

California Department of Managed Health Care

December 10, 2015

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www.HealthHelp.ca.gov
1-888-466-2219

DMHC Mission

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



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What is the DMHC?

- Established in 2000 through consumer-sponsored legislation
- Funded by assessments on health plans
- Regulates 121 plans, including 71 full service health plans and 50 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
- Authority from Knox Keene Health Care Service Plan Act of 1975

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We protect the health care rights of more than



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Health Coverage that is **NOT** Regulated by the DMHC

- California Department of Insurance (CDI) products
- Most Medicare coverage
- Some Medi-Cal coverage (FFS and COHS)
- ERISA self-insured plans
- Private health benefit exchanges

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DMHC Key Functions

- Review Plan Documents for Compliance with State laws
- Ensure Financial Stability
- Review Proposed Premium Increases
- Medical Surveys
- Enforcement Action Against Plans that Violate the Law
- Consumer Help Center

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Ensuring Parity in Health Coverage for Mental Health and Substance Use Disorders

A December 10, 2015, presentation for
the Alzheimer's Disease and Related Disorders Advisory Committee

Elizabeth Spring, Attorney IV, Office of Plan Licensing, DMHC

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Today's Discussion

- **DMHC's oversight of mental health parity**
 - Currently in commercial coverage, not Medi-Cal, Medicare
 - Health care coverage sold by HMOs and PPOs to individuals, small groups, and large groups
 - Parity in coverage that treats medical/surgical conditions with coverage that treats mental health/substance use disorder (MH/SUD) conditions
- **Ensuring compliance with applicable law:**
 - Federal: MHPAEA, Affordable Care Act (EHB)
 - California State: Knox-Keene Act

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Federal Mental Health Parity

➤ The Paul Wellstone and Pete Dominici
Mental Health Parity and Addiction Equity
Act = MHPAEA

- Enacted in 2008, regulations finalized in 2013
- Applies to commercial plan coverage
- Does NOT mandate any coverage of MH/SUD!
- Requires MH/SUD benefits that are covered to be offered in parity with med/surgical benefits

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California Law

1. Requires coverage of severe mental illness of a person of any age (SMI) and serious emotional disturbances of a child (SED)
 - Disorders covered: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa
 - Treatment covered: Inpatient, emergency, outpatient, and partial hospitalization services
 - Since 2000, in coverage of individuals, small and large groups
 - In copays, deductibles, maximum lifetime benefits

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California Law

2. Requires coverage of behavioral health treatment for pervasive developmental disorder or autism:

- Treatment covered: applied behavioral analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual of any age with PDD or autism
- Since 2000, in coverage of individuals, small and large groups

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California Law and the ACA

3. Requires coverage of California's essential health benefits to treat mental disorders:

- Disorders covered: Any mental health condition identified as a “mental disorder” in the DSM 4th edition.
- Inpatient treatments covered: Psychiatric observation for an acute psychiatric crisis, psychiatric hospitalization, crisis residential programs
- Outpatient treatments covered: individual/group mental health evaluation and treatment, psychological testing, partial hospitalization, multidisciplinary treatment in intensive outpatient psychiatric program, monitoring of drug therapy
- Since January 1, 2014, in individual and small group coverage

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California Law and the ACA

4. Requires coverage of California EHB to treat substance use disorders:
- Disorders covered: alcoholism, chemical dependency
 - Inpatient treatments covered: detoxification, transitional residential recovery services in a nonmedical residential recovery setting
 - Outpatient treatments covered: Individual and group chemical dependency counseling, Medical treatment for withdrawal symptoms, Day treatment programs, Intensive outpatient programs
 - Since January 1, 2014, in individual and small group coverage

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California Law and the ACA

- “Coverage of mental health and substance abuse disorder services shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act”

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MHPAEA

- Three key elements in assessing parity:
 1. **Financial requirements (FRs):** what enrollee must pay in cost-sharing, e.g., deductibles, copays, coinsurance
 2. **Quantitative treatment limits (QTLs):** day or visit limits
 3. **Nonquantitative treatment limits (NQTLs):** e.g., definition of medical necessity, prior authorization policies, case management policies and procedures

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MHPAEA: Financial Requirements

“A plan . . . may not apply a financial requirement to mental health/substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement of that type applied to substantially all medical/surgical benefits in the same classification.”

45 CFR 146.136(c)(2)(i)

- “Substantially all” = applies to 2/3 or 67%
- “Predominant” = applies to more than 1/2

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MHPAEA: Financial Requirements

- Process for plan calculation of FRs:
 1. Classify all benefits into permissible 6-8 classifications:
 - Class A: Inpatient, In-Network
 - Class B: Inpatient, Out-of-Network
 - Class C: Outpatient, In-Network: Office Visits
 - Class D: Outpatient, In-Network: Other Outpatient Items, Services
 - Class E: Outpatient, OON: Office Visits
 - Class F: Outpatient, OON: Other Outpatient Items, Services
 - Class G: Emergency Services
 - Class H: Prescription Drugs

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MHPAEA: Financial Requirements

- Process for plan calculation of FRs:
 2. For each classification, estimate the dollar amount that the plan will pay for medical/surgical benefits for the plan year.
 3. For each classification, calculate whether estimated claims involving either copays or coinsurance apply to substantially all (2/3) of the medical/surgical benefits.
 - a) If “yes,” then proceed to #4 calculation of predominant level.
 - b) If “no,” then the financial requirement for mental health/substance use disorder benefits is “0” – no cost-sharing.
 4. If either copays or coinsurance apply to substantially all M/S benefits, then calculate the predominant (>50%) level of either copays or coinsurance that applies. That result is the most the Plan can charge for MH/SUD benefits.

MHPAEA: Quantitative Treatment Limits

- Process for plan calculation of QTLs:
 - Same steps 2 through 4 as for FRs, but this time plan is calculating how many day or visit limits can be placed on mental health/substance use disorder services

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MHPAEA: Nonquantitative Treatment Limits

A group health plan may not impose a non-quantitative treatment limitation on MH/SUD benefits in any classification unless any processes, strategies, evidentiary standards, or other factors used in applying that limitation *are comparable to and applied no more stringently* than the processes, etc. used in applying the limitation to medical/surgical benefits in the classification.

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MHPAEA: NQTLs

- Most common nonquantitative treatment limits used by plans:
 - Definition of medical necessity
 - Medical/case management standards
 - Prescription drug formulary design
 - Standards for provider credentialing, contracts, payment rates
 - Prior, concurrent, retro authorization review processes
 - Pharmacy step-therapy protocols (fail-first therapies)
 - Exclusions based on failure to complete treatment
 - Restrictions based on geographic location, facility type, provider specialty or other criteria limiting scope or duration of benefits

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DMHC 2014-16

MHPAEA Compliance Project

- Phase I, 2014-2015: Review of MHPAEA compliance in filings from 26 full-service commercial and IHSS plans
- Phase II, 2016-?: On-site surveys of MHPAEA compliance by the 26 plans

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Phase I: MHPAEA Compliance Filings

- Filings submitted September 18, 2014:
 - On a representative sample of 7 individual products, 5 small group products, and 3 large group or IHSS products
 - Reviewed by DMHC actuaries, attorneys, and contracted clinical consultants
- Reviewed each product's:
 - Classification of benefits
 - Methodology for determining FRs, QTLs
 - Calculations of FRs and QTLs
 - NQTLs and supporting policies, procedures
 - Enrollee disclosures: evidence of coverage, cost-sharing summaries

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Phase I: MHPAEA Compliance Filings

➤ Most frequent parity violations:

- Wrong level or type of cost-sharing for outpatient MH/SUD services. Most plans had to change the type of cost-sharing or decrease the amount of cost-sharing
- Some plans had illegal day limits on MH/SUD services.
- Definition of medical necessity different for FS, BH plan
- Prior authorization policies more restrictive on MH/SUD services than on medical/surgical services
- Disclosures of MH/SUD benefits and cost-sharing vague, ambiguous, with many benefits omitted

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Phase I: MHPAEA Compliance Filings

- DMHC issued All Plan Letter on July 17
- “As of January 1, 2016, plans shall:
 - Charge enrollees compliant MH/SUD cost-sharing
 - Remove any MH/SUD day or visit limits
 - Implement all parity revisions to NQTL P&Ps
 - Post on website, distribute compliant EOCs, SOBs, SBCs
 - Mail to enrollees a summary of all cost-sharing changes
 - Notify MH/SUD providers about cost-sharing, QTL, NQTL changes
 - Use DMHC-approved classification of benefits, methodology for calculating FRs, NQTLs when determining MHPAEA compliance in all other commercial products offered by the Plan”

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Phase II: Onsite Compliance Surveys

- DMHC will conduct on-site surveys of plans that participated in Phase I:
 - Surveys will begin in April 2016
 - Focus will be on compliance in non-quantitative treatment limits: how plans apply definition of medical necessity, prior and concurrent authorizations to MH/SUD benefits
 - Surveys will also ensure plans are charging correct cost-sharing, provided honest estimate of claims, are not distributing to enrollees inaccurate information about MH/SUD benefits

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DMHC Help Center

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DMHC Help Center

- DMHC's Help Center has helped more than 1.6 million Californians resolve complaints and issues with their health plans
- Services are fast, free and confidential
- If your health plan denies, delays or modifies your request for care you can apply for an Independent Medical Review (IMR)
- If an IMR is decided in your favor, the plan must provide the requested service
- Approximately 60% of IMR requests result in the consumer receiving the requested service

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Need Help?

- First try to work with your health plan
- Call the Help Center
 - Explain health care rights and how to use health benefits
 - Denials of care or treatment
 - Denials of prescription drugs or therapies
 - Delays in getting an appointment or a referral
 - Claims, billing and co-payment issues
 - Access to translation and interpretation services
 - Finding an in-network doctor, hospital or specialist
 - Complaints about a doctor or plan

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Your Health Care Rights

- Your primary care doctor's office should be easy for you to get to. You can usually ask for a doctor within 15 miles or 30 minutes of your home or work.
- You have the right to ask for a provider or have an interpreter who speaks your language when you receive health care services.
- If your health plan changes or you lose your doctor or hospital, you may be able to keep your doctor or hospital for a limited time (continuity of care).
- You have the right to have an appointment when you need one. There are limits on how long you have to wait for an appointment.

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Know Your Rights

http://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights.aspx#.VXcTi7Hn_cs

The screenshot shows the DMHC website interface. At the top left is the logo for the Department of Managed Health Care (DMHC) with the text 'CA .GOV DEPARTMENT OF Managed Health Care'. To the right of the logo is the 'DMHC Help Center' with the phone number '1-888-466-2219'. Further right are links for 'Translate: Select Language', 'Accessibility', and 'Contact Us'. Below the header is a navigation menu with items: 'Home', 'File a Complaint', 'Health Care in California', 'Data & Research', 'Laws & Regulations', 'Licensing & Reporting', and 'About the DMHC'. The main content area shows the breadcrumb 'Home > Health Care in California > Your Health Care Rights' and a 'SHARE' button. The main heading is 'Your Health Care Rights'. Below it is a paragraph: 'In California, health plan members have many rights, and we have some new rights under health care reform.' This is followed by a section titled '1. Your Health Care Rights' with a bulleted list of rights. On the right side, there is a green sidebar titled 'Health Care in California' with a list of links: 'Choose the Right Plan', 'Low or No-Income Options and The Uninsured', 'Types of Coverage', 'Types of Plans', 'I'm Insured, Now What?', 'Get the Best Care', 'Your Health Care Rights' (with sub-links: 'Continuity of Care', 'Language Assistance', 'You and Your Doctor', 'Referrals and Approvals'), 'Disability Access', and 'Timely Access to Care'.

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Translate: Select Language | Accessibility Contact Us

Search...

Home > Health Care in California > Your Health Care Rights

SHARE

Your Health Care Rights

In California, health plan members have many rights, and we have some new rights under health care reform.

1. Your Health Care Rights

- To have an appointment when you need one. There are limits on how long you have to wait for an appointment.
- To have an appointment with a specialist when you need one.
- To request continuity of care if your doctor or medical group leaves your plan.
- To receive treatment for certain mental health conditions.
- To get a second doctor's opinion.
- To know why your plan denies a service or treatment.
- You Have the Right to Understand Your Health Problems and Treatments
- To see a written diagnosis (description of your health problem).
- To give informed consent when you have a treatment.

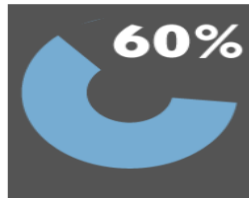
Health Care in California

- ▢ [Choose the Right Plan](#)
- ▢ [Low or No-Income Options and The Uninsured](#)
- ▢ [Types of Coverage](#)
- ▢ [Types of Plans](#)
- ▢ [I'm Insured, Now What?](#)
- ▢ [Get the Best Care](#)
- ▢ [Your Health Care Rights](#)
 - ▢ [Continuity of Care](#)
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IMR/Complaint Form

http://www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForm.aspx#.VZv23bHn_cs



Approximately 60% of enrollees that submit IMR requests to the DMHC receive the service or treatment they requested.

SHARE

To complete and submit an Online Independent Medical Review/Complaint Form:

To complete and submit an Independent Medical Review/Complaint Form online:

1. Select either link below:
 - [ENGLISH Online Independent Medical Review/Complaint Form](#) or
 - [SPANISH \(Español\) Online Independent Medical Review/Complaint Form](#) (other languages available in printed form below).
2. Complete all required fields.
3. Submit the form online.
4. You will receive an e-mail notice that your form has been received.

Online submissions are through a secure web portal.

To print a blank PDF Complaint or Independent Medical Review (IMR) Application form to mail or fax:

- Select the language you want.
- Complete and sign the form.
- Fax or mail the form and copies of any supporting documents to:

Help Center

File a Complaint

- [Submit an Independent Medical Review/Complaint](#)
- [Independent Medical Review and Complaint Reports](#)
- [Fraud Complaints](#)
- [Provider Complaint Against a Plan](#)
- [Frequently Asked Questions](#)

Need Help with Your Health Plan?

Call the DMHC Help Center

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or submit an [Independent Medical Review/Complaint Form](#)

Featured Links

- [Independent Medical Review/Complaint Form](#)
- [Prescription Drug Prior Authorization Request Form](#)
- [Review of Premium Rates](#)
- [California Public Records Act Request](#)
- [Financial Solvency Standards Board](#)
- [Right Care Initiative](#)
- [Career Opportunities](#)

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32

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Department of Managed Health Care Joins California Health and Human Services Open Data Portal

Tuesday, May 26, 2015

The Department of Managed Health Care (DMHC) posted initial datasets on the California Health and Human Services (CHHS) Open Data Portal. The initial data sets include enforcement actions taken by the DMHC, Independent Medical Review (IMR) decisions, and premium rates filed with the DMHC.

CHHS launched its Open Data Portal initiative in order to increase public access to one of the State's most valuable assets – non-confidential health and human services data. Its goals are to spark innovation, promote research and economic opportunities, engage public participation in government, increase transparency, and inform decision-making.

Visit the Open Data Portal here: <https://chhs.data.ca.gov/>

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Rate Review

**MOST DEPENDENT
ON MEDICAL COSTS**

Common Questions

- [What can I do if I am denied care?](#)
- [What can I do if my health coverage is ending?](#)
- [How can I get health insurance?](#)

[New State #Job Opportunity Announcement - Office Technician \(General\) http://bit.ly/1JQxtLV #Office #Technician](#)

Thu, 03 Sep 2015 21:59:00 +0100

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Questions

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