

# CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION STATEWIDE REPORT YEAR ONE

FY2005 (July 1, 2004 - June 30, 2005)

## VOLUME I OF II



PRESENTED TO  
**CALIFORNIA**  
**DEPARTMENT OF MENTAL HEALTH**



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CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

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**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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## CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

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### Executive Summary

The California External Quality Review Organization (CAEQRO) began operations on July 1, 2004 under the terms of a contract between APS Healthcare and the California Department of Mental Health (DMH). Federal regulations issued by the Centers for Medicare & Medicaid Services (CMS) require that states engage an independent external quality review organization (EQRO) to review their respective public sector mental health plan (MHP) systems and present an annual report on findings to their respective mental health departments.

Under the terms of the contract, CAEQRO was to conduct reviews of every MHP in California and of key areas within DMH operations. As highlighted in this Executive Summary and illustrated on page 12, CAEQRO not only fulfilled these core requirements, but also carried out an extended scope of work to include specific areas of interest to DMH. Following each review, CAEQRO provided the MHP and DMH with a site-specific report that reflected this enhanced scope of work. This statewide report details the CAEQRO review process and summarizes findings that are relevant across the MHP system. It also illustrates the CAEQRO consultative and distinctive approach to the EQRO process.

CAEQRO is committed to being of more value to MHPs and DMH than are most EQROs whose review teams typically arrive on site, check for regulatory compliance, issue an annual report and return in a year to repeat the process. Rather, in addition to carrying out the federal mandate, CAEQRO intends to continue employing a consultative approach to assist DMH and MHPs in enhancing their internal quality improvement efforts. And with information from the MHP staff, consumer/family members and quantitative analyses, we can support MHPs and DMH in making data-driven decisions that foster positive change.

Below we summarize the narrative portion of Volume I of our statewide report. Immediately following the narrative portion of this report and also contained in Volume 1 is a series of 22 attachments that supplement the discussion and offer documentation for key processes. In a separate document, Volume II, we provide summaries of each individual MHP report.

- **Section 1: Work Process.** Year One focused on three core reviews: site reviews of every MHP in the state; a review of DMH policies, procedures and operations for performance measure (PM) calculations; and a validation audit of the data elements entered by each MHP in Medi-Cal claims and used by DMH for PM calculations. This section covers these three areas. Concurrently, DMH had the following three additional and important objectives beyond fulfilling the core requirements—two of which were explicitly cited in its Request for Proposal and a third, which emerged as equally as important during initial discussions between CAEQRO and the department.
  - Determine how effectively the MHP activities reflect the core values of the community mental health system—particularly cultural competence and

consumer/family involvement. The MHP site reviews (and subsequent findings) therefore needed to specifically address these activities. Our discussion of the CAEQRO work process includes how the site review teams met this objective.

- Develop and implement a California-specific Information Systems Capabilities Assessment (ISCA) survey to ensure that the review of the MHP information systems and their respective use of technology would be appropriate to a decentralized county-based system. The federal guidelines for developing such a tool are geared toward a large health plan management model. A sample of the ISCA Survey 5.7L was included in the sample notification packet described Section 1. The ISCA development process and the ISCA findings are discussed in greater detail in Section 3.
- Leverage the external quality review (EQR) process to inform the DMH processes that directly involve the MHPs—particularly the various and separate MHP reviews currently conducted by the department. The EQR process provided an additional opportunity to gain insight about improving the department’s processes to potentially reduce the administrative burden on both the DMH and MHP staff. Expanding the EQR process, as described in Section 1, was necessary to achieve this goal.

Because the review process was new to all stakeholders, CAEQRO staff continually evaluated ways to improve both the MHP and DMH site reviews. Our own quality improvement initiatives led to several iterations of our processes as we continued to gain experience and feedback.

- **Section 2: Process Tools and Resources.** The Year One MHP site reviews were viewed as an opportunity to discuss with the MHP staff members their respective processes for tracking and measuring quality improvement activities, as well as an opportunity to introduce concepts of overall performance management. This “conversation about quality” in fact required that we perform the following additional activities to support a shift in orientation from quality assurance and regulatory compliance to quality improvement.
  - **Data analysis.** Despite the huge volume of data available from existing eligibility and claims files, the CAEQRO team is well aware that many MHPs have not yet been able to access data sources and/or adequately use such data. Section 2 describes the data analytic capacity that CAEQRO developed and how we applied this capacity to demonstrate the utility of existing data to support MHP quality improvement activities, as well as to validate DMH PMs.
  - **Technical assistance and training.** Throughout Year One, CAEQRO provided to MHP staff a broad range of technical assistance and training, which is discussed in this section. In addition to the technical assistance directly associated with our site review process, CAEQRO engaged in a wide range of activities—from the development and launch of a Web site to active participation in important professional meetings.
- **Section 3: Information Systems Capabilities Assessment Development and Findings (ISCA).** The ISCA survey is a key element of the MHP health information systems review process. CAEQRO was asked by DMH to create an

ISCA survey relevant to the wide variety of California MHPs. In this section we describe our process for developing a California-focused ISCA survey and the survey instruments key components.

During Year One, the ISCA survey was completed by MHP staff prior to the site review and then discussed with MHP staff during the site review. This information was supplemented by additional site reviews of systems and interviews with MHP staff that play important roles in system operations. While conducting our initial site reviews, we soon recognized the need for and therefore promoted collaboration across the MHP organization to gain the most useful information. In preparing our final health information systems review, we also considered the significant budgetary constraints that affect each California MHP.

- **Section 4: Findings.** Because of CAEQRO's wide range of activities, we applied two different—but equally valid— data-driven approaches to performing our analyses and reporting on our findings:
  - **Quantitative analyses and findings.** Sections 4.3, 4.3.1 and 4.3.2 (DMH PM Operations, DMH Data Analysis and MPH Data Validation, respectively) include concrete quantitative findings and graphs, charts and tables within the narrative that is then further supported by extensive worksheet documentation in our attachments. In applying this kind of analysis, reporting the accuracy and/or adequacy of MHP or DMH processes is relatively straight forward.
  - **Qualitative analyses and findings.** In contrast, while providing a rich source of data, site reviews require a different and highly complex analytical process. CAEQRO tackled this interesting challenge in a number of ways throughout the year and in preparation for the Statewide Report Year One. Section 4.2 includes a detailed discussion of our findings and reflects the 54 MHP site review reports CAEQRO generated for Year One. Volume II of the Year One statewide report contains an abridged version of each MHP site review report.
- **Section 5: Year Two and Beyond.** Section 5 continues and builds on our experience and findings by highlighting changes in the EQR process in response to our experience and findings in Year One. We also provide for review, consideration and critique seven themes that have complex systemic implications. Before developing these themes, we subjected our assumptions to a rigorous analytical process that occurred over a three-month period and involved CAEQRO staff, a consumer/family member consultant, a cultural competence consultant, and three senior consultants who are retired, highly regarded mental health directors. We will continue to monitor these themes to determine whether genuine trends emerge and develop over time.

During Year Two and in subsequent contract years, we intend to be agents of change by participating in statewide and regional meetings, collaborating with other concerned organizations, and providing critical information on our Web site, [www.caeqro.com](http://www.caeqro.com).

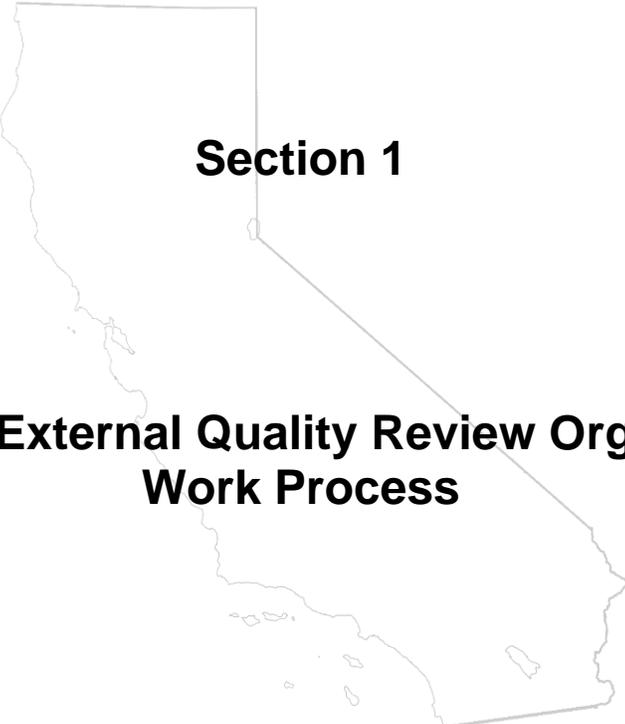
### CAEQRO Activities





**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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A map of California is shown within a black rectangular border. A vertical line is drawn through the state, separating the eastern and western halves. The eastern portion of the state is shaded in light gray. The text "Section 1" is centered over this shaded area.

**Section 1**

**California External Quality Review Organization  
Work Process**

## Section 1.1: Overview

The California External Quality Review Organization (CAEQRO), a division of APS Healthcare, was engaged by the California Department of Mental Health (DMH) to conduct three core reviews: site reviews of every mental health plan (MHP) in the state; a review of DMH policies, procedures and operations for performance measure (PM) calculations; and a validation audit of the data elements entered by each MHP in Medi-Cal claims and used by DMH for PM calculations. The fundamental objective of these reviews was to meet the requirements of Title 42, Code of Federal Regulations, Section 438.242.

Concurrently, DMH had the following three additional and important objectives beyond fulfilling the core requirements—two of which were explicitly cited in its Request for Proposal and a third, which emerged as equally as important during initial discussions between CAEQRO and DMH:

- Determine how effectively MHP activities reflect the core values of the community mental health system—particularly cultural competence and consumer/family involvement. MHP site reviews (and subsequent findings) therefore needed to specifically address these activities.
- Develop and implement a California-specific Information Systems Capabilities Assessment (ISCA) survey to ensure that the review of MHP information systems and the use of technology would be appropriate to a decentralized county-based system. The federal guidelines for developing such a tool are geared toward a large health plan management model.
- Leverage the external quality review (EQR) process to inform the DMH processes that directly involve MHPs—particularly the various and separate MHP reviews currently conducted by the department. The EQR process provided an additional opportunity to gain insight about improving DMH's processes, while potentially reducing the administrative burden on both the DMH and MHP staff.

Because the review process was new to all stakeholders, the CAEQRO staff continually evaluated ways to improve both the MHP and DMH site reviews. Our own quality improvement initiatives led to several iterations of our processes as we continued to gain experience and feedback. We also added a number of features and tools designed to provide additional information and assistance to MHPs as they prepared for their reviews. We established each process and tool to be consistent with a broad mission to help improve quality management throughout the mental health system. We highlight these processes in the brief summaries below.

- **MHP reviews.** CAEQRO conducted a large-scale review of 54 California MHPs. The review team consisted of staff and senior consultants with clinical and information technology (IT) expertise, as well as a consumer/family representative. Here are several examples of how we improved our process as the year progressed, as well as how we expanded our core activities to provide MHPs with additional and ongoing technical assistance:

- **Enhanced notification materials.** We initially provided MHPs with a letter of introduction—which, based on feedback, we expanded to a six-section packet of materials. A sample notification packet is included in Attachment 1.
- **Summary beneficiary data.** Early in the process, CAEQRO recognized that many MHP staff typically had little or no access to important summary beneficiary demographic and service data, which can be easily drawn from Medi-Cal paid claims. CAEQRO teams prepared summary reports of claims data, provided these reports to MHPs, and used each site review as an opportunity to begin a dialog with MHP staff about how data might be collected and effectively used for quality management. Additional information on these and other supplemental reports is included in Section 2.2.
- **Modified review process.** CAEQRO review teams recognized that the best discussions on how to use data must include a full spectrum of staff including quality improvement, finance and clinical program managers, and IT specialists. We modified the review process to include and actively involve these key individuals.
- **DMH PM operations validation.** A team of IT specialists from CAEQRO conducted a series of interviews with key DMH staff to review and evaluate the process used to calculate PMs. In addition, DMH transferred Medi-Cal claims data to CAEQRO so we could analyze DMH's processes for calculating PMs. As part of this effort, CAEQRO consultants evaluated the actual code used by DMH to analyze Medi-Cal data.
- **DMH data analysis.** Using FY03 data provided by DMH, CAEQRO performed a replication of DMH PM calculations. The goal of the replication process was to determine if the same results could be obtained by running the DMH SAS codes against the same or very similar Medi-Cal eligibility and claims data.

SAS is widely used in the healthcare industry and in government for statistical analysis of large, disparate sets of data. SAS was originally an acronym for statistical analysis system. In order to analyze DMH processes, CAEQRO purchased several SAS licenses.

- **MHP PM data validation.** For Year One, CAEQRO's PM data validation process was known locally as the "MHP Medi-Cal Paid Claims Audit," a label which generated some misunderstanding among MHPs. However, this activity was not technically an audit but instead an integral part of the process for validating the integrity of specific data elements provided by MHPs and used by DMH for its calculations. We therefore have relabeled this activity "MHP PM data validation" to accurately reflect the intent and scope of the process. CAEQRO sent each MHP a sample of the beneficiaries for whom we required specific sections of their medical record documentation.

The following discussion provides a detailed description of each of these activities—with the exception of the ISCA survey, which is discussed in Section 3.

## Section 1.2: Mental Health Plan Site Review Process

Prior to initiating our site review process, CAEQRO developed a schedule that reflected each MHP's preference from among three choices of dates offered by CAEQRO. Each review consisted of the following processes.

### Pre-site Review Process

In the early months of Year One, CAEQRO initiated the pre-site review process by forwarding a notification letter to each MHP and requesting that the MHP provide certain materials to CAEQRO by a specific date (thirty to sixty days) in advance of the site review. As the year progressed, and in response to feedback from the MHPs, CAEQRO not only substantially enhanced our notification materials, but also improved and expanded the pre-site review process. We added to our review team three highly respected, retired mental health directors to serve as senior consultants who interviewed the MHP management for background information and offered additional technical assistance to the MHP staff throughout the review process.

Below we offer a brief description of the enhanced notification process and packet, CAEQRO's internal process for reviewing the materials that the MHPs provided and highlights of CAEQRO's pre-site visit technical assistance.

- **Notification process and packet.** After the first few months of Year One, we replaced our notification letter with a multi-part notification packet to help MHPs better prepare for their EQR site visits. A sample notification packet is included in Attachment 1. Each MHP director and quality improvement coordinator received an electronic copy of the notification packet and, in most cases, the CAEQRO lead reviewer and IT analyst had several phone conferences with the MHP staff. The enhanced notification packet contained the following six documents:
  - A notification letter that, in addition to confirming the date of our site visit, identified a senior consultant who would contact each MHP director prior to the site review
  - A detailed "how to prepare" for the site visit
  - A Performance Improvement Project (PIP) Validation Worksheet so the MHP staff could see the form that CAEQRO would use to document the PIP review
  - Guidelines for organizing the consumer/family member focus group
  - The DMH-derived form for conducting a Medi-Cal oversight review
  - A copy of the most recent version of the ISCA survey

The purpose of forwarding these materials was to assist the MHP in preparing for the site visit and providing the following materials in advance of the site visit:

- A completed ISCA

- The most recent Cultural Competence Plan and, where applicable, a Latino Access Study
  - A list of cultural competence training sessions offered during the prior 12-month period
  - The MHP's annual Quality Improvement Plan and Quality Improvement Committee (QIC) meeting minutes for the previous 12-month period
  - PIP materials
  - A Plan of Correction from the most recent DMH oversight review
  - A list of surveys conducted in the prior 12 months, the survey instrument(s) and results from at least one of those surveys
  - An organizational chart and a list of applicable organization providers, if applicable
- **CAEQRO internal review process.** CAEQRO carefully reviewed and jointly discussed the materials provided by each MHP at a staff meeting that included the following participants:
    - Lead reviewer for that MHP and all other site reviewers, as available
    - IT reviewers
    - Site review director
    - Consumer family/member consultant who would take part in the site review
    - CAEQRO Executive Director Sheila Baler who routinely participated in the planning and review sessions for all MHP pre-site reviews (and who also played a key role in post-site review activities)
    - Senior consultant responsible for the background document

CAEQRO also reviewed the MHP's demographic and claims data sets, and the senior consultant's report. Finally, we considered pertinent issues or specific needs that were surfaced by the CAEQRO lead reviewer and the IT reviewer while providing the MHP with pre-site visit technical assistance.

## Site Review Process

CAEQRO provided site reviewers with consistent and detailed guidance as illustrated in the Site Review Template and Consumer/Family Member Focus Group Questions included in Attachment 2. The templates were not intended to be protocols that mandated a pre-set list of questions; instead, these documents offered guidance to the review team and provided prompts for a discussion of issues that might be relevant to a particular MHP.

Site reviews ranged from one to four days, depending upon a number of variables: the size of the MHP, the number of MHP beneficiaries, the number of contract providers and the complexity of the information systems. Core review teams included the:

- Lead reviewer
- IT reviewer
- Consumer/family member consultant

Other individuals, such as additional CAEQRO staff members and consultants, participated in the site review depending on the variables cited above.

We initiated the site review process by meeting with the MHP leadership to confirm the review schedule, to make certain the necessary staff members and beneficiaries would be available, and to gain an understanding of the issues that the MHP felt were significant for the CAEQRO to understand about its programs. Either the lead reviewer or other CAEQRO staff member gave a presentation about APS Healthcare as a company, the CAEQRO contract award process, and our understanding of the origins and policy goals of the Centers for Medicare & Medi-Cal Services (CMS) managed care regulations under which we operate.

We acknowledged in our remarks that compliance is an important activity and provides the foundation for basic operational integrity. However, compliance itself does not necessarily lead to a quality improvement process. We tried to communicate that the Year One process was not a compliance activity, that recommendations were intended to provide ideas and suggestions, and that these recommendations did not require any plans of correction.

Throughout our various review activities, CAEQRO viewed the site visit as a “conversation about quality”—specifically, an opportunity to discuss with the MHP staff the process used to track and measure quality improvement activities and performance management. The site review consisted of the following activities:

- **Document Review and Analysis**
  - MHP surveys
  - Penetration rates and claims data
  - The Plan of Correction, if any, for quality improvement concerns from the MHP’s most recent DMH oversight review
  - The work plan and current year’s update for Quality Improvement Program section of the 2004–2005 DMH “Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services,” as available
  - Cultural Competence Plan and/or yearly update, including a Latino Access Study, where applicable
- **Targeted Discussions**
  - The proposed PIP(s)
  - The status of the cultural competence implementation
  - The Quality Improvement Plan
  - Surveys from the prior 12 months
  - Information systems, including the ISCA survey
  - MHP claiming procedures
- **Focus Groups and Interviews**
  - One or more focus groups with consumer/family members
    - When possible and where applicable, including non-English mono-lingual participants
    - Conducted by the CAEQRO consumer/family member consultant and assisted by a CAEQRO staff member

- Focus group(s) with key supervisory staff
  - Focus group(s) with consumer/family member staff members—as possible
  - Interviews with representatives from organizational contract providers
  - Interviews with clinical and business frontline staff
- **Wrap-up Session.** For the first six months, each site visit ended with a brief wrap-up session with the MHP staff and gave the CAEQRO reviewers the opportunity to request—if necessary—additional materials for the completion of the review. CAEQRO did not draw any conclusions pertaining to the final MHP report. We also explained to the MHP that a post-site review would follow with the CAEQRO staff prior to our completing the final report.

As the year progressed, we realized that because many MHPs operated in silos, key MHP staff members were not effectively communicating with each other. This disconnect was often particularly true for the MHP program and IT staffs. To address this issue and facilitate cross-functional communication, we conducted targeted PIP discussions with appropriate functional area experts in a session that involved both program and IT staffs. We also initiated a wrap-up process in which the CAEQRO team highlighted important themes we observed in the MHP's operations, as well as general issues that were raised by the MHP staff. We then pursued discussions with the MHP staff to evaluate these themes as issues, strengths and /or challenges.

## Post-site Review Process

Following each site review, the CAEQRO review staff met to summarize findings and to discuss what we should include in the final report. The consumer/family member consultant who participated in the pre-site review process participated in this meeting as well. We also jointly established the ratings on the PIP Protocol. This joint assessment insured inter-rater reliability for all MHPs reviewed throughout the year. We also discussed the need for follow-up contact with the MHP if information was incomplete or unclear.

On an ongoing basis, each MHP reviewed in the prior month, as well as those to be reviewed in the following month, were discussed at a standing monthly meeting between the CAEQRO staff and the DMH departments of Oversight, County Operations, and Medi-Cal Policy. The DMH staff members provided any information they felt helpful to CAEQRO in the month preceding the review and CAEQRO offered a short summary of the actual review the following month.

## Technical Assistance

Technical assistance often began following the MHP's receipt of the notification packet and extended, at times, throughout the review process. Section 2.3 contains a detailed discussion of the technical assistance that CAEQRO provided throughout Year One—both directly to MHPs and in conjunction with professional organizations. Specific activities are listed in a series of calendars included as Attachment 3.

We also provided technical assistance in a less prescribed but ongoing basis. For example, during the pre-site visit process, we provided several hours of telephonic coordination and technical assistance, particularly around the development of PIPs. In addition, the MHP and CAEQRO staffs together determined site review agendas and schedules. In general the amount of consultation and discussion with each MHP increased as the year continued. In some cases, the MHP staff would present at the site visit a new version of a previously submitted document. Although we preferred to review documents prior to the site visit, we viewed these revised documents as a positive step by the MHP and accepted them.

## **The Report Process**

Following the post-site review process, the lead reviewer was responsible for developing and writing the non technology sections of the report. The technology section was written by the site technology reviewer and submitted to the CAEQRO director of information technology who in turn submitted the edited report to the lead reviewer. Additionally, the lead reviewer edited and collated any sections provided by other team members, including the consumer/family member who was involved in the review process. Completed draft reports—which included the PIP protocol provided in Attachment 4—were then submitted to the site review director for further editing and were vetted for final review by CAEQRO's executive director. Our internally approved Outside Review Draft was sent simultaneously to the MHP director and quality improvement coordinator, and to the DMH contract monitor to allow for comments concerning factual inaccuracies. When appropriate, corrections were made and the executive director released the final report for distribution to the respective MHP and to DMH.

All CAEQRO official communications with the MHP—from the notification letter to our receipt of MHP documents to the submission of the final MHP report—were conducted electronically.

We include in Section 4.2, a detailed discussion of our consolidated findings and how our report structure enabled us to assess both compliance and quality improvement initiatives.

## **Section 1.3: California Department of Mental Health Performance Measure Operations Validation**

One of the basic EQR requirements is to conduct a validation of the DMH's PMs. Unlike the MHP reviews described in Section 1.2, this process occurs in the offices of DMH data analysts. The PMs are defined by the specific DMH, whose analysts provide PM calculations for each MHP. The methods that an EQRO should use in evaluating PMs are specified in a series of review protocols developed by CMS. CAEQRO used the protocols as guides in the interviews and discussions with California's DMH analytic staff.

Because the data involved in validating PMs are collected from every MHP in a common format using common procedures, it is possible to compare MHP performance over time

and with other MHPs. Therefore it is particularly important that all decision-makers are confident of the accuracy of both the data and the analytic procedures that are used to calculate PMs.

To achieve this level of confidence requires validating both the methodology and findings of DMH and the source data from each MHP that DMH relies on for its analysis. Data for the PM calculations are drawn from several sources including information abstracted from eligibility data and Medi-Cal claims submitted by each MHP. Validation of the MHP submitted data is discussed in Sections 1.3.2 and 4.3.2.

## Process Overview

For Year One of CAEQRO operations, the PMs selected by DMH were:

- Total penetration rate for FY03, and
- FY03 penetrations rates by three age groups: 0–18, 19–64, and 65 and over

While conducting the validation of DMH PM calculations as described in the following pages, CAEQRO worked cooperatively with the DMH staff to clearly understand all of the elements and procedures involved in this complex analysis. CAEQRO can continue to share knowledge learned from this process with DMH and MHPs as they seek to use these data for more informed decisions and quality management. CAEQRO acknowledges and appreciates the active assistance of many DMH staff during the PM validation process. This spirit of collaboration is essential to maintaining accurate data and analysis.

The CAEQRO process consisted of three phases: pre-site, site and post-site activities—each of which is described below. The activities included review of the DMH data management processes, evaluation of algorithmic compliance, and verification of each PM to confirm that the reported results are based on accurate source information. All data received from DMH during this project have been stored by CAEQRO at the APS Healthcare data processing facility in Brookfield, Wisconsin. The data are maintained under strict security standards that are compliant with the Health Information Portability and Accountability Act of 1996 (HIPAA).

## Pre-site Activities

To prepare for pre-site activities, CAEQRO studied the technical specifications for each of the PMs and thoroughly reviewed the claims submission processes used by MHPs for submitting claims to DMH. CAEQRO also communicated with key DMH managers and analytic staff to identify and discuss the measures to be validated, establish procedures for access to the source data, and identify the key staff to be interviewed.

To facilitate ongoing meetings with key DMH staff, CAEQRO developed topic-specific agendas. In January 2005, CAEQRO conducted a series of internal meetings to develop the future DMH PM agendas. On January 21<sup>st</sup> the CAEQRO and the DMH staff met and reviewed the proposed agendas and established the future meeting dates. Topics were constructed around the CMS review protocols. The following meeting topics and dates were agreed upon.

- Assess Data Integration and Control—February 8
- Assess Documentation of Data—March 1
- Assess Processes to Calculate PM—March 15
- Assess Processes to Produce Denominators and Numerators—April 5

We also determined that Sara Gilb and Kari Yoshizuka, from the DMH Statistics and Data Analysis (SDA) unit, were the key staff to be interviewed and would participate in the scheduled meetings. Since DMH IT personnel were not available during the January 21 meeting, CAEQRO agreed to contact them directly and arrange for future meeting dates.

## Site Visit Activities

Site activities focused on validating the PM data by reviewing DMH procedures and documentation. Our reviews considered:

1. DMH's ability to link data from multiple sources in order to calculate the required measures
2. The procedures DMH has in place for integrating eligibility and claims data
3. The processes used by DMH to calculate the denominator and numerator
4. The SAS source code used to produce PMs

To accomplish these tasks, a team of CAEQRO IT specialists conducted a series of meetings with key SDA staff to review and evaluate the department policies, procedures and operations used to calculate PMs. We also conducted a series of interviews with staff from the DMH IT unit. All of these sessions were conducted at the DMH headquarters in Sacramento.

The following bulleted list summarizes the main meeting topics, meeting dates and attendees:

- **Assess Data Integration and Control**—February 8  
Attendees: Sara Gilb, DMH-SDA; Kari Yoshizuka, DMH-SDA; Michael Gorodezky, CAEQRO; William Ullom, CAEQRO
- **Discuss DMH IT Data Files Transfer Procedures**—February 16  
Attendees: John Glabas, DMH-IT; Rafael Estrada, DMH-IT; William Ullom, CAEQRO
- **Assess Documentation of Data**—March 1  
Attendees: Sara Gilb, DMH-SDA; Kari Yoshizuka, DMH-SDA; William Ullom, CAEQRO
- **Review DMH IT Data Files Transfer Documentation**—March 8  
Attendees: John Glabas, DMH-IT; Rafael Estrada, DMH-IT; Lisa Farrell, CAEQRO; William Ullom, CAEQRO

- **Assess Processes to Calculate PM**—March 15  
Attendees: Sara Gilb, DMH-SDA; Kari Yoshizuka, DMH-SDA; William Ullom, CAEQRO
- **Assess Processes to Produce Denominators and Numerators**—April 5  
Attendees: Sara Gilb, DMH-SDA; Kari Yoshizuka, DMH-SDA; Lisa Farrell, CAEQRO; William Ullom, CAEQRO
- **Review PM Processes**—May 17  
Attendees: Sara Gilb, DMH-SDA; Kari Yoshizuka, DMH-SDA; William Ullom, CAEQRO
- **Review PM Processes**—May 24  
Attendees: Sara Gilb, DMH-SDA; Kari Yoshizuka, DMH-SDA; Dennis Louis, CAEQRO; William Ullom, CAEQRO

The CAEQRO staff recorded meeting minutes that we reviewed with SDA staff during the next session to validate the information. Also during the site meetings, the CAEQRO staff, along with the SDA staff, examined and discussed detailed computer queries, programming logic and SAS source code to fully understand the data and the processes used to produce the PM data. In addition, the reviews included steps to integrate the source data, as described below, into the PM data set.

### California Department of Mental Health Source Files

DMH integrates data from the following source files to produce the PM data.

- **Inpatient Consolidation Claims Files (IPC).** Electronic Data Systems (EDS), the California fiscal intermediary for Medicaid, creates and transfers monthly claim files as part of its claims adjudication process. The files are located at the Health and Human Services Data Center (HHSDC). The monthly files contain both paid and denied claims processed during the month.
- **Short-Doyle/Medi-Cal Approved Claims Files (SDMC).** These files are generated by the Department of Health Services (DHS) during the process of adjudicating the SDMC claims. The files are located at the HHSDC. The DMH IT unit downloads these files to the DMH SAS server, after changing the COBOL high values to spaces. The files contain approved claims data, which are subject to year-end cost report settlement.
- **San Mateo Case Rate Files.** These files are generated by San Mateo County. They contain demographic and client information for each month of service as well as the case rate amount for the month. The files are monthly files and do not contain the service month in the file. The service month must be generated based on the file name. The files are encrypted, zipped, password protected, copied to a CD and mailed to DMH.
- **Client Service Information (CSI) Data for San Mateo Services.** The CSI unit of SDA creates a file of CSI services for the fiscal year and puts the data

on the SAS server. Information from the San Mateo Case Rate files and San Mateo CSI data files are combined to produce pseudo SDMC claims data.

- **MEDS Monthly Extract File (MMEF).** The MMEF files are produced by DHS using the Medi-Cal Eligibility Data System (MEDS). A DMH copy of these files resides on the HHSDC. The file is created on the last Friday of the month and the current data refers to the beneficiaries' eligibility on that date. The files contain sixteen months of eligibility data, the current month, plus the fifteen most recent months. The file created May 2005 would contain the following months of eligibility data: Current (June 2005), MAY 2005, APR 2005, MAR 2005, FEB 2005, JAN 2005, DEC 2004, NOV 2004, OCT 2004, SEP 2004, AUG 2004, JUL 2004, MAY 2004, APR 2004, and MAR 2004.

## Post-site Activities

Post-site activities focused on evaluating the information CAEQRO gathered during the pre-site and site activities. These activities included completed protocol assessment tools as supporting documentation.

To document our post-site analysis activities, CAEQRO IT reviewers completed the following fourteen (14) CMS-required worksheets, which are included in the following Attachments:

- **Attachment 5.** Information Systems Data Integration and Control Worksheet
- **Attachment 6.** Data Integration and Control Findings Worksheet
- **Attachment 7.** Performance Measure Worksheets
  - Data and Processes Used to Calculate and Report Performance Measure Worksheet—Penetration Rate
  - Data and Processes Used to Calculate and Report Performance Measure Worksheet—Age Group 0–18
  - Data and Processes Used to Calculate and Report Performance Measure Worksheet—Age Group 19–64
  - Data and Processes Used to Calculate and Report Performance Measure Worksheet—Age Group 65 and Over
  - Documentation of Programming Specifications Worksheet—Penetration Rate
  - Documentation of Programming Specifications Worksheet—Age Group 0–18
  - Documentation of Programming Specifications Worksheet—Age Group 19–64
  - Documentation of Programming Specifications Worksheet—Age Group 65 and Over
- **Attachment 8.** Denominator Analysis
  - Policies, Procedures, Data and Information Used to Produce Denominators Worksheet
  - Denominator Validation Findings Worksheet
- **Attachment 9.** Numerator Analysis
  - Policies, Procedures, Data and Information Used to Produce Numerators
  - Numerator Validation Findings

Findings are discussed in Section 4. This section focuses on the process/assumptions that were applied in completing these worksheets.

The validation requirements scale used was: yes, no and not applicable (n/a). “Yes” indicates the measurement and reporting process was fully compliant with specifications. “No” indicates the measurement and reporting process was not compliant with specifications. This designation was used for any audit element that deviates from the specifications. Any audit element with this designation includes an explanation of the deviation in the comments section. “No answer” indicates the audit element was not applicable to measurement and reporting process.

The validation findings scale used was: met, not met and not applicable (n/a). The validation finding for each measure was determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be “not met.”

Finally, to further our goal of a comprehensive review of the DMH PM review and analysis, CAEQRO contracted with William Viergever of Viergever & Associates. Mr. Viergever was engaged to conduct an independent review of DMH SAS source code to validate the PM results that the programs produce. The report and the findings are included in Attachment 10.

### **Section 1.3.1: California Department of Mental Health Data Analysis**

Using the procedures outlined in Section 1.3, CAEQRO performed a replication of Year One calculations, using data for FY03, for the following PMs:

- Total penetration rate for FY03
- FY03 penetration rate for age group 0–18
- FY03 penetration rate for age group 19–64
- FY03 penetration rate for age group 65 and over

The goal of the replication process was to determine if the same results can be obtained by running the DMH SAS codes against the same or very similar Medi-Cal eligibility and claims data. To replicate the DMH calculations of PMs, CAEQRO used MMEF eligibility data, SDMC claims data, San Mateo County case rates data and IPC data. All data were provided by DMH.

DMH analysis procedures permit them to read some data directly from the DHS mainframe data system. These sections of code were not tested in the replication process because the record formats of the IPC data from DMH are not the same as those maintained in the DHS mainframe system. Only the SDMC data have a similar record layout to the DHS version and the relevant SAS codes were tested in the replication process. For the other parts of the DMH SAS codes, the only parameters CAEQRO changed when necessary were file names, locations and fiscal years.

Below we summarize our process and basic findings. In Section 4.3.1, we use these basic findings to provide additional guidance on the DMH calculations of PMs.

- **Total Penetration Rate for FY03.** The penetration rates that CAEQRO replicated and DMH originally reported were nearly exactly equal. The results for the count of unduplicated eligible beneficiaries (denominator) were exactly the same. The replicated counts of unduplicated consumers (numerator) were always equal or a very slightly larger than the DMH reported numbers. A possible explanation is that the data used by CAEQRO in the replication process were drawn from reported approved claims for a later period of time than used by DMH in its original reports. For example, the SDMC data used for the CAEQRO replication process include claims processed through June 30, 2005, while the DMH original results were based on SDMC data through November 30, 2004. While the time period for processing FY03 claims should have ended by November 2004, there are a few reasons why additional claims would have been approved after that date. The most logical reason for the small difference in the count was that a small number of claims were approved because of delays related to “over-the-fiscal-year” eligibility determination issues.

Findings: The results of the replication of penetration rate confirmed the validity of the DMH calculations of PMs as documented in Attachment 11.

- **Penetration Rate for Age Groups 0–18, 19–64, and 65 and Over.** DMH reported penetration rates for six age categories: 0–17, 18–20, 21–39, 40–59, 60–64 and 65 and over. As specified in the APS Healthcare contract with DMH, CAEQRO used DMH procedures and analyzed penetration rates by the following combined age categories: 0–18, 19–64 and 65 and over. Since the age group categories differed between what DMH reported and the contract-required groupings, it was not feasible to replicate and match the DMH count. However, CAEQRO used DMH analyses procedures to produce the penetration rate data—only changing the age group logic.

Findings: Statewide, the penetration rate was the highest for the 19–64 age group and lowest for Medi-Cal beneficiaries who were age 65 and over. However, the beneficiaries between 0–18 years of age received the highest paid claim dollar per beneficiary as compared to those beneficiaries between 19–64 years of age. Again, the average paid claim per beneficiary was the lowest for those who were 65 and over. Attachment 12 contains details on our analysis.

### **Section 1.3.2: Mental Health Plan Performance Measure Validation**

During Year One, CAEQRO validated PM data for each MHP. During this first year, the project was known locally as the “MHP Medi-Cal Paid Claims Audit,” a label which generated some misunderstanding among MHPs. However, the audit was primarily an integral part of the process for validating the integrity of data elements provided by MHPs and used by DMH for its PM calculations. Thus for future years, CAEQRO will

assign a descriptor that more accurately reflects our activities and eliminates the concerns that many MHPs typically associate with a formal audit process.

The audit of MHP medical records is a portion of the annual PM validation process. A review of the DMH PM calculation processes is another important part of PM validations as discussed in Section 1.3. For Year One, the PMs that the DMH selected for validation at the MHP level were Medi-Cal penetration rate and penetration rates by age and gender categories. The CAEQRO staff worked with representatives from DMH and the California Mental Health Directors Association (CMHDA) Medi-Cal Policy Committee to develop specifications for the audit in compliance with CMS guidelines.

The audit was designed to determine whether Medi-Cal approved claims data are an accurate source of information for calculating penetration rates by age and gender. The methodology used was to compare like information from selected Medi-Cal approved claims to the beneficiary's medical record maintained by the specific MHP. Immediately following the recap of CAEQRO audit activities is a detailed discussion on the audit parameters and on the audit process.

<b>Recap of MHP Medi-Cal Paid Claims Audit Activities</b>	
December 2004	<ul style="list-style-type: none"> <li>• Establish sampling technique</li> <li>• Determine valid sample</li> </ul>
January 2005	<ul style="list-style-type: none"> <li>• Create audit database</li> <li>• Develop reporting tools</li> <li>• Begin San Francisco pilot project</li> </ul>
February 2005	<ul style="list-style-type: none"> <li>• Conclude San Francisco pilot</li> <li>• Revise forms, procedures and MHP instructions</li> <li>• DMH e-mail announcement of audit to mental health directors</li> </ul>
March 2005	<ul style="list-style-type: none"> <li>• CAEQRO letter describing audit to all mental health directors</li> <li>• CAEQRO presentation at California Quality Improvement Committee (CALQIC)</li> <li>• Audit packages delivered via FedEx to MHP Medical Records</li> </ul>
April 2005	<ul style="list-style-type: none"> <li>• Deadline for MHP submission of documentation to CAEQRO</li> <li>• CAEQRO hires review staff</li> <li>• Develop written procedures for tracking and processing records</li> </ul>
May 2005	<ul style="list-style-type: none"> <li>• Process and score MHP medical record documentation</li> </ul>
June 2005	<ul style="list-style-type: none"> <li>• Audit results delivered via FedEx to mental health directors</li> <li>• Deadline for MHP submission of disputes to CAEQRO</li> <li>• Third and final review of MHP error records</li> </ul>
July 2005	<ul style="list-style-type: none"> <li>• Final letters issued to MHPs that submitted disputes</li> <li>• MHP documentation transferred to secure storage facility</li> <li>• Audit process completed</li> </ul>

## Audit Parameters

### Data Elements and Sample Selection

In preparation for the audit process, CAEQRO received Medi-Cal approved claim files for FY03. February 2003 was selected as the target service month in cooperation with and reviewed by DMH and California Mental Health Directors Association (CMHDA) Medi-Cal Policy Committee.

Data elements selected from Medi-Cal approved claim files to measure penetration rates were:

- Medi-Cal beneficiary birth date
- Medi-Cal beneficiary gender
- Medi-Cal beneficiary service date from February 2003

For each MHP we determined the total number of beneficiaries for whom a service was approved for service month February 2003 (Attachment 13). From this list, a random sample of records was extracted for each MHP. The sample size was determined to allow for a 95 percent confidence level with a 10 percent confidence interval. The confidence interval was set very wide in an effort to keep the number of records reasonable and to set a reasonable level of effort on this first audit. However, for small counties the number was still substantial. The size varied from a minimum of 21 records for Mono County (all beneficiaries served in February 2003) to a maximum of 96 records for Los Angeles, with most MHPs in the 85 plus range.

The service date was also randomly selected by beneficiary and four digit Medi-Cal provider identification number. So, for example, if a beneficiary had many services during February 2003, the sampling process randomly selected a single approved claim. The exact date of service was not revealed to the MHP.

During January 2005 a CAEQRO database was created for storing sampled Medi-Cal approved claim records for each MHP. Each approved claim record in the sample was assigned an "EQRO Control ID Number" for tracking purposes. Report tools were developed to facilitate the collection and return of data from each MHP.

### Audit Exclusions: Mental Health Plans and Claim Types

A total of 52 MHPs participated in the audit. San Mateo and Solano MHPs were excluded as they had participated in the DMH pilot project as capitated health plans for several years and therefore had limited Medi-Cal approved claims data. Both Alpine and Sierra MHPs were excluded as they did not have any Medi-Cal approved claims for February, 2003. Sutter/Yuba was counted as a single MHP. Lake MHP submitted requested documents too long after the deadline to be considered.

In an effort to limit the work involved in this first CAEQRO audit, certain categories of claims were excluded to reduce the overall claim volume and to make the collection of medical record information more feasible. Claims for all Medi-Cal providers were included in the audit with the exception of:

- Network (formerly fee-for-service) providers
- Inpatient hospital claims for contract hospitals billed through EDS
- Administrative Service Organization (ASO) claims

## Mental Health Plan Paid Claims Audit Process

### Pilot Project Initiated

San Francisco MHP agreed to participate in our MHP Paid Claims Pilot Project in January 2005. Audit Cover Sheets and the Control Log were provided to them along with instructions and a pre-paid FedEx label for returning the documents to CAEQRO. As requested, medical records documents were returned to the CAEQRO office within ten working days.

Based on San Francisco's feedback, the audit processes and forms were modified to make data collection and return easier for the MHPs. This experience also allowed us to clarify and streamline our internal processing and coding, as well as improve our instructional materials.

### Notification of Mental Health Plan Medi-Cal Paid Claims Audit

Mental health directors and quality improvement coordinators were advised of the upcoming MHP Medi-Cal Paid Claims Audit in several ways, beginning in February 2005:

February 28	Rita McCabe-Hax, chief, Medi-Cal policy and support services for DMH, sent an e-mail message to mental health directors.
March 2	Sheila Baler, CAEQRO executive director, sent a letter to mental health directors providing more detail on the audit and a tentative timeline.
March 7	Audit announcement was posted on the CAEQRO website.
March 17	Michael Gorodezky, CAEQRO IT director, presented an overview of the audit at the CALQIC conference in Monterey.

Audit packets (Attachment 14) were sent via FedEx to the medical records custodian at each MHP on March 29, 2005. Each packet contained the following information.

- A memorandum explaining the authority for the audit, providing detailed instructions for the collection and return of medical record documentation, and stating the ten working day deadline for the return of documents.
- An Audit Cover Sheet for each beneficiary included in the sample.
- An MHP Control Log listing all Medi-Cal beneficiaries included in the sample.
- An MHP Paid Claims Audit Certificate of Authenticity for the medical records custodian to sign certifying that the documents were "accurate and unaltered photocopies of the actual progress notes in the indicated client's medical record."

- Pre-paid FedEx shipping label for returning documents to the CAEQRO office in Sacramento.

We received a number of inquiries during the first few days after MHP staff received their packets. The majority of these inquiries were handled by CAEQRO's director of information technology, who assured the MHP that this audit would not affect funding and explained its intent. Consequently, all but one MHP returned requested data to CAEQRO as instructed within the deadline. All 4,327 Audit Cover Sheets were returned to CAEQRO.

### Security and Confidentiality Measures

Since the documents received from MHPs contained protected health information, as defined by HIPAA, we recognized that specific procedures consistent with HIPAA regulations were needed to assure complete confidentiality. One physical office was designated as the MHP audit secure environment. The office remained locked while unattended, and only a limited number of authorized CAEQRO staff members were provided access to this storage and work space. Following completion of the audit process, the paper documents were transferred to an off-site secure storage facility.

CAEQRO hired two employees to process the records. Each employee was provided with an overview of the project and detailed instructions (Attachment 15) for reviewing and scoring cases. CAEQRO Administrative Director Michael Reiter routinely reviews the laws regarding protected health information with new employees and advises them of penalties that could be assessed for mishandling information. As per CAEQRO protocol, these new employees signed and dated the CAEQRO "Oath of Confidentiality," received on-the-job, supervised training, and received strict guidelines for maintaining security. Each record reviewer was instructed:

- Not to read or in any way attempt to interpret the narrative notes in the MHP documents
- To review only the three items in the record—birth date, gender and date of service
- Not to remove any folders or documents from the MHP audit office

All reviewers were under continuous observation by the CAEQRO staff as an additional protection of the records information.

### Tracking and Processing Procedures

Internal procedures were developed for accurate tracking and processing of the documents once they arrived in our offices in Sacramento. A "Paid Claims Audit Mail Log" was created to track the audit packages sent to MHPs via FedEx. As boxes with medical records were received in our office, the receipt date was entered to the Mail Log. The boxes remained closed until they were transferred to the audit office. There they were opened and packets with the EQRO Cover Sheet were sorted by EQRO Control ID number. All packets for a single MHP were placed in clearly labeled accordion folders, along with the Control Log and signed Certificate of Authenticity, awaiting review. Folders were placed alphabetically by County into storage boxes.

A “Paid Claims Audit Processing Log” was maintained which listed each MHP and the number of Audit Cover Sheets delivered to them. Processing a MHP batch of medical records involved the following steps.

- Enter the date and time the MHP batch was removed from the box on the log.
- Check for the signed and dated Certificate of Authenticity. If absent, do not proceed. (Note: Every MHP returned this form.)
- Compare data on the audit score sheet (which displayed one row per beneficiary with columns for birth date, gender, and service date on the approved claim) with the same data in the documentation supplied by the MHP.
- Where there was agreement for all three criteria, the packet was designated correct.
- If the medical record data did not agree or was missing, it was scored as an error and placed in a separate pile within the MHP batch, awaiting second level review.
- When a MHP batch was completely processed, the date and time completed and number of packets correct and in error were recorded on the log.
- The MHP batch was returned to the appropriate box.

At the conclusion of the review of all MHP documentation, two senior CAEQRO staff performed a second level review of all items coded as errors by the reviewers. At this point, data was entered to the audit database.

## **Audit Scoring**

Over the course of three weeks, reviewers examined all 4,237 medical records from 52 MHPs for the three designated criteria: birth date, gender and service date. Based on unique situations noted in the San Francisco pilot project and continuing through the first few MHPs reviewed, some common scenarios surfaced. A team of senior CAEQRO staff determined the appropriate decision for each scenario and instructed the reviewers to score accordingly.

Below is a list of common scenarios and our scoring decisions—which clearly illustrate that this process was indeed not a formal chart audit.

<b>Common Audit Scenarios &amp; Scoring Decision</b>	
<b>Issue</b>	<b>Decision</b>
If birth date or gender is missing from the document submitted, is it an error?	Yes, missing data is scored as an error.
If the birth month and year are correct, but not the day, is the birth date valid?	Yes.
On the registration document, the gender is blank (isn't marked M or F), but the progress note indicates the gender. Is this acceptable?	No, we aren't reading the progress notes.
Is a "print screen" acceptable documentation to show birth date and gender?	Yes
Is a computer generated report showing the birth date and gender acceptable?	Yes
Is it an error if the name on the EQRO cover sheet doesn't match the name on the county documents?	If the name appears to be an alias, and the birth date and gender match, score as correct. If it is clearly a different person, score as an error.
If there is no service year in the progress notes, is it still a valid date?	Yes
If the service date is changed and initialed, is it acceptable?	Yes
If the service date is changed and not initialed, is it acceptable?	Yes
If the progress note matches the approved claim date, but indicates "no show," is this considered a valid note?	Yes
If the date of service is off by one day, is it acceptable?	No, the service date must be exact.
Some progress note forms have a space for the "date" next to the signature of the clinician. Can that be considered the "service date"?	Yes
Is it acceptable if the progress note has the correct date, but is not signed?	Yes
Some types of service (day treatment, residential) have just a weekly progress note, is that acceptable?	If the service date is within the week that is documented, yes.
How do we know that the progress note submitted is for services at the Medi-Cal provider number identified on the Cover Sheet?	We don't; we assume that it is.

## Audit Results/Dispute Resolution

Each MHP's results were tabulated and returned to mental health directors in early June 2005 via FedEx. The package (Attachment 16) contained:

- An explanatory letter
- The MHP's summarized statistics
- The MHP's detailed list of beneficiaries (de-identified) showing items correct and in error

MHPs were advised of a two-week window to dispute individual claim line errors. As noted in the table below, eight MHPs sent letters requesting that we re-review the medical records previously submitted:

<b>Audit and Dispute Summary</b>	
Number of MHPs reviewed	52
Number of medical records reviewed	4237
Number of MHPs with written inquiries	4
Number of MHPs with disputes	8

Attachment 17 contains a spreadsheet with detailed information on disputes and inquiries from the MHPs. The table below summarizes the categories of disputed errors and their resolution:

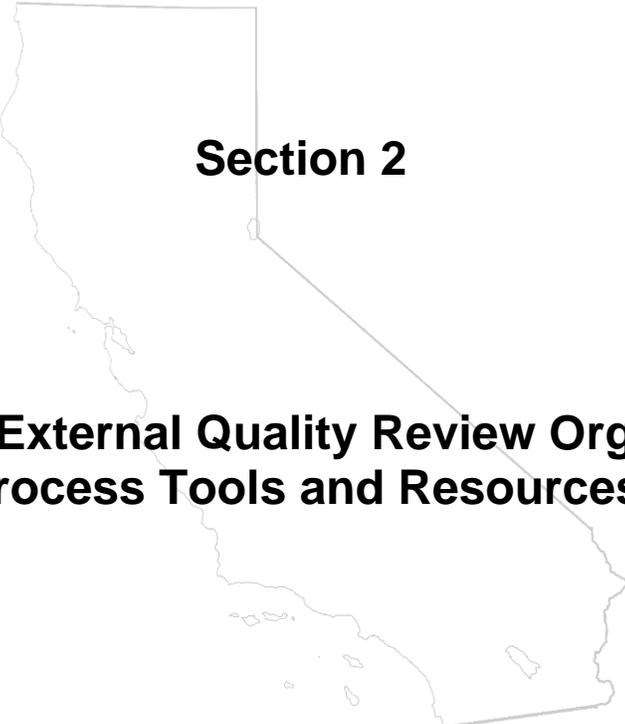
	<b>Birth Date</b>	<b>Gender</b>	<b>Service Date</b>
Disputed Records	6	7	20
Reversed Records	1	1	4

Senior CAEQRO staff pulled disputed records and performed a third and final review of the medical record documentation as compared to the Medi-Cal approved claims. In one case we performed an analysis of raw claims data to ensure accuracy of the gender submitted on the approved claim. On July 8, 2005, individual letters were sent via FedEx to each MHP that filed a dispute with the results of our final review. With this activity, CAEQRO considered the MHP Medi-Cal Paid Claims Audit for FY05 to be concluded.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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**Section 2**

**California External Quality Review Organization  
Process Tools and Resources**

## Section 2.1: Overview

As we discussed in Section 1, The California External Quality Review Organization (CAEQRO) viewed the Year One mental health plan (MHP) site reviews as an opportunity to discuss with MHP staff members their respective processes for tracking and measuring quality improvement activities, as well as an opportunity to introduce concepts of overall performance management. This “conversation about quality” in fact required that we perform a number of additional activities that complemented the scope of our work and infused our reviews with the tactics, as well as the strategy, that drive a shift in orientation from quality assurance and compliance to quality improvement.

- **Data analysis.** CAEQRO is committed to the efficient and effective use of data to inform and support quality management activities. To this end, CAEQRO focused in Year One on developing a data analytic capacity. In section 2.1 we review our process for performing the necessary analyses to validate the California Department of Mental Health (DMH) performance measure (PM) calculations. We also highlight several key reports that we generated to demonstrate the utility of existing data to support MHP quality management activities.

Despite the huge volume of data available from existing eligibility and claims files, CAEQRO is well aware that many MHPs have not yet been able to access data sources and/or have adequately used such data. An important task for the CAEQRO data analysis team going forward will be to continue performing analyses which are useful to both DMH and MHPs using *available data*.

- **Technical assistance and training.** Throughout Year One, CAEQRO provided to the MHP staff a broad range of technical assistance and training, both of which often began the day an MHP received the notification packet described in Section 1 and extended throughout the site and post-site review process. In addition to the technical assistance directly associated with our site review process, CAEQRO engaged in a wide range of activities—from the development and launch of a Web site to active participation in important professional meetings. The impetus driving all of our activities was to assist MHPs in improving internal operations and their services to consumers.

The following narrative describes both of these areas of focus in greater detail.

## Section 2.2: Data Analysis

Based in our Sacramento, California office, CAEQRO assembled a team of analysts with content expertise on the particular data currently available to the DMH and MHP information technology (IT) staff. CAEQRO requested and received a large volume of California data from DMH to build a data repository that enabled us to analyze and seek to validate DMH PM calculations.

CAEQRO's contract with DMH includes a formal business associate agreement as defined by the Health Information Portability and Accountability Act of 1996 (HIPAA). This agreement allows CAEQRO to receive data, including protected health information

(PHI), necessary for CAEQRO to perform DMH analysis calculations and other oversight tasks.

The following sections detail the CAEQRO data analysis process.

## CAEQRO Source Data Files

DMH provided CAEQRO access to eligibility and approved claims for source data through the following secure process:

- DMH placed source data files, which have been compressed and password protected, on one of its secure servers.
- CAEQRO was granted access permission (username and password) by DMH to this secure server.
- An authorized CAEQRO analyst was then able to log-on to the DMH secure server and download the source files to a CAEQRO secure server.
- The source files were uncompressed by using the same password assigned by DMH when they compressed the file. Uncompressed source files were stored as “text format files.”

Using this process, CAEQRO continues to have access to the following source data files for PM and other data analysis purposes:

- **Inpatient Consolidation Claims Files (IPC).** These files are transferred from Electronic Data Systems (EDS), the California fiscal intermediary for Medicaid, to the DMH. These monthly files are created by EDS as part of its claims adjudication process and are located at the Health and Human Services Data Center (HHSDC). The monthly files contain paid and denied claims processed during the respective month.

CAEQRO has created an historical file of approved and denied IPC records processed since August 2000 to current file creation date. At present, CAEQRO receives refreshed IPC data twice a year.

- **Short-Doyle/Medi-Cal Approved Claims Files (SDMC).** Located at HHSDC, these files are generated by DHS during the process of adjudicating the SDMC claims. The DMH IT unit downloads these files to its SAS server, after changing the COBOL high values to spaces. The files contain approved claims data, which are subject to year-end cost report settlement.

SAS is widely used in the healthcare industry and in government for statistical analysis of large, disparate sets of data. SAS was originally an acronym for statistical analysis system. In order to analyze DMH processes, CAEQRO purchased several SAS licenses.

The SDMC file contains adjudicated approved claims during a fiscal year. CAEQRO has successfully loaded historical SDMC data for prior fiscal years. For

partial fiscal year data, DHS generates a cumulative fiscal year-to-date file. With this processing strategy SDMC files typically contain claims for more than one fiscal year. DHS processing ignores when the actual date the service was provided. Currently the SDMC fiscal-year-to-date file is refreshed three times per year.

To date, CAEQRO has uploaded SDMC files for the following fiscal years:

- FY02
- FY03
- FY04 (not final/claims processed through June 30, 2004)
  
- **MEDS Monthly Extract File (MMEF).** The MMEF files are produced by DHS using the Medi-Cal Eligibility Data System (MEDS). A DMH copy of these files resides in the HHSDC. The file is created on the last Friday of the month and the current data refers to the beneficiaries' eligibility status on that date. At the end of each month, the file is prepared for the upcoming month. The file contains 16 months of eligibility data for each eligible beneficiary—including the current upcoming month, plus the 15 most recent months. For example, the file created in May 2005 would contain the following months of eligibility data: Current upcoming (June 2005), May 2005, April 2005, March 2005, February 2005, January 2005, December 2004, November 2004, October 2004, September 2004, August 2004, July 2004, May 2004, April 2004 and March 2004. The MMEF that DMH provides to CAEQRO is refreshed annually.

## CAEQRO Server Environment

Below we describe how we configured our information systems environment to support our ability to analyze DMH's processes for calculating PMs—including evaluating the actual code used by DMH to analyze Medi-Cal claims and eligibility data, and maintaining the security of PHI.

### Server file configuration

The CAEQRO server contains the following three main folders (also called directories) for storing the source data files. This strategy permits CAEQRO to maintain three copies of the same file to independently validate data at the file or field levels among the three different folders or directories.

- **The import folder** contains the original, unaltered version of the source data files that are down loaded from the DMH server. Import folder files are stored in text formats.
  
- **The SAS folder** contains SAS-generated data and work files. SAS files are stored in SAS-readable formats. SAS is the software application used by DMH for data analysis.
  
- **The SQL folder** contains Microsoft-SQL database tables. SQL tables are stored in SQL-readable data formats.

CAEQRO master files

Since the source data files that DMH provides CAEQRO only contain field values, no descriptive labels are included. It was determined that it was necessary to produce master tables for certain key fields. These master tables contain all valid codes for the appropriate table and corresponding label. The source information for the tables was the data records layout and field definitions/descriptions produced by DHS and DMH:

Name	Source
• Race	• DMH recodes MEDS codes for reporting purposes
• Language	• From MEDS
• Gender	• From MEDS and SDMC
• County	• From MEDS and SDMC
• Service Mode	• From SDMC and IPC
• Service Function Code	• From SDMC and IPC
• Aid Code	• From MEDS, SDMC and IPC
• Federal Eligible Status	• From MEDS
• Cross Over Indicator	• From SDMC and IPC
• Claim Paid Status	• From SDMC and IPC
• Denial Reason	• From SDMC and IPC
• Override Code Indicator	• From SDMC and IPC

CAEQRO application software

The following application software is used to process, manipulate and analyze data:

Software	Description
• SAS	• Statistical analysis software
• Transact-SQL	• Software that supports SQL
• Data Transformation Services	• Software that manages SQL files
• Excel	• Software that reads SAS/SQL

CAEQRO data quality assurance processes

Quality assurance validation of the data occurs at two key intervals in the transfer and load processes. The transfer process moves files from the secure DMH server to the CAEQRO server. CAEQRO has in place procedures to validate that the file transfer process was successfully completed. The load processes validates the loading of data files entirely within the CAEQRO server environment. The validation process is done at the field level for the three primary data source files.

### CAEQRO data security

Information in server includes many data files that contain PHI. All data are stored on secure servers in Brookfield, Wisconsin and are maintained under strict HIPAA-compliant security. In addition, the CAEQRO staff with access to the server environment is carefully limited to only those individuals with adequate expertise and a specific need to access this sensitive information. To further protect this information, no PHI is stored on local PCs.

## Year One Work Product Examples

Below are examples of supplemental reports CAEQRO generated during the course of our review process—both to inform Year One activities as well as to provide the building blocks for more quality-improvement-focused analyses in subsequent years.

- **Paid claims analyses.** Shortly after the initiation of our Year One MHP reviews, CAEQRO began preparing a series of reports based on paid claims. The purpose of these analyses was to assist the field review teams whose members were meeting with MHP staff. To help MHPs better understand and interpret available data, CAEQRO reviewers were able to use this MHP-focused report to discuss the implications of reports on demographics, penetration, costs per beneficiary and costs per beneficiary served. The report also allowed MHPs to compare their respective results to regional and statewide findings. These reports were reviewed by staff as part of the pre-site process in order to identify issues to later discuss and emphasize with MHP staff.

The report offered many perspectives on the data since results were available by:

- Age group
- Gender
- Age group and gender
- Eligibility categories (aid group)
- Service activity

To illustrate an example of this report, please see Attachment 18, which shows data for the fictional San Dumas County.

- **Race and ethnicity analyses.** One of the benefits of the dialogue between the CAEQRO reviewer team and the MHP staff is that problems with data can be identified and resolved. While reviewing race and ethnicity analyses, a number of MHPs questioned the values shown for their respective MHP regarding beneficiaries noted as “Hispanic.” Previous investigations by DMH analysts had identified a coding problem with ethnicity in the MMEF data. However, communication about data and data problems is always challenging. The CAEQRO review process allows such problems to be surfaced and understood by all parties. Many MHPs had been unaware of this problem prior to being informed by the CAEQRO staff. After DMH identified the problem in 2004, DHS began to resolve it since DHS manages all Medi-Cal eligibility and ethnicity coding issues.

- **Geographic analyses.** In May 2005 CAEQRO began doing analyses of data using geographical information systems (GIS) technology. This software allows information to be displayed on a map and is thus much easier to interpret. Attachment 19 includes examples of GIS analysis, which is no longer very costly and is within the reach of most MHPs. This type of analysis can be most helpful for program planning and evaluation regarding service distribution and access across a state, county or other region. As a display tool, it can be an effective means of communicating important planning information to a variety of stakeholders including beneficiaries and their families.
- **XY (scatter) chart analyses.** To provide further analysis of paid claims data, CAEQRO also produced XY (scatter) charts (also known as scattergrams). A scattergram shows the relationship between two variables. For Year One CAEQRO chose to analyze the following:
  - The relationship between penetration rate and paid claim amount per beneficiary served
  - The relationship between penetration rate and paid claim amount per eligible person for each of the MHPs reviewed

Attachment 19 also includes examples of scattergram charts. As with GIS mapping, this type of analysis can be helpful for program planning by helping MHPs evaluate access to service and the level of service activity. And as another display tool, scattergrams—like GIS maps—can help convey important planning information to a variety of stakeholders including beneficiaries and their families.

- **Claims and demographic data.** To assist the CAEQRO review team in comparing various measures across MHPs, we developed two reports—both of which are included in Attachment 19. The first report, which displays MHPs by specific size groupings, reflects our appreciation that certain factors do trend across counties of a similar size. The second report is a statewide summary of the individualized data that we presented to each MHP. This report supported our lead reviewers in looking for trends across MHPs—irrespective of size—and assisted in discussions during the site review process.
- **Completeness and timeliness analysis.** While we initiated this analysis in Year One, CAEQRO will continue to analyze paid claims data to understand the extent to which any paid claim file is representative of a particular MHP. While conducting such research, CAEQRO identified particular MHPs that had claims significantly delayed. The delay of data submission is problematic for any analysis. However, it need not delay the analysis of more timely MHPs as well as the use of these data for ongoing management purposes. As part of our effort to support the timely and accurate submission of data, CAEQRO will continue to evaluate and identify problem areas. Site reviews for problematic MHPs will continue this analysis.

## Section 2.3: Technical Assistance and Training

CAEQRO provided a broad range of technical assistance and training—both directly to individual MHPs and in professional forums. We also developed a variety of educational and resource materials—ranging from targeted training guidelines to the launch of a CAEQRO Web site. Attachment 3 contains calendars that display the activities we highlight in the narrative below.

### Individual MHP Technical Assistance

CAEQRO provided 55 MHPs with a wide variety of direct technical assistance, which often began the day an MHP received the initial notification and frequently extended throughout all three phases of the review process. In fact, the notification materials evolved from an introductory letter that we sent to MHPs in the early months of Year One to a detailed notification packet (included in Attachment 1) that, based on MHP feedback, provided specific guidance to help the staff prepare for the site review.

As the year progressed, CAEQRO provided an increased amount of individualized technical assistance to MHPs as their respective staff members recognized that we could be a valuable resource—both specific to the site review process and in formulating improved quality improvement initiatives. Additionally, three former MHP directors were retained as consultants who also contacted each MHP director prior to the site visit to help CAEQRO understand the operations of that particular organization.

#### Pre-site visit technical assistance

Following receipt of notification materials (thirty to sixty days prior to the site visit), the lead reviewer assigned to each MHP initiated the technical assistance process with a pre-site review call to the identified contact person—generally the quality improvement director in medium-size and larger MHPs and the director or deputy director in smaller MHPs—to cover the following topics:

1. Provide an introduction to the review process
2. Assist in identifying the appropriate MHP staff for each CAEQRO review session
3. Clarify the notification letter and the documents requested for the site review
4. Begin a discussion of the agenda and the MHP's particular needs regarding scheduling constraints and staff availability
5. Discuss CAEQRO expectations for the focus group and CAEQRO space, staff, and contractor availability requirements for the review itself
6. Review the Performance Improvement Project (PIP) or PIPs, as well as all other documentation sent by the MHP's staff
7. Discuss general matters pertaining to a strong quality improvement program

8. Conference in the CAEQRO IT reviewer to answer questions about the Information Systems Capabilities Assessment (ISCA) survey, components of the IT review, and expectations of the IT and business process interviewees

The degree of technical assistance for PIP activities varied by each MHP depending on the phase of development of the PIP, potential problems associated with the planned PIP and the desire of the MHP to receive technical assistance. Most MHPs requested and participated in highly detailed pre-site discussions regarding the PIP topic selection, methodology and data analysis.

#### Site review technical assistance

During the site review, the MHP and the CAEQRO staff participated in active discussions regarding issues facing the MHP, and CAEQRO delineated recommendations and identified opportunities for improving several key areas:

- **Cultural competence.** For example, CAEQRO assisted those MHPs that did not have a threshold language requirement from DMH or whose communities did not have cultural issues such as diversity in race, ethnicity or language. In these cases, MHPs provided guidance in identifying other cultures and sub-cultures that may have been underserved in that county. The CAEQRO discussion regarding MHP community cultures beyond that defined by race, ethnicity or language became a regular part of all reviews.
- **Quality improvement work plans.** We assisted MHPs lacking a strong organizational infrastructure, or who were going through a re-organization, in developing the quality improvement component of the organization and cultivating quality throughout the system.
- **Information system operations.** We provided MHPs, as needed, information systems infrastructure guidance, especially regarding processes that related to data integrity.
- **PIPs.** Many MHPs did not have PIPs that were thoroughly formulated, so our PIP review generally focused on assisting an MHP in clarifying the study question, identifying the data associated with the identified problem and understanding the barrier analysis process for determining interventions.
- **Surveys.** MHPs varied in their interest in, and commitment to, surveys as part of their ongoing activities. We requested a list of all surveys that the MHP conducted during the last year. Some MHPs only conducted the DMH-required Mental Health Statistics Improvement Program Consumer Survey. Others conducted a broad range of surveys, including targeting providers, its staff, beneficiaries and/or specific community groups. Therefore, as appropriate, CAEQRO addressed the value of surveys and other feed-back mechanisms, provided assistance in developing efforts to increase survey return rates and/or helped interpret survey results for planning concrete action items.

### Post-site review technical assistance

As described in Section 1.2, CAEQRO met (prior to submitting our final reports) on a monthly basis both internally and with DMH to discuss all MHPs reviewed during that month and those to be reviewed in the following month. Any additional documents forwarded by an MHP were reviewed in advance of the meeting by the appropriate CAEQRO member (e.g., director of IT) and, if necessary, the reviewer would follow-up with a call to clarify and/or discuss any other concerns. After CAEQRO delivered the initial report electronically, the lead reviewer made another follow-up contact with the MHP contact person, as necessary, to discuss any unclear recommendations or questions about the report.

Some MHPs asked to resubmit some material, generally the PIP, after the site review discussion. They wanted to take advantage of additional CAEQRO feedback or to improve what they considered to be their rating for the review. If the lead reviewer received this material along with the MHP's reactions to the draft report, he or she generally noted the sequence in the report and circulated the revised item to the CAEQRO staff members who jointly rated the PIP protocol based on the revised submission.

A few MHPs followed-up with the site team to ask additional general questions about career and training issues, or resources for gaining a more clear understanding of particular issues. As both the time spent with individual MHPs and requests for specific training increased during the second quarter of Year One, we decided to accelerate development of our Web site, an initiative discussed later in this section.

After the conclusion of Year One's review activities, a number of MHPs have continued to maintain close contact with CAEQRO, particularly for ongoing assistance with PIP activities. All MHPs have been invited to contact CAEQRO throughout the year regarding their planned PIP activities, as well as to receive assistance with any other issues.

### **Scheduled Training Sessions**

In addition to individualized technical assistance, CAEQRO provided or participated in training sessions aimed at addressing issues that would help all MHPs embrace or enhance quality improvement initiatives. These training sessions included:

- Initial PIP statewide video training presented in collaboration with DMH and California Institute of Mental Health (CIMH)
- CAEQRO review training at the Southern California Quality Improvement Committee (SOQIC)
- CAEQRO review training at the Northern California Quality Improvement Committee (NORQIC) meeting
- CAEQRO review training at the Bay Area Quality Improvement Committee (BAYQIC) meeting
- Quality improvement and information systems integration at the annual California Quality Improvement Committee (CALQIC) conference
- Quality improvement and information systems integration at the annual CIMH Information Technologies conference

- Consumer and family member CAEQRO peer reviewer training

## Professional Meetings

CAEQRO worked with a number of organizations throughout Year One in variety of capacities, and either participated in or collaborated on the presentation of the following events:

- The formulation of CIMH/DMH guidelines for statewide training in using data management for MHP planning
- A California Mental Health Directors Association (CMHDA) directors' meeting
- The CMHDA/CIMH/DMH/Consumer annual conference
- Medi-Cal policy meetings (part of CMHDA)
- State QIC meetings
- CMHDA IT Committee meetings
- The ISCA development stakeholders' task force
- Monthly DMH review collaboration meetings—involving personnel from DMH County Operations, Oversight, and Medi-Cal Policy
- A statewide video conference presentation at California Protection & Advocacy, Inc.
- Mental Health Service Act (MHSA) planning and development meetings
- Weekly and biweekly contract liaison coordination meetings with the DMH Medi-Cal policy and support staff
- A presentation to the California Planning Council
- Two DMH public hearings on federal managed care regulations
- The Women's Mental Health Policy Council meetings
- CIMH-sponsored managed care teleconferences
- CIMH-sponsored PIP training and manual development

## Interorganization Collaboration

CAEQRO recognizes the value and importance of collaborating with leading behavioral health organizations in developing and championing initiatives that support our shared goal of improving access to, and the quality of, mental health programs in California. The following examples illustrate how this kind of collaboration produced notable results in two key areas during Year One of our contract:

- **PIP training.** CIMH is a major training/technical assistance resource for the California behavioral health system. CIMH took a leadership role in following up on CAEQRO's initial PIP training (July 1, 2004) with a series of teleconferences directed by the CAEQRO consultant who had provided the training. The CIMH director of training who convened and managed the teleconferences continued his involvement by participating in three reviews throughout the year. As a result, he was able to provide useful feedback to MHPs and others on the actual process of the reviews. He also was able to identify training and technical assistance needs of the system.
- **MHSA training.** Implementation of MHSA has been the major system initiative since passage of then Proposition 63 in November 2004. Requirements for the

law include a formal and extensive planning process to determine priorities for initiatives within each county. Data requirements for the plan rest heavily on analyzing population data, estimating prevalence of certain diagnoses in particular populations, and targeting initiatives according to unmet needs as determined by data, stakeholder involvement, and perceptions. Although somewhat beyond our official scope of work, three CAEQRO staff members have participated with CIMH and DMH to develop a training curriculum and process that it is hoped will continue beyond the official MHSA requirements.

## Web Site Development and Implementation

While developing a Web site was an optional requirement for Year One, CAEQRO felt very strongly that this resource was essential to facilitate communication and assistance to all MHPs. The URL is [www.caeqro.com](http://www.caeqro.com).

Launched on February 1, 2005, this user-friendly site includes a broad range of resources that highlighted below.

1. **About the CAEQRO.** We provide general information about CAEQRO to help the MHP staff understand our program objectives, have access to contact information for each CAEQRO staff member and stay current with the full range of our activities. We also post communications for MHPs to reference long before they receive notice of their respective site reviews.
2. **Plan examples and supplemental resources.** To assist MHP staff members in meeting their respective requirements, CAEQRO posts illustrative examples of the following from a representative selection of MHPs:
  - PIPs
  - Cultural competence plans (as well as articles on this important area)
  - Quality improvement work plans
  - ISCA materials
3. **Web site links.** This section includes a broad range of links to both programmatic and professional resources.
4. **CAEQRO calendars.** To facilitate planning, CAEQRO maintains an up-to-date calendar of upcoming and completed site visits. Users can view the dates in a list format and or as monthly calendar.

CAEQRO updates the Web site on a regular basis both to insure that information is current and to respond to suggestions from stakeholders.

## Zoomerang Surveys

Consistent with CAEQRO's efforts to respond to the specific needs of individual MHPs, while assessing trends applicable to all, we decided to conduct a series of surveys using Zoomerang, an easy-to-use, Internet-based survey tool. These surveys focused on areas that support quality improvement initiatives and enabled us to provide timely

feedback to, and receive timely feedback from, MHP staff. These survey efforts included the following:

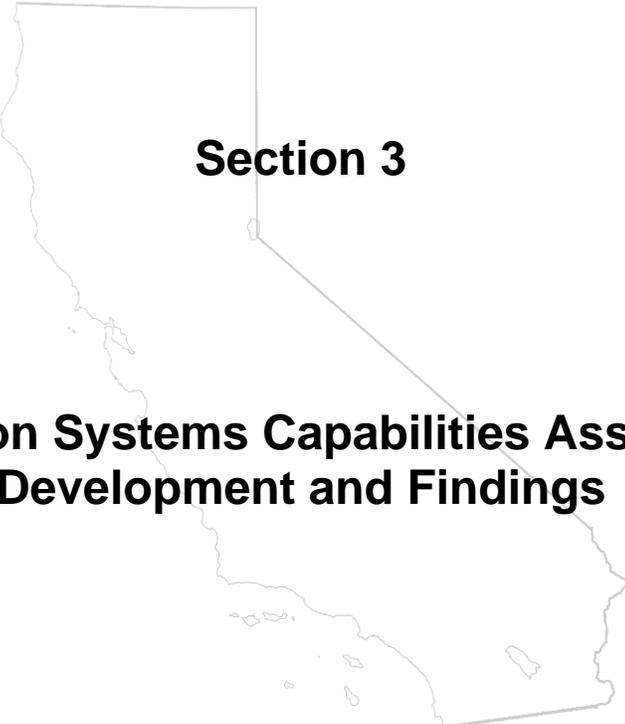
- Post-site review surveys of all the MHP staff members and major contract providers who participated in the review process (for the MHPs reviewed after October, 2004)
  - CAEQRO incorporated feedback received from MHPs throughout Year One as part of our quality improvement process improvement efforts, as noted in Section 1.
- A targeted survey of all MHP quality improvement coordinators
  - CAEQRO presented the analysis of this survey to all attendees at the annual CalQIC meeting on March 16, 2005. The data were used to highlight the need for improved IT/quality improvement collaboration—as discussed further in Section 4.
- A targeted survey of all the MHP IT staffs

CAEQRO presented the analysis of this survey at the annual CMHDA IT Committee conference on April 22, 2005. The Zoomerang survey replicated a 1999 survey so we could compare key results. We learned that 83 percent of responding MHPs were selecting, implementing or actively contracting for a new information systems—a benchmark that informed our findings in Section 4.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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A map of California is shown within a black rectangular border. A vertical line is drawn through the state, and the area to the right of this line is shaded light gray, representing Section 3. The text 'Section 3' is centered over this shaded area.

**Section 3**

**Information Systems Capabilities Assessment  
Development and Findings**

## Section 3.1: Overview

The California External Quality Review Organization (CAEQRO) is responsible for the independent review of the health information systems at each Mental Health Plan (MHP) in the state. The Centers for Medicare & Medicaid (CMS) require this review process as part of Title 42, Code of Federal Regulations, Section 438.242. CMS has not mandated a specific format for collecting the data that will inform the assessment. Instead CMS created a model Information Systems Capabilities Assessment (ISCA) protocol—which is Appendix Z<sup>1</sup> of the federal protocols and is intended to offer guidance regarding the intent, process and purpose of a health information systems review.

The original federal protocol was developed for a large managed care organization providing general healthcare services. As such, it was heavily oriented towards capitated health plans and information systems issues that are associated with encounter management in support of capitation. California operates a fee-for-service system and therefore has different information systems requirements, which were not addressed in Appendix Z.

CAEQRO was asked by the California Department of Mental Health (DMH) to create an ISCA survey relevant to the wide variety of California MHPs. In FY05, CAEQRO successfully developed and employed a California-focused ISCA survey that accommodated these key variables:

- Broad range of agency size
- Structure of fee-for-service Medi-Cal
- Availability of electronic Medi-Cal eligibility information
- Staff resources available to manage information systems

The ISCA survey is a key element of the MHP health information systems review process. The information obtained for each MHP should be updated annually if necessary. During Year One, the ISCA survey was completed by the MHP staff prior to the site review and then discussed with the MHP staff during the site review. This information was supplemented by additional site reviews of systems and interviews with MHP staff that play important roles in system operations. While conducting initial site reviews, CAEQRO soon recognized the need for and therefore promoted collaboration across the MHP organization to gain the most useful information. In preparing our final health information systems review, we also considered the significant budgetary constraints that affect each California MHP.

In the following discussion, we describe how CAEQRO developed the California-focused ISCA survey, summarize the survey components and outline the process for conducting our Year One information systems review. In addition, we summarize the key ISCA findings that we derived from our MHP reviews.

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<sup>1</sup> Appendix Z can be downloaded from the CMS Web site: <http://www.cms.hhs.gov/medicaid/managedcare/protoappz.pdf>.

## Section 3.2: Information Systems Capabilities Assessment Survey Development

### Development Process

CAEQRO began our Year One activities by conducting a careful review of Appendix Z. This review confirmed the need for a completely revised and updated ISCA survey that would be more suitable to the California public mental health environment. Specific goals for the development of the California survey included the following.

- Communicate clearly to a wide variety of MHP personnel—not only those in information technology (IT), but also billing and quality improvement staff, program planners and management personnel.
- Address how MHPs are using information for quality management and how quality improvement processes are supported by the respective MHP information systems.
- Provide a current status on the many MHPs that are planning future system changes.
- Assess how MHPs are verifying that their information systems contain timely and accurate data, which is validated as part of ongoing internal procedures.
- Assess the level at which MHPs use data analysis, reporting and data retrieval for MHP planning.

Beginning in July 2004 and continuing through October 2004, a CAEQRO team created a series of draft ISCA surveys that reflected the following collaborative effort.

#### Stakeholder involvement

The involvement of the stakeholder was essential to the creation of an ISCA survey that was both useful and comprehensive. The MHPs represented on the ISCA stakeholder group were:

- Alameda
- Butte
- Glenn
- Los Angeles
- Merced
- Placer
- Sacramento
- San Luis Obispo
- Stanislaus

The draft ISCA surveys were initially reviewed by a group consisting of DMH representatives and MHP volunteers. Each question on the ISCA survey was reviewed and modified in response to the very useful feedback provided by stakeholder representatives. The final edited document, Version 5.7, was first presented to DMH as a draft deliverable on October 25, 2004. After a period of further stakeholder review and CAEQRO editing, Version 5.7L was officially accepted by DMH on January 25, 2005. Version 5.7L is included with this report as Attachment 20.

### Cross functional participation

One of the earliest lessons learned during the Year One review process was that the ISCA survey should not be exclusively targeted to IT managers. In early reviews, IT managers attempted to complete the ISCA survey alone, only to learn that providing complete information required staff input from a variety of disciplines. Since information systems reach so broadly into the routine operations of an MHP, it was both necessary and desirable that teams of IT, quality improvement, billing, fiscal and administrative staff all play a role in completing the ISCA survey. Such broad participation is consistent with one of CAEQRO's key findings: the need to reduce information silos and to improve communication about information systems issues.

### MHP and DMH input

Since CAEQRO field work also began in July 2004, we were able to field test each version of the ISCA survey with assistance and input from many MHP staff. Over the course of the initial revisions, the ISCA survey was greatly improved by feedback from not only the stakeholder review group, but also the MHPs that participated in the initial reviews and DMH staff. CAEQRO acknowledges the cooperation and assistance of all MHP and DMH staff involved in the development of the ISCA survey.

The CAEQRO web site, [www.CAEQRO.com](http://www.CAEQRO.com), which we developed to share a variety of information with the MHPs, has a section devoted to the ISCA survey development process. It includes examples of completed surveys that assisted various MHP staff members as they completed their respective surveys prior to their MHP site reviews.

## **Summary of Current ISCA Survey (Version 5.7L)**

Attachment 20 contains version 5.7L of the ISCA survey, developed by CAEQRO. The following summaries highlight the four main sections of this version of the ISCA survey.

- **ISCA Section 1: General Information**

The ISCA survey collects basic information about the lead person completing the ISCA. As noted previously, each ISCA survey required different staff to complete particular sections. One important and simple result of the ISCA survey process was the production of a statewide list of lead IT staff.

- **ISCA Section 2: Data Processing Procedures and Personnel**

This section of the ISCA survey collects information on the nature of current MHP IT functions, the nature of current staffing for operations and data analysis, and local policies and procedures for the operation of the MHP information systems. Since all surveyed MHPs (with the exception of the San Mateo MHP) currently use a fee-for-service model, the ISCA survey includes questions on how encounter data is collected and prepared as a claim for submission to DMH.

The purpose of this section is to focus attention on how the information systems captures a large volume of data on Medi-Cal eligibility and the services provided to beneficiaries. In the majority of cases each MHP functions not only as a

mental health plan, but also as a provider of service. Thus, it was important for the ISCA survey to address the process of creating Medi-Cal claims.

Historically, many MHPs have had limited capabilities to analyze their local data. To address this concern, the ISCA survey also includes questions on internal reporting capabilities. To support future technical assistance to MHPs, it is important to understand the local support that is available to write ad hoc reports or to use standard reports to support quality management efforts.

Finally, Section 2 addresses security issues relevant to any health information systems, including considerations around the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- **ISCA Section 3: Incoming Medi-Cal Claims Processing and Adjudication**  
This section was designed for the many MHPs who operate a managed care unit or otherwise assess eligibility, authorize care, manage a network of external providers and process claims.

The ISCA survey captures a variety of information to help CAEQRO understand the scope and nature of the MHP's claims processing operation. These questions are relevant for organizations that process claims manually as well as for the smaller number of MHPs that use an automated claims adjudication process. Questions were designed to gain information about day-to-day operations and to determine if the MHP documents such operations at a policy and procedure level.

- **ISCA Section 4: Automated Incoming Medi-Cal Claims Processing**  
This section has a narrower focus than the first three. It addresses the small number of MHPs who have automated claims adjudication processing. These questions address how claims are edited for validity, how errors are processed, whether claims are pended for review, and how information flows through the automated system on a timely and accurate basis.

## ISCA Operations and Administration for Year One

Assessment of each MHP's information systems consisted of the following four consecutive activities:

- **Step one** involved the collection of standard information about each MHP's information systems by having the MHP complete the ISCA survey that CAEQRO developed for California. DMH defined the time frame in which the MHP was expected to complete and return the survey. The survey included both requests for data and documents. To assist the MHP in providing complete documentation, the survey contained a final checklist that cross-referenced the attachments with the specific item in the survey.
- **Step two** involved a review of the completed ISCA survey by CAEQRO. Materials submitted by the MHP were reviewed in advance of the site visit.
- **Step three** involved a series of site and telephone interviews and discussions with key MHP staff who completed the ISCA survey and with other

knowledgeable MHP staff. These discussions focused on various elements of the ISCA survey. The purpose of these interviews and discussions was to gather additional information to assess the integrity of the MHP's information systems.

- **Step four** produced an analysis of the findings from both the ISCA survey and the follow-up discussions with MHP staff. A summary report of the interviews as well as the completed ISCA document were included in the IT section of the report that CAEQRO prepared for each MHP. In the report, we addressed the MHP's ability to use its information systems and analyze its data to conduct quality assessment and quality improvement initiatives. Further, we considered the ability of the MHP information systems to support the overall goal of quality management as part of the delivery of mental health services to beneficiaries.

## Year One Process Overview

While the survey process for information systems is complex by nature, the ISCA survey process during FY05 had a number of mitigating factors that created a unique set of important considerations.

- **Number of completed ISCA surveys.** Because of the following factors, 52 of the 58 MHPs completed an ISCA survey during the Year One review process:
  - Sutter/Yuba MHP and Placer/Sierra MHP each completed a single ISCA survey—consistent with the structure of these combined MHPs
  - Since the ISCA survey was under development when the review process began, Glenn MHP, Monterey MHP and Colusa MHP were not asked to complete an ISCA survey
  - Solano, which operates as a managed care organization (MCO) was not reviewed during Year One

In addition, because the ISCA survey development was an iterative process, each MHP was not asked all the same questions in the current California ISCA V5.7L. The initial MHP reviews included a combination of segments of Appendix Z and early drafts of the ISCA survey. Questions more appropriate to California were added as the current ISCA survey was completed.

- **Experience with Information Systems Surveys.** The Year One ISCA survey for most MHPs was the first such review of their information systems. Only the larger MHPs had undergone similar reviews in the past. As a result, there was extensive variation among the MHPs as to precisely who completed the survey and how respondents interpreted certain questions. Since a number of smaller MHPs do not have full-time IT staff, they tended to have non-technical staff complete the survey. In larger counties with IT staff, many staff members participated in completing the survey. Regardless of who completed the survey, CAEQRO assumes the survey responses accurately report the characteristics of the MHP information systems. While site reviewers followed up with MHP staff to clarify many of the responses on the ISCA survey, they did not alter MHP responses on the ISCA survey.

### Section 3.3: Analysis of Information Systems Capabilities Assessment Survey Results

Both our analysis of Year One ISCA survey results and an assessment of the survey instrument itself are ongoing processes. As with all data analyses, CAEQRO’s Year One analysis will generate new questions that we will pursue in Year Two and beyond. The following summaries and figures reflect the key information contained in the ISCA survey responses as submitted to CAEQRO.

In analyzing the results displayed in the following figures, we combined the categories "small" and "small-rural." In addition, Los Angeles results are contained in the "large" category. (See Attachment 19, which includes a report displaying MHPs by specific size groupings.)

MHPs with computer-based systems use a wide variety of vendor products.

A variety of systems

Figure 1 clearly shows that an important change is occurring within California. It illustrates the wide variety of vendors with operational systems in

California during CAEQRO’s Year One review. In the recent past, a much smaller number of vendors were doing business with California MHPs. Although a few vendors are more dominant, the marketplace is very active. Therefore, the information displayed below may change over the course of the next two years as many MHPs replace their aging systems.

**Figure 1**  
**Current MHP Information Systems by Vendor and County Size**  
 (Note: Several MHPs have multiple systems)

	MHP Size			Total
	Large	Medium	Small	
CalCis - MHBAR	1	0	0	1
Cerner	1	0	0	1
Clindox/Docdox	0	1	0	1
CMHC	0	1	10	11
Creative Socio Medics	2	0	5	7
Diamond	1	1	0	2
ECHO	6	10	11	27
IDP	0	0	1	1
InfoMC	5	3	0	8
InfoScriber	0	0	1	1
Innvision	1	0	0	1
InterTrac	0	0	2	2
MHP/Local System	1	3	4	8
NetPro	1	0	0	1
Platton Technology	0	2	0	2
POR (Patient Oriented Record)	1	0	0	1
The Clinical Manager	1	0	0	1
Trizetto	1	--	--	1
UniCare	1	0	0	1

*Note: Eight systems were defined by MHPs as local development efforts. Typically such systems are created and managed by the local county IT department.*

California MHPs' systems offer several distinct functions.

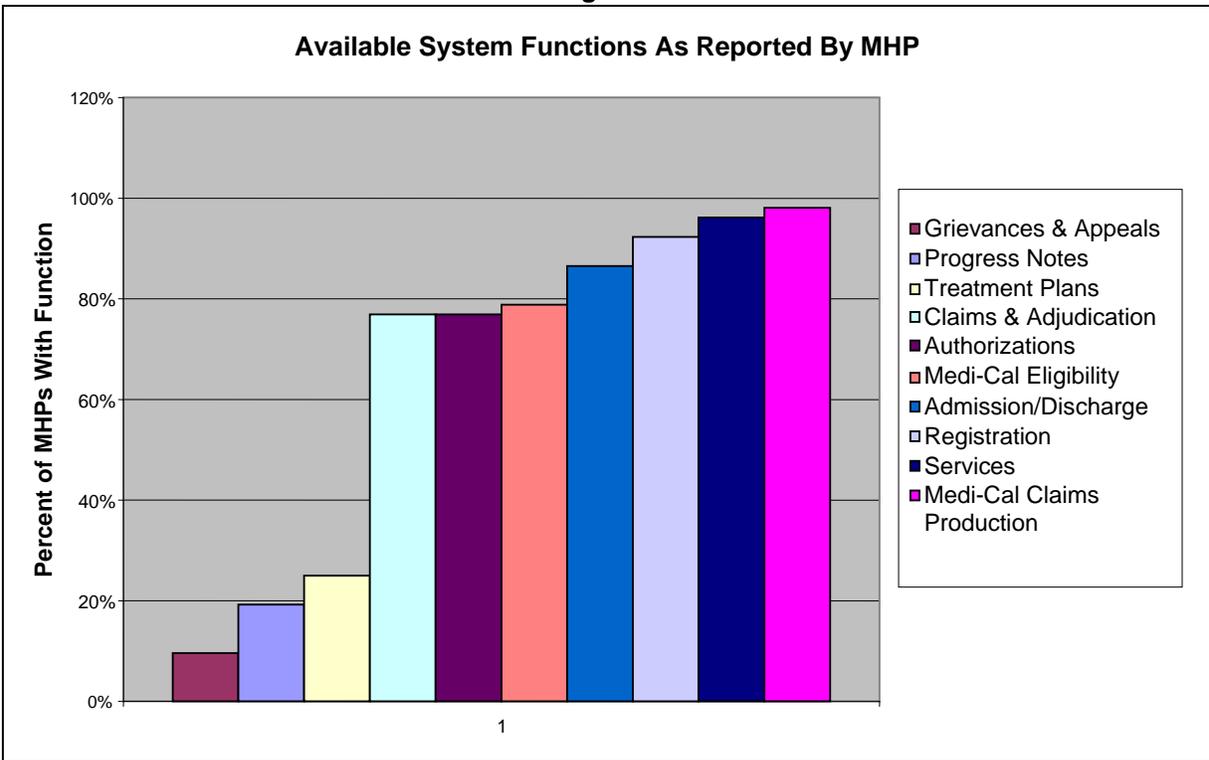
A variety of system functions

In addition to reflecting a wide diversity of vendor products, MHPs' systems have very different functionality. Figure 2 indicates the distribution of MHPs' 10 key information systems functions.

In most cases, MHPs use more than one system to gain access to all functions. In many cases, particularly in the clinical areas of service records and treatment plans, the majority of MHPs have not yet acquired such functionality. Grievances and appeals, while tracked by all MHPs, are rarely integrated into their information systems. Typically, such information is tracked using an independent and often manual system.

Figure 2 reflects the history and evolution of California mental health information systems, which were created as billing systems and, as such, focused on the functions required to support billing and eligibility. Newer electronic medical record functions such as service records and treatment plans are often available from vendors but have not yet been purchased and or implemented.

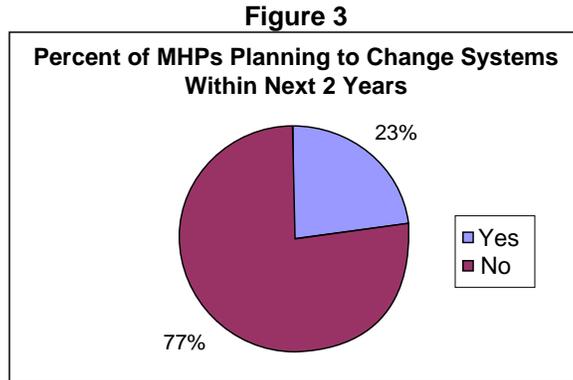
**Figure 2**



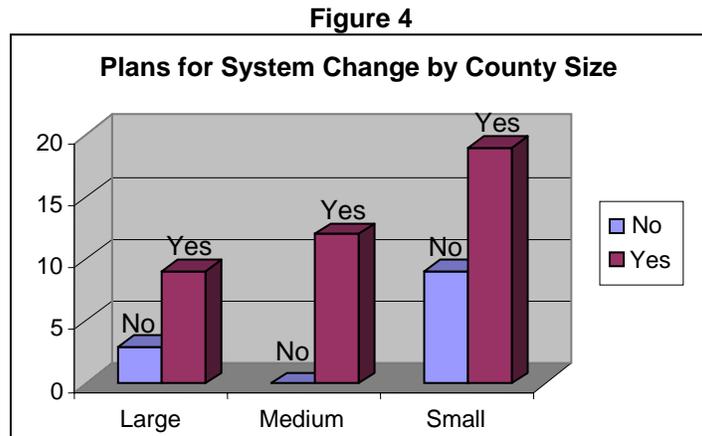
Seventy-seven percent (77 percent) of surveyed MHPs plan to change systems within the next two years.

Systemic plans for change

Figure 3 illustrates the fluidity of the situation.



These plans for change are not restricted to MHPs of a particular size. Figure 4 shows that plans for change are widespread throughout the California mental health system.



Many smaller counties are planning to collaborate on a joint effort to implement new systems. These plans are active and may change the distribution of vendors and MHPs shown in Figure 1.

These plans for change reflect a few key points:

- Aging of systems
- Need for more clinical functions
- General acknowledgement that information systems play a large role in the management of service delivery systems

Since so many MHPs are planning for change in a relatively short time period, the statewide mental health system faces new challenges. Multiple and simultaneous

implementations can be highly problematic, since they frequently create delays in the flow of data and revenues.

Problems with such multiple implementations can often be anticipated and avoided. Careful monitoring of implementation projects and transparent oversight efforts will aid in avoiding some problems and quickly solving those problems that do occur.

Most MHPs lack a data analytic capacity, which is typically misunderstood to mean financial and claims reporting.

**Inadequate Analytic Capacity**

Throughout discussions with MHP staff and management, CAEQRO reviewers learned that the majority of MHPs have very limited or no analytic capacity. Often staff members who have expertise with data analysis are focused exclusively on critical financial and revenue operations. As a result, much of the data collected by MHPs is simply processed, used for claims and Client and Services Information data reporting.

Routine procedures to extract and download data are often not available. As a result, only persons with higher levels of technical skills can access data. While many staff would like to use these data, this information is effectively trapped in the local system.

Figure 5 suggests that many MHPs have staff members who do analyze local data. However, these results are in conflict with the more qualitative discussions during site reviews. It is possible that, while analysts exist at MHPs, they are simply not available for the wide variety of analytic tasks that would support the use of data for more than financial operations. Or it is possible that staff identified as analysts need additional training to interrogate available MHP data.

Field interviews indicate that many smaller MHPs do not have data analysts who are able to interrogate the local database. Rather, they call on their vendor to perform special or ad hoc reports. Typically there is an hourly charge for this service. This expense strictly limits the number of such reports.

**Figure 5  
MHPs with staff analysts**

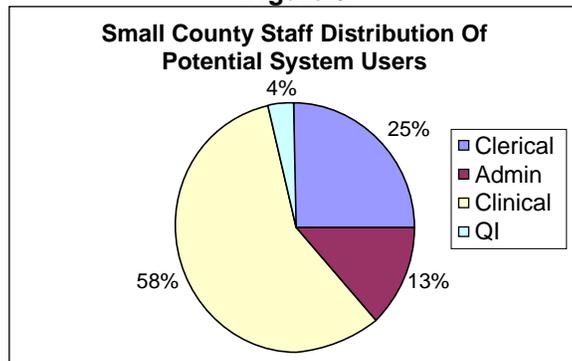
		MHP Size			Total
		Large	Medium	Small	
<b>NO</b>	<b>Count</b>	0	2	4	6
	Row %	0	20%	80%	100%
<b>YES</b>	<b>Count</b>	12	10	24	46
	Row %	26.1%	21.7%	52.2%	100%
<b>Total</b>		12	12	28	52

Despite a high number of reported potential clinician users, data suggest that information systems use is largely administrative.

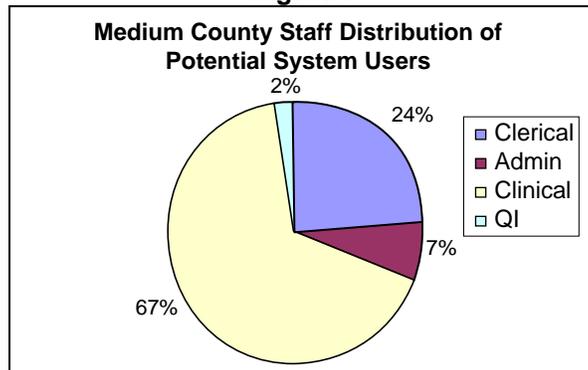
**Administrative use for information systems**

The ISCA survey asked MHPs about their system users. Each MHP was asked to describe the type and number of staff that use their current information systems. Figures 6, 7 and 8 below illustrate how information systems users are distributed for small, medium and large MHPs.

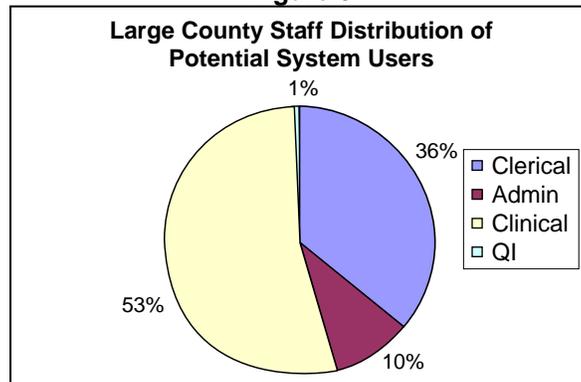
**Figure 6**



**Figure 7**



**Figure 8**



The majority of systems do not yet have clinical functions and thus clinicians are limited as to how they use most current information systems. Considering the functions available to most users, the large number of clinical users reported on the ISCA survey, suggests that use of information systems remains largely for consumer-related inquiries.

It is likely that as new systems are installed, many of the clinicians identified in the figures above will need to be trained to use the newly emerging clinical functions that will become elements of future electronic medical records. The move to such a future will be slow, but CAEQRO reviews have identified a small number of MHPs that have begun to implement new clinical functions. It will be important to learn from the experience of these MHPs.

The implementation of new systems will necessitate a more formal training approach.

Need for information systems training

The ISCA survey results indicate that the vast majority of MHPs have established an organized training program for information systems users.

This activity is essential to effective use of any information systems. In general, the strategy for training tends to be associated with the size of the MHP. Larger MHPs have the ability to establish formal classroom training while smaller and medium-sized MHPs execute their training efforts with on-the-job efforts to teach staff how to use systems.

Many MHP information systems are used largely by support and billing staff. As MHPs implement new systems and the balance of system utilization shifts to a wide variety of staff (including clinicians), new approaches for organized training will be required.

**Figure 9**  
Does the MHP have an organized training program for information systems users?

		MHP Size			Total
		Large	Medium	Small	
<b>NO</b>	<b>Count</b>	0	2	3	5
	Row %	0	25%	75%	100%
<b>YES</b>	<b>Count</b>	11	11	24	46
	Row %	23.9%	23.9%	52.2%	100%
<b>Total</b>		12	12	28	52

New or improved policies and procedures are necessary for establishing an accurate and timely reporting function.

Limited monitoring of data timeliness and integrity

MHPs were asked about how they validated the data within their system. Approximately

33 percent of the responding MHPs indicated that they had no such process to check the integrity of system data. During interviews MHPs that reported that they do conduct periodic verification of data limit such activities to a double check on the entry of services.

Site interviews with the MHP staff suggest that many believe that “the computer” checks for validity. This is a concern since an over reliance on system tables to check incoming data can lead to over confidence in data accuracy. Tables which control such validations are often not routinely checked. Many MHPs neither know the types of tables nor have the ability to access them to check for accuracy.

Site interviews also indicated that while quality improvement staff frequently audit clinical records, MHPs typically do not cross check their information systems with the clinical record. Such cross checking is an important activity that should be shared between quality improvement and IT staff. The results of MHP claims audit for February 2003 suggest that error rates between clinical records and information systems can be reduced by regular internal audit activities.

**Figure 10**  
**Does the MHP perform periodic verification of data in the information systems?**

		MHP Size			Total
		Large	Medium	Small	
<b>NO</b>	<b>Count</b>	3	3	13	19
	Column %	25%	25%	39.29%	32.69%
<b>YES</b>	<b>Count</b>	9	9	15	33
	Column %	75%	75%	53.57%	63.46%
<b>Total</b>		12	12	28	52

In addition to data integrity the ISCA survey addressed the issue of timeliness of data. Key to the effective use of data to manage and improve programs is not only the accuracy but the timeliness of such data. As Figure 11 below indicates, large numbers of surveyed MHPs do not have a policy to maintain timely data. While in practice, more programs may indeed establish policies, the results suggest that more attention to this issue is required. Both a policy and a procedure to monitor this activity is an important element of establishing an accurate and time-sensitive information systems.

**Figure 11**  
**Does the MHP maintain a policy for the timeliness of data?**

		MHP Size			Total
		Large	Medium	Small	
<b>NO</b>	<b>Count</b>	5	6	17	28
	Column %	41.7%	50%	60.7%	54%
<b>YES</b>	<b>Count</b>	7	6	11	24
	Column %	58.3%	50%	39.3%	46%
<b>Total</b>		12	12	28	52

Few MHPs use an automated claims adjudication system, although all but six process claims from external providers.

#### A wide variety of claim processing procedures

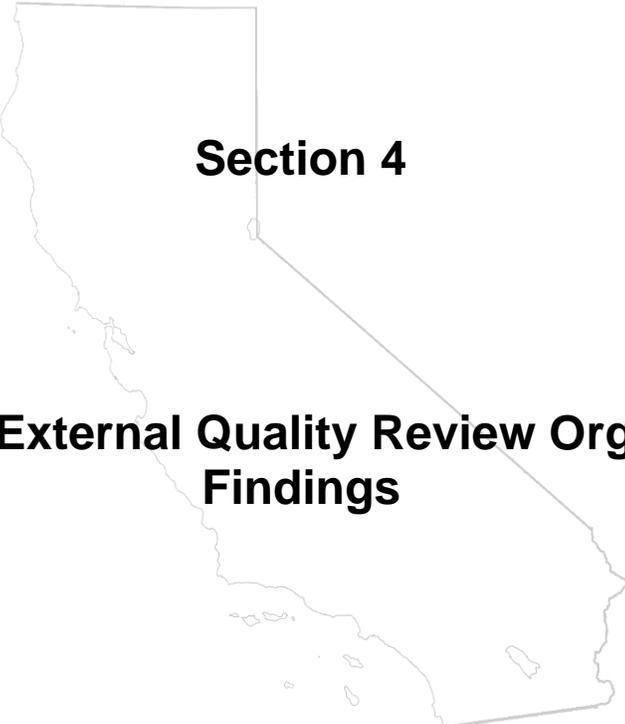
ISCA survey responses from MHPs indicated that all but six small MHPs reported that they process claims from external providers. CAEQRO

determined that a wide variety of claims processing approaches are being used across California. Very few MHPs are using automated adjudication of claims. The vast majority are processing claims using a mix of semi-automated procedures to receive and evaluate claims from external providers. Future CAEQRO assessments of MHP information systems, particularly as new systems are implemented, will gather additional data on the management and processing of external provider claims.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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**Section 4**

A map of California is shown with a thin black outline. A rectangular box is drawn around the northern portion of the state, encompassing the area where the text "Section 4" is located.

**California External Quality Review Organization  
Findings**

## Section 4.1: Overview

As illustrated by our process discussions in Sections 1 through 3 and our many attachments, the California External Quality Review Organization (CAEQRO) devoted substantial time and resources during our first contract year to learning about three key areas of focus within each mental health plan (MHP) and within the California Department of Mental Health (DMH): quality management, data analysis and use of technology. Because of the expanded mandate from DMH, we were fortunate also to be able to look at important related areas that inform the values of the community mental health system—particularly cultural competence and consumer/family involvement. In addition, as Year One progressed, we gained valuable insights into recurring management, financial and human resource issues that influenced overall organizational performance and capacity of the systems.

Because of this wide range of activities, we applied two different—but equally valid—data-driven approaches to performing our analyses and reporting on our findings.

- **Quantitative analyses and findings.** Sections 4.3, 4.3.1 and 4.3.2—DMH Performance Measure (PM) Operations Validations, DMH Data Analysis Results and MPH Data Validation, respectively – include concrete quantitative findings and graphs, charts and tables within the narrative that is then further supported by extensive worksheet documentation in our attachments. Some of the findings related to the Information Systems Capabilities Analysis (ISCA) survey we describe in Section 3 fit this category. In applying this kind of analysis, reporting the accuracy and/or adequacy of MHP or DMH processes is relatively straightforward.
- **Qualitative analyses and findings.** In contrast, while providing a rich source of data, site reviews require a different and highly complex analytical process. CAEQRO tackled this interesting challenge in a number of ways throughout the year and in preparation for the Statewide Report Year One. Section 4.2 includes a detailed discussion of our findings and reflects the 54 MHP site review reports CAEQRO generated for Year One. To assist in this analytical process and enable easy access to our source data, we include 55 abridged versions of our MHP site review reports in Volume II of this report. While we submitted 54 MHP reports, we include a summary for the Alpine MHP for which we provided fairly extensive pre-site visit technical assistance (as noted in Section 2.3). The information in the Individual Mental Health Plan Summaries is solely derived from the data and commentary contained within the original MHP site review report.

The following narrative offers a detailed discussion of our findings and encompasses the expanded scope of work for Year One.

## Section 4.2: Mental Health Plan Site Reviews

In Section 1, we discussed the three phases of our site reviews including our pre-site activities, site review process and post-site analysis. We also summarized our MHP report development process. In this section, we articulate the common findings derived

from our analysis of all CAEQRO MHP site review reports. These findings comprise the following three levels of information.

- The first level includes findings for the specifically defined areas of responsibility included in our MHP site review reports—with the exception of the ISCA survey findings which we include in Section 3.3.
- The second level indicates common MHP strengths and challenges as reflected in the MHP site review reports and includes an assessment of overall administrative, financial and programmatic operations.
- The third level represents complex themes significant for the overall success of the organizations to manage and/or provide crucial services to a large and vulnerable population.

Below we discuss level one and level two findings. Our discussion on complex, yet common, themes follows in Section 5, which covers fairly significant systemic issues and includes our top line recommendations for addressing them.

## **A Focus on Quality Improvement**

During Year One, in addition to meeting the federal guidelines, DMH wished to establish a baseline snapshot of each MHP. CAEQRO's approach to the site reviews and the reports we produced on each MHP not only incorporated both of these objectives, but also reflected our recognition that the external quality review (EQR) process was new to California MHPs. We therefore employed a consultative educational approach—beginning with our initial remarks to the MHP staff in which we framed the site review as a “conversation about quality” and throughout our site review process and finally in our individual MHP reports.

Largely narrative, the body of our MHP reports contained a description of the MHPs' activities and documents for each specific area of assessment followed by our recommendations for improvement. Draft copies of the MHP report were sent to DMH and the MHP for each one's respective review and comments prior to our issuing the final report. Because of the consultative nature of the review process, the reports were consistent with our prior discussions with MHP staff and thus were largely not controversial.

MHP comments typically involved corrections of fact, which were largely limited to participant or program names and program descriptions. Only two MHPs objected to specific content they felt was either inaccurate and/or damaging. In both cases two reviewers had independently documented the content in question. In one of those cases similar content was present in other sections of the report, so we removed the specific reference in question. In the other case, the content in question remained in the report. DMH comments generally requested further clarification or additional detail about a particular item.

Through this collaborative process, CAEQRO was able to gather a substantial body of information that enabled us to identify the common findings we articulate below.

### Cultural competence plans and activities

- **Lack of plans and concrete activities.** All MHPs recognized the importance of attention to particular beneficiary cultures and groups. However, specific plans, goals for training, concrete activities and definitions of desired outcomes, such as specific penetration rates for specific groups by a certain date, were often lacking.
- **A range of human resource issues.** In general MHPs struggled with recruiting and retaining competent bi-lingual bi-cultural staff. Barriers included salary scales, rigid and slow-acting human resource systems, accelerating housing costs, the inability to attract competent candidates, and the geographic isolation of their areas. Each MHP appeared to struggle with this issue alone, without any coordination or consultation with other MHPs facing the same challenge.

In addition to recruitment and retention issues, budget cuts had often forced the elimination of the position of ethnic services manager. While in some cases the MHP made the decision to eliminate this position, this particular staffing cut was often determined at a higher level of the county structure. In some cases, the responsibility for cultural competence activities was added to another staff person's duties. In other cases, the responsibilities associated with this position simply disappeared.

In many cases, especially in small counties, cultural competence plans are not integrated into other quality improvement activities or plans and reflect attention only to language and ethnicity definitions of culture. For example we found a common misperception among some MHP staff that if there is no threshold language, there are no cultural issues.

- **Low penetration rates.** Despite apparent outreach efforts, a number of MHPs had low penetration rates for particular ethnic/cultural groups, particular age groups or particular Medi-Cal eligibility groups. Few MHPs had either written policies about population penetration rates beyond the DMH's contract boilerplate language or ongoing and systematic activities to increase penetration rates for a variety of community populations.

### Quality Improvement Activities

- **Medi-Cal Plan of Correction**

CAEQRO was contractually required to follow up with a review of the quality improvement plans of correction from the most recent Medi-Cal oversight review protocol. During our site review, CAEQRO staff examined relevant documentation to verify that the actions required had been implemented. With some exceptions, the MHP had addressed the few cited items by implementing a plan of correction. Since the time that had elapsed from the most recent oversight review varied, CAEQRO often reviewed documents and actions that could be two- or three-years old.

- **Quality Improvement Protocol**

CAEQRO was contractually required to administer the quality improvement protocol that was previously part of the DMH Medi-Cal compliance review. Prior to the contract's implementation, DMH believed that consolidating all quality improvement reviews under CAEQRO would be most efficient. In practice, this change created confusion among the MHPs. As a consequence of conducting this compliance-focused task, CAEQRO was not perceived as dedicated to quality and performance improvement. Instead, this task reinforced the misperception that the California EQR process was just a compliance review requiring plan corrections and carrying the threat of sanctions.

Both CAEQRO and DMH agreed that CAEQRO's responsibility for this task sent a contradictory message. DMH was and is committed to stimulating an EQR effort that is genuinely focused on quality improvement and outcomes. DMH publicly announced that this change had been ill advised and would be corrected by the next fiscal year's review process. By mid-year this message had been communicated successfully, and CAEQRO continued to carry out this contract requirement. The MHP summaries included in Volume II of this report contain the scores for each MHP on this requirement. Since this requirement had been in place for some time, most MHP scores were generally perfect or nearly perfect.

- **Quality Improvement Work Plan**

- **Human resource-related issues.** Budget reductions have affected quality improvement staff significantly. Current staff members were assigned additional responsibilities and, in many cases, overall staffing had been cut. Many quality improvement coordinators were new to their roles and overwhelmed with their responsibilities.
- **Lack of concrete plans and specific activities.** Many MHPs did not view quality improvement plans as living documents they could actively use as tools to help improve quality. Many plans were minimal, consisted primarily of boilerplate language from DMH contracts and simply monitored required data elements. These boilerplate plans typically contained few concrete targets and milestones, did not identify responsibilities and did not track accomplishments. MHPs reported that since state reviewers criticized "plans that were too inclusive," they developed a minimalist orientation. Such plans appeared to provide little incentive for any participation by either program staff or consumers and families.

In contrast a smaller group of MHPs had well-organized quality management infrastructures that integrated cultural competence, quality improvement and performance improvement. These organizations had active plans, concrete targets and demonstrated results. Since these MHPs did not comment on criticism specific to the amount of plan

content, there appears to have been some inconsistency across DMH reviewers.

- **Inadequate consumer/family member involvement.** Many MHPs struggled to meet the state requirement for consumer/family representation on the mandated Quality Improvement Committee. In many cases, this activity was the most concrete and sometimes only involvement by consumers and families that some MHPs wished to discuss with the CAEQRO review team. It appeared that outreach to consumers and families in these cases was not an overall organizational practice or priority.

### Performance Improvement Project: Site Discussion Findings

The requirement to plan and implement a Performance Improvement Project (PIP) was and continues to be the most controversial, contentious and problematic area for most MHPs. CAEQRO learned early in the year that the discussion of the PIP should not occur during the first half of the site review. The probability of having a constructive discussion increased if a working relationship could be established during an earlier review of more familiar topics. Irrespective of when the PIP review did occur, we did observe a number of common findings.

- **Many MHPs did not understand how to develop a PIP.** Here is a list of some of the common issues we identified:
  - Many of the proposed study questions were inappropriate and required major revision.
  - Many MHPs lacked experience in collecting and analyzing data to support the development of study questions, as well as the ongoing assessment of identified problem.
  - Few MHPs conducted a formal review of the potential variety of causes of an identified problem in performance or were aware of literature-based standards or the performance of other MHPs in the identified problem area.
  - A number of MHPs irrespective of size chose to concentrate on projects that included very small numbers of beneficiaries.
- **Many MHPs did not understand the objective of the PIP.** Many MHPs wanted to utilize the PIP as a tool for evaluating programs they had already implemented or planned. Other MHPs wanted to use the PIP to support compliance-related documentation requirements. The PIP requirement that results be related to consumer outcomes, functional status and/or satisfaction was a point of contention.

Many MHPs attempted to view compliance as appropriate for a PIP. The pressure to fulfill compliance requirements and generate the associated documentation was very strong among many MHP staff members who felt overworked, lacked support and wanted to limit their projects. Improving the percentage of required documentation in clinical charts was frequently perceived as a quality improvement activity rather than a compliance

requirement. MHP staff members were in general committed to providing good services. To see such individuals taking a strong position that there were no resources to look at consumer outcomes made it clear how preoccupied by compliance the systems had become.

- **Lack of access to or experience with data.** Access to data, as well as experience with data, was lacking especially in small-rural MHPs. Often MHPs either did not have a data analyst or the data analyst was unavailable to work with program staff. In the latter cases, there was little or no communication between program and technical staff. Lack of coordination between these staff functions was also common in larger MHPs. Many of these MHPs did not utilize data-driven decision-making processes.

In planning their PIPs, many MHPs relied upon the quality improvement coordinator to assume the major role. Few MHPs involved a variety of staff, including line staff and data analysts, or reviewed many different sources and types of data, such as clinical observation, consumer feedback, case examples, internal data and some consideration of relevant literature.

In general and throughout the year, MHPs viewed the PIP as a “project,” rather than representing a specific orientation for managing an organization and its services.

### Consumer/Family Information

- **Consumer/Family Focus Groups**
  - **Process Findings.** At least one focus group was part of each site review. With two exceptions (due to illness or travel difficulties) the CAEQRO consumer/family team member facilitated the group, while notes were taken by another team member. In larger MHPs two or three focus groups were scheduled. MHPs were asked to recruit 10 participants comprised of consumers who had at least two years’ experience with services and family members of whom at least two represented the children’s system of care. In some large MHPs, the focus groups did take place in clubhouses or recovery centers and group participants were members of the clubhouse. As the year progressed, we were able to request non-English speaking participants for mono-lingual focus groups.

MHPs varied enormously in their attention to and success with this part of the review. While some MHPs publicized and explained the purpose of the focus group several weeks in advance, many MHPs seemed to have difficulties organizing and managing this activity. Often MHP staff called and invited individuals to participate on the day of the focus group, while some literally recruited people in the halls or waiting room to participate at the last minute.

Frequently, the criteria we requested for participant selection were not met. During Year One, we were interested in hearing from individuals who could speak to changes within the service system over a several-year

period. However, most groups had at least one or two participants who had received services for only a few months. MHPs that appeared to be well organized in planning and preparing for other requirements of the site review process did not appear to have conducted the same level of planning for focus groups.

- **Content Findings.** We asked group participants about their personal experiences in accessing and receiving services. As a result their comments could reflect only that part of the MHP's services they had used—which often differed across MHPs. Therefore caution is necessary in generalizing about discussions of content across MHPs.

Nevertheless, in general, focus groups cited overall improvements in the system. Although they discussed staff and program cuts or restructuring as negative events in the system, focus group participants also almost universally commented that they felt somewhat less stigma and much better treated by staff than in the past. Participants felt that staff members were more likely to pay attention to them and be respectful of them. While not painting an unconditionally positive picture, participants did contrast their current experiences with those of a number of years ago.

Understanding and involvement in recovery, resilience and empowerment activities or programs ranged from many who had never heard of the concepts to a few individuals who could eloquently discuss their involvement and status. For those participants who were unfamiliar with these concepts, we explained the general principles. Both consumers and family members were typically able to translate this information into their own wishes and experiences and generally wanted to know where to obtain additional information.

- **Consumer, Families and Staff Surveys.** With a few exceptions many MHPs paid little attention to surveys. They carried out the DMH-required surveys twice per year, and in some cases reviewed the data but then returned to their other duties without using the survey information in any meaningful way. For many MHPs the required surveys were not particularly useful for several reasons:
  - Survey results have only recently been available by specific program
  - DMH returned survey results almost a year after MHPs had submitted them
  - The overall survey results were comparatively stable—from survey period to survey period—and thus served only as a baseline monitor

Some MHPs did develop and use a variety of surveys for beneficiaries, staff, providers and community groups. In many cases these were very useful in determining morale issues, services requested by specific groups such as older adults, staff and provider language capacities, cultural competence training needs, and other related information.

In some cases, conducting a survey appeared to be viewed as the only means to gain available data rather than a part of a multi-faceted plan to improve performance. Often a survey about a population or an issue was simply conducted to collect the data. For example, if an MHP wanted to increase the penetration rate for a particular group, the analytic process rarely included a review of data about patterns of services, retention rate, satisfaction or other information about members of the target group who had accessed the system.

### Performance Improvement Project Evaluation Tool: Findings

During Year One CAEQRO requested that each MHP provide a detailed description of one PIP for our team to review, so we could complete the required PIP Evaluation Tool (included in Attachment 1) during the post-site visit conference. As discussed in Section 1.2, we allowed MHPs to revise their PIPs and submit their revisions in time to be included in the report. In these cases, the ratings in the PIP Evaluation Tool reflected the revised PIP. In addition, CAEQRO and the MHP staff often briefly discussed a second PIP topic under consideration by the MHP.

However, most MHPs were in the planning stages of developing even the PIP they were required to submit. Throughout the year, only two MHPs presented CAEQRO with a project, actually designed to be a PIP, that was well underway or completed and in an extended phase. One of these two met few criteria; the other was well done. Under these circumstances many of the items on the PIP Evaluation Tool are irrelevant in this first year since they refer to activities that occur in the later stages of the PIP development process. Therefore, we chose to analyze only the data from questions 1 through 8, which focus on planning the PIP.

In Year One, CAEQRO reviewers recorded responses as “yes,” “no” and “partial.” With DMH’s agreement we added “partial” to the original tool since we assumed that during the first year there could be some reasonable but incomplete plans. CAEQRO was also quite lenient in assigning both “yes” and “partial” scores. In the actual individual protocols, there are a few “NA” ratings which for this analysis have been included in the “no” category. In the first eight items, we used “NA” only when the project had not reached the stage in which the particular question was relevant. Therefore in this analysis “NA” would reflect PIPs that had not yet reached even these initial planning stages.

In the following pages, we include a series of figures that display our analysis of the data extracted from the PIP Evaluation Tool and which we have aggregated in a PIP database. Because of the wide variation in MHP size, the figures that follow below display results by two categories.

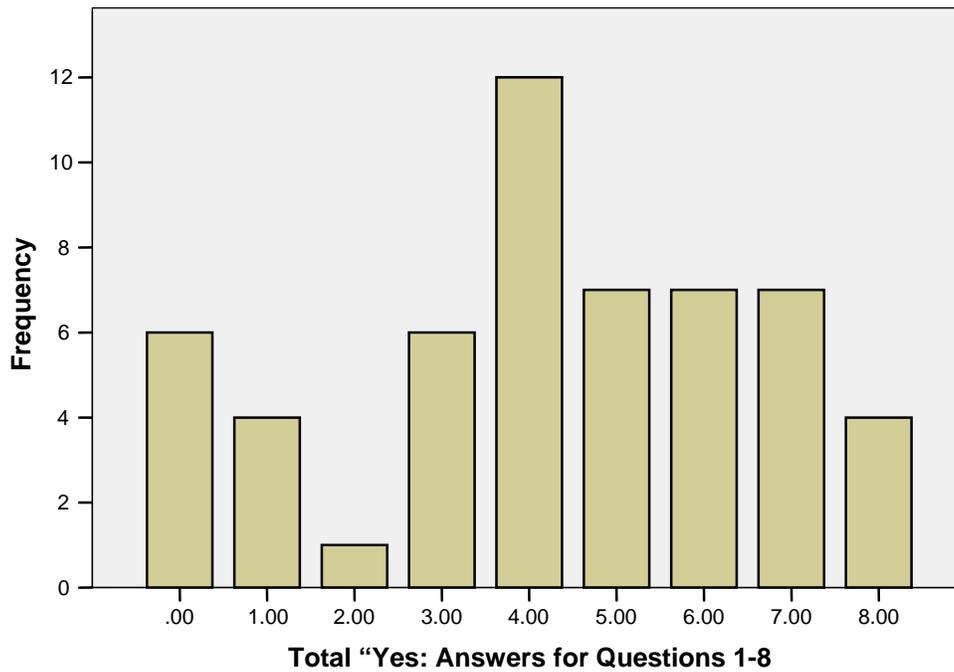
- The first two figures provide aggregated analyses of “yes” responses for a high-level snapshot of all MHPs’ success in meeting the basic PIP requirements.
- Figures 3–10 display the responses to questions 1–8—according to CAEQRO size groupings—and provide more detail on specific areas

within the protocol. Attachment 19 includes a listing of MHPs according to size grouping. Rather than creating a unique category for Los Angeles MHP (i.e., “very large”) as we did within our analyses of claims data, it is included in the “large” category.

**Figure 1**

Figure 1 shows the distribution of all “yes” scores per MHP on questions 1-8. Six MHPs or 11.1 percent received no score of “yes,” while four MHPs or 7.4 percent were rated “yes” on all eight questions.

**Frequency Analysis for Total “Yes” Answers for Questions 1-8**



**Statistics for Figure 1**

Total “Yes” Answers for Questions 1-8		
N	Valid	54
	Missing	0
Mean		4.2593
Median		4.0000
Mode		4.00
Std. Deviation		2.38062
Variance		5.667
Range		8.00
Minimum		.00
Maximum		8.00

Figure 2

Figure 2 shows the same PIP tool rating as displayed in Figure 1 but in percentages by size in addition to the mean numbers.

PIP Tool Ratings of “Yes” by MHP Size

Total Yes Score		MHP Size				Total
		Large	Medium	Small	Small-Rural	
.00	Count	2	1	2	1	6
	% within MHP Size	16.7%	7.7%	13.3%	7.1%	11.1%
1.00	Count	0	0	4	0	4
	% within MHP Size	0%	0%	26.7%	0%	7.4%
2.00	Count	0	1	0	0	1
	% within MHP Size	0%	7.7%	0%	0%	1.9%
3.00	Count	1	2	3	0	6
	% within MHP Size	8.3%	15.4%	20.0%	0%	11.1%
4.00	Count	3	2	3	4	12
	% within MHP Size	25.0%	15.4%	20.0%	28.6%	22.2%
5.00	Count	0	3	1	3	7
	% within MHP Size	0%	23.1%	6.7%	21.4%	13.0%
6.00	Count	2	0	1	4	7
	% within MHP Size	16.7%	0%	6.7%	28.6%	13.0%
7.00	Count	3	3	0	1	7
	% within MHP Size	25.0%	23.1%	0%	7.1%	13.0%
8.00	Count	1	1	1	1	4
	% within MHP Size	8.3%	7.7%	6.7%	7.1%	7.4%
Total	Count	12	13	15	14	54
	% within MHP Size	100.0%	100.0%	100.0%	100.0%	100.0%

The following eight figures display our findings for questions 1-8 in the PIP protocol and are analyzed by MHP size.

**Note:** Guidelines for reading Figures 3–10:

- All have a common layout to facilitate ease of interpretation
- Question responses are organized by the size of the MHP (as defined in Attachment 19)
- The right-hand “Total” column includes both a numeric total for all MHP responses in a specific category and the percentage of all 54 MHPs that numeric total represents.

Using Figure 3 below, here is an example of how to read Figures 3-10:

- The columns display that 3 large, 3 small and 2 small-rural MHPs answered “No”—therefore a **total** of 8 MHPs answered “No” to Question 1
- The percentages in each column indicate what percent of MHPs by size answered “No”: large MHPs/25 percent; small MHPs/20 percent; and small-rural/14.3 percent.
- The right-hand “Total” column shows that 14.8 percent of all 54 MHPs answered “No.”

**Figure 3**

<b>Question 1: Was the topic selected through data collection and analysis of comprehensive aspects of beneficiary needs, care and services?</b>						
<b>Response</b>		<b>MHP Size</b>				<b>Total</b>
		<b>Large</b>	<b>Medium</b>	<b>Small</b>	<b>Small-Rural</b>	
No	Count	3	0	3	2	8
	% within MHP Size	25.0%	.0%	20.0%	14.3%	14.8%
Yes	Count	8	7	4	10	29
	% within MHP Size	66.7%	53.8%	26.7%	71.4%	53.7%
Partial	Count	1	6	8	2	17
	% within MHP Size	8.3%	46.2%	53.3%	14.3%	31.5%
Total	Count	12	13	15	14	54
	% within MHP Size	100.0%	100.0%	100.0%	100.0%	100.0%

Most MHPs did look at some limited data in planning the PIP. However, these results reflect the continued lack of a comprehensive and detailed analysis. Many MHPs were not accustomed to using data for setting priorities, driving decisions and evaluating performance. Many did not perceive that they have any access to meaningful and timely data. For some, “We don’t have it and we don’t use it” characterized their view.

**Figure 4**

<b>Question 2: Did the MHP, over time, address a key aspect of beneficiary care and services?</b>						
<b>Response</b>		<b>MHP Size</b>				<b>Total</b>
		<b>Large</b>	<b>Medium</b>	<b>Small</b>	<b>Small-Rural</b>	
No	Count	1	0	4	1	6
	% within MHP Size	8.3%	0%	26.7%	7.1%	11.1%
Yes	Count	9	10	9	12	40
	% within MHP Size	75.0%	76.9%	60.0%	85.7%	74.1%
Partial	Count	2	3	2	1	8
	% within MHP Size	16.7%	23.1%	13.3%	7.1%	14.8%
Total	Count	12	13	15	14	54
	% within MHP Size	100.0%	100.0%	100.0%	100.0%	100.0%

This figure showed the best overall results. In general, MHPs can identify important issues—without necessarily having the ability to translate issues into a specific study question or process.

**Figure 5**

<b>Question 3: Did the PIP, over time, include all clients for whom the PIP pertained?</b>						
<b>Response</b>		<b>MHP Size</b>				<b>Total</b>
		<b>Large</b>	<b>Medium</b>	<b>Small</b>	<b>Small-Rural</b>	
No	Count	3	1	6	1	11
	% within MHP Size	25.0%	7.7%	40.0%	7.1%	20.4%
Yes	Count	6	8	8	11	33
	% within MHP Size	50.0%	61.5%	53.3%	78.6%	61.1%
Partial	Count	3	4	1	2	10
	% within MHP Size	25.0%	30.8%	6.7%	14.3%	18.5%
Total	Count	12	13	15	14	54
	% within MHP Size	100.0%	100.0%	100.0%	100.0%	100.0%

This table also showed better scores than those for the other questions. The data for this question, and for those that follow, do not verify the common perception that the larger MHPs will invariably have better results.

**Figure 6**

<b>Question 4: Was/were the study question(s) stated clearly in writing?</b>						
<b>Response</b>		<b>MHP Size</b>				<b>Total</b>
		<b>Large</b>	<b>Medium</b>	<b>Small</b>	<b>Small-Rural</b>	
No	Count	3	4	5	4	16
	% within MHP Size	25.0%	30.8%	33.3%	28.6%	29.6%
Yes	Count	9	8	4	6	27
	% within MHP Size	75.0%	61.5%	26.7%	42.9%	50.0%
Partial	Count	0	1	6	4	11
	% within MHP Size	0%	7.7%	40.0%	28.6%	20.4%
Total	Count	12	13	15	14	54
	% within MHP Size	100.0%	100.0%	100.0%	100.0%	100.0%

This question was the first that required a clear statement of the specific problem. Constructing a study question from which the project could proceed was a new and unclear task for many MHPs. Defining the study question was often the most time-consuming part of the entire PIP review discussion. Often the study question related to one concrete aspect of a system but could not be successfully defined or influenced without attention to the whole process. For example, a number of MHPs chose to study timeliness of access to psychiatric or initial appointments. Others chose to look at failures to keep appointments, either an initial or ongoing appointment(s). However, most apparently either did not know or did not consider important variables such as:

- The usual volume of requests by type (emergent, urgent, routine)
- The capacity of the system to handle these requests
- Workload standards (if any) that determine system capacity

**Figure 7**

<b>Question 5: Did the study use objective, clearly defined, measurable indicators?</b>						
<b>Response</b>		<b>MHP Size</b>				<b>Total</b>
		<b>Large</b>	<b>Medium</b>	<b>Small</b>	<b>Small-Rural</b>	
No	Count	0	1	6	3	10
	% within MHP Size	0%	7.7%	40.0%	21.4%	18.5%
Yes	Count	8	3	4	5	20
	% within MHP Size	66.7%	23.1%	26.7%	35.7%	37.0%
Partial	Count	4	9	5	6	24
	% within MHP Size	33.3%	69.2%	33.3%	42.9%	44.4%
Total	Count	12	13	15	14	54
	% within MHP Size	100.0%	100.0%	100.0%	100.0%	100.0%

Figure 7 shows a high number of “partial” ratings, but has the lowest number of “yes” ratings of the eight questions. Without access to or experience with useful data elements, it is very difficult to identify indicators that meet the criteria. Often the management processes were not in place to enable MHP staff to identify indicators that could influence the problem.

**Figure 8**

<b>Question 6: Did the indicators measure changes in mental health status, functional status or beneficiary satisfaction, or process of care with strong associations for improved outcomes?</b>						
<b>Response</b>		<b>MHP Size</b>				<b>Total</b>
		<b>Large</b>	<b>Medium</b>	<b>Small</b>	<b>Small-Rural</b>	
No	Count	2	1	7	2	12
	% within MHP Size	16.7%	7.7%	46.7%	14.3%	22.2%
Yes	Count	7	7	5	11	30
	% within MHP Size	58.3%	53.8%	33.3%	78.6%	55.6%
Partial	Count	3	5	3	1	12
	% within MHP Size	25.0%	38.5%	20.0%	7.1%	22.2%
Total	Count	12	13	15	14	54
	% within MHP Size	100.0%	100.0%	100.0%	100.0%	100.0%

As discussed earlier, “compliance” and “quality improvement” had become synonymous in many MHPs. The same staff person often juggled both roles and the compliance role was paramount. Quality improvement staff often could spend little or no time on projects designed to move beyond achieving compliance with regulations.

**Figure 9**

<b>Question 7: Did the MHP clearly define all the Medicaid beneficiaries to whom the study question and indicators are relevant?</b>						
<b>Response</b>		<b>MHP Size</b>				<b>Total</b>
		<b>Large</b>	<b>Medium</b>	<b>Small</b>	<b>Small-Rural</b>	
No	Count	5	1	6	1	13
	% within MHP Size	41.7%	7.7%	40.0%	7.1%	24.1%
Yes	Count	5	9	6	9	29
	% within MHP Size	41.7%	69.2%	40.0%	64.3%	53.7%
Partial	Count	2	3	3	4	12
	% within MHP Size	16.7%	23.1%	20.0%	28.6%	22.2%
Total	Count	12	13	15	14	54
	% within MHP Size	100.0%	100.0%	100.0%	100.0%	100.0%

Often the definition of the population was ambiguous and thus reviewers often had difficulty determining the study population. In other cases, the original population had decreased through an undefined process such that again it was impossible to determine what population the proposed study actually represented.

**Figure 10**

<b>Question 8: If the MHP studied the entire population, did its data collection approach capture all beneficiaries to whom the study question applied?</b>						
<b>Response</b>		<b>MHP Size</b>				<b>Total</b>
		<b>Large</b>	<b>Medium</b>	<b>Small</b>	<b>Small-Rural</b>	
No	Count	8	5	9	6	28
	% within MHP Size	66.7%	38.5%	60.0%	42.9%	51.9%
Yes	Count	4	8	4	6	22
	% within MHP Size	33.3%	61.5%	26.7%	42.9%	40.7%
Partial	Count	0	0	2	2	4
	% within MHP Size	0%	0%	13.3%	14.3%	7.4%
Total	Count	12	13	15	14	54
	% within MHP Size	100.0%	100.0%	100.0%	100.0%	100.0%

This shows the poorest results of the eight with the small-rural counties, however, still showing a more positive pattern. These MHPs tended to look at fairly simple issues and appeared to be able to control and understand them with minimal support from formal data systems. Some projects were being tracked manually by MHPs in this category.

## **MHP Organizational Strengths and Challenges**

The strengths and challenges we summarize below are all drawn from the MHP site review reports and the abridged information in the Individual Mental Health Plan summaries (Volume II). We begin by discussing the overall strengths and challenges shared by all MHPs and then identify those findings that are common among MHPs within specific size groups.

### Mental Health Plans: Overall Strengths

Two major strengths stand out across all MHP size groups. Almost half of the MHPs had some defined strength related to cultural competence activities. Frequently this referred to MHP attempts at recruitment of bi-lingual, bi-cultural staff to better attract and serve Hispanic/Latino beneficiaries. The strength often referred to the attempt, not necessarily to its success. In some cases the strength identified was an increase in training activities and discussions about a number of cultural issues that raised staff awareness of the importance of the topics.

Almost the same number of MHPs showed some attempt at increasing consumer involvement and some actions designed to promote an orientation towards recovery. These initiatives varied from establishing at least one staff position for a consumer/family member to more general attempts to “promote consumer involvement and recovery.” While many MHPs had developed “boutique recovery programs” that functioned in a silo, they still lacked a comprehensive plan of how they would move their whole system to be wellness- and recovery-oriented. They were, however, actively engaging the topic.

### Mental Health Plans: Overall Challenges

Many MHPs struggle to manage challenges due to geography, population poverty, growth, weather and lack of public transportation. They vary in their active attempts to manage these obstacles, particularly in the face of recent budget and staff reductions, occurrences also frequently listed as challenges. It was surprising how little video conferencing or telepsychiatric technology was named as a potential tool.

The major internal challenge across all size groups was the need for a new technology system combined with the potential of losing valuable historical data during the conversion process. Issues of technology and data were by far the most frequently mentioned. Very few MHPs regularly used data-driven decision support tools.

Evidence of functioning in silos was clear. Very few MHPs showed clear collaboration between quality improvement and IT or analytic staff.

### Challenges and Strengths: Medium and Large MHPs

Medium and large MHPs shared many of the same patterns. Although this group also indicated a strong need for new information systems, about half enjoyed the strength of an experienced and competent IT staff. However, many were dealing with

succession problems due to retirement of long-term IT staff coupled with budget difficulties in recruitment as well as the disincentive represented by old technology. There was also a group experiencing the challenge and dysfunction of a stalled and delayed technology installation. Many of these issues are discussed in Section 3.3, in which we summarize our ISCA findings.

Unlike the group of smaller MHPs, management was more likely to be involved in quality improvement and quality improvement was well organized. However, there was still little evidence of regular collaboration between the quality improvement and the IT staffs even in this group.

### Challenges and Strengths: Small-Rural and Small MHPs

In contrast to medium and large MHPs, these organizations were particularly strong in developing cooperative partnerships and innovative relationships with other allied organizations. Often a number of related county departments were co-located with the MHP. Services were also often co-located in several sites throughout the county to improve access.

Small-rural and small MHPs experienced a cluster of inter-related challenges that together produced an approach summarized by one reviewer: “Data—we do not have it and we do not use it.” The challenges were as follows:

- No formal business policies and procedures
- No cross training of the business staff
- Dependence on one person for business functions
- No IT staff and/or inexperienced IT staff
- Little to no perceived access or use of data
- Need for new information systems
- Need to save historical data contained in current information systems

It is not surprising that IT staff were not involved with quality improvement. More surprising however was the relative infrequency of management involvement in quality improvement unless the director or deputy was also the quality improvement coordinator.

Some small MHPs were in a different situation. They were dealing with a slow and stalled information systems implementation that was interfering with their ability to use data and often was affecting staff morale and confidence in any information system.

Based on the findings articulated in this section, as well as in Section 3.3, we articulate several high-level themes in Section 5.

## Section 4.3: California Department of Mental Health Performance Measure Operations Validation

Using the procedures outlined in Section 1.3, CAEQRO completed the Year One validation of DMH Performance Measure (PM) calculation. The Centers for Medicare & Medicaid Services (CMS) has developed a protocol offering guidance regarding the validation of PM calculations. These protocols were followed closely by DMH in developing a series of fourteen (14) worksheets for use by the CAEQRO technical review team.

The completed worksheets shown in Attachments 5 through 9 document the detailed review that was performed by the CAEQRO technical review team. In addition to the CAEQRO staff, the technical review team also included Mr. William Viergever, an expert on the use of SAS, the statistical analysis application software that is used by DMH to produce PM calculations. Mr. Viergever's report is available as Attachment 10.

### California Department of Mental Health Worksheets

The worksheets developed by DMH and completed by CAEQRO supported a very detailed review of the following areas:

- **Information systems data integration and control documentation review.** Documentation of complex analytic procedures is an important but often neglected element of PM calculation. In cooperation with DMH technical and analytic personnel, the CAEQRO technical review team conducted a careful review of all integration and control documentation relevant to the calculation of performance measures for Year One.

Findings: During the course of the review, which spanned this annual report period, the technical review team determined that some programs and queries do not exist as free-standing documentation. Within the review year, new documentation was prepared by DMH and the draft document was reviewed by the CAEQRO team.

- **Data and processes used to calculate and report reviews of PMs.** CAEQRO reviewed the analytic procedures for each performance measure and evaluated documentation of programs as well as source code. In addition, through interviews and documentation review, we also were able to evaluate the general strategy for calculations.

Findings: This review identified how DMH is able to calculate overall penetration as well as age grouped calculations. The arithmetic for date ranges and age calculation were considered.

- **Policies, procedures, data and information used for numerator and denominator review.** The accurate calculation of the Year One performance measures relies on an accurate determination of the numerator and the denominator used in performance measures. The numerator must be drawn from

the correct group of served beneficiaries. In the Year One performance measures, the CAEQRO review team evaluated how age groups were defined and calculated. The denominator must include all appropriate Medi-Cal beneficiaries in the very large population. The CAEQRO review team assessed how DMH analysts work with the constantly changing Medi-Cal beneficiary eligibility files.

**Findings:** During the course of this portion of the review, and as noted in the attached worksheets, the denominator used in calculations is not based on member months, but rather is based on an unduplicated average monthly member calculation. This strategy may be slightly less sensitive than a member month approach.

## Summary and Conclusion

The following table summarizes the major validation components and the related audit elements that CAEQRO reviewed.

**PERFORMANCE MEASURE VALIDATION TABLE**

Validated Performance Measures:				
Validation Component	Audit Element	Meets Validation Requirements		
		Yes	No	N/A
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, computer source code	X		
Calculations	Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure	X		
Denominator	Data sources used to calculate the denominator were appropriate for the time period	X		
Numerator	Data sources used to calculate the numerator were appropriate for the time period	X		

The primary goal of the entire PM review process is to confirm that the DMH procedures for calculation of these measures are accurate. *The CAEQRO has completed a comprehensive review of the DMH procedures and can confirm the validity of the DMH calculations of PMs as documented in Attachments 5 through 9.*

### Section 4.3.1: California Department of Mental Health Data Analysis Results

CAEQRO conducted both a code review of SAS software used by DMH, as well as a data analysis replication study. For the code review, CAEQRO contracted with William Viergever of Viergever & Associates. Mr. Viergever's conclusion confirmed the accuracy of DMH coding for California penetration analyses. Mr. Viergever's detailed analysis report is available in Attachment 10.

The data analysis replication study was conducted by CAEQRO analysts who gathered all data used by the DMH staff in their calculations and reproduced findings using SAS software for a precise replication of results. The CAEQRO analysis, which is discussed in Section 1.31, confirmed the validity of DMH calculations of PMs. The SAS code is straightforward and relatively efficient, and the annual penetration rates can be exactly reproduced on both the DMH and CAEQRO datasets.

## Recommendations from the Replication Study

Below we list two recommendations that are based on both CAEQRO's and Mr. Viergever's findings:

- 1. Perform monthly PM calculations.** We recommend that DMH consider performing monthly calculations to incorporate into an annual report, instead of performing PM calculation on an annual basis only. Because Medi-Cal eligibility is determined on a monthly basis, it is more precise to calculate a series of monthly reports, which can be later combined into a fiscal year report or an alternate report of desired duration. This per member per month (PMPM) paradigm will more accurately reflect the real changing status of Medi-Cal eligibilities than the current strategy of calculating a annual (full year) penetration rate.

For example, the same person may be eligible for Medi-Cal in one or several months, but ineligible for the other months in a year. The current annual report approach treats this person as Medi-Cal or Medicare eligible for the whole year, while the PMPM paradigm can capture the exact enrollment dynamics. Another example is the age calculation mentioned in the SAS code review; exact monthly ages can be calculated in the PMPM approach.

We believe this approach (using the PMPM paradigm) should be used in future analyses since it will more accurately account for seasonal variability.

- 2. Future analytic work for consideration.** We recommend the following additional analysis to help DMH gain a more precise and meaningful understanding of PM data.
  - Perform a component-adjusted analysis of PM data.** The current annual report only gives aggregated PMs from a high level. For comparisons across counties, these unadjusted PMs are less sensitive indicators for real county differences. Component-adjusted PMs (e.g., demographics) is recommended by the CAEQRO.
  - Perform analyses that enable a precise understanding of mental health utilization.** Similarly, the current methodology for determining annual penetration rate cannot distinguish the quantitative differences in mental health utilization. Persons with only one mental health service and those receiving multiple services were counted only once in the numerator of the penetration rate. Further studies are needed to determine the more precise quantitative distributions and differences in mental health utilization.

With the accumulation of Medi-Cal eligibility and mental health claims data, more in-depth analyses can be performed to help DMH and MHPs better understand mental health utilization patterns and regional variations, as well as their respective underlying determinants, to improve access to and the quality of services for California mental health beneficiaries while controlling mental health program costs.

### Section 4.3.2: Mental Health Plan Data Validation

As noted in Section 1.3.2, the MHP Medi-Cal Paid Claims Audit was performed to fulfill the federal requirement that the CAEQRO annually review and validate PMs designated by DMH. The PMs selected by DMH for validation at the MHP level during Year One were Medi-Cal penetration rate, and penetration rate by age and gender categories.

In this first year of the CAEQRO PM Data Validation process, the project was known locally as the “MHP Medi-Cal Paid Claims Audit.” However, this process was not technically an audit but instead an integral part of the process for validating the integrity of specific DMH data elements provided by MHPs and used by DMH for its calculations. We therefore have relabeled this activity “MHP Data Validation” to more accurately reflect the scope and intent of the process.

The audit was designed to answer one basic question: Is selected data (birth date and gender) collected at program sites, entered to a local information system, and billed on Short-Doyle/Medi-Cal claims, reliable data from which to extrapolate penetration rates for age and gender? *The results of the audit confirm the validity of this approach.*

Data elements extracted from Medi-Cal approved claims files for comparison with MHP medical records were:

- Medi-Cal beneficiary birth date
- Medi-Cal beneficiary gender
- Medi-Cal beneficiary service date from February 2003

### Statewide Results

Statewide statistics shown below demonstrate the close correlation between MHP source documents and Medi-Cal approved claims data for both birth date and gender, where the median error rate is 0 percent. This correlation is less true for service date, with a median error rate of 4.58 percent.

Statewide Results	Birth Date	Gender	Service Date (Feb 2003)
Number of Records Audited	4237	4237	4237
Number Missing or In Error	48	132	278
Mean Error Rate	1.13%	3.12%	6.56%
Median Error Rate	0.00%	0.00%	4.58%
Error Rate Range	0% - 14.94%	0% - 61.80%	0% - 42.53%
Standard Deviation	2.23%	8.97%	7.58%

## Birth Date and Gender Findings

The low error rates for birth date and gender confirm that age and gender can be accurately calculated from Medi-Cal approved claims data, and are thus an appropriate tool for establishing penetration rates, as well as other analyses using these data elements.

The vast majority of errors for birth date and gender were due to completely missing medical records or missing information on the medical record documentation submitted. Two MHPs were outliers in these categories. As displayed in the two tables below, when we subtract results from one MHP with the most missing records, the statewide mean error rate for birth date decreases from 1.13 percent to 0.84 percent. Similarly, removing results from the two MHPs with the greatest number of errors for gender reduces the mean error rate by half, from 3.12 percent to 1.53 percent. The outer range of errors in each category is significantly reduced as well with the removal of number of records and errors from the outliers.

Birth Date	Statewide Results	Statewide Results without 1 MHP Outlier
Number of Records Audited	4237	4150
Number Missing or In Error	48	35
Mean Error Rate	1.13%	0.84%
Error Rate Range	0% - 14.94%	0% - 5.21%

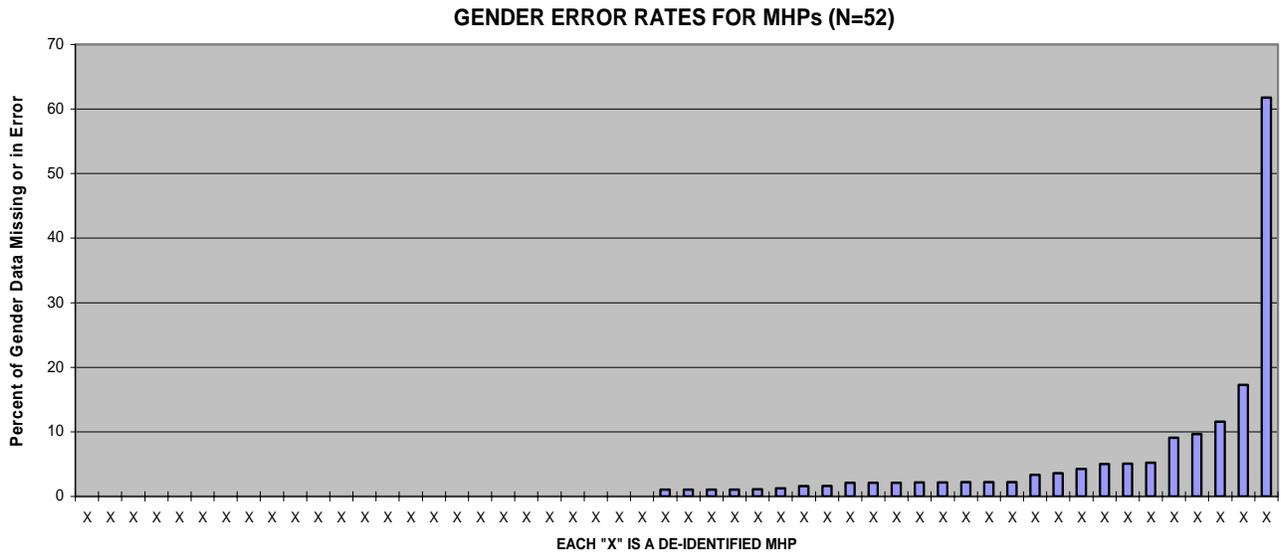
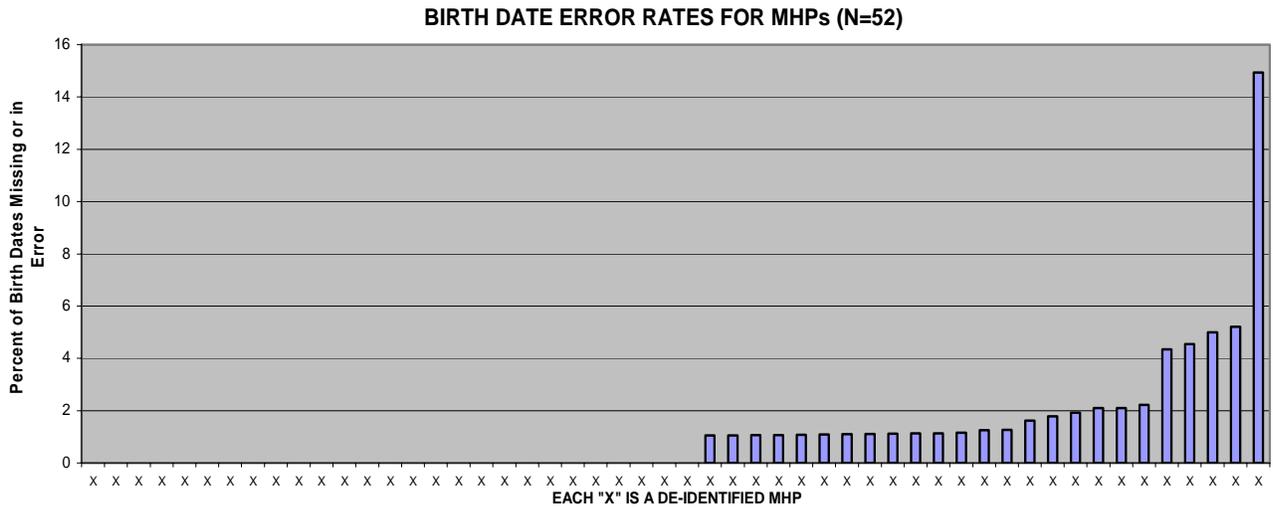
Gender	Statewide Results	Statewide Results without 2 MHP Outliers
Number of Records Audited	4237	4061
Number Missing or In Error	132	62
Mean Error Rate	3.12%	1.53%
Error Rate Range	0% - 61.80%	0% - 11.59%

For most remaining MHPs the differences between Medi-Cal approved claims and the medical record for birth date and gender are minor. Other causes for error were:

- Incorrect gender shown on the original handwritten registration document submitted. Corrected information was recorded in the information system since the February 2003 service was billed and current billing shows correct gender.
- In some cases, the registration form did not capture the data. This was most common when local programs used their own forms for registering consumers.
- There was a space on the form for gender, but it was left blank.
- Discrepancies between the State Medi-Cal eligibility database and MHP records, where it appears the MHP information is valid and the State eligibility tables are not.

It is fairly common for some small number of records to differ between the large state eligibility files and the files maintained by MHPs. The higher error rate for gender versus birth date may be due to the fact that birth date errors fail during Medi-Cal claims processing and are returned to the MHP on error correction reports. Thus, birth date errors are more commonly corrected in the local information system to prevent future claim errors. Gender is not a Medi-Cal claims processing edit, so the MHP is less likely to catch the error and correct it in its internal information system.

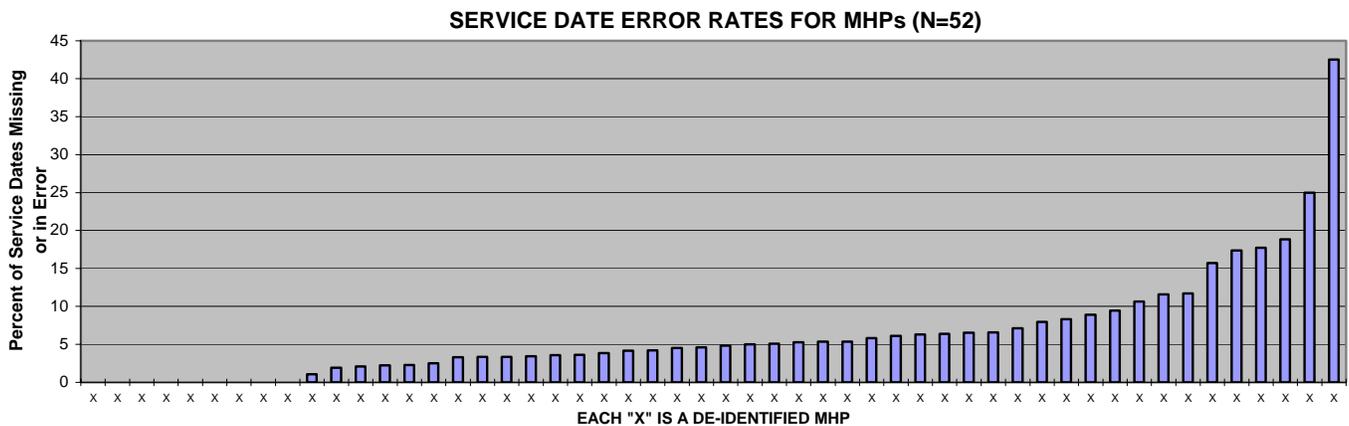
The charts below display error ratios for birth date and gender for each of the 52 MHPs audited. Each X at the bottom of the graph represents a single MHP. Error percentages are arrayed by MHP from lowest to highest ranking.



### Service Date Findings

With a mean error rate of 6.56 percent, service date errors were significantly higher than birth date and gender errors. The majority of errors discovered in comparing a Medi-Cal approved claim with the medical record were for a missing progress note for the service date billed. Unlike birth date and gender, where the median error rate was 0 percent, the median error rate for service date was 4.58 percent, indicating some problems with documentation supporting service delivery across the spectrum of MHPs.

The chart below displays error rates for service dates for each of the 52 MHPs audited. Each X at the bottom of the graph represents a single MHP. Error percentages are arrayed by MHP from lowest to highest ranking.



CAEQRO observed extremely modest guidelines in assessing the presence or absence of a progress note for the approved claim service date. Our basic rule was to score any type of note in the medical record provided by the MHP that had a date of service that matched the date of service on the Medi-Cal approved claim as valid. In our letter requesting medical record documentation, CAEQRO asked for all progress notes for:

- A Medi-Cal beneficiary selected for the sample
- Month of February 2003 (a specific day was not indicated)
- A specific Medi-Cal provider identification number

As evident in the chart below, errors in services billed were not highly influenced by an outlier. Removal of audit results for the primary outlier produced much less variation in the statewide results than it did for either birth date or gender.

Services	Statewide Results	Statewide Results without 1 MHP Outlier
Number of Records Audited	4237	4150
Number Missing or In Error	278	241
Mean Error Rate	6.56%	5.81%
Error Rate Range	0% - 42.53%	0% - 25.00%

Reviewers encountered a variety of scenarios in the medical records submitted by MHPs that may have generated exceptions in a true audit environment. However, for purposes of the CAEQRO PM Data Validation, the standards of acceptability were very broad. As long as the date in the medical record documentation matched the date of the Medi-Cal approved claim in the sample, the progress note was accepted as valid.

Also, we assumed that progress notes submitted were specific to the Medi-Cal provider identification number of the approved claim, as there was no way to determine the location of service by the notes.

While gathering medical record data for the CAEQRO audit, several MHPs identified a variety of local problems. MHPs with high error rates can use this as an early warning of potential record keeping problems.

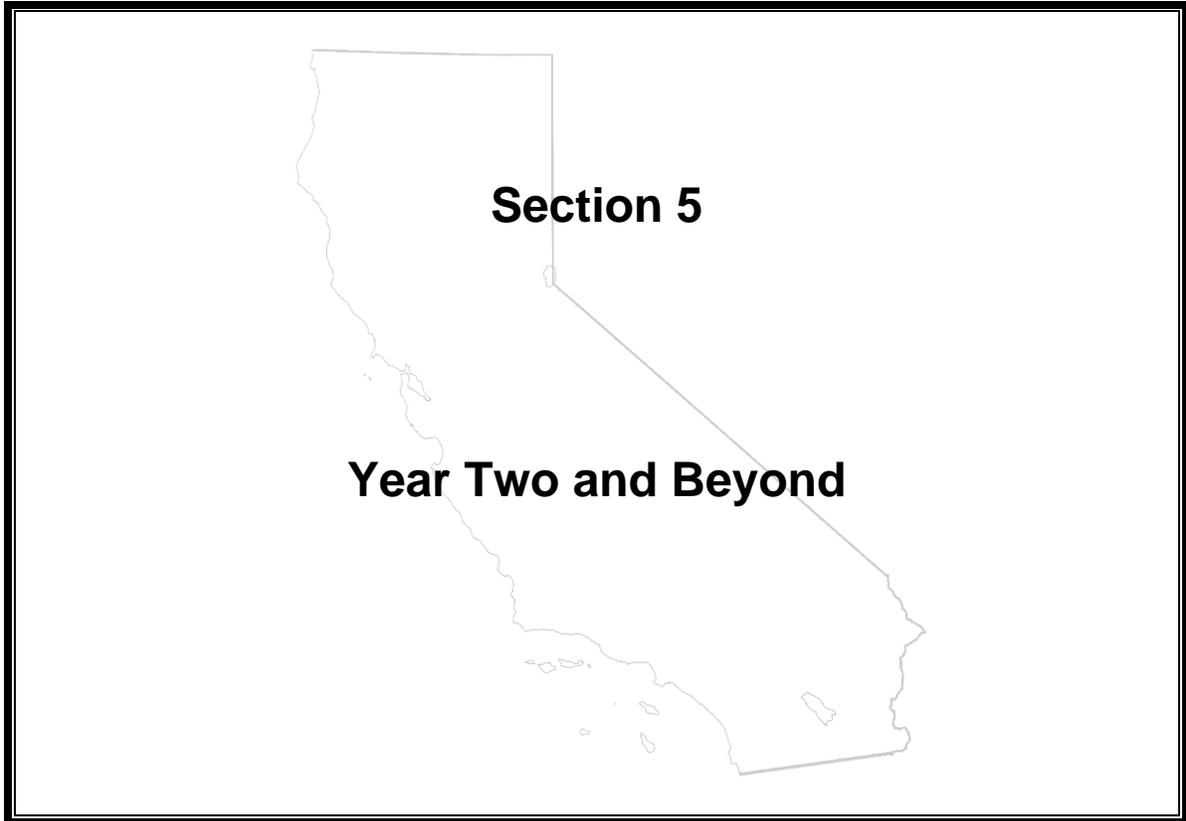
## Other Findings

- There is little uniformity in how data is collected among MHPs, and even within a single MHP. Some MHPs have a standard form for collecting demographic information across all providers. Others allow contract providers to develop and use their own forms. The result of the latter practice is that the same demographic information may not be recorded for all consumers served across the MHP.
- It appears that multiple facility sites share a single four-digit Medi-Cal provider identification number in some cases. MHPs that engage in this practice yet maintain separate charts at each distinct facility location had a more difficult time retrieving all progress notes for the February 2003 audit service period.
- At least one MHP is using the information gained from this audit to begin an internal assessment of problems with medical records documentation and storage procedures.
- Some MHPs had difficulty accessing medical records maintained by contractors, especially given the two week window for return of documents.
- As MHPs move forward in acquiring information systems with electronic clinical records, it's important to maintain mechanisms for quality review and oversight.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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## Section 5.1: Overview

The preceding four sections focused on our FY05 processes, experiences and findings. As discussed, our external quality review (EQR) processes as well as the Information Systems Capabilities Assessment (ISCA) survey, evolved over the first six months of FY05. Collaborative discussions with many mental health plan (MHP) staff and with the California Department of Mental Health (DMH) produced a number of EQR process modifications and informed our findings for Year One.

Section 5 continues and builds on our experience and findings by focusing on two distinct but related activities for Year Two:

- **Process Priorities.** We outline the modifications to the EQR processes we have adopted for Year Two in response to our experiences and findings in Year One. We will continue to review and modify our processes as the year progresses.
- **Complex Themes for Consideration.** Building on concrete Year One findings, we have developed a series of complex themes that have significant systemic implications. Before developing these themes, we subjected our assumptions to a rigorous analytical process that occurred over a three-month period and involved CAEQRO staff, a consumer/family member consultant, a cultural competence consultant, and three senior consultants who are retired, highly regarded mental health directors. We will continue to monitor these themes to determine whether genuine trends emerge and develop over time.

Discussions on these two activities follow below.

## Section 5.2: Year Two Initial Priorities

Based on the baseline knowledge gained in Year One, CAEQRO adopted the following core goals for Year Two.

- Target Year Two MHP reviews according to the following categories:
  - Specific MHP issues and priorities identified in Year One
  - Progress on statewide goals affecting services and outcomes for beneficiaries
- Promote consistency, accountability and authentic quality improvement processes that include a variety of participants who have access to and familiarity with many types and sources of data
- Increase our feedback to MHPs and DMH concerning crucial systemic issues, such as continuing to surface the problematic nature of old technology as well as the major problems with new installations

These in turn led to the following modifications to our Year Two EQR process:

- Expand data reporting and analysis for individual MHPs and across the system as possible
- Expand the number and variety of consumer/family focus groups, especially with specific populations including groups of monolingual non-English speaking participants
- Determine the status of MHP activities on recovery, resiliency and empowerment
- Continue reviewing business processes especially for areas in which system-wide deficiencies had been identified
- Continue promoting cross-program collaboration and increased access to and use of data driven support tools
- Review technical assistance activities to increase effectiveness and reduce redundancy by promoting small group collaboration through a variety of settings (e.g., phone conferences, video conferences, Web casts, regionally based meetings)

CAEQRO will continue to modify and refine these activities during Year Two as our resources allow.

## Section 5.3: Statewide Themes

To help develop and validate statewide themes, CAEQRO engaged in a rigorous analytical process that occurred over a three-month period. Immediately following a summary of this process, we list the overall system themes that require attention to produce improved organizational performance and outcomes for Medi-Cal beneficiaries, as well as other consumers.

### Theme Development Process

Sections 1-3 detail CAEQRO processes for conducting a valid and reliable review of each MHP. To extract high-level themes across all MHPs, CAEQRO engaged in a series of additional activities to gather a variety of perspectives and subject our assumptions to objective scrutiny. This process involved the entire CAEQRO staff and several senior consultants who had worked with the site review teams and management throughout the year.

- **CAEQRO internal two-day review and planning session.** CAEQRO staff participated in a two-day session in the beginning of June 2005 to review findings from all 54 MHP site reviews and begin planning for FY06 activities.
- **Meeting preparation.** To facilitate a discussion on findings, site reviewers prepared for this session by reading all site review reports for those MHPs that they had specifically visited. However, having participated in the pre- and post-site review conferences, other participants were familiar with MHPs that

they had not visited. As a result, all participants were able to provide valuable insight across the system and specific to a particular MHP.

- **Meeting process.** The discussion began with participants delineating three categories of MHPs based on the findings in the site review reports: those with many strengths, those with many issues and those that were neither particularly strong nor problematic. Each category not only accounted for approximately one-third of the total number of MHPs but also represented a variety of MHP size grouping. The participants then extracted common strengths and issues that were shared by all MHPs in the first two categories.
- **Consumer/family member review process.** The CAEQRO lead consumer/family consultant and cultural competence consultant each participated in several site reviews during Year One. In addition, they facilitated a discussion with the group of consumer/family member reviewers who had participated in specific site reviews during the year to gather their feedback on the EQR process.
- **Senior consultant review process.** Three retired highly respected MHP directors worked with us during most of the year to develop a background document for CAEQRO review staff reference prior to the pre-site conference for each MHP. Drawing on their own substantial knowledge of county issues, the senior consultants interviewed MHP management staff to gain their point of view about the environment, the service system and the prospective EQR review. In some instances, they also interviewed California Institute of Mental Health staff members who were familiar with specific MHPs. However, none of the consultants actually participated in any site visits.
- **Joint review session.** At the end of June 2005, CAEQRO conducted a second day-long session that included CAEQRO staff, all three senior consultants and both the cultural competence and consumer/family consultants. To prepare for this meeting, we asked each senior consultant independently to identify common themes, both positive and negative, using CAEQRO site review reports on the MHPs for which they had developed background documents. We also asked the cultural competence consultant and consumer/family consultant—neither of whom read any of the final site review reports—to identify themes based on their knowledge and experience. At the meeting, each consultant presented a list of themes and CAEQRO staff presented the list developed in the earlier meeting. The group jointly developed a list of themes by the end of the day.

Finally, CAEQRO consolidated the group's list of themes for inclusion in the statewide report.

## Common Themes

The following seven themes are comprised of two parts:

1. A high-level challenge shared by the majority of MHPs that CAEQRO reviewed during FY05

2. An equally high-level recommendation for review, critique and consideration as a possible course of action for addressing that issue in the future

In keeping with a consultative approach, CAEQRO will continue assessing the validity of these themes to determine if the issues are indeed trending over time as well as to identify any new themes for inclusion in our FY06 statewide report.

1. Many MHPs operate in silos with limited communication among information technology staff, quality improvement staff, Mental Health System Act program planners, and clinical managers, as well as staff responsible for cultural competency and diversity. Promoting coordination, collaboration and communication will improve operational efficiency and programmatic effectiveness.
2. Many small counties struggle to meet regulatory, program and data requirements that are necessary for MHPs to truly function as managed care systems. Collaboration across county boundaries could provide tremendous opportunities for cost efficiencies in key initiatives such as Performance Improvement Project and information systems implementations.
3. Because many MHPs either have limited access to data or are unaware of what data are available, they focus exclusively on quality assurance and compliance. Access to useful data combined with ongoing training can help MHPs develop quality improvement initiatives.
4. Many MHP information systems are outdated and provide support for business operations only. The few installations of new systems have been highly problematic. With adequate resources, specific guidelines and technical assistance, MHPs would be able to execute critical information systems initiatives.
5. Many MHPs have significant human resource and infrastructure problems—due in part to years of budgetary constraints. However, in addition to funding, data-driven tools and decision-making processes are essential to support effective management practices and business operations.
6. Many MHPs are having difficulty translating the concept of wellness, resiliency and recovery into specific changes in operations. Developing and communicating a variety of locally adaptable recovery program models combined with onsite technical assistance are essential to achieving this shift in orientation
7. In recent years, budget deficits have created a survival orientation in which, regulatory requirements and the associated funding priorities are the primary focus for many MHPs, as well as for interactions between state and county leaders. In a challenging and evolving environment, clear leadership driving new goals and new objectives—focused on quality management, consumer involvement and outcomes, cultural competence, and diversity—is essential for system transformation.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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## **Attachment 1**

### **Sample Notification Packet**

- **Notification Letter**
- **Preparation for the EQRO On-Site Review**
- **PIP Validation Worksheet**
- **Consumer/Family Member Focus Group Guidelines**
- **Medi-Cal Oversight Review Quality Improvement Protocol Year One (Please refer to Attachment 21)**
- **ISCA (Please refer to Attachment 20)**



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

560 J Street, Suite 390 • Sacramento, CA 95814

www.caeqro.com

Date

Name

Mental Health Director

Agency

Address

City

Dear **NAME**:

APS Healthcare is looking forward to the first year external quality review on-site meeting with **COUNTY** on **DATE(S)**, from 9am – 5pm. **(or as MHP specific)**

The on-site review team will include the following APS staff:

- **Name**, On-site Reviewer (Lead for this review)
- **Name**, Field Analyst **(or other title as appropriate)**
- **Name**, On-site Reviewer **(as appropriate)**
- An EQRO Consumer/Family Member Consultant
- Other APS Executive staff **(as appropriate)**

The on-site review will include the following components:

1. An Information Systems Capability Assessment (ISCA).
2. A discussion and review of at least one of the current or proposed Performance Improvement Projects (PIPs).
3. A review of the most current Quality Improvement Work Plan.
4. A review of the most current Cultural Competence Plan, particularly with regard to its relation to the MHP's Quality Improvement Work Plan.
5. A review of the QI Medi-Cal Oversight Protocol (based upon a portion of the 2003-04 Department of Mental Health (DMH) Protocol).
6. A status review of the most recent DMH Program Compliance Division, Medi-Cal Oversight "Plan of Correction" (if any) to the Quality Improvement section.
7. A review of any consumer survey results from the twelve months prior to this review.
8. Interviews with key clinical, administrative, information systems, and clerical staff.
9. A consumer focus group(s) with MHP beneficiaries and family members who have been involved in at least two years of continuous services.

Please schedule the 90 minute consumer/family focus group(s) for **DATE**. Please refer to the enclosed document, "Consumer/Family Member Focus Group Guidelines," for information that will assist you in focus group planning.

The information systems portion of the EQRO review will discuss the MHP's responses on the ISCA document. As the ISCA indicates, the focus of this aspect of the EQRO both IT staff as well as billing and/or fiscal personnel who are knowledgeable about your local Medi-Cal claiming process. Additionally, we will interview staff experts on routine operations associated with the collection of client demographic, eligibility, and service information.

Representatives from the following MHP units should plan on participating:

- Executive leadership
- Information Systems
- Finance and Operations
- Quality Improvement
- Key clinical staff (**NUMBER** line staff and **NUMBER** clinical supervisors)

The MHP may also choose to involve other participants, such as large contracted providers, consumer employees, and/or representatives from the Mental Health Board or advisory committees. EQRO reviewers may interview these individuals as well. We suggest that all involved participants be available for the introductory period on the morning of the first day, either in person or via conference call. During the introductory period, the MHP is encouraged to focus on the current vision within the organization as well as significant issues that may affect quality of services and consumer outcomes.

As part of the Information Systems review on **DATE SECOND DAY**, please select two large contract agencies who can come to the County site to discuss the normal operations associated with the production of a Medi-Cal claim. **(KEEP THIS PARAGRAPH IF APPROPRIATE.)**

To prepare appropriately, please provide **electronically** to the Lead Reviewer ([name@apshealthcare.com](mailto:name@apshealthcare.com); phone **916.xxx.xxxx**) the following information no later than **DATE**.

1. The completed ISCA document. Please note that completion of this document will require input from the staffs in Billing, Quality Improvement, Fiscal, and IS.
2. A copy of the current or planned Performance Improvement Project(s) and the current status of the activity, including the study question, rationale for selection, methodology, measurement period, and any questions or issues to discuss. The National Committee for Quality Assurance (NCQA) Quality Improvement Activity (QIA) Form is recommended but not required.
3. A copy of the most recent Quality Improvement Work Plan, QI Committee minutes from the twelve months prior to this review.
4. A copy of the most recent Cultural Competence Plan and, if applicable, a copy of the Latino Access Study.
5. A copy of the most recent "Plan of Correction."
6. The results of any consumer surveys conducted in the twelve months prior to this review.
7. The names and titles of each staff person who will be participating in the review process.
8. The name(s) of contract agencies that will be involved in the IS review (upon advisement by the Lead Reviewer).
9. Confirmation of Consumer Focus Group preparation: time, location, and interpreters (if needed).
10. Confirmation of on-site office space:
  - Two meeting rooms to allow for concurrent review activity that will accommodate the MHP staff and the APS staff.
  - A confidential group room(s) that will accommodate up to 14 individuals involved in the consumer/family member focus group(s).
11. Information regarding a local restaurant that can deliver lunch so that the APS team can work during the lunch period.

If a particular document is not available electronically, please make arrangements with the Lead Reviewer for providing it in a different medium.

APS Healthcare has also contracted with several former Mental Health Directors, who are familiar with the current system, to provide the EQRO with background and context information about each county prior to our visit. As part of this process, please expect to receive a phone call from **NAME of Consultant for given county**. We hope that this will add to our knowledge about each county, and will complement the information from the documents and service data that we receive prior to our visit.

Along with this letter, you are also receiving the following documents:

1. Preparation for the EQRO On-Site Review
2. Consumer/Family Member Focus Group Guidelines
3. Information Systems Capabilities Assessment
4. QI Medi-Cal Oversight Protocol
5. PIP Validation Tool
6. NCQA QIA Form

Please also refer to the Federal PIP guidelines (“Conducting Performance Improvement Projects”) that you should have previously received.

The EQRO Lead Reviewer will develop a detailed agenda with the designated MHP contact so that involved participants can appropriately plan their time. Please advise the staff person who will be coordinating this review to contact the Lead Reviewer directly at **NUMBER** or **EMAIL**. We would like to schedule a phone call within the next two weeks to discuss the review and begin coordinating the agenda.

Sincerely,

**NAME**  
EQRO On-Site Reviewer

cc: Sheila Baler, Ph.D., M.P.H., Executive Director, California EQRO  
Rita McCabe, Chief, DMH Medi-Cal Policy and Support  
Mike Reiter, Pharm.D., Administrative Director, EQRO  
Mike Gorodezky, Ph.D., IT Systems Director, EQRO  
Rory Osborne, Ph.D., On-site Review Team Director, EQRO  
Johnny Setunyarut, Reporting Manager, EQRO  
Carol Borden-Gomez, Systems Analyst, EQRO  
Bill Ullom, Senior Systems Analyst, EQRO  
Phuc Luong, Field Analyst, EQRO  
Lisa Farrell, Data Analyst, EQRO  
Bob Martinez, Consultant in Cultural Competence  
**Name**, Senior Consultant  
**Name**, MHP QI Manager  
**Name**, MHP Information Systems Manager



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

560 J Street, Suite 390 • Sacramento, CA 95814

www.caeqro.com

**Preparation For The EQRO On-Site Review**

**County of**  
**Review Date(s)**

**Information to Provide to the EQRO by DATE**

1. The consumer/family focus group should be scheduled for **DATE**. Please refer to "Consumer/Family Member Focus Group Guidelines." The review agenda can be developed by the EQRO around this information.
2. Submit the following documents:
  - 1) The completed ISCA survey.
  - 2) An outline/description of one of the MHP's Performance Improvement Projects together with any questions or issues for discussion. The NCQA form is a recommended format but is not required.
  - 3) The most recent Quality Improvement Work Plan, QI Committee composition, and copies of the QIC meeting minutes from the previous twelve months.
  - 4) The most recent Cultural Competence Plan, including a list of trainings that include cultural competence components within the twelve month period prior to the EQR. The list should include dates, type and number of personnel who attended, and specific subject matter.
  - 5) "Plan of Correction" from the QI section of the most recent DMH compliance audit.
  - 6) A list of all surveys that were conducted in the twelve month period prior to the review. If possible, provide a summary of the results. For at least one survey, please provide the survey instrument.
3. A list of the staff who will be involved in the review. This should include the staff from management, quality improvement, fiscal, and information systems. Key clinical and operations staff (line staff and supervisors) will participate in brief interviews. Supervisors and managers should not be present during the line staff interviews.
4. The name(s) of contract providers to include in the IS review. The Lead Reviewer will advise the MHP if this component is required for this review.
5. A copy of a menu for a restaurant that can deliver lunch to the site so the review team can work through the lunch period.

## Review Components and Areas for Discussion

1. The IS review will cover all areas addressed in the ISCA document and will involve interviewing a wide variety of staff (including, but not limited to, office clerks, billing clerks, and fiscal analysts) who are involved in the Medi-Cal claiming process.
2. The PIP review will focus on validating the proposed activity. Discussion will involve the study question, objective data that support the problem definition, study methodology, proposed interventions, proposed indicators, and any anticipated barriers that may arise. Please identify areas of interest or uncertainty for the discussion. This assists the team in preparing for the visit. Please refer to the Federal website that includes information on the PIP review protocol ([www.cms.hhs.gov/medicaid/managedcare/mceqrhmp.asp](http://www.cms.hhs.gov/medicaid/managedcare/mceqrhmp.asp)) as well as the recent PIP Manual developed by CIMH.
3. Please provide some information about ideas the MHP has for a second PIP activity so that the team can be spend some time on this to provide some assistance.
4. The Cultural Competence Review will involve review of the MHP's Cultural Competence Plan. Discussion will involve issues associated with implementation of ideas or goals stated in the Plan and their relation to the MHP's QI Work Plan. Please be prepared to discuss the QI Work Plan relative to the concrete activities, implementation, and progress related to the plan's goals.
5. Consumer/Family Issues are reviewed through the focus group activity, the review of consumer satisfaction surveys, participation in QIC activities, and staff interviews plus relevant observations about the physical plant or environment.
6. The QI Medi-Cal Oversight Protocol is based upon a portion of the former Quality Improvement section from the DMH Compliance Review Protocol. Some of the requested materials relate to this section of the review.
7. If the MHP has a "Plan of Correction" relating to the Quality Improvement area from its most recent DMH audit, please be prepared to discuss actions that have been taken to remedy the deficiencies.

**Please schedule at least one phone conversation with the Lead Reviewer so that plans can be appropriately developed and coordinated.**

The Lead Reviewer is available to answer any questions and discuss details of the review agenda. The Lead Reviewer will send the MHP a detailed agenda prior to the on-site review. There may still be some agenda modifications as more detailed planning occurs and as the on-site visit itself progresses.

*Name*

*(916) xxx-xxx*

*name@apshealthcare.com*

***This is the form which the  
EQRO will use to document the PIP review.***

**PERFORMANCE IMPROVEMENT PROJECT (PIP)  
VALIDATION WORKSHEET**

ID of Evaluator \_\_\_\_\_ Date of Evaluation: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Demographic Information</b>
MHP Name
Project Leader Name:
Telephone Number:
Name of PIP:
Dates in Study Period: ____ / ____ / ____ to ____ / ____ / ____
____ Number of Medi-Cal Enrollees in PIP
____ Number of other clients in PIP
____ Total number of individuals in PIP

<b>Review of Study Methodology</b>					
Component/Standard	Yes	No	N/A	Partial	Comments
<b>Step 1: REVIEW THE SELECTED STUDY TOPIC</b>					
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of beneficiary needs, care and services?					
1.2 Did the MHP, over time, address a key aspect of beneficiary care and services?					
1.3 Did the PIP, over time, include all clients for whom the PIP pertained?					
<b>Step 2: REVIEW THE STUDY QUESTION (S)</b>					
2.1 Was/were the study question(s) stated clearly in writing?					
<b>Step 3: REVIEW SELECTED STUDY INDICATOR (S)</b>					
3.1 Did the study use objective, clearly defined, measurable indicators?					
3.2 Did the indicators measure changes in mental health status, functional status, or beneficiary satisfaction, or process of care with strong associations for improved outcomes?					
<b>Step 4: REVIEW THE IDENTIFIED STUDY POPULATION</b>					
4.1 Did the MHP clearly define all the Medicaid beneficiaries to whom the study question and indicators are relevant?					

<b>Review of Study Methodology</b>					
Component/Standard	Yes	No	N/A	Partial	Comments
4.2 If the MHP studied the entire population, did its data collection approach capture all beneficiaries to whom the study question applied?					
<b>Step 5: REVIEW THE SAMPLING METHODS</b>					
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?					
5.2 Did the MHP employ valid sampling techniques that protected against bias? <i>Specify the type of sampling or census used.</i>					
5.3 Did the sample contain a sufficient number of beneficiaries?					
<b>Step 6: REVIEW DATA COLLECTION PROCEDURES</b>					
6.1 Did the study design clearly specify the data to be collected?					
6.2 Did the study design clearly specify the sources of the data?					
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?					
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?					
6.5 Did the study design prospectively specify a data analysis plan?					
6.6 Were qualified staff and personnel used to collect the data?					
<b>Step 7: ASSESS IMPROVEMENT STRATEGIES</b>					
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?					
<b>Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS</b>					
8.1 Was an analysis of the study findings performed according to the data analysis plan?					
8.2 Did the MHP present numerical PIP results and findings accurately and clearly?					

<b>Review of Study Methodology</b>					
Component/Standard	Yes	No	N/A	Partial	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?					
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful, and of the success of follow-up activities?					
<b>Step 9: ASSESS WHETHER IMPROVEMENT IS “REAL” IMPROVEMENT</b>					
9.1 Was the same methodology as the baseline measurement used, when measurement was repeated?					
9.2 Was there any documented quantitative improvement of processes or outcomes of care?					
9.3 Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?					
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?					
<b>Step 10: ASSESS SUSTAINED IMPROVEMENT</b>					
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?					

## The Consumer/Family Member Focus Group

The Consumer/Family Member Focus Group is an important component of the EQRO On-Site Review process. Obtaining feedback from those who are receiving services from the MHP provides significant information regarding quality of care. The Lead Reviewer will work with the MHP to organize the focus group(s) in such a way that it is convenient for the participants with regard to possible alternate times and/or locations.

The focus group(s) will be led by an APS Healthcare Consumer/Family Member Consultant. An APS Healthcare On-Site Reviewer will also participate and act as a recorder.

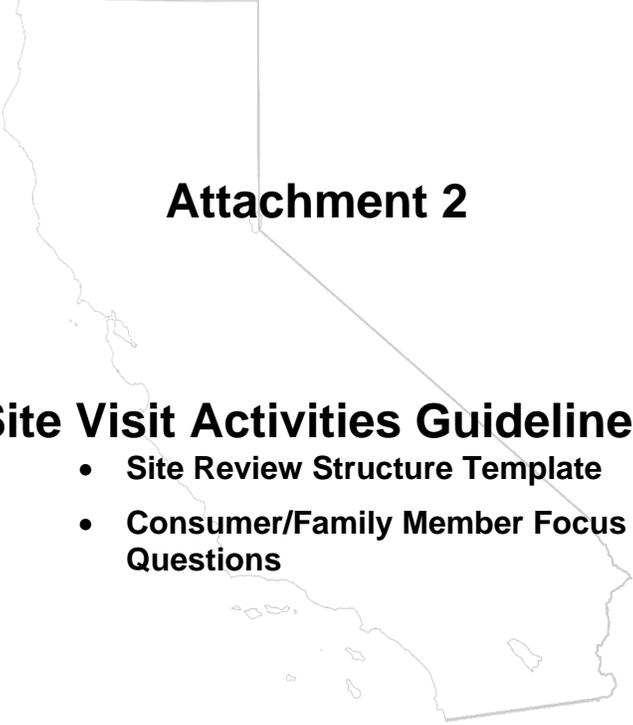
Please consider the following guidelines to improve the likelihood of a successful focus group:

1. Advise potential participants that the group will last for 90 minutes.
2. Invite enough participants to create an ethnically diverse group that contains at least 8 but no more than 10 participants. It is recommended that the group contains 6-8 consumers and 2-4 family members. At least two participants should have experience within the children's program.
3. Be aware that the EQRO will be prepared with 10 gift cards per group. The MHP may elect to invest in two or three extra gift cards in the event that more than ten people attend.
4. Advise the Lead Reviewer if mono-lingual participants are expected in the group so that interpreter needs can be addressed.
5. Try to avoid having more than one threshold language being represented within a single focus group, as multiple translators in a group can be difficult to manage. If the MHP would like to have an additional focus group to reach multiple language groups, this can be explored with the Lead Reviewer.
6. Please do not include "consumer employees," "family advocates," Mental Health Board members, or any participants who represent the MHP in an official capacity. Further, staff or other stakeholders may not participate or observe. Such individuals provide important observations but should be scheduled as part of the key staff interviews. Please discuss any suggestions with the Lead Reviewer.
7. Please avoid inviting consumers or family members who have previously participated in State DMH focus groups.
8. Please avoid inviting participants in the same family (e.g., spouses, parent/child).
9. Consider some strategies that can improve focus group attendance by:
  - a. Scheduling the group at a consumer-friendly location.
  - b. Offering snacks and transportation to participants.
  - c. Posting a sign in the waiting areas inviting participants to volunteer to attend.
  - d. Coordinating with consumer self-help organizations to enlist participants.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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**Attachment 2**

**Site Visit Activities Guidelines**

- **Site Review Structure Template**
- **Consumer/Family Member Focus Group Questions**

## Site Review Structure Template

### Introduction

- A. Introduction of participants
- B. Review intent – Overall QI Review – looking at how QI processes are or are not occurring with the use of objective data, at all levels
  - 1. Federal requirement as part of managed care
  - 2. Same validation at the state DMH
  - 3. APS history
- C. Three-step review process
  - 1. Pre-Site activities – documents, claims data, background of MHP
  - 2. On-Site activities – documents, people
  - 3. Post-Site activities – team input for report
- D. Difference between “wrap-up” and “exit interview”
  - 1. Draft report will come to the county for review, as well as to DMH.
  - 2. Final report will take all feedback into consideration.
  - 3. Process should conclude in approx 45 days with the final report.
  - 4. We remain available for technical assistance and will return in approximately one year.
- E. Nature of the agenda and its flexibility to adequately address all areas.
  - 1. Copies of agenda - review and confirm participants
  - 2. Clarify that there is working space for lunch and a menu available.
  - 3. Confirm location of focus group and, if applicable, offsite directions.
- F. Review occurs via discussion around documents with staff at many levels of the MHP.
  - 1. Identify any missing documents.
  - 2. We will likely ask for additional documents during the review.

**Cultural Competence Review**

- A. Provide APS statistics as an opportunity for discussing the nature of the community that the MHP serves.
1. How is the MHP serving the various demographics?
  2. How were data collected for the CCP? How was the MHP's IT staff involved? Are our statistics in line with what they may have presented in their CCP?
  3. For disparities in the services received by various demographic groups, have any of those disparities been identified by the MHP? If so, how is the MHP planning to address the disparity or barriers to service?
  4. What other counties does the MHP compare itself to?
- B. Cultural Competence Training
1. What has been offered in the past 12 months?
  2. Have these trainings been well-attended?
  3. Did staff have anything to say about the benefit of these trainings?
- C. Cultural Competence Plan
1. How is the MHP using the collected data to impact services?
  2. What are the goals and measurable progress toward those goals?
  3. What is the MHP's process for monitoring and evaluating goals they are working on? Are those goals also included in the QI Work Plan?
- D. How do staff demographics compare to that of the client population or the Medi-Cal community?
- E. What are their plans for recruiting ethnically diverse staff? What have they already done?
- F. What are their community outreach efforts?
- G. How are they using outside providers to assist with services provided to ethnic populations?
- H. What is their process for or efforts to minimize barriers to accessing services? How does the MHP address the disparity in access amongst the population? Has

- the MHP identified specific ways they intend to ensure access to services by specific populations?
- I. How does the agency address issues of language to consumers and family members in diverse communities?
  - J. Latino Access Study?
  - K. Are any demographic changes anticipated in the community? Will this perhaps result in changes in the threshold languages?
  - L. How are consumers, family members, and community involved in planning for services? How?
  - M. If CCP does not require a threshold language, review cultural issues for that specific county and determine if the CCP has identified and addressed those issues in the CCP (e.g., homelessness, migrant workers, gay/lesbian issues, older adults, demographic changes, etc...).
  - N. How is the MHP addressing co-occurring disorders?

**Survey Review**

- A. Number and type of surveys administered in the 12 months prior to the EQR. (The MHP may have provided this in a list prior to the review.)
- B. Survey procedures in the MHP
  - 1. Are surveys provided in the threshold languages?
  - 2. How are consumers who can not read or write handled?
  - 3. Who collects and analyzes the data?
  - 4. How do changes based upon the data get implemented within this system?
  - 5. Who receives the summary of results? How do the survey beneficiaries learn about the survey results?
- C. Detailed review of one survey:
  - 1. Survey tool
  - 2. How are consumers selected for completion of this survey?
  - 3. Summary of results
  - 4. Summary of implementation of change
  - 5. Are there plans for additional changes as a result of the survey?
  - 6. Does the agency anticipate any barriers in sustaining this change?
  - 7. How will the results from this survey impact any future surveys?

**Quality Improvement Work Plan**

- A. How does the QIC function in the MHP?
1. How are consumers, family, and other stakeholders participating?
  2. How does the QIC work with the management team?
  3. How does the work of the QIC get communicated to staff?
  4. How is the QIC involved in the development or monitoring of the QI Work Plan?
  5. Is IT involved in the QIC and other QI activities?
- B. QI Work Plan Document Review
1. How are the goals identified?
  2. Are the goals appropriate to the needs of the MHP?
  3. Are goals measurable?
  4. How are goals tracked?
  5. What is the progress made toward goals?
  6. Does it identify who the responsible party is?
  7. Does it include issues/goals highlighted in the CCP?
  8. Does it include the PIP?

**Plans of Correction**

- A. When was the last compliance review?
- B. Identify any deficiencies that were noted in the QI section of the last review. This may include QI items that are not in the protocol we are currently using.
- C. Was a Plan of Correction submitted and accepted by the State?
- D. Review those areas for demonstration of remedy of the deficiency.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

**Medi-Cal Oversight Review  
Quality Improvement Protocol Year One**

#	Criteria	Comments	Compliance	
			Yes	No
<b>1.</b>	<b>The MHP QI program includes the active participation of the following stakeholders in the ongoing planning, design, and execution of the QI program:</b>			
1a.	Practitioners/providers			
1b.	Beneficiaries			
1c.	Family members			
<b>2.</b>	<b>Regarding the Quality Improvement Committee (QIC) Meetings:</b>			
2a.	The QIC meeting is held as frequently as described in the QI Plan.			
2b.	All minutes are dated.			
2c.	All minutes are signed.			
<b>3.</b>	<b>The QIC is involved in, or overseeing, the following QI activities:</b>			
3a.	Recommending policy changes			
3b.	Reviewing and evaluating the results of QI activities			
3c.	Instituting needed QI actions			
3d.	Ensuring follow-up of QI processes			
<b>4.</b>	<b>The Annual QI Work Plan:</b>			
4a.	The MHP evaluates the effectiveness of the QI program and shows how QI activities have contributed to improvement in clinical and beneficiary service.			
4b.	The MHP incorporates relevant culturally competent and linguistic standards into the Work Plan.			
4c.	The Work Plan monitors previously identified issues, including tracking of issues over time.			
<b>5.</b>	<b>QI Work Plan - Monitoring the service delivery capacity of the MHP as evidenced by:</b>			
5a.	A description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system			
5b.	Goals for the number, type, and geographic distribution of mental health services.			

#	Criteria	Comments	Compliance	
			Yes	No
<b>6.</b>	<b>Monitoring and conducting activities to meet goals for the accessibility of services as evidenced by:</b>			
6a.	Timeliness of routine mental health appointments			
6b.	Timeliness of services for urgent conditions			
6c.	Access to after-hours care			
6d.	Responsiveness of the 24/7 toll-free number			
<b>7.</b>	<b>Monitoring and conducting activities for beneficiary satisfaction as evidenced by:</b>			
7a.	Annual survey of beneficiary satisfaction			
7b.	Annual evaluation of beneficiary grievances and fair hearings			
7c.	Annual review of requests for changing persons providing services			
7d.	Information to providers of the results of the beneficiary/family satisfaction surveys			
7e.	Completion of consumer satisfaction surveys in the threshold languages			
7f.	Satisfaction survey results in each threshold language indicating that at least 75% of the respondents had access to written information in their primary language.			
<b>8.</b>	<b>Monitoring the Service Delivery System as evidenced by:</b>			
8a.	Relevant clinical issues, including the safety and effectiveness of medication practices, are identified.			
8b.	Interventions are implemented when occurrences of potential poor care are identified.			
8c.	Providers, beneficiaries, and family members are evaluating data to identify barriers to improvement related to clinical practice and/or administrative aspects of the delivery system.			
<b>9.</b>	<b>Monitoring provider appeals:</b>			
9a.	The MHP has a mechanism to track provider appeals.			
<b>10.</b>	<b>Latino Access:</b>			
10a.	When required, a Latino Access Study has been implemented or completed.			

**Performance Improvement Project**

- A. Ask the MHP to present the PIP.
- B. Identify how the PIP is meaningful to the MHP.
- C. Is the study question clear?
- D. Is there baseline data to support the existence of the problem?
- E. How is the MHP's IT staff involved in the PIP?
- F. Are the indicators appropriate to the goals of the PIP?
- G. How will the interventions be applied?
- H. How will the data be analyzed?
- I. What barriers does the MHP anticipate in implementation?
- J. PIP Validation Tool may also be relevant for discussion:

<b>Study Methodology</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Partial</b>
Was the topic selected through data collection and analysis of comprehensive aspects of beneficiary needs, care, and services?				
Did the MHP, over time, address a key aspect of beneficiary care and services?				
Did the PIP, over time, include all clients for whom the PIP pertained?				
Was the study question stated clearly in writing?				
Did the study use objective, clearly defined, measurable indicators?				
Did the indicators measure changes in mental health status, functional status, or beneficiary satisfaction, or process of care with strong associations for improved outcomes?				
Did the MHP clearly define all the Medi-Cal beneficiaries to whom the study question and indicators are relevant?				
If the MHP studied the entire population, did its data collection approach capture all beneficiaries to whom study question applied?				
Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (qualitative or quantitative)				

<b>Study Methodology</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Partial</b>
Did the MHP employ valid sampling techniques that protected against bias?				
Did the sample contain a sufficient number of beneficiaries?				
Did the study design clearly specify the data to be collected?				
Did the study design clearly specify the sources of the data?				
Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?				
Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?				
Did the study design prospectively specify a data analysis plan?				
Were qualified staff and personnel used to collect the data?				
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?				
Was an analysis of the study findings performed according to the data analysis plan?				
Did the MHP present numerical PIP results and findings accurately and clearly?				
Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, factors that threaten internal and external validity?				
Did the analysis of study data include an interpretation of the extent to which its PIP was successful, and of the success of follow-up activities?				
Was the same methodology as the baseline measurement used, when measurement was repeated?				
Was there any documented quantitative improvement of processes or outcomes of care?				
Does the reported improvement in performance have "face validity"; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?				
Is there any statistical evidence that any observed performance improvement is true improvement?				
Was sustained improvement demonstrated through repeated measurements over comparable time periods?				

**Key Clinical Staff Interviews**

- A. Introductions
1. Introduce APS staff & MHP staff
  2. Purpose of review, with the relevance of the staff interviews
  3. Confidentiality
- B. Questions – ask those deemed relevant or appropriate
1. What do you know about today’s review and your role in it?
  2. QI Plan
    - 1) How do you view your role in the county’s QI plan?
    - 2) What do you know about the department’s efforts to monitor or improve the quality of services?
    - 3) How are changes in policies or procedures communicated to you?
    - 4) How do you communicate the need for changes in policies or procedures to the management?
  3. Cultural competence
    - 1) How do you view your role in the county’s cultural competence?
    - 2) Are you aware of the department’s goals regarding cultural competence?
    - 3) What do you do to participate in improving the county’s cultural competence?
  4. How well do you think the county is handling cultural competence?
    - 1) What improvements have you experienced in the mental health system over a period of time?
    - 2) If you could change one thing about the MHP, what would it be?
- C. Additional questions for clinical supervisors:
1. How do you know how well your organization is doing?
  2. How do you use data to make decisions regarding the programs you supervise? How do you receive this information?
  3. How are you used for the communication of information from management to line staff and vice-versa?

**Consumer Staff Interview**

- A. Introductions
  - 1. Introduce APS staff & MHP staff
  - 2. Purpose of review, with the relevance of the staff interviews
  - 3. Confidentiality
  
- B. Questions – ask those deemed relevant
  - 1. What is your role? How is your role on the treatment team determined?
  - 2. How are consumers involved in treatment planning?
  - 3. How are consumers involved in program planning?
  - 4. How do you see the “consumer culture” being incorporated or addressed in the County’s cultural competence initiatives?
  - 5. How would you like to be utilized that may be different from what you’re doing now?
  - 6. What is your role regarding Quality Improvement?

**Consumer/Family Member Focus Group**

- A. Obtain Participant Agreement Forms ... other introductory issues
- B. Demographics of the focus group
  - 1. Number of consumers and family
  - 2. Gender, ethnicity
  - 3. Adult or child system
  - 4. Language issues
- C. Focus group questions – use current questions
- D. Thank participants and provide gift certificates

**Wrap-Up**

- A. Not a traditional exit interview.
  - 1. Explain the next steps in the process. – report goes simultaneously to the MHP and to DMH for input/comments.
- B. Thank the participants.
- C. Give feedback from the review areas, focus group, or staff interviews.
- D. Identify any particular themes that have become apparent – either by MHP or APS staff. (These themes should be discussed with the team prior to the wrap-up.)
  - 1. Strengths
  - 2. Challenges/opportunities
- E. Identify any outstanding documentation.
  - 1. Any additional information can be e-mailed
- F. Ask the MHP for feedback on the process.
  - 1. Survey will be coming to many of you within a few days.

## Consumer/Family Member Focus Group Questions

Please ask the questions that are in bold.

The questions beneath the bold questions are “prompts” or examples of additional questions that may be useful in helping the group to answer the main question.

1. **How did you become a participant in this group?**
2. **How did you learn about the services that you are receiving?**
  - If you learned via written material, radio broadcast, or face-to-face outreach, was it in your language?
3. **What has changed in the system over the past two or three years – for the worse or for the better?**
4. **If the Director asked for your advice on what to change, what would you recommend?**
5. **How is the county/program addressing the concept of “recovery”?**
  - Are there self-help or other consumer-run programs?
  - Do consumers have a say in planning programs or services?
  - What services have most helped you with your life?
  - Are there programs that help you with everyday activities/life skills?
  - Are there programs that help you get a job?
  - Do you feel like the services/staff have helped you to feel like you can be a useful member of your community? (job skills, volunteering, peer assistance)
6. **What are the barriers that make it hard to get the services you need?**
  - How do you deal with those things or overcome the barriers?
  - Are services available in your language?
  - When you first go in, is there somebody available who speaks your language?
7. **Do the people at the clinic/program respect you and your culture? (This might be your ethnic background, your age, your religion, etc.)**
  - Does your case manager or therapist speak your language? If not, are the services you receive with an interpreter meeting your needs?
  - Did the staff understand your culture?
  - Has a consumer or family member advocate who speaks your language been made available to you?
8. **How are you involved in planning your treatment? Or, if you are a family member, how are you involved in the treatment of your loved one?**
  - Have you seen your Client Plan?
  - Are your goals actually in your Client Plan?
  - How have other significant people in your life been involved in your treatment? Is your family made to feel welcome?



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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### ***Abbreviations and Acronyms***

<b>APA:</b>	American Psychological Association	<b>DMH:</b>	Department of Mental Health
<b>CAEQRO:</b>	California External Quality Review Organization	<b>DOC:</b>	Documents
<b>CalOHI:</b>	California Office of HIPPA Implementation	<b>EQRO:</b>	External Quality Review Organization
<b>CALQIC:</b>	California Quality Improvement Coordinators	<b>HIPAA:</b>	Health Insurance Portability and Accountability Act
<b>CHIP:</b>	Collaborative HIPPA Implementation Plan	<b>ISCA:</b>	Information Systems Capabilities Assessment
<b>CIMH:</b>	California Institute for Mental Health	<b>IT:</b>	Information Technology
<b>CMH:</b>	California Department of Mental Health	<b>MH:</b>	Mental Health
<b>CMHDA:</b>	California Mental Health Directors Association	<b>MHSA:</b>	Mental Health Services Act
<b>Conf Call:</b>	Conference Call	<b>Mtg:</b>	Meeting
<b>Coord Mtg:</b>	Coordination Meeting	<b>NCCBH:</b>	National Council for Community Behavioral Healthcare
<b>DIG:</b>	Data Integrity Group	<b>PIP:</b>	Performance Improvement Project
		<b>PM:</b>	Performance Measure
		<b>SQIC:</b>	State Quality Improvement Council
		<b>SoQIC:</b>	Southern California Quality Improvement Coordinators

**Activities Calendars (July 2004 – June 2005)**

<b>JULY 2004</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
<b>July 2004 Activities:</b> June 11 – CMHDA Directors Mtg June 30 – DMH/APS Intro Mtg			1 CIMH Video Conference w/ Judy Ashley	2
5	6	7	8	9
12	13	14	15	16
19	20	21 Monterey MHP Review		23
26	27 Colusa MHP Review	28 DMH DIG Mtg	29 DMH EQRO Mtg	30 DMH Coord. Mtg

<b>AUGUST 2004</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
2 DMH Mtg w/ Sara Gilb	3	4	5	6
9	10	11	12	13
16	17	18 Glenn MHP Review		20
23 CIMH PIP Conf Call	24	25	26 Santa Cruz MHP Review	
30	31 DMH EQRO Planning Mtg			

**Activities Calendars (July 2004 – June 2005)**

<b>SEPTEMBER 2004</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
		1	2	3
6	7	8	9	10
13	14	15 Nevada MHP Review	16	17
20 CIMH PIP Conf Call	21	22	23 CMHDA/IT Mtg	24 CIMH PIP Conf Call
27 CIMH PIP Conf Call	28	29 Sacramento MHP Review	30 DMH Data Mtg	

<b>OCTOBER 2004</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
				1
4	5 Shasta MHP Review	6 Alameda MHP Review	7 Lassen MHP Review	8
11	12 DMH Data Mtg	13 Napa MHP Review	14 CMHDA Directors Mtg	15
18 Kern MHP Review	19 Humboldt MHP Review	20 Del Norte MHP Review CMH/IT Medi-Cal Policy Mtg	21	22
25	26	27 San Diego MHP Review	28 CMHDA/IT Mtg	29 CAEQRO Consumer Training

### Activities Calendars (July 2004 – June 2005)

NOVEMBER 2004				
Monday	Tuesday	Wednesday	Thursday	Friday
1 APS HIPAA Workgroup Mtg	2 Tehama MHP Review	3 SQIC Mtg	4 Calaveras MHP Review	5 DMH Review
8	9	10 DMH CHIP Mtg	11	12
15 ISCA at DMH Mtg CA EQRO MH-101 Training APS HIPAA Workgroup Mtg	16	17 Lake MHP Review	18 Sonoma MHP Review	19
22 CIMH Medi-Cal Policy Conf Call	23 Butte MHP Review	24	25	26
29 CAEQRO MH-101 Training	30 DMH Coord. Mtg			

DECEMBER 2004				
Monday	Tuesday	Wednesday	Thursday	Friday
		1	2 SoQIC Conf Call Training CIMH PIP Conf Call	3
6 Marin MHP Review	7	8	9	10 Ventura MHP Review
13 San Mateo MHP Review	14	15 APS Corporate Compliance Training	16 DMH PM Evaluation Project Planning Mtg	17 DMH – Prop 63 Presentation
20	21	22	23	24
27	28	29	30 DMH Coord. Mtg	31

### Activities Calendars (July 2004 – June 2005)

<b>JANUARY 2005</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
3	4	5	6	7
	Management Mtg DMH – Prop 63 Presentation	<b>Amador MHP Review</b>		
10	11	12	13	14
<b>San Bernardino MHP Review</b>				
17	18	19	20	21
DMH PM Mtg	Mtg w/ Rita McCabe-Hax	APS HIPAA Security Committee Surveys CMHDA Medi-Cal Policy Committee Mtg	<b>Tulare MHP Review</b> Sheila Baler & Rita McCabe-Hax at CA Planning Council Mtg	<b>Kings MHP Review</b> Rita McCabe-Hax ISCA Approval Process DMH PM Review Mtg
24	25	26	27	28
SF Pilot PM Begins APS HIPAA Security Committee Mtg		<b>San Joaquin MHP Review</b>		
31			CMHDA/IT Mtg	

<b>FEBRUARY 2005</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
	1	2	3	4
	<b>Orange MHP Review</b>			
	Mtg w/ Rita McCabe-Hax			
7	8	9	10	11
APS HIPAA Security Committee Mtg	DMH Assess Data Integration & Control Review Mtg	<b>Contra Costa MHP</b>		
		<b>Yolo MHP Review</b>		
14	15	16	17	18
	Mtg w/ Rita McCabe-Hax	<b>Stanislaus MHP Review</b>		
		DMH/IT Data Files Transfer Procedures Review Mtg	Annual Review Mtg	
21	22	23	24	25
APS HIPAA Security Committee Mtg	<b>Madera MHP Review</b>	<b>Merced MHP Review</b>		CMHDA/IT Mtg
			Alpine MHP Discussion at DMH Mtg DMH Coord. Mtg	
28	Protection & Advocacy Video Conf Presentation			

### Activities Calendars (July 2004 – June 2005)

<b>MARCH 2005</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
	1 Mtg w/ Rita McCabe-Hax DMH PM Review Assess Doc. of Data Review Mtg	2	3 Mendocino MHP Review DMH/IT Performance Measures Mtg	4
7 APS HIPAA Security Committee Mtg	8 DMH/IT Data Files Transfer Documentation Review Mtg	9	10	11
<b>San Francisco MHP Review</b>				
		CalOHI – Security Management Seminar DMH CHIP Mtg		
14	15	16	17	18
NCCBH		CALOIC Conference		
CIMH Managed Care Call	Mtg w/ Rita McCabe-Hax DMH/IT Assess Processes to Calculate PM Review Mtg		DMH Review Focus Groups	
21 APS HIPAA Security Committee Mtg	22 San Benito MHP Review	23	24 CMHDA/IT Mtg	25
28 San Luis Obispo MHP Review	29 Mtg w/ Rita McCabe-Hax EQRO MHP Paid Claims Audit Doc. Request Sent	30 Santa Barbara MHP Review APA Mtg DMH Coord. Mtg	31	

<b>APRIL 2005</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
				1
4 APS HIPAA Security Committee Mtg	5 El Dorado MHP Review DMH PM Review Mtg*	6	7 Fresno MHP Review APS Monthly Public Programs Development	8 DMH PM Audit Update Mtg with DMH Renae Garcia
11 APS HIPAA Security Committee Mtg DMH PM Audit Review Mtg	12 Mtg w/ Rita McCabe-Hax	13 Sutter/Yuba MHP Review	14	15
18 APS HIPAA Security Committee Mtg EQRO MHP Paid Claims Audit Doc. Request Due	19	20 Tuolumne MHP Review CA Management Information Conference and Exposition	21	22
25	26 Riverside MHP Review	27 Trinity MHP Review	28 DMH Coord. Mtg	29
Mariposa MHP Review	Mtg w/ Rita McCabe-Hax			

\*DMH PM Review Assess Processes to Produce Denominators and Numerators Mtg

### Activities Calendars (July 2004 – June 2005)

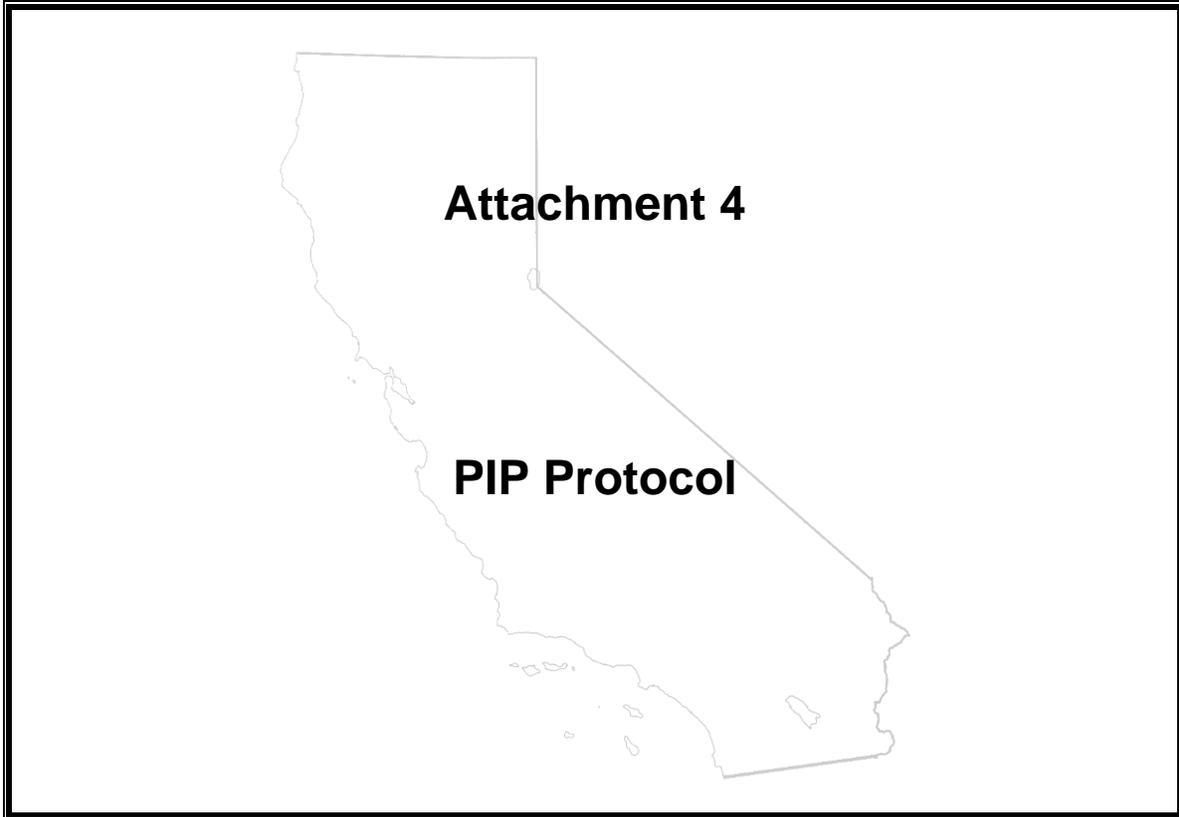
<b>MAY 2005</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
2	3	4	5	6
Los Angeles MHP Review			SOIC Mtg	
9	10	11	12	13
CIMH Managed Care Conf Call	Modoc MHP Review Mtg w/ Rita McCabe-Hax	Santa Clara MHP Review		
16	17	18	19	20
Mono MHP Review	Inyo MHP Review DMH PM Processes Review Mtg	Plumas MHP Review	Siskiyou MHP Review Medi-Cal Policy Committee Mtg	Placer/Sierra MHP Review
23	24	25	26	27
	Imperial MHP Review Mtg w/ Rita McCabe-Hax DMH PM Processes Review Mtg			
30	31			
APA Mtg				

<b>JUNE 2005</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
		1	2	3
		Mtg w/ Rita McCabe-Hax		
6	7	8	9	10
EQRO Retreat APS HIPAA Security Committee Mtg	DMH MHSA – PM Preliminary Indicator Development and IT			DMH MHSA – Planning Estimates and One-Time Funding ECHO Demonstration at CAEQRO
13	14	15	16	17
CIMH Managed Care Call		DMH MHSA – Capital Facilities Medi-Cal Policy Committee Mtg	DMH MHSA – PM Preliminary Indicator Development	
20	21	22	23	24
	Mtg w/ Rita McCabe-Hax			
27	28	29	30	



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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# PERFORMANCE IMPROVEMENT PROJECT (PIP) REVIEW TOOL DATABASE

PIP Sheet#: 
 Reviewer: 
 Review Date: 
 Project Leader Name: 
 Clinical
  Non-Clinical

County Name: 
 County Size: 
 County Region: 
 Dates in Study Period:  to

Number of Medi-Cal Enrollees in PIP: 
 Number of other underserved clients in PIP: 
 Total number of individuals in PIP: 
 Created Date/Time:

## ASSESS THE STUDY METHODOLOGY

7/25/2005 6:30 PM

Notes/Comments

1. Was the topic selected through data collection and analysis of comprehensive aspects of beneficiary needs, care and services?

Yes No N/A Partial

Yes
  No
  N/A
  Partial

Notes/Comments

2. Did the MHP, over time, address a key aspect of beneficiary care and services?

Yes No N/A Partial

Yes
  No
  N/A
  Partial

Notes/Comments

3. Did the PIP, over time, include all clients for whom the PIP pertained?

Yes No N/A Partial

Yes
  No
  N/A
  Partial

Notes/Comments

4. Was/were the study question(s) stated clearly in writing?

Yes No N/A Partial

Yes
  No
  N/A
  Partial

Notes/Comments

5. Did the study use objective, clearly defined, measurable indicators?

Yes No N/A Partial

Yes
  No
  N/A
  Partial

Notes/Comments

6. Did the indicators measure changes in mental health status, functional status, or beneficiary satisfaction, or process of care with strong associations for improved outcomes?

Yes No N/A Partial

Yes
  No
  N/A
  Partial

Notes/Comments



# PERFORMANCE IMPROVEMENT PROJECT (PIP) REVIEW TOOL DATABASE

PIP Sheet#: 
 Reviewer: 
 Review Date: 
 Project Leader Name: 
 Clinical
  Non-Clinical

County Name: 
 County Size: 
 County Region: 
 Dates in Study Period:  to

Number of Medi-Cal Enrollees in PIP: 
 Number of other underserved clients in PIP: 
 Total number of individuals in PIP: 
 Created Date/Time:

## ASSESS THE STUDY METHODOLOGY

7/25/2005 6:30 PM

### Notes/Comments

- 7. Did the MHP clearly define all the Medicaid beneficiaries to whom the study question and indicators are relevant?
- 8. If the MHP studied the entire population, did its data collection approach capture all beneficiaries to whom study question applied?
- 9. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (qualitative or quantitative)
- 10. Did the MHP employ valid sampling techniques that protected against bias?
- 11. Did the sample contain a sufficient number of beneficiaries?
- 12. Did the study design clearly specify the data to be collected?

Yes No N/A Partial



# PERFORMANCE IMPROVEMENT PROJECT (PIP) REVIEW TOOL DATABASE

PIP Sheet#: 
 Reviewer: 
 Review Date: 
 Project Leader Name: 
 Clinical
  Non-Clinical

County Name: 
 County Size: 
 County Region: 
 Dates in Study Period:  to

Number of Medi-Cal Enrollees in PIP: 
 Number of other underserved clients in PIP: 
 Total number of individuals in PIP: 
 Created Date/Time:

## ASSESS THE STUDY METHODOLOGY

7/25/2005 6:30 PM

### Notes/Comments

13. Did the study design clearly specify the sources of the data?

Yes No N/A Partial

14. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?

Yes No N/A Partial

15. Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?

Yes No N/A Partial

16. Did the study design prospectively specify a data analysis plan?

Yes No N/A Partial

17. Were qualified staff and personnel used to collect the data?

Yes No N/A Partial

18. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?

Yes No N/A Partial



# PERFORMANCE IMPROVEMENT PROJECT (PIP) REVIEW TOOL DATABASE

PIP Sheet#: 
 Reviewer: 
 Review Date: 
 Project Leader Name: 
 Clinical
  Non-Clinical

County Name: 
 County Size: 
 County Region: 
 Dates in Study Period:  to

Number of Medi-Cal Enrollees in PIP: 
 Number of other underserved clients in PIP: 
 Total number of individuals in PIP: 
 Created Date/Time:

## ASSESS THE STUDY METHODOLOGY

7/25/2005 6:30 PM

### Notes/Comments

19. Was an analysis of the study findings performed according to the data analysis plan?

Yes No N/A Partial

20. Did the MHP present numerical PIP results and findings accurately and clearly?

Yes No N/A Partial

21. Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, factors that threaten internal and external validity?

Yes No N/A Partial

22. Did the analysis of study data include an interpretation of the extent to which its PIP was successful, and of the success of follow-up activities?

Yes No N/A Partial

23. Was the same methodology as the baseline measurement used, when measurement was repeated?

Yes No N/A Partial

24. Was there any documented quantitative improvement of processes or outcomes of care?

Yes No N/A Partial



# PERFORMANCE IMPROVEMENT PROJECT (PIP) REVIEW TOOL DATABASE

PIP Sheet#: 
 Reviewer: 
 Review Date: 
 Project Leader Name: 
 Clinical
  Non-Clinical

County Name: 
 County Size: 
 County Region: 
 Dates in Study Period:  to

Number of Medi-Cal Enrollees in PIP: 
 Number of other underserved clients in PIP: 
 Total number of individuals in PIP: 
 Created Date/Time:

## ASSESS THE STUDY METHODOLOGY

7/25/2005 6:30 PM

### Notes/Comments

22. Did the analysis of study data include an interpretation of the extent to which its PIP was successful, and of the success of follow-up activities?

Yes No N/A Partial

23. Was the same methodology as the baseline measurement used, when measurement was repeated?

Yes No N/A Partial

24. Was there any documented quantitative improvement of processes or outcomes of care?

Yes No N/A Partial

25. Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?

Yes No N/A Partial

26. Is there any statistical evidence that any observed performance improvement is true improvement?

Yes No N/A Partial

27. Was sustained improvement demonstrated through repeated measurements over comparable time periods?

Yes No N/A Partial



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**Attachment 5**

**IS Data Integration and Control Worksheet**

## IS Data Integration and Control Worksheet

Documentation	Reviewed	Not Reviewed	Comments
Procedures to consolidate information from disparate transaction files to support performance measurement	<b>X</b>		
Record and file formats and descriptions for files used in producing performance measures	<b>X</b>		
Source code for data manipulation programs and processes	<b>X</b>		
Descriptive documentation for data manipulation programs and processes		<b>X</b>	Prior to the site review, documentation existed only in the SAS programs and computer queries, as a separate descriptive document did not exist. Documentation has since been produced.
Comparison of actual results from file consolidation and data abstracts to those which should have resulted according to documented algorithms	<b>X</b>		
Documentation of correct time periods	<b>X</b>		
Procedures governing process for DMH measures	<b>X</b>		



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A light gray outline map of the state of California is centered in the background of the page. The map shows the state's borders and major islands.

**Attachment 6**

**Data Integration and Control Findings Worksheet**

### Data Integration and Control Findings Worksheet

Data Integration and Control Element	Met	Not Met	N/A	Comments
<b>Accuracy of file consolidations, extracts and derivations</b>				
<ul style="list-style-type: none"> <li>▪ DMH processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate</li> </ul>	<b>X</b>			
<ul style="list-style-type: none"> <li>▪ Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications</li> </ul>	<b>X</b>			
<ul style="list-style-type: none"> <li>▪ Proper linkage mechanisms have been employed to join data from all necessary sources</li> </ul>	<b>X</b>			
<b>Assurance of effective management of report production and of the reporting software</b>				
<ul style="list-style-type: none"> <li>▪ Examine and assess the adequacy of the documentation governing the calculation of the performance measures</li> </ul>	<b>X</b>			
<ul style="list-style-type: none"> <li>▪ Appropriate time periods are used</li> </ul>	<b>X</b>			
<ul style="list-style-type: none"> <li>▪ DMH has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced</li> </ul>	<b>X</b>			
<ul style="list-style-type: none"> <li>▪ Review documentation to standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting</li> </ul>		<b>X</b>		Documentation was produced by DMH after the onsite review phase was completed.



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## **Attachment 7**

### **PM Worksheets**

- **Data and Processes Used to Calculate and Report Performance Measure Worksheet – Penetration Rate**
- **Data and Processes Used to Calculate and Report Performance Measure Worksheet – Age Group 0-18**
- **Data and Processes Used to Calculate and Report Performance Measure Worksheet – Age Group 19-64**
- **Data and Processes Used to Calculate and Report Performance Measure Worksheet – Age Group 65 and Over**
- **Documentation of Programming Specifications Worksheet – Penetration Rate**
- **Documentation of Programming Specifications Worksheet – Age Group 0-18**
- **Documentation of Programming Specifications Worksheet – Age Group 19-64**
- **Documentation of Programming Specifications Worksheet – Age Group 65 and Over**

## Data and Processes Used to Calculate and Report Performance Measure Worksheet – Penetration Rate

Documentation	Reviewed	Not Reviewed	Comments
Procedures for displaying denominator counts, numerator counts, precision levels, sums and cross-totals	X		Denominator used in the calculation is not based on member months, but rather is calculated based on unduplicated member year causing the denominator to potentially have minor deviations in certain cases.
Review of reported measures to assess consistency of common elements (e.g., eligible and client counts)	X		
For Each Measure: <b>Total Penetration Rates</b>			
Programming logic and/or source code for arithmetic calculation	X		
A project or measurement plan for performance measurement	X		
Documentation of programming specifications and data sources	X		
Documentation of the original universe of data including record-level client identifiers that can be used to validate entire programming logic for creating denominators, numerators and samples	X		
Documentation of computer queries, programming logic, or source code used to create denominators, numerators and interim data files	X		
Documentation of results of statistical tests and any corrections or adjustment to data along with justification for such changes for each measure, as appropriate	X		

<b>Documentation</b>	<b>Reviewed</b>	<b>Not Reviewed</b>	<b>Comments</b>
Documentation showing calculation of levels of significance of changes for each measure	<b>X</b>		
Documentation of sources of any supporting external data or prior year's data used in reporting for each performance measure, as appropriate	<b>X</b>		

Describe Documentation Reviewed and Demonstrations Provided:

CAEQRO reviewed SAS program code with DMH during onsite phase and independently. Also William Viergever, a SAS expert, tested results of the program code.

## Data and Processes Used to Calculate and Report Performance Measure Worksheet – Age Group 0-18

Documentation	Reviewed	Not Reviewed	Comments
Procedures for displaying denominator counts, numerator counts, precision levels, sums and cross-totals	X		
Review of reported measures to assess consistency of common elements (e.g., eligible and client counts)	X		
For Each Measure: <b>Age Group 0 – 18</b>			
Programming logic and/or source code for arithmetic calculation	X		
A project or measurement plan for performance measurement	X		
Documentation of programming specifications and data sources	X		
Documentation of the original universe of data including record-level client identifiers that can be used to validate entire programming logic for creating denominators, numerators and samples	X		
Documentation of computer queries, programming logic, or source code used to create denominators, numerators and interim data files	X		
Documentation of results of statistical tests and any corrections or adjustment to data along with justification for such changes for each measure, as appropriate	X		
Documentation showing calculation of levels of significance of changes for each measure	X		
Documentation of sources of any supporting external data or prior year's data used in reporting for each performance measure, as appropriate	X		

Describe Documentation Reviewed and Demonstrations Provided:  
CAEQRO reviewed SAS program code with DMH during onsite phase and independently. Also William Viergever, a SAS expert tested results of the program code.

## Data and Processes Used to Calculate and Report Performance Measure Worksheet – Age Group 19-64

Documentation	Reviewed	Not Reviewed	Comments
Procedures for displaying denominator counts, numerator counts, precision levels, sums and cross-totals	X		
Review of reported measures to assess consistency of common elements (e.g., eligible and client counts)	X		
<b>For Each Measure: Age Group 19 – 64</b>			
Programming logic and/or source code for arithmetic calculation	X		
A project or measurement plan for performance measurement	X		
Documentation of programming specifications and data sources	X		
Documentation of the original universe of data including record-level client identifiers that can be used to validate entire programming logic for creating denominators, numerators and samples	X		
Documentation of computer queries, programming logic, or source code used to create denominators, numerators and interim data files	X		
Documentation of results of statistical tests and any corrections or adjustment to data along with justification for such changes for each measure, as appropriate	X		
Documentation showing calculation of levels of significance of changes for each measure	X		
Documentation of sources of any supporting external data or prior year's data used in reporting for each performance measure, as appropriate	X		

Describe Documentation Reviewed and Demonstrations Provided:

CAEQRO reviewed SAS program code with DMH during onsite phase and independently. Also William Viergever, a SAS expert tested results of the program code.

## Data and Processes Used to Calculate and Report Performance Measure Worksheet – Age Group 65 and Over

Documentation	Reviewed	Not Reviewed	Comments
Procedures for displaying denominator counts, numerator counts, precision levels, sums and cross-totals	X		
Review of reported measures to assess consistency of common elements (e.g., eligible and client counts)	X		
For Each Measure: <b>Age Group 65 and Over</b>			
Programming logic and/or source code for arithmetic calculation	X		
A project or measurement plan for performance measurement	X		
Documentation of programming specifications and data sources	X		
Documentation of the original universe of data including record-level client identifiers that can be used to validate entire programming logic for creating denominators, numerators and samples	X		
Documentation of computer queries, programming logic, or source code used to create denominators, numerators and interim data files	X		
Documentation of results of statistical tests and any corrections or adjustment to data along with justification for such changes for each measure, as appropriate	X		
Documentation showing calculation of levels of significance of changes for each measure	X		
Documentation of sources of any supporting external data or prior year's data used in reporting for each performance measure, as appropriate	X		

Describe Documentation Reviewed and Demonstrations Provided:

CAEQRO reviewed SAS program code with DMH during onsite phase and independently. Also William Viergever, a SAS expert tested results of the program code.

## Documentation of Programming Specifications Worksheet – Penetration Rate

Audit Element	Met	Not Met	N/A	Comments
Measurement plans and policies that stipulate and enforce documentation of data requirements, issues, validation efforts and results. These include:				
Data file and field definitions used for each measure	X			
Statistical testing of results and any corrections or adjustments made after processing	X			
Documentation of programming specifications for each measure:				
All data sources and appropriate fiscal years	X			
Documentation of calculation for changes in performance from previous periods (if applicable) including statistical test of significance	X			
Data that are related from measure to measure are consistent (e.g., eligible and client counts)	X			
When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes	X			

## Documentation of Programming Specifications Worksheet – Age Group 0-18

Audit Element	Met	Not Met	N/A	Comments
Measurement plans and policies that stipulate and enforce documentation of data requirements, issues, validation efforts and results. These include:				
Data file and field definitions used for each measure	X			
Statistical testing of results and any corrections or adjustments made after processing	X			
Documentation of programming specifications for each measure:				
All data sources and appropriate fiscal years	X			
Documentation of calculation for changes in performance from previous periods (if applicable) including statistical test of significance	X			
Data that are related from measure to measure are consistent (e.g., eligible and client counts)	X			
When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes	X			

## Documentation of Programming Specifications Worksheet – Age Group 19-64

Audit Element	Met	Not Met	N/A	Comments
Measurement plans and policies that stipulate and enforce documentation of data requirements, issues, validation efforts and results. These include:				
Data file and field definitions used for each measure	X			
Statistical testing of results and any corrections or adjustments made after processing	X			
Documentation of programming specifications for each measure:				
All data sources and appropriate fiscal years	X			
Documentation of calculation for changes in performance from previous periods (if applicable) including statistical test of significance	X			
Data that are related from measure to measure are consistent (e.g., eligible and client counts)	X			
When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes	X			

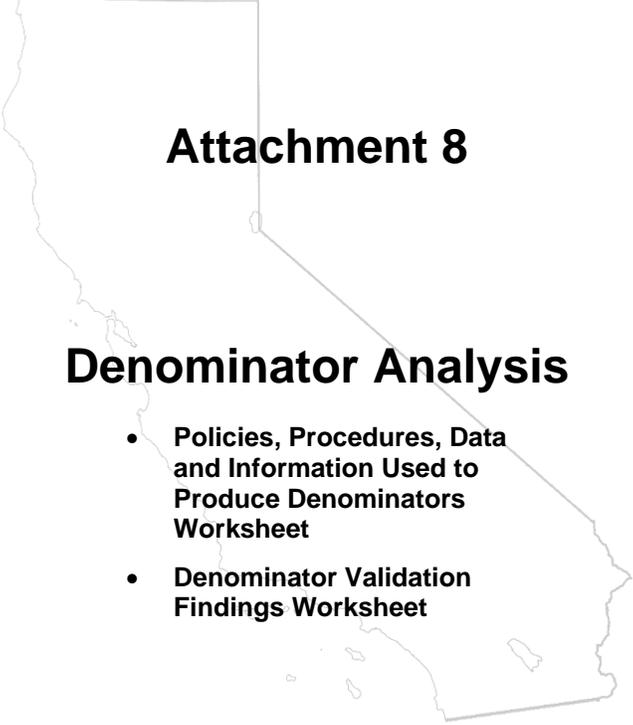
## Documentation of Programming Specifications Worksheet – Age Group 65 and Over

Audit Element	Met	Not Met	N/A	Comments
Measurement plans and policies that stipulate and enforce documentation of data requirements, issues, validation efforts and results. These include:				
Data file and field definitions used for each measure	X			
Statistical testing of results and any corrections or adjustments made after processing	X			
Documentation of programming specifications for each measure:				
All data sources and appropriate fiscal years	X			
Documentation of calculation for changes in performance from previous periods (if applicable) including statistical test of significance	X			
Data that are related from measure to measure are consistent (e.g., eligible and client counts)	X			
When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes	X			



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## **Attachment 8**

### **Denominator Analysis**

- **Policies, Procedures, Data and Information Used to Produce Denominators Worksheet**
- **Denominator Validation Findings Worksheet**

## Policies, Procedures, Data and Information Used to Produce Denominators Worksheet

Documentation	Reviewed	Not Reviewed	Comments
Procedures to identify, track and link eligibles by geographic area, age, gender	X		
Procedures to link eligibility within age group	X		
Description of software or programming languages used to query each database	X		
Programming logic and/or source code for arithmetic calculation of each measure	X		
Programming logic and/or source code for measures with complex algorithms, to ensure adequate matching and linkage among different types of data	X		
Database record layout and data dictionary	X		

## Denominator Validation Findings Worksheet

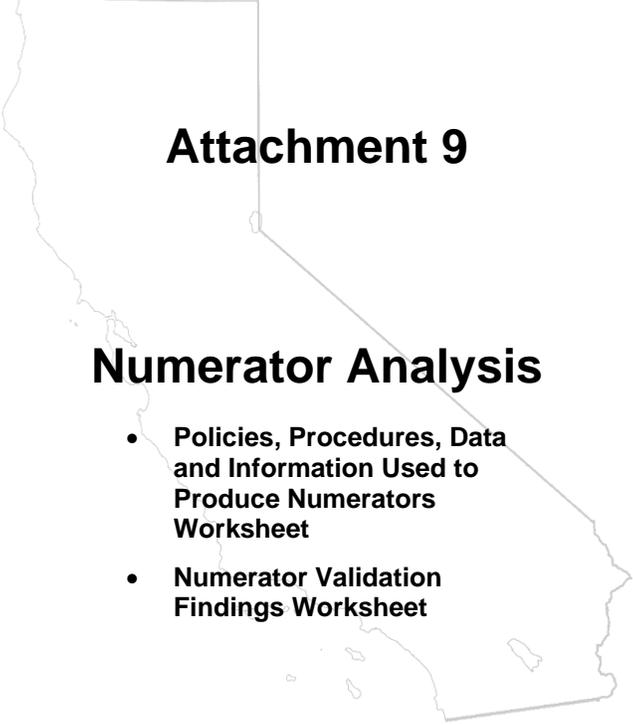
Audit Element	Met	Not Met	N/A	Comments
For each of the performance measures, all members of the relevant populations identified in the performance measure specification are included in the population from which the denominator is produced				
All individuals who were eligible to receive the specified services under study were included in the initial population from which the final denominator was produced. This population will include both clients who received the services, as well as those who did not. This same validation activity applies to other relevant populations identified in the specifications of each performance measure.	X			Denominator used in the calculations is not based on member months, but rather is calculated based on unduplicated member year. Causing the denominator to potentially have minor deviations in certain cases.
Adequate programming logic or source code exists to appropriately identify all “relevant” members of the specified denominator population for each of the performance measures				
Proper mathematical operations were used to determine client age or range	X			
Documentation of calculation for changes in performance from previous periods (if applicable) including statistical test of significance	X			
DMH can explain what classification is used when data are missing, when the missing data are needed to calculate the performance measure(s).	X			
Correct calculation of eligible months				
DMH has correctly calculated eligible month, if applicable to the performance measure	X			

Audit Element	Met	Not Met	N/A	Comments
Completeness and accuracy of the codes used to identify service events has been identified and the codes have been appropriately applied				
DMH has properly evaluated the completeness and accuracy of any codes used to identify service events, such as diagnoses or type of service, and these codes have been appropriately identified and applied as specified in each performance measure	X			
Specified time parameters are followed				
Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.)	X			
Exclusion criteria included in the performance measure specifications have been followed				
Performance measure specifications or definitions that exclude eligibles from a denominator were followed. For example, if a measure relates to selected age groups, the denominator may need to be adjusted to reflect only those clients within the age group	X			



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## **Attachment 9**

### **Numerator Analysis**

- **Policies, Procedures, Data and Information Used to Produce Numerators Worksheet**
- **Numerator Validation Findings Worksheet**

## Policies, Procedures, Data and Information Used to Produce Numerators Worksheet

Documentation	Reviewed	Not Reviewed	Comments
DMH's use of codes to identify service events (such as types of service) were correctly evaluated when classifying individuals for inclusion or exclusion in the numerator	X		
Evidence that DMH has counted each individual and/or event appropriately	X		
Programming logic or demonstration that confirms that any data elements used in determining the numerator have been correctly used in a manner that is consistent, complete and reproducible	X		
Programming logic and/or source code for arithmetic calculation of each measure	X		
Programming logic and/or source code for measures with complex algorithms, to ensure adequate matching and linkage among different types of data	X		

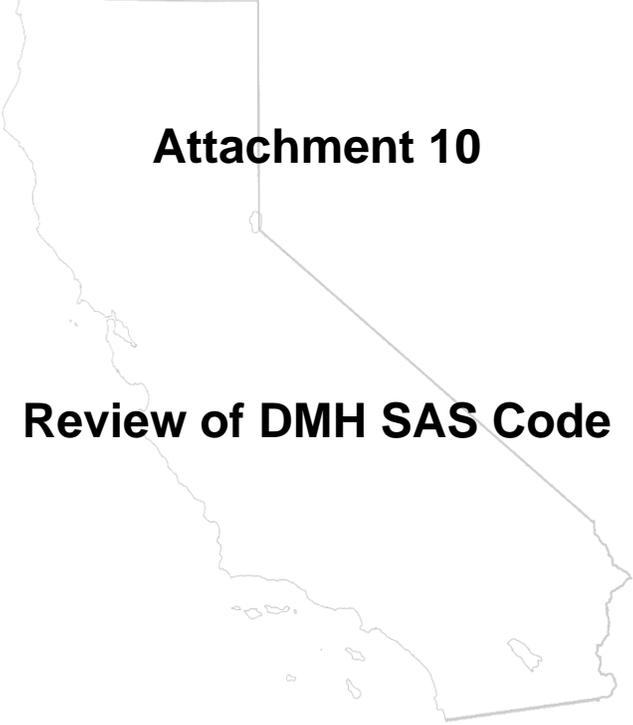
## Numerator Validation Findings – Reviewer Worksheet

Audit Element	Met	Not Met	N/A	Comments
All appropriate data are used to identify the entire at-risk population.				
DMH has used the appropriate data, including linked data from separate data sets, to identify the entire population that meets the specified criteria for inclusion in the numerator	X			
Qualifying service events (such as types of service) are properly identified and confirmed for inclusion in terms of time and services				
DMH's use of codes to identify service events (such as types of service) are complete, accurate, and specific in correctly describing what has transpired and when.	X			
DMH correctly evaluated service codes when classifying individuals for exclusion or inclusion in the numerator	X			
DMH has avoided or eliminated double-counted individuals or numerator events.	X			
Codes used by DMH are correctly mapped in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program	X			
Any time parameters required by the specification of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure	X			



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**Attachment 10**

**Review of DMH SAS Code**

## Review of California's Department of Mental Health (DMH) SAS Code

### Executive Summary

#### Background

DMH is required to annually produce a report on the fiscal year DMH beneficiary population and their utilization of DMH services. Viergever & Associates has been retained by APS Healthcare California EQRO to provide assistance in reviewing the production SAS code employed by DMH in generating their annual report.

There are two fundamental data sources: eligibility data and utilization data.

The eligibility data comes from the State's MEDS (Medicaid Eligibility Data System) network or data system. This network or system is a gestalt of various mainframe ISAM and/or VSAM files and structures, not a single, extant, database. As such, each month the State generates a snapshot or "extract" of the MEDS system that consists of a file w/ a single record for all eligibles who are "active" that current month, or in any of the prior fifteen months. Each record contains information on for a beneficiary on which county and aid code he/she was eligible, for the current month and fifteen months prior. Note: a person may not be eligible continuously across all 16 months.

This MEDS monthly extract is known as the MMEF.

For utilization data, DMH uses three (3) data sources:

1. San Mateo County CSI and Case Rate data,
2. Short-Doyle Medi-Cal claims, and
3. Fee-For-Service (FFS) paid Medi-Cal claims from EDS, the State's Fiscal Intermediary (FI). The EDS claims are known as the 34 File.

DMH thus has three groups of production code for each of the above data sources, and a fourth to bring all the pieces together and put out the final data file to be imported into an Excel file for final formatting and presentation.

All data source production code consists of similar jobs which:

1. Grab the relevant mainframe files then load, or "input", the data into SAS data sets, and
2. Do common data clean-up tasks (e.g., delete non-SD/MC reimbursable aid codes, delete food stamp aid codes, delete unknown counties, remaps Children from the Other and Family aid groups in a new category, Other Children, etc.) and define common variables to be used in the final report (e.g., mapping specific race codes and ages into pre-defined race and age "groups", mapping County into "regions", flagging for both Medicare and EPSDT eligibility, etc.), and
3. Summarize the data, both overall and by numerous subsets (e.g., Statewide, by County, Statewide by Aid Groups, County by Age Groups by Sex, etc.), and, for the last step, a single job to
4. Bring together both the summarized eligibility and summarized utilization data, merge the two together, create the *Penetration Rate* (user per average eligibles), and *Amount per User* and *Amount per (average) Eligible* variables, and output a "flat file" for importing into Excel. These three calculated variables, and the underlying variables used in the calculations, constitute the meat of the final report.

#### Findings

Having reviewed all DMH SAS code, we can stipulate that their code correctly produces the data in their final report.

Their SAS code does, however, make some assumptions, implicit and explicit, that can have consequences in the final numbers. We would like to highlight these for further consideration and discussion:

1. Age. Age is assigned at the mid-point of the fiscal year (i.e., as of January 1<sup>st</sup>) for both the eligibility and utilization data files. On the margin, this can result in inaccurate assignments. This problem could be alleviated by processing all the data, i.e., both the eligibility and utilization data, on a monthly basis. This would result in a “per member per month” (PMPM) paradigm that is more common in rate setting environments and consistent w/ the literature.
2. EPSDT and Medicare assignments. Similar to age, if beneficiary is EPSDT and/or Medicare eligible anywhere in the fiscal year, they are labeled such for the entire year. Again, moving to a PMPM paradigm would make this moot.
3. Combining Sutter and Yuba Counties. The code maps data from both the eligibility and utilization files together into one county. This is consistent w/ them operating as one Mental Health Plan.
4. Lag times. In the SAS code reviewed, two different “lags” were used in processing the MMEF data; e.g., extracting the prior June data from an October extract (a 4-month lag) vs. extracting the prior July data from a June extract (a 12-month lag). Which lag does DMH use? Do they use it consistently? DHS has performed lagged eligibility studies that show a 4-month lag to be a robust lag to employ in measuring accurate eligible counts; has DMH performed any similar studies on their population to justify which lag they employ?
5. CIN vs. MEDS ID. vs. SSN. Individuals are defined in the data based by a variable (UNDUPKEY) which is defined differently across the eligibility and utilization data. Both set UNDUPKEY equal to SSN if SSN is present, however, if not then UNDUPKEY is set equal to the CIN in the eligibility data but equal to a county assigned Case Serial Number-Family Budget Unit-Person Number construct in the claims data. We have no way of gauging the impact of this difference in coding.
6. Dates. DMH uses SAS code to produce their analysis, yet they do not use SAS date variables (a serial number, representing the number of days pre or post January 1, 1960) but rather continue to do all date calculations using simple string dates (e.g., YYMMDD). If for no other reason than code review, it is recommended that they use SAS dates for all date related calculations.
7. EPSDT denials. It is our understanding that currently there are no denied claims in the data. Why is that? Can it be had? If not, then why?
8. The data is output to flat files and then re-inputted into SAS data sets before the final (4<sup>th</sup>) step. This is inefficient data processing and by creating intermediate TXT files, exposes these data to possible corruption before the final Excel file is created. Is there a reason for the outputting of flat files prior to the last step?

## Conclusions

DMH’s SAS code produces the numbers that their annual report it is designed to. Although there are a couple of unnecessary job steps, the code is, overall, straight forward and relatively efficient. From a methodological perspective, however, moving the processing to a PMPM paradigm would result in better granularity of eligibility and utilization cohorts and thus, more accurate final analysis.

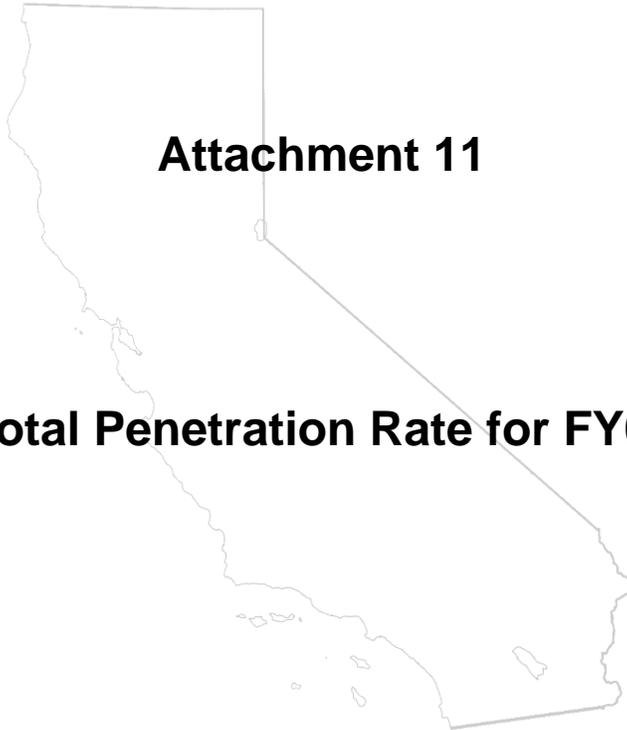


**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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**Attachment 11**

**Total Penetration Rate for FY03**





**Replication of Penetration Rate  
Medi-Cal Approved Claims Data  
Fiscal Year 2003**

Date Prepared: August 12, 2005 / Version 1.0  
 Prepared by: Hui Zhang, APS Healthcare / CAEQRO  
 Peer Reviewed by: Bill Ullom, APS Healthcare / CAEQRO  
 Information Source: DMH Approved Claims & Eligibility Data - Notes - (1) and (2)  
 DMH Process Date: June 30, 2005 - Note (3)

Area Name	Comparison	Penetration Rate	Unduplicated Beneficiaries Served	Monthly Average Unduplicated Eligibles
STATEWIDE	DMH Original	6.2809%	415,867	6,621,127
STATEWIDE	APS Replicate	6.2815%	415,906	6,621,127
STATEWIDE	Difference	0.0006%	39	0
STATEWIDE	% Difference	0.0094%	0	0
BAY AREA	DMH Original	7.8817%	72,858	924,395
BAY AREA	APS Replicate	7.8834%	72,874	924,395
BAY AREA	Difference	0.0017%	16	0
BAY AREA	% Difference	0.0220%	0	0
CENTRAL	DMH Original	6.3618%	72,375	1,137,651
CENTRAL	APS Replicate	6.3621%	72,379	1,137,651
CENTRAL	Difference	0.0004%	4	0
CENTRAL	% Difference	0.0055%	0	0
LOS ANGELES	DMH Original	4.8828%	127,939	2,620,200
LOS ANGELES	APS Replicate	4.8833%	127,951	2,620,200
LOS ANGELES	Difference	0.0005%	12	0
LOS ANGELES	% Difference	0.0094%	0	0
SOUTHERN	DMH Original	6.9592%	119,981	1,724,064
SOUTHERN	APS Replicate	6.9596%	119,988	1,724,064
SOUTHERN	Difference	0.0004%	7	0
SOUTHERN	% Difference	0.0058%	0	0
SUPERIOR	DMH Original	10.5737%	22,714	214,817
SUPERIOR	APS Replicate	10.5737%	22,714	214,817
SUPERIOR	Difference	0.0000%	0	0
SUPERIOR	% Difference	0.0000%	0	0
ALAMEDA	DMH Original	8.0475%	16,261	202,062
ALAMEDA	APS Replicate	8.0480%	16,262	202,062
ALAMEDA	Difference	0.0005%	1	0
ALAMEDA	% Difference	0.0061%	0	0
ALPINE	DMH Original	0.3802%	1	263
ALPINE	APS Replicate	0.3802%	1	263
ALPINE	Difference	0.0000%	0	0
ALPINE	% Difference	0.0000%	0	0
AMADOR	DMH Original	11.8106%	394	3,336
AMADOR	APS Replicate	11.8106%	394	3,336
AMADOR	Difference	0.0000%	0	0
AMADOR	% Difference	0.0000%	0	0
BUTTE	DMH Original	10.5062%	5,143	48,952
BUTTE	APS Replicate	10.5062%	5,143	48,952
BUTTE	Difference	0.0000%	0	0
BUTTE	% Difference	0.0000%	0	0

Area Name	Comparison	Penetration Rate	Unduplicated Beneficiaries Served	Monthly Average Unduplicated Eligibles
CALAVERAS	DMH Original	6.3481%	364	5,734
CALAVERAS	APS Replicate	6.3481%	364	5,734
CALAVERAS	Difference	0.0000%	0	0
CALAVERAS	% Difference	0.0000%	0	0
COLUSA	DMH Original	6.4489%	308	4,776
COLUSA	APS Replicate	6.4489%	308	4,776
COLUSA	Difference	0.0000%	0	0
COLUSA	% Difference	0.0000%	0	0
CONTRA COSTA	DMH Original	8.5360%	8,561	100,293
CONTRA COSTA	APS Replicate	8.5360%	8,561	100,293
CONTRA COSTA	Difference	0.0000%	0	0
CONTRA COSTA	% Difference	0.0000%	0	0
DEL NORTE	DMH Original	12.0445%	952	7,904
DEL NORTE	APS Replicate	12.0445%	952	7,904
DEL NORTE	Difference	0.0000%	0	0
DEL NORTE	% Difference	0.0000%	0	0
EL DORADO	DMH Original	9.6806%	1,361	14,059
EL DORADO	APS Replicate	9.6806%	1,361	14,059
EL DORADO	Difference	0.0000%	0	0
EL DORADO	% Difference	0.0000%	0	0
FRESNO	DMH Original	5.2001%	13,150	252,882
FRESNO	APS Replicate	5.2001%	13,150	252,882
FRESNO	Difference	0.0000%	0	0
FRESNO	% Difference	0.0000%	0	0
GLENN	DMH Original	7.2038%	456	6,330
GLENN	APS Replicate	7.2038%	456	6,330
GLENN	Difference	0.0000%	0	0
GLENN	% Difference	0.0000%	0	0
HUMBOLDT	DMH Original	10.8838%	2,825	25,956
HUMBOLDT	APS Replicate	10.8838%	2,825	25,956
HUMBOLDT	Difference	0.0000%	0	0
HUMBOLDT	% Difference	0.0000%	0	0
IMPERIAL	DMH Original	6.1054%	2,798	45,828
IMPERIAL	APS Replicate	6.1054%	2,798	45,828
IMPERIAL	Difference	0.0000%	0	0
IMPERIAL	% Difference	0.0000%	0	0
INYO	DMH Original	9.7966%	289	2,950
INYO	APS Replicate	9.7966%	289	2,950
INYO	Difference	0.0000%	0	0
INYO	% Difference	0.0000%	0	0
KERN	DMH Original	6.9513%	12,612	181,433
KERN	APS Replicate	6.9513%	12,612	181,433
KERN	Difference	0.0000%	0	0
KERN	% Difference	0.0000%	0	0
KINGS	DMH Original	8.3848%	2,483	29,613
KINGS	APS Replicate	8.3882%	2,484	29,613
KINGS	Difference	0.0034%	1	0
KINGS	% Difference	0.0403%	0	0
LAKE	DMH Original	8.9802%	1,372	15,278
LAKE	APS Replicate	8.9802%	1,372	15,278
LAKE	Difference	0.0000%	0	0
LAKE	% Difference	0.0000%	0	0
LASSEN	DMH Original	12.2275%	617	5,046
LASSEN	APS Replicate	12.2275%	617	5,046
LASSEN	Difference	0.0000%	0	0
LASSEN	% Difference	0.0000%	0	0

Area Name	Comparison	Penetration Rate	Unduplicated Beneficiaries Served	Monthly Average Unduplicated Eligibles
LOS ANGELES	DMH Original	4.8828%	127,939	2,620,200
LOS ANGELES	APS Replicate	4.8833%	127,951	2,620,200
LOS ANGELES	Difference	0.0005%	12	0
LOS ANGELES	% Difference	0.0094%	0	0
MADERA	DMH Original	5.4966%	1,910	34,749
MADERA	APS Replicate	5.4966%	1,910	34,749
MADERA	Difference	0.0000%	0	0
MADERA	% Difference	0.0000%	0	0
MARIN	DMH Original	12.8917%	1,983	15,382
MARIN	APS Replicate	12.8917%	1,983	15,382
MARIN	Difference	0.0000%	0	0
MARIN	% Difference	0.0000%	0	0
MARIPOSA	DMH Original	12.0847%	291	2,408
MARIPOSA	APS Replicate	12.0847%	291	2,408
MARIPOSA	Difference	0.0000%	0	0
MARIPOSA	% Difference	0.0000%	0	0
MENDOCINO	DMH Original	9.0284%	1,852	20,513
MENDOCINO	APS Replicate	9.0284%	1,852	20,513
MENDOCINO	Difference	0.0000%	0	0
MENDOCINO	% Difference	0.0000%	0	0
MERCED	DMH Original	4.6708%	3,253	69,646
MERCED	APS Replicate	4.6708%	3,253	69,646
MERCED	Difference	0.0000%	0	0
MERCED	% Difference	0.0000%	0	0
MODOC	DMH Original	11.6190%	272	2,341
MODOC	APS Replicate	11.6190%	272	2,341
MODOC	Difference	0.0000%	0	0
MODOC	% Difference	0.0000%	0	0
MONO	DMH Original	5.3619%	60	1,119
MONO	APS Replicate	5.3619%	60	1,119
MONO	Difference	0.0000%	0	0
MONO	% Difference	0.0000%	0	0
MONTEREY	DMH Original	4.0025%	3,114	77,802
MONTEREY	APS Replicate	4.0025%	3,114	77,802
MONTEREY	Difference	0.0000%	0	0
MONTEREY	% Difference	0.0000%	0	0
NAPA	DMH Original	7.5489%	968	12,823
NAPA	APS Replicate	7.5489%	968	12,823
NAPA	Difference	0.0000%	0	0
NAPA	% Difference	0.0000%	0	0
NEVADA	DMH Original	12.0323%	997	8,286
NEVADA	APS Replicate	12.0323%	997	8,286
NEVADA	Difference	0.0000%	0	0
NEVADA	% Difference	0.0000%	0	0
ORANGE	DMH Original	5.9975%	20,914	348,710
ORANGE	APS Replicate	5.9981%	20,916	348,710
ORANGE	Difference	0.0006%	2	0
ORANGE	% Difference	0.0096%	0	0
PLACER	DMH Original	11.2120%	2,198	19,604
PLACER	APS Replicate	11.2120%	2,198	19,604
PLACER	Difference	0.0000%	0	0
PLACER	% Difference	0.0000%	0	0
PLUMAS	DMH Original	11.2710%	329	2,919
PLUMAS	APS Replicate	11.2710%	329	2,919
PLUMAS	Difference	0.0000%	0	0
PLUMAS	% Difference	0.0000%	0	0

Area Name	Comparison	Penetration Rate	Unduplicated Beneficiaries Served	Monthly Average Unduplicated Eligibles
RIVERSIDE	DMH Original	6.5934%	17,365	263,371
RIVERSIDE	APS Replicate	6.5934%	17,365	263,371
RIVERSIDE	Difference	0.0000%	0	0
RIVERSIDE	% Difference	0.0000%	0	0
SACRAMENTO	DMH Original	7.0433%	18,546	263,314
SACRAMENTO	APS Replicate	7.0437%	18,547	263,314
SACRAMENTO	Difference	0.0004%	1	0
SACRAMENTO	% Difference	0.0054%	0	0
SAN BENITO	DMH Original	8.6944%	612	7,039
SAN BENITO	APS Replicate	8.6944%	612	7,039
SAN BENITO	Difference	0.0000%	0	0
SAN BENITO	% Difference	0.0000%	0	0
SAN BERNARDINO	DMH Original	6.3701%	22,183	348,234
SAN BERNARDINO	APS Replicate	6.3704%	22,184	348,234
SAN BERNARDINO	Difference	0.0003%	1	0
SAN BERNARDINO	% Difference	0.0045%	0	0
SAN DIEGO	DMH Original	9.1323%	31,703	347,152
SAN DIEGO	APS Replicate	9.1335%	31,707	347,152
SAN DIEGO	Difference	0.0012%	4	0
SAN DIEGO	% Difference	0.0126%	0	0
SAN FRANCISCO	DMH Original	11.5235%	13,997	121,465
SAN FRANCISCO	APS Replicate	11.5342%	14,010	121,465
SAN FRANCISCO	Difference	0.0107%	13	0
SAN FRANCISCO	% Difference	0.0929%	0	0
SAN JOAQUIN	DMH Original	6.8559%	9,110	132,878
SAN JOAQUIN	APS Replicate	6.8559%	9,110	132,878
SAN JOAQUIN	Difference	0.0000%	0	0
SAN JOAQUIN	% Difference	0.0000%	0	0
SAN LUIS OBISPO	DMH Original	9.2160%	2,612	28,342
SAN LUIS OBISPO	APS Replicate	9.2160%	2,612	28,342
SAN LUIS OBISPO	Difference	0.0000%	0	0
SAN LUIS OBISPO	% Difference	0.0000%	0	0
SAN MATEO	DMH Original	8.2925%	5,193	62,623
SAN MATEO	APS Replicate	8.2925%	5,193	62,623
SAN MATEO	Difference	0.0000%	0	0
SAN MATEO	% Difference	0.0000%	0	0
SANTA BARBARA	DMH Original	6.8185%	4,258	62,448
SANTA BARBARA	APS Replicate	6.8185%	4,258	62,448
SANTA BARBARA	Difference	0.0000%	0	0
SANTA BARBARA	% Difference	0.0000%	0	0
SANTA CLARA	DMH Original	6.4755%	12,797	197,621
SANTA CLARA	APS Replicate	6.4755%	12,797	197,621
SANTA CLARA	Difference	0.0000%	0	0
SANTA CLARA	% Difference	0.0000%	0	0
SANTA CRUZ	DMH Original	7.9565%	2,490	31,295
SANTA CRUZ	APS Replicate	7.9629%	2,492	31,295
SANTA CRUZ	Difference	0.0064%	2	0
SANTA CRUZ	% Difference	0.0803%	0	0
SHASTA	DMH Original	11.5232%	4,219	36,613
SHASTA	APS Replicate	11.5232%	4,219	36,613
SHASTA	Difference	0.0000%	0	0
SHASTA	% Difference	0.0000%	0	0
SIERRA	DMH Original	3.6717%	17	463
SIERRA	APS Replicate	3.6717%	17	463
SIERRA	Difference	0.0000%	0	0
SIERRA	% Difference	0.0000%	0	0

Area Name	Comparison	Penetration Rate	Unduplicated Beneficiaries Served	Monthly Average Unduplicated Eligibles
SISKIYOU	DMH Original	13.2669%	1,332	10,040
SISKIYOU	APS Replicate	13.2669%	1,332	10,040
SISKIYOU	Difference	0.0000%	0	0
SISKIYOU	% Difference	0.0000%	0	0
SOLANO	DMH Original	6.6956%	3,408	50,899
SOLANO	APS Replicate	6.6956%	3,408	50,899
SOLANO	Difference	0.0000%	0	0
SOLANO	% Difference	0.0000%	0	0
SONOMA	DMH Original	7.7041%	3,474	45,093
SONOMA	APS Replicate	7.7041%	3,474	45,093
SONOMA	Difference	0.0000%	0	0
SONOMA	% Difference	0.0000%	0	0
STANISLAUS	DMH Original	7.0810%	7,749	109,433
STANISLAUS	APS Replicate	7.0810%	7,749	109,433
STANISLAUS	Difference	0.0000%	0	0
STANISLAUS	% Difference	0.0000%	0	0
SUTTER/YUBA	DMH Original	7.6443%	2,732	35,739
SUTTER/YUBA	APS Replicate	7.6443%	2,732	35,739
SUTTER/YUBA	Difference	0.0000%	0	0
SUTTER/YUBA	% Difference	0.0000%	0	0
TEHAMA	DMH Original	10.5029%	1,466	13,958
TEHAMA	APS Replicate	10.5029%	1,466	13,958
TEHAMA	Difference	0.0000%	0	0
TEHAMA	% Difference	0.0000%	0	0
TRINITY	DMH Original	10.7458%	268	2,494
TRINITY	APS Replicate	10.7458%	268	2,494
TRINITY	Difference	0.0000%	0	0
TRINITY	% Difference	0.0000%	0	0
TULARE	DMH Original	4.1844%	5,359	128,071
TULARE	APS Replicate	4.1860%	5,361	128,071
TULARE	Difference	0.0016%	2	0
TULARE	% Difference	0.0373%	0	0
TUOLUMNE	DMH Original	15.4300%	1,125	7,291
TUOLUMNE	APS Replicate	15.4300%	1,125	7,291
TUOLUMNE	Difference	0.0000%	0	0
TUOLUMNE	% Difference	0.0000%	0	0
VENTURA	DMH Original	5.6176%	5,536	98,547
VENTURA	APS Replicate	5.6176%	5,536	98,547
VENTURA	Difference	0.0000%	0	0
VENTURA	% Difference	0.0000%	0	0
YOLO	DMH Original	8.3197%	2,289	27,513
YOLO	APS Replicate	8.3197%	2,289	27,513
YOLO	Difference	0.0000%	0	0
YOLO	% Difference	0.0000%	0	0

**Notes:**

1 - Reports approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility" (CFR). The report includes approved claims data on MHP eligible beneficiaries who were served by other MHP's.

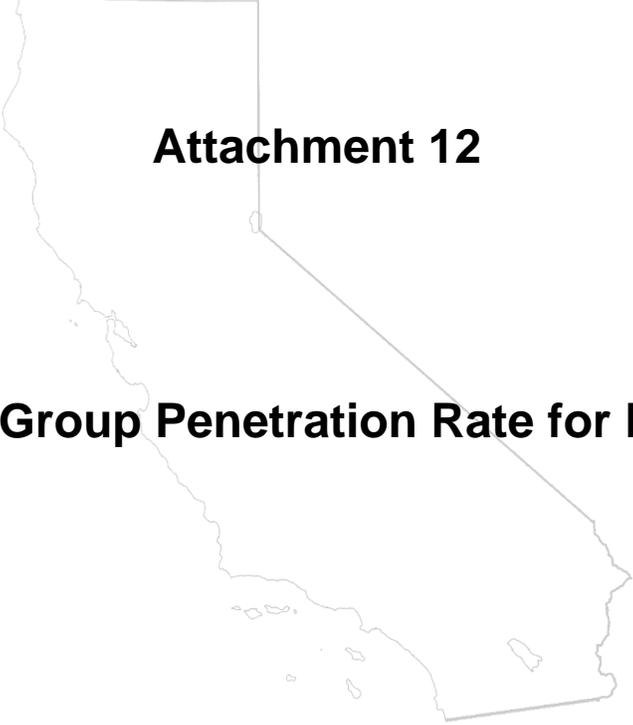
2 - Includes both Inpatient Consolidated (IPC) and Short-Doyle/Medi-Cal (SDMC) approve claims and San Mateo County Case Rates for the MHP. The report includes only those aid codes approved for SDMC program funding.

3 - The most recent date SDMC claims were processed by DHS/DMH for the indicated fiscal year and the data included in the report of CAEQRO replication. The date for DMH original approved claims is as of November 30, 2004



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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**Attachment 12**

**Age Group Penetration Rate for FY03**



**Penetration Rates by Age Group 0-18  
Medi-Cal Approved Claims Data  
Fiscal Year 2003**

Date Prepared: August 12, 2005 / Version 1.0  
 Prepared by: Hui Zhang, APS Healthcare / CA - EQRO  
 Peer Reviewed by: Bill Ullom, APS Healthcare / CAEQRO  
 Information Source: DMH Approved Claims & Eligibility Data - Notes - (1) and (2)  
 DMH Process Date: June 30, 2005 - Note (3)

Area Name	Age Category	Unduplicated Eligibles	Unduplicated Eligibles - Monthly Average	Unduplicated Beneficiaries Served	Penetration Rate	Approved Claim Amount	Amount Approved Per Eligible	Amount Approved Per Beneficiary
STATEWIDE	0-18	3,971,724	3,268,136	166,811	5.10%	\$849,513,399	\$260	\$5,093
BAY AREA	0-18	504,530	397,622	22,559	5.67%	\$157,189,105	\$395	\$6,968
CENTRAL	0-18	714,509	585,258	30,797	5.26%	\$142,742,173	\$244	\$4,635
LOS ANGELES	0-18	1,493,746	1,294,928	55,897	4.32%	\$329,074,026	\$254	\$5,887
SOUTHERN	0-18	1,139,661	895,515	48,774	5.45%	\$182,651,981	\$204	\$3,745
SUPERIOR	0-18	119,278	94,813	8,784	9.26%	\$37,856,115	\$399	\$4,310
ALAMEDA	0-18	111,335	89,086	5,416	6.08%	\$37,577,674	\$422	\$6,938
ALPINE	0-18	157	130	0	0.00%	\$0	\$0	\$0
AMADOR	0-18	2,078	1,502	148	9.85%	\$450,621	\$300	\$3,045
BUTTE	0-18	26,115	21,966	2,409	10.97%	\$11,640,939	\$530	\$4,832
CALAVERAS	0-18	3,430	2,560	126	4.92%	\$236,340	\$92	\$1,876
COLUSA	0-18	3,101	2,331	113	4.85%	\$222,946	\$96	\$1,973
CONTRA COSTA	0-18	60,064	47,035	3,646	7.75%	\$25,112,435	\$534	\$6,888
DEL NORTE	0-18	4,413	3,561	353	9.91%	\$1,007,368	\$283	\$2,854
EL DORADO	0-18	8,650	6,193	490	7.91%	\$1,487,900	\$240	\$3,037
FRESNO	0-18	162,104	136,429	5,425	3.98%	\$19,952,811	\$146	\$3,678
GLENN	0-18	4,117	3,177	183	5.76%	\$777,215	\$245	\$4,247
HUMBOLDT	0-18	13,729	11,031	919	8.33%	\$5,942,962	\$539	\$6,467
IMPERIAL	0-18	25,357	20,766	1,300	6.26%	\$4,356,255	\$210	\$3,351
INYO	0-18	1,763	1,299	124	9.55%	\$530,926	\$409	\$4,282
KERN	0-18	117,840	95,609	6,058	6.34%	\$22,318,136	\$233	\$3,684
KINGS	0-18	19,916	15,871	1,047	6.60%	\$1,857,606	\$117	\$1,774
LAKE	0-18	8,191	6,347	522	8.22%	\$1,595,412	\$251	\$3,056
LASSEN	0-18	3,074	2,276	236	10.37%	\$1,106,073	\$486	\$4,687
LOS ANGELES	0-18	1,493,746	1,294,928	55,897	4.32%	\$329,074,026	\$254	\$5,887
MADERA	0-18	22,814	18,115	875	4.83%	\$3,125,065	\$173	\$3,572
MARIN	0-18	7,548	5,789	556	9.60%	\$2,543,932	\$439	\$4,575
MARIPOSA	0-18	1,488	1,096	121	11.04%	\$236,658	\$216	\$1,956
MENDOCINO	0-18	11,576	9,427	567	6.01%	\$3,940,272	\$418	\$6,949

Area Name	Age Category	Unduplicated Eligibles	Unduplicated Eligibles - Monthly Average	Unduplicated Beneficiaries Served	Penetration Rate	Approved Claim Amount	Amount Approved Per Eligible	Amount Approved Per Beneficiary
MERCED	0-18	45,947	36,785	1,117	3.04%	\$2,774,008	\$75	\$2,483
MODOC	0-18	1,345	1,056	113	10.70%	\$153,491	\$145	\$1,358
MONO	0-18	876	589	25	4.24%	\$277,482	\$471	\$11,099
MONTEREY	0-18	50,523	40,346	1,244	3.08%	\$9,137,058	\$226	\$7,345
NAPA	0-18	7,792	5,914	316	5.34%	\$1,808,978	\$306	\$5,725
NEVADA	0-18	4,736	3,455	316	9.15%	\$983,230	\$285	\$3,111
ORANGE	0-18	225,928	177,961	8,313	4.67%	\$34,445,084	\$194	\$4,144
PLACER	0-18	11,719	8,591	639	7.44%	\$3,163,736	\$368	\$4,951
PLUMAS	0-18	1,609	1,216	132	10.86%	\$450,914	\$371	\$3,416
RIVERSIDE	0-18	187,505	142,969	7,205	5.04%	\$15,324,511	\$107	\$2,127
SACRAMENTO	0-18	159,610	132,661	9,565	7.21%	\$65,390,318	\$493	\$6,836
SAN BENITO	0-18	4,920	3,584	268	7.48%	\$830,391	\$232	\$3,098
SAN BERNARDINO	0-18	245,473	191,721	8,645	4.51%	\$22,265,396	\$116	\$2,576
SAN DIEGO	0-18	218,855	173,015	12,919	7.47%	\$59,536,896	\$344	\$4,608
SAN FRANCISCO	0-18	44,692	36,338	2,978	8.20%	\$16,540,497	\$455	\$5,554
SAN JOAQUIN	0-18	82,980	67,502	2,585	3.83%	\$8,957,464	\$133	\$3,465
SAN LUIS OBISPO	0-18	16,797	12,811	959	7.49%	\$4,446,975	\$347	\$4,637
SAN MATEO	0-18	34,599	27,558	1,373	4.98%	\$7,960,215	\$289	\$5,798
SANTA BARBARA	0-18	39,834	31,767	1,555	4.90%	\$10,853,800	\$342	\$6,980
SANTA CLARA	0-18	105,849	82,671	3,348	4.05%	\$32,481,753	\$393	\$9,702
SANTA CRUZ	0-18	18,908	14,733	887	6.02%	\$9,115,573	\$619	\$10,277
SHASTA	0-18	20,053	15,697	1,647	10.49%	\$4,244,241	\$270	\$2,577
SIERRA	0-18	263	199	7	3.52%	\$48,297	\$243	\$6,900
SISKIYOU	0-18	5,450	4,247	567	13.35%	\$3,873,890	\$912	\$6,832
SOLANO	0-18	31,886	24,302	1,278	5.26%	\$8,941,083	\$368	\$6,996
SONOMA	0-18	26,414	20,267	1,249	6.16%	\$5,139,515	\$254	\$4,115
STANISLAUS	0-18	67,464	54,217	3,483	6.42%	\$12,847,811	\$237	\$3,689
SUTTER/YUBA	0-18	22,509	17,558	983	5.60%	\$4,442,988	\$253	\$4,520
TEHAMA	0-18	8,359	6,489	484	7.46%	\$1,098,202	\$169	\$2,269
TRINITY	0-18	1,384	1,040	92	8.85%	\$239,736	\$231	\$2,606
TULARE	0-18	81,170	68,856	2,806	4.08%	\$11,844,339	\$172	\$4,221
TUOLUMNE	0-18	4,140	3,096	412	13.31%	\$1,287,903	\$416	\$3,126
VENTURA	0-18	62,072	48,896	1,820	3.72%	\$9,104,927	\$186	\$5,003
YOLO	0-18	17,457	13,506	950	7.03%	\$4,409,122	\$326	\$4,641

**Notes:**

- 1- Reports approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility" (CFR). The report includes approved claims data on MHP eligible beneficiaries who were served by other MHP's.
- 2 - Includes both Inpatient Consolidated claims (IPC) and Short-Doyle/Medi-Cal (SDMC) approve claims and San Mateo County Case Rates for the MHP. The report includes only those aid codes approved for SDMC program funding.
- 3 - The most recent date SDMC claims were processed by DHS/DMH for the indicated fiscal year and the data included in the report.



**Penetration Rates by Age Group 19-64  
Medi-Cal Approved Claims Data  
Fiscal Year 2003**

Date Prepared: August 12, 2005 / Version 1.0  
 Prepared by: Hui Zhang, APS Healthcare / CA - EQRO  
 Peer Reviewed by: Bill Ullom, APS Healthcare / CAEQRO  
 Information Source: DMH Approved Claims & Eligibility Data - Notes - (1) and (2)  
 DMH Process Date: June 30, 2005 - Note (3)

Area Name	Age Category	Unduplicated Eligibles	Unduplicated Eligibles - Monthly Average	Unduplicated Beneficiaries Served	Penetration Rate	Approved Claim Amount	Amount Approved Per Eligible	Amount Approved Per Beneficiary
STATEWIDE	19-64	3,153,851	2,569,987	235,612	9.17%	\$812,898,668	\$316	\$3,450
BAY AREA	19-64	461,788	363,153	46,502	12.81%	\$248,696,972	\$685	\$5,348
CENTRAL	19-64	556,350	447,720	39,374	8.79%	\$108,296,934	\$242	\$2,750
LOS ANGELES	19-64	1,200,824	1,030,783	68,106	6.61%	\$216,585,905	\$210	\$3,180
SOUTHERN	19-64	811,957	630,932	68,230	10.81%	\$202,542,059	\$321	\$2,969
SUPERIOR	19-64	122,932	97,400	13,400	13.76%	\$36,776,797	\$378	\$2,745
ALAMEDA	19-64	99,177	79,064	10,382	13.13%	\$40,780,896	\$516	\$3,928
ALPINE	19-64	154	117	1	0.85%	\$8,190	\$70	\$8,190
AMADOR	19-64	1,881	1,378	238	17.27%	\$351,907	\$255	\$1,479
BUTTE	19-64	26,709	22,229	2,618	11.78%	\$7,793,755	\$351	\$2,977
CALAVERAS	19-64	3,364	2,513	234	9.31%	\$532,279	\$212	\$2,275
COLUSA	19-64	2,671	1,930	180	9.33%	\$363,460	\$188	\$2,019
CONTRA COSTA	19-64	50,245	39,146	4,739	12.11%	\$19,400,607	\$496	\$4,094
DEL NORTE	19-64	4,493	3,622	584	16.12%	\$820,414	\$227	\$1,405
EL DORADO	19-64	8,562	6,192	832	13.44%	\$2,212,091	\$357	\$2,659
FRESNO	19-64	116,696	95,322	7,287	7.64%	\$21,804,045	\$229	\$2,992
GLENN	19-64	3,383	2,551	257	10.07%	\$821,004	\$322	\$3,195
HUMBOLDT	19-64	15,960	12,628	1,872	14.82%	\$5,681,076	\$450	\$3,035
IMPERIAL	19-64	22,124	17,747	1,433	8.07%	\$3,025,998	\$171	\$2,112
INYO	19-64	1,665	1,203	152	12.64%	\$483,697	\$402	\$3,182
KERN	19-64	90,519	72,287	6,338	8.77%	\$32,842,779	\$454	\$5,182
KINGS	19-64	14,753	11,286	1,374	12.17%	\$2,606,280	\$231	\$1,897
LAKE	19-64	8,928	7,016	820	11.69%	\$2,656,896	\$379	\$3,240
LASSEN	19-64	3,035	2,239	372	16.61%	\$910,498	\$407	\$2,448
LOS ANGELES	19-64	1,200,824	1,030,783	68,106	6.61%	\$216,585,905	\$210	\$3,180
MADERA	19-64	17,589	13,780	978	7.10%	\$2,969,044	\$215	\$3,036
MARIN	19-64	9,273	7,247	1,370	18.90%	\$7,478,778	\$1,032	\$5,459
MARIPOSA	19-64	1,380	1,012	163	16.11%	\$308,269	\$305	\$1,891
MENDOCINO	19-64	11,337	9,054	1,218	13.45%	\$3,737,860	\$413	\$3,069

MERCED	19-64	34,720	27,364	2,062	7.54%	\$5,199,827	\$190	\$2,522
MODOC	19-64	1,299	1,013	150	14.81%	\$351,089	\$347	\$2,341
MONO	19-64	742	458	34	7.42%	\$123,311	\$269	\$3,627
MONTEREY	19-64	39,156	30,614	1,792	5.85%	\$9,842,134	\$321	\$5,492
NAPA	19-64	6,785	5,113	614	12.01%	\$2,689,977	\$526	\$4,381
NEVADA	19-64	4,932	3,672	651	17.73%	\$1,943,964	\$529	\$2,986
ORANGE	19-64	157,886	122,106	12,025	9.85%	\$21,122,128	\$173	\$1,757
PLACER	19-64	10,991	8,143	1,487	18.26%	\$5,820,977	\$715	\$3,915
PLUMAS	19-64	1,687	1,312	192	14.63%	\$607,170	\$463	\$3,162
RIVERSIDE	19-64	123,388	92,941	9,740	10.48%	\$24,634,973	\$265	\$2,529
SACRAMENTO	19-64	128,781	105,484	8,612	8.16%	\$23,168,278	\$220	\$2,690
SAN BENITO	19-64	3,739	2,656	327	12.31%	\$596,384	\$225	\$1,824
SAN BERNARDINO	19-64	163,085	125,977	13,149	10.44%	\$31,814,403	\$253	\$2,420
SAN DIEGO	19-64	158,006	124,922	17,951	14.37%	\$50,662,931	\$406	\$2,822
SAN FRANCISCO	19-64	60,002	48,691	9,665	19.85%	\$67,875,379	\$1,394	\$7,023
SAN JOAQUIN	19-64	64,683	52,352	6,079	11.61%	\$11,015,620	\$210	\$1,812
SAN LUIS OBISPO	19-64	16,154	12,447	1,614	12.97%	\$4,819,895	\$387	\$2,986
SAN MATEO	19-64	27,950	21,998	3,480	15.82%	\$22,268,840	\$1,012	\$6,399
SANTA BARBARA	19-64	31,602	24,663	2,568	10.41%	\$17,600,617	\$714	\$6,854
SANTA CLARA	19-64	97,450	76,205	8,533	11.20%	\$39,804,299	\$522	\$4,665
SANTA CRUZ	19-64	17,086	13,082	1,500	11.47%	\$16,611,919	\$1,270	\$11,075
SHASTA	19-64	21,499	17,013	2,471	14.52%	\$5,279,239	\$310	\$2,136
SIERRA	19-64	256	177	8	4.52%	\$3,554	\$20	\$444
SISKIYOU	19-64	5,840	4,590	733	15.97%	\$2,147,635	\$468	\$2,930
SOLANO	19-64	26,319	20,108	2,021	10.05%	\$9,232,614	\$459	\$4,568
SONOMA	19-64	24,606	19,230	2,079	10.81%	\$12,115,146	\$630	\$5,827
STANISLAUS	19-64	55,360	44,388	3,985	8.98%	\$14,129,527	\$318	\$3,546
SUTTER/YUBA	19-64	18,902	14,480	1,649	11.39%	\$4,607,173	\$318	\$2,794
TEHAMA	19-64	7,770	6,012	950	15.80%	\$2,436,846	\$405	\$2,565
TRINITY	19-64	1,468	1,142	172	15.06%	\$738,637	\$647	\$4,294
TULARE	19-64	59,064	49,179	2,422	4.92%	\$7,139,352	\$145	\$2,948
TUOLUMNE	19-64	4,317	3,244	663	20.44%	\$1,908,089	\$588	\$2,878
VENTURA	19-64	49,193	37,841	3,412	9.02%	\$16,018,334	\$423	\$4,695
YOLO	19-64	14,411	11,028	1,274	11.55%	\$4,392,676	\$398	\$3,448

**Notes:**

- 1- Reports approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility" (CFR). The report includes approved claims data on MHP eligible beneficiaries who were served by other MHP's.
- 2 - Includes both Inpatient Consolidated (IPC) and Short-Doyle/Medi-Cal (SDMC) approve claims and San Mateo County Case Rates for the MHP. The report includes only those aid codes approved for SDMC program funding.
- 3 - The most recent date SDMC claims were processed by DHS/DMH for the indicated fiscal year and the data included in the report.



**Penetration Rates by Age Group - 65 and Over  
Medi-Cal Approved Claims Data  
Fiscal Year 2003**

Date Prepared: August 12, 2005 / Version 1.0  
 Prepared by: Hui Zhang, APS Healthcare / CA - EQRO  
 Peer Reviewed by: Bill Ullom, APS Healthcare / CAEQRO  
 Information Source: DMH Approved Claims & Eligibility Data - Notes - (1) and (2)  
 DMH Process Date: June 30, 2005 - Note (3)

Area Name	Age Category	Unduplicated Eligibles	Unduplicated Eligibles - Monthly Average	Unduplicated Beneficiaries Served	Penetration Rate	Approved Claim Amount	Amount Approved Per Eligible	Amount Approved Per Beneficiary
STATEWIDE	65+	874,881	783,003	13,483	1.72%	\$32,779,180	\$42	\$2,431
BAY AREA	65+	182,828	163,621	3,813	2.33%	\$14,380,319	\$88	\$3,771
CENTRAL	65+	118,328	104,673	2,208	2.11%	\$4,919,357	\$47	\$2,228
LOS ANGELES	65+	322,415	294,489	3,948	1.34%	\$6,031,023	\$20	\$1,528
SOUTHERN	65+	225,033	197,616	2,984	1.51%	\$6,074,845	\$31	\$2,036
SUPERIOR	65+	26,277	22,604	530	2.34%	\$1,373,636	\$61	\$2,592
ALAMEDA	65+	38,107	33,912	464	1.37%	\$1,674,755	\$49	\$3,609
ALPINE	65+	22	16	0	0.00%	\$0	\$0	\$0
AMADOR	65+	559	456	8	1.75%	\$13,821	\$30	\$1,728
BUTTE	65+	5,519	4,757	116	2.44%	\$305,193	\$64	\$2,631
CALAVERAS	65+	779	660	4	0.61%	\$10,844	\$16	\$2,711
COLUSA	65+	594	515	15	2.91%	\$12,729	\$25	\$849
CONTRA COSTA	65+	16,065	14,112	176	1.25%	\$459,169	\$33	\$2,609
DEL NORTE	65+	834	721	15	2.08%	\$8,538	\$12	\$569
EL DORADO	65+	2,057	1,674	39	2.33%	\$60,324	\$36	\$1,547
FRESNO	65+	23,410	21,130	438	2.07%	\$952,477	\$45	\$2,175
GLENN	65+	703	602	16	2.66%	\$32,511	\$54	\$2,032
HUMBOLDT	65+	2,658	2,298	34	1.48%	\$75,965	\$33	\$2,234
IMPERIAL	65+	8,018	7,315	65	0.89%	\$82,603	\$11	\$1,271
INYO	65+	535	448	13	2.90%	\$16,275	\$36	\$1,252
KERN	65+	15,443	13,536	216	1.60%	\$664,587	\$49	\$3,077
KINGS	65+	2,796	2,456	63	2.57%	\$82,662	\$34	\$1,312
LAKE	65+	2,221	1,915	30	1.57%	\$130,798	\$68	\$4,360
LASSEN	65+	631	532	9	1.69%	\$10,795	\$20	\$1,199
LOS ANGELES	65+	322,415	294,489	3,948	1.34%	\$6,031,023	\$20	\$1,528
MADERA	65+	3,242	2,855	57	2.00%	\$92,991	\$33	\$1,631
MARIN	65+	2,710	2,346	57	2.43%	\$191,394	\$82	\$3,358
MARIPOSA	65+	354	300	7	2.33%	\$20,811	\$69	\$2,973
MENDOCINO	65+	2,300	2,031	67	3.30%	\$181,692	\$89	\$2,712

Area Name	Age Category	Unduplicated Eligibles	Unduplicated Eligibles - Monthly Average	Unduplicated Beneficiaries Served	Penetration Rate	Approved Claim Amount	Amount Approved Per Eligible	Amount Approved Per Beneficiary
MERCED	65+	6,115	5,498	74	1.35%	\$177,127	\$32	\$2,394
MODOC	65+	327	272	9	3.31%	\$12,427	\$46	\$1,381
MONO	65+	84	72	1	1.39%	\$1,781	\$25	\$1,781
MONTEREY	65+	7,721	6,842	78	1.14%	\$385,725	\$56	\$4,945
NAPA	65+	2,165	1,796	38	2.12%	\$113,601	\$63	\$2,990
NEVADA	65+	1,405	1,160	30	2.59%	\$78,053	\$67	\$2,602
ORANGE	65+	54,893	48,643	578	1.19%	\$567,922	\$12	\$983
PLACER	65+	3,488	2,869	72	2.51%	\$156,609	\$55	\$2,175
PLUMAS	65+	467	391	5	1.28%	\$19,745	\$51	\$3,949
RIVERSIDE	65+	32,140	27,461	420	1.53%	\$1,009,419	\$37	\$2,403
SACRAMENTO	65+	28,406	25,169	370	1.47%	\$765,837	\$30	\$2,070
SAN BENITO	65+	933	799	17	2.13%	\$27,943	\$35	\$1,644
SAN BERNARDINO	65+	35,489	30,536	390	1.28%	\$686,434	\$22	\$1,760
SAN DIEGO	65+	54,856	49,214	837	1.70%	\$1,534,846	\$31	\$1,834
SAN FRANCISCO	65+	39,315	36,436	1,367	3.75%	\$4,218,703	\$116	\$3,086
SAN JOAQUIN	65+	14,777	13,024	446	3.42%	\$983,799	\$76	\$2,206
SAN LUIS OBISPO	65+	3,616	3,084	39	1.26%	\$157,491	\$51	\$4,038
SAN MATEO	65+	14,738	13,067	340	2.60%	\$2,007,194	\$154	\$5,904
SANTA BARBARA	65+	6,927	6,017	135	2.24%	\$732,204	\$122	\$5,424
SANTA CLARA	65+	43,015	38,746	916	2.36%	\$3,350,601	\$86	\$3,658
SANTA CRUZ	65+	4,026	3,479	105	3.02%	\$880,614	\$253	\$8,387
SHASTA	65+	4,556	3,903	101	2.59%	\$307,650	\$79	\$3,046
SIERRA	65+	116	87	2	2.30%	\$995	\$11	\$498
SISKIYOU	65+	1,378	1,203	32	2.66%	\$91,888	\$76	\$2,872
SOLANO	65+	7,500	6,489	109	1.68%	\$335,183	\$52	\$3,075
SONOMA	65+	6,533	5,597	146	2.61%	\$735,437	\$131	\$5,037
STANISLAUS	65+	12,314	10,828	281	2.60%	\$733,482	\$68	\$2,610
SUTTER/YUBA	65+	4,203	3,701	100	2.70%	\$342,593	\$93	\$3,426
TEHAMA	65+	1,679	1,456	32	2.20%	\$65,331	\$45	\$2,042
TRINITY	65+	354	313	4	1.28%	\$23,051	\$74	\$5,763
TULARE	65+	11,118	10,035	133	1.33%	\$301,587	\$30	\$2,268
TUOLUMNE	65+	1,143	951	50	5.26%	\$86,694	\$91	\$1,734
VENTURA	65+	13,651	11,810	304	2.57%	\$639,338	\$54	\$2,103
YOLO	65+	3,461	2,980	65	2.18%	\$135,918	\$46	\$2,091

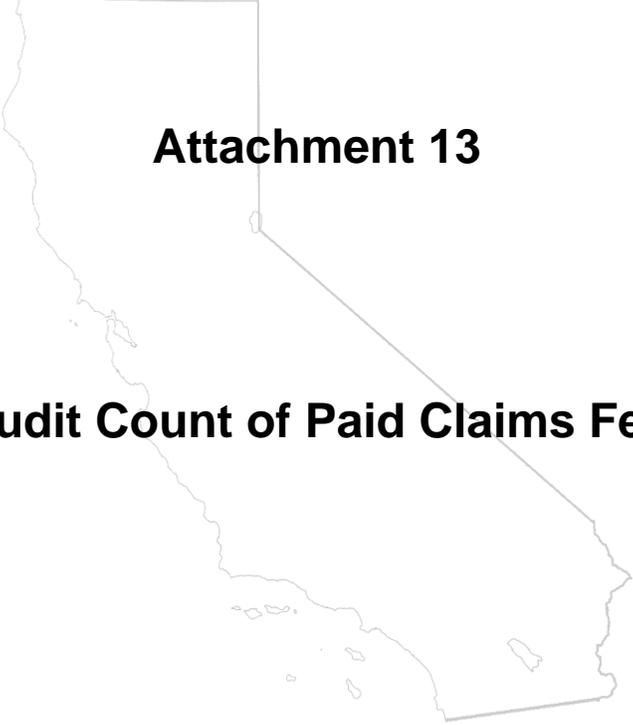
**Notes:**

- 1- Reports approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility" (CFR). The report includes approved claims data on MHP eligible beneficiaries who were served by other MHP's.
- 2 - Includes both Inpatient Consolidated (IPC) and Short-Doyle/Medi-Cal (SDMC) approve claims and San Mateo County Case Rates for the MHP. The report includes only those aid codes approved for SDMC program funding.
- 3 - The most recent date SDMC claims were processed by DHS/DMH for the indicated fiscal year and the data included in the report.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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A faint, light gray outline map of the state of California is centered in the background of the page. The map shows the state's borders and major islands.

**Attachment 13**

**MHP Audit Count of Paid Claims Feb 2003**

**2002-2003 Paid Claims Data  
MHP Audit Sample Size Calculations**

<b>County Code</b>	<b>County Name</b>	<b>Consumers Served - FY 02-03</b>	<b>Consumers Served - Feb 2003</b>	<b>Consumers Served Feb 2003 - Sample Size 95% Confidence Level 10% Interval</b>
1	Alameda	19,425	5,655	94
2	Alpine	0	0	0
3	Amador	516	151	59
4	Butte	6,393	2,340	92
5	Calaveras	389	135	56
6	Colusa	399	113	52
7	Contra Costa	10,053	3,521	94
8	Del Norte	1,134	412	78
9	El Dorado	1,627	547	82
10	Fresno	15,330	5,217	94
11	Glenn	603	190	64
12	Humboldt	3,394	1,077	88
13	Imperial	3,483	1,271	89
14	Inyo	396	128	55
15	Kern	15,744	6,559	95
16	Kings	3,219	1,091	88
17	Lake	1,907	483	80
18	Lassen	802	175	62
19	Los Angeles	152,094	60,440	96
20	Madera	2,418	906	87
21	Marin	2,463	1,089	88
22	Mariposa	364	113	52
23	Mendocino	2,323	838	86
24	Merced	4,375	1,369	90
25	Modoc	322	95	48
26	Mono	71	21	21
27	Monterey	3,963	1,636	91
28	Napa	1,338	471	80
29	Nevada	1,348	503	81
30	Orange	25,483	10,266	95
31	Placer	2,676	1,071	88
32	Plumas	442	171	62
33	Riverside	20,270	7,032	95
34	Sacramento	20,700	9,304	95
35	San Benito	741	246	69
36	San Bernardino	23,608	7,818	95

County Code	County Name	Consumers Served - FY 02-03	Consumers Served - Feb 2003	Consumers Served Feb 2003 - Sample Size 95% Confidence Level 10% Interval
37	San Diego	36,612	14,435	95
38	San Francisco	16,483	7,783	95
39	San Joaquin	10,264	3,503	94
40	San Luis Obispo	3,591	1,171	89
41	San Mateo	552	0	TBD
42	Santa Barbara	5,332	2,312	92
43	Santa Clara	15,161	6,449	95
44	Santa Cruz	2,924	1,324	90
45	Shasta	5,067	1,778	91
46	Sierra	0	0	0
47	Siskiyou	1,628	668	84
48	Solano	4,149	1,685	91
49	Sonoma	4,179	1,760	91
50	Stanislaus	9,136	3,482	93
51	Sutter	0	0	0
52	Tehama	1,707	618	83
53	Trinity	337	105	50
54	Tulare	6,559	2,555	93
55	Tuolumne	1,775	444	79
56	Ventura	6,517	2,352	92
57	Yolo	2,754	962	87
58	Sutter/Yuba	3,692	1,212	89
63	Sutter/Yuba	0	0	0
65	Berkeley	0	0	0
66	Tri-City	5,367	1,835	91
99	Unknown	n/a	n/a	n/a
<b>Total</b>		<b>493,599</b>	<b>188,887</b>	n/a



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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## **Attachment 14**

### **MHP Audit Records Request**

- **MHP Audit Records Request Letter**
- **MHP Control Log**
- **Audit Cover Sheet**
- **MHP Paid Claims Audit Certificate of Authenticity**



## CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

560 J Street, Suite 390 • Sacramento, CA 95814

[www.caeqro.com](http://www.caeqro.com)

To: Medical Records Custodian  
5 Main Street  
San Isidro, CA

From: Michael Gorodezky, APS Healthcare  
Cc: Carol Borden-Gomez, APS healthcare  
Date: March 30, 2005  
Re: EQRO MHP Medi-Cal Paid Claims Audit

### **Background/Authority**

As the External Quality Review Organization (EQRO) for the Medi-Cal managed mental health care program, APS Healthcare is required to perform a validity review between Medi-Cal paid claims and the medical records maintained by the MHP. We have worked with the Department of Mental Health (DMH) and the California Mental Health Director's Association (CMHDA) Medi-Cal Policy Committee to arrive at specifications for the validity review that are in compliance with CMS Federal requirements.

### **Performance Measures**

This activity is being performed to fulfill the federal requirement for the EQRO to review and validate Performance Measures designated by the State on an annual basis. The Performance Measures being validated this year are Medi-Cal penetration rate and penetration rate by age and gender categories.

### **Methodology**

The methodology being used for the validation project involves the identification of a statistically valid sample of Medi-Cal approved claims for your clients and a paper review of the related entries in the clients' charts for consistency with the claims. Detailed instructions below explain what records must be copied and returned to APS Healthcare.

### **Deadline**

Your FedEx package containing all applicable records must be returned (postmarked) within ten working days from the date of receipt of this letter to APS Healthcare in Sacramento.

### **Package Contents**

The following items are included in this package:

- A "MHP Control Log" listing all Medi-Cal beneficiaries included in the sample.
- An "Audit Cover Sheet" for each Medi-Cal beneficiary included in the sample.
- A MHP Paid Claims Audit "Certificate of Authenticity"
- A pre-paid FedEx shipping form for returning documents to APS Healthcare.

### **Instructions**

1. For each Audit Cover Sheet:

- a) Obtain a copy of a source document displaying the **Gender** and the **Birth date** for the client identified. If possible, this should be the original registration form completed. Alternatively, a computer generated document is acceptable.
  - b) Obtain a copy of every progress note for the month of **February, 2003** for the **Medi-Cal Provider ID** shown on the cover sheet. Please be sure each page of notes includes your local client identification number.  
**Important:** The Medi-Cal Provider ID is the 4 digit State assigned number used for billing Short-Doyle/Medi-Cal claims. This may correlate to one or many programs/reporting units in your Information Systems. Be sure to include ALL progress notes for every program/reporting unit that rolls up to the Medi-Cal Provider ID Number printed on the Audit Cover Sheet.
  - c) Attach the Audit Cover Sheet to the top of all copied documents for the client.
  - d) Staple together the Audit Cover Sheet, document showing gender and birthdate, and progress notes.
2. Sort the assembled packets by EQRO Control ID# (printed at top right of Audit Cover Sheet).
  3. Sign and date the Certificate of Authenticity.
  4. Use the enclosed pre-paid FedEx label to send the full set of client documents and the Certificate of Authenticity to:  
MHP Claims Auditor  
APS Healthcare  
560 J Street, Suite 390  
Sacramento, CA 95814

### **Audit Data Elements**

Upon receipt of your documents, the following data elements will be compared to Medi-Cal paid claims data:

- Medi-Cal beneficiary birth date on source document
- Medi-Cal beneficiary gender on source document
- Medi-Cal beneficiary service date from February 2003 progress notes

(Please note that the reviewers will check for presence or absence of specified data only. Progress notes will not be read, nor evaluated during the first year of the MHP Paid Claims Audit.)

### **HIPAA Security**

Be assured that all documents sent to APS will be treated with the utmost concern for confidentiality, as protected health information. The APS Healthcare EQRO is a contractor with the California Department of Mental Health. APS Healthcare has a Trusted Business Partner Relationship with DMH under the terms of HIPAA regulations.

### **APS Healthcare Contact Person**

If you have any questions about this letter or the MHP Medi-Cal Paid Claims Audit process, please contact Michael Gorodezky at [mgorodezky@apshealthcare.com](mailto:mgorodezky@apshealthcare.com).



## California EQRO Audit MHP Control Log

(Sorted by EQRO Control # and Provider ID)

EQRO Control #:	Client Name:	Local ID #:	Medi-Cal ID:	Provider ID:	Provider Name:	Completed:
1	GYS M	000994999	0999Z999901100	9999	ADULT MENTAL HEALTH SERVICES	_____
2	TUA Y	000962999	0999Z998901101	9999	ADULT MENTAL HEALTH SERVICES	_____
3	COO B	000634999	0999Z997901234	9999	ADULT MENTAL HEALTH SERVICES	_____
4	PYP B	001004999	0999Z999602345	9999	ADULT MENTAL HEALTH SERVICES	_____
5	BIL L	000651999	0999Z999806789	9999	ADULT MENTAL HEALTH SERVICES	_____

**EQRO Control #:  
999**

**California EQRO  
Client Record/Paid Claim Audit  
for  
San Isidro County MHP**

**Audit Cover Sheet**

**Instructions**

Please obtain:

- 1) A copy of a document confirming the **Gender** and the **Birth date** for the client identified below. This may be a paper form or computer generated document.
- 2) A copy of each progress note for the month of **February, 2003** for the indicated Medi-Cal provider. Please be sure each page of notes includes your local client identification number.

Please attach this Audit Cover Sheet to the top of the copied documents for this client.

**Client Name: Doe, J.**  
**Local ID #: 1234567890**  
**Medi-Cal ID#: 12345678901234**  
**Medi-Cal Provider: 1234 Adult Service Center**  
**Comments:**

**Confidential Information**

**MHP Paid Claims Audit  
February, 2003  
Certificate of Authenticity**

I state that to the best of my knowledge, the attached photocopied documents are accurate and unaltered photocopies of the actual progress notes in the indicated client's medical record.

County: \_\_\_\_\_

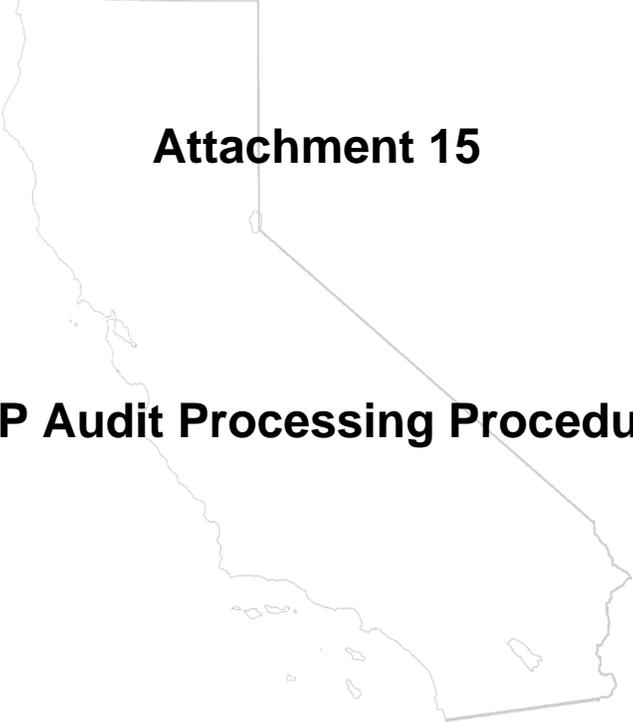
Signed: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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A light gray outline map of the state of California is centered in the background of the page. The map shows the state's borders and major islands.

**Attachment 15**

**MHP Audit Processing Procedures**



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

560 J Street, Suite 390 • Sacramento, CA 95814

[www.caeqro.com](http://www.caeqro.com)

**To: Medical Records Reviewer**  
**From: Carol Borden-Gomez**  
**Date: April 29, 2005**  
**Re: MHP Paid Claims Audit Processing Procedures**

Welcome. Here are the procedures for the work you will be doing here at APS Healthcare. If you have any questions on procedures, or any questions on the documents you are reviewing, please ask me, Mike Gorodezky, or Vicky Gonsalves. You can reach me at (916) 704-2042. If you need additional supplies, please ask Vicky or Laura.

The documents you will be reviewing are confidential patient records. Please sign the APS Healthcare Oath of Confidentiality before you begin.

Please ask me if you have any questions or concerns at all. Thank you for your help.

**Procedures**

1. Select one County folder.
2. Log County folder out on spreadsheet labeled "CA EQRO MHP Paid Claims Audit – Processing Log". Enter "Starting Date/Time".
3. Remove folder to your work space, and remove contents.
4. Check for a signed and dated "Certificate of Authenticity".
  - a) If present, proceed to next step.
  - b) If absent, stop work, put contents back in folder.
  - c) Put Neon Red sheet of paper on folder with a note that "Certificate of Authenticity" is missing.
  - d) Put folder back on table.
  - e) Put note in "Description/Notes" field of Processing Log – "Certificate missing."
5. Sort stapled items by EQRO Control Number.
6. Take packet with EQRO Control number 1.
7. Check Client Name on documents to make sure it matches what we have on the log.
8. Review county-provided document for 4 items:
  - a) Does "Birth date" on document match the "Birth date" on the "MHP Audit – County Score Worksheet"? Circle the field on the document. If there is a match, check the Yes box. If not, check the No box.
  - b) Does "Gender" on document match the "Gender" on the "County Score Worksheet"? Circle the field on the document. If there is a match, check the Yes box. If not, check the No box.
  - c) Does "Service Date" on progress notes match the "Service date" on the "County Score Worksheet"? Circle the field on the document. If there is a match, check the Yes box. If not, check the No box.
  - d) Is there anything in the "Comments" box? If so, follow instructions below regarding color coding.

9. When you have completed processing one packet, put it in a pile depending on the status.
  - a) Green pile – All responses are Yes and there are no “Comments” on cover sheet. (Put green sheet of paper on top of pile. Fasten with clip or rubber band.)
  - b) Red pile – One or more responses are No
  - c) Yellow pile – There are “Comments” on form, or you have questions about it. Write your questions on a Sticky Note and attach to the front of the packet.

Note: If there are any “Comments” on cover sheet, be sure to keep checking for birth date, gender and date. If any of those items are missing, put the packet in Red pile. If all 3 items are valid, put packet in Yellow pile.
10. Once the first packet is reviewed, proceed to the next packet. Continue processing the packets and scoring each on the “County Score Worksheet” until all packets have been processed.
11. When completed, make a copy of the “County Score Worksheet”.
12. Put the copy in the County folder.
13. Place the original on the clipboard, below the “Processing Log”.
14. Enter the following information on the “Processing Log” for the County you have just completed:
  - a) Total number of EQRO worksheets we sent to the County.
  - b) Total number of packets returned
  - c) Total number of packets missing.
  - d) Total number of packets in Green pile (all Yes responses).
  - e) Total number of packets in Red pile (one or more No responses).
  - f) Total number of packets in Yellow pile (something in Comments section or Question).
  - g) Ending date and time. Initial.
15. Put the completed County folder under the table for now. (We may locate another area later.)
16. Follow the same process for every County folder.

**IMPORTANT NOTES:**

1. **Do not read the documents. Just look for the information requested – Birth date, Gender and Date of Service.**
2. **Do not start processing a second county folder until you have completed the first.**
3. **Do not remove any folders or documents from the room where you are working and they are stored.**

**Scenarios that may occur – how to code**

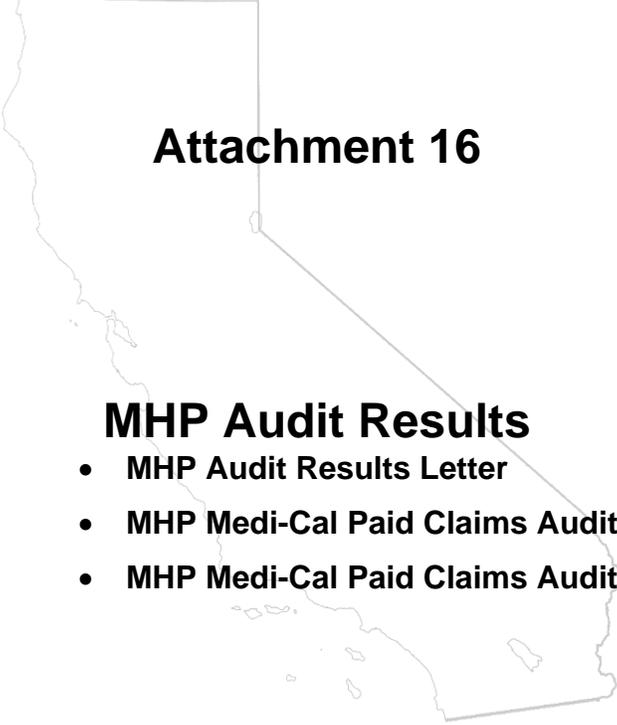
Here are some issues that have come up, along with the decision on how to score them. Please bring any new issues to my attention, and I will add them to the list.

1. If there is no service year in the progress notes, is it still a valid date? Yes
2. If the birth month and year are correct, but not the day, is the birth date valid?  
Yes
3. If the service date is changed and initialed, is it acceptable? Yes
4. If the service date is changed and not initialed, is it acceptable? Yes
5. There is a note on the paid claims date, but it says “No show”. Is this still a valid note? Yes
6. The date of service is off by just one day. Is this OK? No, the service date must be exact.
7. Some progress note forms have a space for the “Date” next to the signature of the clinician. Can that be considered the “Service Date”? Yes.
8. On the registration document, the gender is blank (isn’t marked M or F), but progress note indicates the gender. Is this OK? No, we aren’t reading the progress notes.
9. The county is sending a “print screen” as the registration document. Is this OK? Yes.
10. The name on the EQRO cover sheet doesn’t match the name on the county documents? What should I do? Put the packet in the Yellow pile.



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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**Attachment 16**

**MHP Audit Results**

- **MHP Audit Results Letter**
- **MHP Medi-Cal Paid Claims Audit Statistics**
- **MHP Medi-Cal Paid Claims Audit Detail**



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

560 J Street, Suite 390 • Sacramento, CA 95814

[www.caeqro.com](http://www.caeqro.com)

June 2, 2005

John Doe, LCSW  
Mental Health Director  
San Isidro County Mental Health Plan  
100 Main Street, Suite 1  
San Isidro, CA 99999

APS Healthcare, the External Quality Review Organization (EQRO) for the Medi-Cal managed mental health care program has completed the audit of medical record documents you recently sent to us. This activity was performed to fulfill the federal requirement for the EQRO to review and validate Performance Measures designated by the State Department of Mental Health on an annual basis. The Performance Measures being validated in fiscal year 2004-2005 are Medi-Cal penetration rate and penetration rates by age and gender categories.

The results of your audit are included in two attachments.

1. MHP Medi-Cal Paid Claims Audit Statistics: At the top of this page, your Mental Health Plan's (MHP) error ratio for each criterion audited is displayed, along with statewide statistics. The three graphs below your statistics display results for each criterion (birth date, gender, service date) for all MHP's audited. Each "X" at the bottom of the graphs represents a single MHP. Error percentages are arrayed by MHP from lowest to highest. Use your error ratios at the top of the page to determine your ranking compared to other MHP's for each criterion.
2. MHP Medi-Cal Paid Claims Audit Detail: Each line item shows the first 3 letters of the beneficiary's last name and first initial, and local identification number. Columns for birth date, gender, and service date are completed with data from Medi-Cal Approved Claims. An "X" in "No" column indicates data was in error or missing from your chart documentation.

Data from 52 MHP's were audited and scored. One MHP submitted data too late to be included in the audit. Please note that data elements missing from submitted documents were scored as errors.

If you agree with our findings, you do not need to take any action. If you believe we have made an error on an individual line item, please send us a letter detailing the item and why it is wrong. Do not send new documentation. On receipt of your letter, we will re-review the original materials you provided. Your letter questioning our findings must be postmarked by Friday, June 17. In your letter, please provide the name, address, and phone number of the appropriate person to contact if we have any questions.

Thank you for responding thoroughly and in a timely fashion to our request for documentation. If you have any questions about this letter or the MHP Medi-Cal Paid Claims Audit, please contact Michael Gorodezky at [mgorodezky@apshealthcare.com](mailto:mgorodezky@apshealthcare.com).

Sincerely,

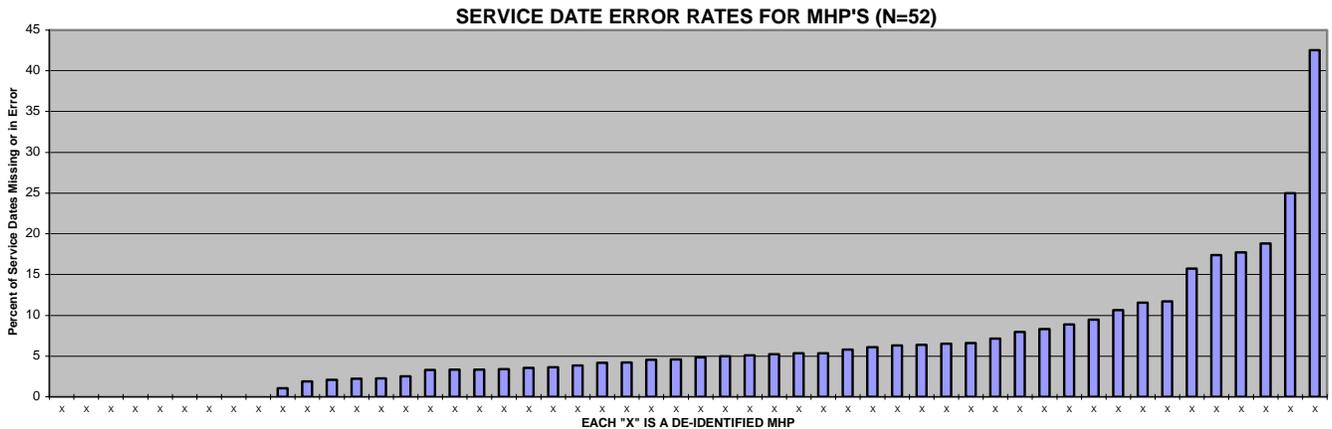
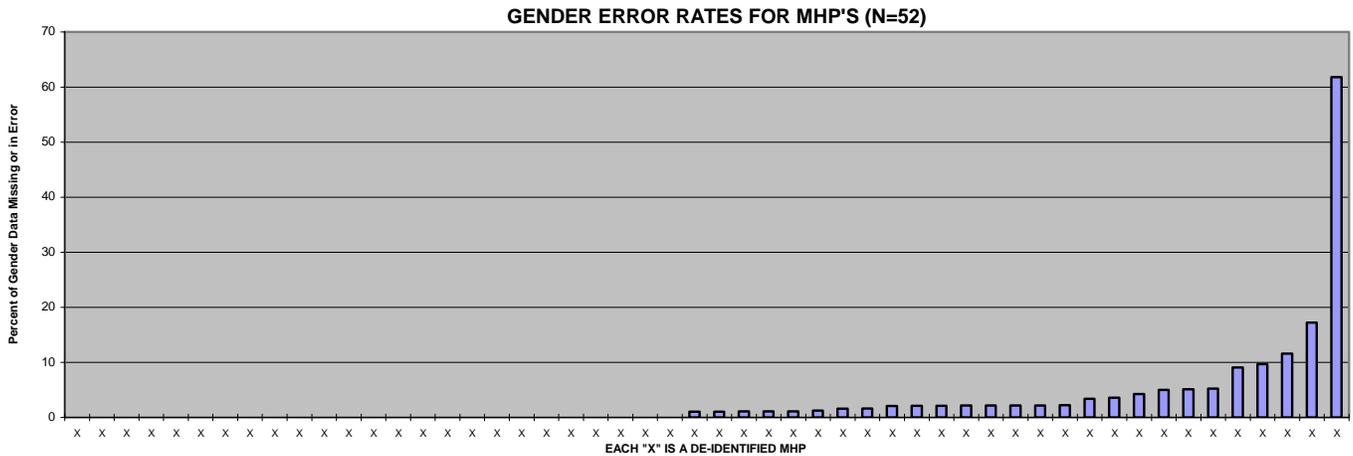
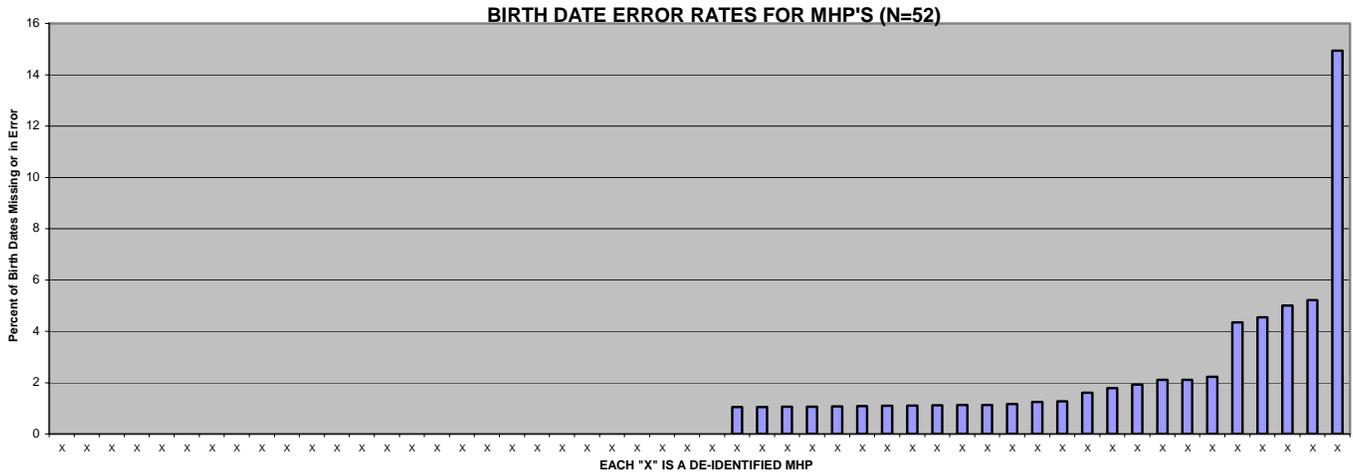
Michael J. Gorodezky, MSW, Ph.D.  
Director, Information Technology



# MHP Medi-Cal Paid Claims Audit Statistics FY 04-05

The Generic MHP	Birth Date	Gender	Service Date
Number of Records Audited	94	94	94
Number Missing or in Error	1	4	11
Error Rate	1.06%	4.26%	11.70%

Statewide Results	Birth Date	Gender	Service Date
Average Error Rate	1.16%	3.07%	6.58%
Median Percent in Error	0.00%	0.00%	4.38%
Range of Percent in Error	0% - 14.94%	0% - 61.87%	0% - 43.5%

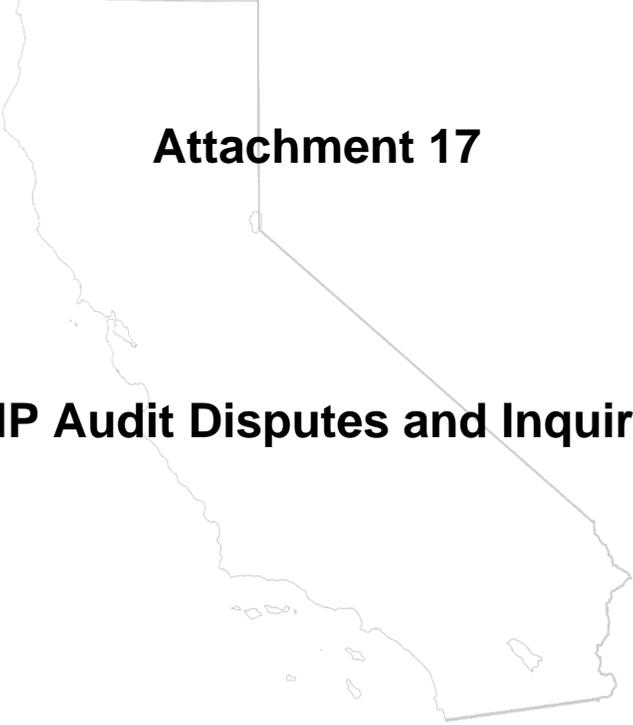






**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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An outline map of the state of California is centered on the page. The map shows the state's borders and major islands in the south.

**Attachment 17**

**MHP Audit Disputes and Inquiries**

## MHP Audit Disputes and Inquiries

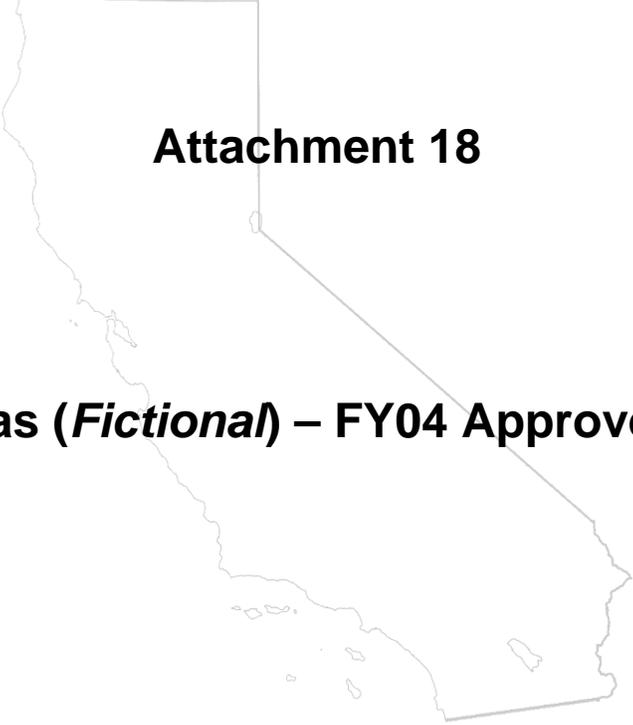
Date	MHP	Who	What	APS Response	By	Date
6/8/2005	Orange	David Horner	birth year	E-mail	MikeG	6/10/2005
6/8/2005	Riverside	Ryan Quist	consequence of errors-financial?	E-mail	MikeG	6/10/2005
6/8/2005	Yolo	Christina Hill-Coillot	request for stats excluding missing records	E-mail	CarolBG	7/8/2005
6/9/2005	Los Angeles	Eydie Dominguez	gender & birth date	E-mail	MikeG	6/10/2005

Date	MHP	Who	What	Response Date	By	Resolution	Original Number of Errors			Revised Number of Errors		
6/6/2005	Mono	Ann Gimpel	Dispute 1 birthdate, 1 gender, 1 service error	7/5/2005	Mike G	Reversed 3 errors. Found missing record for 1 beneficiary.	1	1	1	0	0	0
6/7/2005	Glenn	Michael Cassetta	Dispute 1 gender error	7/5/2005	Mike G	Confirmed finding. Orig claim paid as F.MHP changed to M fy03-04.	0	1	0	0	1	0
6/8/2005	Modoc	Phillip Smith	Dispute 1 gender error	7/5/2005	Mike G	Confirmed finding, special case.	0	1	2	0	1	2
6/15/2005	Imperial	Andrea Kuhlen	Dispute 13 service errors	7/5/2005	Mike G	Confirmed all PN missing	0	55	14	0	55	14
6/15/2005	Tuolumne	Karen Miles	Dispute 1 birth date, 2 services	7/5/2005	Mike G	Reversed 2 service errors, confirm bd error	1	0	2	1	0	0
6/16/2005	Santa Clara	Nancy Pena	Dispute 2 birth dates, 4 services	7/5/2005	Mike G	Reversed 1 service error, confirmed all other errors.	2	0	9	2	0	8
6/17/2005	Merced	Troy Fox	Dispute 1 birth date, 1 gender error	7/5/2005	Mike G	Confirmed errors. 1 face sheet absent (bd&gender)	2	2	3	2	2	3
6/28/2005	San Luis Obispo	Rick Oliver	Dispute 1 birth date, 3 gender error	7/5/2005	Mike G	Confirmed errors. 1 face sheet absent (bd&gender) + 2 gender errors	1	3	0	1	3	0
<b>Dispute totals</b>						<b>Reversal totals</b>						
6 Birth date						1 Birth date						
7 Gender						1 Gender						
20 Services						4 Services						



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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**Attachment 18**

**San Dumas (*Fictional*) – FY04 Approved Claims**



**County Fact Sheet  
Medi-Cal Approved Claims Data  
for San Dumas County MHP  
Fiscal Year 04**

Date Prepared: June 11, 2005/Version 1.0

Prepared by: APS Healthcare/CA-EQRO

Information Source: DMH Approved Claims Summary Data - Notes - (1) and (2)

DMH Process Date: May 13, 2005 - Note (3)

Age Groups	S A N D U M A S C O U N T Y D A T A					C E N T R A L D A T A			S T A T E W I D E D A T A				
	Fiscal Year	Average Monthly	Unduplicated	Approved	Penetration	Average Monthly	Approved Claims	Penetration	Average Monthly	Approved Claims	Penetration	Average Monthly	Approved Claims
	Unduplicated	Unduplicated	Count of Medi-Cal	Approved	Penetration	Approved Claims for	for Unduplicated	Penetration	Approved Claims for	for Unduplicated	Penetration	Approved Claims for	for Unduplicated
	Eligibles	Eligibles	Beneficiaries Served	Claims	Rate	Undup Eligibles	Beneficiaries Served	Rate	Undup Eligibles	Beneficiaries Served	Rate	Undup Eligibles	Beneficiaries Served
0-17	72,385	55,920	3,155	\$11,520,557	5.64%	\$501	\$6,886	4.75%	\$220	\$4,630	4.58%	\$230	\$5,006
18-20	8,331	6,220	444	\$1,761,518	7.14%	\$217	\$5,346	6.03%	\$239	\$3,974	7.04%	\$329	\$4,680
21-39	31,826	24,184	1,699	\$5,453,095	7.03%	\$147	\$2,398	6.47%	\$173	\$2,672	6.35%	\$221	\$3,474
40-59	18,811	15,955	1,956	\$7,470,415	12.26%	\$331	\$2,786	13.28%	\$378	\$2,848	14.49%	\$493	\$3,402
60-64	2,832	2,469	201	\$771,334	8.14%	\$192	\$2,826	8.89%	\$236	\$2,661	12.61%	\$308	\$2,441
65+	12,718	11,174	307	\$808,343	2.75%	\$30	\$2,075	2.31%	\$52	\$2,234	1.98%	\$45	\$2,259
<b>Totals</b>	<b>146,903</b>	<b>115,922</b>	<b>7,762</b>	<b>\$27,785,262</b>	<b>6.70%</b>	<b>\$240</b>	<b>\$3,580</b>	<b>6.16%</b>	<b>\$217</b>	<b>\$3,529</b>	<b>6.19%</b>	<b>\$246</b>	<b>\$3,979</b>

Gender	S A N D U M A S C O U N T Y D A T A					C E N T R A L D A T A			S T A T E W I D E D A T A				
	Fiscal Year	Average Monthly	Unduplicated	Approved	Penetration	Average Monthly	Approved Claims	Penetration	Average Monthly	Approved Claims	Penetration	Average Monthly	Approved Claims
	Unduplicated	Unduplicated	Count of Medi-Cal	Approved	Penetration	Approved Claims for	for Unduplicated	Penetration	Approved Claims for	for Unduplicated	Penetration	Approved Claims for	for Unduplicated
	Eligibles	Eligibles	Beneficiaries Served	Claims	Rate	Undup Eligibles	Beneficiaries Served	Rate	Undup Eligibles	Beneficiaries Served	Rate	Undup Eligibles	Beneficiaries Served
Females	82,741	65,681	4,098	\$13,761,530	6.24%	\$210	\$3,358	5.99%	\$186	\$3,103	5.72%	\$198	\$3,468
Males	64,162	50,241	3,664	\$14,023,732	7.29%	\$279	\$3,827	6.37%	\$257	\$4,041	6.80%	\$309	\$4,547
<b>Totals</b>	<b>146,903</b>	<b>115,922</b>	<b>7,762</b>	<b>\$27,785,262</b>	<b>6.70%</b>	<b>\$240</b>	<b>\$3,580</b>	<b>6.16%</b>	<b>\$217</b>	<b>\$3,529</b>	<b>6.19%</b>	<b>\$246</b>	<b>\$3,979</b>

Age Groups by Gender	S A N D U M A S C O U N T Y D A T A					C E N T R A L D A T A			S T A T E W I D E D A T A				
	Fiscal Year	Average Monthly	Unduplicated	Approved	Penetration	Average Monthly	Approved Claims	Penetration	Average Monthly	Approved Claims	Penetration	Average Monthly	Approved Claims
	Unduplicated	Unduplicated	Count of Medi-Cal	Approved	Penetration	Approved Claims for	for Unduplicated	Penetration	Approved Claims for	for Unduplicated	Penetration	Approved Claims for	for Unduplicated
	Eligibles	Eligibles	Beneficiaries Served	Claims	Rate	Undup Eligibles	Beneficiaries Served	Rate	Undup Eligibles	Beneficiaries Served	Rate	Undup Eligibles	Beneficiaries Served
0-17 female	35,451	27,425	1,265	\$4,323,554	4.61%	\$158	\$3,418	4.02%	\$178	\$4,439	3.78%	\$180	\$4,769
0-17 male	36,934	28,495	1,890	\$7,197,003	6.63%	\$253	\$3,808	5.46%	\$260	\$4,766	5.36%	\$277	\$5,168
18-20 female	4,920	3,645	219	\$865,876	6.01%	\$238	\$3,954	5.07%	\$182	\$3,597	5.46%	\$245	\$4,478
18-20 male	3,411	2,575	225	\$895,642	8.74%	\$348	\$3,981	7.42%	\$323	\$4,350	9.29%	\$451	\$4,850
21-39 female	21,535	16,498	1,049	\$3,019,902	6.36%	\$183	\$2,879	6.15%	\$137	\$2,227	5.45%	\$152	\$2,791
21-39 male	10,291	7,686	650	\$2,433,193	8.46%	\$317	\$3,743	7.17%	\$250	\$3,485	8.45%	\$381	\$4,509
40-59 female	11,027	9,462	1,216	\$4,480,349	12.85%	\$474	\$3,684	14.52%	\$389	\$2,679	14.84%	\$455	\$3,068
40-59 male	7,784	6,493	740	\$2,990,067	11.40%	\$461	\$4,041	11.58%	\$363	\$3,135	13.99%	\$545	\$3,898
60-64 female	1,662	1,474	139	\$562,893	9.43%	\$382	\$4,050	10.37%	\$278	\$2,678	14.01%	\$342	\$2,440
60-64 male	1,170	996	62	\$208,441	6.22%	\$209	\$3,362	6.93%	\$182	\$2,626	10.74%	\$262	\$2,442
65+ female	8,146	7,178	210	\$508,957	2.93%	\$71	\$2,424	2.41%	\$54	\$2,224	2.10%	\$48	\$2,293
65+ male	4,572	3,995	97	\$299,385	2.43%	\$75	\$3,086	2.12%	\$48	\$2,254	1.76%	\$39	\$2,186
<b>Totals</b>	<b>146,903</b>	<b>115,922</b>	<b>7,762</b>	<b>\$27,785,262</b>	<b>6.70%</b>	<b>\$240</b>	<b>\$3,580</b>	<b>6.16%</b>	<b>\$217</b>	<b>\$3,529</b>	<b>6.19%</b>	<b>\$246</b>	<b>\$3,979</b>

Eligibility Categories (Aid Group)	S A N D U M A S C O U N T Y D A T A					C E N T R A L D A T A			S T A T E W I D E D A T A				
	Fiscal Year	Average Monthly	Count of Medi-Cal	Approved	Penetration	Average Monthly	Approved Claims	Penetration	Average Monthly	Approved Claims	Penetration	Average Monthly	Approved Claims
	Unduplicated	Unduplicated	Beneficiaries Served	Approved	Penetration	Approved Claims for	for Unduplicated	Penetration	Approved Claims for	for Unduplicated	Penetration	Approved Claims for	for Unduplicated
	Eligibles	Eligibles	Note - (4)	Claims	Rate	Undup Eligibles	Beneficiaries Served	Rate	Undup Eligibles	Beneficiaries Served	Rate	Undup Eligibles	Beneficiaries Served
Disabled	21,384	18,771	3,517	\$15,434,353	18.74%	\$822	\$4,388	18.20%	\$667	\$3,666	21.36%	\$886	\$4,149
Foster Care	1,009	681	454	\$2,027,932	66.67%	\$2,978	\$4,467	52.85%	\$2,982	\$5,642	51.34%	\$3,428	\$6,677
Other Child	69,545	53,166	2,400	\$6,773,467	4.51%	\$127	\$2,822	3.46%	\$115	\$3,323	3.31%	\$116	\$3,486
Family Adult	34,375	25,866	1,289	\$2,670,033	4.98%	\$103	\$2,071	4.92%	\$81	\$1,642	5.09%	\$82	\$1,601
Other Adult	23,175	17,438	331	\$879,477	1.90%	\$50	\$2,657	1.26%	\$28	\$2,232	1.10%	\$29	\$2,599
<b>Totals (5)</b>	<b>149,488</b>	<b>115,922</b>	<b>7,991</b>	<b>\$27,785,262</b>	<b>6.70%</b>	<b>\$240</b>	<b>\$3,580</b>	<b>6.16%</b>	<b>\$217</b>	<b>\$3,529</b>	<b>6.19%</b>	<b>\$246</b>	<b>\$3,979</b>



**County Fact Sheet  
Medi-Cal Approved Claims Data  
for San Dumas County MHP  
Fiscal Year 04**

Date Prepared: June 11, 2005/Version 1.0

Prepared by: APS Healthcare/CA-EQRO

Information Source: DMH Approved Claims Summary Data - Notes - (1) and (2)

DMH Process Date: May 13, 2005 - Note (3)

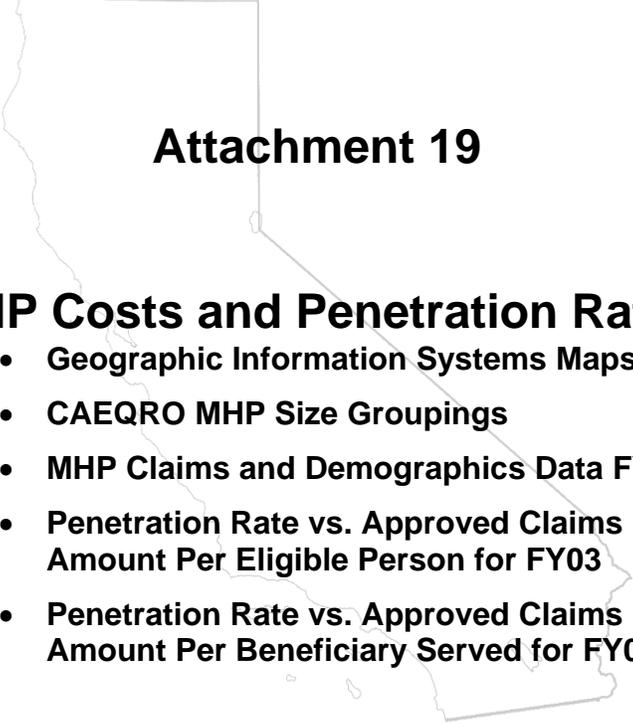
Service Activity	S A N D U M A S C O U N T Y D A T A						C E N T R A L D A T A			S T A T E W I D E D A T A			
	Fiscal Year	Average Monthly	Unduplicated Count	Average Amount	Approved Claims	Approved Claims	Average Amount	Approved Claims	Average Amount	Approved Claims	Approved Claims		
	Unduplicated	Unduplicated	Beneficiaries Served	Paid Per	for Unduplicated	Penetration	Paid Per	for Unduplicated	Penetration	Paid Per	for Unduplicated		
	Eligibles	Eligibles	Note - (6)	Approved Claim	Beneficiaries Served	Rate	Approved Claim	Beneficiaries Served	Rate	Approved Claim	Beneficiaries Served		
Inpatient	146,903	115,922	989	\$5,918,328	0.85%	\$51	\$5,984	0.31%	\$20	\$6,489	0.49%	\$34	\$6,854
Residential	146,903	115,922	119	\$272,399	0.10%	\$2	\$2,289	0.08%	\$4	\$5,515	0.07%	\$5	\$6,998
Day Treatment	146,903	115,922	139	\$1,049,949	0.12%	\$9	\$7,554	0.17%	\$13	\$7,873	0.25%	\$25	\$10,045
Linkage/Brokerage	146,903	115,922	4,160	\$4,773,001	3.59%	\$41	\$1,147	3.51%	\$30	\$864	2.97%	\$25	\$847
MH Services	146,903	115,922	6,730	\$11,320,172	5.81%	\$98	\$1,682	4.84%	\$113	\$2,330	4.87%	\$114	\$2,337
Medication Support	146,903	115,922	3,882	\$3,277,715	3.35%	\$28	\$844	3.32%	\$29	\$860	3.36%	\$32	\$956
Crisis	146,903	115,922	1,789	\$1,173,698	1.54%	\$10	\$656	1.07%	\$8	\$753	1.05%	\$9	\$888
<b>Totals - Note (7)</b>	<b>146,903</b>	<b>115,922</b>	<b>7,762</b>	<b>\$27,785,262</b>	<b>6.70%</b>	<b>\$240</b>	<b>\$3,580</b>	<b>6.16%</b>	<b>\$217</b>	<b>\$3,529</b>	<b>6.19%</b>	<b>\$246</b>	<b>\$3,979</b>

Race/Ethnicity	S A N D U M A S C O U N T Y D A T A						C E N T R A L D A T A			S T A T E W I D E D A T A			
	Fiscal Year	Average Monthly	Unduplicated	Average Monthly	Approved Claims	Approved Claims	Average Monthly	Approved Claims	Average Monthly	Approved Claims	Approved Claims		
	Unduplicated	Unduplicated	Count of Medi-Cal	Undup Eligibles	for Unduplicated	Penetration	Undup Eligibles	for Unduplicated	Penetration	Undup Eligibles	for Unduplicated		
	Note - (8)	Eligibles	Eligibles	Beneficiaries Served	Claims	Rate	Beneficiaries Served	Rate	Beneficiaries Served	Rate	Beneficiaries Served		
White	53,119	43,001	5,179	\$19,682,439	12.04%	\$458	\$3,800	11.01%	\$416	\$3,783	13.09%	\$434	\$3,316
Hispanic	67,325	52,573	1,336	\$3,166,428	2.54%	\$60	\$2,370	2.38%	\$64	\$2,681	2.22%	\$70	\$3,166
African-American	5,367	4,196	464	\$1,648,170	11.06%	\$393	\$3,552	9.22%	\$376	\$4,074	10.03%	\$429	\$4,273
Asian/Pacific Islander	6,614	5,397	81	\$240,727	1.50%	\$45	\$2,972	2.08%	\$54	\$2,578	2.40%	\$67	\$2,787
Native American	360	252	18	\$37,902	7.14%	\$150	\$2,106	6.38%	\$198	\$3,102	6.46%	\$263	\$4,071
Other	14,118	10,503	684	\$3,009,596	6.51%	\$287	\$4,400	8.58%	\$277	\$3,228	8.44%	\$369	\$3,844
<b>Totals</b>	<b>146,903</b>	<b>115,922</b>	<b>7,762</b>	<b>\$27,785,262</b>	<b>6.70%</b>	<b>\$240</b>	<b>\$3,580</b>	<b>6.16%</b>	<b>\$217</b>	<b>\$3,529</b>	<b>6.19%</b>	<b>\$246</b>	<b>\$3,979</b>

Aid Program	S A N D U M A S C O U N T Y D A T A						C E N T R A L D A T A			S T A T E W I D E D A T A			
	Fiscal Year	Average Monthly	Unduplicated	Average Monthly	Approved Claims	Approved Claims	Average Monthly	Approved Claims	Average Monthly	Approved Claims	Approved Claims		
	Unduplicated	Unduplicated	Count of Medi-Cal	Undup Eligibles	for Unduplicated	Penetration	Undup Eligibles	for Unduplicated	Penetration	Undup Eligibles	for Unduplicated		
	Eligibles	Eligibles	Beneficiaries Served	Beneficiaries Served	Claims	Rate	Beneficiaries Served	Rate	Beneficiaries Served	Rate	Beneficiaries Served		
SSI/SSA	22,904	21,024	3,251	\$14,856,422	15.46%	\$707	\$4,570	15.09%	\$584	\$3,870	15.68%	\$675	\$4,305
Non SSA	123,999	94,898	4,511	\$12,928,840	4.75%	\$136	\$2,866	4.21%	\$137	\$3,261	4.07%	\$151	\$3,699
<b>Totals</b>	<b>146,903</b>	<b>115,922</b>	<b>7,762</b>	<b>\$27,785,262</b>	<b>6.70%</b>	<b>\$240</b>	<b>\$3,580</b>	<b>6.16%</b>	<b>\$217</b>	<b>\$3,529</b>	<b>6.19%</b>	<b>\$246</b>	<b>\$3,979</b>

**Footnotes:**

- 1- Reports approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility" (CFR). The report includes approved claims data on MHP eligible beneficiaries who were served by other MHP's.
- 2 - Includes both Inpatient Consolidated (IPC) and Short-Doyle/Medi-Cal (SDMC) approve claims for the MHP. The report includes only those aid codes approved for SDMC program funding.
- 3 - The most recent date SDMC claims were processed by DHS/DMH for the indicated fiscal year and the data included in the report.
- 4 - Individual Aid Category shows the "unduplicated count" of beneficiaries served, since a beneficiary may be eligible under more than one aid category during the reporting period.
- 5 - The Total Count of Beneficiaries Served shows the "duplicated count" beneficiaries served during the reporting period, because some beneficiaries were counted in more than one aid category.
- 6 - Beneficiaries may receive services in two or more Service Activity categories during the fiscal year. Each line item shows the "unduplicated count" of beneficiaries served for the specified Service Activity.
- 7 - The Total Unduplicated Count Beneficiaries Served shows the "unduplicated count" of beneficiaries served, regardless of the type of service activity the beneficiary received.
- 8 - Some MHP "Other Race/Ethnicity" category were overstated (Hispanic, Asian/Pacific Islander, Native American would be the understated categories) due to DHS technical problems with the data for SSI/SSA beneficiaries. DHS was unable to correctly recode individual beneficiary race/ethnicity. It is expected that race/ethnicity data for FY04-05 will be correct.



## **Attachment 19**

### **MHP Costs and Penetration Rates**

- **Geographic Information Systems Maps**
- **CAEQRO MHP Size Groupings**
- **MHP Claims and Demographics Data FY03**
- **Penetration Rate vs. Approved Claims Amount Per Eligible Person for FY03**
- **Penetration Rate vs. Approved Claims Amount Per Beneficiary Served for FY03**

### California Counties By Population January 1, 2003



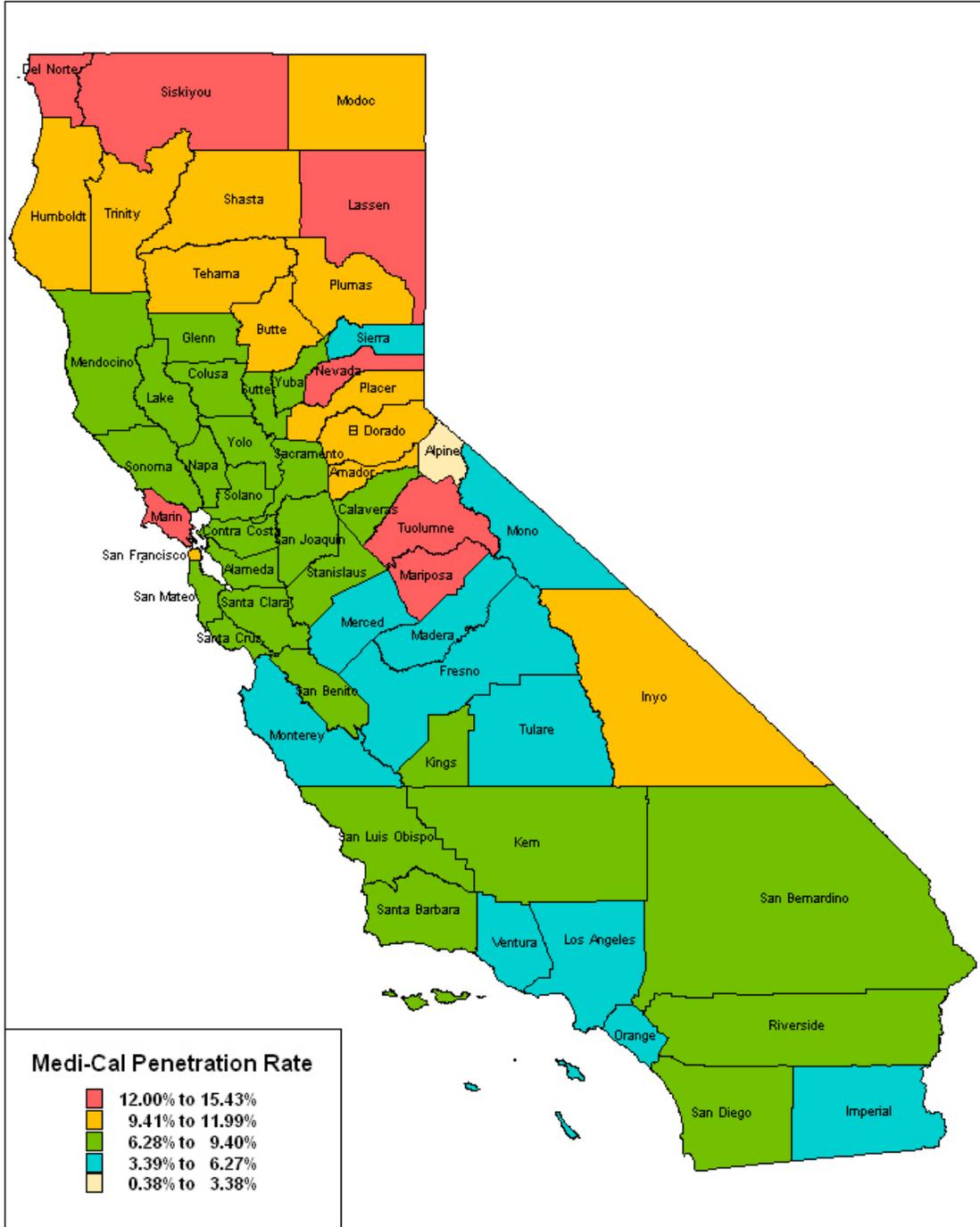
Source: California Department of Finance - Demographic Research Unit

# Medi-Cal Penetration Rate

## Approved Claims FY 2003

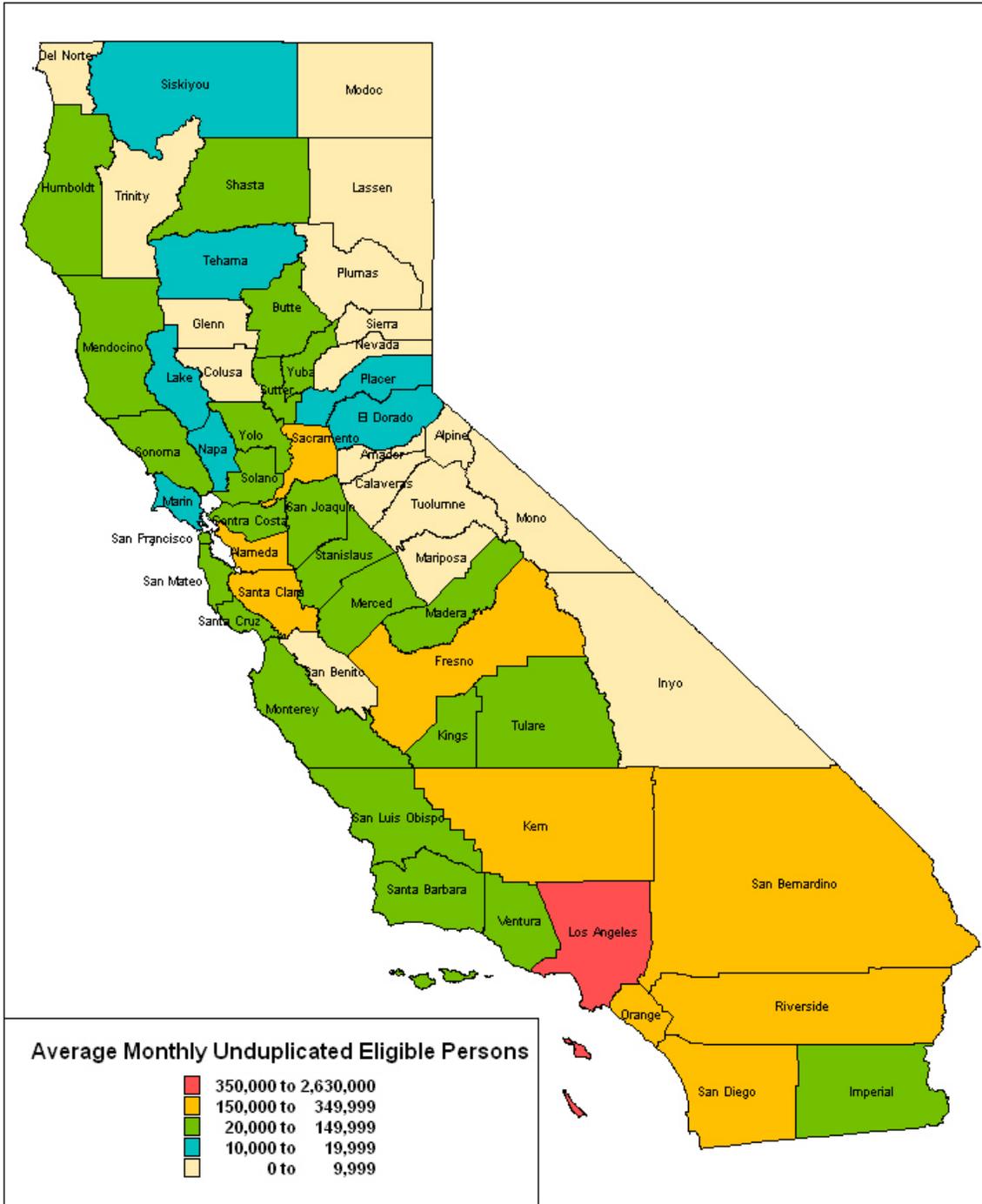
Statewide Average Penetration Rate - 6.28%

Statewide Median Penetration Rate - 8.05%



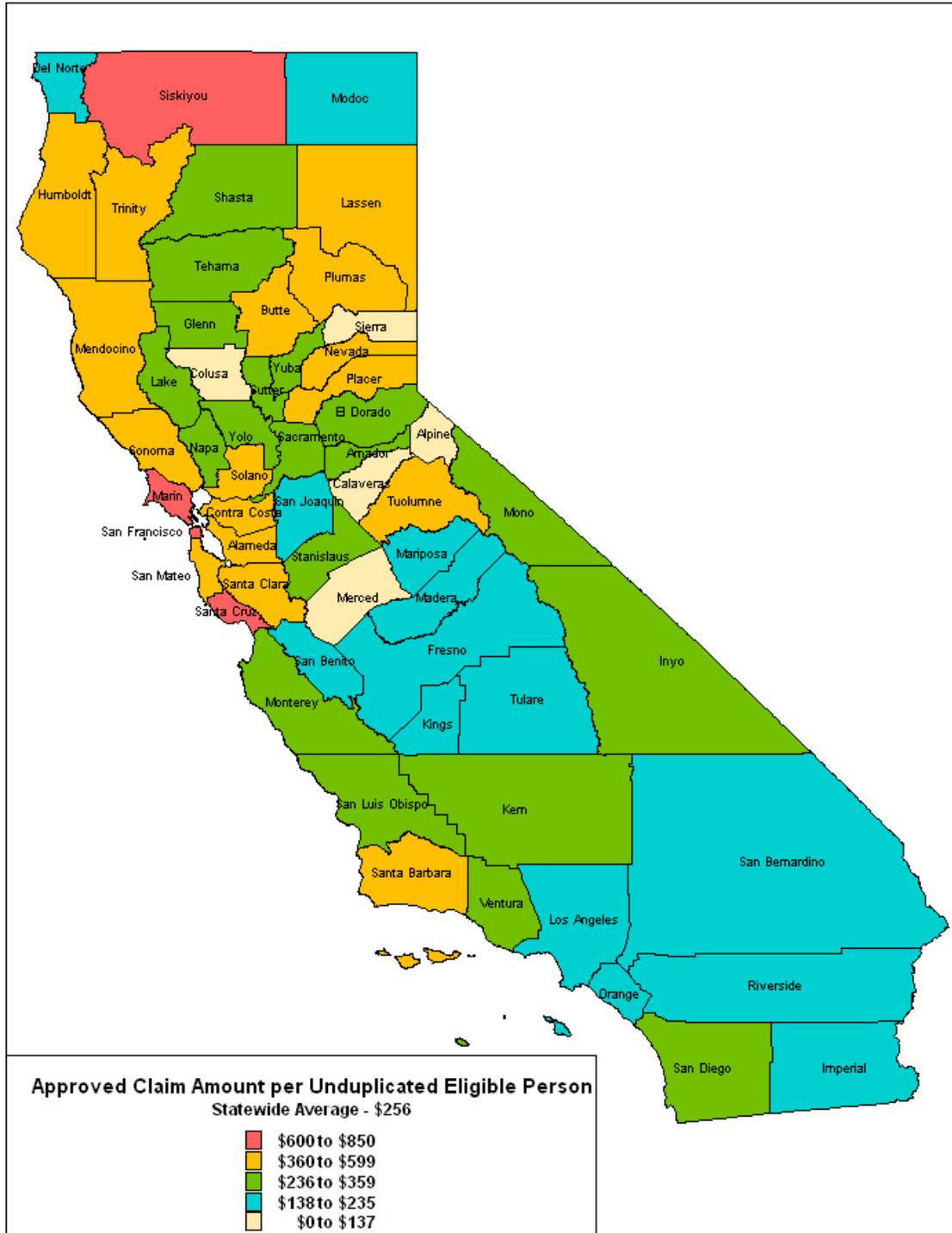
Source: California Department of Mental Health - Approved Claims FY 2002-03 (as of November 30, 2004)  
 Alpine excluded in calculation of median

### Average Monthly Unduplicated Eligible Persons Approved Claims FY 2003



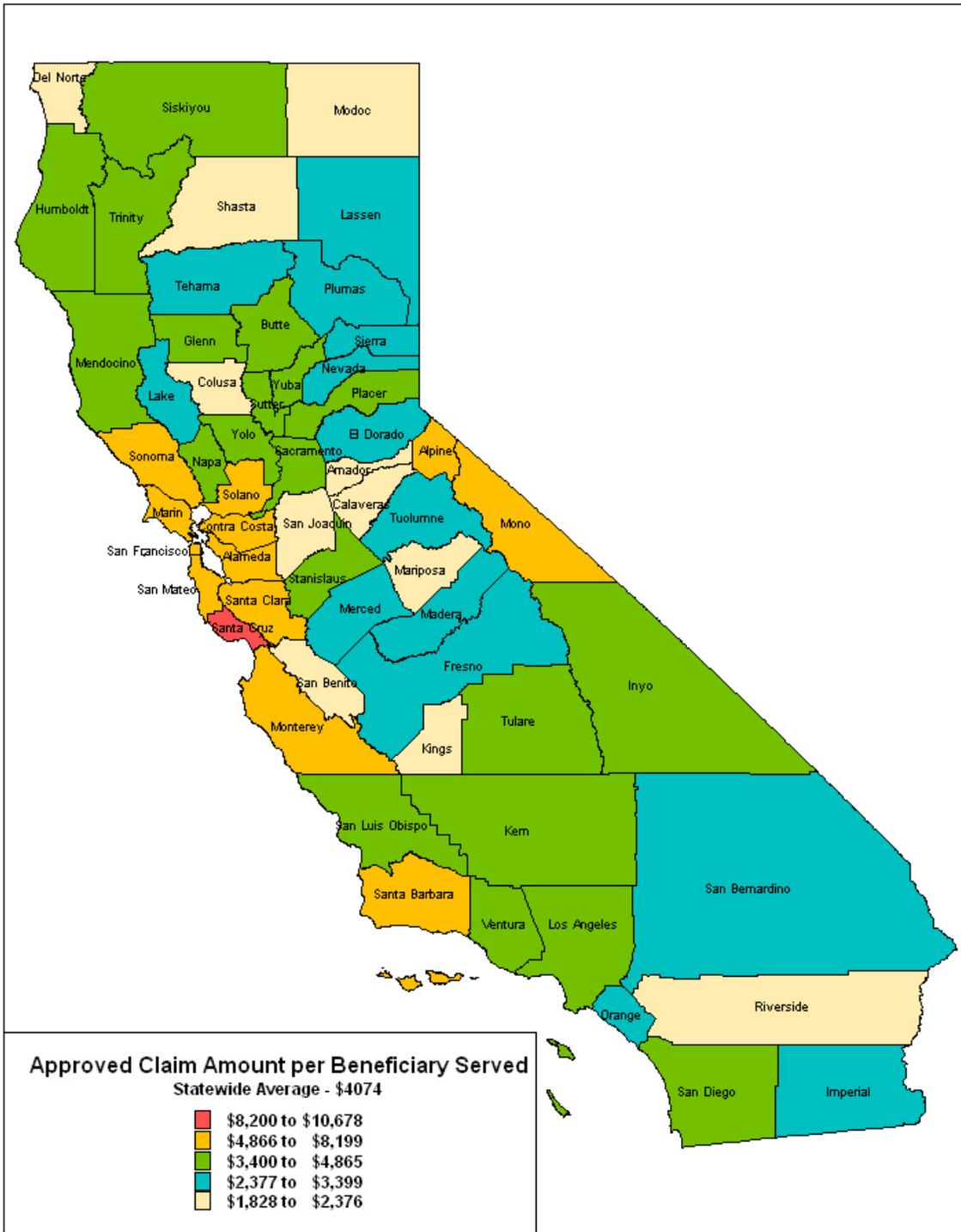
Source: California Department of Mental Health - Approved Claims FY 2002-03 (as of November 30, 2004)

## Approved Claim Amount Per Eligible Person Approved Claims FY 2003



Source: California Department of Mental Health - Approved Claims FY 2002-03 (as of November 30, 2004)

## Approved Claim Amount Per Beneficiary Served Approved Claims FY 2003



Source: California Department of Mental Health - Approved Claims FY 2002-03 (as of November 30, 2004)

### CAEQRO MHP Size Groupings

County	County Size (2003)	Region	County Population (2003)**	FPL Rank 1999	Medi-Cal Rank 2001	Medi-Cal Eligible Rank - % of	Threshold Languages 2001
Los Angeles	Very Large	Los Angeles	10,047,300	12	1	8	11
Alameda	Large	Bay Area	1,495,400	42	8	32	3
Contra Costa	Large	Bay Area	1,003,800	55	15	44	1
Fresno	Large	Central	855,400	3	6	2	2
Orange	Large	Southern	3,001,300	48	4	45	2
Riverside	Large	Southern	1,758,700	32	7	33	1
Sacramento	Large	Central	1,331,500	28	5	11	5
San Bernardino	Large	Southern	1,869,300	25	3	26	1
San Diego	Large	Southern	2,989,300	35	2	42	2
San Francisco	Large	Bay Area	786,900	41	11	28	3
Santa Clara	Large	Bay Area	1,723,900	52	9	49	2
Ventura	Large	Southern	799,200	49	16	41	1
Butte	Medium	Superior	212,400	11	22	14	1
Kern	Medium	Southern	717,300	10	10	7	1
Marin	Medium	Bay Area	250,300	57	37	58	1
Merced	Medium	Central	230,600	5	17	3	1
Monterey	Medium	Bay Area	418,800	30	18	9	1
Placer	Medium	Central	285,400	56	34	56	1
San Joaquin	Medium	Central	625,600	19	12	16	2
San Luis Obispo	Medium	Southern	257,500	40	29	48	1
San Mateo	Medium	Bay Area	712,800	58	20	57	1
Santa Barbara	Medium	Southern	412,100	34	19	34	1
Santa Cruz	Medium	Bay Area	259,200	38	27	43	1
Solano	Medium	Bay Area	416,500	46	21	40	1
Sonoma	Medium	Bay Area	473,300	51	24	50	1
Stanislaus	Medium	Central	489,400	21	14	13	1
Tulare	Medium	Central	392,900	2	13	1	1
El Dorado	Small	Central	168,200	53	39	55	1
Humboldt	Small	Superior	129,400	20	31	20	0
Imperial	Small	Southern	153,600	1	23	4	1
Kings	Small	Central	138,700	6	28	18	1
Lake	Small	Superior	62,300	13	36	6	0
Madera	Small	Central	133,900	8	26	10	1
Mendocino	Small	Superior	89,100	24	33	23	1
Napa	Small	Bay Area	130,900	54	40	52	1
Nevada	Small	Superior	96,900	50	44	54	0
San Benito	Small	Bay Area	56,600	44	47	47	1
Shasta	Small	Superior	175,500	23	25	19	0
Sutter	Small	Central	84,900	27	35	22	1
Tehama	Small	Superior	58,600	14	38	12	1
Tuolumne	Small	Central	57,100	33	42	38	0
Yolo	Small	Central	183,500	29	30	29	2
Yuba	Small	Central	63,900	4	32	5	1
Alpine	Small-Rural	Central	1,210	26	58	27	0
Amador	Small-Rural	Central	37,050	45	50	51	0
Calaveras	Small-Rural	Central	43,550	39	46	37	0
Colusa	Small-Rural	Superior	20,000	22	49	25	1

County	County Size (2003)	Region	County Population (2003)**	FPL Rank 1999	Medi-Cal Rank 2001	Medi-Cal Eligible Rank - % of	Threshold Languages 2001
Del Norte	Small-Rural	Superior	28,100	7	43	9	1
Glenn	Small-Rural	Superior	27,600	15	45	24	1
Inyo	Small-Rural	Superior	18,550	36	51	31	1
Lassen	Small-Rural	Superior	34,600	17	48	35	1
Mariposa	Small-Rural	Central	17,850	31	55	39	0
Modoc	Small-Rural	Superior	9,500	9	54	17	1
Mono	Small-Rural	Central	13,400	47	56	53	1
Plumas	Small-Rural	Superior	21,150	37	52	36	0
Sierra	Small-Rural	Superior	3,520	43	57	46	0
Siskiyou	Small-Rural	Superior	45,050	18	41	15	1
Trinity	Small-Rural	Superior	13,550	16	53	21	0
<b>State Wide</b>		n/a	<b>35,934,000</b>	n/a	n/a	n/a	12

**Note:** \*\* 2003 Population data obtained from CA. Dept. of Finance: <http://www.dof.ca.gov/HTML/DEMOGRAP/E-2.XLS>

[1] Source: California, Department of Finance, E-1City/County Population Estimates. Sacramento, California: May 2004

[2] Source: U.S. Census Bureau, Housing and Household Economic Statistics Division: Estimates for California Counties, 2002. Washington, DC: December 2004.

[3] Source: California, Department of Mental Health (FY2003 Short-Doyle/Medi-Cal Approved Claims data, asFY2004 Approved Claims data not finalized).

[4] Source: California, Department of Health Services, Medical Care Statistics Section: Overview for the Medi-Cal-Beneficiaries-Profiles-by-County File for July 2003 and July 2004. Sacramento, CA: February 2005.

[5] Source: California, Department of Finance, E-1City/County Population Estimates. Sacramento, CA: May 2004.

Group Size	County Population - May 2004
Small-Rural	<54,999
Small	55,000 to 199,999
Medium	200,000 to 749,000
Large	750,000 to 3,999,999
Very Large	>4,000,000

## MHP Claims and Demographics Data FY03

County	County Size (2004)	Region	Fiscal Year Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unduplicated Count of Beneficiaries Served	Penetration Rate	Approved Claims as of May 13, 2005	Average Monthly Approved Claims Undup Eligibles	Approved Claims Unduplicated Beneficiary Served	County Population (2004)**	County Population Rank (2004)**	FPL Rank 1999	Medi-Cal Rank 2004*	Medi-Cal Eligible Rank % of 2004 County Pop	Medi-Cal Eligible % of 2004 County Pop	Threshold Languages Oct 2004
Alameda	Large	Bay Area	268,729	215,937	18,504	8.57%	\$90,532,558	\$419	\$4,893	1,501,952	9	42	9	33	14.4%	4
Alpine	Small-Rural	Central	340	230	7	3.04%	\$8,586	\$37	\$1,227	1,289	57	26	57	27	17.8%	1
Amador	Small-Rural	Central	4,568	3,308	378	11.43%	\$709,216	\$214	\$1,876	37,468	49	45	49	53	8.8%	0
Butte	Medium	Superior	59,771	48,264	4,930	10.21%	\$18,190,290	\$377	\$3,690	213,065	23	11	24	17	22.7%	1
Calaveras	Small-Rural	Central	7,380	5,283	410	7.76%	\$875,467	\$166	\$2,135	44,325	46	39	46	45	11.9%	0
Colusa	Small-Rural	Superior	6,710	4,755	357	7.51%	\$862,599	\$181	\$2,416	20,582	48	22	48	15	23.1%	1
Contra Costa	Large	Bay Area	137,866	107,226	9,088	8.48%	\$47,998,385	\$448	\$5,282	1,016,302	15	55	16	48	10.6%	1
Del Norte	Small-Rural	Superior	10,058	8,022	979	12.20%	\$1,823,449	\$227	\$1,863	28,991	42	7	43	5	27.7%	1
El Dorado	Small	Central	20,616	14,891	1,373	9.22%	\$4,293,430	\$288	\$3,127	172,244	37	53	36	54	8.6%	1
Fresno	Large	Central	324,541	263,843	13,607	5.16%	\$44,677,269	\$169	\$3,283	876,842	7	3	7	3	30.1%	2
Glenn	Small-Rural	Superior	9,054	6,694	534	7.98%	\$2,135,551	\$319	\$3,999	27,926	45	15	45	11	24.0%	1
Humboldt	Small	Superior	33,287	25,972	2,821	10.86%	\$12,488,326	\$481	\$4,427	130,953	32	20	32	23	19.8%	0
Imperial	Small	Southern	60,461	47,385	2,739	5.78%	\$7,644,803	\$161	\$2,791	159,479	24	1	23	4	29.7%	1
Inyo	Small-Rural	Superior	4,125	3,025	307	10.15%	\$1,084,380	\$358	\$3,532	18,636	50	36	50	28	16.2%	1
Kern	Medium	Southern	244,554	190,867	12,989	6.81%	\$54,131,544	\$284	\$4,167	744,325	10	10	10	8	25.6%	1
Kings	Small	Central	39,867	30,836	2,496	8.09%	\$5,101,368	\$165	\$2,044	143,876	29	6	29	20	21.4%	1
Lake	Small	Superior	19,953	15,318	1,224	7.99%	\$4,206,497	\$275	\$3,437	63,110	36	13	37	9	24.3%	1
Lassen	Small-Rural	Superior	6,865	5,060	621	12.27%	\$1,920,869	\$380	\$3,093	35,510	47	17	47	34	14.2%	1
Los Angeles	Very Large	Los Angeles	3,229,932	2,610,499	126,965	4.86%	\$540,246,202	\$207	\$4,255	10,179,716	1	12	1	7	25.6%	11
Madera	Small	Central	48,063	36,306	1,831	5.04%	\$3,806,227	\$105	\$2,079	139,406	26	8	25	6	26.0%	1
Marin	Medium	Bay Area	22,039	16,738	2,084	12.45%	\$11,740,667	\$701	\$5,634	251,440	35	57	35	57	6.7%	1
Mariposa	Small-Rural	Central	3,355	2,436	263	1.80%	\$551,380	\$226	\$2,097	17,856	53	31	53	35	13.6%	0
Mendocino	Small	Superior	27,447	21,759	1,998	9.18%	\$8,799,521	\$404	\$4,404	89,701	34	24	34	10	24.3%	1
Merced	Medium	Central	93,964	73,437	3,366	4.58%	\$8,119,967	\$111	\$2,412	237,155	18	5	18	2	31.0%	2
Modoc	Small-Rural	Superior	2,989	2,279	234	10.27%	\$429,264	\$188	\$1,834	9,917	54	9	54	16	23.0%	1
Mono	Small-Rural	Central	1,931	1,219	77	6.32%	\$322,606	\$265	\$4,190	13,568	55	47	55	52	9.0%	1
Monterey	Medium	Bay Area	105,012	76,794	3,206	4.17%	\$20,049,250	\$261	\$6,254	425,521	17	30	17	26	18.0%	1
Napa	Small	Bay Area	19,014	13,162	1,015	7.71%	\$4,718,062	\$358	\$4,648	132,530	39	54	38	50	9.9%	1
Nevada	Small	Superior	11,547	8,484	920	10.84%	\$3,502,559	\$413	\$3,807	98,857	41	50	41	55	8.6%	1
Orange	Large	Southern	496,867	376,127	20,472	5.44%	\$50,576,496	\$134	\$2,471	3,044,819	2	48	2	44	12.4%	2
Placer	Medium	Central	29,873	22,068	2,428	11.00%	\$10,171,272	\$461	\$4,189	303,016	33	56	33	56	7.3%	1
Plumas	Small-Rural	Superior	3,665	2,753	355	12.90%	\$1,318,522	\$479	\$3,714	21,158	51	37	51	41	13.0%	0
Riverside	Large	Southern	386,822	282,729	17,886	6.33%	\$41,793,564	\$148	\$2,337	1,846,095	5	32	5	32	15.3%	1
Sacramento	Large	Central	333,743	272,178	20,107	7.39%	\$91,226,286	\$335	\$4,537	1,360,346	6	28	6	22	20.0%	5
San Benito	Small	Bay Area	10,881	7,757	589	7.59%	\$1,445,657	\$186	\$2,454	57,353	43	44	42	36	13.5%	1
San Bernardino	Large	Southern	488,953	367,124	24,550	6.69%	\$64,781,202	\$176	\$2,639	1,930,416	3	25	3	24	19.0%	1
San Diego	Large	Southern	471,076	357,997	33,169	9.27%	\$104,143,778	\$291	\$3,140	3,036,373	4	35	4	46	11.8%	3
San Francisco	Large	Bay Area	149,775	125,018	14,520	11.61%	\$89,326,381	\$715	\$6,152	795,180	13	41	13	30	15.7%	4
San Joaquin	Medium	Central	175,983	139,421	9,168	6.58%	\$18,791,541	\$135	\$2,050	646,007	11	19	11	19	21.6%	2
San Luis Obispo	Medium	Southern	38,938	29,866	2,889	9.67%	\$9,485,721	\$318	\$3,283	259,924	30	40	30	47	11.5%	1

## MHP Claims and Demographics Data FY03 (cont.)

County	County Size (2004)	Region	Fiscal Year Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unduplicated Count of Beneficiaries Served	Penetration Rate	Approved Claims as of May 13, 2005	Average Monthly Approved Claims Undup Eligibles	Approved Claims Unduplicated Beneficiary Served	County Population (2004)**	County Population Rank (2004)**	FPL Rank 1999	Medi-Cal Rank 2004*	Medi-Cal Eligible Rank % of 2004 County Pop	Medi-Cal Eligible % of 2004 County Pop	Threshold Languages Oct 2004
San Mateo	Medium	Bay Area	87,332	65,266	5,359	8.21%	\$33,658,189	\$516	\$6,281	720,691	20	58	19	51	9.1%	1
Santa Barbara	Medium	Southern	86,322	67,305	4,768	7.08%	\$31,050,124	\$461	\$6,512	416,625	19	34	20	29	16.2%	1
Santa Clara	Large	Bay Area	273,199	220,430	12,749	5.78%	\$48,608,894	\$221	\$3,813	1,749,365	8	52	8	43	12.6%	5
Santa Cruz	Medium	Bay Area	45,001	34,042	2,712	7.97%	\$27,815,033	\$817	\$10,256	259,990	28	38	28	39	13.1%	1
Shasta	Small	Superior	47,166	36,988	3,991	10.79%	\$10,075,947	\$272	\$2,525	177,002	25	23	26	21	20.9%	0
Sierra	Small-Rural	Superior	670	456	10	2.19%	\$47,104	\$103	\$4,710	3,529	56	43	56	42	12.9%	0
Siskiyou	Small-Rural	Superior	13,052	10,165	1,394	13.71%	\$8,461,310	\$832	\$6,070	45,440	40	18	40	18	22.4%	1
Solano	Medium	Bay Area	71,753	54,993	3,539	6.44%	\$17,022,290	\$310	\$4,810	419,548	21	46	21	38	13.1%	1
Sonoma	Medium	Bay Area	65,411	48,759	3,256	6.68%	\$17,773,963	\$365	\$5,459	477,437	22	51	22	49	10.2%	1
Stanislaus	Medium	Central	146,903	115,922	8,057	6.95%	\$28,520,611	\$246	\$3,540	500,172	14	21	14	14	23.2%	1
Sutter/Yuba	Small	Central	47,056	36,117	2,897	8.02%	\$9,669,008	\$268	\$3,338	153,755	27	27	27	13	23.5%	1
Tehama	Small	Superior	18,830	14,245	1,448	10.16%	\$3,178,716	\$223	\$2,195	59,825	38	14	39	12	23.8%	1
Trinity	Small-Rural	Superior	3,440	2,586	301	11.64%	\$1,478,119	\$572	\$4,911	13,732	52	16	52	25	18.8%	0
Tulare	Medium	Central	166,589	132,870	6,002	4.52%	\$19,440,798	\$146	\$3,237	405,438	12	2	12	1	32.8%	1
Tuolumne	Small	Central	9,931	7,509	905	12.05%	\$2,879,145	\$383	\$3,181	56,977	44	33	44	37	13.2%	0
Ventura	Large	Southern	138,830	105,714	5,594	5.29%	\$26,784,336	\$253	\$4,788	811,505	16	49	15	40	13.0%	1
Yolo	Small	Central	37,827	28,620	2,322	8.11%	\$8,793,941	\$307	\$3,787	186,554	31	29	31	31	15.3%	1
Yuba	n/a	n/a	(no data - included in Sutter/Yuba)													
State Wide	Statewide	Statewide	8,669,926	6,825,055	426,761	6.25%	\$1,679,307,223	\$246	\$3,935	36,590,814	n/a	n/a	n/a	n/a	n/a	13

**Foot Notes:**

<b>County Size</b>	Combination of DMH & APS methodologies to determine county class size
<b>Region</b>	Using DMH - County Operations guidelines
<b>FY Unduplicated</b>	DMH provided data - from Short-Doyle/Medi-Cal Approved Claims Data
<b>Ave. Monthly Eligible</b>	DMH provided data - from Short-Doyle/Medi-Cal Approved Claims Data
<b>Consumers Served</b>	DMH provided data - from Short-Doyle/Medi-Cal Approved Claims Data
<b>Penetration Rate</b>	DMH provided data - from Short-Doyle/Medi-Cal Approved Claims Data
<b>Approve Claims</b>	DMH provided data - from Short-Doyle/Medi-Cal Approved Claims Data
<b>Mo. Approve Claims</b>	DMH provided data - from Short-Doyle/Medi-Cal Approved Claims Data
<b>Consumers Served</b>	DMH provided data - from Short-Doyle/Medi-Cal Approved Claims Data
<b>County Population</b>	Dept of Finance data - from website <a href="http://www.dof.ca.gov/HTML/DEMOGRAP/Hist_E-4.xls">http://www.dof.ca.gov/HTML/DEMOGRAP/Hist_E-4.xls</a>
<b>Cnty Pop Rank</b>	Calculated column, based on county population data
<b>FPL Rank</b>	U.S. Census data
<b>Medi-Cal Rank</b>	Calculated column, from Average Monthly Unduplicated Eligible data
<b>M/C Rank of Cnty Pop</b>	Calculated column, from Medi-Cal Eligible % of County Population
<b>M/C % of Cnty Pop</b>	Calculated column, from Average Monthly Unduplicated Eligible and County Population data
<b>Threshold Language</b>	DMH provided data - from DMH Letter 04-08

**Approved Claims- 2004**

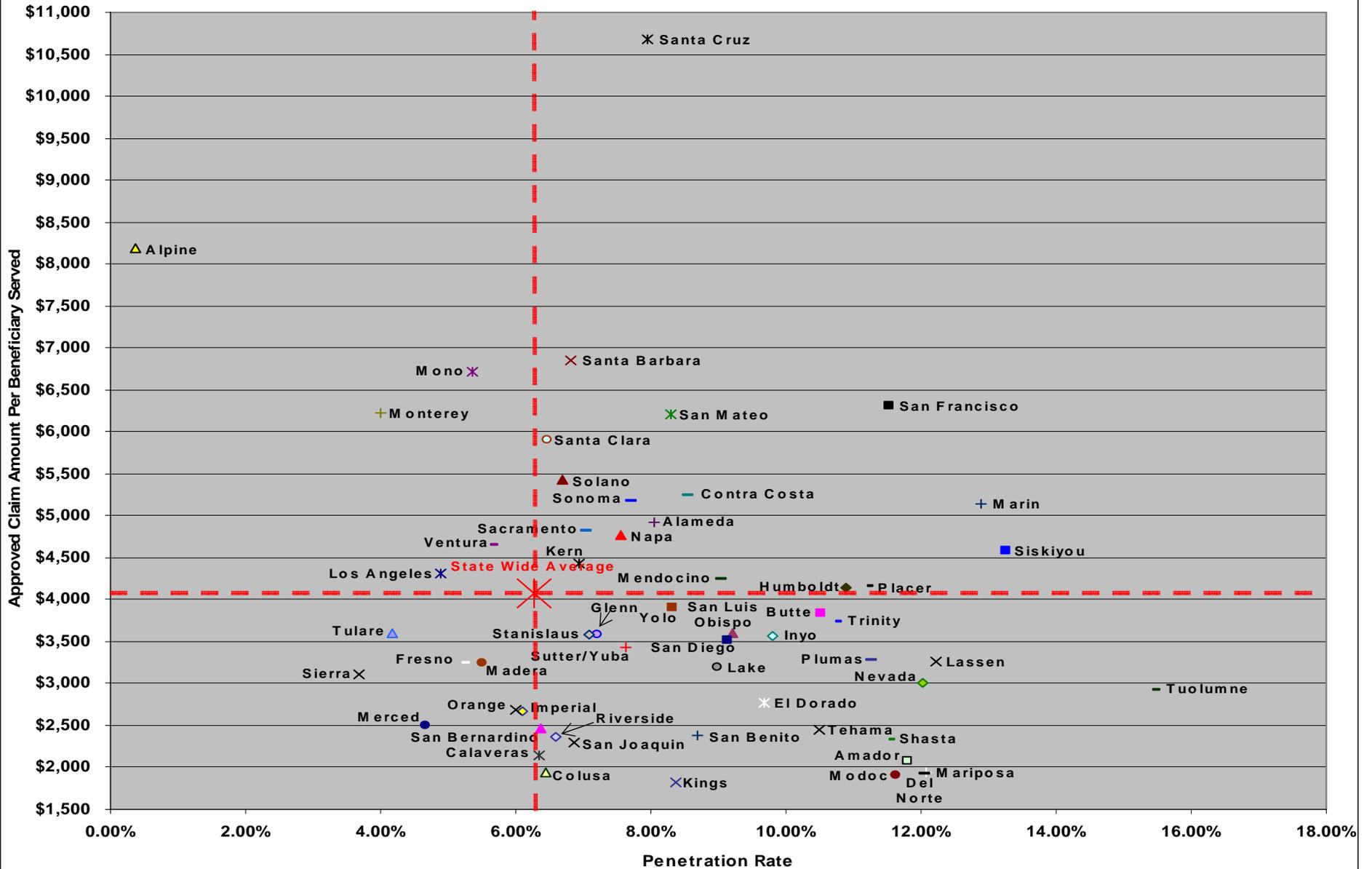
Size	Number	2004 Population	Percent	Monthly Eligible	Percent	Beneficiaries Served	Ave Monthly	Beneficiary Served
small-rural	15	339,927	1%	58,272	0.85%	6,226	\$378	\$3,536
small	16	1,821,622	5%	345,349	5.06%	28,512	\$262	\$3,170
medium	15	6,280,354	17%	1,116,612	16.36%	73,798	\$277	\$4,192
large	11	17,969,195	49%	2,694,323	39.48%	189,973	\$259	\$3,676
very large	1	10,179,716	28%	2,610,499	38.25%	126,849	\$206	\$4,249
<b>Total</b>	<b>58</b>	<b>36,590,814</b>	<b>100%</b>	<b>6,825,055</b>	<b>100%</b>	<b>425,358</b>	<b>\$243</b>	<b>\$3,900</b>

**Approved Claims- 2003**

Size	Number	2003 Population	Percent	Monthly Eligible	Percent	Beneficiaries Served	Ave Monthly	Beneficiary Served
small-rural	15	334,680	0.93%	58,123	0.88%	5,950	\$317	\$3,099
small	16	1,783,100	4.96%	335,252	5.06%	29,009	\$268	\$3,103
medium	15	6,154,100	17.13%	1,063,901	16.07%	71,956	\$305	\$4,507
large	11	17,614,700	49.02%	2,543,651	38.42%	181,013	\$279	\$3,924
very large	1	10,047,300	27.96%	2,620,200	39.57%	127,939	\$210	\$4,310
<b>Total</b>	<b>58</b>	<b>35,933,880</b>	<b>100%</b>	<b>6,621,127</b>	<b>100%</b>	<b>415,867</b>	<b>\$256</b>	<b>\$4,074</b>



### Comparison of Penetration Rate vs. Approved Claim Amount Per Beneficiary Served by California Counties for FY 2003



Data Source: California Department of Mental Health - Approved Claims FY 2002-2003 (as of November 30, 2004)



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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# Information Systems Capabilities Assessment 5.7L

## (ISCA)

### California Mental Health Plans

**Note:** The following document is based on Appendix Z of the External Quality Review Activity Protocols developed by the Department of Health and Human Services Centers for Medicare and Medicaid Services (Final Protocol, Version 1.0, May 1, 2002).

<http://www.cms.hhs.gov/medicaid/managedcare/mceqrhmp.asp>

*This is a Draft Document which will be refined and modified by the California EQRO in collaboration with the California Department of Mental Health and California MHP stakeholders.*



## ISCA Overview

### PURPOSE of the Information Systems Capabilities Assessment (ISCA)

Knowledge of the capabilities of a Mental Health Plan (MHP) Information Systems (IS) is essential to effectively and efficiently evaluate the MHP's capacity to well manage the health care of its beneficiaries. The purpose of this assessment is to specify the desired capabilities of the MHP's IS, and to pose standard questions to be used to assess the strength of a MHP with respect to these capabilities. This will assist an External Quality Review Organization (EQRO) to assess the extent to which a MHP's information systems is capable of producing valid encounter data<sup>2</sup>, performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its beneficiaries.

If a prior assessment has been completed by private sector accreditation or performance measures validation, and the information gathered is the same as or consistent with what is described in this assessment, it may not be necessary to repeat this assessment process. However, information from a previously conducted assessment must be accessible to EQRO reviewers.

### OVERVIEW of the Assessment Process

Assessment of MHP's information systems is a process of 4 consecutive activities.

**Step one** involves the collection of standard information about each MHP's information systems. This is accomplished by having the MHP complete an *Information Systems Capabilities Assessment (ISCA) for California Mental Health Plans*. The ISCA is an information collection tool provided to the MHP developed by the EQRO in cooperation with California stakeholders and the California Department of Mental Health. The California Department of Mental Health has defined the time frame in which the MHP is expected to complete and return the tool. Data will be recorded on the tool by the MHP. Documents from the MHP are also requested throughout the tool, and are summarized on the checklist at the end of this assessment tool. These are to be attached to the tool and should be identified as applicable to the numbered item on the tool (e.g., 1.4, or 2.2.3).

**Step two** involves a review of the completed ISCA by the EQRO reviewers. Materials submitted by the MHP will be reviewed in advance of a site visit.

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<sup>2</sup> "For the purposes of this protocol, an encounter refers to the electronic record of a service provided to an MCO/PIHP [MHP] enrollee by both institutional and practitioner providers (regardless of how the provider was paid) when the service would traditionally be a billable service under fee-for-service (FFS) reimbursement system. Encounter data provides substantially the same type of information that is found on a claim form (e.g., UB-92 or CMS 1500), but not necessarily in the same format." – Validating Encounter Data, CMS Protocol, P. 2, May 2002.

**Step three** involves a series of onsite and telephone interviews and discussion with key MHP staff who completed the ISCA as well as other knowledgeable MHP staff. These discussions will focus on various elements of the ISCA. The purpose of the interviews is to gather additional information to assess the integrity of the MHP's information systems.

**Step Four** will produce an analysis of the findings from both the completed *Information Systems Capabilities Assessment (ISCA)* and the follow-up discussions with MHP staff. A summary report of the interviews as well as the completed ISCA document will be included in an information technology section of the EQRO report. The report will discuss the ability of the MHP to use its information systems and analyze its data to conduct quality assessment and improvement initiatives. Further, the report will consider the ability of the MHP information systems to support the management and delivery of mental health care to its beneficiaries.

# ***Information Systems Capabilities Assessment (ISCA) California Mental Health Plans (MHP)***

## **ISCA Instructions:**

Please complete the following Information Systems Capabilities Assessment (ISCA) questions. For any questions that you believe do not apply to your MHP, please mark the item as “N/A.” For any ISCA survey question, you may attach existing documents which provide an answer. For example, if you have current policy and procedure documents which address a particular item, you may attach and reference such materials.

**Please complete this survey using Microsoft Word. You may supply your answers in the areas indicated. You may tab through the fields.**

## Section 1

### General Information

**Note:** *The information requested in this assessment pertains to the collection and processing of data for **Medi-Cal**. In many situations, if not most, this may be no different than how a MHP collects and processes commercial insurance or Medicare data. However, for questions which may address areas where **Medi-Cal** data is managed differently than commercial or other data, please provide the answers to the questions as they relate to **Medi-Cal** beneficiaries and **Medi-Cal** data.*

#### 1.1 ISCA Contact Information

Please insert (or verify the accuracy of) the MHP identification information below, including the MHP name, ISCA contact name and title, mailing address, telephone and fax numbers, and E-mail address.

<p><b>MHP Name:</b></p> <p><b>ISCA Contact Name and Title:</b></p> <p><b>Mailing Address:</b></p> <p><b>Phone Number:</b></p> <p><b>Fax Number:</b></p> <p><b>E-mail Address:</b></p>
---

#### 1.2 How are services delivered? (Please select one, or specify “Other”.)

- MHP owned and operated (all services provided by MHP employed providers)
- MHP + contractors (services provided by MHP employed providers and contract providers)
- Contractors (all services provided by contract providers)
- Other:

**1.3 Do you have access to the average number of Medi-Cal beneficiaries in your MHP per month on an annual basis?**

Yes  No

**1.3.1 If yes, what is the source of this information?**

**1.3.2 If yes, how is this information used?**

**1.4 Has your organization ever undergone an information systems capabilities assessment? (This assessment could have been performed by County, State or external consultants.)**

Yes  No

**If yes, who performed the assessment?**

**If yes, when was the assessment completed?**

**Note:** If your MHP's information has been formally assessed in the recent past (2 years or less), please attach a copy of the assessment report. Complete only those sections of the ISCA that are not covered by or have changed since the formal assessment was conducted.

## Section 2

### Information Systems: Data Processing Procedures & Personnel

2.1 Is your primary information systems provided by an external vendor or county IT Department?

Please select:

- Information Systems Vendor  
 County IT Department  
 Other – Specify:

**Note:** For purposes of this assessment, please consider your county IT department as a “vendor” for remaining items in Section 2.

#### 2.1.1 Vendor 1:

Vendor Product Name:  
 Vendor Contact Name:  
 Vendor Contact E-mail:

Please check all functions that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> Registrations                    | <input type="checkbox"/> Admissions/Discharges         |
| <input type="checkbox"/> Services                         | <input type="checkbox"/> Medi-Cal claims production    |
| <input type="checkbox"/> Claims receipt and adjudications | <input type="checkbox"/> Authorizations                |
| <input type="checkbox"/> Grievances & Appeals             | <input type="checkbox"/> Medi-Cal eligibility tracking |
| <input type="checkbox"/> Progress notes                   | <input type="checkbox"/> Treatment plans               |

#### 2.1.2 Vendor 2:

Vendor Product Name:  
 Vendor Contact Name:  
 Vendor Contact E-mail:

Please check all functions that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> Registrations                    | <input type="checkbox"/> Admissions/Discharges         |
| <input type="checkbox"/> Services                         | <input type="checkbox"/> Medi-Cal claims production    |
| <input type="checkbox"/> Claims receipt and adjudications | <input type="checkbox"/> Authorizations                |
| <input type="checkbox"/> Grievances & Appeals             | <input type="checkbox"/> Medi-Cal eligibility tracking |
| <input type="checkbox"/> Progress notes                   | <input type="checkbox"/> Treatment plans               |

**2.1.3 Vendor 3:**

Vendor Product Name:

Vendor Contact Name:

Vendor Contact E-mail:

**Please check all functions that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> Registrations                    | <input type="checkbox"/> Admissions/Discharges         |
| <input type="checkbox"/> Services                         | <input type="checkbox"/> Medi-Cal claims production    |
| <input type="checkbox"/> Claims receipt and adjudications | <input type="checkbox"/> Authorizations                |
| <input type="checkbox"/> Grievances & Appeals             | <input type="checkbox"/> Medi-Cal eligibility tracking |
| <input type="checkbox"/> Progress notes                   | <input type="checkbox"/> Treatment plans               |

**2.2 Do you plan to make major information systems changes or to select an alternative system within the next 2 years?**

- Yes  No

**If yes:**

**2.2.1 Please indicate your target date for implementation of your new or changed system.**

**2.2.2 If implementing a new system, when do you expect to generate your first production Medi-Cal claims to California DMH?**

**2.2.3 If available, please attach a copy of your current implementation project plan.**

**If providing attachment(s), please check.**

- Yes for attachment(s)  No attachment

**2.2.4 Please describe the current status of your project.**

**2.3 Please describe your current information systems by selecting one of the following alternatives.**

- Our system is fully operated by MHP IT staff
- Our system is fully operated by County IT staff
- Our system is housed at a 3<sup>rd</sup> party vendor. MHP staff manages local operations (ASP type)
- Our system is housed at a 3<sup>rd</sup> party vendor. The vendor provides operational support. (Service Bureau Type)
- Other (Please describe & elaborate):

**2.4 Does your MHP use your information systems to create ad-hoc reports on Medi-Cal encounter and Medi-Cal eligibility data?**

- Yes  No

**If yes, please indicate the software reporting tools used by your staff.**

**2.5 Do you use standard reports to manage your Medi-Cal encounter or eligibility data?**

- Yes  No

**If yes, please describe your most critical reports.**

**2.6 Do you currently employ staff to extract data and/or produce reports regarding Medi-Cal encounter or eligibility information?**

- Yes  No

**2.7 Does your system provide reports supporting the Medi-Cal claim?**

Yes  No

**2.7.1 If so, please describe the data reported. (You may provide report samples as attachments.)****2.8 What percentage of your reporting and analysis of Medi-Cal encounter and eligibility information is performed by MHP staff?**

%

Please note the title and years of experience of these staff.

**2.9 Please describe the number and experience of those staff that use your current information systems.**

Type of Staff	Number	Estimated Average Years Experience
Support/Clerical		
Administrative		
Clinical		
Quality Improvement		

**2.10 Does your MHP have a training program for users of your information systems?**

Yes  No

**If yes, please check all that apply.**

	Classroom	On-the-Job	One-On-One Trainer	New Hires Only
<b>Clerical/Support Staff</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Quality Improvement Staff</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Program Manager</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IT Staff</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Billing/Fiscal Staff</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Administration Staff</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Managed Care Staff</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Clinical Staff</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Medical (MD) Staff</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2.11 How many staff do you consider “experts” on your information systems? Please indicate their title and years of experience with your system.**

Title	Years of Experience

**2.12 Do you have a policy which specifies the timeliness of data entered to the IS?**

Yes  No

**2.12.1 If so, please provide details of the policy.**

**2.12.2 If so, describe how you monitor this policy.**

**2.13 Do you have a policy specifying the degree of accuracy required for data entered to the IS?**

Yes  No

**2.13.1 If so, please provide details of the policy.**

**2.13.2 If so, describe how you monitor this policy.**

**2.14 Please describe your monthly operations activity cycle at your MHP to prepare a Medi-Cal claim. Note the steps your staff take to produce the claim for submission to the Department of Mental Health.**

**2.15 Do you know the Medi-Cal claim monthly operations activity cycle performed by your information systems vendor?**

Yes  No

**If yes, please outline the steps your vendor performs to produce the claim.**

**2.16 Does your MHP use a standard review process for claims before submission?**

Yes  No

**If yes, please describe the claims review process. What criteria are used to ensure that a claim is accurate before submission to DMH?**

**2.17 What is your MHP’s policy and procedure for reviewing the Error Correction Report (ECR)?**

**Please describe your standard process.**

**2.18 What is your MHP’s policy and procedure for reviewing the Medi-Cal Explanation of Benefits (EOB) that is returned to the MHP?**

**Please describe your review process.**

**2.19 Please describe how Medi-Cal eligibility files within your system are updated.**

**2.20 What Medi-Cal eligibility sources does your MHP use to determine monthly eligibility? Check all that apply.**

- |   |   |
|---|---|
| <input type="checkbox"/> IS Inquiry/Retrieval from MEDS     | <input type="checkbox"/> POS devices      |
| <input type="checkbox"/> MEDS terminal (standalone)         | <input type="checkbox"/> AEVS             |
| <input type="checkbox"/> MEDS terminal (integrated with IS) | <input type="checkbox"/> Web based search |
| <input type="checkbox"/> MMEF                               |   |
| <input type="checkbox"/> FAME                               | <input type="checkbox"/> Other:           |

**2.21 Does your MHP track grievances and appeals?**

- Yes  No

**2.21.1 If so, is it automated or manual?**

- Automated  
 Please describe:
- Manual  
 Please describe:

**2.22 On a periodic basis, key system tables which control data validations enforce business rules and control rates in your information systems must be reviewed and updated. What is your process for management of these tables?**

**2.22.1 Are tables maintained by:**

- MHP Staff  
 County IT Staff  
 Vendor Staff  
 Combination

**2.23 Does your MHP perform periodic verification of data in the IS compared to the medical record, such as ethnicity, birth date, etc?**

- Yes  No

**2.23.1 If yes, please provide a description of your current policy and procedure or a report of a past data validity review.**

**2.24 How does your organization know if changes are required for your information systems in order to meet requirements of the State Medi-Cal Program?**

**2.24.1 How are required State and local policy changes communicated to the staff responsible for implementing the policy change in the information systems (IT staff or vendor)?**

**2.25 Who is responsible within your organization for meeting the State Medi-Cal regulatory requirements (Director, CEO, CFO, COO)?**

## 2.26 Security

**2.26.1 Please describe the frequency of back-ups which are required to protect your Primary Medi-Cal information system(s). Where is the back-up media stored?**

**2.26.2 Describe the controls used to assure that all Medi-Cal direct services are entered into the system (e.g., control numbers, daily audits, and/or data entry logs).**

**2.26.3 Please describe your policy and procedure for password control on your Medi-Cal system(s). For example, how often do you require that passwords be changed?**

**2.26.4 Please describe the provisions in place for physical security of the computer system and manual files. Highlight recent changes which address current HIPAA Security requirements.**

- Premises
- Documents
- Computer facilities
- Terminal access and levels of security

**2.26.5 What other individuals have access to the computer system? Contract Providers, Network Providers, Consumers? Describe how your MHP manages such access controls.**

## ***Section 3***

### **Incoming Medi-Cal Claims Processing and Adjudication**

External providers (commonly known as fee-for-service providers or managed care network providers) may submit claims to the MHP with the expectation of payment. “External providers” do not submit a cost report to the MHP.

#### **3.1 Does the MHP process and pay claims from external providers?**

- Yes. Complete Sections 3 and 4.  
 No. Skip Sections 3 and 4. Go to Section 5.

##### **3.1.1 How many external providers does the MHP contract with?**

##### **3.1.2 On average, how many claims are received monthly from external providers?**

##### **3.1.3 How many claims processors are employed to process claims from external providers?**

##### **3.1.4 On average, what is the length of time between claim receipt and payment to external provider? (An estimate is acceptable.)**

**3.2 Does your MHP use a manual or an automated system to process incoming claims, adjudicate and pay claims?**

- Manual     Automated     Combination of Both

**3.3 What claim form does the MHP accept from external providers?**

- CMS 1500  
 UB-92  
 837I  
 837P  
 MHP specific form: : \_\_\_\_\_

**3.4 Please indicate whether you require the following data elements on claims submitted by external providers.**

Data Elements	Yes or No	
Patient Gender	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient DOB/Age	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diagnosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Procedure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
First Date of Service	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Last Date of Service	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Financial Responsibility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provider Specialty	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Client identification number	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**3.5 How many diagnoses and procedures are captured on each incoming Medi-Cal claim?**

Provider/Provider Group Data	Number	
	Diagnoses	Procedures

**3.6 When processing incoming claims, can you distinguish between principal and secondary diagnoses?**

- Yes, then explain:  
 No

**3.7 Please explain what happens if a Medi-Cal claim is submitted by an external provider and one or more required fields are missing, incomplete or invalid. How does the person processing the claim handle the problem?**

**3.8 What steps do you take to verify the accuracy of information submitted on the claim? (Procedure code or diagnosis edits, date edits such as service date after admission date and before discharge date, etc.)**

**3.9 Under what circumstances can the MHP staff person receiving incoming Medical claims change information on the claim? If you have a written policy for such changes, please note such policy.**

**3.10 Identify any instance where the content of a field is intentionally different from the labeled description or intended use of the field on a standard form such as a CMS 1500 or UB-92.**

**3.11 Please indicate the percentage of claims submitted directly from the provider and those processed by an intermediary such as a service bureau or clearinghouse?**

Source	Received Directly from Provider	Submitted through an Intermediary
Provider Network	%	%

**3.11.1 If the data are received through an intermediary, what changes, if any, are made to the data by the intermediary?**

**3.12 Please indicate which code sets are required by your MHP on claims received from external providers.**

<b>Coding Scheme</b>	<b>Inpatient Diagnosis</b>	<b>Inpatient Procedure</b>	<b>Outpatient Diagnosis</b>	<b>Outpatient Procedure</b>
ICD-9-CM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPT-4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCPCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UB Revenue Code	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DSM-IV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MHP Internal Code	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not Required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3.13 Does your MHP maintain provider profiles in your information systems?**

Yes  No

**3.13.1 If yes, what provider information is maintained in the provider profile database; e.g., languages spoken, special accessibility for individuals with special health care needs?**

**Please describe.**

**3.14 Please describe how external provider directories are updated, how frequently, and who has “update” authority.**

**3.15 How are the Charge Rate table and external provider compensation rules maintained to assure proper claims payment by your MHP? Who has “update” authority?**

**3.16 Describe how you review incoming Medi-Cal claims from external providers to assure that they are adjudicated correctly. Provide a list of the specific edits that are performed on claims as they are adjudicated. Please indicate if each element is manual or automated.**

Edits	Automated / Manual	
	<input type="checkbox"/> Automated	<input type="checkbox"/> Manual
	<input type="checkbox"/> Automated	<input type="checkbox"/> Manual
	<input type="checkbox"/> Automated	<input type="checkbox"/> Manual
	<input type="checkbox"/> Automated	<input type="checkbox"/> Manual
	<input type="checkbox"/> Automated	<input type="checkbox"/> Manual
	<input type="checkbox"/> Automated	<input type="checkbox"/> Manual
	<input type="checkbox"/> Automated	<input type="checkbox"/> Manual
	<input type="checkbox"/> Automated	<input type="checkbox"/> Manual
	<input type="checkbox"/> Automated	<input type="checkbox"/> Manual

**3.17 How does your MHP monitor the accuracy and productivity of individual staff that have responsibility for adjudicating incoming Medi-Cal claims from external providers?**

**Section 4**

## Automated Incoming Medi-Cal Claims Processing

**4.1 Do you use an automated system to process Medi-Cal claims from external providers?**

- Yes, then complete Section 4.  
 No, then skip to Section 5.

**4.2 Please describe any major systems changes/updates that have taken place in the last three years in your Medi-Cal claims adjudication and payment system. (Provide specific dates on which changes were implemented.)**

- New claims processing system purchased and installed to replace old system.  
 New claims processing system purchased and installed to replace most of the old system; old system still used.  
 Major enhancements to old system (describe enhancements).

**Provide a description of changes or enhancements.**

**4.3 Have any of these changes influenced, even temporarily, the quality and/or completeness of the Medi-Cal claims data that are collected? If so, how and when?**

**4.4 How many years of incoming Medi-Cal claims data are retained on-line? How are historical Medi-Cal claims data accessed when needed?**

**4.5 To what extent are incoming Medi-Cal claims data processed on-line vs. batch? If batch, how often are they processed?**

**4.6 Please describe how diagnostic and procedure codes for incoming Medi-Cal claims are edited by your system for validity.**

**4.7 Describe how Medi-Cal claims are suspended/pended for medical review, for non-approval due to missing authorization code(s) or for other reasons. What triggers a processor to follow up on “pending” claims? How frequent are these triggers?**

**4.8 Please identify major sub-systems which are used by the MHP to adjudicate and pay Medi-Cal claims. Please describe any merge processes which are required as part of your claim adjudication and payments process. You may attach a simple graphical representation of these sub-systems.**

**4.9 Beginning with receipt of a Medi-Cal claim in-house, describe the claim handling, logging and processes that precede automated adjudication.**

**4.10 Discuss the pre and post adjudication audits that are performed on incoming Medi-Cal claims to assure the quality, accuracy and timeliness of processing.**

**4.10.1 Pre adjudication audits**

**4.10.2 Post adjudication audits****4.11 Describe how your system's procedures handle validation and payment of Medi-Cal claims when procedure codes are not provided.****4.12 Does the system generate a remittance advice (e.g., EOB)?**

Yes  No

**4.12.1 Does your system generate a HIPAA transaction for the remittance advice?"**

Yes  No

**4.13 Does the system generate an authorization advice (e.g., letters)?**

Yes  No

**4.13.1 Does your system generate a HIPAA transaction for the authorization letter?**

Yes  No

**Section 5****Summary of Requested Documentation**

Please label all attached documentation as described in the table. Remember, you are not limited to providing only the documentation listed below; you are encouraged to provide any additional

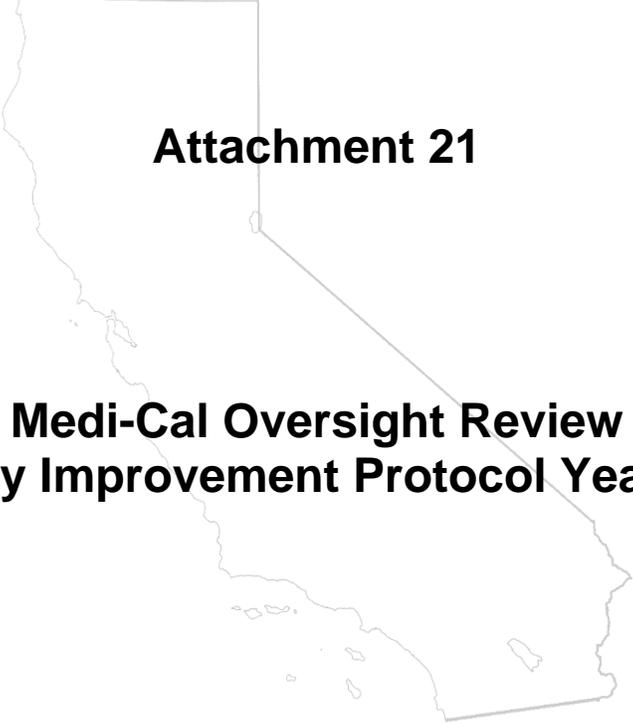
documentation that helps clarify an answer or eliminates the need for a lengthy response.

<b><u>Requested Document</u></b>	<b><u>Details</u></b>
Prior Reviews	If you have had prior formal external reviews of your information systems, please provide a copy.
Organizational Chart	Please attach an organizational chart for your MHP. The chart should make clear the relationship among key individuals/departments responsible for information management.
Prior Internal Audits	If you have recently done an internal audit of your Medi-Cal claims submissions or your Medi-Cal claims adjudication from external providers, please attach a copy for review.
Implementation Project Plan	If you are planning a new system installation and have an available project plan, please attach a copy of the plan.
County Operated Programs and Clinics	List those that bill Medi-Cal, include name, address, and type of program (i.e., outpatient, day treatment, and/or inpatient).
Contract Providers	List those that bill Medi-Cal, include name, address, and type of program (i.e., outpatient, day treatment, and/or inpatient).



**CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION**

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**Attachment 21**

**Medi-Cal Oversight Review  
Quality Improvement Protocol Year One**

## Medi-Cal Oversight Review Quality Improvement Protocol Year One

#	Criteria	Comments	Compliance	
			Yes	No
<b>1.</b>	<b>The MHP QI program includes the active participation of the following stakeholders in the ongoing planning, design, and execution of the QI program:</b>			
1a.	Practitioners/providers			
1b.	Beneficiaries			
1c.	Family members			
<b>2.</b>	<b>Regarding the Quality Improvement Committee (QIC) Meetings:</b>			
2a.	The QIC meeting is held as frequently as described in the QI Plan.			
2b.	All minutes are dated.			
2c.	All minutes are signed.			
<b>3.</b>	<b>The QIC is involved in, or overseeing, the following QI activities:</b>			
3a.	Recommending policy changes			
3b.	Reviewing and evaluating the results of QI activities			
3c.	Instituting needed QI actions			
3d.	Ensuring follow-up of QI processes			
<b>4.</b>	<b>The Annual QI Work Plan:</b>			
4a.	The MHP evaluates the effectiveness of the QI program and shows how QI activities have contributed to improvement in clinical and beneficiary service.			
4b.	The MHP incorporates relevant culturally competent and linguistic standards into the Work Plan.			
4c.	The Work Plan monitors previously identified issues, including tracking of issues over time.			
<b>5.</b>	<b>QI Work Plan - Monitoring the service delivery capacity of the MHP as evidenced by:</b>			
5a.	A description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system			
5b.	Goals for the number, type, and geographic distribution of mental health services.			

#	Criteria	Comments	Compliance	
			Yes	No
<b>6.</b>	<b>Monitoring and conducting activities to meet goals for the accessibility of services as evidenced by:</b>			
6a.	Timeliness of routine mental health appointments			
6b.	Timeliness of services for urgent conditions			
6c.	Access to after-hours care			
6d.	Responsiveness of the 24/7 toll-free number			
<b>7.</b>	<b>Monitoring and conducting activities for beneficiary satisfaction as evidenced by:</b>			
7a.	Annual survey of beneficiary satisfaction			
7b.	Annual evaluation of beneficiary grievances and fair hearings			
7c.	Annual review of requests for changing persons providing services			
7d.	Information to providers of the results of the beneficiary/family satisfaction surveys			
7e.	Completion of consumer satisfaction surveys in the threshold languages			
7f.	Satisfaction survey results in each threshold language indicating that at least 75% of the respondents had access to written information in their primary language.			
<b>8.</b>	<b>Monitoring the Service Delivery System as evidenced by:</b>			
8a.	Relevant clinical issues, including the safety and effectiveness of medication practices, are identified.			
8b.	Interventions are implemented when occurrences of potential poor care are identified.			
8c.	Providers, beneficiaries, and family members are evaluating data to identify barriers to improvement related to clinical practice and/or administrative aspects of the delivery system.			
<b>9.</b>	<b>Monitoring provider appeals:</b>			
9a.	The MHP has a mechanism to track provider appeals.			
<b>10.</b>	<b>Latino Access:</b>			
10a.	When required, a Latino Access Study has been implemented or completed.			