



**OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS**

**BEHAVIORAL HEALTH INVESTIGATION
REPORT**

**SAN FRANCISCO HEALTH AUTHORITY
DBA: SAN FRANCISCO HEALTH PLAN**

DATE: AUGUST 29, 2025

**Behavioral Health Investigation
San Francisco Health Plan**

TABLE OF CONTENTS

EXECUTIVE SUMMARY.....2
FRAMEWORK FOR THE BEHAVIORAL HEALTH INVESTIGATIONS.....4
SECTION I: KNOX-KEENE ACT VIOLATIONS6
SECTION II: SUMMARY OF BARRIERS TO CARE NOT BASED ON KNOX-KEENE
ACT VIOLATIONS36
SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION39
APPENDIX A. INVESTIGATION TEAM MEMBERS41
APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED42
APPENDIX C. LIST OF FILES REVIEWED46

EXECUTIVE SUMMARY

The California Department of Managed Health Care (Department) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the Department licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975 and regulations promulgated thereunder (collectively, Knox-Keene Act).¹ The Department is conducting focused Behavioral Health Investigations (BHI) of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with California law and to assess whether enrollees have consistent access to medically necessary behavioral health care services. The full-service commercial health plans will be investigated in phases. The investigation of San Francisco Health Plan (Plan) was included in Phase Three.

On June 12, 2024, the Department notified the Plan of its BHI covering the time period of April 1, 2022 through March 31, 2024. The Department requested the Plan submit information regarding its health care delivery system, with a focus on the Plan's mental health and substance use disorder services.² The investigation team interviewed the Plan, its behavioral health delegate San Francisco Behavioral Health Services (BHS), and its prescription drug delegate, Prime Therapeutics Management LLC (Prime Therapeutics)/MagellanRx³ on January 28, 2025 through January 30, 2025.

The BHI uncovered **17** Knox-Keene Act violations in the areas of Appointment Availability and Timely Access, Utilization Management, including Triage and Screening, Quality Assurance, and Claims Submission and Payment:

1. The Plan's appointment accessibility monitoring is insufficient to ensure compliance with timely access standards.
2. The Plan does not conduct adequate oversight to ensure BHS offers enrollees behavioral health appointments within timeliness standards.
3. The Plan failed to consistently conduct an annual enrollee experience survey as required.
4. The Plan was unable to demonstrate all persons who conduct utilization review, review claims, and/or make medical necessity determinations for behavioral health services received the required formal training on nonprofit association criteria.

¹ The Knox-Keene Health Care Service Plan Act of 1975 is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

² For purposes of this Report, the term "behavioral health" or "behavioral health services" refers to mental health as well as substance use disorder conditions, and the services used to diagnose and treat those conditions.

³ During the BHI review period, the Plan's prescription benefit manager (PBM) was Magellan Rx Management LLC. Prime Therapeutics Management LLC acquired Magellan Rx Management LLC, with a legal name change on September 16, 2024. The rebranded PBM, Prime Therapeutics Management LLC, was implemented effective October 1, 2024.

San Francisco Health Plan
Behavioral Health Investigation Report

5. The Plan did not demonstrate that all staff who conduct utilization review passed interrater reliability testing.
6. The Plan does not have a process to continuously review utilization of behavioral health services and facilities.
7. The Plan does not ensure BHS timely notifies behavioral health provider applicants of the status of their credentialing application.
8. The Plan does not conduct adequate oversight of BHS to ensure compliance with required utilization management program standards.
9. The Plan does not conduct adequate oversight to ensure BHS identified and referred all grievances to the Plan.
10. Plan customer service representatives are not consistently knowledgeable and competent in providing customer service.
11. Neither the Plan nor BHS have a maternal mental health program, as required.
12. The Plan was operating at variance with its filed quality assurance policy and procedure.
13. The Plan was operating at variance with its filed utilization management policy and procedure.
14. The Plan was operating at variance with its SB 855 compliance filing.
15. The Plan was operating at variance with its filed Delegation Agreement.
16. The Plan was operating at variance with its filed access policy and procedure.
17. The Plan permitted BHS to engage in unjust payment patterns.

Additionally, the Department identified the following **three** barriers to care not based on Knox-Keene Act requirements in the area of Quality Assurance:

1. The Plan's high customer service staff turnover rate impedes efficient and effective customer service.
2. The Plan does not have a mechanism to monitor enrollee telephone calls made to BHS.
3. The Plan does not have a process to track and monitor telephone calls from providers.

This BHI Report also includes Plan initiatives or operations, if any, identified as potentially having a positive impact on the Plan's provision of and/or enrollee access to behavioral health services. In this case, the investigation identified no initiatives/operations resulting in positive impact on the Plan's provision of and/or enrollee access to behavioral health services.

The Plan is hereby advised that the findings and violations noted in this BHI Report will be referred to the Department's Office of Enforcement. The Department's Office of Enforcement will evaluate appropriate enforcement actions, which may include corrective actions and assessment of administrative penalties, based on the Knox-Keene Act violations. In the Phase Three Summary Report, the Department will provide recommendations for the barriers to care not related to Knox-Keene act violations.

FRAMEWORK FOR THE BEHAVIORAL HEALTH INVESTIGATIONS

I. Background

Both California and federal laws require health plans to cover services to diagnose and treat behavioral health conditions. Senate Bill (SB) 855 (Wiener, 2020) made amendments to California's mental health parity law and requires commercial health plans and insurers to provide coverage for the medically necessary treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. Health plans must also provide all covered mental health and substance use disorder benefits in compliance with the Mental Health Parity Addiction Equity Act (MHPAEA). The MHPAEA requires health plans to provide covered benefits for behavioral health in parity with medical/surgical benefits.

Other Knox-Keene Act provisions and corresponding regulations establish standards for access to care, requiring health plans to provide or arrange for the provision of covered health care services, including behavioral health services, in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.⁴ Plans must ensure enrollees can obtain covered health care services, including behavioral health services, in a manner that assures care is provided in a timely manner appropriate for the enrollee's condition.⁵

The Department utilizes a variety of regulatory tools to evaluate access to behavioral health services, including routine medical surveys, annual assessments of provider networks, and tracking enrollee complaints to the Department's Help Center to identify trends or issues in enrollee complaint patterns. In 2014-2017, the Department conducted MHPAEA compliance reviews of health plans subject to MHPAEA. This included analysis of benefit classifications, cost sharing requirements and non-quantitative treatment limitations to determine if health plans were meeting parity requirements under MHPAEA. As a result of this focused compliance review, many health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Several plans were also required to reimburse enrollees because the plans had inappropriately applied cost-sharing out of compliance with MHPAEA. Since the initial compliance review, the Department conducts ongoing review of MHPAEA compliance when plans make changes to policies or operations, or when licensing new health plans. Additionally, the Department has incorporated into routine medical surveys review for compliance and the enforcement of requirements of SB 855 (Wiener, 2020) that expanded the scope of access and coverage for behavioral health benefits.

II. Methods for BHIs

The BHIs involve evaluation of health plans' commercial products regulated by the Department.⁶ To evaluate the Plan's operations for the review period of April 1, 2022

⁴ Rule 1300.67.2.2(c)(1).

⁵ Rule 1300.67.2.2(c)(2).

⁶ The BHIs do not include plan products or plan enrollees covered by Medicare, California's Medi-Cal program, self-insured Administrative Services Organizations or non-Department regulated products.

San Francisco Health Plan Behavioral Health Investigation Report

through March 31, 2024, the Department requested and reviewed Plan documents, files, and data, and conducted interviews with Plan and BHS staff. The BHI involved reviewing and assessing the Plan's operations pertaining to the delivery of behavioral health services. The BHI focused on the following areas:

- Appointment Availability and Timely Access
- Utilization Management, including Triage and Screening
- Pharmacy
- Quality Assurance
- Grievances and Appeals
- Claims Submission and Payment
- Cultural Competency, Health Equity and Language Assistance

To further understand potential barriers to care from the perspective of enrollees and providers, the Department sought enrollee and provider participation in separate interviews concerning their experiences with the Plan. The Department reached out to stakeholders for assistance in identifying enrollees and providers who would be willing to participate in the interviews. Additionally, the Department reviewed complaints submitted to the Department's Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. Despite the Department's attempt to engage Plan enrollees and providers in interviews for this BHI, the Department received no response from either Plan enrollees or providers willing to be interviewed.

PLAN BACKGROUND

San Francisco Health Authority, dba San Francisco Health Plan, obtained its Knox-Keene license in 1996 and is headquartered in San Francisco. The Plan began as a Local Initiative health plan contracted with the Department of Health Care Services to provide Medi-Cal services. In March 1999, the Plan's Healthy Workers line of business began providing commercial health care coverage to eligible individual providers of In-Home Support Services (IHSS).⁷ As of March 31, 2024 (the final quarter of the Plan's BHI review period), the Plan had 11,430 enrollees in its commercial line of business. The Plan operates in San Francisco County.

Behavioral health services are provided to Healthy Workers enrollees through BHS, which is part of the City and County of San Francisco Department of Public Health. Medical services are provided by Department of Public Health clinics and hospital services are provided by Zuckerberg San Francisco General Hospital. Magellan/Prime Therapeutics provides the pharmacy benefit. With respect to behavioral health services, the Plan delegates the following operations to BHS: provision of behavioral health services and related utilization management, credentialing and network management, and claims payment. The Plan retains responsibility for grievances and appeals, quality assurance, SB 855 nonprofit association criteria training and utilization management for medical services.

⁷ Healthy Workers enrollees are IHSS workers ages 16 and older, employed by the City and County. Under the Healthy Workers plan, coverage does not extend to dependents of enrollees.

SECTION I: KNOX-KEENE ACT VIOLATIONS

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: The Plan's appointment accessibility monitoring is insufficient to ensure compliance with timely access standards.

Statutory/Regulatory Reference(s): Sections 1367.03(a)(1), 1367.03(a)(5)⁸ and Rule 1300.67.2.2(c)(5)

Supporting Documentation:

- Plan policy *QI-05 Monitoring Accessibility of Provider Services* (Approved February 23, 2024)
- Plan *Provider Appointment Availability Survey (PAAS)* results (Measurement Years 2022, 2023)

Assessment: Health plans must provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.⁹ Plans must have policies, procedures and quality assurance monitoring systems and processes to ensure compliance with clinical appropriateness standards.¹⁰ Plans must also ensure their networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments within timely access standards.¹¹ Timely access standards are in place for both urgent and nonurgent appointments, with limited exception.¹² These network, timeliness and compliance monitoring obligations are not waived if delegated by the Plan.¹³

The Plan's *Monitoring Accessibility of Provider Services* policy describes timeliness standards, the Plan's internal compliance thresholds for each of the standards, and how the Plan monitors compliance with the standards. The Procedures section of the policy states the Plan conducts a PAAS and annually reviews PAAS results for all provider groups against the listed timeliness and other standards.¹⁴ The policy lists specific evaluated measures, and the Plan's thresholds for compliance with those measures (SFHP Standards). For the measure "Survey Responses," the Plan Standard is that 50% or more of providers who are surveyed respond and complete the PAAS (including

⁸ Section 1367.03, revised by SB 225 to include timely access standards, among other things, became effective January 1, 2023. Although the Plan's BHI review period includes dates prior to enactment of SB 225, the Plan was bound to the same timely access standards already in effect and set forth in Rule 1300.67.2.2(c)(5)

⁹ Section 1367.03(a)(1); Rule 1300.67.2.2(c)(1).

¹⁰ Section 1367.03(a)(1), Rule 1300.67.2.2(c)(1).

¹¹ Section 1367.03(a)(5); Rule 1300.67.2.2(c)(5).

¹² Section 1367.03(a)(5); Rule 1300.67.2.2(c)(5) (The exception to timely appointment requirements includes cases in which the referring or treating provider, or the triaging provider, acting within the scope of their practice and consistent with professionally recognized standards of practice, determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee. In such cases, the waiting time for an appointment may be extended (Section 1367.03(a)(5)(H); Rule 1300.67.2.2(c)(5)(H)).

¹³ Section 1367.03(c); Rule 1300.67.2.2(a)(3).

¹⁴ *Monitoring Accessibility of Provider Services* policy, pages 3-4.

San Francisco Health Plan
Behavioral Health Investigation Report

network providers, delegate providers and providers within each type of provider).¹⁵ According to the policy, findings of non-compliance are reviewed and investigated by the Plan's Access Compliance Committee, which is required to meet at least quarterly.¹⁶

As explained below, when the Plan's reported PAAS response rates did not meet SFHP Standards, the Plan failed to demonstrate it reviewed non-compliance findings or took action to address the findings as required by the Plan's policy.

Health plans' PAAS data is available on the Department's [website](#). The Department reviewed the available PAAS data for the Plan's BHI review period. For the Plan's Healthy Workers line of business, in both Measurement Years (MY) 2022 and 2023, psychiatrist and non-physician mental health provider response rates fell well below the Plan's 50% SFHP Standard. For MY 2022, only 39% of the target sample size response rate was achieved for psychiatrists and 44% for non-physician mental health providers. For MY 2023, only 22% of the target sample size response rate was achieved for psychiatrists and 45% for non-physician mental health providers.

The Department requested the Plan submit copies of Plan and BHS committee meeting minutes from quality committees, access committees and other committees demonstrating how the Plan and BHS reviewed, discussed, documented and addressed data and issues pertaining to access to behavioral health services, among other things.¹⁷ Per Plan's *Monitoring Accessibility of Provider Services* policy, committee meeting minutes should have demonstrated the noncompliant provider response rates that fell below the SFHP Standard of 50% were reviewed, investigated and addressed, as appropriate.

In response to the Department's request, the Plan submitted several committee meeting documents, but none of the documents addressed the noncompliant SFHP Standards, or steps to improve provider response rate. There was no evidence demonstrating the Plan or any committee reviewed, investigated or took corrective action to improve provider response rate. As a result, the Plan's processes failed to ensure compliance with SFHP Standards and was insufficient to ensure compliance with timely access standards.

Conclusion: Health plans must have processes in place to accurately evaluate their networks to ensure adequate provider capacity and appointment availability within timely access standards. Plan documents indicated the Plan relies on PAAS data for evaluating compliance with timely access standards. However, the PAAS provider response rate fell below the SFHP Standard of 50%. The Plan's failure to review, investigate or take corrective action demonstrated the Plan's quality process is insufficient to ensure compliance with timely access standards, in violation of Sections 1367.03(a)(1), 1367.03(a)(5) and Rule 1300.67.2.2(c)(5).

¹⁵ *Monitoring Accessibility of Provider Services* policy, page 4.

¹⁶ *Monitoring Accessibility of Provider Services* policy, page 1.

¹⁷ Crosswalk request BHIQA9.

#2: The Plan does not conduct adequate oversight to ensure BHS offers enrollees behavioral health appointments within timeliness standards.

Statutory/Regulatory Reference(s): Sections 1367.03(a)(5)(E), 1367.03(c), and Rule 1300.67.2.2(c)(5)(E)

Supporting Documentation:

- Plan policy QI-05 *Monitoring Accessibility of Provider Services* (Approved February 23, 2024)
- Plan policy CARE-10 Behavioral Health Services (revised June 18, 2020)
- *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services* (Delegation Agreement) (Effective date: January 1, 2021)
- 25 BHS Inquiry Files (April 1, 2022 to March 31, 2024)

Assessment: As discussed in Violation #1, health plans must ensure their networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments within timely access standards.¹⁸ The obligation of a plan to ensure compliance with timeliness standards is not waived if the plan delegates services or activities to any contracting entity or provider group.¹⁹ The Plan was therefore obligated to oversee BHS processes to ensure BHS offered behavioral health appointments within timeliness standards.

The Plan's *Monitoring Accessibility of Provider Services* policy describes timely access standards that comply with Knox-Keene Act requirements. BHS inquiry files, however, demonstrated when enrollees requested behavioral health services, BHS did not always offer an appointment that complied with timeliness standards.

According to the Plan's *CARE-10 Behavioral Health Services* policy, Healthy Worker enrollees "may access all behavioral health services by calling the [BHS] Access hotline or walk into centers that are part of the [BHS] network." When an enrollee calls BHS seeking a behavioral health appointment, BHS' practice is to conduct an "initial intake assessment." The intake assessment process is lengthy and can create delays in accessing care.

The first part of the intake process involves the customer service representative determining eligibility, verifying which Plan product the enrollee is enrolled in and gathering preliminary information about the enrollee. In some instances, case files document the customer service representative informing the enrollee of a "Warm Line" the enrollee can call for "emotional support" and providing drop-in county clinic hours. The enrollee is then routed to a BHS clinician to conduct an in-depth assessment.

According to BHS, the clinicians, who are often licensed clinical social workers or marriage and family therapists, conduct a clinical evaluation that can take 20 to 30 minutes or longer. The clinician uses a level of care tool to conduct triage, assess acuity

¹⁸ Section 1367.03(a)(5); rule 1300.67.2.2(c)(1).

¹⁹ Section 1367.03(c).

San Francisco Health Plan Behavioral Health Investigation Report

and determine which services, provider or facility to refer the enrollee.²⁰ The level of care tool requires the clinician to ask the enrollee several questions, and based on the enrollee's responses, the clinician assigns scores from zero to three for each item.

Based on the scoring, the clinician generally refers the enrollee to one of the following: specialty behavioral health services, the Private Provider Network (PPN), or to a contracted county behavioral health clinic. Once a referral is made, the inquiry file is closed, although some case files included subsequent notes.

In many cases, there was no evidence demonstrating BHS offered the enrollee a timely appointment, and some case file notes confirmed there were delays resulting in failure to provide timely access to appointments. Additionally, the Plan provided no evidence demonstrating it monitors BHS' intake and referral process, or ensures enrollees are offered timely appointments.

Case File Examples

The Department reviewed 25 BHS Inquiry Files. The case files demonstrated enrollees who requested behavioral health services were not always offered appointments within timeliness standards. Enrollees who request nonurgent appointments with mental health therapists must be offered an appointment within 10 business days of the request, with limited exceptions.²¹

Case Examples:

- **BHS Inquiry File #5:** The enrollee called BHS on March 11, 2024, seeking a therapist. The member services representative documented the following: "Provided info to access SFBH Services. Directed to obtain a clinical assessment. Provided clinic and drop-in hours....Queued for clinical consultation." A clinical risk assessment was conducted the same day, and the enrollee was referred to a county behavioral health clinic. The case notes state the clinician who conducted the risk assessment contacted the clinic and the enrollee was scheduled an intake appointment with the clinic on April 12, 2024, more than 10 business days from the request.
- **BHS Inquiry File #7:** The enrollee called BHS July 19, 2023, seeking mental health therapy services. An initial risk assessment was conducted, and case notes show a referral to a county mental health clinic was made the same day. A month later, on August 16, 2023, BHS received a call stating the enrollee was having

²⁰ BHS Inquiry case files indicated BHS uses the Adult Screening Tool for Medi-Cal Mental Health Services – DHCS 8765A.

²¹ Section 1367.03(a)(5)(E). The exceptions to the 10-day requirement are described in Section 1367.03(a)(5)(H) and (I), as well as Rule 1300.67.2.2(c)(5)(H) and (I). Plans are not subject to the 10-day requirement for offering non-urgent appointments with nonphysician mental health providers when either (i) the treating or triaging provider note in the enrollee's record that a longer wait time will not be a detriment to the enrollee, or (ii) the treating provider determine that periodic office visits for mental health or substance use disorder may be scheduled in advance. Neither of these exceptions apply to the example case files presented in this Report.

San Francisco Health Plan
Behavioral Health Investigation Report

difficulty accessing mental health services and the clinic to which the enrollee was referred indicated the enrollee needed a lower level of care.

- **BHS Inquiry File #10**: On March 16, 2023, the enrollee called BHS seeking psychotherapy. An initial risk assessment was conducted, and case notes show a referral to PPN was made the same day. A case file note dated June 15, 2023, three months after the enrollee's call, noted "PPN services to be provided by [Name of provider], LCSW."
- **BHS Inquiry File #11**: On August 11, 2023, a treating provider called BHS to obtain a PPN referral for the enrollee. The intake assessment with the enrollee was conducted on September 5, 2023, and the enrollee was referred to PPN. On November 30, 2023, BHS was contacted by a provider stating the enrollee had not heard back about getting a PPN therapist. BHS followed up with the specialist responsible for matching the enrollee with a provider who said "he hopes to get [the enrollee] matched by the end of this week."
- **BHS Inquiry File #16**: On August 16, 2023, the enrollee called BHS requesting mental health therapy. An intake assessment was completed the following day and the enrollee was referred to PPN. On October 17, 2023, two months later, the enrollee called BHS to check on the referral. Case notes stated the "referral has not been picked up by a PPN provider." The enrollee was encouraged to go to the nearest county clinic during drop-in hours.

For each of the cases described above, there was no indication a timely appointment was offered to the enrollee following the initial request. There was also no indication the enrollee requested the delay or that either of the exceptions to offering timely appointments applied.

During interviews, BHS representatives acknowledged the intake assessment process can be intense and enrollees do not always want or have time to complete the clinical intake. In those instances, the enrollee may call BHS back or the clinician may call the enrollee at a later time. Referrals to the PPN, a county clinic or for specialty mental health services, did not ensure enrollees were offered timely appointments as required.

Although the Delegation Agreement included provisions requiring the Plan to monitor and evaluate BHS's compliance with the delegated functions of utilization management, credentialing, cultural and linguistic services and claims and provider dispute resolution operations, the Plan did not monitor or evaluate customer service calls, initial risk intake functions, or referrals to behavioral health service providers to ensure enrollees were offered appointments within timeliness standards. Furthermore, although the Plan delegated behavioral health services to BHS, ensuring compliance with timely access standards remained the Plan's responsibility.²²

Conclusion: Health plans must ensure their networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments within timely

²² Section 1367.03(c).

access standards.²³ The obligation of a plan to ensure compliance with timeliness standards is not waived if the plan delegates services or activities to any contracting entity or provider group.²⁴ Case files demonstrated enrollees who called BHS requesting behavioral health services were not consistently offered appointments that met timely access standards. Accordingly, the Department finds the Plan in violation of Sections 1367.03(a)(5)(E), 1367.03(c) and Rule 1300.67.2.2(c)(5)(E).

#3: The Plan failed to consistently conduct an annual enrollee experience survey as required.

Statutory/Regulatory Reference(s): Rule 1300.67.2.2(d)(2)(B)

Supporting Documentation:

- Plan Access & Care Experience Survey (2021)
- Plan Memorandum: “2023 healthy worker enrollee satisfaction results” (undated)
- Plan Memorandum: “2022 healthy worker enrollee satisfaction results” (undated)

Assessment: Health plans’ quality assurance programs are required to include compliance monitoring procedures designed to accurately measure accessibility and availability of contracted providers.²⁵ The compliance monitoring procedures must include conducting an annual Enrollee Experience Survey.²⁶ This enrollee survey must “obtain enrollees’ perspectives and concerns regarding their experience obtaining timely appointments for health care services” as required by timely access standards.²⁷

The Department requested the Plan submit copies of enrollee experience survey results and reports.²⁸ The Plan submitted three documents: a sample 2021 mailer of its template enrollee survey, titled Access & Care Experience, and two memoranda. The “2022 Healthy Worker enrollee satisfaction survey results” memorandum described the enrollee experience survey format of six standardized questions, the sample of enrollees surveyed, and included a summary of enrollee responses to the survey questions for 2021 and 2022. The “2023 Healthy Workers enrollee satisfaction results” memorandum explained the Plan did not conduct its usual enrollee experience survey and planned to conduct an enrollee survey for measurement year 2023 in 2024, but was delayed, and as a result, the Plan did not conduct any enrollee experience survey for 2023. The Plan stated it planned to administer the survey in summer 2024.

Conclusion: Rule 1300.67.2.2(d)(2)(B) requires plans to conduct an annual enrollee experience survey. The Plan did not conduct the required annual enrollee survey for MY 2023. Therefore, the Department finds the Plan in violation of this regulatory requirement.

²³ Section 1367.03(a)(5); rule 1300.67.2.2(c)(1).

²⁴ Section 1367.03(c).

²⁵ Rule 1300.67.2.2(d)(2).

²⁶ Rule 1300.67.2.2(d)(2)(B)

²⁷ Rule 1300.67.2.2(d)(2)(B)(ii) (prior to January 1, 2023, the requirement stated the Enrollee Experience Survey should be designed to “ascertain compliance with the [timely access standards.]”

²⁸ BHIQA8.

UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING

#4: The Plan was unable to demonstrate that all persons who conduct utilization review, review claims, and/or make medical necessity determinations for behavioral health services received the required formal training on nonprofit association criteria.

Statutory/Regulatory Reference(s): Section 1374.721(e)(1)

Supporting Documentation:

- *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services (Delegation Agreement) (Effective date: January 1, 2021)*
- *Amendment Number Eleven to the Mental Health/Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services (Amendment Eleven)*
- BHS policy: *BHS Services for Healthy Workers* (May 11, 2022)
- Plan Narrative Response: *Memorandum Regarding Item #38 and 39* regarding formal nonprofit association training (undated)
- Plan Narrative Response: *Memorandum Regarding Item # BHIUM2* regarding formal nonprofit association training (undated)
- Staff NPA Training List (undated)

Assessment: When conducting utilization review of requests for behavioral health services, health plans, and any entity conducting utilization review on behalf of the plan, must use the applicable current criteria and guidelines developed by the relevant nonprofit professional association.²⁹ Plans and their delegates may apply other utilization review criteria only when the behavioral health service is outside the scope or not covered by the nonprofit criteria.³⁰ To ensure proper use of the nonprofit criteria, plans must sponsor a formal education program by the nonprofit associations to educate plan staff, those who review claims, conduct utilization management reviews, or make medical necessity decisions about the criteria.³¹

The Plan delegates behavioral health services to BHS for the Plan's Healthy Worker enrollees. In accordance with the amended delegation agreement between BHS and the Plan (Delegation Agreement),³² BHS was responsible for the following delegated functions: utilization management, credentialing, cultural and linguistic services, and claims and provider dispute resolutions.³³ Because BHS was responsible for conducting utilization management of behavioral health services, BHS was obligated to use the

²⁹ Section 1374.721(b).

³⁰ Section 1374.721(c). Criteria other than nonprofit criteria must be based on current, generally accepted standards of mental health and substance use disorder care.

³¹ Section 1374.721(e)(1).

³² *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services.*

³³ *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services, Exhibit G, paragraph 2A.*

San Francisco Health Plan Behavioral Health Investigation Report

nonprofit criteria, as applicable. Additionally, Amendment Eleven assigns BHS the responsibility to sponsor the formal training program.³⁴

The Department requested a list identifying Plan and BHS staff who were responsible for conducting utilization review and demonstrating those persons completed the required training on the nonprofit association criteria, along with the date(s) of training completion.³⁵ The Plan provided a spreadsheet identifying persons who received training.³⁶ The spreadsheet listed names, the organization for which the person worked (Plan or BHS), each person's title, the training received, the nonprofit association that provided the training and the date of training completion.³⁷ The spreadsheet included a total of 35 names, including 27 Plan employees and eight BHS and/or San Francisco Department of Public Health employees. The data revealed the following:

- Six individuals, including three BHS staff³⁸ and three Plan staff³⁹ completed training on LOCUS and CALOCUS criteria/guidelines.
- Five individuals completed ASAM training, including four BHS staff⁴⁰ and one Plan medical director.
- 28 individuals, including 26 Plan staff⁴¹ and two Department of Health staff⁴² completed WPATH training.

Based on the spreadsheet data, only six BHS individuals completed nonprofit association criteria training (three individuals completing LOCUS and CALOCUS training, one individual completing LOCUS, CALOCUS and ASAM training, and three other individuals completing only ASAM training). There was no evidence that all BHS utilization review staff completed training on both ASAM and LOCUS/ CALOCUS or that *any* BHS staff were trained on WPATH during the BHI review period.

In interviews, the Plan confirmed that not all staff who make medical necessity decisions were trained in the nonprofit association criteria. The Plan also stated it had no process in place to ensure requests for behavioral health services were handled by clinical reviewers training in nonprofit association criteria and guidelines.

³⁴ Amendment Eleven, Paragraph 4(b)(v)(i).

³⁵ DMHC Document Requests #38 and #39, sent to the Plan on November 8, 2024, responded to by the Plan on December 12, 2024, and January 3, 2025.

³⁶ The NPA criteria or guidelines included Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), American Society of Addiction Medicine (ASAM), and World Professional Association for Transgender Health (WPATH).

³⁷ Staff NPA Training List.

³⁸ The BHS staff who completed the LOCUS and CALOCUS training included a UM program director, behavioral health clinician and a registered nurse.

³⁹ The Plan staff who completed the LOCUS and CALOCUS training included two medical directors and the chief medical officer.

⁴⁰ The BHS staff who completed the ASAM training included the behavioral health clinician who also completed the LOCUS and CALOCUS training, in addition to a medical director, a psychiatric nurse practitioner and an addiction and substance use counselor.

⁴¹ Plan staff who completed the WPATH training included 20 nurses in addition to medical directors, behavioral health clinicians, an addiction and substance use counselor, chief medical officer, program directors and managers.

⁴² San Francisco Department of Health staff who completed the WPATH training included a gender health medical lead and a gender health clinical director.

Conclusion: Plans or their delegates that conduct utilization review for behavioral health services are required to apply nonprofit association criteria as applicable.⁴³ To ensure proper use of criteria, plans (or delegated entity) must sponsor a formal education program by nonprofit clinical specialty associations to educate plan and delegate staff who conduct utilization review, review claims, or who make medical necessity determinations, about the criteria.⁴⁴ The Plan did not demonstrate that all required Plan and BHS staff who review claims, conduct utilization review and/or make medical necessity determinations regarding behavioral health services provided to Healthy Worker enrollees received the required formal nonprofit association training. Accordingly, the Department finds the Plan in violation of Section 1374.721(e)(1).

#5: The Plan did not demonstrate that all staff who conduct utilization review passed interrater reliability (IRR) testing.

Statutory/Regulatory Reference(s): Section 1374.721(e)(5), (f)(3)(A), and (h)

Supporting Documentation:

- BHS policy *BHS Services for Healthy Workers* (May 11, 2022)
- BHS 2024 IRR list
- Plan 2024 IRR list
- BHS Acute Care Inter-Rater Reliability Questions

Assessment: To ensure proper use of the nonprofit criteria when conducting utilization review of behavioral health services, health plans are required to “conduct interrater reliability (IRR) testing to ensure consistency in utilization review decision-making.”⁴⁵ IRR involves administering a test to all persons who conduct utilization review that evaluates application of nonprofit criteria to ensure all staff make consistent level of care coverage decisions given the same set of facts. A pass rate of 90% is required, or immediate remediation must be conducted prior to permitting staff to conduct utilization review without supervision.⁴⁶ The obligation to conduct IRR testing extends to any entity or contracting provider that performs utilization review functions on behalf of a plan.⁴⁷ IRR testing is required to cover all aspects of utilization review,⁴⁸ defined as:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether

⁴³ Section 1374.721(b).

⁴⁴ Section 1374.721(e)(1).

⁴⁵ Section 1374.721(e)(5).

⁴⁶ Section 1374.721(e)(7).

⁴⁷ Section 1374.721(h).

⁴⁸ Section 1374.721(e)(5).

San Francisco Health Plan
Behavioral Health Investigation Report

a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.⁴⁹

The Department requested the Plan submit copies of its and/or BHS's IRR testing policy and procedure and a report demonstrating all required persons completed and passed IRR testing.⁵⁰ The Plan submitted a BHS policy, *BHS Services for Healthy Workers*. This policy states utilization management staff are subject to annual IRR testing, involving consideration of at least 10 questions designed to assess knowledge and ability to make medical necessity determinations. The policy states a "score of 9 or more correct answers is a passing score" and a score of "8 or less is cause for either individual or group level review, education or quality improvement remediation. No retest is required." The policy goes on to say, "UM reviewers must achieve an interrater reliability pass rate of 90 percent and, if this threshold is not met, the department will immediately provide for the remediation of poor interrater reliability through its education and quality improvement process."

Subsequently, the Plan submitted 2024 IRR results for Plan staff who completed IRR testing for medical-surgical case studies, and 2024 IRR results for BHS staff. Neither the Plan nor BHS submitted documents demonstrating BHS staff who conduct utilization review for the Plan's Healthy Worker enrollees took and passed IRR training during the BHI review period, as required by BHS' policy and Section 1374.721(e)(5).

The Department also requested a copy of the 10 questions and scenarios used for IRR. A BHS document, Acute Care Inter-Rater Reliability Questions, was submitted, which included the 10 IRR test questions. The test questions did not cover all aspects of utilization review, as required. Among other things, the questions did not address:

- evaluation of medical necessity
- requests by health care providers, enrollees, or their authorized representatives for coverage of health care
- evaluating appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings
- evaluating prior, concurrent and retrospective requests

Conclusion: Section 1374.721(e)(5) requires IRR testing of all staff who conduct utilization review to ensure consistency in utilization review decision making. BHS's policy requires staff who conduct utilization review to complete IRR testing periodically with an IRR pass rate of 90 percent. However, neither the Plan nor BHS was able to demonstrate BHS staff who perform utilization review on behavioral health service requests for the Plan's Healthy Worker enrollees took and passed IRR testing with a score of at least 90%. Additionally, Section 1374.721(e)(5) requires IRR testing to address all aspects of utilization review as defined in Section 1374.721(f)(3)(A). The IRR test questions submitted by the Plan and BHS did not address all aspects of utilization

⁴⁹ Section 1374.721(f)(3)(A), (B).

⁵⁰ Crosswalk request BHIUM19.

review. Therefore, the Department finds the Plan in violation of these statutory requirements.

#6: The Plan does not have a process to continuously review utilization of behavioral health services and facilities.

Statutory/Regulatory Reference(s): Rules 1300.70(a)(3), 1300.70(c)

Supporting Documentation:

- Plan's *Pharmacy Drug Utilization Review (DUR) Program* policy (revised July 2021, July 2022, October 2022, January 2024)
- Plan *Healthy Workers HMO Retrospective DUR* (Drug Utilization Review) report (October 2022)
- Plan HEDIS reports: Antidepressant Adherence by Affinity Group; Antipsychotic Adherence by Affinity Group (October 2022)
- Magellan Rx IRR Monthly Summary reports (April 2022 to August 2022; October 2022; January 2023 to October 2023; December 2023 to March 2024)
- Plan Units of Service Dashboard (Fiscal Years 2018-2019, 2019-2020)
- Plan Narrative Response: *Memorandum Regarding Item #55-62* (undated)

Assessment: Health plans' quality assurance programs must monitor whether the provision and utilization of services meets professionally recognized standards of practice.⁵¹ Health plans must also implement procedures for continuously reviewing utilization of services and facilities.⁵²

The Department requested the Plan submit copies of policies and procedures pertaining to the identification, monitoring and handling of under- and over-utilization of behavioral health services, in addition to reports including data and analysis of behavioral health service utilization.⁵³ The Plan submitted several documents in response. The Plan's *Pharmacy Drug Utilization Review (DUR) Program* policy included a description of targeted retrospective over- and under-utilization reports, but none of the reports were targeted to behavioral health prescription drugs. Additionally, Magellan Rx, not the Plan, was the prescription drug benefit manager for Healthy Worker enrollees. A Plan report, also pertaining to prescription drug services, titled *Healthy Workers HMO Retrospective DUR* (Drug Utilization Review), had been provided to the Plan's Pharmacy and Therapeutics Committee. This one-page report stated:

Magellan Rx runs a retrospective DUR program that reviews Healthy Workers HMO members for concerning medication prescribing. When these patterns are identified, prescribers are notified through a letter."

The report listed three areas of review and the number of enrollees identified for each area:

⁵¹ Rule 1300.71(a)(3).

⁵² Rule 1300.70(c).

⁵³ Crosswalk Request BHIUM13.

San Francisco Health Plan
Behavioral Health Investigation Report

- (i) Enrollees with chronic opioid use and use of benzodiazepines or muscle relaxants (one enrollee),
- (ii) Enrollees who received three or more prescriptions for acute migraine treatment during a 180-day period (eight enrollees), and
- (iii) Enrollees with a high rate of prescribing for short-acting asthma medication (four enrollees).

The *Healthy Workers HMO Retrospective DUR* document did not demonstrate a continuous review of under or over-utilization of prescription drugs or facilities used to treat behavioral health conditions. Neither the Plan, Magellan Rx nor BHS submitted a policy describing how utilization or monitoring of behavioral health services, including prescription drugs, is conducted, how results of utilization monitoring are reported by BHS or Magellan to the Plan, or Plan oversight of delegate assessment of over- and under-utilization.

Other documents submitted by the Plan included two Plan HEDIS⁵⁴ reports and monthly summaries of Magellan Rx's IRR testing and results. The Plan also submitted two examples of a document referred to as "Units of Service Dashboard." The Units of Service Dashboard stated the dashboard is "used by program managers to monitor over and under-utilization of services." However, the two example outpatient services dashboards provided did not identify any specific service type, including only graphs of numbers representing "units of service," and the data included appeared to be for fiscal years 2018-2019 and 2019-2020, outside the Plan's BHI review period.

On December 12, 2024, the Department again requested the Plan submit policies and procedures for over- and under-utilization reporting, monitoring and actions for behavioral health inpatient and outpatient services.⁵⁵ The Plan's narrative response stated, "Not at this time, but our UM metrics subcommittee has met and discussed the types of reports and data . . . to prioritize."⁵⁶

None of the documents submitted demonstrated the Plan, Magellan Rx or BHS continuously reviewed utilization of behavioral health services, including prescription drugs, as required. None of the documents described mechanisms for how the Plan monitors utilization of behavioral health services or responds to patterns of over- or under-utilization. During interviews, the chief medical director stated evaluation of over- and under-utilization was something the Plan was working on, but had not been done during the review period.

Conclusion: Rule 1300.70(a)(3) requires plans' quality assurance programs to "monitor whether the provision and utilization of services meet professional recognized standard of practice." Rule 1300.70(c) requires plans to "design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities." Utilization that fails to meet professionally

⁵⁴ Healthcare Effectiveness Data and Information Set (HEDIS) is a performance improvement tool of standardized measures used to assess and compare quality of care provided by health plans. The HEDIS reports submitted included: Antidepressant Adherence by Affinity Group and Antipsychotic Adherence by Affinity Group.

⁵⁵ DMHC Document Request 62.

⁵⁶ Memorandum Re: Item #55-62.

recognized standards of practice may result in either overutilization of services (e.g., over prescribing, ordering unnecessary procedures or treating when not medically necessary) or underutilization (e.g., failing to prescribe, denying procedures or not providing treatment when the covered service is medically necessary). Based on Plan and BHS documentation and interviews with Plan staff, the Department finds the Plan failed to demonstrate it has a process for continuously review utilization of services and facilities, and does not monitor whether the provision and utilization of behavioral health services, including prescription drugs, meets professionally recognized standards of practice because the Plan does not effectively track over and under-utilization of services. Therefore, the Department finds the Plan in violation of Rules 1300.70(a)(1) and 1300.70(c).

#7: The Plan does not ensure BHS timely notifies behavioral health provider applicants of the status of their credentialing application.

Statutory/Regulatory Reference(s): Section 1374.197(a)

Supporting Documentation:

- *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services* (Delegation Agreement) (Effective date: January 1, 2021)
- *BHS Credentialing Process* document (undated)
- Plan policy *Initial Credentialing, Recredentialing, Screening, and Enrollment of Practitioners* (revised October 17, 2024)
- Plan policy *Credentialing Verification Sources* (revised August 22, 2024)
- Plan policy *Ongoing Monitoring of Licenses and Other Key Documents* (revised August 22, 2024)
- Credentialing Application Report (April 4, 2022 to March 28, 2024)

Assessment: Beginning January 1, 2023, health plans that cover behavioral health services and credential behavioral health providers were required to “assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Upon receipt of the application by the credentialing department, the health care service plan shall notify the applicant within seven business days, to verify receipt and inform the applicant whether the application is complete.”⁵⁷

Pursuant to the Delegation Agreement, BHS is delegated for credentialing functions.⁵⁸ The Delegation Agreement requires the Plan to review BHS’ credentialing activities “to ensure service levels, quality, and compliance with regulatory requirements.” Among other things, the delegated credentialing requirements include a “Credential Verification” section which requires BHS to verify submitted credentialing information within the

⁵⁷ Section 1374.197(a). The requirements in this section apply to plan-provider contracts issued, amended or renewed on or after January 1, 2023.

⁵⁸ *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services*, page 5, Paragraph 2.

San Francisco Health Plan
Behavioral Health Investigation Report

prescribed time limits.⁵⁹ The Plan did not submit any credentialing oversight reports demonstrating it reviewed BHS' credentialing activities during the BHI review period.

The Department requested policies, procedures and reports regarding the credentialing process, in addition to a report of credentialing data for all applications for behavioral health providers received on and after January 1, 2023.⁶⁰ The Plan submitted a two-page, undated document titled *BHS Credentialing Process*. This document outlined the steps for initiating a credentialing application, gathering provider documents and information, and stated "[v]erification is done on a monthly basis." However, this document did not include timeframes for these actions, did not address circumstances for handling an incomplete application, and did not require BHS to inform the applicant within seven business days of whether the application was complete.

The Plan submitted three additional Plan policies and procedures describing the Plan's credentialing activities for medical and allied health practitioner types, listing and organizations and sources for verifying documents submitted by providers and procedures for monitoring provider licensure between recredentialing cycles.⁶¹ However, none of these policies included requirements for notifying an applicant of whether their application is complete within seven business days of receipt.

The Plan submitted a Credentialing Application Report listing 601 entries reflecting credentialing applications received by the BHS Credentialing Team between January 1, 2023 and March 28, 2024.⁶² The report included provider names, licensure type, license numbers, the date each provider's application was received by the Credentialing Team and dates each application review was completed by the Credentialing Team. Notably, for each entry, the date listed for completion of an application was the same date listed as the date of receipt of the application. The report did not include dates on which applicants were notified of whether their application was complete or dates verification was completed.

During interviews, the Plan's Director, Compliance and Oversight stated the Plan receives quarterly credentialing reports of added names. BHS' Compliance Officer confirmed BHS does not send applicants a notification within seven business days of receipt.

Conclusion: Section 1374.197(a) requires plans, within seven business days of receipt by its credentialing department of a credentialing application, to notify the applicant of receipt and inform the applicant whether the application is complete. BHS is delegated

⁵⁹ *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services*, Exhibit G-1, pages 12-14.

⁶⁰ Crosswalk request BHIUM22 and BHIUM23; Document Request #34, sent to the Plan November 14, 2024.

⁶¹ Plan's *Initial Credentialing, Recredentialing, Screening, and Enrollment of Practitioners* policy, *Credentialing Verification Sources* policy, and *Ongoing Monitoring of Licenses and Other Key Documents* policy, respectively.

⁶² Crosswalk Request BHIUM23 submission. The entire report listed a total of 893 entries, including entries for applications received since April 4, 2022. However, the relevant statutory requirements became effective January 1, 2023, so the Department only reviewed data for applications received on or after January 1, 2023.

for credentialing functions for behavioral health services provided to the Plan's Healthy Worker enrollees. Neither BHS nor Plan documents include the seven business-day notification requirement and BHS was unable to demonstrate it provides applicants with the required notice. Therefore, the Department finds the Plan in violation of this statutory requirement.

QUALITY ASSURANCE

#8: The Plan does not conduct adequate oversight of BHS to ensure compliance with required utilization management program standards.

Statutory/Regulatory Reference(s): Section 1367.01(a) and (j)

Supporting Documentation:

- *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services (Delegation Agreement) (Effective date: January 1, 2021)*
- *Plan Narrative Response: Memorandum Regarding Item #BHIQA5 (undated)*

Assessment: Plans and their delegates that conduct utilization review to determine medical necessity are required to comply with certain utilization management requirements.⁶³ One of these requirements is the Plan must include as part of its quality assurance program, a process by which compliance with utilization management procedures and obligations is assessed and evaluated.⁶⁴ The process must include provisions to evaluate complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms of communication and provisions to evaluate corrective action plans.⁶⁵

Per the Delegation Agreement,⁶⁶ BHS is responsible for utilization management, among other things. With respect to the Plan's oversight of delegated functions, the Delegation Agreement states the Plan "shall monitor and oversee Delegate's performance of delegated functions by conducting continuous monitoring and an annual oversight audit based on health plan's delegation oversight procedures..."⁶⁷ Therefore, in accordance with both the Delegation Agreement and Section 1367.01(j), the Plan was obligated to annually assess and evaluate BHS' compliance with utilization management requirements.

In response to the Department's request for delegation oversight and assessment reports for the BHI review period, the Plan submitted a narrative response stating:

Community Behavioral Health Services is not delegated for Quality or Grievance and Appeals. There has not been enough volume of UM to

⁶³ Section 1367.01(a).

⁶⁴ Section 1367.01(j).

⁶⁵ Section 1367.01(j).

⁶⁶ *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services.*

⁶⁷ *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services*, page 5, paragraph 3.

San Francisco Health Plan
Behavioral Health Investigation Report

conduct an audit during the audit period. There was one authorization during the scope period.⁶⁸

The Plan provided no documents demonstrating it assessed and evaluated BHS's compliance with utilization management requirements, as required. The Plan did not submit any evidence to show it evaluated complaints regarding utilization management or assessed for any trends. Evaluating compliance with utilization management functions requires more than file review since there are utilization management requirements pertaining to policy and procedure requirements, denial decision-maker requirements, enrollee notification content requirements and telephone access requirements, among others.⁶⁹

Conclusion: During the BHI review period, the Plan did not review or evaluate BHS' compliance with utilization management requirements. Therefore, the Department finds the Plan in violation of Section 1367.01(j).

#9: The Plan does not conduct adequate oversight to ensure BHS identified and referred all grievances to the Plan.

Statutory/Regulatory Reference(s): Section 1370; Rules 1300.70(a)(3), 1300.70(b)(1)(B).

Supporting Documentation:

- *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services* (Delegation Agreement) (Effective date: January 1, 2021)
- *Amendment Number Four to the Mental Health/Substance Abuse Services Agreement Between San Francisco Health Plan and City and County of San Francisco, Behavioral Health System* (Effective date: January 1, 2014).
- BHS Grievance Log
- 25 BHS Inquiry Files (April 1, 2022 to March 31, 2024)

Assessment: Plans are required to have reasonable procedures in accordance with Department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities and costs.⁷⁰ Plan quality assurance programs must address service elements, including accessibility, availability and continuity of care, and must ensure quality of care problems are identified and corrected for all provider entities.⁷¹

Pursuant to the Delegation Agreement, the Plan delegated the following functions to BHS: (i) utilization management, (ii) credentialing, (iii) cultural and linguistic services, and (iv) claims and provider dispute resolutions.⁷² The Plan retained responsibility for functions related to handling, resolving and responding to grievances submitted by

⁶⁸ Plan response to Crosswalk Request BHIQA5.

⁶⁹ See, for example, Section 1367.01(b), (e), (h), (i).

⁷⁰ Section 1370.

⁷¹ Rule 1300.70(a)(3), (b)(1)(B).

⁷² Delegation Agreement, Exhibit G, paragraph 2.

San Francisco Health Plan Behavioral Health Investigation Report

enrollees or their authorized representatives. The Plan and BHS agreed “[a]ll patient grievances must be reported to Health Plan.”⁷³ As part of the Plan’s oversight of BHS, the Plan was required to review grievance reports submitted by BHS.”⁷⁴ However, nothing in the Delegation Agreement or other Plan-BHS agreements addressed content, submission frequency, verification or auditing of grievance reports. The Department’s review of Plan and BHS documents demonstrated the Plan failed to conduct adequate oversight of BHS operations to ensure BHS identified and referred all grievances to the Plan.

Enrollees may call their health plan or the delegate, as appropriate, expressing concerns about care, problems with providers or difficulty obtaining timely appointments, among other things. As part of ensuring quality of care and access to care, health plans must identify and review enrollee grievances.⁷⁵ Grievances are defined as:

A written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee’s representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.⁷⁶

The Plan submitted to the Department a log of grievances reported by BHS to the Plan during the two-year BHI review period of April 1, 2022 through March 31, 2024. This log showed that BHS reported a single grievance to the Plan during the two-year BHI review period.

The Department reviewed 25 BHS Inquiry Files involving 14 individual enrollees.⁷⁷ Of the 14 enrollees, case files for seven of the enrollees included complaints, expressions of dissatisfaction, disputes and other grievances submitted to BHS.⁷⁸ None of the issues involving the seven enrollees were identified by BHS as grievances or reported to the Plan.

⁷³ *Amendment Number Four to the Mental Health/Substance Abuse Services Agreement Between San Francisco Health Plan and City and County of San Francisco, Behavioral Health System*, p. 5, paragraph 2.16.5.

⁷⁴ Delegation Agreement, Exhibit G, paragraph 3(2)(i)(b).

⁷⁵ See, e.g., Rule 1300.51(d), Exhibit I, item 5.e (requiring health plans to submit an Exhibit I-5 (both as an applicant and when submitting a notice of material modification or amendment) describing the plan’s system for monitoring and evaluating accessibility, including problems or dissatisfaction identified through grievances from enrollees or subscribers); Rule 1300.67.2.2(d)(2)(D) (stating health plan quality assurance systems must have compliance monitoring policies and procedures requiring plans to review and evaluate, at least quarterly, information available to the plan regarding accessibility, availability and continuity of care, including enrollee grievances and appeals)(revised effective January 1, 2023, to include requirements to review grievances pertaining to advanced access appointments, among other things); Rule 1300.68(e) (requiring plans to track and monitor grievances, identifying issues raised in grievances, including grievances involving access to care and quality of service.)

⁷⁶ Rule 1300.68(a)(1).

⁷⁷ The 25 files included more than one file for the same enrollee. Of the 25 case files, one enrollee was the subject of three case files, nine enrollees were the subject of two case files each (18 files total) and four enrollees were the subject of one case file each (four files total).

⁷⁸ BHS Inquiry File #1, File #2, File #3, File #7, File #11, File #12, File #13, File #16, File #22 and File #23.

Case File Examples

BHS Inquiry File #s 1 and 2: The enrollee called BHS, stating he submitted a grievance and was not happy that he was unable to use his Plan coverage for PPN services. BHS told the enrollee his Plan coverage could not be used after a specific date because he had other, private insurance coverage. The issue was closed as an inquiry without forwarding to the Plan for grievance consideration.

BHS Inquiry File #s 11 and 12: Both the enrollee and the enrollee's treating provider contacted BHS to set up transition of care as the enrollee's provider would be retiring. BHS conducted an initial risk assessment with the enrollee and referred the enrollee to PPN. More than two months later a provider contacted BHS on behalf of the enrollee, stating the enrollee still wanted a PPN provider but had not heard back about the referral.

BHS staff reached out to the person responsible for matching PPN providers with enrollees (matching specialist) then contacted the enrollee with an update. BHS therefore attempted to resolve the appointment delay complaint, and the issue was closed as an inquiry without forwarding to the Plan for grievance or quality of care consideration.

BHS Inquiry File #16: The enrollee called BHS to request mental health therapy services. BHS conducted an initial risk assessment and referred the enrollee to PPN. During the risk assessment, the enrollee stated she called BHS approximately 11 months earlier and at that time a PPN referral was made, but the enrollee never heard back about that referral. Two months following the present call, the enrollee called BHS again about the current PPN referral because she had not heard back.

BHS staff checked into the status of the referral and encouraged the enrollee to go to the nearest county clinic in the meantime. BHS therefore attempted to resolve the appointment delay complaint, and the issue was closed as an inquiry without forwarding to the Plan for grievance or quality of care consideration.

BHI Inquiry File #s 22 and 23: The enrollee contacted BHS requesting a change in therapists because he was seeking in-person therapy. BHS conducted an initial risk assessment and determined the enrollee scored in the "non-serious mental health" category (NSMH). Based on this score, BHS determined the enrollee did not qualify for referral to PPN or a county clinic and instead, instructed the enrollee to contact his primary care physician for care. A month later, the enrollee telephoned BHS requesting to continue seeing his former therapist. Again, BHS conducted an initial risk assessment and again, the enrollee scored as NSMH. The case file documented "Client upset and frustrated he cannot return" to his former therapist. When BHS told the enrollee he needed to seek care through a specific county clinic, the enrollee responded that the particular clinic "is unable to help" him. The BHS staff member reiterated to the enrollee that the specific clinic is where the enrollee needed to receive services. The case notes documented the enrollee "was unhappy with this conversation." BHS staff told the enrollee they would reach out to a social worker at the clinic regarding the enrollee's situation.

San Francisco Health Plan
Behavioral Health Investigation Report

BHS attempted to resolve the enrollee's expression of dissatisfaction by telling the enrollee they would reach out to the clinic, and the issue was closed as an inquiry without forwarding to the Plan for grievance or quality of care consideration.

These case files demonstrate enrollees (or providers on enrollees' behalf) contacted BHS with expressions of dissatisfaction or other grievances and BHS did not identify or report the grievances or potential quality issues to the Plan. BHS reported only one grievance to the Plan during the two-year BHI review period, which did not involve any of the enrollees in the 25 reviewed case files. The Plan lacks a process to oversee or audit BHS to ensure all grievances are identified and reported to the Plan as required by the Plan-BHS agreement. The Plan also has no process in place to ensure BHS is not attempting to resolve grievances, for which BHS is not delegated. By lacking oversight processes, the Plan fails to ensure it identifies and handles all grievances that may include quality of care, access and availability, and service issues.

Conclusion: Plans are required to have procedures for continuously reviewing quality of care, including service elements, accessibility, availability and continuity of care. The Plan did not have an oversight process in place during the BHI review period to ensure BHS identifies and refers all grievances to the Plan, or to ensure BHS is not performing non-delegated functions. The Plan therefore lacked procedures for continuously reviewing services provided by BHS to enrollees that could impact accessibility, availability and continuity of care. Accordingly, the Department finds the Plan in violation of Section 1370 and Rules 1300.70(a)(3) and 1300.70 (b)(1)(B).

#10: Plan customer service representatives are not consistently knowledgeable and competent in providing customer service.

Statutory/Regulatory Reference(s): Section 1367.03(a)(10) and Rule 1300.67.2.2(c)(10)

Supporting Documentation:

- Plan document, *MAGIC Scoring Explained*
- Plan policy, *Training Program for Customer Service Representatives*
- *SFHP New Hire Training Manual: Customer Service Department*
- 29 Plan Inquiry Files (April 1, 2022 to March 31, 2024)

Assessment: Health plans must ensure “during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed 10 minutes.”⁷⁹ This statutory and regulatory requirement has two components, a timeframe component and a knowledge and competency component. First, the wait time component limits the wait time to speak with a customer service representative to 10 minutes. Second, the customer service representative who speaks with the enrollee must be knowledgeable and competent about the enrollee's questions and concerns. Both components must be met for a Plan to comply with the statute.

⁷⁹ Section 1367.03(a)(10) and Rule 1300.67.2.2(c)(10).

San Francisco Health Plan Behavioral Health Investigation Report

Assessment of Plan documents and enrollee calls to the Plan demonstrated Plan customer service representatives lacked knowledge and competence concerning Healthy Worker behavioral health benefits, at times providing enrollees with incorrect information that had the potential to delay care.

Plan Documents

The Department requested copies of Plan policies and procedures, training materials, job aids, scripts and other documents pertaining to use by, or training of, customer service staff, as well as audits of customer service staff.⁸⁰ In response, the Plan provided several documents. Among the documents submitted by the Plan was a document titled *MAGIC Scoring Explained*,⁸¹ a scoresheet used for evaluating customer service staff, *Training Program for Customer Service Representatives* policy,⁸² which described required training modules and timeframes for trainings, and the *SFHP New Hire Training Manual: Customer Service Department*, an extensive document which included 17 modules and in-depth information on several topics, including, for example, use of the Plan's call system software, information about the Plan and its lines of business, translation services the Plan offers, determining enrollee eligibility and other operations. With respect to behavioral health services for Healthy Worker enrollees, the manual states BHS manages all behavioral health services for Healthy Workers.⁸³ Module 7 addressed the Healthy Worker line of business, describing eligibility, which entity provides coverage for medical, behavioral health and vision services, and disenrollment.⁸⁴

Although the Plan submitted documents demonstrating the Plan has customer service training and evaluation programs, nothing in the documents submitted demonstrated customer service staff receive general training to understand behavioral health questions, or that customer service staff are evaluated to ensure they understand who provides behavioral health services for Healthy Worker enrollees. Review of enrollee calls to the Plan demonstrated customer service staff were not consistently knowledgeable and competent regarding these issues.

Case Files

⁸⁰ Crosswalk requests BHICS1, BHICS4, BHICS5, BHICS7, BHICS8, BHICS9, BHICS10, BHICS 19.

⁸¹ This template scoresheet included a list of 36 requirements customer service staff are scored on, for which one point is awarded for successfully completing each requirement, including, for example, whether the customer service person speaks clearly, proactively offers options or solutions to the caller's question, is knowledgeable on the topic and provides accurate information to the caller, speaks professionally, and files a grievance when the caller expresses dissatisfaction with their medical care. The document, however, does not describe how each requirement is evaluated or the basis for determining the requirement was successfully performed. The Plan did not submit completed scorings for customer service representatives.

⁸² This policy listed the types of training modules and materials staff are required to take and the procedure and timing for completing trainings.

⁸³ *SFHP New Hire Training Manual: Customer Service Department*, page 93.

⁸⁴ *SFHP New Hire Training Manual: Customer Service Department*, pages 77-82.

San Francisco Health Plan
Behavioral Health Investigation Report

The Department reviewed 29 Plan Inquiry Files and found in nine instances⁸⁵ (31%), customer service representatives were not knowledgeable and did not provide effective assistance to enrollees.

Case Examples:

- **LFC SHP #4:** The enrollee called the Plan and asked whether they needed a referral from their primary care doctor for behavioral health services. The customer service representative told the enrollee behavioral health services for Healthy Worker enrollees were provided through the County Behavioral Health Department. When the enrollee asked whether services were provided by BHS, the customer service representative replied, “No” and further stated, “Sorry, my knowledge is very limited.” In this case, the customer service representative provided incorrect information to the enrollee since BHS was responsible for providing behavioral health services to Healthy Worker enrollees.
- **LFC SHP #6:** The enrollee called the Plan and inquired about how to obtain behavioral health services. The customer service representative told the enrollee she could ask her primary care physician to refer her to someone in the network, or she could contact Beacon Health Options,⁸⁶ stating, “Beacon is the one that is in charge of everything that is mental health and they can help you find someone.” The customer service representative provided Beacon’s telephone phone number to enrollee. However, BHS, not Beacon/Carelon was delegated for Healthy Worker behavioral health services, and the customer service representative therefore referred the enrollee to the wrong entity.
- **LFC SHP #24 and #28:** The enrollee called the Plan asking whether her mental health provider was in-network and stated she needed assistance with coverage documentation. The customer service representative told the enrollee, “Anything that has to do with mental health is handled through Carelon, our mental health vendor.” The customer service representative provided the enrollee with Carelon’s telephone number. A week later the enrollee called the Plan again, explaining she was trying to confirm whether her therapist was covered by the Plan, and if not, she would need a letter stating the Plan would not cover the services. The customer service representative asked several irrelevant and unwarranted questions demonstrating she did not understand the enrollee’s request. After nearly five full minutes on the call, the customer service representative told the enrollee they would need to call BHS to verify mental health benefits. These two calls from the same enrollee, received by different customer service representatives, demonstrate customer service representatives lacked sufficient knowledge to efficiently and effectively assist the enrollee.

Plans must ensure the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's

⁸⁵ LFC_SFHP Inquiry File #4, File #6, File #7, File #10, File #15, File #17, File #18, File #24, File #28.

⁸⁶ During the BHI review period, Beacon Health Options, which changed its name to Carelon Behavioral Health as of March 1, 2023, provided behavioral health services to the Plan’s Medi-Cal population, but not its Healthy Worker population.

San Francisco Health Plan
Behavioral Health Investigation Report

questions and concerns shall not exceed 10 minutes. Although the wait time for Healthy Worker enrollees to speak with a Plan customer service representative may have been within timeliness standards, file review demonstrates Plan customer service representatives were not consistently knowledgeable and competent about enrollee questions and concerns.

Conclusion: Based on review of Plan documents and Inquiry Case Files, the Department determined the Plan's customer service representatives were not consistently knowledgeable and competent regarding enrollee questions and needs pertaining to behavioral health services. Therefore, the Department finds the Plan in violation of Section 1367.03(a)(10) and Rule 1300.67.2.2(c)(10).

#11: Neither the Plan nor BHS have a maternal mental health program, as required.

Statutory/Regulatory Reference(s): Section 1367.625(a)

Supporting Documentation:

- Plan Narrative Response: *Memorandum Regarding Item #BHIPRP6* (undated)
- Plan *CARE-10* policy (revised January 2024)

Assessment: By July 1, 2019, plans were required to develop a maternal mental health program designed to promote quality and cost-effective outcomes. Maternal mental health programs must "include quality measures to encourage screening, diagnosis, treatment and referral." The term "maternal mental health" is defined as "a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression."⁸⁷

The Department requested the Plan provide several documents pertaining to the Plan and/or BHS maternal mental health program, including:

- Policies and procedures that include a description of the Plan or BHS's maternal mental health program,
- Copies of quality measures used to encourage maternal mental health screening, diagnosis, treatment and referral,
- Documents demonstrating efforts of the Plan and/or BHS to improve screening, treatment and referral to maternal mental health services,
- Reports documenting implementation of the maternal mental health program, and

⁸⁷ Section 1367.625(a), (b)(2). Since the enactment of Section 1367.625 in 2019, the law was revised in 2022 and again in 2024. All versions required plans to develop maternal mental health programs designed to promote quality and cost-effective outcomes, and all versions included the same definition of maternal mental health (a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression). The 2022 revision (Senate Bill 1207, effective January 1, 2023) required plans, by July 1, 2023, to include in the maternal mental health program, quality measures to encourage improved screening, diagnosis, treatment, and referral to mental health services, as well as coverage for doulas, among other things. All legal requirements discussed in this violation were in effect during the Plan's BHI review period of April 1, 2022 through March 31, 2024. The 2024 revision (Assembly Bill 1936, effective January 1, 2025) which was beyond the Plan's review period, added requirements not addressed in this violation.

San Francisco Health Plan
Behavioral Health Investigation Report

- A data report to include the number of enrollees referred to the maternal mental health program, along with other related data.⁸⁸

In response, the Plan submitted a Narrative Response stating there were “no quality measures to encourage maternal mental health screening, diagnosis, treatment and referral during the audit period.” The response continued, “[t]here are no documents demonstrating efforts to improve screening, treatment, and referral to maternal mental health services during the audit period.”⁸⁹ The Plan’s *CARE-10* policy states Healthy Worker enrollees “may access all behavioral health services by calling the CBHS Access hotline or walk into centers that are part of the CBHS network”⁹⁰ but did not specifically address maternal mental health services.

In response to the request for a data report to include data pertaining to maternal mental health, the Narrative Response indicated there had been 14 enrollees diagnosed with a maternal mental health condition and two enrollees receiving maternal mental health services, but provided no additional data.⁹¹

During interviews, the BHS Medical Director advised there is screening for all patients in primary care for depression, interpersonal violence, and substance abuse and if needed, a referral for a “warm hand off” can be made for a psychosocial assessment. Treatment may take place either by the primary care provider or there may be a referral to a specialty behavioral health provider. However, neither the BHS Medical Director nor Chief Medical Officer indicated BHS had a specific maternal mental health program, as required by law.

Conclusion: Section 1367.625(a) requires plans to develop a maternal mental health program designed to promote quality and cost-effective outcomes. The Plan did not provide any documents or narrative evidence demonstrating the Plan or BHS complies with this requirement. Therefore, the Department finds the Plan in violation of this statutory requirement.

#12: The Plan was operating at variance with its filed quality assurance policy and procedure.

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Supporting Documentation:

- Plan *Monitoring Member Experience* QI-16 policy (revised February 24, 2022)

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan’s licensure or with filed amendments or material modification filings.⁹²

⁸⁸ Crosswalk Requests BHIPRP1 and BHIPRP6.

⁸⁹ Undated Narrative Response, BHIPRP6_08072024.

⁹⁰ *CARE-10* policy, page 5.

⁹¹ Undated Narrative Response, BHIPRP6_08072024.

⁹² Section 1386(b)(1).

Included among the types of documents required to be filed are quality assurance policies and procedures.

As required by Section 1352(a), the Plan filed an amendment with the Department in March 2022 (efiling #2022070) that included the Plan's *Monitoring Member Experience* QI-16 policy. The policy requires the Plan to annually conduct member experience surveys, including a Healthy Workers Satisfaction Survey.⁹³ As explained in Violation #3, the Plan did not conduct the required annual enrollee survey for 2023.

Conclusion: By failing to conduct a member experience survey in 2023, the Plan was operating at variance with its filed *Monitoring Member Experience* policy, in violation of Section 1386(b)(1).

#13: The Plan was operating at variance with its filed utilization management policy and procedure.

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Supporting Documentation:

- Plan *BHS Services for Healthy Workers* policy (May 11, 2022)

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or with filed amendments or material modification filings. Included among the types of documents required to be filed are utilization management policies and procedures.

As required by Section 1352(a), the Plan filed an amendment with the Department on March 27, 2021 (efiling #20211154) that included the Plan's *BHS Services for Healthy Workers* policy. The policy states:

Pursuant to SB 855, UM staff are subject to annual interrater reliability testing (including both services and prescription drugs) to ensure appropriate application of the criteria described above, with a goal of achieving a pass rate of at least 90 percent. In addition to annual testing, new staff must complete interrater reliability testing based on LOCUS, CALOCUS, ASAM, and WPATH criteria/guidelines. For all of these criteria, new and existing staff must achieve a pass rate of 90%, and if new or existing staff score below that pass rate on any of the criteria, education is immediately provided before new or existing staff can make UM decisions without supervision.

As explained in Violation #5, the Plan was unable to demonstrate all BHS staff who conduct utilization management for behavioral health services requests for Healthy Worker enrollees took and passed IRR training as required by the BHS Services for Healthy Workers policy.

⁹³ Monitoring Member Experience QI-16 policy, page 2.
933-0349

Conclusion: By not ensuring all staff who conduct utilization management took and passed IRR training with a score of at least 90%, the Plan was operating at variance with its filed *BHS Services for Healthy Workers* policy, in violation of Section 1386(b)(1).

#14: The Plan was operating at variance with its SB 855 compliance filing.

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Supporting Documentation:

- *Amendment Number Eleven to the Mental Health/Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services* (Amendment Eleven) (effective January 1, 2021)
- *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services* (Delegation Agreement) (Effective date: January 1, 2021)
- Plan Narrative Response: *Memorandum Regarding Item #38 and 39* regarding formal nonprofit association training (undated)
- *Services Agreement* between the American Association for Community Psychiatry (AACP) and the Plan (June 9, 2022)
- *Independent Contractor Agreement* between the American Society of Addiction Medicine (ASAM) and the Plan (March 1, 2022)
- *Training Agreement* between the World Professional Association for Transgender Health (WPATH) and the Plan (March 1, 2022)

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or with filed amendments or material modification filings.⁹⁴ Included among the types of documents required to be filed are quality assurance policies and procedures.

The Delegation Agreement delegates to BHS utilization review for requested behavioral health services, among other things. As required by Section 1352(b), the Plan filed a Notice of Material Modification with the Department in March 2021 (efiling #20211542) regarding compliance with SB 855. The filing included the Delegation Agreement, Amendment Eleven, and several other documents.

Among other things, SB 855 requires health plans to sponsor a formal education program by the nonprofit clinical specialty associations (NPA) to educate plan staff, including any third parties contracted with the health plan to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.⁹⁵ The Plan's SB 855 compliance filing included Amendment Eleven. With respect to the NPA training requirement, Amendment Eleven states, in relevant part:

To ensure the proper use of the Criteria and Guidelines, [BHS] shall do the following:

⁹⁴ Section 1386(b)(1).

⁹⁵ Section 1374.721(e)(1).

San Francisco Health Plan
Behavioral Health Investigation Report

- i. Sponsor a formal education program regarding the criteria set(s) by nonprofit clinical specialty associations to educate [BHS'] staff, including any third parties contracted with [BHS], to review claims, conduct Utilization Reviews, or make Medical Necessity determinations about the clinical review criteria. An alternative training program provided by [BHS] may be implemented, if approved by DMHC.
- ii. Make the education program available on [BHS'] website to other stakeholders, including [BHS'] participating providers and Members Participating providers shall not be required to participate in the education program.⁹⁶

Contrary to the requirements in Amendment Eleven, during the Plan's BHI interviews, the Plan represented to the Department that the Plan was responsible for contracting with the NPAs and providing BHS staff with access to the required training.⁹⁷ The Plan's representation was substantiated by the training contracts with the NPAs, which included the Plan, not BHS, as a party to the training contracts.⁹⁸ The executed training contracts with the NPAs were also filed as part of the Plan's SB 855 compliance filing. Additionally, as explained in Violation #4, the Department found no evidence that all BHS utilization review staff completed training on both ASAM and LOCUS/ CALOCUS or that any BHS staff were trained on WPATH during the BHI review period.

Conclusion: The Plan's filed Amendment Eleven stated BHS was responsible for sponsoring the formal education program to educate BHS staff on NPA criteria and guidelines and making the education program available on its website to BHS contracted providers and enrollees. However, the Plan entered the training agreements with the NPA, and did not ensure all applicable BHS utilization review staff were trained on all the NPAs. Therefore, the Department finds the Plan operating at variance with Amendment Eleven, in violation of Section 1386(b)(1).

#15: The Plan was operating at variance with its filed Delegation Agreement.

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Supporting Documentation:

- *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services (Delegation Agreement) (Effective date: January 1, 2021)*

⁹⁶ Amendment Eleven, Paragraph 4(b)(v)(i).

⁹⁷ See DMHC Document Requests #38 and #39, sent to the Plan on November 8, 2024, responded to by the Plan on December 12, 2024, and January 3, 2025.

⁹⁸ See (i) the Services Agreement, dated June 9, 2022 between the American Association for Community Psychiatry (AACP) and the Plan for providing training services to the Plan and its delegate staff on LOCUS and CALOCUS; (ii) the Independent Contractor Agreement, dated March 1, 2022, between the American Society of Addiction Medicine (ASAM) and the Plan for providing training services to the Plan and its delegate staff on ASAM criteria; and (iii) the Training Agreement, dated March 1, 2022, between the World Professional Association for Transgender Health (WPATH) and the Plan for providing training to the Plan and its delegate staff on WPATH Standards of Care.

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or with filed amendments or material modification filings.⁹⁹ Included among the types of documents required to be filed are delegation agreements.

As required by Section 1352(a), the Plan filed an amendment with the Department March 27, 2022 (efiling #20211544) that included the Delegation Agreement. The Delegation Agreement requires the Plan to annually review BHS' UM program, evaluate BHS' performance against UM requirements, and identify and follow up on opportunities for improvement.¹⁰⁰ As explained in Violation #8, the Plan did not conduct the required annual utilization management delegation audit during the BHI review period.

Conclusion: By not conducting an annual audit of UM functions delegated to BHS as required by Sections 1367.01(a) and (j) and the Delegation Agreement, the Plan was operating at variance with its filed Delegation Agreement, in violation of Section 1386(b)(1).

#16: The Plan was operating at variance with its filed access policy and procedure.

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Supporting Documentation:

- Plan *Monitoring Accessibility of Provider Services* QI-05 policy (Approved February 23, 2024)

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or with filed amendments or material modification filings. Included among the types of documents required to be filed are quality assurance and accessibility policies and procedures.

As required by Section 1352(a), the Plan filed an amendment with the Department in January 2023 (efiling #20230584) that included the Plan's *Monitoring Accessibility of Provider Services* policy. The policy requires the Plan to assess PAAS data, among other things, at least quarterly and investigate and take corrective action as necessary to correct deficiencies in the Plan's processes. As explained in Violation #1, when the Plan's PAAS response rate fell below the Plan's standard of 50%, the Plan did not provide evidence it investigated or took corrective action.

Conclusion: By failing to demonstrate it reviewed, investigated and took corrective action, if necessary, when the Plan's compliance with PAAS standards were not met, the Plan was operating at variance with its filed *Monitoring Accessibility of Provider Services* policy, in violation of Section 1386(b)(1).

⁹⁹ Section 1386(b)(1).

¹⁰⁰ *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services*, pages 9-10.

CLAIMS SUBMISSION AND PAYMENT

#17: The Plan permitted BHS to engage in unjust payment patterns.

Statutory/Regulatory Reference(s): Rules 1300.71(a)(8), 1300.71(b)(1), 1300.71(e)(1), 1300.71(e)(8)

Supporting Documentation:

- *Mental Health/Substance Abuse Services Agreement for Healthy Families Benefit Program and IHSS Benefit Program (Entered into July 1, 1998)*
- *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services (Delegation Agreement) (Effective date: January 1, 2021)*
- *BHS CMS 1500 02/12 Guide for PPN: Avatar MSO System Instructions (Guide for PPN) 2018-2019 SFMHP Claims Unit*
- *Plan Memorandum regarding CBHS 2021 Preliminary Audit Report (May 5, 2022)*
- *Plan Narrative Response: Memorandum Regarding Item #52 and 53 (undated)*

Assessment: Health Plans (and their delegates that pay claims on behalf of the plan) must allow contracted providers at least 90 days from the date of service to submit claims.¹⁰¹ The imposition of a claims filing deadline inconsistent with the 90-day requirement for contracted providers in three or more claims over the course of any three-month period shall be considered a “demonstrable and unjust payment pattern.”¹⁰² This legal prohibition does not require showing provider claims were submitted and denied, only that the health plan (or its delegate) imposed an impermissible deadline involving at least three claims over three months.

Health plan contracts with capitated providers must require the capitated provider to accept and adjudicate claims in accordance with the requirements of Rule 1300.71, including the 90-day claims filing deadline, among other provisions.¹⁰³ A plan’s contract with a capitated provider does not relieve the plan of its obligations to comply with Rule 1300.71.¹⁰⁴

The Plan and BHS entered into an agreement whereby the Plan makes monthly capitation payments to BHS for behavioral health services rendered to IHSS enrollees.¹⁰⁵ BHS is delegated responsibility to pay claims for the behavioral health services it provides to the Plan’s Healthy Worker enrollees, and to send a monthly claims

¹⁰¹ Rule 1300.71(b)(1), which states, “Neither the plan nor the plan’s capitated provider that pays claims shall impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service, except as required by any state or federal law or regulation.”

¹⁰² Rule 1300.71(a)(8) (or 180 days for non-contracted providers).

¹⁰³ Rule 1300.71(e)(1).

¹⁰⁴ Rule 1300.71(e)(8).

¹⁰⁵ *Mental Health/Substance Abuse Services Agreement for Healthy Families Benefit Program and IHSS Benefit Program*, paragraph 1.02.

San Francisco Health Plan
Behavioral Health Investigation Report

activity report to the Plan.¹⁰⁶ The obligation of the Plan to ensure claims are timely paid is not waived although delegated to BHS.¹⁰⁷

Some of the behavioral health providers BHS contracts with are part of a private provider network (PPN). The PPN providers submit claims to BHS for behavioral health services and BHS pays those claims. The BHS Guide for PPN document provides PPN providers with a description of the billing and claims process for services provided to Healthy Worker enrollees as well as Medi-Cal enrollees. This document informed PPN providers as early as 2018 that: “All claims must be submitted within 60 days of service. Claims that are not submitted within 60 days from the date of service will be denied.”¹⁰⁸ The Plan submitted no documentation showing the Plan contract with BHS required BHS to adjudicate claims in accordance with the requirements of Rule 1300.71, including appropriate claims submission deadlines.

A Plan audit of BHS showed that as far back as 2021, the Plan was aware BHS imposed a claims submission deadline that was not in compliance with the 90-day requirement. The Plan submitted a summary of its 2021 Preliminary Audit Report findings for BHS. The 2021 audit covered the period January 1, 2020 through December 31, 2020.¹⁰⁹ The Preliminary Audit Report summary stated the standard for a passing score for audited areas was 95%.¹¹⁰ For the audited area of claims and provider dispute resolutions, BHS scored 8% based on the Plan’s review of 30 paid claims, 30 denied claims and 30 provider disputes.¹¹¹ One of the claims findings included:

Claims Manual states that claims must be submitted within 60 days of date of service. CCR section 1300.71(b)(1) states delegate may not impose a deadline for receipt of claims less than 90 days from date of service.¹¹²

The 2021 Preliminary Audit Report summary included recommendations requiring BHS, within 30 days of being notified of the findings, to provide (1) evidence that the audit findings were corrected and (2) a detailed corrective action plan.¹¹³ The Department inquired about the corrective action and follow-up to the audit. The Plan submitted a written response, stating in part, “The Plan and BHS came to an agreement during this time that BHS would be unable to comply with the requirements of the program and BHS requested to be de-delegated.”¹¹⁴ The Plan did not submit any Preliminary Audit Reports or other documents demonstrating the Plan audited BHS’ claims practices after 2021 or implemented corrective action. This is especially concerning since the Plan provided no evidence that BHS had been de-delegated the claims payment function but rather, the

¹⁰⁶ *Amendment Number Fourteen to The Mental Health/ Substance Abuse Services Agreement Between San Francisco Health Plan and Community Behavioral Health Services*, page 5 and Exhibit G-2.

¹⁰⁷ Section 1371(a)(1).

¹⁰⁸ *CMS 1500 02/12 Guide for PPN*, page 2.

¹⁰⁹ Memorandum Re: CBHS 2021 Preliminary Audit Report.

¹¹⁰ Memorandum Re: CBHS 2021 Preliminary Audit Report, page 1.

¹¹¹ Memorandum Re: CBHS 2021 Preliminary Audit Report, page 1.

¹¹² Memorandum Re: CBHS 2021 Preliminary Audit Report (see Finding #36 under “Claims and Provider Dispute Resolutions”).

¹¹³ Memorandum Re: CBHS 2021 Preliminary Audit Report (see Recommendations).

¹¹⁴ Memorandum Re: Item #52 and #53.

San Francisco Health Plan
Behavioral Health Investigation Report

evidence demonstrated that BHS remained responsible for claims payment throughout the BHI review period.

Therefore, although the Plan was aware by 2021 that BHS was imposing noncompliant claims filing deadlines as early as 2020, the Plan took no action to correct the problem, and BHS remained noncompliant with claims submission requirements as late as March 31, 2024, the end of the BHI review period – a total of at least four years. The Plan acknowledged the results of the 2021 Preliminary Audit report demonstrated the Guide for PPN and/or the Claims Manual imposed on contracted providers a requirement that providers submit claims within 60 days rather than 90. Because BHS imposed a claims filing deadline inconsistent with the 90-day requirement on contracted providers for at least four continuous years between 2020 and 2024, it is reasonable to conclude at least three or more claims over the course of a three-month period were subjected to the improper deadline, constituting a demonstrable and unjust payment pattern.

During interviews, BHS stated both in-network and out-of-network providers are now allowed six months from the date of service to submit a claim, in contrast to the Plan's assertion that the Plan and BHS came to an agreement that BHS would not be able to comply with the requirements. Regardless, the Plan was obligated to ensure claims were timely paid at all times, including during the BHI review period.

Conclusion: Plans may not impose a claims submission deadline of less than 90 days from the date of service for contracted providers. The Plan delegated behavioral health claims responsibilities to BHS. The Plan's contract with BHS did not include accurate claims submission deadlines. Rather, BHS imposed a 60-day claims submission deadline on contracted providers. As early as 2021, the Plan became aware the deadline was not compliant with Knox-Keene claim submission requirements during 2020, and as late as March 2024, permitting BHS to engage in a demonstrable and unjust payment pattern. The obligation to timely pay claims is not waived when delegated and the Plan was therefore responsible to ensure claims submission deadlines imposed on providers were compliant with requirements. By permitting BHS to impose improper claims submission requirements continuously between January 2020 and March 2024, the Department finds the Plan in violation of Rules 1300.71(a)(8), 1300.71(b)(1) and 1300.71(e)(1)

SECTION II: SUMMARY OF BARRIERS TO CARE NOT BASED ON KNOX-KEENE ACT VIOLATIONS

The following is an overview of the barriers to care the Department identified through its investigation of the Plan. Additional information on the barriers will be included in the Department's Phase Three Summary Behavioral Health Investigation Report.

For purposes of the BHIs, barriers to care mean those barriers, whether inherent to health plan operations or otherwise, that may create undue, unjustified, needless or unreasonable delays or impediments to an enrollee's ability to obtain timely, appropriate behavioral health care. As applied to providers, barriers refer to those barriers that result in undue, unjustified, needless or unreasonable delays or impediments to a provider's ability to provide timely, appropriate behavioral health services to an enrollee.

The barriers themselves may not arise to a violation of the Knox-Keene Act and/or Rules. The barriers may be caused by a combination of factors, such as a lack of certain provider types due to market conditions (i.e., supply of providers has not kept up with demand for services), health plan acts or omissions that do not arise to a violation of the Knox-Keene Act and/or Rules, circumstances that may not be covered by the Knox-Keene Act and/or Rules, or insufficient facts to support a finding of a violation of the Knox-Keene Act. Although barriers are not enforceable under the Knox-Keene Act, this report and the Summary Report for each phase of the BHIs will include recommendations to reduce barriers and improve access to behavioral health services.

#1: The Plan's high customer service staff turnover rate impedes efficient and effective customer service.

Summary: Plan documents indicated the Plan's customer service department experiences a very high turnover rate. Although BHS provides behavioral health services for the Plan's Healthy Worker enrollees, enrollees often first call the Plan to ask questions and obtain information about their behavioral health benefits or because they are not aware BHS is delegated for behavioral health services.

The Plan stated its customer service department was budgeted for 43 positions, including 27 customer service representatives.¹¹⁵ During the review period, the Plan reported an 84% turnover rate for its customer service department.¹¹⁶ The Plan stated, "customer service jobs are commonly high turnover positions due to the entry-level nature and stress."

With such a high turnover rate, the customer service department must continually onboard and train new staff. Because new staff lack institutional knowledge and Plan experience, they are less likely to provide efficient customer service and accurate information to enrollees. As discussed in Violation #10, the Department's review of

¹¹⁵ DMHC Office of Plan Monitoring 2024 Focused Behavioral Health Investigation of San Francisco Health, Questionnaire, page 9 (the remaining 16 positions are comprised of one Workforce Manager, one Trainer, three Supervisors, one Team Lead, four Specialists and six Customer Service Coordinators.

¹¹⁶ DMHC Office of Plan Monitoring 2024 Focused Behavioral Health Investigation of San Francisco Health, Questionnaire, page 9.

enrollee inquiry calls to the Plan found instances of inaccurate information provided by customer service representatives to enrollees. Because the provision of information about behavioral health services was not always accurate, enrollees may have experienced delays in obtaining care.

#2: The Plan does not have a mechanism to monitor enrollee telephone calls made to BHS.

Summary: Enrollees who call the Plan regarding behavioral health services are to be instructed to call BHS. Enrollees who call BHS may inquire about coverage, services, providers or other issues. Enrollees may also raise concerns about difficulty finding a behavioral health provider, inability to get a timely appointment, problems with providers or BHS, billing issues or other concerns requiring Plan or BHS follow-up. There is no monitoring by the Plan or reporting of calls identified by BHS as inquiry calls.

BHS does not make audio recordings of incoming enrollee telephone calls. The Department requested a log of inquiry calls to BHS. The log included minimal detail concerning the issue about which the enrollee was calling. The BHS inquiry log only identified the category of the call, such as “eligibility inquiry” or “request counseling” or “medication assessment.” However, of the 89 calls on the log, seven were categorized as “N/A” and nine were categorized as “Other.” Because BHS creates minimal documentation of enrollee telephone calls, the nature or content of “N/A” or “Other” calls cannot be ascertained.

The Plan does not monitor or receive reports from BHS regarding enrollee telephone calls and the log data included insufficient detail to analyze call content. For the two-year BHI review period, BHS reported receiving only one grievance involving behavioral health issues, an unusually low number. By not monitoring enrollee telephone calls to BHS, the Plan cannot be certain it is informed of all enrollee grievances, or that it identifies, tracks and trends enrollee difficulties obtaining behavioral health services, reports of provider directory inaccuracies, or other enrollee problems, or addresses and tracks issues requiring additional follow-up.

#3: The Plan does not have a process to track and monitor telephone calls from providers.

Summary: The Department requested the Plan provide documents describing monitoring systems and processes, in addition to monitoring reports, for all points of provider telephone access to the Plan.¹¹⁷ The Plan provided its policy *Monitoring Accessibility of Provider Services*. This policy stated the Plan “annually assesses the provider network’s compliance with...accessibility standards,” and described timely access, provider appointment availability surveys, provider after-hours services and other tools evaluating provider compliance. However, the policy did not address the Plan’s tracking or monitoring of calls it received from providers.

¹¹⁷ Crosswalk Request BHIAA_TA5.

San Francisco Health Plan Behavioral Health Investigation Report

The Department also requested copies of policies, workflows, and reports relevant to how the Plan tracks calls and communication to the Plan from providers.¹¹⁸ The Plan provided a narrative response stating it “receives calls from providers about specific client-level referrals, not general questions,” and provider calls about enrollees are tracked in the enrollee’s record. The Plan further stated providers can communicate with BHS program managers during provider meetings.¹¹⁹ Because BHS is delegated for Provider Dispute Resolution functions, BHS is required to annually submit to the Plan a Claims Payment and Dispute Resolution Mechanism Report regarding claims. However, providers may call health plans for reasons other than to submit a provider dispute. The Plan did not have a mechanism for ongoing, consistent monitoring of provider calls pertaining to anything other than claims. Providers may submit grievances on behalf of enrollees, inquire about delayed referrals, or raise other enrollee-related issues.

In interviews, BHS’s Systems of Care Director reported they did not have a formal tracking system in place for provider telephone queries. The Plan was unable to demonstrate it has a systematic mechanism for receiving, documenting, analyzing or addressing broader issues or concerns submitted by behavioral health providers. This lack of standardized tracking hinders the Plan’s ability to identify trends and address systemic issues involving BHS contracted providers.¹²⁰

¹¹⁸ DMHC Request #100, sent to the Plan January 31, 2025.

¹¹⁹ Plan Narrative Response to DMHC Request #100.

¹²⁰ Plan Narrative Response to Document Request #100.

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified 17 Knox-Keene Act violations and three barriers to care not based on Knox-Keene Act requirements.

Within 10 business days of issuance of this Report, the Plan is required to notify the Department in writing of any **factual** errors in the Report (Response). The Plan's Response shall include all of the following:

- A detailed explanation of the Plan's perceived factual error (factual errors include, for example, a misspelled policy name, incorrectly cited document date, etc.).
- Documentation necessary to demonstrate the factual error and the Plan's asserted correct fact(s) (correct facts may be demonstrated by submission of relevant documentation, for example, the title page with correct policy name, document page with correct date, etc.). Please highlight relevant correct information in the documentation submitted to ensure the Department is able to identify and confirm the correct fact.

Information in the Plan's Response that goes beyond the identification of factual errors will not be considered for purposes of this Report.

Within 30 calendar days from issuance of this Report, the Plan is required to submit a corrective action plan (CAP) that is reasonably calculated to correct the 17 identified Knox-Keene Act violations.

The Plan may submit a statement describing actions the Plan has or will take to address the three barriers to care not based on Knox-Keene Act requirements (Barriers Statement). This separate Barriers Statement is **not** part of the corrective action plan described below, and should be submitted separately. Should the Plan wish to submit a Barriers Statement, please submit it to the Department no later than **Monday, September 15, 2025**, using the DMHC Web Portal process described below.

The Plan must submit its Response, if any, and CAP via the Department's Web portal, eFiling application. Please click on the following link to login: [DMHC Web Portal](#).

Once logged in, follow the steps shown below to view and submit the documents required:

- Click the e-Filing link.
- Click the Online Forms link
- Under Existing Online Forms, click the Details link for the DPS Routine Survey Document Request titled, DPS 2024 Mental Health Investigation– Document Request.

This Report, along with the Plan's submitted CAP will be sent to the Office of Enforcement for review and appropriate enforcement action, which may include corrective actions and assessment of administrative penalties. A copy of the Report that

San Francisco Health Plan
Behavioral Health Investigation Report

includes any appropriate factual corrections, along with the CAP and any Barriers Statement submitted by the Plan, will be posted to the Department's website.

APPENDIX A

APPENDIX A. INVESTIGATION TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS

Name	Title
Holly Pearson	Assistant Chief Counsel
Tammy McCabe	Attorney IV
Jennifer Sharifi	Attorney III
Owen Zion	Attorney III
Oksana Meyer	Staff Services Manager III, Plan Surveys Chief
Kimberly Galli	Staff Services Manager II, BHI Manager
Michele Bogue	Health Program Specialist II, Team Lead

CONSULTANT TEAM MEMBERS: MAXIMUS FEDERAL SERVICES, INC.

Name	Title
Joan R. Kirby	Project Manager
Dr. Beverly Grimshaw	Investigator
Dr. Joshua Jones	Investigator
Andrew Mendonsa	Investigator
Alessandra Beers	Investigator
Martha Crowley	Investigator
Julie Morgan	Manager

APPENDIX B

APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: SAN FRANCISCO HEALTH PLAN

Name	Title
Nina Maruyama	Chief Officer, Compliance and Regulatory Affairs
Steve O'Brien, MD	Chief Medical Officer
Edwin Poon, PhD	Health Equity Officer
Crystal Garcia	Director, Compliance and Oversight
Rina Shah	MD, Sr. Medical Director
Irina Hohlovici	Audit Analyst
Tommy Williams	Manager, Behavioral Health
Kathy Pham	Behavioral Health Specialist
Brian Ellsworth, Pharm.D	Director, Pharmacy
Eileen Kim, Pharm.D	Clinical Pharmacist
Katrina Vo, Pharm.D	Clinical Pharmacist
Sue Chan	Program Manager, Pharmacy Compliance
Sean Dongre	Director, Provider Network Operations
Matija Cale, RN	Director, Clinical Operations
Travis Tiani, Sr.	Manager, Member Services
Yves Gibbons	Manager, Quality Improvement, Population Health
Grace Carino	Supervisor, Grievances and Appeals

San Francisco Health Plan
Behavioral Health Investigation Report

Name	Title
Leslie Mulhern, RN	Nurse Supervisor, Quality Review
Rand Takeuchi	Controller
Micaela Reed	Oversight Specialist
Florence Lo	Regulatory Affairs Analyst
Emily Waters-Leig	Regulatory Affairs Analyst
Islam Suliman	Audit Analyst
Ana Duran Tolama	Customer Service Specialist

DELEGATE STAFF INTERVIEWED FROM: SAN FRANCISCO BEHAVIORAL HEALTH SERVICES (BHS)

Name	Title
Imo Momoh	Director of Managed Care, BHS
Nancy Yu	Regulatory Affairs Manager, BHS
Gloria Fredrico	Director of Private Provider Network, BHS
Annie Shui	Director Utilization Management, BHS
Heather Weisbrod	Director, Office of Coordinated Care, BHS
Ivanna Chavez	Director of Central Access & Eligibility, BHS
Jessica Brown	Director, Office of Justice, Equity, Diversity, and Inclusion, BHS
Maximilian Rocha, LCSW	BHS Systems of Care Director
Kellee Hom	Information Systems Manager, BHS
Melissa Bloom, PhD	Risk Manager

San Francisco Health Plan
Behavioral Health Investigation Report

Name	Title
Michelle Truong, PMHNP-BC	Nurse Practitioner, Clinical Quality Specialist
Christine Soran, MD, MPH	Deputy Director, SUD
Alecia Martin, MPH,	Director, Quality Management and Regulatory Affairs
Joseph A. Turner, PhD, CHC	BHS Compliance Officer
Ana Gonzales, DO	CO-CMO and UM Director
Craig Murdock	Director, Behavioral Health Access Programs
Steven Nolan	Director, Clinical Account Services
Alexander Jackson, LCSW	Deputy Director, Adult & Older Adult Systems of Care
Hamilton Holt, MD	Medical Director, Primary Care Behavioral Health; Deputy Medical Director, Specialty Behavioral Health Services
Stephanie Felder	Director, Comprehensive Crisis Services System of Care
Ivanna Chavez	Director of Central Access & Eligibility, BHS
Chet Valentino	BHS Director of Data Analytics
Heather Clendenin LeMoine, LMFT	Clinical Data Supervisor
Nanalisa Rasaily	BHS Patients Accounts Manager
Linda Wu, LCSW	BHS Quality Assurance and Quality Improvement Manager
Emeterio Garcia	Program Manager for Residential Mental Health Programs
Grace Fung	Sr. Behavioral Health Technician

San Francisco Health Plan
Behavioral Health Investigation Report

Name	Title
Jason Ortega	Claims Services Representative, San Francisco Mental Health Plan
Michael Rojas	BHS Regulatory Affairs Coordinator
Lenh Tsan, MPP	BHS Quality Improvement Coordinator
Kitty Ha	Quality Improvement Coordinator
Jonas Abella	BHS Behavioral Health Access Line call representative

DELEGATE STAFF INTERVIEWED FROM: PRIME THERAPEUTICS MANAGEMENT LLC

Name	Title
Amanda Klar, Pharm.D	Lead Clinical Pharmacist, Prime Therapeutics
Ai Quynh Nguyen, Pharm.D	Pharmacist Account Manager, Prime Therapeutics
Gretchen Miller	Account Executive, Prime Therapeutics
Julie Bueno, PharmD	Clinical Pharmacist, Prime Therapeutics

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

A-1 – Prior and Retrospective Utilization Management Authorizations, Modifications and Denials for BH Services

LFA-1 BHS (Files Reviewed: 1)

Plan File #
0001

A-1 – Prior and Retrospective Utilization Management Authorizations, Modifications and Denials for Pharmacy (Rx) Requests

LFA-1 Pharm (Files Reviewed: 19)

Plan File #
000000062709556
000000063206538
000000063240778
000000063740166
000000064179184
000000064385816
000000064847543
000000065514957
000000065746116
000000067168802
000000068044205
000000068187177

San Francisco Health Plan
Behavioral Health Investigation Report

Plan File #
000000068940375
000000069430848
000000069760587
000000069856804
000000070468139
000000068727442
000000068699950

C – Enrollee Inquiry Contacts

BHS Delegate Inquiry Files

LFC_BHS Repeat Calls (Files Reviewed: 25)

Plan File #
1061474
1061474
1741608
1741608
1645143
1645143
1538873
1538873
6034447
6034447

San Francisco Health Plan
Behavioral Health Investigation Report

Plan File #
1278600
1278600
6029949
5034611
5245038
5116033
5116033
5135160
5101201
5101201
6030570
6030570
200279112
200279112
200333742

Plan Inquiry Files

LFC_SFHP (Files Reviewed: 29)

Plan File #
CLTP00000011706
CLTP00000023527
CLTP00000023959
CLTP00000024502

San Francisco Health Plan
Behavioral Health Investigation Report

Plan File #
CLTP00000032268
CLTP00000038367
CLTP00000043683
CLTP00000045959
CLTP00000047349
CLTP00000051142
CLTP00000072111
CLTP00000103386
CLTP00000119181
CLTP00000140403
CLTP00000168522
CLTP00000176225
CLTP00000191279
CLTP00000201893
CLTP00000208773
CLTP00000214555
CLTP00000224462
CLTP00000224887
CLTP00000226898
CLTP00000228034
CLTP00000228531

San Francisco Health Plan
Behavioral Health Investigation Report

Plan File #
CLTP00000231984
CLTP00000233223
CLTP00000233553
CLTP00000233916

F – Grievances and Appeals

Delegate Grievance Files

LFF_BHS (Files Reviewed: 1)

Plan File #
0001

H – Claims for BH Services

Mental Health Claims

LFH_BHS MH (Files Reviewed: 28)

Plan File #
66647.002
66877.001
66507.001
66792.002
66875.001
66337.001
66458.001

San Francisco Health Plan
Behavioral Health Investigation Report

Plan File #
66338.001
66674.001
66381.001
66911.002
66460.001
66513.001
66389.001
66820.002
66407.004
66759.002
66287.001
66260.001
66211.001
66343.001
66211.001
66209.001
66273.002
66278.001
66649.001
66844.001

San Francisco Health Plan
Behavioral Health Investigation Report

Plan File #
66845.001

BHS Substance Use Disorder Claims

LFH_BHS SUD (Files Reviewed: 19)

Plan File #
66385.001
66327.001
66375.001
66600.001
66833.001
66479.001
66494.001
66284.002
66362.001
66519.001
66370.001
66552.001
66267.001
66519.001
66519.001
66311.001
66746.001

San Francisco Health Plan
Behavioral Health Investigation Report

Plan File #
66849.001
66382.001

Pharmacy Claims

LFH_Pharm (Files Reviewed: 33)

Plan File #
100000109712004
100000108654135
100000121516351
100000111532824
100000113278451
100000110185297
100000110306338
100000112661849
100000109642578
100000109058443
100000110178042
100000115273109
100000121142039
100000116342295
100000120624012
100000116002822

San Francisco Health Plan
Behavioral Health Investigation Report

Plan File #
100000118958321
100000114006512
100000111094032
100000111468762
100000116444196
100000116227979
100000110840675
100000116301502
100000116369359
100000114765366
100000112751821
100000116421992
100000121923132
100000108571461
100000119031833
100000108240675
100000121349001

San Francisco Health Authority
DBA: San Francisco Health Plan
Corrective Action Plan Response

SAN FRANCISCO HEALTH PLAN
Behavioral Health Investigation Audit
Corrective Action Plan

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date
<p>1. The Plan's appointment accessibility monitoring is insufficient to ensure compliance with timely access standards</p>	<p>The Plan acknowledges that Access to Care Committee (ACC) meetings were not held with regular frequency during the audit scope period. ACC meetings have returned to quarterly frequency beginning with the Q2 2024 meeting.</p> <p>For MY2022 and MY2023, BHS was placed on a Corrective Action Plan (CAP) for non-responsiveness, and while the individual provider CAPS were discussed in the committee meetings in which minutes were shared, the Plan recognizes that the larger issue of non-responsiveness from Behavioral Health Providers was not presented as its own independent issue. For MY2024, SFBHS was placed on a CAP for Provider Appointment Availability and Survey Response Rate, see attached document 2024 SFBHS CAP. The survey results and CAPs were discussed at the Q2 ACC meeting held on 07/14/2025, packet attached. In addition, the Q3 ACC meeting is scheduled for 10/02/2025, and a discussion specific to outstanding CAPs will be held, which includes the open BHS CAP and access to Behavioral Health Providers.</p>	<p>SFBHS_CAP_09.11.2025</p> <p>Q2_2025_ACC</p>	<p>ACC Meetings resumed Quarterly-Q2 2024</p> <p>Discussion of Access CAPS-07/14/2025</p> <p>BH Discussion at ACC-10/02/2025</p>

SAN FRANCISCO HEALTH PLAN
Behavioral Health Investigation Audit
Corrective Action Plan

<p>2. The Plan does not conduct adequate oversight to ensure BHS offers enrollees behavioral health appointments within timeliness standards.</p>	<p>As mentioned during the audit, and in the audit report, the Plan has been in the process of finding a replacement vendor for Healthy Worker Behavioral Health since 2021. We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon’s ability to perform the tasks and The Plan’s ability to provide Oversight. As part of the annual oversight audit, a review of Carelon Customer Service will occur. Please see attached audit tool. In addition, Carelon will be required to submit a number of reports by which the Plan will be conducting oversight of availability, including a weekly appointment availability report, out-of-network report and the PHM KPI report which contains access metrics.</p>	<p>CS Audit Tool Carelon RDI Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>
<p>3. The Plan failed to consistently conduct an annual enrollee experience survey as required.</p>	<p>The Plan acknowledges that the survey was not conducted between 2022 and 2024. The enrollee survey was conducted in 2024 for MY 2023. Please see attached results. The survey will continue to be conducted on an annual basis.</p>	<p>Enrollee Survey Comparison Narrative</p>	<p>May 2024- Enrollee Survey resumed</p>

SAN FRANCISCO HEALTH PLAN
Behavioral Health Investigation Audit
Corrective Action Plan

<p>4. The Plan was unable to demonstrate all persons who conduct utilization review, review claims, and/or make medical necessity determinations for behavioral health services received the required formal training on nonprofit association criteria.</p>	<p>The Plan acknowledges that oversight of training was not conducted after initial training provided after implementation of NPA training requirement. We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon’s ability to perform the tasks and The Plan’s ability to provide Oversight. As part of the Pre-Delegation Audit conduct on Carelon, the Plan has reviewed Carelon policy UM015-24, attached, to ensure that the NPA entities are included in the clinical criteria developed by the delegate. The Plan will require Carelon to demonstrate that all persons who conduct utilization review, review claims, and/or make medical necessity determinations for behavioral health services received the required formal training on nonprofit association criteria as part of the annual oversight audit. The Plan will leverage all trainings available through Carelon and sponsor additional trainings, if necessary, to ensure all Carelon and internal SFHP staff performing BH UM activities are trained on the NPA BH Guidelines.</p>	<p>UM 015.24 Policy Oversight Plan</p>	<p>Transition to Carelon-11/15/2025</p> <p>First Annual Oversight Audit-April 2026</p>
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SAN FRANCISCO HEALTH PLAN
Behavioral Health Investigation Audit
Corrective Action Plan

<p>5. The Plan did not demonstrate that all staff who conduct utilization review passed interrater reliability testing</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon's ability to perform the tasks and the Plan's ability to provide Oversight. Carelon will be subject to, at minimum, an annual audit, and as part of the audit, IRR policy and results will be reviewed. As part of the Pre-Delegation audit, it was confirmed that Carelon has an IRR process. Please refer to attached policy.</p>	<p>UM Audit Tool_DO UM Policy Check list Policy 066.18 Policy 116.13E Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>
<p>6. The Plan does not have a process to continuously review utilization of behavioral health services and facilities.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon's ability to perform the tasks and the Plan's ability to provide Oversight. Carelon will be subject to, at minimum, an annual audit. In addition, please refer to the attached Reports Deliverable Index (RDI) for a detailed account of all reports that will be required from Carelon, including Utilization Management reports for both inpatient and outpatient utilization.</p>	<p>UM Audit Tool_DO Carelon RDI Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>

SAN FRANCISCO HEALTH PLAN
Behavioral Health Investigation Audit
Corrective Action Plan

<p>7. The Plan does not ensure BHS timely notifies behavioral health provider applicants of the status of their credentialing application.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon's ability to perform the tasks and the Plan's ability to provide Oversight. Carelon will be subject to, at minimum, an annual audit. Please refer to attached Credentialing tool.</p>	<p>Credentialing Audit Tool_DO Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>
<p>8. The Plan does not conduct adequate oversight of BHS to ensure compliance with required utilization management program standards.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon's ability to perform the tasks and the Plan's ability to provide Oversight. Carelon will be subject to, at minimum, an annual audit. Please refer to attached UM Audit tool.</p>	<p>UM Audit Tool_DO Carelon RDI Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>
<p>9. The Plan does not conduct adequate oversight to ensure BHS identified and referred all grievances to the Plan.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon's ability to perform the tasks and the Plan's ability to provide Oversight. While grievances will not be delegated to Carelon, please refer to attached RDI for list of reports required from Carelon, which includes an exempt grievance report.</p>	<p>Carelon RDI Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>

SAN FRANCISCO HEALTH PLAN
Behavioral Health Investigation Audit
Corrective Action Plan

<p>10. Plan customer service representatives are not consistently knowledgeable and competent in providing customer service.</p>	<p>As noted in the audit report, the Plan was in a period of transition during the audit scope period. An internal audit of Customer Service will be performed by the Compliance and Oversight Department on a semi-annual basis, in addition to the quarterly CS Agent QA monitoring done by CS Management. Carelon will be also subject to an annual audit, which includes a review of telephone calls. Please see attached CS_Audit Tool, which will be used for both internal and external audits.</p>	<p>CS_Audit Tool Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>
<p>11. Neither the Plan nor BHS have a maternal mental health program, as required.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon's ability to perform the tasks and The Plan's ability to provide Oversight. The Plan, in partnership with Carelon, will ensure implementation of a Maternal Mental Health Program for Healthy Worker Members.</p>		<p>Transition to Carelon-11/15/2025 Full Implementation of Maternal Mental Health Program for Healthy Workers- January 2026</p>

SAN FRANCISCO HEALTH PLAN
Behavioral Health Investigation Audit
Corrective Action Plan

<p>12.The Plan was operating at variance with its filed quality assurance policy and procedure.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon’s ability to perform the tasks and the Plan’s ability to provide Oversight. Carelon will be required to submit a number of reports by which the Plan will be conducting oversight of availability, including a weekly appointment availability report, out-of-network report and the PHM KPI report which contains access metrics. Policies and procedures that are related to BH Quality have been provided to the Department as part of filing 20252082.</p>	<p>Carelon RDI Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>
<p>13.The Plan was operating at variance with its filed utilization management policy and procedure.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon’s ability to perform the tasks and the Plan’s ability to provide Oversight. Carelon will be subject to, at minimum, an annual audit, and as part of the audit, IRR policy and results will be reviewed. As part of the Pre-Delegation audit, it was confirmed that Carelon has an IRR process. Please refer to attached policy. Policies and procedures that are related to BH UM have been provided to the Department as part of filing 20252082.</p>	<p>UM Audit Tool_DO UM Policy Check list Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>

SAN FRANCISCO HEALTH PLAN
Behavioral Health Investigation Audit
Corrective Action Plan

<p>14.The Plan was operating at variance with its SB 855 compliance filing.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon’s ability to perform the tasks and the Plan’s ability to provide Oversight. Carelon will be subject to, at minimum, an annual audit, and as part of the audit, IRR policy and results will be reviewed. As part of the Pre-Delegation audit, it was confirmed that Carelon has an IRR process. Policies and procedures that are related to SB855 have been provided to the Department as part of filing 20252082.</p>	<p>Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>
<p>15.The Plan was operating at variance with its filed Delegation Agreement.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon’s ability to perform the tasks and the Plan’s ability to provide Oversight. Carelon will be subject to, at minimum, an annual audit. Policies and procedures that are related to BH Oversight have been provided to the Department as part of filing 20252082.</p>	<p>Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>

SAN FRANCISCO HEALTH PLAN
Behavioral Health Investigation Audit
Corrective Action Plan

<p>16.The Plan was operating at variance with its filed access policy and procedure.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon’s ability to perform the tasks and the Plan’s ability to provide Oversight. As part of the annual oversight audit, a review of Carelon Customer Service will occur. Please see attached audit tool. In addition, Carelon will be required to submit a number of reports by which the Plan will be conducting oversight of availability, including a weekly appointment availability report, out-of-network report and the PHM KPI report which contains access metrics. Policies and procedures that are related to access have been provided to the Department as part of filing 20252082.</p>	<p>Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>
<p>17.The Plan permitted BHS to engage in unjust payment patterns.</p>	<p>We will be transitioning from BHS to Carelon for the Healthy Worker Line of Business effective 11/15/2025. We have filed the intended contract with DMHC under filing # 20252082 and have been working with the Department to demonstrate Carelon’s ability to perform the tasks and the Plan’s ability to provide Oversight. Carelon will be subject to, at minimum, an annual audit. Please refer to attached Claims Audit tool.</p>	<p>Claims_Audit Tool Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>
<p>B1. The Plan’s high customer service staff turnover rate impedes efficient and effective customer service.</p>	<p>The Plan acknowledges that there was a significant turnover rate during the audit scope period. Please note that the Plan has reduced the turnover rate to 23.85% during 2024 and has remained a steady 9.5% during calendar year 2025 to date.</p>	<p>Turnover_Email</p>	<p>December 2024</p>

SAN FRANCISCO HEALTH PLAN
Behavioral Health Investigation Audit
Corrective Action Plan

<p>B2. The Plan does not have a mechanism to monitor enrollee telephone calls made to BHS.</p>	<p>As noted in the audit report, the Plan was in a period of transition during the audit scope period. An internal audit of Customer Service will be performed by the Compliance and Oversight Department on a semi-annual basis, in addition to the quarterly CS Agent QA monitoring done by CS Management. Carelon will be also subject to an annual audit, which includes a review of telephone calls. Please see attached CS_Audit Tool, which will be used for both internal and external audits.</p>	<p>Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>
<p>B3. The Plan does not have a process to track and monitor telephone calls from providers.</p>	<p>As noted in the audit report, the Plan was in a period of transition during the audit scope period. An internal audit of Customer Service will be performed by the Compliance and Oversight Department on a semi-annual basis, in addition to the quarterly CS Agent QA monitoring done by CS Management. Carelon will be also subject to an annual audit, which includes a review of telephone calls. Please see attached CS_Audit Tool, which will be used for both internal and external audits.</p>	<p>Oversight Plan</p>	<p>Transition to Carelon-11/15/2025 First Annual Oversight Audit-April 2026</p>