TESTIMONY

SENATE COMMITTEE ON HEALTH AND

SELECT COMMITTEE ON MENTAL HEALTH

Oversight Hearing: Mental Health Access and Parity Oversight

December 16, 2015 1:30 p.m., State Capitol, Room 112

Good afternoon Senator Hernandez, Senator Beall, and members, I am Shelley Rouillard, Director of the Department of Managed Health Care. I want to thank the Committee members and their staff for inviting the Department to participate in today's hearing on the important topics of access to mental health services and parity in service delivery.

First, let me begin by saying that words cannot express my sorrow and sympathy for the Ragan family – their loss is heartbreaking. It is stories like the Ragan family's and other stories and complaints that we hear at the Department's Help Center that make me so dedicated to making sure that the Department does its part to regulate health plans' responsibility to provide timely access timely access to mental health services.

The mission of the Department is to protect consumers' health care rights and ensure a stable health care delivery system. Mental health services are a critical part of this system and the Department plays a pivotal role in holding health plans accountable for providing mental health benefits in a way that is on par with medical and surgical benefits, and that they have an adequate network of providers to do so.

In 2015, approximately 11% of the requests for Independent Medical Review and 5% of the complaints received by the Department's Help Center relate to mental health services. These complaints typically involve coverage disputes for services such as, residential treatment and acute inpatient care facility admissions as well as rehabilitation and counseling services. We take all these complaints very seriously and work with enrollees to resolve these complaints with their health plans.

The Department is also working with Kaiser to correct deficiencies in the Plan's provision of mental health services that were identified in 2013 during the Department's routine survey. State law requires the Department to conduct a routine survey of each licensed full service and specialty health plan at least once every three years. A routine survey is a comprehensive evaluation of a plan's health care delivery system. During the 2013 survey, the Department identified four deficiencies that limited enrollee access to care. This resulted in a $4 million fine which Kaiser paid in September 2014. The Department then conducted a follow-up survey to determine if Kaiser corrected the deficiencies and is complying with the law.

In February 2015, the Department issued a follow-up report to the 2013 routine medical survey of behavioral health services at Kaiser. The follow-up survey determined that two of the four deficiencies identified during the 2013 survey have been corrected. The uncorrected deficiencies are:

1) That Kaiser does not ensure that effective action is taken to improve care where access issues are identified; and
2) That Kaiser providers relayed inaccurate and misleading information to enrollees regarding the scope of behavioral health services available.

The Department also found that although Kaiser has taken substantial steps to identify and monitor issues related to timely access to behavioral health services, significant concerns remain. Kaiser's actions have not yet been sufficient to ensure enrollees have consistent timely access to behavioral health services. The Department's goal is for Kaiser to correct the deficiencies and ensure that its enrollees have consistent and timely access to behavioral health services. The two uncorrected deficiencies have been referred to the Department's Office of Enforcement for further investigation. The next routine survey of Kaiser, which will include both medical and behavioral health services, is scheduled to begin in early 2016.

The issues uncovered in the Department's survey of Kaiser's behavioral health services are distinct from the issues addressed in federal Mental Health Parity compliance. The

focus of federal Mental Health Parity is on cost sharing and other financial metrics and whether they are applied similarly to medical services and mental health services within the same general service categories (for example, inpatient or outpatient). The focus of the Kaiser survey was on whether enrollees were able to get timely access to medically necessary mental health services within the regulatory timeframes. Although both of these regulatory activities look at mental health services, the specific areas of focus are very distinct.

The remainder of my testimony today will be focused on the Department's compliance efforts with respect to mental health parity and access to care through adequate networks. I will begin by discussing what the department is doing in the area of parity.

Mental Health Parity

The Knox-Keene Health Care Service Plan Act of 1975 is the body of California law that governs the operations of health care service plans. The Knox-Keene Act gives the Department jurisdiction to license and regulate health care service plans. In 1999, the Act was amended to include a mental health parity provision, requiring all plans that offer medical and surgical benefits to also cover diagnosis and treatment of serious mental disorders in children and severe mental illnesses in patients of all ages. This law requires that plans cover treatment for these mental illnesses on the same terms and conditions as they do for coverage of medical and surgical treatment. Additionally, SB 946 in 2011 enacted specific coverage requirements for behavioral health treatments for persons with pervasive developmental disorder or autism.

In addition to these state laws, the federal Affordable Care Act greatly expanded the scope of required coverage in California for individual and small group plans, by establishing the essential health benefits, or EHB, standard. In California, EHBs include all benefits provided for in the benchmark plan, which the Legislature has set as the Kaiser Small Group HMO 30 plan. The designation of this plan as the benchmark in California has made mental health and substance use disorder coverage much more robust, because now plans must cover the diagnosis and treatment of ***all*** mental disorders listed in the DSM 4 as well as for chemical dependency, which previously was

not required under the Knox-Keene Act. The Department's EHB regulation itemizes many types of inpatient and outpatient treatment for both mental health and substance use disorders that previously was not included in state law.

The Department works to ensure that health plans comply with these requirements through our licensing, plan survey, and complaint resolution processes, which I will discuss in greater detail later in my testimony. Since 2008, the Department has been working hard toward ensuring compliance with *federal* mental health parity laws after the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, known as "MHPAEA," was enacted. MHPAEA requires health care service plans that offer coverage for mental health or substance use disorders to provide the same level of benefits as they do for general medical treatment. The federal parity law is distinguished from state law because it does not mandate coverage for specific mental health conditions, but instead requires that the *way* mental health benefits are offered be on par with the way medical and surgical benefits are offered. Because of the many inherent differences between mental health treatment methodologies and treatment for physical conditions, comparing the two types of benefits based on this standard is a difficult and complicated process.

In the several years following the enactment of MHPAEA, the Department reviewed plans' Evidence of Coverage documentation to determine if plans were treating coverage for mental health services differently from medical and surgical coverage with respect to cost-sharing and treatment limits. However, a complete compliance review was not possible until the federal government issued final guidance on the methodology that states must use in order to compare mental health coverage to medical and surgical coverage. This guidance came in November 2013 when the Departments of the Treasury, Labor, and Health and Human Services issued their final MHPAEA compliance rules. Following the release of these rules, the Department developed a two-phase compliance plan: the first phase being comprehensive reviews of the plans' benefit designs and methodologies for providing mental health services and the second phase being on-site surveys of how plans put these benefit designs into practice.

Twenty-six plans with commercial products submitted compliance documents in September 2014 and the Department has been reviewing these and working with plans to correct identified deficiencies since that time. Primarily, the review looks at three key parity indicators for compliance:

- Financial requirements—essentially cost-sharing charged for mental health and substance use disorder services,
- Quantitative treatment limits—such as limits on the number of days or visits inpatient or outpatient services, and
- Non-quantitative treatment limits—such as authorization rules, drug formulary design, and provider qualifications.

In July of this year the Department informed plans that they must come into full compliance with MHPAEA by January 1, 2016. All 26 plans have been evaluated for compliance in the three key parity indicators. The review has already resulted in plans having to make a variety of adjustments. These include:

- Decreases in cost-sharing for mental health and substance use disorder services,
- Revisions in policies and procedures related to prior authorization and definitions of what is medically necessary,
- Elimination of impermissible limits on services, and
- Revisions to coverage documents to more accurately describe the mental health and substance use disorder treatments available to enrollees.

Of the now 25 plans under the Department's MHPAEA review process (one plan has withdrawn from the market since the process began), 10 plans have completed review at this time and their filings are closed. As indicated to plans in a July 17, 2015 All Plan Letter, plans must have MHPAEA compliant cost-sharing as of January 1, 2016. Although the Department has not completed its MHPAEA review for 15 plans, these 15 plans have completed the portion of the MHPAEA review that addresses cost-sharing for mental health and substance use disorder services and therefore should be able to disclose any changes in cost share for these services in 2016. Plans that are

not fully compliant by the end of the year will be referred to the Department's Office of Enforcement for further investigation and potential enforcement action.

The second phase of our compliance review is targeted, on-site surveys of all 25 plans, scheduled to begin in April 2016. These surveys will be conducted by the Department's Division of Plan Surveys, along with Licensing staff and other key members of the phase one compliance review. After surveying the first five health plans, the Department will refine the methodology and make necessary revisions to the survey tools. Our goal is to complete all 25 surveys by the end of the first quarter of 2017. Findings for each of the surveys will be available approximately 180 days after the on-site portion of each plan's survey, and we expect that some survey results will be available on the Department's public website by the end of next year.

Ensuring compliance with MHPAEA has been extensive and extremely labor intensive for both the plans and the Department. California is setting a national standard with our review process and the Department has been asked by the CMS for our insights and expertise as CMS moves forward with its own MHPAEA review.

I'd like to now to describe the work the Department does to ensure that plans have adequate networks of providers to provide these covered mental health benefits.

Plan/Provider Network Arrangements

All full-service and behavioral health plans are required to have contracts with mental health treatment providers. Some full-service plans enter into a plan-to-plan contract with a standalone behavioral health plan to arrange for mental health services. This allows enrollees in the full service plan to access the behavioral health plan's provider network. For example, some of the larger plan-to-plan arrangements are:

- Blue Shield of California (full-service) and Human Affairs International (behavioral health)
- United Health Care (full-service) and U.S. Behavioral Health Plan (behavioral health)

It is not uncommon for plan-to-plan arrangements to exist amongst plans with corporate relationships, such as, United Health Care and U.S. Behavioral Health Plan.

In other cases, health plans may “lease” a mental health network from a provider group. In this scenario, the health plan is still responsible for arranging care for the enrollee, but it utilizes the provider group’s network and delegates some of its health plan functions to the group (e.g. claims payment, credentialing, etc.). For example, enrollees in the Health Plan of San Joaquin and San Francisco Health Plan contract with Beacon for mental health providers. In the case of such a delegation, the health plan still maintains ultimate responsibility and risk for providing care to enrollees and must oversee the delivery of all health plan services provided by the delegate.

Some health plans directly contract with mental health providers. For example, Blue Cross contracts with mental health providers in the same way it contracts for physical health providers, generally through direct contracts with individual providers and provider groups. Kaiser engages in a similar arrangement, relying on its two exclusively-contracted medical groups, The Permanente Medical Group and Southern California Permanente Medical Group, to deliver health care services to Kaiser enrollees. These medical groups directly contract with mental health providers, who are the exclusive providers for Kaiser enrollees. Where the demand for services exceeds the supply of providers available through the directly-contracted network, the Permanente Medical Groups have entered into agreements with Value Options to utilize mental health providers through Value Options’ professional services organization. Also, Kaiser recently submitted a filing to the Department notifying the Department that The Permanente Medical Group, has entered into a formal arrangement with Magellan Healthcare, Inc., also a provider group, to provide supplemental outpatient behavioral health services during a potential behavioral health work stoppage. This proposed arrangement is currently under review by the Department.

Process of Network Adequacy Review

The Department requires that plans demonstrate they have an adequate network of mental health providers. An adequate network provides “reasonable” access to mental

health providers and contains the “appropriate” array of provider types to ensure adequate and timely provision of all medically necessary services.

When assessing whether the Plan’s network is adequate, the Department first looks to determine whether the network contains the following specific provider ***types***:

- psychiatrists,
- psychologists,
- licensed marriage and family therapists,
- licensed clinical social workers,
- licensed professional clinical counselors, and
- qualified autism services providers, professionals and paraprofessionals.

When determining whether the plan has a sufficient ***number*** of providers, the Department considers the following:

- First, we look at the types and numbers of mental health providers actually practicing and contracting with health plans in the service area. (The Department can access this information through our timely access database, the NPI database, and other public sources.);
- Next, we examine the geographic accessibility of providers in the plan’s network compared to the actual geographic availability of all practicing mental health providers in the region who contract with health plans. For example, we might compare the plan’s geographic access report against geographic access reports run for all providers in our timely access database, the NPI database, and other public sources. This exercise helps us understand whether a plan is failing to contract with providers in a certain geographic area or whether no providers exist in the area;
- Third, we consider typical enrollee utilization of different mental health provider types. For example, enrollees typically visit psychiatrists less frequently than masters- or Ph.D.-level non-physician practitioners because psychiatrists are often more involved in medication management, whereas the non-physician practitioners often deliver regular psychotherapy; and

- Finally, we assess the services that are within the scope of licensure for each of these provider types relative to the likely treatment needs of enrollees. Generally speaking, the Department looks for a network to have, at a minimum, an adequate number of psychiatrists, psychologists, masters-level therapists, and qualified autism services providers to meet the needs of its enrollees.

Timely Access to Care

The other way we assess whether a plan has an adequate network is to look at the plan's annual Timely Access Report. Plans must submit these annual reports by March 31st. The report is an overview of the previous year and provides an overall assessment of the plan's ability to meet the appointment wait time standards contained in the Department's timely access regulation (Cal. Code Regs, tit. 28 1300.67.2.2). These standards are:

- 10 days for a Primary Care provider,
- 15 days for a Specialty Care Physician,
- 10 days for a Non- Physician Mental Health Provider, and
- 15 days for non-urgent Ancillary care for the diagnosis and treatment of an illness

For urgent care, the regulation provides a 48 hour standard, or 96 hours when pre-authorization is required.

Since the passage of SB 964 in 2014, the Department now has the authority to require plans to conduct provider surveys using the Department's Standardized Methodology. Plans were required to use this standardized methodology to conduct surveys in 2015 and will report the results of those surveys to the Department as part of the plans' annual reporting in March 2016. The Department's 2015 standardized methodology includes the specific requirement that plans report on appointment wait times for both psychiatrists and child psychiatrists.

The Department's timely access regulation includes additional requirements that apply to a plan's provision of covered services, including both medical and surgical benefits and mental health services. These requirements include:

- Arranging for 24/7 telephone triage or screening services, with waiting time not to exceed 30 minutes;
- Ensuring that the wait time to speak to a customer service representative during normal business hours is not more than 10 minutes;
- Coordinating with interpreter services in a manner that ensures provision of interpreter services at the time of the appointment;
- Monitoring network compliance with the timely access appointment wait time standards and investigating and correcting deficiencies; and
- Ensuring that the plan has sufficient contracted providers and requiring that if a service area has a shortage of providers the plan will arrange for enrollees to access contracted providers in neighboring service areas.

The Department's licensing and survey staff monitor compliance with the timely access requirements by reviewing these reports and taking action as appropriate, including possible enforcement action for plans. In addition to a review of annual reports, the Department reviews the plans' Timely Access policies and procedures, evaluates their operations through routine surveys, and evaluates consumer reports received in the Help Center related to timely access. The Timely Access review is one part of a larger network adequacy review for mental health plans.

Conclusion:

I want to thank you all for the opportunity to share the hard work the Department is doing to ensure that health plans are providing the mental health services required by both federal and state law. I also want to again thank the Ragan family for sharing their story today.

I have brought along two of the Department's senior attorneys from the Office of Plan Licensing, Elizabeth Spring, who has led the mental health parity compliance activities, and Kacey Kamrin, our lead attorney in provider networks. They can assist me in answering any questions you have.

Additional Talking Points:

Narrow networks:

The term “narrow network” is commonly used to describe a provider network that does not include all of the plan’s contracted providers and includes only a portion or subset of the plan’s full contracted network. The DHMC does not differentiate between “narrow” or “non-narrow” networks as to adequacy of services provided. As such, all networks are judged on the same network adequacy standards, regardless of whether the plan’s network is considered narrow or non-narrow.

Future improvements for network adequacy reviews:

The Department plans to cross-reference timely access compliance data with annual provider network data as it conducts its network adequacy analysis pursuant to SB 964. The Department intends to utilize timely access compliance data to assist in identifying any network compliance concerns resulting from that analysis.

Department staffing for mental health parity implementation as a result of the 2014-15 and 2015-16 Budgets:

The Department has filled all five positions that were designated for mental health parity implementation in the 2014-15 budget year. These positions include two attorney positions in the Office of Plan Licensing and three positions (two attorneys and one analyst) in the Help Center’s Division of Plan Surveys. For the 2015-16 budget year, the Department was granted 11 positions for its Help Center and an additional 2 positions in its Office of Enforcement for 2016/2017. The Department is in the process of filling these positions.

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