California's Specialty Mental Health System: Oversight Status and Challenges

Advanced Policy Analysis

A study conducted for the California Senate Office of Research by Peri Weisberg

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Executive Summary

Purpose of this report

California's Specialty Mental Health System delivers certain mental health services to low-income and vulnerable Californians through county-level agencies. The most recent attempts to renew federal authorization of this system highlight the importance of the state's oversight role. The state legislature needs to better understand the oversight system and the critical issues facing service delivery for individuals with severe mental disabilities and behavioral disorders. To address that need, this report endeavors to:

1. Describe the current oversight system, including its regulatory environment.
2. Identify and describe challenges revealed by key oversight processes.
3. Assess the state's ongoing efforts to address these challenges.

Immediate concerns are often linked to broader challenges.

Federally-identified priority areas present **immediate concerns:**

- 24/7 access lines that do not consistently deliver critical consumer information
- Ineffective tracking systems to assess timely access to services
- Poor responsiveness to requests to authorize provision of certain services
- Insufficient monitoring and evaluation of beneficiary grievances and appeals
- Failure to ensure up-to-date provider certification
- Failure to document service provision in compliance with state and federal standards
- No exercise of state authority to sanction or penalize local agencies

And an analysis of additional data reveals that these overlap with **broad challenges:**

- Racial and ethnic disparities in access and consumer experience
- Inadequate statewide standards for timeliness and performance
- Lack of clarity regarding policies of sanctions and penalties

Oversight activities can do better to address both broad challenges and immediate concerns

Enhanced oversight should involve:

- High expectations and clear guidance for ensuring equitable and timely access
- Comprehensive statewide performance standards
- A system of corrective actions that includes sanctions and penalties

Oversight can ensure areas of immediate concern are resolved while addressing the pervasive barriers to providing Specialty Mental Health services that are accessible, accountable, and high-quality. Ensuring progress in the Specialty Mental Health System that effectively addresses current and future challenges will require diligent oversight, long-term commitment, and concerted efforts on the part of state and local stakeholders.

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I. About this report

Oversight challenges for California's Specialty Mental Health system

In California, 56 county-based Mental Health Plans (MHPs) administer mental health services to low-income and vulnerable Californians. This report examines activities by the Department of Health Care Services (DHCS) to monitor and support the Specialty Mental Health system.

The system faces a complex regulatory environment. DHCS, the federal Centers for Medicare & Medicaid Services (CMS), and the state legislature all have important but poorly-aligned roles, and critical information often does not get into the right hands.

The system depends on regular approval by CMS, which has recently communicated concerns about safeguards, integrity, and accessibility. The state is responsible for demonstrating that these concerns are addressed.

Goals of this report

The goals of this report are to:

1. Describe the current oversight system, including its regulatory environment.
2. Identify and describe challenges revealed by key oversight processes.
3. Assess the state's ongoing efforts to address these challenges.

The DHCS, CMS, and MHPs all agree that certain issues need to be addressed immediately on a system-wide basis. Among these are timeliness tracking, and 24/7 phone lines that are accessible to speakers of all languages, and appropriate documentation of services for federal reimbursement. In the following pages, I document what the oversight process can tell us about the nature of these issues and how the system is responding to them.

I also summarize results from annual monitoring processes to assess certain long-term issues; for instance, persistent ethnic disparities in access. Data from and pertaining to the oversight process should direct the state's focus toward broader challenges in addition to the immediate needs, which are often related. Ensuring progress on these broader challenges will require diligent oversight, long-term commitment, and concerted efforts on the part of state and local stakeholders.

Research methods

I reviewed reports, collected information about oversight activities, and interviewed practitioners and stakeholders to determine whether the current oversight and corresponding corrective actions are appropriate.

Much of this report is driven by information in federal and state documents governing the Specialty Mental Health system, California's applications for federal waivers to authorize the system, and annual External Quality Reviews. External Quality Reviews, which are conducted by a contracted organization and include indicators of access, quality, timeliness, and outcomes, provide answers to some critical questions about the state of the SMHS system and are an often-overlooked source of detailed information.

Also critical to this research were meetings by phone and in person with practitioners and advocates, including staff from DHCS and three MHPs.

II. Mental Health in California

In California, almost one adult in six has mental health care needs. Serious mental illnesses or emotional disturbances, which place significant limitations on critical life activities, affect around one million California adults and over 700,000 of children. [i]

Some groups are disproportionately affected by mental illness. Often, these groups are already among the most vulnerable. In general, low-income individuals, women, American Indians, and adults between the ages of 25 and 50 are most likely to be affected.

Public funds pay for a majority of mental health care, and state spending on mental health services of various kinds (both Medi-Cal and non-Medi-Cal) amounts to an annual public investment of around eight billion dollars. [ii] Nearly half of those funds go toward services to Medi-Cal beneficiaries, among whom serious mental illness is more common. The federal Substance Abuse and Mental Health Services Administration estimates that 8.0 percent of adult Medi-Cal beneficiaries in California experience serious mental illness. [1]

The Specialty Mental Health system provides services for these conditions among Medi-Cal beneficiaries. This year, DHCS expects around 230,000 adults and 290,000 children to make use of these services. Still, many of those that this system is designed to serve will not receive needed care: national estimates indicate 40 percent of adults with serious mental illness do not receive any type of mental health care. [iii]

Specialty Mental Health services

Under the Specialty Mental Health system, Medi-Cal beneficiaries with serious mental health needs find or are referred to county mental or behavioral health departments for assessment and care. These agencies are Medi-Cal Mental Health Plans (MHPs), and are governed by both state and federal regulations. Specialty Mental Health services are primarily intended for Medi-Cal beneficiaries, but reach some outside of this population as well.

The Specialty Mental Health system is carved out from the rest of the Medi-Cal system, designed specifically for serious mental disorders (in adults) or emotional disturbance (in children). It is exclusively a managed care environment.

The Specialty Mental Health system is separate from systems to treat substance use and developmental disabilities, although many of the stakeholders are the same. MHPs are required to undertake agreements with other Medi-Cal plans to ensure a continuum of care is in place, with

Sample of services provided in Specialty Mental Health

- Prevention and early intervention services
- Assessment, screening, and diagnosis
- Case management
- Employment and housing supports
- Employment and housing supports
- Counseling and psychotherapy
- Outreach and engagement
- Peer supports
- Rehabilitative services
- Medication support
- Crisis response and stabilization services
- Acute psychiatric hospital services and crisis residential services

[1] These figures reflect the Medi-Cal population prior to Medi-Cal expansion. Prevalence among the Medicaid expansion population is anticipated to be lower, about 4.4 percent, according to SAMHSA.

processes for referral and information-sharing.

The decentralized system has certain key benefits: it allows counties to tailor provision of mental health care to the specific needs of their communities, and to respond nimbly to resources and innovations at the local level. It also allows for additional funding stability.

However, it means quality and access may vary significantly within the state. The higher prevalence of serious mental illness in counties with high poverty may compound this problem, forcing a disproportionate number of adults with serious mental illness into service systems with limited resources to care for them.

Related is the problem of reporting and data analysis. MHPs align their programs with standards that vary from county to county. A metric that illuminates an important strength or weakness in one county may be meaningless in another. Only a handful of standardized metrics exist to allow for summary or comparison.

Prevalence of serious mental illness among adults in California

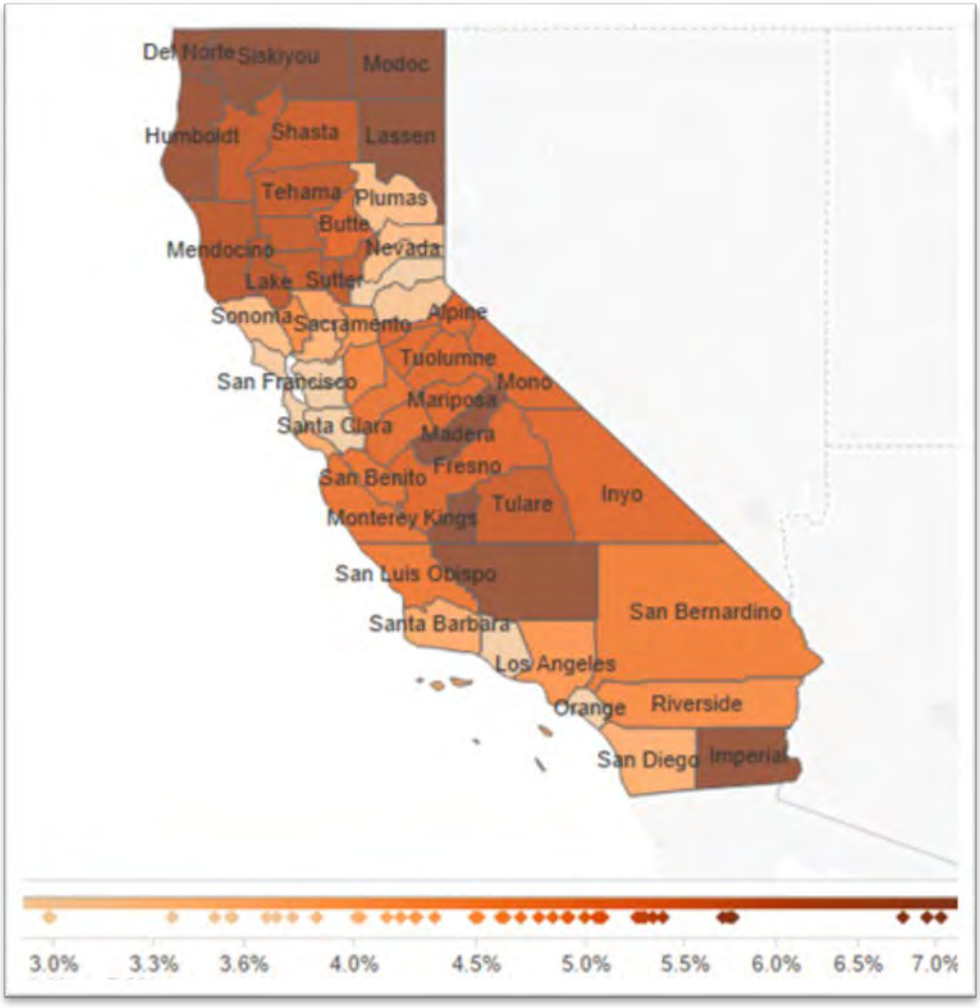


Image credit: California HealthCare Foundation.

Serious mental illness coincides with poverty

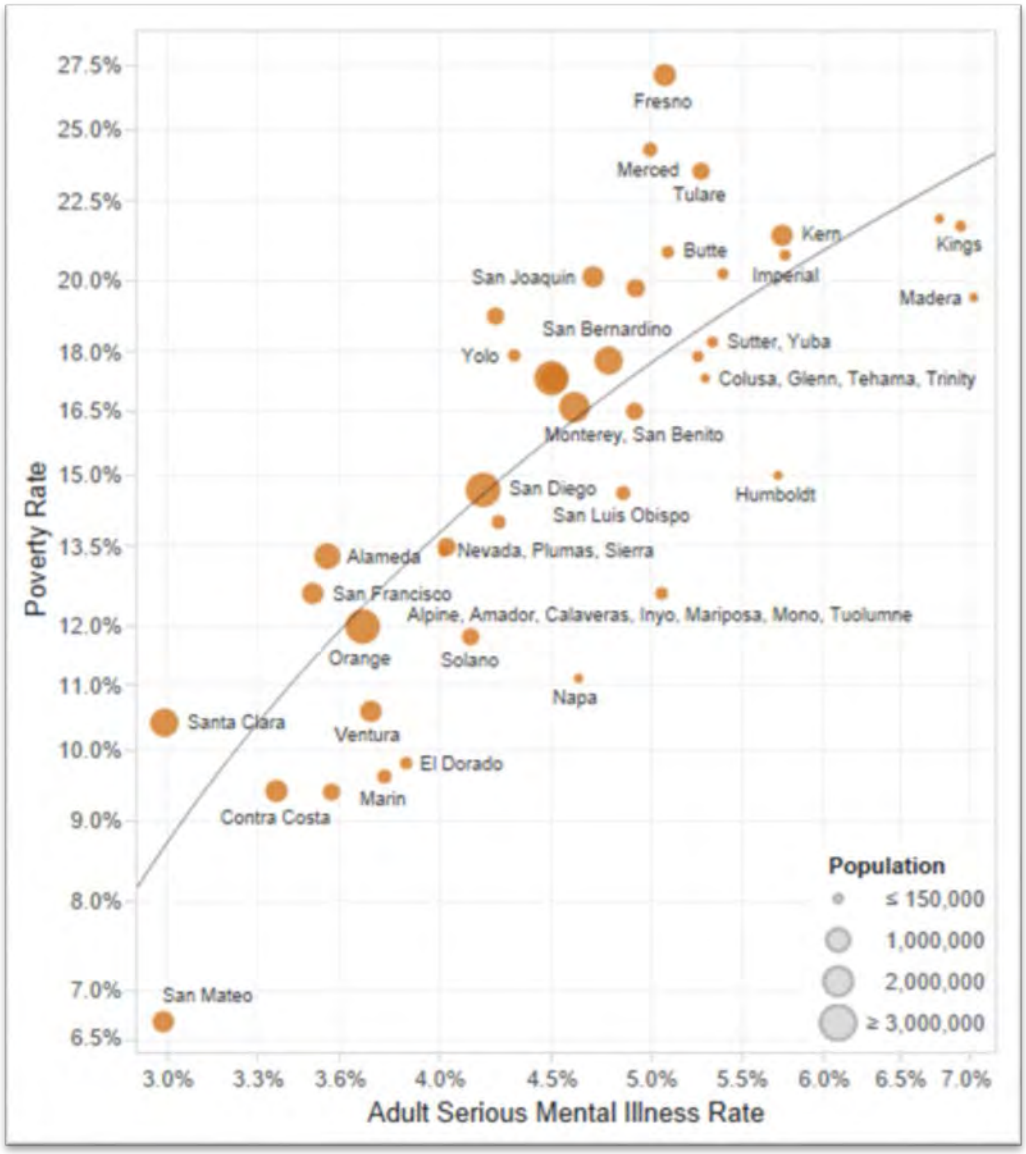


Image credit: California HealthCare Foundation.

About the MHPs

56 MHPs operate in California. In most counties the behavioral department or mental health department plays this role. In two cases, one organization serves as an MHP for two neighboring counties. And in San Mateo and Solano counties, a single managed care organization integrates provision of both mental and physical health services.

The MHP may provide services directly or refer customers to contracted providers. Service delivery can take many forms; agencies may partner with schools, jails, homeless shelters, and other community-based organizations to develop targeted or innovative delivery models.

About one-third of the cost of services is reimbursed with federal Medicaid dollars (California Behavioral Health Directors Association). State tax revenue provides much of the additional funding, in the form of

either personal income taxes collected through the 2004 Mental Health Services Act, or sales taxes allocated to counties in accordance with the 1991 and 2011 realignment policies. Counties and federal grants typically account for a relatively small amount of revenue.

Each MHP has a contract with DHCS that defines standards for services, accessibility, and timeliness, as well as procedures to ensure quality and integrity. DHCS serves as the intermediary between MHPs and the federal government, ensuring compliance with federal standards and facilitating all federal reimbursement for Medi-Cal services.

Accessing care

Customers are generally referred to the Specialty Mental Health system through one of the following means:

- Family members, guardians, conservators
- Physical health care providers
- Schools
- County welfare departments
- Law enforcement agencies
- County mental health 24/7 toll-free access line

III. Oversight in Specialty Mental Health

Although county-level agencies have administrative and fiscal responsibility, DHCS plays a significant role. DHCS must monitor provisions of the contract with each MHP, provide training and technical assistance, facilitate statewide improvement efforts, impose sanctions for violations, and process grievances.

DHCS serves as the point of contact with CMS, the federal agency that oversees Medicaid and administers reimbursement for Medicaid-funded services. The state is ultimately accountable for ensuring that services meet federal standards. It is also charged with implementing provisions of California's Welfare and Institutions Code, which establishes the Specialty Mental Health System.

This section describes the regulatory environment for Specialty Mental Health and three key oversight activities employed by DHCS.

Federal and state regulation

A. Federal waiver: Section 1915(b)

The Specialty Mental Health System requires a waiver from CMS. Included in the waiver request are a description of the program, assurances that federal regulations are met, a monitoring plan and a report on the results of monitoring, and cost-effectiveness information.

History

The state's first 1915(b) waiver was approved in 1995, authorizing consolidation of inpatient hospital services at the county level and a field test in San Mateo of a fully integrated Mental Health Plan. A renewal in 1997 marked the beginning of the program in its current form.

The waiver is subject to regular re-approval by CMS, and has since been renewed about every two years. In response to the 2013 request, CMS indicated several areas of particular concern that it has asked DHCS to address in the waiver request it submitted in March 2015. This most recent request is for a five-year authorization.

Monitoring responsibilities

In its waiver application, the state commits to certain monitoring mechanisms and statewide improvement activities. A full list of the monitoring mechanisms it describes is included in the appendix to this report. With regards to quality and access, the most significant of these are the External Quality Review process, on-site Triennial Reviews by the Department, and the technical assistance and liaison activities of the Department's County Support Unit. These are described in detail below.

The waiver request submitted in March 2015 also proposed specific responses to problems identified by CMS. The responses are described in Section IV of this report.

B. Code of Federal Regulations: 42 CFR Part 438

Federal regulations provide standards for oversight and governance of managed care environments. 42 CFR Part 438 includes requirements for enrollee rights and protections, quality assessment and performance improvement, external quality reviews, grievance systems, certifications, sanctions, and federal financial participation. In addition to ensuring that contracts between the DHCS and MHPs include provisions reflecting many of these requirements, the state has responsibility for monitoring, technical assistance, and processing appeals and grievances.

Quality assessment and performance improvement

In regards to quality assessment and performance improvement, the code requires certain mechanisms to ensure services are available and accessible, including considerations for developing provider networks and the types of standards and monitoring in place to ensure timely and culturally competent services. The state must develop a provider credentialing systems and ensure standards for enrollee protections are met, including those regarding enrollee information, confidentiality, and grievances. It must ensure that MHPs have practice guidelines, quality assessment programs, and performance improvement programs that meet basic standards and are reviewed by the state annually. And finally, it must require that MHPs' health information systems have certain basic capabilities.

External Quality Review

Another subpart mandates the External Quality Review process, including its frequency, required components, data, and methods. It sets standards for the organization that may serve as a reviewer, and specifies that the reviews must assess timeliness, access, and quality. The state is responsible for ensuring the review is carried out according to the required standards, for supplying sufficient information to complete the review, and for making the results available. Among the mandatory activities in the review process are validation of two required annual Performance Improvement Projects (PIPs) and any statewide performance measures, assessment of each MHP's strengths and weaknesses, and developing individual recommendations for improving quality of care. This section also describes conditions under which an MHP may be exempted from the external quality review.

The appendix of this report includes a more detailed description of both of these subparts.

C. California Welfare and Institutions Code: Title 9, Chapter 11

The State of California governs the Specialty Mental Health System through the Welfare and Institutions Code. This code establishes the general structure and goals of the Specialty Mental Health system. It rarely includes detail regarding standards for quality, access, and timeliness, except in the cases of special populations. In general, this responsibility is left to DHCS. DHCS is required to provide oversight that ensures quality, access, cost efficiency, and compliance.

Mechanisms to ensure quality, accessibility, and effectiveness

DHCS must have in place a quality assurance plan, including issuing standards and guidelines for quality assurance activities conducted by MHPs. DHCS is charged with ensuring that each plan has appropriate standards for quality, access, and coordination of services and that there is a mechanism for evaluation of these. The legislature requires that MHPs evaluate effectiveness, accessibility, and quality, using statewide performance outcome measures as a basis. DHCS should also ensure that each plan assesses and plans to meet cultural competency needs with data and technical assistance from the state.

The code authorizes the Department to exempt MHPs from the requirements of the Knox-Keene Health Care Service Plan Act of 1975, which specifies many of the standards for access, quality, and consumer protections that other managed care organizations must meet.

The law expresses intent to develop a performance outcome system for certain services - specifically Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services - "that will improve outcomes at the individual and system levels and will inform fiscal decision-making related to the purchase of services." It explicitly instructs DHCS and other stakeholders to create such a plan specifically for EPSTD mental health services for eligible beneficiaries under age 21.

Sanctions and corrective actions

DHCS is authorized to sanction MHPs for noncompliance with state law, state regulations, the Medi-Cal state plan, or its contractual requirements. Sanctions may include "fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to promptly ensure contract and performance compliance." Fines may be offset from a variety of state funding sources. However, sanctions as authorized in this section are not currently part of the oversight process.

The legislation also specifies that a contract be terminated immediately when there is an immediate threat to the health and safety of Medi-Cal beneficiaries. Otherwise, DHCS is instructed to renew contracts with MHPs provided the agencies have fulfilled contractual terms and conditions and complied with state regulations. Failure to do either is cause for nonrenewal or renewal conditional on a plan of correction.

DHCS oversight

DHCS employs several oversight activities in response to state and federal requirements. A full list of oversight activities is included as an appendix to this report. This section describes three that are most relevant to oversight of quality, access, timeliness, and outcomes.

A. **Triennial Reviews** are conducted for each MHP every three years by the DHCS Program Oversight and Compliance Branch. They are designed primarily to assess compliance with the MHP's contract and the 1915(b) waiver. The March 2015 waiver application proposes some changes to the triennial review process, which are discussed in Section IV of this report.
B. **External Quality Reviews (EQRs)** are conducted annually by a contracted organization. These reviews are concerned with issues of timeliness, access, and quality. The scope of inquiry is broad and affords flexibility to investigate strengths and weaknesses specific to each MHP. EQR results are public; Section V of this report discusses the data they provide.
C. The **DHCS County Support Unit** serves as a primary liaison to MHPs. Staff in this unit are responsible for communication and technical assistance, often in concert with technical assistance duties of the External Quality Review Organization.

The state's response to CMS concerns involve certain changes to these activities, which are discussed further in Section IV. Descriptions in this section reflect the status of oversight as of 2014.

A. Triennial Reviews

Triennial Reviews are conducted on-site by DHCS staff on a three-year rolling basis. These reviews span four days and check for evidence of compliance with specific requirements in the following categories:

- Access
- Authorization
- Beneficiary Protection
- Funding, Reporting and Contracting Requirements
- Target Populations
- Interface with Physical Health Care
- Provider Relations
- Program Integrity
- Quality Improvement

Simultaneously, the Department conducts a review of outpatient charts, Short-Doyle/Medi-Cal Hospital inpatient charts, and provider certifications.

Plans of Correction

Within 60 days of receipt of final report from triennial review, the MHP must provide a Plan of Correction for any items out of compliance. County Support Unit staff receive a copy of the plan of correction and

provide technical assistance in implementation. However, as of 2014 the County Support Unit was not responsible for collecting evidence of corrections on a consistent basis.

Focused Reviews

The Department has occasionally conducted focused reviews in counties that need significant assistance to remain compliant. While these reviews are separate from the protocol for Triennial Reviews, they involve participation from the Program Oversight and Compliance Branch as well as the County Support Unit. Following the on-site review, the Department schedules regular follow-up communications for a period of several months. The Department has conducted Focused Reviews twice in the past four years.

B. External Quality Review

By federal requirement, EQRs involve analysis and evaluation of the quality, timeliness, and access to services furnished to Medicaid recipients. The state has directed the additional focus on outcomes.

The contracted External Quality Review Organization (EQRO) uses claims data to produce a set of key quantitative statistics for each MHP, and evaluates the MHP's performance in regards to qualitative indicators of timeliness, access, quality, and outcomes. The reports discuss any key changes to the organizational and environmental context that may affect each MHP's outcomes.

The EQRO convenes two small consumer and family focus groups and reports on feedback provided in those venues. The review also includes an in-depth assessment of local Performance Improvement Projects (PIPs) and the MHP's information systems.

For each MHP, the EQRO produces individualized assessments of strengths and weaknesses in regards to quality, timeliness, and access; recommendations to improve quality of services; and assessments of how effectively each MHP's has addressed any recommendations made in the previous year.

The structure of an external quality review report is presented in greater detail in the appendix to this document.

EQRO contract

California's EQRO is Behavioral Health Concepts, Inc. as of 2014-15. Behavioral Health Concepts has previously executed this role in Missouri, Louisiana, and Ohio.

In addition to conducting reviews, the EQRO is contracted to provide technical assistance to MHPs and support statewide improvement efforts. The comprehensive and relatively frequent review process allows staff to provide effective and targeted services.

Prior to 2014, the contracted EQRO was APS Healthcare. Practitioners report that several key staff from APS Healthcare have transitioned to Behavioral Health Concepts. The transition involved relatively few changes in the terms of the state's EQRO contract. The contract continues to specify the activities required in producing annual reports for each MHP, as well as terms regarding technical assistance to MHPs and resources to enhance statewide improvement efforts.

Behavioral Health Concepts' contract includes a new requirement to produce quarterly statewide status reports on active PIPs.

Technical assistance

The EQRO is an important vehicle by which the state delivers ongoing technical assistance to MHPs. Frequent topics of technical assistance include PIPs and information systems development. Undertaking the

in-depth annual assessment prepares the EQRO to offer tailored assistance. The EQRO also participates in statewide quality improvement efforts.

C. County Support Unit

County Support Unit staff provide assistance to MHPs as necessary, either in person or remotely. This unit is intended as a single point of contact for MHPs, each of which is assigned to a specific liaison. Critical activities include clarifying policy, reviewing key documents, and participating in Regional Quality Improvement Committees.

Plans of Correction

Staff receive MHPs' Plans of Corrections, which are developed in response to items found to be out of compliance in the Triennial Review; they work with the MHP to provide assistance on implementation.

Technical assistance

The County Support Unit staff monitor statewide trends and share information about successful practices. Staff also participate in focused reviews, which are discussed above under "Triennial Reviews."

MHPs contact the County Support Unit to arrange for technical assistance from the EQRO, which is contacted to provide individualized assistance as needed. Practitioners in two out of three MHPs interviewed indicated that this assistance is especially salient in developing PIPs, which have complex standards and involve significant planning. Interviewees also suggested that aid from the EQRO is not utilized as often as it should be. They indicated that, although the annual EQRs include a reminder about the continued availability of the EQRO, this resource is not usually at top of mind. Since generally the MHP must reach out to county liaisons to submit a request for assistance, they often end up using this resource late or less often than they probably should.

IV. Areas of immediate concern

In 2013, the Centers for Medicare and Medicaid Services (CMS) expressed several concerns about the state of Specialty Mental Health. It approved the 1915(b) authorizing waiver for two years rather than the expected five, and asked California to respond to the concerns in a 2015 waiver request. The areas of concern are:

1. 24/7 phone line
2. Tracking timely access
3. Treatment Authorization Request (TAR) adjudication
4. Tracking grievances and appeals
5. Ensuring provider certification
6. Disallowance rates
7. Sanctions and corrective actions

In response to the charge by CMS to monitor, review, and provide evidence of compliance, the Department of Health Care Services has made several oversight changes in the waiver request submitted in April 2015.

This section describes the nature of each concern and corresponding evidence of its severity. It then discusses proposed changes in monitoring and oversight, which involve changes to both issue-specific training and monitoring, and cross-cutting oversight practices.

1. 24/7 call line

MHPs are required by state law and the 1915(b) waivers to have a toll-free phone line available 24 hours a day, seven days a week. Service must be provided in all languages spoken by Medi-Cal beneficiaries in that county. The phone line should inform callers about how to access services, maintain a log of initial service requests, and provide guidance regarding problem resolution and fair hearings processes.

CMS has asked for efforts to ensure that the phone lines are always answered promptly and the required information is always available. Service requests through the 24/7 access line are also related to issues regarding timely access, which are discussed below.

Monitoring

During Triennial Reviews, DHCS examines documentation to confirm that there are goals and monitoring in place regarding responsiveness of the phone line. It conducts test calls in English and other languages to ensure the phone line has capability to provide the required information. It also reviews protocols for ensuring that goals are in place and language needs are met, as are access needs for those who are Deaf, Hard-of-Hearing, or Speech-disabled.

Evidence of severity

DHCS reported in both its 2013 and 2015 waiver application that noncompliance rates regarding the 24/7 phone line were among three highest. The Department conducted 36 triennial reviews in the two years prior to preparing its most recent waiver, and reports that 28 MHPs were found to be out of compliance during test calls. Upon investigating the log of initial service request, 31 were found to be out of compliance.

The Department indicates that compliance issues tend to involve a failure to accurately provide all the required information upon request. However, MHPs are found to be out of compliance if such a failure is evident in only one or a few of the several test calls made during the review period.

One practitioner at the county level reports that maintaining appropriate language capability is a major challenge for some counties. Separate findings in the triennial reviews reflect that there are related challenges in multiple functions: six of the 36 counties were unable to comply fully with a requirement that beneficiaries of Limited English Proficiency are informed of their to right to free language assistance services in a language they understand, and three failed to adequately demonstrate that their interpreters are trained and monitored. CMS reviews confirm also that there are long waits to see Spanish-speaking service providers.

2. Tracking timely access

Federal regulation requires that each MHP "meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services," and have mechanisms in place to monitor and ensure compliance.

Monitoring

Each MHP must set goals for timeliness for scheduling routine appointments and accessing care for urgent conditions. They must also document methods for assessing progress toward these goals.

During Triennial Reviews, MHPs must provide evidence that contractually-required timeliness tracking goals have been set and monitoring mechanisms are in place. External Quality Reviews provide additional information about timeliness tracking.

Evidence of severity

Triennial reviews in 2012-13 and 2013-14 found that 71-74 percent of MHPs had processes in place for monitoring timeliness for routine appointments. 71-79 percent had processes for monitoring timeliness with urgent appointments.

External Quality Reviews assess five key components related to timely access. The EQRO assesses MHP practices against voluntary standards; failure to meet these standards does not suggest a contractual violation. However, statewide data from 2009-10 indicates that there have been some improvements in timeliness monitoring in recent years.

- Tracks time from initial contact to first appointment: 50 percent of MHPs fully met this standard.
- Tracks time from initial contact to psychiatric appointments: 25 percent of MHPs fully met this standard.
- Tracks timeliness of appointments for urgent conditions: 34 percent of MHPs fully met this standard.
- Has a mechanism to ensure access to follow-up appointments within seven days after hospitalization: 32 percent of MHPs fully met this standard.
- Tracks no-shows: 20 percent of MHPs fully meet this standard.

The EQRO also examines site-specific strengths and weaknesses on this topic. It requires that MHPs conduct a timeliness self-assessment prior to the examination, and conducts focus groups that may reveal insights regarding timeliness (focus group questions are not published). And finally, it conducts a detailed analysis of follow-up appointments after hospitalization.

Statewide results indicate MHPs tend to perform poorly on these indicators compared to others, with relatively few meeting these standards either in whole or in part. Statewide trends are discussed further in Section V.

3. Treatment Authorization Request (TAR) adjudication

Service providers in California use a system of Treatment Authorization Requests (TARs) for certain services that require authorization from Medi-Cal prior to reimbursement. When a Medi-Cal beneficiary is hospitalized for psychiatric inpatient services, hospitals submit a TAR to the MHP to request authorization. By state law, mental health professionals are to assess the request against medical necessity criteria, criteria for emergency psychiatric criteria, and other requirements such as timeliness, and must approve or deny it within 14 calendar days.

There are concerns from CMS about the timeliness of this adjudication process, and DHCS has committed to establishing a statewide metric to track TAR adjudication.

Monitoring

DHCS assesses compliance with the 14-day TAR adjudication standard during its triennial reviews. It obtains a random sample of TARs (the protocol does not specify the sample size) to document whether the requests are approved or denied within 14 calendar days and whether the staff who review the TARs are appropriately qualified.

Additionally, the state handles appeals from providers when payments for emergency psychiatric inpatient hospital services are denied by the MHP. Review of these cases provides additional information about the effectiveness of MHPs adjudication processes.

Evidence of severity

In the 38 Triennial Reviews conducted in 2012-13 and 13-14, between 53 and 58 percent of MHPs were found to have adjudicated all TARs within the required time period.

DHCS reports in its waiver request that appeals result mostly from providers' failures to document requests appropriately. A majority of appeals filed in 2013-14 came from a single provider. The Department intends to target providers who appeal adverse decisions with information about documentation requirements.

4. Tracking grievances and appeals

State law requires MHPs to have a problem resolution process by which beneficiaries may resolve concerns about the MHP's performance. The MHP must maintain a log of basic information about grievances and appeals, including beneficiary name, date, and the nature of the problem.

Monitoring

During Triennial Reviews, the Department reviews logs to ensure that all required information appears. It also assesses presence of other required elements of the grievance and appeals process, such as written acknowledgement to beneficiaries of receipt and notification of providers involved in the incident. DHCS also verifies that the MHP regularly analyzes grievance and appeals data as part of its quality improvement efforts.

The County Support Unit collects logs of grievances and appeals annually, and investigates discrepancies or unusual levels of grievances or appeals.

Evidence of severity

In reviews conducted in 2012-13 and 2013-14, 19 percent of MHPs were out of compliance with the requirement to analyze trends in grievances and appeals.

DHCS analysis of the annually reported grievance and appeals data allowed for no meaningful conclusions about system-wide problems, although it revealed some confusion about protocols for logging grievances, prompting an update to the state reporting form.

5. Ensuring provider certification

CMS requested intervention to ensure that certification and re-certification of service providers occurs in an accurate and timely manner. In the MHP contracts, the Department requires that certification be reviewed at least once every three years; federal requirements mandate review every five years. Other elements of the provider certification process are governed by state law, which requires that the providers meet a variety of standards for safety, privacy, quality, and licensing. For certain providers, the process may require an on-site review.

Monitoring

DHCS maintains a statewide database of providers certified to provide Specialty Mental Health services. This certification process remains separate from the process for providers of other Medi-Cal services.

During Triennial Reviews, the Department assesses whether the MHP has a monitoring system in place to ensure the certification process meets requirements set forth in state law. Concurrently, the state examines provider records to assess the percentage of providers overdue for certification, and examines the dates of a random sample of certifications and re-certifications.

Evidence of severity

Triennial Reviews from the past two years indicate that many MHPs do not have appropriate monitoring systems in place: 26 out of 36 MHPs did not fully comply with this requirement, making it one of the major areas of noncompliance. DHCS indicates that some of the non-compliance is an artifact of incomplete paperwork submitted by MHPs rather than a failure to undertake key recertification tasks.

6. Disallowance rates

CMS has expressed concern over the frequency at which billed services are found to be out of compliance with Medi-Cal reimbursement standards. The rate is alarmingly high, accounting for 32 percent of services in outpatient medical record reviews.

Monitoring

During triennial system reviews, the Department considers a random sample of patient charts and evaluates whether Medi-Cal billed services meet state and federal requirements for reimbursement. This includes assessing medical necessity of claims and ensuring claims are supported by appropriate documentation. To review outpatient services, this sample consists of charts for ten to twenty adults and children in most MHPs, and charts for eighty beneficiaries in Los Angeles' MHP. An additional sample of charts is considered to assess compliance among inpatient services.

Based on findings from chart reviews in both waiver periods, disallowances occur primarily because chart documentation fails to meet medical necessity criteria.

Evidence of severity

DHCS reports the following disallowance rates from chart reviews conducted in 2011-12 and 2012-13:

- MHP average disallowance rate for outpatient medical records: 32 percent
- MHP average disallowance rate for Short-Doyle/Medi-Cal inpatient hospitals records: 50 percent

7. Sanctions and corrective actions

CMS requests that the State attempt to improve compliance by clarifying processes for enacting fines, sanctions, and other corrective actions. The most common responses to deficiencies found by monitoring activities are Plans of Correction and technical assistance provided by the County Support Unit.

Plans of Correction must be submitted in response to any finding of noncompliance in Triennial Reviews. Triggering this requirement is the norm rather than the exception: 80 to 100 percent of MHPs reviewed in each of the last four years submitted a Plan of Correction in response. Such a high frequency indicates that this action alone does not send a sufficiently strong signal to encourage compliance. There is no corresponding consequence to deficiencies identified by External Quality Reviews.

DHCS has not employed sanctions or fines in response in the three years since assuming responsibility for the Specialty Mental Health system.

State response

In preparing the state's 2015 request to renew the federal 1915(b) waiver that authorizes the Specialty Mental Health system, DHCS developed proposals designed to spur progress in the above areas. The proposals include both issue-targeted activities and cross-cutting oversight approaches.

Targeted activities

	Indicate partial compliance	Additional reporting	Technical assistance	Focused reviews	Standardized measures
24/7 phone line	✓	✓	✓	?	
Tracking timely access			?		?
Note: Proposes a statewide Performance Improvement Project conducted in partnership with the EQRO.					
TAR adjudication	✓				?
Note: Will also provide targeted guidance to service providers.					
Tracking grievances and appeals	✓			?	
Note: DHCS will examine reports for local trends and incorporate findings into Triennial Review.					
Ensuring provider certification	✓				
Note: DHCS has begun to send regular reports of provider certification status to MHPs.					
Disallowance rates			✓	?	
Note: The proposal to increase use of Focused Reviews lists several potential indicators that may be used to establish thresholds for selection. Disallowance rates are not among them, but are sufficiently similar to those presented as examples.					

✓ - Activities planned or underway ? - Activities under consideration

Better reflect partial compliance

The Department has adjusted indicators assessed during Triennial Reviews to include options that reflect partial compliance. This change will allow for more accurate information about the severity of the problem.

The affected indicators are in the areas of the 24/7 access line, TAR adjudication, logs of grievances and appeals, and provider certification.

Require additional data and reporting

A more frequent and detailed process for conducting test calls to the 24/7 access line is already in implementation. MHPs conduct test calls quarterly and report results to the Department. DHCS continues to work with MHPs to ensure reporting protocols are clear and manageable.

Execute statewide technical assistance

DHCS is addressing issues of linguistic capabilities in the 24/7 access lines by collecting and maintaining information about successful practices or mechanisms. This information is intended to provide a basis for eventual statewide technical assistance. MHPs are also using local Quality Improvement Committees and the County Behavioral Health Directors Association to share information about services, contractors, and other solutions.

To address disallowance rates, DHCS has planned an intensive statewide chart training in August 2015. The chart training will have separate sessions for MHPs in the Northern and Southern parts of the state. The training is part of a broader initiative to increase annual training opportunities and to ensure that training resources are available online when possible.

To provide technical support regarding grievances and appeals, DHCS is identifying within-county trends among items submitted for DHCS review. Previously, the Department focused on identifying statewide trends. It has also begun to share its results with MHPs prior to Triennial Reviews.

The Department is discussing with the EQRO a statewide Performance Improvement Project regarding timeliness tracking. Such a project is only under consideration at this point.

Utilize enhanced Focused Reviews

The Department may conduct more Focused Reviews, which have been used only occasionally in recent years, for MHPs with significant and continuing compliance issues. DHCS proposes establishing threshold levels of compliance with specific requirements that would trigger focused reviews. Unlike the responses above, the Department has not begun to implement this change and presents it as "under consideration."

These Focused Reviews would target MHPs with satisfactory overall compliance but continuing issues in a specific area. They involve additional in-depth training and technical assistance. State staff from multiple units participate, rather than just from the Oversight and Compliance Branch.

DHCS has not fully specified the compliance indicators and levels that would trigger such a review, but expresses that would initially focus on compliance in areas of concern such as the 24/7 call line, TAR Adjudication, and grievance and appeals tracking. Disallowance rates are not specifically listed, but are included in the summary chart because they are sufficiently similar to those indicators provided.

Develop statewide standardized measures

DHCS has convened workgroups with representation from MHPs and other stakeholders to implement statewide standardized measures for tracking and assessing performance. A timeline for development and implementation are subjects of the ongoing conversations.

The Department specifically indicates it may incorporate relevant standards for timeliness tracking. One proposed metric is a ten-day standard for the time between initial service requests for non-urgent conditions and the offer of an appointment. Other proposals address timeliness standards for follow-up outpatient contact after hospital discharges. Also under consideration is the option to incorporate a 14-day standard for TAR adjudication.

Cross-cutting responses

Many of the above responses are related to broader changes proposed to the monitoring system.

- Create a tiered Triennial Review process
- Create a framework for use of corrective actions
- Improve training frequency and access
- Enhance County Support Unit activities

Importantly, the waiver request submitted in March 2015 does not include a commitment by the Department to implement all of the activities discussed here. Instead, many are reported as being "under consideration" by the Department. Opportunities remain for the legislature and other stakeholders to contribute feedback and guidance regarding these changes.

Create a tiered Triennial Review process

The Triennial Review process may be adapted to incorporate a tiered system, which would lead to more frequent reviews for high-priority MHPs. Overall compliance for the last three review cycles would provide the basis for sorting MHPs into three tiers.

Tier 1 MHPs, which would be the lowest performing based on their compliance ratings, would be the first focus of additional oversight and monitoring. Reviews for this tier would likely be annual, would include validation of Plans of Correction, and would incorporate focused training and technical assistance. Tier 2 MHPs under the system would receive a more moderate intervention, most likely involving biennial reviews, and Tier 3 MHPs would continue on the triennial review schedule. The Department does not disclose whether it plans to validate Plans of Correction for MHPs in these tiers.

The tiered system would be phased in over 2-3 years. MHPs would have capacity to move among tiers between reviews.

Additionally, as mentioned above, the review protocol is being changed to reflect the possibility of partial compliance in several items.

The Oversight and Compliance Branch was budgeted four new positions for the 2014-15 fiscal year, which allow it to increase the scope, intensity, and frequency of monitoring.

Improve training frequency and access

DHCS proposes to develop more regular training opportunities for MHPs, including both statewide and site-specific training. The Department proposes creating an annual training calendar populated including events modeled after the planned statewide chart training in August 2015, which is a two-day training to address issues arising in chart reviews.

Concurrently the Department would begin to improve multi-media training opportunities, including webinars and teleconferences, and make training materials available online.

Create a framework for use of corrective actions

DHCS intends to develop a more comprehensive system of corrective actions. It would include education and training as a primary response. A continuum of more severe corrective actions, like sanctions and fines, would be specified along with corresponding triggers. The vision is for a system that begins with collaboration and leverages progressively severe corrective actions only when cooperation fails to produce meaningful improvement.

Development of this system could enhance the effectiveness of all monitoring and support activities by creating clarity regarding the stakes of continued non-compliance.

In its waiver application, the Department does not specify a list of potential corrective actions or potential triggers. Such a system may require changes in monitoring process, since not all are appropriate as a basis for sanction. For instance, practitioners at each of three MHPs indicate that although individualized EQRO recommendations are helpful, there are instances where they reflect incomplete information on the part of the EQRO.

Enhance County Support Unit activities

The County Support Unit was approved for two additional staff in the 2014-15 fiscal year to increase the level of monitoring and technical assistance it provides, including follow-up when out-of-compliance areas are identified. The County Support Unit would support several of the responses discussed here.

Some existing activities, like technical assistance, would be intensified. There are also brand new activities proposed: liaisons from the County Support Unit will participate in onsite triennial reviews, whereas previously these staffers were in attendance for only the exit interviews; they will consistently collect of evidence of corrections made in accordance with Plans of Correction; and they will attend MHP Quality Improvement Committee meetings.

V. Findings from External Quality Reviews

Legislative staff would like to better understand the standards that Specialty Mental Health Services are held to and how well Californians are served by the system. Annual External Quality Reviews are one source of insight into the status of this system. These reports describe critical features like access, quality, timeliness, and outcomes in MHPs around the state. They take a broad look at the strengths and weaknesses of each MHP and dive deep into specific issues that pose challenges statewide. But their contents and impacts have gone largely unexamined at the legislative level.

In addition to monitoring, the EQR process plays a key role in providing guidance and technical assistance. The annual review process focuses local attention on system-wide priorities. It also provides individualized recommendations to facilitate ongoing improvement. These reports should prompt corrective actions when appropriate, and guide development of statewide priorities.

This section summarizes important statewide findings of the EQR process, focusing on those that indicate access, quality, timeliness, and outcomes. It also discusses the EQR processes effectiveness as an oversight tool.

A note on data: These data were collected in the 2010-11 review cycle and are the most recent statewide statistics published by the EQRO; publication of summary data from more recent review process is delayed due to the transition of the contracted EQRO organization.

Key Summary Statistics

The following statewide statistics reflect conditions as of 2009. All figures are in 2009 dollars.

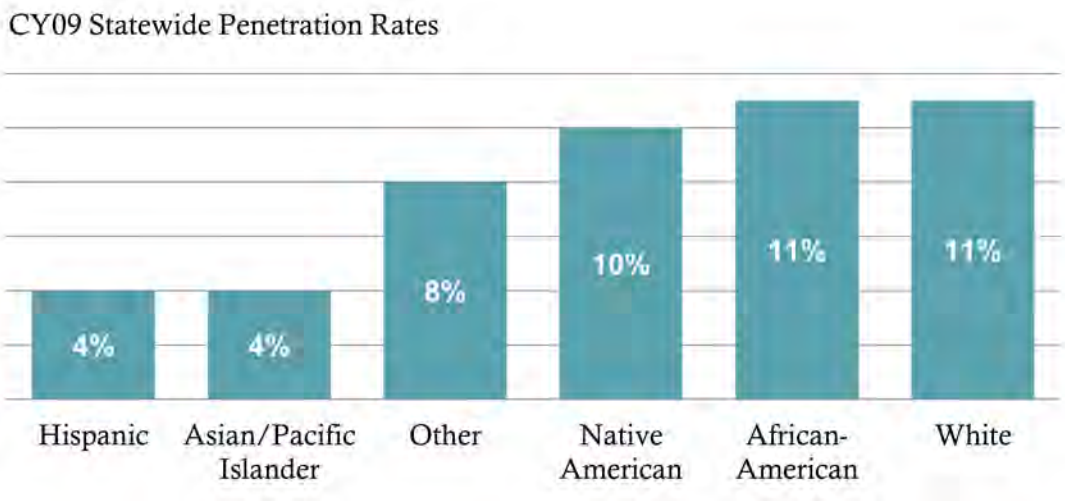
Cost per beneficiary: Average cost per beneficiary was $4,883. Costs assessed do not include psychiatric pharmacy costs, nor costs associated with physical health care. The median cost is much lower, $1,715, corresponding to the incidence of very high-cost beneficiaries. Also reflecting wide variations in costs is the standard deviation of $9,590.

In most of the five years prior to 2009, cost increases only slightly outpaced the rate of inflation.

Gender disparities: While the system has historically served more females than males, the Medi-Cal population is disproportionately female. Therefore the penetration rate for females is lower- consistently about 82% of that for males.

The average payment for females is also consistently about 77% of that for males; average cost of services for men are higher across all types of services. It is among adults in the 18-59 age group that costs disparities are most significant: whereas average cost for men in this group was $4,917, for women it was $3,610. Men outpace women in both access and spending across all service categories.

Racial and ethnic disparities: Disparities in access for Hispanic beneficiaries is an enormous and persistent issue in the Specialty Mental Health system. Whereas the statewide penetration rate for white eligibles is 11.4 percent, it is 3.65 percent for Hispanic eligibles. Asian/Pacific Islanders also have low penetration rates, whereas those for African- Americans and Native Americans are similar, if not quite as high, as those for whites.



The disparities are also reflected in average costs per beneficiary. Approved claims for African-Americans averaged $5,861, the highest among the five groups (excluding Other). They were slightly lower for whites and Native Americans, but approved claims for Hispanics averaged $5,133, and the lowest spending was for Asian-Pacific Islanders, at $4,008 per person.

Spending disparities have steadily diminished in recent years, unlike those for penetration rates. Disparities are also relatively smaller if service intensity is measured by the average number of service encounters in a calendar year.

More Key Summary Statistics

Age disparities: Children between ages six and 17 make up the highest-cost age group on a per-beneficiary basis. Adults over age 60 are consistently the lowest-cost age group, although costs for serving this population are rising the fastest.

Distribution of high-cost beneficiaries: In 2009, five percent of beneficiaries accounted for 38 percent of total approved claims. Annual approved claims for this five percent were above $20,000, whereas 75 percent of beneficiaries incur an annual average cost of $5,000 or less. This distribution has remained roughly unchanged in recent years.

The EQRO collects detailed information about inpatient psychiatric hospitalizations, an important driver of skewed costs. A summary of findings is included in the appendix to this report.

Service intensity: Customers are more likely than not to receive five or more services per year. Around 40 percent of beneficiaries receive more than 15 services each year.

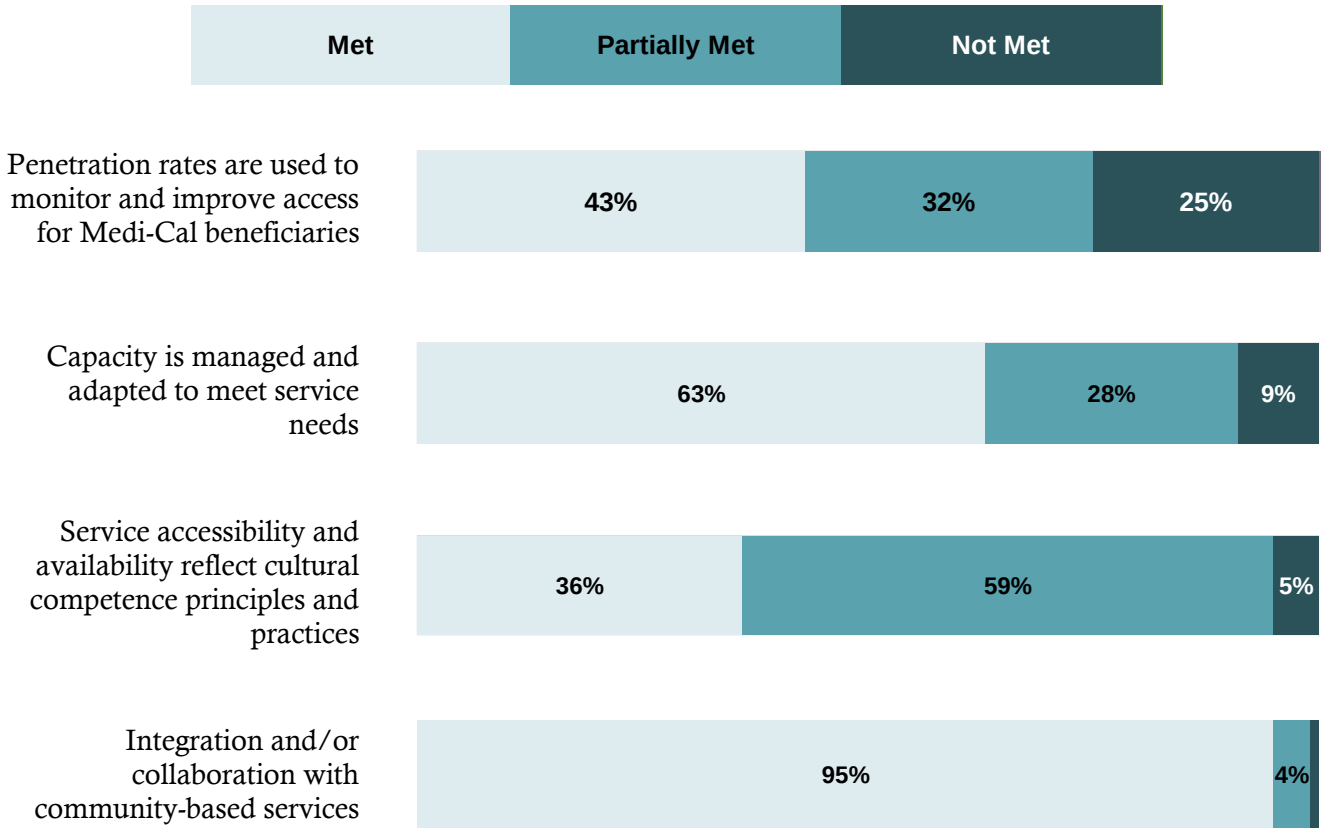
Foster care population: The penetration rate among foster care children statewide is 62 percent. Recent small increases in penetration rates are due to a shrinking of the foster care system. Average spending on foster care children was $7,773, a figure that has remained largely consistent over time.

Key qualitative indicators

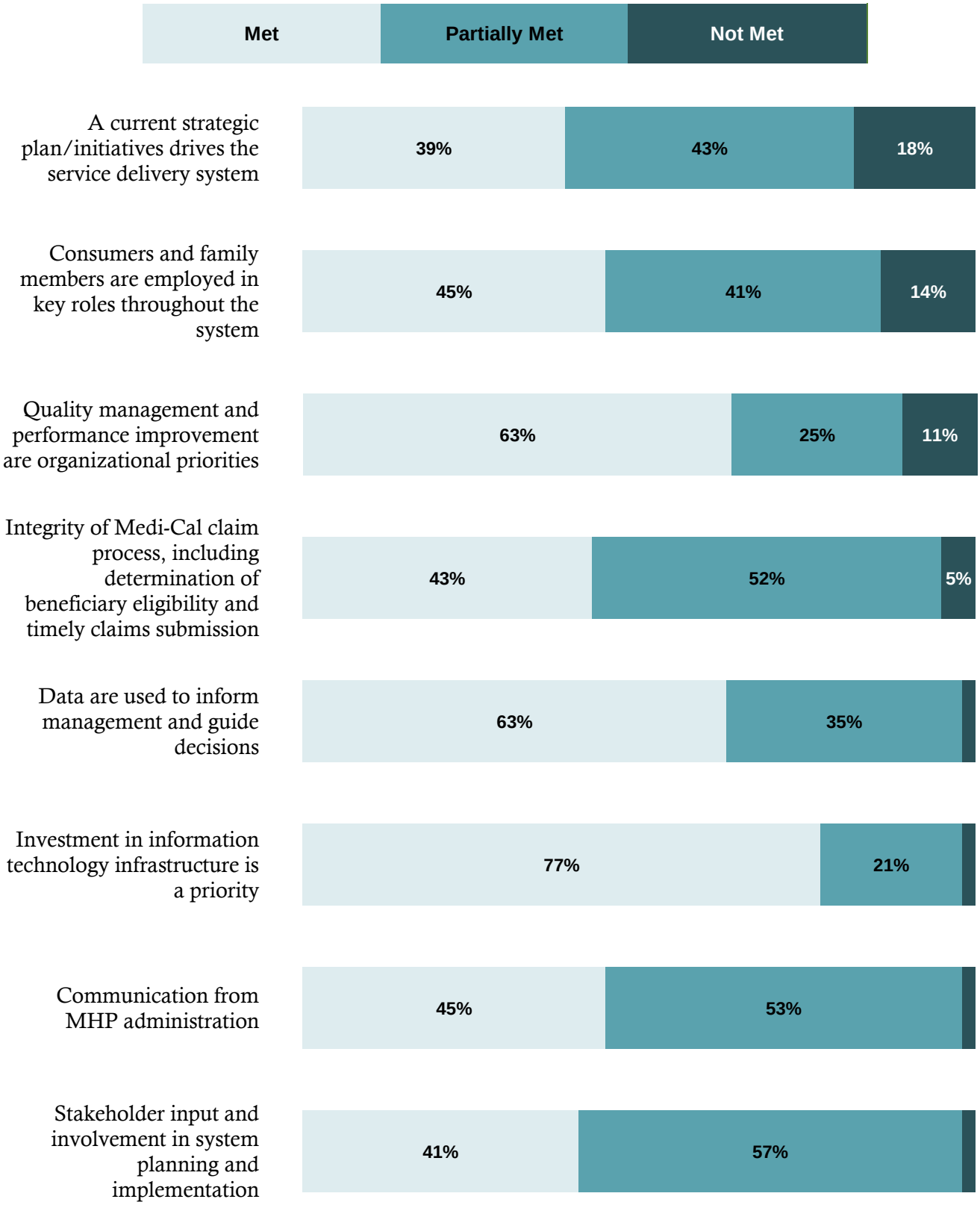
Each MHP is evaluated on 18 key indicators for quality, accessibility, timeliness, and outcomes. As of 2009, MHPs tended to display much stronger results in the quality and access indicators, and poorer results in timeliness and outcome indicators. However, these indicators do not provide a complete picture of consumer's experience with Specialty Mental Health services.

Each indicator is rated "Met," "Partially Met," or "Not Met" in every MHP. The charts below are based on individual EQRO and show the distribution of these ratings among MHPs.

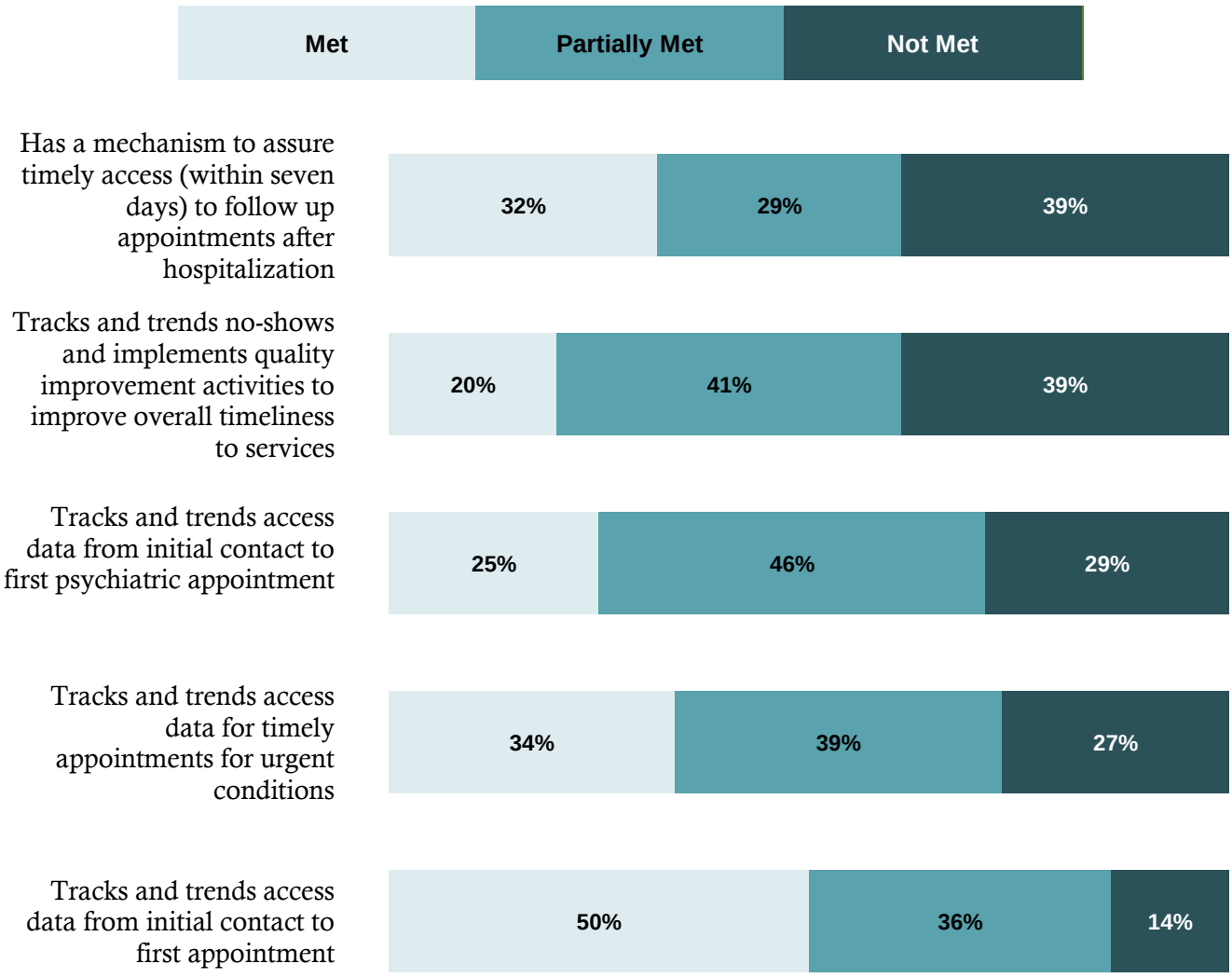
Access indicators



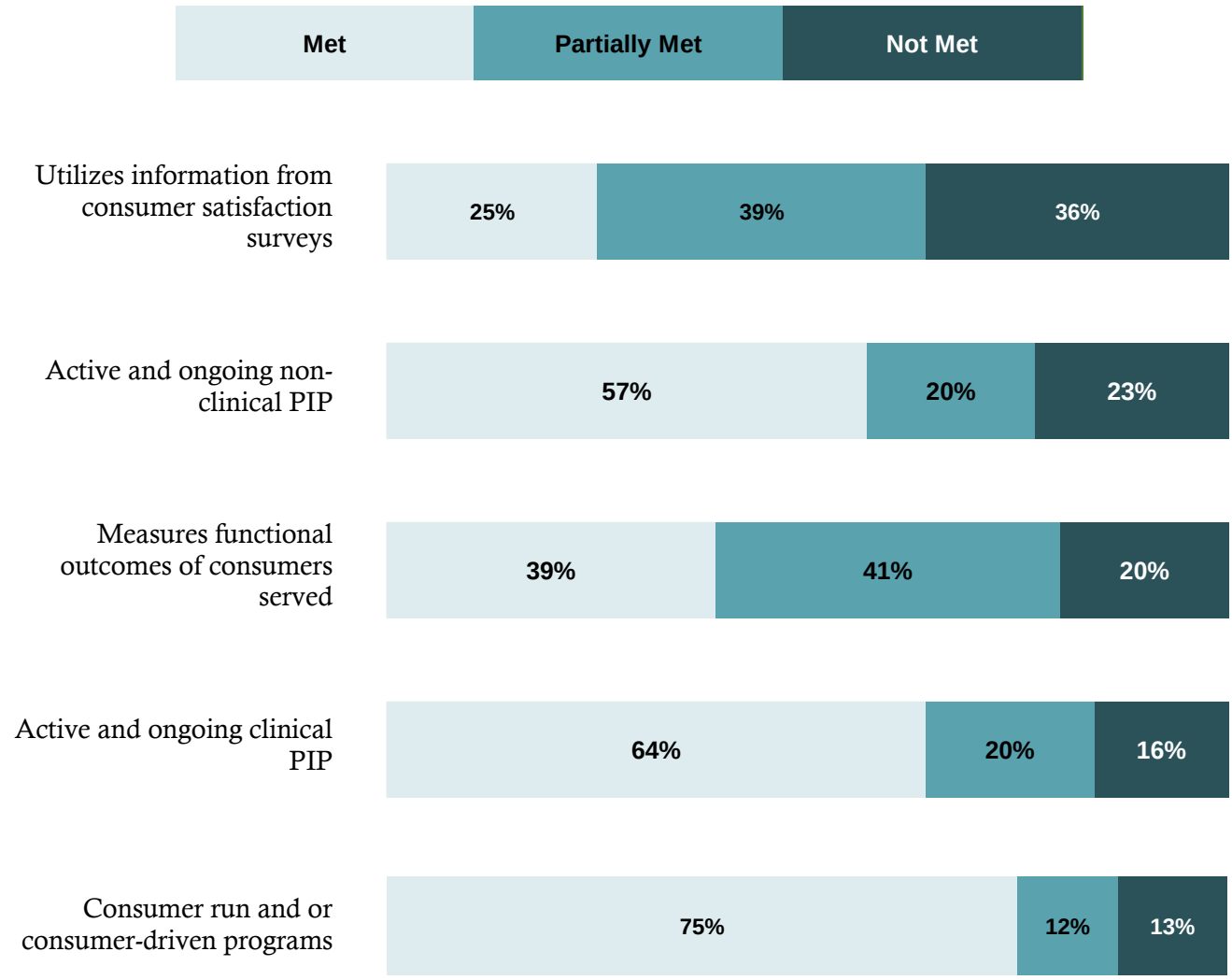
Quality indicators



Timeliness indicators



Outcome indicators



Summary

Good performance on access indicators and poor performance on timeliness stand out. Regardless of the domain, a given indicators is usually fully present in less than half of MHPs, suggesting there is substantial improvement to be made across the board.

These indicators tend to refer to the infrastructure and processes in place rather than an MHP's outcomes. Ratings on timeliness indicators, for instance, do not directly indicate whether consumers face significant lags in accessing service. According to APS Healthcare, "If an MHP's services, according to their own standards, are not timely, but the MHP is monitoring this status and initiating changes within its system intended to improve these measures, an MHP can receive a rating of "present" on these items." The standards are designed to reflect whether the MHP has a mechanism to identify and respond to issues such as long waits for service.

Most of the protocols in place allow insight into an MHP's capacity to initiate and undertake improvement processes. But without refined statewide standards for tracking and reporting, it is impossible to say much with certainty about the typical customer experience.

EQRO effectiveness

In addition to illuminating conditions at the local level, the EQR process is designed to provide frequent, relevant feedback. The EQRO delivers annual individualized recommendations to MHPs, and follows up each year on the response to those recommendations.

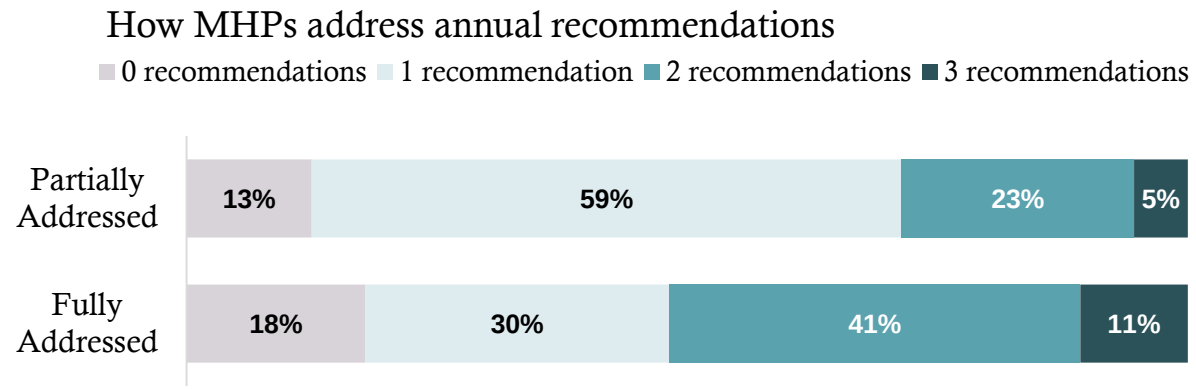
EQRO recommendations to MHPs are categorized as pertaining to access, outcomes, information systems, quality, timeliness, or other. The below chart is an analysis of the top five recommendations for each MHP, out of 280 recommendations in total provided during the 2010-2011 review process.[2]

	Quality	Information Systems	Access	Outcomes	Timeliness	Other
Number of recommendations	161	88	85	69	31	86
MHPs receiving at least one recommendation in category	56	50	47	42	23	46

Timeliness is the least frequent domain for a recommendation from the EQRO, even though the system in general performs worse on indicators of timeliness than anywhere else. The EQRO does not address this apparent gap. It is possible that the EQRO has little expertise to offer in the timeliness domain; alternatively, this issue may only become a priority when beneficiaries experience unreasonable wait times.

In particular, the EQRO notes that tracking timeliness to psychiatric appointments is important to address, considering that there is a statewide scarcity of psychiatrists.

Each year the top three recommendations from the prior year are reviewed. MHPs are asked to provide documentation demonstrating how they were addressed. 64 percent of MHPs addressed all three recommendations either in full or in part in the 2010-11 cycle. Only eleven percent of MHPs fully addressed all three recommendations. 82 percent fully addressed at least one of the recommendations.



What might be the cause of lukewarm responsiveness to EQRO recommendations? No direct consequences accompany failure to act on recommendations by the EQRO. The practitioners interviewed confirm that

[2] The same recommendation can fall into more than one category, so subcategory totals will be higher than 280.

their organization's response to recommendations is driven by the value of the recommendation, but not high stakes.

One practitioner indicated that there is some ambiguity about what drives the EQRO's prioritization on certain recommendations. The annual reports usually include more than three recommendations - they may include up to ten. But the MHPs are asked to respond to only three "priority" recommendations, and the rationale behind the ranking is not always evident.

Finally, recommendations may reflect a limited assessment of the local environment. A unique contribution of the EQRO process is to convene focus groups, and staff I spoke with confirmed that these activities provide important feedback. But practitioners at two different MHPs cited recommendations driven by focus group feedback that they felt could not be understood and effectively addressed without more context.

VI. Improving oversight effectiveness

California's Specialty Mental Health system faces broad challenges in tracking and analyzing critical indicators, maintaining consistent timeliness standards, and ensuring equitable access. These challenges are elevated by the system's decentralized structure as well was the complex nature of Medi-Cal managed care.

The Department of Health Care Services, in planning for the 2015 renewal of the state's 1915(b) waiver, has already begun to undertake several important changes to its monitoring and oversight processes. Appropriately, the new and enhanced activities proposed reflect a narrow focus on areas of immediate concern. However, they ignore several opportunities for California to make progress on the broader long-term challenges of Specialty Mental Health. And they display a hesitancy to exercise state authority to set performance standards and penalize failures to meet them.

The state's oversight system can be enriched to better facilitate transparency and encourage high-quality, accessible, and timely care, while continuing to preserve county autonomy and flexibility. A strong commitment to oversight should be reflected in additional efforts to comprehensively address ethnic disparities and timely access, institute statewide performance standards, and make use of sanctions and penalties when other corrective actions fail to make the desired impact.

Comprehensively address ethnic disparities

Data indicates marked racial and ethnic disparities in terms of penetration rates and costs. Current efforts focus on one potential mechanism for these disparities: 24/7 access lines with limited linguistic capabilities.

But the immediate concerns surrounding the access lines should not detract from a focus on closing the broader access gap. New activities proposed in the 2015 waiver request addresses only a single facet of this issue. Improvements in the access line should not be expected to address elevated wait times for Spanish-speaking providers, which have been high since 2001, or indicators that a significant number of MHPs lack appropriate linguistic capabilities in other functional areas. The state should look for opportunities to expand the scope of research and technical assistance in development in order to help in these areas as well.

Heighten priority on timeliness tracking

Significant proportions of MHPs do not keep track of indicators of timeliness and service outcomes. Only 50% of MHPs fully have the capability to track, so little is known about timeliness in the Specialty Mental Health System. There is no statewide standard MHPs must meet regarding the time between a consumer's initial contact with the system and receipt of health care; instead, each MHP should have its own standard and accompanying tracking processes.

Improvement initiatives at the local or statewide level are hampered without capabilities for tracking and data analysis. Yet the EQRO indicates that timeliness goals and tracking are not a priority for MHPs. As of 2010-11, the same seems to be true for the EQRO: the EQRO's individualized recommendations to MHPs rarely targeted identified challenges with timeliness tracking.

The state should be cognizant of the fact that technical assistance from the EQRO tends to focus on quality, information systems, and access, rather than timeliness, and seek out additional support in this area. Furthermore, timeliness tracking should be a high-priority target of any statewide performance standards or frameworks for employing sanctions or penalties. Casting light on egregious or continued non-compliance even once may serve to motivate local agencies to resolve any remaining barriers to fully tracking timeliness.

Implement statewide performance standards

Statewide performance standards have been an explicit goal since the inception of the Specialty Mental Health system. Some are in place, such as a 30-day timeframe for determining eligibility status. But current issues with timeliness and ethnic disparities have arisen in an environment where uniform standards in these and other important areas are not a clear state priority.

DHCS is in the process of developing a new set of statewide standardized measures in conjunction with MHPs and local stakeholders. The timeline for this process, as well as the specificity of the standards and whether they will be compulsory, are still to be determined.

There remains a clear opportunity for the state to demonstrate a commitment to a thorough, effective policy of statewide standards which compels MHPs to track and report on priority issues, and which is accompanied by an effective process to identify gaps and initiate quality improvement. Standards governing other managed care organizations through the Knox-Keene Act provide a useful template. Alignment with these standards where possible would communicate that all Californians deserve the same guarantees and protections in regards to their health care.

Develop a system for sanctions and penalties

In no instance since assuming oversight responsibilities has DHCS imposed financial sanctions or other penalties on an MHP. Prior to 2012, when the system was under the oversight of the Department of Mental Health, findings of disallowance resulted in some financial penalty. But this practice ended due to concerns about its fairness and has not been replaced.

DHCS generally responds to identified issues in the mental health system by requiring Plans of Corrections and providing targeted technical assistance, often in the form of training and guidance materials. It engages the CBHDA and the Quality Improvement Committee to ensure county guidance, and uses the technical expertise and local experience of the EQRO.

In most cases, these activities constitute a comprehensive and effective response to identified problems. However, there are areas where guidance and technical assistance seem insufficient to spur needed improvements. Several years of data show continued elevated noncompliance with contract terms in key areas affecting system access, quality, and integrity. Issues like sky-high disallowance rates, slow treatment authorization, and limited language capabilities pose serious threats to the system and its beneficiaries.

Changes proposed in the current waiver request demonstrate a continuing hesitancy to use sanctions or penalties. The plan to develop a continuum of corrective actions is framed as "under consideration" and lacks specifics. But continuing development of this strategy should be a priority. Establishing clarity around the conditions for use of sanctions sends a signal that guidance and technical assistance cannot.

This signal may be necessary to ensure progress in some areas of immediate concern, even if sanctions and penalties are only justified rarely.

There are important reasons to consider such a plan carefully before making policy: comprehensive tracking and clear standards are a critical foundation and must contend with complex and diverse service models. Clear communication with stakeholders should remain an important principle in the process of developing sanctions and penalties.

Appendix A. Federal Managed Care Regulations: 42 CFR Part 438

438 CFR governs provision of Medicaid services through Prepaid Inpatient Health Plans, the category that describes California's Specialty Mental Health Plans. It also governs Medicaid services provided through Managed Care Organizations, Prepaid Ambulatory Health Plans, and Primary Care Case Management systems.

In the below summary, I discuss the provisions of two subparts of the code as they apply to California's MHPs: Subpart D, Quality Assessment and Performance; and Subpart E, External Quality Reviews.

I summarize these subparts because they contain substantive information pertinent to the state's quality assessment and oversight role. Other parts in the code address state responsibilities, enrollee rights and protections, grievance systems, certifications and integrity, sanctions, and conditions for federal financial participation.

Subpart D: Quality Assessment and Performance

This section outlines basic requirements for quality assessment within managed care plans, including the specific role of the state. It also specifies requirements for Performance Improvement Projects.

State responsibilities

- Must review at least annually impact and effectiveness of quality assessment and performance improvement programs.
- May require that the MHP itself evaluate the effectiveness of these programs
- Must establish standardized measures for reporting quality. These should incorporate the requirements for tracking enrollee race, ethnicity, and primary language, and any national measures identified by CMS, unless the state specifies alternative measures.

MHP responsibilities

- Each MHP is responsible for annual measurement and reporting on standardized measures established by the state

Performance Improvement Projects (PIPs)

MHPs are required to have an ongoing program of PIPs. PIPs must meet the following minimum requirements:

- involve a systemic interventions designed for specific and sustained improvements in enrollee satisfaction and health outcomes
- collect and report on performance data using objective quality indicators
- include an effectiveness evaluation
- involve mechanism for detecting over- and under-utilization of care
- incorporate a mechanism for assessing quality of care for enrollees with special health care needs
- include planning and activities designed for increasing or sustaining improvement

PIPs must be completed in a time frame allowing for information on quality of care to be updated every year.

Subpart E: External Quality Reviews

This section outlines requirements for external quality review of MHPs. It describes requirements of the review itself, standards for selecting a review organization, and the state's specific responsibilities within the EQR process.

What is an EQR?

External Quality Reviews must be conducted annually for each MHP, with some exceptions. They involve analysis and evaluation by an external organization of the quality, timeliness, and access to services furnished to Medicaid recipients

Required EQR Components

- A technical report on the methods used to collect information and analyze results
- An assessment of each MHP's strengths and weaknesses with regard to quality, timeliness, and access
- Recommendations for each MHP to improve quality of services
- An assessment of how effectively each MHP's has addressed any recommendations made in the previous year
- Comparative information about all MHPs (if directed by the state).

EQR Methods

- Validation of all performance improvement projects (PIPs) underway in the previous year
- Validation of all performance measures
- A review to determine the MHP's compliance with state standards (any reviews conducted in the three years prior are allowable)
- May incorporate validation of encounter data
- May survey consumers or providers regarding quality of care
- May calculate of additional performance measures
- May use information collected from additional PIPs and studies of quality

The EQRO

California uses a private organization as an EQRO. For these types of organizations, qualifications are:

- Staff must have demonstrated knowledge and experience of Medicaid, managed care, quality improvement, and analysis, among other skills necessary to fulfill contractual duties.
- The organization must have sufficient physical, technological, and financial resources.
- Must be independent from the state agency and the MHPs.
- May also provide TA to MHPs separately from its EQR duties.
- The EQRO must be selected via an open and competitive process.

If the contracted organization meets these requirements, the federal government contributes 75% of the EQR cost.

State Responsibilities

The state must ensure that:

- An annual EQR is conducted for each PIHP
- It includes all the required elements
- The EQRO follows established protocols regarding data collection, use, and analysis.
- Results of EQRs are made available to interested parties.
- Results of EQRs do not contain any information that compromises patient privacy.

The state is also responsible for furnishing necessary information to the EQRO.

Appendix B. DHCS Monitoring Activities

In its federal waiver, DHCS commits to a broad variety of monitoring activities and strategies. The following list includes all monitoring activities described in the waiver request submitted March 30, 2015. Note that in several cases one activity fulfills several purposes.

Consumer Self-Report Data	Consumer Perception Survey Triennial Review - Satisfaction policies
Data Analysis (non-claims)	Annual Reporting on Grievance and Appeals Triennial Review - Grievance and Appeals Fair Hearing Data
Measurement of racial/ethnic disparities	Data Review (EQRO) Triennial Review - Access to Culturally/Linguistically Appropriate Services
Network Adequacy Assurances	MHP Contract Triennial Review - Policies/Procedures Regarding Numbers and Types of Providers
Ombudsman	
Onsite System Reviews	Systems Review Outpatient Chart Review SD/MC Hospital Inpatient Charts Review Provider Certification Onsite Reviews
Performance Measures	Indicators Measured on an Ongoing or Periodic Basis Implementation Plan Review Triennial Review - Quality Improvement Program
Review of changes in number and type of Medicaid providers	
Utilization Review	MHP Utilization Management Plan
EQR	Performance Improvement Projects Performance Measures Information System Capabilities Assessment Other EQR Data
Cultural Competence Plans	
Advisory Groups	Compliance Advisory Committee Cultural Competence Advisory Group California Mental Health Planning Council
Provider Appeals - Inpatient Services and EPSDT Services	Appeals to FFS Hospitals Appeals to Specialty Mental Health Services
County Support Unit	

Appendix C. Structure of MHP EQRO Reports

A. **Introduction** - Covers goals and regulatory context of the EQR process, as well as methodology. These do not vary by county.

B. **Review of Findings**

   a. **Status of prior year's review recommendations.** Rates each of five or so recommendations from the prior year as either "Not addressed," "Partially addressed," or "Fully addressed." Provides details of the MHP's progress to support the rating.

   b. **Changes in the MHP environment and within the MHP.** Describes significant changes that may affect access, timeliness, quality, and outcomes. Can include changes to key staff, partnerships, new or significant programming or facilities, and management approaches.

   c. **Performance & Quality Management Key Components.** Describes activities and characteristics of the organization that impact quality, access, timeliness, and outcomes. Each of these categories gets one to two pages of notes on relevant features of the organization. They may, for example, discuss new workplans, staff development practices, language access, or use of data.

   d. **Current Medi-Cal Claims Data For Managing Services.** Each EQR presents standard statistics about claims and beneficiaries, usually accompanied with a few sentences interpreting notable findings.

   e. **Race/Ethnicity of Medi-Cal Eligibles and Beneficiaries Served.** Depicts the racial and ethnic makeup of these populations, both statewide and for the MHP specifically

   f. **Penetration Rates and Approved Claims per Beneficiary.** Includes the number of beneficiaries served, number of eligibles, approved claims per beneficiary, and penetration rates. The MHP's figures are compared to statewide figures and summary figures for MHPs of a similar size. Approved claims per beneficiary and penetration rates are disaggregated for foster care, TAY, African-American, and Hispanic populations. Changes in penetration rates are depicted over the preceding four-year period.

   g. **Medi-Cal Approved Claims History.** Five years of data on number of eligibles, number of beneficiaries served, penetration rate, approved claims, and and approved claims per beneficiary are compared. Penetration rates and approved claims per beneficiaries for foster care, TAY, and Hispanic populations, and compared to averages for similar MHPs and statewide. Disparities in penetration rates and claims between Hispanic and White populations are also examined.

   h. **High-Cost Beneficiaries.** Number and percent of high-cost beneficiaries served, along with the total and averaged approved claims for these populations, is compared over the preceding four-year period. Provides current statewide figures for context.

   i. **Timely Follow-up After Hospital Discharge.** Examines the percentage of beneficiaries who received services within seven and 30 days of discharge from inpatient facilities. Also shows the percentage who are re-hospitalized in these time frames. Provides two years of data, comparing MHP figures to statewide averages. Additional commentary may focus on the magnitude of approved claims for this population.

   j. **Diagnostic Categories.** Depicts the frequency of the top eight primary diagnoses among beneficiaries, both statewide and for the MHP. Also considers how approved claims are dispersed among diagnostic categories.

C. **Consumer and Family Member Focus Groups.** Describes focus group process and demographic composition. For each focus group conducted, includes a write-up of discussion surrounding access, quality, timeliness, and outcomes, and summarizes recommendations from the group.

D. **Performance Improvement Project Validation.** For each of two Performance Improvement Projects (PIP), describes the study questions, status, motivation, and relevant background. The

EQRO analyzes the PIP using a standardized tool that identifies 44 criteria. The full results of the analysis are available in an attachment; this section provides a summary of 13 key elements. Fuller descriptions of the PIPs as submitted by the MHP are also attached.

E. Information Systems Review
    a. Overview (self-reported figures):
        i. **Distribution of services provided by provider type**
        ii. **Frequency of submission of Medi-Cal claim files**
        iii. **Proportion of beneficiaries with co-occurring substance abuse and mental health diagnoses**
        iv. **Average rate of missed appointments**
        v. **Whether the MHP calculates penetration rates**
    b. **IS systems currently in use**. Including their functions, vendors, and the amount of time the MHP has been using them. Also provides summaries of the timeliness and denial rates for Medi-Cal claims.
    c. **IS changes in the past year and priorities for the coming year.** The EQRO notes any significant issues with the IS system not already addressed.
    d. **Electronic Health Record Status.** Identifies key functionalities for Electronic Health Records and indicates whether they are in widespread use at the MHP. Also discusses progress on implementation in the past year.
F. **Site Review Process Barriers.** Records barriers to conducting the review experienced by the EQRO, if any.
G. **Conclusions.** Identifies around five strengths and five opportunities for improvement evidenced in the review process. The content of these is wide-ranging, but is coded by functional areas like "quality," "access," "information systems," and "workforce." Also makes recommendations (usually five) in response to the opportunities for improvement.
H. Attachments
    a. Review Agenda
    b. Review Participants
    c. Approved Claims Source Data
    d. Medi-Cal Approved Claims Worksheets and Additional Tables
    e. PIP Validation Tool
    f. MHP PIPs Submitted

Appendix D. Performance measures regarding psychiatric inpatient services

Psychiatric inpatient hospitalization is among the drivers of the SMHS system's skewed spending on high-cost beneficiaries. For several years DHCS has instructed California's EQRO to collect and analyze data regarding use of psychiatric inpatient services and provision of follow-up services. Statewide performance indicators as of FY2010-11 are summarized here.

Background: Among Medi-Cal beneficiaries there were over 28,000 who had at least one psychiatric inpatient episode in 2009. To understand determinants of these services, the EQRO examines the frequency of inpatient episodes, the incidence of short-term recidivism, and other services following discharge from a psychiatric inpatient facility. Follow-up services after psychiatric inpatient episodes are tracked in accordance with the National Committee for Quality Assurance's HEDIS measures; use of these measures is not related to a contractual obligation by the MHP.

Inpatient Rates: The frequency of inpatient episodes demonstrates significant variation among MHPs. 90 percent of MHPs have inpatient rates (the number inpatient episodes per person-month of eligibility) below 0.11 percent, and most have rates much lower.

Inpatient recidivism: There is significant variation in the proportion of individuals requiring inpatient services who have another inpatient episode within seven days of discharge. For most MHPs, the figure is below ten percent. Nine MHPs had a rate of zero percent in 2009, while 20 had rates between eight and ten percent.

Expanding the window of time to 30 days shows clearer trends: For most MHPs (40), at least ten percent of individuals have another inpatient episode within 30 days of discharge. It is worth noting, however, that five MHPs maintain a zero percent recidivism rate.

Follow-up services: Provision of outpatient services following inpatient episodes indicates high-quality care and may reduce recidivism. Most MHPs provide reach less than half of the relevant population with follow-up services within a week of discharge, although 17 MHPs are able to reach 70 percent or more.

Within a month of discharge, most MHPs are able to reach at least 70 percent of individuals. Ten MHPs achieved rates above 80 percent, whereas at the low end of the range five MHPs had rates between 40 and 60 percent.

In California, follow-up services are usually mental health services, medication support, and case management. However, they may include intensive services such as crisis stabilization and day treatment. The EQRO notes that some MHPs provide a greater proportion of these intensive services - notably large MHPs in the South and Bay Area regions. In spite of these intensive services, recidivism rates in these counties remain high.

Conclusions: The EQRO notes that, when considering inpatient recidivism and connection to supportive follow-up services, small MHPs tend to perform best.

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Endnotes

[i] Arnquist and Harbage
[ii] *Ibid.*
[iii] Holt and Adams