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Medi-Cal Specialty Mental Health Services External Quality Review Technical Report

Contract Year 2024–25

2025 Validation of Network Adequacy

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Table of Contents

Volume 4: Validation of Network Adequacy

Medi-Cal Mental Health Plan Name Abbreviations xiii

Commonly Used Abbreviations and Acronyms xv

1. Introduction 1
Network Adequacy Validation Overview 1
Network Adequacy Standards and Indicators Validated 7

2. Description of Validation Activities 9
Pre-Validation Strategy 9
Validation Team 9
Technical Methods of Data Collection and Analysis 10
Virtual Review Validation Activities 11
Network Adequacy Indicator Validation Rating Determinations 12

3. Validation Results 15
Alameda County Behavioral Health Care Systems 15
ISCA Findings and Data Validity 15
Assessment of Data Validity 19
Network Adequacy Indicator-Specific Validation Ratings 19
Analysis and Conclusions 20
Strengths, Opportunities for Improvement, and Recommendations 21
Alpine County Behavioral Health Services 23
ISCA Findings and Data Validity 23
Assessment of Data Validity 27
Network Adequacy Indicator-Specific Validation Ratings 27
Analysis and Conclusions 28
Strengths, Opportunities for Improvement, and Recommendations 29
Amador County Behavioral Health 31
ISCA Findings and Data Validity 31
Assessment of Data Validity 35
Network Adequacy Indicator-Specific Validation Ratings 36
Analysis and Conclusions 36
Strengths, Opportunities for Improvement, and Recommendations 37
Butte County Department of Behavioral Health Services 39
ISCA Findings and Data Validity 39
Assessment of Data Validity 43
Network Adequacy Indicator-Specific Validation Ratings 44
Analysis and Conclusions 44
Strengths, Opportunities for Improvement, and Recommendations 46
Calaveras County Behavioral Health Services 47
ISCA Findings and Data Validity 47

Assessment of Data Validity 50
Network Adequacy Indicator-Specific Validation Ratings 51
Analysis and Conclusions 51
Strengths, Opportunities for Improvement, and Recommendations 53
Colusa County Department of Behavioral Health 54
ISCA Findings and Data Validity 54
Assessment of Data Validity 58
Network Adequacy Indicator-Specific Validation Ratings 58
Analysis and Conclusions 59
Strengths, Opportunities for Improvement, and Recommendations 60
Contra Costa County Mental Health 62
ISCA Findings and Data Validity 62
Assessment of Data Validity 65
Network Adequacy Indicator-Specific Validation Ratings 66
Analysis and Conclusions 66
Strengths, Opportunities for Improvement, and Recommendations 68
Del Norte County Department of Health and Human Services 69
ISCA Findings and Data Validity 69
Assessment of Data Validity 73
Network Adequacy Indicator-Specific Validation Ratings 74
Analysis and Conclusions 74
Strengths, Opportunities for Improvement, and Recommendations 76
El Dorado County Health & Human Services Agency 77
ISCA Findings and Data Validity 77
Assessment of Data Validity 81
Network Adequacy Indicator-Specific Validation Ratings 81
Analysis and Conclusions 81
Strengths, Opportunities for Improvement, and Recommendations 83
Fresno County Department of Behavioral Health 84
ISCA Findings and Data Validity 84
Assessment of Data Validity 88
Network Adequacy Indicator-Specific Validation Ratings 89
Analysis and Conclusions 89
Strengths, Opportunities for Improvement, and Recommendations 91
Glenn County Behavioral Health 92
ISCA Findings and Data Validity 92
Assessment of Data Validity 97
Network Adequacy Indicator-Specific Validation Ratings 97
Analysis and Conclusions 97
Strengths, Opportunities for Improvement, and Recommendations 99
Humboldt County Health and Human Services 100
ISCA Findings and Data Validity 100
Assessment of Data Validity 104
Network Adequacy Indicator-Specific Validation Ratings 104
Analysis and Conclusions 105

Strengths, Opportunities for Improvement, and Recommendations 106
Imperial County Behavioral Health Services 108
ISCA Findings and Data Validity 108
Assessment of Data Validity 112
Network Adequacy Indicator-Specific Validation Ratings 112
Analysis and Conclusions 113
Strengths, Opportunities for Improvement, and Recommendations 114
Inyo County Health & Human Services Behavioral Health 115
ISCA Findings and Data Validity 115
Assessment of Data Validity 118
Network Adequacy Indicator-Specific Validation Ratings 119
Analysis and Conclusions 119
Strengths, Opportunities for Improvement, and Recommendations 121
Kern County Behavioral Health and Recovery Services 122
ISCA Findings and Data Validity 122
Assessment of Data Validity 126
Network Adequacy Indicator-Specific Validation Ratings 127
Analysis and Conclusions 127
Strengths, Opportunities for Improvement, and Recommendations 129
Kings County Behavioral Health 130
ISCA Findings and Data Validity 130
Assessment of Data Validity 133
Network Adequacy Indicator-Specific Validation Ratings 134
Analysis and Conclusions 134
Strengths, Opportunities for Improvement, and Recommendations 136
Lake County Behavioral Health Services Department 137
ISCA Findings and Data Validity 137
Assessment of Data Validity 140
Network Adequacy Indicator-Specific Validation Ratings 140
Analysis and Conclusions 141
Strengths, Opportunities for Improvement, and Recommendations 142
Lassen County Health and Social Services 143
ISCA Findings and Data Validity 143
Assessment of Data Validity 146
Network Adequacy Indicator-Specific Validation Ratings 147
Analysis and Conclusions 147
Strengths, Opportunities for Improvement, and Recommendations 149
Los Angeles County Department of Mental Health 150
ISCA Findings and Data Validity 150
Assessment of Data Validity 153
Network Adequacy Indicator-Specific Validation Ratings 154
Analysis and Conclusions 154
Strengths, Opportunities for Improvement, and Recommendations 156
Madera County Behavioral Health Services 157
ISCA Findings and Data Validity 157

Assessment of Data Validity 160
Network Adequacy Indicator-Specific Validation Ratings 161
Analysis and Conclusions 161
Strengths, Opportunities for Improvement, and Recommendations 163
Marin County Behavioral Health and Recovery Services 164
ISCA Findings and Data Validity 164
Assessment of Data Validity 168
Network Adequacy Indicator-Specific Validation Ratings 168
Analysis and Conclusions 168
Strengths, Opportunities for Improvement, and Recommendations 170
Mariposa County Human Services, Behavioral Health & Recovery Services Division 171
ISCA Findings and Data Validity 171
Assessment of Data Validity 175
Network Adequacy Indicator-Specific Validation Ratings 175
Analysis and Conclusions 175
Strengths, Opportunities for Improvement, and Recommendations 177
Mendocino County Mental Health 178
ISCA Findings and Data Validity 178
Assessment of Data Validity 181
Network Adequacy Indicator-Specific Validation Ratings 182
Analysis and Conclusions 182
Strengths, Opportunities for Improvement, and Recommendations 184
Merced County Behavioral Health and Recovery Services 185
ISCA Findings and Data Validity 185
Assessment of Data Validity 190
Network Adequacy Indicator-Specific Validation Ratings 191
Analysis and Conclusions 191
Strengths, Opportunities for Improvement, and Recommendations 192
Modoc County Behavioral Health Services 194
ISCA Findings and Data Validity 194
Assessment of Data Validity 197
Network Adequacy Indicator-Specific Validation Ratings 198
Analysis and Conclusions 198
Strengths, Opportunities for Improvement, and Recommendations 200
Mono County Behavioral Health 201
ISCA Findings and Data Validity 201
Assessment of Data Validity 204
Network Adequacy Indicator-Specific Validation Ratings 204
Analysis and Conclusions 205
Strengths, Opportunities for Improvement, and Recommendations 206
Monterey County Behavioral Health 208
ISCA Findings and Data Validity 208
Assessment of Data Validity 212
Network Adequacy Indicator-Specific Validation Ratings 212
Analysis and Conclusions 212

Strengths, Opportunities for Improvement, and Recommendations 214
Napa County Health and Human Services Agency 215
ISCA Findings and Data Validity 215
Assessment of Data Validity 218
Network Adequacy Indicator-Specific Validation Ratings 219
Analysis and Conclusions 219
Strengths, Opportunities for Improvement, and Recommendations 221
Nevada County Behavioral Health 222
ISCA Findings and Data Validity 222
Assessment of Data Validity 227
Network Adequacy Indicator-Specific Validation Ratings 228
Analysis and Conclusions 228
Strengths, Opportunities for Improvement, and Recommendations 230
Orange County Behavioral Health Services 231
ISCA Findings and Data Validity 231
Assessment of Data Validity 235
Network Adequacy Indicator-Specific Validation Ratings 235
Analysis and Conclusions 235
Strengths, Opportunities for Improvement, and Recommendations 237
County of Placer, Department of Health and Human Services 238
ISCA Findings and Data Validity 238
Assessment of Data Validity 242
Network Adequacy Indicator-Specific Validation Ratings 242
Analysis and Conclusions 242
Strengths, Opportunities for Improvement, and Recommendations 244
Plumas County Mental Health Services 245
ISCA Findings and Data Validity 245
Assessment of Data Validity 248
Network Adequacy Indicator-Specific Validation Ratings 249
Analysis and Conclusions 249
Strengths, Opportunities for Improvement, and Recommendations 251
Riverside County Mental Health Services 252
ISCA Findings and Data Validity 252
Assessment of Data Validity 256
Network Adequacy Indicator-Specific Validation Ratings 257
Analysis and Conclusions 257
Strengths, Opportunities for Improvement, and Recommendations 259
Sacramento County Behavioral Health Services 260
ISCA Findings and Data Validity 260
Assessment of Data Validity 263
Network Adequacy Indicator-Specific Validation Ratings 264
Analysis and Conclusions 264
Strengths, Opportunities for Improvement, and Recommendations 266
San Benito County Behavioral Health 267
ISCA Findings and Data Validity 267

Assessment of Data Validity 270
Network Adequacy Indicator-Specific Validation Ratings 271
Analysis and Conclusions 271
Strengths, Opportunities for Improvement, and Recommendations 273
San Bernardino County Department of Behavioral Health 274
ISCA Findings and Data Validity 274
Assessment of Data Validity 278
Network Adequacy Indicator-Specific Validation Ratings 278
Analysis and Conclusions 279
Strengths, Opportunities for Improvement, and Recommendations 280
San Diego County Behavioral Health Division 281
ISCA Findings and Data Validity 281
Assessment of Data Validity 285
Network Adequacy Indicator-Specific Validation Ratings 286
Analysis and Conclusions 286
Strengths, Opportunities for Improvement, and Recommendations 287
San Francisco Community Behavioral Health Services 289
ISCA Findings and Data Validity 289
Assessment of Data Validity 293
Network Adequacy Indicator-Specific Validation Ratings 293
Analysis and Conclusions 294
Strengths, Opportunities for Improvement, and Recommendations 296
San Joaquin Behavioral Health Services 297
ISCA Findings and Data Validity 297
Assessment of Data Validity 303
Network Adequacy Indicator-Specific Validation Ratings 304
Analysis and Conclusions 304
Strengths, Opportunities for Improvement, and Recommendations 306
San Luis Obispo County Behavioral Health Department 307
ISCA Findings and Data Validity 307
Assessment of Data Validity 312
Network Adequacy Indicator-Specific Validation Ratings 313
Analysis and Conclusions 313
Strengths, Opportunities for Improvement, and Recommendations 315
San Mateo County Behavioral Health and Recovery Services 316
ISCA Findings and Data Validity 316
Assessment of Data Validity 319
Network Adequacy Indicator-Specific Validation Ratings 319
Analysis and Conclusions 320
Strengths, Opportunities for Improvement, and Recommendations 321
Santa Barbara Department of Behavioral Wellness 323
ISCA Findings and Data Validity 323
Assessment of Data Validity 328
Network Adequacy Indicator-Specific Validation Ratings 329
Analysis and Conclusions 329

Strengths, Opportunities for Improvement, and Recommendations 330
Santa Clara County Behavioral Health Services Department 332
ISCA Findings and Data Validity 332
Assessment of Data Validity 336
Network Adequacy Indicator-Specific Validation Ratings 337
Analysis and Conclusions 338
Strengths, Opportunities for Improvement, and Recommendations 339
County of Santa Cruz Health Services Agency 341
ISCA Findings and Data Validity 341
Assessment of Data Validity 345
Network Adequacy Indicator-Specific Validation Ratings 346
Analysis and Conclusions 346
Strengths, Opportunities for Improvement, and Recommendations 348
Shasta County Behavioral Health 349
ISCA Findings and Data Validity 349
Assessment of Data Validity 352
Network Adequacy Indicator-Specific Validation Ratings 352
Analysis and Conclusions 353
Strengths, Opportunities for Improvement, and Recommendations 354
Siskiyou Behavioral Health Division 356
ISCA Findings and Data Validity 356
Assessment of Data Validity 360
Network Adequacy Indicator-Specific Validation Ratings 361
Analysis and Conclusions 361
Strengths, Opportunities for Improvement, and Recommendations 363
Solano County Health & Social Services 364
ISCA Findings and Data Validity 364
Assessment of Data Validity 367
Network Adequacy Indicator-Specific Validation Ratings 368
Analysis and Conclusions 368
Strengths, Opportunities for Improvement, and Recommendations 370
County of Sonoma 371
ISCA Findings and Data Validity 371
Assessment of Data Validity 375
Network Adequacy Indicator-Specific Validation Ratings 376
Analysis and Conclusions 376
Strengths, Opportunities for Improvement, and Recommendations 378
Stanislaus County Behavioral Health & Recovery Services 379
ISCA Findings and Data Validity 379
Assessment of Data Validity 383
Network Adequacy Indicator-Specific Validation Ratings 384
Analysis and Conclusions 384
Strengths, Opportunities for Improvement, and Recommendations 386
Sutter-Yuba Behavioral Health Services 387
ISCA Findings and Data Validity 387

Assessment of Data Validity 391
Network Adequacy Indicator-Specific Validation Ratings 391
Analysis and Conclusions 391
Strengths, Opportunities for Improvement, and Recommendations 393
Tehama County Health Services Agency 395
ISCA Findings and Data Validity 395
Assessment of Data Validity 398
Network Adequacy Indicator-Specific Validation Ratings 399
Analysis and Conclusions 399
Strengths, Opportunities for Improvement, and Recommendations 401
Trinity County Behavioral Health Services 402
ISCA Findings and Data Validity 402
Assessment of Data Validity 405
Network Adequacy Indicator-Specific Validation Ratings 406
Analysis and Conclusions 406
Strengths, Opportunities for Improvement, and Recommendations 408
Tulare County Health & Human Services Agency 409
ISCA Findings and Data Validity 409
Assessment of Data Validity 413
Network Adequacy Indicator-Specific Validation Ratings 413
Analysis and Conclusions 414
Strengths, Opportunities for Improvement, and Recommendations 415
Tuolumne County Behavioral Health Department 416
ISCA Findings and Data Validity 416
Assessment of Data Validity 420
Network Adequacy Indicator-Specific Validation Ratings 421
Analysis and Conclusions 421
Strengths, Opportunities for Improvement, and Recommendations 423
Ventura County Behavioral Health 424
ISCA Findings and Data Validity 424
Assessment of Data Validity 428
Network Adequacy Indicator-Specific Validation Ratings 429
Analysis and Conclusions 429
Strengths, Opportunities for Improvement, and Recommendations 431
Yolo County Health & Human Services Agency 432
ISCA Findings and Data Validity 432
Assessment of Data Validity 435
Network Adequacy Indicator-Specific Validation Ratings 436
Analysis and Conclusions 436
Strengths, Opportunities for Improvement, and Recommendations 438
Department of Health Care Services 439
ISCA Findings and Data Validity 439
Assessment of Data Validity 442
Strengths, Opportunities for Improvement, and Recommendations 443

4. Programwide Results 444
Analysis and Conclusions 444
Strengths, Opportunities for Improvement, and Recommendations 448
Strengths 448
Opportunities for Improvement and Recommendations 448
Progress Made from the Prior Year 448
Appendix A. HSAG Validation Team and List of Interviewees A-1

Table of Tables

Table 1.1—List of Plans and State Entity in Scope of Review 3
Table 1.2—Timely Access 8
Table 2.1—Validation Score Calculation 13
Table 2.2—Indicator-Level Validation Rating Categories 13
Table 2.3—Example 1 of a Validation Rating Determination 14
Table 2.4—Example 2 of a Validation Rating Determination 14
Table 3.1—Alameda Results for Timely Access Network Adequacy 20
Table 3.2—Alpine Results for Timely Access Network Adequacy 28
Table 3.3—Amador Results for Timely Access Network Adequacy 36
Table 3.4—Butte Results for Timely Access Network Adequacy 45
Table 3.5—Calaveras Results for Timely Access Network Adequacy 51
Table 3.6—Colusa Results for Timely Access Network Adequacy 59
Table 3.7—Contra Costa Results for Timely Access Network Adequacy 66
Table 3.8—Del Norte Results for Timely Access Network Adequacy 75
Table 3.9—El Dorado Results for Timely Access Network Adequacy 82
Table 3.10—Fresno Results for Timely Access Network Adequacy 89
Table 3.11—Glenn Results for Timely Access Network Adequacy 98
Table 3.12—Humboldt Results for Timely Access Network Adequacy 105
Table 3.13—Imperial Results for Timely Access Network Adequacy 113
Table 3.14—Inyo Results for Timely Access Network Adequacy 119
Table 3.15—Kern Results for Timely Access Network Adequacy 127
Table 3.16—Kings Results for Timely Access Network Adequacy 134
Table 3.17—Lake Results for Timely Access Network Adequacy 141
Table 3.18—Lassen Results for Timely Access Network Adequacy 147
Table 3.19—Los Angeles Results for Timely Access Network Adequacy 154
Table 3.20—Madera Results for Timely Access Network Adequacy 162
Table 3.21—Marin Results for Timely Access Network Adequacy 169
Table 3.22—Mariposa Results for Timely Access Network Adequacy 176

Table 3.23—Mendocino Results for Timely Access Network Adequacy 182
Table 3.24—Merced Results for Timely Access Network Adequacy 191
Table 3.25—Modoc Results for Timely Access Network Adequacy 198
Table 3.26—Mono Results for Timely Access Network Adequacy 205
Table 3.27—Monterey Results for Timely Access Network Adequacy 213
Table 3.28—Napa Results for Timely Access Network Adequacy 219
Table 3.29—Nevada Results for Timely Access Network Adequacy 228
Table 3.30—Orange Results for Timely Access Network Adequacy 236
Table 3.31—Placer Results for Timely Access Network Adequacy 243
Table 3.32—Plumas Results for Timely Access Network Adequacy 249
Table 3.33—Riverside Results for Timely Access Network Adequacy 257
Table 3.34—Sacramento Results for Timely Access Network Adequacy 265
Table 3.35—San Benito Results for Timely Access Network Adequacy 271
Table 3.36—San Bernardino Results for Timely Access Network Adequacy 279
Table 3.37—San Diego Results for Timely Access Network Adequacy 286
Table 3.38—San Francisco Validation Ratings 294
Table 3.39—San Francisco Results for Timely Access Network Adequacy 294
Table 3.40—San Joaquin Results for Timely Access Network Adequacy 304
Table 3.41—San Luis Obispo Results for Timely Access Network Adequacy 313
Table 3.42—San Mateo Results for Timely Access Network Adequacy 320
Table 3.43—Santa Barbara Results for Timely Access Network Adequacy 329
Table 3.44—Santa Clara Validation Ratings 337
Table 3.45—Santa Clara Results for Timely Access Network Adequacy 338
Table 3.46—Santa Cruz Results for Timely Access Network Adequacy 346
Table 3.47—Shasta Results for Timely Access Network Adequacy 353
Table 3.48—Siskiyou Results for Timely Access Network Adequacy 361
Table 3.49—Solano Results for Timely Access Network Adequacy 368
Table 3.50—Sonoma Results for Timely Access Network Adequacy 376
Table 3.51—Stanislaus Results for Timely Access Network Adequacy 384
Table 3.52—Sutter/Yuba Results for Timely Access Network Adequacy 392
Table 3.53—Tehama Results for Timely Access Network Adequacy 399
Table 3.54—Trinity Results for Timely Access Network Adequacy 406
Table 3.55—Tulare Results for Timely Access Network Adequacy 414
Table 3.56—Tuolumne Results for Timely Access Network Adequacy 421
Table 3.57—Ventura Results for Timely Access Network Adequacy 429
Table 3.58—Yolo Results for Timely Access Network Adequacy 436
Table 4.1—MHPs—Timely Access Conditional Pass 444

Table 4.2—MHPs—No Confidence Validation Rating 447
Table A.1—List of Alameda Interviewees A-1
Table A.2—List of Alpine Interviewees A-3
Table A.3—List of Amador Interviewees A-4
Table A.4—List of Butte Interviewees A-4
Table A.5—List of Calaveras Interviewees A-5
Table A.6—List of Colusa Interviewees A-5
Table A.7—List of Contra Costa Interviewees A-5
Table A.8—List of Del Norte Interviewees A-7
Table A.9—List of El Dorado Interviewees A-7
Table A.10—List of Fresno Interviewees A-8
Table A.11—List of Glenn Interviewees A-9
Table A.12—List of Humboldt Interviewees A-10
Table A.13—List of Imperial Interviewees A-11
Table A.14—List of Inyo Interviewees A-12
Table A.15—List of Kern Interviewees A-12
Table A.16—List of Kings Interviewees A-13
Table A.17—List of Lake Interviewees A-14
Table A.18—List of Lassen Interviewees A-15
Table A.19—List of Los Angeles Interviewees A-15
Table A.20—List of Madera Interviewees A-16
Table A.21—List of Marin Interviewees A-16
Table A.22—List of Mariposa Interviewees A-18
Table A.23—List of Mendocino Interviewees A-18
Table A.24—List of Merced Interviewees A-18
Table A.25—List of Modoc Interviewees A-19
Table A.26—List of Mono Interviewees A-20
Table A.27—List of Monterey Interviewees A-20
Table A.28—List of Napa Interviewees A-21
Table A.29—List of Nevada Interviewees A-22
Table A.30—List of Orange Interviewees A-23
Table A.31—List of Placer Interviewees A-24
Table A.32—List of Plumas Interviewees A-25
Table A.33—List of Riverside Interviewees A-25
Table A.34—List of Sacramento Interviewees A-26
Table A.35—List of San Benito Interviewees A-27
Table A.36—List of San Bernardino Interviewees A-28

Table A.37—List of San Diego Interviewees A-30
Table A.38—List of San Francisco Interviewees A-31
Table A.39—List of San Joaquin Interviewees A-33
Table A.40—List of San Luis Obispo Interviewees A-35
Table A.41—List of San Mateo Interviewees A-36
Table A.42—List of Santa Barbara Interviewees A-38
Table A.43—List of Santa Clara Interviewees A-39
Table A.44—List of Santa Cruz Interviewees A-40
Table A.45—List of Shasta Interviewees A-41
Table A.46—List of Siskiyou Interviewees A-42
Table A.47—List of Solano Interviewees A-43
Table A.48—List of Sonoma Interviewees A-43
Table A.49—List of Stanislaus Interviewees A-44
Table A.50—List of Sutter/Yuba Interviewees A-47
Table A.51—List of Tehama Interviewees A-48
Table A.52—List of Trinity Interviewees A-48
Table A.53—List of Tulare Interviewees A-48
Table A.54—List of Tuolumne Interviewees A-50
Table A.55—List of Ventura Interviewees A-50
Table A.56—List of Yolo Interviewees A-51
Table A.57—List of DHCS Interviewees A-51
Table A.58—HSAG Validation Team A-53

Medi-Cal Mental Health Plan Name Abbreviations

Health Services Advisory Group, Inc. (HSAG) uses the following abbreviated Medi-Cal County Mental Health Plan (MHP) names in this volume.

- **Alameda**—Alameda County Behavioral Health Care Systems
- **Alpine**—Alpine County Behavioral Health Services
- **Amador**—Amador County Behavioral Health
- **Butte**—Butte County Department of Behavioral Health Services
- **Calaveras**—Calaveras County Behavioral Health Services
- **Colusa**—Colusa County Department of Behavioral Health
- **Contra Costa**—Contra Costa County Mental Health
- **Del Norte**—Del Norte County Department of Health and Human Services
- **El Dorado**—El Dorado County Health & Human Services Agency
- **Fresno**—Fresno County Department of Behavioral Health
- **Glenn**—Glenn County Behavioral Health
- **Humboldt**—Humboldt County Health and Human Services
- **Imperial**—Imperial County Behavioral Health Services
- **Inyo**—Inyo County Health & Human Services Behavioral Health
- **Kern**—Kern County Behavioral Health and Recovery Services
- **Kings**—Kings County Behavioral Health
- **Lake**—Lake County Behavioral Health Services Department
- **Lassen**—Lassen County Health and Social Services
- **Los Angeles**—Los Angeles County Department of Mental Health
- **Madera**—Madera County Behavioral Health Services
- **Marin**—Marin County Behavioral Health and Recovery Services
- **Mariposa**—Mariposa County Human Services, Behavioral Health & Recovery Services Division
- **Mendocino**—Mendocino County Mental Health
- **Merced**—Merced County Behavioral Health and Recovery Services
- **Modoc**—Modoc County Behavioral Health Services
- **Mono**—Mono County Behavioral Health
- **Monterey**—Monterey County Behavioral Health
- **Napa**—Napa County Health and Human Services Agency
- **Nevada**—Nevada County Behavioral Health

- **Orange**—Orange County Behavioral Health Services
- **Placer**—County of Placer, Department of Health and Human Services
- **Plumas**—Plumas County Mental Health Services
- **Riverside**—Riverside County Mental Health Services
- **Sacramento**—Sacramento County Behavioral Health Services
- **San Benito**—San Benito County Behavioral Health
- **San Bernardino**—San Bernardino County Department of Behavioral Health
- **San Diego**—San Diego County Behavioral Health Division
- **San Francisco**—San Francisco Community Behavioral Health Services
- **San Joaquin**—San Joaquin Behavioral Health Services
- **San Luis Obispo**—San Luis Obispo County Behavioral Health Department
- **San Mateo**—San Mateo County Behavioral Health and Recovery Services
- **Santa Barbara**—Santa Barbara Department of Behavioral Wellness
- **Santa Clara**—Santa Clara County Behavioral Health Services Department
- **Santa Cruz**—County of Santa Cruz Health Services Agency
- **Shasta**—Shasta County Behavioral Health
- **Siskiyou**—Siskiyou Behavioral Health Division
- **Solano**—Solano County Health & Social Services
- **Sonoma**—County of Sonoma
- **Stanislaus**—Stanislaus County Behavioral Health & Recovery Services
- **Sutter/Yuba**—Sutter-Yuba Behavioral Health Services
- **Tehama**—Tehama County Health Services Agency
- **Trinity**—Trinity County Behavioral Health Services
- **Tulare**—Tulare County Health & Human Services Agency
- **Tuolumne**—Tuolumne County Behavioral Health Department
- **Ventura**—Ventura County Behavioral Health
- **Yolo**—Yolo County Health & Human Services Agency

Commonly Used Abbreviations and Acronyms

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

- **§**—section
- **A&I**—access and information
- **ACBHD**—Alameda County Behavioral Health Department
- **ACCESS**—Acute Crisis Care and Evaluation for Systemwide Services
- **ACH**—Alameda County Health
- **API**—application program interface
- **ARF**—access request form
- **ASAM**—American Society of Addiction Medicine
- **ASJ**—Access to Service Journal
- **ASO**—Administrative Services Organization
- **BAA**—business associate agreement
- **BAT**—Business Analytics Team
- **BBH**—Board of Behavioral Health
- **BBS**—Board of Behavioral Sciences
- **BH**—behavioral health
- **BHASO**—Behavioral Health Administrative Services Organization
- **BHIN**—Behavioral Health Information Notice
- **BHIS**—Behavioral Health Information System
- **BHOMD**—Behavioral Health Oversight Monitoring Division
- **BHP**—behavioral health plan
- **BHRS**—Behavioral Health and Recovery Services
- **BHS**—Behavioral Health Services
- **BHSA**—Behavioral Health Services Act
- **BHSD**—Behavioral Health Services Department
- **BI**—business intelligence
- **BSA**—business software analyst
- **CAADE**—California Association for Alcohol/Drug Educators
- **CAAT**—Central Access and Authorization Team
- **CADTP**—California Association of DUI Treatment Programs
- **CalHHS**—California Health and Human Services Agency
- **CalMHSA**—California Mental Health Services Authority
- **CAMS**—Crisis Access 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
- **CDM**—Claims Data Management
- **CFR**—Code of Federal Regulations
- **CHCA**—Certified Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Compliance Auditor
- **CHIP**—Children's Health Insurance Program
- **CIN**—Client Index Number
- **CMO**—chief medical officer
- **CMS**—Centers for Medicare & Medicaid Services
- **CQI**—Continuous Quality Improvement
- **CQIC**—Continuous Quality Improvement Committee
- **CRU**—Crisis Residential Unit
- **CSCHS**—County of Santa Clara Health Services
- **CSI**—Client Services Information
- **CSOC**—Children's System of Care
- **CSV**—comma separated values
- **CVO**—Credentials Verification Organization
- **DAE**—Data Analytics and Evaluation
- **DAT**—generic data file or Data Analytics Team
- **DBH**—Department of Behavioral Health
- **DCA**—Department of Consumer Affairs
- **DEA**—Drug Enforcement Administration
- **DHCS**—California Department of Health Care Services
- **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

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

- **EHR**—electronic health record
- **EPLS**—Excluded Parties List System
- **EPSDT**—Early and Periodic Screening, Diagnosis, and Treatment
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **ESN**—Employee Status Notification
- **FFS**—fee-for-service
- **FTE**—full-time equivalent
- **GIS**—geographic information system
- **GSA**—General Services Administration
- **HCS**—Health Care Services
- **HHS**—Health and Human Services
- **HHSA**—Health and Human Services Agency
- **HIM**—Health Information Management
- **HIMS**—Health Information Management System
- **HIT**—Health Information Technology
- **HPA**—Health Plan Administration
- **HR**—human resources
- **HSA**—health services assistant
- **HSAG**—Health Services Advisory Group, Inc.
- **HSR**—health services representative
- **IBHIS**—Integrated Behavioral Health Information System
- **ICL**—Initial Contact Log
- **I.D.E.A.**—Innovative Development and Evaluation Associates
- **IRIS**—Integrated Record Information System
- **IS**—Information Systems or Information System
- **ISCA**—Information Systems Capabilities Assessment
- **ISCAT**—Information Systems Capabilities Assessment Tool
- **ISD**—Information System Department
- **IT**—information technology
- **KPI**—Key Performance Indicator
- **KPMG**—Klynveld Peat Marwick Goerdeler
- **LEIE**—List of Excluded Individuals and Entities
- **LMS**—learning management system
- **MAC**—move, add, change form
- **MCO**—managed care organization
- **MCP**—managed care health plan

- **MD**—medical doctor
- **MEDS**—Medi-Cal Eligibility Data System
- **MEDSLITE**—Medi-Cal Eligibility Data System Lite
- **MHBU**—Mental Health Billing Unit
- **MHP**—Mental Health Plan
- **MHSA**—Mental Health Services Act
- **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
- **NAPPA**—Network Adequacy Provider and Practitioner Administration
- **NARF**—New Applicant Request Form
- **NAV**—network adequacy validation
- **NCQA**—National Committee for Quality Assurance
- **NP**—nurse practitioner
- **NPDB**—National Practitioner Data Bank
- **NPI**—National Provider Identifier
- **NPPES**—National Plan and Provider Enumeration System
- **OEM**—Outcomes Evaluation Management
- **OIG**—Office of Inspector General
- **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
- **PFAR**—Provider File Adjustment Request
- **PIHP**—prepaid inpatient health plan
- **PIQA**—Program Integrity Quality Assurance
- **POS**— place of service
- **PSV**—primary source verification
- **QA**—quality assurance
- **QCM**—Quality Care Management

- **QI**—quality improvement
- **QIC**—Quality Improvement Committee
- **QIQA**—Quality Improvement and Quality Assurance Unit
- **QM**—Quality Management
- **QMC**—Quality Management Committee
- **QPM**—Quality and Performance Management
- **QMS**—Quality Management Services
- **R**—a programming language which was named using the first letters of the first names of its creators, Robert Ihaka and Robert Gentleman.
- **RCM**—Revenue Cycle Management
- **RFS**—request for service
- **RMU**—Revenue Management Unit
- **S&I**—suspended & ineligible
- **SAM**—System for Award Management
- **SCVHHS**—Santa Clara Valley Health and Hospital System
- **SDN**—Specially Designated Nationals
- **SFHN**—San Francisco Health Network
- **SFTP**—secure file transfer protocol
- **SJC**—San Joaquin County
- **SMHS**—specialty mental health services
- **SOC**—System of Care
- **SPIF**—Service Provider Identification Form
- **SPSS**—Statistical Package for the Social Sciences
- **SQL**—Structured Query Language
- **Sr**.—Senior
- **SRL**—Service Request Log
- **SRTS**—Service Request Tracking System
- **SSB**—Social Services Branch
- **SSIS**—SQL Services Integration Services
- **SSN**—Social Security number
- **SSSD**—Self-Sufficiency Services Division
- **SUD**—substance use disorder
- **TADT**—Timely Access Data Tool
- **TAY**—Transitional Age Youth
- **TSS**—Technology Solutions & Services
- **UAT**—User Acceptance Testing
- **UI**—User Interface

- **UMDAP**—Uniform Method of Determining Ability to Pay
- **UQM**—Utilization and Quality Management
- **VBA**—Visual Basic for Applications
- **VHP**—Valley Health Plan

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 Medi-Cal County Mental Health Plans (MHPs). This report will sometimes collectively refer to these MHPs 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).[2]

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 DHCS, HSAG was responsible for conducting the contract year 2024–25 validation of network adequacy indicators, confirming DHCS' and each MHP's ability to collect

[2] 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: Mar 25, 2025.

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 MHPs' 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 MHP-specific deviations from State and federal requirements for determination of non-compliance and appropriate follow-up and remediations with the MHPs.
- **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
Alpine	May 7, 2025	Kimball Pier, Deputy Director	Rachel Spivey
Amador	March 31, 2025	Raechel Razzano, Utilization and Quality Management (QM) Coordinator	Rachel Spivey
Butte	March 27, 2025	Sam Casale, Senior (Sr.) Program Manager, Systems Performance, Research and Evaluation	Rachel Spivey
Calaveras	April 9, 2025	Stacey Meily, Program Manager	Rachel Spivey
Colusa	April 10, 2025	Theresa Cameron, Electronic Health Records Manager	Rachel Spivey
Contra Costa	April 17, 2025	Priscilla Aguirre, QM Program Coordinator	Marian Seege
Del Norte	March 25, 2025	Shiann Hogan, Deputy Director Samantha Reagen, Compliance Manager Meaghan McGlasson, Program Manager	Rachel Spivey
El Dorado	April 14, 2025	Shaun O'Malley, Acting Alcohol and Drug Programs Division Manager	Sumayyah Hackett

Plan Name/State Entity	Date	Primary Contact Name and Title	HSAG Lead Auditor
Fresno	May 8, 2025	Jeffrey Elliot, Quality Improvement Coordinator	Tamieka Square
Glenn	February 12, 2025	Alysia Miller, Compliance & Quality Improvement Program Manager	Anne Gulley
Humboldt	April 8, 2025	Amy Cone, Behavioral Health Program Manager for QI	Tamieka Square
Imperial	February 27, 2025	Sarah Moore, Behavioral Health Manager	AnnAlisa Cook
Inyo	April 28, 2025	Lori Bengochia, Senior Manager	Tamieka Square
Kern	April 10, 2025	Heather Williams, Behavioral Health Program Supervisor	Tamieka Square
Kings	March 13, 2025	Christi Lupkes, Assistant Director	Tamieka Square
Lake	April 2, 2025	Robert Chalmers, Senior Compliance Analyst	Tamieka Square
Lassen	March 31, 2025	Joshua Bradley, Behavioral Health Analyst	Tamieka Square
Los Angeles	March 11, 2025	Jennifer Hallman, Acting Chief of Quality Assurance	Tamieka Square
Madera	May 7, 2025	Eva Weikel, Behavioral Health Services Manager	Tamieka Square
Marin	April 1, 2025	Katie Smith, Behavioral Health and Recovery Services (BHRS) Division Director, QM	Laura McDermott
Mariposa	April 22, 2025	Lynn Rumfelt, Senior Administrative Analyst	Tamieka Square
Mendocino	February 28, 2025	Robin D. Harris, Staff Services Administrator	Tamieka Square

Plan Name/State Entity	Date	Primary Contact Name and Title	HSAG Lead Auditor
Merced	April 8, 2025	Matthew Reed, BHRS Division Director	Anne Gulley
Modoc	May 6, 2025	Dolores Navarro Turner, Behavioral Health Branch Director	Marian Seege
Mono	May 7, 2025	Danielle Murray, Staff Services Analyst	Marian Seege
Monterey	February 24, 2025	Janet Barajas, Behavioral Health Services Manager	Sumayyah Hackett
Napa	May 1, 2025	Nathan Hobbs, Assistant Deputy Director of Behavioral Health	Marian Seege
Nevada	March 11, 2025	Priya Kannall, Program Manager, Behavioral Health Department	Sumayyah Hackett
Orange	April 29, 2025	Sharon Ishikawa, Assistant Deputy Director Data Analytics and Evaluation	Marian Seege
Placer	February 26, 2025	Julia Soto, QM Program Manager	Marian Seege
Plumas	April 23, 2025	Jessica McGill, QI and Compliance Manager	Marian Seege
Riverside	March 27, 2025	Suzanna Juarez-Williamson, Administrative Services Manager	Sumayyah Hackett
Sacramento	April 15, 2025	Alex Rechs, Health Program Manager, Quality Assurance (QA) Continuous QI	Marian Seege
San Benito	April 7, 2025	Lindsay Garfield, QI Supervisor	Marian Seege
San Bernardino	April 7, 2025	Sarah Hayes, Program Manager II	Sumayyah Hackett

Plan Name/State Entity	Date	Primary Contact Name and Title	HSAG Lead Auditor
San Diego	March 20, 2025	Samantha Marquez, Administrative Analyst	Marian Seege
San Francisco	March 25, 2025	Kitty Ha, QI Coordinator	Marian Seege
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
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
Shasta	April 17, 2025	Kimberly Limon-Stevens, Senior Staff Analyst II	Laura McDermott
Siskiyou	April 24, 2025	Alora Sutcliffe, Project Coordinator	Anne Gulley
Solano	April 14, 2025	Rob George, Quality Assurance Senior Manager	Gina DeBlois
Sonoma	March 27, 2025	Henry Rafferty, QI Manager	Gina DeBlois
Stanislaus	May 2, 2025	Saksham Rana, Information Technology (IT) Manager	Rachel Spivey
Sutter/Yuba	April 28, 2025	Tammy Andersen, Quality Assurance Staff Analyst	Gina DeBlois

Plan Name/State Entity	Date	Primary Contact Name and Title	HSAG Lead Auditor
Tehama	April 30, 2025	Natalie Shepard, Mental Health Director	Gina DeBlois
Trinity	April 25, 2025	Torrie Cardilino, Deputy Director, Quality Assurance	Gina DeBlois
Tulare	April 2, 2025	Betsy Ayello, Quality Manager Chandler Bailey, Quality Manager	Gina DeBlois
Tuolumne	March 18, 2025	Amanda Lawrance, QI Supervisor	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 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 MHPs submit—population stratification for youth 0–20 years of age and adults 21 years of age and over.

Service Type*	Timeliness Standard
Outpatient Non-Urgent Non-Psychiatry Specialty Mental Health Services (SMHS)	Offered an appointment within 10 business days of request for services
Non-Urgent Psychiatric Services	Offered an appointment within 15 business days of request for services
All SMHS Urgent Appointments	48 hours without prior authorization 96 hours with prior authorization

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 MHPs, 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

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* 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 the 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

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

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 *Met* elements	16	*Moderate Confidence*
B. Total number of *Not Met* elements	3	
Validation Score = A / (A + B) x 100%	84.2%	
Number of *Not Met* 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 *Met* elements	15	*No Confidence*
B. Total number of *Not Met* elements	4	
Validation Score = A / (A + B) x 100%	78.9%	
Number of *Not Met* 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

Alameda County Behavioral Health Care Systems

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 substance use disorder (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.
- Some mental health 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). 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 quarterly 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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

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.

— 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	147	127	86%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	64	58	91%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	—	—	—
Non-Urgent Psychiatric Services—Adult (21+)	219	175	80%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	312	312	100%↑
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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

- **Opportunity #1:** Alameda 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 Alameda 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 Alameda 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.

Alpine County Behavioral Health Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Alpine 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 Alpine had in place to support network adequacy indicator reporting, which included the following findings:

- Alpine used Credible as the database management system to maintain enrollment and provider data beginning March 1, 2023.
- Prior to March 1, 2023, Alpine used Anasazi to maintain enrollment and provider data.
- Alpine used appropriate testing and validation measures to ensure completeness and accuracy of data migrated from Anasazi to Credible.
  - Kings View (Credible vendor) defined data quality metrics prior to migration and conducted thorough validation between Anasazi and Credible to identify data discrepancies during the migration process.
  - Kings View compared migrated data in Credible to source data in Anasazi to ensure relevant information was successfully transferred. Additionally, testing was completed to ensure users were able to access data in Credible as expected.
  - Alpine validated migrated data to ensure accuracy and completeness prior to and after migration.
- Alpine staff maintained access to Anasazi for historical reference.

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

- Kings View had a team of six programmers trained and capable of using programming language and programs to support Credible. Kings View programmers had an average of over 10 years of experience.
- Alpine's administrative assistant maintained oversight of timely access reporting.

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

Enrollment System

HSAG evaluated the information systems and processes used by Alpine 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 Alpine's enrollment system included the following findings:

- Enrollment and eligibility data for Alpine were maintained in Credible.
- Alpine received the MMEF from DHCS via the MOVEit secure file transfer protocol (SFTP) portal. Kings View staff were responsible for uploading the file into Credible after receiving a request to download the file from Alpine via a ticketing process. Files were typically uploaded into Credible within two days.
  - After uploading the MMEF, Kings View sent email confirmation to notify Alpine that the file was successfully uploaded into Credible.
  - Once the MMEF was uploaded, Alpine's administrative assistant matched members on the MMEF using name, Client Index Number (CIN), and date of birth (DOB), and manually validated eligibility for members receiving services using the Medi-Cal Eligibility Data System Lite (MEDSLITE) to capture additional changes in eligibility.
- Alpine defined a new member as a member brand new to services or someone previously closed to services who was readmitted.
- Credible captured and maintained both the state-issued Medi-Cal ID and a system-generated ID. Members retained the unique system-generated ID throughout enrollment and disenrollment.
- Alpine collected demographic information prior to a member's initial visit via an intake packet. Typically, the member picked up the packet in person prior to his or her appointment and returned it at the appointment. If a member was unable to pick up the intake packet, Alpine had the ability to mail or deliver it.
  - Alpine's administrative assistant entered member data from the intake packet into Credible. Additionally, Alpine's clinician reviewed the intake packet with the member during the first appointment and updated data in Credible if needed.
  - Alpine requested updated demographic information at each visit and noted members were often seen once a week. If a member had not been seen for more than 30 days, clinical staff contacted the member to schedule a visit and request updated information. If Alpine did not hear back from a member, Alpine sent a notification letter requesting the member to schedule an appointment and a notice of termination of services if the member did not contact Alpine within 30 days of the notice.
  - Members self-reported updates to their information directly, and Alpine's administrative assistant or clinician updated the information in Credible. If a member self-reported a change, the member was referred to his or her Medi-Cal caseworker as needed to update information with DHCS.

HSAG identified no concerns with Alpine'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 Alpine to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in Credible.
- Alpine had two providers on staff, one internal clinician and a contracted psychiatrist through Kings View.
- Alpine validated provider information including license, National Provider Identifier (NPI), address, and taxonomy at hiring and completed a background check. Licensure was validated using the Board of Behavioral Sciences (BBS), and the provider's NPI was verified using the National Plan and Provider Enumeration System (NPPES). Alpine also ensured that providers were enrolled in the DHCS Provider Application and Validation for Enrollment (PAVE) system prior to seeing members and billing for services, and that providers were not on the Social Security Administration's Death Master File.
- After verification, Alpine's administrative assistant entered the provider into Credible.
- Alpine's Human Resources (HR) Department, deputy director, and administrative assistant monitored licenses via a monitoring log that tracked license renewal dates. Alpine reached out to providers prior to expiration dates to request that providers submit updated information.
- Recredentialing was completed every three years.
- Alpine reviewed providers against the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) monthly to identify providers or organizations excluded from the Medicaid and CHIP programs.
- Providers self-reported changes as needed to Alpine's administrative assistant, who updated information in Credible. Alpine maintained a policy which required providers to report updated information in a timely manner.

HSAG identified no concerns with Alpine'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 Alpine's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Alpine utilized an access and information (A&I) log and Credible to track data used to report network adequacy indicators. Alpine used the TADT for reporting timely access annually, or as requested by DHCS.
- Alpine's administrative assistant manually recorded timely access data including date of first contact, referral source information, and appointment dates offered in an Excel spreadsheet A&I log. The A&I log also included requests for services initiated via the after-hours crisis line.
- Information from the A&I log was manually input into the TADT for reporting. If missing or incomplete information was identified in the A&I log, Alpine's administrative assistant reviewed service data in Credible to gather the additional information needed. Once data were populated, the TADT was submitted to DHCS via the MOVEit SFTP portal.
  - Alpine did not have additional validation checks in place to review the TADT prior to submission to DHCS.
- Alpine maintained the A&I log and prior TADT submissions on a shared drive.
- Alpine was collaborating with Kings View for updates in Credible to implement timely access tracking capabilities, with a goal to enter information directly into the system via forms aligned with DHCS reporting requirements and to extract timely access data for reporting.
- Alpine used the above A&I log process to track and report timely access data while Anasazi was in use.
- HSAG assessed Alpine's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Alpine's administrative assistant tracked the number of days between requests for services and first offered appointment dates in the A&I log. Alpine's deputy director reviewed the A&I log to identify gaps between initial contact and first offered appointment dates.
- Alpine maintained timely access goals as part of their annual QI Work Plan and monitored access percentages year over year as part of their QI Work Plan Evaluation Report. Timely

access was also reviewed as a standing item during quarterly Quality Improvement Committee (QIC) meetings, where Alpine reviewed information captured in the A&I log.

- To continue improving timely access metrics, Alpine noted initiatives including ongoing staff training on scheduling new requests for services with emphasis on required time frames, ongoing review and evaluation of the A&I log to monitor the percentage of requests offered within the required time frames, identifying and addressing barriers to meeting time frames during quarterly QIC meetings, and collaboration with Kings View to ensure adequate psychiatry appointment availability.

HSAG identified no concerns with Alpine'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 Alpine 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 Alpine used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Alpine'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.2—Alpine 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	—	—	—
Non-Urgent Psychiatric Services—Adult (21+)	—	—	—
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Urgent Psychiatry—Children/Youth (0–20)	—	—	—
Urgent Psychiatry—Adult (21+)	—	—	—

Strengths, Opportunities for Improvement, and Recommendations

By assessing Alpine'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:** Alpine had thorough processes in place to maintain updated member demographic and eligibility data, which included capturing demographic data via an intake packet, verifying demographic information at appointments, and validating eligibility monthly.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Alpine had manual processes in place to track and report timely access data using an A&I log.
  - **Recommendation:** HSAG recommends that Alpine continue to work with Kings View to implement timely access data tracking capabilities in Credible, minimizing manual data entry required to populate the TADT and reducing the potential for data entry errors.
- **Opportunity #2:** Alpine did not have validation checks in place to review the TADT prior to submission to DHCS.
  - **Recommendation:** HSAG recommends that Alpine consider implementing validation checks, such as a secondary review, prior to submission to DHCS to ensure accuracy and completeness of data reported in the TADT.
- **Opportunity #3:** Alpine 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 Alpine 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 Alpine 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.

Amador County Behavioral Health

ISCA Findings and Data Validity

HSAG completed an ISCA for Amador 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 Amador had in place to support network adequacy indicator reporting, which included the following findings:

- Amador used Credible as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Amador used Anasazi to maintain enrollment and provider data.
  - Amador and Kings View validated data prior to and after migration to ensure no information was lost during the migration to Credible.
  - Kings View defined data quality metrics prior to migration and conducted validation between Anasazi and Credible to identify data discrepancies during the migration process. Kings View validated that all information was successfully migrated and completed testing to ensure users could access data as expected.
  - Amador and Kings View staff maintained access to Anasazi for historical reference.

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

- Kings View had a team of six programmers with an average of 10 or more years of experience.
- Amador's Utilization and Quality Management (UQM) coordinator maintained oversight of timely access reporting.

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

Enrollment System

HSAG evaluated the information systems and processes used by Amador 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 Amador's enrollment system included the following findings:

- Enrollment and eligibility data for Amador were maintained in Credible.

- Amador received the MMEF from DHCS. Kings View staff were responsible for obtaining the MMEF from the DHCS portal monthly and uploading the file into Credible after receiving a request to download the file from Amador via a ticketing process.
- Amador performed monthly reconciliation between Credible and the MMEF to ensure completeness and accuracy of eligibility data.
  - After uploading the MMEF, Kings View attached a screen shot to the ticket to indicate the file was successfully uploaded into Credible.
  - Amador's fiscal staff used an MMEF match workflow to reconcile eligibility data and resolved identified discrepancies using the DHCS MEDSLITE portal to validate information.
  - Amador's front desk staff manually validated eligibility at the start of services via MEDSLITE. Eligibility was checked as needed, such as if Amador received a denied claim.
- Amador defined a new member as a Medi-Cal member who had never received services or a returning member who was previously closed to all services. A returning member would need to reinitiate services by restarting the intake process, which included a screening, intake assessments, and reassignment to treatment programs and providers.
- Credible captured and maintained both the state-issued Medi-Cal ID and a system-generated ID. Credible maintained a feature to check for duplicate accounts when creating a new record based on the member's first and last name, Social Security number (SSN), and DOB. If a duplicate account was identified, Amador submitted a ticket to Kings View to merge the records.
- Amador identified member demographic updates via direct member contact. Amador collected information via intake forms and made a paper change of information form available to members to provide updates as needed after initial intake. Front desk staff entered information into Credible. Members were referred to social services to update information with DHCS.

HSAG identified no concerns with Amador'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 Amador to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in Credible.
- Amador's compliance officer obtained and validated provider information at hiring and created the provider profile in Credible. Amador verified provider data through sources including licensing agencies, the Social Security Administration's Death Master File, and NPPES.
- Amador's compliance officer reviewed provider credentials monthly and sent email reminders for licensure renewal. Recredentialing was completed every three years. Credible did not allow providers to schedule or enter services if a license expired.
- Amador used the OIG LEIE, the DHCS Provider Suspended and Ineligible (S&I) List, and Excluded Parties List System (EPLS)/System for Award Management (SAM) database to identify providers or organizations excluded from the Medicaid and CHIP programs each month.
- Providers were required to update their information as needed by notifying Amador's compliance officer. In addition, Amador maintained a provider credentialing and recredentialing attestation form provided to all staff for completion annually. Amador's compliance officer reviewed the attestation form during a staff meeting and validated provider information once submitted, such as license, board certification or registration, Drug Enforcement Administration (DEA) ID, NPI, and sanction history.

HSAG identified no concerns with Amador'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 Amador's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Amador utilized Credible to track and extract data used to report timely access network adequacy indicators. Amador used the TADT for reporting timely access to DHCS annually, or as requested by DHCS.
- Amador used an access to services assessment form and mental health non-psychiatric or mental health psychiatric form within Credible to track timely access data. If a member met

access criteria, either administrative or screener staff would complete the access to services assessment form. Screener staff included peer support specialists and personal services coordinators who completed initial screenings. Amador's UQM coordinator, BH director, and compliance officer reviewed each access to services assessment form for clinical appropriateness and completeness.

- Amador's UQM coordinator then initiated a mental health non-psychiatric or mental health psychiatric form in Credible using data from the access to services form, such as the date of first contact; signed the form within the system, and routed it to Amador's administrative technician for final completion. The administrative technician monitored for a second access to services assessment form to be completed by front desk staff once an appointment was scheduled; used data from this second form to complete remaining fields within the mental health non-psychiatric or mental health psychiatric form, such as follow-up appointment or closure information; and signed the form in Credible.
- The mental health non-psychiatric or mental health psychiatric form was considered complete when both the UQM coordinator and administrative technician signed the form in Credible. Credible contained programming to run a report based on the number of signatures, which allowed Amador to identify completed mental health non-psychiatric and mental health psychiatric forms for reporting.
- Prior to July 1, 2023, Amador used Anasazi to track and report timely access. Anasazi contained an access to services form utilized for tracking timely access data that were used for DHCS reporting. Amador completed a manual review to validate data and formatting prior to submission.
  - Amador noted reporting errors identified in the initial assessment TADT submission, included missing indicators in the follow-up appointment column and CIN entry errors. Amador staff attended the DHCS instructional TADT webinar and ensured data entry errors for the required reassessment submission were corrected, which included reviewing to ensure the appropriate indicator was populated in the follow-up appointment column, and validating that members included on the TADT were Medi-Cal members and had a CIN.
- Amador's UQM coordinator was responsible for submitting the TADT to DHCS. Amador's administrative technician served as a backup as needed to ensure continuity in reporting.
- Amador maintained submissions to DHCS on a shared drive for historical reference.
- HSAG assessed Amador's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Credible maintained a series of reports and dashboards used by Amador to ensure completeness and accuracy of data. Amador ran a data validation report twice a month to identify and update missing member demographic data. Weekly reports were run to identify services not started, incomplete services, or no-show cancellation notes. Amador also reviewed a medication monitoring dashboard to ensure members were regularly seeing their provider.

- Credible maintained a function to suspend or flag services if an issue was identified with information needed for billing, such as missing or incorrect demographics, diagnosis, NPI, or taxonomy. Amador's administrative staff reviewed a report weekly to correct errors.
- Monthly, Amador reviewed a dashboard to track timeliness data and compliance metrics, and to identify errors. The dashboard identified data including the average, median, and maximum number of days from initial contact to first offered and first rendered appointments, and percentage compliant and non-compliant for each. The dashboard also showed the maximum number of days and the data fields used for reporting timely access via the TADT to allow Amador to identify missing information or potential data entry errors. Amador's QI Committee reviewed the dashboard during monthly meetings.
- If missing or incomplete data were identified, Amador's UQM coordinator reviewed and manually pulled data from the member record.
- Amador's UQM coordinator completed a live walkthrough of the forms used to document timely access data in Credible with staff, as needed, to ensure understanding.
- Amador met with Kings View to request additional dashboard views or Credible reports as needed to assist in ongoing monitoring.

HSAG identified no concerns with Amador'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 Amador 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 Amador used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Amador'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 were 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.3—Amador 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	40	39	98%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	73	70	96%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	19	16	84%↑
Non-Urgent Psychiatric Services—Adult (21+)	41	36	88%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Amador'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:** Amador demonstrated robust oversight and monitoring of timely access reporting through the development of several reporting dashboards to ensure accuracy and completeness of member and service data in Credible, including a bimonthly member demographic report, and weekly reports to identify missing and incomplete services and notes.

Opportunities for Improvement and Recommendations

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

Butte County Department of Behavioral Health Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Butte 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 Butte had in place to support network adequacy indicator reporting, which included the following findings:

- Butte used myAvatar as the database management system to collect and maintain enrollment and provider data.

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

- Butte had a team of 10 programmers, with an average of three and a half years of experience.
- Butte's System Performance, Research, and Evaluation Unit was responsible for timely access reporting.

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

Enrollment System

HSAG evaluated the information systems and processes used by Butte 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 Butte's enrollment system included the following findings:

- Enrollment and eligibility data for Butte were maintained in myAvatar.
- Butte received the MMEF from DHCS. Butte's IT Unit downloaded the MMEF from the DHCS portal and uploaded the file into myAvatar.
- Butte performed monthly reconciliation to ensure completeness and accuracy of eligibility data.
  - Butte validated eligibility prior to beginning services and monthly as part of its billing process using the MEDSLITE portal.

  - Monthly, Butte's clinics and contracted providers provided a list of all members open to programs. Billing staff verified eligibility for each member and validated that member data were entered into myAvatar correctly.
- myAvatar required that staff search a minimum of three unique member identifiers prior to creating a new member record. Butte used a combination of SSN, first and last name, and DOB to identify existing member records prior to creating a new record. If a SSN was already in use, myAvatar contained programming logic to trigger a notification alerting staff of a potential record match. Billing staff reviewed and merged records as needed if a duplicate was identified. If no member was found, the system generated the next available medical record ID number.
- Butte defined a new member as a member initiating services for the first time or who received services previously but was closed to all services. Butte implemented an Access Contact Log to capture member information and timely access data. A member returning to services would have a new Access Contact Log completed.
- 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 programs.
- Butte identified member demographic information and updates via referrals received or direct member contact. Member demographic and financial information was verified at a member's intake appointment. Members completed a registration packet for new admission to a program that included demographic information, financial information, and informed consent paperwork. Members were asked at each subsequent appointment if there were any changes to their information, and financial information was updated annually.

HSAG identified no concerns with Butte'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 Butte to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in myAvatar.
- Butte utilized Laserfiche, a document management system, to capture provider documentation and streamline the process for HR, QM, and IT teams to review information

during the provider credentialing and onboarding process, and to capture any provider changes after hiring, such as a promotion.

- Butte used Valenz, a web-based database system, to screen providers during credentialing when they were hired. Recredentialing was completed every three years. Valenz checked state and federal databases including the California Department of Consumer Affairs (DCA) BreEZe Online Services system, NPPES, and exclusion and sanction databases.
- Butte's HR Team ran a monthly licensure report to identify staff with licenses, certifications, registrations, or waivers due to expire within 90, 60, and 30 days and sent email reminders to ensure timely licensure renewal.
- Butte's QM staff verified that all licensed providers were enrolled in the DHCS PAVE system. If staff determined providers were not already enrolled, Butte facilitated provider completion of enrollment.
- Butte validated and updated provider directory data monthly. The QM Team completed monthly reviews to ensure accuracy and completeness of data used for 274 reporting.
- Butte's QM Team used Valenz, which checked databases including the EPLS/SAM, OIG LEIE, Specially Designated Nationals (SDN), National Practitioner Data Bank (NPDB), DEA Administrative Actions Against Doctors, DHCS S&I Provider List, and Social Security Administration's Death Master File to identify providers or organizations excluded from the Medicaid and CHIP programs each month.
  - Contracted providers submitted verification and attestation of completed exclusion checks to Butte monthly.
- Butte required its provider network to update provider data as needed. Providers were required to report any issues with renewal of licenses, certifications, registrations, or waivers required for their role to their supervisor immediately. The supervisor was required to notify QM and HR of any potential disruption to credentials. Providers were made aware of expectations via a policy and as part of their business associate agreement (BAA).

HSAG identified no concerns with Butte'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 Butte's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Butte utilized myAvatar to track and extract data used to report timely access network adequacy indicators. Butte used the TADT for reporting timely access to DHCS annually, or as requested by DHCS.
- Butte used the Access Contact Log and a Psychiatric Request for Services Log within myAvatar to track and monitor timely access to services. Butte's health services assistants (HSAs) or 24/7 Access Line staff managed intake requests and initiated the Access Contact Log form, which was then completed by clinicians as members progressed through services.
- Butte's contracted providers reported timely access quarterly via Excel spreadsheets based on the TADT, which were uploaded into reporting software including Microsoft Access and SAP Crystal Reports. Butte validated spreadsheets for completeness, accuracy, and formatting; compared encounter data in myAvatar to the Excel data received; and completed post-merge validation checks to validate total record counts.
  - Butte provided reporting guidelines detailing data submission requirements, timeliness, and formatting standards. Any identified discrepancies were addressed, and ongoing meetings and training sessions were held in addition to performance reviews to monitor adherence to contractual requirements and reporting standards.
- Butte's System Performance, Research, and Evaluation Unit was responsible for generating and submitting timely access reports. Using Microsoft Access, this unit queried data from contracted providers and Access Contact Log and psychiatric services forms within myAvatar. Butte developed an SQL script to ensure that required TADT data fields, services, and members were captured, including using a defined date range based on the required reporting period and required service types.
- Butte reviewed the internal member ID, follow-up appointment data, and progress notes to validate information used for reporting. Butte maintained a process for a second analyst to review the data, with supervisory staff completing additional reviews as needed prior to submission via the DHCS portal.
- Data validation was completed by reproducing data using secondary reporting software to ensure that data matched. If a mismatch was identified, the data were re-run until fully validated for accuracy. Analysts completed validation spot checks by reviewing raw data in myAvatar and repeated the process of re-running data if errors were identified.
- Butte archived timely access data submissions which remained accessible for referencing historical submissions.
- To ensure continuity in reporting, Butte's System Performance, Research, and Evaluation Team had five members who were cross-trained, and Butte maintained documentation including policies and procedures for any team member to produce reports as needed.

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

Ongoing monitoring activities:

- Butte used Crystal Reports to audit data for completeness and maintained a series of reports to identify and address missing or incomplete data in myAvatar.
  - Butte's HSA supervisors ran monthly reports from the Access Contact Log that highlighted missing information. HSA staff reviewed myAvatar data including the scheduling calendar to locate and update missing information.
  - Butte's QM Team completed monthly chart reviews to validate accuracy and completeness of documentation. Clinical documentation checklist reports were run to ensure all required clinical documentation was completed and to identify any overdue items. In addition, a missing and incomplete notes report was used to identify missing or incomplete provider documentation.
  - To track data, providers had access to the clinical documentation checklist and a combined services report that tracked and consolidated service entries.
- Butte calculated timely access percentages as part of a clinic metrics summary and reviewed data quarterly during QIC meetings. Butte used the quarterly calculations to compare data produced for the annual TADT submission and to validate accuracy. Butte noted ongoing staffing challenges and retraining as barriers to network adequacy.
  - To continue improving network adequacy and access to care, Butte implemented initiatives including a psychiatric residency program designed to host 16 residents practicing across various clinics, with a goal of at least 50 percent remaining in the county to continue practicing. Butte has worked to address and lower staff vacancy rates from almost 25 percent in February 2023 to below 17 percent as of January 2025.
  - Butte maintained detailed training manuals to guide staff in entering data completely and accurately, and staff completed retraining related to timely access requirements and documentation processes.
  - Additionally, integrated services were available at Butte's Chico location, including crisis services, mental health, housing, and pharmacy. Butte noted a long-term goal of duplicating this model to provide integrated services across three additional facilities in addition to the Chico location.

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

Assessment of Data Validity

HSAG evaluated and assessed the data methods that Butte 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

Butte used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Butte'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.4—Butte 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	62	60	97%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	127	114	90%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	63	40	**63%↓**
Non-Urgent Psychiatric Services—Adult (21+)	124	79	**64%↓**
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Butte'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:** Butte conducted quarterly monitoring and reporting of timely access and reviewed results during QIC meetings, which were designed to highlight trends over time and develop interventions focused on any observed gaps in timely access to services.
- **Strength #2:** Butte continued to improve network adequacy and access to care through initiatives such as lowering staff vacancy rates, implementing a psychiatric residency program, and setting a long-term goal of providing integrated services across three additional facilities in addition to the Chico location.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Butte did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Butte 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 Butte 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.

Calaveras County Behavioral Health Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Calaveras 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 Calaveras had in place to support network adequacy indicator reporting, which included the following findings:

- Calaveras used Credible as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Calaveras used Anasazi to maintain enrollment and provider data.
- Calaveras used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to Credible from Anasazi.
  - Kings View facilitated data mapping and migration of data from Anasazi, which included defining data quality metrics prior to migration and conducting validation between Anasazi and Credible to identify data discrepancies during the migration process. Kings View validated that all information was successfully migrated and completed testing to ensure users could access data as expected.
  - Calaveras staff maintained access to Anasazi for historical reference.

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

- Kings View had a team of six programmers with an average of 10 or more years of experience.
- Calaveras' senior department analyst maintained oversight of timely access reporting.

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

Enrollment System

HSAG evaluated the information systems and processes used by Calaveras 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 Calaveras' enrollment system included the following findings:

- Enrollment and eligibility data for Calaveras were maintained in Credible.

- Calaveras received the MMEF from DHCS. Kings View staff were responsible for uploading the MMEF into Credible monthly after receiving a request to download the file from Calaveras via a ticketing process.
- Calaveras performed monthly reconciliation between Credible and the MMEF to ensure completeness and accuracy of eligibility data.
  - Once the MMEF was uploaded, Calaveras' billing staff reconciled data and resolved eligibility discrepancies as needed using MEDSLITE to validate information.
  - Additionally, Calaveras staff manually validated eligibility using MEDSLITE daily when members checked in for appointments.
- Calaveras defined a new member as a member who had never received services or a previous member who had not received services within the last 12 months.
- Credible captured and maintained both the state-issued Medi-Cal ID and a system-generated ID. Members retained the unique system-generated ID throughout enrollment and disenrollment.
  - Prior to entering a new member in Credible, staff searched to identify existing member records. Credible maintained a feature to notify staff if a matching name, DOB, or SSN was identified.
- Calaveras identified member demographic updates via direct member contact during the intake process and as needed. Members completed an intake packet including a demographic form at the onset of services. The packet was updated annually for adults and every six months for youth. Any changes to member information were captured on a demographic form. Front desk staff updated information in Credible and scanned the demographic form into the member's chart.
  - Calaveras' front desk staff completed a checklist for members enrolling in services and whenever a member had an update. The checklist was sent to the administrative services manager to validate that all items were completed, such as verifying Medi-Cal eligibility and recording timely access information.
  - Calaveras had a contact in the Human Services Department who was notified of member changes to report updates to DHCS.

HSAG identified no concerns with Calaveras' 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 Calaveras to capture provider data and identified the following findings:

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

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

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

- Provider credentialing and network status data were maintained in Credible.
- Calaveras used CertifyOS as its credentials verification organization (CVO) for licensed provider credentialing and recredentialing. Recredentialing was completed annually. For non-licensed providers, information was submitted via email to and verified by Calaveras' program manager.
- Providers submitted applicable information such as an application, resume, license, NPI, DEA number, and taxonomy. CertifyOS cross-referenced the NPPES and BBS to validate provider information including NPI, taxonomy, and license.
- Calaveras' senior data analyst validated that all providers completed required training in the learning management system (LMS) prior to being given access to Credible. Once confirmed, the provider was set up in Credible.
- Providers were responsible for tracking their own license and were required to provide updated information as it was received. Calaveras' Billing Team ran a monthly report to identify providers with upcoming license expirations and notified providers as updated information was needed. Credible did not allow providers to schedule or enter services if a license had expired.
- Calaveras used CertifyOS to identify providers or organizations excluded from the Medicaid and CHIP programs each month.

HSAG identified no concerns with Calaveras' 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 Calaveras' delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Calaveras used Credible to track and extract data used to report timely access network adequacy indicators. Calaveras used the TADT for reporting timely access to DHCS annually, or as requested by DHCS.

- Calaveras' front desk or screener staff initiated a mental health non-psychiatric or mental health psychiatric form within Credible to track timely access data. Clinical staff completed the form as members progressed through services.
- Calaveras' senior department analyst extracted data from Credible to populate the TADT. The TADT contained conditional formatting that highlighted errors or missing data. If a discrepancy was identified, the senior department analyst updated the member's chart in Credible and re-ran the data, completing a line-by-line review until the TADT was complete and accurate.
- Prior to July 1, 2023, Calaveras maintained a similar process while using Anasazi to track and report timely access. Anasazi contained a Client Services Information (CSI) form used for tracking and extracting timely access data used for reporting to DHCS.
- Calaveras maintained extracted data files and TADT submissions in a network adequacy folder for historical reference.
- HSAG assessed Calaveras' processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Calaveras used a dashboard within Credible to monitor timely access data. The dashboard identified data including the average, median, and maximum number of days from initial contact to first offered and first rendered appointments, and percentage compliant and non-compliant for each.
  - The dashboard also contained a missing dates tab that indicated timeliness forms in Credible that did not have an appointment rendered or closure date populated. Staff were trained that either the appointment rendered or closure date must be populated for the form to be considered complete. Calaveras' senior department analyst reviewed this weekly for the month prior to identify missing information. Staff were notified via email to update discrepancies as needed.
- Calaveras reviewed timeliness in QIC and management meetings and implemented efforts such as clinicians blocking off time weekly to complete assessments to ensure ongoing availability and access to appointments.

HSAG identified no concerns with Calaveras' 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 Calaveras 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 Calaveras used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Calaveras' **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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.5—Calaveras 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	23	23	100%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	24	24	100%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	19	17	89%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S
Urgent Psychiatry—Children/Youth (0–20)	S	S	S
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Calaveras' 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:** Calaveras maintained thorough processes to capture accurate and up-to-date member eligibility and demographic data using an intake packet, demographic form, checklist reviewed by Calaveras' administrative services manager, and validation of eligibility at the time of a member's appointment.

Opportunities for Improvement and Recommendations

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

Colusa County Department of Behavioral Health

ISCA Findings and Data Validity

HSAG completed an ISCA for Colusa 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 Colusa had in place to support network adequacy indicator reporting, which included the following findings:

- Colusa used SmartCare as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Colusa used Anasazi to maintain enrollment and provider data.
- Colusa used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from Anasazi.
  - Migration of data to SmartCare underwent several rounds of testing and validation. After each round of information was uploaded into SmartCare, the Electronic Health Record (EHR) Team validated that data were uploaded correctly. Testing was completed prior to the go-live date to validate that information successfully migrated, and that users could access data as expected.

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

- California Mental Health Services Authority (CalMHSA) (SmartCare EHR subcontractor) staff included a number of programmers trained and capable of using programming language and programs to maintain SmartCare. CalMHSA programmers had an average of six years of experience.
- Colusa's QA staff maintained oversight of timely access reporting and ongoing monitoring activities.

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

Enrollment System

HSAG evaluated the information systems and processes used by Colusa 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 Colusa's enrollment system included the following findings:

- Enrollment and eligibility data for Colusa were maintained in SmartCare.
- Colusa received the MMEF from DHCS. Colusa downloaded the MMEF from the DHCS portal and placed it in a SFTP folder for CalMHSA Billing staff to upload into SmartCare monthly.
- Colusa performed monthly reconciliation between SmartCare and the MMEF to ensure completeness and accuracy of eligibility data.
  - Colusa'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. Colusa's EHR manager reviewed members appearing on the report, validated data discrepancies using MEDSLITE, and updated member records in SmartCare as needed.
  - Colusa manually validated member eligibility at initial intake, weekly for appointments scheduled for the following week, and at the time of a member's appointment using Real Time Eligibility verification within SmartCare that confirmed eligibility using a 270/271 transaction process.
- Colusa defined a new member as a member who had never received services or who was completely closed to all programs and services and had returned for additional services.
- 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.
- Colusa identified member demographic updates via direct member contact. Colusa collected demographic information at intake and maintained a paper check-in form for members to report changes to their information at subsequent appointments. Colusa's front desk staff entered updates into SmartCare as needed. Members were referred to Colusa Health and Human Services to report changes to DHCS.

HSAG identified no concerns with Colusa'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 Colusa to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in SmartCare.
- Providers submitted information at hiring including NPI, license, taxonomy, and demographics. HR verified this information using the NPPES, licensing boards, and national databases.
  - New staff also completed a form to be input into SmartCare. After HR verified the provider's information, Colusa's EHR manager entered the provider into SmartCare.
- Colusa's EHR manager reviewed a credentialing report monthly to identify providers with expiring licenses in the following two months, reached out to providers as needed, and updated the license in SmartCare once received.
  - SmartCare contained programming to require an active license on file in order for a provider to bill.
  - Recredentialing was completed every two to three years depending on the provider's license type.
- Colusa contracted with Streamline Verify to complete monthly exclusion screenings to identify providers or organizations excluded from the Medicaid and CHIP programs. Streamline Verify checked databases including the OIG LEIE, EPLS/SAM, Social Security Administration's Death Master File, and applicable license databases.
- Colusa required providers to update information as needed as identified on the credentialing report. Providers could also self-report a change by notifying their supervisor and Colusa's EHR staff.

HSAG identified no concerns with Colusa'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 Colusa's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Colusa utilized an Excel spreadsheet and SmartCare to track data used to report network adequacy indicators. Colusa used the TADT for reporting timely access to DHCS annually, or as requested by DHCS.

- Colusa tracked all members included in timely access reporting on an Excel spreadsheet. The spreadsheet, which front office and QA staff maintained, included data fields needed to complete the TADT. Front office staff initiated a member's entry into the spreadsheet, which the QA Team monitored for additional information, such as a follow-up appointment, to complete the spreadsheet.
  - Colusa used color coding to indicate completed and pending items in the Excel spreadsheet. QA staff monitored and updated the spreadsheet daily as appointments were rendered. QA staff worked with clinicians and reviewed progress notes as needed to capture all data in the spreadsheet.
- Once all data were entered into the Excel spreadsheet for a member, Colusa's QA staff entered timely access data into SmartCare using a mental health psychiatric SMHS timeliness record or mental health non-psychiatric SMHS timeliness record and signed the form in SmartCare.
- Colusa's QA staff extracted data from the mental health psychiatric SMHS timeliness and mental health non-psychiatric SMHS timeliness records in SmartCare and copied and pasted the exported data to the TADT for submission to DHCS. Additional QA staff completed a line-by-line review of the TADT prior to submission to validate data completeness and formatting.
- Colusa maintained the Excel spreadsheet and exported SmartCare data and TADT submissions on a network drive for historical reference.
- Prior to July 1, 2023, Colusa used the Excel spreadsheet and Anasazi to track and report timely access. Anasazi contained an access to services assessment form used for tracking timely access data. Colusa ran a report from Anasazi for DHCS reporting.
- HSAG assessed Colusa's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Colusa's QA staff monitored a dashboard weekly which identified unsigned timeliness records in SmartCare. If an outstanding record was identified, QA staff reviewed it to ensure all data were entered and made updates if needed for the form to be signed.
- Colusa's QA staff completed internal calculations of timeliness metrics by month and aggregated by quarter, which were tracked in the Excel spreadsheet. In addition, Colusa maintained timeliness goals within its QI workplan. Internal timeliness calculations were reviewed during quarterly QIC meetings; and annually, Colusa evaluated the workplan to determine if goals were met and identified areas of improvement.
- Colusa noted using the Excel spreadsheet as an additional check and balance to ensure accuracy and completeness of timely access data due to concerns about data accuracy related to how the number of days was calculated in SmartCare, and due to needing additional data for the QIC.
- To improve and maintain member access to care, Colusa evaluated its intake process and implemented scheduled walk-in hours in 2023 to ensure clinician availability to receive new walk-in members. Colusa noted a decrease in member wait time and increased follow-up appointments offered within 10 business days as a result.

HSAG identified no concerns with Colusa'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 Colusa 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 Colusa used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Colusa'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.6—Colusa 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	16	16	100%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	24	24	100%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Non-Urgent Psychiatric Services—Adult (21+)	17	16	94%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Colusa'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:** Colusa implemented scheduled walk-in hours to ensure clinician availability to provide services to new walk-in members in efforts to improve and maintain access to care.
- **Strength #2:** Colusa had thorough processes to capture up-to-date member eligibility data, including manually validating eligibility at intake, for upcoming appointments, and at the time of a member's appointment.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Colusa noted timely access data were manually tracked in Excel and then input into SmartCare due to concerns about accuracy of data extracted from the system.
  - **Recommendation:** HSAG recommends that Colusa work with CalMHSA to address data accuracy and resolve any remaining system concerns. HSAG also recommends that Colusa consider using SmartCare's embedded reporting functions, which may reduce manual data entry processes and potential data entry errors, and increase efficiency.

Contra Costa County Mental Health

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 Epic as the database management system to maintain enrollment data beginning July 1, 2023.
  - Prior to July 1, 2023, Contra Costa used ShareCare to maintain enrollment data.
  - Contra Costa migrated episode data and certain CSI-required demographic data for active members from ShareCare to Epic, and ShareCare remained available for lookup and queries in Contra Costa's data warehouse.
  - Contra Costa's Patient Accounting staff, ShareCare support staff, and Provider Services retained access to ShareCare for historical reference.
- Contra Costa used ShareCare to maintain provider data.

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

- Contra Costa had eight programmers with an average of 15 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 Epic.
- Contra Costa received the MMEF from DHCS; however, the MMEF was not used for eligibility verification.
- Providers and administrative staff were trained and expected to use the RTE functionality in Epic to verify member eligibility during appointments, and to update information as needed.

Additionally, bulk RTE responses were utilized for scheduled appointments at county clinics. Eligibility and enrollment data were updated into the Epic data warehouse daily to support data analysis and reporting needs, and Epic maintained a record of eligibility history.

- Contra Costa performed monthly reconciliation between Epic and the MMEF using a two out of three match process. Epic matched each member CIN to a system-generated medical record number (MRN) using first name, last name, DOB, and SSN. If the SSN was missing, the first name, last name, and DOB were used. Members who were not matched would not be included in any metrics.
- Epic captured and maintained both the state-issued Medi-Cal CIN and a system-generated MRN to uniquely identify members. If the Medi-Cal ID changed for any reason, Contra Costa used the CIN to link enrollment history. Duplicate members were identified by registration staff and sent to the Health Information Management System (HIMS) Team for review. The HIMS Team reviewed accounts to determine which account should be retained, and merged accounts.
- Contra Costa defined a new member as a Medi-Cal member who had never received services or an existing member who had not received services in six months or more.
- Contra Costa updated member-reported addresses and phone numbers in Epic as needed, and members were instructed to contact DHCS to update their information.

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 ShareCare.
- Providers were required to submit a credentialing application to Contra Costa's Provider Services Team. Upon receipt, the application was reviewed and credential verification was performed, which included checking licensure status and screening for sanctions or disciplinary actions using national databases such as the NPPES, California DCA BreEZe Online Services system, OIG LEIE, and EPLS/SAM.

- Providers were required to undergo recredentialing at least every three years, or sooner if they qualified for a new credentialing category or returned to Contra Costa after an inactive period of more than 30 days.
- The credentialing packet was submitted to the Credentialing Committee for review and approval. Once approved, the Provider Services Team manually entered the provider's information into ShareCare. An automated overnight process then transferred the data from ShareCare to the Epic Professional Billing module for billing. ShareCare served as the source of truth for provider data.
- Contra Costa conducted monthly license, exclusion, and sanction verifications.
- Providers were sent monthly reminders to update their information in preparation for the 274 file submission, and Contra Costa sent quarterly staff verifications to confirm and validate the accuracy of provider information.
- Contra Costa required its provider network to update provider data monthly, quarterly, and during the recredentialing process. Providers were made aware of this expectation during onboarding and via monthly and quarterly reminders.

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 used Epic to track and extract data for reporting timely access network adequacy indicators. Contra Costa used the TADT to report timely access to DHCS. The TADT was submitted annually, or as requested by DHCS.
- Contra Costa used Epic's system-maintained timeliness forms to monitor access to care across outpatient, psychiatric, and non-psychiatric services. The Behavioral Health Access Team documented timeliness data in Epic at the time of a service request and conducted assessments to determine a member's appropriate level of care.
- Epic's timeliness forms contained built-in validations to ensure all data elements were captured, and they included simple checks to validate basic compliance and data entry.

Data entry errors and workflow exception reports were distributed to respective owners for remediation.

- Contra Costa's Quality Improvement and Quality Assurance Unit (QIQA) was responsible for the oversight and compliance of network adequacy timely access reporting.
- Contra Costa's QIQA staff conducted user acceptance testing and contacted providers to resolve data errors identified during the TADT reporting period. QIQA staff finalized and cleaned the data prior to submission, with all reports labeled and stored in a secure folder.
- Prior to July 1, 2023, Contra Costa used ShareCare and Epic to track and report timely access. Contracted providers utilized ShareCare, and internal BH clinics utilized Epic. Both systems contained a CSI form used for tracking timely access data used for DHCS reporting. The CSI form was the basis for TADT reporting.
- 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:

- Any gaps identified in Contra Costa's network adequacy indicator performance against DHCS' indicator-level contract requirements were tracked and monitored by the QIQA. The Quality Management Committee (QMC) established a sub-workgroup with clinics or providers failing to meet the standard and developed a course correction plan which outlined the identified issue, area of deficiency, and the corrective plan required.
- Contra Costa had a shortage of psychiatric providers in the county and implemented initiatives to improve timely access to psychiatric services, which included expanding staff, incorporating telehealth providers, and holding monthly meetings to improve psychiatric availability and identify members who could be served with a lower level of care.
- Contra Costa created a workgroup to improve the collection of time of first contact and time of first offered appointment for urgent appointments in Epic.

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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.7—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	269	261	97%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	413	405	98%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	83	71	86%↑
Non-Urgent Psychiatric Services—Adult (21+)	417	278	**67%↓**
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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 launched several initiatives to improve timely access to psychiatric services, which included expanding staff, identifying members who could transition to a lower level of care, and incorporating telehealth providers.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Contra Costa did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Contra Costa 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 Contra Costa 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.

Del Norte County Department of Health and Human Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Del Norte 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 Del Norte had in place to support network adequacy indicator reporting, which included the following findings:

- Del Norte used Credible as the database management system to collect and maintain enrollment and provider data effective July 1, 2023.
- Prior to July 1, 2023, Del Norte used Anasazi to maintain enrollment and provider data.
- Del Norte used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to Credible from Anasazi.
  - Kings View defined data quality metrics prior to migration and conducted checks between Anasazi and Credible to identify discrepancies during the migration process. Kings View validated that all information was successfully migrated.
  - Kings View completed testing to ensure users could access data as expected.
  - Del Norte validated data prior to and after migration to ensure accuracy and completeness.
  - Del Norte's administrative staff, managers, and supervisors maintained access to Anasazi data for historical reference.

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

- Kings View had a team of six programmers trained and capable of using programming language and programs to maintain Credible. Kings View programmers had an average of 10 or more years of experience.
- Del Norte's compliance manager and deputy director supported timely access reporting.

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

Enrollment System

HSAG evaluated the information systems and processes used by Del Norte 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 Del Norte's enrollment system included the following findings:

- Enrollment and eligibility data for Del Norte were maintained in Credible.
- Del Norte received the MMEF from DHCS. Del Norte's supervising medical records clerk submitted a ticket to Kings View to request that the file be uploaded. Kings View staff were responsible for obtaining the MMEF and uploading the file into Credible. After uploading the file, Kings View attached a screen shot to the ticket indicating the file was successfully uploaded with the total number of records processed, matched records, potential matched records, and non-matched records.
- Del Norte performed monthly reconciliation between Credible and the MMEF to ensure completeness and accuracy of eligibility data.
  - Once the MMEF was uploaded, the supervising medical records clerk reconciled data and resolved eligibility discrepancies using MEDSLITE to validate information.
  - Del Norte validated eligibility using MEDSLITE prior to a member beginning services, annually, and as needed, such as when a member reported a change.
- Del Norte defined a new member as a member who had never received services or a returning member who was previously closed to all services.
- Credible captured and maintained both the state-issued Medi-Cal ID and a system-generated ID. Members retained the unique system-generated ID throughout enrollment and disenrollment.
  - Staff were required to search fields including name, DOB, and SSN prior to creating a new member account in Credible. Credible maintained a feature to check for duplicate accounts when creating a new record based on these data fields. In addition, Del Norte's compliance manager ran a monthly report to identify duplicate accounts. If a duplicate account was identified, Del Norte submitted a ticket to Kings View to merge the records.
- Del Norte identified member demographic updates via direct member contact. Members completed a registration packet during the intake process. Del Norte also had a paper change of information form available for members to provide updates as needed after initial intake. Del Norte's Medical Records Team collected and maintained information in Credible. The supervising medical records clerk maintained a checklist for members entering services to ensure demographic and eligibility information were captured in Credible. To report updates to DHCS, members were referred to the Benefits Issuance office for enrollment updates or the Public Assistance Employment Branch for demographic changes.

HSAG identified no concerns with Del Norte'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 Del Norte to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in Credible.
- Del Norte validated provider information such as NPI, license or board certification or registration, education, and DEA number at hiring using the California DCA BreEZe Online Services system and NPPES. Del Norte's compliance manager also verified the provider was enrolled in the DHCS PAVE system. If the provider was not enrolled, the compliance manager facilitated enrollment or requested that the provider complete enrollment if the provider was a contracted provider.
- Del Norte submitted a ticket to Kings View upon credentialing approval using a staff set-up form to create a new provider profile in Credible. Once completed, Kings View provided confirmation in the ticket request.
- Del Norte ran a report to identify expiring provider licenses monthly. Providers were notified via email to submit updated information 30 days prior to expiration. Credible did not allow providers to schedule or enter services if their license had expired.
- In addition, credentials were validated every three years at recredentialing. Providers completed a provider credentialing and recredentialing attestation prior to hiring and at recredentialing. Del Norte's compliance manager tracked the completion of attestation forms.
- Del Norte used the OIG LEIE, DHCS S&I Provider List, NPDB, and EPLS/SAM database to identify providers or organizations excluded from the Medicaid and CHIP programs each month. Del Norte's HR Team used Screening One to complete exclusion checks.
- Del Norte required its provider network to update provider data as needed if there was a change. Providers notified their manager and Del Norte's compliance manager of changes via email. Contracted providers were made aware of this expectation via their contract, and county providers were made aware via a handbook and policy.

HSAG identified no concerns with Del Norte'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 Del Norte's delegated entity data and oversight included the following findings:

- Del Norte did not subcontract any network adequacy-related services to delegated entities.

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Del Norte used Credible to track and extract data used to report timely access network adequacy indicators annually, or as requested by DHCS. Del Norte used the TADT for reporting timely access to DHCS.
- Credible contained two forms for tracking SMHS, mental health psychiatric and mental health non-psychiatric, which contained data fields needed for network adequacy reporting.
- Del Norte's Medical Records staff entered information into the forms in Credible as services were requested and received, and front desk staff signed the mental health psychiatric or mental health non-psychiatric form in Credible once completed. Del Norte supervisors ran monthly reports to identify incomplete or unapproved forms and notified staff of any identified items. Staff were required to update incomplete data in the form within five days.
- Del Norte's compliance manager exported timely access data from Credible to an Excel spreadsheet for network adequacy indicator reporting via the TADT. Del Norte's deputy director completed a second review of the TADT prior to DHCS submission. Once reviewed, the TADT was submitted via the DHCS portal.
- Del Norte retained Excel spreadsheets used for internal monitoring and all TADT submissions to DHCS for historical reference.
- Prior to July 1, 2023, Del Norte maintained a similar process while using Anasazi to track and report timely access. Anasazi contained a CSI form used for tracking and extracting timely access data used for reporting to DHCS.
- HSAG assessed Del Norte's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Credible maintained a series of reports and dashboards used monthly by Del Norte supervisors, administrative staff, and quality staff to ensure completeness and accuracy of timely access and service data.
  - Del Norte maintained a daily process for a supervisor to review notes entered in Credible, which included checking that notes matched the service billed and that time and locations were appropriately listed, prior to approving the note. If an error was

identified, supervisors worked with providers to update the information as needed. If a trend was identified, notifications were sent to staff to alert them, and additional training was completed to resolve issues.

  - Credible maintained a function to suspend or flag services if an issue was identified with information needed for billing, such as a missing diagnosis code or no active eligibility. Del Norte monitored this weekly, and billing or front desk staff updated information or worked with clinical staff to ensure items were corrected. Supervisors could not approve notes until identified issues were resolved.

- Del Norte's compliance manager also completed quarterly chart reviews. The manager reviewed 5 percent of charts to ensure member demographic and authorization forms were on file, insurance information was listed, and updated liability information was on file. In addition, Del Norte completed annual peer chart reviews wherein all staff would be assigned member charts to review and ensure accuracy of notes.
- Del Norte's compliance manager monitored a timely access dashboard in Credible to identify trends over time and track timeliness metrics. The dashboard populated data from the mental health psychiatric and mental health non-psychiatric forms in Credible and allowed Del Norte to filter requests based on the date of first contact. The dashboard identified data including the average, median, and maximum number of days from initial contact to first offered and first rendered appointments, and percentage compliant and non-compliant for each. The dashboard also showed the maximum number of days and the data fields used for reporting timely access via the TADT to allow Del Norte to identify missing information or potential data entry errors. Dashboard data were reviewed monthly and quarterly during Del Norte's supervisor and QIC meetings.
- Del Norte's compliance manager manually reviewed mental health psychiatric and mental health non-psychiatric forms or service data in Credible as needed to validate accuracy of data. If an outlier was identified, an analyst would research the member's chart and determine if data were incorrectly entered into the system.
- Del Norte noted challenges in retaining BH providers as well as in being a small and rural county. To address challenges, Del Norte has worked to explore options to increase provider hours and add additional providers to improve access to care. In April 2024, Del Norte contracted with Community Behavioral Health to offer psychiatric provider hours.

HSAG identified no concerns with Del Norte'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 Del Norte 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 Del Norte used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Del Norte'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.8—Del Norte 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	27	22	81%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	49	49	100%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	—	—	—
Non-Urgent Psychiatric Services—Adult (21+)	—	—	—
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	—	—	—

Strengths, Opportunities for Improvement, and Recommendations

By assessing Del Norte'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:** Del Norte maintained numerous validation checks to ensure accuracy and completeness of data in Credible, including a process for supervisor approval of notes, peer chart reviews, and monthly reports to identify incomplete or inaccurate data.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Del Norte 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 Del Norte 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 Del Norte 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.

El Dorado County Health & Human Services Agency

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 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 mental health 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 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 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.
  - 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.

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. El Dorado'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 to be run on-demand in myAvatar. The report from myAvatar was exported to an Excel file for submission to DHCS.
- 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.
  - El Dorado reviewed monthly timeliness data for psychiatry and outpatient 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. 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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.9—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	365	333	91%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	416	364	88%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	35	35	100%↑
Non-Urgent Psychiatric Services—Adult (21+)	139	129	93%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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.

Fresno County Department of Behavioral Health

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, DOB, and 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 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 psychiatric and non-psychiatric 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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.10—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	957	878	92%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	523	443	85%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	257	194	**75%↓**
Non-Urgent Psychiatric Services—Adult (21+)	284	237	83%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S
Urgent Psychiatry—Children/Youth (0–20)	S	S	S
Urgent Psychiatry—Adult (21+)	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

- **Opportunity #1:** Fresno did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Fresno 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 Fresno 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.

Glenn County Behavioral Health

ISCA Findings and Data Validity

HSAG completed an ISCA for Glenn 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 Glenn had in place to support network adequacy indicator reporting, which included the following findings:

- Glenn used SmartCare as the database management system to collect and maintain enrollment and provider data beginning March 1, 2023.
- Glenn completed migration of all member and provider data from Anasazi to SmartCare as of March 1, 2023. Clinical documentation image files were not migrated to SmartCare but remained accessible to Glenn staff in legacy system archives.

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

- Five staff were authorized users in SmartCare and contributed to the processing, collection, and performance monitoring of data that were used for timely access reporting and monitoring. These staff included administrative services analysts, office technicians, and compliance and QI program staff.

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

Enrollment System

HSAG evaluated the information systems and processes used by Glenn 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 Glenn's enrollment system included the following findings:

- Enrollment and eligibility data for Glenn were maintained in SmartCare.
- Glenn received the MMEF from DHCS. CalMHSA staff retrieved the MMEF and placed the file in a SFTP folder for importing into SmartCare. A nightly system job in SmartCare imported the file, and a second job processed the file for system integration.
- Glenn's staff services analysts and office technicians had change authority to review and update member data in SmartCare. Updates to member data were only applied during

MMEF error report reviews, to ensure alignment of member IDs in SmartCare against validated member data received in the MMEF.

- Glenn performed monthly reconciliation between uploaded MMEF data and member records in SmartCare to ensure completeness and accuracy of enrollment data. The following processes were in place to ensure consistency of MMEF data:
  - Only one unique member ID was maintained at any time in SmartCare. An authorized user manually reviewed duplicate member IDs using a potential match report following MMEF uploads. The validated record was retained in SmartCare, and the duplicate or erroneous member record was rejected and not retained.
  - MMEF data were validated by the analyst at the beginning of each month and as soon as possible upon receipt of the file.
  - Analysts used the MMEF QA report to validate data reasonability of monthly member uploads using year and month record count comparisons.
  - Analysts used the Medi-Cal Eligibility Data System (MEDS) ID field and SSN field to validate member data using a mismatched field report. If a match error was identified in the report, analysts manually validated member data using MEDS and MEDSLITE. Two of the three critical unique identifiers (member name, SSN, or DOB) were required to be confirmed prior to manual update of member data in SmartCare.
- Upon creation of a SmartCare member account, a member ID was generated. The member was enrolled and eligible for SMHS.
- Glenn defined a new member as any Medi-Cal member who was not enrolled in treatment services at the time of the service request.
- Members were unenrolled or discharged when services were complete. If the member returned for additional services under the same program or a different program, he or she was reactivated in SmartCare with the previous member ID. Member access staff verified existing accounts upon member registration in SmartCare by searching for existing accounts and verifying key demographic information such as SSN, Date of Service (DOS) for a previous service, or member name.
- Glenn office technicians accessed MEDSLITE if an erroneous SSN or CIN was identified to verify member demographic information and proceed with processing for services. The office technician updated member demographic information in SmartCare. SmartCare was updated with unique member demographic fields to house any member demographic information that was not received as a standard field on the MMEF.
- Analysts used SmartCare's 270/271 RTE functionality to verify and update member eligibility. The month of service was entered and submitted in the coverage screen in SmartCare. SmartCare connected in real time to MEDS to retrieve and update eligibility data from the request.
- Office technicians used member information supplied in the request for services to search for and confirm eligibility for services. SmartCare also had a direct connection to the State eligibility database for RTE checks that approved Glenn staff could access on an ad hoc basis.

HSAG identified no concerns with Glenn'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 Glenn to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in SmartCare.
- The Glenn County Health and Human Services Agency maintained provider credentialing data. Glenn used Evolution, an online verification platform, for credential verification. The staff services analyst reviewed new contracted provider data and routinely updated new provider information in SmartCare.
- Providers submitted identifying information, including NPI, taxonomy code, practice location, and DEA certificate if applicable, when applying for contracting with Glenn.
- Glenn received updated contracted provider information from the county department via ongoing email communications. Processes in place to ensure that new and updated provider data were integrated in SmartCare included the following:
  - Changes and updates to provider data were reviewed during monthly QIC meetings held with Glenn's MHP staff and the county agency's contracting staff.
  - Requirements for provider contracting were outlined in Glenn's Individual and Organizational Provider Selection and Credentialing policy.
  - Glenn maintained a policy to govern site certifications for the delivery of SMHS.
  - Prior to contracting, Glenn reviewed the full credentials of potential providers. Glenn reviewed full credentials of existing contracted providers every three years, at a minimum.
  - Glenn validated contracted providers against various exclusion and status lists monthly.

HSAG identified no concerns with Glenn'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 Glenn's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Glenn used SmartCare and Anasazi data to calculate and report network adequacy indicators.
  - Anasazi data were exported to an Excel report for services requested between July 1, 2022, and February 28, 2023. Data from Anasazi and SmartCare were combined in an Excel report and transferred to the TADT for the initial assessment submission July 1, 2022, through March 31, 2023.
  - SmartCare was the system of record for TADT reporting March 1, 2023, through March 31, 2023. Data from SmartCare were exported using a report in SmartCare. Data from the export were transferred to the TADT for reporting during this period.
- Glenn integrated member enrollment data for network adequacy indicator reporting.
- Glenn maintained data control procedures to ensure accuracy and completeness of data merges from SmartCare.
- CalMHSA customized SmartCare reports for export of SmartCare data in alignment with DHCS TADT reporting requirements. User acceptance testing was completed with Glenn to validate report data accuracy. Git, a distributed version control system, and Azure DevOps were used for version control, to store and track changes and to query report logic.
- Referral system of service inquiries were tracked in SmartCare. Glenn's most frequently reported service inquiry source was self-referral. Additional referral type sources that were tracked during the reporting period included family/friend, education/school, health care provider, social services, SUD services, criminal justice services, emergency department, managed care health plan (MCP), inpatient/hospital, unidentified, and other.
- Glenn used appropriate methodologies to assess adherence to DHCS' network adequacy indicators for timely access.
  - The report in SmartCare consolidated data based on SmartCare's timeliness form for psychiatric and non-psychiatric outpatient treatment providers. Glenn manually transferred exported data to the TADT.
  - Data reported on the TADT were validated using record count comparison. Dates were reviewed for reasonability, and character format was validated to ensure alignment with TADT requirements.

  - Analyst staff exported a SmartCare contact log to a Microsoft Access database. The database was used as the internal reporting data source. All data elements that were required for TADT reporting and Glenn's internal timeliness reports were documented in the contact log.
  - Timeliness data were extracted for appropriate reporting time frames.
  - Glenn used the DEA flag to filter psychiatric service providers in SmartCare and view psychiatry service appointment availability.
  - To calculate timeliness of services, time was calculated between the time of member contact request and actual time of member contact by the servicing provider.
  - Days from the date of the appointment request to the date of the first offered or first rendered appointment were calculated for internal reporting. Holidays were excluded and the NETWORKDAYS Excel formula was used for calculation.
- The TADT was reported annually to DHCS unless requested more frequently.
- Glenn QA staff reviewed the reasonability of timely access data through review and investigation of any outlier data points. Data were reviewed in reports, prior to transfer of data to the TADT.
- Glenn labeled TADT reports using the reporting naming conventions for DHCS 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.
- Full SmartCare databases were backed up weekly and differential databases were backed up daily to ensure continuity of data used for network adequacy indicator reporting.
- HSAG assessed Glenn's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Glenn analysts developed a timeliness report used for internal monitoring of timely access. The report included data elements generated during identified reporting periods to calculate a member's first urgent or non-urgent service date, first appointment offered date, first delivered service date, and timeliness to first visit date for psychiatric and non-psychiatric appointments. Counts of appointments that met the standard of 10 business days for non-urgent services and 15 business days for psychiatric visits were calculated.
- Network adequacy data, including the timeliness report, were reviewed at least quarterly during QIC meetings.
- If service type indicators were identified as achieving below the 80 percent performance threshold, Glenn targeted contracting efforts to increase access to services or worked with providers to reduce appointment availability barriers.

HSAG identified no concerns with Glenn'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 Glenn 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 Glenn used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Glenn'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.11—Glenn 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	86	77	90%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	55	54	98%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	—	—	—
Non-Urgent Psychiatric Services—Adult (21+)	—	—	—
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Glenn'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:** Glenn maintained ongoing oversight of county network adequacy for SMHS using internal performance reporting and performance review committees.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Glenn 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 Glenn 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 Glenn 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.

Humboldt County Health and Human Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Humboldt 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 Humboldt had in place to support network adequacy indicator reporting, which included the following findings:

- Humboldt used SmartCare and MD-Staff as the database management systems to collect and maintain enrollment and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Humboldt used myAvatar to maintain enrollment and provider data.
- Humboldt implemented appropriate testing and validation procedures to ensure accurate data migration from legacy systems to SmartCare.
  - Humboldt staff conducted three rounds of systematic data validation, correcting errors and reconciling missing fields.
  - Migration efforts were supported by CalMHSA and Streamline (a SmartCare vendor), who worked jointly with Humboldt teams to resolve discrepancies and adapt to the system's requirements.

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

- 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 Humboldt's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by Humboldt 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 Humboldt's enrollment system included the following findings:

- Enrollment and eligibility data for Humboldt were maintained in SmartCare. Authorized staff established and updated member records through a structured intake and verification process.

- Humboldt received the MMEF from DHCS. Humboldt's IT Department downloaded the MMEF from the DHCS secure e-transfer portal, extracted the contents, and uploaded them into SmartCare via a SFTP server.
- MMEFs were stored on Humboldt's password protected, encrypted local shared drive.
- Humboldt 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.
  - Humboldt'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.
- Humboldt 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 the 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.
  - 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 ID of the user who made the update and the timestamp.
- Humboldt 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 Humboldt'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 Humboldt to capture provider data and identified the following findings:

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

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

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

- Humboldt used SmartCare and MD-Staff to maintain provider credentialing and network status data.
- When new staff were hired, Employee Services staff conducted background checks, Social Security Administration's Death Master File reviews, and exclusion list verification prior to sending clearance for onboarding.
- Supervisors then submitted a completed staff worksheet to the QI Team, which included verified information such as NPI, taxonomy codes, licensure, gender, and DOB. QI staff reviewed and signed off on the data.
  - Once QI verification was complete, Claims Data Management (CDM) and Information Systems personnel enrolled providers into SmartCare.
  - For licensed staff, credentialing data were also entered into MD-Staff, which tracked license validity, DEA registration, OIG LEIE, General Services Administration (GSA) sanctions, and NPI status. MD-Staff generated reminders for renewals and flagged expired or missing data.
  - Each MD-Staff profile included licensure, demographics, credentials, specialties, insurance, peer references, and appointment cycles. Access to MD-Staff was restricted to QI personnel, Employee Services, and credentialing administrators.
- SmartCare maintained staff profiles on the staff details screen, which included a licenses and degrees tab; behind this tab were tracking type, number, state, and expiration. This screen also included a custom fields tab supporting 274 data (i.e., language, contract dates, service types, and specialty).
- System permissions in SmartCare were role-based. Staff flagged as "active" could log in, while accounts marked "can't log in" were restricted even if technically active. Providers could not edit their SmartCare profile directly; all changes required administrative action through the worksheet process.
- Each provider record in SmartCare included an audit trail with created and last modified dates, allowing visibility into data changes over time.
- Provider availability was tracked locally by supervisors using calendars and case lists; SmartCare did not include a centralized scheduling system.
- MD-Staff sent automatic emails to providers to notify them of any date expirations. An initial email would be sent 30 days prior to a credential expiring and again if the credential was past due.

HSAG identified no concerns with Humboldt'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 Humboldt's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Humboldt utilized SmartCare to track and extract data used to report network adequacy indicators annually, or as requested by DHCS. Humboldt used the TADT for reporting timely access to DHCS.
- When a member contacted the county, his or her information was initially recorded in the inquiry form in SmartCare. After screening by a clinician, a timeliness form was generated if the member was referred internally or to an organizational provider. These forms captured the first offered appointment, first attended appointment, and follow-up appointment data.
- Timeliness data were exported from SmartCare and reviewed monthly by the QI Team. Missing or incomplete fields, such as CINs or appointment dates, were flagged and routed to the appropriate teams for correction.
  - If there were discrepancies identified related to CINs, the QI Team added or updated the missing information directly in SmartCare.
  - CIN numbers were pulled from Medi-Cal data and added to the coverage plan section in SmartCare. If CINs were still missing after data pulls, manual lookup processes were used to supplement records.
- HSAG assessed Humboldt's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Humboldt actively monitored timely access data throughout the year, incorporating regular auditing and validation to ensure SmartCare records remained accurate.
  - Timely access data were reviewed and scrubbed monthly. Incomplete or inaccurate records were flagged, and updates were coordinated with administrative and clinical teams.
  - Humboldt held two internal meetings per week focused on access improvement and biweekly meetings with DHCS to review progress and receive clarification on reporting issues.

- QI staff and access supervisors were actively involved in referral tracking improvements, enhanced documentation practices, and ongoing system upgrades to better align with DHCS' requirements.

HSAG identified no concerns with Humboldt'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 Humboldt 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 Humboldt used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Humboldt'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.12—Humboldt 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	88	78	89%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	15	12	80%↑
Non-Urgent Psychiatric Services—Adult (21+)	23	12	**52%**↓
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Humboldt'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:** Humboldt demonstrated a proactive approach to accountability and timely access tracking by involving QI staff and supervisors in referral and documentation improvements, highlighting the county's focus on aligning system usage with evolving DHCS standards.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Humboldt 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 Humboldt 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 Humboldt 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.

Imperial County Behavioral Health Services

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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.13—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	398	365	92%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	434	410	94%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	0	0	ZU

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	14	13	93%↑
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

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.

Inyo County Health & Human Services Behavioral Health

ISCA Findings and Data Validity

HSAG completed an ISCA for Inyo 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 Inyo had in place to support network adequacy indicator reporting, which included the following findings:

- Inyo used Credible as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Inyo used Cerner to maintain enrollment and provider data.
- Inyo used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to Credible from Cerner.
  - Migration of data to Credible was supported by Kings View. Data testing was performed throughout 2022, including backend validation and clinician demonstrations.
  - Inyo maintained access to Cerner as a legacy system for historical records retrieval when needed. Most member demographic and service data were successfully migrated to Credible.

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

- Kings View staff included six programmers trained and capable of using programming language and programs to support Credible. Kings View programmers had an average of 10 years of experience.

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

Enrollment System

HSAG evaluated the information systems and processes used by Inyo 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 Inyo's enrollment system included the following findings:

- Enrollment and eligibility data for Inyo were maintained in Credible.

- Inyo received the MMEF from DHCS. Fiscal staff processed files manually into Credible.
- Inyo performed monthly eligibility verifications using the MMEF, MEDSLITE searches, and coordination with its Employment and Eligibility Division. Duplicate accounts were identified and manually merged.
  - Member eligibility was verified at intake and monthly. Discrepancies were handled by contacting the member or coordinating with caseworkers to update information with DHCS.
  - Credible captured and maintained both the state-issued Medi-Cal ID and a system-generated internal ID.
  - Member demographic updates were identified via direct member interaction. Front office or administrative staff with superuser permissions manually entered updates. Credible logged all manual changes.

HSAG identified no concerns with Inyo'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 Inyo to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in Credible.
- When new providers were onboarded, administrative analysts verified licensure, credentialing, and NPI information via external sources such as the NPPES and licensing boards.
  - Provider profiles were manually created in Credible with required taxonomy and prescriber information. License expiration dates were tracked manually via reports from fiscal staff. Only trained superusers were granted editing access to provider profiles in Credible.
  - Specialty tracking in Credible was limited to basic classifications through taxonomy codes and program assignments (e.g., outpatient, Mental Health Services Act, jail programs). Full specialty annotation was expected with future Credible updates through application program interface (API) integrations and 274 forms.

- Credential expiration dates were tracked through a credentialing report provided by the Fiscal Team. License expiration dates were updated in Credible based on these reports. Every three years, providers were required to submit a renewed credentialing application. Administrative staff coordinated this process, sending notifications and forms to providers.
  - Credentialing data, including license history and modifications to provider profiles, were logged into Credible's audit log, which tracked user activities including edits and profile access.
  - Credible was monitored monthly through mandatory DHCS credentialing logs and Kings View oversight to identify errors and expired credentials.
  - Providers with expired credentials were prevented from accessing Credible until their credentials were renewed.
- When a provider left the organization, the provider's profile was inactivated in Credible rather than deleted, ensuring the retention of historical data. Inactivated profiles appeared grayed out and were no longer selectable for scheduling or service assignments.

HSAG identified no concerns with Inyo'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 Inyo's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Inyo utilized Credible to track data used to report timely access network adequacy indicators annually, unless requested more frequently by DHCS. Inyo used the TADT for reporting timely access to DHCS.
- Inyo extracted data from Credible using internal dashboards and reporting tools to identify timely access information relevant to a reporting period.
- Inyo staff reviewed extracted data for timeliness and completeness prior to submission.
- The data were formatted into Excel spreadsheets according to DHCS' submission specifications, and Kings View staff maintained responsibility for technical support and compilation.
- Files were named using a consistent naming convention and archived with clear references to the submission date and applicable reporting period.

- Credible maintained a function to flag errors, which suspended incomplete or invalid services until staff corrected them.
- Staff verified data using internal error reports to confirm accuracy and completeness.
- Kings View finalized and submitted the cleaned Excel reports to DHCS, ensuring all indicators aligned with reporting requirements and DHCS standards.
- HSAG assessed Inyo's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Inyo and Kings View conducted quarterly reviews to assess compliance with network adequacy indicators and monitor consistency in reporting.
- Staff compared current data to prior reporting periods to identify discrepancies or trends in indicator values.
- Credible BI dashboards and internal reports were used to track errors, guide corrections, and validate data prior to final report submission.
- System access was controlled based on user roles, and over 450 permission levels ensured data access was limited to authorized personnel.
- Staff manually reviewed reports, leveraging the small dataset size to conduct detailed quality checks.
- When discrepancies were identified, staff corrected them in the EHR and reprocessed the data before submission.

HSAG identified no concerns with Inyo'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 Inyo 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 Inyo used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Inyo'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.14—Inyo 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	—	—	—
Non-Urgent Psychiatric Services—Adult (21+)	—	—	—
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Urgent Psychiatry—Children/Youth (0–20)	—	—	—
Urgent Psychiatry—Adult (21+)	—	—	—

Strengths, Opportunities for Improvement, and Recommendations

By assessing Inyo'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:** Inyo's Fiscal Team demonstrated strong oversight of provider data by actively tracking credential expiration dates and coordinating timely updates in Credible. Inyo's proactive monitoring, in collaboration with administrative staff, ensured provider credentials remained current, enhancing data integrity across provider profiles.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Inyo did not meet one or more DHCS standards for timely access indicators due to a failure to submit timely access data to DHCS for the reporting period.
  - **Recommendation #1:** HSAG recommends that Inyo 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 Inyo 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.

Kern County Behavioral Health and Recovery Services

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 MHP 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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.15—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	1,505	1,346	89%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	1,187	1,049	88%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	375	337	90%↑
Non-Urgent Psychiatric Services—Adult (21+)	621	486	**78%↓**
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	79	75	95%↑
Urgent Non-Psychiatry SMHS—Adult (21+)	114	105	92%↑
Urgent Psychiatry—Children/Youth (0–20)	13	S	S
Urgent Psychiatry—Adult (21+)	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 mental health 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

- **Opportunity #1:** Kern did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Kern 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 Kern 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.

Kings County Behavioral Health

ISCA Findings and Data Validity

HSAG completed an ISCA for Kings 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 Kings had in place to support network adequacy indicator reporting, which included the following findings:

- Kings used SmartCare as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Kings used Anasazi to maintain enrollment and provider network data.
- Kings used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to SmartCare from 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 migration data prior to importing to the system to ensure data were in the correct format.

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

- Kings had 10 programmers trained and capable of supporting network adequacy reporting activities. On average, programmers had approximately six years of experience in the field.
- 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 Kings' information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by Kings 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 Kings' enrollment system included the following findings:

- Enrollment and eligibility data for Kings were maintained in SmartCare.

- Kings received the MMEF from DHCS. Authorized users downloaded the MMEF from the DHCS portal approximately two days before the start of the new month. Files were securely transferred to a designated SFTP site and imported into SmartCare.
- Upon file import, SmartCare ran an automated overnight job to upload the MMEF and match records to existing members using first and last name, DOB, SSN, MEDS ID, and gender. If all data matched, member eligibility was automatically updated.
  - If any of the matching data points did not align, the record was flagged for manual review and correction by enrollment staff. SmartCare did not auto-create new members, and manual entry was required for new member enrollments.
  - Any member who had been previously discharged from MHP services and later returned was considered a new member for the purposes of initiating a new episode of care, which included completion of a new full assessment and tracking of timely access indicators. This approach ensured appropriate clinical reassessment and compliance with timely access indicators regardless of the length of time since the last episode, even if it had been less than one year.
  - Historical eligibility data were tracked using a table that retained up to 15 months of data.
- Members retained a unique member ID in SmartCare, which persisted through multiple enrollments and discharges. Authorized users could merge duplicate records when identified.
- Kings defined a new member as any Medi-Cal member who was not enrolled in treatment services at the time of the service request.
- Change authority to update enrollment data was role-restricted and granted to trained front-line staff, billing staff, and EHR administrators. All changes were tracked with user ID, date, and time stamps.

HSAG identified no concerns with Kings' 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 Kings to capture provider data and identified the following findings:

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

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

- Kings used SmartCare, Connex Interoperability, and CertifyOS to manage provider credentialing and network data.
- As part of the EHR transition, historical provider records revealed formatting discrepancies and missing licensure data. Kings completed extensive data validation and cleanup to meet SmartCare's requirements.
  - The provider onboarding process began with completion of credentialing in CertifyOS, including verification of NPI, taxonomy, license, and other required data. This information was then entered into SmartCare.
  - Kings' billing staff further validated provider records using sources such as the Department of Consumer Affairs, NPPES, and BBS.
- Providers submitted monthly updates via a standardized spreadsheet aligned with 274 reporting requirements. Updates included staffing changes, licensure renewals, demographic edits, and specialty or taxonomy updates.
- Kings required biannual recredentialing to ensure provider compliance with licensing, training, and performance standards. Expiring licenses were monitored and flagged for follow-up.
- Provider demographic data including spoken languages, licensure, gender, and contact information were stored and updated in SmartCare, and tracked for version history.
- Monthly, Kings' QI Team sent provider rosters to clinic managers for review. Updates were incorporated into the provider directory, which was posted on Kings' website.

HSAG identified no concerns with Kings' 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 Kings' delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Kings used SmartCare to track and extract data required for reporting for network adequacy indicators annually, or as requested by DHCS. Kings utilized the TADT for submitting timely access data to DHCS.

- SmartCare contained forms for capturing psychiatric and non-psychiatric service data required for network adequacy reporting. These forms included all necessary data fields for accurate and complete network adequacy submissions.
- The next step involved the QA Team conducting a comprehensive review to validate the data. This process required cross-checking provider types and appointment availability, and filling in any data that might have been missing.
- Once the validation process was complete, the QA Department prepared the finalized TADT for submission, following the designated guidelines from DHCS.
- HSAG assessed Kings' processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- The QA specialist flagged any missing information or non-compliance issues for review, and providers were required to verify and update their logs before returning the corrected data.
- After the TADT was submitted to DHCS, confirmation receipts or acknowledgment numbers were obtained and documented. A copy of the completed tool and any supporting records were maintained for compliance tracking and future reference.
- Each quarter, data related to timely access measures were reviewed with all providers during QIC meetings.
  - These reviews included discussions on emerging trends, identification of potential barriers contributing to negative outcomes, and opportunities for improvement. Time was also taken to acknowledge successes and highlight positive performance trends.

HSAG identified no concerns with Kings' 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 Kings 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 Kings used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Kings' **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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.16—Kings 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	233	210	90%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	95	90	95%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	70	70	100%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	16	14	88%↑
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	S	S	S

Strengths, Opportunities for Improvement, and Recommendations

By assessing Kings' 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:** Kings maintained thorough processes to ensure accurate and complete provider data, including the provider onboarding and credentialing process through CertifyOS, biannual recredentialing, and monthly outreach to clinic managers to review provider rosters.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Kings did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Kings 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 Kings 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.

Lake County Behavioral Health Services Department

ISCA Findings and Data Validity

HSAG completed an ISCA for Lake 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 Lake had in place to support network adequacy indicator reporting, which included the following findings:

- Lake used SmartCare as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Lake used Cerner to maintain enrollment and provider data.
- Lake 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.

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

- Lake had eight programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had approximately six years of experience in the field.
- 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 Lake's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by Lake 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 Lake's enrollment system included the following findings:

- Enrollment and eligibility data for Lake were maintained in SmartCare.

- Lake received the MMEF from DHCS. Monthly, an authorized user downloaded the MMEF from the DHCS portal, placed it in a SFTP folder, and imported it into SmartCare. SmartCare used the MMEF to automatically update eligibility records for Medi-Cal members.
- An automated matching process compared incoming eligibility data with existing records based on identifiers such as name, SSN, CIN, DOB, and gender.
  - If a full match was found, records were automatically updated. If discrepancies existed, records were flagged for manual review and reconciliation.
- Members retained a unique member ID in SmartCare across multiple enrollment spans, supporting long-term record continuity.
- Lake defined a new member as any Medi-Cal member who was not enrolled in treatment services at the time of the service request.
- Historical eligibility data remained available in SmartCare and were used to support monthly reconciliation.

HSAG identified no concerns with Lake'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 Lake to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in SmartCare.
- Credentialing was initiated via a submitted form which included license and credentialing information.
- Once the form was received, the Credentialing Team verified provider data utilizing the NPPES and California DCA BreEZe Online Services system.
- After verification, a ticket was submitted to the Business Software Analyst (BSA) Team to formally enter the provider into SmartCare. This process ensured all entries were traceable and handled by authorized staff.
- Only select users and designated team members had editing permissions in SmartCare for provider records. Most changes were processed through ticketed requests to maintain an audit trail.

- Lake conducted monthly reviews of provider credentials to confirm accuracy and compliance. If discrepancies or outdated information were identified, providers were contacted directly before updates were applied.
- Lake used both manual and system-generated tools to track provider edits and access.
- The SmartCare front-end displayed limited edit logs, showing only the most recent editor and timestamp. Full edit histories required SQL queries pulled from the back-end and were dependent on IT staff.
- Lake generated access reports internally that tracked which users accessed which screens (e.g., member or provider records). However, these logs did not specify the exact data that had been changed.
- Audit monitoring for provider data was on-demand at the time of the review. Lake had plans to implement monthly sampling audits to support compliance and improve oversight of data entry practices.

HSAG identified no concerns with Lake'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 Lake's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Lake used SmartCare to track and extract data required for reporting for network adequacy indicators. Lake utilized the TADT for submitting timely access data to DHCS.
- SmartCare contained forms for capturing psychiatric and non-psychiatric service data required for network adequacy reporting. These forms included all necessary data fields for accurate and complete network adequacy submissions.
- Once the client implementation coordinator completed the validation process, the finalized TADT was prepared for submission following the designated guidelines from DHCS.
- HSAG assessed Lake's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Lake actively monitored timely access data throughout the year and did not limit oversight to the annual TADT reporting period.
- Lake's Compliance Team met with the CalMHSA specialist weekly to discuss State reporting, including 274 updates, changes, and submissions. These meetings ensured the maintenance and auditing of EHR records and submission files.
- Additionally, Lake took advantage of CalMHSA's weekly knowledge-sharing sessions which focused on cross-training development and system continuity development.

HSAG identified no concerns with Lake'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 Lake 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 Lake used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Lake'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 the 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**").

Analysis and Conclusions

Table 3.17 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.17—Lake 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	69	64	93%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	162	151	93%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	25	25	100%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Non-Urgent Psychiatric Services—Adult (21+)	68	68	100%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	103	103	100%↑
Urgent Non-Psychiatry SMHS—Adult (21+)	295	295	100%↑
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	19	19	100%↑

Strengths, Opportunities for Improvement, and Recommendations

By assessing Lake'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:** Lake demonstrated strong data governance and system integrity by maintaining member eligibility and provider data in SmartCare using automated processes and controlled use access.

Opportunities for Improvement and Recommendations

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

Lassen County Health and Social Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Lassen 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 Lassen had in place to support network adequacy indicator reporting, which included the following findings:

- Lassen used Credible as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- Prior to this, Lassen used Cerner (Anasazi), FEI Systems, and ShareCare systems sequentially between 2021 and mid-2023.
- Lassen implemented appropriate testing and validation procedures to ensure accurate data migration from legacy systems to Credible.
  - The transition from FEI Systems to Cerner required manual data entry of services due to limited export capabilities in FEI Systems.
  - During the transition from Cerner to Credible, Kings View facilitated the data migration process, allowing the plan to upload demographic information and verify data integrity.
  - Kings View conducted internal testing to ensure no data loss occurred during the migration. Data from prior systems were retained in spreadsheets or PDF formats for historical reference.

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

- Lassen had one programmer trained and capable of supporting network adequacy reporting activities. The programmer had approximately five years of experience in the field.
- Kings View staff included six programmers trained and capable of using programming language and programs to support Credible. Kings View programmers had an average of 10 years of experience.

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

Enrollment System

HSAG evaluated the information systems and processes used by Lassen 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 Lassen's enrollment system included the following findings:

- Enrollment and eligibility data for Lassen were maintained in Credible.
- Lassen received the MMEF from DHCS, which was processed by Kings View and uploaded into Credible.
- At intake, administrative staff manually entered member demographics and eligibility information into Credible. Monthly eligibility checks were conducted for all active members by administrative/front office staff.
- Lassen defined a new member as any member who had not previously had a chart opened in either Cerner or Credible, or who had not received services since before 2022, unless he or she was identified as a returning member during registration.
- Members with a closed chart were required to complete a new registration and mental health assessment to re-enter services.
- Administrative staff scanned member eligibility ID cards into each member's chart in Credible, and member records were updated accordingly.
- Monthly reports showed all active members and their associated insurance IDs. These reports were used to identify eligibility updates or coordination needs with the local Medi-Cal office.
- Each member received a unique Credible ID, with historical IDs from previous systems retained in the chart for searchability and continuity.
- Member addresses were updated in real time in Credible, with the ability to track historical addresses. For members without a permanent address, placeholder values (e.g., general delivery or agency address) were used.

HSAG identified no concerns with Lassen'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 Lassen to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in Credible and in an internal tracking spreadsheet.

- The credentialing workflow was initiated with new hires being reported by Lassen leadership, who ensured all necessary steps were followed for proper credentialing. Lassen then collected provider information such as NPI, taxonomy, license, and insurance dates.
- The credentialing process involved manual verification of licenses monthly, utilizing sources such as the NPPES, California DCA BreEZe Online Services system, and EPLS/SAM. All verified information was then added to an internal spreadsheet and the provider's Credible profile.
  - Any changes to provider status (e.g., updated licensure or departure from the network) were documented in the internal spreadsheet. Providers who left the network were removed from active records, and historical logs were retained for compliance.
  - The monthly provider spreadsheet served as the basis for the DHCS 274 file submission, capturing essential network adequacy metrics such as full-time equivalents (FTEs), service specialties, caseload capacity, and languages spoken.
- Kings View collaborated with Lassen to ensure provider records in Credible aligned with 274 reporting and that directory data were updated in compliance with DHCS requirements.
- A defined exit process ensured timely deactivation of providers from both internal records and the EHR while maintaining historical logs for auditing.

HSAG identified no concerns with Lassen'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 Lassen's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Lassen utilized Credible to track data used to report network adequacy indicators annually, or as requested by DHCS. Lassen used the TADT for reporting timely access to DHCS.
- Lassen's timely access reporting process evolved significantly over time, transitioning from manual tracking methods to a more refined approach through the implementation of Credible.
- With the introduction of Credible BI, the forms used to track timely access data were integrated into the system, enhancing the efficiency and accuracy of data tracking.

- The Credible BI dashboards automatically captured essential metrics, such as the first contact made with members, the first appointment offered, and the first service rendered.
- The Credible BI dashboards provided insights into referral sources, urgency levels, delayed access, and more, allowing for a comprehensive understanding of service delivery.
- Credible had the ability to export data to CSV files, which were pre-formatted to meet the specifications set by DHCS. The responsibility for managing TADT submissions primarily fell to the Lassen analyst staff.
- HSAG assessed Lassen's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Internal oversight played a crucial role in the TADT process, and Lassen analyst staff regularly reviewed data as part of QA and QI workplans.
- Timeliness was tracked quarterly, and when performance issues were identified, they were addressed as agenda items or incorporated into performance improvement plans.
- To maintain transparency and accountability, archived TADT submissions were stored securely on Lassen's X drive in designated audit folders.

HSAG identified no concerns with Lassen'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 Lassen 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 Lassen used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Lassen'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 the 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**").

Analysis and Conclusions

Table 3.18 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.18—Lassen 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	24	24	100%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	69	69	100%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	19	18	95%↑
Non-Urgent Psychiatric Services—Adult (21+)	18	18	100%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	29	29	100%↑
Urgent Non-Psychiatry SMHS—Adult (21+)	61	61	100%↑
Urgent Psychiatry—Children/Youth (0–20)	S	S	S
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Lassen'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:** Lassen's real-time demographic changes, monthly manual eligibility checks, and historical ID tracking demonstrated strong system controls.

Opportunities for Improvement and Recommendations

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

Los Angeles County Department of Mental Health

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 the Integrated Behavioral Health Information System (IBHIS) as the database management system to collect and maintain enrollment and eligibility data.
- Los Angeles used the IBHIS and the Network Adequacy Provider and Practitioner Administration (NAPPA) tool to store and validate provider network and credentialing data.

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

- Los Angeles had a team of 31 programmers trained and capable of supporting network adequacy reporting activities. On average, programmers had approximately 15 years of experience in the field.

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 the IBHIS.
- Los Angeles received the MMEF from DHCS. Monthly, the MMEF was pulled from the DHCS site and imported into the IBHIS for processing.
- A second copy of the MMEF was stored in Los Angeles' data warehouse for use in reporting, reconciliation, and validation.
- Upon file import, financial eligibility staff reviewed the data and performed eligibility assignments in the IBHIS. Historical eligibility data were archived for trend analysis.

  - Discrepancies in Medi-Cal data were reconciled through communication with the Department of Public Social Services. Authorized personnel then reflected the updates in the IBHIS.
  - Members retained the same IBHIS ID at disenrollment and reenrollment. Address history and financial eligibility were tracked in structured IBHIS historical tables.
- Los Angeles defined a new member as someone who had not received services in 180 days.
- Eligibility breaks due to administrative disenrollment and reenrollment were handled using customized guarantor functionality in the IBHIS.
- Demographic and enrollment data could be updated by users with access to the IBHIS or via API from contracted providers.

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 demographic data were maintained in the IBHIS and NAPPA tool and were submitted through the Provider File Adjustment Request (PFAR) system.
- The PFAR system enabled structured workflows for new providers, updates, and changes. All PFAR requests were validated using multiple external sites such as the California Secretary of State, Dun & Bradstreet, geographic information system (GIS) for address validation, and the NPPES for NPI validation.
  - New providers were entered into the IBHIS following credentialing and cross-validation by IT staff. For practitioners, data entered in the NAPPA tool flowed into the IBHIS via real-time Web services.
  - Providers were required to report changes (e.g., staff updates, demographic changes, service additions) through the PFAR system manually. These updates were validated, tracked, and reflected in the IBHIS.
- Los Angeles used monthly exception reports to validate provider data consistency and accuracy, including license ID, NPI, and taxonomy code.

- All providers were expected to verify and update directory data annually. The provider directory included only actively contracted Medi-Cal providers.

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 data captured in the IBHIS to report network adequacy indicators annually, or as requested by DHCS. Los Angeles used the TADT for reporting timely access to DHCS.
- The TADT report process began with the Service Request Tracking System (SRTS) and the Service Request Log (SRL), which were used in the IBHIS and contracted provider EHR. These systems integrated via Web services, enabling data flow between contractors and the central system. As the starting point, these tools tracked requests for services, ensuring that all relevant service requests were properly documented.
- Once a request was logged, follow-up tracking was conducted through the CSI assessment record. This Web service monitored the progress and follow-up actions related to the initial service request. It played a critical role in evaluating psychiatry timeliness, ensuring that patient needs were met within appropriate time frames. Data for this assessment were gathered from the IBHIS, which handled directly operated services, as well as claims data from contractors, ensuring comprehensive tracking of service outcomes.
- The TADT process was complete once all necessary data were collected, verified, and analyzed. By integrating request tracking with follow-up assessments, the system ensured accurate reporting and compliance with service standards.
- Any identified discrepancies or delays were addressed through continuous monitoring, allowing for improvements in service efficiency and effectiveness.
- 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:

- The QA Team oversaw and monitored provider timeliness performance. Providers were categorized as "Meets Timeliness Standards" or "Does Not Meet Timeliness Standards" based on their ability to meet the 80 percent timeliness benchmark across different request types, including routine, urgent, and jail/hospital discharge.
- Providers with 70–79 percent timeliness received email notifications from QA informing them of their status, while providers falling below 70 percent were required to submit a CAP.
- CAP responses were reviewed to ensure that solutions, action steps, and expected implementation dates were clearly identified.
- For providers failing to meet timeliness standards over multiple quarters or submitting incomplete CAPs, the QA Team initiated technical assistance meetings to collaboratively review data, identify trends or data entry errors, and develop solutions to improve performance.

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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.19—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	5,426	4,112	**76%↓**
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	9,758	9,046	93%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	103	66	**64%↓**
Non-Urgent Psychiatric Services—Adult (21+)	1,000	662	**66%↓**
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	1,109	991	89%↑
Urgent Non-Psychiatry SMHS—Adult (21+)	2,220	2,094	94%↑
Urgent Psychiatry—Children/Youth (0–20)	S	S	S
Urgent Psychiatry—Adult (21+)	15	13	87%↑

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 demonstrated commitment to provider collaboration through proactive support and rigorous follow-up on CAPs regarding timely access data.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Los Angeles did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Los Angeles 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 Los Angeles 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.

Madera County Behavioral Health Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Madera 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 Madera had in place to support network adequacy indicator reporting, which included the following findings:

- Madera used InSync Health Care Solutions (InSync) as the database management system to collect and maintain enrollment and provider data.

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

- Madera's QA Team was responsible for timely access reporting and oversight.

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

Enrollment System

HSAG evaluated the information systems and processes used by Madera 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 Madera's enrollment system included the following findings:

- Enrollment and eligibility data for Madera were maintained in InSync.
- Madera received eligibility data from DHCS through two primary sources:
  - Real-time verification in InSync, which allowed immediate verification of member eligibility.
  - MMEF, which the Medical Records Unit downloaded for ongoing eligibility verification and retroactive reconciliation, covering a 15-month eligibility lookback period.
- Madera did not upload the MMEF into InSync automatically but performed manual verification and reconciliation using a centralized process. Staff validated eligibility using the MMEF and directly contacted DHCS for further confirmation as needed.
  - Each new member was manually checked against the InSync database using name, DOB, and SSN to prevent duplication. Once verified, the system auto-generated a unique internal member ID.

  - InSync maintained both the state-issued Medi-Cal ID and an internally generated member ID. If the 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. Staff updated records based on verified information or guided members to DHCS for official changes. Updates to addresses or other demographic fields were stored in InSync and tracked in the InSync system.
- Additionally, the InSync system maintained a real-time eligibility verification function, which allowed immediate verification of member eligibility.
- Madera identified a new member as an individual who contacted Madera to begin or restart services and completed an intake for a mental health assessment to determine eligibility, regardless of funding source or lack thereof.
- Staff with appropriate access permissions, including medical records, crisis response, QA personnel, and clinical supervisors, were authorized to make manual edits to member enrollment records. All changes were logged into InSync, capturing the user, timestamp, and type of modification.
- Madera emphasized that the system employed required fields and default values to prevent incomplete data entries. QA audits of member records were conducted monthly to validate data accuracy and completeness, with discrepancies resolved through coordination with internal teams and DHCS.

HSAG identified no concerns with Madera'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 Madera to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in InSync.
- New providers were onboarded through a structured process that included credentialing and data entry within InSync.
  - The credentialing process verified licenses and certifications using multiple primary sources, including the DEA license search, NPPES, OIG LEIE, and the NPDB.

  - Provider profiles included essential data such as license numbers, taxonomy, NPI, and assigned practice locations. These profiles were updated upon completion of the credentialing process and assignment to specific programs.
  - Madera used the resource tab in InSync to capture detailed provider data required for 274 reporting, including service type, population served, and practice location. The resource tab also stored the provider's assigned facilities and primary practice sites.
- Provider profiles in InSync included a history of changes, including license updates and demographic edits. Staff with access to these profiles included credentialing staff, QA personnel, and clinical supervisors, with each update logged for accountability.
- QA staff tracked license expiration dates internally using Excel spreadsheets, with monthly reviews conducted to ensure timely updates.
- Access to provider data was restricted to authorized personnel to reduce the risk of unauthorized modifications, with all changes logged for accountability.
- Provider contract terminations were managed through an internal Move, Add, Change (MAC) form, which was completed by HR and distributed to relevant supervisors, managers, and the QA Team.

HSAG identified no concerns with Madera'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 Madera's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Madera's timely access data collection process involved capturing member contact and appointment data through dynamic forms within InSync.
- At the point of member intake, front desk staff entered critical data, including initial contact date, assessment attendance, and follow-up appointment details into the system. The data were recorded in real time to ensure accurate tracking of member engagement and timeliness compliance.
- The timely access forms captured multiple data points, including CIN, MRN, DOB, and appointment information, which were pre-populated based on the member's existing

demographic record. Manual entries included appointment dates and follow-up notes, which were monitored daily for accuracy.
  - Data from these forms were aggregated through a dynamic reporting function in InSync, which extracted key metrics into an Excel spreadsheet for further analysis.
  - This process included automatic population of basic demographic details, while more complex fields, such as follow-up status and disposition codes, were manually reviewed for completeness.
- The QA Team conducted daily data checks to validate entries, identify potential discrepancies, and correct errors before the data were finalized for reporting. These reviews focused on ensuring accurate CIN matching and minimizing year-to-year data entry errors.
- Once extracted, the data were reviewed for completeness and consistency. Any discrepancies identified during this process were addressed promptly, ensuring that the final reports aligned with DHCS requirements.
- HSAG assessed Madera's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Madera conducted ongoing oversight of timely access data to ensure compliance with DHCS requirements.
- Front desk staff generated weekly reports to track timely access to care, including 10- and 15-day appointment benchmarks.
- Clinical supervisors received regular reminders when member appointments approached compliance thresholds, allowing for proactive scheduling adjustments.
- Training was provided to front desk staff, clinical supervisors, and division managers to reinforce the importance of timely access and compliance with DHCS standards.
- The QA Team conducted periodic data audits to identify potential gaps in appointment availability and ensure that all data entry accurately reflected member interactions.
- In response to emerging access challenges, Madera staff collaborated across departments to adjust schedules, increase appointment slots, and address potential delays in care delivery.

HSAG identified no concerns with Madera'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 Madera 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 Madera used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Madera'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.20—Madera 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	328	317	97%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	297	294	99%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	48	48	100%↑
Non-Urgent Psychiatric Services—Adult (21+)	118	117	99%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	S	S	S

Strengths, Opportunities for Improvement, and Recommendations

By assessing Madera'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:** Madera demonstrated a proactive approach to monitoring timely access data through a combination of real-time data entry, daily QA validations, and structured reporting mechanisms. Madera's use of network adequacy reporting tools within InSync, regular benchmark tracking, and cross-departmental collaboration helped identify and resolve emerging access barriers.

Opportunities for Improvement and Recommendations

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

Marin County Behavioral Health and Recovery Services

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 Clinician's Gateway and ShareCare to maintain enrollment and provider data.
- Marin conducted appropriate testing and validation methods to ensure completeness and accuracy of data migrated from Clinician's Gateway and ShareCare 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 legacy and test systems.
  - 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 RTE 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 member who was open to no other programs within the behavioral health plan (BHP) system for non-psychiatric services, or any member newly requesting services for psychiatric services.

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 required monthly submissions of contracted provider rosters. Submitted rosters were compared with SmartCare information to ensure data matched.

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.

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. Monthly, Marin reviewed provider compliance with timely access standards to monitor any changes in provider accessibility.

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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.21—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	52	45	87%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	0	0	ZU
Non-Urgent Psychiatric Services—Adult (21+)	0	0	ZU
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

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.

Mariposa County Human Services, Behavioral Health & Recovery Services Division

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 (POS) 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.

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 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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.22—Mariposa 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	24	21	88%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	45	40	89%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

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.

Mendocino County Mental Health

ISCA Findings and Data Validity

HSAG completed an ISCA for Mendocino 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 Mendocino had in place to support network adequacy indicator reporting, which included the following findings:

- Mendocino used myAvatar as the database management system to collect and maintain enrollment and eligibility data.
- Mendocino used Exym, myAvatar, and Credible database systems to store data related to provider credentialing.

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

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

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

Enrollment System

HSAG evaluated the information systems and processes used by Mendocino 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 Mendocino's enrollment system included the following findings:

- Enrollment and eligibility data for Mendocino were maintained in myAvatar.
- Mendocino received the MMEF from DHCS. These files contained key demographic details and Medi-Cal eligibility status, which were imported into myAvatar.
- Contracted providers collected member demographic and financial data during intake, typically using paper-based forms such as Uniform Method of Determining Ability to Pay (UMDAP), which included details like SSNs, CINs, and other applicable information. The data were either documented in the provider's own EHR system or manually submitted for entry into one of the county's maintained systems (myAvatar, Credible or Exym) depending on the provider's workflow and system integration.

- Once the data were collected, Mendocino's QA Department verified eligibility information through MEDSLITE. MEDSLITE served as the official source for confirming Medi-Cal enrollment. Verification occurred during initial intake and was repeated monthly to maintain current eligibility status.
- Mendocino's fiscal department was responsible for identifying discrepancies between the MMEF and member records maintained in myAvatar. Eligibility was validated monthly, and contracted providers assisted with ensuring member data remained active.
- Providers conducted monthly manual checks to ensure members remained eligible for services. Mendocino's fiscal department, which maintained change authority over member records in the EHR, ensured proper version control and oversaw all updates.
- In situations where Medi-Cal eligibility was suspended, such as administrative disenrollments followed by immediate reenrollment, services were still provided to members. These services were later billed retroactively once eligibility was reinstated.
- Mendocino defined a new member as someone brand new to services or someone previously closed to services who was readmitted.
- Each member was assigned a unique identification number upon enrollment, which remained consistent over time and was used for all claims and internal tracking. This assignment supported accurate longitudinal data management.
- Enrollment and eligibility data were processed in monthly batch runs. Manual spot checks and routine audits were conducted to verify data integrity and completeness prior to submission for network adequacy reporting.

HSAG identified no concerns with Mendocino'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 Mendocino to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in Exym, myAvatar, and Credible systems.
- Providers submitted an Excel file monthly containing details about their FTEs, group and site information, and provider specifics. The data were first verified by the providers, then cross-checked against the NPPES to identify discrepancies in NPIs and taxonomies. Once

verified, the data were entered into myAvatar by the QA and IS departments and used to populate 274 forms, which were compiled into a generic data (DAT) file for processing.

- The completed DAT file was sent to DHCS for reconciliation, ensuring provider data aligned with DHCS records. DHCS returned a response file, which was reviewed to identify and correct discrepancies.
- Provider credentialing data were maintained in myAvatar, linking key information like NPI and taxonomy to individual provider profiles. When a new provider was hired, the provider's credentials were verified against multiple databases, including the Social Security Administration's Death Master File and OIG LEIE, to confirm the validity of licenses and NPI's before being approved for processing.
- Any changes in provider data were updated in the system using a credentialing form. Providers submitted their updated forms via email with all necessary attachments. The QA Department was responsible for ensuring updates were accurately reflected in myAvatar, maintaining data integrity across all provider profiles.

HSAG identified no concerns with Mendocino'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 Mendocino's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- The TADT report process began with providers submitting their referral data to the QA Team for the designated reporting period each month. These submissions were sent as password-protected Excel spreadsheets to Mendocino through SharePoint or email, ensuring data security. Upon receipt, the files were saved without any modifications to preserve their original integrity.
- Once collected, the data were copied and pasted into a master Excel file, which served as a central repository for analysis.
- To facilitate report generation, data relevant to the current reporting period were moved to a separate sheet within the master file. Minimal modifications were made, such as adjusting

CINs to the correct nine-character format and standardizing free-form responses into predefined categories for consistency.

- After adjustments were made, data from the updated monthly sheet were used to create reports. Additional refinements, such as further CIN corrections and standardization of appointment response formats, were performed as needed. Reports and visual graphs were then generated from an Excel spreadsheet, which pulled data directly from the adjusted monthly dataset.
- The QA Department reviewed data accuracy before submission, and corrections were made based on internal checks to ensure data were completely and accurately merged.
- Once finalized, the completed TADT was submitted to DHCS, ensuring that all timely access data were accurately reported and aligned with DHCS standards.
- HSAG assessed Mendocino's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Reports were generated monthly, and timeliness was monitored throughout the month.
- Mendocino QA and IS departments conducted comparisons to prior reports and used an internal tracking spreadsheet to review and address trends.
- Data were regularly compared with Crisis Unit reports to ensure consistency and accuracy.
- Subcommittees met monthly to address discrepancies, and specific instances requiring clarification were addressed directly with the providers through chart reviews or additional data requests.

HSAG identified no concerns with Mendocino'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 Mendocino 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 Mendocino used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Mendocino'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.23—Mendocino 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	216	202	94%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	291	284	98%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	26	22	85%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	32	32	100%↑
Urgent Non-Psychiatry SMHS—Adult (21+)	86	86	100%↑
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Mendocino'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:** Mendocino demonstrated strong coordination across departments to ensure accurate and timely enrollment and eligibility data management. The use of multiple verification tools such as MEDSLITE and myAvatar, and manual cross-checks enabled Mendocino to consistently identify and resolve discrepancies in a timely manner.

Opportunities for Improvement and Recommendations

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

Merced County Behavioral Health and Recovery Services

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.
- Behavioral Health and Recovery Services (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 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.
- Non-psychiatric visits were typically initiated through Merced's 24/7 Access Team, which attempted to schedule appointments with a non-psychiatric provider at the time of contact.
- 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.
- Psychiatric appointments were generally initiated following a psychiatrist's initial referral review.
- 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 key performance indicator under Merced's QI workplan. The QIC evaluated the appointment scheduling process to assess barriers to compliance with timely access indicators. Merced identified QI efforts piloting the use of mental health assistants to reduce scheduling barriers.
- 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 service type.

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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.24—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	87	83	95%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	133	132	99%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	42	42	100%↑
Non-Urgent Psychiatric Services—Adult (21+)	98	98	100%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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

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

Modoc County Behavioral Health Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Modoc 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 Modoc had in place to support network adequacy indicator reporting, which included the following findings:

- Modoc used Credible as the database management system to maintain enrollment and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Modoc used Anasazi to maintain enrollment and provider data.
- Kings View performed thorough cross-checks between the legacy EHR and new EHR to identify any data discrepancies that may have occurred during the migration. The team compared migrated data against the original source to confirm that all relevant information was accurately transferred. Comprehensive testing was conducted to ensure the success and integrity of migrated data.
- Modoc validated migrated data to ensure accuracy and completeness both prior to and after migration.
- Kings View and Modoc staff retained access to Anasazi for historical reference.

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

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

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

Enrollment System

HSAG evaluated the information systems and processes used by Modoc 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 Modoc's enrollment system included the following findings:

- Enrollment and eligibility data for Modoc were maintained in Credible.
- Modoc received the MMEF from DHCS, which was downloaded by Kings View monthly and uploaded into Credible to update enrollment and eligibility information. Once the upload was complete, Modoc was notified. The MMEF included eligibility history for the previous

15 months. Modoc also utilized MEDSLITE to verify member eligibility during enrollment, as needed, and monthly through the MMEF process.

- Modoc conducted monthly reconciliations 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. Modoc 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.
- Modoc defined a new member as a Medi-Cal member who had not previously sought services within Modoc's system of care. If an existing member returned after his or her case was closed, the case was reopened and the member was not considered a new member.
- Modoc updated address and phone number changes received from members in Credible, and members were advised to contact DHCS directly to ensure their records remained up to date.

HSAG identified no concerns with Modoc'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 Modoc to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in Credible.
- Modoc's procedures for updating and maintaining provider data included:
  - Providers were required to submit a credentialing application to Modoc. Administrative staff reviewed the application and conducted credential verification upon hire and monthly, which involved confirming licensure status and checking for sanctions or disciplinary actions across multiple national databases including the NPPES, California DCA BreEZe Online Services system, OIG LEIE, and EPLS/SAM.
  - Recredentialing was performed every three years, at a minimum. After verification, Kings View staff manually entered the provider's information into Credible.

  - Kings View received provider data files quarterly for integration into 274 files, ensuring proper formatting, structure, and content compliance.
- Modoc required its provider network to update provider data annually and as changes occurred. Providers were made aware of this expectation during the onboarding process.

HSAG identified no concerns with Modoc'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 Modoc's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Modoc utilized Credible to track and extract data for reporting timely access network adequacy indicators. Modoc used the TADT to report timely access to DHCS. The TADT was submitted annually, or as requested by DHCS.
- Modoc used Credible-maintained forms to track timely access to services, which included outpatient, psychiatric, and non-psychiatric care. The Access Team documented timeliness in Credible when members requested services, and an assessment was conducted to screen members for services. Urgent requests were tracked.
- Prior to July 1, 2023, Modoc used Anasazi to report timely access. Anasazi contained a CSI form utilized for tracking timely access data used for DHCS reporting. Modoc completed a manual review to validate data and formatting prior to submission.
- Modoc contracted with Innovative Development and Evaluation Associates (I.D.E.A.) Consulting to analyze timely access data using access logs provided by Modoc and data exports from Credible. After I.D.E.A. compiled timeliness data, Modoc validated the analysis by reviewing member charts for individuals without a CIN, who either did not begin treatment or failed to meet timely access standards. If any issues were identified during the review, Modoc collaborated with I.D.E.A. to address concerns and make any necessary adjustments to the analysis.
- Modoc's director, in partnership with the QI coordinator, was responsible for overseeing and maintaining timely access standards and ensuring compliance with reporting requirements. The QI coordinator continuously monitored timely access standards and reported any issues or areas of non-compliance to the director.

- Modoc performed data quality checks to ensure the accuracy of its network adequacy reporting programs by identifying and investigating data outliers and conducting month-to-month data comparisons.
- Modoc archived all reports submitted to DHCS on a shared drive for historical reference.
- HSAG assessed Modoc's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Modoc conducted an annual review of the TADT analysis results with its QIC. Additionally, Modoc reviewed quarterly timeliness reports provided by I.D.E.A. to monitor the data and make necessary adjustments to referral and intake processes.
- Modoc continued ongoing efforts to implement automated validation features in Credible to ensure accuracy and completeness of data used for timely access reporting.
- Any gaps identified in Modoc's network adequacy indicator performance against DHCS' indicator-level contract requirements were tracked and monitored by Modoc's QI Team. Modoc did not have any identified gaps during the reporting period.

HSAG identified no concerns with Modoc'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 Modoc 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 Modoc used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Modoc'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.25—Modoc 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	18	18	100%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	S	S	S
Urgent Psychiatry—Adult (21+)	S	S	S

Strengths, Opportunities for Improvement, and Recommendations

By assessing Modoc'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:** Modoc conducted ongoing review and analysis of timely access data, and performed quality checks and month-to-month comparisons to ensure accuracy of timeliness data.

Opportunities for Improvement and Recommendations

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

Mono County Behavioral Health

ISCA Findings and Data Validity

HSAG completed an ISCA for Mono 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 Mono had in place to support network adequacy indicator reporting, which included the following findings:

- Mono used SmartCare as the database management system to maintain enrollment and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Mono used Sharecare and Echo to maintain enrollment and provider data.
- Mono manually performed the data conversion using standardized spreadsheets supplied by CalMHSA. Multiple test runs were conducted to ensure data accuracy and alignment. Throughout the process, CalMHSA generated reports to identify any discrepancies or issues related to the data conversion.
  - Mono staff retained access to Sharecare and Echo for historical reference.

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

- Mono had three programmers with an average of seven years of experience in the field.
- CalMHSA had three programmers with an average of six years of experience in the field.

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

Enrollment System

HSAG evaluated the information systems and processes used by Mono 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 Mono's enrollment system included the following findings:

- Enrollment and eligibility data for Mono were maintained in SmartCare.
- Mono 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.

- Mono also monitored member eligibility through SmartCare's 270/271 RTE functionality. When a member reported a change in eligibility status, staff used the 270/271 process to verify the update. Additionally, the 270/271 process was used to enter end dates for Medi-Cal eligibility.
- Mono conducted monthly reconciliation between SmartCare and the MMEF using a 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. Mono's fiscal and technical support specialist flagged and corrected any inconsistencies.
- SmartCare captured and maintained both the state-issued Medi-Cal ID and a system-generated member ID to uniquely identify members.
- Mono defined a new member as a new Medi-Cal member receiving services with Mono or a returning member who had not been seen in three months.
- Mono performed a demographic clean-up every three months, during which clinicians and front office staff reviewed member information on file in SmartCare with members and updated any relevant details. Additionally, during routine interactions, staff updated member information as needed and directed members to contact their caseworker to ensure their records were fully updated with DHCS.

HSAG identified no concerns with Mono'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 Mono to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in SmartCare.
- Mono's procedures for updating and maintaining provider data included:
  - Mono's program manager and QA coordinator verified staff credentials at the time of employment. Provider information was updated as changes occurred or at least once every three years during the recredentialing process.
  - Mono used OIG Compliance NOW in collaboration with national databases including the Social Security Administration's Death Master File, OIG LEIE, EPLS/SAM, and the DHCS S&I Provider List to verify licensure and identify any sanctions or disciplinary actions. These verifications were conducted at the time of hire and monthly.

  - Mono QA staff entered provider information into SmartCare once it was verified.
- Mono required its provider network to update provider data immediately as changes occurred, and every three years during recredentialing. Providers were made aware of this expectation during the onboarding process.

HSAG identified no concerns with Mono'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 Mono's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Mono utilized SmartCare to track and extract data for reporting timely access network adequacy indicators. Mono used the TADT to report timely access to DHCS. The TADT was submitted annually, or as requested by DHCS.
- Due to Mono's relatively low member volume, a Staff Services analyst completed the TADT manually using data from the inquiries and services screens in SmartCare, which generally included fewer than 100 members. Once completed, the data were manually verified by cross-referencing against registration and tele-psych logs to detect anomalies or discrepancies. Any discrepancies were reviewed and corrected prior to submission.
- Mono's program manager and Staff Services analyst were responsible for the oversight of timely access reporting compliance.
- TADT submissions were saved on internal drives for historical reference and labeled by date to maintain version control.
- To ensure continuity of network adequacy indicator production, Mono 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 to ensure continuity of services were maintained.
- Prior to July 1, 2023, Mono used the Sharecare system to track and report timely access. Data were extracted from CSI data in Sharecare and manually reviewed prior to submission to DHCS.
- HSAG assessed Mono's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Mono's program manager and Staff Services analyst were responsible for the oversight of timely access reporting compliance, and TADTs were monitored semiannually to review performance.

HSAG identified no concerns with Mono'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 Mono 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 Mono used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Mono'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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.26—Mono 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Mono'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:** Mono demonstrated its ability to maintain accurate and complete enrollment and eligibility information by conducting review and clean-up of member data every three months to identify and correct discrepancies in SmartCare.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Mono manually prepared TADT submissions and did not utilize SmartCare's embedded reporting functions.
  - **Recommendation:** HSAG recommends that Mono explore the utilization of SmartCare's embedded reporting functions to minimize manual entry of timely access reporting data, which may increase efficiency and reduce potential data entry errors.
- **Opportunity #2:** Mono 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 Mono 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 Mono 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.

Monterey County Behavioral Health

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 mental health 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 psychiatry and outpatient 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 the 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 3.27 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.27—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	52	44	85%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	111	89	80%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	0	0	ZU
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

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

- **Opportunity #1:** Monterey did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Monterey 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 Monterey 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.

Napa County Health and Human Services Agency

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 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 (HHSA) 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 Psychiatric Referral Logs, which were completed by the HHSA Access Team, Crisis Team, or administrative staff. Assessments were used to determine service criteria, and urgent service requests were recorded in both logs.
- Napa's Behavioral Health Plan (BHP) Access staff used a formula from the Smartsheet database and the Psychiatric Referral Log 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 did not have any identified gaps during the reporting period.

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 the 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 3.28 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.28—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	59	54	92%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	34	34	100%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	15	15	100%↑
Non-Urgent Psychiatric Services—Adult (21+)	39	35	90%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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

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

Nevada County Behavioral Health

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. Members who requested mental health services were administered the Medi-Cal screening tool.
- If the screening tool resulted in a recommendation for MCP care, Nevada's Access staff facilitated a referral to the MCP and offered the member an assessment appointment within appropriate timeliness standards.
- The Nevada County Behavioral Health Access Team determined if medical necessity had been met according to the assessment and either referred the member to follow-up and/or ongoing care in Nevada County or facilitated a referral to the MCP.
- Nevada defined a new member as an individual who had not previously received 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 NPPES. 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. Providers with BH licenses were verified through the California DCA BreEZe Online Services system for license activation and expiration.
  - 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, California Consortium of Addiction Programs and Professionals (CCAPP), California Association of DUI [Driving Under the Influence] Treatment Programs (CADTP), and California Association for Alcohol/Drug Educators (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 (BHQA) 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 CalAIM Assessment or American Society of Addiction Medicine (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 MHP 274 data quality checks, as well as fluctuations in FTEs of key provider groups (e.g., psychiatry) 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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.29—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	60	60	100%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	0	0	ZU
Non-Urgent Psychiatric Services—Adult (21+)	12	12	100%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

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.
- **Opportunity #2:** Nevada did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Nevada 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 Nevada 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.

Orange County Behavioral Health Services

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 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 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) and IRIS (Cerner) extract access records to report routine and urgent appointments. IRIS (Cerner) contained a reports function that analysts used to query a pre-programming graphic user interface. IRIS (Cerner) extracts were merged with contractor monthly appointment log submissions to obtain psychiatry appointment data. 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. Appointments labeled as urgent were identified, and calendar days were translated into hours. 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 (CQIC) 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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.30—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	1,182	1,170	99%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	1,823	1,719	94%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	96	82	85%↑
Non-Urgent Psychiatric Services—Adult (21+)	144	122	85%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	56	50	89%↑
Urgent Non-Psychiatry SMHS—Adult (21+)	35	30	86%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

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.

County of Placer, Department of Health and Human Services

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 outpatient, psychiatric, and non-psychiatric services. 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 mental health non-psychiatric SMHS timeliness record or the mental health psychiatric SMHS 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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.31—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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

- **Opportunity #1:** Placer 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 Placer 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 Placer 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.

Plumas County Mental Health Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Plumas 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 Plumas had in place to support network adequacy indicator reporting, which included the following findings:

- Plumas used Credible as the database management system to maintain enrollment and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Plumas used Anasazi to maintain enrollment and provider data.
- Kings View performed thorough cross-checks between the legacy EHR and the new EHR to identify any data discrepancies that may have occurred during the migration. The team compared migrated data against the original source to confirm all relevant information was accurately transferred. Comprehensive testing was conducted to ensure the success and integrity of migrated data.
- Plumas staff retained access to Anasazi for historical reference.

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

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

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

Enrollment System

HSAG evaluated the information systems and processes used by Plumas 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 Plumas' enrollment system included the following findings:

- Enrollment and eligibility data for Plumas were maintained in Credible.

- Plumas received the MMEF from DHCS, which was downloaded by Kings View monthly and uploaded into Credible to update enrollment and eligibility information. Once the upload was complete, Plumas was notified. The MMEF included eligibility history for the previous 15 months. Plumas also utilized MEDSLITE to verify member eligibility during enrollment, as needed, and monthly through the MMEF process.
- Plumas 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. Plumas 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.
- Plumas defined a new member as either a new Medi-Cal recipient requesting services or a previously discharged member who was reopened in the system, regardless of the length of time since discharge.
- Plumas updated demographic information in Credible using data from the MMEF and member-provided details. Monthly member service information was submitted to DHCS, and members were advised to contact DHCS directly to ensure their records remained up to date.

HSAG identified no concerns with Plumas' 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 Plumas to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in Credible.
- Plumas' procedures for updating and maintaining provider data included:
  - Providers submitted an application to Plumas' HR Department upon hire, which HR screened.
- Plumas conducted credential verification at the time of hire and monthly, using EPStaffCheck to confirm licensure status and identify any sanctions or disciplinary actions.

Verifications were completed across multiple national databases, including the NPPES, DEA, California DCA BreEZe Online Services system, OIG LEIE, and EPLS/SAM.

- A Plumas systems analyst manually entered provider data into Credible once the data were verified.
- Plumas required its provider network to update provider data as changes occurred, and every three years during recredentialing. Providers were made aware of this expectation during the onboarding process.

HSAG identified no concerns with Plumas' 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 Plumas' delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Plumas utilized Credible to track and extract data for reporting timely access network adequacy indicators. Plumas used the TADT to report timely access to DHCS. The TADT was submitted annually, or as requested by DHCS.
- Plumas used Credible-maintained forms to track timely access to services, which included outpatient, psychiatric, and non-psychiatric care. The Access Team documented timeliness in Credible when members requested services, and an assessment was conducted to screen members for services.
- Data from Credible were integrated into a dashboard, reviewed for errors, and discussed by the Plumas Quality Assurance Team weekly, monthly, and quarterly prior to submission to DHCS. Kings View staff checked the data for missing entries and reviewed them prior to submission. Plumas manually reported all required data elements on the TADT based on data captured using the TADT form in Credible.
- Prior to July 1, 2023, Plumas used Anasazi to track and report timely access. Anasazi contained a CSI form utilized for tracking timely access data used for DHCS reporting, and Kings View provided dashboard services to validate accuracy of data.
- Plumas' Utilization Committee was responsible for submitting timely access reports to DHCS. Reports were labeled by date and stored on shared drives for historical reference.

- HSAG assessed Plumas' processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Plumas ran timely access reports twice a week, utilized a dashboard, and conducted monthly meetings with the Utilization Management Committee to discuss performance.
- Any gaps identified in Plumas' network adequacy indicator performance against DHCS' indicator-level contract requirements were tracked and monitored by Plumas' Utilization Management Committee to determine a plan of action, including provider recruitment efforts.
- Plumas acknowledged a low volume of new service requests, which led to a few requests falling outside of timeliness requirements. Due to the limited sample size, these cases had a significant impact on overall compliance percentages. To address the identified issues, staff received refresher training on the process for triaging urgent requests.

HSAG identified no concerns with Plumas' 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 Plumas 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 Plumas used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Plumas' **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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.32—Plumas 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Plumas' 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:** Plumas demonstrated thorough oversight and monitoring of timely access reporting by utilizing various dashboards and reports within Credible, as well as through monthly Quality Assurance Team meetings to review performance and promptly address identified issues or concerns.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Plumas did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Plumas 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 Plumas 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.

Riverside County Mental Health Services

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 mental health 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.
- Practitioners determined medical necessity through a clinical assessment and referred members to the MCP if it was determined that the member did not require SMHS.
- A mental health screening would be administered by the MCP and the patient referred to Riverside's SMHS. Screening information was collected in the EHR on the adult/youth mental health screening form. Screenings conducted by the MCP were uploaded as scanned documents by Riverside's Central Access Unit (CARES) staff; in accordance with DHCS requirements, the adult/youth mental health screening form could be completed by trained clinical or non-clinical staff.
- Riverside defined an urgent condition as a situation experienced by a member who, without timely intervention, would highly likely result in an immediate emergency psychiatric condition. An urgent appointment meant that health care was provided to a member when the member's 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.
- 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 NPPES 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 NPPES. 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 triennially. 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. For the MHP, timely access data were entered into a form that included nearly all the data elements of the TADT, including the date of the request, offered appointments, referral source, and closure reasons. Urgent offered and attended appointments were not exclusively documented in the timely access form. To find urgent appointments, billing records and care communication log entries (i.e., documented offering of crisis services) were used as supplemental data sources. The timely access form included all required elements for non-urgent appointments.

- Riverside used a series of SQL stored procedures in the EHR SQL Server data warehouse to generate SQL tables for the MHP 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 (RUHS-BH) 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 the 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 service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.33—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	592	535	90%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	374	341	91%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	89	83	93%↑
Non-Urgent Psychiatric Services—Adult (21+)	30	27	90%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	11	11	100%↑
Urgent Psychiatry—Children/Youth (0–20)	S	S	S
Urgent Psychiatry—Adult (21+)	S	S	S

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 MHP 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.

Sacramento County Behavioral Health Services

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 used myAvatar to maintain enrollment and provider data.
- Sacramento migrated specific data to SmartCare's testing environment, where both Sacramento and CalMHSA conducted smoke testing to verify the success of the migration. Once validated, the data were then migrated to the live environment, with all data successfully transferred.
- Sacramento's contracted providers and county administrative teams retained access to myAvatar for historical reference.
- Sacramento relied on SmartCare for timely access reporting and did not use any data from myAvatar for this purpose.

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

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, which was imported into SmartCare monthly. Sacramento currently does not use the MMEF to populate member eligibility data in SmartCare and has disabled the 270/271 functionality due to delays in receiving timely eligibility information.
- Providers used the Medi-Cal Provider Portal or MEDSLITE to verify member eligibility before each visit or as needed, and entered eligibility information into SmartCare. Sacramento conducted monthly eligibility verifications and performed additional checks prior to appointments or when investigating claim issues, using the Medi-Cal Eligibility Line or the MEDSLITE portal.
- Sacramento conducted monthly reconciliation between SmartCare and the MMEF using a SmartCare MMEF check report. The report compared member data in SmartCare with information from the MMEF, and identified discrepancies in name, DOB, or SSN. Contracted providers and county staff flagged and corrected any inconsistencies.
- Sacramento used a program demographics report to identify members with incomplete address information.
- Sacramento identified potential duplicate cases based on reports from end users. The Billing Team validated these cases by reviewing them in MEDSLITE. Once confirmed as a duplicate, 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.
- Sacramento defined a new member as any Medi-Cal member requesting a BH service who was not served within the last 12 months.
- Sacramento 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 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's procedures for updating and maintaining provider data included:
  - Sacramento's QM Team verified staff credentials at the time of employment. Provider information was updated as changes occurred or at least once every three years during the recredentialing process.
  - Providers were required to submit a Staff Registration/Credentialing Application to the QM Team upon hire and as updates were needed.
  - Licensed staff were required to enroll in the DHCS PAVE system.
  - Sacramento performed credential verification upon hire and monthly, utilizing national databases such as the NPPES, DEA, OIG LEIE, EPLS/SAM, and NPDB to confirm licensure and identify any sanctions or disciplinary actions.
  - Once verified, staff registration details were entered into SmartCare. This process required collaborative data entry by both the QM Team and Sacramento's EHR Team.
- Sacramento required providers to submit staff rosters monthly to ensure accurate and up-to-date information. Providers were expected to update their details both monthly and when changes occurred. This requirement was communicated through the monthly roster submission process.

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.

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 utilized SmartCare to track and extract data for reporting timely access network adequacy indicators. Sacramento 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 outpatient, psychiatric, and non-psychiatric services. Sacramento utilized a SmartCare report to extract timeliness data used for network adequacy indicator reporting.
- Sacramento used appropriate methodologies to assess adherence with DHCS network adequacy indicators for timely access. Data collected by providers during appointment

requests were used to populate the SmartCare mental health non-psychiatric SMHS timeliness record for tracking initial requests for non-psychiatric SMHS, and the mental health psychiatric SMHS timeliness record for psychiatric SMHS requests. Time entries for urgent requests were also recorded.

- Sacramento utilized a timely access document report which identified incomplete timely access records, and the QM Team used the report to check records for completion and accuracy.
- Sacramento used a SmartCare report to extract timely access data recorded in the system via the timeliness records. The data were used to complete the TADT, which was then reviewed and validated by the clinical implementation coordinator to ensure accuracy before submission to DHCS.
- Sacramento's QM Team and Data Analytics Team (DAT) reviewed TADTs quarterly and shared results with contract monitors to review during monthly provider meetings. Sacramento utilized a dashboard to track and monitor timeliness, and progress was monitored monthly.
- SmartCare software utilized Git and Azure DevOps for report version control, to store and track changes, and query report logic.
- To ensure continuity of network adequacy indicator production, Sacramento 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.
- HSAG assessed Sacramento's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- The DAT conducted quarterly reviews of timely access data, and the results were shared with contract monitors and discussed during their meetings with providers. Any cases of non-compliance prompted the initiation of a corrective action plan (CAP). The DAT and contract monitors held quarterly meetings with providers to address challenges related to timely access reporting. These discussions included efforts to improve scheduling practices, assess staffing adequacy, and implement performance improvement strategies.
- Sacramento utilized a dashboard to monitor providers' completion of timely access data.

HSAG identified no concerns with Sacramento'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 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 the 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 3.34 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.34—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	495	413	83%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	531	458	86%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	12	12	100%↑
Non-Urgent Psychiatric Services—Adult (21+)	91	91	100%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

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's DAT and contract monitors conducted quarterly meetings with providers to address issues affecting timely access reporting, including discussions focused on enhancing scheduling processes, evaluating staffing levels, and implementing performance improvement initiatives.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Sacramento currently does not use the MMEF to populate member eligibility data in SmartCare and has disabled the 270/271 functionality due to delays in receiving timely eligibility information.
  - **Recommendation:** HSAG recommends that Sacramento collaborate with DHCS to explore potential solutions for addressing eligibility data challenges and streamlining the process, subsequently allowing Sacramento the ability to utilize the automated functions in SmartCare.

San Benito County Behavioral Health

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 NPPES, 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 outpatient psychiatric, non-psychiatric, and SMHS urgent appointment service types. 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 for psychiatry services, largely due to a shortage of providers in its small rural county and continued to actively explore opportunities to expand its provider network.

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 the 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 3.35 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.35—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	28	28	100%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	22	22	100%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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.

San Bernardino County Department of Behavioral Health

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 mental health 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 for psychiatry and outpatient services 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. San Bernardino's DBH QM staff co-facilitated the monitoring timeliness subcommittee meetings, which 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.

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 the 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 3.36 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.36—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	503	435	86%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	269	214	80%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	50	45	90%↑
Non-Urgent Psychiatric Services—Adult (21+)	74	70	95%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	11	11	100%↑
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

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

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

San Diego County Behavioral Health Division

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 Cerner Community Behavioral Health (CCBH) 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 CCBH.
- San Diego received the MMEF from DHCS. San Diego's Mental Health Billing Unit (MHBU) downloaded the file from the DHCS website and saved it to a shared drive. The MHBU ran an automated process which imported the MMEF into CCBH.
- Providers were instructed to verify Medi-Cal eligibility using the DHCS Provider Portal or MEDSLITE each time a member received services, and Billing Unit staff verified member eligibility as needed.
- San Diego performed monthly reconciliation between CCBH and the MMEF using a CCBH two out of three report. The report displayed data present in CCBH versus data visible on the MMEF. Discrepancies were verified through MEDSLITE or the DHCS Provider Portal. If the error was a San Diego EHR error, the Billing Unit staff corrected the data in CCBH. If

the error was due to a Medi-Cal enrollment data error, the member was directed to contact DHCS to correct his or her file.

- CCBH captured and maintained both the state-issued Medi-Cal ID and a system-generated member ID to uniquely identify members.
- San Diego defined a new member as someone seeking Medi-Cal services for the first time or who had not received services within San Diego's network in the three years prior to the contact date.
- San Diego identified member demographic updates based on the MMEF and information received from members. The Billing Unit updated non-critical changes (e.g., address and phone number) received from members in CCBH, and members were directed to contact DHCS to update their information. All other critical demographic changes (e.g., name, DOB, SSN) were updated by Health Information Management (HIM), and a form was submitted to DHCS to review and update the MMEF.

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 CCBH.
- 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. Upon verification, Optum manually entered provider information into CCBH.
- 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 either updated the information in CCBH or contacted the provider for any additional details 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 Management Information System (MIS) Team. Once verified, the information was entered into CCBH. 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 CCBH to capture all related data.
- San Diego subcontracted extraction of data for timely access reporting to Optum.

- San Diego established clear data submission requirements, implemented data validation and monitoring processes, provided ongoing support and communication, and utilized QI plans when necessary.
- San Diego's contract with Optum contained requirements for Behavioral Health Administrative Services Organization (BHASO) reports which listed requirements such as reporting frequency and timelines.
- Optum employed validation processes, including reports and SQL queries, to ensure the accuracy and completeness of timely access data prior to submitting to DHCS.
- 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:

- Optum utilized CCBH 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.
- Optum produced the TADT, which included outpatient, psychiatric, and non-psychiatric services. A report was generated using a custom SQL-based CCBH tool called the Access to Service Journal (ASJ). The ASJ compiled data from related records, service entries, and standard forms to calculate the required timely access metrics. As part of the validation process, the Optum Business Analytics Team (BAT) conducted quality assurance checks to ensure reporting accuracy. The BAT reviewed the ASJ data, verified that services were accurately recorded, and confirmed Medi-Cal eligibility of members during the reporting period.
- The TADT included built-in conditional formatting to highlight errors, enhancing the accuracy and reliability of the data entered. Optum reviewed and corrected highlighted errors before forwarding the file to San Diego for further review. Upon receipt, San Diego's Health Plan Administration (HPA) Team conducted an internal analysis to identify discrepancies. If anomalies were detected, HPA and Optum collaborated with San Diego's Data Sciences Team to resolve the issues in the TADT prior to submission 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 Optum and San Diego met weekly to discuss quality assurance strategies, validation reports, and corrections.
- To ensure continuity of network adequacy indicator production, all Optum programmers utilized a shared codebase, shared code reviews, 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. HPA collaborated with Optum as needed to conduct an internal analysis and ensure consistency in methodology and reporting practices. HPA also consulted with DHCS for technical assistance in resolving timely access reporting issues. Progress was documented and tracked through 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 the 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 3.37 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.37—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	503	351	**70%↓**

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	314	281	89%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	250	216	86%↑
Non-Urgent Psychiatric Services—Adult (21+)	544	506	93%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	32	30	94%↑
Urgent Non-Psychiatry SMHS—Adult (21+)	573	561	98%↑
Urgent Psychiatry—Children/Youth (0–20)	15	14	93%↑
Urgent Psychiatry—Adult (21+)	414	392	95%↑

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

- **Opportunity #1:** San Diego did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that San Diego 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 Diego 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.

San Francisco Community Behavioral Health Services

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 implemented Epic effective May 22, 2024.
- 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 six programmers with an average of 10 years of experience in the field.

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 received the MMEF from DHCS. These files were uploaded to the myAvatar User Acceptance Testing (UAT) and myAvatar LIVE systems using an existing SQL Server Integration Services (SSIS) package and distributed to various myAvatar network drives and databases.
- San Francisco's billing teams conducted monthly Medi-Cal eligibility validations using the MMEF. Eligibility data were either imported into myAvatar each month or manually updated as needed, based on verification through MEDSLITE.

- The San Francisco Billing Unit identified discrepancies between the MMEF and myAvatar systems data using a two out of three match process. To verify member name, DOB, and SSN, staff contacted providers and cross-checked the data with MEDSLITE or county human services records. Any necessary corrections were made in myAvatar. If duplicate records were discovered, accounts were merged, and all associated records were updated with the accurate information.
- myAvatar captured and maintained both the state-issued Medi-Cal ID and a unique system-generated member ID to uniquely identify members.
- San Francisco defined a new member as a new Medi-Cal member who had not received a billable service in 12 months prior to the referral date.
- San Francisco identified updates to member demographics based on information from the MMEF and direct input from members. Address and phone number changes provided by members were updated in myAvatar, and members were directed to contact DHCS to ensure their information was updated on subsequent MMEFs.

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 the myAvatar timely access log, time to outpatient psychiatry data table, and the CSI assessment, which included data on outpatient, psychiatric, and non-psychiatric services, for reporting timely access indicators. Information from these sources was consolidated and matched with service data in myAvatar to create unique records linking requests, appointments, and services.
- The timely access log recorded data at the member level, with entries identified by either a member ID or name, while the CSI assessment captured data at the treatment episode level, using both a member ID and a treatment episode number. In myAvatar, services were provided within defined treatment episodes, requiring a new CSI assessment entry for each episode. Mental health outpatient programs used these two forms to document outpatient service requests and record the date of each request.

- San Francisco utilized Comprehensive Crisis Services (CCS) to provide urgent care without requiring prior authorization, and did not offer urgent appointments or services that required authorization. The date and time of urgent appointments offered were extracted from the CCS Crisis Evaluation form in myAvatar, which clinicians used to document member visits.
- 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 and CSI assessment 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:
  - 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.
  - 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.
- San Francisco maintained network adequacy reports in compliance with DHCS' data submission requirements by developing standardized, stored procedures that included version histories to track variances. To support continuity, a new procedure was implemented to document major revisions, and multiple staff members were trained in these processes to provide ongoing support.
- San Francisco transitioned to Epic effective May 22, 2024. San Francisco recognized challenges with data completeness due to transitioning to Epic, which included learning new workflows, developing reliable reporting mechanisms, mapping fields correctly, and capturing needed data points, and was working to address the identified deficiencies by reviewing data and workflows. San Francisco reported that data completeness challenges impacted 26 percent of data for first offered non-psychiatry appointments and 42 percent of data for first offered psychiatry appointments during the CAP submission period.

Ongoing monitoring activities:

- San Francisco's QM Analytics Team tracked and monitored any gaps identified in the county's network adequacy indicator performance relative to DHCS' contract requirements. The team met monthly with the System of Care QIC (SOC QIC) to address topics related to QM functions, including network adequacy. In addition, QM Analytics monitored timeliness and produced quarterly reports that were shared with and discussed by the committee.

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

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 the 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 3.38 summarizes network adequacy indicators resulting in a *Low Confidence* or *No Confidence* rating determination.

Table 3.38—San Francisco Validation Ratings

Indicator	Validation Rating	Comments
Outpatient Non-Urgent Non-Psychiatry SMHS	*No Confidence*	San Francisco reported missing timeliness data for first offered appointments after implementation of Epic, 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 *No Confidence* validation rating.
Non-Urgent Psychiatric Services	*No Confidence*	San Francisco reported missing timeliness data for first offered appointments after implementation of Epic, 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 *No Confidence* validation rating.

Analysis and Conclusions

Table 3.39 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.39—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.

— 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	—	—	—
Non-Urgent Psychiatric Services—Adult (21+)	—	—	—
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Urgent Psychiatry—Children/Youth (0–20)	—	—	—
Urgent Psychiatry—Adult (21+)	—	—	—

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.
- **Strength #2:** San Francisco's SOC QIC, which included members of the QM staff, conducted monthly meetings to address areas in need of improvement or correction, including network adequacy.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** San Francisco faced data completeness challenges after transitioning to its new EHR, Epic.
  - **Recommendation:** HSAG recommends that San Francisco collaborate with DHCS and its current EHR vendor, Epic, to obtain technical assistance and guidance aimed at improving timely access data collection methods.
- **Opportunity #2:** San Francisco 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 Francisco 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 Francisco 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.

San Joaquin Behavioral Health Services

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. Once downloaded, it was placed in a SFTP folder and imported into SmartCare. The file contained key demographic details and Medi-Cal eligibility status. 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 into SMHS. Members who were currently open to mental health services 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.
  - BH 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.
- San Joaquin conducted weekly Mental Health Timeliness Committee meetings to discuss operations, data collection, and reporting. Reports were created for managers to verify that staff correctly entered data.
- To address identified timely access deficiencies, San Joaquin trained leadership and contractors on the definition of and referral process for urgent conditions. The Timeliness Report Application was updated to better track urgent requests, and procedures were established to ensure member access to out-of-network providers. Managers also reviewed all urgent referrals and actively managed scheduling, which included exploring availability across divisions when necessary.
- 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.
- Outpatient Closures Report: A report that provided information for non-psychiatry appointment records that were incomplete and needed closure, or to have both the initial and first follow-up non-psychiatry appointments marked as "show" if the member attended both appointments.
- 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.
- Psychiatry Report: A report of all psychiatry appointment dates that showed statuses by program. This report showed which scheduled psychiatry appointments were still in pending status and needed to have their show status entered.
- Psychiatry Closures Report: A report that provided information for psychiatry appointment records that were incomplete and in need of closure or that needed to have the scheduled appointment status marked as "show" if the member attended the psychiatry appointment.

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 the 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 3.40 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.40—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	408	395	97%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	440	386	88%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	43	43	100%↑
Non-Urgent Psychiatric Services—Adult (21+)	64	57	89%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	86	86	100%↑
Urgent Non-Psychiatry SMHS—Adult (21+)	191	191	100%↑
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

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

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

San Luis Obispo County Behavioral Health Department

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.
- Medi-Cal members were connected with a provider who would then complete a brief adult or youth screening tool for Medi-Cal mental health services to determine the delivery

system and/or level of care. Depending on the outcome of the screening tool, the member was referred accordingly.

- If the results of the screening tool indicated the member should have been referred for non-SMHS, the member was connected with San Luis Obispo's MCP. San Luis Obispo provided a warm handoff to the MCP member access line and provided the completed screening tool so that the member could be referred to a provider.
- Urgent requests were tracked using the mental health non-psychiatric SMHS timeliness record or mental health psychiatric SMHS timeliness record in SmartCare, which had a date and time field. San Luis Obispo defined an urgent request as a member's condition requiring prompt intervention to prevent a crisis.
- 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 SMHS 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 including a mental health non-psychiatric SMHS timeliness record and mental health psychiatric SMHS timeliness record to track timely access of new requests for services and urgent requests. These records were used for reporting timely access to DHCS. San Luis Obispo generated reports from SmartCare that pulled and consolidated information from the mental health non-psychiatric SMHS timeliness record, mental health psychiatric SMHS timeliness record, and from psychiatric and non-psychiatric outpatient treatment. 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 mental health non-psychiatric SMHS timeliness record and mental health psychiatric SMHS timeliness record had a date and time field. Both records required staff to enter the date and time of the request for services 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 mental health non-psychiatric SMHS timeliness record and mental health psychiatric SMHS timeliness record to indicate whether the service was offered within 48 hours.
  - 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, follow-up services, and access to psychiatric 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 the 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 3.41 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.41—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	118	97	82%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	161	140	87%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	88	80	91%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	13	11	85%↑
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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.

San Mateo County Behavioral Health and Recovery Services

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 SMHS in San Mateo's System of Care who was referred to SMHS or an assessment for SMHS.

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 management staff 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 (e.g., no psychiatrist in a service area) 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 the 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 3.42 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.42—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	114	103	90%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	288	264	92%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	66	34	**52%↓**
Non-Urgent Psychiatric Services—Adult (21+)	367	205	**56%↓**
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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's EHR system reported on incomplete timeliness forms and provided an alert to providers on the member's record to indicate a form was incomplete, subsequently reducing instances of incomplete timely access data.

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.
- **Opportunity #2:** San Mateo did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that San Mateo 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 Mateo 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.

Santa Barbara Department of Behavioral Wellness

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.
- For mental health data, effective June 2024, Santa Barbara transitioned from using Excel file 274 and NACT data repositories to holding and updating 274 and NACT data directly in the new EHR SmartCare.
- 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. Members who requested mental health services were administered the Medi-Cal screening tool.
  - If the screening tool resulted in a recommendation for MCP care, Santa Barbara's access staff facilitated a referral to the MCP and offered the member an assessment appointment within appropriate timeliness standards.
- 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, date of service (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 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 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, psychiatric and non-psychiatric outpatient treatment. 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, such as psychiatry, 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 psychiatry timely access requirements and how to complete timely access data forms in SmartCare. The QCM Team reviewed reporting of the psychiatry 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.
  - The medical director reviewed the assignment of psychiatrists throughout the county to ensure caseloads were manageable and allowed for timely access appointments for new psychiatry cases.

  - 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 the 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 3.43 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.43—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	127	105	83%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	274	164	**60%↓**
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	87	70	80%↑
Non-Urgent Psychiatric Services—Adult (21+)	52	23	**44%↓**
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	28	28	100%↑
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

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

- **Opportunity #1:** Santa Barbara did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Santa Barbara 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 Barbara 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.

Santa Clara County Behavioral Health Services Department

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; or 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. 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 and 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 the 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 3.44 summarizes network adequacy indicators resulting in a *Low Confidence* or *No Confidence* rating determination.

Table 3.44—Santa Clara Validation Ratings

Indicator	Validation Rating	Comments
Outpatient Non-Urgent Non-Psychiatry SMHS	*No Confidence*	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 *No Confidence* validation rating.
Non-Urgent Psychiatric Services	*No Confidence*	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 *No Confidence* validation rating.
All SMHS Urgent Appointments	*No Confidence*	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 *No Confidence* validation rating.

Analysis and Conclusions

Table 3.45 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.45—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	28	26	93%↑
Non-Urgent Psychiatric Services—Adult (21+)	—	—	—

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Urgent Psychiatry—Children/Youth (0–20)	15	15	100%↑
Urgent Psychiatry—Adult (21+)	256	256	100%↑

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 Health Services Agency

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 and a qualifying score on the Adult/Youth mental health screening tool.
- Practitioners determined medical necessity through a clinical assessment and referred members to the MCP if it was determined that they did not require SMHS.
- The receptionist or front desk staff collecting the service request data administered a mental health screening. Screening information was collected in the EHR on the Adult/Youth mental health screening form.
- 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 psychiatric 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 for psychiatry and outpatient 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.
  - 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 the 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 3.46 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.46—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	179	155	87%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	133	88	**66%↓**
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	43	41	95%↑
Non-Urgent Psychiatric Services—Adult (21+)	72	72	100%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	S	S	S

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

- **Opportunity #1:** Santa Cruz did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Santa Cruz 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 Cruz 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.

Shasta County Behavioral Health

ISCA Findings and Data Validity

HSAG completed an ISCA for Shasta 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 Shasta had in place to support network adequacy indicator reporting, which included the following findings:

- Shasta used myAvatar as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- Prior to implementing myAvatar, Shasta utilized Cerner to maintain enrollment and provider data.
- Shasta conducted appropriate testing and validation methods to ensure completeness and accuracy of data migrated from Cerner to myAvatar.
  - Shasta contracted with vendor Tejas Behavioral Health Management Association dba Tejas Health Management to extract data from Cerner and create conversion files for importing into myAvatar.
  - Tejas Health Management provided weekly status reports for migration and a final statement of services showing full migration.
- Shasta used Microsoft Access for network adequacy file creation.

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

- Shasta had six programmers with an average of 10 years of experience.

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

Enrollment System

HSAG evaluated the information systems and processes used by Shasta 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 Shasta's enrollment system included the following findings:

- Enrollment and eligibility data for Shasta were maintained in myAvatar.

- Shasta received the MMEF from DHCS and uploaded the file into myAvatar via an automated process. The upload was completed on the same day as the file was received.
- Shasta's reconciliation and oversight of enrollment data included:
  - Automated checks of MMEF data against existing data were completed, producing reports of records that did not upload into the EHR.
  - Records that did not upload were researched for root cause and corrected. Staff compared myAvatar data to MEDSLITE to determine discrepancies that caused record upload failure. Shasta reported that only one record failed to upload since the inception of myAvatar. Human error inputting the member ID number was determined to be the root cause of the failure.
  - Shasta's staff services analyst, accounting technician, and account auditor reviewed a report for missing subscriber policy numbers.
- Shasta performed matching logic to link updated data to existing member records.
- Shasta staff had the ability to find RTE data via the Single Subscriber Eligibility lookup on the DHCS website for Medi-Cal providers. Shasta staff had the ability to request that myAvatar be updated based on the RTE results.
- myAvatar captured manual edits to member records including username and date of edit. Role-based rules limited user access to make manual edits. Manual edits to eligibility were limited to accounting staff.
- Shasta defined a new member as a member who was not currently open (closed chart) and had not received services in the past six months.

HSAG identified no concerns with Shasta'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 Shasta to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in myAvatar.
- Shasta collected data from both county staff and contracted providers in a standardized application format. The application included provider location, license or certification, and NPI. Shasta verified collected data via the OIG LEIE, California DCA BreEZe Online

Services system, and NPPES. Shasta manually entered provider application data into myAvatar. Shasta also housed NPI, licensure, certification, and group information in shared folders.

- Shasta conducted outreach to providers monthly to collect updates to provider data. Outreach emails requesting updates were sent between the 10th and 15th day of each month. Provider contracts contained a requirement to respond to requests for provider data updates.
- Shasta conducted monthly licensure and NPI checks to ensure credentials were current.
- 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 records were limited to accounting staff.
- Shasta performed audits on provider data on a 90-day rotation. Audits included provider data elements such as ensuring licensure was active, determining if any updates occurred that were not captured on monthly requests, and ensuring NPIs matched.

HSAG identified no concerns with Shasta'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 Shasta's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Shasta's providers used standardized system forms to report services included in timeliness standards and indicators. Providers manually completed system forms in the member's record for timeliness services.
- myAvatar calculated timeliness based on data entered in standardized forms.
- Shasta produced timeliness reports from myAvatar via a Microsoft Access database that produced an Excel file which was copied and pasted into the TADT.
- Shasta's QM Team reviewed the Excel file for data completeness prior to populating the TADT.
- HSAG assessed Shasta's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Shasta performed monthly reporting to check for errors in service reporting, which included missing or incomplete fields and out-of-range dates. Errors were sent back to programs for correction.
- Shasta provided both initial service system form training and follow-up training to address and reduce errors in service reporting.

HSAG identified no concerns with Shasta'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 Shasta 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 Shasta used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Shasta'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 the 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 3.47 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.47—Shasta 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	107	97	91%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	76	73	96%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Shasta'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:** Shasta provided both initial service system form training and follow-up training to providers to greatly reduce errors in the service reporting process during the review period.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Shasta had one staff member trained to submit timely access reporting to DHCS and did not have a trained backup staff member.
  - **Recommendation:** To ensure continuity in reporting, HSAG recommends that Shasta explore training backup staff to be available to submit the TADT and create policies and procedures to document the TADT submission process.
- **Opportunity #2:** Shasta 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 Shasta 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 Shasta 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.

Siskiyou Behavioral Health Division

ISCA Findings and Data Validity

HSAG completed an ISCA for Siskiyou 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 Siskiyou had in place to support network adequacy indicator reporting, which included the following findings:

- Siskiyou used SmartCare as the database management system to collect and maintain enrollment and provider data beginning July 1, 2023.
- Siskiyou migrated from Anasazi to SmartCare on July 1, 2023. All historic member and provider data were migrated from Anasazi to SmartCare.

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

- SmartCare was the system of record for provider and member data and was maintained by CalMHSA. CalMHSA's programming staff had an average of six years of experience.

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

Enrollment System

HSAG evaluated the information systems and processes used by Siskiyou 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 Siskiyou's enrollment system included the following findings:

- Enrollment and eligibility data for Siskiyou were maintained in Anasazi. Complete member enrollment data were migrated from Anasazi to SmartCare as of July 1, 2023.
- Siskiyou downloaded the MMEF from the DHCS SFTP server. Monthly, Siskiyou's system administrators matched the MMEF against existing member records in Anasazi. For SmartCare, CalMHSA downloaded the MMEF from the DHCS SFTP server and imported the file into SmartCare. An overnight processing job imported the file, and a second nightly process was run for file integration.
- Siskiyou performed monthly reconciliation between SmartCare and the MMEF to ensure accuracy and completeness of member data.
- Siskiyou's reconciliation and oversight of enrollment data included the following processes:

  - The MMEF updated an existing member's insurance plan with current Medi-Cal eligibility in Anasazi and SmartCare. An error report was generated for any failures that occurred when the MMEF was imported into SmartCare. CalMHSA continually reviewed and resolved errors.
  - Siskiyou used the 270/271 RTE functionality to verify and update member eligibility for members requesting services if eligibility was not received on the MMEF. In SmartCare, the month of service was entered and submitted on the coverage screen, and the insurance plan was updated for members with current Medi-Cal eligibility.
  - After MMEF integration, authorized users reviewed SmartCare's potential match report to reconcile any member data errors and link member history. Siskiyou's RTE system administrator manually updated data for members with discrepancies in the match report to resolve any mismatched records due to data errors. The member record was updated in SmartCare in a subsequent nightly integration job.
- SmartCare demonstrated system capability to track gaps in member eligibility. The SmartCare member ID was retained even after a member's eligibility ended. Address history was retained in the member address history table in SmartCare.
- SmartCare captured and maintained both the CIN and a system-generated member ID. Member demographic information was used to link member ID and CIN. For timely access reporting, the CIN was used.
- Siskiyou identified member demographic data based on information received in the MMEF. Siskiyou's health assistant could enter updated demographic information received from members directly in SmartCare. The health assistant advised members to update any changes with their county eligibility worker directly. The health assistant ran quarterly reports to validate whether any data were missing. Siskiyou reviewed a compare report between the MMEF and manually updated demographic data changes to confirm accuracy.
- Siskiyou identified a new member as someone who was never seen for psychiatric or non-psychiatric services with a county provider or who was discharged from treatment for 30 days or more and seeking services during a new timely access assessment period. Discharge status was designated for members following three no-shows or no-contact for a service.

HSAG identified no concerns with Siskiyou'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 Siskiyou to capture provider data and identified the following findings:

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

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

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

- Provider credentialing and network status data were maintained in Anasazi. All provider data were migrated to SmartCare as of July 1, 2023. Siskiyou staff verified provider credentials during the hiring process and updated them as needed based on monthly review.
- Provider network status data were maintained in SmartCare. End dates were used to identify active versus terminated provider contracts, and expiration dates were used to indicate terminated licenses.
- The DEA flag in SmartCare was used to identify psychiatric providers with prescribing authority.
- Using Siskiyou's contracting form, providers entered all identifying information, including NPI, taxonomy code, practice location, and DEA certificate if applicable, when applying for contracting. Siskiyou's system administrators entered data from provider credentialing forms directly into SmartCare.
- Siskiyou's procedures for updating and maintaining provider data included:
  - Providers used Siskiyou's credentialing form to notify Siskiyou of a change. System administrators edited provider data in SmartCare directly.
  - Siskiyou ran exclusion reports upon contracting and monthly to identify providers or organizations excluded from the Medicaid and CHIP programs.
  - Siskiyou required its provider network to continually update provider data, as needed. Providers were required to verify accurate demographic information annually.

HSAG identified no concerns with Siskiyou'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 Siskiyou's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Siskiyou utilized Anasazi for timely access reporting using a timeliness of service entry report. Following completion of the EHR migration on July 1, 2023, Siskiyou contracted with CalMHSA for SmartCare customization and support. Siskiyou maintained a crosswalk of reporting definitions used to validate reporting and data migration from Anasazi to SmartCare. Siskiyou worked with CalMHSA to customize and validate system forms for exporting SmartCare data, in alignment with DHCS reporting requirements.
- Siskiyou integrated provider and member data for timely access reporting. SmartCare's report consolidated appointment service data for psychiatric and non-psychiatric system forms. CalMHSA customized data extraction for reports in SmartCare using the EHR tables. Provider and member data were joined based on reporting requirements identified during development and testing. Siskiyou's health assistant staff entered appointment service data into SmartCare forms directly. The data were integrated into EHR tables and extracted for timely access reporting.
- Siskiyou maintained data control procedures to ensure accuracy and completeness of data integration throughout the timely access reporting process. Siskiyou maintained desktop procedures that health assistants used for appointment scheduling and TADT reporting steps.
- Siskiyou used appropriate methodologies to assess adherence with DHCS reporting requirements and timely access monitoring standards:
  - CalMHSA used DHCS' annual county network certification BH information notice and the TADT to identify the data elements required for timely access reporting.
  - The SmartCare forms captured appointment service data that Siskiyou staff manually entered, including urgent and non-urgent flags, the date of first contact with the member, and name of the referral source. Forms were customized for psychiatric and non-psychiatric outpatient treatment.
  - Siskiyou manually transferred exported SmartCare data to the TADT prior to submission to DHCS. Data reported were limited to reporting time frames required for the TADT.
  - Siskiyou health assistants used the DEA flag to filter for psychiatric service providers in SmartCare and view psychiatry service appointment availability.
  - Only members with active Medi-Cal CINs were included in the TADT, based on SmartCare's member insurance plan and eligibility status received in the MMEF.
  - The number of days to appointment offered was calculated between the service requested and the actual appointment date by the servicing provider.
- Siskiyou conducted data reasonability checks by ensuring dates entered in the TADT aligned with reporting periods. Siskiyou trended the initial and reassessment reports and evaluated any outlier data.
- Siskiyou maintained network adequacy indicator reports by labeling reports with the month and year of the reporting period, in alignment with DHCS' TADT naming conventions.
- Siskiyou validated data quality in SmartCare by reviewing any missing fields in the system forms at the time of data entry. SmartCare's forms and reporting accuracy were validated during internal testing in Siskiyou's SmartCare quality assurance environment. Azure DevOps and Git and were used to develop reports and track changes to code, query logic, and reporting requirements. The QI coordinator reviewed a customized timely access

document report to flag and resolve any missing or incomplete timely access records prior to reporting, and collaborated with staff to ensure all timely access documentation was entered completely in SmartCare forms prior to reporting. The QI coordinator validated the transfer of data from the export of the SmartCare report to the TADT. The QI coordinator used row count comparisons, random sample validation, and validated dates and character format for reasonability.

- To ensure continuity of timely access indicator production, Siskiyou maintained desktop procedures for the intake of appointment services and data entry in SmartCare. CalMHSA maintained logic and version control mechanisms to document reporting requirements and annual customizations in SmartCare.
- HSAG assessed Siskiyou's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Siskiyou's QIC reviewed timely access data quarterly. Timely access performance based on TADT reports was reviewed by percentage of compliance. Any timely access performance falling below 80 percent compliance was flagged for evaluation.
- For barriers to timely access performance that were due to provider staff, Siskiyou collaborated with the provider program supervisor to resolve or escalate the staff issue. Siskiyou created documentation flows as a result of focused timely access performance gap analysis, which helped to resolve issues related to front-end appointment service data capture and close the identified performance gap. Siskiyou developed a pre-assessment questionnaire to improve patient intake processes and reduce delays in timely access.

HSAG identified no concerns with Siskiyou'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 Siskiyou 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 Siskiyou used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Siskiyou'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 the 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 3.48 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.48—Siskiyou 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	46	46	100%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	58	48	83%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	12	11	92%↑
Non-Urgent Psychiatric Services—Adult (21+)	85	80	94%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Siskiyou'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:** Siskiyou worked closely with CalMHSA to integrate a report co-signer as part of the process to ensure rapid response to any timely access data gaps and enable complete and accurate timely access data capture. Use of a report co-signer was developed as a second layer of data oversight based on the QI coordinator's review of actual rendered service dates, as Siskiyou noted that service dates were the only real-time EHR data that could be used to validate the first appointment offered date.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Siskiyou identified implemented processes for monitoring timely access compliance based on quarterly internal review of SmartCare TADT reports; however, Siskiyou did not monitor performance within age stratifications for adult and child services.
  - **Recommendation:** HSAG recommends that Siskiyou consider monthly appointment availability audits for adult and child services and/or the development of a timely access performance dashboard to support ongoing gap-to-target monitoring, age group performance stratification, and trending of timely access performance.

Solano County Health & Social Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Solano 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 Solano had in place to support network adequacy indicator reporting, which included the following findings:

- Solano used myAvatar as the database management system to collect and maintain enrollment and provider data.

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

- Solano had an equivalent of 1.5 full-time programmers with an average of 10 years of experience.
- Solano's QA Department was responsible for timely access reporting. Staff were trained and capable of supporting network adequacy reporting activities.

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

Enrollment System

HSAG evaluated the information systems and processes used by Solano 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 Solano's enrollment system included the following findings:

- Enrollment and eligibility data for Solano were maintained in myAvatar.
- Solano received the MMEF from DHCS. Solano's IT Unit downloaded the MMEF from the DHCS portal and uploaded it into myAvatar using Ipswitch software.
- Solano performed monthly reconciliation between myAvatar and the MMEF to ensure completeness and accuracy of eligibility data.
  - Solano reviewed error reports monthly to determine whether the MMEF upload created an error such as a duplicate CIN or SSN.
  - Solano validated eligibility prior to beginning services and monthly as part of the billing process using the DHCS website for Medi-Cal providers.

- If a SSN was already in use, myAvatar contained programming logic to trigger an email notification alerting staff of a potential record match. Billing staff reviewed and notified the Quality Assurance Team, which merged records when duplicate records were identified. If no member was found, the system generated the next available medical record ID number.
- Solano defined a new member as a Medi-Cal member who had never received services or an existing member who was previously closed to all services for at least 90 days.
- myAvatar captured and maintained both the state-issued Medi-Cal ID and a system-generated ID. If the Medi-Cal ID changed for any reason, Solano linked enrollment history based on matching the member against unique member identifiers.
- Solano identified member demographic information and updates via referrals received or direct member contact. Member demographic and financial information was verified during the member's intake appointment. Members completed a registration packet for new admission to a program, which included demographic information, financial information, and informed consent paperwork. Members were asked at each subsequent appointment if there were any changes, and financial information was updated annually.

HSAG identified no concerns with Solano'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 Solano to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in myAvatar.
- Solano used the OIG LEIE, DHCS S&I List, Social Security Administration's Death Master File, and the NPPES to complete provider credentialing at initial hiring and at recredentialing, which was completed every three years.
- Solano generated a licensure report at the end of each month to identify staff with upcoming expiring licensures and sent email reminders to ensure timely licensure renewal.
- Solano's QA Department reviewed and processed each provider's request for claiming permissions before adding as a practitioner in myAvatar.
  - QA sent lists of all active staff to all programs by the end of the first week of the month and required responses by the third week of the month to ensure all providers were reviewed monthly and had appropriate permissions in myAvatar.

  - Clinical staff reviewed these lists of all active staff and programs and sent them to the Solano officer coordinator to compile monthly provider reporting.
- Solano required its provider network to update provider data as needed. Providers were required to report any change of information regarding licensures, certifications, registrations, or waivers required for their role to the Behavioral Health Division Quality Assurance Unit within 10 days of any change of status. Providers were made aware of expectations via an internal policy.

HSAG identified no concerns with Solano'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 Solano's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Solano utilized myAvatar to monitor and extract data used to support timely access reporting. Timely access network adequacy indicator data were submitted annually or as requested by DHCS. Solano used the TADT for reporting timely access to DHCS.
- Solano utilized a 24/7 Access call center to provide screenings for Medi-Cal eligible callers and processed referrals from primary care, school districts, and MCPs. Solano's Centralized Assessment team scheduled intake assessments for adult and youth using myAvatar.
  - After the initial assessment was completed, a referral went out to both county and contracted programs for appointment scheduling. The first offered appointment date was captured and maintained in access screening forms, and the first follow-up service date was captured and maintained in the CSI timeliness assessment form in myAvatar, which was used for timely access reporting. The QA office coordinator used Crystal Reports to pull timely access data from various forms, including the Access Screening form and the CSI timeliness assessment form. The data were exported into Excel, audited for completeness, and copied into the TADT.
- Solano maintained network adequacy indicator reports by labeling them with the month and year of the reporting period, in alignment with DHCS' report naming conventions.

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

Ongoing monitoring activities:

- Solano maintained data control procedures to ensure the accuracy and completeness of data extracted from myAvatar.
  - Solano's QA Team reviewed the extracted data from myAvatar by pulling the member's chart based on the myAvatar ID number, in order to validate that data were pulled correctly.
  - The QA Team also performed validation checks against the CIN to determine if the member had active Medi-Cal coverage within the time frame of the reporting period.
- Solano's QA Team had backup personnel trained and capable of populating the TADT to ensure continuity of network adequacy timely access data reporting.
- The TADT included built-in conditional formatting to highlight any type of error, enhancing the accuracy and reliability of the data entered. Solano's QA Team reviewed and corrected highlighted errors before submitting to DHCS.
- Solano's QA Team reviewed timeliness data for SMHS quarterly and provided feedback to programs if timeliness measures were not met regarding SMHS according to DHCS' requirements.

HSAG identified no concerns with Solano'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 Solano 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 Solano used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Solano'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 the 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 3.49 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.49—Solano 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	116	93	80%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	121	84	**69%↓**
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	51	41	80%↑
Non-Urgent Psychiatric Services—Adult (21+)	159	146	92%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Solano'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:** Solano has implemented proactive approaches to training backup personnel to ensure continuity of network adequacy timeliness reporting.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Solano did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Solano 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 Solano 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 Sonoma

ISCA Findings and Data Validity

HSAG completed an ISCA for Sonoma 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 Sonoma had in place to support network adequacy indicator reporting, which included the following findings:

- Sonoma used SmartCare to process and store member enrollment and provider data effective July 1, 2023. Prior to the implementation of SmartCare, Sonoma used myAvatar to maintain member enrollment and provider data.
- Sonoma used appropriate testing procedures to validate the integrity of data migrated to SmartCare from myAvatar.
  - The Information System Department (ISD) verified SQL query results against crosswalks provided by EHR project leads prior to preparing conversion files. The conversion files were verified prior to uploading into SmartCare, and data were tested in SmartCare after the system migration to ensure accuracy of data. Additionally, a review of program permissions was performed upon completion of the EHR transition.

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

- Sonoma had five programmers training and capable of supporting network adequacy activities. The programmers' average years of experience was 10 years.
- Sonoma's QI Team maintained oversight of timely access reporting and ongoing monitoring activities.

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

Enrollment System

HSAG evaluated the information systems and processes used by Sonoma 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 Sonoma's enrollment system included the following findings:

- Enrollment and eligibility data for Sonoma were maintained in SmartCare.

- Sonoma received the MMEF from DHCS. These eligibility files were downloaded from the DHCS portal by an authorized user and placed in a SFTP folder before being imported into SmartCare.
  - After import, an automated matching process was generated to identify member matches, potential matches, and non-matched records. The system matched members based on the CIN.
  - For matched records, SmartCare automatically updated the member's coverage based on the response in the MMEF.
  - For potential matched records, the Programs Team proactively checked the records using a three primary identification match process to review first and last name, DOB, and SSN to determine a match. If a match was identified from the combination of these primary identification fields, the existing member's record would be updated.
- Sonoma defined a new member as either a Medi-Cal member who had never received services or an existing member who was previously closed to all services for at least six months.
- Sonoma also verified member eligibility through the DHCS MEDSLITE portal at point of service request.
  - Sonoma County members requested services via referrals, walk-ins, and the 24/7 Access Line. Once the Youth or Adult Access Team contacted the member or guarantor, the staff created an inquiry in SmartCare. Staff searched demographic information to check for an existing member record. If the member was new to the system (or had not received services in the past six months), the staff member checked Medi-Cal insurance from the inquiry screen in SmartCare. Staff then completed a CalAIM screening tool and directed the patient to an MCP or scheduled an assessment with an Access Team clinician.
- Senior office assistants had access to edit member demographic data in SmartCare.
  - A record of manual edits was stored in SmartCare, which could be seen either on the front end within the system or on the back end by querying the data.
  - Changes made to records included the record modifier's user ID and the date and time of the change.
- SmartCare captured and maintained both the state-issued Medi-Cal ID and a SmartCare autogenerated ID.

HSAG identified no concerns with Sonoma'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 Sonoma to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in SmartCare.
- Sonoma's Revenue Management Unit (RMU) validated provider information such as NPI and license or board certification at hiring and set up the provider in SmartCare. Sonoma verified provider data through sources including licensing agencies, the Social Security Administration's Death Master File, and NPPES. Recredentialing was completed at least every three years.
- Sonoma performed verification against exclusion lists including but not limited to the OIG LEIE, California DCA BreEZe Online Services system, DHCS S&I Provider List, and the EPLS/SAM database to identify providers or organizations excluded from the Medicaid and CHIP programs each month.
- Sonoma's RMU ran a monthly licensure report to identify staff with licenses, certifications, registrations, or waivers due to expire within 30 and 90 days.
  - Reminders were sent to staff to update information, and the RMU completed additional staff supervisor follow-up as needed.
  - If licensure or applicable credential expired, the provider was terminated and access to SmartCare was deactivated.
- SmartCare maintained staff-specific profiles; each provider's license was stored behind the licenses and degrees tab specific to the provider's license type.
  - Psychiatric providers had a license billing type of MD, NP, or PA and a service type of medication support on the custom fields tab in SmartCare. Any other license and service type indicated a non-psychiatric provider.
- Sonoma required its provider network to report any issues or changes of licensure to the Sonoma compliance officer immediately. Providers were made aware of this expectation via their contract and credentialing website.

HSAG identified no concerns with Sonoma'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 Sonoma's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Sonoma utilized SmartCare to track and extract data used to report network adequacy indicators annually, or as requested by DHCS. Sonoma used the TADT for reporting timely access data to DHCS.
- SmartCare maintained two forms for tracking SMHS, psychiatric and non-psychiatric, which contained all data fields needed for network adequacy reporting.
- Sonoma's QI Team extracted data from the psychiatric and non-psychiatric forms using a SmartCare report for network adequacy indicator reporting.
  - Data were queried from SmartCare, and the QI analyst copied extracted data into the TADT. The QI manager performed internal testing to verify record counts, request dates, and appointment offered dates.
  - SmartCare used Git and Azure DevOps to store and track changes in the report and the query logic. Version control was maintained for changes made to query logic.
- Prior to July 1, 2023, Sonoma merged Microsoft Access databases to compile new service requests. Several fields were manually copied into Excel and then populated into the TADT. The QI analyst compiled the timely access data into the TADT, which were reviewed by the QI manager. Validation checks performed by the QI manager included:
  - A review of the data for accuracy, completeness, and adherence to the conditional formatting. If blank CIN numbers were identified during the QA process, Sonoma's QI Team would reach out to RMU for further verification.
  - A review of the number of inquiries per month and rate of timely access per month to identify any outlier trends.
- Sonoma maintained detailed process documentation and training materials to assist staff in tracking timely access and completed ongoing staff training as needed.
- HSAG assessed Sonoma's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Sonoma's QI staff were actively involved in reviewing timely access data to identify any outliers or trends. QI staff reviewed timely access data prior to submission to ensure applicable entries were included, such as validating that members included in reporting were Medi-Cal members.
- Timely access data were reviewed with leadership at Behavioral Health Plan Administration and QI meetings. Discussion items were related to the annual network submission, CAPs, and any additional data submissions required by DHCS. Ongoing monitoring around timely access data included comparison to compliance with established benchmarks and median times for the first offered appointment and first rendered appointment for all SMHS sub-categories. Timely access data were analyzed and used to develop plans to improve compliance. An example of a plan developed to improve compliance was the addition of staff members and implementation of monitoring progress after subsequent reviews.

HSAG identified no concerns with Sonoma'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 Sonoma 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 Sonoma used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Sonoma'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 the 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 3.50 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.50—Sonoma 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	80	62	**78%↓**

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	157	27	**17%↓**
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	43	26	**60%↓**
Non-Urgent Psychiatric Services—Adult (21+)	58	44	**76%↓**
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Sonoma'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:** Sonoma's QI staff maintained proactive monitoring of timely access data to identify outliers or trends along with strong validation procedures to ensure accuracy of timely access data submissions.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Sonoma did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Sonoma 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 Sonoma 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.

Stanislaus County Behavioral Health & Recovery Services

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 mental health psychiatric SMHS timeliness record and mental health non-psychiatric SMHS timeliness record for tracking SMHS, which contained all data fields needed for network adequacy reporting.
- Stanislaus' software administrators extracted data from the psychiatric and non-psychiatric 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 System of Care (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 the 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 3.51 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.51—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	472	466	99%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	571	541	95%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	117	110	94%↑
Non-Urgent Psychiatric Services—Adult (21+)	157	144	92%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	S	S	S
Urgent Psychiatry—Adult (21+)	S	S	S

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.
  - **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.

Sutter-Yuba Behavioral Health Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Sutter/Yuba 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 Sutter/Yuba had in place to support network adequacy indicator reporting, which included the following findings:

- Sutter/Yuba used Credible as the database management system to maintain enrollment and provider data beginning May 1, 2023.
- Prior to May 1, 2023, Sutter/Yuba used Anasazi to maintain enrollment and provider data.
- Sutter/Yuba used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to Credible from Anasazi.
  - Kings View defined data quality metrics prior to migration and conducted thorough validation between Anasazi and Credible to identify data discrepancies during the migration process. Extensive testing was performed in a non-live environment first prior to testing in a live environment as a means to implement a successful migration.
  - Kings View compared data migrated to Credible to source data in Anasazi to ensure relevant information was successfully transferred. Additionally, testing was completed to ensure users were able to access data in Credible as expected.
  - Sutter/Yuba conducted checks on migrated data, including spot checks and random samples of records, to ensure complete and accurate data were transferred to the member record in Credible.
  - Sutter/Yuba maintained access to Anasazi for historical reference.

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

- Kings View had a team of six programmers trained and capable of using programming language to support Credible. Kings View programmers had an average of 10 or more years of experience.
- Sutter/Yuba had one staff member who maintained oversight of timely access reporting with an average of two years of experience.

HSAG identified no concerns with Sutter/Yuba's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by Sutter/Yuba 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 Sutter/Yuba's enrollment system included the following findings:

- Enrollment and eligibility data for Sutter/Yuba were maintained in Credible.
- Sutter/Yuba received the MMEF from DHCS and submitted a ticket to Kings View to request that the file be uploaded. Kings View staff were responsible for obtaining the MMEF and uploading the file into Credible. Once the upload was completed, Kings View attached a screen shot to the ticket indicating the file was successfully uploaded with the total number of records processed, matched records, potential matched records, and non-matched records.
- Sutter/Yuba member eligibility was verified at the point of member service request, via the DHCS provider portal.
- Credible captured and maintained both the state-issued Medi-Cal CIN and a system-generated ID. Members retained the unique system-generated ID throughout enrollment and disenrollment.
  - Staff were required to search fields including name, data of birth, CIN, and sex prior to creating a new member account in Credible. Credible maintained a feature to check for duplicate accounts when creating a new record based on these data fields.
- Sutter/Yuba had processes in place to prevent missing and incomplete member data:
  - Data elements that were required for State reporting were either required fields, meaning the record could not be saved without completing the fields, or they were default fields in Credible. All other fields were listed as optional.
  - Retroactive enrollments could be added at any time, and data elements related to enrollment could be updated as needed for existing records to ensure complete member data.
- Sutter/Yuba defined a new member as an member who had not received services with Sutter/Yuba or an individual who had not received services from Sutter/Yuba in the previous six months.
- Sutter/Yuba identified member demographic updates based on direct communication provided by its members as well as demographic updates provided on the MMEF. Demographic updates received through the MMEF were verified with the member at the time of service. If any updates or discrepancies were identified with member demographic information, the member was advised to reach out to his or her case worker to assist with updating the demographic information with DHCS.

HSAG identified no concerns with Sutter/Yuba'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 Sutter/Yuba to capture provider data and identified the following findings:

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

HSAG's evaluation of Sutter/Yuba's provider data system(s) included the following findings:

- Provider credentialing and network status data were maintained in Credible.
- Provider credentialing was verified upon notification of hire; recredentialing was performed annually to ensure network providers possessed valid and current credentials.
- Sutter/Yuba validated provider information including license, NPI, address, and taxonomy at hiring and conducted a background check. A provider list was sent monthly to Valenz to determine if providers were eligible to bill to Medi-Cal. Sutter/Yuba used sources for provider verification such as the California Consortium of Addiction Programs and Professionals Licensure Report, the California Department of Consumer Affairs Licensure Report, the HHS-OIG Fugitives List, OIG LEIE, EPLS/SAM, and the Specially Designated Nationals List.
- Sutter/Yuba QA staff notified providers within 90 days of an expiring license. If a provider was terminated, the provider's status was changed from active to inactive, and the provider's access was removed from Credible.
- Sutter/Yuba did not have a required time frame for providers to notify the plan of any changes to demographic information.

HSAG identified no concerns with Sutter/Yuba'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 Sutter/Yuba's delegated entity data and oversight included the following findings:

- Sutter/Yuba did not subcontract any network adequacy-related services to delegated entities.

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Sutter/Yuba staff entered timely access data into an Access to Service form located in Credible. An Access Team staff member opened the Access to Service form during the point of first contact. When moving through the assessment process, the Access Team staff member documented relevant information from the clinician's specific interaction with the member, including the first offered appointment date. Once the Access to Service form was opened, it could be pulled from the timely access report in Credible.
- The QA staff analyst generated the TADT from the Access to Service record in Credible. The QA staff analyst reviewed each entry for completeness and opened the member chart to confirm accuracy of the data. Once the TADT had been reviewed and accuracy of the data was confirmed, the QA staff analyst sorted the data, calculated the timely access standard rates, and determined the percentage of encounters that met the timely access standards.
- Sutter/Yuba had strong procedural training documentation in place for tracking timely access. The procedural training documentation included detailed steps to capture data elements needed to populate the TADT and instructions to complete the Access to Service form in Credible. The training documentation also included defined urgent services in alignment with DHCS' definitions.
- HSAG assessed Sutter/Yuba's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Sutter/Yuba's QA staff analyst reviewed timely access data and calculated compliance rates quarterly, which were analyzed by program managers and supervisors. Quarterly results were compared to previous quarter results and reviewed during the quarterly QIC meetings.
- The QA staff analyst completed quality checks on timely access data by reviewing member charts to ensure the information was correct and complete. The data were transferred from Credible to the TADT and submitted to DHCS as deemed necessary.
  - The QA staff analyst reviewed and corrected validation errors on the TADT, which included addressing conditional formatting errors to ensure an accurate and complete submission to DHCS.

HSAG identified no concerns with Sutter/Yuba'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 Sutter/Yuba 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 Sutter/Yuba used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Overall, HSAG determined that Sutter/Yuba's **data collection procedures** were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Sutter/Yuba's **network adequacy methods** were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Sutter/Yuba'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 the 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 3.52 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.52—Sutter/Yuba 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	105	88	84%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	107	103	96%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	30	22	**73%↓**
Non-Urgent Psychiatric Services—Adult (21+)	72	69	96%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Urgent Non-Psychiatry SMHS—Adult (21+)	S	S	S
Urgent Psychiatry—Children/Youth (0–20)	S	S	S
Urgent Psychiatry—Adult (21+)	12	11	92%↑

Strengths, Opportunities for Improvement, and Recommendations

By assessing Sutter/Yuba'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:** Sutter/Yuba had strong procedural training documentation in place for tracking timely access. The procedural training documentation included detailed steps to capture data elements needed to populate the TADT and indicated alignment with DHCS' timely access requirements.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Sutter/Yuba did not have a required time frame for providers to notify the plan of any changes, such as credentialing or demographic updates. The absence of clear reporting expectations could delay updated provider information and impact network adequacy data.
  - **Recommendation:** HSAG recommends that Sutter/Yuba establish a required time frame for providers to notify Sutter/Yuba of any changes to provider information, such as licensure, credentialing, and demographic updates, to ensure this information remains current. HSAG also recommends that Sutter/Yuba communicate the required time frame to providers so that expectations are aligned between Sutter/Yuba and the providers.

- **Opportunity #2:** Sutter/Yuba did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Sutter/Yuba 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 Sutter/Yuba 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.

Tehama County Health Services Agency

ISCA Findings and Data Validity

HSAG completed an ISCA for Tehama 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 Tehama had in place to support network adequacy indicator reporting, which included the following findings:

- Tehama used myAvatar as the database management system to collect and maintain enrollment and provider data as of June 1, 2022.
- Prior to June 1, 2022, Tehama used CMHC as the database management system to maintain enrollment and provider data.
- Tehama used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to myAvatar from CMHC.
  - Tehama performed multiple processes to validate and correct data inaccuracies during the conversion process. Tehama performed a reconciliation on the number of members in CMHC compared to the number of members who migrated to myAvatar.
  - NetSmart assisted with the migration and compared data migrated to myAvatar to source data in CMHC to ensure relevant information was successfully transferred.
- Tehama staff maintained access to CMHC for historical reference.

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

- Tehama had a team of six programmers with an average of three years of experience.
- Tehama's business health analyst maintained oversight of timely access reporting.

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

Enrollment System

HSAG evaluated the information systems and processes used by Tehama 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 Tehama's enrollment system included the following findings:

- Enrollment and eligibility data for Tehama were maintained in myAvatar.

- Tehama did not receive Medi-Cal eligibility via the MMEF from DHCS because Tehama was unable to provide the required level of physical security for on-site servers where the MMEF would be stored.
- Tehama captured members' eligibility for Medi-Cal as they received services. The Tehama front desk staff verified enrollment status at time of service by manually checking the DHCS provider portal.
- 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 and disenrollment.
- Tehama identified member demographic updates based on direct communication from active members in its population. If any discrepancies were found, the Tehama staff would work with the member to report updated demographic information to the Department of Social Services.
- Tehama had processes in place to prevent missing or incomplete member data:
  - myAvatar was configured with built-in error messages to alert the user of crucial data elements that were missing or incomplete. Users could not proceed until the error was addressed and all required files were completed.
  - The Tehama Mental Health Department staff generated a weekly report to review new member setup to ensure all required data fields were completed.
- Tehama defined a new member as someone who had never received services or a previous member who had not received services within the last six months.

HSAG identified no concerns with Tehama'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 Tehama to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in myAvatar.
- Tehama used OIG Compliance Now in collaboration with national databases including the OIG LEIE, EPLS/SAM, and DEA Excluded Parties List to verify licensure and identify

sanctions or disciplinary actions. These verifications were conducted at the time of hire and monthly thereafter.

- Tehama notified providers of upcoming expiring licenses up to four months prior to expiration until renewed. If licensure or applicable credential expired, the provider's status changed to inactive in myAvatar.
- Tehama had thorough processes in place to ensure provider data remained accurate and updated:
  - Tehama required its provider network to self-report updated provider data. Providers were made aware of this expectation during onboarding and in the contract language.
  - Tehama performed a monthly review of the comprehensive provider list to ensure it was accurate and complete before sending to OIG Compliance Now for monthly provider data validation.
  - Tehama's Fiscal and Support Services Center and billing staff worked closely with IT to ensure applicable changes were made to a provider's status in myAvatar appropriately.

HSAG identified no concerns with Tehama'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 Tehama's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Tehama utilized myAvatar to track and extract data used to report timely access network adequacy indicators. Tehama used the TADT for reporting timely access to DHCS annually, or as requested by DHCS.
- Tehama's Health Services staff used data entered into myAvatar to create SQL queries to extract required data elements for timely access reporting.
- Tehama used appropriate methodologies to assess adherence to DHCS' network adequacy timeliness standards.
  - myAvatar was used to capture members initiating services, including both new members and members who had not received services in over six months.

  - Tehama worked closely with NetSmart to make updates in myAvatar to timely access data fields based on DHCS' requirements. As a result of this partnership with NetSmart, Tehama identified and rectified the closure reason code to ensure it was appropriately mapped to the relevant closure reason in accordance with the TADT.
- HSAG assessed Tehama's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Tehama maintained data control procedures to ensure the accuracy and completeness of data extracted from myAvatar by reviewing reports against prior reporting.
  - Tehama used Crystal Reports to audit data for completeness and maintained a series of reports to identify and address missing or incomplete data in myAvatar.
  - Tehama conducted reasonability checks on all data pulled from myAvatar and analyzed for accuracy.
- Tehama's QIC reviewed timely access data quarterly and compared the data to previous timely access data to identify trends.

HSAG identified no concerns with Tehama'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 Tehama 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 Tehama used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Tehama'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 the 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 3.53 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.53—Tehama 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	—	—	—
Urgent Non-Psychiatry SMHS—Adult (21+)	—	—	—
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Tehama'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:** Tehama maintained thorough processes to ensure accurate and current provider data, including the provider onboarding and credentialing process through OIG Compliance Now, along with a monthly review of the comprehensive provider list.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Tehama did not use the MMEF to populate member eligibility data in myAvatar due to security limitations.
  - **Recommendation:** HSAG recommends that Tehama partner with DHCS to explore potential solutions for addressing these eligibility data challenges, subsequently allowing for more automation in populating member eligibility data.
- **Opportunity #2:** Tehama 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 Tehama 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 Tehama 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.

Trinity County Behavioral Health Services

ISCA Findings and Data Validity

HSAG completed an ISCA for Trinity 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 Trinity had in place to support network adequacy indicator reporting, which included the following findings:

- Trinity used Credible as the database management system to collect and maintain enrollment and provider data as of January 1, 2023.
- Prior to January 1, 2023, Trinity used Anasazi to maintain enrollment and provider data.
- Trinity used appropriate testing and validation measures to ensure completeness and accuracy of data migrated to Credible from Anasazi.
  - Prior to and during the transition from Anasazi to Credible, Kings View assisted Trinity with the data migration process.
  - Trinity staff maintained access to Anasazi for historical reference.

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

- Trinity had a team of five programmers with an average of 15 years of experience trained and capable of populating and submitting timely access reporting to DHCS.
- Trinity's Quality Assurance Team maintained oversight of timely access reporting and ongoing monitoring activities.

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

Enrollment System

HSAG evaluated the information systems and processes used by Trinity 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 Trinity's enrollment system included the following findings:

- Enrollment and eligibility data for Trinity were maintained in Credible.
- Trinity received the MMEF from DHCS. Kings View downloaded the MMEF from the DHCS portal and uploaded the file into Credible upon receiving a ticket to initiate the upload.

- Trinity performed monthly reconciliations between Credible and the MMEF to ensure completeness and accuracy of eligibility data.
  - After the MMEF was uploaded successfully, Kings View also uploaded a screen print of the successful ready status in Credible to the ticket.
  - Before entering a new member in Credible, Trinity's QA staff searched to identify existing member records based on a match on name, DOB, and CIN. After existing member records were identified, QA staff processed the matched records and updated eligibility data in Credible.
  - Trinity validated eligibility using MEDSLITE prior to members beginning services and as needed to assist in validating eligibility.
- Credible 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.
- Trinity identified member demographic updates based on the member's self-report at appointment intake. The front desk staff entered required information to manually verify eligibility using MEDSLITE. Credible logged changes made to member records with the date stamp, record modifier's name, and details of the changes made. Retroactive enrollments could be added at any time, and data elements related to enrollment could be updated as needed for existing records. Data elements required for State reporting were required fields and defaulted in Credible.
- Trinity defined a new member as someone who had never received services or a member who had not received services within the past six months.

HSAG identified no concerns with Trinity'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 Trinity to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in Credible.
- Trinity validated provider information at the beginning of each month using DCA BreEZe Online Services system, NPPES, and EPLS/SAM. These data, such as NPI and license or board certification, were tracked on a spreadsheet as provider validation was completed.

- Trinity's procedures for updating and maintaining provider data included:
  - Providers submitted a new user request form, which included all necessary credentialing data components such as the provider's name and contact information, licensure, and NPI.
  - The compliance officer verified credentials at initial application and monthly.
  - The QA deputy director reviewed all manual edits made by new staff to ensure appropriate provider edits were made.
- Trinity required providers to give notification when there was an update in licensure, credentials, or demographic information.

HSAG identified no concerns with Trinity'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 Trinity's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Trinity utilized Credible to track and extract data used to report timely access network adequacy indicators. Trinity's front desk staff entered information into the forms in Credible as services were requested and received. Trinity used the TADT for reporting timely access to DHCS annually, or as requested by DHCS.
- Credible contained two forms for tracking SMHS services: mental health psychiatric and mental health non-psychiatric. Both contained required data fields needed to complete network adequacy timely access reporting.
- Trinity's QA coordinator exported timely access data from Credible to an Excel spreadsheet for network adequacy indicator reporting via the TADT. Trinity's deputy director completed a second review of the TADT prior to DHCS submission. Once reviewed, the TADT was submitted via the DHCS portal.
- Trinity retained Excel spreadsheets used for internal monitoring and all TADT submissions to DHCS for historical reference.
- Prior to July 1, 2023, Trinity maintained a similar process while using Anasazi to track and report timely access. Anasazi contained a CSI form utilized for tracking and extracting timely access data used for reporting to DHCS.

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

Ongoing monitoring activities:

- Credible maintained a series of reports that Trinity QA staff used monthly to ensure completeness and accuracy of timely access and service data.
- Trinity maintained data control procedures to ensure the accuracy and completeness of data extraction from Credible by performing the following:
  - Trinity worked closely with Kings View to make changes in Credible to timely access data fields based on updated DHCS requirements.
  - Trinity's QA staff made changes as needed when preparing data for the reporting period based on updated DHCS requirements.
  - Trinity's deputy director reviewed mental health psychiatric and mental health non-psychiatric forms as needed to validate accuracy of timeliness data. If an outlier was identified, the QA coordinator would research the member chart to determine if data were incorrectly entered into Credible.

HSAG identified no concerns with Trinity'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 Trinity 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 Trinity used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Trinity'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 the 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 3.54 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.54—Trinity 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	15	12	80%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	31	24	**77%↓**
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	S	S	S
Non-Urgent Psychiatric Services—Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Trinity'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:** Trinity implemented strong monitoring procedures to ensure accuracy and completeness of provider data, including the QA director's review of manual edits that new staff made to provider records to ensure the edits were appropriate and complete.
- **Strength #2:** Trinity maintained robust procedural documentation which included instructions to correctly document timely access appointment data from intake through reporting via the TADT to DHCS.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Trinity did not meet one or more DHCS standards for timely access indicators.
  - **Recommendation #1:** HSAG recommends that Trinity 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 Trinity 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.

Tulare County Health & Human Services Agency

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 purposedly 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 a mental health psychiatric SMHS timeliness record and mental health non-psychiatric SMHS timeliness record for tracking SMHS, 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 psychiatric and non-psychiatric 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 the 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 3.55 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.55—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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	471	398	85%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	50	48	96%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	88	73	83%↑
Non-Urgent Psychiatric Services—Adult (21+)	124	102	82%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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.

Tuolumne County Behavioral Health Department

ISCA Findings and Data Validity

HSAG completed an ISCA for Tuolumne 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 Tuolumne had in place to support network adequacy indicator reporting, which included the following findings:

- Tuolumne used Credible as the database management system to collect and maintain enrollment data and provider data beginning July 1, 2023.
- Prior to July 1, 2023, Tuolumne used Anasazi to maintain enrollment and provider data.
- Tuolumne performed quality testing to ensure accuracy and completeness of data migrated to Credible from Anasazi, which included:
  - Defined data quality metrics before the system migration and conducted checks between the source EHR system and the new EHR system to identify any data discrepancies.
  - Compared the migrated data to the source data to ensure all relevant information was successfully transferred, and performed comprehensive testing on the data in the database to ensure applications effectively used the data and allowed end users to retrieve the data as expected.
  - Prior to and during the transition from Anasazi to Credible, Kings View assisted Tuolumne with the data migration process.
- Tuolumne staff maintained access to all data stored in Anasazi for historical reference.
- Tuolumne had strong data quality checks in place and coordinated effectively with Kings View to verify the accuracy and integrity of data migrated from Anasazi to Credible. Tuolumne ensured no downtime or impact to eligibility or provider data, which were used for timely access reporting to DHCS.

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

- Tuolumne had five programmers trained and capable of supporting network adequacy activities. The programmers had an average of six years of experience.
- Kings View had six programmers with an average of 10 or more years of experience.

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

Enrollment System

HSAG evaluated the information systems and processes used by Tuolumne 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 Tuolumne's enrollment system included the following findings:

- Enrollment and eligibility data for Tuolumne were maintained in Credible.
- Tuolumne defined a new member as a member brand new to services or someone previously closed to services who was readmitted.
- Tuolumne downloaded the MMEF from DHCS' MOVEit SFTP portal and uploaded the file into Credible. Tuolumne received a notification when the MMEF was successfully imported into Credible.
  - Eligibility data were verified through the MMEF, and select staff had security clearance to verify online member eligibility data via the DHCS portal.
  - The MMEF included data from the previous 15 months.
- Credible captured and maintained both the state-issued Medi-Cal ID and an internal system-generated ID. The member retained the same unique ID even if disenrolled and reenrolled.
- Member demographic updates were identified during initial member contact.
  - Members completed a Change of Status form in the welcome packet to communicate a change in contact information listed in the system. Intake staff updated Credible with changes from the Change of Status form. Member demographic changes were reported through various required State reporting forms that were reported to DHCS.
  - Intake staff including Medical Records Billing staff, and some Crisis Unit staff had permissions to edit patient demographic data in Credible.
  - Manual edits made were logged in Credible and included the modified date and time, the modifier's user ID, and both the old and new values of the specific field modified.

HSAG identified no concerns with Tuolumne'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 Tuolumne to capture provider data and identified the following findings:

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

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

- Provider credentialing and network status data were maintained in Credible.
- Provider credentialing data were maintained by the Tuolumne HHSA.
- Provider credentialing was verified upon notification of hire, and when required, monthly thereafter. Recredentialing was performed at a minimum of every three years to ensure network providers possessed valid credentials.
  - Tuolumne validated providers against various exclusion lists and verification sources including but not limited to the Social Security Administration's Death Master File, NPPES, OIG LEIE, and DHCS S&I Provider List. Tuolumne performed monthly verification of provider data including NPI, licensure, and taxonomy.
  - Tuolumne notified providers of upcoming expiring licenses at 60 days prior to expiration and with a reminder at 30 days prior to expiration. If a provider allowed a license to expire, the Tuolumne Compliance Unit worked directly with the HR Department for any needed disciplinary action, and suspended access to claims in Credible.
- Providers submitted data using the credential packet materials, including but not limited to the NPI form, W-9 form, professional license/certification, DEA identification, Medi-Cal Provider Application, and any history of sanctions from participating in Medi-Cal.
  - Tuolumne received updated provider demographic information via email. Provider demographic data were stored and updated in Credible and tracked for version history.
  - Tuolumne required providers to notify the plan of any changes to provider demographic information within 30 days of the change. Providers were notified of this requirement via a policy.

HSAG identified no concerns with Tuolumne'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 Tuolumne's delegated entity data and oversight included the following findings:

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

Network Adequacy Indicator Monitoring and Reporting

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

Data preparation and submission to DHCS:

- Tuolumne utilized a CSI Excel spreadsheet and Credible forms to track and extract data used to report network adequacy data annually, or as requested by DHCS.
  - Tuolumne tracked both psychiatric and non-psychiatric timeliness data related to SMHS. Psychiatric data were pulled from Credible using the Initial Contact Form and the Post Hospitalization Form, which contained all psychiatric timeliness data needed for reporting. Non-psychiatric data were extracted from a manual CSI spreadsheet which was used to track all non-psychiatric timeliness data needed for reporting. Data from the Credible forms and the CSI manual data were entered into the TADT.
  - Validation for both psychiatric and non-psychiatric timely access data was performed and reconciled from the TADT to Credible. Tuolumne's QI Team completed a manual review to validate data by checking the member's chart as the data were copied into the TADT.
  - Tuolumne's QI Team also completed a quality check on formatting in the TADT prior to submission.
- Tuolumne maintained all reports submitted to DHCS for historical reference.
- HSAG assessed Tuolumne's processes used to inform ongoing reporting and monitoring of timely access, which demonstrated alignment with DHCS reporting requirements.

Ongoing monitoring activities:

- Tuolumne had strong data quality checks in place to verify accuracy of timely access data reported.
  - Data analysts received extensive training, including one-on-one support and weekly reviews with senior analysts to understand data controls.
  - Detailed procedural documentation was created specifically listing out the steps for populating each field in the TADT.
  - Upon completion of the TADT, A QI lead completed an additional spot check review to verify services.

- The QI Team used a dashboard to monitor timeliness data, which included counts and overall percentages of compliance from the past two fiscal years. The dashboard was reviewed quarterly for trends and outliers.
- Tuolumne held a quarterly QMC meeting to discuss gaps in network adequacy, the frequency of no-show rates, and other areas that potentially impacted timeliness measures. Meeting minutes were kept and referenced to track trends throughout the year and to document suggestions for improvement. As a result of these ongoing monitoring discussions held during the QMC meetings, Tuolumne evaluated the contract for telepsychiatry to ensure those providers were available for all initial psychiatric treatments to improve timeliness of psychiatric treatment appointments.

HSAG identified no concerns with Tuolumne'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 Tuolumne 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 Tuolumne used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Tuolumne'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 the 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 3.56 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.56—Tuolumne 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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	40	38	95%↑

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	73	66	90%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	—	—	—
Non-Urgent Psychiatric Services—Adult (21+)	—	—	—
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	0	0	ZU
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	0	0	ZU

Strengths, Opportunities for Improvement, and Recommendations

By assessing Tuolumne'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:** Tuolumne had strong data quality checks in place and coordinated effectively with Kings View to verify accuracy and integrity of data migrated from Anasazi to Credible. Tuolumne ensured no downtime or impact to eligibility or provider data, which were used for timely access reporting to DHCS

Opportunities for Improvement and Recommendations

- **Opportunity #1:** Tuolumne did not submit the timely access CAP submission using the appropriate DHCS TADT template.
  - **Recommendation:** HSAG recommends that Tuolumne submit all timely access submissions, including the CAP submission, on the appropriate DHCS TADT template.
- **Opportunity #2:** Tuolumne 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 Tuolumne 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 Tuolumne 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.

Ventura County Behavioral Health

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 a mental health psychiatric SMHS timeliness record and mental health non-psychiatric SMHS timeliness record for tracking SMHS, which contained all data fields needed for network adequacy reporting.
- Ventura's QI Team extracted data from the psychiatric and non-psychiatric 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 psychiatric and non-psychiatric 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 non-psychiatric SMHS was reported by matching request for service (RFS) records in myAvatar to CSI assessment and service records in the EHR system. Ventura used dates from the RFS records, CSI assessment, and service no-show records to track and report first offered dates, and dates from CSI assessment records and service records as first service dates.
- For adult psychiatric SMHS, RFS and psychiatric appointment request (PAR) records from myAvatar were matched to service records in the system. Dates from PAR records were used as first offered dates, and dates from service records were used as first service dates. For youth psychiatric SMHS, PAR records from myAvatar were matched to service records in the EHR system. Dates from PAR records were used as first offered dates, and dates from service records were used as first service dates.
- 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 the 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 3.57 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.57—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	727	596	82%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	275	273	99%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	90	76	84%↑
Non-Urgent Psychiatric Services—Adult (21+)	66	66	100%↑
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	0	0	ZU
Urgent Psychiatry—Adult (21+)	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.

Yolo County Health & Human Services Agency

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 and 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 SMHS 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 the 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 3.58 presents DHCS-calculated results for timely access by service 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 non-urgent non-psychiatry SMHS, within 15 business days for non-urgent psychiatric services, and within 48 hours without prior authorization or 96 hours with prior authorization for all SMHS urgent appointments.

Table 3.58—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.

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.

Service Type	Total Number of Service Requests (Denominator)	Total Number of Service Requests Compliant (Numerator)	Request to First Encounter Appointment Offer Date Percentage
Outpatient Non-Urgent Non-Psychiatry SMHS			
Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	44	36	82%↑
Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)	27	24	89%↑
Non-Urgent Psychiatric Services			
Non-Urgent Psychiatric Services—Children/Youth (0–20)	11	11	100%↑
Non-Urgent Psychiatric Services – Adult (21+)	S	S	S
All SMHS Urgent Appointments			
Urgent Non-Psychiatry SMHS—Children/Youth (0–20)	S	S	S
Urgent Non-Psychiatry SMHS—Adult (21+)	0	0	ZU
Urgent Psychiatry—Children/Youth (0–20)	S	S	S
Urgent Psychiatry—Adult (21+)	S	S	S

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 MHPs 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.

- The DHCS Behavioral Health Oversight Monitoring Division (BHOMD) provided resources to MHPs to access eligibility data.
  - The BHOMD provided the MHPs a county-specific MMEF, which contained eligibility data for the current month and previous 15 months. The MMEFs were available to the MHPs via the MOVEit portal and were uploaded to the MHPs monthly.
  - DHCS granted access to MEDSLITE, the internet-based program that queried eligibility data from MEDS, for MHPs to validate member eligibility status.
- MHPs 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:

- MHPs 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 and psychiatry SMHS providers that were within the MHP's provider network at the group, site, and provider detail level. The MHPs reported inpatient/hospital and residential facility reporting at the group and site level.
- DHCS maintained procedures to ensure accuracy and completeness in the receipt of the 274 data files. If an MHP submitted its 274 file late, or the file was incomplete or inaccurate, the MHP could be subject to a CAP and/or other enforcement actions.
- DHCS' Network Adequacy Oversight Section (NAOS) Team utilized provider data received from the MHPs 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 MHPs.
- DHCS had adequate processes in place to ensure timely and consistent receipt of plans' TADT submissions such as requiring MHPs to submit timely access data within the approved TADT template, uploading the TADT file into the IBHIS 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 MHP with one

opportunity for correction and resubmission. This opportunity was only granted if the MHP'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 MHP 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.
- MHPs 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 MHP'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 an MHP to be in compliance with timely access standards, 80 percent of new members who request non-psychiatric services and 80 percent of all members who request psychiatric services must have been offered an appointment within the applicable time frame per indicator.
  - For MHPs with timely access standards that met the 80 percent standard, DHCS granted the MHP a pass on its Network Adequacy Findings Report.
  - For MHPs 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 date was blank or invalid with a valid rendered date.
- The TADTs included new member timely access data collected by the MHPs; however, the definition of new member was inconsistent across the MHPs 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 MHPs through the BHIN. The NAOS Team also had well-established instructions embedded in the TADT to instruct the MHPs 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 MHPs the methodology DHCS used for compliance determination.
- **Strength #2:** DHCS had well-established processes and documentation in place within the TADT to instruct MHPs 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 MHPs, which included new member timely access data; however, the definition of "new member" was not consistent across the MHPs.
  - **Recommendation:** HSAG recommends that DHCS define the criteria for a new member and communicate these criteria to the MHPs to ensure consistent timely access data are collected and analyzed across all MHPs.

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 54 MHPs achieved *a High Confidence* validation rating, which refers to HSAG's overall confidence that the MHPs 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, 25 MHPs met the 80 percent standard across all indicators. Thirty-one MHPs did not meet this 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 MHPs that did not meet DHCS' 80 percent standard by indicator.

Table 4.1—MHPs—Timely Access Conditional Pass

MHP	Timely Access Indicator(s)
Alameda	♦ Non-Urgent Psychiatric Services—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20)
Alpine	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Non-Urgent Psychiatric Services—Children/Youth (0–20) ♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Urgent Psychiatry—Children/Youth (0–20) ♦ Urgent Psychiatry—Adult (21+)
Butte	♦ Non-Urgent Psychiatric Services—Children/Youth (0–20) ♦ Non-Urgent Psychiatric Services—Adult (21+)
Contra Costa	♦ Urgent Non-Psychiatry SMHS— Adult (21+) ♦ Non-Urgent Psychiatric Services—Adult (21+)
Del Norte	♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Non-Urgent Psychiatric Services—Children/Youth (0–20) ♦ Urgent Psychiatry—Adult (21+)

MHP	Timely Access Indicator(s)
Fresno	♦ Non-Urgent Psychiatric Services—Children/Youth (0–20) ♦ Urgent Psychiatry—Children/Youth (0–20)
Glenn	♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Non-Urgent Psychiatric Services—Children/Youth (0–20)
Humboldt	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Non-Urgent Psychiatric Services—Adult (21+)
Inyo	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Non-Urgent Psychiatric Services—Children/Youth (0–20) ♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Urgent Psychiatry—Children/Youth (0–20) ♦ Urgent Psychiatry—Adult (21+)
Kern	♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Urgent Psychiatry—Children/Youth (0–20)
Kings	♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Psychiatry—Adult (21+)
Los Angeles	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Non-Urgent Psychiatric Services—Children/Youth (0–20) ♦ Non-Urgent Psychiatric Services—Adult (21+)
Mono	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Adult (21+)
Monterey	♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Adult (21+)
Nevada	♦ Urgent Non-Psychiatry SMHS—Adult (21+)

MHP	Timely Access Indicator(s)
Placer	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Non-Urgent Psychiatric Services—Children/Youth (0–20) ♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Adult (21+)
Plumas	♦ Urgent Non-Psychiatry SMHS—Adult (21+)
San Diego	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20)
San Francisco	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Non-Urgent Psychiatric Services—Children/Youth (0–20) ♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Urgent Psychiatry—Children/Youth (0–20) ♦ Urgent Psychiatry—Adult (21+)
San Mateo	♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Non-Urgent Psychiatric Services—Children/Youth (0–20)
Santa Barbara	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Non-Urgent Psychiatric Services—Adult (21+)
Santa Clara	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Adult (21+)

MHP	Timely Access Indicator(s)
Santa Cruz	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)
Shasta	♦ Urgent Non-Psychiatry SMHS—Adult (21+)
Solano	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+)
Sonoma	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Non-Urgent Psychiatric Services—Children/Youth (0–20)
Stanislaus	♦ Urgent Psychiatry—Children/Youth (0–20) ♦ Urgent Psychiatry—Adult (21+)
Sutter/Yuba	♦ Non-Urgent Psychiatric Services—Children/Youth (0–20)
Tehama	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Children/Youth (0–20) ♦ Urgent Non-Psychiatry SMHS—Adult (21+)
Trinity	♦ Outpatient Non-Urgent Non-Psychiatry SMHS—Adult (21+) ♦ Non-Urgent Psychiatric Services—Adult (21+)
Tuolumne	♦ Non-Urgent Psychiatric Services—Adult (21+) ♦ Non-Urgent Psychiatric Services—Children/Youth (0–20)

HSAG observed gaps in completeness of timely access data captured and reported by two MHPs to DHCS. As a result, HSAG determined some elements to have significant bias, resulting in a *No Confidence* validation rating. Table 4.2 demonstrates MHPs that received a *No Confidence* validation rating.

Table 4.2—MHPs—No Confidence Validation Rating

MHP	Validation Rating
San Francisco	*No Confidence*
Santa Clara	*No Confidence*

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 MHPs had robust processes in place to collect, maintain, and validate accuracy and completeness of member eligibility and demographic data. MHPs had defined processes in place to collect demographic information at initial request for services, ongoing updates throughout receipt of mental health services, and routine validation of demographic and eligibility information using the DHCS provider portal and MEDSLITE.
- **Strength #2:** HSAG observed strong collaboration between DHCS and the MHPs. Clear expectations were provided to the MHPs on reporting network adequacy data using the TADT and through distributing BHINs. MHPs partnered with their EHR vendors to ensure system updates to capture and report all required data fields in accordance with the TADT.

Opportunities for Improvement and Recommendations

- **Opportunity #1:** HSAG observed variation in the MHPs' 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 to the MHPs 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’ SMHS Program, 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	Behavioral Health Medical Director and Chief Medical Officer (CMO)
Adm Golub	Management Analyst
Adrienne Carlisle	Compliance and Privacy Officer—Alameda County Behavioral Health Department (ACBHD)
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 (EPSDT) 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

Interviewee Name	Title
Henning Schulz	Adult Outpatient Services Division Director
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
Juliene 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

Interviewee Name	Title
Rashad Eady	Program Specialist
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 (ACH)
Torfeh Rejali, LMFT	Division Director, Quality Assurance
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 Alpine staff members interviewed by the HSAG validation team.

Table A.2—List of Alpine Interviewees

Interviewee Name	Title
Kimball C. Pier	Deputy Director
Cinthia Cruz	Administrative Assistant

Table A.3 lists the Amador staff members interviewed by the HSAG validation team.

Table A.3—List of Amador Interviewees

Interviewee Name	Title
Raechel Razzano	UQM Coordinator
Melissa Cranfill	Behavioral Health Director
Karen Vaughn	Deputy Director of Fiscal and Administrative Services
Angie Grau	Compliance Officer
Teresa Boerio	Finance and Administrative Supervisor
Elizabeth Byler	Director of Technical Integration and Solutions, Kings View

Table A.4 lists the Butte staff members interviewed by the HSAG validation team.

Table A.4—List of Butte Interviewees

Interviewee Name	Title
Scott Kennelly	Director of Behavioral Health
Jennifer Stofa	Assistant Director, Clinical Services
Jacob Read	Assistant Director, Clinical Services
Melody Robinson	Assistant Director, Clinical Services
Donovan Wong	Medical Director
Samuel Casale	Senior Program Manager—Systems Performance, Research and Evaluation Mental Health Services Act Coordinator & Public Information Officer
Matthew Gothan	Fiscal Manager
Angela Sorenson	Medical Records Manager
Michelle Perez	Quality Assurance Coordinator—QM
Brenda Tena	Administrative Analyst III—QM
Lauren Kohler	Senior Administrative Analyst—Billing
Michael Larish	Principal IT Analyst
Leila Cooke	Medical Records Supervisor
Jennifer Hargis	Medical Records Supervisor
Quinci Reynolds	Business Systems Supervisor—Systems Performance, Research and Evaluation

Interviewee Name	Title
Sandra Matray	Business Systems Analyst II—Systems Performance, Research and Evaluation

Table A.5 lists the Calaveras staff members interviewed by the HSAG validation team.

Table A.5—List of Calaveras Interviewees

Interviewee Name	Title
Stacey Meily	Behavioral Health Program Manager
David Bugarin	Senior Department Analyst
Morgan Berry	Administrative Services Manager
Wendy Alt	Health and Human Services Deputy Director/Behavioral Health Director

Table A.6 lists the Colusa staff members interviewed by the HSAG validation team.

Table A.6—List of Colusa Interviewees

Interviewee Name	Title
Tony Hobson	Director
Bonnie Briscoe	Deputy Director of Behavioral Health Services—Administration
Theresa Cameron	Electronic Health Records Manager
Heather Bullis-Cruz	Compliance Officer
Bessie Rojas	Quality Assurance Coordinator
Ivan Martinez	Quality Assurance Coordinator
Jeannie Armstrong	Clinical Program Manager

Table A.7 lists the Contra Costa staff members interviewed by the HSAG validation team.

Table A.7—List of Contra Costa Interviewees

Interviewee Name	Title
Steve Hahn-Smith	Director of Quality and Informatics
Priscilla Aguirre	QM Program Coordinator
Todd Peterson	Planner and Evaluator—Level B

Interviewee Name	Title
Ziba Rahimzadeh	Director of Provider Relations & Credentialing
Jorge Pena	Business Analyst
Megan Rice	Project and Change Management Advisor
Cindy Leggett	Health Services Systems Analyst II
Amber Giles	Mental Health Program Manager, Access Line
Matthew R. Lardner	Planner and Evaluator—Level B
Iris Holland	IT Supervisor
Matt White	Data Team Manager
Laura Mendoza	Clinic Coordinator
Paolo Gargantiel	Access Line and Care Management Unit Operations Lead
Chris Melgoza	IT Supervisor
Nick Cunningham	Professional Billing Analyst for ccLink Team
Ross Seagram	IT Analyst
Carmelo Abaoag	Finance/IT Consultant
Michelle Collins	Patient Accounting Manager
Maria Bigol	Administrative Services Assistant III—Provider Services Analyst
Mary Belisle	Administrative Services Assistant III
Rudy Chavez	Business Intelligence Senior Consultant
Erik Nybo	Business Intelligence Developer
Chet Spikes	Assistant Health Services IT Director, Business Systems
Chelsea Walsh	Business Intelligence Analyst
Charles Fisher-Post	Planner and Evaluator—Level B
Vibeth Lardizabal	Health Services Systems Analyst II
Karen Gonzales	Health Services Systems Analyst II
Regina Griffiths	Utilization Review Program Manager
Mark Messerer	Program Manager, Alcohol and Other Drug Services
David Kekuewa	Health Services Systems Analyst II

Interviewee Name	Title
Daniel Colin	Administrative Analyst

Table A.8 lists the Del Norte staff members interviewed by the HSAG validation team.

Table A.8—List of Del Norte Interviewees

Interviewee Name	Title
Ranell Brown	Director
Shiann Hogan	Deputy Director
Samantha Reagen	Compliance Manager
Meaghan McGlasson	Program Manager
Patty Austin	Program Manager
Stephanie Silva	Fiscal Manager
Michelle Stephens	Administrative Analyst
Mary Berry	Staff Services Analyst
Lisa Sellars	Staff Services Analyst
Becky Bohannon	Office Manager, Lead of HR, Remi Vista
Jill Ratliff	Clinical Supervisor, Remi Vista
Elizabeth Byler	Director of Technical Integration and Solutions, Kings View
Tamara Price	Director of Revenue Cycle, Kings View
Sandra Turner	EHR Consultant

Table A.9 lists the El Dorado staff members interviewed by the HSAG validation team.

Table A.9—List of El Dorado Interviewees

Interviewee Name	Title
Nicole Ebrahimi-Nuyken	Director of Behavioral Health
Justine Collinsworth	Manager of Mental Health Programs
Shaun O'Malley	Acting Alcohol and Drug Programs Division Manager
Kristin Gula	Supervising Accountant/Auditor
Dennis Wade	Health Education Coordinator
Lisa Rodriguez	Sr. Department Systems Analyst

Interviewee Name	Title
Moriah Weldy	Administrative Analyst II
Cheyne Close	Administrative Analyst II
Raquel Smith	Administrative Analyst I
Nick Perez	IT Department Specialist
Alex De Guzman	IT Department Specialist
Ramona Diaz	Fiscal Manager
Kristen Monroe	Administrative Analyst Supervisor

Table A.10 lists the Fresno staff members interviewed by the HSAG validation team.

Table A.10—List of Fresno Interviewees

Interviewee Name	Title
Jeffrey Elliott	QI Coordinator
Susan Holt	Director of Behavioral Health and Public Guardian Office
Maryann Le	Deputy Director—Administrative Operations and Public Guardian Office
Ahmad Bahrami	Division Manager—Planning & Quality Management
Emma Rasmussen	Deputy Director
Lesby Flores	Deputy Director
Joseph Rangel	Behavioral Health Division Manager—Plan Administration
Sean Patterson	Behavioral Health 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

Interviewee Name	Title
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)
Lisa Kirlin	Senior Implementation Coordinator (CalMHSA)
Ricky Cruz	Implementation Specialist (CalMHSA)
Charla Rowe	Clinical Implementation Coordinator (CalMHSA)
Gracia Amirtharaj	Director of Software Development (CalMHSA)
Amy Leino	QI Manager (CalMHSA)
Anastassia Kiannu	Office Assistant to Director of Project Management (CalMHSA)

Table A.11 lists the Glenn staff members interviewed by the HSAG validation team.

Table A.11—List of Glenn Interviewees

Interviewee Name	Title
Alysia Miller	Compliance & Quality Improvement Program Manager
Nancy Alvarez	Compliance and QI Program Coordinator
Tami Hanni	Administrative Services Analyst III
Nancy Martinez	Administrative Services Analyst III
Laura Hawkins	HHSA Director

Table A.12 lists the Humboldt staff members interviewed by the HSAG validation team.

Table A.12—List of Humboldt Interviewees

Interviewee Name	Title
Emi Botzler-Rodgers	Behavioral Health Director
Paul Bugnacki	Behavioral Health Deputy Director—Performance Management Unit, Sempervirens, Jail, Community Corrections Resource Center, Mobile Response Team, Mobile Intervention & Services Team
Jack Breazeal	Behavioral Health Deputy Director—Adult Outpatient, Resident Engagement and Support Team Public Guardian, Adult Protective Services, In-Home Supportive Services & Veterans Services
Martin Stephan	Sr. Program Manager in Children's Behavioral Health
Amy Cone	QI Program Manager
Trevis Green	Health and Human Services Deputy Director—Finance
Kat Soderholm	Behavioral Health Budget Specialist
Scott Irvin	Medical Records Manager
Zach Smith	DHHS Deputy Director, Information Systems
Russ Catalan	Departmental Information Systems Supervisor
Bill Classon	Social Services Branch (SSB)—Information Systems Analyst II
Des Morphis	SSB—Information Systems Analyst II
Chris Olson	Accounting Systems Analyst
Scott Berry	Administrative Analyst I—QI
Alex Olivera	Administrative Analyst II—QI
Glen Guidry	Administrative Analyst II—QI
Edward Dudome	Administrative Analyst I—QI
Deanna Bay	Sr. Program Manager—Humboldt Programs for Recovery

Interviewee Name	Title
Michelle Thomas	Administrative Analyst II—Substance Use Disorder
Dalas Hayes	Staff Services Analyst II—DHHS QM Services
Kip Allen	Staff Services Analyst II—DHHS QM Services

Table A.13 lists the Imperial staff members interviewed by the HSAG validation team.

Table A.13—List of Imperial Interviewees

Interviewee Name	Title
Sarah Moore	Behavioral Health Manager
Rosalva Aramburo	Program Supervisor
Debbie Garcia	Administrative Analyst
Jessica Perea	Administrative Analyst
Leticia Plancarte-Garcia	Director of Behavioral Health Services
Gabriela Jimenez	Assistant Director of Behavioral Health Services
Ryan Taylor	Behavioral Health Manager
Alejandro Vasquez	Program Supervisor
Anais Lopez	Program Supervisor
Annette Hughes	Administrative Analyst
Jose Nunez	Administrative Analyst
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)
Eric Cardoza	Senior Electronic Health Records Solutions Engineer (CalMHSA)
Bethany Dominik	Senior Epidemiologist (CalMHSA)

Interviewee Name	Title
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.14 lists the Inyo staff members interviewed by the HSAG validation team.

Table A.14—List of Inyo Interviewees

Interviewee Name	Title
Anna Scott	Health and Human Services (HHS) Director
Gina Ellis	Assistant HHS Director
Lori Bengochia	Program Integrity Quality Assurance (PIQA) Sr. Manager
Gabriel Dominguez	PIQA Administrative Analyst
Lucy Vincent	Behavioral Health Administrative Assistant
Yesenia Ruelas	Front Office Supervisor

Table A.15 lists the Kern staff members interviewed by the HSAG validation team.

Table A.15—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	Behavioral Health Program Supervisor
Myeisha Dhillon	Behavioral Health Program Supervisor

Interviewee Name	Title
Donna Robinson	Behavioral Health Unit Supervisor
Karina Leonzo-Castillo	Behavioral Health 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	Behavioral Health Planning Analyst
Mario Marin	Technical Support Engineer II

Table A.16 lists the Kings staff members interviewed by the HSAG validation team.

Table A.16—List of Kings Interviewees

Interviewee Name	Title
Lisa Lewis, PhD	Director of Behavioral Health
Christi Lupkes	Assistant Director of Behavioral Health
Grant Zweifiel, LMFT	Quality Assurance Manager
Laura Tafolla	Fiscal Manager
Selene Oaks	Fiscal Analyst II
Kaile Williams	Quality Assurance Specialist
Monica Vasquez	Quality Assurance Specialist
Maria Gutierrez	Business Application Specialist
Ryan Campbell	Business Application Specialist
Ashley Bennett	Office Assistant, Quality Assurance Team
Hilda Garcia	Patient's Rights Advocate
Amanda Verhaege	Program Manager, Contracts
Sandra Rivas, LMFT	SUD Quality Assurance Manager
Polo Ortiz, LMFT	Adult System of Care Manager
Stephanie Bealer, LMFT	Children's System of Care Manager
Dustin Biel, LMFT	Clinical Program Manager
Brenda Tamayo-Pagan	Program Manager
Domingo Cruz	Program Manager

Interviewee Name	Title
Jeanette Barajas	Quality Assurance Specialist
Kathlene Barragan	Program Specialist
Ana Lopez	Program Specialist
Leah Hanzlicek	Quality and Compliance Manager (CalMHSA)
Candice Medina	Senior Program Manager (CalMHSA)
Khristy Pease	Director of Revenue Cycle Management (CalMHSA)
Lisa Kirlin	Senior Implementation Coordinator (CalMHSA)
Charla Rowe	Clinical Implementation Coordinator (CalMHSA)
Eric Cardoza	Senior Electronic Health Records Solutions Engineer (CalMHSA)
Ricky Cruz	Implementation Specialist (CalMHSA)
Bethany Dominik	Senior Epidemiologist (CalMHSA)

Table A.17 lists the Lake staff members interviewed by the HSAG validation team.

Table A.17—List of Lake Interviewees

Interviewee Name	Title
Elise Jones	BHS Director
Christine Andrus	Deputy Director, Administration
April Giambra	Deputy Director, Clinical
Vanessa Mayer	BHS Program Manager, Compliance
Michelle Lamkin	Staff Services Manager, Operations
Amber Luch	Staff Services Manager, Fiscal
Amber Westphal	BHS Program Manager, SUD Services
Scott Abbott	Program Manager, Mental Health Services Act
Robert Chalmers	Staff Services Analyst, Senior
Montinque Packs	Staff Services Analyst II, Fiscal
Janet Button	Accountant II
Matt Smith	Business Software Analyst Supervisor

Interviewee Name	Title
Melissa Poplin	Staff Services Analyst II, Compliance
Henry Lin	Staff Services Analyst II, Compliance
Ken Ogawa	Staff Services Analyst II, Compliance
Jennifer Stratton, LMFT	Quality Assurance/QI Clinician for Lake County Behavioral Health Services
Julia Gray	Case Manager
Lan Al-Adeeb	Business Software Analyst

Table A.18 lists the Lassen staff members interviewed by the HSAG validation team.

Table A.18—List of Lassen Interviewees

Interviewee Name	Title
Joshua Bradley	Data Analyst
Lori Griffith	Data Analyst
Kevin Barnetche	Data Analyst
Scott Nordstrom	Clinical Supervisor

Table A.19 lists the Los Angeles staff members interviewed by the HSAG validation team.

Table A.19—List of Los Angeles Interviewees

Interviewee Name	Title
Jennifer Hallman	Acting Chief of Quality Assurance
Susan Cozolino	Health Program Analyst III
Debbie Innes-Gomberg	Deputy Director—Quality, Outcomes and Training Division
Kara Taguchi	Mental Health Program Manager III
Stacey Anne Smith	Mental Health Program Manager I
Lisa Benson	Supervising Psychologist
Douglas Cacialli	Senior Data Scientist
Girivasan Patterikalam	IT Manager II
Nga Dang	IT Manager I
Mark Cheng	Departmental Chief Information Officer II
John Ortega	IT Manager II

Interviewee Name	Title
Juan Fermin	IT Specialist II
Sharon Baker	Chief, Revenue Management Health Services
Judy Porter Wherry	Health Program Analyst II
Kwan Lui	Administrative Services Manager III
Daiya Cunnane	Clinical Psychologist II
Rosa Franco	Clinical Psychologist II
Mychi Davis	Health Program Analyst III
Sandy Chen	Health Program Analyst I
Katia Kermoyan	IT Specialist I
Rhodora Deocariza	Senior Information Systems Analyst
Paul Arns	Mental Health Clinical District Chief

Table A.20 lists the Madera staff members interviewed by the HSAG validation team.

Table A.20—List of Madera Interviewees

Interviewee Name	Title
Arthur Galindo	Interim Assistant Director
Eva Weikel	Division Manager
David Laval	Business Systems Analyst
Aaron Garcia	Fiscal Manager
Gabriela Alanis	Program Assistant II
Olga Maciel	Office Services Supervisor

Table A.21 lists the Marin staff members interviewed by the HSAG validation team.

Table A.21—List of Marin Interviewees

Interviewee Name	Title
Todd Schirmer	Behavioral Health Director
Katie Smith	BHRS Division Director, QM
Catherine Condon	BHRS Division Director, Substance Use Services
Jordan Hall	BHRS Program Manager, Substance Use Services

Interviewee Name	Title
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 Fiscal
Steve Wilbur	QI Coordinator, QM
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)
Ricky Cruz	Implementation Specialist (CalMHSA)
Charla Rowe	Clinical Implementation Coordinator (CalMHSA)
Bethany Dominik	Senior Epidemiologist (CalMHSA)
Gracia Amirtharaj	Director of Software Development (CalMHSA)
Amy Leino	QI Manager (CalMHSA)

Table A.22 lists the Mariposa staff members interviewed by the HSAG validation team.

Table A.22—List of Mariposa Interviewees

Interviewee Name	Title
Lynn Rumfelt	Senior Administrative Analyst—Quality Assurance Supervisor
Laura Chase	Administrative Analyst—Mental Health Quality Assurance Supervisor
Sarah Higgs	Administrative Analyst—SUD Quality Assurance Supervisor
Randy Ridenhour	Senior Administrative Analyst—Fiscal
Lori Norman	Fiscal Officer

Table A.23 lists the Mendocino staff members interviewed by the HSAG validation team.

Table A.23—List of Mendocino Interviewees

Interviewee Name	Title
Jenine Miller, Psy. D.	Health Services Director
Karen Lovato	Acting Deputy Director of Operations
Mailea Pane	Principal Department Analyst
Navin Bhandari	Compliance Manager
Martin Kaye	Acting Principal Department Analyst
Tony Lemus	Acting Senior Department Analyst
Robin Harris	Acting Principal Department Analyst

Table A.24 lists the Merced staff members interviewed by the HSAG validation team.

Table A.24—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

Interviewee Name	Title
Maira Romero	Quality Assurance 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
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.25 lists the Modoc staff members interviewed by the HSAG validation team.

Table A.25—List of Modoc Interviewees

Interviewee Name	Title
Dolores Navarro Turner	Behavioral Health Branch Director
Stacy Sphar	Director of Health Services
Lisa Reed	Health Services Financial Manager
Faith Cole	Supervising Public Health Nurse
Peggy Clevinger	Administrative Specialist—Billing & Organized Delivery System (ODS)
Nancy McCoy	Administrative Assistant
Sandra Turner	EHR Consultant

Interviewee Name	Title
Michael Webster	Electronic Health Record Support Systems Analyst III, Kings View
Tamara Price	Director of Revenue Cycle, Kings View
Elizabeth Byler	Director of Technical Integration and Solutions, Kings View

Table A.26 lists the Mono staff members interviewed by the HSAG validation team.

Table A.26—List of Mono Interviewees

Interviewee Name	Title
Danielle Murray	Staff Services Analyst
Amanda Greenberg	Program Manager
Jimmy Lee	Quality Assurance Coordinator
Kirk Hartstrom	Mono County IT Infrastructure Manager
Jason Housel	Mono County Chief Information Security Officer

Table A.27 lists the Monterey staff members interviewed by the HSAG validation team.

Table A.27—List of Monterey Interviewees

Interviewee Name	Title
Mark Alexakos	Medical Director
Rachel Amerault	Behavioral Health Services Manager
Janet H Barajas	Behavioral Health Services Manager
Isaias Betancourt	Supervising Departmental Information Systems Coordinator
Fabricio Chombo	Assistant Bureau Chief
Nick Cronkhite	Finance Manager
Ruben Gabriel	Behavioral Health Unit Supervisor
Rosary Moreno	Management Analyst
Lindsey M O'Leary	Deputy Director Behavioral Health
Niharika Rao	Epidemiologist
Melanie Rhodes	Bureau Chief

Interviewee Name	Title
Marni Sandoval	Deputy Director Behavioral Health
Lara Clayton	Deputy Director Behavioral Health
Jennifer Ortega Uribe	Management Analyst
Jan Wolf	Management Analyst
Philp Sherwood	Behavioral Health Services Manager
Jackie Townsend	Behavioral Health Services Manager
Liz Perez-Cordero	Behavioral Health Services Manager

Table A.28 lists the Napa staff members interviewed by the HSAG validation team.

Table A.28—List of Napa Interviewees

Interviewee Name	Title
Cassandra Eslami	Deputy Director of Health and Human Services/Behavioral Health Director
Nathan Hobbs	Assistant Deputy Director of Behavioral Health
Chelsea Stoner	Assistant Deputy Director of Behavioral Health
Valerie Cahill	Behavioral Health Manager
Zachariah Todd	Behavioral Health Manager
Adriana Navarro	Behavioral Health Manager
Matt Highland	Deputy Director of Health and Human Services/Administrative Services
Latoya Akil	Deputy Director of Health and Human Services/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

Interviewee Name	Title
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.29 lists the Nevada staff members interviewed by the HSAG validation team.

Table A.29—List of Nevada Interviewees

Interviewee Name	Title
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)
Eric Cardoza	Senior Electronic Health Records Solutions Engineer (CalMHSA)
Ricky Cruz	Implementation Specialist (CalMHSA)
Bethany Dominik	Senior Epidemiologist (CalMHSA)
Brianne Chavez	Quality Assurance Manager
Phebe Bell	Director
Heather Madison	Administrative Analyst II
Nikolas Jones	Quality Assurance Therapist
Joshua Dellis	Senior Administrative Analyst
Jennifer Ramirez	Senior Health Tech
Celestial Dover	Health Tech II
Cari Yardley	Clinical Administrator
Connie Liu	Administrative Analyst 1
Bonny Long	Heath Technician II

Interviewee Name	Title
Amanda Long	Supervising Health Technician
Priya Kannall	Program Manager
Allison Dobbins	Administrative Services Officer

Table A.30 lists the Orange staff members interviewed by the HSAG validation team.

Table A.30—List of Orange Interviewees

Interviewee Name	Title
Ian Kemmer	Behavioral Health Director
Linda Molina	Deputy Director, Behavioral Health Services
Sharon Ishikawa	Assistant Deputy Director, BHS Data Analytics and Evaluation
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	Behavioral Health Clinician II
Ashley Cortez	Behavioral Health Clinician II

Interviewee Name	Title
Timothy Sigafoos	Manager Data Analytics and Evaluation
Ronald Margheim	Applications Development and Support Supervisor
April Jannise	Health Services Manager

Table A.31 lists the Placer staff members interviewed by the HSAG validation team.

Table A.31—List of Placer Interviewees

Interviewee Name	Title
Amy Ellis	Health and Human Services Director, Adult System of Care
Twylla Abrahamson	Health and Human Services Director, Children's System of Care
Dr. Amy Haynes	Health and Human Services 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.32 lists the Plumas staff members interviewed by the HSAG validation team.

Table A.32—List of Plumas Interviewees

Interviewee Name	Title
Jessica McGill	Quality Assurance and Compliance Manager
Samuel Schopplein	Systems Analyst
Avery Pound	Systems Analyst
Anthony Dost	Director of EHR Application Support, Kings View
Tamara Price	Director of Revenue Cycle, Kings View
Elizabeth Byler	Director of Technical Integration and Solutions, Kings View

Table A.33 lists the Riverside staff members interviewed by the HSAG validation team.

Table A.33—List of Riverside Interviewees

Interviewee Name	Title
Matthew Chang	Behavioral Health Plan Director
Deborah Johnson	Director of Innovation & Integration
Amy McCann	Behavioral Health 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

Interviewee Name	Title
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
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.34 lists the Sacramento staff members interviewed by the HSAG validation team.

Table A.34—List of Sacramento Interviewees

Interviewee Name	Title
Alex Rechs	Health Program Manager—Quality Assurance Continuous QI
Dawn Williams	Health Program Manager—Data Analytics
Melony Ibarra	Administrative Services Officer 3—Electronic Health Record and Claiming
Ryan Quist	Behavioral Health Director
Kelli Weaver	Behavioral Health Deputy Director
Emmanuel Amanfor	Division Manager—Continuous Quality Improvement (CQI)

Interviewee Name	Title
Richard Genera	Administrative Services Officer 2
Whitney Owens	Program Planner—CQI
Kristina Duthler	Program Planner—Electronic Health Record
Justin Miller	Administrative Services Officer 2
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)
Bethany Dominik	Senior Epidemiologist (CalMHSA)
Gracia Amirtharaj	Director of Software Development (CalMHSA)
Amy Leino	Quality Improvement Manager
Eric Cardoza	Senior Electronic Health Records Solutions Engineer (CalMHSA)

Table A.35 lists the San Benito staff members interviewed by the HSAG validation team.

Table A.35—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

Interviewee Name	Title
Louise Coombes	Staff Analyst, Behavioral Health Services Act (BHSA) Coordinator
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)
Gracia Amirtharaj	Director of Software Development (CalMHSA)
Bethany Dominik	Senior Epidemiologist (CalMHSA)

Table A.36 lists the San Bernardino staff members interviewed by the HSAG validation team.

Table A.36—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

Interviewee Name	Title
Briceida Tompkins	Ethics and Compliance Coordinator
Barbara Knutson	Business Applications Manager
Patricia Grace	Business Application Analyst III
Kayla Young	Application Specialist
Martha Rodriguez	Business System 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 System Analyst III
Anthoula Poulakos	Research and Planning Supervisor
Anthony Saldana	Staff Analyst II
Hector Barahona Lopez	Business Systems Analyst I
Metra Jaberi	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 System 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

Interviewee Name	Title
Brian Diggle	Department Systems Engineer

Table A.37 lists the San Diego staff members interviewed by the HSAG validation team.

Table A.37—List of San Diego Interviewees

Interviewee Name	Title
Mayuri Lucas	Administrative Analyst
Samantha Marquez	Administrative Analyst
Elizabeth Miles, Ed.D, MPH, MSW	Agency Program and 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
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

Interviewee Name	Title
Marie Kort, LMFT	Utilization Review QI Specialist
Tabatha Lang, LMFT	Operations Administrator
Cheryl Lansang	MIS Supervisor

Table A.38 lists the San Francisco staff members interviewed by the HSAG validation team.

Table A.38—List of San Francisco Interviewees

Interviewee Name	Title
Alecia Martin, MPH	Director, BHS QM and Regulatory Affairs
Alexander Jackson, LCSW	Director, Adult & Older Adult Systems of Care
Alvin Ho	Patient Accounts Supervisor
Ana Gonzalez, DO	Co-CMO and Utilization Management Medical Director
Andre Pelote	Compliance Manager
Andrew Felix	Cogito Project Manager
Annie Shui, LMFT	Utilization Management Director
Carla Love	Credentialing Specialist
Chet Valentino	Behavioral Health Services Director of Data Analytics
Chris Toomey, MPH	Senior Epidemiologist
Christina Rivera	Epidemiologist
Erikson Bautista	Behavioral Health Services Information Systems—Senior Business Analyst
Farahnaz K. Farahmand, PhD	Director, Children, Youth & Families System of Care
Felicia Davis	Credentialing Specialist
Heather Weisbrod, LCSW	Behavioral Health Services Office of Coordinated Care Director
Imo Momoh, MPA	Director, Behavioral Health Services Office of Managed Care
Ivanna Chavez, MPH	Director of Central Access & Eligibility
Jason Ortega	Claims Services Representative, San Francisco Mental Health Plan

Interviewee Name	Title
Jessica Morton	Metrics Analytics and Data Integration Manager
Joseph A. Turner, PhD, CHC	Behavioral Health Services Compliance Officer
Kali Cheung	Director, Transitional Age Youth System of Care
Kathy Tomczak	Information Systems Consultant
Kellee Hom, PhD	Director, SUD System of Care
Kimberly Voelker	Ambulatory Care Applications Manager
Kitty Ha, MPH	QI Coordinator
Lenh Tsan, MPP	QI Coordinator
Linda Wu, LCSW	Behavioral Health Services Quality Assurance and QI Manager
Lisa Hilley, PhD	Deputy Director, Children, Youth & Families System of Care
Lisa Inman, MD	Co-CMO/Deputy Medical Director (San Francisco Health Network [SFHN], BHS)
Lorrie Tanioka	Director, Behavioral Health Billing and San Francisco Mental Health Plan Claims
Marco Lopez, DNP, MBA, MSI, APRN, ACHIP, CPHIMS	Director of Clinical Informatics
Maximilian Rocha, LCSW	Behavioral Health Services Systems of Care Director
Nanalisa Rasaily	Behavioral Health Services Patients Accounts Manager
Nancy Yu	Behavioral Health Services Regulatory Affairs Manager
Petra Jerman, PhD, MPH	Behavioral Health Services QM Analytics: Research Psychologist
Quynh Tang	Epic Cogito/Metrics Analytics and Data Integration—Information System Business Analyst
Renata Ferreira	Director of Value-Based Care Data Analytics
Shameem Mohamed	Information System Metrics Analytics and Data Integration Ambulatory Reporting

Interviewee Name	Title
Theresa Maranon, PharmD	Behavioral Health Services Director of Pharmacy
Tina Lee	Department of Public Health (DPH) IT—Chief Data Officer
Yoonjung Kim, LCSW	Director of Residential System of Care
Yuk Kiu Lee	Behavioral Health Services Network Adequacy Analyst
Ritchie Rubio Ph.D.	Director of Practice Improvement and Analytics

Table A.39 lists the San Joaquin staff members interviewed by the HSAG validation team.

Table A.39—List of San Joaquin Interviewees

Interviewee Name	Title
Fay Vieira	Assistant Director—BHS—Clinical (San Joaquin County [SJC] BHS)
Donna Bickham	Deputy Director—Quality Assessment and Performance Improvement and Medical Records (SJC BHS)
Alicia Tacata	Management Analyst III (SJC BHS)
Isaiah Lilly	Deputy Director—Health Care Services (HCS) 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	Dept. 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)

Interviewee Name	Title
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 Sabean	Deputy Director—Justice and Decriminalization Division (SJC BHS)
Daniel Ray	Management Analyst II (SJC BHS)
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)

Interviewee Name	Title
Edison Chalabi	Department Information Systems 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)
Charla Rowe	Clinical Implementation Coordinator (CalMHSA)
Eric Cardoza	Senior Electronic Health Records 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.40 lists the San Luis Obispo staff members interviewed by the HSAG validation team.

Table A.40—List of San Luis Obispo Interviewees

Interviewee Name	Title
Star Graber, LMFT, Ph.D.	Behavioral Health Administrator
Frank Warren	Behavioral Health Deputy Director
Amanda Getten, LMFT	Behavioral Health 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

Interviewee Name	Title
Enrique Limon	Program Manager of Health Agency Billing Department
Angela Atwell, RN	Mental Health Nurse III, Quality Support Team
Katelyn Yarnold, LCSW	Clinician III, Quality Support Team
Barbara Leveson	Chair of Behavioral Health Board
Mike Bossenberry	Behavioral Health Board
Sara Epps	Administrative Services Officer II, Quality Support Team
Amanda Martinez	Accountant III
Marisa Cervantes	Senior Account Clerk
Rachel Koenig	Administrative Services Manager
Melissa Soares	Program Manager, Health Applications Team
Molly Morgan	Business Systems Analyst III
Julianne Schmidt, LMFT	Behavioral Health Program Supervisor, Quality Support Team

Table A.41 lists the San Mateo staff members interviewed by the HSAG validation team.

Table A.41—List of San Mateo Interviewees

Interviewee Name	Title
Jei 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

Interviewee Name	Title
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
Ana Cianci	Patient Services Supervisor, BHRS Management Information Services
Eddie Lau	Manager, Health Information Systems
Maitreyi Ramachandran	Health Information Technology (HIT) 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.42 lists the Santa Barbara staff members interviewed by the HSAG validation team.

Table A.42—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 Grimmesey	Public Information Officer/Chief of Strategy and Community Engagement
Katie Cohen	Assistant Director of Clinical Operations
Anoushka Moseley	Manager of Quality Care Management
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	Quality Care Management Coordinator
Rebecca Buhl	Quality Care Management Coordinator
Leslie Smith	Quality Care Management Coordinator
Stacey Larsen	Quality Care Management Coordinator
Kassie Knudsen	Quality Care Management Coordinator
Dipak Neupane	Chief Operation Officer
Bonnie Zant	Quality Care Management Coordinator
Jairo Aguilar	Accountant—Auditor

Table A.43 lists the Santa Clara staff members interviewed by the HSAG validation team.

Table A.43—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
Leilani Villanueva	Division Director, Provider Relations
Samantha Lopez	Program Manager
Gaby Gonzalez-Ortiz	Program Manager II
Yasmina Janini	Program Manager
Scott Bray	Business System Analyst
Fernando Jauregui	Senior Management Analyst
Carlo Castuciano	Management Analyst
Gerald Domenden	Management Analyst
Sherri Terao	Director of Behavioral Health Services
Darren Tran	Behavioral Health Services Department Deputy Director
Tiffany Ho	Executive Behavioral Health Medical Director
Cheryl Ho	Executive Behavioral Health Medical Director
Margaret Obilor	Director, System of Care
Zelia Costa Faria	Director, System of Care
Soo Jung	Director, System of Care

Interviewee Name	Title
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 (CSCHS)—Chief Fiscal Officer
Anna Hernandez	Manager, Patient Accounting, Santa Clara Valley Health and Hospital System (SCVHHS)
Sujatha Prabhakaran	Health Care Financial Analyst II
Leticia Rosado	Director of Patient Business Services, Santa Clara Valley Health and Hospital System
Steph Lattimer	Revenue Cycle Management (RCM) Team Lead
Shannon Casey	Director, RCM
Samantha Meyer	RCM Manager

Table A.44 lists the Santa Cruz staff members interviewed by the HSAG validation team.

Table A.44—List of Santa Cruz Interviewees

Interviewee Name	Title
Adriana Bare	Senior Health Services Manager—Behavioral Health
Maria Warnke	IT Business Systems Analyst—Behavioral Health
Samuel Kim	IT Application Developer Supervisor—Behavioral Health

Interviewee Name	Title
Marc Romansky	IT Business Systems Analyst—Behavioral Health
Subé Robertson	QI Director—Behavioral Health
Shelly Barker	QI Manager—Behavioral Health
Israel Balderas	IT Application Developer/Supervisor Analyst II—Health Services Agency
Nancy Mast	QI Utilization Review Specialist—Behavioral Health
Daniel Crews	Health Information Systems Manager—Behavioral Health
Leah Flagg-Wilson	QI Manager—Behavioral Health
Jorge Fernandez	IT Manager—Health Services Agency
Karen Kern	Deputy Director and Acting Director—Behavioral Health
Dylan Jones	IT Developer—Health Services Agency
Christina Lam	Senior Medical Billing Technician—Behavioral Health
Casey Swank	Substance Use Services Director—Behavioral Health
Nicole Campbell	Senior Departmental Analyst—SUD Services—Behavioral Health
Sandra Wieting	IT Support Analyst III—Health Services Agency
Dave Chicoine, LMFT	QI Utilization Review Specialist—Behavioral Health

Table A.45 lists the Shasta staff members interviewed by the HSAG validation team.

Table A.45—List of Shasta Interviewees

Interviewee Name	Title
Christy Coleman, MPA	Acting HHSA Director, Acting Mental Health Director
Erinn Watts, MPA	Compliance Officer, Administrative Branch Director
Cindy Lane, MSW	Behavioral Health and Social Services Branch Director

Interviewee Name	Title
Bailey Cogger, AMFT	Behavioral Health and Social Services Deputy Branch Director
Rachel Ibarra, MPA	HHSA Program Manager
Dominic Evanzia, PhD	Behavioral Health and Social Services Program Manager
Clemencia Heberlein	Supervising Accountant
Lis Holt	Senior Staff Services Analyst
Jeremiah Cox	Staff Services Analyst II
Stacie Xiong	Senior Staff Analyst
Joanna Chorpenning	Senior Staff Services Analyst
Kimberly Limon-Stevens	Staff Services Analyst II
Ashley Riley	Staff Services Analyst II

Table A.46 lists the Siskiyou staff members interviewed by the HSAG validation team.

Table A.46—List of Siskiyou Interviewees

Interviewee Name	Title
Sarah Collard	HHSA Director
Aimee Von Tungeln	Deputy Director Behavioral Health Division
Johnny Schafer	Information Systems Specialist I
Develyn Sippel	Administrative Services Manager II
Alora Sutcliffe	Project Coordinator
Mark Halsebo	Information Systems Supervisor
Dee Barton	Program Manager (Compliance & QM)
Christine Gannon	Systems Administrator of Children's System of Care
Shannon Clymer	Systems Administrator of Adult System of Care—North County
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
Ricky Cruz	Implementation Specialist (CalMHSA)
Charla Rowe	Clinical Implementation Coordinator (CalMHSA)
Amy Leino	QI Manager (CalMHSA)
Anastassia Kiannu	Office Assistant to Director of Project Management (CalMHSA)

Table A.47 lists the Solano staff members interviewed by the HSAG validation team.

Table A.47—List of Solano Interviewees

Interviewee Name	Title
Jennifer Mullane	Chief Deputy Director
Rob George	Senior Mental Health Services Manager—Quality Assurance and Access
Charlynn Askim	Office Coordinator—Quality Assurance
Sheila Upshaw	Office Assistant III—Quality Assurance
Joseph Fulford	Senior Staff Analyst—Billing/Fiscal
Jose Ortiz	IT Analyst III
Christina Urrea	Senior Mental Health Services Manager—Performance Improvement
Devin Ma	Clinical Supervisor—Performance Improvement
Diana Tolentino	Clinical Supervisor—Quality Assurance-Access and Centralized Assessment Team

Table A.48 lists the Sonoma staff members interviewed by the HSAG validation team.

Table A.48—List of Sonoma Interviewees

Interviewee Name	Title
Henry Rafferty	QI Manager—Patient Care Analyst
Wendy Wheelwright	Adult Services Section Manager
Jan Cobaleda-Kegler	Behavioral Health Division Director
Karin Sellite	Youth and Family Services Section Manager

Interviewee Name	Title
David Evans	Acute and Forensic Services Section Manager
Christina Marlow	Quality Assessment Performance Improvement Section Manager
Jennifer Pimentel	Compliance Officer
Katrina Suprise	Compliance—Patient Care Analyst
Katrina Straight	Audit and Monitoring Manager—Patient Care Analyst
Trista Carr	Electronic Health Record Clinical Lead—Patient Care Analyst
Regina Starkey	QI Program Planning and Evaluation Analyst
Christine Thomas	QI Behavioral Health Clinical Specialist
Eric Turner	QI Program Planning and Evaluation Analyst
Victor Delpanno	Systems Software Analyst
Sean Barker	Revenue Management Unit Administrative Services Officer I
Christine Poirier	Revenue Management Unit Department Analyst
Janet Gonzalez	Revenue Management Unit Department Analyst
Lisa Monts	Revenue Management Unit Accounting Technician
Gina Moreno	Revenue Management Unit Department Analyst

Table A.49 lists the Stanislaus staff members interviewed by the HSAG validation team.

Table A.49—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)

Interviewee Name	Title
Ruben Imperial	Behavioral Health 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, Behavioral Health Plan Administration, Compliance Officer
Kim Saing	Children's System of Care Manager IV/Chief
Brittney Kirkland	Crisis Access 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
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

Interviewee Name	Title
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 (CSOC/TAY) 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	Crisis Access Medication Services (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 (CalMHSA)
Candice Medina	Senior Program Coordinator (CalMHSA)
Charla Rowe	Clinical Implementation Coordinator (CalMHSA)
Khristy Pease	Director of Revenue Cycle Management (CalMHSA)
Anastassia Kiannu	Office Assistant to Director of Project Management (CalMHSA)
Lisa Kirlin	Senior Implementation Coordinator (CalMHSA)
Eric Cardoza	Senior Electronic Health Records Solutions Engineer (CalMHSA)
Ricky Cruz	Implementation Specialist (CalMHSA)
Amy Leino	QI Manager (CalMHSA)

Table A.50 lists the Sutter/Yuba staff members interviewed by the HSAG validation team.

Table A.50—List of Sutter/Yuba Interviewees

Interviewee Name	Title
Tammy Andersen	Quality Assurance Staff Analyst
Roxana Castellon	Quality Assurance Staff Services Manager
Melissa Clavel	Quality Assurance Officer
Jaime Gascon	Quality Assurance Secretary
Rusti Bradford	Quality Assurance Utilization Review Specialist
Janet Benzel	Medical Billing Specialist
Darrin Whittaker	Program Manager, Clinical Services
Rick Bingham	Assistant Director, Sutter County Health and Human Services, Director of Sutter—Yuba Behavioral Health
Tara Cole	Administrative and Finance Supervisor
Janet Amaya	Clinical Program Manager
Consuelo Ayala	Office Services Supervisor
Tina Wilson	Medical Records Supervisor
Stacy Lee	Program Manager, SUD Services and Prevention and Early Intervention
Gina Duran	Program Manager, Hospital and Emergency Services
Elizabeth Byler	Director of Technical Integration and Solutions, Kings View
Kristin Hughes	Quality Assurance Mental Health Therapist
Tamara Price	Director of Revenue Cycle, Kings View
Michael Webster	Electronic Health Record Support Systems Analyst III, Kings View
Parminder Heer	Urgent Services Supervisor

Table A.51 lists the Tehama staff members interviewed by the HSAG validation team.

Table A.51—List of Tehama Interviewees

Interviewee Name	Title
Melissa Field	Compliance Officer
Michelle Schmidt	Assistant Executive Director Program
Deanna Gee	Assistant Executive Director Administration
Natalie Shepard	Mental Health Director
Melissa Willams	Business Operations Supervisor, Substance Use Recovery Center
Steven Remington	Information Systems Supervisor
Christian Smith	Health Services Analyst II
Abishek Vijjeswarapu	Health Services Analyst I

Table A.52 lists the Trinity staff members interviewed by the HSAG validation team.

Table A.52—List of Trinity Interviewees

Interviewee Name	Title
Torri Cardilino	Deputy Director of Quality Assurance
Katie Prunty	Behavioral Health Services Compliance Officer
Chan Saetern	Quality Assurance Coordinator
Liz Hamilton	HHSA Behavioral Health Services Director
Erin Hedlund	Eligibility Specialist Supervisor

Table A.53 lists the Tulare staff members interviewed by the HSAG validation team.

Table A.53—List of Tulare Interviewees

Interviewee Name	Title
Gilberto Rivas	Deputy Director, Behavioral Health
Angela Sahagun	Division Manager, Behavioral Health
Betsy Ayello	QI Manager, Mental Health
Chandler Bailey	QI Manager, Substance Use Disorder
Monica Guglielmo	Electronic Health Records Manager

Interviewee Name	Title
Omar Venegas	Electronic Health Records 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	Behavioral Health Clinical Supervisor
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)
Bethany Dominik	Senior Epidemiologist (CalMHSA)
Gracia Amirtharaj	Director of Software Development (CalMHSA)
Amy Leino	QI Manager (CalMHSA)
Eric Cardoza	Senior Electronic Health Records Solutions Engineer (CalMHSA)

Table A.54 lists the Tuolumne staff members interviewed by the HSAG validation team.

Table A.54—List of Tuolumne Interviewees

Interviewee Name	Title
Tami Mariscal	Director
Brock Kolby	Deputy Director of Clinical Services
Misti Ambler	Deputy Director of Business and Operations/Compliance Officer
Lindsey Lujan	Deputy Director of QM
Amanda Lawrance	QI Supervisor
Brittany Madden	Staff Service Analyst
Jennifer Guhl	Mental Health Services Act Manager
Steve Roos	Full Service Partnership Supervisor
Donna Villanueva	SUD Supervisor
Rayanne Tamayo	Outpatient Supervisor
Evan Hammond	Supportive Housing Manager

Table A.55 lists the Ventura staff members interviewed by the HSAG validation team.

Table A.55—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	Electronic Health Records Program Administrator
Juan Mendoza	Billing Manager, Senior Program Administrator
Alicia Duenas	Electronic Health Records Program Administrator
Bethany Dominik	Senior Epidemiologist (CalMHSA)

Table A.56 lists the Yolo staff members interviewed by the HSAG validation team.

Table A.56—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	Child, Youth and Families Branch Director; Interim Mental Health Director
Nate Palmer	Administrative Services Analyst
Amrinder Singh	Administrative Services Analyst
Julie Freitas	Alcohol and Other Drug Administrator/Clinical Manager
Katherine Barrett	Behavioral Health Compliance Officer
Pam Sidhu	Systems Software Specialist II
Sylvia Duarte	Accountant III
Ana Soltero	Accountant I
Michelle Wisterman	Senior Accounting Tech
Katlin Buechler	Clinician II, QM
Justina Larson	Clinician II, QM
Anna Thomas	Clinician II
Emma Latuno	Clinician II

Table A.57 lists the DHCS staff members interviewed by the HSAG validation team.

Table A.57—List of DHCS Interviewees

Interviewee Name	Title
Cristelyn Rebuyon	Health Program Specialist II, EQRO Behavioral Health Activities Project Lead
Kaitlin Maye	Staff Services Manager I, Timely Access Subject Matter Expert
LaMonte Love	Staff Services Manager II, Timely Access Subject Matter Expert

Interviewee Name	Title
Elena Placencia	Health Program Specialist II, EQRO Behavioral Health Activities Project Lead Back-Up
Sherri Garcia	Health Program Specialist II, Timely Access Subject Matter Expert 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 Behavioral Health Timely Access Lead
Srimathy Raghuraman	Research Data Supervisor II, Enterprise Data and Information Management Behavioral Health Timely Access Lead
Monifa Quarels	Staff Services Manager II, EQRO Behavioral Health Activities Manager Support
Stefani Vega	Associate Governmental Program Analyst, Behavioral Health EQRO Liaison
Kimberly Wimberly	Staff Services Manager I, Behavioral Health EQRO Review Section Manager
Anna Wettach	Associate Governmental Program Analyst, Behavioral Health EQRO Liaison
Tara Payne-Steele	Associate Governmental Program Analyst, Behavioral Health EQRO Liaison
Vanessa Sanchez	Staff Services Manager II, EQRO Review Section Chief
Michael Rockenbach	Associate Governmental Program Analyst, Behavioral Health EQRO Liaison

Table A.58 lists the HSAG validation team members, their roles, and their skills and expertise.

Table A.58—HSAG Validation Team

Name and Title	Role
Elisabeth Hunt, MHA, CHCA *Executive Director, Data Science & Advanced Analytics (DSAA)*	Certified Healthcare Effectiveness Data and Information Set (HEDIS) 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 *Director, Audits/Practice Leader, DSAA*	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.
Gina DeBlois, MSHCM *Manager III, Audits, DSAA* *Project Lead/Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
Anne Gulley, MPH *Senior Auditor, DSAA* *Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
Sumayyah Hackett, BBA *Auditor I, Audits, DSAA* *Lead Auditor*	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.
Tamieka Square, MHA *Auditor I, Audits, DSAA* *Lead Auditor*	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.
Marian Seege, MS *Auditor I, Audits, DSAA* *Lead Auditor*	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.
Rachel Spivey, BA *Auditor II, DSAA* *Lead Auditor*	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.
AnnAlisa Cook, MHA *Auditor I, DSAA* *Lead Auditor*	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.

Name and Title	Role
Laura McDermott, BS *Auditor II, DSAA* *Lead Auditor*	Knowledge in managed care, quality measure reporting, data integration, systems review and analysis, and NAV.