

CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION STATEWIDE REPORT

FY2006 (July 1, 2005 - June 30, 2006)

VOLUME I OF II



PRESENTED TO
CALIFORNIA
DEPARTMENT OF MENTAL HEALTH



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YEAR TWO



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

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CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

Executive Summary

California External Quality Review Organization (CAEQRO), a division of APS Healthcare, was engaged by the California Department of Mental Health (DMH) to meet the requirements of Title 42, Code of Federal Regulations, Section 438.2. As in FY05, CAEQRO was committed to evaluating access, timeliness and quality for every mental health plan (MHP) in California, while conducting a review of health information systems and analyzing performance measures (PMs) in compliance with the requirements of an external quality review (EQR). As such, Year Two activities were shaped by four overarching objectives:

1. Continue to support data-driven decision making to help MHPs improve business processes, clinical operations and programmatic initiatives
2. Follow up on the status of our Year One recommendations
3. Conduct MHP-customized site reviews that incorporate our Year One baseline findings
4. Identify themes that warrant additional analysis and suggest system-wide trends

The following narrative summarizes our Statewide Report Year Two which demonstrates how we met these four objectives.

FY06—A Year of Transition

Year Two was a transitional year for both MHPs and CAEQRO alike. Various environmental factors had a significant impact on the EQR process:

- **MHP Priorities and Resources.** Many MHPs were and continue to be in the process of selecting or implementing new information systems. Clearly this process affected our health information systems review—the Information Systems Capabilities Assessment (ISCA). It also meant that many MHPs still do not have the information systems resources for data-driven decision making. And with the implementation of the Mental Health Services Act (MHSA), most counties were in the process of developing and gaining approval for their Community Services and Support plans. The MHPs often dedicated resources and staff priorities to this important initiative and consequently diverted away from particular areas of the EQR process.
- **CAEQRO's Data Analytic Capability.** In Year One, CAEQRO devoted substantial resources to building an information systems infrastructure to support the huge volume of eligibility and claims data provided by DMH. In Year Two, we focused our attention on automating these various data exchange processes, improving the work products, and building the foundation for complex multivariate analyses in Year Three.

CAEQRO also intends to use this data to promote active discussions among all stakeholders about the system of care at the local level and what individual MHPs can do to improve it. We are establishing a folder on our Web site,

www.caegro.com, that contains pivot table reports of all data analyses at the individual MHP level. We are including directions about how to use these pivot tables and offer formal training opportunities.

Highlights of Our FY06 Report

Below we summarize the narrative portion of Volume I of our state report. Immediately following the narrative portion of this report, and contained in Volume II, is a series of 25 attachments that supplement the narrative portion of this report. In a separate document, Volume II, we provide summaries of 56 individual MHP reports.

Recap of our processes

- **Section 1: Work Process.** Within an environment of transition and the implementation of MHSA, we conducted our Year Two review, which was comprised of the following two work processes:
 - **Performance Measures Analysis.** After a series of discussions with CAEQRO, DMH determined that an in-depth analysis of “cost per unduplicated beneficiary served” would produce the most useful information on MHP business operations, clinical practices and programmatic orientation.
 - **MHP Site Reviews.** CAEQRO conducted a large-scale review of 56 California MHPs—which, with the addition of Solano and Alpine MHPs, comprises two more than in Year One. While the fundamental structure of our reviews was unchanged from Year One, we incorporated a number of process improvements that reflected DMH and MHP feedback and drew upon our Year One experience.
- **Section 2: Process Tools and Resources.** Our overarching objective throughout this year’s site review process was to continue providing MHPs with guidance on how to track and measure quality improvement, while building on the fundamental concepts of performance management that we introduced in Year One. Consistent with this objective, we offered each MHP increasingly sophisticated individualized technical assistance—based on our Year One findings and on our Year Two data analyses. We also expanded the number of group training we provided to those MHPs that shared concerns around access and that requested assistance with the Performance Improvement Project (PIP) process.
- **Section 3: ISCA Process and Revision.** Although the ISCA process is mandated by Centers for Medicare & Medicaid Services (CMS), the federal protocol serves only to provide guidance on the intent, process and purpose of a health information systems review. In FY05, CAEQRO technology analysts convened an MHP stakeholder work group and engaged in a thorough field review that included input from DMH. The end result of this inclusive process was the ISCA 5.7L. In response to feedback from MHPs and the CAEQRO staff, we streamlined the ISCA process in FY05 and facilitated a comparable stakeholder review process that resulted in the improved ISCA V6.1, which is the common survey instrument for all MHPs in FY07.

FY06 findings

As in Year One, our findings include both quantitative and qualitative analyses—as the latter remains critical to a comprehensive assessment of performance and performance improvement for California’s complex MHP system:

- **Quantitative analyses and findings.** In this year’s report, all of our findings are informed by quantitative data analyses. In addition to the mandated ISCA review and the Performance Measures analyses, we were able to quantify our findings on MHP site reviews and offer fairly extensive additional data analysis in which we display both statewide and California No Los Angeles (CANOLA) data in a variety of graphs, charts and tables. For certain key areas, we also display and review MHP-specific data.
- **Qualitative analyses and findings.** In addition to the data analysis that informed our site review findings, CAEQRO had to incorporate a substantial body of information—including feedback from a wide range of stakeholders. Our qualitative analysis is most evident in our narrative on the strengths and challenges that we identified across all MHPs after reviewing the 56 MHP summaries contained in Volume II of this report.

We list our findings below, along with the section in which we discuss them:

- **Section 3.3—ISCA Findings.** Overall, our findings underscored the fluidity, the disparity, and consequently the increased need for collaboration within the health information systems environment in California. These data also illustrate the need for broad stakeholder participation in the selection and implementation process of new information systems. For example:
 - Seventy-three (73) percent of MHPs are considering, selecting or implementing a new system.
 - Twenty-nine percent of MHPs that are in the process of selecting or implementing new systems are planning electronic health record modules.
 - One-third of small counties lack a data analytic capacity (and are often more reliant on vendors than are medium and large counties)
- **Section 4.2—Site Review Findings.** Our site review findings cover three categories:
 - **Follow up on Year One recommendations.** Fifty seven percent of 162 Year One recommendations addressed information system replacement and/or implementation; quality improvement committee and associated PIP development; and wellness and recovery. With some exceptions, our findings indicate that for most MHPs these areas all remain prominent as needing improvement.
 - **Priority areas for MHP-specific and system-wide improvement.** Below we provide highlights from areas that we targeted for review in FY06:

- Almost 50 percent of all MHPs showed progress toward developing a quality management system including an active measurable plan. Other key indicators of quality improvement, such as cultural competence and penetration/retention, still need attention.
- With exceptions, consumer/family members view the system as providing fewer services with a smaller staff. Those employed by the system express the most frustration, alienation and low morale.
- Despite high workloads in the midst of changing documentation and accountability burdens, MHP staffs reported good morale when they viewed management as communicative, value-driven and consistent.
- Contract providers almost uniformly felt excluded from MHP business practices and burdened by the high degree of duplicative manual data entry.
- o **Analyses of strengths and challenges.** Because of the complexity of this process, we chose to assess strengths and challenges within 13 areas that we believe need to be targeted for both MHP-specific and system-wide improvement. Below we provide highlights from these areas that we targeted for review in FY06:
 - While access to data was more frequently cited as a strength than in Year One, most MHPs—regardless of size—still appeared unclear about what data they could generate, what data they really need, and how to use the data they do receive.
 - Wellness and recovery are still in a formative stage throughout the system.
 - Information systems or operations together represent the most significant source of challenges for all MHPs—regardless of size.
 - While a few MHPs monitor clinical or business practices, MHPs tend to focus on documentation standards and utilization reviews—i.e., compliance—instead of true quality improvement activities.
- **Section 4.2.1—Performance Measures Analyses.** We analyzed “cost per beneficiary served” against a number of demographic variables, including gender, ethnicity and race. Overall, our data illustrate marked differences among beneficiaries in the type and intensity of services they receive. Gender and race disparities are particularly striking: female beneficiaries have lower service costs than do males, as do Hispanic beneficiaries in comparison with White beneficiaries.
- **Section 4.3—PIP Findings.** In Year One, we reviewed 54 MHPs, each of which was to have one PIP, at least in concept. In Year Two, DMH required that those MHPs that had undergone the review process in FY05 were to have one clinical PIP and one non-clinical PIP. Two new MHPs—Alpine and Solano—were

reviewed by CAEQRO in FY06. Using the PIP Validation Tool, we scored 54 PIPs in FY05 and 110 PIPs in FY06.

As in Year One, PIPs constituted the most challenging area for the majority of MHPs—particularly given the increase in Year Two requirements. Overall, the results were uniformly disappointing and showed little improvement over Year One.

- **Section 4.4—Additional Data Analysis.** As with our PM analyses, these data demonstrate that cost and service patterns differ significantly by demographic variables and among MHPs. For example:
 - MHP penetration rates for foster care beneficiaries ranged from 11 percent to 96 percent.
 - Penetration rates and costs for foster care beneficiaries differed based on ethnicity.
 - A wide disparity exists in various retention rates among MHPs: For example, 12 percent to 42 percent, with a statewide average of 20 percent for beneficiaries who receive 3 services or less.
 - High-cost beneficiaries (+\$30,000 for CY05) represent 1.91 percent of the population receiving services, yet account for 23.38 percent of the cost of care in CY05.

As a very large and heterogeneous state, California represents a variety of ethnicities with varying lifestyles. CAEQRO encourages all stakeholders to consider the relevance of our findings to local operations and programs—particularly in service evaluation, and planning and development activities.

Themes, Exemplary Practices and Emerging Trends

In our Year One report we described seven system-wide themes that we identified predominantly through extensive reviews of the narrative portions of 54 MHP reports. During Year Two, we not only had the benefit of our Year One review as a knowledge base, but also performed the following additional data analyses in extracting high-level themes that capture our report's significant findings. As a consequence of this analysis, several Year One themes no longer had system-wide importance, while others appeared to emerge as trends. In some cases, while a theme still indicated systemic issues, individual MHPs were able to accomplish individual solutions to what remain systemic issues. Section 5 includes these "exemplary practices" and discusses those trends that reflect our Year Two findings. We conclude with a system-wide look at access, timeliness and quality—three variables that are an integral part of our Year Two processes and findings.

Highlights of Section 5 are listed below:

- Many MHPs significantly improved their internal communication, especially between quality improvement and information systems staffs.

- Access to data also improved. However, many MHPs still had difficulty in understanding what their data means or even what questions to ask to gain an understanding. Consequently, many MHPs still do not use data for strategic planning and quality improvement.
- Small counties continued to demonstrate difficulties in meeting the specific regulatory requirements of managed care. These processes assume a much higher number of beneficiaries managed by an individual MHP.
- Operating existing or implementing new information systems continues to represent the highest area of risk for MHPs.
- Difficulties in access and timeliness occur across the system. While some factors are beyond MHP control, cumbersome processes and adherence to traditional service models strongly contribute to these issues.
- With few exceptions, quality assurance and compliance activities remain the major job responsibilities of quality managers—instead of genuine quality improvement/management.

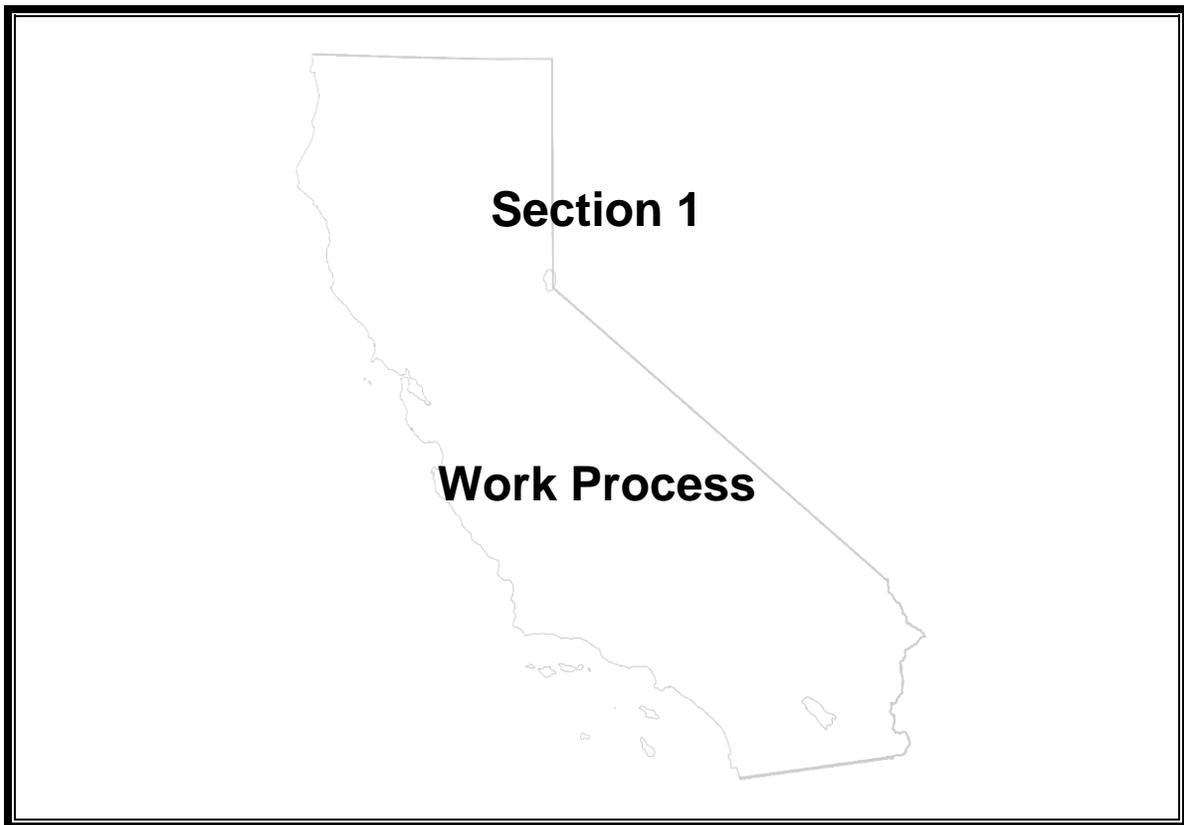
During Year Three, we plan to place increased emphasis on how data can lead to quality improvement and strategic decision making. The vast database that CAEQRO has developed for analysis contains all of the Medi-Cal service contracts, with attending detailed demographic data and the type of services received by each beneficiary. This information is a critical departure point for the “conversations about quality” that CAEQRO initiated in Year One, continued in Year Two, and will focus on in Year Three.

CAEQRO Activities





CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Section 1.1: Overview

California External Quality Review Organization (CAEQRO), a division of APS Healthcare, was engaged by the California Department of Mental Health (DMH) to meet the requirements of Title 42, Code of Federal Regulations, Section 438.2. As in FY05, CAEQRO was committed to extending the value of an external quality review (EQR) beyond a compliance-focused assessment of every mental health plan (MHP) in the state and an analysis of performance measures (PMs). As such, Year Two activities were shaped by three overarching objectives:

1. Continue to support data-driven decision making to help MHPs improve business processes, clinical operations and programmatic initiatives
2. Continue Year One's "conversation about quality"
3. Implement changes to improve upon the Year One EQR process

CAEQRO also recognized that Year Two was a transitional year in which we gained significant data reporting capabilities that will further enhance our EQR activities in Year Three. Within this context, we conducted our Year Two review which was comprised of the following two work processes:

- **Performance Measures Analysis.** In working with DMH to determine PMs for FY06, we discussed both the advantages and the drawbacks of analyzing different variables. Key to this process was an assessment of the usefulness of the particular data set relative to these objectives and to the mental health system's fundamental goals: to promote and increase access to care. After a series of discussions with CAEQRO, including a review of our findings from two preliminary data analyses, DMH determined that an in-depth analysis of "cost per unduplicated beneficiary served" would produce the most useful information on MHP business operations, clinical practices and programmatic orientation.
- **MHP Reviews.** CAEQRO conducted a large-scale review of 56 California MHPs. The review team consisted of staff and senior consultants with clinical and information systems expertise. While the fundamental structure of our review process was unchanged from Year One, our Year Two orientation was MHP-specific, reflected MHPs' feedback and drew upon our Year One experience. To support this targeted focus, we implemented the following changes:
 - A substantially improved notification packet that included MHP-specific agenda items and data reports, as well as a variety of new instructional materials and guidelines
 - The addition of an expert psychiatric quality reviewer who, in addition to reviewing each MHP's Performance Improvement Project (PIP) or PIPs, participated in the post-site review process to gather any additional information that surfaced during the site review
 - A streamlined and more data-focused report template that not only established a consistent framework for documenting site review findings, but also supported our ability to offer quantitative and qualitative analyses

In addition to these two core processes, we offered a breadth of technical assistance which is described in Section 2.3. The remainder of this section provides a detailed discussion on these two areas.

Section 1.2: Performance Measures Analysis

DMH considered several options for the Year Two PM analysis. The final three options were as follows:

1. “Cost per unduplicated beneficiary served” in relation to a number of variables such as gender, age, ethnicity and service patterns
2. Diagnosis as related to a number of variables
3. Characteristics of beneficiaries served through Early and Periodic Screening, Diagnosis and Treatment (EPSDT) funding

Below we summarize the analytical process contributing to DMH’s decision that CAEQRO should focus on “cost per unduplicated beneficiary served.” Attachment 1 displays the MHP size categories that CAEQRO applied in performing data analysis for our Year Two report.

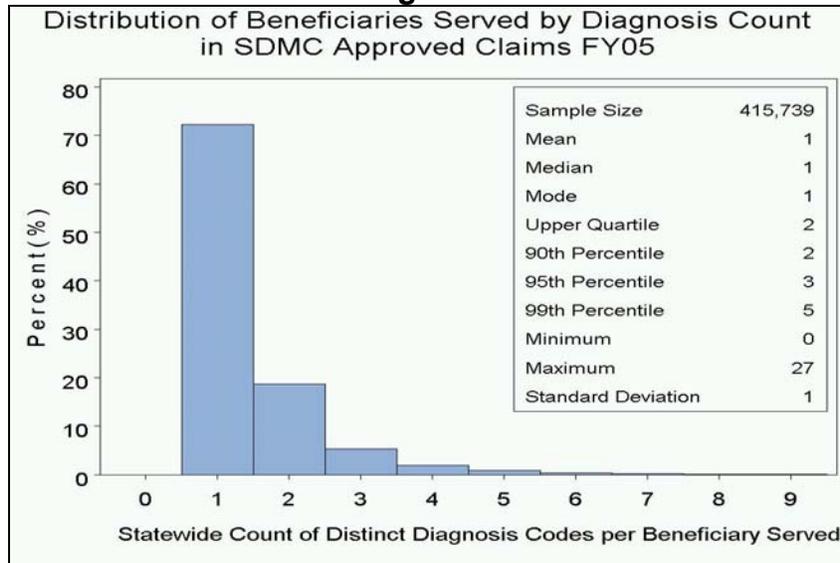
Performance Measures Review

DMH and CAEQRO engaged in a number of productive discussions that addressed both the benefits and drawbacks of each proposed PM:

- **Cost per unduplicated beneficiary served.** CAEQRO and DMH both agreed on the importance of analyzing variables associated with the “cost per unduplicated beneficiary served.” To promote and increase access to care are major goals of California’s mental health system. However regional differences in funding levels warrant consideration when analyzing the findings related to cost per unduplicated Medi-Cal eligible person served. Because of different funding levels, MHPs have varying abilities to match the Federal Financial Participation portion of Medi-Cal reimbursement. The differences across MHPs in turn affect the funds available for potential services to the population eligible for Medi-Cal within a particular county. Nevertheless studying the variations across and within an MHP in the cost of services for those who do access the system can provide important information associated with an MHP’s processes, programs and organizational structure.
- **Diagnosis as related to a number of variables.** Diagnoses are an additional key variable for analysis. However most MHPs still rely upon paper charts and generate billing encounters manually. The current diagnosis in the chart and that used for the claim are often not the same. The MHP has little if any incentive to bear the costs of manually updating the claims diagnosis, since the claim will be paid if it contains a diagnosis eligible for reimbursement without confirmation of its validity for that beneficiary. To provide some quantifiable evidence of this hypothesis, CAEQRO performed two preliminary analyses based on Short-Doyle/Medi-Cal (SDMC) approved claims to look at a sampling of diagnoses:

1. **Number of diagnoses.** We first looked at how many diagnoses were associated with each person during one full year. During an intake and assessment period, individuals typically receive a preliminary diagnosis. Often that diagnosis is changed or at least refined as services continue. However, over 70 percent of beneficiaries had only one diagnosis during one year, while almost 20 percent had only two diagnoses in the same period. These results, which are displayed below, supported the hypothesis shared by both CAEQRO and independent experts with whom we consulted—the claims diagnosis was likely not updated by MHPs on a regular basis:

Figure 1



2. **Problematic diagnoses.** CAEQRO also selected the following three “problematic” diagnoses, often used as introductory “placeholders,” which should therefore have only a few initial claims: “psychosis not otherwise specified (NOS); “deferred”; and “no diagnosis.” Customary clinical practice involves developing a more precise diagnosis, followed by visits associated with that diagnosis. In addition we looked at “dysthymia,” which is both a targeted diagnosis and an initial diagnosis that, if valid, is often treated on a short-term basis and would appropriately have a limited number of claims.

Listed below are our summary findings:

- Clients with “deferred” Axis I diagnoses averaged 10 claims per person
- Clients with “no diagnosis” averaged six claims per person
- “Psychosis NOS” averaged 15 claims per person
- Clients with a diagnosis of “dysthymia” averaged 24 claims per person

Figure 2 below also shows the results of this analysis:

Figure 2

SDMC Problematic Diagnoses for FY05						
Diagnosis	Claims Count	Beneficiaries Served	Claims per Beneficiary	Total Approved Claims	Approved Claims per Beneficiary	Payment per Claim
Psychosis NOS	380,860	26,129	15	\$68,267,650	\$2,613	\$179
Dysthymic Disorder	488,757	20,419	24	\$58,502,262	\$2,865	\$120
Deferred on Axis I	402,137	40,550	10	\$35,275,076	\$870	\$88
No Diagnosis	14,148	2,558	6	\$2,111,250	\$825	\$149
Totals	1,285,902	89,656	14	\$164,156,238	\$1,831	\$128

These results, particularly given the numbers of beneficiaries and the large number of approved claims, again seemed to support our view that an analysis of claims diagnoses was not a useful activity. In other words, these data seemed to confirm the CAEQRO hypothesis that a Medi-Cal claim diagnosis is unlikely to be a valid reflection of the final clinical diagnosis. Therefore further analysis based on the Medi-Cal claims diagnosis would not be useful.

- **Early Periodic Screening, Diagnosis and Treatment.** While EPSDT funding represents the most predominant funding source for children and adolescents, DMH felt that specific attention to one beneficiary population would be better postponed to a later year after a variety of analyses on the entire population had occurred.

Performance Measures Variables

Based on CAEQRO's assessment, DMH agreed that cost per unduplicated beneficiary served could produce valuable findings on MHP business practices, clinical operations and programmatic orientation. DMH proposed that CAEQRO analyze the following variables:

1. Cost per unduplicated beneficiary served by age group
2. Cost per unduplicated beneficiary served by gender
3. Cost per unduplicated beneficiary served by race/ethnicity group
4. Cost per unduplicated beneficiary served by service activity category

After reviewing the first set of analyses, CAEQRO did a more complex analysis to better understand the meaning of the initial results:

1. Cost per unduplicated beneficiary served by service activity category and age group
2. Cost per unduplicated beneficiary served by service activity category and gender
3. Cost per unduplicated beneficiary served by service activity category and race/ethnicity group
4. Cost per unduplicated beneficiary served by aid code plus other variables

To arrive at our findings, which we discuss in Section 4, we analyzed these variables within the following categories:

1. By MHP size and DMH region
2. At three different levels—statewide, California Not Los Angeles (CANOLA) and individual MHP

Performance Measures Methodology

All PMs for cost per beneficiary served are an average dollar amount based on SDMC and Inpatient Consolidation Claims files for specialty mental health services provided in calendar year 2005. To arrive at average dollar amounts, CAEQRO data analysts combined three types of service activities that have different associated costs, service patterns and billing methodologies (i.e., low volume/high cost services are billed either as a day or a program, and high volume/lower cost services are billed in incremental minutes). CAEQRO data analysts developed a common methodology to compare cost per beneficiary served across all MHPs.

Listed below is the specific methodology that CAEQRO data analysts used to calculate cost per beneficiary served for all PMs, excluding cost per beneficiary served by service activity category or aid code groups:

1. Approved payments were first summed across services or claims for each beneficiary served within beneficiary's MHP.
2. Total beneficiaries served, average payments per beneficiary served, and standard deviations of average payments per beneficiary served were calculated according to the following variables: MHP, CANOLA, statewide, age group, gender and race/ethnicity.

Listed below is the specific methodology used to calculate cost per beneficiary served to determine the average costs of different service activity categories or aid code groups:

1. Approved payments were first summed by service activity category or aid group and for each beneficiary served within beneficiary's MHP.
2. Total beneficiaries served by service activity category or aid code group, average payments per beneficiary served by service category or aid group, and their standard deviations were calculated according to the following variables: MHP, CANOLA, statewide, age group, gender and race/ethnicity.

CAEQRO used SAS[®] 9.1 to perform analytical functions on the vast amount of data and to also complete the complex analyses. SAS[®] is widely used in the healthcare industry and government agencies for its sophisticated techniques and reliable performance in large database management.

Section 1.3: Mental Health Plan Site Review Process

Prior to initiating our site review process, CAEQRO developed a proposed schedule and coordinated those dates with the MHPs. We conducted all official communications with the MHP—from the notification letter to our receipt of MHP documents to the submission

of the final MHP report—electronically. Each site review process includes three phases: pre-site, site and post-site, and these processes, along with Year Two enhancements, are described below.

In addition, technical assistance was an integral part of our review process—from initial communications through and often beyond the completion of the final report. Section 2.3 provides a description of these activities.

Pre-site Review Process

The pre-site review process for FY06 evolved from and improved upon the process established in Year One. Pre-site activities included notifying the MHP of the upcoming site review, assisting the MHP in its preparation for the review, and reviewing MHP data and documents to prepare for the site review. Below we offer a brief description of the Year Two notification process and packet, as well as CAEQRO's internal process for reviewing the materials that the MHPs provided:

Notification process and packet

Sixty days prior to the scheduled review, the lead reviewer sent each MHP director and quality improvement coordinator an electronic copy of a comprehensive notification packet—which included a cover letter with detailed instructions and extensive instructive materials. A sample notification packet is included in Attachment 2.

The notification packet illustrates how CAEQRO incorporated feedback from MHPs to improve the Year Two notification process—particularly applying findings from Year One to target the FY06 site review. The cover letter included basic information such as the date by which the MHP and the lead reviewer should begin pre-site coordination. It also identified the different staff members, including contract providers where applicable, who should participate in the site review process. In addition, all cover letters alerted MHPs that the CAEQRO review would include an update on the status of implementing wellness and recovery principles throughout the system.

Enhancements to the packet this year focused on two key areas, which were reflective of a more tailored review process than in Year One:

- **Targeted discussions.** Specific to the MHP, each notification letter identified four to six issues or recommendations that would be discussed during the site review process. The lead and information systems reviewers identified these priority elements based on CAEQRO's Year One report on that specific MHP.
- **Consumer/family member focus group.** For Year One, CAEQRO simply requested that the group contain eight to ten participants who had experienced the service system for several years. This year each cover letter requested a specific emphasis. Most medium and large MHPs were asked to convene at least two consumer/family member focus groups. Lead reviewers provided the parameters for including individuals in those groups based upon issues noted in the Year One report, county demographics or approved claims data. For instance, some MHPs were asked to convene focus groups comprised of Latino consumers and family members; others were asked to convene groups

comprised of transition age youth, self-help center participants or individuals living in particular areas of the county.

In addition to assisting the MHP in preparing for the review, the notification packet's cover letter identified materials for the MHP to submit to CAEQRO approximately thirty days prior to the site visit. The following documents illustrate our targeted approach to each MHP review, as well as our quality improvement process:

- A completed Information Systems Capabilities Assessment (ISCA) V5.7L or Information Systems Review Supplemental Questionnaire, reflecting the streamlined health information systems review process that we describe in Section 3.2
- PIP materials—either a completed outline using the form that CAEQRO provided or any other format that adequately described the PIP(s), including supporting data, surveys, or other materials the MHP used in designing or implementing its PIP(s)
- The most recent Cultural Competence Plan and/or a Latino Access Study if either of these documents was revised since the Year One review
- 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
- 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
- The MHP's mission and vision statements
- A list of up to five current MHP strategic initiatives
- Two counties that the MHP believes are appropriate for comparison
- Other documents deemed relevant based upon CAEQRO's Year One Report of the MHP

After the detailed cover letter, the notification packet contained the following four new or expanded instructional/informational documents that supported the MHP staff in preparing for the upcoming, targeted site review process:

- Revised guidelines for organizing the consumer/family member focus group(s) and reflecting the Year Two requirements
- A worksheet displaying the MHP's most recent Medi-Cal approved claims data—which in Year Two generally included both FY04 and FY05
- A PIP outline that follows the structure of the PIP Validation Tool and encourages MHPs to explain the key areas—PIP development, implementation and analysis
- "Road Map to a PIP"—a process flow document that CAEQRO developed in March 2006 to assist MHPs in conceptualizing their PIPs

The CAEQRO lead reviewer typically had several e-mail communications and phone conferences with the MHP staff following the receipt of this information. We also again asked three senior consultants (retired mental health directors) to follow up with MHP management about background and environmental issues. These discussions were consistent with last year's process for those MHPs who were not interviewed in Year One.

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 lead site reviewers, as available
- Information systems reviewer(s) taking part in the site review and others, as available
- Consumer family/member consultant who would take part in the site review
- Site review director
- CAEQRO administrative director
- CAEQRO executive director
- Senior consultant, if applicable
- Psychiatric quality improvement reviewer, if applicable

This pre-site meeting included the team scheduled to conduct the site review, among other staff, to discuss the significant issues for each review. The agenda typically included a brief review of the MHP's documentation with particular attention to the MHP's PIP(s). We also reviewed the MHP's approved claims data, identifying areas that warranted discussion during the review. This pre-site meeting also included attention to those priority issues identified within the Year One Report or that surfaced during pre-site visit technical assistance. We gave specific attention to strengths, challenges and themes that appeared to exist across different areas within the MHP. Sections 4 and 5 of this report highlights these commonalities on a statewide basis.

In addition, CAEQRO developed consistent and detailed guidance as illustrated in the internal Site Review Template and the Consumer Family Focus Group Questions—both of which are included in Attachment 3. These documents, which are highlighted below, were designed to offer guidance to the review team rather than serve as a rigid protocol.

- **A site review template.** CAEQRO highlighted those areas that we generally found needed improvement across all MHPs:
 - Strategic planning
 - Use of data from various sources to manage the MHP's performance
 - Collaboration between staffs in programs, management, quality improvement, and information systems to ensure that relevant and timely data are available
- **Consumer/family member focus groups questions.** CAEQRO created questionnaires specific to each MHP and specific to each group (e.g., Latinos, self-help center participants, or consumers with co-occurring disorders).

Site Review Process

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, the complexity of the information systems and the number of issues warranting follow-up from the last review. On average, reviews were longer and/or consisted of more CAEQRO staff and consultants than in Year One. Core review teams included the:

- Lead reviewer
- Information systems reviewer
- Consumer/family member consultant
- Other individuals, such as additional CAEQRO staff members and consultants, depending on the variables cited above

We initiated the site review process with an introductory session to confirm the review schedule, introduce participants to each other and to gain an understanding of the issues that the MHP felt were significant. These issues typically focused on the MHP's strategic initiatives and changes in programming that had occurred over the previous year. We reiterated a CAEQRO theme acknowledging 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.

The review team discussed the Year One report with the MHP either in an extended initial session or in a smaller group session immediately thereafter. CAEQRO was interested in discussing any changes in processes that were triggered by the Year One report or the review itself. We paid particular attention to recommendations regarding issues that seemed to be affecting overall quality. We discussed the MHP's perspective on those issues and recommendations that CAEQRO found to be most significant and had described as such within the Year One report. These discussions formed the basis for evaluating these recommendations and/or challenges as "fully addressed," "partially addressed," or "not addressed" within the Year Two report.

Based upon the priorities identified during the pre-site process, site discussions included the following:

- **Additional Targeted Discussions**
 - Two active and ongoing PIPs—one identified as clinical and the other as non-clinical
 - Improvements or changes associated with cultural competence
 - Wellness- and recovery-related activities and their respective implementation status
 - Milestones or changes in the Quality Improvement Work Plan and related processes or projects
 - Consumer, family or staff surveys from the prior 12 months
 - Penetration rates and approved claims data
 - Information systems analysis, including the ISCA V 5.7L and/or supplemental questionnaire
 - MHP claiming procedures
 - Use of data, including staff collaboration and processes for data collection, reporting and analysis
- **Focus Groups and Interviews**
 - One or more focus groups with consumer/family members conducted by the CAEQRO consumer/family member consultant and assisted by a CAEQRO staff member, held off-site or after-hours as requested

- Focus group(s) with key clinical and supervisory staffs from the MHP, and key contract providers
 - Focus group(s) with consumer/family member staff members—as possible
 - Interviews with representatives from organizational contract providers
 - Interviews with information systems end-users and the business frontline staff
- **Wrap-up Session**

We also conducted a wrap-up process in which the CAEQRO team highlighted those important themes observed in the MHP's operations, as well as general issues that were raised by the MHP staff, consumers or family members. We pursued discussions with the MHP staff to evaluate these themes as issues, strengths and/or challenges. We also used this session to emphasize the necessary collaboration between staffs in programs, information systems, quality improvement and management, commenting on the MHP's successes or challenges in this general effort. In addition, we described how the final report will address the findings and recommendations in more detail, discussed the process by which the MHP would receive a draft report for review, and invited the MHP to request technical assistance when needed.

Post-site Review Process

Following each site review, the CAEQRO review staff met to summarize findings and to discuss in the content of the final report. In this meeting, the on-site team discussed the most significant issues identified during the review, and this process facilitated further identification of common themes that were identified in different sessions—and often with different participants and regarding different issues—highlighting its relevance as an overarching theme within the MHP and one which should be emphasized within the report.

The consumer/family member consultant who participated in the review process often participated in this meeting. We also jointly established the ratings on the PIP Validation Protocol. Attachment 4 includes screen shots of the PIP database and a copy of the PIP questionnaire that was used by the review team to collect data. CAEQRO engaged the services of an expert psychiatric consultant who, in addition to reviewing each MHP's PIP(s), participated in the post-site review process to gather any additional information that surfaced during the site review. This joint assessment assured inter-rater reliability for all MHPs reviewed throughout the year. In addition we discussed the need for follow-up contact with the MHP if information was incomplete or unclear.

The Report Process

Our Year Two template enabled reviewers to generate reports that were far less narrative, were more succinct and included more specific ratings than we included in the previous year's reports. This improved report template not only established a consistent framework for recording site review findings, but also supported our ability to offer quantitative and qualitative findings for individual MHPs and for comparative analyses. A sample of the report template is included in Attachment 5. Following the post-site review process, the lead reviewer was responsible for developing and writing the non-information systems sections of the report. The information systems sections were

written by the information systems reviewer and submitted to the lead reviewer, who in turn edited and incorporated sections from all members of the team into a complete and integrated report.

Each MHP report began with a status update of CAEQRO's FY05 recommendations. This section included a brief description of the recommendation, the MHP's response and a determination of whether the recommendation was "fully addressed," "partially addressed" or "not addressed." We did not expect an MHP to address an issue exactly as we had recommended, but we expected MHPs to give reasonable attention to significant problem areas.

The report also included the following major sections:

- Changes in the MHP environment—either changes within the county or other ways in which the MHP was affected by changes outside of its control (e.g., reorganization of the county structure, closure of the only community hospital, etc.)
- Overall service delivery system
- Performance measurement results
- Quality improvement processes and activities
- Consumer/family member focus group(s)
- PIP(s)
- Information systems resources and platform
- Strengths and challenges
- Site review process barriers—problems which affected CAEQRO's ability to conduct a comprehensive review (e.g., documentation not submitted prior to the review, few participants in the consumer/family member focus groups, or lack of appropriate MHP participants)
- Recommendations—suggestions on how the MHP could leverage its strengths and address its challenges
- Attachments: review agenda, review participants, approved claims data provided to the MHP, and validation tools for each PIP

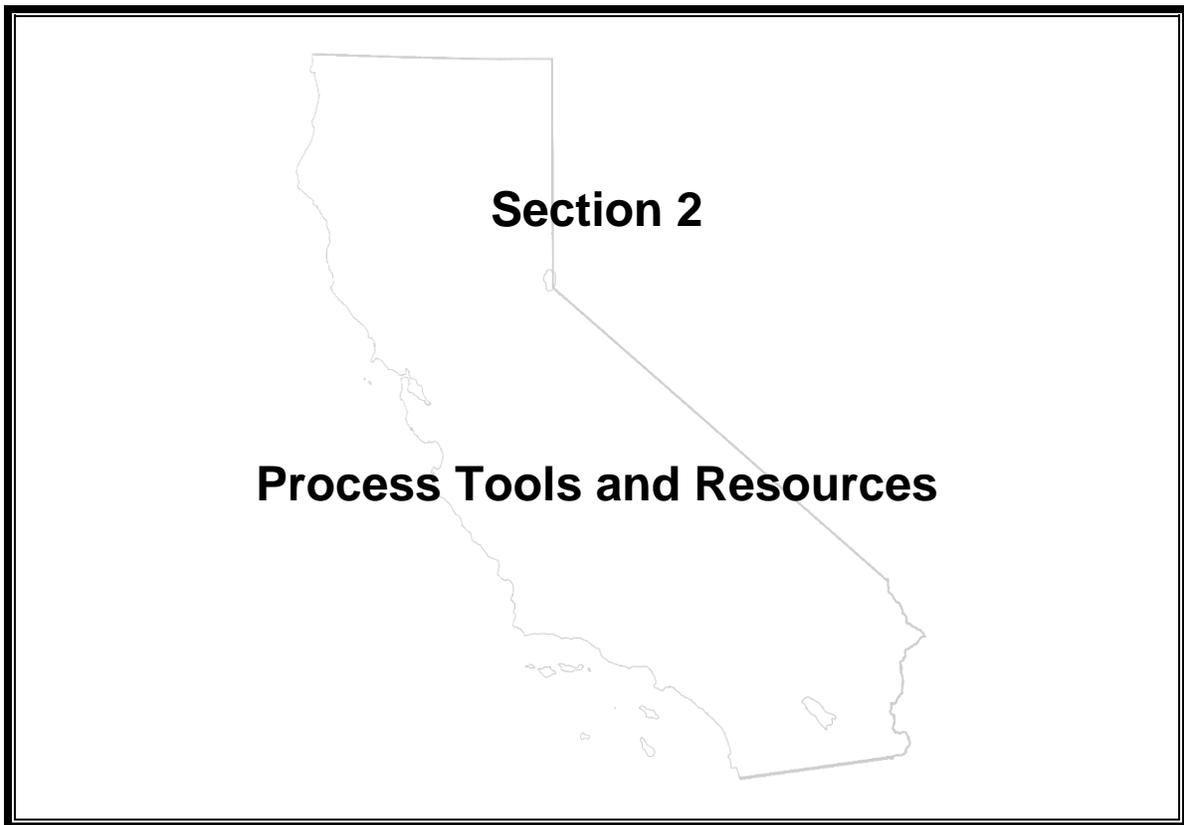
The lead reviewer then submitted completed draft reports to the site review director for further editing and then to CAEQRO's executive director for final review. The lead reviewer then sent our internally approved Outside Review Draft simultaneously to the MHP director, the MHP quality improvement coordinator and the DMH contract monitor to allow a period for review and questions or comments concerning factual inaccuracies.

In contrast to Year One, many MHPs responded with detailed questions, comments and requests for revising statements or impressions discussed in the report. Occasionally, MHPs submitted additional documentation for consideration. This process required significant coordination and discussion among the site review team for appropriate adjudication. CAEQRO responded to each comment made by the MHP prior to issuing the final report. The lead reviewer made changes to the report where indicated. Upon review, the executive director released the final report for distribution to the respective MHP and to DMH.

We include in Section 4, a detailed discussion of our consolidated findings, including a qualitative and quantitative analysis of a variety of issues that affect an MHP's approach to its quality improvement, strategic planning and business processes.



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Section 2.1: Overview

As we discussed in Section 1, California External Quality Review Organization (CAEQRO) fine-tuned and focused our Year Two reviews based on the prior year's findings. Our overarching objective throughout this year's site review process was to continue providing each mental health plan (MHP) with guidance on how to track and measure quality improvement, while building on the fundamental concepts of performance management that we introduced in Year One. Consistent with this objective, we offered each MHP increasingly sophisticated individualized assistance—based on our Year One findings and on our Year Two data analyses—and expanded group trainings, as summarized below:

- **Data Analysis.** In Year One, CAEQRO devoted substantial resources to building an information systems infrastructure to support the huge volume of eligibility and claims data provided by the California Department of Mental Health (DMH). Having established secure, administrative processes for receiving and organizing millions of data records from DMH, we focused our attention in Year Two on automating these processes—a major undertaking that positions us to provide an unprecedented level of MHP-focused strategic analysis in Year Three. For this year's review, we not only improved upon the work products that we delivered in Year One, but also developed two new reports that foreshadow the kind of complex multivariate analyses we have the ability to conduct going forward. Our internal data analytic capability continues to be significant because, for many small MHPs, CAEQRO reports provide otherwise unobtainable data that help to inform data driven decision-making. While Section 2 highlights data analysis that primarily supported the site review process, Section 4 includes data analysis that informed our findings.
- **Technical assistance and training.** As in Year One, CAEQRO provided to the MHP staff a broad range of focused technical assistance and training—which often began prior to the site review and continued well beyond our submitting the final report. In contrast to FY05 in which we focused almost exclusively on individual MHPs, we introduced in Year Two group trainings on such key topics as developing a Performance Improvement Project (PIP). The net result of such trainings was improved communication among MHPs with shared needs and increased economies of scale. However, we found that the “conversation about quality”—our orientation for Year One reviews—was for many MHPs interrupted by the need to focus on developing their respective Community Services and Support Plans—the first phase of implementing the Mental Health Services Act (MHSA). Consequently the depth of technical assistance that CAEQRO could provide varied among MHPs.

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

Section 2.2: Data Analysis

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

(PHI), necessary for CAEQRO to perform DMH analysis and calculations, conduct other oversight tasks and generate a range of reports that inform the site review process. In Year One, CAEQRO built a team of analysts with content expertise on the data available to DMH and MHP information systems staff. CAEQRO established data exchange protocols with DMH and an information systems environment to ensure the security of data—especially PHI.

CAEQRO continues to have access to a variety of source data files provided by DMH:

- Inpatient Consolidation Claims Files
- Short-Doyle/Medi-Cal Approved Claims Files
- MEDS Monthly Extract File
- Provider Files

Attachment 6 contains additional information on the frequency of updates and the processes for the secure data exchange of these source data files. This attachment also includes a description of the CAEQRO master files that we created using source data provided by DMH.

Having established secure, administrative processes for receiving and organizing millions of data records from DMH, we focused our attention in Year Two on increasingly more customized and more sophisticated work products, which are described below.

Year Two Data Analytic Capabilities

By having our data exchange processes in place and gaining familiarity with the voluminous number of data records transmitted by DMH, CAEQRO gained two distinct and related advantages in Year Two as compared to Year One:

- The ability to examine data for a broader range of variables
- The information to identify trends for individual MHPs and across MHPs

Below, we summarize the process we employed in Year Two to gain added insights into the clinical practices and business operations of each MHP:

1. **Data derived from summary reports.** While DMH provided CAEQRO with essentially the same data in Year Two as it did in Year One, we were able to enhance this information as follows:
 - **More timely...**Because we had in place our information systems infrastructure, we were able in Year Two to provide various key reports in advance of our Year Two reviews. For example, most MHPs received claims data information as part of the notification packet instead of concurrent with the site review. (In Year Three, this process is now our routine practice). Early access to this information afforded MHPs the ability to review data findings and helped to produce more useful discussions during the site review process.
 - **More relevant...**Depending on the timing of the review, we were also able to provide individual MHPs with comparative claims data from comparable

MHPs (e.g., size, demographics, etc.), in addition to regional and statewide data. In Year Three, this activity is our routine practice.

- **More in-depth...** Depending on areas of interest that were identified by the MHP and/or CAEQRO (based on Year One findings and Year Two data analyses), we provided an in-depth report on a particular category. For example, following our Santa Cruz MHP review in August of 2005, we began providing to interested MHPs special reports on claims for beneficiaries in foster care. (In Year Three, we are continuing with this kind of targeted reporting and analysis.)
2. **Data derived from database source files.** In both FY05 and FY06, DMH provided most county data in a summary report format. While these data are certainly very useful, a summary format limits the extent to which CAEQRO can sort data and thus analyze that data strategically. Beginning in Year Two and building a foundation for Year Three, CAEQRO expanded our data analytic capabilities as summarized below:
- In Year One, we received five source files (representing up to 15 million data records quarterly) from DMH to produce Performance Measurement (PM) data and replicate DMH's PM validation process. This task is a basic requirement of an external quality review organization and helps to ensure the accuracy of data and the analytic procedures for calculating PMs. We built our own database containing DMH source files but the subsequent fields we generated were exclusively to replicate PM calculation processes.
 - In Year Two, we automated the process for loading the CAEQRO database, so that we could easily populate it with DMH source data files. Given the enormity of this task and because we did not receive current source files from DMH until January 2006, we have only begun to produce sophisticated reports that compare, contrast and combine a broad range of variables. In addition to providing useful information for our FY06 Statewide Report, we are initiating this type of data analysis on a more routine basis in Year Three. Another significant enhancement was our decision to analyze the source data for the purposes of this report for the calendar year ending on December 31, 2005, rather than a fiscal year period. This change means that CAEQRO is analyzing the most currently available annual data.
 - In Year Three, we are well positioned to generate more complex and sophisticated reports comparing and contrasting a broad range of variables that can reveal significant operational trends. For example, one significant data summary from DMH has age and gender defined by eligibility categories. Consequently, we were unable to filter the data to perform a more in-depth analysis. In Year Three, we can perform a highly complex multivariate analysis that includes, for example, age, ethnicity, service category and gender.

The net advantage of having developed a solid information systems infrastructure in Year One was our ability to conduct MHP-focused reviews in Year Two, as illustrated by the following work products. As we discuss in Section 4.4, Additional Data Analysis, our

efforts in Year One and Year Two have positioned us to provide many MHPs with a wide array of important management information.

Year Two Work Product Examples

Below are examples of work products that CAEQRO generated during the course of our review process—both to support this year’s MHP-focused reviews and to build the foundation for increasingly complex and sophisticated data analyses in Year Three:

Source: Summary Reports

- **Approved claims report.** Provided in the notification packet, this report had two objectives: assist the field review teams whose members were meeting with MHP staff; and help MHPs better understand and interpret available data. CAEQRO reviewers were able to use this MHP-focused report to discuss the implications of demographics, penetration, costs per eligible beneficiary and costs per beneficiary served. This report also allowed MHPs to compare their respective results to regional and statewide findings. In addition, these reports were also reviewed by staff as part of the pre-site review process to identify issues to discuss and emphasize with MHP staff during the site review.

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

- Age Group
- Gender
- Age Group and Gender
- Race and Ethnicity
- Eligibility Categories (Aid Group)
- Service Activity

In our Year One report, we included a report detailing Medi-Cal Approved Claims Data for the fictional San Dumas County MHP—which was in fact real data for Stanislaus MHP. We chose to use a fictionalized version of a real report, since data sharing was not customary among MHPs. During Year Two, however, a number of MHPs requested county-specific comparative data in addition to regional or statewide findings. By the end of the Year Two site review process, we asked MHPs to identify comparable MHPs (e.g., size, demographics penetration), provided reports comparing penetration rates and cost per beneficiary served data, and discussed the significance of this comparative data during the site review. In keeping with this growing willingness to share information, we include in Attachment 7 actual Medi-Cal Approved Claims Data for Alameda County. Because Alameda County has a reasonably diverse population (i.e., demographics, ethnicity and cultural), it provides a representative sample of the kind of information we generated for each county.

- **Claims and demographic data analyses.** To assist the CAEQRO review team in comparing various measures across MHPs, we developed three reports, included in Attachment 8. The first report groups MHPs by population size and reflects our appreciation that certain factors do trend across MHPs in counties of

a similar size. The second report reflects DMH-defined regions, which offers a different perspective on how findings may or may not align. The third report is a statewide high-level summary of the data that we presented to each MHP. All reports were periodically updated during the year by CAEQRO data analyst staff and provided to the lead reviewers for pre-site review analysis. The lead reviewers were able to sort and filter the data to identify trends across MHPs—irrespective of size or region.

- **Geographic analyses.** As in Year One, CAEQRO provided geographical information system (GIS) technology. This software allows information to be displayed on a map and is thus much easier to interpret. Attachment 9 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.
- **Foster care analyses.** Based on the approved claims report, the CAEQRO review team noted a very high penetration rate and cost per beneficiary for foster care youth served by the Santa Cruz MHP. We conducted a special drill-down report on this population and presented this information to the MHP during the site review. Attachment 10 is the example of the report produced for Santa Cruz. We also provided the same report to a number of other MHPs that expressed interest in further information on this high-risk group. Eventually we developed a series of new reports, which informed our findings and are discussed in Section 4. Our analysis of foster care claims became part of a significant technical assistance effort that expanded beyond foster care and is discussed in Section 2.3.
- **Denied claims analyses.** CAEQRO identified denied claims as an important area of analysis and discussion with certain MHPs, as they highlight a key indicator of potential systems issues or a possible claims production problem. We developed a new report, which is included in Attachment 11 to assist the CAEQRO review team in comparing denied claims across MHPs prior to the site review. For Year Two, we relied upon summary report data from DMH. However, CAEQRO expects to use DMH source files for Year Three analyses.
- **Completeness and timeliness analysis.** During Year One, CAEQRO used DMH's Information Technology Web Site to identify and discuss with MHPs the problem of delayed claims submission and consequently payment. We continued this procedure in year two.

Source: DMH Database

- **Claims Lag Analyses.** During Year Two, CAEQRO's claims database covered three full calendar years. Historically DMH and many MHPs initiated claims audits several months after the end of the fiscal year. For a cost reconciliation process, freezing data is appropriate, as the objective is to review information within a fixed period of time. However, this process relied on such old data that

MHPs considered the findings of no use to their management and planning activities. Therefore CAEQRO performed a classic managed care claims lag analysis of Incurred But Not Reported (IBNR) claims to determine annual volume and/or financial obligation. The CAEQRO review team discussed our findings during the site review process to facilitate discussions around clinical, business and administrative processes. Figure 1 below displays the three-year summary results for FY03, FY04 and FY05. Attachment 12 provides a drill-down analysis of each of these fiscal years.

Figure 1

Claims Lag Analysis - Three-Year Summary			
Lag Period	FY05	FY04	FY03
Current Month	18.5%	4.3%	2.8%
One Month	78.4%	74.4%	77.8%
Two Months	91.4%	90.4%	90.7%
Three Months	96.2%	93.3%	94.7%
Four Months	97.3%	96.1%	96.5%
Five Months	99.0%	97.3%	97.7%
Six Months	99.4%	98.0%	98.5%
Seven or More Months	100%	100%	100%

- Retention analyses.** CAEQRO identified service retention patterns as an important area of analysis and discussion with those MHPs that had a significant service pattern variance when compared to comparable MHPs. The analysis identified beneficiaries in the following categories for calendar year 2005: services—those receiving one, two, three, four, five, six to fifteen and more than fifteen. This information is important for strategic planning in a range of clinical and administrative areas. For example, it can help with identifying and developing outreach programs for underserved populations. However, analyzing retention data by its self can be misleading, as one needs to also consider penetration rate data to fully understand the implications of service retention patterns. To assist the CAEQRO review team in comparing service retention patterns across MHPs, we developed several reports, which are discussed, along with our findings, in Section 4.

Section 2.3: Technical Assistance and Training

CAEQRO provided a broad range of technical assistance and training—both individually with MHPs and through group forums. Informed by our Year One findings, CAEQRO was able to offer individual MHPs focused technical assistance throughout the review process—beginning with the notification packet and often continuing after receipt of the final report. We also provided additional education and training through a variety of

materials and in public forums, such as our Web site, professional association meetings and industry conferences. Finally, we participated in a full range of professional activities as part of our role as CAEQRO. Attachment 13 contains calendars that display the activities highlighted in the narrative below.

Individual MHP Technical Assistance

As in Year One CAEQRO offered and provided 56 MHPs with a wide variety of direct technical assistance in Year Two. This assistance began the day an MHP received the initial notification packet and frequently extended throughout all three phases of the review process. Some MHPs availed themselves of these services across review years; others participated little in offers for technical assistance.

Pre-site visit technical assistance

As described in Section 1.3, CAEQRO provided MHPs a comprehensive notification packet that contained both new and enhanced materials. Following the MHP's receipt of notification materials (sent sixty days prior to the site visit), the lead reviewer initiated a technical assistance process with a pre-site review call or e-mail to the identified contact person. Generally, the MHP contact was the quality improvement director or coordinator, but sometimes, in small MHPs, it was the mental health director or deputy director. Initial technical assistance over the sixty days prior to the review included the following goals:

- Discuss areas of focus within the Year Two review, including an emphasis on improvement processes within the MHP since the last CAEQRO review
- Answer questions regarding the documents requested by CAEQRO and provide guidance on key concepts, such as "strategic initiatives" and their relevance to a quality review
- Explain the relevance of the Medi-Cal approved claims summary compiled by CAEQRO
- Answer questions regarding the Information Systems Capabilities Assessment (ISCA) survey and other aspects of the information systems review, involving the CAEQRO information systems reviewer in the discussion when appropriate
- Discuss CAEQRO expectations for the consumer/family member focus group(s)
- Clarify CAEQRO's expectation for "two active and ongoing PIPs" and provide preliminary feedback on the PIPs
- Consult with the MHP on developing a detailed agenda, including its scheduling constraints and participant availability

Similar to Year One, pre-site technical assistance focused on guiding the MHP in preparing for its review and developing or improving its two PIP activities. Many MHPs submitted PIPs early in the process and requested detailed feedback on improving PIPs prior to the site review. Often, this assistance included detailed correspondence and in-depth conference calls with committees working on the

PIPs. For instance, some MHPs had conceptualized a PIP but had not developed a study question; others had the beginning elements of a PIP but requested significant feedback on developing it further. Other MHPs, further along in the process, submitted data and results for feedback on the progress and interpretation of the data.

CAEQRO used consultants with specialties in such areas as pharmacy, information systems, complex data analysis, cultural competence and wellness/recovery. In addition CAEQRO engaged a National Committee for Quality Assurance-credentialed physician reviewer to provide consultation and specific feedback on PIP documents submitted by the MHPs. Some former mental health directors also served as senior consultants, and completed the background interviews with all MHP directors begun in Year One. This enabled the site review team to tailor some review aspects to MHP needs that we identified in Year One.

Despite CAEQRO's best attempts, a few MHPs participated minimally or not at all in pre-site technical assistance. For some of those MHPs, the lack of up-front coordination affected the overall quality of the review—including difficulties in identifying and submitting the requested documentation, obtaining the participation of the appropriate staff and contractors, and organizing the requested consumer/family member focus group. When these issues occurred, we referenced them within the MHP report as site review process barriers.

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:

- **Strategic initiatives.** CAEQRO had requested that each MHP submit a list of up to five strategic initiatives prior to the review. These initiatives, generally written by the MHP director, represented systemic priorities for the MHP. Many MHPs were not familiar with strategic planning and some had line or inexperienced staff members write the initiatives. As part of the site review, CAEQRO discussed the MHP's existing priorities and those that warranted identification as high-level initiatives.
- **Quality improvement.** Throughout the reviews, CAEQRO emphasized obtaining, analyzing and applying various sources of data to improve performance throughout the system. We typically addressed the need for more meaningful quality improvement work plans, committees and processes. Since many MHPs had historically focused solely on monitoring compliance-related activities, they often requested assistance in identifying potentially significant clinical- and business-oriented indicators.
- **PIPs.** Just as in Year One, MHPs most often identified PIPs as the area of greatest need for technical assistance. Their respective difficulties are of particular concern since in Year Two, DMH required that every MHP have one clinical PIP and one non-clinical PIP "active and ongoing." The Year One

requirement was to simply have one PIP at least in the conceptual stage. Some MHPs needed assistance simply identifying potential areas that warrant the attention of a PIP. Others had identified topics but had little available data in or from their systems. For these MHPs, the site review team explored potential sources of additional data and strategies for methodology and analysis. While PIPs were in various stages of development, the CAEQRO review teams typically devoted significant time during the site review:

- Developing a strong study question
- Identifying baseline and projecting meaningful numerical indicators
- Considering potential interventions
- Targeting concrete and measurable goals for improvement

CAEQRO developed two tools to clarify PIP processes for MHPs and provided technical assistance for using those tools. In a small number of reviews, the MHPs had two well-developed PIPs that did not require significant assistance.

- **Data and information systems capabilities.** As needed, CAEQRO provided information systems infrastructure guidance, especially regarding data integrity processes, including data access and report use, as well as the involvement of contractors in these processes. Many MHPs were in the process of implementing or preparing to identify or implement a new information systems platform. CAEQRO emphasized the significance of this endeavor and offered guidance on improving/facilitating the implementation process. Technical assistance with data interpretation and with additional data reports for special MHP projects also enabled CAEQRO to meet individual MHP needs, as did tutorials about report generation within the individual MHP's capabilities. Section 2.2 contains a discussion on the wealth of data that CAEQRO provided to MHPs as part of the review process. Section 4.4 illustrates the kind of data analysis that CAEQRO performed—largely to inform our findings in FY06. In FY07, we anticipate performing these kinds of analyses to inform the site review process as well.
- **Wellness, recovery and resilience.** Given the focus of the Mental Health Services Act and the importance of this area throughout the system, CAEQRO included a discussion on wellness, recovery and resilience in every review—consistent with the agenda provided in the notification packet. We approached issues of cultural competence and consumer-driven services through a perspective of wellness, recovery and resilience. The core principles of recovery were discussed with both the staff and consumers, encouraging MHPs to develop or increase their recovery focus. The review team offered references from journals, other MHPs and/or systems to promote these processes. As was the case with many issues, MHPs varied in their need for assistance in this area.

Post-site review technical assistance

Within a week of each site review, CAEQRO convened a post-site meeting of the site review team, consultants and other members of the CAEQRO staff. A significant task for this meeting was to review and score the PIPs submitted by the MHPs. Team discussion throughout the scoring process included alternative approaches for the PIP, such as suggestions for improved study questions, clearer indicators and additional interventions—some of which were additional ideas to those provided during the review

itself. The lead reviewer conveyed some significant ideas generated through post-review team discussion to the MHP in phone calls and e-mail correspondence, or in the review report.

When necessary, lead and information systems reviewers contacted the MHPs after the review to clarify issues or discuss any other concerns. This was particularly important when MHPs had submitted new documents during the site review, or sometimes submitted new documents for consideration after the review.

After submitting the draft report to the MHP, the lead reviewer invited discussion regarding questions about the report or any of the recommendations suggested. This communication sometimes resulted in having additional supporting documentation sent, which CAEQRO then reviewed prior to completion of the final report. Sometimes the report was amended based upon post-review discussion with the MHP. Other times, discussions did not warrant changes in the report but instead highlighted areas the review team would examine at the next year's review.

At the wrap-up session during each review, we invited all MHPs to contact us throughout the year regarding their planned PIP activities or any other areas in which they needed our assistance. After the conclusion of the year's review activities, a number of MHPs have continued to maintain close contact with CAEQRO, particularly for ongoing assistance with PIP activities.

Education and Training Resources

The education and training resources that CAEQRO provided to MHPs included both written materials—offering additional instruction on how to prepare for the site review—and in-person training sessions. Both kinds of technical assistance are described below:

Education and training documents

As described earlier in this report, CAEQRO sends several documents to MHPs to assist them in planning for reviews. This year the documents CAEQRO developed for this purpose included:

- **Enhanced notification letter and packet.** CAEQRO updated the notification letters and supporting documents to assist the MHP in better planning for the review. For example, the “Consumer/Family Member Focus Group Guidelines,” was rewritten and improved based upon problems identified during MHP focus group planning or from MHP feedback. Attachment 2 contains a sample notification packet. Included in this packet was a range of customized work products described in Section 2.2., including spreadsheets detailing approved Medi-Cal claims for the prior one or two fiscal years (depending upon the timing of the review). Some MHPs previously had no knowledge of how to review approved claims data or the ways in which this data could be used to guide performance management processes.
- **Road Map to a PIP.** CAEQRO continued to identify ways to help MHPs improve their understanding of how to develop PIPs. We began the year by sending each MHP a document titled “PIP Outline.” This document was based specifically upon

the elements of the PIP validation tool, and the goal of CAEQRO was to assist MHPs in presenting all of the elements that would be examined through the validation tool. However, CAEQRO learned that not only did many MHPs continue to have difficulties submitting clear documentation of PIPs, they also did not understand how to design a good PIP. We then created the “Road Map to a PIP” to guide MHPs in developing PIPs by using a simplified yet systematic approach. The “Road Map to a PIP” became also a training tool in several joint CAEQRO-MHP presentations. While too early to assess the outcomes of using this tool, MHP feedback has been very positive. CAEQRO will continue to examine ways to foster the growth of the MHPs’ understanding of the PIP process during Year Three.

Formal group 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 the following:

- CAEQRO presented Roadmap to a PIP at a Northern California Quality Improvement Committee (NorQIC) meeting on January 27 in Sacramento. The Sonoma County MHP assisted in this presentation, using one of its PIPs as an example to demonstrate the Road Map concepts.
- CAEQRO again presented its Road Map to a PIP at the annual California Quality Improvement Committee (CalQIC) conference—a forum at which most MHPs are represented. The Butte MHP participated in this presentation, using one of its PIPs as an example to demonstrate the Road Map concepts. CAEQRO also presented a variety of approved claims and penetration rate data for MHPs to consider. Having identified four different PIP-related areas, CAEQRO facilitated the following four simultaneous break-out groups with participants:
 - How to develop a study question, including the validation of a problem and identification of potential interventions
 - How to develop PIPs about co-occurring disorders
 - How to develop PIPs about access to services—including timeliness and MHP capacity
 - How to use the “Road Map to a PIP”—for MHPs that did not participate in this presentation at the earlier NorQIC meeting
- In collaboration with California Institute for Mental Health (CIMH) and California Mental Health Directors Association (CMHDA), CAEQRO agreed to plan and present a series of full-day workshops on specific PIP areas. The first workshop on June 19 addressed the development of foster care PIPs, using the participating MHPs’ approved claims data for foster care beneficiaries. For CAEQRO, this process included preparing data for the thirteen MHPs that signed up to participate, conducting a workshop designed to analyze the data and identify potential MHP-specific PIPs from the data, and furnishing additional data for MHPs requesting additional assistance with these data after the workshop. The topic for the next workshop will also address PIPs in response to a request

from 32 small MHPs that want to participate in a similar session. In addition, a subsequent workshop, slated for FY07, will address co-occurring disorders.

- Consumer and family member CAEQRO peer reviewer training—CAEQRO provided a full day training to 15 individuals to prepare them as consumer or family member consultants on site review teams. In addition, quarterly technical assistance group phone calls were conducted for those who remained in the FY06 pool of consultants. CAEQRO commonly provided assistance to questions about group facilitation and ways to involve non-English speaking participants in the focus group process.

Web Site Resources

Recognizing that many MHPs would benefit from the same information, CAEQRO developed the Web site, www.caeqro.com, in Year One as a forum for broadly disseminating information. The Web site developed in Year One continued in Year Two as a venue for shared information among the MHPs. In Year Two, there were 597 registered users (an increase of almost 100 percent from FY05). Monthly visits to the site ranged from a low of 1,014 to a high of 2,767. Links within the CAEQRO Web site that visitors most frequently accessed included: “Calendars” and “Useful Web Sites.”

With MHP permission, CAEQRO posted a range of MHP-produced documents to provide examples to assist other MHPs, such as PIPs, ISCA surveys, Cultural Competence and Quality Improvement Work Plans. CAEQRO is committed to encouraging MHPs to share resources, knowledge and skills, and this Web site is one venue for doing so.

Other information available on the Web site includes:

- Links to other useful Web sites
- Tools for statistical analysis
- Interesting publications
- CAEQRO documents:
 - Sample notification packet
 - Site review report format
 - Year One Annual Report and power point presentation
 - CalQIC PowerPoint presentation
 - MHP site review schedule
 - Staff contact information

Inter-organization Collaboration and Professional Meetings

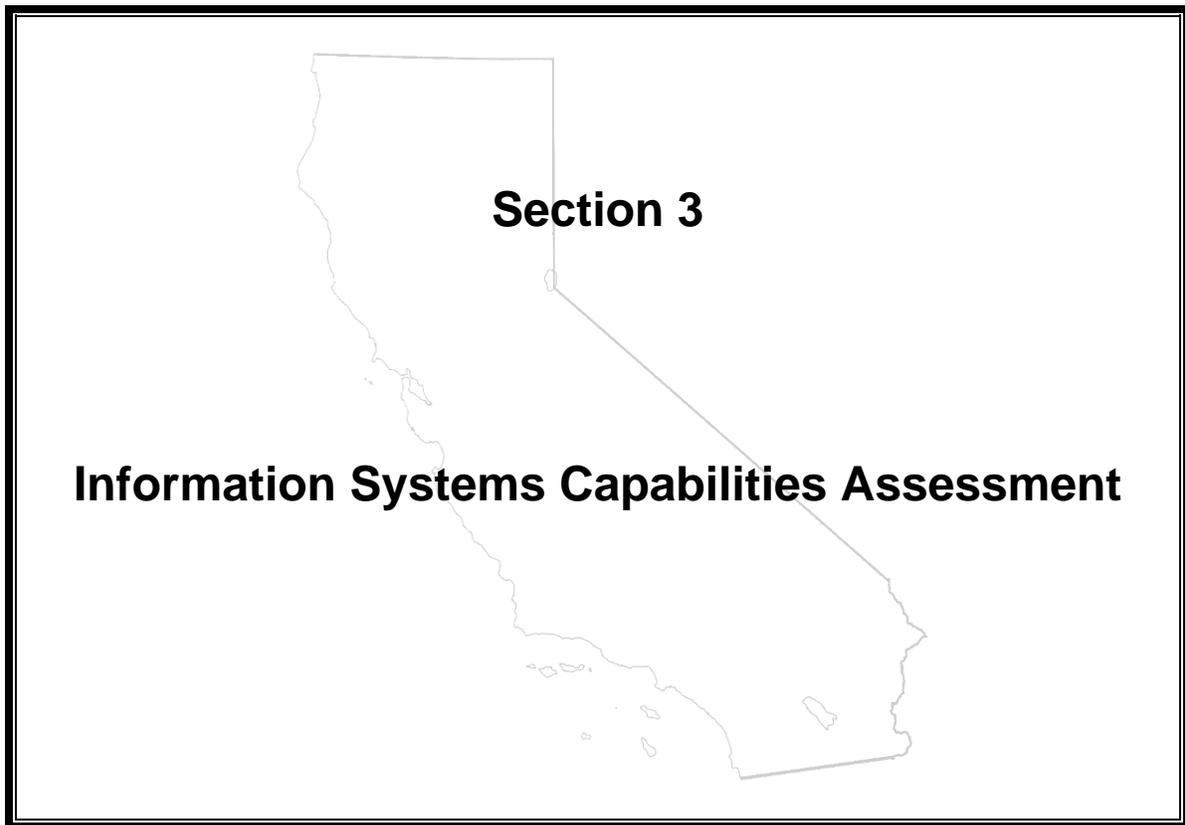
CAEQRO worked with a number of organizations throughout Year Two in a variety of capacities, and either attended or collaborated on one or more presentations at the following events:

- CAEQRO Year One Report presentations in both northern and southern California
- Annual CIMH Information Technologies conference

- ISCA revision stakeholder task force
- CMHDA meeting
- Medi-Cal Policy Committee meetings (a sub-committee of CMHDA)
- State Quality Improvement Committee (QIC) meeting
- CMHDA information systems Committee meetings
- Mental Health Service Act data planning and development meetings
- Contract liaison coordination meetings with the DMH Medi-Cal Policy and Support staff
- California Planning Council meeting
- CalQIC and regional QIC meetings
- Women's Health Partnership



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Section 3.1: Overview

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. Although the Information Systems Capabilities Assessment (ISCA) is mandated by Centers for Medicare & Medicaid Services (CMS), the model federal protocol serves only to provide guidance on the intent, process and purpose of a health information systems review.

In FY05, CAEQRO technology analysts convened an MHP stakeholder work group and engaged in a thorough field review that also included input from the California Department of Mental Health (DMH). The end result of this inclusive process was the ISCA 5.7L, which was completed in February 2005 and is included in Attachment 2. Those MHPs reviewed from February 2005 through May 2005 completed the ISCA V5.7L, which formed the foundation for our FY06 health information systems reviews. As part of our own internal quality improvement orientation, we responded, as highlighted below, to both MHP and CAEQRO staff feedback in FY05 to streamline the health information systems review process in FY06:

- **FY06 Review Process.** CAEQRO data was drawn both from ISCA V5.7L and from an Information Systems Review Supplemental Questionnaire. CAEQRO developed the supplemental questionnaire to update information that had been captured by ISCA V5.7L in the prior year. MHPs that had completed ISCA 5.7L in Year One had only to complete the supplemental questionnaire in Year Two. The remainder of the MHPs had to complete ISCA V5.7L. Our use of two survey instruments was a precipitating factor in the transition to a common ISCA that will be used throughout Year Three.
- **FY06 Analysis of Health Information Systems.** Since ISCA V5.7L and the supplemental questionnaire represent a large number of questions, we report on those categories that provide the best snapshot of the overall status of MHPs' health information systems. Our findings reflect the fluidity, the disparity and consequently the increased need for collaboration within the health information systems environment in California.
- **ISCA V5.7L Revision.** This section details the stakeholder review process that was facilitated by CAEQRO to revise ISCA V5.7L and which began in the spring of 2006. We believe that we accomplished the two primary goals of this initiative:
 - Update ISCA V5.7L to improve usefulness to MHPs, DMH and other stakeholders, in order to better assist MHPs in quality improvement efforts and business process improvement initiatives
 - Simplify and remove any redundancy in the document while still complying with federal and DMH requirements

The end result of this process is the ISCA V6.1, which is the common survey instrument for FY07 and is included in Attachment 14.

The following sections discuss each of these three areas in greater detail.

Section 3.2: Review Process

The ISCA survey is not only a mandated activity, but also a critical element of the MHP health information systems review process. Attachment 2 contains ISCA V5.7L of the ISCA survey, which CAEQRO used during our second year of operation. Developed by CAEQRO in collaboration with DMH and stakeholders who represented the MHPs, this version was officially accepted by DMH on January 25, 2005 and used for many of our FY05 health information systems reviews.

However, in response to requests from a number of MHPs for a more streamlined survey and consistent with our quality improvement orientation, CAEQRO, in collaboration with DMH and various stakeholders, created an Information Systems Review Supplemental Questionnaire with the objective of improving the ISCA survey for our Year Two reviews. As described in Section 1.3, the site review notification packet included one of the following two documents:

1. ISCA V5.7L to complete if this version was not completed in Year One
2. Information Systems Review Supplemental Questionnaire for all MHPs who had completed ISCA V5.7L in Year One

An Information Systems Review Supplemental Questionnaire is included in Attachment 2. Highlighted below are various components of ISCA V5.7L, followed by discussions on how we enhanced our Year Two health information systems review process.

Summary of ISCA V5.7L

The following paragraphs highlight the four main sections of Version 5.7L 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. This information is used when clarification of responses is needed or when questions arise.
- **ISCA Section 2: Data Processing Procedures and Personnel**
This section of the ISCA survey collects information on the nature of current MHP information systems functions, current staffing for operations and data analysis, and local policies and procedures for the operation of the MHP information systems. Since all surveyed MHPs 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 gather information on how the MHP's information system captures and processes 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 also 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 capacity 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 system, 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 and pay 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 Survey Tools for Year Two

In response to internal requests for new information and MHP requests for a streamlined ISCA survey by those who had completed ISCA V5.7L in Year One, CAEQRO drafted an Information Systems Review Supplemental Questionnaire. A copy of this document is attached as Attachment 2.

The supplemental questionnaire requests:

- An explanation of any changes to responses provided in the last ISCA
- A list of the current top priorities of the information systems department
- Information about the current information systems
- An indication of whether Medi-Cal claims are produced in the standard HIPAA or proprietary DMH format
- Status of new system selection and/or implementation efforts
- The names and titles of staff who authorize or perform certain common, critical system activities, such as establishing new provider codes or changing billing rates
- A list of staff most responsible for analyzing data from the information systems, including a description of their working relationship with quality improvement staff

- The existence of any user groups or other forums for the staff to discuss information systems issues and to share knowledge, tips, and concerns
- Average monthly volume of network provider and inpatient hospital claims received and processed by the MHP, to obtain a general sense of the scale and complexity of managed care activities
- The percentage of all services provided by the MHP that are claimed to Medi-Cal and a percentage distribution indicating how Medi-Cal services are delivered by county-operated programs, contract providers, and network providers
- A description of the MHP's response to the most critical information systems-related recommendations made in the last review

After review by DMH, a copy of the draft questionnaire was provided to the Orange County MHP, who generously agreed to pilot test the questionnaire and provide critical feedback to CAEQRO. The valuable feedback they provided was incorporated into the final version.

Once the Supplemental Questionnaire was finalized in January 2006, CAEQRO requested MHPs to complete either the ISCA V5.7L (if an earlier version was completed in Year One) or the Supplemental Questionnaire (if ISCA V5.7L was completed in Year One) prior to the site review.

ISCA Operations and Administration for Year Two

All MHPs completed an ISCA survey or supplemental questionnaire, with these special considerations:

- 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 in the first year of reviews, Glenn MHP, Monterey MHP and Colusa MHP first completed a full ISCA survey in this second year of CAEQRO operation.
- Solano, which had previously operated as a unique managed care organization was not reviewed during Year One, but was included in Year Two

Noting the exceptions listed above, the assessment of each MHP's information systems was largely consistent with our Year One process and comprised 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 in advance of a site visit. The survey included both requests for data and documents. Those MHPs who had previously completed ISCA V5.7L only had to complete the supplemental questionnaire to update the previous ISCA and to provide additional information. CAEQRO review processes were the same whether the MHP completed the ISCA survey or the supplemental questionnaire.

- **Step two** involved a review of the completed ISCA survey or supplemental questionnaire by CAEQRO. Materials submitted by the MHP were reviewed by CAEQRO in advance of the site visit.
- **Step three** consisted of a series of onsite and telephone interviews and discussions with key MHP staff who completed the ISCA survey or supplemental questionnaire and staff who routinely use the MHP's or county's information systems. The purpose of these interviews and discussions was to gather information to assess information system operations and integrity of the MHP's systems.
- **Step four** produced an analysis of the findings from the ISCA survey or supplemental questionnaire, as well as follow-up discussions with MHP staff. CAEQRO included a summary of the interviews and discussion in the MHP's site review report. In the report, we addressed the MHP's ability to effectively use its information systems to support business operations, conduct quality assessment initiatives and measure quality improvement efforts. We also considered the ability of the MHP's information systems to support the overall goal of quality management as part of the delivery of mental health services to beneficiaries. Often, we identified opportunities for improvements and made recommendations or provided ideas to address these areas.

The CAEQRO web site, www.CAEQRO.com, developed to share a variety of information with the MHPs, includes examples of completed ISCA surveys that assisted various MHP staff members as they completed their respective surveys prior to their MHP site reviews.

Section 3.3: Analysis of Health Information Systems

As in FY05, CAEQRO's analysis of the ISCA V5.7L survey results and the assessment of the survey instrument itself were ongoing processes. Year Two was particularly challenging for MHPs and CAEQRO alike: many MHPs were either considering or in some phase of changing information systems (73 percent), and we were and are committed to using a flexible instrument that is sensitive to the fluidity of the MHP's respective environments.

Two factors reflect the particular nature of our Year Two health information systems review process and are important to consider in reviewing the analyses of our findings:

1. **Follow-up on ISCA V5.7L.** While we largely assumed the accuracy of the ISCA V5.7L survey and supplemental questionnaire information, CAEQRO site reviewers did on occasion follow up with MHP staff to clarify a number of the responses. As a result of these discussions, site reviewers changed those responses that were clearly inaccurate or had changed during the year (e.g., a mid-year change in a previously selected information systems vendor).
2. **Transition to a common ISCA survey.** The figures displayed in this section reflect the key information contained in ISCA V5.7L and/or the supplemental questionnaire responses, largely as submitted to CAEQRO (with the exception of

those changes noted above). The accompanying summaries provide an overview of these findings. As noted in Section 3.2., the 17 MHPs that had completed ISCA V5.7L had only to complete a supplemental questionnaire, which included a few new queries. Consequently, a small set of key findings are unique to those MHPs—which include 11 small MHPs, one medium MHP and five large MHPs.

A third consideration in reviewing our findings is the manner in which we categorized MHPs by size. In analyzing our results, we combined the categories "small" and "small-rural." In addition, Los Angeles results are contained in the "large" category. (See Attachment 1, which displays MHPs by specific size groupings.)

Information Systems Environment and Capabilities

The following findings reflect data gathered from all 56 MHPs (unless specified otherwise) and is illustrative of the growth and diversity within the state's health information systems environment.

The number of information systems vendors available to MHPs continues to increase—which will have an impact on coordination around shared needs and concerns.

Current information systems vendors and products

As in Year One, California MHPs continue to have a large number and expanding selection of vendors that are offering information systems. The expansion of the vendor pool is very good for California since it encourages competition among businesses to meet

the needs of MHPs. It is likely that additional vendors will join in the opportunity to serve California MHPs.

As more MHPs use a wider variety of systems, an increasing number of small user groups will emerge to support vendor-specific products. In this environment, joining and participating in a variety of cross vendor groups will become increasingly important to support the mutual efforts and needs of MHPs. Also, efforts by DMH to work cooperatively with vendors will become more challenging as the number of vendors continues to increase.

Figure 1

Current MHP Information Systems by Vendor and County Size				
Vendors	Small	Medium	Large	Total
Cerner			1	1
Echo CD/RM	1			1
Echo INSYST	11	9	7	27
HSD Diamond		1	1	2
Echo ShareCare	1	2		3
InfoMC eCura		4	4	8
Netsmart Avatar	5	1		6

(Note: Several MHPs have multiple systems)

Figure 1 continued

Current MHP Information Systems by Vendor and County Size				
Vendors	Small	Medium	Large	Total
NetSmart InfoScriber	2			2
NetSmart CMHC	10	1		11
NetSmart CSM			1	1
Sierra Integrated Systems			1	1
Qualifacts/CalCIS	1		1	2
UniCare Profiler			1	1
Local MHP	2	3	1	6
Platton Clinician Gateway		2		2
Total	33	23	18	74

(Note: Several MHPs have multiple systems)

Seventy-three (73) percent of MHPs are considering, selecting or implementing a new system—down from seventy-seven (77) percent in FY05.

Selection and implementation of new information systems

In Year One, CAEQRO reported that 77 percent of MHPs were considering a system change within the next two years. Figure 2 below is consistent with that finding, as 73 percent are in various stages of planning for change during Year Two. A large number

of small counties have selected new information systems and will be actively implementing those systems during FY07. Several medium and large counties are actively searching for a new information system.

Approximately one quarter of MHPs have no plans for an information systems change. Some of these MHPs have recently moved to newer systems and now face the challenge of making effective use of them. Other MHPs cite financial considerations, the changing vendor landscape, and/or the lack of a dominant vendor player as reasons for not considering a new information system during FY06.

As the Mental Health Services Act (MHSA) becomes more fully operational, MHPs will be under increased pressure to upgrade their current information systems. New information systems must provide sufficient flexibility to support innovative service programs. It is critical that all stakeholders are informed and active participants in the use of new information systems.

Figure 2

New Information System Status by County Size				
New Information System Status	Small	Medium	Large	Total
No plans for new information systems	9	0	0	9
Considering new information systems	0	7	1	8
Actively searching for new information systems	1	3	7	11
Information systems selected, not implemented	16	3	0	19
Active implementation	0	0	3	3
Extended implementation	3	1	2	6
Total	29	14	13	56

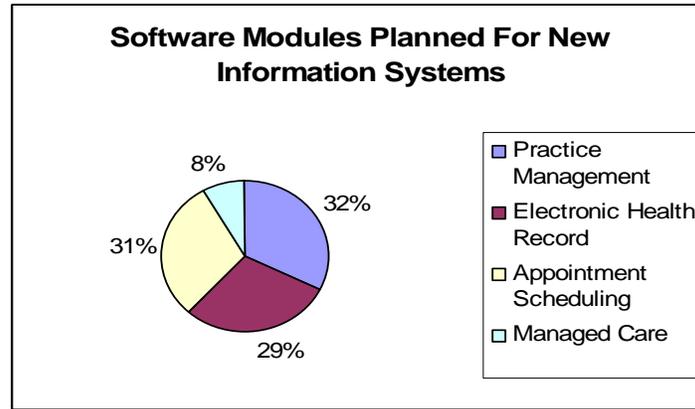
To fully meet the needs of MHPs, new information system selection and implementation needs to actively involve all stakeholders—especially clinicians.

Selection of Key Software Modules

This figure reflects responses from the 22 MHPs that are represented in Figure 2 as “information systems selected, not implemented” or “active implementation.” The data illustrate the importance assigned to consumer tracking, billing, reporting and scheduling functionality. MHPs currently use practice management systems that are limited to these functions. These products support the MHP’s business functions by tracking consumers and services and most importantly generating revenue. While many MHPs are planning to implement systems containing a full clinical record or a separate electronic health record (EHR) system, they must concurrently secure their revenue base while simultaneously meeting state and federal reporting requirements. Meeting the demands of all these requirements is a daunting challenge for any organization.

To assure that all of the required software modules will become operational, it is very important that all stakeholders remain informed of the evolution of their local information system. They can no longer simply purchase a new system and then rely on only information systems personnel and vendors to “install” the system. New systems will for the first time actively engage clinicians. New expectations for system reform and change will require broad participation by all stakeholders in the “installation” process.

Figure 3



General Information Systems Characteristics

The following analysis of information systems characteristics is drawn from all 56 MHPs.

Smaller MHPs are much more reliant on vendors than are large and medium-sized MHPs—resulting in greater dependence on the vendor for both policy and technical advice.

Entity operating the information system

The CAEQRO review process seeks to evaluate how effectively all MHPs—regardless of size—are using their information systems. As Figure 4 illustrates, large and medium-sized MHPs typically operate their own information systems. Because of their size, they are able to recruit and train sufficient staff to operate systems, generate reports and work collaboratively with other MHP staff.

Eighteen (18) small MHPs report that their systems are operated by their vendors. Thus, smaller MHPs are much more reliant on vendors than are large and medium-sized MHPs. Use of vendors has implications beyond day-to-day operations, since these MHPs are likely to rely on the vendor for information on new reporting requirements and for advice on how to make the best use of their systems.

Figure 4

Entity Operating the Information System				
	Small	Medium	Large	Total
MHP Information Systems	8	12	8	28
Health Agency Information Systems	0	0	1	1
County Information Systems	2	0	2	4
Vendor Information Systems	18	2	1	21
Contract Staff	0	0	0	0

Figure 4 continued

Entity Operating the Information System				
	Small	Medium	Large	Total
Other	1	0	0	1
Total	29	14	12	55

Note: Several MHP’s responded that a combination of entities operates their information systems. In these cases, the first entity listed by the MHP on the survey tool was selected by CAEQRO for inclusion in this figure. In addition, the total is 55 instead of 56 because Alpine does not have an automated information system.

One-third of small counties lack a data analytic capacity—a problem that can not be solved simply by selecting a new information system.

Analytic capacity

Information systems capture vast amounts of data, which are used to generate claims, report to federal and state agencies, and provide information for MHPs to manage their operations. However MHPs need to do more than bill, report and simply “operate”. They need to be able to analyze service patterns and costs, and determine unmet needs. To do so, they need the

services of persons trained to analyze the data the system has captured.

Data analysis can provide vital information for measuring the effectiveness of quality improvement initiatives. This is particularly true as an increased amount of clinical information is beginning to flow into the newer information systems.

Figure 5 shows that one third of smaller counties lack a data analytic capacity. This problem cannot be solved by merely selecting a new system. Many small counties are beginning to join together to collaborate on selected projects, most notably in recent years for the evaluation and acquisition of new information systems. In addition they are forming user groups to help them find solutions to a variety of problems.

In the near future small counties, when asked if they have a data analyst, will need to be able to answer “yes.” This resource may be an analyst shared with other departments within the county or with other MHPs, but effective operations will not be possible for MHPs who cannot gain access to their own data.

Figure 5

MHPs with Staff Data Analysts				
	Small	Medium	Large	Total
No	10	1	0	11
Yes	20	13	12	45
Total	30	14	12	56

The majority of MHPs report limited access to data—a pervasive weakness that will have increased consequences as the implementation of MHSA continues.

Information system component ratings – statewide

Figure 6 lists nine key components of a consumer tracking, billing and reporting system which is defined in the ISCA V6.1 as “practice management” and is consistent with the current usage among MHPs. Based on information included in the completed

ISCA 5.7L survey or supplemental questionnaire, as well as discussions and observations during the site review, CAEQRO scored each MHP on these components as part of the final site review report. On a statewide basis MHPs show particular strength in the documentation of policies and procedures for data security issues. The response relating to access to data via reports shows considerable weakness, with nearly half of the MHPs receiving a score of “partially met.” Year Two was the first year that CAEQRO used such a rating methodology, which is more quantitative and serves as a focal point for discussions. Future reviews will continue to employ this methodology.

Figure 6

Information Systems Component Ratings Statewide				
Component	Rating			
	Met	Partially Met	Not Met	Not Reviewed
Procedures to monitor accurate, consistent and timely data collection	34	18	3	1
Procedures to determine a beneficiary’s eligibility status	41	13	0	2
Completeness of Medi-Cal claim production process	42	12	1	1
Timeliness of claims processing and payments for network providers	37	0	2	17
Access to data via standard and ad hoc reports	26	24	5	1
Information systems training program and “Help Desk” support	39	13	1	3
Information systems/fiscal policies and procedures documented and distributed	36	15	2	3
Collaboration between quality improvement and information systems staffs	41	12	1	2
Documented data security and back-up procedures	46	7	1	2

As in Year One, MHPs' ability to adjudicate claims varies widely—and in some cases requires costly and error-prone dual data entry.

Network provider claim and reimbursement process

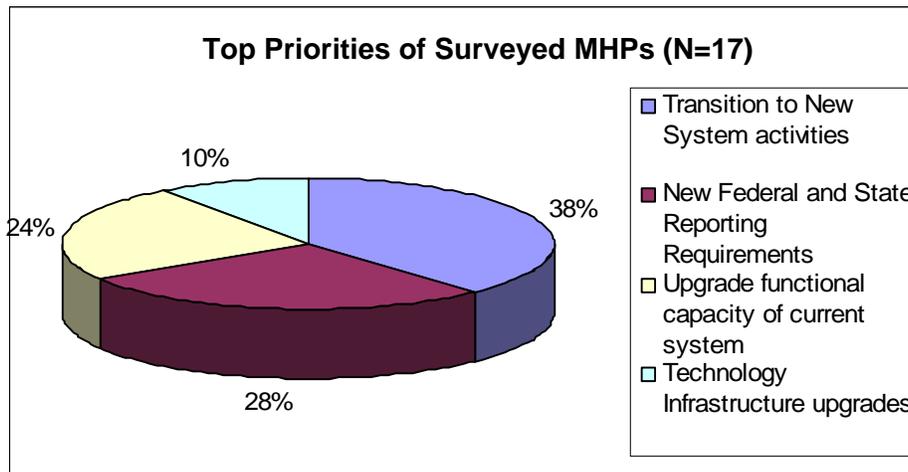
Claims processing capabilities for MHPs that process and pay claims to network providers vary widely throughout the state, just as in Year One. Systems range from fully manual operations to simple spreadsheets to sophisticated systems capable of automated processing of thousands of claims per month. Claims volume is the primary determinant for the sophistication level of an MHP's managed care information system.

In many cases, managed care claims processing systems are not integrated with the MHP's primary information systems used for billing Short-Doyle/Medi-Cal claims. In these cases, dual data entry is the norm, although it is never the preferred method for recording data because of the greater probability of error and the cost of labor.

Top Priorities of Information Systems Departments

The supplemental questionnaire asked each of the 17 MHPs to note current top priorities of the information systems department. Responses shown in Figure 7 were reviewed and coded into four major categories, which follow below:

Figure 7



- **Transition to a new information system.** Many MHP's are actively working to transition to new systems. Logically, such an important move represents a high priority and a very demanding set of tasks for information systems staff as well as virtually all other MHP staff. Transition to a new information system includes activities such as request-for-proposal development, vendor selection, implementation planning, training and data conversion.

It is noteworthy that few MHP's specifically noted activities focusing on new clinical systems as top priorities. This is of concern, since Figure 3 shows that new clinical modules are on the horizon for many MHPs. Successful

implementation of clinical modules will require that clinical, administrative and information systems professionals work closely together.

- **New federal and state reporting requirements.** All MHPs face continuous change in federal and state reporting requirements. Several MHPs continue to struggle with claiming requirements related to the Health Insurance Portability and Accountability Act of 1996, as well as new Client and Service Information System (CSI), California Outcomes Management System (CalOMS) and MHSA requirements. The continuing demands for system change have a serious impact on all MHPs and particularly so during times of new system implementations. Staff must juggle the process of installing new systems, simultaneously changing their current system and configuring the new system. This unstable situation will continue for some years.
- **Upgrades for the functional capacity of current systems.** Although many MHPs continue to use aging legacy systems, they must add functional capacity. This is particularly true for meeting the demands of Federal and State reporting requirements. Despite plans for new systems, the current systems must be enhanced, typically by the current vendor of the legacy system.
- **Technology infrastructure upgrades.** New technology purchases are required for new systems as well as legacy systems. Many MHPs continue to use very old computer systems which are no longer manufactured. Thus, they are planning how to move to more secure operations. Technology upgrades are now understood to be a continuous annual activity.

Additional Information on Billing and Service Delivery

The following information was collected from the supplemental questionnaires and reflects the responses of the 17 MHPs that completed this survey instrument.

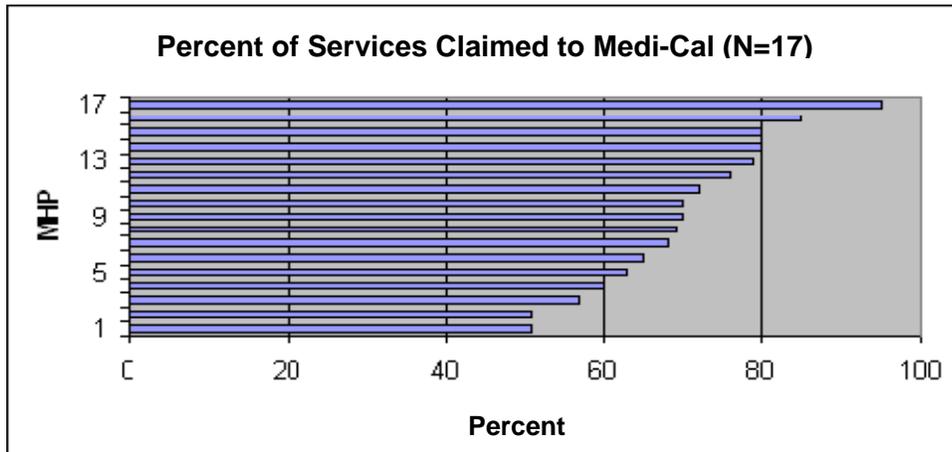
The importance of Medi-Cal revenue underscores the need for more sophisticated systems capabilities in two key areas—data analysis and eligibility determination.

Percentage of services billed to Medi-Cal

As part of the CAEQRO supplemental questionnaire, MHPs were asked to estimate the percentage of services that are currently billed to Medi-Cal. While this survey was limited to 17 MHPs, Figure 8 demonstrates a wide range of Medi-Cal percentages ranging from 50 percent to over 90 percent.

The widely acknowledged importance of Medi-Cal as a major category of revenue is again validated by these findings. A dependence on Medi-Cal revenue when combined with a limited analytic capacity and little systems support for eligibility determination present a particular challenge for many MHPs. Hopefully, those new systems that promise to improve Medi-Cal claiming, eligibility determination and analytic capabilities will provide MHPs with the support needed to secure these revenues.

Figure 8



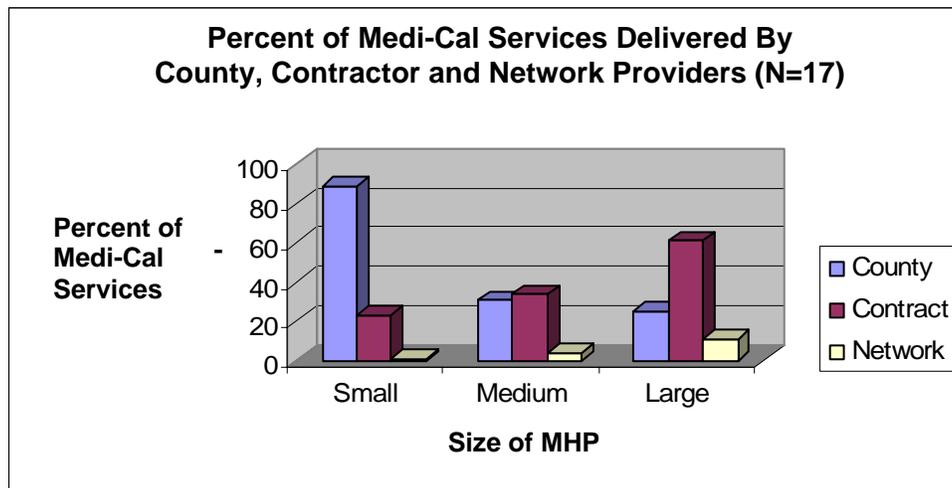
Smaller MHPs are more likely to perform their own services—which explains why they are less likely to select managed care software.

Proportion of Medi-Cal Services by County, Contract and Network Providers

Figure 9 illustrates that smaller MHPs are much more likely to directly perform their services. The lack of contract or network providers in rural communities may well explain such a finding. Many MHPs do not impose the same review processes on county-

operated providers that they impose upon contract and network providers. This may explain why smaller MHPs are much less likely to believe that they require specialized managed care software.

Figure 9



Section 3.4: Revisions for Year Three Reviews

Positive feedback and helpful suggestions from the Orange County pilot and from early users of the supplemental questionnaire prompted the CAEQRO to initiate a process to revise and improve ISCA V5.7L. The thorough and lengthy development process that CAEQRO facilitated in FY05 to draft and finalize earlier versions of the ISCA greatly helped to streamline the revision process in FY06.

CAEQRO enlisted the help of the California Mental Health Directors Association (CMHDA) and its Information Technology (IT) Committee, which agreed to solicit volunteers representing a variety of County MHPs. These volunteers, along with senior CAEQRO information systems reviewers, helped create a new draft ISCA that incorporated the best and most useful parts of the original ISCA and the supplemental questionnaire.

The project began with a presentation at the February 17, 2006 meeting of the IT Committee, during which CAEQRO proposed the following project goals:

1. To update the current ISCA to improve usefulness to MHPs, DMH and other stakeholders, in order to better assist MHPs in quality improvement efforts and business process improvement initiatives
2. To simplify and remove any redundancy in the document while still complying with federal and DMH requirements

CAEQRO requested nominations from committee members to assemble a stakeholder workgroup of at least ten participants. Participants represented a cross-section of small, medium and large counties, to ensure consideration of a variety of MHP perspectives and needs. Representatives from the following MHPs participated in this workgroup:

Alameda	Merced
Butte	Orange
Glenn	Sacramento
Humboldt	San Diego
Kern	Tulare

Content from Version V5.7L and the supplemental questionnaire were combined by CAEQRO into a rough draft that became the starting point for initial discussions among the group. The workgroup scheduled several conference calls during March and April to discuss revisions. CAEQRO distributed evolving working drafts via e-mail to enable those participants who were unable to attend the calls to provide input. The workgroup also solicited input from DMH.

After final modifications and consensus among the workgroup, CAEQRO presented the draft for discussion at the CMHDA IT Committee meeting on May 19, 2006. All participants agreed that the new ISCA was better organized and easier to understand than ISCA V5.7L, while still adhering to federal Appendix Z guidelines. Thus, the draft was accepted by DMH and finalized by CAEQRO as ISCA V6.1. As planned, this new version of the ISCA was completed by early May 2006 for distribution along with county

MHP notification packets for reviews scheduled in July 2006. CAEQRO will use ISCA V6.1 for all reviews in FY07.

Summary of ISCA V6.1 Enhancements

As a result of collective efforts, CAEQRO believes the workgroup achieved the original project goals. Among the improvements are the following:

- Improved clarity, including definitions of terms and acronyms
- Comprehensive questions involving critical subjects such as the status of information systems replacements and the use of data for quality improvement and other management activities
- Focused and precise requests for policies and procedures and other documentation to assist in structuring meaningful agendas and making the best use of staff resources during site reviews
- Background on the structure and size of the MHP, such as the volume and ratios of services provided to Medi-Cal and non-Medi-Cal populations to provide better context for focused reviews
- New questions regarding staff credentialing, fraud detection, system access, and maintenance of system control tables to determine how they may affect information system operations and resulting claims and reports
- Streamlined and simplified sections related to managed care claims processing
- Improved ability to assess how MHPs are progressing toward an electronic health record (EHR) system
- The ability to analyze and report statewide ISCA results through questions requiring quantifiable answers
- Improved overall structure and logical groupings of related questions throughout the document

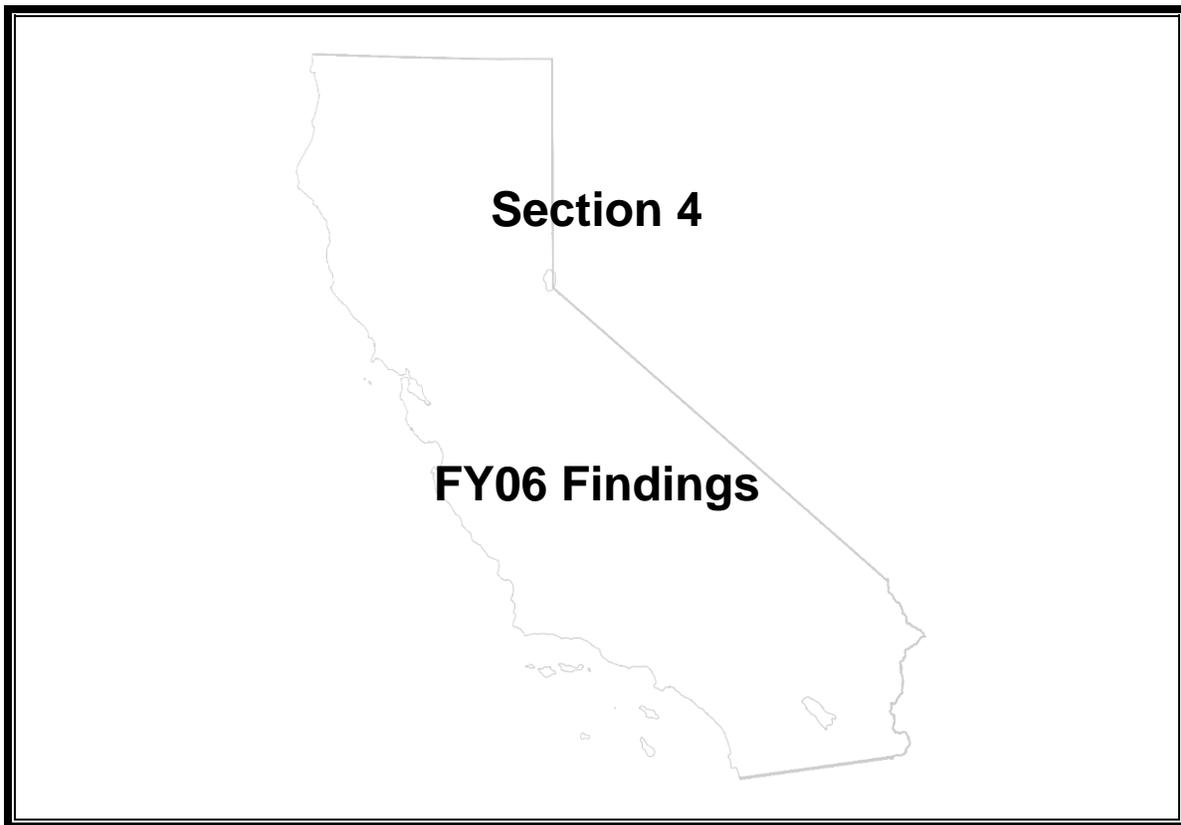
ISCA V6.1 also adheres to the original goals for the development of a California-focused survey, including the following:

- Solicit information from a wide variety of MHP personnel—not only those in information systems roles, but also billing, fiscal, 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
- Determine the current status on the many MHPs that are planning information systems changes
- Assess how MHPs verify 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

During FY07, each MHP will respond to the same set of questions in ISCA V6.1. Information that CAEQRO collects from this improved document will provide an unprecedented view of the status and capabilities of the information systems used by MHPs throughout California.



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Section 4.1: Overview

Based on our FY05 experience in conducting external quality reviews, CAEQRO devoted substantial time and resources in Year Two to implementing a variety of process improvements and building an infrastructure that would increase our own data analytic capability. Sections 1-3 highlight these initiatives, including the development of an improved Information System Capabilities Assessment (ISCA) survey, and illustrate how we are well positioned to perform highly sophisticated data analyses.

While FY06 was in many ways a transitional year, CAEQRO was able to significantly increase our data analytic activities and therefore offer even more useful information than we provided in the Statewide Report Year One. Two primary factors contributed to this improvement over Year One:

- More experience with the millions of data files provided by the California Department of Mental Health (DMH)
 - Established data exchange protocols with DMH
 - Access to three years of paid claims data for analyses throughout FY06
 - The ability to provide a variety of data sorting requests from the CAEQRO staff and from MHPs
- More rich, targeted and inclusive MHP site review information
 - Analyses that built on our Year One baseline findings and targeted individual MHP issues
 - Two additional MHP reviews—Alpine MHP and Solano MHP
 - A planned 11 percent increase in overall person days dedicated to site review teams

As in Year One, our findings include both quantitative and qualitative analyses—as the latter remains critical to a comprehensive assessment of performance and performance improvement for California’s complex MHP system. Also consistent with last year’s report, we created abridged versions of our MHP site review reports in Volume II of this report to assist in this analytical process and enable easy access to our source data. The information in our Individual MHP summaries is solely derived from the data and commentary contained within the original MHP site review report. Unlike last year, however, our individual site review reports and consequently our MHP summaries contain quantitative ratings that are reflected in our findings, as noted below:

- **Quantitative analyses and findings.** In this year’s report, all of our findings are informed by quantitative data analyses. In addition to the mandated Performance Measures analyses (Section 4.3), we were able to quantify our findings on MHP site reviews (Section 4.2) and offer extensive additional data analysis (Section 4.4) in which we display both statewide and California No Los Angeles (CANOLA) data in a variety of graphs, charts and tables. For certain key areas, we also display and review MHP-specific data. Much of this information is contained within the narrative that is then further supported by more detailed reports in our attachments. Some of the findings related to the Information

Systems Capabilities Analysis (ISCA) survey we describe in Section 3 fit this category.

- **Qualitative analyses and findings.** In addition to the data analyses that informed our site review findings, CAEQRO had to incorporate a substantial body of information—including feedback from a wide range of stakeholders. Section 4.2 includes a detailed discussion of our findings and reflects the 56 MHP site review reports CAEQRO generated for Year One.

The following narrative offers a detailed discussion of our findings—which support our belief that data is fundamental to strategic decision making. In FY07 CAEQRO intends to promote the kind of active data discussions we suggest in Section 4.4 to help MHPs improve quality at the service delivery level. We plan to establish a folder on our Web site, www.caegro.com, which will contain pivot table reports of all data analyses at the individual MHP level. A sample of this report, MHP Penetration Rates by Gender, is included as Attachment 15. An MHP (or any stakeholder) can view a number of variables, create data profiles, and compare results with other MHP's. We will include a description of pivot tables and directions about how to use them, as well as formal training opportunities.

Section 4.2: MHP Site Reviews

In Section 1, we discussed the changes in the process and focus of Year Two MHP site reviews. In this section, we discuss the common findings derived from our analysis of all CAEQRO MHP Year Two site review reports. As in last year's report, our findings comprise the following three levels of information.

- The first level includes the data from several rating scales including both compliance-related areas such as PIPs and specific MHP-focused follow up—particularly regarding the status of Year One recommendations.
- The second level indicates MHPs' strengths and weaknesses and reflects our assessment of their overall administrative, financial and programmatic operations. In Year Two, we employed a more data-based approach to aggregating and analyzing this information than we did in Year One.
- The third level represents complex themes significant for the overall success or inadequacy of the organization to manage and/or provide crucial services to a large and vulnerable population.

Below we discuss our level one and level two findings—immediately following a discussion how environmental factors affected CAEQRO site reviews and how several quality improvement initiatives enhanced our report development process. 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.

Site Review Environment

In Year One the mental health system was beginning to emerge from several years of significant budget shortfalls and consequent loss of positions and resources at both the state and MHP level. Although some organizations continued to face additional budget cuts, the majority had reduced their resources and most were relatively stable.

However, during Year Two, most, if not all, the energy and resources of MHPs were consumed by Mental Health Services Act (MHSA) planning and implementation. MHPs appeared to consider MHSA as separate from the current service system and, paradoxically, their greatest burden and universal solution. Here are some of the challenges that resulted from this perspective:

- **Resource Diversion.** Some of the large MHPs were able to dedicate a separate group of staff members to concentrate on this complex and important initiative. Most others, however, engaged whatever resources they could from nearly all areas of the organization to work on MHSA-related activities.
- **Partial Solutions.** MHPs often described the MHSA planning process and associated activities as their only organizational strategic initiative. Consequently, the programs that they developed as result of MHSA were viewed as remedies for other service gaps. These service gaps often represented complex difficulties within their current service system.
- **Diminished Importance.** Some MHP directors and many of the staff communicated that continuing the required activities for the CAEQRO review during the MHSA process was a low priority. They knew of no consequences attached to performance on the review in contrast to the major penalties associated with failure to manage MHSA planning demands or to adequately prepare for chart audits associate with Early and Periodic Screening, Diagnosis and Treatment funding.

In many instances, these challenges did not prevent the review team and the MHP staff from proceeding with the next topic. However, some MHPs found the process frustrating, although they realized that, by contract and regulation, we were to carry out the review process without making “allowances” for what we understood was an additional obligation.

This environment is important to consider in reviewing our findings.

Quality Improvement and the MHP Report Process

In Section 1.3, we detail the CAEQRO MHP pre-site review, site review and post-site review processes, as well as how we collected feedback in finalizing our MHP reports for Year Two. As discussed we made a number of changes to these processes in keeping with our focus on quality improvement. Our site review orientation, as well as our report process and structure, is important to reiterate in introducing our findings:

Site Review Priorities

Having established a baseline picture of each MHP during Year One, we planned our Year Two site reviews with the following priorities:

- MHP-specific priorities
 - To determine the status of key Year One recommendations
 - To understand key system of care characteristics, especially any that had changed since our Year One review
 - To engage a greater number of stakeholders in the site review process and reflect their views in generating our reports

- System-wide priorities
 - To review MHP-identified system strategic initiatives for Year Two
 - To review and discuss the status of wellness, recovery and resilience as a core value in MHP policy and operations
 - To review formal quality improvement/performance management processes including cross-functional use of data for planning and decision making
 - To follow up on the status of selecting and implementing information systems upgrades
 - To review business processes and associated quality management activities

Site Review Report Process

The CAEQRO report process remained the same in Year Two, although as noted in Section 1.3, our report format included more tables and quantitative ratings than did last year's (in addition to the narrative).

We issued a draft Outside Review Report to the MHP and DMH simultaneously for their respective review and comment. Our report format included more tables and ratings than in Year One's report. MHP responses tended to be factual corrections and also included additional information to support our considering a more favorable rating or conclusion. Some MHPs responded in detail to content and/or ratings with which they disagreed. In these cases, we reviewed the comments and responded in detail to each item.

Frequently the site review team followed up with phone conversations to discuss with the MHP staff the issues and sometimes our different perspectives regarding site review findings. However, the majority of MHPs did not issue any response to the draft, usually stating that the report appeared to be an accurate reflection of the discussions during the review. Some MHPs even followed up with a short e-mail or phone call to express a favorable response about the accuracy and potential usefulness of the report.

Report Template

During Year One we were primarily interested in understanding the status of each MHP's quality improvement and quality management processes and programs, as reflected in the federal regulations and in DMH priorities. Consequently our report generally described whether the MHP did or do not have in place the applicable

programs and processes. The only rating scale that appeared in a Year One report was the PIP Validation Tool, which was an attachment. We deliberately scored the PIP tool very liberally, since we considered it a baseline year that marked the beginning of a quality improvement process. Because of the complexity of the PIP rating system, we devote Section 4.2.1 to review our findings.

In Year Two the body of the report template included several rating scales to support a quantitative data analysis process.

- **Status of key recommendations.** The first section showed the general status of key recommendations that we had identified in Year One and noted as important for discussion in the pre-site review notification packet. Each recommendation represented an important area or issue for the MHP staff and management to examine and to remedy or improve, as appropriate. The specific follow up by the MHP was less important than whether the staff made an effort to review, understand and address the issue.
- **PIP status.** The second major rating included a “status” description of the actual PIP and a table with ten consolidated content areas from the PIP Validation Tool.

Of the small number of MHPs that expressed objections to the content in the draft report, the major areas of disagreement were the ratings of the follow-up to Year One recommendations, the PIP status description and, to a lesser extent, the PIP Validation Tool ratings.

To enable easy access to our source data, we include 56 abridged versions of our MHP site review reports in Volume II of this report. These summaries enabled us to extract the salient information from our much longer MHP reports and analyze our findings.

Status of Year One Recommendations

In Year One we made a number of recommendations to each MHP in our individual reports. Each recommendation linked to an issue or a challenge that CAEQRO identified during the Year One review process. Consistent with our Year Two priorities, we followed up on these recommendations during the site review process and devoted a section in our report to quantifying of our findings. Each MHP summary lists the three most important Year One recommendations from among those we discussed during the site review. (The summaries for Alpine MHP and Solano MHP do not contain this information since they were not reviewed in Year One.)

Overview of recommendations

Our reports contained two types of recommendations—depending on the nature of the issue:

1. **Concrete action about specific issues.** For example, a locked elevator created obvious problems for clients. The recommendation was to “unlock the elevator so consumers can more easily get to the clinic office on the second floor of the clinic.”

2. **Multiple efforts over time for complex challenges.** Many recommendations represented challenges that would require multiple efforts over time and could be accomplished in a number of ways. For example, broad organizational issues were typically in this category, such as “Increase knowledge of quality improvement activities and processes among staff throughout the system.”

Rationale for Ratings

In our follow-up to the prior year’s recommendations, we were interested in assessing whether the MHP had addressed the issue and agreed on a response, irrespective of whether the specific recommendation had been followed. This approach guided our rating system. The three ratings are defined below.

- **“Fully addressed.”** We rated a recommendation as “fully addressed” when the MHP took action that appeared to resolve or achieve significant progress towards resolving an identified issue.
- **“Not addressed.”** When the MHP did not respond to problems or recommendations in any way, we assigned a rating of “not addressed.”
- **“Partially Addressed.”** This rating accounts for 60 percent of the total. This high percent reflects a number of factors:
 - Many recommendations represented problem areas that would require long-term attention in order to achieve true improvement.
 - The MHP implemented a partial solution to a concrete issue.
 - The MHP discussed a problem and had developed a detailed action plan but had not implemented any changes.

Clearly “partially addressed” is the broadest category and allows for appropriate flexibility in the rating system. For example, in addressing the problematic locked elevator, the MHP accepted a reasonable compromise given that the MHP was planning to move from the facility. While refusing to unlock the elevator, the MHP’s landlord installed a ringer so the receptionist could activate the elevator. This item was rated “partially addressed” since the MHP had attended to the issue and had improved the situation as it could under its current circumstances. We also rated the recommendation regarding quality improvements activities as “partially addressed” since the MHP revised the quality improvement manual and has planned a number of all-staff training activities.

Summary of findings

Figure 1 shows the broad content areas for major recommendations, as well as the ratings within each content area. The 162 recommendations represent the status of three top recommendations per MHP from the 54 Year One reviews:

Figure 1

FY05 - Recommendations			
Recommendation	Fully Addressed	Partially Addressed	Not Addressed
Wellness/Recovery	8	14	2
Quality Improvement/Performance Improvement Protocol Committee	8	13	9
Business Processes, Documentation, Training, Staff Issues	4	16	1
Improvement Penetration Rate/Access, Latino, Older Adult, Etc.	2	12	1
Collaboration – Quality Improvement/Information Technology	1	3	1
Information System, Replacement/Implementation	10	25	4
Cultural Competence	3	5	1
Data Reporting/Analysis	3	7	2
Coordination/Collaboration With Outside Entities	3	3	1

The three most common recommendation areas represented 57 percent of the 162 recommendations:

- Information system replacement and/or implementation.** This area accounted for 24 percent of the 162 priority recommendations reviewed and was evident in 39 MHP summaries. The MHPs with 10 recommendations rated as “fully addressed” typically either successfully initiated a formal planning process for system replacement and/or included a variety of individuals in that process. The ratings do not indicate a successfully completed installation. Information system replacement and installations remain a consistent area of concern and were cited most frequently in the recommendations in Year Two reports.
- Quality improvement committee and associated PIP development.** This area was evident in 30 of the MHP summaries, represented 18.5 percent of the recommendations, and had both the highest number and highest percentage of “not addressed” ratings. Without a qualitative evaluative processes in place, many MHPs had difficulty responding to recommendations regarding PIP development. In Year Two recommendations, this area remains prominent as requiring improvement.
- Wellness and recovery.** This critical area accounted for 15 percent of the recommendations, with a fairly low percentage of “not addressed.” MHSA gap analysis and planning did not mean that the MHP had made any progress in its current operations. In this area “fully addressed” did not indicate that the system had truly incorporated wellness and recovery into the system; instead, it indicated that the MHP had initiated a number of significant steps towards a foundation dedicated to this goal. “Partially addressed” most often represented that some activities exceeded a minimal effort. For example, a number of training efforts and/or plans for inclusive training were acceptable for a “partially addressed” rating. In Year Two recommendations, this area also remains prominent as requiring continued attention.

Year Two Findings: Targeted Review Areas

In addition to following up on Year One recommendations, CAEQRO had a number of other priorities in conducting our Year Two reviews—both in how we structured the review process and the areas we targeted for review. The following targeted areas for review were typically a reflection of our findings in Year One and included the MHP-specific and system wide concerns previously summarized.

Progress in enhancing quality improvement processes

In Year One and Year Two, we reviewed MHPs' formal quality improvement and cultural competence plans, committee meeting minutes, and annual work plans.

While in Year One we did review specific activities against plan deliverables, in Year Two we concentrated on whether the MHP achieved or progressed towards identified goals. We also focused on whether the MHP had adequate participation by a variety of stakeholders, whether they used/reviewed data to inform its planning activities, and how well they internally publicized issues and activities throughout the organization.

In reviewing quality improvement, we also concentrated on how the MHP incorporated wellness and recovery into its plans and into specific activities. We discussed consumer/family input and their participation on the quality improvement committee as well as in other formalized areas within the organization. In addition, we reviewed training for staff, families and consumers in regard to wellness and recovery, including specific attention to culturally diverse beneficiaries. We looked for indications of meaningful consumer/family involvement in management, policy making and committees, in addition to staffing and service delivery.

Findings. Almost 50 percent of all MHPs achieved significant progress toward developing a quality management system that could increase access to underserved populations, had appropriate staffing levels and skills (including data analysis capabilities), and included meaningful and measurable goals. Generally the line staff's awareness of quality improvement activities improved and the organization paid more attention to consumer/family involvement. The MHP staff cited support and commitment from senior management as a key factor in its ability to strengthen quality improvement processes and priorities.

In addition, cultural competence and penetration rates are important parts of overall quality improvement. Many MHPs mentioned that MHSA plans included emphases on outreach and increased penetration of underserved groups. Once again, MHSA activities were the focus instead of a system-wide quality improvement initiative. Consequently, on-going MHP quality improvement activities largely consisted of staff training and continued efforts to hire bi-lingual, bi-cultural staff members. Overall penetration rates and actual number served decreased in several MHPs, including that of Hispanic/Latino beneficiaries in some MHPs. In Section 4.4, our data analysis details significant discrepancies in cost and service patterns for various beneficiary populations.

Ability to meet the needs of diverse stakeholders

One of our internal priorities for Year Two was to have broader participation in the site review process by diverse groups of participants. The following paragraphs demonstrate how we achieved this goal and include our major impressions from each type of group. As in Year One, the MHP was responsible for recruiting participants for the site review process and, as in Year One, many otherwise well organized MHPs had difficulties with this task.

- **Greater diversity of consumer/family focus groups.** Within the constraints of our resources, we increased the number of focus groups to reflect county demographics. Based on Year One results, we identified additional high-priority populations and chose the most appropriate for that particular MHP. We requested participation from older adults, non-English speaking groups, beneficiaries with co-occurring disorders, Transitional Age Youth, and members of wellness/recovery or client club programs. Focus groups were held at consumer centers, MHP program sites or contract provider sites. Most often these groups were held in environments familiar to the consumers and family members rather than the MHP's administrative headquarters.

Findings. With exceptions, participants continued to view the systems as providing fewer services often with a smaller staff, but were still hopeful that MHSA would bring improvements. In particular, participants had a number of complaints about timely access to services, especially psychiatric services. Participants from many MHPs described waiting times of several months and multiple changes of physicians. In a number of MHPs participants felt that the intake process was complex and slow.

In addition, a high percentage of participants in non-English-speaking groups had no concept of recovery and wellness. Although translation of such concepts can be difficult, it may also reflect the lack of language-specific recovery materials and/or the availability of bilingual staff members within the MHP. Many English- and non-English-speaking participants associated "recovery" with substance abuse exclusively.

Finally, participants in a number of the focus groups for Transitional Age Youth groups demonstrated their high-risk status and a wide gap between the child and adult systems. In these cases, there did not appear to be programming tailored to their issues or a smooth transition among the systems, though many MHSA plans intend to address this issue.

- **Consumer/family staff groups.** In Year Two, we were able to identify a greater number of MHPs with sufficient consumers and family members working as employees or contractors to form a dedicated group. With a few clear exceptions, these groups expressed the most frustration, alienation and low morale.

Findings. Many consumers and family members who had worked in the system for a long time were still contractors without benefits. A number also expected that they and their programs would be eliminated due to budget cuts, while redesigned clinically managed wellness programs would be initiated by the MHP through MHSA funding. They felt the need for their services was high and their

workloads correspondingly high, while reporting spotty acceptance and some good relationships with other staff.

- **MHP staff groups.** Where MHP size permitted, we requested group interviews with MHP staff members we had not interviewed in Year One. We emphasized interviewing staff members representing different programs and geographical areas of the county.

Findings. Consistently, participants described high work loads in the midst of changing documentation and accountability burdens. Their view of these issues and resulting morale was dependent on their view of management. With management that they described as communicative, value driven and consistent, the morale was higher.

- **Contract providers.** In Year Two we met with an increased number of providers—both at their sites and at the MHP. Consequently, we were able to increase input from both the number of provider agencies represented in our findings and the number of individuals whom we interviewed. Our information systems and program staffs often facilitated these sessions together.

Findings. Almost uniformly contractors felt excluded from business process or technology planning discussions with the MHPs. They often described lack of access to needed MHP databases that necessitated additional manual work in addition to their usual double data entry. Providers usually viewed themselves as more advanced than county services in implementing consumer/family participation and wellness and recovery efforts.

MHP Strengths and Challenges

Evaluating strengths and challenges in Year Two was an interesting, complex and somewhat paradoxical process. In many instances, we defined significant improvement in critical areas as a “strength”; however, those same areas often remained the most challenging. Therefore, instead of delineating this section of our findings by strengths and challenges, we believe that a more accurate reflection of the status and progress of the system is to discuss priority areas for both MHP-specific and system-wide improvement.

We arrived at this conclusion after coding the top three strengths and challenges from the MHP Summaries into twelve specific topics and an “other” category. The chart below lists the frequency with which a particular topic is defined as a “strength” or challenge”:

Figure 2

Summary of Key Issues			
Topic	# Strengths	# Challenges	Total
1. Access to data	25	18	43
2. Access to services, penetration rates	14	26	40
3. Wellness and recovery	16	17	33
4. Implementation of new IS	5	28	33
5. Operation of current IS	17	15	32
6. Staff issues	12	13	25
7. QI programs/process	10	13	23
8. Contract provider relationships	4	10	14
9. Documented policies and procedures	9	4	13
10. Collaboration w/other entities	11	1	12
11. Management, direction, leadership	3	7	10
12. Integration of MH and AOD	1	8	9
13. Other – PIP, training, EBP, FQHC, new services	10	7	17
Total	137	167	304

Select areas that are often reflected in other major categories are highlighted below:

Access to data

In contrast to last year's results, access to data was defined as a strength more frequently than as a challenge. Observations such as the following illustrate the rating as a strength:

- Non-information systems staff members who work on available data extracts from the full database widely demonstrate knowledge of report writing tools.
- The quality improvement manager values data, knows how to access the systems to obtain it, and shares the results.
- Staff members of all levels in a variety of departments use data, rather than isolating data within the information systems department.
- The MHSA planning process greatly encouraged the use of data.

In MHPs with legacy systems, staffs were able to extract and utilize data to the maximum permitted by system capabilities. For MHPs with new systems, data analysis activities were limited due to the learning curve. In these cases data access was more often listed as a challenge.

Year Two findings were similar to those in Year One for MHPs that were challenged by a lack of access to data. Challenges included a limited or non-existent analytic staff, limited experience with report writing tools and/or the knowledge of data extraction

techniques. There was also generally limited or no access to data by the non-information systems staffs.

Data access challenges were concentrated in small and small-rural MHPs who comprised 16 out of the 18 challenges. Regardless of size, MHPs often still appeared unclear about what data they can generate, what data they really need, and how to use data they receive.

Access to services/penetration rate

Access to services was typically a challenge for many MHPs across all size groups. The most frequent areas of concern are listed below:

- **Non-Medi-Cal beneficiaries.** A large number of MHPs do not provide ongoing services to non-Medi-Cal beneficiaries. Therefore these individuals appeared in times of crisis and acute need for inpatient services. With a lack of opportunities for early intervention, the need for emergency access continued episodically. Some MHPs attempted to develop several tiers of “eligibility” for services and a few continued to struggle to maintain one standard of care. For MHPs that struggle to preserve access to some percentage of non-Medi-Cal beneficiaries, the community and the staff were understandably uncertain as to what services the MHP could to whom.
- **Hispanic/Latino beneficiaries.** Despite a number of outreach initiatives, MHPs were largely unsuccessful in increasing the penetration rate of Hispanic/Latino beneficiaries. Penetration data indicated continued under-representation by Hispanic/Latino beneficiaries, although some MHPs continued their efforts to recruit bi-lingual, bi-cultural staff members. Centralization of service sites due to lack of funding accentuated these barriers in many MHPs. In other MHPs, barriers existed due to population growth in already underserved areas. Only two small MHP summaries showed the strength of increased Latino penetration.

MHSA planning required a more complete and thorough analysis of prevalence and penetration rates, and many MHPs emphasized improving services to underserved populations, often including Latinos or other ethnic groups, older adults and Transitional Age Youth.

- **Medication support.** Lack of access to psychiatrists and other medication support personnel occurs significantly throughout the system. Intake processes often involved significant bureaucracy, calls, committee reviews, callbacks by the support staff and appointments scheduled significantly beyond the MHP’s timeliness standard.

Many MHPs were concerned about their access delays for those seeking services and developed PIPs around improving the percentage of beneficiaries keeping appointments. Rarely, however, did the MHPs consider reframing the issue in a manner that could lead to restructuring service delivery: how to provide a timely service contact for a higher percentage of those requesting service. They viewed their task as providing appointments rather than providing services and improved timeliness of receiving the services rarely resulted.

Wellness and recovery

This critical area was still in a formative stage throughout the system. Strengths typically were not substantive and almost every review noted the “MHP commitment to wellness and recovery.” Many MHPs associated this area primarily with MHSA-designated programs and consequently concentrated their efforts accordingly.

The MHSA planning process increased consumer involvement and expectations for systematic progress in wellness and recovery. However, county hiring rules were reported as significant barriers to consumer/family employment in many MHPs.

Several MHPs identified many activities dedicated to implementing wellness and recovery throughout the organization. In these cases, executive leadership communicated the priority throughout the organization and viewed the MHSA funding as providing an enhancement to the process rather than the overall impetus.

Information Systems

Information systems operations and implementation together represent the most significant sources of challenge appearing across all size groups. Very few of the MHPs selecting and/or implementing a new information system appear to have identified these processes in their key strategic initiatives.

Few strengths were associated with the implementation of a new system with some exceptions: strengths included executive level support, especially in the areas of sufficient staffing and budget commitment as well as a multi-disciplinary orientation to selection and implementation.

Many small MHPs plan on implementing new information systems within a very tight timeframe this year, representing a challenge to execute. However, those that use time-sharing or an Administrative Services Provider appear to be more adaptable to the new information system.

As compared to MHPs with legacy systems, MHPs with newly implemented systems report greater access to clinical data but also greater data entry for clinicians, requiring training and potential reallocation of work loads. Successive installation of new systems modules is presenting a long-term burden to the information systems staff as well as to the new users. Implementation planning often has not considered an extended timeline to accommodate the learning curve and associated training needs. Because different vendors were chosen by the MHPs, no vendor so far has a dominant number of contracts.

The strengths reflected in operations of information systems are generally associated with a long-term skilled staff familiar with technology, well-organized user groups, and good vendor relations. For most, however, the systems themselves present major limitations.

Especially for large MHPs, resources to support quality improvement and an information systems staff appear to be lacking, a challenge that becomes accentuated during implementation and operation of new more complex systems.

Quality improvement programs/processes

Strengths and challenges both spoke to the presence or absence of:

- Real quality improvement plans with meaningful, measurable goals
- Sufficient staffing, including information systems and/or analyst staff
- Consumer and family member involvement, which has improved but is inconsistent
- Support and commitment from administration—a key factor in quality improvement program success
- Quality improvement and information system communication and collaboration—improved regardless of size

In general the focus on documentation standards and utilization review continues—in other words, compliance, consistent with our Year One findings. Only a few MHPs monitor clinical or business process outcomes.

Contract provider relationships

By meeting with an increased number of providers in Year Two, we were able to obtain a variety of points of view—some often different from the MHP's. We also had the opportunity to revisit some of the larger contractors who shared impressions that we could compare against last year's.

Although challenges far outweigh strengths, MHPs with strengths in this area have established real collaboration and communication with providers on a number of business and planning issues. They also share data and reports regularly and in a timely fashion. Providers have entry into the information systems to input data, extract reports and determine information such as authorizations and eligibility. They view themselves as colleagues of the MHP rather than a less important outside necessity. Unlike most content areas, regional differences exist. Of the ten MHPs for which we defined this area as a challenge, five were in the Bay Area, three in the Superior Region and one in the South.

Integration of Mental Health and Substance Abuse (Alcohol and Drug)

Although less frequently identified in the MHP summaries than other targeted areas, the high percentage co-morbidity in the beneficiary population makes the lack of integration of mental health (MH) and substance abuse (SA) an important issue. Again challenges outnumbered strengths.

One small MHP in the Central Region was a “highly integrated behavioral health system.” In all other cases, practice lagged considerably behind policy.

MH and alcohol and drug program models ranged from “isolated from one another” to “limited coordination” to “initiation of a dual diagnosis program.” Clinical integration occurs as rarely in behavioral health departments, which typically include both MH and SA services, as it does in separate MH and SA departments. The failure to provide integrated services is particularly problematic in youth or teen programs. Almost exclusively, MHPs did not have any confidence in their own data regarding the accuracy

of reported substance use diagnoses. Their information systems reported very low rates of diagnosis that could not realistically represent the MHP's beneficiary population. For this reason, several MHPs initiated PIPs to deal with improving the identification of these diagnoses and, eventually, improved services.

Section 4.2.1: Performance Improvement Projects: Analysis and Discussion

In Year One we reviewed 54 MHPs, each of which was to have one PIP at least in concept. In Year Two, DMH required that those MHPs that had undergone the review process in FY05 were to have two “active and ongoing” PIPs—one clinical and one non-clinical. Two new MHPs, Solano and Alpine, came into the Medi-Cal system and were reviewed according to Year One standards. Consequently, using the PIP Validation Tool, CAEQRO scored 54 PIPs in Year One and 110 PIPs in Year Two. As in Year One, PIPs constituted the most challenging area for the majority of MHPs—especially given the increase in Year Two requirements.

Overall, PIP findings for Year Two show a considerable decrease as compared to Year One. However, a number of positive indicators suggest that MHPs are developing the orientation and skills to improve in this area for Year Three:

- **Initial steps towards collaboration.** In the spring of 2006, a number of MHP staff members volunteered to participate in a PIP committee to determine how MHPs could identify important common issues and develop PIP “templates” or outlines. In addition, CAEQRO, in cooperation with CIMH and CMHDA, convened a full-day workshop that reviewed individual MHP data of potential interest and use for a future PIP, and that primarily small and medium MHPs attended.
- **An increase in data access and sharing.** Our overall site review findings indicated an increase in access to and the sharing of data. A number of factors might account for this change.
 - Quality improvement and the data analytic staff increased their collaboration—many of whom participated in quality improvement committees.
 - Various formal training sessions—including MHPA plan development— included data analysis. Although these sessions did typically concentrate on demographic and epidemiological data, MHPs could apply their new analytic skills to developing and implementing PIPs.
 - More current data is available to MHPs—including data from CAEQRO that is less than a year old, as illustrated by the findings discussed in Section 4.4.

The remainder of Section 4.2.1 displays our Year Two findings on PIPs and is comprised of the following four sections:

- **Situational Analysis**—which provides a discussion on what factors contributed to the MHPs’ challenges in developing and/or implementing a PIP
- **Report Methodology**—which summarizes how CAEQRO evaluated the status of PIPs and aggregated our findings from the PIP Validation Tool
- **Status Findings**—a summary analysis of the status of PIPs for all MHPs, as well as a summary of “yes” responses
- **Specific Question Scores**—data results on specific questions extracted from the PIP Validation Tool

Situational Analysis

Because so many MHPs fell significantly short of the requirements, the site review discussions on PIPs were sometimes contentious and were often the only area of major disagreement. CAEQRO and MHPs have identified the following key reasons for these difficulties, a number of which are interrelated and many of which are touched on in Section 4.2.

Small MHPs

Thirty-two of the 58 counties self-identify as “small,” which is largely consistent with CAEQRO’s size categorizations. (Attachment 1 lists 30 MHPs as “small” or “small-rural” MHPs.) Most small MHPs have significant resource constraints. Ten of the self-identified “small counties” serve 365 or fewer beneficiaries per year and are comparable in size to a small outpatient clinic in other, larger MHPs. Thus, in discussing the challenges associated with developing PIPs, CAEQRO acknowledges those challenges that are either specific to or particularly acute for MHPs within small counties. However, the Centers for Medicare & Medicaid Services does not waive requirements based on size.

- **Lack of collaboration across county lines.** Exacerbating the overall challenge of limited resources, county-based human and health services have not been structurally designed for or culturally inclined towards collaboration or resource sharing. DMH views all system of care activities as centered within individual counties, which are each identified as the official Medi-Cal MHP. California is one of the few states that continue to organize services almost entirely according to individual counties. Therefore, historical, structural and political issues serve as significant barriers to MHP’s combining resources across county lines.

While this orientation affects the entire system of care, an example is direct service resources. Medium and large counties typically both operate and contract for services. In contrast, small counties provide services almost exclusively through county employees and are disinclined to form a formal multi-MHP group entity to employ or contract with data analytic and methodology specialists.

Two notable exceptions to collaborations are important to acknowledge: 1) Small County Emergency Risk Pool (SCERP); and 2) California Regional Mental Health System Coalition Joint Powers Authority (JPA) for management information systems. However, the JPA with only nine members is even smaller than SCERP

due to contract differences in the choice of a new information systems vendor. MHPs that selected or implemented an alternate vendor have each negotiated individual contracts and use a shared administrative entity managing the various installations.

- **Lack of access to data.** In Year One’s statewide report we identified the overall lack of access to data as a major theme. To repeat a quote from that document, “Data—we do not have it and we do not use it.” Despite the improvements noted in Section 4.2, much improvement in data access and sharing within MHPs is still necessary to perform the kind of complex analyses and develop the necessary programming that is characteristic of PIPs. While data limitations are endemic to the system, this area is particularly challenging for small MHPs—again because of resource limitations.

All mental health plans

The following issues impede PIP development and implementation—irrespective of size.

- **Staffing history and allocation.** In small and small rural counties, managers are generalists by necessity; often clinician managers who, in addition to administrative tasks, provide supervision if not actual direct service. While such individuals are often interested in data and are able to manage it, without data to review and without a particular focus, other higher priority duties become more pressing.

However, staffing issues are not limited to small counties. Most MHPs assigned the quality improvement/assurance coordinator or manager the overall responsibility for managing all EQRO activities. Often this individual had already assumed the responsibilities for two positions because of budget cuts. He or she then had to assume responsibility for the many analytic activities necessary for developing and implementing PIPs without additional staffing resources.

In addition, individuals often are promoted into quality improvement/assurance or regulatory/compliance roles from direct clinical service positions. Formal performance management requires additional skill sets, including data analysis skills as well as multi-disciplinary project management. Finally, lacking administrative influence and/or support, the individuals charged with PIPs have difficulty engaging the organization’s efforts in this kind of data-driven activity and the associated intervention to improve outcomes.

- **Mental Health Service Act—the overwhelming priority.** During Year Two, MHSA planning requirements became the overwhelming priority and concentration for all but the very largest MHPs. Large numbers of key staff members were assigned responsibilities associated with MHSA planning. Other projects, such as EPSDT audits, had financial consequences and so were allotted resources. In addition to new skills, PIP development and implementation also requires a defined team with a specific plan and associated tasks that occur over time. As in Year One, many MHPs presented PIP ideas and plans that they had developed in the week or two before this year’s site review. PIP performance

remained the most problematic—even for those MHPs that had maintained and/or improved performance in a number of other areas.

Report Methodology

The following paragraphs summarize two ways in which CAEQRO evaluated PIPs:

1. Status of development and implementation
2. Technical merit

Description of Categories

To assess whether a PIP met the requirement of “active and ongoing,” CAEQRO developed the following categories for the site reviews teams to apply in conducting their evaluations:

- **Active and ongoing:** initiated in either Year One or Two; specific project designed; data collection underway; and at least one re-measurement
- **Active but newly implemented:** initiated in Year Two; baseline data collection and review completed; and evidence of active, ongoing project activity
- **Little activity for PIP that was conceptualized last Year:** same project in almost the same status as last year
- **Not active or ongoing:** at an early conceptual stage; concept and description often developed just prior to the review; and no actual activity
- **No PIP available for review:** no concept or area selected

Organization of PIP Validation Tool Findings

Twenty-seven items comprise the PIP Validation Tool which is included in Attachment 4. While our review teams collected data on every item, in Year One and Year Two, we reported on those findings that would be most useful in capturing the status of PIPs among all MHPs.

Since Year One provided a baseline for evaluation, CAEQRO only reported on Questions 1 through 8 since these items rate planning, conceptualizing, and defining the PIP. In Year Two we report on two sections, Questions 1-8 and Questions 12-16. The second set of questions concentrate on the methodology for study design, data collection and analysis. In summarizing our findings, we do not include responses to Questions 9 -11, which review the adequacy of sampling. Since few MHPs actually used formal sampling, the rating was almost universally, “not applicable.” As in Year One’s report, Los Angeles is included in the “large” category.

While we believe comparing scores from 2005 and 2006 is useful, we rated performance on the PIP generously during the baseline year. During the Year Two, our scoring was more rigorous than in Year One in keeping with the rigors of the requirements. For example, items that dealt with data selection, identification of indicators and

methodology were rated “no” or “partial” instead of N/A if the project had not reached this stage of completion.

Status Findings

To better understand the results of PIP Validation Tool scores, we first present the results of the status descriptions that CAEQRO included in each MHP report, followed by an analysis of “yes” ratings collected from the PIP Validation Tool. Although status and technical performance are distinct areas, there is some relationship. For PIPs with a concept only, it is unlikely that a specific study question has been developed and even more unlikely that the data analysis methodology is clearly defined. It is also unlikely to find an increase in the number “yes” ratings in the technical evaluation for PIPs that have remained fairly static. Thus, the number and percentage of PIPs that actually met the criteria of “active and ongoing” can be a strong indicator of the technical merit of PIPs within MHPs during Year Two.

Only 43 percent of 110 PIPs qualify as “Active.” The small and small-rural MHPs account for nine of the 13 rated as “Concept Only/None.”

Figure 1 combines the five PIP status descriptors into three categories: Active—ongoing/new; “Little Activity”; and “Concept Only/None.” Of the 110 PIPs rated, only 43 percent are in the “Active” category. There were noticeable differences between large, medium, small and small-rural categories in the percentage of PIPs described as Active. The small and small-rural MHPs account for nine of the 13 PIPs with a rating of “Concept Only /None.”

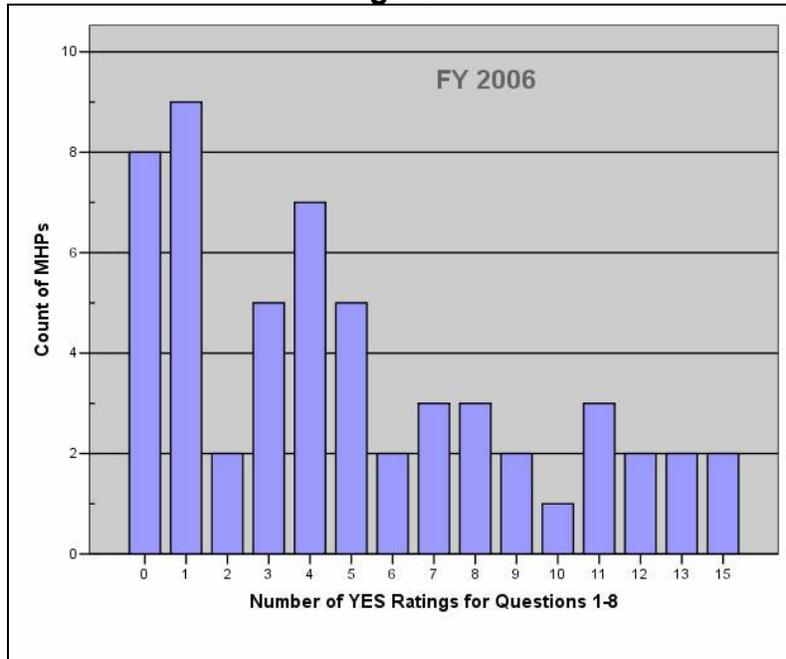
Figure 1

PIP Status by MHP Size		
MHP Size	PIP Status	Count
Large	Active - Ongoing or New	12
	Little Activity	3
	Concept Only or None	11
Medium	Active - Ongoing or New	13
	Little Activity	7
	Concept Only or None	7
Small	Active - Ongoing or New	12
	Little Activity	3
	Concept Only or None	14
Small-Rural	Active - Ongoing or New	10
	Little Activity	3
	Concept Only or None	15
Total	Active - Ongoing or New	47
	Little Activity	16
	Concept Only or None	47

No MHP received the maximum number of “yes” ratings, although two MHPs did receive 15 “yes” ratings—the second highest possible score.

Figure 2 displays the “yes” results for Questions 1-8. For MHPs with two PIPs, 16 is the maximum possible number of “yes” ratings. No MHP received this rating.

Figure 2



MHPs in all size categories, except small-rural, show a clear increase in the number of “yes” ratings.

Figure 3 displays the “yes” ratings for Questions 1-8 for Year One (FY05) and Year Two (FY06) by size of MHP. The maximum number of Yes answers for Year One is 8. The maximum number of Yes answers for Year two is 16, since two PIPs were rated for Year Two. Using the mean and median permits a more direct comparison between the years. All size categories except small-rural show a clear increase in the average number of “yes” ratings for FY06.

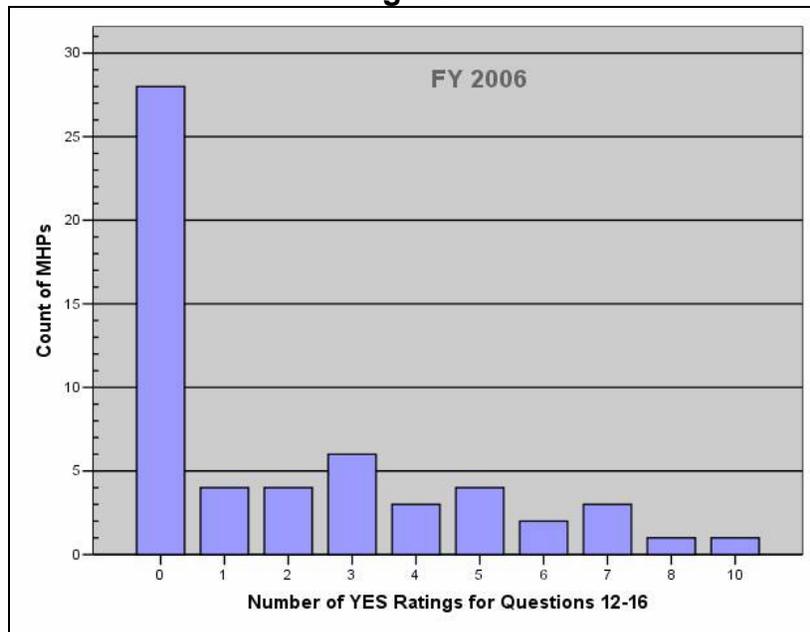
Figure 3

Total YES Ratings for Questions 1-8							
Fiscal Year			County Size				
			Large	Medium	Small	Small-Rural	Total
2005	Number of YES Rating for Questions 1-8	N	13	13	14	14	54
		Mean	4.92	3.62	3.14	4.57	4.06
		Median	6	4	3	4.5	4
		Std. Deviation	2.722	2.599	2.248	2.209	2.483
		Minimum	0	0	0	0	0
		Maximum	8	7	8	8	8
2006	Number of YES Rating for Questions 1-8	N	13	14	15	14	56
		Mean	6.15	6.00	4.80	3.07	4.98
		Median	5	6	4	1.5	4
		Std. Deviation	4.93	4.788	3.895	3.222	4.309
		Minimum	0	0	0	0	0
		Maximum	15	15	13	9	15

No MHP received the maximum number of “yes” ratings, although two MHPs did receive 15 “yes” ratings—the second highest possible score.

Figure 4 shows the number of “yes” ratings for Questions 12-16 for FY06. For MHPs with two PIPs, the maximum number possible is 10. Only one MHP reached this number, while 28 MHPs had 0 “yes” ratings.

Figure 4



Small and small-rural MHPs had considerably lower median and mean scores for Questions 12-16 than did large MHPs.

Figure 5 displays the mean and median number of “yes” ratings according to MHP size. Considering Questions 12-16, the mean and median scores for large and medium MHPs were considerably higher than those for the small-rural MHPs.

Figure 5

Total YES Ratings for Questions 12-16							
Fiscal Year	Number of YES Rating for Questions 12-16	N	County Size				Total
			Large	Medium	Small	Small-Rural	
2006			13	14	15	14	56
		Mean	2.46	2.93	1.80	0.93	2.02
		Median	1.00	2.50	0.00	0.00	0.50
		Std. Deviation	2.537	3.362	2.274	1.94	2.618
		Minimum	0	0	0	0	0
		Maximum	7	10	6	7	10

Specific Question Scores

Most figures in this section summarize key findings in terms of percentages. We display detailed ratings for FY05 and FY06 in the PIP Validation Tool in Attachment 16. Please note that Los Angeles is included in the “large” category.

Figure 6

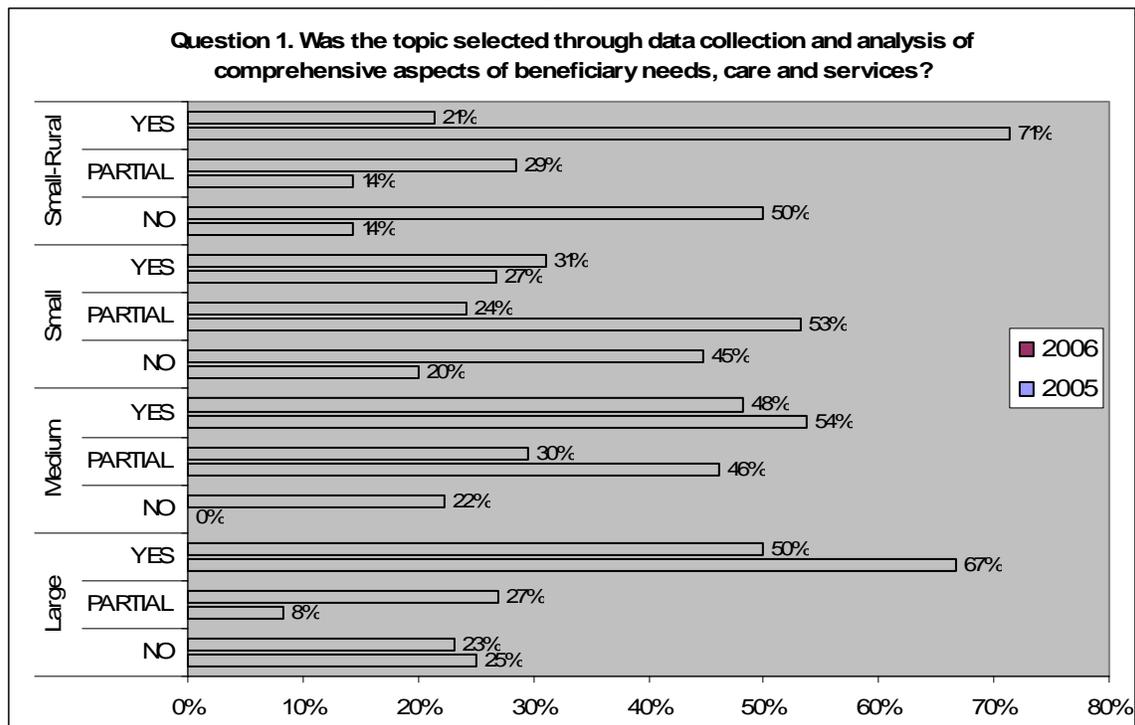
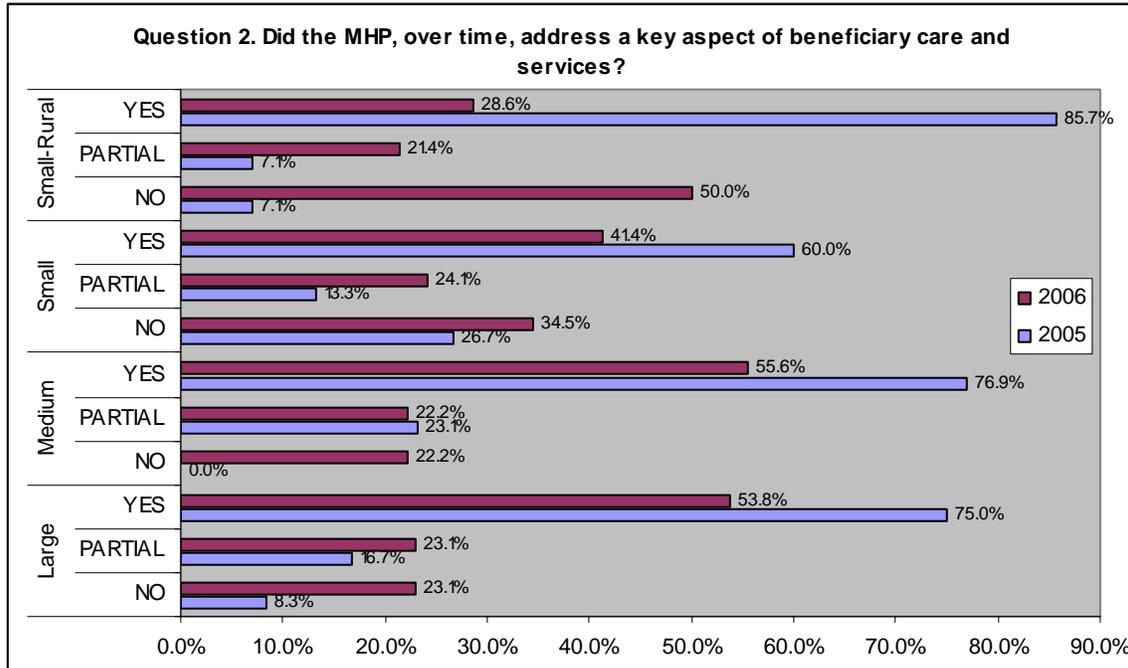


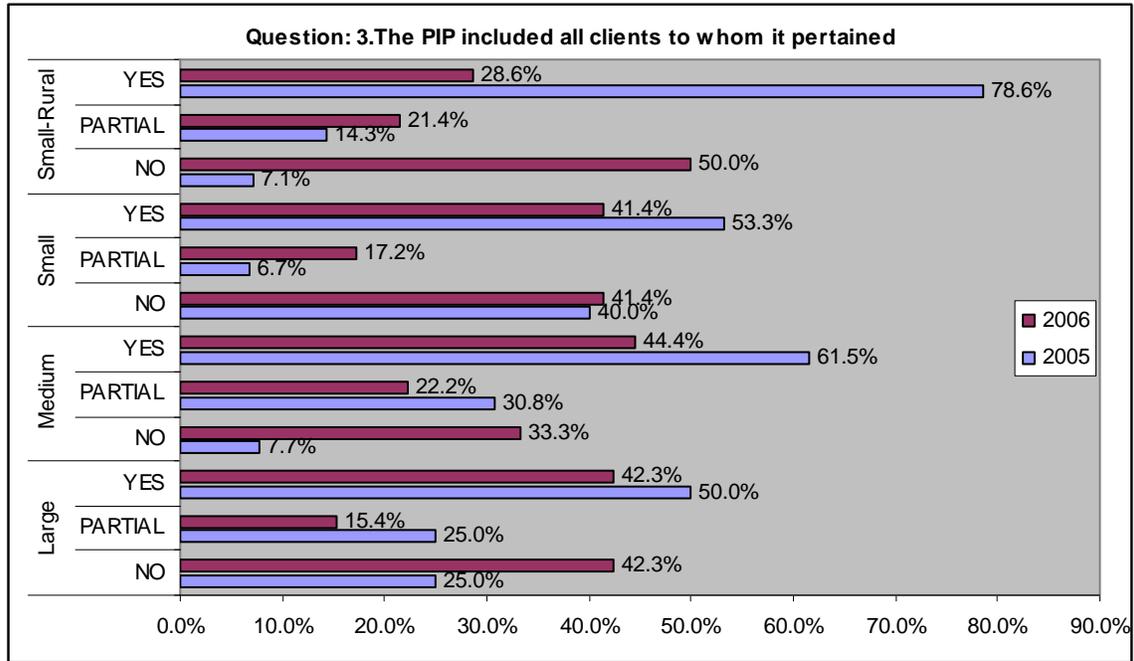
Figure 6 shows more than a twofold increase overall in the percentage of PIPs that did not analyze beneficiary needs, care and service data in developing a project topic. While the large MHPs maintained the same percentage of “no” ratings, all other MHPs showed a significant increase, with the small-rural MHPs showing a more than threefold increase in “no” ratings. Even for the large MHPs, the percentage declined in the “yes” ratings with a corresponding increase in partial ratings.

Figure 7



The total column in Figure 7 shows that a third of the PIPs failed to address a key aspect of beneficiary care and services, reflecting a threefold increase in the percentage of MHPs with “no” ratings. Correspondingly, less than half the PIPs received a “yes” rating, a significant drop from almost 75 percent of the PIPs rated similarly the year before. While a decrease in “yes” ratings and an increase in “no” ratings occurred across MHPs—regardless of size—the small-rural counties registered the most marked changes in both categories.

Figure 8



In Figure 8, MHPs showed a decline in including all beneficiaries to whom the PIPs pertained, with the doubling of the percentage of a “no” ratings and a 20 percent drop in the “yes” ratings. This is one area in which the negative rating is almost uniformly distributed across the MHP size spectrum.

Figure 9

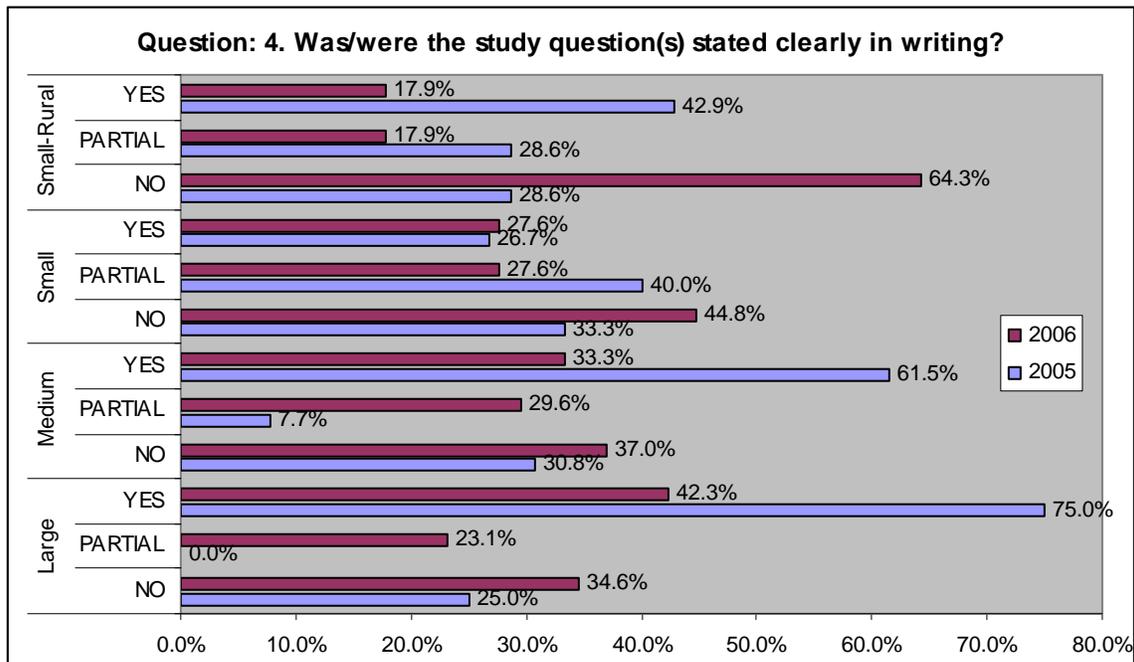


Figure 9 shows that the MHPs continue to struggle in clearly articulating their PIP study questions. The Year Two results show a clear gradient in “yes” and “no” ratings across MHP size, perhaps reflecting the staffing and resource issues by plan size.

Figure 10

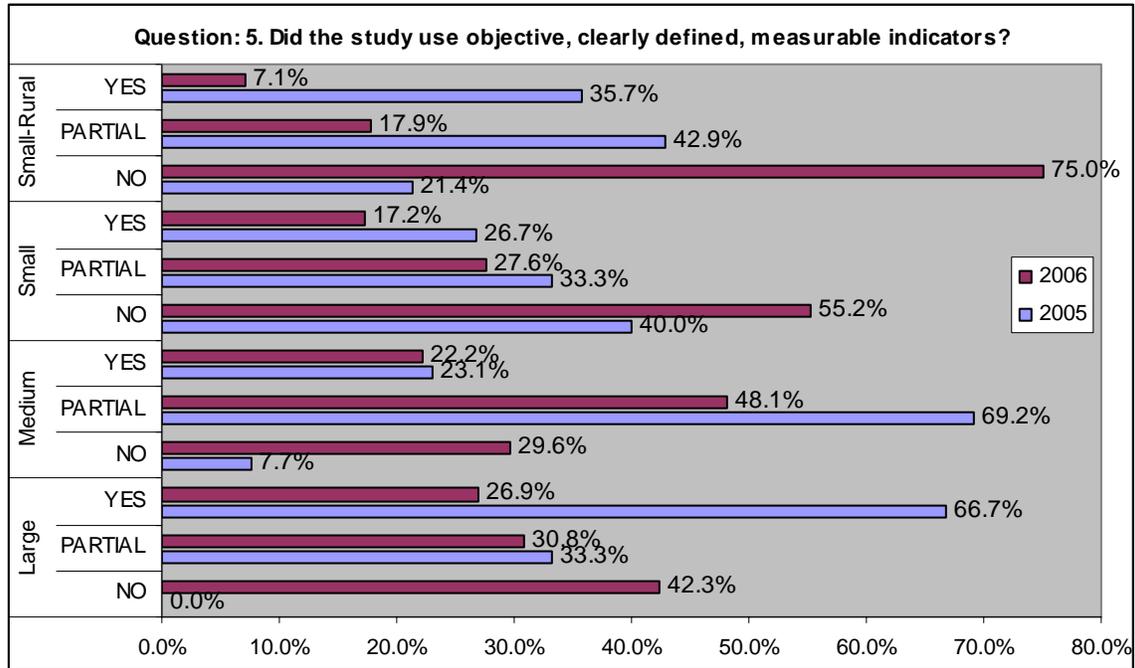


Figure 10 illustrates that 50 percent of the PIPs lacked clearly defined indicators for objective measurements. The problem is particularly acute for the small-rural MHPs with three-quarters of their PIPs not meeting the criteria. The same issue is true for large, medium and small MHPs with three-quarters of their PIPs also not meeting or partially meeting the criteria for objective, clearly defined and measurable indicators.

Figure 11

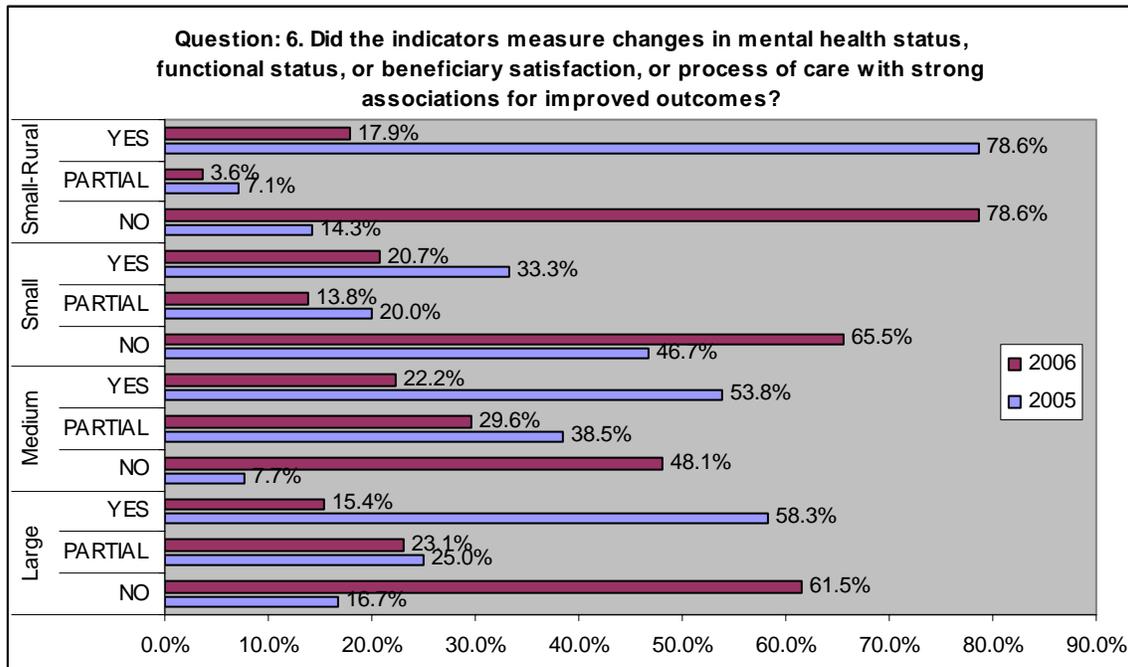


Figure 11 shows that MHPs are selecting indicators with little relevance to measuring changes in mental health or functional status, beneficiary satisfaction, or processes of care. With fewer than 20 percent fully meeting the criteria for a “yes” rating, MHPs will have little likelihood of demonstrating improved outcomes based on their current PIPs.

Figure 12

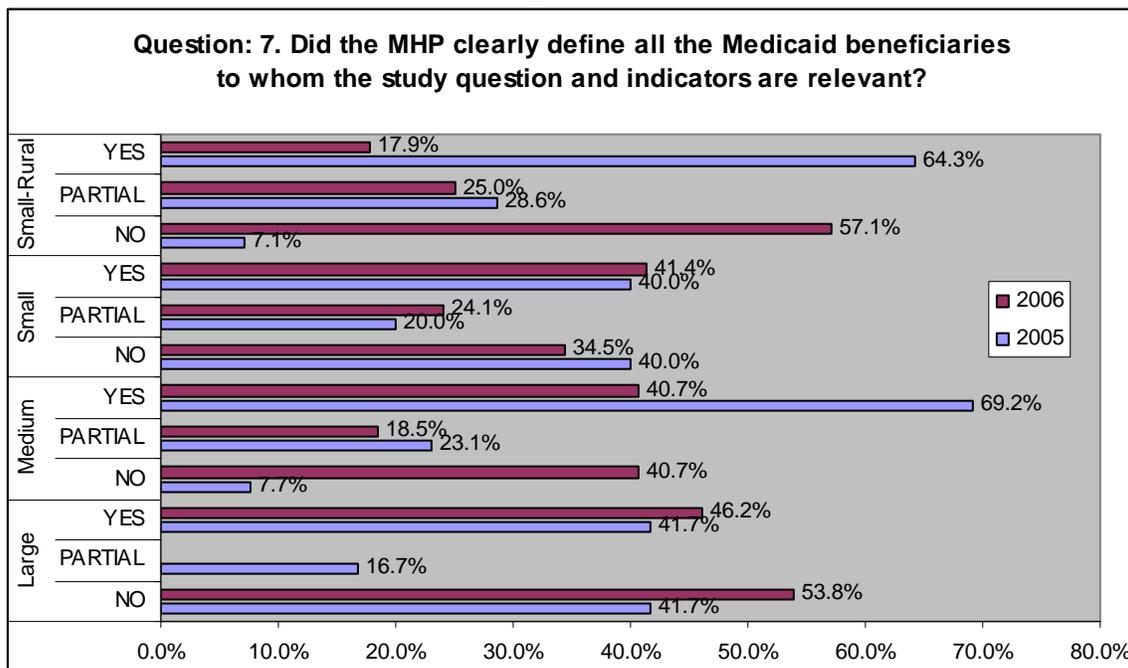


Figure 12 suggests that small MHPs were slightly more successful in fully defining or partially defining the Medi-Cal beneficiaries to whom the study question and indicators were relevant, followed by the medium-size MHPs. More than half of the large and small-rural MHPs failed to define the same.

Figure 13

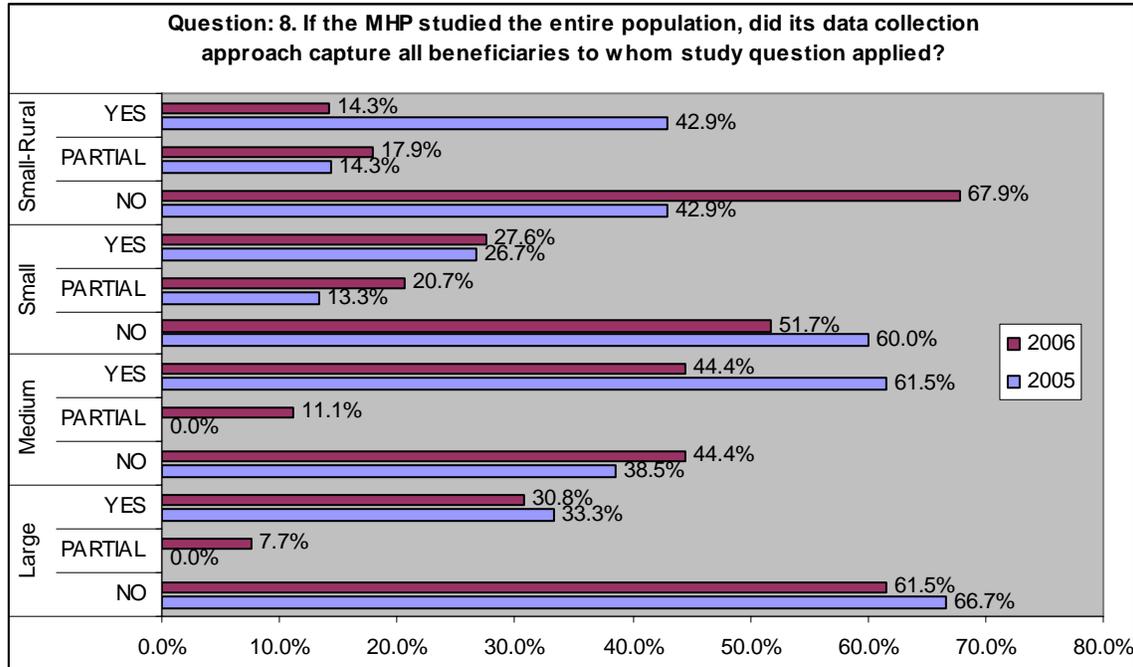


Figure 13 illustrates that MHPs did not fare well in developing data collection approaches that would capture all beneficiaries relevant to the PIPs. Although the medium-size MHPs did slightly better than others, the lack of an appropriate data collection approach was consistent among all MHPs—irrespective of size.

Figure 14

Question: 12. Did the study design clearly specify the data to be collected?

PIP Rating	Fiscal Year	Statistics	MHP Size				Total
			Large	Medium	Small	Small-Rural	
NO	2006	Count	11	8	14	21	54
		Column %	42.3%	29.6%	48.3%	75.0%	49.1%
PARTIAL		Count	6	10	6	5	27
		Column %	23.1%	37.0%	20.7%	17.9%	24.5%
YES		Count	9	9	9	2	29
		Column %	34.6%	33.3%	31.0%	7.1%	26.4%
Total		Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Figure 14 represents the first of the study design items reported this year. The medium-size MHPs were the most successful in clearly specifying the data—with 70 percent of

their PIPs fully or partially meeting the criteria. In contrast, 75 percent of the small-rural PIPs did not meet the criteria in clearly specifying the data to be collected.

Figure 15

Question: 13. Did the study design clearly specify the sources of the data?							
PIP Rating	Fiscal Year	Statistics	MHP Size				
			Large	Medium	Small	Small-Rural	Total
NO	2006	Count	8	5	11	18	42
		Column %	30.8%	18.5%	37.9%	64.3%	38.2%
PARTIAL		Count	6	11	9	6	32
		Column %	23.1%	40.7%	31.0%	21.4%	29.1%
YES		Count	12	11	9	4	36
		Column %	46.2%	40.7%	31.0%	14.3%	32.7%
Total		Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Figure 15 indicates that MHPs were better able to specify clearly the data sources for the PIPs than to specify any of the other PIP areas reported this year. Over 80 percent of the PIPs by medium-size MHPs fully or partially met the criteria, followed by 77 percent of the PIPs by large MHPs.

Figure 16

Question: 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?							
PIP Rating	Fiscal Year	Statistics	MHP Size				
			Large	Medium	Small	Small-Rural	Total
NO	2006	Count	14	12	15	20	61
		Column %	53.8%	44.4%	51.7%	71.4%	55.5%
PARTIAL		Count	9	7	11	6	33
		Column %	34.6%	25.9%	37.9%	21.4%	30.0%
YES		Count	3	8	3	2	16
		Column %	11.5%	29.6%	10.3%	7.1%	14.5%
Total		Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Figure 16 suggests that MHPs had difficulties in developing systematic data collection methods for reliably representing the entire PIP population. We rated fifty-five percent of the medium-size MHP PIPs as “yes” or “partial,” while the other PIPs averaged 44 percent in the same scoring categories.

Figure 17

Question: 15. Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?							
PIP Rating	Fiscal Year	Statistics	MHP Size				
			Large	Medium	Small	Small-Rural	Total
NO	2006	Count	13	11	16	21	61
		Column %	50.0%	40.7%	55.2%	75.0%	55.5%
PARTIAL		Count	9	9	8	4	30
		Column %	34.6%	33.3%	27.6%	14.3%	27.3%
YES		Count	4	7	5	3	19
		Column %	15.4%	25.9%	17.2%	10.7%	17.3%
Total		Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Figure 17 indicates that MHPs had similar ratings for their PIP data collection instruments in terms of providing consistent and accurate data collection over the applicable time period. Again, the PIPs developed by the medium-size MHPs had a slightly higher rate of developing appropriate data collection instruments.

Figure 18

Question: 16. Did the study design prospectively specify a data analysis plan?							
PIP Rating	Fiscal Year	Statistics	MHP Size				
			Large	Medium	Small	Small-Rural	Total
NO	2006	Count	16	13	24	25	78
		Column %	61.5%	48.1%	82.8%	89.3%	70.9%
PARTIAL		Count	6	8	4	1	19
		Column %	23.1%	29.6%	13.8%	3.6%	17.3%
YES		Count	4	6	1	2	13
		Column %	15.4%	22.2%	3.4%	7.1%	11.8%
Total		Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

With the exception of medium-size MHPs, Figure 18 illustrates that few MHPs were able to prospectively specify a data analysis plan in their study design. Seventy percent of the PIPs overall were rated “no” on this item.

Section 4.3: Performance Measure Analysis

As described in Section 1, CAEQRO and DMH selected “cost per beneficiary served” as the Performance Measure (PM) for analysis in Year Two. CAEQRO then generated a series of reports that enabled us to analyze these data by key demographic and service variables. This section displays statewide data on “cost per beneficiary served” from calendar year 2005 Short-Doyle/Medi-Cal approved claims combined with Inpatient Consolidation Claims data from the same period. We present the data according to key demographic variables followed by combinations that reveal various service patterns.

Because the Los Angeles MHP represents 30 percent of beneficiaries served, its data can skew certain findings. Consequently, we display data both with and without Los Angeles—i.e., CANOLA.

Overarching Goals and Orientation

Since validated clinical information, such as level of acuity, level of disability and current diagnosis, is not available, DMH chose to have CAEQRO review important non-clinical beneficiary variables to analyze cost and services. The goal of our analysis was twofold:

1. Determine if patterns emerge
2. Initiate discussions whether these patterns necessitate further review and study by stakeholders

For data analysis in Year Two, CAEQRO applied the following categories which, in three instances, combine mental health service modes and service functions as defined by Medi-Cal:

- **24-hour services:** local hospital inpatient, hospital administrative days, psychiatric health facilities, adult crisis residential, adult residential and professional inpatient visits
- **23-hour services and crisis stabilization**
- **Day treatment**
- **Linkage/brokerage**
- **Outpatient services:** mental health services, medication support and crisis intervention (often used for an unplanned outpatient contact)
- **Therapeutic behavioral services (TBS)**

CAEQRO's findings, as displayed in this section, did indeed surface consistent differences in cost and service patterns associated with specific demographic variables. While various factors can contribute to these findings, these patterns do suggest questions around the types of services and the intensity of those services received by specific groups of beneficiaries. Understanding barriers to initial access to the service system is extremely important in addressing these questions. However, CAEQRO's findings, which are based on paid claims data (i.e., after beneficiaries enter the mental health system of care), can provide stakeholders with useful information on areas of potential review and intervention by individual MHPs.

We also recognize that patterns of service, maintenance or retention will vary across groups of beneficiaries who enter the mental health system. Therefore, rather than speculating about the root cause(s) of these patterns, we pose high-level questions in conjunction with each data set and our associated findings. These questions could help inform how to improve services throughout the system and within specific MHPs.

One high-level finding is important to consider in reviewing the data that follows below. The median (the cost in the mid-point of the distribution) and mean (average cost) are typically significantly different. This difference reflects that the distribution of overall services is highly skewed toward the lower end of both cost and number of services per person.

Statewide Overview

Viewing the data without the Los Angeles MHP is important for realistic comparisons among MHPs.

Data analysis

Figure 1 demonstrates the impact of the Los Angeles MHP data on statewide statistics. Because of the large volume of Medi-Cal eligible beneficiaries (36 percent of statewide total) and the beneficiaries served (30 percent of the state’s total), all statistics that use these data are weighted by the Los Angeles MHP’s trends.

For example, Medi-Cal penetration rate is 6.80 percent when the Los Angeles MHP’s data is excluded, 6.20 percent when it is included, reflecting the overall impact of its low 5.13 percent penetration rate on statewide data. Similarly, the impact on cost per beneficiary served is illustrated in the figure below.

Figure 1

Cost Per Beneficiary Served-Statewide/CANOLA							
	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
Statewide	6,810,962	100%	422,369	100%	\$1,337	\$3,984	\$8,228
CANOLA	4,353,453	64%	296,232	70%	\$1,280	\$3,800	\$8,115
Los Angeles	2,457,509	36%	126,137	30%	\$1,503	\$4,418	\$8,474

Demographic/Service Activity Variables

Why are the service costs for female beneficiaries lower than the service costs for male beneficiaries?

Figure 2 documents an important difference between services to males and females—both in statewide and CANOLA data:

1. Females represent a higher percentage of Medi-Cal eligible beneficiaries.
2. Females represent a higher percentage of the total number of beneficiaries served.
3. *“Cost per beneficiary served” is lower for females than for males.*

Figure 2

Statewide - Cost Per Beneficiary Served by Gender							
Gender	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
Statewide	6,810,962	100%	422,369	100%	\$1,337	\$3,984	\$8,228
FEMALES	3,873,207	57%	221,267	52%	\$1,176	\$3,481	\$7,490
MALES	2,937,749	43%	201,102	48%	\$1,559	\$4,538	\$8,938

CANOLA - Cost Per Beneficiary Served by Gender							
Gender	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Cost Per Beneficiary Served - Std. Dev.
CANOLA	4,353,453	100%	296,232	100%	\$1,280	\$3,800	\$8,115
FEMALES	2,471,320	57%	157,615	53%	\$1,139	\$3,343	\$7,433
MALES	1,882,127	43%	138,617	47%	\$1,483	\$4,319	\$8,797

Based on these findings, CAEQRO further sorted the data according to different types of service activities to identify any differences in overall patterns of services to females. In Figure 3 below, females represent an equal or higher percentage of those served in 24-hour service, 23-hour service, linkage/brokerage and outpatient treatment modalities. A higher percentage of males receive day treatment and TBS. However, the average “cost per beneficiary served” is lower for females in all six categories; CANOLA data shows the same pattern.

Figure 3

Statewide - Cost Per Beneficiary Served by Service Activity and Gender							
Service Activity Category	Gender	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
24 Hr Services	Statewide		44,655		\$2,354	\$5,616	\$9,211
24 Hr Services	FEMALES	57%	23,122	52%	\$2,100	\$5,297	\$8,984
24 Hr Services	MALES	43%	21,533	48%	\$2,603	\$5,960	\$9,436
23 Hr Services	Statewide		21,651		\$1,161	\$1,625	\$2,102
23 Hr Services	FEMALES	57%	10,924	50%	\$1,061	\$1,511	\$2,053
23 Hr Services	MALES	43%	10,727	50%	\$1,279	\$1,741	\$2,145
DAY TX	Statewide		10,472		\$7,164	\$10,309	\$10,128
DAY TX	FEMALES	57%	4,285	41%	\$6,248	\$9,373	\$9,678
DAY TX	MALES	43%	6,187	59%	\$7,860	\$10,957	\$10,379
LINKAGE/BROKERAGE	Statewide		206,204		\$259	\$781	\$1,657
LINKAGE/BROKERAGE	FEMALES	57%	103,391	50%	\$241	\$729	\$1,605
LINKAGE/BROKERAGE	MALES	43%	102,813	50%	\$280	\$833	\$1,705
Outpatient Services	Statewide		406,750		\$1,089	\$2,668	\$4,933
Outpatient Services	FEMALES	57%	213,016	52%	\$977	\$2,358	\$4,426
Outpatient Services	MALES	43%	193,734	48%	\$1,238	\$3,008	\$5,416
TBS	Statewide		3,086		\$9,011	\$13,876	\$16,264
TBS	FEMALES	57%	1,192	39%	\$7,474	\$12,355	\$14,543
TBS	MALES	43%	1,894	61%	\$9,755	\$14,833	\$17,194

CANOLA - Cost Per Beneficiary Served by Service Activity and Gender							
Service Activity Category	Gender	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
24 Hrs Services	CANOLA	100%	26,396	100%	\$3,090	\$6,543	\$9,520
24 Hrs Services	FEMALES	57%	14,004	31%	\$2,796	\$6,142	\$9,268
24 Hrs Services	MALES	43%	12,392	28%	\$3,525	\$6,997	\$9,778
23 Hrs Services	CANOLA	100%	17,419	100%	\$1,164	\$1,695	\$2,236
23 Hrs Services	FEMALES	57%	8,886	41%	\$1,061	\$1,571	\$2,188
23 Hrs Services	MALES	43%	8,533	39%	\$1,300	\$1,825	\$2,278
DAY TX	CANOLA	100%	6,876	100%	\$6,384	\$9,987	\$10,296
DAY TX	FEMALES	57%	2,850	27%	\$5,243	\$8,848	\$9,770
DAY TX	MALES	43%	4,026	38%	\$7,378	\$10,794	\$10,580
LINKAGE/BROKERAGE	CANOLA	100%	140,215	100%	\$261	\$828	\$1,774
LINKAGE/BROKERAGE	FEMALES	57%	70,870	34%	\$243	\$774	\$1,731
LINKAGE/BROKERAGE	MALES	43%	69,345	34%	\$281	\$883	\$1,816
Outpatient Services	CANOLA	100%	285,718	100%	\$1,049	\$2,508	\$4,886
Outpatient Services	FEMALES	57%	152,054	37%	\$952	\$2,233	\$4,392
Outpatient Services	MALES	43%	133,664	33%	\$1,182	\$2,822	\$5,376
TBS	CANOLA	100%	1,978	100%	\$7,197	\$11,068	\$14,582
TBS	FEMALES	57%	789	26%	\$6,125	\$10,018	\$13,182
TBS	MALES	43%	1,189	39%	\$7,926	\$11,764	\$15,407

Attachment 17 displays the numbers of female and male beneficiaries served for each MHP, the costs associated with these services and a ratio of female to male beneficiaries served. MHPs are listed in ascending order according to the ratio of the cost per females served/cost per males served. Were an MHP to have an average cost per female equal to the cost per male, the ratio would be 1.00. In applying this calculation, Kern MHP—at 0.99—is the closest to having an average cost per female equal to the cost per male. The statewide ratio is 0.77. Reviewing MHPs with sufficient numbers of beneficiaries for a meaningful display, CAEQRO determined the range to be from .58 to 1.55. Only five MHPs are 1.00 or above. This statewide ratio is a clear indicator of concern and reaffirms the cost discrepancy between male and female beneficiaries.

Why are the service costs for Hispanic beneficiaries lower than the service costs for White beneficiaries? Why do service costs for African-American beneficiaries appear to be disproportionately high?

Prior to the initiation of the external quality review organization contract, DMH required MHPs to develop and submit a Cultural Competency Plan detailing their respective populations by ethnicity—describing and reporting their service data by ethnicity, as well as indicating the variance in beneficiaries served versus the demographics of the county’s beneficiary population. During the Year One site review process, CAEQRO reviewed these plans

and queried MHPs about follow-up activity to increase penetration rates for underserved populations. In Year Two, cultural competency was again an important part of the site review process. As discussed in Section 1.3, each MHP received an approved claims report that was reviewed by the CAEQRO during the site review. CAEQRO noted that appeared to be major disparities in “cost per beneficiary served” by ethnicity. Further data analysis by CAEQRO for our Year Two Statewide report confirmed these discrepancies.

Figure 4 below shows the statewide and CANOLA data for “cost per beneficiary served” by ethnicity according to beneficiary ethnic code included on each claim. Statewide data show a significant difference in access between White and Hispanic beneficiaries. *Although White beneficiaries represent only 21 percent of the total eligible population, 42 percent of those served are White.* The reverse is true for Hispanic beneficiaries who comprise 53 percent of the eligible population, but only 26 percent of the population receiving services. African-American is another beneficiary group whose percentage served (17 percent) is higher than the percentage of the beneficiaries in the eligible population (10 percent).

“Cost per beneficiary served” shows Whites, African-American and Native American beneficiaries are all above the mean and almost equivalent to each other. However, Hispanic and Asian/Pacific Islander “cost per beneficiary served” are both below the statewide mean.

While removing the Los Angeles MHP from the data slightly increases the percentage of eligible Whites served, it also reduces the percentage of Hispanic beneficiaries that received services from 26 percent to 23 percent. The distribution of the groups above and below the mean, however, remains.

Figure 4

Statewide - Cost Per Beneficiary Served by Race/Ethnicity Categories							
Race/Ethnicity Categories	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median-Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
Statewide	6,810,962	100%	422,369	100%	\$1,337	\$3,984	\$8,228
WHITE	1,459,927	21%	178,039	42%	\$1,344	\$4,161	\$8,633
HISPANIC	3,576,788	53%	108,519	26%	\$1,411	\$3,580	\$6,978
AFRICAN-AMERICAN	705,805	10%	70,113	17%	\$1,321	\$4,287	\$8,773
ASIAN/PACIFIC ISLANDER	689,112	10%	35,621	8%	\$1,004	\$3,270	\$7,604
NATIVE AMERICAN	29,828	0.4%	3,434	1%	\$1,448	\$4,161	\$8,101
OTHER	349,503	5%	26,643	6%	\$1,461	\$4,585	\$9,299

CANOLA - Cost Per Beneficiary Served by Race/Ethnicity Categories							
Race/Ethnicity Categories	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Cost Per Beneficiary Served - Std. Dev.
CANOLA	4,353,453	100%	296,232	100%	\$1,280	\$3,800	\$8,115
WHITE	1,140,105	26%	138,765	47%	\$1,315	\$3,920	\$8,260
HISPANIC	2,050,581	47%	67,176	23%	\$1,221	\$3,166	\$6,679
AFRICAN-AMERICAN	418,089	10%	43,516	15%	\$1,347	\$4,321	\$8,963
ASIAN/PACIFIC ISLANDER	488,306	11%	27,285	9%	\$1,012	\$3,411	\$8,122
NATIVE AMERICAN	26,993	1%	3,016	1%	\$1,428	\$4,147	\$8,188
OTHER	229,378	5%	16,474	6%	\$1,481	\$4,573	\$9,507

Figure 5 below shows “cost per beneficiary served” by service activity and ethnicity, using the same service code grouping as in Figure 3. Figure 6 shows *average service costs for Hispanic beneficiaries were lower than the services costs for White beneficiaries across all categories*. In addition, Hispanics were the only group whose service costs were below the statewide average in all categories. African-American beneficiaries were over represented in relation to their population across all categories, especially in four more intensive levels of care among the six categories (i.e., 24-hour, 23-hour, Day-treatment and TBS-treatment modalities). CANOLA data, which shows the same pattern, is contained in Attachment 18.

Figure 5

Statewide - Cost Per Beneficiary Served by Service Activity and Race/Ethnicity							
Service Activity Category	Race/Ethnicity	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
24 Hrs Services	Statewide	100%	44,655	100%	\$2,354	\$5,616	\$9,211
24 Hrs Services	WHITE	21%	19,450	44%	\$2,625	\$5,905	\$9,343
24 Hrs Services	HISPANIC	53%	10,041	22%	\$1,827	\$4,296	\$7,763
24 Hrs Services	AFRICAN-AMERICAN	10%	9,176	21%	\$2,330	\$5,775	\$9,691
24 Hrs Services	ASIAN/PACIFIC ISLANDER	10%	2,397	5%	\$2,859	\$6,852	\$10,212
24 Hrs Services	NATIVE AMERICAN	0.4%	382	1%	\$2,668	\$4,999	\$7,230
24 Hrs Services	OTHER	5%	3,209	7%	\$2,850	\$6,699	\$10,100
23 Hrs Services	Statewide	100%	21,651	100%	\$1,161	\$1,625	\$2,102
23 Hrs Services	WHITE	21%	9,161	42%	\$1,161	\$1,609	\$1,964
23 Hrs Services	HISPANIC	53%	4,151	19%	\$1,015	\$1,370	\$1,682
23 Hrs Services	AFRICAN-AMERICAN	10%	5,610	26%	\$1,327	\$1,847	\$2,545
23 Hrs Services	ASIAN/PACIFIC ISLANDER	10%	1,372	6%	\$1,096	\$1,541	\$1,908
23 Hrs Services	NATIVE AMERICAN	0.4%	228	1%	\$1,263	\$1,697	\$2,114
23 Hrs Services	OTHER	5%	1,129	5%	\$1,078	\$1,673	\$2,241
DAY TX	Statewide	100%	10,472	100%	\$7,164	\$10,309	\$10,128
DAY TX	WHITE	21%	4,916	47%	\$7,129	\$10,323	\$10,257
DAY TX	HISPANIC	53%	2,105	20%	\$6,286	\$9,328	\$9,417
DAY TX	AFRICAN-AMERICAN	10%	2,365	23%	\$7,619	\$10,988	\$10,566
DAY TX	ASIAN/PACIFIC ISLANDER	10%	490	5%	\$7,642	\$10,528	\$9,928
DAY TX	NATIVE AMERICAN	0.4%	95	1%	\$6,138	\$8,859	\$8,955
DAY TX	OTHER	5%	501	5%	\$8,564	\$11,149	\$9,694
LINKAGE/BROKERAGE	Statewide	100%	206,204	100%	\$259	\$781	\$1,657
LINKAGE/BROKERAGE	WHITE	21%	87,463	42%	\$257	\$823	\$1,756
LINKAGE/BROKERAGE	HISPANIC	53%	55,355	27%	\$242	\$681	\$1,454
LINKAGE/BROKERAGE	AFRICAN-AMERICAN	10%	33,657	16%	\$234	\$768	\$1,654
LINKAGE/BROKERAGE	ASIAN/PACIFIC ISLANDER	10%	16,058	8%	\$334	\$780	\$1,485
LINKAGE/BROKERAGE	NATIVE AMERICAN	0.4%	1,627	1%	\$263	\$865	\$1,860
LINKAGE/BROKERAGE	OTHER	5%	12,044	6%	\$348	\$954	\$1,934
Outpatient Services	Statewide	100%	406,750	100%	\$1,089	\$2,668	\$4,933
Outpatient Services	WHITE	21%	172,397	42%	\$1,099	\$2,757	\$5,146
Outpatient Services	HISPANIC	53%	104,460	26%	\$1,185	\$2,615	\$4,363
Outpatient Services	AFRICAN-AMERICAN	10%	66,781	16%	\$1,030	\$2,678	\$5,029
Outpatient Services	ASIAN/PACIFIC ISLANDER	10%	34,711	9%	\$832	\$2,248	\$4,963
Outpatient Services	NATIVE AMERICAN	0.4%	3,278	1%	\$1,165	\$2,870	\$5,405
Outpatient Services	OTHER	5%	25,123	6%	\$1,131	\$2,801	\$5,261
TBS	Statewide	100%	3,086	100%	\$9,011	\$13,876	\$16,264
TBS	WHITE	21%	1,514	49%	\$9,802	\$15,215	\$17,975
TBS	HISPANIC	53%	694	22%	\$9,735	\$14,264	\$14,711
TBS	AFRICAN-AMERICAN	10%	604	20%	\$6,190	\$10,533	\$12,856
TBS	ASIAN/PACIFIC ISLANDER	10%	120	4%	\$6,753	\$9,889	\$11,721
TBS	NATIVE AMERICAN	0.4%	14	0.5%	\$8,293	\$11,088	\$11,785
TBS	OTHER	5%	140	5%	\$12,834	\$15,585	\$18,458

As with gender, MHP-specific data can be very useful in identifying the distribution of costs of services by ethnicity, as well as identifying outliers. Attachment 19 displays the comparison of the cost ratio for Hispanic and White beneficiaries in ascending order by MHP. With a statewide average of Hispanic/White cost per beneficiary served of 0.86 and CANOLA of 0.81, the range for MHPs with significant volume is 0.45—1.21. Five MHPs of any size have ratios from 1.00-1.76. All others are below 1.0.

Why are the service costs for older beneficiaries (60+) disproportionately low as compared to other age categories?

Services to beneficiaries eligible for federally subsidized Early and Periodic Screening Diagnosis and Treatment (EPSDT) receive significantly higher federal and state reimbursement than do individuals in other Medi-Cal categories. Persons from birth through 21 years old are eligible for EPSDT for which MHPs receive 90 percent reimbursement from federal and state sources versus the approximately 50 percent they receive for most services for adult beneficiaries.

Because MHPs require less local funding for EPSDT-funded services than for beneficiaries funded through other aid codes, services for children and adolescents/young adults tend to be more intensive, varied and available. Figure 6 shows the distribution of services and cost in four age categories. For simplicity and consistency, we chose the age categories that are contained within the Mental Health Services Act for our data analysis.

The two age ranges of 0-15 and 16-25 show significantly higher costs per beneficiary served than the two older categories of 26-59 and 60+. However, the percentage of the eligible population served is highest in the 26-59 range.

Figure 6

Statewide - Cost Per Beneficiary Served by Age Groups							
Age Groups	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
Statewide	6,810,962	100%	422,369	100%	\$1,337	\$3,984	\$8,228
Age 0-15	2,989,125	44%	134,514	32%	\$1,920	\$4,798	\$9,300
Age 16-25	962,798	14%	65,867	16%	\$1,545	\$4,878	\$9,703
Age 26-59	1,879,568	28%	190,171	45%	\$1,107	\$3,377	\$7,127
Age 60+	979,472	14%	31,817	8%	\$835	\$2,320	\$5,017

CANOLA - Cost Per Beneficiary Served by Age Groups							
Age Groups	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Cost Per Beneficiary Served - Std. Dev.
CANOLA	4,353,453	100%	296,232	100%	\$1,280	\$3,800	\$8,115
Age 0-15	1,911,040	44%	91,592	31%	\$1,609	\$4,234	\$8,882
Age 16-25	628,891	14%	45,284	15%	\$1,356	\$4,566	\$9,821
Age 26-59	1,195,494	28%	137,859	47%	\$1,159	\$3,456	\$7,229
Age 60+	618,027	14%	21,497	7%	\$950	\$2,540	\$5,339

Attachment 20 provides more in-depth information on key variables, displaying gender, age and service activity both Statewide and CANOLA. Listed below is a summary of key findings:

- Although female beneficiaries represent higher numbers of those eligible, the percentage of the population of males and females in the 24-hour and 23-hour activity categories is almost equal in all age ranges. In the 0-15 age category, the cost per female beneficiary served is higher.
- Day treatment shows a different pattern from the previous two services, with a higher percentage of males served at all ages except 60+. The average cost per male beneficiary served is higher in every age category as well.
- In the 0-15 age range, a higher percentage of the eligible males are served with higher costs for service activities of linkage/brokerage, outpatient and TBS. A higher percentage of females of ages 26-59 are served through linkage/brokerage and outpatient services, although still at an average cost less than that of males.
- Male beneficiaries 0-15 represent almost double the percentage served in the TBS category with a relative average cost almost 25 percent higher than females served. However, the percentage of female and male beneficiaries 16-25 served is almost the same (11 percent versus 12 percent) with male beneficiaries at a slightly higher average cost.

Summary of Performance Measure Findings

By applying a few simple data categories relative to “cost per beneficiary served”—i.e., gender, ethnicity, age and service activities—CAEQRO was able to demonstrate that a variety of patterns emerge for beneficiaries who have accessed California’s mental health system. The answers to the questions posed by CAEQRO, “why cost and service patterns differ by demographic variables,” can best be addressed by stakeholders in the local system of care.

Since these dramatic cost and service pattern differences appear to reflect statewide trends, it is particularly important to determine whether similar patterns occur in MHP-specific data and, if so, to determine the patterns across MHPs. Each MHP should use data provided by CAEQRO and other sources to ask the same questions posed in this report. A broad stakeholder group can take these data, ask additional questions, and consider possible answers.

As a very large and highly heterogeneous state, California represents a variety of ethnicities and races with varying lifestyles. CAEQRO encourages all stakeholders to consider the relevance of these findings to local operations and programs—particularly service evaluation, planning and development activities.

Section 4.4: Additional Data Analysis

Data analysis is not only a core capability of CAEQRO, but also critical to our approach as an external quality review organization. As discussed previously, CAEQRO applies data analysis in two areas—as mandated by DMH and the Centers for Medicaid & Medicare Services—and a third area that informs our orientation to the external quality review process:

- **To perform the annual, mandated PM analysis.** As discussed in Section 4.3., the PMs that CAEQRO reviewed in Year Two included analyzing “cost per beneficiary served” for a variety of demographic variables.
- **To inform the MHP site review process.** During both our Year One and Year Two site reviews, CAEQRO discussed the results of various analyses with the MHP staff. The purpose of sharing data during site reviews is to encourage a critical dialogue: understanding how programs work and considering how they can be improved. These discussions are not only relevant to data and financial analysts, but also to consumers, families, program managers and other stakeholders who participate in the site review process.
- **To surface significant trends and stimulate quality improvement activities.** CAEQRO also views data analysis as a critical activity that not only informs the site review process and our findings for individual MHPs, but also has the potential to reveal significant trends that affect the system-wide delivery of mental health services. Consequently, CAEQRO has an ongoing program of data analysis primarily using information from SDMC and IPC databases, which contain both inpatient and outpatient paid claims data.

The vast database that CAEQRO has developed for strategic analysis contains all of the Medi-Cal service contacts, with attending detailed demographic data, and the types of services each beneficiary receives. CAEQRO has access to three years of such data. As summarized in Attachment 6, CAEQRO devoted considerable effort in Year One to developing a secure process for the safe transfer and storage of claims data. We continue to assign significant resources to keep this database populated with the most currently available information.

Paid claims data are reflective of the mental health service delivery system. Since MHPs are managers of all California Medi-Cal mental health services, paid claims can provide valuable information about which beneficiary groups enter the system, the intensity and type of services these beneficiaries received, and the cost for those services. This information is a critical departure point for the conversations about quality that CAEQRO initiated in Year One. Thus, our intent is that the following findings precipitate the kinds of questions that can lead to quality improvement and strategic decision making:

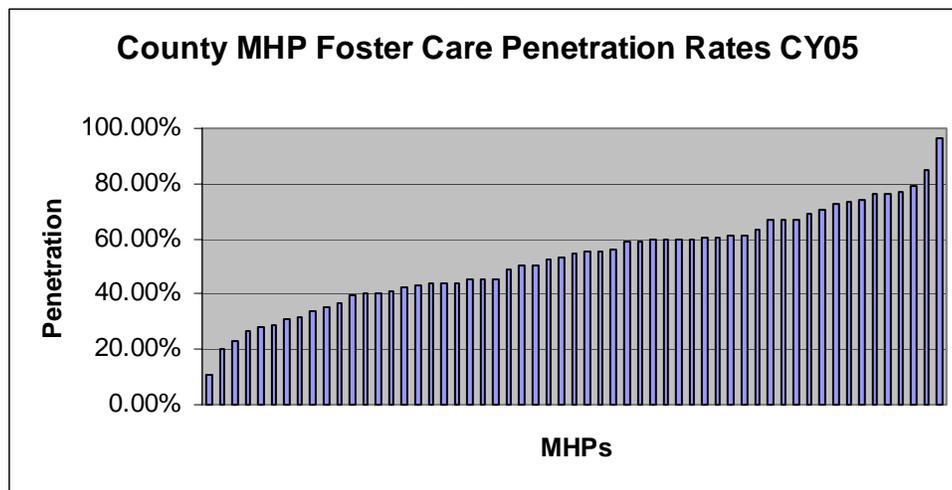
- What do the numbers tell us?
- What new questions come from looking at the data?
- Who best understands what the data may mean?
- What programmatic or operational improvements will address the issues that the data have surfaced?
- Who can best make programmatic or operational improvement decisions based upon the data?

Foster Care Analyses

MHP penetration rates for foster care beneficiaries ranged from 11 percent to 96 percent.

Foster Care Medi-Cal beneficiaries are well known as a high-risk group. “Penetration rate” is a useful analysis that can pinpoint the type and intensity of services that a specific beneficiary group—in this example, foster care—receives. CAEQRO investigated Medi-Cal claims data to better understand each MHP’s service to this population. Figure 1 below illustrates the distribution of penetration rates for the foster care population on a statewide level. The detailed display of this data is included in Attachment 21, Tables 1-4. The CAEQRO analytic team noted the considerable variation in penetration rates that ranged from 11 percent to 96 percent.

Figure 1



What accounts for the significant disparity in penetration rates and costs for foster care beneficiaries in different ethnic groups?

Figures 2 and 3 below show how race/ethnicity, cost and penetration raise questions that if explored by stakeholders can help them understand how foster care beneficiaries are served by the local system of care.

For example: In Figure 2, while White and Hispanic beneficiaries have similar penetration rates, there is a dramatic difference for Asian/Pacific Islanders.

Figure 3 shows that while Hispanic and White beneficiaries had similar penetration rates, the cost of services for White beneficiaries is considerably higher than that for Hispanic beneficiaries. Again, Asian/Pacific Islander beneficiaries had still higher costs than either group.

The data do not explain these differences, but they help focus the analysis and invite discussion among relevant stakeholders.

Figure 2

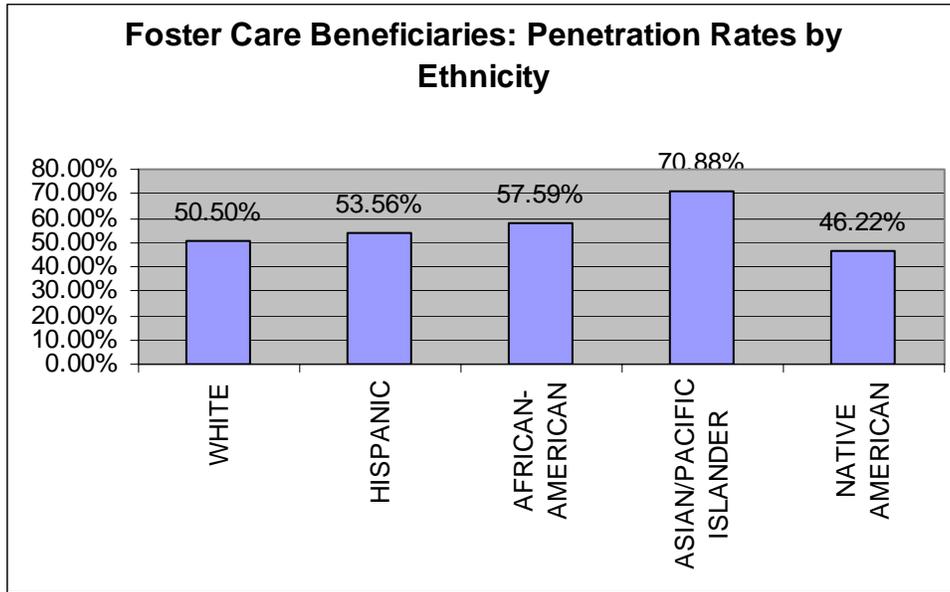
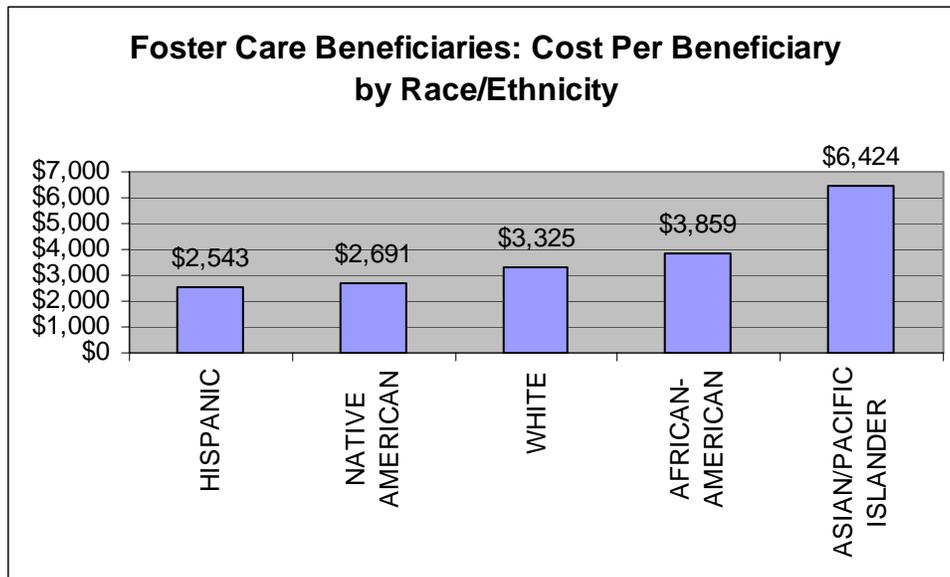


Figure 3



Attachment 21 (Tables 5 and 6) provides additional comparative analyses for the foster care population on a statewide basis. Attachment 22 displays the penetration rates for foster care beneficiaries in San Bernardino MHP and illustrates how such analyses can be performed at the individual MHP level. As discussed in Section 2.3, CAEQRO developed and facilitated a workshop on foster care for a subset of California counties. The objective of this workshop was to help MHPs design services to best reach and benefit these beneficiaries.

For the workshop, CAEQRO provided comparable reports for the following counties in addition to San Bernardino:

Amador	Merced
Butte	Placer
Calaveras	Sacramento
Colusa	Tulare
Los Angeles	Yolo
Marin	

Each MHP and its relevant stakeholders should evaluate the meaning of the penetration rate for its respective county and system of care. By studying this population at a local level, stakeholders can explore the meaning of such data and assess the need for program development or revisions to better serve the foster care beneficiary population.

Retention Analysis

What accounts for the vast disparity among MHPs in retention rates for beneficiaries receiving three or fewer services—12 percent to 42 percent—with a statewide average of 20 percent?

Retention analysis can enable MHPs to track how many beneficiaries enter and leave the mental health system. Some beneficiaries receive the services they need within a relatively few number of visits, while others simply do not return for reasons that are often unknown. Typically, providers require at least three visits to complete an assessment and to begin a service plan. Retention analysis attempts to quantify the numbers of consumers who do not return to the system after either one, two or three visits. This

analysis can lead to questions concerning who leaves the system after such a short time and why.

Figure 4, a high-level overview of statewide retention rates, highlights that 20 percent of all beneficiaries receive one to three services. These data generate many important and unanswered questions about beneficiaries. For example:

1. Were the consumers dissatisfied before they left?
2. Had they received all that they required in terms of services?
3. What percentages did the MHPs refer elsewhere?
4. What percentages self-referred elsewhere?

Figure 4

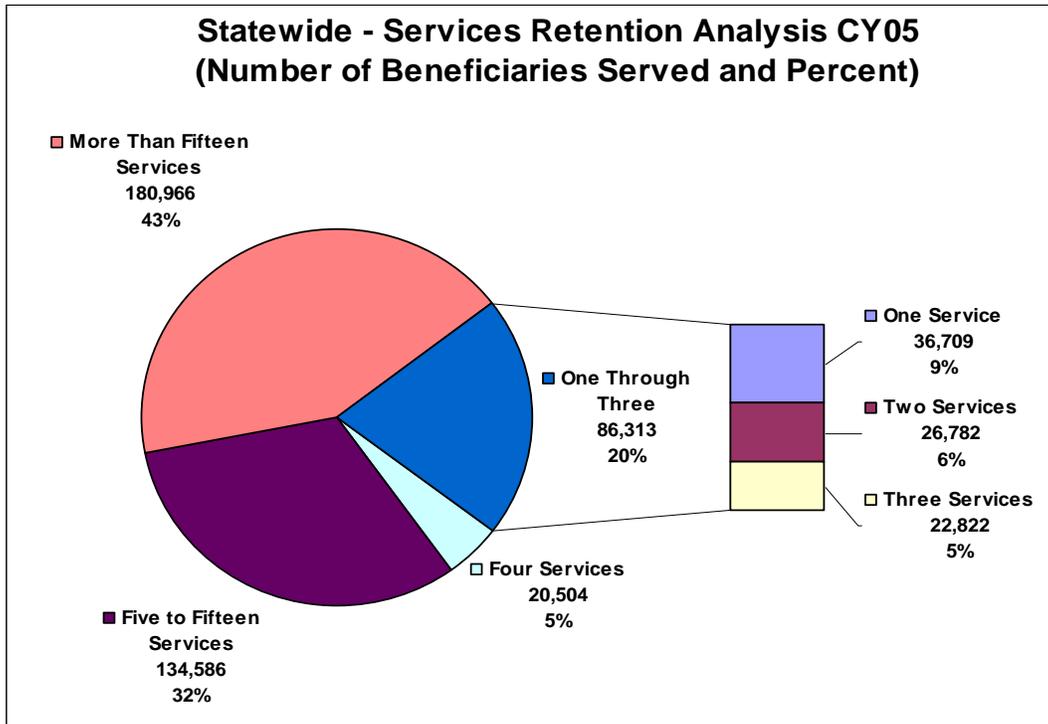
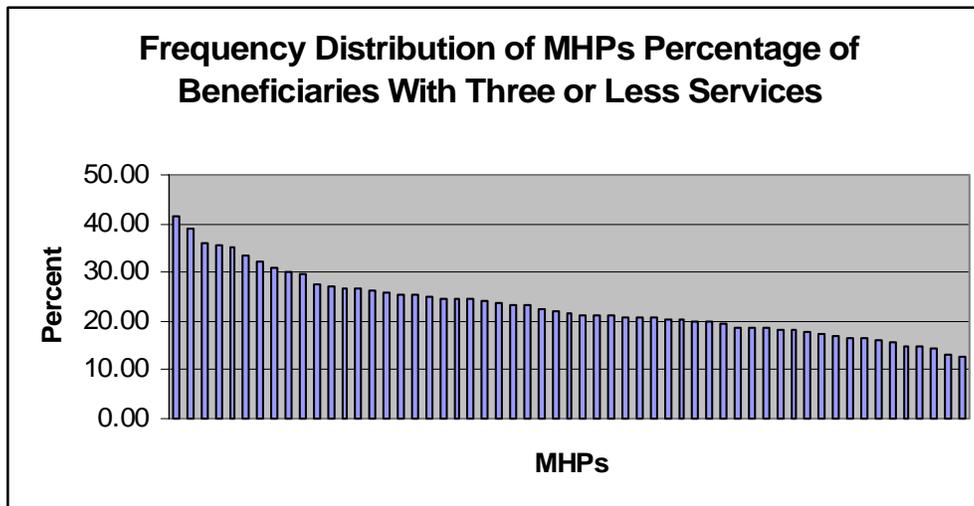


Figure 5 displays an MHP frequency distribution for those beneficiaries receiving three or fewer services for CY05. This figure, which aggregates the detailed analysis in Attachment 23 (Report 1), shows a vast discrepancy among MHPs: 12 percent to 42 percent of the total beneficiary population served by MHPs received three or fewer services for CY05.

Figure 5

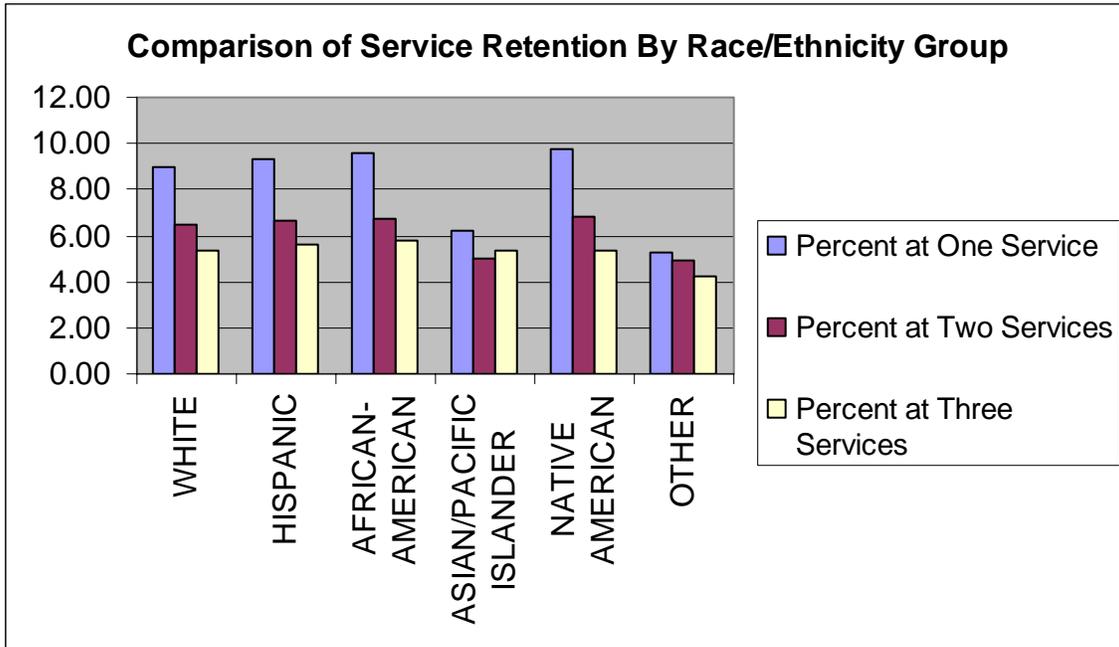


Attachment 23 contains comparable detail for beneficiaries who received one to four services and more than five services. Each MHP needs to evaluate its retention data

and determine if it is acceptable to have large numbers of consumers receiving small numbers of services.

Figure 6 indicates that Race/Ethnicity on a statewide basis did not show major differences for Whites, Hispanics and African Americans. Lower percentages of Asian/Pacific Islanders received three services or less than other ethnic groups.

Figure 6



Attachment 24 provides additional statewide information on cost and service retention by ethnicity. CAEQRO will share similar retention data with MHPs during the Year Three site reviews. Understanding the meaning of why consumers leave the mental health system of care after only receiving one, two or three visits is vitally important to understanding how well the mental health system of care is functioning.

High-cost Beneficiaries

1.91 percent of beneficiaries for CY05 accounted for 23.38 percent of the cost of care for CY05. What is the pattern of services that contribute to these costs?

With the limited resources of the public sector, a constant concern is how the dollars are distributed among beneficiaries. For the purposes of analysis, CAEQRO defined high cost as over \$30,000 for CY05. It is widely acknowledged that relatively small numbers of persons can generate large costs. Figure 7 below summarizes how costs are spread amongst all statewide beneficiaries. Due to the limitations of this graphic display, the highest cost users above 36,200 are not displayed. The average cost for highest group was \$48,159 and this high cost is relatively constant for various age, ethnic and gender groups (as shown in Attachment 25).

Figure 7

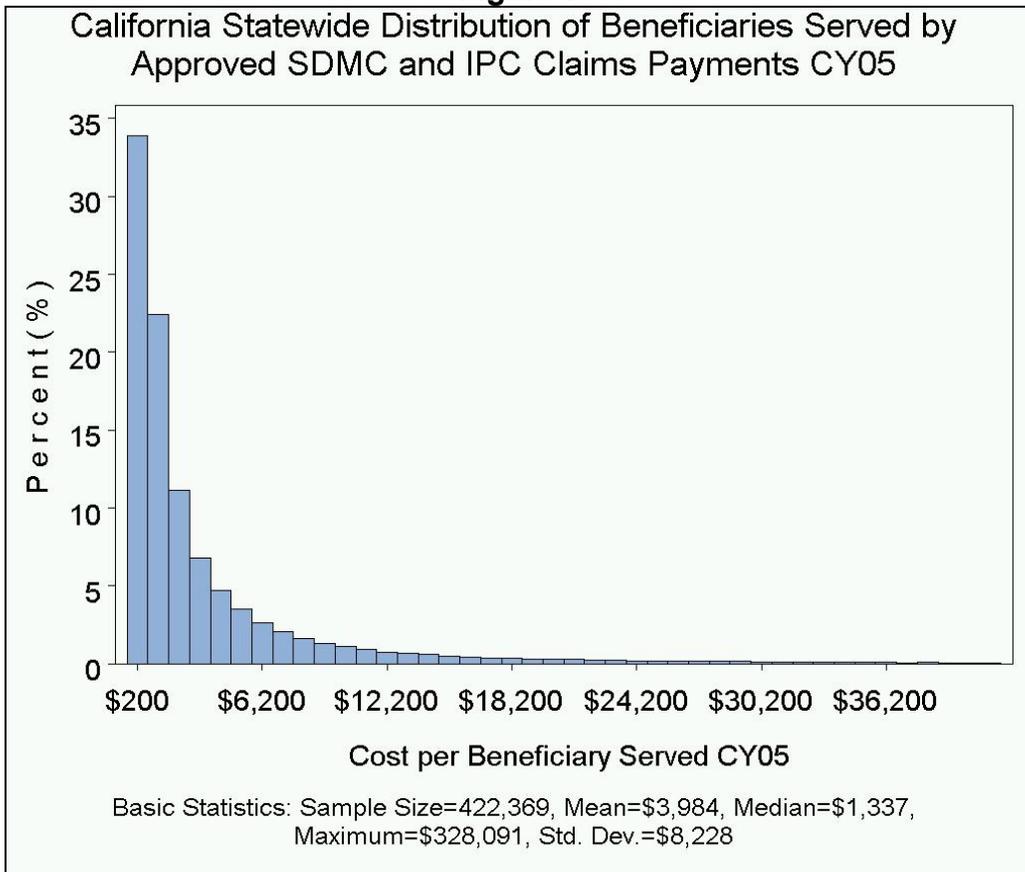


Figure 8 indicates a relatively high (58 percent) representation of males for high-cost beneficiaries. Figure 9 displays the ethnic/race distribution for high-cost beneficiaries. Attachment 25 (Report 1) contains additional detail on this data. Consistent with the general under representation of Hispanic beneficiaries, their representation in the high-cost group is lower than would be expected.

Such figures represent the initial steps towards understanding this small group of high-cost consumers.

Figure 8

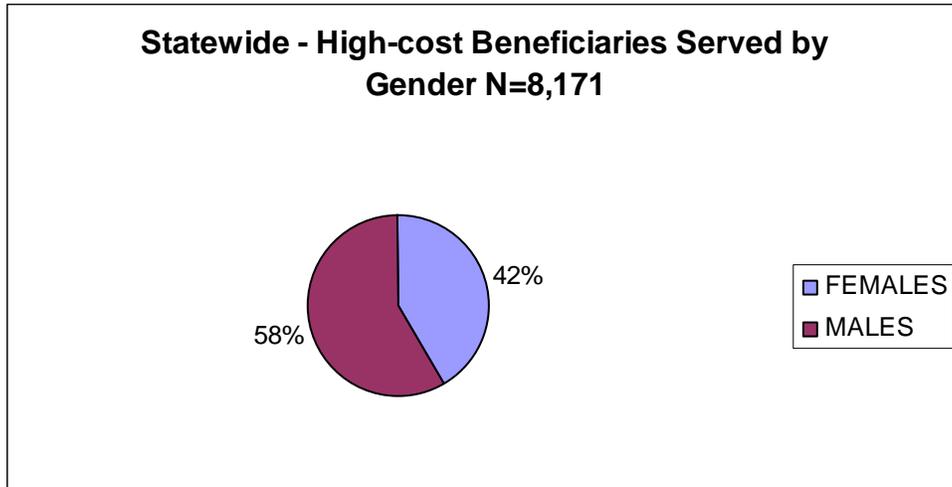
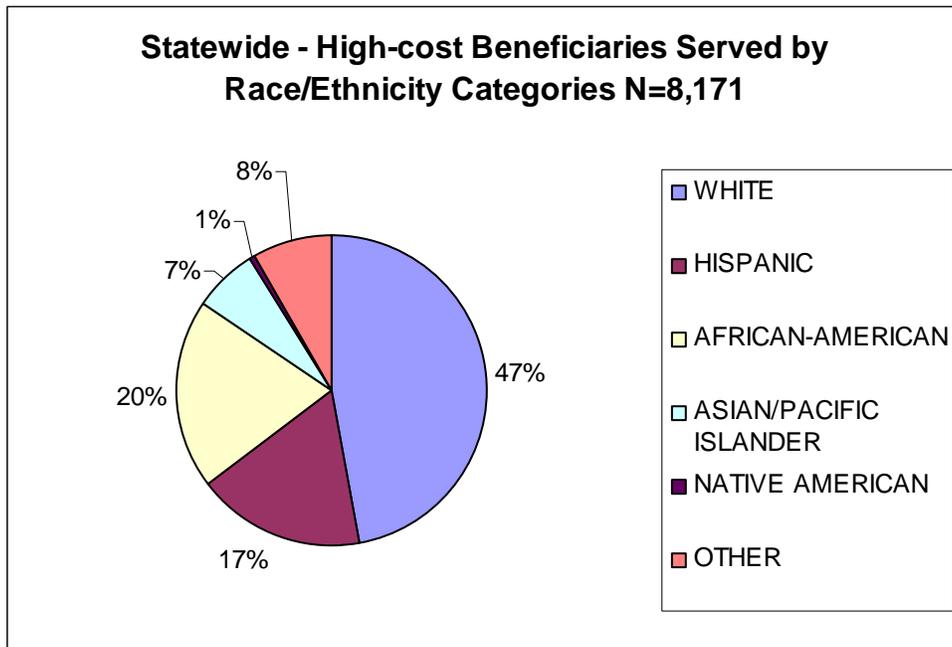


Figure 9



Attachment 25 (Report 2) presents more detailed figures at the individual MHP level. However, as with other data, future analysis is necessary for a better understanding of the nature of these beneficiaries and the pattern of services that contribute to the respective costs. Stakeholders at the local level can consider these figures as they evaluate the nature of high-cost beneficiaries in their communities.



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Section 5.1: Overview

In our Year One report we described seven system-wide themes that we identified predominantly through extensive reviews of the narrative portions of 54 MHP reports. During Year Two, we not only had the benefit of our Year One review as a knowledge base, but also performed the following additional analyses in extracting high-level themes that capture our report's significant findings:

- Analyzed three years of paid claims data from Short Doyle/Medi-Cal and Inpatient Consolidation Claims files
- Reviewed either Information Systems Capabilities Assessment (ISCA) V5.7L or the Information Systems Review Supplemental Questionnaire for 56 MHPs
- Gathered MHP-specific information based on highly targeted reviews
- Conducted formal training to address specific needs that were shared among large numbers of MHPs

As a consequence, of this analysis, several Year One themes no longer had system-wide importance, while others appeared to emerge as trends. In some cases, while a theme still indicated systemic issues, individual MHPs typify exemplary practices, as they were able to accomplish individual solutions to what remain systemic issues. In addition, new themes surfaced in Year Two. The remainder of this section addresses these findings and concludes with a system-wide look at access, timeliness and quality—three variables that are an integral part of our Year Two processes and findings.

Section 5.2: Exemplary Practices, Emerging Trends and New Observations

In Year One, our themes consisted of two parts:

1. A high-level challenge shared by the majority of MHPs based on our FY05 reviews
2. An equally high-level recommendation for review, critique and consideration as a possible course of action for addressing that issue in the future.

As with our MHP site reviews in which we assessed the status of our Year One recommendations, we review the system-wide status of these Year One challenges. Immediately following are two new themes that emerged in our analysis of our Year Two findings.

While many of these challenges are still system-wide issues of a daunting magnitude, individual MHPs demonstrate the creativity and efficacy of local solutions that could be adapted by their colleagues in other counties.

Bench-mark Analyses

Year One Theme: Siloed communications

Many MHPs operate in silos with limited communication among the information technology staff, the quality improvement staff, Mental Health System Act program planners, and clinical managers, as well as the staff responsible for cultural competency and diversity. Promoting coordination, collaboration, and communication will improve operational efficiency and programmatic effectiveness.”

Year Two Status: Improvements in collaboration

Our findings indicated notable improvement in internal MHP communication, particularly between quality improvement and information systems staffs. Some MHPs also integrated cultural competence activities into the overall quality improvement structure—as exemplified by Orange MHP highlighted below in Exemplary Practice #1. MHPs also expanded internal stakeholder representation on committees responsible for information systems replacement. In other areas of collaboration, many small, small-rural and medium-sized MHPs continued to demonstrate close collaboration with other related county departments. Imperial MHP, as described in Exemplary Practice #2, is overcoming challenges that far surpass cross-county issues.

Exemplary Practice #1 Orange MHP

Cultural Competence Report Card

To ensure that cultural competence becomes an integral part of quality improvement, this MHP developed a joint process to improve cultural competence throughout the system. The initial step was a self-evaluation report card that all county-run and contracted facility directors had to complete by obtaining input from their respective staffs. The MHP compiled this data, along with other

performance outcomes measures such as the Annual Facility Survey for both staff and consumers.

All program staffs at each facility reviewed their program-specific data and then developed two quality improvement goals, one of which had to address cultural competence. Each facility then developed two corresponding plans with specific objectives and measurements. These plans were reviewed by the quality improvement and cultural competence directors who approved them only after determining that the projects were meaningful and not already required.

While the results have been varied, some programs have developed promising goals such as “Implement a Spanish language group for medication management to meet the needs of the growing monolingual population.” The next round of evaluations and subsequent project development will occur in September 2006.

**Exemplary Practice #2
Imperial MHP****Communication and
collaboration across
borders**

Imperial County is a largely agricultural area adjacent to Mexico with a high percentage of Latino/Hispanic residents as well as a high percentage of poverty. This MHP fosters a culture that emphasizes strong collaboration, relationships and joint planning with external and internal entities. This approach maximizes service delivery and ensures oversight for resource management.

The MHP is an active member of the Imperial/Mexicali Valleys Substance Abuse Prevention and Mental Health Awareness Bi-national Committee. The committee brings together professionals from both sides of the border to work together in implementing programs aimed at reducing the incidence of mental illness and substance abuse and dependence. The MHP has an active positive relationship with the Mexican consulate in Calexico and the public health equivalent in Mexicali, the state capital of Baja California.

Results from the MHP's approach are evident in the demographics of the population served. The county Medi-Cal eligible population consists of six times as many Hispanic beneficiaries as White beneficiaries. The MHP serves nearly four times as many Hispanic beneficiaries as it does White beneficiaries. In addition, the penetration rate for Hispanic beneficiaries far exceeds that of the southern region and the state. These rates do not include the services the MHP provides to the large Hispanic uninsured population.

Year One Theme: Small county managed care challenges

Many small counties struggle to meet regulatory, program and data requirements that are necessary for MHPs to function truly as managed care systems. Collaboration across county boundaries could provide tremendous opportunities for cost efficiencies in key initiatives such as Performance Improvement Projects (PIPs) and information systems implementations.”

Year Two Status: Challenges increase

This theme, as stated last year, fails to convey the extent of the difficulties faced by small counties. Managed care concepts, operational processes and regulations are designed for entities with thousands of eligible beneficiaries or members. This assumes that the MHP spreads costs of instituting information and performance management systems across revenue generated from managing and/or serving a large population. For these reasons, a number of states that had operated county-based service systems have restructured their Medicaid programs and created umbrella managed care organizations. Each of these organizations is then responsible for the managed care oversight and administrative processes for all county-based centers and providers, who continue to deliver direct services and who might manage some delegated managed care activities.

While this dramatic restructuring may not be under consideration in California, more modest forms of collaboration and resource sharing across MHP boundaries is possible,

especially in those areas that do not require on-site operations or management. The right information technology can centralize those programs that are by definition automated or require automated processes to function most effectively, such as electronic clinical data, performance measure analysis, monitoring of clinical best practices, and various other clinical quality improvement activities.

While some MHPs are beginning to show interest in this type of collaboration, to date only a very small number of MHPs are in the early developmental stages.

**Exemplary Practice #3
Amador, Calaveras,
Tuolumne**

**Regional-based
operations and programs**

These three MHPs have instituted efforts toward addressing a variety of issues on a regional basis. For those MHPs tackling the same problems and facing similar barriers, this kind of collaboration can maximize resource availability, increase the use of creative alternatives, and reduce the duplication of effort.

Meeting monthly, the three mental health directors have identified their first major priorities as follows:

- To create a consortium for addressing homeless/housing needs in the tri-county region. The directors are in the process of establishing an organization to deal with housing issues. Currently no community- or county-based housing organizations or authorities exist in any of the three counties.
- To plan for a possible residential treatment program with combined MHSA funding contributions
- To identify other areas that would benefit from this collaboration, which may include shared training and educational programs, joint PIPs, and mutual cooperation in techniques and resources for data gathering and analysis

Year One Theme: In the absence of data, a focus on compliance

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.”

Year Two Status: Some improved use of data

Quality assurance and compliance activities, rather than performance management and improvement, continue as the major focus for most MHPs in Year Two. However, availability of and access to data did improve significantly. Closer collaboration between quality improvement and information system/data analysts contributed to progress in this area, as did the major emphasis on data in MHSA planning requirements. Despite improvements, lack of data still presented a barrier to initiating true quality improvement activities, particularly for small and small-rural MHPs. (Attachment 1 details size grouping CAEQRO used in this report.) Regardless of size, many MHPs lack the skills required to understand data reports, to frame additional questions, and to use data

effectively. CAEQRO plans to provide additional training in these areas for MHPs during Year Three.

**Exemplary Practice #4
San Mateo**

**Sophisticated data use—
system-wide**

This MHP's Strategic Planning Data Book and Extract process, begun in 2003, initially provided education to managers on data elements available in the system and enlisted their input in identifying additional key markers relevant to specific programs and modalities. Over time, supervisors and other staff members have become actively involved in extensive and ongoing training sessions

regarding the data generated. This process added to the list of key elements and the overall usefulness of the Data Book. The Data Book is now the overall repository for data elements pertaining to the whole system, including contracted providers, and was instrumental in developing functionality specifications for the selection of a new information system.

Originally intending to generate this report annually, the MHP is now generating and disseminating some high-level core data reports monthly or even weekly. Further, the MHP is in the final stages of developing two dashboard reports for separate audiences and purposes—one for program supervisors to share with the staff, and the other for Mental Health Board members.

Year One Theme: System-wide challenges with information systems

Many information systems are outdated and provide support for business operations only. Some major installations of new systems have been highly problematic.

Year Two Status: Virtually unchanged

Information systems issues include three separate areas:

- Operating obsolete solutions while facing new requirements
- Selecting and implementing new systems
- Ongoing retirement of experienced staff

We view these areas together as presenting the greatest overall risk to a large number of MHPs.

Current systems operation continues to be a strength in those MHPs with experienced staff who know how to extract the data and maximize the functionality of old and obsolete systems. However many MHPs are trying to maintain current operations without incurring unnecessary costs due to new mandates, while managing a process and realistic timetable for systems replacement.

Of great concern is that most MHPs do not appear to incorporate a review of their business and clinical operations with their selection and/or implementation of a new information system. Information systems implementation offers a particularly valuable

opportunity to evaluate business practices associated with the delivery of services to consumers.

During new system installations, a review of business practices typically includes documenting the normal flow of consumers as they move through the service delivery system. At each step of the process, information from and about consumers is collected and the review of these processes can easily highlight barriers to service. For example, extensive intake procedures that represent years of new mandates and data requirements may have resulted in time-consuming complex intake processes for new consumers. When combined with potential language issues, such processes can represent barriers that may prevent any access or may precipitate early unplanned terminations from care.

The workflow analysis process can benefit both clinical program managers as well as persons concerned with the operations or billing information systems. Clinical and administrative managers, consumers, and information technology professionals should all critically evaluate traditional workflows to assess for ways of improvement as part of the new information systems installation.

**Exemplary Practice #5
San Francisco**

**Efficient and effective
claims processing**

The MHP billing staff applies a quality management technique that compares SDMC claims data in context with historical and trend information instead of only one month to the next. The analysis allows for variations in claims totals by provider and seasonality, as well as those due to changes in claim processing.

The process allows the staff to identify problems such as “locked out” services, obtain feedback information from or about specific providers to do follow-up, identify corrective action or adjustments needed, and pinpoint areas for improvement. It has resulted in greater claim reimbursements and, more importantly, fewer claim denials.

Year One Theme: Challenges with wellness, resiliency and recovery

Many MHPs are having difficulty translating the concept of wellness, resiliency and recovery into specific changes in operations.

Year Two Status: Largely unchanged

Verbal commitment to recovery and wellness, especially by directors and managers, was very strong. Only a finite number of MHPs appeared to have developed a systematic plan designed to infuse recovery, wellness, consumer choice, education, and participation into all activities across the system of care.

Many MHPs indicated that they were planning to develop or strengthen recovery or consumer-run programs through MHSA funding. We found less clarity regarding the integration of wellness and recovery into those activities not funded by MHSA. Some

MHPs did plan to add consumer/family staff members—only one step in achieving the paradigm shift from a traditional orientation to one that supports wellness and recovery.

Year Two Themes

Year Two themes cover two key areas: addressing the needs of contract providers and beneficiaries with dual diagnoses

1. CAEQRO analysis indicates that contract agencies and individuals provided services that in CY05 accounted for 68% of approved claims dollars state wide, (CANOLA 58%). At the same time, contract providers often report a variety of administrative burdens, communication difficulties, and lack of input into relevant MHP policies, procedures, and decisions. Areas most cited as problematic included administrative processes, access to beneficiary information and eligibility, wasted resources due to double and triple data entry, and lack of input to or even knowledge of MHP information systems planning.
2. Mental health and substance abuse programs remain isolated from each other in most MHPs, including in those plans that are responsible for substance abuse services. Although many MHPs identify coordination/integration of these services as a high priority, many related complex factors cause barriers to achieving this goal. These factors include staff knowledge and diagnostic practices, Medi-Cal billing regulations, and current information systems limitations. In addition, staff understanding of confidentiality requirements presents additional real and perceived legal obstacles.

Section 5.3: Access, Timeliness and Quality: The Focus of Performance Improvement

As stated by CMS, the overall mission of the EQR is to provide “aggregated information on the quality, timeliness and access to health care services that a managed care organization and its contractors furnish to Medicaid recipients.”

Since our Year One reviews established a baseline from which to evaluate quality improvement processes in subsequent years, we did not formally comment on these areas in our Year One report. In Year Three, each of our individual MHP reports will include data and information associated with each area. While these three high-level concepts are implicit throughout our Year Two report, we comment specifically on each one below:

- **Access:** MHPs have significant challenges in providing easy access to services for all groups of beneficiaries. Penetration rate data included in our Performance Measurement discussion in Section 4.3 show lower penetration rates for Hispanic/Latino populations, and show disparities in costs for Hispanics/Latinos and Women. Older adults also appear to be significantly underserved, although more precise data reflecting pre-Medicare eligible populations should be reviewed to determine whether there is a problem and, if so, the nature of the problem.

Highlighted below are several possible causes of access barriers, many of which are related and some of which, because of county demographics, are challenging for specific MHPs. However, MHPs can more easily remedy yet other barriers because they are a function of internal organizational processes:

- County hiring practices and delays, as well as salary levels, affect the highly significant issue of ethnic and linguistic diversity among the MHP staff. In addition, many MHPs limit usual county-operated services to business hours five days per week.
- Many MHPs emphasize increasing adherence to scheduled appointments rather than modifying basic system processes to increase access, such as incorporating flexible walk-in hours or decentralized access sites.
- Many MHPs have multi-step intake processes that require several callbacks and, in some cases, a review by a committee that meets only once or twice a week. One MHP, for example, requires a phone call requesting services, a call back by a clinician within a certain number of days, a review by a supervisor for appropriateness for intake, another call back to the client, the intake appointment, and finally a review by the committee before referral for on-going services. Variations of this type of multi-step assessment process were common.
- MHPs cited “Not meeting medical necessity” as a major reason for referring beneficiaries to services outside the MHP. However, our review of many MHPs’ approved claims indicates an unusually high number of beneficiaries with diagnoses such as “adjustment disorder,” “deferred diagnoses,” or other lesser diagnoses.
- **Timeliness:** Timeliness and access was the most common topic of PIPs planned by MHPs. These PIPs included access and timeliness for intake, timeliness to psychiatric appointments, and reduction in missed appointments.

Most MHPs do not monitor their processes for accessing care. MHPs may maintain logs that demonstrate when beneficiaries request services and when the beneficiary received his/her initial services, but few routinely analyze this data. Wait times of two to six weeks for an initial intake were common, with an additional delay of up to three or four months for a psychiatric appointment.

Although MHPs regretfully acknowledged that these wait periods are not reasonable, they did not offer any remedies, citing additional hiring as unfeasible, and being unable to see other potential solutions. Most MHPs did not know their true capacity and/or did not manage those variables that affected capacity. Instead, many began setting standards for psychiatric appointments without comparing those standards against available psychiatry hours, existing caseloads, and estimated demand to determine how many beneficiaries the MHP could adequately serve.

Few MHPs use groups as a way to increase capacity; most offer some groups but relatively few in number. One MHP refused to offer groups, viewing them as a breach of confidentiality. (When asked, several beneficiaries of this MHP said

they would be happy to participate in a group.) Staffing patterns do not appear to represent either nurse practitioners or physician extender positions frequently.

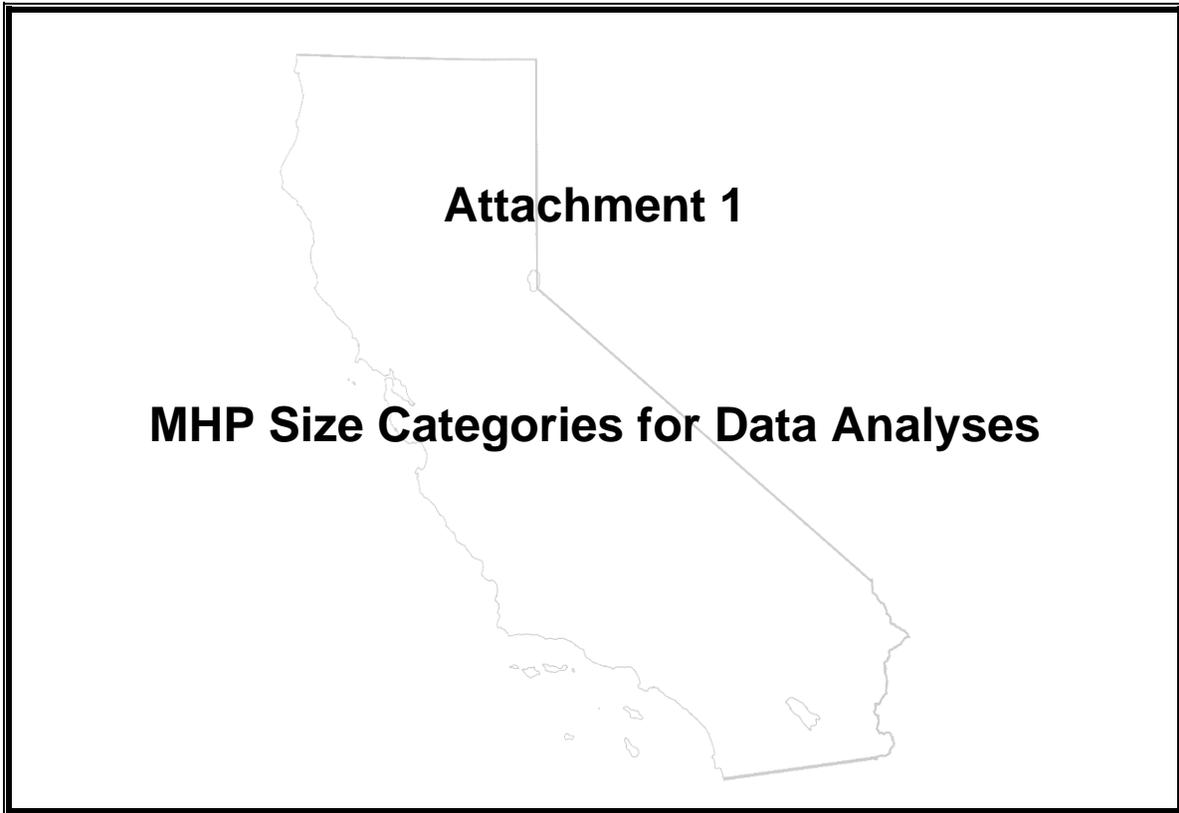
- **Quality:** With few exceptions, MHPs conduct internal reviews of clinical charts for compliance to billing requirements, adherence to record guidelines and, in some MHPs, there is attention to appropriateness of treatment plan in relation to the individual's clinical status. MHPs, responding to recent audits, focus on EPSDT eligible beneficiaries. MHPs audit charts in order to assure they qualify for reimbursement, and they sample records for each individual clinician.

Again, with few exceptions, these quality assurance and compliance activities represent the predominant review of quality of care. Most MHPs did not track clinical or functional outcomes, except to meet requirements associated with special grant-funded programs, especially for children, or to comply with requirements for those beneficiaries enrolled in Welfare to Work programs. In addition, some MHPs survey consumers annually.

During Year Three we will assess and comment on performance for access, timeliness, and quality in each MHP report, and will consolidate these findings for our next statewide report.



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



MHP Size Categories for FY06 Data Analyses

In performing data analysis for the FY06 Statewide Report, CAEQRO categorized mental health plans (MHPs) by two different sets of size categories:

1. Five size categories—data on Medi-Cal beneficiaries, consumers or services: Most of the data analysis discussed in the annual report and displayed in the attachments reflects five size groupings: small-rural, small, medium, large, and very large. These categories are based on county population figures from the California, Department of Finance, E-1City/County Population Estimates, as of January 2006:

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

With literally millions of records, five categories enable a substantial sample size in each category for meaningful analysis, such as revealing statistically significant trends. When appropriate, we extracted Los Angeles from our data set and analyzed California Not Los Angeles (CANOLA) only.

2. Three size categories—health information systems survey data. In Section 3.3, FY06 Analysis of Health Information Systems, the figures are based on a relatively small number – 56 MHPs. In analyzing data collected from Information Systems Capabilities Assessment V5.7L or the Information Systems Review Supplemental Questionnaire, we combined the categories "small" and "small-rural." In addition, Los Angeles results are contained in the "large" category. If we use five size categories, the results are diluted and the frequencies in each cell are very low. For example, the very large category (Los Angeles) would always have one. Therefore, five categories parse a relatively small data set into such a granular level that identifying themes or trends is not possible.

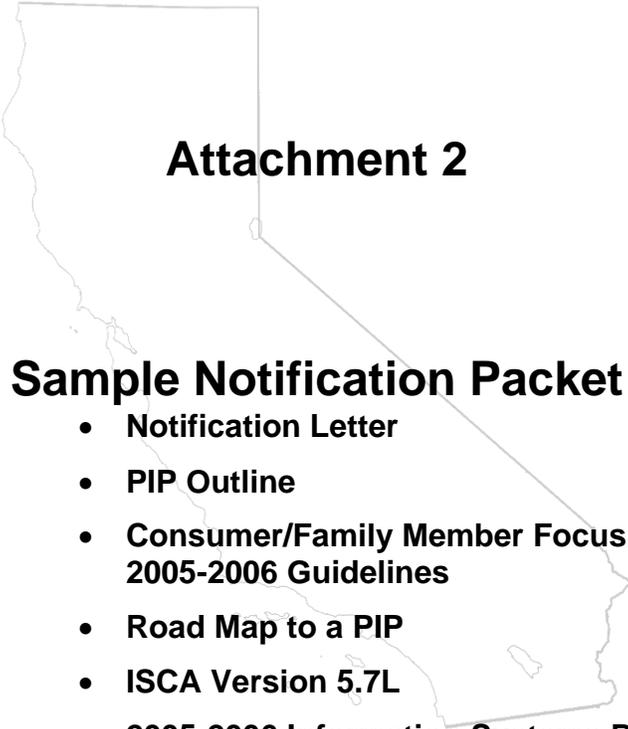
On the following page, we include a table displaying a cross walk that lists each MHP and its associated size category.

Mental Health Plans and Size Categories		
Mental Health Plan	Three Categories	Five Categories
Alameda	Large	Large
Alpine	Small	Small-Rural
Amador	Small	Small-Rural
Butte	Medium	Medium
Calaveras	Small	Small-Rural
Colusa	Small	Small-Rural
Contra Costa	Large	Large
Del Norte	Small	Small-Rural
El Dorado	Small	Small
Fresno	Large	Large
Glenn	Small	Small-Rural
Humboldt	Small	Small
Imperial	Small	Small
Inyo	Small	Small-Rural
Kern	Large	Large
Kings	Small	Small
Lake	Small	Small
Lassen	Small	Small-Rural
Los Angeles	Large	Very Large
Madera	Small	Small
Marin	Medium	Medium
Mariposa	Small	Small-Rural
Mendocino	Small	Small
Merced	Medium	Medium
Modoc	Small	Small-Rural
Mono	Small	Small-Rural
Monterey	Medium	Medium
Napa	Small	Small
Nevada	Small	Small
Orange	Large	Large
Placer	Medium	Medium
Plumas	Small	Small-Rural
Riverside	Large	Large
Sacramento	Large	Large
San Benito	Small	Small
San Bernardino	Large	Large
San Diego	Large	Large
San Francisco	Large	Large
San Joaquin	Medium	Medium
San Luis Obispo	Medium	Medium

Mental Health Plans and Size Categories		
Mental Health Plan	Three Categories	Five Categories
San Mateo	Medium	Medium
Santa Barbara	Medium	Medium
Santa Clara	Large	Large
Santa Cruz	Medium	Medium
Shasta	Small	Small
Sierra	Small	Small-Rural
Siskiyou	Small	Small-Rural
Solano	Medium	Medium
Sonoma	Medium	Medium
Stanislaus	Medium	Medium
Sutter/Yuba	Small	Small
Tehama	Small	Small
Trinity	Small	Small-Rural
Tulare	Medium	Medium
Tuolumne	Small	Small
Ventura	Large	Large
Yolo	Small	Small



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 2

Sample Notification Packet

- Notification Letter
- PIP Outline
- Consumer/Family Member Focus Group
2005-2006 Guidelines
- Road Map to a PIP
- ISCA Version 5.7L
- 2005-2006 Information Systems Review
Supplemental Questionnaire
- Approved Claims Data (Refer to Attachment 7)



Date

Name
Mental Health Director
Name County Mental Health
Address
Address

Dear < Mr./Ms./Dr.> :

APS Healthcare is looking forward to the second year external quality review site meeting with <Name> County < on/from Date(s)> , from 9am – 5pm.

The designated review team will include the following APS staff members:

- Name, Lead Reviewer
- Name, Title of IS Reviewer
- Name, Consumer/Family Member Consultant
- An additional CAEQRO reviewer < if applicable, name(s) if known >

This year, the reviews are customized according to the findings of last year's review and will include an evaluative process of the overall service delivery system as it relates to business practices and strategic planning and development. In particular, CAEQRO will be reviewing the following issues/recommendations based on the < Name > County FY05 CAEQRO review:

(Include approximately five issues from last year's report.)

- A review of ...
-

In addition to those specific issues outlined above, the review will include the following components:

<Select one option for #1>

1. Review of the new Information System Capabilities Assessment V5.7L. Since your last review, the ISCA has been revised and approved by DMH. Please complete the ISCA V5.7L attached.

<OR>

1. Review of the Supplemental IS Questionnaire which highlights any changes that have occurred in the MHP's information system or processes since the ISCA 5.7L was completed for last year's review.
2. A detailed review of two current Performance Improvement Projects (PIPs) – one clinical and one non-clinical. One PIP may be the project (or its revision) that was reviewed last year.
3. A review of any changes, progress, or milestones in quality improvement processes and activities since the FY05 CAEQRO review.
4. A review the status of implementation of wellness and recovery principles throughout the system.
5. Interviews with key clinical, administrative, information systems, and clerical/data entry staffs.
6. < One/two/three > 90-minute focus < group/groups > with a minimum of 8 and a maximum of 10 MHP consumers and family members according to the following criteria (also refer to the attached Focus Group Guidelines):
 - < Identify criteria here for each focus group. >
 -

As part of the pre-site review process, CAEQRO reviews Medi-Cal approved claims data for each MHP. This data is attached and will be discussed on-site as it applies to the various review components described above.

Representatives from the following MHP units should plan on participating in various aspects of the review:

- Executive Leadership
- Information Systems
- Finance, Data Analysis, and Operations
- Quality Improvement
- Key members of the direct clinical service staff and clinical supervisors
- Organizational contract providers < approximate number of providers >

The list of planned participants should be discussed in detail with the Lead Reviewer, prior to the site review, in order to ensure that the appropriate staff members are included in each component of the review. The role of contract providers as part of the site the review also will be determined by prior consultative discussion between the Lead Reviewer and the MHP contact for this review. Additionally, please ensure that relevant program staff members and data analyst(s) involved in the PIPs are involved in the on-site discussion.

< At this time, this section applies to Lassen: >

APS Healthcare has also contracted with several former Mental Health Directors 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 >. 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.

Submit electronically to the Lead Reviewer (name@apshealthcare.com) by < Date in at least 30 days >:

<Select one option for #1>

1. Review of the new Information System Capabilities Assessment V5.7L. Since your last review, the ISCA has been revised and approved by DMH. Please complete the ISCA V5.7L attached.

<OR>

1. Review of the Supplemental IS Questionnaire which highlights any changes that have occurred in the MHP's information system or processes since the ISCA 5.7L was completed for last year's review. Please note that several attachments are requested along with this questionnaire.
2. Detailed descriptions of two PIPs. See the attached PIP Outline for assistance regarding areas to include and describe. These documents will serve as the basis for review with the PIP Validation Tool. Therefore, within each document, include all pertinent information (ongoing activities, data collections, intervention modifications) that indicates the overall findings and changes in processes in response to the PIP findings.
3. The current QI Work Plan and QIC meeting minutes from the last year.
4. A list of cultural competence trainings that have occurred over the last year.
5. A list of beneficiary and/or staff surveys conducted within the last year. For at least one survey, provide the survey tool and a summary of the results.
6. A current, detailed MHP organizational chart. < Delete if the IS Questionnaire is requested, as this document already requests this same item. >
7. The names of two counties to which the MHP compares itself, along with the rationale for choosing these counties.
8. The MHP's current mission or vision statement.
9. A list of up to five current MHP strategic initiatives.
10. < Additional documents requested for this MHP, if applicable. >

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

Please ensure that two group meeting rooms are available that can accommodate the MHP and APS staffs conducting simultaneous review activities, as well as a room which can accommodate a consumer/family member focus group of up to twelve individuals. Note that it may be preferable to schedule consumer/family member focus groups at sites other than the primary review site.

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 name@apshealthcare.com. We would like to schedule a phone call upon receipt of the above documentation to discuss the review and coordinate the agenda.

Sincerely,

Name

EQRO Lead Reviewer

< Delete IS reviewers not involved in the review: >

cc: Sheila Baler, Executive Director, California EQRO
Rita McCabe, DMH Medi-Cal Policy and Support

Marilynn Findley, DMH Medi-Cal Policy and Support
Anne Murray, DMH Medi-Cal Policy and Support
Mike Reiter, Administrative Director, EQRO
Rory Osborne, Site Review Team Director, EQRO
[Carol Borden-Gomez, Senior Systems Analyst, EQRO](#)
[Bill Ullom, Senior Systems Analyst, EQRO](#)
[Hui Zhang, Reporting Manager, EQRO](#)
[Phuc Luong, Field Analyst, EQRO](#)
[Lisa Farrell, Data Analyst, EQRO](#)
[Dennis Louis, Information Systems Consultant, EQRO](#)
[Jerry Marks, Information Systems Consultant, EQRO](#)
Bob Martinez, Consultant in Cultural Competence
[Name](#), Consumer/Family Member Consultant
[Name](#), Senior Consultant <if applicable>
[Name](#), MHP QI Coordinator
[Name](#), MHP IT/IS Manager

Attachments:

Focus Group Guidelines 05-06 V2.1
PIP Outline Form 05-06 V3
Road Map to a PIP V5.5
Information Systems Capabilities Assessment (ISCA 5.7L) <delete if
[appropriate](#)>
Information Systems Supplemental Questionnaire <delete if appropriate>
Approved Claims Data

EQRO PIP Outline

The Background of the Selected Study Topic

1. How was the study topic selected? This should include:
 - a) Description of the identified problem – which should include some key dimension(s) of quality care, such as appropriateness, competency, continuity, effectiveness, efficacy, efficiency, respect and caring, safety, and/or timeliness.
 - b) Description of the collected and analyzed data used to understand the problem that impacts beneficiary care, needs, and/or services. How did you use the data to understand the problem? Use charts, graphs, or tables to display the data.
 - c) How is this topic important to the MHP? Did the identified problem fall under one of the key dimensions of quality care? If not, explain why this problem continues to be an improvement effort priority.
2. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain.

Study Question

3. State the study question:

Indicators

4. Identify the indicators.
 - An outcome indicator measures what happens or does not happen as the result of a process or processes.
 - A process indicator measures a discrete activity that is carried out to provide care or service.

Each indicator should specify:

- a) Denominator – the event being assessed or the enrollees who are eligible for the service or care. Indicate whether all events or eligible enrollees are included, or whether the denominator is a sample.
- b) Numerator – the criteria being assessed for the service or care. For example, the number in a population with a disorder/condition, or those who were involved in a particular event.
- c) Baseline for the indicator
- d) Goal for desired improvement - must be a numerical quantifier (e.g., % points or raw number) rather than simply “improve,” “increase,” or “decrease.”

5. Why were these indicators selected? How do these indicators measure changes in mental health status, functional status, beneficiary satisfaction, or process of care with strong associations for improved outcomes?

Study Population

6. Describe the population to be included in the PIP, including the number of beneficiaries.
7. Describe how the population is being identified for the collection of data.

Sampling Method – if a sample was selected rather than studying an entire population

8. What type of sampling technique was used? How did the MHP ensure that the sample was selected without bias?
9. How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

Data Collection Procedures

10. Describe the data to be collected.
11. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why.
12. Describe the plan for data analysis.
13. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.

Improvement Strategies

14. Describe interventions to address the causes/barriers identified through data analysis and QI processes.

Data Analysis and Interpretation of Study Results

15. Describe the data analysis process. Did it occur as planned?
16. Present objective data results for each indicator – including relevant tables or graphs.
17. Issues associated with data analysis:
 - a. Data cycles clearly identify when measurements occur.
 - b. Statistical significance

- c. Are there any factors that influence comparability of the initial and repeat measures?
 - d. Are there any factors that threaten the internal or the external validity?
18. To what extent was the PIP successful? Describe any follow-up activities and their success.

Determining if the Improvement is “Real”

19. Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated.
20. Does data analysis demonstrate an improvement in processes or client outcomes?
21. Describe the “face validity” – how the improvement appears to be the result of the PIP intervention(s).
22. Describe statistical evidence that supports that the improvement is true improvement.

Determining if the Improvement is Sustained

23. Was the improvement sustained over repeated measurements over comparable time periods?



The Consumer/Family Member Focus Group 2005-2006

The Consumer/Family Member Focus Group is an important component of the EQRO Site Review process. Obtaining feedback from those who are receiving services from the MHP provides significant information regarding quality of care. The focus group(s) will be led by an APS Healthcare Consumer/ Family Member Consultant. An APS Healthcare Site Reviewer will also participate and act as a recorder.

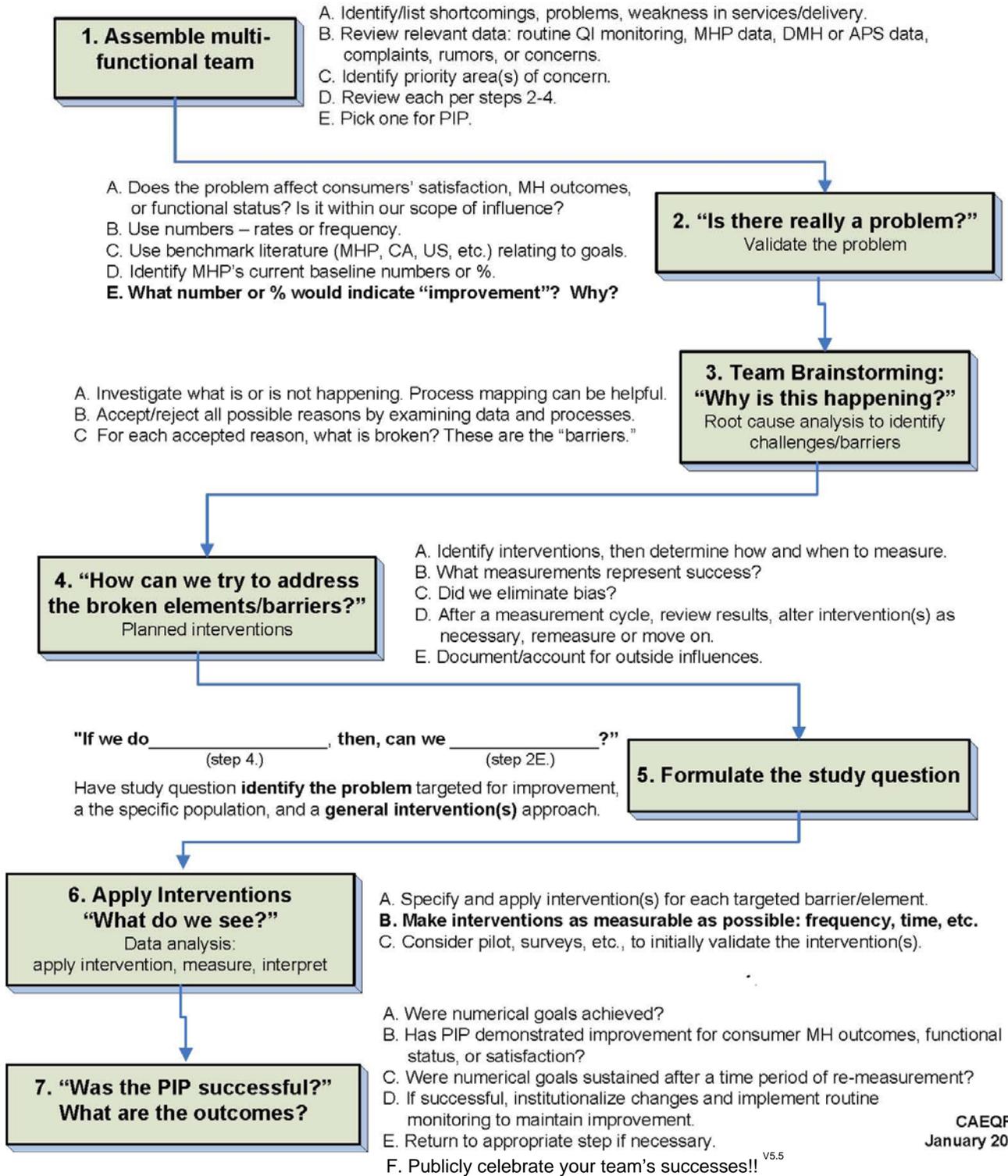
The Notification Letter identifies the demographic parameters of the focus group(s). In addition, the following guidelines apply to all focus groups. The MHP's review coordinator should familiarize him or herself with all of the items below, taking full responsibility for all pre-planning logistics of the focus groups. Any contract provider who is sponsoring a group should have a full understanding of these logistical issues and should coordinate the specifics with the MHP prior to the site review.

Direct any questions or suggested changes to the Lead Reviewer prior to the site review.

1. Advise potential participants that the group will last for 90 minutes.
2. Schedule the focus group at a time and location that is generally convenient to consumers and family members. Late afternoon or early evening hours are an option as well. Discuss the location options with the Lead Reviewer so that travel time can be built into the agenda if necessary.
3. Invite enough individuals so that there are a minimum of 8, and no more than 10, participants in each focus group.
4. The EQRO will be prepared to provide 10 gift cards per group. The MHP may elect to invest in two or three extra gift cards in the event that more than 10 people present for the group. Do not advertise these gift cards as a mechanism of recruiting participants.
5. Participants should be informed of the purpose of the focus group – specifically that APS is an external review organization and not affiliated with the county or DMH, and that the group is being conducted in order to solicit comments about their experiences with the mental health system. The distinction between the focus group and group therapy should be clear prior to the group.
6. Advise the Lead Reviewer if mono-lingual participants are expected in the group so that interpreter needs can be addressed.

7. Since multiple translators in a group can be difficult to manage, limit each focus group to no more than one representative threshold language within a single focus group. If the MHP would like to have an additional focus group to reach multiple language groups, this can be explored with the Lead Reviewer prior to the site review.
8. Do not include “consumer employees,” “family advocates,” Mental Health Board members, or any participants who represent the MHP in an official capacity. Further, staff members or other stakeholders may not participate or observe. Such individuals provide important observations but should instead be scheduled as part of the key staff interviews. Please discuss any suggestions with the Lead Reviewer prior to the site review.
9. Avoid inviting consumers or family members who participated in an EQRO focus group last year or previous State DMH focus groups.
10. Do not invite participants from the same family for the same focus group (e.g., spouses, parent/child).
11. Consider some strategies that can improve focus group attendance by:
 - a. Scheduling the group at a consumer-friendly location;
 - b. Offering snacks, lunch, and/or transportation to participants;
 - c. Posting signs in the waiting areas inviting participants to sign up;
 - d. Coordinating with consumer self-help programs to enlist participants.

Road Map to a PIP



CAEQRO
January 2006

Information Systems Capabilities Assessment

(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 System Capabilities Assessment (ISCA)

Knowledge of the capabilities of a Mental Health Plan (MHP) information system (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 system is capable of producing valid encounter data¹, 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 system. This is accomplished by having the MHP complete an *Information System 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.

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 system.

¹ "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 systems. 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 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 system and analyze its data to conduct quality assessment and improvement initiatives. Further, the report will consider the ability of the MHP information system to support the management and delivery of mental health care to its beneficiaries.

Information System Capabilities Assessment (ISCA) California Mental Health Plans (MHP)

ISCA Instructions:

Please complete the following Information System 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.

MHP Name:	
ISCA Contact Name and Title:	
Mailing Address:	
Phone Number:	
Fax Number:	
E-mail Address:	

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 system 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 system provided by an external vendor or county IT Department?

Please select:

- Information System 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

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 system 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 system 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 3rd party vendor. MHP staff manages local operations (ASP type)
- Our system is housed at a 3rd party vendor. The vendor provides operational support. (Service Bureau Type)
- Other (Please describe & elaborate):

2.4 Does your MHP use your information system 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 system.

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 system?

Yes No

If yes, please check all that apply.

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

2.11 How many staff do you consider “experts” on your information system? 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 system 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 system 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 system 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 system (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?

<input type="checkbox"/>	CMS 1500
<input type="checkbox"/>	UB-92
<input type="checkbox"/>	837I
<input type="checkbox"/>	837P
<input type="checkbox"/>	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.

Coding Scheme	Inpatient Diagnosis	Inpatient Procedure	Outpatient Diagnosis	Outpatient Procedure
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 system?

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.)

<input type="checkbox"/>	New claims processing system purchased and installed to replace old system.
<input type="checkbox"/>	New claims processing system purchased and installed to replace most of the old system; old system still used.
<input type="checkbox"/>	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.

<u>Requested Document</u>	<u>Details</u>
Prior Reviews	If you have had prior formal external reviews of your information system, 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).

Fiscal Year 2006 Information Systems Review Supplemental Questionnaire

General Information

Note: This supplemental questionnaire pertains to the collection and processing of data for **Medi-Cal**. In many situations, this may be no different than how a MHP collects and processes commercial insurance or Medicare data. However, if **Medi-Cal** data is managed differently than commercial or other data, please answer the questions as they relate to **Medi-Cal** beneficiaries and **Medi-Cal** data.

Please insert your responses after each of the following questions. Return an electronic copy of the completed questionnaire, along with documents requested in item 10 to CAEQRO for review by _____ [Desired deadline date here].

Contact Information

Insert MHP identification information below. The contact name should be the person completing or coordinating the completion of this questionnaire.

MHP Name:	APS Fills in Here
IS Contact Name and Title:	
Mailing Address:	
Phone Number:	
Fax Number:	
E-mail Address:	
Date Questionnaire Completed:	

1. Review the ISCA document completed for the last CAEQRO review. Are there any changes?

<input type="checkbox"/> No
<input type="checkbox"/> Yes. <i>If yes, please reference the ISCA Section and item number and explain changes:</i>

2. List the top priorities for your IS department at the present time.

3. Describe the primary information systems currently in use.

3.1. Current information system 1:

Name of product:	Name of vendor/supplier:
When was it implemented? (An estimate is acceptable)	Month: Year:

What are its functions? (Check all that apply)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Clinical Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	
<input type="checkbox"/> Other (Describe)		

Who provides software application support?

<input type="checkbox"/> MHP IT	<input type="checkbox"/> Health Agency IT	<input type="checkbox"/> County IT	<input type="checkbox"/> Vendor IT	<input type="checkbox"/> Contract Staff
---------------------------------	---	------------------------------------	------------------------------------	---

Who is responsible for daily operations of the system?

- MHP IT Health Agency IT County IT Vendor IT Contract Staff

What type of Short-Doyle Medi-Cal claims does it currently produce?

- SDMC proprietary HIPAA 837 Both No claims or N/A

3.2. Current information system 2:

Name of product:

Name of vendor/supplier:

When was it implemented? (An estimate is acceptable) Month: Year:

What are its functions? (Check all that apply)

- Practice Management Appointment Scheduling Medication Tracking
 Managed Care Electronic Clinical Records Data Warehouse/Mart
 Billing State CSI Reporting
 Other (Describe)

Who provides software application support?

- MHP IT Health Agency IT County IT Vendor IT Contract Staff

Who is responsible for daily operations of the system?

- MHP IT Health Agency IT County IT Vendor IT Contract Staff

What type of Short-Doyle Medi-Cal claims does it currently produce?

- SDMC proprietary HIPAA 837 Both No claims or N/A

3.3. Current information system 3:

Name of product:	Name of vendor/supplier:
When was it implemented? (An estimate is acceptable)	Month: Year:

What are its functions? (Check all that apply)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Clinical Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	
<input type="checkbox"/> Other (Describe)		

Who provides software application support?

<input type="checkbox"/> MHP IT	<input type="checkbox"/> Health Agency IT	<input type="checkbox"/> County IT	<input type="checkbox"/> Vendor IT	<input type="checkbox"/> Contract Staff
---------------------------------	---	------------------------------------	------------------------------------	---

Who is responsible for daily operations of the system?

<input type="checkbox"/> MHP IT	<input type="checkbox"/> Health Agency IT	<input type="checkbox"/> County IT	<input type="checkbox"/> Vendor IT	<input type="checkbox"/> Contract Staff
---------------------------------	---	------------------------------------	------------------------------------	---

What type of Short-Doyle Medi-Cal claims does it currently produce?

<input type="checkbox"/> SDMC proprietary	<input type="checkbox"/> HIPAA 837	<input type="checkbox"/> Both	<input type="checkbox"/> No claims or N/A
---	------------------------------------	-------------------------------	---

4. Selection and Implementation of a new Information System.

4.1. Mark the box that best describes your status today and respond to the associated questions:

- A) No plans for a new IS.
- B) Considering a new IS.

What are the obstacles to obtaining a new system?

C) Actively searching for a new IS.
What steps have you taken?

When will you make a selection?

D) New IS selected, not yet in implementation phase.
What system/vendor was selected?

Projected start date?
Go live date?
Projected end date?
Please attach your project plan

E) Implementation in progress.
What system/vendor was selected?

Implementation start date?
Go live date?
Projected end date?
Please attach your project plan

4.2. If you marked box C, D, or E above, complete the following questions.
Otherwise, skip to question 5.

4.2.1. Describe any strategies or safeguards you plan to use to ensure timely and accurate claims, CSI reporting, and other management needs.

4.2.2. If you are converting/transferring data from a legacy system, describe your conversion strategy, including how you plan to coordinate with the State.

4.2.3. Specify key modules included in the system:

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Managed Care
<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Electronic Clinical Records
<input type="checkbox"/> Medication Tracking	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Other:	

4.2.4. What department will use the system? (Check all that apply)

<input type="checkbox"/> Mental Health
<input type="checkbox"/> Alcohol and Drug
<input type="checkbox"/> Public Health
<input type="checkbox"/> Other:
<input type="checkbox"/> Other:

5. Who is responsible for authorizing and implementing the following system activities?

Activity	Who authorizes? (Staff Name/Title)	Who implements? (Staff Name/Title)
Establishes new providers/reporting units/cost centers		
Determines allowable services for a Provider/RU/CC		
Establishes or decides changes to billing rates		
Determines information system UR rules		
Determines assignments of payor types to services		
Determines staff billing rights/restrictions		
Determines level of access to information system		
Terminates or expires access to information system		

6. Who is the person(s) most responsible for analyzing data from your information system? Describe the working relationship between this person(s) and your QI unit. If there is no such person, please state "NONE."

Staff Name/Title	Organization/Dept/Division	Describe relationship to QI unit or "None"

7. Does your MHP have User Groups or other forums for the staff to discuss information system issues and share knowledge, tips, and concerns?

Please complete all that apply	Meeting Frequency -Weekly, Monthly, Quarterly, as needed	Who Chairs Meetings? (name and title)	Meeting Minutes? (Yes/No)
Clerical User Group			
Clinical User Group			
Contract Providers			
IS Vendor Group			
Other			

8. On average, how many claims are received monthly from network (formerly fee-for-service) providers?

Outpatient claims? Inpatient hospital claims?
--

9. Considering the total number of services provided by the MHP, what percentage is billed to Medi-Cal?

--

- 9.1. Of the total number of services billed to Medi-Cal, what percentage is provided by:

County-operated/staffed clinics:	
Contract providers:	
Network (formerly fee-for-service) providers:	
Total	100%

10. Additional Documentation

Please provide documentation listed in the table below. Documentation may be submitted electronically or hardcopy. Label documents as shown under the “Requested Documents” column.

Requested Documents	Description
A. Organizational chart	The chart should make clear the relationship among key individuals/departments responsible for information management.
B. County-operated programs and clinics	A list of those who can bill Medi-Cal, including name, address, and type of program (i.e., outpatient, day treatment, residential, and inpatient).
C. Contract providers	A list of those who can bill Medi-Cal, including name, address, and type of program (i.e., outpatient, day treatment, residential, and inpatient).
D. Procedures to monitor accuracy and timeliness of data collection	Provide a copy of the current policies and procedures, desk procedures, or other written instructions to staff and providers that addresses standards for data collection accuracy and timeliness.
E. Procedures to determine a consumer’s eligibility status	Provide a copy of the current policies and procedures, desk procedures, or written instructions to staff and providers that describes how to determine a consumer’s eligibility status.
F. Procedures to produce Medi-Cal claims and review error/denied claims	Provide a copy of the current policies, procedures, operations manual, flowchart, calendar, or written instructions that document production of the Medi-Cal claim and resolving error/denied claims.
G. Procedures to monitor timeliness of claims processing and payments to network providers	Provide a copy of the current policies and procedures, desk procedures, or other written instructions to staff and providers that describes standards for monitoring timely claims processing/ payment.
H. Procedures for the following topics – new user authorization, disable user accounts, password standards, data security standards, unattended computers, electronic security audits.	Provide a copy of the current policies and procedures, desk procedures, or other written instructions to staff and providers for these activities.

Additional County-Specific Questions:

11. Respond to recommendations made in the last review. Prior review recommendations included:

[Enter no more than a few of the most critical recommendations prompted by or requiring follow-up from last year’s review of this MHP. If none, simply state “Not Applicable” – be sure to keep numbering consistency.]

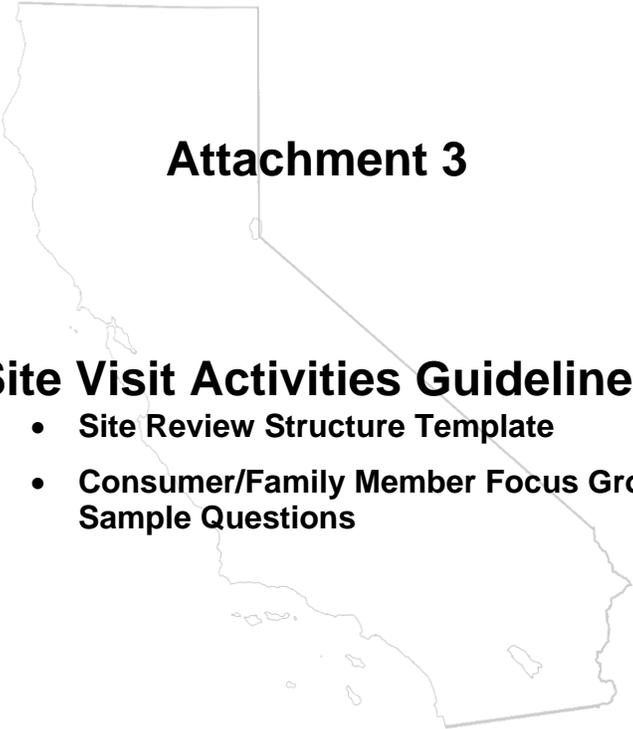
11.1. Recommendation:

11.2. Recommendation:

11.3. Recommendation:



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 3

Site Visit Activities Guidelines

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

Site Review Structure Template

Introduction

- A. Introduction of participants
 - 1. Sign-in sheets
 - 2. Importance of e-mail address
- B. Year Two Review intent – similar to year one - looking at how QI, PI processes are or are not occurring with the use of objective data, at all levels.
 - 1. Activities are described in the Notification Letter.
 - 2. Federal requirement as part of managed care, ie: PIPs
 - 3. Focus on progress or changes since the last review
 - 4. Focus on growth and improvement, not compliance
- C. Three phases to review process
 - 1. Pre-Site activities – documents, claims data, background of MHP
 - 2. On-Site activities – documents, people (staff, contractors, consumers, family)
 - 3. Post-Site activities – team input for report
- D. “Wrap-up” rather than an “exit interview” at the conclusion of the review
 - 1. Draft report to MHP and DMH for review.
 - 2. Final report will take all feedback into consideration.
 - 3. Timeline for report – describe current status.
 - 4. Available for technical assistance over the next year.
- E. Review agenda and its flexibility to adequately address all areas.
- F. Review occurs via discussion around documents with staff at many levels of the MHP.
 - 1. Identify any missing documents.
 - 2. Will likely ask for additional documents during the review.

Strategic Initiatives and MHP Issues

- A. MHP presents strategic initiatives.
- B. How were these initiatives determined?
- C. How will progress be measured or success identified?
- D. How is staff informed of the goals of the organization?
- E. Are there any major changes within the MHP since the last review?
- F. Is the implementation of a new Information System relevant?
- G. Comparison counties – if relevant to discussion.
- H. Potentially relevant questions:
 - 1. MHP annual budget
 - 2. Total FTEs
 - 3. Questions regarding organizational chart and structure
 - 4. FQHCs/Rural Clinics/Indian Health Clinics
 - 5. What percentage of consumers served have Medi-Cal? What percentage has no third-party payor at all?
 - 6. How many consumers are served annually?
 - 7. % of services provided by MHP staff vs. community providers

Last Year's Report – Issues and Recommendations

A. How did the MHP approach last year's report?

1. Was it helpful in any way?
2. Did the recommendations seem to fit?
3. What process was used to review the report and consider the issues?

B. Discuss the major recommendations

1. MHP perception of the problem area.
2. Action regarding each pertinent recommendation.
3. Future Plans.
4. Rate the status/progress for each major recommendation:

- #1 –

Fully addressed Partially addressed Not addressed

- #2 –

Fully addressed Partially addressed Not addressed

- #3 –

Fully addressed Partially addressed Not addressed

- #4 –

Fully addressed Partially addressed Not addressed

- #5 –

Fully addressed Partially addressed Not addressed

- #6 –

Fully addressed Partially addressed Not addressed

- #7 –

Fully addressed Partially addressed Not addressed

Performance Measurement

- A. Review jointly with IS staff.
- B. Decision to review with MHPs is based upon results of service date category and whether the MHP's results were greater than one standard deviation from the mean statewide.
- C. Discuss results MHP results. Statewide results:

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%

- D. MHP response to error rate.
 - 1. Who was involved in review of the results?
 - 2. Additional evaluation done by the MHP?
 - 3. Changes in processes implemented?
- E. Explain status/plans for FY06 PM.

Quality Improvement Processes

- A. Quality Improvement Unit structure and functions
1. Identify sub-committees of the QIC.
 2. Where does the major “work” of QI occur?
 3. How does the QI unit function to impact client care throughout the system?
- B. 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, consumers, and families?
 4. How is the QIC involved in the development or monitoring of the QI Work Plan?
 5. Is IS, Data, or Research staff involved in the QIC and other QI activities?
 6. How are medical and clinical staff involved in QI?
 7. What data are routinely reviewed at the QIC?
- C. QI Work Plan Review
1. How are the goals clearly identified, measurable, and tracked?
 2. How were the goals determined? Discuss MHP-specific goals that are not simply requirements of the MHP managed care contract. Are they QA, QI, PI?
 3. Does it include cultural competence goals?
 4. Does it include the PIPs?
 5. Does it include goals associated with business processes?
 6. What are the goals regarding coordination with physical healthcare?
 7. Does it include community provider goals?
- D. Business Processes and Data
1. What kind of data is routinely reviewed regarding MHP business processes?
 2. How do you monitor and track access to care and its timeliness?
 3. Do QI staff meet regularly with IS staff and other business/operations staff? Does this help to ensure that necessary data is available?
 4. If you need data regarding a certain issue, how would you obtain it? Who would analyze it?
 5. Is data regularly provided to the QI program? What kinds?
- E. Outcomes and Data
1. Is there an annual review of the QI Work Plan to measure achievements and help identify relevant goals for the next year?
 2. How do you monitor and track contractor performance?

3. Measurement of consumer outcomes – how does the MHP know that clients are benefiting from services provided?
- F. Review APS approved claims data
1. Identify any areas in which the MHP’s utilization data appears higher or lower than the region or the State.
 2. Was the MHP aware of these patterns? Is the MHP addressing the relevant issues?
 3. Does the MHP have data that is similar to or different than ours?
- G. Cultural Competence Analysis
1. How is the MHP using the collected data to understand disparities?
 2. How well is/are the threshold language group(s) served?
 3. What are the goals and measurable progress toward those goals?
 4. How do staff demographics compare to that of the client population or the Medi-Cal community?
 5. What are the community outreach efforts to improve access to under-served groups?
 6. How does the MHP address barriers to access by specific populations?
 7. How does the agency address issues of language?
 8. How are issues of Latino access being addressed?
 9. Are any demographic changes anticipated in the community? Will this perhaps result in changes in the threshold languages?
 10. How are non-ethnic related cultural issues addressed (e.g., consumer culture, homelessness, migrant workers, gay/lesbian issues, older adults, demographic changes, etc.)?
- H. Cultural Competence Training
1. What has been offered in the past 12 months?
 2. Have these trainings been well-attended?
 3. Did staff report satisfaction with the trainings?
- I. Surveys
1. Review list of surveys administered in the 12 months prior to the EQR.
 2. 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?

3. Detailed review of one survey:
 - 1) Survey tool
 - 2) How are consumers/families selected for completion of this survey?
 - 3) How broadly distributed was the survey? Response rate?
 - 4) Summary of results Shared with whom? How?
 - 5) Summary of implementation of change
 - 6) Are there plans for additional changes as a result of the survey? Who/how decided?
 - 7) Does the agency anticipate any barriers in sustaining this change?
 - 8) How will the results from this survey impact any future surveys?

Wellness, Recovery, Resilience

- A. What is the MHP's current vision with regard to wellness and recovery?
 - 1. How does the MHP plan to achieve a more recovery-oriented, consumer-driven system?
- B. How are consumers empowered within the system?
 - 1. Policy/program planning level? – QIC and other committees
 - 2. Consumer relationship or interface with the MH Director?
 - 3. Consumer employees or volunteers within the MHP? How many? Are they paid with benefits? How are they supported in their new roles?
 - 4. Peer support programs?
 - 5. Self-help centers?
 - 6. Vocational programs?
- C. How are families involved within the system?
 - 1. Policy/program planning? – QIC and other committees
 - 2. Family member/advocate employees or volunteers within the MHP? How many? Are they paid with benefits? How are they supported in their new roles?
 - 3. How are families involved in treatment planning of adult consumers?
- D. "Back Door" – how are programs set up to facilitate potential exit from the MH system? What community resources have been developed to facilitate these processes?
- E. What client outcomes are examined?
- F. How are grievances reviewed? Have concerns or trends been identified through this analysis?
- H. How are co-occurring disorders addressed? Cross training of staff? Co-location of staff?

Performance Improvement Projects

- A. Ask the MHP to present the PIP.
- B. Identify how the PIP is meaningful to the MHP.
- C. For PIPs that were reviewed last year:
 - 1. Were previously identified problems remedied?
 - 2. How was the data analyzed? Was it analyzed according to plan?
 - 3. Did the PIP include all relevant beneficiaries and an appropriate study size?
 - 4. Are the results meaningful?
 - 5. Were appropriate interventions applied based upon data analysis?
 - 6. Were the goals achieved?
 - 7. What factors appear to impact the validity of the results?
 - 8. Will the PIP continue?
- D. For PIPs that were not reviewed last year:
 - 1. Is the study question clear?
 - 2. Does baseline data support the existence of the problem?
 - 3. Does the PIP include all relevant beneficiaries and an appropriate study size?
 - 4. How are various staff involved in the PIP – Admin, QI, IS, Clinical?
 - 5. How will/do the indicators measure improvement?
 - 6. How will/do the interventions address the root causes/barriers?
 - 7. How will/was the data analyzed?
 - 8. What are/were barriers to implementation?
 - 9. What factors might impact/appear to impact the validity of the results?
 - 10. Are the results meaningful?
 - 11. Were appropriate interventions applied based upon data analysis?
 - 12. Were the goals achieved?
 - 13. Will the PIP continue?
- E. PIP Status
 - Active and ongoing
 - Active but newly implemented
 - Little activity for PIP that was conceptualized last year
 - Not active or ongoing; at an early conceptual stage
 - No non-clinical PIP available for review

F. PIP Validation Tool may also be relevant for evaluation and discussion:

Study Methodology	Yes	No	Partial	N/A
Was the topic selected through data collection and analysis of comprehensive aspects of beneficiary needs, care, and services?				

Study Methodology	Yes	No	Partial	N/A
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)				
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?				

Study Methodology	Yes	No	Partial	N/A
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?				

Clinical Staff & Supervisor Interviews

A. Introductions

1. Introduce APS staff & MHP staff
2. Purpose of review, with the relevance of the staff interviews
3. Confidentiality and impact on report to the MHP

B. Questions – tailor questions to the review, with examples below. Some of the questions below are from last year's review process and may or may not be relevant to this review.

1. What do you know about today's review and your role in it?
2. Quality Improvement
 - 1) What do you know about the MHP's efforts to monitor or improve the quality of services?
 - 2) How are changes in policies or procedures communicated to you?
 - 3) How do you communicate the need for changes in policies or procedures to the management?
3. Cultural competence
 - 1) Are you aware of the department's goals regarding cultural competence?
 - 2) What do you do to participate in improving the county's cultural competence?
 - 3) Has the MHP provided any cultural competence trainings? Have they been beneficial? How are you/your staff supported or encouraged to attend?
4. Wellness & Recovery
 - 1) How familiar are you with "wellness and recovery"?
 - 2) If consumers are employed within the system, how have you been trained and supported in this practice?
5. What improvements have you experienced in the mental health system over a period of time?
6. If you could change one thing about the MHP that would improve the quality of services to consumers, what would it be?
7. Are you aware of the organization's goals for this year?

C. Additional questions for clinical supervisors:

1. How do you know how well your organization is doing?
2. Is data available to you to make decisions regarding the programs you supervise? What kind of data? How do you receive this information?
3. How are you used for the communication of information from management to line staff and vice-versa?

Contract Provider Clinical Staff and Supervisor Interviews

A. Introductions

1. Introduce APS staff & MHP staff
2. Purpose of review, with the relevance of the staff interviews
3. Confidentiality and impact on report to the MHP

B. Questions – tailor questions to the review, with examples below. Some of the questions below are from last year's review process and may or may not be relevant to this review.

1. Quality Improvement
 - 1) What do you know about the MHP's efforts to monitor or improve the quality of services?
2. How well does the MHP communicate with its contract providers?
 - 1) Communication regarding policies and procedures?
 - 2) Coordination of care for consumers served by both MHP and contract providers?
3. Cultural competence
 - 1) Are you aware of the MHP's goals regarding cultural competence?
 - 2) Are contract providers included in trainings the MHP provides regarding cultural competence?
4. Wellness & Recovery
 - 1) How familiar are you with "wellness and recovery"?
 - 2) If consumers are employed within the system, how have you been trained and supported in this practice?
5. What improvements have you experienced in the mental health system over a period of time?
6. If you could change one thing about the MHP that would improve the quality of services to consumers, what would it be?

C. Additional questions for clinical supervisors/directors:

1. How do you know how well your organization is doing?
2. What does the MHP do to monitor your agency's performance as a contract provider?
3. Is data available to you to make decisions regarding the programs you supervise? How do you receive this information? Does the MHP provide it?
4. What kind of communication occurs between the MHP and contract providers? How effective is it?

Consumer Staff Interview

A. Introductions

1. Introduce APS staff & MHP staff
2. Purpose of review and interviewing consumer staff
3. Confidentiality and impact on report to the MHP

B. Questions – ask those deemed relevant

1. What is your role? Are you and other staff clear on your role?
2. How are consumers involved in treatment planning in general?
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. What kind of supervision, support, or on-going training does the MHP provide you?
6. How would you like to be utilized that may be different from what you’re doing now?

Consumer/Family Member Focus Group

- A. Obtain Participant Agreement Forms ... other introductory issues, including confidentiality.
- B. Focus group questions – use MHP-specific questions.
- C. Take notes for the identification of issues and themes.
- D. Thank participants and provide gift certificates.

Consumer Family Focus Group 1

Number/Type of Participants	
Consumers	
Family Members	
Consumer & Family Member	
Total participants	

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	
Adult (approx 25-59)	
Older Adult (approx 60+)	

Preferred Languages	

Estimated Race/Ethnicity	

Gender	
Male	
Female	

Interpreter(s) used for focus group: No Yes, Language(s):

Consumer Family Focus Group 2

Number/Type of Participants	
Consumers	
Family Members	
Consumer & Family Member	
Total participants	

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	
Adult (approx 25-59)	
Older Adult (approx 60+)	

Preferred Languages	

Estimated Race/Ethnicity	

Gender	
Male	
Female	

Interpreter(s) used for focus group: No

Yes, Language(s):

Wrap-Up

- A. It is not a traditional exit interview but rather a conclusion to the review process.
- B. Next steps
 - 1. Report has the findings that you would anticipate from an exit interview.
 - 2. Includes input from entire team based upon our on-site findings.
 - 3. Report goes simultaneously to the MHP and to DMH for input/comments.
- C. Thank the participants and the MHP staff who organized the review.
- D. Identify any particular themes that have become apparent – either by MHP or APS staff. Any these themes or issues should be discussed with the team prior to the wrap-up.
 - 1. Positive feedback from the review areas, focus group, or staff interviews.
 - 2. Major site review deficiencies that would be meaningful to discuss.
- E. Identify any outstanding documentation.
 - 1. Any additional information can be e-mailed.
 - 2. Additional information or documentation may be requested during the report-writing process that will begin after the review.
- F. Ask the MHP for feedback on the process.
 - 1. Zoomerang Survey will be coming via e-mail to many of you within a few days.
 - 2. Identify issues that would be meaningful for inclusion in the report from MHP perspective.

Consumer/Family Member Focus Group Sample Questions

This template represents possible questions for the consumer/family focus groups. Questions are adjusted based upon the issues identified in a given MHP or population.

Prior to asking questions:

1. Explain purpose of EQRO.
2. Review confidentiality and collect signed participation forms.
3. Encourage interaction. We will not ask everybody every question. Answer those that are relevant to you.
4. This group will end in 90 minutes.

Ask participants to introduce themselves – first name, programs they are involved in, how long they have received services in this County's system.

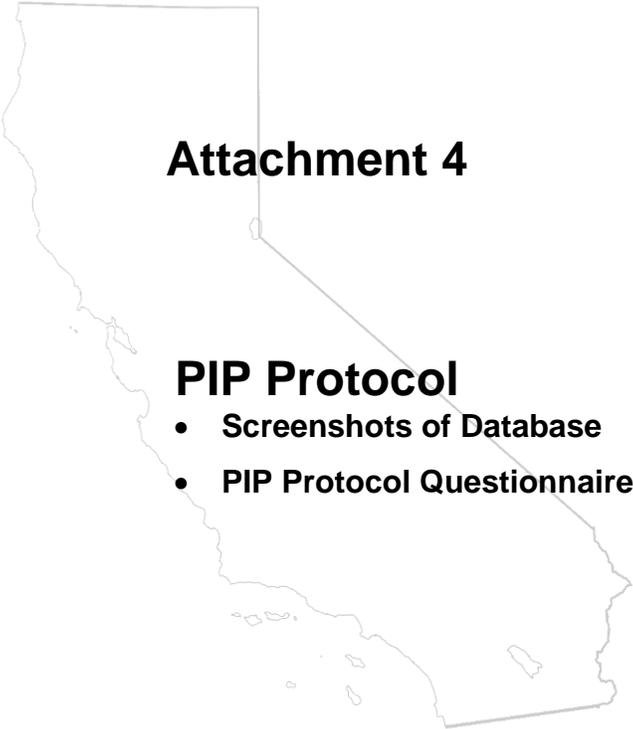
1. How did you become a participant in this focus group?
2. What does Recovery and Wellness mean to you? What are your goals? (Prompts can include asking about life skills, education, employment, housing, etc.)
3. What kind of services does the County/Program provide that helps you to achieve your goals? (Prompts can include asking about whether the staff instills hope, whether the services actually help in terms of achieving wellness.)
 - If you previously participated in a day treatment program, how did you County transition you out of this program?
4. 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? (How was the Client Plan developed? Was it the client's goals?)
5. How is your family or other important people in your life involved in your services? (This question should go quickly based upon answers from above.)
6. If you also have problems with drugs or alcohol, how are those needs addressed? How are those services coordinated?
7. How easy or difficult is to get an appointment with a psychiatrist? How satisfied are you with these services?
8. How does the County take your cultural issues into account in providing services? Do you feel like you are treated respectfully in general?

- 9. If the Director asked for your advice on what to change, what would you recommend?**

- 10. Have there been any improvements in the system over the past couple of years?**



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 4

PIP Protocol

- Screenshots of Database
- PIP Protocol Questionnaire

Attachment E: PIP Validation Tools			
Performance Improvement Project Review Tool - Clinical PIP			
County: XYZ	Review Date: 01-Jan-06	For Fiscal Year: 2006	
Reviewer: Sample	Type: <input checked="" type="radio"/> Clinical <input type="radio"/> Non-Clinical	Study Start:	End:
County Size: Large	Region: Bay Area		
Question	Response	Notes	
1. Was the topic selected through data collection and analysis of comprehensive aspects of beneficiary needs, care and services?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A		
2. Did the MHP, over time, address a key aspect of beneficiary care and services?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A		
3. Did the PIP, over time, include all clients for whom the PIP pertained?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A		
4. Was/were the study question(s) stated clearly in writing?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A		
5. Did the study use objective, clearly defined, measurable indicators?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A		
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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A		
7. Did the MHP clearly define all the Medicaid beneficiaries to whom the study question and indicators are relevant?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A		
Report Printed: 24-Aug-06 15:04			
Page 1 of 4			

<h2 style="text-align: center; margin: 0;">Performance Improvement Project Review Tool - Clinical PIP</h2>		
<p>County: XYZ Review Date: 01-Jan-06 For Fiscal Year:</p>		
Question	Response	Notes
<p>8. If the MHP studied the entire population, did its data collection approach capture all beneficiaries to whom study question applied?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A</p>	
<p>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)</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A</p>	
<p>10. Did the MHP employ valid sampling techniques that protected against bias?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A</p>	
<p>11. Did the sample contain a sufficient number of beneficiaries?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A</p>	
<p>12. Did the study design clearly specify the data to be collected?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A</p>	
<p>13. Did the study design clearly specify the sources of the data?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A</p>	
<p>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?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A</p>	
<p><i>Report Printed: 24-Aug-06 15:04</i></p>		

Performance Improvement Project Review Tool - Clinical PIP		
County: XYZ		Review Date: 01-Jan-06 For Fiscal Year:
Question	Response	Notes
15. Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
16. Did the study design prospectively specify a data analysis plan?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
17. Were qualified staff and personnel used to collect the data?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
18. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
19. Was an analysis of the study findings performed according to the data analysis plan?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
20. Did the MHP present numerical PIP results and findings accurately and clearly?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	

Performance Improvement Project Review Tool - Clinical PIP		
County: XYZ		Review Date: 01-Jan-06 For Fiscal Year:
Question	Response	Notes
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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
23. Was the same methodology as the baseline measurement used, when measurement was repeated?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
24. Was there any documented quantitative improvement of processes or outcomes of care?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
26. Is there any statistical evidence that any observed performance improvement is true improvement?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	
27. Was sustained improvement demonstrated through repeated measurements over comparable time periods?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Partial <input checked="" type="radio"/> N/A	

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

ID of Evaluator _____ Date of Evaluation: ____/____/____

Demographic Information
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

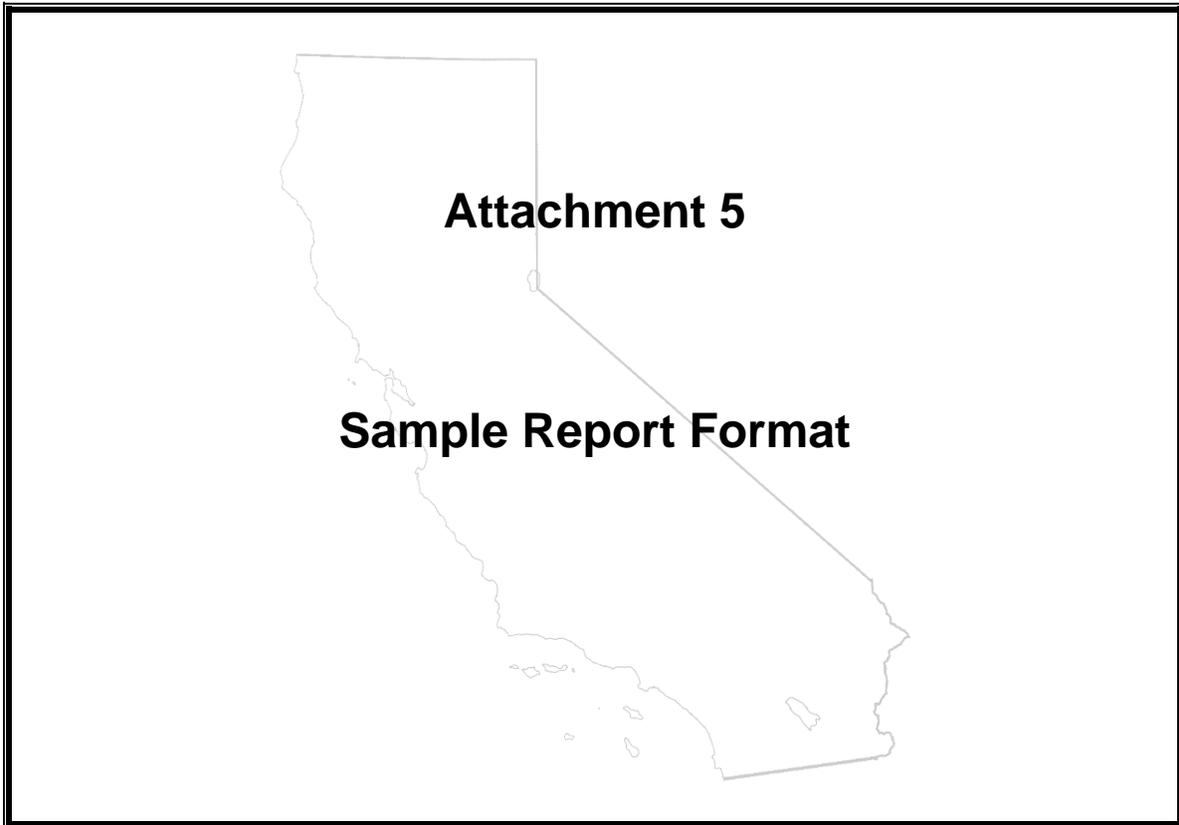
Review of Study Methodology					
Step 1: REVIEW THE SELECTED STUDY TOPIC					
Component/Standard	Yes	No	N/A	Part- ial	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of beneficiary needs, care and services?					
1.2 Did the MHP, over time, address a key aspect of beneficiary care and services?					
1.3 Did the PIP, over time, include all clients for whom the PIP pertained?					
Step 2: REVIEW THE STUDY QUESTION (S)					
2.1 Was/were the study question(s) stated clearly in writing?					
Step 3: REVIEW SELECTED STUDY INDICATOR (S)					
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?					

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION					
4.1 Did the MHP clearly define all the Medicaid beneficiaries to whom the study question and indicators are relevant?					
4.2 If the MHP studied the entire population, did its data collection approach capture all beneficiaries to whom the study question applied?					
Step 5: REVIEW THE SAMPLING METHODS					
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?					
Step 6: REVIEW DATA COLLECTION PROCEDURES					
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?					
Step 7: ASSESS IMPROVEMENT STRATEGIES					
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?					

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS					
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?					
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?					
Step 9: ASSESS WHETHER IMPROVEMENT IS “REAL” IMPROVEMENT					
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?					
Step 10: ASSESS SUSTAINED IMPROVEMENT					
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?					



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION





California External Quality Review Organization

< NAME > County
< Dates of Review >

Introduction and Scope

The California Department of Mental Health (DMH) is charged with the responsibility of evaluating the quality of specialty mental health services provided to beneficiaries enrolled in the Medi-Cal managed mental health care program.

This report presents the second year findings of an external quality review of the < County Name > County mental health plan (MHP) by California External Quality Review Organization (CAEQRO), a division of APS Healthcare, < from/on date to date >. Based upon last year's findings, CAEQRO customized this year's review to include a comprehensive evaluation of the service delivery system's business practices, strategic planning, and program development.

Consistent with this approach, CAEQRO's intent was to include findings on the following areas:

- Information System Capabilities Assessment V5.7L (ISCA)
- Two current Performance Improvement Projects (PIPs) — one clinical and one non-clinical
- Any changes, progress, or milestones in quality improvement processes and activities
- The implementation of wellness and recovery practices throughout the system
- Interviews with key MHP clinical, administrative, information systems, clerical/data entry staffs, and, where appropriate, contract provider staffs
- <#> 90-minute focus group<(s)> with beneficiaries and family members

The review agenda and the participants follow as Attachments A and B. Data provided to the MHP, a list of focus group questions, and detailed results for the PIP validation tool are provided in Attachment C, Attachment D, and Attachment E respectively.

Changes in MHP Environment

CAEQRO views changes in the MHP environment as those external events that have had a significant effect on the overall service delivery system since last year's review. These changes also may have the potential to affect an MHP's business practices, strategic planning, and program development during the new fiscal year and over the long term.

For the MHP, significant events include the following:

- < Issue 1 >
- < Issue 2 >
- < Issue 3 >
- < Issue 4 >

Review Findings for Fiscal Year 2006

Status of Fiscal Year 2005 Recommendations

In the FY05 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. The CAEQRO review team discussed the most significant of these recommendations with the MHP staff during the FY06 site visit. The status of improvement for each area is summarized below:

- List issue:

<input type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
--	--	--

<Brief relevant text, if applicable>
- List issue:

<input type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
--	--	--

<Brief relevant text, if applicable>
- List issue:

<input type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
--	--	--

<Brief relevant text, if applicable>
- List issue:

<input type="checkbox"/> Fully addressed	<input type="checkbox"/> Partially addressed	<input type="checkbox"/> Not addressed
--	--	--

<Brief relevant text, if applicable>

Overall Service Delivery System

< Include brief narrative addressing business practices, strategic planning and program development. Comment on strategic initiatives particularly in relation to wellness and recovery, and quality – including cultural competence. Comment on new programs, decisions, or hires that impact the overall service delivery. >

CAEQRO provided the MHP with a summary report of Medi-Cal approved claims data. These data follow as Attachment C.

Table 1 – FY <YY> Medi-Cal Approved Claims Data (claims processed through << MM/DD/YY >>)

Element	<<insert MHP name>>	<<insert region>>	MHPs of Similar Size	Statewide	Rank Out of 57 MHPs Reviewed
Penetration Rate	XX%	XX%	XX%	XX%	X
Approved Claims for Unduplicated Beneficiaries Served	\$XX	\$XX	\$XX	\$XX	X
Average Monthly Approved Claims for Unduplicated Eligible	\$XX	\$XX	\$XX	\$XX	X

Note: In each category, rank 1 is the highest value; rank 57 is the lowest value.

< Include discussion about any other key issues associated with the MHP's data.>

Performance Measurement Results

During FY05, CAEQRO reviewed selected MHP medical record documents as part of the MHP data validation project. CAEQRO performed this activity to fulfill the federal requirement that an EQRO review and validate Performance Measures (PMs) designated by a state's Department of Mental Health on an annual basis. Working with representatives from DMH and the California Mental Health Directors Association, CAEQRO developed specifications in compliance with federal guidelines and selected a valid audit sample using FY03 Medi-Cal approved claims files provided by DMH.

CAEQRO examined February 2003 Medi-Cal penetration rates for age, gender, and service delivery date to validate DMH accuracy in calculating overall penetration rates. CAEQRO provided MHPs their respective results in July 2005.

< Include this if PM results were reviewed with this MHP > Results are displayed below, along with statewide statistics. Because the MHP's PM results for the service date category were greater than one standard deviation from the mean error rate, CAEQRO reviewed PM results and the associated MHP processes with MHP staff. < Describe MHP's response to the results and any changes that have occurred or are in progress. >

< Include this if PM results were not reviewed with this MHP > Results are displayed below, along with statewide statistics. Because the MHP's results for the service date

category were within one standard deviation from the mean error rate, CAEQRO did not examine the results as part of the site review process.

Table 2 – FY05 Performance Measurement Results of FY03

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%

MHP Results			
Number of Records Audited	XX	XX	XX
Total Errors	XX	XX	XX
Sample Error Rate	XX%	XX%	XX%

DMH is in the process of identifying specific PMs for FY06. Consequently, CAEQRO has not conducted a data validation review of PMs at the MHP level in conjunction with this year's site review process. Once DMH determines PMs for review and approves an analytic strategy, CAEQRO will advise MHPs of data required to validate the selected PMs.

Quality Improvement Processes and Activities

< Include brief narrative addressing effectiveness of committee structure and oversight, quality improvement processes, and status of Work Plan activities, including cultural competence initiatives. Identify the MHP's threshold language(s) in this section if applicable. >

Consumer/Family Member Focus Group<s>

CAEQRO conducted < one/two/three > 90-minute focus < group/groups > with consumers and family members during the site review of the MHP. The focus group was held at ... <and any key issues about the focus group itself.>

< Provide a brief summary of focus group areas of focus, participants, and key issues. >

The focus group questions are included as Attachment D. CAEQRO provided gift certificates to thank the consumers and family members for their participation.

Table 3 – Consumer/Family Member Focus Group 1

Number/Type of Participants	
Consumers	
Family Members	
Consumer and Family Member	
Total Participants	

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	
Adult (approx 25-59)	
Older Adult (approx 60 and older)	

Preferred Languages	
<List all that apply>	

Estimated Race/Ethnicity	
<List all that apply>	

Gender	
Male	
Female	

Interpreter<s> used for focus group 1: No Yes, Language<s>:

< Provide a brief summary of focus group areas of focus, participants, and key issues. >

Table 4 – Consumer/Family Member Focus Group 2

Number/Type of Participants	
Consumers	
Family Members	
Consumer and Family Member	
Total Participants	

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	
Adult (approx 25-59)	
Older Adult (approx 60 and older)	

Preferred Languages	
<List all that apply>	

Estimated Race/Ethnicity	
<List all that apply>	

Gender	
Male	
Female	

Interpreter<s> used for focus group 2: No Yes, Language<s>:

Performance Improvement Project Validation

Clinical PIP activity validation

“< Study Question > “

- Status of the clinical PIP:
 < If “active and ongoing” is not selected, add one sentence which succinctly describes why the category is selected. >

- Active and ongoing
- Active but newly implemented (not ongoing)
- Little activity for PIP conceptualized last year
- Not active or ongoing; at an early conceptual stage
- No clinical PIP available for review

< Briefly discuss key issues associated with the PIP review. >

CAEQRO's discussions with the MHP staff included the following technical assistance to improve this PIP:

-

CAEQRO applied the PIP validation tool to all PIPs, including those PIPs that did not meet minimum criteria as being "active and ongoing." The following table presents a summary of the clinical PIP validation review results. Summary ratings are an aggregation of individual scores by category. Detailed results are included in the PIP validation tool found in Attachment E.

Table 5 – Clinical PIP Validation Review Results Summary

STEP	Rating		
	Met	Partially Met	Not Met
Selection of study topic			
Definition of study question			
Selection of study indicator			
Use of representative and generalizable study population			
Use of sound sampling techniques			
Use of reliable data collection processes			
Implementation of intervention and improvement strategies			
Analysis of data and interpretation of study results			
Creation of a plan for real improvement			
Achievement of sustained improvement			

Non-clinical PIP activity validation

"< Study Question > "

- Status of the non-clinical PIP:
< If "active and ongoing" is not selected, add one sentence which succinctly describes why the category is selected. >

- Active and ongoing
- Active but newly implemented (not ongoing)
- Little activity for PIP conceptualized last year
- Not active or ongoing; at an early conceptual stage
- No non-clinical PIP available for review

< Briefly discuss key issues associated with the PIP review. >

CAEQRO's discussions with the MHP staff included the following technical assistance to improve this PIP:

-

CAEQRO applied the PIP validation tool to all PIPs, including those PIPs that did not meet minimum criteria as being “active and ongoing.” The following table presents a summary of the non-clinical PIP validation review results. Summary ratings are based upon an aggregation of individual scores by category. Detailed results are included in the PIP validation tool found in Attachment E.

Table 6 – Non-Clinical PIP Validation Review Results Summary

STEP	Rating		
	Met	Partially Met	Not Met
Selection of study topic			
Definition of study question			
Selection of study indicator			
Use of representative and generalizable study population			
Use of sound sampling techniques			
Use of reliable data collection processes			
Implementation of intervention and improvement strategies			
Analysis of data and interpretation of study results			
Creation of a plan for real improvement			
Achievement of sustained improvement			

Information Systems Review

Knowledge of the capabilities of an MHP’s information system is essential to evaluate the MHP’s capacity to manage the health care of its beneficiaries. CAEQRO used the written response to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

MHP systems overview

[< Provide a brief summary of MHP current operations. >](#)

The following table provides an overview of the systems and applications that the MHP uses to support data collection, produce the Short Doyle Medi-Cal (SDMC) claim, and permit MHP staff to access the data for analyses and ad hoc reporting.

Table 7 – MHP Current Systems/Applications

System/Application	Function	Software Support	Length of Use	Operated By	Produces SDMC Claims

Plans for change

< Provide a brief summary of any MHP plans for system replacement, or significant changes they plan to make in current review period. >

System component findings

The following table provides a summary of the system components assessed by CAEQRO during the FY06 review that relate to the capabilities and functionalities of the MHP's information systems.

Table 8 – Review of Information System Components

COMPONENT	Rating			
	Met	Partially Met	Not Met	Not Reviewed
Procedures to monitor accurate, consistent and timely data collection				
Procedures to determine a beneficiary's eligibility status				
Integrity of Medi-Cal claim production process				
Timeliness of claims processing and payments for Network Providers				
Access to data via standard and ad hoc reports				
Information systems training program and "Help Desk" support				
System documentation for users				
Information systems/fiscal policies and procedures documented and distributed				
Communication and collaboration between quality improvement and IS staffs				
Documented data security and back-up procedures				

Specific information system component findings <If there are no items to explain here (i.e., all are Met, none are exemplary) then remove this section and header. >

<Items marked as Partially Met, Not Met, or Not Reviewed must be explained here. If you only provide explanations for these categories, use this sentence as the lead-in and delete the other below> Components rated "Partially Met," "Not Met," or "Not Reviewed" are explained below.

<Optionally, you may provide narrative on any exemplary practices that you have categorized as Met. If you do, use this as your lead-in, and delete the other above > Components rated "Partially Met," "Not Met," or "Not Reviewed" are explained below. In addition, some components rated as "Met" are included because they were exemplary practices observed in the course of the review.

Medi-Cal eligibility and claims trend line analysis

The following table provides trend line information of the MHP's Medi-Cal eligibility and approved claims data for the three most recent fiscal years.

Table 9 – MHP Medi-Cal Eligibility and Claims Information

Fiscal Year	Processing Status	Average Monthly Unduplicated Eligibles	Unduplicated Count of Medi-Cal Beneficiaries Served	Penetration Rate	Approved Claims	Average Monthly Approved Claims for Unduplicated Eligible
FY03	Complete	XX	XX	%	\$XX	\$XX
FY04	<<insert process date>>	XX	XX	%	\$XX	\$XX
FY05	<<insert process date>>	XX	XX	%	\$XX	\$XX

Strengths and Challenges

The following strengths and challenges are characteristics of the MHP's program features, business practices, and/or information systems that appear to have a significant impact on the overall delivery system. In the following section on recommendations, the report offers suggestions on how the MHP could leverage its strengths and address its challenges.

Strengths

- < Strength 1 >
- < Strength 2 >
- < Strength 3 >

Challenges

- < Challenge 1 >
- < Challenge 2 >
- < Challenge 3 >

Site Review Process Barriers

CAEQRO considered the following issues significant in affecting the ability to conduct a comprehensive and thorough review:

< Significant issues affecting the overall quality of the review, such as poor focus group planning, lack of requested documentation, problematic timeliness of response, two PIPs not active and on-going, etc. >

- <Process deficiency 1>
- <Process deficiency 2>
- <Process deficiency 3>

Recommendations

The following recommendations are in response to opportunities for improvement that the CAEQRO team identified during the review process:

< To the extent possible, write the recommendations in order of priority, starting with the most important. >

- < Recommendation 1 >
- < Recommendation 2 >
- < Recommendation 3 >
- < Recommendation 4 >
- < Recommendation 5 >
- < Recommendation 6 >
- < Recommendation 7 >

Attachments

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Data Provided to MHP

Attachment D: Consumer/Family Focus Group Questions

Attachment E: PIP Validation Tools

Attachment A: Review Agenda

[< Insert Review Agenda >](#)

Attachment B: Review Participants

The MHP staff, management, <significant stakeholders, and/or contract providers> who participated in the review included:

<List staff>

The following <#> CAEQRO reviewers participated in this year's site review process:

<List staff >

Additional CAEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and, ultimately, the recommendations in this report.

Attachment C: Data Provided to MHP

< This attachment is formatted in landscape. Include copies of any data that was distributed to the MHP with the notification materials. This includes Medi-Cal Approved Claims Data and any other specific data sets that were provided as part of the review (e.g., specific analysis of foster care paid claims, etc.)

Attachment D: Consumer/Family Focus Group Questions

Consumer/Family Member Focus Group #1 Questions –

< List all questions asked at the focus group.>

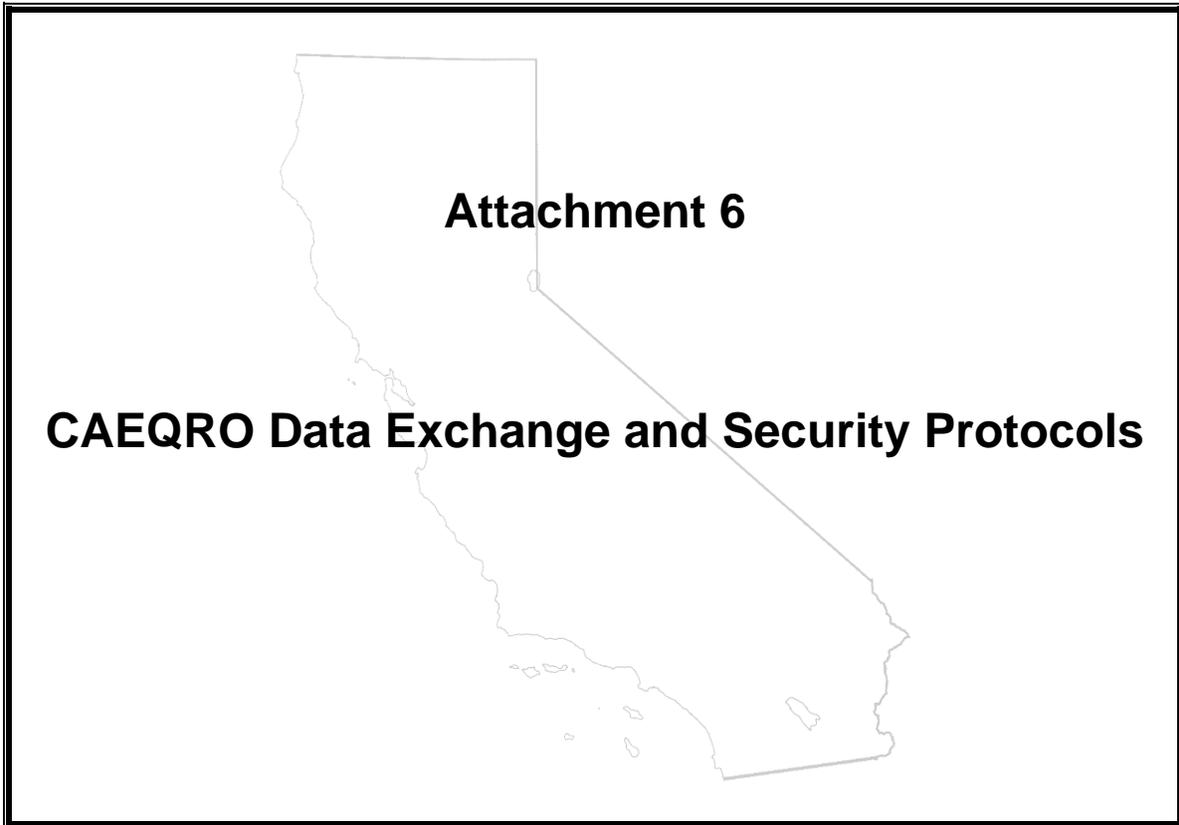
Consumer/Family Member Focus Group #2 Questions –

< List all questions asked at the focus group.>

Attachment E: PIP Validation Tools



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



CAEQRO Data Exchange and Security Protocols

CAEQRO Source Data Files

For our FY06 review, DMH has continued to provide CAEQRO access to eligibility and approved claims for source data through the following secure process that we jointly developed during FY05:

- 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 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 July 2003 to current file creation date. At present, CAEQRO receives refreshed IPC data at least 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.

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 four times per year.

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

- FY01-FY02
 - FY02-FY03
 - FY03-FY04
 - FY04-FY05
 - FY05-FY06 (claims processed through April 30, 2006)
-
- **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 2006 would contain the following months of eligibility data: Current upcoming (June 2006), May 2006, April 2006, March 2006, February 2006, January 2006, December 2005, November 2005, October 2005, September 2005, August 2005, July 2005, June 2005, May 2005, April 2005 and March 2005. The MMEF that DMH provides to CAEQRO is refreshed about three times per year.
 - **Short-Doyle/Medi-Cal Denied Claims File (SDMCD).** Short-Doyle/Medi-Cal Denied Claims Files (SDMCD). 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. Currently the SDMCD fiscal-year-to-date file is refreshed four times per year.
 - **Provider File (PF).** The PF file is produced by DMH using the statewide Provider and Legal Entity File that the department maintains. The PF file contains provider demographic and services information for all authorized SDMC providers. At present, CAEQRO receives refreshed PF data at least twice a year.

CAEQRO Server Environment

Below we review how we configured our information systems (IS) environment during our first contract year to support our ability to analyze data. Because this configuration provided us with regular and secure access to data—including maintaining the security of PHI—it was unchanged for our FY06 review:

- **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, SDMC and IPC
• Service Mode	• From SDMC and IPC
• Service Function Code	• From SDMC and IPC
• Aid Code	• From MEDS, SDMC and IPC
• 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
• SPSS	• Statistical analysis software

Software	Description
<ul style="list-style-type: none"> Data Transformation Services 	<ul style="list-style-type: none"> Software that manages SQL files
<ul style="list-style-type: none"> Transact-SQL 	<ul style="list-style-type: none"> Programming language used to extract data from SQL database files
<ul style="list-style-type: none"> Excel 	<ul style="list-style-type: none"> Software that reads SAS/SQL

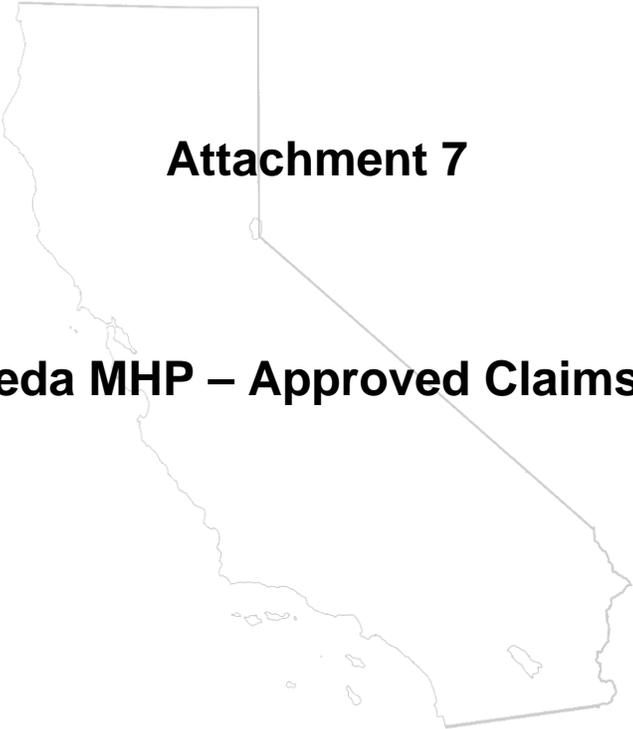
- CAEQRO data quality assurance processes:**

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 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 the CAEQRO 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, 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.



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 7

Alameda MHP – Approved Claims Data



**Medi-Cal Approved Claims Data
for Alameda County MHP
Fiscal Year 03-04**

Date Prepared: August 11, 2005 / Version 1.0
Prepared by: Bill Ulom, APS Healthcare / CA - EQRO
Information Source: DMH Approved Claims Summary Data - Notes - (1) and (2)
DMH Process Date: June 30, 2005 - Note (8)

A L A M E D A C O U N T Y D A T A		B A Y A R E A D A T		S T A T E W I D E D A T A	
Fiscal Year	Average Monthly Unduplicated Count of Medi-Cal Beneficiaries Served	Approved Claims	Penetration Rate	Average Monthly Approved Claims for Unduplicated Beneficiaries Served	Penetration Rate
Totals	200,692	18,000	8.64%	\$4,809	\$6,860
Age Groups					
0-17	120,588	5,423	4.50%	\$7,114	\$6,338
18-20	13,628	596	4.37%	\$4,828	\$4,157
21-39	52,686	4,136	7.87%	\$17,039	\$3,268
40-59	37,766	3,766	10.00%	\$3,778	\$3,027
60-64	5,745	651	11.33%	\$1,688	\$3,569
65+	35,279	457	1.30%	\$1,683	\$3,388
Gender					
Females	155,838	10,284	6.59%	\$3,973	\$5,959
Males	113,864	8,382	7.37%	\$5,649	\$5,959
Age Groups by Gender					
0-17 female	59,404	2,834	4.77%	\$6,191	\$6,191
0-17 male	61,184	3,889	6.36%	\$7,137	\$4,276
18-20 female	8,013	308	3.84%	\$4,276	\$4,276
18-20 male	5,615	288	5.13%	\$5,420	\$5,420
21-39 female	38,060	2,851	7.50%	\$4,874	\$4,874
21-39 male	14,626	1,885	12.90%	\$5,258	\$5,258
40-59 female	21,746	3,850	17.71%	\$3,219	\$3,219
40-59 male	16,020	2,003	12.50%	\$4,638	\$4,638
60-64 female	3,203	408	12.74%	\$3,271	\$3,271
60-64 male	2,542	253	10.00%	\$3,049	\$3,049
65+ female	26,402	333	1.26%	\$3,274	\$3,274
65+ male	13,877	164	1.19%	\$3,518	\$3,518
Eligibility Categories					
Disabled (Aid Group)	48,164	10,165	21.11%	\$1,208	\$5,038
Foster Care	3,409	2,127	62.42%	\$5,638	\$5,638
Other/Child	112,602	4,007	3.56%	\$1,182	\$3,893
Family Adult	64,016	2,646	4.13%	\$84	\$1,331
Other Adult	55,079	465	0.84%	\$31	\$2,884



**Medi-Cal Approved Claims Data
for Alameda County MHP
Fiscal Year 03-04**

Date Prepared: August 11, 2005 / Version 1.0
 Prepared by: Bill Ullom, APS Healthcare / CA - EQRO
 Information Source: DMH Approved Claims Summary Data - Notes - (1) and (2)
 DMH Process Date: June 30, 2005 - Note (3)

Service Activity	A L A M E D A C O U N T Y D A T A				B A Y A R E A D A T				S T A T E W I D E D A T A			
	Fiscal Year Unapproved Eligibles	Average Monthly Unapproved Eligibles	Count of Medi-Cal Beneficiaries Served	Unapproved Claims	Average Monthly Approved Claims	Fiscal Year Approved Claims	Average Monthly Approved Claims	Penetration Rate	Average Monthly Approved Claims for Unduplicated Beneficiaries Served	Fiscal Year Approved Claims for Unduplicated Beneficiaries Served	Average Monthly Approved Claims for Unduplicated Beneficiaries Served	Penetration Rate
Inpatient	269,692	216,040	1,870	\$15,509,173	\$645	\$8,294	0.87%	\$645	\$9,294	\$91	0.63%	\$91
Residential	269,692	216,040	260	\$1,442,416	\$153	\$5,548	0.12%	\$153	\$5,548	\$145	0.23%	\$145
Day Treatment	269,692	216,040	1,013	\$11,725,452	\$119	\$11,575	0.47%	\$119	\$11,575	\$131	0.20%	\$131
Linkage/Bridge	269,692	216,040	6,487	\$5,790,868	\$78	\$881	3.01%	\$78	\$881	\$56	3.71%	\$56
MH Services	269,692	216,040	13,482	\$42,051,127	\$107	\$3,119	6.24%	\$107	\$3,119	\$107	6.03%	\$107
Medication Support	269,692	216,040	9,905	\$8,904,105	\$101	\$899	4.88%	\$101	\$899	\$114	4.34%	\$114
Crisis	269,692	216,040	4,042	\$5,456,980	\$440	\$1,353	1.87%	\$440	\$1,353	\$494	1.55%	\$494

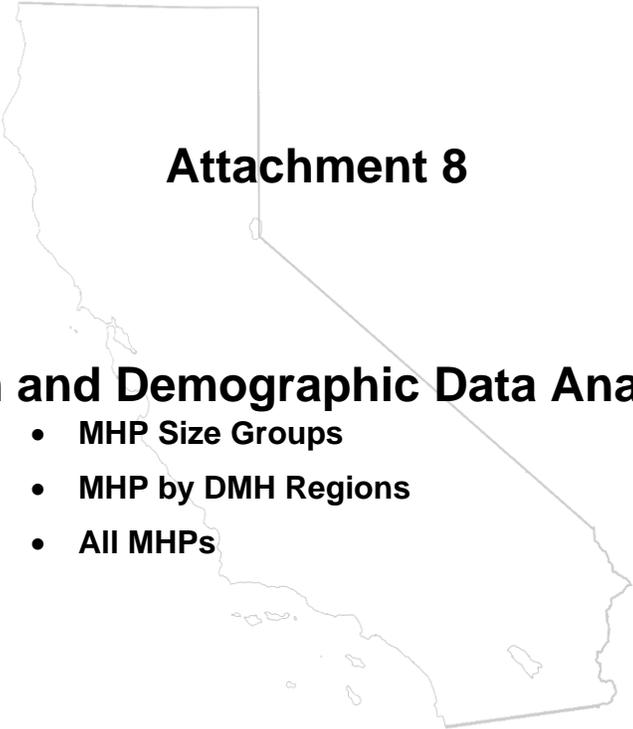
Race/Ethnicity	A L A M E D A C O U N T Y D A T A				B A Y A R E A D A T				S T A T E W I D E D A T A			
	Fiscal Year Unapproved Eligibles	Average Monthly Unapproved Eligibles	Count of Medi-Cal Beneficiaries Served	Unapproved Claims	Average Monthly Approved Claims	Fiscal Year Approved Claims	Average Monthly Approved Claims	Penetration Rate	Average Monthly Approved Claims for Unduplicated Beneficiaries Served	Fiscal Year Approved Claims for Unduplicated Beneficiaries Served	Average Monthly Approved Claims for Unduplicated Beneficiaries Served	Penetration Rate
White	42,755	34,951	5,103	\$25,106,030	\$720	\$4,920	14.84%	\$720	\$4,920	\$888	15.45%	\$888
Hispanic	69,660	51,860	1,564	\$5,118,497	\$99	\$3,273	3.02%	\$99	\$3,273	\$117	2.69%	\$117
African-American	77,871	65,771	8,512	\$48,382,124	\$736	\$5,684	12.94%	\$736	\$5,684	\$730	12.64%	\$730
Asian/Pacific Islander	42,157	34,033	933	\$3,059,132	\$90	\$3,279	2.74%	\$90	\$3,279	\$97	2.60%	\$97
Native American	611	465	39	\$110,595	\$238	\$2,835	8.39%	\$238	\$2,835	\$332	7.15%	\$332
Other	36,637	29,050	2,315	\$9,113,742	\$314	\$3,524	8.65%	\$314	\$3,524	\$450	9.52%	\$450

Aid Program	A L A M E D A C O U N T Y D A T A				B A Y A R E A D A T				S T A T E W I D E D A T A			
	Fiscal Year Unapproved Eligibles	Average Monthly Unapproved Eligibles	Count of Medi-Cal Beneficiaries Served	Unapproved Claims	Average Monthly Approved Claims	Fiscal Year Approved Claims	Average Monthly Approved Claims	Penetration Rate	Average Monthly Approved Claims for Unduplicated Beneficiaries Served	Fiscal Year Approved Claims for Unduplicated Beneficiaries Served	Average Monthly Approved Claims for Unduplicated Beneficiaries Served	Penetration Rate
SSI/SEA	57,060	52,698	9,220	\$47,807,521	\$907	\$5,185	17.50%	\$907	\$5,185	\$1,021	17.20%	\$1,021
Non-SEA	212,632	163,342	9,446	\$43,082,600	\$264	\$4,561	5.78%	\$264	\$4,561	\$235	4.97%	\$235

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-Dwelling/Medi-Cal (SDMC) approved 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 - The average amount paid represents the "per day" amount for inpatient, Residential, and Day Treatment services. The average amount paid for Linkage, MH Services, Medication and Crisis services represents the amount for a single "claim line."
 5 - Some MHP "Other Race/Ethnicity" category were overrated (Hispanic, Asian/Pacific Islander, Native American) would be the understated categories, due to DHS technical problems with the data for SSI/SEA beneficiaries. DHS was unable to correctly recode individual beneficiary race/ethnicity. It is expected that race/ethnicity data for FY04-05 will be correct.



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 8

Claim and Demographic Data Analyses

- **MHP Size Groups**
- **MHP by DMH Regions**
- **All MHPs**

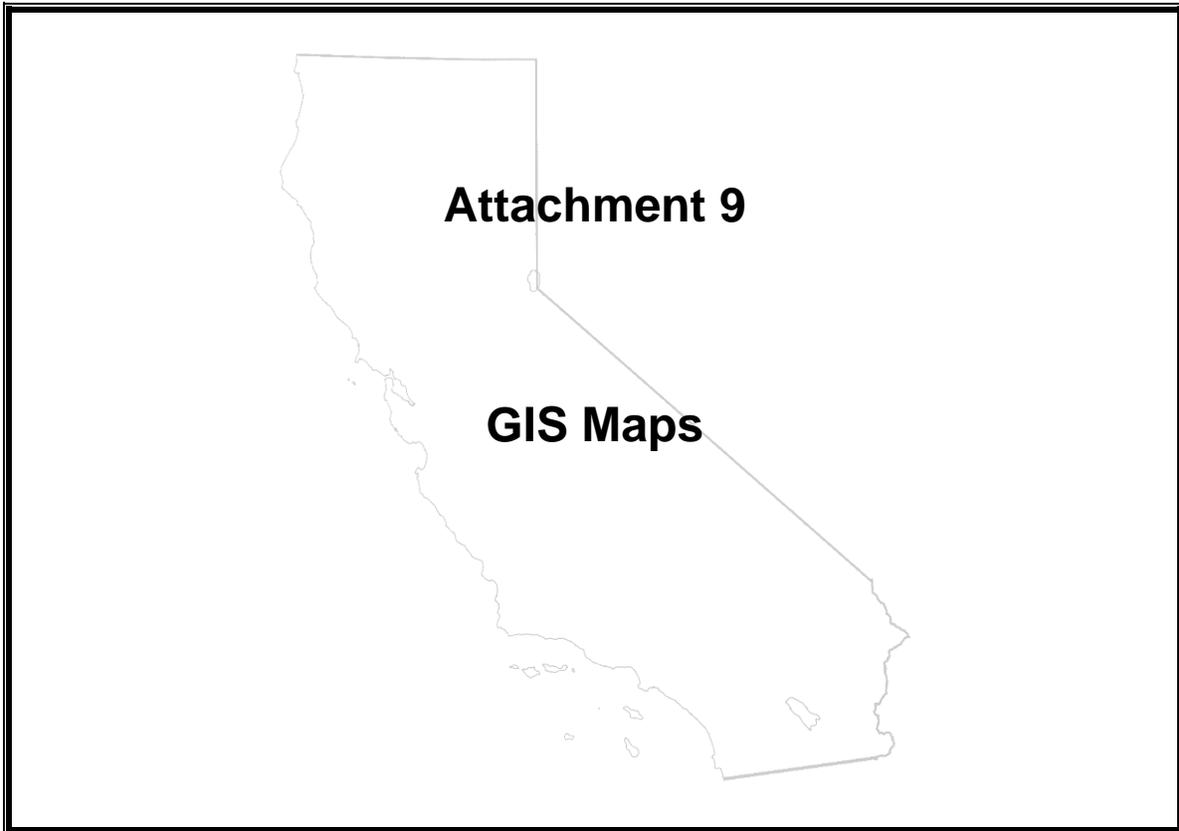
MHP Size Groups										
MHP Size Groups	No. MHPs	Total Eligibles	Ave. Month Elig.	Beneficiaries	Penetration Rate	Approved Claims	Ave Monthly	Ave Benefit	Population	Per 100 Eligible
Small-Rural	15	78,448	59,263	6,429	10.85%	\$23,848,092	\$402	\$3,709	345,774	17.1
Small	15	453,916	352,316	28,780	8.17%	\$90,481,117	\$257	\$3,144	1,856,329	19.7
Medium	14	1,218,311	952,187	62,498	6.56%	\$277,326,601	\$291	\$4,437	5,609,489	17.0
Large	12	3,784,568	2,958,637	205,140	6.93%	\$762,982,564	\$258	\$3,719	18,970,014	15.6
Very Large	1	3,030,459	2,485,721	128,075	5.15%	\$537,756,980	\$216	\$4,199	10,223,055	24.3
Total	57	8,565,702	6,808,119	430,922	6.33%	\$1,692,395,354	\$249	\$3,927	37,004,661	18.4

MHP by DMH Regions										
MHP Regions	No. MHPs	Total Eligibles	Ave. Month Elig.	Beneficiaries	Penetration Rate	Approved Claims	Ave Monthly	Ave Benefit	Population	Per 100 Eligible
Bay Area	12	1,273,883	1,012,359	78,380	7.74%	\$426,350,634	\$421	\$5,440	7,836,559	12.9
Central	18	1,524,223	1,221,304	77,270	6.33%	\$251,518,037	\$206	\$3,255	5,410,352	22.9
Los Angeles	1	3,030,459	2,485,721	128,075	5.15%	\$537,756,980	\$216	\$4,199	10,223,055	24.3
Southern	9	2,459,258	1,869,621	124,809	6.68%	\$397,441,666	\$213	\$3,184	12,459,797	15.2
Superior	17	277,879	219,119	22,388	10.22%	\$79,328,037	\$362	\$3,543	1,074,898	20.6
Total	57	8,565,702	6,808,119	430,922	6.33%	\$1,692,395,354	\$249	\$3,927	37,004,661	18.5

All Mental Health Plans																				
County	County Size	Region	Fiscal Year Unpublished Eligibilities	Average Monthly Unpublished Eligibilities	Unpublished Count of Beneficiaries Served	Penetration Rate	Approved Claims as of April 14, 2006	Average Monthly Approved Claims Unpublished Eligibilities	Approved Unpublished Beneficiaries Served	Rank - Unpublished Beneficiaries Served	Rank - Penetration Rate	Rank - Approved Unpublished Beneficiaries Served	Rank - Average Monthly Unpublished Eligibilities	County Population (2015)*	Rank - County Population (2015)**	Federal Poverty Level (2015)	Rank - Medi-Cal (2015) *	Rank - Medi-Cal Eligible as % of 2015 County Pop	Medi-Cal Eligible Per 100 2015 County Pop	Threshold Languages Oct 2015
Alameda	Large	Bay Area	274,769	221,688	19,726	8.50%	\$93,479,415	\$422	\$42,739	24	12	12	13	1,503,790	9	7	9.7%	33	14.7	4
Alpine	Small-Rural	Central	319	205	12	5.65%	\$56,980	\$176	\$2,989	46	38	38	44	1,242	58	15.6%	57	29	18.6	0
Amador	Small-Rural	Central	4,682	3,398	365	10.24%	\$493,442	\$145	\$1,352	11	11	11	5	36,221	46	9.4%	49	53	8.9	0
Butte	Medium	Sierran	69,663	48,145	4,747	9.86%	\$16,426,549	\$341	\$3,601	14	30	30	30	216,401	27	16.4%	27	17	22.2	2
Calaveras	Small-Rural	Central	7,017	5,192	425	8.19%	\$728,262	\$140	\$1,714	27	56	56	51	45,711	45	9.7%	46	37	11.4	1
Colusa	Small-Rural	Sierran	6,678	4,916	389	7.30%	\$784,312	\$160	\$2,186	37	48	48	47	21,315	51	13.2%	48	16	23.1	1
Contra Costa	Large	Bay Area	140,652	111,641	9,421	8.44%	\$48,545,263	\$435	\$5,633	26	9	9	11	1,025,900	9	6.7%	16	48	10.9	1
Del Norte	Small-Rural	Sierran	10,056	7,966	997	12.46%	\$1,774,043	\$222	\$1,779	6	54	54	38	29,355	48	21.1%	43	5	27.1	1
El Dorado	Small	Central	20,597	15,041	1,429	9.50%	\$4,189,781	\$279	\$2,932	18	18	18	30	175,550	30	7.1%	36	54	8.6	1
Fresno	Large	Central	329,507	269,235	13,830	5.14%	\$40,892,893	\$151	\$2,942	52	29	29	48	893,325	10	21.0%	7	3	30.2	2
Glenn	Small-Rural	Sierran	9,137	6,884	641	9.31%	\$2,290,007	\$333	\$4,573	7	21	21	21	28,523	49	15.4%	45	9	24.1	1
Humboldt	Small	Sierran	33,112	26,460	2,863	10.63%	\$12,121,674	\$468	\$4,334	9	18	18	18	132,434	35	15.5%	32	23	20.0	0
Imperial	Small	Southern	61,532	46,737	2,867	5.88%	\$9,692,672	\$178	\$3,022	45	37	37	41	164,221	31	21.9%	23	4	29.7	1
Inyo	Small-Rural	Sierran	4,157	3,097	303	9.78%	\$1,047,361	\$338	\$3,659	16	16	16	2	16,599	52	9.9%	50	27	16.7	1
Kern	Large	Southern	265,094	199,599	13,024	6.53%	\$53,433,012	\$268	\$4,100	42	32	32	32	770,424	13	16.3%	10	7	25.9	1
Kings	Small	Central	40,638	31,688	2,493	7.86%	\$4,587,452	\$147	\$1,872	32	59	59	50	148,487	32	19.6%	29	20	21.6	1
Lake	Small	Sierran	19,704	15,480	1,311	8.47%	\$4,067,849	\$263	\$3,103	25	36	36	31	64,180	40	15.9%	37	9	24.1	1
Lassen	Small-Rural	Sierran	6,884	5,224	705	13.50%	\$2,553,715	\$489	\$3,622	4	26	26	26	36,686	47	16.9%	47	34	14.6	1
Los Angeles	Very Large	Los Angeles	3,030,459	2,495,721	138,075	5.15%	\$53,756,980	\$216	\$4,199	51	19	19	38	10,223,055	1	17.3%	1	8	24.3	12
Madera	Small	Central	48,428	37,506	1,823	4.86%	\$4,597,127	\$123	\$2,822	53	45	45	58	142,867	33	20.5%	25	6	26.3	1
Marin	Medium	Bay Area	22,188	17,372	2,218	12.77%	\$12,340,996	\$710	\$5,564	5	8	8	3	252,195	25	6.8%	35	57	6.9	1
Mariposa	Small-Rural	Central	3,416	2,475	261	10.45%	\$457,762	\$185	\$1,754	12	56	56	42	18,261	53	11.7%	53	37	13.5	0
Mendocino	Small	Sierran	27,226	21,746	1,978	9.10%	\$7,987,440	\$267	\$4,028	22	23	23	16	90,497	38	14.5%	34	11	24.0	1
Mendocino	Medium	Central	96,336	73,997	3,377	4.85%	\$8,165,084	\$110	\$2,418	55	44	44	51	244,320	24	18.8%	18	2	30.3	2
Monterey	Small-Rural	Sierran	3,084	2,335	228	9.81%	\$447,613	\$193	\$1,963	15	15	15	4	9,813	56	16.9%	54	12	23.7	1
Monterey	Medium	Central	2,009	1,298	93	7.16%	\$313,901	\$242	\$3,371	38	33	33	31	13,512	55	8.1%	55	51	9.6	1
Monterey	Medium	Central	103,821	76,560	3,365	4.40%	\$21,672,344	\$266	\$6,500	5	21	21	21	425,055	18	13.3%	18	26	18.0	1
Napa	Small	Bay Area	18,374	13,311	1,090	8.12%	\$4,976,739	\$374	\$4,608	28	15	15	15	139,526	34	13.0%	39	50	10.0	1
Nevada	Small	Sierran	11,579	8,603	791	9.19%	\$2,949,633	\$343	\$3,729	21	24	24	18	100,227	36	7.6%	41	54	8.6	1
Orange	Large	Southern	503,378	380,029	20,508	5.40%	\$54,294,129	\$145	\$2,847	49	43	43	52	3,061,094	2	10.2%	2	44	12.4	2
Orange	Medium	Central	31,318	24,122	2,451	10.16%	\$11,339,424	\$140	\$4,626	13	14	14	10	31,931	22	5.5%	33	56	7.7	1
Plumas	Small-Rural	Sierran	3,734	2,802	339	12.03%	\$1,603,844	\$672	\$4,731	7	13	13	5	21,567	50	9.8%	51	42	13.0	0
Riverside	Large	Southern	401,058	295,385	17,028	5.75%	\$41,446,234	\$140	\$2,634	47	46	46	51	1,931,437	5	12.9%	5	31	15.3	1
Sacramento	Large	Central	338,796	278,248	21,044	7.95%	\$87,901,978	\$136	\$4,177	34	34	34	24	1,979,103	6	12.7%	6	22	20.2	5
San Benito	Small	Bay Area	11,197	8,202	628	6.53%	\$1,320,088	\$161	\$2,102	33	33	33	46	57,700	43	8.8%	42	35	14.2	1
San Bernardino	Large	Southern	602,193	378,702	25,100	6.63%	\$64,142,448	\$168	\$2,555	40	44	44	46	1,972,822	4	16.7%	3	24	19.1	1
San Diego	Large	Southern	465,706	357,856	32,537	9.09%	\$104,112,317	\$291	\$3,200	23	35	35	26	3,067,000	3	10.9%	3	45	11.7	4
San Francisco	Large	Bay Area	149,918	126,636	14,608	11.52%	\$89,000,752	\$702	\$6,893	8	7	7	4	794,890	14	10.7%	14	30	16.0	4
San Joaquin	Medium	Central	181,998	145,440	8,932	6.14%	\$17,001,430	\$117	\$1,903	44	52	52	56	664,369	15	14.2%	11	19	21.9	2
San Luis Obispo	Medium	Southern	38,482	30,288	2,890	9.41%	\$10,007,881	\$330	\$3,912	19	29	29	21	263,998	23	10.7%	30	46	11.5	1
San Mateo	Medium	Bay Area	88,275	65,871	5,218	7.92%	\$32,52,677	\$497	\$6,271	30	6	6	8	721,360	14	5.9%	14	52	9.1	1
Santa Barbara	Medium	Southern	88,707	69,846	5,149	7.37%	\$34,979,990	\$601	\$6,794	36	4	4	7	419,678	20	12.4%	19	28	16.6	1
Santa Clara	Large	Bay Area	281,389	230,239	12,588	5.46%	\$59,801,560	\$359	\$4,742	48	11	11	34	1,760,741	6	7.8%	8	41	13.1	4
Santa Cruz	Medium	Bay Area	45,760	35,052	2,770	7.91%	\$29,942,865	\$954	\$10,803	31	2	2	2	260,634	24	10.6%	28	38	13.4	1
Shasta	Small	Sierran	47,497	37,510	4,038	10.77%	\$10,942,899	\$322	\$2,710	10	42	42	25	180,984	29	13.4%	27	21	20.7	0
Sierra	Small-Rural	Sierran	668	477	11	2.31%	\$167,705	\$84	\$1,764	57	2	2	14	3,514	57	9.7%	56	36	13.6	0
Siskiyou	Small-Rural	Sierran	13,131	10,319	1,349	13.07%	\$9,704,516	\$940	\$7,194	2	3	3	3	45,410	44	15.6%	40	17	22.2	1
Sulaco	Medium	Bay Area	72,978	56,747	3,951	6.28%	\$15,978,367	\$382	\$4,487	43	17	17	28	42,094	19	7.9%	17	38	13.4	1
Sonoma	Medium	Bay Area	64,562	48,880	3,217	6.58%	\$16,559,278	\$339	\$5,147	41	10	10	20	479,724	22	4.9%	22	49	10.2	1
Stanislaus	Medium	Central	153,277	120,594	8,255	6.68%	\$39,389,469	\$344	\$3,556	39	28	28	36	510,858	18	13.6%	13	13	23.6	1
Sutter/Yuba	Small	Central	47,803	37,311	2,938	7.93%	\$10,148,164	\$322	\$3,431	29	3	3	3	90,627	37	13.0%	26	15	23.4	1
Tehama	Small	Sierran	19,103	14,480	1,387	9.89%	\$3,013,470	\$208	\$2,173	17	40	40	6	61,378	49	16.3%	38	13	23.6	1
Tulare	Small-Rural	Sierran	3,446	2,655	341	12.80%	\$1,425,787	\$535	\$4,181	17	20	20	6	14,025	54	16.1%	52	25	19.0	0
Tulare	Medium	Central	170,965	139,393	6,378	4.86%	\$20,589,937	\$146	\$3,228	54	34	34	48	417,287	21	22.5%	12	1	33.4	1
Tuolumne	Small	Sierran	9,784	7,551	367	12.67%	\$2,772,900	\$367	\$2,852	3	41	41	16	59,215	42	12.1%	44	42	13.0	0
Ventura	Large	Southern	141,108	108,169	5,736	5.03%	\$26,332,983	\$243	\$4,591	50	16	16	36	815,528	11	9.0%	15	40	13.3	1
Yolo	Small	Central	37,542	26,680	2,152	7.54%	\$8,034,129	\$280	\$3,716	35	25	25	26	189,858	28	11.3%	31	32	15.2	2
Yuba	n/a	n/a	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)	(no data)
State Wide	Statewide	Statewide	8,662,702	6,608,119	430,922	6.33%														

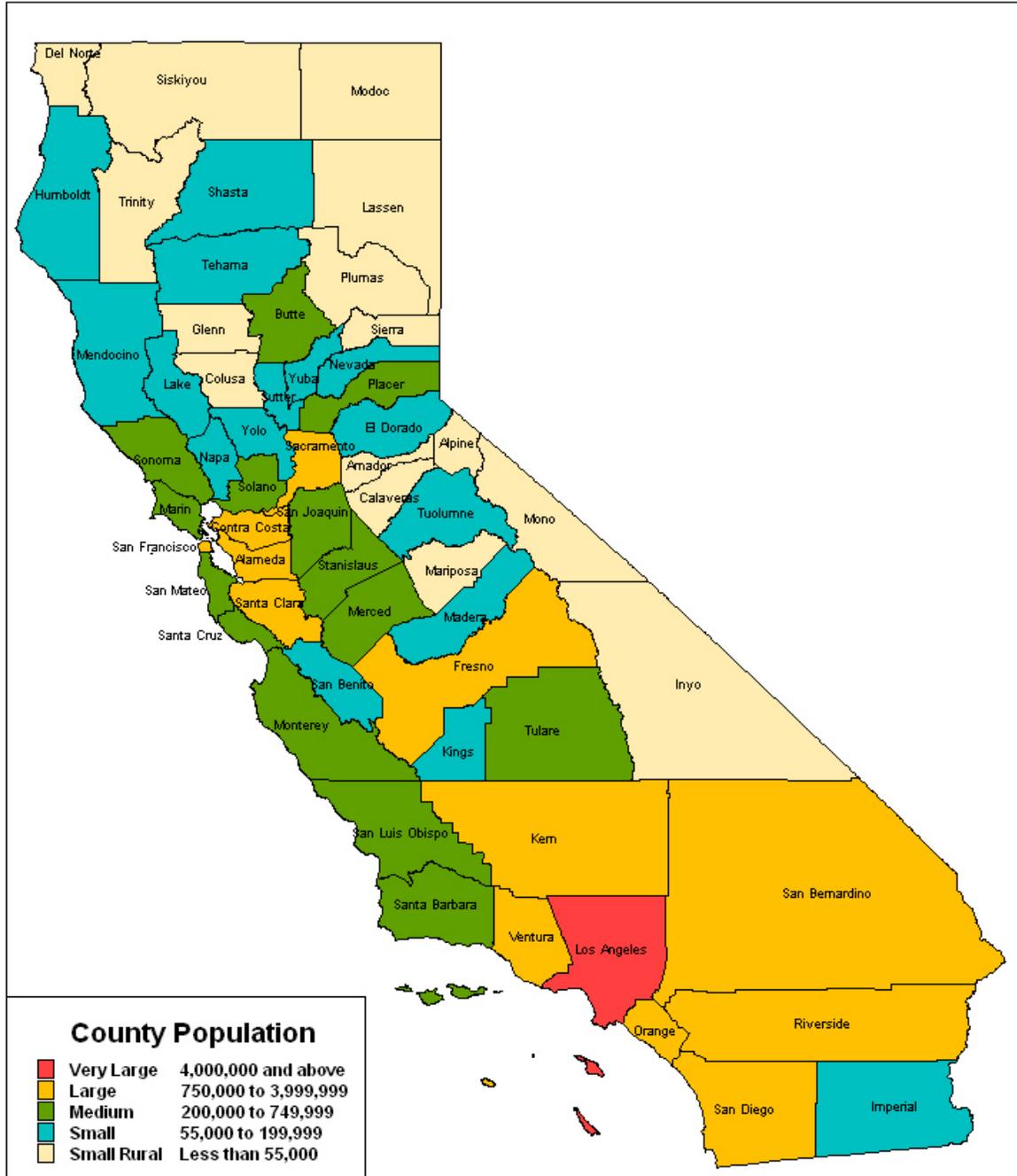


CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



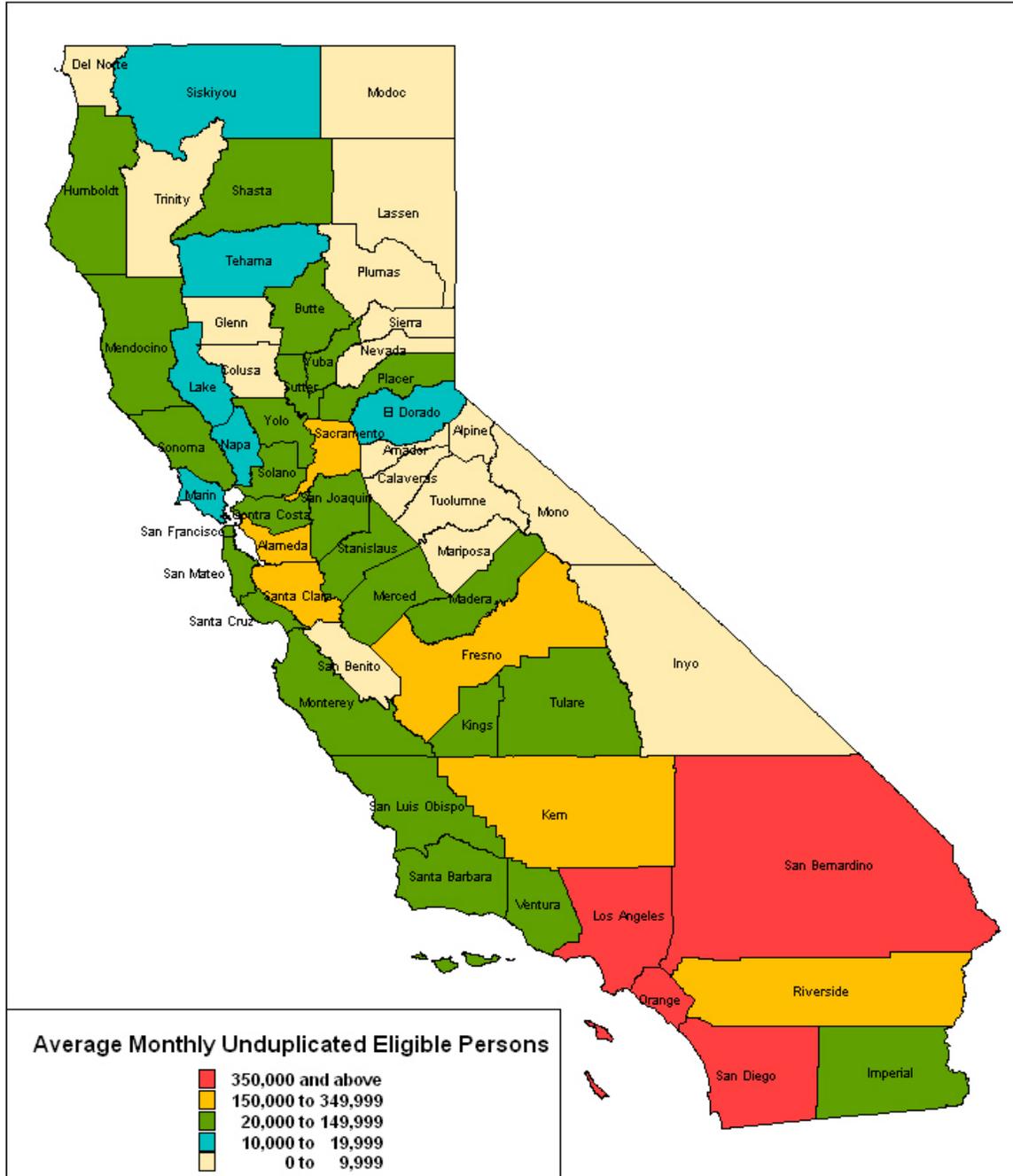
California Counties By Population January 2005

California Department of Finance - Demographic Research Unit, Table E-1 (as of May 2006)



Source: California Department of Finance - Demographic Research Unit, Table E-1 (as of May 2006)

Average Monthly Unduplicated Eligible Persons Approved Claims - Calendar Year 2005

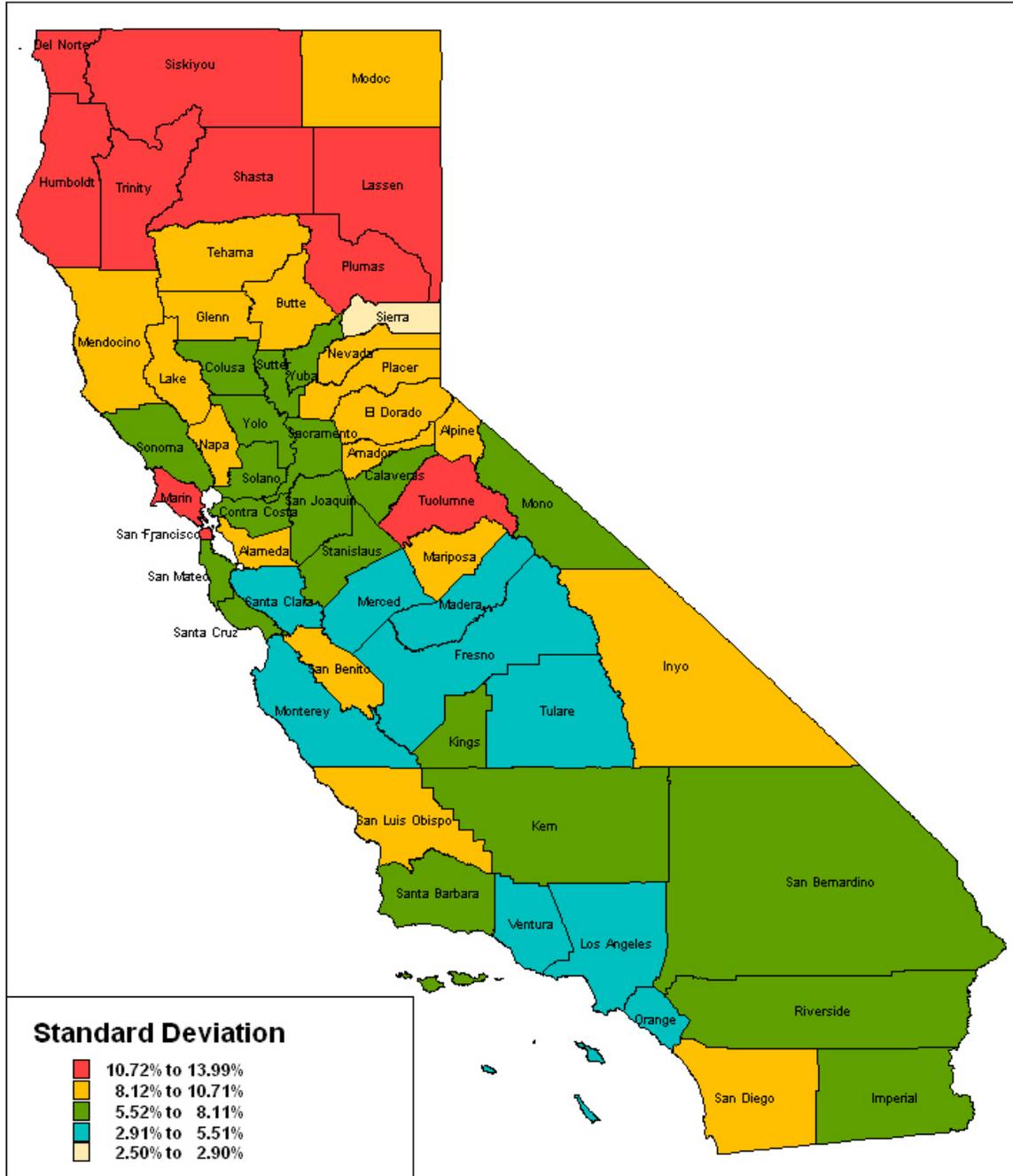


Source: Short-Doyle/Medi-Cal approved claims as of May 9, 2006; Inpatient Consolidated approved claims as of July 13, 2006

Medi-Cal Penetration Rate

Approved Claims - Calendar Year 2005

Statewide Average Penetration Rate - 6.20%

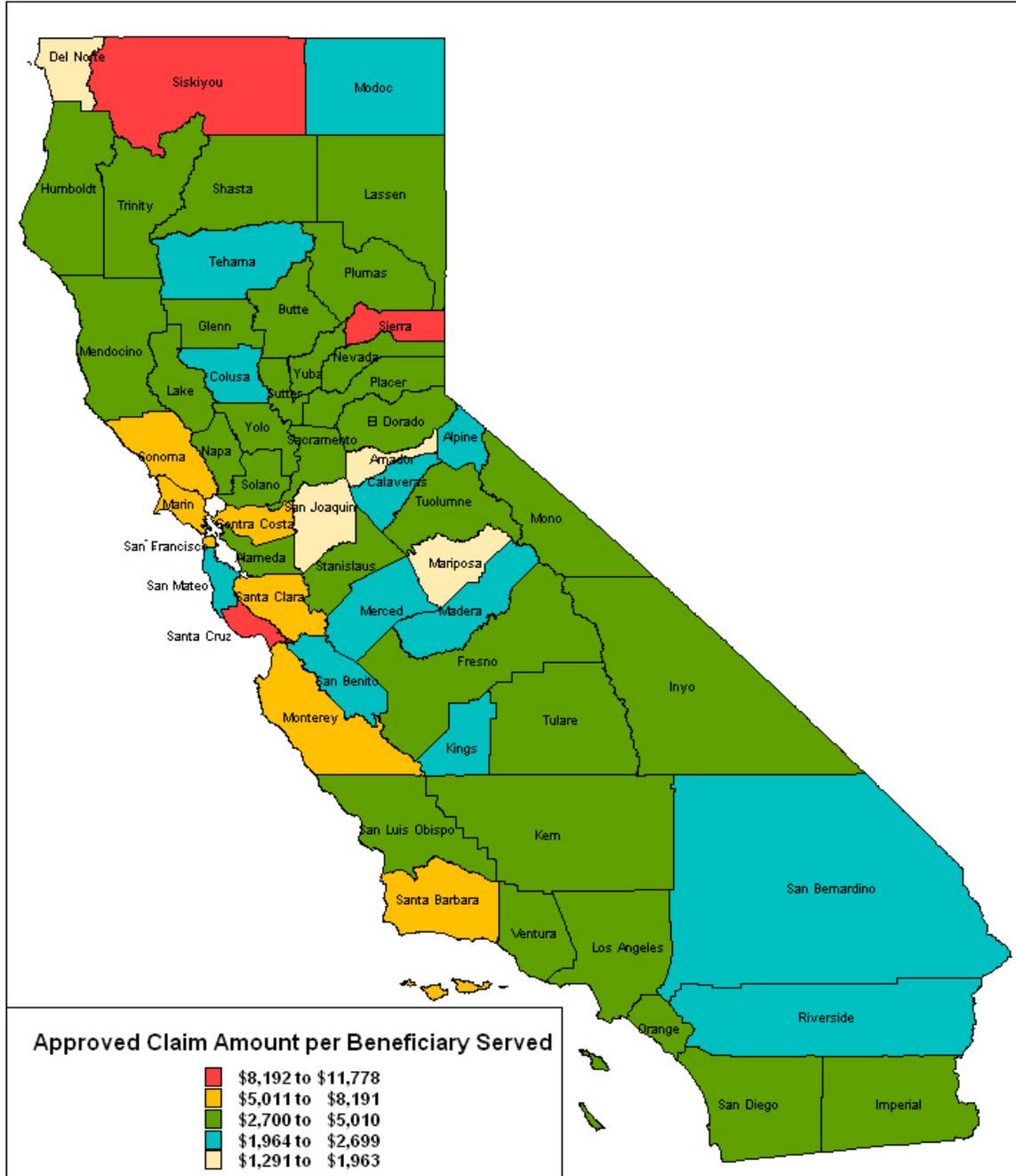


Source: Short-Doyle/Medi-Cal approved claims as of May 9, 2006; Inpatient Consolidated approved claims as of July 13, 2006

Approved Claim Amount Per Beneficiary Served

Approved Claims - Calendar Year 2005

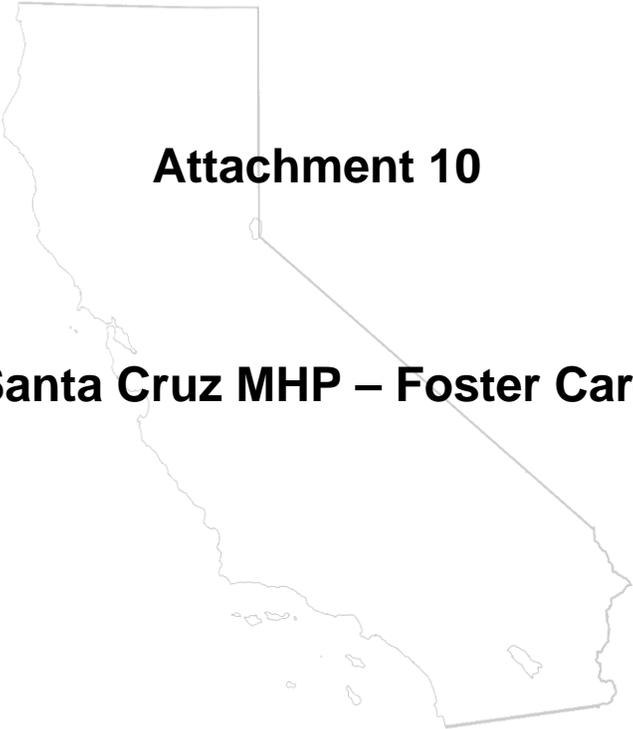
Statewide Average Claim Amount Per Beneficiary Served - \$3984



Source: Short-Doyle/Medi-Cal approved claims as of May 9, 2006; Inpatient Consolidated approved claims as of July 13, 2006



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 10

Santa Cruz MHP – Foster Care



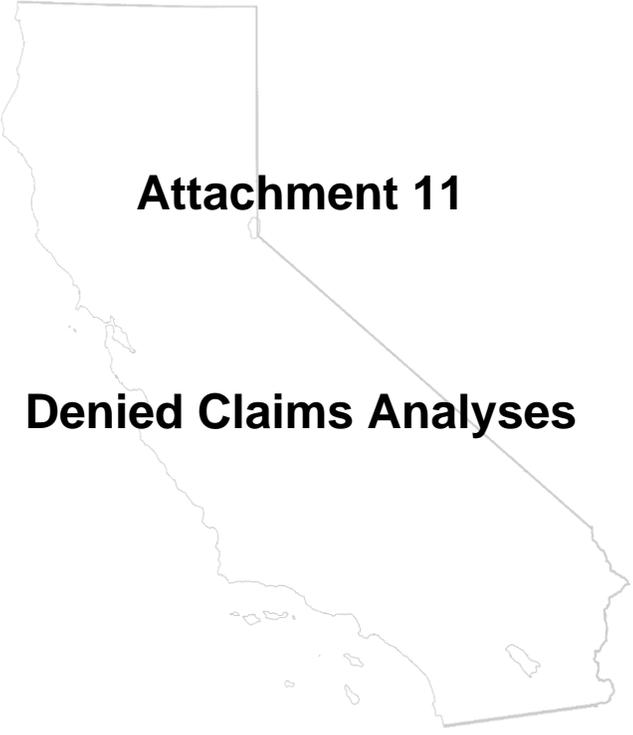
**Approved Claims Data
Foster Care Beneficiaries
for Santa Cruz MHP
Fiscal Year 03-04**

Date Prepared: August 4, 2005/Version 3.0
Prepared by: Bill Ullom APS Healthcare/CA-EQRO
Information Source: DMH Approved Claims Summary Data
DMH Process Date: June 30, 2005

	S A N T A C R U Z			C O U N T Y			D A T A			B A Y A R E A			
	Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unapproved Count of Medi-Cal Beneficiaries Served	Approved Amount	Penetration Rate	Average Monthly Approved Claims Undup Eligibles	Approved Claims Per Unduplicated Beneficiary Served	Penetration Rate	Average Monthly Approved Claims Undup Eligibles	Approved Claims Per Unduplicated Beneficiary Served	Penetration Rate	Average Monthly Approved Claims Undup Eligibles	Approved Claims Per Unduplicated Beneficiary Served
Total Santa Cruz	45,234	34,057	2,713	\$27,801,401	7.97%	\$816	\$10,247	7.79%	\$417	\$5,356	7.79%	\$417	\$5,356
Santa Cruz - Other Child	21,348	15,178	817	\$5,266,392	5.38%	\$347	\$6,446	4.13%	\$179	\$4,333	4.13%	\$179	\$4,333
Santa Cruz - Foster Care	488	281	261	\$4,706,625	92.88%	\$16,750	\$18,033	55.37%	\$4,402	\$7,950	55.37%	\$4,402	\$7,950
Race/Ethnicity													
WHITE	248	146	133	\$2,327,884	91.1%	\$15,944	\$17,503	65.2%	\$5,447	\$8,350	65.2%	\$5,447	\$8,350
HISPANIC	191	109	116	\$2,214,094	100%	\$20,313	\$19,087	53.4%	\$4,141	\$7,751	53.4%	\$4,141	\$7,751
AFRICAN-AMERICAN	14	9	8	\$124,119	88.9%	\$13,791	\$15,515	51.8%	\$4,094	\$7,899	51.8%	\$4,094	\$7,899
ASIAN/PACIFIC ISLANDER	29	13	2	\$8,958	15.4%	\$689	\$4,479	45.5%	\$2,536	\$5,573	45.5%	\$2,536	\$5,573
NATIVE AMERICAN	2	1	1	\$25,205	100%	\$25,205	\$25,205	40.0%	\$3,301	\$8,252	40.0%	\$3,301	\$8,252
OTHER	3	2	1	\$6,364	50.0%	\$3,182	\$6,364	72.7%	\$3,384	\$4,653	72.7%	\$3,384	\$4,653
Gender													
FEMALES	226	132	119	\$2,107,886	90.2%	\$15,969	\$17,713	55.9%	\$4,134	\$7,403	55.9%	\$4,134	\$7,403
MALES	262	150	142	\$2,598,739	94.7%	\$17,325	\$18,301	54.9%	\$4,651	\$8,465	54.9%	\$4,651	\$8,465
Age Groups													
0-17	470	273	251	\$4,577,550	91.9%	\$16,768	\$18,237	55.2%	\$4,452	\$8,058	55.2%	\$4,452	\$8,058
18-20	18	8	10	\$129,075	100%	\$16,134	\$12,908	59.2%	\$2,697	\$4,896	59.2%	\$2,697	\$4,896
Age Groups by Gender													
0-17 - Females	214	126	112	\$2,027,982	88.9%	\$16,095	\$18,107	55.4%	\$4,164	\$7,510	55.4%	\$4,164	\$7,510
0-17 - Males	256	147	139	\$2,549,568	94.6%	\$17,344	\$18,342	55.1%	\$4,719	\$8,571	55.1%	\$4,719	\$8,571
18-20 - Females	12	6	7	\$79,904	100%	\$13,317	\$11,415	69.0%	\$3,123	\$4,525	69.0%	\$3,123	\$4,525
18-20 - Males	6	2	3	\$49,171	100%	\$24,566	\$16,390	51.6%	\$2,723	\$5,279	51.6%	\$2,723	\$5,279
Service Activity													
INPATIENT	488	281	4	\$16,010	1.4%	\$57	\$4,003	1.9%	\$141	\$7,512	1.9%	\$141	\$7,512
DAY TX	488	281	27	\$403,124	9.6%	\$1,435	\$14,931	5.9%	\$856	\$14,431	5.9%	\$856	\$14,431
LINKAGE/BROKERAGE	488	281	114	\$90,637	40.6%	\$323	\$795	23.8%	\$243	\$1,024	23.8%	\$243	\$1,024
MH SERVICES	488	281	252	\$4,167,417	89.7%	\$14,831	\$16,537	52.2%	\$2,758	\$5,284	52.2%	\$2,758	\$5,284
MEDICATION SUPPORT	488	281	4	\$3,619	1.4%	\$13	\$905	14.0%	\$177	\$1,258	14.0%	\$177	\$1,258
CRISIS	488	281	35	\$25,819	12.5%	\$92	\$738	6.0%	\$171	\$1,201	6.0%	\$171	\$1,201



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 11

Denied Claims Analyses

Denied Claims Analyses									
County	Statewide Rank	% Denied	HIPAA Approved Claims	HIPAA Denied Claims	HIPAA Total Claims	non-HIPAA Approved Claims	non-HIPAA Denied Claims	non-HIPAA Total Claims	Grand Total
Sierra	n/a	0.00%				\$0	\$0	\$0	\$0
Alpine	1	0.00%				\$524	\$0	\$524	\$524
Sonoma	2	0.76%	\$4,908,964	\$46,188	\$4,955,153	\$9,788,542	\$66,352	\$9,854,894	\$14,810,047
Siskiyou	3	0.81%				\$10,241,408	\$83,698	\$10,325,106	\$10,325,106
Marin	4	0.86%				\$11,976,122	\$103,404	\$12,079,526	\$12,079,526
Del Norte	5	0.88%	\$1,046,722	\$6,136	\$1,052,858	\$647,815	\$8,986	\$656,800	\$1,709,658
Sutter/Yuba	6	0.92%	\$3,479,613	\$9,995	\$3,489,608	\$6,916,158	\$86,063	\$7,002,221	\$10,491,829
Modoc	7	1.32%	\$295,356	\$1,959	\$297,314	\$149,080	\$3,972	\$153,032	\$450,346
San Luis Obispo	7	1.32%				\$12,456,257	\$166,859	\$12,623,116	\$12,623,116
Shasta	9	1.34%				\$10,166,059	\$138,085	\$10,304,144	\$10,304,144
San Diego	10	1.35%	\$17,308,958	\$27,083	\$17,336,042	\$84,267,889	\$1,366,133	\$85,634,022	\$102,970,063
Kern	11	1.40%	\$13,890,045	\$34,524	\$13,924,569	\$39,417,915	\$721,009	\$40,138,925	\$54,063,493
Tulare	12	1.48%				\$19,873,167	\$298,662	\$20,171,829	\$20,171,829
San Francisco	13	1.53%				\$119,861,204	\$1,856,422	\$121,717,626	\$121,717,626
Tuolumne	14	1.59%				\$2,217,099	\$35,777	\$2,252,876	\$2,252,876
Stanislaus	15	1.78%				\$29,745,849	\$537,582	\$30,283,431	\$30,283,431
Solano	16	1.97%	\$3,328,113	\$2,170	\$3,330,283	\$15,648,085	\$379,527	\$16,027,612	\$19,357,895
San Joaquin	17	2.11%				\$19,206,350	\$413,734	\$19,620,084	\$19,620,084
San Bernardino	18	2.20%				\$58,477,626	\$1,317,195	\$59,794,822	\$59,794,822
Riverside	19	2.23%	\$13,449,112	\$22,687	\$13,471,799	\$25,780,669	\$872,582	\$26,653,251	\$40,125,050
Sacramento	20	2.25%	\$70,959,701	\$1,519,783	\$72,479,484	\$14,920,456	\$454,191	\$15,374,647	\$87,854,130
Plumas	21	2.38%				\$1,706,589	\$41,180	\$1,747,770	\$1,747,770
Santa Barbara	22	2.46%				\$35,916,723	\$904,473	\$36,821,196	\$36,821,196
El Dorado	23	2.47%	\$1,170,023	\$2,599	\$1,172,622	\$3,525,906	\$116,177	\$3,642,083	\$4,814,704
Fresno	24	2.59%				\$38,394,004	\$1,020,721	\$39,414,726	\$39,414,726
Kings	25	2.64%				\$4,486,975	\$121,441	\$4,608,416	\$4,608,416
Madera	26	2.71%				\$4,763,567	\$132,666	\$4,896,233	\$4,896,233
Monterey	27	3.11%				\$21,463,032	\$689,419	\$22,152,451	\$22,152,451
Glenn	28	3.18%	\$1,669,571	\$32,938	\$1,702,509	\$549,139	\$39,880	\$589,019	\$2,291,529
Placer	29	3.29%				\$13,353,544	\$454,419	\$13,807,963	\$13,807,963
Nevada	30	3.42%	\$1,944,641	\$51,419	\$1,996,061	\$1,010,265	\$53,207	\$1,063,472	\$3,059,533
Colusa	31	3.47%	\$479,203	\$10,711	\$489,914	\$269,943	\$16,249	\$286,192	\$776,106
Ventura	32	3.56%				\$29,494,287	\$1,087,573	\$30,581,860	\$30,581,860
Humboldt	33	3.65%				\$13,087,097	\$495,081	\$13,582,177	\$13,582,177
Trinity	34	4.03%				\$1,400,442	\$58,848	\$1,459,290	\$1,459,290
Merced	35	4.72%				\$8,140,788	\$403,346	\$8,544,135	\$8,544,135
Napa	36	5.10%	\$492,548	\$52,166	\$544,714	\$3,556,845	\$185,266	\$3,722,111	\$4,266,824
Tehama	37	5.69%	\$2,806,295	\$100,970	\$2,707,265	\$206,373	\$68,667	\$275,040	\$2,982,305
Imperial	38	6.22%				\$8,515,547	\$565,112	\$9,080,658	\$9,080,658
San Mateo	39	6.38%	\$433,795	\$14,927	\$448,722	\$814,205	\$70,152	\$884,358	\$1,333,080
Calaveras	40	6.59%	\$175,997	\$3,444	\$179,441	\$466,501	\$41,870	\$508,371	\$687,812
Alameda	41	6.94%				\$83,405,836	\$6,222,622	\$89,628,458	\$89,628,458
Mariposa	42	7.09%				\$464,416	\$35,417	\$499,833	\$499,833
Contra Costa	43	7.24%				\$60,662,524	\$4,734,915	\$65,397,438	\$65,397,438
Mendocino	44	7.25%				\$7,257,805	\$567,119	\$7,824,925	\$7,824,925
Orange	45	8.31%				\$41,029,613	\$3,717,402	\$44,747,015	\$44,747,015
Butte	46	8.65%				\$14,311,184	\$1,354,372	\$15,665,555	\$15,665,555
Lake	47	9.35%				\$3,187,742	\$328,937	\$3,516,678	\$3,516,678
Mono	48	9.38%	\$269,465	\$28,607	\$298,072	\$55,293	\$5,012	\$60,305	\$358,377
Santa Cruz	49	10.23%				\$30,766,453	\$3,504,233	\$34,270,686	\$34,270,686
Inyo	50	11.34%				\$1,004,872	\$128,525	\$1,133,397	\$1,133,397
Yolo	51	11.97%				\$7,589,114	\$1,032,424	\$8,621,538	\$8,621,538
Lassen	52	12.84%				\$2,578,708	\$379,738	\$2,958,446	\$2,958,446
San Benito	53	15.71%	\$759,935	\$129,712	\$889,646	\$426,864	\$91,474	\$518,338	\$1,407,984
Los Angeles	54	17.60%	\$250,043,616	\$33,615,761	\$283,659,378	\$164,844,508	\$55,017,749	\$219,862,257	\$503,521,634
Amador	55	21.67%	\$372,421	\$65,981	\$438,402	\$156,871	\$80,489	\$237,360	\$675,763
Santa Clara	56	36.78%	\$11,802,206	\$4,998,737	\$16,800,943	\$64,941,548	\$39,540,424	\$104,481,972	\$121,082,915
Yuba	n/a	n/a	included in Sutter/Yuba						
Statewide		9.95%	\$400,686,299	\$40,778,498	\$441,464,797	\$1,165,563,377	\$132,196,834	\$1,297,760,211	\$1,739,225,008
HIPAA Denial		1.53%	\$139,040,477	\$2,163,999	\$141,204,476				
Non-HIPAA Denial		3.87%				\$935,777,321	\$37,638,662	\$973,415,983	



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 12

Claims Lag Analyses

Claims Lag Analysis - FY05 (Claims Approved During Period July 2004 to May 2005)				
Lag Period	Number Claims Approved	Percent of Approved Claims	Cumulative Number Claims Approved	Cumulative Percent of Approved Claims
Current Month	1,631,330	18.5%	1,631,330	18.5%
One Month	5,274,003	59.9%	6,905,333	78.4%
Two Months	1,144,023	13.0%	8,049,356	91.4%
Three Months	419,747	4.8%	8,469,103	96.2%
Four Months	100,669	1.1%	8,569,772	97.3%
Five Months	153,361	1.7%	8,723,133	99.0%
Six Months	30,836	0.4%	8,753,969	99.4%
Seven to Ten Months	54,225	0.6%	8,808,194	100%

Claims Lag Analysis - FY04				
Lag Period	Number Claims Approved	Percent of Approved Claims	Cumulative Number Claims Approved	Cumulative Percent of Approved Claims
Current Month	556,829	4.3%	556,829	4.3%
One Month	9,128,933	70.1%	9,685,762	74.4%
Two Months	2,080,487	16.0%	11,766,249	90.4%
Three Months	386,705	3.0%	12,152,954	93.3%
Four Months	365,694	2.8%	12,518,648	96.1%
Five Months	157,951	1.2%	12,676,599	97.3%
Six Months	87,601	0.7%	12,764,200	98.0%
Seven to Twenty-One Months	258,486	2.0%	13,022,686	100%

Claims Lag Analysis - FY03				
Lag Period	Number Claims Approved	Percent of Approved Claims	Cumulative Number Claims Approved	Cumulative Percent of Approved Claims
Current Month	380,077	2.8%	380,077	2.8%
One Month	10,098,318	75.0%	10,478,395	77.8%
Two Months	1,735,354	12.9%	12,213,749	90.7%
Three Months	544,102	4.0%	12,757,851	94.7%
Four Months	240,726	1.8%	12,998,577	96.5%
Five Months	155,825	1.2%	13,154,402	97.7%
Six Months	112,927	0.8%	13,267,329	98.5%
Seven to Thirty-One Months	200,009	1.5%	13,467,338	100%



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

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 irregular shape, including the coastline and the San Francisco Bay Area.

Attachment 13

Activities Calendar

July 2005				
Monday	Tuesday	Wednesday	Thursday	Friday
				1
4	5	6 CIMH Coordination Mtg	7	8
11	12	13 CHIP Work Group Mtg	14	15
18	19	20 Solano MHP Review CMHDA Medi-Cal Policy	21 DMH Conference Call	22
25 CalCiS Demonstration	26 MHSA Capital - IT Mtg	27 Colusa MHP Review	28 CMHDA - IT Mtg	29

August 2005				
Monday	Tuesday	Wednesday	Thursday	Friday
1	2	3	4	5 Anasazi Demonstration
8 CIMH – MHSA Web cast	9 Consumer Training	10	11 Lake MHP Review Santa Cruz MHP Review	12
15	16 San Diego MHP Review	17	18 Tehama MHP Review	19 Glenn MHP Review
22	23	24 Sacramento MHP Review	25	26
29	30	31 Monterey MHP Review		

September 2005				
Monday	Tuesday	Wednesday	Thursday	Friday
			1 Monterey MHP Review	2
5	6	7 Nevada MHP Review CMHDA - IT Committee	8 Humboldt MHP Review	9
12	13 Kern MHP Review SDMC Training	14 CHIP Work Group Mtg	15 Napa MHP Review	16
19 Annual Report Presentation - Sacramento	20 San Bernardino MHP Review	21	22 Annual Report Presentation - Riverside	23
26	27 Corporate Compliance Training	28	29 DMH Coordination Mtg	30

October 2005				
Monday	Tuesday	Wednesday	Thursday	Friday
3	4	5	6	7
10	11 Shasta MHP Review JAHCO Teleconference	12	13	14 CSI Training
17	18	19 Alameda MHP Review Medi-Cal Policy	20 Butte MHP Review Planning Council Mtg	21
24	25 Kings MHP Review	26 Tulare MHP Review HIPAA Training CMHDA - IT Mtg	27 DMH Coordination Mtg	28
31				

November 2005				
Monday	Tuesday	Wednesday	Thursday	Friday
	1	2	3	4
		Ventura MHP Review		
7	8	9	10	11
Sonoma MHP Review		CHIP Work Group Mtg		
14	15	16	17	18
Medicaid Conf Call MH Law Conf Call		DBT Training		
21	22	23	24	25
	Cal Healthcare Mtg			
28	29	30		
		Stanislaus MHP Review		

December 2005				
Monday	Tuesday	Wednesday	Thursday	Friday
			1	2
			Stanislaus MHP Review	
			MHSA IT Work Group	
5	6	7	8	9
12	13	14	15	16
		San Luis Obispo MHP Review		Santa Barbara MHP Review
			Marin MHP Review	CMHDA – IT Mtg
19	20	21	22	23
	CSI Training		Medicare Part D Training	
26	27	28	29	30
			DMH Coordination Mtg	

January 2006				
Monday	Tuesday	Wednesday	Thursday	Friday
2	3	4	5	6
9	10	11	12	13
Del Norte MHP Review			Neal Adams and Ed Diksa - CIMH	
16	17	18	19	20
		Fresno MHP Review		
			Women's Health Care Partnership Mtg	
23	24	25	26	27
	DMH Coordination Mtg AHIMA – electronic health record	Mendocino MHP Review	EPSDT Training	NorQIC Presentation on "Roadmap to a PIP"
30	31			
	Orange MHP Review			

February 2006				
Monday	Tuesday	Wednesday	Thursday	Friday
		1	2	3
		Orange MHP Review		
6	7	8	9	10
CMHDA/CIMH Mtg		San Joaquin MHP Review		
13	14	15	16	17
	San Benito MHP Review			CMHD IT Mtg
20	21	22	23	24
		Contra Costa MHP Review		
			Yolo MHP Review	
27	28			
	e-Seminar – Messaging Security			

March 2006				
Monday	Tuesday	Wednesday	Thursday	Friday
		1	2	3
6	7 Amador MHP Review	8 DIG/MHSA Web cast	9 Riverside MHP Review Calaveras MHP Review	10
13	14	15 CIMH Data Conference	16	17
20	21 San Mateo MHP Review	22	23 CalQIC Conference and Presentation	24
27	28 Santa Clara MHP Review Imperial MHP Review Madera MHP Review	29	30 SQIC Quarterly Mtg	31

April 2006				
Monday	Tuesday	Wednesday	Thursday	Friday
3	4 Merced MHP Review	5	6 Placer/Sierra MHP Review	7
10	11 Los Angeles MHP Review	12	13 Rita McCabe - DMH Mtg	14
17	18 Modoc MHP Review	19	20 San Francisco MHP Review Siskiyou MHP Review	21 CMHDA IT Mtg
24	25	26 Sutter/Yuba MHP Review	27	28

May 2006				
Monday	Tuesday	Wednesday	Thursday	Friday
1	2	3	4	5 Mono MHP Review
8	9 Inyo MHP Review Lassen MHP Review	10	11 Plumas MHP Review	12
15	16	17 Tuolumne MHP Review	18 El Dorado MHP Review	19 CMHDA IT Mtg
22	23 Trinity MHP Review	24 Alpine MHP Review	25	26
29	30	31		

June 2006				
Monday	Tuesday	Wednesday	Thursday	Friday
			1 Mariposa MHP Review	2
5	6	7	8	9
12	13	14	15	16 CMHDA IT Mtg
19 CIMH PIP Training	20	21	22	23
26	27	28	29	30



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Information Systems Capabilities Assessment

(ISCA)

California Mental Health Plans

FY 2007

Version 6.1

August 2, 2006

This document was produced by the California EQRO in collaboration with the California Department of Mental Health and California MHP stakeholders.



Information Systems Capabilities Assessment (ISCA) FY2007

California Mental Health Plans

General Information

This information systems capabilities assessment pertains to the collection and processing of data for Medi-Cal. In many situations, this may be no different from how a Mental Health Plan (MHP) collects and processes commercial insurance or Medicare data. However, if your MHP manages Medi-Cal data differently than commercial or other data, please answer the questions only as they relate to Medi-Cal beneficiaries and Medi-Cal data.

- *Please insert your responses after each of the following questions. If information is not available, please indicate that in your response. Do not create documents or results expressly for this review. Be as concise as possible in your responses.*
- *If you provide any attachments or documents with protected health information (“PHI”), please redact or remove such information.*
- *Return an electronic copy of the completed assessment, along with documents requested in section F, to CAEQRO for review by (Desired Deadline Date Here)*

Contact Information

Insert MHP identification information below. The contact name should be the person completing or coordinating the completion of this assessment.

Note: This 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). It was developed and refined by the California EQRO in collaboration with the California Department of Mental Health and California MHP stakeholders.

<i>MHP Name:</i>	APS fills in here
<i>ISCA contact name and title:</i>	
<i>Mailing address:</i>	
<i>Phone number:</i>	
<i>Fax number:</i>	
<i>E-mail address:</i>	
<i>Identify primary person who participated in completion of the ISCA (name, title):</i>	
<i>Date assessment completed:</i>	

ISCA OVERVIEW

PURPOSE of the Information System Capabilities Assessment (ISCA)

Knowledge of the capabilities of a Mental Health Plan (MHP) information system is essential to evaluate effectively and efficiently the MHP's capacity to manage the health care of its beneficiaries. The purpose of this assessment is to specify the desired capabilities of the MHP's Information System (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 an MHP's information system is capable of producing valid encounter data², 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 the MHP's information system(s) is a process of four consecutive activities.

Step one involves the collection of standard information about each MHP's information system. This is accomplished by having the MHP complete an *Information System Capabilities Assessment (ISCA) for California Mental Health Plans*. The ISCA is an information collection tool provided to the MHP and developed by the EQRO in cooperation with California stakeholders and the California Department of Mental Health. The California Department of Mental Health defined the time frame in which it expects the MHP to complete and return the tool. Data will be recorded on the tool by the MHP. Documents from the MHP are also requested through 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.

Step three involves a series of onsite and telephone interviews, and discussion with key MHP staff members who completed the ISCA as well as other knowledgeable MHP staff members. These discussions will focus on various elements of the ISCA. The purpose of

² "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 systems. 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.

the interviews is to gather additional information to assess the integrity of the MHP's information system.

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

INSTRUCTIONS:

Please complete the following 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 that address a particular item, you may attach and reference these materials.

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

Section A – General Information

1. List the top priorities for your MHP’s IS department at the present time.

2. How are mental health services delivered?

Note: For clarification, Contract Providers are typically groups of providers and agencies, many with long-standing contractual relationships with counties that deliver services on behalf of an MHP and bill for their services through the MHP’s Short-Doyle/Medi-Cal system. These are also known as organizational contract providers. They are required to submit cost reports to the MHP and are subject to audits. They are not staffed with county employees, as county-run programs typically are. Contract providers do not include the former Medi-Cal fee-for-service providers (often referred to as network providers) who receive authorizations to provide services and whose claims are paid or denied by the MHP’s managed care division/unit.

Of the total number of services provided, approximately what percentage is provided by:

	Distribution
County-operated/staffed clinics	█ %
Contract providers	█ %
Network providers	█ %
	100%

Of the total number of services provided, approximately what percentage is claimed to Medi-Cal:

	Medi-Cal	Non-Medi-Cal	Total
County-operated/staffed clinics	█ %	█ %	100%
Contract providers	█ %	█ %	100%
Network providers	█ %	█ %	100%

3. Provide approximate annual revenues/budgets for the following:

	Medi-Cal	Non-Medi-Cal	Total
County-operated/staffed clinics	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]
Contract providers	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]
Network providers	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]
Total	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]

4. Please estimate the number of staff that use your current information system:

Type of Staff	Estimated Number of Staff
MHP Support/Clerical	[REDACTED]
MHP Administrative	[REDACTED]
MHP Clinical	[REDACTED]
MHP Quality Improvement	[REDACTED]
Contract Provider Support/Clerical	[REDACTED]
Contract Provider Administrative	[REDACTED]
Contract Provider Clinical	[REDACTED]
Contract Provider Quality Improvement	[REDACTED]

5. Describe the primary information systems currently in use.

The following several pages allow for a description of up to four of the most critical and commonly used information systems. For clarification, certain terms used in this part are defined below:

Practice Management – Supports basic data collection and processing activities for common clinic/program operations such as new consumer registrations, consumer look-ups, admissions and discharges, diagnoses, services provided, and routine reporting for management needs such as caseload lists, productivity reports, and other day-to-day needs.

Medication Tracking – Includes history of medications prescribed by the MHP and/or externally prescribed medications, including over-the-counter drugs.

Managed Care – Supports the processes involved in authorizing services, receipt and adjudication of claims from network (formerly fee-for-service) providers, remittance advices, and related reporting and provider notifications.

Electronic Health Records – Clinical records stored in electronic form as all or part of a consumer’s file/chart and referenced by providers and others involved in direct treatment or related activities. This may include documentation such as

assessments, treatment plans, progress notes, allergy information, lab results, and prescribed medications. It may also include electronic signatures.

Master Patient Index – The function to search and locate patients using an index mechanism. The index synchronizes key patient demographic data including name, gender, social security number, date of birth and mother's name. The synchronization of data is crucial to sharing information across systems.

Current information system 1:

Name of product: <input style="width: 80%;" type="text"/>	Name of vendor/supplier: <input style="width: 80%;" type="text"/>
When was it implemented? (An estimate is acceptable) Month: <input style="width: 40px;" type="text"/> Year: <input style="width: 40px;" type="text"/>	

What are its functions? (Check all that currently are used)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Health Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	<input type="checkbox"/> MHSA Reporting
<input type="checkbox"/> Staff Credentialing	<input type="checkbox"/> Grievances & Appeals	<input type="checkbox"/> Master Patient Index
<input type="checkbox"/> Other (Describe) <input style="width: 40px;" type="text"/>		

Who provides software application support?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) <input style="width: 40px;" type="text"/>				

Who is responsible for daily operations of the system?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) <input style="width: 40px;" type="text"/>				

What type of Short-Doyle/Medi-Cal claims does it currently produce?

<input type="checkbox"/> SDMC proprietary	<input type="checkbox"/> HIPAA 837	<input type="checkbox"/> No claims or N/A
---	------------------------------------	---

Does this system interface or exchange data with other systems? If so, please list them.

Current information system 2:

Name of product: <input style="width: 80%;" type="text"/>	Name of vendor/supplier: <input style="width: 80%;" type="text"/>
When was it implemented? (An estimate is acceptable) Month: <input style="width: 40px;" type="text"/> Year: <input style="width: 40px;" type="text"/>	

What are its functions? (Check all that currently are used)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Health Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	<input type="checkbox"/> MHSA Reporting
<input type="checkbox"/> Staff Credentialing	<input type="checkbox"/> Grievances & Appeals	<input type="checkbox"/> Master Patient Index
<input type="checkbox"/> Other (Describe) <input style="width: 40px;" type="text"/>		

Who provides software application support?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) <input style="width: 40px;" type="text"/>				

Who is responsible for daily operations of the system?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) <input style="width: 40px;" type="text"/>				

What type of Short-Doyle/Medi-Cal claims does it currently produce?

<input type="checkbox"/> SDMC proprietary	<input type="checkbox"/> HIPAA 837	<input type="checkbox"/> No claims or N/A
---	------------------------------------	---

Does this system interface or exchange data with other systems? If so, please list them.

Current information system 3:

Name of product: [REDACTED]	Name of vendor/supplier: [REDACTED]
When was it implemented? (An estimate is acceptable) Month: [REDACTED] Year: [REDACTED]	

What are its functions? (Check all that currently are used)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Health Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	<input type="checkbox"/> MHSA Reporting
<input type="checkbox"/> Staff Credentialing	<input type="checkbox"/> Grievances & Appeals	<input type="checkbox"/> Master Patient Index
<input type="checkbox"/> Other (Describe) [REDACTED]		

Who provides software application support?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) [REDACTED]				

Who is responsible for daily operations of the system?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) [REDACTED]				

What type of Short-Doyle/Medi-Cal claims does it currently produce?

<input type="checkbox"/> SDMC proprietary	<input type="checkbox"/> HIPAA 837	<input type="checkbox"/> No claims or N/A
---	------------------------------------	---

Does this system interface or exchange data with other systems? If so, please list them.

[REDACTED]

Current information system 4:

Name of product: <input style="width: 80%;" type="text"/>	Name of vendor/supplier: <input style="width: 80%;" type="text"/>
When was it implemented? (An estimate is acceptable) Month: <input style="width: 40px;" type="text"/> Year: <input style="width: 40px;" type="text"/>	

What are its functions? (Check all that currently are used)

<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Health Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	<input type="checkbox"/> MHSA Reporting
<input type="checkbox"/> Staff Credentialing	<input type="checkbox"/> Grievances & Appeals	<input type="checkbox"/> Master Patient Index
<input type="checkbox"/> Other (Describe) <input style="width: 40px;" type="text"/>		

Who provides software application support?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) <input style="width: 40px;" type="text"/>				

Who is responsible for daily operations of the system?

<input type="checkbox"/> MHP IS	<input type="checkbox"/> Health Agency IS	<input type="checkbox"/> County IS	<input type="checkbox"/> Vendor IS	<input type="checkbox"/> Contract Staff
<input type="checkbox"/> Other (Describe) <input style="width: 40px;" type="text"/>				

What type of Short-Doyle/Medi-Cal claims does it currently produce?

<input type="checkbox"/> SDMC proprietary	<input type="checkbox"/> HIPAA 837	<input type="checkbox"/> No claims or N/A
---	------------------------------------	---

Does this system interface or exchange data with other systems? If so, please list them.

5 Selection and Implementation of a new Information System:

Mark the box that best describes your status today and respond to the associated questions.

<input type="checkbox"/>	A) No plans to replace current system
--------------------------	---------------------------------------

<input type="checkbox"/>	B) Considering a new system
	What are the obstacles? <div style="background-color: #cccccc; width: 40px; height: 15px; margin-top: 5px;"></div>

<input type="checkbox"/>	C) Actively searching for a new system
	What steps have you taken? <div style="background-color: #cccccc; width: 40px; height: 15px; margin-top: 5px;"></div>
	When will you make a selection? <div style="background-color: #cccccc; width: 40px; height: 15px; margin-top: 5px;"></div>

<input type="checkbox"/>	D) New system selected, not yet in implementation phase
	What system/vendor was selected? <div style="background-color: #cccccc; width: 40px; height: 15px; margin-top: 5px;"></div>
	Projected start date <div style="background-color: #cccccc; width: 40px; height: 15px;"></div>
	Go live date <div style="background-color: #cccccc; width: 40px; height: 15px;"></div>
	Projected end date <div style="background-color: #cccccc; width: 40px; height: 15px;"></div>
	Please attach your project plan.

<input type="checkbox"/>	E) Implementation in progress
	What system/vendor was selected? <div style="background-color: #cccccc; width: 40px; height: 15px; margin-top: 5px;"></div>
	Implementation start date <div style="background-color: #cccccc; width: 40px; height: 15px;"></div>
	Go live date <div style="background-color: #cccccc; width: 40px; height: 15px;"></div>
	Projected end date <div style="background-color: #cccccc; width: 40px; height: 15px;"></div>
	Please attach your project plan.

6 Implementation of a new Information System

If you marked box D, or E in 6 above, complete the following questions. Otherwise, skip to Section B.

6.1 Describe any strategies or safeguards you plan to use to ensure timely and accurate continuation of Medi-Cal claims and CSI reporting during the transition to a new system.

6.2 If you are converting/transferring data from a legacy system, describe your conversion strategy, such as what general types of data will be transferred to the new system and what data will be left behind or archived.

6.3 Will the new system support conversion of the existing consumer identifier as the primary consumer identifier?

Yes No

6.3.1 If No, describe how the new system will assign a unique identifier (you may identify the number as the consumer ID, patient ID, medical record number, unit record number) to new consumers.

6.4 Describe what features exist in the new system to prevent two or more unique identifiers being assigned to the same consumer by mistake (“duplicate charts”).

6.5 Specify key modules included in the system:

What are its functions? (Check all that are currently planned)		
<input type="checkbox"/> Practice Management	<input type="checkbox"/> Appointment Scheduling	<input type="checkbox"/> Medication Tracking
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Electronic Health Records	<input type="checkbox"/> Data Warehouse/Mart
<input type="checkbox"/> Billing	<input type="checkbox"/> State CSI Reporting	<input type="checkbox"/> MHSA Reporting
<input type="checkbox"/> Staff Credentialing	<input type="checkbox"/> Grievances & Appeals	<input type="checkbox"/> Master Patient Index
<input type="checkbox"/> Other (Describe) <input style="width: 40px; height: 15px;" type="text"/>		

6.6 What departments/agencies will use the system? (Check all that apply)

<input type="checkbox"/>	Mental Health
<input type="checkbox"/>	Mental Health Contract Providers
<input type="checkbox"/>	Alcohol and Drug
<input type="checkbox"/>	Public Health
<input type="checkbox"/>	Hospital

Section B – Data Collection and Processing**Policy and Procedures**

1. Do you have a policy and procedure that specifies the timeliness of data entered into the system?

Yes No

- 1.1. If Yes, describe your recent experience using any available data collected on timeliness.

2. Do you have a policy and procedures specifying the degree of accuracy required for data entered into the IS?

Yes No

- 2.1. If Yes, describe your recent experience using any available data collected on data accuracy.

3. Does your MHP perform periodic verification of data in the IS compared to the medical record, such as ethnicity, language, birth date, and gender?

Yes No

- 3.1. If Yes, please provide a description of your current policy and procedure or a report of a past data validity review.

4. Do you have a policy and procedures for detection and reporting of fraud?

Yes No

4.1. If Yes, describe your procedures to monitor for fraud.

5. Describe any recent audit findings and recommendations. This may include EPSDT audits, Medi-Cal audits, independent county initiated IS or other audits, OIG audits, and others.

System Table Maintenance

6. On a periodic basis, key system tables that control data validations, enforce business rules, and control rates in your information system must be reviewed and updated. What is your process for management of these tables?

6.1. Are these tables maintained by (check all that apply):

- MHP Staff
- Health Agency Staff (“Umbrella” health agency)
- County IS Staff
- Vendor Staff

7. Who is responsible for authorizing and implementing the following system activities?

Activity	Who authorizes? (Staff name/title or committee/workgroup)	Who implements? (Staff name/title or committee/workgroup)
Establishes new providers/reporting units/cost centers	█	█
Determines allowable services for a provider/RU/CC	█	█
Establishes or decides changes to billing rates	█	█
Determines information system UR rules	█	█
Determines assignments of payer types to services	█	█
Determines staff billing rights/restrictions	█	█
Determines level of access to information system	█	█
Terminates or expires access to information system	█	█

Staff Credentialing

8. Who ensures proper staff/provider credentialing in your organization for the following groups of providers?

County-operated/staffed clinics	<input type="checkbox"/>
Contract providers	<input type="checkbox"/>
Network (formerly fee-for-service) providers	<input type="checkbox"/>

9. Are staff credentials entered into your information system and used to validate appropriate Medi-Cal billing by qualified/authorized staff?

Yes No

Staff Training and Work Experience

10. Does your MHP have a training program for users of your information system?

Yes No

10.1. If Yes, please check all that apply.

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

11. Describe your training program for users of your information system. Indicate whether you have dedicated or assigned trainers and whether you maintain formal records of this training. If available, include a list of training offerings and frequency, or a sample of a recent calendar of classes.

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12. What is your technology staff turnover rate since the last EQRO review?

Number of IS Staff	Number - New Hires	Number - Retired, Transferred, Terminated

Access to and analysis of data

13. Who is the person(s) most responsible for analyzing data from your information system? Describe the working relationship between this person(s) and your QI unit. If there is no such person, please state "NONE."

Staff Name/Title	Organization/Dept/Division	Describe relationship to QI unit or "None"

14. Considering the reports and data available from your information system, list the major users of this information (such as billing department, program clerical staff, QI unit, management, program supervisors, etc).

15. Does your information system capture co-occurring mental health and substance abuse diagnoses for active consumers?

Yes No

15.1. If Yes, what is the percent of active consumers with co-occurring diagnoses?

%

16. Does your information system maintain a history of diagnoses, as they are changed over time during an episode of care?

Yes No

Staff/Contract Provider Communications

17. Does your MHP have User Groups or other forums for the staff to discuss information system issues and share knowledge, tips, and concerns?

Please complete all that apply	Meeting frequency (weekly, monthly, quarterly, as needed)	Who chairs meetings? (name and title)	Meeting minutes? (Yes/No)
Clerical User Group			
Clinical User Group			
Financial User Group			
Contract Providers			
IS Vendor Group			
Other			

18. How does your organization know if changes are required for your information system in order to meet requirements of the State Medi-Cal Program?

19. How are required State and local policy changes communicated to the staff or vendor responsible for implementing the policy change in the information system?

20. Does your organization use a Web server, intranet server, shared network folders/files, content management software, or other technology to communicate policy, procedures, and information among MHP and contract provider staffs?

Yes No

20.1 If Yes, briefly describe how this is used and managed. Include examples of information communicated.

Other Processing Information

21. Describe how new consumers are assigned a unique identifier (you may identify this number as the consumer ID, patient ID, medical record number, unit record number).

22. Describe how you monitor missed appointments (“no-shows”) and provide a brief report or any available data regarding your rate of missed appointments.

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23. Does your MHP track grievances and appeals?

Yes No

23.1 If Yes, is it automated or manual?

<input type="checkbox"/>	Automated – Integrated into primary information system
<input type="checkbox"/>	Automated – Separate system
<input type="checkbox"/>	Manual
	Please describe:

24. How does your MHP plan to address MHSA reporting requirements for Full Service Partnerships?

<input type="checkbox"/>	Integrate into primary information system, by vendor or in-house staff
<input type="checkbox"/>	Use separate on-line system developed by DMH
<input type="checkbox"/>	Use separate system developed by in-house staff
<input type="checkbox"/>	Use separate system developed by vendor
<input type="checkbox"/>	Have not decided

Section C - Medi-Cal Claims Processing

1. Who in your organization is authorized to sign the MH1982A attestation statement for meeting the State Medi-Cal claiming regulatory requirements?
(Identify all persons who have authority)

Name: 	Title:
Name: 	Title:
Name: 	Title:
Name: 	Title:

2. Indicate normal cycle for submitting current fiscal year Medi-Cal claim files to DMH.

Monthly More than 1x month Weekly Daily Other

3. Provide a high-level diagram depicting your monthly operations activity to prepare a Medi-Cal claim. Note the steps your staff takes to produce the claim for submission to DMH.

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4. If your IS vendor controls some part of the claim cycle, describe the Medi-Cal claim activities performed by your information system vendor.

5. Does your MHP use a standard review process for claims before submission?

Yes No

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

6. Briefly describe your strategy to implement the National Provider Identifier (NPI), as required by HIPAA.

7. Please describe how beneficiaries' Medi-Cal eligibility is stored and updated within your system in order to trigger Medi-Cal claims. Include whether automated matches to the State's MMEF file are performed for the purpose of mass updates to multiple consumers.

8. 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"/>	Eligibility verification using 270/271 transactions	<input type="checkbox"/>	Other:

9. When checking Medi-Cal eligibility, does your system permit storing of eligibility information – such as verification code (EVC), county of eligibility, aid code of eligibility, share of cost information?

Yes No

- 9.1. If Yes, identify which of these fields are stored and describe if a user needs to enter this information manually, or if the process is automated (system does it).

10. Does your MHP use the information system to create ad hoc reports on Medi-Cal claims and eligibility data?

Yes No

10.1 If Yes, please indicate the software reporting tools used by your staff and include a brief description of a recent ad hoc report.

11. Describe your most critical reports for managing your Medi-Cal claims and eligibility data.

12. Do you currently employ staff members to extract data and/or produce reports regarding Medi-Cal claims or eligibility information?

Yes No

13. Please describe your MHP's policy and procedure and timeline for reviewing the Error Correction Report (ECR).

14. Please describe your MHP's policy and procedure for reviewing the Medi-Cal Explanation of Benefits (EOB or 835) that is returned to the MHP.

15. What percent of Medi-Cal claims were denied during:

FY 2004	<input type="text"/> %	FY 2005	<input type="text"/> %
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Section D – Incoming Claims Processing

Note: "Network providers" (commonly known as fee-for-service providers or managed care network providers) may submit claims to the MHP with the expectation of payment. Network providers do not submit a cost report to the MHP.

1. Beginning with receipt of a Medi-Cal claim in-house, provide a diagram of the claim handling, logging, and processes to adjudicate and pay claims.

2. How is Medi-Cal eligibility verified for incoming claims?

3. How are claims paid to network providers billed to Short-Doyle/Medi-Cal?

4. Have any recent system changes influenced, even temporarily, the quality and/or completeness of the Medi-Cal claims data that are collected? If so, how and when?

5. What claim form does the MHP accept from network providers?

<input type="checkbox"/>	CMS 1500
<input type="checkbox"/>	UB-92
<input type="checkbox"/>	837I
<input type="checkbox"/>	837P
<input type="checkbox"/>	MHP specific form (describe):

6. Please indicate which code sets are required by your MHP on claims received from network providers.

Coding Scheme	Inpatient Diagnosis	Inpatient Procedure	Outpatient Diagnosis	Outpatient Procedure
ICD-9-CM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPT-4		<input type="checkbox"/>		<input type="checkbox"/>
HCPCS		<input type="checkbox"/>		<input type="checkbox"/>
UB Revenue Code		<input type="checkbox"/>		<input type="checkbox"/>
DSM-IV-TR	<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"/>

7. Please indicate whether you require the following data elements on claims submitted by network 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
MHP consumer identification number	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Place of service	<input type="checkbox"/> Yes	<input type="checkbox"/> No

8. How does your MHP monitor the accuracy and productivity of individual staff members who have responsibility for adjudicating incoming Medi-Cal claims from network providers?

9. What is the average length of time between claim receipt and payment to network provider? (An estimate is acceptable.)

10. Does your MHP maintain provider profiles in your information system?

Yes No

10.1. If Yes, please describe what provider information is maintained in the provider profile database (e.g., languages spoken, special accessibility for individuals with special health care needs).

11. Please describe how network provider directories are updated, how frequently, and who has “update” authority.

12. Does your MHP use a manual or an automated system to process incoming claims, and adjudicate and pay claims?

Manual Automated Combination of Both

If you marked either “Automated” or “Combination of Both,” complete the following questions. Otherwise, skip to Section E.

13. What percent of claims are received electronically? %

14. What percent of claims are auto adjudicated? %

15. How are the fee schedule and network provider compensation rules maintained in your IS to assure proper claims payment by your MHP? Who has “update” authority?

16. Does the system generate a remittance advice (e.g., EOB)?

Yes No

16.1. If Yes, does your system generate a HIPAA transaction for the remittance advice?

Yes No

17. Does the system generate an authorization advice (i.e., letter)?

Yes No

17.1. If Yes, does your system generate a HIPAA transaction for the authorization letter?

Yes No

Section E – Information Systems Security and Controls

1. Please describe the frequency of back-ups that are required to protect your primary Medi-Cal information systems and data. Where is the back-up media stored?

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 service activity logs).

3. Please describe your policy and procedure for password control on your Medi-Cal system(s). For example, how often do you require passwords to be changed?

4. Please describe the provisions in place for physical security of the computer system(s) and manual files. Highlight provisions that address current HIPAA security requirements.

4.1. Premises

4.2. Documents

4.3. Computer room/server room

4.4. Workstation access and levels of security

5. Describe how your MHP manages access for users. Do you use templates to standardize user access? If so, describe the levels of access for both MHP and contract provider staffs.

6. Describe your procedures to remove/disable access for terminated users. Explain the process for both MHP and contract provider staffs. Include frequency it is done for both groups of users.

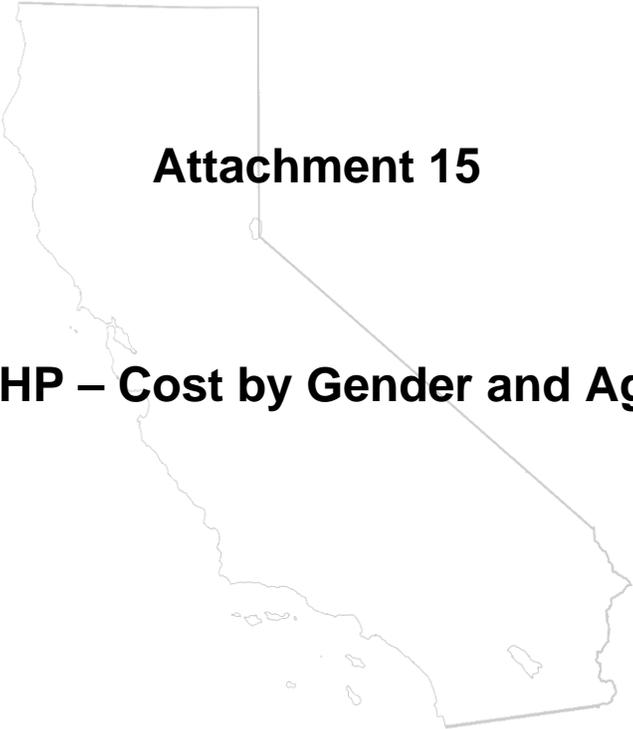
Section F – Additional Documentation

1. Please provide the documentation listed in the table below. Documentation may be submitted electronically or by hardcopy. Label documents as shown under the “Requested Documents” column.

Requested Documents	Description
A. Organizational chart	The chart should make clear the relationship among key individuals/departments responsible for information management.
B. County-operated programs and clinics	A list of those who can bill Medi-Cal, including name, address, and type of program (i.e., outpatient, day treatment, residential, and inpatient).
C. Contract providers	A list of those who can bill Medi-Cal, including name, address, and type of program (i.e., outpatient, day treatment, residential, and inpatient).
D. Procedures to monitor accuracy and timeliness of data collection	Provide copies of the current policies and procedures, desk procedures, and/or other written instructions to the staff and providers that address standards for data collection accuracy and timeliness.
E. Procedures to determine consumer/beneficiary eligibility status	Provide copies of the current policies and procedures, desk procedures, and/or written instructions to the staff and providers that describe how to determine consumer/beneficiary eligibility status.
F. Procedures to produce Medi-Cal claims and review error/denied claims	Provide copies of the current policies and procedures, operations manual, flowchart, calendar, and/or written instructions that document production of the Medi-Cal claim and resolving error/denied claims.
G. Procedures to monitor timeliness of claims processing and payments to network providers	Provide copies of the current policies and procedures, desk procedures, and/or other written instructions to the staff and providers that describe standards for monitoring timely claims processing/payment.
H. Procedures for the following topics: new user authorization, disable user accounts, password standards, data security standards, unattended computers, electronic security audits.	Provide a copy of the current policies and procedures, desk procedures, and/or other written instructions to the staff and providers for these activities.
I. Prior Internal Audits	If you have recently done an internal audit of your Medi-Cal claims submissions or your Medi-Cal claims adjudication from network providers, please attach a copy for review.
J. Ethnicity/race, language code translations	Provide a cross-reference list or table showing what codes are used internally by the staff on source documents for data entry and how they are translated into valid codes for Medi-Cal claims and CSI reporting.
K. Crosswalk from locally used service/procedure codes to CPT/HCPCS codes used in the Medi-Cal claim.	Provide a crosswalk for mapping codes used to record services to codes used to bill Medi-Cal. Include those used by network providers.
L. Index of your Reports Manual	If available, provide a list of all current vendor-supplied and internally developed reports and report titles. Do not include ad hoc reports developed to meet temporary or one-time needs.



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 15

MHP – Cost by Gender and Age

MHP - Cost Per Beneficiary Served by Gender and Age Groups									
MHP	Age Groups	Gender	Total Beneficaries Served	Percent of Beneficaries Served	Total Approved Claims	Percent of Approved Claims	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
STATEWIDE	0-15	FEMALES	53,231	40%	\$238,933,134	37%	\$1,784	\$4,489	\$8,736
STATEWIDE	0-15	MALES	81,283	60%	\$406,508,599	63%	\$2,017	\$5,001	\$9,647
STATEWIDE	16-25	FEMALES	33,095	50%	\$148,887,676	46%	\$1,382	\$4,499	\$9,584
STATEWIDE	16-25	MALES	32,772	50%	\$172,386,683	54%	\$1,722	\$5,260	\$9,808
STATEWIDE	26-59	FEMALES	114,091	60%	\$334,877,055	52%	\$1,014	\$2,935	\$6,399
STATEWIDE	26-59	MALES	76,080	40%	\$307,410,865	48%	\$1,274	\$4,041	\$8,051
STATEWIDE	60+	FEMALES	20,850	66%	\$47,594,512	64%	\$864	\$2,283	\$4,834
STATEWIDE	60+	MALES	10,967	34%	\$26,210,373	36%	\$780	\$2,390	\$5,346
ALAMEDA	0-15	FEMALES	2,203	41%	\$12,654,526	38%	\$1,874	\$5,744	\$11,046
ALAMEDA	0-15	MALES	3,130	59%	\$20,695,172	62%	\$2,426	\$6,612	\$10,949
ALAMEDA	16-25	FEMALES	1,536	53%	\$7,644,706	47%	\$1,336	\$4,977	\$9,840
ALAMEDA	16-25	MALES	1,376	47%	\$8,657,530	53%	\$2,094	\$6,292	\$10,022
ALAMEDA	26-59	FEMALES	5,933	61%	\$17,143,473	49%	\$748	\$2,890	\$6,861
ALAMEDA	26-59	MALES	3,750	39%	\$17,807,543	51%	\$1,339	\$4,749	\$9,053
ALAMEDA	60+	FEMALES	870	64%	\$1,994,192	64%	\$407	\$2,292	\$5,933
ALAMEDA	60+	MALES	488	36%	\$1,137,688	36%	\$509	\$2,331	\$4,730
ALPINE	0-15	FEMALES	6	67%	\$2,932	67%	\$259	\$489	\$616
ALPINE	0-15	MALES	3	33%	\$1,439	33%	\$378	\$480	\$220
ALPINE	16-25	FEMALES	3	100%	\$31,269	100%	\$4,036	\$10,423	\$14,134
ALPINE	16-25	MALES	0	0%	\$0	0%			
ALPINE	26-59	FEMALES	3	60%	\$1,997	46%	\$587	\$666	\$198
ALPINE	26-59	MALES	2	40%	\$2,328	54%	\$1,164	\$1,164	\$645
ALPINE	60+	FEMALES	0	0%	\$0	0%			
ALPINE	60+	MALES	0	0%	\$0	0%			
AMADOR	0-15	FEMALES	29	35%	\$61,841	45%	\$1,443	\$2,132	\$2,149
AMADOR	0-15	MALES	55	65%	\$74,373	55%	\$978	\$1,352	\$1,359
AMADOR	16-25	FEMALES	36	52%	\$35,614	43%	\$516	\$989	\$2,265
AMADOR	16-25	MALES	33	48%	\$47,417	57%	\$819	\$1,437	\$2,403
AMADOR	26-59	FEMALES	106	60%	\$135,032	63%	\$591	\$1,274	\$2,145
AMADOR	26-59	MALES	70	40%	\$79,112	37%	\$478	\$1,130	\$1,581
AMADOR	60+	FEMALES	20	77%	\$17,386	70%	\$360	\$869	\$961
AMADOR	60+	MALES	6	23%	\$7,411	30%	\$707	\$1,235	\$1,678
BUTTE	0-15	FEMALES	686	43%	\$2,792,734	40%	\$2,230	\$4,071	\$5,834
BUTTE	0-15	MALES	925	57%	\$4,219,428	60%	\$2,657	\$4,562	\$5,616
BUTTE	16-25	FEMALES	385	53%	\$1,726,012	51%	\$1,868	\$4,483	\$8,157
BUTTE	16-25	MALES	347	47%	\$1,680,754	49%	\$2,064	\$4,844	\$7,306
BUTTE	26-59	FEMALES	1,229	60%	\$3,814,206	53%	\$1,376	\$3,104	\$6,048
BUTTE	26-59	MALES	832	40%	\$3,330,687	47%	\$1,560	\$4,003	\$6,602
BUTTE	60+	FEMALES	193	65%	\$664,181	61%	\$1,569	\$3,441	\$6,238
BUTTE	60+	MALES	104	35%	\$430,195	39%	\$1,494	\$4,136	\$6,675
CALAVERAS	0-15	FEMALES	44	46%	\$73,741	47%	\$1,213	\$1,676	\$1,583
CALAVERAS	0-15	MALES	52	54%	\$81,746	53%	\$1,200	\$1,572	\$1,938
CALAVERAS	16-25	FEMALES	35	44%	\$63,762	41%	\$581	\$1,822	\$2,629
CALAVERAS	16-25	MALES	45	56%	\$93,630	59%	\$1,320	\$2,081	\$3,304
CALAVERAS	26-59	FEMALES	145	71%	\$278,262	56%	\$1,243	\$1,919	\$2,223
CALAVERAS	26-59	MALES	59	29%	\$218,923	44%	\$1,464	\$3,711	\$4,968
CALAVERAS	60+	FEMALES	17	74%	\$45,856	88%	\$2,088	\$2,697	\$2,779
CALAVERAS	60+	MALES	6	26%	\$6,370	12%	\$629	\$1,062	\$1,057
COLUSA	0-15	FEMALES	48	48%	\$95,273	45%	\$517	\$1,985	\$5,161
COLUSA	0-15	MALES	53	52%	\$117,746	55%	\$644	\$2,222	\$4,784
COLUSA	16-25	FEMALES	32	65%	\$47,118	62%	\$656	\$1,472	\$1,803
COLUSA	16-25	MALES	17	35%	\$29,322	38%	\$646	\$1,725	\$2,461
COLUSA	26-59	FEMALES	109	70%	\$275,116	66%	\$1,263	\$2,524	\$3,921
COLUSA	26-59	MALES	47	30%	\$139,430	34%	\$1,618	\$2,967	\$4,828
COLUSA	60+	FEMALES	14	67%	\$29,546	76%	\$727	\$2,110	\$4,317
COLUSA	60+	MALES	7	33%	\$9,272	24%	\$844	\$1,325	\$1,228
CONTRA COSTA	0-15	FEMALES	1,219	41%	\$6,984,495	37%	\$1,574	\$5,730	\$12,716
CONTRA COSTA	0-15	MALES	1,782	59%	\$12,140,867	63%	\$2,106	\$6,813	\$12,750
CONTRA COSTA	16-25	FEMALES	881	52%	\$4,768,248	44%	\$1,246	\$5,412	\$10,810

MHP - Cost Per Beneficiary Served by Gender and Age Groups									
MHP	Age Groups	Gender	Total Beneficiaries Served	Percent of Beneficiaries Served	Total Approved Claims	Percent of Approved Claims	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
CONTRA COSTA	16-25	MALES	817	48%	\$6,071,230	56%	\$2,027	\$7,431	\$13,079
CONTRA COSTA	26-59	FEMALES	2,589	63%	\$9,244,555	52%	\$996	\$3,571	\$8,197
CONTRA COSTA	26-59	MALES	1,497	37%	\$8,499,596	48%	\$1,583	\$5,678	\$9,832
CONTRA COSTA	60+	FEMALES	329	67%	\$1,025,180	64%	\$1,021	\$3,116	\$6,963
CONTRA COSTA	60+	MALES	159	33%	\$582,221	36%	\$1,304	\$3,662	\$6,829
DEL NORTE	0-15	FEMALES	133	46%	\$319,590	45%	\$883	\$2,403	\$4,397
DEL NORTE	0-15	MALES	156	54%	\$396,448	55%	\$987	\$2,541	\$4,991
DEL NORTE	16-25	FEMALES	77	49%	\$107,941	43%	\$499	\$1,402	\$2,451
DEL NORTE	16-25	MALES	80	51%	\$141,394	57%	\$351	\$1,767	\$3,894
DEL NORTE	26-59	FEMALES	311	61%	\$543,717	64%	\$726	\$1,748	\$3,246
DEL NORTE	26-59	MALES	199	39%	\$306,873	36%	\$638	\$1,542	\$2,917
DEL NORTE	60+	FEMALES	40	67%	\$49,667	76%	\$663	\$1,242	\$1,922
DEL NORTE	60+	MALES	20	33%	\$15,408	24%	\$407	\$770	\$1,370
EL DORADO	0-15	FEMALES	165	37%	\$502,957	39%	\$1,733	\$3,048	\$5,167
EL DORADO	0-15	MALES	278	63%	\$788,058	61%	\$1,438	\$2,835	\$4,589
EL DORADO	16-25	FEMALES	128	57%	\$319,543	47%	\$696	\$2,496	\$5,404
EL DORADO	16-25	MALES	96	43%	\$357,505	53%	\$1,425	\$3,724	\$7,075
EL DORADO	26-59	FEMALES	432	59%	\$1,022,578	55%	\$1,006	\$2,367	\$3,807
EL DORADO	26-59	MALES	303	41%	\$822,880	45%	\$1,071	\$2,716	\$4,163
EL DORADO	60+	FEMALES	66	74%	\$137,185	65%	\$950	\$2,079	\$3,104
EL DORADO	60+	MALES	23	26%	\$74,913	35%	\$1,404	\$3,257	\$5,091
FRESNO	0-15	FEMALES	1,775	40%	\$4,305,564	38%	\$1,039	\$2,426	\$3,944
FRESNO	0-15	MALES	2,699	60%	\$7,108,872	62%	\$1,225	\$2,634	\$3,924
FRESNO	16-25	FEMALES	1,246	54%	\$3,129,233	43%	\$951	\$2,511	\$5,868
FRESNO	16-25	MALES	1,056	46%	\$4,091,140	57%	\$1,454	\$3,874	\$7,138
FRESNO	26-59	FEMALES	3,997	66%	\$11,191,145	58%	\$925	\$2,800	\$5,956
FRESNO	26-59	MALES	2,024	34%	\$8,227,587	42%	\$1,396	\$4,065	\$7,257
FRESNO	60+	FEMALES	610	68%	\$1,570,494	70%	\$1,069	\$2,575	\$4,513
FRESNO	60+	MALES	288	32%	\$671,198	30%	\$765	\$2,331	\$4,390
GLENN	0-15	FEMALES	101	45%	\$322,131	33%	\$1,987	\$3,189	\$4,267
GLENN	0-15	MALES	123	55%	\$641,665	67%	\$3,036	\$5,217	\$5,265
GLENN	16-25	FEMALES	61	58%	\$290,488	57%	\$1,611	\$4,762	\$8,496
GLENN	16-25	MALES	44	42%	\$217,998	43%	\$2,176	\$4,954	\$6,829
GLENN	26-59	FEMALES	192	74%	\$612,218	81%	\$1,407	\$3,189	\$5,642
GLENN	26-59	MALES	69	26%	\$139,353	19%	\$859	\$2,020	\$3,533
GLENN	60+	FEMALES	22	71%	\$78,396	79%	\$1,199	\$3,563	\$7,387
GLENN	60+	MALES	9	29%	\$20,690	21%	\$769	\$2,299	\$3,696
HUMBOLDT	0-15	FEMALES	285	40%	\$1,589,302	42%	\$1,796	\$5,576	\$14,041
HUMBOLDT	0-15	MALES	434	60%	\$2,150,512	58%	\$1,743	\$4,955	\$12,182
HUMBOLDT	16-25	FEMALES	297	57%	\$1,437,483	58%	\$1,386	\$4,840	\$15,974
HUMBOLDT	16-25	MALES	223	43%	\$1,038,930	42%	\$1,981	\$4,659	\$7,157
HUMBOLDT	26-59	FEMALES	852	56%	\$3,262,054	59%	\$1,208	\$3,829	\$8,385
HUMBOLDT	26-59	MALES	675	44%	\$2,242,532	41%	\$1,007	\$3,322	\$6,612
HUMBOLDT	60+	FEMALES	102	67%	\$230,638	63%	\$1,184	\$2,261	\$3,187
HUMBOLDT	60+	MALES	51	33%	\$136,664	37%	\$1,036	\$2,680	\$3,498
IMPERIAL	0-15	FEMALES	320	30%	\$855,933	28%	\$1,116	\$2,675	\$4,375
IMPERIAL	0-15	MALES	744	70%	\$2,241,348	72%	\$1,620	\$3,013	\$4,181
IMPERIAL	16-25	FEMALES	235	46%	\$840,722	40%	\$1,125	\$3,578	\$6,740
IMPERIAL	16-25	MALES	275	54%	\$1,279,020	60%	\$1,858	\$4,651	\$6,552
IMPERIAL	26-59	FEMALES	620	57%	\$1,869,148	49%	\$1,372	\$2,692	\$4,404
IMPERIAL	26-59	MALES	464	43%	\$1,713,697	51%	\$1,617	\$3,693	\$5,820
IMPERIAL	60+	FEMALES	93	56%	\$205,612	65%	\$1,076	\$2,211	\$5,345
IMPERIAL	60+	MALES	73	44%	\$108,400	35%	\$1,058	\$1,485	\$1,611
INYO	0-15	FEMALES	29	39%	\$104,050	33%	\$1,284	\$3,588	\$6,504
INYO	0-15	MALES	46	61%	\$206,819	67%	\$2,365	\$4,496	\$5,569
INYO	16-25	FEMALES	27	51%	\$82,068	52%	\$1,246	\$3,040	\$4,932
INYO	16-25	MALES	26	49%	\$75,554	48%	\$1,417	\$2,906	\$4,812
INYO	26-59	FEMALES	89	60%	\$265,090	52%	\$867	\$2,979	\$5,418
INYO	26-59	MALES	60	40%	\$245,596	48%	\$1,597	\$4,093	\$5,312
INYO	60+	FEMALES	15	60%	\$66,853	82%	\$1,581	\$4,457	\$6,238

MHP - Cost Per Beneficiary Served by Gender and Age Groups									
MHP	Age Groups	Gender	Total Beneficiaries Served	Percent of Beneficiaries Served	Total Approved Claims	Percent of Approved Claims	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
INYO	60+	MALES	10	40%	\$14,723	18%	\$468	\$1,472	\$2,444
KERN	0-15	FEMALES	1,786	35%	\$5,268,209	32%	\$1,587	\$2,950	\$4,248
KERN	0-15	MALES	3,317	65%	\$11,042,814	68%	\$1,877	\$3,329	\$5,324
KERN	16-25	FEMALES	1,079	53%	\$3,959,795	47%	\$1,214	\$3,670	\$8,335
KERN	16-25	MALES	957	47%	\$4,414,643	53%	\$1,789	\$4,613	\$8,037
KERN	26-59	FEMALES	3,293	63%	\$16,401,047	61%	\$2,409	\$4,981	\$7,711
KERN	26-59	MALES	1,942	37%	\$10,552,709	39%	\$2,654	\$5,434	\$7,779
KERN	60+	FEMALES	371	70%	\$1,480,528	69%	\$2,324	\$3,991	\$5,105
KERN	60+	MALES	162	30%	\$673,589	31%	\$2,475	\$4,158	\$7,189
KINGS	0-15	FEMALES	237	33%	\$408,058	29%	\$555	\$1,722	\$3,020
KINGS	0-15	MALES	485	67%	\$1,002,093	71%	\$660	\$2,066	\$4,960
KINGS	16-25	FEMALES	214	53%	\$588,227	57%	\$653	\$2,749	\$8,460
KINGS	16-25	MALES	193	47%	\$451,799	43%	\$785	\$2,341	\$6,534
KINGS	26-59	FEMALES	755	68%	\$1,542,986	66%	\$952	\$2,044	\$3,656
KINGS	26-59	MALES	362	32%	\$781,973	34%	\$928	\$2,160	\$3,449
KINGS	60+	FEMALES	83	71%	\$103,658	66%	\$780	\$1,249	\$1,282
KINGS	60+	MALES	34	29%	\$53,079	34%	\$653	\$1,561	\$2,249
LAKE	0-15	FEMALES	119	40%	\$316,126	29%	\$1,004	\$2,657	\$4,694
LAKE	0-15	MALES	176	60%	\$781,128	71%	\$997	\$4,438	\$14,413
LAKE	16-25	FEMALES	108	52%	\$372,320	58%	\$1,252	\$3,447	\$6,451
LAKE	16-25	MALES	98	48%	\$269,177	42%	\$1,218	\$2,747	\$3,747
LAKE	26-59	FEMALES	468	63%	\$1,342,063	64%	\$1,288	\$2,868	\$4,619
LAKE	26-59	MALES	274	37%	\$740,638	36%	\$1,313	\$2,703	\$4,037
LAKE	60+	FEMALES	52	67%	\$144,211	76%	\$1,158	\$2,773	\$5,517
LAKE	60+	MALES	26	33%	\$45,423	24%	\$732	\$1,747	\$2,606
LASSEN	0-15	FEMALES	94	43%	\$582,268	45%	\$2,342	\$6,194	\$9,080
LASSEN	0-15	MALES	125	57%	\$706,951	55%	\$2,160	\$5,656	\$12,055
LASSEN	16-25	FEMALES	79	53%	\$243,354	42%	\$1,356	\$3,080	\$4,579
LASSEN	16-25	MALES	69	47%	\$333,932	58%	\$1,208	\$4,840	\$7,704
LASSEN	26-59	FEMALES	219	70%	\$688,267	67%	\$1,959	\$3,143	\$4,872
LASSEN	26-59	MALES	96	30%	\$344,688	33%	\$2,052	\$3,590	\$4,751
LASSEN	60+	FEMALES	26	76%	\$137,033	80%	\$2,240	\$5,270	\$8,110
LASSEN	60+	MALES	8	24%	\$34,490	20%	\$1,765	\$4,311	\$6,944
LOS ANGELES	0-15	FEMALES	16,851	39%	\$95,720,395	37%	\$2,718	\$5,680	\$9,471
LOS ANGELES	0-15	MALES	26,071	61%	\$161,903,537	63%	\$2,914	\$6,210	\$10,370
LOS ANGELES	16-25	FEMALES	9,619	47%	\$51,608,030	45%	\$2,005	\$5,365	\$9,245
LOS ANGELES	16-25	MALES	10,964	53%	\$62,911,041	55%	\$2,146	\$5,738	\$9,538
LOS ANGELES	26-59	FEMALES	30,423	58%	\$83,692,727	50%	\$910	\$2,751	\$6,060
LOS ANGELES	26-59	MALES	21,889	42%	\$82,201,023	50%	\$1,069	\$3,755	\$7,769
LOS ANGELES	60+	FEMALES	6,759	65%	\$12,382,372	65%	\$636	\$1,832	\$3,869
LOS ANGELES	60+	MALES	3,561	35%	\$6,814,605	35%	\$531	\$1,914	\$4,847
MADERA	0-15	FEMALES	260	43%	\$760,358	41%	\$1,408	\$2,924	\$3,797
MADERA	0-15	MALES	349	57%	\$1,100,656	59%	\$1,592	\$3,154	\$4,227
MADERA	16-25	FEMALES	178	56%	\$385,088	57%	\$813	\$2,163	\$3,514
MADERA	16-25	MALES	139	44%	\$284,762	43%	\$801	\$2,049	\$3,033
MADERA	26-59	FEMALES	535	67%	\$1,234,847	66%	\$927	\$2,308	\$3,597
MADERA	26-59	MALES	267	33%	\$641,990	34%	\$896	\$2,404	\$3,733
MADERA	60+	FEMALES	65	67%	\$85,421	73%	\$557	\$1,314	\$1,631
MADERA	60+	MALES	32	33%	\$32,111	27%	\$566	\$1,003	\$1,042
MARIN	0-15	FEMALES	218	43%	\$603,387	32%	\$1,633	\$2,768	\$4,785
MARIN	0-15	MALES	288	57%	\$1,285,327	68%	\$2,112	\$4,463	\$8,740
MARIN	16-25	FEMALES	135	48%	\$689,380	42%	\$1,660	\$5,107	\$10,473
MARIN	16-25	MALES	144	52%	\$966,239	58%	\$2,348	\$6,710	\$11,600
MARIN	26-59	FEMALES	747	59%	\$3,633,539	47%	\$1,785	\$4,864	\$7,622
MARIN	26-59	MALES	525	41%	\$4,071,584	53%	\$3,320	\$7,755	\$10,207
MARIN	60+	FEMALES	126	61%	\$530,214	65%	\$1,612	\$4,208	\$5,544
MARIN	60+	MALES	80	39%	\$287,889	35%	\$1,162	\$3,599	\$6,080
MARIPOSA	0-15	FEMALES	26	36%	\$29,264	32%	\$832	\$1,126	\$1,085
MARIPOSA	0-15	MALES	47	64%	\$61,025	68%	\$883	\$1,298	\$1,332
MARIPOSA	16-25	FEMALES	26	58%	\$30,722	43%	\$460	\$1,182	\$1,314

MHP - Cost Per Beneficiary Served by Gender and Age Groups									
MHP	Age Groups	Gender	Total Beneficaries Served	Percent of Beneficaries Served	Total Approved Claims	Percent of Approved Claims	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
MARIPOSA	16-25	MALES	19	42%	\$40,145	57%	\$975	\$2,113	\$4,541
MARIPOSA	26-59	FEMALES	82	63%	\$131,232	51%	\$902	\$1,600	\$2,201
MARIPOSA	26-59	MALES	49	37%	\$123,744	49%	\$988	\$2,525	\$5,953
MARIPOSA	60+	FEMALES	12	63%	\$9,560	47%	\$753	\$797	\$532
MARIPOSA	60+	MALES	7	37%	\$10,592	53%	\$351	\$1,513	\$3,024
MENDOCINO	0-15	FEMALES	263	51%	\$1,382,714	35%	\$1,166	\$5,257	\$11,679
MENDOCINO	0-15	MALES	256	49%	\$2,549,931	65%	\$1,669	\$9,961	\$18,372
MENDOCINO	16-25	FEMALES	185	55%	\$556,820	44%	\$955	\$3,010	\$6,624
MENDOCINO	16-25	MALES	152	45%	\$713,592	56%	\$1,630	\$4,695	\$6,722
MENDOCINO	26-59	FEMALES	587	61%	\$1,385,011	56%	\$1,040	\$2,359	\$4,208
MENDOCINO	26-59	MALES	370	39%	\$1,083,603	44%	\$1,084	\$2,929	\$4,363
MENDOCINO	60+	FEMALES	86	71%	\$198,383	76%	\$796	\$2,307	\$3,665
MENDOCINO	60+	MALES	35	29%	\$61,424	24%	\$868	\$1,755	\$1,916
MERCED	0-15	FEMALES	331	39%	\$552,566	36%	\$827	\$1,669	\$3,064
MERCED	0-15	MALES	507	61%	\$976,536	64%	\$952	\$1,926	\$2,870
MERCED	16-25	FEMALES	292	53%	\$511,886	37%	\$656	\$1,753	\$3,312
MERCED	16-25	MALES	263	47%	\$873,483	63%	\$1,047	\$3,321	\$7,128
MERCED	26-59	FEMALES	1,071	66%	\$2,281,700	59%	\$948	\$2,130	\$4,154
MERCED	26-59	MALES	552	34%	\$1,585,395	41%	\$1,091	\$2,872	\$5,445
MERCED	60+	FEMALES	102	67%	\$208,462	59%	\$813	\$2,044	\$3,711
MERCED	60+	MALES	51	33%	\$147,767	41%	\$1,245	\$2,897	\$4,583
MODOC	0-15	FEMALES	23	52%	\$46,163	64%	\$801	\$2,007	\$3,790
MODOC	0-15	MALES	21	48%	\$25,979	36%	\$811	\$1,237	\$1,537
MODOC	16-25	FEMALES	11	42%	\$19,532	50%	\$562	\$1,776	\$2,858
MODOC	16-25	MALES	15	58%	\$19,286	50%	\$659	\$1,286	\$1,794
MODOC	26-59	FEMALES	76	71%	\$181,312	79%	\$1,079	\$2,386	\$3,190
MODOC	26-59	MALES	31	29%	\$49,272	21%	\$851	\$1,589	\$2,026
MODOC	60+	FEMALES	14	93%	\$31,538	89%	\$1,317	\$2,253	\$3,058
MODOC	60+	MALES	1	7%	\$4,032	11%	\$4,032	\$4,032	
MONO	0-15	FEMALES	9	31%	\$16,491	25%	\$1,914	\$1,832	\$1,127
MONO	0-15	MALES	20	69%	\$49,287	75%	\$2,460	\$2,464	\$1,983
MONO	16-25	FEMALES	12	52%	\$41,567	76%	\$2,185	\$3,464	\$3,037
MONO	16-25	MALES	11	48%	\$13,069	24%	\$1,089	\$1,188	\$616
MONO	26-59	FEMALES	25	66%	\$104,613	75%	\$2,478	\$4,185	\$6,514
MONO	26-59	MALES	13	34%	\$35,804	25%	\$2,177	\$2,754	\$2,878
MONO	60+	FEMALES	2	100%	\$5,845	100%	\$2,923	\$2,923	\$3,619
MONO	60+	MALES	0	0%	\$0	0%			
MONTEREY	0-15	FEMALES	475	43%	\$2,793,791	41%	\$2,155	\$5,882	\$12,412
MONTEREY	0-15	MALES	617	57%	\$3,956,257	59%	\$2,009	\$6,412	\$14,827
MONTEREY	16-25	FEMALES	352	50%	\$2,567,416	52%	\$1,684	\$7,294	\$16,391
MONTEREY	16-25	MALES	355	50%	\$2,404,161	48%	\$2,636	\$6,772	\$10,683
MONTEREY	26-59	FEMALES	839	59%	\$4,275,390	48%	\$1,997	\$5,096	\$9,049
MONTEREY	26-59	MALES	579	41%	\$4,618,764	52%	\$3,944	\$7,977	\$11,522
MONTEREY	60+	FEMALES	116	68%	\$551,069	64%	\$2,368	\$4,751	\$5,448
MONTEREY	60+	MALES	55	32%	\$313,593	36%	\$3,176	\$5,702	\$6,193
NAPA	0-15	FEMALES	112	38%	\$450,511	31%	\$3,081	\$4,022	\$4,636
NAPA	0-15	MALES	184	62%	\$1,025,251	69%	\$3,348	\$5,572	\$7,819
NAPA	16-25	FEMALES	98	54%	\$334,360	47%	\$1,534	\$3,412	\$5,495
NAPA	16-25	MALES	83	46%	\$379,504	53%	\$2,522	\$4,572	\$5,463
NAPA	26-59	FEMALES	337	60%	\$1,291,397	51%	\$1,512	\$3,832	\$6,471
NAPA	26-59	MALES	221	40%	\$1,239,052	49%	\$1,758	\$5,607	\$9,405
NAPA	60+	FEMALES	63	67%	\$219,438	65%	\$1,442	\$3,483	\$5,998
NAPA	60+	MALES	31	33%	\$118,685	35%	\$1,727	\$3,829	\$5,492
NEVADA	0-15	FEMALES	68	41%	\$320,961	46%	\$2,064	\$4,720	\$7,308
NEVADA	0-15	MALES	98	59%	\$380,417	54%	\$2,241	\$3,882	\$4,689
NEVADA	16-25	FEMALES	47	50%	\$103,486	29%	\$1,023	\$2,202	\$3,061
NEVADA	16-25	MALES	47	50%	\$259,171	71%	\$1,151	\$5,514	\$8,765
NEVADA	26-59	FEMALES	247	61%	\$715,053	49%	\$1,428	\$2,895	\$5,408
NEVADA	26-59	MALES	160	39%	\$754,032	51%	\$1,386	\$4,713	\$10,920
NEVADA	60+	FEMALES	43	70%	\$153,329	78%	\$1,581	\$3,566	\$5,474

MHP - Cost Per Beneficiary Served by Gender and Age Groups									
MHP	Age Groups	Gender	Total Beneficiaries Served	Percent of Beneficiaries Served	Total Approved Claims	Percent of Approved Claims	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
NEVADA	60+	MALES	18	30%	\$44,305	22%	\$1,104	\$2,461	\$4,382
ORANGE	0-15	FEMALES	2,861	41%	\$9,512,966	40%	\$1,290	\$3,325	\$6,643
ORANGE	0-15	MALES	4,100	59%	\$14,251,138	60%	\$1,417	\$3,476	\$6,658
ORANGE	16-25	FEMALES	1,440	53%	\$5,689,059	52%	\$1,270	\$3,951	\$7,901
ORANGE	16-25	MALES	1,268	47%	\$5,293,501	48%	\$1,273	\$4,175	\$9,074
ORANGE	26-59	FEMALES	5,285	61%	\$10,552,982	55%	\$505	\$1,997	\$4,903
ORANGE	26-59	MALES	3,323	39%	\$8,706,321	45%	\$875	\$2,620	\$6,179
ORANGE	60+	FEMALES	1,287	64%	\$1,409,084	64%	\$414	\$1,095	\$2,406
ORANGE	60+	MALES	709	36%	\$782,950	36%	\$380	\$1,104	\$3,265
PLACER	0-15	FEMALES	225	41%	\$915,641	35%	\$1,612	\$4,070	\$8,313
PLACER	0-15	MALES	327	59%	\$1,697,550	65%	\$1,298	\$5,191	\$11,671
PLACER	16-25	FEMALES	190	54%	\$940,121	44%	\$1,658	\$4,948	\$10,856
PLACER	16-25	MALES	165	46%	\$1,207,467	56%	\$1,227	\$3,318	\$14,684
PLACER	26-59	FEMALES	821	65%	\$2,637,047	52%	\$1,120	\$3,212	\$8,501
PLACER	26-59	MALES	450	35%	\$2,390,100	48%	\$1,384	\$5,311	\$10,694
PLACER	60+	FEMALES	105	71%	\$372,484	64%	\$825	\$3,547	\$11,244
PLACER	60+	MALES	43	29%	\$213,670	36%	\$1,749	\$4,969	\$8,891
PLUMAS	0-15	FEMALES	33	37%	\$158,235	36%	\$1,301	\$4,795	\$8,804
PLUMAS	0-15	MALES	57	63%	\$282,454	64%	\$2,046	\$4,955	\$7,263
PLUMAS	16-25	FEMALES	30	53%	\$47,181	29%	\$777	\$1,573	\$2,118
PLUMAS	16-25	MALES	27	47%	\$117,008	71%	\$1,988	\$4,334	\$6,003
PLUMAS	26-59	FEMALES	116	66%	\$400,304	55%	\$1,063	\$3,451	\$5,743
PLUMAS	26-59	MALES	60	34%	\$333,452	45%	\$1,404	\$5,558	\$8,331
PLUMAS	60+	FEMALES	16	73%	\$61,011	48%	\$1,905	\$3,813	\$5,538
PLUMAS	60+	MALES	6	27%	\$65,707	52%	\$8,384	\$10,951	\$12,101
RIVERSIDE	0-15	FEMALES	2,061	40%	\$3,963,461	40%	\$578	\$1,923	\$6,184
RIVERSIDE	0-15	MALES	3,143	60%	\$6,059,603	60%	\$660	\$1,928	\$4,957
RIVERSIDE	16-25	FEMALES	1,516	49%	\$3,752,496	42%	\$719	\$2,475	\$6,472
RIVERSIDE	16-25	MALES	1,582	51%	\$5,166,099	58%	\$905	\$3,266	\$7,724
RIVERSIDE	26-59	FEMALES	4,557	61%	\$10,302,494	52%	\$876	\$2,261	\$5,421
RIVERSIDE	26-59	MALES	2,890	39%	\$9,601,538	48%	\$1,189	\$3,322	\$6,877
RIVERSIDE	60+	FEMALES	664	69%	\$1,617,699	69%	\$1,099	\$2,436	\$4,405
RIVERSIDE	60+	MALES	292	31%	\$716,829	31%	\$1,127	\$2,455	\$4,492
SACRAMENTO	0-15	FEMALES	3,354	42%	\$17,577,426	40%	\$2,689	\$5,241	\$9,495
SACRAMENTO	0-15	MALES	4,589	58%	\$26,270,055	60%	\$2,983	\$5,725	\$9,022
SACRAMENTO	16-25	FEMALES	1,623	52%	\$8,621,462	48%	\$1,867	\$5,312	\$10,865
SACRAMENTO	16-25	MALES	1,507	48%	\$9,312,415	52%	\$2,205	\$6,179	\$11,535
SACRAMENTO	26-59	FEMALES	5,359	61%	\$12,368,055	56%	\$1,075	\$2,308	\$5,329
SACRAMENTO	26-59	MALES	3,408	39%	\$9,915,568	44%	\$1,151	\$2,909	\$6,123
SACRAMENTO	60+	FEMALES	706	67%	\$1,738,933	70%	\$1,153	\$2,463	\$4,950
SACRAMENTO	60+	MALES	345	33%	\$761,358	30%	\$1,020	\$2,207	\$4,221
SAN BENITO	0-15	FEMALES	96	38%	\$152,979	28%	\$1,084	\$1,594	\$1,857
SAN BENITO	0-15	MALES	160	63%	\$393,333	72%	\$1,299	\$2,458	\$3,217
SAN BENITO	16-25	FEMALES	74	65%	\$121,578	54%	\$877	\$1,643	\$3,119
SAN BENITO	16-25	MALES	40	35%	\$103,477	46%	\$1,083	\$2,587	\$5,307
SAN BENITO	26-59	FEMALES	211	73%	\$426,574	72%	\$1,157	\$2,022	\$2,952
SAN BENITO	26-59	MALES	77	27%	\$165,258	28%	\$1,381	\$2,146	\$2,200
SAN BENITO	60+	FEMALES	15	60%	\$28,868	60%	\$1,022	\$1,925	\$2,124
SAN BENITO	60+	MALES	10	40%	\$19,005	40%	\$1,848	\$1,901	\$1,079
SAN BERNARDINO	0-15	FEMALES	3,196	37%	\$8,573,806	36%	\$1,289	\$2,683	\$4,954
SAN BERNARDINO	0-15	MALES	5,404	63%	\$15,162,671	64%	\$1,400	\$2,806	\$5,325
SAN BERNARDINO	16-25	FEMALES	2,038	50%	\$5,510,777	48%	\$1,022	\$2,704	\$6,107
SAN BERNARDINO	16-25	MALES	2,052	50%	\$5,865,083	52%	\$1,212	\$2,858	\$5,173
SAN BERNARDINO	26-59	FEMALES	6,994	64%	\$15,546,379	60%	\$1,001	\$2,223	\$4,209
SAN BERNARDINO	26-59	MALES	3,933	36%	\$10,320,870	40%	\$996	\$2,624	\$5,118
SAN BERNARDINO	60+	FEMALES	712	69%	\$1,073,977	67%	\$805	\$1,508	\$3,283
SAN BERNARDINO	60+	MALES	326	31%	\$537,746	33%	\$823	\$1,650	\$3,462
SAN DIEGO	0-15	FEMALES	4,225	41%	\$15,486,309	36%	\$1,188	\$3,665	\$7,578
SAN DIEGO	0-15	MALES	6,141	59%	\$27,407,762	64%	\$1,490	\$4,463	\$8,844
SAN DIEGO	16-25	FEMALES	2,278	52%	\$9,413,844	47%	\$1,040	\$4,133	\$7,908

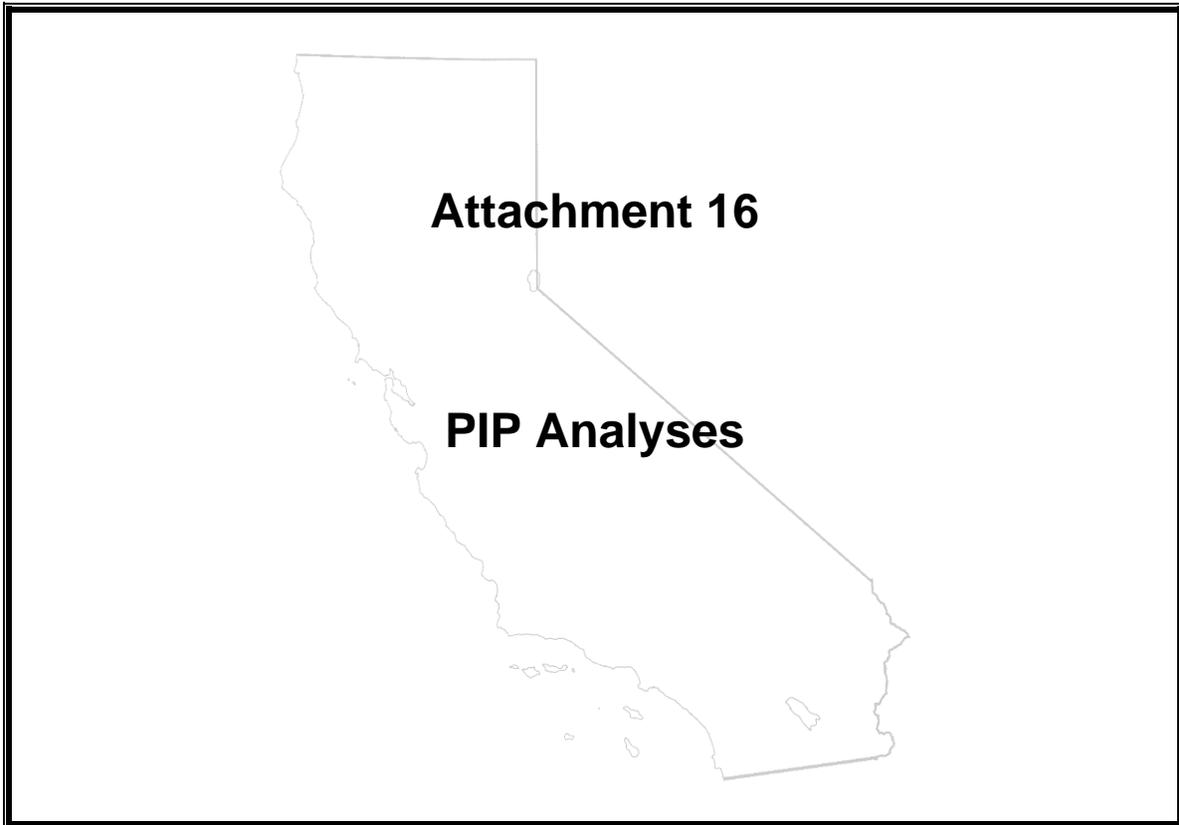
MHP - Cost Per Beneficiary Served by Gender and Age Groups									
MHP	Age Groups	Gender	Total Beneficiaries Served	Percent of Beneficiaries Served	Total Approved Claims	Percent of Approved Claims	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
SAN DIEGO	16-25	MALES	2,073	48%	\$10,547,970	53%	\$1,403	\$5,088	\$8,850
SAN DIEGO	26-59	FEMALES	8,923	61%	\$19,153,782	52%	\$746	\$2,147	\$4,860
SAN DIEGO	26-59	MALES	5,698	39%	\$17,642,892	48%	\$1,043	\$3,096	\$6,047
SAN DIEGO	60+	FEMALES	1,426	64%	\$2,505,538	63%	\$726	\$1,757	\$3,905
SAN DIEGO	60+	MALES	809	36%	\$1,496,588	37%	\$617	\$1,850	\$4,260
SAN FRANCISCO	0-15	FEMALES	818	37%	\$3,273,455	32%	\$1,896	\$4,002	\$10,204
SAN FRANCISCO	0-15	MALES	1,367	63%	\$7,083,273	68%	\$2,355	\$5,182	\$12,381
SAN FRANCISCO	16-25	FEMALES	602	50%	\$2,917,831	37%	\$1,679	\$4,847	\$11,076
SAN FRANCISCO	16-25	MALES	604	50%	\$4,869,804	63%	\$2,150	\$8,063	\$16,780
SAN FRANCISCO	26-59	FEMALES	3,796	47%	\$23,445,046	41%	\$2,113	\$6,176	\$11,168
SAN FRANCISCO	26-59	MALES	4,299	53%	\$33,381,431	59%	\$2,895	\$7,765	\$12,240
SAN FRANCISCO	60+	FEMALES	1,450	58%	\$4,711,291	51%	\$1,391	\$3,249	\$6,384
SAN FRANCISCO	60+	MALES	1,067	42%	\$4,500,946	49%	\$1,511	\$4,218	\$8,292
SAN JOAQUIN	0-15	FEMALES	705	40%	\$1,975,792	40%	\$924	\$2,803	\$5,811
SAN JOAQUIN	0-15	MALES	1,058	60%	\$3,006,378	60%	\$900	\$2,842	\$8,030
SAN JOAQUIN	16-25	FEMALES	663	52%	\$1,453,833	45%	\$563	\$2,193	\$5,464
SAN JOAQUIN	16-25	MALES	621	48%	\$1,776,824	55%	\$737	\$2,861	\$6,287
SAN JOAQUIN	26-59	FEMALES	3,161	63%	\$4,063,845	56%	\$548	\$1,286	\$2,481
SAN JOAQUIN	26-59	MALES	1,831	37%	\$3,159,721	44%	\$604	\$1,726	\$3,235
SAN JOAQUIN	60+	FEMALES	475	62%	\$615,966	60%	\$443	\$1,297	\$2,834
SAN JOAQUIN	60+	MALES	288	38%	\$412,022	40%	\$476	\$1,431	\$3,288
SAN LUIS OBISPO	0-15	FEMALES	355	41%	\$1,799,201	35%	\$1,628	\$5,068	\$14,002
SAN LUIS OBISPO	0-15	MALES	516	59%	\$3,356,344	65%	\$2,002	\$6,505	\$19,202
SAN LUIS OBISPO	16-25	FEMALES	242	52%	\$688,432	40%	\$1,038	\$2,845	\$6,923
SAN LUIS OBISPO	16-25	MALES	225	48%	\$1,020,806	60%	\$1,440	\$4,537	\$10,856
SAN LUIS OBISPO	26-59	FEMALES	852	61%	\$2,169,433	49%	\$1,402	\$2,546	\$3,708
SAN LUIS OBISPO	26-59	MALES	548	39%	\$2,273,659	51%	\$1,552	\$4,149	\$7,356
SAN LUIS OBISPO	60+	FEMALES	77	67%	\$284,188	70%	\$1,481	\$3,691	\$7,472
SAN LUIS OBISPO	60+	MALES	38	33%	\$122,521	30%	\$1,228	\$3,224	\$4,314
SAN MATEO	0-15	FEMALES	295	41%	\$637,276	31%	\$792	\$2,160	\$6,045
SAN MATEO	0-15	MALES	431	59%	\$1,396,963	69%	\$1,179	\$3,241	\$5,861
SAN MATEO	16-25	FEMALES	276	54%	\$858,280	49%	\$1,081	\$3,110	\$5,733
SAN MATEO	16-25	MALES	233	46%	\$881,974	51%	\$1,350	\$3,785	\$5,705
SAN MATEO	26-59	FEMALES	1,322	57%	\$3,393,639	56%	\$959	\$2,567	\$4,802
SAN MATEO	26-59	MALES	978	43%	\$2,646,121	44%	\$1,173	\$2,706	\$4,642
SAN MATEO	60+	FEMALES	369	72%	\$567,638	75%	\$827	\$1,538	\$2,024
SAN MATEO	60+	MALES	147	28%	\$190,106	25%	\$738	\$1,293	\$1,666
SANTA BARBARA	0-15	FEMALES	664	40%	\$3,546,373	34%	\$1,787	\$5,341	\$8,920
SANTA BARBARA	0-15	MALES	1,000	60%	\$6,757,632	66%	\$2,632	\$6,758	\$10,189
SANTA BARBARA	16-25	FEMALES	459	52%	\$3,237,167	51%	\$2,220	\$7,053	\$14,797
SANTA BARBARA	16-25	MALES	419	48%	\$3,099,568	49%	\$3,318	\$7,398	\$12,369
SANTA BARBARA	26-59	FEMALES	1,421	59%	\$9,348,427	53%	\$2,386	\$6,579	\$12,904
SANTA BARBARA	26-59	MALES	978	41%	\$8,188,201	47%	\$3,208	\$8,372	\$15,006
SANTA BARBARA	60+	FEMALES	203	67%	\$1,587,485	73%	\$3,823	\$7,820	\$11,140
SANTA BARBARA	60+	MALES	100	33%	\$589,079	27%	\$2,436	\$5,891	\$9,168
SANTA CLARA	0-15	FEMALES	975	40%	\$7,698,779	35%	\$3,131	\$7,896	\$14,974
SANTA CLARA	0-15	MALES	1,487	60%	\$14,214,841	65%	\$3,353	\$9,559	\$18,587
SANTA CLARA	16-25	FEMALES	675	47%	\$6,704,888	51%	\$2,574	\$9,933	\$23,112
SANTA CLARA	16-25	MALES	775	53%	\$6,522,078	49%	\$2,921	\$8,416	\$15,844
SANTA CLARA	26-59	FEMALES	3,469	57%	\$10,888,074	53%	\$1,306	\$3,139	\$5,315
SANTA CLARA	26-59	MALES	2,663	43%	\$9,733,381	47%	\$1,700	\$3,655	\$5,578
SANTA CLARA	60+	FEMALES	1,313	67%	\$3,002,327	69%	\$941	\$2,287	\$3,637
SANTA CLARA	60+	MALES	640	33%	\$1,350,810	31%	\$591	\$2,111	\$3,536
SANTA CRUZ	0-15	FEMALES	355	43%	\$3,211,121	41%	\$3,389	\$9,045	\$14,781
SANTA CRUZ	0-15	MALES	472	57%	\$4,606,006	59%	\$4,419	\$9,758	\$14,527
SANTA CRUZ	16-25	FEMALES	281	51%	\$3,239,922	38%	\$4,035	\$11,530	\$15,741
SANTA CRUZ	16-25	MALES	266	49%	\$5,335,932	62%	\$11,203	\$20,060	\$23,137
SANTA CRUZ	26-59	FEMALES	636	52%	\$5,962,285	43%	\$2,971	\$9,375	\$15,526
SANTA CRUZ	26-59	MALES	595	48%	\$8,045,205	57%	\$4,598	\$13,521	\$20,339
SANTA CRUZ	60+	FEMALES	63	54%	\$648,710	57%	\$2,068	\$10,297	\$19,668

MHP - Cost Per Beneficiary Served by Gender and Age Groups									
MHP	Age Groups	Gender	Total Beneficiaries Served	Percent of Beneficiaries Served	Total Approved Claims	Percent of Approved Claims	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
SANTA CRUZ	60+	MALES	54	46%	\$482,442	43%	\$1,919	\$8,934	\$18,007
SHASTA	0-15	FEMALES	484	38%	\$1,233,439	34%	\$1,238	\$2,548	\$4,090
SHASTA	0-15	MALES	778	62%	\$2,423,140	66%	\$1,533	\$3,115	\$4,824
SHASTA	16-25	FEMALES	322	51%	\$1,133,375	55%	\$902	\$3,520	\$8,213
SHASTA	16-25	MALES	309	49%	\$929,197	45%	\$1,085	\$3,007	\$4,719
SHASTA	26-59	FEMALES	1,211	63%	\$2,963,948	64%	\$784	\$2,448	\$4,722
SHASTA	26-59	MALES	712	37%	\$1,690,957	36%	\$920	\$2,375	\$3,798
SHASTA	60+	FEMALES	149	69%	\$477,606	78%	\$1,237	\$3,205	\$5,190
SHASTA	60+	MALES	66	31%	\$135,672	22%	\$824	\$2,056	\$3,230
SIERRA	0-15	FEMALES	1	50%	\$620	1%	\$620	\$620	
SIERRA	0-15	MALES	1	50%	\$41,772	99%	\$41,772	\$41,772	
SIERRA	16-25	FEMALES	4	50%	\$8,892	9%	\$1,307	\$2,223	\$2,653
SIERRA	16-25	MALES	4	50%	\$89,452	91%	\$22,922	\$22,363	\$15,282
SIERRA	26-59	FEMALES	1	100%	\$113	100%	\$113	\$113	
SIERRA	26-59	MALES	0	0%	\$0	0%			
SIERRA	60+	FEMALES	0	0%	\$0	0%			
SIERRA	60+	MALES	1	100%	\$490	100%	\$490	\$490	
SISKIYOU	0-15	FEMALES	182	39%	\$2,056,458	32%	\$4,147	\$11,299	\$16,591
SISKIYOU	0-15	MALES	282	61%	\$4,282,473	68%	\$5,691	\$15,186	\$29,211
SISKIYOU	16-25	FEMALES	111	54%	\$742,327	52%	\$1,978	\$6,688	\$10,232
SISKIYOU	16-25	MALES	93	46%	\$675,380	48%	\$2,500	\$7,262	\$12,918
SISKIYOU	26-59	FEMALES	380	65%	\$1,814,373	66%	\$1,835	\$4,775	\$6,985
SISKIYOU	26-59	MALES	206	35%	\$918,847	34%	\$1,816	\$4,460	\$6,734
SISKIYOU	60+	FEMALES	39	60%	\$176,394	56%	\$1,640	\$4,523	\$6,647
SISKIYOU	60+	MALES	26	40%	\$138,630	44%	\$2,205	\$5,332	\$9,828
SOLANO	0-15	FEMALES	372	36%	\$2,297,575	33%	\$2,985	\$6,176	\$10,569
SOLANO	0-15	MALES	657	64%	\$4,615,670	67%	\$3,410	\$7,025	\$11,066
SOLANO	16-25	FEMALES	270	49%	\$1,512,071	50%	\$1,557	\$5,600	\$13,919
SOLANO	16-25	MALES	277	51%	\$1,483,627	50%	\$1,780	\$5,356	\$8,975
SOLANO	26-59	FEMALES	931	56%	\$2,726,446	50%	\$1,107	\$2,929	\$5,152
SOLANO	26-59	MALES	727	44%	\$2,727,380	50%	\$1,310	\$3,752	\$6,099
SOLANO	60+	FEMALES	144	72%	\$283,668	69%	\$1,034	\$1,970	\$3,052
SOLANO	60+	MALES	56	28%	\$129,768	31%	\$1,163	\$2,317	\$4,049
SONOMA	0-15	FEMALES	321	43%	\$1,342,659	42%	\$1,362	\$4,183	\$8,010
SONOMA	0-15	MALES	433	57%	\$1,874,661	58%	\$1,463	\$4,329	\$8,252
SONOMA	16-25	FEMALES	258	55%	\$1,256,431	51%	\$1,638	\$4,870	\$9,366
SONOMA	16-25	MALES	207	45%	\$1,202,108	49%	\$2,256	\$5,807	\$9,285
SONOMA	26-59	FEMALES	880	53%	\$5,045,356	54%	\$1,683	\$5,733	\$10,386
SONOMA	26-59	MALES	774	47%	\$4,217,596	46%	\$2,064	\$5,449	\$8,217
SONOMA	60+	FEMALES	203	70%	\$1,057,939	76%	\$1,942	\$5,212	\$7,965
SONOMA	60+	MALES	85	30%	\$338,095	24%	\$1,662	\$3,978	\$6,710
STANISLAUS	0-15	FEMALES	1,185	40%	\$3,785,165	39%	\$1,392	\$3,194	\$5,775
STANISLAUS	0-15	MALES	1,808	60%	\$5,806,784	61%	\$1,490	\$3,212	\$5,367
STANISLAUS	16-25	FEMALES	681	54%	\$2,758,664	52%	\$1,489	\$4,051	\$7,662
STANISLAUS	16-25	MALES	591	46%	\$2,559,249	48%	\$1,580	\$4,330	\$8,248
STANISLAUS	26-59	FEMALES	1,918	61%	\$6,895,992	57%	\$1,220	\$3,595	\$6,944
STANISLAUS	26-59	MALES	1,232	39%	\$5,167,386	43%	\$1,680	\$4,194	\$7,349
STANISLAUS	60+	FEMALES	311	68%	\$733,971	69%	\$1,025	\$2,360	\$4,321
STANISLAUS	60+	MALES	146	32%	\$335,752	31%	\$1,021	\$2,300	\$3,646
SUTTER/YUBA	0-15	FEMALES	285	36%	\$1,627,201	39%	\$2,130	\$5,709	\$9,108
SUTTER/YUBA	0-15	MALES	503	64%	\$2,561,594	61%	\$1,699	\$5,093	\$9,408
SUTTER/YUBA	16-25	FEMALES	227	58%	\$638,744	41%	\$947	\$2,814	\$5,510
SUTTER/YUBA	16-25	MALES	167	42%	\$914,866	59%	\$1,617	\$5,478	\$9,815
SUTTER/YUBA	26-59	FEMALES	959	65%	\$2,165,418	57%	\$896	\$2,258	\$4,785
SUTTER/YUBA	26-59	MALES	521	35%	\$1,600,850	43%	\$967	\$3,073	\$6,928
SUTTER/YUBA	60+	FEMALES	151	66%	\$456,765	64%	\$738	\$3,025	\$6,151
SUTTER/YUBA	60+	MALES	79	34%	\$256,173	36%	\$871	\$3,243	\$5,225
TEHAMA	0-15	FEMALES	155	41%	\$282,739	37%	\$1,010	\$1,824	\$2,667
TEHAMA	0-15	MALES	219	59%	\$478,401	63%	\$1,051	\$2,184	\$3,723
TEHAMA	16-25	FEMALES	153	62%	\$215,187	62%	\$469	\$1,406	\$2,412

MHP - Cost Per Beneficiary Served by Gender and Age Groups									
MHP	Age Groups	Gender	Total Beneficaries Served	Percent of Beneficaries Served	Total Approved Claims	Percent of Approved Claims	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
TEHAMA	16-25	MALES	92	38%	\$133,796	38%	\$623	\$1,454	\$2,845
TEHAMA	26-59	FEMALES	484	66%	\$982,334	58%	\$792	\$2,030	\$4,100
TEHAMA	26-59	MALES	252	34%	\$723,298	42%	\$815	\$2,870	\$4,973
TEHAMA	60+	FEMALES	52	75%	\$0	0%	\$1,134	\$3,271	\$6,229
TEHAMA	60+	MALES	17	25%	\$37,386	100%	\$710	\$2,199	\$3,456
TRINITY	0-15	FEMALES	52	47%	\$149,681	38%	\$2,006	\$2,878	\$2,856
TRINITY	0-15	MALES	58	53%	\$249,157	62%	\$2,232	\$4,296	\$5,598
TRINITY	16-25	FEMALES	32	59%	\$110,376	41%	\$2,279	\$3,449	\$5,118
TRINITY	16-25	MALES	22	41%	\$158,736	59%	\$6,076	\$7,215	\$6,332
TRINITY	26-59	FEMALES	105	63%	\$457,159	61%	\$3,442	\$4,354	\$4,248
TRINITY	26-59	MALES	63	38%	\$291,156	39%	\$2,805	\$4,622	\$5,202
TRINITY	60+	FEMALES	10	59%	\$44,790	72%	\$4,546	\$4,479	\$3,665
TRINITY	60+	MALES	7	41%	\$17,179	28%	\$1,861	\$2,454	\$2,789
TULARE	0-15	FEMALES	1,128	38%	\$4,006,970	36%	\$2,123	\$3,552	\$4,726
TULARE	0-15	MALES	1,867	62%	\$7,180,955	64%	\$2,240	\$3,846	\$5,684
TULARE	16-25	FEMALES	518	48%	\$1,770,992	49%	\$1,388	\$3,419	\$9,090
TULARE	16-25	MALES	565	52%	\$1,809,213	51%	\$1,681	\$3,202	\$6,333
TULARE	26-59	FEMALES	1,307	63%	\$3,747,584	63%	\$1,856	\$2,867	\$3,869
TULARE	26-59	MALES	763	37%	\$2,227,591	37%	\$1,820	\$2,920	\$3,481
TULARE	60+	FEMALES	179	67%	\$559,398	68%	\$1,818	\$3,125	\$5,570
TULARE	60+	MALES	88	33%	\$261,763	32%	\$2,248	\$2,975	\$3,312
TUOLUMNE	0-15	FEMALES	156	44%	\$469,702	43%	\$1,598	\$3,011	\$3,972
TUOLUMNE	0-15	MALES	195	56%	\$635,111	57%	\$1,768	\$3,257	\$4,857
TUOLUMNE	16-25	FEMALES	101	57%	\$261,218	58%	\$897	\$2,586	\$6,697
TUOLUMNE	16-25	MALES	75	43%	\$189,595	42%	\$1,279	\$2,528	\$3,404
TUOLUMNE	26-59	FEMALES	301	66%	\$903,953	71%	\$1,222	\$3,003	\$6,070
TUOLUMNE	26-59	MALES	158	34%	\$366,904	29%	\$1,169	\$2,322	\$3,091
TUOLUMNE	60+	FEMALES	40	74%	\$82,826	74%	\$1,394	\$2,071	\$1,954
TUOLUMNE	60+	MALES	14	26%	\$28,793	26%	\$1,455	\$2,057	\$2,033
VENTURA	0-15	FEMALES	509	38%	\$2,353,105	30%	\$1,310	\$4,623	\$10,713
VENTURA	0-15	MALES	837	62%	\$5,414,239	70%	\$1,632	\$6,469	\$13,882
VENTURA	16-25	FEMALES	461	53%	\$2,105,154	50%	\$1,443	\$4,566	\$10,211
VENTURA	16-25	MALES	411	47%	\$2,132,621	50%	\$1,778	\$5,189	\$9,603
VENTURA	26-59	FEMALES	1,736	59%	\$6,014,077	47%	\$1,389	\$3,464	\$7,097
VENTURA	26-59	MALES	1,189	41%	\$6,882,525	53%	\$1,998	\$5,788	\$11,550
VENTURA	60+	FEMALES	285	69%	\$649,558	65%	\$1,523	\$2,279	\$2,537
VENTURA	60+	MALES	129	31%	\$345,980	35%	\$1,431	\$2,682	\$4,284
YOLO	0-15	FEMALES	268	43%	\$928,672	42%	\$1,520	\$3,465	\$5,994
YOLO	0-15	MALES	352	57%	\$1,286,957	58%	\$1,473	\$3,656	\$7,771
YOLO	16-25	FEMALES	156	50%	\$641,185	42%	\$1,204	\$4,110	\$8,725
YOLO	16-25	MALES	158	50%	\$873,410	58%	\$1,309	\$5,528	\$11,169
YOLO	26-59	FEMALES	644	63%	\$2,142,163	59%	\$716	\$3,326	\$7,636
YOLO	26-59	MALES	371	37%	\$1,492,249	41%	\$862	\$4,022	\$8,779
YOLO	60+	FEMALES	95	74%	\$320,066	79%	\$676	\$3,369	\$8,828
YOLO	60+	MALES	34	26%	\$86,176	21%	\$439	\$2,535	\$6,053



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Performance Improvement Protocol Analyses							
Question 1. Was the topic selected through data collection and analysis of comprehensive aspects of beneficiary needs, care and services?							
PIP Rating	Fiscal Year	Statistics	MHP Size				Total
			Large	Medium	Small	Small-Rural	
NO	2006	Count	6	6	13	14	39
		Column %	23.1%	22.2%	44.8%	50.0%	35.5%
	2005	Count	3	0	3	2	8
		Column %	25.0%	0.0%	20.0%	14.3%	14.8%
PARTIAL	2006	Count	7	8	7	8	30
		Column %	26.9%	29.6%	24.1%	28.6%	27.3%
	2005	Count	1	6	8	2	17
		Column %	8.3%	46.2%	53.3%	14.3%	31.5%
YES	2006	Count	13	13	9	6	41
		Column %	50.0%	48.1%	31.0%	21.4%	37.3%
	2005	Count	8	7	4	10	29
		Column %	66.7%	53.8%	26.7%	71.4%	53.7%
Total	2006	Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%
	2005	Count	12	13	15	14	54
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Question 2. Did the MHP, over time, address a key aspect of beneficiary care and services?							
PIP Rating	Fiscal Year	Statistics	MHP Size				Total
			Large	Medium	Small	Small-Rural	
NO	2006	Count	6	6	10	14	36
		Column %	23.1%	22.2%	34.5%	50.0%	32.7%
	2005	Count	1	0	4	1	6
		Column %	8.3%	0.0%	26.7%	7.1%	11.1%
PARTIAL	2006	Count	6	6	7	6	25
		Column %	23.1%	22.2%	24.1%	21.4%	22.7%
	2005	Count	2	3	2	1	8
		Column %	16.7%	23.1%	13.3%	7.1%	14.8%
YES	2006	Count	14	15	12	8	49
		Column %	53.8%	55.6%	41.4%	28.6%	44.5%
	2005	Count	9	10	9	12	40
		Column %	75.0%	76.9%	60.0%	85.7%	74.1%
Total	2006	Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%
	2005	Count	12	13	15	14	54
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Question: 3. The PIP included all clients to whom it pertained							
PIP Rating	Fiscal Year	Statistics	MHP Size				Total
			Large	Medium	Small	Small-Rural	
NO	2006	Count	11	9	12	14	46
		Column %	42.3%	33.3%	41.4%	50.0%	41.8%
	2005	Count	3	1	6	1	11
		Column %	25.0%	7.7%	40.0%	7.1%	20.4%
PARTIAL	2006	Count	4	6	5	6	21
		Column %	15.4%	22.2%	17.2%	21.4%	19.1%
	2005	Count	3	4	1	2	10
		Column %	25.0%	30.8%	6.7%	14.3%	18.5%
YES	2006	Count	11	12	12	8	43
		Column %	42.3%	44.4%	41.4%	28.6%	39.1%
	2005	Count	6	8	8	11	33
		Column %	50.0%	61.5%	53.3%	78.6%	61.1%
Total	2006	Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%
	2005	Count	12	13	15	14	54
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Performance Improvement Protocol Analyses							
Question: 4. Was/were the study question(s) stated clearly in writing?							
PIP Rating	Fiscal Year	Statistics	MHP Size				Total
			Large	Medium	Small	Small-Rural	
NO	2006	Count	9	10	13	18	50
		Column %	34.6%	37.0%	44.8%	64.3%	45.5%
	2005	Count	3	4	5	4	16
		Column %	25.0%	30.8%	33.3%	28.6%	29.6%
PARTIAL	2006	Count	6	8	8	5	27
		Column %	23.1%	29.6%	27.6%	17.9%	24.5%
	2005	Count	0	1	6	4	11
		Column %	0.0%	7.7%	40.0%	28.6%	20.4%
YES	2006	Count	11	9	8	5	33
		Column %	42.3%	33.3%	27.6%	17.9%	30.0%
	2005	Count	9	8	4	6	27
		Column %	75.0%	61.5%	26.7%	42.9%	50.0%
Total	2006	Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%
	2005	Count	12	13	15	14	54
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Question: 5. Did the study use objective, clearly defined, measurable indicators?							
PIP Rating	Fiscal Year	Statistics	MHP Size				Total
			Large	Medium	Small	Small-Rural	
NO	2006	Count	11	8	16	21	56
		Column %	42.3%	29.6%	55.2%	75.0%	50.9%
	2005	Count	0	1	6	3	10
		Column %	0.0%	7.7%	40.0%	21.4%	18.5%
PARTIAL	2006	Count	8	13	8	5	34
		Column %	30.8%	48.1%	27.6%	17.9%	30.9%
	2005	Count	4	9	5	6	24
		Column %	33.3%	69.2%	33.3%	42.9%	44.4%
YES	2006	Count	7	6	5	2	20
		Column %	26.9%	22.2%	17.2%	7.1%	18.2%
	2005	Count	8	3	4	5	20
		Column %	66.7%	23.1%	26.7%	35.7%	37.0%
Total	2006	Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%
	2005	Count	12	13	15	14	54
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

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?							
PIP Rating	Fiscal Year	Statistics	MHP Size				Total
			Large	Medium	Small	Small-Rural	
NO	2006	Count	16	13	19	22	70
		Column %	61.5%	48.1%	65.5%	78.6%	63.6%
	2005	Count	2	1	7	2	12
		Column %	16.7%	7.7%	46.7%	14.3%	22.2%
PARTIAL	2006	Count	6	8	4	1	19
		Column %	23.1%	29.6%	13.8%	3.6%	17.3%
	2005	Count	3	5	3	1	12
		Column %	25.0%	38.5%	20.0%	7.1%	22.2%
YES	2006	Count	4	6	6	5	21
		Column %	15.4%	22.2%	20.7%	17.9%	19.1%
	2005	Count	7	7	5	11	30
		Column %	58.3%	53.8%	33.3%	78.6%	55.6%
Total	2006	Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%
	2005	Count	12	13	15	14	54
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Performance Improvement Protocol Analyses							
Question: 7. Did the MHP clearly define all the Medicaid beneficiaries to whom the study question and indicators are relevant?							
PIP Rating	Fiscal Year	Statistics	MHP Size				
			Large	Medium	Small	Small-Rural	Total
NO	2006	Count	14	11	10	16	51
		Column %	53.8%	40.7%	34.5%	57.1%	46.4%
PARTIAL	2005	Count	5	1	6	1	13
		Column %	41.7%	7.7%	40.0%	7.1%	24.1%
YES	2006	Count	5	5	7	7	19
		Column %	18.5%	24.1%	25.0%	25.0%	17.3%
Total	2005	Count	2	3	3	4	12
		Column %	16.7%	23.1%	20.0%	28.6%	22.2%
Total	2006	Count	12	11	12	5	40
		Column %	46.2%	40.7%	41.4%	17.9%	36.4%
Total	2005	Count	5	9	6	9	29
		Column %	41.7%	69.2%	40.0%	64.3%	53.7%
Total	2006	Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%
Total	2005	Count	12	13	15	14	54
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Question: 8. If the MHP studied the entire population, did its data collection approach capture all beneficiaries to whom study question applied?							
PIP Rating	Fiscal Year	Statistics	MHP Size				
			Large	Medium	Small	Small-Rural	Total
NO	2006	Count	16	12	15	19	62
		Column %	61.5%	44.4%	51.7%	67.9%	56.4%
PARTIAL	2005	Count	8	5	9	6	28
		Column %	66.7%	38.5%	60.0%	42.9%	51.9%
YES	2006	Count	2	3	6	5	16
		Column %	7.7%	11.1%	20.7%	17.9%	14.5%
Total	2005	Count	0	0	2	2	4
		Column %	0.0%	0.0%	13.3%	14.3%	7.4%
Total	2006	Count	8	12	8	4	32
		Column %	30.8%	44.4%	27.6%	14.3%	29.1%
Total	2005	Count	4	8	4	6	22
		Column %	33.3%	61.5%	26.7%	42.9%	40.7%
Total	2006	Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%
Total	2005	Count	12	13	15	14	54
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Question: 12. Did the study design clearly specify the data to be collected?							
PIP Rating	Fiscal Year	Statistics	MHP Size				
			Large	Medium	Small	Small-Rural	Total
NO	2006	Count	11	8	14	21	54
		Column %	42.3%	29.6%	48.3%	75.0%	49.1%
PARTIAL	2006	Count	6	10	6	5	27
		Column %	23.1%	37.0%	20.7%	17.9%	24.5%
YES	2006	Count	9	9	9	2	29
		Column %	34.6%	33.3%	31.0%	7.1%	26.4%
Total	2006	Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

Question: 13. Did the study design clearly specify the sources of the data?							
PIP Rating	Fiscal Year	Statistics	MHP Size				
			Large	Medium	Small	Small-Rural	Total
NO	2006	Count	8	5	11	18	42
		Column %	30.8%	18.5%	37.9%	64.3%	38.2%
PARTIAL	2006	Count	6	11	9	6	32
		Column %	23.1%	40.7%	31.0%	21.4%	29.1%
YES	2006	Count	12	11	9	4	36
		Column %	46.2%	40.7%	31.0%	14.3%	32.7%
Total	2006	Count	26	27	29	28	110
		Column %	100.0%	100.0%	100.0%	100.0%	100.0%

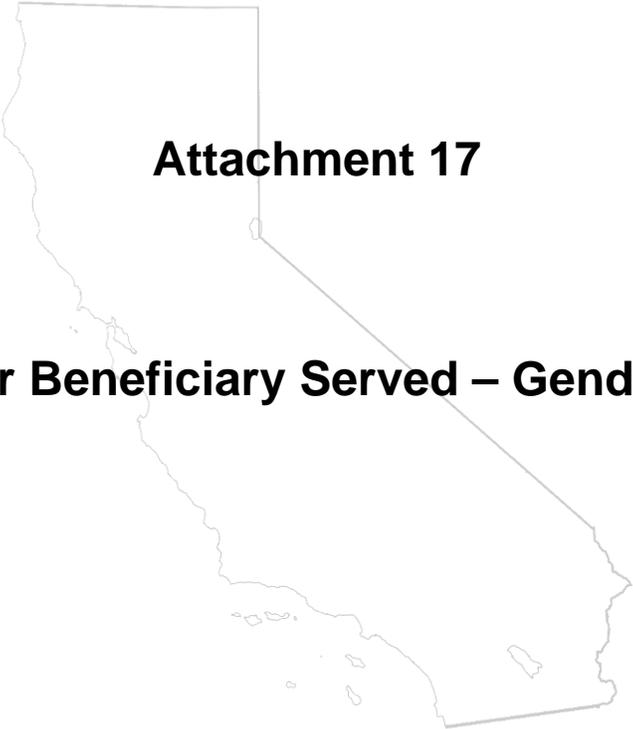
Performance Improvement Protocol Analyses							
Question: 14. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?							
PIP Rating	Fiscal Year	Statistics	MHP Size				Total
			Large	Medium	Small	Small-Rural	
NO	2006	Count	14	12	15	20	61
		Column %	53.8%	44.4%	51.7%	71.4%	55.5%
PARTIAL		Count	9	7	11	6	33
		Column %	34.6%	25.9%	37.9%	21.4%	30.0%
YES		Count	3	8	3	2	16
		Column %	11.5%	29.6%	10.3%	7.1%	14.5%
Total	Count	26	27	29	28	110	
	Column %	100.0%	100.0%	100.0%	100.0%	100.0%	

Question: 15. Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?							
PIP Rating	Fiscal Year	Statistics	MHP Size				Total
			Large	Medium	Small	Small-Rural	
NO	2006	Count	13	11	16	21	61
		Column %	50.0%	40.7%	55.2%	75.0%	55.5%
PARTIAL		Count	9	9	8	4	30
		Column %	34.6%	33.3%	27.6%	14.3%	27.3%
YES		Count	4	7	5	3	19
		Column %	15.4%	25.9%	17.2%	10.7%	17.3%
Total	Count	26	27	29	28	110	
	Column %	100.0%	100.0%	100.0%	100.0%	100.0%	

Question: 16. Did the study design prospectively specify a data analysis plan?							
PIP Rating	Fiscal Year	Statistics	MHP Size				Total
			Large	Medium	Small	Small-Rural	
NO	2006	Count	16	13	24	25	78
		Column %	61.5%	48.1%	82.8%	89.3%	70.9%
PARTIAL		Count	6	8	4	1	19
		Column %	23.1%	29.6%	13.8%	3.6%	17.3%
YES		Count	4	6	1	2	13
		Column %	15.4%	22.2%	3.4%	7.1%	11.8%
Total	Count	26	27	29	28	110	
	Column %	100.0%	100.0%	100.0%	100.0%	100.0%	



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 17

Cost per Beneficiary Served – Gender Ratio

Cost Per Beneficiary Served - by Female to Male Ratio						
Sorted by Cost Per Beneficiary Ratio Female to Male						
MHP	Females Served	Males Served	Female Average - Cost Per Beneficiary	Male Average - Cost Per Beneficiary	Ratio of Females to Males	Cost Per Beneficiary Ratio - Females to Males
STATEWIDE	221,267	201,102	\$3,481	\$4,538	1.10	0.77
SIERRA	6	6	\$1,604	\$21,952	1.00	0.07
MENDOCINO	1,121	813	\$3,143	\$5,423	1.38	0.58
SAN LUIS OBISPO	1,526	1,327	\$3,238	\$5,104	1.15	0.63
PLUMAS	195	150	\$3,419	\$5,324	1.30	0.64
VENTURA	2,991	2,566	\$3,718	\$5,758	1.17	0.65
PLACER	1,341	985	\$3,628	\$5,593	1.36	0.65
ALAMEDA	10,542	8,744	\$3,741	\$5,524	1.21	0.68
SISKIYOU	712	607	\$6,727	\$9,910	1.17	0.68
CONTRA COSTA	5,018	4,255	\$4,389	\$6,415	1.18	0.68
MARIN	1,226	1,037	\$4,451	\$6,375	1.18	0.70
NAPA	610	519	\$3,763	\$5,323	1.18	0.71
MARIPOSA	146	122	\$1,375	\$1,930	1.20	0.71
SAN DIEGO	16,852	14,721	\$2,763	\$3,878	1.14	0.71
NEVADA	405	323	\$3,192	\$4,452	1.25	0.72
SUTTER/YUBA	1,622	1,270	\$3,014	\$4,200	1.28	0.72
SANTA CRUZ	1,335	1,387	\$9,784	\$13,316	0.96	0.73
SAN JOAQUIN	5,004	3,798	\$1,621	\$2,200	1.32	0.74
MERCED	1,796	1,373	\$1,979	\$2,610	1.31	0.76
SAN FRANCISCO	6,666	7,337	\$5,153	\$6,792	0.91	0.76
LOS ANGELES	63,652	62,485	\$3,824	\$5,022	1.02	0.76
SOLANO	1,717	1,717	\$3,972	\$5,216	1.00	0.76
SANTA CLARA	6,432	5,565	\$4,399	\$5,718	1.16	0.77
CALAVERAS	241	162	\$1,915	\$2,473	1.49	0.77
SAN BENITO	396	287	\$1,843	\$2,373	1.38	0.78
SACRAMENTO	11,042	9,849	\$3,650	\$4,697	1.12	0.78
FRESNO	7,628	6,067	\$2,648	\$3,313	1.26	0.80
TRINITY	199	150	\$3,829	\$4,775	1.33	0.80
ORANGE	10,873	9,400	\$2,498	\$3,089	1.16	0.81
MONTEREY	1,782	1,606	\$5,717	\$7,032	1.11	0.81
RIVERSIDE	8,798	7,907	\$2,232	\$2,725	1.11	0.82
IMPERIAL	1,268	1,556	\$2,817	\$3,433	0.81	0.82
BUTTE	2,493	2,208	\$3,609	\$4,375	1.13	0.82
TEHAMA	844	580	\$1,955	\$2,367	1.46	0.83
LASSEN	418	298	\$3,950	\$4,765	1.40	0.83
GLENN	376	245	\$3,466	\$4,162	1.53	0.83
SAN MATEO	2,262	1,789	\$2,412	\$2,859	1.26	0.84
INYO	160	142	\$3,238	\$3,822	1.13	0.85
YOLO	1,163	915	\$3,467	\$4,086	1.27	0.85
EL DORADO	791	700	\$2,506	\$2,919	1.13	0.86
SANTA BARBARA	2,747	2,497	\$6,450	\$7,463	1.10	0.86
SAN BERNARDINO	12,940	11,715	\$2,373	\$2,722	1.10	0.87
MADERA	1,038	787	\$2,375	\$2,617	1.32	0.91
LAKE	747	574	\$2,911	\$3,199	1.30	0.91
TULARE	3,132	3,283	\$3,220	\$3,497	0.95	0.92
COLUSA	203	124	\$2,202	\$2,385	1.64	0.92
STANISLAUS	4,095	3,777	\$3,461	\$3,672	1.08	0.94
KINGS	1,289	1,074	\$2,050	\$2,131	1.20	0.96
DEL NORTE	561	455	\$1,820	\$1,890	1.23	0.96
SHASTA	2,166	1,865	\$2,682	\$2,777	1.16	0.97
KERN	6,529	6,378	\$4,152	\$4,184	1.02	0.99
SONOMA	1,662	1,499	\$5,236	\$5,092	1.11	1.03
AMADOR	191	164	\$1,308	\$1,270	1.16	1.03
TUOLUMNE	598	442	\$2,872	\$2,761	1.35	1.04
HUMBOLDT	1,536	1,383	\$4,244	\$4,026	1.11	1.05
MODOC	124	68	\$2,246	\$1,450	1.82	1.55
MONO	48	44	\$3,511	\$2,231	1.09	1.57
ALPINE	12	5	\$3,017	\$753	2.40	4.01



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



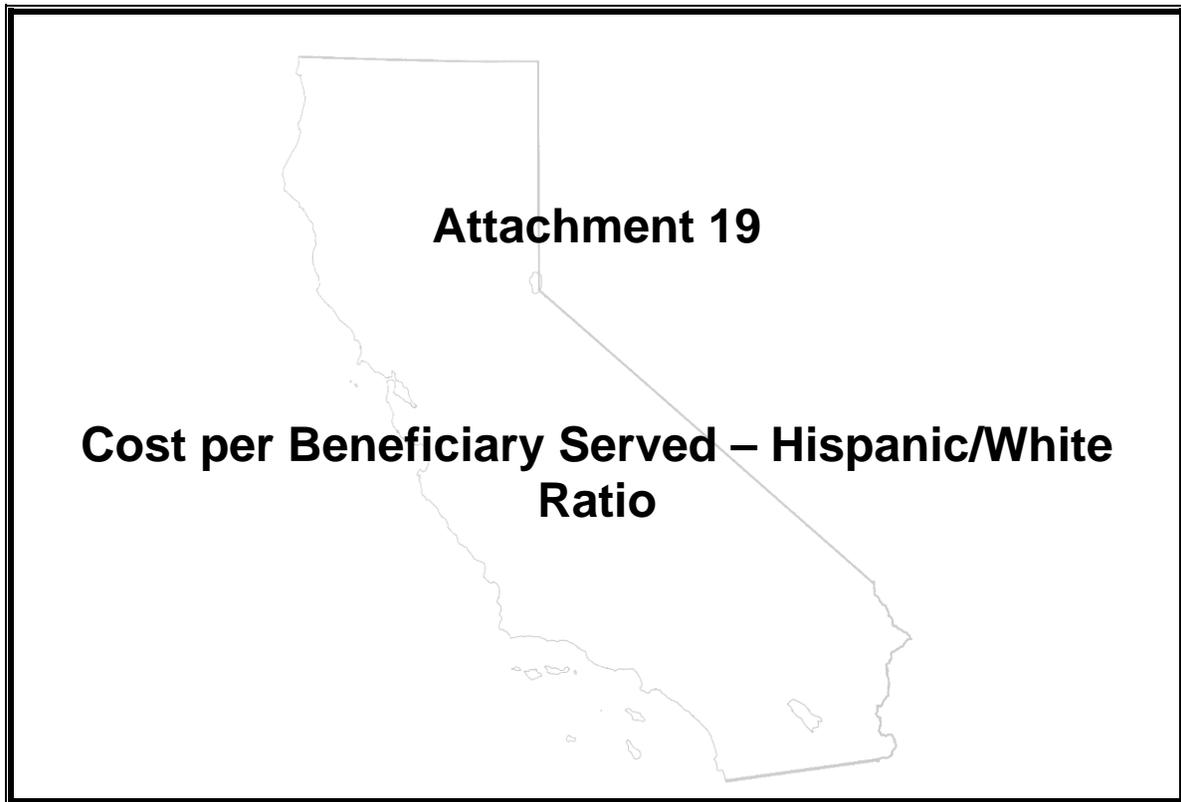
Attachment 18

CANOLA – Cost by Activity and Race/Ethnicity

CANOLA - Cost Per Beneficiary Served by Service Activity and Race/Ethnicity							
Service Activity Category	Race/Ethnicity	Total Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
24 Hrs Services	Statewide	100%	26,396	100%	\$3,090	\$6,543	\$9,520
24 Hrs Services	WHITE	1,459,927	13,565	51%	\$3,108	\$6,576	\$9,583
24 Hrs Services	HISPANIC	3,576,788	4,986	19%	\$2,375	\$5,116	\$8,153
24 Hrs Services	AFRICAN-AMERICAN	705,805	4,296	16%	\$3,468	\$6,865	\$9,720
24 Hrs Services	ASIAN/PACIFIC ISLANDER	689,112	1,583	6%	\$4,118	\$8,147	\$10,844
24 Hrs Services	NATIVE AMERICAN	29,828	283	1%	\$2,886	\$5,754	\$7,533
24 Hrs Services	OTHER	349,503	1,683	6%	\$4,568	\$8,307	\$10,558
23 Hrs Services	Statewide	100%	17,419	100%	\$1,164	\$1,695	\$2,236
23 Hrs Services	WHITE	1,459,927	8,025	46%	\$1,160	\$1,652	\$2,045
23 Hrs Services	HISPANIC	3,576,788	2,928	17%	\$1,061	\$1,477	\$1,845
23 Hrs Services	AFRICAN-AMERICAN	705,805	4,113	24%	\$1,326	\$1,957	\$2,802
23 Hrs Services	ASIAN/PACIFIC ISLANDER	689,112	1,205	7%	\$1,149	\$1,581	\$1,964
23 Hrs Services	NATIVE AMERICAN	29,828	208	1%	\$1,243	\$1,697	\$2,155
23 Hrs Services	OTHER	349,503	940	5%	\$1,096	\$1,744	\$2,362
DAY TX	Statewide	100%	6,876	100%	\$6,384	\$9,987	\$10,296
DAY TX	WHITE	1,459,927	3,301	48%	\$6,138	\$9,414	\$9,750
DAY TX	HISPANIC	3,576,788	1,177	17%	\$4,770	\$8,897	\$10,038
DAY TX	AFRICAN-AMERICAN	705,805	1,682	24%	\$7,746	\$11,523	\$11,269
DAY TX	ASIAN/PACIFIC ISLANDER	689,112	376	5%	\$8,087	\$11,056	\$10,641
DAY TX	NATIVE AMERICAN	29,828	84	1%	\$4,553	\$8,421	\$8,823
DAY TX	OTHER	349,503	256	4%	\$8,057	\$11,258	\$10,246
LINKAGE/BROKERAGE	Statewide	100%	140,215	100%	\$261	\$828	\$1,774
LINKAGE/BROKERAGE	WHITE	1,459,927	67,621	48%	\$256	\$853	\$1,824
LINKAGE/BROKERAGE	HISPANIC	3,576,788	31,228	22%	\$227	\$707	\$1,611
LINKAGE/BROKERAGE	AFRICAN-AMERICAN	705,805	20,237	14%	\$259	\$853	\$1,833
LINKAGE/BROKERAGE	ASIAN/PACIFIC ISLANDER	689,112	12,267	9%	\$332	\$804	\$1,559
LINKAGE/BROKERAGE	NATIVE AMERICAN	29,828	1,407	1%	\$273	\$895	\$1,932
LINKAGE/BROKERAGE	OTHER	349,503	7,455	5%	\$385	\$1,059	\$2,058
Outpatient Services	Statewide	100%	285,718	100%	\$1,049	\$2,508	\$4,886
Outpatient Services	WHITE	1,459,927	134,011	47%	\$1,081	\$2,586	\$4,995
Outpatient Services	HISPANIC	3,576,788	65,123	23%	\$1,034	\$2,258	\$4,072
Outpatient Services	AFRICAN-AMERICAN	705,805	41,649	15%	\$1,051	\$2,670	\$5,163
Outpatient Services	ASIAN/PACIFIC ISLANDER	689,112	26,573	9%	\$842	\$2,336	\$5,371
Outpatient Services	NATIVE AMERICAN	29,828	2,892	1%	\$1,158	\$2,850	\$5,461
Outpatient Services	OTHER	349,503	15,470	5%	\$1,146	\$2,684	\$5,249
TBS	Statewide	100%	1,978	100%	\$7,197	\$11,068	\$14,582
TBS	WHITE	1,459,927	895	45%	\$7,979	\$12,631	\$17,625
TBS	HISPANIC	3,576,788	438	22%	\$7,637	\$10,584	\$10,786
TBS	AFRICAN-AMERICAN	705,805	444	22%	\$5,363	\$7,919	\$8,569
TBS	ASIAN/PACIFIC ISLANDER	689,112	116	6%	\$6,753	\$9,667	\$11,579
TBS	NATIVE AMERICAN	29,828	13	1%	\$7,533	\$11,160	\$12,264
TBS	OTHER	349,503	72	4%	\$10,359	\$16,235	\$21,636



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Average Approved Payments Ratios Between Hispanic and White Beneficiaries CY05						
Beneficiary County	Count of Beneficiary Served		Average Payment Per Beneficiary Served		Ratio of Hispanic vs. White for	
	Hispanic	White	Hispanic	White	Beneficiary Count	Average Payment
ALPINE	0	6		\$5,537	0.00	
SIERRA	1	10	\$376	\$13,499	0.10	0.03
CALAVERAS	18	341	\$969	\$2,162	0.05	0.45
YOLO	295	1,266	\$1,880	\$4,217	0.23	0.45
MARIPOSA	7	248	\$682	\$1,480	0.03	0.46
PLUMAS	13	306	\$2,069	\$4,298	0.04	0.48
MARIN	322	1,409	\$3,265	\$5,685	0.23	0.57
COLUSA	103	180	\$1,641	\$2,740	0.57	0.60
INYO	24	238	\$2,126	\$3,476	0.10	0.61
NEVADA	17	625	\$2,114	\$3,321	0.03	0.64
MERCED	1,031	1,324	\$1,706	\$2,575	0.78	0.66
SACRAMENTO	1,648	9,337	\$2,942	\$4,289	0.18	0.69
SONOMA	354	2,241	\$3,712	\$5,377	0.16	0.69
MONO	7	66	\$2,258	\$3,216	0.11	0.70
SANTA BARBARA	2,042	2,449	\$5,542	\$7,846	0.83	0.71
KINGS	995	1,009	\$1,744	\$2,415	0.99	0.72
KERN	4,152	6,410	\$3,366	\$4,638	0.65	0.73
SAN FRANCISCO	1,638	4,907	\$4,774	\$6,497	0.33	0.73
FRESNO	5,177	4,228	\$2,487	\$3,354	1.22	0.74
MONTEREY	1,523	1,378	\$5,422	\$7,263	1.11	0.75
SANTA CRUZ	513	1,619	\$8,681	\$11,425	0.32	0.76
RIVERSIDE	4,654	8,147	\$1,964	\$2,550	0.57	0.77
SHASTA	137	3,484	\$2,199	\$2,819	0.04	0.78
NAPA	161	786	\$3,429	\$4,314	0.20	0.79
TEHAMA	104	1,171	\$1,621	\$2,025	0.09	0.80
LAKE	76	1,123	\$2,479	\$3,064	0.07	0.81
DEL NORTE	53	765	\$1,581	\$1,939	0.07	0.82
PLACER	101	1,977	\$3,684	\$4,513	0.05	0.82
STANISLAUS	1,983	4,676	\$2,943	\$3,607	0.42	0.82
SUTTER/YUBA	308	1,984	\$3,139	\$3,783	0.16	0.83
SISKIYOU	61	1,078	\$6,666	\$7,916	0.06	0.84
LASSEN	45	619	\$3,525	\$4,161	0.07	0.85
LOS ANGELES	41,343	39,274	\$4,253	\$5,011	1.05	0.85
SAN LUIS OBISPO	435	2,236	\$3,476	\$4,062	0.19	0.86
SAN MATEO	910	1,790	\$2,278	\$2,663	0.51	0.86
TULARE	3,114	2,609	\$3,109	\$3,604	1.19	0.86
BUTTE	285	3,634	\$3,616	\$4,139	0.08	0.87
SOLANO	317	1,496	\$4,004	\$4,623	0.21	0.87

Average Approved Payments Ratios Between Hispanic and White Beneficiaries CY05						
Beneficiary County	Count of Beneficiary Served		Average Payment Per Beneficiary Served		Ratio of Hispanic vs. White for	
	Hispanic	White	Hispanic	White	Beneficiary Count	Average Payment
ALAMEDA	2,541	4,944	\$3,765	\$4,197	0.51	0.90
CONTRA COSTA	1,313	3,914	\$4,707	\$5,206	0.34	0.90
IMPERIAL	2,064	542	\$3,033	\$3,374	3.81	0.90
SAN BENITO	395	233	\$1,908	\$2,127	1.70	0.90
ORANGE	5,959	8,210	\$2,888	\$3,171	0.73	0.91
SAN JOAQUIN	1,709	3,728	\$1,916	\$2,102	0.46	0.91
TRINITY	6	319	\$3,820	\$4,091	0.02	0.93
TUOLUMNE	59	913	\$2,603	\$2,812	0.06	0.93
MENDOCINO	142	1,497	\$3,648	\$3,877	0.09	0.94
SAN BERNARDINO	6,847	10,927	\$2,383	\$2,533	0.63	0.94
VENTURA	1,696	3,035	\$4,292	\$4,583	0.56	0.94
SANTA CLARA	2,147	3,937	\$4,901	\$5,169	0.55	0.95
SAN DIEGO	8,658	13,813	\$3,173	\$3,278	0.63	0.97
AMADOR	17	318	\$1,240	\$1,267	0.05	0.98
GLENN	112	399	\$3,757	\$3,775	0.28	1.00
MADERA	692	957	\$2,587	\$2,409	0.72	1.07
HUMBOLDT	104	2,486	\$4,985	\$4,117	0.04	1.21
MODOC	11	163	\$2,397	\$1,822	0.07	1.32
EL DORADO	80	1,258	\$4,345	\$2,472	0.06	1.76

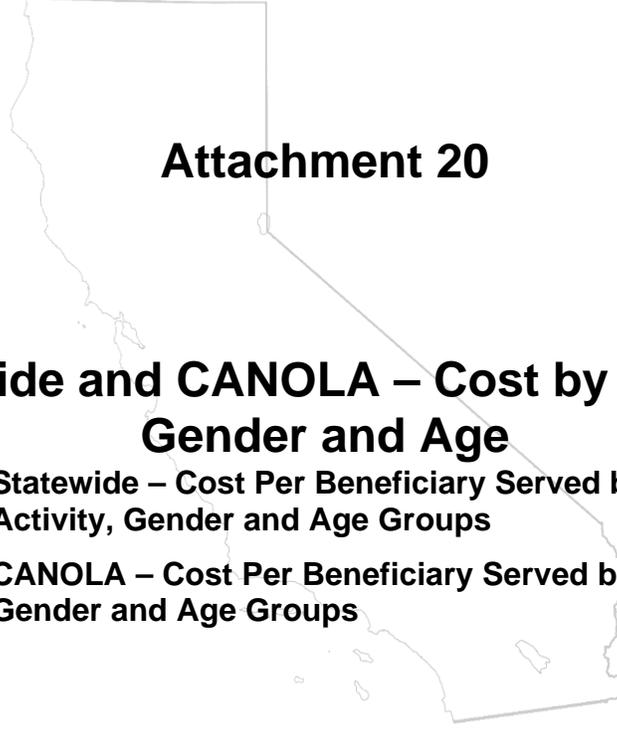
Prepared by APS Healthcare / CA EQRO

Data source: Short-Doyle/Medi-Cal approved claims as of May 9, 2006;

Inpatient Consolidated approved claims as of July 13, 2006



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

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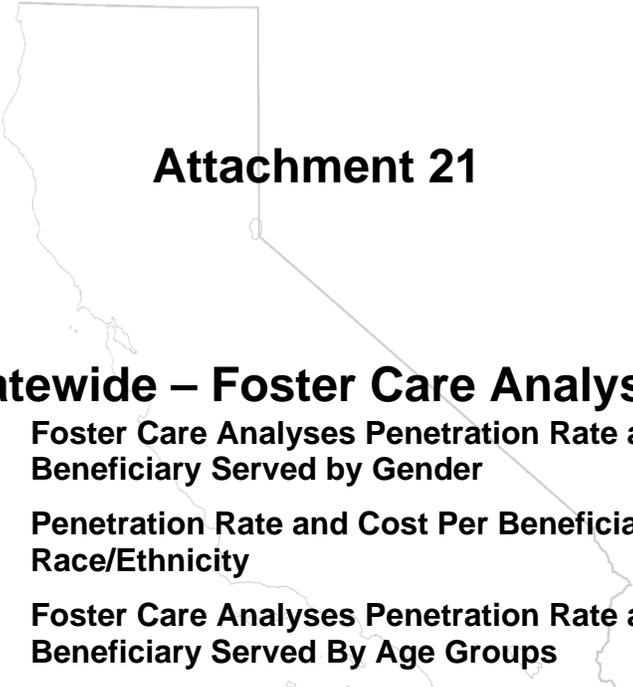
Attachment 20

Statewide and CANOLA – Cost by Activity, Gender and Age

- **Statewide – Cost Per Beneficiary Served by Service Activity, Gender and Age Groups**
- **CANOLA – Cost Per Beneficiary Served by Service Activity, Gender and Age Groups**

Statewide - Cost Per Beneficiary Served by Service Activity, Gender and Age Groups								
Service Activity Category	Gender	Age Groups	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
24 Hrs Services	Statewide	Statewide	100%	44,655	100%	\$2,354	\$5,616	\$9,211
24 Hrs Services	FEMALE	Age 0-15	55%	2,779	6%	\$2,280	\$4,695	\$9,214
24 Hrs Services	MALE	Age 0-15	45%	2,667	6%	\$2,280	\$4,212	\$5,887
24 Hrs Services	FEMALE	Age 16-25	54%	4,843	11%	\$1,827	\$4,586	\$8,547
24 Hrs Services	MALE	Age 16-25	46%	4,956	11%	\$2,280	\$5,627	\$9,240
24 Hrs Services	FEMALE	Age 26-59	58%	14,183	32%	\$2,343	\$5,603	\$9,058
24 Hrs Services	MALE	Age 26-59	42%	12,984	29%	\$2,741	\$6,475	\$10,050
24 Hrs Services	FEMALE	Age 60+	54%	1,317	3%	\$2,517	\$5,890	\$9,042
24 Hrs Services	MALE	Age 60+	46%	926	2%	\$2,120	\$5,545	\$9,197
23 Hrs Services	Statewide	Statewide	100%	21,651	100%	\$1,161	\$1,625	\$2,102
23 Hrs Services	FEMALE	Age 0-15	55%	917	4%	\$832	\$1,217	\$1,454
23 Hrs Services	MALE	Age 0-15	45%	845	4%	\$729	\$981	\$953
23 Hrs Services	FEMALE	Age 16-25	54%	2,404	11%	\$935	\$1,307	\$1,544
23 Hrs Services	MALE	Age 16-25	46%	2,415	11%	\$1,202	\$1,646	\$1,953
23 Hrs Services	FEMALE	Age 26-59	58%	7,060	33%	\$1,161	\$1,634	\$2,294
23 Hrs Services	MALE	Age 26-59	42%	7,026	32%	\$1,410	\$1,884	\$2,310
23 Hrs Services	FEMALE	Age 60+	54%	543	3%	\$1,042	\$1,304	\$1,288
23 Hrs Services	MALE	Age 60+	46%	441	2%	\$1,184	\$1,440	\$1,665
DAY TX	Statewide	Statewide	100%	10,472	100%	\$7,164	\$10,309	\$10,128
DAY TX	FEMALE	Age 0-15	55%	1,597	15%	\$7,923	\$11,436	\$11,509
DAY TX	MALE	Age 0-15	45%	2,847	27%	\$10,783	\$13,363	\$11,316
DAY TX	FEMALE	Age 16-25	54%	1,269	12%	\$7,493	\$10,302	\$9,504
DAY TX	MALE	Age 16-25	46%	1,714	16%	\$7,952	\$10,999	\$10,557
DAY TX	FEMALE	Age 26-59	58%	1,254	12%	\$3,816	\$6,068	\$6,134
DAY TX	MALE	Age 26-59	42%	1,527	15%	\$5,033	\$6,563	\$6,220
DAY TX	FEMALE	Age 60+	54%	165	2%	\$6,713	\$7,390	\$6,027
DAY TX	MALE	Age 60+	46%	99	1%	\$6,723	\$8,844	\$7,543
LINKAGE/BROKERAGE	Statewide	Statewide	100%	206,204	100%	\$259	\$781	\$1,657
LINKAGE/BROKERAGE	FEMALE	Age 0-15	55%	26,847	13%	\$241	\$706	\$1,612
LINKAGE/BROKERAGE	MALE	Age 0-15	45%	43,093	21%	\$259	\$763	\$1,685
LINKAGE/BROKERAGE	FEMALE	Age 16-25	54%	15,765	8%	\$247	\$867	\$2,163
LINKAGE/BROKERAGE	MALE	Age 16-25	46%	17,015	8%	\$293	\$944	\$2,030
LINKAGE/BROKERAGE	FEMALE	Age 26-59	58%	51,049	25%	\$234	\$696	\$1,432
LINKAGE/BROKERAGE	MALE	Age 26-59	42%	38,030	18%	\$293	\$863	\$1,590
LINKAGE/BROKERAGE	FEMALE	Age 60+	54%	9,730	5%	\$274	\$743	\$1,356
LINKAGE/BROKERAGE	MALE	Age 60+	46%	4,675	2%	\$303	\$827	\$1,442
Outpatient Services	Statewide	Statewide	100%	406,750	100%	\$1,089	\$2,668	\$4,933
Outpatient Services	FEMALE	Age 0-15	55%	52,657	13%	\$1,613	\$3,375	\$5,289
Outpatient Services	MALE	Age 0-15	45%	80,740	20%	\$1,801	\$3,706	\$6,072
Outpatient Services	FEMALE	Age 16-25	54%	31,371	8%	\$1,097	\$2,959	\$5,789
Outpatient Services	MALE	Age 16-25	46%	31,067	8%	\$1,284	\$3,253	\$5,854
Outpatient Services	FEMALE	Age 26-59	58%	109,111	27%	\$829	\$1,844	\$3,540
Outpatient Services	MALE	Age 26-59	42%	71,636	18%	\$945	\$2,329	\$4,504
Outpatient Services	FEMALE	Age 60+	54%	19,877	5%	\$708	\$1,542	\$2,945
Outpatient Services	MALE	Age 60+	46%	10,291	3%	\$614	\$1,515	\$2,968
TBS	Statewide	Statewide	100%	3,086	100%	\$9,011	\$13,876	\$16,264
TBS	FEMALE	Age 0-15	55%	814	26%	\$7,841	\$12,811	\$14,312
TBS	MALE	Age 0-15	45%	1,546	50%	\$10,325	\$15,462	\$17,999
TBS	FEMALE	Age 16-25	54%	373	12%	\$6,698	\$11,522	\$15,043
TBS	MALE	Age 16-25	46%	346	11%	\$8,182	\$12,089	\$12,700

CANOLA - Cost Per Beneficiary Served by Service Activity, Gender and Age Groups								
Service Activity Category	Gender	Age Groups	Percent of Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	Median - Cost Per Beneficiary Served	Average - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
24 Hrs Services	CANOLA	CANOLA	100%	26,396	100%	\$3,090	\$6,543	\$9,520
24 Hrs Services	FEMALE	Age 0-15	56%	1,522	6%	\$2,652	\$4,704	\$6,777
24 Hrs Services	MALE	Age 0-15	44%	1,385	5%	\$2,741	\$4,760	\$6,143
24 Hrs Services	FEMALE	Age 16-25	55%	2,866	11%	\$2,103	\$5,232	\$9,049
24 Hrs Services	MALE	Age 16-25	45%	2,919	11%	\$2,956	\$6,525	\$9,836
24 Hrs Services	FEMALE	Age 26-59	58%	8,881	34%	\$3,000	\$6,556	\$9,574
24 Hrs Services	MALE	Age 26-59	42%	7,605	29%	\$3,800	\$7,567	\$10,221
24 Hrs Services	FEMALE	Age 60+	55%	735	3%	\$3,920	\$7,663	\$10,161
24 Hrs Services	MALE	Age 60+	45%	483	2%	\$3,811	\$7,287	\$9,744
23 Hrs Services	CANOLA	CANOLA	100%	17,419	100%	\$1,164	\$1,695	\$2,236
23 Hrs Services	FEMALE	Age 0-15	56%	729	4%	\$796	\$1,228	\$1,551
23 Hrs Services	MALE	Age 0-15	44%	675	4%	\$707	\$1,004	\$1,002
23 Hrs Services	FEMALE	Age 16-25	55%	1,919	11%	\$915	\$1,344	\$1,631
23 Hrs Services	MALE	Age 16-25	45%	1,831	11%	\$1,184	\$1,714	\$2,101
23 Hrs Services	FEMALE	Age 26-59	58%	5,779	33%	\$1,164	\$1,705	\$2,446
23 Hrs Services	MALE	Age 26-59	42%	5,649	32%	\$1,418	\$1,981	\$2,444
23 Hrs Services	FEMALE	Age 60+	55%	459	3%	\$1,096	\$1,371	\$1,324
23 Hrs Services	MALE	Age 60+	45%	378	2%	\$1,187	\$1,498	\$1,746
DAY TX	CANOLA	CANOLA	100%	6,876	100%	\$6,384	\$9,987	\$10,296
DAY TX	FEMALE	Age 0-15	56%	1,012	15%	\$6,709	\$10,988	\$11,791
DAY TX	MALE	Age 0-15	44%	1,738	25%	\$10,947	\$13,624	\$11,853
DAY TX	FEMALE	Age 16-25	55%	737	11%	\$7,312	\$10,450	\$9,994
DAY TX	MALE	Age 16-25	45%	1,105	16%	\$8,169	\$11,040	\$10,377
DAY TX	FEMALE	Age 26-59	58%	969	14%	\$3,404	\$5,609	\$6,087
DAY TX	MALE	Age 26-59	42%	1,104	16%	\$4,313	\$6,260	\$6,466
DAY TX	FEMALE	Age 60+	55%	132	2%	\$5,773	\$7,277	\$6,188
DAY TX	MALE	Age 60+	45%	79	1%	\$5,233	\$8,437	\$7,519
LINKAGE/BROKERAGE	CANOLA	CANOLA	100%	140,215	100%	\$261	\$828	\$1,774
LINKAGE/BROKERAGE	FEMALE	Age 0-15	56%	16,657	12%	\$213	\$702	\$1,785
LINKAGE/BROKERAGE	MALE	Age 0-15	44%	26,819	19%	\$233	\$774	\$1,836
LINKAGE/BROKERAGE	FEMALE	Age 16-25	55%	10,347	7%	\$231	\$922	\$2,446
LINKAGE/BROKERAGE	MALE	Age 16-25	45%	10,891	8%	\$290	\$1,018	\$2,220
LINKAGE/BROKERAGE	FEMALE	Age 26-59	58%	36,781	26%	\$250	\$751	\$1,493
LINKAGE/BROKERAGE	MALE	Age 26-59	42%	28,102	20%	\$326	\$928	\$1,639
LINKAGE/BROKERAGE	FEMALE	Age 60+	55%	7,085	5%	\$312	\$843	\$1,453
LINKAGE/BROKERAGE	MALE	Age 60+	45%	3,533	3%	\$349	\$926	\$1,564
Outpatient Services	CANOLA	CANOLA	100%	285,718	100%	\$1,049	\$2,508	\$4,886
Outpatient Services	FEMALE	Age 0-15	56%	36,060	13%	\$1,357	\$2,974	\$5,243
Outpatient Services	MALE	Age 0-15	44%	54,902	19%	\$1,539	\$3,296	\$5,950
Outpatient Services	FEMALE	Age 16-25	55%	22,362	8%	\$956	\$2,686	\$5,832
Outpatient Services	MALE	Age 16-25	45%	20,709	7%	\$1,170	\$2,973	\$5,846
Outpatient Services	FEMALE	Age 26-59	58%	80,240	28%	\$862	\$1,873	\$3,556
Outpatient Services	MALE	Age 26-59	42%	51,130	18%	\$1,009	\$2,410	\$4,667
Outpatient Services	FEMALE	Age 60+	55%	13,392	5%	\$781	\$1,642	\$3,078
Outpatient Services	MALE	Age 60+	45%	6,923	2%	\$711	\$1,641	\$3,103
TBS	CANOLA	CANOLA	100%	1,978	100%	\$7,197	\$11,068	\$14,582
TBS	FEMALE	Age 0-15	56%	532	27%	\$6,441	\$10,045	\$11,951
TBS	MALE	Age 0-15	44%	968	49%	\$8,210	\$12,108	\$16,168
TBS	FEMALE	Age 16-25	55%	252	13%	\$5,995	\$10,154	\$15,540
TBS	MALE	Age 16-25	45%	219	11%	\$6,784	\$10,321	\$11,431



Attachment 21

Statewide – Foster Care Analyses

- **Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served by Gender**
- **Penetration Rate and Cost Per Beneficiary Served by Race/Ethnicity**
- **Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served By Age Groups**
- **Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served by Service Activity**
- **Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served by Diagnoses Groups**
- **Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served by Diagnoses Groups and Gender**

Table 21.1 - Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served by Gender

	Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unduplicated Count of Medi-Cal Beneficiaries	Approved Amount	Penetration Rate	Average Monthly Approved Claims Unduplicated Eligibles	Approved Claims Per Unduplicated Beneficiary Served
Gender							
FEMALES	57,768	40,423	20,406	\$124,856,854	50.48%	\$3,089	\$6,119
MALES	61,120	42,538	23,757	\$153,982,618	55.85%	\$3,620	\$6,482
Totals	118,888	82,961	44,163	\$278,839,472	53.23%	\$3,361	\$6,314

Table 21.2 - Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served by Race/Ethnicity

	Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unduplicated Count of Medi-Cal Beneficiaries	Approved Amount	Penetration Rate	Average Monthly Approved Claims Unduplicated Eligibles	Approved Claims Per Unduplicated Beneficiary Served
Race/Ethnicity							
WHITE	64,834	46,920	23,694	\$156,010,063	50.50%	\$3,325	\$6,584
HISPANIC	28,020	17,998	9,639	\$45,767,301	53.56%	\$2,543	\$4,748
AFRICAN-AMERICAN	20,398	14,502	8,351	\$55,956,910	57.59%	\$3,859	\$6,701
ASIAN/PACIFIC ISLANDER	3,382	2,280	1,616	\$14,646,381	70.88%	\$6,424	\$9,063
NATIVE AMERICAN	1,187	859	397	\$2,311,530	46.22%	\$2,691	\$5,822
OTHER	1,067	402	466	\$4,147,287	115.92%	\$10,317	\$8,900
Total	118,888	82,961	44,163	\$278,839,472	53.23%	\$3,361	\$6,314

Table 21.3 - Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served by Age Groups

	Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unduplicated Count of Medi-Cal Beneficiaries	Approved Amount	Penetration Rate	Average Monthly Approved Claims Unduplicated Eligibles	Approved Claims Per Unduplicated Beneficiary Served
Age Groups							
0-8	46,429	29,835	11,290	\$45,306,750	37.84%	\$1,519	\$4,013
9-15	47,642	36,998	22,942	\$166,397,774	62.01%	\$4,494	\$7,247
16-17	17,972	13,066	8,247	\$59,599,834	63.12%	\$4,561	\$7,227
18-20	6,845	3,062	1,684	\$7,535,114	54.41%	\$2,464	\$4,528
Total	118,888	82,961	44,163	\$278,839,472	53.23%	\$3,361	\$6,314

Table 21.4 - Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served by Service Activity

	Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unduplicated Count of Medi-Cal Beneficiaries	Approved Amount	Penetration Rate	Average Monthly Approved Claims Unduplicated Eligibles	Approved Claims Per Unduplicated Beneficiary Served
Service Activity							
INPATIENT	118,888	82,961	1,530	\$10,039,707	1.84%	\$121	\$6,562
RESIDENTIAL	118,888	82,961	12	\$35,769	0.01%	\$0	\$2,981
DAY TX	118,888	82,961	3,830	\$45,251,911	4.62%	\$545	\$11,815
LINKAGE/BROKERAGE	118,888	82,961	24,882	\$25,663,013	29.99%	\$309	\$1,031
MH SERVICES	118,888	82,961	41,091	\$155,820,454	49.53%	\$1,859	\$3,753
TBS	118,888	82,961	1,488	\$16,956,909	1.79%	\$204	\$11,396
MEDICATION SUPPORT	118,888	82,961	15,763	\$20,664,290	19.00%	\$249	\$1,311
CRISIS	118,888	82,961	3,936	\$4,407,419	4.74%	\$53	\$1,120
Total	n/a	n/a	n/a	\$278,839,472	53.23%	\$3,361	\$6,314

Table 21.5 - Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served by Diagnoses Groups

Diagnosis	Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unduplicated Count of Medi-Cal Beneficiaries Served	Approved Amount	Penetration Rate	Average Monthly Approved Claims Unduplicated Eligibles	Approved Claims Per Unduplicated Beneficiary Served
ADHD&CONDUCT DISORDERS	118,888	82,961	8,493	\$41,502,622	10.24%	\$500	\$4,887
SCHIZOPHRENIA&OTH PSYCH	118,888	82,961	310	\$2,761,852	0.37%	\$33	\$8,909
DEPRESSION DISORDERS	118,888	82,961	7,834	\$49,106,722	9.44%	\$592	\$6,268
BIPOLAR DISORDERS	118,888	82,961	1,111	\$17,083,735	1.34%	\$206	\$15,377
ANXIETY DISORDERS	118,888	82,961	4,490	\$40,083,330	5.41%	\$483	\$8,927
ADJUSTMENT DISORDER	118,888	82,961	9,506	\$41,893,666	11.46%	\$505	\$4,407
OTHER MH	118,888	82,961	5,542	\$38,081,354	6.68%	\$459	\$6,871
DEFERRED/MISSING	118,888	82,961	6,877	\$48,326,191	8.29%	\$583	\$7,027
Total	n/a	n/a	44,163	\$278,839,472	53.23%	\$3,361	\$6,314

Table 21.6 - Foster Care Analyses Penetration Rate and Cost Per Beneficiary Served by Diagnoses Groups and Gender

Diagnosis	Gender	Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unduplicated Count of Medi-Cal Beneficiaries Served	Approved Amount	Penetration Rate	Average Monthly Approved Claims Unduplicated Eligibles	Approved Claims Per Unduplicated Beneficiary Served
ADHD&CONDUCT DISORDERS	FEMALES	57,768	40,424	2,572	\$11,474,081	6.36%	\$284	\$4,461
ADHD&CONDUCT DISORDERS	MALES	61,120	42,538	5,921	\$30,028,540	13.92%	\$706	\$5,072
SCHIZOPHRENIA&OTH PSYCH	FEMALES	57,768	40,424	96	\$759,928	0.24%	\$19	\$7,916
SCHIZOPHRENIA&OTH PSYCH	MALES	61,120	42,538	214	\$2,001,925	0.50%	\$47	\$9,355
DEPRESSION DISORDERS	FEMALES	57,768	40,424	3,957	\$23,166,111	9.79%	\$573	\$5,854
DEPRESSION DISORDERS	MALES	61,120	42,538	3,877	\$25,940,610	9.11%	\$610	\$6,691
BIPOLAR DISORDERS	FEMALES	57,768	40,424	497	\$7,212,122	1.23%	\$178	\$14,511
BIPOLAR DISORDERS	MALES	61,120	42,538	614	\$9,871,612	1.44%	\$232	\$16,078
ANXIETY DISORDERS	FEMALES	57,768	40,424	2,542	\$21,637,757	6.29%	\$535	\$8,512
ANXIETY DISORDERS	MALES	61,120	42,538	1,948	\$18,445,574	4.58%	\$434	\$9,469
ADJUSTMENT DISORDER	FEMALES	57,768	40,424	4,987	\$21,705,498	12.34%	\$537	\$4,352
ADJUSTMENT DISORDER	MALES	61,120	42,538	4,519	\$20,188,168	10.62%	\$475	\$4,467
OTHER MH	FEMALES	57,768	40,424	2,533	\$16,180,460	6.27%	\$400	\$6,388
OTHER MH	MALES	61,120	42,538	3,009	\$21,900,894	7.07%	\$515	\$7,278
DEFERRED/MISSING	FEMALES	57,768	40,424	3,233	\$22,870,884	8.00%	\$566	\$7,074
DEFERRED/MISSING	MALES	61,120	42,538	3,644	\$25,455,308	8.58%	\$598	\$6,986
Total		n/a	n/a	44,163	\$278,839,472	53.23%	\$3,361	\$6,314



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION

A map of California is shown within a black rectangular border. The state of California is outlined in grey. A small white rectangle highlights the San Bernardino region in the central-eastern part of the state.

Attachment 22

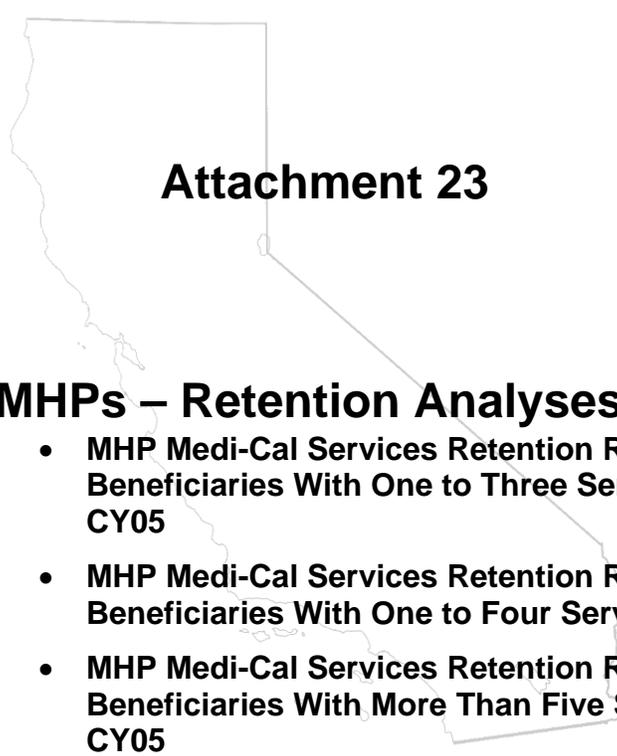
San Bernardino MHP – Foster Care Analysis



**Medi-Cal Approved Claims Data
Foster Care Beneficiaries
for San Bernardino County MHP
Fiscal Year 04-05**

Date Prepared: June 8, 2006/Version 2.0
Prepared by: Bill Ulloa/APS Healthcare/CA-EQRO
Information Source: DMH Approved Claims Summary Data
DMH Process Date: April 14, 2006

Diagnosis	San Bernardino		Foster Care		Foster Care		Foster Care		Foster Care		Foster Care		Foster Care																											
	Unduplicated Eligibles	Average Monthly Unduplicated Eligibles	Unduplicated Beneficiaries Served	Approved Amount	Penetration Rate	Average Monthly Approved Claims Unsup. Eligibles	Approved Claims Per Unduplicated Beneficiary Served	Penetration Rate	Average Monthly Approved Claims Unsup. Eligibles	Approved Claims Per Unduplicated Beneficiary Served	Penetration Rate	Average Monthly Approved Claims Unsup. Eligibles	Approved Claims Per Unduplicated Beneficiary Served																											
Diagnosis	S	A	B	E	R	N	A	R	D	I	N	O	F	O	S	T	E	R	C	A	R	E	S	O	U	T	H	E	R	N	F	O	S	T	E	R	C	A	R	E
ADHD&CONDUCT DISORDERS	7,409	5,016	706	\$1,556,675	14.07%	\$310	\$2,205	8.78%	\$318	\$3,625	8.78%	\$318	\$3,625																											
SCHIZOPHRENIA&BOTH PSYCH	7,409	5,016	24	\$55,889	0.48%	\$13	\$2,745	0.30%	\$15	\$4,910	0.30%	\$15	\$4,910																											
DEPRESSION DISORDERS	7,409	5,016	487	\$1,791,143	9.71%	\$367	\$3,678	7.05%	\$333	\$4,717	7.05%	\$333	\$4,717																											
BIPOLAR DISORDERS	7,409	5,016	53	\$326,998	1.05%	\$65	\$6,170	1.04%	\$122	\$11,669	1.04%	\$122	\$11,669																											
ANXIETY DISORDERS	7,409	5,016	166	\$757,972	3.31%	\$151	\$4,566	2.90%	\$180	\$6,185	2.90%	\$180	\$6,185																											
ADJUSTMENT DISORDER	7,409	5,016	517	\$936,009	10.31%	\$186	\$1,809	9.87%	\$286	\$2,898	9.87%	\$286	\$2,898																											
OTHER MH	7,409	5,016	442	\$1,678,989	8.81%	\$335	\$3,799	8.68%	\$353	\$4,068	8.68%	\$353	\$4,068																											
DEFERRED/MISSING	7,409	5,016	82	\$310,616	1.53%	\$62	\$3,788	13.71%	\$830	\$6,052	13.71%	\$830	\$6,052																											
Diagnosis & Gender	S	A	B	E	R	N	A	R	D	I	N	O	F	O	S	T	E	R	C	A	R	E	S	O	U	T	H	E	R	N	F	O	S	T	E	R	C	A	R	E
ADHD&CONDUCT DISORDERS FEMALES	3,636	2,515	197	\$402,877	7.83%	\$160	\$2,045	5.05%	\$176	\$3,478	5.05%	\$176	\$3,478																											
ADHD&CONDUCT DISORDERS MALES	3,773	2,501	509	\$1,153,798	20.35%	\$461	\$2,267	12.34%	\$454	\$3,662	12.34%	\$454	\$3,662																											
SCHIZOPHRENIA&BOTH PSYCH FEMALES	3,636	2,515	11	\$42,164	0.44%	\$17	\$3,833	0.20%	\$10	\$5,094	0.20%	\$10	\$5,094																											
SCHIZOPHRENIA&BOTH PSYCH MALES	3,773	2,501	13	\$23,724	0.52%	\$9	\$1,825	0.40%	\$19	\$4,822	0.40%	\$19	\$4,822																											
DEPRESSION DISORDERS FEMALES	3,636	2,515	242	\$967,583	9.62%	\$385	\$3,998	7.45%	\$334	\$4,479	7.45%	\$334	\$4,479																											
DEPRESSION DISORDERS MALES	3,773	2,501	245	\$823,560	9.80%	\$329	\$3,361	6.66%	\$331	\$4,973	6.66%	\$331	\$4,973																											
BIPOLAR DISORDERS FEMALES	3,636	2,515	20	\$132,743	0.80%	\$53	\$5,637	0.84%	\$75	\$6,974	0.84%	\$75	\$6,974																											
BIPOLAR DISORDERS MALES	3,773	2,501	33	\$194,255	1.32%	\$78	\$5,887	1.24%	\$166	\$13,423	1.24%	\$166	\$13,423																											
ANXIETY DISORDERS FEMALES	3,636	2,515	95	\$366,849	3.78%	\$154	\$4,072	3.55%	\$208	\$5,853	3.55%	\$208	\$5,853																											
ANXIETY DISORDERS MALES	3,773	2,501	71	\$371,123	2.84%	\$148	\$5,227	2.28%	\$152	\$6,681	2.28%	\$152	\$6,681																											
ADJUSTMENT DISORDER FEMALES	3,636	2,515	283	\$476,474	11.25%	\$189	\$1,684	10.95%	\$320	\$2,920	10.95%	\$320	\$2,920																											
ADJUSTMENT DISORDER MALES	3,773	2,501	234	\$466,535	9.36%	\$183	\$1,960	8.83%	\$254	\$2,872	8.83%	\$254	\$2,872																											
OTHER MH FEMALES	3,636	2,515	209	\$836,335	8.31%	\$333	\$4,002	8.11%	\$308	\$3,791	8.11%	\$308	\$3,791																											
OTHER MH MALES	3,773	2,501	233	\$842,655	9.32%	\$337	\$3,617	9.22%	\$397	\$4,301	9.22%	\$397	\$4,301																											
DEFERRED/MISSING FEMALES	3,636	2,515	51	\$216,787	2.03%	\$87	\$4,290	13.41%	\$790	\$5,895	13.41%	\$790	\$5,895																											
DEFERRED/MISSING MALES	3,773	2,501	31	\$91,830	1.24%	\$37	\$2,962	14.01%	\$668	\$5,197	14.01%	\$668	\$5,197																											

A faint outline map of the state of California is visible in the background of the text.

Attachment 23

MHPs – Retention Analyses

- **MHP Medi-Cal Services Retention Rates – Beneficiaries With One to Three Services During CY05**
- **MHP Medi-Cal Services Retention Rates – Beneficiaries With One to Four Services During CY05**
- **MHP Medi-Cal Services Retention Rates – Beneficiaries With More Than Five Services During CY05**

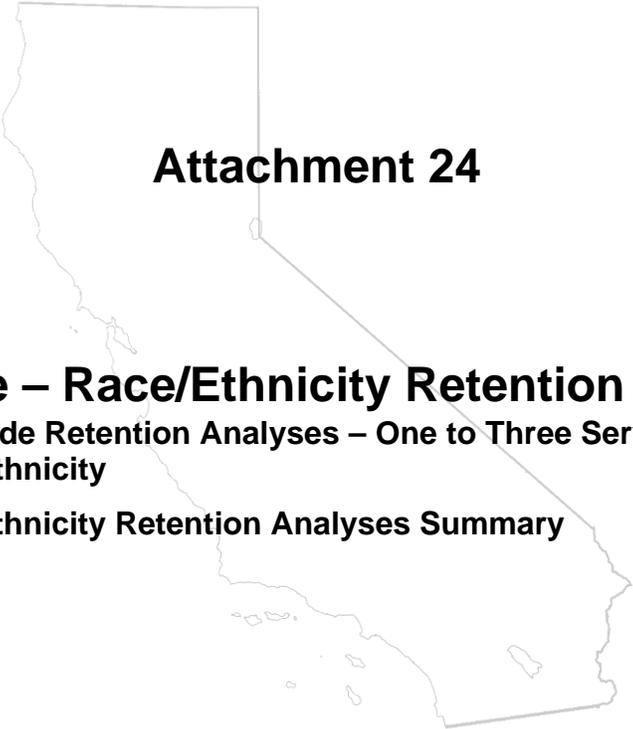
MHP Medi-Cal Services Retention Rates								
Beneficiaries With One to Three Services During CY05								
MHP	One Service Number Beneficiary	One Service Percent	Two Services Number Beneficiary	Two Services Percent	Three Services Number Beneficiary	Three Services Percent	Cumulative Number Beneficiary	Cumulative Percent
STATEWIDE	36,709	8.69	26,782	6.34	22,822	5.40	86,313	20.43
SIERRA	3	25.00	1	8.33	1	8.33	5	41.66
SAN JOAQUIN	1,257	14.30	1,152	13.09	1,005	11.47	3,414	38.86
MODOC	30	15.71	22	11.52	17	8.90	69	36.13
AMADOR	59	16.71	33	9.35	34	9.63	126	35.69
ALPINE	3	17.65	1	5.88	2	11.76	6	35.29
COLUSA	35	10.70	45	13.76	29	9.17	109	33.63
INYO	41	13.91	27	8.94	28	9.27	96	32.12
MARIPOSA	39	14.55	31	11.57	13	4.85	83	30.97
STANISLAUS	1,438	18.31	519	6.62	402	5.12	2,359	30.05
MERCED	488	15.44	241	7.64	211	6.63	940	29.71
DEL NORTE	137	13.48	90	8.96	53	5.31	280	27.75
LAKE	192	14.55	104	7.88	63	4.85	359	27.28
FRESNO	1,583	11.62	1,158	8.43	927	6.84	3,668	26.89
TEHAMA	154	10.81	135	9.48	92	6.46	381	26.75
YOLO	275	13.69	147	7.28	109	5.40	531	26.37
CALAVERAS	39	10.25	44	11.00	20	4.75	103	26.00
SAN BENITO	67	9.81	57	8.49	50	7.32	174	25.62
MADERA	222	12.14	113	6.26	129	7.14	464	25.54
TUOLUMNE	104	10.78	83	7.67	68	6.50	255	24.95
ALAMEDA	2,217	11.55	1,359	7.03	1,175	6.12	4,751	24.70
RIVERSIDE	1,746	10.56	1,337	8.14	977	5.96	4,060	24.66
SAN BERNARDINO	2,275	9.32	1,962	8.11	1,672	6.96	5,909	24.39
HUMBOLDT	307	10.52	230	7.88	170	5.82	707	24.22
EL DORADO	177	11.88	97	6.58	80	5.44	354	23.90
LASSEN	78	11.05	50	7.13	39	5.31	167	23.49
PLUMAS	40	11.63	24	6.98	15	4.65	79	23.26
KINGS	252	10.64	128	5.42	148	6.40	528	22.46
SHASTA	480	11.91	237	5.90	161	4.04	878	21.85
MENDOCINO	176	9.17	120	6.22	116	6.11	412	21.50
SAN LUIS OBISPO	281	9.86	183	6.49	139	4.88	603	21.23
NAPA	92	8.36	71	6.22	74	6.58	237	21.16
SAN DIEGO	2,237	7.22	2,012	6.46	2,326	7.44	6,575	21.12
VENTURA	461	8.44	410	7.52	272	4.98	1,143	20.94
SAN MATEO	309	7.64	277	6.82	250	6.16	836	20.62
BUTTE	468	9.98	297	6.32	201	4.30	966	20.60
SUTTER/YUBA	246	8.52	188	6.54	155	5.30	589	20.36
ORANGE	1,815	9.05	1,204	5.95	1,061	5.33	4,080	20.33
CONTRA COSTA	712	7.70	608	6.58	521	5.69	1,841	19.97
GLENN	68	10.95	38	6.12	18	2.90	124	19.97
PLACER	187	8.18	145	6.24	116	5.04	448	19.46
LOS ANGELES	9,944	8.06	7,063	5.74	6,055	4.90	23,062	18.70
TULARE	481	7.65	408	6.43	278	4.39	1,167	18.47
MONTEREY	244	7.19	158	4.68	221	6.57	623	18.44
SOLANO	212	6.18	213	6.20	203	5.91	628	18.29
MARIN	189	8.41	118	5.23	96	4.38	403	18.02
KERN	876	6.81	814	6.30	581	4.51	2,271	17.62
NEVADA	65	9.08	39	5.36	20	2.89	124	17.33
IMPERIAL	60	2.13	372	13.19	52	1.84	484	17.16
SANTA CLARA	786	6.67	575	4.86	581	4.84	1,942	16.37
TRINITY	27	7.74	16	4.58	14	4.01	57	16.33
MONO	7	7.61	5	5.43	3	3.26	15	16.30
SANTA CRUZ	213	7.86	103	3.84	107	4.02	423	15.72
SACRAMENTO	1,434	6.91	901	4.31	769	3.71	3,104	14.93
SAN FRANCISCO	828	5.94	638	4.58	580	4.18	2,046	14.70
SISKIYOU	79	5.92	69	5.24	44	3.34	192	14.50
SANTA BARBARA	267	5.16	216	4.17	195	3.71	678	13.04
SONOMA	207	6.57	94	3.21	84	2.86	385	12.64

MHP Medi-Cal Services Retention Rates										
Beneficiaries With One to Four Services During CY05										
MHP	One Service Number Beneficiary	One Service Percent	Two Services Number Beneficiary	Two Services Percent	Three Services Number Beneficiary	Three Services Percent	Four Services Number Beneficiary	Four Services Percent	Cumulative Number Beneficiary	Cumulative Percent
STATEWIDE	36,709	8.69	26,782	6.34	22,822	5.40	20,504	4.85	106,817	25.28
ALPINE	3	17.65	1	5.88	2	11.76	3	17.65	9	52.94
SAN JOAQUIN	1,257	14.30	1,152	13.09	1,005	11.47	810	9.20	4,224	48.06
AMADOR	59	16.71	33	9.35	34	9.63	31	8.73	157	44.42
SIERRA	3	25.00	1	8.33	1	8.33	0	0.00	5	41.66
MODOC	30	15.71	22	11.52	17	8.90	8	4.17	77	40.30
COLUSA	35	10.70	45	13.76	29	9.17	21	6.42	130	40.05
MARIPOSA	39	14.55	31	11.57	13	4.85	20	7.46	103	38.43
MERCED	488	15.44	241	7.64	211	6.63	221	6.97	1,161	36.68
INYO	41	13.91	27	8.94	28	9.27	13	4.30	109	36.42
STANISLAUS	1,438	18.31	519	6.62	402	5.12	369	6.09	2,728	36.14
FRESNO	1,583	11.62	1,158	8.43	927	6.84	1,087	7.94	4,755	34.83
DEL NORTE	137	13.48	90	8.96	53	5.31	60	5.91	340	33.66
YOLO	275	13.69	147	7.28	109	5.40	118	5.40	649	31.77
LAKE	192	14.55	104	7.88	63	4.85	56	4.24	415	31.52
CALAVERAS	39	10.25	44	11.00	20	4.75	20	4.96	123	30.96
SAN BENITO	67	9.81	57	8.49	50	7.32	34	4.98	208	30.60
MADERA	222	12.14	113	6.26	129	7.14	89	4.88	553	30.42
RIVERSIDE	1,746	10.56	1,337	8.14	977	5.96	949	5.68	5,009	30.34
SAN BERNARDINO	2,275	9.32	1,962	8.11	1,672	6.96	1,431	5.80	7,340	30.19
TEHAMA	154	10.81	135	9.48	92	6.46	92	2.87	473	29.62
TUOLUMNE	104	10.78	83	7.67	68	6.50	56	4.61	311	29.56
HUMBOLDT	307	10.52	230	7.88	170	5.82	145	4.97	852	29.19
ALAMEDA	2,217	11.55	1,359	7.03	1,175	6.12	862	4.47	5,613	29.17
LASSEN	78	11.05	50	7.13	39	5.31	37	5.17	204	28.66
KINGS	252	10.64	128	5.42	148	6.40	141	5.97	669	28.43
EL DORADO	177	11.88	97	6.58	80	5.44	63	4.23	417	28.13
PLUMAS	40	11.63	24	6.98	15	4.65	16	4.64	95	27.90
MENDOCINO	176	9.17	120	6.22	116	6.11	105	5.43	517	26.93
SAN DIEGO	2,237	7.22	2,012	6.46	2,326	7.44	1,803	5.71	8,378	26.83
SUTTER/YUBA	246	8.52	188	6.54	155	5.30	176	6.46	765	26.82
VENTURA	461	8.44	410	7.52	272	4.98	256	5.68	1,399	26.62
SHASTA	480	11.91	237	5.90	161	4.04	166	4.12	1,044	25.97
NAPA	92	8.36	71	6.22	74	6.58	52	4.61	289	25.77
SAN MATEO	309	7.64	277	6.82	250	6.16	204	5.04	1,040	25.66
CONTRA COSTA	712	7.70	608	6.58	521	5.69	501	5.40	2,342	25.37
ORANGE	1,815	9.05	1,204	5.95	1,061	5.33	989	4.88	5,069	25.21
BUTTE	468	9.98	297	6.32	201	4.30	210	4.47	1,176	25.07
SAN LUIS OBISPO	281	9.86	183	6.49	139	4.88	104	3.65	707	24.88
PLACER	187	8.18	145	6.24	116	5.04	118	5.07	566	24.53
GLENN	68	10.95	38	6.12	18	2.90	25	4.03	149	24.00
TULARE	481	7.65	408	6.43	278	4.39	266	5.38	1,433	23.85
LOS ANGELES	9,944	8.06	7,063	5.74	6,055	4.90	5,645	4.48	28,707	23.18
MONTEREY	244	7.19	158	4.68	221	6.57	144	4.25	767	22.69
NEVADA	65	9.08	39	5.36	20	2.89	32	4.40	156	21.73
MARIN	189	8.41	118	5.23	96	4.38	82	3.62	485	21.64
KERN	876	6.81	814	6.30	581	4.51	474	3.67	2,745	21.29
IMPERIAL	60	2.13	372	13.19	52	1.84	114	4.04	598	21.20
SISKIYOU	79	5.92	69	5.24	44	3.34	37	6.23	229	20.73
MONO	7	7.61	5	5.43	3	3.26	4	4.35	19	20.65
SOLANO	212	6.18	213	6.20	203	5.91	214	2.25	842	20.54
TRINITY	27	7.74	16	4.58	14	4.01	10	4.15	67	20.48
SANTA CLARA	786	6.67	575	4.86	581	4.84	491	4.09	2,433	20.46
SACRAMENTO	1,434	6.91	901	4.31	769	3.71	727	3.48	3,831	18.41
SANTA CRUZ	213	7.86	103	3.84	107	4.02	72	2.65	495	18.37
SAN FRANCISCO	828	5.94	638	4.58	580	4.18	509	3.63	2,555	18.33
SONOMA	207	6.57	94	3.21	84	2.86	71	4.69	456	17.33
SANTA BARBARA	267	5.16	216	4.17	195	3.71	151	2.88	829	15.92

MHP Medi-Cal Services Retention Rates						
Beneficiaries With More Than Five Services During CY05						
MHP	Five to Fifteen Services - Number Beneficiary	Five to Fifteen Services Percent	More Than Fifteen Services Number Beneficiary	More Than Fifteen Services Percent	Cumulative Number Beneficiary	Cumulative Percent
STATEWIDE	134,586	31.86	180,966	42.85	315,552	74.71
ALPINE	6	35.29	2	11.76	8	47.05
SAN JOAQUIN	2,641	30.00	1,937	22.01	4,578	52.01
AMADOR	132	37.18	66	18.59	198	55.77
SIERRA	0	0.00	7	58.33	7	58.33
MODOC	60	31.25	55	28.65	115	59.90
COLUSA	101	30.89	96	29.36	197	60.25
MARIPOSA	106	39.55	59	22.01	165	61.56
MERCED	1,159	36.57	849	26.79	2,008	63.36
INYO	84	27.81	109	36.09	193	63.90
FRESNO	4,107	29.99	4,833	35.29	8,940	65.28
STANISLAUS	2,077	26.38	3,067	38.96	5,144	65.34
DEL NORTE	338	33.27	338	33.27	676	66.54
TEHAMA	537	37.71	414	29.07	951	66.78
LAKE	358	27.10	548	41.48	906	68.58
YOLO	696	33.49	733	35.27	1,429	68.76
CALAVERAS	133	33.00	147	36.48	280	69.48
SAN BENITO	236	34.55	239	34.99	475	69.54
MADERA	634	34.74	638	34.96	1,272	69.70
RIVERSIDE	6,602	39.52	5,094	30.49	11,696	70.01
TUOLUMNE	275	26.44	454	43.65	729	70.09
SAN BERNARDINO	10,241	41.54	7,074	28.69	17,315	70.23
HUMBOLDT	961	32.92	1,106	37.89	2,067	70.81
ALAMEDA	5,176	26.84	8,497	44.06	13,673	70.90
LASSEN	207	28.91	305	42.60	512	71.51
KINGS	782	33.09	912	38.60	1,694	71.69
EL DORADO	467	31.32	607	40.71	1,074	72.03
PLUMAS	113	32.75	137	39.71	250	72.46
MENDOCINO	588	30.40	829	42.86	1,417	73.26
SAN DIEGO	10,948	34.68	12,247	38.79	23,195	73.47
SUTTER/YUBA	1,135	39.25	992	34.30	2,127	73.55
SHASTA	1,171	29.05	1,816	45.05	2,987	74.10
SAN MATEO	1,410	34.81	1,601	39.52	3,011	74.33
NAPA	327	28.96	513	45.44	840	74.40
CONTRA COSTA	2,841	30.64	4,090	44.11	6,931	74.75
VENTURA	1,832	32.97	2,326	41.86	4,158	74.83
BUTTE	1,542	32.80	1,983	42.18	3,525	74.98
ORANGE	7,957	39.25	7,247	35.75	15,204	75.00
SAN LUIS OBISPO	832	29.16	1,314	46.06	2,146	75.22
SOLANO	1,128	32.85	1,464	42.63	2,592	75.48
PLACER	794	34.14	966	41.53	1,760	75.67
GLENN	196	31.56	276	44.44	472	76.00
LOS ANGELES	38,306	30.37	59,124	46.87	97,430	77.24
MONTEREY	862	25.44	1,759	51.92	2,621	77.36
TULARE	1,756	27.37	3,226	50.29	4,982	77.66
MARIN	603	26.65	1,175	51.92	1,778	78.57
NEVADA	211	28.98	361	49.59	572	78.57
KERN	2,892	22.41	7,270	56.33	10,162	78.74
IMPERIAL	692	24.50	1,534	54.32	2,226	78.82
MONO	37	40.22	36	39.13	73	79.35
SANTA CLARA	3,922	32.69	5,642	47.03	9,564	79.72
TRINITY	76	21.78	206	59.03	282	80.81
SACRAMENTO	7,167	34.31	9,893	47.36	17,060	81.67
SAN FRANCISCO	4,159	29.70	7,289	52.05	11,448	81.75
SANTA CRUZ	547	20.10	1,680	61.72	2,227	81.82
SISKIYOU	341	25.85	749	56.79	1,090	82.64
SANTA BARBARA	1,259	24.01	3,156	60.18	4,415	84.19
SONOMA	826	26.13	1,879	59.44	2,705	85.57



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 24

Statewide – Race/Ethnicity Retention Analyses

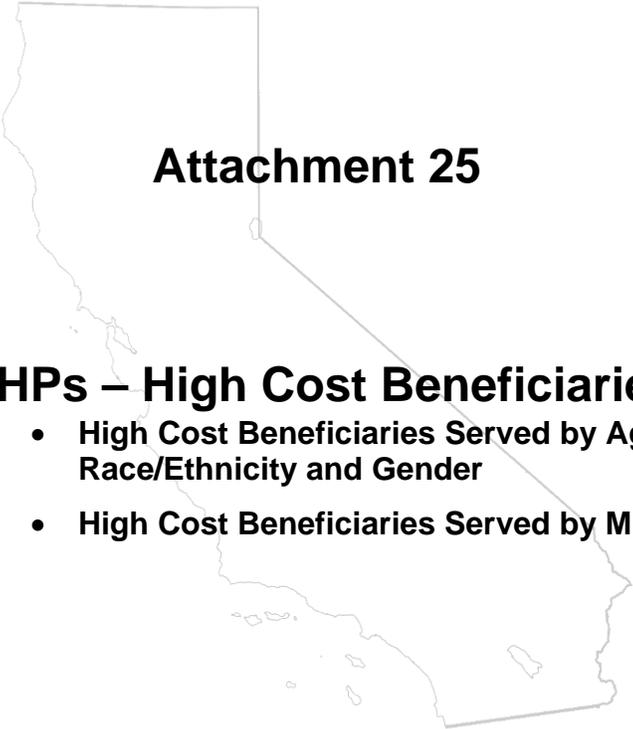
- **Statewide Retention Analyses – One to Three Services by Race/Ethnicity**
- **Race/Ethnicity Retention Analyses Summary**

Statewide Retention Analysis - One to Three Services by Race/Ethnicity			
	Cumulative Number Beneficiaries	Cumulative Percent	Cumulative Amount Per Beneficiary
WHITE	36,957	20.75	\$971
HISPANIC	23,434	21.60	\$1,036
AFRICAN-AMERICAN	15,452	22.03	\$1,018
ASIAN/PACIFIC ISLANDER	5,891	16.53	\$809
NATIVE AMERICAN	751	21.88	\$1,135
OTHER	3,828	14.36	\$860

Race/Ethnicity Retention Analysis Summary									
	One Service Number Beneficiaries	One Service Percent	One Service Amount Per Beneficiary	Two Services Number Beneficiary	Two Services Percent	Two Services Amount Per Beneficiary	Three Services Number Beneficiary	Three Services Percent	Three Services Amount Per Beneficiary
WHITE	15,932	8.95	\$204	11,528	6.47	\$326	9,497	5.33	\$441
HISPANIC	10,143	9.35	\$213	7,230	6.66	\$338	6,061	5.59	\$485
AFRICAN-AMERICAN	6,691	9.54	\$212	4,708	6.71	\$345	4,053	5.78	\$461
ASIAN/PACIFIC ISLANDER	2,209	6.20	\$176	1,782	5.00	\$274	1,900	5.33	\$359
NATIVE AMERICAN	335	9.76	\$230	233	6.79	\$385	183	5.33	\$520
OTHER	1,399	5.25	\$197	1,301	4.88	\$286	1,128	4.23	\$377



CALIFORNIA EXTERNAL QUALITY REVIEW ORGANIZATION



Attachment 25

MHPs – High Cost Beneficiaries

- **High Cost Beneficiaries Served by Age, Race/Ethnicity and Gender**
- **High Cost Beneficiaries Served by MHP**

Statewide - High Cost Beneficiaries Served by Age Groups												
	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles Served	Total Beneficiaries Served	Percent of Beneficiaries Served	High Cost Beneficiaries Served	Percent of High Cost Beneficiaries Served	Total Approved Claims	High Cost Approved Claims	High Cost Approved Percent	Average - Cost Per Beneficiary Served	Median - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
Statewide	6,810,962	100%	422,369	100%	8,171	1.91%	\$1,682,808,897	\$393,503,188	23.38%	\$48,159	\$41,731	\$20,218
Age 0-15	2,989,125	44%	134,514	32%	3,228	2.40%	\$645,441,733	\$162,402,967	25.16%	\$50,311	\$43,095	\$23,018
Age 16-25	962,798	14%	65,867	16%	1,847	2.80%	\$321,274,358	\$89,439,485	27.84%	\$48,424	\$41,302	\$21,022
Age 26-59	1,879,568	28%	190,171	45%	2,886	1.52%	\$642,287,920	\$132,427,446	20.62%	\$45,886	\$40,873	\$15,931
Age 60+	979,472	14%	31,817	8%	210	0.66%	\$73,804,885	\$9,233,289	12.51%	\$43,968	\$39,168	\$15,196

Statewide - High Cost Beneficiaries Served by Race/Ethnicity Categories												
	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles Served	Total Beneficiaries Served	Percent of Beneficiaries Served	High Cost Beneficiaries Served	Percent of High Cost Beneficiaries Served	Total Approved Claims	High Cost Approved Claims	High Cost Approved Percent	Average - Cost Per Beneficiary Served	Median - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
Statewide	6,810,962	100%	422,369	100%	8,171	1.91%	\$1,682,808,897	\$393,503,188	23.38%	\$48,159	\$41,731	\$20,218
WHITE	1,459,927	21%	178,039	42%	3,862	2.17%	\$740,790,264	\$186,470,766	25.17%	\$48,283	\$42,045	\$20,225
HISPANIC	3,576,788	53%	108,519	26%	1,420	1.31%	\$388,528,907	\$67,122,532	17.28%	\$47,269	\$40,376	\$19,858
AFRICAN-AMERICAN	705,805	10%	70,113	17%	1,617	2.31%	\$300,569,163	\$76,637,876	25.50%	\$47,395	\$40,690	\$19,974
ASIAN/PACIFIC ISLANDER	689,112	10%	35,621	8%	536	1.50%	\$116,478,648	\$26,964,809	23.15%	\$50,307	\$43,355	\$22,413
NATIVE AMERICAN	29,828	0.4%	3,434	1%	63	1.83%	\$14,289,541	\$3,038,116	21.26%	\$48,224	\$42,330	\$18,306
OTHER	349,503	5%	26,643	6%	673	2.53%	\$122,152,373	\$33,269,090	27.24%	\$49,434	\$43,908	\$19,700

Statewide - High Cost Beneficiaries Served by Gender												
	Total Medi-Cal Eligibles	Percent of Medi-Cal Eligibles Served	Total Beneficiaries Served	Percent of Beneficiaries Served	High Cost Beneficiaries Served	Percent of High Cost Beneficiaries Served	Total Approved Claims	High Cost Approved Claims	High Cost Approved Percent	Average - Cost Per Beneficiary Served	Median - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
Statewide	6,810,962	100%	422,369	100%	8,171	1.91%	\$1,682,808,897	\$393,503,188	23.38%	\$48,159	\$41,731	\$20,218
FEMALES	3,873,207	57%	221,267	52%	3,405	1.54%	\$770,292,377	\$164,178,379	21.31%	\$48,217	\$41,509	\$20,379
MALES	2,937,749	43%	201,102	48%	4,766	2.37%	\$912,516,521	\$229,324,809	25.13%	\$48,117	\$41,822	\$20,105

Statewide - High Cost Beneficiaries Served by MHP											
MHP	Total Medi-Cal Eligibles	Total Beneficiaries Served	Percent of Beneficiaries Served	High Cost Beneficiaries Served	Percent of High Cost Beneficiaries Served	Total Approved Claims	High Cost Approved Claims	High Cost Approved Percent	Average - Cost Per Beneficiary Served	Median - Cost Per Beneficiary Served	Std. Dev. - Cost Per Beneficiary Served
Statewide	6,810,962	422,369	6.20%	8,171	1.91%	\$1,682,808,897	\$393,503,188	23.38%	\$48,159	\$41,731	\$20,218
SIERRA	480	12	2.50%	3	25.00%	\$141,338	\$112,898	79.74%	\$37,566	\$36,700	\$3,846
SANTA CRUZ	36,319	2,722	7.49%	324	11.90%	\$31,531,623	\$18,773,756	53.20%	\$51,771	\$45,925	\$20,757
SISKIYOU	10,352	1,319	12.74%	83	6.29%	\$10,804,883	\$4,347,888	40.24%	\$52,384	\$37,225	\$41,962
SANTA BARBARA	70,015	5,244	7.49%	236	4.50%	\$36,353,932	\$12,350,396	33.97%	\$52,332	\$43,428	\$23,640
SAN FRANCISCO	127,224	14,003	11.01%	618	4.41%	\$84,183,077	\$30,043,267	35.69%	\$48,614	\$42,944	\$20,591
MONTEREY	76,085	3,388	4.45%	\$141	4.16%	\$21,480,441	\$7,451,999	34.69%	\$52,851	\$44,138	\$24,493
CONTRA COSTA	114,548	8,273	8.10%	351	3.79%	\$49,316,393	\$17,062,973	34.60%	\$48,612	\$42,407	\$19,704
SONOMA	49,572	3,161	6.38%	103	3.26%	\$16,334,846	\$4,328,458	26.50%	\$42,024	\$37,044	\$12,270
VENTURA	109,190	5,557	5.08%	170	3.06%	\$25,887,259	\$8,735,138	33.73%	\$51,383	\$46,767	\$19,950
SANTA CLARA	229,051	11,997	5.24%	351	2.93%	\$60,115,179	\$20,238,800	33.67%	\$57,660	\$46,663	\$30,525
PLACER	24,534	2,326	9.48%	67	2.88%	\$10,374,080	\$3,508,108	33.82%	\$52,360	\$44,697	\$23,596
YOLO	29,005	2,078	7.16%	59	2.84%	\$7,770,876	\$2,507,079	32.26%	\$42,493	\$39,947	\$11,139
MARIN	17,815	2,263	12.70%	64	2.83%	\$12,067,559	\$2,860,761	22.05%	\$41,574	\$38,636	\$11,218
ALAMEDA	223,128	19,286	8.64%	529	2.74%	\$87,734,831	\$24,315,127	27.71%	\$45,964	\$39,979	\$18,842
MENDOCINO	21,944	1,934	8.81%	52	2.69%	\$7,931,479	\$2,643,197	33.33%	\$50,831	\$50,767	\$15,820
SOLANO	58,326	3,434	5.89%	78	2.27%	\$15,776,206	\$3,862,771	23.22%	\$46,959	\$39,703	\$21,372
HUMBOLDT	26,812	2,919	10.89%	66	2.26%	\$12,088,115	\$3,571,892	29.55%	\$54,120	\$42,289	\$33,921
SAN LUIS OBISPO	30,388	2,853	9.39%	60	2.10%	\$11,714,584	\$3,870,226	33.04%	\$64,504	\$52,481	\$37,152
LOS ANGELES	2,457,509	126,137	5.13%	2,628	2.08%	\$557,233,731	\$125,528,704	22.53%	\$47,766	\$42,017	\$18,562
SACRAMENTO	286,583	20,891	7.29%	416	1.99%	\$86,565,271	\$20,303,105	23.45%	\$48,806	\$43,712	\$19,520
SUTTER/YUBA	37,725	2,892	7.67%	53	1.83%	\$10,221,612	\$2,234,733	21.86%	\$42,165	\$37,856	\$12,959
NEVADA	8,721	728	8.35%	13	1.79%	\$2,730,753	\$587,748	21.52%	\$45,211	\$39,074	\$13,751
NAPA	13,445	1,129	8.40%	20	1.77%	\$5,058,197	\$838,828	16.58%	\$41,941	\$42,091	\$9,403
PLUMAS	2,810	345	12.28%	6	1.74%	\$1,465,352	\$212,408	14.50%	\$35,401	\$35,535	\$4,386
KERN	203,171	12,907	6.35%	187	1.45%	\$59,793,333	\$8,171,972	15.19%	\$43,700	\$36,074	\$15,015
SAN DIEGO	356,422	31,573	8.86%	448	1.42%	\$103,854,685	\$20,053,000	19.35%	\$44,761	\$39,940	\$14,786
BUTTE	48,049	4,701	9.78%	60	1.28%	\$18,658,195	\$2,412,986	12.93%	\$40,216	\$36,309	\$12,644
STANISLAUS	120,413	7,872	6.54%	98	1.24%	\$28,042,963	\$4,489,585	16.01%	\$45,812	\$41,085	\$15,242
LAKE	15,531	1,321	8.51%	15	1.14%	\$4,011,085	\$714,256	17.81%	\$47,617	\$36,850	\$31,540
MONO	1,320	92	6.97%	1	1.09%	\$266,676	\$32,853	12.32%	\$32,853	\$32,853	
ORANGE	378,760	20,273	5.35%	218	1.08%	\$56,198,001	\$10,315,064	18.35%	\$47,317	\$41,743	\$17,652
LASSEN	5,276	716	13.57%	7	0.98%	\$3,070,981	\$380,338	12.38%	\$54,334	\$39,650	\$30,820
GLENN	6,998	621	8.88%	8	0.97%	\$2,322,938	\$236,498	10.18%	\$39,416	\$35,403	\$10,674
RIVERSIDE	299,982	16,705	5.57%	159	0.95%	\$41,180,218	\$7,683,327	18.66%	\$48,323	\$41,297	\$19,972
FRESNO	271,763	13,695	5.04%	122	0.89%	\$40,295,234	\$5,344,184	13.26%	\$43,805	\$39,258	\$13,126
TUOLUMNE	7,433	1,040	13.99%	8	0.77%	\$2,938,101	\$339,004	11.54%	\$42,375	\$39,829	\$12,537
IMPERIAL	49,234	2,824	5.74%	19	0.67%	\$8,913,880	\$706,766	7.93%	\$37,198	\$34,036	\$7,496
SAN BERNARDINO	384,306	24,655	6.42%	166	0.67%	\$62,591,310	\$7,217,089	11.53%	\$43,476	\$38,413	\$14,997
INYO	3,090	302	9.77%	2	0.66%	\$1,060,752	\$62,777	5.92%	\$31,389	\$31,389	\$1
TULARE	142,140	6,415	4.51%	41	0.64%	\$21,564,466	\$2,003,497	9.29%	\$48,866	\$39,739	\$24,086
COLUSA	4,939	327	6.62%	2	0.61%	\$742,825	\$64,136	8.63%	\$32,068	\$32,068	\$2,441
SHASTA	37,515	4,031	10.75%	22	0.55%	\$10,987,333	\$893,790	8.13%	\$40,627	\$35,369	\$12,198
SAN MATEO	65,453	4,051	6.19%	22	0.54%	\$10,571,997	\$912,224	8.63%	\$41,465	\$38,506	\$12,458
EL DORADO	15,199	1,491	9.81%	7	0.47%	\$4,025,619	\$288,058	7.16%	\$41,151	\$41,168	\$9,088
MERCED	74,240	3,189	4.27%	15	0.47%	\$7,137,795	\$627,663	8.79%	\$41,844	\$36,298	\$13,478
KINGS	32,175	2,363	7.34%	10	0.42%	\$4,931,873	\$540,555	10.96%	\$54,055	\$52,263	\$19,291
TEHAMA	14,587	1,424	9.76%	6	0.42%	\$3,023,225	\$212,385	7.03%	\$35,398	\$34,510	\$3,793
MARIPOSA	2,547	268	10.52%	1	0.37%	\$436,283	\$41,279	9.46%	\$41,279	\$41,279	
SAN JOAQUIN	146,461	8,802	6.01%	\$33	0.37%	\$16,464,382	\$1,879,865	10.20%	\$50,905	\$36,285	\$26,337
TRINITY	2,751	349	12.69%	1	0.29%	\$1,478,233	\$32,621	2.21%	\$32,621	\$32,621	
DEL NORTE	8,034	1,016	12.65%	2	0.20%	\$1,881,037	\$86,133	4.58%	\$43,067	\$43,067	\$13,167
SAN BENITO	8,291	683	8.24%	1	0.15%	\$1,411,072	\$32,306	2.29%	\$32,306	\$32,306	
MADERA	37,580	1,825	4.86%	1	0.05%	\$4,525,233	\$38,937	0.86%	\$38,937	\$38,937	
ALPINE	192	17	8.85%	0	0.00%	\$39,965	\$0	0.00%			
AMADOR	3,482	355	10.20%	0	0.00%	\$458,185	\$0	0.00%			
CALAVERAS	5,204	403	7.74%	0	0.00%	\$662,291	\$0	0.00%			
MODOC	2,299	192	8.35%	0	0.00%	\$377,114	\$0	0.00%			