

B-7A.2.14 (c) Provider Profiles

January 29, 2009

Dear Iowa Plan Provider,

Enclosed please find Iowa Plan Medicaid Provider Profiling for the quarterly time period of October 1, 2008 – December 31, 2008 and year-to-date time period of July 1, 2008 – December 31, 2008. In some instances, a quarterly profiling report may not have been included if the minimum requirements of 25 total admissions or 50 claims processed were not reached. Instead, there may only be a year-to-date report.

The report package includes:

- **Iowa Plan Medicaid Provider Profiling – Provider-Specific**
*Identified by your provider name in the **Provider:** field.*

This profile is specific to your practice and includes only data on clients served during the profiling time period.

- **Iowa Plan Medicaid Provider Profiling – Peer**
*Identified by Agency, CMHC, Facility, Group, Other, or Practitioner in the **Provider:** field.*

This profile is an aggregate report of all providers of the same provider type. Each Iowa Plan provider is assigned to one of the following provider types for reporting purposes: Agency, CMHC, Facility, Group, or Practitioner. This report can be used to compare your provider-specific profile to the profile of your peers during the profiling time period.

- **Iowa Plan Medicaid Provider Profiling – All**
*Identified by the word ALL in the **Provider:** field.*

This profile is an aggregate report of all providers, regardless of provider type. This report can be used to compare your provider-specific profile to the profile of the entire provider network during the profiling time period.

- **Iowa Plan Medicaid Provider Profiling – Template**

The template shows each field on the profiling report. It should be retained and used as a reference along with the Medicaid Provider Profiling Guide.

- **Medicaid Provider Profiling Guide**

The guide lists and describes each field on the profile. It should be retained and used as a reference along with the Iowa Plan Medicaid Provider Profiling – Template.

Provider Profiling incorporates feedback received from providers and others. Because feedback will continue and because we review Provider Profiling for quality improvement opportunities, the exact format and content of the profile reports may change over time. We will update the profiles as well as the Template and Guide as changes occur.

If you have any questions or concerns about Provider Profiling -- or about any other issues relating to the Iowa Plan -- please contact the following Iowa Plan staff:

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Sincerely,

Chris Sims
Quality & Compliance Director

Enclosures

Iowa Plan for Behavioral Health Medicaid Provider Profiling Guide

#	Field	Description
1	Date	The period of time that the report covers.
2	Provider	The provider's name and provider type. Possible provider types are as follows: A = Agency C = CMHC F = Facility G = Group P = Practitioner O = Other
3a	Client Demographics - Clients	The unique number of clients for whom a claim was paid.
3b	Client Demographics - Age	The percentage of clients (3a) broken out by age category.
3c	Client Demographics - Gender	The percentage of clients (3a) broken out by gender category.
3d	Client Demographics - Diagnosis Grouping	The percentage of clients (3a) broken out by diagnosis grouping category.
3e	Client Demographics - Plan Group	The percentage of clients (3a) broken out by eligibility category.
4	Level of Care	The level of care provided to a client.
5	Initial Authorizations	The number of <u>initial</u> authorizations to each level of care. An initial authorization is counted each time a client is authorized a different level of care than what has been previously authorized. Only managed levels of care are reported. This does not measure all services delivered.
6	Managed Average Length of Stay (Days)	The average length of stay, measured in days, from the date of admission to the date MBC of Iowa stops utilization management of the client. This could be the actual date of discharge or the date of non-certification. This is for 24 Hour Levels of Care only.
7	Actual Average Length of Stay (Days)	The average length of stay, measured in days, from the date of admission to the date of actual discharge from the level of care. This is for 24 Hour Levels of Care only.
8	Total Number of Units	The total number of units paid for each level of care.
9a	Clinical Non-Authorizations - Initial	The number of clinical non-authorizations of care during initial requests for authorization, defined as clinical criteria not met for an initial request for the level of care and an alternative level was offered, but declined by the provider.

Iowa Plan for Behavioral Health Medicaid Provider Profiling Guide

#	Field	Description
9b	Clinical Non-Authorizations - Concurrent Reviews	The number of non-authorizations during the concurrent review process. A concurrent review non-authorization is defined as clinical criteria not met for a request for an extension of the current level of care and an alternative level was offered or prior authorization procedures were not followed.
10	Claim Denials	The number of claim lines denied as a percentage of the total number of claim lines processed (paid and denied). The denial percentages are sorted by denial categories.
11	Inpatient Readmissions - Mental Health	The percentage of inpatient discharges which resulted in a readmission to inpatient care. This is broken out by readmissions to the same facility, to another facility, and total readmissions in 7, 30, 60, and 90 day increments.
12	Client Involvement	The percentage of authorizations (both initial and concurrent reviews) in which a provider involved the client or client representative (for children or adolescents) in the treatment plan.
13	Discharge Types	<p>The number of total discharges, as well as the percentage of discharges for each discharge type. The discharge types are as follows:</p> <p>RESOLUTION OF PROBLEM - Present and subsequent symptoms have been resolved. No additional care requested.</p> <p>TRANSFERRED TO ANOTHER LOC - Client transferred to another level of care.</p> <p>TRANSFERRED TO ANOTHER FACILITY - Client was transferred to another facility.</p> <p>CLIENT AMA - Client left care against medical advice.</p> <p>CLIENT DENIED SERVICES - Client declined to be treated.</p> <p>ADMISSION/CCR DENIED - Authorization was non-certified. Alternative level of care offered.</p> <p>OTHER - All other reasons.</p>
14	PCP Contacts	<p>The percentage of admissions where the provider:</p> <ul style="list-style-type: none"> Contacted the client's primary care physician Did not contact the client's primary care physician Not Applicable - meaning the client did not have a primary care physician listed

Iowa Plan for Behavioral Health Medicaid Provider Profiling Guide

#	Field	Description
15	7 Day Follow-Ups - Mental Health	The number of clients discharged from Inpatient or SubAcute levels of care for mental health and the percentage of those that the client had a follow-up visit within 7 day

Report ID: PPIAP01
 Run Date: 3/11/2009
 Run Time: 2:45 PM

MBC of Iowa
 Iowa Plan Provider Profiling: Medicaid
 Date: 07/01/2000 - 09/30/2000

Provider: XXXXXXXXXXXXXXXX 2

3		
Client Demographics per Claims Data		
Clients:		
3a	Unique Client Count	x,xxx
Age:		
3b	< 18 Years	xx.x%
	18+ Years	xx.x%
Gender:		
3c	Female	xx.x%
	Male	xx.x%
Diagnosis Grouping:		
3d	Mental Health Only	xx.x%
	Substance Abuse Only	xx.x%
	Mental Health & Substance Abuse	xx.x%
Plan Group:		
3e	FMAP	xx.x%
	SSI	xx.x%
	Dual Eligible	xx.x%

10	
Claims Denials	
Client Not Eligible	xx.x%
Duplicate Billing	xx.x%
Incomplete Billing Information	xx.x%
Lack of Authorization	xx.x%
Medical Expenses	xx.x%
Medicare Filing Required	xx.x%
Miscellaneous	xx.x%
Primary Insurance Filing Required	xx.x%
Service Non-Authorized	xx.x%
Service Not Covered	xx.x%
TOTAL	xx.x%

11			
Hospital Inpatient Readmissions-Mental Health Only			
	Same	Other	Total
7 Days	xx.x%	xx.x%	xx.x%
30 Days	xx.x%	xx.x%	xx.x%
60 Days	xx.x%	xx.x%	xx.x%
90 Days	xx.x%	xx.x%	xx.x%

12	
Consumer Involvement	
Consumer Involvement-Admissions	xx.x%
Consumer Involvement-Reviews	xx.x%

4	5	6	7	8	9	
Level of Care	Initial Authorizations	Managed ALOS (Days)	Actual ALOS (Days)	Total Number of Units	Initial	Concurrent Reviews
24 Hour Levels of Care					9a	9b
Mental Health						
23 Hour Observation	x,xxx	x,xxx.x	x,xxx.x	x,xxx	xx.x%	xx.x%
Inpatient	x,xxx	x,xxx.x	x,xxx.x	x,xxx	xx.x%	xx.x%
Residential	x,xxx	x,xxx.x	x,xxx.x	x,xxx	xx.x%	xx.x%
Respite	x,xxx	x,xxx.x	x,xxx.x	x,xxx	xx.x%	xx.x%
Subacute	x,xxx	x,xxx.x	x,xxx.x	x,xxx	xx.x%	xx.x%
Substance Abuse						
Halfway House	-	-	-	x,xxx	-	-
Medically Monitored Inpatient	x,xxx	x,xxx.x	x,xxx.x	x,xxx	xx.x%	xx.x%
PMIC	x,xxx	x,xxx.x	x,xxx.x	x,xxx	xx.x%	xx.x%
Primary Extended Residential	x,xxx	x,xxx.x	x,xxx.x	x,xxx	xx.x%	xx.x%
Medically Managed Inpatient	x,xxx	x,xxx.x	x,xxx.x	x,xxx	xx.x%	xx.x%
Non 24 Hour Levels of Care						
Mental Health						
Partial Hospitalization	x,xxx	-	-	x,xxx	xx.x%	xx.x%
Intensive Outpatient	x,xxx	-	-	x,xxx	xx.x%	xx.x%
Day Treatment	x,xxx	-	-	x,xxx	xx.x%	xx.x%
ACT/PACT	x,xxx	-	-	x,xxx	xx.x%	xx.x%
Home-based Care	x,xxx	-	-	x,xxx	xx.x%	xx.x%
Community Support Services	x,xxx	-	-	x,xxx	xx.x%	xx.x%
Outpatient	x,xxx	-	-	x,xxx	xx.x%	xx.x%
Substance Abuse						
Day Treatment/IOP	-	-	-	x,xxx	-	-
Extended Outpatient	-	-	-	x,xxx	-	-

13	
Discharge Types	
Total	x,xxx
Resolution of Problem	xx.x%
Transferred to Another Level of Care	xx.x%
Transferred to Another Facility	xx.x%
Client AMA	xx.x%
Client Declined Services	xx.x%
Admission/CCR Denied	xx.x%
Other	xx.x%

14	
PCP Contacts	
Contacted PCP	xx.x%
Did not contact PCP	xx.x%
Not Applicable	xx.x%

15	
7 Day Follow-ups-Mental Health	
Client Discharges	x,xxx
% of Follow-ups Completed in 7 Days	xx.x%

Provider Name: ALL

Client Demographics per Claims Data	
Clients:	
Unique Client Count	55,592
Age:	
<18 Years	50.8%
18+ Years	50.3%
Gender:	
Female	53.4%
Male	46.6%
Diagnosis Grouping	
Mental Health Only	87.2%
Substance Abuse Only	6.9%
Mental Health & Substance Abuse	5.9%
Plan Group:	
FMAP	56.6%
SSI	22.6%
Dual Eligible	11.5%

Claim Denials	
Client Not Eligible	0.0%
Duplicate Billing	4.3%
Incomplete Billing	0.2%
Lack of Authorization	1.8%
Medical Expense	0.1%
Medicare Filing Required	0.9%
Miscellaneous	1.8%
Primary Insurance Filing Required	1.3%
Service Non-authorized	0.4%
Service Not Covered	5.1%
Total	15.8%

Hospital Inpatient Readmissions - Mental Health Only			
	Same	Other	Total
7 Days	3.4%	1.3%	4.7%
30 Days	8.7%	4.4%	13.1%
60 Days	12.2%	6.3%	18.6%
90 Days	15.0%	7.6%	22.6%

Client Involvement	
Client Involvement - Admissions	N/A
Client Involvement - Reviews	N/A

Level of Care	Initial Authorizations	Actual ALOS (Days)	Managed ALOS (Days)	Total Number of Units	Clinical Non-Authorization Initial	Concurrent Reviews
24 Hour Levels of Care						
Mental Health						
23 Hour Observation	1,007	0.9	0.8	325	6.6%	0.0%
Inpatient	7,765	5.0	4.9	54,232	8.5%	6.5%
Residential	228	17.7	30.1	2,617	20.0%	23.2%
Respite	55	3.0	5.4	74	2.0%	2.6%
Subacute	333	6.6	10.8	1,886	3.1%	15.3%
Substance Abuse						
Halfway House	0	-	-	9,358	-	-
Medically Monitored Inpatient	399	2.4	2.0	503	0.6%	1.4%
PMIC	140	80.3	72.5	10,140	8.0%	0.2%
Primary/Extended Residential	1,344	24.1	23.1	28,103	3.1%	0.1%
Medically Managed Inpatient	747	2.6	2.5	2,282	2.6%	8.1%
Non 24 Hour Levels of Care						
Mental Health						
Partial Hospitalization	706	-	-	4,757	5.0%	0.2%
Intensive Outpatient	418	-	-	2,877	1.7%	1.1%
Day Treatment	0	-	-	1,005	0.0%	0.0%
ACT/PACT	53	-	-	2,530	0.0%	0.0%
Home-Based Care	0	-	-	11,626	0.0%	0.0%
Community Support Services	0	-	-	22,575	0.0%	0.0%
Outpatient	2,115	-	-	435,931	3.1%	6.2%
Substance Abuse						
Day Treatment/IOP	-	-	-	28,720	-	-
Extended Outpatient	-	-	-	52,699	-	-

Discharge Types	
Total Discharges	11,986
Resolution of Problem	0.7%
Transferred to Another Level of Care	92.6%
Transferred to Another Facility	0.6%
Client AMA	4.2%
Client Declined Services	1.1%
Admission/CCR Denied	0.7%
Other	0.0%

PCP Contacts	
Contacted PCP	0.0%
Did not contact PCP	0.0%
Not Applicable	100.0%

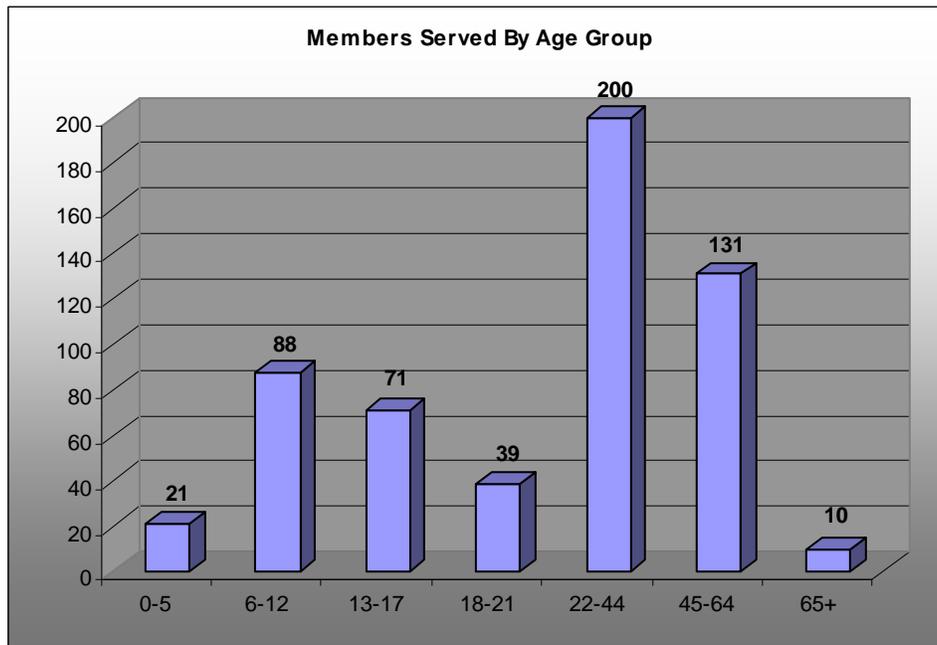
7 Day Follow-ups - Mental Health	
Client Discharges	1,067
% of Follow-ups Completed in 7	441.0%

**Magellan Behavioral Health
 Provider Profile -- 231496225
 1/1/2008 – 6/30/2008**

Demographic Information

Demographic Information - Age: The following table shows the total number of members served in all levels of care during the report period. The data is broken out by seven age groups and shows the number of members served by the provider as a percentage of the total members served in the County and as a percentage of the total HealthChoices membership.

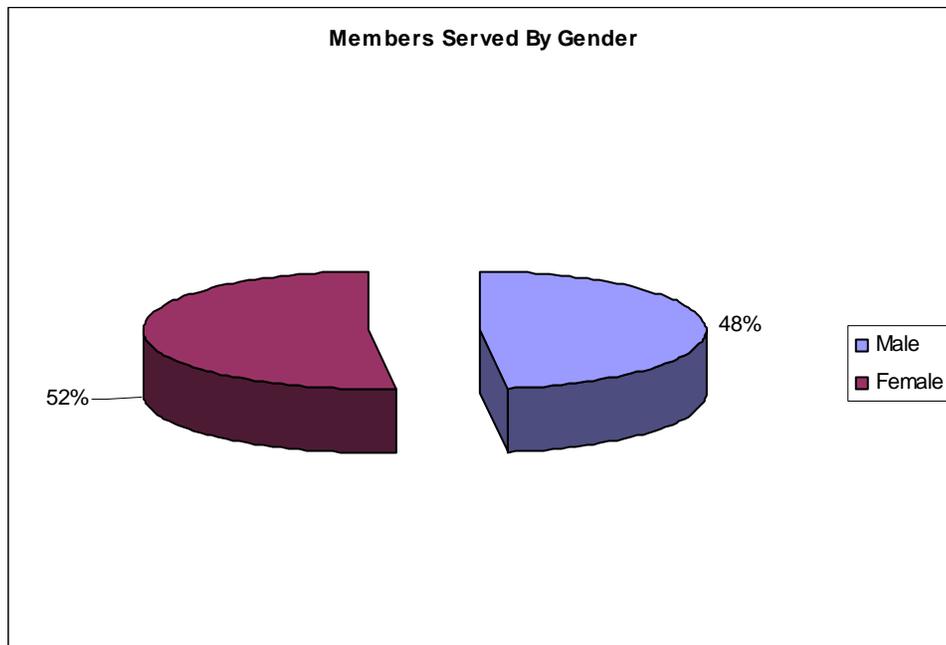
Provider Undup Mbr Served	
0-5	21
6-12	88
13-17	71
18-21	39
22-44	200
45-64	131
65+	10
Provider Total	560
Provider % of County Mbr Served	7.4103
Provider % of County Elig Served	1.1174



Discussion: Of the 560 total members served by the provider in this report period, 200 (36%) were in the 22-44 age group. The next largest age group was 45-64 with 131 members (23%). This was followed by the 6-12 age group with 88 members (16%). The smallest group was 65+ with 10 members (1%).

Demographic Information – Gender Served: The following table shows the total number of members served by gender. Each gender group is also shown as a percentage of the total members served by the provider.

Provider Gender Served		
	Male	269
	Male % of Provider Served	48.0357
	Female	291
	Female % of Provider Served	51.9643



Discussion: The [Provider] served slightly more females (52%) than males (48%). This profile is consistent with other base service units in the County.

Claims Information

Claims Paid: The following table shows the total number of claims paid for the provider during the report period. The data is broken out by seven age groups. The total number of paid claims for the provider is also shown as a percentage of the total paid claims for the County.

Provider Number of Paid Claims		
	0-5	720
	6-12	1418
	13-17	1110
	18-21	432
	22-44	5276
	45-64	3694
	65+	91
	Provider Paid Claims	12741
	County Paid Claims	217462
	Provider % of Overall County Paid Claims	5.859

Discussion: The majority of claims paid to the provider were for services provided to members in the 22-44 age group (41%). This was followed by the 45-64 age group which accounted for 29% of claims paid. This is consistent with members served data which shows both groups as the largest represented in members served by age.

Claims Denied: The following table shows the total number of denied claims for all levels of care for the provider during the report period. The data is broken out by seven age groups. The total number denied claims for the provider is shown as a percentage of all claims submitted by the provider. The percentage of all denied claims for the County is shown for comparison.

Provider Number of Denied Claims		
	0-5	15
	6-12	78
	13-17	23
	18-21	33
	22-44	134
	45-64	114
	65+	16
	Provider Denied Claims	413
	Provider % Denied Claims	3.1397
	County Overall % Denied Claims	8.1249

Discussion: Denied claims data for the provider shows that the majority of claims denied (32%) were for services provided to members in the 22-44 age group. This was followed by the 45-64 age group which accounted for 28% of claims denied. Claims denied data is consistent with data showing members served by age group and claims paid by age group. The highest claims denial reason was Patient Not Eligible, which accounted for 40% of the provider's denied claims.

The provider's rate of claims denied (3%) is significantly below the County's combined rate of denied claims (8.1%).

Utilization For Each 24 Hour Level of Care

The following table presents utilization data for each level of care delivered by the provider based on paid claims. This data includes:

- Total number of discharges
- Number of members readmitted
- Percent of members readmitted
- Average length of stay

Provider D/A Rehab (R4Q)	
Discharges	24
90 Day Readmits	9
% Readmit 90 Day	37.5
ALOS	16.4167

Discussion: Of the 24 members discharged from the provider's residential D&A program nine (37.5%) were readmitted within 90 days. The provider's average length of stay for the D&A program was 16 days.

Complaints

The following table shows the total number of complaints by members for the provider during the profile period. The total number of complaints is also presented as a measure of per thousand members served. The total number of complaints for all providers in the County per thousand members served is also included for comparison.

Provider Complaints		
	Access/Responsiveness	0
	Adverse Treatment Exper	0
	Clinical Judgment/Competence	1
	No Return Call/Follow Up	0
	Request to Change Provider	0
	Unprofessional/Rude Treatment	0
	Other	0
	Provider Total Complaints	1
	Provider Undup Member Complaints	1
	Provider Complaints Per 1000 Mbr Served	1.7857
	County Total Complaints	21
	County Complaints Per 1000 Mbr Served	2.6466

Discussion: One complaint involving the provider was filed during the reporting period which is 1.79 complaints per 1000 members served. This is lower than the overall county rate of 2.65 complaints per 1000 members served.

Adverse Incidents

The following table shows the total number of adverse incidents for the provider during the profile period. The total number of adverse incidents for the provider is also presented as a measure of per thousand members served. The total number of adverse incidents for the County is shown per thousand members served as a comparison.

Provider Adverse Incidents		
	Provider Total AI	2
	Provider Undup Members AI	2
	Provider AI Per 1000 Mbr Served	3.5714
	County AI Per 1000 Mbr Served	15.2177

Discussion: The provider had two adverse incidents reported during the reporting period which is 3.57 incidents per 1000 members served. This rate is significantly lower than the overall county per 1000 rate of 15.22 though consistent with other County base service units. The majority of adverse incidents are reported by residential treatment (RTF) providers. The provider does not provide this level of care which may account for the significantly lower number of incidents per 1000 compared to the county total which does include RTF providers.

Provider Performance Concerns

The following table shows the total number of Provider Performance Concerns (PPCs) for the provider during the profile period. The total number of PPCs for the provider is also presented as a measure of per thousand members served. The total number of PPCs for the County is included as a measure of per thousand 1000 per members served in the County.

Provider Performance Concerns		
	Provider Total PPC	0
	Provider PPC Per 1000 Mbr Served	0
	County PPC Per 1000 Mbr Served	1.1909

Discussion: No PPCs were reported involving the provider during the reporting period.

Clinical Audit/Treatment Record Review

Provider Clinical Audit/ Treatment Record Review		
	Date	6/30/2008
	LOC	Outpatient Mental Health
	Records Reviewed	6
	Type	Treatment Record Review

Discussion: The provider scored 91% on the Corporate Treatment Record Documentation Worksheet and 95% on the HealthChoices of PA Addendum tool. The provider received an overall audit score of 93% on the 2008 Treatment Record Review for its Outpatient Mental Health Program. The provider was the only provider to have a treatment record review in this report period so a comparison to other providers is not available.

Outpatient Access Study

In 2008, the provider decreased the percentage of new members seen for a follow-up appointment within 7 days at one of its programs over 2007 (Appendix A). The provider's percentage of members seen for a follow-up appointment within 7 days is significantly less than the County average of outpatient providers combined.

During this same time period comparison, the provider increased the percentage of members who received services from the provider following their initial evaluation by 60% (Appendix B).

**Initial outpatient evaluations are measured by a claim received for a member for whom a claim has not been received by any provider for any service within the 90 days preceding the date of the initial evaluation.*

Co-Occurring Disorder (COD) Reporting

In 2008, the provider increased the number of members with co-occurring disorders reported on its claim submissions from 2007 (Appendix C). In 2008, the variation increased slightly between what the provider reported as the number of members with co-occurring disorders on its claims and the number of members with co-occurring disorders as reported by Magellan's claims based data system. The provider may want to examine its reporting of co-occurring disorders for accuracy.

Appendix A

**County Ambulatory Care Report (Evals 1/1/07 - 6/30/07, Paid through 10/31/08)
Follow-up to Same Provider (Number of Days Detail)**

Eval Prov#	Eval Provider Name	No FU	FU 0-7 Days		FU 8-14 Days		FU 15-21 Days		FU 22-31 Days		FU 32-59 Days		FU 60-89 Days		FU >= 90 Days		FU Total	FU Total (undup)
231496225	[Provider]MAIN SITE	1	3	21.43%	2	14.29%	4	28.57%	1	7.14%	4	28.57%	0	0.00%	0	0.00%	14	14

**County Ambulatory Care Report (Evals 1/1/08 - 6/30/08, Paid through 10/31/08)
Follow-up to Same Provider (Number of Days Detail)**

Eval Prov#	Eval Provider Name	No FU	FU 0-7 Days		FU 8-14 Days		FU 15-21 Days		FU 22-31 Days		FU 32-59 Days		FU 60-89 Days		FU >= 90 Days		FU Total	FU Total (undup)
		0	3	17.65%	1	5.88%	2	11.76%	8	47.06%	2	11.76%	0	0.00%	1	5.88%	17	17
		0	3	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	3	3
		0	1	50.00%	1	50.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	2
		2	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	100.00%	1	1
		0	1	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	1
		0	1	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	1
		16	13	13.83%	17	18.09%	13	13.83%	14	14.89%	25	26.60%	5	5.32%	7	7.45%	94	92
		1	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0
		5	5	22.73%	2	9.09%	5	22.73%	2	9.09%	6	27.27%	0	0.00%	2	9.09%	22	22
		0	2	50.00%	1	25.00%	0	0.00%	0	0.00%	0	0.00%	1	25.00%	0	0.00%	4	4
		0	1	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	1
		0	0	0.00%	0	0.00%	1	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	1
		0	0	0.00%	1	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	1
		0	1	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	1
		0	1	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	1
		1	0	0.00%	0	0.00%	0	0.00%	1	100.00%	0	0.00%	0	0.00%	0	0.00%	1	1
		0	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	100.00%	0	0.00%	0	0.00%	1	1
		0	4	57.14%	3	42.86%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	7	7
		2	11	91.67%	1	8.33%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	12	12
		1	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0
		0	3	75.00%	1	25.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	4	4

Eval Prov#	Eval Provider Name	No FU	FU 0-7 Days		FU 8-14 Days		FU 15-21 Days		FU 22-31 Days		FU 32-59 Days		FU 60-89 Days		FU >= 90 Days		FU Total	FU Total (undup)
		4	13	44.83%	6	20.69%	4	13.79%	2	6.90%	3	10.34%	1	3.45%	0	0.00%	29	29
		0	2	66.67%	1	33.33%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	3	3
		0	1	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	1
231496225	PROVIDER MAIN SITE	1	3	15.79%	6	31.58%	3	15.79%	3	15.79%	3	15.79%	1	5.26%	0	0.00%	19	19
		1	2	40.00%	1	20.00%	2	40.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	5	5
		2	2	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	2
		0	0	0.00%	1	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	1
		1	1	9.09%	2	18.18%	0	0.00%	3	27.27%	4	36.36%	0	0.00%	1	9.09%	11	11
		1	3	37.50%	4	50.00%	0	0.00%	1	12.50%	0	0.00%	0	0.00%	0	0.00%	8	8
		0	2	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	2
		1	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0
		38	79	30.86%	49	19.14%	30	11.72%	34	13.28%	44	17.19%	8	3.13%	12	4.69%	256	254

Appendix B

County Ambulatory Care Report Summary (Evals 1/1/07 - 6/30/07, Paid through 10/31/08)

Eval Prov#	Eval Provider Name	Total Evals	FU to Same Provider			FU to Different Provider			No FU	
			Eval to Same Provider	Avg Number of Days Until FU (Same Provider)	% of Total Evals with FU to Same Provider	Eval to Different Provider	Avg Number of Days Until FU (Different Provider)	% of Total Evals with FU to Different Provider	Eval with No FU	% of Total Evals with No FU
231496225	PROVIDER MAIN SITE	17	14	21.14	82.35%	2	17.00	11.76%	1	5.88%

County Ambulatory Care Report Summary (Evals 1/1/08 - 6/30/08, Paid through 10/31/08)

Eval Prov#	Eval Provider Name	Total Evals	FU to Same Provider			FU to Different Provider			No FU	
			Eval to Same Provider	Avg Number of Days Until FU (Same Provider)	% of Total Evals with FU to Same Provider	Eval to Different Provider	Avg Number of Days Until FU (Different Provider)	% of Total Evals with FU to Different Provider	Eval with No FU	% of Total Evals with No FU
		19	17	26.76	89.47%	2	6.50	10.53%	0	0.00%
		3	3	0.00	100.00%	0	0.00	0.00%	0	0.00%
		2	0	0.00	0.00%	2	1.00	100.00%	0	0.00%
		3	2	7.00	66.67%	1	1.00	33.33%	0	0.00%
		4	1	226.00	25.00%	1	57.00	25.00%	2	50.00%
		1	1	4.00	100.00%	0	0.00	0.00%	0	0.00%
		1	1	0.00	100.00%	0	0.00	0.00%	0	0.00%
		135	94	35.77	69.63%	25	32.08	18.52%	16	11.85%
		1	0	0.00	0.00%	1	0.00	100.00%	0	0.00%
		1	0	0.00	0.00%	0	0.00	0.00%	1	100.00%
		31	22	35.82	70.97%	4	0.25	12.90%	5	16.13%
		5	4	21.75	80.00%	1	8.00	20.00%	0	0.00%
		1	1	1.00	100.00%	0	0.00	0.00%	0	0.00%
		1	1	15.00	100.00%	0	0.00	0.00%	0	0.00%
		1	1	8.00	100.00%	0	0.00	0.00%	0	0.00%
		3	1	7.00	33.33%	2	18.00	66.67%	0	0.00%
		1	1	7.00	100.00%	0	0.00	0.00%	0	0.00%

Eval Prov#	Eval Provider Name	Total Evals	FU to Same Provider			FU to Different Provider			No FU	
			Eval to Same Provider	Avg Number of Days Until FU (Same Provider)	% of Total Evals with FU to Same Provider	Eval to Different Provider	Avg Number of Days Until FU (Different Provider)	% of Total Evals with FU to Different Provider	Eval with No FU	% of Total Evals with No FU
		3	1	30.00	33.33%	1	8.00	33.33%	1	33.33%
		1	1	36.00	100.00%	0	0.00	0.00%	0	0.00%
		7	7	7.00	100.00%	0	0.00	0.00%	0	0.00%
		1	0	0.00	0.00%	1	6.00	100.00%	0	0.00%
		1	0	0.00	0.00%	1	4.00	100.00%	0	0.00%
		16	12	0.75	75.00%	2	0.00	12.50%	2	12.50%
		1	0	0.00	0.00%	0	0.00	0.00%	1	100.00%
		5	4	6.00	80.00%	1	0.00	20.00%	0	0.00%
		36	29	14.93	80.56%	3	29.67	8.33%	4	11.11%
		3	3	5.33	100.00%	0	0.00	0.00%	0	0.00%
		1	1	7.00	100.00%	0	0.00	0.00%	0	0.00%
231496225	PROVIDER MAIN SITE	20	19	21.68	95.00%	0	0.00	0.00%	1	5.00%
		6	5	12.60	83.33%	0	0.00	0.00%	1	16.67%
		4	2	6.50	50.00%	0	0.00	0.00%	2	50.00%
		1	1	9.00	100.00%	0	0.00	0.00%	0	0.00%
		19	11	36.18	57.89%	7	23.71	36.84%	1	5.26%
		9	8	10.38	88.89%	0	0.00	0.00%	1	11.11%
		2	2	0.00	100.00%	0	0.00	0.00%	0	0.00%
		4	0	0.00	0.00%	3	28.67	75.00%	1	25.00%
		287	207		72.13%	48		16.72%	32	11.15%

Appendix C

(1/1-6/30) County Dual Diagnosis Reporting By Service Category By Provider

Provider	Total Members Served	D&A Members Served	MH Members Served	Provider Reported COD Members Served	Provider Reported COD/Total Members Served	System Reported COD members	System Reported COD/Total Members Served	% of Members not Recognized as COD
2007 [PROVIDER] MAIN SITE	532	45	441	42	7.89%	46	8.65%	0.75%
2008 [PROVIDER] MAIN SITE	560	44	459	52	9.29%	57	10.18%	0.89%