



CALIFORNIA DEPARTMENT OF
Mental Health

**MENTAL HEALTH PARITY-
BARRIERS AND RECOMMENDATIONS**

A Report to the Legislature

In Response to

Chapter 228, Statutes of 2004, SB 1103

Section 34-Budget Trailer Bill

March 1, 2005

SUMMARY OF SB 1103, CHAPTER 228, STATUTES OF 2004, SECTION 34,
2004 BUDGET TRAILER BILL
MENTAL HEALTH PARITY –BARRIERS AND RECOMMENDATIONS

The State Department of Mental Health, the Department of Managed Health Care, the Department of Insurance and applicable representatives from the California public and private mental health systems have collaboratively worked to produce this report. The report identifies core issues that explain why mental health parity in California is not being achieved, the barriers to achieving that parity, and what approaches over the short-term and long-term can be done to effectuate a more comprehensive mental health system.

There are a number of barriers at the operational level that keep California from achieving mental health parity. The largest barrier to full implementation is lack of access. Confusion remains about what parity actually means beyond the fiscal and structural requirements. Covered diagnoses are clear, but what array of services is covered for individuals with these diagnoses and for how long remains inconsistent from plan to plan. It remains unclear what services are the responsibility of health plans versus the responsibility of public agencies and organizations.

MENTAL HEALTH PARITY-BARRIERS AND RECOMMENDATIONS

A report to the legislature in Response to Chapter 228,
Statutes of 2004, SB 1103, Section 34-Budget Trailer Bill

Purpose of Report

This document is a report to the Legislature as required by Chapter 228, Statutes of 2004, SB 1103, Section 34-Budget Trailer Bill which contains the following language:

“The State Department of Mental Health, in collaboration with the Department of Managed Health Care, the Department of Insurance and applicable representatives from the California public and private mental health systems shall identify the core reasons that mental health parity in California is not being achieved, the barriers to achieving that parity, and what approaches over the short-term and long-term can be done to effectuate a more comprehensive mental health system in California, both public and private. The State Department of Mental Health shall submit a report of this information to the appropriate policy committees of the Legislature on or before March 1, 2005.”

Background

A. Mental Health Parity

Generally, mental health parity means that a health insurer must provide coverage for mental health care that is equal to that provided for physical health care. In the United States in the 1990's there has been a movement toward achieving parity for mental health care. This has resulted in federal legislation and state laws that provide for either “full parity” or “partial parity”.

Full parity requires equal benefit coverage for all mental health conditions and physical health conditions for all populations. *Partial parity* is limited in some way; limitations may be in the benefits structure, or in the definition of diagnoses that are covered and/or in the populations that are covered.

B. National Context

The National Mental Health Parity Act of 1996, established parity between mental health and medical health insurance coverage with respect to annual and lifetime dollar limits. These limited protections were set to sunset in 2004 and were extended through December 31, 2005 under tax legislation signed into law by President Bush. The current Act offers partial parity, with limited protections. Advocates have worked to pass The Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, a more comprehensive mandate that would guarantee parity in areas such as co-payments, deductibles, and visit limits, but to date their efforts have been unsuccessful

As of March 2003, 34 states had passed mental health parity laws, some of which preceded the national legislation and many of which are broader than the federal law. Fifteen state parity laws cover all mental health diagnoses. Eighteen states have restricted their parity laws to either Seriously Mentally Ill (SMI) or “biologically based” conditions, similar to California’s parity legislation. Currently, 13 states have extended parity to include treatment of substance abuse. Some states cover only certain populations, such as state employees.

C. California Context

California has been working on parity legislation since the late 1980’s. Several bills were drafted and some passed both the Senate and the Assembly, but were vetoed by the Governor at the time. In December 1998, Assemblywoman Thomson introduced AB 88 (ATTACHMENT A) which passed both houses of the legislature and was signed into law by Governor Gray Davis on September 27, 1999. AB 88 (Chapter 534, Statutes of 1999) became effective in July 2000, and requires private health insurance plans to provide equal coverage for physical health and the following selected mental health conditions which are considered “covered conditions”:

- Severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder (some times referred to as manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa
- Serious emotional disturbances (SED) of a child, other than a primary substance abuse disorder or developmental disorder, that results in behavior inappropriate to the child’s age, according to expected developmental norms¹

¹ To qualify for parity-level coverage, children must meet one or more of the following functional criteria: substantial functional impairments; risk of removal from the home; a mental disorder or impairment that has been present for more than six months; psychosis, risk of suicide or violence due to a mental disorder; or eligibility for special education. They also must be diagnosed with a mental health condition listed in Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

For covered conditions, the law requires health plans to eliminate the benefit limits and cost-sharing requirements that have traditionally made mental health benefits less comprehensive than physical health benefits. These include higher co-payments and deductibles, and limits on the number of outpatient visits or inpatient days covered. The law further specifies that every health care service plan that provides hospital, medical or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of those with covered conditions and that these benefits shall include:

- (1) Outpatient services.
- (2) Inpatient hospital services.
- (3) Partial hospital services.
- (4) Prescription drugs, if the health plan contract includes coverage for prescription drugs.

California was the 25th state to pass parity legislation. California's legislation is considered partial parity since it only covers certain diagnoses and conditions.

The expansion of mental health benefits under AB 88 ultimately is intended to improve access to, and the quality of, mental health services for people with SMI or SED. Other goals of the law include decreasing the financial burden on California's public sector which traditionally provides the majority of mental health services to these populations, ending discriminatory practices in the provision of mental health benefits, and reducing the stigma associated with mental illness and the delivery of mental health services (California Senate Rules Committee 2001).

D. Implementation

During the summer of 2001, the California HealthCare Foundation commissioned Mathematica Policy Research, Inc. (MPR) to conduct an early "snapshot" study of the implementation of California's mental health parity law. MPR interviewed over sixty individuals representing more than three dozen stakeholder groups including representatives from state and county governments, health plans, providers, employers and consumer advocates. Their report, issued in February of 2002, (ATTACHMENT B) concluded that health insurance benefits for mental health services had been expanded in compliance with the law's mandate but reported the following issues and challenges:

- Disruptions in continuity of care for some mental health clients, particularly when health plans carved out behavioral health services from their general health plans and transitioned to a behavioral health plan for management and delivery of mental health services.

- Administrative challenges and confusion for some stakeholders due to partial parity for a limited set of SMI and SED conditions rather than all mental health diagnoses.
- The need for clarification of the role of the private vs. the public sector in providing services to children with SED.
- The need for more consumer education to facilitate increased access to care².

In 2003, the Department of Managed Health Care (DMHC) promulgated mental health parity regulations (Health and Safety Code (H&S), Title 28 California Code of Regulations, (CCR), Section 1374.72) (ATTACHMENT C). When these regulations were posted for public comment various stakeholder groups identified issues in the areas of consumer knowledge about parity, access, continuity of care, grievance and complaint processes and monitoring of plans performance. The final regulations clarified some of the services, access, continuity of care and monitoring requirements for health care plans. At the time these regulations were being developed and public comment was being submitted, stakeholders were advised that there would be additional opportunities for input regarding some of these issues during the subsequent development of general access regulations. The first draft access regulations were issued July 9, 2004. Following public hearings and a public comment period, proposed modifications to the proposed text are under review by DMHC and are expected to be promulgated for an additional public comment period in March 2005.

In addition, DMHC is conducting an extensive survey regarding mental health parity. All major plans, and their behavioral health carve-out components where they exist, are going to be surveyed. A pilot survey period was started on March 7, 2005 and will be completed by May 31, 2005. The pilot survey currently in use was developed by DMHC and put into use reportedly without consultation on the content of the survey from other state agencies or stakeholder organizations. Therefore, we recommend DMHC convene additional opportunities to solicit comments from other state agencies and stakeholder groups involved with the public mental health system after the pilot survey is completed in order to receive input and consultation to consider in the development of a final survey.

E. Roles of State Departments Regarding Mental Health Parity

Although DMH is the agency required to submit this report, three state agencies are involved in the various aspects of mental health parity:

The Department of Managed Health Care (DMHC) was established under the Business, Transportation and Housing Agency to regulate California's health care service plans, including Health Maintenance Organizations (HMO) and preferred

² Mathematica Policy Research, Inc., "A Snapshot of the Implementation of California's Mental Health Parity Law" February 20, 2002, Cambridge, MA.

provider organizations (PPO) and thus has the responsibility for ensuring that these organizations comply with mental health parity³

- The California Department of Insurance (CDI) regulates indemnity and some PPO health insurance plans and thus has the responsibility for insuring that these types of health insurance plans comply with mental health parity.⁴
- The Department of Mental Health (DMH) has the responsibility for the State's Medi-Cal Specialty Mental Health Services Consolidation Program which administers the Medi-Cal Mental Health Managed Care Program including 56 Mental Health Plans (MHP). These plans are not included in the parity legislation; however, when mental health parity is not implemented appropriately, the burden of providing medically necessary mental health services often falls on the public sector.

Scope of Report

California's mental health parity legislation requires health insurers to provide "diagnosis and medically necessary treatment" to insured individuals with conditions as designated in the legislation. The report of the President's New Freedom Commission on Mental Health speaks to the need for a broad range of comprehensive medical, educational, vocational, social and consumer directed and provided services for adults with severe mental illness and children with serious emotional disorders and their families. California's mental health parity statutes do not require health plans to provide such a range of comprehensive services that individuals with these diagnoses need to achieve recovery. Although "medically necessary treatment", alone, has not been found to be the most successful approach to treatment of these conditions, it is what is required by the existing mental health partial parity law in California. The scope of this report is to identify what is and is not working with what is required under the current parity legislation, and to identify what short term and long term approaches should be considered to create a more comprehensive system in the public and private sectors of mental health.

Some of the information for this report was obtained from the Mathematica report cited earlier. In addition, in preparation for this report, DMH, in collaboration with DMHC and CDI, employed the expertise of a consultant currently under contract to DMH who obtained input from various stakeholders through individual interviews and a public meeting, including:

- Mental health clients and families
- Health plans
- California Coalition for Mental Health, representing 36 member organizations
- California Mental Health Directors Association (CMHDA)
- California Society for Clinical Social Work

California Health and Safety Code 1374.72

⁴ California Insurance Code 10144.5

- National Alliance for the Mentally Ill (NAMI)
- California Psychiatric Association (CPA)
- Other advocacy organizations
- DMHC
- CDI
- DMH

DMHC, in collaboration with DMH and CDI, held a public input session on mental health parity at the DMHC's January Clinical Advisory Panel meeting on January 5, 2005. (ATTACHMENT D). Written comments were also invited at that time and several were received.

Please note that the issues and challenges identified in this report do not necessarily apply to every health plan. Plans differ in how successful they have been in achieving timely access and referral, in the operation of their telephone access systems, and in their prior authorization policies. Problems with coordination are more often an issue for health plans that have carved out their behavioral health benefits to a Managed Behavioral Health Organization (MBHO). What is presented here is an aggregate picture of all issues.

Achieving Mental Health Parity: Challenges and Issues

This section of the report addresses areas identified as "core issues" and provides recommendations for solutions to move towards the full implementation of the parity law in California. Some of the solutions may be achievable in a short period of time; others will take longer.

A. Benefit Structure and Fiscal Parity

The majority of stakeholders consulted in the preparation of this report agree that the fiscal and benefit structure requirements of AB 88 are being met in California. Health plans have eliminated the differential coverages that previously existed in the areas of deductibles, service limitations, co-payments and maximum benefit limitations. As one advocate expressed it, "parity is working well on paper".

B. Covered Services

Medically Necessary Services

Issue: There continues to be a lack of clarity about the full scope of services covered under this legislation (AB 88).

Mental health parity requires healthcare service plans and health insurers to provide medically necessary health care services required under the Act including *but not*

limited to basic health care services within the meaning of Health and Safety (H&S) Code, CCR, Section 1345(b) and 1367(i), and Section 1300.67 of Title 28, CFR (ATTACHMENT E). Regulations issued by DMHC, which became effective on October 23, 2003, (Title 28, CCR, Section 1300.74.72), further specified that mental health parity provides for the coverage of crisis intervention and stabilization, psychiatric inpatient services, including voluntary inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists. These are listed as “minimum services”. However, there is no comprehensive description of the full range of services covered under parity.

Recommendation: To provide clarification and consistency, DMHC should consider adopting the description of services in the current statutes that govern the Medi-Cal Specialty Mental Health Services program.

This description of covered services is found in Title 9, CCR, Chapter 11, Subchapter 1, Article 2 (ATTACHMENT F). DMH has already undergone an extensive public process in developing the regulations and the State Medicaid Plan for the public mental health system, which included defining the covered services. Thus, a mental health service that is considered necessary in a public plan would also be considered necessary and be consistent with those provided in a private plan. This would have the added advantage of promoting continuity of care between plans and continuity of care for individuals who lose their private coverage and become eligible for Medi-Cal or vice-versa.

Specific Services, Treatments/Therapies

Issue: There is no clear definition of covered services. Health plans are left to decide individually which services to cover and utilize standards, which exclude potentially effective modes of mental health treatment.

Some health plans take the position that a particular type of service or treatment is not required if there is not sufficient rigorous evidence that the treatment is effective or evidence based. Unlike the physical health field, there are currently very few evidence-based services or types of treatments in the mental health field. The body of evidence-based mental health services is in its infancy, and many services and types of treatment that are considered to be best and promising practices do not have a strict evidence base.

For example, for individuals with the condition of autism, applied behavioral analysis (ABA) is a type of service that advocates argue is effective and should be covered, while health plans indicate they do not believe it should be a covered service. Proponents argue that ABA is a behavioral therapy that is necessary to remediate deficits caused by a neurological disease and that it can result in improvement in the quality of life for some individuals with autism. Health insurers and plans argue that there is insufficient evidence as to the effectiveness of ABA for individuals with autism

and that it is an educational rather than a medical treatment and they consequently deny service authorization.

Recommendation: In general, DMHC and CDI should require the health plans or insurers to undertake a review of their policies or the scope of coverage to assure they are not overly restrictive. In addition, DMHC and CDI should require the health plans or insurers to undertake an additional review and revision of their policies or the scope of coverage when their decision to deny is overturned through IMR.

Currently, both DMHC and CDI can refer patient disputes to the California Independent Medical Review (IMR) process when services are denied because they are not considered medically necessary or they are considered experimental or investigational. The results of IMR address only the specific patient's need within the particular coverage that is available. The outcomes of reviews do not require the health plans or insurers to undertake a review of their policies or the scope of coverage even if their decision is overturned through IMR. Because the field of evidence-based mental health services is an emerging one and standards are just beginning to be developed, additional flexibility is necessary to insure consistency of coverage across health plans.

Continuing Treatment

Issue: There is a lack of clarity about “how much” treatment an adult with severe mental illness or a child with a serious emotional disorder needs, and/or for how long and a lack of reasonable recourse to solve authorization disputes. This results in providers’ frustration with the authorization and reauthorization processes.

Providers report on-going difficulties in obtaining continued authorization for treatment of individuals with conditions covered by parity. One therapist reported that the patient's health plan required a “harassing” 20-30 minute telephone review every three weeks to maintain continued authorization for treatment. Others report having to “beg case managers” for several more weeks of treatment. This issue was perhaps best addressed by a mental health advocate who talked about the stigma and suspicion that surrounds mental illness. The advocate talked about the skepticism that still exists about serious mental illness as a medical condition, and how this impacts the way administrative agencies and health insurers look at coverage and on-going treatment. Stigma remains a significant barrier to achieving mental health parity.

Current IMR procedures do provide remedies for individuals whose continuing service has been totally denied. Individuals must file a grievance directly with the denying health plan. If the plan upholds its initial decision, or does not take action on the grievance, the individual can apply for a medical necessity IMR through DMHC or CDI. This process is complicated and time consuming. Not only can this be a difficult process for someone suffering general medical symptoms but also poses a particular challenge for some one suffering from the symptoms of a severe mental illness. This process also

does not provide a remedy when providers leave a plan or decrease or terminate needed treatment with their mental health clients because of the difficulty of getting continuing authorization.

Recommendation: DMHC should gather information about the nature and extent of the “amount of treatment” issue in their upcoming survey in order to make specific recommendations to address this area.

One of the objectives of the upcoming survey planned by DMHC should be to get a clearer understanding of this issue, which may lead to specific recommendations in this area. In the meantime, DMHC should encourage health plans to use existing mental health practice guidelines to develop treatment protocols that recognize the chronicity of severe mental illness and provide for adequate treatment and disease management strategies.

C. Access Issues

Most of the concerns expressed by those providing input for this report were in the area of access. Access issues fall into three main areas:

Telephone Access

Issue: Mental health clients and other stakeholders providing input for this report testified about the difficulty of obtaining telephone information about benefits and timely access to services

This issue was identified in the attached Mathematica Report in 2002. That report found that early education efforts by both health plans and the State were insufficient and mental health clients were not always aware of the expanded benefits as a result of AB 88 and how to access them. Although there has been some improvement in this area over time, there still appears to be confusion about procedures for learning about benefits, obtaining prior authorization and accessing mental health services, particularly in crisis and urgent situations. DMHC regulations require that membership cards from plans shall include the telephone number listed where a member can obtain information about benefits, coverage, etc. However they do not require this number to be answered after normal business hours or that it be answered by someone who is knowledgeable about their mental health benefits as well as the procedures necessary to obtain care in urgent situations and in emergencies. Mental health clients report that many plans use confusing, cumbersome and unworkable voicemail and telephone decision-tree options. Individuals with severe mental illness, who may be particularly anxious or upset, cannot negotiate these systems and often end up abandoning their efforts to get help. DMHC regulations require specialized health service plans to maintain a telephone number, but only during business hours.

Recommendation: The new access regulations should address telephone access standards and, at a minimum, should be consistent with existing DMH telephone access standards for Specialty Mental Health Services.

Although the National Council on Quality Assurance (NCQA) behavioral health standards, which call for plans to monitor to the standard of a non-recorded voice within thirty seconds and the ability to triage to a live clinician, set an ideal standard, at a minimum, the new access regulations being developed by DMHC should be consistent with existing DMH standards for Specialty Mental Health Services.

These DMH standards (Title 9, CCR, Section 1810.405) state that “Each MHP shall provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in the languages spoken by beneficiaries...that will provide information to beneficiaries about how to access specialty mental health services, including services needed to treat a beneficiary’s urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.” (ATTACHMENT G). It should be the responsibility of the health plan to ensure that their mental health providers or providers in their carve-out plan have accurate information about how to access care, the plan’s crisis and urgent care procedures and how to access emergency services and inform their client’s accordingly.

Issue: When individuals with private health insurance are redirected to the public mental health system when their routine provider is unavailable or are unable to obtain information about how and where to get care in a crisis situation, they often end up going to the county public mental health system. The public mental health system is then unable to obtain reimbursement for the care provided.

MHPs have reported that individuals are referred to county services when they are unable to obtain routine, urgent or emergency services from their health plan. Not only does this create capacity issues for the county system, but also counties providing urgent crisis services to HMO plan enrollees are often denied reimbursement because they did not obtain prior authorization. MHPs also indicate the process to pursue reimbursement is time consuming and complex and generally unsuccessful because MHPs lack the resources to take action. One MHP reported that they had provided over \$700,000 in crisis services to privately insured individuals in a single year and only received about \$13,000 in reimbursement from the insurance plans despite spending a lot of effort trying to be reimbursed for their costs.

Recommendation: DMHC should work with DMH and MHPs to establish a more reasonable recourse procedure at the State level when an MHP is unable to obtain reimbursement for routine or crisis care provided by the county system because the member was unable to obtain the necessary care from his/her plan.

MHPs and health plans have the option of negotiating collaborative agreements regarding access to crisis and urgent care if they desire to do so. Negotiating contracts is labor intensive and not always realistic or possible when mental health clients require

immediate crisis intervention. In the absence of contracting, health plans should be prohibited from intentionally redirecting routine care and relying on public services for non-reimbursed coverage. In the event the private system fails to meet the needs of mental health clients the burden falls directly on the public system, counties should have some recourse for reimbursement for these services

Timely Access to Providers and Services

Issue: Lack of access to qualified and appropriate providers is perhaps the largest barrier to making mental health parity successful.

This was the major barrier to achieving mental health parity identified by those providing input for this report. It is difficult to ascertain the full extent of this problem, as accessibility varies widely among health plans and by different geographic areas. Some plans reported that they believe they have sufficient providers and do a number of things to try to insure accessibility, such as periodic availability surveys, geographic mapping, etc. A number of examples, however, were reported about members' inability to find a provider. Some primary care providers report that their patients have to wait up to several months between the time of their referral to a licensed mental health practitioner and the time their patient actually starts receiving mental health services as reported in testimony from the California Coalition for Mental Health. Individuals providing input for this report testified that some plans simply don't have enough providers in their networks. There was also testimony that some plans don't have sufficient number of providers in certain locations, so members have to travel large distances to see someone. Others may have a sufficiently appropriate number of mental health providers listed as in their networks but in reality, many of these providers are not taking new patients. This issue is frequently referred to as the "phantom provider" issue. Plan members report having to contact as many as seven or eight providers before finding someone who is accepting new patients. An "Access to Psychiatric Care Survey for San Francisco" in April 2003 done by the San Francisco Medical Society found that only 45% of psychiatrists were accepting PPO patients and only 27% were accepting HMO patients. Even more complex is the issue of members being unable to find an appropriate provider who has expertise in treating their particular condition or who is skilled in their language and culture.

Recommendation: DMHC in partnership with DMH and CDI should conduct an in-depth independent study to more clearly determine the extent of the inadequacy of provider access and the specific reasons for this problem in California's health plans.

Since the lack of provider access is the most frequently mentioned barrier to achieving mental health parity, there is a need to more fully understand this issue. California has a human resource problem in the mental health field which affects both the private and the public mental health systems.⁵ In 1999 the Mental Health Planning Council

⁵ *The Mental Health Workforce: Who's Meeting California's Needs?* University of California, San Francisco, The Center for the Health Professions (2003). A copy of this report may be

conducted a vacancy rate study (ATTACHMENT H) which found that particularly in specialty areas, such as child psychiatrists and culturally competent mental health professionals, mental health organizations have difficulty maintaining adequate providers.⁶ While some of these issues are outside the scope of the health plan, some provider shortage problems are due to things that health plans do have some control over. The California Psychiatric Association and the Society for Clinical Social Work provided testimony about problems with complex and burdensome administrative procedures that discourage providers, policies and procedures which make it difficult to obtain continued treatment authorization, inadequate reimbursement rates, and limits on practice that providers find clinically unacceptable. DMHC Regulations (Title 28, CCR, Section 1300.74.72 (f) require that a plan's referral system shall provide "timely access and ready referral in a manner consistent with good professional practice". It is apparent from input provided by many of those providing testimony for this report that health plans are not in full compliance with these requirements. Proposed new access regulations may provide more specific definitions of "timely access", but are unlikely to solve the whole problem. When more information is available, specific issues should be addressed individually. In the meantime, upcoming access regulations should be consistent with DMH standards as written into DMH performance contracts with MHPs. These state that MHPs "shall make all medically necessary covered services available in accordance with Title 9, CCR, Sections 1810.345 and 1810.405 with respect to:

1. The availability of services to meet beneficiaries' emergency psychiatric conditions 24 hours a day, 7 days a week.
2. The availability of services to meet beneficiaries' urgent conditions as defined in Title 9, CCR, Section 1810.253, 24 hours a day, 7 days a week
3. Timeliness of routine services as determined by the Contractor to be sufficient to meet beneficiaries' needs."

Prior Authorization Procedures

Issue: Mental health clients and advocacy organizations report difficulty in obtaining information about prior authorization procedures.

Even when information is available, the prior authorization procedures required by many plans are reported to be complicated and burdensome.

Recommendation: Amended DMHC access regulations should clearly specify requirements regarding prior authorization.

- Involuntary services – An individual who is determined to require involuntary treatment under the California Lanterman Petris Short (LPS) Act may be transported

obtained from the following website: <http://www.futurehealth.ucsf.edu/CWI>.

⁶ The Human Resources Project vacancy rate study may be accessed at the following website: <http://www.dmh.ca.gov/mhpc/webvacancies>.

to a medical facility chosen by law enforcement. In such cases, health plans should be required to reimburse the receiving facility, public or private, and licensed mental health practitioners for services required to stabilize the plan member, whether or not the facility or provider has a contract with the plan. These services should be covered as emergency services under the enrollee's health plan.

- Emergency services – Prior authorization should not be required for emergency services. Providers, including non-network hospitals and/or crisis centers, public or private, who follow plan procedures for treatment and/or transfer, should be given retroactive payment authorization for services necessary to treat the emergency.
- Urgent mental health services – Regulations should be consistent with the Medi-Cal Specialty Mental Health Service standards for urgent care. As such they should state that each plan shall make mental health services to treat a member's urgent condition available 24 hours a day, seven days per week. If the plan requires that a provider obtain prior approval in order to receive payment for providing a mental health service necessary to treat a member's urgent condition, the plan shall have a statewide, toll-free telephone number available 24 hours a day, seven days per week, to act on the provider's payment authorization request for services necessary to treat the urgent condition. Under these circumstances the plan shall act on the payment authorization request within one hour of the request." (ATTACHMENT G)

D. Coordination and Continuity Issues

Coordination

Issue: Some primary care providers still report that they receive no information regarding what happens to patients they refer to licensed mental health practitioners unless they get it directly from their patients.

Based on the Mathematica Report, there was concern in the early stages of mental health parity implementation about the potential loss of coordination of care between primary care physicians and mental health specialists, especially in cases where plans carved out mental health services to an MBHO. The mental health parity regulations promulgated in 2003 addressed this concern. These regulations place the responsibility for coordination of physical and mental health care with the health plan itself. They require health plans contracting with a specialized health care service plan for providing mental health services to monitor the continuity and coordination of care that enrollees receive, and take action to assure this coordination. Further, plans are required to monitor, at least annually, the collaboration between medical and mental health providers including, but not limited to exchange of information, appropriate diagnosis, treatment and referral and access to treatment and follow-up.

Recommendation: DMHC should monitor for compliance with existing regulations in their upcoming mental health parity survey and in their routine and non-routine surveys.

Continuity of Care

Issue: Continuity issues, although improving, still arise when plans change or drop providers.

The ability to continue treatment with one's therapist/provider was another concern cited in the Mathematica report. This was a significant issue in the early implementation of mental health parity, as health plans developed their networks and providers made decisions about what health plans they would work with. It was also more of an issue for health plans that decided to move from an integrated physical and mental health delivery system to a system in which mental health services were carved out to an MBHO. The incidence of continuity problems appears to have decreased over time. Continuity issues still arise periodically when providers leave or are dropped from plan networks and when members change from one health plan to another. In these instances, plans are required to develop reasonable transition plans and monitor to make sure these are followed.

Recommendation: DMHC should monitor plans for consistency with existing clinical standards regarding continuity and completion of covered services.

E. Grievances and Appeals

Issue: Mental health clients need easy access to grievance and appeal processes.

If a person with a covered mental health condition does not know how to access mental health services or cannot find a provider, there is no process by which a denial of service can generate a grievance. Furthermore, many health plans' procedures are complex and difficult for individuals or families dealing with serious mental health conditions to negotiate. All health plans are required to have grievance and appeal procedures. In the physical health care field, these procedures have largely been focused on denials of provider service requests on behalf of a plan member. The same is true for the IMR at the state level. Policies, procedures and processes have been designed for individuals with physical illnesses and their physicians. Many of these procedures are not easily accessible or appropriate for individuals with severe mental illness.

Recommendation: DMHC should work with DMH to review the current grievance and appeal processes and policies and using the stakeholder process historically employed by DMH to solicit feedback from mental health clients and their families, DMHC should revise the existing processes creating procedures that are mental health consumer-friendly and accessible.

When the Medi-Cal Specialty Mental Health program was consolidated under the Department of Mental Health and local MHPs, DMH conducted a broad stakeholder

process, which included providers, mental health clients and family members of mental health clients. The process resulted in the development of a set of grievance and appeal regulations (Title 9, CCR, Section 1850.205) (ATTACHMENT I), which were easy to utilize by providers, mental health clients and the family members.

F. Public/Private Interface

Issue: There is confusion about public and private responsibilities for mental health services.

One of the stated purposes of AB 88 was to decrease the financial burden on California's public sector. In some instances, what has resulted is confusion about areas of responsibility which has not reduced the public financial burden, but has created frustration on the part of private health plans, public agencies and mental health clients as to which entity is responsible for providing what kind of care. For example, occupational and speech therapy are generally considered covered services under medical health plans. However, one of the individuals providing input to this report cited a recent example of a child with autism who was denied coverage for occupational and speech therapy, reportedly because the health plan said the child was ineligible because of the diagnosis of autism and also that the service was being provided by the school district. Historically, the majority of the burden of providing services for individuals with severe mental illness and youth with serious emotional disorders has been with the public agencies. Public mental health programs have been primary providers of services, but Regional Centers, schools and other agencies and organizations have also been charged with responsibilities for individuals with conditions, which should now be covered under California's mental health parity statutes.

Recommendation: Public agencies and private health plans need to collaboratively define their individual responsibilities for the provision of mental health services.

The key to resolving the confusion about public/private responsibilities is collaboration among the state departments involved. Because California's mental health parity law does not provide all of the services that individuals with covered conditions need, public agencies and private insurers need to work together at the local level to provide and coordinate care for this population. DMHC, DMH and CDI have an excellent opportunity to provide collaborative leadership in addressing issues related to mental health parity. DMHC should establish a mechanism for discussions with DMH and other relevant state agencies, with the goal of clarifying the various responsibilities of the health plans and the public sector and thereby model the type of public/private interface that also needs to occur at the local level.

Summary

Mental health parity has been in effect for approximately four and one-half years. During this time virtually all of the health plans to which parity applies have adopted fiscal and benefit structures that attempt to achieve mental health parity. There are a number of barriers at the operational level that keep California from achieving mental health parity as legislated under AB 88. As one stakeholder expressed in the public input session, "We do not have a crisis yet, but we do have a problem."

One of the major goals of mental health parity legislation was to reduce the stigma associated with mental illness and the delivery of mental health services. Although the structural aspects of parity have been implemented, stigma remains as a major barrier to achieving parity at the operational level. Many in the health insurance community are perceived as viewing the need for a range of mental health services and ongoing mental health treatment for individuals with serious mental illness and children with serious emotional disorders with some skepticism. Regulatory agencies and private health insurers have not reached out effectively to mental health clients to assist in the development of policies and procedures to insure that parity will be achieved for mental health clients and their families. The approach of including mental health clients and their families as primary stakeholders is one that DMH has found successful in the development of policies and practices for implementation of Medi-Cal Specialty Mental Health Services. DMHC, CDI and health plans would benefit from more involvement of DMH, mental health clients and the family members of mental health clients in the development of regulations, policies and practices to clarify issues of mental health parity.

The largest barrier to achieving parity is lack of access – most importantly to mental health services and providers in general, but also in easily and quickly obtaining crisis and urgent care, getting information about benefits, and having easily understandable policies and procedures for obtaining routine mental health services.

Confusion remains about what parity actually means beyond the fiscal and benefits structure requirements. Covered diagnoses are clear, but what array of services is covered for individuals with these diagnoses and for how long, remain inconsistent from health plan to health plan. Which services are the responsibility of health plans versus the responsibility of public agencies and organizations is also not clear. When individuals with private insurance end up receiving services from the public sector because they are unable to get covered services privately, there needs to be recourse for the public system to get reimbursement from the individual's health plan.

Covered services and access standards for private health insurers should be at least equal to those that taxpayers pay for under public health plans such as Medi-Cal. Where the extent of the barriers to mental health parity are not clear, additional surveys and studies need to be undertaken to more fully understand the issues and identify remedies. Existing health plan policies and state regulations governing requirements for plans providing physical healthcare services need to be reviewed for their appropriateness for the provision of mental health services. Where existing policies or regulations are not relevant, or where more specification or simplification is needed to

make services and processes accessible and available to individuals with severe mental illness and families in which a child has a serious emotional disorder, DMHC, CDI and health plans should develop policy revisions and amended regulations in collaboration with DMH and representatives of local MHPs, mental health clients and their families. The departments charged with overseeing and regulating health plans should then monitor compliance with these revised policies and regulations. Finally, the involved State departments and local health plans and public agencies must work together to clarify the public/private interface necessary to achieve the goals of mental health parity.

ATTACHMENT B

Contract No.: 01-1350
MPR Reference No.: 8816

MATHEMATICA
Policy Research, Inc.

**A Snapshot of the
Implementation of
California's Mental
Health Parity Law**

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**A Snapshot of the
Implementation of
California's Mental
Health Parity Law**

February 20, 2002

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EXECUTIVE SUMMARY

In 1999, California passed a mental health parity law—referred to as Assembly Bill 88 (AB88)—that requires private health insurance plans to provide equal coverage for physical health and selected mental health conditions, including serious mental illnesses (SMI) in adults and serious emotional disturbances (SED) in children. The law requires health plans to eliminate the benefit limits and reduce the cost-sharing requirements that have traditionally made mental health benefits less comprehensive than physical health benefits. These include higher copayments and deductibles and limits on the number of outpatient visits or inpatient days covered.¹

Ultimately, the expansion of mental health benefits under AB88 is intended to improve access to and quality of mental health services for people with SMI and SED. Other goals of the law are decreasing the financial burden on California's public sector in providing mental health services, ending discriminatory practices in the provision of mental health benefits, and reducing the stigma associated with mental illness and the delivery of mental health services (California Senate Rules Committee 2001).

In summer 2001, the California HealthCare Foundation commissioned Mathematica Policy Research, Inc. (MPR) to conduct an early “snapshot” study of the implementation of California's mental health parity law. The study's purpose was to assess the perceived objectives, initial experiences, and anticipated outcomes of the new law after its first year of implementation. Results from the study are intended to help identify the early successes, as well as the remaining challenges, in implementing the parity law. MPR interviewed more than 60 individuals representing more than three dozen stakeholder organizations at the state and local levels, including representatives from state and county governments, health plans, providers, employers, and consumer advocates.

¹Self-insured health plans are exempted from state mental health parity laws under the Employee Retirement Income Security Act (ERISA).

Stakeholders reported that most aspects of the implementation of AB88 during the first year have gone smoothly. They agreed that health insurance benefits for mental health services have been expanded in compliance with the law's mandate. In addition, the law does not appear to have had any adverse consequences on the health insurance market to date, such as large increases in premiums or decreases in health insurance offerings by employers.

Nevertheless, stakeholders identified several issues and remaining challenges related to the implementation of AB88 during the first year:

- The transition to managed behavioral health organizations (MBHOs) by some health plans in response to the law caused initial disruptions in care for some consumers. These disruptions appear to have been exacerbated by inadequate communication efforts and a short lead time for implementing these changes.
- The implementation of “partial parity” for a limited set of SMI and SED diagnoses, rather than all mental health diagnoses, has created administrative challenges and caused confusion for some stakeholders.
- The role of the private sector in delivering services to children with SED needs further clarification, especially given the traditional role of the public sector in providing children's services.
- Consumer education about expanded benefits needs to be improved in order to facilitate increased access to care under AB88.

In summary, an important goal of AB88 appears to have been achieved during the first year of implementation; but much work remains to be done to make the parity law a success in future years. In particular, mental health benefits have been expanded to conform with the parity mandate, but it will take time and additional effort to address such goals as reducing stigma and improving access to care for people with mental illness. The law has prompted discussions among stakeholders about such issues as the responsibility for additional education efforts, the availability of mental health providers in health plan networks, the delivery and management of mental health services in a managed care environment, and the delivery and coordination of mental health services for children by both the private and public sectors. Finally, there is a broad consensus that the full impact of parity may not be known for several years, until consumers become more aware of the expanded benefits.

CHAPTER I

INTRODUCTION

In 1999, California passed a mental health parity law—referred to as Assembly Bill 88 (AB88)—that requires private health insurance plans to provide equal coverage for physical health and the following selected mental health conditions:

Severe mental illnesses (SMI), including schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa

Serious emotional disturbances (SED) of a child, other than a primary substance abuse disorder or developmental disorder, that result in behavior inappropriate to the child's age, according to expected developmental norms¹

Governor Gray Davis signed the bill into law in September 1999, and it became effective in July 2000. The law requires health plans to eliminate the benefit limits and cost-sharing requirements that have traditionally made mental health benefits less comprehensive than

¹To qualify for parity-level coverage, children must meet one or more of the following functional criteria: substantial functional impairments; risk of removal from the home; a mental disorder or impairment that has been present for more than six months; psychosis, risk of suicide or violence due to a mental disorder; or eligibility for special education. They also must be diagnosed with a mental health condition listed in Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

physical health benefits. These include higher copayments and deductibles, and limits on the number of outpatient visits or inpatient days covered.²

The expansion of mental health benefits under AB88 ultimately is intended to improve access to, and the quality of, mental health services for people with SMI or SED. Other goals of the law include decreasing the financial burden on California's public sector in providing mental health services, ending discriminatory practices in the provision of mental health benefits, and reducing the stigma associated with mental illness and the delivery of mental health services (California Senate Rules Committee 2001).

Thirty-three other states currently have mental health parity laws. California's law is similar to those of 18 states that have restricted their parity laws to either SMI or "biologically based" conditions. The law is more narrowly defined than 15 other state parity laws that cover all mental health diagnoses. It also excludes coverage for substance abuse treatment. Currently, 13 states have extended parity to include treatment of substance abuse (Gitterman et al. 2000; and Rosenbach et al. 2001).

California is one of the few states with a mental health parity law that focuses specifically on children's conditions such as SED and autism. Only Vermont, Tennessee, Arkansas, and Maryland have specific provisions in their parity laws that mandate broader children's coverage than California; these states cover any diagnoses in the DSM-IV or ICD-10, regardless of the child's functioning. In April 2000, Massachusetts became the second state to enact a separate children's provision for the treatment of children with SED (Peck 2001).

Like most other states with parity laws, AB88 mandates that mental health services be covered as part of the overall health benefit package offered by health plans. That is, mental health benefits cannot be offered as an option to purchasers. Unlike some state parity laws, and the federal parity law, AB88 provides no exemption for benefits offered to either individuals or small groups, or on the basis of actual or expected cost increases (Gitterman et al. 2000; and GAO 2000).³ The law also includes specific provisions allowing health plans to pursue managed care or other cost-containment strategies—including the use of specialized mental health plans, or managed behavioral health organizations (MBHOs) and managed care arrangements, such as utilization review, case management, and networks of mental health providers.

AB88 was enacted concurrently with a number of consumer protection and managed care-related laws. The Department of Managed Health Care (DMHC) was created to provide regulatory oversight for these new laws. DMHC has responsibility for monitoring

²Self-insured health plans are exempted from state mental health parity laws under the Employee Retirement Income Security Act (ERISA).

³The federal parity law, which expired in September 2001, requires congressional legislation for renewal.

the implementation of AB88 and ensuring compliance with it for managed care plans.⁴ To date, DMHC's primary concerns have been to ensure that health plans fully disclose information about benefit changes to their enrollees, and that enrollees have appropriate access to care under AB88. The agency has also taken steps to clarify how health plans and employers may subcontract to managed behavioral health organizations, while continuing to ensure compliance with the law. The agency has not promulgated state regulations regarding AB88.

STUDY OVERVIEW

In summer 2001, the California HealthCare Foundation commissioned Mathematica Policy Research, Inc. (MPR) to conduct an early "snapshot" study of the implementation of California's mental health parity law. The study's purpose was to assess the perceived objectives, initial experiences, and anticipated outcomes of the new law after its first year of implementation. Results from the study are intended to help identify the early successes, as well as the remaining challenges, in implementing the parity law.

From September to November 2001, MPR interviewed more than 60 individuals representing more than three dozen stakeholder organizations at the state and local levels. These individuals represented the following stakeholder groups:

- *State and county government officials.* Representatives from the Department of Managed Health Care, the Department of Mental Health, county mental health departments, and the office of Assembly Member Helen Thomson, the bill's sponsor

Health plans. Medical directors and other staff from eight major health plans (including the seven largest plans in the state) as well as medical directors of the managed behavioral health organizations associated with some of these plans

Employers. At the state level, several employer purchasing groups, an insurance underwriter, and a statewide union; at the local level, both public and private employers representing large and small firms in the high technology, telecommunications, and education sectors

⁴DMHC also has responsibility for regulating Blue Cross and Blue Shield plans in California. The Department of Insurance regulates traditional indemnity health insurance plans, and is responsible for ensuring that these insurers comply with AB88.

- *Providers.* At the state level, state associations representing hospitals, psychiatrists, psychologists, social workers, and marriage and family therapists; at the local level, the behavioral health and administrative directors of two multi-specialty medical groups, two behavioral health independent practice associations (IPAs), and one hospital system, as well as two psychiatrists in private practice
- *Consumers.* Statewide and local consumer advocacy groups representing adults, families, and parents of children with SED or other conditions

Most interviews were completed in about an hour and were conducted as open-ended discussions guided by a structured interview protocol created specifically for each stakeholder group. The interviews addressed the following topics:

Perceived objectives of the parity law and anticipated effects on access to care for people with mental illness

Education and communication efforts related to implementation of AB88, and the level of awareness and understanding of its provisions by stakeholders

Changes in the organization and financing of mental health services, including the use of mental health “carve-out” organizations and efforts to manage utilization of mental health services

Implementation challenges or other implications related to: (1) the limited set of mental health diagnoses addressed by the law; (2) the inclusion of autism, developmental disorders, and all serious emotional disturbances for children; and (3) the exclusion of substance abuse services from the parity mandate

This report presents the findings of these stakeholder interviews. Chapter II describes the changes that have occurred during the first year of implementation. Chapter III discusses stakeholder perceptions of the first year of implementation. Chapter IV presents the study’s conclusions.

CHAPTER II

BASIC CHANGES DURING THE FIRST YEAR OF IMPLEMENTATION

This chapter describes the key changes that occurred in the California health care market during the first year of implementation of AB88, discussing both expectations about these changes and stakeholders' actual experiences during this period.

First, we discuss the changes in mental health benefits that occurred as a result of the law. Although health plans were expected to expand benefits in compliance with the law, the extent of these expansions varied, given the differences across health plans in the level of mental and physical health benefits prior to AB88.

Second, we identify the changes that health plans have made in their mental health delivery systems for managing and delivering services covered under the expanded benefits. A key question for the study was how health plans would decide to contain costs and manage financial risk under the expansion of mental health benefits, and what new services, if any, they would provide under AB88.

Finally, we describe how benefit and system changes were communicated to consumers during the first year. All stakeholders—health plans, providers, employers, consumer advocates, and the state—had the potential to be involved in notification efforts; but it was not certain what role each of these groups would play in consumer education during the first year.

EXPANSION OF MENTAL HEALTH BENEFITS

All the health plans that we interviewed expanded coverage of mental health services in order to be compliant with AB88, typically as purchaser contracts came up for renewal on or after July 1, 2000. However, the extent of benefit changes for consumers varied because of

preexisting differences in the level of physical and mental health benefits prior to the parity law. Our interviews identified two important areas of variation: (1) whether consumers were enrolled in an HMO or PPO product, and (2) whether coverage was provided through large or small employers.

Prior to the parity law, typical HMO benefit packages were limited to coverage of 20 to 50 outpatient or office-based mental health visits and 30 to 60 inpatient days per year. Under AB88, these limits were eliminated for the diagnoses specified in the law. With passage of AB88, both inpatient and outpatient mental health copayments were reduced to be equal to physical health copayments. Typical outpatient mental health copayments prior to the parity law often were \$25 or more per visit, with some higher than \$50. These have now typically been reduced to \$10 or \$20 per visit.

Prior to the parity law, PPOs tended to provide less comprehensive mental health benefits than HMOs, although this is difficult to generalize, since benefit packages offered by PPOs tend to be less standardized than HMOs. Two health plans in California account for the vast majority of enrollees covered under PPO products subject to the parity law. In one plan, PPO coverage of mental health services was virtually nonexistent prior to parity. Some large employers, however, purchased separate benefit riders from this plan, in order to expand mental health coverage for their employees. In the other plan, there was wide variation in the level of PPO coverage across purchaser contracts, ranging from extremely limited benefit packages—with very high out-of-pocket cost-sharing provisions for enrollees—to more comprehensive packages that were already near parity with physical health benefits. Thus, the extent of benefit expansions under AB88 for consumers covered by PPO products varied widely.

Coverage also varied for consumers depending on the size of their employer. Small employers typically offered a “barebones” mental health benefit, or no benefit at all, prior to implementation of AB88. In contrast, some of the larger employers in the state offered mental health benefits that were on par with or even more comprehensive than what AB88 requires. For example, one large employer with approximately 300,000 employees moved toward a parity model in the year prior to AB88’s passage by expanding visit limits (to 50 visits per year) and by setting copayments for all mental health services equal to those for physical health services.

As a result, consumers working in small companies, and many of those covered by PPOs, tended to experience the largest increases in mental health benefits under AB88. Nonetheless, many stakeholders report that it is challenging to characterize a typical change in benefits for consumers, because of the variation in preexisting mental health and physical health benefit levels.

CHANGES IN MENTAL HEALTH DELIVERY SYSTEMS

Prior to AB88, health plans used a variety of approaches for delivering mental health services. Some plans in California delivered mental health services through large medical

II. Basic Changes During the First Year of Implementation

groups and IPAs for their HMO products. Based on data from Interstudy (2000), we estimate that about half of all HMO enrollees in California received mental health services through these groups. Under these arrangements, health plans delegated financial risk and responsibility for health care services (including mental health) to these provider organizations. Other plans “carved out” mental health services to MBHOs that specialize in delivery of these services.¹ A few plans used both an MBHO and medical groups for delivering mental health services.

Following passage of AB88, four of the eight health plans we interviewed made no major changes to their mental health delivery systems—continuing to use an MBHO, at-risk medical groups or IPAs, or a mix of both approaches. Together, these four plans represent a little less than half of HMO enrollment in California, but account for only a small percentage (7 percent) of PPO coverage:

Two plans continued to contract with at-risk medical groups for their HMO products, either delegating responsibility for mental health services to these groups or providing services from within an integrated delivery system.

- One plan maintained its practice of delivering services through an MBHO or a delegated medical group, depending on the geographic location of its enrollees.

One plan continued to rely exclusively on a subsidiary MBHO for providing mental health services.

The other four plans we interviewed (including two with substantial PPO enrollment) have shifted to, or increased their use of, MBHOs for delivering mental health services following implementation of AB88.

One plan carved out mental health services from at-risk medical groups to a subsidiary MBHO for its HMO product, but has allowed selected medical groups to become members of the MBHO’s provider network.

One plan using both at-risk medical groups and an MBHO has given all additional service responsibility (and financial risk) for expanded benefits under AB88 to the MBHO, including services exceeding the outpatient visit

¹MBHOs specialize in the delivery of mental health services through a network of contracted providers. Consumers typically access services by calling a toll-free telephone number and obtaining a list of network providers available in the local geographic area. Under these arrangements, primary care physicians and other providers who make an initial diagnosis of a mental health problem are also required to refer patients to the MBHO. Once a consumer begins seeking treatment from an MBHO provider, care is monitored by the MBHO.

or inpatient day limits that existed prior to the law. This plan continues to use at-risk medical groups to provide short-term “crisis” benefits.

Two plans completely changed their mental health provider networks, shifting from at-risk medical groups to the exclusive use of MBHOs for mental health service delivery.

Health plans that made few changes in their approach tended to have relatively comprehensive mental health benefits prior to passage of AB88. Among these plans, few changes were also reported in the overall size and composition of existing provider networks (that is, the number or types of providers) or in the approaches to managing care.

In contrast, plans that shifted to an MBHO tended to have somewhat less comprehensive benefits prior to the parity law. One of these plans, in particular, had very limited mental health benefits prior to parity. Plans cited the ability of MBHOs to manage expanded mental health benefits and contain costs as their main rationale for making changes in their provider networks. They also cited the ease of contracting with a single entity, rather than multiple organizations, in responding to the parity law.

Some providers expressed concerns about the increased use of MBHOs by health plans—including the potential loss of coordination of care between primary care physicians and mental health specialists. Under carve-out arrangements, a primary care physician and the selected mental health provider in the MBHO may be less likely to have an established relationship with or pattern of communication for referred patients.² Depending on how stringently MBHOs manage mental health care, some are also concerned that these arrangements may reduce access to care. MBHOs typically allow for greater management of mental health services through the use of medical necessity criteria, utilization management, and prior authorization of treatment. Regardless of whether plans changed their overall delivery systems, many have also taken incremental steps during the first year to fill some of the gaps in provider networks and to ensure adequate access to AB88 services. Some plans have asked mental health providers within medical groups in underserved areas to apply for recertification since the July 1, 2000 implementation date. Others have contracted with mental health providers to provide crisis intervention services in areas where they have gaps in their network. One provider reported that health plans have negotiated single-case agreements in which a patient needing treatment will be sent to an out-of-network specialist who will be paid a higher fee for that case only.

NOTIFICATION ABOUT BENEFIT AND SYSTEM CHANGES

Consumers received notification about benefit changes under AB88 through several sources. Health plans usually sent a letter to employers or enrollees announcing changes in

²Other respondents noted, however, that there is little evidence documenting the quality of referral relationships in non-MBHO settings.

mental health benefits. Some employers also communicated the change in benefits to their employees, usually through brochures describing the basic list of benefits each plan offered during the open enrollment period. A major mental health consumer advocacy group in the state notified its members of the passage of AB88 and benefit changes related to the law. Stakeholders generally characterized media coverage regarding AB88 as uneven. The bill was covered extensively when it was being debated in the legislature, but there was little media coverage of the law following its passage.

Consumer education efforts on the part of the state have centered around more general patient advocacy efforts undertaken during the first year of implementation. The DMHC published a brochure through its Office of the Patient Advocate describing consumers' basic rights as HMO members, what the mental health parity law was, and what organizations to contact if consumers encountered problems with coverage or access. The brochures are distributed in response to consumers' specific questions or complaints about AB88. DMHC also collaborated with a large consumer advocacy group to provide a series of briefings for legislative district office staff responsible for addressing consumer concerns in their districts.

During the first year of implementation, mental health providers emerged as the primary educators of mental health consumers about the provisions of AB88, largely because providers usually are the first to be asked about changes in benefits. For example, in the department of psychiatry of one large multi-specialty group, patient questions have become so routine that department staff created a one-page handout for patients, informing them of the basic expansion in benefits, as well as their options for accessing mental health services following passage of AB88.

Providers expressed concern about the limited availability of staff resources for continuing education of consumers about changes related to AB88. As a result, providers often directed their patients to other resources—health plans, advocacy groups, or the state—that are designed to respond to individual consumer questions and complaints. Health plans indicate that they routinely answer questions from consumers regarding the change in benefits and how to access services. Consumer advocates note that some consumers have difficulty navigating the dispute-resolution process, and engage advocacy groups or caretakers to help them. Consumers were also advised by providers to call DMHC's toll-free hotline, known as the HMO Help Center, if there was a problem with their coverage or they were unable to gain access to care.

CHAPTER III

EARLY PERCEPTIONS OF THE IMPLEMENTATION OF MENTAL HEALTH PARITY IN CALIFORNIA

The transition to mental health parity was perceived as fairly smooth for most stakeholders. In fact, a basic expansion of mental health benefits was the most notable change for many of those we interviewed. The transition was especially uneventful for providers, purchasers, and consumers who were affiliated with health plans that made few changes to their delivery systems or that already offered fairly comprehensive mental health benefits. However, some stakeholders reported that they experienced complications due to delivery system or benefit design changes that were made during the first year.

This chapter presents the key findings from our interviews with stakeholders regarding their perceptions of the implementation of California's mental health parity law. First, we discuss some initial communication issues related to system changes regarding the delivery of mental health services. Second, we describe the key implementation challenges related to design aspects of AB88, including the law's coverage of a limited list of diagnoses, the exclusion of parity for substance abuse coverage, and its particular focus on children's conditions. Finally, we discuss stakeholder perceptions of initial effects of the law on delivery of mental health services and on the broader health insurance market.

COMPLICATIONS DURING THE INITIAL TRANSITION

Stakeholders identified two areas in which complications arose during the initial transition to parity-level coverage. These included confusion about how employers' direct contracts with MBHOs should be handled under AB88 and disruptions in care for some consumers as the result of increased use of MBHOs by health plans. Complications arising during the first year of implementation appear to be caused by, or at least exacerbated by, the lack of lead time in preparing for system changes and inadequate communication about

these changes. Some respondents in our interviews noted that there was less than a year in which to pursue options for changes in their delivery system, given that the law was signed in September 1999. However, one respondent noted that California state laws are usually implemented at the beginning of the next year (January), so that the mental health parity legislation provided six additional months of lead-time. Many also believe that some stakeholders could have been more proactive in their responses to the law, and more comprehensive in their communication efforts.

Confusion About Employer Contracts with Health Plans

Prior to the parity law, many large employers provided mental health benefits through a separate, carve-out arrangement with an MBHO, and offered physical health services through one or more full-service health plans. However, employer representatives report that one provision of AB88 caused initial confusion and ultimately forced some large employers to abandon their carve-out arrangements. In particular, full-service health plans were deemed ultimately responsible for ensuring mental health parity coverage under AB88, including coverage provided by separate carve-out companies that contracted directly with employers (DMHC 2000).

In response, full-service health plans have added “wraparound coverage” to ensure that enrollees’ mental health benefits (including those provided through the preexisting carve-out arrangement) were equal to the health plans’ physical health benefits under AB88. These plans have charged an additional premium to employers for the wraparound coverage, which is intended to ensure that enrollees have parity-level coverage in the cases where coverage offered in the carve-out arrangement is not equal to physical health benefits offered by the plans. However, employers believe that plans have overestimated the additional premium required to cover these services. Rather than pay twice to cover mental health benefits for employees in these full-service health plans, large employers typically dropped their preexisting coverage with the MBHO and bought the HMO mental health coverage for their employees. These large employers believe that an unintended consequence of the law is that they can no longer offer a uniform benefit to all of their employees, despite having provided a benefit that was sometimes richer than what was required under AB88.

Employers also expressed concern about inadequate notification about these issues from both health plans and the state. For example, one large employer reported that it was not informed of any potential contractual issues by health plans until June 2000—one month before the law became effective. The delayed notification left little time for employers to negotiate new contracts with health plans to cover AB88 diagnoses. In addition, DMHC did not issue an advisory addressing the coordination of mental health benefits for large employer groups until September 2000—after many of these contracts, which were to begin in January, had been negotiated.¹ Moreover, employers do not believe that the advisory fully

¹The advisory was issued two months after DMHC was created in July 2000.

resolved the underlying contract issues that they face, since health plans still require employers to purchase wraparound coverage.

Disruptions in Care For Consumers

Provider representatives and consumer advocates expressed concerns about disruptions in care for enrollees in the health plans that carved out mental health services to MBHOs for the first time under AB88. Some consumers had difficulty obtaining new sources of mental health care during this transition, and thus sought the assistance of their current providers. Plan representatives noted that many providers had declined the opportunity to participate in new MBHO networks, on either a transitional or permanent basis, because they felt that MBHO fees were too low. Thus, patients were given the choice of seeking care on a self-pay basis with their existing provider or changing to a new provider in the MBHO network. Providers in medical groups not participating in MBHO provider networks often needed to act as intermediaries for patients, helping them obtain appointments during the first six to eight months of implementation within new MBHO networks, even though patients were allowed to self-refer through use of a toll-free number.

Our interviews provide some evidence of the magnitude of consumer difficulties in accessing care during the transition to new systems of care under AB88. Several medical groups documented a surge in telephone calls during the first six months of implementation of AB88 from consumers who did not know how to access their care or obtain a referral through their health plans' new MBHO. One medical group documented a 250 percent increase in telephone volume to its psychiatry department—accompanied by a 9 percent decrease in the number of patient visits to the medical group—during the first six months after AB88 was implemented, compared to the previous six months. Providers also reported that patients often experienced waits of up to two hours when trying to schedule an appointment because MBHO toll-free telephone lines were inundated with calls. In response, one large medical group provided scheduling assistance for patients needing urgent or crisis care during the transition period to help them obtain care through the MBHOs.

Providers' role as the primary educators of consumers was complicated by the lack of timely communication from health plans about these system changes. They commented that written notifications from health plans were either cursory or confusing. In addition, providers noted that several health plans did not release their new provider panel lists until several weeks before the July 1 date. This further hindered the ability of providers to obtain referrals for their patients during the law's implementation.

One health plan in particular was widely criticized by providers for delays in communicating changes due to their late decision to carve out mental health services. A large medical group contracting with this health plan reported that they did not receive any notification until May 2000, regarding changes to be implemented by July 1, 2000. An administrator of a behavioral health group reported that, as late as September 2000—three months into implementation—neither the health plan nor the MBHO could give her clear operational guidance regarding AB88.

Ongoing contract renewals also complicated communication between health plans and providers as employers renewed their contracts with plans during the renegotiation process. Whereas renewals under the parity law occurred once for employers, it was an ongoing process for providers as patients' coverage changed at different times during the year. Providers had difficulty keeping track of individual changes in coverage and had to contact health plans in many cases to determine whether the patient was covered under AB88, and, if so, which providers the patient could see within the plan network.

ONGOING CHALLENGES RELATED TO THE DESIGN OF AB88

Most stakeholders believe that AB88's coverage of a limited set of SMI and SED diagnoses was appropriate in its focus on the most severe illnesses for adults and children, and in its concern for limiting cost increases. However, the focus on specific mental health diagnoses has also introduced some special challenges for the stakeholders we interviewed. These include the complexity associated with a partial list of mental health diagnoses covered under AB88, the effects of excluding parity-level coverage for substance abuse, and the challenges related to coverage of children's mental health conditions.

“Partial Parity” Adds Complexity to Delivery Systems

All of the health plan representatives we interviewed noted that AB88's focus on selected SMI and SED diagnoses (sometimes referred to as “partial parity”) has introduced new administrative challenges, including modifying claims adjudication systems to account for varying benefit structures for different diagnoses, developing policies for different copayment arrangements, notifying providers about these policies, and clarifying the definition of specific diagnoses in terms of DSM codes.

To avoid administrative difficulties and possible confusion on the part of consumers and providers, two plans decided to extend parity beyond the selected diagnoses in AB88. Other health plans have chosen to limit parity primarily to AB88 diagnoses to reduce their financial risk, but have made exceptions in certain areas. For example:

One plan reduced copayment levels for all mental health diagnoses to simplify its cost-sharing approach, while maintaining outpatient visit and inpatient day coverage limits for non-AB88 diagnoses.

One plan applied parity-level benefits (reduced cost-sharing and elimination of benefit limits) for all inpatient mental health diagnoses, since the vast majority of patients treated on an inpatient basis have AB88 diagnoses anyway. However, this plan still distinguishes between AB88 and non-AB88 diagnoses in changes made in the coverage of outpatient services.

One plan has decided to apply parity-level copayments for new patients making initial outpatient visits, until a more permanent diagnosis (either covered or not covered by AB88) is made.

Providers also reported several challenges related to implementation of “partial parity.” For example, provider representatives said that variation in plans’ approaches has caused confusion among providers. Varying copayment policies for AB88 and non-AB88 diagnoses have also led to billing difficulties during the initial visits, when a diagnosis had not yet been established. Provider information systems do not distinguish copayment amounts based on diagnosis, thus making the new benefits difficult to administer.

Effects of Excluding Substance Abuse Coverage

Many stakeholders believe that parity coverage for substance abuse services, in addition to mental health services, would be helpful in improving clinicians’ ability to treat problems experienced by patients with co-occurring or “dual” diagnoses, including both mental illness and substance abuse.² Because private health plan coverage for substance abuse treatment typically emphasizes inpatient detoxification, with more limited coverage for rehabilitation and counseling, patients’ underlying chemical dependency disorders often receive relatively little treatment. Without coverage for these services, many providers believe that patients often fall into a cycle of detoxification and relapse, decreasing their chances for long-term recovery. In essence, the exclusion of substance abuse coverage leads to a “revolving door” where detoxification is covered under medical services, but subsequent rehabilitation is not, creating a break in treatment. Providers reported that this discontinuity of care can greatly complicate mental health providers’ ability to treat patients with “dual” diagnoses.

Some plan and employer representatives, however, expressed concerns about the impact that parity for substance abuse coverage would have on health care costs. They do not believe that the added costs associated with expanded substance abuse coverage would be offset by savings in other health care services, although there is no empirical evidence to support or dispute this argument. In September 2001, a California Senate bill mandating parity for substance abuse (SB 59) failed to gain passage in the legislature.

Uncertain Role for the Private Sector in Covering Children’s Services Under AB88

Most stakeholders identified mental health services for children as the most complex area in implementing California’s mental health parity law. Health plans and providers remain uncertain about what services they are required to provide under AB88—especially given the traditional role of the public sector in providing these services to children (see box on the next page).

²Approximately 15 percent of persons with severe mental illnesses are estimated to have a substance abuse problem (Kessler et al. 1996).

**PUBLIC PROVISION OF SERVICES FOR CHILDREN
WITH SED AND AUTISM IN CALIFORNIA**

During the 1970s and 1980s, federal and state laws were passed to allow children who were severely disabled or who had physical, learning, or communication disabilities, to obtain comprehensive special education instruction and services specific to their needs through the public school system. Since then, California has developed a complex infrastructure involving public schools, regional centers, and state and county mental health providers to serve the educational, medical, mental health, and social support service needs of these children.

Under the existing system, most children with SED are first identified through the school system. If an educational assessment indicates that a child needs special education, a school-based team works with the parents to develop an individualized education plan (IEP) that outlines what special education services will be provided, subject to approval and funding by the school district. This may include a range of health and social services, such as language and speech development, audio and vision services, physical and occupational therapy, psychological services, as well as vocational education and career development counseling. Service delivery is coordinated by a regional Special Education Local Plan Area (SELPA) that administers funds and ensures that each child receives the appropriate services. Each SELPA works closely with its local school districts to coordinate the services its students receive between the regular and special education programs.

Children with SED may also receive services through California's county mental health departments. The Department of Mental Health provides state-wide leadership to the county mental health system, and also provides inpatient services to children through its state mental health facilities. The department also provides oversight for the Children's System of Care initiative, which is intended to enhance coordination among many local agencies that are involved in providing services to children with SED in California.

Children with autism receive services through the public school system, as well as the state's regional centers. The regional centers operate as private, non-profit organizations funded primarily by the state Department of Developmental Services to provide and coordinate medical and non-medical support services, including in-home services for autistic and developmentally disabled children and adults.

The need for clarification about the private sector's role in providing *diagnostic* services stems in part from the definition of SED and autism. For example, SED is based on functional criteria defined in the state's Welfare and Institutions code, in addition to DSM-based diagnoses. Some respondents believe that local school systems currently are the most experienced and best equipped to apply these functional criteria to children. Autism, on the other hand, is a developmental disorder that health plans typically cover as a physical health condition. Providers also were uncertain about whether higher-functioning disorders closely related to autism, such as Asperger's syndrome, are eligible for parity-level coverage, although these conditions are covered under the broader category "pervasive developmental disorders" as defined in the law.

In general, we were told that private health plans and mental health providers in their networks currently lack the assessment tools and the expertise to make appropriate diagnoses and develop treatment plans for SED or autism. One health plan noted that, because of the lack of resources for determining functional criteria, it currently is providing parity-level coverage for mental health services to all enrollees under age 18 with any DSM diagnosis.

Stakeholders also identified a need for greater clarification about what *treatment* services health plans should cover for children under AB88. For example, many children with autism receive up to 40 hours a week of in-home behavioral intervention from educational specialists funded by California's school districts. Stakeholders raised the issue of whether health plans should pay for additional services, or cover parents' out-of-pocket costs for these or other autism services. Providers also noted that the treatment of autism has traditionally been the domain of pediatricians, rather than mental health specialists, given the developmental nature of the condition. Providers are unsure about how services will be coordinated between the physical and mental health domains, especially given the fact that AB88 benefits have been carved out to MHBOs that specialize in mental health service delivery.

Stakeholders report that there have been no significant changes in approaches for delivering services to children with SED and autism. The public sector continues to play a large role in the provision of services to children. Health plans have generally not recruited new providers or developed new services for treating these conditions. They continue to provide such services as hospitalization, pharmacy benefits, and office-based psychotherapy for children. Other services, however, such as educational psychology assessments and in-home services for children with autism, continue to be provided primarily by the public sector. At least one plan, though, has started working with specialists at well-recognized centers in assessing enrollees' needs and coordinating with providers and case managers to get patients and families the resources they need through schools and regional centers.

Representatives of DMHC, the California Psychiatric Association, the California Association of Health Plans, and others have begun working together to develop clarification about provisions in AB88 related to children. These efforts led to a statewide

meeting in November 2001. Issues addressed by these collaborative efforts and the recent meeting include:

How should children with private insurance be screened and diagnosed for conditions covered by the law?

What types of services should be delivered to children with different conditions?

How should services and information be coordinated and communicated among health plans, providers, and public agencies?

The stakeholders we interviewed have mixed opinions about the need for state regulation in the area of children's services under AB88. Some respondents believe that the state should take steps to formally specify the services that are required of health plans under AB88 through the publication of regulations. Others suggest that these issues can be resolved through more informal processes, including greater communication and clarification among stakeholders about their current and future roles in providing children's services.

STAKEHOLDERS' PERCEPTIONS OF THE EARLY EFFECTS OF AB88

Although it is too soon to quantify the effects of AB88, stakeholders provided some early assessments of the likely impact of the law in a few key areas. First, stakeholders believe that AB88 has the potential to expand access, but better consumer education is needed to achieve this goal. Many stakeholders also expressed concerns that shortages of mental health providers could limit potential increases in access to care under AB88. Finally, stakeholders identified few adverse effects on the overall health insurance market so far.

Expanded Benefits Can Improve Access, But Further Education Is Needed

Many stakeholders believe that expanded benefits under AB88 have the potential to increase access to care for consumers of mental health services in California, especially for those with severe mental illness. Consumers are likely to find mental health services more affordable under the parity law, given the elimination of outpatient visit limits and inpatient day limits and the reduction of copayment levels. Some consumer advocates believe that these changes may also enable or encourage consumers to seek care in the private sector, rather than the public sector. Advocates predict that increased private sector use will be most common among consumers with new onset of severe mental illness, rather than those with long-standing illness who are already accustomed to obtaining services from the public sector.

Despite education efforts undertaken during the first year of implementation, most interview respondents believe that consumers in California remain largely unaware of the

benefit expansions under AB88. In the view of these stakeholders, it appears that initial notification efforts were not effective in increasing awareness of expanded mental health benefits among the general population. Many respondents questioned whether initial notifications were read and well understood by consumers. A respondent in the state legislature reported receiving numerous telephone calls from consumers who expressed difficulty getting clarification about benefit or delivery system changes from their customer service representatives at health plans. Providers reported that patients appeared to know very little about the law or the change in benefits when making appointments for mental health services, and that they were confused about changes in provider networks. As a result, most stakeholders anticipate that use of mental health services will not increase until consumers learn more about the benefit and until they better understand how to navigate changes in the mental health delivery system.

Most stakeholders believe that improved education efforts are essential for increasing access to mental health services that were previously unavailable or unaffordable for consumers. Providers and consumer advocates, as well as some employer representatives, suggested that additional notifications about AB88 should be sent to consumers following the first year of implementation because of the general lack of awareness. However, health plan representatives questioned the effectiveness of broad outreach efforts, believing that most consumers will not attempt to understand these benefits until they need them.

Concerns About Shortages of Mental Health Providers

Provider and consumer representatives expressed concerns about the availability of providers in health plans' mental health provider networks. These stakeholders noted that the reported size of plans' current mental health provider networks may not represent the true availability of providers, given that some providers in these networks may not be accepting new patients because their practices are full. Providers cited anecdotes of patients' difficulties in obtaining referrals to providers within the MBHO network who were willing to take new patients. Employers also noted that during the first few months of implementation, network provider information was often outdated.

In our interviews, respondents frequently cited the generally short supply of psychiatrists in California, noting an especially severe shortage of child psychiatrists.³ One provider representative asserted that the number of current psychiatric residency training positions is currently too low to meet demand for services. Some also noted shortages among other professionals, such as psychiatric nurses, who treat the severely mentally ill. Given the law's focus on people with biologically based conditions, many stakeholders believe that the current shortage in psychiatry may ultimately constrain the ability of the law to increase access to care for some services. Respondents also noted a significant shortage of hospital-

³These perceptions may reflect a growing nationwide shortage of psychiatrists. Only about three percent of U.S.-trained medical residents now choose psychiatry—the lowest percentage since 1929 (Clay 1998).

based eating disorder treatment programs, which may inhibit the law's goal of expanding access to care for patients with anorexia or bulimia.

According to some stakeholders we spoke with, payment reductions in some health plan networks may have compounded these provider supply problems. We learned that discussions were held between state officials, health plans, MBHOs, and provider associations over the past year to address the problem of provider availability and payment issues. At least one health plan has since increased its fees by 15 to 30 percent, in an effort to entice more psychiatrists to their network. However, health plans say that there are significant challenges to enticing psychiatrists into their networks. Health plan and provider representatives note that psychiatrists are in such high demand by patients that many psychiatrists do not need to participate in MBHO networks in order to maintain viable practices.

Few Adverse Effects on the Health Insurance Market, Thus Far

Initial perceptions indicate that utilization changes have been small during the first year of implementation. However, since most contracts had been renewed under AB88 within the last 12 months at the time of our interviews, health plans indicated that they have had relatively little experience or actual data with which to make judgments about the impact of the law on utilization patterns. Thus, respondents were not yet able to quantify these initial perceptions.

Premium increases associated with mental health parity have also been small. Although employers faced premium increases of 10 to 20 percent in 2001, little of the increase was attributed to parity. Rather, health plans cited a variety of factors contributing to the increases, such as inpatient hospital use, prescription drug costs, and other state benefit mandates passed in 1999. Health plan representatives noted that it was difficult to determine the extent to which each of these factors contributed to the premium increases, but generally noted that the parity was a minor factor. One health plan cited a three percentage point increase in the overall premium in 2001 due to the parity law, but acknowledged, in retrospect, that this figure probably was an overestimate of the effect on its costs. Other plans gave smaller estimates of premium increases, or were unable to give an average estimate across benefit packages. One plan said that none of the premium increase for their benefit packages in 2000 was attributed to AB88.

Thus far, there is no evidence that employers—large or small—were dropping health care coverage because of AB88, as some had feared prior to the bill's passage. One employer purchasing group noted that, to the contrary, an increasing number of employers were offering health insurance in recent years. However, the same group cautioned that some firms—particularly, small businesses—could still decide to drop their existing health coverage if parity ultimately led to large increases in premiums in the future.

As of fall 2001, health insurance purchasers said that they have not seen “earth-shattering” changes in premium costs related to the mental health parity law. One employer

representative referred to the parity law as a “non-event.” Given AB88’s potential to increase costs, employers were most concerned about the law immediately prior to its passage in the legislature, as well as during the renewal of their health insurance contracts during the first year of implementation. Since then, employer interest in the parity law has waned, as they have shifted their attention to other issues. Because of the small changes in premiums, mental health parity is perceived to be a “small blip” on employers’ radar screens compared with other human resources issues, such as increasing costs for workers’ compensation, unemployment insurance, general liability insurance, and especially general medical coverage.

We also were told that mental health parity is likely to remain low on the list of employer concerns so long as utilization and premium costs remain a small part of future premium increases. Yet, most employers report that it is “too early to tell” whether their health care costs will increase in the future as a result of the benefit expansions under AB88.

Indeed, the recent experience of one large employer we interviewed suggests that mental health costs could rise in the future, as consumers become more aware of the expansion of benefits under AB88. This employer, which moved toward a mental health parity model in its health insurance benefit package in the year prior to implementation of AB88, has observed the impact on utilization and costs for the past two years. Consistent with early experience under AB88, there was little increase in either the use or the cost of mental health services during the first year. However, after the second year, the mental health carve-out they were using to provide benefits to their employees increased premiums substantially, in part because of increased utilization. This employer speculates that few people knew about the benefit initially, accounting for the low utilization during the first year. It expects that utilization increased during the second year as knowledge of the benefit became more widespread.

Employers noted that any future increases in premiums due to AB88 could result in one of several responses from employers. Employers may decide to purchase less-generous combinations of physical and mental health benefits; decide to increase cost-sharing with employees; or, at the extreme, possibly drop health coverage altogether. Interview respondents also noted that broader market trends unrelated to AB88, such as increases in general medical costs, could trigger this type of employer response.

CHAPTER IV

CONCLUSIONS

This chapter presents the conclusions from our snapshot study of the implementation of California's mental health parity law. First, we provide an overall assessment of the first year of implementation of AB88, based on the perceived objectives and expectations of the major stakeholders in California. We then discuss the remaining challenges faced by stakeholders in the implementation of California's parity law in future years, as well potential lessons from our study for other states.

ASSESSMENT OF THE FIRST YEAR OF IMPLEMENTATION

An assessment of the success of the first year of implementation depends in part on expectations about what can reasonably be accomplished during this period. At a minimum, there is widespread agreement that health insurance benefits for mental health services have been expanded in compliance with the law's mandate. In addition, the law does not appear to have had any adverse consequences on the health insurance market to date, such as large increases in premiums or decreases in health insurance offerings by employers.

Early education and communication efforts about benefit and delivery system changes were not viewed as adequate by several stakeholders. Some attributed this to a relatively short lead time in which to respond to the law (signed in September 1999 and implemented in July 2000). The new state agency charged with overseeing managed care plans' implementation of the law had little time in which to clarify technical compliance issues, since it too was established in July 2000. Several respondents, especially those representing health plans, also noted the challenges of focusing on changes necessary to comply with the parity law, given the large number of other managed care reforms that were being implemented in California during this period. Yet, some stakeholders believe that health plans could have been more proactive in making decisions earlier and informing others about the changes they were planning to make. Earlier and more extensive communication

about system changes may have prevented some initial transition problems for providers, employers, and consumers.

Some stakeholders encountered challenges during the first year that were related to basic design features of the law. For example, stakeholders confronted administrative complexities associated with implementing the limited list of SMI and SED diagnoses under AB88. The law also introduced unanticipated regulatory challenges. Large employers expressed concern that the law's mandate on full-service health plans has unintentionally discouraged employers' use of separate carve-out arrangements with MBHOs.

Finally, some areas of implementation are considered to be at such an early stage of development that it is too soon to judge the degree of success at this point. For example, major changes in the delivery of children's services have not yet taken place, given the complexity of this area and the prominent and well-established role played by the public sector in providing services for children.

REMAINING CHALLENGES

We identified several remaining challenges faced by stakeholders as the implementation of AB88 proceeds in the future. First, continued efforts are needed to improve coordination and communication among health plans, providers, and employers in implementing or responding to system changes—particularly, given the complexity of implementing “partial parity” and the possible disruptions in service delivery because of the expanded use of MBHOs. These efforts should include more up-to-date network provider listings, improved communications about when and how referrals should be made for mental health services in new systems of care, clarification about which diagnoses are covered under parity-related benefit expansions, and clarification about how cost-sharing and benefit limits should be applied to mental health consumers with different diagnoses or at different stages of treatment.

Second, stakeholders should continue their discussions about the role of the private and public sectors in delivering services to children with SED and autism under AB88. Issues that remain to be addressed include whether the responsibility of the public sector for providing services will be reduced, what services should be covered by private health plans, who should be responsible for diagnosing AB88 conditions in children with private insurance coverage, and how needed services should be coordinated between the private and public sectors. Currently, most discussions appear to be among state-level leaders. Ultimately, statewide discussions and leadership efforts should be translated into specific efforts at the local level, to respond to the law's focus on children's conditions.

Third, stakeholders will need to develop appropriate strategies for improving consumer awareness about benefit expansions under AB88 to facilitate their access to mental health services. There is no consensus yet about how consumers should be further educated about their expanded benefits, which types of consumers should be targeted, and who should be

responsible for undertaking such efforts. A range of efforts could be considered, including a broad-based public education campaign, additional notifications sent by health plans to their enrollees, training of customer service representatives about mental health parity changes, or educational materials distributed by providers to their patients. The choice of strategies should consider which consumers would benefit most from further notification, and which stakeholders, including state agencies, health plans, providers, employers, or consumer advocates, are in the best position to undertake education efforts.

Finally, stakeholders should attempt to identify strategies for addressing shortages in certain provider specialties or programs viewed as important for meeting increased service demand under AB88, such as child psychiatry and eating-disorder programs. Longer-term policy changes may be required to address secular shortages in the overall number of licensed providers in California. However, strategies targeted to the current delivery system may help AB88 achieve its goals of expanding availability of services in the short term. Reassessment of current payment levels for services was the most important area noted by stakeholders in our interviews. Other strategies to consider include expanded provider recruitment and recredentialing efforts by health plans, reduction of administrative burdens for mental health providers, and development of partnerships between plans, providers, and other stakeholders to develop new treatment programs. At the same time, the effectiveness of these strategies will need to be balanced against the potential effects on costs.

LESSONS FOR OTHER STATES

The results from this study provide several early implementation lessons for other states that are implementing or considering passage of mental health parity laws. These lessons relate to how goals of the parity reforms may be most effectively pursued, what may be expected in terms of unintended consequences of the reforms, and how any adverse outcomes might be avoided or ameliorated.

The results highlight the regulatory complexity of what appears to be a relatively straightforward mandate to expand coverage for mental health services. For example, state officials may need to consider how parity laws will affect employers that contract directly with MBHOs. They may also need to anticipate the types of responses health plans have to a parity mandate during the initial transition, assess what types of disruptions in care this may cause, if any, and develop communication and other mechanisms for easing the transition and reducing confusion among stakeholders. Stakeholders may want to think proactively about what information should be conveyed to health plans, employers, providers or consumers, and when notifications should be made. In particular, the needs for consumer education should be addressed early on during the implementation process to facilitate access to care under a parity law. Stakeholders may want to consider such issues as who should be primarily responsible for educating consumers, what are likely to be the best methods for improving consumer awareness of reforms, and when education efforts should take place.

The initial diversity of responses by health plans in California to the limited list of diagnoses—and stakeholders’ mixed views about “partial parity” in California—may also be instructive to states that have either passed similar parity laws or that are considering doing so. States considering passage of a parity law will need to weigh the potential administrative costs of a limited parity law, versus the potentially increased health care costs associated with expanding parity to all mental health diagnoses. States in the early stage of implementation of a limited parity law may also want to ensure that early communication efforts specifically address the complexities of implementing partial parity, in order to reduce potential confusion about this issue.

Finally, states may need to assess how rapidly or effectively a parity law, on its own, can expand the role of private providers in delivering mental health services traditionally provided by the public sector. Our findings from early implementation in California indicate that additional, proactive efforts on the part of state leaders will be necessary to achieve this goal under the parity law.

MENTAL HEALTH PARITY IN THE FUTURE

In summary, an important goal of AB88 in California appears to have been achieved during the first year of implementation; but a great deal of work remains to be done to make the parity law a success in the future. In particular, mental health benefits have been expanded to conform with the parity mandate, but it will take time and additional effort to achieve goals such as reducing stigma and improving access to care for people with mental illness. The law has prompted discussions among stakeholders about such issues as responsibility for additional education efforts, availability of mental health providers in health plan networks, delivery and management of mental health services in a managed care environment, and delivery and coordination of mental health services for children by both the private and the public sector. There is a broad consensus, however, that the full impact of parity may not be known for several years, as longer-term implementation issues are addressed and as consumers become aware of expanded benefits and begin accessing newly covered services.

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ATTACHMENT C

Title 28 California Code of Regulations, Section 1374.72.

(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

b) These benefits shall include the following:

- (1) Outpatient services.
- (2) Inpatient hospital services.
- (3) Partial hospital services.
- (4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section that shall be applied equally to all benefits under the plan contract shall include, but not be limited to, the following:

- (1) Maximum lifetime benefits.
- (2) Co-payments.
- (3) Individual and family deductibles.

(d) For the purposes of this section, "severe mental illnesses" shall include:

- (1) Schizophrenia.
- (2) Schizoaffective disorder.
- (3) Bipolar disorder (manic-depressive illness).
- (4) Major depressive disorders.
- (5) Panic disorder.
- (6) Obsessive-compulsive disorder.
- (7) Pervasive developmental disorder or autism.
- (8) Anorexia nervosa.
- (9) Bulimia nervosa.

(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

(f) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing

with Section 14200) of Division 9 of Part 3 of the Welfare and Institutions Code, between the State Department of Health Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(g)

(1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, co-payments, or other cost sharing.

(h) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

ATTACHMENT D



DATE: DECEMBER 21, 2004

TO: INTERESTED PARTIES

FROM: THOMAS L. GILEVICH, SENIOR COUNSEL – HMO HELP CENTER

Re: Mental Health Parity –

Dept. of Mental Health Report under SB 1103

The Clinical Advisory Panel (CAP) of the California Department of Managed Health Care (Department) has scheduled a meeting in collaboration with the Department of Mental Health. Public input will be sought regarding the report required by the Department of Mental Health under Section 34 of SB 1103, regarding achieving mental health parity in California.

The meeting will be held on Wednesday, January 5, 2005, from 10:00 a.m. – 3:00 p.m., in the 2nd Floor Conference Room A and B, located in the US Bank Plaza Building, 980 Ninth Street, Sacramento, CA 95814.

The Department encourages the public and interested stakeholders to file written comments focusing on:

- (1) Any identified problems arising from the implementation of California's mental health parity legislation;
- (2) The commenter's meaning of "parity" regarding difficulties or failures in obtaining mental health services - such as differences in payments or charges for services, the types of services or benefits available or differences in access and availability of mental health services;
- (3) What areas of mental health services have worked better since the enactment of mental health parity laws and what areas have not improved or have not worked as well as expected;
- (4) What barriers are believed to exist in achieving parity and how advocates, regulators or legislation might address them?

Persons filing written comments with the Department on or before January 5, 2005, will be given priority to speak during the hearing. Written comments may

be e-mailed to TGilevich@dmhc.ca.gov, faxed to (916) 229-3124; or mailed to the Department: Attention: Thomas L. Gilevich, Senior Counsel – HMO Help Center, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814-2738. Written comments may also be submitted following the hearing.

As noted in the agenda, the CAP meeting will begin at 10 a.m. with public comments regarding mental health parity expected to begin before the lunch break. To allow time for all members of the public to speak, comments will be limited to the subject of the hearing and those wishing to speak will be asked to limit their comments to no more than five minutes in length.

ATTACHMENT E

Health and Safety Code, California Code or Regulations, Section 1345 (b)

- (b) "Basic health care services" means all of the following:
- (1) Physician services, including consultation and referral.
 - (2) Hospital inpatient services and ambulatory care services.
 - (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.
 - (4) Home health services.
 - (5) Preventive health services.
 - (6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.
 - (7) Hospice care pursuant to Section 1368.2.

Health and Safety Code, CCR, Section 1367 (i)

- (i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of **Section 1345**, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a co-payment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the co-payments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of **Section 1363**.

1300.67. Scope of Basic Health Care Services

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve

- (a) Physician services, which shall be provided by physicians licensed to practice medicine or osteopathy in accordance with applicable California law. There shall also be provided consultation with and referral by physicians to other physicians

- (1) The plan may also include, when provided by the plan, consultation and referral (physician or, if permitted by law, patient initiated) to other health professionals who are defined as dentists, nurses, podiatrists, optometrists, physician's assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health services who are licensed to practice, are certified, or practice under authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.
- (b) Inpatient hospital services, which shall mean short-term general hospital services, including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, drugs, medications, biologicals, anesthesia and oxygen services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and other diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early rehospitalization.
- (c) Ambulatory care services, (outpatient hospital services) which shall include diagnostic and treatment services, physical therapy, speech therapy, occupational therapy services as appropriate, and those hospital services which can reasonably be provided on an ambulatory basis. Such services may be provided at a hospital, any other appropriate licensed facility, or any appropriate facility which is not required by law to be licensed, if the professionals delivering such services are licensed to practice, are certified, or practice under the authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.
- (d) Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services, which shall include, but not be limited to, electrocardiography and electroencephalography
- (e) Home health services, which shall include, where medically appropriate, health services provided at the home of an enrollee as prescribed or directed by a physician or osteopath licensed to practice in California. Such home health services shall include diagnostic and treatment services which can reasonably be provided in the home, including nursing care, performed by a registered nurse, public health nurse, licensed vocational nurse or licensed home health aide.
 - (1) Home health services may also include such rehabilitation, physical, occupational or other therapy, as the physician shall determine to be medically appropriate.

- (f) Preventive health services (including services for the detection of a symptomatic diseases), which shall include, under a physician's supervision,
- (1) reasonable health appraisal examinations on a periodic basis
 - (2) a variety of voluntary family planning services
 - (3) prenatal care
 - (4) vision and hearing testing for persons through age 16
 - (5) immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service
 - (6) venereal disease tests;
 - (7) cytology examinations on a reasonable periodic basis;
 - (8) effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.
- (g)
- (1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.
 - (2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in section 1317.1 include active labor. "Urgently needed services" are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. "Urgently needed services" includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.
- (h) Hospice services as set forth in Section 1300.68.2

Note

Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1317.1, 1345 and 1367, Health and Safety Code.

ATTACHMENT F

TITLE 9. CALIFORNIA CODE OF REGULATIONS

Chapter 11. Medi-Cal Specialty Mental Health Services

Subchapter 1. General Provisions

Article 2. Definitions, Abbreviations and Program Terms

1810.201. Acute Psychiatric Inpatient Hospital Services.

"Acute Psychiatric Inpatient Hospital Services" means those services provided by a hospital to beneficiaries for whom the facilities, services and equipment described in Section 1810.350 are medically necessary for diagnosis or treatment of a mental disorder in accordance with Section 1820.205.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code.

1810.202. Administrative Day Service.

"Administrative Day Services" means psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at appropriate, non-acute treatment facilities.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code.

1810.203. Adult Residential Treatment Service.

"Adult Residential Treatment Service" means rehabilitative services, provided in a non-institutional, residential setting, which provide a therapeutic community including a range of activities and services for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.204. Assessment.

“Assessment” means a service activity which may include a clinical analysis of the history and current status of a beneficiary’s mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.206. Collateral.

“Collateral” means a service activity to a significant support person in a beneficiary’s life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.208. Crisis Residential Treatment Service.

“Crisis Residential Treatment Service” means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program for beneficiaries as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service supports beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.209. Crisis Intervention.

“Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who are not eligible to deliver crisis stabilization or who are eligible, but deliver the service at a site other than a

provider site that has been certified by the department or a Mental Health Plan to provide crisis stabilization.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.210. Crisis Stabilization

“Crisis Stabilization” means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis stabilization must be provided on site at a 24 hour health facility or hospital-based outpatient program or at other provider sites which have been certified by the department or a Mental Health Plan to provide crisis stabilization services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.212. Day Rehabilitation.

“Day Rehabilitation” means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries and is available at least three hours and less than twenty-four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.213. Day Treatment Intensive.

“Day Treatment Intensive” means a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with services available at least three hours and less than twenty-four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.215. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services.

“EPSDT supplemental specialty mental health services” means those services defined in Title 22, Section 51184, that are provided to correct or ameliorate the diagnoses listed in Section 1830.205, and that are not otherwise covered by this chapter.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code, and Title 42, Section 1396d(r), United States Code.

1810.220. Hospital-Based Ancillary Services.

“Hospital-Based Ancillary Services” means services, which include but are not limited to prescription drugs, laboratory services, x-ray, electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI), that are received by a beneficiary admitted to a hospital, other than routine hospital services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.225. Medication Support Services.

“Medication Support Services” means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.227. Mental Health Services.

“Mental Health Services” means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.232. Plan Development.

“Plan Development” means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.237. Psychiatric Health Facility Services.

“Psychiatric Health Facility Services” mean therapeutic and/or rehabilitative services provided in a non-hospital psychiatric health facility on an inpatient basis to beneficiaries who need acute care and whose physical health needs can be met in an affiliated hospital or in outpatient settings. The determination of the need for acute care shall be made in accordance with Section 1820.205.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.237.1. Psychiatric Inpatient Hospital Professional Services.

“Psychiatric Inpatient Hospital Professional Services” means specialty mental health services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a psychiatric inpatient hospital. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.238. Psychiatric Inpatient Hospital Services.

“Psychiatric Inpatient Hospital Services” means both acute psychiatric inpatient hospital services and administrative day services provided in a hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5778, 14132, and 14684, Welfare and Institutions Code.

1810.240. Psychiatrist Services.

“Psychiatrist Services” means services provided by licensed physicians, within their scope of practice, who have contracted with the MHP to provide specialty mental health services or who have indicated a psychiatrist specialty as part of the provider enrollment process for the Medi-Cal program, to diagnosis or treat a mental illness or condition. For the purposes of this chapter, psychiatrist services may only be provided by physicians who are individual or group providers.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code.

1810.241. Psychologist Services.

“Psychologist Services” means services provided by licensed psychologists, within their scope of practice, to diagnose or treat a mental illness or condition. For the purposes of this chapter, psychologist services may only be provided by psychologists who are individual or group providers.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code.

1810.243. Rehabilitation.

“Rehabilitation” means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary’s or group of beneficiaries’ functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.244. Routine Hospital Services.

“Routine Hospital Services” means bed, board and all medical, nursing and other support services usually provided to an inpatient by a psychiatric inpatient hospital. Routine hospital services do not include hospital-based ancillary services, psychiatrist or other physician services, or psychologist services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.245. Service Activities

“Service Activities” means activities conducted to provide specialty mental health services when the definition of the service includes these activities.

“Therapy” means a service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

Article 3. Administration

1810.345. Scope of Covered Specialty Mental Health Services.

(a) The MHP of a beneficiary shall provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Sections 1820.205, 1830.205, or 1830.210 are met and when specialty mental health services are required to assess whether the medical necessity criteria are met. Except as provided elsewhere in this chapter, the MHP shall not be required to provide or arrange for any specific specialty mental health service, but shall ensure that the specialty mental health services available are adequate to meet the needs of the beneficiary as described in the medical necessity criteria in Sections 1820.205, 1830.205, or 1830.210 as applicable. The MHP of a beneficiary shall be required to provide specialty mental health services only to the extent the beneficiary is eligible for those services based on the beneficiary's Medi-Cal eligibility under Title 22, Division 3, Subdivision 1, Chapter 2, Article 5 and Article 7.

(b) The department may exclude psychiatric nursing facility services from the specialty mental health services covered by the MHP until the department determines that all necessary systems are in place at the State level to ensure proper payment of the providers of psychiatric nursing facility services and proper claiming of federal funds pursuant to Subchapter 4. The department shall adjust the contract between the MHP and the department and the allocation to the MHP pursuant to Section 1810.330 to reflect the exclusion and inclusion of these services as appropriate. *(NOTE: Psychiatric nursing facility services are currently excluded from all contracts.)*

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5775, 5777, 14007.5, 14011, 14142, 14145, 14682, Welfare and Institutions Code.

1810.350. Scope of Covered Psychiatric Inpatient Hospital Services.

Service activities include, but are not limited to, assessment, collateral, therapy, rehabilitation, and plan development.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.247. Specialty Mental Health Services.

“Specialty Mental Health Services” means:

(a) Rehabilitative Services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.

(b) Psychiatric Inpatient Hospital Services;

(c) Targeted Case Management;

(d) Psychiatrist Services;

(e) Psychologist Services;

(f) EPSDT Supplemental Specialty Mental Health Services; and

(g) Psychiatric Nursing Facility Services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.3, 14021.4, 14132, and 14684, Welfare and Institutions Code.

1810.249. Targeted Case Management.

“Targeted Case Management” means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; and plan development.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14021.3, and 14684, Welfare and Institutions Code.

1810.250. Therapy

(a) An MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services as described in Section 1810.345 and in (b) and (c).

(b) Psychiatric Inpatient Hospital Services for a Fee-for-Service/Medi-Cal hospital shall include:

- (1) Routine hospital services and
- (2) All hospital-based ancillary services.

(c) Psychiatric Inpatient Hospital Services for a Short-Doyle/Medi-Cal hospital shall include:

- (1) Routine hospital services,
- (2) All hospital-based ancillary services, and
- (3) Psychiatric inpatient hospital professional services.

(d) An MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services provided to a beneficiary eligible for Medicare (Part A) if the payment being authorized is for administrative day services following any approved acute psychiatric inpatient hospital services day and there is compliance with Section 1820.220(j)(5).

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.355. Excluded Services.

(a) MHPs shall not be responsible to provide or arrange and pay for the following services:

(1) Medi-Cal services, which are those services described in Title 22, Division 3, Subdivision 1, Chapter 3, that are not specialty mental health services as defined in Section 1810.247.

(A) Prescribed drugs as described in Title 22, Section 51313, and laboratory, radiological, and radioisotope services as described in Title 22, Section 51311, are not the responsibility of the MHPs, except when provided as hospital-based ancillary services. Medi-Cal beneficiaries may obtain Medi-Cal covered prescriptions drugs and laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice and employed by or contracting with the MHP under applicable provisions of Title 22, Division 3, Subdivision 1.

(B) Medical transportation services as described in Title 22, Section 51323, are not the responsibility of the MHP except when the purpose of the medical transportation service is to transport a beneficiary from a psychiatric inpatient hospital to another psychiatric inpatient hospital or another type of 24 hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP.

(C) Physician services as described in Title 22, Section 51305, that are not psychiatric services as defined in Section 1810.240, even if the services are provided to treat a diagnosis included in Sections 1820.205 or 1830.205.

(2) Out-of-state specialty mental health services except when it is customary practice for a California beneficiary to receive medical services in a border community outside the State.

(3) Specialty mental health services provided by a hospital operated by the department or the State Department of Developmental Services.

(4) Specialty mental health services provided to a beneficiary eligible for Medicare, prior to the exhaustion of beneficiary's Medicare mental health benefits. Administrative day services are excluded only if the beneficiary is in a hospital reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRGs), when the DRG reimbursement covers administrative day services according to Medicare (Part A).

(5) Specialty mental health services provided to a beneficiary enrolled in a Medi-Cal Managed Care Plan to the extent specialty mental health services are covered by the Medi-Cal Managed Care Plan.

(6) Psychiatric inpatient hospital services received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as defined in Section 1820.100(a).

(7) Medi-Cal services that may include specialty mental health services as a component of a larger service package as follows:

(A) Psychiatrist and psychologist services provided by adult day health centers pursuant to Title 22, Section 54325.

(B) Home and community based waiver services as defined in Title 22, Section 51176.

(C) Specialty mental health services authorized by the California Children's Services (CCS) Program to treat CCS eligible beneficiaries.

(D) Local Education Agency (LEA) services as defined in Title 22, Section 51190.4.

(E) Specialty mental health services provided by Federally Qualified Health Centers, Indian Health Centers, and Rural Health Clinics.

(F) Home health agency services as described in Title 22, Section 51337.

(b) Beneficiaries whose diagnoses are not included in the applicable listing of diagnoses in Sections 1820.205 or 1830.205 may obtain specialty mental health services under applicable provisions of Title 22, Division 3, Subdivision 1.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5775, 5776, 5777, 5778, 5780, 14681, 14682, 14683, 14684, 14685, Welfare and Institutions Code.

ATTACHMENT G

Title 9, CCR, Section 1810.405. Access Standards for Specialty Mental Health Services.

(a) The MHP of the beneficiary shall be responsible for assuring that the beneficiary has access to specialty mental health services as provided in Section 1810.345 and Section 1810.350.

(b) Referrals to the MHP for Specialty Mental Health Services may be received through beneficiary self referral or through referral by another person or organization, including but not limited to:

- (1) Physical health care providers
- (2) Schools
- (3) County welfare departments
- (4) Other MHPs.
- (5) Conservators, guardians, or family members.
- (6) Law enforcement agencies.

(c) Each MHP shall make specialty mental health services to treat a beneficiary's urgent condition available 24 hours a day, seven days per week. If the MHP requires that a provider obtain approval of an MHP payment authorization request prior to the delivery of a specialty mental health service to treat a beneficiary's urgent condition as a condition of payment to the provider, the MHP shall have a statewide, toll-free telephone number available 24 hours a day, seven days per week, to act on MHP payment authorization requests for specialty mental health services to treat a beneficiary's urgent condition. Under these circumstances, the MHP shall act on the MHP payment authorization request within one hour of the request.

(d) Each MHP shall provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in the languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access specialty mental health services, including services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

(e) At the request of a beneficiary, the MHP of the beneficiary shall provide for a second opinion by a licensed mental health professional employed by, contracting with or otherwise made available by the MHP when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The MHP shall determine whether the second opinion requires a face-to-face encounter with the beneficiary.

(f) The MHP shall maintain a written log of the initial requests for specialty mental health services from beneficiaries of the MHP. The requests shall be recorded whether they are made via telephone, in writing, or in person. The log shall contain the name of the beneficiary, the date of the request, and the initial disposition of the request.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

ATTACHMENT H

California Mental Health Planning Council 1999 Vacancy Rate Study

Background

In order to document the human resources crisis facing California's public mental health system, in 1999 the Planning Council conducted a vacancy rate study focusing on 22 occupations employed by county-operated mental health programs and state hospitals. Respondents reported vacancies for occupations in the Children's System of Care, Adult System of Care, and the Older Adult System of Care.

The statewide response rate was 44.7% from county mental health departments. In addition, response rates were calculated for county mental health departments by Department of Mental Health Regions. The response rates represent the number of counties responding per region. Bay Area counties responded at a rate of 38.46%; Central counties at a rate of 38.89%; Southern counties at a rate of 60.00%; Superior counties at a rate of 41.18%; and Los Angeles County responded. The response rate for state hospitals represents the participation of all state hospital facilities and resulted in a response rate of 100%. Vacancies were projected to represent the number of positions that would be vacant if every county had responded.

Tables

A statewide overview table and tables by systems of care have been created to more easily compare vacancy rates. The Statewide Overview Table is entitled "Projected Total Full Time Equivalent (FTE) Positions and Vacancies." The overview table includes four distinct headings: Children's System of Care, Adult System of Care, Older Adult System of Care, and a Total Column, representing vacancies among all systems of care. Under each column heading, three categories of information are included: Projected Total FTE Positions, Projected Total Vacancies, and the Percent Vacant. Projected Total FTE Positions and Projected Total Vacancies are the combined total reported by all county mental health programs and state hospitals.

The Tables by Systems of Care provide an overview of vacancies reported by county mental health departments and state hospitals by Children's System of Care, Adult System of Care, and Older Adult System of Care. Each table includes four columns. The first column contains the occupations being examined, the second column contains vacancy data provided by county-operated mental health programs, the third column contains information provided by state hospitals, and the fourth column offers statewide totals by system of care. Under each column

heading three categories of information are included: Projected Total FTE Positions, Projected Total Vacancies, and the Percent Vacant.

Summary of Findings

The projected FTE position reported by survey participants was 12,479. Of these positions 17.1% or 2,132 are vacant. As you look at vacancies among system of care, the average vacancy for positions is 20.9% in the Children's System of Care, 16.5% in the Adult System of Care, and 8.9% in the Older Adult System of Care. When examining vacancies by system of care, county-operated mental health programs reported the most vacancies in the Children's and Older Adult System of Care with rates at 21.8% and 12.3%. State hospitals reported the highest rate of vacancies among the Adult System of Care, reporting vacancies at a rate of 18.6% compared to 15.8% reported by county mental health programs.

By occupation, vacancy rates for psychiatrists and LCSWs stand out. Statewide, the vacancy rate for psychiatrists is 23%. The vacancy rate for LCSWs is 24.3%.

ATTACHMENT I

Title 9, CCR, Section 1850.205. Beneficiary Problem Resolution Processes.

(a) An MHP shall develop problem resolution processes that enable a beneficiary to resolve a concern or complaint about any specialty mental health service-related issue.

(b) The MHP's beneficiary problem resolution processes shall include:

(1) A complaint resolution process.

(2) A grievance process.

(c) For both the complaint resolution process and the grievance process, the MHP shall ensure:

(1) That each beneficiary has adequate information about the MHP's processes by taking at least the following actions:

(A) Including information describing the complaint resolution process and the grievance process in the MHP's beneficiary brochure and providing the beneficiary brochure to beneficiaries as described in Section 1810.360.

(B) Posting notices explaining complaint resolution and grievance process procedures in locations at all MHP provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. For the purposes of this section, an MHP provider site means any office or facility owned or operated by the MHP or a provider contracting with the MHP at which beneficiaries may obtain specialty mental health services.

(C) Making grievance forms and self addressed envelopes available for beneficiaries to pick up at all MHP provider sites without having to make a verbal or written request to anyone.

(2) That a beneficiary may authorize another person to act on the beneficiary's behalf.

(3) That a beneficiary's legal representative may use the complaint resolution process or the grievance process on the beneficiary's behalf.

(4) That an MHP staff person or other individual is identified as having responsibility for assisting a beneficiary with these processes at the beneficiary's request.

(5) That a beneficiary is not subject to discrimination or any other penalty for filing a complaint or grievance.

(6) That procedures for the processes maintain the confidentiality of beneficiaries.

(7) That a procedure is included by which issues identified as a result of the complaint resolution or grievance process are transmitted to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the MHP for review and, if applicable, implementation of needed system changes.

(d) In addition to meeting the requirements of subsection (c), the complaint resolution process shall, at a minimum:

(1) Provide for resolution of a beneficiary's concerns or complaints as quickly and simply as possible.

(2) Involve simple, informal and easily understood procedures that do not require beneficiaries to present their concerns or complaints in writing.

(3) Inform a beneficiary of his or her right to use the grievance process or request a fair hearing at any time before, during or after the complaint resolution process has begun.

(4) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(e) In addition to meeting the requirements of subsection (c), the grievance process shall, at a minimum:

(1) Require that beneficiaries provide their concerns or complaints to the MHP as a written grievance.

(2) Provide for two levels of review within the MHP.

(3) Provide for a decision on the grievance at each level of review within 30 calendar days of receipt of the grievance by that level of review within the MHP.

(4) Provide for an expedited review of grievances where the beneficiary is grieving a decision by a provider or the MHP to discontinue adult residential or crisis residential services. When the written grievance is received by the MHP prior to the beneficiary's discharge from the services, the beneficiary shall continue to receive the adult residential or crisis stabilization services and the MHP shall continue payment for the services until the MHP responds to the grievance at the

first level of review, at which point action may be taken by the provider or the MHP as appropriate based on the grievance decision. Services shall not be continued if the provider or the MHP determines that ongoing placement of the beneficiary in that facility poses a danger to the beneficiary or others.

(5) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(6) Provide for:

(A) Recording the grievance in a grievance log within one working day of the date of receipt of the grievance. The log entry shall include but not be limited to:

1. The name of the beneficiary.
2. The date of receipt of the grievance.
3. The nature of the problem.

(B) Recording the final disposition of a grievance, including the date the decision is sent to the beneficiary, or documenting the reason(s) that there has not been final disposition of the grievance.

(C) An MHP staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance.

(D) Notifying the beneficiary or the appropriate representative in writing of the grievance decision and documenting the notification or efforts to notify the beneficiary, if he or she could not be contacted. When the notice contains the decision of the MHP's first level of review, the notice shall include the beneficiary's right to appeal to the second level of review and to request a fair hearing if the beneficiary disagrees with the decision instead of, before, during or after filing the grievance at the second level of review. When the notice contains the decision of the MHP's second level of review, the notice shall include the beneficiary's right to request a fair hearing if the beneficiary disagrees with the decision.

(E) If any providers were cited by the beneficiary or otherwise involved in the grievance, notifying those providers of the final disposition of the beneficiary's grievance.

(f) An MHP's grievance log and any other grievance process files, and any complaint resolution process files shall be open to review by the department, the State Department of Health Services, and any appropriate oversight agency.

(g) Nothing in this section precludes a provider other than the MHP from establishing complaint or grievance processes for beneficiaries receiving services from that provider. When such processes exist, beneficiaries shall not be required by the MHP to use or exhaust the provider's processes prior to using the MHP's beneficiary problem resolution process, unless the following conditions have been met:

(1) The MHP delegates the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation.

(2) The provider's beneficiary problem resolution process fully complies with this section.

(3) No beneficiary is prevented from accessing the grievance process solely on the grounds that the grievance was incorrectly filed with either the MHP or the provider.

(h) No provision of an MHP's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code, Section 5520.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5520 and 14684, Welfare and Institutions Code.

ATTACHMENT I

Title 9, CCR, Section 1850.205. Beneficiary Problem Resolution Processes.

(a) An MHP shall develop problem resolution processes that enable a beneficiary to resolve a concern or complaint about any specialty mental health service-related issue.

(b) The MHP's beneficiary problem resolution processes shall include:

(1) A complaint resolution process.

(2) A grievance process.

(c) For both the complaint resolution process and the grievance process, the MHP shall ensure:

(1) That each beneficiary has adequate information about the MHP's processes by taking at least the following actions:

(A) Including information describing the complaint resolution process and the grievance process in the MHP's beneficiary brochure and providing the beneficiary brochure to beneficiaries as described in Section 1810.360.

(B) Posting notices explaining complaint resolution and grievance process procedures in locations at all MHP provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. For the purposes of this section, an MHP provider site means any office or facility owned or operated by the MHP or a provider contracting with the MHP at which beneficiaries may obtain specialty mental health services.

(C) Making grievance forms and self addressed envelopes available for beneficiaries to pick up at all MHP provider sites without having to make a verbal or written request to anyone.

(2) That a beneficiary may authorize another person to act on the beneficiary's behalf.

(3) That a beneficiary's legal representative may use the complaint resolution process or the grievance process on the beneficiary's behalf.

(4) That an MHP staff person or other individual is identified as having responsibility for assisting a beneficiary with these processes at the beneficiary's request.

(5) That a beneficiary is not subject to discrimination or any other penalty for filing a complaint or grievance.

(6) That procedures for the processes maintain the confidentiality of beneficiaries.

(7) That a procedure is included by which issues identified as a result of the complaint resolution or grievance process are transmitted to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the MHP for review and, if applicable, implementation of needed system changes.

(d) In addition to meeting the requirements of subsection (c), the complaint resolution process shall, at a minimum:

(1) Provide for resolution of a beneficiary's concerns or complaints as quickly and simply as possible.

(2) Involve simple, informal and easily understood procedures that do not require beneficiaries to present their concerns or complaints in writing.

(3) Inform a beneficiary of his or her right to use the grievance process or request a fair hearing at any time before, during or after the complaint resolution process has begun.

(4) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(e) In addition to meeting the requirements of subsection (c), the grievance process shall, at a minimum:

(1) Require that beneficiaries provide their concerns or complaints to the MHP as a written grievance.

(2) Provide for two levels of review within the MHP.

(3) Provide for a decision on the grievance at each level of review within 30 calendar days of receipt of the grievance by that level of review within the MHP.

(4) Provide for an expedited review of grievances where the beneficiary is grieving a decision by a provider or the MHP to discontinue adult residential or crisis residential services. When the written grievance is received by the MHP prior to the beneficiary's discharge from the services, the beneficiary shall continue to receive the adult residential or crisis stabilization services and the MHP shall continue payment for the services until the MHP responds to the grievance at the

first level of review, at which point action may be taken by the provider or the MHP as appropriate based on the grievance decision. Services shall not be continued if the provider or the MHP determines that ongoing placement of the beneficiary in that facility poses a danger to the beneficiary or others.

(5) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(6) Provide for:

(A) Recording the grievance in a grievance log within one working day of the date of receipt of the grievance. The log entry shall include but not be limited to:

1. The name of the beneficiary.
2. The date of receipt of the grievance.
3. The nature of the problem.

(B) Recording the final disposition of a grievance, including the date the decision is sent to the beneficiary, or documenting the reason(s) that there has not been final disposition of the grievance.

(C) An MHP staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance.

(D) Notifying the beneficiary or the appropriate representative in writing of the grievance decision and documenting the notification or efforts to notify the beneficiary, if he or she could not be contacted. When the notice contains the decision of the MHP's first level of review, the notice shall include the beneficiary's right to appeal to the second level of review and to request a fair hearing if the beneficiary disagrees with the decision instead of, before, during or after filing the grievance at the second level of review. When the notice contains the decision of the MHP's second level of review, the notice shall include the beneficiary's right to request a fair hearing if the beneficiary disagrees with the decision.

(E) If any providers were cited by the beneficiary or otherwise involved in the grievance, notifying those providers of the final disposition of the beneficiary's grievance.

(f) An MHP's grievance log and any other grievance process files, and any complaint resolution process files shall be open to review by the department, the State Department of Health Services, and any appropriate oversight agency.

(g) Nothing in this section precludes a provider other than the MHP from establishing complaint or grievance processes for beneficiaries receiving services from that provider. When such processes exist, beneficiaries shall not be required by the MHP to use or exhaust the provider's processes prior to using the MHP's beneficiary problem resolution process, unless the following conditions have been met:

(1) The MHP delegates the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation.

(2) The provider's beneficiary problem resolution process fully complies with this section.

(3) No beneficiary is prevented from accessing the grievance process solely on the grounds that the grievance was incorrectly filed with either the MHP or the provider.

(h) No provision of an MHP's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code, Section 5520.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5520 and 14684, Welfare and Institutions Code.