HHSC: The Mental Health Condition and Substance Use Disorder Parity Workgroup, November 2nd, 2020

The Mental Health Condition and Substance Use Disorder Parity Workgroup was established by HB10. During the 2017 Texas Regular Legislative Session, lawmakers passed an important bill related to mental health parity (House Bill 10). The new law, signed by Governor Abbott, aims to address ongoing challenges with mental health and substance use disorder "parity" protections. The goal is for more insured Texans have equal access to both physical health care and care for mental health and substance use disorder needs. The new law took effect September 1, 2017, though full implementation will take more time.

In health care, "parity" describes the equal treatment of mental health conditions and substance use disorders by insurance plans, when compared to coverage for physical health care. When a plan has "parity" it means that health insurance coverage of mental health is equal to coverage for physical health. For example, if an insurer provides unlimited doctor visits for a condition like diabetes, then the insurer should also provide unlimited doctor's visits for mental health conditions like depression or schizophrenia. It is important to note that "parity" requires *equal* coverage, not necessarily *good* or *comprehensive* coverage.

The workgroup, which is a subcommittee of the Behavioral Health Advisory Committee, is established to increase the understanding of and compliance with state and federal rules, regulations and statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions and substance use disorders.

The workgroup is tasked with studying and making recommendations on:

- Increasing compliance with the rules, regulations and statutes described above.
- Strengthening enforcement and oversight of these laws at state and federal agencies.
- Improving the complaint process relating to potential violations of these laws for consumers and providers.
- Ensuring HHSC and Texas Department of Insurance can accept information on concerns relating to these laws and investigate potential violations based on de-identified information and data submitted to providers in addition to individual complaints.
- Increasing public and providers' education on these laws.

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Members include (from HHSC website. The listing may be incomplete):

Greg Hansch, Chair
National Alliance on Mental Illness Texas
Term ends: Sept. 1, 2021
Advocate

Diane J. Felder, M.D., Vice Chair
Magellan Health
Term ends: Sept. 1, 2021
Physician

Naomi Garcia Alvarez
Molina Healthcare of Texas
Term ends: Sept. 1, 2021
MCO

Bill Bailey
Cenikor Foundation
Term ends: Sept. 1, 2021
Family member

Joe A. Bedford, M.D.
United Healthcare
Term ends: Sept. 1, 2021
Commercial benefit plan

Christine Bryan
Clarity Child Guidance Center
Term ends: Sept. 1, 2021
Children

Luis Calo, M.D., MMM
United Healthcare
Term ends: Sept. 1, 2021
Utilization Review

Tracy Vilella Gartenmann
Recovery Brands, LLC
Term ends: Sept. 1, 2021
Family member

Meredith Stacy Jones
Bluebonnet Trails Community Services
Term ends: Sept. 1, 2021
Advocate

Kirk Kureska
Signature Behavioral Health Hospitals
Term ends: Sept. 1, 2021
Hospital

Sherri Layton, MBA, LCDC, CCS
La Hacienda Treatment Center
Term ends: Sept. 1, 2021
Provider

Debbie A. Mitchell
Starcare Specialty Health Services
Term ends: Sept. 1, 2021
Consumer

Andrea Ramirez
Project Amistad
Term ends: Sept. 1, 2021
Provider

Deborah Rosales-Elkins
National Alliance on Mental Illness Texas
Term ends: Sept. 1, 2021
Consumer

Alba Villegas
The Harris Center for Mental Health and Intellectual and Development Disabilities
Term ends: Sept. 1, 2021
Provider

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1. Welcome and opening remarks. Mr. Hansch convened the 16th Workgroup meeting. Agenda item 4.d. is tabled for another meeting. The plan is not ready to be voted on. A quorum was established. The workgroup sunsets in September of 2021.

2. Review and approve September 2, 2020, meeting minutes. The minutes were approved as written.

3. State agency updates

Medicaid and Children's Health Insurance Program. (Daphney Augustin) The past half century, there has been an increase in outpatient and residential care and federal and state governments are moving toward community-based settings prompted by both the Olmstead decision and Americans with Disabilities Act. SB 1177 86th Legislature, Regular Session, 2019 stated in part that "…a contract described by that subsection must contain language permitting a managed care organization to offer medically appropriate, cost-effective, evidence-based services from a list approved by the state Medicaid managed care advisory committee..."

In-Lieu-Of Services Must be:

- Medically appropriate, cost-effective, evidence-based
- Offered "instead of" an existing Medicaid Service
- Able to be reported via MCO encounter data
- Unique procedure code
- Distinct from existing Medicaid services
- Must be a service and not a program or modality

The MCO may provide services in the following HHSC-approved settings in lieu of covered settings:

- The MCO may provide inpatient services for acute psychiatric conditions in a freestanding psychiatric hospital in lieu of an acute care inpatient hospital setting for Members age 21-64
- The MCO may provide substance use disorder treatment in a chemical dependency treatment facility in lieu of an acute care inpatient hospital

Project Overview

- Receive recommendations
- Review data from Medicaid Evidence Based Decisions (MED) Project
- Review for cost-effectiveness and evidence-base
- Propose managed care contract amendments
- Annual legislative report

Phase 1 Considerations --Services in-lieu-of inpatient hospitalization

- Coordinated Specialty Care (CSC)
- Crisis Respite

- Crisis Stabilization Units
- Extended Observation Units
- Partial Hospitalization
- Intensive Outpatient Program

Phase 2 Considerations-- Services in-lieu-of outpatient services

- Cognitive Rehabilitation
- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)

Other Considerations-- Requires further consideration

- Collaborative Care Model
- Integrated Pain Management Day Program*
- Health & Behavior Assessment & Intervention*
- Systemic, Therapeutic, Assessment, Resources, and Treatment (START)
- Treatment/Therapeutic Foster Care
- Mobile Crisis Outreach Team (MCOT)

* Current State Plan benefits for ages 0-20

Next Steps

- Execute Phase 1 contract amendments (March 2021)
- Complete cost-effectiveness analysis for Phase 2 (2022)
- Develop contract amendments for Phase 2
- Continue researching other services

Office of the Ombudsman. April Hunter and Julie Palmer. They have been working with TDI on parity cases. The case was brought by a provider on behalf of a client. There is a position posted for a parity staff member.

Posters are available online at no charge on parity-related issues.

Texas Department of Insurance. TDI can help with mental health parity questions and complaints from consumers, advocates, health care providers, and the HHSC Behavioral Health Ombudsman. TDI has a toll-free Help Line (1-800-252-3439) to help callers with insurance questions. Complaints are handled through a formal complaint resolution process and TDI has an informal health care escalation process. The call capture rate is 95-98% and calls are answered with 30 seconds.

Complaint Process:

- TDI accepts complaints online or by email.
- Staff review complaints to see if they involve health plans that TDI regulates. If they do, staff ask the plan why they settled a claim the way they did.
- Staff review the plan's response and the information in the complaint to determine whether the complaint is "confirmed."

- A complaint is confirmed if the plan violated state insurance laws or rules, a federal requirement TDI has authority to enforce, or the terms or conditions of an insurance policy or certificate.
- A complaint is also confirmed if the complaint and the plan's response suggest that the plan was in error or that the complainant had a valid reason for the complaint.
- If staff find potential violations of laws or rules, staff can refer the complaint to TDI's Enforcement Division.
- Staff also work with the health plan and the complainant to help find solutions to problems.
- Staff provide the complainant with a copy of the plan's response and the resolution of the complaint. Staff may also give the complainant information about community programs or other ways to get help.

Informal Health Care Escalation Process:

- When a consumer has an issue with access to benefits for critical care or life-saving services (including behavioral health services) staff send the complainant's information to the Life Accident & Health manager to handle directly.
- TDI staff will need to identify the type of coverage (individual or group and PPO, HMO, EPO).
- The manager, team lead, or auditor will contact the plan directly and ask them to address the issue, communicate with the consumer, and report back to TDI.
- This kind of intervention often solves the problem without the consumer needing to file a formal complaint.

Mental health parity complaints						
	2016	**2017**	**2018**	**2019**	**2020**	**Total**
Complaints	77	66	54	32	64	433
Confirmed complaints	12	10	9	4	16	79
All health complaints	14,783	14,690	18,955	11,686	8,290	106,254
Mental health parity complaints	0.52%	0.45%	0.28%	0.27%	0.57%	0.41%

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TDI's Role:

- TDI can only help with complaints against health plans it regulates.
- TDI does not regulate self-funded plans (health plans offered by large employers).
- TDI can accept a complaint submitted by a Provider on behalf of their client.
- If TDI gets a complaint against a health plan it doesn't regulate, staff will contact the complainant and connect them with the regulatory entity that can help.

TDI Suggestions:

- Allow TDI's complaint process to work for you by using the complaint portal.
- The COVID-19 pandemic has heightened the use of technology and security measures.
- Certain protocols have been put in place to protect the technological integrity of the agency.
- If a file attachment is too large or has confidential information (such as Social Security and drivers license numbers) TDI's firewall will remove the attachment.
- Using the complaint portal minimizes the risk of documents attached to the complaint being deleted.
- A family member or friend can submit a complaint on behalf of the policyholder.
- The TDI website has accessible features.
- To submit a complaint through the TDI complaint portal, visit tdi.texas.gov.

Need help with an insurance question? Call our Help Line at 1-800-252-3439. Monday through Friday, 8 a.m. to 5 p.m. Central time.

Questions/Answers/Comments

How are you determining that it is a true parity complaint? Staff stated that there are 30-50 key words that they use to indicate a parity complaint.

How many have been resolved? Staff stated that data is available. How the complaint was resolved— you would have to file an open records request.

We may be getting more mental health complaints and they may not be related to parity. We need a breakdown of which ones are actual parity complaints.

We need education around what parity is and how to file a complaint

When we look at all the health complaints, it could be more than the 64 reported because they may not be using the key words. Staff stated that we need for complaints to be formal so the complaint gets to TDI.

Rachel Bowden continued with the presentation. TDI is working toward getting the parity rule published. It will be a fine-tuning of the informal comment process. (See Texas Insight Report on TDI stakeholder meeting.) The Department of Labor guide has been published and they are working to incorporate those issues.

DOL Final Guide. The DOL has finalized the biennial update of its self-compliance tool designed to help employers comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). The 2020 update integrates recent MHPAEA guidance and includes revised compliance examples, best practices for establishing an internal compliance plan, and "warning signs" that may indicate potential violations. The update is similar to the proposed version released in June 2020 (see our Checkpoint **article**) but includes "minor modifications and clarifications" based on public comments. Here are highlights of those modifications:

- *Provider Reimbursement Rates.* The final update includes an additional warning sign that may be indicative of MHPAEA noncompliance—the consideration of different sets of factors to establish provider reimbursement rates. As an example, a plan that considers market dynamics, supply and demand, and geographic location to set reimbursement rates for medical/surgical benefits might violate the parity rules if it considers only quality measures and treatment outcomes in setting reimbursement rates for mental health/substance use disorder (MH/SUD) benefits. A revised note clarifies that the MHPAEA's requirements for nonquantitative treatment limitations (NQTLs) apply to methods for establishing both in-network and out-of-network provider reimbursement rates. And Appendix II (which includes a tool for comparing a plan's reimbursement schedule to Medicare rates) now explains that comparing a plan's average reimbursement rates for both medical/surgical and MH/SUD providers with an external benchmark of reimbursement rates, such as Medicare, may help identify whether the underlying methodology used to determine the plan's reimbursement rates warrants additional review for MHPAEA compliance.
- *Internal Compliance Plans.* The final update continues to emphasize that internal compliance plans, while not required by the MHPAEA, promote the prevention, detection, and resolution of potential parity violations and can help plans comply with the law. Characteristics of successful internal compliance plans are listed, including training and education, records retention, internal monitoring, and compliance review. The final update adds that plans that delegate benefits management to other entities should ensure that service providers for both medical/surgical and MH/SUD benefits provide documentation necessary for the plan to ensure compliance. It also reminds plans of the importance of maintaining any documentation that may be prepared for compliance with applicable state law reporting requirements.
- *NQTLs.* The compliance tool devotes significant attention to NQTLs—treatment limitations that are not expressed numerically—and provides as one example standards for provider admission to participate in a network. The final update notes that a plan network that includes far fewer MH/SUD providers than medical/surgical providers is a red flag that the plan may be imposing an impermissible NQTL. The final update also includes a new note addressing residential treatment limitations. If a plan classifies covered intermediate levels of care, such as skilled nursing care and

residential treatment, as inpatient benefits, and covers room and board for all inpatient medical surgical care but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction only on MH/SUD benefits. The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment.

4. The State of Parity presentation by David Lloyd, Senior Policy Advisor, Kennedy Forum

The Mental Health Parity and Addiction Equity Act (MHPAEA)

- Signed into law by President Bush in 2008 (sponsored by former Congressman Patrick Kennedy, founder of The Kennedy Forum)
- Insurance plans don't have to cover behavioral health treatment, but if they do, it must be comparable to other coverage of other medical treatment
- With ACA's essential health benefits, nearly all plans must offer mental health and addiction coverage, therefore they must comply with parity (primary exception is Medicare)

Broadly plans cannot:
1. Charge higher co-payments or other out-of-pocket expenses for behavioral health than for physical health. ("Financial Requirements")
2. Limit more stringently the number of visits or days for behavioral health services than they do for physical health. ("Quantitative Limitations")
3. Use more restrictive managed care practices for behavioral health than for physical health. ("Non-Quantitative Treatment Limitations" – NQTLs)

Parity must occur within each of six separate classifications of care: inpatient (in/out-of-network), outpatient (in/out-of-network), emergency, and prescription drugs. Both as written and as applied.

Violations most likely for managed care practices (NQTLs), where applied more stringently to behavioral health coverage:

- More frequent and burdensome prior authorization requirements
- More frequent concurrent reviews to see if care is "medically necessary"
- More frequent fail-first protocols
- Stricter medical necessary criteria for behavioral health
- Stricter network admission criteria for behavioral health providers
- Formulary design that has behavioral health drugs on higher tiers
- Many others…

Highlights from 2019 Milliman Report

National Out-of-Network Disparities Growing Since Last Report

FIGURE 2: OUT-OF-NETWORK UTILIZATION RATES FOR PPO PLANS BY CARE SETTING AND YEAR

	INPATIENT FACILITY			OUTPATIENT FACILITY		
YEAR	MEDICAL/ SURGICAL	BEHAVIORAL	HIGHER PROPORTION OF BEHAVIORAL OUT-OF-NETWORK CARE	MEDICAL/ SURGICAL	BEHAVIORAL	HIGHER PROPORTION OF BEHAVIORAL OUT-OF-NETWORK CARE
2013	3.4%	9.6%	2.8x	5.3%	15.6%	3.0x
2014	3.9%	11.0%	2.8x	5.4%	21.8%	4.0x
2015*	4.2%	16.1%	3.8x	5.8%	29.4%	5.1x
2016	3.4%	16.3%	4.8x	4.6%	28.1%	6.1x
2017*	3.3%	17.2%	5.2x	4.8%	27.6%	5.7x

	OFFICE VISITS				
YEAR	PRIMARY CARE	SPECIALISTS	BEHAVIORAL	COMPARED TO PRIMARY CARE	COMPARED TO SPECIALISTS
2013	3.8%	5.1%	19.0%	5.0x	3.7x
2014	4.0%	5.1%	19.1%	4.8x	3.7x
2015*	3.7%	5.2%	18.9%	5.1x	3.6x
2016	3.1%	4.3%	17.9%	5.9x	4.2x
2017*	3.2%	4.3%	17.2%	5.4x	4.0x

- Texas disparities a bit worse than national average.

[Follow this link to see the full Milliman Report]

MH and SUD Spending Very Low

FIGURE 9: DISTRIBUTION OF COSTS BETWEEN BEHAVIORAL HEALTH AND MEDICAL/SURGICAL CARE FOR PPO PLANS

	PERCENTAGE OF TOTAL HEALTHCARE COSTS				
YEAR	MENTAL HEALTH (ONLY)	SUBSTANCE USE DISORDERS (ONLY)	TOTAL BEHAVIORAL HEALTH	MEDICAL/SURGICAL	TOTAL (BEHAVIORAL & MEDICAL/SURGICAL)
TOTAL HEALTHCARE COSTS					
2013	4.4%	0.7%	5.1%	94.9%	100%
2014	4.4%	0.9%	5.3%	94.7%	100%
2015*	4.5%	1.1%	5.6%	94.4%	100%
2016	4.3%	0.9%	5.3%	94.7%	100%
2017*	4.3%	1.0%	5.2%	94.8%	100%

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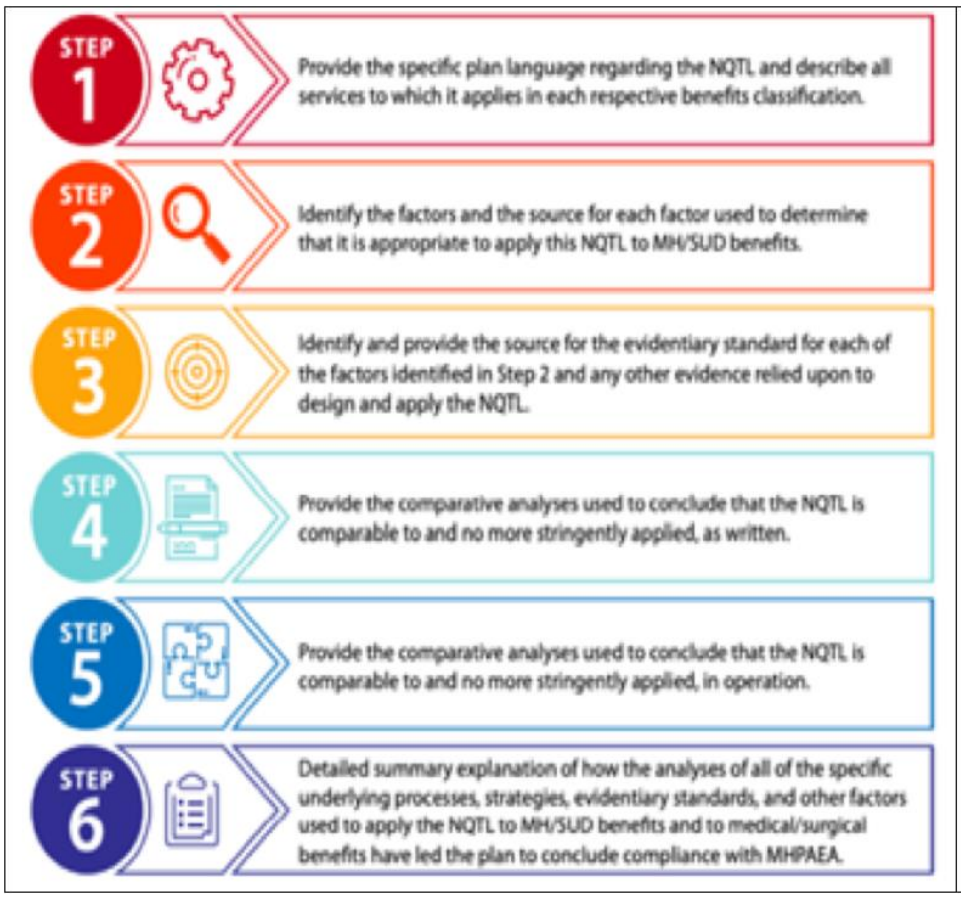
A group health plan (or health insurance coverage) may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

Measures Compliance with Each Component of NQTL Rule



Similar to steps in U.S. Dept. of Labor's MHPAEA Self-Compliance Tool

12 states now have enacted these requirements into statute (AZ, CO, CT, DC, DE, IL, IN, MD, NJ, OK, TN, WV)

Other state regulators are doing without legislation (e.g. Louisiana)

Failure to test each component of rule can lead to illusion of compliance

If Adopted, the TDI Rule Would Follow National Best Practices

- "Quantitative Parity" Spreadsheet – Excellent. Should be adopted.
    - Federal Parity Act's requirements on Quantitative Treatment Limitations and Financial Requirements are very explicit and requires calculations

    - Spreadsheet captures all essential information necessary to determine compliance. Avoids duplicative and time-consuming work of evaluating and validating variety of tools developed internally by insurers.
- "Nonquantitative Parity" Spreadsheet – Excellent. Should be adopted. o Is the best practice being adopted by wide range of states. It has the necessary specificity to test all aspects of the federal NQTL parity rule
- Parity violations are not inconveniences – they can result in bankruptcy, deterioration of health, disability, unemployment, homelessness, and even death
- Identifying violations after-the-fact in market conducts exams is not enough. Must work to proactively ensure MH/SUD care is properly covered

Other Suggestions:

- Require Parity Compliance Programs
    - Essentially impossible for plans to be in compliance without formal parity compliance program
    - New York State now requiring formal parity compliance programs
- Ensure Disclosures Are Made
    - Federal law requires plans to provide parity compliance analysis, medical necessity criteria (for both MH/SUD and med/surg) upon request
    - Plans frequently do not provide requested information as provided by law
- Follow Generally Accepted Standards of Care
    - Insurers should be explicitly required to follow Generally Accepted Standards of Behavioral Health Care when making medical necessity determinations
    - Described in detail by Federal Court in Wit v. United Behavioral Health

8 Generally Accepted Standards of Care

1. Effective treatment of underlying conditions, rather than mere amelioration of current symptoms, such as suicidality or psychosis.

2. Treatment of co-occurring behavioral health disorders or medical conditions in a coordinated manner.

3. Treatment at the least intensive and restrictive level of care that is safe and effective; a lower level or less intensive care is appropriate only if it safe and just as effective as treatment at a higher level or service intensity.
4. Erring on the side of caution, by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care, or when the recommended level of care is not available.

5. Treatment to maintain functioning or prevent deterioration.

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6. Treatment of mental health and substance use disorders for an appropriate duration based on individual patient needs rather than on specific time limits.

7. Accounting for the unique needs of children and adolescents when making level of care decisions.

8. Applying multidimensional assessments of patient needs when making determinations regarding the appropriate level of care.

They would encourage parity when looking at mental health complaints. Wherever there is a complaint and an analysis is required review it and see if it complies with the NQTL rule.

Questions/Answers/Comments
Who will receive the disclosures aside from TDI? There are disclosures to consumers, general public, etc. The speaker stated that TDI is to receive the information. If the disclosures become public, that is a different question. Under existing federal law, an enrollee can request information— if denied care, the reason for the denial and parity compliance and analyses that have been completed. There is a right to the criteria to ensure the plan is parity compliant.

5. Subcommittee reports and approval of the Mental Health Condition and Substance Use Disorder Parity Workgroup Statewide Strategic Plan. The Chair stated that they are not ready to vote on the strategic plan. They hope to get to a point where the report could be finalized at this meeting, but it is not ready yet. The plan is not required to be finished until September of next year. It would be good to have legislative consideration during the upcoming legislative session. There is a fair amount of cleanup that has to be done. The Chair asked for members to review the draft that they had received (a copy was not provided for the public) and make suggestions in Google Docs. Use of terminology was discussed.

Compliance, Enforcement, and Oversight. Dr. Felder stated that they met September 16th. The focus has been on the strategic plan and there have been numerous updates made. They reviewed the goals, objectives and strategies and no changes were made.

Complaints, Concerns, and Investigations. There was not a big update. There has not been a meeting since the last full workgroup meeting. Their changes for the strategic plan have been finalized. They are awaiting feedback from the Ad Hoc subcommittee. The two sections will be cross-referenced.

Education and Awareness. The Chair stated that they had met and added a second objective under Education and Awareness. Aspiring professionals should have access to parity education through licensing boards (continuing education credits), universities (curriculum), and others. The dollar figure for education and awareness efforts still has to be developed. In

parity improvement, the recommendations reflect the goals, objectives, and strategies. Beyond this, there are some education and awareness recommendations inserted:

- Providers should be prohibited from using carrier logos if not a network provider.
- Awareness information on network adequacy should be included in consumer information.

Approval of the strategic plan (vote required). Tabled for another meeting.

6. Public comment. No public comment was offered.

7. Planning for next meeting and action items

- January 26th is the next meeting
- Presentation of comparison of medical behavior health compared to those for parity
- Discussion of the strategic plan

8. Closing remarks. There being no further business, the meeting was adjourned.

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