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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: **BHS Services for Healthy Workers**	
Issued By: DocuSigned by: imo momoh 360E6E598F1D468... Imo Momoh Director of Managed Cared, Behavioral Health Services Effective Date: September 19, 2024	Manual Number: 3.03-14 References: SB 855

Technical Revision. Replaces Policy 3.03-14 of May 11, 2022.

Equity Statement: The San Francisco Department of Public Health, Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum of becoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, members, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, leads with an equity and anti-racist lens. Our policies will provide the highest quality of care for our diverse members. We are dedicated to ensuring that our providers are equipped to provide services that are responsive to our members' needs and lived experiences.

Purpose

The following are the Behavioral Health Services (BHS) services available to San Francisco Health Plan (SFHP) Healthy Workers members.

Scope

As of March 1, 1999, membership in BHS's San Francisco Mental Health Plan became automatic for SFHP Healthy Workers members. These are In-Home-Support-Services (IHSS) workers ages 16 and older, employed by the City and County of San Francisco, who were previously uninsured. Under a plan offered by the City and County, those individuals who work more than 25 hours a month for at least two months, and live or work in San Francisco, become eligible for health insurance through the SFHP. *This means that some covered members may not reside in San Francisco, but they will be eligible for BHS services.* Basic benefits provided by SFHP include health (including mental health and substance use disorder) and vision coverage. Individuals pay a low monthly premium, and there are also co-payments for behavioral health treatment services provided by Beacon. Through a contract with SFHP, BHS offers Mental Health and Substance Use Disorder services to these individuals.

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Behavioral Health Benefits and Services

All services offered by BHS' Mental Health Plan are available to Healthy Workers members when clinically appropriate as determined by the latest version of Diagnostic and Statistical Manual of Mental Disorders (DSM) and the criteria from the nonprofit specialty associations. Services or products to treat mental health or substance use disorders are considered medically necessary when they address the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

1. In accordance with the generally accepted standards of mental health and substance use disorder care.
2. Clinically appropriate in terms of type, frequency, extent, site, and duration.
3. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

Additionally, Healthy Workers members have a benefit to address substance use disorders. This benefit is offered to members when medically necessary as determined by the American Society of Addiction Medicine (ASAM) Criteria and DMS diagnosis. Healthy Workers who require substance use disorder counseling should be referred to the Behavioral Health Access Center (BHAC).

Healthy Workers members have a benefit for acute inpatient detoxification that is covered by their medical provider, the Community Health Network (CHN). Members who need to access this benefit must be referred through their primary care provider.

Medications are covered through the San Francisco Health Plan. Formulary information can be found on the sfhp.org webpage.

Laboratory tests ordered by a mental health professional will be covered by BHS.

The San Francisco Health Plan has contracted with the Department of Public Health's CHN, including San Francisco Zuckerberg General Hospital, to be the preferred health care provider for Healthy Workers members. Likewise, BHS has contracted with the CHN's Department of Psychiatry to be the preferred provider of psychiatric inpatient and outpatient services to Healthy Workers members. This means that Healthy Workers members will be referred to the Department of Psychiatry if they offer the appropriate service in the preferred language.

Referral Procedures

Healthy Workers members are instructed to either walk into the Behavioral Health Access Center (BHAC) or call the Behavioral Health Access Line (BHAL), a 24/7 access line, at (888) 246-3333 to receive a referral for services.

However, newly enrolled Healthy Workers members may already be in treatment in our system of care, or they may choose to walk-in at any one of our clinics.

The procedures that follow govern the way BHAC, other access points, and system of care clinics (both civil service and contract) handle Healthy Workers members.

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Identifying Healthy Workers Members

Providers need to be able to identify Healthy Workers members so that they can assure Healthy Workers have access to their benefits and BHS can bill correctly for services delivered. There are 2 ways to identify Healthy Workers members:

1. A new member may self-identify as a Healthy Workers/San Francisco Health Plan member. They will have an identification card.
2. BHS offers verification of coverage through phone at (628) 217-7750, email at BHS-Eligibility@sfdph.org, or in Epic via inbound basket message to BHS Eligibility Pool.

Serving Healthy Workers

To assure proper billing and reimbursement for services delivered to Healthy Workers, the following steps are taken:

1. If a current member enrolls in Healthy Workers, update their Episode Guarantor Information (EGI) and/or coverage information in the Electronic Health Record with their healthcare coverage information.
2. Healthy Worker Plan enrollees have a $0 per visit co-pay for outpatient mental health treatment services.
3. In the event a clinic does not offer the necessary service, refer to the BHAC point person for Healthy Workers, who will assure triage to appropriate treatment.
4. All treatment authorizations follow the authorization process described below within Centralized Utilization Management for Healthy Workers using a level of care utilization system assessment for authorization.

Timely Access

BHS ensures beneficiaries of specialty mental health and substance use disorder services experience timely access to care and access to a sufficient number of high-quality, culturally competent and effective service providers.

BHS adheres to standards set by the state for large counties, in compliance with CFR 42, Part 438.68 Time and Distance and Part 438.206 Timely Access standards. Time and distance are measured from the member's place of residence to the service provider site.

Timely Access Standards for Mental Health Plan (MHP)		
Provider Type	**Timely Access for Non-Urgent Appointments**	**Time and Distance**
Psychiatry	Within 15 business days from request to appointment	Up to 15 miles or 30 minutes from the member's place of residence
Mental Health (non-psychiatry) Outpatient Service (Adult and Pediatric)	Within 10 business days from request to	Up to 15 miles or 30 minutes from the member's place of residence
Urgent Care services that do not require prior authorization	48 hours of the request for an appointment for urgent care appointments for services that do not require prior authorization	Up to 15 miles or 30 minutes from the member's place of residence

Urgent Care services that do require prior authorization	96 hours of the request for an appointment for urgent care appointments for services that do require prior authorization	Up to 15 miles or 30 minutes from the member's place of residence
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)	Up to 15 miles or 30 minutes from the member's place of residence

Timely Access Standards for Drug Medi-Cal Organized Delivery System (DMC-ODS)		
Provider Type	**Timely Access for Non-Urgent Appointments**	**Time and Distance**
Outpatient SUD services, other than opioid treatment programs (OTPs)	Within 10 business days from request to appointment	Up to 15 miles or 30 minutes from the member's place of residence
Opioid Treatment Programs (OTPs)	Within 3 business days from request to appointment	Up to 15 miles or 30 minutes from the member's place of residence
Residential Treatment	10 days from Level of Care (LOC) assessment to intake for residential treatment	Up to 15 miles or 30 minutes from the member's place of residence
Withdrawal Management (urgent services)	2 days from referral to service for withdrawal management	Up to 15 miles or 30 minutes from the member's place of residence

For Substance Use Disorder services, time, distance, and timely access standards differ between outpatient SUD services and OTPs due to the need for members in an OTP to receive their medication daily since imminent withdrawal will occur without medication.

Out of Network Access

BHS ensures members of specialty mental health and substance use disorder services timely access to care, including access to out of network mental health and substance use disorder services for the provision of medically necessary evaluation, services, and treatment when these services are not available in-network within geographic or timely access standards.

BHS permits American Indian eligible beneficiaries to obtain covered services from out-of-network Indian health care providers (IHCP). BHS permits an out-of-network IHCP to refer an American Indian member to a network provider.

BHS shall select and contact an out-of-network provider or providers who are qualified and available to provide the MH/SUD services the enrollee needs. Such provider(s) shall be located consistent with the geographic access standards in Rule 1300.67.2.1, if possible. Within three (3) business days of when BHS contacts the selected provider, BHS shall furnish a written authorization to the provider specifying, at a minimum, the following: (a) provider name; (b) service authorization number; (c) services authorized; (d)

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negotiated reimbursement rate(s); (e) date range for the authorization; (f) BHS's contact and claims submission information; and (g) BHS' provider dispute resolution information. BHS shall document and retain a record of this communication.

Appointment Type	Standard
Urgent care appointment for services that do not require prior authorization	Within 48 hours of the initial request for urgent MH/SUD services, unless Health and Safety Code section 1367.03 subdivision (a)(5)(H) or (a)(5)(I) apply.
Urgent care appointments for services that require prior authorization	Within 96 hours of the initial request for urgent MH/SUD services, unless Health and Safety Code section 1367.03 subdivision (a)(5)(H) or (a)(5)(I) apply.
Non-urgent appointments with specialist physicians (i.e., psychiatrists)	Within 15 business days of a request for specialist physician MH/SUD services, unless Health and Safety Code section 1367.03 subdivision (a)(5)(H) or (a)(5)(I) apply.
Non-urgent appointments with a non-physician mental health care provider	No more than 10 business days after the initial request for non-urgent MH/SUD services, unless Health and Safety Code section 1367.03 subdivision (a)(5)(H) or (a)(5)(I) apply.
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of the request for appointment, except as provided in Health and Safety Code section 1367.03 subdivision (a)(5)(H) and (a)(5)(I) apply.

In cases where an OON provider is not available within the time and distance standards, BHS will arrange for telehealth or transportation to an in-person visit.

BHS shall issue a written notice to the enrollee, the enrollee's authorized representative (if any), and the requesting provider (if any), within five (5) calendar days following the initial request for in-network MH/SUD services, which shall include the required statement in Rule 1300.74.72(c)(1) in a paragraph separate from other content and in no less than 12-point font on page one or two of the notice.

If the enrollee is unable to attend the appointment offered by the health plan, BHS shall continue to arrange and schedule a new appointment with the same out-of-network provider or a different out-of-network provider to ensure the delivery of medically necessary MH/SUD services.

Within 24 hours of scheduling the appointment or admission, BHS shall communicate the following information in the most expeditious manner possible to the enrollee, the enrollee's authorized representative, or the enrollee's provider:

(A) that BHS has scheduled the appointment or admission; (B) the name of the provider; (C) the date and time of the appointment or admission; and (D) the location and contact information for the provider.

BHS shall document and retain a record of all communications with the enrollee pursuant to subdivision (c), including a description of the requested MH/SUD services, the name and location of the provider(s) contacted, the date(s) the plan contacted the provider(s), the type of provider(s), the MH/SUD service(s) authorized, and the selected provider(s), location(s), and duration of the MH/SUD service(s) provided.

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The limit on the enrollee's financial obligation for out-of-network MH/SUD services pursuant to Health and Safety Code section 1374.72(d) shall be set forth in the written agreement between BHS and the out-of-network provider(s). BHS shall contact the enrollee in writing to explain the enrollee's financial obligation to the out-of-network provider(s).

If BHS fails to arrange coverage for an enrollee as set forth in Rule 1300.74.72(c), all the following shall apply:

1. The enrollee or enrollee's representative may arrange for the enrollee to obtain care from any appropriately licensed provider(s), regardless of whether the provider contracts with BHS, so long as the enrollee's first appointment with the provider or admission to the provider occurs no more than 90 calendar days after the date the enrollee, the enrollee's representative, or the enrollee's provider initially submitted a request for covered MH/SUD services to BHS. If an appointment or admission to a provider is not available within 90 calendar days of initially submitting a request, the enrollee may arrange an appointment or admission for the earliest possible date outside the 90-day window so long as the appointment or admission was confirmed within 90 days.
2. If the enrollee receives MH/SUD services pursuant to subdivision (d) of this Rule from an out-of-network provider, BHS shall reimburse all claims from the provider(s) for MH/SUD service(s) delivered to the enrollee by the provider(s), and shall ensure the enrollee pays no more than the same cost sharing that the enrollee would pay for the MH/SUD services if the services had been delivered by an in-network provider, pursuant to Health and Safety Code section 1374.72(d).

If out-of-network coverage is arranged pursuant to Rule 1300.74.72(c) or Rule 1300.74.72(d), BHS shall reimburse the provider for the entire course of medically necessary services to treat the enrollee's MH/SUD, including follow up MH/SUD services in accordance with Health and Safety Code section 1374.72(d), unless there is an in-network, timely and geographically accessible provider and all of the following criteria are satisfied: the provider can deliver the MH/SUD services to the enrollee, requiring the enrollee to transition to the in-network provider would not harm the enrollee, and transitioning providers is within the standard of care for the enrollee's MH/SUD condition at the time of the transition. BHS shall be responsible for making the determination in accordance with good professional practice and with the clinical standards set forth in Health and Safety Code sections 1374.721 and 1374.722, that the requirements of Rule 1300.74.72(e) are satisfied and shall retain a record of the determination and underlying analysis, rationale, record, and other supporting information.

Before BHS may transition the enrollee to an in-network provider, BHS shall provide the enrollee, the enrollee's representative (if any), and the provider(s) treating the enrollee with at least 90 calendar days' notice. The notice shall inform the enrollee of the name and contact information of the in-network provider to which the plan intends to transition the enrollee and information about how the enrollee may file a complaint with the plan if the enrollee, the enrollee's representative, or enrollee's provider believes transitioning the enrollee to an in-network provider will harm the enrollee or is not within the standard of care.

If the enrollee or the enrollee's representative expresses dissatisfaction to the transition to an in-network provider, the health plan shall treat that objection as a grievance pursuant to Health and Safety Code section 1368.

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Utilization Management

Utilization management for members covered by Healthy Workers shall be conducted by the BHS Centralized Utilization Management Program (UMP) to ensure all members have timely access to clinically sound, medically necessary, authorized behavioral health care, services, and resources.

UMP Clinical Reviewers conduct a level of care assessment and obtain approval for medically necessary services that require prior authorization. The following services require prior authorization from UMP:

- Mental health services:
  - Intensive home-based services
  - Therapeutic behavioral services
  - Therapeutic foster care
  - Mental health residential facilities
  - Intensive Case Management (ICM)/Full-Service Partnership (FSP)
- Inpatient mental health services, including acute and administrative care days:
  - Concurrent review for all inpatient psychiatric hospital services
  - Concurrent review for all psychiatric health facility services
- Substance use disorder services:
  - Residential levels of care 3.1, 3.3, and 3.5

The following services do not require prior authorization from UMP:

- Mental health services:
  - Crisis intervention
  - Crisis stabilization
  - Mental health outpatient services (including treatment for gender dysphoria)
  - Targeted Case Management
  - Intensive care coordination
  - Medication support services
- Substance use disorder services:
  - Outpatient level 1
  - Narcotic Treatment Program level 1
  - Intensive outpatient treatment level 2.1
  - Withdrawal management level 3.2[1]

Healthy Workers UM staff use the Level of Care Utilization System (LOCUS and CALOCUS-CASII) to make medical necessity determinations and level of care placement decisions for mental health services; the American Society of Addiction Medicine (ASAM) for substance use disorder services; and World Professional Association for Transgender Health (WPATH) Standards of Care for treatment of gender dysphoria. UMP may authorize multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria.

- BHS decisions are communicated to the member in writing in a Notice of Adverse Benefit Determination (NOABD), a formal letter informing the member that a medical service has been denied, partially denied, or deferred. Decisions adhere to the following turnaround times as required by DMHC: Routine / Standard / Non-urgent authorization requests – 5 business days

[1] Extended authorization is needed.

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from receipt of request
- Urgent / Expedited / Urgent Preservice – 72 hours from receipt of request
- Retrospective / Post service – 30 calendar days from receipt of the request

Pursuant to SB 855, UM staff are subject to annual interrater reliability. New staff are tested between 60-90 days of hire and annually thereafter. BHS has developed a framework for interrater reliability (IRR) assessment to broadly test UM reviewers on essential core knowledge and ability to make medical necessity determinations necessary to authorize treatment of mental health and substance use disorders. The goal of this assessment is to demonstrate that UM reviewers can competently and consistently determine medical necessity based upon designated criteria for treatment service requests and approve or disapprove those requests as under guidelines stipulating health care service plan coverage. Observed inconsistencies in assessing for medical necessity for treatment services should be remediated though department's education or quality improvement process.

IRR-UM Assessment Procedure

1. The UM department director, supervisor or quality designee develop at least ten (10) questions designed to assess core knowledge and ability to make determinations of medical necessity for treatment and services authorization.
2. These questions test basic knowledge of medical necessity as determined by specified plan criteria and assess the ability to apply those criteria to a selected (one) case.
3. A score of 9 or more correct answers is a passing score. A score of 8 or less is cause for either individual or group level review, education, or quality improvement remediation. No retest is required.

IRR Testing Remediation

The IRR-UM assessment is a quality assurance activity intended to assure competency and consistency in making medical necessity determinations necessary for authorization of plan coverage for treatment services. New applicants are tested for initial competence and core knowledge before they can conduct utilization review without supervision. Department UM reviewers must achieve an interrater reliability pass rate of at least 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.

Second Opinion

BHS ensures Healthy Workers members have access to second opinions by qualified health care professionals. CMO or physician designee(s) review second opinion cases and make final determinations on whether to approve the request. Requests for second opinion can be made through BHS Member Services or through Central UM Healthy Workers staff. Requests are coordinated with the Chief Medical Officer (CMO) or physician designee (MD) to review the case and make a determination on whether to approve the request. Requests for second opinions are not granted if the CMO or physician designee determine the same opinion has been reached by two different qualified providers. Under such circumstances, no additional opinions may be requested. Healthy Workers requesting services through BHS have a designated Psychiatrist to conduct second opinions, when necessary.

Care Coordination

Providers within BHS MHP and DMC-ODS are responsible for the appropriate management of each

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member's mental health and substance use disorder treatment and care. Coordination efforts include referral, treatment, case management, coordination, and documentation of all medically necessary covered services. Care coordination begins with treatment inquires at the Behavioral Health Access Center (BHAC) and extends to placement, care, and transitions across the BHS continuum of care. BHS utilizes a variety of programs with multidisciplinary teams that work with members both in person and over the phone to develop and implement member centered care plans.

Member Rights, Responsibilities, and Informing Materials
SFHP Healthy Workers members are entitled to be informed of their rights and responsibilities. *"Your Rights and Responsibilities"* are described on the sfhp.org webpage. Member materials including the *Member Handbook* and *Provider Directory* are available to members via the Member Materials section of sfhp.org webpage or at the request for SFHP Customer Service.

Grievance and Appeals Process
Healthy Workers members are encouraged to resolve complaints and grievances having to do with BHS services using established SFHP grievance policy and procedures.

SFHP categorizes expressions of dissatisfaction made by members into two categories: grievances and appeals. An appeal is a review of a request for a behavioral health care service that was previously denied, delayed, or modified by BHS. A grievance is an expression of dissatisfaction about any matter other than a decision by BHS to deny, delay or modify a health care service. BHS provides the member with information on how to file a grievance or appeal with SFHP. Grievance and appeal forms in English, Spanish, Chinese, Vietnamese, and Russian can be obtained by contacting SFHP or through the SFHP website.

SFHP works with the member, and BHS, to provide the member with a letter describing the resolution of the member's grievance within 30 calendar days of receipt of the grievance. A grievance may be expedited if it involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb, or major body function.

Appeals are member and provider requests for review of a delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit. Healthy Workers HMO members have 180 days from the date of the NOA to file an appeal with SFHP.

Members have external appeal options if they do not agree with the decision in the grievance resolution letter or Notice of Appeal Resolution. Healthy Workers HMO members can ask for an Independent Medical Review (IMR) and an outside reviewer that is not otherwise affiliated with SFHP will review the case.

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Responding to Provider Questions

1. Provider questions related to the information provided by the Billing Unit, PFIs, co-pays, and patient collections should be directed to the BHS Billing Unit Director.
2. Provider questions related to appropriate triage and referral of Healthy Workers members should be directed to the Healthy Workers authorizers within Centralized UM.
3. Other provider questions should be addressed to the BHS program manager assigned to the provider.

Contact Person: Regulatory Affairs Manager, Quality Management, (628) 271-7215

Distribution:
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