REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF SAN FRANCISCO COUNTY FISCAL YEAR 2025-26

DHCS Audits and Investigations
Contract and Enrollment Review Division
Specialty Mental Health Review Section

Contract Number: 22-20129
Contract Type: Specialty Mental Health Services
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

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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 mental health 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 13,107 Medi-Cal members receiving services and a total of 1,868 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 six categories of performance: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care, Access and Information Requirements, Coverage and Authorization of Services, Member Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2019, through June 30, 2022, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was closed at 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 – Network Adequacy and Availability of Services

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

Category 2 – Care Coordination and Continuity of Care

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

Category 4 – Access and Information Requirements

There were no findings noted for this category during the audit 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 is required to maintain a grievance log and record grievances in the log within one working day of the date of the grievance. A complaint is the same as a formal grievance. Finding 6.1.1: The Plan did not ensure complaints/grievances received by providers were logged within one working day of the date of the receipt of the grievance.

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 Specialty Mental Health Services 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 – Network Adequacy and Availability of Services

Mobile Crisis Service Encounters: Ten member samples were reviewed for evidence of documentation of standardized dispatch, assessment tools, and progress notes of crisis planning.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Ten member referrals from the Managed Care Plan (MCP) to the Mental Health Plan (MHP) and ten member referrals from the MHP to MCP were reviewed for evidence of referrals, initial assessments, progress notes of treatment planning, and follow-up care between MCP and MHP.

Category 4 – Access and Information Requirements

Access Line Test Call Log: Two test calls requesting information about SMHS and how to treat an urgent condition were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements; two test calls requesting information about the beneficiary problem resolution and fair hearing processes were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements.

Access Line Test Call Log: The Plan's call log was reviewed to ensure all required log components were documented for four test calls made to the Plan.

Member Telehealth Consent: Fourteen telehealth consent samples were reviewed for evidence of documentation of telehealth consent prior to the initial delivery of telehealth services.

Category 5 – Coverage and Authorization of Services

Services Authorizations: Twenty member files were reviewed for evidence of appropriate services authorization requests.

Treatment Authorization: Twenty member files were reviewed for evidence of appropriate treatment authorization including the concurrent review authorization process.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: Nine grievances regarding the quality of care and nine 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 6 – Member Rights and Protection

6.1 Grievance and Appeals Systems Requirements

6.1.1 Grievance Tracking

The Plan shall maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. *(Contract, Exhibit A, Attachment 12, section 2(A)); (CFR, Title 42, section 438.416(a); California Code Regulation, Title 9, section 1850.205 subdivision (d)(1))*

The Plan may delegate duties and obligations to subcontracting entities if the Plan determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. The Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with the DHCS, notwithstanding any relationship(s) that the Plan may have with any subcontractor. *(Contract, Exhibit A, Attachment 1, section 3: CFR, Title 42, section 438.230(b)(1))*

A complaint is the same as a formal grievance. A member need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance. Grievances received over the telephone or in person by the Plan, or a network provider of the Plan, that are resolved to the members satisfactory by the close of the next business day following receipt are exempt from the requirement to send written acknowledgement and disposition letter. Plans shall maintain a log of all grievances containing the date of the 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. (*Mental Health Substance Use Disorder Information Notice Number 18-010E)*

The Plan's policy, *3.11-01, Grievance and Appeal System for Behavioral Health Services (effective April 26, 2024)*, stated when a Behavioral Health Services grievance is received by the Grievance Office, the information will is recorded in the grievance log within one working day of the receipt of the grievance.

Finding: The Plan did not ensure complaints/grievances received by providers were logged within one working day of the date of the receipt of the grievance.

Plan Policy *3.11-01*, stated that, San Francisco Behavioral Health Services supports the resolution of issues at the program where services are being received. Every effort should be made by providers to resolve member concerns as quickly and as simply as possible. However, the policy did not state that these issues need to be logged by providers.

In a verification study, 18 of 18 grievances process by the Plan were logged within one working day of the date of receipt of the grievance. However, providers did not log grievances; therefore, the Plan was unable to ensure that grievances were logged within one working day of the date of the receipt of the grievance.

In an interview and narrative, the Plan thought they were right; however, the Plan misinterpreted the requirement, since the Plan acknowledged that they don't expect providers to maintain a log of complaints investigated and closed at the provider level. Additionally, the Plan confirmed they may not hear about these issues and don't have a way to track them.

When the Plan does not accurately track grievances, it can cause a delay in the grievance process, which in turn can lead to a delay in member access to necessary services.

Recommendation: Revise and implement policies and procedures to ensure that all grievances are logged within one working day of the date of receipt of the grievance.