Department of Managed Health Care

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DMHC Mission Statement

The California Department of Managed Health Care protects consumers' health care rights
and ensures a stable health care delivery system.

What is the DMHC?

- Established in 2000 through consumer-sponsored legislation.
- Funded by assessments on health plans.
- Regulates 121 plans: 72 full service plans and 49 specialized plans:
  - All HMO, some PPO/EPO products, dental and vision plans.
  - Some large group, most small group, most Medi-Cal Managed Care plans and many individual products.
  - 95% of California's commercial and public health care coverage.
- Authority from Knox Keene Health Care Service Plan Act of 1975.

We protect the health care rights of more than

DMHC Key Functions

- Review licensed health care service plan (plan) documents for compliance with state and some federal laws.
- Ensure financial stability of licensed plans.
- Review proposed premium increases.
- Conduct onsite medical surveys.
- Monitor provider network adequacy and timely access to care.
- Take enforcement action against plans that violate the law.
- Assist consumers through DMHC Help Center.

Ensuring Compliance with MHPAEA

- November 2013 federal rules directed states to enforce compliance in commercial coverage.
- CA legislature approved:
  - Budget for DMHC to hire attorneys, analysts, and clinical consultants to review and monitor MHPAEA commercial coverage compliance.
  - Statute directing individual, small group plans to comply with MHPAEA.
- DMHC focused initial compliance efforts in two phases:
  - Phase 1: Desk audit
  - Phase 2: Onsite surveys

Phase 1 – Preparations for Desk Audit

Asked 25 plans with commercial HMO or PPO coverage to submit filings demonstrating compliance with MHPAEA:

Aetna, Alameda Alliance, Blue Cross, Blue Shield, Central California Alliance for Health, Chinese Community Health Plan, Cigna, Community Care, Contra Costa County, County of Ventura, Health Net, Health Plan of San Mateo, Kaiser, L.A. Care, L.A. Care Joint Powers Authority, Medi-Excel, Molina, San Francisco Health Authority, Santa Clara County/Valley Health Plan, Seaside, Sharp, SIMNSA (Sistemas Medicos Nacionales), Sutter, United, Western Health Advantage

Phase 1 – Preparations for Desk Audit

- Selected 15 commercial products for review:
  - 7 on- or off-Exchange individual coverage benefit plan designs.
  - 5 on- or off-Exchange small group benefit plan designs.
  - 3 “most popular” large group or In-Home Supportive Services designs.
- Held webinars on MHPAEA compliance, submitting filing electronically.

Phase 1 – Preparations for Desk Audit

- Created worksheets to assist plans:
  - In classifying benefits into 5 (HMO) or 8 (PPO) classifications.
  - In recording benefit cost-sharing, quantitative treatment limits (QTLs), and financial requirements (FRs).
  - In demonstrating plan's method for estimating annual claims and calculating FRs ("substantially all" and "predominant" tests).
  - In recording standards and factors for applying nonquantitative treatment limits (NQTLs) on medical/surgical (M/S) benefits as compared to mental health/substance use disorder (MH/SUD) benefits.

Phase 1 – DMHC Review of Plan Filings

- Beginning September 2014, DMHC reviewed filings and issued comments on compliance deficiencies.
- Department actuaries reviewed the FR, QTL worksheets.
- Clinical consultants reviewed classification of benefits and NQTL policies.
- Department attorneys reviewed each plan's evidence of coverage and cost-sharing summaries.
- Plans conferred with Department on deficiencies they did not understand, revised documents, and resubmitted their filing for continued review.

Phase 1 – DMHC Deadline for Compliance

- In July 2015, DMHC issued an All Plan Letter setting January 1, 2016, as the deadline for plans to come into compliance with MHPAEA.
- The All Plan Letter required plans to send notices to enrollees and providers of changes to cost-sharing, QTLs, NQTLS, and disclosures due to compliance with MHPAEA.

Phase 1 – Corrections to Achieve Parity

- 24 out of 25 plans had to lower MH/SUD cost-sharing in one or more products.
- 3 out of 25 plans had to eliminate impermissible day or visit limits on MH/SUD benefits.
- 12 out of 25 plans modified or clarified prior or concurrent authorization requirements.
- Several plans had to revise definitions of medical necessity, add MH/SUD experts to their pharmacy committee, or modify their credentialing standards to achieve parity.
- All 25 plans had to revise EOC text to more clearly describe MH/SUD benefits.

Ongoing Review of MHPAEA Compliance

- After being reviewed for compliance, plans are authorized to use filed methodologies in all commercial coverage, unless:
  - The benefit plan design changes, or
  - The cost-sharing structure changes, or
  - Enrollee utilization changes significantly, or
  - Plan enters a new commercial market, or
  - Plan makes a substantive change to its MH/SUD provider network.

Phase 2 – Onsite Survey

- In April 2016, Phase 2 was launched with first 5 plans.
- Primary task: to evaluate utilization management (UM) process – how the plan decides to authorize or deny services to treat MH/SUD conditions as compared to how that plan decides to authorize or deny services to treat medical/surgical conditions.

Phase 2 – Onsite Survey Focus on UM

- Each plan submitted lists of UM records dating from 1/1/2016.
- DMHC randomly selected up to 10 medical/surgical records, 10 mental health records, and 10 SUD records in each benefits classification:
  - Inpatient services,
  - SNF and MH or SUD residential care services,
  - Outpatient office visits,
  - Outpatient services other than office visits, and
  - Retrospective review of any unauthorized services.

Phase 2 – Onsite Surveys: UM Review

- DMHC clinical consultants – psychologist, nurses, licensed clinical social worker – conducted the audit of UM records onsite.
- Survey team also interviewed clinical, UM, provider relations, member services directors – for plan and plan delegates.
- From auditing UM records and interviewing plan and delegate staff, DMHC determined if plan's UM processes for MH/SUD services were comparable to and applied no more stringently than plan's UM processes for medical/surgical services.

Phase 2 – Surveys: Cost-Sharing Review

- Plans submitted information on 3-4 products to evaluate compliance with MHPAEA financial requirements.
- DMHC revised and added worksheets for plans:
  - To classify benefits.
  - To record annual estimated claims for medical/surgical benefits to show how they calculated FRs.
- From reviewing completed worksheets, DMHC determined whether a plan correctly calculated FRs and is charging MHPAEA-compliant cost-sharing.

Phase 2 – Onsite Survey Reports and CAPs

- DMHC will issue a preliminary report that highlights plan compliance efforts as well as citing any applicable deficiencies.
- The preliminary reports will be issued to the 5 plans simultaneously later this fall.
- Plans will have 45 calendar days to respond to the findings and propose a corrective action plan (CAP) for deficiencies.
- DMHC will summarize response and proposed CAP and issue a Final Report for each plan.
- The Final Reports will be posted online and available to the public.

Phase 2 – Onsite Surveys

- This fall, the DMHC will further refine its survey tools, such as the pre-onsite survey questionnaire and financial requirements worksheets.
- The remaining 20 onsite MHPAEA surveys are scheduled for October 2016 through June 2017.

Lessons Learned

- Meaning of parity not readily understood:
  - Implementing federal rules requires extensive training of plans, DMHC staff, clinical consultants.
  - DMHC found most plans' initial submission of financial requirements problematic; plans had to make many revisions to reach compliance.
  - Therefore, would not recommend that states rely solely on plan or insurer affirmations of compliance, or that states not review proof of compliance.

Lessons Learned

- Desk audit using worksheets to classify benefits, compute FRs, QTLs, best way to ensure:
  - Consistent standards in classifying benefits.
  - Plan covers all state-required M/S and MH/SUD benefits.
  - “Substantially all,” “predominant” tests are calculated correctly.
  - Noncompliant MH/SUD day, visit limits are eliminated.
  - MH/SUD cost-sharing complies with MHPAEA.

Lessons Learned

- Compliance in some NQTLs possible through review of policies: formulary development, credentialing standards, fail-first policies, exclusions based on failure to complete course of treatment, geographic restrictions on services.
- Compliance in utilization management standards more accurate through UM record review, interviewing plan and delegate staff.

Lessons Learned

- Monitoring compliance with MHPAEA an opportunity to review compliance with state-required MH/SUD benefits:
  - Large group vs individual and small group coverage.
  - Benchmark plan MH/SUD essential health benefits.
  - All MH/SUD benefits disclosed in enrollee contracts.
  - MH/SUD cost-sharing accurately listed in SBCs, EOCs.
  - Complete, accurate disclosures facilitate regulatory enforcement.

Still In Progress . . .

- Determining parity in provider reimbursement, when:
  - Medical/surgical services compensated separately from MH/SUD services.
  - Inpatient services compensated separately from outpatient.
  - Some compensation straight capitation; MH/SUD combines capitation with fee-for-service.
- More guidance?

A Regulator's Wish

- That MHPAEA compliance in financial requirements (cost-sharing) was more intuitive, less variable:
  - For health care plans.
  - For regulators, health benefits exchange.
  - For the media.
  - For enrollees and the public.

Questions?

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