Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

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

SACRAMENTO DRAFT REPORT

☒ MHP
☐ DMC-ODS

Prepared for:

California Department of
Health Care Services (DHCS)

Review Dates:

August 24-26, 2021

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

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 — Sacramento

Review Type — Virtual

Date of Review — August 24-26, 2021

MHP Size — Large

MHP Region — Central

MHP Location — Sacramento

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 23,228

MHP Threshold Language(s) — Arabic, Cantonese, English, Farsi, Hmong, Russian, Spanish, and Vietnamese

SUMMARY OF FINDINGS

Of the five recommendations for improvement that resulted from the FY 2020-21 External Quality Review (EQR), the MHP addressed or partially addressed four of five 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: 66.6 percent (four of six components)
- Quality of Care: 100 percent (ten of ten components)
- Information Systems (IS): 100 percent (six of six components)

The MHP submitted both required Performance Improvement Projects (PIPs). The clinical PIP, “Improving Access, Engagement and Satisfaction Through Telehealth Services”, is completed and was found to have a high confidence rating. The non-clinical PIP, “Timeliness to first Outpatient Assessment after Inpatient Discharge” is completed and was found to have a moderate confidence rating.

CalEQRO conducted three consumer family member focus groups, comprised of 15 participants.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: implementation and availability of telehealth services; improved outcomes related to inpatient utilization; extensive peer employment opportunities; roll-out of multi-factor authentication, which greatly increases security; and interoperability through joining the local Health Information Exchange (HIE).

The MHP was found to have notable opportunities for improvement in the following areas: low penetration rates for FC, Latino/Hispanic, and API beneficiaries; contracted organizations report significant challenges in recruiting and retaining staff; the MHP does not track and report timeliness to urgent service requests that do not require prior authorization; the MHP currently has neither a standard nor does it track and report no-shows for psychiatrists and/or clinicians other than psychiatrist; and the MHP does not have a universally utilized Level of Care (LOC) tool.

FY 2021-22 CalEQRO recommendations for improvement include: continue work to reduce barriers to and improve access for FC, Latino/Hispanic, and API beneficiaries; research ways to support recruitment and retention in collaboration with contracted agencies; develop and implement a system to accurately track and report urgent service requests that do not require prior authorization; develop and implement a system to accurately track and report no-shows for psychiatrists and/or clinicians other than psychiatrists; and select and implement a LOC tool for universal use across the system of care.

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 Sacramento County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on August 24-26, 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 (QI) 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 MHP experienced loss of staff due to various issues of the COVID-19 Public Health Emergency, was required to adjust service delivery processes, and needed to rapidly pivot to increased telehealth services and telework for staff. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

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 has established interoperability by joining the local Health Information Exchange (HIE): CareQuality.
- The MHP has six Mobile Crisis Support Teams that collaborate with local law enforcement organizations across Sacramento County, and expansion efforts are in place to add three more within a year.
- In collaboration with the California Institute for Behavioral Health Solutions (CIBHS), Behavioral Health Services (BHS) facilitated the development of the Behavioral Health Racial Equity Collaborative (BHREC). BHREC partners with representatives from a spectrum of the African American/Black/of African Descent community across age, gender identity, and sexual orientation. The purpose of the BHREC is to collaborate with community partners to define goals and measures that will shape racial equity action plans aimed at creating just opportunities for behavioral health and wellness in Sacramento County, regardless of race.
- As one of the actions to address loss of staff over the period of the pandemic, in partnership with Sacramento County Department of Personnel Services, BHS created and posted a webinar that highlighted a step-by-step process for how to apply for a county job. It is currently available to view on the county's Job Seeker Resources page: https://personnel.saccounty.net/Pages/ESJobSeekerResources.aspx

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: Review with DHCS the method currently used to measure the time to first offered and first kept appointment, which has resulted in meeting the standard 100 percent of the time. Also review whether the time to the second clinical appointment is at or near 100 percent.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The current process of conducting the assessment to determine medical necessity at the Access Team was discussed with DHCS during the Triennial that took place July 2021, and the MHP is awaiting the final report from DHCS prior to making any changes in process.
- The MHP has reviewed the time to second clinical appointment; it is currently tracked as the time from the assessment by the Access Team to the first billable service by the ongoing outpatient service provider.

Recommendation 2: Continue efforts to recruit and retain adequate psychiatry coverage and measure progress in terms of full-time equivalents (FTE) and time to first psychiatry appointment. *(This recommendation is a carry-over from FY 2019-20.)*

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP's partnership with the University of California, Davis (UCD), continues to support the goal of recruiting and retaining quality psychiatric staff.

- UCD hired a new psychiatrist who will be covering as an attending physician on the B-Team of the county psychiatric health facility.
- The MHP has added a fourth child psychiatry resident who will begin January 2022.
- The MHP has pooled funding for child psychiatry at the Youth Detention Facility.
- The MHP has a Workforce Education and Training effort that partners with UCD Psychiatry to have a Residency Training Program.

Recommendation 3: Begin to track and report no-shows separately for psychiatrists and clinicians. Disaggregate data for adults, older adults, children, and youth in foster care (FC).

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP reports having the ability to track no-shows for psychiatry by using a psychiatry practitioner-type search parameter and that it can use the Date of Birth parameter to disaggregate no-shows into categories of adults, older adults, children, and youth in FC.
- However, the MHP does not have a standard nor does it track no-shows for either psychiatrists or clinicians other than psychiatrists.

Recommendation 4: Determine a methodology to track time to response for urgent conditions and implement. Track and report this data, disaggregating adults, older adults, children, and FC.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Beneficiaries who call the 24/7 Access line and indicate that they have an urgent mental health need are directed to the Mental Health Urgent Care Clinic (MHUCC) for a face-to-face assessment. This is documented in the Service Request disposition.
- Timeliness for response to urgent conditions is tracked from the point the beneficiary contacts the MHUCC for a face-to-face assessment; data is aggregated for reporting purposes. Beneficiaries who indicate an urgent mental health need but do not follow up with the MHUCC as directed are not included in the urgent timeliness reporting.

Recommendation 5: Implement a system to ensure that beneficiaries (especially those participating in surveys) receive information regarding outcomes of the surveys, including the Consumer Perception Survey (CPS).

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP implemented a new process to disseminate the results of the CPS, which includes posting the CPS report results on the Sacramento Behavioral Health Services (BHS) website and sending a notification of the website link with the CPS report results to providers to share with beneficiaries and their families, especially those who participated in the survey.
- The results of the June 2021 CPS survey will be disseminated by the above method when the results are received from DHCS.

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 Sacramento County, the time and distance requirements are 30 minutes and 15 miles for 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].

[1] AB 205 and BHIN 21-023

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.

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.

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 SACRAMENTO COUNTY

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Eighty (80) organizational provider sites, as part of thirty-nine (39) legal entities, delivered services to MHP beneficiaries across Sacramento County. This spread reflected a vast geographic area of service, and includes services delivered in clinic, field-based, residential, and inpatient settings. Regardless of payor source, approximately 6.17 percent of services were delivered by county-operated/staffed clinics and sites, and approximately 93.83 percent were delivered by contractor-operated/staffed clinics and sites. The MHP served 23,228 unduplicated beneficiaries in 2020. Overall, approximately 79.13 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; beneficiaries may request services through the Access Line. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Urgent service requests are immediately referred to the Sacramento County Mental Health Urgent Care or the emergency room. The MHP deploys some Access clinicians with the homeless encampment teams, but the majority are in the call center. Certain programs do their own admissions based on the population they serve but are mostly crisis response programs.

In addition to clinic-based mental health services, the MHP provides telehealth and mobile mental health services. The MHP delivers psychiatry and mental health services via telehealth to youth and adults. In FY 2020-21, the MHP reports having served 3,916 adult beneficiaries, 4,460 youth beneficiaries, and 547 older adult beneficiaries across two county-operated sites and 55 contractor-operated sites. Among those served, 1,989

beneficiaries received telehealth services in a language other than English in the preceding 12 months.

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 Component – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	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:

- Telehealth implementation for most outpatient services during the COVID-19 Public Health Emergency restrictions has ensured beneficiaries continuity of access during this time.
- The MHP reports that of 400 staff, 32.3 percent are bi-lingual, demonstrating fluency in English and one other language.
- Community Base Organizations (CBOs) reported significant challenges in recruiting staff. There have been many resignations and departures from positions for a variety of reasons; this, coupled with a lack of competitive salaries and benefits, creates an unsustainable situation.
- The MHP created a multi-tiered plan for crisis services. This is a multi-year initiative (initial framework in 2015) that continues to be a high priority.

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 (PR), 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.

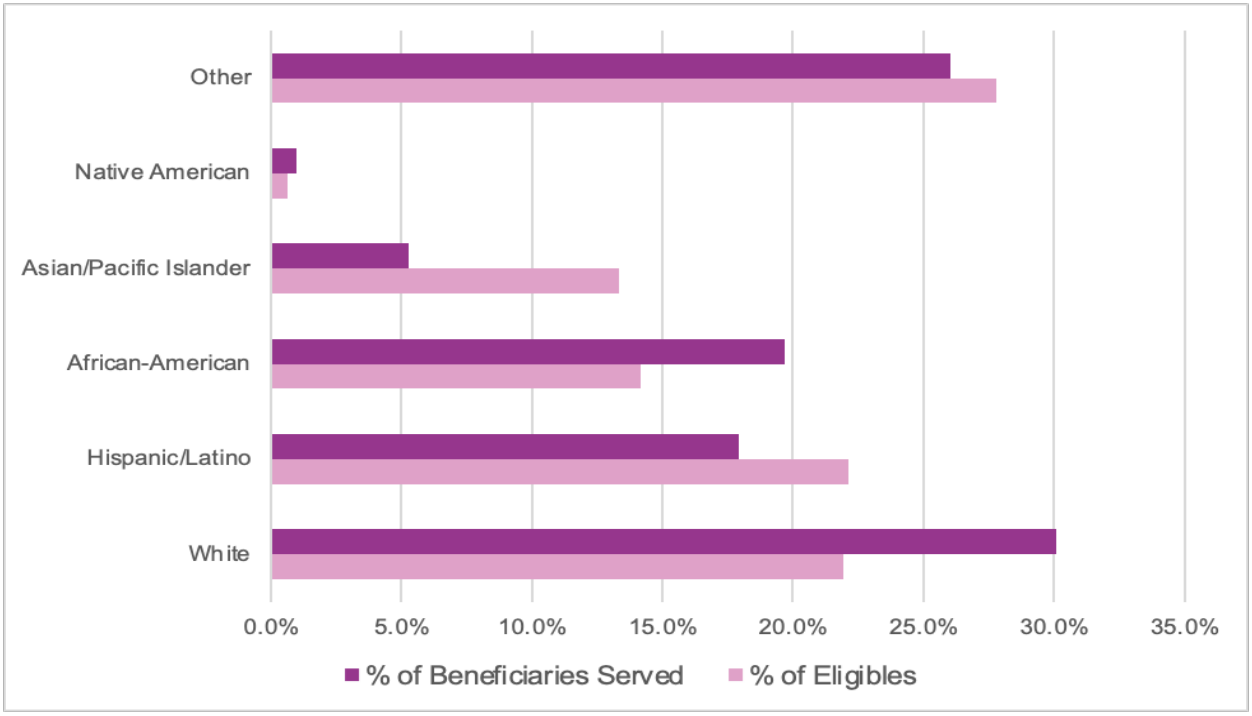
Table 2: County Medi-Cal Eligible Population and Beneficiaries Served in CY 2020, by Race/Ethnicity

Sacramento 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	120,308	21.9%	6,991	30.1%
Latino/Hispanic	121,399	22.1%	4,169	17.9%
African-American	77,773	14.2%	4,577	19.7%
Asian/Pacific Islander	73,132	13.3%	1,221	5.3%
Native American	3,492	0.6%	226	1.0%
Other	152,655	27.8%	6,044	26.0%
Total	**548,759**	**100%**	**23,228**	**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



The MHP has strong penetration in the African-American community, at 19.7 percent. It does not have an equally strong penetration in the Latino/Hispanic population which makes up 22.1 percent of the beneficiaries, while serving 17.9 percent. The disparity in penetration is more striking in the Asian/Pacific Islander population, which is 13.3 percent, but only 5.3 percent are being served.

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

Sacramento MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Farsi	65	0.3%
Arabic	109	0.5%
Cantonese	82	0.4%
Vietnamese	188	0.8%
Hmong	219	1.0%
Russian	242	1.1%
Spanish	1,759	7.7%
Other Languages	20,305	88.4%
Total	**22,969**	**100%**
Threshold language source: Open Data per IN 20-070		
Other Languages include English		

Sacramento added a new threshold language of Farsi (also known as Persian), a small but growing population.

Penetration Rates and Approved Claim Dollars per Beneficiary Served

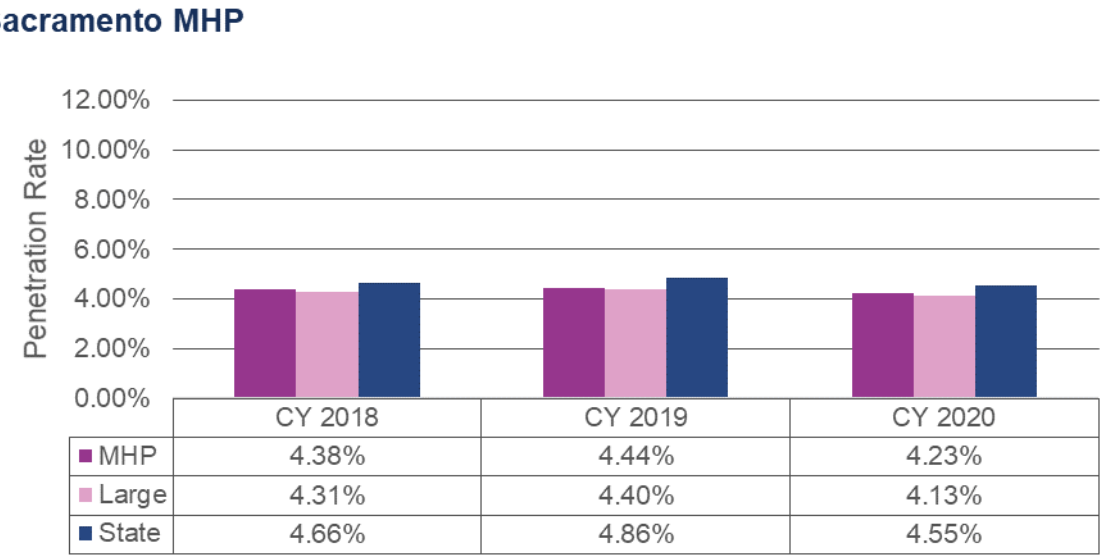
The penetration rate (PR) is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The ACB served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries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

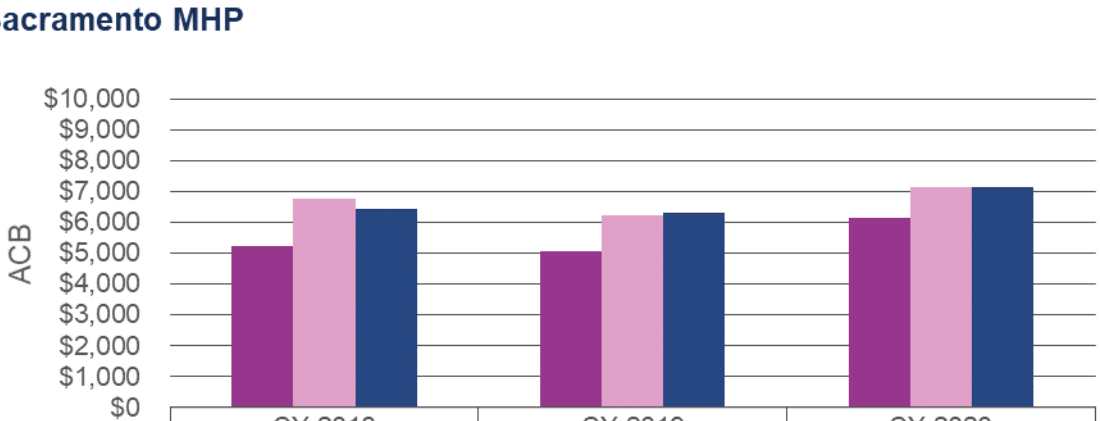
The MHP's penetration rates, while slightly lower than the state averages, are more in line with the averages of other large MHPs, while the MHP's ACB averages are lower than the statewide average across comparison groups.

Figure 2: Overall Penetration Rates CY 2018-20



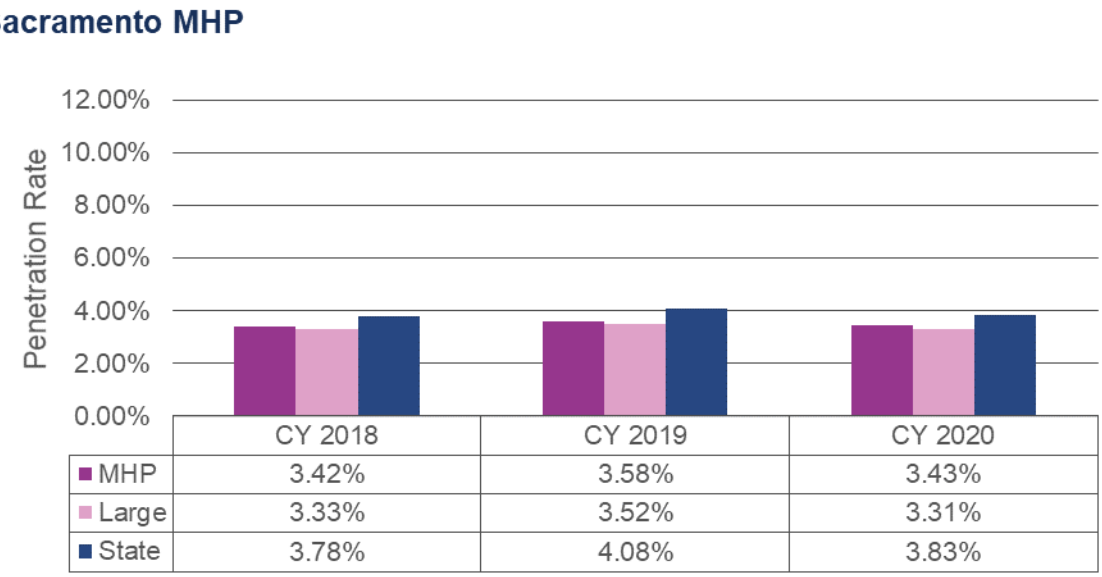
	CY 2018	CY 2019	CY 2020
MHP	4.38%	4.44%	4.23%
Large	4.31%	4.40%	4.13%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20



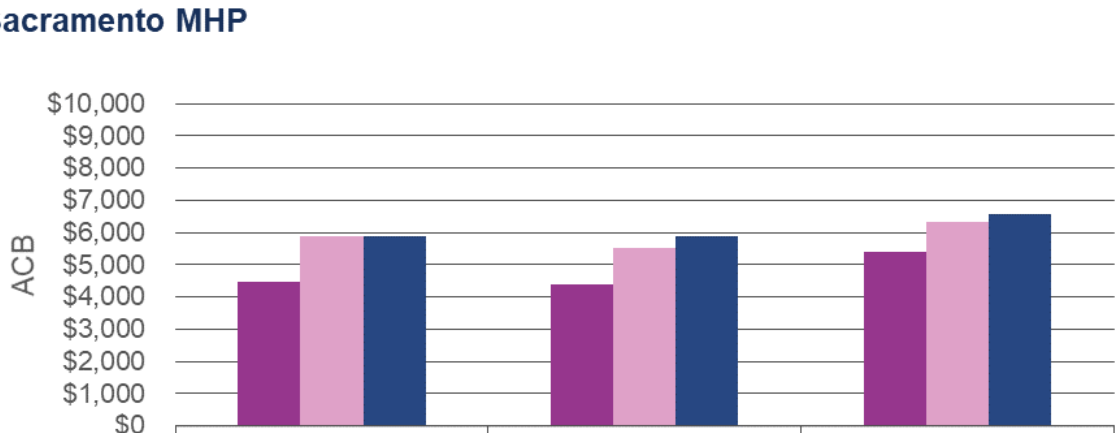
	CY 2018	CY 2019	CY 2020
MHP	$5,224	$5,055	$6,138
Large	$6,750	$6,219	$7,156
State	$6,454	$6,316	$7,155

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



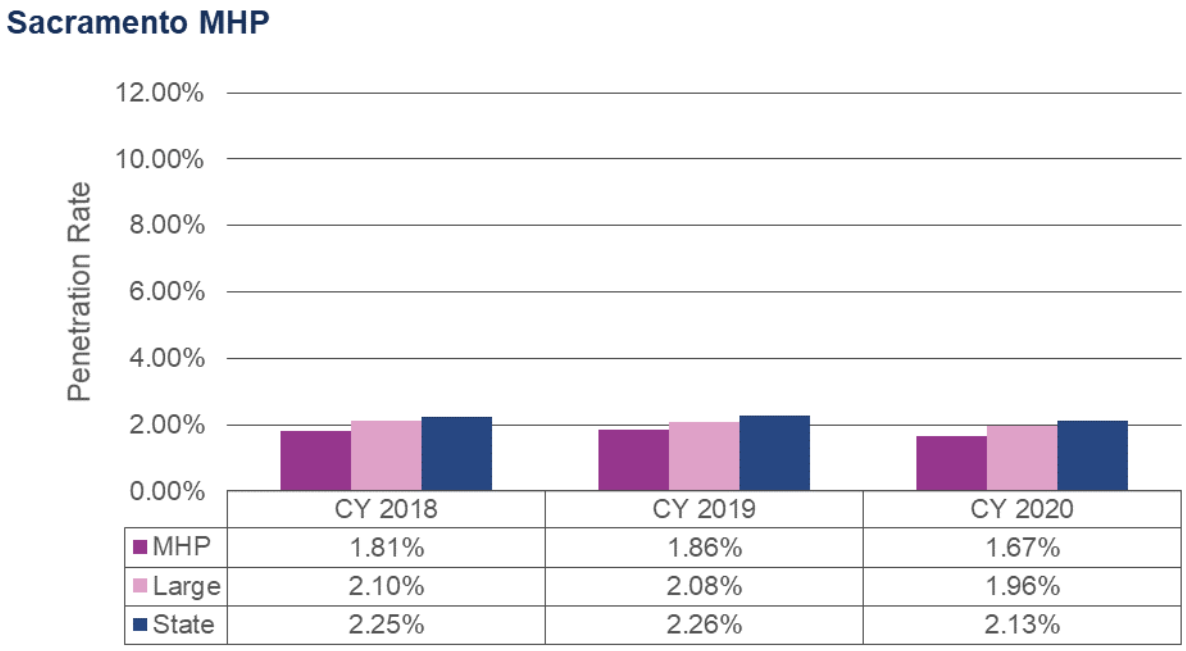
	CY 2018	CY 2019	CY 2020
MHP	3.42%	3.58%	3.43%
Large	3.33%	3.52%	3.31%
State	3.78%	4.08%	3.83%

Figure 5: Latino/Hispanic ACB CY 2018-20



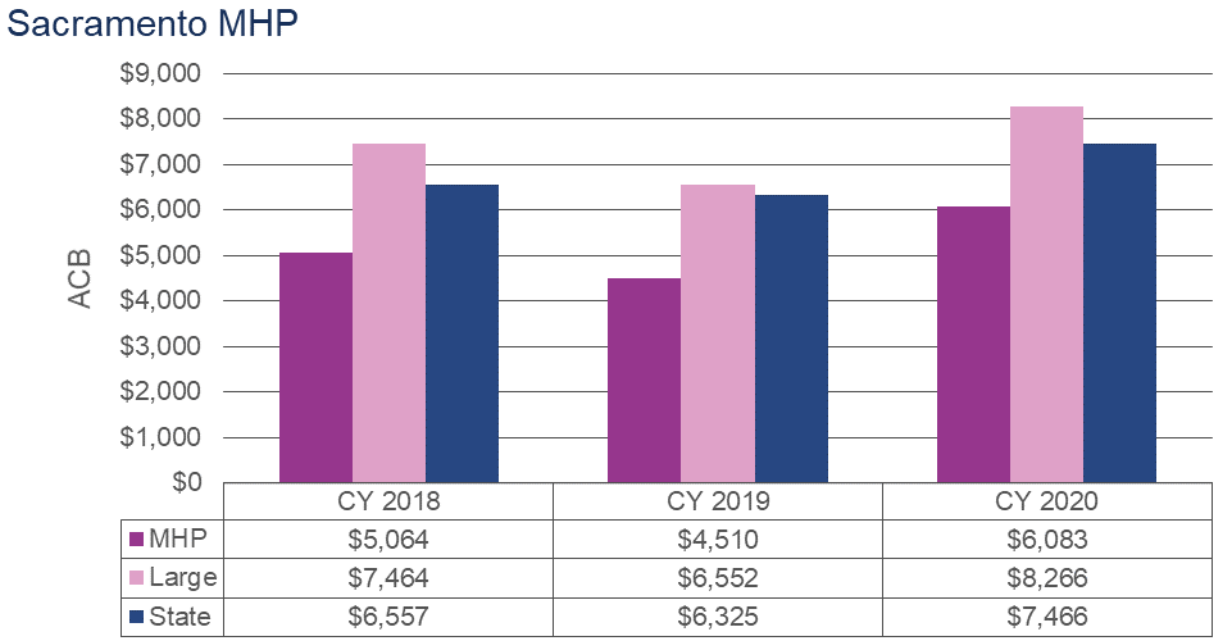
	CY 2018	CY 2019	CY 2020
MHP	$4,480	$4,398	$5,392
Large	$5,884	$5,523	$6,317
State	$5,904	$5,869	$6,551

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



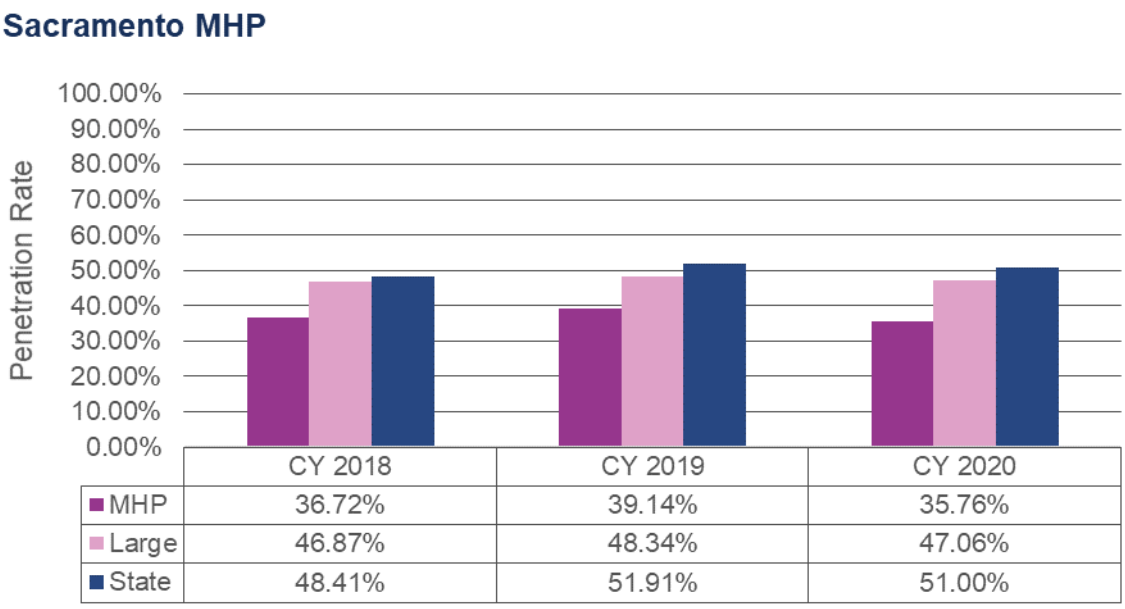
	CY 2018	CY 2019	CY 2020
MHP	1.81%	1.86%	1.67%
Large	2.10%	2.08%	1.96%
State	2.25%	2.26%	2.13%

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



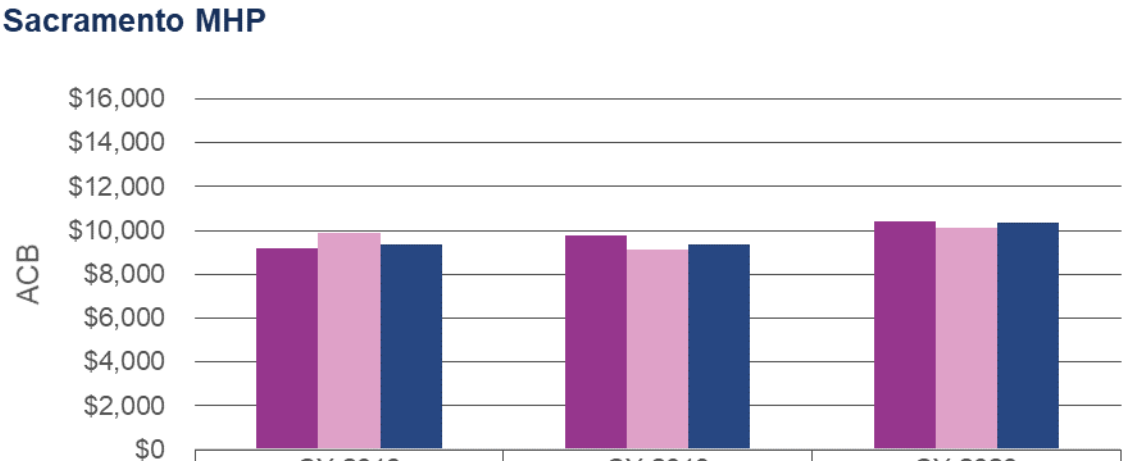
	CY 2018	CY 2019	CY 2020
MHP	$5,064	$4,510	$6,083
Large	$7,464	$6,552	$8,266
State	$6,557	$6,325	$7,466

Figure 8: FC Penetration Rates CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	36.72%	39.14%	35.76%
Large	46.87%	48.34%	47.06%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	$9,157	$9,758	$10,421
Large	$9,895	$9,125	$10,129
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

With seven threshold languages and a community with significant linguistic and cultural diversity, the MHP continues to monitor and refine strategies for improvement of disparities.

While the MHP's overall penetration rates are consistent with like-sized MHP and statewide averages, there are some notable differences between beneficiary populations that suggest disparity in access among beneficiary groups. The following warrants closer analysis and potential action:

- Higher than other large MHP averages, the MHP's Latino/Hispanic penetration rates remain below the statewide average and have remained largely unchanged across the past three years.
- FC penetration rates have been 25-30 percent lower than like-sized MHP and statewide averages for the past three years.
- API beneficiaries represent 13.3 percent of the Medi-Cal eligible population but only 5.3 percent of the beneficiaries served by the MHP.
- White beneficiaries, while only representing 21.9 percent of eligible, comprise 30.1 percent of beneficiaries served.
- African-American beneficiaries comprise a higher percentage of beneficiaries served (19.7 percent) than the eligible population (14.2 percent).

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 SACRAMENTO COUNTY

In preparation for the EQR, the MHP submitted the Assessment of Timely Access form with available timeliness data as of July 2021. Reported data were stratified by age and FC status and represented the complete SMHS delivery system, inclusive of county-operated and contractor-operated services.

Since the last EQR, the MHP adopted the DHCS outpatient timeliness standards for first offered non-urgent appointment (10-business days) and first offered non-urgent psychiatry appointment (15-business days). New data entry procedures were implemented in April 2021, at which time the MHP began to track time to first offered psychiatry appointment and urgent services data. As a result, the performance measures below reflect psychiatry services between April and June 2021. The MHP did not have urgent services data available for this year's EQR and plans to submit CY 2021 data in the FY 2022-23 EQR cycle.

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 Component – Timeliness

KC #	Key Component – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Not Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Partially Met
2F	No-Shows/Cancellations	Not Met

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

- The MHP has now adopted and meets the 10-business day standard for first non-urgent request to first offered appointment 82.7 percent of the time, for an average of 5.6 days.
- Timeliness for "Urgent Services, Prior Authorization Required" is tracked and reported. The percent of appointments that met the DHCS standard of 96 hours was 54.4 percent overall.
- The MHP does not track "Urgent Services, Prior Authorization Not Required" nor has it adopted the related DHCS 48-hours standard. Rather, beneficiary requests for urgent services are immediately directed to the MHUCC for face-to-face assessments, and the requests are documented in the Service Request disposition. From that date, the time to first assessment at the MHUCC is tracked and aggregated for reporting purposes. This does not include those beneficiaries who do not follow up with the MHUCC.
- The MHP currently has neither a standard nor the ability to accurately track and report no-shows for psychiatrists and/or clinicians other than psychiatrist.

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. 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

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. For the FY 2021-22 EQR, the MHP reported its performance for CY2020 for the entire service delivery system, disaggregated by adults, children, and FC services. Data for first offered psychiatry appointment was not tracked in CY 2020 but was reported for April to June 2021; the MHP reports that it received no initial psychiatry service requests for FC beneficiaries during this time.

No-show rates for psychiatrists and clinicians other than psychiatrists was reported as 4.6 percent and 1.4 percent respectively. However, there is low confidence in this data, as the MHP reports difficulty capturing valid no-show data.

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	5.6 Days	10-Business Days*	82.7%
First Non-Urgent Service Rendered	6.1 Days	10-Business Days**	80.3%
First Non-Urgent Psychiatry Appointment Offered	19.9 Days	15-Business Days*	47.3%
First Non-Urgent Psychiatry Service Rendered	26.5 Days	15-Business Days**	29.3%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	*** Hours	48-Hours*	n/a
Urgent Services Offered (including all outpatient services) – Prior Authorization Required	139.6 Hours	96-Hours*	54.4%
Follow-Up Appointments after Psychiatric Hospitalization	11 Days	7-Days**	66.7%
No-Show Rate – Psychiatry	*** %	%**	n/a
No-Show Rate – Clinicians	*** %	%**	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

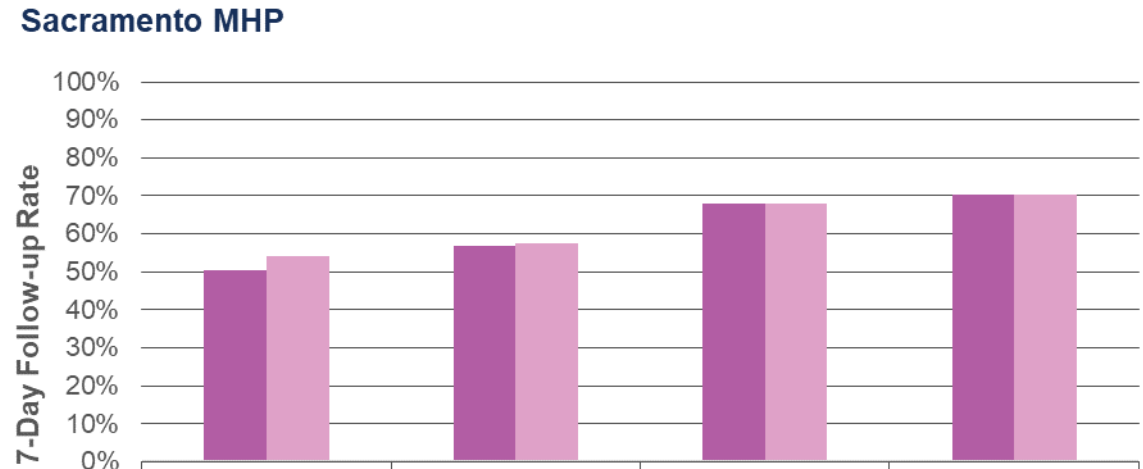
The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; 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 MHP's 7-day follow up has improved by four percentage points from last year's rate of 50 percent to 54 percent. The 30-day follow-up rate (68 percent) is the same as last year and is in line with the state average.

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



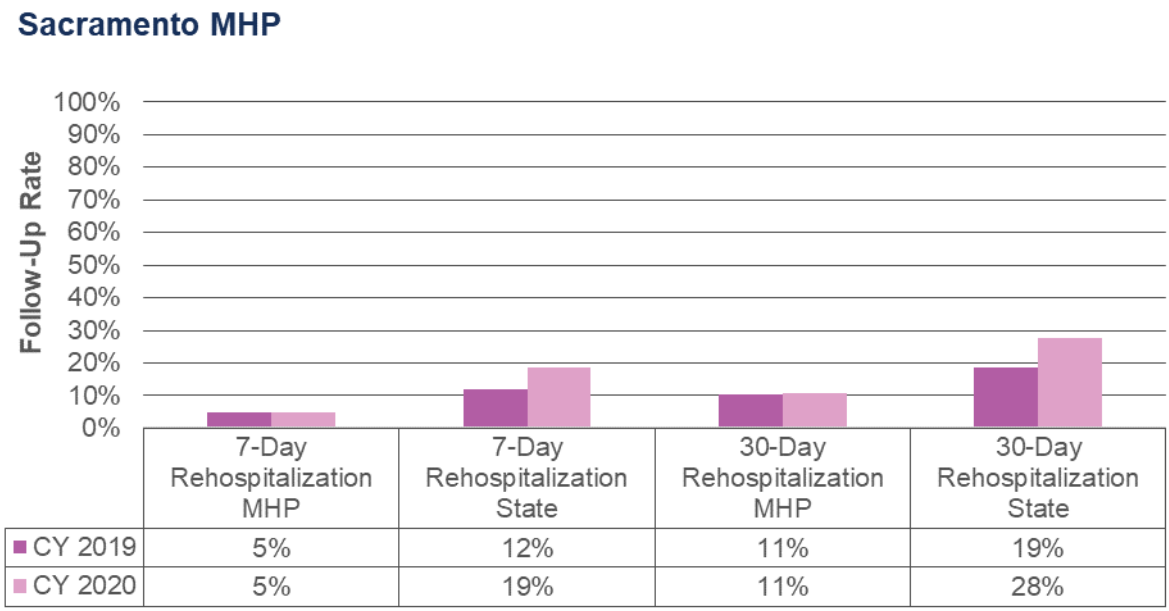
	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	50%	57%	68%	70%
CY 2020	54%	57%	68%	70%

Readmission rates

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

The MHP's rehospitalization rates are consistent this year with last year. Both 7- and 30-day rates are well below the state average. The 7-day MHP rate is 5 percent while the state average is almost four times that at 19 percent. The 30-day rate, at 11 percent, is less than half the state average of 28 percent.

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



	7-Day Rehospitalization MHP	7-Day Rehospitalization State	30-Day Rehospitalization MHP	30-Day Rehospitalization State
CY 2019	5%	12%	11%	19%
CY 2020	5%	19%	11%	28%

IMPACT OF FINDINGS

Discussed later in the report, the MHP continued efforts at increasing timeliness to first appointment by focusing its Performance Improvement Projects (PIPs) on expanding the utilization of the e-Scheduling Tool to include adult providers.

The MHP's 7-day timely follow-up of beneficiaries' post hospital discharge increases engagement and likely facilitates the lower rehospitalization rates seen in CY 2020.

The MHP's CY 2020 7-day rehospitalization rates (5 percent) are roughly one-fourth the statewide average (19 percent), and the 30-day rehospitalization rates (11 percent) are less than half the statewide average (28 percent). Lower readmission rates suggest positive outcomes of treatment.

The MHP's current practice of not monitoring the beneficiaries who request urgent services but who do not follow up with the referral to MHUUC may result in missed opportunities for engagement. Further exploration and possible modification of practices is warranted to ensure the needs of these beneficiaries are addressed.

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 SACRAMENTO COUNTY

In the MHP, the Quality Improvement Policy Council guides the Mental Health Plan's Quality Improvement processes. The Policy Council also functions as the Executive Management Team for the Mental Health Division.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the Quality Assessment and Performance Improvement (QAPI) workplan, and the annual evaluation of the QAPI workplan. Since the previous EQR, the MHP QIC met ten times; the QIC includes representatives of the MHP, the Drug Medi-Cal Organized Delivery System (DMC-ODS), contract providers, and beneficiaries and family members. The 21 identified FY 2019-20 QAPI workplan goals were divided into four essential domains: access, timeliness, quality, and beneficiary outcomes. The MHP addressed all 21, meeting or progressing toward each goal. Below are some highlights provided by the MHP of information detailed in the report:

- A total of 300 trainings were recorded specifically on increasing cultural competency skills.
- The Pharmacy & Therapeutics Committee and Medication Monitoring Committees continued to provide critical input and oversight for medication practices and medication practice guidelines. The Medication Monitoring Committee reviewed 1,109 charts across providers for polypharmacy issues, medication guidelines and laboratory work. In all cases, feedback was provided to service providers.

The Level of Care Utilization System (LOCUS) is reportedly used by a small number of contracted agencies.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths Assessment (ANSA), Pediatric Symptoms Checklist (PSC-35), and the Child and Adolescent Needs and Strengths (CANS). The ANSA was recently implemented within the MHP, and the data from it will be available in the FY 2022-23 EQR.

Wellness Centers have been closed to walk-ins during the pandemic, with some being able to offer individual appointments.

Peer employment exists across the contracted agencies and is on the precipice of being part of the MHP work force. It is expected that there will be peers employed as county employees within the MHP at the next EQR. This will open the opportunity for a career ladder to be developed by the MHP in collaboration with contracted agencies.

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 Component – Quality

KC #	Key Component - Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	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	Met

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

- Participants in the CBO focus group highly complimented the MHP's contract liaison as being effective, easy to communicate with, available, and responsive.
- The MHP tracks and trends the following HEDIS measures as required by SB 1291:
    - 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)
- The MHP reports that the EHR does not capture LOC recommendations, referrals, and admissions, and that 2.2 percent of MHP beneficiaries who request treatment are screened for referrals using LOC criteria. The MHP does not have a universally utilized LOC tool.

PERFORMANCE MEASURES

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

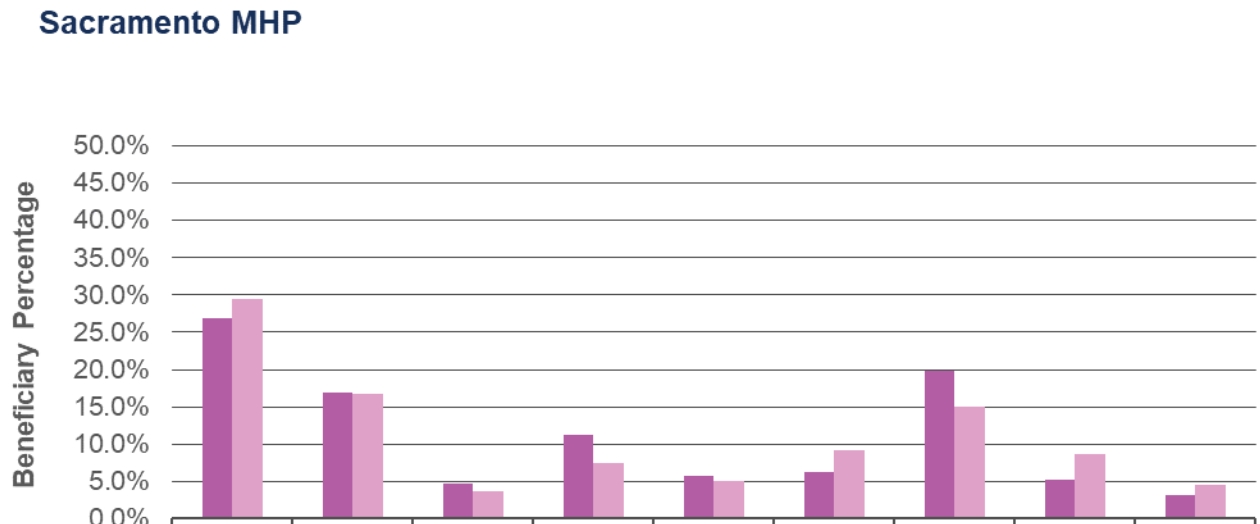
- Beneficiaries Served by Diagnostic Category
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay (LOS)
- Retention Rates
- High-Cost Beneficiaries (HCB)

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.

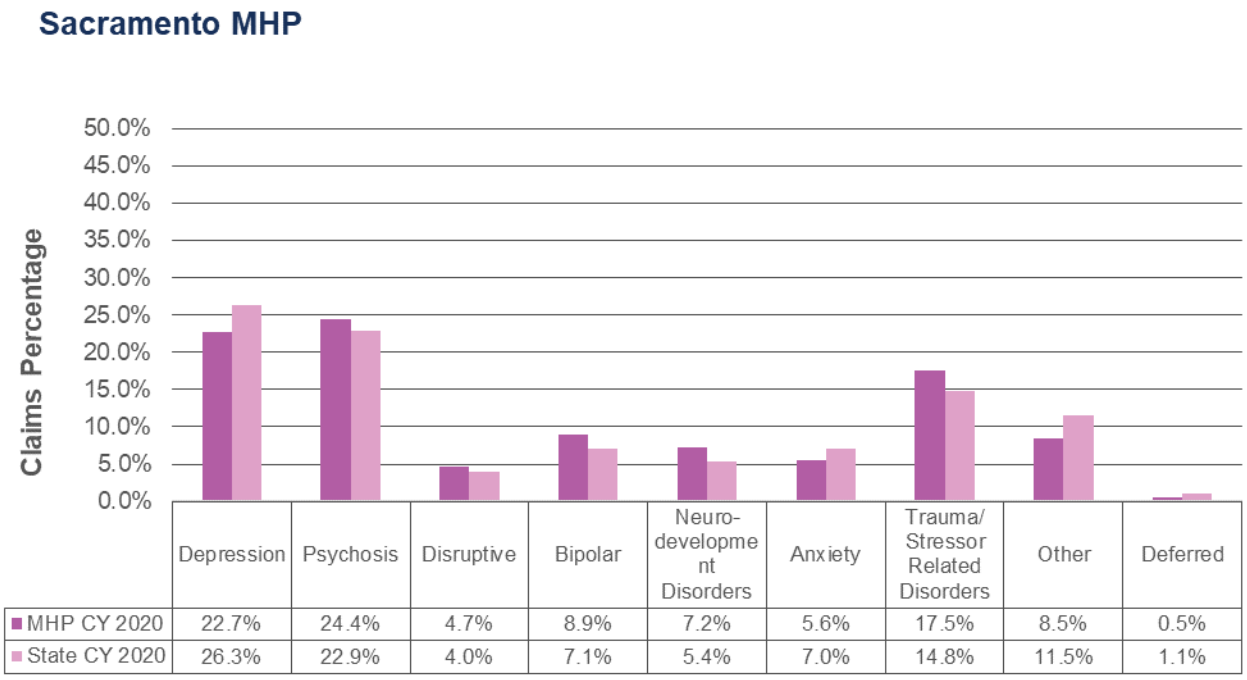
The MHP serves a higher proportion of beneficiaries with trauma/stressor related disorders (19.8 percent) than is seen statewide (15.1 percent), and the proportion of deferred diagnoses (3.2 percent) is well below the statewide average (4.5 percent).

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020



	Depression	Psychosis	Disruptive	Bipolar	Neuro-developmental Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	26.9%	16.8%	4.7%	11.3%	5.7%	6.3%	19.8%	5.3%	3.2%
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



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	22.7%	24.4%	4.7%	8.9%	7.2%	5.6%	17.5%	8.5%	0.5%
State CY 2020	26.3%	22.9%	4.0%	7.1%	5.4%	7.0%	14.8%	11.5%	1.1%

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 MHP saw a significant reduction in both numbers of beneficiaries hospitalized and the number of inpatient admissions since CY 2018. While the MHP's average LOS (10.9 days) is higher than the state's average (8.68 days), it has decreased by 44 percent since CY 2018; statewide average LOS has increased by 13.8 percent during the same time period.

Table 7: Psychiatric Inpatient Utilization CY 2018-20

Sacramento 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	1,518	2,687	10.90	8.68	$12,432	$11,814	$18,872,005
CY 2019	1,540	2,857	10.28	7.80	$11,265	$10,535	$17,347,981
CY 2018	1,919	3,604	19.52	7.63	$11,724	$9,772	$22,499,113

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.

Although the number of HCBs served by the MHP increased from 2018 (505) to 2020 (644), the total beneficiary count decreased, resulting in an overall increase in the percentage of the HCB, to 2.77 percent in 2020. The average approved claims per HCB remains lower than the state average, which is consistent with findings for Figures 3, 5, and 7.

Table 8: HCB CY 2018-20

Sacramento 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	644	23,228	2.77%	$49,305	$31,752,324	22.27%
	CY 2019	478	23,842	2.00%	$48,398	$23,134,369	19.19%
	CY 2018	505	23,775	2.12%	$51,348	$25,930,552	20.88%

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

While the MHP has a slightly higher number of initial contacts than the state average, its -service delivery levels drop in each of the following categories of services: two services, three services, and four services, each of these being lower than the state averages. Note that 53.86 percent of the MHP's beneficiaries receive 15 or more services, compared to the state's average of 45.33 percent receiving this number of services.

Table 9: Retention of Beneficiaries

	SACRAMENTO			STATEWIDE			
Number of Services Approved per Beneficiary Served	**# of beneficiaries**	**%**	**Cumulative %**	**%**	**Cumulative %**	**Minimum %**	**Maximum %**
1 Service	2,308	9.94	9.94	9.76	9.76	5.69	21.86
2 Services	1,141	4.91	14.85	6.16	15.91	4.39	17.07
3 Services	781	3.36	18.21	4.78	20.69	2.44	9.17
4 Services	758	3.26	21.47	4.50	25.19	2.44	7.78
5-15 Services	5,729	24.66	46.14	29.47	54.67	19.96	42.46
>15 Services	12,511	53.86	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

The MHP has lower levels of two, three, and four services than the state and a larger percentage of beneficiaries receiving fifteen or more services. This may reflect service delivery system design intended to retain beneficiaries in appropriate levels of treatment. These high levels of services may also correlate with the lower than state average approved claims per HCB, indicating that the MHP provides effective outpatient services obviating the need for high levels of inpatient treatment.

Decreasing trends in inpatient utilization, including fewer unduplicated beneficiaries admitted, fewer overall hospital admissions, and a 44 percent reduction in average LOS, accompanied by increased post hospital discharge follow-up rates and decreased readmissions, suggest meaningful improved beneficiary outcomes.

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 and 457.1240(b)[2]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or MHP system level.

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

Validation tools for each PIP are located in 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: "Improving Access, Engagement and Satisfaction Through Telehealth Services"

Date Started: April 2020

Aim Statement: Will providing Telehealth services from office to beneficiary's home improve engagement, access, and satisfaction of services, while decreasing no shows and cancelations during a 12-month period?

Target Population: The study population consisted of all MHP beneficiaries receiving outpatient services via telehealth video conferencing.

Validation Information: The MHP's clinical PIP is completed and considered high confidence rating.

Summary

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

The goal of the PIP was to utilize the intervention of telehealth services to maintain or increase access, timeliness, and engagement in services for MHP beneficiaries, leading to improved beneficiary satisfaction. Offering telehealth options for beneficiaries and providers was expected to support access, timeliness, and engagement in services by having less limitations and barriers to scheduling appointments around travel time, work schedules, access to transportation, schedules of the beneficiary caregivers, as well as many other identified barriers unique to each person.

Interventions were: The utilization of telehealth and telehealth surveys for beneficiaries to rate satisfaction with telehealth; satisfaction with access to care using telehealth; and satisfaction with service provider interaction. Staff were given parallel surveys.

Performance measures included: Duration by service type = Total units of services by type/total number of beneficiaries; Frequency by service type = Total number of services by type/total number of beneficiaries; Number of no shows = Total number of no shows/total number of beneficiaries served; Number of cancellations = Total number of cancellations/total number of beneficiaries served: Number of beneficiaries who agreed or strongly agreed to the survey questions (satisfaction/future use section); Number of beneficiaries who agreed or strongly agreed to the survey questions (access to care); Number of beneficiaries who agreed or strongly agreed to the survey questions (use of system); Number of beneficiaries who agreed or strongly agreed to the survey questions (service provider interaction section); Number of staff who agreed or strongly agreed to the survey questions (satisfaction/future use section); Number of staff who agreed or strongly agreed to the survey questions (access to care section); Number of staff who agreed or strongly agreed to the survey questions (use of system section); and, Number of staff who agreed or strongly agreed to the survey questions (service provider section).

Results: The conclusion of this PIP is that using telehealth was successful in maintaining engagement and access to services that allowed for continued process toward treatment goals, especially during the COVID-19 stay at home order. Staff using telehealth provided case management services, linking, and referring beneficiaries to much needed resources and supports. Survey results indicate that a majority of beneficiaries would continue to use telehealth after the restrictions are lifted to decrease barriers to consistent treatment appointments. While service utilization data did not demonstrate a significant improvement this may have been impacted by the continuing COVID-19 restrictions. As there were very limited opportunities to have in-person services, due to both beneficiary and provider concerns, many reported “telehealth fatigue” which may have contributed to the lack of change in service utilization regardless of the positive satisfaction survey results. There is statistical evidence that supports the use of telehealth as an equitable modality of service. The service utilization results were consistent through the repeated measures. There was an increase from 3-month survey responses to year one responses. Data will continue to be collected to determine whether the external factors (COVID-19 restrictions) affected the results or if

new interventions should be put in place for further success in ongoing outpatient services.

TA and Recommendations

As submitted, this clinical PIP was found to have high confidence, because: Credible, reliable, and valid methods for the PIP were documented, and the PIP adhered to acceptable methodology for all phases of design and data collection, as well as conducted accurate data analysis and interpretation of PIP results.

The TA provided to the MHP by CalEQRO consisted of:

- Discussion of the PIP process included the following: The MHP reported a low significance of improvement in the no-show rate, yet a high rate of beneficiary engagement. The limited opportunity for in-person services may have also contributed to the lack of change in service utilization.
- Discussed ideas for development of new PIP and encouraged engagement with EQRO for TA.

CalEQRO recommendations for improvement of this clinical PIP include:

- The MHP reported the conclusion of the PIP as of August 2021. Follow up on satisfaction and efficacy of telehealth services after the COVID-19 Public Health Emergency ends to determine the effects of the pandemic on the rates of telehealth, as well as beneficiary satisfaction with it.
- Utilize the findings of this PIP to inform a new more useful policy on telehealth.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: “Timeliness to first Outpatient Assessment after Inpatient Discharge”

Date Started: January 2020

Aim Statement: Will utilizing the Adult Psychiatric Support Services (APSS) program as an assessment center and providing appointments prior to or at the time the beneficiary discharges from the hospital increase the follow up to hospitalization intake appointments from 34.7 percent to 50 percent.

Target Population: The study population included all adult unlinked Medi-Cal beneficiaries, 18 and older, discharged from one of Sacramento’s three acute psychiatric facilities or one of the three psychiatric health facilities (PHF), who were subsequently admitted to outpatient services in the MHP. (Note: unlinked is defined as

not receiving services from an outpatient provider within the MHP at the time of inpatient hospital admission.)

Validation Information: The MHP's non-clinical PIP is completed and considered moderate confidence rating.

Summary

The aim of this PIP was to provide a walk-in assessment center for beneficiaries discharged from the hospital as well as scheduling an outpatient appointment prior to a beneficiary discharging from the hospital to improve the likelihood of the beneficiary showing up to the appointment, whereby improving timeliness and engagement in services. The PIP was designed to demonstrate whether utilizing the County-run APSS program as an assessment center for all unlinked beneficiaries who are discharging from an inpatient episode and scheduling an appointment prior to discharge from the hospital for outpatient services will improve beneficiary engagement and increase the number of beneficiaries linking to ongoing outpatient services, whereby decreasing the hospital readmission rates.

Intervention: Providing an appointment to beneficiaries prior to discharge scheduled for 1-2 days after discharge; and engagement with beneficiary prior to or within the day of notification of discharge from inpatient hospital.

Performance measures: Number of beneficiaries receiving a follow-up outpatient appointment within 7-days of inpatient discharge; and 1) Number of no shows prior to first kept outpatient appointment (1st assessment appointment claimed) 2) Number of cancellations prior to first kept outpatient appointment (1st assessment appointment not claimed).

Results: The study produced a 50 percent increase in number of beneficiaries receiving a follow-up outpatient appointment within 7-days of inpatient discharge; a 4 percent decrease in no-shows, and a 2 percent decrease in cancellations. True improvement is not supported by the data.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: credible, reliable, or valid methods were implied or able to be established for part of the PIP. The MHP saw a reduction in no-show/cancelations that cannot be attributed to telehealth verses the PIP intervention. The MHP achieved a lower no-show/cancellation rate, which is most likely attributed to the availability of telehealth services. The MHP supports the explanation that beneficiaries have had fewer barriers which previously led to higher rates of no-shows and cancellations. The MHP further identified a need for enhanced communication with the hospital. Due to the pandemic, beneficiaries were not

discharged in a timely manner which impacted the MHP's ability to study the time from discharge to walk-in services.

The TA provided to the MHP by CalEQRO consisted of:

- Discussion of barriers that presented in the PIP that might be foreseen in the future development of PIPs.
- The PIP is completed. Discussed ideas for development of new PIP and encouraged engagement with EQRO for TA.

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

- Continue the service as defined in the PIP in order to assess if these interventions are successful post-pandemic.
- The MHP is encouraged to create a process for timeliness of information with their hospital partners.

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 SACRAMENTO COUNTY

California's MHP EHRs fall into two main categories, those that are managed by county 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 Avatar hosted by Netsmart, which has been in use for 12 years. It is being operated as an ASP. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Approximately 4.12 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 doubled the IT budget from last year's 2.00 percent to this year's 4.12 percent so that its budget is now above the state average for large MHPs. While the EHR is run as an ASP, the number of IT staff to named users continues to be out of proportion as the CBOs have their own IT staff who are not included.

The MHP has 1,960 named users with log-on authority to the EHR, including approximately 540 county-operated staff and 1420 contractor-operated staff. Support for the users is provided by 11 full time equivalent (FTE) IS technology positions which has not changed since last year. Currently there is one vacancy. It is noted that these IT staff are a pool of resources dedicated to the MHP (including both MH and DMC-ODS).

As of the FY 2021-22 EQR, all contract providers have access to document imaging/scanning and care coordination/client resources; approximately 70 percent 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
☒	Direct data entry into MHP IS by provider staff	☒ Daily ☒ Weekly ☒ Monthly	90%
☒	Documents/files e-mailed or faxed to MHP IS	☒ Daily ☒ Weekly ☒ Monthly	10%
			100%

Beneficiary Personal Health Record (PHR)

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 plans to implement a beneficiary PHR within the next two years.

Interoperability Support

The MHP is a member of an HIE. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: both MH and SUD community-based 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 Component – IS Infrastructure

KC #	Key Component – 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	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Met

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

- The MHP has doubled its IT budget from last year's 2.0 percent to 4.12 percent.
- The MHP's roll-out of multi-factor authentication greatly increases security of the system as a whole.
- The MHP maintains consistent claims volume with an annual denial rate of 2.65 percent, reduced from last year's 3.4 percent. The current year's denial rate is .75 percent below last year's state average of 3.4 percent. 4B has a Partially Met finding as one of five items, maintain a Data Warehouse, has not been met. The MHP reports that they run reports and obtain data when necessary and as needed.

IMPACT OF FINDINGS:

- The MHP has a unique IT structure that while appearing to be disconnected from management is universally praised as providing data and support in a timely manner.
- The inclusion of management and IT staff in the monthly Avatar meeting promotes effective and good working relationships. Open communication, responsiveness to requests, and IT innovation result in a high level of satisfaction.
- The MHP's consistently strong volume of Medi-Cal billing results in a reliable cash-flow.
- Failure to fully implement the scheduler hinders the agency's ability to measure capacity, impeding efforts to decrease wait times and overloaded caseloads.
- Beneficiary engagement could be enhanced if a PHR were available. It has been on a list to implement for several years.
- While the MHP offers a variety of EHR trainings, feedback from a focus group of providers was consistent that it is insufficient, citing the need to provide additional in-house trainings.

- By joining the HIE, CareQuality, the MHP is increasing access to the EHR. This increased access could be enhanced by the implementation of a PHR.

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 created a new system to ensure beneficiaries were included in results from the CPS survey. It was decided to post CPS results to the BHS website. At that time a notification and link will be sent to providers with the direction to pass notice and link to beneficiaries and families. Due to the DHCS cancelation of the November cycle, the MHP will post the results of the June CPS cycle when the report is complete.

The MHP analyzes results of each CPS and created a written report on the analysis of data. This analysis includes examination of disparities by race, ethnicity, and language. Findings are used in the creation of plans to address issues that are highlighted in the CPS.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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 three 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held via virtual platform (Zoom) and

included five participants; no language interpreter was used for this focus group. All consumers participating receive/have a family member who receives clinical services from the MHP.

Most participants reported that the initial entry into services was timely, and that the MHP assisted them in accessing services. The time between appointments is approximately once a month for psychiatrists, or as needed. There was general agreement among participants that they knew what to do if they missed an appointment, and that they receive text messages or reminder calls prior to appointments. All participants were aware of a warm line, peer partners, and ways to reach out if in crisis. However, none of the participants knew of the BHS website. All participants felt the staff were supportive and addressed their cultural and linguistic needs. Only one participant appeared to know what a Wellness Center was; however, all remarked on different types of drop-in centers that they had accessed.

Recommendations from focus group participants included:

- Participants express a need for more organized and available information on how to get transportation to/from services.
- Most participants reported feeling insecure about housing due to lack of clarity on rules on length of stay, how to ensure somewhere to go when time in one place runs out, and secure housing in general.
- Many participants would like groups (therapy and otherwise) to return, even if it were virtual. They reported feeling cut off from their peers during the pandemic.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of transition age youth (TAY) consumers who initiated services in the preceding 12 months. The focus group was held via virtual platform (Zoom) and included five participants; no language interpreter was used for this focus group. All consumers participating receive/have a family member who receives clinical services from the MHP.

Most participants reported that the initial entry into services was timely; however, appointments for therapy and psychiatry were slow once admitted. Time between appointments was reported as adequate, one to two weeks, or as needed for clinical appointments. Psychiatry is monthly, or as required for medication evaluations. The participants thought this was generally enough, although at times it stretches out timewise between sessions. Most of the participants were unaware of opportunities within the MHP or other agencies to volunteer or be paid for work. If an appointment is missed the participants can reschedule through email, text, or by phone. The next available appointment may be a longer wait than desired. All participants were aware of how to reach and to where in the event they are in crisis. All participants felt the staff were supportive and addressed their cultural and linguistic needs. Due to the pandemic

restrictions, Wellness Centers are by appointment and participants reported that they are difficult to obtain.

Recommendations from focus group participants included:

- More outreach is needed for suicide prevention.
- Staff turnover is a barrier to continued recovery.
- There is a need for more and better outreach to the TAY population.

Consumer Family Member Focus Group Three

CalEQRO requested a diverse group of caretakers of school age children who initiated services in the preceding 12 months. The focus group was held via virtual platform (Zoom) and included six participants; two language interpreters (Dari and Spanish) were used for this focus group. All consumers participating receive/have a family member who receives clinical services from the MHP.

The participants reported that the initial entry into services was timely, and that the MHP, and often the child's school, assisted them in accessing services. Time between appointments was reported as adequate, one to two weeks, or as needed for clinical appointments; and psychiatry, if needed, is according to the psychiatrist's decision of frequency. If an appointment is missed the participants can reschedule through email, text or by phone. The next available appointment may be a longer wait than desired. All participants were aware of how to reach and to where in the event they are in crisis. All participants felt the staff were supportive and addressed their cultural and linguistic needs. While satisfied with the treatment that their children received, some participants expressed feelings of stigma of their child receiving mental health services. They felt that not knowing English was the child's real issue in one case; and, in another case the parent thought the child needed help with education and that applying mental health treatment is detrimental.

Recommendations from focus group participants included:

- The participants offered no recommendations and overall were satisfied with services that their children were receiving.

IMPACT OF FINDINGS

Overall, beneficiaries attending the three CFM focus groups reported they are receiving adequate services that are generally timely. The MHP keeps them informed (text and telephone reminders) of when they have appointments and how to reschedule as necessary. They receive information on how to access crisis services. All those interviewed agreed that their service providers are supportive, engaged in facilitating their recovery, and that their cultural and linguistic needs are respected and addressed.

Turnover of staff was mentioned as a barrier to optimum service delivery, and at times decreased timely appointments ongoing. The need for virtual service delivery due to the COVID-19 Public Health Emergency has resulted in beneficiaries being able to continue services; however, many noted a disconnected feeling at not being in a group, often not even a virtual one. These two issues will need to be addressed when the MHP returns to in-person services as the pandemic recedes.

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. Telehealth implementation for most outpatient services during the COVID-19 Public Health Emergency restrictions has ensured beneficiaries continuity in access during this time. (Access)

2. Decreasing trends in inpatient utilization, including fewer unduplicated beneficiaries admitted, fewer overall hospital admissions, and a 44 percent reduction in average LOS, accompanied by increased post hospital discharge follow-up rates and decreased readmissions, suggest meaningful improved beneficiary outcomes. (Timeliness, Quality)

3. Peer employment exists across the contracted agencies and is on the precipice of being part of the MHP work force. (Quality)

4. The MHP's roll-out of multi-factor authentication greatly increases security of the system as a whole. (IS)

5. The MHP has established interoperability by joining the local Health Information Exchange (HIE): CareQuality. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP continues historically to report low penetration rates for FC, Latino/Hispanic, and API beneficiaries. (Access)

2. Approximately 93.83 percent of SMHS were delivered by contractor-operated/staffed clinics and sites. Contracted organizations report significant challenges in recruiting staff. There have been many resignations and departure from positions for a variety of reasons; this coupled with lack of competitive salaries and benefits, creates an unsustainable situation. (Access)

3. The MHP does not track and report urgent service requests that do not require prior authorization and have a DHCS 48 hours standard, and it does not monitor the beneficiaries who request urgent services but who do not follow up with the referral to MHUUC. (Timeliness)

4. The MHP currently has neither a standard nor does it track and report no-shows for psychiatrists and/or clinicians other than psychiatrist. (Timeliness)

5. The MHP does not have a universally utilized LOC tool. (Quality)

RECOMMENDATIONS

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

1. Continue work in Cultural Competency and Quality Improvement Committees to reduce barriers to access for FC, Latino/Hispanic, and API beneficiaries, and, implement ways to increase outreach. (Access)

2. Research and implement strategies to support recruitment and retention in collaboration with contracted agencies. (Access, Quality)

3. Develop and implement a system to accurately track and report urgent service requests, including requests that do not require prior authorization and for beneficiaries who request urgent services but who do not follow up with the referral to MHUUC. (Timeliness)

4. Develop and implement a system to accurately track and report no-shows for psychiatrists and/or clinicians other than psychiatrists. (Timeliness)

5. Select and implement a level of care (LOC) tool for universal use across the system of care. (Quality)

SITE REVIEW BARRIERS

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

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

Sacramento
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
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Clinical Management and Supervision
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Community-Based Services Agencies Group Interview
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

Sacramento
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer

Kiran Sahota, Quality Reviewer

Lamar Brandysky, Information Systems Reviewer

Gloria Marin, Consumer Family member Reviewer

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.

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Adams	Rolanda	Program Coordinator	Sacramento County Behavioral Health
Anderson	Dana		
Bader	Sandena	Family and Youth Advocate Liaison	Cal Voices
Barney	Robin	Family Advocate Liaison	Cal Voices
Blackman	Brandi		Telecare SOAR
Bliss	Erin		Sacramento County Behavioral Health
Davis	Danielle	Clinician	Telecare SOAR
Duthler	Kristina		
Fortes	Mary Ann	Senior Accountant	Sacramento County Behavioral Health
Gerolamo	Matt		Turning Point Urgent Care
Gillette	Robert	Senior Accounting Manager	Sacramento County Behavioral Health

Last Name	First Name	Position	Agency
Grant	Janelle		Sacramento County Behavioral Health
Green	Sheri	Program Manager - Children's Services	Sacramento County Behavioral Health
Grizoffi	Shawna	Clinician	Telecare Arise
Hark	Roxanne	Clinician	Dignity Health Children's
Hawkins	Pamela	Program Coordinator	Sacramento County Behavioral Health
Hayward	Audrey		Turning Point
Her	Pahoua		Sacramento County Behavioral Health
Ibarra	Melony	Administrative Services Officer II	Sacramento County Behavioral Health
Jacobs	Melissa	Division Manager – Children's Services	Sacramento County Behavioral Health
Jurkovich	Jessica		River Oaks Center for Children
Kelly	Stephanie	Program Manager – Adult Services	Sacramento County Behavioral Health
Kesselring	Rob	Program Manager - Children's Services	Sacramento County Behavioral Health
Kunker	Shelly		
Kushida	Leslie	Clinician	Visions Unlimited
Lane	Rachel		Dignity Health
Leung	Julie	Acting Program Manager – MHSA	Sacramento County Behavioral Health
Long	Samantha	Clinician	River Oak- Center for Children
Mayer	Joaquin	Clinician	Sacramento Children's Home
McClure	Erin	Program Coordinator	Sacramento County Behavioral Health
Minasayan	Lusine	Clinician	Dignity Health Children's
Mitchell	Ann	Administrative Services Officer 3 – Avatar Training & Support/DBHS Billing	Sacramento County Behavioral Health

Last Name	First Name	Position	Agency
Mutinda	Peggy		Addicted to Health
Nakamura	Mary	Program Manager – Cultural Competence/Ethnic Services	Sacramento County Behavioral Health
Ngo-Agard	Alexus	Clinician	Heartland CFS
Owens	Whitney	Program Planner	Sacramento County Behavioral Health
Panyala	Anantha	Division Manager – Mental Health Treatment Center	Sacramento County Behavioral Health
Quinley	Matt	Program Manager – Children's Services	Sacramento County Behavioral Health
Quist	Ryan	Deputy Director – Division of Behavioral Health	Sacramento County Behavioral Health
Rechs	Alex	Program Manager – Quality Management	Sacramento County Behavioral Health
Reedy	Meghan		Reedy- heartland CFS
Reiman	Jennifer		
Rickards	Kris		Sac Children's Home- FIT
Riddell	JR	Clinician	Stanford and Sierra Youth and Family
Rowell	Liz		Turning Point RST
Sawyer	John	IT Analyst II	Sacramento County Behavioral Health
Sincliar	Martha		El Hogar Community Services
Skalsky	Robin		Sacramento County Behavioral Health
Taylor	Eryca		Sacramento County Behavioral Health
Thompson	Alondra		
Twitchell	Geoff		
Umayam	Maria	Senior Accountant	Sacramento County Behavioral Health

Last Name	First Name	Position	Agency
Veal	Hailey	Clinician	Turning Point PATHWAYS
Wan	Emily	Clinician	Turning Point RST
Weaver	Kelli	Division Manager – Adult Services	Sacramento County Behavioral Health
Williams	Dawn	Program Manager – Research, Evaluation and Performance Outcomes	Sacramento County Behavioral Health
Wilson	Kari	Senior Administrative Analyst	Sacramento County Behavioral Health
Yamamoto	Patrick		Telecare Arise
Zakhary	Jane Ann	Division Manager – Administration, Planning and Outcomes	Sacramento County Behavioral Health

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☒ →High confidence ☐ →Moderate confidence ☐ →Low confidence ☐ →No confidence	Credible, reliable, and valid methods for the PIP were documented The MHP reported a low significance of improvement in the no-show rate, yet a high rate of beneficiary engagement. The limited opportunity for in-person services may have also contributed to the lack of change in service utilization. The MHP reported the conclusion of the PIP as of August 2021.
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Sacramento MHP	
PIP Title: "Improving Access, Engagement and Satisfaction Through Telehealth Services "	
PIP Aim Statement: **a.** **"**Will providing telehealth services from office to beneficiary's home improve engagement, access, and satisfaction of services, while decreasing no shows and cancelations during a 12-month period?"	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one):	

☐ Children only (ages 0–17) * ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): The study population consists of all MHP beneficiaries receiving outpatient services via telehealth**.**
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) Beneficiaries will improve their ability to engage in clinical appointments, crisis intervention, case management and medication support through telehealth services.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Providers to conduct sessions via telehealth, including Medication Support, clinical and peer/advocate staff.
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) MHP to utilize telehealth to provide mental health, crisis intervention, case management, medication support and peer services

Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent remeasure-ment year (if applicable)**	**Most recent remeasure-ment sample size and rate (if applicable)**	**Demon-strated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Change in service delivery (duration by service type)	2020	Case Management Brokerage: C = 85.3 A = 72.4 Crisis Intervention: C = 1.8	☐ Not applicable—PIP is in Planning or implementation phase, results not available	Case Management Brokerage: C = 134.4 A =76.6	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05

		A = 3.2 Medication Services: C = 22.9 A = 49.6 Mental Health: C = 659.9 A = 359.5 Peer Services: C = .06 A = 20.1 Engagement: C = 0.6 A = 6.3		Crisis Intervention: C = 3.0 A = 2.8 Medication Services: C = 20.6 A = 54.8 Mental Health: C = 559.2 A = 257.2 Peer Services: C = 2.7 A = 54.8 Engagement: C = 2.8 A = 3.7		Other (specify):

Change in service delivery (frequency by service type)	2020	Average Number of Services Per beneficiary: Case Management Brokerage: C = 2.0 A = 2.0 Crisis Intervention: C = 0.4 A = 0.1 Medication Services: C = 0.47 A = 1.6 Mental Health: C = 8.54 A = 4.5 Peer Services: C = 0.3 A = 0.7 Engagement: C = 0.1 A = 0.2	☐ Not applicable—PIP is in Planning or implementation phase, results not available 2021	Average Number of Services Per beneficiary: Case Management Brokerage: C = 3.8 A = 2.5 Crisis Intervention: C = 0.1 A = 0.1 Medication Services: C = 0.5 A = 1.7 Mental Health: C = 9.5 A = 4.0 Peer Services: C = 0.1 A = 0.9 Engagement: C = 0.2 A = 0.2	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Change in no-shows	2020	Average Number of No-shows Per beneficiary C = 0.63 A = 0.5	☐ Not applicable—PIP is in Planning or implementation phase, results not available 2021	Average Number of No Shows Per beneficiary C = 1.11 A = 0.6	☒ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Change in cancellations	2020	Average Number of Cancellations Per beneficiary C = 0.64 A = 0.5	☐ Not applicable—PIP is in Planning or implementation phase, results not available 2021	Average Number of Cancellations Per beneficiary C = 0.64 A = 0.1	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Beneficiary satisfaction with telehealth 1	2020	Q10.1 = 41.0% Q10.2 = 39.6% Q10.3 = 42.2% Q10.4 = 61.8%	☐ Not applicable—PIP is in Planning or implementation phase, results not available 2021	Q6.1 = 81.0% Q6.2 = 72.3% Q6.3 = 88.7% Q6.4 = 73.1% Q6.5 = 74.5%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Beneficiary satisfaction with access to care	2020	Q6.1 = 75.9% Q6.2 = 70.7% Q6.3 = 79.6% Q6.4 = 47.1% Q6.5 = 56.9%	☐ Not applicable—PIP is in Planning or implementation phase, results not available 2021	Q6.1 = 81.0% Q6.2 = 72.3% Q6.3 = 88.7% Q6.4 = 73.1% Q6.5 = 74.5%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Beneficiary satisfaction with use of system	2020	Q7.1 = 66.3% Q7.2 = 65.9% Q7.3 = 62.5%	☐ Not applicable—PIP is in Planning or implementation phase, results not available 2021	Q7.1 = 75.7% Q7.2 = 80.0% Q7.3 = 80.7%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Beneficiary satisfaction with service provider interaction	2020	Q9.1 = 88.1% Q9.2 = 72.9% Q9.3 = 84.0% Q9.4 = 70.0% Q9.5 = 65.5%	☐ Not applicable—PIP is in Planning or implementation phase, results not available 2021	Q9.1 = 88.7% Q9.2 = 76.7% Q9.3 = 85.3% Q9.4 = 70.1% Q9.5 = 70.1%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Staff satisfaction with telehealth	2020	Q10.1 L = 81.5% MHA = 69.4% MHR = 65.0% P/A = 50.0% Pr = 80.0% Q10.2 L = 86.6% MHA = 69.6% MHR = 69.5% P/A = 71.4% Pr = 93.3% Q10.3 L = 51.8% MHA = 59.0% MHR = 50.9% P/A = 67.6% Pr = 33.3% Q10.4 L = 81.9% MHA = 66.2%	☐ Not applicable—PIP is in Planning or implementation phase, results not available 2021	Q10.1 L = 93.1% MHA = 76.3% MHR = 88.2% P/A = 88.2% Pr = 85.7% Q10.2 L = 96.6% MHA = 78.9% MHR = 90.9% P/A = 100.0% Pr = 85.7% Q10.3 L = 72.5% MHA = 71.9% MHR = 67.7% P/A = 87.5% Pr = 50.0% Q10.4 L = 90.8% MHA = 81.6%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

		MHR = 59.3% P/A = 61.1% Pr = 71.4% Q10.5 L = 80.3% MHA = 67.1% MHR = 66.7% P/A = 58.3% Pr = 100.0%		MHR = 76.5% P/A = 81.3% Pr = 100.0% Q10.5 L = 89.5% MHA = 73.7% MHR = 87.9% P/A = 88.2% Pr = 100.0%		
Staff satisfaction with use of system	2020	Q8.1 L = 76.2% MHA = 72.6% MHR = 70.0% P/A = 62.2% Pr = 76.9% Q8.2 L = 72.8% MHA = 68.5% MHR = 68.3% P/A = 59.5% Pr = 84.6% Q8.3 L = 60.9% MHA = 57.5% MHR = 55.9% P/A = 68.4% Pr = 84.6%	☐ Not applicable—PIP is in Planning or implementation phase, results not available 2021	Q8.1 L = 95.5% MHA = 82.1% MHR =93.9 % P/A = 100.0% Pr = 85.7% Q8.2 L = 89.8% MHA = 74.4% MHR = 84.8% P/A = 75.0% Pr = 85.7% Q8.3 L = 80.7% MHA = 79.5% MHR = 78.8% P/A = 85.7% Pr = 71.4%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Staff satisfaction with service provider interaction	2020	Q9.1 L = 63.6% MHA = 55.9% MHR = 62.3%	☐ Not applicable—PIP is in Planning or implementation phase, results not	Q9.1 L = 79.3% MHA = 81.1% MHR = 69.7%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value:

		P/A = 67.6% Pr = 78.6% Q9.2 L = 64.0% MHA = 63.2% MHR = 49.1% P/A = 52.9% Pr = 78.6% Q9.3 L = 65.0% MHA = 69.1% MHR = 69.8% P/A = 47.1% Pr = 85.7% Q9.4 L = 35.3% MHA = 44.1% MHR = 28.8% P/A = 33.3% Pr = 46.2% Q9.5 L = 50.7% MHA = 47.5% MHR = 40.0% P/A = 44.4% Pr = 66.7%	available 2021	P/A = 64.7% Pr = 85.7% Q9.2 L = 81.4% MHA = 70.3% MHR = 81.3% P/A = 76.5% Pr = 85.7% Q9.3 L = 83.9% MHA = 83.8% MHR = 81.3% P/A = 82.4% Pr = 100.0% Q9.4 L = 49.4% MHA = 61.1% MHR = 45.2% P/A = 53.9% Pr = 57.1% Q9.5 L = 60.8% MHA = 52.0% MHR = 77.3% P/A = 71.4% Pr = 100.0%		☐ <.01 ☐ <.05 Other (specify):
Staff satisfaction with access to care	2020	Q7.1 L = 75.5% MHA = 66.7% MHR = 63.8%	☐ Not applicable—PIP is in Planning or implementation phase, results not	Q7.1 L = 92.0% MHA = 84.2% MHR = 81.8%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value:

		P/A = 51.4% Pr = 100.0% Q7.2 L = 61.2% MHA = 65.5% MHR = 74.0% P/A = 48.1% Pr = 83.3% Q7.3 L = 64.8% MHA = 66.2% MHR = 63.5% P/A = 54.8% Pr = 66.7% Q7.4 L = 84.5% MHA = 82.4% MHR = 80.4% P/A = 75.8% Pr = 100.0% Q7.5 L = 39.6% MHA = 43.9% MHR = 40.7% P/A = 33.3% Pr = 35.7% Q7.6 L = 70.6% MHA = 59.5%	available 2021	P/A = 88.2% Pr = 85.7% Q7.2 L = 73.5% MHA = 77.1% MHR = 73.3% P/A = 69.2% Pr = 100.0% Q7.3 L = 67.9% MHA = 83.3% MHR = 78.1% P/A = 82.4% Pr = 85.7% Q7.4 L = 90.1% MHA = 86.1% MHR = 87.5% P/A = 100.0% Pr = 66.7% Q7.5 L = 64.8% MHA = 63.2% MHR = 51.5% P/A = 75.0% Pr = 75.0% Q7.6 L = 80.8% MHA = 72.0%		☐ <.01 ☐ <.05 Other (specify):

		MHR = 56.7% P/A = 68.4% Pr = 100.0%		MHR = 90.0% P/A = 85.7% Pr = 80.0%		

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): Completed

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: The MHP reported a low significance of improvement in the no-show rate, yet a high rate of beneficiary engagement. The limited opportunity for in-person services may have also contributed to the lack of change in service utilization. The MHP reported the conclusion of the PIP as of August 2021.

Non-Clinical PIP

Table C2: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☒ →Moderate confidence ☐ →Low confidence ☐ →No confidence	Credible, reliable, or valid methods were implied or able to be established for part of the PIP. However, the MHP saw a reduction in no-show/cancelations that can be attributed to telehealth verse the PIP intervention. The MHP identified a need for enhanced communication with the hospital. Due to the Pandemic, beneficiaries were not discharged in a timely manner which impacted the MHP's ability to study the time from discharge to walk-in services.
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name:	
PIP Title:	
PIP Aim Statement: **a.** Will utilizing the Adult Psychiatric Support Services (APSS) program as an assessment center and providing appointments prior to or at the time the beneficiary discharges from the hospital increase the follow up to hospitalization intake appointments from 34.7 percent to 50 percent?	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17) * ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify):	
Improvement Strategies or Interventions (Changes in the PIP)	

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Beneficiaries will receive a timely assessment within 7-days of discharge.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Hospitals will notify MP of beneficiary discharge.
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) Walk-in assessment center will schedule outpatient appointments prior to beneficiary being discharged from the hospital.

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
Timeliness to 1st assessment appointment after inpatient hospital discharge (unlinked beneficiaries)	CY2019	10.1%	☐ Not applicable—PIP is in Planning or implementation phase, results not available CY 2020	4th Qtr (Oct-Dec 2020) 9.1% 4th Qtr – 30.5% decrease from 3rd quarter 9.9% decrease from baseline	☐ 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
No shows prior to first appointment	CY 2019	5.4%	☐ Not applicable—PIP is in Planning or implementation phase, results not available CY 2020	4th Qtr (Oct-Dec 2020) 1.2% 4th Qtr – 7.7% decrease from 3rd quarter 77.7% decrease from baseline	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Cancellations prior to first appointment	CY 2019	3.4%	☐ Not applicable—PIP is in Planning or implementation phase, results not available CY 2020	4th Qtr 0.0% No change from 3rd quarter 100% decrease from baseline	☐ 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): completed 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: The MHP saw a reduction in no show/cancelations that can be attributed to telehealth verse the PIP intervention. The MHP identified a need for enhanced communication with the inpatient hospitals. Due to the pandemic, beneficiaries were not discharged in a timely manner which impacted the MHP's ability to study the time from discharge to walk-in services. The MHP is encouraged to create a process for timeliness with their hospital partners.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Sacramento 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
Large	31,253	2,174	6.96%	$12,033,576	$5,535
MHP	148,687	5,100	3.43%	$24,990,851	$4,900

Table D2: CY 2020 Distribution of Beneficiaries by ACB Range

Sacramento 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	21,793	93.82%	92.22%	$91,833,266	$4,214	$4,399	64.41%	56.70%
>$20K-$30K	791	3.41%	3.71%	$18,998,745	$2,814	$24,274	13.32%	12.59%
>$30K	644	2.77%	4.07%	$31,752,324	$49,305	$53,969	22.27%	30.70%

Table D3: Summary of CY 2020 Short-Doyle/Medi-Cal Claims

Sacramento MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
TOTAL	765,110	$142,770,359	14,860	$3,778,021	2.65%	$138,992,338	$132,735,830
JAN20	62,771	$11,563,407	1,574	$384,187	3.32%	$11,179,220	$10,630,330
FEB20	57,912	$10,955,432	1,350	$341,590	3.12%	$10,613,842	$9,991,021
MAR20	64,377	$12,648,996	1,464	$393,508	3.11%	$12,255,488	$11,645,259
APR20	70,562	$12,044,782	1,522	$347,162	2.88%	$11,697,620	$11,135,944
MAY20	63,535	$11,728,751	1,013	$235,953	2.01%	$11,492,798	$11,023,195
JUN20	67,055	$12,744,922	1,169	$263,755	2.07%	$12,481,167	$12,106,886
JUL20	67,443	$12,436,820	1,241	$299,466	2.41%	$12,137,354	$11,257,418
AUG20	65,847	$12,337,596	1,200	$328,092	2.66%	$12,009,504	$11,176,803
SEP20	65,221	$12,366,730	1,101	$304,272	2.46%	$12,062,458	$11,737,561
OCT20	66,622	$12,387,136	1,094	$271,912	2.20%	$12,115,224	$11,785,718
NOV20	56,849	$10,822,744	1,099	$308,141	2.85%	$10,514,603	$10,129,726
DEC20	56,916	$10,733,045	1,033	$299,982	2.79%	$10,433,063	$10,115,971

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 D4: Summary of CY 2020 Top Five Reasons for Claim Denial

Sacramento 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	5,273	$1,214,006	32%
Claim/service lacks information which is needed for adjudication	3,013	$826,809	22%
Beneficiary not eligible or non-covered charges	1,589	$493,699	13%
Beneficiary not eligible	898	$358,928	10%
Rendering provider taxonomy code does not march Service Facility location	1,346	$310,429	8%
TOTAL	**12,119**	**$3,203,871**	**85%**