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

LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY PLAN DBA L.A. CARE HEALTH PLAN

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: JULY 18, 2018

Final Report
Focused Survey of Mental Health Parity and Addiction Equity Act Implementation
Local Initiative Health Authority for Los Angeles County
dba: L.A. Care Health Plan
July 18, 2018

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EXECUTIVE SUMMARY

On January 18, 2017, the California Department of Managed Health Care (Department) notified Local Initiative Health Authority for Los Angeles County dba: L.A. Care Health Plan (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 April 18, 2017 to April 20, 2017. For the survey review period of January 1, 2016 to January 18, 2017, the Department identified two findings requiring corrective action summarized below.

The Preliminary Report was issued to the Plan on February 26, 2018. The Plan had 45 days to file a certification document that bears the signature of one of the Plan's principal officers to certify the Report's accuracy.

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

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

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

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

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

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

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

To determine whether UM processes are comparable between M/S and MH/SUD services, the Department reviewed and compared UM files,[6] to the extent plans were able to produce files, within Inpatient, Outpatient, and Other Findings categories.[7] The Department also conducted interviews with plan staff to assess implementation of processes, strategies, evidentiary standards, and/or other factors used in plans' daily operations when applying UM criteria to both MH/SUD and M/S services. The Department evaluated whether plans' UM processes utilized for MH/SUD services were being applied in a manner that is no more stringent than the processes applied for M/S services. Finally, the Department reviewed relevant plan documents such as policies and procedures, and Evidences of Coverage (EOCs) to assess application of UM criteria and other written NQTLs.

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

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

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

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

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

FOCUSED SURVEY TABLE OF FINDINGS

NONQUANTITATIVE TREATMENT LIMITATIONS	
1	**The Plan does not ensure that the processes, standards, and 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	
2	**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)(2)(i) and (c)(3)(i)(A); 45 CFR 146.136 (c)(3)(i)(B)(1).

PLAN BACKGROUND

In 1993, Los Angeles Department of Health Services formed a council to plan and develop managed care services under a local government agency. As a result, Local Initiative Health Authority for Los Angeles County, dba: L.A. Care Health Plan (Plan) was founded in 1994. The Plan received its Knox-Keene license and first enrollees in April 1997. Current enrollment is 2,101,802 enrollees. For this MHPAEA survey, 23,000 enrollees are covered by the L.A. Care Covered California line of business.

The Plan offers 18 individual benefit plan designs to individuals. The Plan does not service small and large groups.

The Plan is a delegated model with three health plan partners: Blue Cross of California, Kaiser Foundation Health Plan, Inc., and Care First Health Plan. The health plan partners sub-delegate to eighteen participating physician groups (PPGs) which provide

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

services to Plan enrollees. The Plan maintains responsibility for oversight of the health plan partners' sub-delegates.

The Plan has an extended delegation program that allows select PPGs to authorize and coordinate UM activities. The goal of the extended delegation program is to streamline referral management by moving the decision-making process and care coordination closer to the provider and the member. The Plan maintains financial risk for these services. PPGs requesting extended delegation privileges are reviewed against established regulatory and accreditation requirements for the additional activities to be delegated. The Plan utilizes an enhanced oversight audit tool to assess the PPGs' UM capabilities to manage inpatient concurrent review for acute and sub-acute care, as well as outpatient ancillary and facility-based services. PPGs that are granted extended delegation are required to report activities to the Plan on a daily or weekly basis via an electronic data file exchange program.

MH/SUD services are delegated to Beacon Health Strategies/College Health IPA (CHIPA.) The agreement between Beacon, CHIPA, and the Plan is a tri-party agreement. Beacon's Director of UM explained that Beacon performs administrative services including credentialing. CHIPA is responsible for performing UM functions in California. CHIPA's UM staff are Beacon employees.

UM Responsibility Chart

Entity	UM Responsibility
Plan	Resolution of appeals Delegation oversight
18 Medical Groups	M/S services
Beacon/CHIPA	MH/SUD

MHPAEA IMPLEMENTATION OVERVIEW

MHPAEA was enacted by Congress in 2008.[9] Originally applicable only to large group coverage, MHPAEA was amended by the Affordable Care Act to also apply to individual and small group coverage.[10] The U.S. Departments of Treasury, Labor, and Health and Human Services issued final rules for MHPAEA on November 13, 2013.[11] 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.[12] 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.[13] 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 Local Initiative Health Authority of Los Angeles County dba: L.A. Care Health Plan are described in this Report.

[9] Public Law 110-343, 42 U.S.C. § 300gg-26.
[10] 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).
[11] 45 CFR § 146.136 (2013).
[12] 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.
[13] 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 six 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 all six of the 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 BPD[14] 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 Plan does not ensure that the processes, standards, and 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 36 utilization management (UM) files total
- Plan policies and procedures
- Interviews with Plan staff conducted April 18, 2017 to April 20, 2017

[14] Except for Plans that only offer IHSS coverage.

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 files. The Plan responded that it had no cases for review in the categories of Residential Treatment, MH and SUD Outpatient Office Visits, as well as files that were appropriate for the Department's Other Findings classification review, such as retrospectively reviewed MH/SUD files. Accordingly, the Department was unable to review files in those categories, and because MHPAEA compliance is based on comparison with M/S operations, the Department did not review the corresponding M/S files in those classifications.

The Department reviewed the Plan's approval files and found the files often lacked documentation that identified the formal UM criteria/guidelines utilized or narrative that explained the full rationale for approval. However, the Department's purpose in reviewing these files was not to ensure the Plan documented the basis for approval. MHPAEA and the Knox-Keene Act do not require plans to document criteria/guidelines in approval files. Rather, the Department reviewed UM files to gather information about the Plan's processes for approving requested services. In reviewing the files, the Department assessed the following within each classification of benefits:

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

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

Table 1 – Total Number of Files Reviewed

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	0
Other Outpatient	10	3	3
Total Files Reviewed	**20**	**13**	**3**

1. Inpatient

A. File Review

(i) Inpatient Hospitalization

Medical/Surgical:

The Department reviewed ten M/S files involving patient hospitalization from the Plan and Plan delegates. All of the services were approved. Three of the files demonstrated application of InterQual criteria. Four of the files demonstrated application of Milliman Care Guidelines (MCG). One file demonstrated application of clinical reasoning. Two of the files were auto-authorizations. Concurrent review was performed on three of the files.

Mental Health:

The Department reviewed ten mental health files for services such as involuntary admissions. Ten of the files demonstrated application of the CHIPA Guidelines for Inpatient Psych. Concurrent review was performed on eight of the ten files.

Substance Use Disorder:

No substance use disorder files were identified for review.

Table 2 – Inpatient Hospitalization Summary

File Type	Number of Files	Basis for UM Determination
Inpatient M/S Files	10	InterQual (3) MCG (4) Clinical Reasoning (1) Auto-authorized (2)
Inpatient MH Files	10	CHIPA Guidelines for Inpatient Psych (10)
Inpatient SUD Files	0	N/A

B. Inpatient Interviews and Documents

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 some of the UM review for M/S services to the delegated medical groups and UM review for MH/SUD services exclusively to Beacon/CHIPA. The Plan stated that M/S services are reviewed using a hierarchy of criteria, which is reviewed on an annual basis. The Plan stated it "demands that medical groups use the hierarchy, but not where they go in the hierarchy."

The Plan provided documentation regarding M/S services and procedures that are auto-authorized by the delegated medical groups. The Plan's Medical Director stated that the Plan is aware that auto-authorization lists, policies, and procedures vary between

delegated medical groups. The Medical Director also stated that the Plan has been discussing means to provide structure and consistency around the auto-authorization processes and lists set forth by its delegated medical groups. The Plan's goals are to ensure every member gets the same level of service, regardless of the medical group they are assigned to, and to achieve compliance with parity requirements through comparable approval processes for M/S and MH/SUD services and procedures. Policies and procedures are in the early stages of development to address this issue. The current L.A. Care *Auto-Authorization Policy* (MM-UM-004) states that "L.A. Care's delegates may maintain current Auto-Authorization Guidelines when approved by their UM committee." The policy does not require the Plan's review or approval of delegate auto-authorization guidelines.

Beacon/CHIPA confirmed that no MH or SUD procedures are auto-authorized. Every authorization request is reviewed by an appropriate professional using evidence-based guidelines or clinical reasoning, when applicable. The CHIPA Policy and Procedure regarding *Level of Care (LOC) Guidelines*, revised August 31, 2016, states that all admissions to inpatient MH/SUD facilities require prior authorization.

The Plan's after-hours post-stabilization process is described in L.A. Care's *Admission and Concurrent Review Policy* (MMUM-007), which was discussed during interviews. The Plan has an after-hours, on-call Licensed Vocational Nurse (LVN) who authorizes after-hours requests for inpatient admissions and for post-stabilization admissions following emergency room care. The LVN reviews clinical information and supporting documentation for medical necessity. The case is then routed to a Registered Nurse (RN) for review the following day. RN staff do not work on weekends therefore admissions that occur after business hours on Friday will not be reviewed by an RN until Monday morning. The delay in clinical review by an RN could result in M/S weekend admissions that do not meet criteria or medical necessity. Though the Plan stated that the Medical Director is on call, the Medical Director stated that she had never received a call after-hours.

In comparison, Beacon/CHIPA is staffed with appropriate levels of professionals qualified to review requests for medical necessity against criteria 365 days a year, 24 hours per day. If a member does not meet medical necessity criteria, a psychiatrist is called to apply clinical reasoning to determine if the member should be admitted.

Inpatient Conclusion:

In the Inpatient classification, while the Department found evidence the Plan had approved enrollees to obtain necessary M/S and MH/SUD services,[15] the file review results demonstrated that the Plan applied UM criteria more stringently to MH/SUD services than for M/S services. File review demonstrated consistent application of CHIPA guidelines for Inpatient MH services, while M/S services were reviewed and approved using various criteria including less stringent auto-authorization. Auto-authorization involves no risk of denial, and is therefore a less stringent process than

[15] 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.

application of criteria or use of clinical judgment. Interviews and document review further supported the Department's file review findings that the Plan's processes to review and approve M/S services is less stringent than those applied to MH/SUD services. The delegated medical groups' use of auto-authorization for some M/S services, which was not demonstrated in a comparable manner for the review and approval of MH/SUD services, established that when medical groups conduct UM, the processes used for MH/SUD services are not comparable to and are more stringent than the processes used for M/S services.

2. Outpatient

A. File Review

i. Outpatient – Other Items and Services

Medical/Surgical:

The Department reviewed 10 M/S files involving requests for outpatient, non-office visit services. The various requested services included a requested colonoscopy, biopsy, request for an MRI, and other services. All requested services were approved. The files came from a number of the Plan's delegates. One file demonstrated application of MCG to review and approve the requested service. One file included MCG but did not explicitly demonstrate application of MCG. Eight files demonstrated application of clinical information to review and approve the requested service. None of the files demonstrated concurrent review.

Mental Health:

The Department reviewed three MH files handled by Beacon. All requested services were approved. All three files demonstrated use of the CHIPA Guidelines for both prior authorization and concurrent review.

Substance Use Disorder:

The Department reviewed three SUD files handled by Beacon. All requested services were approved. All three files demonstrated use of the CHIPA Guidelines for both prior authorization and concurrent review.

Table 3 –Outpatient Other Summary

File Type	Number Of Files	Basis for UM Determination
M/S Outpatient – Other Services	10	MCG (2) Clinical Information (8)
MH Outpatient - Other Services	3	CHIPA Guidelines (3)
SUD Outpatient - Other Services	3	CHIPA Guidelines (3)

B. Outpatient Interviews and Documents

During interviews, Plan staff clarified the Plan's application of criteria in the files. With regard to M/S files, the Plan explained reviewing staff may have utilized national guidelines to review and approve each requested service, although the files did not necessarily document these guidelines. However, with regard to MH/SUD files, the Plan confirmed CHIPA Guidelines are used to review and approve all requested Outpatient MH/SUD services. The CHIPA policy and procedure regarding application of level of care (LOC) Guidelines (UM 205.10) states that all medical necessity behavioral health determinations are based on the application of CHIPA's LOC criteria, American Society of Addiction Medicine (ASAM) criteria for all substance abuse treatment, and the Health Plan/Managed Care Organization (HP/MCO) benefit plan.

With regard to prior authorization for outpatient services, Plan staff explained that CHIPA does not require prior authorization to obtain outpatient MH/SUD services. The CHIPA LOC Policy and Procedure confirms this statement: "A member may initiate outpatient BH services, without prior authorization from CHIPA, as determined by his/her HP/MCO benefit package. Prior authorization is required for Psychological and Neuropsychological testing, Outpatient Transcranial Magnetic Stimulation (TMS) and Electroconvulsive Therapy (ECT)." Review and comparison of the Plan's policy and procedure for prior authorization of M/S services indicates that outpatient surgeries and procedures (except minor office procedures) require prior authorization.

However, the Plan's written policies and procedures for prior authorization appear to conflict with those for auto-authorization of M/S services. The Department reviewed the Plan's written policies and procedures regarding auto-authorization of M/S services (MM-UM-004 and MMUM-013) and found both policies allow the Plan (not the delegates) to develop and apply auto-authorization guidelines to review and approve M/S services. The Plan's auto-authorization matrix for M/S services, for instance, indicates that certain outpatient services such as outpatient ambulatory surgery procedures are auto-authorized. The Department also reviewed an "auto-authorization list" of providers affiliated with an acute care facility and a delegated medical group, which demonstrated that numerous outpatient M/S services are approved with auto-authorization. Accordingly, based on a review of the Plan's policies and procedures, the distinction is not clear between outpatient M/S services that require approval through prior authorization and which are approved through auto-authorization. Further, it is not clear whether the Plan's auto-authorization approval processes for outpatient M/S services is comparable to the processes utilized by the Plan's delegates. Finally, given these ambiguities, it was not possible for the Department to determine whether the auto-authorization processes were comparable between M/S and MH/SUD and/or whether application of auto-authorization review criteria was applied more stringently to MH/SUD than M/S services.

<u>Outpatient Conclusion:</u>

In the Outpatient classification, the file review results demonstrated that the Plan applied UM criteria to MH/SUD requested services in a manner that was not comparable and more stringent than for M/S requests. However, the Department acknowledges it only reviewed three MH and three SUD files. As a result, based on file review in the Outpatient classification, the Department could not conclusively determine

whether the Plan's application of UM criteria was applied in a comparable manner or applied more stringently to MH/SUD than M/S services.

With regard to prior authorization, the Department also could not conclusively determine whether prior authorization was applied in a comparable manner or more stringently to MH/SUD than M/S services. While CHIPA's written policy and procedure expressly states prior authorization is not required to obtain most MH/SUD outpatient services, the Department found conflicting information whether prior authorization is required for M/S outpatient services. It was also unclear how the Plan's prior authorization and auto-approval processes compared with those of its delegates. As a result, the Department could not conclusively determine whether prior authorization and/or auto-authorization was applied in a comparable manner or more stringently to MH/SUD than M/S 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. The Department could not conclusively determine whether the Plan's application of UM criteria was applied in a comparable manner to MH/SUD than M/S services in the outpatient classification. However, based on file review, interviews with Plan staff, and document review, the Department found that the Plan's processes, strategies and other factors used to conduct UM review in the Inpatient classification were not MHPAEA compliant.

Plan Response:

The Plan acknowledged the challenges in meeting MHPAEA parity requirements in regards to inconsistencies in the Plan's auto-authorization policy and delegates' auto-authorization policy. In 2011, the Plan reviewed internal utilization data and incorporated auto-authorization into UM practice. The Plan reviews its auto-authorization matrix and processes at least annually. However, the Plan has agreed to reassess current data to ensure the auto-authorization process for hospital admissions is still clinically justified and meets MHPAEA parity requirements. The Plan will also conduct a biannual internal survey to review the auto-authorization process.

The Plan will also schedule regular meetings with the Beacon/CHIPA UM team in order to improve parity. The Plan will compare and clarify Plan, delegate, and Beacon/CHIPA policies and procedures so that review and approval processes are comparable between all three entities to ensure parity. The Plan has submitted evidence that the Plan has commenced with these meetings.

Regarding the Plan's after-hours post-stabilization process, the Plan has indicated that the on-call LVN's now have weekend backup from the RN UM Managers and from the on-call Medical Director. The Plan is currently reorganizing the UM Department's positions and reporting structure so that a UM Medical Director is on-call per the monthly schedule and is available during weekends.

The Plan will review and revise all prior authorization policies and procedures, and auto-authorization policies and procedures for conflicts to ensure parity.

The Plan states that it delegates utilization management to its medical groups and ensures that the medical groups adhere to DHCS and DMHC requirements regarding the denial and modification of requested services. However, the particular design of prior authorizations or auto-authorization is a delegated responsibility because processes and referral systems may be different. The Plan audits medical groups to ensure that the authorization process meets regulatory requirements. The Plan will work on correcting any ambiguities and re-evaluate its auto-authorization processes to ensure they are comparable between M/S and MH/SUD.

Status:

The Plan will implement a more robust oversight process of the Plan's auto-authorizations, but has not provided evidence of how the Plan proposes to remedy inconsistencies between Plan auto-authorization processes and M/S delegate auto-authorization processes. The Plan does not review or approve delegate auto-authorization guidelines. Though the Plan has taken measures to ensure parity between the Plan and the behavioral health delegate, the Plan has not submitted evidence that it has ensured that the delegated medical groups' use of auto-authorization for M/S services is comparable to and no more stringent than the processes used for MH/SUD services.

The Plan has provided evidence of weekend clinical coverage for M/S after-hours post-stabilization, which will provide staffing with appropriate levels of professionals qualified to review requests for medical necessity against criteria 24 hours a day and seven days a week.

The Plan has agreed to review and revise Plan policies and procedures regarding prior authorization and auto-authorization, but has not stated that it will also review delegate auto-authorization processes to ensure they are comparable and in parity. Moreover, the Plan delegates prior authorizations and auto-authorizations, but has not shown how the Plan oversees the delegates' prior and auto-authorizations to ensure parity. The Plan has stated that it will review and revise Plan auto-authorization processes, but has not stated if it will also be reviewing delegate auto-authorization processes to ensure parity.

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 appears to address most of the issues, the Plan has not had enough time to demonstrate full implementation and has not proposed corrective action to address the delegation oversight issues. The Department will assess the Plan's implementation of the corrective actions and report the findings during the Plan's next Routine Survey.

B. QUANTITATIVE TREATMENT LIMITATIONS

#2 The Plan did not calculate financial requirements in accordance with the MHPAEA final regulations.
Health & Safety Code section 1374.76; 45 CFR 146.136(c)(2)(i) and (ii); 45 CFR 146.136(c)(3)(i)(A); 45 CFR 146.136 (c)(3)(i)(B)(1)

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),[16] mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits.

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

45 CFR 146.136 (c)(3)(i)(B)(1) provides that the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

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

Supporting Documentation or Evidence:

- The Plan's Exhibit J-11-A and Exhibit J-12 worksheets[17]
- 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 BPD #1, L.A. Care Covered Silver 87. 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.

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

The Plan retained Milliman, Inc. to perform the MHPAEA calculation of financial requirements for the BPD and submitted calculations demonstrating its predominant financial requirement in each classification of benefits that applies to substantially all benefits within the classification. Based on the Plan's annual estimated M/S claims, the actuaries determined that the MHPAEA-compliant financial requirement in the Outpatient-Other classification should be 15% coinsurance. The Department found that the Plan has been charging a $10.00 copayment for psychological testing to evaluate a mental disorder in the Outpatient-Other category.

Conclusion:

45 CFR 146.136(c)(2)(i) provides that plans providing both M/S benefits and MH/SUD benefits may not apply any financial requirement or treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all M/S benefits in the same classification. Health and Safety Code section 1374.76 requires plans to provide all covered MH/SUD benefits in compliance with MHPAEA. For the benefit plan design reviewed during the onsite survey, the Plan applied financial requirements to MH/SUD benefits that were more restrictive than the predominant financial requirement of that type applied to substantially all M/S benefits in the same classification.

Although the Plan made the required changes to its cost-sharing for the benefit plan design reviewed by the Department during the onsite survey process, the Plan was not

[17] 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.

in compliance with MHPAEA cost-sharing requirements for these benefit plan designs from the initial compliance date of January 1, 2016 through the end of the review period.

With respect to the identified noncompliant financial requirements findings, the Department requests that the Plan describe the corrective action it will take to address the findings. The Plan's response should also provide the following information:

A. For the period of January 1, 2016 to the present, list the individual, small group, and large group commercial Plan products that, in addition to the identified noncompliant products, also have non-MHPAEA compliant cost-sharing. Identify for each listed product the mental health and substance use disorder (MH/SUD) services for which the Plan charged noncompliant copays, coinsurance, and/or deductibles.
B. For the period of January 1, 2016 to the present, identify the total number of enrollees that have been overcharged MH/SUD cost-sharing and the specific product in which each enrollee is or was enrolled.
C. For each noncompliant product from January 1, 2016 to the present, provide a dollar estimate of the following:
    a. The amount of noncompliant cost-sharing erroneously charged to enrollees, by type of cost-sharing (e.g., erroneously charged copays, coinsurance, and/or deductible)
    b. The amount of MHPAEA-compliant cost-sharing, if any, that should have been charged to enrollees, by type of cost-sharing.
D. For each Plan product with noncompliant cost-sharing, describe changes to Evidences of Coverage (EOCs) and other disclosure documents that have been or need to be made as a result of the Plan's corrective actions.
E. Explain how and when the Plan notified or will notify affected enrollees and MH/SUD providers to disclose that it charged noncompliant cost-sharing for MH/SUD services and to provide details on the Plan's corrective actions to remedy the overcharges.

Plan Response:

A. For the period of January 1, 2016 to present, no Plan products other than the Silver 70 product have been identified as having non-MHPAEA complaint cost-sharing. The only non-MHPAEA compliant cost-sharing identified for mental health and substance use disorder services was the copayment for Psychological Testing under the Silver 70 product.

B. Per Plan collaboration with its behavioral health provider (Beacon Health Options) it was confirmed that two (2) members were charged incorrectly for the MH/SUD Psychological Testing services specified during the 2016 to current audit period. One was a Silver 70 benefit recipient who paid $35.00 for three visits. L.A. Care will reimburse this member for each visit for a total of $73.50. The second is a Silver 70 recipient who paid $35.00 for one visit and will be reimbursed a total of $24.50. The total reimbursement for the four (4) services received by the two (2) members is $98.00. Beacon Health Options has confirmed receipt of the non-compliant findings and has submitted evidence that it reimbursed these members.

C.

a. Copayments of $35.00 were collected for Psychological Testing under the Silver 70 benefit. The total reimbursement for the four (4) services received by the two (2) members is $98.00.
b. The MHPAEA compliant amount for the MH/SUD MH Outpatient Other Visits has been identified as; 15% coinsurance. This would result in coinsurance of not more than $10.50 per visit.

D. The Plan's 2018 member communication including EOCs, website disclosures and all other disclosure documents will be updated to reflect MHPAEA compliant cost per product and per service. All affected LACC members will receive a member notice to clarify and restate the 2018 cost-share.

E. The Plan's 2018 member communications and web services will be updated to reflect the modified cost-share amount. The two impacted members will be reimbursed.

Status:

The Plan has provided evidence that all affected members have been reimbursed and member communications have been updated. Accordingly, the Department has determined the finding to be corrected

SECTION III: PLAN EXPERIENCE IN IMPLEMENTING MHPAEA

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

1. Delegation Oversight

The Plan's delegation oversight process is thorough. The Plan utilizes two separate audit tools, a utilization management tool and a care coordination tool, for oversight of its delegates. The annual delegate oversight is detailed and includes evaluation of all key UM functions, including UM Program content, UM administrative capacity, under- and over-utilization policies and procedures, and UM determinations made by delegates. In addition to the annual review of delegates' UM policies, procedures and UM guidelines/criteria, the Plan receives UM reports, activity logs, and other materials from each delegated group at least semi-annually. Reports generated by delegated medical groups include, but are not limited to, referral and authorization activity logs, copies of denial letters, and mental health and drug and alcohol referrals. Medical groups with extended delegation are required to submit reports daily or weekly.

Responsibility for delegation oversight is assigned to the Plan's Compliance Department. The Compliance Department maintains the delegation oversight audit schedule, reviews delegate reports, and conducts the delegation oversight audits. The Compliance Department reports audit results to the Compliance Committee.

2. Assessment of Plan's Ability to Maintain Parity

The Plan must continue to implement and monitor the operation of NQTLs and QTLs in a manner that ensures parity. Ongoing constructive communications with CHIPA concerning MHPAEA is encouraged to ensure that any changes to M/S UM limitations are reviewed and compared with corresponding MH/SUD benefits in each classification, and any necessary revisions are made.

The Plan should compare and clarify Plan, delegate, and CHIPA policies and procedures so that review and approval processes such as prior authorization and auto-authorization are comparable between all three. The Department found inconsistencies between the Plan and delegates' auto-authorization processes. The Plan and delegates are permitted to develop their own auto-authorization lists to review and approve M/S services. However, MH/SUD services are never auto-authorized under CHIPA guidelines. The Plan's Medical Director acknowledged that the Plan is aware auto-authorization lists and procedures vary between delegated medical groups, and the Plan has been discussing means to provide structure and consistency around the auto-authorization processes and lists set forth by its delegated medical groups. These concerns should be addressed in revised UM policies and procedures that significantly clarify in detail the Plan and delegates' UM practices.

The Plan does not have the same level of licensed, clinical staff working after-hours, including weekends, to apply UM criteria or use clinical reasoning to approve or deny M/S inpatient admissions as CHIPA for MH/SUD admissions within the same classification. The after-hours' review process for inpatient admissions is currently more

stringent for MH and SUD services than for M/S services. The Plan must enhance the availability of appropriate staff for UM decisions made after-hours to achieve a comparable process for M/S and MH/SUD.

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 3rd quarter 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

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 30, 2015

VIA ELECTRONIC MAIL

Local Initiative Health Authority for L.A. County
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017

The Department of Managed Health Care (Department) has reviewed the information submitted in the above-referenced filing (Amendment) filed by Local Initiative Health Authority for L.A. County (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] 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 and disclosures 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 disclosures and revisions are summarized in the charts below. Cost-sharing for MH/SUD benefits within nongrandfathered or grandfathered on- or off-Exchange individual and small group coverage shall first comply with MHPAEA for 2016 coverage 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.

Benefit Plan Design #1, Individual, Platinum 90

Type of Service	Specific Benefits Impacted	Current Cost-Sharing or Disclosure	Cost-Sharing as of 1/1/2016[5]
Mental Health Care Outpatient, Office Visit	Behavioral Health Treatment for Autism Spectrum Disorder	$20 - Previously not disclosed in Plan's Summary of Benefits	$20
Mental Health Care Outpatient, Office Visit	Psychological Testing	$20 - Previously not disclosed in Plan's Summary of Benefits	$20
Mental Health Care Outpatient, Office Visit	Psychiatric Observation	$0 - Previously not disclosed in Plan's Summary of Benefits	$0
Mental Health Care Inpatient	Crisis Residential Program	$250 per day up to 5 days Previously not disclosed in Plan's Summary of Benefits	$250 per day up to 5 days
Mental Health Care, Outpatient, Office Visit	Intensive Outpatient Treatment Programs	$20 - Previously not disclosed in Plan's Summary of Benefits	$20
Substance Use Disorder Outpatient, Office Visit	Day Treatment	$20 - Previously not disclosed in Plan's Summary of Benefits	$20
Substance Use Disorder Outpatient, Office Visit	Intensive Outpatient Treatment Programs	$20 - Previously not disclosed in Plan's Summary of Benefits	$20
Substance Use Disorder Outpatient, Office Visit	Medical Treatment For Withdrawal	$20 - Previously not disclosed in Plan's Summary of Benefits	$20
Mental Health Care/ Substance Use Disorder, Outpatient, Office Visit	Transcranial Magnetic Stimulation and Electroconvulsive Therapy	$20 - Previously not disclosed in Plan's Summary of Benefits	$20

[5] 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.

Benefit Plan Design #2, Individual, Gold 80

Type of Service	Specific Benefits Impacted	Current Cost-Sharing or Disclosure	Cost-Sharing as of 1/1/2016[6]
Mental Health Care Outpatient, Office Visit	Behavioral Health Treatment for Autism Spectrum Disorder	$30 - Previously not disclosed in Plan's Summary of Benefits	$35
Mental Health Care Outpatient, Office Visit	Psychological Testing	$30 - Previously not disclosed in Plan's Summary of Benefits	$35
Mental Health Care Outpatient, Office Visit	Psychiatric Observation	$0 - Previously not disclosed in Plan's Summary of Benefits	$0
Mental Health Care Inpatient	Crisis Residential Program	$600 per day up to 5 days - Previously not disclosed in Plan's Summary of Benefits	$600 per day up to 5 days
Mental Health Care Outpatient, Office Visit	Intensive Outpatient Treatment Programs	$30 - Previously not disclosed in Plan's Summary of Benefits	$35
Substance Use Disorder Outpatient, Office Visit	Day Treatment	$30 - Previously not disclosed in Plan's Summary of Benefits	$35
Substance Use Disorder Outpatient, Office Visit	Intensive Outpatient Treatment Programs	$30 - Previously not disclosed in Plan's Summary of Benefits	$35
Substance Use Disorder Outpatient, Office Visit	Medical Treatment For Withdrawal	$30 - Previously not disclosed in Plan's Summary of Benefits	$35
Mental Health Care/Substance Use Disorder, Outpatient, Office Visit	Transcranial Magnetic Stimulation and Electroconvulsive Therapy	$30 - Previously not disclosed in Plan's Summary of Benefits	$35

[6] Ibid.

Benefit Plan Design #3, Individual, Silver 70

Type of Service	Specific Benefits Impacted	Current Cost-Sharing or Disclosure	Cost-Sharing as of 1/1/2016[7]
Mental Health Care Outpatient, Other	Behavioral Health Treatment for Autism Spectrum Disorder	$45 - Previously not disclosed in Plan's Summary of Benefits	$0
Mental Health Care Outpatient, Office Visit	Psychological Testing	$45 - Previously not disclosed in Plan's Summary of Benefits	$45
Mental Health Care Outpatient, Other	Psychiatric Observation	$0 - Previously not disclosed in Plan's Summary of Benefits	$0
Mental Health Care Outpatient, Other	Partial Hospitalization	20% after deductible	$0
Mental Health Care Inpatient	Crisis Residential Program	20% after deductible - Previously not disclosed in Plan's Summary of Benefits	20% after deductible
Mental Health Care Outpatient, Other	Intensive Outpatient Treatment Programs	$45 - Previously not disclosed in Plan's Summary of Benefits	$0
Substance Use Disorder Outpatient, Other	Day Treatment	$45	$0
Substance Use Disorder Outpatient, Other	Intensive Outpatient Treatment Programs	$45	$0
Substance Use Outpatient, Office Visit	Medical Treatment For Withdrawal	$45 - Previously not disclosed in Plan's Summary of Benefits	$45
Mental Health Care/Substance Use Disorder, Outpatient, Other	Transcranial Magnetic Stimulation and Electroconvulsive Therapy	$45 - Previously not disclosed in Plan's Summary of Benefits	$0

[7] Ibid.

Benefit Plan Design #4, Individual, Silver 73

Type of Service	Specific Benefits Impacted	Current Cost-Sharing or Disclosure	Cost-Sharing as of 1/1/2016[8]
Mental Health Care Outpatient, Other	Behavioral Health Treatment for Autism Spectrum Disorder	$40 - Previously not disclosed in Plan's Summary of Benefits	$0
Mental Health Care Outpatient, Office Visit	Psychological Testing	$40 - Previously not disclosed in Plan's Summary of Benefits	$40
Mental Health Care Outpatient, Other	Psychiatric Observation	$0 - Previously not disclosed in Plan's Summary of Benefits	$0
Mental Health Care Outpatient, Other	Partial Hospitalization	$40	$0
Mental Health Care Inpatient	Crisis Residential Program	20% after deductible - Previously not disclosed in Plan's Summary of Benefits	20% after deductible
Mental Health Care, Outpatient, Other	Inpatient Outpatient Treatment Programs	$40 - Previously not disclosed in Plan's Summary of Benefits	$0
Substance Use Disorder Outpatient, Other	Day Treatment	$40	$0
Substance Use Disorder Outpatient, Other	Intensive Outpatient Treatment Programs	$40	$0
Substance Use Outpatient, Office Visit	Medical Treatment For Withdrawal	$40 - Previously not disclosed in Plan's Summary of Benefits	$40
Mental Health Care/Substance Use Disorder, Outpatient, Other	Transcranial Magnetic Stimulation and Electroconvulsive Therapy	$40 - Previously not disclosed in Plan's Summary of Benefits	$0

[8] Ibid.

Benefit Plan Design #5, Individual, Bronze 60

Type of Service	Specific Benefits Impacted	Current Cost-Sharing or Disclosure	Cost- Sharing as of 1/1/2016[9]
Mental Health Care Outpatient, Other	Behavioral Health Treatment for Autism Spectrum Disorder	$60 (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	$0 (deductible applies after three non-preventive visits)
Mental Health Care Outpatient, Office Visit	Psychological Testing	$60 (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	$70 (deductible applies after three non-preventive visits)
Mental Health Care Outpatient, Other	Psychiatric Observation	$0 - previously not disclosed in Plan's Summary of Benefits	$0
Mental Health Care Outpatient, Other	Partial Hospitalization	30% after deductible	$0 (deductible applies after three non-preventive visits)
Mental Health Care Inpatient	Crisis Residential Program	30% after deductible Previously not disclosed in Plan's Summary of Benefits	100% after deductible
Mental Health Care, Outpatient, Other	Intensive Outpatient Treatment Programs	$60 (deductible applies after three non-preventive visits)	$0 (deductible applies after three non-preventive visits)
Substance Use Disorder Outpatient, Other	Day Treatment	$60 (deductible applies after three non-preventive visits)	$0 (deductible applies after three non-preventive visits)
Substance Use Disorder Outpatient, Other	Intensive Outpatient Treatment Programs	$60 (deductible applies after three non-preventive visits)	$0 (deductible applies after three non-preventive visits)

[9] Ibid.

Benefit Plan Design #5, Individual, Bronze 60

Type of Service	Specific Benefits Impacted	Current Cost-Sharing or Disclosure	Cost- Sharing as of 1/1/2016[10]
Substance Use Disorder Outpatient, Office Visit	Medical Treatment For Withdrawal	$60 (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	$70 (deductible applies after three non-preventive visits)
Mental Health Care/Substance Use Disorder, Outpatient, Other	Transcranial Magnetic Stimulation and Electroconvulsive Therapy	$60 (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	$0 (deductible applies after three non-preventive visits)

Benefit Plan Design #6, Individual, Minimum Coverage

Type of Service	Specific Benefits Impacted	Current Cost-Sharing or Disclosure	Cost-Sharing as of 1/1/2016[11]
Mental Health Care Outpatient, Other	Behavioral Health Treatment for Autism Spectrum Disorder	0% after deductible (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	0% after deductible (deductible applies after three non-preventive visits)
Mental Health Care Outpatient, Office Visit	Psychological Testing	0% after deductible (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	0% (deductible applies after three non-preventive visits)

[10] Ibid.
[11] Ibid.

Benefit Plan Design #6, Individual, Minimum Coverage

Mental Health Care Outpatient, Other	Psychiatric Observation	$0 - Previously not disclosed in Plan's Summary of Benefits	$0
Mental Health Care Outpatient, Other	Intensive Outpatient Treatment Programs	0% after deductible (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	0% (deductible applies after three non-preventive visits)
Mental Health Care Inpatient	Crisis Residential Treatment	0% after deductible Previously not disclosed in Plan's Summary of Benefits	0% after deductible
Substance Use Disorder Outpatient, Other	Day Treatment	0% after deductible (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	0% (deductible applies after three non-preventive visits)
Substance Use Disorder Outpatient, Other	Intensive Outpatient Treatment Programs	0% after deductible (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	0% (deductible applies after three non-preventive visits)
Substance Use Disorder Outpatient, Office Visit	Medical Treatment For Withdrawal	0% after deductible (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	Substance Use Disorder Outpatient, Office Visit

Mental Health Care/Substance Use Disorder, Outpatient, Other	Transcranial Magnetic Stimulation and Electroconvulsive Therapy	0% after deductible (deductible applies after three non-preventive visits) Previously not disclosed in Plan's Summary of Benefits	0% (deductible applies after three non-preventive visits)

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 following revised policies and procedures: revisions to policy and procedure regarding prior authorization, CHIPA Policy UM 205.3; revisions to CHIPA Policy UM 205.3 to remove the limitation to the number of outpatient mental health/substance use disorder visits regarding prior authorization and concurrent review; revisions to the definition of medical necessity within policy and procedure, CHIPA 205.3; newly developed Level of Care Criteria related to Transcranial Magnetic Stimulation; and revisions to policies and procedures as affirmed by the Plan in filing #20142230-17. The Department may ask the Plan to submit its revised policies and procedures regarding medical necessity definition at a later time.

3. The Plan shall revise its EOCs, Schedule of Benefits and Coverage Matrix, Summaries of Benefits and Coverage (SBCs), and other disclosure documents for enrollees to disclose MHPAEA-compliant cost-sharing, quantitative treatment limits, and non-quantitative treatment limits, and other revisions to disclosure text that have been reviewed and not objected to by the Department in the Amendment. These revisions include, but are not limited to:

    a. EOC revisions:
        i. How to Get Care, Referrals and Prior Authorization section: mental health and substance use disorder services requiring prior authorization have been clarified.
        ii. How to Get Care, Behavioral Health Services section: revised to clearly explain how members may access MH/SUD benefits.
        iii. Plan Benefits, Substance Use Disorder Services section: covered services have been clarified.
        iv. Plan Benefits, Mental Health Care section: updated definition of mental disorder to reference DSM IV. Inpatient Mental Health Services section: revised to explain psychiatric emergency.
        v. Exclusions and Limitations: updated the description for Biofeedback Services.
        vi. Summary of Benefits, Mental Health and Substance Use Disorder Benefits section: the types of covered services have been more fully listed to clarify an enrollee's cost sharing for some MH/SUD services (see above).
        vii. Definitions: Behavioral Health Services, Behavioral Health Treatment, Behavioral Health Treatment, Severe Mental Illness (SMI) and "Medically Necessity/Medically Necessary" revised in the "Definitions" section.

b. SBC revisions: Revisions to clarify the cost-sharing for outpatient MH/SUD services.

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 all covered mental health and substance use disorder benefits in compliance with MHPAEA within the Plan's individual commercial plan coverage.[12]

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.[13]

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 there are any questions regarding the above.

Plan Response to the Final Report

[12] California Health and Safety Code § 1374.76.
[13] Ibid