

2024–25 MENTAL HEALTH PLAN FOSTER CARE ANALYSIS REPORT

December 2025



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COMMONLY USED ABBREVIATIONS AND ACRONYMS

Following is a list of abbreviations and acronyms used throughout this report.

- » **ADHD**—Attention Deficit/Hyperactivity Disorder
- » **CA WIC**—California Welfare and Institutions Code
- » **CFR**—Code of Federal Regulations
- » **CMS**—Centers for Medicare & Medicaid Services
- » **DHCS**—California Department of Health Care Services
- » **EDIM**—Enterprise Data and Information Management
- » **EQRO**—external quality review organization
- » **FC**—foster care
- » **FFS**—fee-for-service
- » **FY**—fiscal year
- » **HEDIS**^{®1}—Healthcare Effectiveness Data and Information Set
- » **HSAG**—Health Services Advisory Group, Inc.
- » **ICC**—intensive care coordination
- » **IHBS**—intensive home-based services
- » **MHP**—mental health plan
- » **NCQA**—National Committee for Quality Assurance
- » **POS**—Performance Outcome System
- » **SDMC**—Short-Doyle/Medi-Cal
- » **SMHS**—specialty mental health services
- » **TFC**—Therapeutic Foster Care
- » **§**—section

¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

EXECUTIVE SUMMARY



Introduction

The California Department of Health Care Services (DHCS) provides ongoing monitoring and oversight of its contracted Medi-Cal mental health plans (MHPs), including ensuring that Medi-Cal-eligible minors and non-minor dependents in foster care (FC) can access quality mental health services. Pursuant to California Welfare and Institutions Code (CA WIC) section (§)14717.5, DHCS contracted with its external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG), to conduct an analysis of specialty mental health services (SMHS) provided to Medi-Cal FC members.²

Key Findings

The FC Analysis examined 12 DHCS-calculated measure indicators to assess the SMHS provided to Medi-Cal FC members. The key findings of each measure indicator are outlined in Table 1.

Table 1—Measure Indicator Key Findings

Note: Fiscal years (FYs) range from July 1 through June 30 of the following year and are identified with the year of the ending date (e.g., FY 2022 represents July 1, 2021, through June 30, 2022). Measurement years are based on calendar years (e.g., measurement year 2023 represents January 1, 2023, through December 31, 2023).

| Measure Indicator | Key Finding |
|---|--|
| 1. <i>Number of FC Members Served by Medi-Cal Annually</i> | » The number of current FC members decreased from FY 2022 to FY 2023, while the number of former FC members increased. |
| 2. <i>Description of Specialty Mental Health Preventive and Treatment Services Covered by MHPs for FC Members</i> | » MHPs provided FC members with coverage for 18 specialty mental health preventive and treatment services during the reporting period. |

² California Legislative Information. CA WIC 14717.5. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14717.5.&nodeTreePath=16.6.24&lawCode=WIC. Accessed on: Oct 27, 2025.

| Measure Indicator | Key Finding |
|--|---|
| 3. <i>SMHS Penetration Rates</i> | <ul style="list-style-type: none"> » Statewide SMHS penetration rates were consistent from FY 2022 to FY 2023, varying based on age group and race but not varying based on gender. |
| 4. <i>Summary of SMHS Network Adequacy</i> | <ul style="list-style-type: none"> » The majority of MHPs did not meet all network adequacy standards. » Annual network adequacy reports used to evaluate this measure were only available at the MHP level and did not provide data specific to FC members.³ As a result, results may not fully capture FC member network adequacy. |
| 5. <i>Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase</i> | <ul style="list-style-type: none"> » FC members performed better than all Medi-Cal members and Centers for Medicare & Medicaid Services (CMS) national Medicaid 50th percentile benchmarks for all Healthcare Effectiveness Data and Information Set (HEDIS) measures evaluated from FY 2019 to FY 2023. » FC members performed better than all Medi-Cal members on medication monitoring measures, referenced in CA WIC §14717.5(a)(8) (Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics and Metabolic Monitoring for Children and Adolescents on Antipsychotics). |
| 6. <i>Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase</i> | |
| 7. <i>Follow-Up After Hospitalization for Mental Illness, Ages 6–17—7-Day Follow-Up</i> | |
| 8. <i>Follow-Up After Hospitalization for Mental Illness, Ages 6–17—30-Day Follow-Up</i> | |

³ California Department of Health Care Services. Network Adequacy. Available at: <https://www.dhcs.ca.gov/formsandpubs/Documents/2023-BH-MC-NAAAR-ANC.xlsx>. Accessed on: Oct 14, 2025.

| Measure Indicator | Key Finding |
|--|--|
| 9. <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i> | <ul style="list-style-type: none"> » CMS national Medicaid 50th percentile benchmark data were reported on a calendar year basis, while the DHCS-reported FC rates were reported by FY. As a result, rate comparisons should be interpreted with caution. |
| 10. <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i> | |
| 11. <i>Availability of Interpretation and Translation Services (Language Capacity)</i> | <ul style="list-style-type: none"> » All MHPs indicated that they are prepared to offer translation and interpretation services to FC members upon request. |
| 12. <i>FC Member Utilization of SMHS</i> | <ul style="list-style-type: none"> » The SMHS with the highest average utilization per FC member were therapeutic FC (TFC), full-day treatment intensive services, and therapeutic behavioral services. |

METHODOLOGY



This section outlines the methodology HSAG employed to conduct the FC Analysis, including the DHCS-calculated measure indicators, data sources, analytic methodology, and limitations.

Measure Indicators

The FC Analysis assessed 12 DHCS-calculated measure indicators, outlined in Table 2 with the associated CA WIC §14717.5 reporting elements.⁴

Table 2—DHCS-Calculated Measure Indicators

| DHCS-Calculated Measure Indicator | CA WIC Reporting Element |
|---|--------------------------|
| 1. <i>Number of FC Members Served by Medi-Cal Annually</i> | (a)(1) |
| 2. <i>Description of Specialty Mental Health Preventive and Treatment Services Covered by MHPs for FC Members</i> | (a)(2) |
| 3. <i>SMHS Penetration Rates</i> | (a)(3) |
| 4. <i>Summary of SMHS Network Adequacy</i> | (a)(3) |
| 5. <i>Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase</i> | (a)(4), (a)(6), (a)(8) |
| 6. <i>Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase</i> | (a)(4), (a)(6), (a)(8) |
| 7. <i>Follow-Up After Hospitalization for Mental Illness, Ages 6–17—7-Day Follow-Up</i> | (a)(4), (a)(6), (a)(8) |
| 8. <i>Follow-Up After Hospitalization for Mental Illness, Ages 6–17—30-Day Follow-Up</i> | (a)(4), (a)(6), (a)(8) |
| 9. <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i> | (a)(4), (a)(6), (a)(8) |

⁴ The *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* measure was included in the DHCS-approved Scope of Work/Methodology; however, it is not included in this report. This measure was retired from the CMS Core Set in 2019, and there is a pending legislative request to remove the measure from CA WIC §14717.5; therefore, DHCS directed the removal of the measure from the analysis.

| DHCS-Calculated Measure Indicator | CA WIC Reporting Element |
|--|--------------------------|
| 10. <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i> | (a)(4), (a)(6), (a)(8) |
| 11. <i>Availability of Interpretation and Translation Services (Language Capacity)</i> | (a)(5) |
| 12. <i>FC Member Utilization of SMHS</i> | (a)(7) |

Data Sources

Table 3 outlines the data sources utilized in the FC Analysis and the applicable FYs or measurement years reported for each measure indicator.

Table 3—Data Sources

Note: FYs range from July 1 through June 30 of the following year and are identified with the year of the ending date (e.g., FY 2022 represents July 1, 2021, through June 30, 2022). Measurement years are based on calendar years (e.g., measurement year 2023 represents January 1, 2023, through December 31, 2023).

| DHCS-Calculated Measure Indicator | Data Source | Measurement Period |
|---|--|--------------------|
| 1. <i>Number of FC Members Served by Medi-Cal Annually</i> | » Counts of FC members served by Medi-Cal annually, obtained by request to DHCS Enterprise Data and Information Management (EDIM) for 2022 and 2023 data used for the Performance Outcome System (POS) | FYs 2022 and 2023 |
| 2. <i>Description of Specialty Mental Health Preventive and Treatment Services Covered by MHPs for FC Members</i> | » POS back-end data | FY 2023 |

| DHCS-Calculated Measure Indicator | Data Source | Measurement Period |
|--|--|---------------------------------|
| 3. <i>SMHS Penetration Rates</i> | » POS back-end data | FYs 2022 and 2023 |
| 4. <i>Summary of SMHS Network Adequacy</i> | » Annual Network Adequacy Reports | FY 2024 |
| 5. <i>Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase</i> | » Publicly posted HEDIS measure calculations | FYs 2019–2022 |
| 6. <i>Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase</i> | » Publicly posted HEDIS measure calculations | FYs 2019–2022 |
| 7. <i>Follow-Up After Hospitalization for Mental Illness, Ages 6–17—7-Day Follow-Up</i> | » Publicly posted HEDIS measure calculations | FYs 2019–2022 |
| 8. <i>Follow-Up After Hospitalization for Mental Illness, Ages 6–17—30-Day Follow-Up</i> | » Publicly posted HEDIS measure calculations | FYs 2019–2022 |
| 9. <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i> | » Publicly posted HEDIS measure calculations | FYs 2019–2022 |
| 10. <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i> | » Publicly posted HEDIS measure calculations | FYs 2019–2022 |
| 11. <i>Availability of Interpretation and Translation Services (Language Capacity)</i> | » MHP-provided translation and interpretation services information | Measurement Years 2023 and 2024 |
| 12. <i>FC Member Utilization of SMHS</i> | » POS back-end data | FYs 2022 and 2023 |

Counts of FC Members Served by Medi-Cal Annually

DHCS provided annual counts of FC members served by Medi-Cal, obtained by request to DHCS EDIM for 2022 and 2023 data used for the POS.

Children and Youth in FC SMHS Performance Dashboard/POS Back-End Data

The Children and Youth in FC SMHS Performance Dashboard contains data on mental health outcomes for children and youth in FC, including:⁵

- » Demographic data reporting counts of members utilizing and eligible for SMHS and penetration rates by age, race, and gender.
- » Utilization data reporting counts of members who received SMHS by type, total dollars approved, and total approved length of SMHS.

DHCS provided the POS back-end data that populate the Children and Youth in FC SMHS Performance Dashboard. HSAG used these POS back-end data to conduct the analysis.

Publicly Posted HEDIS Measure Calculations

DHCS calculated and reported behavioral health quality of care HEDIS measures for Medi-Cal FC children, including *Follow-Up Care for Children Prescribed ADHD Medication (Initiation and Continuation Phases)*, *Follow-Up After Hospitalization for Mental Illness (7-Day and 30-Day Follow-Up)*, *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*, and *Metabolic Monitoring for Children and Adolescents on Antipsychotics*.⁶ HSAG used these rates to report on service quality and medication monitoring utilization.

⁵ California Department of Health Care Services. Children and Youth in Foster Care SMHS Performance Dashboard. Available at: <https://behavioralhealth-data.dhcs.ca.gov/pages/fc-smhs-performance-dashboard>. Accessed on: Oct 27, 2025.

⁶ California Department of Health Care Services. Quality of Care Measures in Foster Care. Available at: <https://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx>. Accessed on: Oct 27, 2025.

Annual Network Adequacy Reports

Annual Network Adequacy Reports outlined MHPs meeting or failing to meet required standards for access to mental health care.⁷

MHP Translation and Interpretation Services Information

In July 2025, HSAG contacted MHPs via email to request that they complete a brief questionnaire regarding the translation and interpretation services available to FC members since January 2023. In August and September 2024, 54 MHPs completed the questionnaire, providing written descriptions of available services. Up to nine rounds of follow-up outreach were conducted for two non-responsive plans to gather their information before determining to exclude these plans from this portion of the analysis.

Analysis

The FC Analysis assessed all data to identify deficiencies in the SMHS provided to Medi-Cal-eligible minors and non-minor dependents in FC, consistent with CA WIC §14717.5.

DHCS provided MHP-level data for HSAG to use to assess SMHS penetration rates. Analysis individually identified high- and low- performing MHPs through quintiles. MHPs in Quintile 1 (e.g., the lowest rates) were considered relatively low performing plans, while MHPs in Quintile 5 (e.g., the highest rates) were considered relatively high-performing plans.

For standardized HEDIS and/or CMS Core Set performance measures, comparisons were made between DHCS-calculated statewide rates and the national Medicaid performance measure rates published on the Medicaid Open Data website, stratified by Medi-Cal members and FC youth.⁸

⁷ California Department of Health Care Services. Network Adequacy. Available at: <https://www.dhcs.ca.gov/formsandpubs/Documents/2023-BH-MC-NAAAR-ANC.xlsx>. Accessed on: Oct 27, 2025.

⁸ Centers for Medicare & Medicaid Services. 2022 Child and Adult Health Care Quality Measures Quality. Available at: <https://data.medicare.gov/dataset/dfd13757-d763-4f7a-9641-3f06ce21b4c6>. Accessed on: Oct 27, 2025.

Qualitative Synthesis

Relevant MHP representatives responded to targeted email outreach and provided descriptions of the translation and interpretation services available to FC members since January 2023. MHPs completed a brief questionnaire containing open-ended questions to maximize the diversity and richness of responses, ensuring a holistic understanding of each MHP's service array.

HSAG imported responses into MAXQDA, a qualitative data analysis software. Within MAXQDA, data were extracted, aggregated, summarized, and analyzed using open coding techniques to identify key themes and concepts raised by MHPs. The resulting coding system and analysis informed written synthesis of the translation and interpretation services offered.

Limitations

Two primary limitations were encountered during the development of the FC Analysis Report.

- » Annual Network Adequacy Reports were only available at the MHP level and did not provide data specific to the FC population. Consequently, results may not fully capture FC member network adequacy.
- » National HEDIS and/or CMS Core Set performance measure benchmark data were reported on a calendar year basis, while the DHCS-reported FC rates were reported by FY. As a result, rate comparisons should be interpreted with caution.

FINDINGS



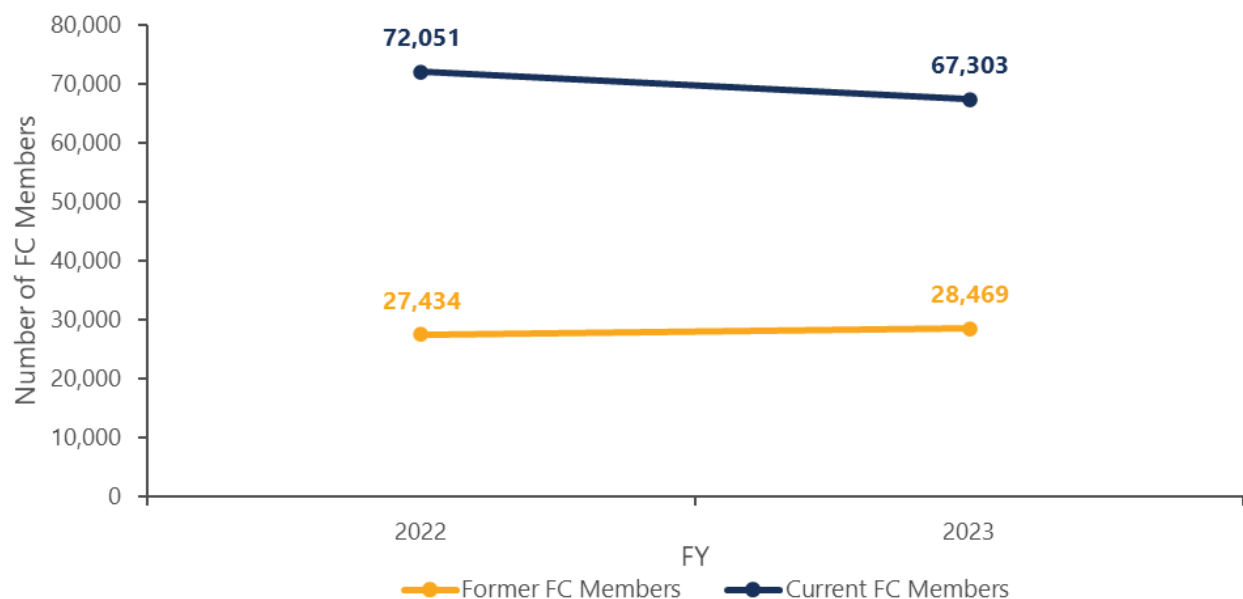
Findings

This section presents the findings of the FC Analysis by measure indicator.

Number of FC Members Served by Medi-Cal Annually (Measure 1)

Figure 1 displays the number of former and current FC members in FYs 2022 and 2023. The number of former FC members increased from 27,434 to 28,469 (3.8 percent), while the number of current FC members decreased from 72,051 to 67,303 (6.6 percent).

Figure 1—FC Member Count



Description of Specialty Mental Health Preventive and Treatment Services Covered by MHPs for FC Members (Measure 2)

MHPs provided FC members with coverage for a range of SMHS during the reporting period, described in Table 4.

Table 4—SMHS Description

| Service | Description ⁹ |
|---|--|
| Adult Residential Treatment Services ¹⁰ | <ul style="list-style-type: none"> » Non-institutional residential rehabilitative services to support independence for members at risk of hospitalization/institutional placement. Activities include assessment, plan development, therapy, rehabilitation, and collateral.¹¹ |
| Behavioral Health Prevention Education Services ¹² | <ul style="list-style-type: none"> » Group environment teaching members coping and problem-solving skills. Activities promote socialization, recovery, self-sufficiency and advocacy, and skill maintenance. |
| Case Management/Brokerage | <ul style="list-style-type: none"> » Services promoting access to medical, educational, social, rehabilitative, or other community services, including communication, coordination, and referral; service delivery monitoring; and member progress, placement, and plan development monitoring. |

⁹ California Department of Health Care Services. 2021 Performance Outcomes System Measures Catalog. Available at: https://www.dhcs.ca.gov/Documents/CSD_YV/MHSA/MeasuresCatalog-Mar2021.pdf. Accessed on: Oct 27, 2025.

¹⁰ Adults include members who are ages 21 years and older. This service may not be applicable to most FC youth.

¹¹ For the definitions of assessment, collateral, plan development, rehabilitation, and therapy, please see the DHCS Performance Outcomes System Measures Catalogue available at: https://www.dhcs.ca.gov/Documents/CSD_YV/MHSA/MeasuresCatalog-Mar2021.pdf. Accessed on: Oct 27, 2025.

¹² County of San Diego HHS Behavioral Health Services. Billing Codes for Certified Peer Support Specialist Services. Available at: <https://optumsandiego.com/content/dam/san-diego/documents/calaim/peer-support/San%20Diego%20Certified%20Peer%20Support%20Specialists%20%E2%80%93%20BILLING%20CODES%20.pdf>. Accessed on: Oct 27, 2025.

| Service | Description ⁹ |
|---------------------------------------|--|
| Crisis Intervention/Stabilization | <ul style="list-style-type: none"> » Services provided for less than 24 hours for conditions requiring a timelier response than a scheduled visit. Activities include assessment, collateral, and therapy. |
| Crisis Residential Treatment Services | <ul style="list-style-type: none"> » Alternative to acute psychiatric hospital services for members who otherwise would require hospitalization, providing integrated emergency psychiatric care, psychosocial rehabilitation, case management, and social work in residential communities. |
| Full-Day Rehabilitation | <ul style="list-style-type: none"> » Structured rehabilitation and therapy to improve, maintain, or restore independence and functioning. Activities include assessment, plan development, therapy, rehabilitation, and collateral. |
| Full-Day Treatment Intensive | <ul style="list-style-type: none"> » Structured multi-disciplinary therapy to maintain members in the community rather than hospitalization or a more restrictive setting. Activities include assessment, plan development, therapy, rehabilitation, and collateral. |
| Hospital Inpatient ¹³ | <ul style="list-style-type: none"> » Services provided in an acute psychiatric hospital or an acute psychiatric portion of a general hospital to provide medically necessary psychiatric services. |

¹³ California Department of Health Care Services. Mental Health Services Division Medi-Cal Billing Manual. Available at: <https://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/MH-Billing-Manual-2019.pdf>. Accessed on: Nov 25, 2025.

| Service | Description ⁹ |
|---|---|
| Inpatient Administrative Day Services ¹⁴ | <ul style="list-style-type: none"> » Services for members who, during a hospital stay, meet medical necessity criteria for acute psychiatric inpatient hospital services; however, there is no appropriate treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of five appropriate, non-acute treatment facilities per week. |
| Intensive Care Coordination | <ul style="list-style-type: none"> » Targeted coordination services for members under age 21 years who meet medical necessity criteria. Service components include assessing; planning and implementation; monitoring and adapting; transition; and establishing the Child and Family Team. |
| Intensive Home-Based Services | <ul style="list-style-type: none"> » Individualized interventions to improve mental health conditions and help build skills to function in the home and community. Activities include assessment, plan development, therapy, rehabilitation, and collateral. |
| Medication Support Services | <ul style="list-style-type: none"> » Services include prescribing, administering, dispensing, and monitoring psychiatric medications. Activities include evaluating need; evaluating clinical effectiveness and side effects; obtaining informed consent; instructing use, risks, benefits of, and alternatives to medication; collateral and plan development; prescribing, administering, dispensing, and monitoring psychiatric medications; and education. |

¹⁴ Ibid.

| Service | Description ⁹ |
|--------------------------------------|--|
| Psychiatric Health Facility | <ul style="list-style-type: none"> » Therapeutic and/or rehabilitative services provided in a psychiatric health facility to members who need acute care and whose physical health needs can be met in a hospital or outpatient setting. |
| Self-Help Peer Service ¹⁵ | <ul style="list-style-type: none"> » Individual and group services promoting recovery, resiliency, engagement, socialization, self-sufficiency and advocacy, support, and steps to achieve goals. Activities include coaching, linking to community resources, and member and family education. |
| TFC | <ul style="list-style-type: none"> » Rehabilitative mental health services, including plan development, rehabilitation, collateral, and crisis intervention provided to members up to age 21 years in a residential treatment foster home and meeting medical necessity criteria. |
| Therapeutic Behavioral Services | <ul style="list-style-type: none"> » Intensive, individualized, and short-term outpatient treatment for members up to age 21 years with serious emotional disturbance who are experiencing a stressful transition or life crisis and need short-term support services. |

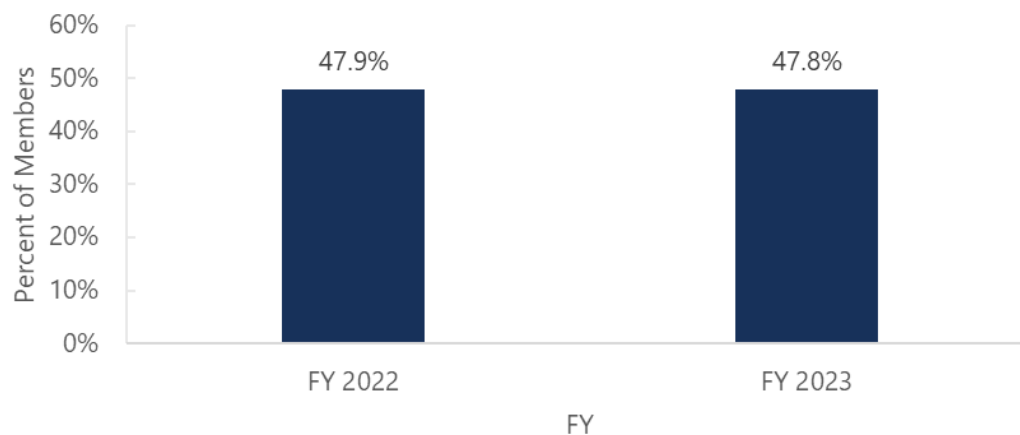
¹⁵ California Department of Health Care Services. CalAIM Approval Letter. Available at: <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Approval-Letter-Technical-Corrections-and-Attachments.pdf>. Accessed on: Oct 27, 2025.

| Service | Description ⁹ |
|--|---|
| Therapy and Other Service Activities ¹⁶ | <ul style="list-style-type: none"> » Individual or group therapies and interventions to reduce mental disability and improve or maintain functioning, development, independent living, and self-sufficiency. Activities include assessment, plan development, therapy, rehabilitation, and collateral. |

SMHS Penetration Rates (Measure 3)

Figure 2 displays statewide SMHS penetration rates in FYs 2022 and 2023.¹⁷ Statewide penetration rates remained stable, with over 47 percent of FC members receiving at least one SMHS in FYs 2022 and 2023. Neither higher nor lower rates indicate better performance.

Figure 2—SMHS Penetration Rates, Statewide



¹⁶ Therapy and Other Service Activities were formerly referred to as Mental Health Services. For consistency with verbiage utilized in the 2021 DHCS Performance Measures Catalog, these services are labeled Therapy and Other Service Activities throughout this report. California Department of Health Care Services. 2021 Performance Outcomes System Measures Catalog. Available at: https://www.dhcs.ca.gov/Documents/CSD_YV/MHSA/MeasuresCatalog-Mar2021.pdf. Accessed on: Nov 25, 2025.

¹⁷ SMHS penetration rates were calculated as the percentage of SMHS-eligible FC members who received at least one SMHS in a FY.

Figure 3 displays SMHS penetration rates by age group for FYs 2022 and 2023. Children ages 6 to 11 years and ages 12 to 17 years had the highest penetration rates at over 58 percent. SMHS penetration rates were consistent between FYs 2022 and 2023 across all age groups.

Figure 3—SMHS Penetration Rates, by Age Group

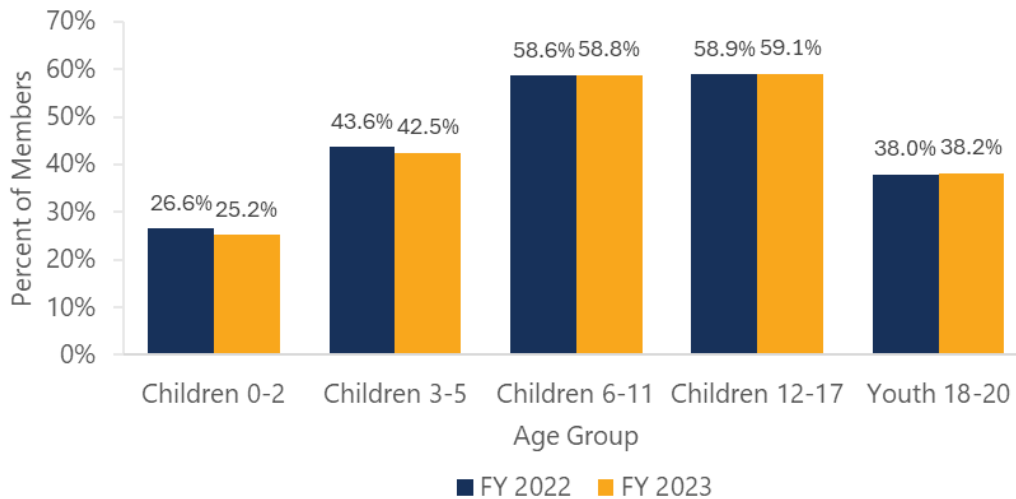


Figure 4 displays FYs 2022 and 2023 SMHS penetration rates by race. Black FC members had the highest penetration rates at over 51 percent in both years. Hispanic and White FC member penetration rates were slightly lower at over 48 percent and 46 percent, respectively. SMHS penetration rates were consistent between FYs 2022 and 2023 across all race stratifications.

Figure 4—SMHS Penetration Rates, by Race

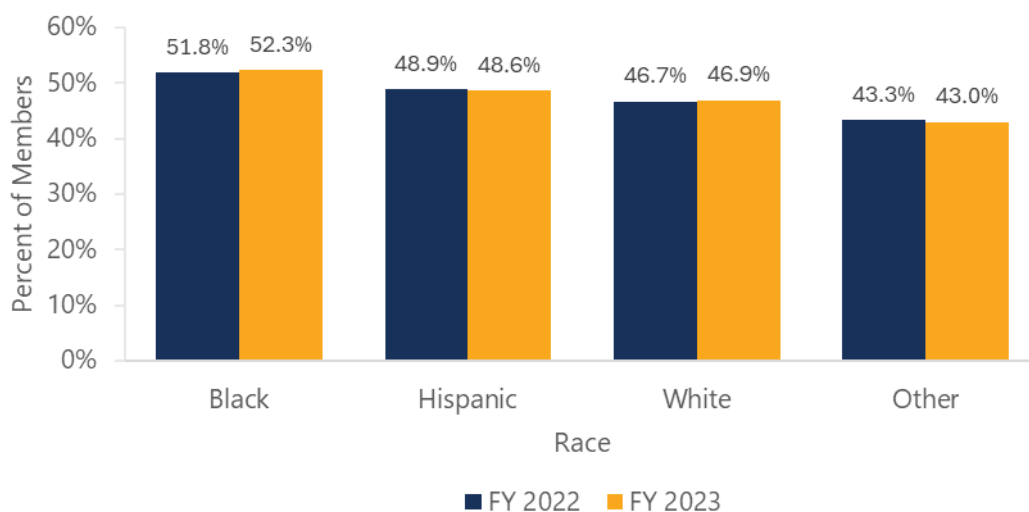


Figure 5 displays FYs 2022 and 2023 SMHS penetration rates by sex. Female FC members had slightly higher penetration rates than male FC members in both years. The difference increased slightly in FY 2023, when female SMHS penetration rates were greater than male SMHS penetration rates by 2.2 percentage points (48.9 percent and 46.7 percent, respectively).

Figure 5—SMHS Penetration Rates, by Sex

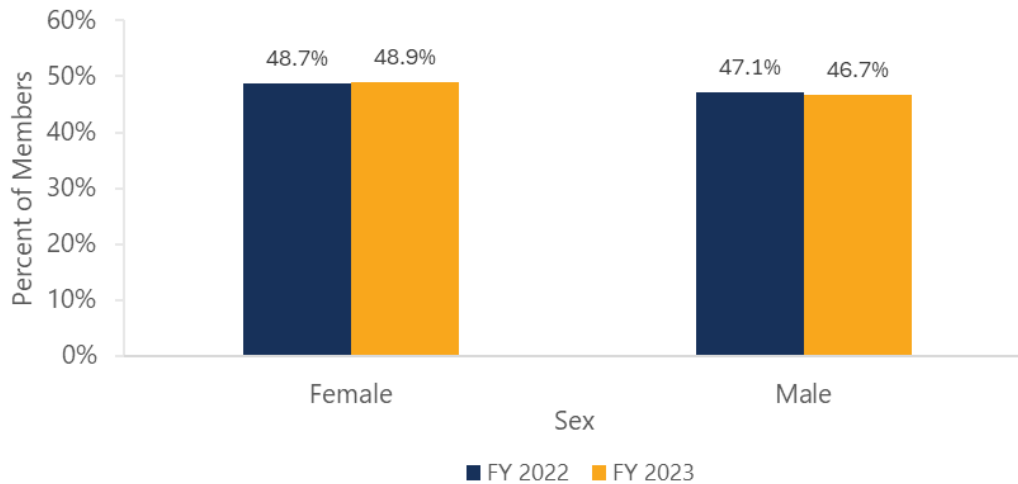


Table 6 displays SMHS penetration rates by county for FYs 2022 and 2023. County SMHS penetration rates were shaded based on the corresponding quintile, displayed in Table 5. Out of 57 counties, 28 had SMHS penetration rates in the same quintile in FYs 2022 and 2023. Penetration rates for 14 counties increased in quintiles from FY 2022 to FY 2023, while 12 counties’ rates decreased across quintiles. Modoc County experienced the largest increase of 21.96 percentage points, from 37.50 percent in FY 2022 to 59.46 percent in FY 2023.

Table 5—SMHS Penetration Rates Quintiles

| |
|---|
| ▼ Below the 20th percentile |
| ◀ At or above the 20th percentile but below the 40th percentile |
| ▶ At or above the 40th percentile but below the 60th percentile |
| ▲ At or above the 60th percentile but below the 80th percentile |
| ◆ At or above the 80th percentile |

Table 6—SMHS Penetration Rates by County

Note: Cells containing numerators or denominators between one and 30 were suppressed to ensure anonymity and are represented with a dash (—). No SMHS penetration rate data were available for Alpine County MHP.

| County | FY 2022 Penetration Rate | FY 2023 Penetration Rate |
|--------------|--------------------------|--------------------------|
| Alameda | ◆56.59% | ◆52.36% |
| Amador | ▲45.56% | ◆60.26% |
| Butte | ◆51.83% | ▲48.46% |
| Calaveras | ▶42.62% | ▲48.78% |
| Colusa | ▶43.86% | ▼25.93% |
| Contra Costa | ▲47.92% | ▲44.93% |
| Del Norte | ◀34.90% | ◀37.41% |
| El Dorado | ◀37.83% | ▼32.41% |
| Fresno | ◆53.87% | ◆52.33% |
| Glenn | ▶42.86% | ▼28.38% |
| Humboldt | ▼28.74% | ▼30.53% |
| Imperial | ▲45.04% | ▶40.66% |
| Inyo | — | — |
| Kern | ▲48.43% | ▲48.35% |
| Kings | ◀36.53% | ▶41.55% |
| Lake | ◀35.61% | ▼27.91% |
| Lassen | ▼28.95% | ◀36.71% |
| Los Angeles | ◆56.19% | ◆56.02% |
| Madera | ▶38.83% | ▶39.67% |
| Marin | ▲45.13% | ▲50.00% |
| Mariposa | ▼32.26% | ▶41.30% |
| Mendocino | ◀36.87% | ▶40.60% |
| Merced | ▼31.91% | ◀34.39% |
| Modoc | ◀37.50% | ◆59.46% |

| County | FY 2022 Penetration Rate | FY 2023 Penetration Rate |
|-----------------|--------------------------|--------------------------|
| Mono | — | — |
| Monterey | ▲45.88% | ▲44.88% |
| Napa | ▶40.12% | ▲45.93% |
| Nevada | ▲44.57% | ◀35.16% |
| Orange | ▼33.01% | ◀34.89% |
| Placer | ◀38.39% | ▼32.30% |
| Plumas | ◆54.00% | ◆56.41% |
| Riverside | ▶42.35% | ▶43.43% |
| Sacramento | ◀34.75% | ◀33.05% |
| San Benito | ▲47.46% | ▶41.30% |
| San Bernardino | ◆49.89% | ◆50.84% |
| San Diego | ◀33.68% | ◀33.17% |
| San Francisco | ◆65.23% | ◆67.78% |
| San Joaquin | ◆50.79% | ◆53.43% |
| San Luis Obispo | ▲49.47% | ▲47.73% |
| San Mateo | ▲50.00% | ◆53.63% |
| Santa Barbara | ◆56.00% | ▲48.49% |
| Santa Clara | ◆55.28% | ◆52.92% |
| Santa Cruz | ▲47.00% | ▶43.66% |
| Shasta | ▶43.19% | ▶42.21% |
| Sierra | — | — |
| Siskiyou | ◀36.67% | ▼31.11% |
| Solano | ▶43.44% | ▶42.62% |
| Sonoma | ▼31.93% | ◀37.87% |
| Stanislaus | ▶40.22% | ▶41.71% |
| Sutter | ▼20.31% | ▼24.86% |
| Tehama | ▼32.39% | ▼28.57% |

| County | FY 2022 Penetration Rate | FY 2023 Penetration Rate |
|----------|--------------------------|--------------------------|
| Trinity | ▶ 40.43% | ◆ 54.05% |
| Tulare | ▼ 29.87% | ▼ 31.53% |
| Tuolumne | ▼ 20.00% | ◀ 35.90% |
| Ventura | ▲ 47.90% | ▲ 48.11% |
| Yolo | ▲ 46.15% | ▲ 45.76% |
| Yuba | ▼ 21.13% | ▼ 26.12% |

Summary of SMHS Network Adequacy (Measure 4)

HSAG used the 2023 Network Adequacy Report to summarize county MHP network adequacy compliance established in Title 42 of the Code of Federal Regulations (CFR) §438.68.¹⁸ The five compliance standards assessed are listed below:

- » **Network capacity/composition** assessed whether MHPs maintained a network sufficient to provide adequate access to all members within a community through calculating provider-to-member ratios for outpatient SMHS and psychiatry services.
- » **Time or distance** standards were met if 85 percent of members resided within the required maximum time needed to travel to outpatient SMHS and psychiatric providers, stratified by county type.¹⁹
- » **Timely access** standards assessed the time to the first appointment or first SMHS with non-urgent non-psychiatry, urgent non-psychiatry, non-urgent psychiatry, and urgent psychiatry providers based on the DHCS-developed Timely Access Data Tool submitted by each MHP.
- » **Language capacity** assessed whether MHPs had at least one subcontractor for interpretation and language line services.

¹⁸ Annual Network Adequacy reports were only available at the MHP level and did not provide data specific to FC members. Consequently, results may not fully capture FC member network adequacy.

¹⁹ The maximum time to travel for outpatient SMHS is 30 minutes in large counties, 60 minutes in medium counties, 75 minutes in small counties, and 90 minutes in rural counties. The maximum distance to travel for psychiatric providers is 15 miles in large counties, 30 miles in medium counties, 45 miles in small counties, and 60 miles in rural counties.

- » **Mandatory provider type** standards assessed whether an MHP had sufficient Indian Health Care Providers (IHCPs) participating in its provider network and/or demonstrated that it made a good faith effort to contract with IHCPs in the county.

Table 7 displays compliance standards met by each MHP, indicated by a checkmark. MHPs operating in seven counties—Amador, El Dorado, Imperial, Merced, Modoc, Napa, and Sacramento—complied with all five network adequacy standards. On average, MHPs were compliant with 3.6 network adequacy standards out of five. Time or Distance standards had the most MHPs meeting compliance (94.6 percent), followed by Language Assistance Capabilities (92.9 percent), Mandatory Provider Types (85.7 percent), Network Capacity and Composition (70.2 percent), and Timely Access (16.1 percent).

Table 7—Network Adequacy Compliance

Note: Blank cells indicate that the MHP did not meet the compliance standards.

| County | Network Capacity/Composition | Time or Distance | Timely Access | Language Assistance Capability | Mandatory Provider Types | All |
|--------------|------------------------------|------------------|---------------|--------------------------------|--------------------------|-----|
| Alameda | | ✓ | | ✓ | ✓ | |
| Alpine | ✓ | | | | ✓ | |
| Amador | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Butte | | ✓ | | ✓ | ✓ | |
| Calaveras | ✓ | ✓ | | ✓ | ✓ | |
| Colusa | ✓ | ✓ | ✓ | ✓ | | |
| Contra Costa | ✓ | ✓ | | ✓ | ✓ | |
| Del Norte | ✓ | ✓ | | ✓ | ✓ | |
| El Dorado | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Fresno | ✓ | ✓ | | ✓ | ✓ | |
| Glenn | ✓ | ✓ | | ✓ | ✓ | |
| Humboldt | ✓ | ✓ | | ✓ | ✓ | |
| Imperial | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

| County | Network Capacity/ Composition | Time or Distance | Timely Access | Language Assistance Capability | Mandatory Provider Types | All |
|----------------|-------------------------------|------------------|---------------|--------------------------------|--------------------------|-----|
| Inyo | | | | | | |
| Kern | | ✓ | | ✓ | ✓ | |
| Kings | ✓ | ✓ | | ✓ | | |
| Lake | ✓ | ✓ | ✓ | ✓ | | |
| Lassen | ✓ | ✓ | | ✓ | ✓ | |
| Los Angeles | ✓ | ✓ | | ✓ | ✓ | |
| Madera | ✓ | ✓ | | | ✓ | |
| Marin | | ✓ | | ✓ | ✓ | |
| Mariposa | ✓ | ✓ | | ✓ | ✓ | |
| Mendocino | | ✓ | | ✓ | ✓ | |
| Merced | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Modoc | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mono | ✓ | ✓ | | ✓ | | |
| Monterey | | ✓ | | ✓ | ✓ | |
| Napa | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Nevada | ✓ | ✓ | | ✓ | ✓ | |
| Orange | ✓ | ✓ | | ✓ | ✓ | |
| Placer/Sierra | ✓ | ✓ | | ✓ | ✓ | |
| Plumas | | ✓ | | ✓ | ✓ | |
| Riverside | | ✓ | | ✓ | ✓ | |
| Sacramento | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| San Benito | ✓ | ✓ | | ✓ | ✓ | |
| San Bernardino | | ✓ | | ✓ | ✓ | |
| San Diego | | ✓ | | ✓ | ✓ | |

| County | Network Capacity/ Composition | Time or Distance | Timely Access | Language Assistance Capability | Mandatory Provider Types | All |
|-----------------|-------------------------------|------------------|---------------|--------------------------------|--------------------------|-----|
| San Francisco | ✓ | ✓ | | ✓ | ✓ | |
| San Joaquin | ✓ | ✓ | | ✓ | ✓ | |
| San Luis Obispo | ✓ | ✓ | | ✓ | ✓ | |
| San Mateo | ✓ | ✓ | | ✓ | ✓ | |
| Santa Barbara | ✓ | ✓ | | ✓ | ✓ | |
| Santa Clara | ✓ | ✓ | | ✓ | ✓ | |
| Santa Cruz | ✓ | ✓ | | ✓ | ✓ | |
| Shasta | ✓ | ✓ | | ✓ | ✓ | |
| Siskiyou | | ✓ | | ✓ | | |
| Solano | ✓ | ✓ | | ✓ | ✓ | |
| Sonoma | ✓ | ✓ | | ✓ | ✓ | |
| Stanislaus | | ✓ | | | ✓ | |
| Sutter/Yuba | | ✓ | | ✓ | ✓ | |
| Tehama | | ✓ | | ✓ | ✓ | |
| Trinity | | | | ✓ | | |
| Tulare | ✓ | ✓ | | ✓ | | |
| Tuolumne | ✓ | ✓ | | ✓ | ✓ | |
| Ventura | | ✓ | | ✓ | ✓ | |
| Yolo | ✓ | ✓ | | ✓ | ✓ | |

HEDIS Performance Measures

Six DHCS-calculated HEDIS performance measures were evaluated for FC members and all Medi-Cal members, and compared against the CMS national Medicaid 50th percentile benchmark:²⁰

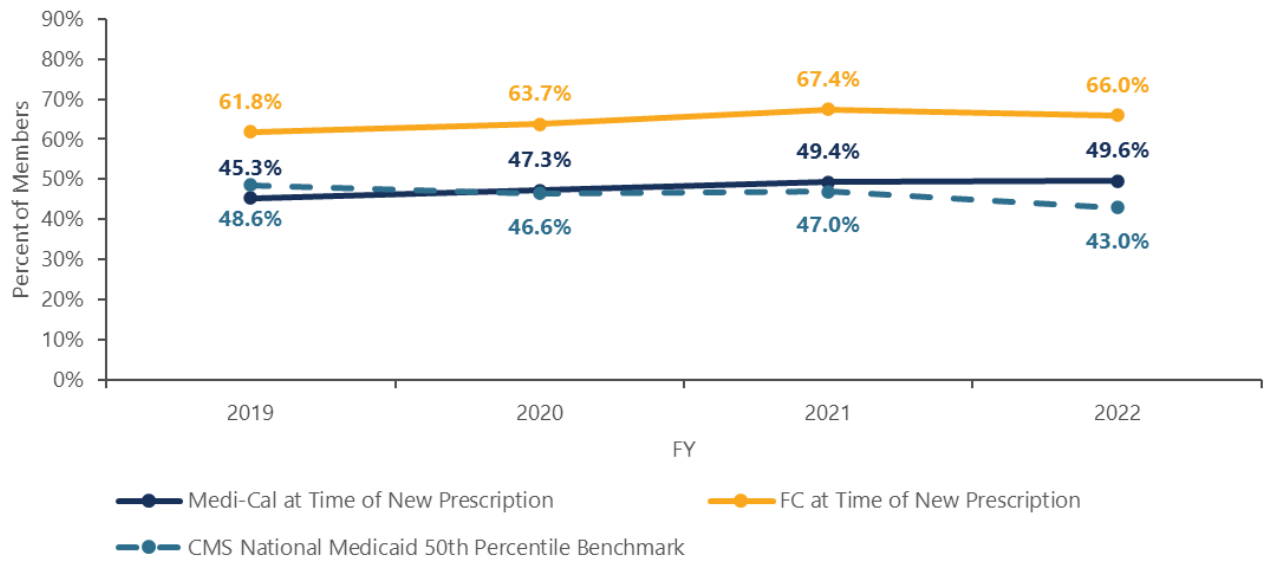
- » *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- » *Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase*
- » *Follow-Up After Hospitalization for Mental Illness, Ages 6–17—7-Day Follow-Up*
- » *Follow-Up After Hospitalization for Mental Illness, Ages 6–17—30-Day Follow-Up*
- » *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*
- » *Metabolic Monitoring for Children and Adolescents on Antipsychotics*

Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (Measure 5)

Figure 6 displays rates for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* from FY 2019 to FY 2022. FC members ages 6 to 12 years at time of new prescription had higher rates of ADHD medication follow-up care at the initiation phase than all Medi-Cal members. The difference between FC and all Medi-Cal members was at least 16 percentage points for each FY. Medi-Cal member rates were comparable to the CMS national Medicaid 50th percentile benchmark.

²⁰ CMS national Medicaid HEDIS and/or CMS Core Set performance measure benchmark data were reported on a calendar year basis (e.g., January 1 through December 31), while the DHCS-reported FC rates were reported by FY (e.g., July 1 through June 30). As a result, all CMS national Medicaid benchmark rate comparisons should be interpreted with caution.

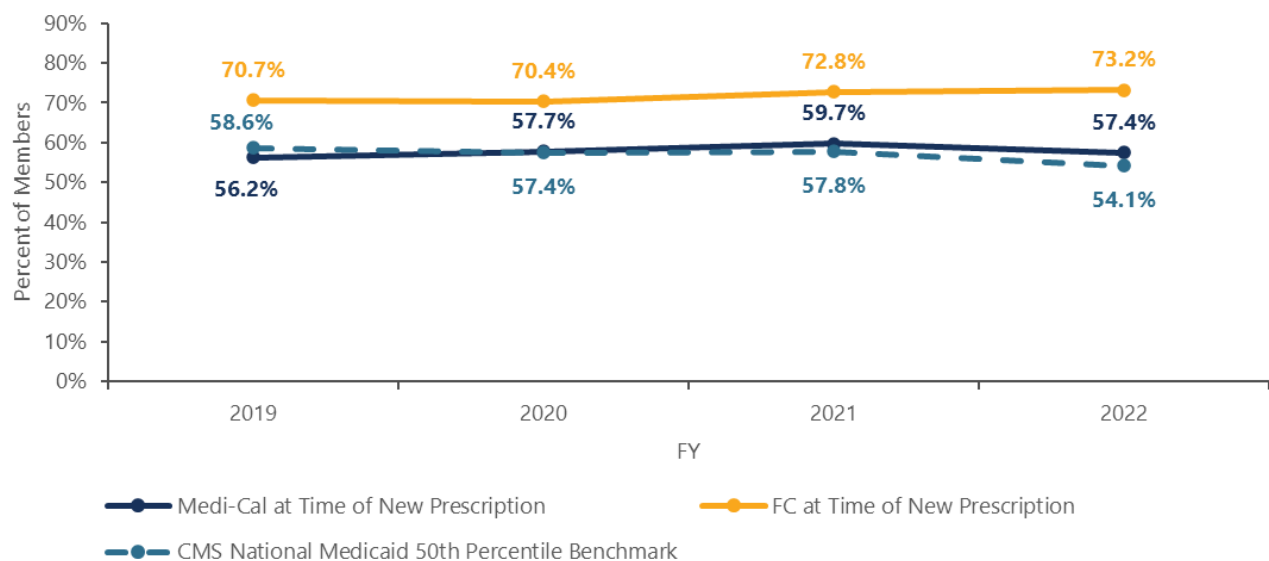
Figure 6—ADHD Medication Follow-Up, Initiation Phase, Ages 6–12



Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase (Measure 6)

Figure 7 displays rates for *Follow-Up Care for Children Prescribed ADHD—Continuation Phase*. FC members ages 6 to 12 years at time of new prescription had higher rates of ADHD medication follow-up care at the continuation phase than all Medi-Cal members from FY 2019 to FY 2022. The difference between FC and all Medi-Cal members was at least 12 percentage points for each FY. Medi-Cal member rates were comparable to the CMS national Medicaid 50th percentile benchmark.

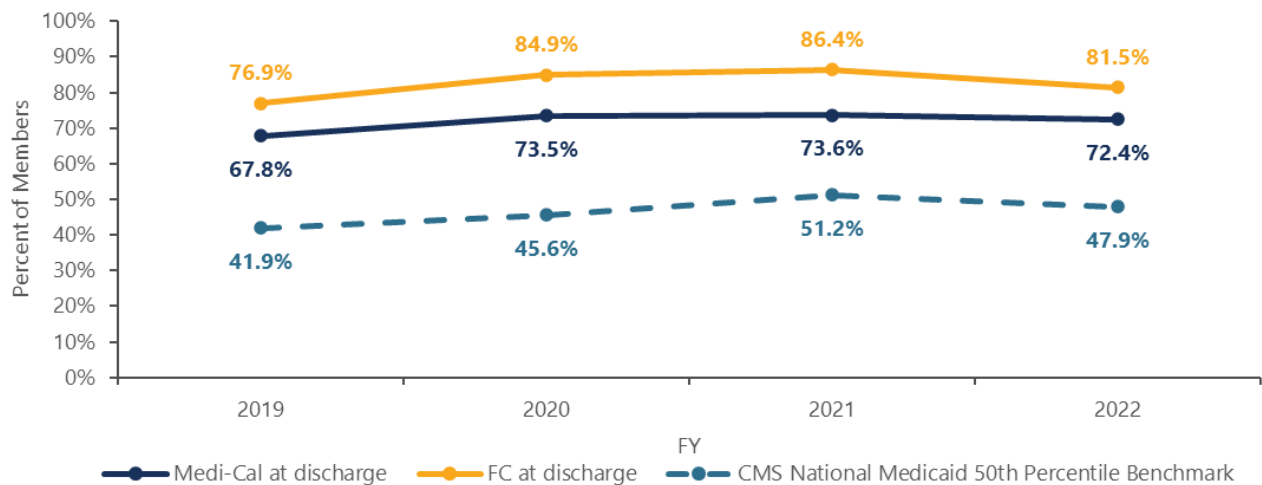
Figure 7—ADHD Medication Follow-Up, Continuation Phase, Ages 6–12



Follow-Up After Hospitalization for Mental Illness, Ages 6–17 (7-Day Follow-Up) (Measure 7)

Figure 8 displays rates for 7-Day Follow-Up after Hospitalization for Mental Illness. From FY 2019 to FY 2022, FC members ages 6 to 17 years at discharge had higher rates of follow-up seven days after hospitalization for mental illness compared to all Medi-Cal members. The difference between FC and all Medi-Cal members was at least 9 percentage points during each FY. Medi-Cal member rates were consistently higher than CMS national Medicaid 50th percentile benchmark rates by at least 22 percentage points.

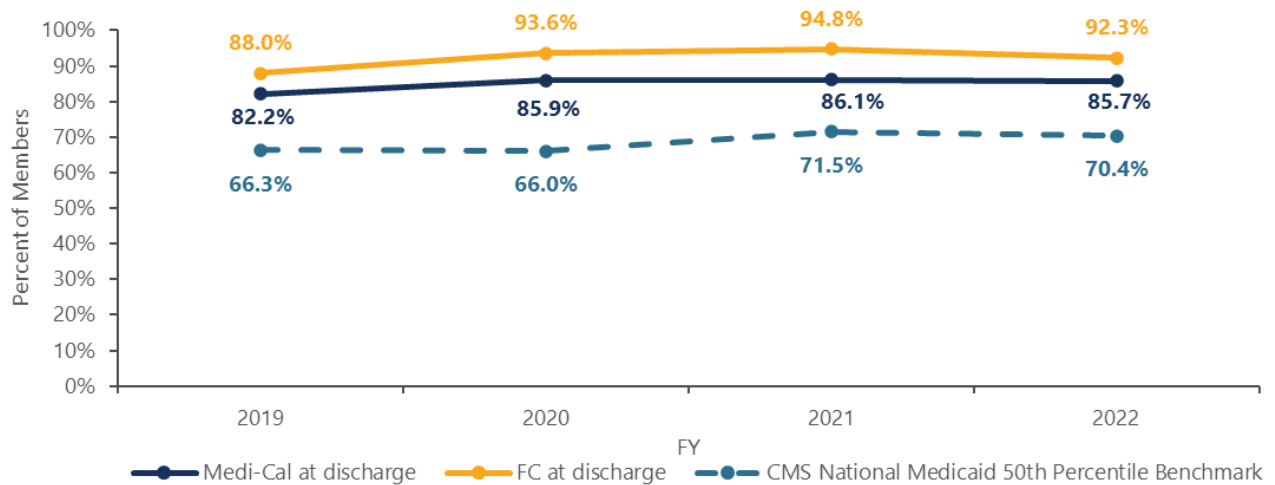
Figure 8—Follow-Up After Hospitalization for Mental Illness, 7-Day, Ages 6–17



Follow-Up After Hospitalization for Mental Illness, Ages 6–17 (30-Day Follow-Up) (Measure 8)

Figure 9 displays rates for *30-Day Follow-Up after Hospitalization for Mental Illness*. Similar to seven-day follow-up rates, FC members ages 6 to 17 years at discharge had higher rates of 30-day follow-up after hospitalization for mental illness than all Medi-Cal members from FY 2019 to FY 2022. However, the difference in 30-day follow-up rates between FC and Medi-Cal members was smaller than the difference in 7-day follow-up rates in each FY. Medi-Cal member rates were consistently higher than CMS national Medicaid 50th percentile benchmark rates by at least 14 percentage points.

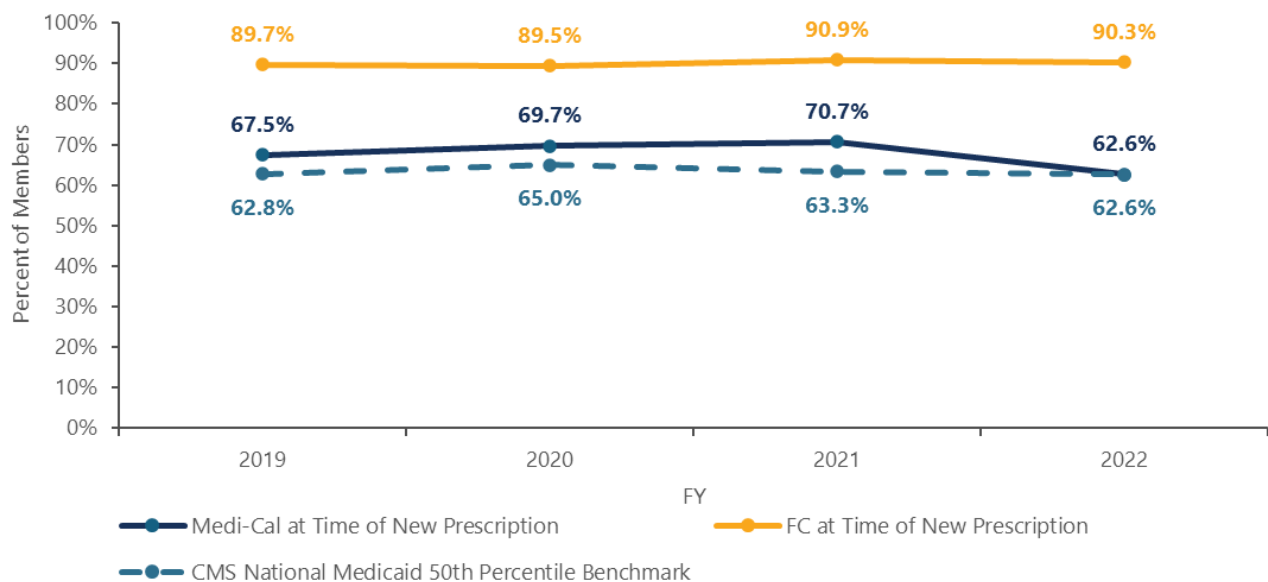
Figure 9—Follow-Up After Hospitalization for Mental Illness, 30-Day, Ages 6–17



Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Measure 9)

Figure 10 displays rates for *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*. From FY 2019 to FY 2022, FC members ages 1 to 17 years at time of new prescription had higher rates of first-line psychosocial care at the initiation phase than all Medi-Cal members. The difference between FC and Medi-Cal members was at least 20 percentage points for each FY. Medi-Cal member rates were comparable to the CMS national Medicaid 50th percentile benchmark.

Figure 10—First-Line Psychosocial Care, Ages 1–17

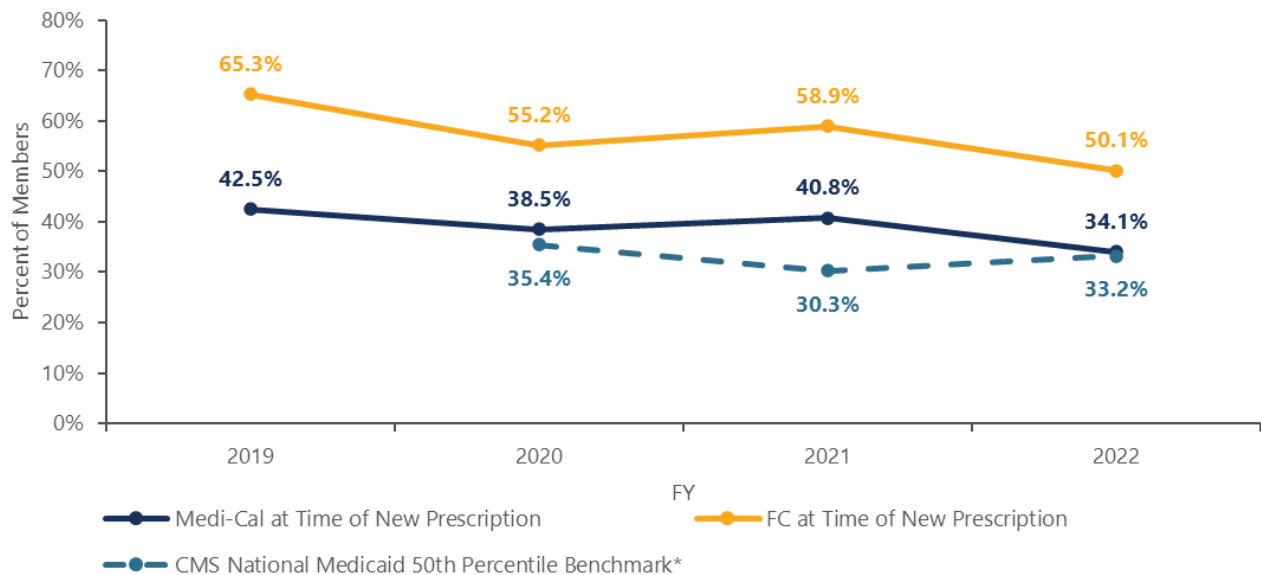


Metabolic Monitoring for Children and Adolescents on Antipsychotics (Measure 10)

Figure 11 displays rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics*. From FY 2019 to FY 2022, FC members had higher rates metabolic monitoring for children and adolescents on antipsychotics than all Medi-Cal members. FC member trends aligned with all Medi-Cal members, decreasing from FY 2019 to FY 2020, increasing in FY 2021, and decreasing in FY 2022. The difference between FC and all Medi-Cal members was at least 16 percentage points for each FY. Though Medi-Cal member rates were comparable to the CMS national Medicaid 50th percentile benchmark for FY 2022, Medi-Cal member rates were higher than CMS national Medicaid 50th percentile benchmarks in FY 2020 and FY 2021.

Figure 11—Metabolic Monitoring, Ages 1–17

*CMS publicly reported *Metabolic Monitoring for Children and Adolescents on Antipsychotics* beginning in FY 2020.



Availability of Interpretation and Translation Services (Language Capacity) (Measure 11)

Representatives from all MHPs were asked to describe the interpretation and translation services available to FC members. All respondents indicated that, if requested, they were prepared to offer these services to FC members between January 1, 2023, and August 31, 2025. While all MHPs indicated the ability to provide the services if requested, several MHPs noted that they received no such request from FC members during the reporting period. Additionally, several MHPs reported that services were available to all members and were not specific to FC youth.

MHPs reported an array of interpretation service options to accommodate members' preferred languages, outlined in Table 8. Services were available to members who spoke threshold and non-threshold languages, with the primary difference being that in-person interpretation services were more readily available in threshold languages.²¹

Table 8—Interpretation Services Offered by MHPs

| Service | Description |
|----------------------------------|--|
| Remote language services vendors | Live interpretation was conducted via telephone or video calls by a contracted language service provider. These services were available for up to 240 languages, including Arabic, Armenian, Cambodian, Cantonese, Farsi, French, German, Haitian Creole, Hmong-Mien, Italian, Japanese, Korean, Mandarin, Polic, Portuguese, Russian, Spanish, Tagalog, Thai, Urdu, and Vietnamese. |
| Bilingual staff | Bilingual staff, including bilingual SMHS providers, contracted interpreters, or bilingual MHP support staff, were available to assist members at health care visits and other key points of contact (e.g., intake or family sessions). |

²¹ A threshold language is any language other than English that is the primary language of 3,000 members or 5 percent of the member population, whichever is lower, in an identified service area.

| Service | Description |
|--------------------|---|
| Non-oral services | MHPs offered American Sign Language interpretation for members who were deaf or hard of hearing and translated materials in Braille, large print, or audio formats for visually impaired members. |
| Community outreach | Outreach and educational meetings were tailored to specific language communities, along with collaboration with community-based organizations that served those populations to build trust and increase engagement in mental health services. |

MHPs also reported on the availability of translation services. All MHPs proactively provided an array of critical documents translated into threshold languages or other languages commonly spoken within their regions. Multiple MHPs further noted that they accepted requests for document translation in non-threshold languages. A list of critical written materials that MHPs commonly translated for members is shown in Table 9.

Table 9—Commonly Translated Materials and Documentation Offered by MHPs

| Translated Written Materials and Documentation | |
|---|---|
| <ul style="list-style-type: none"> » Advanced medical directives » Appointment reminders » Change of provider forms » Client authorization forms » Community outreach materials » Consent forms » Cost and financial information » Educational materials, including mental health or medication education » Fair hearing process posters and forms | <ul style="list-style-type: none"> » Grievance and appeal forms » Individual care and treatment plans » Member brochures » Notices of action » Notices of rights and responsibilities » Patient rights posters and information » Privacy notices » Problem resolution documents and guides » Provider directories » Screening tools |

FC Member Utilization of SMHS (Measure 12)

Figure 12 displays total SMHS utilization for services with utilization measured in days. Fee-for-service (FFS) inpatient service utilization, measured in days, was the highest across all SMHS, followed by utilization of TFC, psychiatric health facility services, and Short-Doyle/Medi-Cal (SDMC) hospital inpatient services.

Figure 12—SMHS Utilization, Total Days

*Rates with numerators or denominators with less than 30 members were suppressed to ensure anonymity.

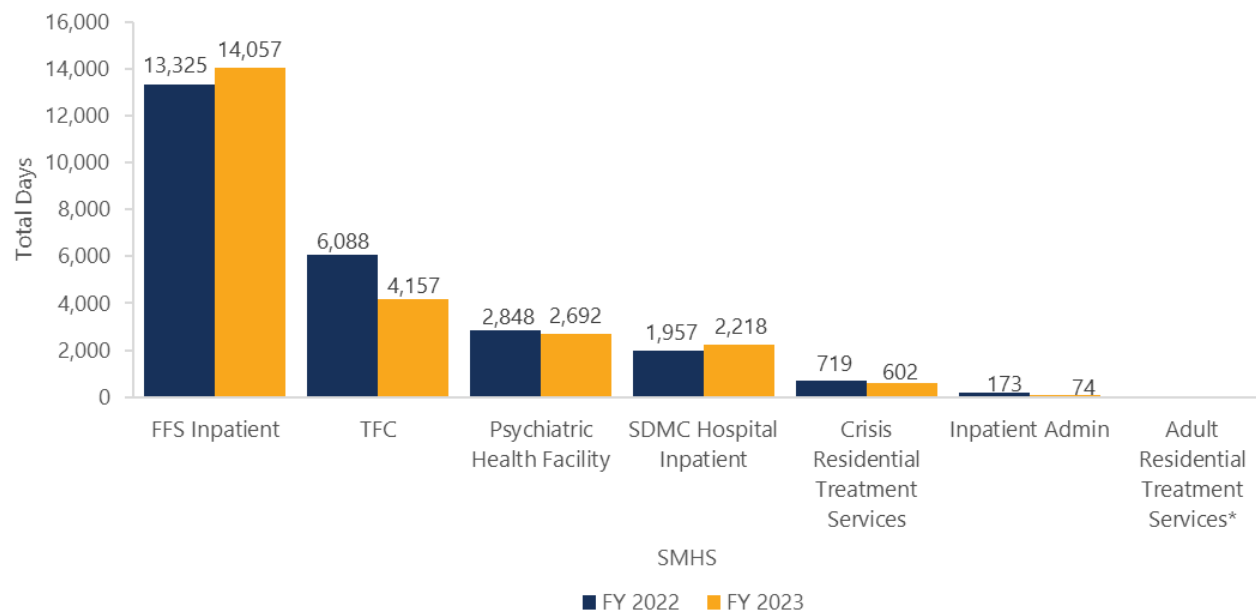


Figure 13 displays average SMHS utilization per member for services measured in days. TFC had the highest average days utilized per member among all SMHS, though the average days per member decreased slightly between FY 2022 and 2023. The average days per member for adult residential treatment services was high, at over two months per year; however, the number of members utilizing these services was low since the FC population was primarily composed of children and adolescents.

Figure 13—SMHS Utilization, Average Days per Member

*Rates with numerators or denominators with less than 30 members were suppressed to ensure anonymity.

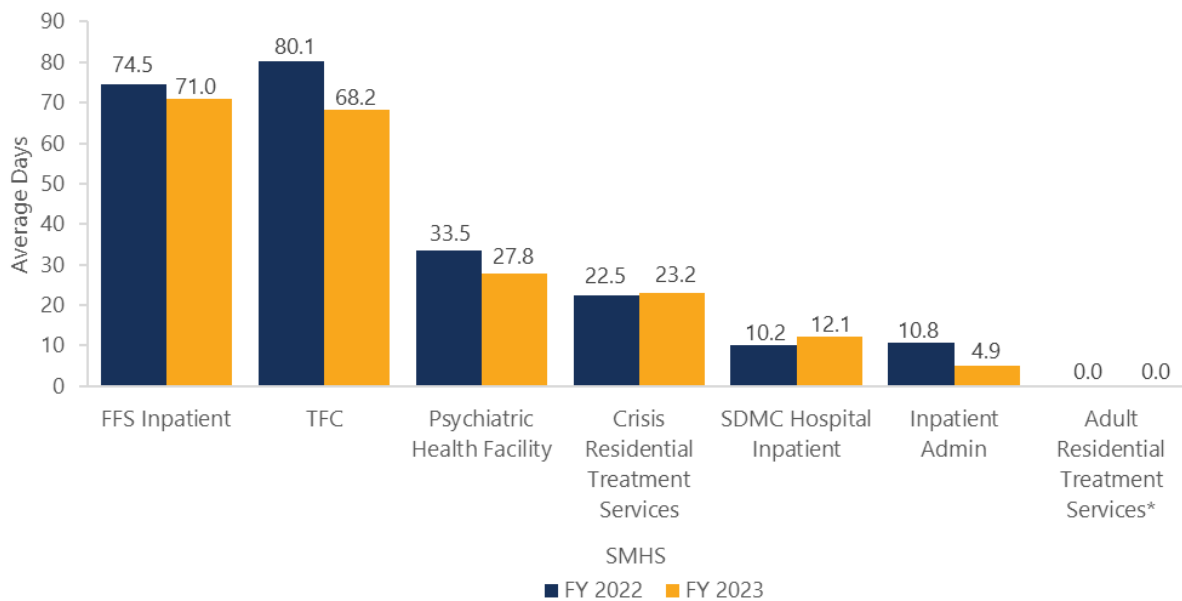


Figure 14 displays total SMHS utilization for services with utilization measured in hours. In FY 2022, full-day rehabilitation service utilization was the highest among SMHS measured in total hours, followed by full-day treatment intensive services. While full-day treatment intensive service utilization increased slightly in FY 2023, full-day rehabilitation service utilization decreased by 62 percent. Crisis stabilization services were consistently the least utilized services from FY 2022 to FY 2023.

Figure 14—SMHS Utilization, Total Hours

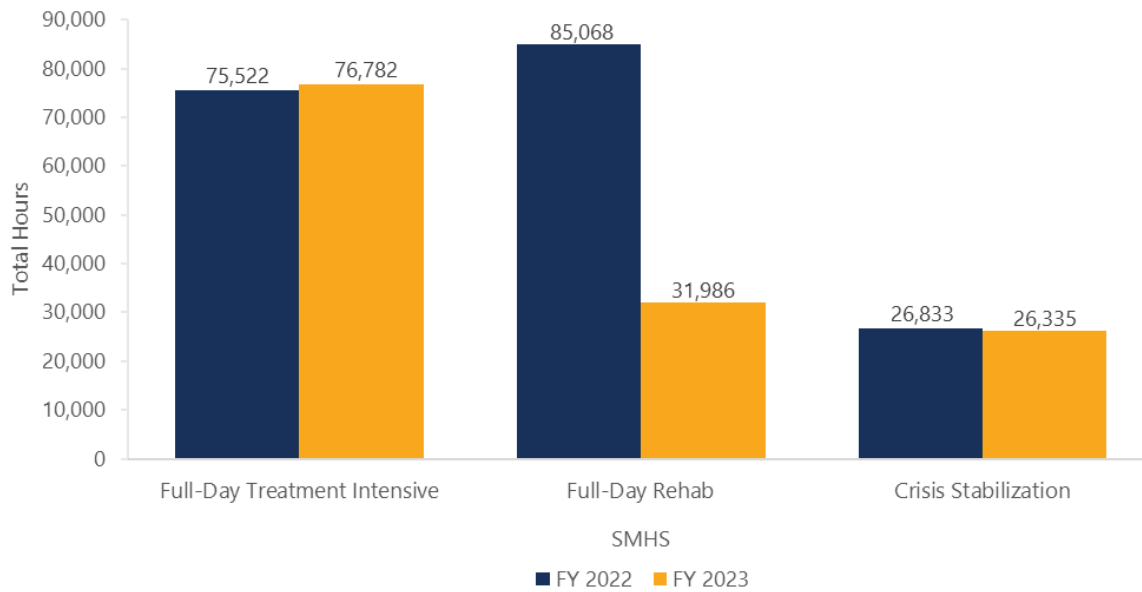


Figure 15 displays average SMHS utilization per member for services with utilization measured in hours. Although the average hours of full-day rehabilitation services utilized per member decreased between FY 2022 and 2023, this decrease was not as large as the decrease in the total hours utilized. Full-day treatment services had the highest average utilization per member, which remained consistent at approximately 30 days per year from FY 2022 to FY 2023.

Figure 15—SMHS Utilization, Average Hours per Member

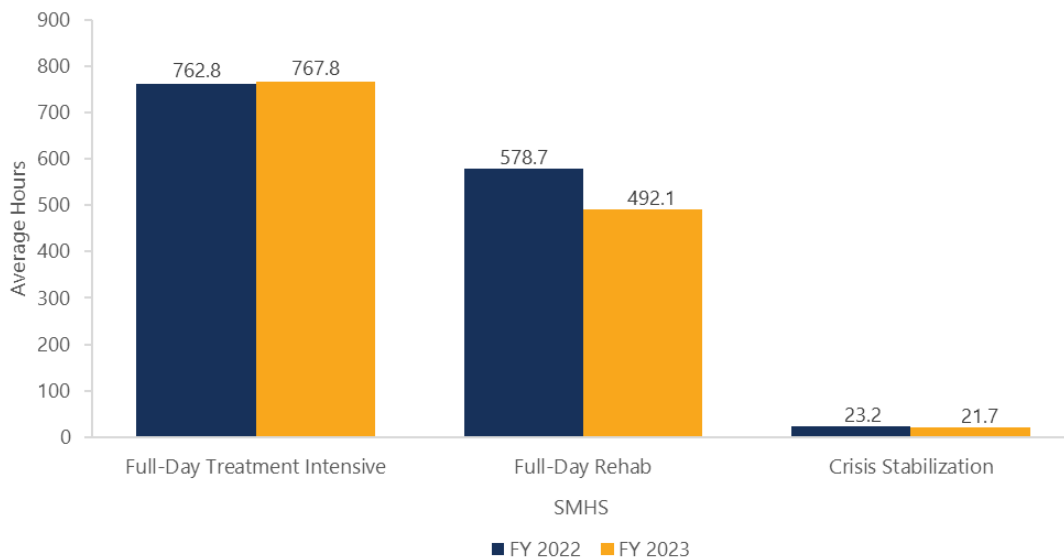


Figure 16 displays total SMHS utilization for services with utilization measured in minutes. Utilization of therapy and other service activities was the highest among SMHS measured in total minutes, followed by intensive care coordination (ICC) and intensive home-based services (IHBS). ICC and IHBS utilization increased by 13.8 percent and 10.8 percent, respectively. Utilization of therapeutic behavioral services, case management/brokerage services, and crisis intervention services were the lowest SMHS measured in total minutes.

Figure 16—SMHS Utilization, Total Minutes (Millions)

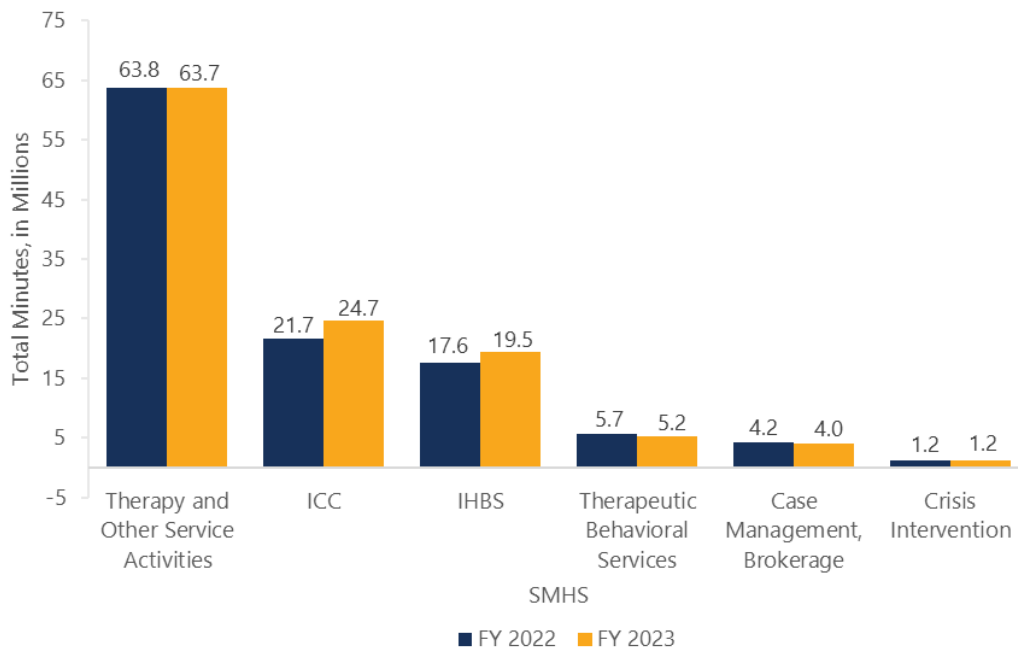
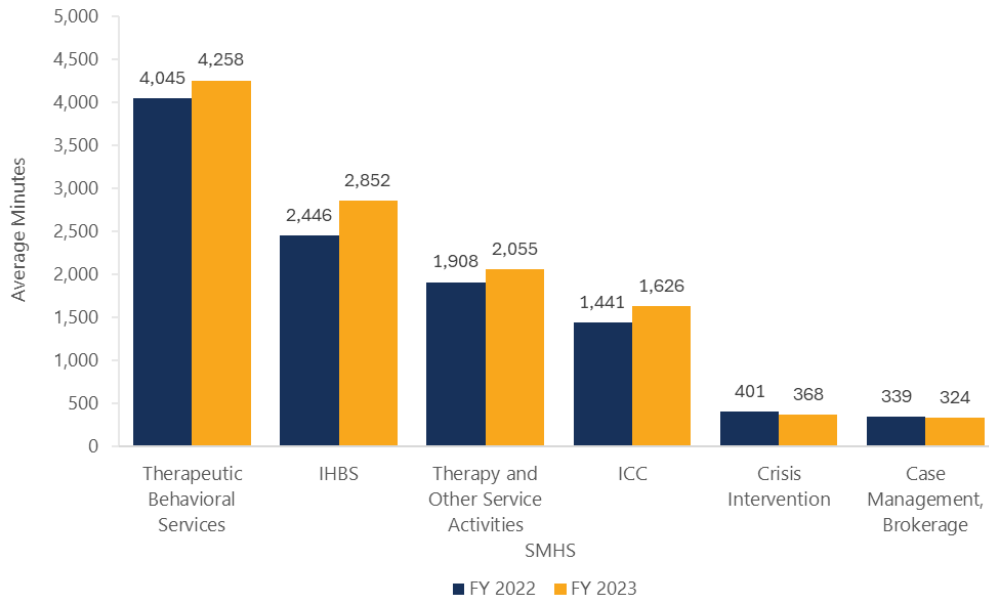


Figure 17 displays average SMHS utilization per member for services with utilization measured in minutes. Therapeutic behavioral services in average minutes per member was the highest among SMHS with utilization measured in minutes. The average utilization of all SMHS measured in minutes increased from FY 2022 to FY 2023, except for case management, brokerage and crisis intervention services.

Figure 17—SMHS Utilization, Average Minutes per Member



CONCLUSIONS



Conclusions

The following conclusions were developed based on the FC Analysis results:

- » The number of current FC members decreased by 6.6 percent from FY 2022 to FY 2023, while the number of former FC members increased by 3.7 percent.
- » Statewide SMHS penetration rates remained consistent from FY 2022 to FY 2023, with over 47 percent of FC members receiving at least one SMHS annually. Penetration rates varied based on age and race but did not vary based on sex.
 - FC members ages 6 to 11 years and ages 12 to 17 years had the highest penetration rates, each over 58 percent.
 - Black and, to a lesser extent, Hispanic FC members had higher penetration rates than White FC members.
 - The majority of MHPs did not meet all network adequacy standards. The standards with the highest compliance were Time or Distance and Language Assistance Capabilities. The standard with the lowest compliance was Timely Access.²²
 - High compliance with the Language Assistance Capabilities standards aligned with MHPs' description of interpretation and translation services available to FC members. All MHPs indicated that, if requested, they were prepared to offer these services.
- » FC members performed better than all Medi-Cal members and the CMS national Medicaid 50th percentile benchmarks for all HEDIS measures evaluated from FY 2019 to FY 2023.²³
 - The largest performance gaps between FC and Medi-Cal members were observed for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*, and *Metabolic Monitoring for Children and Adolescents on Antipsychotics*.
- » The SMHS with the highest average utilization per FC member included TFC, full-day treatment intensive services, and therapeutic behavioral services.

²² These conclusions may not fully represent the experiences of FC members.

²³ Caution should be exercised when interpreting the HEDIS results and conclusions due to the differences in reporting periods and lack of sample size information.