# REPORT ON THE SUBSTANCE USE DISORDER (SUD) AUDIT OF SAN FRANCISCO COUNTY FISCAL YEAR 2025-26

**DHCS Audits and Investigations**
**Contract and Enrollment Review Division**
**Substance Use Disorder Review Section**

**Contract Number: 22-20154**
**Contract Type: Drug Medi-Cal Organized Delivery System (DMC-ODS)**
**Audit Period: July 1, 2024 — June 30, 2025**
**Dates of Audit: March 17, 2026 — March 27, 2026**
**Report Issued: August 26, 2026**

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

# TABLE OF CONTENTS

# I. INTRODUCTION

San Francisco County Behavioral Health (Plan) is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of providing substance use disorder services to county residents.

San Francisco County is situated on the west coast of California at the northern tip of the San Francisco Peninsula. The Plan provides services exclusively within the City of San Francisco.

As of May 1, 2025, the Plan had a total of 6,339 Medi-Cal members receiving DMC-ODS services and a total of 375 active providers.

# II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2024, through June 30, 2025. The audit was conducted from March 17, 2026, through March 27, 2026. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on July 29, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On August 12, 2026, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated four categories of performance: Availability of Drug Medi-Cal Organized Delivery System (DMC-ODS) Services, Coverage and Authorization of Services, Beneficiary Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2023, through June 30, 2024, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was closed during the time of the audit. Therefore, this audit included a review of documents to determine the implementation and effectiveness of the Plan's corrective actions.

The summary of the findings by category follows:

## Category 1 – Availability of Drug Medi-Cal Organized Delivery System Services

The Plan is required to follow the guidelines, Adolescent SUD Best Practices Guide, in developing and implementing adolescent treatment programs. Finding 1.2.1: The Plan did not demonstrate it developed or implemented youth treatment programs using the Adolescent SUD Best Practices Guide during the review period.

## Category 5 – Coverage and Authorization of Services

There were no findings noted for this category during the audit period.

## Category 6 – Beneficiary Rights and Protection

The plan must keep a log of all grievances with relevant details, transmit issues identified through grievances and appeals to the appropriate internal committee or body, and ensure exempt grievances are included in the Beneficiary G&A Report submitted to DHCS. Finding 6.1.1: The Plan did not ensure that all grievances are logged and reported to DHCS.

## Category 7 – Program Integrity

There were no findings noted for this category during the audit period.

# III. SCOPE/AUDIT PROCEDURES

## SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medically necessary services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's DMC-ODS Contract.

## PROCEDURE

DHCS conducted an audit of the Plan from March 17, 2026, through March 27, 2026, for the audit period of July 1, 2024, through June 30, 2025. The audit included a review of the Plan's policies for providing services, procedures to implement these policies, and the process to determine whether these policies were effective. Documents were reviewed and interviews were conducted with the Plan's representatives.

The following verification studies were conducted:

### Category 1 – Availability of Drug Medi-Cal Organized Delivery System Services

There were no verification studies conducted for the audit review.

### Category 5 – Coverage and Authorization of Services

There were no verification studies conducted for the audit review.

### Category 6 – Beneficiary Rights and Protection

Grievance Procedures: Seven grievances regarding the quality of care and five grievances regarding the quality of services were reviewed for timely resolution, an appropriate response to the complainant, and submission to the appropriate level for review.

### Category 7 – Program Integrity

There were no verification studies conducted for the audit review.

# COMPLIANCE AUDIT FINDINGS

## Category 1 – Availability of Drug Medi-Cal Organized Delivery System Services

### 1.2 Children's Adolescent (Youth) Services

#### 1.2.1 Adolescent Substance Use Disorder Best Practices Guide

The Plan is required to follow the guidelines, Adolescent SUD Best Practices Guide, in developing and implementing adolescent treatment programs. *(Contract, Exhibit A, Attachment I, Section III, Program Specifications, DD, 13 (i))*

**Finding:** The Plan did not demonstrate it developed or implemented youth treatment programs using the Adolescent SUD Best Practices Guide during the review period.

In an interview, the Plan confirmed that an adolescent treatment program did not serve any members during the audit period because the program was still waiting to receive certification and licensing.

During the audit period, supplementary documentation (*ID 380013-MPF New Provider Request Form_Homeless Children's Network*) identified an adolescent treatment provider, added to the Plan's network in February 2025. A second adolescent treatment provider maintained an active contract for Adolescent/Youth Treatment Services within the reviewed fiscal year; however, the Plan did not furnish any policies, procedures, monitoring, or communications concerning Adolescent Best Practices for this program.

A review of the Plan's monitoring document, *YLI Expanded SUD SUBG Checklist FY 23*-24, revealed monitoring for a Youth Prevention program that does not provide treatment services for youth or adolescent members. Additionally, the departure of the Plan's adolescent program manager contributed to a communication gap with providers and resulted in no annual oversight monitoring conducted with the Plan's youth or adolescent treatment providers.

Failure to implement best practices may result in its youth members not receiving the appropriate level of care for SUD treatment.

**Recommendation:** Develop and implement policies, procedures and conduct monitoring to ensure the Adolescent SUD Best Practices Guidelines are implemented at youth treatment providers.

# COMPLIANCE AUDIT FINDINGS

## Category 6 – Beneficiary Rights and Protection

### 6.1 Grievance and Appeal System Requirements

#### 6.1.1 Grievance Tracking

The Plan shall ensure that grievances received over the telephone or in person by the Plan, or a network provider of the Plan, that are resolved to the member's satisfaction by the close of the close of the next business day following receipt are exempt from the requirement to send written acknowledgment and disposition letter. The Plan shall maintain a log of all grievances containing the date of receipt of the grievance, the name of the member, nature of the grievance, the resolution, and the representative's name who received and resolved the grievance. Additionally, the Plan must transmit issues identified as a result of the grievance, appeals, or expedited appeal processes to the Plan's Quality Improvement Committee, the Plan's administration, or another appropriate body within the Plan's operations. The Plan shall ensure exempt grievances are included in its Beneficiary G&A Report that is submitted to DHCS. *(Mental Health Substance Use Disorder Information Notice Number 18-010E)*

The Plan's policy, *Grievance and Appeal System for Behavioral Health Services* (revised 7/25/2025), requires all Plan providers to comply with DHCS guidelines for grievance and appeal system and describes three main components: the grievance process, the standard appeal process, and the expedited appeal process for behavioral health services.

**Finding:** The Plan did not ensure that all grievances are logged and reported to DHCS.

During the verification study, it was revealed that seven of the 12 grievances recorded in the grievance log maintained by the Plan were associated with a single network provider. In response to a follow-up request, the Plan provided a grievance log for that network provider containing all required elements; however, this log reflected the significantly greater number of 119 grievances compared to what was reflected in the grievance log maintained by the Plan. Additionally, the Plan also provided a grievance log for a county-operated network provider that included only four of the nine required log components and listed three grievances. One grievance from this log was included in the log maintained by the Plan.

In an interview and narrative, the Plan thought they were right; however, the Plan misinterpreted the requirement and did not follow its own policies and procedures since regulations actually require that network providers maintain a log of grievances that are investigated and resolved at the provider level.

In a narrative, the Plan confirmed that all grievances and appeals included in the log maintained by the Plan received during fiscal year 2024-2025 were completed in writing by the member and submitted to the Plan by the member. To further document these efforts, The Plan provided the Beneficiary Grievance and Appeal Report that was submitted to DHCS, which included only the grievances recorded in the grievance log maintained by the Plan.

When the Plan does not ensure that all grievance and appeals are logged, relevant member data is not included in its Beneficiary Grievance and Appeal Report that is submitted to DHCS. This omission may result in inaccurate reporting of member information, which impedes the Department's ability to effectively analyze and monitor trends.

**Recommendation:** Implement policies and procedures to ensure that all grievances are logged and reported to DHCS.