



Joint Hearing
Senate Committee on Health and Select Committee on Mental Health
Mental Health Parity and Access Oversight
Wednesday, December 16, 2015
1:30 p.m., Room 112

The purpose of this hearing is to examine access to mental health services for Californians with health insurance and assess the extent to which a shortage of mental health providers is an issue. The Senate Committee on Health and the Select Committee on Mental Health will hear from health insurance regulators, health plans, health care providers, patients and their family members about challenges accessing the right mental health services at the right frequency of time. Despite mental health parity requirements in California since 1999, timely access requirements in California since 2002 (regulations effective 2010), and more recent network adequacy requirements, patients and their families continue to report frustration with access to adequate mental health services. Reports in the media and pending litigation describe patients committing suicide after attempts to seek services through their managed care plan.¹ The hearing will examine how laws to ensure mental health parity, timely access and adequate health insurance networks are being implemented with respect to mental health services and if more needs to be done to improve access for Californians.

Mental Health Care in California

Nearly one in six California adults has a mental health need, and approximately one in 20 suffers from a serious mental illness that makes it difficult to carry out major life activities.² About half of California adults with mental health needs did not get any mental health services during the past year. Only one-third of children whose parents rated their emotional difficulties as definite or severe had a mental health visit in the past year. Rates varied dramatically by race. White and African American children were considerably more likely to have had a mental health visit than

¹ <http://www.pressdemocrat.com/news/4257827-181/kaiser-permanente-faces-renewed-criticism?artslide=0>

² California HealthCare Almanac: Mental Health Care in California: Painting a Picture. July 2013.
<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MentalHealthPaintingPicture.pdf>

Asian or Latino children. Compared to the U.S., California had a lower overall suicide rate, although it varied considerably within the state by gender, age, race/ethnicity, and region.

Managed Care Report Cards

California's Office of the Patient Advocate publishes report cards on health maintenance organizations (HMOs) and preferred provider organizations (PPOs) that serve Californians. While some of California's health plans and insurance products received top marks for mental health services, many did not. The report cards are based on national quality measures.³ The data comes from patient medical records and consumer surveys and the accuracy of the information is independently verified. The 2015-16 HMO and PPO Quality Report Cards for Behavioral and Mental Health indicate that of the 16 California HMOs and PPOs rated, almost half received a three star rating of "good," for helping consumers get the behavioral and mental health care they need. Kaiser Permanente Northern California is the only plan that received an "excellent" rating of four stars. Six HMOs and PPOs received two stars and Health Net's HMO and PPO each received a "poor" rating of one star. Kaiser Permanente Northern California is the only HMO or PPO that exceeded national counterparts on quality measures related to the diagnosis and services of depression in the acute phase (first 12 weeks). Only Aetna's PPO product exceeded national counterparts in making sure patients were continuing with services six months following the start of services. Twelve plans fell below national counterparts on follow-up within seven days of a mental illness hospital stay, and 14 plans fell below national counterparts for services 30 days after leaving a hospital for mental illness.

Although Kaiser has received some excellent ratings, in 2013 the Department of Managed Health Care (DMHC) identified four uncorrected deficiencies related to Kaiser's delivery of mental health services to its enrollees. Based on these deficiencies DMHC levied a \$4 million dollar fine on Kaiser that year. In a recent follow-up survey, DMHC found two of the four deficiencies had been corrected, but appointment wait times and the plan's timely access reports show volatility in timely access to mental health services in both regions, and the plan has failed to provide accurate and understandable mental health benefit and coverage education services to its enrollees. Additionally, lawsuits seeking class action status for violations involving parity and access are also pending against Kaiser.⁴

Timely Access Requirements

California statutes and regulations establish requirements on HMOs and PPOs to ensure patients have access to needed health care services in a timely manner. HMOs and PPOs regulated by DMHC are required to contract with adequate numbers of health care providers to meet clinical and time elapsed standards that are appropriate for their conditions. Under these requirements:

- Urgent care appointments for services by a physician or non-physician provider that do not require prior authorization must be available within 48 hours.

³ HEDIS®, CAHPS®, and the National Committee for Quality Assurance. HEDIS® and CAHPS® measures are important parts of a national system of accreditation of health plans and some medical groups. These measures are administered by the NCQA, a private, not-for-profit organization dedicated to improving health care quality.

⁴ "Health Policy Brief: Enforcing Mental Health Parity, *Health Affairs*, November 9, 2015. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=147

- Mental health services must be offered within 15 business days of a request for an appointment with a specialist, such as a psychiatrist, and within 10 business days of a request for an appointment with non-physician mental health care providers.
- Plans responsible for arranging mental health services must provide telephone triage or screening services 24 hours a day, seven days a week and a callback time of not more than 30 minutes.
- Plans must ensure during normal business hours, phone wait times do not exceed 10 minutes, and plans must monitor compliance with timely access standards and investigate and correct any deficiencies.
- Plans must ensure all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.
- Within each service area of a plan, basic health care services and specialized health care services must be readily available and accessible to each of the plan's enrollees. The location of facilities providing the primary health care services of the plan must be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility.
- The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, must be such as to reasonably ensure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees.
- There shall be approximately one full-time equivalent primary care physician for each 2,000 enrollees, or an alternative mechanism must be provided by the plan to demonstrate an adequate ratio of physicians to enrollees.

Health plans generally provide mental health services through one of four arrangements:

- An integrated model where the medical and mental health providers belong to a multi-specialty group either employed by or contracted with the health plan.
- A single plan model where a plan directly contracts with mental health providers.
- A subsidiary model where the health plan contracts with a subsidiary that specializes in mental health services.
- A carve out model where the health plan contracts with a managed mental health plan which recruits and maintains its own network of mental health providers. The mental health plan is responsible for managing and monitoring access to mental health services, credentialing providers, utilization, case management and quality.

In all of these arrangements the full service health plan is ultimately held responsible for meeting requirements of the laws which govern health plans. All full service health plans and mental health plans are required to report annually by March 31 to DMHC on compliance with these timely access requirements.

Findings from DMHC's August 2013 Timely Access report (based on 2011 measurement year data from 33 health plans and seven mental health plans) indicate that plans revised their access policies and procedures to comply with the standards, but additional revisions were necessary to

come into full compliance. Because the regulations did not require the use of standardized metrics to measure timely access, plans used a variety of approaches to demonstrate compliance making it difficult to make cross-plan comparisons. Out of 33 plans, 25 plans reported no patterns of non-compliance and eight plans identified and reported patterns of non-compliance. Of the plans that reported non-compliance patterns, timely access to certain pediatric specialists and other non-urgent primary visits were reported. These patterns were not necessarily specific to services for mental illness. Specific to mental health plans, two of the seven identified and reported patterns of non-compliance. Issues with access to psychiatrists in rural areas and after-hours messaging were identified. No health or mental health plan reported any incidents of non-compliance resulting in substantial harm to an enrollee. The report also found that few health or mental health plans had made extensive use of health information technology to improve timely access.

With the passage of SB 964 (Hernandez), Chapter 573, Statutes of 2014, DMHC has been given authority to develop a standardized methodology for monitoring compliance with timely access requirements and to require that plans use the standardized methodology. SB 964 required DMHC to annually review health plan submissions and post the findings by December 1. SB 964 also requires health plans to submit data regarding network adequacy, including grievances relating to network adequacy and timely access. The first report required under SB 964 has been delayed until the beginning of 2016 due to reporting errors.

A plan's referral system must provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary services of conditions as appropriate, upon referral from a primary care physician, mental health provider or pediatrician. If a plan contracts with a mental health plan the mental health plan is required to maintain a telephone number that an enrollee can call during normal business hours to obtain information about benefits, providers, coverage and any other relevant information concerning an enrollee's mental health services.

The California Department of Insurance (CDI) regulates PPOs that are not licensed by DMHC. CDI has similar timely access and network adequacy regulations, which include requirements that there are mental health professionals with skills appropriate to care for the mental health needs of covered persons and with sufficient capacity to accept covered persons within 30 minutes or 15 miles of a covered person's residence or workplace. Additional requirements include: at least one full-time physician per 1,200 covered persons; at least one full-time primary care physician per 2,000 covered persons, primary care network providers within 30 minutes or 15 miles of each covered person's residence or workplace, medically required network specialists with sufficient capacity to accept covered persons within 60 minutes or 30 miles of a covered person's residence or workplace, and a network hospital within 30 minutes or 15 miles of a covered person's residence or workplace.

Mental Health Parity

Mental health insurance coverage is governed by state and federal law which has evolved over time. According to a *Health Affairs*⁵ policy brief on mental health parity, insurance plans have historically covered services for mental health and substance abuse disorders at a much lower rate than benefits for other health conditions. For instance, coverage for mental health and substance use disorders typically would have its own cost-sharing structure, more restrictive limits on inpatient and outpatient visits allowed, separate annual and lifetime caps on coverage, and different prior authorization requirements than coverage for other medical services. To address this issue, in 1996, Congress passed the Wellstone and Domenici Mental Health Parity Act (MHPA), which prohibited large group health plans from imposing higher annual or lifetime dollar limits on mental health benefits. However, the law did not mandate coverage for mental health services. The MHPA also did not apply to substance use disorders, services limits, limitations on the types of facilities covered, or differences in cost sharing, and plans could have stricter prior authorization requirements for mental health services than for other medical services.

In 1999, California passed its own state Mental Health Parity Law (AB 88, Thomson, Chapter 534, Statutes of 1999), which mandates all California health insurance plans provide coverage for the diagnosis and medically necessary services of severe mental health conditions under the same terms and conditions as applied to other medical conditions. AB 88 also requires copayments, deductibles and maximum lifetime benefits to be applied equally to all benefits under the plan.

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to cover some of the gaps in the MHPA. Similar to the MHPA, the MHPAEA only applies to large-group health plans. However, the MHPAEA also included Medicare Advantage plans offered through group health plans, state and local government plans, Medicaid managed care plans, and state Children's Health Insurance Program plans. Unlike the MHPA, the MHPAEA prohibited differences in services limits, cost-sharing, in-and-out-of-network coverage, and applied to services for substance use disorders. Like the MHPA though, the MHPAEA did not mandate mental health or substance services. MHPAEA requires, if health plans include services for mental health or substance use disorders as part of their benefits, to provide those services under the same terms and conditions as other medical services. The MHPAEA eliminated all differences between mental health and substance use disorder services and other medical services as they related to: (1) services and visit limits; (2) deductibles, copayments, and coinsurance; (3) and the use of out-of-network providers when a health plan gave this option. Further, federal regulations in 2010 and then the final rule in 2013, prohibited plans from imposing a financial requirement or services limit restriction that is more restrictive than what they offered for medical and surgical benefits in the same classification.

The passage of the Affordable Care Act (ACA), in 2010, took coverage for mental health and substance abuse disorders a step further than the MHPAEA by mandating coverage for services, instead of only requiring parity, if mental health coverage is provided. The ACA applied the

⁵ "Health Policy Brief: Enforcing Mental Health Parity, *Health Affairs*, November 9, 2015. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=147

MHPAEA to all health plans in the individual market and qualified health plans offered through the Health Benefit Exchange (Exchange), including those products in the Small Business Health Options Program. The ACA also specified that coverage of mental health and substance use services must be included as one of the ten essential health benefits. Due to the ACA, all health insurance plans in the individual and small-group market, inside and outside the Exchange, must now include coverage for the services of mental health and substance use disorders.

Both DMHC and CDI provide regulatory oversight of federal and California parity laws and have begun to examine plan filings for compliance with these laws. DMHC has requested that health plans file how each plan meets parity standards. The filing only needed to include 15 representative products. On July 17, 2015, DMHC sent an all plan letter to the health plans informing them that they must be MHPAEA compliant by January 1, 2016. The all plan letter includes products in the individual, small and large group markets. DMHC is reviewing plans for compliance and has cleared some plans for compliance. Beginning April 2016, DMHC will survey health plans to ensure they are in compliance with parity requirements.

Similarly, CDI has issued questionnaires to insurers requesting information on how the health insurer meets the parity requirements in state law, the MHPAEA, and other general questions. CDI also filed amicus briefs on behalf of patients in two recent cases involving health plan coverage for mental health services: *Harlick vs. Blue Shield*⁶ and *Rea vs. Blue Shield*.⁷ In both cases, patients were seeking coverage for medically necessary services for anorexia that had been denied by the health plan. The courts ruled in favor of the plaintiffs. CDI filed the amicus brief because it does not have regulatory authority to take action against the health plan.

Complaints and Independent Medical Review

DMHC and CDI provided the Committees with complaint data related to accessing mental health services. According to DMHC, in general, standard complaints can include not getting a referral or services, waiting too long for an appointment, getting discharged from the hospital, poor care, or rude services. An Independent Medical Review (IMR) is an independent review of a specific complaint about services, such as when a plan refuses to cover a drug because it is considered experimental. IMR is conducted by physicians who are independent of the health plan, must be resolved within 30 days. In 2014, DMHC resolved 1,821 IMRs. Overall, enrollees receive the requested services in 53% of all qualified IMR cases. According to DMHC, most common standard complaints related to mental health services fall under the following categories: individual counseling and psychotherapy, residential services admission, acute inpatient care, antidepressants, drug rehabilitation and partial hospitalization. With regard to IMR, the most commonly requested categories include residential services admission, acute inpatient care, partial hospitalization, transcranial magnetic stimulation, psychotherapy/individual counseling, drug rehabilitation, alcohol rehabilitation, and early discharge from residential services.

⁶ <http://www.insurance.ca.gov/01-consumers/110-health/upload/HarlickAmicusCuriae.pdf>

⁷ <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/05-autism/upload/AMICUSBRIEFFINAL808769.pdf>

All Mental Health Complaints by year and Type Compared to All Complaints, DMHC

Complaint Type	2013	% of overall	2014	% of overall	2015 YTD	% of overall
IMR	256	16%	335	17%	238	11%
Standard	304	7%	295	4%	334	5%

This year (year-to-date 2015) CDI has received 9 complaints about network adequacy related to mental health out of 53 overall. CDI also administers an IMR program that enables people to request an impartial appraisal of medical decisions within certain guidelines as specified in law. An IMR can be requested only if the insurance company's decision involves: the medical necessity of services, an experimental or investigational therapy for certain medical conditions, or a claims denial for emergency or urgent medical services. In 2014, CDI had 142 mental health complaints that went through the entire IMR process. In 57% of the cases decided by IMR reviewers, the denials were partially or entirely overturned, resulting in coverage for the insured.

All Mental Health Complaints by year and Type Compared to All Complaints, CDI

Complaint Type	2013	% of Overall	2014	% of overall	2015 YTD (12/1/15)	% of overall
IMR	192	39.34%	179	39.34%	125	28.86%
Standard	107	3.28%	90	3.12%	88	3.69%

Note: The “% Overall” for IMR data is the percentage of Mental Health IMRs to non-Mental Health IMRs. The “% Overall” for Standard data is the percentage of “Standard” Mental Health complaints (non-IMR) to all Standard Health complaints (non-IMR).

From 2011-2014, CDI received 861 consumer (or provider) complaints that involved a mental health diagnosis. The most common of the diagnoses CDI receives complaints about include Autism, Depression, and Anorexia Nervosa (and other eating disorders). The types of services involved in these cases also varies greatly including office visits, medication, residential services, and disputes over whether a patient should be treated in an in-patient or out-patient setting.

CDI Total Results for All Mental Health Cases (2011-2014)

	Total All Mental Health Complaints	All Mental Health Cases Resolved in Favor of Insured	IMR Mental Health Cases Resolved in Favor of Insured	Non-IMR Mental Health Cases Resolved in Favor of Insured (coverage issues, etc)
4-Year Total	861	463 (54%)	309 of 574 (54%)	154 of 287 (54%)

While CDI gets more complaints for non-mental-health cases, it spends significantly more time per case on mental health cases such as autism, out of state services centers for teens (including wilderness centers), depression, and eating disorders than for most complaints related to mental health coverage.

Mental Health Workforce

An adequate mental health workforce is necessary for Californians to receive mental health services. Some stakeholders have indicated to the Committees' staff that there are shortages of mental health providers in California and that some mental health providers will not contract with HMOs or PPOs.

Under the federal health professional shortage area (HPSA) designation there are areas identified as having a shortage of mental health providers on the basis of availability of psychiatrist and mental health professionals. According to these designations, approximately 16% of Californians live in a Mental HPSA. MHPSAs are based upon a rational service area; the population-to-core mental health professional and/or the population-to-psychiatrist ratio; and there is a lack of access to mental health care in surrounding areas because of excessive distance, overutilization, or access barriers. Mental health providers in designated MHPSAs are eligible for the National Health Services Corp/State Loan Repayment Program; improved Medicare reimbursement; and enhanced federal grant eligibility.

According to April 2014 data from the Kaiser Family Foundation (KFF),⁸ California has 339 MHPSAs and an unmet need of slightly less than 44%. This unmet need standard is based on provider to population ratio that is more than 30,000 to one or 20,000 to one where high needs are indicated. The percent of need met is computed by dividing the number of psychiatrists available to serve the population by the number of psychiatrists that would be necessary to eliminate the MHPSA. According to KFF, California would need 167 more psychiatrists to eliminate the MHPSA designations. According to a report from the California Healthcare Foundation, there were 4,092 active patient care psychiatrists in California in 2009.⁹

According to the California HealthCare Foundation's Almanac, California had:

- More psychiatrists (16.5 per 100,000) than the U.S. overall (14.4 per 100,000),
- Fewer nurses with psychiatric prescribing privileges (CA: 1 per 100,000 compared to U.S.: 3.3 per 100,000):
- More marriage and family therapists (MFTs) (CA: 76.9 per 100,000 compared to U.S.: 16.3 per 100,000): and,
- Fewer social workers (CA: 53.4 per 100,000 compared to U.S.: 82 per 100,000) and counselors (CA: 22.2 per 100,000 compared to U.S.: 54.4 per 100,000).

The distribution of licensed mental health providers varied considerably among California regions. The Bay Area had the greatest concentration of licensed mental health professionals, far exceeding the state average. The Inland Empire and San Joaquin Valley fell well below the state average for all mental health professions. The Northern and Sierra region was below average in the numbers of psychiatrists and psychologists, but above average for marriage and family therapists.

⁸ <http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/>

⁹ <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaliforniaPhysicianFactsFigures2010.pdf>

Mental Health Services Act

California's Proposition 63, the Mental Health Services Act (MHSA), passed in November 2004, provided funding to increase staffing and other resources that support public mental health programs, increase access to needed services, and monitor progress toward statewide goals for serving children, transition age youth, adults and older adults, and their families. According to the Office of Statewide Health Planning and Development (OSHPD) website¹⁰, California's public mental health system (PMHS) has suffered from a shortage of public mental health workers; misdistribution of certain public mental health occupational classifications; a recognized lack of diversity in the workforce; underrepresentation of professionals with consumer and family member experience; and underrepresentation of racial, ethnic, and cultural communities in the provision of services and support.

The MHSA included a component for a Mental Health Workforce Education and Training (WET) assessment. To this end, OSHPD contracted-out to survey counties in 2013 (41 counties responded) about workforce needs in the PMHS and again in 2015 (43 counties responded) to identify any changes to the first survey. The positions identified as the top five with the highest need in both 2013 and 2015 were, in order: psychiatrists, licensed clinical social workers, MFTs, psychiatric mental health nurse practitioners, and bilingual workers.

Some key findings from the WET report on the state's mental health workforce supply include:

- Most professions in the PMHS workforce grew each year from 2006 to 2013, and are anticipated to continue to grow from 2014 to 2019.
- Rates of growth varied by professions, with registered nurses (the profession with the highest growth rate) estimated to increase by 50%. Psychiatrists (the profession with the lowest growth rate) are estimated to increase by 14% over the same period.
- Of 19 different types of providers in the PMHS workforce, MFTs comprise the largest share (46% of the licensed, non-prescribing, clinical class), both in 2013 and in 2019 estimates.
- Of the licensed, prescribing class, psychiatrists (47%) and physician assistants (PAs, 51%) comprise the largest share of providers while psychiatric mental health nurse practitioners comprise the smallest share.
 - The highest counts of each profession are located in the Bay Area region, followed by the Southern and Los Angeles regions.
 - Psychiatrists and PAs were located mostly in large counties.
 - Most PAs practice in non-public mental health settings.
- Based on supply projections, retirement among the workforce is not expected to seriously affect the supply of psychiatrists, MFTs, or LCSWs.
- While the Bay Area, Los Angeles, and Southern regions had the largest concentrations of providers in the state, the highest provider-to-population ratios for some professional categories occurred in the Central and Superior (16 northern counties) regions.
 - The Bay Area, Los Angeles, and Southern regions have fewer providers relative to their populations.

¹⁰ <http://www.oshpd.ca.gov/HWDD/WET.html>

- However, the Central and Superior regions have counties with rural populations, which means those communities will have greater difficulty accessing providers even if they are available.

The MHSAs included funding under WET for a variety of programs to address mental health workforce challenges. For example, OSHPD offers loan repayment of up to \$10,000 to mental health workers in hard-to-fill and/or hard-to-retain positions in the PMHS in exchange for a 12-month service obligation. OSHPD contracts with educational institutions to provide stipends for graduate students who plan to work in the PMHS. OSHPD contracts with Psychiatric Residency and Psychiatric Mental Health Nurse Practitioner programs to fund residency and training slots to increase capacity to train residents and trainees and to provide clinical rotations in the PMHS. OSHPD funds organizations that engage in training, education, placement, support, planning, and development activities that lead to increased consumer and family member employment in the PMHS.

In coordination with the California Mental Health Planning Council, OSHPD developed the second WET Five-Year Plan (2014-2019), which contains a budget for how OSHPD will allocate the remaining state-administered MHSAs WET funds, estimated at about \$114.7 million. According to OSHPD, the five-year plan budget will be reassessed this Fiscal Year (FY) 2015-16 to determine if funding is being guided by priority needs, at which point funding amounts for programs may change for FYs 2016-17 and 2017-18. OSHPD will provide a written update in the five-year plan and budget to the California Mental Health Planning Council on an annual basis.

Despite the passage of federal and state mental health parity laws, state laws on network adequacy and timely access, and additional support to enhance California's mental health workforce, access to mental health services remains a concern for California consumers and their families. With the ACA requirement that health plans provide mental health services as an essential health benefit, Californians will seek more services for mental health conditions through health insurance plans. While some of California's health plans and insurance products received top marks, many did not, and even with high marks, major deficiencies remain. Have plans and regulators been given adequate time to come into compliance with state and federal laws? Are national quality measures adequate to gauge access to care in California? There are geographic hot spots where mental health provider shortages exist. Can health information technology address gaps in access? What more should policymakers, regulators, and providers do to ensure access?