FY 2019-20

VALIDATION OF PERFORMANCE MEASURES

MEDI-CAL SPECIALTY MENTAL HEALTH

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

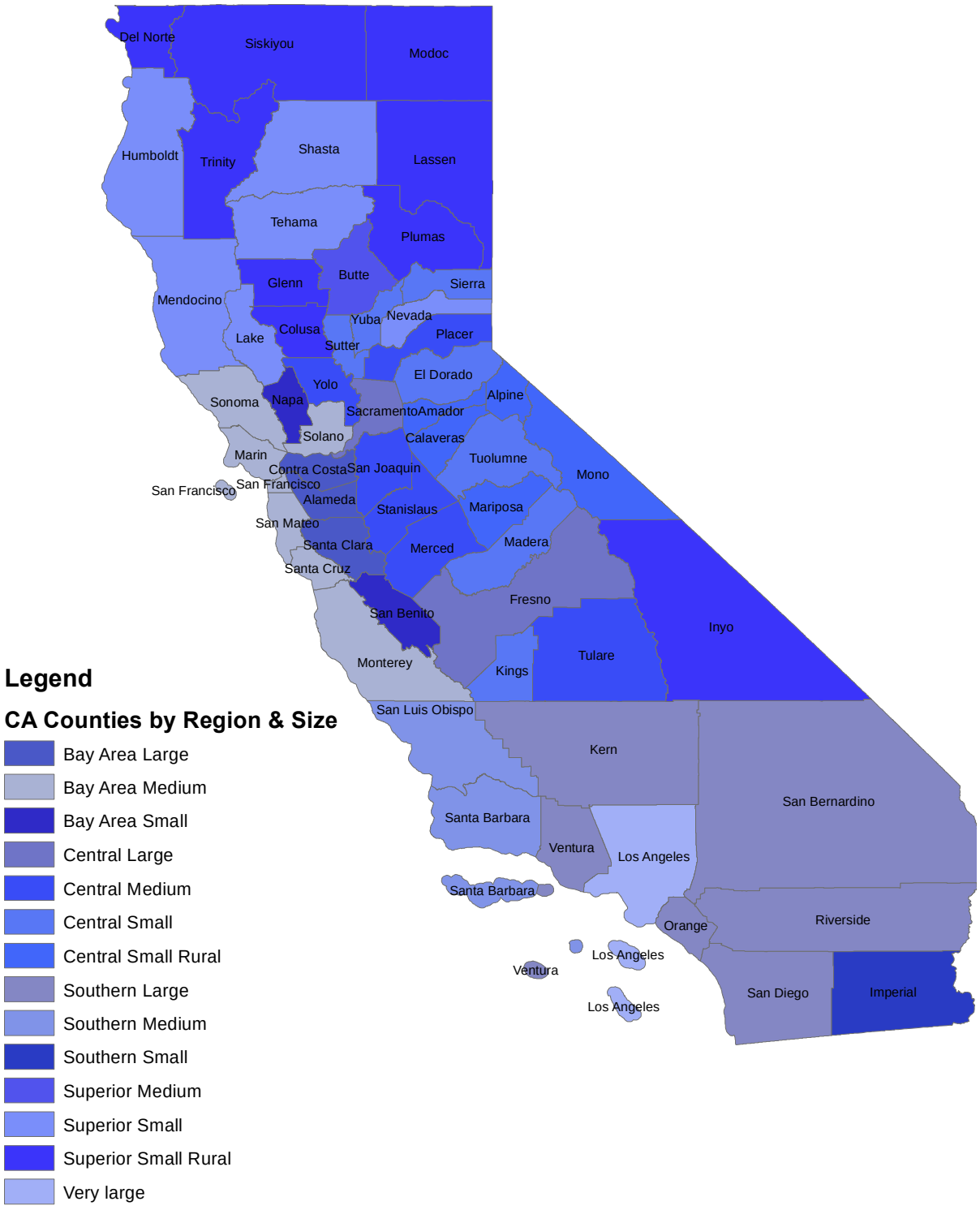
This report presents California External Quality Review Organization's (CalEQRO) fiscal year (FY) 2019-20 findings on key performance measures (PMs) for California's Medi-Cal funded SMHS delivered by the county MHPs. The statewide annual report presents the results of CalEQRO's validation of seven mandatory 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
  - 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

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 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 2018 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. The PMs are reported by the following domains: Access, Timeliness, Quality, Beneficiary Progress and Outcomes, and Structure and Operations.

Access

California experienced a significant drop in Medi-Cal eligible population.

During the three-year period between CY 2016 and CY 2018, statewide, the number of Medi-Cal eligible beneficiaries declined by almost 450K, or 3.3 percent. For comparison, it is as if the entire Superior region beneficiary pool has disappeared in three years from the state Medi-Cal roll (Fig. 2).

The decline is seen in the four large population regions: Bay Area, Central, Los Angeles, and Southern. Only the smallest region, Superior, showed a modest increase (Fig. 3) in Medi-Cal eligible count.

Figure 2: Statewide Eligibles and Beneficiaries CY 2016-2018

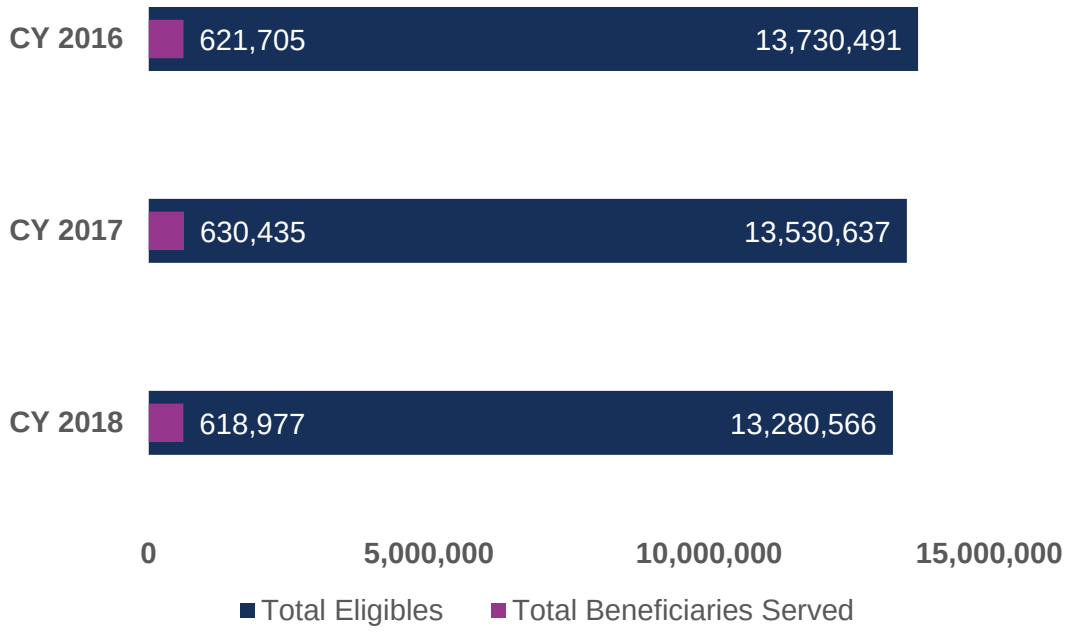


Figure 3: Region Eligibles and Beneficiaries Served, CY 2016-2018

Region / CY	Total Eligibles	Total Beneficiaries Served
Bay Area		
CY 2016	2,199,639	113,740
CY 2017	2,158,883	112,851
CY 2018	2,087,709	107,905
Central		
CY 2016	2,429,407	97,127
CY 2017	2,426,532	97,208
CY 2018	2,378,549	96,284
Los Angeles		
CY 2016	4,159,585	204,249
CY 2017	4,022,848	212,478
CY 2018	3,964,272	210,337
Southern		
CY 2016	4,531,270	179,361
CY 2017	4,510,484	180,408
CY 2018	4,437,502	177,370
Superior		
CY 2016	410,593	25,315
CY 2017	411,893	25,527
CY 2018	412,535	25,165

Access has improved in Los Angeles region more than the others.

During the same period, there was also a corresponding decrease of 3.3 percent in the number of beneficiaries served statewide. However, this was not as uniformly distributed across the large regions. Los Angeles recorded an increase of 2.9 percent in the number of beneficiaries served at the same time that its number of Medi-Cal eligible beneficiaries was declining.

As a result, Los Angeles region, which consists of the only Very Large sized MHP, showed the most increase in penetration rate between CY 2016 and CY 2018, and continued to register a higher penetration rate than the Bay Area for the second year in a row. CY 2017 was the first time it happened since CalEQRO started reporting on this metric. Penetration rate remained mostly flat for the other regions and MHP sizes (Figs. 4 and 5).

Figure 4: Overall Penetration Rate by Region, CY 2016-2018

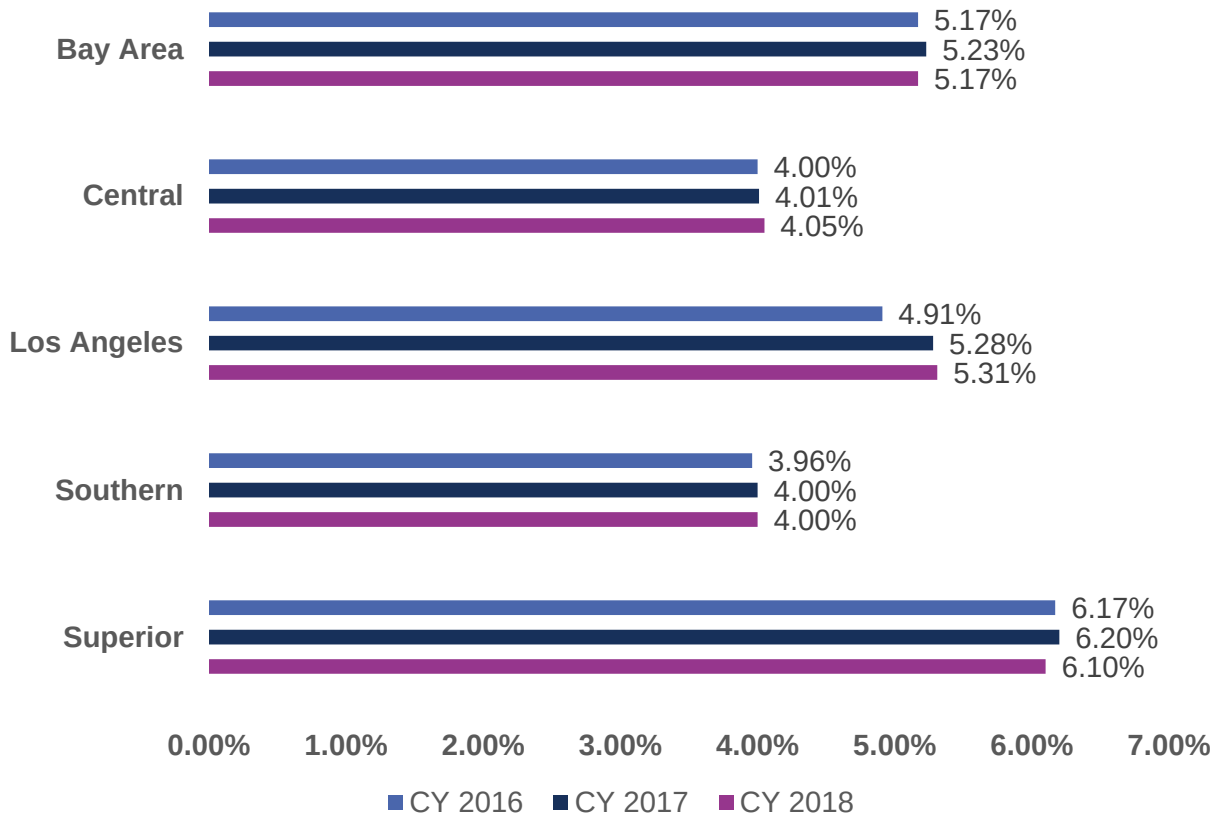
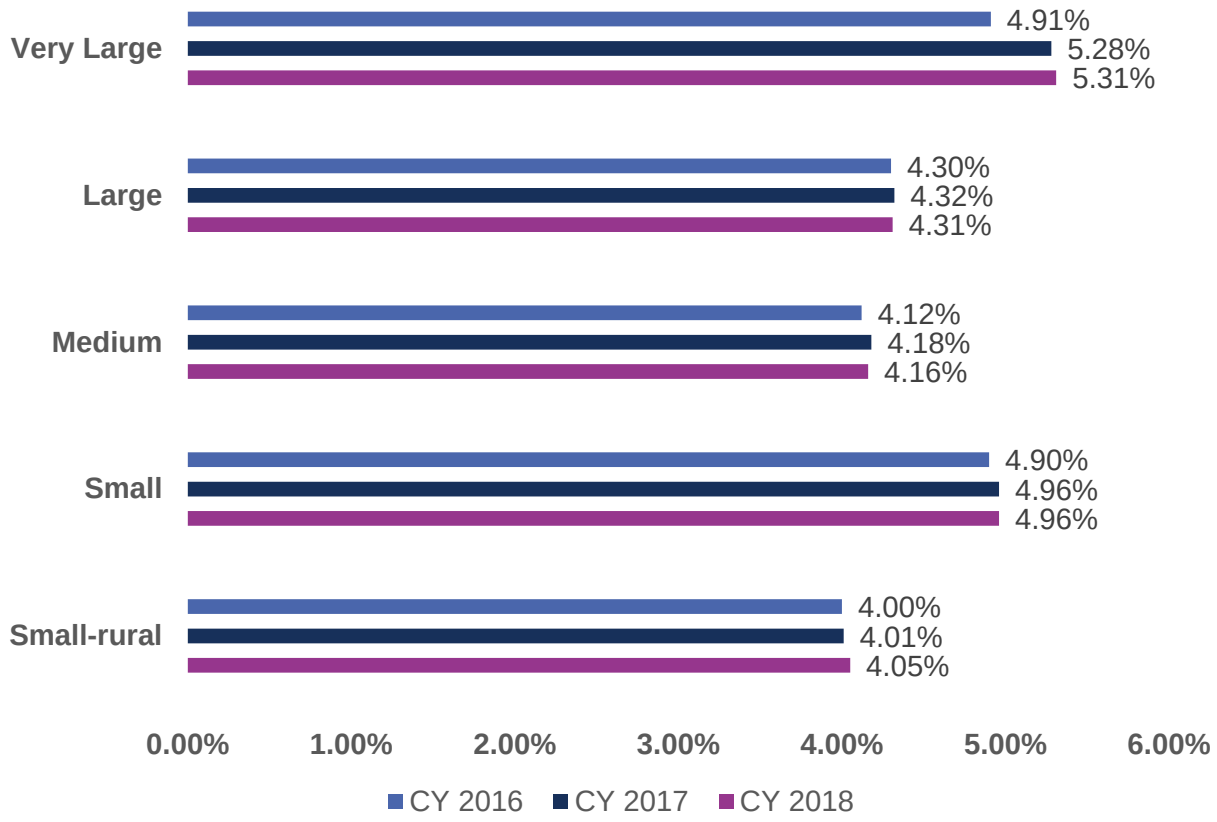


Figure 5: Overall Penetration Rate by Size, CY 2016-2018



Children aged 6 to 17 have greater access to SMHS than other age group.

In CY 2018, children aged between 6 and 17 had the highest penetration rate across all MHP regions and sizes (Figs. 6 and 7). However, there were large variations for all age groups by MHP region and size. Assuming a naturally low penetration rate for children between 0 and 5 and discounting that statistic, the older adult population had the lowest penetration rates irrespective of MHP size and region.

Figure 6: Penetration Rate by Region and Age, CY 2018

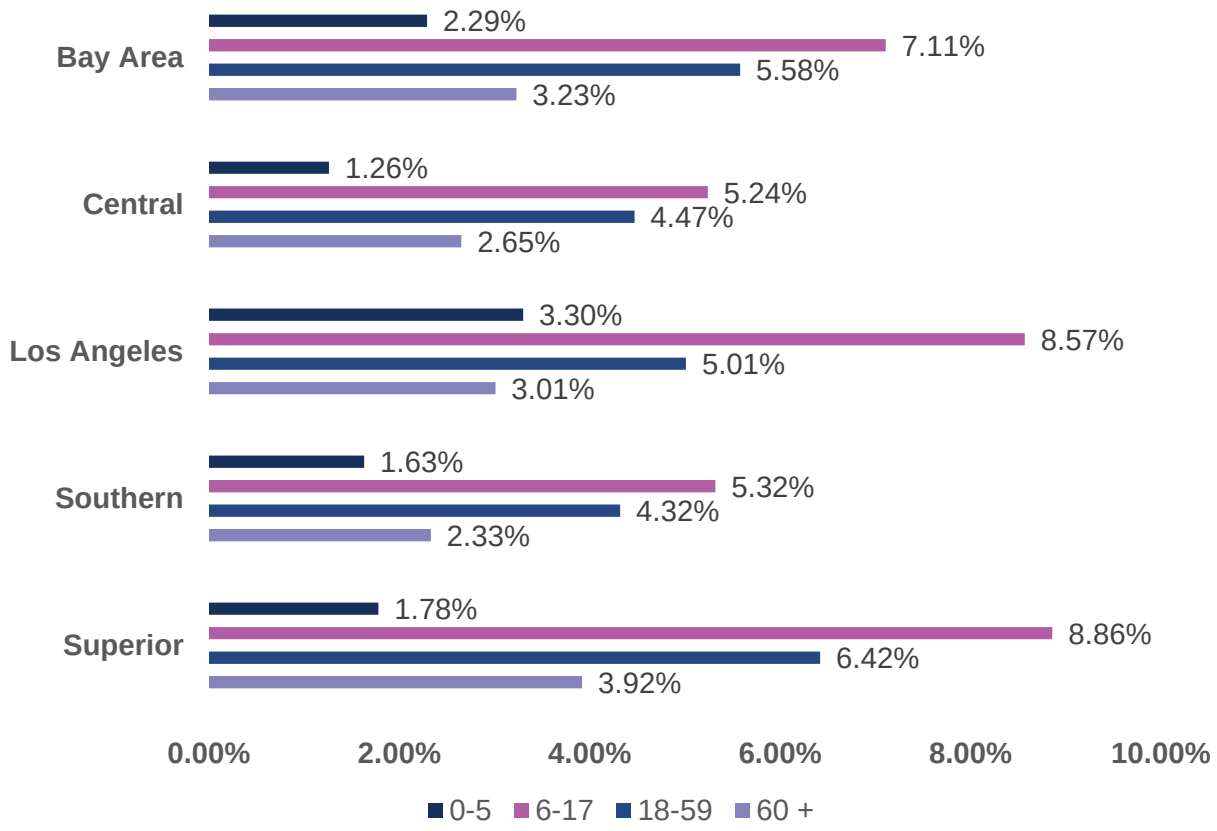
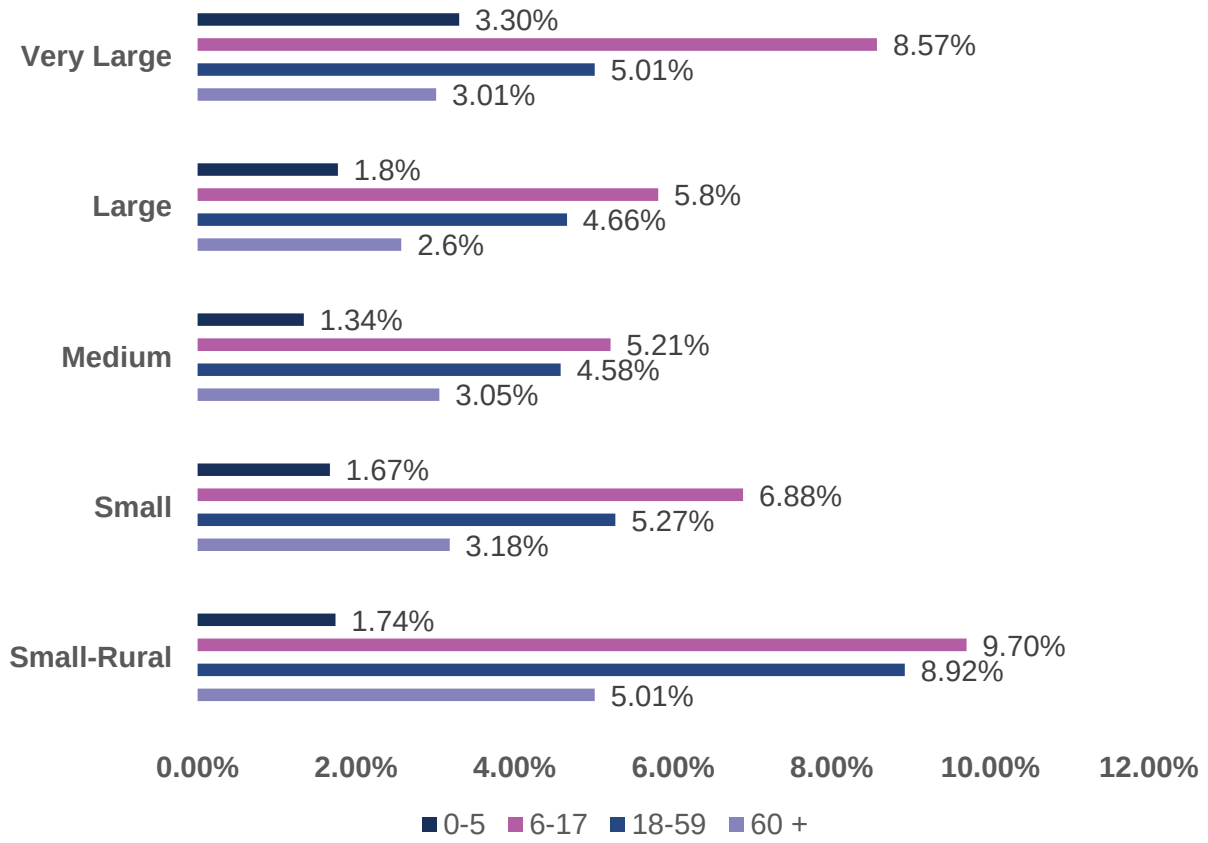


Figure 7: Penetration Rate by Size and Age, CY 2018



Disparities continue in Hispanic/Latino access to SMHS.

Statewide, Hispanic/Latinos constitute over half of the Medi-Cal eligible beneficiaries (calculated using Figs. 2 and 8), but they constitute only 40 percent of the beneficiaries served. However, the penetration has been steadily but unevenly increasing across all MHP regions. Los Angeles has taken the lead in improving the Hispanic/Latino penetration rate, followed by the Bay Area and the Superior regions. Central and Southern regions lag behind in reaching mental health services to the Hispanic/Latino beneficiaries in comparison to the other regions (Fig. 8).

Figure 8: Hispanic/Latino Penetration Rates, CY 2016-2018

Table 1: Eligibles and Beneficiaries by Race/Ethnicity, CY 2018

Category	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate
African-American	1,004,291	80,235	7.99%
Asian/Pacific Islander	1,316,629	29,595	2.25%
Hispanic/ Latino	6,677,877	252,104	3.78%
Native American	53,655	3,689	6.88%
White	2,514,792	163,485	6.50%
Other	1,713,326	89,869	5.25%

Hispanic/Latino beneficiaries constitute a lower percentage of ACA eligible beneficiaries, about 43 percent. However, the disparity persists for this population as well with the number of beneficiaries served constituting only 32 percent of the total served (Table 6). CalEQRO notes that Asian/Pacific Islanders had the lowest ACA penetration rate of just 1.74 percent among all race/ethnicity groups in CY 2018 (Table 2).

Table 2: ACA Eligibles and Beneficiaries by Race/Ethnicity, CY 2018

Category	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate
African-American	298,851	20,403	6.83%
Asian/Pacific Islander	465,562	8,121	1.74%
Hispanic/Latino	1,671,973	49,302	2.95%
Native American	17,974	1,122	6.24%
White	903,874	52,458	5.80%
Other	449,597	21,162	4.71%

Foster Care penetration rates have plateaued.

Statewide, the number of FC eligible and beneficiaries served remained stable over the three years between CY 2016 and CY 2018 (Fig. 9). However, the Southern and Los Angeles regions had an increase in the FC penetration rate that compensated for the decline in the other three regions (Fig. 10).

Figure 9: Foster Care Eligibles and Beneficiaries Served, CY 2016-2018

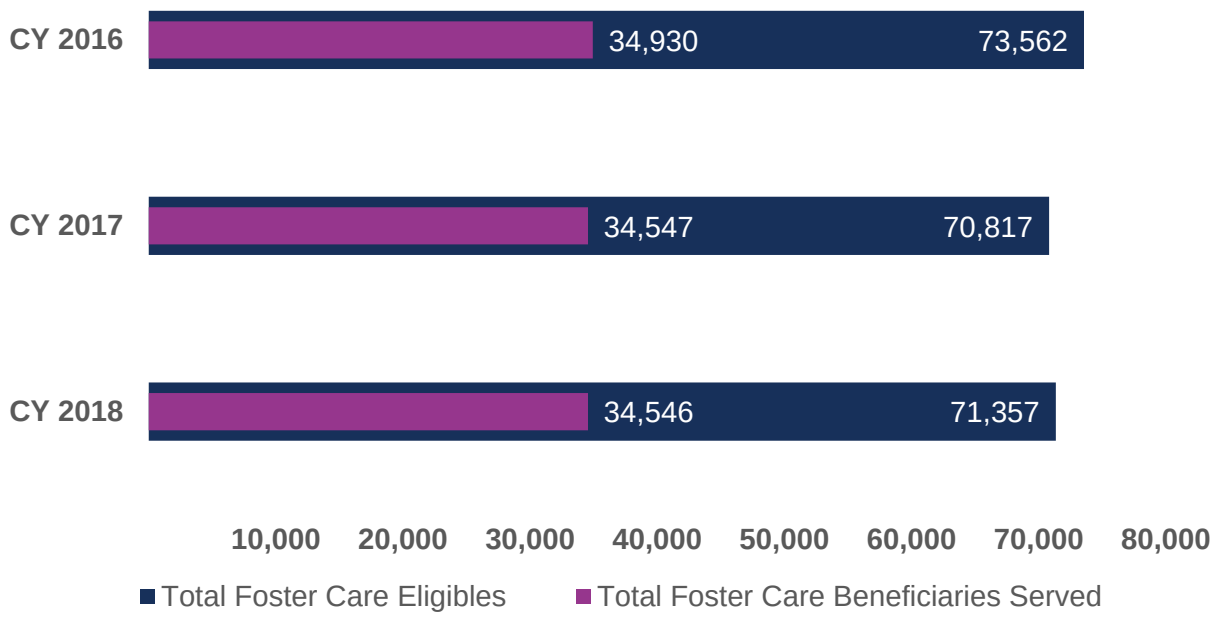
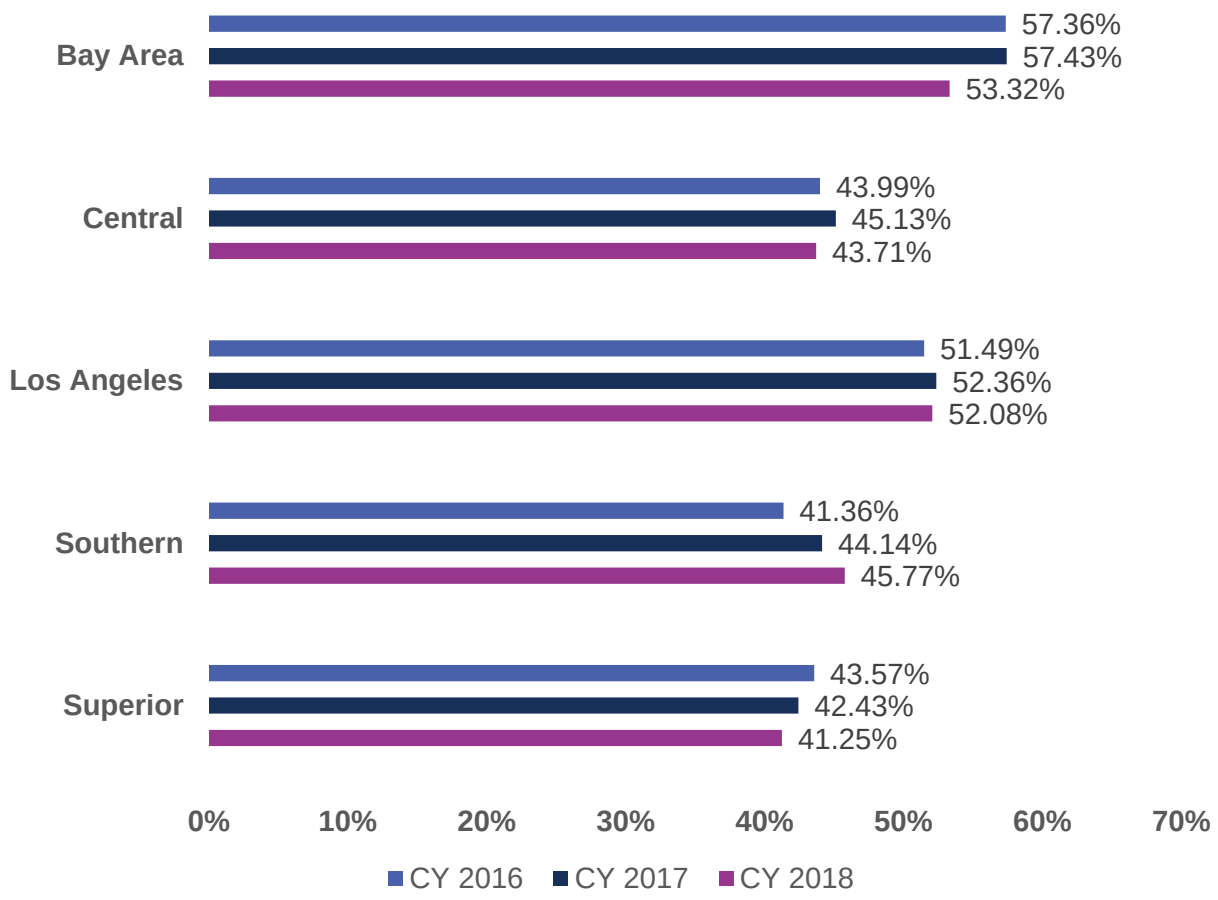


Figure 10: Penetration Rates by Region, CY 2016-2018

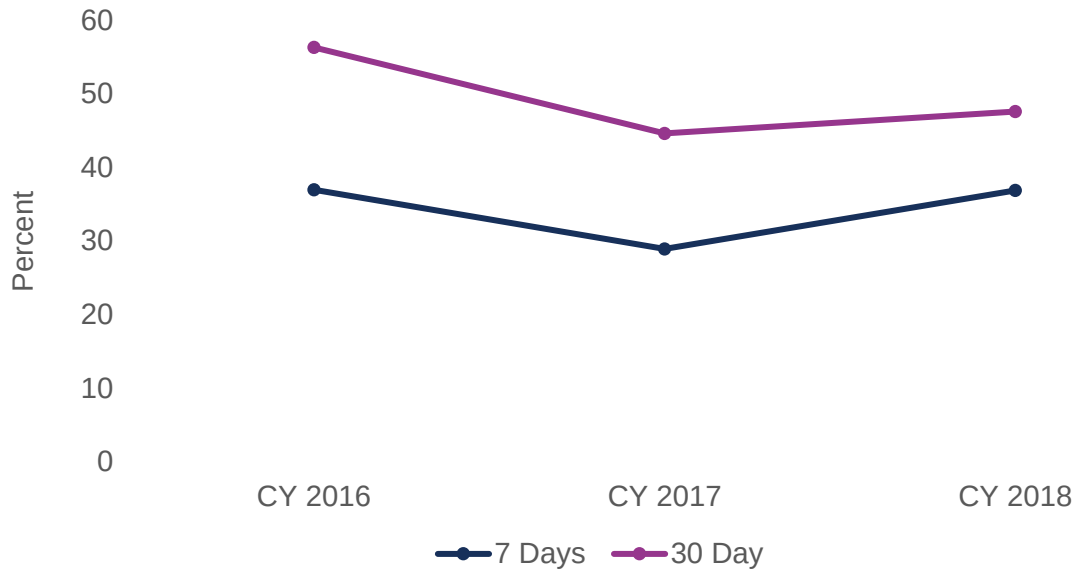


Timeliness

Outpatient follow-up rates have not improved.

The 7-day outpatient follow-up rate after a psychiatric inpatient discharge (HEDIS measure) in CY 2018 went back up to the CY 2016 level after a dip in CY 2017 (Fig. 11). The 30-day follow-up rate remained lower than the CY 2016 level.

Figure 11: Outpatient Follow-up, CY 2016-2018



Quality

Bay Area ACB continues to be the highest in the state.

It is not clear that higher ACB in the Bay Area necessarily translates to better quality of care. Rather, it probably reflects the generally higher cost of doing business in the Bay Area, and the lingering effects of inequities in SD/MC funding across the state since its inception. Smaller and rural MHPs continue to have the lowest ACBs, often termed as under equity counties.

After a spike in CY 2017, Bay Area average came down to the CY 2016 level. Other MHP regional averages showed modest increases during the same three-year period (Fig. 12). Nonetheless, Bay Area ACB continues to be nearly twice that of the other regions. Small-Rural MHP ACB remained stable between CY 2016 and CY 2018, and significantly lower than the other MHP size averages (Fig. 13).

Figure 12: ACB by Region

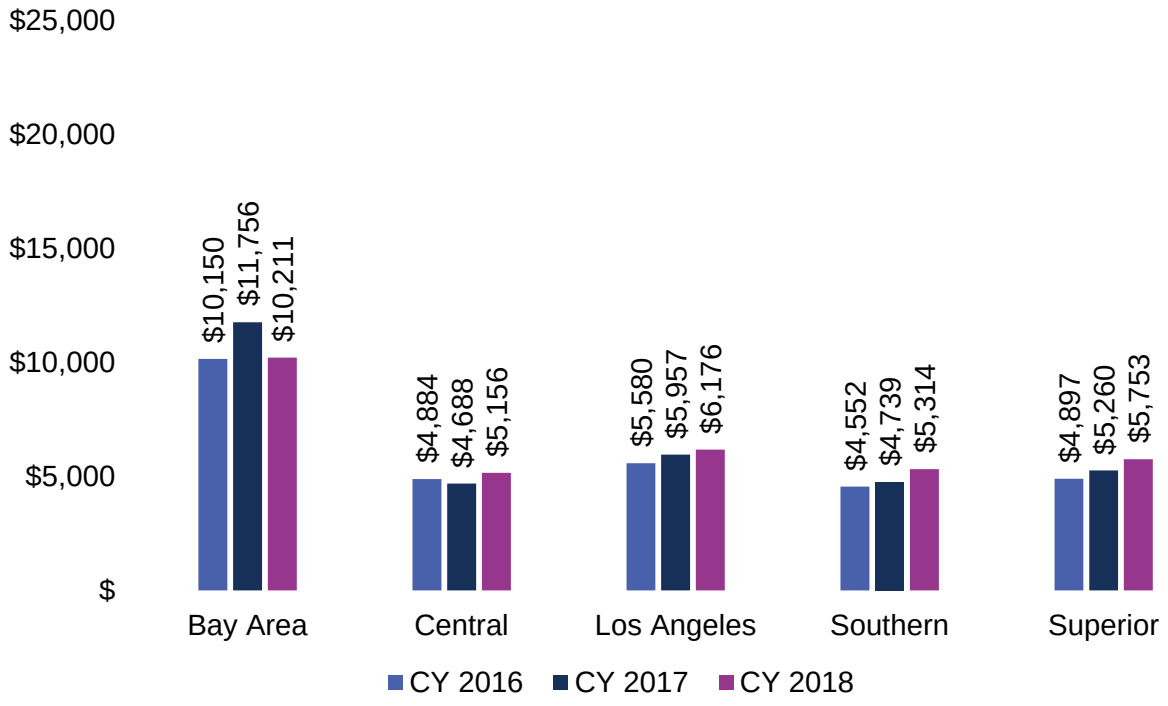
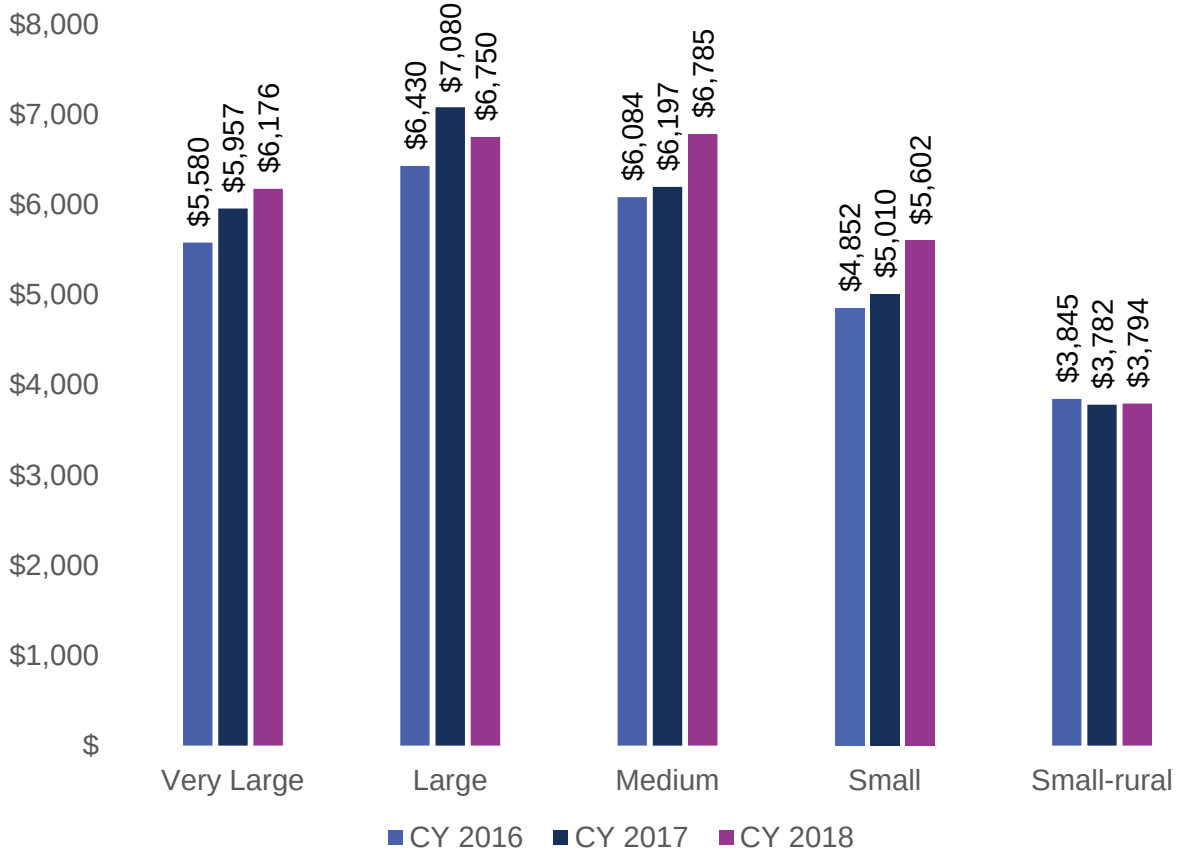


Figure 13: ACB by Size



SMHS for children aged 6 to 17 is among the highest.

The ACB for the 6-17 age group is the highest, or among the highest, regardless of MHP size or region, although, like the overall ACB, it varies by MHP size and region (Figs. 14 and 15).

Figure 14: ACB by Region and Age, CY 2018

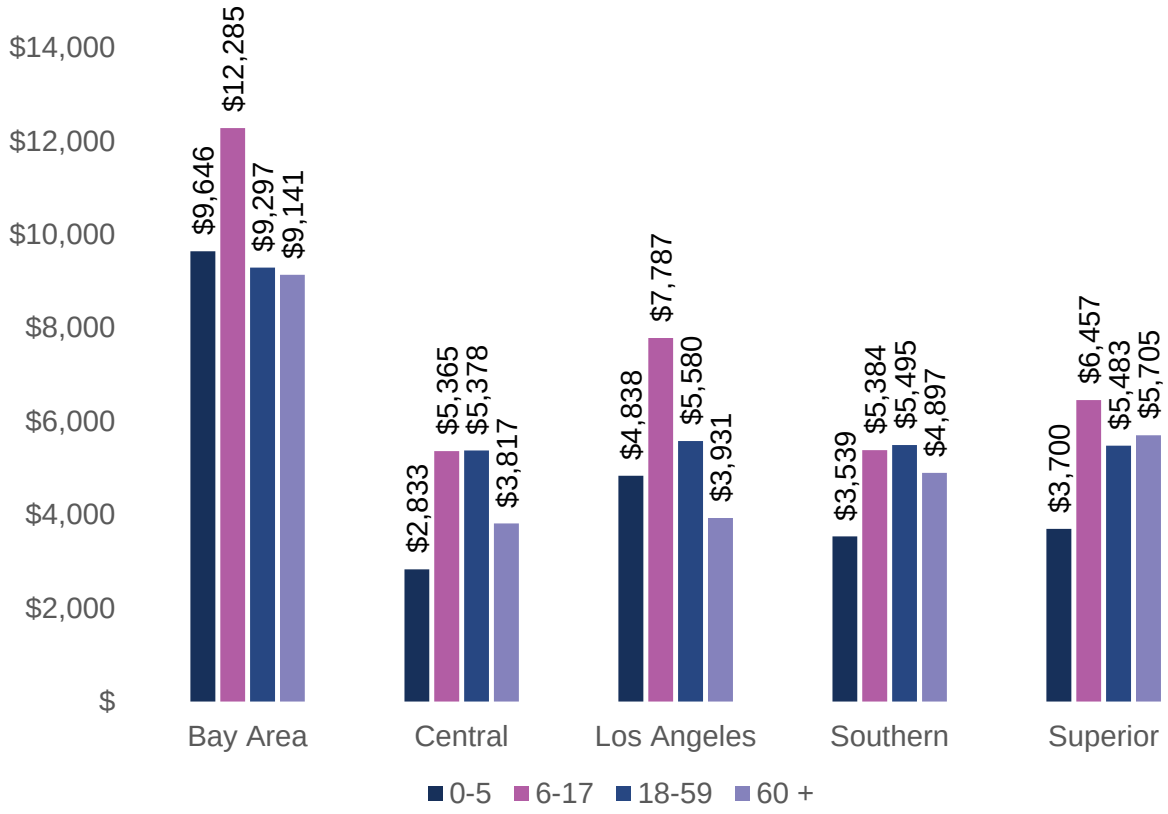
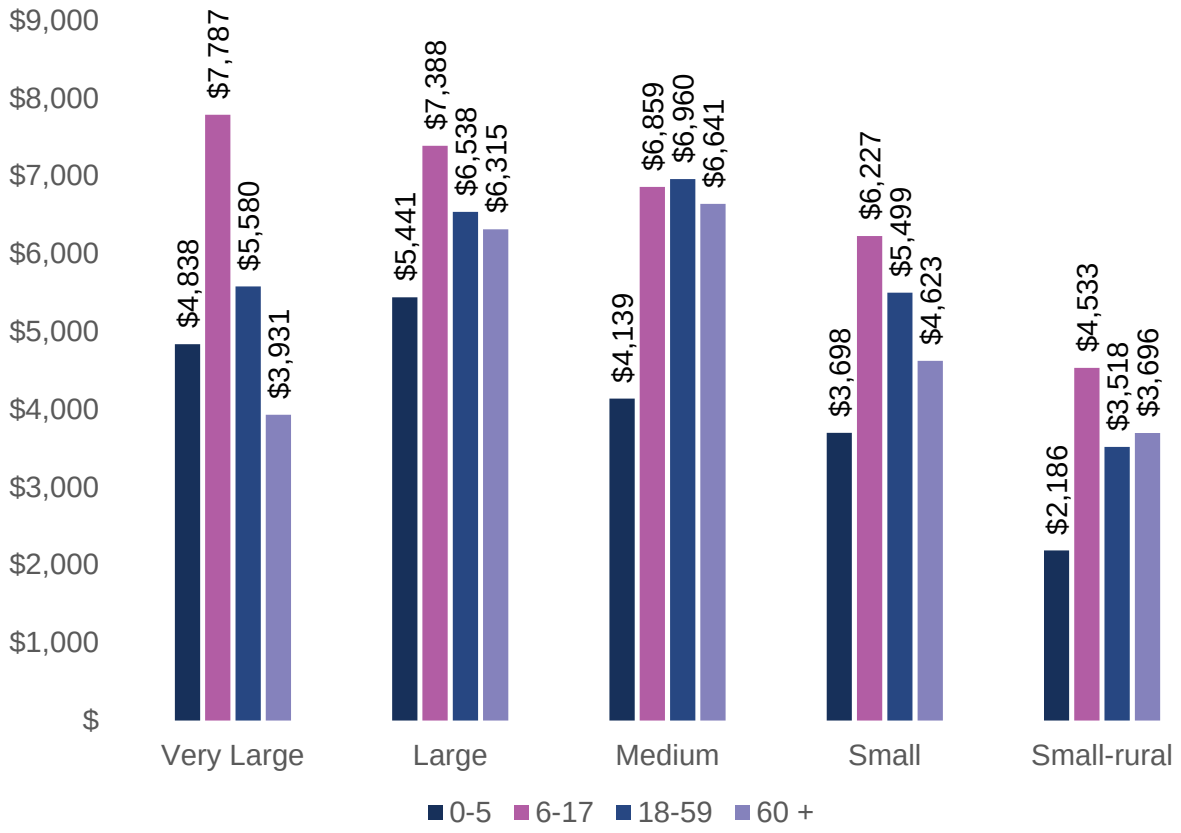


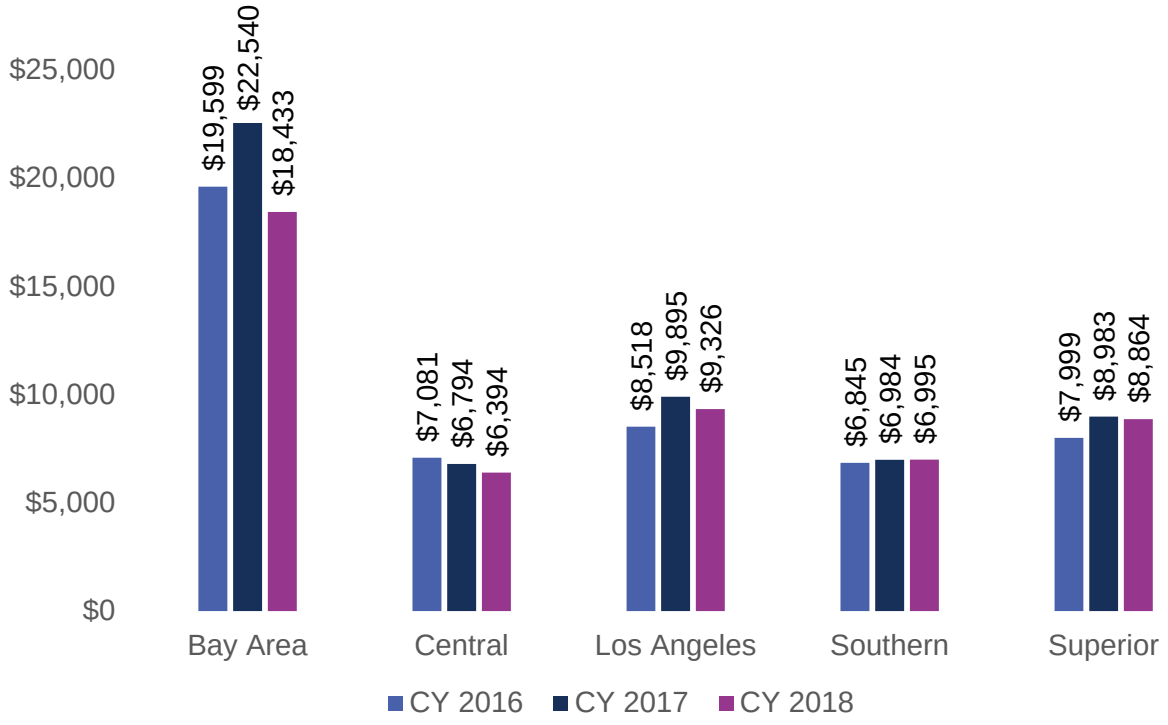
Figure 15: ACB by Size and Age, CY 2018



FC ACB is higher than overall ACB in all regions, but the differences vary significantly.

FC beneficiaries had a higher ACB than the overall ACB in each of the MHP regions (Figs. 12 and 16). However, the magnitude of the difference varied from 25 percent to 80 percent depending on the region.

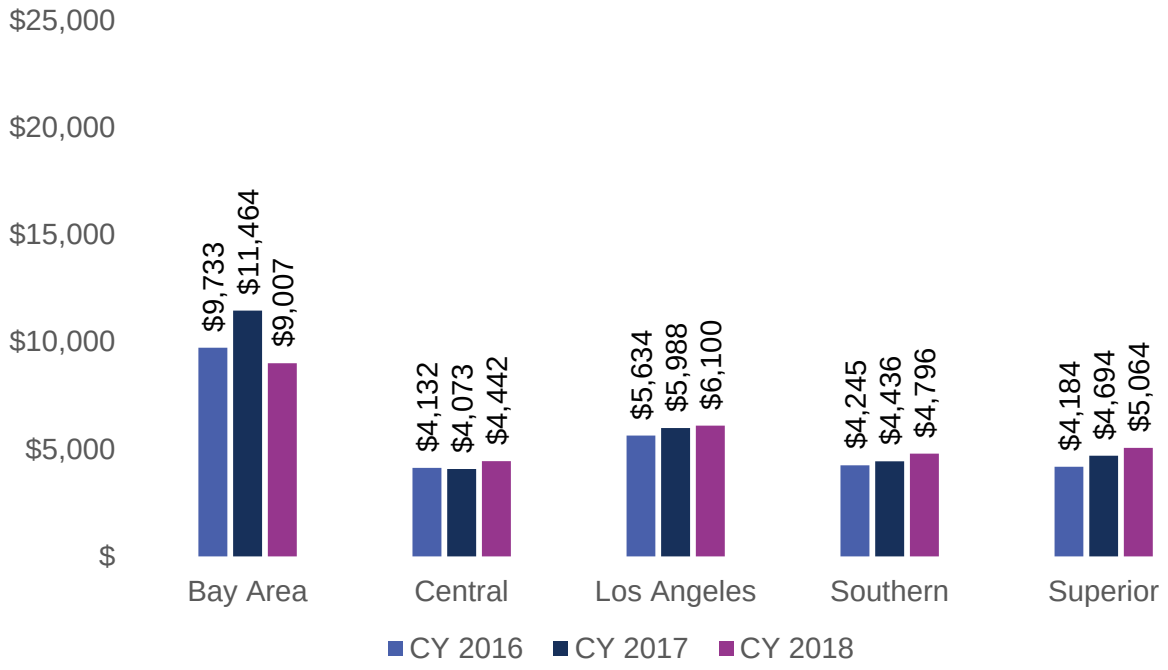
Figure 16: Foster Care ACB per Beneficiary CY 2016-2018



Hispanic/Latino ACB pattern mirrors the overall ACB, but lower than the overall average.

The Hispanic/Latino ACB distribution across the MHP regions is similar to the overall ACB pattern with each of the averages being slightly lower than the overall ACB (Figs. 12 and 17).

Figure 17: Hispanic/Latino ACB per Beneficiary, CY 2016-18



Other disorders diagnoses emerged as one of the more prevalent categories such as depression and psychosis.

Statewide, depressive disorders continue to be the most prevalent category of diagnoses, outpacing the next highest diagnoses category, psychotic disorders, by over 75 percent (77 percent), and more than double that of the next highest category of anxiety disorders (Fig. 18).

Slight reductions in most diagnoses categories have shown up in the other diagnoses category, which shot up by nearly 70 percent (69 percent) between CY 2017 and CY 2018 (Fig. 18).

The increase in the prevalence of other diagnoses is mirrored in the corresponding ACB which more than doubled during the same two CYs (Fig. 19), surpassing even the ACB for psychotic disorder diagnoses, which have had the highest ACB for many years.

While depressive disorder diagnoses are the most prevalent among Medi-Cal beneficiaries receiving SMHS, the ACB for psychotic and disruptive disorders have been the top two, and now joined by that of the other diagnoses (Fig. 19).

Both the prevalence and the ACB for deferred diagnoses are the lowest of all categories, likely reflecting the relatively short duration of these diagnoses.

Figure 18: Statewide Beneficiaries by Diagnosis, CY 2016-2018

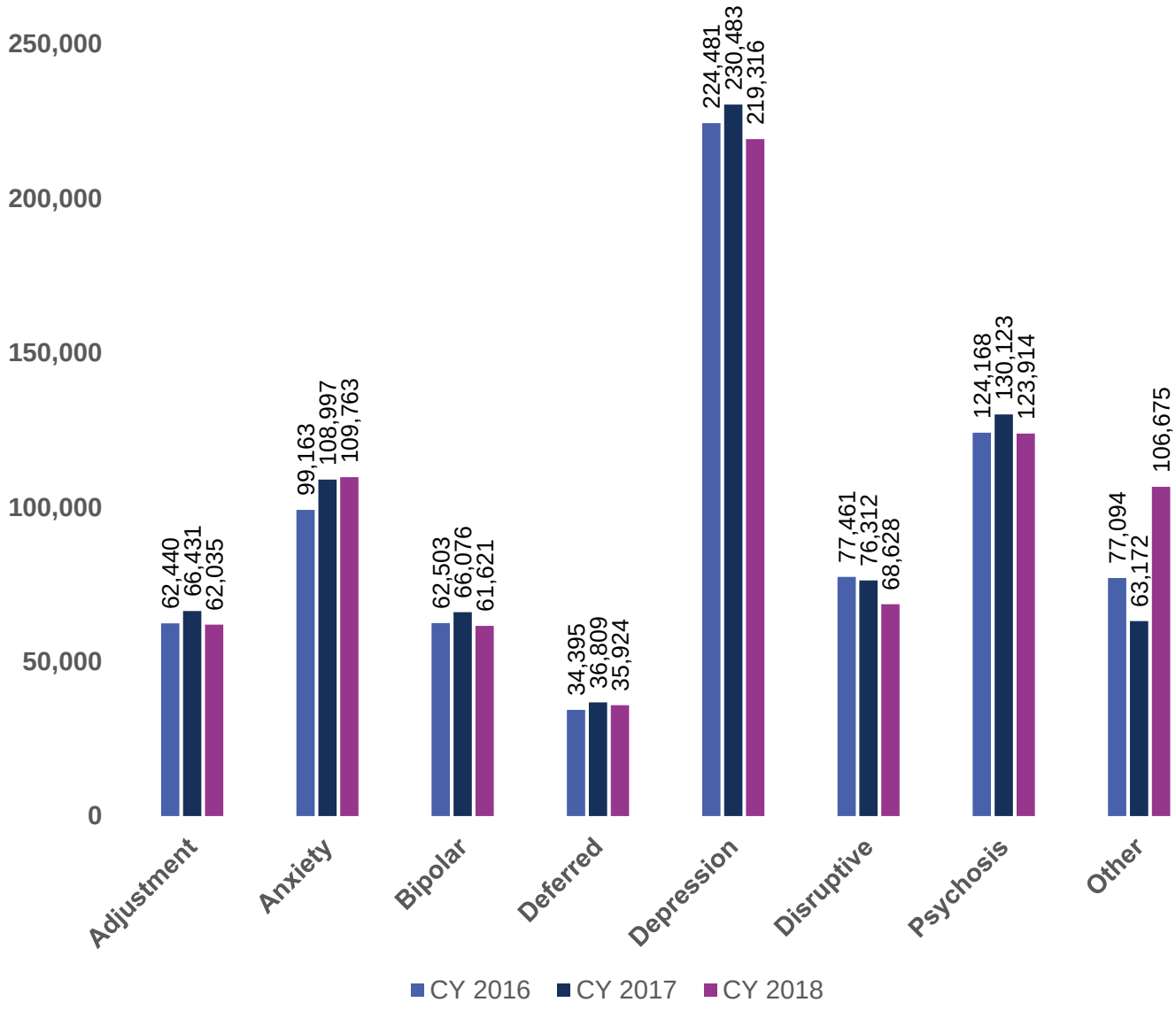
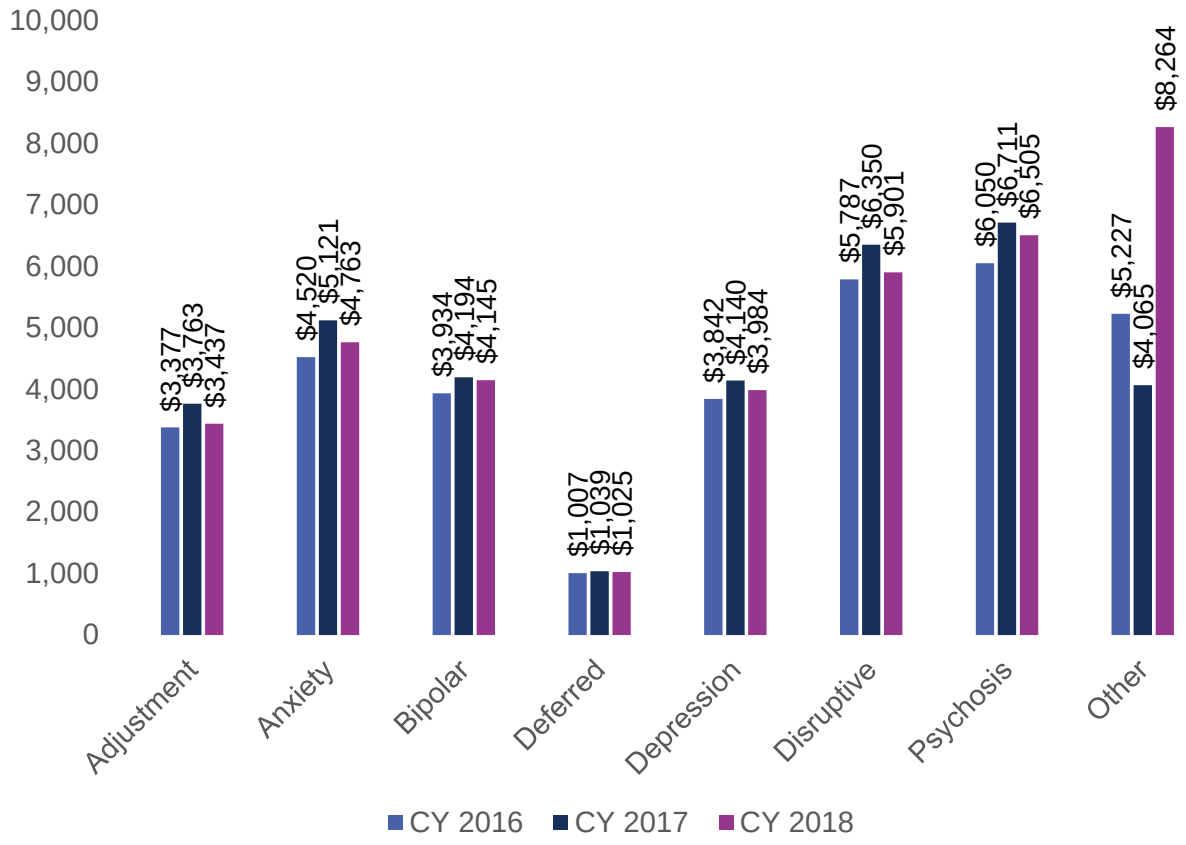


Figure 19: ACB by Diagnosis, CY 2016-2018

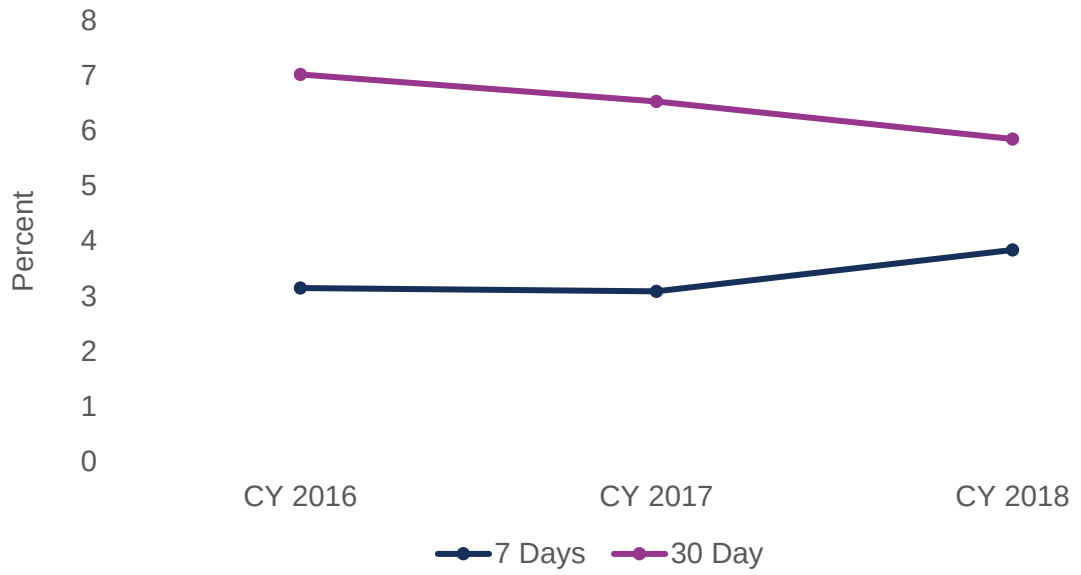


Beneficiary Progress and Outcomes

30-day rehospitalization rate decreased.

Statewide the 7-day rehospitalization rate went up slightly from 3.15 to 3.84 percent (Fig. 20).

Figure 20: 7- and 30-Day Rehospitalization Rates, CY 2016-2018



However, the 30-day rehospitalization rate (HEDIS measure) went down by more than a percentage point between CY 2016 and CY 2018 (Fig. 20).

Structure and Operations

There are correlations between availability of in-county psychiatric inpatient beds, distance from county of eligibility, MHP size and region, and the average inpatient LOS.

Average inpatient LOS is very similar for the three relatively more urban regions: Bay Area, Los Angeles, and Southern (Fig. 21). Superior region had the highest LOS in CY 2018, followed by the Central region. This may point to a structural issue in that the Superior region MHPs have very few, if any, inpatient beds in-county. Central region also has many MHPs lacking in-county inpatient psychiatry beds. As such, arranging for inpatient release is more time consuming for the MHPs in these regions often requiring long-distance transportation and staff time.

A similar pattern is seen by MHP size as well. Small-rural and small MHPs that constitute most of the Superior and Central regions have the highest inpatient LOS (Fig. 22).

Figure 21: Average LOS by Region, CY 2018

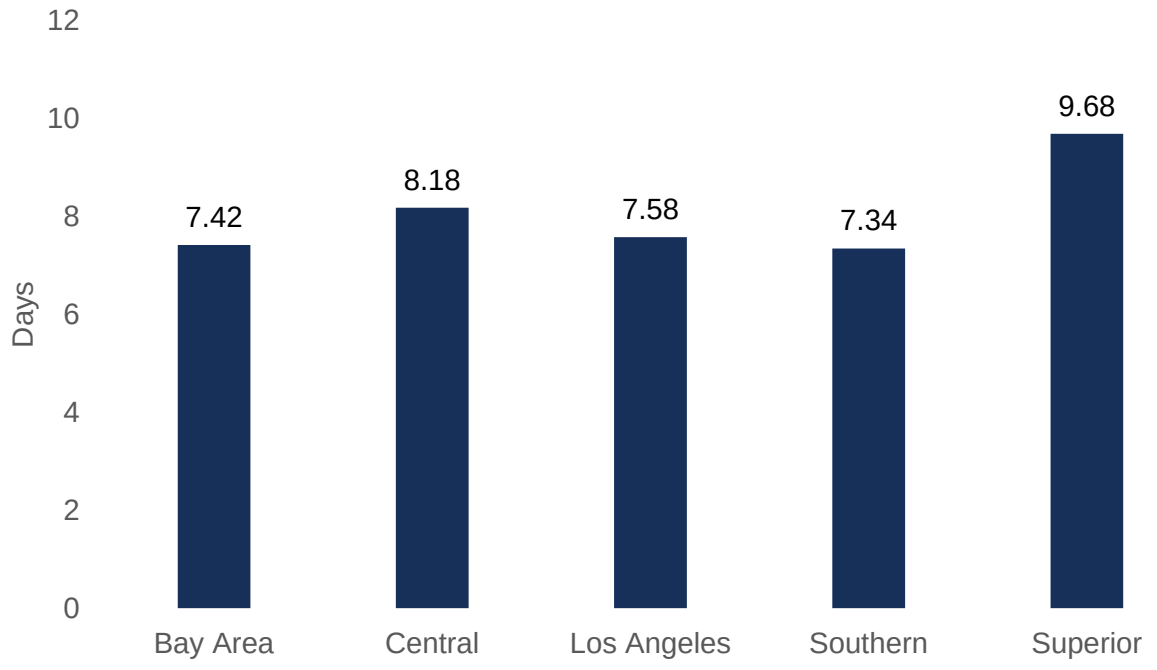


Figure 22: Average LOS by Size, CY 2018