Performance Evaluation Report

Family Mosaic Project

July 1, 2009–June 30, 2010

Medi-Cal Managed Care Division
California Department of
Health Care Services

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to the domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Family Mosaic Project ("FMP" or "the plan"), which delivers care in San Francisco County, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

FMP is a specialty plan which provides intensive case management and wraparound services for Medi-Cal managed care children and adolescents in San Francisco County who are at risk of our-of-home placement. FMP is part of the Child, Youth, and Family System of Care operated by the City and County of San Francisco Department of Public Health, Community Behavioral Health Services. To receive services from FMP, a member must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of (or already in) out-of-home placement. The plan submits appropriate clients to the DHCS for approval to be enrolled in FMP's Medi-Cal managed care program. Once a client is approved and included under FMP's contract with the DHCS, the plan receives a per-member, per-month capitated rate to provide mental health and related wraparound services to these members.

FMP became operational with the MCMC Program in February 1993. As of June 30, 2010, the plan had 123 MCMC members.[2]

Due to the plan's unique membership, some of FMP's contract requirements have been modified from the MCMC Program's full-scope health plan contracts.

[2] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about FMP's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Physical and Mental Health Care Performance Review

For most MCMC plans, medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work with the Department of Mental Health (DMH) to conduct joint audits of MCMC plans. Due to the unique nature of FMP's membership and the plan's emphasis on the mental health component of the services it delivers, FMP is not subject to medical performance review audits by the DHCS and the Department of Managed Health Care (DMHC). FMP, as part of San Francisco County's mental health plan, is subject to review by the Division of Program Compliance—Medi-Cal Oversight, DMH.

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. HSAG reported the February 2008 DMH review results in the prior year's plan evaluation report.

DMH performs reviews every three years. The results of the FMP review will be reported in the next annual plan performance evaluation report.

The 2008 DMH audit focused on the larger San Francisco County mental health plan. HSAG could not determine if any of the audit findings related specifically to FMP and the Medi-Cal managed care program and recommended that the plan review the audit report to identify any findings that may apply to FMP/Medi-Cal managed care and address those issues.

FMP identified three findings that applied to the plan's Medi-Cal contract:

- Ensuring second opinions are available through a licensed mental health practitioner.
- Providing written notification to members of termination of a contracted provider within 15 days of receipt.
- Updating various policies and procedures related to changes in behavioral health providers, cultural and linguistic competency requirements, notice of action for denial of Medi-Cal funding for specialized mental health services, appeal and expedited appeal procedures for outpatient mental health Medi-Cal clients, and individual provider selection and retention.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2010.

MRPIU conducted a routine monitoring visit of FMP in June 2010 which covered the review period of January 1, 2008, through December 31, 2009. MRPIU conducted a desk review of policies and procedures, reviewed grievance files, and visited four provider office sites.

The review found FMP to be fully compliant with all requirements; no deficiencies were noted. This was an improvement over the prior review results, which noted deficiencies related to timeline requirements when resolving member grievances and maintenance of grievance information.

Strengths

FMP was fully compliant with all areas evaluated by the MRPIU, with no deficiencies found. The plan resolved most of the grievance deficiencies that were identified during the prior MRPIU review conducted in May 2008. FMP also self-reported that the plan had addressed all deficiencies from the 2008 DMH review.

Opportunities for Improvement

Because FMP is evaluated under the larger San Francisco County mental health plan, the plan should identify and continually monitor itself to ensure compliance with all requirements that apply to its Medi-Cal population.

Conducting the Review

For its full-scope plans, the DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. Due to the small size and unique populations served by the specialty plans, the DHCS modified the performance measure requirements applied to these plans. The DHCS required specialty plans to report two performance measures. In collaboration with the DHCS, a specialty plan may select measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[3] or design a measure that is appropriate to the plan's population. Furthermore, the specialty plan must report performance measure results specific to the plan's Medi-Cal managed care members, not for the plan's entire population.

Standardized performance measures such as HEDIS do not apply to FMP's population or services provided. During the prior evaluation period (July 1, 2008–June 30, 2009), HSAG assisted FMP in developing written specifications for two performance measures specific to the plan's specialized services. During the current evaluation period, the plan was able to report two performance measures: inpatient hospitalizations and out-of-home placements.

As with all MCMC plans—full scope and specialty—HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its performance measures when calculating rates.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about FMP's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Inpatient Hospitalizations* measure fell under the Quality domain, and the *Out-of-Home Placements* fell under both the quality and access domains.

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

Performance Measure Validation

HSAG validated the two performance measures that were calculated and reported by FMP. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities,* Final Protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol). The validation process included three phases:

- The pre-on-site phase included a review of the Information Systems Capabilities Assessment (ISCA) tool completed by FMP, supportive documentation, and source code used to calculate the performance measures; and planning for the on-site visit.
- The on-site visit included system evaluation and demonstration, review of data integration and data control, evaluation of data output files, and primary source verification of performance measure member-level files.
- The post-on-site phase included review of follow-up documentation and preliminary performance measure results, and final approval of calculations and final results.

Based on the validation findings, HSAG determined that each performance measure was fully compliant with the written specifications and was calculated accurately. The review team noted that the performance measures were collected and calculated using data extracted from three separate systems and several manual processes that were not well documented. The review team recommended that for future performance measure reporting efforts, FMP should clearly document all steps taken to collect and report each performance measure.

Performance Measure Results

HSAG presents the performance measure results for each reported measure for the measurement period of calendar year 2009.

Inpatient Hospitalizations

Measure Description: The percentage of capitated Medi-Cal managed care members enrolled into Family Mosaic Project with a mental health admission to an inpatient hospital facility during the measurement period January 1, 2009–December 31, 2009.

Inpatient Hospitalizations			
Data Element	**1 admission**	**2 admissions**	**3 or more admissions**
Number of numerator events	3	2	0
Denominator	212	212	212
Reported Rate	1.415%	0.943%	0%

Out-of-Home Placements

Measure Description: The percentage of Medi-Cal capitated managed care members enrolled into Family Mosaic Project who were discharged to an out-of-home placement during the measurement period January 1, 2009–December 31, 2009.

Out-of-Home Placements	
Data Element	**Discharge to Out-of-Home Placement**
Number of numerator events	11
Denominator	81
Reported Rate	13.58%

Performance Measure Result Findings

This is the first year that FMP has reported the performance measures, which were developed to evaluate the effectiveness of services provided to its specific population. FMP's prime objective is to provide the appropriate services in order to reduce or eliminate undesirable outcomes, such as inpatient hospitalizations or out-of-home placements.

For calendar year 2009, FMP's rate of inpatient admissions was just over 1.4 percent for members with one admission, and less than 1 percent for members with two admissions. The plan had no members that had more than two inpatient admissions during the measurement period. The rate for out-of-home placements was 13.6 percent, which allows room for improvement.

Strengths

FMP has made notable progress in clearly defining two meaningful performance measures and reporting the results accurately. This framework establishes a baseline result and will allow for trending of performance over time. The rate of inpatient admissions appears relatively low; however, additional measurement periods are needed to determine if there is room for improvement in this area of performance.

Opportunities for Improvement

FMP appears to have an opportunity to improve its out-of-home placement rate. At 13.6 percent, the rate leaves room for improvement by implementing targeted quality improvement interventions. As with the inpatient admission rate, additional measurement periods are needed to objectively evaluate performance in this area.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (CMS') validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about FMP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

Specialty plans must be engaged in two QIPs at all times. However, because specialty plans serve unique populations that are limited in size, the DHCS does not require specialty plans to participate in the statewide collaborative QIP. Instead, specialty plans are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty plan's MCMC members.

In the prior plan evaluation report, HSAG indicated that FMP's initial efforts to develop plan-specific QIPs were not successful. Upon the DHCS's approval, HSAG provided technical assistance to FMP on the development and implementation of a QIP. FMP faced several challenges with identifying and collecting standardized data on which to base a QIP, which delayed its ability to develop a sound QIP proposal. The DHCS, in collaboration with HSAG, required FMP to submit one QIP proposal in May 2010, and a second QIP proposal in January 2011. HSAG provided ongoing technical assistance to the plan, which included strategies toward addressing data collection challenges. FMP continued to experience delays in the internal implementation of a data system, which impacted the development of the QIP proposals.

Once a standardized performance measure was developed and validated, FMP opted to focus its first QIP on reducing out-of-home placements. The plan submitted the initial QIP proposal to the DHCS in July 2010. The results of the EQR validation of this QIP and presentation of baseline data will be included in next year's plan evaluation report.

FMP is on target for completing the second QIP proposal, due January 2011.

Strengths

FMP showed much progress in the QIP area and was able to prepare and submit a QIP proposal. The plan's efforts to learn the QIP process and collect standardized data were commendable.

Opportunities for Improvement

FMP should apply the technical assistance received when developing the new QIP proposal and documenting the progression of both QIPs. When completing the QIP documentation, FMP should reference the *Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans*, available at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/QIA_Assessment_Guide_November_2010.pdf.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. Specialty plans are required to administer an annual consumer satisfaction survey to their members to evaluate member satisfaction with care and services.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

FMP administered a member satisfaction survey to youth and families who received intensive case management and full-service partnership services. The survey was collected from December 2009 through January 2010. The survey used a Likert scale of one to five with five indicating the highest level of satisfaction.

For youth, two indicators had the lowest satisfaction findings (between 3.0 and 4.0):

- The location of services was convenient for me.
- I am satisfied with my family life right now.

All other indicators had satisfaction scores above 4.0, with higher levels of satisfaction in these areas: staff treating the youth with respect, staff speaking to the youth in a way that was understood, and the youth received services that were right for him or her.

For family members, four indicators had lower satisfaction scores (between 3.0 and 4.0):

- My child is better able to do things he/she wants to do.
- I am satisfied with my family life right now.
- My child is better able to cope when things go wrong.
- My child is doing better in school and/or work.

All other indicators had satisfaction scores above 4.0, with higher levels of satisfaction in the areas of staff speaking in a way that was understood, staff respecting the family's religious/spiritual beliefs, and staff treating the family member with respect.

Strengths

FMP youth and family members expressed high levels of satisfaction. Even the lower satisfaction scores exceeded 3.0 on the Likert scale, and the highest levels related to how FMP provided respectful and appropriate services.

Opportunities for Improvement

FMP has an opportunity to improve satisfaction by working toward making the location of services more convenient to its members.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

The DHCS uses the results of performance measures and quality improvement project (QIP) to assess care delivered to members by a plan in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, the DHCS monitors aspects of a plan's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems. Finally, some member satisfaction measures relate to quality of care.

The plan showed average performance based on FMP's 2010 performance measure rates (which reflect 2009 measurement data), member satisfaction survey results, and the results of member rights reviews as they related to measurement and improvement. Although there are no external benchmarks available for comparison of the performance measure results, the inpatient hospitalization measure results appear relatively low, while the rate for out-of-home placements allows room for improvement. The plan addressed the areas of findings identified by the DMH review, and the most recent MRPIU review found FMP fully compliant with all areas evaluated.

FMP was also able to prepare and submit its first QIP proposal and is on target for the second QIP proposal, due in January 2011.

FMP enrollees expressed high levels of satisfaction, particularly in the areas of staff providing respectful and appropriate care.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members.

The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, cultural and linguistic services, and coverage of services.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. The *Out-of-Home Placements* measure falls under the domains of quality and access because members rely on access to services and their availability to receive care to impact successful outcomes.

The plan demonstrated average performance based on a review of 2010 performance measure rates related to access, results of the member rights review regarding availability and accessibility of care, and member satisfaction results. The *Out-of-Home Placements* rate had no national comparison benchmark available; however, room for improvement was noted. FMP was fully compliant with cultural and linguistic standards evaluated by the MRPIU, reflecting no access-related concerns in that area.

FMP youth expressed lower satisfaction with the location of services not being convenient; however, both youth and family members indicated high levels of satisfaction when asked if the services were available at convenient times.

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, member satisfaction with the timeliness of services provided is also evaluated.

FMP exhibited above-average performance in the timeliness domain of care based on 2010 member rights reviews and member satisfaction results related to timeliness.

Member satisfaction results showed that services were available at convenient times, indicated by high levels of satisfaction of both youth enrollees and their family members.

FMP was fully compliant with all timeliness-related standards when evaluated by the MRPIU review including prior authorization processes and procedures for collecting and resolving member grievances.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. FMP's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, FMP achieved average performance in the quality and access to care domains. The plan demonstrated above-average performance in providing timely services.

Based on the overall assessment of FMP in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following:

- Conduct periodic, internal reviews to ensure compliance with the DMH and MRPIU standards.
- Ensure consistent measurement of each performance measure, maintaining complete documentation of all steps taken for data collection and measure calculations.
- As QIPs progress, ensure QIP documentation meets all CMS requirements by referencing the *Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans* and obtaining technical assistance as needed.
- Explore factors that impact FMP youth satisfaction with the location of services and take action to address these concerns.

In the next annual review, HSAG will evaluate FMP's progress with these recommendations along with its continued successes.

Appendix A. Follow-Up on the Prior Year's Recommendations Grid

for Family Mosaic Project

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
Explore tracking and trending internal quality improvement indicators for the Medi-Cal managed care capitated membership to better assess the quality and timeliness of and access to care provided to this specialty population.	Currently the FMP Plan has multiple quality indicators that track and trend quality improvement for the Medi-cal managed care capitated members. FMP measures access to care by tracking timelines from the first call/fax made by a provider requesting FMP services, to the date the FMP Intake Unit made contact with the client/family, to the date the CANS initial assessment was completed, to the date case was assigned to an FMP care manager. Current data shows that this entire process takes no longer the 5–7 days. FMP tracks membership satisfaction annually. FMP tracks quality indicators through two performance measures: (1) number of out-of-home placements at discharge, and (2) number of inpatient psychiatric hospitalizations. FMP is tracking and trending to ensure that for each FMP member, a monthly client/family and provider treatment planning meeting is being held. FMP is tracking and trending that all initial CANS/assessments and plan of care/treatment plans are completed within 30 business days of opening to the program.
Finalize performance measures, resolve all outstanding action items provided by HSAG as part of the Information Systems Capabilities Assessment, and conduct test data pulls to ensure readiness for 2010 reporting.	For 2010 performance measures, FMP was fully compliant with the validation report. There were no outstanding action items that needed to be resolved. In the final audit report for the validation of the performance measures, HSAG noted that the data used by FMP to report performance measures were housed across three independent technology systems. As of July 1, 2010, FMP begin to use AVATAR, an electronic health record (EHR) system. This EHR currently houses all data used by FMP to report performance measures.
Continue QIP technical assistance calls with HSAG to assist in the development of a QIP proposal through the study design phase.	FMP has already submitted and been fully approved for QIP # 1 in 2010, and is currently awaiting approval from HSAG for QIP # 2. Technical assistance calls with HSAG has been in place throughout the development of both QIPs.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
Revise the grievance policy and procedure to include the required time frames to resolve member grievances and maintain grievance files.	FMP has updated its policy and procedure regarding "Client Compliant and Grievance Resolution Procedure" # 3.11-03 on December 14, 2010, and on March 8, 2011. This policy specifically states that all FMP grievances will be retained in locked administrative files for five years.
Review the Department of Mental Health's audit report to identify any findings that may apply to FMP and Medi-Cal managed care, and address those issues.	The DMH audit report identified that the San Francisco County mental health plan (SFMHP) should ensure that second opinions be made available by the MHP through a licensed mental health professional and that the MHP needs to issue a policy regarding second opinions. The SFMHP developed a policy and procedure, "Request for Second Opinion by Medi-Cal Beneficiaries Due to Not Meeting Medical Necessity." The SFMHP needed to ensure that it makes a good faith effort to give affected beneficiaries a written notice of termination of a contractor provider, within 15 days after receipt or issuance of the termination notice to each enrollee. SFMHP developed a policy and procedure to ensure compliance. Another procedure entitled, "Request for Change in Behavioral Health Provider" was written. Other policies and procedures were updated in response to audit findings. These include: ◆ "Cultural and Linguistic Competency Requirement for Behavioral Health Services." ◆ "Denial of Medi-Cal Funding for Specialized Mental Health Services, Notice of Action." ◆ "Appeal and Expedited Appeal Procedures for Outpatient Mental Health Medi-Cal Clients." ◆ "SFMHP Individual Provider Selection and Retention." Please note that the Department of Mental Health audited the SFMHP in April 2011 (the DMH conducts compliance audits of the SFMHP every three years). The SFMHP received a passing score of 97 percent meeting compliance on all items.