

***Volume 4 of 5***  
**Drug Medi-Cal**  
**Organized Delivery System**  
**External Quality Review**  
**Technical Report**  
*Contract Year 2024–25*

*2025 Validation of Network Adequacy*

California Department of Health Care Services

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## Drug Medi-Cal Organized Delivery System Plan Name Abbreviations

Health Services Advisory Group, Inc. (HSAG) uses the following abbreviated Drug Medi-Cal Organized Delivery System (DMC-ODS) plan names in this volume.

- ◆ **Alameda**—County of Alameda
- ◆ **Contra Costa**—County of Contra Costa
- ◆ **El Dorado**—County of El Dorado
- ◆ **Fresno**—County of Fresno
- ◆ **Imperial**—County of Imperial
- ◆ **Kern**—County of Kern
- ◆ **Los Angeles**—County of Los Angeles
- ◆ **Marin**—County of Marin
- ◆ **Mariposa**—County of Mariposa
- ◆ **Merced**—County of Merced
- ◆ **Monterey**—County of Monterey
- ◆ **Napa**—County of Napa
- ◆ **Nevada**—County of Nevada
- ◆ **Orange**—County of Orange
- ◆ **PHC**—Partnership HealthPlan of California Regional Model (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties)
- ◆ **Placer**—County of Placer
- ◆ **Riverside**—County of Riverside
- ◆ **Sacramento**—County of Sacramento
- ◆ **San Benito**—County of San Benito
- ◆ **San Bernardino**—County of San Bernardino
- ◆ **San Diego**—County of San Diego
- ◆ **San Francisco**—County of San Francisco
- ◆ **San Joaquin**—County of San Joaquin
- ◆ **San Luis Obispo**—County of San Luis Obispo
- ◆ **San Mateo**—County of San Mateo
- ◆ **Santa Barbara**—County of Santa Barbara
- ◆ **Santa Clara**—County of Santa Clara
- ◆ **Santa Cruz**—County of Santa Cruz
- ◆ **Stanislaus**—County of Stanislaus

- ◆ **Tulare**—County of Tulare
- ◆ **Ventura**—County of Ventura
- ◆ **Yolo**—County of Yolo

## Commonly Used Abbreviations and Acronyms

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

- ◆ §—section
- ◆ **ACCESS**—Acute Crisis Care and Evaluation for Systemwide Services
- ◆ **AEVS**—automated eligibility verification system
- ◆ **AODS**—Alcohol and Other Drugs Services
- ◆ **API**—Application Programming Interface
- ◆ **ARF**—access request form
- ◆ **ASAM**—American Society of Addiction Medicine
- ◆ **ASO**—Administrative Services Organization
- ◆ **BBH**—Board of Behavioral Health
- ◆ **BBS**—Board of Behavioral Sciences
- ◆ **BH**—behavioral health
- ◆ **BHD**—Behavioral Health Department
- ◆ **BHIN**—Behavioral Health Information Notice
- ◆ **BHIS**—Behavioral Health Information System
- ◆ **BHOMD**—Behavioral Health Oversight Monitoring Division
- ◆ **BHP**—Behavioral Health Plan
- ◆ **BHQM**—Behavioral Health Quality Management
- ◆ **BHRS**—Behavioral Health and Recovery Services
- ◆ **BHS**—Behavioral Health Services
- ◆ **BHSD**—Behavioral Health Services Department
- ◆ **BI**—business intelligence
- ◆ **BU**—business unit
- ◆ **CAADE**—California Association for Alcohol/Drug Educators
- ◆ **CAAT**—Central Access and Authorization Team
- ◆ **CADTP**—California Association of Driving Under the Influence Treatment Programs
- ◆ **CalAIM**—California Advancing and Innovating Medi-Cal
- ◆ **CalHHS**—California Health and Human Services Agency
- ◆ **CalMHSA**—California Mental Health Services Authority
- ◆ **CalOMS**—California Outcomes Measurement System
- ◆ **CAMS**—Crisis, Access, and Medication Services
- ◆ **CAP**—corrective action plan
- ◆ **CAQH**—Council for Affordable Quality Healthcare

- ◆ **CARE**—Community Assistance, Recovery and Empowerment
- ◆ **CARES**—Community Access, Referral, Evaluation, and Support
- ◆ **CARF**—Computer Access Request Form
- ◆ **CCAPP**—California Consortium of Addiction Programs and Professionals
- ◆ **CCBH**—Cerner Community Behavioral Health
- ◆ **CENS**—Client Engagement and Navigation Services
- ◆ **CFR**—Code of Federal Regulations
- ◆ **CHCA**—Certified Healthcare Effectiveness Data and Information Set (HEDIS®)<sup>1</sup>  
Compliance Auditor
- ◆ **CHIP**—Children’s Health Insurance Program
- ◆ **CIN**—Client Index Number
- ◆ **CMO**—chief medical officer
- ◆ **CMS**—Centers for Medicare & Medicaid Services
- ◆ **CRU**—Crisis Residential Unit
- ◆ **CSI**—Client Services Information
- ◆ **CSV**—comma separated values
- ◆ **CVO**—Credentials Verification Organization
- ◆ **CYF**—Child, Youth and Families
- ◆ **DAE**—Data Analytics and Evaluation
- ◆ **DATAR**—Drug and Alcohol Treatment Access Report
- ◆ **DBH**—Department of Behavioral Health
- ◆ **DCA**—California Department of Consumer Affairs
- ◆ **DDG**—Data De-Identification Guidelines
- ◆ **DEA**—Drug Enforcement Administration
- ◆ **DHCS**—California Department of Health Care Services
- ◆ **DMC-ODS**—Drug Medi-Cal Organized Delivery System
- ◆ **DOB**—date of birth
- ◆ **DOS**—date of service
- ◆ **DPH**—Department of Public Health
- ◆ **DSAA**—Data Science & Advanced Analytics
- ◆ **DUI**—driving under the influence
- ◆ **EDIM**—Enterprise Data Information Management
- ◆ **EHR**—electronic health record
- ◆ **EPLS**—Excluded Parties List System
- ◆ **EQR**—external quality review

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<sup>1</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ **EQRO**—external quality review organization
- ◆ **ESN**—Employee Status Notification
- ◆ **FFS**—fee-for-service
- ◆ **FTE**—full-time equivalent
- ◆ **FY**—fiscal year
- ◆ **HHS**—Health and Human Services
- ◆ **HHS A**—Health and Human Services Agency
- ◆ **HIMS**—Health Information Management System
- ◆ **HODA**—Health Outcomes and Data Analytics
- ◆ **HPA**—Health Plan Administration
- ◆ **HR**—human resources
- ◆ **HSAG**—Health Services Advisory Group, Inc.
- ◆ **HSR**—health service representative
- ◆ **ICL**—Initial Contact Log
- ◆ **InSync**—InSync Health Care Solutions
- ◆ **IRIS**—Integrated Record Information System
- ◆ **IS**—Information Systems or Information System
- ◆ **ISCA**—Information Systems Capabilities Assessment
- ◆ **ISCAT**—Information Systems Capabilities Assessment Tool
- ◆ **IT**—information technology
- ◆ **KPI**—key performance indicator
- ◆ **KPMG**—Klynveld Peat Marwick Goerdeler
- ◆ **LEIE**—List of Excluded Individuals and Entities
- ◆ **LOC**—level of care
- ◆ **MCO**—managed care organization
- ◆ **MCP**—managed care health plan
- ◆ **MEDS**—Medi-Cal Eligibility Data System
- ◆ **MEDSLITE**—Medi-Cal Eligibility Data System Lite
- ◆ **MHP**—mental health plan
- ◆ **MIS**—Management Information System
- ◆ **MMEF**—Monthly MEDS Extract File
- ◆ **MRN**—medical record number
- ◆ **MRU**—Management Reporting Unit
- ◆ **NACT**—Network Adequacy Certification Tool
- ◆ **NAOS**—Network Adequacy Oversight Section
- ◆ **NARF**—New Applicant Request Form
- ◆ **NAV**—network adequacy validation

- ◆ **NCQA**—National Committee for Quality Assurance
- ◆ **NPDB**—National Practitioner Data Bank
- ◆ **NPI**—National Provider Identifier
- ◆ **NPES**—National Plan and Provider Enumeration System
- ◆ **OEM**—Outcomes Evaluation Management
- ◆ **OIG**—Office of Inspector General
- ◆ **OTP**—opioid treatment program
- ◆ **PA**—patient accounts or physician assistant
- ◆ **PACT**—Provider Access Collection Tool
- ◆ **PAD**—Plan Administration Division
- ◆ **PAHP**—prepaid ambulatory health plan
- ◆ **PAR**—psychiatric appointment request
- ◆ **PAVE**—Provider Application and Validation for Enrollment
- ◆ **PCP**—primary care provider
- ◆ **PECOS**—Provider Enrollment, Chain, and Ownership System
- ◆ **PGE**—payor group enrollment
- ◆ **PHIS**—Public Health Information Systems
- ◆ **PIHP**—prepaid inpatient health plan
- ◆ **PSV**—primary source verification
- ◆ **QA**—quality assurance
- ◆ **QCM**—Quality Care Management
- ◆ **QI**—quality improvement
- ◆ **QIC**—Quality Improvement Committee
- ◆ **QM**—Quality Management
- ◆ **QMS**—Quality Management Services
- ◆ **QPM**—Quality and Performance Management
- ◆ **RCM**—Revenue Cycle Management
- ◆ **RFP**—request for proposal
- ◆ **RFS**—request for service
- ◆ **S**—suppressed
- ◆ **S&I**—suspended & ineligible
- ◆ **SAM**—System for Award Management
- ◆ **SAPC**—Substance Abuse Prevention and Control
- ◆ **SASH**—Substance Abuse Service Helpline
- ◆ **SBAT**—Service and Bed Availability Tool
- ◆ **SFTP**—secure file transfer protocol
- ◆ **SME**—subject matter expert

- ◆ **SOC**—System of Care
- ◆ **SPIF**—Service Provider Identification Form
- ◆ **SPSS**—Statistical Package for the Social Sciences
- ◆ **SQL**—Structured Query Language
- ◆ **SSN**—Social Security number
- ◆ **SSSD**—Self-Sufficiency Services Division
- ◆ **SUD**—substance use disorder
- ◆ **TADT**—Timely Access Data Tool
- ◆ **TSS**—Technology Solutions & Services
- ◆ **UI**—User Interface
- ◆ **VBA**—Visual Basic for Applications
- ◆ **VHP**—Valley Health Plan
- ◆ **WITS**—Web Infrastructure for Treatment Services
- ◆ **ZU**—zero utilization

# 1. Introduction

## Network Adequacy Validation Overview

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), as its external quality review organization (EQRO), to conduct network adequacy validation (NAV) for the Drug Medi-Cal Organized Delivery System (DMC-ODS) plans. This report will sometimes collectively refer to these DMC-ODS plans as “plans.” Title 42 of the Code of Federal Regulations (CFR) Section (§) 438.350(a) requires states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) to have a qualified EQRO perform an annual external quality review (EQR) that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries across the continuum of services. HSAG conducted NAV, validating the systems and processes, data sources, methods, and results, according to the Centers for Medicare & Medicaid Services (CMS) *EQR Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).<sup>2</sup>

HSAG worked with DHCS to identify applicable quantitative network adequacy standards by service and plan type to be validated. Information such as description of network adequacy data and documentation, information flow from plans to DHCS, prior year network adequacy reports, and additional supporting information relevant to network adequacy monitoring and validation were obtained from DHCS and incorporated into all phases of validation activities.

The purpose of NAV is to (1) assess the accuracy of state-defined network adequacy indicators; (2) evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used; and (3) determine the overall validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by the state. If states elect to calculate network adequacy results for each plan, the EQRO will validate the indicator level results produced by the state as if they were calculated by the plan, and validate the plan systems and processes, as well as source data provided to the state, to inform network adequacy analysis activities.

As the EQRO for the DHCS, HSAG was responsible for conducting the contract year 2024–25 validation of network adequacy indicators, confirming DHCS’ and each DMC-ODS plan’s ability

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<sup>2</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Jul 29, 2025.

to collect reliable and valid network adequacy monitoring data, use of sound methods to assess the adequacy of the managed care networks, and ability to produce accurate results to support DHCS' and DMC-ODS plans' network adequacy monitoring efforts.

HSAG completed the following CMS EQR Protocol 4 activities to conduct the NAV:

- ◆ **Defined the scope of the validation of quantitative network adequacy standards:** HSAG obtained information from DHCS (i.e., network adequacy standards, descriptions, and samples of documentation the plans submit to DHCS, a description of the network adequacy information flow, and any prior NAV reports), then worked with DHCS to identify and define network adequacy indicators and provider types, and to establish the NAV activities and timeline.
- ◆ **Identified data sources for validation:** HSAG worked with DHCS and the plans to identify NAV-related data sources and to answer clarifying questions regarding the data sources.
- ◆ **Reviewed information systems underlying network adequacy monitoring:** HSAG reviewed any previously completed plan Information Systems Capabilities Assessments (ISCAs), then assessed processes for collecting network adequacy data that were not addressed in the ISCA, completed a comprehensive NAV ISCA by collecting an updated Information Systems Capabilities Assessment Tool (ISCAT) from DHCS and each plan, and interviewed DHCS and plan staff members or other personnel involved in production of network adequacy results.
- ◆ **Validated network adequacy assessment data, methods, and results:** HSAG used the CMS EQR Protocol 4 Worksheet 4.6 to document each plan's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its networks, and produce accurate results that support DHCS' and the plans' network adequacy monitoring efforts. When evaluating DHCS and the plans for this validation step, HSAG assessed data reliability, accuracy, timeliness, and completeness; DHCS' and the plans' methods to assess network adequacy; and the validity of the network adequacy results that DHCS and the plans submitted. HSAG summarized its NAV findings, which are documented in the individual plan-specific sections of this report. HSAG did not assess compliance with State or federal requirements through the NAV activity; however, HSAG's compliance subject matter experts and DHCS evaluated any potential DMC-ODS plan-specific deviations from State and federal requirements for determination of non-compliance and appropriate follow-up and remediations with the DMC-ODS plans.
- ◆ **Communicated preliminary findings to each plan:** HSAG communicated preliminary NAV findings to DHCS and each plan that included findings, preliminary validation ratings, areas of potential concern, and recommendations for improvement. DHCS and each plan were provided the opportunity to correct any preliminary report omissions and/or errors.
- ◆ **Submitted the NAV findings to DHCS in the form of the NAV aggregate report:** HSAG used the state-approved NAV aggregate report template to document the NAV findings and submitted the draft and final NAV aggregate report according to the state-approved timeline.

Table 1.1 displays the plan names and State entity (i.e., DHCS) within the scope of review, review date, primary contact, and HSAG lead auditor.

**Table 1.1—List of Plans and State Entity in Scope of Review**

Plan Name/State Entity	Date	Primary Contact Name and Title	HSAG Lead Auditor
Alameda	March 19, 2025	Michelle Manor, Supervising Program Specialist, Quality Improvement (QI) and Data Analytics	AnnAlisa Cook
Contra Costa	April 21, 2025	Mark Messerer, Alcohol and Other Drugs Program Manager	Marian Seege
El Dorado	April 14, 2025	Shaun O'Malley, Acting Alcohol and Drug Programs Division Manager	Sumayyah Hackett
Fresno	May 8, 2025	Jeffrey Elliott, QI Coordinator	Tamieka Square
Imperial	February 27, 2025	Sarah Moore, Behavioral Health (BH) Manager	AnnAlisa Cook
Kern	April 10, 2025	Heather Williams, BH Program Supervisor	Tamieka Square
Los Angeles	April 17, 2025	Tina Kim, Division Chief, Health Outcomes and Data Analytics	Anne Gulley
Marin	April 1, 2025	Katie Smith, Behavioral Health and Recovery Services (BHRS) Division Director, Quality Management (QM)	Laura McDermott
Mariposa	April 22, 2025	Lynn Rumpfelt, Senior Administrative Analyst	Tamieka Square
Merced	April 8, 2025	Matthew Reed, BHRS Division Director	Anne Gulley
Monterey	February 24, 2025	Janet Barajas, BH Services Manager	Sumayyah Hackett

Plan Name/State Entity	Date	Primary Contact Name and Title	HSAG Lead Auditor
Napa	May 1, 2025	Nathan Hobbs, Assistant Deputy Director of BH	Marian Seege
Nevada	March 11, 2025	Priya Kannall, Program Manager, Behavioral Health Department (BHD)	Sumayyah Hackett
Orange	April 29, 2025	Sharon Ishikawa, Assistant Deputy Director Data Analytics and Evaluation (DAE)	Marian Seege
PHC	April 30, 2025	Nicole Escobar, Senior BH Manager	Rachel Spivey
Placer	February 26, 2025	Julia Soto, QM Program Manager	Marian Seege
Riverside	March 27, 2025	Suzanna Juarez-Williamson, Administrative Services Manager	Sumayyah Hackett
Sacramento	March 20, 2025	Alex Rechs, Health Program Manager, Quality Assurance (QA) Continuous QI	Laura McDermott
San Benito	April 7, 2025	Lindsay Garfield, QI Supervisor	Marian Seege
San Bernardino	April 7, 2025	Sarah Hayes, Program Manager II	Sumayyah Hackett
San Diego	March 20, 2025	Samantha Marquez, Administrative Analyst	Marian Seege
San Francisco	April 24, 2025	Lenh Tsan, QI Coordinator	Sumayyah Hackett
San Joaquin	March 10, 2025	Zarmeen Merchant, Information Systems Manager	Sumayyah Hackett
San Luis Obispo	March 19, 2025	Amanda Getten, Quality Support Services Division Manager	Sumayyah Hackett
San Mateo	April 23, 2025	Betty Ortiz-Gallardo, Manager, BHRS QM	Laura McDermott

Plan Name/State Entity	Date	Primary Contact Name and Title	HSAG Lead Auditor
Santa Barbara	April 28, 2025	Caitlin Lepore, Research and Evaluation Manager	Sumayyah Hackett
Santa Clara	March 19, 2025	Hung Nguyen, QI Division Director Rachel Potens, Program Manager III Veronica Marquez, Program Manager	Rachel Spivey
Santa Cruz	April 2, 2025	Subé Robertson, QI Director	Sumayyah Hackett
Stanislaus	May 2, 2025	Saksham Rana, Information Technology (IT) Manager	Rachel Spivey
Tulare	April 2, 2025	Betsy Ayello, Quality Manager Chandler Bailey, Quality Manager	Gina DeBlois
Ventura	March 10, 2025	Sloane Burt, QI Manager	Rachel Spivey
Yolo	March 25, 2025	Jennifer Gay, QM Clinical Manager	Gina DeBlois
DHCS	April 16, 2025	LaMonte Love, Staff Services Manager II Kaitlin Maye, Staff Services Manager I	Gina DeBlois

## Network Adequacy Standards and Indicators Validated

States that contract with MCOs, PIHPs, or PAHPs to provide Medicaid or CHIP services are required to develop quantitative network adequacy standards across a subset of provider types to set expectations for each contracted MCO's, PIHP's, or PAHP's provider network. States may elect to use a variety of quantitative standards including, but not limited to, minimum provider-to-enrollee ratios, time and distance, percentage of providers accepting new patients, and/or combinations of these quantitative measures. Based on the DHCS-identified network adequacy standards, DHCS and HSAG defined the network adequacy indicators, which HSAG then validated. The indicators are metrics used to assess adherence to the quantitative

network adequacy standards required and set forth by DHCS. HSAG worked with DHCS to identify the applicable network adequacy indicators to be validated for contract year 2024–25. The reporting period HSAG validated was Fiscal Year (FY) 2023–24.

Table 1.2 lists the network adequacy standards HSAG validated.

### Table 1.2—Timely Access

\* DHCS calculates population breakouts using the data the DMC-ODS plans submit—population stratification for youth 0–17 years of age and adults 18 years of age and over.

Modality Type*	Timeliness Standard
Outpatient Services—Outpatient Substance Use Disorder (SUD) and Residential	Offered an appointment within 10 business days of request for services (RFS)
Opioid Treatment Program (OTP)	Offered an appointment within three business days of RFS

## 2. Description of Validation Activities

### Pre-Validation Strategy

Validation of network adequacy consists of activities that fall into three phases: (1) planning, (2) analysis, and (3) reporting, as outlined in the CMS EQR Protocol 4. To complete validation activities for DHCS and plans, HSAG obtained all state-defined network adequacy standards and indicators.

HSAG prepared a document request packet that was submitted to DHCS and each plan, outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG’s ability to assess DHCS and the plans’ information systems and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with DHCS and the plans to identify all data sources informing calculation and reporting at the network adequacy indicator level. Data and documentation from DHCS and the plans were obtained through a single documentation request packet provided to DHCS and each plan.

HSAG hosted webinars to provide technical assistance to DHCS and the plans to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines.

Validation activities were conducted via interactive virtual review and are referred to as a “virtual review,” as the activities are the same in a virtual format as in an on-site format.

### Validation Team

The HSAG validation team was composed of the lead auditor(s) and validation team members. HSAG assembled the team based on the skills required for NAV and requirements established by DHCS. Team members, including the lead auditor(s), participated in the virtual review meetings; other validation team members participated in the desk review of submitted documentation only. A full list of validation team members, their roles, and their skills and expertise are provided in Appendix A.

## Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- ◆ **Information systems underlying network adequacy monitoring:** HSAG conducted an ISCA using DHCS' and each plan's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how DHCS and the plan tracks providers over time, across multiple office locations, and through changes in participation in the plan's network. The ISCAT was used to assess the ability of DHCS' and the plan's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand DHCS' and the plan's IT system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- ◆ **Validate network adequacy logic for calculation of network adequacy indicators:** HSAG required DHCS and each plan that calculated the state-defined network adequacy indicators to submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG completed a line-by-line review of the logic provided to ensure compliance with the state-defined indicator specifications. HSAG identified whether the required variables were in alignment with the state-defined indicators used to produce DHCS' and the plan's indicator calculations. HSAG required DHCS and each plan that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps DHCS and the plan took for indicator calculation.
- ◆ **Validate network adequacy data and methods:** HSAG assessed data and documentation from DHCS and plans that included, but was not limited to, network data files or directories, provider specialty mapping, data systems and processes workflows, and/or provider and member handbooks. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness.
- ◆ **Validate network adequacy results:** HSAG assessed DHCS' and the plans' ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support DHCS' and the plans' network adequacy monitoring results. HSAG validated network adequacy reporting against state-defined indicators and against the most recent network adequacy reports to assess trending patterns and reasonability of reported indicator-level results, if available. HSAG assessed whether the results were valid, accurate, and reliable, and if the plan's interpretation of the data was accurate.
- ◆ **Supporting documentation:** HSAG requested documentation that would provide auditors with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

## Virtual Review Validation Activities

HSAG conducted a virtual review with DHCS and the plans. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, primary source verification (PSV), observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each plan are described below:

- ◆ Opening meeting
- ◆ Review of ISCAT and supporting documentation
- ◆ Evaluation of underlying systems and processes
- ◆ Overview of data collection, integration, methods, and control procedures
- ◆ Network adequacy source data PSV and results
- ◆ Closing conference

HSAG conducted interviews with key DHCS and plan staff members who were involved with the calculation and reporting of network adequacy indicators. Appendix A lists the DHCS and plan interviewees.

**Opening meeting:** The opening meeting included an introduction of the validation team and key DHCS and plan staff members involved in the NAV activities, the review purpose, the required documentation, basic meeting logistics, and organization overview.

**Review of the ISCAT and supporting documentation:** This session was designed to be interactive with key DHCS and plan staff members so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and understand systems and processes for maintaining and updating provider data and assessing DHCS' and the plan's information systems required for NAV. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.

**Evaluation of underlying systems and processes:** HSAG evaluated DHCS' and the plan's information systems, focusing on DHCS' and the plan's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; DHCS and plan oversight of external information systems, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key DHCS and plan staff members familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff members included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors, and other front-line staff members familiar with network adequacy monitoring and reporting activities.

**Overview of data collection, integration, methods, and control procedures:** The overview included discussion and observation of methods and logic used to calculate each network

adequacy indicator. HSAG evaluated the integration and validation process across all source data and how the analytics files were produced to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures during this session.

**Network adequacy source data PSV and results:** HSAG performed additional validation using PSV to further validate the accuracy and integrity of the source data files used to inform network adequacy monitoring and reporting at the indicator level. PSV is a review technique used to confirm that the information from the primary source information systems matches the analytic output files used for reporting. Using this technique, HSAG assessed the methods, logic, and processes used to confirm accuracy of the data and detect errors. HSAG selected key data elements within each source data output file to confirm that the primary source system maintained by DHCS and the plan or obtained through external entities matched. For example, the PSV review may detect programming logic errors resulting in further root cause analysis and corrections. HSAG reviewed indicator-level results and assessed alignment with state-defined requirements.

**Closing conference:** The closing conference included a summation of preliminary findings based on the review of the underlying systems and processes, data collection, integration, and methods used. In addition, findings from the virtual review and documentation requirements for any post-virtual review activities were shared with DHCS and the plans.

**Assessment of progress made from the prior year:** Note that since this is the first year a NAV audit was conducted for the DMC-ODS plans, no information regarding assessment of progress from the prior year is included in this report. During future reporting cycles, HSAG will incorporate an evaluation of each plan's network adequacy standards progress made from the prior year.

## Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated DHCS' and the plans' ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support DHCS' and the plans' network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that DHCS and the plans used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of "Met" and "Not Met" elements recorded in HSAG's CMS EQR Protocol 4 Worksheet 4.6, noted in Table 2.1.

**Table 2.1—Validation Score Calculation**

<b>Worksheet 4.6 Summary</b>
A. Total number of <i>Met</i> elements
B. Total number of <i>Not Met</i> elements
Validation Score = $A / (A + B) \times 100\%$
Number of <i>Not Met</i> elements determined to have significant bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if DHCS' and the plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table 2.2, and assigned by HSAG once HSAG has calculated the validation score for each indicator.

**Table 2.2—Indicator-Level Validation Rating Categories**

<b>Validation Score</b>	<b>Validation Rating</b>
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

Table 2.3 and Table 2.4 present sample validation rating determinations. Table 2.3 presents an example of a validation rating determination that is based solely on the validation score, as there were no *Not Met* elements that were determined to have significant bias on the results, whereas Table 2.4, presents an example of a validation rating determination that includes a *Not Met* element that had significant bias on the results.

**Table 2.3—Example 1 of a Validation Rating Determination**

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of <i>Met</i> elements	16	<i>Moderate Confidence</i>
B. Total number of <i>Not Met</i> elements	3	
Validation Score = $A / (A + B) \times 100\%$	84.2%	
Number of <i>Not Met</i> elements determined to have significant bias on the results	0	

**Table 2.4—Example 2 of a Validation Rating Determination**

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of <i>Met</i> elements	15	<i>No Confidence</i>
B. Total number of <i>Not Met</i> elements	4	
Validation Score = $A / (A + B) \times 100\%$	78.9%	
Number of <i>Not Met</i> elements determined to have significant bias on the results	1	

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- ◆ Requesting that DHCS and the plan provide a root cause analysis of the finding.
- ◆ Working with DHCS and the plan to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- ◆ Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG’s NAV Oversight Review Committee, to determine the degree of bias.
- ◆ Finalizing a bias determination within the HSAG NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., indicator result changed from compliant to non-compliant or changed from non-compliant to compliant), or the impact could not be quantified and therefore was determined to have the potential for significant bias.

## 3. Validation Results

### County of Alameda

#### *ISCA Findings and Data Validity*

HSAG completed an ISCA for Alameda and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

#### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Alameda had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Alameda used InSyst as the database management system to collect and maintain enrollment and provider data until June 2024.
- ◆ Alameda used Clinicians Gateway to document services provided to members and to capture data used for timely access reporting.
- ◆ In August 2023, Alameda began transitioning to a new system, SmartCare. The rollout began with the movement of member registration and program enrollment data in August 2023. Member service entry data were then moved in March 2024. SmartCare and Clinicians Gateway Interface went live in June 2024, and Medi-Cal claims processing went live in July 2024.
  - Member IDs from the legacy system InSyst were migrated to SmartCare and stored as a secondary member ID number.

HSAG evaluated the personnel that Alameda had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Alameda had eight programmers trained and capable of supporting network adequacy reporting activities. On average, staff had approximately 20 years of experience.

HSAG identified no concerns with Alameda’s information systems data processing procedures and personnel.

#### Enrollment System

HSAG evaluated the information systems and processes used by Alameda to capture enrollment data for members to confirm that the system was capable of collecting data on

member characteristics as specified by DHCS. HSAG's evaluation of Alameda's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Alameda were maintained in InSyst.
- ◆ Alameda received the Monthly Medi-Cal Eligibility Data System (MEDS) Extract File (MMEF) from DHCS. The MMEF was retrieved from the DHCS portal and uploaded into InSyst through a series of predeveloped reports.
  - The MMEF was also stored in Alameda's data warehouse. Automated code in Airflow, a workflow management platform, checked the secure network drive for new MMEFs. When a new file was identified, code imported the data into the data warehouse and automatically ran member matching. Once matching was completed, the system ran enrollment and eligibility counts which were then reported through Yellowfin, a business intelligence (BI) platform, within a day of receipt.
- ◆ When processing the MMEF, only members with a matching record in InSyst were uploaded. Member data listed on the MMEF but not recognized in InSyst were not uploaded into the system.
- ◆ Alameda conducted ongoing reconciliation and oversight of eligibility data, which included the following activities:
  - Alameda had systems in place to verify that all member eligibility information was successfully uploaded by generating an output report that identified errors. Alameda staff then reconciled identified errors.
- ◆ InSyst captured and maintained both the state-issued Medi-Cal ID and a system-generated ID. InSyst had two separate environments; if a member received both mental health and SUD services, the member had up to two member IDs, one for each system.
- ◆ Alameda identified member demographic information from the MMEF. Members were also able to report alternative mailing addresses to Alameda.
- ◆ Alameda defined a new member as a Medi-Cal-eligible member who was new to the health plan or a member who had not received outpatient services from the health plan in the past 12 months.

HSAG identified no concerns with Alameda's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Alameda to capture provider data and identified the following findings:

- ◆ Alameda ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Alameda screened the data for completeness and consistency.

- ◆ Alameda collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Alameda's provider data system(s) included the following findings:

- ◆ Provider demographic data were maintained in InSyst.
- ◆ Provider credentialing data were maintained in the Council for Affordable Quality Healthcare (CAQH) credentialing platform.
- ◆ Alameda's procedures for updating and maintaining provider data included the following:
  - Alameda completed provider recredentialing every three years.
  - Alameda utilized ProviderTrust, an application to verify and monitor provider credentials. Providers were uploaded into ProviderTrust monthly, which produced alerts for issues identified in provider data. Alameda's Contracts Unit reviewed and resolved alerts as necessary.
  - Alameda required behavioral health (BH) providers to create and maintain an electronic provider profile through the National Committee for Quality Assurance (NCQA) Credential Verification web-based portal and to attest every 120 days to the accuracy of their data.
  - Alameda required contracted staff to provide contractor staff rosters including all clinical and non-clinical individuals who provided or supported services. Contractors were to submit to Alameda an electronic form documenting any staffing changes within five business days. The form included license discipline, license number, license expiration, and taxonomy code.
  - Alameda used a Program Change Request Form to document and track requested changes to provider data. Alameda's Contracts Unit reviewed community-based organization requests, and operational staff leads vetted all county program requests. When updates were received, Alameda verified that the reported updates were correct by comparing them to external data sources. Billing and Benefits Support teams completed these verifications.
- ◆ Providers used Clinicians Gateway for documentation of clinical notes and services provided. Data collected in Clinicians Gateway were also recorded in InSyst.
- ◆ Alameda experienced a delay in transitioning provider data to SmartCare. Since the time of review, Alameda reported completing the migration of all provider data.

HSAG identified no concerns with Alameda's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Alameda's delegated entity data and oversight included the following findings:

- ◆ Alameda did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Alameda's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Alameda utilized electronic forms to collect data used to complete the Timely Access Data Tool (TADT). The electronic form was available for providers in Clinicians Gateway. Data from the electronic form were sent to the individual who submitted the form via email, and the data were also sent to a data repository. The data captured in the electronic form were exported from the data repository and sent to the Data Warehousing Team who used the exported data to complete the TADT.
- ◆ Alameda generated data used for the TADT through a series of standardized Structured Query Language (SQL) queries that were run against the production database to retrieve all electronic form data.
- ◆ Alameda had providers who did not require referrals and members could request appointments directly from the provider. When this occurred, providers were trained to report the day of the initial appointment as the first offered service date. In all other circumstances, when a member called into the Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) Division to request an appointment, the ACCESS Division captured the initial intake information through its Contract Tracking database which would then be provided to the provider through the referral letter.
- ◆ To ensure data quality, Alameda performed the following:
  - Alameda tracked referral information gathered by the ACCESS Division and generated a monthly provider report. This report was used to identify and track members who needed to have the timeliness electronic form completed. Each month the report was reviewed to identify outstanding timeliness forms, and the Quality Assurance (QA) Team reached out to providers for completion.
  - The Information Systems (IS) Team sent Alameda's QA Team a Microsoft Excel (Excel) version of reports to review data for accuracy. When reviewing and for verification, Alameda compared the report data to claims data. The QA Team validated the data monthly.
- ◆ Alameda provided multiple resources to providers to ensure that data captured were timely and accurate.
  - The QA Team provided training to providers on how to complete forms and provided education on members who should be captured.
  - Alameda developed documentation for providers containing definitions and instructions on how to complete timeliness forms.
  - Alameda had built-in definitions to key data points within the electronic form. When filling out the forms, providers could hover over fields to view a definition of what information needed to be provided.

- ◆ HSAG assessed Alameda’s processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

**Ongoing monitoring activities:**

- ◆ Alameda conducted its own network adequacy calculations for internal monitoring which were saved on an internal file directory.
- ◆ Alameda’s Network Adequacy Committee met quarterly. A key agenda item for every meeting was to discuss the electronic form data and any outstanding information or gaps in network adequacy.
- ◆ Alameda maintained dashboards in Yellowfin to monitor systemwide performance for timely access standards.

HSAG identified no concerns with Alameda’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Alameda used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that Alameda used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Alameda’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Alameda’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Alameda’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.1 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.1—Alameda Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	194	190	98%↑

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Services— Outpatient SUD and Residential (0–17)	S	S	S
<b>OTP</b>			
OTP (18+)	42	38	90%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Alameda’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Alameda had robust processes in place to maintain and validate accurate provider data, which included using ProviderTrust for ongoing credentials monitoring, an attestation process, staff rosters, and forms to track changes in provider data.
- ◆ **Strength #2:** HSAG observed multiple efforts to assist staff in reporting accurate, timely access data through trainings, resource documents, and reporting form design, including built in definitions to data points within the electronic forms.

### Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Alameda had in place to inform network adequacy reporting.

# County of Contra Costa

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Contra Costa and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Contra Costa had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Contra Costa used SmartCare as the database management system to maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Contra Costa used ShareCare to maintain enrollment and provider data.
  - Contra Costa utilized the developers for its legacy system to extract required fields from ShareCare in the format that California Mental Health Services Authority (CalMHSA), SmartCare's EHR subcontractor, required for conversion to SmartCare. CalMHSA conducted smoke testing to verify the success of migration. Once validated, the data were then migrated to the live environment, with all data successfully transferred.
  - Contra Costa's system analysts and Business Intelligence Team retained access to ShareCare for historical reference.

HSAG evaluated the personnel that Contra Costa had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Contra Costa had four programmers with an average of 11 years of experience in the field.
- ◆ CalMHSA had 10 programmers with an average of six years of experience in the field.

HSAG identified no concerns with Contra Costa's information systems data processing procedures and personnel.

## Enrollment System

HSAG evaluated the information systems and processes used by Contra Costa to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Contra Costa's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Contra Costa were maintained in SmartCare.

- ◆ Contra Costa received the MMEF from DHCS. The MMEF was imported into SmartCare and used to track eligibility. The MMEF included a lookback period of 15 months and an eligibility table that included historical data.
- ◆ Contra Costa performed monthly reconciliation between SmartCare and the MMEF using a SmartCare two out of three match report. The report displayed member data present in SmartCare versus data that were visible on the MMEF. Contracted providers and county staff flagged and corrected any inconsistencies.
- ◆ Contra Costa identified potential duplicate cases based on end user reports. The Billing Team validated these cases by reviewing Medi-Cal Eligibility Data System Lite (MEDSLITE). Once confirmed as duplicates, the records were automatically merged in SmartCare.
- ◆ SmartCare captured and maintained both the state-issued Medi-Cal ID and a system-generated member ID to uniquely identify members.
- ◆ Contra Costa defined a new member as any Medi-Cal member requesting services who had not received services or intake within the last 30 days.
- ◆ Contra Costa updated demographic information in SmartCare based on details provided by members and advised members to contact DHCS to update their records accordingly.

HSAG identified no concerns with Contra Costa's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Contra Costa to capture provider data and identified the following findings:

- ◆ Contra Costa ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Contra Costa screened the data for completeness and consistency.
- ◆ Contra Costa collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Contra Costa's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.
- ◆ Providers were required to submit a credentialing application to Contra Costa's IT Team. Upon receipt, the IT Team reviewed the application and performed credential verification during the hiring process. This process included checking licensure status and screening for sanctions or disciplinary actions using several national databases, such as the National Plan and Provider Enumeration System (NPPES), Drug Enforcement Administration (DEA), California Department of Consumer Affairs (DCA) BreZE Online Services system, Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), and Excluded

Parties List System (EPLS)/System for Award Management (SAM). Once the data were verified, the IT Team manually entered the provider data into SmartCare.

- ◆ The DHCS Licensing and Certification Branch directly licensed SUD providers, and fee-for-service (FFS) providers were required to enroll in the Medi-Cal program via the DHCS Provider Application and Validation for Enrollment (PAVE) system.
- ◆ Contra Costa's Alcohol and Other Drugs Services (AODS) contract staff performed ongoing quality control by monitoring providers' certification and licensure status monthly. This team also conducted regular on-site visits to review procedures, licenses, and certifications. Any identified issues required a corrective action from the provider, which was reported to DHCS.
- ◆ Contra Costa required its provider network to update provider data as changes occurred, and annually. Providers were made aware of this expectation during the onboarding process and via monthly reminders during fiscal data monitoring meetings.

HSAG identified no concerns with Contra Costa's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Contra Costa's delegated entity data and oversight included the following findings:

- ◆ Contra Costa did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Contra Costa's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Contra Costa utilized SmartCare to extract and report network adequacy indicators. Contra Costa used the TADT to report timely access to DHCS. The TADT was submitted annually, or as requested by DHCS.
- ◆ SmartCare maintained forms for tracking timely access which included SUD and opioid treatment modalities. Contra Costa utilized a SmartCare report to extract timeliness data used for network adequacy indicator reporting.
- ◆ Contra Costa used appropriate methodologies to assess adherence with DHCS' network adequacy indicators for timely access. The Access Team or administrative staff collected data during appointment requests which were used to populate the DMC outpatient timeliness record or the DMC opioid timeliness record in SmartCare, and an assessment was conducted to determine the service required.

- ◆ Contra Costa utilized a report to identify incomplete timely access records. The report was run monthly, and the AODS staff used the report to check records for completion and accuracy. Validations were performed to ensure only members with a Client Index Number (CIN) were included.
- ◆ Contra Costa used a SmartCare report to extract timely access data recorded in the system. The data were used to complete the TADT, and the clinical implementation coordinator reviewed and validated the report to ensure accuracy before submission to DHCS.
- ◆ Prior to July 1, 2023, Contra Costa used ShareCare to track and report timely access.
- ◆ SmartCare software utilized Git and Azure DevOps to manage version control and track modifications to report content and query logic. Contra Costa stored reports on internal storage drives for historical reference.
- ◆ Contra Costa performed data quality checks to ensure the accuracy of its network adequacy reporting programs by identifying and investigating data outliers. SmartCare reports were updated in the electronic health record (EHR) system to comply with DHCS requirements. Accuracy was validated through internal testing and review within the county's QA environment, ensuring data were properly managed in alignment with the TADT.
- ◆ To maintain continuity in producing network adequacy indicators, Contra Costa had multiple programmers and analysts trained on timely access reporting procedures, and the CalMHSA Software Team held weekly knowledge-sharing calls to support developer training and ensure uninterrupted service delivery.
- ◆ HSAG assessed Contra Costa's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

#### **Ongoing monitoring activities:**

- ◆ The AODS Team tracked and monitored any gaps identified in Contra Costa's network adequacy indicator performance against DHCS' indicator-level contract requirements. Contra Costa did not identify any gaps during the reporting period.
- ◆ Contra Costa implemented several initiatives to ensure compliance with timely access indicators, including contracting efforts through requests for proposals (RFPs), ongoing provider recruitment efforts, assisting providers with onboarding set-up costs to become established in the community, and hiring additional staff to support caseloads.

HSAG identified no concerns with Contra Costa's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Contra Costa used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Contra Costa used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Contra Costa's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Contra Costa's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Contra Costa's **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume ("**Description of Validation Activities**").

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.2 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein

80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.2—Contra Costa Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	717	710	99%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	40	40	100%↑
<b>OTP</b>			
OTP (18+)	46	46	100%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Contra Costa’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

## Strengths

- ◆ **Strength #1:** Contra Costa demonstrated a robust process to keep provider data up to date and accurate, including its credentialing process and monthly monitoring of multiple sanction/exclusion lists.
- ◆ **Strength #2:** Contra Costa has undertaken several initiatives to meet timely access indicators, including continuous provider recruitment and expanded staffing efforts.

## Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Contra Costa had in place to inform network adequacy reporting.

# County of El Dorado

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for El Dorado and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that El Dorado had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ El Dorado used myAvatar as the database management system to collect and maintain enrollment and provider data.
- ◆ El Dorado used SQL Server to inform network adequacy reporting.

HSAG evaluated the personnel that El Dorado had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ El Dorado had three programmers with two and a half years of experience who were trained and capable of supporting network adequacy reporting activities.
- ◆ El Dorado's QA Team and myAvatar IT Team maintained oversight of timely access reporting.

HSAG identified no concerns with El Dorado's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by El Dorado to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of El Dorado's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for El Dorado were maintained in myAvatar.
- ◆ El Dorado received the MMEF from DHCS. The MMEF contained key demographic details and Medi-Cal eligibility status, which were downloaded and imported directly into myAvatar via secure file transfer protocol (SFTP), with a processing time of two hours.
  - myAvatar ran the file and compared the data elements against the most recently uploaded MMEF, as well as 15 months of historical member data. myAvatar added Medi-Cal as the financial guarantor to each member who had an open episode and did not have Medi-Cal eligibility prior to the upload.

- El Dorado's Fiscal/Billing Team added alerts into myAvatar to notify the program staff that Medi-Cal eligibility was either incomplete or in an inactive status.
- El Dorado's QM staff used error reports to identify and assign Medi-Cal eligibility to members who were not added and processed with the MMEF upload. QI staff verified member eligibility through MEDSLITE.
- Member eligibility was also verified at the point of member service request via MEDSLITE.
  - El Dorado members requested DMC-ODS services by referral, calling the 24/7 access number, or by walking into any El Dorado provider clinic.
- ◆ myAvatar captured and maintained both the state-issued Medi-Cal ID and a system-generated member ID. If a member disenrolled and reenrolled, the member retained the same unique ID.
- ◆ El Dorado identified member demographic updates via the MMEF and direct member contact. Intake staff had permissions to edit member demographic data in myAvatar. Changes made to records were tracked in myAvatar, including the user ID of the person who modified the record and the date and time of the change.
- ◆ El Dorado identified a new member as an individual who had never received care according to myAvatar. Members who had received care in the past for whom all outpatient episodes had been closed for longer than 365 days were also considered new members.

HSAG identified no concerns with El Dorado's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by El Dorado to capture provider data and identified the following findings:

- ◆ El Dorado ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ El Dorado screened the data for completeness and consistency.
- ◆ El Dorado collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of El Dorado's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in myAvatar.
- ◆ El Dorado's procedures for updating and maintaining provider data included the following:
  - El Dorado had a manual review process that used provider reports and credentialing verification to track providers over time, across multiple office locations, and through changes in participation in El Dorado's network.

- When hired, providers submitted a new user request either electronically through myAvatar or in PDF format. Designated QI staff were alerted through a myAvatar widget for electronic submissions or via email for PDFs. QI reviewed requests for completeness based on the type of work the provider would be performing.
- If the provider required licensure, staff validated credentials through the DCA website and verified National Provider Identifier (NPI) and taxonomy using the NPPES. For unlicensed providers delivering services, only the NPI and taxonomy were verified. El Dorado's QI staff also searched the LEIE database to validate provider data. Recredentialing was completed every three years.
- For providers with BH licenses, El Dorado's QI Team used the California DCA BreZE Online Services system to verify the activation and expiration of BH licensure.
- Once all provider information was confirmed, a provider profile was created in myAvatar using the practitioner enrollment form. myAvatar maintained a set of roles and permissions that granted staff access to the system dependent on their role.
- El Dorado's QI staff downloaded a monthly Excel file report to compare and validate provider data. QI staff notified providers as needed of expiring licenses. myAvatar also contained programming to prevent providers from billing if their license expired. Providers were given a 90-, 60-, and 30-day notice of licensure expiration. If the provider license was not validated and updated prior to expiration, providers were declassified to mental health rehab specialists and would be unable to access fields in myAvatar that were available to licensed providers.
- ◆ El Dorado's QI staff updated myAvatar as needed to ensure complete and accurate provider data were used for 274 reporting and El Dorado's provider directory.
- ◆ El Dorado's QM staff monitored network adequacy via monthly attestations. At the beginning of each month, QA staff sent a status check form to each provider to complete indicating key changes and compliance with reporting requirements, including provider directory reporting. Providers completed and returned the attestation and any supporting documentation by the 10th day of each month. QA staff reviewed the completed information and updated the electronic provider directory no later than 30 calendar days after receipt of the provider's information. Paper provider directories were updated at least monthly.

HSAG identified no concerns with El Dorado's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of El Dorado's delegated entity data and oversight included the following findings:

- ◆ El Dorado did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of El Dorado's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ El Dorado used SQL Server to extract data for reporting network adequacy indicators.
- ◆ El Dorado's myAvatar IT Team used data entered into myAvatar to create SQL queries which corresponded to the data points required by DHCS for timely access. Each data point listed on the TADT was mapped to fields in myAvatar. A report organized to match the TADT as closely as possible to make reporting more seamless was created to be run on-demand in myAvatar. The report from myAvatar was exported to an Excel file for submission to DHCS.
- ◆ El Dorado's BHD reviewed the Excel file for completeness and accuracy on three levels:
  - El Dorado's office assistant reviewed for completeness and verified there were no missing data.
  - El Dorado's administrative analyst completed an accuracy review for matching data.
  - El Dorado's QA administrative analyst completed the final accuracy and completeness review of outcome data, performed data matching, and made a final determination of accuracy.
- ◆ El Dorado used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
  - myAvatar was used to capture members initiating services, based on a specific time frame (e.g., reporting period) and El Dorado's new member definition. The reporting period and new member definition were captured using SQL to pull the data.
  - El Dorado's urgent requests were tracked using an admission form in myAvatar, which had a date and time field.
  - El Dorado's providers and contracted provider staff entered this information in myAvatar, which captured timeliness data in several fields that were then extracted and added to the TADT for reporting to DHCS.
- ◆ El Dorado maintained network adequacy indicator reports by storing reports in myAvatar and appending them to a table of historical results.
- ◆ HSAG assessed El Dorado's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ El Dorado maintained data control procedures to ensure the accuracy and completeness of data extracted from myAvatar by performing a manual review of code and results using queries and reports.
  - El Dorado conducted data reasonability checks by manually reviewing reports and validations against other reporting.

- Timely access standards were reviewed and updated annually to reflect any changes in provider accessibility in El Dorado County and in the population of county Medi-Cal members.
- El Dorado reviewed monthly timeliness data by either running an on-demand report or SQL query and reviewing the data points which had been mapped to the EHR. El Dorado completed a chart review of any data discrepancies.
- El Dorado made changes as needed when preparing data for the reporting period based on updated DHCS requirements.

HSAG identified no concerns with El Dorado’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that El Dorado used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that El Dorado used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that El Dorado’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that El Dorado’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that El Dorado’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the

validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.3 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.3—El Dorado Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	79	70	89%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	0	0	ZU

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>OTP</b>			
OTP (18+)	S	S	S
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing El Dorado’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** El Dorado established strong processes to manage and validate Medi-Cal eligibility data monthly from the MMEF. The QI Team effectively identified and addressed missing or incomplete data through consistent use of fallout and error reports, along with manual validation procedures. These practices contributed to the accuracy and completeness of member eligibility data.

### Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities El Dorado had in place to inform network adequacy reporting.

# County of Fresno

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Fresno and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Fresno had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Fresno used SmartCare as the database management system to maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Fresno used myAvatar to maintain enrollment and provider data.
- ◆ Fresno used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from myAvatar.
  - The migration included three rounds of data mapping and conversion testing, including a final validation phase approximately one month before the go-live date.
  - CalMHSA also used a validation tool to analyze migration data prior to importing to the system to ensure data were in the correct format.
  - Historical clinical data were retained as PDF files within the new system for ongoing reference.

HSAG evaluated the personnel that Fresno had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Fresno had a team of five programmers with an average of five years of experience.
- ◆ CalMHSA staff included 26 programmers trained and capable of using programming language and programs to maintain SmartCare. CalMHSA programmers had an average of six years of experience.

HSAG identified no concerns with Fresno's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Fresno to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Fresno's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Fresno were maintained in SmartCare.
- ◆ Fresno received the MMEF from DHCS through a secure download process. The MMEF was retrieved from the DHCS portal by IT staff and uploaded into SmartCare using a SFTP site. The files were extracted from their original ZIP format before being transferred to the SFTP directory, ensuring data integrity.
  - SmartCare performed overnight jobs to process the MMEF. The first job imported the MMEF data into the system, while the second job attempted to match member records based on first name, last name, date of birth (DOB), and Social Security number (SSN). Members who did not match all criteria were flagged in a two out of three match report for manual review.
  - The two out of three match report allowed Fresno staff to identify potential record discrepancies, including minor variations in names or DOB errors. If a member record required correction, the staff made updates in SmartCare to align with the MMEF.
- ◆ Fresno defined a new member as any Medi-Cal member who was not enrolled in treatment services at the time of the service request.
- ◆ Demographic updates, including address changes, were managed by admitting staff members in SmartCare. These staff members updated key data points, including address and contact information, in the member profile. Changes were logged in SmartCare, capturing the user ID, date, and time of the modification for auditing purposes.
- ◆ Fresno relied on MEDSLITE as the authoritative source for Medi-Cal eligibility data. If a member reported discrepancies in his or her eligibility information, the member was referred to the Decision Support System for updates.
- ◆ SmartCare maintained both the state-issued Medi-Cal ID and an internally generated ID for each member. If a Medi-Cal ID changed, the system preserved historical data to ensure continuity of care and accurate enrollment tracking.
- ◆ Fresno's IT and Client Administration divisions managed access to SmartCare, ensuring that only authorized personnel had the ability to edit enrollment and eligibility data. Access logs were maintained to track all modifications to member records.
- ◆ Monthly reconciliation processes were conducted to verify the completeness and accuracy of MMEF data in SmartCare, aligning Fresno's enrollment records with DHCS data to reduce discrepancies and ensure accurate billing.

HSAG identified no concerns with Fresno's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Fresno to capture provider data and identified the following findings:

- ◆ Fresno ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.

- ◆ Fresno screened the data for completeness and consistency.
- ◆ Fresno collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Fresno's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data for Fresno were maintained in SmartCare.
- ◆ Fresno's Plan Administration Division (PAD) initiated the credentialing process for new providers. Providers submitted applications with required documents, including license number, DEA certificate, NPI, taxonomy code, and discipline classification.
  - Applications were reviewed against national databases including the NPPES, DEA License Search, OIG LEIE, EPLS/SAM, and the National Practitioner Data Bank (NPDB) to verify provider credentials and identify disciplinary actions or sanctions.
  - Once the required verifications were completed, applications were forwarded to the Credentialing Committee for final clinical review and approval. The Credentialing Committee conducted a thorough review to confirm that all provider qualifications were met before granting credentialed status.
- ◆ The IT Team added approved providers to SmartCare. Provider profiles included key data points such as name, license number, discipline, taxonomy code, and NPI, which were used for billing and data reporting.
  - The PAD ensured that each provider's profile included the necessary licensure and certification details. Staff monitored license expiration dates through a combination of Excel spreadsheets and SmartCare reports, including license history logs that tracked changes and captured expiration dates for compliance purposes.
- ◆ SmartCare maintained a comprehensive record of each provider's credentials, including historical data on expired licenses and changes in practice locations. Modifications to provider data in SmartCare were tracked with user ID, date, and time stamps to ensure accountability.
- ◆ Provider access to SmartCare was managed through user profiles, which included role-based permissions to limit access to sensitive data. Provider records were flagged as inactive when employment ended, removing login access to protect member data.
- ◆ Fresno validated the accuracy of provider data in SmartCare daily to ensure compliance with DHCS reporting requirements. Staff utilized internal audits and reports to identify discrepancies and correct errors prior to data submission.
- ◆ Fresno explored the potential for enhanced credentialing tools to further automate and streamline the credentialing process, including discussions with CalMHSA regarding potential integration with SmartCare.

HSAG identified no concerns with Fresno's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Fresno's delegated entity data and oversight included the following findings:

- ◆ Fresno did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Fresno's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Fresno used SmartCare to track and extract data required for reporting network adequacy indicators annually, or as requested by DHCS. Fresno utilized the TADT for submitting timely access data to DHCS.
- ◆ SmartCare contained forms for capturing service data required for network adequacy reporting. These forms included all necessary data fields for accurate and complete network adequacy submissions.
- ◆ Fresno's QM Team developed an internal report utilized to conduct additional validation checks on data used for the TADT prior to submission.
  - The internal report included features to identify discrepancies such as missing data, incorrect dates, and incomplete entries. The report also captured the staff names of individuals who entered the data, allowing Fresno to trace errors back to the appropriate program or provider for correction.
  - Fresno's internal report also included monitoring tools to track when data entries were updated and to identify records with missing or inconsistent dates.
  - Fresno's QM Team extracted data from the forms in SmartCare using a system report and copied data into the TADT for submission. Staff reviewed the extracted data to ensure completeness and accuracy, which included verifying that reported members were Medi-Cal members and that all required data fields were correctly populated.
  - QM staff conducted ongoing data quality checks before final submission to DHCS to reduce the risk of errors.
- ◆ Fresno's internal report was designed to provide additional oversight beyond the SmartCare report, which included tracking missing data, outdated provider information, and data entry errors. These checks were performed regularly to ensure data accuracy prior to each TADT submission.
- ◆ Fresno saved TADT submissions to a secure local drive for historical record-keeping and auditing.
- ◆ HSAG assessed Fresno's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

**Ongoing monitoring activities:**

- ◆ Fresno conducted continuous monitoring of TADT data quality, utilizing internal reports to identify errors, track data entry trends, and ensure compliance with DHCS’ standards.
- ◆ Fresno’s QM Team maintained ongoing communication with program managers and clinical staff to address data quality issues. This communication included sending alerts for missing or incomplete data and coordinating follow-up actions to correct discrepancies.
- ◆ Fresno conducted regular training sessions for staff responsible for TADT data entry to ensure accurate and consistent data capture. These sessions included guidance on proper form completion, data entry protocols, and the importance of accurate timeliness reporting.
- ◆ Fresno used SmartCare system logs and internal reports to track data entry and record updates, providing transparency and accountability in the TADT reporting process.

HSAG identified no concerns with Fresno’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## ***Assessment of Data Validity***

HSAG evaluated and assessed the data methods that Fresno used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that Fresno used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Fresno’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Fresno’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Fresno’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.4 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.4—Fresno Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services— Outpatient SUD and Residential (18+)	474	474	100%↑
Outpatient Services— Outpatient SUD and Residential (0–17)	214	213	100%↑

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>OTP</b>			
OTP (18+)	98	91	93%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Fresno’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Fresno maintained strong data oversight through SmartCare, internal QA checks, and staff training to ensure that accurate and timely TADT submissions aligned with DHCS’ standards.

### Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Fresno had in place to inform network adequacy reporting.

# County of Imperial

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Imperial and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Imperial had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Imperial used SmartCare as the database management system to collect and maintain enrollment and provider data as of February 1, 2023.
- ◆ Prior to February 1, 2023, Imperial used myAvatar to maintain enrollment and provider data.

HSAG evaluated the personnel that Imperial had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ CalMHSA had 26 programmers trained and capable of using programming language and programs to maintain SmartCare. On average, analysts had approximately six years of experience.

HSAG identified no concerns with Imperial's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Imperial to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Imperial's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Imperial were maintained in SmartCare.
- ◆ Imperial received the MMEF from DHCS. The MMEF was received on the first day of the month and processed within one business day. Imperial staff retrieved the MMEF and uploaded the file to a SFTP site for CalMHSA. CalMHSA retrieved the MMEF and uploaded the file into SmartCare. No changes were made to the MMEF before CalMHSA uploaded the file.
- ◆ SmartCare retained all enrollment dates; therefore, the member's initial enrollment date was always available. SmartCare had the ability to track enrollment changes over time.

- ◆ Imperial conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - SmartCare flagged potential member matches in the MMEF that were not automatically matched to member records in the system. The potential matches were sent to Access and Benefit managers to review and manually update. Matches were validated by referring to MEDSLITE. When a match was identified, the Access and Benefit managers updated the file and uploaded it into SmartCare. When no matches were identified in the file, the member record was not uploaded into SmartCare.
    - When a minimum of two sets of matching data were identified between a member record and MMEF, the matching data were flagged for review.
    - Common errors flagged included the spelling of the member's name, DOB and the gender reported.
- ◆ SmartCare captured and maintained both the system-generated number and the DHCS-provided MEDS number.
- ◆ Imperial identified member demographic information from the MMEF and stored the data in SmartCare. Imperial also documented and maintained demographic information reported by the member from member intake forms captured during the registration process. Self-reported data were stored in the member information page of SmartCare.
- ◆ Imperial defined a new member as a member with no open or ongoing services regardless of previous services provided.

HSAG identified no concerns with Imperial's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Imperial to capture provider data and identified the following findings:

- ◆ Imperial ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Imperial screened the data for completeness and consistency.
- ◆ Imperial collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Imperial's provider data system(s) included the following findings:

- ◆ Provider credentialing data were stored and maintained in an Excel spreadsheet, referred to as the credentialing status list spreadsheet, which was saved on an on-premises file server. Data on this spreadsheet included provider demographic information, credentialing expiration date, licensures, DEA expiration dates, and NPIs.
- ◆ New provider data were manually entered into SmartCare on an ongoing basis and maintained by an administrative analyst.

- Two provider groups maintained their own credentialing within the counties in which they operate. These two provider groups provided attestations to Imperial for each provider confirming that credential information was being regularly monitored.
- ◆ Imperial's procedures for updating and maintaining provider data included the following:
  - Imperial staff manually reviewed all lines of data in their credentialing status list spreadsheet to identify necessary provider recredentialing. Imperial recredentialed staff providers on their three-year anniversary month.
  - Providers were required to update data as needed in a 274 file submission to Imperial. All county and contracted providers were required to submit 274 files to Imperial monthly. QM staff incorporated provider updates to SmartCare as updates were received.
  - All provider data were manually entered into SmartCare. For contracted providers, credentialing staff provided the data via email with an Excel sheet attached, which included all provider information necessary to be added into SmartCare. Imperial's HR Department communicated via email any county staff provider to be manually entered into SmartCare. Data were entered at the time of receipt for new providers and when existing providers indicated updates in their monthly submission of 274 data.
- ◆ SmartCare tracked the history and modified date as provider data were updated.
- ◆ Provider panel capacity was reported via an Excel spreadsheet provided to Imperial monthly. All provider panel capacity was then recorded on a master Excel sheet and monitored.
- ◆ When Imperial migrated from myAvatar to SmartCare, data were extracted from the legacy system using reports and SQL queries. When data were unable to be moved through the automated process, an Imperial administrative analyst was responsible for manually entering the provider data into SmartCare. Service and timeliness information stored in myAvatar prior to February 1, 2023, was still available in the legacy system. Imperial conducted random sampling of provider data entered in SmartCare to ensure accuracy.
- ◆ Imperial maintained access to myAvatar and historical timeliness data; however, no new data were entered into myAvatar after the February 1, 2023, migration. Imperial planned to archive myAvatar in July 2025.

HSAG identified no concerns with Imperial's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Imperial's delegated entity data and oversight included the following findings:

- ◆ Imperial did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Imperial's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Imperial used reports generated from SmartCare to complete the annual TADT submission and to conduct its own network adequacy calculations.
- ◆ Imperial updated SmartCare reports in alignment with DHCS reporting requirements. Git and Azure DevOps were used for version control, to store and track changes and to query report logic. Accuracy was checked through internal testing in a county QA environment to ensure that data were managed accurately.
- ◆ Data for the TADT were collected using timeliness forms. Timeliness forms were tailored to collect data corresponding to the data required to complete the TADT.
  - Timeliness forms were initiated at the time of registration and completed by providers as services were provided.
  - Forms tracked initial request and appointment data, follow-up appointment data, referral source, date and time of first contact, and date and time of service appointment rendered.
- ◆ SmartCare tracked all started timeliness forms. Imperial staff reviewed all incomplete forms monthly and worked with providers to complete forms.
- ◆ SmartCare reports were generated in a format that allowed Imperial to copy and paste the information directly into the TADT, limiting the need for manual data entry.
- ◆ When DHCS requested additional data fields that were not already assigned to be captured by SmartCare reporting, Imperial staff manually reviewed member data to identify and add the missing information to the TADT.
- ◆ Datasets for the TADT used data from both myAvatar and SmartCare. All data previous to February 1, 2023, were derived from the legacy system, and all data as of February 1, 2023, were generated from SmartCare. No concerns for duplicate data were identified.
- ◆ While using myAvatar, Imperial utilized a timeliness intake appointment report to gather all data necessary for timeliness reporting.
- ◆ HSAG assessed Imperial's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Imperial maintained ongoing monitoring activities by conducting its own calculations of the timeliness standards quarterly. Results from the calculations were shared internally and used to monitor gaps.

HSAG identified no concerns with Imperial’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Imperial used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that Imperial used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Imperial’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Imperial’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Imperial’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.5 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.5—Imperial Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	251	245	98%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	58	58	100%↑
<b>OTP</b>			
OTP (18+)	36	36	100%↑
OTP (0–17)	0	0	ZU

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## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing Imperial's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** Imperial maintained ongoing oversight of data used to inform network adequacy reporting by reviewing completeness of timeliness forms monthly and working with providers to complete pending forms.

### **Opportunities for Improvement and Recommendations**

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Imperial had in place to inform network adequacy reporting.

# County of Kern

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Kern and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### **Information Systems Data Processing Procedures and Personnel**

HSAG evaluated the information systems data processing procedures that Kern had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Kern used SmartCare as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Kern used Cerner to maintain enrollment and provider data.
- ◆ Kern used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from Cerner.
- ◆ Migration of data to SmartCare underwent three rounds of testing, including post-upload validations after each round to ensure data were accurately reflected in the system.
- ◆ CalMHSA also used a validation tool to analyze migration data prior to importing to the system to ensure data were in the correct format.
- ◆ Kern used Power BI and Azure DevOps for programming and reporting.

HSAG evaluated the personnel that Kern had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Kern had nine programmers trained and capable of supporting network adequacy reporting activities. On average, programmers had approximately eight years of experience in the field.
- ◆ CalMHSA staff included three programmers trained and capable of using programming language and programs to maintain SmartCare. CalMHSA programmers had an average of six years of experience.

HSAG identified no concerns with Kern's information systems data processing procedures and personnel.

## **Enrollment System**

HSAG evaluated the information systems and processes used by Kern to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Kern's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Kern were maintained in SmartCare. Authorized staff established and updated member records through a structured intake and verification process.
- ◆ Kern received the MMEF from DHCS. Kern's IT Department downloaded the MMEF from the DHCS secure e-transfer portal, extracted the contents, and uploaded them into SmartCare via a SFTP (WinSCP). Files were stored on Kern's internal T drive.
- ◆ Kern performed monthly reconciliation between SmartCare and the MMEF using a two out of three match report created by CalMHSA. The report identified potential member matches based on open program status, allowing the team to isolate members actively receiving services.
  - Kern's reconciliation process included a manual review of records that failed to match all three data points such as first and last name, DOB, and SSN. Staff reviewed SmartCare demographic data, made corrections where needed, and coordinated with members for documentation when discrepancies could not be immediately resolved. Once corrected, matching would occur in subsequent MMEF uploads.
  - Eligibility verification was conducted in SmartCare through a built-in process that validated coverage using DHCS data. Staff could verify eligibility daily, and eligibility records included insurance plan details, insured ID, and coverage history. Only specific staff had access to add or modify eligibility information.
- ◆ Direct service teams were also responsible for checking Medi-Cal eligibility prior to appointments. This added an additional layer of oversight at the team level to ensure coverage was current before delivering services.
- ◆ Kern defined a new member as any Medi-Cal member who was not enrolled in treatment services at the time of the service request.
- ◆ SmartCare maintained both a state-issued Medi-Cal ID and a system-generated member ID. Eligibility data and member enrollment history were linked through identifiers such as name, SSN, and DOB.
- ◆ SmartCare supported demographic updates including address history and housing status.
  - Member demographic fields such as gender, DOB, race, and language were editable by authorized registration and billing staff. All changes were tracked in SmartCare, which recorded the user who made the update and the timestamp.
  - Kern monitored edits through SmartCare's audit functionality, which logged when a change was made and by whom. However, the system did not retain a record of the original data before the revision. Edits were reviewed on an as-needed basis, with no formal validation process currently in place.

HSAG identified no concerns with Kern's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Kern to capture provider data and identified the following findings:

- ◆ Kern ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Kern screened the data for completeness and consistency.
- ◆ Kern collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Kern's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare and a custom-built Network Adequacy Certification Tool (NACT) application. SmartCare housed practitioner records necessary for member services, while the NACT was used to support 274 monthly reporting and the provider directory.
- ◆ Provider data entry into SmartCare was initiated using a staff master worksheet submitted by team supervisors. The worksheet included required fields such as name, title, contact information, license, taxonomy, team assignment, and NPI. EHR Support staff used this worksheet to create and manage staff accounts.
- ◆ SmartCare profiles included tabs for demographic and professional details, program access, license and degree tracking, role assignments, and login permissions. Providers were not permitted to edit their own profiles; updates required supervisor approval and administrative processing through EHR Support.
  - Login permissions in SmartCare were strictly managed. New users were marked as "cannot log in" until all credentialing requirements were completed. When a provider separated from the agency, access was deactivated immediately, and active status was removed following documentation and service closure review.
  - SmartCare included limited data validation features, such as NPI field requirements, role-based permissions, and tracking of edit dates and users. However, it did not retain a historical record of previous values for edited data.
- ◆ Provider records in the NACT were never deleted. Instead, staff were marked as inactive with associated contract and termination dates. The NACT maintained a full employment and activity history, with edits restricted to point personnel designated at each site or agency.
  - Edits made in the NACT triggered internal quality control processes. The system performed real-time validations against SmartCare and the NPPES to prevent duplicate or conflicting records, including mismatched NPIs or taxonomy codes. The NACT used automated color-coded alerts to flag discrepancies.
  - Monthly submissions were tracked through the NACT's submission history interface. Kern used a comma-separated values (CSV) download feature to interpret and validate the 274 XML file output, to identify and correct errors prior to DHCS submission.

Submission logs included correction reasons and submission types (e.g., production or correction).

- ◆ The NACT also housed detailed program and site-level data, including certification status, hours of operation, population served, and capacity (e.g., bed counts or member capacity). Provider sites and teams were structured hierarchically by agency, location, and service type. Provider data were matched against contract specifications for accuracy.
- ◆ Kern monitored alignment between SmartCare and the NACT by checking for staff activity and service delivery records before records were included in network adequacy tracking. SmartCare and the NACT operated as complementary systems with limited but essential integration.
- ◆ Changes to provider records in SmartCare and the NACT were only made after supervisor notification and documentation review, such as legal name changes or updated site certifications. Edits were processed by EHR Support and tracked based on internal procedures, though not all changes were logged systematically in SmartCare.

HSAG identified no concerns with Kern's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Kern's delegated entity data and oversight included the following findings:

- ◆ Kern did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Kern's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Kern utilized SmartCare to track and extract data used to report network adequacy indicators annually, or as requested by DHCS. Kern used the TADT for reporting timely access to DHCS.
- ◆ The submission process was jointly managed by two internal teams, who extracted timely access data from SmartCare, performed quality checks, and formatted the final files for submission.
- ◆ Data required for the TADT were exported from SmartCare into CSV format. The exported file was then manually transferred into the TADT.
  - Prior to submission, data were thoroughly cleaned to avoid errors related to formatting, spacing, or invalid entries. For example, validation checks were run on the CIN field to

ensure correct length and structure, as well as on date fields and closure reasons to verify compliance with DHCS' formatting rules.

- Kern used a spreadsheet-based formula to flag errors in real time such as CIN and date formatting.
- ◆ HSAG assessed Kern's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Kern actively monitored timely access data and analyzed SmartCare data monthly through its internal Key Performance Indicator (KPI) Committee, which tracked timeliness access across divisions, agencies, and teams.
  - Bimonthly KPI meetings were held with supervisors and program administrators to review data, identify access issues (e.g., delays in intake or follow-up appointments), and implement process improvement strategies. These efforts supported continuous QI using iterative testing and feedback loops.
  - Kern emphasized data entry consistency and accuracy in SmartCare as the foundation of reliable TADT reporting. Two SmartCare forms for the DMC-ODS captured critical timeliness data. Staff across all agencies and contractors were trained to use these forms correctly.
- ◆ To improve data accuracy, Kern conducted targeted systemwide training. In early 2024, mental health providers received refresher sessions focused on timely documentation.
  - Timeliness data extracted from SmartCare were validated using formulas embedded in the TADT. Kern used an internal spreadsheet to run additional checks on formatting, blank fields, and outliers prior to submission.

HSAG identified no concerns with Kern's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Kern used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Kern used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Kern's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Kern’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Kern’s **network adequacy results** were:

- Acceptable
- Not acceptable

## **Network Adequacy Indicator-Specific Validation Ratings**

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## **Analysis and Conclusions**

Table 3.6 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

### **Table 3.6—Kern Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	865	843	97%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	29	29	100%↑
<b>OTP</b>			
OTP (18+)	159	158	99%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Kern’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Kern conducted targeted systemwide training for SUD providers to ensure proper data entry in SmartCare. These training efforts showed a proactive approach to data quality and focus on long-term improvement for timely access reporting processes.

### Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Kern had in place to inform network adequacy reporting.

# County of Los Angeles

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Los Angeles and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Los Angeles had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Los Angeles used Sage as the database management system to collect and maintain enrollment and provider data.
  - Database access was restricted using the Sage credentialing process which followed the Department of Public Health (DPH)—Information Systems authorization and access process. The process included both Azure authentication and multi-factor authentication.

HSAG evaluated the personnel that Los Angeles had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Los Angeles maintained Public Health Information Systems (PHIS) software developers, one data scientist, and five analysts. The PHIS software developer had five years of experience. The average experience of Health Outcomes and Data Analytics (HODA) data scientists and analysts was eight years, ranging from 1.5 to 20 years.

HSAG identified no concerns with Los Angeles' information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Los Angeles to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Los Angeles' enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Los Angeles were maintained in Sage.
- ◆ Los Angeles received the MMEF from DHCS and integrated the MMEF into Sage databases used for network adequacy reporting.
- ◆ Los Angeles performed monthly reconciliation between Sage and the MMEF to ensure completeness and accuracy of eligibility data. Reconciliation and oversight of eligibility data included comparison of MMEF loads in Sage with Los Angeles' member meta file. Los Angeles retrieved the MMEF from the DHCS SFTP server. Utilization Management Team

care managers validated MMEF data at the beginning of each month and as soon as possible upon receipt of the MMEF. MMEF data were transferred to the Sage data warehouse nightly.

- ◆ The IT Team pulled the MMEF from the SFTP server and uploaded it into Sage. Netsmart IT staff validated that the file loaded properly and without errors, and provided notification of validation to other relevant Substance Abuse Prevention and Control (SAPC) Business Units.
- ◆ Analysts validated MMEF data loads to ensure accurate and complete data updates in Sage using stored procedures to validate load completion. Any errors that occurred during the transfer were identified using Netsmart's error handling routines, which generated an email alert. The Netsmart IT Team oversaw merge and deduplication of member records. Only one unique ID was maintained at any time in Sage. If duplicate records were identified, the Netsmart IT Team retained only the validated record.
- ◆ SAPC IT staff validated data reasonability of monthly member loads using year and month record count comparisons. The SAPC IT Team downloaded the MMEF to the network drive and then integrated the file into Sage. The file was then downloaded into the enterprise data warehouse. MMEF data were stored in the archive database. A one-day lag between the data warehouse and Sage was identified due to loading and processing time.
- ◆ The MMEF was the data source for member Medi-Cal eligibility. The 270/271 process initiated member data updates received in the subsequent MMEF. Los Angeles' IT staff and providers had change authority to review and update enrollment data in Sage. Member eligibility was updated in Sage when the MMEF was uploaded or when the 270 query was run. Member eligibility was validated at the time of admission for services and monthly while the member was in treatment. The Automated Eligibility Verification System (AEVS) was used to initiate the 270/271 process for eligibility verification. Los Angeles noted that county eligibility verification was a limitation of the 270/271 process and that county eligibility was validated using MEDS.
- ◆ Sage captured and maintained both the state-issued Medi-Cal ID and a unique system-generated ID. Sage automatically assigned the next available Sage ID number upon member initiation and enrollment for treatment services.
- ◆ Los Angeles identified member demographic updates based on the MMEF.
- ◆ Los Angeles' reconciliation and oversight of member enrollment data included the following steps and processes:
  - Upon creation of a Sage member account, a member ID was generated. The member was enrolled and eligible for services. Member Access staff verified existing accounts upon member registration in Sage by searching for existing accounts and verifying key demographic information such as SSN, date of service (DOS) for a previous service, or member name.
- ◆ Los Angeles defined a new member as a member who requested a SUD or OTP appointment during the reporting period and had no previous appointment requests during the reporting period, regardless of any service history prior to the reporting period.

HSAG identified no concerns with Los Angeles' documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Los Angeles to capture provider data and identified the following findings:

- ◆ Los Angeles ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Los Angeles screened the data for completeness and consistency.
- ◆ Los Angeles collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Los Angeles' provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in Sage.
- ◆ Provider data were maintained at the practitioner level. Providers self-reported data upon onboarding and submitted identifying information including NPI, phone number, practice location, and DEA certificate if applicable, upon application for contracting.
- ◆ Providers initiated contracting requests using a contract request form. Provider taxonomy was retrieved from the NPPES Application Programming Interface (API).
- ◆ Provider Tax Identification Number, taxonomy, specialty, license and certifications, and phone number were validated upon onboarding and verified annually.
- ◆ Los Angeles required providers to maintain information on whether they were accepting new Medi-Cal members. This information was updated in the Service and Bed Availability Tool (SBAT). Providers updated contract service information with the Contract Management Team via contract request form.
- ◆ Los Angeles' procedures for updating and maintaining provider data included:
  - Los Angeles used a finance report to track providers over time, across multiple office locations, and through changes in participation in Los Angeles' provider network.
  - Provider credentials were validated prior to contracting and at a minimum of every three years following the contracting date. Providers were reviewed against various exclusion and status lists monthly. Los Angeles used the Medical Board of California, NPDB, and OIG LEIE for credential and exclusion verification. Contracted provider credentials were audited and monitored by Sage Access Management Section (SAMS) staff, who updated new provider information as changes occurred.
  - Los Angeles required its provider network to update provider data as changes occurred. Providers were made aware of this expectation upon contract application.

HSAG identified no concerns with Los Angeles' documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Los Angeles' delegated entity data and oversight included the following findings:

- ◆ Los Angeles did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Los Angeles' network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Los Angeles used member and provider data extracts from Sage and customized SQL datasets to calculate and report timely access data.
- ◆ For network adequacy indicator reporting, Los Angeles integrated member eligibility data and provider data from Sage, as well as data captured during a member's RFS using call center data that were integrated into the data warehouse and used for TADT reporting and internal monitoring.
  - Appointment data from entry point databases were integrated for timely access reporting. Member points of entry for services were the Substance Abuse Service Helpline (SASH) call center 24/7 Access Line, Client Engagement and Navigation Services (CENS), and the online provider directory.
  - Call center staff entered member service data into a service treatment database using a service connection lock application. Electronic forms were formatted for intake of appointment and treatment data at the call center.
  - Call center staff entered contact date and initial appointment offered date, which were extracted from the service treatment database for timely access reporting. The call center application also had the ability to document diagnosis codes, which were used for internal timely access monitoring.
  - Sage data were transferred to the data warehouse. A nightly automated process copied data from the Sage database to the data warehouse for a select subset of tables. The HODA Team maintained tables based on the relevancy of the data required for reporting and reviewed tables quarterly to ensure alignment with updated reporting needs.
  - Los Angeles' service treatment data sources included the SASH, Connecting Opportunities for Recovery and Engagement Centers, and CENS. Screening for appointment services was implemented during an RFS, and staff connected the member to CENS if needed.
  - SUD services were initiated through member self-referral and Los Angeles' online provider directory. SUD providers entered the RFS date and appointment offered date into Sage.

- The initial contact date and appointment date were extracted from Los Angeles' data warehouse level of care (LOC) data.
- Providers had access to modify their service availability using the SBAT backend survey tool to update current appointment availability.
- ◆ Los Angeles maintained data control procedures to ensure accuracy and completeness of data merges for TADT and internal timely access reporting. Call center staff, clinicians, utilization management, and finance staff reviewed and validated data when an RFS was received.
- ◆ Los Angeles used appropriate methodologies to assess adherence to DHCS' network adequacy indicators by ensuring review of DHCS All Plan Letters and reporting requirements.
  - If an updated requirement was identified, the HODA Team applied the change in reporting scripts and tracked the change as part of the change log of reporting requirements. Los Angeles' HODA Team updated customized data extracts in alignment with DHCS reporting requirements and documented changes in the Microsoft Git repository for version control.
  - Alternate funding sources were evaluated if a member's Medi-Cal eligibility could not be determined at the time of request using the California Outcomes Measurement System (CalOMS) eligibility check. Following eligibility verification, providers submitted a service authorization request. Alternate funding sources for services were tracked in Sage until a member's Medi-Cal eligibility was verified.
  - Los Angeles' HODA Team conducted data reasonability checks using monthly, quarterly, and annual performance comparisons and evaluated any unexpected performance data gaps against expected performance and performance targets.
  - The system of service for referral inquiries was tracked in Sage. Los Angeles' most frequently reported service inquiry source was self-referral.
- ◆ Los Angeles maintained timely access reports using the reporting naming conventions for DHCS' TADT submission. Internal timely access reports were labeled using the timely access measurement period and the date of report production. Reports were stored and maintained over time for internal reference.
- ◆ To ensure data quality, Los Angeles' IT staff created a view in the data warehouse to verify and compare data warehouse tables with the corresponding tables in the Sage database. Stored procedures were used to flag any errors during loading of source data to the data warehouse. Los Angeles validated timely access data reported in the TADT by comparing the intake cache database data against the data warehouse tables used for TADT reporting. The HODA Team reviewed and resolved any identified errors.
- ◆ To ensure continuity of network adequacy indicator production, Los Angeles backed up timely access data using cache databases, which were copied to the SQL data warehouse nightly.
- ◆ HSAG assessed Los Angeles' processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

**Ongoing monitoring activities:**

- ◆ Los Angeles' HODA Team was responsible for ongoing monitoring of network compliance with timely access standards. Division chiefs and managers reviewed the Drug and Alcohol Treatment Access Report (DATAR) and timely access performance metrics monthly to evaluate adequacy of timely access to services.
- ◆ Los Angeles' division chiefs and managers incorporated timely access performance results into program planning and policy decisions, based on timely access performance data.
- ◆ Timely access reports were reviewed and trended quarterly and against the previous fiscal year. Access to care was evaluated based on report metrics showing the number of days between the request date and the appointment date. Performance was reviewed for outpatient SUD treatment programs and OTPs.

HSAG identified no concerns with Los Angeles' documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

**Assessment of Data Validity**

HSAG evaluated and assessed the data methods that Los Angeles used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Los Angeles used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Los Angeles' **data collection procedures** were:

- Acceptable  
 Not acceptable

Overall, HSAG determined that Los Angeles' **network adequacy methods** were:

- Acceptable  
 Not acceptable

Overall, HSAG determined that Los Angeles' **network adequacy results** were:

- Acceptable  
 Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.7 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.7—Los Angeles Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services— Outpatient SUD and Residential (18+)	2,325	2,279	98%↑
Outpatient Services— Outpatient SUD and Residential (0–17)	163	161	99%↑

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>OTP</b>			
OTP (18+)	301	300	100%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Los Angeles’ performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Los Angeles’ homegrown patient access to care portals, as source systems for timely access reporting, enabled the rapid identification and resolution of data gaps and implementation of data control processes to improve overall accuracy of timely access reporting.
- ◆ **Strength #2:** Los Angeles’ value-based incentive program included workforce development metrics to increase access to OTP and SUD providers, and access to care metrics designed to reduce system barriers to SUD treatment.

### Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Los Angeles had in place to inform network adequacy reporting.

# County of Marin

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Marin and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Marin had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Marin used SmartCare as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to implementing SmartCare, Marin utilized Web Infrastructure for Treatment Services (WITS).
- ◆ Marin conducted appropriate testing and validation methods to ensure completeness and accuracy of data migrated from WITS to SmartCare.
  - Marin created and reviewed data sheets and files from legacy systems prior to sending to CalMHSA.
  - CalMHSA conducted quality checks and test uploads to a pre-go-live version of SmartCare to check for errors. Errors were sent back to Marin to correct.
  - Marin also completed spot check comparisons of data in both the legacy system and test system.
  - Marin determined that due to merging member data from two systems, some member demographics did not align. To ensure no member data were lost, demographic information that did not align to demographic fields was stored in SmartCare as a text attachment to the member record. Providers were requested to review member data annually and update demographic data into demographic/member profile screens.
- ◆ Marin used SQL for network adequacy reporting.

HSAG evaluated the personnel that Marin had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ CalMHSA staff included 26 programmers with an average of six years of experience.
- ◆ Marin had four in-house programmers with an average of eight years of experience.

HSAG identified no concerns with Marin's information systems data processing procedures and personnel.

## Enrollment System

HSAG evaluated the information systems and processes used by Marin to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Marin's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Marin were maintained in SmartCare.
- ◆ Marin received the MMEF from DHCS. The MMEF was uploaded into SmartCare to systematically update eligibility data on existing member records and add new member records.
- ◆ Marin's reconciliation and oversight of enrollment data included:
  - Marin performed automated data rationality checks prior to importing the MMEF into SmartCare.
  - Marin performed matching logic including DOB, gender, and SSN to link updated data to existing members.
  - Marin produced a bimonthly report to identify potential duplicate members, merged validated duplicate files, and retained data from both records.
- ◆ SmartCare had a function to allow staff to check real time eligibility via a 270/271 process. SmartCare automatically adjusted member eligibility based on response to this process.
- ◆ SmartCare captured manual edits to member records including username and date of edit. Role-based rules limited user access to make manual edits. Marin users were prevented from making edits to eligibility.
- ◆ Marin defined a new member as a new admission to DMC-ODS outpatient, intensive outpatient, residential, residential withdrawal management, or OTP LOC.

HSAG identified no concerns with Marin's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Marin to capture provider data and identified the following findings:

- ◆ Marin ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Marin screened the data for completeness and consistency.
- ◆ Marin collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Marin's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.
- ◆ Marin collected data from both county staff and contracted providers in a standardized application format. A staff user access form was required for new staff, staff updates, and terminated staff.
  - Credentials were verified at time of employment and during recredentialing every three years. Provider license, taxonomy, NPI, and appropriate attestations were validated.
- ◆ Marin manually entered provider data into SmartCare, which automatically checked for taxonomy and license mismatches. End users identified data entry errors which were corrected manually.
- ◆ Marin allowed the optional use of SmartCare for appointment scheduling for both county and contracted providers, which included an appointment search function.
- ◆ As part of the EHR system migration, Marin identified provider data gaps due to discrepancies in data formatting, incomplete record entries, and inconsistencies in historical information from the legacy system. This included blanks in qualifications, licensure information, and historical information such as prior roles, certifications, and training records.
  - Marin conducted a data validation process to address gaps. Incomplete or misaligned data were identified, and Marin coordinated with various county departments to gather missing information, reviewed county staff records against source documents, and cross-checked for accuracy.
  - EHR staff utilized SmartCare to produce reports to identify missing provider information and worked with providers to address the gaps.
  - Marin resolved provider data gaps within the first two months of the SmartCare go-live date.
- ◆ Marin conducted monthly provider checks by sending each contracted provider an attestation form to complete, indicating key changes and compliance with reporting requirements as well as a list of staff nearing license/certification expiration.
  - Marin contract managers reviewed submitted attestations, verified compliance, and followed up with providers to address areas of potential non-compliance.
  - Marin reported 100 percent compliance with the monthly contracted provider check process.

HSAG identified no concerns with Marin's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

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## Delegated Entity Data and Oversight

HSAG's assessment of Marin's delegated entity data and oversight included the following findings:

- ◆ Marin did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Marin's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Marin's providers utilized standardized SmartCare system forms to track and report network adequacy indicators. Providers manually completed system forms in the member's record for timeliness services.
- ◆ SmartCare captured timely access standards based on data entered in standardized system forms.
- ◆ Marin's QM Team extracted timeliness data reports from SmartCare into Excel to perform timeliness calculations. Data were copied and pasted into the TADT for timely access reporting to DHCS.
- ◆ The clinical implementation coordinator reviewed and tested the TADT reports to check for data accuracy.
- ◆ The QM Department analyst submitted the TADT to DHCS annually. The QM Team served as a backup for continuity in reporting.
- ◆ HSAG assessed Marin's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Marin produced a monthly report from SmartCare to review timeliness data. The report was exported to Excel to review timeliness calculations.
  - Calculations performed in the report determined if data were missing from timeliness records. Providers were contacted to correct and backfill data.
- ◆ Marin produced a report from SmartCare to review new members who did not have timeliness data entered in their records. Missing report data were addressed with providers and updated.
- ◆ Marin created a training video and written procedures for providers on timeliness reporting requirements.
- ◆ Annually, Marin reviewed, analyzed, and reported on data included in the BHRS DMC-ODS QI plan for both county and contracted providers. The review and analysis process included timeliness of first initial contact to face-to-face appointment.

HSAG identified no concerns with Marin’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Marin used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that Marin used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Marin’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Marin’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Marin’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.8 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.8—Marin Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	97	97	100%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	0	0	ZU
<b>OTP</b>			
OTP (18+)	14	14	100%↑
OTP (0–17)	0	0	ZU

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## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing Marin's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** Marin maintained strong processes to capture and report timeliness data through creating and reviewing reports of missing timeliness data and addressing data gaps via communication to providers. Additionally, Marin created a training video and written procedures detailing processes for provider-reported timeliness data.

### **Opportunities for Improvement and Recommendations**

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Marin had in place to inform network adequacy reporting.

# County of Mariposa

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Mariposa and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Mariposa had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Mariposa used InSync as the database management system to collect and maintain enrollment and eligibility data and store data related to provider credentialing.

HSAG evaluated the personnel that Mariposa had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Mariposa had two programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had approximately seven years of experience in the field.

HSAG identified no concerns with Mariposa's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Mariposa to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Mariposa's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Mariposa were maintained in InSync.
- ◆ Mariposa received eligibility data from DHCS through real-time verification within InSync and via the MMEF, which was downloaded and reviewed by the Medical Records Unit monthly.
- ◆ The MMEF was used for both current eligibility checks and retroactive reconciliation, covering a 15-month eligibility lookback period.
  - Mariposa did not upload the MMEF into the EHR automatically but instead performed manual verification and reconciliation using a centralized process.
  - When discrepancies were identified, eligibility was validated using the MMEF, and staff contacted eligibility services directly for clarification.

- ◆ Mariposa defined a new member as an individual who contacted Mariposa to begin or restart services.
- ◆ Each new member was manually checked against the InSync database using name, DOB, and SSN (if available) to prevent duplication. Once verified, the system autogenerated a unique internal member ID.
- ◆ InSync maintained both the state-issued Medi-Cal ID and an internally generated member ID. If a Medi-Cal ID changed, prior EHR records were linked to the current record to maintain enrollment history.
  - Demographic updates were identified through the MMEF or directly from the member.
  - Updates to address or other demographic fields were stored in InSync and tracked within the InSync system.
  - Staff with access permissions, including medical records, crisis response, QA, and clinical supervisors, had authority to make manual edits to member enrollment records. All changes were logged in the system, capturing the user, timestamp, and type of modification.
- ◆ Monthly QA audits of member records were conducted to validate data accuracy and completeness, with issues resolved through coordination with internal teams and external eligibility services.

HSAG identified no concerns with Mariposa's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Mariposa to capture provider data and identified the following findings:

- ◆ Mariposa ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Mariposa screened the data for completeness and consistency.
- ◆ Mariposa collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Mariposa's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in both InSync and Valenz systems.
- ◆ When new staff were hired, the site supervisor or contracted provider completed a new user setup form. This form included all required elements needed for reporting, including license type, assigned facility, and NPI. The completed form was submitted to Mariposa's QA Team, who verified the information and entered the provider into InSync's resource management module.

- The QA Team confirmed the provider was not already in the system and ensured that data entry aligned with internal coding standards. If any discrepancies were found, such as mismatched roles (e.g., therapist marked as case manager), the team followed up with the originator for clarification.
- InSync maintained role-based permissions, and access to the system was restricted based on the provider's license and designation. Supervisors were assigned superuser roles, granting them higher system permissions.
- Once the provider was entered into InSync, all associated information was stored in the provider profile, including license details, NPI, taxonomy, credentials, facility assignments, and e-signature data.
- ◆ Provider active and inactive status was tracked through color indicators in InSync: red for inactive, blue for active, and black for fully inactive. The QA Team had the ability to inactivate providers or lock their system access. Full inactivation was typically delayed until billing activities were completed.
- ◆ Provider profiles were not editable by providers themselves. If changes were needed, such as a license update or role transition (e.g., case manager to clinician), a new setup form was submitted with the revised information.
- ◆ Required fields on the new user form were marked and enforced through form validation. Any missing fields prevented completion. The QA Team triaged errors identified through 274 reporting before submission.
- ◆ Telehealth services were tracked in InSync using built-in encounter types and modifiers. Providers selected telehealth options during documentation, and the system applied appropriate place of service codes.
- ◆ Provider facility access was role-based and limited to assigned locations. Contracted versus in-house status was determined by the provider's preferred login facility.
- ◆ Multiple specialties and taxonomies could be selected within provider profiles for 274 reporting. Default taxonomy was generally aligned with the primary service rendered.
- ◆ QA validated taxonomy accuracy through the NPPES and licensing boards. Updates to taxonomy were not tracked with end dates, but updates were verified at provider onboarding.
- ◆ Mariposa used the Valenz system to monitor provider data. Access to the system was limited to one analyst and one supervisor. Automated reports were generated on the first day of each month. If a provider's license was nearing expiration, the provider's name appeared in the report, prompting Mariposa QA staff to notify the provider directly.

HSAG identified no concerns with Mariposa's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

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## Delegated Entity Data and Oversight

HSAG's assessment of Mariposa's delegated entity data and oversight included the following findings:

- ◆ Mariposa did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Mariposa's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Mariposa utilized InSync to track data used to report timely access network adequacy indicators annually, unless requested more frequently by DHCS. Mariposa used the TADT for reporting timely access to DHCS.
- ◆ Timely access data were exported from InSync, and Mariposa staff manually appended CIN numbers during the export process to ensure alignment with DHCS requirements.
- ◆ Discrepancies or incomplete fields identified during the review process were addressed in collaboration with the EHR vendor to improve data integrity.
- ◆ InSync automatically captured timeliness data through structured workflows including scheduler entries, encounter fields, and referral tracking. Alerts were triggered when appointment availability approached the seven-day threshold, enabling staff to take proactive measures to avoid access delays.
- ◆ Each TADT reporting domain was assigned to designated teams, with files submitted through a coordinated shared folder. Supervisors conducted final reviews to ensure documentation accuracy, compliance with naming conventions, and proper file uploads.
- ◆ HSAG assessed Mariposa's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Mariposa actively monitored timely access to care monthly throughout the year, supplementing TADT submissions with ongoing internal oversight mechanisms.
- ◆ Timeliness data were reviewed monthly through utilization management meetings and quarterly through the Quality Improvement Committee (QIC).

HSAG identified no concerns with Mariposa's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Mariposa used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Mariposa used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Mariposa's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Mariposa's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Mariposa's **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume ("**Description of Validation Activities**").

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Mariposa went live as a DMC-ODS plan on June 30, 2023. As such, Mariposa was not required to submit to DHCS any documentation related to FY 2023–24. According to the DHCS protocol, plans that opt into the DMC-ODS are not required to submit annual network certification documents for DMC-ODS during the fiscal year in which they went live, as the

certification process confirming the plan's readiness to operate as a DMC-ODS plan applies to the subsequent annual network certification cycle.

## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing Mariposa's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** Mariposa integrating the Valenz system for license monitoring and proactive alerting, reflected Mariposa's commitment to maintain current and compliant provider records.

### **Opportunities for Improvement and Recommendations**

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Mariposa had in place to inform network adequacy reporting.

# County of Merced

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Merced and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Merced had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Merced used Credible as the database management system to collect and maintain enrollment and provider data beginning April 1, 2023.
- ◆ Prior to April 1, 2023, Merced used Anasazi to maintain enrollment and provider data. All system data were migrated completely from Anasazi, except for clinical record images. Historic Anasazi data were accessible through an archive database after the migration.

HSAG evaluated the personnel that Merced had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Merced IS staff maintained an average of five years of experience.
- ◆ BHRS Automation Services data analysts had an average of two years of experience.
- ◆ Kings View staff had over 10 years of experience.

HSAG identified no concerns with Merced's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Merced to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Merced's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Merced were maintained in Credible.
- ◆ Merced fiscal analysts retrieved the MMEF from the DHCS SFTP server. Three analysts from Merced's Fiscal Team had access to upload the MMEF.
- ◆ Merced performed monthly reconciliation between Credible and the MMEF to ensure complete and accurate eligibility data. The MMEF processing time for Credible integration was approximately one business day. The MMEF integration process was the same in Anasazi. The MMEF was integrated as a background process. Member records were

compared with MMEF records and any data changes in eligibility data received in the MMEF were retained as updated member records in Credible and Anasazi.

- ◆ Merced's reconciliation and oversight of enrollment data included use of an upload and match report to validate any member record discrepancies between MMEF data and active member data in Credible. Analysts validated discrepancies using MEDSLITE and manually updated Credible with the corrected information.
- ◆ Merced searched Credible to ensure a duplicate record would not be created before entering a new member. The Automation Services Team ran a duplicate chart report to ensure that a duplicate member record was not created at any time in error. If a duplicate record was identified, a technician merged the record.
- ◆ RTE was not functional in Credible. At the time of the virtual review, Merced was in progress of implementing system functionality in Credible to accommodate RTE verification.
- ◆ Inactive member status in Credible was used when Merced's Medical Records Team identified a member as discharged from treatment or if a member chart was created in Credible for storage of medical records, such as receipt of charts for inmates released from custody from the Justice Community Integration Division, but services were never initiated.
- ◆ The 24/7 Access Team referenced MEDSLITE to verify eligibility prior to proceeding to schedule appointments. Member appointment services were not denied based on a member's status for Medi-Cal eligibility. If a member was ineligible for Medi-Cal at the time of the request, the 24/7 Access Team staff informed the member of potential cost-sharing responsibility. Retroactive eligibility received on the MMEF was captured in Credible.
- ◆ Retroactive enrollments were captured during MMEF uploads as updates to existing records. For new members, eligibility was manually entered in Credible and a member ID was generated. Changes were logged and accessible with date, time, staff name, and details.
- ◆ Credible captured and maintained both CIN and a system-generated member ID. The unique member ID was assigned to each member when the member was added in Credible. The system automatically generated the next available member ID in sequence. CINs were used to uniquely identify members and link across claims and MMEF data sources. If a member was opened previously in Anasazi, then the Anasazi member ID was manually added in an additional field for reference as needed.
- ◆ Merced identified member demographic updates based on information in the MMEF and information collected by the 24/7 Access Team. Members could provide updated demographic information directly to this team, and all Credible users had authority to update member demographic information as needed. Only fiscal, automations services, crisis staff, and front desk staff had authority to update member eligibility and insurance information in Credible. Changes were logged with a timestamp, staff name, and details of the change.
- ◆ Merced defined a new member as a Medi-Cal member requesting services who did not currently have any open assigned teams or programs in Credible.

HSAG identified no concerns with Merced's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Merced to capture provider data and identified the following findings:

- ◆ Merced ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Merced screened the data for completeness and consistency.
- ◆ Merced collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Merced's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in Credible.
- ◆ Merced's program managers initiated provider profile setup in Credible at provider onboarding. The Credentialing Team verified the provider's credentials at onboarding. Providers gained access to the Employee Status Notification (ESN) form and updated the form with their own credentials and demographic details. Merced's Automations Team validated and integrated ESN data into Credible to complete provider setup.
- ◆ Providers self-reported specialty, taxonomy, license, and telephone number. Merced validated these data every three years during the credentialing process. Provider taxonomy was verified using the NPPES for accuracy based on the provider's position title.
- ◆ Merced's QA specialist routinely validated the accuracy of provider data. If a provider was identified as requiring termination during a routine audit, the QA specialist notified Merced's credentialing staff, and the provider was deactivated in Credible.
- ◆ Merced's procedures for updating and maintaining provider data included:
  - Merced used the Credible 274 Network Provider Data Updates form to maintain provider data for existing or new providers in a format consistent with DHCS' 274 file submission requirements. The contract expiration date was used to identify terminated providers. Provider data updates were reported monthly to DHCS through Merced's NACT 274 process.
  - Licenses and certifications were verified using the DCA license search site. Merced's Personnel Team validated credentials and worked with providers to ensure provider information was updated. The Personnel Team also used an expired license report to identify providers or organizations excluded from the Medicaid and CHIP programs each month.
  - Merced required its provider network to update provider data monthly as part of the NACT 274 process. Providers were made aware of this expectation through the provider contract.

HSAG identified no concerns with Merced's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Merced's delegated entity data and oversight included the following findings:

- ◆ Merced did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Merced's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Merced utilized Credible as the data source and main data warehouse for member and provider data used for timely access reporting. Merced used Anasazi as the TADT data source for services requested between July 1, 2022, and March 31, 2023.
- ◆ Merced integrated member and provider data from Credible for network adequacy indicator reporting. Merced created custom reports and tailored datasets to enable timely access analysis using Credible's ad hoc reporting function and SQL queries.
  - Merced subcontracted development of timely access extract forms to Kings View. Kings View customized forms in alignment with the DHCS TADT reporting requirements.
  - TADT data reported for services requested between July 1, 2022, and March 31, 2023, were exported from Anasazi. Data were exported using Anasazi's Client Services Information (CSI) Assessment Record Data Report.
  - TADT data for services requested between April 1, 2023, and June 30, 2023, were extracted using Credible extract forms and SQL databases to capture all relevant data.
  - Merced maintained oversight of contracted report development and EHR support services with Kings View through contract language included in the Contract for Expanded Support.
- ◆ Merced maintained desktop procedures for the consolidation and export of timely access source data from Anasazi and from Credible's CSI report, to ensure data control, accuracy, and completeness of data merges for timely access reporting.
- ◆ Merced used appropriate methodologies to assess adherence with timely access reporting requirements.
  - Appointment services with members were initiated based on Merced's received referrals or members contacting Merced's 24/7 Access Line. Referrals originated from California Health and Human Services Agency (CalHHS), probation officers, education facilities, primary care providers (PCPs), community-based organizations, MCPs, naloxone treatment and residential treatment providers, and inpatient units. Merced's Quality and

Performance Management (QPM) Team processed presumptive transfers, which were forwarded to the 24/7 Access Team for scheduling. Members initiated residential and naloxone treatment program services with the contracted provider directly. The QPM Team reviewed residential services referral authorizations.

- The 24/7 Access Team was responsible for new member intake. Member demographic information was documented in the EHR CSI form. The Central Intake Team completed a review of the initial assessment and determined which service the member needed. The 24/7 Access Team was then notified via email and proceeded with scheduling the service.
- Merced's 24/7 Access Team documented requests for services in a 24/7 Access database. Scheduled appointments were then entered in Credible's CSI form and linked for timely access reporting.
- For DMC-ODS services, an American Society of Addiction Medicine (ASAM) assessment was completed with all members to determine LOC, and referrals were made based on that recommendation.
- Merced ensured that consistent review criteria for prior authorization decisions were used and consulted with the requesting provider when appropriate. The prior authorization procedure was followed prior to scheduling urgent visits. Prior authorization procedures governed authorization. Merced's QPM staff processed patient referrals within 24 hours of the request. The QPM Team reviewed authorized referral packets for Crisis Residential Unit (CRU) services and worked with the referring party for clarifications as needed. Upon authorization, the QPM Team submitted referrals to the CRU and notified the referring party. If the QPM Team became aware of the need to process an out-of-county referral, Merced verified the responsible county code using MEDSLITE.
- ◆ Merced conducted data reasonability checks of timely access data reported. Extracted data were compared with data entered in Credible and Anasazi for accuracy. Analysts evaluated dates to validate reasonability based on the reporting time frames.
- ◆ Merced maintained TADT submissions in designated file folders for report documentation. Submissions were labeled using standard naming conventions that were documented in the TADT instructions desktop procedure and referenced the month and year of the data pull and TADT submission date.
- ◆ Merced conducted data quality and validation procedures throughout the process of timely access data reporting. CSI forms in Anasazi and Credible were referenced by the 24/7 Access Team, Central Intake Team, clinicians, and analysts throughout the process used for service requests and demographic data updates.
- ◆ To ensure continuity of network adequacy indicator production, Merced backed up critical Credible and information systems data nightly.
- ◆ HSAG assessed Merced's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

**Ongoing monitoring activities:**

- ◆ Merced's QIC held monthly meetings for ongoing quality assessment and performance improvement. The QIC reviewed timely access quarterly.
- ◆ Timeliness of service was identified as a KPI under Merced's QI workplan. The QIC evaluated the appointment scheduling process to assess barriers to compliance with timely access indicators. Timely access data collection processes were evaluated for underperforming SUD timely access indicators to improve data collection and performance reporting accuracy.
- ◆ Timely access reports were developed for internal monitoring using Credible's customized timely access data sets. Data were exported to a Microsoft Access database and formatted for performance monitoring in Excel. Filters and visual formatting highlighted compliance and gaps against 80 percent compliance standards for each modality.

HSAG identified no concerns with Merced's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

***Assessment of Data Validity***

HSAG evaluated and assessed the data methods that Merced used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Merced used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Merced's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Merced's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Merced's **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.9 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.9—Merced Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	99	75	<b>76%</b> ↓
Outpatient Services—Outpatient SUD and Residential (0–17)	16	14	88%↑

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>OTP</b>			
OTP (18+)	53	50	94%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Merced’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Merced implemented job aids, QA checks, and process improvements in response to an identified data issue for members with restricted charts, improving overall accuracy of member data.
- ◆ **Strength #2:** With the implementation of Credible, Merced leveraged the available system enhancements to increase automation and validation, staff oversight of processes, data control, and data quality, contributing to more accurate timely access reporting.
- ◆ **Strength #3:** In 2024, Merced implemented a reoccurring new staff eligibility notification system that helped Merced to interview and hire new clinicians and improve appointment availability.

### Opportunities for Improvement and Recommendations

- ◆ **Opportunity #1:** Merced did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Merced conduct an in-depth review of the indicators for which it did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.

- **Recommendation #2:** HSAG recommends that Merced continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

## County of Monterey

### *ISCA Findings and Data Validity*

HSAG completed an ISCA for Monterey and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Monterey had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Monterey used myAvatar as the database management system to collect and maintain enrollment and provider data.
- ◆ Monterey used SQL Server to inform network adequacy reporting.

HSAG evaluated the personnel that Monterey had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Monterey had eight programmers with seven years of experience trained and capable of supporting network adequacy reporting activities.
- ◆ Monterey's QI manager and myAvatar IT Team maintained oversight of timely access reporting.

HSAG identified no concerns with Monterey's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Monterey to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Monterey's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Monterey were maintained in myAvatar.
- ◆ Monterey downloaded the MMEF from DHCS. These files contained key demographic details and Medi-Cal eligibility status, which were imported directly into myAvatar via SFTP, with a loading processing time of two hours.

- ◆ myAvatar ran the file and compared the data elements against the most recently uploaded MMEF, as well as 15 months of historical member data. myAvatar added Medi-Cal as the financial guarantor for each member who had an open episode and did not have Medi-Cal eligibility prior to the upload.
- ◆ Monterey's QI Team used error reports to identify and assign Medi-Cal eligibility to members who were not added and processed with the MMEF upload. QI staff verified member eligibility through MEDSLITE.
- ◆ Member eligibility was also verified at the point of member service request via MEDSLITE.
  - Monterey members requested services by calling the Monterey County Behavioral Health access number, walking into any Monterey or provider clinic, or receiving a referral to SUD services directly through one of its contracted providers.
- ◆ myAvatar captured and maintained both the state-issued Medi-Cal ID and a system-generated member ID. If a member disenrolled and reenrolled, the member retained the same unique ID.
- ◆ Monterey defined a new member as a Medi-Cal member who had either never received services or an existing member who was closed to all services for at least six months.
- ◆ Monterey identified member demographic updates via the MMEF and direct member contact. Intake staff had permissions to edit member demographic data in myAvatar. Changes made to records were tracked in myAvatar including the user ID who modified the record and the date and time of the change.
  - Self-reported member address and phone number updates were updated in myAvatar. Members were directed to contact DHCS to ensure their information was updated in their systems.

HSAG identified no concerns with Monterey's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Monterey to capture provider data and identified the following findings:

- ◆ Monterey ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Monterey screened the data for completeness and consistency.
- ◆ Monterey collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Monterey's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in myAvatar.
- ◆ Monterey's procedures for updating and maintaining provider data included the following:

- Monterey had a manual review process that used provider reports and credentialing verification to track providers over time, across multiple office locations, and through changes in participation in Monterey's network.
- Upon hire, providers submitted a new user request either electronically through myAvatar or in PDF format. Designated QI staff were alerted through a myAvatar widget for electronic submissions or via email for PDFs. The QI Team reviewed requests for completeness based on the type of work the provider would be performing.
- If the provider required licensure, staff validated credentials through the DCA website and verified NPI and taxonomy using the NPPES. For unlicensed providers delivering services, only the NPI and taxonomy were verified. Monterey's QI staff also searched the OIG LEIE.
- For providers with BH licenses, Monterey's QI Team used the California DCA BreEZe Online Services system to verify the activation and expiration of BH licensure.
- Once all provider information was confirmed, a provider profile was created in myAvatar using the Practitioner Enrollment form. myAvatar maintained a set of roles and permissions that granted staff access to the system dependent on their role.
- Monterey's QI staff downloaded a monthly Excel file report to compare and validate provider data. QI staff notified providers as needed of expiring licenses. myAvatar also contained programming to prevent providers from billing if their license expired. Providers were given a 90-, 60-, and 30-day notice of licensure expiration. If the provider license was not updated and validated prior to expiration, providers were declassified to mental health rehab specialists and would not be able to access fields in myAvatar that were available to licensed providers.
- Recredentialing was completed every three years. Monterey's QI staff updated myAvatar as needed to ensure complete and accurate provider data were used for 274 reporting and Monterey's provider directory.

HSAG identified no concerns with Monterey's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Monterey's delegated entity data and oversight included the following findings:

- ◆ Monterey did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Monterey's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Monterey used SQL Server to extract data for reporting network adequacy indicators .
- ◆ Monterey's myAvatar IT Team used data entered into myAvatar to create SQL queries which corresponded to the data points required by DHCS for timely access. Each data point listed on the TADT was mapped to fields in myAvatar. Monterey's QI services manager and other relevant staff such as access services managers, QI Unit supervisor, and QI social worker reviewed the data for accuracy. A report organized to match the TADT as closely as possible to make reporting more seamless was created in myAvatar to be run on-demand. The report from myAvatar was exported to an Excel file for submission to DHCS.
- ◆ Monterey used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
- ◆ myAvatar was used to capture members initiating services, based on a specific time frame (i.e., reporting period) and on Monterey's new member definition: an individual who had never received care according to myAvatar or a member who had received care in the past for whom all outpatient episodes had been closed for longer than 365 days. The reporting period and new member definition were captured using SQL to pull the data.
- ◆ Monterey's urgent requests were tracked using the admission form in myAvatar, which had a date and time field.
- ◆ Monterey's providers and contracted provider staff entered this information in myAvatar, which captured timeliness data in several fields that were then extracted and added to the TADT for reporting to DHCS.
- ◆ Monterey conducted data reasonability checks by manually reviewing reports and validations against other reporting.
- ◆ Monterey maintained network adequacy indicator reports by storing reports in myAvatar and appending them to a table of historical results.
- ◆ HSAG assessed Monterey's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Monterey maintained data control procedures to ensure the accuracy and completeness of data extracted from myAvatar by performing a manual review of code and results using queries and reports.
- ◆ Monterey reviewed monthly timeliness data for SUD services. This review was completed by either running an on-demand report or SQL query and reviewing the data points which had been mapped to the EHR. If there were any discrepancies in the data, then a chart review of the timeline was completed.

- ◆ Monterey made changes as needed when preparing data for the reporting period based on updated DHCS requirements.

HSAG identified no concerns with Monterey's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Monterey used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Monterey used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Monterey's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Monterey's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Monterey's **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume ("**Description of Validation Activities**").

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.10 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.10—Monterey Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	273	228	84%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	0	0	ZU
<b>OTP</b>			
OTP (18+)	0	0	ZU
OTP (0–17)	0	0	ZU

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## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing Monterey's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** Monterey implemented initiatives to improve provider data accuracy and completeness, including data used for 274 reporting, utilizing monthly Excel reports to identify expiring licenses and reaching out to providers to obtain updated information.

### **Opportunities for Improvement and Recommendations**

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Monterey had in place to inform network adequacy reporting.

## County of Napa

### *ISCA Findings and Data Validity*

HSAG completed an ISCA for Napa and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Napa had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Napa used Credible as the database management system to maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Napa used Anasazi to maintain enrollment and provider data.
- ◆ Data prior to July 2023 were not migrated to Credible and remained in the legacy Anasazi system. While this did not impact data quality or analysis, it did increase processing time. Napa accessed both systems to complete data extractions.
  - A read-only version of Anasazi was maintained to ensure ongoing access. Clinicians and other authorized staff could access and review historical records when necessary.

HSAG evaluated the personnel that Napa had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Napa had seven programmers with an average of five years of experience in the field.
- ◆ Kings View had six programmers with an average of 10 years of experience in the field.

HSAG identified no concerns with Napa's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Napa to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Napa's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Napa were maintained in Credible.
- ◆ Napa downloaded the MMEF from DHCS and uploaded the file into Credible to update enrollment and eligibility information. The MMEF included eligibility history for the previous 15 months. Napa also utilized MEDSLITE to verify member eligibility during enrollment, as needed, and monthly through the MMEF process.

- ◆ Napa conducted monthly reconciliation between Credible and the MMEF using a match report within Credible. The report compared member data in Credible with information from the MMEF, identifying discrepancies in name, DOB, or SSN. Enrollment staff flagged and corrected any inconsistencies.
- ◆ Credible captured and maintained both the state-issued Medi-Cal ID and a system-generated member ID to uniquely identify members. If a member was previously in the legacy system, the legacy system member ID could be manually added for future reference.
- ◆ Napa defined a new member as a new Medi-Cal member who had never received BH services or an existing member who had not received services within six months or more.
- ◆ Napa recorded member address and phone number changes in Credible and provided monthly updates to the staff services analyst in Napa County's Self-Sufficiency Services Division (SSSD). The SSSD then relayed the information to DHCS for updates in MEDS. Members were instructed to contact DHCS directly for any other demographic changes.

HSAG identified no concerns with Napa's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Napa to capture provider data and identified the following findings:

- ◆ Napa ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Napa screened the data for completeness and consistency.
- ◆ Napa collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Napa's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in Credible.
- ◆ Napa conducted credential verification at the time of hire and monthly through a Credentials Verification Organization (CVO), CertifyOS. CertifyOS used NCQA-approved primary sources to verify licensure status and identify any sanctions or disciplinary actions. Verifications were performed across several national databases, including the NPPES, OIG LEIE, EPLS/SAM, and NPDB.
- ◆ Once verified, provider data were manually entered into Credible by Napa's staff service analysts and reviewed monthly by clerical staff to confirm the accuracy of data.
- ◆ After initial credentialing, CertifyOS continued to perform monthly checks on behalf of Napa between recredentialing cycles to ensure ongoing accuracy and validity of provider information.

- ◆ Napa's Health and Human Services Agency (HHS) Behavioral Health Division leveraged the Smartsheet database to automate the NACT 274 process, enabling the monthly collection and verification of provider network data. Providers were required to submit a monthly attestation to confirm the accuracy of their information and report any updates.

HSAG identified no concerns with Napa's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Napa's delegated entity data and oversight included the following findings:

- ◆ Napa did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Napa's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Napa utilized Credible to track and extract data used to report timely access network adequacy indicators annually, unless requested more frequently by DHCS. Napa used the TADT for reporting timely access to DHCS.
- ◆ Napa utilized Credible-maintained forms to monitor timely access data. This included the Central Access and Authorization Team (CAAT) Log and the SUD Access Log which were completed by the HHS Access Team, Crisis Team, or administrative staff. Assessments were used to determine service criteria.
- ◆ Napa's Behavioral Health Plan (BHP) Access staff used a formula from the Smartsheet database to calculate the number of business days between a service request and the first offered appointment. The data were exported into an Excel file and audited for accuracy using an assessment service report generated in Credible. Additional validation occurred during population of the TADT. The primary method for matching members was by CIN. Validation steps included pre-merge data checks to ensure fields were standardized and cleaned before merging, as well as post-merge audits to sample records and confirm consistency and completeness.
- ◆ Prior to July 1, 2023, Napa used Anasazi to track and report timely access. Anasazi contained a CSI form utilized for tracking timely access data used for DHCS reporting.
- ◆ The Analyst Team, which was part of the Quality Assurance and Performance Improvement Unit, was responsible for the oversight and compliance of network adequacy timely access standard reporting.

- ◆ Napa stored all network adequacy indicator reports on a shared drive and retained previous versions to support version control.
- ◆ HSAG assessed Napa's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

#### Ongoing monitoring activities:

- ◆ The network adequacy analyst held monthly meetings with the BHP access supervisor to review timeliness data and address any concerns. Additionally, the BHP access supervisor monitored the CAAT log weekly to ensure compliance with timeliness requirements. The CAAT log was audited for accuracy by utilizing an assessment service report generated in Credible.
- ◆ Identified network adequacy gaps were escalated to Behavioral Health Division leadership for review and discussion, and an implementation plan with defined action steps was developed and executed to address the identified gap.
- ◆ Napa identified delays in offering non-urgent outpatient SUD intake appointments following service requests. To address this issue, the new Brief Questionnaire for Initial Placement screening and referral process was implemented, availability for initial intake appointments was increased, and the SUD Screening and Referral Team was expanded to include mental health access assessors.

HSAG identified no concerns with Napa's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Napa used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Napa used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Napa's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Napa's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Napa's **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume ("[Description of Validation Activities](#)").

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.11 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

### Table 3.11—Napa Results for Timely Access Network Adequacy

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

— Indicates nonreported data, data that were not reported to DHCS in a timely manner, and/or data that exceeded DHCS' 5 percent data error threshold and were therefore unusable.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	—	—	—
Outpatient Services—Outpatient SUD and Residential (0–17)	0	0	ZU
<b>OTP</b>			
OTP (18+)	S	S	S
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Napa’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Napa demonstrated thorough oversight and monitoring of timely access reporting by utilizing Credible reports and validation tools, as well as holding monthly network adequacy analyst and BHP Access meetings to review performance and promptly address any issues or concerns.

### Opportunities for Improvement and Recommendations

- ◆ **Opportunity #1:** Napa did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS’ 5 percent data error threshold.
  - **Recommendation #1:** HSAG recommends that Napa conduct an in-depth review of the indicators for which it did not meet the timely access requirements to determine whether

the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.

- **Recommendation #2:** HSAG recommends that Napa continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

## County of Nevada

### *ISCA Findings and Data Validity*

HSAG completed an ISCA for Nevada and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Nevada had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Nevada used SmartCare as the database management system to collect and maintain member enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Nevada used Anasazi to maintain enrollment and provider data.
- ◆ Nevada used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from Anasazi.
  - Effective June 2024, NACT data and 274 data transitioned from Excel file repositories to SmartCare.
  - Effective July 2023, Nevada changed vendors for submitting 274 and NACT files from Kings View to CalMHSA.
  - Nevada had a data archiving contract with its previous EHR vendor and parent company Oracle to preserve access to the Anasazi legacy system for perpetuity. Clinical, billing, and administrative staff had access to Anasazi.
  - Migration of data to SmartCare underwent three rounds of testing, including post-upload validations after each round to ensure data were accurately reflected in the system.
  - CalMHSA also used a validation tool to analyze data prior to importing to the system to ensure data were in the correct format.
- ◆ Nevada used SQL Server to inform network adequacy reporting.

HSAG evaluated the personnel that Nevada had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Nevada had three programmers with three years of experience trained and capable of supporting network adequacy reporting activities.

- ◆ CalMHSA staff included 10 programmers trained and capable of using programming language and programs to maintain SmartCare. CalMHSA programmers had six years of experience.
- ◆ Nevada's senior administrative analyst and the program manager of administration maintained oversight of timely access reporting.

HSAG identified no concerns with Nevada's information systems data processing procedures and personnel.

## Enrollment System

HSAG evaluated the information systems and processes used by Nevada to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Nevada's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Nevada were maintained in SmartCare.
- ◆ During an overnight processing job, the MMEF was imported from the DHCS website directly into SmartCare via SFTP. The MMEF contained key demographic details and was used to track eligibility.
- ◆ SmartCare ran a real time eligibility check and compared the data elements against the most recently uploaded MMEF, as well as 15 months of historical member data. SmartCare automatically added Medi-Cal coverage to each member who had an open episode. SmartCare identified any member matches, non-matches, or potential matches.
- ◆ Nevada performed monthly reconciliation between SmartCare and the MMEF to ensure completeness and accuracy of eligibility data.
- ◆ Nevada's reconciliation and oversight of eligibility data included using a SmartCare two out of three match report to identify potential member record matches; however, the record could not be automatically updated using the MMEF due to one member data point not matching.
- ◆ Members were matched based on first and last name, SSN, and DOB. If all data points matched, the member's eligibility was automatically updated in SmartCare. Nevada reviewed members appearing on the report, validated eligibility for members receiving services via MEDSLITE, and updated eligibility records in SmartCare as needed.
- ◆ Member eligibility was also verified at the point of member service request via MEDSLITE.
- ◆ Nevada members requested services by calling the 24/7 Access Line.
- ◆ Nevada defined a new member as an individual who had not previously received DMC-ODS services within Nevada County, or who had previously received services but was not currently open to Nevada County programs.
- ◆ In SmartCare, a member ID was assigned to uniquely identify members. The generation of the member ID was based on member identifiers such as DOB, SSN, last name, and first name. When a member was registered in SmartCare, there was an option to search for existing accounts by verifying key demographic data such as SSN, DOB, and Name.

Members were enrolled into programs for treatment, and then unenrolled or discharged when services were complete. The member ID remained the same even if the member was enrolled and discharged from the program multiple times.

- ◆ The member ID and CIN from SmartCare were used to reference the member for timeliness reporting.
- ◆ SmartCare captured and maintained both the state-issued Medi-Cal ID and a SmartCare autogenerated ID.
- ◆ Nevada identified member demographic updates via the MMEF. Intake and billing staff had permissions to edit member demographic data in SmartCare. Changes made to records were tracked in SmartCare, including the user ID who modified the record and the date and time of the change. Demographic changes did not overwrite the MMEF because this file was informed by the Department of Social Services. Members who reported a demographic change were advised to contact their Medi-Cal eligibility worker for the changes to be made to the MMEF.

HSAG identified no concerns with Nevada's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Nevada to capture provider data and identified the following findings:

- ◆ Nevada ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Nevada screened the data for completeness and consistency.
- ◆ Nevada collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Nevada's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.
- ◆ Nevada's procedures for updating and maintaining provider data included the following:
  - Upon hiring, Nevada used a JotForm to collect provider information, such as name, taxonomy, and NPI. Once the clinical staff received the JotForm, the provider's NPI was verified using the NPES. Provider data such as name, taxonomy, and NPI were verified based on the service type and license required. If there were any discrepancies, a request was made for the provider to update the NPI registry accordingly. Nevada reviewed provider data for completeness and validated these data against the Social Security Administration's Death Master File, the California Consortium of Addiction Programs and Professionals (CCAPP) credentialing website, the California Association of DUI [Driving Under the Influence] Treatment Programs (CADTP) credentialing website, the California Association for Alcohol/Drug Educators [CAADE] certification

board website, and available exclusion lists prior to generating a provider account in SmartCare.

- Upon the provider's license verification, the administrative assistant was notified of the JotForm submission. The administrative assistant then double checked the validity of the information, such as NPI, valid licensure, and taxonomy, and entered the corresponding fields into SmartCare.
- SmartCare collected all data fields in the NACT 274 file such as licensure, provider focus, and areas of expertise.
- Nevada maintained a master spreadsheet that included clinicians' licenses and credentials, along with expiration dates. Nevada's administrative staff reviewed the spreadsheet each month to track these expiration dates. If an expiration date was approaching, the administrative staff checked the database associated with the licensure type to validate the date. Databases used for verification of provider data included the Board of Behavioral Health (BBH), Certified Peers, CCAPP, CADTP, and CAADE. The administrative staff then emailed the provider/staff representative to update the provider's credentials. SmartCare prevented providers with expired credentials from entering services.
- Nevada conducted an annual credentialing attestation for all providers.
  - Annually, in September, all internal Nevada staff members completed a credentialing attestation. These attestations were saved to Nevada's Behavioral Health Quality Assurance SharePoint site. If credentials changed, information was updated in SmartCare. The administrative assistant also updated the master staff spreadsheet.
- Quarterly, staff lists were distributed to Nevada's contracted providers, with the dates of the last credential forms for each provider. If the annual update was approaching, Nevada's administrative assistant informed providers and requested updates. During this process, the contracted provider reported any information changes. Nevada's administrative assistant then entered the updated information into SmartCare.

HSAG identified no concerns with Nevada's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Nevada's delegated entity data and oversight included the following findings:

- ◆ Nevada did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Nevada's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Nevada used SmartCare to report network adequacy data annually, or as requested by DHCS. Nevada used the TADT for reporting timely access to DHCS.
- ◆ Nevada used SQL Server to extract data for reporting network adequacy indicators.
- ◆ Prior to July 1, 2023, network adequacy data were primarily tracked and maintained in a separate Microsoft Excel spreadsheet.
- ◆ Nevada used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
- ◆ For annual TADT submissions to DHCS, Nevada utilized a SmartCare report which was formatted to match the columns, fields, and input requirements of the TADT. Nevada also utilized the TADT data validation and conditional formatting rules to identify data quality issues or items in need of correction.
- ◆ SmartCare's timeliness record forms had built-in data validations to monitor for missing data fields. If information was identified as missing beyond the data validations, Nevada's analyst staff worked with the appropriate team (e.g., Billing Team for CIN, Clinical Team for timely access data) to assist in completing the required data.
- ◆ Nevada conducted data reasonability checks by manually reviewing timeliness data reports.
  - Analysis included a year-to-date comparison to demonstrate volume trends and reasonableness. The administrative analyst I was also responsible for pulling timeliness data from SmartCare and entering these data into the TADT.
  - The analyst utilized the TADT's built-in validations to address any outstanding data quality issues prior to submission to DHCS. The analyst also performed additional data analysis after populating the TADT to analyze summary metrics such as first offered appointment.
- ◆ Nevada maintained network adequacy indicator reports by storing reports in SmartCare and appending them to a table of historical results.
- ◆ HSAG assessed Nevada's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Nevada maintained data control procedures to ensure the accuracy and completeness of data extracted from SmartCare by performing a manual review of code and of timeliness results.
- ◆ Nevada performed quarterly audits to identify timeliness forms with an "in progress" status that may need to be finalized. The audits included a month-over-month and year-over-year

trend analysis to identify significant dips or increases in data that may indicate missing data.

- ◆ Timeliness data were reviewed monthly at the QIC meeting and quarterly with the Behavioral Health Management Team, which included the director, clinical administrator, program managers, and clinical supervisors. Reports were exported from SmartCare and summarized by an administrative analyst who mirrored the TADT fields that DHCS monitored such as percentage of requests offered within timeliness standards.
- ◆ Nevada performed ad hoc audits to identify members who had received a California Advancing and Innovating Medi-Cal (CalAIM) Assessment or ASAM Assessment but were missing a timeliness form.
- ◆ Nevada provided feedback to its SmartCare vendor and CalMHSA regarding recommendations on additional document validations and reporting amendments to reduce the volume of data quality issues as needed.
- ◆ Nevada developed a summary report of timeliness data to monitor for needed process improvements or staff training around timely access. The summary report monitored monthly timeliness mental health plan (MHP) 274 data quality checks, as well as fluctuations in full-time equivalents (FTEs) of key provider groups and addressed any identified deficiencies or flagged areas of concern.
  - Nevada experienced significant staff turnover among those responsible for submitting timely access reports. As a result, several errors were identified in the initial TADT submission, such as missing CINs and other required data fields. Nevada utilized the updated TADT with embedded data validation and conditional formatting rules to ensure that all data submitted were complete and accurate.
  - Nevada also determined that staff were confused about which date to input for first offered appointment and what was classified as an urgent appointment. Nevada identified that many staff were inputting the first appointment date a member accepted rather than the first date that was available. This resulted in data inaccuracies, with several services not meeting the timeliness standard in Nevada's SharePoint database even though the first offered appointment was within the DHCS standard. The one urgent timeliness record that was out of compliance was determined to have been inaccurately classified as urgent.
  - Nevada addressed deficiencies by providing additional clarification and training on first offered appointment dates, definition of "urgent appointment," and timely access requirements for urgent appointments, and continued to send reminders to staff to input the first available appointment.

HSAG identified no concerns with Nevada's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Nevada used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Nevada used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Nevada's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Nevada's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Nevada's **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume ("**Description of Validation Activities**").

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.12 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein

80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.12—Nevada Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services— Outpatient SUD and Residential (18+)	114	104	91%↑
Outpatient Services— Outpatient SUD and Residential (0–17)	S	S	S
<b>OTP</b>			
OTP (18+)	14	13	93%↑
OTP (0–17)	0	0	ZU

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## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing Nevada's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** Nevada established a robust process to keep provider data up to date and accurate through its annual directory attestation requirement, and credentialing process.

### **Opportunities for Improvement and Recommendations**

- ◆ **Opportunity #1:** During the reassessment period of April 1, 2023, through June 30, 2023, Nevada faced challenges in maintaining consistent quality oversight due to prolonged vacancies in key positions responsible for the development, review, and submission of the timely access report. As a result, several errors were identified with Nevada's original TADT submission, such as missing CINs and other required data fields.
  - **Recommendation:** To increase continuity in QA functions and timeliness reporting, HSAG recommends that Nevada create desktop processes providing consistent instructions to staff on the creation, review, and submission of timely access reports.

## County of Orange

### *ISCA Findings and Data Validity*

HSAG completed an ISCA for Orange and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Orange had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Orange used Cerner/Oracle Health (Oracle) and Integrated Record Information System (IRIS) as the database management systems to collect and maintain enrollment and provider data.

HSAG evaluated the personnel that Orange had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Orange County Healthcare Agency had six staff, plus contractors with Oracle Health and other vendors (for reporting), with an average of 17 years of experience in the field.
- ◆ The Data Analytics and Evaluation (DAE) Team had nine staff with various programming expertise, with an average of 11 years of experience in the field.

HSAG identified no concerns with Orange's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Orange to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Orange's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Orange were maintained in Oracle.
- ◆ DHCS provided Orange with the MMEF, which was ingested into Databricks.
- ◆ Oracle was not set up to upload the MMEF or check Medi-Cal eligibility from within the system. Front office staff and/or providers were trained to verify a member's current Medi-Cal enrollment/eligibility status in MEDSLITE or the DHCS Provider Portal before each service and manually update any information in Oracle as needed.
- ◆ Once member eligibility was confirmed, staff performed a three-tiered search in Oracle to identify an existing member record. If a match was found, the existing record was used. If no match was found, front office staff/providers were responsible for obtaining a completed

information form from members prior to the initial appointment. After reviewing the form for completeness, front office staff registered the member in Oracle.

- ◆ Orange defined a new member as a Medi-Cal member who had never received services or a returning member with a closed case. A returning member with a closed case would have an Access Log and an initial assessment appointment scheduled, and would be classified as a new member for timely access reporting.
- ◆ Oracle captured and maintained both the state-issued Medi-Cal ID and a system-generated unique medical record number (MRN). Oracle's HNACombine application searched for duplicate charts; if duplicates were identified, the application merged all data elements to the retained chart. End users reviewed the resulting retained chart and opened a ticket if the merge was inaccurate or incomplete.
- ◆ Orange identified member demographic updates based on information received from members during the intake process, periodic updates, and pre-service MEDSLITE or Medi-Cal website eligibility checks. Information was updated in Oracle, and members were referred to contact DHCS to update their information.

HSAG identified no concerns with Orange's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Orange to capture provider data and identified the following findings:

- ◆ Orange ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Orange screened the data for completeness and consistency.
- ◆ Orange collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Orange's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status were maintained in Oracle and RLDatix.
- ◆ Providers submitted a New Applicant Request Form (NARF) to the Quality Management Services (QMS) Managed Care Support Team. Provider information was validated and verified by Orange's CVO, RLDatix. The CVO verified provider data including NPI and taxonomy through the NPPES, DEA, provider license, board certification, and exclusions using various sources.
- ◆ The IT Team entered the information into Oracle manually once it was verified.
- ◆ Orange implemented a 274 User Interface (UI) in April 2024 to maintain site and provider information for submitting 274 files to DHCS.

- ◆ Orange checked the DHCS Suspended & Ineligible (S&I) Provider List and OIG LEIE upon hire and monthly to identify providers or organizations excluded from the Medicaid and CHIP programs.
- ◆ Providers were required to confirm their data or report changes monthly, and every three years during recredentialing. Providers were made aware of this expectation during the onboarding process and via monthly notifications via the 274 UI database.

HSAG identified no concerns with Orange's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Orange's delegated entity data and oversight included the following findings:

- ◆ Orange did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Orange's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Orange utilized Cerner to track and extract data used to report timely access network adequacy indicators. Orange used the TADT for reporting timely access to DHCS. Orange utilized Carelon as the vendor to manage the member access line.
- ◆ Orange used data merged from Carelon (Excel), IRIS (Cerner), and Network Time Protocol log extract access records to report SUD and opioid treatment appointments.
- ◆ Access log datasets were merged with data sources that captured CINs and dates of services rendered. Only records with applicable dates and Medi-Cal members were kept for inclusion in the TADT. IT personnel queried IRIS (Cerner) Charge Audit data to capture DOS, and extracts were provided to the Data Analytics Team. Orange implemented a new process in January 2025 which utilized the 837 file in place of Charge Audit data to match established MRN/CIN pairs and captured dates of service.
- ◆ Count verifications were used to ensure the merges were done correctly and were accurate and complete. The QMS Clinical Records Team and Data Analytics and Evaluation (DAE) Team checked dates, record or row counts, and other critical fields for accuracy and consistency prior to submission.
- ◆ The completed TADT was submitted to DHCS annually by the QMS Clinical Records Team unless requested more frequently. The DAE Team conducted quarterly analysis of Orange's timeliness metrics outside of the annual TADT submission.

- ◆ Orange used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access. The Access Team or front office staff completed the appropriate access log and charge data were used to identify first rendered and follow-up appointments. The output of data merges was used to populate the TADT.
- ◆ Orange ensured the reliability and accuracy of its network adequacy indicator reports by performing several checks. The Data Science Team validated the syntax used to identify TADT categories through multiple data checks, including monthly comparisons and quarterly monitoring.
- ◆ Orange maintained all reports submitted to DHCS on an internal drive and labeled each submission for version control. The DAE metrics were maintained in the Statistical Package for the Social Sciences (SPSS) scripts in common folders, significant modifications were saved as a new script, and previous versions were archived.
- ◆ To ensure continuity of network adequacy indicator production, Orange had multiple staff cross-trained on the programming scripts used to produce network adequacy timely access data files and reports.
- ◆ HSAG assessed Orange's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

#### **Ongoing monitoring activities:**

- ◆ Orange's QMS Clinical Records Team was responsible for the oversight and compliance of network adequacy timely access reporting. Any gaps identified in Orange's network indicator-level contract requirements were tracked, monitored, and addressed with appropriate staff to determine a solution. To address identified gaps, Orange has hired additional staff, recruited new providers, and offered alternative programs/services to accommodate appointment requests.
- ◆ The DAE Team conducted quarterly analysis of timeliness metrics to ensure compliance with network adequacy indicators required by DHCS. Findings were reported in quarterly Community Quality Improvement Committee meetings and to other QI workgroups, subcommittees, and program management as requested.
- ◆ Orange acknowledged the following identified issues with TADT submissions:
  - CINs not entered but Cerner MRN available. This issue was partially remedied by utilizing service data (e.g., charge records, 837 files) to identify missing CINs using MRNs.
  - Lack of data (e.g., closure reason/date, follow-up appointment offered). This issue was partially remedied by including more service data to locate follow-up appointments and confirm follow-up offered and closure reason/dates.

HSAG identified no concerns with Orange's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Orange used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Orange used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Orange's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Orange's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Orange's **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume ("**Description of Validation Activities**").

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.13 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.13—Orange Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	384	383	100%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	S	S	S
<b>OTP</b>			
OTP (18+)	265	265	100%↑
OTP (0–17)	0	0	ZU

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## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing Orange's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** Orange exhibited strong procedures to maintain accurate and up-to-date provider data. These included a thorough credentialing process, monthly reviews of multiple sanction and exclusion lists, and mandatory monthly verification of provider information.

### **Opportunities for Improvement and Recommendations**

- ◆ **Opportunity #1:** Orange's EHR system, Oracle, was not configured to verify Medi-Cal eligibility internally, and eligibility data were obtained manually without the use of automated tools, potentially introducing opportunities for human error.
  - **Recommendation:** HSAG recommends that Orange partner with DHCS to explore alternative solutions for obtaining eligibility data, such as using the MMEF.

# Partnership HealthPlan of California

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for PHC and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that PHC had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ PHC used its claims payment system, Amisys, to collect and maintain enrollment data.
- ◆ PHC used Intelli as the database management system to collect and maintain provider credentialing data.
- ◆ PHC used SugarCRM as the database management system to collect and maintain provider data.
- ◆ PHC served as the administrator of DMC-ODS services on behalf of seven counties included in the DMC-ODS regional model: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano. PHC was responsible for the collection and submission of timely access data on behalf of each county.

HSAG evaluated the personnel that PHC had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ PHC had five analysts and two BH staff trained and capable of supporting network adequacy reporting activities. The PHC Analytics Team prepared the data extracts used to inform network adequacy reporting. The PHC BH Team was responsible for timely access reporting.

HSAG identified no concerns with PHC's information systems data processing procedures and personnel.

## Enrollment System

HSAG evaluated the information systems and processes used by PHC to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of PHC's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for PHC were maintained in Amisys.

- ◆ PHC did not use the MMEF and instead received daily and monthly enrollment files in the 834 file format from DHCS. PHC downloaded 834 files from DHCS' SFTP server and uploaded the files to Amisys.
- ◆ PHC performed monthly reconciliation between Amisys and the 834 file to ensure completeness and accuracy of eligibility data.
  - Data on the 834 file were run through five qualifiers prior to uploading to identify potential duplication including member name, DOB, CIN, address, and SSN. PHC's Amisys Team reconciled duplicates as needed by validating data against previous months of service.
  - PHC performed data validation of 834 files to ensure they were complete, including matching the total number of records received to the number of records uploaded to Amisys.
- ◆ Amisys captured and maintained both the state-issued Medi-Cal ID and a system-generated ID.
- ◆ PHC identified member demographic updates via 834 files and member self-reported changes. If a lag in updated data being received via the 834 file occurred, PHC's Member Services Enrollment Unit could update a member's record once information was validated against MEDSLITE. PHC conveyed member-reported demographic changes to the member's assigned county to relay to DHCS.

HSAG identified no concerns with PHC's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by PHC to capture provider data and identified the following findings:

- ◆ PHC ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ PHC screened the data for completeness and consistency.
- ◆ PHC collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of PHC's provider data system(s) included the following findings:

- ◆ Provider credentialing data were maintained in Intelli.
- ◆ Provider network status data were maintained in SugarCRM.
- ◆ Provider contract payment information was also entered into Amisys, including contract effective date spans and NPI.
- ◆ Providers submitted a provider agreement request form to initiate contracting with PHC. PHC's Credentialing Team reviewed for sanctions against the provider and sent feedback

to the Contracting Team, who then initiated the provider agreement and credentialing packet.

- The credentialing packet was returned to the Credentialing Team. Once the Credentialing Committee approved the packet and a site review was completed, the provider was entered into Amisys.
- Provider taxonomy was verified using the NPPES, and the provider's license was verified through applicable licensing boards including the DCA BreZE Online Services system.
- PHC also validated that providers were on the DHCS Master Provider File or the Out of County Referral File. PHC considered these files a source of truth for provider data as PHC would not be eligible for claim reimbursement if a provider was not listed on one of the files.
- PHC's Provider Relations Team completed all provider data entry and updates.
- ◆ PHC's procedures for updating and maintaining provider data included:
  - The Provider Relations Team had an Audit Team which conducted quality control and accuracy oversight of provider data across Intelli, SugarCRM, and Amisys. The provider directory was audited twice a year and included review of provider credentialing and recredentialing information and provider information change forms. Data elements reviewed included provider name, address, phone number, specialty, hospital affiliation(s), language, and office staff language. If the Audit Team identified a discrepancy, the Data Team would correct and resubmit the discrepancy.
  - PHC used LexisNexis as a vendor to provide database reports. PHC's Provider Relations Team ran monthly comparison reports against data supplied by LexisNexis to validate accuracy of provider data in SugarCRM and made updates as needed.
  - Providers could submit a change to their information via a provider information change form submitted to the Provider Relations Team.
  - Provider offices reviewed and confirmed their data at least annually. PHC's online provider directory allowed providers to confirm that displayed information was accurate or to submit a request for changes. The directory also displayed the date information was last verified. Providers could submit a request for changes via the online directory using the report inaccuracy button at any time.
  - Providers were made aware of expectations to maintain updated information through provider contract language, policies, and the provider manual.
- ◆ PHC had processes in place to review exclusion and suspension lists including the OIG LEIE, SAM, and DHCS S&I Provider List at hiring, at recredentialing every 36 months, and monthly to identify providers or organizations excluded from the Medicaid and CHIP programs.

HSAG identified no concerns with PHC's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of PHC's delegated entity data and oversight included the following findings:

- ◆ PHC did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of PHC's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ PHC used 24/7 Access Line, LOC, and encounter data to track and report network adequacy indicators.
- ◆ PHC used the TADT to report timely access to DHCS annually, unless requested more frequently. PHC collected and reported timely access data for the seven counties included in the DMC-ODS regional model.
- ◆ Members initiated SUD services by contacting PHC's 24/7 Access Line via Carelon BH or contacting a SUD provider directly.
  - For members who contacted the 24/7 Access Line, the date of contact was used for the initial RFS in the TADT. The initial request date was used in conjunction with encounter data for timely access reporting.
  - For members who directly initiated services with a provider via walk-in or self-referral, providers sent a monthly LOC data file to PHC. The LOC data file contained the initial RFS date which was used with encounter data for timely access reporting.
  - PHC noted ongoing efforts with DHCS to clarify standards for reporting timely access. PHC indicated that guidance received from DHCS included using the first rendered appointment as the first service appointment offer date and the second rendered appointment as the first follow-up appointment offer date.
- ◆ PHC's Analytics Team prepared data extracts used for populating the TADT and data dashboards used for monitoring. The Analytics Team scrubbed data prior to the data being ingested into the dashboard. Three levels of review for data completeness and accuracy were conducted prior to the data being loaded to the dashboard.
- ◆ PHC's BH Team was responsible for submitting the TADT. PHC submitted the TADT to DHCS via secure email.
- ◆ PHC defined a new member based on the member's enrollment date. For timely access reporting, all members who had an encounter during the reporting period were included in TADT submissions.
- ◆ PHC maintained TADT submissions on a department-specific site to which only PHC's BH Team had access. Additionally, submissions were stored on an SFTP site to which each regional model county had access.

- ◆ HSAG assessed PHC's processes used to inform ongoing reporting and monitoring of timely access. PHC used appropriate methods to ensure accuracy and completeness of data captured and reported; however, HSAG noted potential misalignment compared to DHCS reporting requirements due to the regional model approach.
  - DHCS held DMC-ODS contracts with each of the seven regional model counties instead of contracting with PHC; however, given how timely access data were collected and reported during the review period, PHC was the entity audited.
  - PHC relied on encounter data to report timely access, which included reporting rendered appointment dates for appointment offered fields in the TADT.

### Ongoing monitoring activities:

- ◆ PHC used a data dashboard for ongoing monitoring of timely access data. The dashboard was refreshed monthly and tracked the total number of SUD treatment episodes, the number and percentage of compliant episodes, whether the request was a walk-in or received through the 24/7 Access Line, average number of days between initial contact and treatment, and urgency of requests. The dashboard displayed an episode ID which linked to the correlating claim number.
  - PHC presented timely access data during quarterly Substance Use Internal Quality Subcommittee meetings, including review of 24/7 Access Line data and timeliness of appointments.
- ◆ Additionally, the counties included in the regional model maintained a monitoring tool to assess PHC's performance annually. Any identified issues were addressed via a corrective action plan (CAP) process. PHC did not identify any issues related to timely access requiring corrective action during the NAV review period.

HSAG identified no concerns with PHC's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that PHC used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that PHC used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that PHC's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that PHC’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that PHC’s **network adequacy results** were:

- Acceptable
- Not acceptable

## **Network Adequacy Indicator-Specific Validation Ratings**

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## **Analysis and Conclusions**

Table 3.14 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

### **Table 3.14—PHC Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	1,011	983	97%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	27	27	100%↑
<b>OTP</b>			
OTP (18+)	306	301	98%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing PHC’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** PHC had thorough processes in place to maintain accurate and up-to-date provider data using standardized forms including the psychiatric appointment request (PAR) and provider information change form, Audit Team and biannual provider directory audits, and an annual requirement for providers to confirm their information or report changes via the online directory.

### Opportunities for Improvement and Recommendations

- ◆ **Opportunity #1:** HSAG identified misalignment of reporting of timely access for the regional model in relation to DHCS requirements, including the use of encounter data for offered appointment dates.

- **Recommendation:** HSAG recommends that PHC and the regional model counties continue collaboration with DHCS to understand and streamline timely access reporting requirements in relation to the regional model.

## County of Placer

### *ISCA Findings and Data Validity*

HSAG completed an ISCA for Placer and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Placer had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Placer used SmartCare as the database management system to maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Placer used myAvatar to maintain enrollment and provider data.
- ◆ Placer conducted testing prior to migrating files to SmartCare. CalMHSA and Streamline staff uploaded and imported the migration files. CalMHSA contacted Placer, and several data tables were crosschecked to confirm accuracy of data transfers.
- ◆ Member IDs and all historical member data in myAvatar were imported into SmartCare.
- ◆ myAvatar remained accessible in read-only status for medical record and clinical staff.

HSAG evaluated the personnel that Placer had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Placer had four programmers and data analysts with an average of five to 10 years of experience in the field.
- ◆ CalMHSA had 10 programmers with an average of six years of experience in the field.
- ◆ Placer's QM Team maintained oversight of timely access reporting.

HSAG identified no concerns with Placer's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Placer to capture enrollment data for members to confirm that the system was capable of collecting data on member

characteristics as specified by DHCS. HSAG's evaluation of Placer's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Placer were maintained in SmartCare.
- ◆ Placer received the MMEF from DHCS. The MMEF was imported into SmartCare and used to track eligibility. The MMEF included an eligibility table that contained 15 months of historical member data.
- ◆ Placer performed monthly reconciliation between SmartCare and the MMEF using a SmartCare two out of three match report. The report compared member data present in SmartCare versus data visible on the MMEF, highlighting discrepancies in name, DOB, or SSN. QM staff reviewed these discrepancies, validated eligibility using MEDSLITE, or followed up with the member and corrected data errors in SmartCare as needed.
- ◆ Placer validated member eligibility prior to each appointment and monthly using MEDSLITE or the SmartCare RTE function which verified eligibility using a 270/271 process.
- ◆ SmartCare captured and maintained both the state-issued Medi-Cal ID and a system-generated member ID to uniquely identify members.
- ◆ Placer defined a new member as a brand new member or a returning member who had not received services in three years.
- ◆ Placer identified updates to member demographics through direct contact with members. The MMEF served as the source of truth. When necessary, Placer updated the information in SmartCare and advised members to report changes to DHCS.

HSAG identified no concerns with Placer's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Placer to capture provider data and identified the following findings:

- ◆ Placer ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Placer screened the data for completeness and consistency.
- ◆ Placer collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Placer's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.
- ◆ Placer's procedures for updating and maintaining provider data included:
  - BH organizational providers were required to submit a Credentialing and EHR Staff Registration Application, and Placer QM staff gathered and verified provider data.

- The provider's name, address, NPI, and taxonomy were verified using the NPPEs.
- License and certifications were verified through various licensing and certification boards.
- DHCS PAVE system enrollment was verified for licensed staff.
- Once verified, information was sent to the IT Team to set up the provider in SmartCare.
- Monthly emails were sent to organizations/providers to verify their credentialed staff and provide updates or information changes, and providers were required to submit a Credentialing and EHR Staff Registration Application to QM staff each time changes or updates were made to their demographic information. QM staff verified information prior to requesting that the IT Team update the information in SmartCare.
- Recredentialing was performed yearly for registered staff, every two years for licensed and certified staff, and every three years for non-licensed staff.
- Placer checked the DHCS S&I Provider List and OIG LEIE upon hire and monthly to identify providers or organizations excluded from the Medicaid and CHIP programs.
- Placer required its provider network to update provider data immediately as changes occurred, and during recredentialing. Providers were made aware of this expectation during the onboarding process and monthly via email reminders.

HSAG identified no concerns with Placer's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Placer's delegated entity data and oversight included the following findings:

- ◆ Placer did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Placer's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Placer used SmartCare to extract and report network adequacy indicators. Placer used the TADT to report timely access to DHCS. The QM Team submitted the completed TADT to DHCS annually as part of the network adequacy submission, unless requested more frequently.
- ◆ SmartCare maintained forms for tracking timely access which included SUD and opioid treatment modalities. Placer utilized a SmartCare report to extract timeliness data used for network adequacy indicator reporting.

- ◆ Placer used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access. The Access Team completed the DMC outpatient timeliness record or the DMC opioid timeliness record in SmartCare when members requested services, and an assessment was conducted to determine if a member required urgent services.
- ◆ Placer used the SmartCare report to export timely access data from the system, which were then used to complete the TADT. Reports were generated weekly and reviewed by Placer's QM, Fiscal, and IT departments. Data analysts pulled member enrollment information for a specific time frame and compared it to a report showing the number of completed TADTs. The QM Team worked with program staff to ensure TADTs were entered for any members missing a TADT in their chart. For any data elements required on the TADT that were not included in the SmartCare report, the QM Team reviewed program enrollment and service records to gather and verify the missing information, which was then manually entered into the TADT.
- ◆ SmartCare reports were updated in the EHR system to align with DHCS requirements. Git and Azure DevOps were used for version control, to store and track changes and query report logic. Placer checked accuracy through internal testing and the county quality assurance environment to ensure that data were managed accurately according to DHCS requirements.
- ◆ To ensure continuity of network adequacy indicator production, Placer had multiple programmers and analysts trained on timely access reporting processes, and the CalMHSA Software Team conducted weekly knowledge share calls to train developers and ensure continuity of services were maintained.
- ◆ Prior to July 1, 2023, Placer used myAvatar to track and report timely access. Data were extracted from CSI records within myAvatar and submitted to DHCS. These CSI data aligned with the information required on the TADT.
- ◆ HSAG assessed Placer's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### **Ongoing monitoring activities:**

- ◆ Gaps identified in Placer's network adequacy indicator performance against DHCS' indicator-level contract requirements were tracked and monitored by Placer's QM Team. The QM manager addressed the concern at a manager and director level to determine a plan of action and, if necessary, seek new vendors and contracts.
- ◆ Placer acknowledged gaps in timely access in county rural areas due to limited providers in these areas. Placer was actively working on efforts to improve access to services, which included a policy that assessed referrals and services to out-of-network providers based on criteria outlined by DHCS to arrange appointments for members if Placer was unable to arrange an appointment with a network provider that met the timely access standard.

HSAG identified no concerns with Placer's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Placer used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that Placer used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Placer’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Placer’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Placer’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.15 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein

80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.15—Placer Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	25	25	100%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	0	0	ZU
<b>OTP</b>			
OTP (18+)	29	29	100%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Placer’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

## Strengths

- ◆ **Strength #1:** Placer's QM, Fiscal, and IT departments conducted weekly meetings with CalMHSA to review Placer's performance and to address identified challenges or concerns including arranging out-of-network referrals and efforts to improve access to services.

## Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Placer had in place to inform network adequacy reporting.

# County of Riverside

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Riverside and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Riverside had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Riverside used myAvatar as the database management system to collect and maintain member enrollment and provider data.
- ◆ Riverside used SQL Server for member data extracts to inform network adequacy reporting.

HSAG evaluated the personnel that Riverside had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Riverside had 17 programmers with an average of five years of experience, trained and capable of supporting network adequacy reporting activities.
- ◆ Riverside's Management Reporting Unit (MRU), IT Team, and Patient Accounts (PA) Team maintained oversight of timely access reporting. Staff were trained and capable of supporting network adequacy reporting activities.

HSAG identified no concerns with Riverside's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Riverside to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Riverside's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Riverside were maintained in myAvatar.
- ◆ Riverside imported the MMEF into myAvatar. The MMEF contained key demographic details and Medi-Cal eligibility status.
- ◆ myAvatar ran the file and compared the data elements against the most recently uploaded MMEF.

- ◆ Riverside's PA Team and program staff used error reports to identify and assign Medi-Cal eligibility to members who were not added and processed with the MMEF upload. Riverside staff verified member eligibility through MEDSLITE.
- ◆ The loss of eligibility report identified members who were no longer Medi-Cal eligible.
- ◆ The reinstatement of eligibility report identified members whose eligibility had been reinstated or reported retroactive.
- ◆ The Medi-Cal eligibility report identified members who may be eligible, but for whom there was no Medi-Cal guarantor in financial eligibility.
- ◆ Member eligibility was also verified at the point of member service request via MEDSLITE.
- ◆ Riverside members requested services by calling the 24/7 Access Line (Community Access, Referral, Evaluation, and Support [CARES]) or by receiving a referral from outside agencies such as the Department of Social Services, First Five, courts, probation offices, schools, and MCPs.
- ◆ A member was determined to be eligible for services if he or she had active Riverside County Medi-Cal and a qualifying score on the adult/youth SUD screening tool. In addition, individual practitioners could immediately provide clinical services to patients who presented under DHCS' No Wrong Door policy.
- ◆ Riverside defined a new Medi-Cal member using the MMEF or DHCS Medi-Cal portal. Members who had active Medi-Cal but had not received a BH service in the previous six months were considered new for the purposes of needing to have a new episode opened in myAvatar along with being clinically assessed.
- ◆ myAvatar captured and maintained both the state-issued Medi-Cal ID and a system-generated MRN.
- ◆ Riverside identified member demographic updates via the MMEF. Intake and billing staff had permissions to edit member demographic data in myAvatar. Changes made to records were tracked in myAvatar including the user ID who modified the record and the date and time of the change.

HSAG identified no concerns with Riverside's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Riverside to capture provider data and identified the following findings:

- ◆ Riverside ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Riverside screened the data for completeness and consistency.
- ◆ Riverside collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Riverside's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in myAvatar.
- ◆ Riverside's procedures for updating and maintaining provider data included the following:
  - During the onboarding process, Riverside's direct service providers submitted their provider data via the electronic Computer Access Request Form (CARF). Contracted providers submitted their data electronically via the Practitioner Enrollment Form. Both forms contained provider details such as first and last name, NPI, and taxonomy codes, and were submitted to the provider's supervisor/program manager for initial review and validation. The supervisor/program manager reviewed and validated the NPI via the NPPEES to ensure the taxonomy code aligned with the employee's job duties and practitioner categories for coverage.
- ◆ If the contracted provider had dual roles, both taxonomy codes were required to be listed under the provider's NPI.
- ◆ CARFs and Practitioner Enrollment forms were then submitted to the MRU for further validation and processing. The MRU validated the NPI and taxonomy codes via the NPPEES. If a correction was needed, MRU contacted the CARF or Practitioner Enrollment Form submitter to have the provider update the information. Once corrected, the CARF or Practitioner Enrollment Form was processed, and a provider account was created in myAvatar.
- ◆ Provider access required a new CARF or Practitioner Enrollment Form to be submitted whenever providers were promoted or transitioned to different roles.
- ◆ Riverside's QI Team manually reviewed contracted provider sites for evidence of a practitioner license, which was obtained through attestation, with random selections of contracted providers examined to verify compliance. If contracted providers changed their credentials (e.g., becoming a licensed provider after being pre-licensed) or if staff separated from the county BH or contracted provider, changes were communicated to the MRU, who validated and made appropriate provider updates in myAvatar.
- ◆ There was no specific time frame for submitting a change; however, Riverside advised to submit a practitioner enrollment form as soon as the contracted providers were aware of any changes to the provider data. Riverside's QI Team also emphasized that delays in notifying Riverside of the changes may affect billing status. The MRU only updated the provider profile after receiving a Practitioner Enrollment Form from the contract provider.
- ◆ On-site reviews were conducted triannually. The QM Department reviewed the contractor staff list for accuracy. Any changes in staffing (either the staff member's work location or any required reportable details about him or her) were recorded in myAvatar.
- ◆ Credentialing was verified at initial application and updated every five years and as needed.

HSAG identified no concerns with Riverside's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Riverside's delegated entity data and oversight included the following findings:

- ◆ Riverside did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Riverside's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Riverside used SQL Server to calculate and report network adequacy indicators.
- ◆ Riverside integrated member records and contracted provider timely access data from myAvatar for network adequacy indicator reporting.
- ◆ Timely access data were reported on the TADT at least annually as outlined in the annual Network Certification Behavioral Health Information Notice (BHIN). The BHIN outlined the date range for the submission.
- ◆ Riverside used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
- ◆ Program staff, which included contractors and county program staff, entered the data for the TADT in myAvatar forms and widgets. Timely access data were entered into a form that included data elements of the TADT, including the date of the request, offered appointments, referral source, and closure reasons.
- ◆ Riverside used a series of SQL stored procedures in the EHR SQL Server data warehouse to generate SQL tables for the TADT worksheets that conformed to the TADT specifications. The tables were copied into the TADT. Outliers, such as records that were the least compliant with the standards in timeliness, were examined for accuracy.
  - Prior to finalizing the TADT, an analyst identified records that were the least compliant with the standards. For those records, the analyst examined the clinical record and contacted relevant staff to validate whether the information in the TADT was accurate or needed to be updated to reflect the timely access for that member.
- ◆ The completed TADT was uploaded to DHCS' file sharing site or emailed as required by DHCS.
- ◆ Riverside maintained network adequacy indicator reports by storing reports in myAvatar and appending them to a table of historical results.
- ◆ HSAG assessed Riverside's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Riverside maintained data control procedures to ensure the accuracy and completeness of data extracted from myAvatar by performing a manual review of code and monthly timely access report results.
- ◆ Riverside generated monthly timely access reports with compliance metrics overall, by program and region. These reports were distributed to administrators and leadership. Timely access data such as first offered, first kept, and follow-up appointment data were presented and challenges were discussed periodically in the monthly Riverside University Health System—Behavioral Health QIC meetings.

HSAG identified no concerns with Riverside’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Riverside used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that Riverside used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Riverside’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Riverside’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Riverside’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.16 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.16—Riverside Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	4,440	3,939	89%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	294	260	88%↑

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>OTP</b>			
OTP (18+)	869	783	90%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Riverside’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Riverside implemented multiple strategies to maintain the accuracy of timeliness data reporting, which included the QI Team conducting a monthly review of timely access reports for DMC-ODS compliance metrics overall, by program and region.

### Opportunities for Improvement and Recommendations

- ◆ **Opportunity #1:** Riverside did not have defined time frames for contracted providers to report changes, such as credential updates or terminations. The absence of clear reporting expectations may lead to delays in updating provider information, which could affect network adequacy.
  - **Recommendation:** HSAG recommends that Riverside establish a required time frame for providers to notify Riverside of any changes to provider information such as licensure, credentialing, and demographic updates to ensure provider information remains current. HSAG also recommends that Riverside communicate this required time frame to providers so that expectations are aligned between Riverside and the providers.

# County of Sacramento

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Sacramento and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Sacramento had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Sacramento used SmartCare as the database management system to maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Sacramento utilized myAvatar to maintain enrollment and provider data.
- ◆ Sacramento conducted appropriate testing and validation methods to ensure completeness and accuracy of data migrated from myAvatar to SmartCare.
- ◆ Sacramento migrated data into a testing environment and conducted testing for data completeness prior to migration into the SmartCare production environment.
- ◆ Sacramento used SQL for network adequacy reporting.

HSAG evaluated the personnel that Sacramento had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Sacramento had eight programmers with an average of 10 years of experience.
- ◆ CalMHSA had 10 programmers with an average of six years of experience.

HSAG identified no concerns with Sacramento's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Sacramento to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Sacramento's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Sacramento were maintained in SmartCare.
- ◆ Sacramento received the MMEF from DHCS. The MMEF was imported into SmartCare; however, Sacramento indicated the MMEF was not used to automatically update member

eligibility or demographic data, and that all eligibility and demographic data were entered in SmartCare manually.

- ◆ Sacramento relied on providers to utilize MEDSLITE to validate and manually input eligibility data into SmartCare. Sacramento created a report for providers that compared data in SmartCare to the MMEF to identify mismatched information such as DOB or CIN.
- ◆ Sacramento used a program demographics report to identify members with incomplete address information.
- ◆ Sacramento's reconciliation and oversight of enrollment data included:
  - Sacramento had a policy requiring providers to check eligibility data for members monthly.
  - Providers were encouraged to review member eligibility prior to providing services.
  - Sacramento had the ability to review manual edits made by providers in SmartCare via back-end reports.
  - Sacramento's fiscal liaisons reviewed claims rejection data monthly to identify eligibility data entry errors. Eligibility data for rejected claims were reviewed in MEDSLITE and updated in SmartCare.
  - Sacramento identified potential duplicate cases via reported instances from end users. The Billing Team validated potential duplicate cases by reviewing MEDSLITE. SmartCare had an automated merge of validated duplicate records.
  - Members with address changes were encouraged to contact their Department of Human Assistance eligibility worker to update their address.
- ◆ Sacramento defined a new member as one who had not received services within the past year.

HSAG identified no concerns with Sacramento's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Sacramento to capture provider data and identified the following findings:

- ◆ Sacramento ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Sacramento screened the data for completeness and consistency.
- ◆ Sacramento collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Sacramento's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.

- ◆ Sacramento collected data from both county staff and contracted providers in a standardized application format. A Staff Registration/Credentialing Application Form was required for new staff, staff updates (e.g., name change, professional classification, and employment status), and terminated staff. The form included a Staff Registration/Credentialing Checklist to assist with a complete submission. Credentials were verified at the time of employment and during recredentialing every three years. Provider data were validated via the NPPES.
- ◆ Sacramento EHR staff input provider records and updated records in SmartCare based on submitted Staff Registration/Credentialing Application Forms.
- ◆ Providers and provider agencies were responsible for reviewing their records in SmartCare for accuracy.
- ◆ Sacramento required monthly submissions of staff rosters for validation of taxonomy. Submitted rosters were compared with SmartCare data to ensure the data matched.
- ◆ As part of the EHR system migration, Sacramento identified provider data gaps due to discrepancies in data formatting, incomplete record entries, and inconsistencies in historical information from the legacy system. This included blanks in qualifications, licensure information, and historical information such as prior roles, certifications, and training records.
  - Sacramento conducted a data validation process to address discrepancies. Incomplete or misaligned data were identified, and Sacramento coordinated with various county departments to gather missing information, reviewed county staff records against source documents, and cross-checked records for accuracy.
  - EHR staff utilized SmartCare to produce reports to identify missing provider information and worked with providers to address the gaps.
  - Sacramento continued to address provider data gaps by producing quarterly reports and following up with provider agencies.

HSAG identified no concerns with Sacramento's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Sacramento's delegated entity data and oversight included the following findings:

- ◆ Sacramento did not subcontract any network adequacy-related services to delegated entities.

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## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Sacramento's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Sacramento providers utilized standardized SmartCare system forms to track and report network adequacy indicators. Providers manually completed system forms in the member's record for timeliness services.
- ◆ SmartCare captured timely access standards based on data entered in the standardized system forms.
- ◆ Sacramento's TADT Team extracted timeliness data reports from SmartCare into Excel and performed internal timeliness calculations using Excel formulas. Data for reporting were copied and pasted into the TADT.
- ◆ Sacramento utilized member ID numbers and CIN matches to validate accuracy of merged data in reporting.
- ◆ The clinical implementation coordinator reviewed and tested the TADT for data accuracy.
- ◆ The QA Department health program manager submitted the TADT to DHCS annually. The TADT Team served as a backup for continuity in reporting.
- ◆ Archived report submissions were stored on a shared drive for historical reference.
- ◆ Sacramento's Management Team reported that an estimated 70 percent of timeliness data were not being submitted by providers, which impacted all TADT submission periods in scope of review.

### Ongoing monitoring activities:

- ◆ Sacramento created a monthly dashboard and reviewed the dashboard for provider completion of timeliness elements by demographics and referral source.
- ◆ Sacramento's Management Team and contract monitors reviewed the TADT quarterly. Contract monitors followed up with providers to emphasize completing timeliness forms in the system in a timely manner. Missing information due to incomplete timeliness forms was sent to providers for resolution. Contract monitors also reviewed timeliness reporting during monthly provider meetings.
- ◆ Sacramento's contract monitors reviewed provider vacancies as part of Sacramento's contract monitoring tools.
- ◆ Sacramento indicated that identified gaps in timeliness data tracking were addressed through reminder emails and meetings such as QIC, EHR user forums, CEO meetings, and utilization review committees. Additionally, the QM Team, Data Analytics Team, and EHR Team provided technical assistance and training for providers on completing timely access forms.

HSAG identified concerns with Sacramento's ability to capture and report complete timely access data to DHCS during the scope of the audit; however, HSAG identified no concerns with Sacramento's ongoing monitoring tools in place.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Sacramento used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Sacramento used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Sacramento's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Sacramento's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Sacramento's **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume ("**Description of Validation Activities**").

Table 3.17 summarizes network adequacy indicators resulting in a *Low Confidence* or *No Confidence* rating determination.

**Table 3.17—Sacramento Validation Ratings**

Indicator	Validation Rating	Comments
Outpatient Services— Outpatient SUD and Residential	<i>No Confidence</i>	Sacramento reported that 70 percent of its timeliness data were missing across all indicators impacting all TADT submission periods in scope of review for FY 2023–24. As a result, HSAG determined some elements to have significant bias, resulting in a <i>No Confidence</i> validation rating.
OTP	<i>No Confidence</i>	Sacramento reported that 70 percent of its timeliness data were missing across all indicators impacting all TADT submission periods in scope of review for FY 2023–24. As a result, HSAG determined some elements to have significant bias, resulting in a <i>No Confidence</i> validation rating.

## Analysis and Conclusions

Table 3.18 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.18—Sacramento Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

— Indicates nonreported data, data that were not reported to DHCS in a timely manner, and/or data that exceeded DHCS’ 5 percent data error threshold and were therefore unusable.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	75	73	97%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	15	15	100%↑
<b>OTP</b>			
OTP (18+)	66	61	92%↑
OTP (0–17)	—	—	—

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Sacramento’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Sacramento performed extensive provider data cleanup for system transition and continued a quarterly reporting process to address missing provider data, including qualifications, licensure, and historical information.

### Opportunities for Improvement and Recommendations

- ◆ **Opportunity #1:** Sacramento reported that an estimated 70 percent of services for timeliness indicators were not submitted by providers.
  - **Recommendation:** HSAG recommends that Sacramento consider expanding provider training opportunities to further increase understanding and emphasize the importance of tracking timeliness data in SmartCare. HSAG also recommends that Sacramento

explore system reporting capabilities, such as self-service tools, for providers to identify and address missing or incomplete timeliness records.

- ◆ **Opportunity #2:** Sacramento did not conduct proactive validation of eligibility, which would include checks to identify potential duplicate member records, or validation of manual eligibility entries made in SmartCare to MMEF data, resulting in full reliance on end users to identify potential duplicate records.
  - **Recommendation:** HSAG recommends that Sacramento explore developing automated reporting methods to identify potential duplicate member records in the system and to validate manual eligibility entries made in SmartCare.
- ◆ **Opportunity #3:** Sacramento reported that the MMEF was not utilized as a resource to populate the EHR system with member eligibility data.
  - **Recommendation:** HSAG recommends that Sacramento explore utilizing the MMEF to allow for more automation in populating member eligibility data.
- ◆ **Opportunity #4:** Sacramento did not meet one or more DHCS standards for timely access indicators due to a failure to submit timely access data to DHCS in a timely manner.
  - **Recommendation #1:** HSAG recommends that Sacramento conduct an in-depth review of the indicators for which it did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - **Recommendation #2:** HSAG recommends that Sacramento continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts, to ensure adequate access, as applicable.

# County of San Benito

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for San Benito and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that San Benito had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Benito used SmartCare as the database management system to maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, San Benito used Anasazi to maintain enrollment and provider data.
- ◆ San Benito developed conversion files using templates provided by CalMHSA, which also reviewed and approved the conversion process on San Benito's behalf. Completeness of uploads was confirmed by matching row counts for each file.
- ◆ All San Benito staff retained access to Anasazi for historical reference.

HSAG evaluated the personnel that San Benito had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ CalMHSA had 10 programmers with an average of six years of experience in the field.

HSAG identified no concerns with San Benito's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by San Benito to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of San Benito's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for San Benito were maintained in SmartCare.
- ◆ San Benito received the MMEF from DHCS. The MMEF was imported into SmartCare monthly and used to track eligibility. The MMEF included a lookback period of 15 months and an eligibility table that included historical data.
- ◆ San Benito utilized SmartCare 270/271 functionality to confirm eligibility and utilized MEDSLITE to verify member eligibility as needed.

- ◆ San Benito conducted monthly reconciliation between SmartCare and the MMEF using a SmartCare two out of three match report. The report compared member data in SmartCare with information from the MMEF, identifying discrepancies in name, DOB, or SSN. San Benito's Fiscal Team flagged and corrected any inconsistencies.
- ◆ San Benito identified potential duplicate records based on user notifications. Both the county system administrator and a designated Fiscal Team member were trained and authorized to merge member charts.
- ◆ SmartCare captured and maintained both the state-issued Medi-Cal ID and a system-generated member ID to uniquely identify members.
- ◆ San Benito defined a new member as either a first-time member seeking services or an existing member who had not received services within the past year.
- ◆ San Benito updated address and phone number changes in SmartCare based on details provided by members and advised members to contact DHCS to update their records accordingly.

HSAG identified no concerns with San Benito's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by San Benito to capture provider data and identified the following findings:

- ◆ San Benito ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ San Benito screened the data for completeness and consistency.
- ◆ San Benito collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of San Benito's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.
- ◆ San Benito's procedures for updating and maintaining provider data included:
  - Providers were required to submit a credentialing application, and provider data were gathered and verified by San Benito's QI Team.
  - San Benito performed credential verification upon hire, monthly, and every three years during recredentialing, utilizing national databases such as the NPES, DEA License Search, OIG LEIE, EPLS/SAM, and NPDB to confirm licensure and identify any sanctions or disciplinary actions.
  - Once verified, staff registration details were recorded in an Excel spreadsheet and were manually entered into SmartCare by QI staff. SmartCare contained built-in error

messages which identified when any data required by DHCS 274 guidelines were missing or incomplete, and users could not proceed until the error was addressed.

- ◆ San Benito required its provider network to update provider data as changes occurred and annually; updates were made by phone, email, or in person. Providers were made aware of this expectation during the onboarding process.

HSAG identified no concerns with San Benito's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of San Benito's delegated entity data and oversight included the following findings:

- ◆ San Benito did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of San Benito's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ San Benito utilized SmartCare and Excel to track and extract data for reporting timely access network adequacy indicators. San Benito used the TADT to report timely access to DHCS. The TADT was submitted annually, or as requested by DHCS.
- ◆ SmartCare housed forms used to track timely access to services, including SUD and opioid treatment modalities. San Benito used a built-in SmartCare report to extract timeliness data for network adequacy indicator reporting. Only members with an active CIN were included, with member matches verified using both the member ID and CIN.
- ◆ Reports were exported from SmartCare into Excel and manually reviewed by the QI Team annually, including month-to-month comparisons. SmartCare included built-in validations and checks for missing fields. Additionally, TADTs were reviewed and tested by the clinical implementation coordinator to ensure data accuracy.
- ◆ Prior to July 1, 2023, San Benito used Anasazi to track and report timely access. Anasazi contained reports that could be generated by the QI Team as needed.
- ◆ San Benito applied appropriate methodologies to evaluate compliance with DHCS' network adequacy indicators for timely access. Data gathered by providers at the time of appointment requests were used to populate timeliness records for tracking initial service requests.
- ◆ San Benito stored TADT submissions on internal shared drives for historical reference.

- ◆ To maintain continuity in producing network adequacy indicators, San Benito collaborated with CalMHSA, which had multiple programmers and analysts trained in timely access reporting. The CalMHSA Software Team held weekly knowledge-sharing calls to train developers and ensure consistent service delivery.
- ◆ HSAG assessed San Benito’s processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

**Ongoing monitoring activities:**

- ◆ Any gaps in San Benito’s network adequacy indicator performance, as compared to DHCS’ contract requirements, were tracked and monitored by the QI Team. The team met regularly to address concerns and developed action plans as needed.
- ◆ San Benito recognized ongoing challenges in meeting timely access standards, largely due to a shortage of providers in its small rural county and continued to actively explore opportunities to expand its provider network and utilized single case agreements to fulfill requirements.

HSAG identified no concerns with San Benito’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that San Benito used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that San Benito used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that San Benito’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Benito’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Benito’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.19 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.19—San Benito Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	48	48	100%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	0	0	ZU

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>OTP</b>			
OTP (18+)	0	0	ZU
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing San Benito’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** San Benito demonstrated the ability to maintain an adequate provider network, supported by a thorough credentialing process and effective provider data management practices.

### Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities San Benito had in place to inform network adequacy reporting.

# County of San Bernardino

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for San Bernardino and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that San Bernardino had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Bernardino used myAvatar as the database management system to collect and maintain enrollment and provider data.
- ◆ San Bernardino used SQL Server to inform network adequacy reporting.

HSAG evaluated the personnel that San Bernardino had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Bernardino had 19 programmers with seven years of experience trained and capable of supporting network adequacy reporting activities.

HSAG identified no concerns with San Bernardino's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by San Bernardino to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of San Bernardino's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for San Bernardino were maintained in myAvatar.
- ◆ San Bernardino received the MMEF from DHCS. These files contained key demographic details and Medi-Cal eligibility status, which were downloaded and imported directly into myAvatar via SFTP, with a processing time of two days.
- ◆ myAvatar ran the file and compared the data elements against the most recently uploaded MMEF, as well as 15 months of historical member data. myAvatar added Medi-Cal as the financial guarantor for each member who had an open episode and did not have Medi-Cal eligibility prior to the upload.

- ◆ San Bernardino's IT Team used error reports to identify and assign Medi-Cal eligibility to members who were not added and processed with the MMEF download. QI staff verified member eligibility through MEDSLITE.
- ◆ Member eligibility was also verified at the point of member service request via MEDSLITE.
  - San Bernardino members requested services by calling the San Bernardino access number, walking into any San Bernardino or provider clinic, or receiving a referral to services directly through one of its contracted providers.
- ◆ myAvatar captured and maintained both the state-issued Medi-Cal ID and a system-generated member ID. If a member disenrolled and reenrolled, the member retained the same unique ID.
- ◆ San Bernardino identified member demographic updates via the MMEF and direct member contact. Intake staff had permissions to edit member demographic data in myAvatar. Changes made to records were tracked in myAvatar including the user ID of the person who modified the record and the date and time of the change.
- ◆ San Bernardino identified a new member as a Medi-Cal member who had never received services or an existing member whose services had been closed for at least six months.

HSAG identified no concerns with San Bernardino's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by San Bernardino to capture provider data and identified the following findings:

- ◆ San Bernardino ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ San Bernardino screened the data for completeness and consistency.
- ◆ San Bernardino collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of San Bernardino's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in myAvatar.
- ◆ San Bernardino's procedures for updating and maintaining provider data included the following:
  - San Bernardino had a manual review process that used provider reports and credentialing verification to track providers over time, across multiple office locations, and through changes in participation in San Bernardino's network.
  - Upon hire, providers submitted a new user request either electronically through myAvatar or in PDF format. San Bernardino's Research and Evaluation staff were

alerted through a myAvatar widget for electronic submissions or by email for PDFs. QI staff reviewed requests for completeness based on the type of work the provider would be performing.

- If the provider required licensure, staff validated credentials through the DCA website and verified NPI and taxonomy using the NPPEs. For unlicensed providers delivering services, only the NPI and taxonomy were verified. San Bernardino's QI staff also searched the OIG LEIE.
- For providers with BH licenses, San Bernardino's QI Team used the California DCA BreEZe Online Services system to verify the activation and expiration of BH licensure.
- Once all provider information was confirmed, a provider profile was created in myAvatar using the practitioner enrollment form. myAvatar maintained a set of roles and permissions that granted staff members access to the system dependent on their role.
- San Bernardino's QI staff downloaded a monthly Excel file report to compare and validate provider data. QI staff notified providers as needed of expiring licenses. myAvatar also contained programming to prevent providers from billing if their license expired. Providers were given a 90-, 60-, and 30-day notice of licensure expiration. If the provider license was not updated and validated prior to expiration, providers were declassified to mental health rehab specialists and would not be able to access fields in myAvatar that were available to licensed providers.
- Recredentialing was completed every three years. San Bernardino's QI staff updated myAvatar as needed to ensure complete and accurate provider data were used for 274 reporting and San Bernardino's provider directory.

HSAG identified no concerns with San Bernardino's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of San Bernardino's delegated entity data and oversight included the following findings:

- ◆ San Bernardino did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of San Bernardino's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ San Bernardino used SQL Server to extract data for reporting network adequacy indicators.
- ◆ San Bernardino reported annual network adequacy data to DHCS via the TADT.

- ◆ San Bernardino's myAvatar IT Team used data entered into myAvatar to create SQL queries which corresponded to the data points required by DHCS for timely access. Each data point listed on the TADT was mapped to fields in myAvatar. San Bernardino's QI services manager and other relevant staff such as access services managers, QI Unit supervisor, and QI social worker III reviewed the data for accuracy. A report organized to match the TADT as closely as possible to make reporting more seamless was created in myAvatar to be run on-demand. The report from myAvatar was exported to an Excel file for submission to DHCS.
- ◆ San Bernardino used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
- ◆ myAvatar was used to capture members initiating services, using the Initial Contact Log (ICL) and CSI assessment record based on a specific time frame (i.e., reporting period) and on San Bernardino's new member definition: an individual who had never received care according to myAvatar or a member who had received care in the past for whom all outpatient episodes had been closed for longer than 365 days. The reporting period and new member definition were captured using SQL to pull the data.
- ◆ San Bernardino's urgent requests were tracked using the admission form in myAvatar, which had a date and time field.
- ◆ San Bernardino and contracted provider staff entered this information in myAvatar, which captured timeliness data in several fields that were then extracted and added to the TADT for reporting to DHCS.
- ◆ San Bernardino conducted data reasonability checks by manually reviewing reports and validations against other reporting.
- ◆ San Bernardino maintained network adequacy indicator reports by storing reports in myAvatar and appending them to a table of historical results.
- ◆ HSAG assessed San Bernardino's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### **Ongoing monitoring activities:**

- ◆ San Bernardino maintained data control procedures to ensure the accuracy and completeness of data extracted from myAvatar by performing a manual review of timeliness data results using queries and reports.
- ◆ San Bernardino ran on-demand reports or SQL queries and reviewed the data points which had been mapped to myAvatar. If there were any discrepancies in the data, a chart review of the timeline was completed.
- ◆ San Bernardino's QM Team hosted monthly meetings, including the provider network and directory review meeting, and the monitoring timeliness subcommittee meeting. The monitoring timeliness subcommittee meetings were co-facilitated by San Bernardino's DBH QM staff, and included executive staff, program managers, San Bernardino's Department of Behavioral Health (DBH) Research and Evaluation Team, supervisors, analysts, and program specialists. During these meetings participants reviewed timeliness and network adequacy reports (including provider ratios, 274 survey data, and the provider directory),

developed strategies to ensure compliance with appointment requirements, and disseminated updates to the Quality Management Action Committee and DBH leadership.

- ◆ San Bernardino made changes as needed when preparing data for the reporting period based on updated DHCS requirements.

HSAG identified no concerns with San Bernardino’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that San Bernardino used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that San Bernardino used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that San Bernardino’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Bernardino’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Bernardino’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“[Description of Validation Activities](#)”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.20 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.20—San Bernardino Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	271	193	<b>71%↓</b>
Outpatient Services—Outpatient SUD and Residential (0–17)	S	S	S
<b>OTP</b>			
OTP (18+)	28	28	100%↑
OTP (0–17)	0	0	ZU

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## Strengths, Opportunities for Improvement, and Recommendations

By assessing San Bernardino's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** San Bernardino demonstrated effective oversight of network adequacy reporting through regular timeliness review meetings and multi-level validation of key indicators, such as appointment timeliness tracking, provider data, and service requests through myAvatar.

### Opportunities for Improvement and Recommendations

- ◆ **Opportunity #1:** San Bernardino did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that San Bernardino conduct an in-depth review of the indicators for which it did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - **Recommendation #2:** HSAG recommends that San Bernardino continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

# County of San Diego

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for San Diego and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that San Diego had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Diego used San Diego WITS (SanWITS) as the database management system to maintain enrollment and provider data.
- ◆ San Diego implemented SmartCare effective September 1, 2024.
- ◆ San Diego utilized Optum as its contracted Administrative Services Organization (ASO).

HSAG evaluated the personnel that San Diego had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Optum had five programmers with an average of 15 years of experience in the field.

HSAG identified no concerns with San Diego's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by San Diego to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of San Diego's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for San Diego were maintained in SanWITS.
- ◆ San Diego received the MMEF from DHCS; however, SanWITS lacked functionality to support MMEF processing. Instead, the MMEF was uploaded into Optum's SQL database. Optum then validated CINs against the MMEF data. Members with unverified CINs were excluded from reporting but were retained in the system for documentation reference.
- ◆ SUD programs/providers and billing staff were instructed to verify Medi-Cal eligibility using the DHCS Provider Portal or MEDSLITE each time a member received services, and the BHS-SUD Billing Unit (SUD BU) manually updated eligibility information on the SanWITS eligibility screen as needed.
- ◆ SUD programs staff were required to manually enter member Medi-Cal and demographic information collected from the intake form into the payor group enrollment (PGE) section of

SanWITS. The SUD BU provided training on this process and conducted monthly reconciliation and validation using SanWITS export data (known as the claim item list) to identify discrepancies. The SUD BU contacted the SUD programs staff to address any errors that could not be resolved at the department level.

- ◆ SanWITS captured and maintained both the state-issued Medi-Cal ID and a system-generated ID to uniquely identify members. The Medi-Cal ID was stored in the subscriber ID field within the member's PGE in SanWITS.
- ◆ San Diego defined a new member as someone seeking Medi-Cal services for the first time, or an individual who had not had services provided in San Diego's network within three years prior to the contact date.
- ◆ San Diego identified member demographic updates based on information received directly from members and verified through MEDSLITE. The SUD BU then updated the information in SanWITS and submitted the demographic changes to DHCS. Members were also advised to contact DHCS directly to ensure their information was updated.

HSAG identified no concerns with San Diego's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by San Diego to capture provider data and identified the following findings:

- ◆ San Diego ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ San Diego screened the data for completeness and consistency.
- ◆ San Diego collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of San Diego's provider data system(s) included the following findings:

- ◆ Provider credentialing and network data were maintained in SanWITS.
- ◆ San Diego's procedures for updating and maintaining provider data included:

### Fee-for-Service (FFS) Providers:

- ◆ New providers were required to submit an access request form (ARF) and a provider clinical application form. They were also instructed to enroll in the DHCS PAVE system.
- ◆ Optum conducted credentialing and recredentialing of providers in accordance with contract requirements and NCQA-established guidelines. San Diego's Management Information System (MIS) staff manually entered provider information into SanWITS upon verification.

- ◆ Providers received a semiannual attestation to confirm the accuracy of their contract and provider information.
- ◆ Providers submitted requests to update their practice information through the Optum Provider Portal. These requests were received via email, and Optum Provider Services routed information to MIS staff to update the information or contacted the provider for any additional details as needed.
- ◆ San Diego conducted checks of the OIG LEIE, EPLS/SAM, and DHCS S&I Provider List at the time of hire and monthly to identify providers or organizations excluded from participation in the Medicaid and CHIP programs.
- ◆ San Diego required its FFS provider network to update provider information when changes occurred, every six months during attestation, and every three years during recredentialing.

### **Organizational Program Contracts:**

- ◆ Contractors staffed treatment providers in accordance with contractual obligations, internal policies and procedures, established staffing models, and credentialing requirements.
- ◆ Programs collaborated with Optum to complete provider enrollment and credentialing processes.
- ◆ Programs submitted an ARF with the necessary information to the MIS Team. The MIS Team entered the information into SanWITS upon verification. MIS and Optum coordinated to ensure that providers requesting access adhered to the credentialing process.
- ◆ Providers received a monthly attestation form to confirm the accuracy of their contract and provider information.
- ◆ San Diego conducted checks of the OIG LEIE, EPLS/SAM, and DHCS S&I Provider List at the time of hire and monthly to identify providers or organizations excluded from participation in the Medicaid and CHIP programs.
- ◆ San Diego required its organizational program contracts to update provider data as changes occurred, monthly during attestation, and every three years during recredentialing. Providers were made aware of this expectation during the onboarding process and during attestations.

HSAG identified no concerns with San Diego's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## **Delegated Entity Data and Oversight**

HSAG's assessment of San Diego's delegated entity data and oversight included the following findings:

- ◆ San Diego utilized Optum as its ASO. San Diego subcontracted provider data management and credentialing to Optum, which used SanWITS to capture all related data.

- ◆ San Diego established clear data submission requirements, implemented data validation and monitoring processes, provided ongoing support and communication, and utilized quality improvement plans when necessary.
- ◆ San Diego did not identify any delegated entity network adequacy data-related items requiring corrective action for the time frame in scope of the NAV audit.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of San Diego's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ San Diego utilized SanWITS to track and extract data for reporting timely access network adequacy indicators. San Diego used the TADT to report timely access to DHCS. The TADT was submitted annually, or as requested by DHCS.
- ◆ San Diego's BHS Data Science Team generated the TADT, which included outpatient SUD and opioid treatment modalities. New members were identified through the initial contact report and matched with data from the intake, enrollment, and admissions reports to compile key TADT elements such as service dates, closure reasons, and other relevant service details. Member records were linked using unique identifiers such as member ID, CIN, and intake ID to accurately connect initial contact data with subsequent services, admissions, or intake processes, including termination reasons.
- ◆ Data accuracy was validated by confirming intake dates, service entries, and admissions aligned with the designated reporting periods. The BHS Data Science Team reviewed the compiled data before forwarding to the Health Plan Administration (HPA) Team for further feedback. Only members with a valid CIN were included in the final TADT submission to DHCS.
- ◆ The TADT included built-in conditional formatting to highlight errors, enhancing the accuracy and reliability of the data entered. The BHS Data Science Team corrected the highlighted errors, and the HPA Team performed an internal analysis to identify discrepancies. If anomalous results were found, the HPA Team worked with the BHS Data Science Team to correct discrepancies in the tool before submitting to DHCS.
- ◆ San Diego met with DHCS for technical assistance sessions if clarifications were needed.
- ◆ San Diego created dashboards to review and monitor trend data month to month, as well as year over year, for various indicators, and the BHS Data Science Team and HPA Team met weekly to discuss quality assurance strategies, validation reports, and corrections.
- ◆ To ensure continuity of network adequacy indicator production, all San Diego staff had similar skillsets and were familiar with the generation of network adequacy reports.
- ◆ HSAG assessed San Diego's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

**Ongoing monitoring activities:**

- ◆ The HPA Team monitored any gaps in San Diego’s network adequacy performance relative to DHCS’ contractual indicator requirements. Data from the reporting period were analyzed and compared to DHCS’ findings. Any discrepancies with DHCS’ results were addressed through technical assistance. Timely access deficiencies prompted internal discussions with leadership to develop corrective action strategies. The HPA Team documented and tracked progress using a quarterly CAP tracker.
- ◆ San Diego implemented a new EHR, SmartCare, effective September 1, 2024, to increase efficiency and streamline data collection and timely access reporting methods.

HSAG identified no concerns with San Diego’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

**Assessment of Data Validity**

HSAG evaluated and assessed the data methods that San Diego used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that San Diego used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that San Diego’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Diego’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Diego’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.21 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.21—San Diego Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	2,276	2,175	96%↑

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Services— Outpatient SUD and Residential (0–17)	98	93	95%↑
<b>OTP</b>			
OTP (18+)	160	160	100%↑
OTP (0–17)	S	S	S

## Strengths, Opportunities for Improvement, and Recommendations

By assessing San Diego’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** San Diego maintained comprehensive processes and documentation for developing network adequacy reports, and the HPA Team conducted thorough analyses to identify, anticipate, and address potential or existing deficiencies.

### Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities San Diego had in place to inform network adequacy reporting.

# County of San Francisco

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for San Francisco and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that San Francisco had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Francisco used myAvatar as the database management system to maintain enrollment and provider data.
- ◆ San Francisco used MD-App and MD-Staff to maintain credentialing data.
- ◆ San Francisco used SQL and R for report production and file storage.

HSAG evaluated the personnel that San Francisco had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Francisco had three programmers with an average of 10 years of experience in the field.
- ◆ San Francisco's QI manager and the myAvatar IT Team maintained oversight of timely access reporting.

HSAG identified no concerns with San Francisco's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by San Francisco to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of San Francisco's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for San Francisco were maintained in myAvatar.
- ◆ San Francisco downloaded the MMEF from DHCS. This file contained key demographic details and Medi-Cal eligibility status, which were imported directly into myAvatar via SFTP.
- ◆ myAvatar ran the file and compared the data elements against the most recently uploaded MMEF, as well as 15 months of historical member data. myAvatar added Medi-Cal as the financial guarantor to each member who had an open episode and did not have Medi-Cal eligibility prior to the upload.

- ◆ San Francisco's Billing Team used error reports to identify and assign Medi-Cal eligibility to members who were not added and processed with the MMEF upload. QI staff verified member eligibility through MEDSLITE.
- ◆ Member eligibility was also verified at the point of member service request via MEDSLITE.
- ◆ San Francisco members requested services by calling the 24/7 Access Line, walking into a San Francisco clinic, or receiving a referral to SUD services directly through a contracted provider.
- ◆ myAvatar captured and maintained both the state-issued Medi-Cal ID and a system-generated member ID. If a member disenrolled and reenrolled, the member retained the same unique ID.
- ◆ San Francisco identified member demographic updates via the MMEF from DHCS and through direct member contact. Intake staff had permissions to edit member demographic data in myAvatar. Changes made to records were tracked in myAvatar including the user ID of the person who modified the record and the date and time of the change.
- ◆ Intake staff initially updated a member's self-reported address change in myAvatar. The San Francisco County BHS Billing Department validated the information against MEDSLITE while verifying and entering guarantor information in myAvatar. If the member's address did not match the address in MEDSLITE, the member was directed to contact DHCS to ensure his or her information was updated.

HSAG identified no concerns with San Francisco's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by San Francisco to capture provider data and identified the following findings:

- ◆ San Francisco ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ San Francisco screened the data for completeness and consistency.
- ◆ San Francisco collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of San Francisco's provider data system(s) included the following findings:

- ◆ Provider credentialing and network data were maintained in myAvatar.
- ◆ San Francisco's procedures for updating and maintaining provider data included:
  - New providers were required to submit their applications through MD-App.
  - San Francisco BHS Credentialing used MD-App software to collect and receive provider information. Applications were imported into MD-Staff, which performed the necessary database checks both before employment and after enrollment to ensure providers

consistently met the eligibility criteria for their specific provider type. The Credentialing Team manually transferred the information from MD-Staff to myAvatar once it was approved.

- ◆ MD-Staff automatically monitored credentialing status and issued system-generated reminder emails to providers.
- ◆ Provider information was verified through monthly database checks including the NPPES, DEA license searches, and every three years as part of the recredentialing process.
- ◆ BHS conducted manual checks of the DHCS S&I Provider List, while MD-Staff automatically screened the OIG LEIE both at the time of hire and monthly to identify any providers or organizations excluded from participation in Medicaid and CHIP programs.
- ◆ Providers were required to update their demographic information through MD-App when changes occurred and during the recredentialing process. This requirement was communicated to providers at the time of hire and reinforced through monthly email reminders.

HSAG identified no concerns with San Francisco's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of San Francisco's delegated entity data and oversight included the following findings:

- ◆ San Francisco did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of San Francisco's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ San Francisco utilized myAvatar and SQL queries to track and extract data for reporting timely access network adequacy indicators.
- ◆ San Francisco used the TADT to report timely access to DHCS. The TADT was submitted annually, or as requested by DHCS.
- ◆ San Francisco used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
- ◆ The QM Analytics Team pulled timeliness data from myAvatar using SQL according to the instructions and definitions on the TADT. Both data cleaning and validation were performed in Excel. The final dataset was used to complete the TADT. The completed TADT was submitted to the Regulatory Affairs Team for final review and submission to DHCS.

- ◆ San Francisco used the myAvatar timely access log for reporting timely access indicators. Information from this log was consolidated and matched with service data in myAvatar to create unique records that linked requests, appointments, and services.
- ◆ The timely access log recorded data at the member level, with entries identified by either a member ID or name.
- ◆ San Francisco utilized R statistical software to extract and clean data, calculate the number of business days from request to service, and determine measures of central tendency and the percentage of cases meeting the established standard.
- ◆ TADT data were extracted from the timely access log to align with DHCS requirements. The automated data loads contained built-in validations to detect issues such as discrepancies in volume and record counts, and data truncation errors.
- ◆ San Francisco conducted the following data quality reasonableness checks to support the accuracy of its network adequacy reporting programs:
  - Data cleaning procedures were implemented to ensure the reliability of information used to populate the TADT, including the use of SQL queries and unique identifiers to generate clean, validated datasets.
- ◆ HSAG assessed San Francisco's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

#### **Ongoing monitoring activities:**

- ◆ San Francisco maintained data control procedures to ensure the accuracy and completeness of data extracted from myAvatar by performing a manual review of code and results using queries and reports.
- ◆ San Francisco reviewed monthly timeliness data for SUD services. This review was completed by either running an on-demand report or SQL query and reviewing the data points which had been mapped to the EHR. If there were any discrepancies in the data, a chart review of the timeline was completed.
  - Unique identifiers were used to track monthly trends and ensure the accuracy of data merges. Month-to-month comparisons were performed, and dashboards were employed to monitor performance metrics monthly.
- ◆ San Francisco made changes as needed when calculating data for the reporting period based on State requirement updates.
- ◆ San Francisco maintained network adequacy reports in compliance with DHCS requirements for submitting data files. Stored procedures included version histories to account for any variances, and a new procedure was implemented to document major revisions.
- ◆ To maintain continuity in the production of network adequacy indicators, San Francisco developed stored procedures based on standardized processes and ensured that multiple staff members were trained in these programs and available to provide support as needed.

HSAG identified no concerns with San Francisco’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that San Francisco used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that San Francisco used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that San Francisco’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Francisco’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Francisco’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.22 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.22—San Francisco Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	666	660	99%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	S	S	S
<b>OTP</b>			
OTP (18+)	750	742	99%↑
OTP (0–17)	S	S	S

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## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing San Francisco's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** San Francisco demonstrated appropriate provider data validation processes, ensuring any missing data were identified and promptly resolved as appropriate.

### **Opportunities for Improvement and Recommendations**

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities San Francisco had in place to inform network adequacy reporting.

# County of San Joaquin

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for San Joaquin and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### **Information Systems Data Processing Procedures and Personnel**

HSAG evaluated the information systems data processing procedures that San Joaquin had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Joaquin used SmartCare as the database management system to collect and maintain member enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, San Joaquin used its legacy system, Clinicians Gateway, to maintain enrollment and provider data.
- ◆ San Joaquin used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from the legacy system.
- ◆ Migration of data to SmartCare underwent three rounds of testing, including post-upload validations after each round to ensure data were accurately reflected in the system.
- ◆ CalMHSA also used a validation tool to analyze data prior to importing to the system to ensure data were in the correct format.
- ◆ San Joaquin used the Timeliness Data Collection Application, an in-house timeliness Web application, to collect, extract, and report network adequacy data.
- ◆ San Joaquin used SQL Server for member data extracts to inform network adequacy reporting.

HSAG evaluated the personnel that San Joaquin had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Joaquin had two programmers with 10 years of experience trained and capable of supporting network adequacy reporting activities.
- ◆ CalMHSA staff included 10 programmers trained and capable of using programming language and programs to maintain SmartCare. CalMHSA programmers had an average of six years of experience.
- ◆ San Joaquin's Quality Assessment and Performance Improvement Informatics and Information System (IS) teams maintained oversight of timely access reporting.

HSAG identified no concerns with San Joaquin's information systems data processing procedures and personnel.

## Enrollment System

HSAG evaluated the information systems and processes used by San Joaquin to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of San Joaquin's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for San Joaquin were maintained in SmartCare.
- ◆ On the first day of each month, an authorized user from the IS Team downloaded the MMEF from the DHCS portal. The file contained Medi-Cal eligibility status and key demographic details, which were imported directly into SmartCare via SFTP. The file was downloaded through a nightly processing job.
- ◆ SmartCare ran a RTE check and compared the data elements against the most recently uploaded MMEF, as well as 15 months of historical member data. SmartCare automatically added Medi-Cal coverage for each member who had an open episode.
- ◆ San Joaquin performed monthly reconciliation between SmartCare and the MMEF to ensure completeness and accuracy of eligibility data.
- ◆ San Joaquin's reconciliation and oversight of eligibility data included using a SmartCare two out of three match report to identify potential member record matches; however, the record could not be automatically updated using the MMEF due to one member data point not matching. Members were matched based on first and last name, SSN, and DOB. If all data points matched, the member's eligibility was automatically updated in SmartCare. San Joaquin reviewed members appearing on the report, validated eligibility for members receiving services via MEDSLITE, and updated eligibility records in SmartCare as needed.
- ◆ Member eligibility was also verified at the point of member service request via MEDSLITE.
- ◆ San Joaquin members requested services via walk-ins, referrals, and by calling the 24/7 Access Line. The 24/7 Access Line was the most common way that services were initiated. A screening tool in the timeliness reporting application was used to assess the urgency of the member's request. The timeliness application captured timeliness reporting details such as first contact date, first and follow-up scheduled appointment dates, and urgency determination based on the screening tool.
- ◆ In SmartCare, a member ID was assigned to uniquely identify members. The generation of the member ID was based on unique identifiers such as DOB, SSN, last name, and first name. The member ID and CIN from SmartCare were used to reference the member for timeliness reporting.
- ◆ Before creating a new member ID, a search was performed in SmartCare to identify members based on last name, first name, and member ID.
- ◆ Members who were enrolled prior to SmartCare were issued a unique member ID in the legacy system that was carried over to SmartCare so that San Joaquin would not have to map multiple ID numbers.
- ◆ San Joaquin defined a new Medi-Cal member as someone who did not have any current admissions within the SUD system. Members who were currently open to the SUD system were not deemed as new members.

- ◆ SmartCare captured and maintained both the state-issued Medi-Cal ID and a SmartCare autogenerated ID.
- ◆ Members reporting demographic changes were informed to contact their Medi-Cal eligibility worker so the changes could be made to the MMEF.
- ◆ San Joaquin identified member demographic updates via direct member contact. Intake and billing staff had permissions to edit member demographic data in SmartCare. Changes made to records were tracked in SmartCare, including the record modifier's user ID and the date and time of the change.

HSAG identified no concerns with San Joaquin's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by San Joaquin to capture provider data and identified the following findings:

- ◆ San Joaquin ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ San Joaquin screened the data for completeness and consistency.
- ◆ San Joaquin collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of San Joaquin's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.
- ◆ San Joaquin's procedures for updating and maintaining provider data included the following:
  - San Joaquin utilized the CertifyOS platform to collect and check provider information upon hire and prior to providing services to members.
  - The program manager turned in a sanction check form and/or SmartCare access form to the Compliance Team. Once the Compliance Team received notification of a new staff or contract provider, an email was sent to the provider to complete the credentialing packet in CertifyOS.
    - CertifyOS reviewed the credentialing file and flagged it as either clean or non-clean. The Credentialing Committee voted on non-clean files to be approved or denied. Clean files were presented to the Credentialing Committee and approved.
  - Provider data were then sent to San Joaquin's IS Team, who notified providers via email of a separate request to submit their provider information to the DHCS PAVE system; Provider Enrollment, Chain, and Ownership System (PECOS), a web-based platform managed by CMS for Medicare provider enrollment; and CertifyOS. Credentialing was completed before the provider could bill. Recredentialing for county and contracted providers occurred every three years.

- ◆ Monthly, San Joaquin's QI staff sent a file to clinic managers to validate current staff rosters and capture changes in provider information such as location, maximum caseload, telehealth capability, and NPI. Provider data were updated in SmartCare as needed to ensure complete and accurate information was used for 274 reporting and San Joaquin's provider directory.
- ◆ San Joaquin's HR staff notified providers as needed of expiring licenses. Recredentialing was completed every three years. SmartCare also contained programming to prevent providers from billing if their license expired.
- ◆ San Joaquin's EHR, QI, and Billing staff had access to edit provider data. Changes made to provider data in SmartCare were noted in the comment section of the provider profile. If a provider's employment ended, the provider's profile in SmartCare was updated to remove login access.
- ◆ San Joaquin had processes in place to review exclusion and suspension lists including the OIG LEIE, EPLS/SAM, and DHCS S&I Provider List at initial hiring and monthly to identify providers or organizations excluded from the Medicaid and CHIP programs.

HSAG identified no concerns with San Joaquin's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of San Joaquin's delegated entity data and oversight included the following findings:

- ◆ San Joaquin did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of San Joaquin's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ San Joaquin integrated member records from SmartCare and the internal Web Timeliness Report Application for network adequacy indicator reporting.
- ◆ San Joaquin used SQL Server to extract data for reporting network adequacy indicators.
- ◆ Timeliness data were reported annually to DHCS using the TADT. San Joaquin's IS Department ran queries of the timeliness application databases to gather data regarding the timeliness of offered and rendered appointments.
- ◆ The IS Team populated the data fields on the TADT and sent them to the Quality Assessment and Performance Improvement Informatics Team manager for review, cleaning, and validation prior to submission to DHCS. Any missing data were reviewed by

the team manager, who coordinated a review of progress notes in SmartCare to obtain missing data. Once all information was received, this team ensured all data were complete and properly formatted. The TADT was then forwarded to executive leadership for review and approval. Once the review was complete and approved, the TADT was submitted to DHCS.

- ◆ San Joaquin used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
- ◆ San Joaquin's clerks and front office staff who worked in various programs across the county used the internal Timeliness Data Collection Web application to collect timeliness data daily.
  - Approximately a month before the TADT was due, the IS Team began extracting data entered in the Web application and consolidating it in Excel file form into the TADT using SQL.
    - The timeliness data collection application sometimes had gaps in data related to actual service rendered dates for initial and follow-up appointments due to appointment show statuses not being entered into the timeliness application. In the rare instances that data were incomplete, data for the TADT were also pulled from the underlying data entered in SmartCare to fill any gaps. The IS Team ran SQL queries to pull service rendered dates to fill in missing data on the TADT.
    - San Joaquin created the Web application prior to the implementation of SmartCare in order to track initial requests for services. Due to the updates required from DHCS and these updates not being available in SmartCare, San Joaquin made the required changes to the Web application and continued its use versus switching to the new EHR.
- ◆ The completed TADT was sent to the Quality Assessment and Performance Improvement Department and was carefully analyzed by management analysts who validated both accuracy and completeness of the data.
  - The Quality Assessment and Performance Improvement Informatics Team and IS Team worked in close collaboration to ensure that data in the TADT were accurate and complete. If needed, the IS Team updated the SQL code to regenerate the TADT and sent it back to the Quality Assessment and Performance Improvement Informatics Team for validation. This process, if needed, reoccurred until the Quality Assessment and Performance Improvement Informatics Team was satisfied with the results.
- ◆ Once the Quality Assessment and Performance Improvement Informatics Team validated the TADT for accuracy and completeness, it was reviewed by the Executive Team before dedicated Quality Assessment and Performance Improvement Informatics Team staff submitted the TADT to DHCS.
- ◆ San Joaquin's contracts department conducted data reasonability checks by manually reviewing variance and staff reports. Variance reports identified which clinicians provided services at specific locations and calculated the percentage of time each staff member dedicated to each site. The variance report was used in conjunction with the staff report submitted by contractors, which included key details such as DOB, gender, licensure, and

training information. Together, the reports helped validate and cross-reference staffing data.

- ◆ HSAG assessed San Joaquin’s processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ San Joaquin maintained data control procedures to ensure the accuracy and completeness of data extracted from the Timeliness Report Application and SmartCare by performing a manual review of code and of results. San Joaquin’s IS Department and Quality Assessment and Performance Improvement Informatics Team reviewed and validated the data and corrected any errors found in the Timeliness Report Application. Often, entries were validated against SmartCare as well.
- ◆ For timeliness monitoring, two mock TADTs were run collaboratively by the IS Department and the Quality Assessment and Performance Improvement Informatics Team for the time periods of July 2024, and then a follow-up mock TADT for the time period of July–October 2024. The mock TADTs uncovered an issue of appointment “show” statuses and/or closure dates not being regularly updated in the timeliness data collection application, which led to the creation of reports in this application to ensure program staff update appointment show statuses and/or closure dates.
  - Behavioral health program staff were trained to use these reports, and data entry staff filled in missing appointment show statuses and closure dates. Spot checks and error corrections were conducted during the TADT data cleaning process, and errors were corrected in the timeliness data collection application and the TADT.
  - The timeliness data collection application was used only for collecting appointment offered, appointment rendered, show statuses, and closure dates/reasons for reporting on timely access to services. SmartCare served as San Joaquin’s EHR and collected all relevant clinical and demographic data.
- ◆ Managers reviewed Timeliness Report Application reports weekly to verify staff data entry. These reports included:
  - First Contacts Report: A report of all member appointment requests that were entered into the Timeliness Report Application, by program.
  - First Scheduled Service Report: A report of all first scheduled service appointment dates that showed statuses by program, to determine which first scheduled service appointments were still in a pending status and needed to have their show status entered.
  - First Follow-Up Service Report: A report of all first follow-up service appointment dates that showed statuses by program, to see which first follow-up service appointments were still in a pending status and needed to have their show status entered.
  - SmartCare Timeliness Application Report: A report that provided a list of new admissions to outpatient programs that were not already open to other outpatient programs (i.e., a new member), and a corresponding timeliness data collection application record ID. This allowed managers to validate that BHS, contractor clinics, and staff were completing the timeliness data.

- ◆ San Joaquin identified deficiencies in meeting the 80 percent timely access standard for DMC-ODS outpatient services. In response, San Joaquin enhanced its access to services training; ensured 24/7 Access Line and front-line staff were trained to inform members about out-of-network options; and maintained related training materials, call scripts, policies, and tracking logs.

HSAG identified no concerns with San Joaquin’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that San Joaquin used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that San Joaquin used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that San Joaquin’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Joaquin’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Joaquin’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“[Description of Validation Activities](#)”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.23 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.23—San Joaquin Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

— Indicates nonreported data, data that were not reported to DHCS in a timely manner, and/or data that exceeded DHCS’ 5 percent data error threshold and were therefore unusable.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	—	—	—
Outpatient Services—Outpatient SUD and Residential (0–17)	—	—	—
<b>OTP</b>			
OTP (18+)	91	89	98%↑
OTP (0–17)	0	0	ZU

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## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing San Joaquin's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** San Joaquin developed an in-house timeliness web-based application that integrated member records to support network adequacy indicator reporting and that completed updates to allow for more complete data tracking capabilities.

### **Opportunities for Improvement and Recommendations**

- ◆ **Opportunity #1:** San Joaquin did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS' 5 percent data error threshold.
  - **Recommendation #1:** HSAG recommends that San Joaquin conduct an in-depth review of the indicators for which it did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - **Recommendation #2:** HSAG recommends that San Joaquin continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

# County of San Luis Obispo

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for San Luis Obispo and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### **Information Systems Data Processing Procedures and Personnel**

HSAG evaluated the information systems data processing procedures that San Luis Obispo had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Luis Obispo used SmartCare as the database management system to collect and maintain member enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, San Luis Obispo used the legacy EHR system, Anasazi, to maintain enrollment and provider data.
- ◆ San Luis Obispo migrated core clinical information for each member served within five years of the transition to a new health record.
- ◆ San Luis Obispo noted some data had not transitioned to the new system and remained stored in the legacy system.
- ◆ Demographic information, assessments, progress notes, program assignment information, scanned attachments, and treatment plans remained in the legacy system.
- ◆ San Luis Obispo did not use both EHR systems for timely access reporting; only SmartCare was used.
- ◆ Select staff continued to have access to the legacy system including health information technicians, health applications staff, division managers, program supervisors, some line staff, and medical records support staff at contracted agencies.
- ◆ San Luis Obispo used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from the legacy system.
- ◆ Migration of data to SmartCare underwent three rounds of testing, including post-upload validations after each round to ensure data were accurately reflected in the system.
- ◆ CalMHSA also used a validation tool to analyze data prior to importing to the system to ensure data were in the correct format.
- ◆ San Luis Obispo used SQL Server for member data extracts to inform network adequacy reporting.

HSAG evaluated the personnel that San Luis Obispo had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Luis Obispo had eight programmers with 20 years of experience trained and capable of supporting network adequacy reporting activities.

- ◆ CalMHSA staff included 26 programmers trained and capable of using programming language and programs to maintain SmartCare. CalMHSA programmers had an average of six years of experience.
- ◆ San Luis Obispo's QI Team maintained oversight of timely access reporting.

HSAG identified no concerns with San Luis Obispo's information systems data processing procedures and personnel.

## Enrollment System

HSAG evaluated the information systems and processes used by San Luis Obispo to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of San Luis Obispo's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for San Luis Obispo were maintained in SmartCare.
- ◆ On the first day of each month, the Internal Systems Administration Support Team downloaded the MMEF from the DHCS portal. The file contained key demographic details and Medi-Cal eligibility status and was imported directly into SmartCare via SFTP. The file was downloaded through a nightly processing job.
- ◆ SmartCare ran a real time eligibility check and compared the data elements against the most recently uploaded MMEF as well as 15 months of historical member data.
- ◆ San Luis Obispo's reconciliation and oversight of eligibility data included using a SmartCare two out of three match report to identify potential member record matches; however, the record could not be automatically updated using the MMEF due to one member data point not matching. Members were matched based on first and last name, SSN, and DOB. If all data points matched, the member's eligibility was automatically updated in SmartCare. San Luis Obispo reviewed members appearing on the report, validated eligibility for members receiving services via MEDSLITE, and updated eligibility records in SmartCare as needed.
- ◆ Member eligibility was also verified at the point of member service request via MEDSLITE.
- ◆ San Luis Obispo members requested services via walk-ins, referrals, and by calling the 24/7 Access Line. The 24/7 Access Line was the most common way that services were initiated. A screening tool in SmartCare was used to assess the urgency of the member's request. SmartCare captured timeliness reporting details such as first contact date, first and follow-up scheduled appointment dates, and urgency determination based on the screening tool.
- ◆ SmartCare captured and maintained both the state-issued Medi-Cal ID and a system-generated ID. If the Medi-Cal ID changed for any reason, San Luis Obispo used the member's first and last name, SSN, and DOB to link enrollment history.
- ◆ San Luis Obispo defined a new member as a member not currently open to a treatment program.

- ◆ San Luis Obispo identified member demographic updates via direct member contact. Intake and billing staff had permissions to edit member demographic data in SmartCare. Members were also referred to their DHCS case worker to update their demographic information.
- ◆ Changes made to records were tracked in SmartCare, including the record modifier's user ID and the date and time of the change.

HSAG identified no concerns with San Luis Obispo's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by San Luis Obispo to capture provider data and identified the following findings:

- ◆ San Luis Obispo ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ San Luis Obispo screened the data for completeness and consistency.
- ◆ San Luis Obispo collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of San Luis Obispo's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.
- ◆ San Luis Obispo's procedures for updating and maintaining provider data included the following:
  - The Health Applications Team and Internal Systems Administration Support Team performed verification of clinical staff members' NPI, taxonomy, and any licensure/credential the staff held, as well as applicable start and expiration dates. Validation included checking the NPPES and California DCA BreEZe Online Services system. The medical director validated DEA numbers.
  - Provider licensure and credentialing data were verified at initial application, monthly, and as needed, such as a change to the license or credential. San Luis Obispo's Health Applications Team and Internal Systems Administration Team monitored expiration dates, requested updates, validated provider licenses/credential renewals, and entered the initial provider profile in SmartCare.
    - Providers or provider supervisors notified the Health Applications Team via the Health Agency IT Service Desk by phone or email when their information changed. The Health Applications Team was also notified of provider updates and missing or expired provider data using automatic hard stops and error alerts in SmartCare. For example, when compiling 274 reports, if a provider's taxonomy code did not match information on the NPPES, San Luis Obispo received an error message. Similarly, if

- a provider's license was out of date, San Luis Obispo received an error message with an alert to make a correction.
- All 274 reporting provider directory/site required fields were required in SmartCare. If data were missing or needed to be updated, SmartCare alerted the Health Applications Team via system errors. The Health Applications Team then manually corrected these errors by updating the related provider data fields in SmartCare.
  - Provider information was maintained in SmartCare and updated as needed by the Health Applications Team. Data were submitted monthly to DHCS via the mental health Provider Directory (274) and via the CalMHSA Connex Provider Directory/CMS API requirement.

HSAG identified no concerns with San Luis Obispo's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of San Luis Obispo's delegated entity data and oversight included the following findings:

- ◆ San Luis Obispo did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of San Luis Obispo's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ San Luis Obispo used SQL Server to report network adequacy indicators.
- ◆ San Luis Obispo integrated member records from SmartCare for network adequacy indicator reporting.
- ◆ San Luis Obispo used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
- ◆ San Luis Obispo's Health Information Technician staff completed SmartCare timely access forms that were used for reporting timely access to DHCS. San Luis Obispo generated reports from SmartCare that pulled and consolidated information from the timely access forms. The reports were exported to Excel, and information was then entered into the TADT for network adequacy submissions.
  - San Luis Obispo's Quality Support Services Team ran reports from SmartCare to identify timely access deficiencies. When a timely access deficiency for a reporting period was identified, the program not in compliance was investigated for contributing factors including reporting errors, staffing issues, or other barriers to access, and a

correction plan was identified with the division manager, program supervisors, and medical director as appropriate.

- San Luis Obispo maintained network adequacy indicator reports by storing reports in SmartCare and appending them to a table of historical results.
- ◆ San Luis Obispo's timely access forms contained a date and time field that required staff to enter the date and time of the RFS as well as the date and time of the first offered service.
- ◆ The number of hours between dates and times entered was automatically calculated in the timeliness record to indicate whether the service was offered within the required time frame.
  - If the first offered service did not meet the timely access requirement, staff were prompted to enter the reason for the delay.
- ◆ HSAG assessed San Luis Obispo's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### **Ongoing monitoring activities:**

- ◆ San Luis Obispo maintained data control procedures to ensure the accuracy and completeness of data extracted from SmartCare by performing a manual review of code and of results.
- ◆ San Luis Obispo regularly monitored access timeliness for initial assessment and follow-up services by tracking and reporting timeliness deficiency metrics in monthly QIC meetings.
- ◆ San Luis Obispo's Health Applications Team conducted monthly data reasonability checks by manually reviewing reports. The 274 data were corrected when automated system checks or hard stops in SmartCare (such as an expired contract date) alerted the Health Applications Team to verify and update data. The Health Applications Team monitored 274 results and made corrections to the data as needed. Corrections also occurred when DHCS notified San Luis Obispo of inaccuracies through its monthly 274 data quality checks.

HSAG identified no concerns with San Luis Obispo's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## ***Assessment of Data Validity***

HSAG evaluated and assessed the data methods that San Luis Obispo used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that San Luis Obispo used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that San Luis Obispo’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Luis Obispo’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Luis Obispo’s **network adequacy results** were:

- Acceptable
- Not acceptable

## ***Network Adequacy Indicator-Specific Validation Ratings***

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## ***Analysis and Conclusions***

Table 3.24 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

### **Table 3.24—San Luis Obispo Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	195	195	100%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	12	12	100%↑
<b>OTP</b>			
OTP (18+)	94	94	100%↑
OTP (0–17)	S	S	S

## Strengths, Opportunities for Improvement, and Recommendations

By assessing San Luis Obispo’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** San Luis Obispo implemented the new Integrated Behavioral Health plan contract with the State to eliminate barriers for members seeking care. This included the implementation of Community Assistance, Recovery and Empowerment (CARE) Court in December 2024, which created two new housing options through the Bridge Housing program, including one new adult residential treatment facility.

## Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities San Luis Obispo had in place to inform network adequacy reporting.

## County of San Mateo

### *ISCA Findings and Data Validity*

HSAG completed an ISCA for San Mateo and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that San Mateo had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Mateo used myAvatar as the database management system to collect and maintain enrollment and provider data.
- ◆ San Mateo used SQL, Microsoft Access, and Excel for network adequacy reporting.

HSAG evaluated the personnel that San Mateo had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ San Mateo had nine programmers with an average of 10 years of experience.

HSAG identified no concerns with San Mateo's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by San Mateo to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of San Mateo's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for San Mateo were maintained in myAvatar.
- ◆ San Mateo received the MMEF from DHCS.
- ◆ San Mateo's reconciliation and oversight of enrollment data included:
  - San Mateo ran a monthly comparison report log that showed members who lost or gained eligibility in the monthly update file. The comparison report was utilized to make

manual updates to member eligibility in myAvatar. San Mateo performed a quality control check to reconcile monthly manual edits.

- Manual edits to member records were captured in the system including username and date of edit.
- San Mateo required staff to check member eligibility in MEDSLITE prior to providing services.
- System access to edit member eligibility data was limited by role-based access rules. Administrators and call center staff had access to edit member eligibility.
- ◆ Members who had address changes were encouraged to contact their Department of Human Assistance eligibility worker to update their address.
- ◆ Potential duplicate records were identified by end users, who notified the MIS Team via a dedicated data corrections email. The MIS Team also conducted periodic QA checks to identify duplicate IDs. The MIS Team researched potential duplicate records and utilized the member merge functionality in myAvatar to merge duplicate records. Once records were merged, a field in the merged record housed the duplicate record ID for searching.
- ◆ San Mateo defined a new member as a member who was not currently open to DMC-ODS services in San Mateo's System of Care (SOC) who was referred or requested assessment for DMC-ODS services.

HSAG identified no concerns with San Mateo's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by San Mateo to capture provider data and identified the following findings:

- ◆ San Mateo ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ San Mateo screened the data for completeness and consistency.
- ◆ San Mateo collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of San Mateo's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in myAvatar.
- ◆ San Mateo collected data from county staff providers in a standardized application format. A BHRS credentialing form was required for new staff and staff updates (including provider type, taxonomy, license, and service location).
- ◆ Credentials were verified at time of employment and at recredentialing every three years. Providers were validated via the NPPES and licenses via the DCA website. San Mateo utilized Streamline Verify to check sanctions monthly.

- ◆ San Mateo utilized credentialing forms to manually enter provider data into myAvatar.
- ◆ San Mateo required all providers, county and contracted, to complete system training requirements prior to receiving access to myAvatar.
- ◆ myAvatar captured manual edits to provider records including username and date of edit. Role-based rules limited user access to make manual edits. Manual edits to provider data were limited to IS staff. San Mateo did not regularly monitor manual edits to the system.
- ◆ San Mateo conducted monthly checks of provider sanctions and exclusions.
- ◆ San Mateo utilized myAvatar and a separate license tracker to maintain license information and to notify providers of an upcoming license expiration.
- ◆ San Mateo required contracted providers to provide a monthly listing of all staff including license changes, terminations, and new staff. Rosters were compared with myAvatar data, and records were manually updated as needed.

HSAG identified no concerns with San Mateo's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of San Mateo's delegated entity data and oversight included the following findings:

- ◆ San Mateo did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of San Mateo's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ San Mateo's providers utilized standardized system forms to report services included in timeliness indicators. Providers manually completed system forms in the member's record for timeliness services.
- ◆ myAvatar captured timely access standards based on data entered in the standardized system forms.
- ◆ San Mateo produced timeliness reports from myAvatar via a Microsoft Access database that produced an Excel file which was copied and pasted into the TADT.
- ◆ Timeliness reports were validated and flagged for mismatches in eligibility dates and provider affiliations and to identify missing data.
- ◆ San Mateo's management staff for DMC-ODS services reviewed the TADT for data completeness prior to submission.

- ◆ The TADT was submitted annually and as requested by the compliance manager.
- ◆ HSAG assessed San Mateo's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

#### Ongoing monitoring activities:

- ◆ San Mateo maintained a timely access dashboard which was reviewed and refreshed monthly. San Mateo management reviewed the dashboard against timeliness standards.
- ◆ San Mateo's system included alerts that detected network gaps in order to determine access deficiencies.
- ◆ San Mateo analyzed timeliness and data integrity in various committees including the Office of Improvement and Innovation, Data Dream Team, and Performance Reporting Group.

HSAG identified no concerns with San Mateo's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that San Mateo used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that San Mateo used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that San Mateo's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Mateo's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that San Mateo's **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.25 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.25—San Mateo Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	284	268	94%↑

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Services— Outpatient SUD and Residential (0–17)	S	S	S
<b>OTP</b>			
OTP (18+)	21	21	100%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing San Mateo’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** San Mateo maintained an email box dedicated to reporting potential data corrections. This allowed the MIS Team to quickly identify and correct potential data errors.

### Opportunities for Improvement and Recommendations

- ◆ **Opportunity #1:** San Mateo’s EHR system tracked manual edits to provider records; however, San Mateo did not regularly review manual edits made.
  - **Recommendation:** HSAG recommends that San Mateo consider implementing a process to review manual edits to provider records to assist in maintaining accurate provider data.

# County of Santa Barbara

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Santa Barbara and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### **Information Systems Data Processing Procedures and Personnel**

HSAG evaluated the information systems data processing procedures that Santa Barbara had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Santa Barbara used SmartCare as the database management system to collect and maintain member enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Santa Barbara used Clinician's Gateway to maintain enrollment and provider data.
- ◆ Santa Barbara used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from Clinician's Gateway.
- ◆ Effective July 2023, Santa Barbara changed vendors for submitting 274 and NACT files from Kings View to CalMHSA.
- ◆ Santa Barbara had a data archiving contract with its previous EHR vendor parent Oracle to preserve access to the Clinician's Gateway legacy system for perpetuity. Clinical, billing, and administrative staff had access to Clinician's Gateway.
- ◆ Migration of data to SmartCare underwent three rounds of testing, including post-upload validations after each round to ensure data were accurately reflected in the system.
- ◆ CalMHSA also used a validation tool to analyze data prior to importing to the system to ensure data were in the correct format.
- ◆ Santa Barbara used SQL Server to inform network adequacy reporting.

HSAG evaluated the personnel that Santa Barbara had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Santa Barbara had seven programmers with 14 years of experience trained and capable of supporting network adequacy reporting activities.
- ◆ CalMHSA staff included three programmers trained and capable of using programming language and programs to maintain SmartCare. CalMHSA programmers had an average of eight years of experience.
- ◆ Santa Barbara's Quality Care Management (QCM) Team maintained oversight of timely access reporting.

HSAG identified no concerns with Santa Barbara's information systems data processing procedures and personnel.

## Enrollment System

HSAG evaluated the information systems and processes used by Santa Barbara to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Santa Barbara's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Santa Barbara were maintained in SmartCare.
- ◆ On the first day of each month, Santa Barbara's administrative analyst downloaded the MMEF from the DHCS portal. The file contained key demographic details and Medi-Cal eligibility status and was imported directly into SmartCare via SFTP. The file was downloaded through a nightly processing job.
- ◆ Santa Barbara's reconciliation and oversight of eligibility data included:
  - SmartCare ran a real time eligibility check and compared data elements such as first and last name, DOB, and gender against the most recently uploaded MMEF as well as 15 months of historical member data. SmartCare contained software procedures to perform validation checks and generate error reports to flag non-matches and potential matches from the MMEF.
    - For matches, SmartCare automatically updated the member's coverage based on the response in the MMEF.
    - If two of the three data elements did not match, the member was flagged as a potential match in an error report for manual review.
    - Santa Barbara's administrative analyst manually reviewed error reports to identify and validate discrepancies. The administrative analyst validated Medi-Cal eligibility through MEDSLITE.
    - Once confirmed, eligibility and coverage were updated in SmartCare during the next overnight processing job.
- ◆ Member eligibility was also verified at the point of member service request via MEDSLITE.
- ◆ Santa Barbara members requested services via walk-ins, referrals, and by calling the 24/7 Access Line.
- ◆ In SmartCare, a member ID was assigned to uniquely identify members. Member ID generation was based on identifiers such as DOB, SSN, last name, and first name. When a member was registered in SmartCare, an option to search for existing accounts by verifying key demographic data such as SSN, DOS, and name was available. Members were enrolled into programs for treatment and then unenrolled or discharged when services were complete. The member ID remained the same even if the member was enrolled and discharged from a program multiple times.
- ◆ The member ID and CIN from SmartCare were used to reference the member for timeliness reporting.
- ◆ SmartCare captured and maintained both the state-issued Medi-Cal ID and a SmartCare autogenerated ID.

- ◆ Santa Barbara identified a new member as a Medi-Cal member who had never received services or an existing member with services that had been discontinued for at least six months.
- ◆ Santa Barbara identified member demographic updates based on direct member communication provided by its active member population. Financial specialists verified member addresses against MEDSLITE for accuracy and alignment. Intake and billing staff had permissions to edit member demographic data in SmartCare. Changes made to records were tracked in SmartCare including the record modifier's user ID and the date and time of the change.

HSAG identified no concerns with Santa Barbara's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Santa Barbara to capture provider data and identified the following findings:

- ◆ Santa Barbara ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Santa Barbara screened the data for completeness and consistency.
- ◆ Santa Barbara collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Santa Barbara's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.
- ◆ Santa Barbara's procedures for updating and maintaining provider data included the following:
  - Upon hiring, Santa Barbara used the Service Provider Identification Form (SPIF) to collect provider information. The SPIF contained provider information such as first and last name, NPI, taxonomy, and licensure information.
  - Once the Quality Care Management (QCM) Team received the SPIF, the provider's information was verified through the following:
    - Santa Barbara required licensed providers to submit a copy of their license. Santa Barbara verified the license using the applicable board, such as the BBS. A screen shot was captured from the site and attached to the provider's credentialing file.
    - The NPPES was used to verify NPI and confirm that taxonomy matched the job description of services the provider would be providing under that particular role.
    - The DEA website was used to verify DEA registration.
    - Santa Barbara verified that providers were not on any provider exemption lists such as the Medi-Cal Exemption List and EPLS/SAM.

- Providers with BH licenses were verified through the California DCA BreEZe Online Services system for license activation and expiration.
- ◆ SmartCare collected all data fields in the NACT 274 file such as licensure, provider focus, and areas of expertise.
- ◆ Santa Barbara provider credentials were verified at initial application, monthly, as needed, and at recredentialing which occurred every three years.

HSAG identified no concerns with Santa Barbara's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Santa Barbara's delegated entity data and oversight included the following findings:

- ◆ Santa Barbara did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Santa Barbara's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Santa Barbara utilized SmartCare to track data used to report network adequacy indicators annually or as requested by DHCS. Santa Barbara used the TADT for reporting timely access to DHCS.
- ◆ Santa Barbara used SQL Server to extract member data for reporting network adequacy indicators.
- ◆ Prior to July 1, 2023, network adequacy data were primarily tracked and maintained in a separate Excel spreadsheet.
- ◆ Santa Barbara used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
- ◆ SmartCare maintained two forms for tracking timely access. A SmartCare report was used to consolidate data from all forms in SmartCare.
- ◆ SmartCare contained software procedures to ensure that errors were flagged as validations to be checked and corrected to ensure data accuracy in each database management system.
- ◆ Santa Barbara conducted data reasonability checks by manually reviewing reports and validations against other reporting.

- ◆ Santa Barbara maintained network adequacy indicator reports by storing reports in SmartCare and appending them to a table of historical results.
- ◆ HSAG assessed Santa Barbara's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Santa Barbara maintained data control procedures to ensure the accuracy and completeness of data extracted from SmartCare by performing a manual review of code and of timeliness results.
- ◆ Santa Barbara performed quarterly audits to monitor timeliness reporting at its QIC meetings which included a month-over-month and year-over-year trend analysis to identify significant dips or increases in data that may indicate missing data. Additionally, Santa Barbara performed ad hoc audits to identify members who received a CalAIM or ASAM assessment but were missing a timeliness form.
- ◆ Santa Barbara developed a summary report of timeliness data to monitor for needed process improvements or staff training around timely access. Santa Barbara monitored monthly timeliness MHP 274 data quality checks, as well as FTE fluctuations of key provider groups, and addressed any identified deficiencies or flagged areas of concern.
- ◆ Santa Barbara corrected identified timely access deficiencies with the following actions:
  - The QCM Team reviewed and retrained all staff on timely access requirements and how to complete timely access data forms in SmartCare. The QCM Team reviewed reporting of the timely access data biweekly and reached out to teams not meeting timely access.
  - Santa Barbara hired Klynveld Peat Marwick Goerdeler (KPMG), a global professional services firm, to provide audit, advisory, and consulting services for Santa Barbara. KPMG reviewed Santa Barbara's intake and assessment processes and provided recommendations to improve timely access to care. These included streamlining the intake workflow to reduce delays and simplify entry into services.
  - Santa Barbara implemented a peer program to ensure that a peer reached out to any individual who had come through the 24/7 Access Line and provided peer services and linkages while they were waiting for their formal assessment.
  - If a timely appointment could not be made, the case worker emailed the Access Team to determine if there were times available that had been set aside for returning inpatient admissions.
- ◆ Santa Barbara conducted annual monitoring of network adequacy indicators via the NACT process.
- ◆ Santa Barbara used the TADT data validation and conditional formatting rules to identify data quality issues or items in need of correction.
- ◆ Santa Barbara provided feedback to its EHR vendor and CalMHSA regarding recommendations on additional document validations and reporting amendments to reduce the volume of data quality issues.

HSAG identified no concerns with Santa Barbara’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Santa Barbara used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that Santa Barbara used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Santa Barbara’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Santa Barbara’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Santa Barbara’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.26 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.26—Santa Barbara Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	221	214	97%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	43	43	100%↑
<b>OTP</b>			
OTP (18+)	71	63	89%↑
OTP (0–17)	0	0	ZU

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## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing Santa Barbara's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** Santa Barbara demonstrated effective oversight of network adequacy reporting by successfully transitioning to the SmartCare EHR system and applying structured data validation processes. These included three rounds of data migration testing with post-upload verifications, SmartCare-integrated error reporting, and ongoing manual audits to flag discrepancies in timeliness data.

### **Opportunities for Improvement and Recommendations**

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Santa Barbara had in place to inform network adequacy reporting.

# County of Santa Clara

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Santa Clara and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Santa Clara had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Santa Clara used myAvatar as the database management system to collect and maintain enrollment and provider data.

HSAG evaluated the personnel that Santa Clara had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Santa Clara's staff included an Analytics & Reporting Division that employed one senior data analyst, five data analysts, and two BI analysts. On average, staff had five to 10 years of experience.
- ◆ Santa Clara's Technology Solutions & Services (TSS) Department included one data engineer, one senior business systems analyst, five business systems analysts, one application administrator, and one associate business systems analyst. On average, staff had 10 or more years of experience.
- ◆ In addition, Santa Clara's QI staff were responsible for timely access reporting. Staff were trained and capable of supporting network adequacy reporting activities.

HSAG identified no concerns with Santa Clara's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Santa Clara to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Santa Clara's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Santa Clara were maintained in myAvatar.
- ◆ Santa Clara received the MMEF from DHCS. Santa Clara's TSS Team downloaded the MMEF from the DHCS SFTP site and uploaded the file into myAvatar. The system matched members based on the CIN or a combination of name, DOB, and SSN to automatically link and update eligibility information.

- ◆ Santa Clara's reconciliation and oversight of eligibility data included:
  - Santa Clara's call center and screening staff, which included health service representatives (HSRs) and clinicians, validated member eligibility via MEDSLITE when entering a new member into the system at the time services were requested.
  - myAvatar maintained a real-time inquiry function that verified eligibility using a 270/271 transaction process. Santa Clara's clerical staff completed monthly eligibility checks for all members open to services to capture changes in eligibility.
- ◆ Santa Clara identified member demographic information and updates via direct member contact. Call center or screening staff collected member demographics during initial contact when services were requested. HSR and clinical staff verified and updated information if a change was reported when members presented for and received services using a myAvatar form.
- ◆ Santa Clara's EHR Team ran monthly reports to identify missing and incomplete member data including financial eligibility, email address and phone numbers for telehealth appointments, SSNs, and diagnoses. Clinical and clerical staff updated discrepancies as needed using MEDSLITE, confirming information with the member, or validating the diagnosis with the clinician who provided it.
- ◆ Santa Clara defined a new member as a member who had never received services; a member who had been discharged from services for at least one year; and a member who had an episode change such as an increase or decrease in level of care.
- ◆ myAvatar captured and maintained both the state-issued Medi-Cal ID and a system-generated ID. Members retained the unique system-generated ID throughout enrollment into and disenrollment from services.
  - Santa Clara had a biweekly process to run a query to identify demographic information across multiple member records in myAvatar. Health Information Management System (HIMS) staff reviewed and merged accounts if a duplicate was identified and confirmed to be the same member. Members retained both unique system ID numbers, with one ID stored in an alias field to avoid the ID being reused for another account and allow staff who were familiar with either ID to continue to locate the member's record.

HSAG identified no concerns with Santa Clara's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Santa Clara to capture provider data and identified the following findings:

- ◆ Santa Clara ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Santa Clara screened the data for completeness and consistency.

- ◆ Santa Clara collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Santa Clara's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in myAvatar.
- ◆ Providers were directed to Santa Clara's website for information and resources related to the credentialing process and applications. Santa Clara's Valley Health Plan (VHP) completed credentialing and recredentialing activities for both county and contracted providers. Credentialing was completed at initial application, and recredentialing was completed every 36 months.
- ◆ Providers submitted a completed application, or CAQH application if they were licensed, to VHP. Once the credentialing process was completed, VHP entered the provider into myAvatar. Santa Clara's TSS Team ensured providers were mapped to the correct location and program.
- ◆ VHP submitted a raw provider data file to Santa Clara monthly. If a discrepancy or issue was identified regarding provider data entered into myAvatar, Santa Clara reviewed the data file if needed to crosscheck information.
- ◆ VHP used the OIG LEIE, DHCS S&I Provider List, and sanction databases to identify providers or organizations excluded from the Medicaid and CHIP programs each month.
- ◆ Santa Clara used a Provider Access Collection Tool (PACT) Web application to maintain complete and accurate provider data and capture changes to provider information over time. The PACT contained required fields and formatting logic to assist with data collection, such as flagging an NPI that was entered as less than 10 digits. The PACT showed the date, time, and user who last updated a specific provider's data within the tool. PACT data were validated against myAvatar data.
- ◆ Monthly, individual providers or a designated site contact logged into the PACT to enter updates or attest that provider information on file was up to date. Information captured in the PACT included but was not limited to provider first and last name, gender, NPI, address/site location, license, caseload, telehealth capabilities, and DEA number if applicable. Santa Clara utilized the PACT to capture required data fields used for monthly 274 provider network reporting to DHCS and the provider directory.
- ◆ Required time frames for providers to log into the PACT and complete updates, as well as detailed instructions on how to access the tool, were documented in Santa Clara's provider manual. In addition, a monthly email reminder was sent to site contacts to update the PACT.
- ◆ Organizational changes such as location, contract closure, or changes in legal name or entity were reported using a network change request form submitted to Santa Clara's Provider Relations Team.
- ◆ Santa Clara required its provider network to update or confirm provider data monthly via the PACT. Providers were made aware of this expectation via provider contracts, provider manual, and policies.

HSAG identified no concerns with Santa Clara's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Santa Clara's delegated entity data and oversight included the following findings:

- ◆ Santa Clara did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Santa Clara's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Santa Clara utilized myAvatar beginning June 1, 2024, to track and extract data used to report timely access network adequacy indicators annually, or as requested by DHCS.
- ◆ Prior to June 1, 2024, Santa Clara tracked timely access by submitting monthly Excel spreadsheets. Each program submitted these spreadsheets, which were uploaded to SharePoint. The Excel spreadsheet had conditional formatting to assist with accuracy and completeness of entered data. Missing or incorrect data were sent back to the provider for corrections.
- ◆ Santa Clara used the TADT for reporting timely access to DHCS.
- ◆ Providers entered timely access data using the Behavioral Health Services Department (BHSD) timeliness tool in myAvatar. The BHSD timeliness tool was designed to capture fields within the TADT, and it contained conditional formatting and validation rules for data entry.
- ◆ Santa Clara's QI Team was responsible for compiling and submitting the TADT. Timely access data from the BHSD timeliness tool were extracted and formatted to align with the TADT. Santa Clara completed manual review of the TADT prior to submission to DHCS, such as validating that a service date was not before an appointment offer date. If a discrepancy was identified, Santa Clara reached out to the provider to determine the root cause.
- ◆ Santa Clara maintained timely access data files and TADT submissions to DHCS for historical reference.
- ◆ Santa Clara reported that the completion rate for myAvatar timeliness tools was under 50 percent and implemented a CAP process to address deficiencies.
  - Beginning February 2025, Santa Clara issued CAPs to agencies that did not have 50 percent of their timeliness tools entered between July–October 2024. Providers who

had between 51 percent to 79 percent completed received a monitoring notice from their provider liaison. Providers were requested to correct any identified discrepancies.

### Ongoing monitoring activities:

- ◆ Providers were expected to complete the timeliness tool in myAvatar as soon as possible after member contact and within a maximum of 60 calendar days. This expectation was also in place when timely access was tracked via Excel spreadsheet.
- ◆ Santa Clara created self-service tools available for providers in myAvatar to assist in tracking complete timely access data, including referral reports to identify referrals received by program or error reports to identify timeliness tools with missing or incorrect information. Santa Clara was also working to implement additional self-service reports to aid providers in reviewing and tracking data.
- ◆ Santa Clara held technical assistance office hours and met with individual providers to review timeliness tracking completion rates and offer assistance as needed.
- ◆ Santa Clara's Provider Relations Team implemented a monitoring dashboard to identify services or admissions wherein a timeliness form was not completed. Additionally, Santa Clara has worked to increase its network capacity since 2022 by adding 194 treatment beds, an increase of 18 percent, and is working to add 227 more beds.

HSAG identified concerns with Santa Clara's ability to capture and report complete timely access data to DHCS during the scope of the audit; however, HSAG identified no concerns with Santa Clara's ongoing monitoring tools in place.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Santa Clara used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Santa Clara used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Santa Clara's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Santa Clara's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Santa Clara’s **network adequacy results** were:

- Acceptable
- Not acceptable

### Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

Table 3.27 summarizes network adequacy indicators resulting in a *Low Confidence* or *No Confidence* rating determination.

**Table 3.27—Santa Clara Validation Ratings**

Indicator	Validation Rating	Comments
Outpatient Services— Outpatient SUD and Residential	<i>No Confidence</i>	Santa Clara reported that 50 percent of its timeliness data were missing across all indicators after implementation of the timeliness tool, which impacted the CAP TADT submission period of October 1, 2024–December 31, 2024. As a result, HSAG determined some elements to have significant bias, resulting in a <i>No Confidence</i> validation rating.
OTP	<i>No Confidence</i>	Santa Clara reported that 50 percent of its timeliness data were missing across all indicators after implementation of the timeliness tool, which impacted the CAP TADT submission period of October 1, 2024–December 31, 2024. As a result, HSAG determined some elements to have significant bias, resulting in a <i>No Confidence</i> validation rating.

## Analysis and Conclusions

Table 3.28 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.28—Santa Clara Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

— Indicates nonreported data, data that were not reported to DHCS in a timely manner, and/or data that exceeded DHCS’ 5 percent data error threshold and were therefore unusable.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	—	—	—
Outpatient Services—Outpatient SUD and Residential (0–17)	—	—	—
<b>OTP</b>			
OTP (18+)	—	—	—
OTP (0–17)	—	—	—

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Santa Clara's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Santa Clara maintained a comprehensive provider manual detailing expectations, which included accurate and up-to-date provider data processes, timely access standards, performance standard goals, and the requirement for providers to track timeliness in myAvatar.
- ◆ **Strength #2:** Santa Clara implemented multiple tools to monitor completeness of timeliness data, including self-service tools for providers, a monitoring dashboard used by Provider Relations, and a CAP process to address deficiencies.

### Opportunities for Improvement and Recommendations

- ◆ **Opportunity #1:** Santa Clara reported that the completion rate for timeliness tools in myAvatar was less than 50 percent.
  - **Recommendation:** HSAG recommends that Santa Clara maintain ongoing provider education and technical assistance opportunities to reinforce understanding of timeliness tracking expectations, processes, and self-service tool capabilities. Additionally, HSAG recommends that Santa Clara's Provider Relations Team continue monitoring and compliance efforts via the monitoring dashboard and the CAP process to improve timeliness tracking completion rates.
- ◆ **Opportunity #2:** Santa Clara did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS' 5 percent data error threshold.
  - **Recommendation #1:** HSAG recommends that Santa Clara conduct an in-depth review of the indicators for which it did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - **Recommendation #2:** HSAG recommends that Santa Clara continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

# County of Santa Cruz

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Santa Cruz and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Santa Cruz had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Santa Cruz used myAvatar as the database management system to maintain enrollment and provider data.
- ◆ Santa Cruz used SQL Server to inform network adequacy reporting.

HSAG evaluated the personnel that Santa Cruz had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Santa Cruz had a team of two programmers with an average of 14 years of experience.
- ◆ Santa Cruz's QI Team maintained oversight of timely access reporting. Staff were trained and capable of supporting network adequacy reporting activities.

HSAG identified no concerns with Santa Cruz's information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Santa Cruz to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Santa Cruz's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Santa Cruz were maintained in myAvatar.
- ◆ On the first day of each month, Santa Cruz imported the MMEF into myAvatar via SFTP processing. The MMEF contained key demographic details and Medi-Cal eligibility status.
- ◆ myAvatar ran the file and compared the data elements against the most recently uploaded MMEF.
- ◆ Santa Cruz used an admission and discharge process for enrollment which included comparing members with services posted in the date range of the downloaded MMEF to MEDSLITE. Data elements such as first and last name, DOB, and SSN were compared to MEDSLITE data. myAvatar matched two out of three data element criteria to assign Medi-Cal eligibility.

- ◆ Santa Cruz's Admissions Team used a two out of three match report and manually verified member eligibility through MEDSLITE, verifying two of the three data elements listed above, to reconcile and assign Medi-Cal eligibility to members who were not added and processed with the MMEF upload.
- ◆ Member eligibility was also verified at the point of member service request via MEDSLITE.
- ◆ Santa Cruz members requested services by calling the 24/7 Access Line (CARES) or by receiving a referral from outside agencies such as the Department of Social Services, First Five, courts, probation, schools, and MCPs. At the time of service request, a Service Request Disposition Log form was completed that captured the date of request, urgency level, disposition, screening tool, and the appointment offered date.
- ◆ Members were determined to be eligible for services if they had active Santa Cruz County Medi-Cal.
- ◆ Santa Cruz defined an urgent condition as a situation experienced by a member who, without timely intervention, would highly likely result in an immediate emergency condition. An urgent appointment meant health care was provided to a member whose condition was such that the member faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal time frame for the decision-making process would be detrimental to the member's life or health or could jeopardize his or her ability to regain maximum function.
- ◆ myAvatar captured and maintained both the state-issued Medi-Cal ID and a system-generated MRN.
- ◆ Santa Cruz identified member demographic updates via the MMEF. Intake and billing staff had permissions to edit member demographic data in myAvatar. Changes made to records were tracked in myAvatar including the user ID who modified the record and the date and time of the change.

HSAG identified no concerns with Santa Cruz's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Santa Cruz to capture provider data and identified the following findings:

- ◆ Santa Cruz ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Santa Cruz screened the data for completeness and consistency.
- ◆ Santa Cruz collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Santa Cruz's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in myAvatar.

- ◆ Santa Cruz had a manual review process that used provider reports and credentialing verification to track providers over time, and across multiple office locations. Santa Cruz's procedures for updating and maintaining provider data included the following:
  - Upon hire, providers submitted a practitioner enrollment form via email to their supervisor, who reviewed for completeness and validated information for both county and contracted providers. The practitioner enrollment form included fields such as NPI, taxonomy code, SSN, and licensure. Supervisors conducted an initial validation before submitting the practitioner enrollment form to Santa Cruz's QI Team, who also verified the information. Provider data were validated using the following:
    - Santa Cruz used the DCA website, OIG LEIE, and NPPES for the validation of NPI and taxonomy.
    - For unlicensed providers who delivered services, only the NPI and taxonomy were verified.
    - Santa Cruz's QI Team used the California DCA BreEZe Online Services system to verify the activation and expiration of BH licensure for providers with BH licenses.
  - Once validated, the QI Team forwarded the practitioner enrollment form to Santa Cruz's IT Team, who performed a final review before creating the provider profile in myAvatar.
    - myAvatar maintained a set of roles and permissions that granted providers access to the system dependent on their role.
  - Santa Cruz's QI Team downloaded a monthly Excel file report to validate provider data and issued 90-, 60-, and 30-day notices to providers for upcoming license expirations.
  - Providers with expired licenses were reclassified as mental health rehab specialists and restricted from accessing licensed provider fields in myAvatar.
  - Recredentialing was completed every five years. Santa Cruz's QI staff updated myAvatar as needed to maintain accurate provider data for 274 reporting.

HSAG identified no concerns with Santa Cruz's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Santa Cruz's delegated entity data and oversight included the following findings:

- ◆ Santa Cruz did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Santa Cruz's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Santa Cruz used SQL Server to extract data for reporting network adequacy indicators.
- ◆ Santa Cruz's IT Team used data entered into myAvatar to create SQL queries which corresponded to the data points required by DHCS for timely access. Each data point listed on the TADT was mapped to fields in myAvatar. Santa Cruz's QI Team reviewed the data for accuracy. A report organized to match the TADT was created in myAvatar to be run on-demand. The report was exported from myAvatar to an Excel file for submission to DHCS.
- ◆ Santa Cruz used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
  - myAvatar was used to capture members initiating services, based on a specific time frame (i.e., reporting period) and on Santa Cruz's new member definition: an individual who had never received care according to myAvatar or a member who had received care in the past for whom all outpatient episodes had been closed for longer than 365 days. The reporting period and new member definition were captured using SQL to pull the data for reporting.
  - Santa Cruz's urgent requests were tracked using the admission form in myAvatar, which had a date and time field.
  - Santa Cruz and contracted provider staff entered this information into myAvatar, which captured timeliness data in several fields that were then extracted and added to the TADT for reporting to DHCS.
- ◆ Santa Cruz conducted data reasonability checks by manually reviewing reports and validations against other reporting.
- ◆ Santa Cruz maintained network adequacy indicator reports by storing reports in myAvatar and appending them to a table of historical results.
- ◆ HSAG assessed Santa Cruz's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Santa Cruz maintained data control procedures to ensure the accuracy and completeness of data extracted from myAvatar by performing a manual review of code and results using queries and reports.
  - Santa Cruz reviewed monthly timeliness data. This review was completed by either running an on-demand report or SQL query and reviewing the data points which had been mapped to the EHR. If there were any discrepancies in the data, a chart review of the timeline was completed.

- Santa Cruz made changes as needed when preparing data for the reporting period based on updated DHCS requirements.

HSAG identified no concerns with Santa Cruz’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Santa Cruz used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that Santa Cruz used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Santa Cruz’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Santa Cruz’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Santa Cruz’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.29 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.29—Santa Cruz Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	192	173	90%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	S	S	S
<b>OTP</b>			
OTP (18+)	46	41	89%↑
OTP (0–17)	0	0	ZU

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## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing Santa Cruz's performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** Santa Cruz demonstrated a well-structured approach to provider data management, with internal controls that included multiple levels of credential verification, separation of duties across teams, and system restrictions to prevent billing by unlicensed providers. Automated license expiration alerts and role-based access in myAvatar further supported compliance and data integrity.

### **Opportunities for Improvement and Recommendations**

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Santa Cruz had in place to inform network adequacy reporting.

# County of Stanislaus

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Stanislaus and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Stanislaus had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Stanislaus used SmartCare as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Stanislaus used Cerner Community Behavioral Health (CCBH) to maintain enrollment and provider data.
- ◆ Stanislaus used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from CCBH.
  - Several rounds of testing were completed prior to the go-live date to ensure migrated files were complete and accurate. Comparative reports were also reviewed to validate matches in member count, program enrollments, and demographic data during dry run and smoke testing.

HSAG evaluated the personnel that Stanislaus had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Stanislaus had a team of five software administrators with SQL experience. Staff had an average of 12 years of experience.
- ◆ CalMHSA staff included 12 programmers trained and capable of using programming language and programs to maintain SmartCare. CalMHSA programmers had an average of six years of experience.

HSAG identified no concerns with Stanislaus' information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by Stanislaus to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Stanislaus' enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Stanislaus were maintained in SmartCare.

- ◆ Stanislaus received the MMEF from DHCS. Stanislaus downloaded the MMEF from the DHCS MOVEit SFTP portal on the first day of every month and uploaded the file into SmartCare.
- ◆ Stanislaus performed monthly reconciliation between SmartCare and the MMEF to ensure completeness and accuracy of eligibility data.
  - Stanislaus' reconciliation and oversight of eligibility data included using a SmartCare two out of three match report to identify potential member record matches; however, the record could not be automatically updated using the MMEF due to one member data point not matching. Members were matched based on first and last name, SSN, and DOB. If all data points matched, the member's eligibility was automatically updated in SmartCare. Business Office staff reviewed potential matches, validated eligibility using MEDSLITE and a RTE verification within SmartCare that confirmed eligibility using a 270/271 transaction process, and updated discrepancies in SmartCare as needed.
  - Additionally, staff verified eligibility via MEDSLITE at the time of a request for services and via the 270/271 process for members open to services monthly.
- ◆ Stanislaus defined a new member as a member who had never received services or a member who had not received services within the last 90 days.
- ◆ SmartCare captured and maintained both the state-issued Medi-Cal ID and a system-generated ID. Members retained the system-generated ID throughout enrollment and disenrollment into treatment programs and services.
- ◆ Stanislaus identified member demographic updates via direct member contact. Changes made to records were tracked in SmartCare, including the record modifier's user ID and the date and time of the change. Stanislaus referred members to their caseworker to communicate updates to DHCS.

HSAG identified no concerns with Stanislaus' documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Stanislaus to capture provider data and identified the following findings:

- ◆ Stanislaus ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Stanislaus screened the data for completeness and consistency.
- ◆ Stanislaus collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Stanislaus' provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.
- ◆ Stanislaus used CertifyOS as its CVO for provider credentialing and recredentialing.

- ◆ Providers submitted information including license, NPI, and taxonomy during the onboarding process. Stanislaus' HR Division also validated that the provider was not on the Social Security Administration's Death Master File and that the provider's information in NPPES was current and valid.
- ◆ Once credentialing was completed, the provider's direct supervisor or program administrator submitted a ticket via Jira, a project management tool, for the provider to be added to SmartCare.
  - Stanislaus' Training Team created a training environment in SmartCare prior to a provider having access to the live environment. Once the provider was approved for live access, the IT Team created a live access SmartCare account.
- ◆ CertifyOS reached out to providers for updated information such as insurance or expiring licenses at recredentialing every three years. Additionally, Stanislaus' HR Division ran a report from SmartCare monthly to identify and reach out to providers with expiring licenses to ensure updated information was received.
- ◆ SmartCare maintained a custom fields tab that included provider data required for monthly 274 reporting. Monthly, supervisors reviewed a staff information report to validate that provider data on file were current, including license, degree, taxonomy, telehealth capabilities, and language.
- ◆ Changes to contracted provider information, such as changes in program, location, or credentials, were reported via Jira tickets. Depending on the request, the ticket was routed to Stanislaus' HR Division, Training, and/or IT teams for information to be updated in SmartCare. Stanislaus County providers reported changes directly to the HR Division via email as needed.
- ◆ Stanislaus' HR Division reviewed exclusion and suspension lists including the OIG LEIE, EPLS/SAM, and DHCS S&I Provider List at hiring and monthly to identify providers or organizations excluded from the Medicaid and CHIP programs.

HSAG identified no concerns with Stanislaus' documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Stanislaus' delegated entity data and oversight included the following findings:

- ◆ Stanislaus did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Stanislaus' network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Stanislaus used SmartCare to track and extract data used to report network adequacy indicators annually or as requested by DHCS. Stanislaus used the TADT for reporting timely access to DHCS.
- ◆ SmartCare maintained a DMC-ODS outpatient timeliness record and DMC-ODS opioid timeliness record for tracking SUD services, which contained all data fields needed for network adequacy reporting.
- ◆ Stanislaus' software administrators extracted data from the outpatient and opioid timeliness records using a SmartCare report which formatted data in alignment with the TADT.
- ◆ Stanislaus' Outcomes Evaluation Management (OEM) Network Adequacy Certification Team compiled exported data from SmartCare into the TADT and completed validation checks. The TADT contained conditional formatting which highlighted any errors that were corrected prior to submission. Once the TADT was populated, the OEM Network Adequacy Certification Team presented the TADT to leadership and identified any items requiring review prior to submission. The OEM Network Adequacy Certification Team submitted the TADT to DHCS via the MOVEit SFTP portal. Submissions were saved to Stanislaus' NACT drive for historical reference.
- ◆ Prior to July 1, 2023, Stanislaus used CCBH to track and report timely access. CCBH had the capability to create custom forms, and Stanislaus created a contact log form which tracked timely access data used for DHCS' reporting.
- ◆ HSAG assessed Stanislaus' processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Stanislaus created customized reports in SmartCare to monitor completeness and accuracy of member and provider data, including timely access data. Stanislaus maintained a guide for staff reference that indicated staff roles with access to a specific report, intended use of the report, and how often staff should run the report.
  - Reports included:
    - An invalid CIN report to identify CINs that did not adhere to the nine-digit format.
    - A report that identified data quality issues including invalid member names or missing information such as SSN or address in SmartCare, potential duplicate member IDs based on the member's first name and DOB matches, services rendered to members with no coverage, provider data reported as part of the 274 reporting process, in-progress timeliness records in SmartCare, and missing timeliness records in SmartCare.

- Program supervisors typically reviewed reports to identify missing or incomplete timeliness records monthly and followed up with staff as needed for updates.
- Timeliness record reports contained a summary with the total unique member count, number of requests, number of requests that met the timeliness indicator, compliance percentage, average wait time between initial request and offered date, and average wait time between initial request and rendered date for a specific date range for ongoing monitoring.
- ◆ If appointment dates could not be made within the required time frame, the 24/7 Access Line coordinator worked with the SOC chief to assess timely access needs and create a mitigation plan. In addition, Stanislaus' medication teams blocked time to allow for urgent and emergency appointments.
- ◆ Stanislaus conducted monthly provider network meetings and monthly SmartCare Q&A sessions with providers. During these meetings, timeliness record reports were reviewed, which included identifying timeliness records that were not signed in SmartCare or that were showing as in progress.
- ◆ Stanislaus identified challenges related to timely access due to staffing and workflow changes, and training of new processes and procedures. To mitigate identified issues, Stanislaus added IT and OEM positions to support data reporting, and continued collaboration with CalMHSA for system updates. Also, Stanislaus' HR Division and Training teams continued to work to fill staff vacancies and provide ongoing training for timely access tracking and error correction.

HSAG identified no concerns with Stanislaus' documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Stanislaus used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Stanislaus used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Stanislaus' **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Stanislaus' **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Stanislaus' **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume ("**Description of Validation Activities**").

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.30 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

### Table 3.30—Stanislaus Results for Timely Access Network Adequacy

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

— Indicates nonreported data, data that were not reported to DHCS in a timely manner, and/or data that exceeded DHCS' 5 percent data error threshold and were therefore unusable.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	—	—	—
Outpatient Services—Outpatient SUD and Residential (0–17)	—	—	—
<b>OTP</b>			
OTP (18+)	188	187	99%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Stanislaus’ performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Stanislaus implemented numerous customized SmartCare reports to ensure accuracy and completeness of member and provider data, including reports to monitor and track timeliness record completion and metrics.

### Opportunities for Improvement and Recommendations

- ◆ **Opportunity #1:** Stanislaus did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS’ 5 percent data error threshold.
  - **Recommendation #1:** HSAG recommends that Stanislaus conduct an in-depth review of the indicators for which it did not meet the timely access requirements to determine

whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.

- **Recommendation #2:** HSAG recommends that Stanislaus continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

## County of Tulare

### *ISCA Findings and Data Validity*

HSAG completed an ISCA for Tulare and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Tulare had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Tulare used SmartCare as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Tulare used myAvatar to maintain enrollment and provider data.
- ◆ Tulare used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from myAvatar.
- ◆ Migration of data to SmartCare underwent several rounds of testing and validation, which included data mapping validation and record-level comparison between the legacy data and the new EHR interfaced data. Data functionality and usability were validated during each round of testing. Administrative staff reviewed migrated member records to confirm completeness, accessibility, and usability. Any discrepancies identified were addressed before the go-live date, which ensured a seamless transition.
- ◆ Tulare had a data retention strategy in place to allow secure access to any legacy data that were purportedly not migrated to the new EHR, such as service data, scanned documents, and program enrollments older than three years.

HSAG evaluated the personnel that Tulare had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Tulare had a team of two programmers trained and capable of supporting network adequacy timely access reporting. The programmers had an average of two years of experience.

HSAG identified no concerns with Tulare's information systems data processing procedures and personnel.

## Enrollment System

HSAG evaluated the information systems and processes used by Tulare to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Tulare's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Tulare were maintained in SmartCare.
- ◆ Tulare defined a new member as a member who had never received services or a member discharged from a program who returned to receive BH services.
- ◆ Tulare received the MMEF from DHCS. Tulare downloaded the MMEF from the DHCS MOVEit SFTP portal and saved it to a secure drive to be uploaded into SmartCare.
- ◆ Tulare performed monthly reconciliations between SmartCare and the MMEF to ensure completeness and accuracy of eligibility data.
  - Tulare's front desk and billing staff validated member eligibility for all members using RTE verification within SmartCare that confirmed eligibility using a 270/271 transaction process, which was connected through VPN to DHCS directly. Tulare sent a 270 inquiry from SmartCare to DHCS to request eligibility information and received a 271 response from DHCS into SmartCare. The 270/271 transaction process allowed Tulare front desk and billing staff to update member records in SmartCare monthly to capture changes in eligibility.
  - Tulare's reconciliation and oversight of eligibility data included using a SmartCare two out of three match report to identify potential member record matches. Members were matched based on first and last name, SSN, and DOB. If all data points matched, the member's eligibility was automatically updated in SmartCare. If at least one data point did not match, these records were labeled as potential matches. Business staff reviewed potential matches, validated eligibility using MEDSLITE and a 270/271 transaction process, and updated discrepancies in SmartCare as needed.
  - Tulare utilized the SmartCare error report feature to identify members with eligibility updates and to ensure the correct application of updates in SmartCare. This SmartCare feature allowed data to be updated before State reporting.
- ◆ Tulare's system captured and maintained both the state-issued Medi-Cal ID and a system-generated ID.
- ◆ Tulare identified member demographic updates based on direct communication provided by its active member population via member intake forms completed by members at registration and/or during the time of an applicable service.

HSAG identified no concerns with Tulare's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Tulare to capture provider data and identified the following findings:

- ◆ Tulare ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Tulare screened the data for completeness and consistency.
- ◆ Tulare collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Tulare's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.
- ◆ Tulare's procedures for updating and maintaining provider data included:
  - Tulare required all new providers to submit a credentialing application to the Behavioral Health Credentialing Team inbox. The Behavioral Health Credentialing Team reviewed the entirety of each application for accuracy and completeness, including NPI, taxonomy code, license number, DEA number, and DOB. The Behavioral Health Credentialing Team immediately responded to all applications with feedback required to be addressed before the provider was allowed to begin providing services. The Behavioral Health Credentialing Team inputted the application data into the License Tracking Access Database, which was used to produce the monthly provider directory. The provider's application was then forwarded to the EHR Team to set up the provider user profile in SmartCare.
  - Tulare required providers to keep current demographic and licensure data. The Behavioral Health Credentialing Team sent a 274 Expansion Tool Excel worksheet monthly to every BHP and MHP program. Each site was required to respond with any provider updates and an accompanying attestation as to the validity of the updated provider information provided. These updates were input into SmartCare and reported to DHCS monthly via the 274 file.
  - Tulare's EHR system administrator and QI staff had access to edit provider license and demographic data. Changes made to provider data in SmartCare were noted in the comment section of the provider profile. Tulare QI staff had the capability to query SmartCare to identify a log of manual edits, including who edited the data and when.
- ◆ Tulare's administrative staff notified providers within 90 days of an expiring license. If a provider's employment ended, the provider's profile in SmartCare was updated to remove login access to SmartCare. SmartCare also contained programming to prevent providers from billing with an expired license.
- ◆ Tulare had processes in place to review exclusion and suspension lists including the OIG LEIE, EPLS/SAM, and DHCS S&I Provider List at initial hiring and monthly to identify providers or organizations excluded from the Medicaid and CHIP programs.

HSAG identified no concerns with Tulare's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Tulare's delegated entity data and oversight included the following findings:

- ◆ Tulare did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Tulare's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Tulare utilized SmartCare to track and extract data used to report network adequacy indicators annually, or as requested by DHCS. SmartCare used Git and Azure DevOps for version control, to store and track changes, and to query logic within the reports used to report network adequacy timely access data.
- ◆ SmartCare maintained an outpatient timeliness record and opioid timeliness record for tracking SUD services, which contained all data fields needed for network adequacy reporting.
- ◆ Tulare used the TADT for reporting timely access to DHCS. Tulare's QI Team extracted data from the outpatient and opioid timeliness records using a SmartCare report which formatted data in alignment with the TADT. The QI Team exported timely access data into Excel and reviewed the Excel file for data completeness prior to populating the TADT.
- ◆ Prior to July 1, 2023, Tulare used the Excel spreadsheet and myAvatar to track and report timely access. myAvatar contained forms for tracking timely access data which were used to report to DHCS.
- ◆ HSAG assessed Tulare's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ The QI Team was responsible for oversight of the timely access data exported from SmartCare into the Excel worksheet to identify negative timely access values, missing descriptions, and outliers exceeding 60 days. The QI Team reviewed each member record that was highlighted in yellow, as a result of outlier identification in accordance with conditional formatting, after importing from the Excel worksheet into the TADT. The data were reviewed and corrected until every cell in the TADT was white to ensure all conditional formatting errors were addressed.

- ◆ Tulare’s QI staff maintained proactive monitoring of timeliness record completion and established additional staff training to ensure timely access data were accurate and complete.
  - Tulare regularly monitored timeliness data and reported trends to the QIC monthly. One trend that was identified and brought to the QIC was staff not completing and signing timeliness records within the established time frame. As a result, Tulare’s QI Team proactively met with providers quarterly to perform live demonstrations of timeliness reporting.
- ◆ Tulare developed internal timeliness monitoring reports to measure program requests and enrollments in comparison to TADT initiation and completion. The reports were generated on demand using parameters specific to each program site. These internal reports allowed each program site to monitor TADT initiation and completion.

HSAG identified no concerns with Tulare’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Tulare used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that Tulare used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Tulare’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Tulare’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Tulare’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.31 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.31—Tulare Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

S = Suppressed. The numerator or denominator is between one and 10; therefore, HSAG suppresses displaying the numerator, denominator, and rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	283	268	95%↑

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Services— Outpatient SUD and Residential (0–17)	S	S	S
<b>OTP</b>			
OTP (18+)	23	19	83%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Tulare’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Tulare’s QI staff maintained proactive monitoring of timeliness record completion and established additional staff training to ensure timely access data were accurate and complete.

### Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Tulare had in place to inform network adequacy reporting.

# County of Ventura

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Ventura and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### **Information Systems Data Processing Procedures and Personnel**

HSAG evaluated the information systems data processing procedures that Ventura had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Ventura used SmartCare as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- ◆ Prior to July 1, 2023, Ventura used myAvatar to maintain enrollment and provider data.
- ◆ Ventura used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from myAvatar.
- ◆ Migration of data to SmartCare underwent three rounds of testing, including post-upload validations after each round to ensure data were accurately reflected in the system.
- ◆ CalMHSA also used a validation tool to analyze data prior to importing to the system to ensure data were in the correct format.

HSAG evaluated the personnel that Ventura had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Ventura had a team of three programmers who used SQL. Programmers had an average of 15 years of experience.
- ◆ CalMHSA staff included 12 programmers trained and capable of using programming language and programs to maintain SmartCare. CalMHSA programmers had an average of six years of experience.
- ◆ Ventura's QI Team maintained oversight of timely access reporting and ongoing monitoring activities.

HSAG identified no concerns with Ventura's information systems data processing procedures and personnel.

## **Enrollment System**

HSAG evaluated the information systems and processes used by Ventura to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Ventura's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Ventura were maintained in SmartCare.
- ◆ Ventura received the MMEF from DHCS. Ventura downloaded the MMEF from the DHCS MOVEit SFTP portal and saved it to a secure drive to be uploaded into SmartCare.
- ◆ Ventura performed monthly reconciliation between SmartCare and the MMEF to ensure completeness and accuracy of eligibility data.
  - Ventura's front desk staff validated member eligibility for all open members using RTE verification within SmartCare that confirmed eligibility using a 270/271 transaction process, and updated member records in SmartCare monthly to capture changes in eligibility.
  - For discrepancies in demographic data such as DOB, Ventura confirmed information with affected members at their next visit and referred members to their caseworker to make updates with DHCS as needed.
  - Ventura used MEDSLITE as needed to assist in validating eligibility.
- ◆ Ventura defined a new member as a member who had never received services, or a member discharged from services who returned and a clinical decision was made to rescreen and reassess the member for level of care.
- ◆ SmartCare captured and maintained both the state-issued Medi-Cal ID and a system-generated ID. Members retained the system-generated ID throughout enrollment and disenrollment into treatment programs and services.
- ◆ Ventura identified member demographic updates via direct member contact. Office Assistant staff captured changes to member information in SmartCare during check-in for an appointment. Changes made to records were tracked in SmartCare, including the record modifier's user ID and the date and time of the change. Ventura referred members to their caseworker to communicate updates to DHCS.

HSAG identified no concerns with Ventura's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Ventura to capture provider data and identified the following findings:

- ◆ Ventura ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Ventura screened the data for completeness and consistency.
- ◆ Ventura collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Ventura's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in SmartCare.

- ◆ Providers submitted several forms at hiring including employment history and licensing information to Health Care Agency HR staff who completed a background check.
- ◆ Ventura used a Microsoft form to collect additional provider information to assist in capturing all required data for monthly 274 reporting and the credentialing process such as license, NPI, and DEA number. Credentialing and personnel staff, including the site manager, reviewed the information, and the site manager submitted a SmartCare account request form to Ventura's EHR Team.
- ◆ Ventura's EHR Team received the SmartCare account request form via a ticketing process. The EHR Team validated that the provider was not already in SmartCare and created the provider profile.
  - Once the EHR Team entered the provider into SmartCare, the ticket was assigned to billing staff to perform additional data validation of the provider's license, degree, NPI, and taxonomy. Billing staff validated provider information using the NPPES and BBS and entered the provider's licensure and degree information in SmartCare after verification.
- ◆ Monthly, Ventura's QI staff sent a file to clinic managers to validate current staff rosters and capture changes in provider information such as location, maximum caseload, telehealth capability, and NPI. Provider data were updated in SmartCare as needed to ensure complete and accurate information was used for 274 reporting and Ventura's provider directory.
- ◆ Ventura's HR staff notified providers as needed of expiring licenses. Recredentialing was completed every two years. SmartCare also contained programming to prevent providers from billing if their license had expired.
- ◆ Ventura's EHR, QI, and billing staff had access to edit provider data. Changes made to provider data in SmartCare were noted in the comment section of the provider profile. If a provider's employment ended, the provider's profile in SmartCare was updated to remove login access.
- ◆ Ventura had processes in place to review exclusion and suspension lists including the OIG LEIE, EPLS/SAM, and DHCS S&I Provider List at hiring and monthly to identify providers or organizations excluded from the Medicaid and CHIP programs.

HSAG identified no concerns with Ventura's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Ventura's delegated entity data and oversight included the following findings:

- ◆ Ventura did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Ventura's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Ventura utilized SmartCare to track and extract data used to report network adequacy indicators annually, or as requested by DHCS. Ventura used the TADT for reporting timely access to DHCS.
- ◆ SmartCare maintained an outpatient timeliness record and opioid timeliness record for tracking SUD services, which contained all data fields needed for network adequacy reporting.
- ◆ Ventura's QI Team extracted data from the outpatient and opioid timeliness records using a SmartCare report which formatted data in alignment with the TADT.
  - Exported data were copied and pasted into the TADT. Ventura's QI Team reviewed the TADT to identify irregularities and performed data validation, which included verifying the total records per member, volume by request date, and offered date range. Staff reviewed any discrepancies to ensure accuracy of entered data in SmartCare and made updates as needed, such as correcting an incorrectly formatted date. QI staff also reviewed the TADT to ensure applicable entries were included, such as validating that members included in reporting were Medi-Cal members.
  - SmartCare contained programming logic to extract signed outpatient and opioid timeliness records to ensure completeness of data being used for reporting and allowed staff to specify a start and end date to capture all services requested within a specified reporting period.
  - Ventura's QI Team submitted the TADT via the DHCS MOVEit SFTP portal. Submissions were saved to Ventura's local drive for historical reference.
- ◆ Prior to July 1, 2023, Ventura used myAvatar as its EHR system. Timely access for SUD outpatient services was reported by matching RFS records in myAvatar to billed services data for the first and follow-up rendered services.
- ◆ For OTP reporting, Ventura's OTP contracted providers completed the DHCS template based on their own EHR data. Ventura validated data for completeness prior to submission.
- ◆ HSAG assessed Ventura's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

### Ongoing monitoring activities:

- ◆ Ventura created queries to identify timeliness record errors such as incomplete or missing records within SmartCare. Common errors included timeliness records in progress for more than 15 or 30 days, first offered appointment fields left blank, invalid program assignments, urgent records missing a time stamp, and timeliness records missing for a newly enrolled member.

- Ventura maintained detailed process documentation and training materials to assist staff in tracking timely access in SmartCare, including strategies to reduce commonly identified errors, and completed ongoing staff training as needed.
  - Ventura's QI staff monitored error reports and sent weekly emails to program administrators to identify errors and members with missing or incomplete timeliness records, including forms that were in progress for more than 15 or 30 days. Errors continued to appear on the error report until program staff updated the timeliness record in SmartCare.
  - Ventura summarized error volumes by program and worked with leadership to address process or resource gaps identified, which included consulting with managers and administrative staff to provide additional training or refine workflows.
- ◆ Ventura compared network adequacy results to prior submissions and operational metrics such as requests for service or program enrollment to monitor timely access over time.

HSAG identified no concerns with Ventura's documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that Ventura used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that Ventura used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Ventura's **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Ventura's **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Ventura's **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.32 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.32—Ventura Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services—Outpatient SUD and Residential (18+)	271	249	92%↑
Outpatient Services—Outpatient SUD and Residential (0–17)	19	18	95%↑

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>OTP</b>			
OTP (18+)	106	97	92%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Ventura’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Ventura implemented logic for generating error reports on timeliness data in SmartCare and had a weekly process to reach out to staff to notify them of missing or incomplete timeliness records.
- ◆ **Strength #2:** Ventura maintained detailed training materials and process documentation to assist staff in tracking complete and accurate timeliness data.

### Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Ventura had in place to inform network adequacy reporting.

# County of Yolo

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for Yolo and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### **Information Systems Data Processing Procedures and Personnel**

HSAG evaluated the information systems data processing procedures that Yolo had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Yolo used myAvatar as the database management system to collect and maintain enrollment and provider data.

HSAG evaluated the personnel that Yolo had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ Yolo had two programmers trained and capable of supporting network adequacy activities. On average, the programmers had eight years of experience.
- ◆ Yolo's QM Team maintained oversight of timely access reporting. Staff were trained and capable of supporting network adequacy reporting activities.

HSAG identified no concerns with Yolo's information systems data processing procedures and personnel.

### **Enrollment System**

HSAG evaluated the information systems and processes used by Yolo to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of Yolo's enrollment system included the following findings:

- ◆ Enrollment and eligibility data for Yolo were maintained in myAvatar.
- ◆ Yolo received the MMEF from DHCS. Yolo's Enterprise Application Team downloaded the MMEF from the DHCS portal and uploaded it into myAvatar. The data were converted from their original format into a format for myAvatar to ingest, then stored as a California MEDS file upload and kept for historical reference.
- ◆ Yolo performed monthly reconciliation between myAvatar and the MMEF to ensure the completeness and accuracy of enrollment data.
- ◆ Yolo's reconciliation and oversight of enrollment data included a review of the number of records included in each MMEF against the myAvatar data uploads for completeness.

- Yolo's access staff manually entered enrollment data into myAvatar during initial services. Yolo staff performed monthly manual checks of the Medi-Cal DHCS website for its active population and manually updated myAvatar to ensure ongoing enrollment data accuracy. Yolo indicated that it did not use the 270/271 data exchange process in myAvatar.
- Yolo staff reviewed a two out of three match report to identify partial matches between the MMEF and myAvatar and manually researched each member for confirmed alignment.
- ◆ Yolo's system captured and maintained both the state-issued Medi-Cal ID and a system-generated ID.
- ◆ Yolo identified member demographic updates based on direct communication provided by its active member population.
- ◆ Yolo defined a new Medi-Cal member as a member who had never received services or a member who is subsequently re-eligible to receive services after three years from close of previous BH services.

HSAG identified no concerns with Yolo's documented enrollment data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed enrollment systems through the ISCA and supporting documentation submission.

## Provider Data Systems

HSAG evaluated the information systems and processes used by Yolo to capture provider data and identified the following findings:

- ◆ Yolo ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- ◆ Yolo screened the data for completeness and consistency.
- ◆ Yolo collected data from providers in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Yolo's provider data system(s) included the following findings:

- ◆ Provider credentialing and network status data were maintained in myAvatar.
- ◆ Yolo's procedures for updating and maintaining provider data included:
  - Providers submitted a Practitioner Enrollment Application and supporting documentation to the Behavioral Health Quality Management (BHQM) Team.
  - The BHQM Team reviewed all data for completeness and validated the accuracy of the provider's information against databases such as the NPPEs, EPLS/SAM, the Department of Consumer Affairs License Verification, the DEA Registration search, the NPDB, and the Social Security Administration's Death Master File. The BHQM Team also checked the provider's information against the OIG LEIE to identify providers or organizations excluded from the Medicaid and CHIP programs.

- Yolo staff and contracted providers were expected to notify Yolo when changes in licensure, location, status, or additional provider data were necessary. Providers also resubmitted the enrollment application every three years for non-licensed staff and according to the licensure expiration date for licensed staff. The BHQM Team validated the provider data against all databases and the provider exclusion lists during provider reenrollment.
- ◆ Yolo distributed monthly Excel templates to providers and requested provider verification to ensure ongoing data accuracy in myAvatar.

HSAG identified no concerns with Yolo's documented provider data capture, data processing, data integration, data storage, or data reporting. The HSAG auditor assessed provider systems through the ISCA and supporting documentation submission.

## Delegated Entity Data and Oversight

HSAG's assessment of Yolo's delegated entity data and oversight included the following findings:

- ◆ Yolo did not subcontract any network adequacy-related services to delegated entities.

## Network Adequacy Indicator Monitoring and Reporting

HSAG's assessment of Yolo's network adequacy indicator monitoring and reporting processes included the following findings:

### Data preparation and submission to DHCS:

- ◆ Yolo used the TADT to report timely access to DHCS, which was submitted annually or as requested by DHCS.
- ◆ Yolo had processes in place to ensure appropriate timely access data were captured:
  - Yolo QM staff utilized a strict definition of "initial access event" for a member to define the member's access even for screening against any previous member activity. Any prior or subsequent entry that would pose a double count was manually screened and excluded. Members who had previous access history who fell outside the county plan's definition of a new member were removed from the data set. A master file tab including all initial member access events was kept for comparison to the screened members for historical reference.
  - Yolo used myAvatar forms for timely access data compilation. QM staff researched any missing information identified through the member's chart and other reports from myAvatar.
- ◆ Yolo maintained timely access reporting in compliance with DHCS requirements for submitting data files.
- ◆ HSAG assessed Yolo's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

**Ongoing monitoring activities:**

- ◆ Yolo had robust ongoing monitoring in place to ensure continuity of network adequacy data files:
  - Yolo’s QM Team compared timely access data to previously produced timely access data to review continuity of processes while accounting for improvements to reporting.
  - Yolo’s data production team consisted of analysts from the QM Team and the IT Team. Team meetings and cross-training have ensured production knowledge to safeguard future production efforts for network adequacy timely access reporting.
  - Yolo maintained a development instruction manual with proposed, completed, and active improvements to the tools used for timeliness data production for the TADT.
- ◆ Yolo’s QM Team performed internal reviews that included subpopulation definition verification, data quality checks of data elements for analysis, and episodic comparisons of TADT data.
- ◆ Yolo’s QM supervisory staff performed data checks after TADT production to ensure the TADT was complete before submission to DHCS.

HSAG identified no concerns with Yolo’s documented network adequacy monitoring and reporting processes, given that DHCS was responsible for the annual calculation and reporting of the timely access indicators in scope of the review period.

**Assessment of Data Validity**

HSAG evaluated and assessed the data methods that Yolo used to inform network adequacy reporting for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that Yolo used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Yolo’s **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Yolo’s **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that Yolo’s **network adequacy results** were:

- Acceptable
- Not acceptable

## Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 2.2 included in Section 2 of this volume (“**Description of Validation Activities**”).

No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

## Analysis and Conclusions

Table 3.33 presents DHCS-calculated results for timely access by modality type. DHCS utilizes the TADT to calculate county compliance using the date of first contact to request services and the number of days between the date and the assessment appointment first offer date, wherein 80 percent of members must have been offered an appointment within 10 business days for outpatient SUD and residential services, and within three business days for the OTP.

**Table 3.33—Yolo Results for Timely Access Network Adequacy**

Rates shaded in gray and denoted with an upward arrow (↑) are at or above the 80 percent standard and have met the standard.

Rates **bolded** and denoted with a downward arrow (↓) are less than the 80 percent standard and have conditionally met the standard.

ZU = Zero utilization. DHCS considers this result to have met the standard.

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>Outpatient Services—Outpatient SUD and Residential</b>			
Outpatient Services— Outpatient SUD and Residential (18+)	59	50	85%↑
Outpatient Services— Outpatient SUD and Residential (0–17)	0	0	ZU

Modality Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
<b>OTP</b>			
OTP (18+)	18	18	100%↑
OTP (0–17)	0	0	ZU

## Strengths, Opportunities for Improvement, and Recommendations

By assessing Yolo’s performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** Yolo demonstrated robust coordination across departments along with various quality checks to ensure complete and accurate reporting of timely access data.

### Opportunities for Improvement and Recommendations

HSAG identified no specific opportunities for improvement related to the systems, processes, data submissions, and monitoring activities Yolo had in place to inform network adequacy reporting.

# Department of Health Care Services

## *ISCA Findings and Data Validity*

HSAG completed an ISCA for DHCS and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

### Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that DHCS had in place to support network adequacy indicator calculation and reporting, which included the following findings:

- ◆ DHCS used the Behavioral Health Information System (BHIS) MOVEit portal for extracting TADTs submitted by DMC-ODS plans to inform timely access network adequacy calculation.
- ◆ MEDS was the source system of record for enrollment information.

HSAG evaluated the personnel that DHCS had in place to support network adequacy indicator reporting, which included the following findings:

- ◆ DHCS' Behavioral Health Timely Access Project Team was trained and capable of supporting network adequacy calculations and reporting activities. On average, staff had approximately five years of experience.

HSAG identified no concerns with DHCS' information systems data processing procedures and personnel.

### Enrollment System

HSAG evaluated the information systems and processes used by DHCS to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by DHCS. HSAG's evaluation of DHCS' enrollment system included the following findings:

- ◆ Enrollment data were obtained through the Medi-Cal application process, which generated a unique member ID in the form of a CIN. The CIN was tied to the MEDS-ID, also known as the member's SSN.
- ◆ MEDS maintained members' current enrollment and the prior 12 months of history. The enrollment broker processed the enrollment or disenrollment, and then data were sent to MEDS as the system of record.

- ◆ DHCS identified member demographic information and any demographic changes through the Medi-Cal application process. Changes to demographic information could be reported to counties directly or through plans' reported address changes.
- ◆ DHCS' Behavioral Health Oversight Monitoring Division (BHOMD) provided resources to DMC-ODS plans to access eligibility data.
  - The BHOMD provided the DMC-ODS plans a county-specific MMEF, which contained eligibility data for the current month and previous 15 months. The MMEFs were available to the DMC-ODS plans via the MOVEit portal and were uploaded to the DMC-ODS plans monthly.
  - DHCS granted access to MEDSLITE, the internal-based program that queried eligibility data from MEDS, for DMC-ODS plans to validate member eligibility status.
- ◆ DMC-ODS plans leveraged eligibility data via the MMEF and validated eligibility using MEDSLITE for timely access data reporting submitted to DHCS.

HSAG identified no concerns with DHCS' documented enrollment data capture, data processing, data integration, data storage, or data reporting.

## Provider Data Systems

HSAG evaluated the information systems and processes used by DHCS to capture provider data and identified the following:

- ◆ DMC-ODS plans were required to submit provider network data to DHCS using the X12 274 Health Provider Directory standard (274 standard) monthly between the first and 10th day of each month.
  - The 274 standard was an electronic data interchange standard selected by DHCS to ensure provider network data submitted to DHCS were consistent, uniform, and aligned with national standards.
  - The monthly 274 provider network data submissions included outpatient, intensive outpatient, residential, and opioid treatment program providers that were within the provider network of the DMC-ODS plan at the group, site, and provider detail level.
- ◆ DHCS maintained procedures to ensure accuracy and completeness in the receipt of the 274 data files. If a DMC-ODS plan submitted its 274 file late, or the file was incomplete or inaccurate, the DMC-ODS plan could be subject to a CAP and/or other enforcement actions.
- ◆ DHCS' Network Adequacy Oversight Section (NAOS) Team utilized provider data received from the DMC-ODS plans as the source of truth for provider data within timely access data reporting. The NAOS Team used the TADT to collect timely access data from the DMC-ODS plans.
- ◆ DHCS had adequate processes in place to ensure timely and consistent receipt of plans' TADT submissions such as requiring DMC-ODS plans to submit timely access data within the approved TADT template, uploading the TADT file into the BHIS folder, and naming the file in accordance with the DHCS-required naming convention. Upon receipt of the TADT,

the DHCS network adequacy county liaison extracted and uploaded the TADT into SharePoint where copies were created for an initial review of any critical data errors. If the TADT contained no errors, a copy of the TADT was submitted to the Enterprise Data Information Management (EDIM) Team via an internal network drive for calculation and analysis. If the TADT contained errors, the county liaison returned the TADT to the DMC-ODS plan with one opportunity for correction and resubmission. This opportunity was only granted if the DMC-ODS plan's initial submission was made using the correct, unaltered TADT.

HSAG identified no concerns with DHCS' documented provider data capture, data processing, data integration, data storage, or data reporting.

## Delegated Entity Data and Oversight

HSAG's assessment of DHCS' delegated entity data and oversight included the following findings:

- ◆ DHCS did not rely on any external delegated entity data for network adequacy indicator calculation or reporting during the reporting period in scope of review.

## Network Adequacy Indicator Reporting

HSAG's assessment of DHCS' network adequacy indicator reporting processes included the following findings:

- ◆ DHCS required each DMC-ODS plan to have a system in place for tracking and measuring timeliness of care, which included the timeliness of receiving a first appointment. For this purpose, DHCS developed the TADT, a spreadsheet which served as a uniform data collection tool.
- ◆ DMC-ODS plans submitted TADTs to DHCS via the MOVEit portal. Upon receipt of the TADT, the NAOS Team conducted quality checks on the submitted data as part of its annual network adequacy certification. Quality checks included:
  - A review of each DMC-ODS plan's TADT for any critical data errors in preparation for submission to the EDIM Team for analysis of timely access data.
  - A quality review to ensure the TADT met data quality processing standards. These standards included ensuring that all entries were formatted appropriately and fell within the reporting period, and that dates in data elements did not contradict the logic of an appointment flow.
- ◆ After the quality checks were conducted, the NAOS Team submitted the TADTs to the EDIM Team via an internal network drive for timely access analysis and calculation.
- ◆ The EDIM Team used Visual Basic for Applications (VBA) coding to calculate compliance using the date of first contact to request services, the date of the first available appointment, and the number of business days between those dates. For a DMC-ODS plan

to be in compliance with timely access standards, 80 percent of new members must have been offered an appointment within the applicable time frame per indicator.

- For DMC-ODS plans with timely access standards that met the 80 percent standard, DHCS granted the DMC-ODS plan a pass on its Network Adequacy Findings Report.
- For DMC-ODS plans with timely access standards that did not meet the 80 percent standard, DHCS required the plan to submit a CAP.
- ◆ The EDIM Team also checked the CINs in the TADTs against an eligibility list pulled from MEDS to ensure the CIN was valid. Additional data validation checks performed by the EDIM Team included determining if the offered date preceded the contact date and/or if the first appointment offer data was blank or invalid with a valid rendered date.
- ◆ The TADTs included new member timely access data collected by the DMC-ODS plans; however, the definition of new member was inconsistent across the DMC-ODS plans since there was a lack of guidance surrounding new member criteria.
- ◆ The DHCS NAOS Team and the EDIM Team used appropriate methodologies to assess adherence to network adequacy standards. The NAOS Team maintained and distributed the methodology used for compliance determination for timely access standards to DMC-ODS plans through the BHIN. The NAOS Team also had well-established instructions embedded in the TADT to instruct the DMC-ODS plans on how to submit timely access data to DHCS.
- ◆ To ensure continuity of network adequacy indicator production, DHCS had adequate backup procedures and documentation of network adequacy timely access indicator reporting production, logic, and methodology. DHCS conducted regular training and had backup support available to ensure all project members remained well-versed in the logic and details of the network adequacy timely access indicator production procedures.

HSAG identified no concerns with DHCS' network adequacy indicator reporting processes.

## Assessment of Data Validity

HSAG evaluated and assessed the data methods that DHCS used to calculate results generated for each network adequacy indicator in the scope of NAV.

Overall, HSAG determined that DHCS' **data collection procedures** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that DHCS' **network adequacy methods** were:

- Acceptable
- Not acceptable

Overall, HSAG determined that DHCS' **network adequacy results** were:

- Acceptable
- Not acceptable

## ***Strengths, Opportunities for Improvement, and Recommendations***

By assessing DHCS' performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### **Strengths**

- ◆ **Strength #1:** DHCS established a clear and consistent framework for analysis of timely access data and communicated to the DMC-ODS plans the methodology DHCS uses for compliance determination.
- ◆ **Strength #2:** DHCS has well-established processes and documentation in place within the TADT to instruct DMC-ODS plans on how to submit timely access data to DHCS to facilitate timely access indicator calculation and reporting.

### **Opportunities for Improvement and Recommendations**

- ◆ **Opportunity #1:** DHCS collected timely access data from the DMC-ODS plans, which included new member timely access data; however, the definition of "new member" was not consistent across the DMC-ODS plans.
  - **Recommendation:** HSAG recommends that DHCS define the criteria for a new member and communicate these criteria to the DMC-ODS plans to ensure consistent timely access data are collected and analyzed across all DMC-ODS plans.

## 4. Programwide Results

### Analysis and Conclusions

Based on the results of the NAV audit combined with the detailed validation of each indicator, HSAG determined that 30 DMC-ODS plans achieved a *High Confidence* validation rating, which refers to HSAG’s overall confidence that the DMC-ODS plans used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

HSAG assessed DHCS’ submitted results and found that at the county level, 24 DMC-ODS plans met the 80 percent standard across all indicators. One DMC-ODS plan was not required to submit timely access data for the period in scope of review and therefore did not receive a pass or conditional pass rating. Seven DMC-ODS plans did not meet the 80 percent standard due to errors within data submissions, lack of data submissions, or not meeting the 80 percent standard for one or more indicators and received a conditional pass rating. Table 4.1 demonstrates DMC-ODS plans that did not meet DHCS’ 80 percent standard by indicator.

**Table 4.1—DMC-ODS Plans—Timely Access Conditional Pass**

DMC-ODS Plan	Timely Access Indicator(s)
Merced	◆ Outpatient Services—Outpatient SUD and Residential (18+)
Napa	◆ Outpatient Services—Outpatient SUD and Residential (18+)
Sacramento	◆ OTP (0–17)
San Bernardino	◆ Outpatient Services—Outpatient SUD and Residential (18+) ◆ Outpatient Services—Outpatient SUD and Residential (0–17)
San Joaquin	◆ Outpatient Services—Outpatient SUD and Residential (18+) ◆ Outpatient Services—Outpatient SUD and Residential (0–17)
Santa Clara	◆ Outpatient Services—Outpatient SUD and Residential (18+) ◆ Outpatient Services—Outpatient SUD and Residential (0–17) ◆ OTP (18+) ◆ OTP (0–17)
Stanislaus	◆ Outpatient Services—Outpatient SUD and Residential (18+) ◆ Outpatient Services—Outpatient SUD and Residential (0–17)

HSAG observed gaps in completeness of timely access data that two DMC-ODS plans captured and reported to DHCS; therefore, some elements were determined to have significant bias, which resulted in a validation rating of *No Confidence*. Table 4.2 demonstrates DMC-ODS plans that received a *No Confidence* validation rating.

**Table 4.2—DMC-ODS Plans—No Confidence Validation Rating**

DMC-ODS Plan	Validation Rating
Sacramento	<i>No Confidence</i>
Santa Clara	<i>No Confidence</i>

## Strengths, Opportunities for Improvement, and Recommendations

By assessing statewide performance and NAV reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

### Strengths

- ◆ **Strength #1:** HSAG observed that the DMC-ODS plans had robust processes in place to collect, maintain, and validate accuracy and completeness of member eligibility and demographic data. DMC-ODS plans had defined processes in place to collect demographic information at the initial RFS, complete ongoing updates throughout receipt of services, and routinely validate demographic and eligibility information using the DHCS provider portal and MEDSLITE.
- ◆ **Strength #2:** HSAG observed strong collaboration between DHCS and the DMC-ODS plans. Clear expectations were provided to the DMC-ODS plans on reporting network adequacy data using the TADT and through distribution of BHINs. DMC-ODS plans partnered with their EHR vendors to ensure system updates were completed to capture and report all required data fields according to the TADT.

## ***Opportunities for Improvement and Recommendations***

- ◆ **Opportunity #1:** HSAG observed variation in the DMC-ODS plans' definition of a new member and which members were included in timely access reporting.
  - **Recommendation:** HSAG recommends that DHCS develop and communicate a standardized definition of a new member to the DMC-ODS plans indicating which members should be included in reporting to ensure consistency.

## **Progress Made from the Prior Year**

Since this is the first year a NAV audit was conducted for DHCS' DMC-ODS, no information regarding assessment of progress from the prior year is included in this report. During future reporting cycles, HSAG will incorporate an evaluation of programwide network adequacy standards progress made from the prior year.

## Appendix A. HSAG Validation Team and List of Interviewees

Table A.1 lists the Alameda staff members interviewed by the HSAG validation team.

**Table A.1—List of Alameda Interviewees**

Interviewee Name	Title
Aaron Chapman, MD	BH Medical Director and Chief Medical Officer (CMO)
Adm Golub	Management Analyst
Adrienne Carlisle	Compliance and Privacy Officer—Alameda County BHD
Amy Saucier	Clinical Review Specialist Supervisor
Angela Coombs, MD	Associate Medical Director
Arlene Pabustan	Health Insurance Technician
Cameren Sales	Information Systems Analyst
Catherine Powell, AMFT	Early Childhood Mental Health Coordinator
Cecilia Serrano	Finance Director
Charles Edwards, LCSW	ACCESS Division Director
Charles Raynor, PharmD	Pharmacy Services Director
Cheryl Narvaez, LCSW, MPA	Early and Periodic Screening, Diagnosis, and Treatment Coordinator, Children and Young Adult System of Care
Danielle Benjamin	Information Systems Analyst
Derek Crabbe	Information Systems Specialist
Ed Lozano	Applications Development Manager, Information Systems
Emily Galimba	QI Data Analytics Division Director
Eric Yuan	Manager, Integrated Care Services
Fonda Houston	Substance Use Operational Specialist
Gabriel Orozco	Business Intelligence Analyst
Greg Arenius	Information Systems Analyst
Henning Schulz	Adult Outpatient Services Division Director

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Interviewee Name	Title
Jade Phan	Information Systems Manager
Jaime Perez	Information Systems Manager
James Wagner, LMFT/LPCC	Clinical Operations Deputy Director
Janet Biblin	Information Systems Manager
Jenny Bruton	Program Specialist
Jenny Wong	Management Analyst
John Hanson	Information Systems Coordinator
Joshua Kayman, MD	Medical Director, Substance Use Continuum of Care
Juanita Grampsas	Information Systems Analyst
Julienne Schrick, LCSW	Older Adult Services Division Director
Karen Capece, LCSW	QM Program Director
Kate Jones, RN, MS, MSN	Adult & Older Adult System of Care Director
Kate Rowe	Information Systems Manager
Kinzi Richholt	Chief Nursing Officer
Krishna Henry	Administrative Assistant
Laphonsa Gibbs, LCSW	Interim Children and Young Adult System of Care Director
Lisa Moore	Billing & Benefits Support Unit Director
Lorenza Hall, PhD	Senior Management Analyst
Lori Shallcross, LCSW	Clinical Review Specialist, Utilization Management
Doris Sunga	Information Systems Analyst
Marnie Purciel-Hill	Performance Improvement Manager, Senior Management Analyst
Matt Madrid	Information Systems Analyst
Melissa Yamamoto	Program Specialist
Michelle Lewis, LCSW	Division Director, County Clinics
Michelle Manor, MA	Supervising Program Specialist
Mona Shah, MSW	Health Equity Policy and Systems Manager
Necole Goodman	Associate Data Analyst
Rashad Eady	Program Specialist

Interviewee Name	Title
Rickie Lopez	Assistant Finance Director
Scott Hamner	Information Systems Analyst
Shannon Singleton-Banks	Interim Assistant Director Substance Use Continuum of Care
Sheryl Diedrick	Information Systems Analyst, SmartCare Implementation
Shukura Reynolds	Management Analyst
Stephanie Lewis	Crisis System of Care Director
Stephanie Montgomery	Health Equity Division Director/Health Equity Officer
Steve Kline	Information Systems Analyst
Sue Louie	Information Systems Analyst
Sun Lee, LCSW, MPH	Transition Age Youth Services Division Director
Tasha Lopez	Supervising Financial Services Specialist
Tom MacMillan	Deputy Director, Information Systems—Alameda County Health
Torfeh Rejali, LMFT	Division Director, QA
Traci Cross	Assistant Director
Vanessa Baker, LMFT	Deputy Director/Plan Administrator
Wendi Vargas	Contracts Director
Samantha Brown	Program Specialist
Abigail Chente	Administrative Assistant
Angelica Gums	Transition Age Youth Program Specialist

Table A.2 lists the Contra Costa staff members interviewed by the HSAG validation team.

**Table A.2—List of Contra Costa Interviewees**

Interviewee Name	Title
Suzanne Tavano	Director of BH Services
Steve Hahn-Smith	BH Informatics Director
Fatima Matal-Sol	Alcohol and Other Drugs Program Chief
Chet Spikes	Assistant Health Services IT Director, Business Systems

Interviewee Name	Title
Mark Messerer	Alcohol and Other Drugs Program Manager
Jorge Pena	Business Analyst
Mitchell Brown	AODS Program Manager
David Kekuewa	AODS Health Services System Analyst II
Leah Hanzlicek	Quality and Compliance Manager (CalMHSA)
Candice Medina	Senior Program Coordinator (CalMHSA)
Khristy Pease	Director of Revenue Cycle Management (CalMHSA)
Lisa Kirlin	Senior Implementation Coordinator (CalMHSA)
Charla Rowe	Clinical Implementation Coordinator (CalMHSA)
Ricky Cruz	Implementation Specialist (CalMHSA)
Anastassia Kiannu	Office Assistant to Director of Project Management (CalMHSA)
Gracie Amirtharaj	Director of Software Development (CalMHSA)

Table A.3 lists the El Dorado staff members interviewed by the HSAG validation team.

**Table A.3—List of El Dorado Interviewees**

Interviewee Name	Title
Nicole Ebrahimi-Nuyken	Director of BH
Justine Collinsworth	Manager of Mental Health Programs
Shaun O'Malley	Acting Alcohol and Drug Programs Division Manager
Ramona Diaz	Fiscal Manager
Kristin Gula	Supervising Accountant/Auditor
Dennis Wade	Health Education Coordinator
Lisa Rodriguez	Senior Department Systems Analyst
Moriah Weldy	Administrative Analyst II
Cheyne Close	Administrative Analyst II
Raquel Smith	Administrative Analyst I

Interviewee Name	Title
Kristen Monroe	Administrative Analyst Supervisor
Nick Perez	IT Department Specialist
Alex De Guzman	IT Department Specialist

Table A.4 lists the Fresno staff members interviewed by the HSAG validation team.

**Table A.4—List of Fresno Interviewees**

Interviewee Name	Title
Jeffery Elliott	QI Coordinator
Susan Holt	Director of BH and Public Guardian
Maryann Le	Deputy Director—Administrative Operations and Public Guardian Office
Ahmad Bahrami	Division Manager—Planning & QM
Emma Rasmussen	Deputy Director
Lesby Flores	Deputy Director
Joseph Rangel	BH Division Manager—Plan Administration
Sean Patterson	BH Division Manager—Finance
Michael Miller	Division Manager of Health and IT
Ricardo Ochoa	Senior Staff Analyst—Finance
Lawrence Seymour	Program Manager—Finance
Sage Dreith	Staff Analyst—Plan Administration
Michael Muro	Program Manager—Plan Administration
Loretta Brandon	Staff Analyst—Finance
Domenica Tamayo	Program Manager—Finance
Pa Ge Xiong	Staff Analyst—Planning & QM
Chad Sargent	Epidemiologist—Planning & QM
Meng Moua	Senior Staff Analyst—Plan Administration
Karla Boyd	Clinical Supervisor
Kathryn Sleboda	Business Systems Analyst—Health & IT
Leah Hanzlicek	Quality and Compliance Manager (CalMHSA)
Candice Medina	Senior Program Coordinator (CalMHSA)
Khristy Pease	Director of Revenue Cycle Management (CalMHSA)

Interviewee Name	Title
Lisa Kirlin	Senior Implementation Coordinator (CaMHSA)
Ricky Cruz	Implementation Specialist (CaMHSA)
Charla Rowe	Clinical Implementation Coordinator (CaMHSA)
Gracia Amirtharaj	Director of Software Development (CaMHSA)
Amy Leino	QI Manager (CaMHSA)
Anastassia Kiannu	Office Assistant to Director of Project Management (CaMHSA)

Table A.5 lists the Imperial staff members interviewed by the HSAG validation team.

**Table A.5—List of Imperial Interviewees**

Interviewee Name	Title
Sarah Moore	BH Manager
Rosalva Aramburo	Program Supervisor
Debbie Garcia	Administrative Analyst
Jessica Perea	Administrative Analyst
Leticia Plancarte-Garcia	Director of BH Services
Gabriela Jimenez	Assistant Director of BH Services
Ryan Taylor	BH Manager
Alejandro Vasquez	Program Supervisor
Anais Lopez	Program Supervisor
Annette Hughes	Administrative Analyst
Jose Nunez	Administrative Analyst
Leah Hanzlicek	Quality and Compliance Manager (CaMHSA)
Candice Medina	Senior Program Coordinator (CaMHSA)
Khristy Pease	Director of Revenue Cycle Management (CaMHSA)
Lisa Kirlin	Senior Implementation Coordinator (CaMHSA)
Charla Rowe	Clinical Implementation Coordinator (CaMHSA)

Interviewee Name	Title
Eric Cardoza	Senior EHRs Solutions Engineer (CalMHSA)
Bethany Dominik	Senior Epidemiologist (CalMHSA)
Gracia Amirtharaj	Director of Software Development (CalMHSA)
Peter Merna	Senior Implementation Coordinator (CalMHSA)
Mohan Mahalingam	Director of Analytics, Insights and Reporting (CalMHSA)
Roksana Dahl	Director of Project Management (CalMHSA)

Table A.6 lists the Kern staff members interviewed by the HSAG validation team.

**Table A.6—List of Kern Interviewees**

Interviewee Name	Title
Heather Homibrook	Deputy Director
Jessica Armstrong	Deputy Director
Robin Taylor	Deputy Director
Lesleigh Davis	QI Division Administrator
Candee Del Rio	Finance Director
Rachelle Hunt	Resources Operations Manager
Heather Williams	BH Program Supervisor
Myeisha Dhillon	BH Program Supervisor
Donna Robinson	BH Unit Supervisor
Karina Leonzo-Castillo	BH Unit Supervisor
Jamie Whitlock	EHR Support Supervisor
Sheri Bulley	Fiscal Support Supervisor
Christopher Garcia	Technology Services Supervisor
Brian Richards	Senior Systems Analyst
Miles Middleton	Administrative Coordinator
Melanie McIntyre	EHR Support Supervisor
Crystal Barboza	BH Planning Analyst
Mario Marin	Technical Support Engineer II

Table A.7 lists the Los Angeles staff members interviewed by the HSAG validation team.

**Table A.7—List of Los Angeles Interviewees**

Interviewee Name	Title
Gary Tsai, MD, DFAPA, FASAM	SAPC Bureau Director
Tina Kim, PhD, MA	Division Chief, Health Outcomes & Data Analytics Division
Antonne Moore	Chief, Strategic and Network Development Division
Simona Lovin	Division Chief, IT
Daniel Deniz	Division Chief, Finance Services Division
David Hindman, PhD	Division Chief, Sage Management Division
Brian Hurley, MD, MBA, FAPA, DFASAM	Medical Director
Setareh Yavari	Division Chief, Contracts and Compliance Division
Maribel Garcia	Head Contract Program Auditor
Adam Loomis	Head Contract Program Auditor
Christina Villegas	Senior Staff Analyst, Health
Akbar Siddiqui	Principal Application Developer
Esther Orellana, PhD	Clinical Psychologist II
Nima Amini, MD, MHA	Associate Medical Director
Vinay Garg	IT Supervisor
Ariel Young	Senior Staff Analyst, Health
Janie Ka-Yee Yeung	Senior Application Developer
Kairong Wang	Data Scientist Supervisor
Eric Luong	Data Scientist
Harim Yoo	Data Scientist
Kelly Sadamitsu	Staff Analyst, Health

Table A.8 lists the Marin staff members interviewed by the HSAG validation team.

**Table A.8—List of Marin Interviewees**

Interviewee Name	Title
Todd Schirmer	BH Director
Katie Smith	BHRS Division Director, QM

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Interviewee Name	Title
Catherine Condon	BHRS Division Director, Substance Use Services
Jordan Hall	BHRS Program Manager, Substance Use Services
Charis Baz	Senior Department Analyst, Substance Use Services
Leigh Steffy	Business Systems Analyst
Alberto Palomo	Technology Systems Coordinator
Michelle Nobori	BHRS Operations Director
German Valencia	Department Analyst II, QM
Celia Lara	Department Analyst II, QM
Walter Ongwongsakul	Department Analyst II, QM
Brittany Rudolph	BHRS Program Manager, QM
Rose Smedley	Assistant Chief Fiscal Officer
Zane Tran	Senior Department Analyst, Health and Human Services (HHS) Fiscal
Steve Wilbur	QI Coordinator, QM
Leah Hanzlicek	Quality and Compliance Manager (CaIMHSA)
Candice Medina	Senior Program Coordinator (CaIMHSA)
Khristy Pease	Director of Revenue Cycle Management (CaIMHSA)
Lisa Kirlin	Senior Implementation Coordinator (CaIMHSA)
Ricky Cruz	Implementation Specialist (CaIMHSA)
Charla Rowe	Clinical Implementation Coordinator (CaIMHSA)
Bethany Dominik	Senior Epidemiologist (CaIMHSA)
Gracia Amirtharaj	Director of Software Development (CaIMHSA)
Amy Leino	QI Manager (CaIMHSA)

Table A.9 lists the Mariposa staff members interviewed by the HSAG validation team.

**Table A.9—List of Mariposa Interviewees**

Interviewee Name	Title
Lynn Rumfelt	Senior Administrative Analyst—QA Supervisor
Laura Chase	Administrative Analyst—Mental Health QA Supervisor
Sarah Higgs	Administrative Analyst—SUD QA Supervisor
Randy Ridenhour	Senior Administrative Analyst—Fiscal
Lori Norman	Fiscal Officer

Table A.10 lists the Merced staff members interviewed by the HSAG validation team.

**Table A.10—List of Merced Interviewees**

Interviewee Name	Title
Elizabeth Byler	Director of Technical Integration and Solutions, Kings View
Tamara Price	Director of Revenue Cycle, Kings View
Adrian Angel	Compliance Manager
Roland Bernard	Automations Services Manager
Kit Chang	BHRS Assistant Director
Maira Romero	QA Specialist
Christina DuPont	Staff Services Analyst II
Sharon Jones	Mental Health Services Act Coordinator
Manjit Kaur	Director of Administrative Services
Iris Kong	Staff Services Assistant
Villyginn Morris	Staff Services Analyst II
Pa Moua	Staff Services Analyst
Arturo Ochoa	Staff Services Analyst
Alexandra Pierce	BHRS Assistant Director
Liliana Pulido	QI Managed Care Program Manager
Matthew Reed	BHRS Division Director
Julianne Sims	BHRS Assistant Director

Interviewee Name	Title
Kevin Suico	Staff Services Assistant II
Kimiko Vang	BHRS Director
Josette Torres	Staff Services Manager
May-Ci Xiong	BHRS Division Director
Lidia Caza-Burdick	BHRS Division Director
Francisco Higareda	Staff Services Analyst
Melyssa Hintz	Staff Services Analyst

Table A.11 lists the Monterey staff members interviewed by the HSAG validation team.

**Table A.11—List of Monterey Interviewees**

Interviewee Name	Title
Mark Alexakos	Medical Director
Rachel Amerault	BH Services Manager
Janet H Barajas	BH Services Manager
Isaias Betancourt	Supervising Departmental Information Systems Coordinator
Fabricio Chombo	Assistant Bureau Chief
Nick Cronkhite	Finance Manager
Ruben Gabriel	BH Unit Supervisor
Rosary Moreno	Management Analyst
Lindsey M O’Leary	Deputy Director, BH
Niharika Rao	Epidemiologist
Melanie Rhodes	Bureau Chief
Marni Sandoval	Deputy Director, BH
Lara Clayton	Deputy Director, BH
Jennifer Ortega Uribe	Management Analyst
Jan Wolf	Management Analyst
Philp Sherwood	BH Services Manager
Jackie Townsend	BH Services Manager
Liz Perez-Cordero	BH Services Manager

Table A.12 lists the Napa staff members interviewed by the HSAG validation team.

**Table A.12—List of Napa Interviewees**

Interviewee Name	Title
Cassandra Eslami	Deputy Director of HHS/BH Director
Nathan Hobbs	Assistant Deputy Director of BH
Chelsea Stoner	Assistant Deputy Director of BH
Valerie Cahill	BH Manager
Zachariah Todd	BH Manager
Adriana Navarro	BH Manager
Matt Highland	Deputy Director of HHS/Administrative Services
Latoya Akil	Deputy Director of HHS/QM
Kevin Powers	Assistant Compliance and Privacy Officer
Roxana Castro	Principal QM Specialist
Kimberly Danner	Chief Fiscal Officer
Wendy Howell	Staff Services Manager
Sweta Mistry	Project Manager
Clay Kyle	Supervising Mental Health Counselor II
Tracy Ulitin	Supervising Mental Health Counselor II
Jayson Rice	Supervising Staff Services Analyst
Lourdes Solorio	Staff Services Analyst II
Mandy McClanahan	Staff Services Analyst II
Janelle Samansky	Staff Services Analyst II
Delaney Messner	Staff Services Analyst II
Jason Curletto	Senior Systems Support Analyst
Khaila Zherine Flores	Utilization Review Clinician
Sandra Schmidt	Senior QM Specialist

Table A.13 lists the Nevada staff members interviewed by the HSAG validation team.

**Table A.13—List of Nevada Interviewees**

Interviewee Name	Title
Leah Hanzlicek	Quality and Compliance Manager (CaIMHSA)
Candice Medina	Senior Program Coordinator (CaIMHSA)
Khristy Pease	Director of Revenue Cycle Management (CaIMHSA)
Lisa Kirlin	Senior Implementation Coordinator (CaIMHSA)
Charla Rowe	Clinical Implementation Coordinator (CaIMHSA)
Eric Cardoza	Senior EHRs Solutions Engineer (CaIMHSA)
Ricky Cruz	Implementation Specialist (CaIMHSA)
Bethany Dominik	Senior Epidemiologist (CaIMHSA)
Brianne Chavez	QA Manager
Phebe Bell	Director
Heather Madison	Administrative Analyst II
Nikolas Jones	QA Therapist
Joshua Dellis	Senior Administrative Analyst
Jennifer Ramirez	Senior Health Technician
Celestial Dover	Health Technician II
Cari Yardley	Clinical Administrator
Connie Liu	Administrative Analyst I
Bonny Long	Health Technician II
Amanda Long	Supervising Health Technician
Priya Kannall	Program Manager
Allison Dobbins	Administrative Services Officer

Table A.14 lists the Orange staff members interviewed by the HSAG validation team.

**Table A.14—List of Orange Interviewees**

Interviewee Name	Title
Ian Kemmer	BH Director
Linda Molina	Deputy Director, BH Services
Sharon Ishikawa	Assistant Deputy Director, BHS DAE
Kindra Dimitriadis	Technology Services Manager, Senior
Corinne McDonald	IT Systems Technician II
April Howard	Senior Research Analyst
Matthew Miltimore	IT Applications Developer II
Ewa Borucki	Research Analyst IV
Hanh Le	DevOps Manager
Ida Stroem	Research Analyst IV
Jennifer Henriquez	Business Services Administrator
Thomas Ngo	Application Developer 2
Diane S Martin	Service Chief II
Nicholas Mabe	Senior IT Application Developer
Vi Ly	Staff Specialist
Berenice Moran	Health Services Administrator
Chiyo Matsubayashi	Health Services Manager
Annette Tran	Health Services Administrator (Managed Care Support Team)—Credentialing
David Castellanos	Information Security Officer
Shelby Chung	Technology Services Administrator
Yeonsoo Yoo	Research Analyst IV
Elaine Estrada	BH Clinician II
Ashley Cortez	BH Clinician II
Timothy Sigafos	Manager, Data Analytics and Evaluation
Ronald Margheim	Applications Development and Support Supervisor
April Jannise	Health Services Manager

Table A.15 lists the PHC staff members interviewed by the HSAG validation team.

**Table A.15—List of PHC Interviewees**

Interviewee Name	Title
Emi Botzler-Rodgers	BH Director
Paul Bugnacki	Deputy BH Director
Amy Cone	Quality Improvement Analyst
Deanna Bay	SUD Administrator
Michelle Thomas	Quality Improvement Analyst
Tiffany Armstrong	BH Director
Lori Griffith	Quality Improvement Analyst
Josh Bradley	Quality Improvement Analyst
Jill Ales	SUD Manager
Navin Bhandarin	Senior Program Manager
Dolores Navarro-Turner	BH Director
Bailey Cogger	Deputy BH Director
Joanna Chorpenning	Quality Supervisor
Rachel Ibarra	QA Supervisor
Sarah Collard	BH Director
Lorraine Wisler	SUD Administrator
Alora Sutcliffe	Quality Improvement Analyst
Rob George	Senior Manager of Quality and Access
Ruth Leonard	Clinical Quality Analyst
Mark Bontrager	Senior Director of BH
Nicole Escobar	Senior BH Manager
Stephanie Wilson	Program Manager
Lola Powell	Senior Quality Analyst

Table A.16 lists the Placer staff members interviewed by the HSAG validation team.

**Table A.16—List of Placer Interviewees**

Interviewee Name	Title
Amy Ellis	HHS Director, Adult System of Care
Twylla Abrahamson	HHS Director, Children’s System of Care
Dr. Amy Haynes	HHS Assistant Director, Adult System of Care
Julia Soto	QM Program Manager
Scott Genschmer	Program Manager
Curtis Budge	Program Manager
Daniel Apgar	Program Manager
Leslie Roth	Program Manager
Leslie Medina	Program Manager
Jamie Gallagher	Program Manager
Kelly Couture	QM Program Supervisor
Danielle Gold	QM Program Supervisor
Nathan Cozington	QM Program Supervisor
Teresa Mulcahy	IT Supervisor
Russell Graham	Fiscal Supervisor
Casey Heinzen	Staff Services Manager
Serena Bennett	Staff Services Analyst, Senior
Kevin Griffiths	IT Analyst, Senior
Samuel Northam	Staff Services Analyst
Susan Stephens	Staff Services Analyst
Rohnie Saunders	Accounting Assistant

Table A.17 lists the Riverside staff members interviewed by the HSAG validation team.

**Table A.17—List of Riverside Interviewees**

Interviewee Name	Title
Matthew Chang	BH Plan Director
Deborah Johnson	Director of Innovation & Integration
Amy McCann	BH Plan Assistant Director/Riverside University Health System Comptroller
Christopher Benitez	Medical Director
Brandon Jacobs	Deputy Director, QM
Jacob Ruiz	Deputy Director, Finance and Administration
Rhyan Miller	Deputy Director, Integrated Programs
Janine Moore	Deputy Director, Children & Transition Age Youth Services
Bill Brenneman	Deputy Director, Adult Services
Marcus Cannon	Deputy Director, Forensics
Shannon McCleerey-Hooper	Deputy Director, Peer Support Services
Abbie Suayan	Business Process Analyst II
Angelica Cholula	Administrative Services Assistant
Barbara Borninkhof	Supervising Accounting Technician
Belinda Flournoy	Business Process Analyst III
Daniel Flores	Administrative Services Analyst II
Darren Anderson	Business Process Analyst II
Joan Twohey-Jacobs	Administrative Services Manager I
Lisa Ledesma	Administrative Services Supervisor
Mark Osuna	Administrative Services Analyst
Nichol Edwards	Supervising Research Specialist
Robyn Anderson	Accounting Technician II
Sharn Chan	Business Process Analyst III
Shirley Leanos-Moreno	Business Process Analyst III
Suzanna Juarez-Williamson	Administrative Services Manager I
Robert Watson	IT Manager III
Ryan Torres	Business Services Analyst III
Amy Brown	Medical Staff Coordinator

Interviewee Name	Title
Preston Mote	Research Specialist II
Nebu Varghese	Business Process Analyst II
Uwase Kalimba	Research Specialist I
Sarah Stewart	Administrative Services Manager I
Ashley Trevino-Kwong	Administrative Services Manager III
Latisha Chavez	Director of Medical Staffing

Table A.18 lists the Sacramento staff members interviewed by the HSAG validation team.

**Table A.18—List of Sacramento Interviewees**

Interviewee Name	Title
Alex Rechs	Health Program Manager—QA Continuous QI
Dawn Williams	Health Program Manager—Data Analytics
Melony Ibarra	Administrative Services Officer 3—EHR and Claiming
Lori Miller	Division Manager—Drug Medi-Cal Organized Delivery System

Table A.19 lists the San Benito staff members interviewed by the HSAG validation team.

**Table A.19—List of San Benito Interviewees**

Interviewee Name	Title
Lindsay Garfield	QI Supervisor
Dana Edgull	Director
Rachel White	Assistant Director
Maxe Cendana	QI Supervisor
Marcus Padilla	QI Supervisor
Rumi Saikia	QI Supervisor
Katherine Nakao	QI Supervisor
Elizabeth Lopez	Clinical Supervisor of Substance Use and Collaborative Court Programs & Services
Louise Coombes	Staff Analyst, Behavioral Health Services Act Coordinator

Interviewee Name	Title
Leah Hanzlicek	Quality and Compliance Manager (CaIMHSA)
Candice Medina	Senior Program Coordinator (CaIMHSA)
Khristy Pease	Director of Revenue Cycle Management (CaIMHSA)
Lisa Kirlin	Senior Implementation Coordinator (CaIMHSA)
Charla Rowe	Clinical Implementation Coordinator (CaIMHSA)
Ricky Cruz	Implementation Specialist (CaIMHSA)
Gracia Amirtharaj	Director of Software Development (CaIMHSA)
Bethany Dominik	Senior Epidemiologist (CaIMHSA)

Table A.20 lists the San Bernardino staff members interviewed by the HSAG validation team.

**Table A.20—List of San Bernardino Interviewees**

Interviewee Name	Title
Marina Espinosa	Assistant Director
Julie Hale	Deputy Director
Amber Carpenter	Deputy Director
Rick Shackelford	Senior Program Manager
Kristen Mungcal	Program Manager II
Sarah Hayes	Program Manager II
Kimberlee Van	Administrative Manager
Zakiya Otis	Program Manager I
Cheryl St. Louis	Staff Analyst II
Gloria Ugwuala	Staff Analyst II
Iris Khan	Staff Analyst I
Andy Cendejas	Administrative Assistant
Erica Ochoa	Chief Compliance Officer/Privacy Officer
Kinshasa Hamilton	Compliance Manager
Briceida Tompkins	Ethics and Compliance Coordinator
Barbara Knutson	Business Applications Manager

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Interviewee Name	Title
Patricia Grace	Business Application Analyst III
Kayla Young	Application Specialist
Martha Rodriguez	Business Systems Analyst III
Jim Grant	Business Application Manager
April Guzman	Administrative Manager
Karina Rutherford-Ayala	Program Manager I
Ricardo Alvarez	Revenue Analyst Trainee
Yvonne Caballero	Supervising Fiscal Specialist
Kim Carson	Health System Analyst III
Prem Daniel	Business Systems Analyst III
Anthoula Poulakos	Research and Planning Supervisor
Anthony Saldana	Staff Analyst II
Hector Barahona Lopez	Business Systems Analyst I
Metra Jaber	Program Manager II
Rafael Villa	Program Manager I
Christopher Bailey	Supervising Program Specialist
Alicia Trivison	Senior Program Manager
Artemio Moran	Program Specialist II
Robert LoPatriello	Supervising Social Worker
Michael Sweitzer	Senior Program Manager
Matty Grounds	Program Manager II
Priscilla Valencia	Supervising Office Specialist
Roxanna Sanchez	Staff Analyst II
Deanna Mendoza	Application Specialist
Kenny Wang	Business Systems Analyst II
Jennifer Bacon	Staff Analyst II
Bryan Bagwell	Business Systems Analyst I
Glenna Cook	Staff Analyst II
Mark Dela	Biostatistician
Jason Hung	Business Staff Analyst I
Maribel Gutierrez	Deputy Director
Brian Diggle	Department Systems Engineer

Table A.21 lists the San Diego staff members interviewed by the HSAG validation team.

**Table A.21—List of San Diego Interviewees**

Interviewee Name	Title
James Beck, RN	Clinical Informatics Specialist
Nora David, MFT	Assistant Medical Services Administrator
Adrian Escamilla	IT Analyst
Nicole Esposito, MD	Chief Population Health Officer
Rebecca Ferry-Rutkoff, RN	IT Principal
Alfie Gonzaga	Program Coordinator
Jacqueline Hamed	Agency Program & Operations Manager
Skylar Hayes	Manager of Reporting and Application Development (Optum)
Catherine Houghton	Utilization Review QI Specialist
Derek Kemble, MPH, MSW	Agency Program and Operations Manager
Marie Kort, LMFT	Utilization Review QI Specialist
Tabatha Lang, LMFT	Operations Administrator
Cheryl Lansang	MIS Supervisor
Mayuri Lucas	Administrative Analyst
Samantha Marquez	Administrative Analyst
Elizabeth Miles, EdD, MPH, MSW	Agency Program & Operations Manager
Conscilla Nwabueze, RN	Utilization Review QI Specialist
Dave Post	Administrative Analyst
Jill Raimo	Health Informaticist/Project Manager
Ezra Ramirez	Administrative Analyst
Maria Carmen Saline	Administrative Analyst
Russel Villareal	Administrative Analyst
Tracey Weston	Senior Data and Research Analyst
Samantha Wilson	Utilization Review QI Specialist
Huda Yousif	IT Analyst
Lalaine Banaag	Principal Accountant
Toan Pham	Revenue & Budget Manager
Michael Martinez	Administrative Analyst
Debbie Ordonez	Revenue & Budget Manager

Table A.22 lists the San Francisco staff members interviewed by the HSAG validation team.

**Table A.22—List of San Francisco Interviewees**

Interviewee Name	Title
Alecia Martin, MPH	Director, BHS QM and Regulatory Affairs
Alvin Ho	Patient Accounts Supervisor
Andre Pelote	Compliance Manager
Annie Shui, LMFT	Utilization Management Director
Carla Love	Credentialing Specialist
Chet Valentino	BH Services Director of Data Analytics
Christina Rivera	Epidemiologist
Christine Soran	Deputy Medical Director of Substance Use Services
Erik Dubon	Project Manager
Erikson Bautista	BH Services Information Systems—Senior Business Analyst
Felicia Davis	Credentialing Specialist
Heather Weisbrod, LCSW	BH Services Office of Coordinated Care Director
Hillary Kunins	Director of BH Services
Imo Momoh, MPA	Director, BH Services Office of Managed Care
Ivanna Chavez, MPH	Director of Central Access & Eligibility
Jena Jenson	Eligibility and Member Services Manager
Jennifer Chee	IS Business Analyst
Jessica Morton	Metrics Analytics and Data Integration Manager
Jessie Escobar	Substance Use Services Program Manager—OTP and Outpatient Programs
Joseph A. Turner, PhD, CHC	BH Services Compliance Officer
Karina Simonova	Principle IS Engineer
Kellee Hom	SUD System of Care Director, Alcohol and Other Drug Administrator
Kimberly Voelker	Ambulatory Care Applications Manager
Kitty Ha, MPH	QI Coordinator

Interviewee Name	Title
Laurel Snead	Substance Use Services Principle Administrative Analyst
Lenh Tsan	QI Coordinator
Liliana De La Rosa	Substance Use Services Program Coordinator
Linda Wu, LCSW	BH Services QA and QI Manager
Lorrie Tanioka	Director, BH Billing and San Francisco MHP Claims
Marco Lopez, DNP, MBA, MSI, APRN, ACHIP, CPHIMS	Director of Clinical Informatics
Maria Renelda Dimatulac	Administrative Clerk—Substance Use Services
Matthew Sur	Reimbursement Director
Maximilian Rocha, LCSW	BH Services System of Care Director
Nanalisa Rasaily	BH Services Patients Accounts Manager
Nancy Yu	BH Services Regulatory Affairs Manager
Philippe Kennedy	IS Business Analyst
Quynh Tang	Epic Cogito/Metrics Analytics and Data Integration—Information System Business Analyst
Rebecca Mathew	Child, Youth and Families (CYF) Director of Substance Use Prevention & Treatment Services
Renata Ferreira	Director of Value-Based Care Data Analytics
Ryan Fuimaono	Residential Substance Use Services Program Manager
Shameem Mohamed	Information System Metrics Analytics and Data Integration Ambulatory Reporting
Sherry Lam	Senior Epidemiologist
Tina Lee	DPH IT—Chief Data Officer
Yuk Kiu Lee	BH Services Network Adequacy Analyst

Table A.23 lists the San Joaquin staff members interviewed by the HSAG validation team.

**Table A.23—List of San Joaquin Interviewees**

Interviewee Name	Title
Fay Vieira	Assistant Director—BHS—Clinical (SJC BHS)
Donna Bickham	Deputy Director—QA and Performance Information and Medical Record (SJC BHS)
Alicia Tacata	Management Analyst III (SJC BHS)
Isaiah Lilly	Deputy Director Health Care Services—Fiscal (SJC BHS)
Stefenee Clinton	Chief Mental Health Clinician (SJC BHS)
Courtney Flores	Deputy Director Children and Youth Services (SJC BHS)
Shahloh Jones-Mitchell	Management Analyst II (SJC BHS)
Betsey Pettis	Deputy Director—BHS—Clinical (SJC BHS)
Zarmeen Merchant	Department Information Systems Manager (SJC BHS)
Debra Perry	Administrative Assistant II (SJC BHS)
Robert Morris	Department Applications Analyst IV (SJC BHS)
Tiffany DeWitte	Deputy Director—BHS—Clinical (SJC BHS)
Vimesh Patel	Management Analyst II (SJC BHS)
Marc Santos	Management Analyst III (SJC BHS)
Nicole LeClaire-Henricks	Management Analyst II (SJC BHS)
Sabrina Parker	Deputy Director—Administration (SJC BHS)
Cara Dunn	Assistant Director—BHS—Administration (SJC BHS)
Tamika Miller	Management Analyst II (SJC BHS)
Chelsea Rambo	Chief Mental Health Clinician (SJC BHS)
Jeffrey Sabeau	Deputy Director—Justice and Decriminalization Division (SJC BHS)
Daniel Ray	Management Analyst II (SJC BHS)

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Interviewee Name	Title
Ani Thomas	Management Analyst II (SJC BHS)
Jessica Wieland	Chief Mental Health Clinician (SJC BHS)
Giselle Castillo	Mental Health Clinician I (SJC BHS)
Kathy Hannah	Deputy Director—BHS—Clinical (SJC BHS)
Sonia Comparan-Romero	Office Assistant Specialist (SJC BHS)
Jennifer Spruill	Chief Mental Health Clinician (SJC BHS)
Xuan Dinh	Accounting Technician II (SJC BHS)
Olivia Roccucci	Accountant II (SJC BHS)
Sarah Ala	Accounting Technician I (SJC BHS)
Joaquin Vivero	SUD Program Manager (SJC BHS)
Melissa Guerrero	Mental Health Clinician III (SJC BHS)
Tamara Crummett	Substance Abuse Program Supervisor (SJC BHS)
Tina Breedlove	Accounting Technician I (SJC BHS)
Randall Smith	Department Applications Analyst II (SJC BHS)
Carmencita Bringas	Chief Mental Health Clinician (SJC BHS)
John Salwolke	Management Analyst II (SJC BHS)
Kelly Mraz	Contracts Supervisor (SJC BHS)
Dawn Graves	Program Supervisor (SJC BHS)
Douglass Richardson	Mental Health Specialist II (SJC BHS)
Michelle Berdahl	Substance Abuse Program Manager (SJC BHS)
Edison Chalabi	Department Information Sys. Analyst IV (SJC BHS)
Richard Parker	Management Analyst II (SJC BHS)
Jose DelToro	Chief Mental Health Clinician (SJC BHS)
Leah Hanzlicek	Quality and Compliance Manager (CalMHSA)
Candice Medina	Senior Program Coordinator (CalMHSA)
Khristy Pease	Director of Revenue Cycle Management (CalMHSA)
Lisa Kirlin	Senior Implementation Coordinator (CalMHSA)

Interviewee Name	Title
Charla Rowe	Clinical Implementation Coordinator (CalMHSA)
Eric Cardoza	Senior EHRs Solutions Engineer (CalMHSA)
Ricky Cruz	Implementation Specialist (CalMHSA)
Bethany Dominik	Senior Epidemiologist (CalMHSA)
Gracia Amirtharaj	Director of Software Development (CalMHSA)
Helen Sicsic	Accountant III (SJC BHS)
Jennifer D Susskind	Consultant (Praxis Associates, Inc.)

Table A.24 lists the San Luis Obispo staff members interviewed by the HSAG validation team.

**Table A.24—List of San Luis Obispo Interviewees**

Interviewee Name	Title
Star Graber, LMFT, PhD	BH Administrator
Frank Warren	BH Deputy Director
Amanda Getten, LMFT	BH Division Manager Quality Support Services
Michelle Archer	Medical Records Supervisor
Kathy McGuire	Program Manager, Medical Records
Jean Scott	Administrative Services Officer II, Quality Support Team
Enrique Limon	Program Manager of Health Agency Billing Department
Angela Atwell, RN	MH Nurse III, Quality Support Team
Katelyn Yarnold, LCSW	Clinician III, Quality Support Team
Barbara Leveson	Chair of BH Board
Mike Bossenberry	BH Board
Sara Epps	Administrative Services Officer II, Quality Support Team
Amanda Martinez	Accountant III
Marisa Cervantes	Senior Account Clerk
Rachel Koenig	Administrative Services Manager

Interviewee Name	Title
Melissa Soares	Program Manager, Health Applications Team
Molly Morgan	Business Systems Analyst III
Julianne Schmidt, LMFT	BH Program Supervisor, Quality Support Team

Table A.25 lists the San Mateo staff members interviewed by the HSAG validation team.

**Table A.25—List of San Mateo Interviewees**

Interviewee Name	Title
Jeï Africa	Director, BHRS
Scott Gruendl	Assistant Director, BHRS
Betty Ortiz-Gallardo	Manager, BHRS QM
Claudia Tinoco-Elizondo	Supervisor, BHRS QM
Eri Tsujii	Program Specialist, BHRS QM
Laura Shih	Health Services Manager, BHRS Office of Improvement and Innovation
Tasha Souter	Medical Director, BHRS
Clara Boyden	Deputy Director, BHRS Alcohol and Other Drugs
Sheryl Uyan	Health Services Manager II, BHRS Alcohol and Other Drugs
Talisha Racy	Deputy Director, BHRS Adult Services
Ziomara Ochoa	Deputy Director, BHRS Child & Youth Services
Chad Kempel	Management Analyst, BHRS Data Accountability & Transparency, Organizational Engagement
Janet Gard	Deputy Director, BHRS Finance & Administration
Marie Fontana	Financial Services Manager II, BHRS Management Information Services
Kannika Toonnachat	Administrative Services Manager I, BHRS Management Information Services
Analiza Salise	Management Analyst, BHRS Management Information Services

Interviewee Name	Title
Ana Cianci	Patient Services Supervisor, BHRS Management Information Services
Eddie Lau	Manager, Health Information Systems
Maitreyi Ramachandran	Health Information Technology Application Support Supervisor, BHRS Health Information Systems & Technology
Tracey Chan	Mental Health Program Specialist, BHRS Alcohol and Other Drugs
Maya Greene	Management Analyst, BHRS Alcohol and Other Drugs
Yadhira Christensen	Services Analyst II, BHRS Alcohol and Other Drugs
Mary Taylor	Clinical Services Manager II, BHRS Alcohol and Other Drugs
Eliseo Amezcua	Supervisor, BHRS Alcohol and Other Drugs
Brad Johnson	Administrative Services Manager, BHRS Contracts Management
Annina Altomari	Program Specialist, BHRS QM
Laurie Bell	Clinical Analyst, BHRS QM

Table A.26 lists the Santa Barbara staff members interviewed by the HSAG validation team.

**Table A.26—List of Santa Barbara Interviewees**

Interviewee Name	Title
Toni Navarro	Director
Joshua Woody	Branch Chief of Quality Care Management
Melissa Wilkins	Branch Chief of Alcohol and Drug Programs
Waseem Kadada	Interim IT Manager
Ryan Weyman	Branch Chief of Information Systems
Chris Ribeiro	Chief Financial and Administrative Officer
Suzanne Grimesey	Public Information Officer/Chief of Strategy and Community Engagement
Katie Cohen	Assistant Director of Clinical Operations
Anoushka Moseley	Manager of Quality Care Management

Interviewee Name	Title
Caitlin Lepore	Research & Evaluation Manager
Shereen Khatapoush	Research & Evaluation
John Winkler	Branch Chief of Crisis and Homeless Services
Christina Lombard	Branch Chief of Clinical Outpatient Operations
Melanie Becerra	Administrative Services Lead
Katlin Phillips	QCM Coordinator
Rebecca Buhl	QCM Coordinator
Leslie Smith	QCM Coordinator
Stacey Larsen	QCM Coordinator
Kassie Knudsen	QCM Coordinator
Dipak Neupane	Chief Operations Officer
Bonnie Zant	Quality Care Management Coordinator
Jairo Aguilar	Accountant—Auditor

Table A.27 lists the Santa Clara staff members interviewed by the HSAG validation team.

**Table A.27—List of Santa Clara Interviewees**

Interviewee Name	Title
Courtney Gray	Director of QM
Hung Nguyen	QI Division Director
Rachel Potens	Program Manager III
Tammy Ramsey	Managed Care Division Director
Maribel Banuelos	Instructional Designer
Howard Lim	Senior Business Management Analyst
Aaron Weinstein	Program Manager II
Veronica Marquez	Program Manager
Joe Fan	Senior Data Analyst
Fannie Stein	Program Manager III
Monique Grijalva	Management Analyst
Sandy Mendoza	Management Analyst
Olena Chesnakova	Data Analyst

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Interviewee Name	Title
Leilani Villanueva	Division Director, Provider Relations
Samantha Lopez	Program Manager
Gaby Gonzalez-Ortiz	Program Manager II
Yasmina Janini	Program Manager
Scott Bray	Business Systems Analyst
Fernando Jauregui	Senior Management Analyst
Carlo Castuciano	Management Analyst
Gerald Domenden	Management Analyst
Sherri Terao	Director of BH Services
Darren Tran	BH Services Department Deputy Director
Tiffany Ho	Executive BH Medical Director
Cheryl Ho	Executive BH Medical Director
Margaret Obilor	Director, System of Care
Zelia Costa Faria	Director, System of Care
Soo Jung	Director, System of Care
Katelyn Lu	Financial and Administrative Service Manager
Stephanie Macwhorter	Director, System of Care
Indira Choudhuri	Director, IT
Lisa Pfizer	Chief Compliance Officer
Vanessa Alcantar	Senior Management Analyst
Anh T. Pham	Program Manager II
Gustavo Lozano	Program Manager II
Elizabeth Herrera	Program Manager II
Christopher Weare	Director of Research & Outcome Measures
Tina Cordero	County of Santa Clara Health Services— Chief Fiscal Officer
Anna Hernandez	Manager, Patient Accounting, Santa Clara Valley Health and Hospital System
Sujatha Prabhakaran	Health Care Financial Analyst II
Leticia Rosado	Director of Patient Business Services, Santa Clara Valley Health and Hospital System

Interviewee Name	Title
Steph Lattimer	Revenue Cycle Management (RCM) Team Lead
Shannon Casey	Director, RCM
Samantha Meyer	RCM Manager

Table A.28 lists the Santa Cruz staff members interviewed by the HSAG validation team.

**Table A.28—List of Santa Cruz Interviewees**

Interviewee Name	Title
Adriana Bare	Senior Health Services Manager—BH
Maria Warnke	IT Business Systems Analyst—BH
Samuel Kim	IT Application Developer Supervisor—BH
Marc Romansky	IT Business Systems Analyst—BH
Subé Robertson	QI Director—BH
Shelly Barker	QI Manager—BH
Israel Balderas	IT Application Developer/Supervisor Analyst II—Health Services Agency
Nancy Mast	QI Utilization Review Specialist—BH
Daniel Crews	Health Information Systems Manager—BH
Leah Flagg-Wilson	QI Manager—BH
Jorge Fernandez	IT Manager—Health Services Agency
Karen Kern	Deputy Director and Acting Director—BH
Dylan Jones	IT Developer—Health Services Agency
Christina Lam	Senior Medical Billing Technician—BH
Casey Swank	Substance Use Services Director—BH
Nicole Campbell	Senior Departmental Analyst—SUD Services—BH
Sandra Wieting	IT Support Analyst III—Health Services Agency
Dave Chicoine, LMFT	QI Utilization Review Specialist—BH

Table A.29 lists the Stanislaus staff members interviewed by the HSAG validation team.

**Table A.29—List of Stanislaus Interviewees**

Interviewee Name	Title
Roberta Garza	Staff Services Coordinator (Outcomes & Evaluation Management—OEM)
Gurmanpreet Kaur	Quality Services Manager II
Maria Camarillo	Staff Services Coordinator (Outcomes & Evaluation Management—OEM)
Ruben Imperial	BH Director
Nasrin Safi	Quality Services & Risk Management Manager III
Saksham Rana	IT Manager
Angela Wee	Quality Services & Risk Management Administrative Clerk III
Keri Magee	Assistant Director
Samual Groves	Assistant Director Fiscal/Administrative Services
Bernardo Mora, MD	Medical Director
Abraham Andres	Manager IV/Chief
Monica Salazar	Chief, BH Plan Administration, Compliance Officer
Kim Saing	Children’s System of Care Manager IV/Chief
Brittney Kirkland	Crisis, Access, and Medication Services (CAMS) Manager IV/Chief
Vanessa Portillo	Fiscal Manager
Megan Vylonis	Compliance Manager II
Tiffany Bibbins	Medical Records Manager I
Naomi Kamunyu	HR/Equity Officer Chief
Vick Guinard	Quality Services Staff Services Analyst
Bee Thao	Quality Services Mental Health Clinician II
MaryCruz Vargas	Quality Services Mental Health Clinician II
Cam Quach	EHR Manager I
Aurelia Vazquez	Special Projects Manager III
Yeng Lysaythong	Business Office Manager II

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Interviewee Name	Title
Pam Esparza	Supportive Services Manager IV/Chief
Fred Tabangcura	Software Administrator III
Paula McDowell	SUD Manager III
Tracey McCullough	SUD Manager III
Saira Alvarez	HR Confidential Assistant III
Charles Yarnell	SUD Program Manager
Amber Hayslett-Atkison	Workforce Development & Training Manager
Gabriela Marquez	Utilization Management Manager III
Chandra Campbell	Adult System of Care/Forensic Services Manager III
Vanessa Torres	Staff Services Analyst (Compliance)
Ashley Boyd	Children's System of Care/Transitional Age Youth Manager III
Linnea Worthy	Staff Services Analyst (Compliance)
Katrina Cosner	Adult System of Care Manager III
Moriah Bettencourt	HR Manager II
Cheryl Graham	HR Confidential Assistant III
Sushma Patla	CAMS Manager III
Sergio Landeros	Staff Services Coordinator Workforce Development and Training
Leonor Sierra	Workforce Development and Training Chief/Manager IV
Leah Hanzlicek	Quality and Compliance Manager (CaMHSA)
Candice Medina	Senior Program Coordinator (CaMHSA)
Charla Rowe	Clinical Implementation Coordinator (CaMHSA)
Khristy Pease	Director of Revenue Cycle Management (CaMHSA)
Anastassia Kiannu	Office Assistant to Director of Project Management (CaMHSA)
Lisa Kirlin	Senior Implementation Coordinator (CaMHSA)

Interviewee Name	Title
Eric Cardoza	Senior EHRs Solutions Engineer (CaMHSA)
Ricky Cruz	Implementation Specialist (CaMHSA)
Amy Leino	QI Manager (CaMHSA)

Table A.30 lists the Tulare staff members interviewed by the HSAG validation team.

**Table A.30—List of Tulare Interviewees**

Interviewee Name	Title
Gilberto Rivas	Deputy Director, BH
Angela Sahagun	Division Manager, BH
Betsy Ayello	QI Manager, Mental Health
Chandler Bailey	QI Manager, SUD
Monica Guglielmo	EHRs Manager
Omar Venegas	EHRs Specialist Supervisor
Debora Hutcheson	Administrative Specialist
Jeffrey Blackmon	Administrative Specialist
Andrew Ruddy	Staff Services Analyst
Veronica Maldonado	Staff Services Analyst
Kiani Murphy	Staff Services Analyst
Rosa Sanchez	Administrative Specialist
Angie Tipton	Division Manager, Fiscal Operations
Imelda Arroyo	Medical Billing Manager
Aziza Citi	BH Clinical Supervisor
Leah Hanzlicek	Quality and Compliance Manager (CaMHSA)
Candice Medina	Senior Program Coordinator (CaMHSA)
Khristy Pease	Director of Revenue Cycle Management (CaMHSA)
Lisa Kirlin	Senior Implementation Coordinator (CaMHSA)
Charla Rowe	Clinical Implementation Coordinator (CaMHSA)
Ricky Cruz	Implementation Specialist (CaMHSA)

Interviewee Name	Title
Bethany Dominik	Senior Epidemiologist (CalMHSA)
Gracia Amirtharaj	Director of Software Development (CalMHSA)
Amy Leino	QI Manager (CalMHSA)
Eric Cardoza	Senior EHRs Solutions Engineer (CalMHSA)

Table A.31 lists the Ventura staff members interviewed by the HSAG validation team.

**Table A.31—List of Ventura Interviewees**

Interviewee Name	Title
Sloane Burt	QI Manager
Leisa Donovan	Senior Accounting Manager
Yvette Chen	Data Informatics Senior Program Administrator
Narcisa Egan	Chief Financial Officer
Katheryn Rabinovitz	QI Program Administrator
Michelle Rojas	EHRs Program Administrator
Juan Mendoza	Billing Manager, Senior Program Administrator
Alicia Duenas	EHRs Program Administrator
Bethany Dominik	Senior Epidemiologist (CalMHSA)

Table A.32 lists the Yolo staff members interviewed by the HSAG validation team.

**Table A.32—List of Yolo Interviewees**

Interviewee Name	Title
Jennifer Gay	Clinical Manager, QM
Sophia Sandoval	Senior Administrative Services Analyst, QM
Timothy Tormey	Supervising Clinician, QM
Sukhveer Cheema	Supervising Clinician, QM
Samantha Fusselman	Adult and Aging Branch Director
Tony Kildare	CYF Branch Director; Interim Mental Health Director

Interviewee Name	Title
Nate Palmer	Administrative Services Analyst
Amrinder Singh	Administrative Services Analyst
Julie Freitas	Alcohol and Other Drug Administrator/Clinical Manager
Katherine Barrett	BH Compliance Officer
Pam Sidhu	Systems Software Specialist II
Sylvia Duarte	Accountant III
Ana Soltero	Accountant I
Michelle Wisterman	Senior Accounting Technician
Katlin Buechler	Clinician II, QM
Justina Larson	Clinician II, QM
Anna Thomas	Clinician II
Emma Latuno	Clinician II

Table A.33 lists the DHCS staff members interviewed by the HSAG validation team.

**Table A.33—List of DHCS Interviewees**

Interviewee Name	Title
Cristelyn Rebuyon	Health Program Specialist II, EQRO BH Activities Project Lead
Kaitlin Maye	Staff Services Manager I, Timely Access Subject Matter Expert (SME)
LaMonte Love	Staff Services Manager II, Timely Access SME
Elena Placencia	Health Program Specialist II, EQRO BH Activities Project Lead Back-Up
Sherri Garcia	Health Program Specialist II, Timely Access SME Support
Wajeeha Young	Research Scientist Supervisor I, Enterprise Data and Information Management Data Team
Mahsa Ebrahiminia	Research Data Supervisor I, Enterprise Data and Information Management BH Timely Access Lead

Interviewee Name	Title
Srimathy Raghuraman	Research Data Supervisor II, Enterprise Data and Information Management BH Timely Access Lead
Monifa Quarels	Staff Services Manager II, EQRO BH Activities Manager Support
Stefani Vega	Associate Governmental Program Analyst, BH EQRO Liaison
Kimberly Wimberly	Staff Services Manager I, BH EQRO Review Section Manager
Anna Wettach	Associate Governmental Program Analyst, BH EQRO Liaison
Tara Payne-Steele	Associate Governmental Program Analyst, BH EQRO Liaison
Vanessa Sanchez	Staff Services Manager II, EQRO Review Section Chief
Michael Rockenbach	Associate Governmental Program Analyst, BH EQRO Liaison

Table A.34 lists the HSAG validation team members, their roles, and their skills and expertise.

**Table A.34—HSAG Validation Team**

Name and Title	Role
Elisabeth Hunt, MHA, CHCA <i>Executive Director, Data Science &amp; Advanced Analytics (DSAA)</i>	Certified Healthcare Effectiveness Data and Information Set (HEDIS®) <sup>3</sup> Compliance Auditor (CHCA); multiple years of auditing experience with expertise in data integration, information systems, provider data, NAV, and performance measure development and reporting.
Rachael French, CHCA <i>Director, Audits/Practice Leader, DSAA</i>	CHCA; subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, provider data, and NAV. Multiple years of auditing experience.

<sup>3</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Name and Title	Role
Gina DeBlois, MSHCM <i>Manager III, Audits, DSAA Project Lead/Lead Auditor</i>	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
Anne Gulley, MPH <i>Senior Auditor, DSAA Lead Auditor</i>	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
Sumayyah Hackett, BBA <i>Auditor I, Audits, DSAA Lead Auditor</i>	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.
Tamioka Square, MHA <i>Auditor I, Audits, DSAA Lead Auditor</i>	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.
Marian Seege, MS <i>Auditor I, Audits, DSAA Lead Auditor</i>	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.
Rachel Spivey, BA <i>Auditor II, DSAA Lead Auditor</i>	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.
AnnAlisa Cook, MHA <i>Auditor I, DSAA Lead Auditor</i>	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.
Laura McDermott, BS <i>Auditor II, DSAA Lead Auditor</i>	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.