A Tale of Two EQROs

Working toward Quality Improvement in California’s Behavioral Health

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Educational Objectives

• Identify the basic elements of an EQRO review
• Recognize the distinct features of MHP and DMC-ODS reviews
• Recognize the distinct features of MHP and DMC-ODS reviews
• Organize county documentation for an EQRO review
• Coordinate the logistics of an EQRO review
• Effectively utilize EQRO resource materials and technical assistance
Outline for this Session

• Background on the waivers
• Requirements of External Quality Review
• Elements of the review
• Similarities and distinctions between mental health and SUD reviews
• Towards fully integrated behavioral health external quality reviews
A Tale of Two Waivers

1995: Medi-Cal Psychiatric Inpatient Hospital Service Consolidation Waiver

1997: Medi-Cal SMHS Consolidation

2000: Consolidated SMHS Waiver

2015: DMC-ODS Waiver

2020: Waiver renewal

Section 1915(b) Waiver: Specialty Mental Health Services

Section 1115 Waiver: Drug Medi-Cal Organized Delivery System
What is EQRO?

E - External
Q - Quality
R - Review
O - Organization

- Access
- Timeliness
- Quality
- Outcomes
- Structure and Operations
External Quality Review (EQR): Background

**Section 1932(c)(2)(A) of the Social Security Act**
- Annual external independent review

**Balanced Budget Act**
- Requires states to develop a quality assessment and improvement strategy consistent with federal HHS standards.
- Requires HHS to develop protocols for use in performance of independent, external reviews of the quality and timeliness of, and access to, care and services provided to Medicaid beneficiaries by Medicaid MCOs and prepaid inpatient health plans (PIHPs).

**Federal Regulations 42 CFR Part 438, Subpart E**
- External Quality Review (recently updated in Final Rule 2016 )

**§438.354-8**
- Activities related to external quality review
- EQR Protocols, May 2016
- Medicaid.gov is great source for research of these issues
# EQR: CMS Definitions

## Quality

The degree to which the MCO increases the likelihood of *desired health outcomes of its enrollees* through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of *the six domains of quality* as specified by the Institute of Medicine (IOM) – *efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness*.

## Validation

Means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

This is the definition of quality in the context of Medicaid/CHIP MCOs, and was adapted from the IOM definition of quality.
### EQR Activities: Mandated Activities

#### Protocol 1
- Compliance Reviews—DHCS does these in CA for MHP and DMC-ODS

#### Protocol 2
- Annual Validation of Performance Measures (PM) – BHC – Drug MediCal EQRO

#### Protocol 3
- Annual Validation of Performance Improvement Projects (PIP) – BHC – Drug MediCal EQRO One Clinically and one Administrative PIP to improve efficiency/compliance

#### Appendix V
- Annual Information Systems Capabilities Assessment (ISCA) – Applicable to Protocols 1, 2, 3, 4, 6 – BHC for both MHP and DMC-ODS for fiscal, claiming, integrity and efficiency
EQR Activities: Additional State Directed Activities

<table>
<thead>
<tr>
<th>Protocol 4</th>
<th>Validation of encounter (service) data reported by MCO/PIHP (done by BHC for MHP and DMC-ODS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol 5</td>
<td>Design and administration of a survey or validation of the results of a previously administered survey – (done by BHC for MHP and DMC-ODS though no survey is selected yet)</td>
</tr>
<tr>
<td>Protocol 6</td>
<td>Calculation of performance measures - done by BHC using claims, eligibility, and CalOMS data.</td>
</tr>
<tr>
<td>Protocol 7</td>
<td>Implementation of PIPs required by the State in addition to the 2 conducted for CMS for MPH and DMC-ODS (none in place at this time)</td>
</tr>
<tr>
<td>Protocol 8</td>
<td>Other quality activities as required by DHCS focused, one-time studies of the DMCs clinical and/or non-clinical services as directed by the State – none in place at this time other than UCLA evaluation which is part of waiver</td>
</tr>
</tbody>
</table>
EQR: State Requirements

**Validation and Analysis of:**

- SUD Performance Measures (PMs)
- DMC-ODS’s Performance Improvement Projects (PIPs)
- DMC-ODS’s Health Information Systems (HIS) Capabilities
- State and County Consumer Satisfaction Surveys

**Additional Items:**

- Client or Family members (CMF) on review teams
- Focus groups with CFM, DMC-ODS Staff, SUD Providers and Other Stakeholders
- Special consultation to DHCS on quality and performance outcomes
- Final written annual report of each DMC-ODS Plan by County or Group
- Annual aggregate statewide report with trends and findings
- Statewide report on DMC-ODS Performance Measure results
- Annual report presentation
EQR: Seven Mandatory Performance Measures

1. Total beneficiaries served by each DMC-ODS
2. Total costs per beneficiary served by each DMC-ODS
3. Penetration rates in each DMC-ODS (what percentage of eligible MediCal persons were served)
4. Timeliness Measures - How much time from request to first treatment visit for different types of care?
5. Measures of Coordination - Signed MOUs, Agreements and protocols for transfers/referrals, consultations and documented access to care in partner system or agency and back to DMC-ODS, also existence of joint programs for co-occurring disorders,
6. Measure of Cultural Competence- threshold languages for access and treatment available, specialty access for disabled and specialty populations and risk groups.
7. Timely Access to Treatment after an acute episode such as detox in a hospital or residential setting – numbers of days to access care.
EQR: Flexible Additional Performance Measures

Additional SUD Performance Measure domains (five in year 1, nine in years 2-5) on care (Below are Examples):

• Access (Network Adequacy for timely access)
• Client Engagement in Services (Intensity of services linked to recovery or length of stay in treatment)
• Services Appropriate to Need (ASAM levels match assessed needs)
• Effectiveness of Services (Use of Evidence Based Practices / Models of care to enhance sustained recovery two or more offered by DMC)
• Linkage to non-DMC-ODS Services and Supports (vocational, housing, childcare, food, education, etc.)
EQR – Performance Improvement Projects (PIPs)

- Use a systematic, proven approach to fix problems in the care system
- Developed with client, family, and community input
- Each DMC-ODS is required to have two active PIPs (underway in the previous 12 months): one clinical and one non-clinical
- PIP Development and Validation tools are on CalEQRO website as part of the review preparation materials (www.caleqro.com)
- The tools closely track each other in terms of the areas they cover, and the process is tightly defined by CMS so use the tools, get examples.
- Trainings and TA offered
EQR: Information Systems Capabilities Assessment (ISCA) Required Components

- Practice Management Systems
- Electronic Health Records Capacity/Integrity
- Billing and Claims
- Privacy, Security and Integrity of Data Systems
- Clinician and Other User Interfaces for Care and Administration
- Provider Interface and/or Interoperability
- Reporting Capabilities for Management of DMC-ODS requirements (operational and clinical)
- Integration of Clinical Care Appropriateness, Timeliness, Access, Quality and Outcome Measures into Data Support Systems
Medi-Cal Specialty Mental Health (MH)

- Focused on validation: Are the counties continuing to meet state requirements?
- Active in all counties across the state
- BHC is the sole evaluator
Drug Medi-Cal Organized Delivery System

- Focused on documentation: telling the story of implementation in each county and how their programs meet the state waiver requirements
- Still rolling out to new counties each year (see map)
- Evaluation occurring in partnership between BHC and UCLA
EQRO Annual Review Cycle

- **September – May**: County reviews and reports
- **March 31**: Next year’s review schedule to DHCS and counties for review
- **July 31**: Draft state aggregate report to DHCS
- **August 31**: Final state aggregate report to DHCS
EQRO County Review Schedule

ON-SITE VISIT
- Executive Leadership and Managers kick off
- Supervisors and Line Staff focus groups
- QM Staff/Analysts responsible for PIPs & PMs
- Contract Provider Exec Leadership and/or Supervisors/Staff
- IS, Billing/Claims, Operations & Fiscal Staff meet w/ IT Reviewer
- Beneficiaries/Consumers and Family Members focus group

POST-SITE VISIT
- Post-site internal team discussions
- Follow-up with DMC-ODS contact on pending items, if any
- Finalize PIP validation
- ISCA report
- Quality reviewer submits draft report to CalEQRO leadership for review and edits
## Elements of a Review: Differences and similarities between MH & DMC-ODS

<table>
<thead>
<tr>
<th>Category</th>
<th>DMC-ODS only</th>
<th>Both</th>
<th>MH only</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASAM Levels of Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PIPs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ISCA</td>
<td>Very similar; Counties choose to do integrated or separate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeliness</td>
<td>Some contents differ based on specialty area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Components</td>
<td>Some contents differ based on specialty area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMs</td>
<td>Six are the same; Others linked to clinical research or national guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Focus Groups</td>
<td>Groups and interview guides vary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiary Focus Groups</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pathways to Wellness</td>
<td></td>
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</tr>
</tbody>
</table>

**Note:**
- DMC-ODS only: Contents specific to DMC-ODS.
- Both: Contents common to both MH and DMC-ODS.
- MH only: Contents specific to MH.
# MH/DMC-ODS County-Level Reporting Differences

<table>
<thead>
<tr>
<th></th>
<th>MH</th>
<th>DMC-ODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>Key Initiatives</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>Response to Recommendations</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Performance Measures</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Performance Improvement Plans</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Information Systems Capabilities Assessment</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Network Adequacy</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>Beneficiary Focus Groups</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Key Components</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Summary of Findings</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Recommendations</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Integrated Reviews (Side-by-Side Reviews)

Shared sessions where possible:

- ISCA (when on one data system)
- Coordination with health plan(s)
- Coordination with criminal justice
- Treatment and assistance to individuals who are homeless
- Performance Improvement Plans (PIPs) for Co-Occurring Clients
- Coordinating programs between SUD and MH

Other Features:

- Joint team assessments of regional BH systems
- Joint team assessments of children’s systems of care
Looking to the Future: Integrating Services

According to the National Survey on Drug Use and Health, 9.2 million U.S. adults experienced both mental illness and a substance use disorder in 2018.

Individuals with a mood or anxiety disorder are about twice as likely to have a substance use disorder as well.

Co-occurring disorders require a comprehensive approach to diagnosis and treatment.

Waiver renewal process is focused on ways to overcome barriers to integration across systems.
## Co-Occurring Disorders Quadrant Model

<table>
<thead>
<tr>
<th>I</th>
<th>II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse System</td>
<td>Specialized Co-Occurring Disorder Treatment Programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care System</td>
<td>Mental Health System</td>
</tr>
</tbody>
</table>

Co-Occurring Disorders: Current System of Coverage

- Mild-to-Moderate mental health services
- Emergency SUD

Physical Health MCO

- Serious mental health services

MHPs

- SUD services along the entire ASAM Levels of Care (gaps exist)

DMC-ODS

- Providing all behavioral health services

Integrated Systems
# SAMHSA Framework for Levels of Integrated Care

<table>
<thead>
<tr>
<th>Coordinated</th>
<th>Co-Located</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Element:</strong> Communication</td>
<td><strong>Key Element:</strong> Physical Proximity</td>
<td><strong>Key Element:</strong> Practice Change</td>
</tr>
<tr>
<td>Level 1: Minimal Collaboration</td>
<td>Level 2: Basic Collaboration at a Distance</td>
<td>Level 3: Basic Collaboration Onsite</td>
</tr>
<tr>
<td>Level 4: Close Collaboration w/ Some System Integration</td>
<td>Level 5: Close Collaboration Approaching Integrated Practice</td>
<td>Level 6: Full Collaboration in a Merged Integrated Practice</td>
</tr>
</tbody>
</table>
Preliminary IPAT Rating of Mental Health and Physical Health Service Integration in SUD Programs

Integrated Practice Assessment Tool (IPAT)
Developed by SAMHSA-HRSA Center for Integrated Health Solutions
Adapted to assess SUD-MH and SUD-PH integration using SAMHSA Framework for Levels of Integrated Healthcare

Areas of Integration in MH/DMC Programs

Access Call Center
Outpatient Access and Treatment Points
Specialty Services for COD
Information Systems
Organization and Leadership
Quality Improvement Planning
Individual Clinicians
## Barriers and Challenges to Integrating Care

<table>
<thead>
<tr>
<th>Systems &amp; Operations Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Different billing &amp; documentation requirements</td>
</tr>
<tr>
<td>• Different data reporting requirements (federal and state)</td>
</tr>
<tr>
<td>• Separate cost reporting</td>
</tr>
<tr>
<td>• Differing licensing requirements at facility and clinician level</td>
</tr>
<tr>
<td>• Firewalls due county counsel interpretations of 42CFR Part 2</td>
</tr>
<tr>
<td>• Data lag</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No equivalent to ASAM Levels of Care for mental health</td>
</tr>
<tr>
<td>• Different lengths of stay in optimal treatment engagement</td>
</tr>
<tr>
<td>• Inpatient availability</td>
</tr>
<tr>
<td>• Mild-to-moderate access</td>
</tr>
<tr>
<td>• Differing causal factors and best practices</td>
</tr>
<tr>
<td>• Stigma and denial</td>
</tr>
</tbody>
</table>
Documents to be Completed by the MHP prior to On-Site Review

**PIP Development Outline**
- No change

**MHP Assessment of Timely Access**
- New this year – Timeliness standards are now aligned with DHCS standards

**ISCA**
- No significant change
- Three versions – MHP only, DMC only, MHP-DMC joint review

**Katie A./Pathways to Well-Being**
- No change at this time, may be revised during FY 2019-20

**MHP Response to FY 2018-19 Recommendations**
- Organized by domains
Documents for MHP and DMC Reference

PIP Development Implementation & Submission Tool (www.calegro.com)
• No Change

Key Components (www.calegro.com)
• Significantly Revised (see next slides)

Approved Claims Summaries – Overall, Foster Care, TAY, ACA, PM Tables (available on Box by invitation only)

CFM Focus Group Guidelines (see slide 14)
DMC-ODS Specialty Mental Health Services (SMHS) Coordination of Care Efforts: BHC reviews required efforts related to coordination with physical health and mental health for Seniors and Persons with Disabilities (SPDs) Project

- Medi-Cal Managed Care Health Plans (MCPs)
- Fee for Service Medi-Cal (FFS/MC) Providers
- Community Clinics (Federally Qualified Health Clinics) FQHCs and RHCs (Rural Health Clinics)
- County Mental Health Plans (MHP)
- MCP Rural Health Initiatives
EQR: Performance Improvement Guidelines

• Clinical PIPs might target
  • Prevention and care/treatment of acute and chronic Substance Use conditions, like binge drinking, opioids overdose prevention in methadone clients, etc.
  • High-volume services for clients using super intensive service levels (For example, many detox and residential services without stabilization or reduced drug use)
  • High-risk conditions
    • Infrequent but high-risk conditions, services, or procedures (for example, HIV plus IV Opioid use)
    • Populations with special health care needs (example, complex cases with cardiac conditions using Meth)
EQR: Performance Improvement Guidelines

• Non-Clinical PIPs might target
  • Coordination of care systems (example, increasing Primary Care Physicians using SBIRT screening and referral with releases)
  • Appeals, grievances process improvements
  • Access or authorization systems improvements to reduce delays (example, reduction of dropped calls at access phone line or reduction in wait times or direct phone access to person in your primary language)
  • Member services (example, customer service improvements and enhanced options for client choice of counselors or programs, more regular client experience of care feedback from different cultures)
EQR: PIP Validation

Activity 1 – Assess the study methodology (does it follow CMS guidelines – on www.caleqro.com website)

Activity 2 – Verify Performance Improvement study findings (optional)

Activity 3 – Evaluate overall performance improvement validity and reliability of study results
EQR: PIP Validation Activity 1 - Assessment of Study Methodology

1. Review the selected PIP study topics
2. Review the PIP study question(s)
3. Review the selected PIP study indicators of improvement
4. Review the identified PIP study target population
5. Review the sampling methodology (if sampling is used)
6. Review the data collection procedures to insure consistency
7. Assess the DMC-ODS Plan’s improvement strategies
8. Review the PIP data analysis and interpretation of study results
9. Assess the likelihood that reported improvement is “real” improvement
10. Assess the sustainability of documented improvement
EQR: PIP Validation Activity 2 – Verify Study Findings (Optional)

- The key focus in this activity is validating the processes through which data needed to produce quality measures were obtained, converted to information, and analyzed for integrity.
- This is optional for States as this is a resource intensive activity (not done at this time)
EQR: PIP Validation Activity 3 – Evaluate and Report Overall Validity and Reliability of PIP Results

• Following Activity 1 and Activity 2 (if performed), the EQRO will assess the validity and reliability of all findings to determine whether or not the State has confidence in the MCO’s reported PIP findings.

• As studies generally have some weaknesses, the EQRO will need to accept threats/potential problems to the accuracy of the PIP, and determine PIP generalizability of improvement results as a routine fact of QI activities.

• EQRO reports a level of confidence in its findings for the DMC-ODS Validity for PIPs:
  • High confidence in reported PIP results
  • Confidence in reported PIP results
  • Low confidence in reported PIP results
  • Reported PIP results not credible
CalEQRO Resources

CMS Resources

EQRO Protocol:
Questions?