Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 402
Emeryville, CA 94608

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

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

ALAMEDA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

October 26-28, 2021

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EXECUTIVE SUMMARY

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

MHP INFORMATION

MHP Reviewed — Alameda

Review Type — Virtual

Date of Review — October 26-28, 2021

MHP Size — Large

MHP Region — Bay Area

MHP Location — Oakland

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 18,874

MHP Threshold Language(s) — English, Spanish, Cantonese, Mandarin, Vietnamese

SUMMARY OF FINDINGS

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

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

- Access to Care: 100 percent (4 of four components)
- Timeliness of Care: 100 percent (6 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 of the required Performance Improvement Projects (PIPs). The clinical PIP, “Reducing Psychiatric Emergency Services Recidivism through Pre-Discharge Visits/Follow-up Texts”, was found to be active with a moderate confidence validation rating. The non-clinical PIP, “Care Coordination with Primary Care”, was found to be in the planning phase with a low confidence validation rating.

CalEQRO conducted two consumer family member focus groups, comprised of one and 12 participants, respectively.

SUMMARY OF STRENTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: 1) a thoughtful and well-developed cultural competence plan and diverse staff; 2) use of data to adapt capacity and meet beneficiary crisis needs, resulting in decreased psychiatric inpatient admissions; 3) a robust Quality Improvement (QI) work plan and data tracking approach; 4) use of Yellowfin dashboards; and 5) participation in the community Health Information Exchange (HIE).

The MHP was found to have notable opportunities for improvement in the following areas: 1) a disproportionately low percentage of Asian/Pacific Islander (API) beneficiaries being served; 2) despite an overhaul to the MHP's website, crisis services information is not prominently displayed; 3) beneficiaries report mixed experiences with timeliness; 4) the need for a peer career ladder; and 5) stakeholders for both the County and Community Based Organization (CBO) providers do not experience bidirectional communication with MHP leadership and management.

FY 2021-22 CalEQRO recommendations for improvement include: 1) investigate the disproportionately low percentage of API beneficiaries served and implement strategies to ameliorate findings, if warranted; 2) evaluate and improve the MHP website for ease of use and access to crisis services information, wellness centers and rapid language options; 3) investigate beneficiaries' experiences with timeliness across the system, implement strategies, and begin to address; 4) develop a peer career implementation plan; and 5) improve bidirectional communication with MHP leadership and management.

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 Alameda County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on October 26-28, 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, which continues to impact the service delivery system. The MHP discontinued some services such as the wellness centers; shifted to telehealth services, including telephonic; and experienced more frequent staff absences and departures due to illness, stress, and family obligations. 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 began a quarterly departmental newsletter to communicate with internal staff and external CBO stakeholders. So far, March and July 2021 issues were distributed, with content centered on departmental news and initiatives.
- The MHP formed three budget teams: a Budget Executive Committee, Budget Work Group, and a Budget Stakeholder Advisory Committee to generate solutions to mitigate revenue deficit and become a more viable system beyond the COVID-19 pandemic.
- In April 2021, the MHP expanded the number of professionals permitted to place and/or lift Lanterman-Petris-Short (LPS) holds (5150/5585) through a pilot project with five CBOs.
- In anticipation of California Advancing and Innovating Medi-Cal (CalAIM), the MHP submitted a proposal to its local managed care plans to serve as an Enhanced Care Management (ECM) provider and to integrate CalAIM ECM Services into three county-operated Adult Community Support Centers (CSCs).
- The MHP aligned its QI operations with CalAIM revisions to medical necessity and documentation requirements. Further, the Non-Clinical PIP is dedicated to CalAIM processes.
- The MHP overhauled its agency website for easier access, including translation for all threshold languages.

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: Investigate reasons for children's urgent appointments not meeting the 48-hour standard. Implement interventions as barriers to timely access are identified.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- On investigation, the MHP found that the definition of "urgent" had been inconsistent. It will be training staff on a new operational definition of "urgent."
- The Quality Management (QM) team investigated the data underlying the children's urgent appointment outcomes from the previous year and corrected the data from 33.3 percent to 52.3 percent meeting the standard.

Recommendation 2: The MHP must offer a psychiatric appointment within the 15-business day standard. The MHP should comply with the state timeliness metric as per Behavioral Health Information Notices (BHIN) 18-011.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP added an objective to improve timeliness for routine psychiatric appointments into the FY 2020 21 QI Work Plan (QIWP). Action steps are to improve provider compliance with submitting data, create an automated tool for tracking timeliness, and analyze timeliness data.

- The MHP performed a trend analysis to identify providers with high and low telepsychiatry to develop a strategy to expand telepsychiatry for populations with less access to services.
- The MHP expanded the number of locum tenens contracts to enhance the capacity of its clinics.
- The MHP is creating a dynamic web-based application for the Access unit. This will provide information about psychiatry appointment availability to improve timely access to psychiatry.

Recommendation 3: Evaluate the current role of parents/caregivers in assessment, treatment planning and post discharge planning of youth. Include parents/caregiver feedback in evaluation. Expand/augment opportunities where appropriate.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP reviewed the role of parents/caregivers with the Child and Young Adult System of Care (CSOC) Leadership, including the System of Care (SOC) Director, Division Director of Outpatient Clinics, Division Director for Transition Age Youth, and Clinic Managers for Children's Specialized Services and Oakland Children's Clinic.
- The MHP plans to update the website to facilitate navigation, providing more information to support families/caregivers in understanding MHP's system.
- The MHP plans to include a new "Children's" tab on the webpage which will include drop down menus for different modalities of services and accordion tabs for special programs such as school-based and "specialty" programs (i.e., foster care youth, Child Welfare, Probation, and eating disorders).

Recommendation 4: Investigate reasons for low rate of timely post hospital discharge appointments for FC youth. Implement interventions as barriers to timely post hospital discharge appointments are identified.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- For FC, 38 percent of follow-up appointments after psychiatric hospital discharge met the seven-day standard. QI staff conferred with CSOC leadership to identify reasons for non-timely post hospital discharge appointments. CSOC identified two processes for improvement which could potentially impact timeliness for FC post-discharge appointments if processes were streamlined.
- The MHP initiated the following improvement activities earlier this month: updated referral forms for hospital appointments and updated the Access protocol for school-based providers. The MHP is encouraged to monitor processes to determine if these activities yield the desired results.

Recommendation 5: Investigate reasons for increasing readmission rate for FC. Implement interventions as causes are identified.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- QI staff conferred with CSOC leadership to discuss reasons for increasing readmission.
- The primary cause identified is when Short Term Residential Therapeutic Program (STRTP) beneficiaries transition placements. The highest number of referrals come from STRTPs. In addition, beneficiaries who re-enter Alameda County as AB 1299 Presumptive Transfers from other counties traditionally have high utilization of psychiatric emergency services.
- For this reason, CSOC will continue to work on improving the transition between STRTPs and for presumptive transfer beneficiaries from other counties through new inter-county collaborations as mandated by the State under SB 2083. At the time of the review, the multijurisdictional memorandum of understanding (MOU) between partner agencies was on track for approval in October 2021.

Recommendation 6: Continue work on hosting a public website with aggregated Yellowfin performance dashboards and expand access to all contract providers as soon as practical.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP is updating its website to display aggregate graphs and reports from dashboards by October 2021.
- The MHP included goals for making Yellowfin dashboards available to all contracted providers and publicly available as a QI project in its annual QIWP, both in FY 2020-21 and FY 2021-22.
- The MHP coordinated with the Interim Privacy Officer and the IS account/security staff to streamline the current process for MHP staff and contracted providers to sign up for Yellowfin while still adhering to privacy/security best practices for information systems management.
- The MHP's Data Services Team and QM/QI analysts selected a "suite" of dashboards to automatically set up for contracted providers to see their key metrics when they create Yellowfin accounts.

Recommendation 7: Monitor project management staffing closely during the new billing/managed care systems implementation, with special attention to the use of subject matter staffing resources adequate to support the project as well as efficiently manage current systems.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has delegated project management to an IS manager, who is leading implementation of the new billing system.
- The Project Manager oversees a Steering Committee for SmartCare implementation.
- The SmartCare Steering Committee identified a Core Team of representative stakeholders with subject matter expertise including staff from Information Services, Billing and Benefits, QM, Access, SOC, County and CBOs.
- The MHP established a weekly Moratorium Committee in October 2021 to manage change requests to its current information systems applications (InSyst, eCura, and Clinician's Gateway) during the transition to new systems. The Moratorium change request process controls change requests to ensure the SmartCare Billing Implementation remains on schedule and within budget and provides the agreed-upon deliverables.

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 Alameda County, the time and distance requirements are 30 minutes and 15 miles for outpatient mental health and psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services

and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over)[1].

Alternative Access Standards and Out-of-Network Providers

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

Planned Improvements to Meet NA Standards

Not Applicable.

MHP Activities in Response to FY 2020-21 AAS

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

PROVIDER NPI AND TAXONOMY CODES

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

[1] AB 205 and BHIN 21-023

ACCESS TO CARE

BACKGROUND

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

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

ACCESS IN ALAMEDA COUNTY

SMHS are delivered by both county-operated and contractor operated providers in the MHP. Regardless of payment source, approximately 18.46 percent of services were delivered by county-operated/staffed clinics and sites, and approximately 81.54 percent were delivered by contractor operated/staffed clinics and sites. Overall, approximately 72.02 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 staffed by county-operated staff; beneficiaries may request services through the Access Line as well as through the following system entry points: the community, schools, pediatric offices, internal and external therapists, hospital, and social services. The MHP operates a centralized access team that is responsible for linking most beneficiaries to appropriate, medically necessary services; however, children may also enter through various school referrals. Beneficiaries call the Access line and are screened for symptomology and program qualification, then they are linked to a service provider who schedules an assessment, followed by assignation to an appropriate level of service/program.

In addition to clinic-based mental health services, the MHP provides telehealth and mobile mental health services. Specifically, the MHP delivers psychiatry, crisis, targeted case management, and mental health services via telehealth to youth and adults. In FY 2020-21, the MHP reports having served 5,345 adult beneficiaries, 5,259 youth beneficiaries, and 464 older adult beneficiaries across 14 county-operated sites and 330 contractor-operated sites via telehealth. Among those served, 2,494 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 Components – 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:

- The MHP has a robust cultural plan that is evident in outreach, service delivery, and training, with plans to host a statewide cultural training on mental health, the development of an African American Wellness Hub, and providing special outreach to the Afghan population. Stakeholders indicate that the County and CBOs hire a diverse staff and utilize the language line as needed.
- The MHP's website does not have a transparent crisis connection. Crisis and supervisor sessions validated that information on access and crisis services are developed more regionally and are population- or need-specific.
- The MHP recognizes the importance of using data to identify gaps in service and has included in its QIWP plan to increase the penetration rates by 50 percent for API Medi-Cal beneficiaries.
- For its 330 CBO sites and 14 county sites, recruitment and retention is priority, and although a concern, some stakeholders indicated that their agencies were staffed at 80 percent or higher.

- Stakeholders at various sessions validated active county and agency coordination with hospitals, residential facilities, law enforcement, and social services. Service is available through a flexible continuum versus being siloed.

PERFORMANCE MEASURES

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

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

Total Beneficiaries Served

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

Alameda is one of the larger and more diverse MHPs as evidenced by an overall average monthly beneficiary population of 416,106. Latino/Hispanic, African-American and Asian/Pacific Islander beneficiary populations are all represented in greater numbers than the White beneficiary population. The MHP served 18,874 beneficiaries in CY 2020.

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

Alameda MHP				
Race/ Ethnicity	**Average Monthly Unduplicated Medi-Cal Eligibles**	**Percentage of Average Monthly Medi-Cal Eligibles**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Unduplicated Annual Beneficiaries Served by the MHP**
White	42,329	10.2%	2,815	14.9%
Latino/Hispanic	120,271	28.9%	5,024	26.6%
African-American	69,042	16.6%	5,317	28.2%
Asian/Pacific Islander	92,830	22.3%	1,428	7.6%
Native American	942	0.2%	71	0.4%
Other	90,692	21.8%	4,219	22.4%
Total	**416,106**	**100%**	**18,874**	**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.				

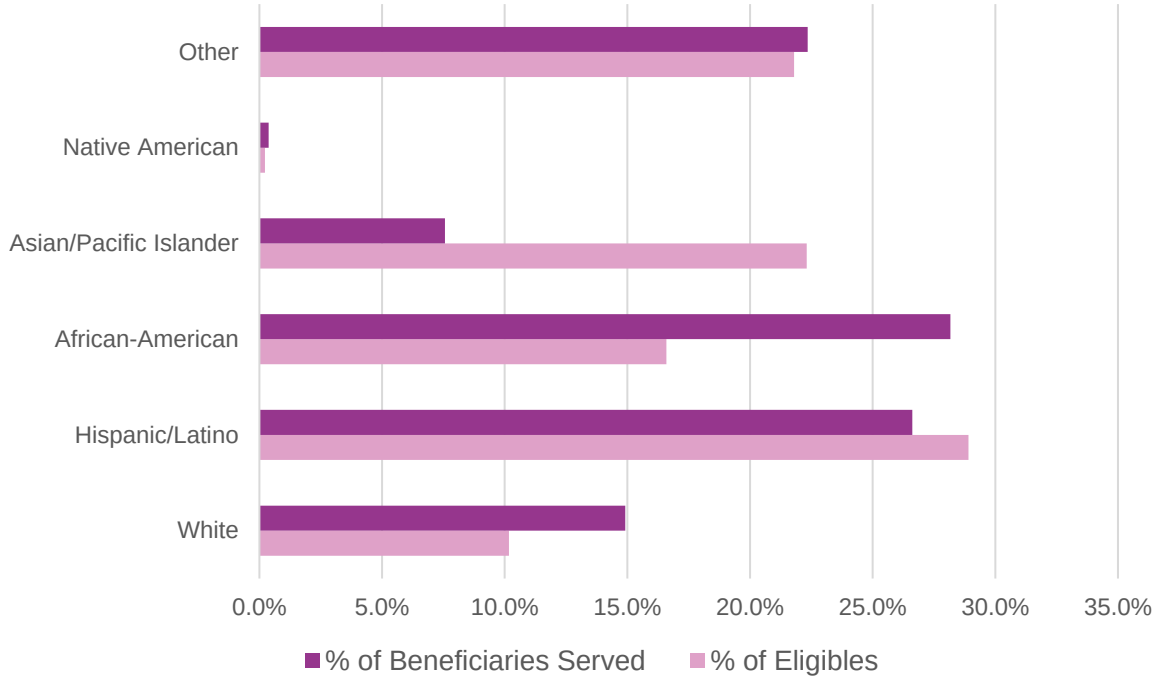
The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

The percentage of Latino/Hispanic beneficiaries served by the MHP (26.6 percent) is comparable to the percentage of Latino/Hispanic beneficiaries who comprise the Alameda County Medi-Cal eligible population (28.9 percent), suggesting parity in access to services for this population.

The percentage of API beneficiaries served by the MHP (7.6 percent) is significantly lower than the percentage of Asian/Pacific Islanders beneficiaries who comprise the Alameda County Medi-Cal eligible population (22.3 Percent), suggesting considerable disparity in access to services for this population.

The percentage of African American beneficiaries served by the MHP (28.2 percent) is more than ten percentage points higher than the percentage of African American beneficiaries who comprise the Alameda County Medi-Cal eligible population (16.6 percent), suggesting an overrepresentation of services to this population.

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



The MHP has four threshold languages in addition to English: Cantonese, Mandarin, Spanish, and Vietnamese. Of these four, Spanish, with 3,138 beneficiaries, is the most frequently represented language, representing 16.6 percent of beneficiaries served by the MHP. The remaining three threshold languages combined account for only 416 of the 18,858 documented unique beneficiaries served, or 2.2 percent.

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

Alameda MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	3138	16.6%
Mandarin	40	0.2%
Cantonese	243	1.3%
Vietnamese	133	0.7%
Other Languages	15,304	81.2%
Total	**18,858**	**100%**
Threshold language source: Open Data per BIN 20-070 Other Languages include English		

Penetration Rates and Approved Claim Dollars per Beneficiary Served

The penetration rate 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.

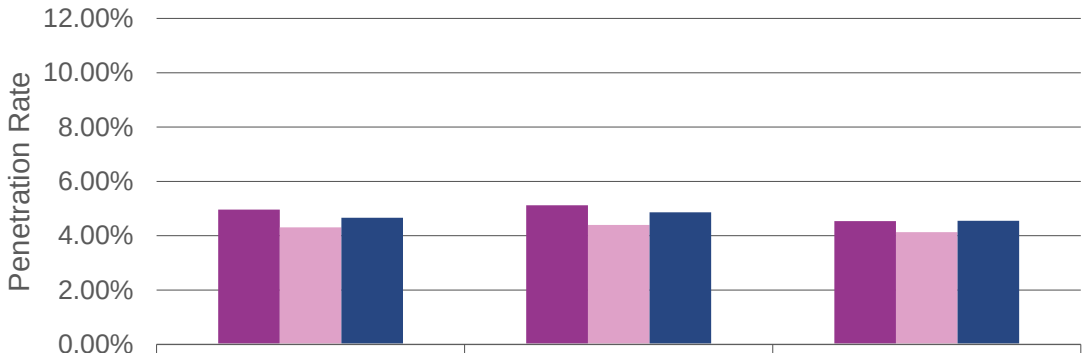
CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. See Table D1 for the CY 2020 ACA penetration rate and ACB.

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.

CY 2020 penetration rates, across the board, have decreased from their CY 2019 levels. The MHP's overall penetration rate of 4.54 percent is in line with the state's average of 4.55 percent. The Bay Area continues to have the highest ACBs among all MHP regions in each category. During the last three years, the MHP's overall ACBs average $3,000 more than the state's averages. The MHP's Latino/Hispanic penetration rate (4.18 percent) is 26 percent higher than the large county average (3.31 percent) and 9 percent higher than the state's average (3.83 percent). Conversely, the MHP's API penetration rate (1.54 percent) is 21 percent lower than the large county average (1.96 percent) and 28 percent lower than the statewide average (2.13 percent).

Figure 2: Overall Penetration Rates CY 2018-20

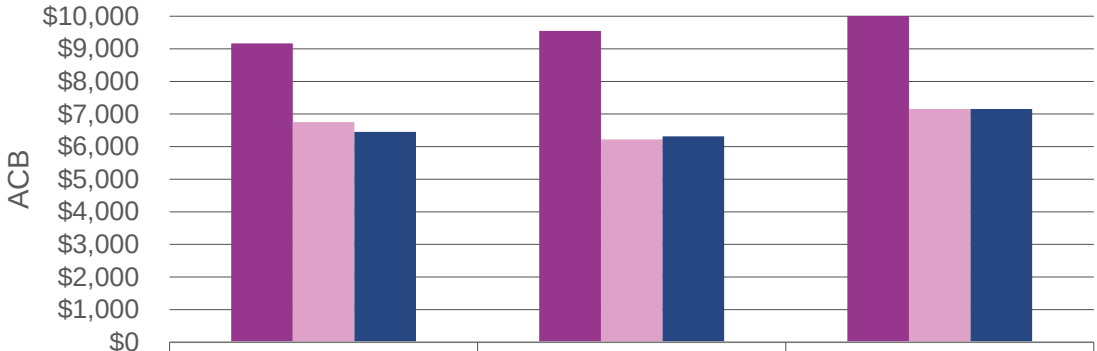
Alameda MHP



	CY 2018	CY 2019	CY 2020
MHP	4.96%	5.12%	4.54%
Large	4.31%	4.40%	4.13%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20

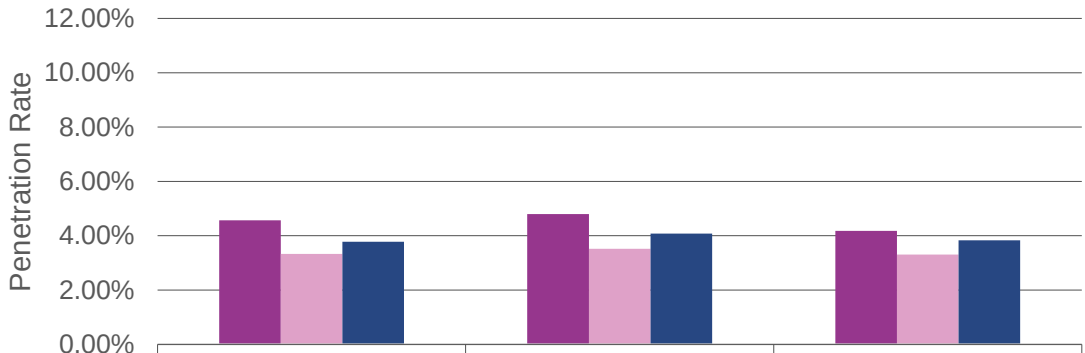
Alameda MHP



	CY 2018	CY 2019	CY 2020
MHP	$9,168	$9,547	$10,743
Large	$6,750	$6,219	$7,156
State	$6,454	$6,316	$7,155

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

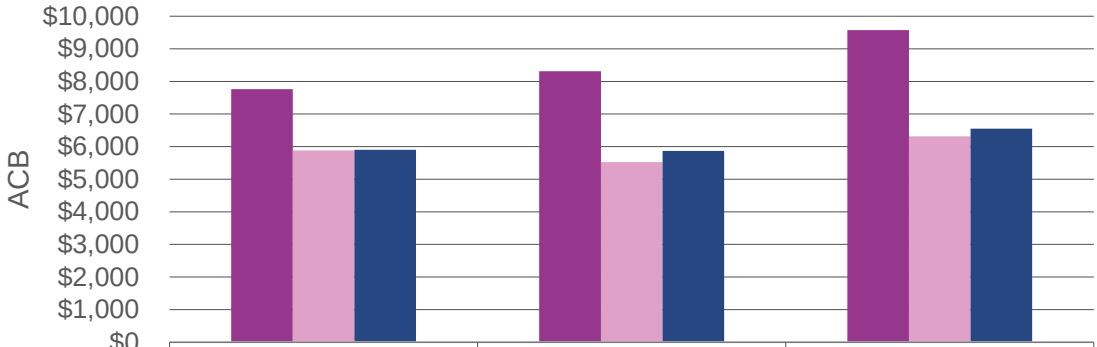
Alameda MHP



	CY 2018	CY 2019	CY 2020
MHP	4.57%	4.80%	4.18%
Large	3.33%	3.52%	3.31%
State	3.78%	4.08%	3.83%

Figure 5: Latino/Hispanic ACB CY 2018-20

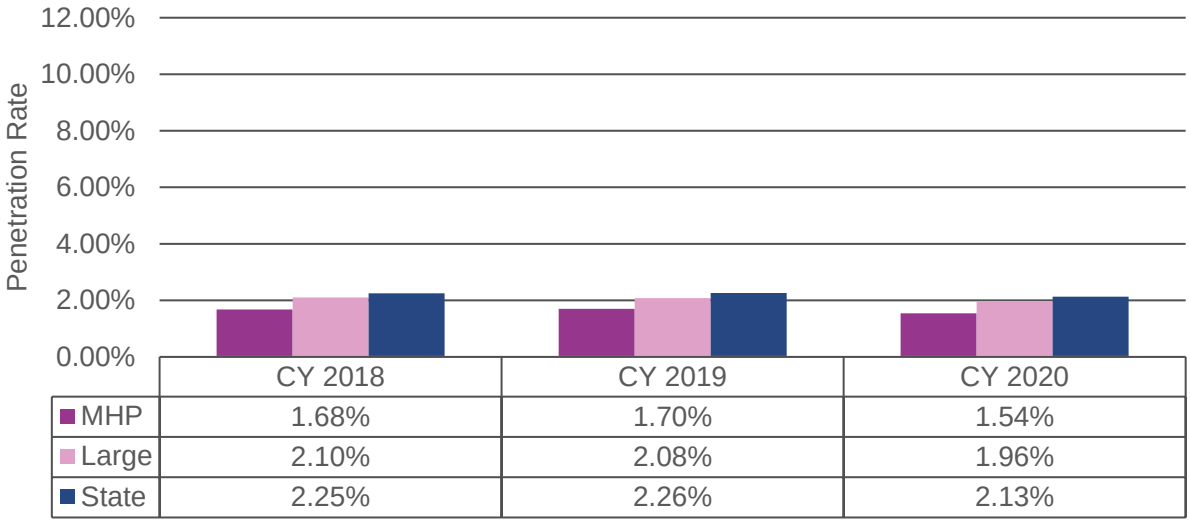
Alameda MHP



	CY 2018	CY 2019	CY 2020
MHP	$7,763	$8,312	$9,573
Large	$5,884	$5,523	$6,317
State	$5,904	$5,869	$6,551

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

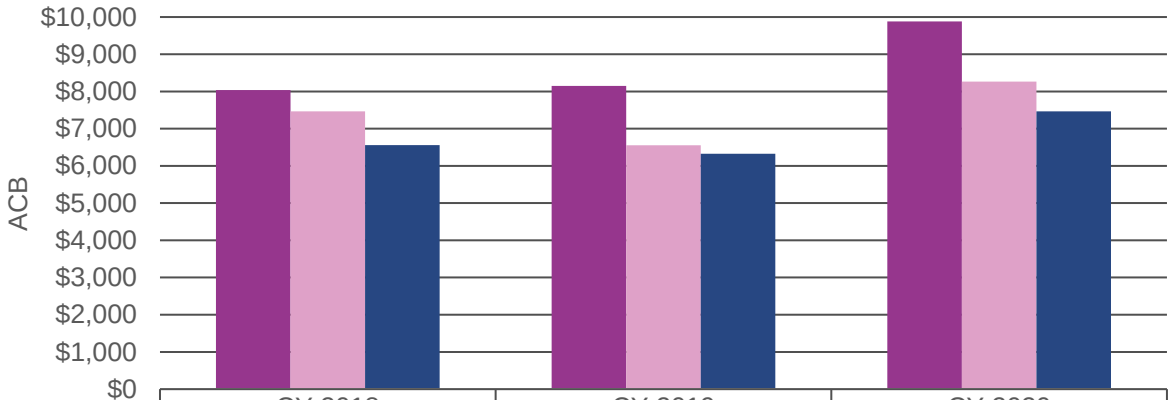
Alameda MHP



	CY 2018	CY 2019	CY 2020
MHP	1.68%	1.70%	1.54%
Large	2.10%	2.08%	1.96%
State	2.25%	2.26%	2.13%

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

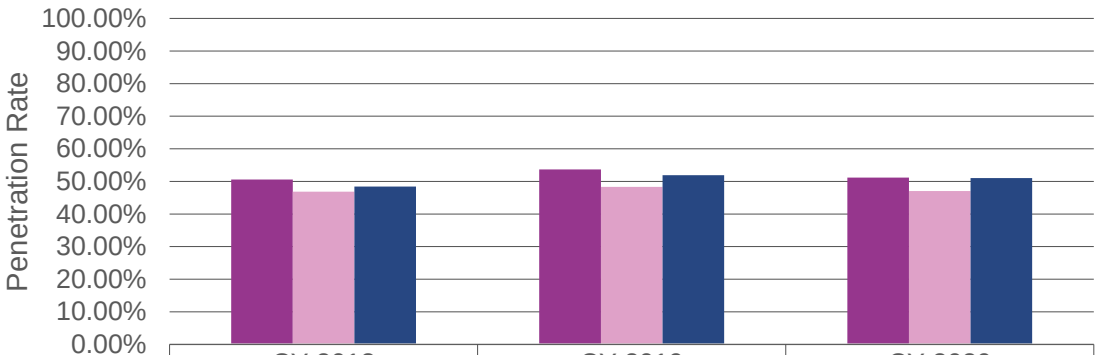
Alameda MHP



	CY 2018	CY 2019	CY 2020
MHP	$8,037	$8,150	$9,883
Large	$7,464	$6,552	$8,266
State	$6,557	$6,325	$7,466

Figure 8: FC Penetration Rates CY 2018-20

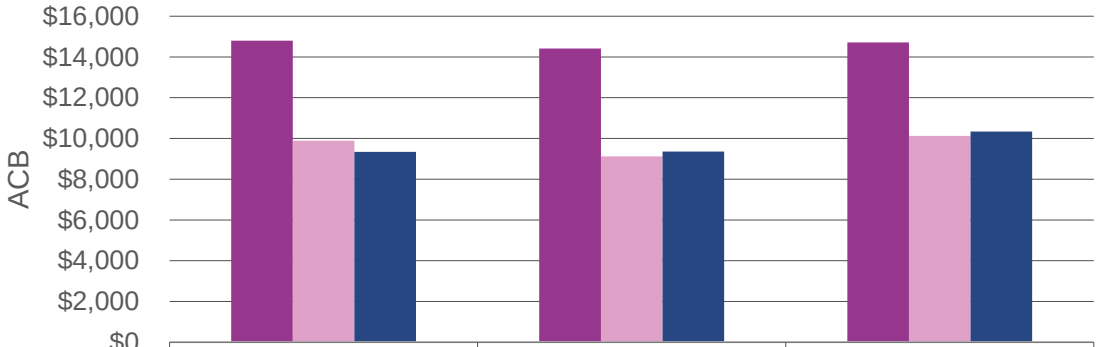
Alameda MHP



	CY 2018	CY 2019	CY 2020
MHP	50.58%	53.66%	51.16%
Large	46.87%	48.34%	47.06%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20

Alameda MHP



	CY 2018	CY 2019	CY 2020
MHP	$14,803	$14,418	$14,710
Large	$9,895	$9,125	$10,129
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

The API population has historically had less access to SMHS than beneficiaries of other racial/ethnic groups, and this is seen in Alameda County as well. The number of API beneficiaries that access SMHS is lower than expected based on their proportion in the population. Despite constituting 22.3 percent of total Medi-Cal eligibles, they accounted for only 7.6 percent of the beneficiaries who received SMHS. The MHP is aware of this disparity and has established a QIWP goal to increase the API penetration rate (1.54 percent) by 50 percent as an indicator of improved access for this population.

ACB served is a proxy for the scope and intensity of SMHS that beneficiaries receive from MHPs, and thus as a proxy for the quality of care received. CalEQRO underscores that in a large and diverse state like California, ACB may depend on contextual and historical factors of individual MHPs, MHP regions, and MHP sizes. Such factors may include the type and mix of county and contract providers, general cost-of-living, service types utilized, distribution of Medi-Cal eligible population by age group, race/ethnicity, and other demographic characteristics, as well as individual MHP's ability to set their reimbursement rates. Historically, the Bay Area has the highest ACB among all regions, and this is reflected in the MHP's high ACB ($10,743) that is 50 percent higher than the statewide average ($7,155).

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 ALAMEDA COUNTY

The MHP reported timeliness data stratified by age and foster care status. Further, timeliness data presented to CalEQRO represented the complete SMHS delivery system.

TIMELINESS KEY COMPONENTS

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

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

Table 4: Key Components – Timeliness

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- The MHP, with an expansive provider network, tracks and trends timeliness data for its entire system.
- Beneficiaries may experience wait times between assessment and ongoing service. Stakeholders report that supervisors provide follow-up to assessments with interventions and weekly safety planning in the interim between assessment and being assigned a therapist.
- Overall 84 percent of initial service requests receive an offered appointment within 10 business days; however, stakeholders report that some providers are at capacity. When that occurs, beneficiaries report calling but being unable to reach a provider, thus effectively extending wait times to services beyond that which is reported.
- Others report that they either did not have a waitlist or that the waitlist was temporary during operational shifts, and that there is no longer a wait. If there were a delay in service, beneficiaries were referred back to Access to be connected to another provider.

PERFORMANCE MEASURES

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

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

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

MHP-Reported Data

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access (ATA) 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 FY 2020-21 as follows:

- The MHP's timeliness measures are all reported as above 70 percent except First Non-Urgent Psychiatry Service Rendered (61 percent) and Follow-Up Appointments after Psychiatric hospitalization (32 percent). The Follow-Up Appointments after Psychiatric hospitalization calculations appear questionable in that the MHP reports achieving an average of 5.1 days for follow-up appointments but only 32 percent meeting the 7-day HEDIS standard.

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

MHP Reported Performance of Timely Access submitted for FY 2021-22			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	6 Days	10 Business Days*	84%
First Non-Urgent Service Rendered	9 Days	10 Business Days	71%
First Non-Urgent Psychiatry Appointment Offered	12 Days	15 Business Days*	73%
First Non-Urgent Psychiatry Service Rendered	15 Days	15 Business Days	61%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	13 Hours	48 Hours*	95%
Urgent Services Offered – Prior Authorization Required ***	n/a	96 Hours*	n/a
Follow-Up Appointments after Psychiatric Hospitalization	5.1 Days	7 Days**	32%
No-Show Rate – Psychiatry	6%	15%**	n/a
No-Show Rate – Clinicians	10%	15%**	n/a

* DHCS-defined timeliness standards as per BHIN 20-012

** MHP-defined timeliness standards

*** MHP does not separately track urgent services offered based on authorization requirements; all urgent services are held to a 48-hour standard.

Medi-Cal Claims Data

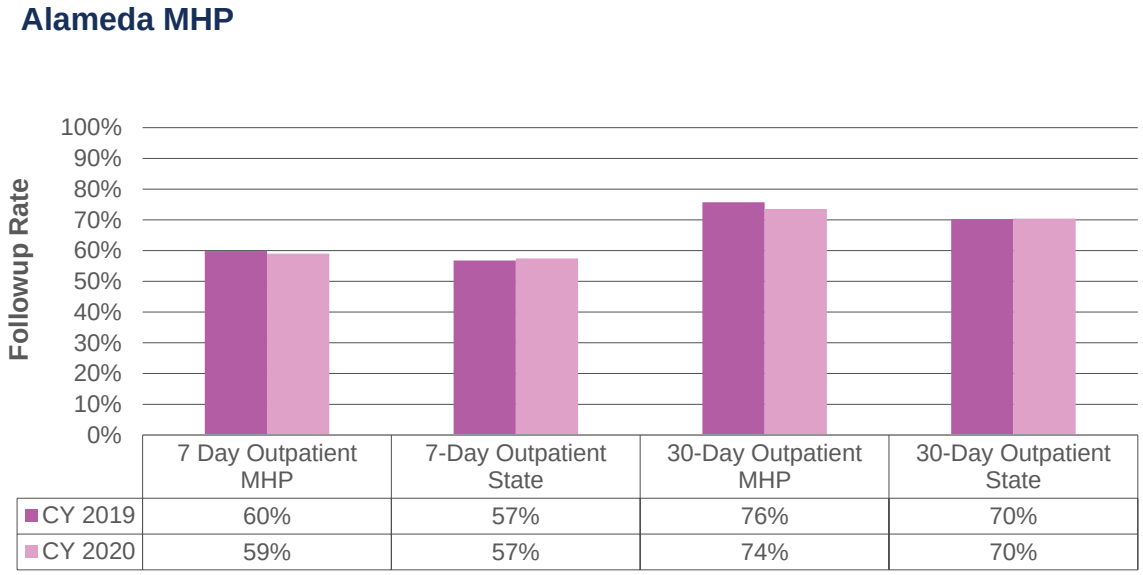
The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; 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.

Both the MHP's 7-day and 30-day post psychiatric inpatient follow-up percentages are slightly higher than the state's averages. As with most other measures, the rates declined from CY 2019 levels.

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



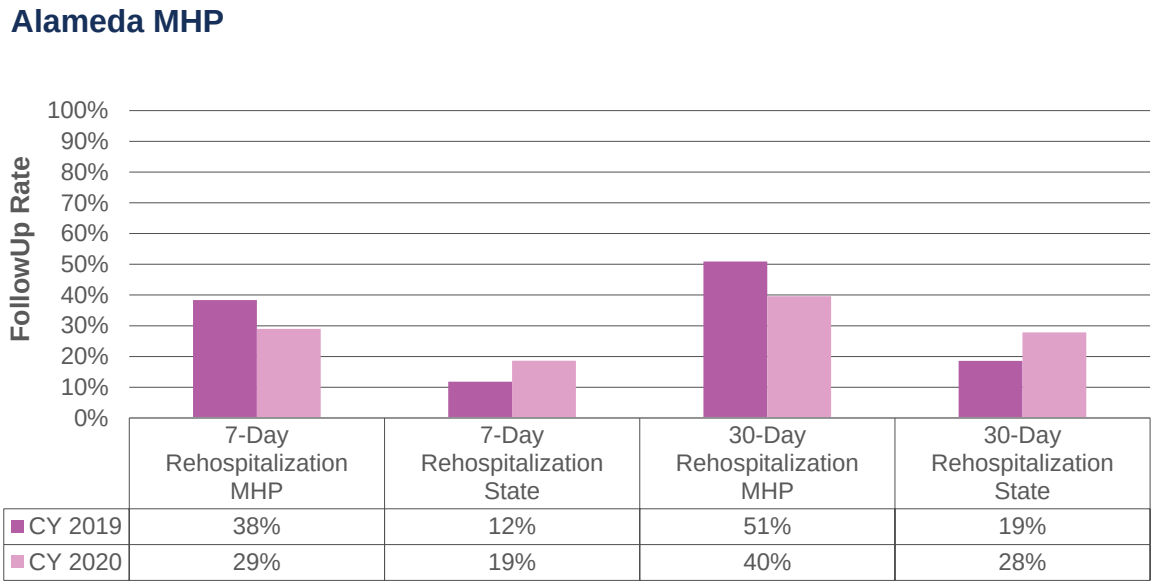
	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	60%	57%	76%	70%
CY 2020	59%	57%	74%	70%

Readmission rates

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

MHP readmission rates have dropped by 9 percentage points from CY 2019 in both the 7-day and 30-day category, while readmission rates statewide increased by nearly the same amount across the same time period. Adult crisis transport teams were deployed to assist beneficiaries accessing the most appropriate services and reduce admissions to PES. Even with these improvements, however, both the MHP's 7-day and 30-day post psychiatric inpatient follow-up percentages are greater than the state's averages by 10 percent and 12 percent, respectively.

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	38%	12%	51%	19%
CY 2020	29%	19%	40%	28%

IMPACT OF FINDINGS

The MHP's 7- and 30-day hospital readmission rates remain above the statewide averages; however, the gap is shrinking. Between CY 2019 and CY 2020, MHP 7-day readmission rates decreased by 9 percentage points (38 to 29 percent) and the 30-day rates decreased by 11 percentage points (51 to 40 percent). These significant decreases in MHP readmission rates suggest successful strategies implemented by the MHP and indicate improved beneficiary outcomes. The MHP is encouraged to evaluate current processes, continue those that are determined to have been most effective, and implement additional solutions if indicated.

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 ALAMEDA COUNTY

In the MHP, the responsibility for QI is under the QM Program Director, who directly oversees four FTEs: QI Manager, QI Supervising Program Specialist, Utilization Management (UM) Division Director, and Quality Assurance Administrator; all of these staff collectively oversee other FTEs.

The MHP monitors its quality processes through the QAPI Program, comprised of its Quality Improvement Committee (QIC), development of the QIWP, and the semi-annual evaluation of the QIWP workplan. The QIC, comprised of staff, providers, community stakeholders and beneficiary and family member participants, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met 12 times. Of the 30 identified FY 2020-21 QIWP workplan goals, the MHP met 93 percent of its goals were met or partially met.

The MHP utilizes the following level of care tools: Adult/Older Adult Outpatient Level of Care Determination Tool and Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary.

The MHP utilizes the following outcomes tools: The Child Adolescent Needs Strengths (CANS-50) outcome tool and Pediatric Symptom Check List (PSC-35) are used as an assessment aide to assist with treatment planning and care coordination. In addition, CANS-50 and Adult Needs Strengths Assessment (ANSA) are used for goal development and outcomes. Results are given to providers for treatment planning, goal

setting, and tracking improvement areas of life functioning, and to determine level of service needed.

QUALITY KEY COMPONENTS

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

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

Table 6: Key Components – Quality

KC #	Key Components - Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	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	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:

- The MHP has a robust QIWP and tracking approach, which includes monthly meetings and reporting to CBOs and extensive work on social equity.

- QI utilizes Yellowfin reporting feature to keep the SOC informed with provider memos; web-blasts internally and externally; website updates; distribution lists; required policies with attestations.
- The QIC has involved CFMs who engage in the policy review process.
- Most beneficiaries in focus groups acknowledged completing surveys. However, in the Cantonese focus group with 12 participants, no one acknowledged completing any surveys or could recall ever being asked for feedback of services.
- 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 MHP does not track and trend the use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)

PERFORMANCE MEASURES

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

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

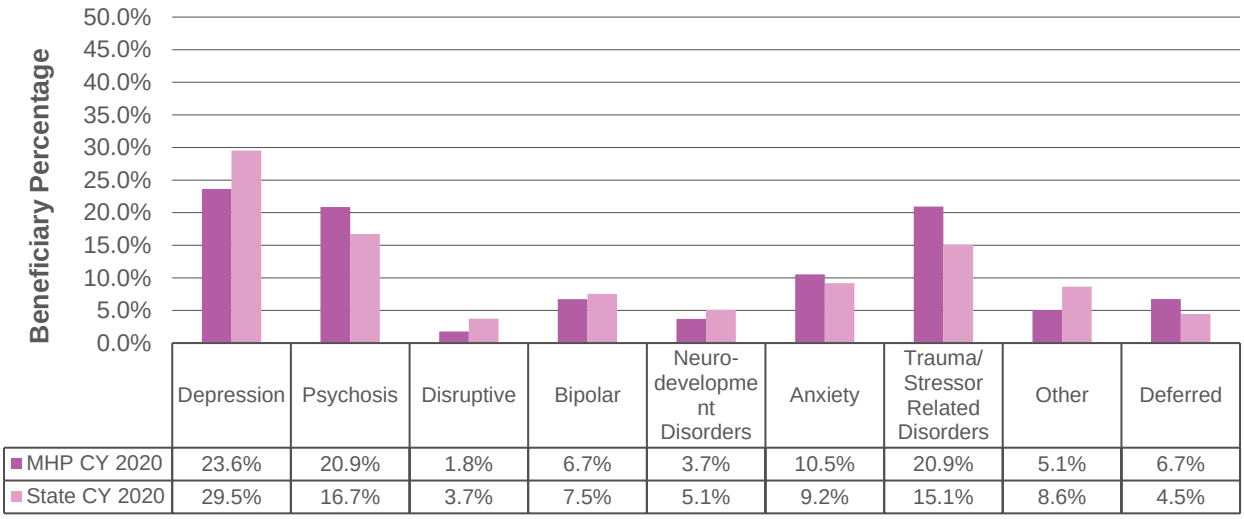
Diagnosis Data

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

The MHP serves a higher proportion of beneficiaries with trauma/stressor related disorders (20.9 percent) than is seen statewide (15.1 percent), and the proportion of depressive disorders (23.6 percent) is lower than the statewide average (29.5 percent).

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020

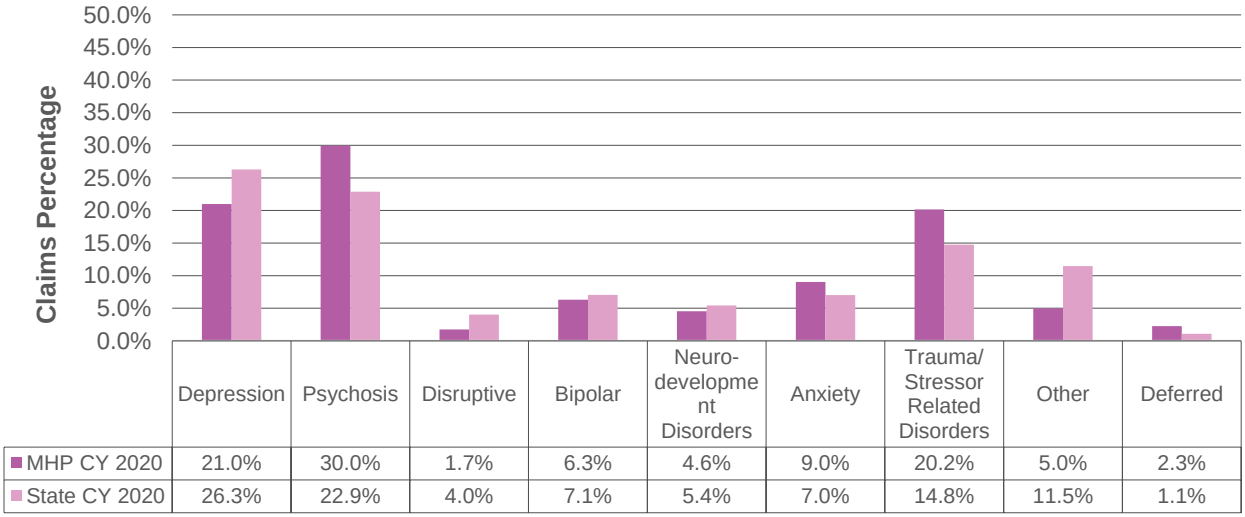
Alameda MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	23.6%	20.9%	1.8%	6.7%	3.7%	10.5%	20.9%	5.1%	6.7%
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

Alameda MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	21.0%	30.0%	1.7%	6.3%	4.6%	9.0%	20.2%	5.0%	2.3%
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's LOS has declined each of the last three years from 6.71 percent in 2018, to 6.37 percent in CY 2020 and was 2.3 days less than the state average (8.68 days), which is 6.37 days. Consistent with outpatient services, ACBs for inpatient services exceed statewide averages by approximately $3,000.

Table 7: Psychiatric Inpatient Utilization CY 2018-20

Alameda 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	1,911	6,047	6.37	8.68	$14,284	$11,814	$27,297,370
CY 2019	1,991	6,674	6.46	7.80	$14,698	$10,535	$29,263,228
CY 2018	2,150	5,610	6.71	7.63	$13,580	$9,772	$29,196,526

High-Cost Beneficiaries

Table 8 provides a three-year summary (CY 2018-20) of HCB trends for the MHP and compares the MHP's CY 2020 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

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

While the MHP's HCB counts have increased by 100 from the CY 2019 level of 1,454, to 1,554 in CY 2020, the total beneficiary count has decreased from last year's 21,372 to this year's 18,874. At the same time, the HCB percentage has increased from 6.80 percent in CY 2019, to 8.23 percent in CY 2020. This level of HCB's, at 8.23 percent, is over twice the state average. The MHP's average approved claim per HCB is greater than the statewide average ($54,954 vs. $53,969). These higher costs are consistent with the high-cost findings in Figures 3 and *7.*

Table 8: HCB CY 2018-20

Alameda 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	1,554	18,874	8.23%	$54,954	$85,398,183	42.12%
	CY 2019	1,454	21,372	6.80%	$55,267	$80,358,031	39.39%
	CY 2018	1,413	21,657	6.52%	$54,245	$76,648,595	38.60%

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

Retention rates for number of services approved per beneficiary served in CY 2020 are lower than the statewide average in all categories except the greater than 15 services category, where the MHP has a nearly 27 percent higher rate (57.54 percent) than is seen statewide (45.33 percent) and represents the highest rate of all MHPs.

Table 9: Retention of Beneficiaries, CY2020

	Alameda MHP			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 Service	1,608	8.52	8.52	9.76	9.76	5.69	21.86
2 Services	834	4.42	12.94	6.16	15.91	4.39	17.07
3 Services	646	3.42	16.36	4.78	20.69	2.44	9.17
4 Services	535	2.83	19.20	4.50	25.19	2.44	7.78
5-15 Services	4,391	23.26	42.46	29.47	54.67	19.96	42.46
>15 Services	10,860	57.54	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

The percentage of HCBs has steadily increased between CY 2018 (6.52 percent) to CY 2020 (8.23 percent) so that it is now more than twice the state's average of 4.07 percent. In CY 2020, 8.23 percent of the beneficiaries served accounted for 42.12 percent of all MHP approved Medi-Cal claims.

Inpatient utilization has been trending downward since CY 2018. The MHP utilizes a multi-pronged approach to positively impact psychiatric inpatient admissions. The MHP implemented transport teams to assist beneficiaries in crisis to access services prior to a PES admission. The MHP actively uses data and Yellowfin reports to communicate HCB status and needs to staff. QI uses PIPs and the QIWP to adapt capacity and services to meet beneficiary crisis needs. In addition, the LOS has declined from the CY 2018 level of 6.71 days to the CY 2020 level of 6.37 days, between CY 2019 and CY 2020, 7- and 30-day psychiatric inpatient readmission rates exceeded state averages by 10 percent.

As indicated in Table 7, 1,911 unique beneficiaries accounted for 6,047 admissions. The MHP would benefit from further evaluation of readmission trends to determine potential root causes and to identify opportunities for improved outcomes for beneficiaries.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Reducing Psychiatric Emergency Services Recidivism through Pre-Discharge Visits/Follow-up Texts

Date Started: June 2021

Aim Statement: Over the next 15 months, will 1) pre-discharge in-person contact and 2) post-discharge text message follow-up for adults who receive psychiatric emergency services:

- Improve the percentage of beneficiaries with outpatient follow-up visits within 7 days and 30 days by 15 percent?
- Reduce the percentage of beneficiaries who return to psychiatric emergency services within 7 days and 30 days by 15 percent?

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

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

Target Population: The study population is adults who received psychiatric emergency services (PES) who are not admitted to inpatient services and who do not meet "Familiar Faces" program criteria. The descriptions below are based on the 3,728 beneficiaries who met these criteria between June 2020 and May 2021.

Overall, the Study Population beneficiaries are mostly English speaking, primarily Black/African American, between the ages of 18-24, and male, from North County. The most common diagnoses at time of first PES episode are psychotic disorder, adjustment disorder, and schizophrenia.

The beneficiaries in this population may be "Already Connected" to mental health outpatient services with the MHP at the time of their PES episode.

Validation Information: The MHP's clinical PIP is in the implementation phase and considered active. CalEQRO has moderate confidence that the methodology is sound, however, it is too early to make conclusions as to the impact of the intervention.

Summary

Beneficiaries and Family Member stakeholders engaged extensively in identifying both the problem and potential interventions through the Whole Person Care sponsored "Fellowship" program, which provided stipends for community members with lived experience to participate in discussions and decision-making processes. The PIP aims to promote effective communication and coordination of care. Interventions included a pre-discharge in-person contact and a post-discharge phone calls and text messages to provide information, referral, assessment for ongoing care, and linkage/brokerage to encourage clients to consent to voluntary mental health services. Baseline data was robust, however, follow-up after intervention did not yield a large enough sample size to confirm whether a positive impact was being made. The MHP is using a complex data collection approach which may impact the strength and reliability of the data.

TA and Recommendations

PIP is considered active although additional information is needed: the year for baseline data collection and subsequent remeasurement periods, an explanation for low remeasurement numbers given the large size of the MHP, and information that supports the chosen interventions as related to the root cause. Further, given the size of the MHP, it is unclear why statistically significant analysis would not be included when evaluating the impact of the intervention.

The TA provided to the MHP by CalEQRO consisted of:

- Ongoing video, email, and phone consultation.

- Discussion regarding root cause analysis and intervention selection.
- Discussion concerns regarding population size and expanding participants.
- Discussion regarding sample size and statistical significance.

CalEQRO recommendations for improvement of this clinical PIP include:

- Provide additional information on data collection time periods.
- Correct methodology which yields low remeasurement numbers.
- Research and identify contributors to the problem.
- Develop interventions based on root cause analyses or identified causes.
- Consider methodologies which yield a statistically significant result from robust data collection.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Care Coordination with Primary Care

Date Started: January 2022

Aim Statement: This PIP will examine whether implementing care coordination strategies for adult beneficiaries in "service team" case management programs over an 18-month period will:

- Reduce beneficiary psychiatric emergency services utilization by 10 percent;
- Improve beneficiary engagement with physical health services by 20 percent;
- Increase the percent of beneficiaries with reduced avoidable physical emergency services utilization by 15 percent over 18 months; and
- Improve quantifiable physical health outcomes by 10 percent.

Target Population: This PIP will study adult beneficiaries enrolled in CBO "Service Team" programs. Service Teams provide outpatient mental health, psychiatric, and care management services to individuals living with serious mental health conditions.

Validation Information: The MHP's non-clinical PIP is in the planning phase and considered inactive.

Summary

The MHP observed an increase in beneficiaries without primary care outpatient utilization despite being eligible for physical health services through Medi-Cal managed care plan, from 5.8 percent in January 2017 to 17 percent in December 2020. This PIP studies adult beneficiaries enrolled in CBO “Service Team” programs. In January 2022, the MHP will provide three interventions - implementation of new Primary Care Coordination protocol to increase beneficiary engagement, use of a monthly Primary Care Coordination Report, utilization of the Community Health Record. Several performance measures will be tracked including the percent of beneficiaries 1) who had no service within 90 days; 2) received fewer psychiatric emergency services in the year prior; 3) received a primary care service within the previous year; 4) received fewer avoidable physical health emergency services; and 5) had higher than normal body mass index (BMI) score who reduced their BMI by 10 percent.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence. Even though the PIP is ambitious, it is unclear whether all measures are connected to primary care linkage and mental health. This PIP would benefit from a scaled back approach, where there is a clear link between the cause of the problem, the impact on mental health outcomes, and proposed intervention. The focus seems to be centered on service teams and less about population mental health. A root cause analysis or related peer reviewed literature would provide more information on both the population, the problem and cause, the mental health impact, and point to a connected solution.

The TA provided to the MHP by CalEQRO consisted of:

- Ongoing video, email, and phone consultation.
- Discussion regarding root cause analysis and intervention selection.
- Discussion regarding concerns on linkage of problem to mental health impacts and known outcomes.

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

- Provide additional information on data collection time periods.
- Research and identify contributors to the problem through root cause analysis and/or supporting research literature.
- Develop interventions based on root cause analyses or identified causes.

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 ALAMEDA COUNTY

California MHP EHRs fall into two main categories, those that are managed by county of MHP IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. Alameda fully supports its EHR set up. The primary EHR systems used by the MHP are a hybrid of InSyst by The Echo Group and Clinician's Gateway by Krassons, Inc., which have been in use for 30 and 12 years, respectively. Currently, the MHP is working with Xpio expecting to produce a Request For Proposal for a new Clinical EHR in the next 18 to 24 months.

Approximately 4.21 percent of the MHP budget is dedicated to support the IS (County IT overhead for operations, hardware, network, software licenses, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control.

The MHP has 2,732 named users with log-on authority to the EHR, including approximately 619 county-operated staff and 2,113 contractor-operated staff. Support for the users is provided by 32 full-time equivalent IS technology positions. Currently all positions are filled. It is notable that IT staffing has declined from the total of 38 in CY 2019 to this year's number of 32.

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

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

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	%
☐	Electronic Data Interchange (EDI) to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
☒	Electronic batch file transfer to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	35%
☒	Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	55%
☐	Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
☒	Paper documents delivered to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	10%
			100%

Beneficiary Personal Health Record

The 21st Century 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. Although the MHP does not have a PHR, it has determined that it would be a more effective use of limited resources to delay its implementation until a new EHR is selected.

Interoperability Support

The MHP is a participant in a HIE named Social Health Information Exchange (SHIE) Community Health Record for Alameda County. The MHP does not collect information from the SHIE. However, the MHP sends ADT data files every 15 minutes and new client data once a week to the SHIE.

Healthcare professional staff use secure information exchange directly with service partners through secure email. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: both MH and DMC-ODS CBOs/Contract Providers.

IS KEY COMPONENTS

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

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

Table 11: Key Components – IS Infrastructure

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	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's use of Yellowfin dashboards across the agency's website is exemplary.
- The MHP's use of Objective Arts to derive reports from its data warehouse is an effective manner to meet state reporting requirements.
- The MHP is using a mindful and thorough approach to developing the RFP for a new Billing/Revenue system. It is notable that it has included stakeholders from not only multiple areas of care from within the agency but also from within the CBOs.
- The MHP maintains consistent claims volume with an annual denial rate of 2.28 percent, lower than the 3.19 percent state average.
- The MHP would benefit from providing sufficient resources and staff to fill the vacant IT manager slot in a timely manner. This position is of vital importance as the MHP replaces its Billing and EHR systems.

- Participation in the California Mental Health Services Act (CalMHSA) project for the procurement of a state-wide EHR, forms, and service delivery processes would assist in the timely update of its own systems.

IMPACT OF FINDINGS

- The MHP has a unique hybrid billing and EHR structure that is aging and in need of timely replacement. Assuring robust funding and prioritization will be vital.
- The MHP's methodical approach to the replacement of both the billing and EHR systems is cautious yet prudent. Participation in CalMHSA's EHR project will provide insight and skill sets of peer organizations.
- The MHP has been challenged with staffing issues that are concomitant with the COVID-19 health emergency. The vacancy of an IT manager position could impair numerous IT projects that have fundamental importance.
- The MHP's use of Yellowfin dashboards not only increase the efficiency of the work force, but their provision on the agency webpage allows for transparency with their beneficiaries.
- The MHP's consistently strong volume of Medi-Cal billing results in a reliable cash-flow that prevents interruptions in service delivery.

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.

While the MHP typically administers the CPS twice each year, the State decreased survey frequency to once per year in both 2020 and 2021 as a result of the pandemic. The MHP compares the most recent CPS findings to its prior data as part of its QI efforts with findings distributed to both staff and presented to providers and other stakeholders at QIC meetings. Staff worked with county and CBO providers to distribute the surveys broadly to beneficiaries.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

As part of the pre-site planning process, CalEQRO requested two 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 culturally diverse group of 10-12 English Speaking caregivers/parents of beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 15 months. The focus group was held via Zoom video conferencing and included one participant who attended the session in error. Information from this participant is not included as she was not a parent or caregiver of a beneficiary.

Consumer Family Member Focus Group Two

CalEQRO conducted one 90-minute focus group with consumers and/or their family members during the site review of the MHP. CalEQRO requested a culturally diverse group of 6-8 Cantonese-speaking adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 15 months. The focus group was held via Zoom video conferencing and included 12 participants; a Cantonese language interpreter was used for this focus group. All consumers participating receive clinical services from the MHP.

The four participants who were new to services reported wait times of two months to begin services and a wait time of one to two months between services. Participants received text or reminder calls but were not aware of any crisis number to call apart from 9-1-1.

Regarding cultural and language support, participants reported that speaking to another Chinese speaker is easier and that when there is an interpreter, it is still difficult to express what they need to say. Additionally, most participants were not aware of any written information about services in their language.

Over this last year, making appointments was more difficult. Without face-to-face interaction it is hard to express needs. Participants did not attend wellness centers or committees to provide feedback.

Recommendations from focus group participants included:

- Provide more staff and funding to Asian Health Services. They do not have enough psychiatrists to serve the community.
- Address mental health stigma in the API community to improve access to mental health services; moreover, community activities and efforts to manage stigma for the community at large would be helpful.
- Provide information about services to large groups of Chinese people to lessen fear about services and consequences.

IMPACT OF FINDINGS

The MHP successfully connects beneficiaries from various cultures to its many services; however, language barriers and mental health stigma act in concert to further isolate Cantonese-speaking beneficiaries from successful linkage to service. Insights from the focus group underscore the necessity for the MHP to prioritize the API population with special efforts in outreach, stigma reduction, and mental health service provision.

CONCLUSIONS

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

STRENGTHS

1. The MHP's cultural competence plan is thoughtful and well developed as is the MHP's approach to hiring a diverse staff which reflects the diversity of the community.

   (Access, Quality)

2. The MHP prioritizes HCBs and uses data to adapt its capacity to meet beneficiary crisis needs resulting in trend of improved psychiatric inpatient admissions.

   (Quality)

3. The MHP has a robust QIWP and tracking approach, which includes monthly meetings and reporting to CBOs and extensive work on social equity. The QIC boasts regularly involved peers who provide feedback on policies, programing and service delivery.

   (Quality)

4. MHP's use of Yellowfin dashboards across its system is exemplary.

   (Quality, IS)

5. The MHP has established interoperability by participating in the local Health Information Exchange (HIE): SHIE Community Health Record for Alameda County.

   (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP serves a disproportionately low percentage of API beneficiaries relative to the Medi-Cal eligible population. Feedback from stakeholders highlights opportunities for improved outreach, services in preferred languages, and reduction of mental health stigma within cultural communities.

   (Access)

2. The MHP's website contains a lot of information and links with program descriptions, but the font is small and it is difficult to find information on how to access crisis services, hotline phone numbers, wellness centers, or rapid language options.

   (Access)

3. Stakeholders provided mixed feedback regarding wait times to obtain services and/or wait times between services. While the specifics are unclear and likely lost in 'averaging,' it is apparent that some beneficiaries are experiencing delays while others are not.

   (Timeliness)

4. While there is a peer 'specialty designation' that can be added as a requirement to civil service positions, there are no "peer"-specific civil service approved job descriptions. The MHP has "opted in" to the CalMHSA plan to develop the SB803 Peer Certification for counties. Beneficiaries in peer job descriptions are hired through the CBO network.

   (Quality)

5. County and CBO stakeholders indicate that they receive information regularly (email; blasts; reports), but they do not have structured opportunity to provide feedback or participate in a bidirectional communication process.

   (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. Investigate the relatively low percentage of API beneficiaries served and implement strategies to improve access to specialty mental health services for this population.

   (Access)

2. Evaluate the MHP website for language level and "user-friendly" accessibility. Amend the site to provide easily viewed information on crisis services, wellness centers, and rapid language options.

   (Access)

3. Investigate beneficiaries' experiences with timeliness across the system, implement strategies, and begin to address.

   (Access, Timeliness)

4. Develop a peer career implementation plan and timeline related to the MHP's level of participation in SB803 Peer Certification. The peer career ladder should include increasing levels of responsibilities and commensurate benefits and salary.

   (Quality)

5. Identify and expand opportunities for both County and CBO staff to provide feedback on program planning and implementation, allowing for bidirectional communication. Include County and CBO staff in the process. Consider periodic surveys measuring County and CBO staff satisfaction.

   (Quality)

SITE REVIEW BARRIERS

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

- The CFM focus groups are an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. However, only one person attended one of the two CFM focus groups, resulting in limited beneficiary feedback to this year's EQR.

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

Alameda MHP
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 Groups
Peer Inclusion/Peer Employees within the System of Care
Contract Provider 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 Hands-On Observation
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Cyndi Lancaster, Lead Quality Reviewer

Bill Walker, Quality Reviewer

Lamar Brandysky, Information Systems Reviewer

Gloria Marrin, Consumer/Family Member Consultant

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Anderson	Kara	Human Resource Officer	Alameda County Health Care Services Agency
Aslami Tamplen	Khatera	Office of Peer Support Services Manager	Alameda County Behavioral Health (ACBH)
Bailey	Annie	Administrator	City of Fremont
Baker	Vanessa	Older Adult Services Division Director	Alameda County Behavioral Health
Bernhisel	Penny	Clinical Program Supervisor for ACBH Court Programs	Alameda County Behavioral Health
Bettencourt	Roy	Associate Director of Community Mental Health	Bay Area Community Services
Biblin	Janet	Performance Measurement Manager	Alameda County Behavioral Health
Bruton	Jenny	Program Specialist, Child & Young Adult System of Care	Alameda County Behavioral Health
Bryant	Gimone	Mental Health Specialist II, Oakland Community Support	Alameda County Behavioral Health
Capece	Karen	Quality Management Program Director	Alameda County Behavioral Health
Carlisle	Lisa	Child & Young Adult System of Care Director	Alameda County Behavioral Health
Castilla	Michael	Senior Program Specialist, Adult Older Adult System of Care	Alameda County Behavioral Health
Chapman	Aaron	Chief Medical Officer	Alameda County Behavioral Health
Chau	Mandy	Audit and Cost Reporting Director	Alameda County Behavioral Health
Chen	Jennifer	Clinical Supervisor	Asian Health Services
Cheng	Michael	Behavioral Health Clinician II, Eden Children's Services	Alameda County Behavioral Health
Coffin	Scott	Chief Executive Officer	Alameda Alliance
Collins	Rochelle	Program Director, Project Eden	Horizon Services, Inc.
Coombs	Angela	Associate Medical Director	Alameda County Behavioral Health
Courson	Natalie	IS Deputy Director	Alameda County Behavioral Health
Davila	Anna	Behavioral Health Program Manager	Kidango, Inc.
DeSantis	Adrianne	Consumer Relations Program Assistant	Alameda County Behavioral Health
Diamond	Marc	Clinical Supervisor, Eden Community Support	Alameda County Behavioral Health
Dickson	Thad	Founder/CEO	XPIO
Diedrick	Sheryl	IS Analyst	Alameda County Behavioral Health

Last Name	First Name	Position	Agency
Eady	Rashad	Program Specialist, QI	Alameda County Behavioral Health
Elliott	Ann	Critical Care Manager, Adult & Older Adult System of Care	Alameda County Behavioral Health
Franklin	Paulette	Mental Health Specialist II	Alameda County Behavioral Health
Gibbs	Laphonsa	Division Director Children's Outpatient Clinics	Alameda County Behavioral Health
Gray	Heidi	Clinical Supervisor	Fred Finch Youth Center
Gums	Angelica	Assistant to the Health Equity Officer	Alameda County Behavioral Health
Henry	Krishna	Administrative Assistant, Quality Management	Alameda County Behavioral Health
Hogden	Mary	POCC Manager, Office of Peer Support Services	Alameda County Behavioral Health
Huynh	Vy	Family Advocate	Family Education & Resource Center
Isegen	Jasmine	Family Advocate	Family Education & Resource Center
Jones	Katherine	Adult & Older Adult SOC Director	Alameda County Behavioral Health
Jones	Yvonne	Forensic Diversion, Re-entry Services System of Care Out-patient Services Associate Director	Alameda County Behavioral Health
Judkins	Andrea	Supervising Financial Services Specialist, Budget & Fiscal Services	Alameda County Behavioral Health
Kiefer	Andrea	Program Specialist, Child & Young Adult System of Care	Alameda County Behavioral Health
Kolda	Deanna	Clinical Review Specialist Supervisor, UM	Alameda County Behavioral Health
Kong	Jennifer	FSP Supervisor, Strides	Telecare Corporation
Ladov	Nicole	Clinical Supervisor	La Clinica
Lai	Sophia	Supervising Program Specialist, QI; Privacy Officer	Alameda County Behavioral Health
Lee	Sun Hyung	TAY Services Interim Division Director	Alameda County Behavioral Health
Lewis	Clyde	Interim SUD Director	Alameda County Behavioral Health
Lewis	Stephanie	Crisis Services Division Director	Alameda County Behavioral Health
Ling	Jennifer	Program Specialist, TAY, Child & Young Adult System of Care	Alameda County Behavioral Health
Lopez	Rickie Michelle	Finance Assistant Director	Alameda County Behavioral Health
Lott	Yesenia	BH Clinical Manager, Crisis	Alameda County Behavioral Health
Louie	Jill	Budget & Fiscal Services Director	Alameda County Behavioral Health
Louis	L.D	Co-Chair	Mental Health Advisory Board

Last Name	First Name	Position	Agency
Lua	Juan	Specialist Clerk II, Finance	Alameda County Behavioral Health
Marshland	Susanna	Regional Vice President	Fred Finch Youth Center
Mayfield	Amber	AOT, CC & Steps Clinical Director	Telecare Corporation
Mayo	Tucker	IS Specialist	Alameda County Behavioral Health
McKenzie	Anna	Management Analyst, Contracts	Alameda County Behavioral Health
McMonagle	Kieran	HEAT FSP Supervisor	Bay Area Community Services
Mehta	Ravi	Chief Compliance & Privacy Officer	Alameda County Health Care Services Agency
Meinzer	Chet	Data Services Team Manager	Alameda County Behavioral Health
Montgomery	Stephanie	Health Equity Division Director/Health Equity Officer	Alameda County Behavioral Health
Moore	Lisa	Billings & Benefits Support Director	Alameda County Behavioral Health
Mukai	Christine	Critical Care Manager, Youth Services, CANS Coordinator	Alameda County Behavioral Health
Mullane	Jennifer	Adult & Older Adult System of Care Assistant Director	Alameda County Behavioral Health
Oliver	Constance	Psychiatric Social Worker	West Oakland Health Center
Orozo	Gabriel	Management Analyst, Quality Management	Alameda County Behavioral Health
Ortiz	Aaron	Chief Executive Officer	La Familia Counseling Services
Ou	Sarah	Program Specialist, Crisis Services Division	Alameda County Behavioral Health
Paquin	Stephanie	Clinical Supervisor	East Bay Agency for Children
Perales	Joseph	Clinical Director	La Clinica
Peterson	Camille	IS Analyst	Alameda County Behavioral Health
Phillips	Justin	Executive Director	Options Recovery Services
Pingali	Samira	Director of Behavioral Health	Community Health Center Network
Pitman	Nick	Consumer Staff	Peers Organizing for Community Change (POCC)
Quiroz	Ana	Mental Health Counselor	La Familia Counseling Services
Rassette	Kim	Administrative Specialist II, QI	Alameda County Behavioral Health
Raynor	Charles	Pharmacy Services Director	Alameda County Behavioral Health
Razzano	Theresa	Vocational Services Interim Division Director	Alameda County Behavioral Health
Rejali	Torfeh	Quality Assurance Administrator	Alameda County Behavioral Health
Reyes	Trinh	Behavioral Health Crisis Intervention Specialist Supervisor	Alameda County Behavioral Health
Rocha	Maximillian (Max)	Director of Behavioral Health Services	Children's Hospital Oakland
Rosales	Claudia	Mental Health Counselor	La Clinica

Last Name	First Name	Position	Agency
Roush	Barbara	VP Operations	Telecare Corporation
Saechao	Susie	Mental Health Specialist II, Oakland Community Support	Alameda County Behavioral Health
Sampson	Sakara	Administrative Assistant II, QI	Alameda County Behavioral Health
Valle	Elizabeth	Family Advocate	Family Education & Resource Center
Velasquez	Edilyn	Contracts Director	Alameda County Behavioral Health
Wagner	James	Deputy Director, Clinical Operations	Alameda County Behavioral Health
Warder	Rosa	Family Empowerment Manager	Alameda County Behavioral Health
Washington	Tiffany	Program Manager	Anthem, Inc.
Wilson	Javarre	Ethnic Services Manager	Alameda County Behavioral Health
Wolff	Laura	Regional Director of Operations	Telecare Corporation
Wong	Jenny	Management Analyst, Quality Management	Alameda County Behavioral Health
Yano	Aiko	Wraparound Supervisor, Crisis Stabilization Unit	Seneca Family of Services
Yuan	Eric	Manager, Integrated Care Services	Alameda County Behavioral Health
Yun	Jennifer	Mental Health Specialist II, Schreiber Center	Alameda County Behavioral Health
Zastawney	Wendy	Clinical Review Specialist Supervisor	Alameda County Behavioral Health
Valle	Elizabeth	Family Advocate	Family Education & Resource Center
Velasquez	Edilyn	Contracts Director	Alameda County Behavioral Health
Wagner	James	Deputy Director, Clinical Operations	Alameda County Behavioral Health
Warder	Rosa	Family Empowerment Manager	Alameda County Behavioral Health
Washington	Tiffany	Program Manager	Anthem, Inc.
Wilson	Javarre	Ethnic Services Manager	Alameda County Behavioral Health
Wolff	Laura	Regional Director of Operations	Telecare Corporation
Wong	Jenny	Management Analyst, Quality Management	Alameda County Behavioral Health
Yano	Aiko	Wraparound Supervisor, Crisis Stabilization Unit	Seneca Family of Services
Yuan	Eric	Manager, Integrated Care Services	Alameda County Behavioral Health
Yun	Jennifer	Mental Health Specialist II, Schreiber Center	Alameda County Behavioral Health
Zastawney	Wendy	Clinical Review Specialist Supervisor	Alameda 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	CalEQRO has moderate confidence that the methodology is sound, however, it is too early to make conclusions as to the impact of the intervention.
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Alameda County Behavioral Health	
PIP Title: Reducing Psychiatric Emergency Services Recidivism through Pre-Discharge Visits/Follow-up Texts	
PIP Aim Statement: Over the next 15 months, will 1) pre-discharge in-person contact and 2) post-discharge text message follow-up for adults who receive psychiatric emergency services: • Improve the percentage of beneficiaries with outpatient follow-up visits within 7 days and 30 days by 15 percent? • Reduce the percentage of beneficiaries who return to psychiatric emergency services within 7 days and 30 days by 15 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: n/a	

Target population description, such as specific diagnosis (please specify):

The study population is adults who received psychiatric emergency services (PES) who are not admitted to inpatient services and who do not meet "Familiar Faces" program criteria. The descriptions below are based on the 3,728 beneficiaries who met these criteria between June 2020 and May 2021.

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)
A) Pre Discharge In Person Contact B) Post Discharge Text Message Follow up

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
A) Pre Discharge In Person Contact B) Post Discharge Text Message Follow up

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)
n/a

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
7-Day Outpatient Follow-Up	**2019**	5.0% (168/3340)	☐ Not applicable—PIP is in Planning or implementation phase, results not available	**0% (0/5)**	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
30-Day Outpatient Follow-Up	2019	11.0% (366/3340)	☐ Not applicable—PIP is in Planning or implementation phase, results not available	**0% (0/5)**	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
7-Day PES Re-Admission	**2019**	6.3% (209/3340)	☐ Not applicable—	**20.0% (1/5)**	☐ Yes	☐ Yes ☐ No

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
			PIP is in Planning or implementation phase, results not available		☒ No	Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
30-Day PES Re-Admission	**2019**	14.4% (482/3340)	☐ Not applicable—PIP is in Planning or implementation phase, results not available	**60.0% (3/5)**	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

Validation phase (check all that apply):

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

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

Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence
"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

CalEQRO has moderate confidence that the methodology is sound, however, it is too early to make conclusions as to the impact of the intervention.

EQRO recommendations for improvement of PIP:
Some TA was provided during the planning of the PIP. PIP is considered active although additional information is needed – the year for baseline data collection and subsequent remeasurement periods, explanation for low remeasurement numbers given the large size of the MHP, and information that supports the chosen interventions as related to the root cause. Further, given the size of the MHP, it is unclear why statistically significant analysis would not be included when evaluating the impact of the intervention.

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	The PIP, as written, does not establish the causes contributing to beneficiaries not having a primary care doctor. A root cause analysis is needed before the selection of a successful intervention.

General PIP Information
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Alameda County Behavioral Health Care Services
PIP Title: Care Coordination with Primary Care
PIP Aim Statement: This PIP will examine whether implementing care coordination strategies for adult beneficiaries in "service team" case management programs over an 18-month period will: • Reduce beneficiary psychiatric emergency services utilization by 10 percent; • Reduce beneficiary psychiatric emergency services utilization by 10 percent; • Improve beneficiary engagement with physical health services by 20 percent; • Increase the percent of beneficiaries with reduced avoidable physical emergency services utilization by 15 percent over 18 months; and • Improve quantifiable physical health outcomes by 10 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):

This PIP will study adult beneficiaries enrolled in Community Based Organization (CBO) "Service Team" programs. Service Teams provide outpatient mental health, psychiatric, and care management services to individuals living with serious mental health conditions.

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)

The three interventions for this PIP are:

- Implementation of new Primary Care Coordination protocol to increase beneficiary engagement with primary care. (See Protocol Framework.)
- Incorporation of a monthly Primary Care Coordination Report into Primary Care Coordination protocol
- Incorporation of the Community Health Record into the Primary Care Coordination protocol

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

n/a

MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

n/a

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
Percent of beneficiaries who had no service within 90 days	n/a	n/a	☒ Not applicable—PIP is in Planning or implementation phase, results not available	**Goal: -10%**	☐ 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
Percent of beneficiaries who received fewer psychiatric emergency services in the year prior to intervention compared to the year following intervention	n/a	n/a	☒ Not applicable—PIP is in Planning or implementation phase, results not available	Goal: +10%	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of beneficiaries who received a primary care service within the previous year	n/a	n/a	☒ Not applicable—PIP is in Planning or implementation phase, results not available	Goal: +20%	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of beneficiaries who received fewer avoidable physical health emergency services in the year prior to intervention compared to the year following intervention	n/a	n/a	☒ Not applicable—PIP is in Planning or implementation phase, results not available	**Goal: +15%**	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of beneficiaries with a higher-than-normal BMI who reduced their body mass index (BMI) score by 10%	n/a	n/a	☒ Not applicable—PIP is in Planning or implementation phase, results not available	**Goal: +10%**	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of beneficiaries with a higher-than-normal HbA1c who reduced Hemoglobin A1c (HbA1c) score by 10%	n/a	n/a	☒ Not applicable—PIP is in Planning or implementation phase, results not available	**Goal: +10%**	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of beneficiaries with a higher-than-normal blood pressure who reduced their blood pressure measurement by 10%	n/a	n/a	☒ Not applicable—PIP is in Planning or implementation phase, results not available	**Goal: +10%**	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The MHP observed an increase in beneficiaries without primary care outpatient utilization despite being eligible for physical health services through Medi-Cal managed care plan, from 5.8 percent in January 2017 to 17 percent in December 2020. This PIP studies adult beneficiaries enrolled in Community Based Organization (CBO) "Service Team" programs. The MHP will provide three interventions - implementation of new Primary Care Coordination protocol to increase beneficiary engagement , use of a monthly Primary Care Coordination Report, utilization of the Community Health Record. Several performance measures will be tracked including the percent of beneficiaries 1) who had no service within 90 days; 2) received fewer psychiatric emergency services in the year prior; 3) received a primary care service within the previous year; 4) received fewer avoidable physical health emergency services; and 5) had higher than normal body mass index (BMI) score who reduced their BMI by 10 percent. Even though the PIP is ambitious, it is unclear whether all measures are connected to primary care linkage and mental health. This PIP would benefit from a scaled back approach, where there is a clear link between the cause of the problem, the impact on mental health outcomes, and proposed intervention. The focus seems to be centered on service teams and less about population mental health. A root cause analysis or related peer reviewed literature would provide more information on both the population, the problem and cause, and point to a connected solution.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

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

Alameda 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	1,859,411	68,297	3.67%	$419,802,216	$6,147
MHP	131,665	4,213	3.20%	$32,857,798	$7,799

Table D2: CY 2020 Distribution of Beneficiaries by ACB Range

Alameda 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	16,184	85.75%	92.22%	$89,619,179	$5,538	$4,399	44.20%	56.70%
$20K-$30K	1,136	6.02%	3.71%	$27,740,179	$24,419	$24,274	13.68%	12.59%
>$30K	1,554	8.23%	4.07%	$85,398,183	$54,954	$53,969	42.12%	30.70%

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

Alameda MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**701,230**	**$213,822,263**	**13,762**	**$4,871,172**	**2.28%**	**$208,951,091**	**$196,836,952**
JAN20	65,002	$20,342,352	1,365	$550,853	2.71%	$19,791,499	$17,927,105
FEB20	62,217	$18,744,331	1,183	$361,440	1.93%	$18,382,891	$16,872,625
MAR20	67,854	$18,811,732	1,582	$590,693	3.14%	$18,221,039	$16,360,491
APR20	65,787	$16,730,645	1,171	$504,362	3.01%	$16,226,283	$14,773,345
MAY20	60,450	$15,681,012	971	$253,430	1.62%	$15,427,582	$14,211,040
JUN20	55,874	$15,150,235	846	$299,587	1.98%	$14,850,648	$14,022,142
JUL20	54,771	$18,121,210	1,931	$557,957	3.08%	$17,563,253	$16,810,388
AUG20	52,254	$17,510,746	722	$249,049	1.42%	$17,261,697	$16,833,173
SEP20	57,470	$18,970,001	923	$339,407	1.79%	$18,630,594	$18,078,762
OCT20	58,698	$19,450,424	1,100	$420,271	2.16%	$19,030,153	$18,520,629
NOV20	49,341	$16,965,203	924	$346,230	2.04%	$16,618,973	$16,018,473
DEC20	51,512	$17,344,372	1,044	$397,893	2.29%	$16,946,479	$16,408,780
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

Alameda 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	5,932	$1,860,738	38%
Beneficiary not eligible or non-covered charges	2,684	$1,196,664	25%
Claim/service lacks information which is needed for adjudication	1,691	$691,042	14%
Beneficiary not eligible	1,553	$613,574	13%
Service line is a duplicate and a repeat service procedure code modifier not present	549	$220,448	5%
TOTAL	**12,409**	**$4,582,466**	**94%**