



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

**FINAL REPORT**

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

**OF**

**MOLINA HEALTHCARE OF CALIFORNIA**

**A FULL SERVICE HEALTH PLAN**

**DATE ISSUED TO PLAN: OCTOBER 23, 2017**

**Final Report**  
**Focused Survey of Mental Health Parity and Addiction Equity Act Implementation**  
**Molina Healthcare of California**  
**October 23, 2017**

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## **EXECUTIVE SUMMARY**

On May 16, 2016, the California Department of Managed Health Care (Department) notified Molina Healthcare of California (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 to submit information regarding its healthcare delivery system. The survey team conducted the onsite portion of the survey from July 26 through 28, 2016. The Preliminary Report was issued to the Plan on May 15, 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.

For the survey review period of January 1, 2016 to May 16, 2016, the Department did not identify any findings that were non-MHPAEA compliant.

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,<sup>1</sup> 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 Survey evaluated the Plan's 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.<sup>2</sup>

- 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.<sup>3</sup> Medical management standards, one NQTL, is 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

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<sup>1</sup> 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.

<sup>2</sup> 45 CFR 146.136(a)

<sup>3</sup> 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.

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<sup>4</sup> 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.<sup>5</sup>

To determine whether UM processes are comparable between M/S and MH/SUD services, the Department reviews and compares UM files,<sup>6</sup> to the extent plans are able to produce files, within Inpatient, Outpatient, and Other Findings categories.<sup>7</sup> The Department also conducts 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 evaluates whether plans' UM processes utilized for MH/SUD services are being applied in a manner that is no more stringent than the processes applied for M/S services. Finally, the Department reviews 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 caps on benefits based on the frequency of treatment, number of visits, days of coverage or days in a waiting period.

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<sup>4</sup> 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.

<sup>5</sup> 45 CFR 146.136(c)(4)(i).

<sup>6</sup> 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.

<sup>7</sup> 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.

MHPAEA prohibits a health plan that provides both M/S and MH/SUD benefits from applying a financial requirement and/or QTL to MH/SUD services in any benefits classification<sup>8</sup> 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 the Plan's 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.

## **PLAN BACKGROUND**

Molina Healthcare of California, licensed by the Department in 1994, is a for-profit health care organization located in Long Beach, California. The Plan operates in the following counties: Imperial, Los Angeles, Riverside, Sacramento, San Bernardino, and San Diego.

As of the second quarter of 2016, the Plan had 681,476 enrollees in all lines of business. For purposes of this survey, the Plan had 69,810 enrollees in nine different individual commercial products subject to MHPAEA.

For MH/SUD, the Plan performs its own UM. However, for M/S, the Plan delegates some aspects of UM to 28 medical groups. These groups have a total Plan enrollment of 39,775 (57%) of the enrollees subject to MHPAEA.

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<sup>8</sup> The six classifications provided in 45 CFR 146.136(c)(2)(ii).  
933-0322

## **MHPAEA IMPLEMENTATION OVERVIEW**

MHPAEA was enacted by Congress in 2008.<sup>9</sup> Originally applicable only to large group coverage, MHPAEA was amended by the Affordable Care Act to also apply to individual and small group coverage.<sup>10</sup> The U.S. Departments of Treasury, Labor, and Health and Human Services issued final rules for MHPAEA on November 13, 2013.<sup>11</sup> 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.<sup>12</sup> 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 benefit plan designs (BPDs) that were reviewed for MHPAEA compliance.<sup>13</sup> 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 Molina Healthcare of California are described in this Report.

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<sup>9</sup> Public Law 110-343, 42 U.S.C. § 300gg-26.

<sup>10</sup> 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).

<sup>11</sup> 45 C.F.R. § 146.136 (2013).

<sup>12</sup> 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.

<sup>13</sup> 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 five 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 one additional BPD that was not previously submitted for the Department's review and assessed whether this BPD 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 and 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 in 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.

**Supporting Documentation or Evidence:**

- Review of 123 UM files in the following categories: Inpatient, Skilled Nursing Facility (SNF) /Residential, Outpatient Office Visit, Other Outpatient, Retrospective Review (see Table 1)
- Plan policies and procedures
- Interviews with Plan and delegate staff conducted July 26-28, 2016.

## **Assessment:**

### Interviews

During onsite interviews, the Chief Medical Director, the Behavioral Health Medical Director, and UM staff each described how the Plan's UM practices utilize clinical criteria. The Plan's Medical Directors affirmed that when reviewing UM requests for both M/S and for MH/SUD services, the Plan relies upon similar criteria and processes for all services. The Plan staff explained when making a UM determination, they first consult clinical standards. However, if those standards are silent on a particular M/S or MH/SUD treatment or condition, they will then consult Molina clinical criteria. If those criteria are silent, the staff will consult other criteria as follows: InterQual online standards, Apollo standards, Hayes standards, and then peer-reviewed articles. In addition, with regard to UM decisions rendered by the Plan's delegated entities, the Plan staff and representatives from the delegates explained that the delegates utilize either the same or similar written guidelines and/or criteria as the Plan when rendering UM decisions.

### Plan Documents

The Department's review of the Plan's policies and procedures supports the Plan and delegates' representations concerning reliance on written guidelines and/or criteria when rendering UM decisions. For instance, two of the Plan's policies and procedures for UM<sup>14</sup> and one for case management<sup>15</sup> state that nationally recognized evidenced based criteria must be used when rendering decisions related to all enrollee inpatient care and services, utilization review, continuity of care and quality of care.

### 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;

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<sup>14</sup> Policies UM-16 and UM-22.

<sup>15</sup> CM-04.

- 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 table below lists the total number of files reviewed by the Department:

**TABLE 1 – Total Number of Files Reviewed**

<b>Category of Benefits</b>	<b>Number of Medical/Surgical Files Reviewed</b>	<b>Number of Mental Health Files Reviewed</b>	<b>Number of Substance Use Disorder Files Reviewed</b>
Inpatient	20	8	7
SNF/ Residential	14	0	1
Office Visit	20	9	0
Other Outpatient	20	1	1
Retrospective	20	1	1
<b>Total files Reviewed</b>	<b>94</b>	<b>19</b>	<b>10</b>

### **1. Inpatient Hospitalization**

#### Plan Files

The Department reviewed 10 M/S files involving inpatient hospitalization. The Plan approved all of the services. Eight of the 10 files involved emergency room admissions. Seven of the 10 files involved requests for in-network services. The length of admission ranged from one to six days. All 10 files demonstrated application of InterQual criteria.<sup>16</sup>

The Department reviewed eight inpatient MH files. The Plan reviewed and approved all of the services. All eight files involved requests for in-network services, and all files involved an admission based on a 5150<sup>17</sup> hold. The length of admission ranged from two to 15 days. All eight files demonstrated application of InterQual criteria.

The Department reviewed seven inpatient SUD files. The Plan reviewed and approved all of the services. All seven files involved requests for in-network services, and all files involved an admission for detoxification. The length of admission ranged from two to six days. All seven files demonstrated application of InterQual criteria.

#### Delegated Medical Group Files

The Department reviewed 10 M/S files for inpatient hospitalization from one delegated entity, which approved all of the services. All 10 files involved requests for in-network services, and all files involved an emergency admission. Three of the cases included enrollees with a history of alcohol abuse, but only one included a referral to MH/SUD treatment in the discharge plan. The length of admission ranged from one to 19 days.

<sup>16</sup> InterQual is a standardized medical review tool to establish level of care.

<sup>17</sup> 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.

All 10 files demonstrated that the services were approved based on clinical information and judgment consistent with the Plan's policy. The files did not cite specific guidelines/criteria for the approvals.

## **2. SNF/Residential**

### Plan Files

The Department reviewed 10 M/S files involving approvals for skilled nursing facility services. The Plan approved all of the services. All of the files involved enrollee transfer to a skilled nursing facility (SNF) for services such as physical therapy and rehabilitation for injuries associated with stroke, shortness of breath, injuries due to fall, and heart issues. Nine of the 10 files involved requests for in-network services. The length of admission ranged from two to 80 days. All 10 files demonstrated application of InterQual criteria.

The Plan did not have any inpatient MH files to review and thus the Department did not review these files.

The Department reviewed one SUD file. In this file, concerning a request for residential treatment for treatment of alcohol abuse, rather than waiting for two failed attempts at rehabilitation as required by InterQual, the Plan's Medical Director approved the request noting immediate residential treatment was in the enrollee's best interest. The enrollee received approval for a stay of 33 days. This file provided an example where the Plan applied a SUD process that was less restrictive than the process used in its M/S cases since the Plan's Medical Director used clinical judgement to override the more restrictive use of InterQual criteria.

### Delegated Medical Group Files

The Department reviewed four medical/surgical files from one delegated entity that approved all of the services. Two of the four files involved emergency services. The requests were for services related to congestive heart failure, stroke, respiratory failure, and knee rehabilitation. The length of admission ranged from two to 46 days. All four files demonstrated that the services were approved based on clinical information. The files did not cite specific guidelines/criteria for the approvals.

## **3. Outpatient Office Visits**

### Plan Files

The Department reviewed 10 M/S files involving approvals for outpatient office visit referrals. The Plan approved all of the services. Eight of the 10 files involved enrollee requests for office treatment related to cancer; one involved services for nasal congestion, and the other involved a service related to reproduction. Seven of the 10 files involved requests for in-network services. Nine of the 10 files cited the Molina prior authorization guideline, which does not require prior authorization when services are

provided in-network, and thus the services were approved.<sup>18</sup> The remaining file was a request by an enrollee with advanced pancreatic cancer and the Plan approved the service based on medical necessity per clinical information.

The Department reviewed nine MH files. The Plan reviewed and approved all of the services. All nine files involved requests for out-of-network services, and all files involved requests for psychotherapy. Six of nine files demonstrated application of Medi-Cal criteria, and two files demonstrated application of InterQual criteria. The remaining file did not cite the criteria relied upon to approve the service. During the onsite interviews, the Plan explained it applied Medi-Cal criteria since it has a lower threshold for approval than InterQual criteria, and thus provides the best opportunity for the enrollee to receive the requested service.

The Plan did not have any SUD files, and thus the Department did not review these files.<sup>19</sup>

#### Delegated Medical Group Files

The Department reviewed 10 M/S files from five delegated entities. The delegates approved all of the services, and one file was modified from a request for services with an out-of-network provider to an approval for services with an in-network provider. The requests for services related to dermatology, scoping, x-rays, Magnetic Resonance Imaging (MRI), consultations with providers for issues related to gastroenterology, back issues, shoulder issues, and chest pain. Six of the 10 files lacked documentation of the criteria/guidelines used to approve the service, three files cited InterQual, and the remaining file cited Molina guidelines.

### **4. Outpatient – Other Items and Services**

#### Plan Files

The Department reviewed 10 M/S files involving requests for outpatient, non-office visit services. The Plan approved all of the services. The requested services varied: a nuclear stress test for a member with an abnormal electrocardiogram, outpatient surgery, MRIs, computed tomography scans (CTs), and genetic testing. Nine of the 10 files involved requests for in-network services. Nine of the 10 files demonstrated application of InterQual criteria while one (the genetic test) applied Molina Clinical Policy.<sup>20</sup>

The Department reviewed one MH file, which was a request for neuropsychological and psychological testing. The Plan modified the request by approving neuropsychological testing only. The file demonstrated application of InterQual criteria.

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<sup>18</sup> Regarding the out-of-network requests, the Plan clarified that it has letters of agreement with those facilities, and thus handled those requests as though they were for in-network services.

<sup>19</sup> The Plan produced two files, but the Department determined these files were not actual requests for office treatment.

<sup>20</sup> The Department file review noted these files did not consistently document the reviewer's rationale for the approval.

The Department reviewed one SUD file. The Plan approved the request for alcohol detoxification. The file demonstrated application of InterQual criteria. However, the file did not document the reviewer's rationale for the approval.

#### Delegated Medical Group Files

The Department reviewed 10 M/S files from five delegated entities. The delegates approved all of the services and one request was modified from a CT request (without contrast) to include contrast. All 10 files involved requests for in-network services. The requested services included an ultrasound, CTs, physical therapy, x-rays, extracorporeal shock wave lithotripsy, and a continuous positive airway pressure (CPAP) device. Only one file (the request for lithotripsy) documented clinical information, cited guidelines, and provided a statement justifying the approval. The other nine files did not document the rationale or the guidelines relied upon by the delegate for the approval.

### **5. Retrospective Review**

#### Plan Files

The Department reviewed 10 M/S files involving authorization for previously rendered services. The Plan denied seven of the 10 requests. The diagnosis for the requested services for review varied: ectopic pregnancy, syncope, chest pain, dehydration, anemia, and chronic pain. Seven of the 10 files demonstrated application of InterQual criteria while one file relied upon clinical information, one was determined not to be a covered service, and one did not document the basis for the approval.

The Department reviewed one MH file, which involved a request from an out-of-network provider for outpatient office visits to treat bipolar disorder. The Plan approved the service based on InterQual criteria.

The Department reviewed one inpatient SUD file, which involved a request from an out-of-network provider for intensive outpatient office visits to treat drug and alcohol issues. The Plan approved the service based on InterQual criteria.

#### Delegated Medical Group Files

The Department reviewed 10 M/S files from five delegated entities. The delegates approved all of the services. Two of the 10 files involved requests for out-of-network services. The diagnosis varied from chronic knee pain to heart issues, and the requested services for review included: services for plantar fasciitis, nursing facility care for chronic respiratory failure, dialysis, and contraception. Six approvals cited clinical information as the justification for the approval. Two particular groups (which handled the remaining four approvals) were the only two delegates that cited Molina guidelines to justify their approvals.

**Conclusion:** While the Plan's UM files for MH/SUD showed consistent application of written criteria when rendering UM decisions, the delegates' files did not. Given the lack of documentation in the delegates' files, the Department was therefore unable to compare the UM process used for the delegates' M/S decisions with the Plan's MH/SUD process. However, the Plan and delegates' staff provided a sufficient

explanation that the guidelines and/or criteria used for rendering UM decisions was comparable and not less stringent. This explanation established how the guidelines and/or criteria are applied by both the Plan and delegates in a similar manner when rendering UM decisions for both M/S and MH/SUD services in all categories. These representations were supported by the Plan's written policies and procedures, which require the Plan to use written criteria when rendering UM decisions. Accordingly, the Department has determined that the application of UM criteria to MH/SUD benefits was comparable and no more stringent than the criteria applied to approve M/S services in each of the five (5) categories described above.

**Plan Response:** The Plan timely responded to the Preliminary Report, signed the required certification, and accepted the Department's findings to be accurate.

**Status:** No MHPAEA issues were identified.

## **B. QUANTITATIVE TREATMENT LIMITATIONS**

### **#2 The Department identified no MHPAEA issues with respect to the Plan's implementation of financial requirements.**

Health & Safety Code section 1374.76; 45 CFR 146.136(c)(2)(i) and (ii); 45 CFR 146.136(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),<sup>21</sup> 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

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<sup>21</sup> See footnote 4 above for a description of the classifications.

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.

**Supporting Documentation or Evidence:**

- The Plan's Exhibit J-11-A and Exhibit J-12 worksheets<sup>22</sup>
- 2016 Evidence of Coverage and Summary of Benefits

**Assessment:** The Department reviewed and analyzed one Plan BPD not previously submitted to the Department to assess whether Plan methodologies for determining cost-sharing amounts are MHPAEA compliant. The Department reviewed the Molina Silver 94 HMO, which is classified as an Individual Silver 94 Plan, 100-150 FPL. The Department's review of this BPD determined whether the Plan's financial requirements, as applied to MH/SUD benefits, are in parity with the financial requirements applied to its M/S benefits.

The results of the Department's review of the Molina Silver 94 HMO showed that the Plan appropriately determined cost-sharing for MH/SUD benefits in each category, as compared with M/S benefits in the same category. The Department determined the Plan correctly calculated the financial requirements and properly applied the federal rules concerning cost-sharing to ensure that it is acting within parity in what it charges enrollees receiving MH/SUD benefits.

**Conclusion:** The Department identified no MHPAEA issues for the BPD reviewed in the Focused Survey.

**Plan Response:** The Plan timely responded to the Preliminary Report, signed the required certification, and accepted the Department's findings to be accurate.

**Status:** No MHPAEA issues were identified.

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<sup>22</sup> 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.

### **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**

With regard to improved oversight of its delegates, the Plan acknowledged an opportunity exists to determine whether the delegates are applying standards for UM of M/S services in a manner that is comparable and no less stringent than the Plan's standards for MH/SUD. As part of its routine internal audit of the delegates, the Plan explained it would likely include a review and comparison of the delegates' UM procedures with the UM procedures used by the Plan. The Plan stated it does conduct file review audits of the delegates to assist in determining whether the delegates apply comparable standards for its M/S determinations in a manner that is no more stringent than the standards applied by the Plan for its MH/SUD review. The Department finds the Plan's proposed improvement of its ability to compare the delegates' UM processes with the Plan's processes will assist the Plan in maintaining MHPAEA parity.

#### **2. Assessment of Plan's Ability to Maintain Parity**

The Department found the Plan implemented several processes to assist its future MHPAEA compliance. To improve MHPAEA implementation, the Plan increased its behavioral health staffing by hiring a mental health Medical Director, a Director of behavioral health, and two autism specialists. The Plan also updated several policies, and provided training to its UM and member services staff regarding MH/SUD services. The Plan also sends providers quarterly mailings with notice of MH/SUD matters that might affect payment or processes. These noteworthy efforts, in addition to improved delegation oversight, should assist the Plan with its MHPAEA compliance.

Finally, during the Survey, the Department found that the Plan's grievance and appeals system does not allow for the identification and tracking of parity-related grievances. The system only includes a general code for behavioral services and only allows for coding for one level of complaints. If a member has multiple complaints, the most prevalent complaint is assigned a grievance code. Plan staff acknowledged they cannot search the grievance and appeal database for complaints related to MH/SUD issues. Therefore, in order to increase its identification, tracking and trending of parity issues, the Plan should change its system to capture more than one complaint code.

**Plan Response:** The Plan timely responded to the Preliminary Report, signed the required certification, and accepted the Department's findings to be accurate. With respect to the Delegation Oversight section, the Plan stated that it has already been conducting file review of both approval and denial files for all delegates conducting UM review for medical/surgical services and thus there was no need to specify the Plan would review medical/surgical approval files.

**Status:** The Department made the corrections identified by the Plan in its response.

#### **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**

January 15, 2016

### **VIA ELECTRONIC MAIL**

Molina Healthcare of California  
200 OceanGate, Suite 100  
Long Beach, CA 90802

The Department of Managed Health Care (Department) has reviewed the information submitted in the above-referenced filing (Amendment) filed by Molina Healthcare of California (Plan) for compliance with the Knox-Keene Health Care Service Plan Act of 1975, as amended<sup>1</sup> and with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act<sup>2</sup> (MHPAEA) and federal final rules.<sup>3</sup> 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 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<sup>4</sup>. Hence, the Plan may need to further modify the MH/SUD cost-sharing summarized below within standard benefit plan design coverage for 2016.

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<sup>1</sup> 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

<sup>2</sup> Public law 110-343, 42 U.S.C. § 300gg-26.

<sup>3</sup> 45 CFR § 146.136 (2013).

<sup>4</sup> Government Code sections 100503 and 100504(c), Health and Safety Code section 1366.6(e), and 10 CCR section 6460

<b>Plan Coverage Name</b>	<b>Types of Service</b>	<b>Current Cost-Sharing</b>	<b>Cost-Sharing as of 1/1/2016<sup>5</sup></b>
Individual Platinum 90 HMO Plan	Mental health services: partial hospital treatment program, multidisciplinary treatment in an intensive outpatient program, day treatment programs, behavioral health treatment for PDD/autism	10% coinsurance	10% coinsurance (maximum \$20)
Individual Platinum 90 HMO Plan	Substance use disorder services: intensive outpatient programs, day treatment programs	10% coinsurance	10% coinsurance (maximum \$20)
Individual Gold 80 HMO Plan	Mental health services: partial hospital treatment program, multidisciplinary treatment in an intensive outpatient program, day treatment programs, behavioral health treatment for PDD/autism	20% coinsurance	20% coinsurance (maximum \$35)
Individual Gold 80 HMO Plan	Substance use disorder services: intensive outpatient programs, day treatment programs	20% coinsurance	20% coinsurance (maximum \$35)
Individual Silver 70 HMO Plan	Mental health services: partial hospital treatment program, multidisciplinary treatment in an intensive outpatient program, day treatment programs, behavioral health treatment for PDD/autism	20% coinsurance after deductible	20% coinsurance after deductible (maximum \$45)
Individual Silver 70 HMO Plan	Substance use disorder services: intensive outpatient programs, day treatment programs	20% coinsurance after deductible	20% coinsurance after deductible (maximum \$45)

<sup>5</sup> Cost-sharing within individual and small group nongrandfathered standard benefit plan design coverage may need to be further revised to comply with Covered California regulations for 2016 coverage.

Individual Silver 73 HMO Plan	Mental health services: partial hospital treatment program, multidisciplinary treatment in an intensive outpatient program, day treatment programs, behavioral health treatment for PDD/autism	20% coinsurance after deductible	20% coinsurance after deductible (maximum \$40)
Individual Silver 73 HMO Plan	Substance use disorder services: intensive outpatient programs, day treatment programs	20% coinsurance after deductible	20% coinsurance after deductible (maximum \$40)
Individual Bronze 60 HMO Plan	Mental health services: partial hospital treatment program, multidisciplinary treatment in an intensive outpatient program, day treatment programs, behavioral health treatment for PDD/autism	30% coinsurance after deductible	100% coinsurance after deductible (maximum \$70)
Individual Bronze 60 HMO Plan	Substance use disorder services: intensive outpatient programs, day treatment programs	30% coinsurance after deductible	100% coinsurance after deductible (maximum \$70)

2. The Plan shall utilize nonquantitative treatment limits that have been reviewed and not objected to by the Department in the Amendment, including but not limited to the Plan's revised definition of medical necessity.
3. The Plan shall revise its EOCs and other disclosure documents to disclose MHPAEA-compliant cost-sharing, quantitative treatment limits, and nonquantitative treatment limits, and other revisions that have been reviewed and not objected to by the Department in the Amendment. These revisions include, but are not limited to:
  - a. EOCs:
    - i. Updating cost-sharing for mental health and substance use disorder services, as noted in the chart above.
    - ii. Clarifying the mental and substance use disorders that are covered under the plan contract and expanding the descriptions of the inpatient and outpatient services that are covered to treat those disorders.
    - iii. Clarifying prior authorization requirements for MH/SUD services.
    - iv. Updating the definition of medical necessity.
  - b. Schedules of Benefits and SBCs: Updating cost-sharing information on inpatient and outpatient MH/SUD services, as noted in the chart above.

4. 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.<sup>6</sup>
5. 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.<sup>7</sup>

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.

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<sup>6</sup> California Health and Safety Code § 1374.76.

<sup>7</sup> Ibid.