From: DMHC Licensing eFiling

Subject: APL 21-002 – Implementation of SB 855, MH/SUD Coverage

Date: Tuesday January 5, 2021 1:41 PM

Attachments: APL 21-002 – SB 855, MHSUD Coverage.pdf
APL 21-002 – Attachment A Criteria.pdf

Dear Health Plan Representative,

Please see attached All Plan Letter (APL) 21-002 and Attachment A Criteria, regarding the implementation of Senate Bill 855, Mental Health and Substance Use Disorder Coverage.

Thank you.

Gavin Newsom, Governor
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ALL PLAN LETTER

DATE: January 5, 2021

TO: All Commercial Full-Service Health Plans and Specialized Health Care Service Plans Offering Behavioral Health Services[1]

FROM: Nancy Wong, Office of Plan Licensing

SUBJECT: APL 21-002 - Implementation of Senate Bill 855, Mental Health and Substance Use Disorder Coverage

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Senate Bill 855 (Wiener, Stats. 2020, ch. 151 §2) enacts Health and Safety Code section 1367.045, 1374.72, and 1374.721 effective January1, 2021.[2] This All Plan Letter (APL) provides guidance regarding implementation of this new legislation as well as filing and compliance requirements for all full service and certain specialized health care service plans (plan or plans).

A. General Overview of the New Law

Senate Bill 855 (Weiner, 2020) repeals and replaces section 1374.72 of the California Health and Safety Code. Additionally, SB 855 adds sections 1374.721 and 1367.045 to the Health and Safety Code.

Section 1374.72 requires, in part, every plan that provides hospital, medical, or surgical coverage to cover medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). The revised statute defines "medically necessary" for MH/SUD in subdivision (a)(3). Among other requirements, plans may not limit benefits or coverage for MH/SUD to short-term or acute treatment.

Pursuant to section 1374.72(d), plans are required to arrange coverage for out-of-network services for medically necessary treatment of a mental health or substance use disorder when services are not available in network within geographic and timely

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[1] This All Plan Letter does not apply to Medicare Advantage plans, Medi-Cal managed care plans, or Medicare Supplement products. Specialized health care service plans are impacted by SB 855 to the extent they cover mental health, substance use disorder, or behavioral health services.

[2] All references are to the California Health and Safety Code unless otherwise noted.

access standards to ensure the delivery of these services, to the maximum extent possible, within geographic and timely access standards. This provision does not alter the plan's obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.

Section 1374.72(h) prohibits a plan from limiting benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program.

Section 1374.721 requires plans to base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care. Additionally, plans must apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders. Further, plans must sponsor a formal education program by nonprofit clinical specialty associations to educate all plan staff and any third parties contracted to review claims, conduct utilization review, or make medical necessity determinations. Section 1374.721 also requires plans to conduct interrater reliability testing and run reports to achieve an interrater reliability pass rate of at least 90 percent[3].

Section 1367.045 provides that contract provisions that reserve discretionary authority to the plan, or agent of the plan, to determine eligibility for benefits or coverage, interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this are void and unenforceable.

B. Filings to Demonstrate Compliance with SB 855

The compliance deadline for implementation of SB 855 is January 1, 2021. Please submit compliance filings by dates described below and in Section E, Compliance and Filing Deadline Roadmap.

1. Submit initial filing via eFiling as an Amendment titled "**Compliance with SB 855 Section 1374.72**" no later than **February 1, 2021**. Include an Exhibit E-1 that addresses how the plan intends to comply with specific requirements discussed in Section C of this APL.

2. Submit subsequent filing via eFiling as a Notice of Material Modification titled **"Compliance with SB 855 Section 1374.721"** no later than **March 1, 2021**. Include an Exhibit E-1 describing the plan's implementation process related to adoption of nonprofit professional association treatment criteria and compliance with specific requirements described in SB 855 and discussed in Section D of this APL, including education program and training requirements.

[3] Interrater reliability testing measures the consistency in decision making by individuals authorized to determine whether services are medically necessary.

3. To the extent **policies and procedures** are revised to accommodate new coverage requirements and/or the medical necessity definition for MH/SUD services pursuant to section 1374.72 and outlined in this APL, or utilization review requirements and definitions in section 1374.721, including interrater reliability testing procedures, these policies and procedures must be filed with the Department as a *separate* Amendment Filing titled **"Revised Policies and Procedures for Compliance with SB 855 section 1374.72 and 1374.721."** Policies and procedures related to section 1374.72 must be submitted for review no later than **March 1, 2021**. (This is a separate filing for the purpose of streamlining the review and approval processes.)

4. Plan documents (EOCs, provider contracts, notices, etc.) must be consistent with the newly enacted legislation and should be filed pursuant to the timelines and requirements of the Knox Keene Health Care Service Plan Act of 1975, (Act) and other applicable laws. Examples include, but are not limited to:
    a. While Plans are not required to submit SB 855 updates to previously-approved 2021 EOCs, if a plan intends to update 2021 EOCs, it should submit those changes consistent with section 1352 and 1300.52.
    b. Qualified Health Plans (QHPs) must file 2022 plan year documents according to timeframes set forth by Covered California and the DMHC.
    c. Plans do not need to refile previously filed and approved documents, unless otherwise directed by the DMHC.
    d. To the extent a plan hires additional providers as a result of requirements in SB 855, the plan should submit Network filings consistent with the Act and Rules when there is a 10% change to the plan's network.
    e. If a plan does not intend to update 2021 EOCs, the Department highly recommends the plan issue an errata describing changes to enrollee benefits based on SB 855, including the expanded MH/SUD benefits and application of less restrictive utilization review based on nonprofit association guidelines and criteria. To the extent a plan intends to issue an errata, that document must be filed with the Department for approval in advance of issuance.

C. Section 1374.72 Compliance Requirements

1. Section 1374.72(a)(1) and (2): **Effective January 1, 2021**, any plan that provides hospital, medical, or surgical coverage must comply with coverage requirements for medically necessary treatment of mental health and substance use disorders as expanded by subdivision (a)(2) to include "any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders" (currently DSM-5).

2. 1374.72(a)(3): **Effective January 1, 2021**, plans must implement the definition of "medically necessary treatment of a mental health or substance use disorder" described in this subdivision.

3. **Effective January 1, 2021**, plans must ensure services outlined in section 1374.72(a) are available in-network within geographic and timely access standards and should review policies and procedures to ensure the plan will arrange for out-of-network services when necessary, pursuant to section 1374.72(d).

D. Section 1374.721 Compliance Requirements

1. Section 1374.721(b): **Effective January 1, 2021**, in conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, pursuant to this section, plans must apply criteria and guidelines set forth in the "most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty."

2. The Department compiled a list of the most recent versions of treatment criteria and clinical guidelines developed by nonprofit professional associations for the treatment of mental health and substance use disorders. (See Attachment A.)
   a. The Department acknowledges it may take time to finish incorporating these criteria into plan systems, policies and procedures, and training modules.
   b. As the criteria is integrated into plan systems, plans must utilize criteria and clinical guidelines outlined in Attachment A for utilization review in response to **any and all** relevant initial denials or modifications, prior to enrollee and/or provider notification, for coverage of services required under section 1374.72 beginning **January 1, 2021**. Plans will be expected to review any such denials or modifications to determine whether the requested service would be approved under SB 855 criteria. This includes implementation of definitions included in section 1374.721(f).

3. Pursuant to section 1374.721(e), plans must ensure proper use of Attachment A Criteria (section 1374.721(b)) (and any other section 1374.721(b) criteria approved for use by the Department) by sponsoring formal education programs by the nonprofit clinical specialty associations, distributed and made available as described in subdivision (e)(1), (2) and (3). Plans may develop these education programs separately or through a coordinated effort.

4. Plans shall submit as an Amendment filing all changes made in compliance with section 1374.721 to policies and procedures (Exhibit Js) no later than **March 1, 2021**, as described above in Section B.3. Provider and facility contracts (Exhibit K), plan-to-plan contracts (Exhibit P-5) and administrative service agreements (Exhibit N) should be submitted via eFiling in accordance with section 1352 and rule 1300.52, for approval by the Department.

5. Plans have asked whether it is permissible to continue to contract with entities that offer clinical criteria services. To the extent these entities implement and apply the clinical criteria required under section 1374.721 and identified in Attachment A, such contracts are consistent with the statute so long as the plan

demonstrates to the Department the contracted entity does not apply "different, additional, conflicting, or more restrictive utilization review criteria than criteria set forth" in section 1374.721(b). Amendments to contracts and scopes of work outlining the entities' use of compliant clinical criteria must be filed according to D.3 above. (See section 1374.721(d).)

a. Pursuant to section 1374.721(c), the plan may not use "different, additional, conflicting or more restrictive utilization review criteria to health care services and benefits for mental health and substance use disorders *unless* use of such criteria meets the requirements and circumstances enumerated in section 1374.721(c)(1) and (2).
b. Pursuant to section 1374.721(d), if a plan purchases or licenses criteria pursuant to (c)(1) and (2), the plan and its contracted entity must verify to the Department through submission of a Notice of Material Modification the criteria were developed pursuant to section 1371.721(a).

6. Interrater Reliability Testing: Plans shall develop and run interrater reliability reports pursuant to 1374.721(e)(5) to (7), with the plan being able to run initial reports no later than **July 1, 2021**.

E. Compliance and Filing Deadlines Roadmap

Activity	Type	Deadline	Exhibits Required
Compliance with section 1374.72	Expanded range of covered services per subdiv. (a)(2) Definition of Medical Necessity for MH/SUD services per subdiv. (a)(3)(A). All other requirements set forth in subdiv. (a) through (i)	January 1, 2021	NA
Compliance with section 1374.721	Application of Attachment A Criteria per subdiv. (b), as well as definition of UR in subdiv. (f)(3) to prior to	January 1, 2021	NA

Activity	Type	Deadline	Exhibits Required
	issuing any denial or modification of requested services.		
Filing: "Compliance with SB 855 Section 1374.72"	Amendment	On or before February 1, 2021	Exhibit E-1 • Describe actions the plan has taken to comply with SB 855. • Describe what documents need to be revised for consistency/compliance with SB 855 and a timeline for those revisions. • Affirm the plan has taken steps to offer the broader range of mental health/substance use disorder benefits required under section 1374.72. • Affirm the plan has taken steps to implement revised definition of "medical necessity" for purposes of mental health/substance use disorder determinations. Exhibit U or T: Include any errata the plan intends to issue to enrollees/subscribers.
Filing: "Compliance with SB 855 Section 1374.721"	Material Modification	On or before March 1, 2021	Exhibit E-1 • Provide roadmap of documents submitted • Describe implementation procedures • Affirm all new nonprofit professional association clinical criteria have been

Activity	Type	Deadline	Exhibits Required
			fully implemented into MH/SUD utilization review. • Affirm how the plan will comply/has complied with section 1374.721(e), education and training materials. The plan should affirm it has engaged with each of the nonprofit associations to sponsor a formal education program, provide timelines for implementation, and what plan staff is taking or will take the training. Affirm education and training materials will be made available to other stakeholders including providers and enrollees Exhibit N-1: File as ASAs any contracts with nonprofit professional associations
Filing: "Revised Policies and Procedures for Compliance with SB 855 Section 1374.72"	Amendment	On or before March 1, 2021	Exhibit E-1 • Provide a roadmap for proposed changes • Describe whether changes to each policy/procedure are related to section 1374.72 or 1374.721 or both. Exhibit J-9s, including for • Medical Necessity • Utilization Review
Filing: Plan documents such as EOCs, plan-to-plan	Amendment unless new contract with new delegated entity or per	Rolling These revised documents should be	Exhibit E-1 • In addition to other information relevant to the filing, be certain to describe

Activity	Type	Deadline	Exhibits Required
contracts and administrative services agreements	instructions for particular filing requirement	submitted in the regular course of business pursuant to section 1352 and DMHC guidelines such as the QHP Checklists and Off-Exchange Checklist.	any changes relevant to SB 855. • For Plan-to-Plan contracts amended to accommodate SB 855 requirements, make certain to describe the changes made relevant to SB 855, specify those portions of utilization review being handled by the delegated plan, and verify the delegated plan will be using the plan's revised SB 855 UR/UM criteria based on section 1374.721(b). Other exhibits/documents as necessary, including: Exhibit S, U or T (EOCs/Disclosure Forms) Exhibit P-5 (Plan-to-Plan Contracts) Exhibit N (Administrative Service Agreements, network leases, etc.)

If you have questions regarding the applicable timelines for filing or other questions about the requirements of this APL, please contact your plan's assigned reviewer in the DMHC's Office of Plan Licensing.

Attachment A
1374.721 Mental Health and Substance Use Disorder Criteria & Guidelines

Health & Safety Code section 1374.721(b) requires health care services plans conducting utilization review of covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders (MH/SUD) in children, adolescents, and adults to apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

The Department of Managed Health Care (Department), in conjunction with health plans, the California Department of Insurance, and various stakeholder groups, developed the following initial list (Attachment A Criteria) to promote consistency among health care service plans and delegated entity partners in delivering MH/SUD services. To the extent a plan utilizes criteria (or the most recent versions) identified in this Attachment A in the delivery of these services, the Department will consider this use a "safe harbor." In the event a plan elects to implement a nonprofit association criteria for conditions not specified below, the plan will be required to demonstrate to the Department the elected criteria meets the requirements of section 1374.721.

Level of Care Criteria

	Clinical Specialty	**Nonprofit Professional Association**	**Criteria or Guideline (Current Version)**
1.	Substance Use Disorder Any Age	American Society of Addiction Medicine (ASAM)	ASAM 3rd Edition 2013
2.	Mental Health Disorders Patients 18 and Older	American Association of Community Psychiatrists	Level of Care Utilization System (LOCUS) 20 2020
3.	Mental Health Disorders Patients 6 to 17 Years of Age	American Association of Community Psychiatrists Or American Academy of Child & Adolescent Psychiatry	Child and Adolescent Level of Care Utilization System (CALOCUS) 20* Or Child and Adolescent Service Intensity Instrument (CASII)* 2019

	Clinical Specialty	Nonprofit Professional Association	Criteria or Guideline (Current Version)
			*instruments in process of being merged into a single instrument.
4.	Mental Health Disorders Patients 0 to 5 Years of Age	American Academy of Child and Adolescent Psychiatry	Early Childhood Service Intensity Instrument (ESCII)

Clinical Practice Guidelines for Specific Diagnoses

	Clinical Specialty	Nonprofit Professional Association	Criteria or Guidelines (Current Version)
1.	Gender Dysphoria	World Professional Association for Transgender Health (WPATH)	WPATH Standards of Care Version 7 2012 Anticipated release of Version 8 in 2021