



January 27, 2023

Department of Managed Health Care

Office of Legal Services

Attn: Regulations Coordinator

980 Ninth Street, Suite 500

Sacramento, CA 95814

Via email <[regulations@dmhc.ca.gov](mailto:regulations@dmhc.ca.gov)>

**Re: Mental Health and Substance Use Disorder Coverage Requirements, Title 28, California Code of Regulations, Adopting Rules 1300.74.72, 1374.72.01 and 1300.74.721, Repealing Rule 1300.74.72, Control No. 2022-MHSUD.**

We appreciate the opportunity to comment on the Department of Managed Health Care's proposed regulations dated December 16, 2022 to implement Senate Bill 855 (Chapter 151, 2020). We are grateful for the Department's constructive engagement with us on numerous issues as regulations were drafted. The Department's proposed Rules lessen the possibility that health care service plans (health plans) will exploit ambiguities to inappropriately limit

enrollees' access to mental health and substance use disorder (MH/SUD) care. We provide our comments to protect enrollee rights and lessen their burden in obtaining medically necessary MH/SUD services.

Specifically, we request the Department make the following changes in the final Rules:

- Remove limitations on enrollees' right to arrange medically necessary treatment out of state after a health plan has failed to arrange coverage.
- Ensure crisis services, including those accessed through 988, are covered (1) without medical necessity reviews, (2) without prior authorization, (3) without regard to provider network status, and (4) subject only to only in-network cost sharing.
- Require individuals conducting utilization review to have appropriate qualifications.
- Correctly reference the appropriate subsection requiring health plans to limit enrollee cost sharing to in-network amounts in some instances.
- Strengthen language requiring health plans to bear the burden of demonstrating by clear and convincing evidence that ongoing MH/SUD services arranged out-of-network (due to network inadequacy) are interrupted only in accordance with generally accepted standards of care.
- Require health plans to communicate information regarding access to out-of-network services to all of the following: the enrollee, the enrollee's authorized representative, and the enrollee's provider.
- Require health plans to make utilization review criteria and education materials available to enrollees, their authorized representatives, and (in- and out-of-network) providers notwithstanding any claims about their "proprietary or confidential business" nature.
- Add yearly health plan reporting requirements on timely access and out-of-network referrals.
- Provide Department-produced materials to enrollees.
- Align definition of health care providers with statute.
- Adopt the California Department of Insurance's Geographic Access standards.
- Issue a Technical Assistance Guide upon adoption of final Rules.

With these changes incorporated, the Final Rules will help fully realize the promise of ensuring that Californians receive coverage for the MH/SUD services they need.

#### Arrange Out-of-Network Coverage (§1300.74.72)

Our organizations support most of the proposed requirements in §1300.74.72 relating to health plans' obligation to arrange out-of-network services when medically necessary services are not available within geographic and timely access standards. Particularly critical are (1) establishing specific timelines in which health plans must arrange out-of-network services and (2) providing enrollees the ability to arrange such care themselves when health plans fail to meet their obligations. Below we outline key requirements that we believe are necessary to ensure health

plans meet their statutory obligations. We request three changes to §1300.74.72. For two of these changes, we believe the proposed text is likely not what the Department intends. For the final requested change in this Rule – relating to enrollees’ ability to secure out-of-network medically necessary treatment only in California – we strongly oppose the proposed language and believe the current proposed language lacks a statutory basis.

**Require health plans to initiate the arrangement of out-of-network services.** We strongly support the requirements in subdivision (b) requiring health plans – not enrollees – to initiate the process of arranging out-of-network treatment when medically necessary services are not available in-network within geographic or timely access standards. These requirements are essential to ensuring that enrollees receive medically necessary treatment on a timely basis. When enrollees request in-network services, the Department correctly obligates health plans to initially determine whether their network providers can deliver the requested services within timely and geographic access standards. If appropriate network providers cannot render medically necessary treatment within these standards, health plans have all the information they need to start the process of arranging out-of-network care. Without requiring this of health plans, the burden to initiate out-of-network care will fall on enrollees and their families, who often do not know their rights and are not well-positioned to navigate a complicated system while simultaneously confronting MH/SUD challenges. We urge the Department to maintain these requirements.

Our first requested change is small, but very important. In (b)(3), health plans must communicate enumerated information “in the most expeditious manner possible to the enrollee, the enrollee’s authorized representative, *or* the enrollee’s provider” (emphasis added). The “or” creates ambiguity concerning who will receive this critical information relating to appointments/admissions and will likely result in communication gaps that adversely affect enrollees. We strongly urge the Department to change “or” to “and”. Doing so will ensure that enrollees, their authorized representatives (selected by enrollees to help them navigate complicated systems), and the provider receive this critical information. Indeed, it would be inexplicable to allow health plans to meet the technical requirements of the Rule by providing appointment / admission information (i.e., name of the provider, date/time, and location/contact information) *to the same (out-of-network) provider*, rather than to enrollees and their authorized representatives, who cannot receive the services they need without this essential information. Such a requirement could paradoxically result in enrollees and their authorized representatives never being informed of appointments / admissions and the Department being unable to hold health plans accountable.

*Suggested language in (b)(3): “(3) Within 24 hours of scheduling the appointment or admission, the health plan shall communicate the following information in the most expeditious manner possible to the enrollee, the enrollee’s authorized representative, ~~or~~ **and** the enrollee’s provider...”*

**Require health plans to issue written authorizations when geographic and timely access standards are not met.** But for one significant change, we strongly support the proposed

requirements in subdivision (b)(1) requiring health plans to issue written authorizations that include provider names, service authorization numbers, services authorized, negotiated reimbursement rate(s), date ranges for the authorizations, the health plans' contact and claims submission information, and the health plans' provider dispute resolution process. However, we believe the Department must clarify that negotiated reimbursement rates ***must be agreed to in writing by the provider(s)***, and therefore we request the following change:

*Suggested language in (b)(3):* "Within three (3) business days of when the health plan contacts the selected provider, the health plan shall furnish a written authorization specifying, at a minimum, the following: (a) provider name; (b) service authorization number; (c) services authorized; (d) negotiated reimbursement rate(s) **that have been agreed to in writing by the provider(s)**; (e) date range for the authorization; (f) the health plan's contact and claims submission information; and (g) the health plan's provider dispute resolution information.

In the absence of negotiated rates reduced to writing, health plans routinely authorize out-of-network services due to network inadequacy and subsequently pay non-negotiated amounts, leaving enrollees financially liable for unreimbursed charges that exceed their in-network cost shares. We are aware of numerous enrollee complaints to and findings by DMHC of health plans engaging in this unlawful practice. We strongly believe that, if rates are not agreed to ***in writing*** before treatment commences, health plans will attempt to subject out-of-network providers to unacceptable reimbursements after services have been rendered, including by falsifying provider ascent to rates that have not been agreed to. This all too frequent scenario would dissuade out-of-network providers from ever treating enrollees who cannot receive timely and/or geographically accessible MH/SUD care from network providers and will undermine the ability of enrollees to access the MH/SUD services to which they are entitled under SB 855. Thus, by requiring health plans to secure ***written*** provider agreements to negotiated rates—which can easily be obtained through electronic means like DocuSign—the Department could spare all stakeholders, including itself, significant turmoil resulting from unilateral authorizations that lack verifiable proof of provider ascent (at least to reimbursement rates).

**Clarity on inpatient setting including residential levels of care.** We strongly support the proposed language from the Department that makes it clear that residential settings are included under the umbrella of "inpatient settings" in (b)(2). Such clarity helps ensure residential levels of care are included in these important protections.

**Clear timelines for urgent and non-urgent requests.** We are also pleased to see clearly specified timelines under which health plans must arrange coverage, with earlier timeframes for urgent care. The timeframes for both non-urgent and urgent care outlined in (b)(2) are wholly appropriate and are consistent with Health and Safety Code (HSC) requirements.

**Limit cost-sharing for out-of-network care arranged by enrollees.** We strongly support the proposed language limiting enrollee cost sharing for out-of-network services and the obligation

of health plans to inform enrollees in writing of their financial obligations to out-of-network providers in both (b) and (c). This language is critical to ensuring that health plans fully reimburse out-of-network MH/SUD providers for medically necessary MH/SUD treatment that health plans fail to ensure are available in-network within geographic and/or timely access standards.

However, we ask for one important change to correct what we believe is a clear error in the proposed regulation. This apparent error could allow health plans to argue (though, the statutory language would not support this) that the law does not require them to limit an enrollee's cost sharing to the in-network amount in some instances. Specifically, the language in (c)(2) as proposed says:

“If the enrollee receives MH/SUD services pursuant to **this subsection (b)** from an out-of-network provider, the health plan shall reimburse all claims from the provider(s) for MH/SUD service(s) delivered to the enrollee by the provider(s), and shall ensure the enrollee pays no more than the same cost sharing that the enrollee would pay for the MH/SUD services if the services had been delivered by an in-network provider, pursuant to Health and Safety Code section 1374.72(d).” (emphasis added)

We strongly believe this reference to “this subsection (b)” should instead refer to subdivision (c), and given the reference to “this subsection” in the proposed text, we believe the reference to (b) instead of (c) may indeed be an error.<sup>1</sup> Subdivision (b) relates to when health plans arrange for out-of-network services themselves and contains a provision in (b)(6) that clearly limits enrollee cost-sharing to the in-network amounts in accordance with HSC 1374.72(d). It does not make sense for the reference in subdivision (c), which relates to when enrollees are forced to arrange out-of-network care themselves because their health plans have failed to arrange care according to the requirements of subdivision (b), to reference services the enrollees received pursuant to subdivision (b), where their health plans have arranged care. Such a reference leaves care arranged pursuant to subdivision (c) without any apparent regulatory protection limiting cost-sharing to the in-network amount. (Though, again, the statutory requirement of Section 1374.72(d) is clear.) To remedy this issue, we call on the Department to change “subsection (b)” to “subdivision (c)” in the text copied above.

**Do not limit enrollees' right to arrange medically necessary treatment out of state after a health plan has failed to arrange coverage.** In (c)(1), we are deeply concerned about a limitation the Department is placing on enrollees' right to secure medically necessary out-of-network treatment on their own when a health plan fails to arrange such coverage when in-network services are not available within geographic or timely access standards. Specifically, the enrollee, enrollee's representative, or the enrollee's provider may “arrange for the enrollee to obtain care from any appropriately licensed provider(s) *in California...*” (emphasis added).

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<sup>1</sup> We note that the Department is inconsistent when referring to “subdivision” and “subsection” in the proposed Rules and appears to use them interchangeably. We believe the references to “subsection” should be changed to “subdivision” throughout the Rules for consistency and clarity.

Under the circumstances in which subdivision (c)'s protections are triggered (due to a health plan's failure to arrange medically necessary MH/SUD services within geographic and/or timely access standards), a health plan may no longer limit coverage to a geographic area under Section 1374.72(f)(2). This is because the ability of a health plan to limit coverage to a geographic area is only allowed if "all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards." Therefore, the Department should make clear in subdivision (c) that an enrollee may arrange care with an out-of-state provider—particularly since not all medically necessary MH/SUD services may be available in California.

*To be clear, we strongly believe there is no statutory basis for limiting enrollees' right to secure care in (c)(1) to providers only located in California.* When a health plan fails to meet its contractual obligations to provide or arrange care, it forfeits control over the location of the provider chosen by the enrollee. The statute does not limit health plans' obligations to secure care within California. Under the proposed language, if health plans cannot secure care in state and enrollees are forced to go out-of-state to find out-of-network providers for medically necessary MH/SUD treatment, health plans are relieved from their clear obligations under SB 855 to cover all medically necessary MH/SUD treatment. We strongly believe this language is contrary to the statute and, therefore, puts Californians at risk by impairing their right to arrange medically necessary services out-of-network and, if need be, out-of-state.

*Suggested language in (c)(1): "The enrollee, enrollee's representative, or the enrollee's provider acting on the enrollee's behalf may arrange for the enrollee to obtain care from any appropriately licensed provider(s) ~~in California~~, regardless of whether the provider contracts with the health plan..."*

**Retain enrollees' right to secure their own care.** Notwithstanding the apparently errant reference to subdivision (b) in (c)(2) and the geographic limitation in (c)(1) that we believe is not supported by the statute, we endorse the Department's proposed requirements in (c)(1) that allow enrollees, their authorized representatives, or providers acting on enrollees' behalf to arrange out-of-network services at in-network cost sharing upon expiration of the time period specified in the standards. It is health plans' responsibility to arrange out-of-network coverage when medically necessary treatment is not available within geographic or timely access standards. When health plans fail to do so, enrollees should have the right to arrange care themselves without delay or financial repercussions.

**Allow enrollees to schedule appointments/admissions beyond 90 days when not available within 90 calendar days.** Our organizations strongly support the 90-calendar-day timeframe for enrollees to arrange out-of-network care when their health plans fail to arrange such care. Ninety days is an appropriate standard, and the Department should not consider timeframes less than 90 days. Unfortunately, medically necessary MH/SUD services are sometimes not available within 90 days. In instances when appointments/admissions cannot occur within 90 days, enrollees should not be penalized. We support the proposed language that specified, if appointments/admissions are not available within 90 days, then enrollees may arrange

appointments/admissions for the earliest possible date outside the 90-day window so long as the appointments/admissions are confirmed within 90 days. This will prevent undermining access due to the lack of immediately available appointments/admissions.

**Require reimbursement for an entire course of treatment.** Our organizations strongly support the Department’s inclusion of language in (d) requiring that health plans not interrupt, in a manner inconsistent with generally accepted standards of care, ongoing medically necessary MH/SUD services, that have been arranged out-of-network due to in-network care not being available within geographic and timely access standards at the time MH/SUD services were initially sought.

HSC Section 1374.72(d) specifies that health plans must “arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow up services...” We support the proposed language, which makes clear that “follow up services” include an entire course of medically necessary treatment and that health plans may not interrupt such a course of treatment based on the subsequent availability of an in-network provider if such an interruption would not be consistent with generally accepted standards of care or if the newly identified network provider is not available within geographic or timely access standards. We also strongly support the due process required of health plans in the event of proposed treatment interruptions, including the advance notice to enrollees of at least 90 days.

The proposed language is critical because SB 855 promises enrollees access to medically necessary treatment initial and follow up care across the MH/SUD treatment continuum, and defines “medically necessary treatment” in Section 1374.72(a) as being consistent with “generally accepted standards of mental health and substance use disorder care” and “not primarily for the economic benefit of the health care service plan[s].” Furthermore, Section 1374.721(f)(3) requires that all medical necessity determinations, including those concerning transitions of care, must be consistent with generally accepted standards of care. Because health plans may not make medical necessity determinations, including with respect to transition of care, that are primarily for their economic benefit, health plans should indeed be required to demonstrate that requiring transitions to in-network providers is within the standard of care for enrollees’ MH/SUD conditions at the time of any proposed transitions. This should, by definition, be a difficult standard for health plans to meet since generally accepted standards of MH/SUD care disfavor preventable treatment interruptions in virtually all cases.

While we support the proposed language in (d), it could be strengthened by requiring health plans to bear the burden of demonstrating by clear and convincing evidence that that these conditions have been met. Placing the burden on health plans to demonstrate satisfaction of the enumerated conditions should reduce the likelihood that financial incentives will cause health plans to disrupt ongoing treatment when doing so could be inconsistent with generally accepted standards of care, and therefore harmful.

*Suggested language in (d):* “If out-of-network coverage is arranged pursuant to subdivision (b) or (c) of this Rule, the plan shall reimburse the provider for the entire course of medically necessary services to treat the enrollee’s MH/SUD, including follow up MH/SUD services in accordance with Section 1374.72(d), unless there is an in-network, timely and geographically accessible provider and all of the following criteria are satisfied: **the plan shall bear the burden of proof by clear and convincing evidence that** the provider can deliver the MH/SUD services to the enrollee, requiring the enrollee to switch to the in-network provider would not harm the enrollee, and switching providers is within the standard of care for the enrollee’s MH/SUD condition at the time of the transition.”

**Ensure coverage for services regardless of contracting and third-party delegation.** We support the Department’s proposed requirements that medical necessity and utilization review requirements apply regardless of contracting and delegation arrangements. We agree with the Department’s view, as expressed in subdivision (e), that health plans are responsible for ensuring that medical necessity determinations and utilization reviews are conducted in accordance with this Rule and Rule 1300.74.721 and believe the proposed language clearly implements the stated requirements as outlined in HSC Section 1374.721 (h). It is important that health plans understand that they are not released from their obligations with respect to medical necessity determinations and utilization review just because they may not be directly engaged in these processes.

**Require coverage of full range of levels of care.** Our organizations support the proposed language in subdivision (f) requiring health plans to cover the full range of the levels of care and prohibiting health plans from limiting coverage to short-term or acute care. Health plans have historically limited coverage to short-term or acute treatment to alleviate enrollees’ current symptoms and denied coverage for services needed to treat enrollees’ oftentimes chronic conditions. Such limitations on care have resulted in enrollees frequently relapsing because their underlying conditions have never been effectively treated. The proposed language is consistent with the statutory language in HSC section 1374.72(a)(6).

**Add reporting requirements to track compliance.** To ensure that compliance with this Rule can be measured, we urge the Department to add reporting requirements. This will regularly provide the Department with important information. Without regular data collection, we fear the Department will be severely hindered in identifying compliance issues and will be overly reliant on enrollee complaints, placing the burden of surveillance on enrollees and their families, who are frequently enduring significant MH/SUD crises, to fight for the care to which they are entitled.

*Suggested language (inserted after current (h)):* **“(i) On March 31 of each year, health plans shall submit to the DMHC a timely access and out-of-network referral report that includes information related to network access for MH/SUD treatment and compliance rates for the previous calendar year. This information shall include data on the timeliness, type, duration, and frequency of diagnostic, treatment, and other**



**appointments/admissions as well as the diagnosis(es) associated with each appointment/admission and the number and location of appointments/admissions delivered by out-of-network providers. Health plans also must include MH/SUD in the timely access and network adequacy grievance report and in an out-of-network payment report, as applicable.”**

#### Scope of Required Benefits (§1300.74.72.01)

We deeply appreciate the Department’s efforts to detail the myriad types of services and levels of care that fall under the scope of the coverage requirements of Section 1374.72(a). This specificity provides urgently needed clarity on many services that health plans continue to deny but that fall within SB 855’s requirements. We strongly support the Department’s attempt to provide detailed examples of types of required coverage, when medically necessary for enrollees. However, we strongly urge the Department to add additional detail on coverage requirements for behavioral health crisis services to ensure that health plans are covering these life-saving services properly.

**List service coverage requirements.** We are particularly grateful that the Department has listed key evidence-based services, including coordinated specialty care (CSC) for the treatment of first episode psychosis, drug testing, gender dysphoria care, schoolsite services, and withdrawal management services – all of which are frequently not covered by health plans. For example, CSC is the evidence-based treatment modality for first episodes of psychosis and is almost never covered by health plans. Denials of this integrated, team-based care can result in an increase in the severity of psychotic conditions and degradation of quality of life for those experiencing early psychosis when medically necessary care can alter the trajectory of their lives. CSC is recommended by the American Psychiatric Association’s Practice Guideline for the Treatment of Patients with Schizophrenia<sup>2</sup> and has been identified as a key evidence-based intervention by CMS, the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA).<sup>3</sup> We believe listing these services will have a profound impact on the ability of enrollees to receive the coverage they need.

**List all ASAM levels of care.** We support the Department’s listing of required the levels of care that must be covered, including those described in The ASAM Criteria. Yet, we note that, while the proposed language includes inpatient services ((a)(8)(A)), residential treatment facility services ((a)(21)(D)), and withdrawal management services ((a)(24)), the Department does not specifically list ASAM Level 3.7 (Medically Monitored High-Intensity Inpatient Services), unlike other levels of The ASAM Criteria. Though we read the proposed language of (a)(8)(A) to encompass all inpatient levels of care described by the ASAM Criteria, we recommend that the

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<sup>2</sup> Practice Guideline for the Treatment of Patients with Schizophrenia, Third Edition, The American Psychiatric Association, <https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890424841>

<sup>3</sup> Joint Informational Bulletin: Coverage of Early Intervention Services for First Episode Psychosis, CMS, NIH, and SAMHSA, October 16, 2015. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf>

Department list both ASAM Level 3.7 (Medically Monitored High-Intensity Inpatient Services) and ASAM Level 4.0 (Medically Managed Intensive Inpatient Services) in (a)(8)(A). For withdrawal management (WM), the Department already lists both ASAM Level 3.7-WM and ASAM Level 4.0-WM in (a)(24), creating an apparent inconsistency in how the Department is listing ASAM inpatient levels of care (WM versus non-WM). Listing all the levels specifically will ensure help ensure complete clarity that both ASAM Levels 3.7 and 4.0 must be covered for both WM and non-WM.

**Ensure crisis services, including those accessed through 988, are appropriately covered.** Our organizations strongly urge the Department to include additional detail on health plans' obligation to cover behavioral health crisis services, which are emergency services that can occur both inside or outside facilities prior to enrollee stabilization. SB 855's coverage requirements in Section 1374.72 clearly apply to behavioral health crisis services – a fact made unambiguous by AB 988, which was recently enacted. While the Department's proposed language in (d)(2) references health plans' obligations to cover behavioral health crisis services, we request additional detail that describes services included under "behavioral health crisis services" and clearly prohibits health plans from covering behavioral health crisis services more restrictively than physical health emergency services.

The California Department of Insurance (CDI) has released draft regulations under SB 855 that include behavioral health crisis services. In its draft regulations, CDI includes provisions that ensure that CDI-regulated plans are covering crisis services (1) without medical necessity reviews, (2) without prior authorization, and (3) without regard to provider's network status, which limits enrollees to only in-network cost sharing. We strongly recommend the Department follow suit so that Californians enrolled in health plans subject to the HSC have the same protections as Californians enrolled in plans subject to the Insurance Code are likely to have. While we urge the Department to adopt CDI's robust draft language on behavioral health crisis services, we also believe it is possible for the Department to add language to its current proposed text to ensure behavioral health crisis services are covered at parity with other emergency health care services.

Therefore, we request that the Department make it unambiguous that emergency health care services include behavioral health crisis services and tie the definition of "behavioral health crisis services" to the definition of this term in HSC Section 1374.724.

*Suggested language in (d)(2):* Emergency health care services, **which include behavioral health crisis services**, that are furnished or delivered by, or under the direction of, a health care provider or facility acting within the scope of practice of the provider's or facility's license or certification under applicable state law, including by or at a licensed or certified health care provider or facility owned or operated by, employed by, or contracted with, a political subdivision to provide emergency health care services or behavioral health crisis services, regardless of whether the health plan is contracted with the health care provider, facility, or political subdivision to furnish emergency health care services or behavioral health crisis services to its enrollees. **"Behavioral**

**health crisis services” has the same meaning as that term is defined in Health and Safety Code section 1374.724.**

Furthermore, we request language to make clear that, consistent with health plans’ parity obligations under California and federal law, health plans must cover behavioral health crisis services under the same standards and no more restrictively than physical health emergency services.

*Suggested language to be added after (d)(2)):*

**“(d)(3) A health plan shall cover behavioral health crisis services no more restrictively and using the same coverage standards as it does for physical health emergency services, including but not limited to doing the following:**

**(A) Covering behavioral health crisis services in the same manner as emergency services and care pursuant to HSC 1371.4, including without prior authorization or regard for whether the provider furnishing such services is a participating provider; and**

**(B) Ensuring that the enrollee pays no more in cost-sharing that the enrollee would pay if the same services were provided by a participating provider.**

**(d)(4) For purposes of compliance with the Mental Health Parity and Addiction Equity Act of 2008, a health plan shall place behavioral health crisis services within the emergency classification of care in the same manner as physical health emergency services.”**

The Department should not wait to ensure proper coverage of behavioral health crisis services. While the currently proposed language will help ensure coverage of behavioral health crisis services, additional language is needed to ensure that health plans cover these services no more restrictively and using the same coverage standards as health plans must use for physical health emergency services. If the Department delays, health plans may well escape their responsibility to reimburse behavioral health crisis services for their enrollees, continuing to inappropriately cost-shift this expense to California taxpayers and to inhibit California from scaling up behavioral health crisis services to meet their rapidly increasing need. Ensuring health plans meet their responsibilities is particularly urgent given California’s ongoing efforts to build a robust behavioral health crisis system surrounding 988.

**Utilization Review Requirements (§1300.74.721)**

We strongly support most of the proposed provisions in the proposed Rule, including those relating to use of nonprofit professional association criteria and health plans responsibility to ensure compliance by contracted entities and delegates. Though, we urge the Department to require that any individual conducting utilization review for a health plan must be a clinical peer with appropriate training and experience in the nonprofit professional association criteria by the nonprofit professional association(s).

**Ensuring contracted entities and delegates follow requirements.** Our organizations support the language in subdivisions (a) and (g) requiring health plans to ensure that contracted entities or delegates conducting utilization review comply with the requirements of the Rule. Health plans must not be allowed to avoid compliance with these requirements simply by delegating medical necessity determinations and utilization reviews to third parties.

**Require exclusive use of nonprofit professional association criteria.** We strongly support the proposed language in (c), (d), (h), and (j) relating to the exclusive use of nonprofit professional association criteria for utilization review and level of care determinations within the scope of these criteria. The exclusive use of these criteria, unmodified, and used in the manner intended by the associations is essential to ensuring that enrollees receive the appropriate intensity and duration of services to meet their specific needs in a manner consistent with generally accepted standards of care. These requirements are entirely consistent with HSC Section 1374.721.

**Prohibit repeated utilization review inconsistent with nonprofit criteria.** We support the proposed language in subdivision (d) that prohibits health plans from conducting repeated utilization reviews at intervals more frequently than those prescribed or recommended by the relevant nonprofit professional association criteria. Such a requirement will help prevent burdensome utilization reviews that interfere with patient treatment, recovery, and coverage of medically necessary MH/SUD treatment.

**Demonstrate compliance of other criteria.** We support the proposed language in (e) and (f) that require health plans to provide detailed information about the use of other criteria that are used pursuant to SB 855's exceptions, including that such criteria must be consistent with generally accepted standards of care. The requirements are consistent with the statutory requirements of HSC Section 1374.721.

**Clarity on compliant criteria for level of care determinations.** We strongly support the Department's listing in subdivision (h) of the *age-appropriate* criteria compliant with HSC Section 1374.721 for utilization review determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge. While we believe it is implied given numerous references elsewhere to "the most recent versions" of the criteria, we urge the Department to add clarity in (h) that the most recent versions of the criteria must be used.

*Suggested language for (h): "Utilization review determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge that are within the scope **of the most recent version** of the following instruments shall be considered compliant with Health and Safety Code section 1374.721...."*

Ensuring clarity that the most recent version must be used is critical here and throughout the proposed Rules. HSC Section 1374.721(b) makes unambiguous that plans must use "the most recent versions" when conducting utilization review. This is particularly important given that ASAM has announced that it intends to release a 4<sup>th</sup> edition of The ASAM Criteria in the fourth

quarter of 2023.<sup>4</sup> Additionally, the recently released CALOCUS-CASII is the most recent version of criteria for level of care / service intensity determinations for children ages 6 to 18 with a primary mental health diagnosis.

**Require appropriate use of criteria for level of care determinations.** We strongly support the Department’s language in (i) that requires health plans to assign the higher score for any dimension of the ASAM Criteria and LOCUS family of criteria whenever there is ambiguity about the correct score. This is a generally accepted standard of care and is also required by the ASAM Criteria and LOCUS family of criteria. If health plans fail to do this, they will be making utilization review decisions contrary to generally accepted standards of mental health and substance use disorder care in violation of Section 1374.721(a).

**Require the full detail of criteria scoring.** Our organizations also support the requirement in subdivision (l) that health plans provide the full details of their scoring, as outlined in subdivision (l). Without this information, it is impossible for enrollees and providers to evaluate the health plans’ application of the criteria, to meaningfully challenge adverse benefit determinations, and to understand what level of care the plan believes would be appropriate for the enrollee. We appreciate the Department’s inclusion of what shall be included by written notification.

**Require individuals conducting utilization review to have appropriate qualifications.** We note that the Department’s proposed language does not include a requirement that individuals conducting utilization reviews for health plans must have the appropriate qualifications to conduct such reviews. Last legislative session, the legislature passed SB 999, which would have required individuals conducting utilization reviews to have the same qualifications as the requesting provider. In vetoing the bill, Governor Newsom pointed to the forthcoming SB 855 regulations as an opportunity to address this issue. Unfortunately, the Department has not done so. In contrast, CDI's draft regulations contain such language, indicating that this is within the Department’s purview. Therefore, we urge the Department to specify that individuals conducting utilization review must have the appropriate qualifications and the necessary training on the relevant nonprofit professional association criteria.

*Suggested language to be added after current subdivision (l): **Utilization review shall be made only by a licensed physician or other licensed health care provider who is competent to evaluate the specific clinical issues involved in the health care services under review. “Competent to evaluate the specific clinical issues involved in the health care services under review” means, at a minimum, that the provider is a clinical peer with appropriate training and relevant direct experience in the clinical specialty involved in the coverage determination.***

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<sup>4</sup> American Society of Addiction Medicine, “4<sup>th</sup> Edition Development,” <https://www.asam.org/asam-criteria/4th-edition-development>.

**Require an education program on criteria.** We support the Department’s requirement in subdivision (o) that health plans educate health plan staff, contracted and affiliated staff, and utilization reviewers on this Rule. Additionally, we support the requirement that individuals be trained on the relevant criteria *before* being allowed to conduct utilization reviews applying the criteria.

**Remove unjustified limitation on providing statutorily required information.** However, while we appreciate requirements that health plans make utilization review criteria and education materials available to enrollees, their authorized representatives, and the enrollees’ out-of-network providers in subdivision (o) – and notify them of their right to request such materials in subdivision (p) – ***we strongly oppose the unjustifiable restriction that limits this right when information is “proprietary or confidential business nature.” This limitation does not appear in HSC Section 1374.721, and we believe it is inconsistent with the requirements of the statute, California public policy, and federal law.***

*Suggested language in (o) and (p): “(o)(3) Pursuant to Health and Safety Code section 1374.721(e)(2), a health plan shall make any utilization review determination criteria and any education program materials ~~that are not of a proprietary or confidential business nature~~ available upon request to other stakeholders, including....”*

*“(p) A health plan shall notify the enrollee or the enrollee’s authorized representative, and the enrollee’s requesting out-of-network provider(s) that all utilization review determination criteria and any education program materials ~~that are not of a proprietary or confidential business nature~~ identified in paragraph (o) of this Rule shall be made available upon request at no cost...”*

The Department has appropriately cited HSC Section 1374.721(e)(2), which is where the underlying statutory requirement is located. Yet, this provision does not limit health plans’ obligation to provide this information to only information that is not deemed “proprietary or confidential business nature.” In fact, such a restriction on disclosure is contrary to California public policy, as reflected by HSC Section 1363.5(b)(5), which requires health plans to make **publicly** available “the criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services.” Additionally, federal guidance issued by the US Department of Labor clearly states that “The criteria for making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing the underlying NQTL and in applying it, must be disclosed with respect to both MH/SUD benefits and medical/surgical benefits, **regardless of any assertions as to the proprietary nature or commercial value of the information.**”<sup>5</sup> The DOL’s guidance is binding on all Knox-Keene Act plans that are also subject to ERISA. Thus, ***we strongly urge the***

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<sup>5</sup> FAQs about Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation, Q12, available at <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxix.pdf>

***Department to remove this unjustifiable language that will make it harder for many enrollees to access medically necessary treatment.***

**Provide Department-produced materials to enrollees.** We encourage the Department to add a requirement that health plans provide enrollees with copies of all Department-produced materials about their rights under Section 1374.72 and 1374.721. Such a requirement will help ensure that enrollees receive such information.

*Suggested language after current subdivision (q): **“A health plan shall provide all enrollees a copy of Department-produced materials that educate enrollees about their rights under Sections 1374.72 and 1374.721.”***

#### Align definition of health care providers with statute

Final regulations should reflect SB 855 as enacted, which clearly defines a “health care provider” in HSC Section 1374.72. Since the passage of SB 855, providers have reported claim denials when associates appropriately provided medically necessary services under existing law. Aligning the definition of health care provider with how it is defined in the HSC makes crystal clear that the use of associate providers is permitted under the statute.

#### Adopt Geographic Access Standards

To ensure appropriate MH/SUD care for Californians in health plans subject to the HSC, we call upon the Department to also adopt the Department of Insurance’s express geographic access standards in 10 C.C.R. § 2240.1. Without such explicit standards, enrollees’ right to geographically accessible care is demonstrably weakened. Our organizations believe it is inappropriate for Californians in health plans subject to the HSC to have much weaker rights to geographically accessible care than Californians enrolled in insurance plans subject to the Insurance Code simply because the Department, in contrast to CDI, has not adopted quantitative geographic access standards that are authorized by the HSC. The protections of SB 855 will be significantly strengthened if the Department adopts geographic access standards, which are clearly authorized by HSC Section 1366.1.

#### Issue Technical Assistance Guide

Upon adoption of final Rules, our organizations strongly encourage the Department to issue a Technical Assistance Guide that describes how it will monitor and measure compliance with SB 855 and details what information and data health plans must report to the Department. Without such detailed requirements, it will be difficult for the Department to fully enforce SB 855 and its implementing regulations.

## Train Department Staff

Finally, upon adoption of final Rules, we request the Department create and conduct regular trainings for Department attorneys and Help Center staff on SB 855's requirements, including relating to generally accepted standards of mental health and substance use disorder care, nonprofit profession association criteria, and health plans' obligations to arrange out-of-network services when in-network services are not available within geographic or timely access standards. Help Center staff, in particular, have a critical role to play in assisting consumers obtain the medically necessary treatment to which they are entitled under SB 855. Without comprehensive training for Help Center staff, Californians needing mental health or substance use disorder services will likely continue to be unlawfully denied medically necessary treatment when health plans are not appropriately held accountable for following SB 855's strong requirements.

Thank you for considering our comments and proposed changes to the proposed Rules. As always, our organizations stand ready to assist you in any way we can. If you have any questions, please contact David Lloyd or Lauren Finke ([david/lauren@thekennedyforum.org](mailto:david/lauren@thekennedyforum.org)). For matters requiring physical or printed communication, please send to 1121 L Street, Sacramento, California 95814 suite #300.

Sincerely,

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