network providers | 8.00% |
| **Total** | **100%*** |

*Percentages may not add up to 100 percent due to rounding.

## Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

**Table 15: Technology Staff**

| Fiscal Year | Total FTEs (Include Employees and Contractors) | Number of New FTEs | Employees / Contractors Retired, Transferred, Terminated (FTEs) | Currently Unfilled Positions (FTEs) |
|---|---|---|---|---|
| 2020-21 | 3 | 0 | 0 | 0 |
| 2019-20 | 2 | 0 | 0 | 0 |
| 2018-19 | 3 | 3 | 0 | 0 |

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

**Table 16: Data Analytical Staff**

| Fiscal Year | Total FTEs (Include Employees and Contractors) | Number of New FTEs | Employees / Contractors Retired, Transferred, Terminated (FTEs) | Currently Unfilled Positions (FTEs) |
|---|---|---|---|---|
| 2020-21 | 0 | 0 | 1 | 0 |
| 2019-20 | 3 | 0 | 1 | 0 |
| 2018-19 | 3 | 3 | 3 | 0 |

The following should be noted with regard to the above information:

- Technology staff positions include an Administrative Analyst I and two Administrative Analyst II's.
- Some analytic support is performed by the Administrative Analyst I and Administrative Analyst II listed in Table 15, Technology Staff.

- A data analytic staff position, vacated in February 2020, remains on hold and is not in recruitment due to the currently evolving COVID-19 work environment and the uncertainly of the economic impact of COVID-19 on the MHP's budget.
- The MHP receives additional EHR support, such as EHR software upgrades/enhancements and reporting support, from Kings View.

## Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by MHP and does not account for user's log-on frequency or time spent daily, weekly, or monthly using EHR.

**Table 17: Count of Individuals with EHR Access**

| Type of Staff | Count of MHP Staff with EHR Log-on Account | Count of Contract Provider Staff with EHR Log-on Account | Total EHR Log-on Accounts |
|---|---|---|---|
| Administrative and Clerical | 49 | 0 | 49 |
| Clinical Healthcare Professional | 88 | 5 | 93 |
| Clinical Peer Specialist | 0 | 0 | 0 |
| Quality Improvement | 8 | 0 | 8 |
| Total | 145 | 5 | 150 |

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results reflect staffing-level resources, they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

### Table 18: Ratio of IT Staff to EHR User with Log-on Authority

| Type of Staff | MHP FY 2020-21 | Small MHP Average FY 2019-20 |
|---|---|---|
| Number of IT Staff FTEs (Source: Table 15) | 3 | 5.30 |
| Total EHR Users Supported by IT (Source: Table 17) | 150 | 200.00 |
| Ratio of IT Staff to EHR Users | 1:50 | 1:38 |

### Table 19: Additional Information on EHR User Support

| EHR User Support | Status | |
|---|---|---|
| The MHP maintains a local Data Center to support EHR operations. | ☐ Yes | ☒ No |
| The MHP utilizes an ASP model to support EHR operations. | ☒ Yes | ☐ No |
| The MHP also utilizes QI staff to directly support EHR operations. | ☐ Yes | ☒ No |
| The MHP also utilizes Local Super Users to support EHR operations. | ☐ Yes | ☒ No |

### Table 20: New Users' EHR Support

| Support Category | QI | IT | ASP | Local Super Users |
|---|---|---|---|---|
| Initial network log-on access | ☐ | ☒ | ☐ | ☐ |
| User profile and access setup | ☐ | ☒ | ☐ | ☐ |
| Screen workflow and navigation | ☐ | ☒ | ☐ | ☐ |

**Table 21: Ongoing Support for the EHR Users**

| Ongoing EHR Training and Support | Status | |
|---|---|---|
| The MHP routinely administers EHR competency tests for users to evaluate training effectiveness. | ☐ Yes | ☒ No |
| The MHP maintains a formal record or attendance log of EHR training activities. | ☐ Yes | ☒ No |
| The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs. | ☒ Yes | ☐ No |

## Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

**Table 22: Summary of MHP Telehealth Services**

| Telehealth Services | Count |
|---|---|
| Total number of sites currently operational | 3 |
| Number of county-operated telehealth sites | 3 |
| Number of contract providers' telehealth sites | 0 |
| Total number of beneficiaries served via telehealth during the last 12 months | 3,485 |
| • Adults | 1,870 |
| • Children/Youth | 1,275 |
| • Older Adults | 282 |
| Total number of telehealth encounters (services) provided during the last 12 months: | N/A |

- Telehealth services are available at three sites: Madera, Oakhurst and Chowchilla.

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

| | |
|---|---|
| ☒ | Hiring healthcare professional staff locally is difficult |
| ☒ | For linguistic capacity or expansion |
| ☒ | To serve outlying areas within the county |
| ☐ | To serve beneficiaries temporarily residing outside the county |
| ☒ | To serve special populations (i.e. children/youth or older adult) |
| ☒ | To reduce travel time for healthcare professional staff |
| ☒ | To reduce travel time for beneficiaries |
| ☒ | To support NA time and distance standards |
| ☒ | To address and support COVID-19 contact restrictions |

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- During the initial California COVID-19 Shelter in Place order, issued March 19, 2019, the MHP provided County phones to clinicians for support in providing ongoing services. Based on the individual consumer's technological capacity and needs, services were provided either by phone or with Zoom. While some services can now be provided onsite, telehealth, phone, and Zoom services continue to be utilized.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Arabic | ☐ | Armenian | ☐ | Cambodian |
| ☐ | Cantonese | ☐ | Farsi | ☐ | Hmong |
| ☐ | Korean | ☐ | Mandarin | ☐ | Other Chinese |
| ☐ | Russian | ☒ | Spanish | ☐ | Tagalog |
| ☐ | Vietnamese | | | | |

## Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

**Table 23: Contract Providers Delivering Telehealth Services**

| Contract Provider | Count of Sites |
|---|---|
| JDT Consultants | 1 |

## Current MHP Operations

- The MHP continues to utilize the Cerner Community Behavioral Health (CCBH) system, implemented in 2007, in an application service provider (ASP) model with Kings View as their provider.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

**Table 24: Primary EHR Systems/Applications**

| System/Application | Function | Vendor/Supplier | Years Used | Hosted By |
|---|---|---|---|---|
| CCBH | EHR | Cerner | 13 | Kings View |

## The MHP's Priorities for the Coming Year

- Apply CCBH Promotion 230.08.
- Revisit Action Schedules to review settings and current information.
- Finalize a decision for post-implementation InSync support.

- Provide InSync training to staff.
- Implement InSync EHR and performance management functionality.

## Major Changes since Prior Year

- The implementation of the U
- Assessment tracking form for the tracking of the first contact was completed in June 2019.
- The implementation of Client Services Information (CSI) Assessment reporting as part of monthly CSI submissions was completed in August 2019.
- An electronic bi-directional referral form was implemented in September 2019.
- CCBH Promotion 230.01 was applied in November 2019.
- The electronic clinical intake form revision was completed in April 2020.
- A contract was signed with InSync Healthcare Solutions for EHR/performance management software.
- The implementation of updates for Functional Assessment Screening Tool reporting to satisfy DHCS IN 20-003 was completed in June 2020.

## Other Areas for Improvement

- Madera is among the first MHPs to implement the InSync EHR/performance management software. Due to the InSync product being a new presence in the State, due diligence should be performed to assure this software meets all state-mandated data reporting and compliance requirements.

## Plans for Information Systems Change

- The MHP's implementation of the InSync EHR and performance management functionality is in progress.
- The MHP is working collaboratively with its current ASP, Kings View, to migrate from CCBH to InSync.
- The MHP is currently reviewing options for post-implementation InSync support, with operational support provided by either the MHP or Kings View.

## MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

**Table 25: EHR Functionality**

| Function | System/ Application | Rating | | | |
|---|---|---|---|---|---|
| | | Present | Partially Present | Not Present | Not Rated |
| Alerts | CCBH | ☒ | ☐ | ☐ | ☐ |
| Assessments | CCBH | ☒ | ☐ | ☐ | ☐ |
| Care Coordination | | ☐ | ☐ | ☒ | ☐ |
| Document Imaging/Storage | CCBH | ☒ | ☐ | ☐ | ☐ |
| Electronic Signature—MHP Beneficiary | CCBH | ☒ | ☐ | ☐ | ☐ |
| Laboratory results (eLab) | | ☐ | ☐ | ☒ | ☐ |
| Level of Care/Level of Service | | ☐ | ☐ | ☒ | ☐ |
| Outcomes | CCBH | ☒ | ☐ | ☐ | ☐ |
| Prescriptions (eRx) | CCBH | ☒ | ☐ | ☐ | ☐ |
| Progress Notes | CCBH | ☒ | ☐ | ☐ | ☐ |
| Referral Management | | ☐ | ☐ | ☒ | ☐ |
| Treatment Plans | CCBH | ☒ | ☐ | ☐ | ☐ |
| Summary Totals for EHR Functionality: | | | | | |
| FY 2020-21 Summary Totals for EHR Functionality: | | 8 | 0 | 4 | 0 |
| FY 2019-20 Summary Totals for EHR Functionality: | | 8 | 0 | 4 | 0 |
| FY 2018-19 Summary Totals for EHR Functionality: | | 8 | 0 | 4 | 0 |

Progress and issues associated with implementing an EHR over the past year are summarized below:

- No progress has been made on the implementation of eLab functionality in the past three years.

## Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

**Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR**

| Type of Input Method | Percent Used | Frequency |
|---|---|---|
| Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR | 0% | Not Applicable |
| Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system | 0% | Not Applicable |
| Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system | 0% | Not Applicable |
| Direct data entry into MHP EHR system by contract provider staff | 25% | Daily |
| Electronic files/documents securely emailed or faxed to MHP for processing or data entry input into EHR system | 50% | Daily |
| Paper documents submitted to MHP for data entry input by MHP staff into EHR system | 25% | Daily |

The rest of this section is applicable: ☐ Yes ☒ No

Some contract providers have EHR systems which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in-place to support transmission of beneficiary and services information from contract providers to the MHP.

**Table 27: EHR Vendors Supporting Contract Provider to MHP Data Transmission**

| EHR Vendor | Product | Count of Providers Supported |
|---|---|---|
| n/a | n/a | n/a |

## Personal Health Record (PHR)

The beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or a third-party PHR.

☐ Yes ☒ No ☐ Implementation Phase

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

**Table 28: PHR Functionalities**

| PHR Functionality | Status | |
|---|---|---|
| View current, future, and prior appointments through portal. | ☐ Yes | ☒ No |
| Initiate appointment requests to provider/team. | ☐ Yes | ☒ No |
| Receive appointment reminders and/or other health-related alerts from provider team via portal. | ☐ Yes | ☒ No |
| View list of current medications through portal. | ☐ Yes | ☒ No |
| Have ability to both send/receive secure Text Messages with provider team. | ☐ Yes | ☒ No |

# Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

- ☐ Dimension Reports application
- ☐ Web-based application, including the MHP EHR system, supported by Vendor or ASP Staff
- ☐ Web-based application, supported by MHP or DMC staff
- ☐ Local SQL database, supported by MHP/Health/County staff
- ☒ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP's SDMC claims.

### Table 29: Summary of CY 2019 Short-Doyle/Medi-Cal Claims

| Madera MHP | | | | | | | |
|---|---|---|---|---|---|---|---|
| Service Month | Number Submitted | Dollars Billed | Number Denied | Dollars Denied | Percent Denied | Dollars Adjudicated | Dollars Approved |
| **TOTAL** | **43,035** | **$12,017,364** | **404** | **$113,307** | **0.93%** | **$11,904,057** | **$8,002,818** |
| JAN19 | 3,838 | $1,034,339 | 28 | $7,918 | 0.76% | $1,026,421 | $633,675 |
| FEB19 | 3,509 | $959,831 | 32 | $10,237 | 1.06% | $949,594 | $585,970 |
| MAR19 | 4,009 | $1,063,525 | 33 | $9,670 | 0.90% | $1,053,855 | $647,990 |
| APR19 | 4,028 | $1,084,257 | 31 | $11,714 | 1.07% | $1,072,543 | $662,678 |
| MAY19 | 4,064 | $1,097,684 | 43 | $9,965 | 0.90% | $1,087,719 | $666,105 |
| JUN19 | 3,475 | $907,938 | 32 | $4,737 | 0.52% | $903,201 | $561,714 |
| JUL19 | 3,613 | $1,011,147 | 31 | $5,952 | 0.59% | $1,005,195 | $756,093 |
| AUG19 | 3,838 | $1,061,018 | 28 | $6,551 | 0.61% | $1,054,467 | $785,371 |
| SEP19 | 3,593 | $1,015,570 | 28 | $5,922 | 0.58% | $1,009,648 | $762,629 |
| OCT19 | 3,451 | $1,042,005 | 41 | $11,299 | 1.07% | $1,030,706 | $765,847 |
| NOV19 | 2,760 | $919,317 | 42 | $13,720 | 1.47% | $905,597 | $605,213 |
| DEC19 | 2,857 | $820,734 | 35 | $15,622 | 1.87% | $805,112 | $569,532 |

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

- During CY 2019, the MHP experienced claims submission delays that resulted in a number of claim transactions for December not being included in Table 29 results.

Table 30 summarizes the top five reasons for claim denial.

### Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

| Madera MHP | | | |
|---|---|---|---|
| **Denial Reason Description** | **Number Denied** | **Dollars Denied** | **Percent of Total Denied** |
| Medicare or Other Health Coverage must be billed before submission of claim. | 219 | $51,937 | 46% |
| ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid. | 130 | $38,694 | 34% |
| Beneficiary not eligible or non-covered charges. | 15 | $10,634 | 9% |
| Beneficiary not eligible. | 29 | $10,369 | 9% |
| Service line is a duplicate and a repeat service procedure code modifier not present. | 8 | $1,142 | 1% |
| **Total** | 404 | $113,307 | NA |
| The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials. | | | |

- Denied claim transactions with reason “Medicare or Other Health Coverage must be billed before submission of claim” is generally re-billable within the State guidelines.

# NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

## Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The travel time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Madera MHP, the time and distance requirements are 75 minutes and 45 miles for mental health services, and 75 minutes and 45 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups: youth (0-20) and adults (21 and over).

### Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

### Review Sessions

CalEQRO conducted one consumer and family member focus group, two stakeholder interviews, one staff and contractor interview, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

## Findings

The county MHP met all time and distance standards and did not require AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

## Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

The MHP was not required to submit a plan of correction. However, the MHP provided additional information on ways it enhances service access for Medi-Cal beneficiaries.

Transportation – In addition to the transportation provided by the two MCPs in the county, the MHP provides transportation as needed to ensure beneficiary access to mental health services and psychiatry appointments. The MHP makes additional transportation arrangements, if needed, for psychiatric inpatient discharged beneficiaries.

Limited Mobility Beneficiaries – The MHP arranges visits by clinical line staff to beneficiary locations. For psychiatry appointments, it provides telehealth appointments.

Mobile Mental Health – The MHP has full-time MHP staff dedicated to crisis services who provide services at the local emergency room and at local police stations. In addition, contracted staff through a non-profit agency, Westcare, provide crisis services after hours and weekends at the emergency room. In addition, case managers are in the community most of the time providing services to MHP beneficiaries including transportation from inpatient facilities.

## Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI or taxonomy code exceptions noted by CalEQRO.

### Table 31: NPI and Taxonomy Code Exceptions

| Description of NPI Exceptions | Number of Exceptions[5] |
|---|---|
| NPI Type 1 number not found in NPPES | 2 |
| NPI Type 1 and 2 numbers are the same | 0 |
| NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent | 57 |
| NPI Type 1 number reported is associated with two or more providers | 1 |
| NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes | 1 |
| NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services | 0 |

[5] Data Sources:

1. MHP's NACT Rendering Providers, Exhibit A.3 worksheets
2. Health Care Provider Taxonomy, version 20.0, January 2020 ©2020 AMA
3. NPPES Link: https://nppes.cms.hhs.gov/#/
4. PAVE Portal: https://pave.dhcs.ca.gov/sso/login.do

# CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted one 90-minute focus group with consumers (MHP beneficiaries) and their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested one focus group with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFMs for their participation.

## CFM Focus Group One

**Table 32 : Focus Group One Description and Findings**

| Topic | Description |
|---|---|
| Focus group type | CalEQRO requested a focus group consisting of a culturally diverse group of adult beneficiaries and parents/caregivers of child/youth beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months.<br>The focus group was remotely conducted using Zoom teleconferencing software. |
| Total number of participants | Four |
| Number of participants who initiated services during the previous 12 months | One |
| Interpreter used | No<br>If yes, specify language: Not applicable |
| Summary of the main findings of the focus group: | |

| Topic | Description |
|---|---|
| Access - new beneficiaries | (Part of the beneficiary feedback has been suppressed to protect the participant identity as there was only one new beneficiary.)<br>The participant reported that during intake and assessment, the case worker and clinician explained what to expect, beneficiary rights, responsibilities, and other ancillary services that may benefit the beneficiary. They encouraged the beneficiary to go to the wellness center and join activities there as well.<br>The beneficiary described the experience as very reassuring as the beneficiary and family members had no prior experience with mental health services. |
| Access – overall | The participants reported receiving access information from various sources including social services, primary care, and substance use disorder services.<br>Overall, the beneficiaries were satisfied with access once they got to the MHP. One individual noted that previous service providers (non-mental health) at other agencies did not provide any information on availability of mental health services in the county. |
| Timeliness | All participants reported receiving text reminders, thus validating the effort undertaken by the MHP through its current non-clinical PIP.<br>One participant reported frustration with repeated clinician-initiated cancellations but felt that it happens because the clinician has a high caseload. |
| Urgent care and resource support | All participants noted receiving a toll-free number which is supposed to be available for any questions, and during the weekend and after hours. |
| Quality | The participants noted their satisfaction with the following:<br>• Medication and the information they received on their medications.<br>• Telehealth appointments.<br>• Dialectical Behavioral Therapy (DBT).<br>• Check-ins with the case manager.<br><br>No participants were aware of Wellness Recovery Action Plans (WRAP). |

| Topic | Description |
|---|---|
| Peer employment | The participants who have gone to the wellness center, reported being satisfied with the groups and facilities available there. However, none of the participants were aware of any educational or employment resources. One participant recalled hearing about a job fair from the case manager but did not have transportation to attend. |
| Structure and operations | No participants had heard of the QI committee.<br>All participants who had received services for longer than a year reported knowing about the POQI survey. |
| Recommendations from this focus group | • Would like a therapist who will not cancel appointments.<br>• Monthly treatment team meeting with the adult beneficiaries.<br>• A monthly newsletter that could be web-based.<br>• The MHP having beneficiary focus groups to find out what is needed, like the CalEQRO focus group.<br>• Clarification of the roles of the probation officer.<br>• Greater safety for the beneficiaries.<br>• More housing for women. |
| Any best practices or innovations (optional) | • DBT for those who need it. |

# PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

## Access to Care

Table 33 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

### Table 33: Access to Care Components

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| 1A | Service Access and Availability | 14 | 12 |
| The MHP website provides clear information on accessing services including in crisis.<br>In the past year, another independent website was developed by an organization called Credible Minds that provides detailed information on different types of mental health topics. The MHP should consider providing a link to this website on its own homepage.<br>The MHP has service brochures in Spanish on the website. It also provides google translate function on the website. Beneficiaries reported that these are also available in the clinics, but that sometimes the changes were not reflected in the printed materials available.<br>The MHP maintains an up-to-date provider directory with a Spanish version and each clinician's language capability.<br>The MHP provided its monitoring results with the 24/7 Access line. | | | |
| 1B | Capacity Management | 10 | 9 |

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| As part of its cultural competency plan updates, the MHP assesses service needs by demographics, identifies disparities, and plans new strategies to address those. The evaluation of the effectiveness of these efforts are ongoing, but not identified in detail in the QI plan evaluation.<br>Since October 2018, the MHP has hired a total of 11 case workers, six of them being bilingual; ten pre-licensed clinicians, four of them being bilingual; and two monolingual English-speaking licensed clinicians. The MHP has also been making efforts to recruit pre-licensed line staff and rehire retired licensed clinicians if they are interested.<br>CalEQRO's performance measures calculations show that between CY 2017 and CY 2019, both the statewide and small MHP average Latino/Hispanic penetration rates have increased; Madera MHP's corresponding rates have been on a downward trend. | | | |
| 1C | Integration and Collaboration | 24 | 22 |
| The MHP now has a designated staff member to liaise with the inpatient psychiatry units to facilitate transition to SMHS.<br>Mental health and substance use disorder services are integrated.<br>The MHP has outreach staff as part of public health's Tobacco Coalition. They have also collaborated in suicide prevention.<br>The MHP collaborates with Second Street Church and pastor Mike Pastor in suicide prevention, and MHP staff participating in the parenting classes.<br>The MHP received a grant for Homeless Mentally Ill Outreach and Treatment (MIOT) funds and received $100,000 that it contracted with Community Action Partnership (CAP) to provide homeless outreach services.<br>There is a new student mental health grant and a No Place Like Home grant for housing for 14 SMHS beneficiaries. Another housing unit is being built and will provide seven MH supportive housing apartments. | | | |

## Timeliness of Services

As shown in Table 34, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

**Table 34: Timeliness of Services Components**

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| 2A | First Offered Appointment | 16 | 16 |

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| The MHP does not have any organizational contract provider providing outpatient services. Therefore, the data on county operated clinics capture the entire system's first offered timeliness appointment.<br>The MHP reported an average of four days for first offered appointment and meeting the 10 business day standard 98 percent of the time. It instituted the following workflow two years ago to accomplish such quick turnaround for first offered appointment:<br>If the reception cannot find an appointment in the standard time, they call the supervisors/managers and they will make sure the beneficiaries get an appointment within the standard time. One manager is responsible for making sure the assessment takes place in 72 hours.<br>In addition, the MHP has also put in place a pre-screening process to ensure that the first or assessment appointments are offered to those who are looking for mental health services and likely to meet medical necessity criteria, not referral to other ancillary services such as housing or employment. For those seeking such services, the MHP has put in place appropriate referrals and routing of such calls.<br>The participants in the beneficiary focus group also noted that the initial access was quick and easy. | | | |
| 2B | First Offered Psychiatry Appointment | 12 | 12 |
| The MHP tracks and trends all psychiatry appointments by adult, children, and FC. It reported an average wait time of six days for first offered psychiatry appointments and met its standard of 15 business days 98 percent of the time. This is an improvement from 84 percent reported in FY 2019-20.<br>For FC beneficiaries, the average was four days with 100 percent meeting the standard. | | | |
| 2C | Timely Appointments for Urgent Conditions | 18 | 18 |
| The MHP has a 48-hour standard for urgent appointment requests that do not require prior authorization. It reported an average of three hours wait time with 80 percent meeting the standard overall.<br>For urgent appointment requests requiring prior authorizations, the MHP reported an average of 16 hours wait time overall with 80 percent meeting the 96-hour standard. The MHP stated that these requests mostly involve out-of-county service authorization requests (SARs) or children's hospital admissions. There were no adult beneficiaries who needed prior authorization in FY 2019-20, only children. | | | |
| 2D | Timely Access to Follow-up Appointments after Hospitalization | 10 | 8 |

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| The MHP has a 7-day follow-up standard for psychiatric inpatient discharges, but only 42 percent overall receive a follow-up appointment within that timeframe. The MHP acknowledges that the inpatient follow-up processes have not been optimal so far and has recently initiated a PIP on improving the timeliness of follow-up appointments. This PIP is currently in implementation phase.<br>The MHP also stated it had not received treatment authorization requests (TARs) for about 10 percent of beneficiaries for whom the timely follow-up could not be measured. | | | |
| 2E | Psychiatric Inpatient Rehospitalizations | 6 | 6 |
| The MHP reported a 12 percent rehospitalization overall. Reducing rehospitalization is the main outcome of the newly initiated clinical PIP mentioned in 2D. | | | |
| 2F | Tracks and Trends No-Shows | 10 | 9 |
| The MHP reported no-show rates of 18 and 14 percent for psychiatrist and other clinician appointments respectively. These exceeded the standard of 10 percent set by the MHP. High no-show rate has been a longstanding issue for the MHP, and it started a non-clinical PIP with text reminder system as the main intervention in June 2019. This PIP was initially delayed as the MHP dealt with privacy concerns arising from the proposed intervention. Once those were addressed and the PIP interventions officially started in January 2020, they had to be put on hold again due to COVID-19 impact on the system. At the time of the review, the MHP has again started the system as planned. | | | |

## Quality of Care

In Table 35, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

**Table 35: Quality of Care Components**

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| 3A | Cultural Competence | 12 | 8 |

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| The MHP compares its workforce race/ethnicity composition with the county population, Medi-Cal eligible population, 200 percent of poverty population, and beneficiaries served population. It provided two examples of responsiveness of SMHS to beneficiary cultural and linguistic needs and preferences in its cultural competency plan. However, it was not clear how any of the strategies were firmly based on assessment and findings from evaluation of beneficiary needs.<br>The MHP offered a number of cultural competency trainings in the past two years. The training topics are identified in the quality monitoring meetings, and once finalized, the trainings are delivered through an online platform called Relias. Due to COVID-19, the in-person trainings slated for the first half of 2020 had to be cancelled. These were being reorganized for possible offering through Relias.<br>In its goals for FY 2020-21, the MHP has identified offering educational and informative articles on culture related topics in its agency-wide newsletter, and bilingual staff wearing badges indicating their language capabilities as two tasks to accomplish. | | | |
| 3B | Beneficiary Needs are Matched to the Continuum of Care | 12 | 9 |
| The MHP does not have a formal process for assigning beneficiaries to appropriate levels of care. It uses the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) to assess the service needs for adults and children respectively.<br>The MHP uses a number of other tools for assessment and diagnostic purposes including SCARED, the 35-item Pediatric Symptoms Checklist (PSC-35), World Health Organization Disability Assessment Schedule, Ages and Stages Questionnaire (ASQ), and others. Most of these are used for specific sets of beneficiaries such as the PIP population or recipients of an evidence-based treatment<br>The MHP has a warm hand-off process for transition between SMHS and MCPs. The beneficiary focus group participants reported that they have a voice in their treatment planning, and their treatment and medication information are adequate. | | | |
| 3C | Quality Improvement Plan | 10 | 8 |
| The MHP has a current QI work plan and completed its evaluation of the FY 2019-20 QI work plan. The MHP has three distinct functions identified in its plan consisting of QI, quality assurance, and utilization management. The meetings are also divided into these three distinct entities.<br>The QI work plan and activities address all state required activities; however, the plan is more compliance-oriented, and as such, will benefit from further stakeholder-identified quality and access goals, and tracking thereof. | | | |

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| The MHP has taken one step toward greater engagement by the leadership in developing the QI work plan as the full Quality Management Committee (QMC) participated in the process.<br>One example of setting and tracking of quality and access goals would be the downward trending Latino/Hispanic penetration rates, assessing the root causes, and identifying strategies to address the issue. All such processes should be guided by the relevant stakeholders including the beneficiaries and the line staff. | | | |
| 3D | Quality Management Structure | 14 | 10 |
| The MHP has a designated QM unit, and QI and analytics staff that appear adequate to perform QM functions. At present, the QMC consists only of the leadership team members. The QI team is more diverse including clinical supervisors, but no clinical line staff, beneficiaries, or family members. The QMT has contract provider and community representatives in addition to the supervisors. These last two teams would benefit from inclusion of beneficiary, family member, and line staff representatives for a more stakeholder-driven QI topic identification and strategies. Currently, input from these groups is listed as one of the stated QI activities.<br>The MHP is transparent with its QI work plan and posts it on its website. It also shares much of the information internally through agency newsletter, emails, and posting on its intranet. | | | |
| 3E | QM Reports Act as a Change Agent in the System | 10 | 8 |
| During FY 2019-20, the MHP reports focused mostly on timeliness metrics and demographics. As mentioned in 3C, there are other access and quality areas that the MHP can expand its reporting on with further stakeholder input.<br>The MHP cited examples of QI activities initiated because of the QM reports last year. These include the re-establishment of the pre-screening process in order to improve the initial assessment timeliness, and efforts to improve the 7-day follow-up rates after inpatient discharge through a newly established clinical PIP.<br>The change management efforts are ongoing, and the MHP acknowledged that not all of these result in accomplishing the intended outcomes but emphasized that those outcomes lead to further changes toward improving the outcomes. | | | |
| 3F | Medication Management | 12 | 8 |
| The MHP coordinates its medication management in collaboration with primary care providers (PCPs) by making our medical director available for consultation by any provider internal or external as well as by initiating coordination of care via the PCP Letter process. Data collected from PCP in response to the MHP's coordination of | | | |

| Component | Maximum Possible | MHP Score |
|---|---|---|
| care efforts are logged into the PCP letter database and all documents are scanned into the EHR.<br>The MHP has medication monitoring guidelines by class of medications, and a contracted registered pharmacist acts as the medication monitoring coordinator.<br>At this time, the MHP does not track any HEDIS measures, including none specified in SB 1291 for FC beneficiaries. The only exception is the 7-day follow-up after psychiatric inpatient discharge measure. The MHP has embarked on a new clinical PIP to improve this metric, and thereby improving another HEDIS measure of 30-day rehospitalization rate. | | |

## Beneficiary Progress/Outcomes

In Table 36, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

**Table 36: Beneficiary Progress/Outcomes Components**

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| 4A | Beneficiary Progress | 16 | 12 |
| The MHP uses ANSA for the adult beneficiaries, and CANS-50 and PSC-35 for the children. These instruments are available electronically and the clinicians are able to look up the results through the EHR.<br>In addition, the children's services utilize CANS-50, PSC-35, ASQs and the SCARED screening tool as means of measuring beneficiary progress in treatment. Additionally, they are utilized in the review and verification of the appropriateness of the beneficiaries' treatment plan/services.<br>At this time, the MHP is not able to produce aggregate reports based on these instruments. It expects that the new EHR being implemented will give the MHP ability to do aggregate reports, as well as open up the possibility of using additional outcomes and beneficiary progress tracking tools. | | | |
| 4B | Beneficiary Perceptions | 10 | 9 |

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| The MHP uses the POQI findings for further investigation and quality improvement purposes. It is planning to gather further information from monolingual Spanish-speaking beneficiaries in coordination with the ethnic services manager. In addition, the MHP has a beneficiary feedback form on its website to facilitate receiving suggestions for service improvement on a continuous basis. The MHP did not present any findings or information on how well this form is utilized. | | | |
| 4C | Supporting Beneficiaries through Wellness and Recovery | 12 | 12 |
| The MHP contracts with Turning Point to manage wellness center programs at two sites. Hope House is located in Madera and the Mountain Wellness Center is in Oakhurst. Both sites have peer staff (over 50 percent of the employees) and offer programs that are peer-driven and include support groups and activities leading to wellness and recovery. Laundry and shower facilities are also available. Due to COVID-19, after March, neither of the centers are offering programs but are open for laundry and showers. | | | |

## Structure and Operations

In Table 37, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

**Table 37: Structure and Operations Components**

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| 5A | Capability and Capacity of the MHP | 30 | 30 |
| The MHP provides all DHCS contract required services either through county operated, or through contract provided clinics and facilities. The MHP provided a comprehensive listing of the services provided by clinic and contract locations in the FY 2020-21 QI work plan. | | | |
| 5B | Network Enhancements | 18 | 18 |
| The MHP has various means through which it enhances its network and services. The MHP has relationships with primary care and social services. Mobile crisis responders work with law enforcement as needed. It is also enhancing its efforts to rapidly connect inpatient-discharged beneficiaries to follow-up services through a new PIP. | | | |

| Component | | Maximum Possible | MHP Score |
|---|---|---|---|
| The MCPs provide transportation to the beneficiaries for mental health appointments. Both plans contract with Logisticare to provide this service. Some beneficiary focus group participants reported difficulties with this service in terms of scheduling and last-minute cancellation by the transportation provider, while the others were satisfied with the service.<br>The MHP has two wellness centers in the county and beneficiary focus group participants reported attending them and benefitting from the groups there.<br>Due to COVID-19, the MHP has expanded its telehealth services to include the non-psychiatrist clinician provided services. This process has undergone rapid evolution from check-ins to actual clinical sessions.<br>The MHP had reached out to the Indian Health Services, but they declined to collaborate on collocated services. | | | |
| 5C | Subcontracts/Contract Providers | 16 | 16 |
| Contract providers account for only 2.8 percent of Medi-Cal funded services provided by Madera MHP. Additional contract provided services consist of ancillary services or Mental Health Services Act (MHSA) funded services such as the wellness centers. Nonetheless, the MHP QI and cultural competency committee minutes show presence of contract provider representation and evidence of regular communication with them. | | | |
| 5D | Stakeholder Engagement | 12 | 8 |
| MHSA and cultural competency plan update efforts included community meetings where beneficiaries and family members were given the opportunity to provide feedback and input. Beneficiary focus group participants, however, were not aware of opportunities for participation in planning for the MHP.<br>The MHP supervisors are present in different QI meetings. However, the MHP has been challenged in line staff involvement, partly due to high turnover rates in the past and resulting workload for the remaining staff.<br>The MHP communicates with the staff through internal staff meetings and a staff newsletter. | | | |
| 5E | Peer Employment | 8 | 4 |
| The MHP uses employees through a local temp agency who may work full time, but do not receive benefits. Others are hired directly through the county and are in a civil service classification with benefits. There are no direct career ladder positions for advancement. A contract provider, Turning Point, manages the two wellness centers where they offer employment services. | | | |

# SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Madera MHP related to access, timeliness, and quality of care.

## MHP Environment – Changes, Strengths and Opportunities

### PIP Status

**Clinical PIP Status:** Completed

**Non-clinical PIP Status:** Active and ongoing

### Access to Care

**Changes within the Past Year:**

- The MHP continues to have challenges in recruiting and retaining clinical line staff, especially bilingual staff. It is working on recruiting more pre-licensed staff, and retired clinicians to maintain access and NA.
- The MHP has reinstituted its pre-screening protocol in order to reduce a significant number of service requests from individuals who do not meet the medical necessity criteria for SMHS and may benefit from referral to other services. This has improved both its assessment capacity and is likely going to improve its low retention rates by reducing the number of individuals with only an assessment on their claim records.
- The MHP hired an additional psychiatrist to provide services for both substance use disorders (SUD) and mental health.
- The MHP has developed a collaborative with the superintendent of Madera Unified school district and Camarena Health to apply for Mental Health Student Services Act funding from the Mental Health Services Oversight and Accountability Commission, and currently awaiting notification of award. If awarded, this would fund two clinicians and three navigators to identify and link school aged children with appropriate level of mental health services.
- The MHP received a grant for Homeless Mentally Ill Outreach and Treatment (MIOT) funds and received $100,000 that it contracted with CAP to provide homeless outreach services.
- Due to COVID-19, the MHP had to adapt its services to be provided through telehealth. This has evolved from initially ensuring check-ins to full-fledged outpatient treatment sessions.

**Strengths:**

- The Credible Minds website provides comprehensive information on mental health and SUD diagnosis and treatment. The website is well organized and easy to navigate.
- The MHP's official website is transparent and easy to navigate with relevant information prominently displayed. The provider directory is now automatically updated whenever there are any changes.

**Opportunities for Improvement:**

- CalEQRO could not find a direct link to the Credible Minds website on the official county behavioral health website.
- The Latino/Hispanic penetration rate has been dropping since CY 2016.

## Timeliness of Services

**Changes within the Past Year:**

- The MHP has rolled out its text reminder system (TEARS) for appointments systemwide.
- The MHP has designated one of its division managers as the point person to ensure that the first assessment appointment is scheduled within 72 hours of request.

**Strengths:**

- During FY 2019-20, the MHP has been able to provide a first offered appointment within four days on average and met its standard of ten days 98 percent of the time.
- During the same period, the MHP has been able to offer initial psychiatrist appointments within six days on average and met its 15-day standard 98 percent of the time.

**Opportunities for Improvement:**

- Although the average inpatient follow-up appointment time is four days, only 42 percent of the inpatient discharges meet the 7-day follow-up standard.
- While the MHP has improved overall timeliness tracking, it does not monitor timeliness to service by language. As nearly 18 percent of the beneficiaries served by the MHP speak Spanish, this would be a meaningful metric to track.

## Quality of Care

**Changes within the Past Year:**

- Due to COVID-19, most of the outpatient services are being temporarily offered through telehealth.
- The MHP has now included contract providers in its QMT meetings.
- In response to one of CalEQRO's recommendations from FY 2019-20, the MHP has modified its QI work plan to include baseline and quantifiable for applicable indicators starting with the FY 2020-21 plan.

**Strengths:**

- The MHP now has a strong QI team with adequate analyst positions.
- The MHP has a warm hand-off process for transition between SMHS and MCPs.
- The beneficiary focus group participants reported that they have a voice in their treatment planning, and that their treatment and medication information are adequate.

**Opportunities for Improvement:**

- In general, the MHP's QI work plan is primarily compliance-focused. One example of setting and tracking of quality goals would be the downward trending Latino/Hispanic penetration rates, assessing the root causes, and identifying strategies to address the issue. All such processes should be guided by the relevant stakeholders including the beneficiaries and the line staff.
- The MHP has several committees that are part of the overall quality management structure, but there is a notable lack of line staff and beneficiary participation in these committees.

## Beneficiary Outcomes

**Changes within the Past Year:**

- None noted.

**Strengths:**

- The MHP has a number of outcome tools that are used overall, or in parts of the system such as the Full-Service Partnerships (FSPs).

**Opportunities for Improvement:**

- At this time, the MHP is not able to produce aggregate reports based on these instruments. It expects that the new EHR being implemented will give the MHP ability to do aggregate reports, as well as open up the possibility of using additional outcomes and progress tracking tools.

## Foster Care

**Changes within the Past Year:**

- None noted.

**Strengths:**

- None noted.

**Opportunities for Improvement:**

- The MHP did not present any evidence of monitoring the available SB 1291 mandated HEDIS measures for which the data is available from the state websites.

## Information Systems

**Changes within the Past Year:**

- None noted.

**Strengths:**

- The ANSA, CANS-50 and PSC-35 are available electronically.
- The MHP receives EHR, data analytic and fiscal support from Kings View Behavioral Health Systems.
- Kings View provides the MHP with monthly beneficiary demographics, penetration rate, and claims processing reports to the MHP.

**Opportunities for Improvement:**

- The MHP has made no progress on the implementation of eLab functionality during the past three years.

## Structure and Operations

**Changes within the Past Year:**

- The MHP has selected InSync as their replacement electronic health record/performance management software and will work collaboratively with InSync Healthcare Solutions and Kings View to migrate from CCBH to InSync.

**Strengths:**

- The MHPs mobile crisis and case workers work closely with law enforcement.
- The MHP runs two wellness providers through a contract agency which the beneficiary focus group participants reported having benefitted from.

**Opportunities for Improvement:**

- The beneficiary focus group participants stated that they would like further information on current events at the MHP, preferably through a publicly accessible forum or the MHP website in the form of a newsletter.

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# FY 2020-21 Recommendations

## PIP Status

**Recommendation 1:** Ensure the non-clinical PIP data are tracked and presented as planned.

**Recommendation 2:** Add a performance measure to the non-clinical PIP that reflects the PIP aim statement. See the PIP section for the specific measure.

**Recommendation 3:** Activate the new clinical PIP on reducing rehospitalization rate and ensure that it addresses the low adherence to the 7-day follow-up standard.

### Access to Care

**Recommendation 4:** Investigate the reasons for declining Latino/Hispanic penetration rate.

### Timeliness of Services

**Recommendation 5:** Use data analytics to evaluate frequency of beneficiary contact and timely service. This should include tracking and adjusting to address any timeliness to service issues for mono-lingual Spanish speaking beneficiaries. (*This is a carry-over recommendation from FY 2019-20*.)

### Quality of Care

**Recommendation 6:** Engage in a stakeholder-driven planning process for identifying ways to enhance the QI work plan as the main vehicle for true quality improvement. Seek CalEQRO's TA as needed. (*This is a carry-over recommendation from FY 2019-20*.)

**Recommendation 7:** Ensure representation of line staff and beneficiaries in QI activities including feedback and reporting. (*This is a carry-over recommendation from FY 2019-20*.)

**Recommendation 8:** If therapy and outpatient services continue to be delivered through telehealth, provide appropriate training to the line staff in this modality of diagnosis, treatment planning, and delivery.

### Beneficiary Outcomes

**Recommendation 9:** Ensure aggregate outcome and level of care tools results capabilities are embedded in the new EHR that is under implementation.

### Foster Care

**Recommendation 10:** Incorporate analyses of and reporting on SB 1291 mandated HEDIS measures. (*This is a carry-over recommendation from FY 2019-20*.)

### Information Systems

**Recommendation 11:** Assure eLab functionality is included in the InSync implementation plan.

**Recommendation 12:** Due to the newness of the InSync EHR/performance management software among California MHPs, perform due diligence to make sure this product meets all state-mandated data reporting requirements for Medi-Cal certification.

### Structure and Operations

None noted.

# ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

# Attachment A—On-site Review Agenda

The following sessions were held during the MHP on-site review, either individually or in combination with other sessions.

**Table A1: EQRO Review Sessions**

| Madera |
|---|
| Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations |
| Cultural Competence, Disparities and Performance Measures |
| Timeliness Performance Measures/Timeliness Self-Assessment |
| Quality Management, Quality Improvement and System-wide Outcomes |
| Performance Improvement Projects |
| Clinical Line Staff Group Interview |
| Consumer and Family Member Focus Group |
| Peer Employee/Parent Partner Group Interview |
| Validation of Findings for Pathways to Mental Health Services (Katie A./CCR) – Desk Review |
| Information Systems Billing and Fiscal Interview – Desk Review |
| Information Systems Capabilities Assessment (ISCA) – Desk Review |

# Attachment B—Review Participants

## CalEQRO Reviewers

Saumitra SenGupta, Lead Reviewer
Lisa Farrell, Information Systems Reviewer
Deb Strong, Consumer and Family Member Reviewer
Olivia Kozarev, Quality Reviewer (pre-site review only)

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

## Sites of MHP Review

MHP Sites:

The review was conducted through Zoom video conferencing software.

Contract Provider Sites:

Not applicable

### Table B1: Participants Representing the MHP

| Last Name | First Name | Position | Agency |
|---|---|---|---|
| Casillas | Kathy | Clinician | MCBH |
| Colbert | Joan | Case Worker | MCBH |
| DeGuzman | Sherrie | Privacy and Compliance Officer | MCBH |
| Galindo | Art | Division Manager, Children's Services | MCBH |
| Garcia | John | Case Worker | MCBH |
| Garcia | Melissa | CSL | MCBH |
| Gonzalez | Miriam | CSL | MCBH |
| Gonzalez | Jael | CSL | MCBH |
| Graves | Teresa | CSL | MCBH |
| Griggs | Baylee | Case Worker | MCBH |
| Hamilton | Juliette | Managed Care Administrative Data Analyst | MCBH |
| **Koch** | **Dennis** | **MHP Director** | **MCBH** |
| Lopez | Sarah | CSL | MCBH |
| Mojica | Ambar | Managed Care Administrative Analyst | MCBH |
| Morgan | Julie | Assistant Director | MCBH |
| Parra | Alejandra | Clinician – Assessments | MCBH |
| Pressley | Annette | Division Manager, Adult Services | MCBH |
| Rhinehart | Missie | Division Manager, Managed Care | MCBH |
| Weikel | Eva | Managed Care Administrative Analyst | MCBH |

# Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

### Table C1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

| Madera MHP | | | | | |
|---|---|---|---|---|---|
| Entity | Average Monthly ACA Enrollees | Beneficiaries Served | Penetration Rate | Total Approved Claims | ACB |
| Statewide | 3,719,952 | 159,904 | 4.30% | $824,153,538 | $5,154 |
| Small | 171,297 | 8,082 | 4.72% | $39,384,225 | $4,873 |
| MHP | 16,566 | 755 | 4.56% | $1,891,470 | $2,505 |

Table C2 shows the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

### Table C2: CY 2019 Distribution of Beneficiaries by ACB Range

| Madera MHP | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ACB Range | MHP Beneficiaries Served | MHP Percentage of Beneficiaries | Statewide Percentage of Beneficiaries | MHP Total Approved Claims | MHP ACB | Statewide ACB | MHP Percentage of Total Approved Claims | Statewide Percentage of Total Approved Claims |
| < $20K | 3,048 | 97.54% | 93.31% | $6,477,204 | $2,125 | $3,998 | 71.09% | 59.06% |
| >$20K - $30K | 37 | 1.18% | 3.20% | $882,028 | $23,839 | $24,251 | 9.68% | 12.29% |
| >$30K | 40 | 1.28% | 3.49% | $1,752,241 | $43,806 | $51,883 | 19.23% | 28.65% |

# Attachment D—List of Commonly Used Acronyms

### Table D1: List of Commonly Used Acronyms

| Acronym | Full Term |
|---|---|
| AAS | Alternative Access Standard |
| ACA | Affordable Care Act |
| ACL | All County Letter |
| ACT | Assertive Community Treatment |
| ART | Aggression Replacement Therapy |
| ASP | Application Service Provider |
| CAHPS | Consumer Assessment of Healthcare Providers and Systems |
| CalEQRO | California External Quality Review Organization |
| CARE | California Access to Recovery Effort |
| CBT | Cognitive Behavioral Therapy |
| CCBH | Cerner Community Behavioral Health |
| CDSS | California Department of Social Services |
| CFM | Consumer and Family Member |
| CFR | Code of Federal Regulations |
| CFT | Child Family Team |
| CIT | Crisis Intervention Team or Training |
| CMS | Centers for Medicare and Medicaid Services |
| CPM | Core Practice Model |
| CPS | Child Protective Service |
| CPS (alt) | Consumer Perception Survey (alt) |
| CSD | Community Services Division |
| CSI | Client Services Information |
| CSU | Crisis Stabilization Unit |
| CWS | Child Welfare Services |
| CY | Calendar Year |
| DBT | Dialectical Behavioral Therapy |

| Acronym | Full Term |
|---|---|
| DHCS | Department of Health Care Services |
| DPI | Department of Program Integrity |
| DSRIP | Delivery System Reform Incentive Payment |
| EBP | Evidence-based Program or Practice |
| EHR | Electronic Health Record |
| EMR | Electronic Medical Record |
| EPSDT | Early and Periodic Screening, Diagnosis, and Treatment |
| EQR | External Quality Review |
| EQRO | External Quality Review Organization |
| FC | Foster Care |
| FG | Focus Group |
| FQHC | Federally Qualified Health Center |
| FSP | Full-Service Partnership |
| FY | Fiscal Year |
| I | High-Cost Beneficiary |
| HIE | Health Information Exchange |
| HIPAA | Health Insurance Portability and Accountability Act |
| HIS | Health Information System |
| HITECH | Health Information Technology for Economic and Clinical Health Act |
| HPSA | Health Professional Shortage Area |
| HRSA | Health Resources and Services Administration |
| IA | Inter-Agency Agreement |
| ICC | Intensive Care Coordination |
| ISCA | Information Systems Capabilities Assessment |
| IHBS | Intensive Home-Based Services |
| IT | Information Technology |
| LEA | Local Education Agency |
| LGBTQ | Lesbian, Gay, Bisexual, Transgender or Questioning |

| Acronym | Full Term |
|---|---|
| LOS | Length of Stay |
| LSU | Litigation Support Unit |
| M2M | Mild-to-Moderate |
| MCP | Managed Care Plan |
| MDT | Multi-Disciplinary Team |
| MHBG | Mental Health Block Grant |
| MHFA | Mental Health First Aid |
| MHP | Mental Health Plan |
| MHSA | Mental Health Services Act |
| MCBHD | Medi-Cal Behavioral Health Division (of DHCS) |
| MHSIP | Mental Health Statistics Improvement Project |
| MHST | Mental Health Screening Tool |
| MHWA | Mental Health Wellness Act (SB 82) |
| MOU | Memorandum of Understanding |
| MRT | Moral Reconation Therapy |
| NA | Network Adequacy |
| n/a | Not Applicable |
| NACT | Network Adequacy Certification Tool |
| NP | Nurse Practitioner |
| NPI | National Provider Identifier |
| ONA | Out-of-Network Access |
| PA | Physician Assistant |
| PATH | Projects for Assistance in Transition from Homelessness |
| PHF | Psychiatric Health Facility |
| PHI | Protected Health Information |
| PIHP | Prepaid Inpatient Health Plan |
| PIP | Performance Improvement Project |
| PM | Performance Measure |
| PM (alt) | Partially Met |

| Acronym | Full Term |
|---|---|
| QI | Quality Improvement |
| QIC | Quality Improvement Committee |
| RN | Registered Nurse |
| ROI | Release of Information |
| SAR | Service Authorization Request |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SB | Senate Bill |
| SBIRT | Screening, Brief Intervention, and Referral to Treatment |
| SDMC | Short-Doyle Medi-Cal |
| SELPA | Special Education Local Planning Area |
| SED | Seriously Emotionally Disturbed |
| SMHS | Specialty Mental Health Services |
| SMI | Seriously Mentally Ill |
| SOP | Safety Organized Practice |
| STRTP | Short-Term Residential Therapeutic Program |
| SUD | Substance Use Disorders |
| TAY | Transition Age Youth |
| TBS | Therapeutic Behavioral Services |
| TFC | Therapeutic Foster Care |
| TSA | Timeliness Self-Assessment |
| WET | Workforce Education and Training |
| WRAP | Wellness Recovery Action Plan |
| YSS | Youth Satisfaction Survey |
| YSS-F | Youth Satisfaction Survey-Family Version |