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

WESTERN HEALTH ADVANTAGE

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: APRIL 26, 2018

Final Report
Focused Survey of Mental Health Parity and Addiction Equity Act Implementation
Western Health Advantage
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TABLE OF CONTENTS

EXECUTIVE SUMMARY

On April 4, 2016, the California Department of Managed Health Care (Department) notified Western Health Advantage (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 from June 14 through 16, 2016. For the survey review period of January 1, 2016 to April 1, 2016, the Department identified four findings requiring corrective action summarized below.

The Preliminary Report was issued to the Plan on November 28, 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 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

[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.

investigative. The Department's NQTL review focused on medical management standards based on plans' 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 caps on benefits based on the frequency of treatment, number of visits, days of coverage or days in a waiting period.

[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.

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 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).
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).
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).
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).

PLAN BACKGROUND

Western Health Advantage is a Sacramento-based, full-service, not-for-profit, mutual benefit corporation, classified as a Group Model HMO. It received its Knox-Keene license in 1997. The Plan has membership in the following counties: Amador, Colusa, Contra Costa, El Dorado, Marin, Napa, Nevada, Placer, Sacramento, Solano, Sonoma,

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

and Sutter. As of March 31, 2016, the Plan had 125,292 enrollees in commercial individual, large, and small group products.

The Plan contracts with six medical groups: Hill Physicians Medical Group, Mercy Medical Group, Dignity Health Woodland Healthcare, UC Davis Health System, North Bay Healthcare, and Meritage Medical Network. These medical groups are delegated to perform utilization review for M/S services.

For utilization review of MH/SUD, the Plan contracts with Human Affairs International (HAI), which is owned by Magellan Health.[9]

[9] Where this report refers to Magellan criteria, HAI has reviewed the enrollee's requested service through the application of Magellan guidelines and criteria.

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 Western Health Advantage 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 nine 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 five additional BPDs for Western Health Advantage:

- BPD #1: Individual: Silver 94
- BPD #2: Small Group: Gateway 70
- BPD #3: Small Group: Sierra 40
- BPD #4: Large Group : Advantage 420 MHP
- BPD #5: Large Group: Western 4025 MHP

These BPDs were not previously submitted to the Department, and were reviewed to assess whether the Plan demonstrated it was applying appropriate cost-sharing and financial requirements.

FINDINGS

A. NONQUANTITATIVE TREATMENT LIMITATIONS

#1 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).

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). Plans offering benefits to individuals and small groups must also comply with 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 117 utilization management (UM) files (see Table 1)
- Plan policies and procedures
- Western Health Advantage 2016 Combined Evidence of Coverage and Disclosure Form (EOC) – CalChoice Sierra 40
- Interviews with Plan and delegate staff

Assessment:

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; and
- 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

Category of Benefits	Number of Medical/Surgical Files Reviewed	Number of Mental Health Files Reviewed	Number of Substance use Disorder Files Reviewed
Inpatient	10	10	4
SNF/ Residential	10	2	10
Office Visit	10	0	0
Other Outpatient	10	20	10
Other Findings	10	10	1
Total files Reviewed	**50**	**42**	**25**

1. Inpatient

A. File Review

(i) Inpatient Hospitalization

Medical/Surgical:

The Department reviewed 10 M/S files involving inpatient hospitalization. The files were from Plan delegates: UC Davis Medical Group, Meritage Medical Network, Mercy Medical Group, Hill Physicians Medical Group, and the Woodland Clinic Medical Group. The delegates approved all of the requested services. Six of the 10 files involved ER admissions for various issues such as an inflamed gallbladder, GI bleeding, fevers, abdominal pain, and electrolyte imbalance. Other services included a thyroidectomy and a total knee replacement. All of the 10 files involved requests for in-network services. The length of admission ranged from one to four days. Eight of the 10 files demonstrated application of criteria. Six files from UC Davis, Mercy, and Woodland Clinic demonstrated application of InterQual[15] criteria; 2 files from Meritage demonstrated application of the medical group's criteria, and two files (one from UC Davis and one from Hill Physicians) demonstrated no application of criteria.

Mental Health:

The Department reviewed 10 inpatient MH files from HAI, which approved all requested services. All 10 files involved requests for in-network services. All files involved an admission due to the enrollee threatening self-harm, and five files specifically involved an admission based on a 5150[16] hold. The length of admission ranged from one to 11 days. All 10 files demonstrated application of Magellan criteria.

Substance Use Disorder:

The Department reviewed four inpatient SUD files. The Plan handled one file[17] and HAI handled the other three, and all requested services were approved. Three of the four files involved requests for in-network services for detoxification. The length of admission ranged from two to five days. Two files demonstrated application of Magellan criteria and two demonstrated application of Plan criteria.

(ii) SNF/Residential

Medical/Surgical SNF:

The Department reviewed 10 M/S files involving approvals for skilled nursing facility (SNF) services. The files came from Plan delegates: UC Davis Medical Group, Woodland Clinic Medical Group, Mercy Medical Group, Hill Physicians Medical Group, and Meritage Medical Network, which approved all of the requests for SNF services.

[15] InterQual is a standardized medical review tool to establish level of care.
[16] 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.
[17] The Plan explained that it sometimes handles less complicated mental health matters.

Nine of the 10 files involved requests for in-network services. The length of admission ranged from four to 84 days. Three files demonstrated application of Plan and Centers for Medicare/ Medicaid Services criteria while the other seven files did not specify any criteria and/or discuss the medical necessity criteria relied upon for the approval.

MH Residential:

The Department reviewed two inpatient MH files involving approvals for residential treatment services. Both files involved requests for in-network services, and were requests for residential treatment of an eating disorder and a psychiatric condition. The length of admission ranged from 18 to 23 days. Both files demonstrated application of Magellan criteria.

SUD Residential:

The Department reviewed 10 SUD files, handled by HAI. All 10 files involved requests for in-network services related to admissions for detoxification. The length of admission ranged from one to 5 days. Six of the 10 files demonstrated application of Magellan criteria while the other four did not document criteria, but did include the clinical rationale for allowing the enrollee detoxification treatment through partial hospitalization or residential treatment.

Table 2 – Inpatient Hospitalization and SNF/Residential Summary

File Type	Number of Files	Basis for UM Determination
Inpatient M/S Files	10	InterQual (6); Medical Group (2); no criteria (2)
Inpatient MH Files	10	Magellan (10)
Inpatient SUD Files	4	Magellan (2) WHA (2)
M/S SNF	10	Medicare/ Medicaid Services (3); no criteria and/or evidence of clinical rationale (7)
MH Residential	2	Magellan (2)
SUD Residential	10	Magellan (6); clinical rationale (4)

A. Inpatient Interviews

The Department conducted interviews with Plan staff to understand the Plan's operational processes when applying UM criteria in the Inpatient classification. The Plan

delegates almost all of the UM review for M/S services to six different medical groups[18] and UM review for MH/SUD services exclusively to HAI/Magellan. Plan staff acknowledged that when approving M/S services, each of the six medical groups utilized differing UM processes and varied UM criteria including national guidelines as well as specific medical group criteria. However, the staff could not specifically account for the differences in the UM processes and/or application of UM criteria between the six delegated medical groups. The staff also could not explain whether the processes and criteria used by the six medical groups were comparable to the UM processes and criteria used by Magellan for MH/SUD services. Accordingly, the Plan was not able to demonstrate that a process exists to ensure comparable application of UM process or criteria between MH/SUD and M/S services.

The interviews also established that the Plan, in operation, has a different relationship with the six medical groups when approving M/S services than with HAI/Magellan when approving MH/SUD services. The Plan's Medical Director emphasized having a close working relationship with the Medical Directors at the six different medical groups, and that in some instances M/S services are approved after a phone call and a discussion concerning treatment. However, the Medical Director did not indicate he engaged in similar discussions with HAI/Magellan to approve MH/SUD services.

Inpatient Conclusion:

In the Inpatient classification, while the Department found evidence enrollees had obtained necessary M/S and MH/SUD services,[19] the file review results and the information obtained during interviews demonstrated that the processes and evidentiary standards used in applying UM to MH/SUD services were not comparable to those used when applying UM to M/S services. Furthermore, the results from the file review in this classification established the Plan applied UM criteria more stringently to MH/SUD services than for M/S services.

The interviews clarified how the Plan's reliance on its delegates has resulted in a process that is not comparable between MH/SUD and M/S for approving services. The Department determined that while the M/S approval processes for the six medical groups is likely beneficial for enrollees to obtain services timely, and may also serve to streamline the Plan's day-to-day operations, the Department also found that the authorization process for approving MH/SUD services was not comparable to the authorization process for approving M/S services. The Department therefore determined the Plan does not apply a comparable process and/or criteria between M/S and MH/SUD services and that UM criteria is applied in a more stringent manner to MH/SUD services.

In addition, the Department found that the strict use of Magellan criteria by HAI/Magellan to authorize MH/SUD services is not comparable to the range of criteria such as InterQual, medical group specific criteria, and/or clinical rationale used by the

[18] The Plan oversees Emergency and Out-of-Network requests.
[19] The NQTL analysis does not focus on whether the final result in terms of obtaining services is the same. Rather, MHPAEA compliance depends on parity in application of the underlying processes and strategies. See FAQ #3 from the October 27, 2016 Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury.

six medical groups to authorize M/S services. MH/SUD files documented that only HAI/Magellan criteria were applied. However, M/S files documented that a range of UM criteria were applied, including InterQual evidence-based criteria used by health care plans, insurers, hospitals, and companies nationally; as well as criteria developed by the Plan itself; and/or criteria developed by the Plan's contracted medical groups. While the Department did not thoroughly compare the HAI/Magellan criteria to the varied criteria utilized by the six medical groups, the Department nevertheless has concerns that the criteria may not be comparable. For instance, the criteria developed by companies such as InterQual and/or MCG, which are used by health care organizations nationally, were developed and implemented based on clinical evidence and peer-reviewed literature without consideration to a specific plan or medical group's day-to-day operations. Thus, the use of a single set of criteria by HAI for authorizing MH/SUD services, which was developed by HAI's affiliate, Magellan, does not appear comparable to the various criteria developed by the Plan and/or its medical groups for authorizing M/S services.

2. Outpatient

A. File Review

(i) Outpatient Office Visits

Medical Surgical:

The Department reviewed 10 M/S files involving approvals for outpatient office visit referrals. The files came from Plan delegates: Mercy Medical Group, North Bay Healthcare, UC Davis Medical Group, and Woodland Clinic Medical Group. The delegates approved all of the services, which included requests for annual obstetrician visits, an orthopedic consultation, and treatment for sleep apnea. Seven of the 10 files involved requests for in-network services. For the approvals, one of the 10 requests demonstrated reliance on Plan guidelines; three demonstrated clinical rationale; two received automatic authorization, and four did not expressly cite criteria.

Mental Health/Substance Use Disorder:

The Plan did not have any MH or SUD UM approval files and thus the Department did not review files in this category.

(ii) Outpatient – Other Items and Services

Medical Surgical:

The Department reviewed 10 M/S files involving requests for outpatient, non-office visit services. The files came from Plan delegates: North Bay Healthcare, Mercy Medical Group, Woodland Clinic Medical Group, and UC Davis Medical Group. The various requested services included a request for foot orthotics, Magnetic Resonance Imaging (MRI), a minor outpatient surgery, speech therapy, physical therapy, and treatment for sleep apnea. Nine of the 10 files involved requests for in-network services. Three of the 10 files demonstrated approval of services based on application of InterQual criteria, one was based on Milliman Care Guidelines (MCG), two were based on WHA guidelines, one did not cite any guidelines, but demonstrated clinical reasoning, and

three were based on the *Exceptions Approvals Policy*, which allows the Plan's utilization management reviewer to bypass physician review if the requested service has been determined by the medical group to merit automatic approval. The two *Exceptions Approvals Policy* files did not cite criteria or clinical reasoning for the Plan's decision.

Mental Health:

The Department reviewed 20 MH files handled by HAI. All 20 requests were for in-network services, which were requests for partial hospitalization or intensive outpatient treatment for eating disorders, suicidal ideation, anxiety, and Applied Behavior Analysis (ABA) to treat children with autism. HAI approved all services. Sixteen of the 20 files demonstrated application of Magellan criteria while the other four files did not cite any criteria, but did document the clinical rationale for the approval.

Substance Use Disorder:

The Department reviewed 10 SUD files handled by HAI. All 10 requests were for in-network services seeking intensive outpatient services. HAI approved all services. All 10 files demonstrated application of Magellan criteria for treatment of substance use.

Table 3 – Outpatient Office Visit and Outpatient Other - Summary

File Type	Number Of Files	Basis for UM Determination
M/S Office visits	10	Plan guidelines (1); clinical rationale (3); auto-authorization (2); none (4)
MH Office visits	0	N/A
SUD Office visits	0	N/A
M/S Outpatient – other services	10	InterQual criteria(3); MCG guidelines (1); WHA guidelines (2); clinical reasoning (1); Exceptions Approvals Policy without citation to criteria or clinical reasoning (3)
MH Outpatient – other services	20	Magellan (16); clinical rationale (4)
SUD Outpatient – other services	10	Magellan/HAI (10)

B. Outpatient Interviews

During interviews, HAI stated that for MH/SUD outpatient services there is generally no prior authorization or concurrent review.[20] HAI's representation that prior authorization and/or concurrent review is not required for outpatient services, therefore provided some evidence that in practice, HAI may utilize a more favorable, less stringent, UM criteria standard to approve MH/SUD services. The interviews established the six medical group delegates used prior authorization and/or concurrent review to approve M/S services.

C. Documents

The Department reviewed the Plan's 2016 EOC, which did not support HAI's representation that there is generally no prior authorization review for MH/SUD outpatient services. The Plan's 2016 EOC provides a specific list of MH/SUD services that require prior authorization: "non-routine outpatient behavioral health services, outpatient electroconvulsive therapy, intensive outpatient, partial hospitalization, psychological testing, repetitive transcranial magnetic stimulation, applied behavioral analysis and office based opioid treatment." With regard to M/S services, the 2016 EOC indicated that prior authorization was required for "physical, speech, and occupational therapy, rehabilitation services such as cardiac, respiratory, and pulmonary services, all surgeries, infertility services, scheduled tests and procedures." Accordingly, based on review of the Plan's 2016 EOC, the Department found that the Plan appears to require comparable prior authorization for both MH/SUD and M/S services.

Outpatient Conclusion:

In the Outpatient classification, the lack of MH/SUD files resulted in the Department's inability to draw a conclusion from file review in the Outpatient Office Visits category. However, for Outpatient Other Items and Services, file review results demonstrated the Plan applies a range of UM criteria for M/S services while only Magellan criteria is applied to MH/SUD approvals. The Department therefore determined the Plan does not apply a comparable process and/or criteria between M/S and MH/SUD services and that UM criteria is applied in a more stringent manner to MH/SUD services.

While HAI represented that no prior authorization is required for outpatient services, which provided some evidence that a less stringent standard may be applied when approving MH/SUD outpatient services, this statement was not supported by the Department's file review or the language of the Plan's 2016 EOC, which required prior authorization for numerous M/S and MH/SUD services. The 2016 EOC language, therefore, established that in the outpatient services classification, the Plan appears to require comparable prior authorization for both MH/SUD and M/S services. However, based on the 2016 EOC language, which requires prior authorization, the Department could not determine the Plan applies a less stringent standard with respect to prior authorization when approving MH/SUD services in the Outpatient Other Items and Services classification.

3. Other Findings

[20] HAI represented that the only MH/SUD outpatient services requiring preauthorization are electroconvulsive therapy, psychological testing, and transmagnetic stimulation.

A. File Review

(i) Retrospective

Medical Surgical:

The Department reviewed 10 M/S files involving retrospective authorization for previously rendered services. The files came from Plan delegates: Hill Physicians Medical Group, North Bay Healthcare, and Mercy Medical Group. The delegates approved nine of the 10 requests,[21] which included requests for various services including: removal of excess bone from a toe, freezing of skin tags, vaccinations, and durable medical equipment (shoulder brace and walking boot.) Six of the 10 files were for in-network services. Only one of the 10 files demonstrated specific application of medical group criteria (Hill Physicians.) The other nine files did not list any criteria for the approvals, but did cite clinical information justifying the approval.

Mental Health:

The Department reviewed 10 MH files handled by HAI, which approved all 10 requests. Nine of the 10 requests were for in-network services, which included five bridge appointments,[22] intensive outpatient services, and partial hospitalization. Bridge appointments are approved automatically, and therefore these files did not document specific criteria. The remaining services were approved on the basis of administrative overturn without specific criteria cited. The basis for HAI's approval in the remaining five files was inconclusive. None of the 10 files contained criteria for HAI's approval.

Substance Use Disorder:

The Department reviewed one inpatient SUD file, handled by HAI, which was an in-network request for five days of partial hospitalization treatment. HAI approved the service by noting the entire claim had not initially been paid due to administrative error, and therefore the file did not cite any clinical criteria.

Table 4 – Other Findings Summary

File Type	Number Of Files	Basis for UM Determination
M/S Retrospective	10	criteria (1); no criteria (9)
MH Retrospective	10	No criteria in all10; but (5) files cited were auto authorized as bridge appointments

[21] An out-of-network x-ray was denied because a medical group did not send the claim for payment.
[22] For MH and SUD enrollees in HAI/Magellan contracted facilities, HAI arranges a "bridge appointment" which consists of the enrollee meeting with a facility provider after discharge but before leaving the facility to review the discharge plan and assure that the enrollee has a post-discharge appointment with a provider. Bridge appointments are not subject to prior approval and are automatically approved retroactively.

SUD Retrospective	1	No criteria; approved as admin. error

B. Other Findings Interviews

During the interviews, HAI/Magellan stated that bridge appointments are automatically approved retrospectively. HAI/Magellan explained that a "bridge appointment" is provided to enrollees in HAI/Magellan contracted facilities. At the bridge appointment, the enrollee's discharge plan is discussed, and the enrollee is assured to have a post-discharge appointment.

Other Findings Conclusion:

Given the disparity in the type of files reviewed, the results of the file review in the Other Findings classification were inconclusive to establish whether the Plan has a comparable process when approving MH/SUD and M/S services and/or whether criteria is being applied more stringently to MH/SUD than M/S services. However, in this category, the Department determined the Plan's automatic approval of MH/SUD bridge appointments established that the Plan utilizes a retrospective approval process for MH/SUD services that is not comparable to M/S services; yet, the process is being applied in a less stringent manner for approving MH/SUD services.

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 not MHPAEA compliant in the Inpatient and Outpatient classifications.

Plan Response:

The Plan responded timely to the Preliminary Report and acknowledged the findings. The Plan reports that all Plan delegates are using national criteria developed by either InterQual or Milliman Care Guidelines (MCG) to review both M/S and MH/SUD services. The Plan has also reviewed its Evidence of Coverage and Disclosure Form documents to ensure that the information regarding the necessity of prior authorization for MH/SUD outpatient services is accurate and clear.

In order to ensure that the criteria used to apply utilization management to MH/SUD benefits are comparable and applied no more stringently than the criteria applied to M/S services, the Plan explained it will contract with a third party to conduct a Comparability Study. The Comparability Study will begin in July 2018 and conclude in October 2018 with a report to the Department. The Comparability Study will compare the Plan's UM criteria with the 2017 medical group and behavioral health delegates (collectively "Plan delegates"). For each Plan delegate, the Comparability Study will review the prior

authorization, concurrent, and retrospective review processes within each of the classifications and subclassifications set forth in the Department's MHPAEA report. If any areas of non-compliance are found, the Plan will require the Plan delegate to change its UM policies and procedures. Lessons and experience gained from performing the Comparability Study, including any feedback from the Department, will be used to expand the Comparability Study to review new Plan delegates added in 2018.

In addition, beginning in 2018, the Plan will also conduct an annual review of all Plan delegates' UM policies & procedures. The Plan will evaluate the UM policies & procedures to ensure that parity has not been compromised, and any non-compliance will be corrected promptly by communicating the findings with the Plan delegate. Finally, as part of its annual UM audit of delegates, the Plan will audit a sample of files to determine whether the Plan delegate is adhering to its UM policies and procedures, and any results and corrective actions will be reported to the Plan's Quality Improvement Committee (QIC).

Status:

Based upon the Plan's response, the Department has determined that Finding #1 has not been corrected. While the Plan has presented a corrective action plan that addresses the issues, the Plan has not yet submitted evidence to demonstrate it has taken the steps proposed to address Finding #1. The Department will assess the Plan's compliance and report the findings in the Plan's 2018 routine survey report.

#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).

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). Plans offering benefits to individuals and small groups must also comply with 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 if 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.

Assessment:

The Plan's behavioral health delegate, HAI, performs UM for MH/SUD services, including emergency services. During the Department's onsite interviews, HAI explained that it conducts retrospective review of all emergency room psychiatric claims as a regular part of its UM process. The purpose of HAI's review is to determine whether the visit qualified as a medically necessary psychiatric emergency. However, the Plan does not perform a similar retrospective review of all emergency M/S claims.[23]

Conclusion:

45 CFR 146.136(c)(4)(i) requires plans to apply criteria for approvals and denials for MH/SUD benefits in a manner that is comparable and no more stringent than the factors used for M/S approvals and denials. With respect to emergency room MH/SUD claims, HAI retrospectively reviews all such claims for medical necessity while the Plan only performs retrospective review of M/S claims for emergency claims submitted by non-contracted providers. The Department therefore determined the Plan is applying a standard of retrospective review for emergency room MH/SUD claims that is not comparable and is more stringent than the review of M/S emergency claims.

Plan Response:

The Plan responded timely to the Preliminary Report and acknowledged the findings in Finding #2. The Plan explained that HAI/Magellan's retrospective review of emergency claims was performed solely to allow its system to pay claims, and that effective June 15, 2017, HAI/Magellan revised its processes to discontinue retrospective review UM for emergency services.

Status:

Based upon the Plan's response, the Department has determined that Finding #2 has not been corrected. The Plan has not yet submitted evidence to demonstrate it has taken the steps proposed to address Finding #2. The Department will assess the Plan's compliance and report the findings in the Plan's 2018 routine survey report.

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

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

[23] During onsite interviews, the Plan explained that it reviews emergency claims submitted only by non-contracted facilities.

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). Plans offering benefits to individuals and small groups must also comply with Section 1367.005.

45 CFR 146.136(c)(2)(ii)(A) requires that when determining the classification of a particular benefit, a plan must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits.

45 CFR 146.136(c)(3)(iii)(C) provides that for purposes of applying the financial requirement and treatment limitation rules, a plan may divide its benefits furnished on an outpatient basis into two subclassifications: office visits and all other outpatient items and services.

Supporting Documentation or Evidence:

- The Plan's Exhibit J-11-A and Exhibit J-12-A worksheets[24]
- 2016 Evidence of Coverage and Summary of Benefits

Assessment:

In order to determine whether the Plan correctly classified covered services as required in the final federal regulations, the Department reviewed the Exhibit J-11-A and Exhibit J-12-A worksheets. The Plan's initial Exhibit J-11-A classified BHT for PDD in the Outpatient subclassification, Outpatient Office Visits. In support of this classification, the Plan contends that treatment BHT for PDD could be provided in a provider's office. However, the Plan further contends that for the convenience and benefit to enrollees, this service is provided in the enrollee's home, which the Plan characterizes as a "mobile office." During the survey, the Plan offered varying accounts as to where BHT for PDD services are provided. The Plan initially stated the services were provided exclusively in the home and then clarified that approximately 25% of these services are provided in an office. The Department therefore determined that the majority of services associated with BHT for PDD are provided in a non-office setting.

Conclusion:

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. In addition, 45 CFR 146.136(c)(3)(iii)(C), for purposes of applying financial requirements and treatment limitations, permits plans to divide outpatient benefits into two subclassifications: office visits and all other outpatient items and services. The federal rules therefore allow plans to distinguish between classifying services provided in the office from those provided in a location other than an office, such as an enrollee's home. Regarding the classification for BHT for PDD, there is a reasonable basis to classify this benefit in the Outpatient Other Items and Services

[24] Exhibit J-11-A and J-12-A 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-A is utilized to demonstrate compliance with the financial requirements of MHPAEA

subclassification, since the Plan acknowledged the majority of services associated with this service are not provided in the office. With regard to comparable M/S benefits, the Department found the Plan classified such benefits in the Outpatient Other subclassification rather than the Outpatient Office Visit subclassification. Alternatively, the Plan could classify BHT for PDD under both the Outpatient Office Visits and Outpatient Other Items and Services subclassifications. Based on the Plan's representations as to where BHT for PDD is provided, the Department found the Plan was unable to provide sufficient rationale required under 45 CFR 146.136(c)(2)(ii)(A) to support its reasoning for classifying BHT for PDD in the Outpatient Office Visit subclassification.

Plan Response:

The Plan responded timely to the Preliminary Report and acknowledged the findings in Finding #3. Effective January 1, 2018, the Plan will classify Applied Behavioral Analysis (ABA) in two classifications depending on the specific location where the enrollee receives ABA services.

Status:

Based upon the Plan's response, the Department has determined that Finding #3 has not been corrected. The Plan has not yet submitted evidence to demonstrate it has taken the steps proposed to address Finding #3. The Department will assess the Plan's compliance and report the findings in the Plan's 2018 routine survey report.

#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)

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). Plans offering benefits to individuals and small groups must also comply with Section 1367.005.

45 CFR 146.136(c)(ii) states that whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. Copayments and coinsurance are separate and distinct types of financial requirements.

45 CFR 146.136(c)(2)(i) prohibit plans from applying any financial requirement that is more restrictive than the predominant financial requirement of that type that applies to substantially all the M/S benefits in the same classification.

45 CFR 146.136(c)(3)(i)(A) provide that if a type of financial requirement does not apply to at least two-thirds of all the 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-A worksheets
- 2016 Evidence of Coverage and Summary of Benefits

Assessment:

In order to determine whether the Plan is correctly applying MHPAEA compliant cost-sharing in all BPDs, the Department reviewed five BPDs that were not previously submitted for the Department's review. The Department reviewed BPDs #1-5 (listed above). For all five BPDs, the Plan did not differentiate the copay from coinsurance when calculating the cost share of the predominant amount that applies to substantially all M/S benefits. In addition, for BPD #1, Classification C, the Plan incorrectly listed a 10% copay. The Department found that upon separating copays from coinsurance, this copay was actually less than 66.67%, and thus it failed the "substantially all" test for cost share since it did not apply to at least two-thirds of all M/S benefits in the classification. This copay therefore cannot be applied to MH/SUD benefits in that classification.

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. When examining the claims history for BPDs #1-5 to determine the predominant financial requirement or treatment limitation that applies to substantially all M/S benefits in those classifications, the Plan combined copayment and coinsurance claims in violation of 45 CFR section 146.136(c)(ii). In addition, for the 10% copay shown in BPD #1, Classification C, the Plan improperly calculated this copay since it did not apply to at least two-thirds of all M/S benefits in the classification and therefore violates 45 CFR section 146.136(c)(2)(i) and (c)(3)(i)(A).

Plan Response:

The Plan responded timely to the Preliminary Report and acknowledged the findings in Finding #4. For the time period beginning January 1, 2016 until the time that the Plan revised its copayments to comply with the proper amounts identified in Finding #4, the Plan has worked with HAI/Magellan to identify enrollees that have paid improper cost-sharing. For these enrollees, the Plan will issue refunds by no later than June 30, 2018.

Status:

Based upon the Plan's response, the Department has determined that Finding #4 has not been corrected. While the Plan has presented a corrective action plan that addresses the issue of improper cost-sharing, the Plan has not yet submitted evidence of reimbursement to enrollees to demonstrate it has completed the steps proposed to correct Finding #4. To ensure the Plan has corrected this deficiency, the Department will review the Plan's evidence of enrollee reimbursement and report the findings in the Plan's 2018 routine survey report.

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. The purpose of this review was to capture the challenges faced by plans when implementing MHPAEA. By memorializing such issues, the Department's intent is to assist plans with their future MHPAEA compliance. The Department's observations are set forth below:

1. Delegation Oversight

In its implementation of MHPAEA, the Plan responded it had not made any changes to its oversight of HAI.[25] The Plan reasoned that since HAI holds a Knox-Keene license, HAI is required to meet MHPAEA requirements.[26] The Plan also explained that its agreement requires HAI to meet MHPAEA requirements. However, the Department notes that full service plans are responsible for ensuring that a behavioral health delegate such as HAI must provide MH/SUD services in parity with the Plan.

With regard to the Plan's six delegates and HAI/Magellan performing UM review, the Department finds the Plan must improve its oversight over the UM processes and UM criteria being applied to both M/S and MH/SUD services. For the six medical groups, the Department's file review indicated the delegates utilized a number of various criteria and guidelines for M/S approvals. Also, in some instances, the M/S files did not document the clinical guidelines/criteria relied upon to approve M/S services. Without uniformity in the application of criteria and guidelines and/or adequate documentation of the criteria applied for M/S approvals, the Plan may face challenges to assess whether comparable criteria is being applied in a manner that is not less stringent between MH/SUD and M/S services.

2. Assessment of Plan's Ability to Maintain Parity

The Plan explained its MHPAEA implementation included adding a parity grievance code to identify and monitor its parity complaints. The addition of this code should help the Plan identify and resolve parity issues.

[25] The Plan's oversight activities are based on the Industry Collaboration Effort (ICE) standard activities and reports. Each medical group and HAI are required to submit ICE reports, including monthly authorization and denial logs, annual reports, the UM program, and the case management program. The Plan prepares quarterly internal reports that look at the delegates' appeal and grievance activities and conducts annual onsite audits. If issues are identified, the Plan conducts focused audits, as necessary.
[26] The Plan's reasoning is incorrect. Since HAI's licensure is limited to mental health services, MHPAEA does not apply to HAI.

SECTION IV: SURVEY CONCLUSION

The Plan's operations were not found to be 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. The Plan's compliance will be further assessed at the Plan's next Routine Medical Survey, scheduled for June 2018.

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

DEPARTMENT OF Managed Health Care

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

December 2, 2015

VIA ELECTRONIC MAIL

Western Health Advantage
2349 Gateway Oaks, Suite 100
Sacramento, CA 95833

The Department of Managed Health Care (Department) has reviewed the information submitted in the above-referenced filing (Amendment) filed by Western Health Advantage (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	Cost-Sharing as of 1/1/2016[5]
Individual: Platinum 90 HMO Plan	Mental health and substance use disorder outpatient services other than an office visit: intensive outpatient program, partial hospitalization	$125 per day (day 1-5)	$20
Individual: Gold 80 HMO Plan	Mental health and substance use disorder outpatient services other than an office visit: intensive outpatient program, partial hospitalization	$300 per day (day 1-5)	$35
Individual: Silver 70 HMO Plan	Mental health and substance use disorder outpatient services other than an office visit: intensive outpatient program, partial hospitalization	20% after deductible	20% up to $45
Individual: Silver 73 HMO Plan	Mental health and substance use disorder outpatient services other than an office visit: intensive outpatient program, partial hospitalization	20% after deductible	20% up to $40 after deductible
Individual: Bronze 60 HMO Plan	Mental health and substance use disorder outpatient services other than an office visit: intensive outpatient program, partial hospitalization	30%	100% up to $70 after deductible

[5] Cost-sharing within individual and small group non grandfathered standard benefit plan design coverage may need to be further revised to comply with Covered California regulations for 2016 coverage.

Plan Coverage Name	Benefits Impacted (All In-Network)	Current Cost-Sharing	Cost-Sharing as of 1/1/2016[6]
Small Group: Platinum 90 HMO Plan	Mental health and substance use disorder outpatient services other than an office visit: intensive outpatient program, partial hospitalization	$125 per day (day 1-5)	$20
Small Group: Gold 80 HMO Plan	Mental health and substance use disorder outpatient services other than an office visit: intensive outpatient program, partial hospitalization	$300 per day (day 1-5)	$35
Small Group: Silver 70 HMO Plan	Mental health and substance use disorder outpatient services other than an office visit: intensive outpatient program, partial hospitalization	20% after deductible	20% up to $45
Small Group: Bronze 60 HMO Plan	Mental health and substance use disorder outpatient services other than an office visit: intensive outpatient program, partial hospitalization	30%	100% up to $70 after deductible

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 following revised policy and procedure: Pharmaceutical Management Procedures.

2. The Plan shall revise its EOCs, copayment summaries, Summaries of Benefits and Coverage (SBCs), and other disclosure documents for enrollees to disclose MHPAEA-compliant cost- sharing, quantitative treatment limits, and

[6] Cost-sharing within individual and small group non grandfathered standard benefit plan design coverage may need to be further revised to comply with Covered California regulations for 2016 coverage.

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. Copayment Summaries: the revisions in cost-sharing for the plans listed above.
b. EOCs:
    i. Behavioral Health Services section: the types of covered inpatient services, outpatient services, and office visits for mental health and substance use disorder services have been listed.
    ii. Prior Authorization Requirements: the covered mental health and substance use disorder services that require prior authorization and the process for obtaining prior authorization have been clarified.
    iii. Definitions section: the definition of "prior authorization" has been revised.
c. SBCs:
    i. Mental/behavioral health outpatient services: revisions to all the individual, small group, and large group benefit plan designs within the filing to disclose the cost- sharing for both office visit services and for outpatient services other than office visits.
    ii. Substance use disorder outpatient services: same revisions as noted in 3.c.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[7].

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[8].

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. 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

[7] California Health and Safety Code § 1374.76
[8] Ibid

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.