BHS Policies and Procedures

City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

1380 Howard Street, 5th Floor
San Francisco, CA 94103
628-754-9500
FAX 628-754-9585

POLICY/PROCEDURE REGARDING: **Grievance and Appeal System for Behavioral Health Services**

DocuSigned by:
imo momoh
360E6E598F1D468...

Issued By: Imo Momoh
Director of Managed Care

Effective Date: April 26, 2024

Manual Number: 3.11-01

References: BHIN No: 25-014; BHIN No: 22-036; BHIN No: 21-023; BHIN No: 23-062; Title 42, CFR, Part 431, Subpart E; Title 42, CFR, Part 438, Subparts A and F; Business and Professions Code §§ 4980.01, 4980.32, 4989.17. 4996.14, 4996.15, 4996.75, 4999.22 and 4999.71.

Technical Revision. Last reviewed February 11, 2026.

Equity Statement: Behavioral Health Services (BHS) is committed to prioritizing intersectionality, including race, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to become an anti-racist and trauma informed organization. We are committed to ensuring that every policy and procedure leads with an equity lens. We are dedicated to ensuring that our providers are equipped to respond to our members' diverse needs and lived experiences.

Purpose: The purpose of this policy is to define the grievance and appeal system for clients, henceforth referred to as *members*, to describe the processes for handling grievances and appeals of adverse benefit determinations, to ensure that members are informed of these processes and that their rights are protected, to describe the mechanisms for collecting and tracking information about these processes, and to identify the respective roles and responsibilities of BHS, providers, and members through its stated procedures, informing materials, and documentation requirements. San Francisco Behavioral Health Services (BHS) recognizes that member satisfaction and access to services are essential parts of providing effective care. Members will be advised of the BHS grievance and appeal system and provided the opportunity to file a grievance or to request an appeal of an adverse benefit determination.

Definition of Terms

Member is broadly defined as any recipient of Behavioral Health Services from San Francisco Department of Public Health.

Grievance is defined as an expression of dissatisfaction about any matter other than *adverse benefit determinations*. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the member's rights regardless of whether remedial action is requested, and the member's right to dispute an extension of time proposed by BHS to make an authorization decision. There is no distinction between informal and formal grievance.

Discrimination Grievance means a complaint by a member about their behavioral health services concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Appeal means the request by or on behalf of a Medi-Cal member for a review by BHS of an adverse benefit determination.

Expedited Appeal means an expedited review process for appeals when BHS determines that taking the time for a standard resolution could seriously jeopardize the Medi-Cal member's mental health or substance use disorder condition and/or the member's ability to attain, maintain, or regain maximum function.

Adverse Benefit Determination is defined to mean any of the following actions taken by BHS in regard to a Medi-Cal member's specialty mental health or drug Medi-Cal services:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
(2) The reduction, suspension, or termination of a previously authorized service;
(3) The denial, in whole or in part, of payment for a service;
(4) The failure to provide services in a timely manner;
(5) The failure of BHS to act within the required timeframes for standard resolution of grievances and appeals; or
(6) The denial of a member's request to dispute a financial liability.

Scope: This policy applies to all mental health and substance use services provided through San Francisco Behavioral Health Services.

Policy: San Francisco Behavioral Health Services supports the resolution of issues at the program where services are being received. Every effort should be made by providers to resolve member concerns as quickly and as simply as possible; however, it is the policy of BHS that members may use the BHS grievance and appeal system whether or not they have already attempted to resolve their issue. Invoking the BHS grievance and appeal system is always at the member's discretion. Members shall not be discouraged or subject to discrimination or any other penalty for filing a grievance, or for requesting an appeal or expedited appeal nor their providers who request or support members in this process. This policy is implemented consistent with laws and regulations

regarding member confidentiality, and its procedures shall maintain the confidentiality of each member's information.

When a program has its own problem resolution protocols, members must still be informed about the BHS grievance and appeal system. Members cannot be required to go through a program's protocol before they are allowed to use the BHS grievance and appeal system and can choose the BHS grievance and appeal system at any time. Program specific protocols must be consistent with this policy. BHS programs shall respond promptly to requests for information by the BHS Grievance/Appeal Office.

Use of the BHS grievance and appeal system does not replace any existing avenues of review or redress provided by law. Members have full access to these avenues and to all rights guaranteed under the law. BHS grievance and appeal system is not a substitute for, nor does it preclude assistance through other entities, such as the Mayor's Office on Disability, San Francisco Mental Health Clients' Rights Advocates, or legal counsel. There are some issues that are not within the scope of this policy and will be redirected accordingly, including, but not limited to:

- Issues regarding children and youth receiving behavioral health services as part of their Individual Education Program (IEP) will be referred to the Coordinator of Educational Related Mental Health Services (formally *AB3632*).
- Issues regarding disability accommodation and access will be addressed by the BHS ADA Coordinator per BHS policy 3.04-03.
- Issues relating to involuntary detention and conservatorships are handled through existing legal remedies rather than the BHS grievance and appeal system.
- For information and advocacy regarding mental health rights, members may contact San Francisco Mental Health Clients' Rights Advocates at 415-552-8100 or 1-800-729-7727, or via email at admin@sfmhcra.org regarding their mental health services. The BHS grievance and appeal system shall not replace or conflict with the duties of San Francisco County clients' rights advocates.
- Grievances and appeals filed by or on behalf of Healthy Worker members will be re-directed to the San Francisco Health Plan for review at https://www.sfhp.org/about-us/healthy-workers-non-discrimination-notice/

A member may ask for assistance in resolving issues regarding the provision of behavioral health services. With the member's written consent, other persons, such as a provider, family member or friend, may serve as the member's authorized representative. An authorized representative acting on behalf of the member may file a grievance, request an appeal or expedited appeal, or request a state hearing. Providers cannot request continuation of benefits, as specified in 42 CFR §438.420(b)(5). Assistance includes, but is not limited to, notifying members of the location of related documents on the website, completing the *Grievance and Appeal Form*, assisting the member in requesting continuation of benefits during an appeal of an adverse benefit determination, and arranging for auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with TTY/TDD: 711 and interpreter capability. If using an authorized representative, confidentiality must be protected. In order to permit BHS to discuss

the issue with the authorized representative, the member must sign an *Authorization for Use or Disclosure of Protected Health Information* form, which is available at all program sites.

Posting, Informing, and Documenting Requirements

Posting and Informing

BHS programs shall post the *Grievance Process* and the *Appeal Process* posters in appropriate languages and in a highly visible location (e.g., waiting room). BHS programs are required to have the form used for filing a grievance/requesting an appeal *(BHS 316)* and the postage-paid, self-addressed envelope for mailing readily available for members to pick up without having to make a verbal or written request to anyone.

All members of BHS are to receive written and oral information concerning the BHS grievance and appeal system. Informing members means explaining the process to them in their primary language and giving them the informational handout *(BHS 315)*, the form used for filing a grievance/requesting an appeal *(BHS 316)*, the BBS Notice to Clients (BHS 317), and a postage-paid, self-addressed envelope. A copy of this policy is to be made available at all BHS programs for review by members upon request.

Staff shall inform members about the BHS grievance and appeal system:

- at the initial face-to-face evaluation;
- at admission to the Private Provider Network or to any organizational provider program;
- during treatment reauthorization; or
- the occurrence of any action taken by BHS defined as an adverse benefit determination.

In compliance with the Business and Professions Code relating to the healing arts, all members will be given the BBS Notice to Clients (BHS 317) as one of the required handouts provided during the initial intake process. The informational handout (BHS 315), the form used for filing a grievance/requesting an appeal (BHS 316), the postage-paid, self-addressed envelope, and posters are available from Forms Control, 1380 Howard Street, 2nd Floor, San Francisco, CA 94103 at 628-754-9288 or cbhsforms@sfdph.org. The informational handout (BHS 315), the form used for filing a grievance/requesting an appeal (BHS 316), and the BBS Notice to Clients (BHS 317) in the threshold languages are also available on the SFGOV website at: https://www.sf.gov/resource/2024/grievance-and-appeal-documents-members-behavioral-health-services-bhs

The forms and posters are available in Chinese, English, Spanish, Vietnamese, Russian, and Tagalog and in large type to accommodate persons with visual problems. Requests for other means of communication or translations in additional languages should be submitted for review and

consideration to the BHS Office of Justice, Equity, Diversity & Inclusion (JEDI), 1380 Howard Street, 5th Floor, San Francisco, CA 94103, or emailing BHS-Lang-Support@sfdph.org.

Documenting

Staff will document that members have been informed about the BHS grievance and appeal system at the initial face-to-face evaluation, and at admission to the Private Provider Network and to any organizational provider program. Documentation will be indicated on the *Acknowledgement of Receipt of Materials.* Staff will document that members have been provided the BBS Notice to Clients (BHS 317) during the initial intake process. Staff will review the BHS grievance and appeal system with members when services are being authorized and whenever an adverse benefit determination occurs. These activities will be documented in the *Progress Notes*.

Filing a Grievance

The member, the minor member's parent/legal guardian, or an authorized representative may file grievances at any time. Individuals may present their grievances orally or in writing, and may be submitted in person, by phone, email, or via US Mail using the *Grievance and Appeal Form (BHS 316).* Assistance may be obtained from the Behavioral Health Access Center (BHAC), San Francisco Mental Health Clients' Rights Advocates, or authorized representative. Orally filed grievances can be entered on the form *(BHS 316)* by the individual aiding. Individuals filing a grievance shall be given a copy of their completed *Grievance and Appeal Form* upon request. Grievances may be submitted:

In person or by phone-	Officer of the Day Behavioral Health Access Center 1380 Howard Street, 1st Floor San Francisco, CA 94103 888-246-3333 TDD/TTY: 711
Via US Mail, email, or by phone-	Grievance/Appeal Office Quality Management 1380 Howard Street, 2nd Floor San Francisco, CA 94103 628-754-9299 **-OR-** postage-paid, self-addressed envelope **-OR-** BHS.GrievanceAppeal@sfdph.org

Responding to Grievances

When a BHS grievance is received by the Grievance/Appeal Office, the information is recorded in the grievance/appeal log within 1 working day of the date of receipt of the grievance.

A written acknowledgement of receipt of the grievance will be issued by the Grievance/Appeal Officer to the grievant and must be postmarked within 5 calendar days of the receipt of the grievance. (Grievances received over the phone or in-person that are resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and decision letter.) The grievance will then be assigned to an investigator. The acknowledgment letter shall include the date of receipt, and the name, phone number, and work address of the investigator who the member may contact about the grievance. In conjunction with the written acknowledgment, a copy of the *Nondiscrimination Notice* and the *Notice of Availability (*formerly known as *Language Assistance* taglines) will be provided. A grievance investigation should involve contact with the grievant whenever possible.

The Grievance/Appeal Officer or investigator has the responsibility to provide information upon request by the grievant or one's authorized representative regarding the status of the grievance.

The investigator must not have been involved in any previous level of review or decision-making related to the grievance being processed, and was not a subordinate of any individual who was involved in a previous level of review or decision-making. If the grievance is about a clinical issue or a grievance regarding denial of a request for an expedited appeal, the investigator must have the appropriate clinical expertise in treating the condition of the member filing the grievance.

Each grievance shall be resolved as expeditiously as the member's health condition requires and shall not exceed **30** calendar days from the date the grievance is received by the Grievance/Appeal Office.

The investigator shall provide a written decision, including date completed, notifying the grievant and/or authorized representative of the resolution of the grievance by using the California Department of Health Care Services (DHCS) required *Notice of Grievance Resolution* (NGR). Responses are to be written in a format and language that meets applicable notification standards, and which contain a clear and concise explanation of the decision. In conjunction with the NGR, a copy of the *Nondiscrimination Notice* and the *Notice of Availability (*formerly known as *Language Assistance* taglines) will be provided. Notification, or efforts to notify the grievant and/or authorized representative if unable to be contacted, shall be clearly documented. One copy shall be given or mailed to the grievant and/or authorized representative. One copy, with all the supporting documents, shall be provided to the Grievance/Appeal Officer, Quality Management, 1380 Howard Street, 2nd Floor, San Francisco, CA 94103. The investigator is responsible for conveying the content of the grievances and their resolution to the provider(s) cited by the grievant or otherwise involved in the grievance.

In the event BHS fails to act within the established timeline for the resolution of a grievance, the investigator shall provide the grievant with a *Notice of Adverse Benefit Determination – Grievance/Appeal Resolution.*

Discrimination Grievances

The Grievance/Appeal Officer is designated by BHS as the Discrimination Grievance Coordinator who, in collaboration with the BHS ADA Coordinator as needed, is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating discrimination grievances related to any action that would be prohibited by, or out of compliance with federal or state nondiscrimination law.

BHS will follow the grievance resolution process described above for regular grievances to ensure the prompt and equitable resolution of discrimination-related complaints. BHS will not require a member to file a discrimination grievance with San Francisco Behavioral Health Services before filing the complaint directly with the DHCS Office of Civil Rights and the US Department of Health and Human Services' Office for Civil Rights.

Requesting Standard Appeals or Expedited Appeals

Appeals can only be requested by or on behalf of Medi-Cal members regarding their Medi-Cal reimbursed behavioral health services (i.e., specialty mental health services or Drug Medi-Cal).

The Medi-Cal member, the minor Medi-Cal member's parent/legal guardian, or an authorized representative may request an appeal.

Appeals may be requested only for the review of an adverse benefit determination as defined above.

An appeal must be requested within **60** calendar days from the date on the *Notice of Adverse Benefit Determination* (NOABD). There are no deadlines for filing an appeal when a NOABD is not issued.

Known as Aid Paid Pending (APP), members have the right to keep receiving approved services during the appeal process if the appeal involves the termination, suspension, or reduction of a previously authorized service, the member's services were ordered by an authorized provider, and the period covered by the original authorization has not expired. Requests for continuation of services while the appeal is pending must be made on or before the latter of the following: within 10 days of sending the NOABD or the intended effective date of the adverse benefit determination. If the final resolution of the appeal (or State Hearing) upholds the adverse benefit determination, BHS shall not recover the cost of continued services provided to the member while the appeal or State Hearing was pending and notification that the member shall not be held liable for this cost. BHS will continue to provide services while the appeal or State Hearing is pending until the member withdraws the appeal or request for State Hearing, the member does not request a State Hearing and continuation of benefits within 10 calendar days from the date the NAR is sent, or a State Hearing decision adverse to the member is issued.

Medi-Cal members must exhaust BHS's appeal processes and receive notice that the adverse benefit determination has been upheld before requesting a State hearing. Medi-Cal members have the right to request a State hearing if BHS fails to send a resolution notice in response to the appeal within the required timeframe.

Individuals may present their appeals orally, or in writing, and may be submitted in person, by phone, email, or via US Mail using the *Grievance and Appeal Form (BHS 316).* Assistance may be obtained from the Behavioral Health Access Center (BHAC), San Francisco Mental Health Clients' Rights Advocates, or authorized representative. Orally filed appeals can be entered on the form *(BHS 316)* by the individual aiding. Medi-Cal members requesting an appeal shall be given a copy of their completed *Grievance and Appeal Form* upon request. Appeals may be submitted:

In person or by phone-	Officer of the Day Behavioral Health Access Center 1380 Howard Street, 1st Floor San Francisco, CA 94103 888-246-3333 TDD/TTY: 711
Via US Mail, email, or by phone-	Grievance/Appeal Office Quality Management 1380 Howard Street, 2nd Floor San Francisco, CA 94103 628-754-9299 **-OR-** postage-paid, self-addressed envelope **-OR-** BHS.GrievanceAppeal@sfdph.org

Responding to Standard Appeals and Expedited Appeals

BHS provides one level of appeal for Medi-Cal members. When the request for an appeal is received by the Grievance/Appeal Office, the information is recorded in the grievance/appeal log within 1 working day of the date of receipt of the appeal. In the case of expedited appeals, the specific time of receipt is also noted.

A written acknowledgement of receipt of the appeal will be issued by the Grievance/Appeal Officer to the appellant and must be postmarked within 5 calendar days of the receipt of the appeal. The appeal will then be assigned to an investigator. The acknowledgment letter shall include the date of receipt, and the name, phone number, and work address of the investigator who the appellant may contact about the appeal. In conjunction with the written acknowledgment, a copy of the *Nondiscrimination Notice* and the *Notice of Availability (*formerly known as *Language Assistance* taglines) will be provided. An appeal investigation should involve contact with the appellant whenever possible.

The Grievance/Appeal Officer or investigator has the responsibility to provide information upon request by the appellant or authorized representative regarding the status of the appeal. The appellant and/or authorized representative may have a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person or in writing. The appellant must be informed of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and expedited appeals.

The appellant and/or authorized representative may examine the appellant's case file, including medical records, and any other documents and records, and any new or additional evidence considered, relied upon, or generated by BHS in connection with the appeal of the adverse benefit determination, provided there is no disclosure of the protected health information of any individual other than the appellant. BHS shall provide this information free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. The appellant and/or authorized representative, or the legal representative of a deceased Medi-Cal member's estate, are to be included as parties to the appeal.

The investigator or decision-maker of an appeal or expedited appeal must not have been involved in any previous level of review or decision-making related to the appeal being processed, and was not a subordinate of any individual who was involved in a previous level of review or decision-making. If the appeal is about a clinical issue, or denial of an expedited appeal, or involves an appeal based on a denial of medical necessity, the investigator must have the appropriate clinical expertise in treating the condition of the Medi-Cal member requesting the appeal. The investigator shall consider all comments, documents, records, and other information submitted by the appellant or authorized representative, regardless of whether such information was submitted or considered in the initial adverse benefit determination.

The investigator shall provide a written decision, including date completed, notifying the appellant and/or authorized representative of the resolution of the appeal by using the appropriate DHCS required *Notice of Appeal Resolution* (NAR), and a copy of the *NAR Your Rights* attachment if the decision is upheld. In conjunction with the NAR and the *NAR Your Rights* attachment, a copy of the *Nondiscrimination Notice* and the *Notice of Availability (*formerly known as *Language Assistance* taglines) will be provided. In the case of expedited appeals, the investigator will also make reasonable efforts to provide oral notice. Responses are to be written in a format and language that meets applicable notification standards, and which contain all DHCS required elements. Notification, or efforts to notify the appellant and/or authorized representative if unable to be contacted, shall be clearly documented. The written decision shall be given or mailed to the appellant and/or authorized representative. A copy of the written decision, with all the supporting documents, shall be provided to the Grievance/Appeal Officer, Quality Management, 1380 Howard Street, 2nd Floor, San Francisco, CA 94103. The investigator is responsible for conveying the content of the appeal and their resolution to the provider(s) cited by the appellant or otherwise involved in the appeal, and to document this activity.

In the event BHS fails to act within the established timelines for the resolution of a standard appeal or an expedited appeal, the investigator shall provide the appellant with a *Notice of Adverse Benefit Determination – Grievance/Appeal Resolution*.

Standard Appeals:

A Medi-Cal member may request an appeal orally or in writing with BHS.

The date of the oral appeal is the filing date for the purpose of applying the appeal timeframes.

BHS notifies the appellant and/or authorized representative in writing the results of the appeal and the date that the appeal decision was made. Appeals must be resolved within **30** calendar days of BHS's receipt of the appeal.

If the decision is wholly in favor of the appellant (*NAR-ABD Overturned*), then it is the end of the appeal process. BHS will provide or arrange and pay for the disputed services if the decision of the appeal resolution process reverses a decision to deny, limit or delay services as expeditiously as the appellant's health condition requires, but no later than 72 hours from the date of the decision reversing the determination. If, however, the decision is not wholly in favor of the appellant, then written notice (*NAR-ABD Upheld*) shall also contain information regarding the right to a State hearing and the procedure for filing for a State hearing, the right to continue to receive services while the hearing is pending and the procedure for making this request, and notification that the appellant will not be held liable for the cost of those benefits if the State hearing upholds the BHS adverse benefit determination.

Expedited Appeals:

A Medi-Cal member may file an expedited appeal orally or in writing with BHS only to review an adverse benefit determination when using the standard appeal process as determined by SF BHS could seriously jeopardize the Medi-Cal member's mental health or substance use disorder condition and/or the Medi-Cal member's ability to attain, maintain, or regain maximum functions.

If BHS denies the expedited appeal process, the request is transferred to the standard appeal process. BHS must make reasonable efforts to give prompt oral notice to the appellant and authorized representative and provide written notice within 2 calendar days of the date of the denial. When the appeal does meet the criteria for an expedited appeal, the appellant may present evidence in person or in writing. The appellant may file a grievance if one disagrees with BHS's decision that the appeal does not meet the criteria for an expedited appeal.

Expedited appeals must be resolved, and the affected parties must be notified in writing no later than **72 hours** after BHS receives the expedited appeal. BHS will make reasonable efforts to provide prompt oral notice to the appellant and/or authorized representative.

If the decision is wholly in favor of the appellant (*NAR-ABD Overturned*), then it is the end of the expedited appeal process. BHS will provide or arrange and pay for the disputed services if the decision of the appeal resolution process reverses a decision to deny, limit or delay services as expeditiously as the appellant's health condition requires, but no later than 72 hours from the date of the decision reversing the determination. If, however, the decision is not wholly in favor of the appellant, then written notice (*NAR-ABD Upheld*) shall also contain information regarding the right to a State hearing and the procedure for filing for a State hearing, the right to continue to receive services while the hearing is pending and the procedure for making this request, and notification that the appellant will not be held liable for the cost of those benefits if the State hearing upholds the BHS adverse benefit determination.

Retention of Records and Record Keeping

A copy of all grievances, appeals, and expedited appeals shall be retained in locked administrative files for 10 years from the date the original grievance or appeal was received unless there are program specific requirements that demand a longer retention period.

As required by DHCS, the Grievance/Appeal Officer maintains a log of grievances and appeals which are to be entered within 1 working day of the date of receipt of the grievance or appeal. This information is to be maintained accurately and, in a manner, accessible to DHCS and available upon request to Centers for Medicare & Medicaid Services (CMS). This log contains at least the following information on each grievance or appeal:

- name of the member
- date and time of receipt of the grievance or appeal
- name of the individual recording the grievance or appeal
- name of the investigator reviewing the grievance or appeal
- a general description of the reason for the grievance or appeal
- date of each review or review meeting
- resolution at each level, if applicable
- date of resolution at each level
- final disposition of the grievance or appeal
- date the decision is sent to the member/authorized representative (or document reason why there is not a final disposition).

Reporting Requirements

The Grievance/Appeal Officer will ensure compliance with the following requirements of **Drug Medi-Cal (DMC):**

- Grievances and appeals received by BHS regarding a DMC certified Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by using the Complaint Form, which is available and may be submitted online: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx
- Grievances or appeals pertaining to suspected Medi-Cal fraud, waste, or abuse will be reported to (800) 822-6222 or Fraud@dhcs.ca.gov.
- Upon completion of the investigation of a grievance or appeal pertaining to a DMC certified facility, the results or decision shall be submitted within 2 working days by secure, encrypted email to MCBHOMDMonitoring@dhcs.ca.gov.
- Complete and submit the required annual report (MCPAR) to DHCS that summarizes grievances, appeals and expedited appeals filed from July 1 of the previous year through June 30 of that year by the first business day in September of each year by email to MCBHOMDMonitoring@dhcs.ca.gov. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by DHCS, and by disposition.
- Within 10 calendar days of mailing a discrimination grievance resolution letter to the member, the following information will be submitted to the DHCS Office of Civil Rights' designated email at DHCS.DiscriminationGrievances@dhcs.ca.gov:
    - the original complaint
    - the provider's or other accused party's response to the grievance
    - contact information for the Grievance/Appeal Officer
    - contact information for the member filing the grievance and for the provider or other accused party that is the subject of the grievance
    - all correspondence with the member regarding the grievance including, but not limited to, the acknowledgement and resolution letters
    - the results of the investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination

The Grievance/Appeal Officer will ensure compliance with the following requirement of **DHCS Specialty Mental Health Services (SMHS):**

- Complete and submit the required annual report (MCPAR) to DHCS that summarizes grievances, appeals and expedited appeals filed from July 1 of the previous year through June 30 of that year by the first business day in September of each year by email to MCBHOMDMonitoring@dhcs.ca.gov. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by DHCS, and by disposition.
- Within 10 calendar days of mailing a discrimination grievance resolution letter to the member, the following information will be submitted to the DHCS Office of Civil Rights' designated email at DHCS.DiscriminationGrievances@dhcs.ca.gov:
    - the original complaint
    - the provider's or other accused party's response to the grievance
    - contact information for the Grievance/Appeal Officer

- contact information for the member filing the grievance and for the provider or other accused party that is the subject of the grievance
- all correspondence with the member regarding the grievance including, but not limited to, the acknowledgement and resolution letters
- the results of the investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination

The Grievance/Appeal Officer will ensure compliance with the following requirement of DHCS Network Adequacy standards:

- Annual report of grievances and appeals related to availability of services and/or problems in obtaining services in a timely fashion, as well as the resolutions of such grievances and appeals covering the reporting period of July 1st through March 31st.

The Grievance/Appeal Officer will ensure compliance with CalAIM Section 1915(b) Waiver by completing and submitting the quarterly appeals and grievance report to DHCS no later than 10 business days after the end of each quarter for both the MHP and DMC-ODS.

Quality Improvement

BHS will ensure all BHS providers follow DHCS regulations regarding the BHS grievance and appeal system. BHS Quality Management and Regulatory Affairs will monitor these processes.

BHS Quality Management and Regulatory Affairs will track the timeliness of responses to member grievances and appeals, the number of cases submitted, types of issues, number and reasons of unresolved grievances or appeals, and number of resolved grievances and appeals.

The Grievance/Appeal Officer will inform the Risk Management Committee at least quarterly of any significant system or programmatic issues subsequent to a grievance or appeal investigation, or State hearing. The Grievance/Appeal Officer will make an annual report on grievances, appeals, and expedited appeals to the Risk Management Committee and to the System of Care Quality Improvement Committee that is charged with making policy recommendations and developing quality improvement activities to ensure that BHS members are receiving appropriate care. Issues identified as a result of the BHS grievance and appeal system will be transmitted to the System of Care Quality Improvement Committee who shall take appropriate action to remedy identified problems and require corrective action as indicated. These issues will be discussed by the System of Care Quality Improvement Committee and, if needed, will be brought to BHS administration or another appropriate body within the BHS organization.

Contact Person:
Grievance/Appeal Office, BHS Quality Management and Regulatory Affairs, 628-754-9299

Attachments (include English only):
Grievance and Appeal Form - BHS 316
Informational Handout - BHS 315 (double-sided description of grievance and appeal processes) BBS Notice to Clients – BHS 317

Distribution:
BHS Policies and Procedures are distributed by BHS Quality Management and Regulatory Affairs.

Administrative Manual Holders
BHS Programs
SOC Program Managers
BOCC Program Managers
CDTA Program Managers

San Francisco Health Network
Behavioral Health Services

Grievance and Appeal Form

Member Name _____ **Date of Birth** _____

Address _____ **Phone**_____ **Best way to contact**_____

Type of Request (check one): ☐ Grievance ☐ Appeal ☐ Expedited Appeal *(see informational handout for definition of each type)*

My problem or concern is about the following program or provider: _____

Describe the problem or concern: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What I would like to have happen: _____

_____

_____

_____

I understand that I will not be subject to discrimination as a result of filing a grievance or requesting an appeal or State Hearing.
Signature of member or legal guardian _____ Date _____
I authorize the following person to act on my behalf *(optional)* _____
Signature of authorized person if not signed by the member or legal guardian _____ Date _____

Mail the completed form in the postage-paid envelope **or** mail to the BHS Grievance/Appeal Office, 1380 Howard Street, 2nd Floor, San Francisco, CA 94103 **or** email to BHS.GrievanceAppeal@sfdph.org

BHS 316/English 3/24

APPEAL PROCESS

For Medi-Cal Members Receiving San Francisco Behavioral Health Services

Appeals can be requested only to review ***adverse benefit determinations.*** *Adverse benefit determinations* are delays in resolving grievances or appeals, disputes of financial liability, or when your mental health or substance use disorder services have been denied, limited, stopped, or not provided in a timely manner. A ***Notice of Adverse Benefit Determination*** will inform you of your right to request an appeal if you do not agree with San Francisco Behavioral Health Services' (BHS) decision.

What you need to know about the appeal process:

- You have **60 days** from the date of the notice to file an appeal.
- If you are currently receiving behavioral health services and want to keep receiving services while the appeal is pending, you must file an appeal within **10 days** from the date of the notice OR before the date BHS says services will change AND say that you want to keep receiving services. BHS will promptly provide for the disputed services if the decision of the appeal process reverses the decision to deny, limit or delay services. You are not required to pay for these services if BHS upholds the *adverse benefit determination*.
- The **e*xpedited appeal*** process is used if BHS agrees that using the ***standard appeal*** process could seriously jeopardize you or your ability to function. If the appeal does not meet the criteria for an *expedited* process, the appeal will revert to the *standard* process, and you will be promptly informed. You may file a grievance if you do not agree with this decision.
- You or your authorized representative or provider may request an appeal by letter or using the *Grievance and Appeal Form* available at all program sites and on **SF.GOV** → SCAN ME
- With your written consent, your authorized representative or provider can assist you in the appeal process, including help completing the *Grievance and Appeal Form*, or arranging for needed support services, such as language assistance.
- You may request an appeal by mail, email, in person, or by phone. To request an appeal:

In person or by phone:	Via US Mail, email, or by phone:
Officer of the Day Behavioral Health Access Center 1380 Howard Street, 1st Floor San Francisco, CA 94103 888-246-3333 TDD/TTY: 711	Grievance/Appeal Office 1380 Howard Street, 2nd Floor San Francisco, CA 94103 628-754-9299 **OR** postage-paid envelope **OR** BHS.GrievanceAppeal@sfdph.org

- You will receive a written acknowledgement within 5 calendar days of receipt of your appeal. The investigator will review all information, will not have any prior involvement in your appeal, and will have the appropriate training if your appeal involves clinical matters.
- Before any decision is made about your appeal, you have the right to provide information, to request a copy of your case file free of charge, and to be informed on the status of your appeal.
- A written decision will be sent to you within **30 calendar days** of receipt of the *standard* appeal and within **72 hours** of receipt of the *expedited* appeal with reasonable effort to provide you oral notice.
- If you do not agree with the appeal decision or did not receive the decision within the specified timeframe, you may request a State Hearing within 120 days of the decision due date by calling toll free 1-800-952-5253 or TTY/TDD 1-800-952-8349.

GRIEVANCE PROCESS

For All Members Receiving San Francisco Behavioral Health Services

A **grievance** is any expression of dissatisfaction about any matter regarding your behavioral health services except an *adverse benefit determination (*see *Appeal Process)*. Grievances include, but are not limited to, unprofessional behavior of your provider, failure to respect your rights, or concerns about the quality of services provided, including treatment issues, medication, or cultural appropriateness.

If you want help concerning a problem with your mental health or substance use treatment services, you have the right to file a grievance at any time by using the grievance process provided by San Francisco Behavioral Health Services (BHS). You will not be discriminated against in any way for filing a grievance. You may also call the State Ombudsman Office at 1-888-452-8609.

Here is how you file a grievance:

- You or your authorized representative may file a grievance, preferably by using the *Grievance and Appeal Form,* which is available at all program sites and on **SF.GOV** → SCAN ME
- Authorized representatives are persons, such as a relative, friend, advocate, or your provider, who can assist you in the grievance process with your written consent. Assistance can include help completing the *Grievance and Appeal Form*, or arranging for needed support services, such as language assistance.
- You may file a grievance in person, by phone, email, or via US Mail to:

In person or by phone:	Via US Mail, email, or by phone:
Officer of the Day	Grievance/Appeal Office
Behavioral Health Access Center	1380 Howard Street, 2nd Floor
1380 Howard Street, 1st Floor	San Francisco, CA 94103
San Francisco, CA 94103	628-754-9299
888-246-3333	**OR**
TDD/TTY: 711	postage-paid envelope
	OR
	BHS.GrievanceAppeal@sfdph.org

- You will receive a written acknowledgement within 5 calendar days of receipt of your grievance. The investigator will make every attempt to contact you. The investigator will review all information, will not have any prior involvement in your grievance, and will have appropriate training if your grievance concerns clinical matters.
- The Grievance/Appeal Office will provide information on the status of your grievance at any time during the process upon request by you or your authorized representative.
- A written decision will be sent to you or your authorized representative within **30 calendar days** of receiving your grievance.
- If you are dissatisfied with the decision of your grievance, you may file another grievance with BHS.

San Francisco
Department of Public Health
Behavioral Health Services

REQUIREMENT TO PROVIDE NOTICE TO CLIENTS

All clients receiving behavioral health services can file a complaint according to the informational handout provided to you (BHS 315). This process includes complaints about services provided by an unlicensed or unregistered professional. The following notice is provided as required by law:

NOTICE TO CLIENTS
The Grievance & Appeal Office of Behavioral Health Services receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at any of our sites, including here. To file a complaint, contact the Grievance & Appeal Office by calling 1-628-754-9299.

In addition, you may be provided behavioral health services by a licensed or registered professional with the Board of Behavioral Sciences. Please be advised that the following notice may apply to you and is provided as required by law:

NOTICE TO CLIENTS
The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of **marriage and family therapists, licensed educational psychologists, clinical social workers, and professional clinical counselors**. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

To be completed by the BBS licensee or registrant-

Full Name as filed with BBS: _____

License/Registration Number: _____

Type of License/Registration: _____

Expiration Date: _____

If registrant, include name and license type of supervisor below-

Supervisor's Name: _____

License Type: _____