

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
 DF-46 (REV 08/15)

Fiscal Year 2016-17	Business Unit 4150	Department Department of Managed Health Care	Priority No. 2
Budget Request Name 4150-002-BCP-BR-2016-GB		Program 3870-Health Plan Program	Subprogram

Budget Request Description
 Federal Mental Health Parity Ongoing Compliance Review

Budget Request Summary

The Department of Managed Health Care (DMHC) requests \$529,000 for FYs 2016-17 and 2017-18 for clinical consulting services to design new compliance filing instructions and forms, conduct review of plans' classification of benefits and nonquantitative treatment limits (NQTLs), and for resolving clinical issues arising in compliance filings associated with performing ongoing oversight of compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its Final Rules.

Requires Legislation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Code Section(s) to be Added/Amended/Repealed	
Does this BCP contain information technology (IT) components? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Department CIO	Date

For IT requests, specify the date a Special Project Report (SPR) or Feasibility Study Report (FSR) was approved by the Department of Technology, or previously by the Department of Finance.

FSR SPR Project No. Date:

If proposal affects another department, does other department concur with proposal? Yes No

Prepared By Jennifer Clark, CFO	Date January 4, 2016	Reviewed By <i>[Signature]</i>	Date 1-4-2016
Department Director <i>[Signature]</i>	Date 1/4/2016	Agency Secretary <i>[Signature]</i>	Date 1-6-16

Department of Finance Use Only

Additional Review: Capital Outlay ITCU FSCU OSAE CALSTARS Dept. of Technology

BCP Type: Policy Workload Budget per Government Code 13308.05

PPBA *[Signature]* Date submitted to the Legislature

JAN 07 2016

A. Budget Request Summary

The DMHC requests \$529,000 for FYs 2016-17 and 2017-18 for clinical consulting services to assist the DMHC in revising current compliance filing instructions and forms, conducting review of commercial plans' classification of benefits and NQTLs, and resolving clinical issues arising in compliance filings with MHPAEA and its Final Rules.

This request is for the resources required to perform initial compliance reviews on new plan offerings and conduct ongoing clinical monitoring of MHPAEA compliance for all new commercial products offered by newly licensed plans and current licensees. The DMHC is committed to implementing sustained oversight activities to ensure compliance with the MHPAEA Final Rules and any subsequent Center for Medicare and Medicaid Services (CMS) rulemaking or guidance. Future oversight activities are needed to ensure MHPAEA compliance in all new products. New licensees will have to demonstrate their coverage complies with the financial, quantitative treatment limits (QTLs) and NQTLs, and disclosure requirements of MHPAEA; the Knox Keene Act; and regulations of the Covered California health benefits exchange. Current licensees proposing to add new products also will have to demonstrate that their new coverage complies with MHPAEA. Compliance review also must be conducted for plans that change the terms of their previously-approved MHPAEA compliance – their cost-sharing or treatment limits – due to a significant change in benefit design, cost-sharing structure, or enrollee utilization of the coverage.

B. Background/History

In 2008, Congress enacted the MHPAEA, requiring only large group health plans that offer mental health and substance use disorder (MH/SUD) benefits to do so in a manner comparable to medical and surgical (M/S) benefits. After the enactment of the Affordable Care Act (ACA) in 2010, federal regulations and a state statute implementing essential health benefits (EHB) made MHPAEA also applicable to individual and small group health insurance products. On November 13, 2013, federal regulators issued Final Rules for implementing parity, which laid out how health plans must conduct parity analyses to comply with MHPAEA. The Final Rules apply for all group products as employers renew or purchase coverage, as well as individual products.

Assessing compliance with the Final Rules requires an analysis that is significantly different and more complex than the analysis the DMHC currently conducts to enforce state mental health parity requirements. Under the California mental health parity law, the DMHC reviewed health plans' evidences of coverage (EOCs) for compliance with state law and the ACA, with a general focus on whether analogous benefits for specific severe mental illnesses and serious emotional disturbances in children are subject to the same cost-sharing and utilization management requirements as medical conditions.

In contrast, under MHPAEA the Final Rules reject a static approach of comparing specific MH/SUD benefits to M/S benefits, and instead require analysis of broader benefit classifications. Rather than a relatively simple comparison of the applicable terms and conditions, the Final Rules require extensive review of the health plans' processes and justifications for classifying benefits within the following six permissible classifications and two subclassifications:

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network
 - a. Outpatient Office Visits
 - b. Outpatient Other Items and Services
4. Outpatient, Out-of-Network
 - a. Outpatient Office Visits

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- b. Outpatient Other Items and Services
- 5. Emergency Care
- 6. Prescription Drugs

After classifying all benefits into these categories, health plans must then determine parity for financial requirements (e.g., deductibles, copays, coinsurance), QTLs (e.g., number of visits, number of days of treatment), and NQTLs. The analyses of the health plans' methodology for determining compliance require extensive reviews that are beyond the DMHC's existing capacity and expertise. Moreover, the analyses required under the Final Rules are data-intensive and require information that health plans do not routinely file with the DMHC (e.g., methodologies to determine benefit classifications, projected plan claims, and rationale for application of NQTLs).

The evaluation of MHPAEA compliance in a plan product filing includes the following steps:

1. Prior to submission, the DMHC shall instruct the plan on how it must meet the necessary elements of federal compliance in the plan's description of its standards for classifying benefits and its methodology for calculating the predominant financial requirements that apply to substantially all the medical/surgical benefits in each classification;
2. Provide guidance on the data that plans must submit pursuant to the Final Rules detailing the benefits the plans cover, the cost-sharing charged for those benefits, the QTL and NQTL placed on the benefits, together with relevant supporting documentation such as utilization management criteria;
3. Analyze the way the plan classified its benefits for compliance with the Final Rules and clinical soundness;
4. Evaluate the soundness of the plan's financial calculations and QTLs based on estimated claims and whether its MH/SUD cost-sharing and day/visit limits, respectively, are in parity with those for M/S benefits;
5. Examine supporting utilization management, credentialing, and authorization policies and procedures to determine parity in NCTLs;
6. Analyze evidences of coverage to ensure they accurately disclose compliant MH/SUD cost-sharing, QTLs, and NQTLs, and clearly identify the MH/SUD treatments that are covered under the plan contract;
7. Issue comments on deficiencies in any of the aforementioned parity elements to the plans;
8. Teleconference with plans to answer questions and resolve legal issues;
9. Coordinate clinical, actuarial, legal, and administrative review of each filing; and
10. Document a plan's eventual compliance in reports and in briefing memos.

Compliance reviews consist of two components: 1) front-end reviews - the review of documentation submitted by plans to ensure compliance with MHPAEA, and 2) back-end reviews - onsite reviews to verify plans are operating in accordance with compliance filings.

In a FY 2014-15 May Revise MHPAEA BCP, the DMHC received approval for a one-time augmentation of \$369,000 to contract with clinical consultants to conduct initial front-end compliance reviews of the 26 health plans subject to MHPAEA. The reviews include analyses of benefits classifications and NQTLs (limits such as the definition of medical necessity or medical management standards that affect access to, scope, and duration of benefits) to determine if health plans are meeting parity requirements under MHPAEA. The results will establish a baseline of information the DMHC will utilize in future compliance and enforcement activities.

The 2014 Budget Act authorized 5.0 permanent positions and \$2.1 million dollars to help support sustained compliance oversight of the 26 health plans subject to MHPAEA in the individual, small

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group, and large group markets. One of these positions was designated to lead the DMHC's department-wide efforts, one position was allocated for Office of Plan Licensing (OPL) to conduct initial front-end compliance reviews, and three positions were allocated to the Division of Plan Surveys (DPS). The DPS positions perform onsite medical surveys, or back-end reviews, to verify plans are operating consistently with their approved compliance filings once the initial compliance review is complete. The 2015 Budget Act authorized additional resources to further support onsite medical surveys of the plans affected by the MHPAEA. As a result, sufficient resources exist to support the back-end component of MHPAEA compliance reviews; however, based on the results of the 2014-15 MHPAEA compliance project described below, existing resources will not be sufficient to perform the work attributed to the initial front-end reviews and associated actuarial duties.

The DMHC initiated monitoring of plan compliance with MHPAEA in the 2014-15 MHPAEA compliance project, which is anticipated to be completed during FY 2015-16. This project has been a focused review of one to fifteen standard individual and small group Exchange products and large group products to determine initial compliance within 26 plans' commercial coverage. One Attorney IV (the designated department-wide MHPAEA coordinator), one Attorney III, one Associate Governmental Program Analyst, and one Associate Life Actuary have been devoting time to this effort since 2014.

Based on the results of this project to date, the DMHC anticipates a significant increase in workload associated with the ongoing monitoring and review of 28 complex filings and 125 routine filings of commercial products to ensure compliance with MHPAEA.

Resource History (Dollars in thousands)

Program Budget	FY 10-11	FY 11-12	FY 12-13	FY 13-14	FY 14-15
Authorized Expenditures	Workload began in PY				8,145,759
Actual Expenditures					7,925,483
Revenues					-
Authorized Positions					50.5
Filled Positions					44.5
Vacancies					6.0

Workload History

Workload Measure	FY 10-11	FY 11-12	FY 12-13	FY 13-14	FY 14-15	FY 15-16 (Projected)
Clinical, legal, and actuarial review for compliance with mental health parity in 26 initial project filings.	Workload began in PY				26	26

C. State Level Considerations

Implementation and enforcement of MHPAEA and its Final Rules requires the DMHC to undertake an initial front-end analysis, a back-end onsite analysis, and a continuing evaluation of compliance in new products, due to the complexities of the Final Rules and the inter-relationship with existing California mental health parity laws and EHB requirements.

This proposal continues California's efforts to implement the ACA across all affected commercial market segments – individual, small group, and large group – and continues the DMHC's commitment to ensuring parity in the coverage of services to treat mental health and substance use disorders.

D. Justification

Upon completion of the 2014-15 MHPAEA compliance project, ongoing compliance monitoring is anticipated to begin with the clinical consultant and DMHC staff drafting instructions, filing forms, and preparing FAQs for use in the ongoing monitoring of compliance.

Complex Reviews

All commercial products from new licensees will require MHPAEA compliance review. In 2013-14, the DMHC received one commercial full-service application; in 2014-15 two commercial full-service applications were received; and to date in 2015-16 there are two commercial full-service applications currently under review for licensure. Given this trend, the DMHC estimates two new applications that require review will be filed on an annual basis beginning in 2016-17.

The DMHC estimates three applications that require review will be filed by current licensees proposing a PPO or multi-tiered benefit system. Health Maintenance Organization (HMO) coverage is a single-tier product, with one set of cost-sharing for M/S and MH/SUD benefits. In contrast, a Point of Services or Preferred Provider Organization (PPO) product has multiple tiers of cost-sharing for each benefit, as well as more-restrictive to less-restrictive nonquantitative treatment limits (such as prior authorization rules), starting with the HMO-tier of in-network coverage, to the preferred provider-tier of in-network coverage and out-of-network provider tier of coverage. Review of multi-tiered products takes almost twice as long as the review required for MHPAEA compliance in a single-tier HMO product.

The DMHC estimates 23 applications that require review will be filed by current licensees entering a new market with a new product. In 2013-14 the DMHC received 214 new commercial product filings and in 2014-15 the DMHC received 487 new commercial product filings. The OPL estimates that the majority of new filings in both fiscal years were for the initial offering of on- and off-Exchange standard and alternative benefit plan design products in the individual and small group markets; these same products will continue to be offered in the future. However, a portion of new commercial coverage each year includes new large group products with unique pricing and a set of benefits negotiated between the plan and a certain employer group. Also, plans that are currently only in the group market may decide to expand into individual plan coverage, or vice versa. Since these changes are considered new products with a different number and type of subscriber than the products reviewed for that plan in the 2014-15 MHPAEA compliance project, the DMHC will need to review these new product/new market filings for compliance with the MHPAEA.

Routine Reviews

In addition to the 28 annual filings, any of the 26 plans that change the compliance methods or factors approved for products in the 2014-15 MHPAEA compliance project will need to submit the changes for DMHC review. The 2014-15 initial MHPAEA compliance review determined whether a plan's methodology for classifying benefits is reasonable, whether the plan's approach to calculating the financial requirements is actuarially sound and based on a plausible estimate of claims for each product, and whether the MH/SUD cost-sharing and QTLs for each product are no more restrictive than the predominant cost-sharing or QTL that applies to substantially all of the M/S benefits in each benefits classification or subclassification. The initial compliance evaluation also determined whether the plan imposes NQTLs with respect to MH/SUD benefits applying benefit-neutral factors no more stringently than how the plan applies those same factors when determining NQTLs for M/S benefits. Changes to those methodologies or factors could significantly alter the cost-sharing and QTLs imposed on MH/SUD benefits and would require DMHC re-evaluation for compliance with MHPAEA.

The DMHC anticipates that on an annual basis it will receive approximately 125 routine filings for changes that will require review, although these filings will require less review time than the complex filings previously described. These filings will also include those noted in the Final Rules' preamble as requiring a re-review of MHPAEA compliance: products with a significant change in benefit design, cost-sharing structure, or enrollee utilization of the coverage.

Anticipated Workload

OPL and the clinical consultant will work together to complete the benefits classification and clinical review of the 28 most complex filings and the 125 standard filings. These reviews can be very time consuming as a typical filing requires approximately 10 to 16 review and comment cycles between the plan and DMHC before the plan's coverage is deemed in compliance and the filing is closed. Based on

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actual OPL staff work conducted on the MHPAEA compliance project, the typical filing requires on average 60 hours of legal review, 76 hours of benefits classification and clinical review (performed by clinical consultants in conjunction with OPL), and 35 hours of filing and review coordination by an analyst. An additional 10 hours of actuarial review is also required for each filing.

The DMHC does not have the necessary clinical resources to absorb this new ongoing workload. If this proposal is not approved, the DMHC will not be able to perform MHPAEA compliance reviews of new plans and products. This has the potential to cause significant harm to enrollees, such as unfair denials of authorization to receive costly intensive MH/SUD outpatient or partial hospitalization treatment, being charged cost-sharing that is much higher and not in parity with the copays charged for M/S benefits, not knowing the many types of outpatient MH/SUD treatments that are promised under the ACA because plan subscriber contracts fail to disclose these treatments as covered benefits, or being discharged prematurely from inpatient psychiatric or chemical dependency care due to a plans illegal day limits.

Clinical Consulting Services

Clinical consultants provide the specialized medical, mental health, and substance use disorder knowledge that is not available through the civil service system but is necessary for reviewing critical aspects of MHPAEA compliance, including the classification of benefits and NQTLs. The classification of benefits is a threshold issue that must be determined in a plan filing before the actuary can evaluate compliance in the financial requirements and QTLs, and before the attorneys can evaluate compliance in EOCs and other enrollee disclosures. This evaluation takes a considerable amount of time. It requires analysis of the plan's logic for classifying benefits and whether the benefits listed comply with state and federal law for individual, small group, or large group contracts; and letters must be drafted detailing compliance deficiencies identified in the analysis and directing plans to add missing benefits to data tables and re-categorize benefits erroneously classified. The analysis of plans' NQTLs, and the dozens of supporting policies and procedures for those NQTLs, also involves a lengthy review to determine if the plan is applying factors to limit access to MH/SUD benefits more stringently than how the plan applies those same factors to M/S benefits. The clinical consultants also assist reviewing attorneys with understanding clinical issues in EOC text that describes MH/SUD benefits, or exclusions to those benefits.

Generally the clinical consultant team consists of one lead that is a non-clinician reviewer who drafts comment letters to plans, based on the clinical review conducted by three-four clinicians. The lead reviewer also coordinates the consultant team's workflow with that of the attorneys and actuary and participates in the teleconferences with the plans to resolve compliance matters. The clinical consultant team will work primarily on review of the 28 complex and 125 routine filings.

E. Outcomes and Accountability

This proposal supports the DMHC's role in regulating health plans and their products that are subject to MHPAEA and the need for the DMHC to evaluate information regarding each plan's underlying methodologies for determining MHPAEA compliance. These compliance measures will ensure that plans' application of those methodologies results in cost-sharing, treatment limits, and disclosures for the MH/SUD benefits covered under the product's subscriber contract that fulfill the requirements of MHPAEA.

This proposal will provide the DMHC with additional resources to ensure that newly licensed plans' products comply with MHPAEA, as well as the products of current licensees who enter new markets, or who offer a complex product with multi-tiered benefits or a carve-out of MH/SUD benefits, or whose underlying methodologies change due to significant changes in plan benefit design, cost-sharing structure, or enrollee utilization of current plan coverage.

Existing legal, actuarial, and administrative staff resources will be redirected, as available, to perform the initial compliance reviews on new plan offerings and conduct ongoing monitoring of MHPAEA compliance in conjunction with the clinical consultant contractor.

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Based on data from the compliance project, the number of filings displayed in the following table is anticipated workload:

Workload Measure	Projected Outcomes					
	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Clinical, legal, and actuarial review for 28 complex mental health parity filings.	0	28	28	28	28	28
Clinical, legal, and actuarial review for 125 routine mental health parity filings.	0	125	125	125	125	125

F. Analysis of All Feasible Alternatives

Alternative 1: Approve the DMHC's request for \$529,000 for FYs 2016-17 and 2017-18 for clinical consulting services to assist the Department in conducting complex filings for compliance with the MHPAEA.

Pros:

- DMHC will have the necessary resources to ensure plans' compliance with MHPAEA.

Cons:

- Increases State expenditures.

Alternative 2: Approve the request at a lower level.

Pros:

- Provides limited resources to ensure plans' compliance with MHPAEA.

Cons:

- Would cause delays in the compliance review process.

Alternative 3: Deny the request.

Pros:

- Does not increase the size of State expenditures.

Cons:

- DMHC would not have the information necessary to determine health plan compliance with MHPAEA outside of the products that were reviewed during the 2014-15 MHPAEA compliance project. Thus the DMHC would lack the evidence to resolve enrollee complaints involving MHPAEA or take enforcement action against plans for MHPAEA violations.

G. Implementation Plan

The clinical consulting services requested are effective July 1, 2016. The DMHC will begin solicitations in late 2015-16 to ensure the contract is awarded by the effective date.

The federal government is still in the process of finalizing regulations governing the applicability of MHPAEA to Medicaid coverage. When these regulations are finalized, states will have 18 months from that date to implement compliance with MHPAEA in Medicaid coverage. Therefore, this request does not encompass ongoing oversight of MHPAEA compliance in California's Medicaid coverage (Medi-Cal), but focuses instead on compliance in commercial coverage, for which federal regulations were finalized on November 13, 2013.

H. Supplemental Information

This request will be funded through annual assessments of the health plans that are regulated by the DMHC. The fiscal impact of this request to full service health plans is approximately \$0.01 per enrollee.

I. Recommendation

Alternative 1: Approve the DMHC's request for \$529,000 for FYs 2016-17 and 2017-18 for clinical consulting services to assist the Department in conducting complex filings for compliance with the MHPAEA.

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BCP Fiscal Detail Sheet

BCP Title: Federal Mental Health Parity Ongoing Compliance Review

DP Name: 4150-002-BCP-DP-2016-GB

Budget Request Summary

	FY16					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	0	529	529	0	0	0
Total Operating Expenses and Equipment	\$0	\$529	\$529	\$0	\$0	\$0
Total Budget Request	\$0	\$529	\$529	\$0	\$0	\$0

Fund Summary

Fund Source - State Operations						
0933 - Managed Care Fund	0	529	529	0	0	0
Total State Operations Expenditures	\$0	\$529	\$529	\$0	\$0	\$0
Total All Funds	\$0	\$529	\$529	\$0	\$0	\$0

Program Summary

Program Funding						
3870 - Health Plan Program	0	529	529	0	0	0
Total All Programs	\$0	\$529	\$529	\$0	\$0	\$0