From: DMHC Licensing eFiling

Subject: All Plan Letter for MHPAEA

Date: Friday, July 17, 2015 3:53:49 AM

Attachments: APL 1-1-2016 MHPAEA Compliance 7-17-15.pdf
Sample EOC Update for Enrollees 7-17-15.pdf
Sample Notice for Providers 1-17-15.pdf

Dear Health Plan Representative,

This message is being sent to the 26 plans that submitted amendment filings to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and final federal regulations.

The Department has started to prepare closing letters on several MHPAEA compliance filings and so is providing guidance in the attached All Plan Letter as to how plans must implement compliance by January 1, 2016. Also attached are template notices that plans may use when drafting their own notices to enrollees and providers informing them of changes to plan coverage related to MHPAEA compliance.

If you have questions about the guidance provided in the All Plan Letter, then please contact your assigned counsel in Office of Plan Licensing. The Department is also scheduling with CAHP a teleconference to answer plan questions about the All Plan Letter; information on that teleconference will be sent to you early next week.

Thank you

State of California
Health and Human Services Agency
Department of Managed Health Care

ALL PLAN LETTER

DATE: July 17, 2015

TO: All IHSS and Commercial Full-Service Health Plans

FROM: Nancy Wong

Deputy Director, Office of Plan Licensing

SUBJECT: FINAL IMPLEMENTATION OF MHPAEA COMPLIANCE

This All Plan Letter provides guidance regarding compliance with The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA).

Background: MHPAEA was enacted by Congress in 2008.[1] Originally applicable only to large group coverage, MHPAEA was amended by the Affordable Care Act to also apply to individual and small group coverage.[2] The Departments of the Treasury, Labor, and Health and Human Services issued final rules for MHPAEA on November 13, 2013.[3] The federal government authorized states to ensure compliance with MHPAEA within health plan and insurer coverage.

California Health and Safety Code section 1374.76(c) provides that the director of the Department of Managed Health Care (Department) may issue guidance not subject to the Administrative Procedure Act to plans regarding compliance with MHPAEA until January 1, 2016. The Department asked 26 plans to submit filings in September 2014 that demonstrate that In-Home Supportive Services (IHSS) coverage and a selection of full-service commercial plan products are in compliance with MHPAEA. Based on review of compliance within this coverage sample, plans would follow the Department's guidance to implement approved methodologies and correct compliance deficiencies within all their commercial products, grandfathered and nongrandfathered.

The Department anticipates concluding review of most of the 2014-15 MHPAEA compliance filings within the next few months. When the Department issues a closing letter with conditions for a compliance filing, the closing letter will signify that the Department has reviewed and, at this time, has no further objections to the following, as amended: the methodology for classifying benefits; the methodology for calculating financial requirements and quantitative treatment limits; and the mental health/substance use disorder cost-sharing, nonquantitative treatment limits, and disclosures. The conditions in the closing letter will summarize the revisions to

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[1] Public Law 110-343, 42 U.S.C. § 300gg-26.

[2] 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).

[3] 45 CFR § 146.136 (2013).

mental health/substance use disorder cost-sharing, treatment limits, and disclosures that the plan must make to achieve compliance with MHPAEA, according to the guidance provided in this AllPlan Letter.

A plan may then use the methodologies approved in its 2014-15 MHPAEA compliance filing to calculate financial requirements and quantitative treatment limits based on estimated claims for products of the same type in the same market (e.g., individual HMO coverage, large group POS coverage) that the plan submitted in its 2014-15 compliance filing to determine MHPAEA- compliant coverage in the future. A plan may use approved nonquantitative treatment limits anddisclosures similarly.

Action: Now that review of several compliance filings is nearly complete, the Department provides guidance regarding two further implementation activities. First, the Department directsthe 26 plans who submitted 2014-15 MHPAEA compliance filings to provide all covered mentalhealth and substance use disorder (MHSUD) benefits in compliance with MHPAEA by January 1, 2016, consistent with the Department's review and approval of each plan's MHPAEA filing. Second, plans are to e-File their process to achieve this compliance by September 1, 2015.

Details of these two activities are discussed below.

Application of 2014-2015 MHPAEA Filings to 2016 Plan Documents and Operations:

Final compliance implementation by January 1, 2016, means that, effective on and after January1, 2016, a plan:

1. Shall charge enrollees cost-sharing for MHSUD benefits that complies with MHPAEA and the federal final rules, as computed by the plan using a methodology and classification of benefits that have been reviewed and not objected to by the Departmentwithin the plan's 2014-15 MHPAEA compliance filing. Cost-sharing for MHSUD benefits within nongrandfathered on- and off-Exchange individual and small group coverage shall first comply with MHPAEA and secondly comply with the regulations ofCovered California for 2016 coverage.

2. Shall impose quantitative treatment limits on MHSUD benefits that comply with MHPAEA and the federal final rules, as computed by the plan using a methodology andclassification of benefits that have been reviewed and not objected to by the Departmentwithin the plan's 2014-15 MHPAEA compliance filing.

3. Shall utilize nonquantitative treatment limits that comply with the federal final rules, ashave been reviewed and not objected to by the Department within the plan's 2014-15 MHPAEA compliance filing.

4. Shall distribute to enrollees and post on plan websites evidences of coverage (EOCs), cost-sharing summaries, and other disclosure forms and subscriber contracts that have been revised to disclose MHPAEA-compliant cost-sharing, quantitative treatment limits,and nonquantitative treatment limits and to describe MHSUD services clearly and accurately in text that has been reviewed and not objected to by the Department withinthe plan's 2014-15 MHPAEA compliance filing.

5. For enrollees in coverage that has revised MHSUD cost-sharing and for subscribers who received a 2016 EOC that does not include all MHPAEA compliance changes, a plan shall distribute an EOC update that summarizes the changes to the cost-sharing, treatmentlimits, and descriptions for MHSUD benefits that were made to bring the EOC into compliance with MHPAEA. Plans whose group subscriber contract delegates distribution of disclosure documents to the employer may delegate distribution of the EOC update to the employer. Attached is a template update for enrollees that plans may edit and lengthen as needed to reflect changes made in their EOCs to comply with MHPAEA. The Department is providing the template to be helpful, but plans may draft their own template EOC updates for enrollees if they prefer.

6. Prior to January 1, 2016, plans shall distribute to their MHSUD providers a notice that makes providers aware that the plan has made changes to its MHSUD benefits within certain plan products, including changes to cost-sharing and treatment limits, such as revised prior authorization or utilization management requirements. Attached is a template notice that plans may edit to send to their providers. Plans may draft their owntemplate provider notice, if they prefer, or provide general notice of MHPAEA changes within their customary provider bulletin, if distributed before January 1, 2016.

The January 1, 2016, implementation deadline for MHPAEA compliance of commercial coverage is not a rolling implementation for contracts as they are issued or renewed in 2016. Rather, all plan contracts in effect on January 1, 2016, must be in compliance with MHPAEA onthat day, including mid-term 2015-16 small and large group contracts.

Commercial coverage includes not only the IHSS and sampling of products that plans submittedwithin their 2014-15 MHPAEA compliance filing, but also any grandfathered and nongrandfathered plan contracts in effect in 2016. MHPAEA compliance within Medi-Cal, Medicare, Healthy Families, AIM, and Healthy Kids coverage is not addressed in the 2014-15 MHPAEA compliance filings nor is the Department providing guidance on such compliance within this All Plan Letter.

E-Filing of Process to Comply by January 1, 2016:

The Department also directs plans to submit an amendment filing by September 1, 2015, with a detailed narrative and timeline setting forth the process by which they will ensure that their commercial coverage complies with MHPAEA by January 1, 2016. These filings shall also include a plan's template EOC updates for enrollees and template notices for MHSUD providerssummarizing the changes the plan has made in the 1-15 plan products included in the 2014-15 MHPAEA compliance filing. Plans should submit the September 1 filing as follows:

- Plans whose 2014-15 MHPAEA compliance filing has been closed before September 1,2015, will submit a separate amendment filing with their January 1, 2016, compliance implementation plan. The title of the filing should be “MHPAEA January 1, 2016,Compliance Implementation.”

- Plans whose 2014-15 MHPAEA compliance filing has not been closed by September 1, 2015, will submit their January 1, 2016, compliance implementation plan within their stillopen 2014-15 MHPAEA compliance filing.

If you have questions about the January 1, 2016, deadline for compliance with MHPAEA or about submitting your health plan’s September 1, 2015, amendment, please do not hesitate tocontact the Office of Plan Licensing through your assigned counsel.

California Health Care Service Plan

Update to the 2016 Evidence of Coverage for the

Individual Bronze 60 EPO Plan

California Health Care Service Plan (Plan) changed several mental health and substance use disorder benefits starting on January 1, 2016. A federal law, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, and Covered California rules require these changes.

The changes listed below start January 1, 2016. This information updates the benefits described in an evidence of coverage (EOC) that you may have received already for 2016. The EOC is a written guide to the services the health plan covers and what you pay for services.

Changes to Cost-Sharing

The amount you pay (also known as cost-sharing) for outpatient mental health and substance use disorder services has changed. Note that the changes do not increase cost-sharing but instead either keep cost-sharing the same or decrease cost-sharing:

Plan Name	Type of Service	Current Cost-Sharing	Cost-Sharing of 1/1/2016
Individual Bronze 60 EPO Plan	Outpatient: Individual therapy office visits	$60 copayment, subject to the deductible after three non-preventative visits.	$60 copayment per visit. Copayments are not subject to the deductible.
Individual Bronze 60 EPO Plan	Outpatient: group therapy office visits	$30 copayment, subject to the deductible after three non-preventative visits	$30 copayment per visit. Copayments are not subject to the deductible.
Individual Bronze 60 EPO Plan	Outpatient: psychiatric evaluation neuropsychiatric testing, intensive outpatient care program, day treatment, partial hospitalization, transcranial magnetic stimulation, electroconvulsive therapy, behavioral health treatment (including applied behavioral analysis) for autism, 23-hour observation, detoxification	30% coinsurance, subject to the deductible after three non-preventative visits	30% coinsurance per visit. Subject to the deductible after the first three non-preventative visits.

Changes to Cost-Sharing

The requirements to obtain precertification for some mental health and substance use disorder services changed. The definition of "medical necessity" also changed (see the EOC changes below).

Changes to the EOC for Mental Health and Substance Use Disorder Services

Please contact the Plan, at 800-xxx-xxxx or www.CHCSP.org, to obtain an updated 2016 EOC and for more information on the EOC changes listed below

- Information about cost-sharing for services to treat mental disorders and chemical dependency is listed on pages 27-28. Cost-sharing for the outpatient services has changed (see the chart above).
- Precertification requirements are described on pages 52-55. The listing of mental health and substance use disorder services that require precertification has changed. There is new information about how to obtain precertification for these services.
- Covered services for mental disorders and chemical dependency are described on pages 74-77. The list of the types of covered inpatient and outpatient mental health and substance use disorder services has changed.
- The definition of "medical necessity" has changed and can be found on page 125.

Questions

If you have questions about mental health and substance use disorder benefits, or how to access them, please contact the Plan at 800-xxx-xxxx.

California Health Care Service Plan

Notice to Providers
Revisions to 2016 Coverage of
Mental Health, Substance Use Disorder Benefits

California Health Care Service Plan ("Plan") has revised several mental health and substance use disorder benefits within individual, small group, and large group coverage that is in effect or becomes effective on January 2016. Federal law, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, and California Health and Safety Code section 1374.76 and Covered California regulations require these changes.[1]

The revisions summarized below are effective January 1, 2016. They likely represent changes from information you or your patients have already received on the cost-sharing, treatment limits, and evidence of coverage (EOC) disclosures for the plan's mental health and substance use disorder benefits.

Revisions to Cost-Sharing

Cost-Sharing for certain mental health and substance use disorder services hs changed in the following Plan coverage:

- Individual Bronze 60 EPO Plan
- Small Group Silver Standard EPO Plan
- Small Group Bronze Standard EPO Plan
- Large Group Coverage for Employer A
- Large Group Coverage for Employer B
- Large Group Coverage for Employer C

When your office contacts the Plan to determine the amount to collect or bill the enrollee for cost-sharing, our cost-sharing database will be updated to reflect cost-sharing for the plans listed above. If you have questions about the correct cost-sharing amount to collect or bill for the type of mental health or substance use disorder services rendered, please contact the Plan at 800-xxx-xxxx.

Revisions to Quantitative and Nonquantitative Treatment Limits

The Plan has revised for accuracy the following policy and procedure: Concurrent Review for Higher Level of Care. The revised policy and procedure is available to providers, upon request.

[1] Government Code sections 100503 and 100504(c), Health and Safety Code section 1366.6(e) and 10 CCR section 6460.

Revisions to the EOC Concerning Mental Health and Substance Use Disorder Services

The Plan has revised the EOCs for plan products that have cost-sharing changes as itemized above. The Plan has also revised the text in all EOCs to clarify the types of inpatient and outpatient services and treatment that the Plan provides for mental health and substance use disorder conditions. The most significant text changes can be found in the following EOC sections:

- Benefits Summary, Mental Disorders and Chemical Dependency Benefits section: 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 services.
- Certification, Prior Authorization Requirements: 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.
- Covered Services, Mental Disorders and Chemical Dependency: the list of the types of covered inpatient and outpatient mental health and substance use disorder services has been expanded.
- Definitions: the definition of "medical necessity" has been revised.

Questions

If you have questions about the revisions summarized above, want a copy of a revised EOC or policy and procedure, or would like more information about the Plan's coverage of mental health and substance use disorder services, please contact the Plan at 800-xxx-xxxx or via the provider portal at www.CHCSP.org.

From: DMHC Licensing eFiling

Subject: All Plan Letter for MHPAEA Follow Up

Date: Friday, August 07, 2015

Dear Health Plan Representative,

On July 22, 2015, the Department held an audioconference with plans to answer questions concerning the All Plan Letter (APL) of July 17, 2015, regarding compliance with The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). The All Plan Letter provides guidance to the 26 full-service plans whose commercial or in- home supportive services coverage currently is being reviewed for compliance with MHPAEA. The guidance pertains to the plans providing all covered mental health and substance use disorder (MHSUD) benefits in compliance with MHPAEA by January 1, 2016.

Since the audioconference, many plans have reached out individually to the Department with questions on MHPAEA. We encourage you to do so.

We would like to take this opportunity to provide the following clarification regarding APL item #4 and #6:

- APL Item #4 applies to the distribution of the EOC and other disclosure documents to individual and group subscribers and to posting of the EOC. Plans are required to post the MHPAEA compliant EOC on their website and provide a copy to prospective and new enrollees in an individual plan beginning January 1, 2016. This would include an individual plan enrollee who received a non-MHPAEA compliant EOC in 2015 and requests an EOC on or after January 1, 2016.

- While APL item #4 does not specifically address group subscribers, this e-mail provides clarification that plans should distribute EOCs to group subscribers based on their contract with the employer. If the contract obligates the employer to disseminate copies of the DF/EOC to employees who are eligible for coverage under their employment agreement, then the plan may rely upon that contractual provision, versus disseminating copies to each individual in the group.

- The provider notice must list the names of the plan's products that have changes to MHSUD cost-sharing. The notice can be general, meaning it does not require detailing what the cost-sharing changes are, but should include enough information for the provider to identify the affected benefit plans. For example, a health plan in the individual market may have filed seven products for the MHPAEA compliance project, but only the Bronze 60 HMO and Gold 80 HMO need cost-sharing changes due to MHPAEA. The provider notice must identify those two plans (Bronze 60 HMO and Gold 80 HMO) as having changes.

If you have any further questions about the guidance provided in the All Plan Letter, then please contact your assigned counsel in Office of Plan Licensing.

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