2020-2021 Validation of Performance Measures

MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW STATEWIDE REPORT

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 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) 2020-21 findings on key performance measures (PMs) for California's Medi-Cal funded SMHS delivered by the county MHPs, including:

- 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

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 SMHS. 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. MHPs also are grouped by five regions: Bay Area, Central, Los Angeles, Southern, and Superior. To avoid focusing any subgroup analysis on a single county, Los Angeles is sometimes included in the Large and Sothern categories.

Figure PM-1: California MHPs, by Region

Figure PM-2: California MHPs, by MHP Size

CalEQRO produces summaries and reports that are released to the MHPs prior to the EQRO reviews. Below are the CY 2019 PM results; several measures are trended across three years (CY 2017-19) at the statewide, regional, and MHP size levels. Most PM data reported in this section were used for the MHP reviews and reports. The PMs are reported by the following domains: Access, Timeliness, and Quality.

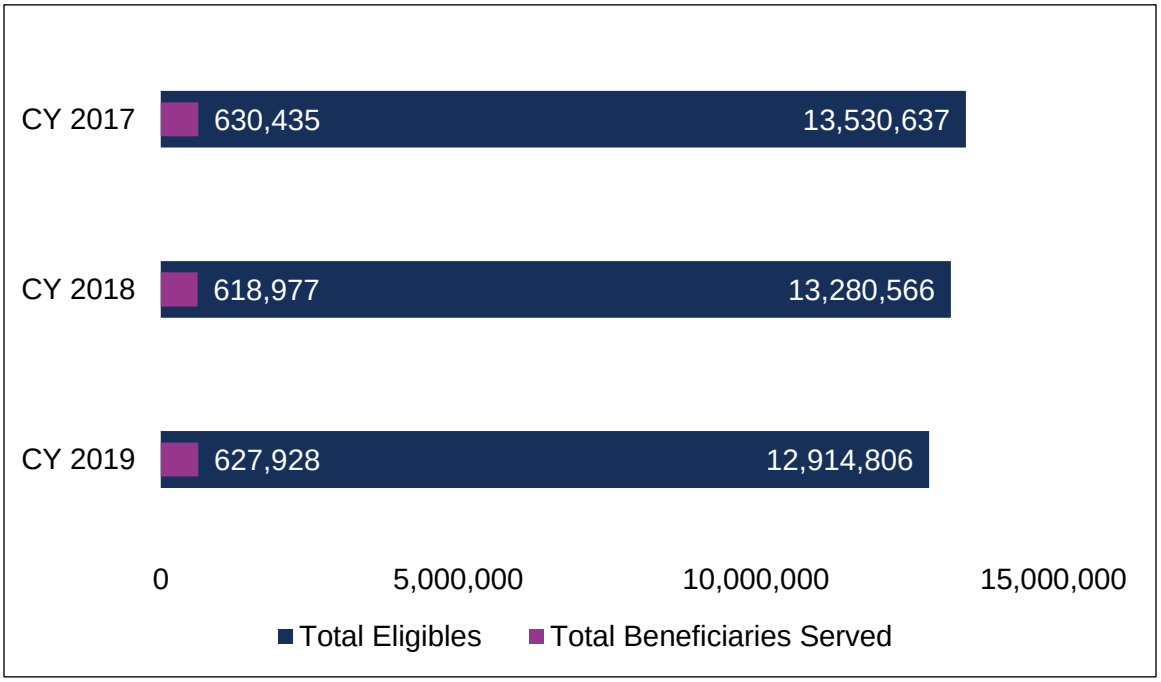
Access

Overall

Trends in the counts of Medi-Cal beneficiaries and those who receive SMHS provide a broad overview of potential service needs and a measure of access to SMHS. A corresponding indicator that is constructed of these two indicators, the penetration rate, summarizes the level of access at each MHP level, as well as by MHP region, MHP size, statewide, and by various demographic factors. It can also act as a good measure of disparities in access to SMHS by various groups.

In its FY 2019-20 annual report CalEQRO had noted a three-year decline in the number of Medi-Cal eligibles from CY 2016 to CY 2018. In CY 2019, the decline continued at a faster pace with a reduction of over 365,000 or 2.75 percent from the CY 2018 Medi-Cal eligible count (Figure PM-3). This took place while the state overall population increased slightly by over 100,000.

Figure PM-3: Medi-Cal Eligibles and Beneficiaries Served Statewide, Three-Year Trend



The decline in Medi-Cal eligible beneficiaries is seen across the regions with the Southern and Los Angeles regions showing the greatest reductions in Medi-Cal eligible beneficiaries accounting for over 60 percent of the decline statewide (Table PM-1).

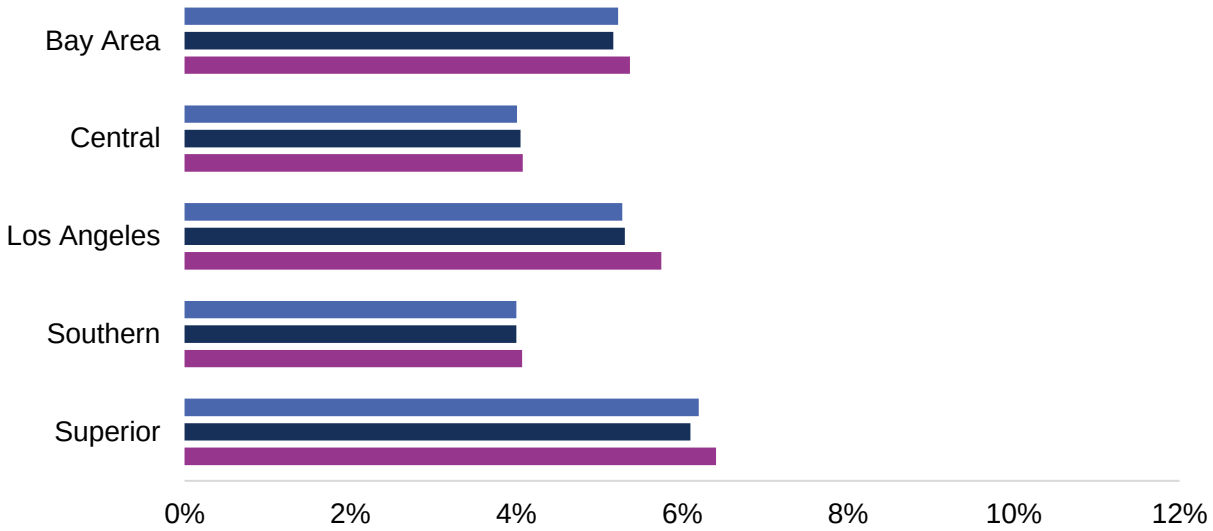
Table PM-1: Medi-Cal Eligibles and Beneficiaries Served by MHP Region, CY 2017-19

Region / CY	Monthly Average of Medi-Cal Eligibles	Total Beneficiaries Served
Bay Area		
CY 2017	2,158,883	112,851
CY 2018	2,087,709	107,905
CY 2019	2,012,246	108,028
Central		
CY 2017	2,426,532	97,208
CY 2018	2,378,549	96,284
CY 2019	2,327,951	95,006
Los Angeles		
CY 2017	4,022,848	212,478
CY 2018	3,964,272	210,337
CY 2019	3,843,353	221,136
Southern		
CY 2017	4,510,484	180,408
CY 2018	4,437,502	177,370
CY 2019	4,329,683	176,209
Superior		
CY 2017	411,893	25,527
CY 2018	412,535	25,165
CY 2019	401,573	25,754

In CY 2019, the number of beneficiaries served by the MHPs increased by 1.46 percent from CY 2018 and almost returned to the CY 2017 level. However, not all regions showed an increase in the number of beneficiaries served. Los Angeles, Bay Area, and Superior regions showed an increase while the Southern and Central regions showed a decrease. Los Angeles region alone showed an increase (5.13 percent) greater than the overall statewide increase in the number of beneficiaries served.

Because of the declining number of Medi-Cal eligible beneficiaries, the penetration rate increased in CY 2019 across all regions (Figure PM-4) despite the Southern and Central regions serving less beneficiaries than the year before. Los Angeles, because of its declining number of eligible beneficiaries and the significant increase in the number of beneficiaries it served, showed the highest increase in the penetration rate, and continued to have the second highest penetration rate in the state after the Superior region. This is significant as Los Angeles accounts for almost one-third of the state's Medi-Cal beneficiaries.

Figure PM-4: Overall Penetration Rates by MHP Region, CY 2017-19



	Superior	Southern	Los Angeles	Central	Bay Area
CY 2017	6.20%	4.00%	5.28%	4.01%	5.23%
CY 2018	6.10%	4.00%	5.31%	4.05%	5.17%
CY 2019	6.41%	4.07%	5.75%	4.08%	5.37%

Every group of MHPs by size had a decline in the number of Medi-Cal eligible beneficiaries each of the three years between CY 2017 and CY 2019 (Table PM-2). The rate of decline during those three years varied between 5 percent for the medium sized MHPs and 2 percent for the small sized ones.

During the same period, the very large, small, and small-rural sized MHPs saw an increase in the number of beneficiaries served. Even among the large and medium sized MHPs that saw a decrease in the number of beneficiaries served, the rates of decrease were less than that in the number of Medi-Cal eligible beneficiaries. This is seen in the penetration rate discussion below.

Table PM-2: Medi-Cal Eligibles and Beneficiaries served by MHP Size, CY 2017-19

Size / CY	Monthly Average of Medi-Cal Eligibles	Total Beneficiaries Served
Very Large		
CY 2017	4,022,848	212,478
CY 2018	3,964,272	210,337
CY 2019	3,843,353	221,136
Large		
CY 2017	6,639,240	287,010
CY 2018	6,494,707	280,189
CY 2019	6,323,746	278,182
Medium		
CY 2017	2,098,188	87,684
CY 2018	2,053,900	85,397
CY 2019	1,993,115	84,704
Small		
CY 2017	657,869	32,598
CY 2018	655,800	32,502
CY 2019	644,702	33,219
Small-Rural		
CY 2017	112,495	8,688
CY 2018	111,888	8,628
CY 2019	109,891	8,877

Looking at penetration rate by MHP size, small-rural MHPs' penetration rate doubled from CY 2018 to CY 2019 (Figure PM-5). While this is remarkable, the relatively smaller numerator for this group makes it a more volatile indicator compared to the same for other MHP sizes.

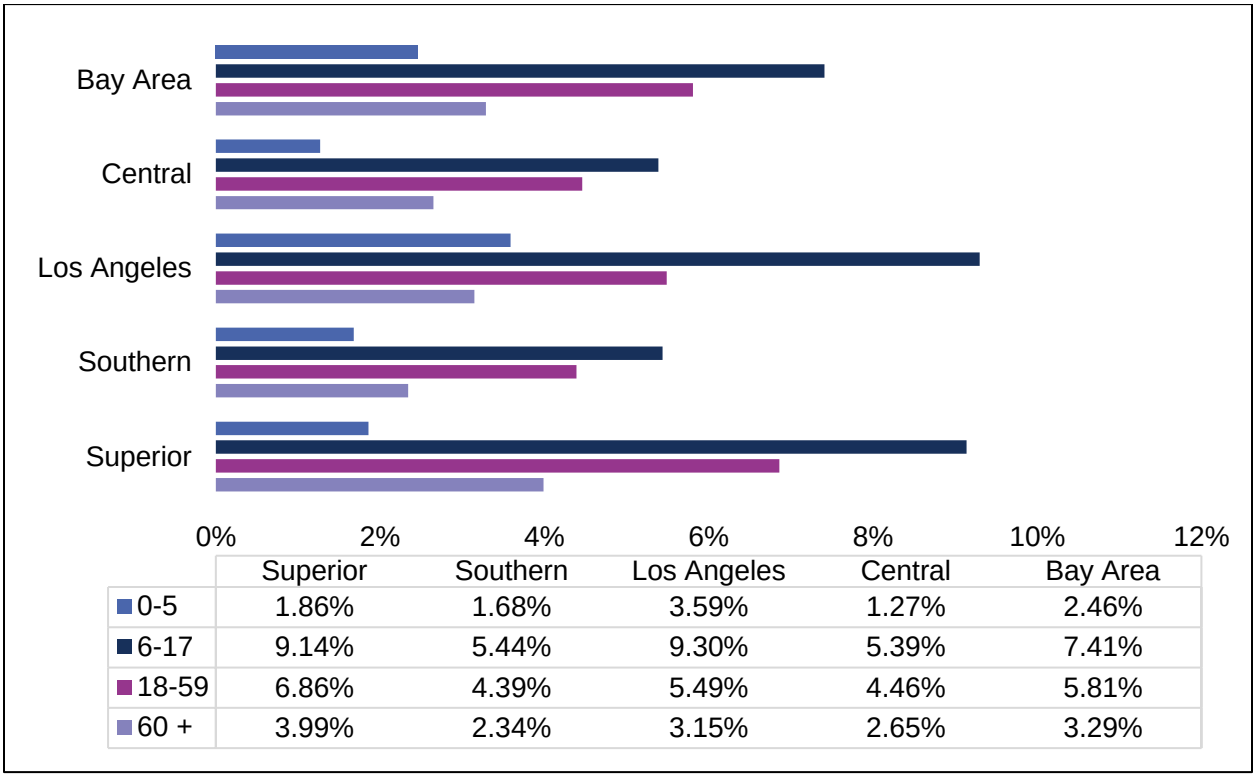
Penetration rate by MHP size shows that Los Angeles, which is the only very large MHP, had the second highest rate in CY 2019 behind only the small-rural MHPs. However, the penetration rate analysis by MHP size shows less variations in the averages than when done by MHP region.

Figure PM-5: Overall Penetration Rates by MHP Size, CY 2017-19

	Small-rural	Small	Medium	Large	Very Large
CY 2017	4.01%	4.96%	4.18%	4.32%	5.28%
CY 2018	4.05%	4.96%	4.16%	4.31%	5.31%
CY 2019	8.08%	5.15%	4.25%	4.40%	5.75%

All MHP regions display a similar pattern in penetration rates by beneficiary age groups (Figure PM-6). Children and youth in the 6–17-year age group show the highest penetration rates followed by adults in 18-59 age group, older adults 60 or above, and infants and very young children in the 0-5 age group respectively. Los Angeles had the highest penetration rate for the 6-17 years-old closely followed by the Superior region. Superior region had the highest penetration rate, and the Central and Southern regions had the two lowest penetration rates for adults in the 18-59 age group.

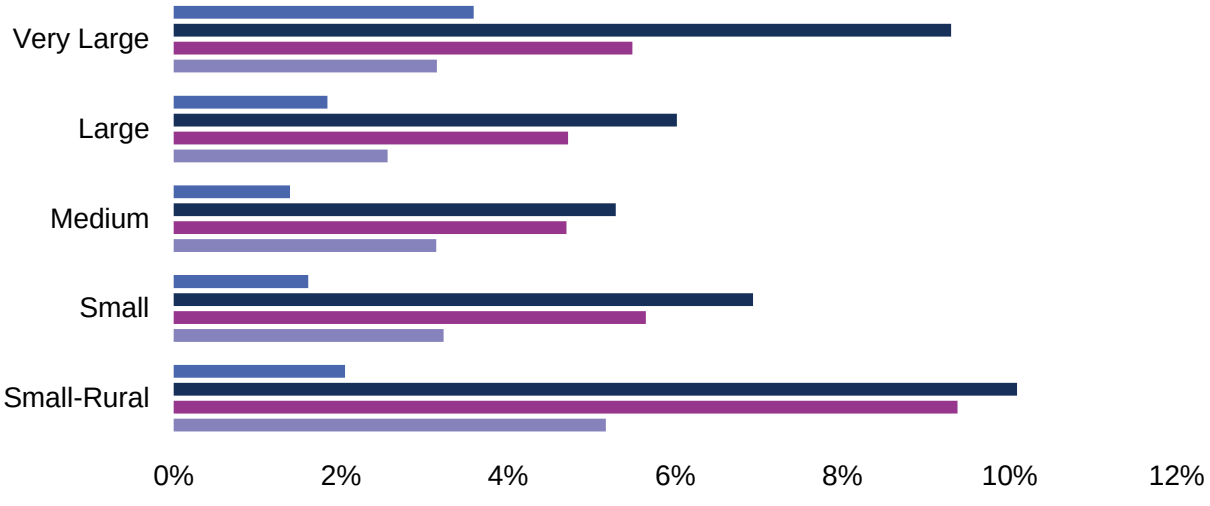
Figure PM-6: Penetration Rates by MHP Region and Beneficiary Age Groups, CY 2019



	Superior	Southern	Los Angeles	Central	Bay Area
0-5	1.86%	1.68%	3.59%	1.27%	2.46%
6-17	9.14%	5.44%	9.30%	5.39%	7.41%
18-59	6.86%	4.39%	5.49%	4.46%	5.81%
60 +	3.99%	2.34%	3.15%	2.65%	3.29%

The penetration rate distribution by MHP size (Figure PM-7) has a similar age group pattern as the distribution by MHP region (Figure PM-6). As in the MHP region distribution, the 6-17 age group had the highest average penetration rate for each MHP size. The small-rural size average penetration rates for all age groups were the highest except 0-5, for which the very large size (Los Angeles) MHP had the highest penetration rate.

Figure PM-7: Penetration Rates by MHP Size and Beneficiary Age Groups, CY 2019



	Small-Rural	Small	Medium	Large	Very Large
0-5	2.05%	1.61%	1.39%	1.8%	3.59%
6-17	10.09%	6.93%	5.29%	6.0%	9.30%
18-59	9.38%	5.65%	4.70%	4.7%	5.49%
60 +	5.17%	3.23%	3.14%	2.6%	3.15%

ACA Penetration Rates

Since the expansion of Medi-Cal under the Affordable Care Act (ACA), CalEQRO has separately tracked the access and ACB for those who became eligible for SMHS under the ACA. As PM-3 below shows, statewide, 29 percent of Medi-Cal beneficiaries were eligible under the ACA in CY 2019. This percentage varied slightly by region with Los Angeles having the highest at 31 percent. Although the Southern region had the highest number of ACA beneficiaries, as a percentage of its overall Medi-Cal beneficiaries, it had the lowest percentage at 28 percent.

The percentage of ACA beneficiaries who received SMHS was lower than the percentages of total Medi-Cal beneficiaries statewide and across all regions by 2 to 5 percent. This essentially meant that the SMHS penetration rates for the ACA beneficiaries were lower than the overall penetration rates statewide and among corresponding regions (Table PM-3 and Figure PM-4). For instance, the Bay Area's overall penetration rate was 5.37 percent in CY 2019 whereas its ACA penetration rate was 4.45 percent. In Los Angeles, the overall penetration rate was higher by 1.5 percentage point than the ACA penetration rate; for all other regions, the difference was lower than 1 percentage point.

The SMHS utilization rate among the ACA beneficiaries points toward greater access to SMHS for a population a significant part of which did not have such access before the Medi-Cal expansion. In other words, ACA fulfilled significant unmet needs among previously uninsured individuals.

Table PM-3: ACA Eligibles, Beneficiaries Served, and Penetration Rates by Region, CY 2019

Region	Average Number of Medi-Cal Eligibles per Month	ACA Percentage of Overall Medi-Cal Eligibles	Number of Beneficiaries Served per Year	ACA Percentage of Beneficiaries Served per Year	ACA Penetration Rate
Statewide	3,719,952	29%	159,904	25%	4.30%
Bay Area	593,369	29%	26,414	24%	4.45%
Central	587,608	25%	21,584	23%	3.67%
Los Angeles	1,207,217	31%	58,929	27%	4.25%
Southern	1,217,101	28%	46,326	26%	3.81%
Superior	114,658	29%	6,247	24%	5.45%

Access by Race/Ethnicity

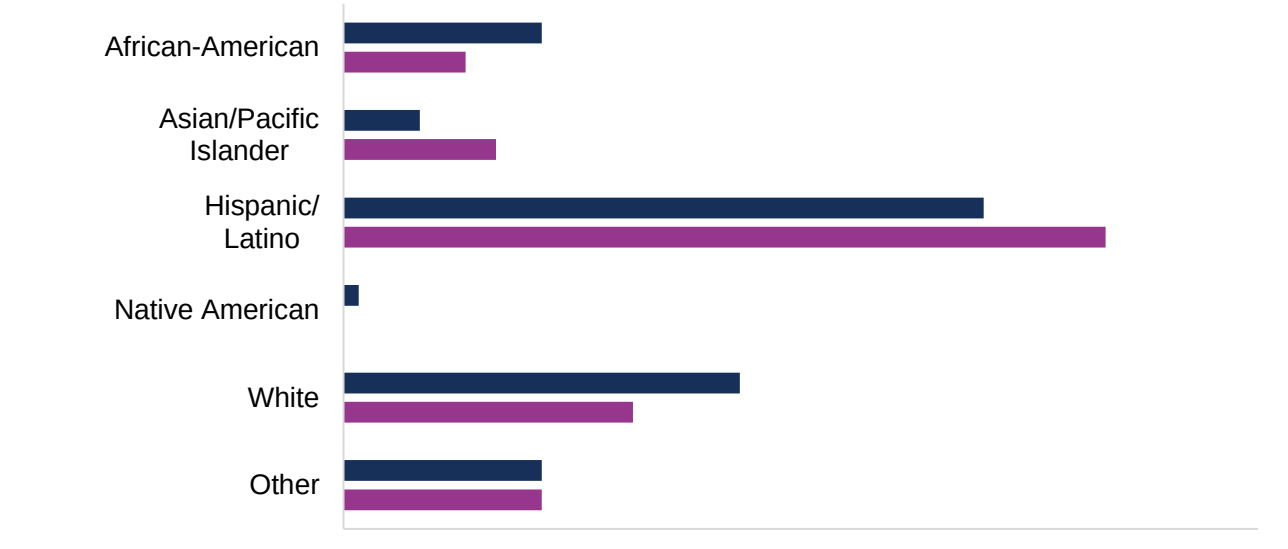
In CY 2019, Hispanic/Latinos constituted the largest group by race/ethnicity at 50 percent of Medi-Cal beneficiaries statewide. At the other end, Native Americans constituted less than 1 percent of the beneficiaries (Figure PM-8). In terms of the actual counts, there were 6.5 million Latino/Hispanic eligible beneficiaries out of 12.9 million total Medi-Cal beneficiaries statewide (Table PM-4). The next largest group were Whites who accounted for 19 percent of the beneficiary count at 2.4 million, followed by other, Asian/Pacific Islanders (API), African Americans, and Native Americans respectively. The other group consists of those who identify as mixed-race, or whose race/ethnicity was unknown.

Table PM-4: Medi-Cal Eligibles, Beneficiaries Served, and Penetration Rates Statewide by Race/Ethnicity, CY 2019

Category	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate
African-American	984,839	83,567	8.49%
Asian/Pacific Islander	1,284,330	29,007	2.26%
Hispanic/Latino	6,519,605	265,989	4.08%
Native American	51,789	3,885	7.50%
White	2,401,489	161,683	6.73%
Other	1,672,756	83,797	5.01%

Among racial/ethnic groups served by MHPs, Hispanic/Latino beneficiaries are the largest group, but the percentage is lower than that in the Medi-Cal eligible population. This disproportionality is seen across all racial/ethnic groups except for “Other” (Fig. PM-8).

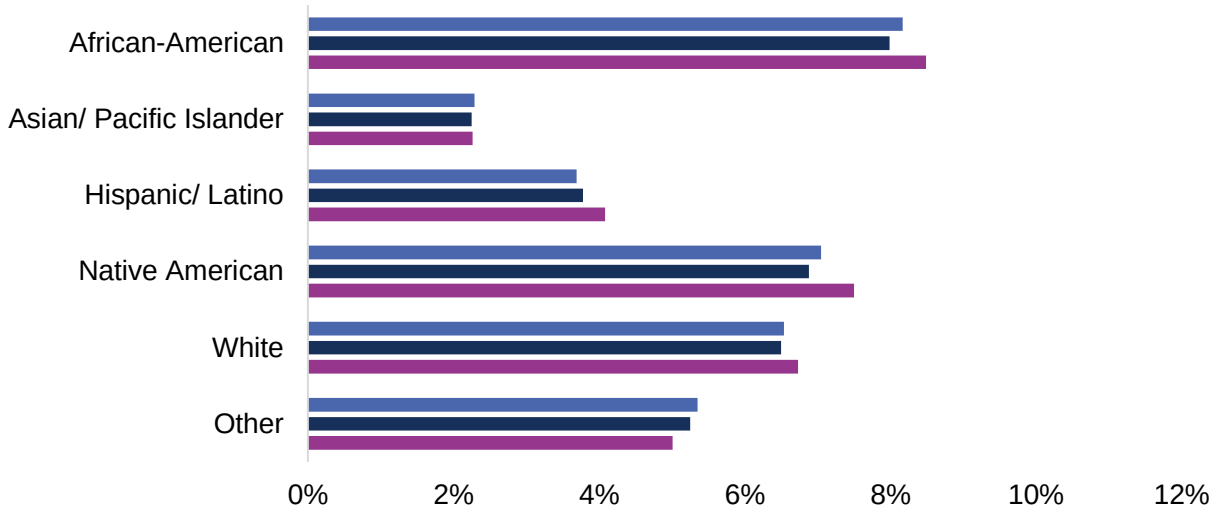
Figure PM-8: Percentage of Eligibles and Beneficiaries Served Statewide by Race/Ethnicity, CY 2019



	Other	White	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
% of Beneficiaries Served	13%	26%	1%	42%	5%	13%
% of Eligibles	13%	19%	0%	50%	10%	8%

This disparity is further demonstrated by a lack of uniform penetration rates among different racial/ethnic groups (Table PM-4), essentially pointing to unequal service access for different groups. As the 3-year trend in Figure PM-9 shows, this disparity is not a one-time event. This has persisted over the years despite some changes in penetration rates within each group. The two groups who have historically had lesser access to SMHS, Latino/Hispanics and APIs are discussed further in the following sections along with the foster care beneficiaries.

Figure PM-9: Penetration Rate Statewide by Race/Ethnicity, CY 2017-19



	Other	White	Native American	Hispanic/ Latino	Asian/ Pacific Islander	African-American
CY 2017	5.35%	6.54%	7.05%	3.69%	2.29%	8.17%
CY 2018	5.25%	6.50%	6.88%	3.78%	2.25%	7.99%
CY 2019	5.01%	6.73%	7.50%	4.08%	2.26%	8.49%

ACA Access by Race/Ethnicity

The ACA beneficiary percentage of the overall Medi-Cal beneficiaries vary significantly by race/ethnicity and range from 25 percent for Latino/Hispanic beneficiaries to 36 percent for White beneficiaries in CY 2019 (Table PM-5). In other words, the ACA expansion population included Whites at a higher rate than all other races/ethnicities, very closely followed by Asian/Pacific Islanders, at 35 percent.

The percentage of beneficiaries who received SMHS also varied significantly by race/ethnicity, ranging from only 20 percent for Latino/Hispanic beneficiaries to 33 percent for White beneficiaries. This shows that the ACA expansion increased access to SMHS differently for different race/ethnicity groups with the Whites benefitting the most and the Latino/Hispanics the least.

The corresponding penetration rates reflected almost the same picture. Although the Native American penetration rate was slightly higher than that for Whites, the former only accounted for a very small percentage of the total ACA expansion population. Although all race/ethnicity groups displayed lower ACA penetration rates than their corresponding overall penetration rates (Table PM-4), those with historical disparities showed much lower penetration rates than Whites and African Americans. The ACA penetration rate for Whites came the closest to their corresponding overall penetration rate at 6.15 percent compared to 6.73 percent overall. The African American ACA penetration rate was almost a percentage point lower than its corresponding overall rate, while Latino/Hispanic and API penetration rates dropped even lower than their already low overall penetration rates.

Table PM-5: ACA Eligibles, Beneficiaries Served, and Penetration Rate Statewide by Race/Ethnicity, CY 2019

Race/Ethnicity	Average Number of Eligibles per Month	ACA Percentage of Overall Medi-Cal Eligibles	Number of Beneficiaries Served per Year	ACA Percentage of Beneficiaries Served per Year	Penetration Rate
African-American	293,378	30%	22,002	26%	7.50%
Asian/Pacific Islander	445,561	35%	8,227	28%	1.85%
Hispanic/Latino	1,654,344	25%	54,278	20%	3.28%
Native American	17,138	33%	1,187	31%	6.93%
White	856,136	36%	52,682	33%	6.15%
Other	453,397	27%	21,528	26%	4.75%

Access for Groups with Historical Disparities

As Figure PM-9 demonstrates, the Hispanic/Latino and API access to SMHS persistently lagged behind the other racial/ethnic groups. This has been an ongoing focus of the EQRO annual aggregate reports in the past years, as well as featured in individual MHP reports and site review discussions.

Latino/Hispanic

Latino/Hispanic Medi-Cal beneficiaries' access to SMHS has been historically low since the EQRO started tracking the penetration rates. Over the past 15 years, a number of efforts by the MHPs, the contract providers, and mental health advocates, have resulted in a slow but steady increase in their penetration rates over the years.

Between CY 2017 and CY 2019, the number of Latino/Hispanic Medi-Cal beneficiaries dropped by 3.9 percent from 6.78 million to 6.52 million (Figure PM-10). During the same time, however, the number of beneficiaries receiving SMHS increased by 15,740 statewide, or by 6.3 percent. This corresponded to a steady increase in the Latino/Hispanic penetration rate, topping 4 percent statewide for the first time in CY 2019 since this indicator has been tracked by the EQRO (Figure PM-9). However, this rate in CY 2019 still lagged behind the corresponding White penetration rate by nearly 40 percent.

The Latino/Hispanic SMHS access varies significantly by MHP size and region. Los Angeles, the only MHP classified as very large and accounting for a third of the Latino/Hispanic beneficiaries statewide, registered a significant increase in its penetration rate to 5.19 percent in CY 2019 (Table PM-6). On the other hand, the large and medium size MHPs, together accounting for nearly two-thirds of the Latino/Hispanic beneficiaries, showed more modest increases in penetration rates, and stood at 3.52 percent and 3.04 percent respectively. Small-rural MHPs had the highest average penetration rate of 5.31 percent in CY 2019, but they accounted for less than half-a-percent of Latino/Hispanic beneficiaries who received SMHS statewide.

Figure PM-10: Latino/Hispanic Eligibles and Beneficiaries Served Statewide, Three-Year Trend

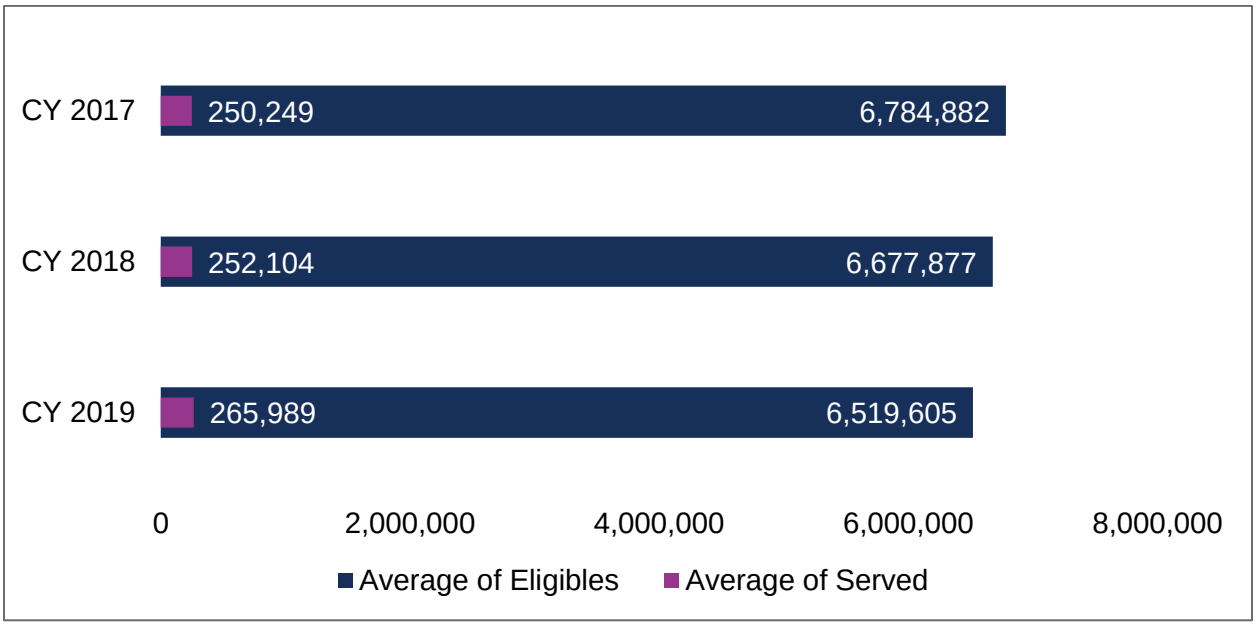


Table PM-6: Latino/Hispanic Eligibles and Beneficiaries Served by MHP Size, CY 2017-19

Size / CY	Monthly Average of Medi-Cal Eligibles	Total Beneficiaries Served	Penetration Rate
Very Large			
CY 2017	2,343,489	106,134	4.53%
CY 2018	2,319,414	108,093	4.66%
CY 2019	2,265,857	117,531	5.19%
Large			
CY 2017	3,093,484	100,865	3.26%
CY 2018	3,024,319	100,861	3.33%
CY 2019	2,942,832	103,624	3.52%
Medium			
CY 2017	1,037,295	29,813	2.87%
CY 2018	1,022,090	29,480	2.88%
CY 2019	1,000,328	30,402	3.04%
Small			
CY 2017	283,772	11,865	4.18%
CY 2018	284,744	12,036	4.23%
CY 2019	283,434	12,683	4.47%
Small-rural			
CY 2017	26,843	1,274	4.75%
CY 2018	27,312	1,309	4.79%
CY 2019	27,156	1,443	5.31%

Los Angeles maintained its position as the MHP region with the highest Latino/Hispanic penetration rates between CY 2017 and CY 2019 (Figure PM-11), and also showed the highest increase in CY 2019 as the only region with higher than 5 percent penetration rate. The rest of the regions also show larger growth in Latino/Hispanic in CY 2019 after relatively flat growth between CY 2017 and CY 2018. Central and Southern regions continue to have the lowest Latino/Hispanic penetration rates at 3.07 percent and 3.31 percent, respectively. Bay Area had the second highest penetration rate at 4.41 percent.

Figure PM-11: Latino/Hispanic Penetration Rates by MHP Region, CY 2017-19

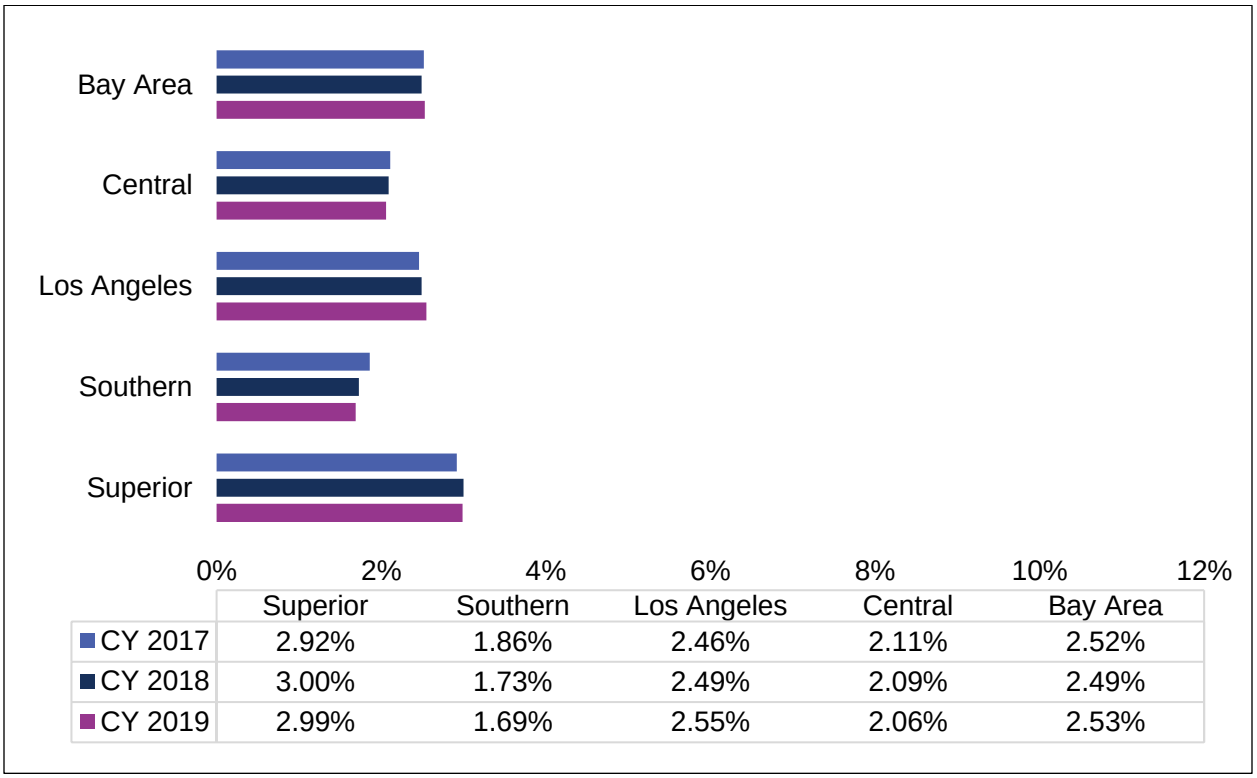
	Superior	Southern	Los Angeles	Central	Bay Area
CY 2017	3.88%	3.06%	4.53%	2.86%	4.14%
CY 2018	3.91%	3.14%	4.66%	2.91%	4.16%
CY 2019	4.20%	3.31%	5.19%	3.07%	4.41%

Asian/Pacific Islanders

Of all race/ethnicity groups, API Medi-Cal beneficiaries are the least likely to receive or access SMHS. As the fourth largest race/ethnicity group among Medi-Cal beneficiaries statewide, there were more than 1.28 million APIs with a penetration rate of only 2.26 percent in CY 2019 (Table PM-4). In other words, despite constituting 10 percent of total Medi-Cal beneficiaries, they accounted for only 5 percent of the beneficiaries who received SMHS.

A 3-year trend of API penetration rate by MHP region (Figure PM-12) shows that this metric has mostly stagnated, or even gone down as seen in Central and Southern regions. Southern region with several large MHPs excluding Los Angeles, had the lowest API penetration rate of 1.69 percent in CY 2019, a 9 percent drop from its CY 2017 penetration rate. The decline in API penetration rate in these two regions stands in contrast to the slight increase in their overall penetration rates during the same period (Figure PM-4), and merits further examination or focused study on this phenomenon for identification of the underlying factors and potential remedies.

Figure PM-12: Asian/Pacific Islander Penetration rates by MHP region, CY 2017-19

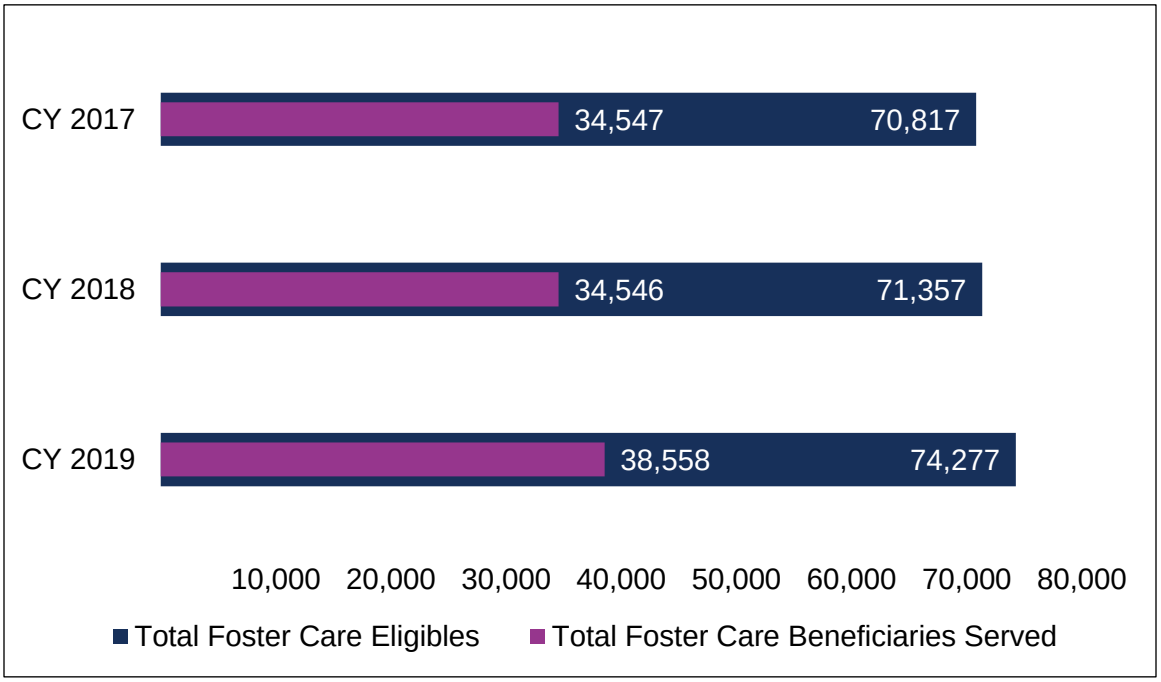


	Superior	Southern	Los Angeles	Central	Bay Area
CY 2017	2.92%	1.86%	2.46%	2.11%	2.52%
CY 2018	3.00%	1.73%	2.49%	2.09%	2.49%
CY 2019	2.99%	1.69%	2.55%	2.06%	2.53%

Foster Care

Unlike the downward trend in the overall Medi-Cal beneficiary count (Figure PM-3), the FC beneficiary count increased by nearly 5 percent between CY 2017 to CY 2019 from 70,817 to 74,277 (Figure PM-13). During the same period, the number of FC beneficiaries who received SMHS increased by 11.6 percent.

Figure PM-13: Foster Care Eligibles and Beneficiaries Served Statewide, Three-Year Trend



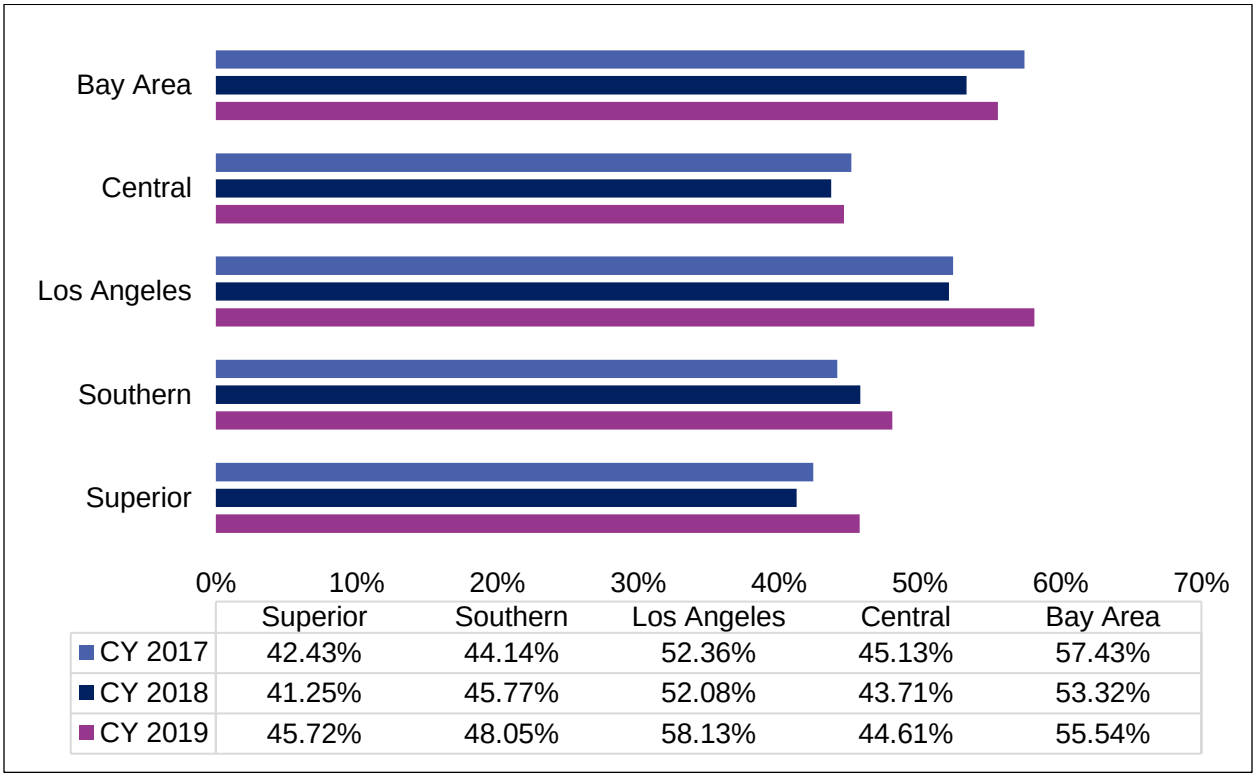
However, these increases were not uniform across the regions. These increases in FC beneficiaries and those receiving SMHS were largely driven by the Southern region and Los Angeles, which alone accounted for almost three-quarters of the total increases (Table PM-7). The Bay Area region showed large decreases in both FC beneficiaries and those receiving SMHS, 5.6 percent and 8.6 percent respectively, between CY 2017 and CY 2019.

Table PM-7: Foster Care Eligibles and Beneficiaries Served by MHP Region, CY 2017-19

Region / CY	Monthly Average of Foster Care Eligibles	Total Foster Care Beneficiaries Served
Bay Area		
CY 2017	8,693	4,992
CY 2018	8,481	4,522
CY 2019	8,210	4,560
Central		
CY 2017	13,160	5,939
CY 2018	13,137	5,742
CY 2019	13,330	5,946
Los Angeles		
CY 2017	24,102	12,620
CY 2018	24,829	12,931
CY 2019	26,906	15,641
Southern		
CY 2017	21,662	9,562
CY 2018	21,593	9,883
CY 2019	22,484	10,803
Superior		
CY 2017	3,203	1,359
CY 2018	3,319	1,369
CY 2019	3,349	1,531

Due to those declines in the FC beneficiaries served, the Bay Area also fell to second position in penetration rate while Los Angeles with more than 6 percentage point increase became the region with the highest FC penetration rate (Figure PM-14). Southern and Superior region also showed increases in their FC penetration rates, while the Central region was the other region beside the Bay Area that experienced a decline in the FC penetration rate. However, unlike the Bay Area, the Central region's decline was driven by an increase in the number of FC eligible beneficiaries, not due to a drop in the number of beneficiaries who received SMHS (Table PM-7).

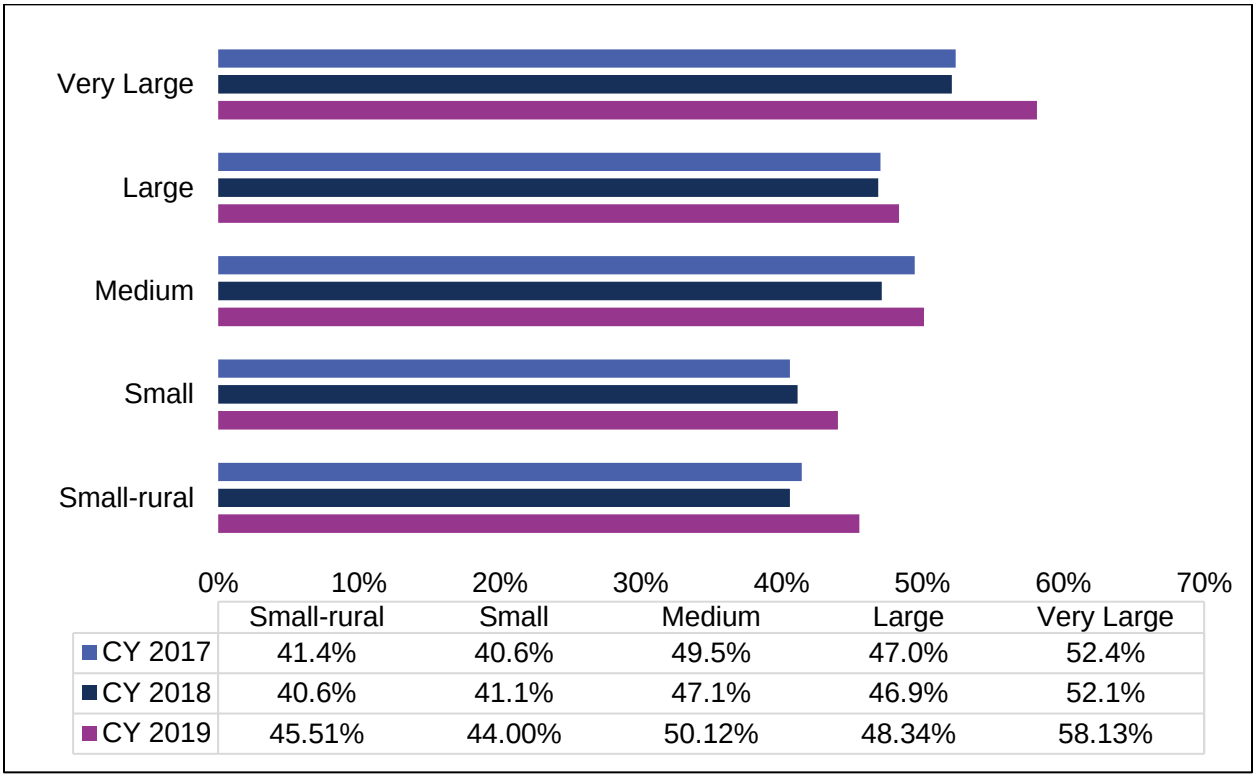
Figure PM-14: Foster Care Penetration Rates by MHP Region, CY 2017-19



	Superior	Southern	Los Angeles	Central	Bay Area
CY 2017	42.43%	44.14%	52.36%	45.13%	57.43%
CY 2018	41.25%	45.77%	52.08%	43.71%	53.32%
CY 2019	45.72%	48.05%	58.13%	44.61%	55.54%

In contrast to the analysis by MHP region, the average penetration rate for all MHP sizes increased between CY 2017 and CY 2019 (PM-15), albeit in varying degrees. Los Angeles, the only very large MHP, still stood out for its large increase in FC penetration rate, followed by the small-rural MHPs which showed a 5-percentage point increase. Medium size MHPs continued to have the second highest penetration rate followed by large size MHPs for all three years. Unlike the overall statewide penetration rate which increased primarily because of a decrease in Medi-Cal beneficiaries, the FC penetration rate increase was driven by an increase in the beneficiaries served that outpaced the growth in FC beneficiaries.

Figure PM-15: Foster Care Penetration Rate by MHP Size, CY 2017-19



	Small-rural	Small	Medium	Large	Very Large
CY 2017	41.4%	40.6%	49.5%	47.0%	52.4%
CY 2018	40.6%	41.1%	47.1%	46.9%	52.1%
CY 2019	45.51%	44.00%	50.12%	48.34%	58.13%

CalEQRO tracks the utilization of TBS by the EPSDT beneficiaries on a statewide basis only. As a result of the Settlement Agreement in the Emily Q. v. Bontá class action lawsuit, the former Department of Mental Health, and DHCS, with local county Mental Health Plan (MHP) agencies worked to increase utilization of Therapeutic Behavioral Services (TBS) and ensured accessible, effective, and sustained TBS for children and their families in the Emily Q. class in California (https://www.dhcs.ca.gov/services/MH/Pages/Court_Documentation.aspx).

As part of the settlement of this lawsuit, the state had agreed to maintain a 4 percent or higher TBS penetration rate for those EPSDT beneficiaries that meet the criteria of the class. CalEQRO has no current mechanism to determine the number of eligibles and continues to use the same denominator from six years ago. This is represented by the row in Table PM-8 that shows yes as the row header. Based on this, the TBS penetration rate in CY 2019 remained higher than 4 percent. It should be noted that many MHPs around the state also provide TBS to Pathways to Well-Being (PWB) eligible EPSDT beneficiaries, especially in situations they are not able to provide TFC.

Table PM-8: EPSDT Beneficiaries Receiving TBS, CY 2019

	EPSDT Eligibles Count	Beneficiaries Receiving TBS	TBS Penetration Rate
Statewide	265,401	12,124	4.57%
No	31,018	1,145	3.69%
Yes	234,383	10,979	4.68%

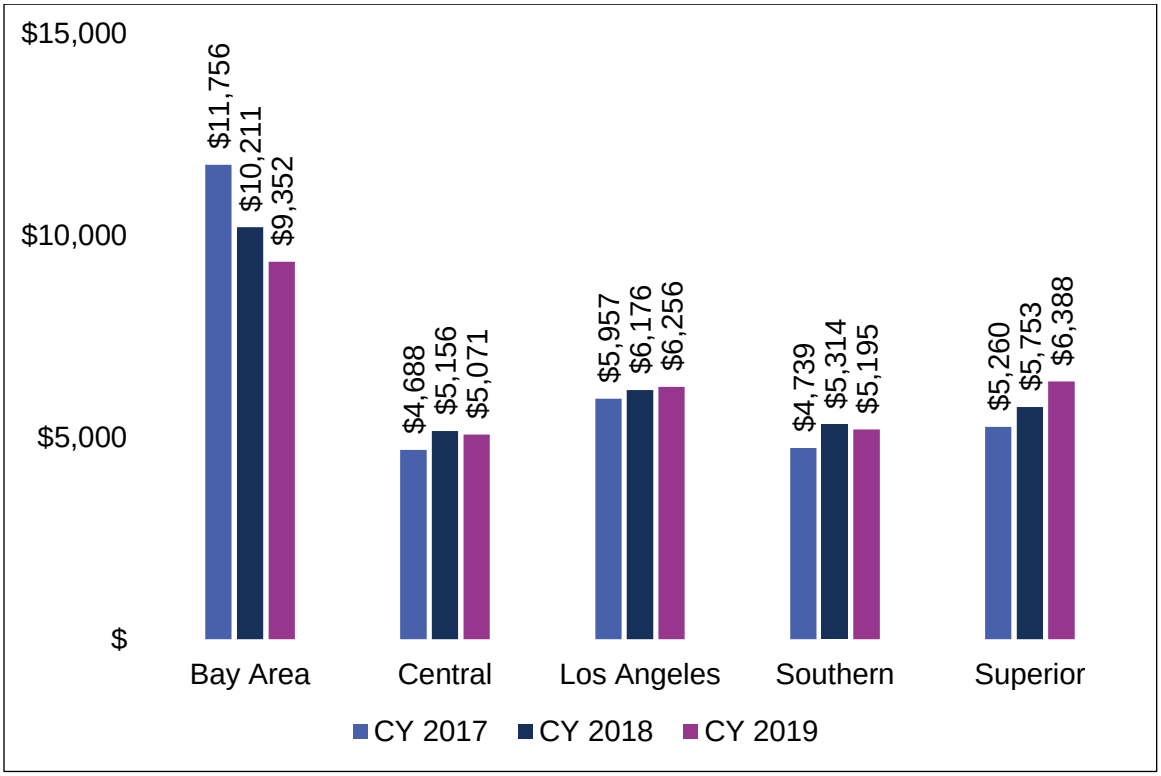
Quality

Approved Claims per Beneficiary

Approved claims per beneficiary (ACB) serve as a proxy for the scope and intensity of SMHS beneficiaries receive from the MHPs, and thus also as a proxy for the quality of care received. It should be recognized that in a large and diverse state like California, ACB may depend on contextual and historical factors of individual MHPs, MHP regions, and MHP sizes. Such factors may include the type and mix of county and contract providers, general cost-of-living, service types utilized, distribution of Medi-Cal eligible population by age group, race/ethnicity, and other demographic characteristics, as well as individual MHP's ability to set their reimbursement rates. Despite such variation, ACB can illustrate patterns and distributions that are essential to quality improvement efforts at a statewide level.

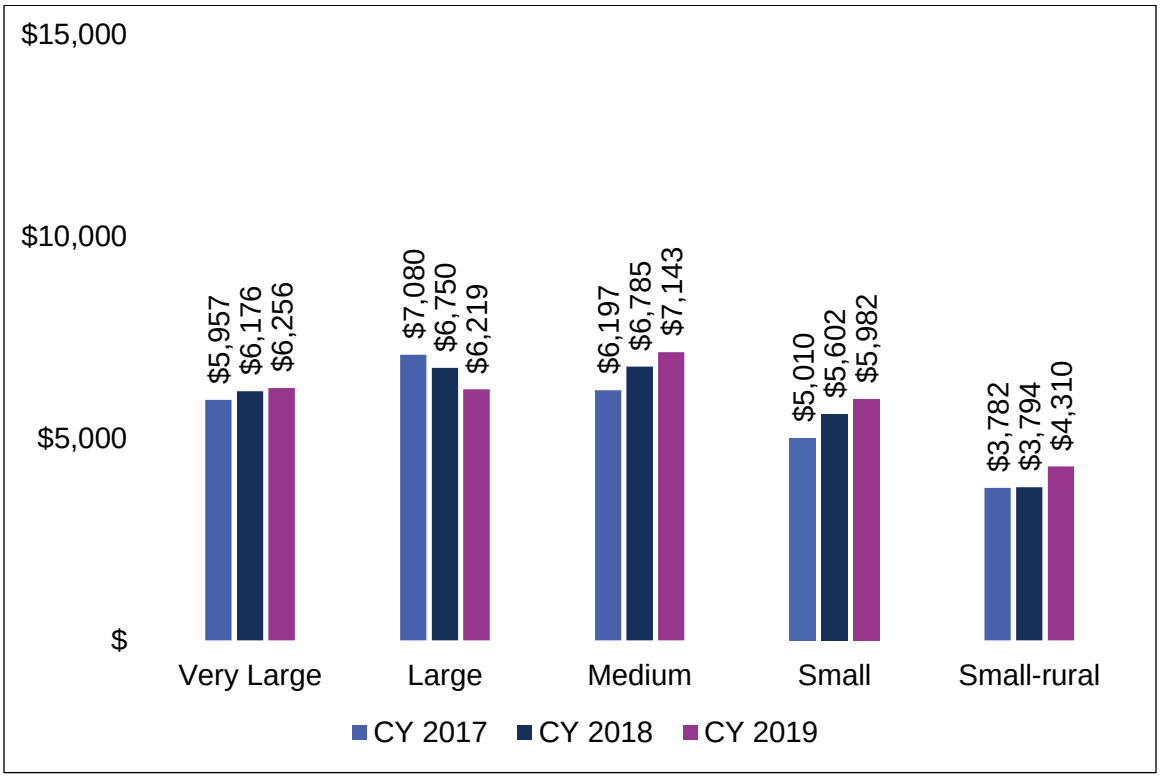
The Bay Area continues to have the highest ACB among all regions (Figure PM-16). However, it is also the only region showing a consistent declining trend for three years from CY 2017 to CY 2019. Despite the decline, and the modest increases in ACB in the next highest regions of Los Angeles and Superior, the Bay Area's ACB was still nearly 50 percent higher than those regions. In addition to being the regions with the lowest ACBs, the Southern and Central regions both showed a slight decline in ACB from CY2018 to CY2019.

Figure PM-16: Approved Claims per Beneficiary Served by MHP Region, CY 2017-19



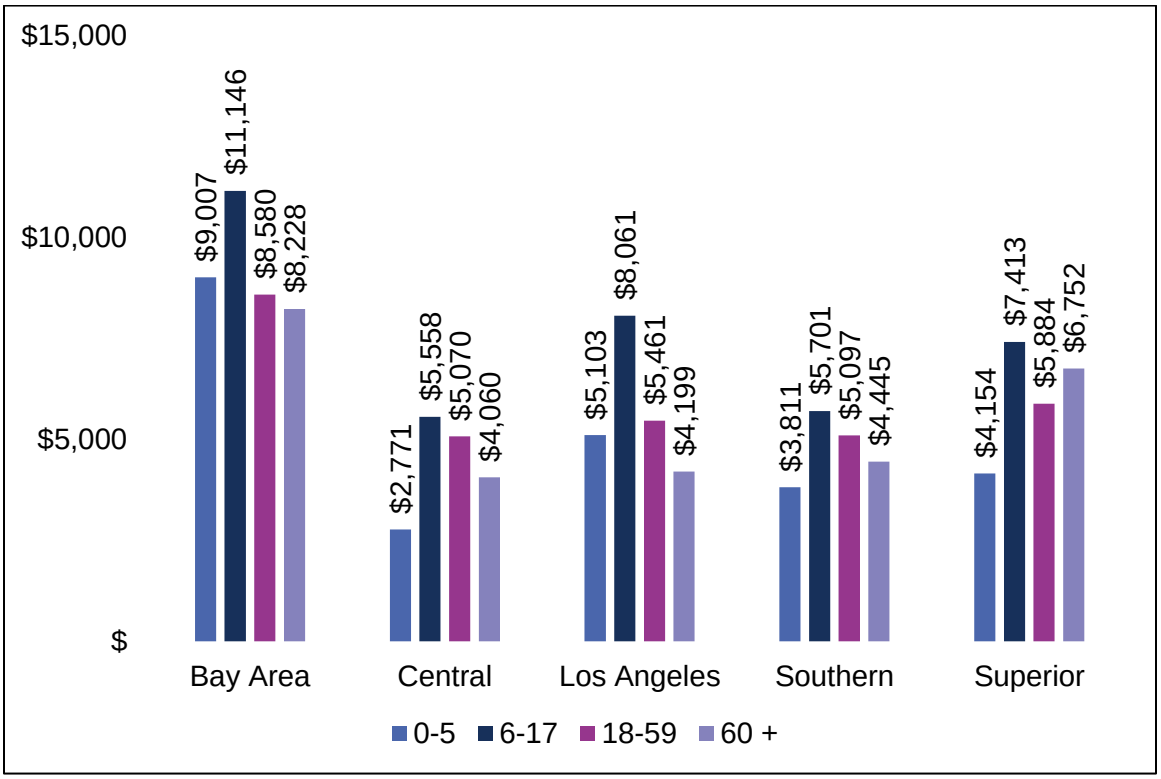
By MHP size, the small-rural MHPs' ACB continues to be the lowest of all MHP sizes despite a 13.6 percent increase from CY 2018 to CY 2019 (Figure PM-17). All MHP sizes' average ACB show an increasing 3-year trend from CY 2017 to CY 2019, except for the large MHPs. The large MHP average ACB declined from the highest in the state for three years in a row, surpassed by the medium MHPs.

Figure PM-17: Approved Claims per Beneficiary Served by MHP Size, CY 2017-19



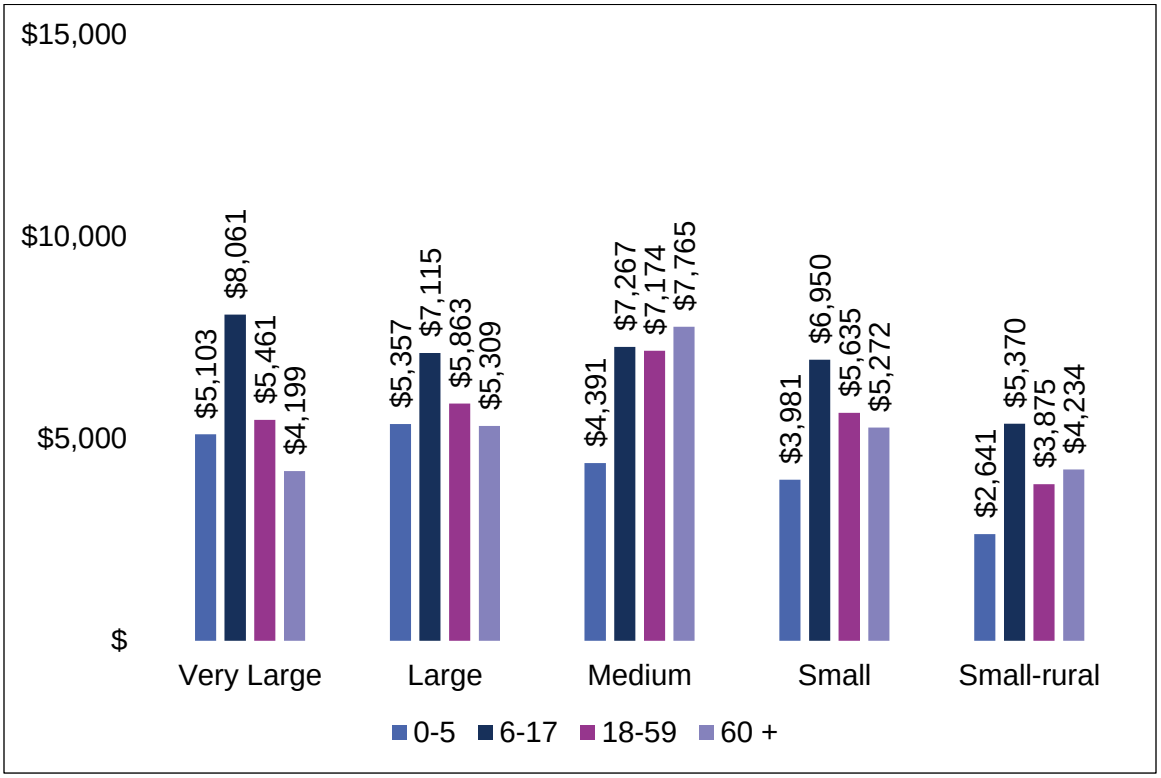
Beneficiaries in the 6-17 age group had the highest ACB across all regions in CY 2019; however, it was most prominent in the Bay Area and Los Angeles, perhaps reflecting the complexities of care for this age group in urban settings (Figure PM-18). The Bay Area region had the highest ACB of all regions in every age group category, while the Central and Southern regions had significantly higher ACBs for all age groups compared to the other regions; this was consistent with the overall ACB pattern seen in Figure PM-16. The Superior region had the second highest ACB for the older than 60 age group and was the only region where the ACB for that age group exceeded the average for the adult 18-59 age group. The Central region had significantly lower ACB for the 0-5 age group than all other regions.

Figure PM-18: Approved Claims per Beneficiary Served by MHP Region and Age Group, CY 2019



Beneficiaries in the 6-17 age group had the highest ACB across all MHP sizes in CY 2019, except for medium-sized MHPs, where the 18-59 age group had the highest ACB (Figure PM-19). Medium size MHPs had the highest ACB for the adult 18-59 age group as well. The small-rural MHPs had the lowest ACBs for most age groups except for the older adult (60 and above) group. For the latter group, very large or Los Angeles had the lowest ACB of all MHP size groups.

Figure PM-19: Approved Claims per Beneficiary Served by MHP Size and Age Group, CY 2019



ACA Approved Claims

The ACA ACB for most regions were lower than their corresponding overall ACBs (Table PM-9 and Figure PM-23). Only the Southern region had a higher ACA ACB than its corresponding overall ACB. The Bay Area and Los Angeles regions had the most significantly lower ACA ACB than their corresponding overall ACBs. The generally lower ACA ACB than overall may indicate that the ACA beneficiaries who receive SMHS require fewer intensive services.

Table PM-9: ACA Approved Claims by MHP Region, CY 2019

Region	Approved Claims	Approved Claims per Beneficiary Served	Penetration Rate
Statewide	$824,153,538	$5,154	4.30%
Bay Area	$188,052,924	$7,119	4.45%
Central	$98,075,790	$4,544	3.67%
Los Angeles	$281,938,135	$4,784	4.25%
Southern	$226,025,179	$4,879	3.81%
Superior	$28,814,532	$4,613	5.45%

High-Cost Beneficiaries

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

CalEQRO defines HCBs as those with ACBs of $30K in a year. However, as Table PM-10 shows, the average ACB per HCB has been consistently over $50K between CY 2017 and CY 2019, meaning a large number of HCBs had much higher ACBs than the $30K threshold. After a spike in CY 2018 in HCB count, HCB percentage, and HCB ACB, all three came down in CY 2019. Although neither the HCB count nor the HCB percentage by count went below the CY 2017 levels, the HCB ACB went down lower than the CY 2017 level by 5 percent.

HCB percentage of total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries. Although in each of the three years between CY 2017 and CY 2019 the percentage of HCB beneficiaries was below 4 percent, they accounted for well over a quarter of the percentage of total claims, including a spike to a third of the total claims in CY 2018.

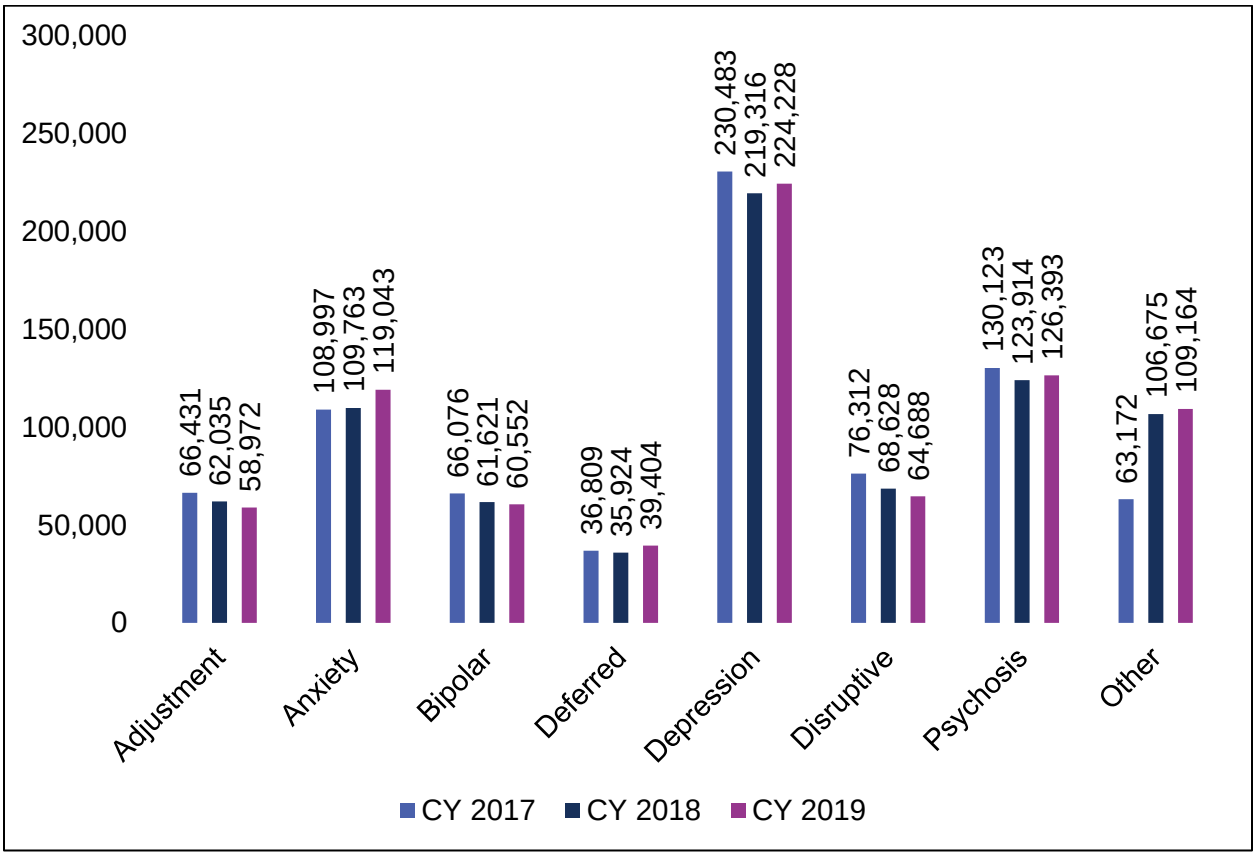
Table PM-10: High-Cost Beneficiaries, CY 2017-19

Year	HCB Count	Total Beneficiary Count	HCB Percent by Count	Average Approved Claims per HCB	HCB Percentage of Total Claims
CY 2017	19,962	626,334	3.19%	$54,777	29.61%
CY 2018	23,164	618,977	3.74%	$57,725	33.47%
CY 2019	21,904	627,928	3.49%	$51,883	28.65%

Diagnoses

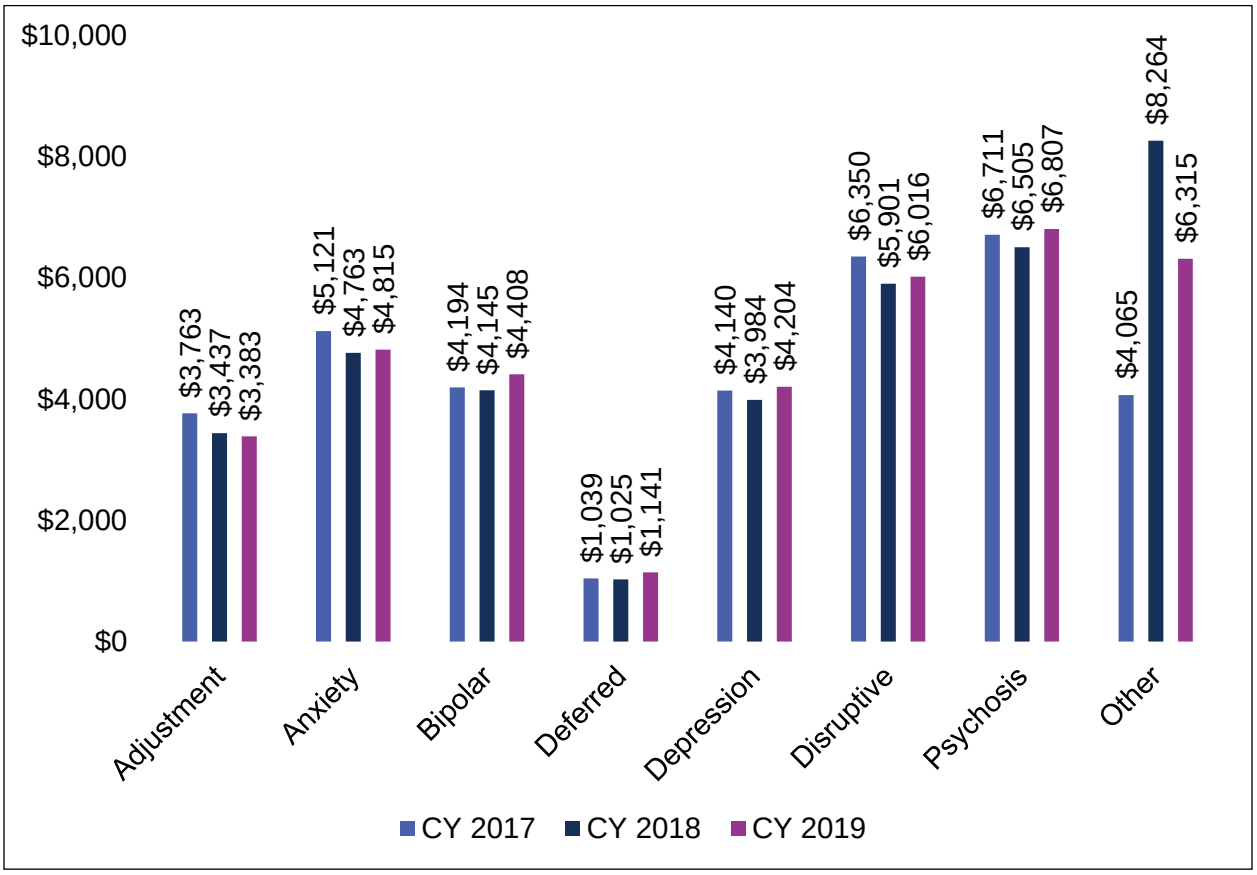
Accurate diagnosis is key to formulating appropriate treatment plans and providing quality care. For most diagnostic categories, there are only small variations in the statewide count of beneficiaries from year to year (Figure PM-20). The exception to this is the "other" category which showed a nearly 70 percent jump in count of beneficiaries from CY 2017 to CY 2018 and then remained at that level in CY 2019. Depressive disorders are the most common diagnostic category accounting for more than a third of Medi-Cal beneficiaries who received SMHS. This is followed by psychosis and anxiety disorders, respectively.

Figure PM-20: Statewide Distribution of Beneficiaries Served by Diagnoses, CY 2017-19



The most important finding here is how the ACB by diagnostic categories vary from the count of beneficiaries in each category. While the count of beneficiaries with psychosis diagnosis is 50 percent less than depression diagnosis, the ACB for beneficiaries with psychosis was 62 percent higher than that for depression diagnosis. In fact, the ACB for disruptive disorders, anxiety disorders, bipolar disorders, and other disorders were all higher than that for depression although all of these had far fewer beneficiaries than those with depression diagnosis. For the "other" disorders category, the unusual spike in ACB in CY 2018 came down significantly but still remained more than 50 percent higher in CY 2019 than the corresponding figure for CY 2017.

Figure PM-21: Approved Claims per Beneficiary Served Statewide, by Diagnoses, CY 2017-19

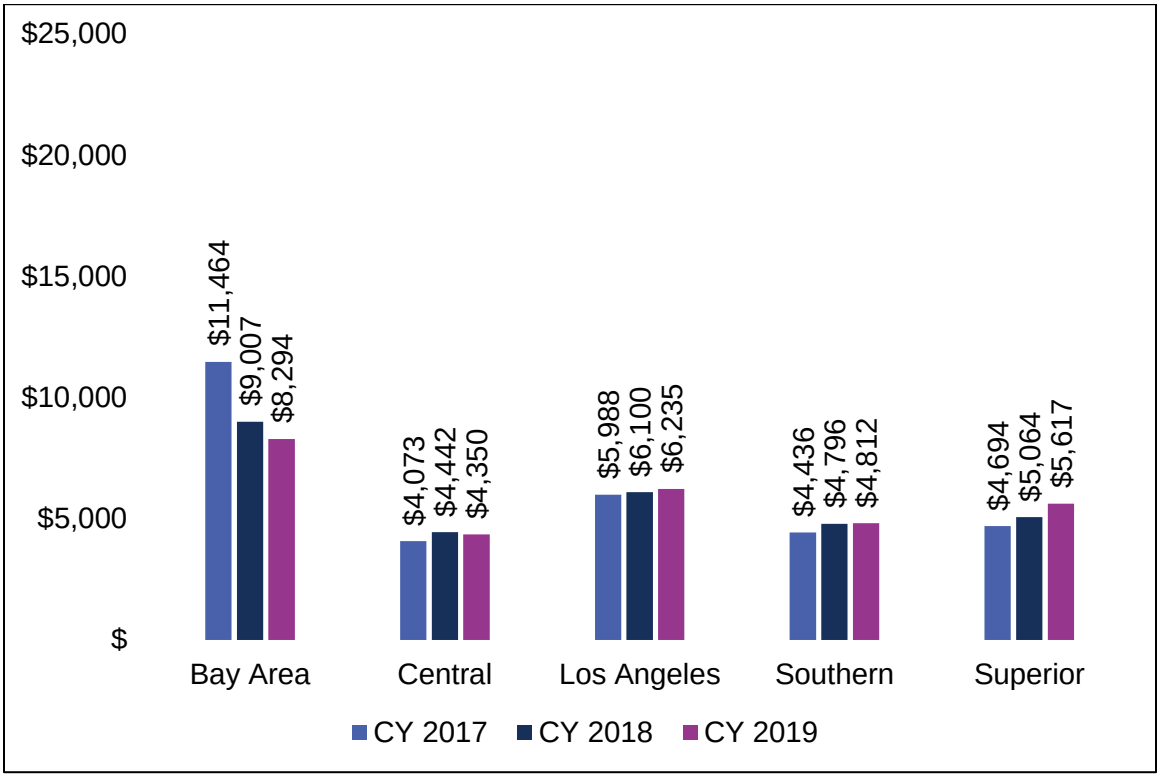


Quality of Care for Groups with Historical Disparities

The pattern of Latino/Hispanic ACB distribution by MHP region (Figure PM-22) closely resembles the corresponding chart for the overall ACB distribution by region (Figure PM-16). However, a closer look reveals that in general, the Latino/Hispanic ACBs in CY 2019 was lower by more than 10 percent for the Bay Area, Central, and Superior regions and by 7 percent compared to the overall ACBs. Only Los Angeles had virtually the same ACB both overall and for Latino/Hispanic beneficiaries.

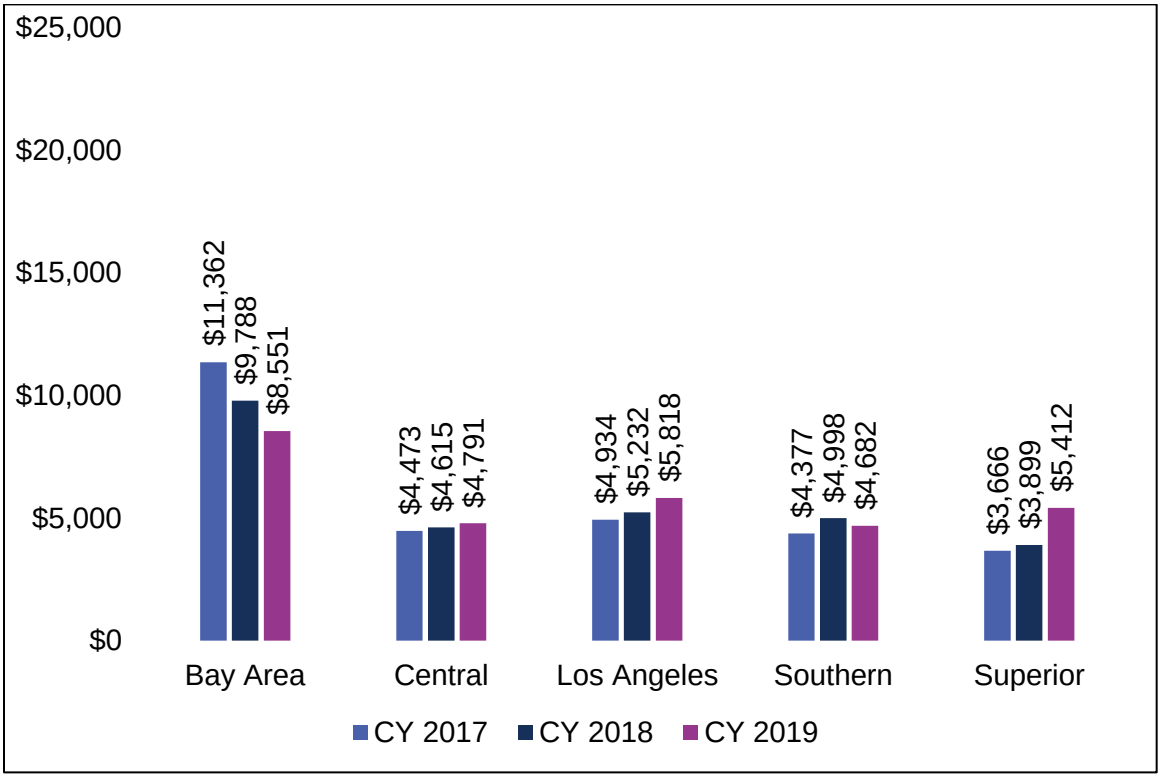
The Bay Area experienced significant drops in the Latino/Hispanic ACB each year between CY 2017 and CY 2019, with a total decline of 27.6 percent. This is in contrast to all other regions that either stayed mostly the same, or experienced modest increases in Latino/Hispanic ACB. However, it should be noted that despite the decline, Bay Area's Latino/Hispanic ACB was still 33 percent higher than the next highest Latino/Hispanic ACB region, Los Angeles, and 90 percent higher than the Central region, which had the lowest Latino/Hispanic ACB.

Figure PM-22: Latino/Hispanic Approved Claims per Beneficiary Served by MHP Region, CY 2017-19



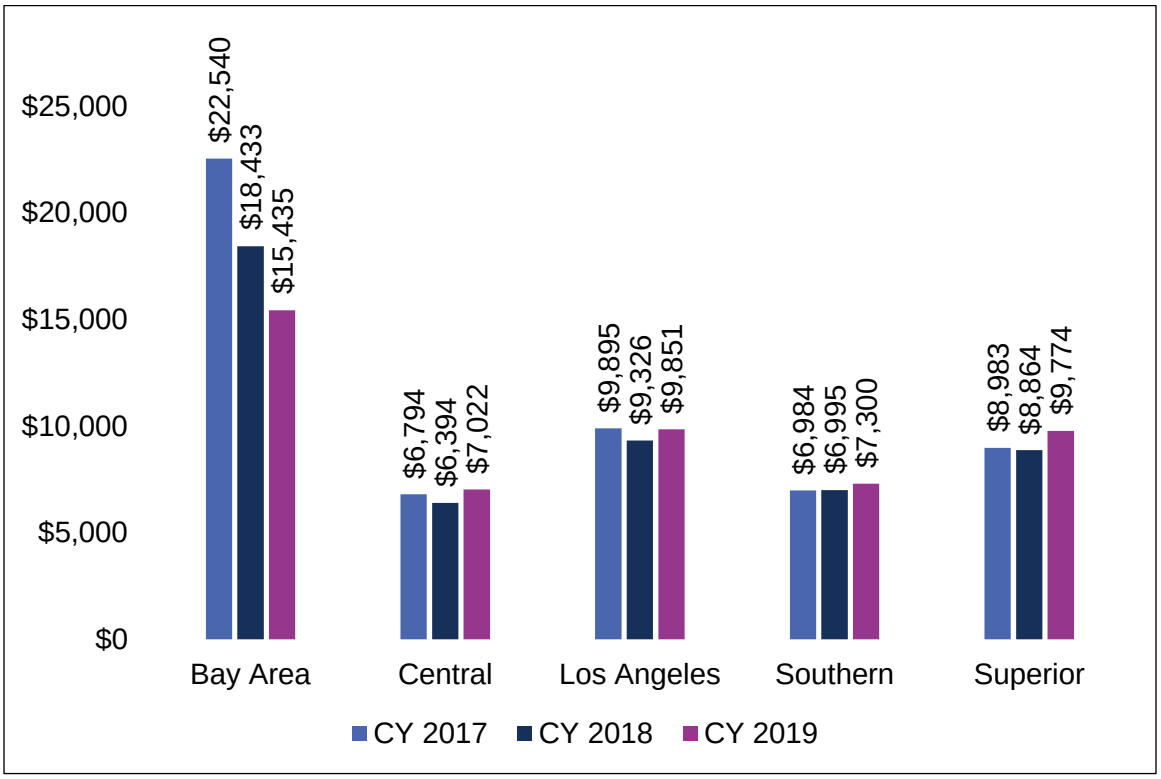
The distribution of ACB for API beneficiaries by region shows that the Bay Area's ACB decreased by 25 percent between 2017 and CY 2019 (Figures PM-23 and PM-16). During the same time, Los Angeles and the Superior regions increased by 15 and 47 percent respectively. The Central and Southern regions had little change in their API ACB during that period. Compared to the overall ACB distribution, the API ACB across all regions remained lower than the overall ACB distribution.

Figure PM-23: Asian/Pacific Islander Approved Claims per Beneficiary Served by MHP Region, CY 2017-19



The FC ACB across all regions were significantly higher than the overall ACB (Figure PM-24). This points toward more intensive services such as Intensive Care Coordination, Intensive Home-Based Services, and TBS for a certain segment of the FC beneficiaries. However, the pattern across regions remained similar to that for the overall ACB (Figure PM-16). In other words, the regions with higher overall ACB also had higher FC ACB than other regions. Bay Area FC ACB fell by 31 percent between CY 2017 and CY 2019 yet remained higher than all other regions and 36 percent higher than the next highest FC ACB (Los Angeles). The FC ACB mostly remained unchanged during CY 2017-19 in all other regions.

Figure PM-24: Foster Care Approved Claims per Beneficiary Served by MHP Region, CY 2017-19



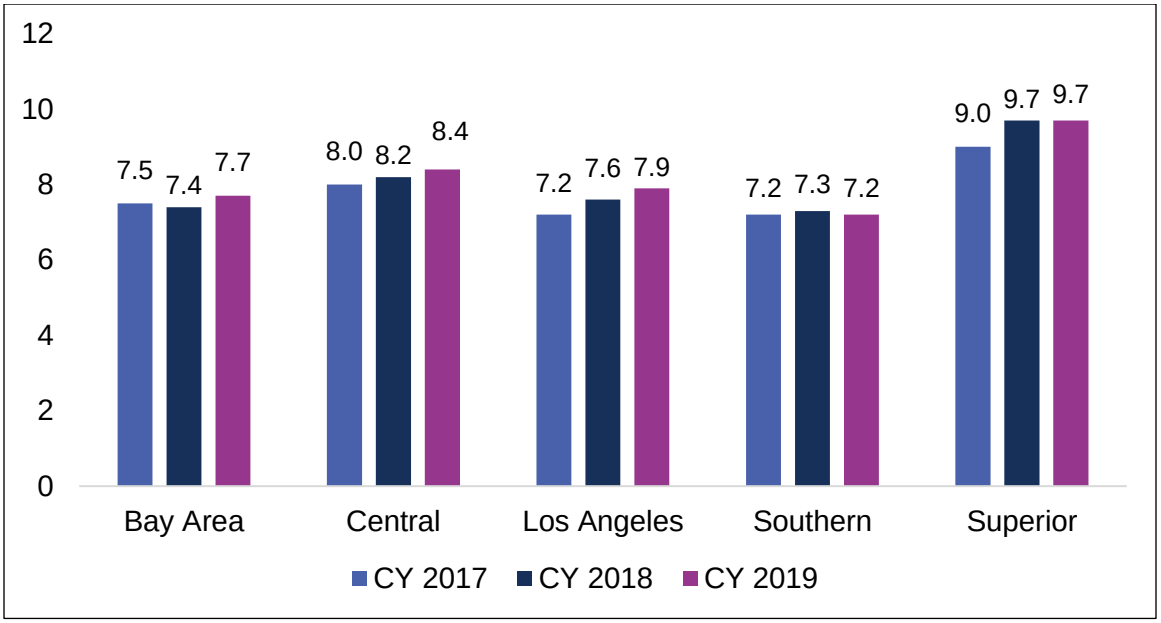
Timeliness

The inpatient LOS varies from region to region. Although the Superior region has much fewer beneficiaries who are hospitalized for psychiatric reasons, it has the highest inpatient length of stay (LOS) (Figure PM-25). The Southern region has the lowest inpatient LOS, and the other MHP regions have LOS between these two, with the Central region having the second highest LOS.

In addition, all regions except the Southern region showed increases in their average LOS in CY 2019 compared to their corresponding figures for the previous two years. The average LOS stayed mostly the same in the Southern region. The increase in LOS was the most pronounced in the Los Angeles and the Superior regions, both increasing by 0.7 percentage point.

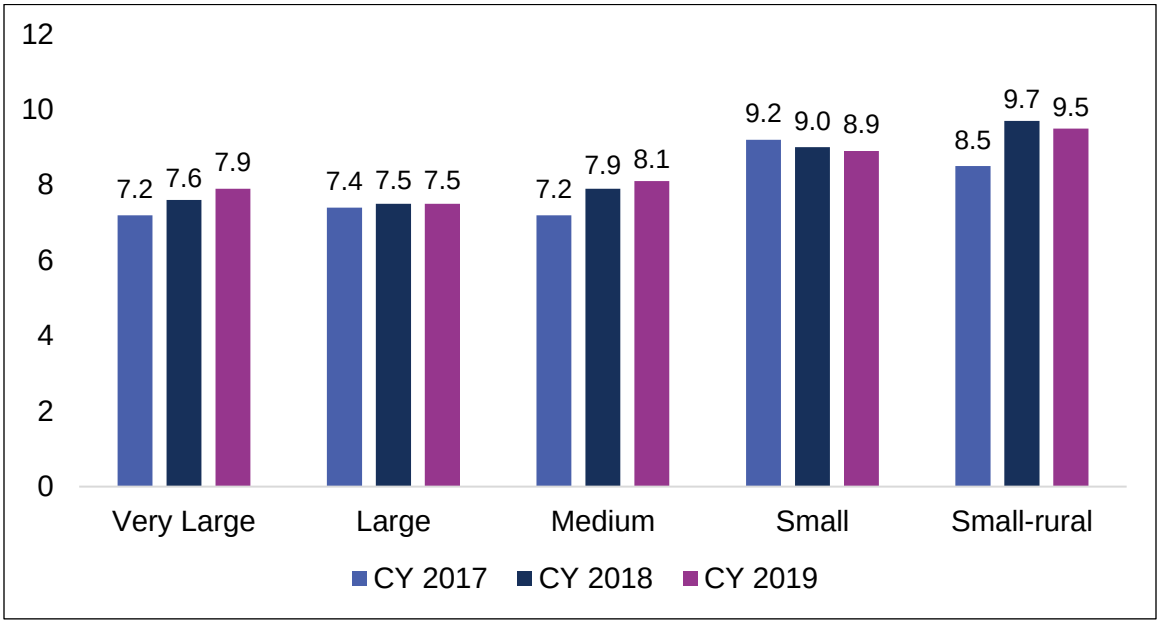
The longer LOS for the Superior region MHPs may be associated with their relatively low hospitalization rate. Most Superior region MHPs do not have psychiatric inpatient units in their own counties, and the beneficiaries need to be transported long distances for hospitalization. Consequently, most Superior region MHPs utilize local crisis intervention or crisis residential modalities of services to keep their beneficiaries from getting hospitalized. In other words, those who get hospitalized from the Superior region require longer hospital stays, which in turn, pushes up the average LOS. However, this does not explain the relatively sharp increases in average LOS for the Superior or Los Angeles region between CY 2017 and CY 2019.

Figure PM-25: Average Inpatient Length of Stay by MHP Region, CY 2017-19



By MHP size, the small-rural size MHPs have the highest average inpatient LOS, followed by the small and medium-sized MHPs (Figure PM-26). Large and very large MHPs have the shortest LOS. The three-year trend between CY 2017 and CY 2019 shows that along with the very large, which is Los Angeles, the medium and small-rural sized MHPs' average LOS increased significantly, 0.9 and 1 percentage points respectively. Large MHP average stayed the same, while the small MHP average declined slightly. Small-rural and small MHPs' average LOS were the two highest, which perhaps reflects a strong overlap between the small-rural and small MHPs and those in the Superior region.

Figure PM-26: Average Inpatient Length of Stay by MHP Size, CY 2017-19



Both the 7- and 30-day outpatient follow-up rates after inpatient discharges have been going up statewide between CY 2017 and CY 2019. The 7-day follow-up rate increased almost by 22.6 percent, while the 30-day follow-up rate went up by 17.8 percent during the same period (Figure PM-27). However, the outpatient follow-up rate seems to have little or no impact on the 7- and 30-day rehospitalization rates (Figures PM-27 and PM-28).

Figure PM-27: Follow-up Rates post Hospital Discharge Statewide, CY 2017-19

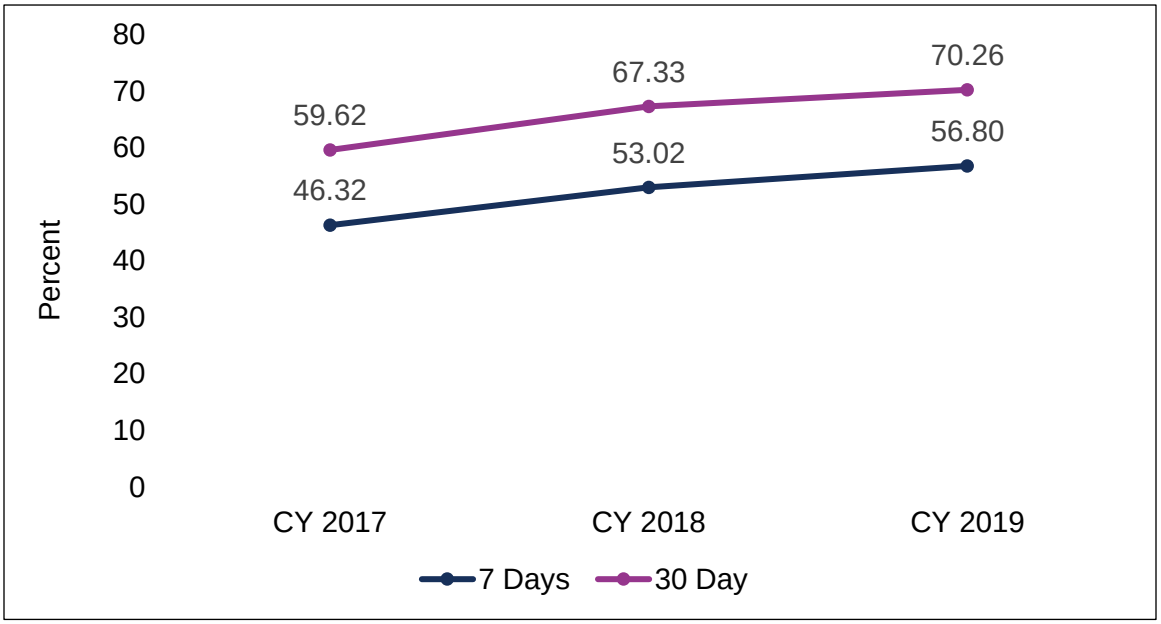
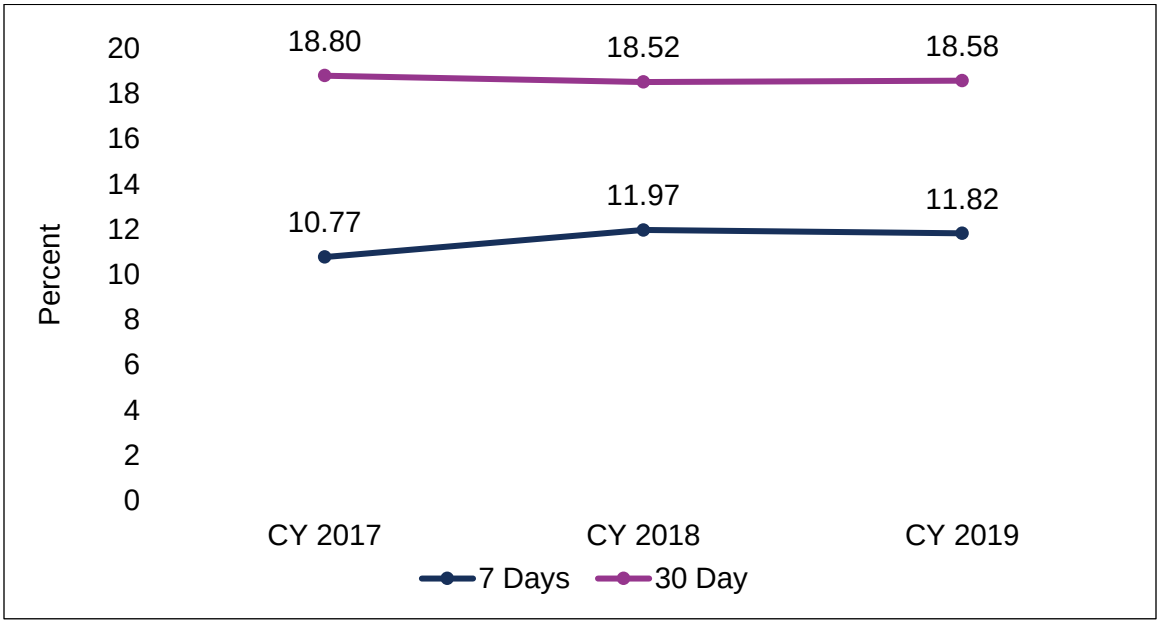


Figure PM-28: Rehospitalization Rates Statewide, CY 2017-19*



* Beginning with CY 2019 data, CalEQRO changed its methodology to fully align with the corresponding HEDIS measure. This was retroactively done for CY 2017 and CY 2019 as well. Therefore, those figures will not match the corresponding ones in the FY 2019-20 statewide annual report.

Conclusion

California continued to experience a decline in the total number of Medi-Cal eligibles in CY 2019. In the three-year period between CY 2017 and CY 2019, California lost more than half-a-million or 4.5 percent of Medi-Cal beneficiaries. Although this has not resulted in much reduction in the number of beneficiaries who received SMHS, it is not clear of those who lost Medi-Cal eligibility, how many needed SMHS at a lower level of care but did not receive it due to the loss in eligibility.

Asian/Pacific Islander beneficiaries continued to have the lowest penetration rates of all race/ethnicity groups, followed by Latino/Hispanic beneficiaries. The latter has been experiencing a gradually improving penetration rate, but still significantly lags behind other groups except the Asian/Pacific Islanders.

FC beneficiaries fared better in terms of access largely due to greater numbers served by the largest MHP, Los Angeles. Since Los Angeles accounts for roughly a third of Medi-Cal beneficiaries served, the significant increase in FC access there pushed up the overall FC penetration rate statewide. This made up for the significant decrease in FC beneficiaries served by the Bay Area region.

Despite significant drops in the ACB between CY 2017 and CY 2019, the Bay Area region continues to have a significantly higher ACB than other regions which registered increases during the same period. Bay Area's high ACB is partly explained by its significantly higher ACB for the 6–17-year-old beneficiaries. Statewide, the number of HCB beneficiaries increased, but the HCB percentage of total approved claims declined from CY 2018.

Depressive disorders account for the largest percentage Medi-Cal beneficiaries, almost a third, who received SMHS. However, psychosis, disruptive disorders, and other disorders show the highest ACBs.

Both the 7- and 30-day outpatient follow-up rates after inpatient discharges continued to increase with both rates registering more than 10 percentage point increase in the three-year period between CY 2017 and CY 2019. This is an area where many MHPs have undertaken PIPs during this period. However, the higher follow-up rate is not directly correlated with the 30-day rehospitalization rate as the latter has remained the same. To ascertain the real impact of increasing follow-up rates on reducing rehospitalization rates, the MHPs will need to do further longitudinal analysis on individual beneficiaries.