

MEDI-CAL SPECIALITY MENTAL HEALTH EXTERNAL QUALITY REVIEW

VALIDATION OF PERFORMANCE MEASURES



Prepared for
**the California Department of Health
Care Services (DHCS)**

By
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INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid managed care services. CMS rules (42 Code of Federal Regulations [CFR], Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) specify the requirements for evaluation of Medicaid managed care programs. These rules require an onsite review or a desk review of each Medi-Cal Mental Health Plan (MHP).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents California External Quality Review Organization's (CalEQRO) fiscal year (FY) 2018-19 findings on key performance measures (PMs) for California's Medi-Cal funded SMHS delivered by the county MHPs.

The statewide annual report presents the results of CalEQRO's validation of seven mandatory PMs as defined by DHCS (listed in bold, below), as well as additional PMs. They include:

- **Total beneficiaries served by each county MHP**
- **Penetration rates in each county MHP**
- **Total costs per beneficiary served by each county MHP**
- Penetration rates for vulnerable and underserved populations
 - Hispanic/Latino
 - Foster Care
- Approved claims for vulnerable and underserved populations

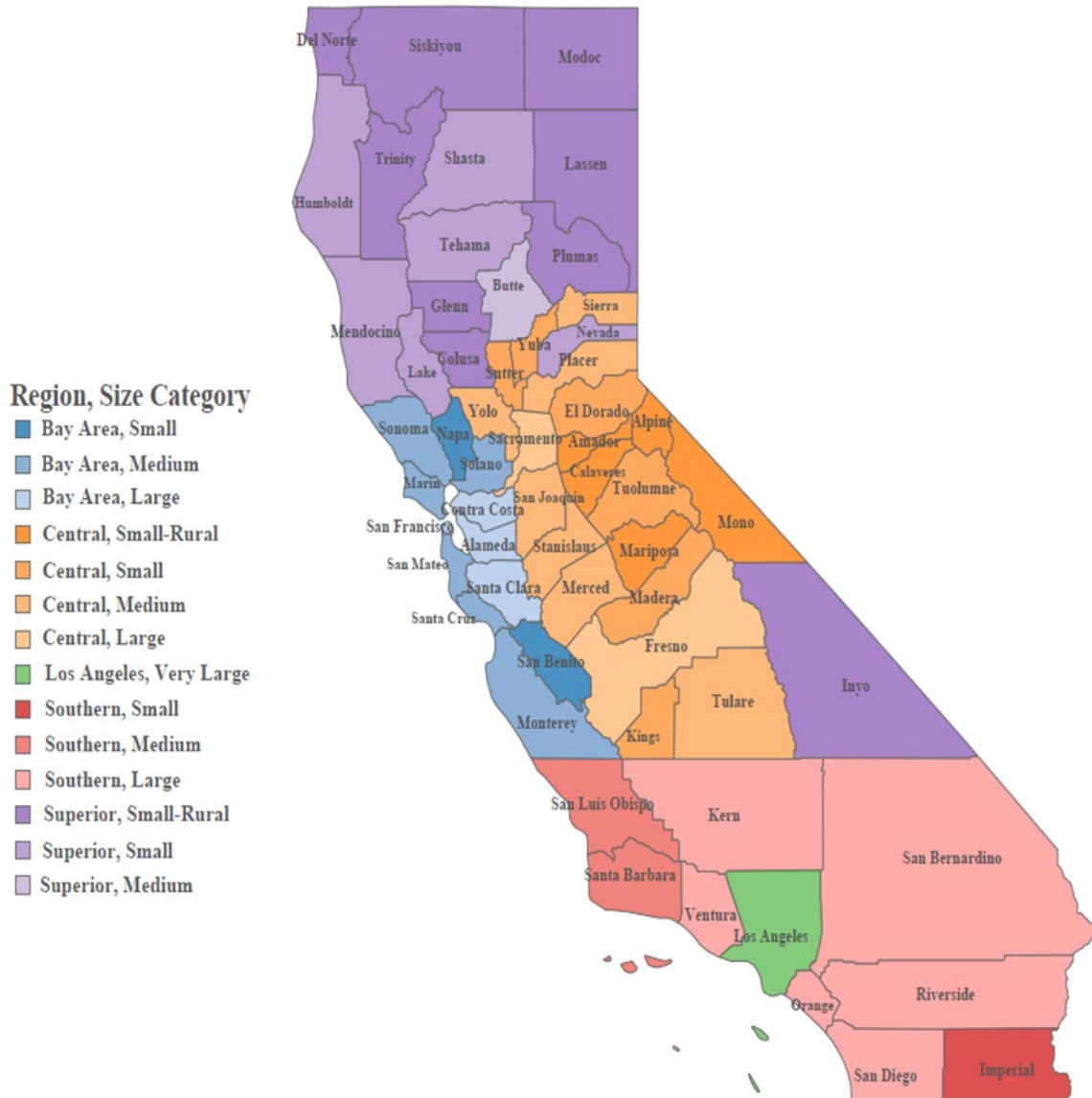
INTRODUCTION

- Hispanic/Latino
- Foster Care
- High-Cost Beneficiaries (HCBs), incurring approved claims of \$30,000 or higher during a calendar year (CY)
- **Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent *Emily Q.* benchmark**
- **Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates**
- **Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates**
- **Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS)**
- Beneficiary counts by diagnostic groups
- Approved claims by diagnostic groups
- Affordable Care Act (ACA) analysis:
 - Eligibles and beneficiaries served
 - Penetration rates
 - Approved claims per beneficiary (ACB)
 - Beneficiary counts by diagnostic groups
 - Approved claims by diagnostic groups

CalEQRO also reports on various timeliness PMs self-reported by the MHPs using the Timeliness Self-Assessment (TSA). A full analysis of those measures can be found in Section 2 of the annual report.

Figure 1 displays California MHPs by region and size.

Figure 1: California MHPs, by Region and Size



METHODOLOGY

CalEQRO analyzes a specific subset of California's population. Specifically, the analyses include California residents who are elderly, disabled, fall below the poverty line, and are in need of mental health services. To be included in this population, a person must meet the criteria for Medi-Cal benefits. The term "eligible" is used to describe a person who is eligible to receive services funded through Medi-Cal. Eligibles are counted even if they have not received SMHS. The term "beneficiary" is used to describe a person who is Medi-Cal eligible and has received SMHS funded by Short-Doyle Medi-Cal (SDMC). PMs are calculated on a CY basis.

Data sources for the analysis include: SDMC, Inpatient Consolidation Claims (IPC), Medi-Cal Eligibility File (MMEF), and provider files. SDMC and IPC files are requested from DHCS on a bi-annual basis and cover one CY of claims for reporting. An MMEF is requested during the same time period and covers 15 months of eligibility.

After CalEQRO data requests have been submitted and approved, DHCS processes the request and goes through a series of steps that include pulling the data, conducting quality assurance for accuracy, and initiating the approval process. Once the data are approved and ready for release, DHCS posts all data through the Information Technology Web Services for CalEQRO to download. Data files are then securely downloaded onto CalEQRO's Health Insurance Portability and Accountability Act (HIPAA)-compliant server. SAS® (Statistical Analysis Software) is used to process and produce all data and reports. The analysis plan follows the guidelines of the specified PMs created with DHCS.

All data files are first read into SAS through a series of tailored programs to input different file types and combine datasets. After the initial datasets are in the working directory, basic formatting and many calculations and groupings are applied, such as CalEQRO's method for reporting on eligibility. Medi-Cal eligibility is reported in CalEQRO summaries as a monthly average, to account for those who have varying eligibility throughout the year. This monthly average is calculated by summing the eligible counts for each month by client index number and eligibility status and then dividing the annual sum by 12, resulting in a monthly average of eligibles. This average is later used for

METHODOLOGY

many analyses, such as penetration rate reporting. The SDMC and IPC data undergo formatting and calculations as well, generating a larger clean dataset combined with the MMEF where service categories, eligibility groups, and demographic information are together, ready to be analyzed.

The service categories and eligibility groupings are derived from the Aid Code Master Chart and the SDMC Billing Manual, in addition to expert knowledge from DHCS's Information Technology team. CalEQRO uses five size categories based on California Department of Finance population estimates in computing its PMs: very large, large, medium, small, and small-rural. Los Angeles is sometimes included in the large size category depending on the EQRO report areas. MHPs are also grouped by five regions: Bay Area, Central, Los Angeles, Southern, and Superior.

CalEQRO produces summaries and reports that are released to the MHPs prior to their onsite EQRO visits. Below are the CY 2017 PM results; several measures are trended across three years at the statewide, regional, and MHP size levels. Most PM data reported in this section were used onsite for the MHP reviews and reports.

RESULTS

Beneficiaries Served by MHPs

The numbers of eligibles and beneficiaries served are calculated at the statewide, MHP, region, and size levels. This calculation is derived from the total number of approved claims in the combined SDMC and IPC dataset. It accounts for beneficiaries who have moved to different MHPs throughout the year or received services across MHP lines. The beneficiaries are uniquely identified by client index number (CIN). Beneficiaries who received multiple services in the same level (MHP, region, and size) would not be counted more than once in this measure. The number of eligibles is calculated using the monthly average discussed in the methodology section, above. This measure allows CalEQRO to examine the number of people who are eligible for Medi-Cal against the number of beneficiaries who were served by the MHPs, giving an overall idea of how many people can receive a service and how many people actually do so.

As seen in Figure 2-1a, the total number of statewide eligibles increased between CY 2015 and CY 2016 but decreased between CY 2016 and CY 2017, with the total number of statewide eligibles in CY 2017 standing at 13,532,216.

The number of beneficiaries served continued to decrease slightly over the years. This decrease in beneficiaries served, as displayed here, may be partly due to the lag in claims submissions in the final months of CY 2017 for a few MHPs.

At the region and MHP size levels, the same patterns seen in the statewide data are noted in the number of eligibles and beneficiaries served, as displayed in Figure 2-1b, Figure 2-1c, and Figure 2-1d. Figures 2-1b and 2-1c show that the Southern and Los Angeles regions account for the greatest number of eligibles and beneficiaries served in the state. Los Angeles also showed a slight increase in beneficiaries served, while the other regions registered small declines. Figure 2-1d shows small-rural and small MHPs had the smallest number of eligibles and served the smallest number of beneficiaries.

RESULTS

Figure 2-1a: Statewide Eligibles and Beneficiaries Served, CY 2015-17

A decrease in beneficiaries served is observed between CY 2016 and CY 2017.

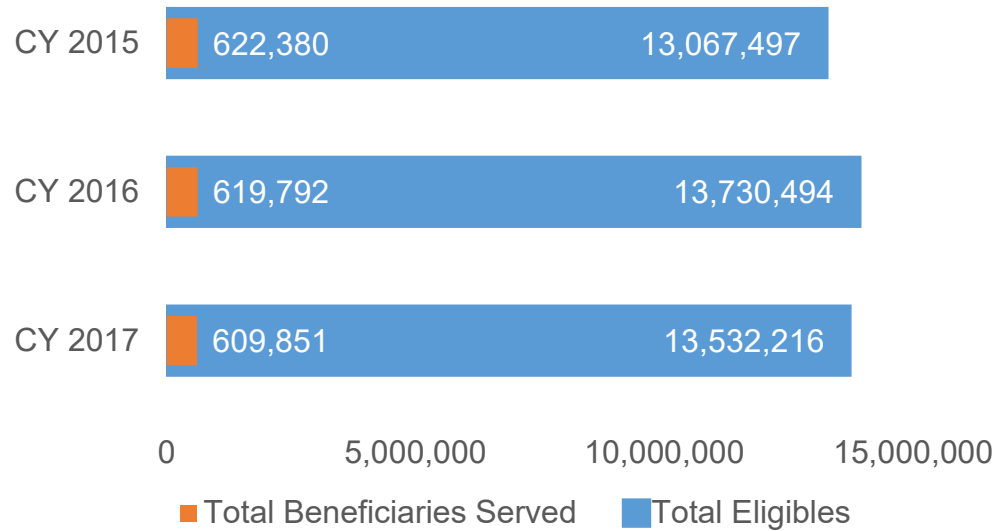


Figure 2-1b: Region Eligibles and Beneficiaries Served, CY 2015-17
The Los Angeles and Southern regions continuously account for the greatest number of eligibles and beneficiaries served each year.

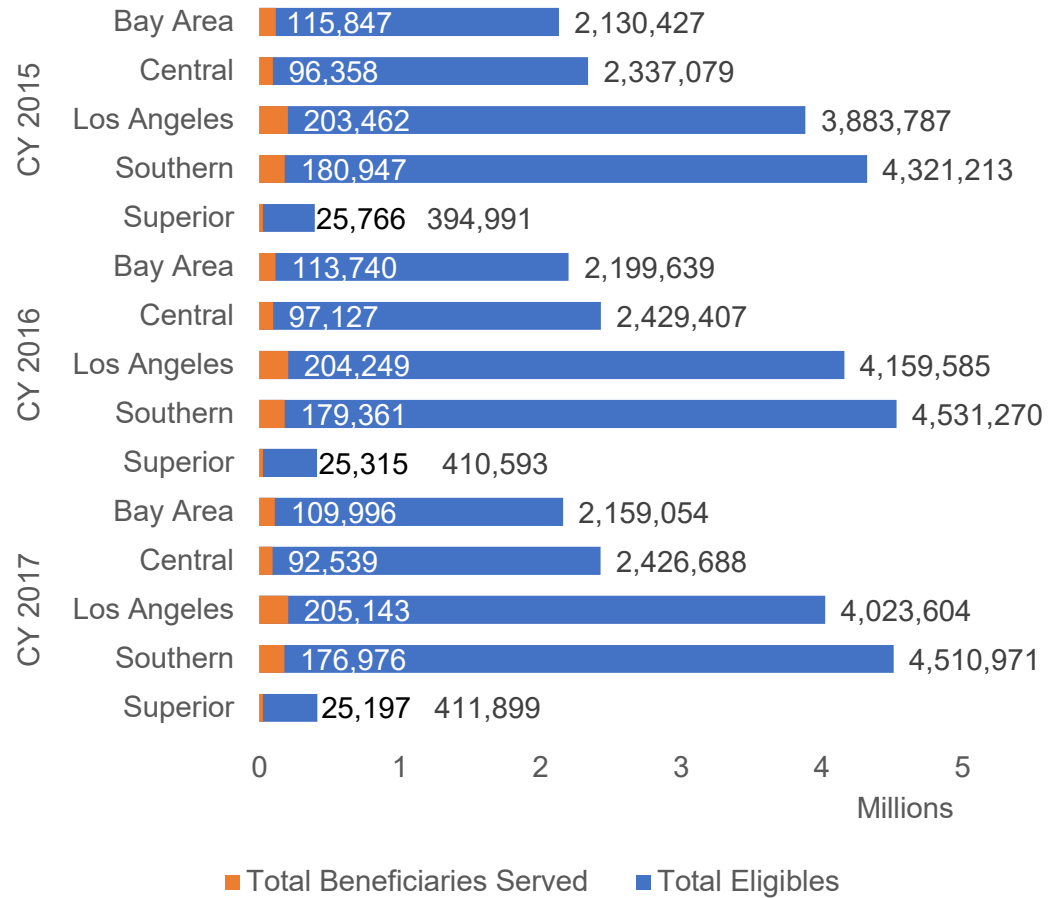


Figure 2-1c: Beneficiaries Served by Region, CY 2015-17

Another view of beneficiaries served by region: the number served. Los Angeles accounted for one-third of Medi-Cal beneficiaries served.

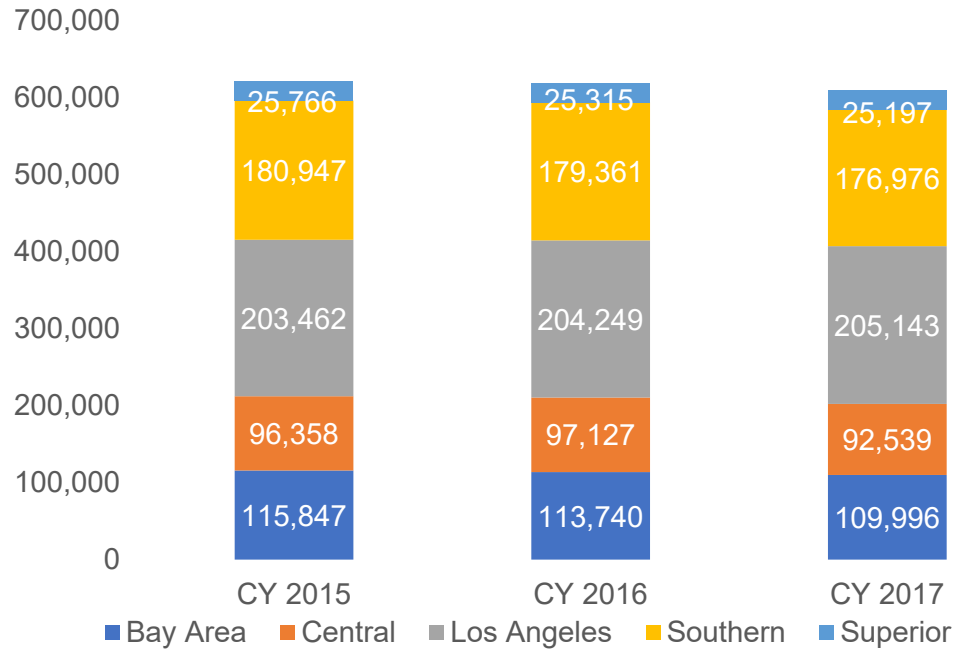
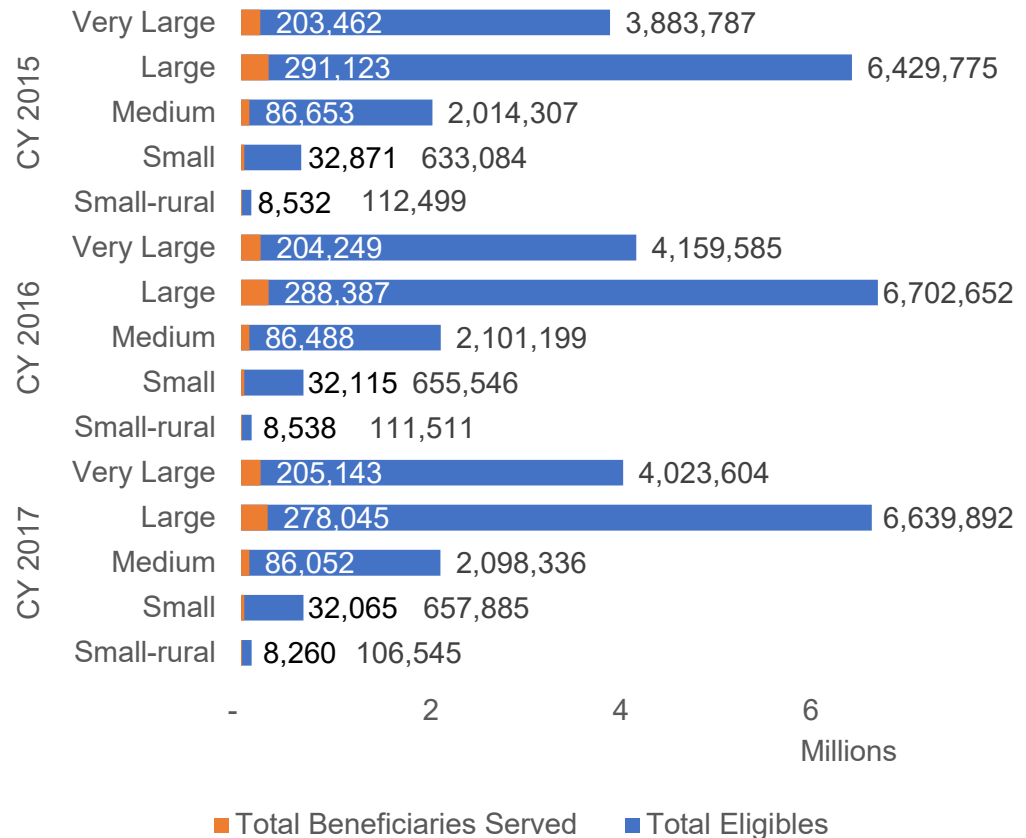


Figure 2-1d: Total Eligibles and Beneficiaries served by MHP Size, CY 2015-17



Penetration Rates

Penetration rate is a parameter used to measure access to SMHS for the Medi-Cal population. It remains a widely used standard for measuring access to care across different health care areas, including behavioral health, and is calculated by dividing the number of beneficiaries served each year by the number of eligibles. The penetration rate is calculated at the statewide, region, size, and MHP levels.

As seen in Figure 3-1a, statewide penetration rates decreased from 4.8 percent in CY 2015 to 4.5 percent in CY 2016, while remaining the same for CY 2017. This decrease may be attributable to significant increases in the number of eligibles during this period coupled with a slightly lower number of beneficiaries served.

Figure 3-1a shows that regional penetration rates have been decreasing with the exception of Los Angeles, which increased slightly in CY 2017. The Central and Southern regions had the lowest penetration rates, which were significantly lower than the other regions. The Superior region had the highest penetration rate in CY 2017.

Penetration rates have declined slightly or remained steady for most MHP sizes as well since CY 2015 (Figure 3-1b). In CY 2017, medium and large MHPs had the lowest penetration rates. The small-rural MHPs have consistently had one of the highest penetration rates across the past few years, including in CY 2017. The urban areas have had a greater influx of new Medi-Cal eligibles than the small-rural MHPs, which directly affected the penetration rates of large and very large MHPs.

Figure 3-1a: Overall Penetration Rates by Region, CY 2015-17

Penetration rates have been decreasing or remain the same each year across regions, with the exception of the Los Angeles region.

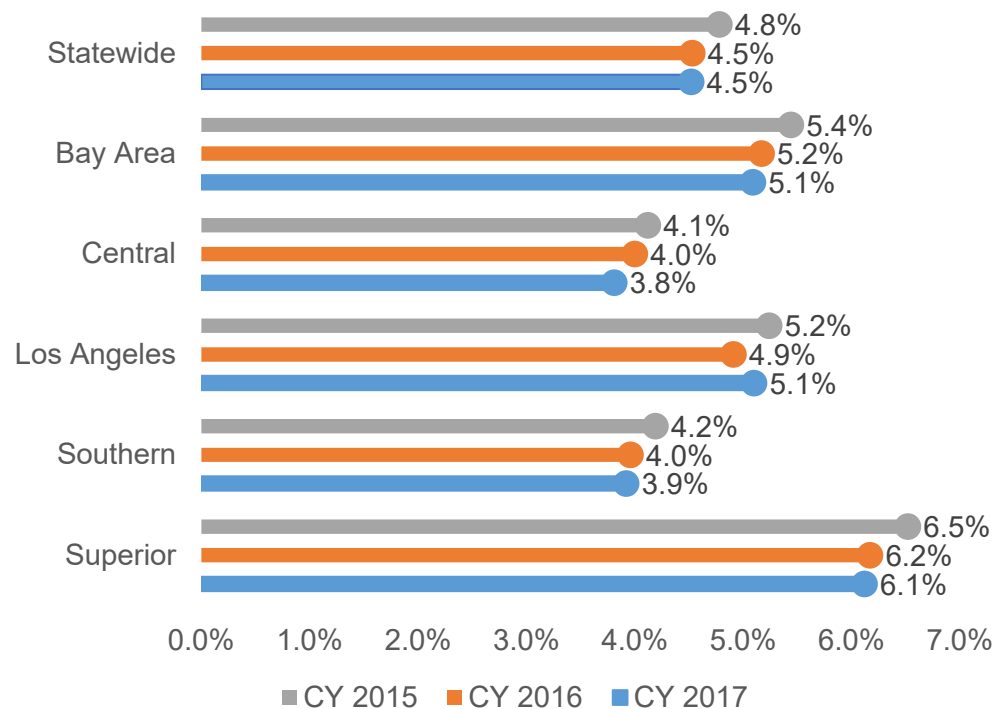


Figure 3-1b: Overall Penetration Rates by Size, CY 2015-17

Penetration rates have been decreasing or remain the same each year for all MHP sizes, with the exception of the very large MHP.

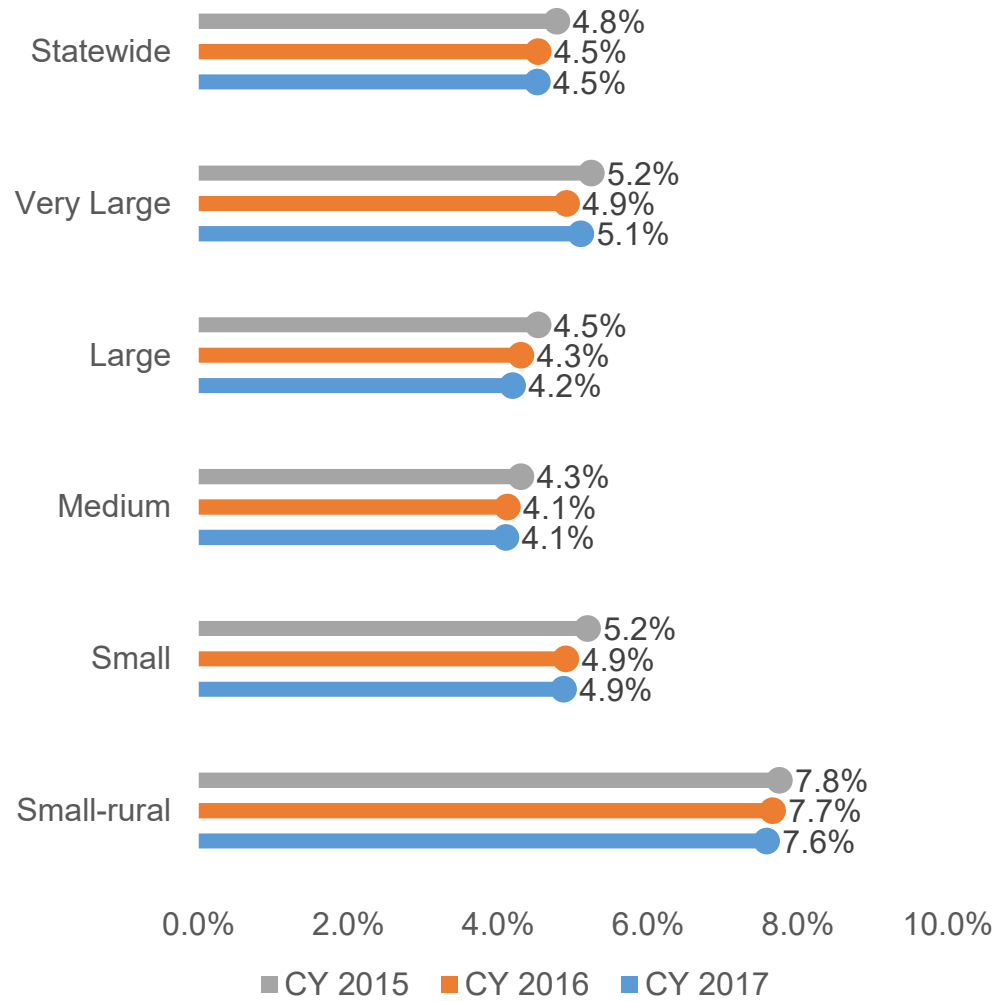


Figure 3-1c shows some regional variations in penetration rates, by age group. Statewide, the highest penetration rate is seen among children ages 6 to 17, followed by adults ages 18 to 59. The exception was Los Angeles, where the adult penetration rate was higher than the children’s and the older adult population (60+) had the lowest penetration rate. Children 0 to 5 have the lowest penetration rates in each region, at about a third the rate of children 6 to 17 and about half or less the rate of adults. This pattern most likely reflects a lower rate of serious mental

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illness diagnoses among very young children as well as other payer sources, including Medicare, for older adults.

The Superior and Los Angeles regions show proportionately much higher penetration rates for 6- to 17-year-olds. Bay Area and Superior MHPs show a slightly higher penetration rate for adults ages 18 to 59 than the other regions.

Figure 3-1c Penetration Rates by Region and Age, CY 2017

The age group of 6 to 17 had the highest penetration rate in each region during CY 2017.

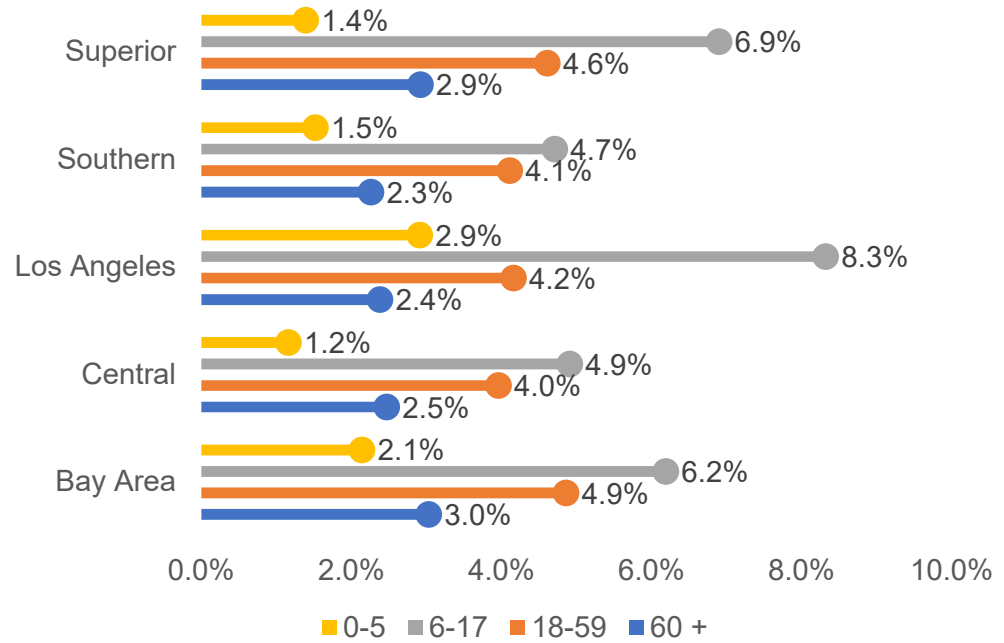
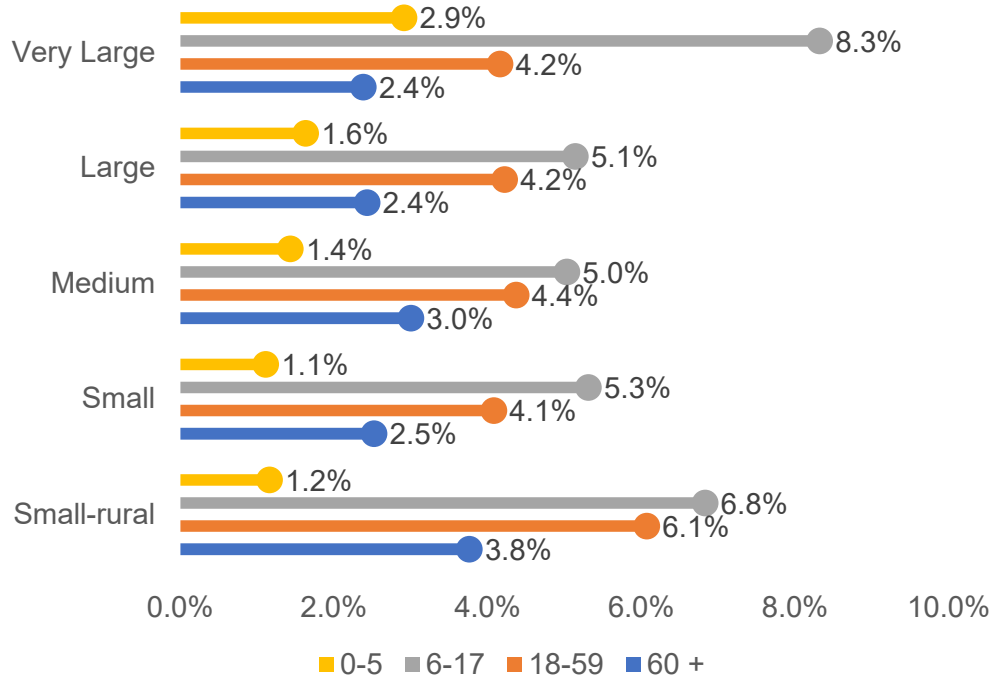


Figure 3-1d shows that in terms of MHP size, the small-rural MHPs show a higher penetration rate for older adults, at 3.8 percent. While not numerically large, this shows a greater need for Medi-Cal-funded SMHS for older adults in rural areas. The older adult penetration is approximately equal for the other MHPs sizes, ranging from 2.4 percent in the large MHPs to 3.0 percent in the medium-sized MHPs.

Small-rural MHPs had the highest penetration rate for adults at 6.1% while the other MHP size averages had little variation in adult penetration rates.. Very large MHPs show the highest penetration rate for children ages 6 to 17 at 8.3 percent, followed by the small-rural MHPs at 6.8%.

Figure 3-1d: Penetration Rates by Size and Age, CY 2017

The age group of 6 to 17 had the highest penetration rates across all MHP sizes



Costs per Beneficiary Served

Approved claims are calculated as a total amount as well as the average ACB. The figure for total approved claims dollars is generated from the SDMC and IPC data. The total numbers of approved, denied and replaced, and voided and replaced claims are considered when calculating dollar amounts.

As seen in Figure 4-1a, the statewide approved claims were mostly increasing or relatively unchanged each year in terms of regional trends, with the exception of the Central region, which decreased by about \$60,000,000 between CY 2016 and CY 2017. The Bay Area and Central regions saw the most year-to-year variation in approved claims. Conversely, the Southern and Superior regions' approved claims were relatively steady during CY 2015 and CY 2017, with only small increases within the three years.

Figure 4-1b shows that very large and large MHPs experienced an increase in total approved claims in CY 2017, while medium-sized,

small, and small-rural MHPs stayed the same. In CY 2015, the total approved claims amount for large MHPs was \$1,569,980,425, increasing to \$1,854,360,021 in CY 2016 and then decreasing to \$1,869,331,440 in CY 2017.

Figure 4-1c shows that the Bay Area region had the highest amount of approved claims for children aged 6 to 17 and that this age group had the highest total amount of approved claims in each region. Children in the age group 0 to 5 had the lowest amount of approved claims in all regions except Los Angeles, where older adults had the lowest amount of approved claims. Similarly, Figure 4-1d shows children in the age group of 6 to 17 had the highest approved claim amounts across various size categories.

Figure 4-1a: Overall Approved Claims by Region, CY 2015-17

Overall approved claims have changed unevenly from CY 2015 to CY 2017 across the regions. The Bay Area and Los Angeles regions' claims increased the most; together, they accounted for two-thirds of the total approved claims in the state. The Central region MHPs showed a decline in total approved claims.

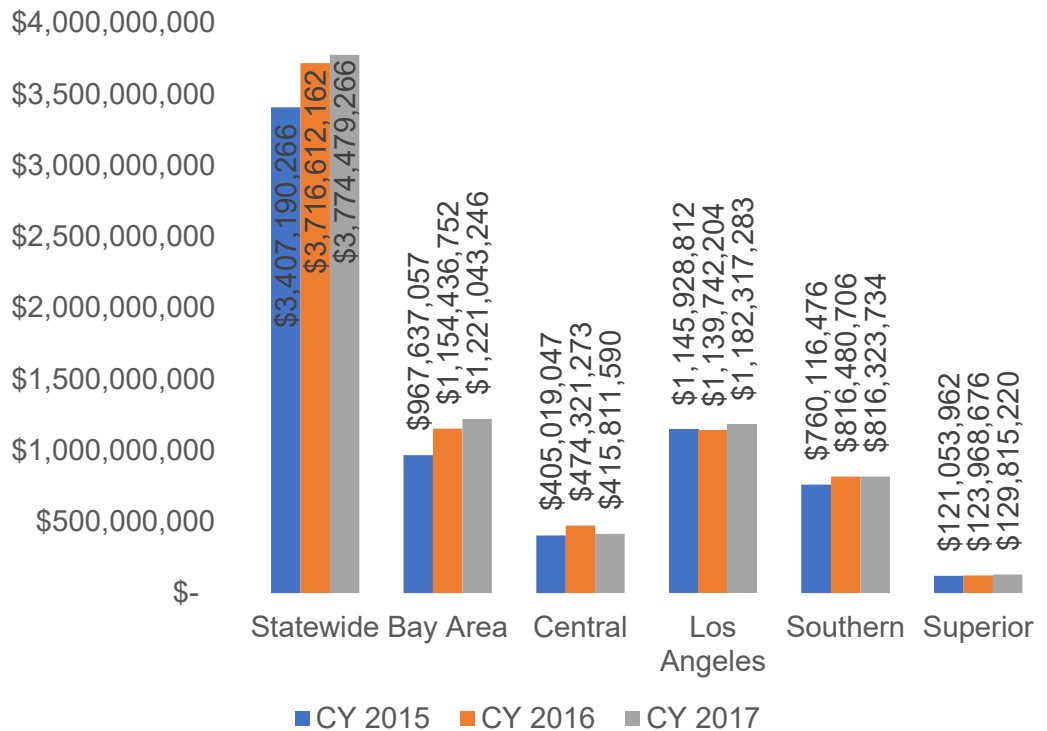


Figure 4-1b: Overall Approved Claims by Size, CY 2015-17

Large and very large MHPs had slight increases in approved claims during CY 2016-17, while all other sized MHPs stayed about the same.

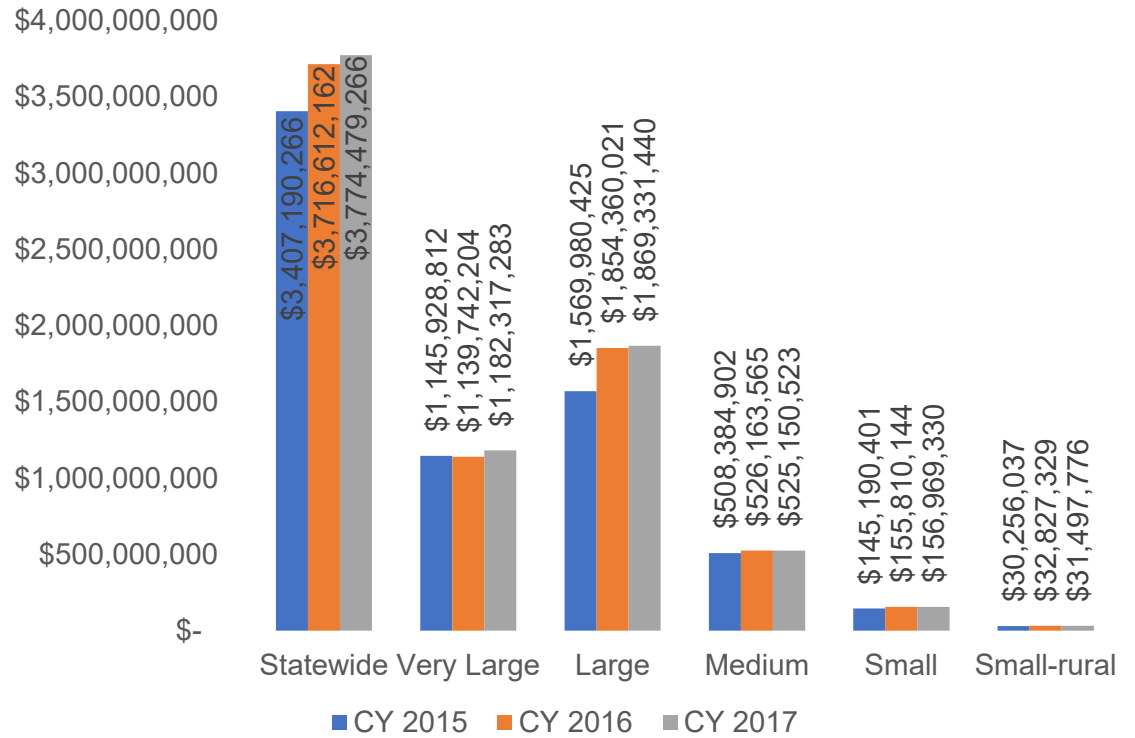


Figure 4-1c: Approved Claims per Beneficiary by Region and Age, CY 2017

ACBs for ages 6 to 17 were the highest among all age categories and across regions. The Bay Area regions' total claims were significantly higher than other regions for all age groups.

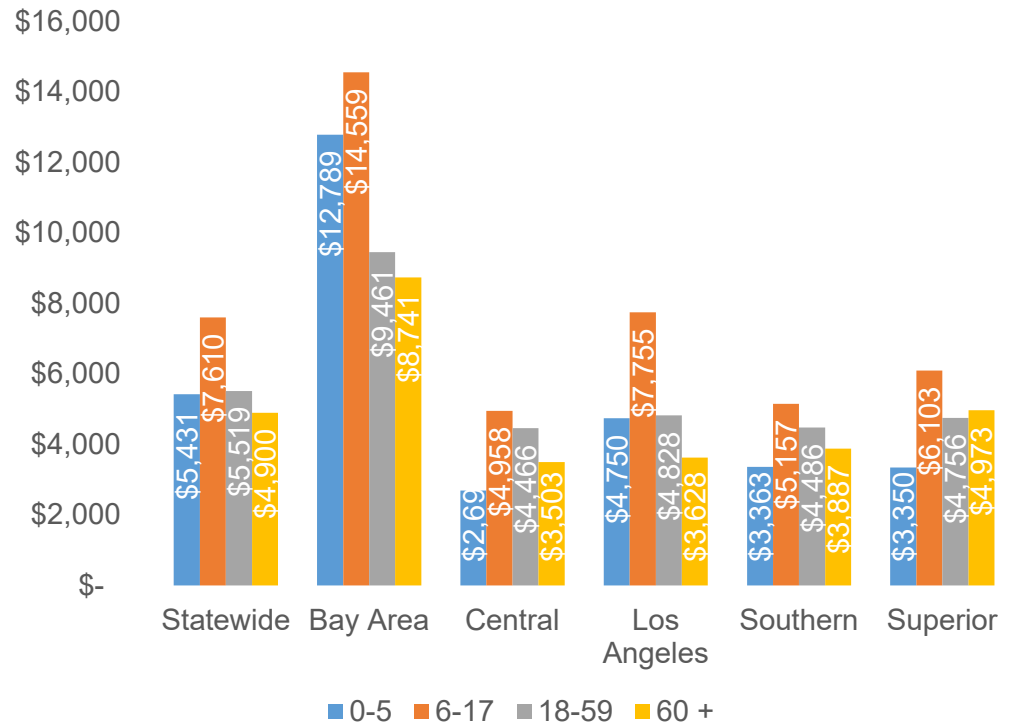
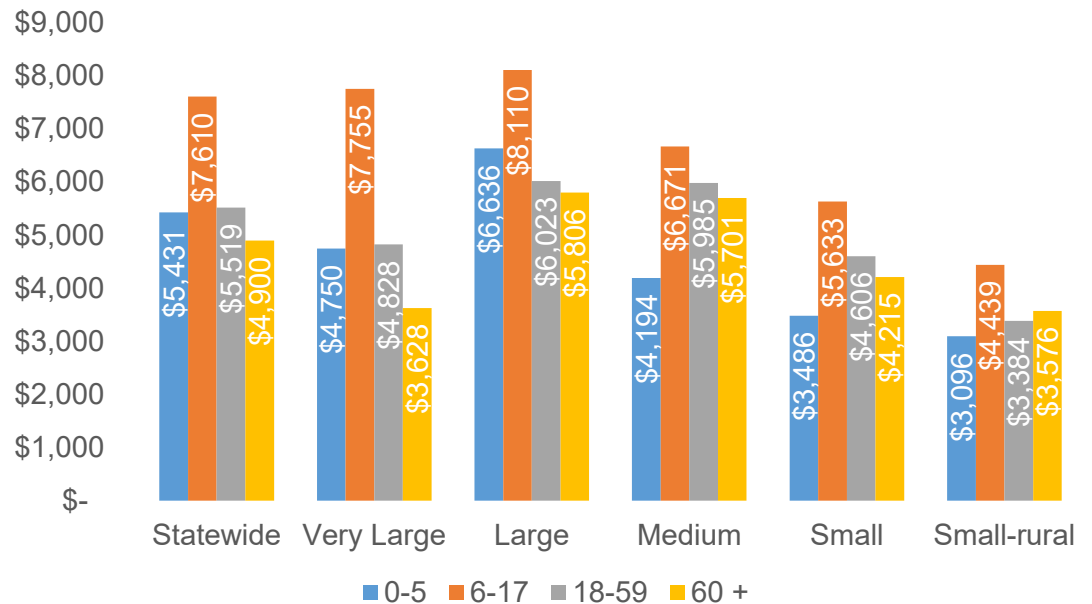


Figure 4-1d: Approved Claims per Beneficiary by Size and Age, CY 2017

ACB for ages 6-17 were the highest among all age categories and MHP sizes.



Penetration Rates for Vulnerable and Underserved Populations

Penetration rates were analyzed at the race/ethnicity level, with demographic information derived from the MMEF. This measure can reveal disparities in services accessed by different ethnic groups within a particular MHP.

As displayed in Tables 1a and 1b, between CY 2015 and CY 2017, the penetration rate varied depending on the MHP’s size, region, and the race/ethnicity of beneficiaries.

The penetration rate dropped for every race/ethnicity except Other, which increased in every region from CY 2016. The same was true for MHP size, where Other was the only race/ethnicity category that increased regardless of MHP size. It decreased for most other categories in most sizes, with a few exceptions. The Asian/Pacific Islander penetration rate remained the same in medium MHPs and the Latino/Hispanic rate increased slightly for small MHPs.

RESULTS

Tables 1a and 1b shows that the decreases in penetration rates by MHP region and size, as seen in Figures 3-1a and 3-1b, occurred across all races/ethnicities except for Other. This is directly attributable to the increasing numbers of Medi-Cal eligibles across all races/ethnicities, with a slight decrease in the number of beneficiaries served between CY 2016 and CY 2017.

The increase in the Other race/ethnicity category may reflect population shifts underway in California, especially in the Coastal, Inland Empire, and Central Valley areas. Because CalEQRO uses the Medi-Cal eligibility files to determine beneficiary race/ethnicity, this points to the population-based phenomenon being reflected in the Medi-Cal beneficiary pool. Another possibility is that it also reflects individuals becoming more open to identifying themselves outside the main racial/ethnic categories.

The three-year trend also establishes Asian Americans as another underserved community, alongside the Hispanic/Latino population. Further, their declining penetration rates across all regions have made the Asian-American beneficiaries the lowest-served of the racial/ethnic categories. This may have social, cultural, economic, or other explanations, but certainly merits further examination by DHCS and the MHPs.

African-American penetration rates used to be highest for most MHP regions and sizes, often higher than for Whites. However, in CY 2017, CalEQRO noticed a distinct shift in declining African-American penetration rates in all regions, making their rates lower than those for the Other beneficiaries in the Southern, Los Angeles, and Central regions. This is another phenomenon that requires further examination.

RESULTS

Table 1a: Penetration Rate by Region and Race, CY 2015-17

Race/ Ethnicity	Region	CY 2015 Penetration Rate	CY 2016 Penetration Rate	CY 2017 Penetration Rate
African-American				
	Bay Area	9.2%	8.7%	8.1%
	Central	6.4%	6.1%	5.4%
	Los Angeles	9.7%	9.8%	8.9%
	Southern	7.0%	6.6%	5.9%
	Superior	9.2%	9.0%	8.3%
Asian/Pacific Islander				
	Bay Area	2.7%	2.6%	2.4%
	Central	2.2%	2.1%	1.9%
	Los Angeles	2.4%	2.3%	2.2%
	Southern	2.1%	1.9%	1.6%
	Superior	3.7%	3.3%	2.9%
Hispanic/Latino				
	Bay Area	4.1%	4.1%	3.9%
	Central	2.8%	2.8%	2.5%
	Los Angeles	4.0%	4.1%	4.1%
	Southern	3.1%	3.0%	2.8%
	Superior	3.9%	3.8%	3.7%

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Race/ Ethnicity	Region	CY 2015 Penetration Rate	CY 2016 Penetration Rate	CY 2017 Penetration Rate
Native American				
	Bay Area	8.8%	9.0%	8.5%
	Central	6.0%	6.3%	5.5%
	Los Angeles	11.9%	10.8%	9.4%
	Southern	7.6%	7.3%	6.2%
	Superior	5.8%	5.7%	5.2%
White				
	Bay Area	8.5%	8.1%	7.6%
	Central	6.2%	5.9%	5.4%
	Los Angeles	8.6%	6.1%	5.6%
	Southern	6.6%	6.1%	5.5%
	Superior	7.3%	6.9%	6.7%
Other				
	Bay Area	6.9%	6.4%	7.1%
	Central	5.3%	5.2%	5.9%
	Los Angeles	6.2%	6.0%	9.9%
	Southern	4.7%	4.5%	6.2%
	Superior	7.7%	7.2%	8.3%

Table 1b: Penetration Rate by MHP Size and Race, CY 2015-17

Race/ Ethnicity	MHP Size	CY 2015 Penetration Rate	CY 2016 Penetration Rate	CY 2017 Penetration Rate
African-American				
	Very Large	9.7%	9.8%	8.9%
	Large	7.7%	7.2%	6.5%
	Medium	7.0%	6.6%	6.1%
	Small	8.0%	7.9%	7.2%
	Small-rural	10.1%	9.6%	9.3%
Asian/Pacific Islander				
	Very Large	2.4%	2.3%	2.2%
	Large	2.3%	2.2%	2.0%
	Medium	2.5%	2.3%	2.3%
	Small	2.2%	2.1%	1.7%
	Small-rural	3.8%	3.8%	3.2%
Hispanic/Latino				
	Very Large	4.0%	4.1%	4.1%
	Large	3.3%	3.2%	3.0%
	Medium	2.8%	2.8%	2.7%
	Small	4.0%	3.9%	4.0%
	Small-rural	4.6%	4.8%	4.5%
Native American				
	Very Large	11.9%	10.8%	9.4%

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	Large	7.9%	8.0%	7.0%
	Medium	6.3%	6.2%	5.5%
	Small	5.3%	5.0%	4.5%
	Small-rural	6.4%	7.1%	6.4%
White				
	Very Large	8.6%	6.1%	5.6%
	Large	7.2%	6.8%	6.1%
	Medium	6.3%	5.9%	5.6%
	Small	6.4%	5.8%	5.4%
	Small-rural	9.1%	8.8%	8.6%
Other				
	Very Large	6.2%	6.0%	9.9%
	Large	5.3%	5.1%	6.2%
	Medium	6.0%	5.8%	7.1%
	Small	6.3%	6.0%	7.2%
	Small-rural	8.3%	8.7%	10.1%

Hispanic/Latino Populations

The Hispanic/Latino population is historically known to be an underserved population in California when it comes to SMHS. Figure 5-1a presents the statewide number of Hispanic/Latino eligibles and beneficiaries served. The number of eligibles continued to rise each year between CY 2015 and CY 2017. However, the number of beneficiaries served declined between CY 2016 and CY 2017.

Figure 5-1a: Hispanic/Latino Eligibles and Beneficiaries Served, CY 2015-17

The number of Hispanic/Latino eligibles continued to increase each year, but the number of Hispanic/Latino beneficiaries served declined in CY 2017.

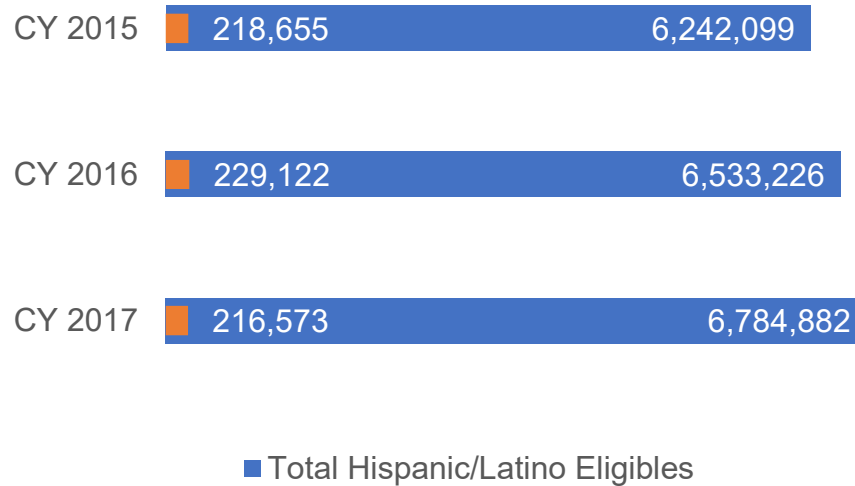


Figure 5-1b displays an overall increase in the number of Hispanic/Latino eligibles each year in each region, with the exception of the very large MHP (Los Angeles). After increases in the beneficiaries served across all regions during CY 2015 and CY 2016, there were decreases in large and very large MHPs. Since the latter two groups of MHPs together account for more than four-fifths of the Hispanic/Latino beneficiaries served, the slight increases in the other three MHP size averages were not enough to offset the decline in the total number of Hispanic/Latino beneficiaries.

Figure 5-1b: Hispanic/Latino Eligibles and Beneficiaries Served, by MHP Size, CY 2015-17

The number of Hispanic/Latino eligibles has increased each year. The number of Hispanic/Latino beneficiaries served also has increased each year.

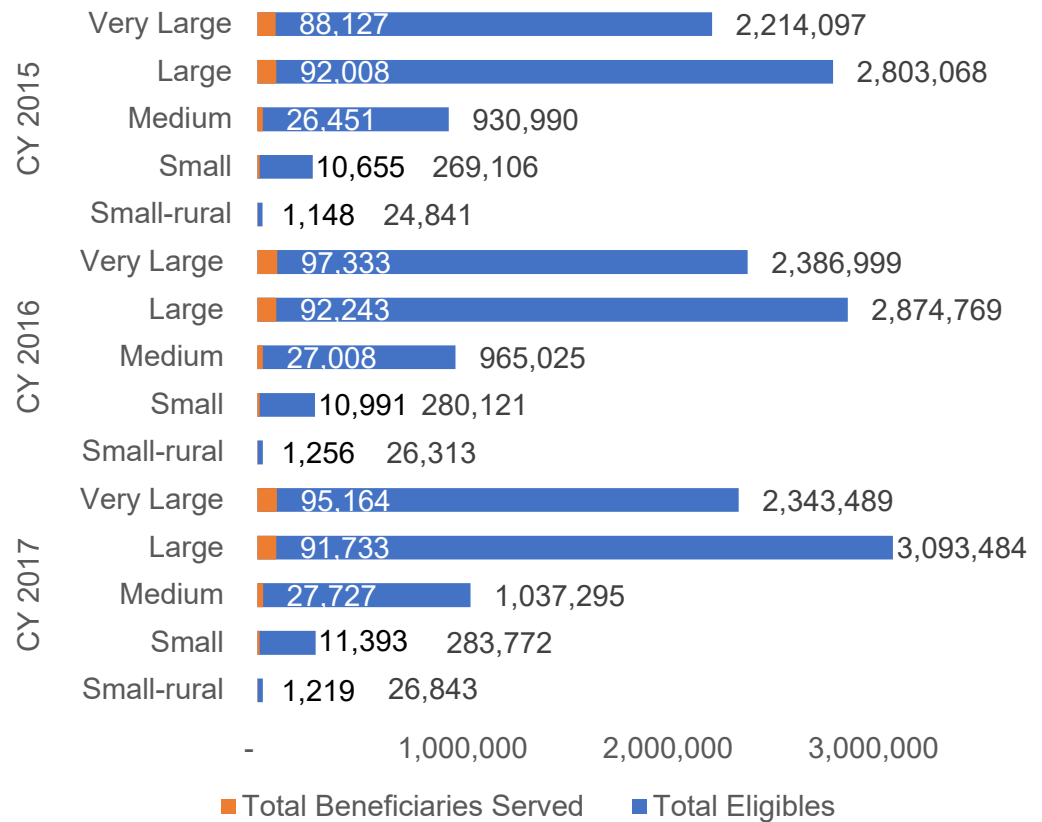


Figure 5-1c displays the Hispanic/Latino penetration rates over the last three years, by region. At the statewide level, the Hispanic/Latino penetration rate dropped over the three-year period, although it was similar between CY 2015 and CY 2016. This decrease is reflected in all regions except Los Angeles, which remained mostly the same. This decrease is primarily attributable to the increase in new eligibles during this time frame, along with decreases in beneficiaries served.

Figure 5-1c: Hispanic/Latino Penetration Rates CY 2015-17
Statewide, and across most regions, the Hispanic/Latino penetration rate decreased over the three years.

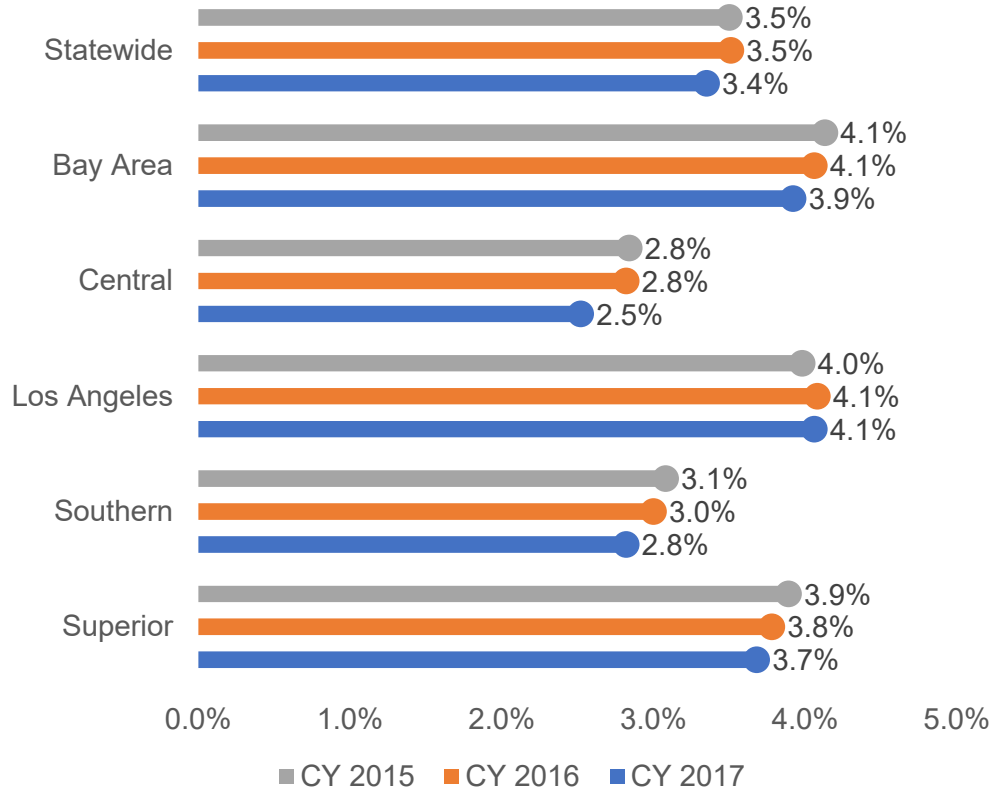
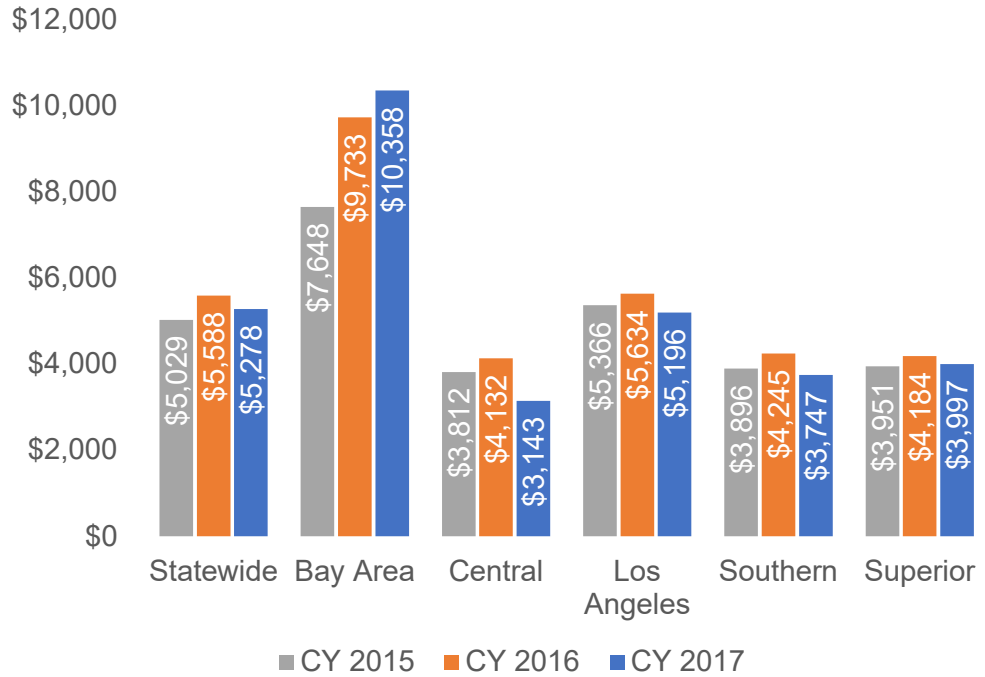


Figure 5-1d displays the Hispanic/Latino ACB. At the statewide level, the ACB decreased by over \$300 from CY 2016 to CY 2017. This average decrease can be attributed to the total approved claims remaining stable and the number of beneficiaries served increasing, causing the ACB to decrease.

The only region that showed an increase in Hispanic/Latino ACB was the Bay Area, where it stood at twice the statewide figure. The Hispanic/Latino distribution of ACB by region mirrored the overall approved claims distribution by region as shown in Figure 4-1a.

Figure 5-1d: Hispanic/Latino Approved Claims per Beneficiary, CY 2015-17

Statewide average ACB for Hispanic/Latino beneficiaries decreased in CY 2017. The Bay Area ACB was twice that of the statewide ACB.



Foster Care Population

Children in foster care represent a particularly vulnerable subset of the Medi-Cal-eligible population; their access to care issues have led to at least two major lawsuit settlements involving DHCS in the past 15 years. Figure 6-1a displays the number of foster care eligibles statewide, showing fairly consistent decreasing levels from CY 2015 to CY 2017. The number of beneficiaries served steadily decreased from 35,564 in CY 2015 to 33,484 in CY 2017.

Figure 6-1b shows the regional distribution of foster care eligibles and beneficiaries served from CY 2015 to CY 2017. Southern region MHPs and Los Angeles account for two-thirds of the foster care eligibles and beneficiaries served.

RESULTS

Figure 6-1a: Foster Care Eligibles and Beneficiaries Served, CY 2015-17

Foster care eligibles and the number served both decreased over the last three years.

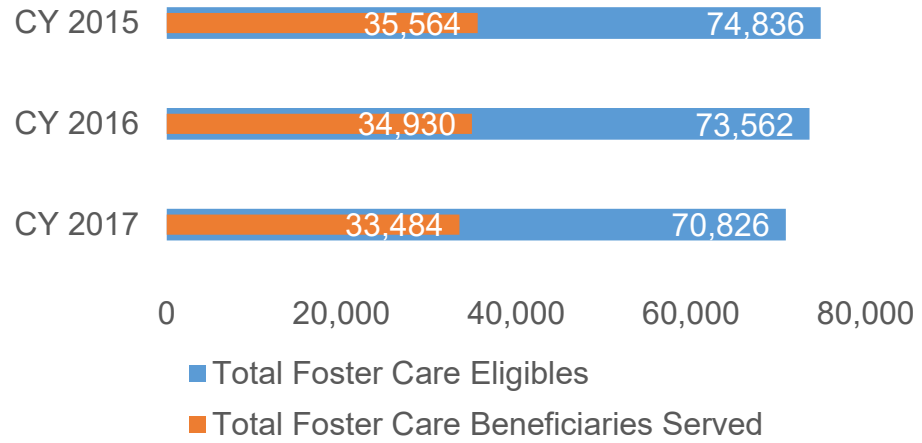


Figure 6-1b: Foster Care Eligibles and Beneficiaries by Region, CY 2015-17

Los Angeles and Southern regions continued to have both the highest number of foster care eligibles and served over the last three years.

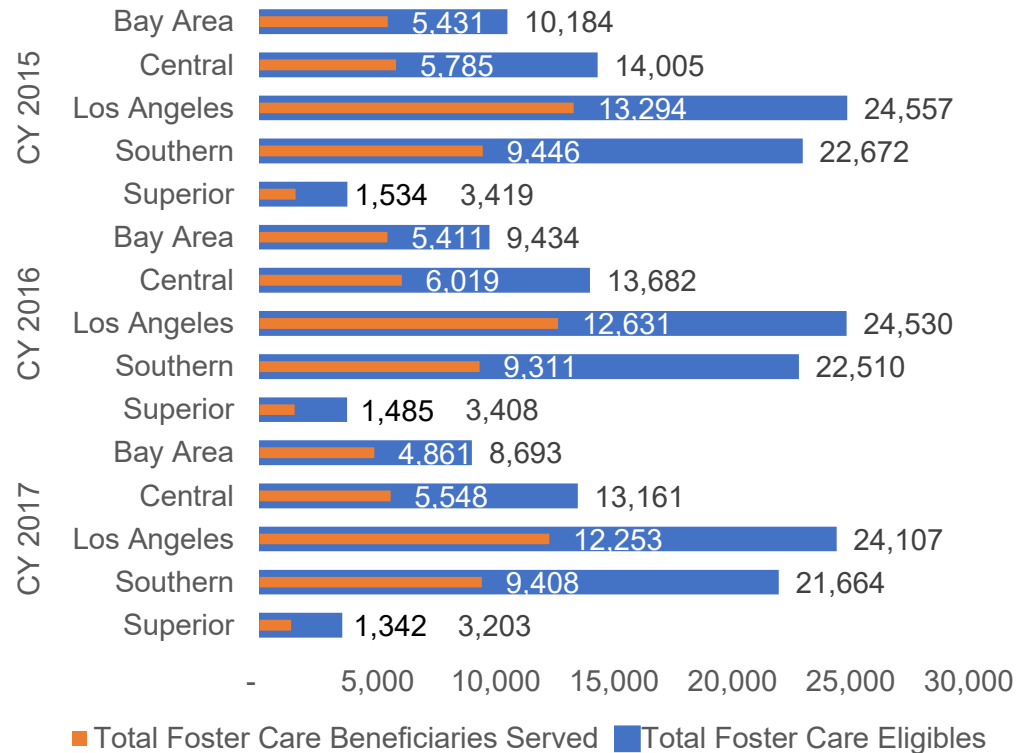


Figure 6-1c shows that after a very slight increase in the foster care penetration rate between CY 2015 and CY 2016, the foster care penetration rate declined back to the CY 2015 level in CY 2017, primarily caused by the declining number of beneficiaries served.

Figure 6-1c: Foster Care Penetration Rates, CY 2015-17

The statewide foster care penetration rate held steady in CY 2017.

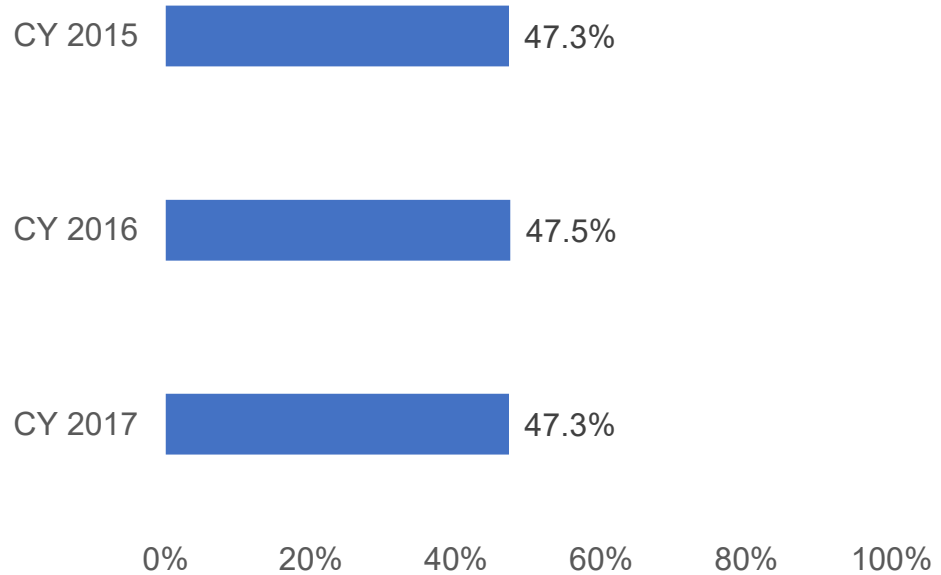
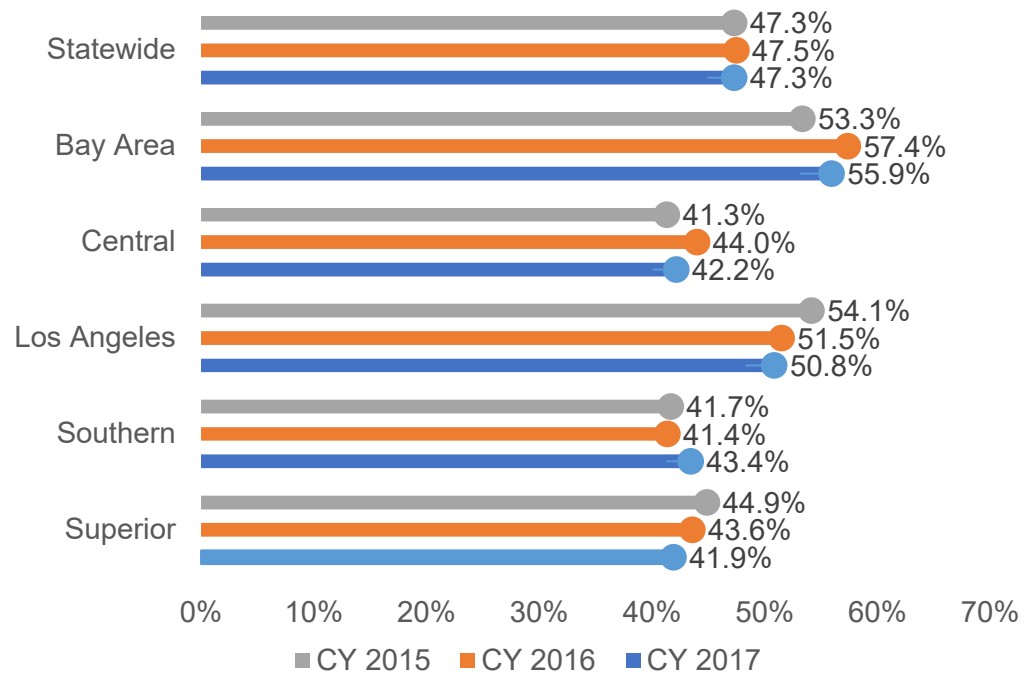


Figure 6-1d shows the three-year trend in penetration rates by region for foster care. All regions showed a decline, except the Southern region. The Bay Area region continued to have the highest foster care penetration rate in the state, but it too declined in CY 2017. This was closely followed by the Los Angeles region, which experienced a smaller decrease in the foster care penetration rate.

Figure 6-1d: Foster Care Penetration Rates by Region, CY 2015-17.

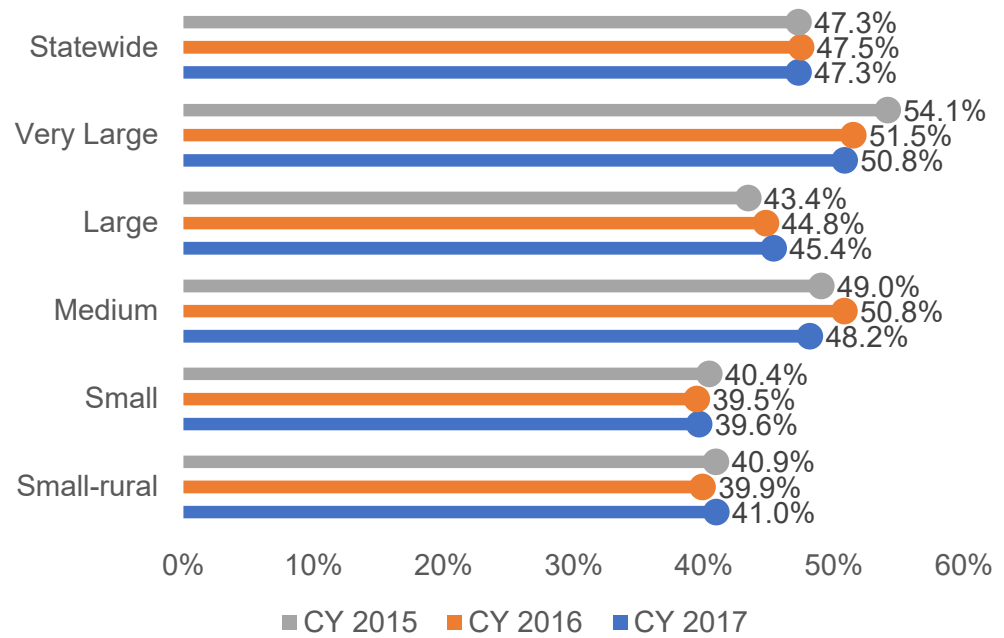
Foster care penetration rates decreased in the Superior and Los Angeles regions and increased in all other regions. The Bay Area had the highest foster care penetration rates in all years.



However, when looked at from the MHP size perspective, small-rural, small, and large MHPs showed slight increases in foster care penetration rates, while the medium and very large MHPs showed decreases between CY 2016 and CY 2017.

Figure 6-1e: Foster Care Penetration Rates by MHP Size, CY 2015-17.

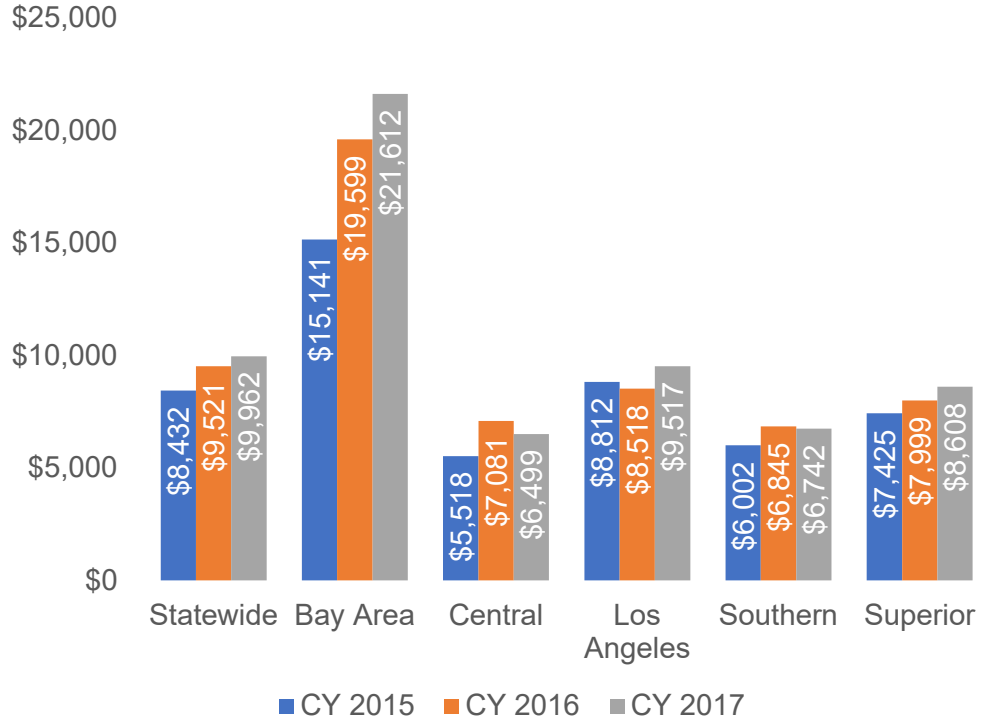
Foster care penetration rates remained fairly stable across most county sizes. However, rates have decreased in very large and medium-sized MHPs and increased in other sized MHPs.



As shown in Figure 6-1f, most regions had similar foster care ACB as statewide claims. The Bay Area region, where foster care ACB was more than twice the statewide figure, was the exception. The Central and Southern regions had the lowest two ACBs and both showed declines in CY 2017, while the other regions all showed varying degrees of increases.

Figure 6-1f: Foster Care Approved Claim per Beneficiary, CY 2015-17.

Foster care ACB increased from CY 2015 to CY 2017 across all regions. Average claims were highest in the Bay Area, where they were around double the statewide average.



High-Cost Beneficiaries (HCBs) Analysis

HCBs are consumers who incur approved claims of \$30,000 or more. Table 2 below shows the HCB rates from CY 2015 to CY 2017. At the statewide level, both the HCB count and the average approved claims of HCBs rose between CY 2015 and CY 2017. The count of HCB increased at the same time the total beneficiary count went down, resulting in increases in the HCB percentage.

Table 2: HCB Counts and Costs, CY 2015-17

The number and percentage of HCBs and the average approved claims per HCB have increased consistently in the past three years.

Year	HCB Count	Total Beneficiary Count	HCB Percent by Count	Average Approved Claims per HCB
CY 2015	18,110	622,380	2.90%	\$52,945
CY 2016	20,693	619,792	3.33%	\$54,378
CY 2017	21,522	609,851	3.52%	\$54,563

Therapeutic Behavioral Services (TBS)

Children’s SMHS are provided under the federal requirements of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which is available to full-scope beneficiaries under age 21. The MHPs are required to provide TBS services to EPSDT beneficiaries who meet certain criteria as a result of the *Emily Q.* lawsuit settlement. The settlement established a benchmark whereby 4 percent of children and youth receiving EPSDT services would be recipients of TBS in Level II MHPs, as well as statewide.

Level II consists of mostly the large and medium-sized MHPs that serve most of the EPSDT beneficiaries. As shown in Table 3, in CY 2017, the statewide EPSDT client count was 243,514. For Level II MHPs, the count was 221,738. The statewide TBS recipient count in CY 2016 was 11,067, yielding a penetration rate of 4.5 percent. It should be noted that the MHPs may also provide what are considered “equivalent” services in order to reach the 4 percent threshold. The equivalent services cannot be detected automatically through the approved claims data and therefore are not included in this calculation. It is possible that with the equivalent services, both statewide and Level II MHPs will meet the 4 percent requirement.

Table 3: Statewide TBS Penetration Rate, CY 2017

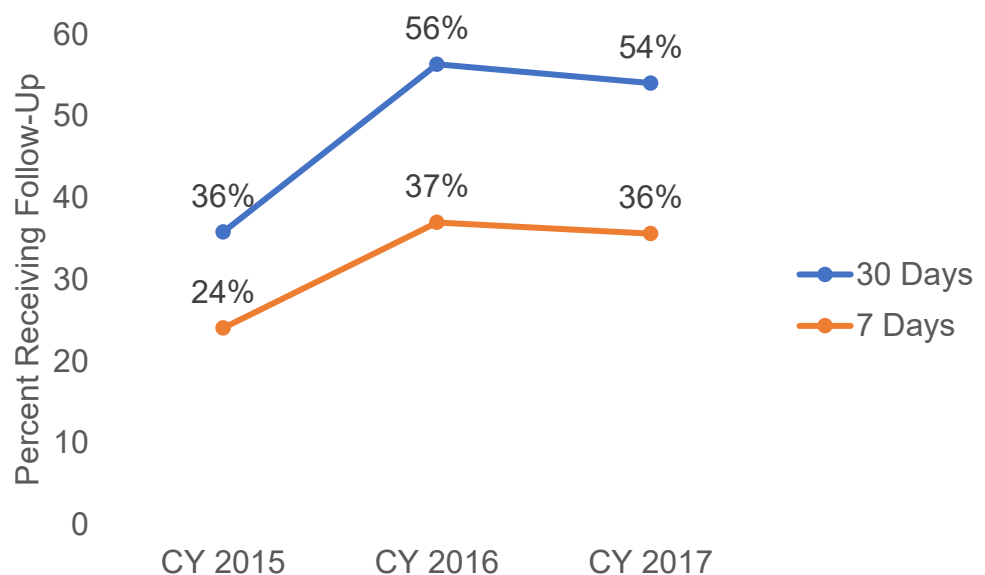
TBS Level II	EPSDT Client Count	TBS Client Count	TBS Penetration Rate
Statewide	243,514	11,067	4.5%
No	53,778	1,933	3.6%
Yes	433,250	20,200	4.7%

Outpatient Follow-up Rates

Outpatient follow-up rates track the percentage of beneficiaries who are seen by an MHP after psychiatric inpatient discharge, at 7 and 30 days post-discharge. Figure 7-1a shows the outpatient follow-up rates at the statewide level from CY 2015 to CY 2017. Outpatient follow-up rates have fluctuated over the last three years. There was a significant statewide increase in both 7- and 30-day follow-up rates from CY 2015 to CY 2016. In CY 2016, both rates declined slightly.

Figure 7-1a: Outpatient Follow Up at 7 and 30 Days, CY 2015-17

After significant increases in the follow-up rates, both 7- and 30-day follow-up rates declined in CY 2017.

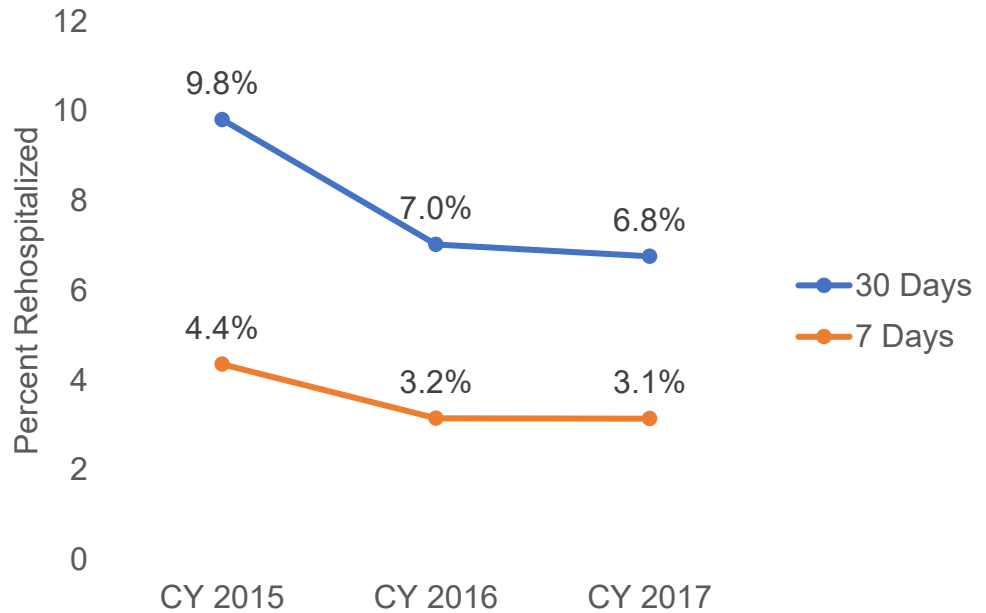


CalEQRO also tracks inpatient recidivism or rehospitalization within 7 and 30 days post-discharge. Figure 7-1b shows that after a significant decline in both rehospitalization rates between CY 2015 and CY 2016, they almost hit a plateau in CY 2017. The patterns between Figures 7-1a and 7-1b suggest that rehospitalization can be prevented with greater outpatient follow-up.

It should be noted, however, that the CalEQRO claims data do not include Institute of Mental Diseases (IMD) episodes since those are not reimbursed through Medi-Cal claims. It is also not clear how the PIPs targeting prevention of rehospitalization through various alternative strategies factor in any reduction.

Figure 7-1b: Rehospitalization Rates at 7 and 30 Days Post-Discharge, CY 2015-17

The declines in 7- and 30-day inpatient recidivism (rehospitalization) rates plateaued.



Average Inpatient Length of Stay (LOS)

This measure considers the average LOS during an inpatient episode at the statewide, region, and MHP size levels. At the statewide level, in CY 2017 the average LOS was 8.3 days, as seen in Figures 8-1a and 8-1b. Of the five regions, Superior had the highest average LOS at 9.7 days. The remaining regions had an average LOS of around seven days.

RESULTS

Figure 8-1a shows the Bay Area and Southern regions had the lowest average LOS, and all regions other than Superior had average LOS lower than the statewide average LOS.

Figure 8-1b shows the average LOS by size. Small and small-rural MHPs had the longest average LOS. This tracks with the Superior region's average; the region consists mostly of small and small-rural MHPs.

Figure 8-1a: Average LOS by Region, CY 2017

Average LOS of an inpatient episode is about one week; Superior region, which has few inpatient episodes, registered the longest LOS, significantly higher than other regions.

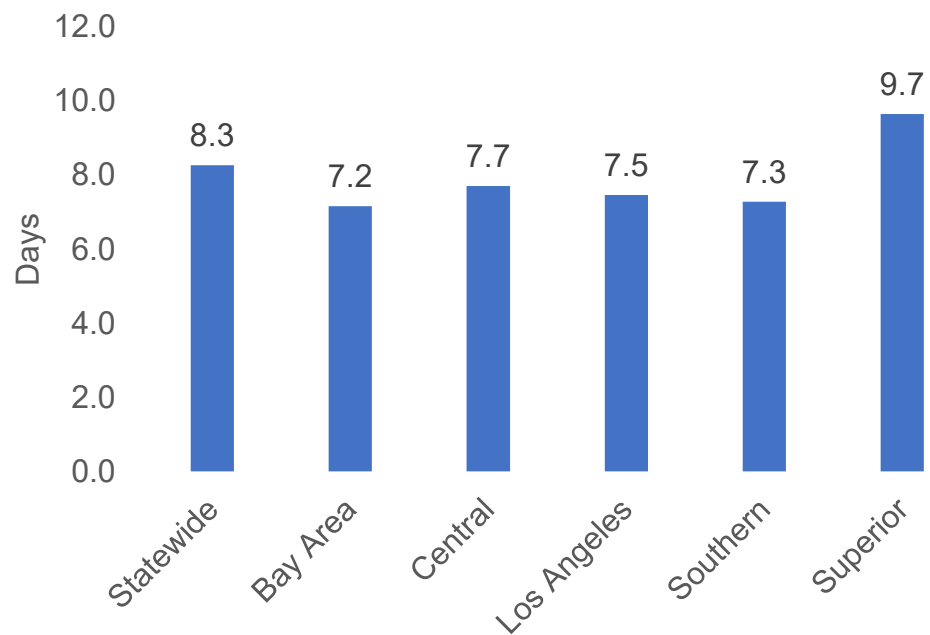
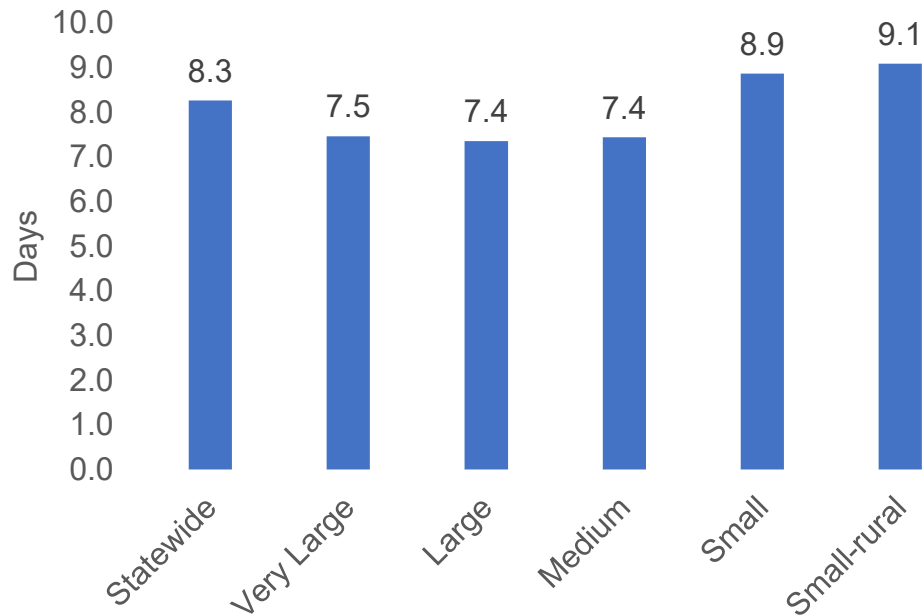


Figure 8-1b: Average LOS by Size, CY 2017

Small-rural and small MHPs have the greatest average length of inpatient stay; both are longer than the statewide average and averaged over a week in CY 2017.



Beneficiaries Served, by Diagnostic Categories

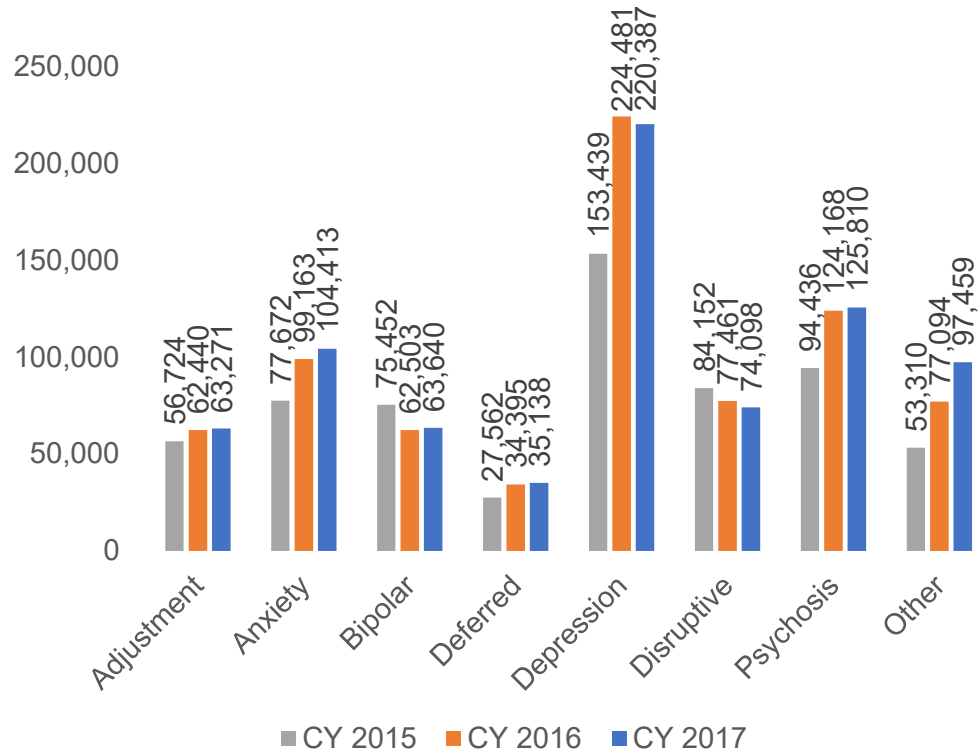
Diagnostic categories are generated from the approved claims data, using ICD-10 codes. All diagnoses are classified in the following diagnostic categories in CalEQRO’s analysis: adjustment, anxiety, bipolar, depression, disruptive, psychosis, deferred, and other disorders. Figure 8-2a shows the statewide trend in diagnostic categories of beneficiaries served between CY 2015 and CY 2017.

In CY 2017, depression continued to be the most frequent diagnostic category, although the count declined slightly from CY 2016. The next two most frequent diagnosis groups, psychosis and anxiety disorders, respectively, both ticked up slightly higher. The most significant increase was in the Other diagnosis category, which includes deferred diagnoses. It appears that after two successive years of significant increase in use of the Other diagnoses category, MHPs need to start

investigating whether their particular MHP has a similar trend. If so, they should explore any underlying causes, including whether diagnosis groups with declining numbers are being shifted to the Other diagnoses category.

Figure 8-2a: Diagnosis Categories, CY 2015-17

Depression is the most frequent diagnosis category year over year, followed by psychosis.



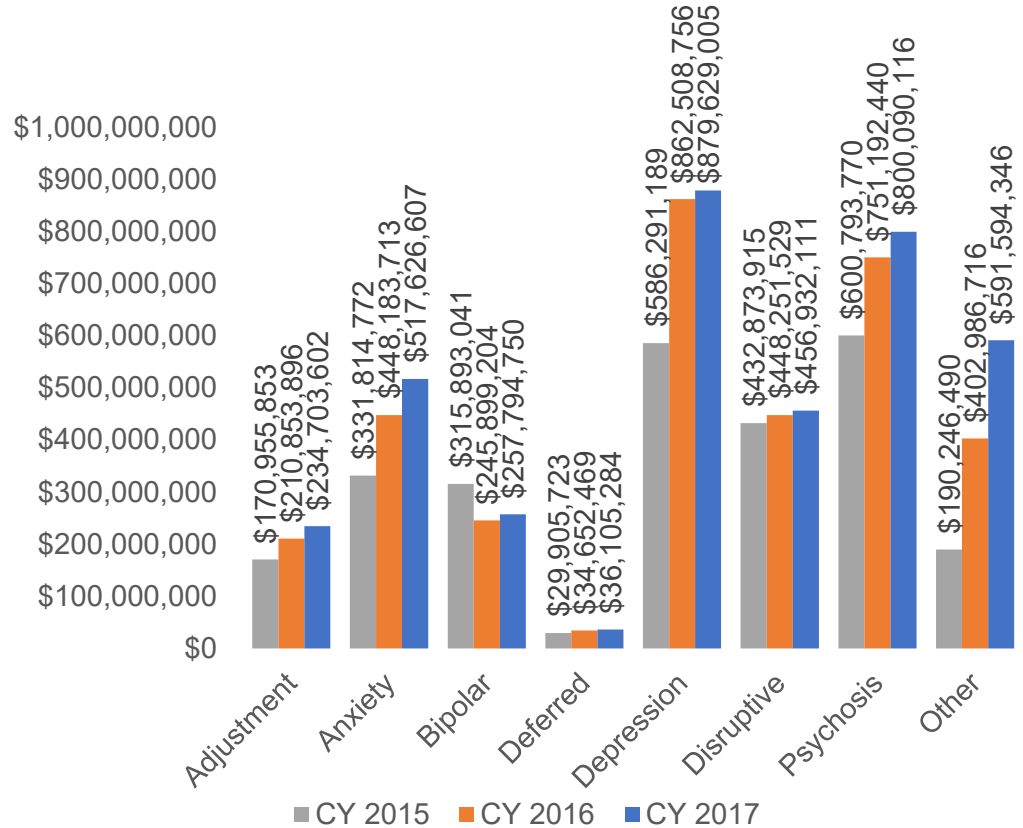
Approved Claims by Diagnostic Groups

Figure 8-2b displays the trends in total approved claims for beneficiaries in each diagnostic category between CY 2015 and CY 2017. Despite the drop in the total number of beneficiaries, every diagnosis category showed an increase in total approved claims between CY 2016 and CY 2017. The increase was particularly large in the Other category, which surpassed the anxiety and disruptive disorder categories to become the third-highest in approved claims dollars, behind only the depression and psychosis categories. This reinforces the argument for greater examination of the Other diagnoses assignments. When viewed in

conjunction with Figure 8-2a, it is clear that ACB for Other diagnoses now ranks with psychosis and higher than depression.

Figure 8-2b: Approved Claims by Diagnosis, CY 2015-17

Approved claims have increased for all categories from CY 2016, albeit at varying rates.



Affordable Care Act (ACA) Expansion Population Analysis

CalEQRO started tracking select PMs for the ACA expansion population with the analyses of CY 2015 data. These PMs were computed separately for CY 2015. Starting with CY 2016 data, CalEQRO started combining the traditional Medi-Cal data with the ACA data and the report on overall PMs. The data presented so far included all Medi-Cal SMHS beneficiary information. In this section, the SMHS penetration rate and approved claims for the ACA expansion beneficiaries are presented separately.

RESULTS

Table 4 displays the number of ACA eligibles and number of beneficiaries served in CY 2017. At the statewide level, there were nearly 4 million ACA eligibles. The distribution of eligibles and beneficiaries served by region follows a similar distribution as that of the overall Medi-Cal population. The Southern and Los Angeles regions had almost two-thirds of the ACA eligibles and served the most ACA beneficiaries.

The ACA penetration rates for CY 2017, shown in Table 5, are lower than the corresponding penetration rates for all Medi-Cal eligibles (Figure 3-1a). The data available to CalEQRO cannot fully explain the lower penetration rates for the ACA beneficiaries. Several potential factors may be lowering the penetration rate. The prevalence of serious mental illness that qualifies for SMHS in the ACA population may be lower. It is also possible that the ACA eligibles include a larger share of those referred to as the mild-to-moderate group (meaning those categorized as not having a serious mental illness). If so, it is also likely that ACA eligibles with mild-to-moderate conditions would seek mental health care in primary care settings under their managed care plans, which may also be the most appropriate level of care for their needs.

Table 4: ACA Eligibles, Beneficiaries Served, and Penetration Rates, CY 2017

Region	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate
Statewide	3,816,091	147,828	3.9%
Bay Area	636,150	25,535	4.0%
Central	611,548	20,498	3.4%
Los Angeles	1,210,153	49,408	4.1%
Southern	1,238,955	45,544	3.7%
Superior	119,285	5,810	4.9%

RESULTS

Table 5 shows the statewide distribution for CY 2017 ACA eligibles and beneficiaries by race/ethnicity. Hispanic/Latinos had the largest number of eligibles, followed by Whites and then Asian/Pacific Islanders. Whites constituted the highest number of ACA beneficiaries (47,089) who received SMHS, followed by Hispanic/Latinos (40,135) and African-American beneficiaries (17,947). Like the overall Medi-Cal beneficiaries, the Asian/Pacific Islander and Hispanic/Latino beneficiaries had the lowest penetration rates in the ACA population of all the racial/ethnic groups. All groups had lower penetration rates than the corresponding overall figures.

Table 5: ACA Eligibles and Beneficiaries by Race/Ethnicity, CY 2017

Race/Ethnicity	Statewide Monthly Average Eligibles	Statewide Total Beneficiaries Served	Penetration Rate
African-American	296,354	17,947	6.1%
Asian/Pacific Islander	479,904	7,254	1.5%
Hispanic/Latino	1,644,868	40,135	2.4%
Native American	18,355	1,033	5.6%
White	938,881	47,089	5.0%
Other	437,730	33,738	7.7%

Table 6 shows the statewide total ACA approved claims (\$703,932,487) and ACB (\$4,762) in CY 2017. The Bay Area and the Superior regions had the highest and the lowest ACB, respectively. This may indicate that the ACA beneficiaries generally utilized lower levels of care.

RESULTS

Table 6: ACA Approved Claims and Approved Claims per Beneficiary, CY 2017

Region	Approved Claims	ACB
Statewide	\$703,932,487	\$4,762
Bay Area	\$201,832,877	\$7,904
Central	\$81,677,834	\$3,985
Los Angeles	\$207,342,203	\$4,197
Southern	\$190,566,453	\$4,184
Superior	\$21,480,741	\$3,697

CONCLUSION

Rise in the Number of Medi-Cal Eligibles in Comparison to the Growth in California's Population

The most important lesson from examining the statewide PMs involves access to SMHS, timeliness of such services, and quality of care. These all depend on the MHPs' service capacity—specifically, their ability to absorb a rapidly growing number of Medi-Cal eligibles.

Persistent Disparities

Despite years of focus on Hispanic/Latino penetration rates by state officials, providers, and advocates, the number of beneficiaries served for this underserved population has remained fairly unchanged from CY 2015 to CY 2017, resulting in low penetration rates. This was relatively consistent across MHP sizes and statewide. While the MHPs often provided anecdotes to CalEQRO of Hispanic/Latino populations being served in primary care settings, very few were able to provide strong evidence of such a phenomenon.

In addition, CalEQRO is calling out the Asian/Pacific Islander population as another underserved Medi-Cal beneficiary group. Historically, this group ranked slightly higher than the Hispanic/Latino beneficiaries in terms of penetration rates. However, the past three years' trend shows that their penetration rate is going down across all regions, and now Asian/Pacific Islander beneficiaries have the lowest penetration rates of any racial/ethnic group, more markedly among the ACA expansion population.

At the state and MHP levels, further attention needs to be focused on the Other racial/ethnic beneficiary group. Members of this group have no advocates behind them; no one really knows who constitutes the Other Medi-Cal racial/ethnic category. This creates a vacuum in understanding and providing culturally appropriate SMHS to this fastest-growing beneficiary population. Any efforts toward understanding this phenomenon better will necessitate collaboration with CDSS and county social services departments, which are the authorities assigning the Medi-Cal codes to and recording the required demographic information of each beneficiary. Their first-hand knowledge will be essential to understanding this shift.

CONCLUSION

These ongoing disparities warrant fundamental re-examination by DHCS, the MHPs, contract providers, and other stakeholders if any significant statewide change is to occur.

Foster Care Penetration Rate Declines Back to CY 2015 Level

The number of foster care eligibles and beneficiaries served both declined in 2017. However, the drop in the number of beneficiaries served somewhat outpaced that of the number of foster care eligibles, resulting in a slight drop in the foster care penetration rate back to the CY 2015 level.

There are differences in these changes by MHP region and size. The Southern region showed an increase in the number of foster care beneficiaries served and consequently in the foster care penetration rate. All other regions showed a decline in the foster care penetration rate.

The Southern and Central regions had the lowest ACB for foster care beneficiaries of all regions, while the Bay Area ACB was twice the statewide figure in CY 2017.

These regional differences for foster care beneficiaries, who should receive the same quality of care and access to SMHS, should be explored further, alongside the tracking of the PMs mandated by SB 1291. During FY 2018-19 reviews, CalEQRO found variations in MHPs' knowledge of the SB 1291 mandates and mandated PMs. Many MHPs were completely unaware of the SB 1291-mandated HEDIS data that are made available by CDSS through the California Child Welfare Indicators Project (CCWIP) on the UC Berkeley Center for Social Services Research (CSSR) website.

Diagnoses Show Changes

While depression continues to be the most frequent diagnosis, its prevalence declined slightly, while the psychotic disorder diagnoses remained about the same between CY 2016 and CY 2017 after a sharp increase the previous year.

The sharp and continued increase in the other disorders category during the three-year period between CY 2015 and CY 2017 is perhaps the most significant trend. This increase coincided with the changeover from DSM-IV TR to DSM V for diagnostic practice, and ICD-9 to ICD 10 code set for claims purposes. In CY 2017, it leapfrogged over a few other categories and became the fourth most frequently used diagnostic

CONCLUSION

category behind depression, psychosis, and anxiety diagnoses. This has implications for care quality and prescription practices. While most prescriptions target the symptoms, most pharmaceutical formularies are geared toward the major diagnostic categories. None bill themselves as targeting the other SMI diagnoses. Therefore, this is another area that requires close attention from DHCS and the MHPs.