Committee on Health Care of the Oregon Legislative Assembly

Mental Health

Provider Reimbursement

Carrier Data Call

As required by 2017 Senate Bill 860

Volume V – Maximum Allowable Reimbursement Rate Methodology

Prepared for:

Oregon Department of Consumer and Business Services
Division of Financial Regulation

March 31, 2020

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D. Data Call Analysis and Observations - Maximum Allowable Reimbursement Rate Methodology

This section addresses whether the methodologies used by the 11 carriers to determine the carrier's reimbursement rate schedule are equivalent for in-network Behavioral Health Providers[1] and in-network Medical Providers as they relate to SB 860, Section 1, Subsection (2)(d).

The Contractor requested and reviewed information regarding each carrier's Maximum Allowable Reimbursement Rate (MARR) methodology for Medical Providers and BH Providers to determine if the process is equivalent for these provider types. As previously noted, the Data Call requested information regarding provider reimbursement policies, procedures, methodologies and equations. Specific requests were made regarding how reimbursements were developed, calculated, negotiated, factors considered, the standards considered (i.e., evidentiary standards) and how the 11 carriers (collectively, Carriers) operationalized the process for establishing reimbursement allowances. The Carriers were also requested to provide a comprehensive listing of the treatment limitations (i.e., utilization management, code edits, provider-specific restrictions and credentialing) applied to outpatient time-based office visits/services. In a number of instances, the Carriers did not provide the requested information or the information submitted was insufficient or incomplete. As such, follow-up requests were issued to Carriers.

There were 22 health plans (plans) among the 11 carriers as follows:

- Carrier 1 had three plans – A, B and C
- Carrier 2 had six plans – D, E, F, G, H and I
- Carrier 3 had one plan – J
- Carrier 4 had one plan – K
- Carrier 5 had four plans – L, M, N and O
- Carrier 6 had one plan – P
- Carrier 7 had two plans – Q and R
- Carrier 8 had one plan – S
- Carrier 9 had one plan – T
- Carrier 10 had one plan – U
- Carrier 11 had one plan -- V

Two charts are presented below that summarize key points from the Contractor's analysis of the reimbursement methodology information provided by the Carriers. Report Chart D1 reports each carrier's reimbursement rate methodology for Medical Providers and BH Providers. Report Chart D2 reports the factors that each carrier considered when setting reimbursement rates. Specific analysis regarding each carrier's reimbursement rate methodology, including any variances between BH Provider and Medical Providers', is included further below in the section titled "Carrier Methodology Analysis" within this Section of the Report.

[1] While part (c) mentions "behavioral mental health providers" and part (d) references "behavioral health providers" the term "behavioral health" refers to both mental Health and substance use disorder treatment, so the two provider descriptions are equivalent in their meaning.

It should be noted that one of the 11 carriers operates as an integrated care delivery system where many services and treatments are provided to members by medical and behavioral health professionals. This carrier offered a leased network option to members of two of its plans. Under this arrangement, the carrier pays a per member/per month fee to the network lessor. Specific to this carrier, the information discussed in the sections below will report on this carrier's contracted providers.

Summary Trending Analysis - Reimbursement Rate Methodologies

As explained below, in some instances, carrier reimbursement rate methodologies for BH Providers varied from the methodologies for Medical Providers. The summary trending analysis below includes information for the Carriers and the 22 plans, as follows:

- Two carriers (carriers 1, and 7) had more than one plan; however, the reimbursement rate methodologies were the same for all of their plans. As such, for these carriers, the summaries in Report Charts D1 and D2 are presented at a carrier level rather than plan level.

- Two carriers (carriers 2 and 5) also had more than one plan, but these carriers utilized the Centers for Medicare & Medicaid Services (CMS) resource-based relative value scale (RBRVS) rate methodology and relative value units (RVUs) as a basis for reimbursement rate methodologies, and rate calculations varied by plan. For example, the following comments apply to carrier 2 and carrier 5:
    - Carrier 2:
        - Plans F and I - A negotiated conversion factor is multiplied by the RVUs for the billed CPT (Current Procedural Terminology) code. Also, the carrier stated that, "We may consider a providers participation in our Pay for Performance program, a Total Cost of Care arrangement, CPC+ participation or other alternative payment arrangements."
        - Plan D - Under this plan rates follow those for plans F and I as explained above. In addition, medical homes are also paid a per member per month rate in addition to their fee for service rate outlined above.
        - Plan G – Under this plan rates follow those for plans F and I as explained above. However, the carrier noted, "In a small number of cases, the *plan G* rate is lower than the *plan* F and I rate but is generally equal." In addition, medical homes are also paid a per member per month rate in addition to their fee for service rate outlined above. Finally, the carrier indicated that some provider groups are paid on a capitated basis.
        - Plans E and H - Under these plans, the carrier noted the following: "In setting and negotiating the rates for plans E and H, we asked for a lower rate than the provider's rate in the plans F and I network, in most cases. That proposed decrement depended on the level of the plans F and I rate." A negotiated conversion factor is multiplied by the RVUs for the billed CPT code. Also, the carrier stated, "We may consider a providers participation in our Pay for Performance program, a Total Cost of Care arrangement, CPC+ participation or other alternative payment arrangements." Finally, the carrier indicated that some primary care groups are paid on a capitated basis.

- Carrier 5:
    - The carrier stated that the MARR was determined by multiplying the RVU and the conversion factor in the provider contract by the number of units billed, including modifiers when applicable. For plans L and O, the carrier indicated that modifiers were not used.
    - For plans M and N, the carrier indicated that they had MARRS for some modifiers and in those situations they utilized the following "Equation: RVU * RBRVS conversion factor, possible mid-level reductions, LOBA impact." The modifiers utilized varied by plan and by year.

- Two of the 11 carriers (carriers 9 and 10) noted that they did not have written policies and procedures regarding the reimbursement allowance methodology process. However, these carriers provided written descriptions of their reimbursement methodologies to the Division.

- Three of the 11 carriers (carriers 2, 6 and 11) stated that BH Provider and MH Provider base rate calculations were developed several years ago by their third party entity and they do not have the historical calculations for each rate by procedure code.

- Four of the 11 carriers (carriers 1, 7, 8 and 10) utilize the CMS's RBRVS method and relative value units (RVUs) as a basis for developing reimbursement allowances for time-based outpatient (OP) office visits and services for both Medical Providers and BH Providers. Three of these carriers (carriers 1, 7 and 10) also apply a conversion factor to the RVU. One of the carriers (carrier 8) assigns a fixed rate to the RVU.
    - In reference to carrier 10, the carrier noted the following information regarding their methodology: "*Carrier 10* uses a CMS reimbursement methodology involving RVUs that involve weight factors and RBRVS conversion factors to calculate and establish reimbursement allowances for Medical Providers. In addition, that [sic] methodology, *carrier 10* uses the Medical Physicians Fee Schedule (MPFS) for Medical Providers as well. In negotiations with providers, RBRVS and MPFS conversion factors and the percentages of the MPFS are agreed upon to determine contracted payments. For services that do not carry RVU weights or set fees on the MPFS, *carrier 10* uses a percentage of billed charges to establish a default rate to use for reimbursement to the providers for services that falls within their scope of practice." The carrier further noted the following regarding their use of conversion factors: "The conversion factors are based on market rates. These are determined by internal discussions between Contracting and Finance, as well as with external providers. *Carrier 10s' third party entity* is the primary mental health network utilized by *carrier 10* for commercial plans. Conversion rates are developed closely with them through mutually beneficial negotiations. This coordination is valuable in determining acceptable conversion factors."

- Two of the 11 carriers (carriers 3 and 5) had Medical Provider and BH Provider reimbursement rate methodologies that were based on CMS's RBRVS RVUs where conversion factors and/or weights were also utilized. However, the process varied for BH Providers which resulted in lower MARRs as follows:
    - One of the carriers (carrier 5) had reimbursement allowances for BH Providers that were a lower percentage of the Medical Provider rate

- One of the carriers (carrier 3) had BH Provider reimbursement rates that were based on a tiered percentage of the Medical Provider rate

- One of the 11 carriers (carrier 9) had Medical Provider and BH Provider reimbursement rate methodologies that entailed the use of a standard fee schedule. The carrier indicated that the standard fee schedule was derived from industry standard methodologies and sources, such as RBRVS. However, reimbursement allowances for BH providers were a lower percentage of the Medical Provider rate. Also, the information provided by the carrier did not explain the differences in MARRs for the provider types included in SB 860.

- Four of the 11 carriers (2, 4, 6 and 11) had BH Provider reimbursement rate methodologies that were based on internally developed fee schedules. This process varied from the Medical Provider methodologies that were based on CMS RBRVS RVU where conversion factors, weights and/or Geographic Practice Cost Index (i.e., Portland, Oregon) were also applied.
    - For example, carrier 4 provided the following information regarding their use of fee schedules for BH Provider reimbursement rate methodologies: "The reasons for not adopting RVU-based reimbursement for these provider types were continuity, fairness, and clinical value. Changing to RVU-based reimbursement in an actuarially sound manner, even with an adjustment for inflation, would mean increasing reimbursement for some codes and decreasing reimbursement for other codes. In particular, it would mean decreasing reimbursement for 90834 which is the standard 50-minute psychotherapy hour. As a result, such a change would result in a reduction in overall compensation for many providers, which would be untenable. The potential disruption from adopting RVU-based reimbursement is heightened by the poor alignment between the new CPT coding adopted in 2013 and actual practice patterns. A standard 50 minute psychotherapy visit is billed with 90834; the threshold for coding up to 90837 is 53 minutes. The RVU for 90837 in 2017 was 55% higher than for 90834, for as little as 3 minutes of additional work. To adopt a 55% differential between those two codes in an actuarially sound way would artificially punish providers who provide a standard 50 minute session. Any patients whose benefit structures include deductible and co-insurance for office visits would be stuck paying half again more for a 53 minute visit than for a 50 minute visit. We think this would be grossly unfair. *Carrier 4* did not want to impose those consequences on providers and members unless there was good reason to do so. We could find no good reason to do so. Given national and local pressures to move from paying for activity toward paying for value, *carrier 4* determined there was sound reason not to adopt RVU-based reimbursement in these fee schedules. Moving to an RVU basis would move us in the opposite direction from value-based contracting. RVUs are based on the amount of work and resources involved in providing a service, with no consideration to the clinical value of that service. Value-based reimbursement seeks to incorporate the clinical value of services into the compensation schema."

Summary Trending Analysis - Reimbursement Rate Factors Considered

The Carriers were requested to provide information regarding the factors considered when setting reimbursement allowances for Medical Providers and BH Providers. The following was noted:

- Five of the 11 carriers (carriers 3, 4, 7, 9 and 10) considered the same factors when setting MARRs for Medical Providers and BH Providers.

- For two of the 11 carriers (carriers 1 and 2), the factors considered varied where there was one or two additional factors considered for BH Providers.

- For three of the 11 carriers (carriers 5, 6 and 11), the factors considered for BH Providers varied from those for Medical Providers. For example, for BH Providers, carriers 6 and 11 considered third party publications, license and education levels, specialty, geographic location, purpose of codes and duration of services. However, for Medical Providers, the factors considered by these carriers were specialty and geographic location.

- One of the 11 carriers (carrier 8), considered few factors for BH Providers. This carrier only considered network need, geographic area and Medicare fee schedule benchmarks for BH Providers while other factors such as information from third parties such as CMS and site of service information were considered for Medical Providers.

Summary Trending Analysis - Reimbursement Rate Factors Considered for Negotiations

Information regarding the factors considered when negotiating reimbursement rates for Medical Providers and BH Providers were also requested from the Carriers. The following were noted:

- Six of the 11 carriers (carriers 1, 3, 4, 8, 9 and 10) considered the same factors while negotiating reimbursement amounts with their respective Medical Providers and BH Providers.
    - Regarding carrier 8, the carrier noted the following: "*Carrier 8* negotiates with both medical and behavioral providers mutually agreed upon reimbursement rates based upon a mutual determination of what is deemed to be market competitive reimbursement for that particular provider rendering that particular service for that particular amount of time. It is not a formula-based process and there are no additional policies, procedures or supporting documents to provide." The carrier also noted the following: "The Company's maximum allowable rates are set through what can be negotiated in the market. Another factor is the frequency the providers approach us to re-new their contracts. For medical, the majority of providers re-new annually; resulting in more frequent rates changes. The Company does not encounter the same frequency of renewals from the MH/SUD providers."

- One of the 11 carriers (carrier 2) considered factors such as supply and demand, specialty, geography and license/education for BH Providers. However, factors such as line of business being served, historic claim performance, marketplace rates and competitiveness were also considered for Medical Providers.

- Two of the 11 carriers (carriers 6 and 11) considered the same factors while negotiating reimbursement amounts with Medical Providers and BH Providers, however, the carriers utilized a proprietary pricing modeling tool for Medical Providers only.

- One of the 11 carriers (carrier 7) considered the same factors while negotiating reimbursement allowances with Medical Providers and BH Providers. However, for Medical Providers, the carrier utilized an executive level manager to approve all increases to standard rates, which varied for BH Providers, wherein increases to standard rates were approved by a professional relations representative.

- One of the 11 carriers (carrier 5) considered the providers credentials and specialty for Medical Providers and BH Providers. However, for BH Providers, an adjustment was made for the credentials or level of licensure for these provider types. For instance, Psychologist's allowances were set at eighty-five percent of the Medical Provider's rate, Licensed Clinical Social Worker and Licensed Professional Counselors and Licensed Marriage and Family Therapist allowances were set at sixty percent of the Medical Provider's rate.

A summary of Medical Provider and BH Provider Reimbursement Rate Methodologies is presented by carrier and plan in Report Chart D1 below. A summary of factors considered by carriers when setting reimbursement allowances is presented in Report Chart D2.

Report Chart D1 - Medical Provider and BH Provider Reimbursement Rate Methodologies

Carrier	Plan(s)	MARR Methodology for Medical Providers	MARR Methodology for Behavioral Health Providers
1	A - C	Specific to contracted providers for plans A, B and C, the carrier stated: "practitioners are paid utilizing standard Current Procedural Terminology (”CPT”) coding and resource-based relative value scale (“RBRVS”) methodology. *Carrier 1* uses the equation {RVUs * Conversion Factor, adjusted for Provider Type} for all subcontracted Medical Providers, Mental Health Providers with Prescribing Privileges and Behavioral Mental Health Providers.” The carrier's methodology also allows for negotiations with Providers. “The factors considered when negotiating reimbursement amounts for Medical Providers are as follows: credentials of the provider, treatment protocols, the market benchmarks and demand and supply conditions."	The carrier follows the same methodology for BH Providers as stated for Medical Providers. The factors considered when negotiating reimbursement amounts for BH Providers is the same as for Medical Providers.

Carrier	Plan(s)	MARR Methodology for Medical Providers	MARR Methodology for Behavioral Health Providers
2	D - I	This carrier has six plans and the following information applies to all plans. The carrier stated: "Our standard approach to developing reimbursement allowances are to use the negotiated conversion factor multiplied by the applicable RVUs for the RVU year being used. We do have some arrangements where there is a capitation payment (pmpm) that covers these services in part or in full. We do not have policies and procedures or documentation of our standard methodologies." The carrier's methodology also allows for negotiations with Providers. The factors considered when negotiating reimbursement amounts for Medical Providers are as follows: "Current rates, Marketplace rates and competitiveness, Position of provider in the community, Alternatives in that specialty in the community, Capacity in the community, Line of business being served, Participation in pay for performance or other programs and Historic claims experience."	This carrier has six plans. The following information applies to all six plans. The network of BH Providers and all associated functions such as MARR methodology is handled by the carrier's third party entity. The carrier stated: "Providers are reimbursed based on an internally developed fee schedule and the contracted entity's approach is to reimburse at 100% of these fee schedules; however, the entity allows providers to negotiate an inflator to these fee schedules. In addition, reimbursement may be affected by payment policies based on the specialty of the billing provider (e.g., NPs, PAs), procedure code modifiers, and coding edits." Base rate calculations were developed several years ago and the contracted entity does not have the historical calculations for each rate by procedure code. The carrier's methodology also allowed for negotiations with Providers. The carrier considered the following factors when negotiating reimbursement amounts for BH Providers: "License/education levels, Geography, Supply and demand and Specialty"

Carrier	Plan(s)	MARR Methodology for Medical Providers	MARR Methodology for Behavioral Health Providers
3	J	The carrier stated the following: "National standards of CMS resource-based relative value scale (RBRVS) relative value units (RVUs) professional reimbursement guidelines are the fundamental framework used in developing reimbursement allowances for time-based OP office visits and services. These RVUs are used in proprietary actuarial modeling to reprice historical experience into future rating periods. Occasionally, commercial reimbursement for time-based office visits/services may deviate from the RBRVS/RVU-based methodology and would be reimbursed at a percent of billed charge or a fixed rate otherwise set according to its published policy. Maximum allowable reimbursement rates were calculated as the product of Medicare's RVU weight for the service and the conversion factor established for the service category." The carrier's methodology also allowed for negotiations with Providers. The process is the same for Medical Providers and BH Providers. For additional information, please see the factors considered when setting MARR for Medical Providers since the carrier provided the same information regarding the negotiation process.	The carrier followed the same methodology for BH Providers as stated for Medical Providers. However, specific to BH Providers, MARRs are calculated as a tiered percentage of the Medical Provider's RVU. The carrier noting the following: "*Carrier 3* created its BH outpatient professional tiering by reviewing average levels of reimbursement provided to each practitioner type and then comparing that analysis to the CMS Pricing Reduction Methodology, as found in Chapter 12 of the Medicare Claims Processing Manual. Regulatory guidelines, including reimbursement parity for NPs per HB 2902, was also considered. Additionally, the carrier measured the delta between the then-current reimbursement levels and the CMS values to assess the significance of member impact of rate change and sought to mitigate excessive increases in order to avoid a spike in Member financial liability amounts." The carrier's methodology also allowed for negotiations with Providers. The process is the same for Medical Providers and BH Providers. For additional information, please see the factors considered when setting MARR for BH Providers since the carrier provided the same information regarding the negotiation process.

Carrier	Plan(s)	MARR Methodology for Medical Providers	MARR Methodology for Behavioral Health Providers
4	K	The carrier utilized RBRVS established by CMS as the basis for the MARR calculation. The RBRVS assigns a RVU weight to services and procedures that are used in conjunction with a conversion factor to determine reimbursement allowances for procedure codes. The carrier's methodology also allowed for negotiations with Providers. The process was the same for Medical Providers and BH Providers. For additional information, please see the factors considered when setting MARR for Medical Providers since the carrier provided the same information regarding the negotiation process.	The carrier utilized set fee schedules to reimburse BH Providers. The carrier's methodology also allowed for negotiations with Providers. The process was the same for Medical Providers and BH Providers. For additional information, please see the factors considered when setting MARR for BH Providers since the carrier provided the same information regarding the negotiation process.
5	L - O	This carrier has four plans and the following information applies to all plans. Relative to Medical Providers' MARRs, the carrier indicated that the rate is determined by multiplying the Relative Value Unit and the conversion factor in the provider contract by the number of units billed, including modifiers when applicable. Current year RVUs were the most recent prior year RVU schedule available; for example, the 2017D version of RVUs was used for the 2018 calendar year. If a billed procedure code did not correspond with an RVU value in the provider contract's Federal Register year, the carrier utilized the Data Sources and Pricing Methodology Hierarchy to calculate MARRs.	Relative to BH Providers, the carrier stated, "*Carrier 5* determines allowables for participating Behavioral Mental Health Providers by multiplying the RVU and conversion factor in the provider contract by the number of units billed. An adjustment is made for the level of licensure for these provider types; psychologist allowables are set at eighty-five percent (85%) of the Medical Provider rate, licensed clinical social worker and, licensed professional counselors and licensed marriage and family therapist allowables are set at sixty percent (60%) of the Medical Provider rate. Please reference the Non Physician Default Reimbursement for Participating Providers Policy. Should the billed CPT code not correspond with an RVU value in the provider contract's Federal Register year, *carrier 5* utilizes the Data

Carrier	Plan(s)	MARR Methodology for Medical Providers	MARR Methodology for Behavioral Health Providers
			Sources and Pricing Methodology Hierarchy to calculate allowables."
6	P	The carrier provided the following response: "Using the CMS RVUs and Geographic Practice Cost Index (GPCI) files each code's fee basis is calculated using the CMS published formula for physician fee schedule payment: [(Work RVU * Work GPCI) +(PE RVU * PE GPCI) +(MP RVU * MP GPCI)] * Conversion Factor (CF). In the event, the Primary Fee Source does not publish a Fee Basis amount, an Alternate Fee Source will be applied, if available. The final fee amount is derived by multiplying the fee basis by the provider's contracted percentage. NOTE: Reimbursement may be affected by payment policies based on the specialty of the billing provider (e.g. NPs, PAs), procedure code modifiers, and coding edits." The carrier noted the following regarding negotiations with Providers: "*Carrier 6* reimbursement allowances are negotiated following receipt of a proposal from the provider. *Carrier 6* then pulls 12 months of claims utilization data and models the provider's proposal using a proprietary pricing modeling tool. After the modeling is complete and the parties agree to rates, the fee schedule is built. Fee schedules can vary depending upon medical specialty and geographic area."	The network of BH Providers and all associated functions such as MARR methodology is handled by the carrier's third party entity. Providers are reimbursed based on an internally developed fee schedule and the carrier noted the following: "The standard approach is to reimburse at 100% of these fee schedules, though providers may negotiate an inflator to these fee schedules. In addition, reimbursement may be affected by payment policies based on the specialty of the billing provider (e.g. NPs, PAs), procedure code modifiers, and coding edits. *Carrier 6s' third party entity* evaluates fee schedules on a periodic basis and any necessary adjustments are made to remain competitive in the marketplace." As noted above, the carrier's methodology allows for negotiations with Providers. However, the proprietary pricing modeling tool used by the carrier is not included in the third party entity's negotiation process. Specific to base rate calculations the carrier stated: "*Carrier 6* does not have the actual calculations as the base rate calculations were developed several years ago. As such, we do not have

Carrier	Plan(s)	MARR Methodology for Medical Providers	MARR Methodology for Behavioral Health Providers
6 (Cont.)	P		the historical files that have the calculations resulting in a rate for each code. The base rates have not been adjusted since development. However, throughout the years any deviation in rates are due to negotiations with providers and adjustments are made as needed." As noted above, negotiations with the provider is a step in the MARR process, however, the proprietary pricing modeling tool is only utilized during the Medical Provider negotiation process.
7	Q - R	This carrier has two plans and the following information applies to both plans: MARRs for each CPT code are developed based on RVUs multiplied by a conversion factor. Rate schedules varied by geography and the license level of provider. The exceptions for MARRs were based on network need, such as geographical location and provider specialty. The carrier stated, "When *carrier 7* negotiated reimbursement amounts for Medical Providers, *carrier 7*'s contractors reviewed licensure level and network adequacy, including geographical location, as well as the carrier's annual plan budget. Additionally, the carrier reviewed annual spending on historical utilization. When the carrier's provider requested an increase to the standard rate, an increase was only allowed if it was approved by an executive-level manager."	The carrier follows the same methodology for BH Providers as stated for Medical Providers. However, the network of BH Providers and all associated functions such as MARR methodology is handled by the carrier's third party. The carrier stated, "When negotiating reimbursement amounts for Behavioral Mental Health Providers, *carrier 7s' third party entity contractor*s also reviewed licensure level and network adequacy (i.e. geographical location), as well as *carrier 7s' third party entity* annual plan budget." The carrier stated, "When a *third party entity* provider requested an increase to the standard rate, the rate increase was only allowed if approved by a professional relations representative." As such, the Medical Provider's MARR methodology varied from the methodology used for BH Providers.

Carrier	Plan(s)	MARR Methodology for Medical Providers	MARR Methodology for Behavioral Health Providers
8	S	The carrier stated the following: "Each CPT code has its own assigned fixed rate based upon the RVU's assigned to it, the GPCI for the region and the % RBRVS which is negotiated in the contract. Anything that does not have an RVU value assigned goes to the default discount that has been designated in the contract." In terms of negotiating rates with Providers, the carrier stated: "*carrier 8* negotiates with both medical and behavioral providers mutually agreed upon reimbursement rates based upon a mutual determination of what is deemed to be market competitive reimbursement for that particular provider rendering that particular service for that particular amount of time. It is not a formula-based process and there are no additional policies, procedures or supporting documents to provide."	The carrier follows the same methodology for BH Providers as stated for Medical Providers. However, the network of BH Providers and all associated functions such as MARR methodology is handled by the carrier's third party entity.
9	T	The carrier stated the following: "We have not identified any policies, procedures, or supporting documents pertaining to the development of reimbursement allowances for participating providers offering time-based outpatient office visits. *Carrier 9* provides time-based outpatient office visit reimbursement based on our standard fee schedule – the *carrier 9* Market Fee Schedule is derived from industry standard methodologies and sources, such as the Resource-Based Relative Value System (RBRVS) established by CMS."	The carrier follows the same methodology for BH Providers as stated for Medical Providers. The carrier also stated: "Behavioral health providers are classified in four different classes based on market need. Generally, behavioral health medical doctors and behavioral health clinical nurse specialists are reimbursed the maximum amount (100% level). All clinical psychologist and masters level practitioners are reimbursed at a lesser percentage of the maximum amount paid to behavioral health medical doctors and behavioral health clinical nurse specialists. Medical

Carrier	Plan(s)	MARR Methodology for Medical Providers	MARR Methodology for Behavioral Health Providers
		However, the carrier described the MARR process as follows: "In setting our fee schedule for CPT codes, we look at industry standard methodologies and sources, such as the Resource-Based Relative Value System (RBRVS) established by CMS. For our 2017 *carrier 9* fee schedule, we will use 2016 Relative Value Units (RVUs). For codes using RBRVS, we use the "site-of-service" differential as defined in the transitional RVUs supplied by CMS. This differential allows an additional amount to be paid on certain codes, based on where the service is performed. We adjust our fee schedule based on the Portland, Oregon Medicare Geographic Price Cost Index (GPCI). We will not apply any further changes CMS makes in 2017, except for new codes valued by CMS." In terms of rate negotiations, the carrier utilizes a pricing model (p-model) that established the price ceiling on rates that the contract negotiators were allowed to negotiate for all provider types. The negotiation factors considered for Medical Providers are the same for BH Providers.	doctors/physicians are reimbursed the maximum amount (100% level), whereas midlevel practitioners (e.g. physician assistances and nurse practitioners) are reimbursed 85% of the maximum amount."
10	U	The carrier stated that there was not a formal policy in place from 2015 through 2018. Although a formal policy was not in place during the Period of Review, the carrier explained the MARR methodology process through a procedural document that was created in 2019 (a date that follows the Period of Review).	The carrier stated that there was not a formal policy in place from 2015 through 2018. Although a formal policy was not in place during the Period of Review, the carrier explained the MARR methodology process through a procedural document that was created in 2019 (a date that follows the Period of Review).

Carrier	Plan(s)	MARR Methodology for Medical Providers	MARR Methodology for Behavioral Health Providers
		The carrier stated the following: "*Carrier 10* uses a CMS reimbursement methodology involving RVUs that involve weight factors and RBRVS conversion factors to calculate and establish reimbursement allowances for Medical Providers. In addition, that [sic] methodology, carrier uses the Medical Physicians Fee Schedule (MPFS) for Medical Providers as well. In negotiations with providers, RBRVS and MPFS conversion factors and the percentages of the MPFS are agreed upon to determine contracted payments. For services that do not carry RVU weights or set fees on the MPFS, carrier uses a percentage of billed charges to establish a default rate to use for reimbursement to the providers for services that falls within their scope of practice." As stated above, the carrier's reimbursement methodology includes negotiations with providers. The negotiation factors considered for Medical Providers are the same for BH Providers. The carrier did not identify any negotiations tools that may be utilized during the process.	The carrier stated the following: "*Carrier 10* uses an RVU methodology identical to what is used for reimbursement with Medical providers to establish reimbursement allowance. As is the case for Medical providers, carrier uses a percentage of billed charges to establish a default rate to use for reimbursement that falls within their scope of practice."
11	V	The carrier stated: "Using the CMS RVUs and Geographic Practice Cost Index (GPCI) files each code's fee basis is calculated using the CMS published formula for physician fee schedule payment: [(Work RVU * Work GPCI) +(PE RVU * PE GPCI) +(MP RVU * MP GPCI)] * Conversion Factor (CF). In the event, the Primary Fee Source does not publish a Fee Basis amount, an	The network of BH Providers and all associated functions such as MARR methodology is handled by the carrier's third party entity. Providers are reimbursed based on an internally developed fee schedule. Specific to fee schedules, the carrier stated the following: "The standard approach is to reimburse at 100% of these fee schedules, though

Carrier	Plan(s)	MARR Methodology for Medical Providers	MARR Methodology for Behavioral Health Providers
		Alternate Fee Source will be applied, if available. The final fee amount is derived by multiplying the fee basis by the provider's contracted percentage. NOTE: Reimbursement may be affected by payment policies based on the specialty of the billing provider (e.g. NPs, PAs), procedure code modifiers, and coding edits." Specific to negotiations with Providers, the carrier stated: "*Carrier 11's* reimbursement allowances are negotiated following receipt of a proposal from the provider. *Carrier 11* then pulls 12 months of claims utilization data and models the provider's proposal using a proprietary pricing modeling tool. After the modeling is complete and the parties agree to rates, the fee schedule is built. Fee schedules can vary depending upon medical specialty and geographic area."	providers may negotiate an inflator to these fee schedules. In addition, reimbursement may be affected by payment policies based on the specialty of the billing provider (e.g. NPs, PAs), procedure code modifiers, and coding edits. *Carrier 11s' third party entity* evaluates fee schedules on a periodic basis and any necessary adjustments are made to remain competitive in the marketplace." As noted above, the carrier's methodology allows for negotiations with Providers. However, the proprietary pricing modeling tool used by the carrier is not included in the third party entity's negotiation process. Specific to base rate calculations, the carrier stated: "*Carrier 11* does not have the actual calculations as the base rate calculations were developed several years ago. As such, we do not have the historical files that have the calculations resulting in a rate for each code. The base rates have not been adjusted since development. However, throughout the years any deviation in rates are due to negotiations with providers and adjustments are made as needed." As noted above, negotiations with the provider is a step in the MARR process, however, the proprietary pricing modeling tool is only utilized during the Medical Provider negotiation process.

Report Chart D2 - Factors Considered When Setting Reimbursement Allowances

Carrier	Plan(s)	Factors Considered When Setting MARR for Medical Providers	Factors Considered When Setting MARR for Behavioral Health Providers	Additional Comments
1	A - C	• Treatment protocols • Market benchmarks • Demand and supply conditions"	• Credentials of the provider • Treatment protocols • The market benchmarks • Demand and supply conditions	See additional comments in the "Carrier Methodology Analysis" section below regarding MARR methodologies for carrier 1, Plans A-C
2	D - I	• Current rates • Marketplace rates and competitiveness • Position of provider in the community • Alternatives in that specialty in the community • Capacity in the community • Line of business being served • Network structure • Participation in pay for performance or other programs • Historic claims experience • Network design including medical home structure	• Description of the code including but not limited to information such as service rendered, purpose of code and duration of service • External sources including CMS RVUs, 3rd party publications • License/education levels • Geography • Supply and demand • Specialty • Negotiation	See the summary for carrier 2, Plans D-I in the "Carrier Methodology Analysis section" below regarding additional information in reference to reimbursement methodologies including the variance in BH Provider and Medical Provider methodologies

Carrier	Plan(s)	Factors Considered When Setting MARR for Medical Providers	Factors Considered When Setting MARR for Behavioral Health Providers	Additional Comments
3	J	The carrier indicated that significant research and analysis was conducted when determining MARRs for services during the Period of Review, as follows: • Consumer and Producer Price Indices information were reviewed related to inflationary trends for general medical/professional/ hospital categories, as applicable. • Regulatory mandates in addition to market and industry trends were reviewed, to include changes in service mix due to proposed MARRs. • The global budget for claims costs are reviewed to determine the availability of unit cost changes.	The factors considered for BH Providers are the same as Medical Providers	See additional comments in the "Carrier Methodology Analysis section" below regarding MARR methodologies including the tiering process for BH Providers for carrier 3, Plan J
4	K	• The services provided and the level of credentials of rendering providers. • Market conditions, including: i. Abundance or shortage of providers within the panel with the same specialty, language(s), and/or cultural background	The factors considered for BH Providers are the same as Medical Providers	See the summary for carrier 4, Plan K in the "Carrier Methodology Analysis section" below regarding additional information in reference to reimbursement methodologies including the variance in BH Provider and Medical Provider methodologies

Carrier	Plan(s)	Factors Considered When Setting MARR for Medical Providers	Factors Considered When Setting MARR for Behavioral Health Providers	Additional Comments
		within the same geographic area ii. Competitiveness of *carrier 4* rates within the marketplace iii. Inflation rate as identified by the Bureau of Labor Statistics as identified by the reports for Medical Services and Hospital Services (reported nationally) and for Professional Services in the Western Urban Region. iv. Fees typically charged by providers with similar specialties in similar locations v. Adequacy of the panel as measured by standards adopted by *carrier 4*.		
5	L - O	The carrier stated they use market research, analysis of claims billed and medical consumer price index figures to negotiate MARRs for in-network providers in an outpatient office-based setting.	The carrier stated they have a standard base conversion factor that was determined based on global market factors applicable to specific service areas, consultation with internal medical directors, review of RVU weights, and analysis of current rates and historical claims data. On an individual contract basis, conversion factors were negotiated taking into consideration other	See the summary for carrier 5, Plans L-O in the "Carrier Methodology Analysis section" below regarding additional information in reference to reimbursement methodologies including the variance in BH Provider and Medical Provider methodologies

Carrier	Plan(s)	Factors Considered When Setting MARR for Medical Providers	Factors Considered When Setting MARR for Behavioral Health Providers	Additional Comments
			determining factors, such as market forces, medical CPI, and network adequacy.	
6	P	• Specialty • Geographic location	• Description of the code including but not limited to information such as service rendered • Purpose of code, and duration of service • Sources including CMS RVUs • 3rd party publications • License/education levels • Geography • Supply and demand • Specialty • Negotiation	See the summary for carrier 6, Plan P in the "Carrier Methodology Analysis section" below regarding additional information in reference to reimbursement methodologies including the variance in BH Provider and Medical Provider methodologies
7	Q - R	• Licensure level • Specialty type • Network adequacy (i.e. geographical location) • Plan budget	The factors considered for BH Providers are the same as Medical Providers	See additional comments in the "Carrier Methodology Analysis section" below regarding MARR methodologies for carrier 7, Plans Q-R
8	S	• CMS – RVUs are obtained from CMS • Third Party Entity – the carrier gap fills any codes not populated in CMS with third party entity data. Many of these codes are services not provided by Medicare such as obstetric and pediatric services	• "Reimbursement allowances are created by benchmarking Medicare fee schedules. Further as noted in Response A.3, network need and geographic area are also taken into considerations when setting reimbursement allowances."	See additional comments in the "Carrier Methodology Analysis section" below regarding MARR methodologies for carrier 8, Plan S.

Carrier	Plan(s)	Factors Considered When Setting MARR for Medical Providers	Factors Considered When Setting MARR for Behavioral Health Providers	Additional Comments
		• Clinical Lab and Pathology codes – CMS uses flat rates for these and populates for each state. However, the carrier prices at % RBRVS • Site of Service (SOS) – carrier currently use our own assignment of Facility or Non-facility by a yearly process of evaluating the data and assigning SOS, which will be converted to a dual SOS reimbursement designated by the location on the Healthcare Financing Administration (HCFA) 1500 form (this is a claim form completed by providers and submitted to carriers) beginning 1/1/2017 • Geographic practice cost index (GPCI) is populated by regions within markets. • Carrier RBRVS is developed using Work RVU, Practice Expense RVU and Malpractice RVU with adjustments for GPCI and a conversion factor		
9	T	The carrier noted that the following factors are considered: industry standard methodologies and	The factors considered for BH Providers are the same as Medical Providers	See additional comments in the "Carrier Methodology Analysis section"

Carrier	Plan(s)	Factors Considered When Setting MARR for Medical Providers	Factors Considered When Setting MARR for Behavioral Health Providers	Additional Comments
		sources such as RBRVS, site of service differential and the Portland, Oregon Medicare Geographic Price Cost Index		below regarding MARR methodologies for carrier 9, Plan T
10	U	The carrier stated the following: "*Carrier 10* Finance Department develops acceptable base points and acceptable ranges for Provider Contracting for Medical services. The allowable base rates and re-negotiated rates are determined by actuarial assumptions for various specialty types of professional grouping of specialties. A Rate Range Guidance Report is provided by Finance that breaks out each line of business that *carrier 10* administers by major service categories where possible. Provider Contracting use the Rate Range Guidance when negotiating with providers. Rate requests above the allowed range guidelines are reviewed with the Director of Finance or a *carrier 10* executive for approval."	The carrier stated the following: "The same factors are used for Behavioral Mental Health Providers as outlined above for medical providers. Prior to contracting with these providers in 2015 rates developed and contracts were set up with mental health providers. Rate reviews have occurred with providers since then either upon requests by the providers or by the plan using the same criteria involving rate ranges. These include base rates and rate ranges for psychologists, licensed professional counselors and marriage and family therapists."	See additional comments in the "Carrier Methodology Analysis section" below regarding MARR methodologies for carrier 10, Plan U
11	V	• Specialty • Geographic location	• Description of the code including but not limited to information such as service rendered	See the summary for carrier 11, Plan V in the "Carrier Methodology Analysis section" below

Carrier	Plan(s)	Factors Considered When Setting MARR for Medical Providers	Factors Considered When Setting MARR for Behavioral Health Providers	Additional Comments
			• Purpose of code, and duration of service • Sources including CMS RVUs • 3rd party publications • License/education levels • Geography • Supply and demand • Specialty • Negotiation	regarding additional information in reference to reimbursement methodologies including the variance in BH Provider and Medical Provider methodologies

Carrier Methodology Analysis

The following summaries by carrier supplement the tables above and provides additional details regarding each carrier's MARR development methodologies and the factors considered when setting MARRs.

Carrier 1 - Plans A-C

The carrier provided information on the reimbursement allowance methodology used in the contract with the leased provider network. The maximum allowable reimbursement contract rates are fee-for-service reimbursement rates; the remainder of this section applies only to the leased network or non-carrier employee, in-network contracted providers.

The carrier indicated that the contracted provider reimbursement methodology is the same for all provider types covered in this review. The carrier provided the following response: "When *carrier 1* subcontracts with community Medical Providers, Mental Health Providers with Prescribing Privileges and Behavioral Mental Health Providers for in-network care, these practitioners are paid utilizing standard Current Procedural Terminology ("CPT") coding and resource-based relative value scale ("RBRVS") methodology. *carrier 1* uses the equation {RVUs * Conversion Factor, adjusted for Provider Type} for all subcontracted Medical Providers, Mental Health Providers with Prescribing Privileges and Behavioral Mental Health Providers."

When asked how conversion factors are determined, the carrier indicated that they utilize current CMS promulgated conversion factors and RVU values, historical rates, if any, demand and supply conditions, provider's market position, projected volumes, market benchmarks, any unique market conditions and the credentials of the provider. Finally, in terms of modifiers, carrier stated that they typically do not utilize modifiers for reimbursement purposes.

The carrier indicated that the factors considered when setting reimbursement allowances for outpatient time-based office services for in-network Medical Providers include:

- Treatment protocols
- Market benchmarks
- Demand and supply conditions

Regarding the factors considered when setting reimbursement allowances for contracted in-network BH Providers and MH Providers, the carrier listed the following factors:

- "Credentials of the provider
- Treatment protocols
- The market benchmarks
- Demand and supply conditions"

In relation to treatment protocols, the carrier provided the following additional information:

> "The "treatment protocols" listed in the original reply refers to services defined within each CPT code and which may include time based increments. For example, 98033 psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service. The description of the "treatment protocols" would be found in the AMA official CPT codebook. Each CPT code has an RVU value that determines the final reimbursement allowance based on the negotiated conversion factor."

In terms of market benchmarks, the carrier indicated that they review the following information: "compare existing contract rates for similar providers, review current market rates, review CMS Medicare promulgated conversion factors, review Consumer Price Index data and review claims data. Finally, regarding demand and supply conditions, *carrier 1* indicated that they consider the number of providers and the volume of referrals that the *carrier 1* anticipates to the provider."

The Contractor also requested the carrier to state the evidentiary standards, national treatment guidelines and other considerations utilized to establish participating provider reimbursement allowances for outpatient time-based office visits and services. The carrier indicated that evidentiary standards and national treatment guidelines are not relied upon to establish participating provider reimbursement allowances for outpatient time-based office visits and services. However, the carrier indicated that they follow the standardized resource-based CPT procedural code methodology and CMS payment rules.

The carrier provided the 2015 maximum allowable reimbursement calculation (prior to the application of other factors, such as the result of negotiation) for procedure code 90832 (Psychotherapy Services and Procedures, 30 minutes) for each of the eight provider types, which are included in Report Chart D3 below.

Report Chart D3 - Carrier 1 Example of 2015 Maximum Allowable Reimbursement Rate for Procedure Code 90832 – All Provider Types

Procedure Code	Provider	2015 Maximum Allowable Reimbursement Rate
90832	Doctor of Medicine	2015 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.79 * $66.30 Conversion Factor = $118.67
90832	Doctor of Osteopathic Medicine	2015 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.79 * $66.30 Conversion Factor = $118.67
90832	Psychiatrist	2015 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.79 * $66.30 Conversion Factor = $118.67
90832	Nurse Practitioner	2015 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.79 * $55.25 Conversion Factor = $98.90
90832	Psychiatric and Mental Health Nurse Practitioner	2015 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.79 * $51 Conversion Factor = $91.29
90832	Psychologist	2015 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.79 * $66.30 Conversion Factor = $118.67
90832	Licensed Clinical Social Worker	2015 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.79 * $45 Conversion Factor = $80.55
90832	Licensed Professional Counselor/Licensed Marriage Family Counselor	2015 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.79 * $45 Conversion Factor = $80.55

Carrier 2 - Plans D – I

The carrier stated, "Our standard approach to developing reimbursement allowances are to use the negotiated conversion factor multiplied by the applicable RVUs for the RVU year being used. We do have some arrangements where there is a capitation payment (pmpm) that covers these services in part or in full. We do not have policies and procedures or documentation of our standard methodologies."

Applies to:
• Plan Years: 2015, 2016, 2017, 2018
• Lines of Business: Large Group, Small Group, Individual
• Networks: Plans D-I

The carrier provided the following factors, which were considered when setting reimbursement allowances for outpatient time-based medical office services.

- Current rates
- Marketplace rates and competitiveness
- Position of provider in the community
- Alternatives in that specialty in the community
- Capacity in the community
- Line of business being served
- Network structure
- Participation in pay for performance or other programs
- Historic claims experience
- Network design including medical home structure

The carrier stated, "The Contracting Department conducts negotiations with a medical group/provider to agree upon rates for the current contract. The Provider Analytics team provides contract modeling upon request of the Contracting Department to measure the impact of new CMS published fee schedules and reimbursement allowance changes. In general, the Provider Analytics team will look at current period claims experience and project reimbursement for the following period based on changes in fee schedules, reimbursement rates (e.g. Conversion Factors, payment as % of CMS rates) in accordance with % change agreed upon by the medical group and the Contracting Department. Once reimbursement allowances are set, the contract is modified accordingly, stipulated the year of the CMS fee schedules, and the rates, and that contract is sent to the Business Office for implementation in the claims payment system. The contract will describe any payment policy rules such as reimbursement will not be greater than billed charges. The members of the Provider Analytics team have many years of experience doing this type of work but there is not a specific license or credential required. Discretion regarding reimbursement allowances comes through the Contracting Department who follow pre-determined guidelines for annual changes to contract rates. Any agreements which would fall outside those guidelines would go through the hierarchical approval process, including the CFO and the Medical Director."

The carrier was asked how it developed base rates. The carrier's response was as follows:

> "The base rate is the conversion factor in the contract. *Carrier 2* does not have a single base rate that (sic) to which we apply different factors to derive the conversion factor in a particular contract. Most of our contracts have been in place for many years. The current base rates ("conversion factors") are the result of many years of negotiations or evaluation. Many of our provider contracts are renegotiated every year. We consider many factors in those negotiations such as our market competitive position, the position of the provider in the community, other alternatives in the community, our ability to have a competitive and adequate network in the community. We may also consider network design, geography, product/benefit design and participation in pay for performance or other alternative payment models. We may use Coordination of Benefit information. We do review the change in RVUs if we are updating a contract to move to the new RVU year to set or negotiate a new base rate. PHP does not track or document the percentage of reimbursement for each provider compared to other providers of the same provider type. Since many of the contracts are negotiated, the reimbursement rate will follow the conversion factor in the contract."

The carrier stated, "*Carrier 2* configuration department, Systems Administration (SA), loads the payment rate information into the claims processing system, *carrier 2's claims system*, based on the contract. The RVU weight files are publically posted and supplied to SA by (*carrier 2*) Informatics department. The contract indicates which RVU year to use and the conversion factor. SA enters all of these different pieces into separate tables within *carrier 2's claims system* and the system performs the calculation. *Carrier 2* does not manually multiply the RVU x CF and load a flat calculated schedule."

The carrier provided the following:

> Plans F and I NETWORK – "All Lines of Business Office based services are not separately determined or set. All services are negotiated or determined using the same methodology. Most of our provider contracts have been in place for several years. The rates in the contracts are a result of many years of negotiations. We have a standard rate that we evaluate annually that is used with non-negotiated groups. In evaluating rates for any given provider contract, we evaluate our market-competitive position, the position of that provider in the community, the alternatives in that community, our ability to have a competitive and adequate network to serve our members. We also account for factors such as network design, geography, product/benefit design, and the health plan's market position. We may consider a providers participation in our Pay for Performance program, a Total Cost of Care arrangement, CPC+ participation or other alternative payment arrangements. Payment methodology for most participating providers is fee-for-service, with a negotiated conversion factor multiplied by the RVUs for the billed CPT code."

Applies to:
- Plan Years: 2015, 2016, 2017, 2018
- Lines of Business: Large Group, Small Group, Individual
- Network: Plans F and I

Plan D NETWORK – Large Group, Small Group

> "Office based services are not separately determined or set. All services are negotiated or determined using the same methodology. The Plan D network is a medical home based network that requires the Primary Care provider to administer referrals and manage their assigned patients. Generally the medical homes are paid an additional pmpm care management fee in addition to their FFS rates. Rates follow the Plan F rates. In evaluating rates for any given provider contract, we evaluate our market competitive position, the position of that provider in the community, the alternatives in that community, our ability to have a competitive and adequate network to serve our members. We also account for factors such as network design, geography, product/benefit design, and the health plan's market position. We may consider a providers participation in our Pay for Performance program, a Total Cost of Care arrangement, CPC+ participation or other alternative payment arrangements. Payment methodology for most participating providers is fee-for-service, with a negotiated conversion factor multiplied by the RVUs for the billed CPT code."

Applies to:
- Plan Years: 2015, 2016, 2017, 2018
- Lines of Business: Large Group, Small Group
- Network: Plan D

Plan G NETWORK – Individual

"Office based services are not separately determined or set. All services are negotiated or determined using the same methodology. The Plan G network is a medical home based network that requires the Primary Care provider to administer referrals and manage their assigned patients. Generally the medical homes are paid an additional pmpm care management fee in addition to their FFS rate. In a small number of cases, the Plan G rate is lower than the Plan I rate but is generally equal. The groups with which we negotiated lower rates were dependent on their Plan I rates. Rates followed the Plan I rates. Several factors were considered including, the position of that provider in the community, the alternatives in that community, our ability to have a competitive and adequate network to serve our members. Some of the primary care groups are paid on a capitated basis. We may consider a providers participation in our Pay for Performance program, a Total Cost of Care arrangement, CPC+ participation or other alternative."

Applies to:
• Plan Years: 2015, 2016, 2017, 2018
• Line of Business: Individual
• Network: Plan G

Plan E NETWORK – Large Group, Small Group

"Office based services are not separately determined or set. All services are negotiated or determined using the same methodology. The Plan E network is a narrower network, medical home based network, only available in the Portland metro area. In setting and negotiating the rates for Plan E, we asked for a lower rate than the provider's rate in the Plan F network, in most cases. That proposed decrement depended on the level of the Plan F rate. Rates were negotiated from there and several factors were considered including, the position of that provider in the community, the alternatives in that community, our ability to have a competitive and adequate network to serve our members. Some of the primary care groups are paid on a capitated basis. We may consider a providers participation in our Pay for Performance program, a Total Cost of Care arrangement, CPC+ participation or other alternative payment arrangements. Payment methodology for most participating providers is fee-for-service, with a negotiated conversion factor multiplied by the RVUs for the billed CPT code."

Applies to:
• Plan Years: 2015, 2016, 2017, 2018
• Lines of Business: Large Group, Small Group
• Network: Choice

Plan H – Individual

"Office based services are not separately determined or set. All services are negotiated or determined using the same methodology. The Plan H network is a narrower network, medical home based network, only available in the Portland metro area. While it is available to all members, it has a particular focus on the Individual Exchange. In setting and negotiating the rates for Plan H, in particular for the Individual line of business, we asked for a lower rate than the provider's rate in the Plan I network, in most cases. That proposed decrement depended on the level of the Plan I rate. Rates were negotiated from there and several factors were considered including, the position of that provider in the community, the alternatives in that community, our ability to have a competitive and adequate network to serve our members. In some cases we negotiated a lower rate for Individual Plan H line of business than other lines of business on Plan H. Some of the Primary Care groups are

paid on a Primary Care Capitated basis. We may consider a providers participation in our Pay for Performance program, a Total Cost of Care arrangement, CPC+ participation or other alternative payment arrangements. Payment methodology for most participating providers is fee-for-service, with a negotiated conversion factor multiplied by the RVUs for the billed CPT code."

Applies to:
• Plan Years: 2015, 2016, 2017, 2018
• Line of Business: Individual
• Network: Plan H

As noted earlier in the Report, the carrier contracted with a third party entity to provide behavioral health management services and a behavioral health network. The carrier stated, "Carrier 2s' *third party entity* administers all behavioral health and substance use disorder benefits across all Commercial Fully Insured Plans. *Carrier 2* determines the plan design, e.g. the overall structure of the plan and member cost-shares, and provides these plan designs to *its third party entity* for administration of behavioral health benefits. *Carrier 2* ensures benefits for BH/SUD are consistent across all plan designs, meeting MHPAEA QTL and NQTL requirements." The third party entity's delegated services included behavioral health network, claims processing, customer service and medical management. The third party entity is not delegated administration of member appeals.

The carrier stated:

"*Carrier 2s' third party entity* reimburses providers based on an internally developed network fee schedules. The standard approach is to reimburse at 100% of these fee schedules, though providers may negotiate an inflator to these fee schedules. In addition, reimbursement may be affected by payment policies based on the specialty of the billing provider (e.g. NPs, PAs), procedure code modifiers, and coding edits. *The third party entity* evaluates fee schedules on a periodic basis and any necessary adjustments are made to remain competitive in the marketplace." The third party entity indicated it developed its standard fee schedule following the steps below:

"1. Description of code. Define or obtain a detailed description of the code including but not limited to information such as service rendered, purpose of code, and duration of service.

2. Find similar codes. If other codes that are similar in nature exist, those codes are used as a guide to develop the rate for the new code. Adjustments are then made to these codes to reflect the nuances of the new code.

3. Crosswalk possible codes. When a new code replaces or supplements existing codes, providers can change the way they bill. When this happens, it is necessary to determine what old codes, if any, will now be replaced by the new codes. Therefore, a crosswalk from the old codes to the new needs to be completed. Possible scenarios that can exist include 1) one to one crosswalk, 2) many old codes cross walking to one new code, 3) one old code cross walking to several new codes, or 4) many old codes cross walking to many new codes.

4. Determine utilization distribution. Once the codes are cross walked, in order to account for each of the scenarios above, where there isn't a straight one to one crosswalk (i.e. several codes affect) an assumed utilization distribution must be developed. Using guidance from CMS, external sources, or other methodologies, an expected utilization distribution to the new codes are derived.

5. Compare to external sources for appropriateness of relativities. CMS national RVUs are used as a guide to check the relativities among the codes to ensure they are properly aligned. The RVUs are obtained from the CMS Physician Fee Schedule Final Rule, Addendum B, which is posted on the CMS.gov website. The RVU for a specific code represent the relative resources required to perform that service compared to other services. Additional adjustments to rates are made if necessary. Other sources can also include Fairhealth (sic – FAIR Health) and rates/relativities obtained through studies from 3rd party vendors.

6. Adjusting for geography. Rates are compared to cost variances among geography and if necessary, adjusted accordingly.

7. Adjusting for market conditions. Other factors that influence the market including but not limited to, supply/demand, license level, and market conditions are used to make any additional adjustments to the fee schedule.

8. Negotiation. Some providers' fee schedules are negotiated on a case by case basis."

The carrier provided the following list of factors considered when setting reimbursement allowances for BH Providers and MH Providers outpatient time-based office visits/services:

"1. Description of the code including but not limited to information such as service rendered, purpose of code, and duration of service
2. External sources including CMS RVUs, 3rd party publications
3. License/education levels
4. Geography
5. Supply and demand
6. Specialty
7. Negotiation."

The carrier stated, "while assessing non-quantitative treatment limitations (NQTL) it did not assign a mathematical value or formula to the factors and sources above, which may be different from provider to provider and community to community, for the purpose of comparative analysis. Rather, the factors and sources only played a role with contracting professionals during negotiations with providers."

The carrier further stated:

"Negotiating reimbursement allowances for a participating provider who offers outpatient time-based office visits/services occurs when the provider is unwilling to accept the Plan's standard fee schedule. The provider is required to submit a rate request in writing. Upon receipt of the request, Plan staff will outreach to provider to begin negotiations. Discussions with provider will include a reinforcement of the standard fee schedule and rates of reimbursement, how it was established, and why provider thinks the rates are not acceptable. Rate increase requests that deviate from standard rates may be considered under the following circumstances:

• Provider is located in a geographic area where there is limited appointment availability
• Provider is located in a geographic area where there is a limited number of providers for contracting
• Provider offers unique and/or specialized areas of expertise or experience

- Provider license/education levels
- Unique and/or special circumstances such as pilot programs requiring expanded services
- Specific customer requests for a provider's participation
- Documented business need for network expansion

Requests that qualify under the exception criteria are reviewed by designated Plan staff, as outlined in the Plan's delegation of authority process. Upon elevated review, new rate parameters may be established. Plan contractor may go back to provider and attempt to come to agreement based on newly established rates. The two parties work together to agree to rates that are reflective of the services, expertise and availability of the provider. Upon agreement, updated contracts are executed and updates in systems for claims payment are finalized."

The carrier stated that the third party entity does not have the actual calculations performed when determining reimbursement allowances as the base rate calculations were developed several years ago, and therefore it did not have the historical calculations for each rate by procedure code, and that base rates have been adjusted since development and throughout the years any deviation in rates were due to negotiations.

The carrier's negotiated allowances for Medical Providers varied from the methodology utilized by the third party entity when negotiating allowances for the MH Providers and BH Providers. However, the carrier stated, "Consistent with the DOL guidance, *carrier 2* examined the process of establishing rates by *carrier 2* and *its third party entity* and found that factors and sources utilized by *carrier 2* and *its third party entity* were sufficiently similar on their face. *Carrier 2* determined that rate establishment processes were not more stringently applied to MH/SUD services than M/S services. The information we provided and the analysis here is reflective of that comparative analysis."

The carrier was requested to provide a detailed description for each plan benefit design on how the plan determines the reimbursement amount for each procedure code and modifier combination. The third party entity's response stated, "Modifiers not used for Commercial Plans." The carrier's response stated, "No claims with these modifies (sic)."

The carrier also provided its collaborative NQTL comparison with its third party entity by providing Report Chart D4 below regarding the MARR methodology for in-network providers:

Report Chart D4 - Carrier 2 - NQTL Comparison for Carrier and its Third Party Entity

Category	Carrier 2	Third Party Entity
Describe the plan's in-network reimbursement methodology, e.g., fee schedule developed on internal factors, market factors, % Medicare.	"*Carrier 2*'s network reimbursement methodology is a fee for service model. Reimbursement can be based on DRGs, per diems or billed charges and are negotiated on a facility by facility basis. Rates and fee schedules are reviewed on an annual basis. Factors in determining rates include CMS guidance, market dynamics and business needs."	"The *third party entity*'s network reimbursement methodology is a fee for service model. Network per diems are negotiated on a facility by facility basis. Schedules are reviewed annually with several factors being taken into consideration in the rate-setting process, including CMS guidelines, as well as regional market dynamics and current business needs."
Does reimbursement vary by physician specialty (e.g., cardiologist vs. internist) for the same E&M code? If YES, describe in detail.	"Unless mandated by law, the methodology used to determine fee schedules does not vary."	"Unless mandated by law, the methodology used to determine fee schedules do not vary."
Does reimbursement vary by license/facility type? (e.g., Provider: MD vs. RN vs. PA, Facility: acute hospital vs. SNF). If YES, describe in detail.	"Unless mandated by law, the methodology does not vary by license. CMS payment methodology for Skilled Nursing facilities is not the same as acute hospital."	"Unless mandated by law, reimbursement do not vary by license/facility type."
Does the plan limit benefits based on geographic location (e.g., State, County, etc.). If YES, describe in detail.	"No."	"The *third party entity* does not own the benefits and only administers them. Therefore, it is up to PHP to determine whether or not benefits are limited by location."
Does the plan have contractual or systematic "inflators"? If YES, describe in detail.	"Some facility contracts have inflators. These are negotiated on a facility by facility basis."	"Some facility contracts have inflators. These are negotiated on a facility by facility basis."
Does reimbursement vary based on provider/facility quality and/or efficiency or any	"*Carrier 2* has some contracts where providers can receive additional reimbursement for meeting certain cost and quality metrics."	"We have pay for performance contracts where providers will receive a higher per diem rate for meeting certain metrics. "

Category	Carrier 2	Third Party Entity
other performance metrics? If YES, describe in detail.		
Does the plan contract with behavioral health providers directly (e.g., neuropsychologists, social workers, etc.)? If Yes, describe in detail.	"Yes, for services billed with a medical diagnosis."	"Yes, for services billed with a behavioral health diagnosis. "

Carrier 3 - Plan J

The carrier indicated that significant research and analysis was conducted when determining MARRs for services during the Period of Review. The carrier stated that Consumer and Producer Price Indices information were reviewed related to inflationary trends for general medical/professional/hospital categories, as applicable. The carrier stated that it reviewed regulatory mandates in addition to market and industry trends, to include changes in service mix due to proposed MARRs. The carrier indicated it then looks at the global budget for claims costs to determine the availability of unit cost changes.

The carrier stated, "National standards of CMS resource-based relative value scale (RBRVS) relative value units (RVUs) professional reimbursement guidelines are the fundamental framework used in developing reimbursement allowances for time-based OP office visits and services. These RVUs are used in proprietary actuarial modeling to reprice historical experience into future rating periods. Occasionally, commercial reimbursement for time-based office visits/services may deviate from the RBRVS/RVU-based methodology and would be reimbursed at a percent of billed charge or a fixed rate otherwise set according to its published policy." According to the carrier, MARRs were calculated as the product of Medicare's RVU weight for the service and the conversion factor established for the service category. As noted above, the carrier further stated that proprietary modeling was used to reprice historical experience into future rating periods, taking into account service mix, billed charges, billed charge trend, and other fixed rates or percent-of-charge terms, as applicable. BH and MH Provider rates were calculated at a reduced percent of the Medical Providers' (i.e., MD and DO) MARR, in accordance with the carrier's health plan policy.

Additionally, the carrier stated that "the following policies guide the development of reimbursement allowances for participating providers and are designed to ensure network stability, cost viability, quality, member access and specialty availability (see attached documents)," and provided copies of the policies which are summarized below:

1. The carrier's Behavioral Health Contracting Policy states, "The purpose of this policy is to outline the work flow and decision points within Regional Behavioral Health Contracting that support the Network Management process, ensuring requirements are met for Plan quality, access, and cost for Behavioral Health Facilities, and to document the Network Management contracting process for Behavioral Health Professional Contracting managed by the local markets' Network Management Contracting teams for each Plan."

2. The carrier's Commercial Network Adequacy Policy states, "The purpose of this policy is to describe how we evaluate, measure, report, and address provider network availability of health care services for all members on all lines of business except Medicare Advantage. Please see the Medicare Advantage Provider Network Availability policy for questions on Medicare Advantage standards."

3. The carrier's Compliance with Mental Health Parity Policy states, "*Carrier 3* products for groups and individuals will be compliant with MHPAEA requirements, with the exception of certain grandfathered, grand mothered (sic), and retiree-only plans. Financial requirements (such as copays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits including pharmacy. Analysis of financial requirements and quantitative treatment limitations will be done upon request for customization and semi-annually for standard benefit packages. Underwriting will ensure the requested benefits, including out of network and pharmacy benefits, are compliant (sic – compliant) with the MHPAEA. Utilization management protocols will be comparable to, and applied no more stringently than, those used for medical/surgical benefits. A detailed non-quantitative analysis of utilization management protocols will be conducted annually."

4. The carrier's Policy 113, Pricing Codes Without RVUs, states, "In situations where a fee has not been established for a CPT or HCPCS code (i.e. unlisted codes, new codes or codes which CMS has not published an RVU or a clinical lab allowance), the following protocol will be followed:

   1. RVUs published by *third party entity* in *The Essential RBRVS*. For modifier 26 and TC codes, *third party entity* RVUs will be used only when CMS has determined that the code-modifier combination is valid. If CMS has determined a code is invalid with 26 or TC, no pricing will be established for the combination, or
   2. CMS Local carrier published fee where applicable
   3. When either of the above allowances are not available, the following comparable service methodology is used.
   • Base the allowance on the most closely comparable code. For example, in the case of a laparoscopic procedure without a specific CPT or HCPCS code, base the allowance on the most closely comparable open code, or
   • Base the allowance on the most closely comparable code with modifier 22. When the procedure or service is a combination of two or more existing CPT or HCPCS codes or components of these codes, determine the appropriate combination of the applicable CPT or HCPCS code components and base the allowance on those.
   • Base the allowance on a percentage of charges.

   When additional information becomes available subsequent to establishing a fee, the fee will be re-evaluated using the above hierarchy. For example, when a CMS RVU becomes available in a subsequent year's CMS file for a code that was previously considered a code with no fee, our health plan will prospectively implement the RVU for that code at the time of its first final publication and no changes will be made in subsequent quarters. CPT or HCPCS codes without a published CMS RVU will be priced using the methodology described above, and the code will be attributed (sic – to) not only the RVU but the associated indicators in the National Physician Fee Schedule Relative Value File. Unlisted codes generally cannot have fees established and will be priced using the methodology

described in step 3 above every time they are submitted on a claim. Claim lines billed with an unlisted or not otherwise classified code must be submitted with a description of services provided; claim lines submitted without a description, with a generic description or with an incomplete description may be denied. Appropriate medical records such as operative report, may additionally be required to adjudicate the claim. Medical records not submitted upon request may result in denial of all or a portion of a claim."

When the carrier receives additional information subsequent to establishing a MARR, the rate is re-evaluated using the above hierarchy.

The carrier stated that Medicare's RVU-based methodology was followed for the MARR of outpatient time-based services for BH Providers, Medical Providers and MH Providers. MARRs were calculated at the lesser of the provider's billed charge or the MARR stipulated in the contract, which would have been established using: a) product of Medicare's RVU weight for the service and the conversion factor established for the service category; b) the fixed rate established for the service; or c) a percent of billed charges. For BH Providers and MH Providers, MARRs were calculated at the applicable tiered percent of the Medical Provider-level evaluation and management RVU allowable as noted in Report Chart D4 below. Actuarial modeling was used for development and calculation of MARRs via its modeling tools for providers at all levels of credentialing.

The carrier stated, "In those limited situations where *Carrier 3* utilizes fixed-fee reimbursement, we may develop a rate by looking at historical billing patterns and payment levels for the impacted services, adding the aggregate costs and volumes, and then pricing the new rate at the approximate average cost. The objective was to find a revenue neutral point for patients, providers, and payers, with the intention of minimizing windfall gains or losses for the parties involved."

The carrier indicated, "*Carrier 3* discourages the use of percent-of-charge reimbursement whenever possible, and so RVU-based reimbursement methodology is the standard approach. Percent-of-charge reimbursement is the CMS methodology for codes without an RVU value (unlisted codes). However, charges billed by providers can vary widely for the same service. Consequently, for frequently-billed unlisted services, or for those services where an extreme variance in billed charges is observed, *Carrier 3* may seek to establish a reasonable fixed rate in a variety of ways, including based on the average reimbursement provided under the percent-of-charge method, based on reasonable reimbursement for similar services. Additionally, *Carrier 3* maintains a policy that establishes protocols for pricing services in situations where a fee has not been established by CMS for a CPT or HCPCS code (*Policy 113_Pricing Codes Without RVUs*). This policy is available on our website."

The carrier stated that "the negotiation process is nuanced and situationally-specific. Each negotiation is approached uniquely, following a review of factors, including but not limited to: a provider's impact on network adequacy and access to care; the reimbursement rates and terms being requested and their relativity to industry standards, *Carrier 3* contract standards, and competitive analysis." The carrier stated, "*Carrier 3* does not differentiate its approach to implementing alternate reimbursement methodology between Medical or Mental Health Providers." See Report Chart D5 below, which provides the methodology applied to both Medical Providers and MH Providers. As to procedure code 90837, where the rate setting methodology varies from all other procedure codes, the carrier stated the following, "In the case of 90837, which is the only code in the set displayed below that is reimbursed at a fixed fee, the methodology change was due to changes in the minutes of service associated with the code. We found that providers were utilizing the higher-intensity code due to rounding, which was inappropriate and resulted in increased costs to patients."

Report Chart D5 - Carrier 3 MARR Setting Methodology

Procedure Code	Methodology
90832	RVU - Based
90833	RVU - Based
90834	RVU - Based
90836	RVU - Based
90837	Fixed Fee
90838	RVU - Based
90839	RVU - Based
90840	RVU - Based
90846	RVU - Based
90847	RVU - Based
90863	RVU - Based
90875	RVU - Based
90876	RVU - Based
90101	RVU - Based
96102	RVU - Based
96116	RVU - Based
96118	RVU - Based
96150	RVU - Based
96151	RVU - Based
96152	RVU - Based
96153	RVU - Based
96154	RVU - Based
96155	RVU - Based
99201	RVU - Based
99202	RVU - Based
99203	RVU - Based
99204	RVU - Based
99205	RVU - Based
99211	RVU - Based
99212	RVU - Based
99213	RVU - Based
99214	RVU - Based
99215	RVU - Based
99354	RVU - Based
99355	Data not provided

The carrier provided the chart below, Report Chart D6, and indicated it represented the "*BH Out-patient Professional Tiering % of MD Evaluation and Management Rates* for which CMS Guidelines are noted as the starting point".

The following are definitions the carrier provided with Report Chart D6 below:

MD (E&M): Doctor of Medicine, evaluation and management
PMHNP: Psychiatric and Mental Health Nurse Practitioner
PAs: Physician Assistant
NPs: Nurse Practitioner
PhD: Doctor of Philosophy
ADTS: Alcohol & Drug Testing Services
LCSW: Licensed Clinical Social Worker
LMFT: Licensed Marriage Family Therapist

Report Chart D6 - Carrier 3 Tiering Percentage Rating Factors

Provider Type	Oregon Plans	Provider Types
MD (E&M)	100%	Psychiatrist
PMHNP, PAs, NPs	100%	Nurse practitioners, Prescribing Mental Health Nurse practitioners
PhD	76.80%	Doctoral, Psychologist
Masters Level	56.67%	LCSW, LMFT
ADTS	52.46%	Trainee

The carrier stated, "*carrier 3* created its BH outpatient professional tiering by reviewing average levels of reimbursement provided to each practitioner type and then comparing that analysis to the CMS Pricing Reduction Methodology, as found in Chapter 12 of the Medicare Claims Processing Manual. Regulatory guidelines, including reimbursement parity for NPs per HB 2902, was also considered. Additionally, *carrier 3* measured the delta between the then-current reimbursement levels and the CMS values to assess the significance of member impact of rate change and sought to mitigate excessive increases in order to avoid a spike in Member financial liability amounts."

In addition, the carrier stated, "Final tiering percentages were constructed to find an equilibrium between those factors, when there was disparity, as well as to account for differing levels of resources required to obtain the level of licensure. This is a parity approach between medical and behavioral health services. *Carrier 3* applies the tiering factors for the listed provider types' percentages to the maximum allowable for MD E&M services when calculating reimbursement for services rendered." Lastly, the carrier provided the MARR for each of the 35 procedure codes and modifier combinations. During the Period of Review, the carrier used the following modifiers: Masters Degree Level (HO), Doctoral Level (HP), Psychiatrist (UA) and Advanced Practice Nurse Prescriber with Psychiatric Specialty (UB) level. The Qualified Treatment Trainee (U6) modifier was not applicable during the Period of Review. The carrier did not submit the required detailed information by procedure code relating to the use and applicability of procedure code and modifier combinations for each procedure code under review. Limited information was provided on three procedure codes and modifications. For procedure code 90832, the carrier stated that the MARR is calculated by taking the product of the conversion factor and RVU. For procedure code 90833, the carrier indicated that the

Masters Degree Level is paid at 56.67% of Medical Providers and the Doctoral Level is paid at 76.80% of Medical Providers. The MARR for procedure code 90837 is a fixed fee.

The carrier provided the following chart, Report Chart D7, of its RVU weight factors and conversion rate factors by year for the 18 procedures codes noted below:

Report Chart D7 - Carrier 3 RVU Weight Factors and Conversion Rate Factors by Year

		RVU					Conversion Factors					Max Allowable			
	Calendar Year	2015	2016	2017	2018		2015	2016	2017	2018		2015	2016	2017	2018
CPT	Category														
90832	Medicine	1.84	1.84	1.79	1.79		61.00	61.00	60.70	61.55		$112.24	$112.24	$108.65	$110.17
90833	Medicine	1.22	1.22	1.84	1.86		61.00	61.00	60.70	61.55		$74.42	$74.42	$111.69	$114.48
90834	Medicine	2.37	2.37	2.37	2.38		61.00	61.00	60.70	61.55		$144.57	$144.57	$143.86	$146.49
90836	Medicine	1.98	1.98	2.33	2.35		61.00	61.00	60.70	61.55		$120.78	$120.78	$141.43	$144.64
90837	Medicine	3.47	3.47	3.56	3.57		61.00	61.00	60.70	61.55		$211.67	$211.67	$216.09	$219.73
90838	Medicine	3.20	3.20	3.08	3.10		61.00	61.00	60.70	61.55		$195.20	$195.20	$186.96	$190.81
99201	EM	1.29	1.29	1.23	1.24		59.00	59.00	62.10	63.50		$76.11	$76.11	$76.38	$78.74
99202	EM	2.19	2.19	2.10	2.11		59.00	59.00	62.10	63.50		$129.21	$129.21	$130.41	$133.99
99203	EM	3.18	3.18	3.05	3.05		59.00	59.00	62.10	63.50		$187.62	$187.62	$189.41	$193.68
99204	EM	4.84	4.84	4.64	4.63		59.00	59.00	62.10	63.50		$285.56	$285.56	$288.14	$294.01
99205	EM	5.99	5.99	5.83	5.83		59.00	59.00	62.10	63.50		$353.41	$353.41	$362.04	$370.21
99211	EM	0.60	0.60	0.56	0.57		59.00	59.00	62.10	63.50		$35.40	$35.40	$34.78	$36.20
99212	EM	1.29	1.29	1.23	1.23		59.00	59.00	62.10	63.50		$76.11	$76.11	$76.38	$78.11
99213	EM	2.14	2.14	2.04	2.06		59.00	59.00	62.10	63.50		$126.26	$126.26	$126.68	$130.81
99214	EM	3.14	3.14	3.03	3.03		59.00	59.00	62.10	63.50		$185.26	$185.26	$188.16	$192.41
99215	EM	4.20	4.20	4.09	4.08		59.00	59.00	62.10	63.50		$247.80	$247.80	$253.99	$259.08
99354	EM	2.86	2.86	2.81	3.66		59.00	59.00	62.10	63.50		$168.74	$168.74	$174.50	$232.41
99355	EM	2.80	2.80	2.73	2.76		59.00	59.00	62.10	63.50		$165.20	$165.20	$169.53	$175.26

The carrier stated, "*carrier 3* ensures that Financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits including pharmacy. We do not apply any limitations on treatment through our credentialing process, nor any provider-specific restrictions other than assessing credentialing applications for only those recognized provider types with whom *carrier 3* contracts. *Carrier 3* does not currently apply treatment limitations to outpatient time-based office visits or services. This includes any benefit limitations, as well as treatment limitations applied via reimbursement allowances, utilization management or code edits requiring medical necessity review or other pended claim review. However, if a billing error is noted, it would be addressed regardless of mental health or medical/surgical categorization. Reimbursement audits may be conducted, but without regard to service categorization, and so there is no inconsistency. Prior authorizations may be required for select services, but again without regard to categorization."

Carrier 4 - Plan K

The carrier provided policies, procedures and methodologies regarding the development of reimbursement allowances for participating providers offering time-based outpatient office visits. The carrier provided this information for the provider types under review. The carrier provided a procedure document labeled, "Establishment of Provider Rates: In-Network Providers," for each year under the Period of Review. The carrier notes the purpose of the document as follows, "Optimal provider discounts are a vital element in ensuring the affordability of health coverage for employers and healthcare services for members. Rates must be fair to providers to allow for sustainable practices and to ensure high quality services remain available to members. The objective of this policy is to ensure consistency across departments and lines of business in the establishment of methodology of rates with directly contracted providers, in accordance with the Federal Mental Health Parity Act."

Carrier uses set fee schedules to reimburse the following provider types:

(a) BH Providers that do not have prescribing privileges, such as Psychologists, LCSWs, LPCs and LMFTs; and
(b) MH Providers such as NPs and PMHNPs.

However, for Medical Doctors, including Psychiatrists, MDs and DOs, reimbursement is derived by using a fee-for-service model in which the RBRVS method established by CMS is the basis for the allowance calculation**.** The RBRVS assigns an RVU weight to services and procedures that are used in conjunction with a conversion factor to determine reimbursement allowances for procedure codes. As such, the provider reimbursement methodology for Medical Doctors varies from the methodology used for BH Providers, Psychologists, NPs and PMHNPs. It was also noted that mid-level medical professionals associated with the Medical Doctor classification of providers, such as Registered Nurse First Assistant, Physician Assistant and Certified Nurse Midwife, are reimbursed based upon the RBRVS methodology used for Medical Doctors.

For illustrative purposes, the 2015 allowable reimbursement calculation (prior to the application of other factors, such as the result of negotiation) for procedure code 90832 (Psychotherapy Services and Procedures, 30 minutes) for each of the eight provider types included in this area review are included in Report Chart D8 below.

Report Chart D8 - Carrier 4 Example of 2015 Maximum Allowable Reimbursement Rate for Procedure Code 90832 – All Provider Types

Procedure Code	Provider	2015 Maximum Allowable Reimbursement
90832	Doctor of Medicine	2014 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.81 * $62 Conversion Factor = $112.22
90832	Doctor of Osteopathic Medicine	2014 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.81 * $62 Conversion Factor = $112.22
90832	Psychiatrist	2014 Resource-Based Relative Value Scale (RBRVS) Non-Facility of 1.81 * $62 Conversion Factor = $112.22
90832	Nurse Practitioner	Set Fee = $65
90832	Psychiatric and Mental Health Nurse Practitioner	Set Fee = $65
90832	Psychologist	Set Fee = $51
90832	Licensed Clinical Social Worker	Set Fee = $44
90832	Licensed Professional Counselor/Licensed Marriage Family Counselor	Set Fee = $42

Carrier further stated that other factors were considered while setting or negotiating MARRs with all provider types. The carrier stated:

"The factors considered include:
(a) The services provided and the level of credentials of rendering providers.
(b) Market conditions, including:
i. Abundance or shortage of providers within the panel with the same specialty, language(s), and/or cultural background within the same geographic area
ii. Competitiveness of the *carrier 4* rates within the marketplace
iii. Inflation rate as identified by the Bureau of Labor Statistics as identified by the reports for Medical Services and Hospital Services (reported nationally) and for Professional Services in the Western Urban Region.
iv. Fees typically charged by providers with similar specialties in similar locations
v. Adequacy of the panel as measured by standards adopted by *carrier 4*."

The carrier was required to provide information regarding the evidentiary standards, national treatment guidelines and other considerations that were relied upon to establish participating provider reimbursement

allowances for outpatient time-based office visits/services. For all provider types under review, carrier provided the following response:

> "Evidentiary standards apply primarily to adopting medical necessity criteria and making medical necessity determinations and are generally not applicable to setting provider reimbursement allowances. National treatment guidelines were not considered. National treatment guidelines are applicable to the development of medical necessity criteria and clinical guidelines but not to the setting of reimbursement rates."

In terms of other considerations, the carrier noted that market conditions and other factors as stated above are also considered. The carrier was required to provide information regarding standards that were considered but rejected. Regarding Medical Doctors, carrier stated that no standards were considered but rejected. Regarding standards that were considered and rejected in reference to BH Providers and MH Providers, the carrier responded:

> "*Carrier 4* considered adopting Relative Value Unit (RVU)-based reimbursement for psychologists, LCSWs, LPCs and LMFTs. Both times, we rejected RVUs as the basis for our standard fee schedules for these provider types. While some provider contracts have RVU-based compensation for these provider types (due to provider preference), most do not. In 2015 and 2017, *carrier 4* considered adopting Relative Value Unit (RVU)-based reimbursement for PMHNPs in group practice in place of the fee schedules in use at the time. Both times, we rejected RVUs as the basis for our standard fee schedules for these provider types. While some provider contracts have RVU-based compensation for these provider types (due to provider preference), most do not."

Upon inquiry as to the reasons an RVU-based reimbursement methodology was considered and rejected in 2015 and 2017 for psychologists, LCSWs, LPC/LMFTs and PMHNPs, the carrier responded:

> "The reasons for not adopting RVU-based reimbursement for these provider types were continuity, fairness, and clinical value. Changing to RVU-based reimbursement in an actuarially sound manner, even with an adjustment for inflation, would mean increasing reimbursement for some codes and decreasing reimbursement for other codes. In particular, it would mean decreasing reimbursement for 90834 which is the standard 50-minute psychotherapy hour. As a result, such a change would result in a reduction in overall compensation for many providers, which would be untenable. The potential disruption from adopting RVU-based reimbursement is heightened by the poor alignment between the new CPT coding adopted in 2013 and actual practice patterns. A standard 50 minute psychotherapy visit is billed with 90834; the threshold for coding up to 90837 is 53 minutes. The RVU for 90837 in 2017 was 55% higher than for 90834, for as little as 3 minutes of additional work. To adopt a 55% differential between those two codes in an actuarially sound way would artificially punish providers who provide a standard 50 minute session. Any patients whose benefit structures include deductible and co-insurance for office visits would be stuck paying half again more for a 53 minute visit than for a 50 minute visit. We think this would be grossly unfair. *Carrier 4* did not want to impose those consequences on providers and members unless there was good reason to do so. We could find no good reason to do so. Given national and local pressures to move from paying for activity toward paying for value, *carrier 4* determined there was sound reason **not** to adopt RVU-based reimbursement in these fee schedules. Moving to an RVU basis would move us in the opposite direction from value-based contracting. RVUs are based on the amount of work and resources

involved in providing a service, with no consideration to the clinical value of that service. Value-based reimbursement seeks to incorporate the clinical value of services into the compensation schema."

The carrier also provided an analysis regarding procedure codes 90853 and 90837 in order to illustrate the variance between clinical value and RVU reimbursement. The carrier explained that their non-RVU based fee schedules consider such variances. The carrier did not provide a similar analysis for the other 33 procedure codes under review. The carrier provided the following statement:

> "*Carrier 4* has considered and rejected using RVU-based compensation in our standard behavioral health fee schedules because it would be disruptive and unfair, and because it would move us away from value-based reimbursement. While the amount of work (including time) as represented by RVUs is a factor in setting reimbursement rates, it is not the only factor and we assessed that adopting a strict RVU-based compensation schema would do more harm than good."

As explained above, the carrier employs an RVU-based reimbursement methodology for MDs, DOs and Psychiatrists and a non-RVU based reimbursement methodology for psychologists, LCSWs, LPCs/LMFTs and PMHNPs. The carrier was requested to explain how they determined compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). The carrier provided the following response, which includes information as stated in MHPAEA:

> "Reimbursement policies including establishing rates for contracted providers are categorized under MHPAEA as NQTLs:
>
> > (D) Standards for provider admission to participate in a network, including reimbursement rates;
> > (E) Plan methods for determining usual, customary, and reasonable charges; [**Ibid,** p. 68282].
>
> The rule provides eleven illustrative examples of permissible and impermissible NQTLs; none of the examples address reimbursement rates or fee structures. The Departments make clear in the "Supplemental Information" issued with the rules that "the regulations do not require plans and issuers to use the same NQTLs for both mental health and substance use disorder benefits and medical/surgical benefits" and that "Disparate results alone do not mean that the NQTLs in use do not comply with these requirements" [**Ibid,** p. 68245].
>
> Our analysis of the permissibility of applying non-RVU based fee schedules to behavioral health providers addresses whether we created the fee schedules using processes "comparable to" and "applied no more stringently than" how we created fee schedules for med/surg providers. Here is how we find that we are fully compliant under this standard:
>
> 1. Our methods are comparable for medical and behavioral providers. We develop and update the BH fee schedules following the same Policy and Procedure ("Establishment of Provider Rates: In-Network Providers," provided in the initial data call) for medical and behavioral health providers. The P&P indicates fee schedules may be appropriate for "providers who typically bill a limited range of procedure codes," as is the case for non-prescribing BH providers. We evaluate market conditions, network adequacy, budgetary constraints and provider credentials when considering rates for BH and non-BH providers alike. In all material respects, our "processes, strategies, evidentiary

standards, [and] other factors" are comparable if not identical in establishing BH rates and med/surg rates.

2. They are applied no more stringently for BH providers than for non-BH providers. "Stringently" in this context would have to be understood to mean "unfavorable to members seeking behavioral health services." The rule suggests two ways in which this could happen: First, if rates are unfavorable to providers, then the panel size may be restricted, leading to members to have difficulty accessing services. Second, if "usual & customary" fees are set too low, members could end up with excessive balance billing. The second issue can be dismissed because "usual and customary" applies to out-of-network providers, not in-network providers; and because our contracts prohibit in-network providers from balance billing members."

The carrier further explained how their differing reimbursement methodologies impact members. As such, the carrier provided the following comments:

"This leaves us to determine whether a non-RVU-based fee schedule adversely impacts members via reimbursement rates that are unfavorable to providers. To answer this, we need to determine whether the non-RVU-based fee schedule is unfavorable to providers, and if so, whether it restricts members' access to care. Our analysis shows the non-RVU-based fee schedule is **not** unfavorable to providers. We believe it is fairer and more favorable than switching to an RVU-based fee schedule, primarily because of the negative impact an RVU-based fee schedule would have on reimbursement for CPT code 90834. We are confident in this assessment. In fact, it appears that some providers who vocally oppose this approach may not be aware that their own IPA deliberately negotiated a non-RVU-based fee schedule with *carrier 4* on their behalf.

We also do not have reason to believe that non-RVU-based fee schedules have adversely affected our ability to attract and retain a robust BH provider panel. We are not aware of a single case in which a non-prescribing BH provider terminated or refused to join our panel because the fee schedule was not RVU-based. With a panel of more than 4,500 behavioral health providers, our behavioral health network performs better against our provider availability standards than our medical provider network does. For example, in 2018 we met our provider to member ratio standards in every county for master's level BH therapists and in 27 counties for psychologists. In comparison, we met our standards for primary care providers in 23 counties. We met our geographic distribution/distance standards for behavioral health providers in nine out of nine categories; we met the same standards for primary care providers in only eight out of nine categories.

In summary: we have determined this approach complies with MHPAEA by assessing whether our "processes, strategies, evidentiary standards, [and] other factors" are comparable, and finding that they are; and whether they are applied any more "stringently" for behavioral health then for med/surg, and finding that they are not."

Carrier 5 - Plan L-O

For commercial policies, the carrier stated, "*carrier 5* contracts with individual providers and provider groups. Reimbursement is reviewed and negotiated based on the provider's credentials and specialty. To align ourselves in the marketplaces in which we do business, *carrier 5* may discount reimbursement based on the credentials of the provider. The default credentials and discounts are listed below. The percent discount is

taken from the Base Rate conversion factor/ fee schedule for services only related and payable under the RBRVS (sic - Resource-based Relative Value Scale) fee schedule. If there is an already established conversion factor specifically spelled out on the Attachment A for any provider type listed below, the below discount will not apply. For laboratory, radiology or any other type of facility within the group, the facilities will obtain the same reimbursement as the Base Rate if and when their services fall within the RBRVS reimbursement method. This will be configured by Facets Business Support. Facets Business Support will configure all Mid-Levels into the agreement."

The carrier provided the chart below regarding practitioners' credentials and the adjustment percentage of the Base Rate conversion factor for services payable under the RBRVS fee schedule. If there was an established conversion factor specifically provided for in the providers' contract for any provider type listed below, the factor below did not apply. (Note: A legend was not provided by the carrier which defines the acronyms for Practitioners Credentials included in Report Chart D9 below.

Report Chart D9 - Carrier 5 Practitioner Credentials and Base Rate Conversion Factors

Practitioners Credential	Oregon
DPM (and DC, DCPT, DCND, DCLA, DCAN for Washington)	100%
FNP, NP, CNM, CRNA, MHNP, AHNP, CNS, PHNP, WHNP, NDCM	100%
PHD, PsyD, Phar	85%
PA	100%
OD, PSYR	75%
DC, PT, OT, ST, ND, AUD, RD, MA, SLP, NDLA, NDPT, DCPT, DCND, DCLA, DCAN	70%
LAC, MSW, LCSW, LPC, LMFT, SW, BCBA, LMHC (WA only), GENC	60%
LMT, LMP, RN, LDEM	40%

Relative to Medical Providers' MARR, the carrier indicated that such rate is determined by multiplying the RVU and the conversion factor in the provider contract by the number of units billed, including modifiers when applicable. Current year RVUs were the most recent prior year RVU schedule available; for example, the 2017D version of RVUs was used for the 2018 calendar year. If a billed procedure code did not correspond with an RVU value in the provider contract's Federal Register year, the carrier utilized the Data Sources and Pricing Methodology Hierarchy to calculate MARRs. The carrier provided the following example of the rate methodology:

Calculating Allowed Amounts - Commercial

- 99213 in an office (nonfacility)

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
All Professional Services: CPT procedures categorized with RVU as defined by the Federal Register (including Pathology)	RBRVS[1] conversion factor $ 86.00

rate determination.

1RBRVS Relative Value Units (RVUs) as defined and instructed by the Federal Register for use in 2016. Site of service specific

- 2.05 RVU x $86.00 CF = $176.30

Relative to BH Providers, the carrier stated, "*Carrier 5* determines allowables for participating Behavioral Mental Health Providers by multiplying the RVU and conversion factor in the provider contract by the number of units billed. An adjustment is made for the level of licensure for these provider types; psychologist allowables are set at eighty-five percent (85%) of the Medical Provider rate, licensed clinical social worker and, licensed professional counselors and licensed marriage and family therapist allowables are set at sixty percent (60%) of the Medical Provider rate. Please reference the Non Physician Default Reimbursement for Participating Providers Policy. Should the billed CPT code not correspond with an RVU value in the provider contract's Federal Register year, *carrier 5* utilizes the Data Sources and Pricing Methodology Hierarchy to calculate allowables."

The carrier further stated, "*Carrier 5* determines allowables for participating Mental Health Providers with Prescribing Privileges by multiplying the RVU and conversion factor in the provider contract by the number of units billed. Should the billed CPT code not correspond with an RVU value in the provider contract's Federal Register year, *carrier 5* utilizes the Data Sources and Pricing Methodology Hierarchy to calculate allowables."

The carrier indicated carrier had a standard base conversion factor that was determined based on global market factors applicable to specific service areas, consultation with internal medical directors, review of RVU weights, and analysis of current rates and historical claims data. On an individual contract basis, conversion factors were negotiated taking into consideration other determining factors, such as market forces, medical CPI, and network adequacy.

As noted above, the carrier adjusted the MARRs based upon the credentials of the provider, and supplied the default credentials and its discounts. The hierarchy of pricing methodologies was established using Essentials Resource-Based Relative Value Scale as the most comprehensive data source available. Additional sources were used to supplement RBRVS in the absence of an Essential RVU. Data sources included government fee schedule source files with rates scaled to mirror commercial base rates. The adjustment factor was taken from the Base Rate conversion factor / fee schedule for services payable under the RBRVS fee schedule established by CMS. If there was an established conversion factor, the discount did not apply. As noted above, for laboratory, radiology or any other type of facility within the group, the facilities were provided the same MARR as the Base Rate if the services fell within the RBRVS reimbursement rate method.

As noted above, the carrier reimbursed in-network providers in accordance with its negotiated contracts for individual providers and provider groups. The carrier provided its 2017 and 2018 actuarial trending and indicated that commercial plans were relatively new, actuarial assumptions were completed at a high level and it did not discriminate between medical and mental health providers. Annual contract changes were negotiated in relation to expected trends and market factors.

The carrier indicated it utilized market research, analysis of claims billed and medical consumer price index figures to negotiate MARRs for in-network providers in an outpatient office-based setting.

During the Period of Review, the carrier did not use any modifiers on Plans L and O. In regard to Plan M, in 2015, modifier HO was used for procedure code 96152 and modifier UB was used for procedure code 99211 and 99213. In 2016, modifier HO was used for procedure code 90834, 90837 and 96152, modifier HP was used for procedure code 90834 and modifier UB was used for 90839, 90840, 90847, 99201, 99202, 99203, 99211, 99212, 299213, 99214. In 2017 modifier HO was used for procedure code 90834 and 90837, modifier UA was used for 99213, and modifier UB was used for 90832, 90834, 99201, 99202, 99203, 99211, 99212, 299213, and 99214. In 2018, modifier HO was used for 90834 and 90837, and modifier UB was used for 90834 and 99212. The carrier stated that the reimbursement rate was determined using "Equation: RVU * RBRVS conversion factor, possible mid-level reductions, LOBA impact." Modifier UB was used on Plan N in 2017, for procedure codes 99201, 99213, and 99214, and in 2018, for procedure codes 99201, 99202, 99212, 99213, and 99214. The carrier stated that the MARR was determined using "Equation: RVU * RBRVS conversion factor, possible mid-level reductions, LOBA impact." Limited information was provided regarding possible reductions applicable to the modifier equations.

Carrier 6 - Plan P

The carrier and its third party entity provided policies, procedures and methodologies regarding the development of MARRs for participating providers offering time-based outpatient office visits. The third party entity provided information regarding MH Providers and BH Providers and carrier provided information regarding Medical Providers. The third party entity indicated that provider MARRs are based upon an internally developed rate schedule. The third party entity also provided the following information:

> "The standard approach is to reimburse at 100% of these fee schedules, though providers may negotiate an inflator to these fee schedules. In addition, reimbursement may be affected by payment policies based on the specialty of the billing provider (e.g. NPs, PAs), procedure code modifiers, and coding edits. The carriers' third party entity evaluates fee schedules on a periodic basis and any necessary adjustments are made to remain competitive in the marketplace.
> 1. Description of code. Define or obtain a detailed description of the code including but not limited to information such as service rendered, purpose of code, and duration of service.
> 2. Find similar codes. If other codes that are similar in nature exist, those codes are used as a guide to develop the rate for the new code. Adjustments are then made to these codes to reflect the nuances of the new code.
> 3. Crosswalk possible codes. When a new code replaces or supplements existing codes, providers can change the way they bill. When this happens, it is necessary to determine what old codes, if any, will now be replaced by the new codes. Therefore, a crosswalk from the old codes to the new needs to be completed. Possible scenarios that can exist include 1) one to one crosswalk, 2) many old codes cross walking to one new code, 3) one old code cross walking to several new codes, or 4) many old codes cross walking to many new codes.

4. Determine utilization distribution. Once the codes are cross walked, in order to account for each of the scenarios above, where there isn't a straight one to one crosswalk (i.e. several codes affect) an assumed utilization distribution must be developed. Using guidance from CMS, external sources, or other methodologies, an expected utilization distribution to the new codes are derived.
5. Compare to external sources for appropriateness of relativities. CMS national RVUs are used as a guide to check the relativities among the codes to ensure they are properly aligned. The RVUs are obtained from the CMS Physician Fee Schedule Final Rule, Addendum B, which is posted on the CMS.gov website. The RVU for a specific code represent the relative resources required to perform that service compared to other services. Additional adjustments to rates are made if necessary. Other sources can also include Fairhealth (sic – FAIR Health) and rates/relativities obtained through studies from 3rd party vendors.
6. Adjusting for geography. Rates are compared to cost variances among geography and if necessary, adjusted accordingly.
7. Adjusting for market conditions. Other factors that influence the market including but not limited to, supply/demand, license level, and market conditions are used to make any additional adjustments to the fee schedule.
8. Negotiation. Some providers' fee schedules are negotiated on a case by case basis."

Based on the third party entity's response above, the carrier was requested to submit the third party entity's rate schedule analysis, calculations (including adjustments made as noted above, such as geographic location, modifiers, coding edits, provider type, etc.) and all documentation supporting the analysis and calculations performed for each of the 35 procedure codes and by each provider type in this review. The following response was provided:

"*Carrier 6s' third party entity* does not have the actual calculations as the base rate calculations were developed several years ago. As such, we do not have the historical files that have the calculations resulting in a rate for each code. The base rates have not been adjusted since development. However, throughout the years any deviation in rates are due to negotiations with providers and adjustments are made as needed."

In terms of Medical Provider related policies, procedures and methodologies regarding the development of MARRs for participating providers offering time-based outpatient office visits, carrier did not provide sufficient information. In their response, carrier directed the Contractor to a document labeled, Carrier 6 Fee Schedule Disclosure, which described the contracted provider standards for carrier's allowable reimbursement rate contract terms. Another document labeled, Fee Schedule Sample Carrier 6, was also provided. This document included information regarding rates by procedure code and information regarding the calculation of fees. In particular, the document notes that the carrier utilizes CMS's RBRVS method, where each procedure code has RVUs associated with it as stated in the annual RBRVS fee schedule, in order to determine each rate. However, a defined approach explaining the methodologies regarding the development of MARRs for participating Medical Providers offering time-based outpatient office visits was not provided. As such, a second request for this information was made and the carrier provided the following response:

"There are several factors that are taken into consideration in this regard including CMS benchmarks, regional market dynamics and current business needs. Depending on provider type, contract rates may be based on a MS-DRG, Per Diem, Per Case, Per Visit, Per Unit, Fee Schedule, etc. basis. Inpatient and outpatient contract rates are negotiated on a facility by facility basis. Contract rates are typically negotiated for a 2-3 year term with agreed upon escalators for each year. Centers for

Medicare & Medicaid Services (CMS) is the main Fee Source used to supply the fee basis amount for deriving the fee amount for outpatient time-based office visits/services. Using the CMS published relative value units (RVUs) and Geographic Practice Cost Index files each code's fee basis is calculated using the CMS published formula for physician fee schedule payment: [(Work RVU * Work GPCI) +(PE RVU * PE GPCI) +(MP RVU * MP GPCI)] * Conversion Factor (CF). In the event, the Primary Fee Source does not publish a Fee Basis amount, an Alternate Fee Source will be applied, if available. The final fee amount is derived by multiplying the fee basis by the provider's contracted percentage. NOTE: Reimbursement may be affected by payment policies based on the specialty of the billing provider (e.g. NPs, PAs), procedure code modifiers, and coding edits."

In terms of modifiers used in the MARR development process, the carrier indicated that they do not use modifiers for commercial plans.

The carrier also provided information regarding the negotiation of MARRs with participating providers offering outpatient time-based office visits/services. Carrier provided the following response:

"The provider is required to submit a rate request in writing. Upon receipt of the request, Plan staff will outreach to provider to begin negotiations. Discussions with provider will include a reinforcement of the standard fee schedule and rates of reimbursement, how it was established, and why provider thinks the rates are not acceptable. Rate increase requests that deviate from standard rates may be considered under the following circumstances:

- Provider is located in a geographic area where there is limited appointment availability
- Provider is located in a geographic area where there is a limited number of providers for contracting
- Provider offers unique and/or specialized areas of expertise or experience
- Provider license/education levels
- Unique and/or special circumstances such as pilot programs requiring expanded services
- Specific customer requests for a provider's participation
- Documented business need for network expansion

Requests that qualify under the exception criteria are reviewed by designated Plan staff, as outlined in the Plan's delegation of authority process. Upon elevated review, new rate parameters may be established. Plan contractor may go back to provider and attempt to come to agreement based on newly established rates. The two parties work together to agree to rates that are reflective of the services, expertise and availability of the provider. Upon agreement, updated contracts are executed and updates in systems for claims payment are finalized. In addition, reimbursement allowances are negotiated following receipt of a proposal from the provider. *Carrier 6* then pulls 12 months of claims utilization data and models the provider's proposal using a proprietary pricing modeling tool. After the modeling is complete and the parties agree to rates, the fee schedule is built. Fee schedules can vary depending upon medical specialty and geographic area."

As carrier stated in their response above, a proprietary pricing modeling tool is utilized during the MARR negotiation process. The Contractor requested information regarding the pricing tool in terms of how the tool is utilized during the negotiation process for the provider types and procedure codes under review. The carrier provided the following response: "The physician pricing tool is proprietary software. The tool itself pulls in 12 months of claims data including all CPT codes that a provider has billed to the company based

upon their Tax ID number. The tool models the provider's proposal and provides options in incremental increases that are used in the negotiation."

The carrier was also requested to provide a listing of providers that requested a negotiated rate including information regarding the provider type, initial rate offered, final negotiated rate and the reason for the negotiated rate. The carrier provided the following response: "*the carriers' third party entity* can provide a list of providers with a negotiated fee schedule. However, *the carriers' third party entity* does not track that level of negotiation detail." The Contractor reviewed the listing provided and 1,283 providers have a negotiated fee schedule, which included 618 providers that hold a Masters of Social Work, 297 individuals that hold a Doctor of Philosophy Degree, 244 Medical Doctors and 124 Registered Nurses. *Carrier 6* provided the following response for Medical Providers: "Not every medical provider contacts the Company to negotiate new rates every year, in which case the existing fee schedule continues into the next year. Negotiations that occur on an annual basis are protected by the confidentiality clause in the contract."

The carrier provided information regarding the factors considered when setting MARRs for outpatient time-based office visits/services. The carrier's third party entity indicated that the following factors are considered for BH Providers and MH Providers: "description of the code including but not limited to information such as service rendered, purpose of code, and duration of service, external sources including CMS RVUs, 3rd party publications; license/education levels; geography; supply and demand; specialty and negotiation." Carrier did not provide a complete response and instead directed the Contractor to a document labeled, Fee Schedule Sample Carrier 6. As previously noted above, this document included information regarding rates by procedure code and information regarding the calculation of rates. In particular, the document notes that the carrier utilizes CMS's RBRVS method where each procedure code has RVUs associated with it, as stated in the annual RBRVS fee schedule, to determine each rate. Also, carrier indicated that provider rates will vary based on their specialty and geographic area.

The carrier was requested to describe any evidentiary standards, national treatment guidelines or other considerations (including standards that were considered but rejected) that were relied upon to establish participating provider reimbursement allowances for outpatient time-based office visits/services. Carrier provided the following response for Medical Providers:

> "None of the above listed standards are considered to establish provider reimbursement allowances for medical providers."

The Contractor was unable to locate information in the carrier's submission that was responsive to the request. The third party entity provided the following response for BH Providers and MH Providers:

> "Other considerations - CMS national RVUs are used as a guide to check the relativities among the codes to ensure they are properly aligned."

The carrier was asked to submit the reimbursement calculations for each provider type and for each procedure code included under this review. The following response was provided:

a. "Psychologist – 100% of the Psych rate
b. Licensed Clinical Social Worker (LCSW) 25-100% of psych
c. Licensed Professional Counselor (L.P.C.) 25%-100% of psych
d. Licensed Marriage Family Therapist (L.M.F.T.) 25-100% of psych

e. Doctor of Osteopathic Medicine (D.O.) for the treatment of a mental health or substance abuse conditions 100% of psych
f. Doctor of Medicine (M.D.) for the treatment of a mental health or substance abuse conditions 100% of psych
g. Nurse Practitioner (N.P.) 100% of psych
h. Psychiatrist – 100% of psych
i. Psychiatric and Mental Health Nurse Practitioner (P.M.H.N.P.) 100% of psych"

As outlined in the preceding paragraphs of this section, the carrier utilized a fee-for-service model in which the RBRVS established by CMS is the basis for the MARR calculation for Medical Providers. However, internally developed rate schedules were utilized for BH Providers and MH Providers. As such, the carrier was requested to explain the variance in the process for setting reimbursement rates for Medical Providers and the process for setting rates for BH Providers and MH Providers. The carrier provided the following response:

> "*Carrier 6* and *its third party entity* uses comparable factors, evidentiary standards and methods of analysis in the development of reimbursement allowances, and the process is applied no more stringently to MH/SUD providers than to M/S providers. The process may differ, however, based on the following factors:
>
> - Type and/or duration of service provided
> - Guidance from external sources relied upon in the industry and specific to either MH/SUD or M/S providers
> - Utilization for MH/SUD services as compared to M/S services
> - Provider availability, including licensure type and consideration of patient volume versus provider demand in a geographic region."

The carrier also provided the following additional information regarding the difference in calculating MARRs:

> "MH/SUD and M/S services are inherently different in terms of frequency, manner and extent of usage. While MH/SUD services can be allocated in defined time units, the availability of which are finite based on the provider's work schedule, M/S services are provided on a basis that is uncertain and more focused on provider particulars than time allocated for treatment. Having said that, the evidentiary standards and methods of analysis for both is comparable and applied no more stringently to MH/SUD providers than to M/S providers. As indicated in our prior response, the determination of rates, whether negotiated or standardized, in (sic – is) grounded in a consideration of differing service or provider type, supply and demand (including experience, license level and market conditions) and industry guidelines."

The carrier was requested to provide the comparative analysis that was performed regarding the reimbursement rates for BH Providers, MH Providers and Medical Providers. The carrier provided the following response: "*Carrier 6* and *its third party entity* uses comparable factors, evidentiary standards and methods of analysis in the development of reimbursement allowances, and the process is applied no more stringently to MH/SUD providers than to M/S providers."

Carrier 7 - Plans Q and R

The carrier's third party entity provided behavioral health and substance use disorder (MH/SUD) services, including employee assistance programs (EAPs) for the carrier. Both the carrier and its third party entity developed maximum allowable reimbursement allowances for each CPT code based on RVUs multiplied by a conversion factor. Rate schedules varied by geography and the license level of provider. The exceptions for MARR allowances were based on network need, such as geographical location and provider specialty.

When the carrier negotiated reimbursement amounts for Medical Providers, the carrier's contractors reviewed licensure level and network adequacy, including geographical location, as well as the carrier's annual plan budget. Additionally, the carrier reviewed annual spending on historical utilization. When the carrier's provider requested an increase to the standard rate, an increase was only allowed if it was approved by an executive-level manager.

When negotiating reimbursement amounts for BH Providers, the third party entity's contractors also reviewed licensure level and network adequacy (i.e., geographical location), as well as the third party entity's annual plan budget. When a third party entity provider requested an increase to the standard rate, the rate increase was only allowed if approved by a professional relations representative. As such, the Medical Provider's MARR methodology varied from the methodology used for BH Providers.

Evidentiary standards and national treatment guidelines were not considered by the carrier when establishing Medical Provider reimbursement allowances. The carrier's factors considered when setting reimbursement allowances for Medical Providers included:

- Licensure level
- Specialty type
- Network adequacy (i.e., geographical location)
- Plan budget

During the Period of Review, the carrier's finance department produced a provider trend report spreadsheet, which included spending for each contracted provider. The carrier noted the budget for the current and upcoming three years was included in the spreadsheet. The carrier's budget was expressed as a percentage increase over the rates in the existing individual provider contract fee schedules. A typical budget allowed up to a 4% increase, but each provider had their own range between 0% and 6% based upon utilization, geography, and current contracted rates.

The carrier also noted there were pre-determined provider specific budgets, which were set for providers that represent the top 80% of overall spend. The budget/trend report is maintained by the finance department. The carrier noted the following: "If a provider did not have a specific budget in the trend report, the default budget parameters were based on a 2% rate increase, or the base provider standard fee schedule, whichever was applicable for an individual provider."

The carrier indicated when a negotiation required an exception outside of the current budget target or standard fee-for-service fee schedule, then the contract negotiator must complete an "Over Budget Approval Summary form" and send to Senior Management and Contract Configuration and Implementation Teams for review and approval.

The carrier provided its Medical Provider MARR methodology as follows (including its conversion factors based on MARRs) and its base rate targets:

> "Rates are calculated using resource-based relative value scale (RBRVS) weights and conversion factors.
>
> RBRVS Year relative value units (RVU) weight x Conversion Factor = Allowed amount
> Calculation Example Parameters: 2015 RBRVS Year, CF = $60
> Procedure 99203 2015's relative value units (RVU) weight = 3.02.
> 3.02 x $60CF = $181.20 Allowed Amount
>
> PPO Conversion factors (Based on highest Commercial Agreement rates)
>
Year	CF
2015	$88.49
2016	$92.73
2017	$95.89
2018	$97.37

> EPO-POS Conversion factors (Based on highest Commercial Agreement rates)
>
Year	CF
2015	$84.40
2016	$88.23
2017	$91.19
2018	$97.37

> Base Rate targets for new provider Contracts:
>
> - Current Year RVU
> - $60.00 Conversion Factor for Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Doctors of Podiatric Medicine (DPM) and Doctor of Optometry (OD)
> - Radiology rate was $55.00 Conversion Factor
> - Anesthesia rate was $36.00 per Unit/ASA
> - Labs, seventy percent (70%) of current year CMS
> - Durable Medical Equipment, seventy percent (70%) of current CMS Durable Medical Equipment Regional carrier (DMERC) fee schedule
> - Pharmaceutical rate is 100% of CMS (ICM05 fee schedule) or the lesser of 100% of the average wholesale price (AWP) or CMS (ILS05 fee schedule)".

The carrier indicated "N/A (the modifiers [SIC] are not used in our contracts. Not found in our claims data)". Report Chart D10 below summarizes the carrier's actual calculations performed in determining the MARRs for Medical Providers for select outpatient procedure codes. The calculations supported the 2015 data supplied for its MARRs for its EPO/POS plans.

Report Chart D10 - Carrier 7 Calculations for MARRs Allowances

CPT Code	Medical Reimbursement Rates
90832	Medical Calculation 2015 RVU Weight: 1.81 RVU x $84.40 CF = $152.76 Allowed
90833	Medical Calculation 2015 RVU Weight: 1.85 RVU x $84.40 CF = $156.14 Allowed
90834	Medical Calculation 2015 RVU Weight: 2.40 RVU x $84.40 CF = $202.56 Allowed
90836	Medical Calculation 2015 RVU Weight: 2.34 RVU x $84.40 CF = $197.50 Allowed
90837	Medical Calculation 2015 RVU Weight: 3.59 RVU x $84.40 CF = $303.00 Allowed
90838	Medical Calculation 2015 RVU Weight: 3.09 RVU x $84.40 CF = $260.80 Allowed
99201	Medical Calculation 2015 RVU Weight: 1.21 RVU x $84.40 CF = $102.12 Allowed
99202	Medical Calculation 2015 RVU Weight: 2.08 RVU x $84.40 CF = $175.55 Allowed
99203	Medical Calculation 2015 RVU Weight: 3.02 RVU x $84.40 CF = $254.89 Allowed
99204	Medical Calculation 2015 RVU Weight: 4.64 RVU x $84.40 CF = $391.62 Allowed
99205	Medical Calculation 2015 RVU Weight: 5.78 RVU x $84.40 CF = $487.83 Allowed
99211	Medical Calculation 2015 RVU Weight: 0.56 RVU x $84.40 CF = $47.26 Allowed
99212	Medical Calculation 2015 RVU Weight: 1.22 RVU x $84.40 CF = $102.97 Allowed
99213	Medical Calculation 2015 RVU Weight: 2.04 RVU x $84.40 CF = $172.18 Allowed
99214	Medical Calculation 2015 RVU Weight: 3.01 RVU x $84.40 CF = $254.04 Allowed
99215	Medical Calculation 2015 RVU Weight: 4.03 RVU x $84.40 CF = $340.13 Allowed
99354	Medical Calculation 2015 RVU Weight: 2.80 RVU x $84.40 CF = $236.32 Allowed
99355	Medical Calculation 2015 RVU Weight: 2.74 RVU x $84.40 CF = $231.26 Allowed

Carrier 8 - Plan S

The following acronyms were included in carrier's responses:

RVU - Relative Value Units
RBRVS - Resource-based Relative Value Scale
GPCI - Geographic Practice Cost Indices
CMS - Centers for Medicare & Medicaid Services

The carrier stated, "*Carrier 8* negotiates with both medical and behavioral providers mutually agreed upon reimbursement rates based upon a mutual determination of what is deemed to be market competitive reimbursement for that particular provider rendering that particular service for that particular amount of time. It is not a formula-based process and there are no additional policies, procedures or supporting documents to provide."

The carrier further stated, "Each CPT code has its own assigned fixed rate based upon the RVU's assigned to it, the GPCI for the region and the % RBRVS which is negotiated in the contract. Anything that does not have an RVU value assigned goes to the default discount that has been designated in the contract." The carrier did not provide any information of their use of modifiers in their methodology

The carrier also considered the frequency in which the individual providers approached the carrier to renew their contracts. The carrier stated, "The Company's maximum allowable rates are set through what can be negotiated in the market. Another factor is the frequency the providers approach us to re-new their contracts. For medical, the majority of providers re-new annually; resulting in more frequent rates changes. The Company does not encounter the same frequency of renewals from the MH/SUD providers."

The carrier stated, "The Company's calculations for Medicare benchmarking follows CMS's own calculation methodology for non-site of service office visits using the CMS GPCI and RVU values for the year in which the schedule was created and/or updated. The calculation is as follows:

> ((CPT code work RVU*Portland Work GPCI)+(CPT code non-facility RVU*Portland Practice GPCI)+(CPT code malpractice RVU*Portland Malpractice GPCI))*CMS Conversion Factor"

The carrier further stated, "*Carrier 8* does not impose treatment limitations to medical or behavioral outpatient time-based office visits/services."

For medical reimbursement, the carrier provided the following list of factors and stated, "The factors considered when setting reimbursement rates are listed below:

> • CMS – We obtain our RVU (relative value units) from CMS (Medicare).
>
> • *Third party entity* – We gap fill any codes not populated in CMS with *third party entity* data. Many of these codes are services not provided by Medicare such as obstetric and pediatric services.
>
> • Clinical Lab and Pathology codes – CMS uses flat rates for these and populates for each state. However, we price at % RBRVS
>
> • Site of Service (SOS) – currently use our own assignment of Facility or Non-facility by a yearly process of evaluating the data and assigning SOS, which will be converted to a dual Site of Service reimbursement designated by the location on the HCFA 1500 form beginning 1/1/2017.
>
> • GPCI (geographical practice cost index) – populated by regions within markets.
>
> • *Carrier 8* RBRVS is developed using Work RVU, Practice Expense RVU and Malpractice RVU with adjustments for GPCI and a conversion factor."

In terms of BH Providers, the carrier provided the following response regarding the factors considered when setting reimbursement rates: "reimbursement allowances are created by benchmarking Medicare fee schedules. Further as noted in Response A.3, network need and geographic area are also taken into considerations when setting reimbursement allowances."

The carrier stated, "*Carrier 8* Medical Economics team in conjunction with local provider contracting develop, calculate, and negotiate reimbursement allowances" and "There are no "policies" around negotiating reimbursement. The ultimate reimbursement that we come to agreement on with a provider is based on a number of factors within that specific negotiation such as:

• Geographic market (i.e. market rate and payment type for provider type and/or specialty)
• Type of provider (i.e. hospital, clinic and practitioner) and/or specialty
• Supply of provider type and/or specialty
• Network need and/or demand for provider type and/or specialty
• Medicare reimbursement rates
• Training, experience and licensure of provider
• NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes)
• Plan population density within geographic regions (i.e. zip codes)
• Time and/or distance to access provider type within urban, suburban and rural areas
• Appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data, etc."

Based on the carrier's response, the carrier delegates the administration of the mental health and substance use disorder benefits covered by its health plans to a third party entity exclusively. The third party entity maintains a network of mental health and substance use disorder providers, which was separate and distinct from carrier's provider network during the Period of Review. The carrier stated that the third party entity and carrier issued fee schedules for their network providers. The carrier stated it provided combined 2015, 2016, 2017 and 2018 maximum allowable reimbursement calculations for mental health and substance use disorder providers because the reimbursement rates were the same for each year. The carrier's data, titled "Maximum Allowable Rates Calculation" is presented in Report Charts D11 – D15 below. Report Chart D11 is the carriers' combined Behavioral Health and Mental Health reimbursement methodology for 2015 - 2018 and Report Charts 12 – 15 are the carrier's Medical Providers reimbursement methodology for 2015 – 2018.

Report Chart D11 - Maximum Allowable Rates Calculation – MH / SUD_2015-2018

RBRVS Year	2008 / 2011 / 2013
Contract Year	Current
Contract %	125.70%
GPCI	Portland, OR

GPCI	Work	Practice	Malpractice
	1.008	1.052	0.746
2008	1.002	1.037	0.453
2011	1.003	1.016	0.542
2013	1.005	1.044	0.625

Procedure Code	Site of Service	Work RVU	Non Fac RVU	Malpractice RVU	CF	100%	126%	Max Rate - corresponds to value in Part 1 - Provider Reimbursement Worksheet
90832	N	1.25	0.54	0.05	34.023	$63.47	120%	$75.99
90833	N	0.98	0.2	0.04	34.023	$41.78	91%	$38.00
90834	N	1.89	0.41	0.07	34.023	$81.27	142%	$115.00
90836	N	1.6	0.32	0.06	34.023	$67.85	91%	$62.00
90837	N	2.83	0.53	0.11	34.023	$118.82	164%	$194.35
90838	N	2.56	0.54	0.1	34.023	$109.66	92%	$101.00
90839	N	3.13	0.51	0.11	35.889	$135.43	212%	$287.50
90846	N	1.61	0.58	0.04	38.087	$85.04	135%	$115.00
90847	N	1.95	0.78	0.05	38.087	$106.09	127%	$135.24
90875	N	1.06	0.71	0.04	38.087	$69.19	121%	$83.43
90876	N	1.67	0.92	0.05	38.087	$100.93	120%	$121.42
96101	N	1.64	0.5	0.05	38.087	$83.20	135%	$112.13
96102	N	0.44	0.88	0.01	38.087	$51.72	102%	$52.90
96116	N	1.64	0.68	0.18	38.087	$92.55	133%	$122.92
96118	N	1.64	1.11	0.18	38.087	$109.53	136%	$148.72
96150	N	0.5	0.11	0.01	33.976	$21.02	84%	$17.75
96151	N	0.48	0.11	0.01	33.976	$20.34	84%	$17.18
96152	N	0.46	0.1	0.01	33.976	$19.31	84%	$16.31
99201	N	0.4	0.52	0.03	38.087	$36.32	118%	$42.80
99202	N	0.77	0.81	0.05	38.087	$62.24	122%	$75.79
99203	N	1.18	1.12	0.09	38.087	$90.82	124%	$112.30
99204	N	2.03	1.49	0.12	38.087	$138.39	115%	$158.75
99205	N	2.64	1.78	0.15	38.087	$173.64	116%	$201.48
99211	N	0.15	0.36	0.01	38.087	$20.12	127%	$25.59
99212	N	0.4	0.55	0.03	38.087	$37.51	120%	$45.10
99213	N	0.81	0.73	0.03	38.087	$60.26	102%	$61.62
99214	N	1.25	1.06	0.05	38.087	$90.43	107%	$96.45
99215	N	1.76	1.35	0.08	38.087	$121.87	115%	$139.64

Report Chart D12 - Maximum Allowable Rates Calculation – Med_2015

RBRVS Year	2014			GPCI	Work	Practice	Malpractice
Contract Year	2015				1	1	1
Contract %	256.80%						
GPCI	National						
							Max Rate - corresponds to value in Part 1 - Provider Reimbursement Worksheet
Procedure Code	Site of Service	Work RVU	Non Fac RVU	Malpractice RVU	CF	100%	256.80%
90832	N	1.5	0.25	0.06	35.8228	$64.84	$166.51
90833	N	1.5	0.29	0.06	35.8228	$66.27	$170.19
90834	N	2	0.32	0.08	35.8228	$85.97	$220.78
90836	N	1.9	0.37	0.07	35.8228	$83.83	$215.26
90837	N	3	0.48	0.11	35.8228	$128.60	$330.25
90838	N	2.5	0.49	0.1	35.8228	$110.69	$284.26
90839	N	3.13	0.51	0.11	35.8228	$134.34	$344.97
90840	N	1.5	0.24	0.06	35.8228	$64.48	$165.59
90846	N	2.4	0.42	0.09	35.8228	$104.24	$267.70
90847	N	2.5	0.41	0.09	35.8228	$107.47	$275.98
90863	N	n/a	n/a	n/a	n/a	n/a	n/a
90875	N	1.2	0.47	0.08	35.8228	$62.69	$160.99
90876	N	1.9	1.03	0.11	35.8228	$108.90	$279.66
96101	N	1.86	0.33	0.07	35.8228	$80.96	$207.90
96102	N	0.5	1.32	0.03	35.8228	$66.27	$170.19
96116	N	1.86	0.69	0.1	35.8228	$94.93	$243.78
96118	N	1.86	0.84	0.07	35.8228	$99.23	$254.82
96150	N	0.5	0.09	0.01	35.8228	$21.49	$55.20
96151	N	0.48	0.09	0.01	35.8228	$20.78	$53.36
96152	N	0.46	0.08	0.01	35.8228	$19.70	$50.60
96153	N	0.1	0.02	0.01	35.8228	$4.66	$11.96
96154	N	0.45	0.08	0.01	35.8228	$19.34	$49.68
96155	N	0.44	0.17	0.03	35.8228	$22.93	$58.88
99201	N	0.48	0.69	0.04	35.8228	$43.35	$111.31
99202	N	0.93	1.08	0.07	35.8228	$74.51	$191.35
99203	N	1.42	1.47	0.13	35.8228	$108.18	$277.82
99204	N	2.43	1.99	0.22	35.8228	$166.22	$426.85
99205	N	3.17	2.35	0.26	35.8228	$207.06	$531.72
99211	N	0.18	0.37	0.01	35.8228	$20.06	$51.52
99212	N	0.48	0.7	0.04	35.8228	$43.70	$112.23
99213	N	0.97	1	0.07	35.8228	$73.08	$187.67
99214	N	1.5	1.41	0.1	35.8228	$107.83	$276.90
99215	N	2.11	1.79	0.13	35.8228	$144.37	$370.73
99354	N	1.77	0.92	0.11	35.8228	$100.30	$257.58
99355	N	1.77	0.86	0.11	35.8228	$98.15	$252.06

Report Chart D13 - Maximum Allowable Rates Calculation – Med_2016

RBRVS Year	2015
Contract Year	2016
Contract %	265.70%
GPCI	National

GPCI	Work	Practice	Malpractice
	1	1	1

Procedure Code	Site of Service	Work RVU	Non Fac RVU	Malpractice RVU	CF	100%	Max Rate - corresponds to value in Part 1 - Provider Reimbursement Worksheet 265.70%
90832	N	1.5	0.24	0.05	35.7547	$64.00	$170.05
90833	N	1.5	0.29	0.05	35.7547	$65.79	$174.80
90834	N	2	0.31	0.06	35.7547	$84.74	$225.15
90836	N	1.9	0.36	0.07	35.7547	$83.31	$221.35
90837	N	3	0.46	0.1	35.7547	$127.29	$338.20
90838	N	2.5	0.48	0.1	35.7547	$110.12	$292.60
90839	N	3.13	0.49	0.1	35.7547	$133.01	$353.40
90840	N	1.5	0.23	0.05	35.7547	$63.64	$169.10
90846	N	2.4	0.4	0.07	35.7547	$102.62	$272.65
90847	N	2.5	0.4	0.09	35.7547	$106.91	$284.05
90863	N	n/a	n/a	n/a	n/a	n/a	n/a
90875	N	1.2	0.46	0.07	35.7547	$61.86	$164.35
90876	N	1.9	1.03	0.14	35.7547	$109.77	$291.65
96101	N	1.86	0.32	0.06	35.7547	$80.09	$212.80
96102	N	0.5	1.26	0.03	35.7547	$64.00	$170.05
96116	N	1.86	0.66	0.1	35.7547	$93.68	$248.90
96118	N	1.86	0.82	0.06	35.7547	$97.97	$260.30
96150	N	0.5	0.09	0.02	35.7547	$21.81	$57.95
96151	N	0.48	0.08	0.02	35.7547	$20.74	$55.10
96152	N	0.46	0.08	0.01	35.7547	$19.67	$52.25
96153	N	0.1	0.02	0.01	35.7547	$4.65	$12.35
96154	N	0.45	0.08	0.01	35.7547	$19.31	$51.30
96155	N	0.44	0.17	0.03	35.7547	$22.88	$60.80
99201	N	0.48	0.71	0.04	35.7547	$43.98	$116.85
99202	N	0.93	1.1	0.07	35.7547	$75.08	$199.50
99203	N	1.42	1.48	0.15	35.7547	$109.05	$289.75
99204	N	2.43	1.99	0.22	35.7547	$165.90	$440.80
99205	N	3.17	2.37	0.29	35.7547	$208.45	$553.85
99211	N	0.18	0.37	0.01	35.7547	$20.02	$53.20
99212	N	0.48	0.71	0.04	35.7547	$43.98	$116.85
99213	N	0.97	1.01	0.06	35.7547	$72.94	$193.80
99214	N	1.5	1.43	0.1	35.7547	$108.34	$287.85
99215	N	2.11	1.82	0.16	35.7547	$146.24	$388.55
99354	N	1.77	0.92	0.12	35.7547	$100.47	$266.95
99355	N	1.77	0.84	0.12	35.7547	$97.61	$259.35

Report Chart D14 - Maximum Allowable Rates Calculation – Med_2017

RBRVS Year	2016
	2017
Contract %	273.30%
GPCI	National

GPCI	Work	Practice	Malpractice
	1	1	1

Procedure Code	Site of Service	Work RVU	Non Fac RVU	Malpractice RVU	CF	100%	Max Rate - corresponds to value in Part 1 - Provider Reimbursement Worksheet 273.30%
90832	N	1.5	0.24	0.05	35.8043	$64.09	$175.16
90833	N	1.5	0.29	0.06	35.8043	$66.24	$181.03
90834	N	2	0.31	0.07	35.8043	$85.21	$232.89
90836	N	1.9	0.37	0.08	35.8043	$84.14	$229.95
90837	N	3	0.47	0.11	35.8043	$128.18	$350.31
90838	N	2.5	0.49	0.11	35.8043	$110.99	$303.34
90839	N	3.13	0.49	0.11	35.8043	$133.55	$364.99
90840	N	1.5	0.23	0.05	35.8043	$63.73	$174.18
90846	N	2.4	0.4	0.09	35.8043	$103.47	$282.80
90847	N	2.5	0.4	0.09	35.8043	$107.05	$292.58
90863	N	n/a	n/a	n/a	n/a	n/a	n/a
90875	N	1.2	0.46	0.07	35.8043	$61.94	$169.29
90876	N	1.9	1.03	0.11	35.8043	$108.85	$297.47
96101	N	1.86	0.32	0.07	35.8043	$80.56	$220.17
96102	N	0.5	1.26	0.03	35.8043	$64.09	$175.16
96116	N	1.86	0.66	0.1	35.8043	$93.81	$256.38
96118	N	1.86	0.83	0.07	35.8043	$98.82	$270.07
96150	N	0.5	0.09	0.02	35.8043	$21.84	$59.69
96151	N	0.48	0.08	0.02	35.8043	$20.77	$56.75
96152	N	0.46	0.08	0.02	35.8043	$20.05	$54.80
96153	N	0.1	0.02	0.01	35.8043	$4.65	$12.72
96154	N	0.45	0.08	0.02	35.8043	$19.69	$53.82
96155	N	0.44	0.17	0.03	35.8043	$22.91	$62.63
99201	N	0.48	0.7	0.05	35.8043	$44.04	$120.36
99202	N	0.93	1.09	0.08	35.8043	$75.19	$205.49
99203	N	1.42	1.47	0.15	35.8043	$108.85	$297.47
99204	N	2.43	1.99	0.22	35.8043	$166.13	$454.04
99205	N	3.17	2.36	0.29	35.8043	$208.38	$569.51
99211	N	0.18	0.37	0.01	35.8043	$20.05	$54.80
99212	N	0.48	0.7	0.04	35.8043	$43.68	$119.38
99213	N	0.97	1.01	0.07	35.8043	$73.40	$200.60
99214	N	1.5	1.42	0.1	35.8043	$108.13	$295.52
99215	N	2.11	1.81	0.15	35.8043	$145.72	$398.26
99354	N	1.77	0.92	0.13	35.8043	$100.97	$275.95
99355	N	1.77	0.85	0.12	35.8043	$98.10	$268.12

Report Chart D15 - Maximum Allowable Rates Calculation – Med_2018

RBRVS Year	2017
Contract Year	2018
Contract %	274.90%
GPCI	Portland, OR

GPCI	Work	Practice	Malpractice
	1.008	1.052	0.746

Procedure Code	Site of Service	Work RVU	Non Fac RVU	Malpractice RVU	CF	100%	Max Rate - corresponds to value in Part 1 - Provider Reimbursement Worksheet 274.90%
90832	N	1.5	0.24	0.05	35.8887	$64.66	$177.76
90833	N	1.5	0.29	0.07	35.8887	$67.09	$184.42
90834	N	2	0.31	0.07	35.8887	$85.93	$236.22
90836	N	1.9	0.37	0.08	35.8887	$84.85	$233.24
90837	N	3	0.46	0.11	35.8887	$128.84	$354.18
90838	N	2.5	0.49	0.11	35.8887	$111.88	$307.57
90839	N	3.13	0.49	0.11	35.8887	$134.68	$370.22
90840	N	1.5	0.23	0.05	35.8887	$64.29	$176.72
90846	N	2.4	0.39	0.09	35.8887	$103.96	$285.77
90847	N	2.5	0.4	0.09	35.8887	$107.95	$296.76
90863	N	n/a	n/a	n/a	n/a	n/a	n/a
90875	N	1.2	0.47	0.07	35.8887	$63.03	$173.27
90876	N	1.9	1.04	0.11	35.8887	$110.94	$304.99
96101	N	1.86	0.32	0.07	35.8887	$81.24	$223.34
96102	N	0.5	1.22	0.03	35.8887	$64.95	$178.55
96116	N	1.86	0.65	0.09	35.8887	$94.24	$259.06
96118	N	1.86	0.82	0.07	35.8887	$100.12	$275.23
96150	N	0.5	0.09	0.02	35.8887	$22.02	$60.54
96151	N	0.48	0.09	0.02	35.8887	$21.30	$58.55
96152	N	0.46	0.08	0.02	35.8887	$20.20	$55.52
96153	N	0.1	0.02	0.01	35.8887	$4.64	$12.76
96154	N	0.45	0.08	0.02	35.8887	$19.83	$54.53
96155	N	0.44	0.17	0.03	35.8887	$23.14	$63.61
99201	N	0.48	0.71	0.05	35.8887	$45.51	$125.10
99202	N	0.93	1.1	0.08	35.8887	$77.32	$212.54
99203	N	1.42	1.48	0.15	35.8887	$111.26	$305.86
99204	N	2.43	1.98	0.22	35.8887	$168.55	$463.35
99205	N	3.17	2.37	0.29	35.8887	$211.92	$582.57
99211	N	0.18	0.38	0.01	35.8887	$21.13	$58.08
99212	N	0.48	0.71	0.04	35.8887	$45.24	$124.37
99213	N	0.97	1.02	0.07	35.8887	$75.47	$207.48
99214	N	1.5	1.43	0.1	35.8887	$110.93	$304.95
99215	N	2.11	1.82	0.15	35.8887	$149.06	$409.77
99354	N	2.33	1.17	0.16	35.8887	$132.75	$364.92
99355	N	1.77	0.87	0.12	35.8887	$100.09	$275.15

The carrier stated, "Please note that the Company uses a consistent calculation for medical and behavioral provider rates. The Company's calculations for Medicare benchmarking follows CMS's own calculation methodology for non-site of service office visits using the CMS GPCI and RVU values for the year in which the schedule was created and/or updated." Carrier also stated, "Factors may drive some of the variability in the rates due to cost to do business in the market, general market forces and negotiations to secure a successful contract." Additionally, carrier stated, "Generally, a smaller set of specialists in a rural area could have created a higher rate than a larger number of non-specialists in an urban area. The need to fill a network void would have been a factor during negotiations."

Carrier 9 - Plan T

The carrier was required to provide all policies and procedures or other supporting documents pertaining to the development of the MARR for the provider types and procedure codes included in the request. The carrier stated:

> "We have not identified any policies, procedures, or supporting documents pertaining to the development of reimbursement allowances for participating providers offering time-based outpatient office visits. *Carrier 9* provides time-based outpatient office visit reimbursement based on our standard fee schedule – the carrier Market Fee Schedule is derived from industry standard methodologies and sources, such as the Resource-Based Relative Value System (RBRVS) established by CMS."

The carrier provided an overview regarding the providers' reimbursement rate process for each of the provider types under review. As noted in carrier's responses above, carrier designed the carrier Market Fee Schedule for the Oregon market, which the carrier uses to reimburse participating providers offering time-based outpatient services. In establishing the carrier Market Fee Schedule, the carrier stated:

- "In setting our fee schedule for CPT codes, we look at industry standard methodologies and sources, such as the Resource-Based Relative Value System (RBRVS) established by CMS. For our 2017 *carrier 9* Market Fee Schedule, we will use 2016 Relative Value Units (RVUs).

- For codes using RBRVS, we use the "site-of-service" differential as defined in the transitional RVUs supplied by CMS. This differential allows an additional amount to be paid on certain codes, based on where the service is performed.

- We adjust our fee schedule based on the Portland, Oregon Medicare Geographic Price Cost Index (GPCI). We will not apply any further changes CMS makes in 2017, except for new codes valued by CMS."

The carrier stated it uses industry methodologies and sources, such as the RBRVS established by CMS, which establishes RVUs in consideration of physician work, practice expense, and malpractice insurance using a Geographic Practice Cost Index (GCPI). In setting the carrier's Market Fee Schedule and participating provider MARRs, the carrier provided the same methodologies and factors considered and utilized for Medical Providers, MH Providers and BH Providers. The information provided by the carrier did not explain the differences in MARRs for the provider types included in SB 860. In regards to establishing rates, the carrier also stated:

> "For codes where the RBRVS methodology is either not used or unavailable, we use other sources to develop the fees, such as the American Society of Anesthesiologists, Medicare fee schedules, our nationally contracted rates, etc."

Regarding how the carrier determines the carrier Market Fee Schedule percentage of reimbursement for each provider type compared to other providers for the same procedure code, the carrier stated:

> "Behavioral health providers are classified in four different classes based on market need. Generally, behavioral health medical doctors and behavioral health clinical nurse specialists are reimbursed the maximum amount (100% level). All clinical psychologist and masters level practitioners are reimbursed at a lesser percentage of the maximum amount paid to behavioral health medical doctors and behavioral health clinical nurse specialists.
>
> Medical doctors/physicians are reimbursed the maximum amount (100% level), whereas midlevel practitioners (e.g. physician assistances and nurse practitioners) are reimbursed 85% of the maximum amount."

The MARR percentages provided by the carrier in this response varies with the actual MARRs in the carrier's reported maximum allowable reimbursement data for this review.

The carrier further stated that when necessary, they negotiate custom reimbursement allowances apart from their standard Market Fee Schedule on an ad hoc basis. Although the carrier indicated that they do not have policies or procedures regarding the negotiation process, they provided an overview of the process. The negotiation is performed by senior level contract negotiators in consideration of the following factors:

- The amount allowed by other carriers in the market
- The credentials and qualifications of the provider
- The shortage of the provider type in the geographic area
- Availability of budget allowance based on previous year's spending.

The carrier also noted that the senior level contract negotiators use a pricing model (p-model) that is provided annually to them by an internal business unit. The p-model tool establishes the price ceiling on rates that the contract negotiators are allowed to negotiate for all provider types. The carrier stated that if a highly sought after provider required rates in excess of the price ceiling established by the p-model, the contract negotiator could seek permission to exceed the price ceiling. If a contract is negotiated below the p-model ceiling, the carrier stated this allows it to pay higher rates to another provider without exceeding the aggregate budget allowance.

From 2015 to 2018, the carrier's behavioral health contracting unit allowed ad hoc negotiations and negotiated non-standard rates on contracts a total of 26 times. Each year, there was an average of 4,432 Behavioral Health Providers that serviced Oregon residents. As such, less than one percent of all Behavioral Health Providers received a negotiated rate. From 2015 to 2018, carrier's Medical Provider contracting unit allowed ad hoc negotiations and negotiated non-standard rates on contracts a total of 97 times. Each year, there was an average of 9,787 Medical Providers that serviced Oregon residents. As such, less than one percent of all Medical Providers received a negotiated rate. The carrier stated that some well-qualified providers or provider groups warrant ad hoc negotiations because their inclusion in the plan's network

increases the marketability of the network and health plan. The carrier does not record the specific reason that ad hoc negotiations occurred within the contracting database.

The carrier also indicated modifiers HO (Master's Degree Level), HP (Doctoral Level), U6 (Qualified Treatment Trainee), UA (Psychiatrist), and UB (Advanced Nurse Prescriber with Psychiatric Specialty) did not impact the procedure codes and provider types during the Period of Review. The carrier stated:

> "The noted procedure code and modifier combination of "HO" is utilized only when billed by facilities for outpatient therapy services. These modifiers are not utilized by any of the provider types listed in the data request."

The carrier also stated the following regarding the process for establishing reimbursement allowances for providers:

> "*Carrier 9* has implemented a flat fee schedule that is loaded with set dollar amounts for each CPT code. There is no party that is calculating the rate on a claim by claim basis. The fee schedule is hard coded and paid at the flat amount. Upon establishing the fee schedule for a participating provider, whether it is *carrier 9* Market Fee Schedule or a negotiated fee schedule, it is loaded into our pricing system."

Carrier 10 - Plan U

The Carrier provided policies, procedures, methodologies and other supporting documents regarding the development of MARRs for participating providers offering time-based outpatient office visits.

The Carrier stated:

> "There was not a formal policy in place from 2015 through 2018."

However, the carrier provided one policy, *Financial Planning and Analysis - Budget Guidelines for Contracting Ranges*. This policy has an original effective date of 1/1/2019, but the carrier stated:

> "The same methodology was used from 2015-2018 as stated in the 2019 policy."

The carrier's 2019 policy addresses the budget and contracting processes. The policy *Financial Planning and Analysis - Budget Guidelines for Contracting Ranges* stated:

> "Finance determines acceptable ranges of contracting increases for the Contracting/Network Strategy function. These ranges are based on Actuarially developed rates. Contracting will use its best judgement in negotiating rates given the financial guidelines established, market forces, and Provider needs. The rate guidelines are to be used as guidance to achieve financial sustainability of the Plan. The rate guidelines to [sic] do not take precedence over regulatory requirements governing Provider contracting or other Compliance requirements of the Plan.
>
> Finance develops acceptable ranges for Contracting to use in determining contracted rates in the coming Plan year. The allowable rate increase/decrease by categories will be determined by Actuarial assumptions used to develop rates.

A Rate Range Guidance report is provided by Finance the [sic – that] breaks out each Health Plan by major service categories where possible.

Contracting uses the Rate Range Guidance when negotiating with Providers. Requests above allowed ranges are reviewed with the Director of Finance and/or COO for approval.

The Reimbursement department can evaluate specific rate schedule modifications and requested contract changes to calculate the year over year financial impact of the change. These changes must also fall within the Rate Range Guidance or be approved by Finance/COO. All outcomes are documented through the Financial Analysis Request workflow."

For Medical Providers, the carrier stated the following factors were considered in the setting of MARRs for outpatient time-based office services:

"*Carrier 10* Finance Department develops acceptable base points and acceptable ranges for Provider Contracting for Medical services. The allowable base rates and re-negotiated rates are determined by actuarial assumptions for various specialty types of professional grouping of specialties. A Rate Range Guidance Report is provided by Finance that breaks out each line of business that *carrier 10* administers by major service categories where possible. Provider Contracting use the Rate Range Guidance when negotiating with providers. Rate requests above the allowed range guidelines are reviewed with the Director of Finance or a *carrier 10* executive for approval."

The carrier stated the following regarding those factors considered for BH Providers compared to Medical Providers:

"The same factors are used for Behavioral Mental Health Providers as outlined above for medical providers. Prior to contracting with these providers in 2015 rates developed and contracts were set up with mental health providers. Rate reviews have occurred with providers since then either upon requests by the providers or by the plan using the same criteria involving rate ranges. These include base rates and rate ranges for psychologists, licensed professional counselors and marriage and family therapists."

Additionally, the carrier provided this information for MH Providers. The carrier stated:

"The same factors are used for Mental Health Providers with prescribing privileges as outlined above for medical providers and other Behavioral Mental Health Providers. Prior to contracting with these providers in 2015 rates were developed and contracts were set up with mental health providers. Rate reviews have occurred with providers since then either upon requests by the providers or by the plan using the same criteria involving rate ranges. These include base rates and rate ranges for psychiatrists, and certified nurse practitioners with a specialty in psychiatric mental health."

The Contractor requested the carrier to provide information on the total number of times the plan performs rate reviews at the request of each of the three provider types included within SB 860. The carrier stated:

> "Requests for rate reviews were not tracked by *carrier 10* during the audit period. Communications for rate requests were handled through phone calls and emails by the Provider Service department. *Carrier 10* did not have a system to monitor and track these communications prior to 2019. Starting in 2019 we are using our *carrier's claims system* as the system of record for Provider requests and changes."

The carrier uses CMS's reimbursement methodology utilizing RVUs that include weight factors and RBRVS conversion factors to calculate and establish MARRs. Regarding the reimbursement methodology used, the carrier stated:

> "*Carrier 10* uses a CMS reimbursement methodology involving RVUs that involve weight factors and RBRVS conversion factors to calculate and establish reimbursement allowances for Medical Providers. In addition, that [sic] methodology, *carrier 10* uses the Medical Physicians Fee Schedule (MPFS) for Medical Providers as well. In negotiations with providers, RBRVS and MPFS conversion factors and the percentages of the MPFS are agreed upon to determine contracted payments. For services that do not carry RVU weights or set fees on the MPFS, *carrier 10* uses a percentage of billed charges to establish a default rate to use for reimbursement to the providers for services that falls within their scope of practice."

The carrier also stated for BH Providers and MH Providers:

> "*Carrier 10* uses an RVU methodology identical to what is used for reimbursement with Medical providers to establish reimbursement allowance. As is the case for Medical providers, *carrier 10* uses a percentage of billed charges to establish a default rate to use for reimbursement that falls within their scope of practice."

The carrier stated that for BH Providers and MH Providers' reimbursement rates, it used an RVU methodology identical to what was used for Medical Provider rates. As for Medical Providers, the carrier used a percentage of billed charges to establish a default rate to use for reimbursements that fell within their scope of practice.

The carrier indicated that when negotiating reimbursement amounts for participating Medical Providers in an outpatient office-based setting:

> "*Carrier 10* does both a Provider Network Adequacy review and a financial analysis when re-negotiating reimbursement amounts. Included in that analysis are both the projected impact of the new rates as well as the volume of service rendered by the Medical provider. *Carrier 10* looks at the number of contracted providers within the provider's service area in their specialty (done by County) to determine the need to stay contracted with the providers involved for both adequacy and access purposes. For instances where the rates cannot be agreed to on the rate ranges given, the Contracting area by *Carrier 10* Finance, additional input is asked for from *carrier 10's* Medical Management Department as to the need to stay contracted with the provider."

The carrier stated it used the same factors for MH Providers and BH Providers as it did for Medical Providers when negotiating reimbursement amounts for participating providers. However, relevant to BH Providers and MH Providers, the carrier indicated:

> "For many mental health providers, the number of services that they do is limited to certain services. This allows for targeted negotiations to address the more highly utilized codes that the Mental Health Providers would like to see increased."

The carrier was required to provide additional information regarding how reimbursement rates are established including the base rate of the procedure code and how the plan determines the percentage of reimbursement for each provider type compared to other providers for the same procedure code. The carrier stated:

"Base rates and ranges are based on standard fee schedules. *Carrier 10* contracts with both Medical and Mental health providers are generally tied to an industry standard fee schedule, using RVUs as an example. Each contract will vary depending on negotiated rates in relation to a fee schedule."

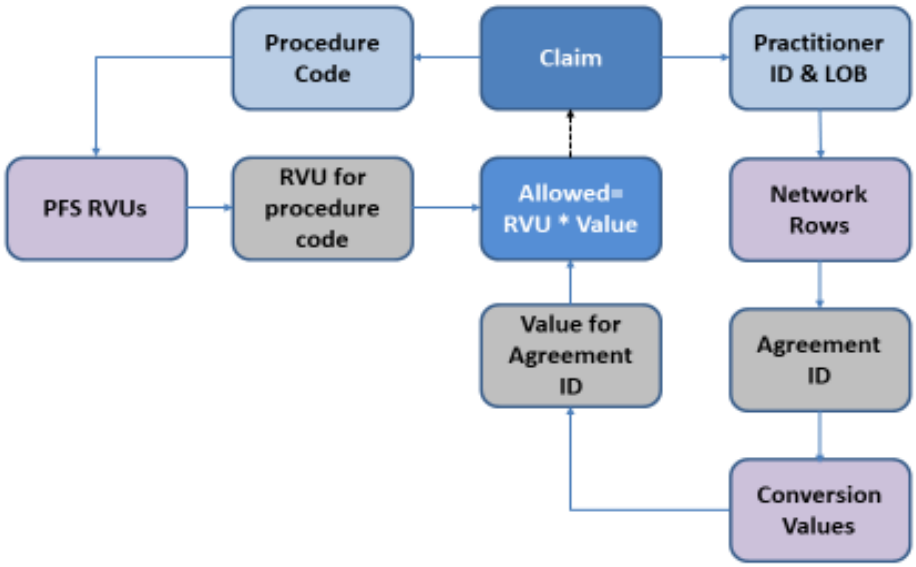
The carrier also indicated that since 2015, rate reviews had only occurred consistent with their *Rate Range Guidance* and upon individual providers request to renegotiate rates. This also included base rates and rate range changes.

The Carrier provided the 2017 and 2018 *Rate Range Guidance*. Upon request by the Contractor, the carrier also provided the 2017 and 2018 actuarial trend analysis that supports the *Rate Range Guidance*. The trends analyses for 2017 and 2018 included the carrier's large group rating tables. With the submission of the actuarial trend analysis, the carrier stated:

> "These are the trend tables provided by our Commercial actuary in 2017 and 2018. The commercial plans are still relatively new to *carrier 10*). Actuarial assumptions are done at a high level, and do not discriminate between medical and mental health providers."

The carrier also provided the following Report Chart D16 below illustrating its reimbursement calculation and the flow of claims in association with its provider contracting:

Report Chart D16 - Carrier 10 Reimbursement Calculation Flow Chart



The carrier also indicated modifiers HO (Master's Degree Level), HP (Doctoral Level), U6 (Qualified Treatment Trainee), UA (Psychiatrist), and UB (Advanced Nurse Prescriber with Psychiatric Specialty) were not used during the Period of Review. The carrier stated:

> "*Carrier 10* does not determine reimbursement amounts [sic- for] procedure code and modifier combinations."

The Contractor requested additional information regarding the conversion factors utilized by carrier. The carrier stated:

> "The conversion factors are based on market rates. These are determined by internal discussions between Contracting and Finance, as well as with external providers. *Carrier 10's network* is the primary mental health network utilized by *carrier 10* for commercial plans. Conversion rates are developed closely with them through mutually beneficial negotiations. This coordination is valuable in determining acceptable conversion factors."

The carrier also stated:

> "Our other large provider is *carrier 10's facility*. *Carrier 10's facility* is paid under *carrier 10's network* by *carrier 10*. *Carrier 10's network* is the party responsible for rate establishment and negotiations."

The carrier provided the following reimbursement schedule Report Chart D17:

Report Chart D17 - Carrier 10 Reimbursement Schedule for Commercial Plans

COMMERCIAL REIMBURSEMENT SCHEDULE		
Payment Category:	**Payment Methodology:**	**Payment Source:**
Anesthesia Services	Conversion Factor: $50.00	Current Year ASA Relative Value Guide
Surgical Services	Conversion Factor: $65.00	Current Year Medicare RVU
Radiology Services	Conversion Factor: $65.00	Current Year Medicare RVU
Laboratory/Pathology Services	100%	Current State of Oregon Medicare CLAB Fee Schedule
Medical / Evaluation & Management	Conversion Factor: $65.00	Current Year Medicare RVU
Drugs	100%	Current Medicare Average Sales Price (ASP)
Durable Medical Equipment	100%	Current State of Oregon Medicare DMEPOS Fee Schedule
Services not priced above	100%	*carrier 10* Allowable Fee Schedule
All Other	60%	Billed Charges

Carrier 11 - Plan V

The carrier and its BH and MH provider third party entity provided policies, procedures and methodologies regarding the development of MARRs for participating providers offering time-based outpatient office visits. The third party entity provided information for MH Providers and BH Providers and the carrier provided information for Medical Providers. The third party entity indicated that provider MARRs are based upon an internally developed rate schedule. The third party entity also provided the following information:

> "The standard approach is to reimburse at 100% of these fee schedules, though providers may negotiate an inflator to these fee schedules. In addition, reimbursement may be affected by payment policies based on the specialty of the billing provider (e.g. NPs, PAs), procedure code modifiers, and coding edits. *The Carriers' third party entity* evaluates fee schedules on a periodic basis and any necessary adjustments are made to remain competitive in the marketplace.
> 1. Description of code. Define or obtain a detailed description of the code including but not limited to information such as service rendered, purpose of code, and duration of service.
> 2. Find similar codes. If other codes that are similar in nature exist, those codes are used as a guide to develop the rate for the new code. Adjustments are then made to these codes to reflect the nuances of the new code.
> 3. Crosswalk possible codes. When a new code replaces or supplements existing codes, providers can change the way they bill. When this happens, it is necessary to determine what old codes, if any, will now be replaced by the new codes. Therefore, a crosswalk from the old codes to the new needs to be completed. Possible scenarios that can exist include 1) one to one crosswalk, 2) many old codes cross walking to one new code, 3) one old code cross walking to several new codes, or 4) many old codes cross walking to many new codes.
> 4. Determine utilization distribution. Once the codes are cross walked, in order to account for each of the scenarios above, where there isn't a straight one to one crosswalk (i.e. several codes affect) an assumed utilization distribution must be developed. Using guidance from CMS, external sources, or other methodologies, an expected utilization distribution to the new codes are derived.

5. Compare to external sources for appropriateness of relativities. CMS national RVUs are used as a guide to check the relativities among the codes to ensure they are properly aligned. The RVUs are obtained from the CMS Physician Fee Schedule Final Rule, Addendum B, which is posted on the CMS.gov website. The RVU for a specific code represent the relative resources required to perform that service compared to other services. Additional adjustments to rates are made if necessary. Other sources can also include Fairhealth (sic – FAIR Health) and rates/relativities obtained through studies from 3rd party vendors.
6. Adjusting for geography. Rates are compared to cost variances among geography and if necessary, adjusted accordingly.
7. Adjusting for market conditions. Other factors that influence the market including but not limited to, supply/demand, license level, and market conditions are used to make any additional adjustments to the fee schedule.
8. Negotiation. Some providers' fee schedules are negotiated on a case by case basis."

Based on the third party entity's response above, the carrier was requested to submit the third party entity's rate schedule analysis, calculations (including adjustments made as noted above, such as geographic location, modifiers, coding edits, provider type, etc.) and all documentation supporting the analysis and calculations performed for each of the 35 procedure codes and by each provider type in this review. The following response was provided:

"*Carrier 11s' third party entity* does not have the actual calculations as the base rate calculations were developed several years ago. As such, we do not have the historical files that have the calculations resulting in a rate for each code. The base rates have not been adjusted since development. However, throughout the years any deviation in rates are due to negotiations with providers and adjustments are made as needed."

In terms of Medical Provider related policies, procedures and methodologies regarding the development of MARRs for participating providers offering time-based outpatient office visits, carrier did not provide sufficient information. In their response, carrier directed the Contractor to a document labeled, Carrier 11 Fee Schedule Disclosure, which described the contracted provider standards for carrier's allowable reimbursement rate contract terms. Another document labeled, Fee Schedule Sample Carrier 11, was also provided. This document included information regarding rates by procedure code and information regarding the calculation of fees. In particular, the document notes that the carrier utilizes CMS's RBRVS, where each procedure code has RVUs associated with it as stated in the annual RBRVS fee schedule in order to determine each rate. However, a defined approach explaining the methodologies regarding the development of MARRs for participating Medical Providers offering time-based outpatient office visits was not provided. As such, a second request for this information was made and the carrier provided the following response:

"There are several factors that are taken into consideration in this regard including CMS benchmarks, regional market dynamics and current business needs. Depending on provider type, contract rates may be based on a MS-DRG, Per Diem, Per Case, Per Visit, Per Unit, Fee Schedule, etc. basis. Inpatient and outpatient contract rates are negotiated on a facility by facility basis. Contract rates are typically negotiated for a 2-3 year term with agreed upon escalators for each year. Centers for Medicare & Medicaid Services (CMS) is the main Fee Source used to supply the fee basis amount for deriving the fee amount for outpatient time-based office visits/services. Using the CMS published relative value units (RVUs) and Geographic Practice Cost Index files each code's fee basis

is calculated using the CMS published formula for physician fee schedule payment: [(Work RVU * Work GPCI) +(PE RVU * PE GPCI) +(MP RVU * MP GPCI)] * Conversion Factor (CF). In the event, the Primary Fee Source does not publish a Fee Basis amount, an Alternate Fee Source will be applied, if available. The final fee amount is derived by multiplying the fee basis by the provider's contracted percentage. NOTE: Reimbursement may be affected by payment policies based on the specialty of the billing provider (e.g. NPs, PAs), procedure code modifiers, and coding edits."

In terms of modifiers used in the MARR development process, the carrier indicated that they do not use modifiers for commercial plans.

The carrier also provided information regarding the negotiation of MARRs with participating providers offering outpatient time-based office visits/services. The carrier provided the following response:

"The provider is required to submit a rate request in writing. Upon receipt of the request, Plan staff will outreach to provider to begin negotiations. Discussions with provider will include a reinforcement of the standard fee schedule and rates of reimbursement, how it was established, and why provider thinks the rates are not acceptable. Rate increase requests that deviate from standard rates may be considered under the following circumstances:

• Provider is located in a geographic area where there is limited appointment availability
• Provider is located in a geographic area where there is a limited number of providers for contracting
• Provider offers unique and/or specialized areas of expertise or experience
• Provider license/education levels
• Unique and/or special circumstances such as pilot programs requiring expanded services
• Specific customer requests for a provider's participation
• Documented business need for network expansion

Requests that qualify under the exception criteria are reviewed by designated Plan staff, as outlined in the Plan's delegation of authority process. Upon elevated review, new rate parameters may be established. Plan contractor may go back to provider and attempt to come to agreement based on newly established rates. The two parties work together to agree to rates that are reflective of the services, expertise and availability of the provider. Upon agreement, updated contracts are executed and updates in systems for claims payment are finalized. In addition, reimbursement allowances are negotiated following receipt of a proposal from the provider. *Carrier 11* then pulls 12 months of claims utilization data and models the provider's proposal using a proprietary pricing modeling tool. After the modeling is complete and the parties agree to rates, the fee schedule is built. Fee schedules can vary depending upon medical specialty and geographic area."

As the carrier stated in their response above, a proprietary pricing modeling tool is utilized during the MARR negotiation process. The Contractor requested information regarding the pricing tool in terms of how the tool is utilized during the negotiation process for the provider types and procedure codes under review. The carrier provided the following response: "The physician pricing tool is proprietary software. The tool itself pulls in 12 months of claims data including all CPT codes that a provider has billed to the company based upon their Tax ID number. The tool models the provider's proposal and provides options in incremental increases that are used in the negotiation."

The carrier was also requested to provide a listing of providers that requested a negotiated rate including information regarding the provider type, initial rate offered, final negotiated rate and the reason for the negotiated rate. The carrier provided the following response: "*Carrier 11s' third party entity* can provide a list of providers with a negotiated fee schedule. However, *Carrier 11s' third party entity* does not track that level of negotiation detail." The Contractor reviewed the listing provided and 1,283 providers have a negotiated fee schedule, which included 618 providers that hold a Masters of Social Work, 297 individuals that hold a Doctor of Philosophy Degree, 244 Medical Doctors and 124 Registered Nurses. *Carrier 11* provided the following response for Medical Providers: "Not every medical provider contacts the Company to negotiate new rates every year, in which case the existing fee schedule continues into the next year. Negotiations that occur on an annual basis are protected by the confidentiality clause in the contract."

The carrier provided information regarding the factors considered when setting MARRs for outpatient time-based office visits/services. The third party entity indicated that the following factors are considered for BH Providers and MH Providers: "description of the code including but not limited to information such as service rendered, purpose of code, and duration of service, external sources including CMS RVUs, 3rd party publications; license/education levels; geography; supply and demand; specialty and negotiation." The Carrier did not provide a complete response and instead directed the Contractor to a document labeled, Fee Schedule Sample Carrier 11. As previously noted above, this document included information regarding rates by procedure code and information regarding the calculation of rates. In particular, the document notes that the carrier utilizes CMS's RBRVS method where each procedure code has RVUs associated with it, as stated in the annual RBRVS fee schedule, to determine each rate. Also, the carrier indicated that provider rates will vary based on their specialty and geographic area.

The carrier was requested to describe any evidentiary standards, national treatment guidelines or other considerations (including standards that were considered but rejected) that were relied upon to establish participating provider reimbursement allowances for outpatient time-based office visits/services. The carrier provided the following response for Medical Providers:

> "None of the above listed standards are considered to establish provider reimbursement allowances for medical providers."

The Contractor was unable to locate information in the carrier's submission that was responsive to the request. The third party entity provided the following response for BH Providers and MH Providers:

> "Other considerations - CMS national RVUs are used as a guide to check the relativities among the codes to ensure they are properly aligned."

The carrier was asked to submit the reimbursement calculations for each provider type and for each procedure code included under this review. The following response was provided:

a. "Psychologist – 100% of the Psych rate
b. Licensed Clinical Social Worker (LCSW) 25-100% of psych
c. Licensed Professional Counselor (L.P.C.) 25%-100% of psych
d. Licensed Marriage Family Therapist (L.M.F.T.) 25-100% of psych

e. Doctor of Osteopathic Medicine (D.O.) for the treatment of a mental health or substance abuse conditions 100% of psych
f. Doctor of Medicine (M.D.) for the treatment of a mental health or substance abuse conditions 100% of psych
g. Nurse Practitioner (N.P.) 100% of psych
h. Psychiatrist – 100% of psych
i. Psychiatric and Mental Health Nurse Practitioner (P.M.H.N.P.) 100% of psych"

As outlined in the preceding paragraphs of this section, the carrier utilized a fee-for-service model in which the RBRVS method established by CMS is the basis for the MARR calculation for Medical Providers. However, internally developed rate schedules were utilized for BH Providers and MH Providers. As such, the carrier was requested to explain the variance in the process for setting reimbursement rates for Medical Providers and the process for setting rates for BH Providers and MH Providers. The carrier provided the following response:

> "*Carrier 11* and *its third party entity* uses comparable factors, evidentiary standards and methods of analysis in the development of reimbursement allowances, and the process is applied no more stringently to MH/SUD providers than to M/S providers. The process may differ, however, based on the following factors:
>
> - Type and/or duration of service provided
> - Guidance from external sources relied upon in the industry and specific to either MH/SUD or M/S providers
> - Utilization for MH/SUD services as compared to M/S services
> - Provider availability, including licensure type and consideration of patient volume versus provider demand in a geographic region."

The carrier also provided the following additional information regarding the difference in calculating MARRs:

> "MH/SUD and M/S services are inherently different in terms of frequency, manner and extent of usage. While MH/SUD services can be allocated in defined time units, the availability of which are finite based on the provider's work schedule, M/S services are provided on a basis that is uncertain and more focused on provider particulars than time allocated for treatment. Having said that, the evidentiary standards and methods of analysis for both is comparable and applied no more stringently to MH/SUD providers than to M/S providers. As indicated in our prior response, the determination of rates, whether negotiated or standardized, in (sic – is) grounded in a consideration of differing service or provider type, supply and demand (including experience, license level and market conditions) and industry guidelines."

The carrier was requested to provide the comparative analysis that was performed regarding the reimbursement rates for BH Providers, MH Providers and Medical Providers. The carrier provided the following response: "*Carrier 11 and its third party entity* use comparable factors, evidentiary standards and methods of analysis in the development of reimbursement allowances, and the process is applied no more stringently to MH/SUD providers than to M/S providers."