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FY 2021-22
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

MADERA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 25, 2021

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report.

MHP INFORMATION

MHP Reviewed — Madera

Review Type — Virtual

Date of Review — August 25, 2021

MHP Size — Small

MHP Region — Central

MHP Location — Madera

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 2,598

MHP Threshold Language(s) — English, Spanish

SUMMARY OF FINDINGS

Of the twelve recommendations for improvement that resulted from the FY 2020-21 EQR, the MHP addressed or partially addressed seven recommendations.

CalEQRO evaluated the MHP on the following four Key Components that impact beneficiary outcomes; among the 26 components evaluated, the MHP met or partially met the following, by domain:

- Access to Care: 100 percent (four of four components)
- Timeliness of Care: 83 percent (five of six components)
- Quality of Care: 80 percent (eight of ten components)
- Information Systems (IS): 100 percent (six of six components)

The MHP submitted both required Performance Improvement Projects (PIPs). The clinical PIP, “<Reducing Psychiatric Re-Hospitalizations >”, is in the first remeasurement phase with a high confidence validation rating. The non-clinical PIP, “<Healthcare Effectiveness Data and Information Set (HEDIS) Module Development”, is in the PIP submitted for approval stage; however, the submission is considered not to meet the criteria for a PIP.

CalEQRO conducted one consumer family member focus group, comprised of a total of three participants.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: quality and quantity of direct services during COVID-19; improved outcomes related to psychiatric inpatient utilization and post-discharge follow-up within 7-days; bi-directional communication and active coordinated relationships with partner agencies; and diligence with the new InSync EHR information system implementation.

The MHP was found to have notable opportunities for improvement in the following areas: access penetration rate, especially for Latino/Hispanic, and retention after the first service; timeliness to first non-urgent services rendered and first non-urgent psychiatry appointments offered; quality input in the Quality Monitoring Meeting (QMM) from beneficiaries; validation of a non-clinical PIP; information system reports utilizing the new December 2020 implemented EHR, InSync.

FY 2021-22 CalEQRO recommendations for improvement include: Investigate reasons and develop strategies to address overall declining penetration rates, especially for Latino/Hispanics, and retention after the first service; investigate reasons and develop strategies to address insufficient timeliness to first non-urgent services rendered and first non-urgent psychiatry appointments offered; develop and implement strategies to incorporate beneficiary input into data-driven decision-making as part of the Quality Assessment and Performance Improvement (QAPI) and QMM processes; develop and submit a new or revised non-clinical PIP; and prioritize, develop, and implement reporting monitors and aggregate data trending through the InSync EHR.

INTRODUCTION

BACKGROUND

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs to provide specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal Mental Health Plan (MHP). DHCS contracts with Behavioral Health Concepts, Inc., the California EQRO (CalEQRO), to review and evaluate the care provided to the Medi-Cal beneficiaries.

Additionally, DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill (AB) 205.

This report presents the fiscal year (FY) 2021-22 findings of the EQR for Madera County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on August 25, 2021.

METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process,

CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files, unless otherwise specified. These statewide data sources include: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File (IPC). CalEQRO reviews are retrospective; therefore, data evaluated are from CY 2020 and FY 2020-21, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data–overall, FC, transitional age youth, and Affordable Care Act (ACA). CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

FINDINGS

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 of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of three elements pertaining to NA: Alternative Access Standards (AAS) requests, use of out-of-network (OON) providers, and rendering provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).
- Summary of MHP-specific activities related to the following four Key Components, identified by CalEQRO as crucial elements of quality improvement and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, and an examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per SB 1291 (Chapter 844).
- Review and validation of submitted Performance Improvement Projects (PIPs).
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the MHP's quality and operational processes.
- Consumer perception of the MHP's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data; its corresponding penetration rate percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

In this section, the status of last year's (FY 2020-21) EQR recommendations are presented, as well as changes within the MHP's environment since its last review.

ENVIRONMENTAL IMPACT

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The impact of COVID-19 was continuous throughout the Fiscal Year, up to and including the time of the site review in August 2021. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. The review was held as a full virtual review except for the Consumer meetings that were conducted as individual phone calls to three beneficiaries.

MHP SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP had significant leadership and key staff losses and transitions. Approximately seventy percent of the business, clinical and administrative leadership changed during this review period. Changes included: Behavioral Health Director; Fiscal Manager; Quality, Compliance, and Administrative Support Division Manager; and the Adult System of Care (ASOC), Housing and Ethnic Services Division Manager.
- Given the number of leadership changes, and that most were added in the last half of the fiscal year, many significant changes are under development. Specifically, the MHP is revamping the organizational flow and the quality and cultural competency processes; considering changes in their crisis and homeless care continuums; developing improved data reporting through a new EHR; and developing a CalAIM plan.
- The MHP contracted with, transitioned to, and implemented a new EHR, InSync, in December 2020. Madera is only the second California county to acquire the InSync EHR. Active work with the vendor to stand up several reporting, billing and documentation functions and requirements are in development.
- Clinic-based direct services were maintained for minor, adult, and older adult beneficiaries at all 4 MHP-operated clinics, despite the challenges posed by COVID-19. Clinics implemented staggered staffing patterns, personal protection equipment and social distancing. Face-to-face services were augmented by

telephone, and, later in the FY, limited virtual telehealth services. The two contractor-operated wellness centers also remained open in limited capacity.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2020-21

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

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Data collection for the non-clinical PIP, "Text and Email Appointment Reminder System (TEARS)" began in January 2020. When COVID-19 impacted the county in March 2020 the MHP continued the TEARS interventions but was not able to monitor and report the data analytics. Since this is no longer an MHP PIP, the recommendation will be retired.

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.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

The MHP made the recommended change, but the PIP was later stopped.

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.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The clinical PIP, "Reducing Psychiatric Re-Hospitalizations", was implemented and clinical interventions began in July 2020. This PIP was validated with a high confidence rating and is in its first remeasurement cycle.

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

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP made efforts to address this area; however, due to staffing changes impacted by COVID-19, the MHP reports it did not have the administrative support to take further actions in this area. The MHP transitioned to a new EHR in late 2020 and plans to address this area in FY 21-22, although it is unclear if the MHP will regain the necessary staffing capacity.

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 recommendation is a carry-over from FY 2019-20.)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Data analytic staffing for this MHP are housed in quality improvement. The MHP indicated that, for this application, the prior Anasazi EHR was quite cumbersome and unreliable. In December of 2020, the MHP implemented a new EHR, InSync. The MHP is working with the vendor to develop several reporting functions. The MHP expects to meet this recommendation in FY 22-23.

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 recommendation is a carry-over from FY 2019-20.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The QI Workplan was a focal point for the QMM Quality Improvement Committee (QIC) stakeholder group in FY 20-21. Progress of QIWP initiatives were

discussed during this monthly meeting. QMM minutes document attendance of Community Business Organizations, staff, and beneficiaries. Limited staff input is documented, but other stakeholder groups are not documented as active participants

Recommendation 7: Ensure representation of line staff and beneficiaries in QI activities including feedback and reporting.

(This recommendation is a carry-over from FY 2019-20.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The QMM expanded from a committee consisting primarily of management and supervisors to include staff and beneficiaries. As in Recommendation 6, limited staff input is documented but other stakeholder groups are not documented as active participants.

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.

(This recommendation is a carry-over from FY 2019-20.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Services are primarily provided in-person, via telephone and limited Zoom sessions. The MHP took advantage of CIBHS' *Minimizing Disruption in Care Through the Use of Behavioral Telehealth* 11-week webinar series from April – July 2020. An additional resource was training software *Relias* from which 17 telehealth training modules were utilized. In addition, clinical supervisors provided ongoing supervision and training to ensure continuity and clinical appropriateness of client care.

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

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The CANS, PSC-35 and ANSA are in use by the MHP and available in the EHR; however, individual client score trending and aggregate reporting are not yet available. The MHP indicated that it intends to work with the vendor to develop aggregate data reporting from the EHR.

Recommendation 10: Incorporate analyses of and reporting on SB 1291 mandated HEDIS measures.

(This recommendation is a carry-over from FY 2019-20.)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The Plan collects data relevant to various HEDIS measures but does not incorporate analyses of and reporting. The MHP intends to work with the EHR vendor to develop a HEDIS module which will centralize all measures and allow for simple data export and analysis.

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

(This recommendation is a carry-over from FY 2019-20.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- InSync has eLab functionality; however, as of July 2021, the MHP's primary lab, Quest, did not want to partner with them due to lab volumes being too low for Quest to consider providing resources to complete eLab interoperability and testing. Authorized MHP medical staff can access lab results by logging into the Quest system.

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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP reports meeting mandated reporting requirements; however, although the InSync performance management module went live in December 2020, the MHP did not successfully submit a claim to DHCS until August 2021. While submitted, the claim had not yet been adjudicated at the time of the review.

NETWORK ADEQUACY

BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All MHPs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services, for youth and adults. If these standards are not met, DHCS requires the MHP to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports 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 reviews separately and with MHP staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the MHP's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

FINDINGS

For Madera County, the time and distance requirements are 75 minutes and 45 miles for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over)[1].

Alternative Access Standards and Out-of-Network Providers

The MHP met all time and distance standards and was not required to submit an AAS request. Further, because the MHP is able to provide necessary services to a beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries to access services via OON providers.

Planned Improvements to Meet NA Standards

Not Applicable

MHP Activities in Response to FY 2020-21 AAS

The MHP did not require AAS in FY 2020-21.

PROVIDER NPI AND TAXONOMY CODES

CalEQRO provides the MHP a detailed list of its rendering provider's NPI Type 1 number and associated taxonomy code and description. Individual technical assistance is provided to MHPs to resolve issues which may result in claims denials, when indicated. The data comes from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. The data are linked to the NPPES using the rendering service provider's NPI, Type 1 number. A summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO will be presented in the FY 2021-22 Annual Aggregate Statewide report.

[1] AB 205 and BHIN 21-023

ACCESS TO CARE

BACKGROUND

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

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

ACCESS IN MADERA COUNTY

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 89.2 percent of services were delivered by county-operated/staffed clinics and sites, and 10.8 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 91.88 percent of services provided are claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff during the workday and contractor staff nights and weekends; beneficiaries may request services through the Access Line as well as through the following system entry points: the MHP website and, by phone or in person, at any of the four outpatient clinics. The MHP operates a decentralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries may receive screening and assessment directly through the closest outpatient clinic to their residence or the clinic of their choice. Given the population distribution, Madera MHP provides youth, adult, and older adult outpatient services in Madera (two clinics), Chowchilla, and Oakhurst.

In addition to clinic-based mental health services, the MHP provides phone telehealth and limited virtual telehealth. Specifically, the MHP delivers psychiatry and mental health services via telehealth to youth, adults, and older adults. In FY 2020-21, the MHP reports having served 1094 adult beneficiaries, 1075 youth beneficiaries, and 195 older adult beneficiaries across four county-operated sites, two in-county contractor-operated sites, and 13 out-of-county provider sites. The two in-county contractor sites are wellness centers that do not provide Medi-Cal reimbursable outpatient services. Among those served, 65 beneficiaries received telehealth services in a language other than English in the preceding 6 months.

Beneficiary transportation is accessible for medical appointments and post psychiatric hospitalization transports. Due to COVID-19 restrictions and safety measures, the MHP's ability to provide transportation decreased due to health concerns from both clients and providers and because many services moved to telehealth. The MHP continues to take precautions while establishing dedicated staff to transport clients back to Madera after psychiatric hospitalization.

All MHP sites are ADA certified to facilitate access. Contracts exist with Deaf & Hard of Hearing Service Center, Inc. dba. Interpreting Services of Central California to ensure accessibility for the specific population. The MHP also has TTY for the deaf, hard of hearing or speech impaired, Relay Phone Services for the deaf, hard of hearing, and those with speech disorders or who are deaf, Speech to Speech Phone Services for those with speech disorders or impediments.

The MHP will work with any community agency to ensure beneficiaries have access and receive the services they require. In the past, the MHP attempted to establish a contract with the local Central Valley Indian Health, Inc., however, they declined.

ACCESS KEY COMPONENTS

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

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

Table 1: Key Components - Access

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Partially Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Partially Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- While the current Cultural Competency Plan (CCP) is developed utilizing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare, it does not evidence barrier analysis and development of specific measurable goals and reporting that is inclusive of stakeholder and beneficiary input.
- The MHP has historically demonstrated effective collaborations with partner stakeholders and other public and private agencies. Under the transition to a new director and key leadership positions, networking continues to be priority. For example, the MHP is actively seeking a grant to increase a partnership with law enforcement, mobile crisis services, and the possible development of a Crisis Stabilization Unit (CSU).
- The MHP is in the process of conducting an overhaul of the Behavioral Health website. The new website will be much more user-friendly and provides significantly improved Spanish language access.

PERFORMANCE MEASURES

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

- Total beneficiaries served, stratified by race/ethnicity and threshold language.
- Penetration rates, stratified by race/ethnicity and FC status.
- Approved claims per beneficiary (ACB) served, stratified by race/ethnicity and FC status.

Total Beneficiaries Served

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

The race/ethnicity results in Table 2 and Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

Madera served 2,598 unique beneficiaries in CY 2020. Their eligible population was largely comprised of Latino/Hispanic beneficiaries with this group comprising 67.1 percent of the eligible population but only 50.6 percent of those served. White

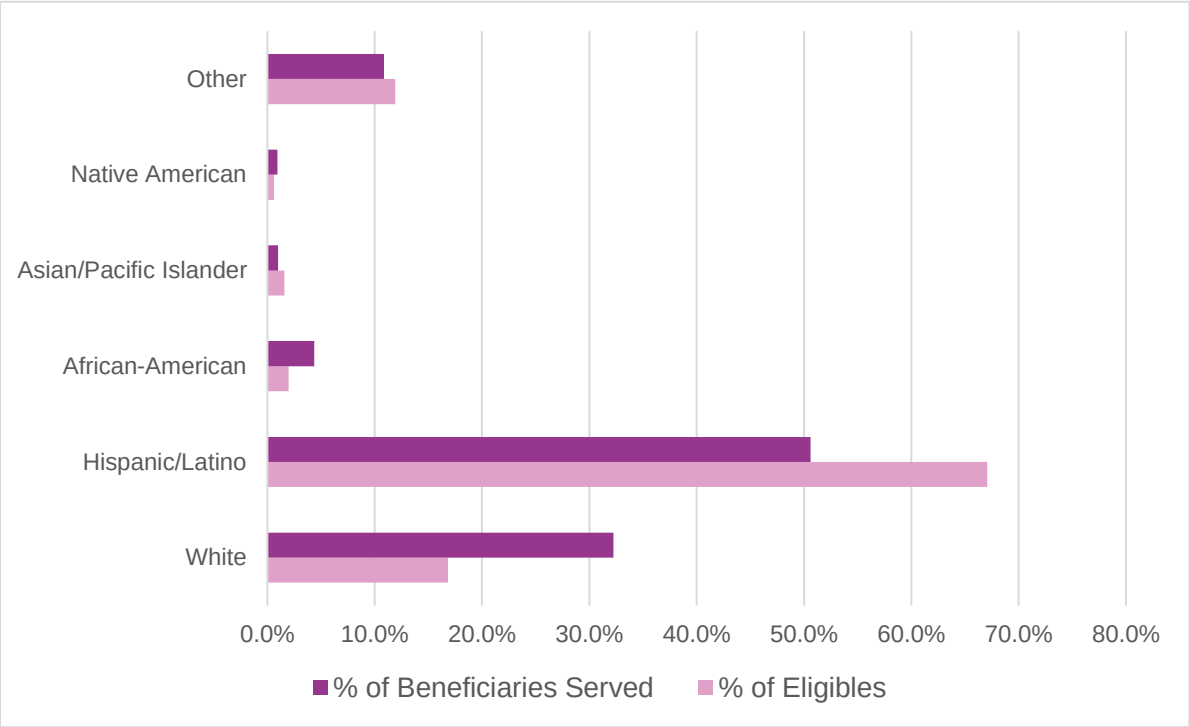
beneficiaries comprised the next largest race/ethnicity group being 16.8 percent of the eligible population and 32.3 percent of those served.

Table 2: County Medi-Cal Eligible Population and Beneficiaries Served in CY 2020, 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	12,393	16.8%	838	32.3%
Latino/Hispanic	49,389	67.1%	1,315	50.6%
African-American	1,454	2.0%	113	4.3%
Asian/Pacific Islander	1,180	1.6%	26	1.0%
Native American	452	0.6%	24	0.9%
Other	8,759	11.9%	282	10.9%
Total	**73,627**	**100%**	**2,598**	**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.				

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020



Madera has one threshold language, Spanish, and served 462 unique beneficiaries (18.4 percent) who identified Spanish as a preferred language.

Table 3: Beneficiaries Served in CY 2020, by Threshold Language

Madera MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	462	18.4%
Other Languages	2,050	81.6%
Total	**2,512**	**100%**
Threshold language source: Open Data per IN 20-070 Other Languages include English		

Penetration Rates and Approved Claim Dollars per Beneficiary Served

The PR is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The ACB served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. See Table D1 for the CY 2019 ACA penetration rate and ACB.

Figures 2 through 9 highlight three-year trends for penetration rates and average approved claims for all beneficiaries served by the MHP as well as the following three populations with historically low penetration rates: FC, Latino/Hispanic, and Asian/Pacific Islander (API) beneficiaries.

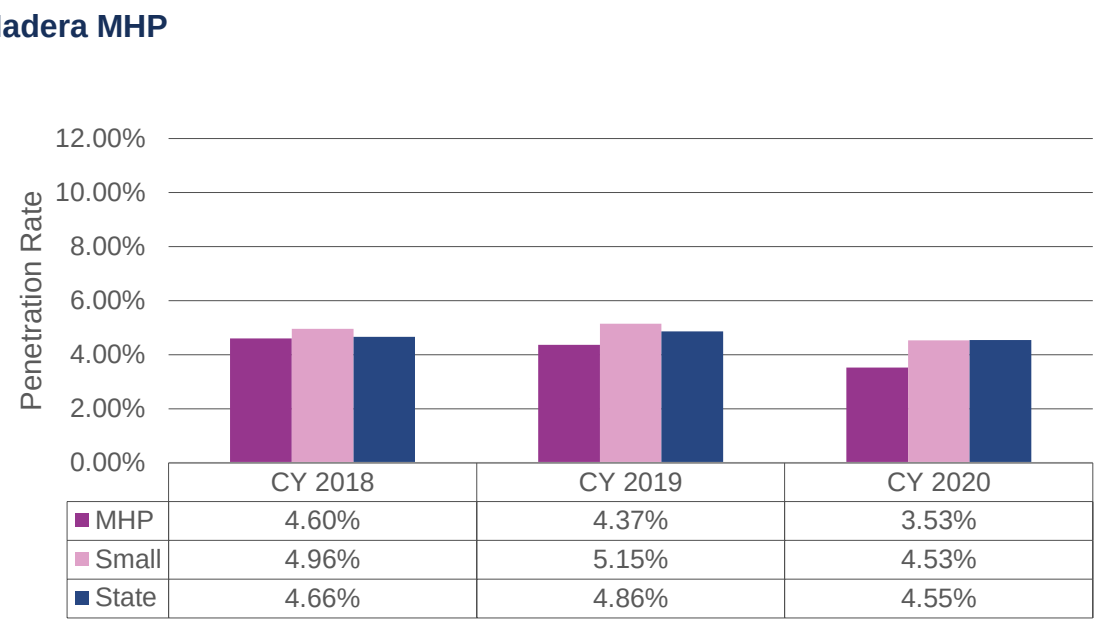
Madera's overall penetration rate declined each year from CY 2018 to CY 2020. It is now one percentage point below both the small county (3.53 percent vs. 4.53 percent) and statewide averages (3.53 percent vs. 4.55 percent). This extrapolates to an approximately 22 percent lower penetration rate.

The Overall approved claims dollars per beneficiary rose each year from CY 2018 to CY2020. Approved claims dollars more than doubled from CY2019 to CY2020 ($2,916 vs. $5,927). The full implication of this increase is difficult to ascertain due to the MHP claiming at the higher COVID-19 rate throughout most of CY 2020. In addition, claims data indicated an increase in the 15+ category percent of services approved per beneficiary from CY 2019 of 24.61 percent to 33.99 percentage CY 2020.

The Latino/Hispanic penetration rate declined each year from CY 2018 to CY 2020 and remains below both small county (2.66 percent vs. 3.87 percent) and statewide averages (2.66 percent vs. 3.83 percent). The difference extrapolates to 31.27 percent vs. small counties and 30.54 percent fewer beneficiaries served compared to the state average.

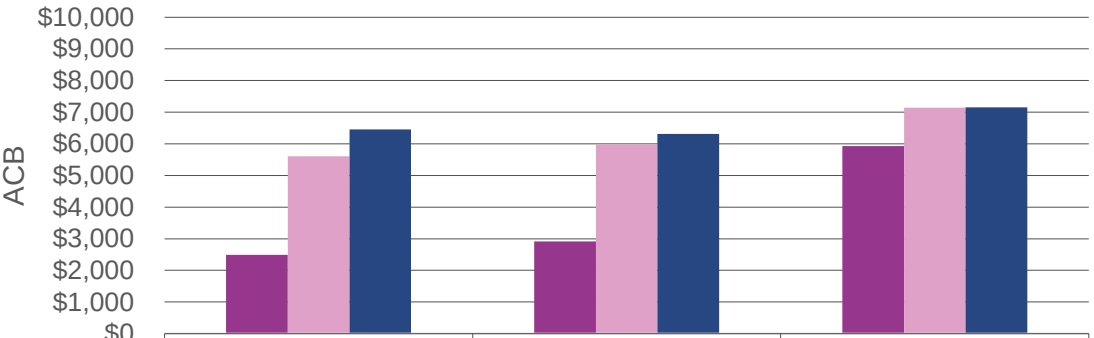
The foster care penetration rate rose by four percentage points from CY 2019 to CY 2020 and while below the statewide average (48.04 percent vs. 51.00 percent), it now exceeds the small county average (48.04 percent vs 43.16 percent).

Figure 2: Overall Penetration Rates CY 2018-20



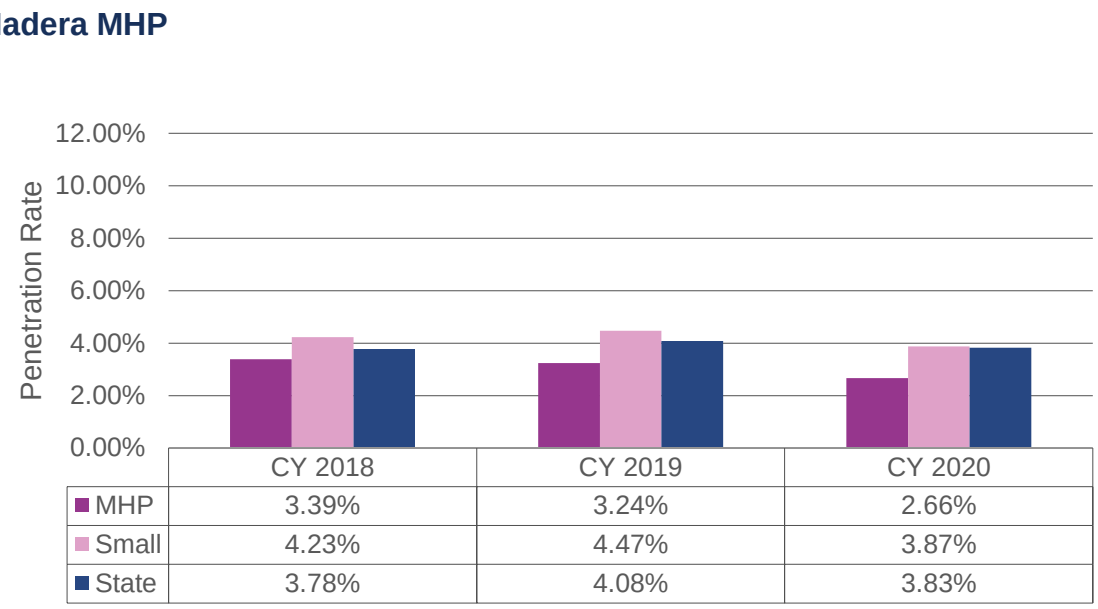
	CY 2018	CY 2019	CY 2020
MHP	4.60%	4.37%	3.53%
Small	4.96%	5.15%	4.53%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20



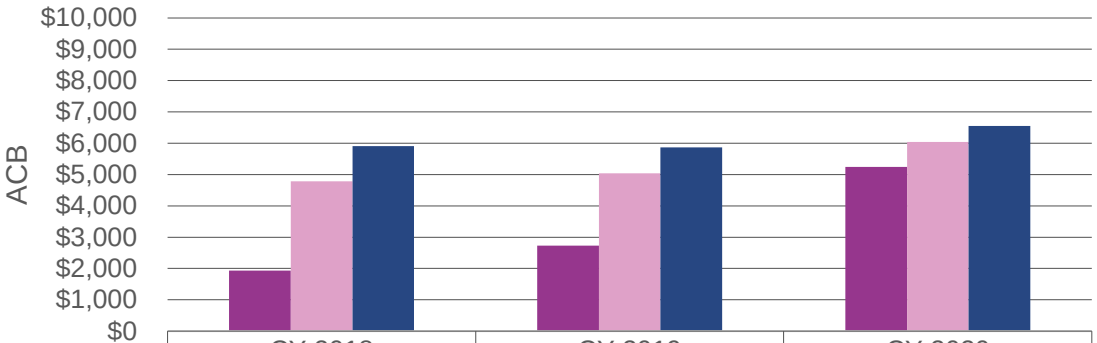
	CY 2018	CY 2019	CY 2020
MHP	$2,493	$2,916	$5,927
Small	$5,602	$5,982	$7,142
State	$6,454	$6,316	$7,155

Figure 4: Latino/Hispanic Penetration Rates CY 2018-20



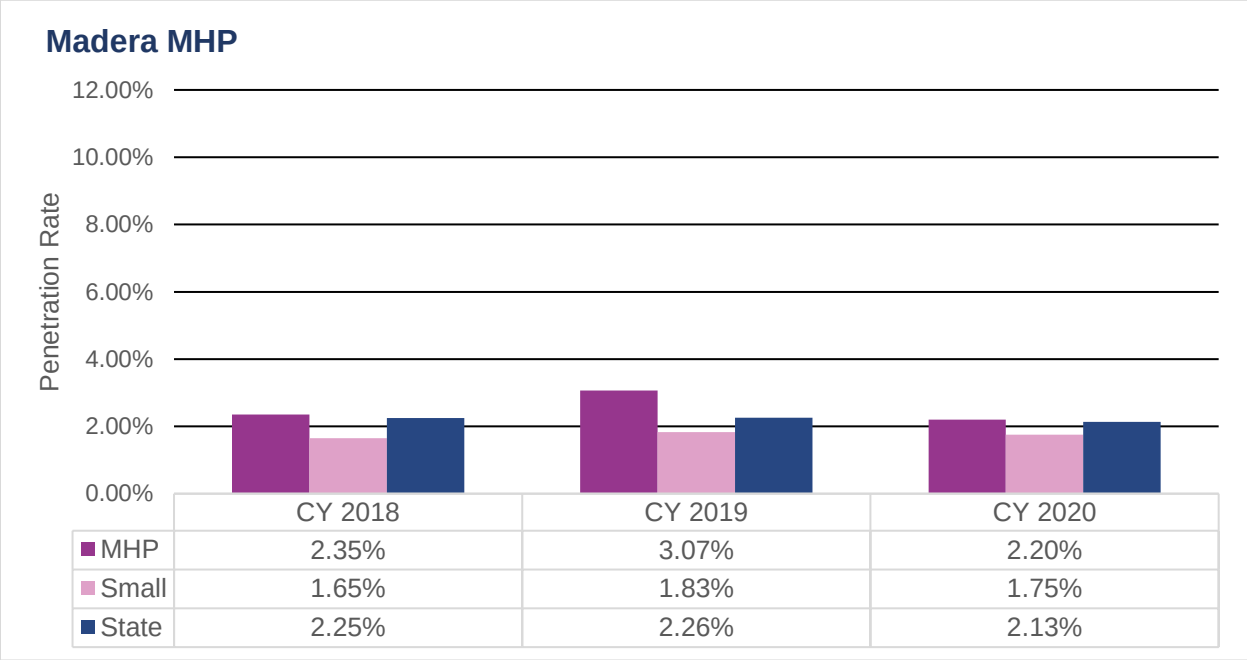
	CY 2018	CY 2019	CY 2020
MHP	3.39%	3.24%	2.66%
Small	4.23%	4.47%	3.87%
State	3.78%	4.08%	3.83%

Figure 5: Latino/Hispanic ACB CY 2018-20



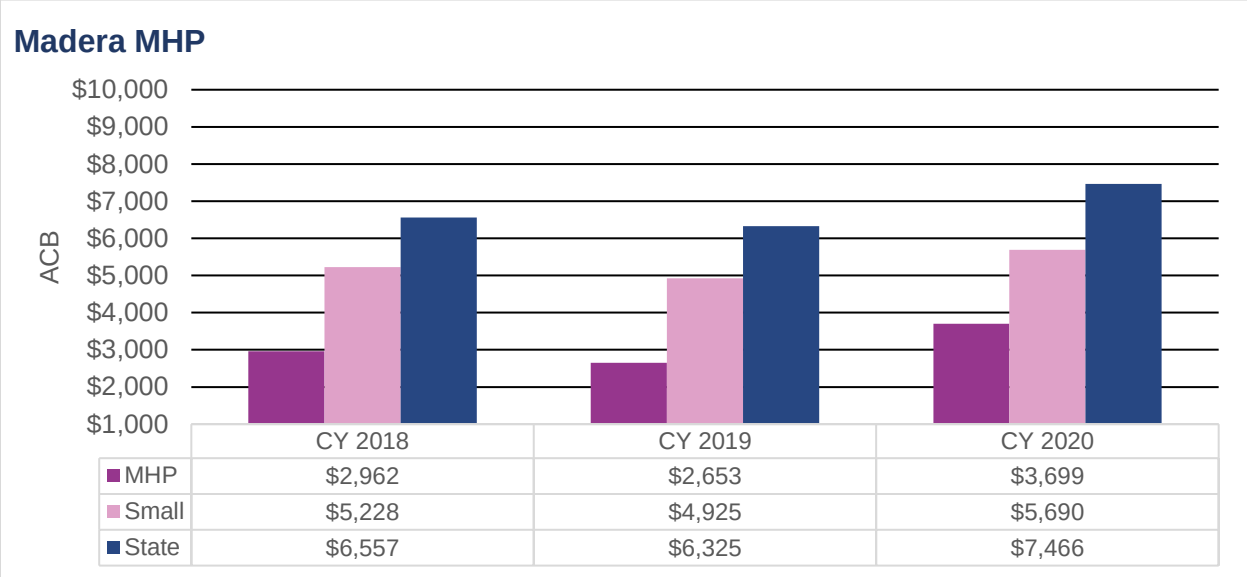
	CY 2018	CY 2019	CY 2020
MHP	$1,929	$2,728	$5,243
Small	$4,788	$5,040	$6,037
State	$5,904	$5,869	$6,551

Figure 6: Asian/Pacific Islander Penetration Rates CY 2018-20



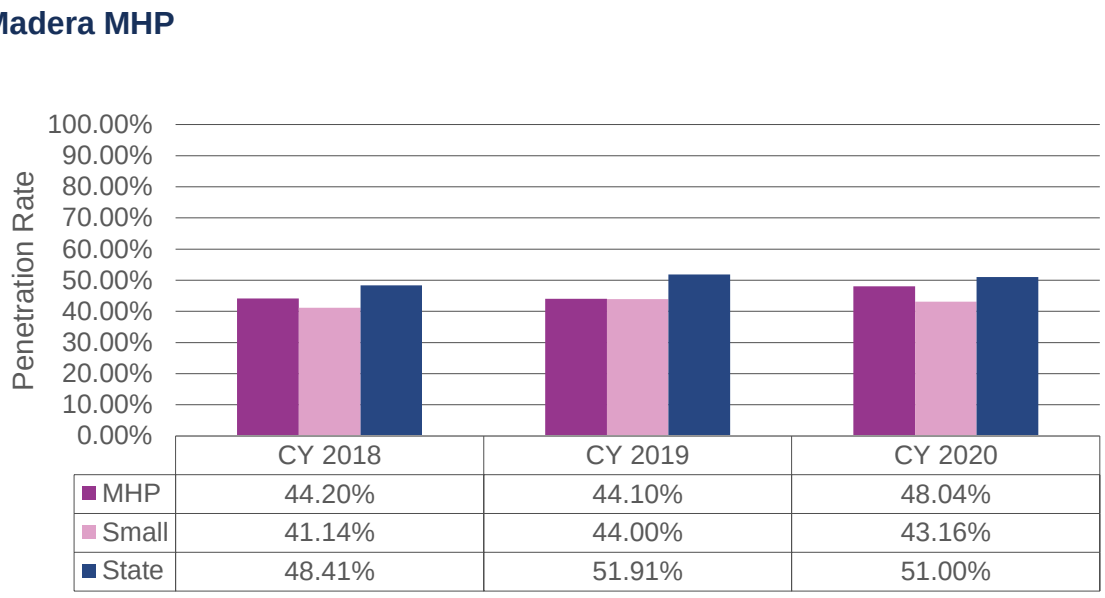
	CY 2018	CY 2019	CY 2020
MHP	2.35%	3.07%	2.20%
Small	1.65%	1.83%	1.75%
State	2.25%	2.26%	2.13%

Figure 7: Asian/Pacific Islander ACB CY 2018-20



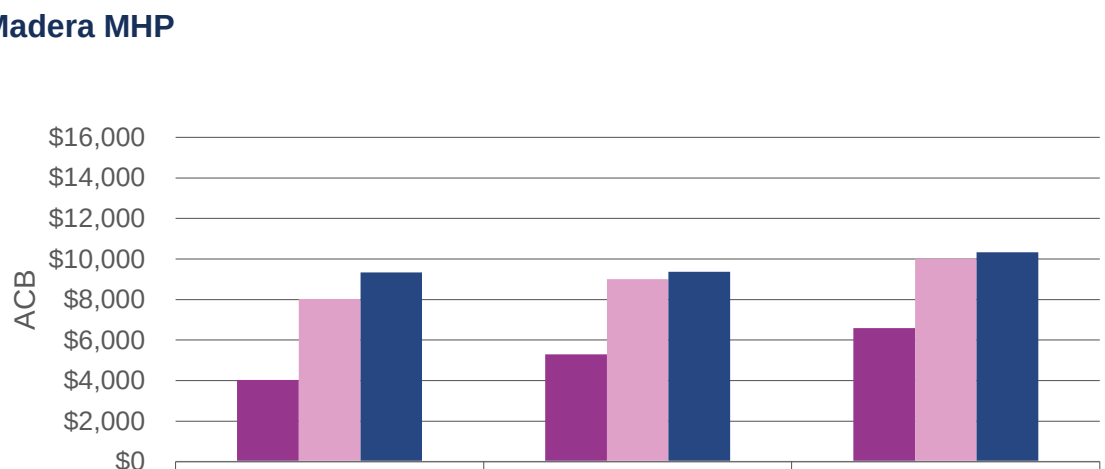
	CY 2018	CY 2019	CY 2020
MHP	$2,962	$2,653	$3,699
Small	$5,228	$4,925	$5,690
State	$6,557	$6,325	$7,466

Figure 8: FC Penetration Rates CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	44.20%	44.10%	48.04%
Small	41.14%	44.00%	43.16%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	$4,029	$5,296	$6,597
Small	$8,033	$9,010	$10,017
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

The overall penetration rate has trended down from CY 2018 to CY2020, primarily due to a reduction in White and Latino/Hispanic beneficiaries served, as evidenced in the overall reduction from 4.6 percent in CY 2018 to 3.53 percent in CY 2020.

The disproportion between percent of Latino/Hispanic eligibles and percent of beneficiaries (67.1 percent vs 50.6 percent) and the almost double proportion of White's served compared to their eligible population (16.8 percent vs. 32.3 percent), indicates that the Latino/Hispanic population may be underserved and offers the MHP an opportunity to study potential barriers to care and outreach efforts to this subpopulation.

While still below the statewide average, MHP FC penetration rate increased by four percentage points to 48.04 percent from CY 2019 to CY 2020. An increasing penetration rate can be a possible indicator for a reduction in unmet need for this vulnerable subpopulation.

The full implication of increases in approved claims per beneficiary is difficult to ascertain due to the MHP claiming at the higher COVID-19 rate throughout most of CY 2020.

TIMELINESS OF CARE

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likely the delay will result in not following through on keeping the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track the timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. CalEQRO uses a number of indicators for tracking and trending timeliness, including the Key Components and Performance Measures addressed below.

TIMELINESS IN MADERA COUNTY

The MHP reported timeliness data stratified by age and foster care status. Further, timeliness data presented to CalEQRO represented county-operated services only. InSync's initial functionality did not have the system processes or reports for the timeliness measures, and due to changes in the EHR, data reports submitted by the MHP may not accurately reflect performance.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the Performance Measures section.

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

Table 4: Key Components – Timeliness

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Partially Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met

KC #	Key Components – Timeliness	Rating
2C	Urgent Appointments	Not Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Partially Met

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

- Monitoring and reporting the timeliness of services was compromised this rating period. The new EHR InSync's current functionality for the Timeliness measures is still under development. The data reported for FY2020-2021 is a combination of reports extracted from the old EHR and reports provided from the new EHR, InSync. The MHP attributed the low percentage meeting the first offered or rendered non-urgent service and/or psychiatric service to the new EHR's inability to properly track the first offered data. The MHP is currently working with the new EHR vendor to create reporting modules that will provide timeliness measure data.
- The MHP reports it is unable to report data on timeliness to urgent services.
- The MHP initiated a PIP to improve meeting the 7-day follow-up standard for psychiatric inpatient discharges for adults (21+) as only 42 percent of discharges met the 7-day standard in the previous year. Performance improved, as shown in Table 6 below.
- No show data was limited to the InSync performance management module, which was implemented on December 14, 2020 and therefore represents half of the FY.

PERFORMANCE MEASURES

Through BHINs 20-012 and 21-023, DHCS set required timeliness metrics to which MHPs must adhere for initial offered appointments for non-urgent SMHS, non-urgent psychiatry, and urgent care. In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Additionally, utilizing approved claims data, CalEQRO analyzes MHP performance on psychiatric inpatient readmission and follow up after inpatient discharge.

The following PMs reflect the MHP's performance on these and additional timeliness measures consistent with statewide and national quality standards, including Healthcare Effectiveness Data and Information Set (HEDIS) measures:

- First Non-Urgent Appointment Offered

- First Non-Urgent Service Rendered
- First Non-Urgent Psychiatry Appointment Offered
- First Non-Urgent Psychiatry Service Rendered
- Urgent Services Offered – Prior Authorization not Required
- Urgent Services Offered – Prior Authorization Required
- No-Shows – Psychiatry
- No-Shows – Clinicians
- Psychiatric Inpatient Hospital 7-Day and 30-Day Readmission Rates
- Post-Psychiatric Inpatient Hospital Discharge 7-Day and 30-Day SMHS Follow-Up Service Rates

MHP-Reported Data

For the FY 2021-22 EQR, the MHP reported its performance for FY 2020-21 as follows:

- Average wait time of 4.86 days from initial service request to first non-urgent appointment offered
- Average wait time of 15.09 days from initial service request to first non-urgent psychiatry appointment offered; the MHP measures this metric from the point of initial beneficiary request.
- Average wait time from initial service request to first urgent appointment offered was not reported.

Table 5: FY 2021-22 MHP Assessment of Timely Access

FY 2021-22 MHP Assessment of Timely Access			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	4.86 Days	10-Business Days*	95.2 %
First Non-Urgent Service Rendered	6.49 Days	10-Business Days**	34.29 %
First Non-Urgent Psychiatry Appointment Offered	15.09 Days	15-Business Days*	24.71 %
First Non-Urgent Psychiatry Service Rendered	4.21 Days	15-Business Days**	100 %
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	*** Hours	48-Hours*	***
Urgent Services Offered – Prior Authorization Required	*** Hours	96-Hours*	***
Follow-Up Appointments after Psychiatric Hospitalization	6.49 Days	7 days	67.45 %
No-Show Rate – Psychiatry	16.45 %	10%**	n/a
No-Show Rate – Clinicians	27.00 %	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 20-012 ** MHP-defined timeliness standards			

***MHP did not report data for this measure

Medi-Cal Claims Data

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

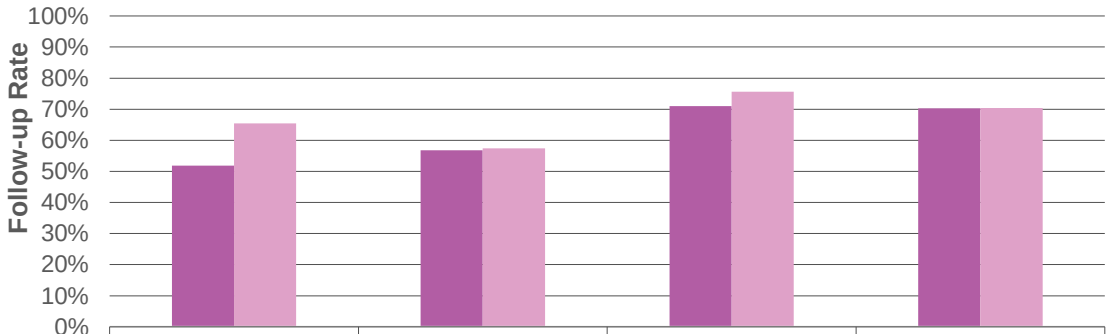
Follow-up post hospital discharge

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care.

The 30-day follow-up rate increased by five percentage points from CY2019 to CY2020 (71 percent vs. 76 percent) and exceeds the CY 2020 statewide average (70 percent) by six percentage points.

Figure 10: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-20

Madera MHP



	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	52%	57%	71%	70%
CY 2020	65%	57%	76%	70%

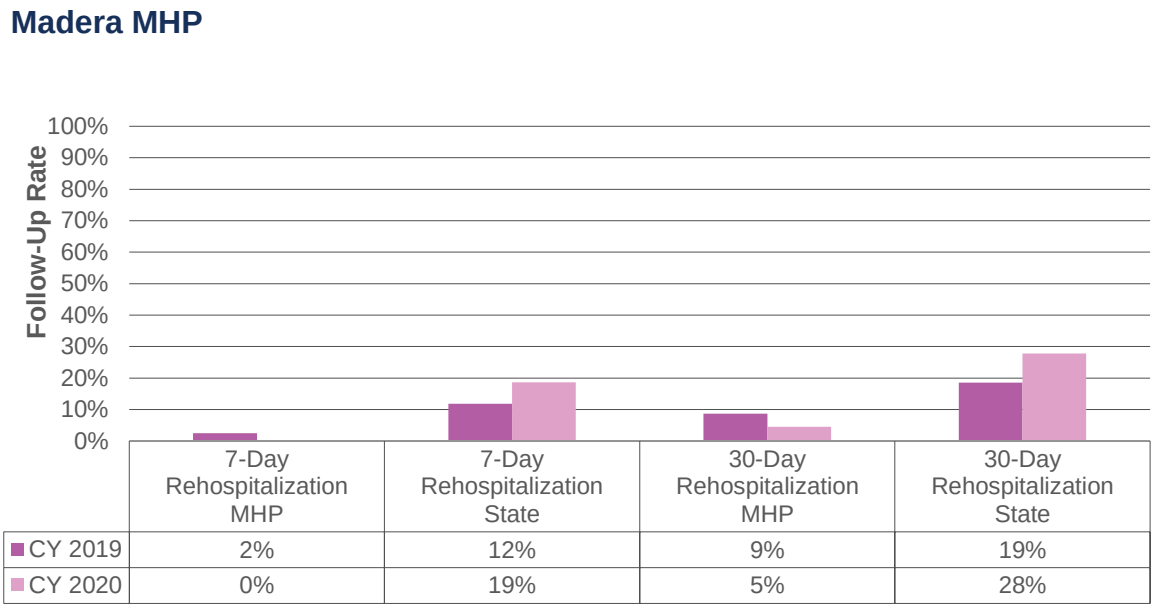
Readmission rates

The 7- and 30-day rehospitalization rates (HEDIS measures) are important proximate indicators of outcomes.

The 7-day psychiatric readmission rate decreased from 2 percent in CY 2019 to zero percent in CY 2020, notably below the CY 2020 statewide average of 19 percent.

The 30-day psychiatric readmission rate decreased by 44 percent during the same time period, from 9 percent to 5 percent, also notably below the CY 2020 statewide average of 28 percent.

Figure 11: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-20



IMPACT OF FINDINGS

The increased 7- and 30-day post psychiatric inpatient follow-up rates indicate successful beneficiary service engagement and are likely contributing to the MHP's decreased readmission rates. Improvements in these performance measures, and more importantly the related improved beneficiary outcomes, are also reflected in the MHP's clinical PIP.

The transition to a new EHR produced an anomaly in report generation by merging reports from two different EHRs. Timeliness reports are not yet available in the InSync system. Lack of available data on timeliness to first appoint compromises the ability of the MHP to know when timeliness challenges arise and to then take steps to improve processes. Attention is needed to support all treatment gateways in entering data on date/time of first request for treatment, first offered appointment, and first actual assessment or intake session.

Despite challenges in reporting of timeliness metrics and the related low performance for timeliness to first rendered service and first offered psychiatry appointment, staff and beneficiaries universally reported initial and ongoing access and timeliness to be a strength of this MHP. Key informant interviews suggest that beneficiaries obtain timely care that meets their needs, inclusive of clinical, case management, psychiatric, and crisis services.

QUALITY OF CARE

BACKGROUND

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through:

- Its structure and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based knowledge.
- Intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services furnished to beneficiaries. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN MADERA COUNTY

In the MHP, the responsibility for Quality Improvement is organized under a division manager who oversees compliance (1 FTE), quality management (9 FTEs) and administrative support services inclusive of medical records (7 FTEs).

The MHP monitors its quality processes through the QIC (referred to as the QMM), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QMM, comprised of leadership, line staff, beneficiaries, and the MHP director, is scheduled to meet monthly.

Of the 12 identified FY 2020-21 QAPI workplan goals, the MHP fully met six, partially met two, and did not meet four of these goals. The primary reasons cited for not met or partially met were impacts of COVID-19 and/or transition to a new EHR. The MHP and EHR vendor are jointly developing aggregate reporting in multiple areas and therefore were not able to address trends in psychotropic medication monitoring for youth or measures of clinical and/or functional outcomes of beneficiaries served.

Since the previous EQR, the QMM met eight times. QMM minutes reflect limited data and limited discussion. There were no formal action steps documented to coordinate improvement activities meeting-to-meeting, and there was no documentation of beneficiary participation in the QMM. As noted in the previous EQRO report, The QAPI and QMM emphasize mandated quality assurance and compliance activities; evidence prioritizing quality improvement, performance measurement, and beneficiary outcomes

is sparse. Although clinical outcome measures are utilized, they are driven at the case level and not utilized in aggregate system improvement activities.

In the May QMM meeting, the new MHP director introduced a new QMM process. The QMM will move to quarterly and will operate with six reporting sub-committees that will meet separately and report into the quarterly QMM: Quality Assurance/Performance Improvement; Policies & Procedures; Compliance, Incidents & Grievances; Cultural Competence and Medication Monitoring.

QUALITY KEY COMPONENTS

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

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

Table 6: Key Components – Quality

KC #	Key Components - Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Partially Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Not Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Partially Met

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

- The MHP's implementation of a new EHR is an effort to improve the quality and aggregate reporting to set measurable quality improvement goals, monitor, and improve the service delivery system.
- The MHP has a general chart review process which consists of a structured review of all areas of the chart. This includes monitoring for the provision of appropriate services that are consistent with addressing the identified level of impairment, timeliness, and appropriateness of client follow up.
- Medication services were reviewed and monitored by the MHP's Medication Monitoring Committee chart review process.
- The MHP reports difficulty tracking the followingHEDIS measures as required by SB 1291. Compliance with HEDIS tracking and trending to enable systematic quality improvement is a goal of the new EHR implementation. With the implementation of new Electronic Health Care, the MHP is working with EHR development and implementation specialists to develop functionality to formally track information specific to these HEDIS measures:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD)
    - The use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC)
    - Metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)
    - The use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP:

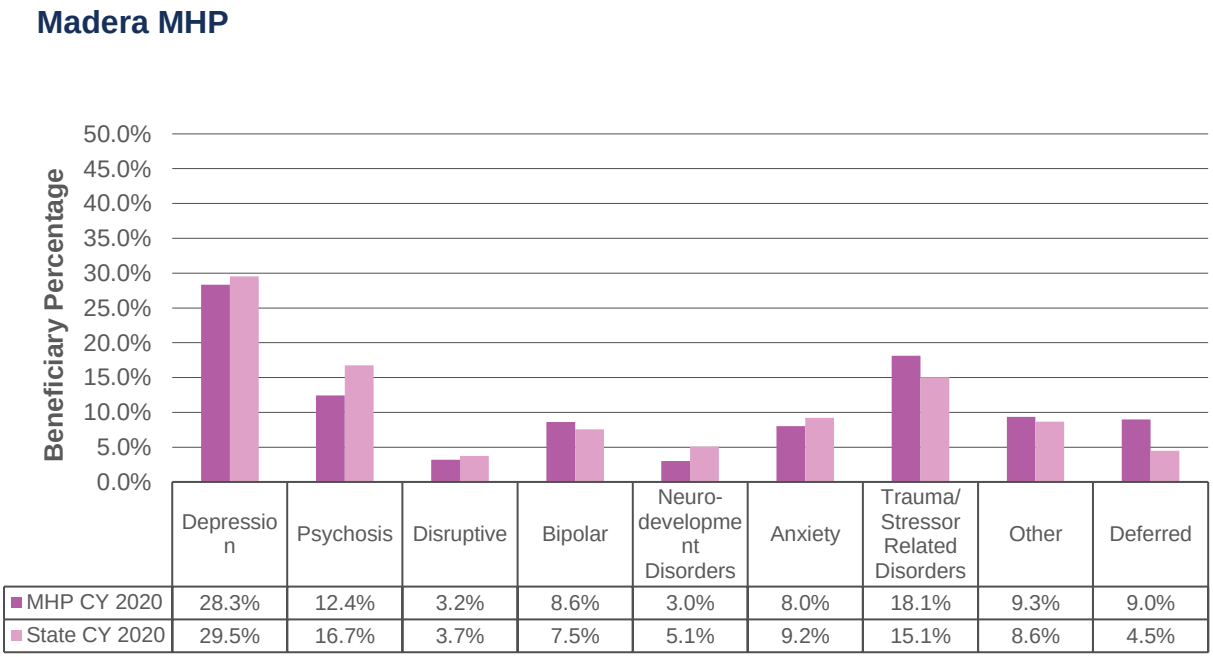
- Beneficiaries Served by Diagnostic Category
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay (LOS)
- Retention Rates
- High-Cost Beneficiaries (HCB)

Diagnosis Data

Figures 12 and 13 compare the percentage of beneficiaries served and the total approved claims by major diagnostic categories, as seen at the MHP and statewide for CY 2020.

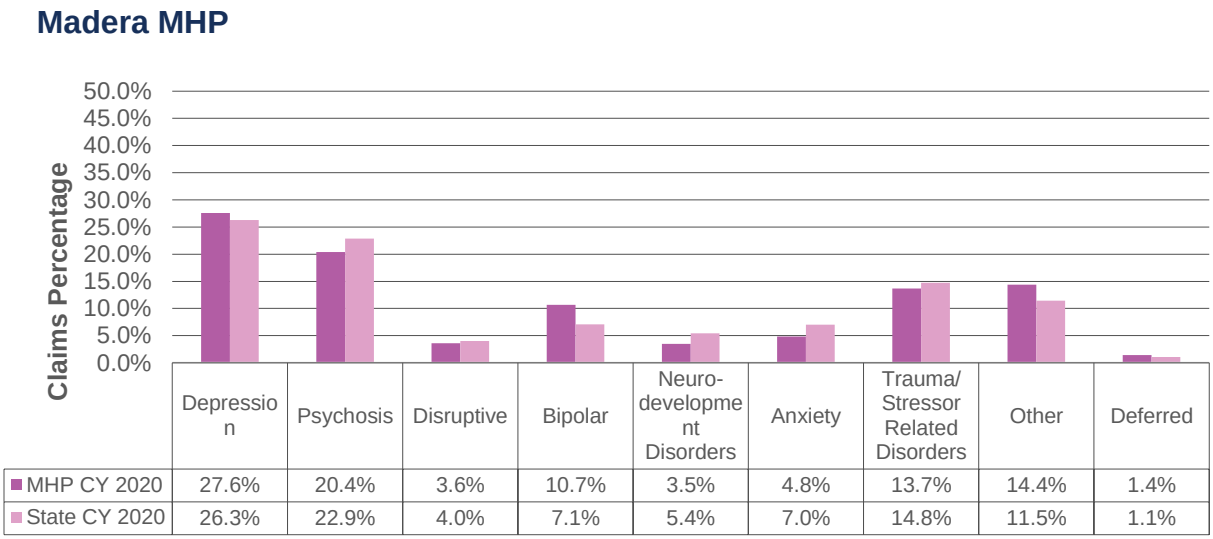
Over 50 percent of clients have one of three diagnoses: depression (28.3 percent), trauma/stressor related disorders (18.1 percent) and psychosis (12.4 percent). No significant variation from corresponding statewide data is noted in Madera's distribution of beneficiaries served by diagnosis apart from deferred diagnosis, which is twice the statewide rate (9.0 percent vs. 4.5 percent). The approved claims dollars by diagnosis also show no significant variation from corresponding statewide data.

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	28.3%	12.4%	3.2%	8.6%	3.0%	8.0%	18.1%	9.3%	9.0%
State CY 2020	29.5%	16.7%	3.7%	7.5%	5.1%	9.2%	15.1%	8.6%	4.5%

Figure 13: Diagnostic Categories by Percentage of Approved Claims CY 2020



Psychiatric Inpatient Services

Table 7 provides a three-year summary (CY 2018-20) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

The number of beneficiaries hospitalized, while stable from CY 2018 to CY 2019, rose from CY 2019 to CY 2020 (146 vs.166). The total inpatient admissions also rose from CY 2019 to CY 2020 (221 vs. 292) as did the average length of stay (7.96 days to 8.68 days). The CY 2020 average length of stay is comparable to the statewide average (8.58 days vs. 8.68 days).

Table 7: Psychiatric Inpatient Utilization CY 2018-20

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 2020	166	292	8.58	8.68	$11,489	$11,814	$1,907,115
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

High-Cost Beneficiaries

Table 8 provides a three-year summary (CY 2018-20) of HCB trends for the MHP and compares the MHP's CY 2020 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.

Tracking the HCBs provides another indicator of quality of care. High cost of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than the rest of the beneficiaries receiving SMHS. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

While the MHPs HCBs more than doubled from CY2019 to CY2020 (40 vs. 87), the full implication of the increase is difficult to ascertain due to the MHP claiming at the higher COVID-19 rate throughout most of CY 2020. This offers the MHP the opportunity to identify how many of the increased HCBs were associated with the increased COVID-19 billing rates. The MHP's average approved claim per HCB is less than the statewide average ($49,338 vs. $53,969) In addition, the total beneficiary count reduced by 16.86 percent from CY 2019 to CY 2020 (3,125 vs.2,598).

Table 8: HCB CY 2018-20

Madera MHP							
	Year	HCB Count	Total Beneficiary County	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
MHP	CY 2020	87	2,598	3.35%	$49,338	$4,292,436	27.87%
	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%

See Attachment D, Table D2 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.

Retention Data

The MHP has had the highest percentage of beneficiaries receiving a single service in the State for the last three calendar years: CY 2018 (24.03 percent); CY 2019 (27.3 percent); and CY 2020 (21.86 percent). The last year saw nearly a 20 percent decrease in beneficiaries receiving a single service. Although the MHP still remains well below the state average, beneficiaries receiving 15+ services saw a trending increase across the last three calendar years: CY 2018 (23.26 vs. 40.51); CY 2019 (24.61 vs. 41.48 percent); and CY 2020 (33.99 percent vs. 45.33 percent).

Table 9: Retention of Beneficiaries

	Madera			STATEWIDE			
Number of Services Approved per Beneficiary Served	**# of beneficiaries**	**%**	**Cumulative %**	**%**	**Cumulative %**	**Minimum %**	**Maximum %**
1 Service	568	21.86	21.86	9.76	9.76	5.69	21.86
2 Services	265	10.20	32.06	6.16	15.91	4.39	17.07
3 Services	119	4.58	36.64	4.78	20.69	2.44	9.17
4 Services	84	3.23	39.88	4.50	25.19	2.44	7.78
5-15 Services	679	26.14	66.01	29.47	54.67	19.96	42.46
>15 Services	883	33.99	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

These impact findings are also in the context of MHP changes related to COVID-19, leadership and staffing, the QMM process changes and the new EHR data development process. Taken together they offer the MHP an opportunity to analyze data and processes to strategically evaluate and improve MHP practices moving forward.

The MHP initiated a PIP July 2020 and reported reductions in psychiatric hospital re-admissions. Inpatient data for CY 2020 presented by CalEQRO reported increases in inpatient admissions, re-admissions, and average length of stay; this data includes services delivered during the six months prior to the PIP's initial implementation and

therefore may not reflect improvements reported by the MHP. CY 2021 will overlap with FY 2020-21, allowing for a full comparison of the PIP impact across CY admissions and re-admissions. The MHP would benefit from further analysis of inpatient data and trends and may consider an analysis of factors contributing to first admissions.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

All MHPs are required to have two active and ongoing clinical PIPs, one clinical and one non-clinical, as a part of the plan's quality assessment and performance improvement program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.calegro.com.

Validation tools for each PIP are located in Appendix C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Reducing Psychiatric Hospitalizations

Date Started: 07/2020

Aim Statement: "Will the use of a Hospital Services Case Worker (HSCW) as the single point of contact for IP and OP transitions to provide clinical assessment and interventions during inpatient hospitalization and post-discharge follow-up no later than 7 days for adult beneficiaries 21 years of age or older result in a reduction of at least three percentage points on average for the 30-day recidivism rate of 17.58% to no greater than 15%, and the three or more hospitalization within 60 days rate of 8.31% to no greater than 6% over the two-year period from July 1, 2020 thru June 30, 2022."

[2] https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf

[3] https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf

Target Population: The consumer population included in this PIP is adults 21 years of age or older who are Madera County Medi-Cal beneficiary residents or Madera County indigent residents with no health insurance admitted to an inpatient psychiatric hospital.

Validation Information:

The MHP's clinical PIP is in the first remeasurement phase and considered active and ongoing.

Summary

As indicated in the PIP AIM statement "Will the use of an HSCW as the single point of contact for IP and OP transitions to provide clinical assessment and interventions during inpatient hospitalization and post-discharge follow-up no later than 7 days for adult beneficiaries 21 years of age or older result in a reduction of at least three percentage points on average for the 30-day recidivism rate of 17.58% to no greater than 15%, and the three or more hospitalization within 60 days rate of 8.31% to no greater than 6% over the two-year period from July 1, 2020 thru June 30, 2022".

The PIP goals sought to decrease patient rehospitalization episodes and increase the number of beneficiaries receiving post-discharge services within 7days for beneficiaries age 21 and older. The rehospitalization Performance Measures were one or more admissions in 30 days and three or more admissions in 6 months. The discharge Performance Measure was the number of target population beneficiaries that received post-discharge services within 7days.

The core intervention was assigning a highly skilled HSCW, with a bilingual assistant, as a single point of contact to: liaison between IP and OP services; build rapport with the beneficiary while they were in the IP setting; assess, determine, link and warm-handoff beneficiaries to the selected services based on need; and perform follow-up as appropriate. The intervention was guided by a Systematic Inpatient Tailored Assessment and Intervention Hospital Liaison Form.

The first remeasurement period was from July 1, 2020, thru June 30, 2021. The results of the study suggest the two categories or rehospitalization the MHP tracking: 1) the 30-day recidivism percentage rate decreased to a percentage no greater than 15 percent, actual was 11.16 percent and 2) the percentage rate of three or more hospitalization episodes within six months decreased to a percentage no greater than 6 percent, actual was 4.92 percent. The number of target population beneficiaries that received post-discharge follow-up no later than 7 days improved form a baseline of 42.50 to 74.73 percent. If these trends continue, the MHP is expected to meet the project goal of decreasing re-hospitalization episodes for adults 21 years or older during the PIP period.

TA and Recommendations

As submitted, this clinical PIP was initially found to have moderate confidence, because the MHP did not articulate specific interventions the HSCW would employ. After TA sessions the MHP greatly improved the documented interventions, raising the confidence validation to high.

The TA provided to the MHP by CalEQRO consisted of:

- Identify specific interventions, skills and linkages employed by the HSCW.
- Develop a documentation process to be able to track and monitor interventions

CalEQRO recommendations for improvement of this clinical PIP include:

- Utilize the feedback from the hospitals, OP system, beneficiaries and the HSCW and bilingual support staff, to identify and refine core practices.
- The plan includes assigning a bilingual support staff to provide translation for the HSCW. This does not address any specific cultural barriers, stigmas, informing and obtaining input.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: HEDIS Module Development

Date Started: 07/2021

Aim Statement: “Will the use of HEDIS Module Data Reports to obtain reliable benchmark data help improve the MHP meeting HEDIS data compliance and identify effective beneficiary treatment modalities as measured by a 50% or better compliance with EQRO standards within two years?”

Target Population: The MHP identified all BH service recipients as the target population.

Validation Information:

The MHP’s non-clinical PIP is in the PIP submitted for approval stage; however, the submission is considered not to meet the criteria for a PIP as explained below.

Summary

The goals, interventions, variables, performance measures and target improvement rates are all dedicated to compliance with HEDIS reporting. There are 9 goals, all written in the same format. The first is provided as an example.

- Goal: Establish baseline for Antidepressant Medication Management
- Interventions: Create/addition of Prescription of Antidepressant Report
- Variables (Indicators): Number of clients being treated with antidepressants
- Performance Measures (Outcomes): Number of clients who remained on antidepressant for at least 84 days (12 weeks) and, number of clients who remained on antidepressant for at least 180 days (6 months)

Target Improvement Rate: 50% or better EQRO/HEDIS compliance.

TA and Recommendations

As submitted, this non-clinical PIP was found to have a no confidence rating, because:

This PIP does not meet the standard that PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. PIPs should have a direct beneficiary impact and may be designed to create improvement at a member, provider, and/or MHP/DMC-ODS system level. A compliance measure is not a quality improvement measure.

The MHP abandoned their FY 2020-21 submitted non-clinical PIP due to COVID-19 complications. This PIP was developed and submitted for the FY 2021-22 annual review without an opportunity to receive TA. The MHP was impacted by COVID-19, the need to replace their active non-clinical PIP, a reduction in available analyst staff and leadership changes. There was not enough time to completely develop, submit, TA and improve the non-clinical PIP plan. Although the current form of this PIP cannot be validated, this MHP has demonstrated an ability to develop very good PIPs as evidenced by the clinical PIP already reviewed in this report.

There was no TA requested or provided to the MHP by BHC regarding this PIP.

CalEQRO recommendations for improvement of this non-clinical PIP include:

- The MHP to review the PIP development tool and reconsider developing this, or a new PIP, designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. They should have a direct beneficiary impact and may be designed to create improvement at a member, provider, and/or MHP/DMC-ODS system level.

- The MHP was provided an analysis of the non-clinical PIP developmental tool they submitted as well as a CalEQRO completed PIP validation tool to assist a redesign of this PIP from HEDIS compliance to beneficiary quality improvement.
- A copy of the most recent training power-point on the FY 2021-22 PIP developmental tool and a copy of a blank FY 2021-22 PIP validation tool was provided to assist the MHP developing and validating this or any future PIP.
- BHC encouraged the MHP to request TA to assist in the development and validation of their non-clinical PIP.

INFORMATION SYSTEMS (IS)

BACKGROUND

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

IS IN MADERA COUNTY

California MHP EHRs fall into two main categories-- those that are managed by county of MHP IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is InSync, which has been in use for less than one year. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 9.13 percent of the MHP budget is dedicated to support the IS (County IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency. The MHP had not yet calculated a current budget percentage and chose to report the 9.13 percent budget that was cited in their previous year's ISCA.

The MHP has 150 named users with log-on authority to the EHR, including approximately 145 county-operated staff and five contractor-operated staff. Support for the users is provided by one full-time equivalent (FTE) IS technology position. Currently all positions are filled. The MHP receives additional IT infrastructure and helpdesk support from County IT. EHR support is provided by their application service provider (ASP), InSync Healthcare Solutions.

As of the FY 2021-22 EQR, some contract providers have access to directly enter clinical data into the MHP's EHR. Line staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 10: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	%
☐	Electronic Data Interchange (EDI) to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
☐	Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
☒	Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	25%
☒	Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	50%
☒	Paper documents delivered to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	25%
			100%

Beneficiary Personal Health Record

The 21st Century Cures Act (Cures Act) of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a PHR enhances beneficiaries' and their families' engagement and participation in treatment. The MHP has not yet implemented a PHR. The MHP plans to implement a PHR within two years.

Interoperability Support

The MHP is not a member or participant in a Health Information Exchange (HIE). Healthcare professional staff use secure information exchange directly with service partners through secure email. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: contract providers.

IS KEY COMPONENTS

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

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

Table 11: Key Components – IS Infrastructure

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

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

- Investment in IT Infrastructure and Resources is a Priority
    - The Director and Assistant Director were active participants on the InSync implementation team.
    - The MHP receives InSync operational and reporting support from their ASP, InSync Healthcare Solutions.
    - At 9.13 percent, the MHP has an IT budget that exceeds the FY20-21 small county average of 3.01 percent. An increased IT budget for this period is expected due to the acquisition and implementation of a replacement EHR system.
- Integrity of Medi-Cal Claims Process
    - The MHP's CY 2020 claim denial rate of 2.85 percent was lower than the statewide average of 3.19 percent. This denial percentage is based on the MHP's previous EHR system which was in operation until mid-December 2020.
    - The MHP went live with the InSync performance management module in December 2020; however, a claim was not successfully sent to DHCS until August 2021. While submitted, this claim had not yet been adjudicated at the time of the review.
    - The Fiscal manager retired in August 2020 and the position was filled in July 2021.
- Integrity of Data Collection and Processing

    - While 25% of contract provider services can be entered directly into the system, 75% of services are sent to the MHP by secure email or hand delivered (Table 11).
    - The MHP does not maintain a data warehouse that replicates the EHR system and is in the early stages of report development in the InSync system.

- EHR Functionality
    - The MHP went live with the InSync system in December 2020. While the implementation is ongoing, there is a robust EHR for the early stage of the implementation, including electronic availability of the CANS, PSC-35 and ANSA outcome and level of care tools. Aggregate reporting of these tools is not yet available.

- Security and Controls
    - County IT has the responsibility to provide and monitor IT security, including IT security training and providing phishing risk identification information through email.

- Interoperability
    - All contract provider staff have the capability to directly enter clinical data into the InSync EHR and some can enter beneficiary service data into the performance management system.
    - The MHP is a not member/participant of a local, regional, or statewide HIE.

IMPACT OF FINDINGS:

The InSync EHR and performance management module were implemented in December 2020. While the MHP has a robust EHR and leadership were active participants on the implementation team, complete PM module functionality has been implemented more slowly. A claim was not successfully sent to DHCS until August 2021. While submitted, this claim had not yet been adjudicated at the time of the review.

The MHP is supported by County IT and has a Senior Program Assistant position at the MHP level to provide first level IT helpdesk support to staff. EHR and billing support are provided by InSync Healthcare Solutions. InSync also provides EHR and software promotion training online through InSync University.

During the InSync implementation fiscal/billing training and cross training occurred to provide staff with the necessary knowledge to perform current job functions in the new InSync system.

The CANS, PSC-35 and ANSA outcome and level of care tools are available in the EHR; however, aggregate reporting for these tools is not yet available.

While the MHP had penetration rate, timeliness and caseload reporting available in the previous EHR, this functionality remains in development for the InSync system.

The MHP has eLab functionality in InSync. However, the MHP's primary lab, Quest, did not want to partner with them due to lab volumes being too low for Quest to consider providing resources to complete eLab interoperability and testing. Authorized MHP medical staff can access lab results by logging into the Quest system.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

BACKGROUND

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

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of beneficiaries: adult, older adult, youth, and family members. MHPs administer these surveys to beneficiaries receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS and provides a comprehensive analysis in the annual statewide aggregate report.

The MHP administers the CPS twice a year with the Fall 2020 survey being cancelled due to the pandemic. The MHP reported difficulties in obtaining the aggregated CPS data from prior survey administrations; thus, the MHP has not been able to compare most recent CPS findings with past results.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

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

Consumer Family Member Focus Group One

The MHP was unable to coordinate a focus group as requested; however, the MHP identified four beneficiaries for CalEQRO to interview individually, thereby meeting the requirement for beneficiary participation in the EQR.

Each consumer was contacted individually by phone by the BHC-EQRO Consumer Family Member (CFM). Three were reached and interviewed in their identified preferred language, English. All consumers participating received clinical services from the MHP.

The beneficiaries experienced initial and ongoing access to generally be timely, although one person indicated some delays during the past year. All reported they were able to see staff regularly in person or by phone, and they knew how to get help in a crisis. Overall, participants reported good MH and cultural experiences, think well of the staff, and feel the staff are working in their best interest. None of the beneficiaries interviewed use the wellness center. While they indicated they have not been offered opportunities to be involved in the MHP processes, they were unsure if they would like to participate.

Recommendations from focus group participants included:

- The participants had no recommendations for improvement.

IMPACT OF FINDINGS

Overall, the consumers experienced access, timeliness, and quality to meet their needs. Although responses were positive, the small number of participants (3) does not allow full confidence in the results. Consumers are not representing as engaged in MHP processes and the QMM minutes did not document engagement.

CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP Maintained direct face-to-face service, field response, and increased telehealth phone and later virtual options at all clinics and wellness centers throughout the COVID-19 pandemic. (Access)

2. The first year clinical PIP, Reducing Psychiatric Hospitalizations for adults 21+, reported several positive outcomes, including: psychiatric inpatient 30-day readmissions decreased from 17.58 percent to 11.16 percent and beneficiaries who received post-discharge follow-up within 7-days increased from 42.5 percent to 74.7 percent. (Timeliness)

3. The MHP evidenced active bi-directional communication and active coordinated relationships with partner agencies such as law enforcement, schools, public health, and the MCOs. They are coordinating with law enforcement on an outreach grant that will increase crisis response and homeless outreach. There are regular meetings with the MCOs to assist beneficiary access. (Quality)

4. Despite considerable leadership changes and COVID-19, the MHP maintained diligence with the EHR implementation. (Information Systems)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP penetration rate is 3.53 percent for all beneficiary populations and 2.66 percent for Latino/Hispanic beneficiaries: both have been trending down the last two years. The percentage of beneficiaries who only receive one MHP service (21.86 percent) remains the highest in the state. (Access)

2. The MHP timeliness to first non-urgent service rendered met the 10-business day standard 34.29 percent of the time and the first non-urgent psychiatry appointment offered met the 15-business day standard 24.71 percent of the time. (Timeliness)

3. The QMM minutes did not evidence participation from beneficiaries in any data review, discussions, or decision making. (Quality)

4. The HEDIS measures non-clinical PIP was not validated. (Quality)

5. The MHP is working with the EHR Vendor to develop and implement data and usage reporting with the new EHR. (Information Systems)

RECOMMENDATIONS

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

1. Investigate the reasons, develop strategies, and address the declining penetration rates for Latino/Hispanic beneficiaries and overall retention after the first service. (Access)

2. Investigate reasons, develop strategies, and improve timeliness to first rendered clinical service and first offered psychiatric appointments. An emphasis should be placed on addressing any timeliness to service issues for mono-lingual Spanish-speaking beneficiaries. (Timeliness)

3. Develop strategies, address, and implement data-driven decisions, inclusive of beneficiary engaged input, in the QAPI and QMM processes. (Quality)

4. Develop and submit a new or revised non-clinical PIP. Seek TA as needed. (Quality)

5. Prioritize, develop, and implement reporting monitors and aggregate data trending through the InSync EHR. The priorities may include but not be limited to the following: CANS, PSC-35, ANSA timeliness of first offered and rendered clinical and psychiatric appointments, HEDIS measures, urgent appointments. (Information Systems)

SITE REVIEW BARRIERS

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

The MHP had difficulty obtaining participation in a CFM process, resulting in only four beneficiaries volunteering and ultimately three attending. There were no other barriers.

ATTACHMENTS

ATTACHMENT A: CalEQRO Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: CALEQRO REVIEW AGENDA

The following sessions were held during the EQR, 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
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Consumer and Family Member Interview
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Bill Walker, Quality Reviewer

Lisa Farrell, Information Systems Reviewer

Valarie Garcia, Consumer Family Member Consultant

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

MHP Sites

All sessions were held via video conference.

Contract Provider Sites

All sessions were held via video conference.

Table B 1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Moreno-Peraza	Connie	Director	Madera BHS
Morgan	Julie	Assistant Director	Madera BHS
Agayan	Mariam	Division Manager	Madera BHS
Galindo	Art	Division Manager	Madera BHS
Holmes	Carlton	Fiscal Manager	Madera BHS
Rosen	Eric	Division Manager	Madera BHS
Avila	Nick	Division Manager	Madera BHS
Weikel	Eva	Administrative Analyst II	Madera BHS
Yang	Say	Administrative Analyst I	Madera BHS
Louid	Lauren	Pre-Licensed MH Clinician	Madera BHS
Secula	Robert	Licensed MH Clinician	Madera BHS
Chapman	Valerie	Pre-Licensed MH Clinician	Madera BHS
Rivera	Silvia	Pre-Licensed MH Clinician	Madera BHS
Segura	Crystal	Licensed MH Clinician	Madera BHS
Bunting	DeAnn	Case Worker / Hospital Liaison	Madera BHS
Jelavic	Ivane	Licensed MH Clinician	Madera BHS
Conteras	Courtney	Licensed MH Clinician	Madera BHS

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C 1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☒ →High confidence ☐ →Moderate confidence ☐ →Low confidence ☐ →No confidence	Job well done. See comments in the PIP chapter.
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Madera MHP	
PIP Title: Reducing Psychiatric Re-Hospitalizations	
PIP Aim Statement: Will the use of a HSCW as the single point of contact for IP and OP transitions to provide clinical assessment and interventions during inpatient hospitalization and post-discharge follow-up no later than 7 days for adult beneficiaries 21 years of age or older result in a reduction of at least three percentage points on average for the 30-day recidivism rate of 17.58% to no greater than 15%, and the three or more hospitalization within 60 days rate of 8.31% to no greater than 6% over the two-year period from July 1, 2020 thru June 30, 2022?	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: Adults 21 and older	
Target population description, such as specific diagnosis (please specify): Adults 21 and older	

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) n/a
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): The PIP seeks to decrease patient rehospitalization episodes by improving service needs and finding the most appropriate level of care for clients admitted into an inpatient psychiatric hospital by utilizing a newly assigned Hospital Services Case Worker (HSCW). The HSCW will be the single point of contact and provide tailored clinical support interventions for Madera County beneficiaries during and after hospitalization discharge.

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
# of 1+ admissions within 30 days for adults (21+)	**17.58%**	41 of 232	☐ Not applicable—PIP is in Planning or implementation phase, results not available	**11.16%**	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
# of adults (21+) with 3 or more admissions within 6 months	**8.31%**	14 of 162	☐ Not applicable—PIP is in Planning or implementation phase, results not available	**4.92%**	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
# of adult (21+) admitted to the CRU	**None**	**No data**	☐ Not applicable—PIP is in Planning or implementation phase, results not	**100%**	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
			available			
# of adults (21+) clients who received post-discharge follow-up no later than 7 days	**42.5%**	**No data yr +44% yr / 2 See comments 8.2**	☐ Not applicable—PIP is in Planning or implementation phase, results not available	**74.73%**	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

- Identify specific interventions, skills and linkages employed by the HSCW.
- Develop a documentation process to be able to track and monitor interventions

Non-Clinical PIP

The MHP did not submit a valid Non-Clinical PIP.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D 1: CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Madera MHP					
Entity	**Average Monthly ACA Enrollees**	**Beneficiaries Served**	**Penetration Rate**	**Total Approved Claims**	**ACB**
Statewide	3,835,638	155,154	4.05%	$934,903,862	$6,026
Small	31,253	2,174	6.96%	$12,033,576	$5,535
MHP	17,673	638	3.61%	$3,629,427	$5,689

Table D 2: CY 2020 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	2,436	93.76%	92.22%	$15,399,561	$3,829	$4,399	60.58%	56.70%
>$20K - 30K	75	2.89%	3.71%	$1,778,578	$2,911	$24,274	11.55%	12.59%
>$30K	87	3.35%	4.07%	$4,292,436	$49,338	$53,969	27.87%	30.70%

Table D 3: Summary of CY 2020 Short-Doyle/Medi-Cal Claims

Madera MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**48,967**	**$18,944,827**	**1,209**	**$540,287**	**2.85%**	**$18,404,540**	**$13,754,791**
JAN20	3,789	$1,065,153	59	$19,769	1.86%	$1,045,384	$783,713
FEB20	3,565	$1,064,082	54	$16,606	1.56%	$1,047,476	$799,248
MAR20	4,202	$1,766,501	105	$35,468	2.01%	$1,731,033	$1,282,422
APR20	5,075	$1,661,978	181	$51,576	3.10%	$1,610,402	$1,163,167
MAY20	4,586	$1,686,661	114	$61,470	3.64%	$1,625,191	$1,167,301
JUN20	4,631	$1,811,579	73	$31,931	1.76%	$1,779,648	$1,295,118
JUL20	4,552	$1,898,862	93	$73,836	3.89%	$1,825,026	$1,373,505
AUG20	4,218	$1,817,546	109	$47,696	2.62%	$1,769,850	$1,361,670
SEP20	4,327	$1,818,365	170	$80,723	4.44%	$1,737,642	$1,295,410
OCT20	4,435	$1,903,992	122	$58,404	3.07%	$1,845,588	$1,412,610
NOV20	3,625	$1,599,426	92	$47,308	2.96%	$1,552,118	$1,172,066
DEC20	1,962	$850,682	37	$15,500	1.82%	$835,182	$648,562

Includes services provided during CY 2020 with the most recent DHCS claim processing date of July 30th, 2021. Only reports Short-Doyle Medi-Cal claim transactions and does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2020 was 3.19 percent.

Table D 4: Summary of CY 2020 Top Five Reasons for Claim Denial

Madera MHP			
Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B or Other Health Coverage must be billed before submission of claim	523	$220,801	40.9%
Claim/service lacks information which is needed for adjudication	438	$186,705	34.6%
Beneficiary not eligible or non-covered charges	225	$124,553	23.1%
Beneficiary not eligible	9	$5,982	1.1%
Rendering provider taxonomy code does not march Service Facility location	5	$1,401	0.3%
TOTAL	**1,200**	**$539,442**	**100%**