SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

MEMORANDUM

DATE: **October 7, 2021**

TO: **Connie Chan, Member**
Board of Supervisors District I

FROM: **Abbie Yant, Executive Director**
Health Service System

RE: **Letter of Inquiry: Mental Health Care Access for City Employees**

Introduction

The rich diversity of the San Francisco Health Service System (SFHSS) membership requires us to design benefits and influence the delivery of healthcare services to meet their needs. SFHSS looks to continuously improve the quality of care for members when they become ill or develop chronic conditions as well as support members throughout their life course to maintain well-being. We take into consideration the whole person, social determinants, quality, and clinical outcomes. As we approach whole-person care in an ever-increasingly complex system, our goal is to ensure the delivery of services that maintain health and well-being and ensure that our members receive the right care in the right setting. Our Mission, Vision, and Core Values guide us through this era of innovation, disruption, and uncertainty in an increasingly complex world of healthcare. We are aligned with the Board of Supervisors in the effort to ensure the delivery of quality, cost-effective care to our members, particularly around mental health services as identified in Supervisor Chan's September 14, 2021 Letter of Inquiry.

The systems in place to diagnose and treat mental health are constantly evolving. Historically, the care for mental health needs was built to treat people with Severe Mental Illness (SMI) and not for those with Any Mental Illness (AMI) (as defined by the National Institute of Mental Health), where self-care and other self-directed tools and resources may be appropriate. Additionally, mental health has been fraught with stigma and inequities.

The reduction of stigma has declined over the last decade, and particularly in the last 18 months as sparked by the COVID-19 pandemic. During these unprecedented times, many people have been subject to quarantine and have experienced significant changes in their lives. These changes include spending more time at home with or without family members, loss of employment, and the illness and death of friends and family. The COVID-19 pandemic brought a broad and unprecedented surge of strenuous events to mental health systems ill-equipped to meet even pre-pandemic needs. Combined with the workforce shortage and limited access to in-person care at the onset of the pandemic, the world has seen a profound impact on physical, social, and emotional health. While we have seen an increase in SFHSS members seeking mental health services through SFHSS' Employee Assistance Program (EAP) program, and through health plans' behavioral health services, some of this increased demand has been met by an increase in the availability, accessibility, and utilization of virtual and digital care options.

SFHSS shares the interest in ensuring quality and timely access to mental health care for its members. We continue to push the dialogue and act in this area. SFHSS has found its health plan partners to be responsive and

flexible in working together to resolve concerns within the confines of the workforce shortage that has created barriers that are beyond the scope of what SFHSS can address, however, we acknowledge the many opportunities to further meet the needs of our membership. SFHSS encourages the Board of Supervisors, the Health Service Board, its health plans, and the many organizations focused on mental health workforce shortages to consider both short and long-term solutions to address current and future needs.

1. What is the number of City enrollees and their family members with each of our health providers?

The following table outlines the San Francisco Health Service System enrollment by health provider as of January 1, 2021. These counts include employees and dependents.

Health Plan	SFHSS Employee and Dependent Lives as of 1/1/2021
Blue Shield of California (BSC)	34,418
Kaiser Permanente (KP)	55,172
UnitedHealthcare (UHC)	2,843

Source (page 3):
https://sfhss.org/sites/default/files/2021-03/March%2011%2C%202021%20The%202021%20Plan%20Year%20Enrollee%20Demographics%20Report.pdf

2. For each of our health plans please provide the Board of Supervisors with the average wait to get a first behavioral health appointment from a patient's first request for treatment.

3. Please share data on the average wait time after intake for follow-up appointments for each health plan.

4. Please provide a comparison to show how these two data sets – 1) wait times for initial appointments and 2) wait times for follow-up appointments – may differ between providers.

Introduction Response to 2, 3, and 4

There are several mental health-related state and federal regulations in existence today (see question 7). In addition, there are several agencies providing oversight and evaluation of health plans on an involuntary and voluntary basis. The agencies that provide oversight vary based on the health plan's "insured" status, meaning that fully insured plans (where the health plan owns the risk of claims to premium spend) are generally subject to different agencies than those that are self-funded (where the plan sponsor owns the risk of claims to premium spend). There are also several organizations that provide accreditations, generally on a voluntary basis, such as the National Committee for Quality Assurance (NCQA) which includes the Healthcare Effectiveness Data and Information Set (HEDIS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) assessments (note: the California Office of the Patient Advocate utilizes the information provided by the NCQA CAHPS survey for patient satisfaction scores). **Due to overlapping legal requirements and oversight agencies, published third-party data on mental health utilization, timeliness, etc., does not exist on a comparable basis. Moreover, each SFHSS health plan issues reports based on different measures that are not comparable.**

(See tables below) Nonetheless, SFHSS will continue to work with its health plans, including the new Health Net CanopyCare plan effective January 1, 2022, to report out on aligned and synchronized data elements (including mental health and other health care quality metrics) as part of its Data Measurement Plan that is currently under development.

2019 DMHC Timely Access Report Results for Plans Available to SFHSS Members

Data from this Department of Managed Health Care (DMHC) table combines Commercial (i.e., Non-Medicare) product survey results, across **all provider types** (primary care, specialty, non-physician mental health, and ancillary). DMHC Timely Access to Care policies do not differentiate between initial and routine follow-up appointments and do not stipulate an emergent appointment wait time standard. This data is directly reported from health plans to the DMHC. UnitedHealthcare (UHC) is not subject to DMHC regulations for SFHSS' self-funded PPO plan so there is no data to report.

Table 1: DMHC Timely Access Results—All Services 2019

Plan	DMHC % Surveyed Providers Meeting Urgent Appointment Wait Time Standards (48 hours)	DMHC % Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards (10 Business Days)
Blue Shield of California	66%	81%
Kaiser Permanente	77%	91%

Notes:

- DHMC Timely Access to Care Standard: https://www.dmhc.ca.gov/healthcareincalifornia/yourhealthcarerights/timelyaccesstocare.aspx
- Data extracted from: https://www.dmhc.ca.gov/Portals/0/Docs/OPM/2019TAR.pdf (Charts 6 and 10)

Mental Health Access Data Submitted to SFHSS

Mental health access data is regularly submitted to SFHSS from health plan carriers per contractual and performance agreements. Appointment Wait Time data in the tables below are specific to mental health services. UHC's reporting capabilities on appointment wait times are currently under development.

Table 2a: Appointment Wait Time Standards for Initial Appointments—Blue Shield of California 2020 Data

	% Meeting Emergent Appointment Wait Time Standards (6 hours)*		% Meeting Urgent Appointment Wait Time Standards (48 hours)*		% Meeting Non-Urgent Appointment Wait Time Standards (10 Business Days)	
Plan	**Measure Result for SFHSS Members**	**Measure Result for Book of Business**	**Measure Result for SFHSS Members**	**Measure Result for Book of Business**	**Measure Result for SFHSS Members**	**Measure Result for Book of Business**
Blue Shield of California	100%	100%	100%	100%	89%	83%

* *These metrics are contractually obligated by BSC with its subcontracted vendor, resulting in 100% compliance.*

Table 2b: Appointment Wait Time Standards for Initial Appointments: Kaiser Permanente 2020 Data

	% Meeting Urgent Appointment Wait Time Standards (48 hours)		% Meeting Non-Urgent Appointment Wait Time Standards (10 Business Days)	
Plan	**Measure Result for SFHSS Members**	**Measure Result for Book of Business**	**Measure Result for SFHSS Members**	**Measure Result for Book of Business**
Kaiser Permanente	Insufficient Sample Size	98.7%	95.4%	96.2%

5. What tools does the HSS have to affect the quality of patient care including the length of time it takes for City enrollees to receive behavioral healthcare?

SFHSS has many tools at its disposal to affect the care provided to its members. This includes:

- Ongoing health plan reporting on utilization metrics to identify changes and action plans for improvement.
- Monitoring external health plan reporting such as DMHC, NCQA HEDIS, NCQA CAHPS, and California Office of the Patient Advocate.
- Monitoring state and federal legislation to understand and confirm health plan implementation of new provisions as applicable based on funding status, i.e., self-funded or fully insured.
- Working with health plans and large Bay Area provider groups to promote and influence the integration of mental health care into primary care; and
- Continuing the dialogue with SFHSS health plan partners and other third-party supportive partnerships (Aon Consulting, Inc., Catalyst for Payment Reform, and Purchasers Business Group on Health, etc.) to monitor changes in the market (legislative, network, emerging vendors, etc.).

6. How does the availability of behavioral care compare across race, ethnicity, language, and provider?

SFHSS and its health plan partners understand the importance of working with mental health providers who have deep personal and/or professional knowledge of the member's physical, social, emotional, cultural, gender identity, sexual orientation, race, ethnicity, and language identifiers. We are also aware that the mental health workforce shortage also includes a significant gap of providers that align with these identifiers. The American Psychological Association predicts that by 2030, there is a projected demand within racial/ethnic minority populations in the United States for 37,650 FTE (full-time equivalent) psychologists – an **increase** of 7,250 FTEs from 2015. These projections consist of a demand for 11,870 FTE psychologists within the Black/African American population, 17,630 FTEs within the Hispanic population, and 8,150 FTEs within other racial/ethnic minority populations.

SFHSS has encouraged its health plan partners to continue to develop the network to be inclusive of providers who serve the diversity of its membership and to find creative solutions to match members to ideal providers. Following is the status of searchable provider demographic attributes by health plan:

- **Blue Shield of California:** Through its provider search site, the member has the capability to search for providers by distance, gender, provider type, specialty, ethnicity, ages treated, preferred language, and location accommodations such as public transportation and wheelchair accessibility. Through its mental

health service administrator (a national organization), BSC can state that nationwide provider network data is readily available as follows:

  - 13.38% reported a language other than English
  - 88% reported a gender
  - 68% reported ethnicity and race

- **Kaiser Permanente:** Provider search through My Doctor Online includes information about clinicians, such as languages spoken, gender, special skills, and biography and photo. Race and ethnicity are not among the searchable options on My Doctor Online. Members may partner with a physician based on cultural concordance are accommodated as much as possible by the call center or the outpatient specialty mental health departments.
- **UnitedHealthcare:** As of November 2020, 41% of providers in UHC's nationwide provider network have populated self-reported race, ethnicity, and language data in UHC's online provider search tool. Of those, 29% identify with ethnicities other than White, and of those 8% identify as African American.

7. What has the HSS done to enhance the quality of care and the length of time it takes for a City enrollee to receive a behavioral health appointment?

SFHSS has taken several actions to monitor and expand members' access to mental health care.

Monitoring Mental Health Care

SFHSS engages with its health plans frequently to review utilization reporting and significant network, program, and utilization changes. These conversations include establishing expectations for cost and utilization and engaging with SFHSS Communications to ensure consistent, focused engagement methods and language with members. Starting in Plan Year 2020, SFHSS has incorporated specific mental health components into the annual health plan renewal process. This includes a response to the Catalyst for Payment Reform (CPR) Mental Health Toolkit, which in turn includes a framework to address challenges to accessing mental health benefits, such as appointment times for emergent, urgent, and routine visits which align with the DMHC requirements for urgent and non-urgent (or routine) care (DMHC does not address emergent care).

Additionally, as part of the SFHSS audit and assessment plan, we monitor and ensure vendor compliance with state and federal regulations. Following is a sample of items currently being monitored and/or assessed:

- **Federal Mental Health Parity and Addiction Equity Act, 2008 (MHPAEA):** Regulations state that plans may not apply financial requirements (e.g. deductibles, copays), quantitative treatment limitations (e.g. frequency, duration), and nonquantitative treatment limitations (NQTLs, e.g. medical management standards, preauthorization requirements) to mental health or substance use disorder (MH / SUD) benefits that are more restrictive than the predominant benefit applied to substantially all medical/surgical benefits in the same classification. SFHSS' BSC and KP plans are responsible for this compliance and have confirmed they are in incompliance. As the plan sponsor for SFHSS' self-funded UHC plan, SFHSS is responsible for compliance with MHPAEA. Using a third party, SFHSS completed an assessment of UHC's MHPAEA compliance for financial requirements and quantitative treatment limitations in the fall of 2020. The California Health Care Foundation, in partnership with Georgetown Health Policy Institute, published the following information in July 2020 as to the interaction of federal and California state parity laws:
  - All state-regulated health plans and insurance must comply with federal MHPAEA, which requires parity for any mental health/substance use disorder (MH/SUD) benefits.

- All state-regulated non-grandfathered individual and small group market health plans and insurance must comply with Essential Health Benefits (EHB) as required under federal Affordable Care Act provisions, including MH/SUD.
  - EHB in California law requires benefits and diagnostic conditions to be covered to be "substantially equal" to the state's benchmark plan.
  - State's EHB benchmark plan defines mental health conditions using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV).
- State-regulated large group health plans are subject to more limited benefit requirements than EHB (i.e., nine severe mental illnesses, serious emotional disturbances of a child, care at a psychiatric facility, certain biologically based severe mental disorders).

- **Consolidated Appropriations Act, 2021 (CAA):** Adds to the MHPAEA and explicitly requires group health plans and issuers that cover mental health/substance use disorder and medical/surgical benefits to prepare a comparative analysis of any NQTLs that apply. BSC and KP plans are responsible for this compliance and have confirmed they will be compliant as of the effective date of 1/1/2022. As the plan sponsor for SFHSS' self-funded UHC plan, SFHSS is responsible for producing an NQTL comparative analysis. Because of the detailed and clinical nature of the information necessary for conducting the required comparative analysis is held by UHC, SFHSS' self-funded plan partner, SFHSS is working with UHC to confirm compliance.
- **California Senate Bill 855:** This bill was approved by the Governor on 9/25/2020 for plans beginning 1/1/2021. For plans under the jurisdiction of the DMHC, the legislation requires that plans provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. SFHSS has confirmed with its health plans that they are in compliance with this legislation.
- **California Senate Bill 221:** This new bill codifies the regulations adopted by the DMHC and the Department of Insurance (DOI) to provide timely access standards for health care service plans and insurers for non-emergency health care services. The bill would require plans to ensure that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements, as specified. The bill would additionally require, commencing July 1, 2022, plans to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health or substance use disorder condition is able to get a follow-up appointment with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment. The bill would also require that a referral to a specialist by another provider meet the timely access standards. If a plan is operating in a service area that has a shortage of providers and is not able to meet the geographic and timely access standards for providing mental health or substance use disorder services with an in-network provider, the bill would require the plan to arrange coverage outside the plan's contracted network. SFHSS has proactively reached out to its health plans to confirm that they are aware of the legislation and that each health plan is prepared to confirm compliance as of the legislation's effective date.

Expanding Access to Mental Health Care and Support

SFHSS and its health plan partners have taken several actions recently to ensure continued access to mental health care and support, particularly considering pandemic-related access reduction and increased mental health care needs. These supportive programs, listed below, are not a replacement for mental health services provided by the health plan rather, they are an added benefit for employees.

SFHSS Employee Assistance Program

SFHSS offers assistance to employees through its Employee Assistance Program (EAP) program. This program provides individual and couples counseling, individual and organizational consultations, and referrals, management coaching, mediation, workshops and trainings, critical incident response, grief, and chronic stress

support. The program also offers coaching for individuals to assist them in how to navigate their mental health benefits through their health plan. Additionally, the EAP team acts as advocates for members and utilizes their relationship with a designated liaison within each health plan to help members access mental health services where they might be experiencing barriers to accessing care.

The EAP includes workshops such as EAP 101, Mental Health First Aid, Leadership in Action, Stress First Aid, vicarious trauma, psychological first aid, small group sessions, and anger management.

In 2020, SFHSS expanded its EAP services to add a 24/7 model in partnership with ComPsych. Through ComPsych employees can receive free and confidential services to help problem-solve and develop skills to meet life's challenges. This includes individual and couples counseling, video/text/tele-counseling, consultations and referrals, support for critical incidents and disruptive events, meditation, and workshops and training on mental health.

Utilization of the SFHSS EAP has increased over the last 3 years as outlined in the following table:

Data Point	2019**	2020*	2021***	% Change from 2019 to 2021
Management Consultations	Avg. 13 / month	Avg. 21 / month	Avg. 21 / month	47% increase
Organizational Services	337 / year (Avg. 28 / month)	1,185 / year (Avg. 99 / month)	1,219 YTD (Avg.152 / month)	138% increase
Individual Cases	Avg. 49 / month	Avg. 74 / month	Avg. 77 / month	44% increase

* *2020 data represents monthly averages from 2019 from January through March for SFHSS EAP and real-time data that includes data from ComPsych from April through December.*

** *2021 data represents January through August.*

SFHSS has also expanded member access through two additional programs:

- **Cordico:** External partner providing wellness technology for high-stress professions, providing confidential, 24/7 proactive and preventative wellness support specially developed for law enforcement, firefighters, dispatchers, medical professionals, and others serving in the most demanding and critical roles. The platform solutions provide handheld access to anonymous self-assessments, peer support, instructional videos, geo-mapping of vetted therapists, one-touch calling, and on-demand tools targeting alcohol abuse, anger management, anxiety, mental health, and more.
- **CredibleMind:** CredibleMind's core information system helps users with early intervention and prevention of mental health and emotional well-being issues by providing, for over 200 topics, evidence-based approaches, and access to over 13,000 expert-ranked, high quality, actionable resources.

SFHSS health plans have also expanded access to mental health support through an array of expanded programs and investments in workforce, access, and digital health solutions.

Blue Shield of California	■ **BrightHeart Health**—By referral through Magellan care managers, members can access BrightHeart Health telemedicine services for Mental Health, Substance Use, Eating Disorder, and Chronic Pain services. (https://www.brighghearthealth.com) ■ **myStrength**—Digital personalized programming, online self-assessment tools, and dedicated coaching in areas including stress, depression, sleep, and more. (https://mystrength.com) ■ **Teladoc**—BSC eligible plans have 24/7 access to U.S. board-certified physicians and mental health professionals from Teladoc (https://www.blueshieldca.com/Teladoc) ■ **Wellvolution**—BSC's wellbeing program offers a wide range of self-care solutions including two industry-leading emotional well-being solutions: one focused on mindfulness and one providing a full range of support from digital tools and coaching to clinical care beginning Q4 of 2021
Kaiser Permanente	■ **Calm**—Digital application for meditation and sleep—designed to help lower stress, reduce anxiety, and more. (https://www.calm.com) ■ **myStrength**—Digital personalized programming, online self-assessment tools, and dedicated coaching in areas including stress, depression, sleep, and more. (https://mystrength.com)
UnitedHealthcare	■ **AbleTo**—The AbleTo program supports members with comorbid medical and mental health conditions with 8 weeks of telephonic or video-enabled services, therapy, and weekly coaching (https://www.ableto.com) ■ **Live and Work Well**—UHC Members can access board-certified doctors and licensed therapists through partnerships with AmWell and Doctors on Demand (https://amwell.com/cm/how-it-works/unitedhealthcare-virtual-visits-on-amwell and https://uhc.doctorondemand.com) ■ **TalkSpace**—With TalkSpace online therapy, members can regularly communicate with a therapist, safely and securely from their phone or desktop—no office visit required ■ **Sanvello**—An on-demand emotional support mobile application is available to anyone to help you cope with stress, anxiety, and depression. With some UHC health plans, members may have Sanvello premium access to all self-care content, including all Guided Journeys, tools, and meditations (https://www.sanvello.com)

Integrating Mental Health into Primary Care

SFHSS agrees with the Commonwealth Fund's assessment on the importance of integrating the delivery of mental health services into the primary care setting. According to the Commonwealth Fund, historically mental health care is separated from the primary care system—a practice that the Institute of Medicine (IoM) concluded over 25 years ago was leading to inferior care. Since the IoM's report, additional studies have shown that having two, mostly independent systems of care, leads to worse health outcomes and higher total spending, particularly for patients with comorbid physical and mental health conditions ranging from depression and anxiety, which often accompany physical health conditions, to substance abuse and more serious and persistent mental illnesses. CMS' Collaborative Care Model (CoCM) aligns with these studies and stands out as the ideal framework for SFHSS to promote with its health plans. SFHSS is working with its health plan partners to understand what each has in place today or is planning to support the CoCM model.

Blue Shield of California: BSC's goal is to provide access for all SFHSS members to have a true medical mental health integration experience within the Brown and Toland Physician network by employing the Collaborative Care Model (CoCM) within contracted provider clinics. While there may be variations from site to site, the collaborative care model is designed to ensure that a member's behavioral health needs are carefully assessed and supported by the behavioral health specialist that will be assigned to, and ideally be co-located with, the Primary Care Provider (PCP) in the clinic to ensure that the overall care plan is focused on the physical, mental, and emotional well-being of the member. The behavioral health specialist will act as the liaison and feedback loop for the PCP in the area of the behavioral health provider community and will help the member, PCP office, and larger community begin to see these needs as a very significant and common part of health care delivery. In addition, behavioral health specialists will receive weekly psychiatric consultation to ensure alignment and provide an additional layer of support.

BSC believes this delivery system model will accomplish its goals of member-centric, whole-person care that addresses needs in one place and ensures timely follow-up, tracking, and communication between the behavioral health and medical delivery systems. BSC's goal is to have a provider platform that allows easy communication, tracking, and monitoring. The model is designed to save costs for emergency services utilization and overall cost of care and to be sustainable by utilizing CoCM codes, which will include all the activities of the behavioral health specialist.

Kaiser Permanente: KP's mental health program focuses on access and availability of services, proactive screening, educational resources, and wellness tools, and providing care that is coordinated among primary care physicians and mental health practitioners. Through an integrated model, physicians and mental health professionals work collaboratively to provide a continuum of high-quality care and comprehensive treatment to address our members' total health care needs.

Kaiser primary care physicians are trained to look for signs of mental health and substance abuse needs when they are treating members in the primary care setting. They can perform effective screenings to identify mental health issues and work with members in shared decision-making regarding further evaluation and treatment, including connecting the member with mental health care clinicians as appropriate. Clinicians use depression screening tools that incorporate elements of the Patient Health Questionnaire (PHQ-9) questionnaire for the identification of depression. This depression screening tool may be used during a routine physical, whenever a clinician suspects depression, or when the patient presents with chief complaints such as fatigue, stress, insomnia, or chronic pain.

Additionally, Kaiser outpatient mental health departments are typically co-located in the same medical facilities as primary care, pharmacy, and specialty services, making it easy for primary care clinicians to make referrals. With the transition of most specialty mental health services to the virtual setting in 2020 due to the pandemic, these services are now accessible regardless of patient or clinician location. Virtual care and care co-located settings help some patients with concerns about the stigma of mental health care to receive care. In many locations, mental health clinicians are embedded in primary care, providing one-on-one consultations and other services in the primary care setting for members who may be reluctant to self-refer to mental health services.

UnitedHealthcare: UHC has implemented the following strategic investments to advance medical-mental health integration:

- **Depression Screening within our Medical Programs:** UHC nurses screen members across all case management programs for depression. Based on these screenings, and the member's needs and preferences, nurses warm transfer the member to a licensed mental health specialist, ask the member if a specialist can contact them, schedule an appointment with a specialist or work behind the scenes with specialists to make appropriate referrals and provide education and resources. Nurses are also trained to identify signs of anxiety, stress, and substance use and refer, as appropriate, to mental health providers,

resources (such as UHC's Substance Use Disorder Helpline), or mental health specialists. Behavioral health specialists can also refer to medical, wellness, or other programs offered by SFHSS.

- **Shared Clinical Platform:** Behavioral and medical case managers work within UHC's Integrated Clinical User Experience (ICUE) system, a component of UHC's proprietary eSync Platform. eSync uses a powerful intelligence system to translate thousands of data points—including medical, clinical, behavioral, and pharmacy data—into health care opportunities prioritized to help close gaps in care, manage chronic conditions and help members live healthier lives. This integrated case management approach enhances UHC's ability to proactively identify and support members who may require mental health interventions, as well as enable shared notes and easy referrals between medical and behavioral case managers working with the same member.
- **PCP Toolkits:** UHC provides access to digital Behavioral Health Toolkit for Medical Providers and Quality Assurance Toolkit for PCPs through its Provider Express portal that includes screening tools for substance use, mental health, suicide, trauma, and more, as well as UHC's Clinical Criteria and Best Practice Guidelines and search tools for its provider network, including Medication-Assisted Treatment (MAT) providers who treat substance use disorders. Primary physicians and other providers benefit from resources, training, tools, and more that can assist them in helping patients receive proper screening and referrals for mental health needs.

8. How have our behavioral health plans explained the reasons for any long wait times?

SFHSS can see from its own cost and utilization information and can infer from public information sources like DMHC Access to Timely Care, that most members are receiving care within the access standards established by DMHC. We believe that the workforce shortage has created an opportunity for improvement in the delivery of mental health services both in the short- and long term. Like many health plans across the U.S. and in California specifically, SFHSS health plans have experienced challenges in meeting the increasing demand for mental health care due to the mental health workforce shortage. This applies to general mental health support, and more significantly for those seeking specialized care such as psychiatrists (able to prescribe and manage medication). There are also provider diversity gaps for Black Indigenous People of Color (BIPOC) and LGBTIQ+.

While SFHSS health plans are actively working to increase access to providers who can address the needs of the Severely Mentally Ill (SMI), they are also working to provide additional tools and resources for Any Mentally Ill (AMI) where self-guided apps and other digital tools are appropriate. In addition to these short-term challenges, SFHSS is supportive of reforms at local, state, and national levels to identify and address long-term interventions whose implementation should begin now.

9. How do long wait times for behavioral healthcare potentially affect other behavioral health providers including the San Francisco Department of Public Health and DPH contracted providers?

The San Francisco Department of Public Health is not aware of any impact on their resources from the private sector.

10. What steps has each health plan taken to ensure compliance with SB 855, and what steps will each health plan take to comply with SB 221 if enacted.

SFHSS and its health plan partners are aware of SB 855 and SB 221. SFHSS health plan partners are legally obligated to comply with SB 855 as of its effective date of January 1, 2021. SFHSS, in partnership with its health plans, is actively monitoring the status of SB 221 and will seek to ensure its full compliance when it goes into effect.