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

ALAMEDA ALLIANCE FOR HEALTH

A FULL SERVICE HEALTH PLAN

DATE OF FINAL REPORT: FEBRUARY 16, 2018

Final Report
Focused Survey of Mental Health Parity and Addiction Equity Act Implementation
Alameda Alliance for Health
February 6, 2018

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EXECUTIVE SUMMARY

On September 7, 2016, the California Department of Managed Health Care (Department) notified Alameda Alliance for Health (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 December 7 through 8, 2016. For the survey review period of January 1, 2016 to September 7, 2016, the Department identified one finding requiring corrective action summarized below.

The Preliminary Report was issued to the Plan on November 7, 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 Survey evaluated 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

> 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 plans' utilization management (UM) processes.
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> For NQTLs, MHPAEA provides a general rule that a health plan may not impose
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> 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 are 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.

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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.

[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.

- 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.

  MHPAEA prohibits a health plan that provides both M/S and MH/SUD benefits from applying a financial requirement and/or QTL to MH/SUD services in any benefits classification[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)
QUANTITATIVE TREATMENT LIMITATIONS	
2	**The Department identified no MHPAEA deficiencies with respect to the Plan's implementation of financial requirements.** Health and Safety Code section 1374.76; 45 CFR 146.136(c)(2)(i) and (ii); 45 CFR 146.136(c)(3)(i)(A)

PLAN BACKGROUND

Alameda Alliance for Health received its Knox-Keene license from the DMHC in September 1995. In January 1996, the Plan established itself as a public, not-for-profit health plan committed towards making high quality health care services accessible and affordable to Alameda County residents. Its sole commercial product is an HMO benefit plan design for In-Home Supportive Services (IHSS) workers with 5,556 enrollees as of June 30, 2016.

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

On May 8, 2014, the Department appointed Mark Abernathy of the Berkeley Research Group to serve as the Plan's conservator. The Plan's conversion to a new claims payment system had contributed to a backlog of claims that eventually led to the Plan's failure to maintain a minimum tangible net equity. In addition, the Plan had experienced dramatic growth in enrollment in January 2014. On October 29, 2015, the Department terminated the conservatorship as the Plan had eliminated its backlog of claims and the conservator had sufficiently rehabilitated the Plan such that operations no longer constituted a substantial risk to enrollees.

Community Health Center Network (CHCN) is the Plan's medical/surgical (M/S) delegated entity for 2,171 enrollees (40 percent of total enrollment.) Delegation includes utilization management, claims processing, and case management for the IHSS line of business. CHCN is a Managed Services Organization that manages eight federally qualified health centers throughout Alameda County.

For utilization review of mental health/substance abuse disorder services, the Plan contracts with Beacon Health Strategies/College Health IPA (CHIPA).

The Plan contracts with Sutter Health to provide Hospital and ancillary services pursuant to a Division of Financial Responsibility (DOFR) Agreement.

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 Alameda Alliance for Health 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 its only commercial BPD for the Department's review. The Department assessed the BPD 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 the BPD 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 the same BPD for benefit year 2016 that was 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 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 45 utilization management (UM) files total in the following categories: Inpatient, Skilled Nursing Facility (SNF)/Residential, Outpatient Office Visit, Other Outpatient, Retrospective Review (see Table 1)
- Plan policies and procedures
- Interviews with Plan staff conducted December 7, 2016 and December 8, 2016

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;
- file documentation of the UM processes and/or clinical rationale, and variation in application of UM processes by the Plan and/or its delegated entities.

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

Table 1- Total Number of Files Reviewed

Classification of Benefits	Number of Medical/Surgical Files Reviewed	Number of Mental Health Files Reviewed	Number of Substance Use Disorder Files Reviewed
Inpatient	15	3	0
SNF/ Residential	8	1	0
Office Visit[14]	0	0	0
Other Outpatient	15	3	0
Other Findings[15]	0	0	0
Total files Reviewed	**38**	**7**	**0**

1. Inpatient

A. File Review

(i) Inpatient Hospitalization

Medical/Surgical:

[14] There were no comparable MH or SUD files to review; therefore, no M/S files were reviewed.
[15] The Plan did not identify any files for M/S, MH or SUD retrospective reviews within the review period.

The Department reviewed 15 M/S files involving inpatient hospitalization. Utilization management for these services was conducted by the Plan (eight files), and the Plan's delegate, CHCN (two files). Five files were admissions to Sutter Hospital (5), for which no UM is performed by the Plan. Prior authorization was requested and approved for one of the 15 admissions. Concurrent review was conducted in six of the 10 Plan and CHCN cases. All 10 Plan and CHCN files demonstrated application of nationally recognized criteria, Milliman Care Guidelines (MCG).

In the five files that were admissions to Sutter Hospital facilities, a written statement in these files stated, "Per contractual obligations, Plan does not perform clinical reviews on admissions for this hospital." The Plan's Chief Medical Officer stated that per contractual agreement with Sutter Hospital, the Plan does not review admissions to Sutter Hospital facilities. The Plan's Chief Medical Officer also stated that Sutter Hospital uses InterQual[16] guidelines, which are comparable to the MCG guidelines used by the Plan.

Mental Health:

The Department reviewed three MH files from Beacon for 5150[17] inpatient admissions, which did not require prior authorization. Concurrent review was conducted on each case resulting in nine continued treatment approvals and one modification. All files either utilized and documented nationally recognized criteria or clinical judgment based on medical necessity (CHIPA LOC.[18])

Substance Use Disorder:

No substance use disorder files were presented for review.

(ii) SNF/Residential

Medical/Surgical SNF:

The Department reviewed eight SNF files. Seven of the eight files involved Plan prior authorization for skilled nursing facility services. All seven files utilized nationally recognized criteria (MCG.) One of the eight files involved a delegate approval for skilled nursing facility services utilizing nationally recognized criteria (MCG.) Concurrent review was conducted on all eight of the cases resulting in six approvals and two denials.

Mental Health Residential:

The Department reviewed one mental health file. No prior authorization was required. The file utilized Beacon/CHIPA criteria resulting in a modification of the request.

Substance Use Disorder:

[16] InterQual is a standardized medical review tool to establish level of care.
[17] A 5150 hold generally occurs when any person is a danger to themselves or others as a result of a mental disorder. This process is described in California Welfare and Institutions Code Section 5150.
[18] Beacon utilizes the CHIPA Level of Care Guidelines, which are developed by the medical management committee and are national scientific evidence based criteria.

No substance use disorder files were available for review.

Table 2 – Inpatient Hospitalization and SNF/Residential Summary

File Type	Number of Files Reviewed	Plan's Basis for UM Determination
Inpatient M/S Files	15	MCG (10)
Inpatient M/S Files	15	InterQual (5)[19]
Inpatient MH Files	3	CHIPA (3)
Inpatient SUD Files	0	NA
M/S SNF	8	MCG (8)
MH Residential	1	CHIPA (1)
SUD Residential	0	NA

B. Inpatient Interviews

The Department conducted interviews with appropriate Plan staff to understand the Plan's operational processes for applying UM criteria in the Inpatient classification. The Plan delegates more than half of its utilization review for M/S services to one medical group, CHCN. The Plan delegates UM review for MH/SUD services exclusively to Beacon. As stated above, the Plan was unable to provide complete files for inpatient admissions at Sutter Hospital due to the Division of Financial Responsibility agreement with Sutter. The Plan's Chief Medical Officer stated that approximately 26% of admissions are Sutter admissions, and those are reviewed by Sutter Case Managers using Sutter criteria. The Plan's Chief Medical Officer also stated that Sutter uses InterQual criteria, but the Department was unable to review any complete files to verify criteria used. Accordingly, the Department is not able to determine if the Plan is using comparable criteria and application of the criteria between MH/SUD and M/S services.

Plan staff also explained the "administrative weekend approval" process, wherein M/S admissions that occur on the weekend are not reviewed against medical necessity criteria. Plan staff stated during interviews that the Plan issues one-day auto-authorization for inpatient admissions of enrollees for whom the Plan performs UM.

The Plan's Chief Medical Officer stated the policy for one-day auto-authorization was implemented to approve the first day to ensure patients are stabilized and under the care of a contracted physician. The UM reviews are completed later. Plan staff stated that the Plan does not have UM staff working on weekends. The Plan issues an auto-authorization for the entire weekend and weekend admissions are reviewed on Monday.

[19] See above discussion regarding Sutter Hospital admissions. The Plan stated that Sutter conducts its own UM reviews using InterQual, but no files were available for Department review.

Monday is considered the time of the request for UM review timing purposes.[20] The Plan's delegate, CHCN, implemented reviews of all admissions within twenty-four hours and does not have a similar weekend approval process. Likewise, Beacon has staff working twenty-four hours a day and seven days a week, and reviews all weekend inpatient admissions within twenty-four hours. The interviews established that the M/S administrative weekend approval process is less stringent and not comparably applied to approvals for MH/SUD services.

The Plan's M/S delegate's (CHCN) *UM Policy, UM-04,* sets forth a hierarchy of criteria for medical/surgical reviews. First, CHCN refers to MCG criteria as the first primary medical review criteria. Next, CHCN relies on the State of California's manual of *Medi-Cal Provider Manual Criteria* as secondary authorization criteria when there are no MCG guidelines pertaining to the request. Lastly, CHCN will use CHCN's *General Utilization Management Criteria* when medical necessity criteria cannot be found within the MCG Guidelines and the *Medi-Cal Provider Manual* or Health Plan specific criteria. However, the MH delegate, Beacon, primarily relies on the *CHIPA Level of Care* (LOC) *Criteria* in making UM decisions.

CHIPA utilizes internal guidelines to determine medical necessity. During interviews, Beacon's Director of Inpatient Clinical Services described the process for development of the guidelines as follows: "Criteria are developed by the Beacon Health Strategies LOC Committee. The Medical Management Committee reviews the criteria set and CHIPA adopts the criteria. The way they adopt the criteria is by comparing the national scientific based criteria set…it is presented to the CHIPA Executive Committee, and it is reviewed annually in the Beacon LOC Committee."

The Department found the variation in the type of criteria being applied to authorize MH/SUD and M/S services is not comparable. MH/SUD files documented that only CHIPA criteria were applied. However, M/S files documented that a range of UM criteria were applied, including MCG and InterQual evidence-based criteria used by health care plans, insurers, hospitals, and companies nationally; as well as criteria developed by the Plan; and/or criteria developed by the Plan's contracted medical group. The Department has concerns that the criteria may not be comparable. For instance, the criteria developed by companies such as InterQual or MCG, which are used by health care organizations nationally, were developed and implemented based on clinical evidence and peer-reviewed literature without consideration of a specific plan or medical group's day to day operations. Thus, the use of a single set of criteria by Beacon for authorizing MH/SUD services, which was developed by CHIPA, may not be comparable to the various criteria developed by the Plan and/or its medical group for authorizing M/S services.

<u>Inpatient Conclusion:</u>

[20] The Plan's Chief Medical Officer stated: "Outside the scope of this audit, I've been evaluating our practices in terms of automatic approval and staffing over the weekends as well as looking at concurrent review from the beginning of the stay which is what many plans do in terms of medical benefits. We are in the process of converting that process over and working directly with our contracted hospitals and letting them know one by one that the Plan is revising its staffing and procedures to provide weekend coverage for UM reviews."

In the Inpatient classification, while the Department found evidence enrollees had obtained necessary M/S and MH/SUD services,[21] 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. The Plan and its medical surgical delegate utilized a variety of processes and criteria for Inpatient UM determinations, such as use of Plan or national guidelines, use of auto-authorizations, and administrative weekend approvals. Use of those processes and criteria are not comparable to the processes and criteria used by Beacon, which was largely restricted to use of CHIPA LOC criteria. Moreover, it is not possible for the Department to verify that comparable criteria is being utilized in some instances since the Plan does not perform clinical reviews on admissions to Sutter Hospital. While the Plan alleges that Sutter applies nationally recognized criteria (InterQual), the Plan does not review these files to ensure that criteria is being properly applied.

In addition, the Plan's UM criteria is applied in a more stringent manner to MH/SUD services due to the inpatient admission auto-authorization process. Since the Plan does not have staff working on the weekends, weekend admissions are not reviewed until the following Monday. On the MH/SUD side, however, staff are available to authorize or deny services twenty-four hours a day and seven days a week. Accordingly, the Plan applies a more stringent standard when approving MH/SUD services in the inpatient category.

Use by the Plan and its delegates of varying processes and criteria in making UM determinations for M/S Inpatient services are not comparable to, and are less stringent than, those applied for MH/SUD Inpatient services. M/S UM involves use of auto-authorization, varying clinical guidelines and clinical judgment. By comparison, UM performed by Beacon for MH/SUD Inpatient services were based nearly exclusively on use of a single set of criteria –CHIPA LOC. Therefore, the process applied to make UM determinations for MH/SUD services (a single set of criteria by Beacon, multiple criteria by the Plan/delegates) were not comparable to and were largely more stringent than the processes applied to UM determinations for M/S service (multiple criteria, auto-authorization and clinical judgment).

2. Outpatient

A. File Review

(i) Outpatient Office Visits

There were no comparable MH or SUD files to review; therefore, no M/S files were reviewed.

(ii). Outpatient – Other Items and Services

[21] The NQTL analysis does not focus on whether the final result is the same; instead, 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 jointly issued FAQs regarding Mental Health and Substance Use Disorder Parity Implementation.

Medical/Surgical:

The Department reviewed 15 M/S files involving requests for outpatient, non-office visit services. The various requested services included a request for carpal tunnel surgery, requests for physical therapy and occupational therapy evaluations, and cataract surgery. The files came from the Plan (5) and Plan delegate CHCN (10). Eight of the ten files demonstrated approval of services based on the use of nationally recognized criteria (Milliman Care Guidelines). Two of the files did not reflect the application of nationally recognized guidelines but relied on clinical judgment to make the treatment decision. Five of the files were auto-authorizations by both the Plan and CHCN.

Mental Health:

The Department reviewed three MH files handled by Beacon. Each file demonstrated the use of the CHIPA guidelines for both prior authorization and concurrent review, resulting in approval of the treatment requests.

Substance Use Disorder:

The Department did not review any substance use disorder files, as the Plan did not identify any files in the classification during the review period.

TABLE 3 – Outpatient Other Items and Services Summary

File Type	Number of Files Reviewed	Plan's Basis for UM Determination
M/S Outpatient - other services	15	MCG (8)
M/S Outpatient - other services	15	Clinical Factors (2)
M/S Outpatient - other services	15	Auto-Authorization (5)
MH Outpatient - other services	3	CHIPA (3)
SUD Outpatient - other services	0	NA

B. Outpatient Interviews:

During interviews, Plan staff stated that the five auto-authorizations were approved based on the CHCN Prior Authorization Grid. There is no similar auto-approval grid or process on the MH/SUD side.

During Interviews, Beacon staff stated that there is no prior authorization required for MH/SUD outpatient office visits. Prior authorization is required for higher levels of care, such as inpatient admissions, partial hospitalization, and intensive outpatient treatment.

Beacon staff stated that they first look at the CHIPA criteria to make a determination, but if there is a concern, the request is elevated to the Medical Director. Beacon staff stated that they take into account clinical presentation, and criteria is then used as a guideline.

Outpatient Conclusion:

Despite not having any outpatient office visit files to review, the Department finds that the Plan may apply a less stringent standard for the approval of MH/SUD outpatient office visits because Beacon does not require prior authorization for outpatient office visits.

In the Outpatient classification, the file review results demonstrated that the Plan applies UM criteria more often for MH/SUD approvals than for approvals of M/S services. The file review results demonstrated that the Plan and its delegates use Milliman Care Guidelines, clinical factors, and an auto-authorization process. The results showed that UM criteria was applied in nine out of 15 (60%) M/S files and in three out of three (100%) MH files. The file review results did not conclusively demonstrate a lack of parity; however, the Department finds that the auto-authorization process could potentially result in parity issues.

3. Other Findings (Retrospective Review)

A. File Review

The Plan did not identify any files for M/S, MH and SUD retrospective reviews within the review period.

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. UM operations are a NQTL.

The Department determined that the processes and factors used in making inpatient M/S UM determinations were not comparable to the processes, factors and strategies predominantly used in making inpatient MH/SUD UM determinations, as required by 45 CFR 146.136(4)(i), because the Plan's various criteria and processes used for M/S determinations is not comparable to the single set of criteria utilized by Beacon for authorizing MH/SUD services. Additionally, the UM processes applied to MH/SUD benefits were more stringent than those applied to M/S benefits because of the inpatient admission auto-authorization process.

Plan Response:

In its response, the Plan identified a number of changes it would be making to ensure parity. The Plan updated its policies and procedures regarding the Plan's 24-hour inpatient admission authorization review process. The Plan will conduct retraining and

staff modification to ensure all M/S and MH/SUD inpatient admission reviews are conducted within 24 hours. These processes will be implemented by March 1, 2018.

The Plan reviewed its contract with Sutter Hospital and is in the process of setting up meetings to explore contract amendments concerning the concurrent review process. The Plan has stated that it will provide an update to the Department by July 31, 2018.

The Plan also updated its policies and procedures to ensure outpatient authorization review aligns with the regulatory requirements. Plan delegates will be required to align processes with the Plan's updated policies and procedures. The Plan will conduct retraining and staff modification and implement these processes by March 1, 2018.

Status:

As of the date of the Plan's response, it had not yet fully implemented all of the identified and described efforts. The Plan has made policy and staffing changes to ensure that 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. At the Plan's next routine survey, the Department will assess the Plan's efforts.

B. QUANTITATIVE TREATMENT LIMITATIONS

#2 The Department identified no MHPAEA deficiencies with respect to the Plan's implementation of financial requirements.
Health & Safety Code section 1374.76; 45 CFR 146.136(c)(2)(i) and (ii); 45 CFR 146.136(c)(3)(i)(A).

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

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

45 CFR 146.136(c)(2)(ii) provides that if a plan provides mental health or substance use disorder benefits in any classification of benefits described in paragraph (c)(2)(ii),[22] 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.

Supporting Documentation or Evidence:

- The Plan's Exhibit J-11-A and Exhibit J-12 worksheets[23]
- 2016 Evidence of Coverage and Summary of Benefits

[22] See footnote 4 for a description of the classifications.
[23] 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.

Assessment:

The Department reviewed and analyzed the Alameda Alliance for Health IHSS 2016 BPD to assess whether Plan methodologies for determining cost-sharing amounts are MHPAEA compliant. The Department's review of this BPD determined whether the Plan's financial requirements, as applied to MH/SUD benefits, are in parity with the financial requirements applied to its M/S benefits.

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

Conclusion:

Based on the Department's review of the Plan's Exhibit J-11-A worksheet and Exhibit J-12, as well as review of the EOC and information from staff interviews, the Department identified no MHPAEA deficiencies for the BPD reviewed in the Focused Survey.

Plan Response:

The Plan timely responded to the Preliminary report and submitted the required signed certification. The Plan's response offered no comment with respect to the Department's findings in this section.

Status:

No QTL MHPAEA issues were identified during this Focused Survey.

SECTION III: PLAN EXPERIENCE IN IMPLEMENTING MHPAEA

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

With regard to the Plan ensuring MHPAEA parity, the Department asked the Plan to describe any changes in operations with its delegated entities. The Plan conducts annual audits, which include review of authorization case files for all Plan delegates. The Plan holds Joint Operations meetings with its delegates during which policy changes are discussed. The Plan also reviews all delegates' and Plan policies and procedures annually, and any deficiencies in policy or practice are addressed through a corrective action plan.

2. Assessment of Plan's Ability to Maintain Parity

In order for the Plan to maintain parity, the Plan must improve the oversight of its M/S delegates with respect to the UM approval processes for inpatient admissions. For both approvals and denials, the Plan must ensure that criteria applied for MH/SUD services is applied in a manner that is both comparable to, and not more stringent than, the application of criteria for M/S services. The Department's review found that the Plan's files for inpatient admissions did not adequately document the clinical rationale or criteria that provided the basis for the decision. As stated above, the Plan must review inpatient admissions to Sutter Hospitals and ensure that UM criteria is being applied correctly. Without such documentation of M/S decisions, the Plan may have difficulty assessing whether it is applying comparable criteria for behavioral health services. The Plan may therefore have difficulty assessing parity.

The Plan appears to have appropriate oversight mechanisms in place to achieve and maintain parity in its non-quantitative treatment limits, quantitative treatment limits, and financial requirements, with the exception of more stringent criteria for weekend MH inpatient admissions. However, the Plan is in the process of revising the weekend authorization process for M/S inpatient services and adding additional staff to conduct utilization management coverage twenty-four hours a day and seven days a week.

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 Routine Medical Survey scheduled for 1st Q 2021.

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

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

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

APPENDIX A PHASE ONE CLOSING LETTER

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

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

November 5, 2015

VIA ELECTRONIC MAIL

Alameda Alliance Joint Powers Authority
1240 South Loop Road
Alameda, CA 94502

The Department of Managed Health Care (the Department) has reviewed the information submitted in the above-referenced filing (the Amendment) filed by Alameda Alliance Joint Powers Authority (the Plan) for compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act[24] (MHPAEA) and federal final regulations[25] and for compliance with the Knox- Keene Health Care Service Plan Act of 1975, as amended.[26]

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 (MH/SUD) benefits that have been reviewed and not objected to by the Department within the Amendment. Those revisions are summarized in the chart below:

[24] Public law 110-343, 42 U.S.C. § 300gg-26.
[25] 45 Code of Federal Regulations §146.136
[26] California Health and Safety Code Sections 1340 et. seq. (the Act). References herein to Section are to Sections of the Act. References to Rule refer to the regulations promulgated by the Department at Title 28 California Code of Regulations.

Plan Coverage Name	Type of Service	Current Cost- Sharing	Cost-Sharing as of 1/1/2016
In-Home Supportive Services – Alliance Group Care	Outpatient MH Services Other than Office Visits: MH multidisciplinary treatment/intensive outpatient psychiatric treatment program; behavioral health treatment for PDD/autism (including applied behavioral analysis)	$10	$0
In-Home Supportive Services – Alliance Group Care	Outpatient SUD Services Other than Office Visits: SUD intensive outpatient program; SUD medical treatment for withdrawal; opioid replacement therapy	$10	$0

2. The Plan shall implement the revisions to the quantitative treatment limits (day and visit limits) on MH/SUD services that have been reviewed and not objected to by the Department within the Amendment. Those revisions are summarized in the chart below:

Plan Coverage Name	Type of Service	Current Cost- Sharing	Cost-Sharing as of 1/1/2016
In-Home Supportive Services – Alliance Group Care	Inpatient Psychiatric Hospitalization	10 days per benefit year for any mental disorder other than a severe mental illness condition	No day limits for any mental disorder
In-Home Supportive Services – Alliance Group Care	MH Crisis Residential Program	10 days per benefit year for any mental disorder other than a severe mental illness condition	No day limits for any mental disorder
In-Home Supportive Services – Alliance Group Care	SUD Inpatient Detoxification	3 days per benefit year	No day limits for detoxification

In-Home Supportive Services – Alliance Group Care	SUD Inpatient Services	10 days per benefit year for any substance use disorder related to a severe mental illness condition	No day limits for any substance use disorder
In-Home Supportive Services – Alliance Group Care	Outpatient MH Office Visits: individual and group evaluation and treatment, psychological testing, psychiatric observation, outpatient monitoring of drug therapy	10 visits per benefit year for combined MH/SUD office visits	No visit limits
In-Home Supportive Services – Alliance Group Care	Outpatient SUD Office Visits: individual and group evaluation and treatment, individual and group chemical dependency counseling	10 visits per benefits year for combined MH/SUD office visits	No visit limits
In-Home Supportive Services – Alliance Group Care	Urgent Care for any MH/SUD Condition	10 visits per benefits year for combined MH/SUD urgent care visits	No visit limits
In-Home Supportive Services – Alliance Group Care	Outpatient MH Services Other than Office Visits: MH multidisciplinary treatment/intensive outpatient psychiatric treatment program; behavioral health treatment for PDD/autism (including applied behavioral analysis)	10 visits per benefits year for combined MH/SUD services	No visit limits
In-Home Supportive Services – Alliance Group Care	Outpatient SUD Services Other than Office Visits: SUD intensive outpatient program; SUD medical treatment for withdrawal; opioid replacement therapy	10 visits per benefits year for combined MH/SUD services	No visit limits

3. The Plan shall revise its EOC and other disclosure documents to disclose MHPAEA- compliant cost-sharing, quantitative treatment limits, and nonquantitative treatment limits, and other revisions to disclosure text that have been reviewed and not objected to by the Department in the Amendment. EOC revisions include, but are not limited to:
   a. Benefits and Coverage Matrix, Inpatient and Outpatient Alcohol/Substance Use Disorder (SUD) and Mental Health (MH) Services sections: the types of inpatient and outpatient diagnostic and therapeutic services have been more fully listed to clarify an enrollee's cost-sharing for each type of service.
   b. Authorizations: the listing of mental health and substance use disorder services that require precertification or prior authorization has been revised and the process for obtaining certification or prior authorization for mental health and substance use disorder services has been clarified.
   c. Schedule of Medical Benefits, Mental Health and Substance Use Disorder Care: the list of the types of covered inpatient and outpatient mental health and substance use disorder services has been expanded.
   d. Definitions: the definition of "Emergency Services" has been revised and the definition of "Behavioral Health Treatment" added.

4. The Plan shall use the classification of benefits standards, the methodology for calculating financial requirements and quantitative treatment limits, and the factors used to apply nonquantitative treatment limits that have been reviewed and not objected to by the Department within the Amendment to provide covered mental health and substance use disorder benefits in compliance with MHPAEA within the Plan's commercial plan coverage[27].

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.[28]

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

[27] California Health and Safety Code § 1374.76.
[28] Ibid.

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

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