

Overview of California External Quality Review Activities

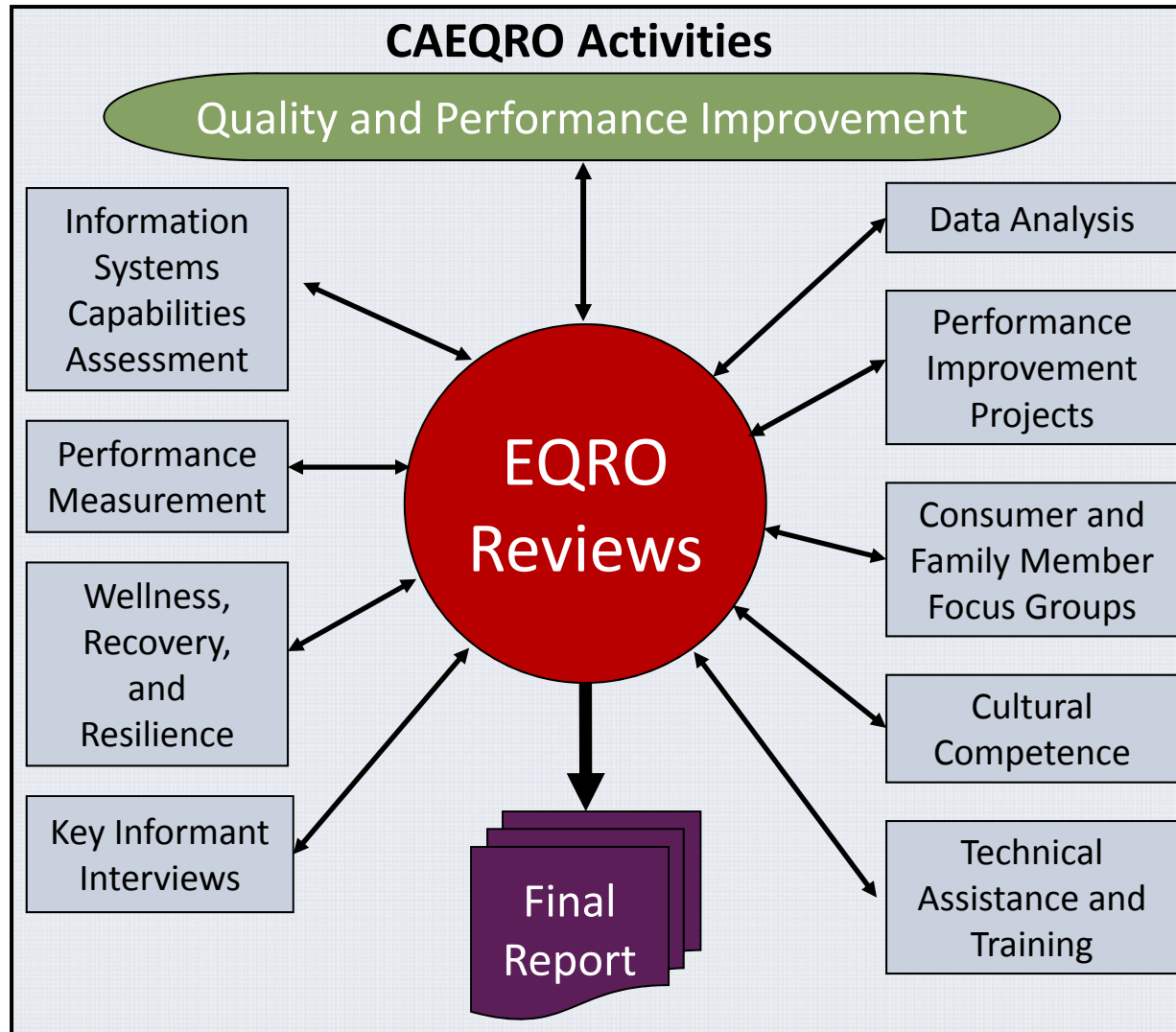
CBHDA Fiscal Administrator Conference

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Rama Khalsa, Director Drug Medi-Cal EQRO
Bill Ullom, Information Systems Chief

BHC | Behavioral Health
Concepts, Inc

Review Activities and Process



Site Review Process for MHPs and DMC-ODS

Highlights

- Consistent core phases
 - Pre-site planning
 - Site visit
 - Post-site analysis
- Customized to MHP/DMC
 - Historical Data
 - Input from many individuals
 - Year-to-year follow up
- Annual update and revision of review materials

We Hear From...

- Clients
- Family Members
- Line Clinical Staff
- Contractor providers
- Key Community Stakeholders
- Health Plans
- Criminal Justice
- Primary Care
- Child Protective Services
- Schools
- Administrative staff

Key Components of an External Quality Review

Mandated by Centers for Medicare and Medicaid Services (CMS)

1. Quality of Care -
2. Access to Care -
3. Timeliness of Services for routine and urgent needs -
4. Outcomes from Treatment -

Key Components EQRO Looks For

1. Quality Components

- A current strategic plan/initiatives drives the service delivery system
- Quality management and performance improvement are organizational priorities
- Data is used to inform management and guide decisions
- Investment in information technology infrastructure is a priority
- Integrity of Medi-Cal claim process, including determination of beneficiary eligibility and timely claims submission
- Effective communication from MHP & DMC-ODS administration
- Stakeholder input and involvement in system planning and implementation
- Consumers and family members are employed in key roles throughout the system

Key Components

2. Access Components

- Service accessibility and availability are reflective of cultural competence principles and practices
- Manages and adapts its capacity to meet service needs
- Penetration Rates are used to monitor and improve access
- Integration and/or collaboration with community based services to facilitate access to care
- Network adequacy is monitored and tracked per State requirements

Key Components

3. Timeliness Components

- Tracks and trends access data from initial contact to first appointment.
- Tracks and trends access data from initial contact to first psychiatric appointment or first dose of Medication Assisted Treatment for SUD.
- Tracks and trends access data for timely appointments for urgent conditions.
- Has a mechanism to assure timely access (within 7 days) to follow up appointments after hospitalization or withdrawal management/SUD residential treatment (within 14 days).
- Tracks and trends No Shows and implements quality improvement activities to improve overall timeliness to services.

Key Components

4. Outcomes Components

- Consumer run and or consumer driven programs & Recovery Support Services
- Measures clinical and/or functional outcomes of consumers served with tools such as CANS, MORS, Treatment Perception Survey
- Has two active Performance Improvement Projects (PIPs)
- Results of PIP activities are spread through programs to enhance best practices and outcomes
- Utilizes information from DMH/POQI Satisfaction Surveys
- Utilizes information from Consumer Satisfaction Surveys and SUD Treatment Perception Survey
- Tracks outcomes using ASAM levels of care for SUD

Consumer/Client/Family Focus Group Processes

- Respect for Culture
- Timely Access
- Responsiveness of Clinical Staff to Needs
- Effectiveness of interventions and services
- Options for improvements
- Customer service
- Recovery supports

Quality: Performance Improvement Projects

- What is a Performance Improvement Project (PIP)?
 - In general terms, a PIP is “a systematic process for improving the quality of care and service designed, conducted and reported in a methodologically sound manner.”
 - To elaborate, the Protocol defines a PIP as “a set of related activities designed to achieve measurable improvement in processes and outcomes of care. Improvements are achieved through interventions that target health care providers, practitioners, plans, and/or beneficiaries.”
(Human Services Research Institute, 2004)
- PIPs are generally more functional if the MHP receives support from team rather than creating it in isolation.
- Challenges
 - Rapid cycle measurements or too many indicators or interventions have been problematic; CalMEND can be of assistance, university collaborations also can be very helpful.

Outcomes

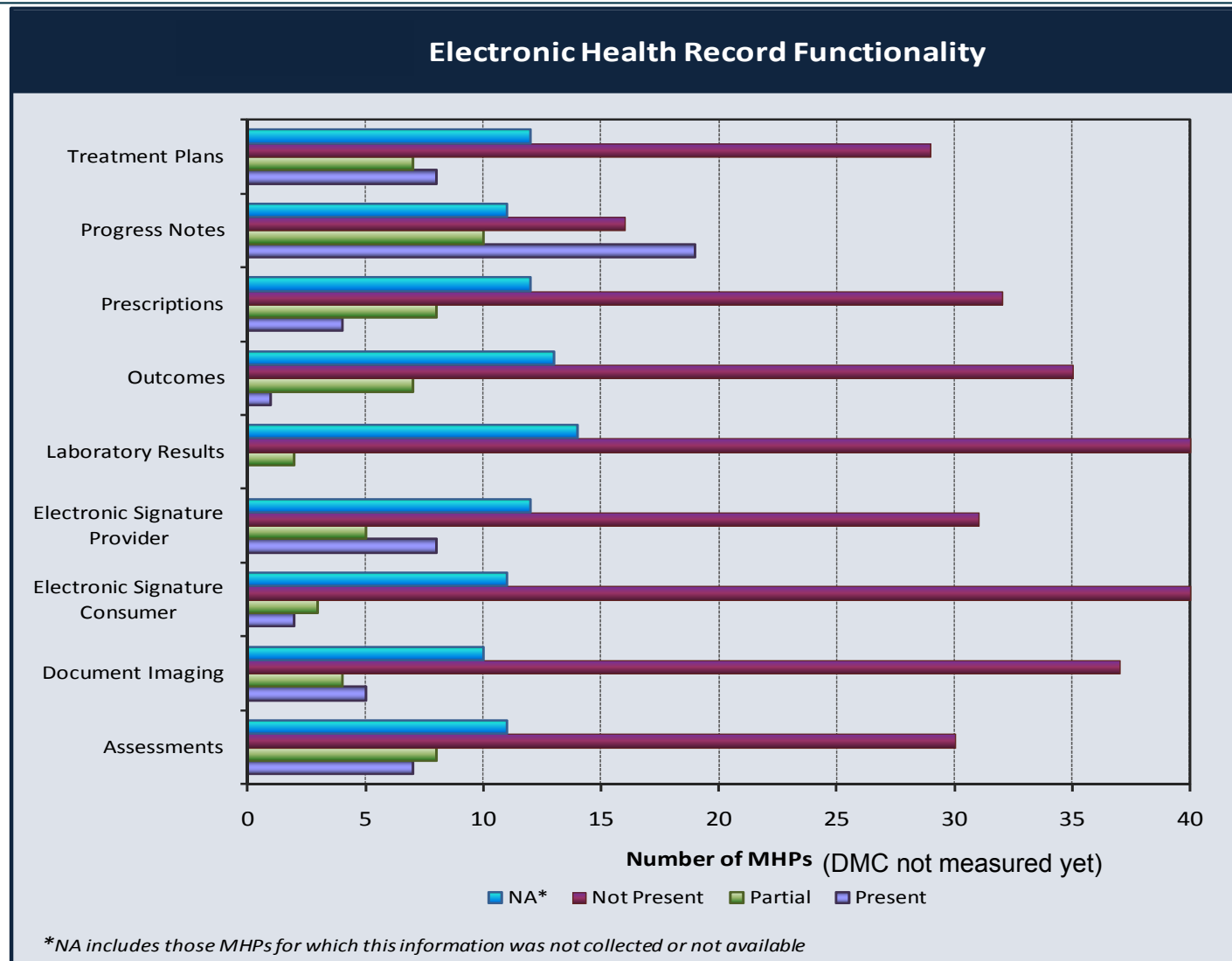
Increase in Beneficiaries Served & High Cost

Statewide Medi-Cal Eligibles & Beneficiaries Served Approved Claims Summary Drug MediCal Baselines			
	2014	2015	2016
Total Medi-Cal Eligibles	6,310,462	7,528,318	8,733,437
Total Beneficiaries Served	51,874	73,122	81,976
Total Approved Claims (in Millions)	\$84.7	\$165.3	\$216.7
% of Beneficiaries served with \$30,000 or more per year*	36%	37%	37%

Timeliness

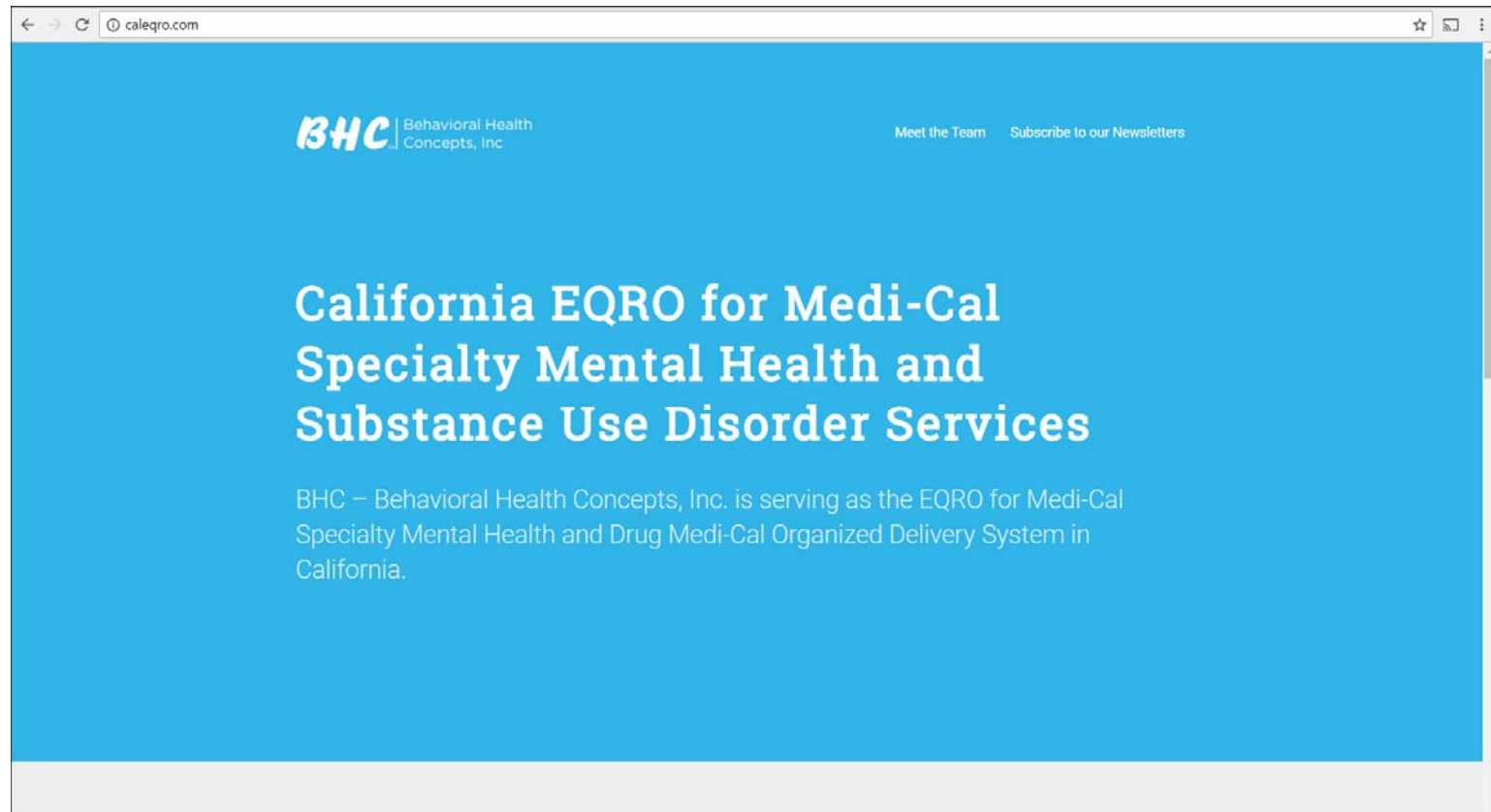
- Use Timeliness Self Assessment Form
- Request to assessment/ first face to face
- Assessment to first treatment contact/service
- Request to first MAT & Psychiatry Appointments
- Post-hospitalization and post residential services
- No show rates

Information Systems



CAEQRO Website – Homepage

- www.calegro.com



SAMPLE PERFORMANCE MEASURES MHP KERN 2016

Table 2: Kern MHP High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY16	19,019	609,608	3.12%	\$53,215	\$1,012,099,960	28.90%
Kern	CY16	258	16,979	1.52%	\$50,519	\$13,033,915	16.27%
	CY15	211	12,794	1.65%	\$47,799	\$10,085,626	15.89%
	CY14	184	13,106	1.40%	\$51,107	\$9,403,685	16.72%

SAMPLE PERFORMANCE MEASURES MHP KERN 2016

Table 14: Kern MHP Summary of CY16 Short Doyle/Medi-Cal Claims

Number Submitted	Gross Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
228,888	\$80,692,445	3,304	\$1,758,887	2.18%	\$78,933,558	\$3,014,412	\$75,919,146

Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017.

The statewide average denial rate for CY2016 was 4.48 percent.

Change to the FFP reimbursement percentage for ACA sld codes delayed all claim payments between the months of January-May 2017.

SAMPLE PERFORMANCE MEASURES MHP KERN 2016

Table 15: Kern MHP Summary of CY16 Top Three Reasons for Claim Denial

Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Other coverage must be billed prior to submission of this claim	1,472	\$638,547	36%
Beneficiary not eligible or aid code invalid or restricted service indicator must be "Y"	967	\$474,190	27%
Missing, incomplete, invalid ICD-10 diagnosis or condition	426	\$309,653	18%
Total Denied Claims	3,304	\$1,758,887	100%

SAMPLE PERFORMANCE MEASURES MHP KERN 2016

Table C1: Kern MHP CY16 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary

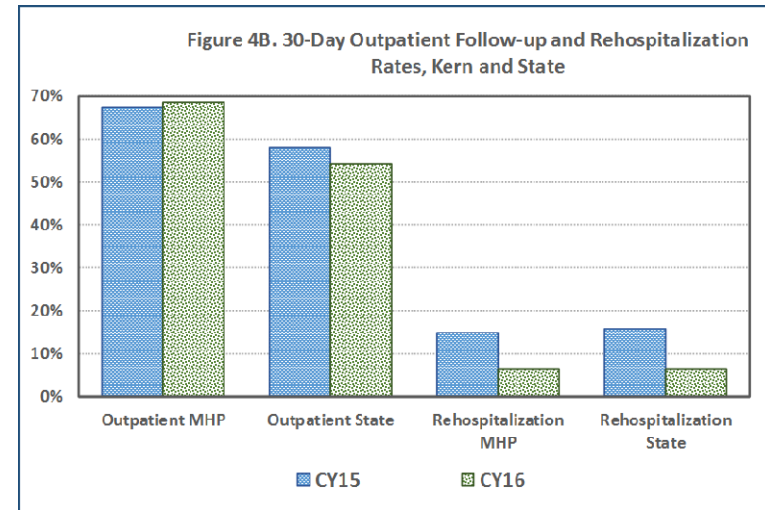
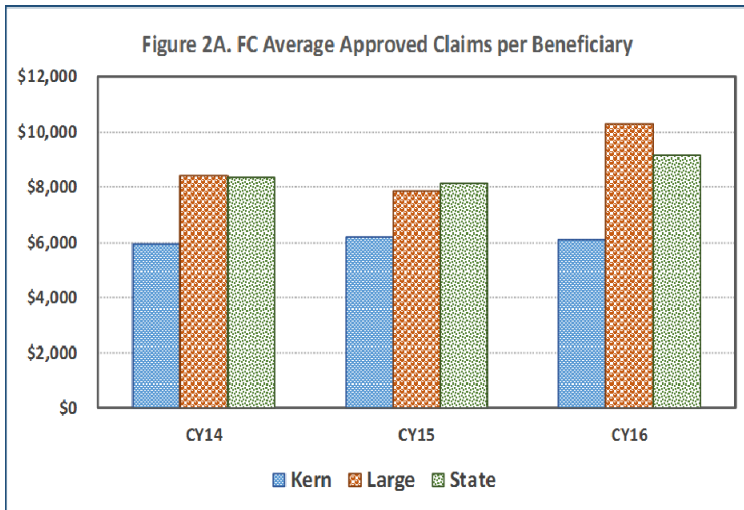
Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,674,069	141,926	3.86%	\$611,752,899	\$4,310
Large	1,778,582	67,721	3.81%	\$318,050,214	\$4,696
Kern	94,261	3,632	3.85%	\$16,182,165	\$4,455

SAMPLE PERFORMANCE MEASURES MHP KERN 2016

Table C2: Kern MHP CY16 Distribution of Beneficiaries by ACB Range

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< \$20K	16,414	96.67%	94.05%	\$59,669,179	\$3,635	\$3,612	74.47%	59.13%
>\$20K - \$30K	307	1.81%	2.83%	\$7,426,496	\$24,191	\$24,282	9.27%	11.98%
>\$30K	258	1.52%	3.12%	\$13,033,915	\$50,519	\$53,215	16.27%	26.90%

SAMPLE PERFORMANCE MEASURES MHP KERN 2016



SAMPLE PERFORMANCE MEASURES MHP KERN 2016

	KERN						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
ELIGIBILITY CATEGORIES											
Disabled	3,101	457	\$3,021,232	14.74%	\$6,611		16.66%	\$8,779		17.54%	\$8,350
Foster Care	617	226	\$1,810,500	36.63%	\$8,011		39.74%	\$12,212		42.42%	\$10,406
Other Child	11,454	821	\$3,353,698	7.17%	\$4,085		6.95%	\$6,710		7.54%	\$6,296
Family Adult	21,069	745	\$2,505,463	3.54%	\$3,363		3.67%	\$4,563		3.90%	\$4,391
Other Adult	305	18	\$44,733	5.90%	\$2,485		9.97%	\$3,518		10.29%	\$3,391
MCHIP	7,432	223	\$810,045	3.00%	\$3,632		2.68%	\$6,240		2.72%	\$6,018
ACA	26,692	910	\$4,059,897	3.41%	\$4,461		2.95%	\$5,061		3.05%	\$4,717

SAMPLE PERFORMANCE MEASURES MHP KERN 2016

	KERN					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
SERVICE CATEGORIES									
Inpatient Services	71,852	228	\$1,912,019	0.32%	\$8,386	0.62%	\$8,748	0.61%	\$8,202
Residential Services	71,852	67	\$398,409	0.09%	\$5,946	0.09%	\$8,669	0.07%	\$8,752
Crisis Stabilization	71,852	751	\$1,401,757	1.05%	\$1,867	0.71%	\$2,463	0.60%	\$2,106
Day Treatment	71,852	4	\$59,985	0.01%	\$14,996	0.04%	\$13,954	0.03%	\$14,168
Case Management	71,852	755	\$474,865	1.05%	\$629	1.47%	\$1,206	1.57%	\$1,033
Mental Health Services	71,852	2,728	\$8,999,258	3.80%	\$3,299	3.30%	\$4,656	3.58%	\$4,416
Medication Support	71,852	1,071	\$1,440,379	1.49%	\$1,345	1.92%	\$1,466	1.96%	\$1,594
Crisis Intervention	71,852	601	\$662,514	0.84%	\$1,102	0.47%	\$1,055	0.66%	\$1,266
TBS	71,852	45	\$188,075	0.06%	\$4,179	0.06%	\$10,905	0.06%	\$9,856

Questions?

Comments?

Suggestions?