

## Request for information

The Texas Department of Insurance is developing rules to implement [House Bill 10](#) (HB 10), 85th Texas Legislature, Regular Session (2017).

HB 10 requires issuers to have health insurance coverage and benefits for mental health and substance use disorder treatment be in parity with coverage and benefits for medical and surgical care. It also requires TDI to enforce compliance by evaluating the quantitative and nonquantitative treatment limitations that plans place on benefits and coverage.

TDI will draft rules to align Texas parity standards with the federal rules that implement the Mental Health Parity and Addiction Equity Act (MHPAEA).

TDI is also exploring parity analysis tools and relevant data elements for monitoring parity to evaluate quantitative and nonquantitative treatment limitations within health plans.

TDI is seeking public input on best practices for parity compliance, enforcement, and oversight. Specifically, we would like answers to these questions:

1. TDI is considering requiring plans to, at a minimum, conduct standardized internal parity analyses and to have the results available to TDI during an examination.
  - a. Which of the following existing parity analysis frameworks do you think best supports health plan compliance efforts?
    - i. [Six Step Parity Compliance Guide](#)
    - ii. [Department of Labor Self-Compliance Tool for MHPAEA](#)
    - iii. NAIC Market Regulation Handbook [guidance document and data collection](#) tool for conducting Mental Health Parity analysis and verifying compliance with MHPAEA
    - iv. [HHSC approach](#) for assessing parity in Medicaid and CHIP plans
    - v. Other parity analysis framework (please specify)
  - b. Which framework above best illustrates whether a nonquantitative treatment limitation meets parity standards?

2. TDI is aware that outcomes by themselves do not represent a parity violation and not all parity issues will be shown in the data. But certain data can provide a valuable benchmark and can identify areas of potential concern. Section 3 of HB 10 required TDI to collect certain data and issue a [report](#) in 2018. The [attached scope of data](#) reflects a subset of the data collected in 2018.
  - a. Please provide feedback on the [attached scope of data](#), including:
    - i. Is it feasible to provide reliable data for each data element?
    - ii. What clarification do issuers need to ensure the data is consistent across issuers?
    - iii. Are other data elements needed?
    - iv. Should any data elements be modified or deleted?
3. What do you think is the most appropriate schedule for collecting data? Why?
4. Are there other best practices that TDI should consider as it drafts rules to support parity compliance, enforcement, and oversight?

Submit comments to [LHLcomments@tdi.texas.gov](mailto:LHLcomments@tdi.texas.gov). The comment deadline has been extended to 5 p.m., central time on February 18, 2020.

MEADOWS  
MENTAL HEALTH  
POLICY INSTITUTE

Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104

February 12, 2020

To Whom It May Concern,

The Meadows Mental Health Policy Institute (MMHPI) appreciates the opportunity to submit recommendations in response to the Texas Department of Insurance's (TDI's) request for input on best practices for parity compliance, enforcement, and oversight.

1. TDI is considering requiring plans to, at a minimum, conduct standardized internal parity analyses and to have the results available to TDI during an examination.
  - a. Which of the following existing parity analysis frameworks do you think best supports health plan compliance efforts?
    - i. [Six Step Parity Compliance Guide](#)
    - ii. [Department of Labor Self-Compliance Tool for MHPAEA](#)
    - iii. NAIC Market Regulation Handbook [guidance document and data collection](#) tool for conducting Mental Health Parity analysis and verifying compliance with MHPAEA
    - iv. [HHSC approach](#) for assessing parity in Medicaid and CHIP plans
    - v. Other parity analysis framework (please specify)

The **Six-Step Parity Compliance Guide**, **Department of Labor Self-Compliance Tool for MHPAEA** and the **Model Data Definitions and Methodology** template, together, will best support health plan compliance efforts. The Six-Step Parity Compliance Guide and the Self-Compliance Tool, alone, are not sufficient to enable a complete examination. Thus, we recommend adding the **Model Data Definitions and Methodology** template under Subsection v.

- b. Which framework above best illustrates whether a nonquantitative treatment limitation meets parity standards?

The **Six-Step Parity Compliance Guide**, which was developed by leading industry organizations prior to the issuance of the Department of Labor Self-Compliance Tool for MHPAEA, provides structured guidance for analyzing nonquantitative treatment limitation (NQTL) compliance. Many components of the guide have now been incorporated into Department of Labor regulatory guidance, and a number of states have incorporated the steps into their parity compliance and review processes. However, these efforts alone are insufficient to provide a valid and auditable NQTL analysis.

To provide a more precise analysis, the Mental Health Treatment and Research Institute LLC (MHTARI), a not-for-profit subsidiary of The Bowman Family Foundation, funded the development of the **Model Data Request Form (MDRF)**. The MDRF is a targeted, quantitative tool that employers can use to obtain meaningful data reporting from their third-party administrators with respect to four key NQTL measures: (1) network adequacy (out-of-network use); (2) in-network provider reimbursement rates; (3) denial rates; and (4) network provider directory accuracy. Employers and employer coalitions, led by the National Alliance of Healthcare Purchaser Coalitions,<sup>1</sup> are now using the MDRF to obtain quantitative outcomes data for their plans.

The regulator version of the MDRF, with the same definitions and methodology, is known as the **Model Data Definitions and Methodology (MDDM)** template; a recent version of the MDDM is attached. At least one state has incorporated the MDDM into their parity compliance audits and examinations. Of course, TDI can modify the MDDM and adapt the MDDM to meet TDI's particular needs, including which insurance products it chooses to examine, converting tables into excel format, etc. MHTARI is available to assist in these undertakings. If TDI wants to conduct standardized parity analyses and obtain meaningful data, the department must use an approach that includes detailed uniform definitions and methodologies; the MDDM fits this need best.

Additional information can be found in the 2019 Milliman white paper, *Nonquantitative treatment limitation analyses to assess MHPAEA compliance: A uniform approach emerges*, [http://assets.milliman.com/ektron/NQTL\\_Guidelines\\_White\\_Paper\\_10-07-19.pdf](http://assets.milliman.com/ektron/NQTL_Guidelines_White_Paper_10-07-19.pdf)

2. TDI is aware that outcomes by themselves do not represent a parity violation and not all parity issues will be shown in the data. But certain data can provide a valuable benchmark and can identify areas of potential concern. Section 3 of HB 10 required TDI to collect certain data and issue a [report](#) in 2018. The [attached scope of data](#) reflects a subset of the data collected in 2018.
  - a. Please provide feedback on the [attached scope of data](#), including:
    - i. Is it feasible to provide reliable data for each data element?
    - ii. What clarification do issuers need to ensure the data is consistent across issuers?
    - iii. Are other data elements needed?
    - iv. Should any data elements be modified or deleted?

This scope of data was sufficient for purposes of the one-time, legislatively-directed report issued in 2018. However, without specifying detailed definitions and comparative analytical methodologies,

<sup>1</sup> The National Alliance of Healthcare Purchase Coalitions is a nonprofit, purchaser-led coalition that represents over 40 regional business coalitions of healthcare purchasers. In total, National Alliance members represent more than 12,000 employers, which sponsor plans for over 40 million Americans.

such a request is unlikely to yield accurate data to enable a valid parity determination both within a health plan and across multiple health plans. Absent rigorously specific definitions and methodologies, health plans will interpret data requests in different ways, resulting in inconsistent results across plans (for example, approvals for less days than requested or for a lower level of care than requested are often counted as an approval by a plan, rather than as a denial of the remaining days requested or of the higher level of care requested).

The National Alliance of Healthcare Purchaser Coalitions has collected similar data elements and identified significant inconsistencies in responses across insurers. In 2018, for example, the National Alliance assessed eight large health plans with respect to over 40 areas of behavioral health policies and practices. The survey, known as the “Mental Health Deep Dive”, contained language on denial rates and reimbursement rates that lacked sufficient specificity. As a result, the responses from the health plans were inconsistent and impossible to compare. Therefore, the National Alliance has now adopted the definitions and methodology for all four categories addressed in the MDRF/MDDM.

Finally, by using the MDDM, TDI would replace the need for much of this data request spreadsheet; SECTION III of the MDDM focuses on denial rates and would provide more accurate data due to its precise and consistent definitions and methodology. The MDDM also includes three additional sections that together result in a more complete and more accurate NQTL evaluation.

### **3. What do you think is the most appropriate schedule for collecting data? Why?**

The most appropriate schedule for collecting data is every year, on a calendar year basis. The Six-Step Parity Compliance Guide can be used for any 12-month period. However, the MDDM is specific to calendar years. This is the most appropriate schedule as amendments to health plans, such as changes to medical necessity criteria or reimbursement rates, will most likely align with calendar year. The MDDM also uses Medicare rates for benchmark comparison purposes and such rates vary by calendar year.

### **4. Are there other best practices that TDI should consider as it drafts rules to support parity compliance, enforcement, and oversight?**

85(R) House Bill 10, along with the extensive regulatory and sub-regulatory guidance issued at the federal level, gives TDI the clear authority to use the best practice tools we recommend without additional rulemaking. Data shows that significant disparities in mental health and substance use disorder treatment exist, and those disparities have widened between 2013 and 2017.<sup>2</sup> Data specific to Texas is summarized at page 76 of the [2019 Report](#).

<sup>2</sup> Milliman. (2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement.

There is a public health imperative to ensure that behavioral health conditions are given the same level of care and insurance coverage as other health conditions, such as heart disease and diabetes. We urge TDI to implement the MDDM as a compliance tool and begin conducting parity analyses as expeditiously as possible; lives are depending on it. To the extent that rulemaking is deemed necessary, that process should not delay the conducting of detailed parity compliance analyses now, including quantitative assessment of outcomes.

Thank you again for the opportunity to provide feedback on best practices for parity compliance, enforcement, and oversight. If you have questions regarding these recommendations, we are happy to assist you at your earliest convenience.

Sincerely,

A handwritten signature in black ink that reads "Andy Keller PhD". The signature is fluid and cursive, with the letters "AK" being particularly prominent.

Andy Keller, PhD  
President and Chief Executive Officer  
Meadows Mental Health Policy Institute  
akeller@texasstateofmind.org  
(231) 881-0770

[http://assets.milliman.com/ektron/Addiction\\_and\\_mental\\_health\\_vs\\_physical\\_health\\_Widening\\_disparities\\_in\\_network\\_use\\_and\\_provider\\_reimbursement.pdf](http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf)

MEADOWS MENTAL HEALTH POLICY INSTITUTE

T (972) 884-4660    2800 Swiss Avenue, Dallas, Texas 75204    [texasstateofmind.org](http://texasstateofmind.org)

**MODEL DATA DEFINITIONS AND METHODOLOGY:  
A QUANTITATIVE OUTCOMES DISPARITIES TOOL  
FOR NQTL ANALYSES**

[INSERT AN INTRODUCTION BY STATE REGULATOR, SUCH AS:

[The Office of the Insurance Commission (OIC)] is using this Model Data Definitions and Methodology form (MDDM) as part of its ongoing review of behavioral health network adequacy and, more generally, parity compliance. In separate correspondence we will provide instructions as to those health plans for which data should be provided, which are referred to as “identified health products” [We will also provide “Response Worksheets” in Excel format for submission of your responses. You will see that the Response Worksheets have embedded formulae for certain cells, so that the requested calculations are performed automatically.]

If you have questions about how to complete the MDDM, please contact us.]

**DATA DEFINITIONS AND METHODOLOGY FOR THE FOLLOWING NQTL OUTCOMES MEASURES:**

1. **OUT-OF-NETWORK USE**
2. **IN-NETWORK REIMBURSEMENT RATES**
3. **DENIAL RATES**
4. **IN-NETWORK PROVIDER DIRECTORY ACCURACY**

Within 90 days of issuance of this data request, please provide the data analyses as set forth below for the identified health products. Information and data submitted as part of this data request is confidential under state confidentiality laws [insert citation].

**SECTION I - OUT-OF-NETWORK USE (BASED ON ALLOWED CLAIMS)**

Separately, for each of the identified health products that have Out-of-Network benefits, utilizing total claims allowed for both In-Network and Out-of-Network (OON) services, complete [Response Worksheet \_\_\_\_\_] [the table below] with respect to the percentage of all allowed claims that were for OON services. **Note:** Claims “allowed” are sometimes referred to as claims “paid”, and consist of claims approved for payment. In some cases, the actual payment may be the member’s responsibility, either in whole or in part (e.g., unmet deductible, copay or coinsurance). However, all claims approved for payment are considered “allowed” claims. The analysis should be for claims allowed in Calendar Year [2018] [2019].

For purposes of this data requested herein:

Inpatient facility is defined as a hospital, non-hospital based facility or residential treatment facility and encompasses all medical and surgical admissions to general acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities and skilled nursing facilities; all MH/SUD admissions to psychiatric hospitals, general acute care hospitals, non-hospital based inpatient facilities and residential treatment facilities.

Outpatient facility is defined as physical, occupational, speech, and cardiovascular therapy,

**MODEL DATA DEFINITIONS AND METHODOLOGY:  
A QUANTITATIVE OUTCOMES DISPARITIES TOOL  
FOR NQTL ANALYSES**

surgeries, radiology, pathology and pharmacy services for medical or surgical care provided in an outpatient facility setting; intensive outpatient and partial hospitalization services for behavioral health conditions in an outpatient facility setting.

Office visit is defined as a non-facility based medical/surgical or MH/SUD office visit.

Please refer to the following Milliman report for further definitions regarding OON analyses: [http://assets.milliman.com/ektron/Addiction\\_and\\_mental\\_health\\_vs\\_physical\\_health\\_Widening\\_disparities\\_in\\_network\\_use\\_and\\_provider\\_reimbursement.pdf](http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf)

[Please use Response Worksheet \_\_\_\_\_, in lieu of the table below, to complete this analysis.]

Table 1 – Plan/Product Data for Calendar Year [2018] [2019]			
Setting	<b><u>Column A</u> <u>Medical/Surgical</u> <u>Providers</u> Percentage of all allowed claims that were for OON services</b>	<b><u>Column B</u> <u>MH/SUD</u> <u>Providers</u> Percentage of all allowed claims that were for OON services</b>	<b><u>Column C</u> The absolute difference in percentage points between Column A versus Column B</b>
Inpatient Facility Stays			
Outpatient Facility Visits			
Office Visits			

If the above analyses result in any disparities of more than 5 percentage points (as shown in Column C), with the percentage for MH/SUD OON use being higher, (e.g., M/S 2.0% versus MH/SUD 7.1%; or M/S 11.0% versus MH/SUD 16.1%), this suggests that a closer audit of the processes, strategies, evidentiary standards and other factors used in applying certain NQTLs is warranted to determine whether they are comparable and no more stringent both as written and as applied, in operation. If such disparities have been found, please advise whether you plan to engage in a closer audit, and if after completion of the audit, whether you are planning to take any actions to reduce the disparities. If so, provide details regarding the steps you deem necessary and your intended timetable. Such steps could include, for example:

- Increasing in-network reimbursement rates;
- Reducing utilization review requirements for MH/SUD providers, such as frequency of reviews, that are not required for M/S providers;
- Increasing similarity in credentialing and contracting requirements between M/S and MH/SUD providers

**MODEL DATA DEFINITIONS AND METHODOLOGY:  
A QUANTITATIVE OUTCOMES DISPARITIES TOOL  
FOR NQTL ANALYSES**

**SECTION II – IN-NETWORK REIMBURSEMENT RATES**

For In-Network provider office visits only, for the CPT codes provided in Tables 2A and 2B below, and using the methodology described in the Instructions set forth below each table, please calculate the weighted average allowed amounts for the following four (4) groups of providers:

- Primary Care Physicians, “PCPs”, defined as general practice, family practice, internal medicine, and pediatric medicine physicians.
- Non-psychiatrist Medical/Surgical Specialist Physicians, defined to include non-psychiatrist specialty physicians, such as orthopedic surgeons, dermatologists, neurologists, etc. This category excludes PCPs.
- Psychiatrists, including child psychiatrists.
- Non-psychiatrist Behavioral Health (“BH”) Professionals, defined as psychologists and clinical social workers.

Complete a separate table for each of the identified health products. *The tables should be completed with claims data for Calendar Year [2018] [2019].*

[Please use Response Worksheets to complete this analysis. The Response Worksheets named \_\_\_\_\_ correspond to Table 2A below. Response Worksheets named \_\_\_\_\_ correspond to Table 2B below.]

<b>Table 2A - Plan/Product Data for Calendar Year [2018] [2019] Medical/Surgical Physicians compared to Psychiatrists</b>			
	<b>Description</b>	<b>Column A</b>	<b>Column B</b>
	<b>In-Network Office Visits Only (non-facility based)</b>	<b>CPT Code 99213</b>	<b>CPT Code 99214</b>
<b>1</b>	Weighted average allowed amount for primary care physicians (PCPs)		
<b>2</b>	Weighted average allowed amount for non-PCP, non-psychiatrist medical/surgical specialist physicians		
<b>3</b>	Weighted average allowed amount for PCPs and non-psychiatrist medical/surgical specialist physicians combined		
<b>4</b>	Weighted average allowed amount for psychiatrists, including child psychiatrists		
<b>5</b>	Ratio of Row 3 to Row 4, expressed as a percentage (Row 3 / Row 4 = %)		

**Instructions for completing Table 2A follow:**

**MODEL DATA DEFINITIONS AND METHODOLOGY:  
A QUANTITATIVE OUTCOMES DISPARITIES TOOL  
FOR NQTL ANALYSES**

- In Rows 1– 4, insert the weighted average allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A (CPT 99213) and Column B (99214). This will provide the same result as calculating the sum of the allowed amounts for every claim that was allowed for these providers, and dividing that sum by the total number of claims allowed for such providers.
- Row 5, is calculated by deriving the ratio of the amount in Row 3 to the amount in Row 4, for both Columns A and B, expressed as a percentage (e.g.,  $110 / 98 = 112\%$ ; or  $105 / 108 = 97\%$ ).

**Table 2A Comparisons to be conducted:**

If the ratio in Row 5, Column A and/or. Row 5, Column B is above 100% (indicating that PCPs and non-psychiatrist medical/surgical specialist physicians (combined) receive higher allowed amounts than psychiatrists), this disparity suggests that a closer audit of the processes, strategies, evidentiary standards and other factors used in developing and applying in-network reimbursement rates is warranted to determine whether they are comparable and no more stringent both as written and as applied, in operation. If such disparity has been found, please advise whether you plan to engage in a closer audit, and if after completion of the audit, whether you are planning to take any actions to reduce the disparities. If so, provide details regarding the steps you deem necessary and your intended timetable. Such steps could include, for example, increasing in-network reimbursement rates for psychiatrists.

Please note the following for completion of **Table 2B below**. There is only one National Medicare Physician Fee Schedule allowed amount for all physicians participating in Medicare for the following four (4) CPT codes for which data is requested: 99213, 99214, 90834 and 90837. The Medicare fee schedule allowed amounts for [2018] [2019] for non-facility based services have been provided in the template table that follows.<sup>1</sup> National Medicare fee adjustments are sometimes made for non-physician providers. In this regard, the adjusted fee schedule allowed amount for clinical social workers has been provided in the template table. Provider locality adjustments have not been taken into account for regional markets, as the testing herein is comparative, rather than absolute, and will thus yield useful allowed amount comparative information irrespective of region.

<sup>1</sup> These amounts can be found at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/> Click on [Medicare Physician Fee Schedule Look-up Tool](#), " accept license for use, select the last complete calendar year, select "Pricing information," select "list of HCPCS codes," select "National payment amount," enter each of the four codes, select "All modifiers," and submit. **Please utilize the "Non-facility Price" column.** Also refer to the one page "[Medicare Physician Fee Schedule \(MPFS\) Quick Reference Search Guide](#)" for a step-by-step summary of how to use the MPFS. Also refer to "Medicare Claims Processing Manual," Chapter 12, "Physicians/ Nonphysician Practitioners" to verify any provider-type adjustments to the MPFS, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>

**MODEL DATA DEFINITIONS AND METHODOLOGY:**  
**A QUANTITATIVE OUTCOMES DISPARITIES TOOL**  
**FOR NQTL ANALYSES**

Table 2B - Plan/Product Data for Calendar Year [2018] [2019] Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers using Medicare as Benchmark Comparison						
	Description	Col. A	Col. B	Col. C	Col. D	Col. E
	<b>In-Network Office Visits only (non-facility based)</b>	CPT 99213	CPT 99214	CPT 90834	CPT 90837	Provider allowed amounts relative to National Medicare Fee Schedule Amounts, expressed as a percentage
1	Plan/product data: Weighted average allowed amount for primary care physicians (“PCPs”) and non-psychiatrist medical/surgical specialist physicians (combined)	(a)	(a)			(b) CPT 99213 (c) <u>CPT 99214</u>
2a	Plan/product data: Weighted average allowed amount for psychologists			(a)	(a)	(d) CPT 90834 (e) <u>CPT 90837</u>
2b	Plan/product data: Weighted average allowed amount for clinical social workers			(a)	(a)	(f) CPT 90834 (g) <u>CPT 90837</u>
3	National Medicare Fee Schedule allowed amount for participating physicians in Row 1	[2018: \$74.16] [2019: \$75.32]	[2018: \$109.44] [2019: \$110.28]			
4a	National Medicare Fee Schedule allowed amount for participating psychologists			[2018: \$88.56] [2019: \$91.18]	[2018: \$132.84] [2019: \$139.95]	
4b	National Medicare Fee Schedule allowed amount for participating clinical social workers			[2018: \$66.42] [2019: \$68.39]	[2018: \$99.63] [2019: \$104.96]	
5a	Ratio of Row 1, Col. E allowed amount to Row 2a, Col. E (Row 1, Col. E / Row 2a, Col. E)					(h) CPT 90834 (h) CPT 90837
5b	Ratio of Row 1, Col. E allowed amount to Row 2b, Col. E (Row 1, Col. E / Row 2b, Col. E)					(i) CPT 90834 (i) CPT 90837

**MODEL DATA DEFINITIONS AND METHODOLOGY:  
A QUANTITATIVE OUTCOMES DISPARITIES TOOL  
FOR NQTL ANALYSES**

**Instructions for completing cells marked (a) through (i) of Table 2B follow:**

Please do **not** add any data to the other cells in this table. Applicable Medicare allowed amounts have been provided for you in Rows 3, 4a and 4b.

- Cells marked “(a)” = Insert the weighted average allowed amount (weighted by the proportion of claims allowed at each allowed amount level). This will provide the same result as calculating the sum of the allowed amounts for every claim that was allowed for these providers, and dividing that sum by the total number of claims allowed for such providers.
- Cell marked “(b)” = Insert the percentage calculated as: (Row 1 Column A / Row 3 Column A) x 100.

*Example 1:* If the amount in Row 1 Column A is \$80.09, and the amount in Row 3 Column A is \$75.32, then the percentage is  $(80.09 / 75.32) \times 100 = 106\%$ .

*Example 2:* If the amount in Row 1 Column A is \$71.19, and the amount in Row 3 Column A is \$75.32, then the percentage is  $(71.19 / 75.32) \times 100 = 95\%$ .

- Cell marked “(c)” = Insert the percentage calculated as: (Row 1 Column B / Row 3 Column B) x 100.
- Cell marked “(d)” = Insert the percentage calculated as: (Row 2a Column C / Row 4a Column C) x 100.
- Cell marked “(e)” = Insert the percentage calculated as: (Row 2a Column D / Row 4a Column D) x 100.
- Cell marked “(f)” = Insert the percentage calculated as: (Row 2b Column C / Row 4b Column C) x 100.
- Cell marked “(g)” = Insert the percentage calculated as: (Row 2b Column D / Row 4b Column D) x 100.
- Cells marked “(h)” = Insert the ratio of the amount in Row 1, Column E to the amount in Row 2a, Column E, expressed as a percentage (e.g.,  $110\% / 98\% = 112\%$ , or  $105\% / 108\% = 97\%$ )
- Cells marked “(i)” = Insert the ratio of the amount in Row 1, Column E to the amount in Row 2b, Column E, expressed as a percentage.

**Comparisons to be conducted for Table 2B:**

If the ratio set forth in Row 5a, Column E and/or in Row 5b, Column E, for CPT 90834 and/or 90837 is above 100%, indicating that PCPs and non-psychiatrist medical/surgical specialist physicians (combined) receive higher allowed amounts relative to the National Medicare Fee Schedule than psychologists and/or clinical social workers, this suggests that a closer audit of the processes, strategies, evidentiary standards and other factors used in developing and applying in-network reimbursement rates is warranted to determine whether they are comparable and no more stringent both as written and as applied, in operation. If such disparities have been found, please advise whether you plan to engage in a closer audit, and if after completion of the audit, whether you are planning to take any actions to reduce the disparities. If so, provide details

**MODEL DATA DEFINITIONS AND METHODOLOGY:**  
**A QUANTITATIVE OUTCOMES DISPARITIES TOOL**  
**FOR NQTL ANALYSES**

regarding the steps you deem necessary and your intended timetable. Such steps could include, for example, increasing in-network reimbursement rates for psychologists and/or social workers.

**END OF SECTION II. SECTION III BEGINS ON NEXT PAGE.**

**MODEL DATA DEFINITIONS AND METHODOLOGY:  
A QUANTITATIVE OUTCOMES DISPARITIES TOOL  
FOR NQTL ANALYSES**

**SECTION III - DENIAL RATES:** Using the definitions and tables below, provide a breakdown of In-Network and Out-of-Network denials for MH/SUD and for M/S services. A **denial** is defined as a refusal to authorize or allow any or all parts of a service requested or performed in any of the following 3 settings: (1) Inpatient facility; (2) Outpatient facility; and (3) Office visits. These settings, as well as the term “allow(ed)” are defined in **Section I** entitled **Out-of-Network Use**. A **denial** is further defined as follows:

Any “modified” authorizations, i.e., for lower-cost services than requested by the provider, are to be considered a denial.

Any “partial denials” i.e., number of days or visits approved are less than what the provider requested, are to be considered a denial unless subsequently approved on concurrent or retrospective review of the full requested number of days or visits.

Please provide information on the number of denials and percent of denials for MH/SUD services compared to M/S services, to be reported separately for:

(1) Lack of medical necessity reasons; and

(2) Administrative reasons (an administrative denial is one that does not involve a clinician in review of the claim), as follows:

**(A) Denials on utilization review for which no claim was submitted** (i.e., authorization for coverage of service denied; service either not delivered or self-pay), shown as a percentage (%):

- (1) Numerator: Pre-authorization and concurrent review denials based on *lack of medical necessity* for services requested in the particular setting noted.  
Denominator: All pre-authorization and concurrent reviews conducted for the particular setting noted.
- (2) Numerator: Pre-authorization and concurrent review denials based on *administrative reasons* for services requested in the particular setting noted.  
Denominator: All pre-authorization and concurrent reviews conducted for the particular setting noted.

**(B) Claim denials** (i.e., authorization for coverage of service denied; service delivered; claim submitted and not allowed), shown as a percentage (%) (counted as one denial for each unique claim, not counting denials on resubmissions of the same claim):

- (1) Numerator: Claims denied for *lack of medical necessity*, including upon pre-authorization, concurrent review and retrospective review in the particular setting noted.  
Denominator: Total claims submitted for the particular setting noted.
- (2) Numerator: Claims denied for *administrative reasons*, including upon pre-authorization, concurrent review and retrospective review in the particular setting noted.  
Denominator: Total claims submitted for the particular setting noted. [Insert percentages in Response Worksheet \_\_\_\_\_ to complete this analysis for prior authorization for inpatient services and Response Worksheet \_\_\_\_\_ for concurrent review of inpatient

**MODEL DATA DEFINITIONS AND METHODOLOGY:  
A QUANTITATIVE OUTCOMES DISPARITIES TOOL  
FOR NQTL ANALYSES**

and outpatient services.]

For In-Network treatment, complete a *pair of tables for each* of the identified health products , *and a pair of tables for the aggregate* of all the identified health products.

Separately, for Out-of-Network treatment, prepare the same pair of tables for the *aggregate* of the identified health products that have Out-of-Network benefits. *The tables below should be completed for Calendar Year [2018] [2019].*

[Please use Response Worksheet \_\_\_\_\_ to complete this analysis for prior authorization for inpatient services and Response Worksheet \_\_\_\_\_ for concurrent review of inpatient and outpatient services.]

<b><u>Table 3A - Denials for which no claim submitted</u></b>				
<b><u>Percentages</u></b>				
<b>Plan/Product Data for Calendar Year [2018] [2019]</b>				
<b>Setting</b>	<b>Medical Necessity</b>		<b>Administrative</b>	
	<b>Med/Surg</b>	<b>MH/SUD</b>	<b>Med/Surg</b>	<b>MH/SUD</b>
Inpatient Facility Stays				
Outpatient Facility Visits				
Office Visits				

<b><u>Table 3B - Claim Denials</u></b>				
<b><u>Percentages</u></b>				
<b>Plan/Product Data for Calendar Year [2018] [2019]</b>				
<b>Setting</b>	<b>Medical Necessity</b>		<b>Administrative</b>	
	<b>Med/Surg</b>	<b>MH/SUD</b>	<b>Med/Surg</b>	<b>MH/SUD</b>
Inpatient Facility Stays				
Outpatient Facility Visits				
Office Visits				

If there is any disparity in any category of denial rates for M/S compared to MH/SUD that is more

**MODEL DATA DEFINITIONS AND METHODOLOGY:  
A QUANTITATIVE OUTCOMES DISPARITIES TOOL  
FOR NQTL ANALYSES**

than 5 percentage points (e.g., 10.0% denials for M/S versus 15.1% for MH/SUD; or 15.0% denials for M/S compared to 20.1% for MH/SUD), this suggests that a closer audit of the processes, strategies, evidentiary standards and other factors used in applying pre- authorization, concurrent, and/or retrospective reviews is warranted to determine whether they are comparable and no more stringent both as written and as applied, in operation. If such disparities have been found, please advise whether you plan to engage in a closer audit, and if after completion of the audit, you are planning to take any actions to reduce the disparities. If so, provide details regarding the steps you deem necessary and your intended timetable. Such steps could include, for example:

- The use of generally accepted standards of care criteria and guidelines;
- Reducing utilization review requirements for MH/SUD providers, such as frequency of reviews, that are not required for M/S providers;
- Examining benefit exclusions for intermediate levels of care and provider types for MH/SUD benefits that are not on par with coverage for intermediate levels of care and provider types for M/S benefits.

**END OF SECTION III, SECTION IV BEGINS ON NEXT PAGE.**

**MODEL DATA DEFINITIONS AND METHODOLOGY:  
A QUANTITATIVE OUTCOMES DISPARITIES TOOL  
FOR NQTL ANALYSES**

**SECTION IV – NETWORK DIRECTORY ACCURACY:** To assist us in evaluating network adequacy, please provide the following information regarding your MH/SUD provider network applicable to each of the identified health products (e.g., PPO, POS, HMO, etc.), including inpatient facility, outpatient facility and office visit settings (combined). Prepare a separate table for each identified health product’s **provider network**.

[Please use Response Worksheets \_\_\_\_\_ to complete this analysis.]

<b>Table 4 – In-Network Provider Directory Listings – Psychiatrists</b>		
	<b>Description</b>	<b>Response</b>
1	Total number of psychiatrists (including child psychiatrists) who were listed as participating in the MH/SUD network for the identified health product (the “Network”) during the period of [July 1, 2018 to December 31, 2018] [January 1, 2019 to June 30, 2019] (the “Six Month Period”):	
2	Number of psychiatrists (including child psychiatrists) who submitted zero in-network claims for the Network for any commercially insured beneficiaries of the identified health product and all of your other health products using the Network during the Six Month Period:	
3	Number of psychiatrists (including child psychiatrists) who submitted in-network claims for the Network for 1 to 4 commercially insured beneficiaries (unique individuals) of the identified health product and all of your other health products using the Network during the Six Month Period:	
4	Number of psychiatrists (including child psychiatrists) who submitted in-network claims for the Network for 5 or more commercially insured beneficiaries (unique individuals) of the identified health product and all of your other health products using the Network during the Six Month Period:	
5	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
6	Number of psychiatrists who are child psychiatrists:	
7	Total number of commercially insured covered lives (unique individuals) enrolled in all of your health products using the Network :	
8	Ratio of psychiatrists (including child psychiatrists) to unique commercial lives, indicated as 1:xxx (calculating xxx by dividing Row 7 by Row 1):	
9	What is the network adequacy standard, e.g., 1 psychiatrist for every xxx members and/or for every yy miles for the identified health product:	

If the number of psychiatrists (including child psychiatrists) who submitted zero claims (Row 2) added to the number of psychiatrists (including child psychiatrists) who submitted claims for 1 - 4 unique individuals (Row 3), constitutes more than 10% of the number of psychiatrists (including child psychiatrists) listed as participating in your provider network during the Six Month Period (Row 1), this reveals that your in-network provider directories may not be in compliance with state and/or federal law governing same. This also suggests that a closer audit of the processes, strategies, evidentiary standards and other factors used in developing and maintaining your

**MODEL DATA DEFINITIONS AND METHODOLOGY:  
A QUANTITATIVE OUTCOMES DISPARITIES TOOL  
FOR NQTL ANALYSES**

provider networks and the adequacy of such provider networks may be warranted. If such disparities have been found, please advise whether you plan to engage in a closer audit, and if after completion of the audit, you are planning to take any actions to reduce the disparities. If so, provide details regarding the steps you deem necessary and your intended timetable. Such steps could include, for example:

- Monitoring actual in-network provider network participation in providing services to your enrollees; and
- Correcting directory inaccuracies.

**MODEL DATA DEFINITIONS AND METHODOLOGY ENDS HERE.**



Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104

February 18, 2020

To Whom It May Concern:

The Kennedy Forum appreciates the opportunity to submit comments in response to the Texas Department of Insurance's (TDI) request for input on best practices for parity compliance, enforcement and oversight.

1. TDI is considering requiring plans to, at a minimum, conduct standardized internal parity analyses and to have the results available to TDI during an examination.
  - a. Which of the following existing parity analysis frameworks do you think best supports health plan compliance efforts?
    - i. [Six Step Parity Compliance Guide](#)
    - ii. [Department of Labor Self-Compliance Tool for MHPAEA](#)
    - iii. NAIC Market Regulation Handbook [guidance document and data collection](#) tool for conducting Mental Health Parity analysis and verifying compliance with MHPAEA
    - iv. [HHSC approach](#) for assessing parity in Medicaid and CHIP plans
    - v. Other parity analysis framework (please specify)

*The Six-Step Parity Compliance Guide and the U.S. Department of Labor's Self-Compliance Tool for MHPAEA best support health plans' parity compliance efforts. This is because both tools break down the federal rule on non-quantitative treatment limitations (NQTL)<sup>1</sup> into its component parts in a manner that facilitates apples-to-apples comparisons of each aspect of the NQTL development and implementation. If a plan does not conduct a parity analysis based on comparable information about each type of NQTL in each of the six classifications of care under MHPAEA, it is impossible for the plan (or TDI) to know whether the plan is in compliance with MHPAEA. The other tools are insufficient to verify compliance because they do not fully break down the federal NQTL rule to provide enough specificity to ensure meaningful comparisons between the application of an NQTL to mental health and substance use disorder benefits compared to medical/surgical benefits. Rather than allow plans to submit incomplete or amorphous information that is labor intensive to produce and review but does not ensure*

---

<sup>1</sup> <https://www.federalregister.gov/d/2013-27086/p-426>.

*compliance, The Kennedy Forum urges TDI to require that plans submit analyses that test each indispensable part of the final NQTL rule.*

*One commercial tool that TDI might wish to explore using that aligns with the Six-Step process and the USDOL is ParityManager™. This web-based tool was originally developed by ClearHealth Quality Institute with robust stakeholder input, including from health plans, parity experts, and mental health and addiction advocacy organizations. Recently purchased by URAC, ParityManager is an enterprise-solution that TDI could require plans to use that streamlines the parity compliance process and takes plans through a stepwise process that could potentially make data collection and analysis much easier for both plans and TDI.*

*Milliman has highlighted the uniform approach that has recently emerged.<sup>2</sup> Again, this approach comes directly from the federal NQTL rule and, thus, is its logical outcome.*

- b. Which framework above best illustrates whether a nonquantitative treatment limitation meets parity standards?

*As indicated in a., The Kennedy Forum believes the Six-Step and the USDOL documents are the only resources in the list above that have the potential to demonstrate compliance with the federal NQTL rule for each NQTL in each classification of care. Because ParityManager essentially automates the Six-Step process (which, again, is taken directly from the federal NQTL rule), it can also be used to help ensure that plans' NQTLs are parity compliant.*

2. TDI is aware that outcomes by themselves do not represent a parity violation and not all parity issues will be shown in the data. But certain data can provide a valuable benchmark and can identify areas of potential concern. Section 3 of HB 10 required TDI to collect certain data and issue a [report](#) in 2018. The [attached scope of data](#) reflects a subset of the data collected in 2018.
  - a. Please provide feedback on the [attached scope of data](#), including:
    - i. Is it feasible to provide reliable data for each data element?
    - ii. What clarification do issuers need to ensure the data is consistent across issuers?
    - iii. Are other data elements needed?
    - iv. Should any data elements be modified or deleted

*The Kennedy Forum supports the comments of the Meadows Mental Health Policy Institute and the work of the Mental Health Treatment and Research Institute (MHTARI). Data collection is vital not only because it can provide a valuable benchmark and identify areas of potential concern, but also because it should be a component of health plans' parity compliance analyses. Having only qualitative descriptions in NQTL analyses is usually insufficient, given that plans are usually guided by quantitative data when imposing an NQTL.*

---

<sup>2</sup> Milliman, Nonquantitative treatment limitation analyses to assess MHPAEA compliance: A uniform approach emerges, October 2019, [http://assets.milliman.com/ektron/NQTL\\_Guidelines\\_White\\_Paper\\_10-07-19.pdf](http://assets.milliman.com/ektron/NQTL_Guidelines_White_Paper_10-07-19.pdf).

*To get meaningful data, definitions and a precise methodology are critical. Lacking these, the results are likely to be of dubious quality and are unlikely to be able to compared across time or across health plans. While MHTARI's Model Data Request Form was started to help employers improve mental health and addiction coverage for their employees (an essential endeavor), the Model Data Definitions and Methodology template can help TDI collect meaningful data from plans.*

3. What do you think is the most appropriate schedule for collecting data? Why?

*Data should be collected each calendar year. This is the time period when most health plans renew and are amended. Furthermore, as the Meadows Mental Health Policy Institute pointed out, the Model Data Definitions and Methodology template is designed to be used for the calendar year, and Medicare reimbursement rates change on a calendar-year basis.*

*Anything less than a calendar year allows plan changes that might affect compliance to potentially go undetected because no data was collected.*

4. Are there other best practices that TDI should consider as it drafts rules to support parity compliance, enforcement, and oversight?

*There is now extensive federal regulatory and sub-regulatory guidance on MHPAEA, and HB 10 gives TDI clear authority to ensure MHPAEA compliance. Unfortunately, disparities in out-of-network utilization between behavioral health and physical health continue to grow, with disparities in reimbursement a key reason for this trend.<sup>3</sup> TDI has the tools to increase Texans' access to mental health and addiction treatment by ensuring health plans are not discriminating in the coverage of mental health and addiction services.*

Sincerely,



David Lloyd  
Senior Policy Advisor  
The Kennedy Forum  
[david@thekennedyforum.org](mailto:david@thekennedyforum.org)  
(313) 590-0241

---

<sup>3</sup> Milliman, *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*, November 2019, <https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx>.

February 18, 2020

Via electronic submission to:  
[LHLcomments@tdi.texas.gov](mailto:LHLcomments@tdi.texas.gov)

## COMMENT LETTER

Re: TDI Request for Information Regarding best practices for parity compliance, enforcement, and oversight.

To whom it may concern:

On behalf of our more than 450 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association is pleased to submit these comments regarding the Texas Department of Insurance's request for information related to mental health parity.

THA and its member hospitals supported the passage of HB 10, 85<sup>th</sup> Legislative Session, and have been following implementation efforts through the Health and Human Services Commission. While THA offers the below comments, we strongly encourage TDI to work in concert with the Mental Health Condition and Substance Use Disorder Parity Workgroup (the "Parity Workgroup"), which is currently developing a strategic plan with recommendations related to increasing compliance with parity rules, regulations, and statutes. As you are aware, the Parity Workgroup was established by HB 10 and is specifically charged with studying and making recommendations on several topics, including (1) increasing compliance with state and federal rules, regulations, and statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions and substance use disorders and (2) ensuring that the Texas Department of Insurance can accept information on concerns relating to these laws and investigate potential violations. Much of TDI's information request falls within the work already being undertaken by the Parity Workgroup.

In its Request for Information, TDI posed the following questions:

1. *TDI is considering requiring plans to, at minimum, conduct standardized internal parity analyses and to have the results available to TDI during an examination.*
  - a. *Which of the following existing parity analysis frameworks do you think best supports health plan compliance efforts?*
    - i. [\*Six Step Parity Compliance Guide\*](#)
    - ii. [\*Department of Labor Self-Compliance Tool for MHPAEA\*](#)
    - iii. *NAIC Market Regulation Handbook [\*guidance document and data collection\*](#) tool for conducting Mental Health Parity analysis and verifying compliance with MHPAEA*
    - iv. [\*HHSC approach\*](#) for assessing parity in Medicaid and CHIP plans
    - v. *Other parity analysis framework (please specify)*

Regarding which parity tool would best support health plan compliance, we have found that most stakeholders agree rather than a single tool, a combination of tools would be a better approach. Therefore, we recommend starting with the **Six-Step Parity Compliance Guide** and the **Department of Labor Self-Compliance Tool for MHPAEA**. Beyond those two things, we again urge you to look to the Parity Workgroup and to other policy analysis organizations.

- b. Which framework above best illustrates whether a nonquantitative treatment limitation meets parity standards?*

As we understand it, the **Six-Step Parity Compliance Guide** is a good measure for nonquantitative treatment limitations.

2. *TDI is aware that outcomes by themselves do not represent a parity violation and not all parity issues will be shown in the data. But certain data can provide a valuable benchmark and can identify areas of potential concern. Section 3 of HB 10 required TDI to collect certain data and issue a [report](#) in 2018. The [attached scope of data](#) reflects a subset of the data collected in 2018.*
  - a. Please provide feedback on the [attached scope of data](#), including:*
    - i. Is it feasible to provide reliable data for each data element?*
    - ii. What clarification do issuers need to ensure the data is consistent across issuers?*
    - iii. Are other data elements needed?*
    - iv. Should any data elements be modified or deleted?*

The 2018 TDI report provided some beneficial data and lays the groundwork for future analysis of parity issues. THA recommends looking further into some of the initial findings of the 2018 report, which began to uncover some of the problems providers and patients face. For example, for mental health and substance use disorder, inpatient claims were denied over 60 percent more often than medical and surgical claims. Further, the report showed that denial rates for in-network and out-of-network claims among PPO plans shows that mental health and substance use disorder claims were denied approximately 30 percent more often than medical and surgical claims. The largest category of these denials fell into the category of outpatient in-network claims, accounting for 80 percent of the total claims reported.

We believe further research is necessary regarding these initial outliers, among others. Additionally, the report could be strengthened by adding some context. For inpatient behavioral health providers, insurance coverage at all is not as common for this patient population, so when denials for those with coverage is 60 percent higher than for medical and surgical, it puts additional pressure on an already fragile safety net. Moreover, the finding that outpatient in-network claims also account for a large percentage of denials is extremely troubling. Outpatient services are what keep behavioral health and substance use disorder patients from readmitting into the hospital setting and experiencing mental health emergencies. Those services are a crucial part of the continuum of care and difficult to find in many communities. Denying the care again puts unnecessary pressure on a fragile infrastructure.

Therefore, it would be important to provide some analysis on the level of routine, outpatient or partial in-patient services available and the level at which they are denied. It would also be helpful to see a breakdown comparing

intensive outpatient services or partial hospitalization to similar step-down services available to physical health patients (ex: dialysis services and intensive outpatient behavioral health services). From a parity perspective, those types of services should be as available in insurance product design, as they would be for physical care patients needing ongoing services for chronic diseases.

3. *What do you think is the most appropriate schedule for collecting data? Why?*

THA believes yearly data collection would be beneficial. A yearly analysis should be able to provide the agency and interested stakeholders a better understanding of problems with parity compliance, as well as improvements in compliance.

4. *Are there other best practices that TDI should consider as it drafts rules to support parity compliance, enforcement, and oversight?*

THA has no additional substantive comments related to best practices, but we again urge you to work with the parity workgroup and policy experts, such as the Kennedy Forum, Meadows Mental Health Policy Institute, and others. We would also encourage you to reach out to providers, who can help inform what they see in the market place in order to inform future data collection and enforcement practices. The spirit of HB 10 largely relied on collaboration between agencies and stakeholders, and incorporating information sharing and collaboration during rulemaking is key.

We appreciate your consideration of these comments. Should you have any questions or need additional information, please do not hesitate to contact me at 512/465-1000 or [swohleb@tha.org](mailto:swohleb@tha.org).

Respectfully submitted,



Stephen G. Wohleb  
Senior Vice President and General Counsel  
Texas Hospital Association

**From:** [Sherri Layton, LCDC, CCS](#)  
**To:** [LHLComments](#)  
**Subject:** Comments re HB 10 implementation  
**Date:** Monday, February 17, 2020 3:03:58 PM

---

**ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown or unexpected emails.**

Thank you to TDI for all the work that has been done related to parity since HB 10 became law. In regard to the request for comments for mental health (and substance use disorder) parity best practices, I would like to submit the following –

1. Please be sure to include “substance use disorder” in any reference to the work on parity. That is a key piece of the legislation and important to make that distinction.
2. I encourage you to incorporate the work that has been done by the Mental Health and Substance Use Disorder Parity Workgroup. Although some of the work runs parallel to what you have here, for example the analysis tools, there are additional ideas the workgroup has been considering that would be valuable to consider.
3. As for existing parity analysis frameworks, the DOL Self Compliance Tool for MHPAE appears to be one of the most user friendly. The NAIC Market Regulation Handbook is very similar in the way it is laid out but the DOL tool seems to be a bit more straightforward. I do believe the NAIC Handbook is a bit more specific on QTLs and that is valuable. The Six Step Parity Compliance Guide is a good tool but only focuses on NQTLs so QTLs could be overlooked. The HHSC approach as linked in 1. iv does not appear to be a tool but a report. The excel worksheet linked to the “attached scope of data” is a good tool for actually collecting/reporting data but would need a companion tool to expand on the information being sought.
4. Some of the tools speak to potential rate differences between medical/surgical care and MH/SUD care, but I don’t see that all do. That is a significant consideration with parity. If MH and SUD providers are not paid at rates comparable to other healthcare service providers that is an area of concern. This is an area that needs to be evaluated in any parity analysis.
5. As for appropriate schedule for collecting data, the workgroup has identified an analysis for any product before it is offered to the market. This seems to be a good place to start. Insurers should evaluate their practices, not just their products, and that will need to happen on an ongoing basis, with reports at least every other year. Complaints and market conduct examinations could/should trigger a requirement for analysis at any point determined necessary.
6. The Legal Action Center has done a significant amount of work in five states in their Parity at Ten campaign. Best practices should be considered from that body of work as well. Lac.org.

Thank you for the opportunity to give input,  
Sherri Layton, LCDC  
Member, Mental Health and Substance Use Disorder Parity Workgroup

Sherri Layton, LCDC, CCS  
Outpatient Services Administrator  
La Hacienda Treatment Center  
P: (830) 238-4222 x103  
[www.lahacienda.com](http://www.lahacienda.com)

Confidentiality Notice:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. If you have received this email in error, please notify the sender and permanently delete and/or destroy the original and any electronic or printed copies of this communication, including any attachments.



---

---

## Texas Psychological Association

February 11, 2020

Via email to [LHLcomments@tdi.texas.gov](mailto:LHLcomments@tdi.texas.gov)

To Whom it May Concern:

The Texas Psychological Association (TPA) represents the voices of over 4,500 psychologists in this state. We appreciate this opportunity to comment on the implementation of HB 10 (85<sup>th</sup> Regular Session). Our members regularly express their concerns with federal parity laws and state enforcement mechanisms.

TPA is pleased to hear that the Texas Department of Insurance (TDI) is considering requiring plans to conduct standardized internal parity analyses. While not strictly required by the Mental Health Parity and Addiction Equity Act (MHPAEA), mandating strong parity analysis tools will align insurers in the state with the spirit of the law. These measures will ensure that patients have access to the best possible care.

**1.a. Which of the following existing parity analysis frameworks do you think best supports health plan compliance efforts?**

The Six-Step Parity Compliance Guide best supports health plan compliance efforts. The steps are embedded within spreadsheets for 19 different nonquantitative treatment limitations (NQTLS), ranging from prior authorization, to provider credentialing, to formulary design, among others. While there are other NQTLS, the spreadsheets serve as examples as to how other NQTLS should be analyzed using the six-step approach. These spreadsheets, as well as example responses provided in the toolkit, facilitate compliance efforts in a way that the other frameworks do not.

**1.b. Which framework above best illustrates whether a nonquantitative treatment limitation meets parity standards?**

Again, the Six-Step Parity Compliance Guide is the best analytical framework. The Guide ensures a thorough analysis will be conducted. For example, it requires insurers to identify reasons, and evidence supporting those reasons, for the application of an NQTL to mental health and substance abuse disorder (MH/SUD) benefits. It also requires a comparative analysis between MH/SUD and medical NQTLS, both as the NQTL is written and as it is applied.

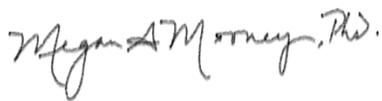
Other frameworks simply do not require as thorough of an analysis and therefore are less illustrative of whether an NQTL meets parity standards. For example, the National Association of Insurance Commissioner's Market Regulation Handbook offers little guidance as to standards for health plan MHPAEA reviews. MHPAEA compliance evaluation is not binary, and yet most of the questions in the guidance document and data collection tool elicit simple yes/no responses.

**2. a. iii. Are other data elements needed?**

Yes. The data should indicate disparities between reimbursement rates paid to behavioral health providers and other medical providers. The 2019 Milliman parity report found that primary care physicians received between 16.3 percent and 22.3 percent more than behavioral health care professionals for the same service. This NQTL on mental health services present serious access-to-care concerns.

We again appreciate this opportunity to comment and we look forward to continued involvement throughout the rulemaking process. If you have any questions or concerns, please contact our Executive Director, Jessica Magee, at [Jessica@TexasPsyc.org](mailto:Jessica@TexasPsyc.org).

Sincerely,

A handwritten signature in black ink that reads "Megan A. Mooney, Ph.D." The signature is written in a cursive style.

Megan A. Mooney, Ph.D.  
President, Texas Psychological Association

**From:** [Dr. McCoy](#)  
**To:** [LHLComments](#)  
**Cc:** [admin@texaspsyc.org](mailto:admin@texaspsyc.org)  
**Subject:** Comments on Parity.  
**Date:** Thursday, February 13, 2020 6:09:02 PM

---

**ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown or unexpected emails.**

To Whom it May Concern:

I have read and agree with the response sent to you by the Texas Psychological Association.

With regards to the answer to 3 "what do you think is the most appropriate schedule for collecting data? Why?"-- I believe a both random and representative sampling from mental health practitioners every biennium so that the data can be available to the legislature during their session or even by the December prior to their session so that they have the opportunity to be responsive to the data. The recommendation would be to use random and representative sampling based on research standards and not by guidelines set by the industry, which I distrust and believe would try to encourage TDI to use a sampling method that would be biased in favor of the insurance industry. Secondly, every 10 to 12 years a comprehensive survey to collect data from any mental health provider willing to participate should be sought to collect what I would call a periodic comprehensive sampling and would be cost and time prohibitive to do more frequently than every 10 to 12 years.

Sincerely,

Joseph H. McCoy, Ph.D./Licensed psychologist  
Pres. Valley Psychological Services, P.C.  
Volunteer Faculty UTRGV School of Medicine, Department of Psychiatry and Neurology  
Supervising and Consulting Psychologist, Doctor's Hospital at Renaissance  
5109 S. McColl Rd. (In Plaza D'Oro North Entrance)  
Edinburg, TX 78539      ph:956.682.0385, fx:956.682.0388

NOTICE!!! This e-mail is confidential, intended only for the named recipient(s) above and may contain information that is privileged, professional work product or exempt from disclosure under applicable law. If you have received this message in error, or are not the named recipient(s), please immediately notify the sender and delete this e-mail message from your computer. Thank you. You accept that communicating with me via e-mail is a non-secure form of communication that cannot guarantee confidentiality once this message leaves your or my computer and passes through the internet to be received by the other. You must not communicate with me in this fashion if this is not satisfactory and you must accept the responsibility for loss of confidentiality that is outside of my control. Thus, you e-mail VPS or have us e-mail you at your own risk. Thanks, Dr. McCoy



**Texas Association of Health Plans**

1001 Congress Ave., Suite 300  
Austin, Texas 78701  
P: 512.476.2091  
www.tahp.org

February 18, 2020

**RE: TAHP Response to House Bill 10 Request for Information**

**Via Email:** [LHLcomments@tdi.texas.gov](mailto:LHLcomments@tdi.texas.gov).

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related healthcare entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

TAHP advocates for a sound and competitive health insurance market that maximizes private market competition, consumer choice and affordable coverage options. We are writing in response to the recent Request for Information regarding best practices for mental health parity compliance, enforcement, and oversight.

The RFI states that TDI is considering requiring health plans to conduct standardized internal parity analyses and to have the results available to TDI during an examination. It provides a list of existing parity analysis frameworks and asks which best supports health plan compliance efforts and which best illustrates whether a nonquantitative treatment limitation meets parity standards. TAHP and its member plans believe that the NAIC Market Regulation Handbook guidance document and data collection tool with “Table 5” best serves these purposes.

Health plans should have the ability to demonstrate required mental health parity by employing a process and framework that has a close fidelity to the federal regulations and guidance on the application of those regulations. A compliance tool should require plans to:

- Provide their assessment of an NQTL by classification, based on the plan’s analysis of the strategy, processes, evidentiary support or other factors used to apply the NQTL to medical/surgical (MED/SURG) and mental health/substances use disorder (MH/SUD) benefits; and,
- Confirm that the NQTL is comparable to and no more stringently applied to MH/SUD benefits than to MED/SURG benefits under the plan as designed or in operation.

With respect to existing parity analysis frameworks, we believe use of the **NAIC Market Regulation Handbook** guidance document and data collection tool, in conjunction with Table 5 of the Centers for Medicare and Medicaid Services (CMS) questionnaire, is the best option for use in the conduct of plan compliance efforts. The NAIC working group developed these tools with extensive stakeholder input, including health plan input. Table 5 is used by the CMS to ensure a consistent and uniform approach in parity enforcement efforts of NQTLs. It is comprehensive, detailed, and provides useful information for validating compliance by providing flexibility to carriers in regard to disclosing information on “any processes, strategies,

evidentiary standards or other factors” *actually utilized* by the issuer. The result of the NAIC effort with the use of Table 5 is a process and tool that has close fidelity to the federal regulations and the guidance on the application of those regulations for both QTLs and NQTLs.

While not every NQTL component in the tool may apply to each health plan, and so flexibility is necessary, we feel Table 5 is clear and easy to read, which will ultimately aid examiners in conducting efficient and productive NQTL examinations. Health plans have found through experience in other markets that a narrative approach to NQTLs, as opposed to a rigid excel-spreadsheet comparative analysis grid, works best. The NAIC tool appropriately notes *that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.*

The NAIC tool is preferable to the others listed in the RFI. The Kennedy Forum “six-step” compliance tool presents an overly complex approach to parity analysis that also appears limited in scope. While NQTL requirements and standards are detailed, there is limited information presented for QTL requirements (which is specific to actuarial testing and compliance within health plan product/plan designs). The Six Step Parity Guide was developed by the Kennedy Forum, a patient and provider advocacy organization that takes a view of parity that is unduly expansive and beyond the scope of the actual regulations and guidance. It requires the use of elements that are not identified in federal regulations and imposes a level of detailed reporting and analysis of data that is neither relevant nor probative of the actual NQTL parity standard of “comparable and no more stringent” limitations on the scope or duration of benefits.

Specific problems in the Kennedy Forum tool include (but are not limited to):

- Step Number 3 specifically requires health plans to “Describe evidentiary standards that were considered but rejected, and the rationale for rejecting those evidentiary standards.” (page 5). It is unduly burdensome to house documentation for every potential evidentiary standard that could exist and the rationale for the rejection of it.
- Step Number 4 requires plans to include “the number of staff members allocated, time allotted, [and] qualifications of staff involved” in the processes and strategies of NQTLs (page 4); Gathering and maintaining this type of information for each NQTL would be administratively burdensome.
- Step Number 5 provides many illustrative analysis examples that are implied as demonstrating the NQTL is comparable and no more stringent for BH/SUD, but they do not appear to be all reliable analyses of comparability or stringency. For example:
  - Medical Management bullet #2 (page 8) states “Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g. review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classification of

benefits.” Many services are provided differently based on the type of condition and needs of the patient. Treatment for MH/SUD conditions often focus on less discrete services (e.g., ongoing therapy rather than an MRI or surgical procedure) and it is rarely linear (e.g., many patients will have regressions and gaps in treatments that will require backtracking or adjustments to a treatment plan). For this reason, review intervals or length of time should not be considered a demonstration of comparability or stringency.

- Network Adequacy bullet #1 (page 9) states “Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.” Plans do not have control of the utilization of the emergency room by beneficiaries and, therefore, this is not be reflective of whether there is a comparability issue and should not be included or utilized.

The DOL stepwise NQTL analysis requires an overly prescriptive approach, such as requiring every NQTL to be based upon a list of factors and requiring every factor to be based upon an evidentiary standard and/or source information. We would not want to see a framework that erroneously separates out “processes, strategies and evidentiary standards” from their equivalent “factors” used in applying the NQTL. Some stakeholders have argued that there should be an evidentiary standard for each factor, but such a requirement is unworkable and is not supported by state or federal law. In our view, this tool would not satisfy the objectives of HB 10 – it is limited in that it requires only conclusory statements as to the standards for NQTLs and not actual NQTL assessment that would set forth ‘analysis’ of the comparability of a given NQTL, for example.

The approach of the Texas Health and Human Services Commission (HHSC) for assessing parity in Medicaid and CHIP plans is not appropriate due to the limited scope of focus and high risk for interpretative variability. Specifically, the HHSC approach is heavily based upon MHPAEA Medicaid rules and operational requirements and less inclusive of commercial product considerations. For example, with regard to quantifiable treatment limitations, because there is no enrollee cost-sharing, the Medicaid model would be limited and/or not apply the actuarial testing methodology that commercial plans are required to perform to ensure plan designs are compliant.

We appreciate TDI’s acknowledgement in the RFI that “outcomes by themselves do not represent a parity violation and not all parity issues will be shown in the data” and would like to elaborate on that point. A one-way parity analysis does not always lead to the best quality of care for consumers and there are times when a NQTL should not be imposed in the same manner as

for physical health care. It is critical to recognize that differences do exist between behavioral health and physical health in order to ensure that the highest quality, evidence-based care is provided to enrollees. Quality should not be sacrificed in the name of parity.

Regardless of the tool the Department chooses to utilize to confirm compliance with HB 10 and MHPAEA, we strongly urge TDI to focus on methodology comparisons and not differences in outcomes within the reported data for MED/SURG benefits compared to MH/SUD benefits. We believe it is important to reference **FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39** (U.S. Department of Labor, September 5, 2019, pages 3-4), which states in part:

An NQTL is generally a limitation, often non-numeric, on the scope or duration of benefits for treatment. In developing and applying an NQTL, the regulations provide that a plan or issuer may consider a wide array of factors. For example, a plan can consider economic factors, such as high cost growth, or other factors such as the incidence of fraud with respect to services in a particular classification. **In applying those factors, the NQTL analysis does not focus on whether the final result (for example, coverage denial rates) is the same for MH/SUD benefits and medical/surgical benefits; instead, compliance depends on parity in development and application of the underlying processes and strategies.** [Emphasis added.]

With regard to data elements and scope, the focus of regulators is often not on methodology comparisons, but on results. Although factors for determining provider reimbursement rates and medical management standards may be applied in evaluating NQTLs, **it is critical to remember that, as the federal agencies have stated on numerous occasions, the NQTL requirements of the MHPAEA Final Rule do not require identical results or usage of identical NQTLs as between medical/surgical benefits and mental health/substance used disorder benefits.**

Rather, the *processes, strategies, evidentiary standards or other factors* used in determining whether and to what extent a benefit is subject to an NQTL must be *comparable to and applied no more stringently* for mental health/substance used disorder benefits than for medical/surgical benefits. Disparate results alone do not mean that the NQTLs in use fail to comply with MHPAEA. All too often, the fact that disparate results exist for a data point creates a more prejudicial than probative framework that subsumes any comparable methodology analyses. While the Department of Labor has said that certain disparate denial rates may be evidence of a parity violation (or a “red flag”), it is crucial that the focus of the TDI NQTL analysis should be on methodologies as opposed to outcomes. Given such a focus, we recommend that only limited essential data elements be collected as part of the parity requirements and the scope should be refocused on process instead of results.

Given that the Market Conduct Annual Statement (Health) already includes some mental

health/SUD claim data reporting by health insurers in TX and 49 other states, the Health MCAS would be a more suitable and reliable vehicle for collection of this level and quantity of behavioral health data, and would result in a more consistent and useful baseline of standardized data elements for comparison by TDI across plans and markets, and allow multistate health insurers to avoid creating and maintaining unique system programming schemes for data collection and reporting for each jurisdiction in which they operate. While the mental health/substance use disorder data collected under the Health MCAS is currently limited, any expansion of the scope or depth of this information could be properly vetted within the more established and appropriate NAIC process governing regulatory market analysis initiatives and tools.

Regarding the scope of data attached to the RFI, the scope and content of each data element and field should be better defined to ensure consistent responses across all submitters in a timely manner to allow issuers to successfully meet requirements. For example, does prior authorization data include requests that occur for extension of services already initiated or is it truly just authorizations requested pre-service? Additional examples are included below.

As noted, we believe the content populated in any report, based on the data elements alone, may be misleading. As acknowledged by TDI, outcomes themselves do not present a parity violation, but even reported as part of a benchmark effort the figures may be misinterpreted. The categories within the scope of data, such as reported claims, or utilization reviews, are not aligned to the NQTLs as defined by any given benefit plan. Health plans are allowed to determine the categorization and classification of M/S and MH/SUD services, and so there may be inconsistencies across health plans. The data therefore should not be used as a benchmark.

If required for collection, the data should be modified to capture information at higher levels (e.g., eliminate breakdown of information by enrollee age). Further, several elements of the data request appear to point to a level of parity assessment that is not required by MHPAEA. For example, appeals figures are requested for age bands, but there is no requirement to assess parity by age band in MHPAEA.

We have several additional and more specific comments regarding the scope of data attached to the RFI:

- There should be an option for no data (“N/A”) to be an appropriate response where applicable. For example, one of the queries involves prior authorization data where a “fail first” requirement was involved but if a plan does not apply step therapy it should be able to respond as N/A. The tool makes assumptions about NQTLs that may not apply to all plans or in all cases.
- The data set indicates it should be submitted with a separate sheet for individual, small group, large group, PPO, EPO and HMO but it is unclear whether it would be expected for there to be six different data submissions or nine (e.g. Individual PPO, Individual

EPO, Individual HMO, Small Group PPO, Small Group HMO, etc.).

- For any data request, there is a need for clear definitions for every data element as these are unclear given the many variables that may impact each one. A limited list of examples is:
  - Should claims be reported on an incurred basis or on a paid basis?
  - Should run-out be included? If so, how much run-out?
  - Should the number of claims include facility, professional, and other places of service?
  - Should claims be reported as unique claims?
  - What type of denials should be included? (adverse determinations, non-covered services, duplicate claims, incorrect billing, etc.)
- For Reported Claims Section:
  - Line 1 – what is a “reported claim?”
  - What about claims that may be submitted multiple times? (Note that pharmacy claims may be “rejected” multiple times based on errors in the claim before being paid or approved. We suggest that you consider requesting data on pharmacy transactions vs. claims).
  - What about claims that are partly paid and partly denied?
- For the Utilization Reviews Section- we object to the breakdown by age as unnecessary, overly burdensome, and not authorized by law.
- Lines 18-20 – please clarify whether “external review organization” means an independent review organization (IRO).
- Lines 21-23 – please clarify what is meant by “appealed to a physician-to-physician review.” As you know, Texas law requires health plans/UR agents to offer a peer-to-peer discussion prior to issuing a denial/adverse determination. How are these different from internal appeals (referenced in lines 15-17)? These rows should not be included.
- The tool contains a sub-classification of pharmacy benefits (generics and non-generics) that is not recognized under MHPAEA and should be removed as not authorized by law.
- It would be difficult to determine which ER claim (columns L-O) are “mental health /SUD” vs “medical/surgical.” These services are typically provided in the same ERs and have the same claim billing codes, so how should they be categorized? The use of diagnosis codes or something similar may be arbitrary and inappropriate. For example, alcohol withdrawal is almost always considered a medical emergency, but is TDI suggesting this go under MH/SUD based on diagnosis? We suggest deletion of this category.
- Regarding the complaints and enrollment tab, please clarify the meaning of the request regarding number of received complaints “regarding procedures or services relating to benefits covered under the plan” in each of the markets? (What are procedures or services *relating to* covered benefits?)

**Regarding the most appropriate schedule for collecting data, we recommend no more**



**Texas Association of Health Plans**

1001 Congress Ave., Suite 300  
Austin, Texas 78701  
P: 512.476.2091  
www.tahp.org

**frequently than annually.** This would provide a broader report of the claims and prior authorizations as there is a lag in claims and UR data. We would recommend that standards for MHPAEA reporting and examination by the Department be done to the extent possible consistent with existing reporting and examination processes. For example, routine market conduct examinations with respect to MHPAEA should occur with the same frequency and on the same cycle as existing market conduct examination activity. If TDI chooses one date for all plans, we recommend that it be in May or June to allow plans sufficient time to gather, review, and analyze the prior year's data.

Finally, TDI should provide health plans with sufficient time to respond to a particular data collection taking into account, among other things, the scope, rigor and complexity of the request. Health plans will need more time than was given for the initial data request conducted in 2018. Depending on the definitions used for each data element, there may be significant adjustment needed, for example to a plan's standard reports or standard data elements, as well as to data elements requiring coordination with vendors.

In conclusion, we urge you to support a flexible, streamlined and clear approach to parity analysis that is consistent with the federal law and our comments above for the benefit of all stakeholders.

TAHP appreciates the opportunity to submit this information for your consideration. We look forward to working with you on these issues. Please contact me with any questions or to discuss further.

Regards,

A handwritten signature in black ink that reads "Jamie Dudensing". The signature is written in a cursive, flowing style.

Jamie Dudensing, RN  
CEO  
Texas Association of Health Plans

cc: Melissa Eason  
Regulatory counsel

1. TDI is considering requiring plans to, at a minimum, conduct standardized internal parity analyses and to have the results available to TDI during an examination.
  - a. Which of the following existing parity analysis frameworks do you think best supports health plan compliance efforts?
    - i. Six Step Parity Compliance Guide
    - ii. Department of Labor Self-Compliance Tool for MHPAEA
    - iii. NAIC Market Regulation Handbook guidance document and data collection tool for conducting Mental Health Parity analysis and verifying compliance with MHPAEA
    - iv. HHSC approach for assessing parity in Medicaid and CHIP plans
    - v. Other parity analysis framework (please specify)

**Community Health Choice Response:** *HHSC\_approach for assessing parity in Medicaid and CHIP plans*

- b. Which framework above best illustrates whether a nonquantitative treatment limitation meets parity standards?

**Community Health Choice Response:** *HHSC approach for assessing parity in Medicaid and CHIP plans*

2. TDI is aware that outcomes by themselves do not represent a parity violation and not all parity issues will be shown in the data. But certain data can provide a valuable benchmark and can identify areas of potential concern. Section 3 of HB 10 required TDI to collect certain data and issue a report in 2018. The attached scope of data reflects a subset of the data collected in 2018.
  - a. Please provide feedback on the attached scope of data, including:
    - i. Is it feasible to provide reliable data for each data element?

**Community Health Choice Response:** *It is not feasible to provide reliable data for the following requested elements:*

**#7-** How many prior authorization requests in line 5d required a peer-to-peer or physician-to-physician review?

**Community Health Choice Response:** *Requesting clarification on which data is requested - Is the intent of this question to determine the number of prior authorization requests that required physician review by a medical director or how many determinations made by physician review required a peer to peer for the determination to be made?*

**#8-** Number of prior authorization requests that were subject to a fail-first requirement?

**Community Health Choice Response:** *Measurement of the requested data is not feasible.*

**#10-** Number of prior authorization requests in line 5d that are pending determination

**Community Health Choice Response:** *Clarification is needed about how the term 'pending a determination' is being used.*

**#11-** Number of reported claims in line 1 subject to concurrent, retrospective or other utilization review (excluding prior authorization)

**Community Health Choice Response:** *Clarification is needed regarding if the claim was based upon concurrent, retrospective or other utilization review.*

**#14-** Number of reported claims in line 11 that are pending a determination

**Community Health Choice Response:** *More clarification is needed regarding 'pending determination.'*

ii. What clarification do issuers need to ensure the data is consistent across issuers?

**Community Health Choice Response:** *Ensure that issuers have the same understanding of terms; develop a legend/dictionary of defined terms for the document.*

iii. Are other data elements needed?

**Community Health Choice Response:** *No other data elements are needed.*

iv. Should any data elements be modified or deleted?

**Community Health Choice Response:** *Fail-first identification; Overall modification of descriptions for clarity*

3. What do you think is the most appropriate schedule for collecting data?

**Community Health Choice Response:** *Triennial audit schedule will provide opportunity for health plans to look for trends.*

4. Are there other best practices that TDI should consider as it drafts rules to support parity compliance, enforcement, and oversight?

**Community Health Choice Response:** *Attempt to align with HHSC rules to reduce conflicting requirements between HHSC and TDI; Provide a legend of defined terms to avoid misinterpretation by health plans.*