DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FOLLOW-UP REPORT

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

OF

WESTERN HEALTH ADVANTAGE

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: JANUARY 22, 2019

Follow-Up Report
Focused Survey of Mental Health Parity and Addiction Equity Act Implementation
Western Health Advantage, Inc.
January 22, 2019

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EXECUTIVE SUMMARY

In the Final Report for the Focused Survey of Mental Health Parity and Addiction Equity Act (MHPAEA) Implementation, dated April 26, 2018, the Department of Managed Health Care (Department) identified four non-compliant findings requiring corrective action. Western Health Advantage, Inc. (Plan) was advised that the Department would conduct a follow-up review (Follow-Up Survey) to assess the status of the four outstanding findings and issue a report.

On May 16, 2018, the Department notified the Plan that the Follow-Up Survey had commenced, and requested the Plan submit information regarding its uncorrected findings as cited in the Final Report. The Final Report may be reviewed here: Western Health Advantage Final Report of the Focused Survey of MHPAEA Implementation.

The Department conducted the Follow-Up Survey pursuant to the Knox-Keene Health Care Service Act of 1975 (Act), codified at Health and Safety Code section 1340 *et seq.,* and Title 28 of the California Code of Regulations section 1000 *et seq*.[1], specifically Section 1374.76, which directs group and individual plans to provide all covered mental health and substance use disorder (MH/SUD) benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA) no later than January 1, 2015, and authorizes the Department to issue guidance to plans concerning MHPAEA compliance.

The Follow-Up Survey found the outstanding findings to be corrected.

	MHPAEA FOLLOW-UP SURVEY STATUS OF FINDINGS FROM FINAL REPORT ISSUED ON APRIL 26, 2018	
#	**FINDING STATEMENT**	**FOLLOW-UP SURVEY STATUS**
	NONQUANTITATIVE TREATMENT LIMITATIONS	
1	**The Plan does not ensure that the processes, standards, and factors used to apply utilization management to mental health/substance use disorder benefits are comparable to, and applied no more stringently than the criteria used to apply utilization management to medical/surgical benefits in the same classifications.** Health and Safety Code section 1374.76; 45 CFR 146.136(c)(4)(i).	**Corrected**

[1] All references to "Section" are to the Health and Safety Code unless otherwise indicated. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

2	**For emergency services, the Plan does not ensure that the criteria used to apply utilization management to mental health/substance use disorder benefits are comparable to, and applied no more stringently than the criteria used to apply utilization management to medical/surgical benefits in the same classifications.** Health and Safety Code section 1374.76; 45 CFR 146.136(c)(4)(i).	**Corrected**
	QUANTITATIVE TREATMENT LIMITATIONS	
3	**The Plan has not classified behavioral health treatment for pervasive development disorder/autism (BHT for PDD) delivered in the home using the same standards for classification as used for medical/surgical benefits.** Health and Safety Code section 1374.76; 45 CFR 46.136(c)(2)(ii)(A) and (c)(3)(iii)(C).	**Corrected**
4	**The Plan did not properly calculate financial requirements in accordance with the MHPAEA final regulations.** Health and Safety Code section 1374.76; 45 CFR 146.136(c)(ii), (c)(2)(i) and (c)(3)(i)(A).	**Corrected**

SECTION I: SUMMARY OF OUTSTANDING FINDINGS FROM FINAL REPORT AND FOLLOW-UP SURVEY FINDINGS QUANTITATIVE TREATMENT LIMITATIONS

The following details the Department's assessment regarding the outstanding findings.

FINDINGS

A. NONQUANTITATIVE TREATMENT LIMITATIONS

#1 The Plan does not ensure that the processes, standards, and factors used to apply utilization management to mental health/substance use disorder benefits are comparable to, and applied no more stringently than the criteria used to apply utilization management to medical/surgical benefits in the same classifications.

Statutory/Regulatory Reference: Health and Safety Code section 1374.76; 45 CFR 146.136(c)(4)(i).

Plan's Follow-Up Compliance Effort: The Plan contracted with an outside vendor to assess MHPAEA compliance with respect to the Plan's review processes for prior authorization, concurrent, and retrospective review in four benefit classifications: Inpatient, Residential/SNF, Outpatient Office, and Outpatient-Other Services. The vendor reviewed and compared the language in utilization management policies and procedures (UM P&Ps) between the medical/surgical (M/S) delegates and mental health/substance use disorder (MH/SUD) delegate and found that the UM P&P language was MHPAEA compliant with respect to the Plan's review processes for prior authorization, concurrent, and retrospective review.

The Plan also provided a newly drafted policy *COMP-022-POL-MHPAEA Compliance Policy* (MHPAEA Compliance Policy). The purpose of the MHPAEA Compliance Policy is to ensure comparable classification of benefits between M/S and MH/SUD services. In addition, the Plan also provided a newly drafted document, *COMP-022-STD-MHPAEA Compliance Standard* (MHPAEA Compliance Standard), which ensures MHPAEA compliance by requiring the Plan to perform an annual comparability analysis of M/S and MH/SUD benefits. The Plan's review includes:

- Ensuring that NQTLs imposed by the Plan and/or its delegates are comparable and applied no more stringently to MH/SUD benefits;
- Auditing denial files of delegates to ensure that NQTLs are comparable and applied no more stringently to MH/SUD benefits;
- Reviewing Evidence of Coverage and Disclosure Form and Copayment Summary documents so that descriptions regarding MHPAEA are clear and complete; and
- Training and oversight of delegates.

Finally, the Plan provided its *Delegate Audit Tool* and supplemental audit tools, which are used to review delegate files for MHPAEA compliance. The Plan uses these tools to

review the criteria used for reviewing requested services, comparing actual turn-around timeframes with those listed in the policies and procedures, evaluating how often concurrent review took place, and reviewing documentation noted in the files.

Plan Document Review

The Plan submitted the following documents regarding its corrective actions:

- Comparability Study;
- COMP-022-POL-MHPAEA Compliance Policy;
- COMP-022-STD-MHPAEA Compliance Standard;
- Delegate Audit Tools

Follow-Up Survey Assessment: The Plan commenced a comprehensive NQTL *Comparability Study*, which provided the Plan with an extensive analysis of the UM processes utilized by the Plan's M/S and BH delegates. In addition, the Plan's *MHPAEA Compliance Policy*, *MHPAEA Compliance Standard*, and *Delegate Audit Tools* demonstrate that the Plan has implemented a process to ensure parity by improving its oversight by assessing MHPAEA compliance on an annual basis. Thus, the Plan has taken action to ensure that UM criteria is comparable and not applied in a more stringent manner to requests for MH/SUD services.

Follow-Up Report Finding Status: Corrected

The Department finds that the Plan has developed and implemented MHPAEA review and oversight processes to ensure comparable application of UM criteria between M/S and MH/SUD services. 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 document review, the Department found that the Plan's processes, strategies and other factors used to conduct UM review are MHPAEA compliant in the Inpatient and Outpatient classifications.

Based upon the corrective actions undertaken, the Department has determined that this finding has been corrected by the Plan.

#2 For emergency services, the Plan does not ensure that the criteria used to apply utilization management to mental health/substance use disorder benefits are comparable to, and applied no more stringently than the criteria used to apply utilization management to medical/surgical benefits in the same classifications.

Statutory/Regulatory Reference: Health and Safety Code section 1374.76; 45 CFR 146.136(c)(4)(i).

Plan's Follow-Up Compliance Effort: The Plan's behavioral health (BH) delegate agreed to end retrospective review of emergency room (ER) claims. The Plan provided the *WHA Account Information Summary* as evidence that its BH delegate pays ER claims without any review as of June 15, 2017. The Plan further explained that it will include a review of its BH delegate's ER claims to ensure compliance.

Plan Document Review

The Plan submitted the following documents regarding its corrective actions:

- WHA Account Information Summary

Follow-Up Survey Assessment: The Plan demonstrated that its BH delegate is no longer providing retrospective review of ER claims as of June 15, 2017. The Plan will further ensure compliance by reviewing BH delegate ER claims. Thus, the Plan has taken action to ensure that UM criteria for ER claims is comparable and will not be applied in a more stringent manner to requests for MH/SUD services.

Follow-Up Report Finding Status: Corrected

By eliminating retrospective review of ER claims by the BH delegate, the criteria used to apply UM to review of MH/SUD ER claims is comparable and is not being applied more stringently than the criteria used to apply UM to M/S ER claims. 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. The Department finds that by eliminating retrospective review of MH/SUD ER claims, the Plan is MHPAEA compliant.

Based upon the corrective actions undertaken, the Department has determined that this finding has been corrected by the Plan.

B. QUANTITATIVE TREATMENT LIMITATIONS

#3 The Plan has not classified behavioral health treatment for pervasive development disorder/autism (BHT for PDD) delivered in the home using the same standards for classification as used for medical/surgical benefits.

Statutory/Regulatory Reference: Health and Safety Code section 1374.76; 45 CFR 46.136(c)(2)(ii)(A) and (c)(3)(iii)(C).

Plan's Follow-Up Compliance Effort: The Plan submitted revised Exhibit J-11 and J-12-A worksheets, which show the classifications assigned to each type of service. The Plan also submitted the *2018 Evidence of Coverage* (EOC) for three different benefit plan designs demonstrating that as of January 1, 2018, the Plan classifies BHT for PDD in both the outpatient office visits and outpatient other items and services classifications.

Plan Document Review

The Plan submitted the following documents regarding its corrective actions:

- Exhibit J-11-A and J-12-A worksheets
- 2018 Evidence of Coverage (EOC)

Follow-Up Survey Assessment: The Department's examination of the Plan's revised worksheets and EOC demonstrate that the Plan has appropriately classified BHT for PDD to reflect that this service is primarily provided in a home setting. Review of the EOC confirmed the Plan has appropriately revised the cost-sharing for this service.

Follow-Up Report Finding Status: Corrected

The Plan's revision of its classification of BHT for PDD to reflect that this service is provided primarily in the home is consistent with the Plan's classification of comparable M/S benefits. 45 CFR 146.136(c)(2)(ii)(A) provides that in determining the classification in which a particular benefit belongs, a plan must apply the same standards to M/S benefits as to MH/SUD benefits. The Department finds that by revising the classification for BHT for PDD delivered in the home to utilize the same standards for classification as used for medical/surgical (MS) benefits the Plan is MHPAEA compliant.

Based upon the corrective actions undertaken, the Department has determined that this finding has been corrected by the Plan.

#4 The Plan did not properly calculate financial requirements in accordance with the MHPAEA final regulations.

Statutory/Regulatory Reference: Health and Safety Code section 1374.76; 45 CFR 146.136(c)(ii), (c)(2)(i) and (c)(3)(i)(A).

Plan's Follow-Up Compliance Effort: The Plan now differentiates co-pay from co-insurance when calculating the cost-share of the predominant amount that applies to substantially all M/S benefits in the affected Benefit Plan Designs (BPDs) categories. The Plan published the corrected cost-sharing amounts in the EOC for each affected BPD. The Plan also worked with its BH delegate to identify all affected enrollees who overpaid as a result of the Plan's improper cost-sharing. The Plan identified 15 enrollees and reimbursed a total amount of $9,725.78.

Plan Document Review

The Plan submitted the following documents regarding its corrective actions:

- 2018 Evidence of Coverage (EOC)
- Attestation of mailed checks

Follow-Up Survey Assessment: The Plan submitted evidence detailing that affected enrollees were appropriately reimbursed for overpayments. The Department's review of the EOC determined that the Plan differentiates co-pay from co-insurance amounts

when calculating the cost-share of the predominant amount that applies to substantially all M/S benefits.

Follow-Up Report Finding Status: Corrected

The Plan corrected this parity issue by differentiating co-pays from co-insurance amounts when determining the predominate amount of cost-sharing that applies to substantially all M/S benefits in each classification of benefits and applying that same amount to the MH/SUD benefits in the same classification. 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. The Plan has corrected this parity finding by differentiating co-pays and co-insurance when calculating cost-sharing amounts. Finally, the Plan provided evidence that it had identified and reimbursed all affected enrollees.

Based upon the corrective actions undertaken, the Department has determined that this finding has been corrected by the Plan.

SECTION II: SURVEY CONCLUSION

Issuance of this Follow-Up Report concludes the Focused Survey of the Plan. The Department finds that the Plan has corrected all of the findings that remained uncorrected upon issuance of the Final Report on April 26, 2018.

In the event the Plan would like to append a brief statement to the Follow-Up Report as set forth in Section 1380(i)(3), 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 Follow-Up Report:

- Click the eFiling link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the **DPS Routine Survey Document Request** titled**, 2018 Routine Full Service Survey - Document Request.**
- Submit the response to the Follow-Up Report via the DMHC Communication tab.

As a reminder, any amendments and modifications made to the Plan's licensing documents as a result of this Focused Survey must be submitted to the Department via the web portal using the File Documents link. The Plan should indicate in its Exhibit E-1 Summary of eFiling Information that the document is being filed as a result of a MHPAEA finding identified by the Division of Plan Surveys**.**