DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

FOCUSED SURVEY OF MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) IMPLEMENTATION

OF

KAISER FOUNDATION HEALTH PLAN, INC.

DBA: KAISER PERMANENTE

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: JULY 2, 2018

Final Report
Focused Survey of Mental Health Parity and Addiction Equity Act Implementation
Kaiser Foundation Health Plan, Inc. dba: Kaiser Permanente
July 2, 2018

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EXECUTIVE SUMMARY

On December 14, 2016, the California Department of Managed Health Care (Department) notified Kaiser Foundation Health Plan, Inc., dba: Kaiser Permanente (Plan) that the Focused Survey for compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA) and California Health and Safety Code section 1374.76 had commenced, and requested the Plan submit information regarding its healthcare delivery system.

The survey team conducted the onsite portion of the survey for the Northern California Region from March 7-9, 2017 and from March 28-30, 2017 for the Southern California Region. For the survey review period of January 1, 2016 to December 16, 2016, the Department identified one finding requiring corrective action summarized below.

The Preliminary Report was issued to the Plan on December 21, 2017. The Plan had 45 days to file a certification document that bears the signature of one of the Plan's principal officers to certify the Report's accuracy.

This Final Report describes the Focused MHPAEA Survey of the Plan.

MHPAEA does not require health plans to offer mental health and substance use disorder (MH/SUD) benefits, but plans that do so are required to provide covered MH/SUD benefits in parity with medical/surgical (M/S) benefits. The Knox-Keene Health Care Service Plan Act of 1975,[1] specifically California Health and Safety Code section 1374.76, directs group and individual plans to provide all covered MH/SUD benefits in compliance with MHPAEA no later than January 1, 2015, and authorizes the Department to issue guidance to plans concerning MHPAEA compliance.

The Department's Focused Surveys evaluated the plans' MHPAEA compliance, for the survey review period specific to each plan, by reviewing the two general categories of MHPAEA treatment limitations which are Nonquantitative Treatment Limitations (NQTLs) and Quantitative Treatment Limitations (QTLs). MHPAEA states that treatment limitations are applicable to both NQTLs and QTLs.[2]

- NQTLs are types of treatment limitations that limit the scope or duration of benefits, but are not quantifiable by a specific number. MHPAEA regulations provide an illustrative list of eight specific NQTLs, but explains the list is not meant to be comprehensive.[3] Medical management standards, one NQTL, is

[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to Section are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to Rule are to Title 28 of the California Code of Regulations unless otherwise indicated.
[2] 45 CFR 146.136(a)
[3] The illustrative NQTL list at 45 CFR 146.136(c)(4)(ii) includes: (A) medical management standards limiting or excluding benefits on the basis of medical necessity or medical appropriateness, or on the basis of whether the treatment is experimental; (B) formulary design for prescription drugs; (C) standards for provider admission to participate in a network, including reimbursement rates; (D) refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective; (E) conditioning benefits on completion of a course of treatment; (F) restrictions based on geographic location, facility type, or provider specialty; (G) standards for providing access to out-of-network providers.

listed and is defined as a NQTL that limits or excludes benefits based on medical necessity, medical appropriateness or whether the treatment is experimental or investigative. The Department's NQTL review focused on medical management standards based on the Plan's utilization management (UM) processes.

For NQTLs, MHPAEA provides a general rule that a health plan may not impose a NQTL with respect to mental health or substance use disorder benefits in any classification[4] unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification.[5]

To determine whether UM processes are comparable between M/S and MH/SUD services, the Department reviewed and compared UM files,[6] to the extent plans were able to produce files, within Inpatient, Outpatient, and Other Findings categories.[7] The

Department also conducted interviews with plan staff to assess implementation of processes, strategies, evidentiary standards, and/or other factors used in plans' daily operations when applying UM criteria to both MH/SUD and M/S services. The Department evaluated whether plans' UM processes utilized for MH/SUD services were being applied in a manner that is no more stringent than the processes applied for M/S services. Finally, the Department reviewed relevant plan documents such as policies and procedures, and Evidences of Coverage (EOCs) to assess application of UM criteria and other written NQTLs.

- QTLs are typically numeric based treatment limitations. They may include financial requirements such as deductibles and copayments/coinsurance, limits on the total number of hospital days allowed within a year, and other limits or

[4] Regarding the classification of benefits, the federal rules at 45 CFR 146.136(c)(2)(ii) and 45 CFR 146.136(c)(3)(iii)(C) set forth the following 8 benefits classifications and outpatient subclassifications: 1) Inpatient, in-network; 2) Inpatient, out-of-network; 3) Outpatient office visits, in-network; 4) Outpatient other items and services, in-network; 5) Outpatient office visits, out-of-network; 6) Outpatient other items and services, out-of-network; 7) Emergency care; and 8) Prescription drugs.
[5] 45 CFR 146.136(c)(4)(i)
[6] With regard to approval files, the Department found the files often lacked documentation that identified formal UM criteria/guidelines utilized or narrative that explained the full rationale for approval. As a result, the Department reviewed both approval and denial files and assessed factors evident in file review together with information presented during interviews and processes described in policies and procedures.
[7] The categories reviewed by the Department are: 1) Inpatient Hospitalization; 2) Skilled Nursing Facility/Residential; 3) Outpatient Office Visits; 4) Outpatient – Other Items and Services and 5) Other Findings. Although the Department recognizes that MHPAEA identifies Emergency as a separate classification, the Department utilized an Other Findings classification because it determined an Emergency classification, by itself, would not provide meaningful analysis of the Plan's UM processes because plans do not conduct prior authorization of emergency services and few plans conduct retrospective review of emergency services. The Other Findings category allowed the Department to evaluate each Plan's unique operations. Finally, the Department did not review the prescription drug classification in this focused survey.

caps on benefits based on the frequency of treatment, number of visits, days of coverage or days in a waiting period.

MHPAEA prohibits a health plan that provides both M/S and MH/SUD benefits from applying a financial requirement and/or other QTL to MH/SUD services in any benefits classification[8] that is more restrictive than the predominant financial requirement or QTL of that type applied to substantially all M/S benefits in the same classification.

The Department assessed plans' QTL compliance by reviewing financial requirements such as co-pays and coinsurance, within specific plan products. The Department also conducted interviews concerning QTL processes and reviewed relevant documents.

FOCUSED SURVEY TABLE OF FINDINGS

NONQUANTITATIVE TREATMENT LIMITATIONS	
1	**The Department identified no MHPAEA issues with respect to utilization management.** Health & Safety Code section 1374.76; 45 CFR 146.136(c)(4)(i)
QUANTITATIVE TREATMENT LIMITATIONS	
2	**The Plan did not properly calculate financial requirements in accordance with the MHPAEA final regulations.** Health & Safety Code section 1374.76; 45 CFR 146.136(c)(2)(i) and (ii) and (c)(3)(i)(A).

PLAN BACKGROUND

Kaiser Foundation Health Plan, Inc. obtained its Knox-Keene license in 1977. The Plan covers over 7,000,000 enrollees in California, primarily through arrangements with three separate entities. The Plan is closely integrated with Kaiser Foundation Hospitals (KFH) and two medical groups: The Permanente Medical Group (TPMG) that serves the Northern California Region and the Southern California Permanente Medical Group (SCPMG), which serves the Southern California Region.

The Plan contracts exclusively with TPMG and SCPMG for physician services. The medical groups contract with non-Permanente physicians and other clinicians for services that are regularly or temporarily unavailable in the Medical Group.

In both the Northern and Southern California Regions, the Plan contracts with non-KFH hospitals for additional inpatient M/S bed capacity on a regular basis or on a "surge" basis (when a KFH facility has a high census.) Kaiser Foundation Hospitals has one inpatient facility in Santa Clara with 24 adult mental health (MH) beds and one 63-bed MH inpatient facility in Los Angeles' Chinatown. Therefore, the Plan contracts with mental health hospitals throughout both regions for inpatient services. The Plan also contracts with mental health and substance use disorder residential treatment centers.

[8] The six classifications provided in 45 CFR 146.136(c)(2)(ii).

The Plan has limited skilled nursing facility (SNF) beds in both regions and contracts for SNF beds.

In all of these situations, Permanente physicians may be the attending physicians in the facilities, depending on the contractual arrangements between the Plan and the facility. Alternatively, the Medical Groups may contract with local physicians to provide the services. According to the staff interviewed, there are Kaiser Permanente case managers "embedded" in high-volume contract facilities.

The Plan contracts for home health and hospice services in both regions. The Plan also contracts with centers of excellence for complicated, high-risk services, such as organ transplants.

Contracts with Beacon Health Options, Inc. and Magellan Healthcare

The Plan has several contracts in both Northern and Southern California to provide outpatient MH/SUD services. In June 2014, the Plan entered into a contract with Beacon Health Options, Inc.[9] to provide outpatient mental health therapy to adult enrollees with mild to moderate mental health conditions in the Northern California Region. In February 2015, the Plan entered into a similar contract with Beacon Health Options, Inc. to provide outpatient mental health therapy to adult enrollees with mild and moderate mental health conditions in the Southern California Region.

In the Northern California Region, the Plan contracts with Magellan Healthcare for outpatient therapy services, including medication management.

Easter Seals

In February 2012, the Plan entered into an agreement with Easter Seals to provide Behavioral Health Treatment (BHT) to individuals with autism or pervasive developmental delay in Northern and Southern California. The five parties to the agreement are:

- Kaiser Foundation Health Plan, Inc.
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group, Inc.
- Easter Seals Bay Area
- Easter Seals Southern California

American Specialty Health Plans (ASHP)

The Plan's only delegation agreement is with American Specialty Health Plans (ASHP). In the Northern California Region, the delegation agreement is for chiropractic services, and the Plan also delegates utilization management, quality review and credentialing of participating practitioners. The agreement specifies that "No authorization from either KP or ASH Plans is required for a capitated member (other than a Medi-Cal member) to access an ASH Plans Participating Practitioner to initiate the process for obtaining

[9] Value Options of California, Inc. is a subsidiary of Beacon Health Options, Inc.

Professional Services. ASH Plans shall manage the utilization of Professional Services in accordance with its utilization management program."

In the Southern California Region, the delegation agreement is for chiropractic and acupuncture services. The term and conditions are the same as for the Northern California Region agreement.

MHPAEA IMPLEMENTATION OVERVIEW

MHPAEA was enacted by Congress in 2008.[10] Originally applicable only to large group coverage, MHPAEA was amended by the Affordable Care Act to also apply to individual and small group coverage.[11] The U.S. Departments of Treasury, Labor, and Health and Human Services issued final rules for MHPAEA on November 13, 2013.[12] The federal government authorized states to ensure compliance with MHPAEA and the final rules within health plan and insurer coverage.

California law mandates that commercial health plans cover specified mental and substance use disorders as well as certain services to treat those disorders.[13] MHPAEA requires health plans to provide covered benefits for MH/SUD in parity with M/S benefits.

The Department's Oversight

To ensure health plan compliance with MHPAEA, the Department has undertaken a two-phased approach.

Phase One began in September 2014 when the Department required 26 licensed full service health plans to submit up to 15 benefit plan designs (BPDs) that were reviewed for MHPAEA compliance[14]. The Department's Office of Plan Licensing, Office of Financial Review, and clinical consultants reviewed each of the health plans' submissions. After extensive discussions with the Department, each plan was required to make corrections and implement changes by January 1, 2016.

Phase Two is the Focused Survey. The purpose of the Focused Survey is to review the Plan's implementation of the required changes made in Phase One, and to further evaluate NQTL and QTL to determine MHPAEA compliance.

The Department's findings for Phase One and Two with respect to Kaiser Foundation Health Plan, Inc., dba: Kaiser Permanente are described in this Report.

[10] Public Law 110-343, 42 U.S.C. § 300gg-26.
[11] 42 U.S.C. § 300gg-26(a)(1)-(a)(3), as amended by ACA, Title X, subtitle A, § 10107(b)(1); 78 Fed. Reg. 68240-68241, 68251 (Nov. 13, 2013); 45 C.F.R. § 156.115(a)(2).
[12] 45 CFR § 146.136 (2013).
[13] Health and Safety Code section 1374.72 requires plans to cover inpatient, outpatient, and psychiatric hospitalization treatment for nine severe mental illnesses for a person of any age and children with serious emotional disturbances. In addition, Health and Safety Code section 1367.005 applies the Affordable Care Act's essential health benefits to nongrandfathered commercial individual and small group coverage while Rule 1300.67.005 requires plans to cover substance use disorders and almost all mental disorders with a range of medically necessary treatments such as intensive outpatient programs, outpatient counseling, and residential care.
[14] Depending on each plan's participation in the individual, small group and large group commercial markets, plans were required to submit up to a maximum of 15 BPDs for review (5 products for each market served).

SECTION I: PHASE ONE OVERVIEW

For the Phase One review, the Plan submitted 15 BPDs for the Department's review.

The Department assessed the BPDs for compliance with parity requirements in the Knox-Keene Act and with MHPAEA requirements. Upon completion of its review, the Department issued the Plan a closing letter (the Phase One Closing Letter) that described changes required for seven of the 15 BPDs submitted. A copy of the Phase One Closing Letter is attached to this report (see Appendix A.)

SECTION II: DISCUSSION OF FOCUSED SURVEY – PHASE TWO

The Department verified whether the Plan met the conditions set forth in the Department's Phase One Closing Letter. The Department also reviewed Plan documents (Evidences of Coverage, Summaries of Benefits and Coverage, and other disclosure documents), conducted interviews with Plan representatives and delegated entities, and reviewed and compared the UM practices for M/S and MH/SUD in each classification as described in the Plan and delegates' (if applicable) M/S and MH/SUD files.

The Department also reviewed three additional BPDs for Kaiser:

- BPD #1: Non-grandfathered Silver 70 DHMO
- BPD #2: Non-grandfathered Gold 80 HMO 0/30
- BPD #3: Large Group California Public Employees' Retirement System

The three BPDs were submitted for the Department's review. The Department assessed whether these BPDs demonstrated appropriate cost-sharing and financial requirements.

FINDINGS

A. NONQUANTITATIVE TREATMENT LIMITATIONS

#1 The Department identified no MHPAEA issues with respect to utilization management.
Health & Safety Code section 1374.76; 45 CFR 146.136(c)(4)(i).

Statutory/Regulatory Reference: Health and Safety Code section 1374.76 requires that plan contracts for individual, small and large group shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110 343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) and Section 1367.005.

45 CFR 146.136(c)(4)(i) requires that the processes, strategies, evidentiary standards, or other factors used by a health plan it applying a nonquantitative treatment limitation to mental health or substance use disorder benefits within a classification be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the same classification.

Northern California Region

Supporting Documentation or Evidence:

- Review of 67 UM files (see Table 1)
- Plan policies and procedures
- Interviews with plan staff

Assessment:

1. Inpatient

A. File Review

In order to assess MHPAEA parity between the Plan's MH/SUD and M/S benefits, the Department requested the Plan and delegates submit UM approval files. The Department reviewed the Plan's approval files and found the files often lacked documentation that identified the formal UM criteria/guidelines utilized or narrative that explained the full rationale for approval. However, the Department's purpose in reviewing these files was not to ensure the Plan documented the basis for approval.

MHPAEA and the Knox-Keene Act do not require plans to document criteria/ guidelines in approval files. Rather, the Department reviewed UM files to gather information about the Plan's processes for approving requested services. In reviewing the files, the Department assessed the following within each classification of benefits:

- the nature, frequency of use and application of UM factors, criteria and processes utilized for M/S and MH/SUD services;
- application of clinical rationales;
- file documentation of the UM processes and/or clinical rationale, and variation in application of UM processes by the Plan and/or its delegated entities.

The chart below lists the total number of files reviewed by the Department:

Table 1 – Total Number of Files Reviewed – Northern California Region

Category of Benefits	Number of Medical/Surgical Files Reviewed	Number of Mental Health Files Reviewed	Number of Substance Use Disorder Files Reviewed
Inpatient	0	0	0
SNF/ Residential	0	0	0
Office Visit	10	10	0
Other Outpatient	10	10	0
Other Findings	10	8	9
Total files Reviewed	**30**	**28**	**9**

(i) Inpatient Hospitalization

There were no Inpatient files for the Department to review with respect to M/S, MH or SUD Inpatient services.

(ii) SNF/Residential

There were no Inpatient files for the Department to review with respect to M/S, MH or SUD Inpatient services.

B. Interviews

The Plan explained it typically does not require the provider to request permission to proceed with recommended treatment. The Plan discussed UM practices that apply to both the Northern and Southern California regions, which are summarized below:

- The goal of the Plan's UM Program is to ensure the provision of appropriate, high quality, cost effective M/S and MH/SUD services to all enrollees across the continuum of care.

- The Plan's UM criteria is developed to be consistent with sound clinical principles and processes and is reviewed and approved annually.

- The UM processes are the same for both M/S and MH/SUD services. The only exception takes place for review of MH services when the Plan reviews the behavioral health treatment plan to treat pervasive developmental disorder and autism every six months, which is required under Health and Safety Code section 1374.73(c)(1)(C).

- The Health Plan Physician Advisor provides oversight, guidance, and direction of all UM Program functions and activities on behalf of the Plan.

- Treatment decisions made by the treating physician using his/her professional medical judgement about what is best treatment for the enrollee are not subject to UM and do not require prior authorization.

- UM occurs in limited circumstances, such as referrals to seek treatment out-of-network, transplants, and durable medical equipment.

- The Plan's UM determination only determines whether the recommended service is medically necessary, but the enrollee's Evidence of Coverage (EOC) ultimately determines whether the service is covered.

C. Plan Documents

The Department's review of Plan documents supported the Plan's representations concerning UM processes. Set forth below is a summary of the findings from the Department's document review.

<u>2015 UM Program for Northern California</u>

The Plan's *Northern California Region 2015 UM Utilization Management/ Resource Management Program Description* is a comprehensive document that provides extensive details concerning the Plan's UM practices for both M/S and MH/SUD services. With regard to Inpatient services, the Program Description explains how the Plan applies UM criteria to review requests for Inpatient services by stating:

> The process to admit a patient for care in an inpatient setting, including: acute general hospital, acute rehabilitation, skilled nursing facility, residential MH/CD or hospice facility, is conducted by RM[15] staff to determine appropriate patient classification and most appropriate level of inpatient care for the treatment plan.
>
> The review relies on clinical guidelines appropriate for the care setting, including, but not limited to: InterQual, Medicare guidelines, KP standards including, specific unit admission/transfer guidelines, community standards, facility licensure restrictions and KFHP benefits and approved guidelines. Kaiser relies on Integrated Urgent Services (IUS) Resource Management Guidelines for determining clinical necessity/appropriate levels of care for MH admissions and continued stay.

The Program Description also highlights that the Plan reviews M/S and MH/SUD services in a comparable manner. The document states:

> Patients meeting defined diagnoses under the AB 88 Mental Health Parity law will be covered under the same terms and conditions applied to other medical conditions covered by the Kaiser Health Plan. The long-term therapy exclusion and visit/day limits will be eliminated for specified psychiatric conditions. Kaiser Permanente does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the same classification.

Finally, the Program Description notes the importance of the treating provider's clinical judgment to determine how the enrollee receives treatment by stating:

> If you [the provider] are in a treatment relationship with a member your clinical recommendations are not subject to these [UM] criteria. Your treatment recommendations are guided by your professional judgment and influenced, where applicable, by clinical practice guidelines (CPG) and clinical support tools found in the Clinical Library under 'Guidelines'.

The document also states, "Kaiser Permanente practitioners and health care professionals make decisions about a member's care based on clinical needs in association with appropriate treatments and services."

<u>Inpatient Conclusion - Northern California Region:</u>

[15] The Program Description explains Resource Management (RM) as: "RM is an essential component of providing appropriate and affordable health care to members as part of Kaiser Foundation Health Plan, Inc. (KFHP) quality improvement program. TPMG physicians and other health care professionals provide the majority of care to KFHP members. The Health Plan and Hospital non-physician RM staff are available to support the clinical staff as they manage member health care needs throughout the care continuum by providing a variety of services, including discharge planning and care management."

While the Plan provided the Department with M/S Inpatient files, it was unable produce MH/SUD files. There were no comparable MH or SUD files to review; therefore, no M/S files were reviewed. Thus, the Department was unable to compare M/S with MH/SUD files to determine whether the processes, strategies, evidentiary standards with regard to application of UM criteria were comparable and less stringently applied to MH/SUD services than the UM criteria applied to M/S services.

However, the Department found evidence based on interview statements and document review that the Plan applies comparable UM processes to review and approve M/S and MH/SUD services. Interviews and Plan documents emphasized that for both M/S and MH/SUD requests, the Plan applies comparable UM review processes between M/S and MH/SUD services by typically deferring to the treating provider's expertise. UM occurs in limited circumstances for both M/S and MH/SUD, which may substantiate why the Plan was unable to produce MH and SUD files. Finally, the Plan emphasized that the Health Plan Physician Advisor provides oversight, guidance, and direction of all UM Program functions and activities on behalf of the Plan. Nevertheless, without file review to compare the application of UM criteria, the Department was unable to determine whether the Plan necessarily applied UM criteria more or less stringently to MH/SUD than M/S services.

2. Outpatient

A. File Review

(i) Outpatient Office Visits

Medical/Surgical:

The Department reviewed 10 M/S files involving requests for outpatient office visit referrals. All 10 requests were approved. Nine requests were for acupuncture services and one was for out-of-network dermatology services. ASHP handled the nine requests for acupuncture services. Out of the nine ASHP files, three cited ASHP guidelines, three cited ASHP policies, and three cited clinical judgment. For the one Plan file, the request cited clinical reasoning as the basis for approving the out-of-network dermatology service.

Mental Health:

The Department reviewed 10 MH approval files involving requests to treat autism with Applied Behavioral Analysis (ABA) from Easter Seals. All 10 requests were approved with auto-authorization.

Substance Use Disorder:

There were no files for the Department to review with respect to SUD services.

(ii) Outpatient – Other Items and Services

Medical/Surgical:

The Department reviewed 10 M/S approval files involving requests for services related to kidney and liver transplants. All 10 requests received auto-authorization because the enrollee had a standing referral to obtain necessary outpatient services.

Mental Health:

The Department reviewed 10 MH approval files involving requests to treat autism with Applied Behavioral Analysis (ABA) from Easter Seals. All 10 requests were approved with auto-authorization.

Substance Use Disorder:

There were no files for the Department to review with respect to SUD services.

Outpatient file review results are summarized as follows:

File Type	Number of Files Reviewed	Basis for UM Determination
M/S Office visits	10	ASHP guidelines (3); ASHP policies (3); clinical judgment/reasoning (4)
MH Office visits	10	Auto-authorization (10);
SUD Office visits	0	N/A
M/S Outpatient – other	10	Auto-authorization(10);
MH Outpatient – other services	10	Auto-authorization (10)
SUD Outpatient – other services	0	N/A

B. Interviews

In this classification, the Department reviewed numerous MH files with auto-authorization approvals for autism treatment at Easter Seals. The Plan explained its contractual arrangement with Easter Seals to provide Applied Behavioral Analysis (ABA) services. While the Plan does not require prior authorization for initial assessment of services associated with speech and language, occupational and physical therapy, subsequent care must receive prior authorization. In both Northern and Southern California, in order to obtain a referral to receive behavioral health treatment (BHT) at Easter Seals, the enrollee must first obtain an autism diagnosis as determined by a multidisciplinary team that includes a developmental pediatrician, speech and language therapist, occupational therapist and physical therapist. If it is determined the enrollee requires BHT services, the referral is processed and sent to Easter Seals with relevant documentation. Easter Seals is responsible for completing an assessment of the enrollee's BHT needs, developing the treatment plan and arranging for services.

Easter Seals submits reports to the Plan every six months, which are reviewed to determine whether the enrollee should continue to receive BHT services.

C. Documents

Prior Authorization Description

The *Prior Authorization Description* specifies which M/S and MH/SUD services require prior authorization.

While the document notes that in the majority of cases, the provider is not required to request permission from the Plan, the document also states the provider must obtain prior authorization for the following services in Northern California:

> Acupuncture; BHT for pervasive developmental disorder and autism; Chiropractic care; Community based adult services for Medi-Cal members; Durable medical equipment; Home health continuous shift care and shift care for Medi-Cal children; Medical Transportation (non-urgent/emergent), Occupational, speech, and physical therapies; Ostomy and urological supplies; Out-of-plan referrals; Prosthetic and orthotic devices; Transplants; Transgender surgery; Hyperbaric oxygen therapy.

The Plan's website, https://mydoctor.kaiserpermanente.org clarifies the pre-authorization process for BHT: "If your child's doctor recommends further evaluation, you will be referred to a developmental pediatrician and/or an ASD Evaluation Center for a full assessment. At the center, a team of experts (doctors, psychologists, speech therapists, and occupational therapists) will observe how your child behaves, plays, and communicates and let you know if your child has an autism or other developmental disorder and what to do next."

The *Prior Authorization Description* also states:

> The UM and Prior Authorization process employed by the Plan is the same for medical/surgical services and behavioral/mental health services except where the law explicitly allows for divergence. For example, *Section 1374.73(c)(1)(C) of California's Health & Safety Code* [emphasis in original] requires that a behavioral health treatment plan for pervasive developmental disorder and autism be reviewed by a qualified autism provider no less than once every six (6) months. This specific 6 month review interval requirement is unique to this service and is not required for other services.

The Plan's Contract with Easter Seals

The contract between the Plan and Easter Seals specifies that Easter Seals must provide BHT, speech therapy, physical therapy and occupational therapy. The Agreement also specifies that these services must be provided through Qualified Autism Service Providers who supervise and employ Qualified Autism Service Professionals or Qualified Autism Services Paraprofessionals.

Outpatient Conclusion - Northern California Region:

In both the Outpatient Office and Outpatient Other classification, the file review results demonstrated that the Plan applied UM criteria in a comparable manner when reviewing and approving M/S and MH services, and that UM criteria was applied less stringently to MH services than for M/S services.

In the Outpatient Office classification, nine of the 10 M/S files were requests for acupuncture, and all 10 MH files were ABA requests to treat autism. In Northern California, the Plan requires prior authorization before approving acupuncture and ABA. File review demonstrated all nine requests for acupuncture were approved per application of ASHP guidelines. However, the Plan auto-authorized all requests for ABA therapy. Thus, based on file review, the Department determined that the Plan demonstrated approval for MH services based on auto-authorization, which is a less stringent review process than application of ASHP guidelines to approve M/S services. Finally, the Plan's review of the enrollee's BHT treatment Plan every six months is a process that is not comparable to any review process for M/S services. Although this process is being applied more stringently to MH services, this review is permissible under Health and Safety Code section 1374.73(c)(1)(C).

In the Outpatient Other classification, the 10 M/S files were requests for kidney and/or liver transplants, and all 10 MH files were ABA requests to treat autism. In the Northern California Region, the Plan requires prior authorization before approving either transplants or ABA. File review demonstrated the Plan applied auto-authorization to approve all 10 requests for the kidney and/or liver transplants as well as the ABA services. Thus, the file review demonstrated the Plan applied a comparable auto-authorization approval process, and there was no evidence this auto-authorization process was applied more stringently to MH services than to M/S services.

Finally, for both the Outpatient Office and Outpatient Other classification, the Plan was unable to produce SUD files, and therefore the Department could not compare and evaluate the Plan's review and approval process between M/S and SUD files. The Department therefore could not determine whether the processes, strategies, evidentiary standards with regard to application of UM criteria were comparable and less stringently applied to SUD services than the UM criteria applied to M/S services.

3. Other Findings

A. File Review

(i) Retrospective

Medical/Surgical:

The Department reviewed 10 M/S retrospective review files. All services were approved. Four files were for emergency services; four were for inpatient hospitalization services; and two were for imaging. The four emergency services were approved per Plan guidelines, the four inpatient hospitalizations were approved per clinical review of documentation, and the images were approved as benefit approvals without evidence of criteria or clinical review.

Mental Health:

The Department reviewed eight MH files. All services were approved. Five of the files were for emergency services; one was a request for out-of-network services for diagnosis related to a major depressive disorder, one was a request for hospitalization related to schizophrenia, and one was a request for hospitalization due to self-injury. The five emergency files demonstrated approval per Plan guidelines. The three requests for hospitalization were approved per the enrollee's benefits.

Substance Use Disorder:

The Department reviewed nine SUD files. All services were approved. Seven of the files were for emergency services, which were approved per Plan guidelines; two were for inpatient services and were approved per the enrollee's benefits.

Other Findings file review results are summarized as follows:

File Type	Number of Files	Basis for UM Determination
M/S Retrospective	10	Plan guidelines (4); Clinical review (4); Benefit approval (2)
MH Retrospective	8	Plan guidelines (5); Benefit approvals (3)
SUD Retrospective	9	Plan guidelines (7); Benefit approvals (2)

B. Document Review

2015 Utilization Management Resource Management / Program Description

Regarding retrospective review of emergency services, the Plan's *2015 Utilization Management Resource Management / Program Description states*: "KFHP covers out-of-plan emergency services that are necessary to screen and stabilize the member. Authorization is not required for emergency admissions." The document further states, "Non-plan emergency claims are reviewed retrospectively by the Claims Clinical Review Department staff to confirm the existence of an emergency medical condition, or if none was found, to apply the prudent layperson[16] standard to determine claim payment. All potential claim denials are reviewed with final decision made by a physician."

[16] The correct terminology should be "reasonable person" standard rather than "prudent layperson standard." California's Health and Safety Code Sections 1317.1 and 1371.4(c) contemplate that an emergency medical condition exists from the enrollee's subjective viewpoint, which is referred to as the "reasonable person" standard. Federal law uses the "prudent layperson standard" which defines an emergency medical condition as a condition that manifests itself by acute symptoms of sufficient severity such that a prudent layperson would experience provided they possess an average knowledge of health and medicine. Application of the prudent layperson standard generally provides more restrictive coverage than the reasonable person standard.

Other Findings Conclusion - Northern California:

In the Other Findings review category, based on file review, the Department determined the review process using plan guidelines and benefit approvals to retrospectively review M/S and MH/SUD emergency services was comparable, and there was no evidence that UM was being applied more stringently to review MH/SUD than M/S services. File review demonstrated that both M/S and MH/SUD emergency services were typically approved with Plan guidelines or as a benefit approval. However, file review also demonstrated the Plan utilizes clinical review to approve M/S emergency services, but did not use clinical review to review and approve MH/SUD services. Thus, there was no evidence the Plan's use of clinical review was applied more stringently to retrospectively review MH and/or SUD emergency services.

In support of the Department's file review, the Plan's written UM Program Description for the Northern California Region states that the retrospective review process for emergency services is applied in the same manner for both M/S and MH/SUD. UM review is not applied to M/S and/or MH/SUD emergencies at Kaiser facilities; however, for emergencies at non-Kaiser facilities, the Plan utilizes a comparable retrospective review process by confirming the existence of the medical emergency and utilizing physician review to reach all final decisions concerning approval of emergency services.

Northern California Conclusion:

Health and Safety Code section 1374.76 requires the Plan to comply with MHPAEA requirements. MHPAEA, at 45 CFR 146.136(c)(4)(i), requires processes, strategies and factors used to apply NQTLs to MH/SUD benefits to be comparable and no more stringent than the processes, strategies and factors used in applying the NQTLs to M/S benefits. Based on file review, interviews, and document review, the Department found that the Plan's processes, strategies and other factors used to conduct UM review were MHPAEA compliant in the Inpatient, Outpatient and Other Findings classifications.

Southern California Region

Supporting Documentation or Evidence:

- Review of 48 UM files (see Table 2)
- Plan policies and procedures
- Interviews with plan staff

Assessment:

File Review

The chart below lists the total number files reviewed by the Department:

Table 2 – Total Number of Files Reviewed – Southern California Region

Category of Benefits	Number of Medical/Surgical Files Reviewed	Number of Mental Health Files Reviewed	Number of Substance Use Disorder Files Reviewed
Inpatient	10	15	3
SNF/ Residential	0	0	0
Office Visit	8	10	0
Other Outpatient	9	10	0
Other Findings	10	10	10
Total files Reviewed	37	45	13

1. Inpatient

A. File Review

(i) Inpatient Hospitalization

Medical/Surgical:

The Department reviewed 10 Inpatient M/S files. Six services were approved as follows: two neurosurgeries to treat a hemorrhage; respiratory failure; septic shock; gunshot wound; and fractured skull. Four services were denied as follows: diabetic ketoacidosis; gangrene; aneurysm; injuries from a motor vehicle accident. All 10 files demonstrated review with the application of InterQual criteria.

Mental Health:

The Department reviewed 15 Inpatient MH files. Ten files were approval and five were denial files. The 10 approvals were for services for enrollees with diagnoses including suicide attempt, depressive disorder, depression, and danger to self. The denials included diagnoses including depression and suicidal ideation. Seven files demonstrated application of InterQual criteria, six files involved an admission based on a 5150[17] hold and two were approvals for admission by clinical reasoning into a contracted hospital without documentation of either criteria or guidelines.

Substance Use Disorder:

The Department reviewed three SUD files for detoxification services. All services were approved. All three demonstrated admission by auto-authorization.

(ii) SNF/Residential

Medical/Surgical:

[17] A 5150 hold generally occurs when any person is a danger to themselves or others as a result of a mental disorder. This process is described in California Welfare and Institutions Code Section 5150

There were no files for the Department to review with respect to MH services.

Mental Health:

There were no files for the Department to review with respect to MH services.

Substance Use Disorder:

There were no files for the Department to review with respect to SUD services.

Inpatient file review results are summarized as follows:

File Type	Number of Files	Basis for UM Determination
Inpatient M/S Files	10	InterQual criteria (10)
Inpatient MH Files	15	InterQual criteria (7); Auto-authorization (5150) (6); Clinical reasoning (2)
Inpatient SUD Files	3	Auto-authorization (3)
M/S SNF	0	N/A
MH Residential	0	N/A
SUD Residential	0	N/A

B. Inpatient Interviews

As noted above, the Southern California Region essentially utilizes the same UM processes as the Northern California Region.

However, the Southern California Region utilizes one different UM process than the Northern California Region by having UM nurses and/or licensed clinical social worker staff use InterQual criteria to perform concurrent review.

C. Plan documents

Southern California Regional UM Policy and Procedures: UM Criteria and Guidelines

The Plan's *Southern California Regional UM Policy and Procedures: UM Criteria and Guidelines* provides that the non-physician staff utilize InterQual criteria for medical care and Medi-Cal Access Program (MCAP) guidelines for mental health. With regard to out-of-network referrals, the Southern California UM Policy and Procedure states that out-of-network referrals are determined based on whether care is a covered benefit and/or if comparable medical care is available within the Plan. If care is medically necessary, as determined by physicians from the medical group, and is not available in network, the Plan arranges for referral for out-of-network care.

Utilization Management Program Description Southern California 2016

The Plan's *Utilization Management Program Description Southern California 2016* is a comprehensive document that provides extensive details concerning the Plan's UM practices for both M/S and MH/SUD services. This document highlights that the Plan reviews M/S and MH/SUD services in a comparable manner by stating:

> Behavioral Health Care (BHC) services are subject to the same processes and Plan oversight as provided for medical care. Review processes include benefit coverage determination for and medical necessity determination for all non-plan mental health admissions and in plan mental health admissions at specified medical centers. BHC UM utilizes and adopts commercially recognized criteria sets to assist in the provision of BHC services in the appropriate setting and at the appropriate level of care. All criteria sets are reviewed and/or revised annually by the BHC Service Chiefs who are all licensed and board certified physician specialists within the Southern California Permanente Medical Group (SCPMG).

The document states in another section that UM criteria are "developed with involvement from actively practicing health care providers; consistent with sound clinical principles and processes; evaluated, and updated if necessary, at least annually; when used as a basis of a decision to modify, delay, or deny services in a specified case under review, are disclosed to the provider and the enrollee in that specified case; available to the public upon request."

The Program Description highlighted the integration between M/S and MH/SUD services. The document states:

> The BHC program supports the overall KHFP UM program in tracking and managing the coordination of services between medical and mental health services at the appropriate level of care for members as well as members with co-existing conditions who are hospitalized in contracted and non-contracted acute psychiatric facilities. The UM program operates 7 days per week and is staffed by Registered Nurses (RN) and Licensed Clinical Social Workers (LCSW) who have experience with inpatient psychiatric work. The staff performs daily concurrent UM reviews, consults with SCPMG mental health specialists as needed and uses approved BHC UM criteria as applicable.

The Program Description notes the importance of the treating provider's clinical judgment to determine how the enrollee receives treatment by stating, "Kaiser Permanente (KP) practitioners and health care professionals, using their professional expertise, knowledge, skills and judgment, make patient care decisions based on the member's clinical needs." The document continues, "KFHP promotes open practitioner-patient communication regarding appropriate treatment alternatives and options, without penalizing practitioners for discussing all medically necessary or appropriate care with the Member. KFHP does not reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage of coverage or care.

No financial incentives exist that encourage UM decisions that result in denials or create barriers to care and services."

Inpatient Conclusion - Southern California Region:

For Inpatient services, the Department's review of Inpatient M/S and MH/SUD files demonstrated that the Plan in the Southern California Region uses InterQual criteria in a comparable manner between M/S and MH/SUD inpatient admissions. The Plan's demonstrated use of InterQual to review both Inpatient M/S and MH/SUD files was consistent with the Plan's written UM Policies and Procedures. In addition, file review for Inpatient services also demonstrated the Plan utilized auto-authorization to review and approve MH and SUD services and in two instances utilized clinical review for MH services. The Department did not find evidence the Plan used auto-authorization and/or clinical review to approve M/S services. Thus, the Department found evidence the Plan applied a less stringent review standard by applying auto-authorization and clinical reasoning to review and approve MH/SUD than M/S services. Finally, interviews and the Plan's written documents describing UM processes emphasized that the Plan uses the same UM processes to review and approve Inpatient M/S and MH/SUD services.

For SNF and MH/SUD residential treatment, the Plan was unable to produce files. Thus, the Department was unable to compare M/S SNF with MH/SUD residential treatment files to determine whether the processes, strategies, evidentiary standards with regard to application of UM criteria were comparable and less stringently applied to MH/SUD services than the UM criteria applied to M/S services.

2. Outpatient

A. File Review

(i) Outpatient Office Visits

Medical/Surgical:

The Department reviewed eight M/S files involving requests for out-of-network outpatient office visit referrals. All eight requests were approved. The requests involved services such as fertility, lap-band adjustments, a consultation for back surgery, and a gastroenterological consultation. All eight files cited medical group guidelines for the approval.

Mental Health:

The Department reviewed 10 MH approval files. Nine files involved requests to treat autism with Applied Behavioral Analysis (ABA) from Easter Seals, and one was a request for additional psychiatric visits with an out-of-network provider. All 10 requests were approved with citation to medical group guidelines.

Substance Use Disorder:

There were no files for the Department to review with respect to SUD services.

(ii) Outpatient – Other Items and Services

Medical/Surgical:

The Department reviewed nine M/S approval files involving out-of-network requests. Three of the requests were for speech therapy, three were for physical therapy, two were for occupational therapy, and one was for a consultation related to a bone marrow transplant. All of the services were approved based on clinical reasoning and medical group guidelines.

Mental Health:

The Department reviewed 10 MH files. All files were related to treatment for autism. Six files were requests for speech therapy and four were for occupational therapy. All of the services were approved based on clinical reasoning and medical group guidelines.

Substance Use Disorder:

There were no files for the Department to review with respect to SUD services.

Outpatient file review results are summarized as follows:

File Type	Number of Files	Basis for UM Determination
M/S Office visits	8	Medical group guidelines (8)
MH Office visits	10	Medical group guidelines (10);
SUD Office visits	0	N/A
M/S Outpatient – other	9	Clinical reasoning and medical group guidelines (9)
MH Outpatient – other services	10	Clinical reasoning and medical group guidelines (10)
SUD Outpatient – other services	0	N/A

B. Document Review

Utilization Management Program Description 2016

The Plan's *Utilization Management Program Description 2016* specifies that in Southern California, the enrollee's provider must obtain prior authorization from the Plan for the following services:

> Acupuncture; BHT for pervasive developmental disorder and autism Chiropractic care; Community based adult services for Medi-Cal members
>
> Durable medical equipment; Home health continuous shift care and shift care for Medi-Cal children; Occupational, speech, and physical therapies; Ostomy and urological supplies; Out-of-plan referrals; Prosthetic and

orthotic devices; Transplants; Transgender surgery; Dental anesthesia; Medical transport (non-urgent/emergent); Home based phlebotomy; Implantable spinal cord stimulators; Referrals to a plastic surgeon for breast reduction or panniculectomy; Pre-bariatric preparation program referral.

Outpatient Conclusion - Southern California Region:

In both the Outpatient Office and Outpatient Other classification, the file review results demonstrated that Plan applied UM criteria in a comparable manner when reviewing and approving M/S and MH services. There was also no evidence UM criteria was applied less stringently to MH services than M/S services.

In the Outpatient Office classification, file review demonstrated the Plan reviewed and approved all requested out-of-network M/S and all ABA MH services utilizing medical group guidelines. Although in Southern California, the Plan requires prior authorization before approving out-of-network requests and/or ABA services, file review demonstrated the Plan applied medical group guidelines in a comparable manner to review and approve both M/S and MH services. In addition, there was no evidence in the file review that the medical group guidelines were applied more stringently to MH services than to M/S services.

In the Outpatient Other classification, nine M/S files were out-of-network requests for speech, physical, and occupational therapies and transplants, and all 10 MH files were out-of-network requests for services to treat autism. In Southern California, the Plan requires prior authorization to approve these services. However, file review demonstrated the Plan reviewed and approved both M/S and MH services utilizing comparable application of clinical reasoning and medical group guidelines to approve all requests. File review therefore demonstrated the Plan applied a comparable approval process by applying clinical reasoning and medical group guidelines. Finally, the Department did not find evidence these approval processes were applied more stringently to MH services than to M/S services.

Finally, for both the Outpatient Office and Outpatient Other classification, the Plan was unable to produce SUD files, and therefore the Department could not compare and evaluate the Plan's review and approval process between M/S and SUD files. The Department therefore could not determine whether the processes, strategies, evidentiary standards with regard to application of UM criteria were comparable and less stringently applied to SUD services than the UM criteria applied to M/S services.

3. Other Findings

A. File Review

(i) Retrospective

Medical/Surgical:

The Department reviewed 10 M/S retrospective review files. All services were approved. Nine files were for emergency services, and one was for occupational therapy. All nine

emergency files documented approval per auto-authorization, and the one occupational therapy demonstrated review and approval per the enrollee's benefits.

Mental Health:

The Department reviewed 10 MH files. All services were approved. All 10 files were for ER services. The six files for emergency services were approved per Plan guidelines. All 10 files documented approval per auto-authorization.

Substance Use Disorder:

The Department reviewed 10 SUD files. All services were approved. Eight of the files were for ER services; one was a claim for payment of lab services related to an out-of-network referral; and one was for payment of an out-of-network office visit. The eight emergency files demonstrated approval per auto-authorization, and the lab request and outpatient office visit were approved per enrollee benefits.

Other Findings file review results are summarized as follows:

File Type	Number of Files	Basis for UM Determination
M/S Retrospective	10	Auto-authorization (9); Benefit approval (1)
MH Retrospective	10	Auto-authorization (10)
SUD Retrospective	10	Auto-authorization (8); Benefit approval (2)

B. Interviews

The Plan explained how in the Southern California Region, it utilizes out-of-network physicians to manage the care of enrollees that present to non-Plan facilities. The Plan has a contract with Affiliated Intensivist Network (AIN), which is a professional provider network composed of board-certified community physicians with admitting and ICU privileges at local community facilities. Each AIN physician is contracted to manage the care of enrollees at non-Plan facilities.

C. Document Review

Utilization Management Program Description 2016

With regard to retrospective review of emergency services, the Plan's *Utilization Management Program Description 2016* states, "KFHP covers out-of-plan emergency services that are necessary to screen and stabilize the member. Authorization is not required for emergency admissions." The document further states, "Non-plan emergency claims are reviewed retrospectively by the Claims Clinical Review Department staff to confirm the existence of an emergency medical condition, or if none

was found, to apply the prudent layperson[18] standard to determine claim payment. All potential claim denials are reviewed with final decision made by a physician."

SCAL Emergency Prospective Review Program (EPRP) Notification and Authorization Process Policy

This Policy states that AIN is a "professional provider network composed of board-certified community physicians with admitting and ICU privileges at local community facilities. Each of these physicians is contracted by the network to manage the care of Health Plan members who present to a non-Plan facility where he or she has privileges . . . . AIN physicians are required to have full ICU privileges . . . ."

Emergency Prospective Review Program (EPRP) Policy

The Policy states, "In appropriate instances, EPRP has the discretion to dispatch a physician contracted with AIN, who already has privileges at the facility in question, to assumed ongoing responsibility for management of the patient's care to the point of appropriate discharge or inter-facility transfer to a Plan or Plan-designated Facility, consistent with the intent of Health and Safety Code, Section 1371.4(d) and its accompanying regulations."

Other Findings Conclusion - Southern California Region:

In the Other Findings review category, based on file review, the Department determined the review process applying auto-authorization to retrospectively review and approve M/S and MH/SUD emergency services was comparable, and there was no evidence that UM retrospective review was more stringent for MH/SUD services. File review also demonstrated that the Plan reviewed and applied the enrollee's benefits to retrospectively review non-emergency services. The Plan appeared to have a comparable process utilizing the enrollee's benefits, and there was no evidence the criteria was applied more stringently to the SUD services. However, given that there were only two non-ER SUD files to compare with one non-ER M/S file, the Department's findings were inconclusive whether the Plan's application of the enrollee's benefits between M/S and MH/SUD services were comparable.

Southern California Conclusion:

Health and Safety Code section 1374.76 requires the Plan to comply with MHPAEA requirements. MHPAEA, at 45 CFR 146.136(c)(4)(i), requires processes, strategies and factors used to apply NQTLs to MH/SUD benefits to be comparable and no more stringent than the processes, strategies and factors used in applying the NQTLs to M/S benefits. Based on file review, interviews, and document review, the Department found that the Plan's processes, strategies and other factors used to conduct UM review were MHPAEA compliant in the Inpatient, Outpatient and Other Findings classifications.

[18] See discussion in footnote 16.

Plan Response:

The Plan responded timely to the Preliminary Report and submitted the required signed certification.

Status:

No NQTL MHPAEA issues were identified during this Focused Survey.

B. QUANTITATIVE TREATMENT LIMITATIONS

#2 The Plan did not properly calculate financial requirements in accordance with the MHPAEA final regulations.
Health & Safety Code section 1374.76; 45 CFR 146.136(c)(2)(i) and (ii) and (c)(3)(i)(A).

Statutory/Regulatory Reference: Health and Safety Code section 1374.76 requires that plan contracts for individual, small and large group shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) and Section 1367.005.

45 CFR 146.136(c)(2)(i) requires that plans providing both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

45 CFR 146.136(c)(2)(ii) provides that if a plan provides mental health or substance use disorder benefits in any classification of benefits described in paragraph (c)(2)(ii),[19] mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits.

45 CFR 146.136(c)(3)(i)(A) provides that a financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

[19] See footnote 4 above for a description of the classifications.

Supporting Documentation or Evidence:

- The Plan's Exhibit J-11-A and Exhibit J-12 worksheets[20]
- 2016 Evidence of Coverage and Summary of Benefits

Assessment:

The Plan filed and the Department reviewed cost-sharing amounts within each classification of benefits for three BPDs filed during Phase One. By reviewing three additional BPDs, the Department had the opportunity to assess whether the Plan properly implemented cost-sharing in other BPDs as set forth at the close of Phase One (see Appendix A.)

In furtherance of this review, the Plan filed an Exhibit J-11-A and J-12 for the three BPDs that included the services identified by the Plan as belonging in each classification of benefits, for M/S and MH/SUD benefits, along with the applicable cost-sharing requirements for each classification as calculated by the Plan. The Department reviewed the Plan's Exhibit J-11-A for MHPAEA compliance and found the following:

BPD #1: Non-grandfathered Silver 70 DHMO

In Classification D, Outpatient In-Network Other Items and Services, the Department found the Plan had been charging MH/SUD cost-sharing that was not compliant with MHPAEA. When there is no type of financial requirement such as a copayment or coinsurance in a classification that applies to substantially all of the M/S benefits, MHPAEA requires the Plan to charge nothing ($0 or 0%) for the MH/SUD benefits within that same benefits classification regardless of the cost-sharing required under Covered California regulations. For BPD #1, Classification D, Outpatient In-Network Other Items and Services, the Department found the Plan was charging enrollees 20% for MH/SUD services when it should have been charging no cost-sharing.

Conclusion:

45 CFR section 146.136(c)(ii) and (c)(2)(i) require plans to determine the predominant financial requirement or treatment limitation that applies to substantially all M/S benefits in each classification, and requires plans to calculate that amount by separating the types of payments such as copayment claims from coinsurance claims. As set forth above, when the Department examined BPD #1, the Department determined the Plan is not covering all required services appropriate with MHPAEA compliant cost-sharing.

Plan Response:

The Plan responded timely to the Preliminary Report and acknowledged the findings. The Plan's narrative response to the Preliminary Report addressed the Department's findings.

[20] Exhibit J-11-A and J-12 are worksheets developed by the Department to guide the plans (use is optional) in demonstrating compliance with MHPAEA. Exhibit J-11-A addresses the classification of benefits requirement of MHPAEA. Exhibit J-12 is utilized to demonstrate compliance with the financial requirements of MHPAEA.

BPD #1: Non-grandfathered Silver 70 DHMO

Regarding this finding, the Plan explained that prior to the release of Frequently Asked Questions (FAQs) about the Affordable Care Act, FAQs Part 31 and 34, the MHPAEA actuarial testing methodology by the Plan relied on "any reasonable methodology," as permitted by MHPAEA regulations. The actuarial calculations utilized book of business data for all commercial plans. Based on testing results from book of business data, the Plan created business rules to ensure Plan compliance for all plan designs across the commercial lines of business. This methodology was used in the actuarial calculations for the Plan's 2015 MHPAEA compliance filing. The Plan noted there were fifteen benefit plan designs tested and all passed the "substantially all" and "predominant" tests under the MHPAEA regulations.

FAQs Part 31 and 34 released in April and October 2016 respectively, clarified that the testing methodologies set forth by the MHPAEA regulations and indicated that plans should no longer rely exclusively on book of business data, and instead should use plan level and group-specific claims data for testing plans. As a result, the previous business rules that were based on book of business data and implemented by the Plan to ensure MHPAEA compliance could no longer be utilized. However, because FAQs Part 31 and 34 were not released until after the Plan had finalized, filed with the Department, and sold its 2017 benefit plan designs, the Plan was unable to implement cost share system changes until 2018.

The Plan reviewed and identified specific plan designs that may not satisfy the substantially all type requirement when calculated according to the guidance set forth by FAQs 31 and 34. To ensure that enrollees were not overcharged for M/SUD services in 2017, the Plan retrospectively reimbursed cost share amounts paid by members for MH/SUD outpatient other items and services in BPD #1 and all other 2017 commercial plans where there was not a type of cost-sharing that met the 2/3 substantially all test. The Plan therefore reimbursed enrollees cost-share amounts for dates of service back to January 1, 2017 without interest and without adjustments for deductibles and/or out of pocket accumulation.

The Plan attested that for the period of January 1, 2017 through December 31, 2017, as of May 7, 2018, it had reimbursed a total amount of $371,181.00 to a total of 3,654 enrollees.

Finally, beginning in 2018, the Plan confirmed it has not charged any amount for MH/SUD services in Classification D, outpatient "other items and services," for the KPIF Silver 70 DHMO Plan.

Status:

The Department accepted the Plan's response and has determined the Finding to be corrected.

SECTION III: PLAN EXPERIENCE IN IMPLEMENTING MHPAEA

The Department's Focused Survey also included inquiry into the Plan's experience in implementing MHPAEA and maintaining parity.

1. Delegation Oversight

The Plan essentially provides oversight of all UM functions, except for its delegation of chiropractic and acupuncture services to ASHP. The Department's review of the Plan's UM Program Descriptions found that in both the Northern and Southern California regions, the Plan acknowledged it retains final responsibility for delegated functions including UM. Thus, the Department found that the Plan's minimal delegation does not have any apparent impact on the Plan's ability to oversee application of UM criteria and maintain MHPAEA parity. Finally, the Plan's close relationship with its medical groups and uniform application of UM criteria in both the Northern and Southern regions have enhanced the Plan's ability to provide oversight of UM application.

2. Assessment of Plan's Ability to Maintain Parity

The Plan's integration with its medical groups and hospitals serves as an advantage to maintain parity. The Plan is able to control and implement programs because its M/S and MH/SUD services are under the aegis of a single medical group in each region.

The Department also found that the Plan had taken numerous favorable steps to implement MHPAEA. The Plan issued a Health Plan Alert in October 2009 to comply with MHPAEA by highlighting benefit changes including changes to limits and cost sharing.

The Plan has also taken steps to integrate M/S, MH, and SUD services at Kaiser Medical Centers. For example, in Southern California the Plan has implemented several behavioral health quality initiatives such as implementing screening for alcohol use, depression and suicide prevention as part of the enrollee's primary care service.

3. Challenges in Implementing MHPAEA

The Plan shared with the Department challenges to implement MHPAEA, which included:

- In each benefit classification, the Plan had difficulty matching the cost-share type (copayment, coinsurance) for M/S benefits with the appropriate corresponding MH/SUD service.

- The Plan faced complications when the MHPAEA compliant cost-share was coinsurance rather than a copayment. The Plan explained it had a long history of offering a residential treatment benefit for chemical dependency with a $100 copayment. However, if the appropriate MHPAEA cost-share was a coinsurance amount, the Plan could not offer the service with a $100 copayment. There were complications when the Plan attempted to configure the coinsurance amount to be $100. The Plan needed to track benefit data, which then created a need for more

complex systems during enrollee check-in at the medical offices and new claims systems.

- The Plan found it was more difficult to negotiate Plan products with purchasers while ensuring those products maintained appropriate MHPAEA cost-sharing.

- The Plan found that determining whether Plan products were compliant with MHPAEA required the Plan to analyze much more data than merely comparing Plan products against the MHPAEA rules

SECTION IV: SURVEY CONCLUSION

Within the scope of this Focused Survey, the Plan's operations were found compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA) and California Health and Safety Code section 1374.76.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, **DMHC Web Portal**.

Once logged in, follow the steps shown below to submit the Plan's response to the Preliminary Report:

- Click the eFiling link.
- Locate the MHPAEA Filing.
- Submit the Plan's response to the Final Report as an Amendment to the MHPAEA filing, as an Exhibit J-12-D MHPAEA Survey, Plan Response to the Final Report.

APPENDIX A PHASE ONE CLOSING LETTER

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

November 16, 2015

VIA ELECTRONIC MAIL

The Department of Managed Health Care (Department) has reviewed the information submitted in the above-referenced filing (Amendment) filed by Kaiser Foundation Health

Plan (Plan) for compliance with the Knox-Keene Health Care Service Plan Act of 1975, as amended,[1] and with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act[2] (MHPAEA) and federal final rules.[3]

The Department has completed review of the Amendment, and at this time has no further objection to implementation of the changes as described in the Amendment, as amended, subject to the following conditions:

1. The Plan shall implement the revisions to the cost-sharing for mental health and substance use disorder benefits (MH/SUD) that have been reviewed and not objected to by the Department within the Amendment. Those revisions are summarized in the chart below. Cost-sharing for MH/SUD benefits within nongrandfathered on- or off-Exchange individual and small group coverage shall first comply with MHPAEA and secondly comply with the regulations of Covered California for 2016 coverage.[4] Hence, the Plan may need to further modify the revised MH/SUD cost-sharing summarized below within standard benefit plan design coverage for 2016.

[1] California Health and Safety Code sections 1340 et seq. (Act). References herein to "Section" are to sections of the Act. References to "Rule" refer to California Code of Regulations, title 28.
[2] Public law 110-343, 42 U.S.C. § 300gg-26.
[3] 45 CFR § 146.136 (2013).
[4] Government Code sections 100503 and 100504(c), Health and Safety Code section 1366.6(e), and 10 CCR section 6460.

Plan Coverage Name	Benefits Impacted (all In-Network)	Current Cost-Sharing	Revised Cost-Sharing
Individual: Silver 70 HMO	Outpatient services other than office visit: chemical dependency day treatment programs, chemical dependency intensive outpatient programs	$5, subject to deductible	20% coinsurance, up to $5 per day, not subject to the deductible
Individual: Silver 70 HMO	Outpatient services other than office visit: mental health intensive outpatient programs, mental health partial hospitalization	20%, subject to deductible	20% coinsurance, up to $45 per day, not subject to deductible
Individual: Silver 73 HMO	Outpatient services other than office visit: chemical dependency day treatment programs, chemical dependency intensive outpatient programs	$5, subject to deductible	20% coinsurance, up to $5 per day, not subject to deductible
Individual: Silver 73 HMO	Outpatient services other than office visit: mental health intensive outpatient programs, mental health partial hospitalization	20%, subject to deductible	20% coinsurance, up to $40 per day, not subject to deductible
Individual: Bronze 60 HMO	Outpatient services other than office visit: chemical dependency day treatment programs, chemical dependency intensive outpatient programs	$5	100% coinsurance, up to $5 per day
Individual: Bronze 60 HMO	Outpatient services other than office visit: mental health intensive outpatient programs, mental health partial hospitalization	30%	100% coinsurance, up to $70 per day

Individual: KPIF Silver 70 HMO 1250/40 *[note: the 2016 version of this product is the KPIF Silver 70 HMO 1500/40]*	Outpatient services other than office visit: chemical dependency day treatment programs, chemical dependency intensive outpatient programs	$5	30% coinsurance, up to $5 per day
Individual: KPIF Silver 70 HMO 1250/40 *[note: the 2016 version of this product is the KPIF Silver 70 HMO 1500/40]*	Outpatient services other than office visit: mental health intensive outpatient programs, mental health partial hospitalization	$40	30% coinsurance, up to $40 per day
Small Group: Silver 70 HMO	Outpatient office visits: chemical dependency individual evaluation and treatment visits, mental health individual evaluation and treatment visits (including medication monitoring and psychological testing), behavioral health treatment for PDD/autism	$45, subject to deductible	$45, not subject to deductible
Small Group: Silver 70 HMO	Outpatient office visits: chemical dependency group treatment visits, mental health group treatment visits	$5, subject to deductible $22, subject to deductible	$5, not subject to deductible $22, not subject to deductible
Small Group: Silver 70 HMO	Outpatient services other than office visit: chemical dependency day treatment programs, chemical dependency intensive outpatient programs	$5	20% coinsurance, up to $5
Small Group: Bronze 60 HMO	Outpatient services other than office visit: chemical dependency day treatment programs, chemical dependency intensive outpatient programs	$5	30% coinsurance, up to $5

Small Group: Silver 70 HMO 1000/40	Outpatient services other than office visit: chemical dependency day treatment programs, chemical dependency intensive outpatient programs	$5	30% coinsurance, up to $5

2. The Plan shall revise its EOCs, Summaries of Benefits and Coverage (SBCs), and other disclosure documents for enrollees to disclose MHPAEA-compliant cost-sharing, quantitative treatment limits, and nonquantitative treatment limits, and other revisions to disclosure text that have been reviewed and not objected to by the Department in the Amendment. Cost- sharing shall also be revised to comply with Covered California regulations for 2016 coverage. These revisions include, but are not limited to:
   a. EOC revisions:
      i. Benefits and Coverage Matrix: changes to the applicability of the deductible for individual and group MH/SUD office visits, within the benefit plan designs as summarized in the chart, above.
      ii. Chemical Dependency Services section: revised text for "residential treatment" that replaces the former descriptions of "transitional residential recovery services" and "residential rehabilitation," which are now removed; removal of exclusion for treatment in a specialized facility; revised list of outpatient treatments; and revised disclosures of the cost-sharing for individual and group office visits and for day treatment and intensive outpatient program services, within the benefit plan designs as summarized in the chart, above.
      iii. Mental Health Services section: revised text for inpatient "residential treatment;" revised text for "outpatient mental health services" to include outpatient intensive psychiatric treatment programs; revised list of outpatient psychiatric programs to include partial hospitalization, intensive outpatient psychiatric treatment programs, and psychiatric observation for an acute psychiatric crisis; and revised disclosures of the cost-sharing for individual and group office visits and for intensive psychiatric treatment programs, within the benefit plan designs as summarized in the chart, above.
      iv. Exclusions and Limitations section: revisions to "residential care," if for residential treatment program services covered in the Chemical Dependency or Mental Health Services sections.
   b. SBC revisions:
      i. Mental/behavioral health outpatient services: revisions to the cost-sharing for the Individual Silver 70 HMO, Individual Silver 73 HMO, Individual Bronze 60 HMO, Individual Silver 70 HMO 1250/40, Small Group Silver 70 HMO 1500/45, Small Group Bronze 60 HMO 5000/60, and Small Group Silver 70 HMO 1000/40 plans.
      ii. Substance use disorder outpatient services: same revisions as noted in 2.b.i.

3. The Plan shall use the classification of benefits standards, the methodology for calculating financial requirements and quantitative treatment limits, and the factors used to apply nonquantitative treatment limits that have been reviewed and not objected to by the Department within the Amendment to provide covered mental health and substance use disorder benefits in compliance with MHPAEA within the Plan's individual and group commercial plan coverage.[5]

4. The Plan shall implement the changes to comply with MHPAEA delineated above according to the Department's guidance in the July 17, 2015, All Plan Letter concerning January 1, 2016, final implementation of MHPAEA compliance and the August 7, 2015, email update to the July 17 All Plan Letter.[6]

This letter does not constitute a waiver of any compliance issues that may be identified on subsequent review and analysis of the Amendment, whether or not highlighted to reflect a change, or of any other Plan documents or operations, whether or not disclosed in the Amendment.

The revisions necessary to correct the compliance concerns identified by the Department in this Amendment apply to all Plan documents that contain similar language or provisions, whether previously filed or not. Plan documents and operations that do not reflect compliance with the Act, Rules, and MHPAEA in accordance with the Department's determinations regarding this Amendment are not approved. Accordingly, please review and revise all Plan documents as necessary to identify and correct similar compliance concerns where they may exist. If language approved in the context of this Amendment is the only change made by the Plan to its existing variations of the same forms of documents as submitted in this Amendment, the Plan need not file those revised documents. The Department reserves the right to require additional revisions to the Plan's operations and documents, including but not limited to subscriber and provider documents, and written policies and procedures, as further review may indicate is necessary for compliance with the Act.

Please contact the Department if you have any questions regarding the above.

[5] California Health and Safety code §1374.76
[6] Ibid.