

Texas Mental Health Condition and Substance Use Disorder Parity Strategic Plan

**As Required by
House Bill 10, 85th Legislature,
Regular Session, 2017**

**Mental Health Condition and
Substance Use Disorder
(MHCSUD) Parity Work Group**

August 2021

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1. Disclaimer

This report was not authored by and does not reflect the views and opinions of, the Texas Health and Human Services system, its component agencies, or staff.

2. Message from the Work Group

The Mental Health Condition and Substance Use Disorder (MHCSUD) Parity Work Group (the Work Group) is grateful for the opportunity to develop this Strategic Plan. We come from diverse backgrounds, and we bring a variety of perspectives on access to mental health and substance use disorder care. We, as members of the MHCSUD Parity Work Group (the Work Group), recognize these facts:

- Behavioral health is integral to overall health, which includes successfully coping with mental health problems and substance use disorders.
- Mental health and substance use disorders affect millions of Texans, costing billions of dollars in health care and other economic impacts.
- Nationwide, only 43 percent of adults and 51 percent of youth (age 6-17) with mental illness get treatment in a given year,¹ while 44.7 percent of Texas adults with serious mental illness did not receive mental health treatment in 2018-19.²
- The declining life expectancy of working age Americans is deeply concerning and can be partially attributed to a rise in “deaths of despair,” including drug overdoses, alcohol abuse, suicides, and psychiatric diseases.³

During our time as a Work Group the coronavirus (COVID-19) pandemic impacted our world. Mental health conditions (MHCs) and substance use disorders (SUDs) escalated as individuals faced uncertainty and fear about their financial condition and job stability, concerns about their health, loneliness and isolation, and loss of loved ones. We anticipate those who have struggled will face greater challenges in returning to normal, making the provision of services for people with mental health conditions or substance use disorders even more urgent.

¹ National Alliance on Mental Health. (n.d). *Mental Health Care Matters*.

<https://www.nami.org/NAMI/media/NAMI-Media/Infographics/NAMI-Mental-Health-Care-Matters-FINAL.pdf>

² Kaiser Family Foundation. (n.d.). *Mental Health in Texas*.

<https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/texas>

³ Woolf, S.H., & Schoomaker, H. (2019). Life Expectancy and Mortality Rates in the United States, 1959-2017. *JAMA*, 322(20). doi:10.1001/jama.2019.16932

This Strategic Plan is the culmination of four years of information gathering, research and stakeholder input. The Work Group would like to acknowledge the many hours and countless contributions of its membership, the state agency representatives and the community representatives, from mental health professionals to community advocates and those with lived experience in this subject matter. The Work Group respectfully requests the same thoughtful consideration be offered to the recommendations put forth in this report.

Work Group Membership

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3. Executive Summary

The Meadows Mental Health Policy Institute reports that one in five Texans have mental health needs and that up to 33 percent have a mental health or substance use disorder.⁴ Of those needing treatment, Texas ranks 44th for adults with mental health issues not receiving treatment (61.7 percent)⁵; similarly, 65 percent of Texas children with a major depressive disorder also receive no services.⁶ There are a variety of reasons so many people do not receive the mental health and substance use disorder treatment they need, such as lack of available services, provider network inadequacy, lack of covered benefits, and the lack of fully realized protections against disparate application of treatment limitations.

Some individuals with mental health conditions and/or substance use disorders (MHC/SUD) encounter treatment limitations that either do not exist for medical/surgical (M/S) health conditions or are applied differently for M/S health conditions. In one survey, nearly one third (29 percent) of respondents reported that they or their family members had been denied mental health care on the basis of medical necessity, more than twice the percentage who reported being denied general medical care on that basis.⁷ Over the past two decades multiple pieces of federal and state legislation have been enacted to ensure that health plan coverage for MHC/SUD is equal to the coverage for M/S conditions, which is referred to as “parity.”

The central purpose of House Bill 10 (H.B. 10), 85th Legislature, Regular Session, 2017, is to establish and ensure fundamental fairness for consumers of healthcare

⁴ Meadows Mental Health Policy Institute. (2016, February 10). *Texas Mental Health Landscape – Brief Overview*. <https://www.texasstateofmind.org/wp-content/uploads/2016/02/Brief-Overview-of-Landscape.pdf>

⁵ Mental Health America, Inc. (2020). *2020 Mental Health in America - Adult Data*. <https://mhanational.org/issues/2020/mental-health-america-adult-data#six>

⁶ Mental Health America, Inc. (2020). *2020 Mental Health in America - Youth Data*. <https://www.mhanational.org/issues/mental-health-america-youth-data>

⁷ National Alliance on Mental Illness. (2015, April). *A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care*. <https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead>

services in Texas. Historically, coverage for treatment of MHC/SUD has been inferior, as compared with treatment for other types of medical conditions. For example, an insurer provides unlimited doctor visits for a condition like diabetes, but limits visits for SUD or MHC like major depression or schizophrenia. In order to address this disparity, the Texas Legislature passed H.B. 10, which includes multiple features designed to improve parity compliance in Texas.

An important piece of this legislation includes bringing stakeholders together in a work group to develop a Texas strategy and common understanding for successful compliance with parity protections.⁸ The Mental Health Condition and Substance Use Disorder Parity Work Group was established to study and make recommendations to increase understanding of, and compliance with, state and federal rules, regulations, and statutes related to parity protections and use these improvements to develop a Strategic Plan designed to improve enforcement, accountability, and public awareness.

Over the past 10 years, the State of Texas, with the support of the Texas Legislature, has made great strides to advance the funding, access, and treatment of those with mental health conditions and substance use disorders. Over the past four years, as we researched and studied parity processes and best practices, we were pleased when national experts pointed to work Texas has done as some of the best in the country. We also found areas still in need of significant improvement and reform. The Work Group recognizes mental health and substance use disorder parity in Texas as imperative to advancing truly integrated care, alternative payment models, holistic treatments, and interventions. It is in that spirit this Strategic Plan is offered.

We have made recommendations that will require legislative action, and some we believe Health and Human Services Commission (HHSC) and Texas Department of Insurance (TDI) already have the authority to accomplish needed changes. Section 7 includes our Parity Improvement Recommendations with additional detail and timelines contained for some items in Section 6, Parity Work Group Goals, Objectives and Strategies. We also recognize additional resources are needed to accomplish some improvements and hope legislators and agency leadership will

⁸ Mental Health Condition and Substance Use Disorder Parity Work Group, Texas Government Code §531.02252, (2017).

make these commitments. With the work Texas has already done, along with the recommendations we offer, Texas will be the leader in providing access to mental health and substance use disorder services, free of barriers currently caused by parity violations and lack of information available to affected individuals, service providers, and health plan employees. We look forward to what can be accomplished.

4. Legislative Charge

The House Select Committee on Mental Health Interim Report to the 85th Texas Legislature in December 2016 highlighted the complexity of parity compliance and enforcement, while also addressing the ongoing difficulty in accessing mental health and substance use disorder care identified by individuals and providers. The Select Committee made several recommendations regarding parity. The 85th Legislature responded with several provisions in H.B. 10, including the establishment of the Work Group and a call for the Strategic Plan.

H.B. 10, 85th Legislature, Regular Session, 2017 requires the Work Group to submit a progress report each even-numbered year on September 1st to the appropriate legislative committees and state agencies. The progress report must include findings, recommendations, and information on the development of the Strategic Plan, including:

- Increase compliance with the rules, regulations, and statutes concerning the availability of, and terms and conditions of, benefits for MHC/SUD services;
- Strengthen enforcement and oversight of parity laws at state agencies;
- Improve the complaint processes relating to potential violations of parity laws for consumers and providers;
- Ensure HHSC and TDI can investigate potential parity violations based on de-identified information and data submitted by providers in addition to individual complaints; and
- Increase public and provider education on these laws.

Per the requirements of H.B. 10, in September 2018 and September 2020, the Work Group issued Progress Reports describing the Work Group's progress towards the development of the Strategic Plan, along with preliminary recommendations.

The Work Group is charged with developing a Strategic Plan with metrics to serve as a roadmap to increase compliance and enforcement with parity laws, improve complaint and investigation processes, and increase education and outreach relating to parity.

Work Group Roles

In an effort to improve access to MHC/SUD services in Texas, H.B. 10 directed HHSC to create the MHC/SUD Parity Work Group, which expired on September 1, 2021. The Work Group is comprised of representatives from the following:

- HHSC Medicaid and the Children’s Health Insurance Program (CHIP) Services Department
- HHSC Office of Mental Health Coordination
- TDI
- Medicaid managed care organization (MCO)
- Commercial health plan
- Mental health provider organization
- Physicians
- Hospitals
- Children’s mental health providers
- Utilization review agents
- Independent review organizations
- Substance use disorder provider or a professional with co-occurring mental health and substance use disorder expertise
- Mental health consumer
- Mental health consumer advocate
- Substance use disorder treatment consumer
- Substance use disorder treatment consumer advocate
- Family member of a mental health or substance use disorder treatment consumer
- HHSC Ombudsman for Behavioral Health Access to Care

Work Group Meetings

The MHCSUD Parity Work Group has met regularly since the legislation became effective. Meetings were held on:

- November 27, 2017
- February 20, 2018
- April 6, 2018
- June 12, 2018
- July 24, 2018

- July 31, 2018
- October 9, 2018
- February 12, 2019
- June 4, 2019
- August 20, 2019
- October 8, 2019
- January 14, 2020
- March 11, 2020
- July 22, 2020
- September 2, 2020
- November 2, 2020
- January 26, 2021
- March 16, 2021
- May 20, 2021
- July 14, 2021

Meetings included stakeholder testimonials on parity issues from the provider, consumer, and health plan perspective. National parity experts have made presentations on best practices, lessons learned, and national parity trends. HHSC’s Ombudsman for Behavioral Health and Medicaid/CHIP Office provided updates at each meeting on progress toward implementation of legislative directives. TDI also provided regular updates related to H.B. 10 implementation.

Strategic Planning Process and Methodology

Starting in November of 2017, the Work Group began a series of meetings to develop, initiate, and carry forward its strategic planning process and methodology. The Work Group identified that the Statewide Behavioral Health Strategic Plan would be an important tool for the development of the Parity Strategic Plan and agreed to adopt its basic framework. One of the initial steps was to develop a vision, a mission, and guiding principles. Additionally, the Work Group formed subcommittees to study and make recommendations on the five topics that H.B. 10 requires be addressed. The Work Group heard from a wide range of invited guests who provided insights into the parity topics addressed in H.B. 10. Importantly, the Work Group invited non-Work Group members to serve on subcommittees, broadening the conversations and insights, and helping to inform the recommendations in the Strategic Plan. Additionally, securing the perspective of

people with lived experiences and providers was necessary for developing the Strategic Plan’s recommendations.

Invited Guests

Name	Affiliation
Ms. Nikki Saurage, PRSS	White Lily House
Dr. Jacob Cuellar, CEO	Laurel Ridge Treatment Center
Ms. Jamie Dudensing, CEO	Texas Association of Health Plans
Ms. Laura Lucinda, Strategic Engagement Specialist	Office of Transformation and Innovation, HHSC
Mr. Irvin “Sam” Muszynski, Sr. Policy Analyst, Director of Parity Compliance and Enforcement	American Psychiatric Association
Dr. Uma Dua, Manager, Pharmacy and Healthcare Solutions	Risk & Regulatory Consulting
Mr. Tim Clement, Sr. Policy Advisor	Kennedy Forum (at the time of his testimony)
Ms. Sara Gonzales, VP Advocacy and Public Policy	Texas Hospital Association
Mr. Will Francis, Executive Director	NASW-Texas
Mr. Joel Schwartz, Director	Office of the Ombudsman, HHSC
Ms. Stacey Pogue, Sr. Policy Analyst	Every Texan (formerly Center for Public Policy Priorities)
Ms. Erica Haller-Stevenson, Program Specialist	Office of Mental Health Coordination, HHSC
Ms. Ellen Weber, VP Health Initiatives	Legal Action Center
Ms. Tina Godfrey, Sr. Adviser Health Investigations	Employee Benefits Security Administration, US Dept. of Labor

Each subcommittee established goals, objectives, and strategies, which gave focus to how the Work Group would obtain the information and insights necessary to craft the final recommendations in the Strategic Plan.

The Work Group was well served by various HHSC and TDI staff, who supported the Work Group in running meetings, learning about strategic planning, and understanding current parity processes.

5. Vision, Mission and Guiding Principles for the Strategic Plan

The Work Group developed the following vision, mission, and guiding principles for the MHC/SUD Strategic Plan.

Vision

Elimination of barriers to care that consumers and providers commonly encounter as they seek to access and utilize mental health and substance use disorder services.

Mission

To provide a coordinated approach that serves as a roadmap to improve compliance, complaint resolution, education, and outreach relating to the parity laws concerning benefits for mental health conditions and substance use disorders in Texas.

Guiding Principles

Compliance, education, and outreach efforts relating to the parity laws concerning benefits for mental health conditions and substance use disorders in Texas must emphasize:

- **Accountability:** All stakeholders will be subject to oversight regarding their obligations under the laws.
- **Timely access to care:** Consumers in need of care deserve access to the right care at the right time.
- **Equity:** Treatment and service determinations must be made fairly and impartially.
- **Awareness:** All stakeholders should have the opportunity to know and understand the laws.
- **Efficiency:** Systems must be streamlined, coordinated, and cost-effective.

- **Continuous improvement and evaluation:** Efforts to reduce barriers to care and increase compliance, education, and outreach must be subject to ongoing improvement and evaluation efforts.
- **User-friendliness:** Systems must be simple, understandable, and navigable.
- **Transparency:** Stakeholders must have a clear window into processes concerning benefits for mental health conditions and substance use disorders.

6. The Foundations of Parity: History and Landscape

In health plans, “parity” describes the equal treatment of MHC/SUDs when compared to coverage for other types of medical/surgical (M/S) problems. The idea behind parity is simple: health plans should treat MHC/SUD coverage the same way they treat coverage of M/S care. Coverage should be just as extensive and care should be just as accessible, regardless of the type of condition. It is important to note that the federal parity law requires *equal* coverage if MHC/SUD coverage is offered but does not require such coverage to be offered. Self-funded large employer plans, which are not subject to Texas insurance laws or federal essential health benefit requirements, may choose not to cover treatment for MHC/SUD.

Generally speaking, under parity law, both quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs) must be no more restrictive for MHC/SUD coverage than they are for coverage of M/S conditions. QTLs are defined as treatment limitations that determine whether, or to what extent, benefits are provided based on a numerical amount, such as an annual or lifetime limit on days of coverage or number of visits. NQTLs are defined as limits on the scope or duration of treatment that are not expressed numerically, such as requirements to obtain authorization prior to seeking care, or that a less expensive treatment be shown to be ineffective before the treatment recommended by the doctor is authorized. Other examples of NQTLs include retrospective reviews, medical necessity criteria, and inequitable provider contracting processes. Financial requirements are also considered in parity and include deductibles, copayments, and coinsurance.

Before parity laws were enacted, health plans often discriminated against people in need of MHC/SUD care. If health plans included MHC/SUD benefits at all, they often included more cost sharing for the insured person, and MHC/SUD benefits were more limited than M/S benefits. In general, accessing MHC/SUD benefits often

required overcoming more significant administrative barriers compared to M/S services.⁹

Federal law on parity has been evolving since 1996, starting with the Mental Health Parity Act (MHPA), which required comparable annual and lifetime dollar limits on mental health and medical coverage in large group health plans.¹⁰

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), which expanded on MHPA with the goal of eliminating the differences in health coverage between services for MHC/SUD conditions and services for M/S conditions.

MHPAEA added requirements such as:

- Financial requirements (e.g., co-payments) applied to MHC/SUD can be no more restrictive than the predominant financial requirements applied to substantially all M/S benefits;
- Treatment limitations applied to MHC/SUD can be no more restrictive than the predominant treatment limitations applied to substantially all M/S benefits; and,
- No separate financial requirements or treatment limits can apply solely to MHC/SUD.¹¹

But MHPAEA only applied to health insurance plans offered by large employers (those with 51 or more employees). In 2010, the Patient Protection and Affordable Care Act (ACA) expanded parity protections to most private health insurance plans when MHC/SUD services were included as one of the ten Essential Health Benefits (EHB).

⁹ Center for Public Policy Priorities, (August 28, 2017), "Mental Health Parity in the 2017 Legislative Session." Center for Public Policy Priorities, retrieved May 23, 2019.

¹⁰ Mental Health and Substance Use Disorder Parity Task Force. (2018, December 18). *Parity Policy and Implementation*. U.S. Health and Human Services. <https://www.hhs.gov/about/agencies/advisory-committees/mental-health-parity/task-force/resources/index.html>

¹¹ Mann, C. Center for Medicaid and State Operations. (2009). <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf>

In 2016, federal regulations clarified how federal parity protections applied to Medicaid Managed Care plans and the Children’s Health Insurance Program (CHIP). Although there are still some exceptions to parity requirements, those are very few, and most insured individuals now have the benefit of these federal laws and regulations.

Two additional federal laws have further enhanced parity. The 21st Century Cures Act, passed in 2016 directed U.S. Department of Labor, HHS, and the Treasury Department to issue guidance on parity compliance. The SUPPORT Act followed in 2018 and required DOL coordination with state regulators on enforcement activities. The Consolidated Appropriations Act of 2021 requires group health plans and issuers that cover MHC/SUD and M/S benefits to prepare a comparative analysis of any NQTLs that apply. Plans must supply this analysis and other information if requested by federal regulators.

The Parity Landscape

The Work Group benefitted from the work of TDI, HHSC, and national organizations like The Legal Action Center, based in Washington D.C., and the Mental Health Treatment and Research Institute, a subsidiary of The Bowman Family Foundation, along with numerous other reports, as well as research done by Work Group members.

The Legal Action Center completed a comprehensive review of parity compliance in Texas in 2019.¹² Although their report highlighted work still needed, there were many references to things Texas lawmakers and regulators have done well.

Through H.B. 10, the Texas Legislature focused on Texas’ enforcement of MHPAEA as a tool to improve MHC/SUD treatment access and has already adopted several best practices:

- Authorized TDI to enforce parity and provide oversight;

¹² Legal Action Center. (2020, April 1). *Texas Landscape Review: An Analysis of Public and Private Insurance Coverage for Mental Health and Substance Use Disorder Services and Enforcement of Parity Laws*. <https://www.lac.org/assets/files/Texas-Landscape-Review-final-1.pdf>

- Created a consumer ombudsman dedicated to parity and access to behavioral health care;
- Required one-time data reporting to evaluate disparate implementation of NQTLs, which was conducted by HHSC and TDI in 2018; and,
- Implemented network adequacy standards for health maintenance organization (HMO), preferred provider organization (PPO), and exclusive provider organization (EPO) plans.

While H.B. 10 and other Texas legislation provide a parity framework that is similar to MHPAEA and the associated federal rules, state law is not identical to federal law. One element not included in the Texas law is the required availability of plan information, addressed in federal law at [42 USC §300gg-26\(a\)\(4\)](#) and [45 CFR §146.136\(d\)](#). Federal law requires plans to disclose “information on medical necessity criteria for both [M/S and MHC/SUD], as well as the processes, strategies, evidentiary standards, and other factors used to apply a non-quantitative treatment limitation with respect to [M/S and MHC/SUD] benefits under the plan.” In contrast, Texas has disclosure requirements for services requiring prior authorization, but not for services that may be subject to concurrent or retrospective review. Texas also permits plans to post a summary of the medical guideline, rather than the primary source material. Texas law does not require plans to provide enrollees with the processes, strategies, evidentiary standards, and other factors used to apply a NQTL.

Texas passed H.B. 2174, 86th Legislature, Regular Session, 2019, which limits Medicaid from imposing prior authorization requirements on SUD medications. Under H.B. 2174, Medicaid is prohibited from requiring prior authorization for medication-assisted opioid or SUD treatment medications, including opioid use disorder specific medications, except as needed to minimize the opportunity for fraud, waste, or abuse. This law will expire on August 31, 2023.

The Work Group benefited from the data gathering by HHSC and TDI which is required by H.B. 10, as well as the focus on parity by agency staff. The Legal Action Center cited TDI and HHSC data collection tools as being among the most comprehensive in the nation.

Despite the progress made, more work is needed. The Texas House Select Committee on Opioids and Substance Abuse Report, issued November 2018, identified “lack of parity in insurance coverage for mental health and substance use

disorder” as one of the state’s challenges and recommended that efforts to ensure the enforcement of parity continue.¹³

In addition, the Milliman Report, commissioned by the Mental Health Treatment and Research Institute, LLC, (November 2019) noted that parity has been getting worse, not better, since they started analyzing claims data in 2013.¹⁴ The report analyzed out-of-network utilization and reimbursement rates for 37 million PPO recipients (employees and dependents) across the country and identified disparities in out-of-network utilization and reimbursement rates. Texas-specific data will be addressed in the respective sections.

Use of Prior or Continuing Authorization for MHC/SUD Services and Medications

Health plans routinely require individuals to obtain authorization for a prescribed health service or medication as a way to control costs and oversee coverage decisions. Prior authorization requirements impose a unique barrier for individuals seeking MHC/SUD treatment; they delay the initiation of care at the critical moment when an individual needs treatment, which places the patient at risk of psychiatric crisis, continued substance use, medical complications, overdose, and death. Historically, health plans have required prior authorization for MHC/SUD services and medications more frequently than other medical services.

Concurrent reviews occur while the individual is in treatment, and continued care can be denied if the reviewer determines that the individual no longer meets medical criteria for the level of care. Reviewers and providers often disagree on needed care determinations. In some cases, reviews are done retrospectively, and claims are denied after treatment is completed.

¹³ House Select Committee on Opioids and Substance Abuse. (2018, November). *Interim Report to the 86th Texas Legislature*. Texas House Representatives. <https://house.texas.gov/media/pdf/committees/reports/85interim/Interim-Report-Select-Committee-on-Opioids-Substance-Abuse-2018.pdf>

¹⁴ Davenport, S., Gray, T.J., & Melek, S. (2019, November 20). *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*. Milliman, Inc. <https://us.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p>

Prior and continuing authorization requirements for MHC/SUD care, along with retrospective reviews, may violate parity rules for NQTLs if they are more frequent than for M/S care and the plan does not have a comparable process for establishing the appropriate frequency of such reviews. Denials of care or payment may occur during the prior authorization process, as part of a concurrent review while the patient is in treatment, or as a retrospective review when the claim is filed.

In the report required by H.B. 10,¹⁵ TDI evaluated claim data in four categories: inpatient, outpatient, emergency, and pharmacy. The data indicated:

- In the inpatient category, MHC/SUD claims were denied over 60 percent more often than M/S claims. Denial rates were higher in the outpatient and emergency categories as well.
- In the small group and large group markets, a much larger proportion of prescription drugs for MHC/SUDs were subject to step therapy requirements compared to drugs for M/S use. More prescription drugs were subject to concurrent review for MHC/SUD in all markets.
- Lower rates of MHC/SUD denials were overturned on internal appeal as compared to M/S denials.

HHSC's examination of Medicaid MCO and CHIP claims data¹⁶ found:

- While the overwhelming majority of MCO and CHIP claims were for M/S services, in Medicaid, denial rates for MHC/SUD services (26 percent) were higher than denial rates for M/S services (18.8 percent).
- Medicaid and CHIP imposed prior authorization more frequently for MHC/SUD services than for M/S services, but service approval rates were higher for MHC/SUD services in both programs.
- In Medicaid, internal appeals for claims with adverse determination for MHC/SUD claims (12.5 percent) were more likely than appeals for M/S

¹⁵ Texas Department of Insurance. (2018, August). *Study of Mental Health Parity to Better Understand and Consumer Experiences with Accessing Care*.

<https://www.tdi.texas.gov/reports/documents/Final-draft-H.B.-10-report-8.31.18.pdf>

¹⁶ Texas Health and Human Services Commission. (2018, September). *Report to Assess Medical or Surgical Benefits, and Benefits for Mental Health and Substance Use Disorders*. <http://mmhpi.org/wp-content/uploads/2020/10/HHSC-H.B.10-Report-2018.pdf>

services (6.8 percent) (CHIP – 11.4 percent MH/SUD compared to 7.3 percent M/S), and denials were more likely to be upheld.

Carriers offering plans in Texas are mandated to comply with utilization review standards and guidelines established by the Texas Commission on Alcohol and Drug Abuse for admission, continued stay, and discharge. The functions of the Texas Commission on Alcohol and Drug Abuse were transitioned to the Department of State Health Services in 2004 through Sunset Review, and later transitioned to HHSC through subsequent Sunset Review, which indicates how old these standards and guidelines are. Many carriers do not operate under these standards, and many stakeholders believe they should be updated. Consequently, providers often do not know what standards are being used for review, as required by MHPAEA.

In September 2020, TDI published a proposed rule to repeal these standards and instead reference the standards of care for chemical dependency treatment established in [25 TAC, Chapter 448](#), which are maintained by HHSC; but there are concerns that this move was premature, as Chapter 448 does not contain such standards. TDI withdrew the rule proposal and is now working to revise the rules in response to stakeholder concerns.

Network Adequacy

Beyond just the number of providers in a network, practices related to building and maintaining a network - network admission, credentialing, contracting, and reimbursement rate setting - are subject to the requirements of parity legislation as a NQTL. Unfortunately, disparities have worsened in the past decade, despite the existence of parity legislation.

The Milliman Foundation has examined Texas health plan data for two-time periods, 2013 - 2015, reported in 2017, and 2016 - 2017, reported in 2019. Their 2019 report contrasted the data¹⁷ and found significantly higher out-of-network (OON) utilization of MHC/SUD services as compared to M/S services. The Legal Action

¹⁷ Davenport, S., Gray, T.J., & Melek, S. (2019, November 20). *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*. Milliman, Inc. <https://us.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p>

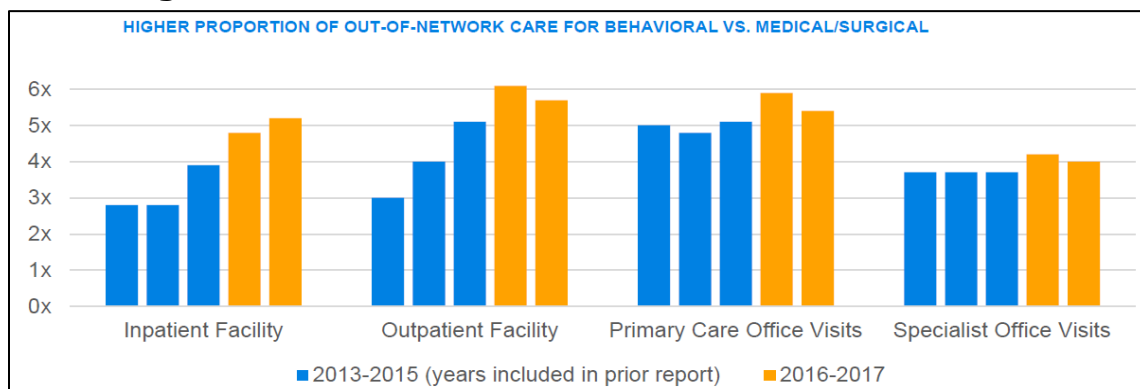
Center’s Texas Landscape Review suggested several areas for further investigation that influence networks, including admission criteria and processes and contracting standards.

The Milliman Report

Out-of-Network Utilization

While out-of-network utilization rates for inpatient services were 2.8 times higher for mental health in 2013, that disparity almost doubled, to 5.2 times, by 2017, an 85 percent increase in disparity over four years. In the same reporting period, outpatient services also showed a widening of disparity; in 2017, 17.2 percent of behavioral health services were out-of-network as compared to 3.2 percent for primary care, and 4.3 percent for M/S specialists. Children were ten times more likely to be out-of-network for outpatient behavioral health services. In 2017, the out-of-network utilization rate for residential treatment facilities was an astonishing 50 percent.

Graph 1: Higher Proportion of Out-of-Network Care for Behavioral vs. Medical/Surgical¹⁸



¹⁸ Davenport, S., Gray, T.J., & Melek, S. (2019, November 20). *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*. Milliman, Inc. <https://us.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p>

Table 1: Out-of-Network Utilization Levels in Texas, PPO Plans¹⁹

	2013 Behavioral Health	2017 Physical Health	2017 Behavioral Health	2017 Disparity in Out-of-Network utilization
Inpatient	10.1%	2.5%	17.4%	6.99x
Outpatient	15.1%	3.3%	26.3%	8.03x
Office Visits	16.9%	2.8%	14.5%	5.2x

Provider Reimbursement Disparity

Disparate reimbursement rates for MH/SUD providers as compared to M/S providers are often cited as an obstacle to network participation. Milliman compared reimbursement rates relative to the Medicare Physician Fee Schedule. In 2017, primary care reimbursement rates were 23.8 percent higher than behavioral health reimbursements, an increase of 20 percent since 2015. The report states that lower reimbursement services may prevent providers from joining a network, especially if the out-of-network rate is higher. And while reimbursement rates for behavioral health have closed the gap to the Medicare standard, the disparity to primary care has widened nationally. The SUD reimbursement rate has declined each year of the study; Milliman points out that this is the same time period as the opioid crisis. The rates for behavioral health services in Texas have moved closer to the Medicare standard; although the disparity has decreased, there is still a significant gap at a 10 percent differential to primary care.

¹⁹ Davenport, S., Gray, T.J., & Melek, S. (2019, November 20). *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*. Milliman, Inc. <https://us.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p>

Graph 2: Office Visits – In-Network Provider Payment Level Differences Compared to Medicare-Allowed Amounts²⁰

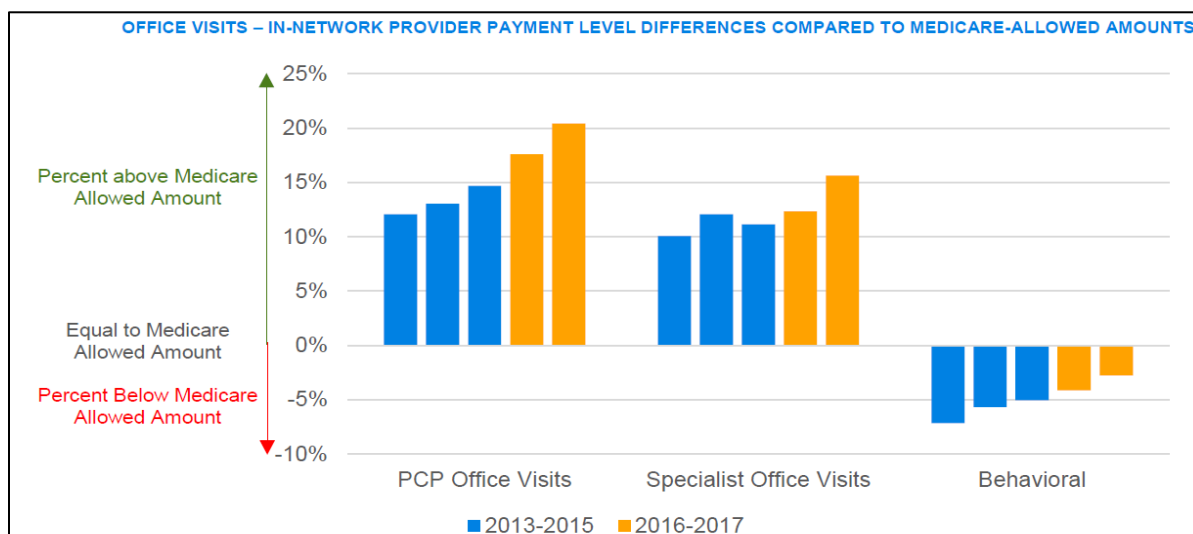


Table 2: In-Network Reimbursement Rates in Texas Relative to Medicare-Allowed for Office Visits²¹

	2013	2017
Primary Care	107.5%	105.1%
Medical/Surgical Specialists	109.1%	90.3%
Behavioral Health	80.3%	95.8%

²⁰ Davenport, S., Gray, T.J., & Melek, S. (2019, November 20). *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*. Milliman, Inc. <https://us.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p>

²¹ Ibid, 20.

TDI Data on Network Utilization

In their report required by H.B. 10, TDI found²²:

- Across all treatment categories and markets (individual, small group, large group), out-of-network (OON) utilization was greater for MHC/SUD than for M/S, 114 percent higher for inpatient and 31 percent for outpatient. The report indicates network limitations may contribute to higher OON utilization; and,
- 11 of 12 reporting insurance companies require separate contracts for MHC/SUD coverage. Some are external contracts, but some are divisions within the company. If double contracting is required, this factor may place an added burden on MHC/SUD providers.

Barriers to Network Participation

Barriers exist that impact network breadth and may violate parity standards for NQTLs. Examples of NQTLs related to network adequacy include standards for network admission, contracting procedures and terms, reimbursement rates, and other factors that affect an MHC or SUD provider's willingness to participate in networks. Many MHC/SUD providers do not participate with insurance and only accept out-of-pocket payment. Reasons cited include low reimbursement rates; the administrative burden of dealing with the health plan for authorization and payment; and untimely payments. Medicaid rules allow for "claw-back" payments for up to two years. This disincentivizes providers from participating in the Medicaid program. In contrast, commercial insurance has a 180 day "claw-back" time limitation.

Without adequate networks, all other policy initiatives to expand access to affordable care will fall short.

²² Texas Department of Insurance. (2018, August). *Study of Mental Health Parity to Better Understand and Consumer Experiences with Accessing Care*. <https://www.tdi.texas.gov/reports/documents/Final-draft-H.B.-10-report-8.31.18.pdf>

Adopted Network Standards

Ahead of most states, Texas has adopted network adequacy standards in two of three recommended metrics: appointment wait time and geographic distance. (Texas does not have provider-enrollee ratios.) Appointments for routine behavioral care must be available within two weeks, while routine care for medical conditions must be available within three weeks. For HMOs, a primary care provider and general care hospital must be within 30 miles, and specialty care, special hospitals, and single health care plan physicians or providers must be within 75 miles. For PPOs, primary care and general hospital care must be not more than 30 miles in urban areas and 60 miles in rural areas, and specialty care and specialty hospitals must be within 75 miles.²³

Despite these standards for geographic distance, Texas has insufficient treatment capacity for MHC/SUD services, especially in rural areas:

- Most HHSC contracted providers are in urban areas;
- Patients without access to outpatient care may have to seek costlier residential treatment;
- Publicly funded services have long waiting lists for care; and
- Access to medication-assisted treatment for SUD is limited.

Texas Mental Health and Substance Use Disorder Benefit Mandates

Interaction between Parity and Texas Benefit Mandates

A number of limitations exist in the Texas MHC/SUD benefit mandates that are a direct violation of parity law. TDI's proposed rules for parity enforcement, published February 19, 2021, sought to address these contradictions and clarify that a health plan may apply those limits only to the extent they do not violate H.B. 10's parity requirements.

²³ Weber, E. (2020, May). *Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services*. Legal Action Center.
<https://www.lac.org/resource/spotlight-on-network-adequacy-standards-for-substance-use-disorder-and-mental-health-services>

In order to modernize and clarify the Texas Insurance Code, the Work Group feels it is important to consider and potentially amend any of these problematic statutes that may not be addressed in TDI's final rules.

- [Insurance Code Chapter §1368.006\(b\)](#), which requires group health plans to cover treatment for SUD, permits plans to impose a lifetime maximum of three episodes of treatment and authorizes plans to set financial and quantitative limits on SUD benefits that are less favorable than limits on medical benefits, "if those limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted."
- Texas has adopted benefit mandates for serious mental illness, alternative mental health benefits, and psychiatric day treatment, but those mandates apply inconsistently to different types of plans.
 - ▶ [Insurance Code §1355.054](#) allows a plan to apply coverage limits in a crisis stabilization unit or residential treatment center for children and adolescents that may be more restrictive than comparable limits applied to M/S care.
 - ▶ [Insurance Code §1355.104](#) allows a plan to apply restrictions on care in a psychiatric day treatment facility that may be more restrictive than comparable limits on M/S care.
 - ▶ [Insurance Code §1355.105](#) may allow a plan to restrict coverage for mental health treatment in a day facility in a way it would not restrict comparable coverage for M/S care.
 - ▶ [Insurance Code §1355.106](#) allows a plan to exclude or offer reduced coverage for treatment of mental or emotional illness in a psychiatric day treatment facility.
- [Insurance Code 1355.006\(b\)\(2\)](#) allows a plan to exclude coverage of a serious mental illness if it results from the illegal use of a controlled substance. If a plan applied this exclusion only to benefits for mental illness, it would violate parity requirements.
- [Insurance Code §1355.015\(a-1\)](#) allows a plan to exclude or reduce autism coverage for people diagnosed at age 10 or older; [§1355.015\(c-1\)](#) allows a dollar limit for applied behavioral analysis treatment. These unusual limits are unlikely to apply to M/S benefits. A plan may need to remove these limits to comply with parity.

If a plan applies the limits above to MH/SUD care in a manner that is more restrictive than limits applied to M/S care, it may violate parity requirements.

In addition to the statutes identified above, which create potential conflicts with parity requirements, there are also gaps in the coverage requirements for MHC/SUD treatment.

- Access to behavioral health care would be more robust if the existing mandates for serious mental illness and chemical dependency were expanded to apply to state employee plans, retired state employee plans, retired teacher plans, and individual market plans.
- Although most individual and small group market plans are required to cover MH/SUD benefits as an essential health benefit, pursuant to ACA, expanding the protections under state law would help ensure that coverage is more consistent and robust.
- Given the opioid addiction crisis, it is also important to establish consistent standards for coverage of opioid treatment programs, including coverage for medication-assisted treatment.

Compliance, Enforcement, and Oversight Processes

Regulatory responsibility for parity compliance in Texas is spread across three agencies: Texas Department of Insurance (TDI) for state-regulated insurance and HMO plans, US Department of Labor (DOL) for self-funded Employee Retirement Income Security Act of 1974 (ERISA) regulated single employer plans, and Health and Human Services Commission (HHSC) for Medicaid and CHIP plans. This makes compliance, enforcement, and oversight a challenge to navigate for even the most knowledgeable stakeholder. H.B. 10 required data gathering from TDI and HHSC for plans they regulate. The Work Group considered the data they collected, as well as input from other organizations, and also included an overview of DOL processes.

In its American Community Survey (ACS), the U.S. Census Bureau estimated the total Texas population to be 28.5 million in 2018. Of that number, as provided by Department of Labor (DOL) (Calendar Year 2018):

- 4.9 million Texans are uninsured.
- 5.4 million are covered by fully insured individual and employer plans regulated by TDI.
- 4.5 million Texans are covered by Medicare and other public plans.

- 3.5 million are covered by Medicaid/CHIP.
- 2.7 million are covered by local, state and federal government employee plans, not regulated by TDI.
- 7.5 million are covered under self-insured employer plans, not regulated by TDI.

The Texas Department of Insurance

TDI first adopted rules to implement MHPAEA in 2011 ([28 Texas Administrative Code \(TAC\), Chapter 21](#)). These rules focused on the financial requirements and numerical treatment limits within plans issued to employers with at least 51 employees (large employer health plans). When H.B. 10 passed in 2017, TDI's authority to enforce parity expanded to include association, individual, and small employer plans. TDI also gained authority to enforce compliance with NQTLs.

Historically, TDI's form review function has been the primary enforcement mechanism for parity. The Life and Health Lines Office reviews and approves the policy form of each health plan issued to Texas residents. For each health plan filing, staff evaluate the financial requirements and treatment limitations for compliance with parity and the following related laws:

- Coverage for autism spectrum disorder, consistent with [Insurance Code, Section 1355.015](#), subject to exclusion by consumer choice plans authorized under [Insurance Code, Chapter 1507](#);
- Coverage for serious mental illness, consistent with [Insurance Code, Section 1355.004](#);
- Coverage for inpatient care in a residential treatment center for children or adolescents; or a crisis stabilization unit, consistent with [Insurance Code, Chapter 1355, Subchapter B](#);
- Coverage for care in a psychiatric day treatment facility, and offer of coverage for treatment of mental or emotional illness, consistent with [Insurance Code, Chapter 1355](#); and
- Coverage for chemical dependency, consistent with [Insurance Code, Chapter 1368](#), subject to exclusion by consumer choice plans authorized under [Insurance Code, Chapter 1507](#).

TDI staff review financial requirements and numerical treatment limits to ensure that benefits for MHC/SUD are not less generous than medical and surgical benefits. TDI staff look for disparities, but do not perform the mathematical analysis

required under federal rules. That analysis looks at expected M/S claim amounts aggregated by category of coverage. This type of information is not available to TDI within the form review process. Instead, staff questions or objects to all disparities, and requires a change or an explanation confirming compliance. For forms with variable material,²⁴ staff ensures that the company's explanation of variability states that any bracketed amounts will be issued in compliance with parity requirements.

After H.B. 10 passed, TDI expanded form review checklists to review non-numerical treatment limitations within health plan contracts, like utilization management requirements and the methodology used to calculate reimbursements for out-of-network benefits. However, form review and other existing regulatory processes do not allow TDI to evaluate most non-numerical treatment limits for parity compliance. Instead, TDI staff closely reviews complaints about behavioral health access to care and questions how company processes adhere to parity requirements. TDI takes enforcement action where appropriate.

TDI continues to work to incorporate mental health parity into its market conduct and quality of care examination processes. In July 2020, they announced the creation of a new team, the Health Market Actions Section, which will work to identify and quickly resolve health insurance issues. When parity rules are adopted, TDI will incorporate parity into regularly scheduled exams. HMO, PPO, and EPO plans are subject to "quality of care" exams every three years. TDI may examine other insurers through a general or targeted market conduct exam. TDI may perform a targeted exam related to parity based on a pattern of data that suggests an issuer is not meeting parity requirements.

TDI regulates utilization review agents (URAs) and processes for prior authorization and appeals, which are a key area of interest for parity compliance. URAs are responsible for reviewing whether care is medically necessary, experimental, or investigational. While TDI requires clinical screening criteria to be evidence-based and compatible with established principles of health care, it does not have the clinical expertise to determine whether URA screening criteria and procedures are

²⁴ Rules at 28 TAC, Section 3.4(e), permit forms to be filed with variability, including a range of cost-sharing amounts. For example, a schedule of benefits may reflect a deductible of [\$0 - \$10,000].

medically appropriate. TDI staff review URA policies and procedures and look for parity issues, like barriers to behavioral health care access that do not exist in the M/S policies and procedures. Outside of the one-time H.B. 10 data collection, TDI does not currently collect data that would highlight potential parity issues related to screening criteria or processes for prior authorization and appeals that occur in practice. TDI's proposed rule implementing H.B. 10 includes an annual data collection requirement that would include comparative information on claims, utilization reviews, appeals, and reimbursement rates.

TDI's network adequacy regulation ensures that networks include access to the following categories of behavioral health providers:

- Psychiatrists
- Psychologists
- Chemical dependency treatment facilities, including residential, partial hospitalization, and intensive outpatient facilities
- Crisis stabilization units
- Residential treatment, partial hospitalization, and intensive outpatient facilities for behavioral health issues

TDI does not directly assess parity compliance within network adequacy reviews. PPO and EPO data reported annually—related to out-of-network claims and network-related complaints—does not distinguish between M/S and MHC/SUD claims and complaints.

In implementing H.B. 10, TDI initially delayed rulemaking to evaluate the data published in [TDI's H.B. 10 Report](#) in August 2018 and to give the Parity Work Group a chance to make recommendations. In January 2020, TDI issued a request for information to seek input on data elements and analysis tools for assessing parity compliance. The responses provided informed an informal draft parity rule published in June 2020. TDI also held a stakeholder meeting to solicit input on the informal draft rule text. After considering input received on the informal draft, TDI published a proposed rule in February 2021.

Medicaid and CHIP

Federal law on parity was first applied to Medicaid managed care organizations (MCOs) in 1998 and addressed annual and lifetime dollar limits on mental health and medical coverage.²⁵

A State Health Official letter issued by the Centers for Medicare and Medicaid Services (CMS) on November 4, 2009, clarified that the new MHPAEA requirements applied to Medicaid only insofar as the requirements applied to managed care organizations. The letter further clarified that the application of MHPAEA to CHIP was broader as a result of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which included requirements that M/S benefits and MHC/SUD benefit treatment limitations, lifetime and annual dollar limits or out-of-pocket costs comply with parity as they would apply to a group health plan.²⁶

On March 29, 2016, the CMS adopted rules that clarified the application of parity protections from MHPAEA to enrollees of state Medicaid MCOs and CHIP.²⁷ Due to Hurricane Harvey, Texas was granted an extension for compliance and submitted documentation to CMS on December 1, 2017.²⁸

The CMS rule on Medicaid and CHIP parity is designed to align, as much as possible, to rules issued to implement MHPAEA. The parity rule was designed to create consistency across the different insurance markets, including Medicaid and CHIP, employer-sponsored insurance, and the Health Insurance Marketplace.

²⁵Richardson, S. Center for Medicaid and State Operations. (1998).

<https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd012098d.pdf>

²⁶ Mann, C. Center for Medicaid and State Operations. (2009).

<https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf>

²⁷ Mental Health Parity and Addiction Equity Act of 2008, 81 Fed Reg. 18389 (May 30, 2016) (to be codified at 45 C.F.R. pts. 438, 440, 456, 457).

<https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>

²⁸ Texas Health and Human Services Commission. (n.d.). *Mental Health & Substance Use Disorder Parity*. <https://hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/mental-health-substance-use-disorder-parity>

The CMS rule specified that for the purpose of comparing benefits to assess parity in Medicaid and CHIP, benefits must be mapped to one of the four classifications:

- Inpatient
- Outpatient
- Emergency
- Pharmacy

Texas Medicaid and CHIP offer MHC/SUD benefits in all classifications.

Parity is analyzed by benefit package, rather than the individual service level (i.e. a comparison of a specific M/S benefit to an MHC/SUD benefit).

A **benefit package** is defined as a unique set of benefits, financial requirements and treatment limitations.

The benefit packages, which are subject to parity rules, are provided to the specific populations of:

- Medicaid for adults (21 and older);
- Medicaid for children (newborn through 20 years old); and,
- Children’s Health Insurance Program (CHIP).

In Texas, the financial limitation portion of parity doesn’t apply to Medicaid as there is no financial requirement. CHIP does allow for members to be subject to co-pays and out-of-pocket maximums.

HHSC conducted the QTL analysis for the Medicaid benefit packages, since the state determines any quantitative limits for these benefits and found no limitations on children’s Medicaid services. They did, however, find three limitations in adult Medicaid services. HHSC identified QTLs in SUD benefits: residential treatment and counseling. In the adult Medicaid program, Texas limited SUD residential treatment services to two episodes per six-month period and four episodes per 12-month rolling period, with each episode of care not to exceed 35 days. The adult Medicaid program also limited SUD counseling services to 26 hours per year of individual counseling and 135 hours per year of group counseling. In January 2019, HHSC updated these policies to allow for additional services with prior authorization and documentation supporting the medical necessity for continued treatment.

Texas removed all QTLs for MHC/SUD in its CHIP program in each of the four classifications in 2010.

To determine NQTLs within the Medicaid and CHIP benefits packages, HHSC developed NQTL tools to analyze:

- Prior authorizations;
- Concurrent reviews;
- Medical necessity criteria development (including, but not limited to fail first policies, level of engagement requirements, and probability of improvement); and
- Network participation and reimbursement.

Beginning in 2017, Texas Medicaid and CHIP MCOs began to use the Texas HHSC NQTL tools to conduct a self-assessment to analyze and identify when NQTLs were applied to services within the four benefit classifications for each benefit package. MCOs documented their processes, strategies and evidentiary standards used to apply the NQTLs. These same processes were evaluated against their M/S benefit packages for comparability and stringency. HHSC held multiple one-on-one technical assistance meetings with each MCO to set expectations and discuss the submissions in greater detail. Following the evaluation, MCOs documented any modifications that were needed to their offerings to be parity compliant. HHSC staff reviewed more than 1600 pages of MCO responses. HHSC also reviewed claims data for expense disparities. Some of the findings included:

- Prior authorizations were being performed in both M/S and MHC/SUD benefit packages. However, MHC/SUD claims were subject to a prior authorization almost twice as often as M/S claims;²⁹
- Concurrent reviews were substantially higher for MHC/SUD, especially for outpatient services and children;
- Use of medical necessity criteria was higher for MHC/SUD. In outpatient services, the use of medical necessity criteria was 10-15 percent higher, depending on the age group;

²⁹ "Report to Assess Medical or Surgical Benefits, and Benefits for Mental Health Substance Use Disorders", Health and Human Services Commission, September 2018.

- Fail-first or low-cost therapies were significantly higher, between 5-15 percent, based on the benefit package and the age group. This criteria delays appropriate treatment; and
- Pharmacy NQTLs were comparable across MHC/SUD and M/S.

As a result of HHSC's NQTL analyses, three MCOs reported modifying their outpatient prior authorization requirements and three MCOs reported making modifications to their concurrent review process.

The templates of the HHSC NQTL tools were submitted to CMS as well as de-identified copies of MCOs' answers.

Before a new MCO begins providing services to Medicaid or CHIP members, a Readiness Review is conducted, which includes an NQTL parity analysis.

Similarly, when MCOs make changes to their services or processes, HHSC evaluates whether a Readiness Review is needed, which may include a new NQTL analysis. In 2019, one MCO that previously subcontracted their behavioral health services to a behavioral health organization, brought those services in-house. A new NQTL analysis was conducted with the health plan as part of their Readiness Review. HHSC may also conduct NQTL analyses as part of Operational Reviews, which assess whether MCOs are following contract requirements.

As part of the 2016 CMS guidance on the application of MHPAEA to Medicaid and CHIP, HHSC made the following updates to the managed care contracts as well as the Uniform Managed Care Manual (UMCM), which defines and interprets the procedures MCOs must follow in order to meet certain requirements in the contracts:^{30,31}

- MCOs must comply with MHPAEA and all related regulations.

³⁰ Mental Health Parity and Addiction Equity Act of 2008, 81 Fed Reg. 18389 (May 30, 2016) (to be codified at 45 C.F.R. pts. 438, 440, 456, 457).

<https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>

³¹ Texas Health and Human Services Commission. (n.d.). *Managed Care Contract Management*. <https://hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management>

- MCOs must provide HHSC with NQTL tools, statements of attestation, and corrective action plans related to compliance with MHPAEA. MCOs must provide any other information as requested by HHSC. The information must be provided within the timeframe included in HHSC's request.
- MCOs policies, as written and in operation, must not apply any NQTLs to MHC/SUD benefits in a classification (inpatient, outpatient, emergency services, or pharmacy) that violate MHPAEA.
 - ▶ Any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MHC/SUD benefits are required to be comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the same classification. MCOs must use benefit classifications as defined by HHSC to complete the parity analyses.
- Upon request, MCOs must make available to any member, potential member, or contracting provider, the MCO's practice guidelines for the specific, requested MHC/SUD disorder benefit. Practice guideline information include at minimum:
 - ▶ Clinical guidelines such as established treatment guidelines and/or plan-specific treatment guidelines;
 - ▶ Processes and procedures required to access the benefit; and,
 - ▶ Utilization management guidelines.
- When payment for a service is denied, MCOs must, upon request, make available to the member the reason for any denial of reimbursement or payment for benefits. At minimum, MCOs must explain the reasons for denial, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of:
 - ▶ All medical documents, records, and other information relevant to the enrollee's adverse benefit determination;
 - ▶ Medical necessity criteria relevant to the enrollee's adverse benefit determination; and,
 - ▶ Any processes, strategies, or evidentiary standards used in setting coverage limits.

The Department of Labor

The Department of Labor (DOL), the Department of Health and Human Services (HHS), and the Treasury Department issued the rules for implementation of MHPAEA along with all additional guidance documents. DOL oversees self-funded

employer-sponsored plans governed under the Employee Retirement Income Security Act of 1974 (ERISA). In 2020, this included 2.4 million private insurance plans, which cover roughly 135 million individuals in the US. DOL provides education for insurers, providers, and regulators and conducts investigations.

DOL's Employee Benefits Security Administration (EBSA) gives presentations at outreach events around the country each year to provide training on the obligations of health plans and individuals' rights under the parity laws and regulations. They hold webinars, develop consumer-focused publications, and provide compliance assistance tools and checklists designed to improve understanding of parity requirements. In 2019 the Department released the "FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39". EBSA also holds nationwide compliance outreach events for the regulated community. They have worked with the Substance Abuse and Mental Health Services Administration (SAMHSA) to host several policy academies to support state regulators with parity enforcement responsibilities. As directed by the SUPPORT Act, EBSA works closely with state regulators and the National Association of Insurance Commissioners (NAIC). EBSA staff issued a model disclosure request form that an individual or provider can use to request information to evaluate parity when they have received a denial. The DOL MHPAEA Self Compliance Tool is an instrument the Work Group has identified as a national best practice resource.

EBSA relies on investigators to review plans for compliance with parity. The investigations are conducted out of the regional offices. The Texas office is in Dallas. Investigations are based on leads from the DOL Benefit Advisors and other enforcement agencies, feedback from consumer groups, and complaints received through their website. DOL's 2020 Report to Congress, Parity Partnerships: Working Together, stated, "Since October 2010, EBSA has conducted approximately 2,000 investigations in which compliance with MHPAEA was reviewed, and cited approximately 345 violations that involve MH/SUD benefits." This includes 180 investigations closed in FY 2020 with 127 involving plans subject to MHPAEA. Eight violations were cited. This compares to 191 investigations with 44 cited for violations in FY 2016 and 187 investigations with 92 violations cited in FY 2017. The report does not speculate on the reduction in cited violations.

DOL parity investigations can take a year or more. The process generally followed is:

- Relevant documents are collected;
- Interviews and depositions are conducted;
- Initial analysis may be coordinated with attorneys, economists, subject matter experts, and other partners;
- Coordination with HHS and Treasury is required;
- Coordination with state insurance department may be involved;
- If a violation is determined, voluntary correction is attempted;
- If the insurer agrees to remedy violation, determination of appropriate redress is determined and implementation is monitored; and
- Plan documents are updated to correct any violations identified.

EBSA cannot directly enforce MHPAEA with insurance companies, even when there is evidence of a parity violation. They also cannot assess civil monetary penalties even in egregious cases of noncompliance to deter bad actors. When violations are identified, the plan is asked to make necessary changes and to re-adjudicate any improperly applied benefit claims. Any penalties are limited to equitable relief. EBSA also asks that the violation be corrected for the remainder of the plan year and for future plan years, and they may also require the plan or service provider to provide notice to potentially affected participants and beneficiaries.

EBSA has no authority to assess penalties. The MH Parity and SUD Parity Task Force (2016)³² and the President's Commission on Combating Addiction and the Opioid Crisis (2017)³³ have both recommended Congress allow DOL to assess civil monetary penalties for parity violations.

³² Mental Health and Substance Use Disorder Parity Task Force. (2016, October). *Final Report*. <https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.PDF>

³³ The President's Commission on Combating Drug Addiction and the Opioid Crisis. (2017, November). *The President's Commission on Combating Drug Addiction and the Opioid Crisis Report*. <https://www.doh.wa.gov/Portals/1/Documents/2300/2017/PresidentsCommissionOnCombatingDrugAddictionOpioidCrisis.pdf>

Complaints, Concerns, and Investigations Process

Ombudsman for Behavioral Health Complaints, Concerns, and Investigations

Ombudsman for Behavioral Health (OBH) began as Consumer Services & Rights Protection (CSRP) office at the Texas Department of Mental Health and Mental Retardation in 1982 under the authority of Section [532.019 of the Health & Safety Code](#). Rights Protection Officers / Ombudsmen were appointed to all State Hospital facilities and Community Mental Health and Mental Retardation Centers. CSRP was created to ensure the rights of individuals receiving mental health services from community mental health centers and state run mental health facilities. This service was inclusive of family members or any individual in the state of Texas who was in need of mental health services. Contacts regarding consumers who receive care and treatment in a state hospital were handled regardless of diagnosis. [TAC Chapter 404](#) sets out related policy.

In October 2017, CSRP transitioned to the HHSC Office of the Ombudsman to create independence and was renamed Ombudsman for Behavioral Health.

Upon passage of H.B 10, 85th Legislature, Regular Session, 2017, OBH's role was expanded to serve as a neutral party to help consumers and their health care providers navigate and resolve issues related to access to services, including care for MHC/SUD.

Inquiry and/or complaint contacts are received by the OBH via phone, email, fax or letter. Information is subsequently entered into HHS Enterprise Administrative Report and Tracking System (HEART). OBH then reviews complaint information/documentation in an effort to determine (in discussion with the complainant) if the case appears to present a potential parity violation. If the investigation reveals that a potential parity violation exists, the case is referred to the appropriate regulatory or oversight agency, including HHSC program staff (for Medicaid), the TDI (for private insurance), the U.S. DOL (for self-funded plans), or the Employee's Retirement System (for those covered by the state employee health plan). The contact is left open until a response is received from the appropriate regulatory or oversight agency.

In fiscal year 2018 and 2019 OBH received a total of 12 parity complaints³⁴ and three inquiries related to parity³⁵. The three inquiries consisted of consumers contacting OBH in an effort to gain education, resources, and information regarding their health plan. Of the 12 parity complaints that OBH received:

- Seven were specific to minor-youths requesting and requiring access to care in a residential treatment facility.
 - ▶ Four of which had a private insurance or self-ensured employer plan.
 - ▶ Three of which had a Medicaid plan.
- One was related to a minor-youth who was diagnosed with Autism and had private insurance and was requesting more therapeutic hours of service than the private insurance initially authorized.
- Four were filed on behalf of an adult, two of whom had Medicaid.
 - ▶ One was related to access to care for an eating disorder.
 - ▶ One related to network adequacy.
 - ▶ Two involved a plan purchased on the exchange and requested access to a residential treatment facility for adults; and a second consumer who sought to receive services for both a SUD and a MHC in a therapeutic facility that provided care and treatment for both conditions.

The most common reason for a request for parity assistance and or complaint for youth is the need for access to residential treatment services for an individual child or youth with a severe and persistent mental health condition most often related to trauma, specifically, a history of severe emotional, physical, and/or sexual abuse. Currently Texas Medicaid does not provide access to residential treatment services. Each MCO can independently choose to authorize residential treatment service, however, the MCOs are not required to provide this benefit as this is not a benefit that Texas covers. In cases involving complaints from consumers who received Medicaid benefits, the MCOs appeared highly motivated to provide assistance and a favorable resolution if possible. Individual complaints that involve private insurance

³⁴ A complaint would be a call OBH received that they would pursue through an investigation.

³⁵ An inquiry is different from a complaint. An example of an inquiry would be if someone called OBH to ask for resources or referrals.

purchased on the exchange or an employer related plan were referred to TDI or DOL respectively.

OBH also met with HHSC Medicaid Services in an effort to understand and address the concern related to the specific barrier to Medicaid recipients being able to access residential treatment center (RTC) Services. It was determined that Texas Medicaid currently does not offer or provide an RTC benefit for children-youth that may need this service.

OBH met with the Association of Substance Abuse Providers in September 2019 to provide general information regarding parity, and complaint and inquiry services available. OBH also participated in a joint presentation at the Texas Hospital Association Behavioral Health Conference in October 2019, to provide general information about the role of the OBH and the ability to receive both inquiries and complaints related to parity.

Texas Department of Insurance Complaint, Concern, and Investigation Processes

TDI's complaint process produces data that can identify complaint patterns for a company. In addition to a "mental health parity" reason code, the data also contains relevant keywords, including alcoholism, chemical dependency, and mental illness. TDI treats all complaints with these keywords and codes as relating to parity and behavioral health access to care. Staff sends complaints needing additional attention to subject-matter experts for review. A complaint with evidence of an alleged violation of insurance laws may be sent to TDI's Enforcement Section for further investigation.

Table 3: MHC/SUD Parity Complaints received by the TDI³⁶

TDI Complaint Data										
MHC/SUD Parity Complaints										
	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
Parity Complaints	0	0	7	11	13	13	14	13	17	88
Confirmed complaints	0	0	3	0	3	1	4	3	4	18
% of Parity complaints confirmed	0%	0%	43%	0%	23%	8%	29%	23%	24%	20%

For confirmed complaints, TDI ensured that the plan took the appropriate corrective action, such as making payments for services or approval of services. In one case, complaints staff referred the complaint for further investigation.

It is important to note that the low level of complaints regarding MH and SUD services does not reflect an absence of claim or coverage problems.

Texas Department of Insurance Mental Health Parity Complaint Process

TDI can help with mental health parity questions and complaints from consumers, advocates, health care providers, and the HHSC Ombudsman for Behavioral Health.

TDI has a toll-free Help Line (1-800-252-3439) to assist callers with insurance questions. Complaints are handled through a formal complaint resolution process.

³⁶ Texas Department of Insurance. (2021, January). *Mental Health Parity Complaints* [PowerPoint slides]. <https://texashhsc.swagit.com/play/01262021-2023>

H.B. 2595, 87th Legislature, 2021, requires TDI to develop and maintain a parity complaint portal that is an integrated system that allows for the enrollee of a health benefit plan to submit complaints of suspected parity violations.

How the Complaint Process Works

TDI accepts complaints online or by email.

- Staff first review complaints to determine whether they involve health plans that TDI regulates. If they do, staff then contact the plan for a response.
- Staff review the response and the information in the complaint to determine whether the complaint is “confirmed.” A complaint is confirmed if it appears that 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, the complaint can be referred to TDI’s Enforcement Division for possible enforcement action.
- 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 health 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.

If TDI Can Not Help

TDI can only help with complaints against health plans it regulates. It can’t help with complaints about self-funded plans (health plans offered by large employers). Complaints against health plans that TDI does not regulate are logged as “non-confirmed” complaints. TDI also can’t help with complaints against doctors or other health care providers. If the agency gets a complaint against a health plan it doesn’t regulate, staff will contact the complainant and provide other options for help.

TDI’s website (www.tdi.texas.gov) also has information about how to get help with insurance-related questions and complaints.

Parity Education and Awareness Processes

Various state agencies have made an effort to provide educational resources aimed at increasing awareness for Texans on MH/SUD parity.

H.B. 2595, 87th Legislature, 2021, designates October as Mental Health Condition and Substance Use Disorder Parity Awareness Month.

HHSC Medicaid/CHIP Parity Education and Awareness Processes

The HHSC Medicaid/CHIP Parity webpage lists the areas in which MCOs must demonstrate parity. It gives background on the law that requires MCOs to be in compliance with parity and links to the following webpages:

- CMS Mental Health Parity Final Rule³⁷
- Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children’s Health Insurance Programs³⁸
- The Ombudsman for Behavioral Health³⁹

HHSC Office of Mental Health Coordination Parity Education and Awareness Processes

The HHSC Office of Mental Health Coordination maintains the MentalHealthTX.org

³⁷ Mental Health Parity and Addiction Equity Act of 2008, 81 Fed Reg. 18389 (May 30, 2016) (to be codified at 45 C.F.R. pts. 438, 440, 456, 457).

<https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>

³⁸ Center for Medicare and Medicaid Services. (2017, January 17). *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children’s Health Insurance Programs*. <https://www.medicaid.gov/sites/default/files/2019-12/parity-toolkit.pdf>

³⁹ Texas Health and Human Services Commission. (n.d.). *HHS Ombudsman Behavioral Health Help*. <https://www.hhs.texas.gov/about-hhs/your-rights/office-ombudsman/hhs-ombudsman-behavioral-health-help>

website. The Office has added parity content under each of the eight Commons Conditions pages listed on MentalHealthTX.org.

HHSC Ombudsman for Behavioral Health (OBH) Parity Education and Awareness Processes

The OBH webpage also explains how their office can help with concerns about access to behavioral health care through an insurance plan. The page contains links to Parity Track’s webpage that explains common violations of parity law in other states⁴⁰ and to NAMI’s page explaining important concepts related to parity.⁴¹

The OBH developed a brochure and a poster entitled “We Can Help With Behavioral Health Parity” and provided links to them on the HHS Ombudsman Publications webpage.⁴² The brochure⁴³ and poster⁴⁴ provide an overview of parity, describe what parity looks like, provide examples of the types of benefits that should be equal or comparable, identify scenarios that suggest the need to raise a parity concern, and spell out the process to use when a parity concern is identified. Individuals with MHC/SUD conditions are the target audience of the brochure and the poster. The brochure and the poster are also available in Spanish on the HHS Ombudsman Publications in Spanish webpage. The OBH has made print copies of the brochure and posters available to stakeholders upon request.

⁴⁰ The Kennedy Forum. (n.d.). *Common Violations*. Parity Track.

<https://www.paritytrack.org/know-your-rights/common-violations/>

⁴¹ National Alliance on Mental Illness. (2015, April 8). *What is Mental Health Parity?*.

<https://www.nami.org/Blogs/NAMI-Blog/April-2015/What-Is-Mental-Health-Parity>

⁴² Texas Health and Human Services Commission. (n.d.). *HHS Ombudsman Publications*.

<https://hhs.texas.gov/about-hhs/your-rights/office-ombudsman/hhs-ombudsman-publications>

⁴³ Texas Health and Human Services Commission. (n.d.). *We Can Help Behavioral Health Parity* [Brochure]. <https://hhs.texas.gov/sites/default/files/documents/about-hhs/your-rights/office-ombudsman/behavioral-health-parity-help.pdf>

⁴⁴ Texas Health and Human Services Commission. (n.d.). *We Can Help Behavioral Health Parity* [Flyer]. <https://hhs.texas.gov/sites/default/files/documents/about-hhs/your-rights/office-ombudsman/we-can-help-behavioral-health-parity.pdf>

TDI Parity Education and Awareness Processes

The Texas Health Options website of the TDI has a webpage that provides information on parity and insurance coverage for MHC/SUD services.⁴⁵ The page provides a definition of parity, steps that can be taken following a treatment denial, and information about state and federal parity standards, consumer rights and protections, appeals of adverse determinations, complaints, and links to relevant laws. The webpage provides links to several other resources, including:

- MentalHealthTX.org⁴⁶
- Medicaid and CHIP Mental Health and Substance Use Disorder Parity⁴⁷
- House Select Committee on Mental Health, Interim Report, December 2016⁴⁸
- Hogg Foundation for Mental Health, A Guide to Understanding Mental Health Systems and Services in Texas⁴⁹
- MentalHealth.gov page on Health Insurance and Mental Health Services⁵⁰
- Kennedy Forum⁵¹
- NAMI's December 2015 State Mental Health Legislation report⁵²

⁴⁵ Texas Department of Insurance. (2021, January 20). *Insurance coverage and parity for mental health and substance use disorder services*. Texas Health Options.

<http://www.texashealtheoptions.com/health/mentalhealthcoverage.html>
⁴⁶ Texas Statewide Behavioral Health Coordinating Council. (2021). MentalHealthTX. <https://mentalhealthtx.org/>

⁴⁷ Texas Health and Human Services Commission. (n.d.). *Mental Health & Substance Use Disorder Parity*. <https://www.hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/mental-health-substance-use-disorder-parity>

⁴⁸ House Select Committee on Mental Health. (2016, December). *Interim Report to the 85th Texas Legislature*. Texas House of Representatives. <https://house.texas.gov/media/pdf/committees/reports/84interim/Mental-Health-Select-Committee-Interim-Report-2016.pdf>

⁴⁹ Hogg Foundation for Mental Health. (2020). *A Guide to Understanding Mental Health Systems and Services in Texas*. <https://hogg.utexas.edu/what-we-do/policy-engagement/mental-health-guide>

⁵⁰ U.S. Department of Health and Human Services. (n.d.). *Health Insurance and Mental Health Services*. MentalHealth.gov <https://www.mentalhealth.gov/get-help/health-insurance>

⁵¹ <https://www.parityregistry.org/>

⁵² National Alliance on Mental Illness. (2015, December). *State Mental Health Legislation 2015: Trends, Themes, & Effective*. <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf>

- NAMI’s report “A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care”⁵³
- U.S. Department of Labor’s webpage on Mental Health Benefits⁵⁴
- American Psychological Association parity webpage⁵⁵
- Substance Abuse and Mental Health Services Administration (SAMHSA);⁵⁶
- U.S. Department of Health and Human Services parity webpage;⁵⁷
- SAMHSA, programs webpage⁵⁸
- SAMHSA, Texas Behavioral Health Barometer⁵⁹

The TDI webpage on “How to Get Help with a Mental Health Issue”⁶⁰ provides a basic description of parity and lists 4 items to know about parity. These items list the fundamental idea behind parity and provide an example, appealing an insurance company’s denial, how to ask for an external review if the health plan’s appeal process didn’t solve the problem, and how to get help from HHSC and TDI in these scenarios. The links on this page include:

- Mental health services in the age of COVID-19 (video)⁶¹

⁵³ National Alliance on Mental Illness. (2015, April). *A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care*. <https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead>

⁵⁴ U.S. Department of Labor. (n.d.). *Mental Health Benefits*. <https://www.dol.gov/general/topic/health-plans/mental>

⁵⁵ Texas Department of Insurance. (2021, January 20). *Insurance coverage and parity for mental health and substance use disorder services*. Texas Health Options. <http://www.texashealthoptions.com/health/mentalhealthcoverage.html>

⁵⁶ Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/>

⁵⁷ U.S. Health and Human Services. (2021, April 23). *Mental Health and Substance Use Disorder Parity*. <https://www.hhs.gov/programs/topic-sites/mental-health-parity/index.html>

⁵⁸ Substance Abuse and Mental Health Services Administration. (n.d.) *Programs*. <https://www.samhsa.gov/programs>

⁵⁹ Substance Abuse and Mental Health Services Administration. (2014). *Behavioral Health Equity Barometer*. <https://www.samhsa.gov/data/report/behavioral-health-equity-barometer>

⁶⁰ Texas Department of Insurance. (2021, March 22). *How to get help with a mental health issue*. <https://www.tdi.texas.gov/tips/mental-health-parity.html>

⁶¹ Texas Department of Insurance. (2020, June 18). *Mental health services in the age of COVID-19*. [Video]. <https://www.youtube.com/watch?v=nZfOgJfoQL8&feature=youtu.be>

- Disaster Distress Helpline⁶²
- Texas Health Options page on Insurance coverage for mental health and substance use disorder services⁶³
- Texas Health and Human Services^{64,65}
- 2-1-1 Texas: Care and housing resources⁶⁶

⁶² Substance Abuse and Mental Health Services Administration. (2021, June 17). *Disaster Distress Helpline*. <https://www.samhsa.gov/find-help/disaster-distress-helpline>

⁶³ Texas Department of Insurance. (2021, January 20). *Insurance coverage and parity for mental health and substance use disorder services*. Texas Health Options. <http://www.texashealtoptions.com//health/mentalhealthcoverage.html>

⁶⁴ Texas Health and Human Services Commission. (n.d.). *Mental Health & Substance Use*. <https://hhs.texas.gov/services/mental-health-substance-use>

⁶⁵ Texas Health and Human Services Commission. (n.d.). *Mental Health & Substance Use Disorder Parity*. <https://hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/mental-health-substance-use-disorder-parity>

⁶⁶ Texas Health and Human Services Commission. (n.d.). 2-1-1 Texas. <https://www.211texas.org/mental-health/>

7. Parity Work Group Goals, Objectives, and Strategies

When considering the Goals, Objectives, and Strategies it is important to account for resources necessary for implementation, many of which may require additional support for the responsible agencies. The Workgroup recognizes this and requests the Texas Legislature and agency leadership support any needed financial commitment to strengthen parity compliance, enforcement, and education.

Subcommittee 1: Compliance, Enforcement, and Oversight

This subcommittee was created to focus on the first two tasks of H.B. 10:

- Increase compliance with the rules, regulations, and statutes concerning the availability of, and terms and conditions of, benefits for MHC/SUD; and
- Strengthen enforcement and oversight of these laws and rules at state and federal agencies.

Purpose: To promote compliance with and enforcement of MHC/SUD statutes, rules, and regulations.

Goal 1: Ensure state-regulated health plans comply with state and federal parity statutes, rules, and regulations.

Objective 1.1: By September 1, 2024, HHSC and TDI will develop and maintain standardized compliance tools that align with best practices to evaluate parity compliance with all products. To the extent possible, the tools should be consistent across agencies, to minimize the burden on plan providers.

- **Strategy 1.1.1:** The HHSC/TDI tool(s) must assess the compliance of any financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations applied to mental health or substance use disorder benefits.
- **Strategy 1.1.2:** The tool(s) will reflect best practices as identified by national experts.

Objective 1.2: All plans will complete a parity analysis using the standardized tool and submit the analysis to the appropriate regulatory authority.

- **Strategy 1.2.1:** All existing plans will complete the analysis by September 1, 2025, unless an earlier date is adopted by either agency.
- **Strategy 1.2.2:** Any new plan issued after January 1, 2025 will complete the analysis before the plan is offered to consumers unless an earlier date is adopted by either agency.
- **Strategy 1.2.3:** All plans will reassess parity compliance annually, using the most up-to-date standardized tool, and submit their analyses to the appropriate regulatory authority.
- **Strategy 1.2.4:** State regulators will require health plans to adopt internal parity education programs for all staff involved with benefit management, to include verification, utilization management, case management, and/or claims administration. The health plans will submit copies of their parity education curriculum to TDI and HHSC annually, concurrently with their annual parity compliance reports.

Goal 2: State regulators will actively monitor and enforce compliance with parity.

Objective 2.1: By September 1, 2025, regulators will be able to identify any parity compliance violation, require corrective action, and deter future violations.

- **Strategy 2.1.1:** State regulators will incorporate parity compliance into existing processes for contract oversight and enforcement by September 1, 2025.
- **Strategy 2.1.2:** State regulators will require annual reports of key data to inform parity compliance by September 1, 2025. Such reports should be made publicly available in an aggregated format that does not specifically identify any plan by name, and include comparisons of MHC/SUD and M/S data with regard to:

- ▶ Utilization of in-network vs. out-of-network providers (MHC/SUD providers v. M/S providers; MHC providers v. SUD providers);
 - ▶ Reimbursement rates for in-network and out-of-network providers (relative to Medicare rates);
 - ▶ Rate of utilization review frequency, by service category (inpatient, outpatient, pharmacy, emergency, etc.) and by type of utilization review process (e.g. prior authorization, concurrent review, retrospective review);
 - ▶ Rate of denials of claims or requested care; and
 - ▶ Network adequacy, including 1.) network adequacy complaints (provider and member/enrollee) and 2.) provider ratios, which refers to the number of MHC/SUD providers per enrollee in comparison to the number of M/S providers per enrollee.
- **Strategy 2.1.3:** State regulators will conduct exams or investigations of plans for parity compliance based on complaints, audits, quality measures, data metrics from annual reports, or outlier status by September 1, 2024. State regulators will require health plans to submit all information that the regulators need to determine whether the plans are in compliance with the parity laws.
 - **Strategy 2.1.4:** State regulators will review existing enforcement mechanisms and bolster tools for enforcing compliance with parity. Some specific tools for enforcement could include:
 - ▶ Corrective action plans
 - ▶ Remediation of denied claims
 - ▶ Monetary penalties or liquidated damages
 - ▶ Requirements for additional oversight
 - ▶ Referral to Attorney General’s office for possible civil litigation

Subcommittee 2: Complaints, Concerns, and Investigations

This subcommittee was created to focus on the third and fourth tasks of H.B. 10:

- Improve the complaint processes relating to potential violations of these laws for consumers and providers; and
- Ensure HHSC and TDI 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.

Purpose: To support consumers, providers, advocates and policymakers by reviewing and improving the process of parity complaints, concerns, and investigations to increase access to care and remove barriers to service.

Goal 1: Improve complaint portals (including web, phone, and other) and workflow processes for easier locations and navigation for complainants.

Objective 1.1: By September 1, 2024, HHSC/TDI will collaboratively review parity complaint portals of other states and compare with Texas portals for visibility and location, make improvements to reflect the research, and report the research publicly.

- **Strategy 1.1.1:** HHSC/TDI will identify five most visible, accessible complaint portals around the country and evaluate their ease of location and access. HHSC and TDI will collaborate with stakeholders on visibility strategies and best practices.
- **Strategy 1.1.2:** HHSC/TDI will offer at least two methods to file a parity complaint, including at minimum a phone option and an online option.
- **Strategy 1.1.3:** HHSC/TDI will identify the top 10 key words, themes or concepts used in parity complaints and education materials. Based on those items, HHSC and TDI will develop appropriate meta-tags and search engine optimization techniques to improve the visibility of their complaint portals.

Objective 1.2: By September 1, 2024, HHSC/TDI will collaboratively review parity complaint portals of other states and compare with Texas portals for user-

friendliness and disability accessibility, make improvements to reflect the research, and report the research publicly.

- **Strategy 1.2.1:** HHSC/TDI will identify the top five parity complaint portals nationwide, compare and contrast the Texas portals with the top five from other states, and adopt best practices in complaint submission processes and complaint tracking processes.
- **Strategy 1.2.2:** HHSC/TDI will collaborate on standardization and consistency of complaint portal submission processes and complaint tracking based on the identified best practices.
- **Strategy 1.2.3:** HHSC/TDI will utilize plain language best practices across their complaint materials and portals to improve ease of navigation.

Goal 2: Ensure complaints related to MHC/SUD treatment limitations issues are investigated and resolved in a transparent, effective, and equitable manner.

Objective 2.1: Identify strategies to increase consumer and provider understanding of parity-related denials, as well as status throughout the complaint process.

- **Strategy 2.1.1:** Each denial letter will be easily readable according to federal plain language guidelines and must provide the reason for denial, information on complaint portals, agency contact information and options for different languages.
- **Strategy 2.1.2:** Each portal will offer a “Track Your Complaint” option and easily identify the status of the complaint, who to contact for information, an aging of the complaint, and estimated resolution time.
- **Strategy 2.1.3:** HHSC/TDI will require health plans to disclose all information needed by consumers to understand why their claim was denied, what medical guidelines were used to issue the denial, and what their consumer rights are.

Objective 2.2: By September 1, 2024, implement industry-standard metrics for complainant satisfaction and user experience to inform process improvement and effectiveness.

- **Strategy 2.2.1:** HHSC/TDI will gather feedback and measure satisfaction from complainants regarding ease of access, understanding of the process, agency support and professionalism, and transparency, regardless of resolution outcome.
- **Strategy 2.2.2:** HHSC/TDI will regularly review and optimize complaint channels (phone, web portal, etc.) by measuring for minimal customer effort and first-rate customer experience using current industry standards and metrics.
- **Strategy 2.2.3:** HHSC/TDI will collect productivity data and quality measures, such as resolution status, follow up with outside agencies and payers, communication touchpoints with complainants and timeliness trends.
- **Strategy 2.2.4:** HHSC/TDI will implement performance improvement initiatives on a consistent basis to address concerns related to complainant satisfaction, workflow breakdowns, complaint trending and aging of requests.
- **Strategy 2.2.5:** HHSC/TDI will ensure completion of initial and annual training of all staff responsible for handling potential parity-related complaints, concerns and investigations.

Objective 2.3: HHSC/TDI will allow complainants the option of providing and publishing standardized parity complaint demographic data to ensure diversity, equity and inclusion standards are being met.

- **Strategy 2.3.1:** HHSC/TDI will review and report complainants' demographic analytics, resolution and timeliness trends, and satisfaction to ensure equitable resolution of complaints across all demographics.
- **Strategy 2.3.2:** HHSC/TDI will provide complainants with an explanation of the importance of collecting demographic information.

Subcommittee 3: Education and Awareness

This subcommittee was created to focus on the fifth task of H.B. 10:

- Increase public and provider education on MHC/SUD regulations and laws.

Purpose: To educate all appropriate stakeholders (including MCOs, commercial insurers, consumers, family members/support systems, advocates, providers, hospitals, public, etc.) on parity laws in order to increase access to care and ensure awareness of avenues to reconciliation of complaints.

Goal 1: To ensure stakeholders understand federal and state parity rights and responsibilities and their impact on mental health conditions and substance use disorder care access.

Objective 1.1: By September 2024, TDI and HHSC Office of the Ombudsman should build upon existing education and awareness materials, creating and providing additional basic teaching and/or training related to parity rights and responsibilities.

- **Strategy 1.1.1:** TDI and HHSC should identify existing and/or develop and make available new audience-specific parity law training modules, such as webinars, to provide a fuller understanding of parity law to all stakeholders.
- **Strategy 1.1.2:** TDI and HHSC should provide at least one annual update on the status of parity rights and responsibilities.
- **Strategy 1.1.3:** TDI and HHSC should recognize the month of October every year as MHC/SUD parity awareness month, engaging in activities like community forums, press releases, etc.⁶⁷

⁶⁷ H.B. 2595, 87th Legislature, Regular Session, 2021, put this strategy into statute

- **Strategy 1.1.4:** TDI and HHSC should consider options, such as mailers, videos, town hall meetings, etc. outside of Internet trainings for educating all stakeholders, some of whom may not have readily available Internet access.
- **Strategy 1.1.5:** TDI and HHSC should use shared language and both emblems for use on any and all parity publications.
- **Strategy 1.1.6:** TDI and HHSC will put on their parity webpages a link to external education and awareness materials, and periodically scan for new materials with parity information.
- **Strategy 1.1.7:** TDI and the Office of the Ombudsman should be provided with at least \$500,000 each biennially to engage in parity education and awareness.
- **Strategy 1.1.8:** TDI and HHSC should provide parity training at the conferences of trade associations for mental health professionals, peers, family members, and health plans.

Objective 1.2: By September 2024, aspiring and current health care professionals should have access to parity training through the public university system and through licensing boards that oversee continuing education.

- **Strategy 1.2.1:** One or more public university systems should be required to develop a course addressing parity rights and responsibilities.
- **Strategy 1.2.2:** The mental health professional licensing boards should be required to develop and/or recognize parity training for the purposes of continuing education credit.

8. Parity Improvement Recommendations

When H.B. 10 became law in 2017, the lack of MHC/SUD parity was a serious problem in Texas. Individuals with MHC/SUD did not receive equal treatment from health plans as compared to those with other types of medical problems. This discrimination in coverage persists today.

While the idea behind parity is simple, full compliance with parity laws is complex and requires multiple strategies to address all components. To improve enforcement of the parity laws, the Work Group has approached this project in three separate, but related areas: (1) Compliance, Enforcement and Oversight; (2) Complaints, Concerns and Investigations; and (3) Education and Awareness. In addition, there were some problems identified that were outside of these topic areas, and they are included in (4) Additional Recommendations.

When considering the recommendations, it is important to account for resources necessary for implementation, many of which may require additional support for the responsible agencies. The Work Group recognizes this and requests the Texas Legislature and agency leadership support any needed financial commitment to strengthen parity compliance, enforcement, and education.

Based on its research, discussions, and analysis, the Work Group makes the following recommendations for proactive regulatory enforcement and, in some cases, new legislation.

1. Compliance, Enforcement and Oversight

In violation of the state and federal parity laws, health plans in Texas frequently fail to provide coverage for treatment of MHC/SUD which is equal to the coverage they provide for treatment of other M/S conditions. As discussed in the Parity Landscape section of this report, compliance issues have been found in the areas of:

- Financial requirements, quantitative and non-quantitative treatment limitations;
- Medical necessity and utilization management standards;
- Network adequacy, including contracting and reimbursement practices, which lead to higher utilization of out-of-network services for MH/SUD; and

- Various outdated treatment limitations in Texas Insurance Code Chapters 1355 (related to Benefits for Certain Mental Disorders) and 1368 (related to Availability of Chemical Dependency Coverage) that are inconsistent with parity laws.

RECOMMENDATIONS

- The Texas Legislature should enact legislation to modernize the mental health and chemical dependency statutes:
 - ▶ Broaden the applicability of all parts of Chapters 1355 and 1368 of the Insurance Code to ensure that all state-regulated plans (including individual, small group, and large group commercial plans, as well as state and university employee plans under Chapters 1551, 1575, 1579, and 1601) are subject to consistent coverage standards for serious mental illness and chemical dependency treatment.
 - ▶ Remove outdated treatment limitations from Insurance Code Chapters 1355 and 1368 that are inconsistent with parity laws.
- The Texas Legislature should enact legislation to help consumers compare networks and get protection from surprise billing when no in-network providers are reasonably available:
 - ▶ Health plans should be required to cover the cost of MHC/SUD services obtained from an out-of-network provider as an in-network benefit when a plan's network is inadequate, as compared with the network of providers for other medical services. While [Texas Insurance Code §1271.055\(b\)](#) and [§1301.005\(b\)](#) appear intended to protect consumers from inadequate networks, the law does not protect consumers from balance billing in these instances. Consider extending the balance billing protections from S.B. 1264, 86th Legislature, Regular Session, 2015, to circumstances where a network provider was not reasonably available.
 - ▶ The HMO report cards published by Office of Public Insurance Counsel (OPIC) should be expanded to include PPO and EPO plans and include comparative information about health plan networks. TDI should publish this information on its website: www.texashealthplancompare.com.

- Texas should enact legislation to improve coverage for SUD and MH medications:
 - ▶ H.B. 2174, 86th Legislature, Regular Session, 2019, limits Medicaid from imposing prior authorization requirements on opioid medications. H.B. 2174's provisions will expire August 31, 2023.
 - ▶ TDI's 2018 Report, "Study of Mental Health Parity to Better Understand Consumer Experiences with Accessing Care"⁶⁸ found that "In the small group and large group markets, a much larger proportion of prescription drugs for mental health and substance use disorders was subject to step therapy requirements compared to drugs for medical and surgical use."
 - ▶ New legislation is needed to:
 - ◇ Remove the expiration date from the H.B. 2174 provisions;
 - ◇ Expand opioid medication protections to commercial plans as well as Medicaid; and
 - ◇ Restrict step therapy protocols and "fail-first" requirements for mental health medications in the small group and large group markets.

- Texas should enact legislation that will request (as needed) from the federal government, or allow (as permitted), waiver(s) to authorize HHSC to use Medicaid funds for residential treatment for children and adults with mental health conditions.

The Work Group believes that the Texas Legislature has given HHSC and TDI the necessary authority to enforce parity requirements. We recommend that HHSC and TDI take the following actions to ensure more robust parity compliance, enforcement, and oversight.

- HHSC and TDI should develop standardized tools to evaluate parity compliance of all products. Tools should reflect national best practices, including the tri-agency compliance program guidance document required by the federal parity law, and be updated over time as needed.

⁶⁸ Texas Department of Insurance. (2018, August). *Study of Mental Health Parity to Better Understand and Consumer Experiences with Accessing Care*. <https://www.tdi.texas.gov/reports/documents/Final-draft-H.B.-10-report-8.31.18.pdf>

- HHSC and TDI should require health plans to complete and submit parity analysis for each of their products, using the standardized tool.
 - ▶ Analysis should be completed on all existing plans.
 - ▶ Health plans must complete the analysis for any new product prior to offering this product to consumers.
 - ▶ All plans should reassess compliance annually.

- The Work Group strongly supports the adoption of the TDI rules proposed in February 2021.

- HHSC and TDI should require plans to report data annually to identify potential parity issues and monitor changes over time. The data reporting requirement established by H.B. 10 has been cited as an example other states should follow, but it was a one-time requirement.

- TDI should replace the current rules in [28 TAC, Chapter 3](#), which implement [Insurance Code Chapter 1368](#) and reference outdated “TCADA” criteria for admission, continued stay, and discharge with updated utilization review standards for Texas providers.
 - ▶ TDI’s [proposed rule published September 25, 2020](#) is inadequate as it points to Chapter 448, Substance Use Disorder Facility Licensing Rules, which do not include the guidelines for treatment periods required by [Insurance Code Chapter 1368](#). The rule proposal has been withdrawn as TDI seeks to address stakeholder concerns.

- HHSC and TDI should prioritize evaluating parity compliance with respect to NQTLs where issues are known to exist, including:
 - ▶ Medical necessity guidelines;
 - ▶ Utilization management practices, including prior authorization and concurrent review requirements;
 - ▶ Step therapy or “fail first” requirements for prescription drugs; and
 - ▶ Network participation standards and reimbursement rates.

- HHSC and TDI should monitor and address the reason for disparate practices in any QTL or NQTL between MHC/SUD and M/S conditions.

- HHSC and TDI should require plans to offer adequate networks of providers for treatment of MHC/SUD that are developed using processes and standards

that are comparable to the processes and standards used to develop networks of M/S providers. Special attention should be given to Texas' large rural areas that have little or no access to MHC/SUD providers.

- ▶ These networks should include community-based providers of MHC/SUD services who serve lower income and other underserved populations, such as those in rural areas.
 - ▶ Telehealth services for treatment of MHC/SUD should be provided to the same extent they are available for treatment of other medical problems.
 - ▶ MH/SUD providers should be incentivized to participate in-network with the same strategies used for providers of other medical services, including reimbursement rate setting and expedited network credentialing.
 - ▶ Regulators should investigate disparities in out-of-network utilization and reimbursement rates for parity compliance. MHC claims and complaints should be separate from those for SUD, and also should be distinguished from M/S claims and complaints.
 - ◇ TDI and the UT Health Science Center at Houston should consider MHC/SUD parity, when implementing the all-payer claims database created by H.B. 2090, 87th Legislature, Regular Session, 2021.
- HHSC should remove all treatment limitations for substance use disorder coverage from the adult Medicaid program.

2. Complaints, Concerns and Investigations

When health plans deny coverage for treatments of MHC/SUD, individuals frequently have great difficulty pursuing their legitimate rights under parity laws for coverage of services and medications prescribed by professional providers. As TDI noted in their report, the low level of complaints regarding MHC/SUD services does not reflect an absence of parity-related problems. Under these circumstances, the individual needs the assistance of government regulators in pursuing their claims and enforcing their rights under the applicable benefit plans and the parity laws.

RECOMMENDATIONS

- HHSC and TDI should consult with regulators in other states to determine the most effective complaint process and portals and develop each agencies' processes in alignment with best practices.

- The complaint process will:
 - ▶ Offer at least two methods to file a parity complaint, including a phone option and an online option.
 - ▶ Be user friendly by minimizing the number of tree options on their parity complaint phone lines and by requiring no more than two clicks to enter their parity complaint online portals.
 - ▶ Offer a “Track Your Complaint” option so a complainant can easily identify the status of the complaint, who to contact for information, the aging of the complaint, and the estimated resolution time.
 - ▶ Gather feedback and measure satisfaction from each complainant regarding ease of access in filing a complaint, understanding of the process, agency support and professionalism, and transparency, regardless of the outcome of the complaint.
 - ▶ After a complaint has been transferred to the Ombudsman, representatives of that office should contact the complainant, obtain as much information as possible concerning the complaint, and assist the complainant in pursuing his or her rights.

- HHSC and TDI should continue monitoring national standards and ensure consistency of complaint process options and data collected.

- HHSC and TDI should require health plan providers to notify individuals in writing of their rights to challenge denials of coverage. This should include contact information for the Ombudsman for Behavioral Health.

- OBH administrative rules ([26 TAC 87.405](#)) indicate 'a consumer, the consumer’s legally authorized representative, or a health care provider may contact OBH'. However, stakeholders have expressed a lack of clarity on someone other than consumer being able to file a complaint with the OBH. The process for someone other than the consumer being able to file a complaint should be clarified, and stakeholders should be educated on [26 TAC 87.405](#).

3. Education and Awareness

Members of the public and providers of mental health and substance use disorder services are frequently unaware of federal and Texas parity laws. In addition, there

is little public awareness of the Ombudsman for Behavioral Health and the services that this office provides.

RECOMMENDATIONS

- TDI, HHSC, and the Ombudsman should educate all appropriate stakeholders (including consumers, family members and other caregivers, providers, advocates, hospitals, and the public) concerning the mental health and substance use disorder parity laws in order to increase access to care and ensure awareness of ways to assert and resolve complaints.
 - ▶ TDI and HHSC should make available audience-specific parity law training modules, such as webinars, to provide a fuller understanding of parity laws to all stakeholders.
 - ▶ TDI and HHSC should provide parity training at the conferences of trade associations for mental health professionals, health insurance plans, consumers, and family members.
 - ▶ TDI and HHSC should use shared languages and both emblems for use on all parity publications.
- TDI and HHSC should provide an annual update on the status of parity rights and responsibilities.
- TDI and HHSC should publicize the month of October every year as MHC/SUD Parity Awareness Month, engaging in activities like community forums, social media, and press releases. H.B. 2595, 87th Legislature, Regular Session, 2021, put this recommendation into statute.
- Behavioral health and medical professional licensing boards should be required to develop and recognize parity training for purposes of continuing education credit.
 - ▶ Public universities in Texas should be encouraged to develop courses addressing parity rights and responsibilities.
- Health plan providers should include a statement of parity rights and contact information for the Ombudsman for Behavioral Health in all coverage or authorization denial letters.

- Providers should be prohibited from using carrier logos on their website if they are not contracted as an in-network provider.

4. Additional Recommendations

There are other matters relating to improved enforcement of parity which do not fit within the scope of the three problem areas previously discussed. The Work Group has developed the following recommendations to address these issues, which will provide further support for covered individuals who are seeking to invoke their rights with health plans under mental health and substance use disorder parity laws.

- 19 million Texans are covered by self-insured plans or government health programs. The DOL governs those covered by self-insured plans, yet there are no civil monetary penalties available when parity violations are identified; and parity violations within those plans cannot be addressed by regulators in Texas. The national MH and SUD Parity Task Force (2016) and the President's Commission on Combating Addiction and the Opioid Crisis (2017) have both recommended that Congress allow DOL to assess civil monetary penalties for parity violations. Texas legislators should support these recommendations and call on federal lawmakers to authorize DOL to assess civil monetary penalties.
- HHSC should only contract with MCOs that follow national guidelines regarding medical approvals or denials of care.

The behavioral health workforce shortage in Texas contributes to network adequacy issues and should be addressed through support of national and state workforce initiatives.

9. Glossary of Terms

Behavioral Health: Mental health and Substance Use Disorder (addiction).

Commercial Health Plan: For the purposes of this report, the term “commercial health plan” refers to health plans offered by entities listed in Texas Insurance Code, Chapter 1355, Subchapter F, Section 1355.252.

Concurrent Review: The process of conducting ongoing review for continued access or coverage to a benefit.

Fail-First/Low cost Alternatives: Requiring a beneficiary to try one type of benefit before gaining access to another.

Financial requirement: A requirement that includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit in accordance with the definitions and applications of those limits in 28 TAC, Chapter 21, Subchapter P.

Medicaid/CHIP Managed Care Organizations: Managed Care is a health care delivery system in which the overall care of a patient is coordinated by or through a single provider or organization. Managed Care Organizations are contracted by HHSC to provide services for Medicaid and CHIP managed care clients.

Mental Health Benefit: A benefit relating to an item or service for a mental health condition, as defined under the terms of a health plan and in accordance with applicable federal and state law.

Non-quantitative Treatment Limitation (NQTL): Any limitation, often non-numeric, on the scope or duration of benefits for treatment. This includes the companies’ operations and management, benefit classifications, medical management standards, benefit design, provider reimbursement, grievance and appeals processes, and claims handling practices.

Prior Authorization: The process of obtaining approval for a service before the member receives services. The plan may review the member’s eligibility, benefit coverage, medical necessity, place of service and appropriateness of services.

Quantitative Treatment Limitation (QTL): A treatment limitation that determines whether, or to what extent, benefits are provided based on an accumulated amount such as an annual or lifetime limit on days of coverage or number of visits. The term includes a deductible, copayment, coinsurance, or another out-of-pocket expense or annual or lifetime limit, or another financial requirement.

Self-funded Health Plan: A self-funded health plan is one in which the employer pays claims itself. The employer may hire an insurance company, HMO, or another entity to manage healthcare for clients.

Substance Use Disorder: Substance use disorders refer to drug and alcohol dependence.

Substance Use Disorder Benefit: A benefit relating to an item or service for a substance use disorder, as defined under the terms of a health plan and in accordance with applicable federal and state law.

Treatment Limitation: A limitation that includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

Utilization Review (UR)/Utilization Review Agent (URA): a system for review of the medical necessity and appropriateness of health care services; and to determine the experimental or investigational nature of health care services. UR occurs on a prospective, concurrent, or retrospective basis and is conducted by a utilization review agent (URA) on behalf of a health plan. URAs and the UR process are regulated by TDI under [Insurance Code Chapter 4201](#) and rules in Title 28 of the Texas Administrative Code, [Chapter 19, Subchapter R](#).

10. List of Acronyms

OBH - Ombudsman for Behavioral Health
CHIP - Children's Health Insurance Plan
CMS - Center for Medicare and Medicaid Services
DOL - United States Department of Labor
EH.B. - Essential Health Benefit
EBSA - Employee Benefits Security Administration
ERISA - Employee Retirement Income Security Act of 1974
H.B. - House Bill
HEART - HHS Enterprise Administrative Report and Tracking System
HHSC - Health and Human Services Commission
MCO - Managed Care Organization
MH - Mental Health
MHC/SUD - Mental Health Condition and Substance Use Disorder
MHPA - Mental Health Parity Act
MHPAEA - Mental Health Parity and Addiction Equity Act
MOU - Memorandum of Understanding
M/S - Medical or Surgical Conditions other than Mental Health Conditions and Substance Use Disorders
NAIC - National Association of Insurance Commissioners
NQTL - Non-Quantitative Treatment Limitation
RTC - Residential Treatment Center
SUD - Substance Use Disorder
TDI - Texas Department of Insurance
QTL - Quantitative Treatment Limitation

11. Resources

Federal

1. Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP;
<https://www.medicaid.gov/sites/default/files/2019-12/fact-sheet-cms-2333-f.pdf>
2. 21st Century Cures Act Action Plan for Enhanced Enforcement of Mental Health Enforcement of Mental Health and Substance Use;
<https://www.hhs.gov/sites/default/files/parity-action-plan-b.pdf>
3. Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children’s Health Insurance Programs;
<https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>
4. Form to Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations;
<https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Model-Form-to-Request-MH-SUD-Treatment-Limitation-information.pdf>
5. Department of Labor, Employee Benefits Security Administration (EBSA) Health Plans and Benefits <https://www.dol.gov/general/topic/health-plans/mental>
6. Department of Labor Form To Request Documentation From An Employer-Sponsored Health Plan Or A Group Or Individual Market Insurer Concerning Treatment Limitations <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template.pdf>
7. HHS Mental Health and Addiction Services Parity Help Web Portal <https://www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html>

Parity Resources of Stakeholder Organizations

1. American Psychological Association, Parity Guide: <http://www.apa.org/helpcenter/parity-guide.aspx>
2. Health Law Advocates, Guidance for Advocates: Identifying Parity Violations and Taking Action www.healthlawadvocates.org
3. Hogg Foundation for Mental Health, Mental Health Parity Fact Sheet <https://hogg.utexas.edu/project/mental-health-parity>
4. Parity Enforcement Coalition [https:// parityispersonal.org/](https://parityispersonal.org/)
5. Kennedy Forum, Parity Registry: <https://www.parityregistry.org>
6. Kennedy Forum, Parity Track: <https://www.paritytrack.org/>
7. Milliman, Mental & Behavioral Health: <https://us.milliman.com/en/health/mental-health>
8. Legal Action Center, Parity at 10: <https://www.lac.org/major-project/parity-at-10>
9. NAMI, What is Mental Health Parity?: <https://www.nami.org/Your-Journey/Individuals-with-Mental-Illness/Understanding-Health-Insurance/What-is-Mental-Health-Parity>

Mental Health and Substance Use Disorder Resources

1. MentalHealth.gov, How To Get Mental Health Help - Health Insurance and Mental Health Services <https://www.mentalhealth.gov/get-help/health-insurance>
2. NAMI What Is Mental Health Parity: <https://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Understanding-Health-Insurance/What-is-Mental-Health-Parity>
3. Parity Implementation Coalition: Parity Resource Guide <https://parityispersonal.org/answers/resources>
4. Shatterproof: State Mental Health and Substance Use Disorder Parity Information <https://www.shatterproof.org/advocacy/state-by-state-information/parity>
5. Texas Department of Insurance (TDI): <https://store.samhsa.gov/product/Consumer-Guide-To-Disclosure-Rights->

[Making-The-Most-Of-Your-Mental-Health-and-Substance-Use-Disorder-Benefits/SMA16-4992](#)

6. Insurance Coverage and Parity for Mental Health and Substance Use Disorder Services
<http://www.texashealthoptions.com/health/mentalhealthcoverage.html>
7. Texas Health and Human Services Office of the Ombudsman
8. Behavioral Health Help <https://www.hhs.texas.gov/about-hhs/your-rights/office-ombudsman/hhs-ombudsman-behavioral-health-help>
9. Kennedy Forum Parity Track for complaints questions
<https://www.paritytrack.org/know-your-rights/common-violations/>

Additional Resources

1. [Alliance for Health Policy](#)
2. [American Academy of Addiction Psychiatry](#)
3. [American Association on Health and Disability](#)
4. [American Foundation for Suicide Prevention](#)
5. [American Group Psychotherapy Association](#)
6. [American Psychological Association](#)
7. [American Society of Addiction Medicine](#)
8. [Association for Ambulatory Behavioral Healthcare](#)
9. [Bazelon Center for Mental Health Law](#)
10. [California Consortium of Addiction Programs & Professionals](#)
11. [Community Catalyst](#)
12. [Depression and Bipolar Support Alliance](#)
13. [Faces and Voices of Recovery](#)
14. [Harm Reduction Coalition](#)
15. [Health Law Advocates](#)
16. [Kaiser Family Foundation](#)
17. [Legal Action Center](#)
18. [Mental Health America \(MHA\)](#)
19. [National Alliance on Mental Illness \(NAMI\)](#)
20. [National Alliance on Mental Illness \(NAMI\) Texas](#)
21. [National Association of Addiction Treatment Providers](#)
22. [National Association of County Behavioral Health and Developmental](#)
23. [Disability Directors \(NACBHDD\)](#)
24. [National Association for Behavioral Healthcare](#)

25. [National Association for Rural Mental Health \(NARMH\)](#)
26. [National Association of Insurance Commissioners \(NAIC\)](#)
27. [National Council for Behavioral Health](#)
28. [National Council on Alcoholism and Drug Dependence \(NCADD\)](#)
29. [NCADD-Maryland](#)
30. [Partnership to End Addiction](#)
31. [The Consumers Union](#)
32. [The Kennedy Forum](#)
33. [The Patient Advocate Foundation](#)
34. [The Thomas Scattergood Behavioral Health Foundation](#)
35. [Thresholds \(Illinois\)](#)
36. [Treatment Communities of America](#)
37. [Hazelden Betty Ford Foundation](#)
38. [Young People in Recovery](#)
39. Departments of Insurance in the five states with parity laws worthy of review and consideration
 - a. Connecticut: <https://portal.ct.gov/cid>
 - b. Maryland: <https://insurance.maryland.gov/Pages/default.aspx>
 - c. Minnesota: <https://mn.gov/commerce/industries/insurance/>
 - d. Vermont: <https://dfr.vermont.gov/industry/insurance>
 - e. Oregon: https://healthcare.oregon.gov/Pages/index.aspx?qclid=EAIaIQo_bChMIv6br9I2z8QIVEv2zCh1PCQjJEAAYASAAEgJGGvD_BwE