From: DMHC Licensing eFiling

Subject: APL 24-007 – Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage

Date: Wednesday, April 3, 2024 4:16 PM

Attachments: APL 24-007 – Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage.pdf

Dear Health Plan Representative:

The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-007 to provide guidance regarding implementation of the regulation as well as filing and compliance requirements for commercial full-service health plans and specialized health care service plans (plan or plans) offering behavioral health services.

Thank you.

Gavin Newsom, Governor
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ALL PLAN LETTER

DATE: April 3, 2024

TO: All Commercial Full-Service Health Plans and Specialized Health Care Service Plans Offering Behavioral Health Services[1]

FROM: Jenny Phillips
Deputy Director
Office of Plan Licensing

SUBJECT: APL 24-007 Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage

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Senate Bill (SB) 855 (Stats. 2020, ch. 151 §2) enacts Health and Safety Code section 1367.045, 1374.72, and 1374.721 effective January 1, 2021.[2] On January 12, 2024, the Office of Administrative Law approved the Department of Managed Health Care's (Department) proposed regulation implementing SB 855. This regulation takes effect April 1, 2024, and is codified in California Code of Regulations, title 28, sections 1300.74.72, 1300.74.72.01 and 1300.74.721.[3] This All Plan Letter (APL) provides guidance regarding implementation of the regulation as well as filing and compliance requirements for commercial full-service health plans and specialized health care service plans (plan or plans) offering behavioral health services.

A. General Overview of the Regulation

1. Coverage Requirements- Rule 1300.74.72

Rule 1300.74.72 repeals and replaces previous Rule 1300.74.72. Rule 1300.74.72 requires, in part, health care service plans maintain a provider network sufficient to provide all medically necessary services, including services to treat mental health and substance use disorders (MH/SUD), within geographic and timely access standards. If the health care service plan is unable to demonstrate that it is able to offer an in-network appointment within timely and geographic access standards, plan shall provide and arrange coverage for medically necessary MH/SUD services from an out-of-network provider or providers.

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[1] This All Plan Letter does not apply to Medicare Advantage plans, Medi-Cal managed care plans, or Medicare Supplement products.
[2] *See* APL 21-002, issued January 5, 2021.
[3] References herein to "Section" are to sections of the Knox-Keene Act. References to "Rule" refer to the California Code of Regulations, title 28.

Pursuant to Rule 1300.74.72(c), in instances where a plan provides and arranges for out-of-network coverage for medically necessary MH/SUD services due to network inadequacy, within 5 days the plan must provide written notice to the enrollee, the enrollee's authorized representative (if any) and the requesting provider (if any) of the plan's obligation to arrange and pay for out-of-network services because the plan does not have an in-network provider available within the required timeframe or geographic area. The enrollee shall also be notified of their right to only be responsible for paying their usual in-network cost sharing amount for these services, pursuant to Rule 1300.74.72(c)(6).

Further, Rule 1300.74.72(c)(3) requires plans to schedule the appointment or arrange for the admission with the out-of-network provider for an enrollee within the following timeframes, unless 1367.03(a)(5)(H) or (a)(5)(I) apply:

- No more than 10 business days after the initial request for non-urgent MH/SUD services
- Within 15 business days of a request for a specialist physician MH/SUD services
- Within 48 hours of the initial request for urgent MH/SUD services if no prior authorization is required
- Within 96 hours of the initial request for urgent MH/SUD services if prior authorization is required

Within 24 hours of the scheduling of the out-of-network appointment or admission accepted by the enrollee, the plan must provide the enrollee, the enrollee's authorized representative, or the enrollee's provider with information regarding the appointment or admission. If the plan is unable to arrange for covered services as set forth above, Rule 1300.74.72(d) permits the enrollee or the enrollee's representative to arrange for care from any appropriately licensed provider, so long as the appointment or admission occurs no more than 90 days after the initial request for services. If an appointment or admission to a provider is not available within 90 calendar days of initially submitting a request, the enrollee may arrange an appointment or admission for the earliest possible date outside the 90-day window so long as the appointment or admission was confirmed within 90 days.

Pursuant to Rule 1300.74.72(e), if out-of-network coverage is obtained pursuant to Rule 1300.74.72(c) or (d) as described above, the plan shall reimburse the provider for the entire course of medically necessary services unless there is an in-network timely and geographically accessible provider available to deliver MH/SUD services, transfer to the new provider would not harm the enrollee and transfer is within the standard of care for the enrollee's MH/SUD condition. Before the health plan may transition the enrollee to an in-network provider, the health plan shall provide the enrollee, the enrollee's representative (if any), and the provider(s) treating the enrollee with at least 90 calendar days' notice. The notice shall inform the enrollee of the name and contact information of the in-network provider to which the plan intends to transition the enrollee and information about how the enrollee may file a complaint with the plan if the enrollee, the

enrollee's representative, or enrollee's provider believes transitioning the enrollee to an in-network provider will harm the enrollee or is not within the standard of care.

Plans shall be responsible for making the determination in accordance with good professional practice and with the clinical standards set forth in sections 1374.721 and 1374.722 and that the requirements of subdivision (e) as described above are satisfied and shall retain a record of the determination and underlying analysis, rationale, and other supporting information.

Additionally, Rule 1300.74.72(g) and (h) require plans to set forth their obligation to cover the full range of MH/SUD care pursuant to section 1374.72(b)(2) in Evidence of Coverage and Disclosure documents.

2. Scope of Required Benefits- Rule 1300.74.72.01

Rule 1300.74.72.01 provides a non-exhaustive list of required benefits for MH/SUD care. Plans are required to provide coverage for preventing, diagnosing, and treating MH/SUD as medically necessary for an enrollee in accordance with current generally accepted standards of MH/SUD care.

3. Utilization Review Requirements- Rule 1300.74.721

Rule 1300.74.721 requires plans conducting medical necessity and utilization review use only the nonprofit professional association criteria listed in this rule[4] unless circumstances set forth in section 1374.721(c)(1) and/or (2) apply. If a plan proposes to adopt any nonprofit or other criteria not listed in this rule, a Notice of Material Modification shall be filed with the Department consistent with Rule 1300.721(e).

Pursuant to Rule 1300.74.721(f) plans shall submit an Amendment filing containing any revised policies and procedures reflecting the adoption of nonprofit professional association criteria.

Rule 1300.74.721(g) further requires plans who use a contracted entity or delegate to conduct utilization review of MH/SUD services on the plans' behalf to submit a Notice of Material Modification containing specific information regarding the plans' delegation of MH/SUD utilization review.

Rule 1300.74.721(l) requires a plan, its contracted entity, or delegate who delays, denies or modifies MH/SUD services following utilization review to issue written communication to the enrollee or the enrollee's authorized representative and any requesting provider outlining the basis for the delay, denial or modification. The communication must be sent within five (5) calendar days of the decision for non-urgent care and 72 hours for urgent care. The decision must also include the following:

[4] The Department notes Rule 1300.74.721(c)(13) is intended to read "Council of Autism Service Providers."

1. The enrollee's condition for which the plan conducted utilization management review;
2. The clinical specialty at issue;
3. A list of the criteria or guidelines used;
4. A summary of the reasons for deviating from the criteria listed in this Rule, if applicable; and,
5. A summary of the plan's clinical reason(s) for its decision including full details of the application of and/or scoring using the criteria listed in this Rule.

Rule 1300.74.721(o) requires plans sponsor a formal education program by a nonprofit clinical specialty association to educate all plan staff and contracted third parties that conduct utilization review within six (6) months of adoption of this Rule and at least every three (3) years thereafter. Health plans are also reminded of the existing statutory requirement that no individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.

Lastly, Rule 1300.74.721(q) requires plans, upon request, to provide all utilization review determination criteria and any education program materials to enrollees, the enrollee's authorized representative, and the enrollee's requesting provider at no cost in one or more of the following ways: paper form, electronically by email, or website. Utilization review determination criteria and training materials are required to be sent to the requesting party within 30 calendar days of the request.

B. Compliance and Filing Requirements

The compliance deadline for implementation of the Rule is April 1, 2024. Plans are expected to fully comply with the Rule as of April 1, 2024, regardless of filing deadlines outlined below. Please submit compliance filings via eFiling according to the dates and titles described below. Separate filings may be required for the purpose of streamlining the review and approval processes.

1. <u>Initial Amendment filing no later than June 3, 2024- Titled "Initial Compliance with SB 855 Regulation"</u>

- ***Documents for submission to demonstrate compliance with Rule***

Plans shall submit the following new or amended documents demonstrating compliance with the Rule in this filing. All other compliance documents shall be submitted as outlined in sections (2)-(4) below. If the plan believes any filing(s) is not necessary in items (2)-(4) below, provide an explanation in the plan's Exhibit E-1 of this initial filing identifying the filing the plan does not intend to file and providing the reason.

i. **Exhibit E-1 Affirmations and Explanation**

Rule 1300.74.72

- Affirm the plan maintains a provider network sufficient to provide all medically necessary services, including MH/SUD services, within geographic and timely access standards, pursuant to the Knox-Keene Act.
- Affirm within three (3) business days of when the health plan contacts the selected provider, the plan will furnish a written authorization to the provider in accordance with Rule 1300.74.72(c)(2).
- Affirm if MH/SUD services are not available to an enrollee from an in network provider within the geographic and timely access standards, the plan will provide and arrange coverage for medically necessary MH/SUD services from an out-of-network provider or providers pursuant to the timeframes provided in Rule 1300.74.72(c)(3), unless section 1367.03(a)(5)(H) or (a)(5)(I) apply.
- Affirm that if the plan offers a product type with an out-of-network benefit, such as a PPO, and arranges for out-of-network care pursuant to Rule 1300.74.72(c) or (d), the plan will reimburse the provider for the entire course of medically necessary services pursuant to Rule 1300.74.72(e).
- Affirm if an enrollee receives services pursuant to Rule 1300.74.72(c) or (d), the plan ensures the enrollee will pay no more than the same cost share that the enrollee would pay for the MH/SUD services if the services had been delivered by an in-network provider.
- Affirm if an enrollee receives services pursuant to Rule 1300.74.72(c) or (d), the plan reimburses the provider for the entire course of medically necessary services unless the circumstances outlined in Rule 1300.74.72(e) exist and the health plan complies with all provisions of that subdivision.

Rule 1300.74.72.01

- Affirm the plan provides coverage of health care benefits for preventing, diagnosing, and treating mental health conditions and substance use disorders as medically necessary for an enrollee in accordance with current generally accepted standards of MH/SUD care pursuant to Rule 1300.74.72.01.

Rule 1300.74.721

- Affirm the plan does not apply criteria other than those set forth in Rule 1300.74.721(c) unless the circumstances in section 1374.721(c)(1) or (c)(2) apply.

- Affirm the plan does not conduct repeated utilization review of a case at intervals more frequent than those prescribed or recommended by the relevant nonprofit association criteria or guidelines.
- Affirm when an enrollee has met criteria for a level of care as determined by a *ASAM Criteria, LOCUS, CALOCUS/CASII*, and/or *ECSII* assessment but either clinical services or supports consistent with that care are not available, the health plan authorizes the next higher level of care.
- Affirm when the plan delays, denies, or modifies MH/SUD services following utilization review when such services were requested by an enrollee, the enrollee's authorized representative, or the enrollee's providers, the health plan issues a written communication including the information listed in Rule 1300.74.721(l)(1)-(4).
- Affirm the plan will sponsor a formal education program consistent with the requirements of Rule 1300.74.721(o).
- Affirm the plan provides the enrollee, enrollee's authorized representative and the enrollee's requesting provider(s) all utilization review determination criteria and any education program materials at no cost within thirty (30) calendar days of the request.

General Affirmations and Explanations

- Affirm the plan will comply with APL 23-026 and instructions from DHCS regarding establishing necessary protocols for reimbursement of valid claims received from the states third-party administrator for school linked services claim processing.
- Explain any provider or public education outreach the plan has engaged in to educate providers and enrollees on Rule 1300.74.72, 1300.74.72.01 and 1300.74.721.

ii. **EOCs** as Exhibit T-1 or Exhibit U-1 including amendments, errata, or endorsements in compliance with the Rule. If a plan has submitted or intends to submit an EOC in a separate filing, provide the eFiling number of the separate filing(s) (QHP, newly enacted legislation, etc.).

iii. **Policies and Procedures** as Exhibit I-6 for arranging services under Rule 1300.74.72.

iv. **Notices** as Exhibit I-9 (enrollee) and Exhibit I-7 (provider) for arranging services under Rule 1300.74.72
and determination letters under Rule 1300.74.721(l) and (p).

2. **<u>Amendment Filing no later than June 3, 2024 Titled "Compliance with Rule 1300.74.721(f)"</u>**

To the extent the plan has revised policies and procedures reflecting adoption of nonprofit professional association criteria and guidelines since approval of previously submitted SB 855 policies and procedures, plans should submit the documents below.

- ***Documents for submission to demonstrate compliance with Rule***

  i. **Exhibit E-1** providing a roadmap of the documents submitted and describing the plan's proposed changes.
  ii. **Policies and Procedures** as Exhibit J-9 in compliance with Rule 1300.74.721(f) including a list of MH/SUD services provided by the plan that meet the criteria under subdivision (d) of Rule 1300.74.721, a description of the process the plan used to determine the MH/SUD services meet the criteria of subdivision (d) of Rule 1300.74.721 and a description of the plan's process for determining that the criteria and guidelines proposed by the plan are consistent with generally accepted standards of MH/SUD care.
  iii. **Miscellaneous** documents that include any valid, evidence-based periodically updated sources, setting forth generally accepted standards of MH/SUD care the plan relied on when developing or licensing/purchasing criteria and guidelines.

3. <u>Material Modification Filing no later than June 3, 2024, Titled "Delegated Compliance with Health and Safety Code sections 1374.72, 1374.721, and 1374.722"</u>

If a plan does not delegate utilization review for MH/SUD services, this Material Modification is not required. If a plan delegates utilization review of MH/SUD services to a specialized plan, both the full-service plan and specialized plan must submit a Notice of Material Modification.[5]

- ***Documents for submission to demonstrate compliance with Rule***

  i. **Exhibit E-1** providing the name of the entity or delegate company and a complete list of all the nonprofit professional association criteria the company will use when conducting MH/SUD utilization review.
  ii. **Policies and Procedures** as Exhibit J-9 the entity or delegate will utilize to conduct MH/SUD utilization review as well as policies and procedures the plan will utilize to conduct oversight of the delegate or contracted entity.
  iii. **Plan's Contract** as Exhibit P-5 or Exhibit N-1 between the plan and its delegate or entity which sets forth the requirement for compliance with this Rule and sections 1374.72, 1374.721, and 1374.722, including

[5] If a specialized plan is delegated utilization review by more than one full-service plan, the specialized plan shall submit a separate Notice of Material Modification for each full-service plan in which it contracts.

exclusive use of the relevant nonprofit professional association criteria, and all provisions of that criteria to conduct utilization review.

4. <u>Material Modification Filing, on a rolling basis, Titled "Rule 1300.74.721(e) Use of [Insert nonprofit professional association] Criteria"</u>

To the extent plans adopt any nonprofit criteria and/or other guidelines not provided in the plan's underlying SB 855 compliance filing, plans shall be required to submit a Notice of Material Modification including the information below. Plans are permitted to include submission of multiple nonprofit professional association criteria in one single Notice of Material Modification if preferred.

- ***Documents for submission to demonstrate compliance with Rule***

  i. **Exhibit E-1** outlining the plan's proposal to adopt nonprofit professional association criteria and/or other guidelines for use in utilization review including information about the adopted nonprofit professional associations described in Rule 1300.74.721(c)(1)-(c)(14) and criteria or guidelines adopted from other nonprofit professional organizations. Additionally, the plan shall include an explanation why any nonprofit professional associations listed in subdivision (c) of Rule 1300.74.721 do not cover the applicable conditions and what the health plan proposes as MH/SUD criteria.

  ii. **Administrative Service Contracts** as Exhibit N-1 between the plan and nonprofit professional association.

If you have questions regarding the applicable timelines for filing or other questions about the requirements of this APL, please contact your plan's assigned OPL reviewer.