REPORT ON THE MEDICAL AUDIT OF SAN FRANCISCO HEALTH PLAN CALENDAR YEAR 2025

DHCS Audits and Investigations
Contract and Enrollment Review Division
San Francisco Section

Contract Number: 23-30237
Audit Period: March 1, 2025 — December 31, 2025
Dates of Audit: May 4, 2026 — May 15, 2026
Report Issued: September 14, 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TABLE OF CONTENTS

I. INTRODUCTION

In 1994, the San Francisco City and County created the San Francisco Health Authority (SFHA) under the authority granted by the California Welfare and Institutions Code Section 14087.36. The SFHA was established as a separate public entity to operate programs involving health care services, including the authority to contract with the State of California to serve as a health plan for Medi-Cal members.

SFHA received a Knox-Keene Health Care Service Plan license in 1996. On January 1, 1997, the State of California entered into a contract with the SFHA to provide medical managed care services to eligible Medi-Cal members as the local initiative under the name San Francisco Health Plan (Plan).

The Plan contracts with 13 medical entities and 1 transportation broker to provide or arrange comprehensive health care services. The Plan delegates several functions to these entities.

As of December 31, 2025, the Plan served 188,352 members through the following programs: Medi-Cal 175,960, Healthy Workers 12,392.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of March 1, 2025, through December 31, 2025. The audit was conducted from May 4, 2026, through May 15, 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 August 27, 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 September 11, 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: Utilization Management Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals and Member Rights, Quality Improvement and Health Equity Transformation Program, and Plan Administration and Organization.

The prior DHCS medical audit for the period of April 1, 2024, through February 28, 2025, was issued on August 22, 2025. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year, Corrective Action Plan.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management Program

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

Category 2 – Population Health Management and Coordination of Care

The Plan must ensure accurate and up-to-date member-level records related to the provision of Enhanced Care Management (ECM) services are maintained for Members authorized for ECM. Finding 2.25.1: The Plan did not ensure that accurate, up-to-date member-level ECM records were maintained. ECM members authorized for services had no documented evidence of receiving any ECM service components.

The Plan must ensure all members receive all seven Enhanced Care Management core service components: Outreach and Engagement; Comprehensive Assessment and Care Management Plan (CMP); Enhanced Coordination of Care; Health Promotion; Comprehensive Transitional Care; Member and Family Supports; and Coordination of and Referral to Community and Social Support Services. Finding 2.25.2: The Plan did not ensure that all members received three of seven ECM core service components.

Category 3 – Network and Access to Care

The Plan must ensure it has a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. Finding 3.17.1: The Plan did not meet regulatory timeframes for acknowledging provider disputes or issuing written determinations.

Category 4 – Grievances, Appeals, and Member Rights

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

Category 5 – Quality Improvement and Health Equity Transformation Program

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

Category 6 – Plan Administration and Organization

The Plan must ensure all network providers were screened and enrolled according to the contract, applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013. The Plan may delegate their authority to perform screening and enrollment activities to a subcontractor, but the Plan remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. Finding 6.14.1: The Plan and its delegate's managed care provider screening and enrollment process did not comply with all contractual enrollment standards.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

DHCS conducted an audit of the Plan from May 4, 2026, through May 15, 2026, for the audit period of March 1, 2025, through December 31, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management Program

There was no verification studies conducted for the audit review.

Category 2 – Population Health Management and Coordination of Care

ECM: Seven files were reviewed to confirm coordination of care and compliance with requirements.

Category 3 – Network and Access to Care

Emergency Services and Family Planning: Twenty emergency services and 20 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation: Twenty claims were reviewed for timeliness and appropriate adjudication.

Non-Medical Transportation: Twenty claims were reviewed for timeliness and appropriate adjudication.

Category 4 – Grievances, Appeals, and Member Rights

Grievances: Thirty standard grievances were reviewed for timely resolution, appropriate classification, response to complainant, and submission to the appropriate level for review. Twenty inquiries were also reviewed.

Confidentiality Rights: Ten Health Insurance Portability and Accountability Act/Protected Health Information breach and security incidents were reviewed for processing and timeliness requirements.

Category 5 – Quality Improvement and Health Equity Transformation Program

There was no verification studies conducted for the audit review.

Category 6 – Plan Administration and Organization

Fraud and Abuse: Ten fraud and abuse cases were reviewed for appropriate reporting and processing.

Provider Screening and Enrollment: Ten provider application records were reviewed for compliance with all contractual enrollment requirements. Seven delegated provider application records were reviewed for compliance with all contractual enrollment requirements.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.25 Enhanced Care Management

2.25.1 Enhanced Care Management Program Administration

The Plan must follow the appropriate processes to ensure members who may benefit from ECM receive ECM as defined in this Contract. *(Contract, Exhibit A, Attachment III, Section 4.4.1(G))*

The Plan must ensure accurate and up-to-date member-level records related to the provision of ECM services are maintained for Members authorized for ECM. *(Contract, Exhibit A, Attachment III, Section 4.4.9(D))*

The Plan must require the ECM Provider to notify the Plan to discontinue ECM for Members when any of the following circumstances are met (including but not limited to) the Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or the ECM Provider has not been able to connect with the Member after multiple attempts. *(Contract, Exhibit A, Attachment III, Section 4.4.10(B)(3)(4))*

The ECM Policy Guide outlines ECM policies and contains details of the Plan's contractual requirements for ECM. The Plan must use the ECM Policy Guide as a key resource for implementation and administration of ECM. Plans are further responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, ECM requirements, contract requirements, and other DHCS guidance, including APLs and Policy Letters. *(APL 23-032, Enhanced Care Management Requirements)*

The Plan should actively monitor sources of referrals for ECM, levels of Member engagement/acceptance of ECM, and improving overall referral and engagement patterns to improve ECM utilization among eligible Members. *(CalAIM Enhanced Care Management Policy Guide, August 2024)*

Plan policy, *CARE-13 Enhanced Care Management* (reviewed 6/2025), stated that ECM providers are responsible for conducting outreach to and engaging ECM-eligible members assigned to their ECM program. Members assigned will be included on the Eligibility and Enrollment File. Members may stay in outreach for four weeks. For the

four weeks that a member is in outreach, ECM providers should conduct at least weekly outreach attempts using different modalities such as phone, mail, in person, or other method. ECM providers may conduct more frequent outreach and up to eight attempts if it would benefit the member. The Plan will not pay for more than eight attempts made to a member during a single authorization period.

FINDING: The Plan did not ensure that accurate, up-to-date member-level ECM records were maintained. ECM members authorized for services had no documented evidence of receiving any ECM service components.

A verification study sample was selected from Plan members admitted to ECM. There were no records for 8 of 15 samples in the verification study of ECM members. The Plan provided information about the eight samples but never submitted medical records to validate details contained in its written response. The Plan's written narrative stated the following:

- The Plan had reached out to the eight members, but seven remained in outreach status.
- The Plan offered ECM to one member, but this member declined ECM.

The Plan's written response did not include a rationale for why members remained in a prolonged and drawn-out ECM outreach stage. In the verification study, the outreach stage extended to nine and ten months. However, the Plan's policies and procedures stated that member assignment should occur within ten business days of ECM referral while the ECM provider secures agreement by the member to participate in the ECM program. ECM providers are required to conduct weekly outreach attempts, at a minimum, while a member is in outreach status. If the Plan observes no outreach activity for a member within 120 days after provider assignment, that member may be re-assigned to an alternate ECM provider. Nevertheless, the Plan did not provide any records to validate implementation of its policy and procedures. There was no record of interventions, including but not limited to, outreach attempts, case notes, or other efforts by the Plan or the ECM Provider to assist members obtain ECM services.

When the Plan does not ensure accurate and up-to-date member-level records for provision of ECM services are maintained, members may experience delays and disruptions with care management to address member's needs.

Recommendation: Implement policies and procedures to ensure accurate and up-to-date member-level records for provision of ECM services are maintained.

2.25.2 Enhanced Care Management Core Services

The Plan must ensure members receive all of the following seven ECM core service components, as further defined in APLs: Outreach and Engagement; Comprehensive Assessment and Care Management Plan (CMP); Enhanced Coordination of Care; Health Promotion; Comprehensive Transitional Care; Member and Family Supports; and Coordination of and Referral to Community and Social Support Services. *(Contract, Exhibit A, Attachment III, Section 4.4.11)*

The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social needs, and long-term services and supports for members, including participating in the care planning process. *(CalAIM Enhanced Care Management Policy Guide, Section V)*.

ECM core service components: The requirements under each core service component are described below, including but not limited to:

- Outreach and Engagement:
    - The Plan is responsible for reaching out to and engaging members who are identified to be eligible for ECM.
- Comprehensive Assessment and Care Management Plan (CMP):
    - Developing a comprehensive, individualized, person-centered CMP with input from the member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate, to assess strengths, risks, needs, goals and preferences and make recommendations for service needs.
    - Ensuring the member is reassessed at a frequency appropriate for the member's individual progress, changes in needs, and/or as identified in the CMP.
- Enhanced Coordination of Care:
    - Organizing patient care activities, as laid out in the Care Management Plan; sharing information with those involved as part of the Member's multi-disciplinary care team; and implementing activities identified in the Member's Care Management Plan;
    - Ensuring care is continuous and integrated among all service Providers and refers to and follows up with primary care, physical and developmental health,

mental health, substance use disorder (SUD), treatment Long-Term Services and Supports (LTSS), oral health, palliative care, and necessary community-based and social services, including housing, as needed;

- Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
- Ensuring regular contact with the Member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as appropriate, consistent with the Care Management Plan.

(APL 23-032, Enhanced Care Management Requirements)

Plan policy, *CARE-13 Enhanced Care Management* (reviewed 6/2025), stated that the Plan's Care Management Department encompasses several levels of care coordination services, including Enhanced Care Management (ECM). The Plan contracts with and oversees a network of community ECM providers to ensure all ECM eligible members can access services.

Finding: The Plan did not ensure that all members received all ECM core service components.

The verification study revealed that six of seven member records provided did not contain evidence that three ECM core service components were received. Examples include the following:

- Component 1, Outreach and Engagement:
  - One member had a Care Management Plan (CMP) that stated the Lead Care Manager (LCM) would contact the member three or more times a month. However, for three months, the member received less than three contact attempts. In a written response, the Plan agreed that the provider's documentation did not reflect the rationale for the reduction of contact.
  - Another member was authorized for ECM and excluded a month later without any outreach or engagement attempts being conducted. There was no documented rationale for the lack of attempts or exclusion from ECM. While the member was re-authorized several months later, there was only one outreach attempt documented per month for two months. In a written response, the Plan stated that it was unable to validate the timeframe for the

outreach and engagement attempts due to limited supporting documentation from the provider.

- Component 2, Comprehensive Assessment and CMP:
    - One ECM member with multiple medical conditions including diabetes, cancer, back pain, and numbness in hips going down both legs, reported during the comprehensive assessment of having a fear of falling. The CMP did not address the member's concern of falling or that a multi-disciplinary team had reviewed the member's CMP.
    - Two members had CMPs created without dates for goals to measure progress.
    - One member had a case note stating that the LCM had reviewed the member's notes and CMP. However, the CMP was not provided for review.
- Component 3, Enhanced Coordination of Care:
    - Four ECM members had various medical conditions, and additional needs for housing or other resources. While individual providers such as PCPs may have been contacted, there was no documented involvement by the multi-disciplinary team for these members. This component includes sharing information with those involved as part of the member's multi-disciplinary team and communicating the member's needs and preferences timely to the multi-disciplinary team.
    - Another ECM member did not receive contact by the ECM provider consistent with the CMP. The LCM did not maintain contact three or more times a month as stated in the member's CMP. This component states that contact should be consistent with the CMP. Additionally, regular and consistent contact helps ensure better care coordination.

In a written response, the Plan stated that it was unable to fully validate that all clinical needs were prioritized and addressed through a CMP with a clearly documented multi-disciplinary care team structure.

Review of Plan policy showed that the policy required ECM providers to conduct weekly outreach attempts, at a minimum, when a member is in outreach status. Outreach should include multiple and varied modality attempts that span over four weeks. If the Plan observes no outreach activity occurs within 120 days after provider assignment, that member may be reassigned to an alternate ECM provider. In several member

records, this process was not followed as evidenced by a lack of documented outreach and engagement.

Review of the Plan's ECM Policy Guide showed that the care plan should include goals that are specific, measurable, and time bound. Additionally, review of Plan policy showed that the ECM provider organizes ongoing case conferences and reaches out to the member's multi-disciplinary care team to communicate the member's needs and preferences, discuss referrals, and identify member's needs in a timely manner. This process was not followed in several member records as evidenced by a lack of documented case conference notes and multi-disciplinary care team involvement.

During an interview, the Plan stated that it had identified challenges to ECM service delivery including that some ECM providers may not be able to deliver on a member's clinical needs with care planning. In a written response, the Plan stated that challenges with delivery of ECM core service components included variability in provider understanding and consistent application of ECM requirements. During the audit period, the Plan conducted quarterly monitoring of ECM providers but did not generate any formal ECM oversight reports, follow-ups, or corrective actions.

When the Plan does not ensure that all ECM core services are provided, members may not receive comprehensive care management to address their health needs.

Recommendation: Implement policies and procedures to ensure that members receive all ECM core service components.

COMPLIANCE AUDIT FINDINGS

Category 3 – Network and Access to Care

3.17 Timely Payments

3.17.1 Provider Dispute Resolution Timeframe

The Plan must comply with Title 42 of the United States Code (USC), section 1396u-2(f) and Health and Safety Code (HSC), sections 1371 - 1371.39 and their implementing regulations, including Title 42 of Code of Federal Regulations (CFR), sections 447.45 - 447.46 and Title 28, California Code of Regulations (CCR), section 1300.71. *(Contract, Exhibit A, Attachment III, Section 3.3.5)*

The Plan shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. The Plan may maintain separate dispute resolution mechanisms for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes, provided that each mechanism complies with sections of title 28 1300.71.38. *(California Code of Regulations, Section 1300.71.38)*

The Plan shall identify and acknowledge the receipt of each provider dispute:

(1) In the case of an electronic provider dispute, the acknowledgement shall be provided within two working days of the date of receipt of the electronic provider dispute by the office designated to receive provider disputes, or

(2) In the case of a paper provider dispute, the acknowledgement shall be provided within 15 working days of the date of receipt of the paper provider dispute by the office designated to receive provider disputes. *(California Code of Regulations, Section 1300.71.38(e))*

The Plan shall resolve each provider dispute or amended provider dispute and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. *(California Code of Regulations, Section 1300.71.38(f))*

Plan policy, *CL-07 Provider Dispute Resolution Mechanism* (approved 2/28/2024), stated that the Plan sends a letter of acknowledgment indicating receipt of the dispute and the tracking number assigned to the dispute claim. Acknowledgment letters are sent within

15 working days of receipt for written submissions, or within two working days of receipt for electronic submissions. The PDR Unit responds to provider disputes with a determination letter within 45 working days from the date of receipt.

Finding: The Plan did not meet regulatory timeframes for acknowledging provider disputes or issuing written determinations.

A review of five paper provider disputes showed the Plan did not meet acknowledgement or determination timeframes in any case. Acknowledgements ranged from 16 to 39 working days, and determinations ranged from 63 to 120 working days. Additionally, the Plan's internal PDR audit for November found that none of the 23 post-payment disputes reviewed were resolved within 45 working days.

In an interview, the Plan stated that the PDR timeliness issue was due to attrition in the claims department; 9 of 21 staff members departed during the audit period. 8 of 9, including two claims directors and one claims manager, had termination dates between July to December 2025. The Plan hired four temporary staff from a staffing agency in December 2025. The Plan also had a quality review nurse shortage that affected the clinical review component of the PDR process. The staffing shortage contributed to the overall noncompliance of PDR timeliness.

If the Plan does not maintain a fast, fair and cost-effective dispute resolution mechanism to process and resolve provider disputes, it may cause financial burden to providers and negatively impact members' access to care.

Recommendation: Implement policies and procedures to ensure that PDR requests are processed and resolved according to regulatory timeframes.

COMPLIANCE AUDIT FINDINGS

Category 6 – Plan Administration and Organization

6.14 Provider Screening and Enrollment

6.14.1 Plan Developed Provider Screening, and Enrollment Process

All Network Providers must be screened and enrolled in accordance with this Contract, applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013. *(Contract, Exhibit A, Attachment III, Section 1.3.3(A))*

The State must screen and enroll, and periodically revalidate, all network providers in accordance with the requirements of CFR, Part 455, Subparts B and E. *(Title 42, CFR, Section 438.602(b))*

The Medi-Cal managed care program and Plans must comply with statewide Medi-Cal FFS enrollment standards and federal enrollment standards when verifying enrollment of providers through a state-level enrollment pathway or developing a provider enrollment pathway. Plans may screen and enroll Network Providers in a manner that is substantively equivalent to DHCS' process. The Plan's screening and enrollment requirements are separate and distinct from their credentialing and re-credentialing processes.

At the time of application, Plans must inform their Network Providers, as well as any providers seeking to enroll with a Plan, of the differences between the Plan's and DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

The Plan must screen initial provider applications, including applications for a new practice location, and any applications received in response to a Network Provider's reenrollment or revalidation request to determine the provider's categorical risk level as limited, moderate, or high. If a provider fits within more than one risk level, the Plan must screen the provider at the highest risk level. Plans must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the Plan and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements.

As part of the enrollment process, Plans are responsible for ensuring that all successfully enrolled providers execute and sign the Medi-Cal Provider Agreement (DHCS Form 6208). The agreement between the Plan and a provider (Network Provider Agreement) is

separate and distinct from the Medi-Cal Provider Agreement. Both the Medi-Cal Provider Agreement and the Network Provider Agreement are required for Plan Network Providers.

The Plan must complete the process and provide the applicant with a written determination on the Plan's letterhead within 120 calendar days of its receipt of a provider application.

Plans may delegate their authority to perform screening and enrollment activities to a Subcontractor. The delegation must be in a written subcontract or agreement and comply with the requirements set forth in APL 17-004 and any subsequent APL requirements. When doing so, the Plan remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

Plans are required to retain all provider screening and enrollment materials and documents for ten years. Additionally, Plans must make all screening and enrollment documents and materials promptly available to DHCS upon request.

(APL 22-013, Provider Credentialing/Re-Credentialing and Screening/Enrollment)

Plan Policy, *CR-06, Initial Credentialing, Recredentialing, Screening, and Enrollment of Practitioners,* reviewed 10/17/2024, stated all practitioners are stratified into Limited, Moderate, and High-Risk categories in accordance with the guidelines established by DHCS. The Plan verifies prospective providers' and practitioners' enrollment with the DHCS prior to enrolling them with the Plan. The Plan may collaborate with DHCS and other Medi-Cal Managed Care Plans in California to share provider enrollment results. If the provider or practitioner has not completed the Medi-Cal enrollment process through DHCS, the provider or practitioner will complete SFHP's Medi-Cal enrollment process.

Plan policy, *CR-06*, also stated that when SFHP delegates credentialing and recredentialing to a medical group, health plan, or vendor, SFHP also delegates screening, verification, and enrollment. SFHP ensures through regular audits and reports that the delegated providers and their sub-delegates perform these functions in compliance with industry-approved requirements. SFHP retains the right to approve, suspend and terminate individual practitioners, providers, and sites in situations where it has delegated decision making.

Finding: The Plan and its delegate's managed care provider screening and enrollment process did not comply with all contractual enrollment standards.

The Plan did not ensure that providers were screened and enrolled according to the contractual and regulatory requirements and did not verify that its delegate followed the Medi-Cal enrollment standards.

A review of 17 provider applications found that neither the Plan nor its delegate consistently performed required screening and enrollment activities. Ten Plan-enrolled provider application records lacked evidence of risk-level screening, enrollment disclosures, and separate network provider agreements. Four of seven delegate-enrolled provider application records contained no screening and enrollment documentation at all, and three records lacked evidences of required risk stratification, site visits, provider enrollment disclosures required by APL 22-013 (Attachment B), and written determinations. No documentation demonstrated how risk levels were determined.

The Plan's delegation contract for credentialing functions stated the responsibilities of the Plan and the delegates. The type of credentialing verification includes license verification, education and training, board certification, work history, history of professional liability claims that resulted in settlement of judgment paid on behalf of the provider, and sanction data bases verification. However, the delegation agreement did not mention provider screening or enrollment as a specific delegated function, nor did it include information related to the provider enrollment and screening requirements on the Contract, APL 22-013 and applicable regulations.

In an interview, the Plan stated that network providers were screened through a vendor for various databases including the Medi-Cal suspension and ineligible list. However, the Plan could not articulate or provide evidence of how the risk levels were determined and applied. In addition, the Plan stated that network providers' who were enrolled by the delegates were evaluated at the annual delegation oversight audit under credentialing. A review of the Plan's credentialing audit tool shows that it checks for whether the providers or organizations are enrolled in Medi-Cal FFS. If they are not enrolled in Medi-Cal FFS, the reviewer must check the NPI, System for Award Management (SAM), Social Security Administration's Death Master File, SFHP addendum C and D (DHCS 6207 & 6208) or equivalent enrollment documents, and if they are enrolled with another health plan. Nevertheless, the audit tool does not contain a review of the delegate's provider categorical risk level determination, network provider agreement, and provider enrollment disclosures required by APL 22-013 (Attachment B).

When provider screening and enrollment processes are incomplete, the Plan and its delegates cannot ensure that only qualified, compliant providers participate in the Medi-Cal network. This increases the risk of member harm, improper payments, fraud

exposure, and violations of federal and State enrollment standards. When the Plan and its delegated entities' managed care provider screening and enrollment process does not comply with all enrollment standards, it cannot prevent providers who do not meet Medi-Cal provider enrollment requirements from participating in the Plans' provider network.

Recommendation: Revise and implement policies and procedures to ensure the Plan and the delegated entities are compliant with all required managed care screening and enrollment standards.

REPORT ON THE MEDICAL AUDIT OF SAN FRANCISCO HEALTH PLAN CALENDAR YEAR 2025

DHCS Audits and Investigations
Contract and Enrollment Review Division
San Francisco Section

Contract Number: 23-30269
Contract Type: State Supported Services
Audit Period: March 1, 2025 — December 31, 2025
Dates of Audit: May 4, 2026 — May 15, 2026
Report Issued: September 14, 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the results of the audit of San Francisco Health Authority dba San Francisco Health Plan (Plan) compliance and implementation of the State Supported Services contract number 23-30269 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of March 1, 2025, through December 31, 2025. The audit was conducted from May 4, 2026, through May 15, 2026, which consisted of a document review and verification study with the Plan administration and staff.

Twenty claims were reviewed for appropriate and timely adjudication.

An Exit Conference with the Plan was held on August 27, 2026. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members enrolled under this Contract or the Primary Contract, the following private services:

1) Current Procedure Terminology codes: 59840 through 59857
2) Centers for Medicare and Medicaid Services Common Procedure Coding System codes: X1516, X1518, X7724, X7726, and Z0336

These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code set provisions. *(Contract, Exhibit A, (1.2.1) (1.2.2))*

The Plan is required to cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements in the Medi-Cal Provider Manual. The Plan, network providers and subcontractors are prohibited from requiring medical justification, imposing any utilization management or utilization review requirements, including prior authorization, for the coverage of outpatient abortion services. *(All Plan Letter 24-003, Abortion Services)*

Finding: No deficiencies were identified in the audit.

Recommendation: None.