Committee on Health Care of the Oregon Legislative Assembly

Mental Health

Provider Reimbursement

Carrier Data Call

As required by 2017 Senate Bill 860

Volume I - Background and Executive Summary

Prepared for:

Oregon Department of Consumer and Business Services
Division of Financial Regulation

March 31, 2020

Report by: Risk & Regulatory Consulting, LLC

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Background

This report (Report) was drafted in coordination with the Division of Financial Regulation (DFR or Division), of the Oregon Department of Consumer and Business Services (DCBS or Department), pursuant to the requirements of Senate Bill 860 (SB 860). SB 860 requires the Department to examine and adopt rules or take other actions based upon the results of the Department's examination to ensure that carriers meet the requirements of Oregon Revised Statutes (ORS) 743A.168 and 743B.505 in policies, certificates or contracts for health insurance that the carriers offer to residents of Oregon. The Department examined the following:

(a) The historical trends of each carrier's maximum allowable reimbursement rates for time-based outpatient office visit procedural codes and whether each carrier's in-network behavioral mental health providers have been paid reimbursement that is equivalent to the reimbursement for the carrier's in-network medical providers and mental health providers with prescribing privileges.

(b) Whether each carrier imposes utilization management procedures for behavioral mental health providers that are more restrictive than the utilization management procedures for medical providers as indicated by the time-based outpatient office visit procedural codes applied to providers in each category, including a review of whether a carrier restricts the use of longer office visits for behavioral mental health providers more than for medical providers.

(c) Whether each carrier pays equivalent reimbursement for time-based procedural codes for both in-network behavioral mental health providers and in-network medical providers, including the reimbursement of incremental increases in the length of an office visit.

(d) Whether the methodologies used by each carrier to determine the carrier's reimbursement rate schedule are equivalent for in-network behavioral health[1] providers and in-network medical providers.

In accordance with the requirements of SB 860, Section 1, Subsections (2)(a) – (d), the Division commenced a data call (Data Call) of 11 health carriers (Carriers) transacting business in the state of Oregon for the review period of January 1, 2015 through June 30, 2018 (Period of Review). The Data Call included fully-insured individual, small group and large group health benefit plans issued in Oregon, as well as student health benefit plans and associations. The Data Call consisted of two sections for the purpose of collecting and analyzing information and data to address the requirements of SB 860. Section One of the Data Call, *Policies, Procedures, and Methodologies*, requested the following information from the Carriers:

(a) Part One -- Reimbursement methodology and equations
(b) Part Two – Negotiation process for in-network outpatient services, and
(c) Part Three – Utilization management for in-network outpatient services

[1] While parts (a) through (c) mention "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.

Section Two of the Data Call, *Data Collection for In-network Outpatient Services*, requested the following data:

(a) Part One – Reimbursement allowances
(b) Part Two – Membership and providers
(c) Part Three – Utilization and final disposition
(d) Part Four – Modifiers
(e) Part Five – In-network, outpatient time-based office visit/service

The Data Call was submitted to the Carriers and required a written response to 24 questions and numeric responses to 15 categories of questions. The analysis included the review of policies, procedures and methodologies relating to the development and setting of the Carriers' Maximum Allowable Reimbursement Rates (MARR) for 35 different CPT[2] or procedure codes, across eight different provider types, among 22 health plans (Plans) for 11 different health carriers. The 35 CPT codes were specified time-based outpatient office visit procedure codes based upon provider contracts for each year in the Period of Review. Over 190,000 data points were collected and analyzed. In addition, subsequent to the submission of the Data Call to the Carriers, the DCBS received 53 different questions from Carriers, the responses to which were compiled and shared with all Carriers. DCBS also received numerous requests for extensions of the submission of data requests, which DCBS managed on a case-by-case basis.

As noted above, the Data Call requested information regarding provider reimbursement policies, procedures, methodologies, equations and other information regarding the creation of MARR and reimbursement rate schedules by provider type, including the negotiation process. The Data Call requested MARRs for the 35 procedure codes based on actual provider contracts. Accordingly, examination values and analysis within this Report are based upon the carrier's maximum allowable reimbursement contract rates.

Relative to the MARR negotiation process for in-network outpatient services, information was requested regarding the factors considered during the rate setting process and in negotiating maximum allowable reimbursement rates with providers for the in-network time-based outpatient services. Specific requests were made regarding how MARR was developed, calculated, negotiated, any factors and standards considered (i.e., evidentiary standards) and how the carrier operationalizes the process for establishing maximum allowable reimbursement rates.

Utilization management (UM) policies and procedures were requested specific to prior authorizations, concurrent reviews, retrospective reviews and outlier management. In addition, the factors considered when designing prior authorizations, concurrent reviews, retrospective reviews and outlier management for participating providers in an outpatient office-based setting were also requested. The Data Call considered the Carrier's use of third party entity for UM services. While a carrier may retain a third party entity to provide certain benefit administration services, the carrier cannot delegate its responsibility to comply with federal and state laws – the carrier is ultimately responsible for its compliance. In addition, a comprehensive listing of the treatment limitations (i.e., utilization management, code edits, provider-specific restrictions and credentialing) was requested which were applied to outpatient time-based office visits/services.

[2] "CPT" means Current Procedural Terminology codes and terminology under the American Medical Association's Current Procedural Terminology (CPT® 2018), Edition Revised, 2018, for billing by medical providers.

Finally, as part of the Data Collection section of the Data Call, the following data was requested:

(a) The number of members in commercial health benefit plans issued in Oregon, defined as the total number of members for each plan type available during the Period of Review, not the number of primary insureds. The data call also requested the number of Medical Providers, Behavioral Mental Health Providers and Mental Health Providers, with prescribing privileges, available to Oregon plan members.
(b) The utilization management results indicating the number of times the procedure codes were received by the Carriers and the number of times the procedure codes were processed to pay per plan and per year during the Period of Review.
(c) Each carriers' use of modifiers during the rate setting process and how the carrier determines the amount for each procedure code and modifier combination and equations to determine professional reimbursement.

The provider types listed in SB 860 and subject to this review include:

(a) Behavioral Mental Health Providers (BH Providers)
    1. Psychologist licensed under ORS 675.010 to 675.150
    2. Clinical Social Worker (LCSW) licensed under ORS 675.530
    3. Professional Counselor (LPC) or Marriage Family Therapist (LMFT) licensed under ORS 675.715
(b) Medical Providers means a physician licensed under ORS chapter 677
    1. Doctor of Medicine (MD)
    2. Doctor of Osteopathic Medicine (DO)
(c) Mental Health Providers with prescribing privileges (MH Providers)
    1. Psychiatrist licensed under ORS chapter 677
    2. Certified Nurse Practitioner (NP)* licensed under ORS 678.375
    3. Certified Psychiatric and Mental Health Nurse Practitioner (PMHNP) licensed under ORS 678.375, ORS 678.390 and OAR 851-050-0005(9)(k)

*Upon agreement with the Division, Certified Nurse Practitioner was included as a Mental Health Provider.

This Report is organized in eight volumes as follows:

Volume I – Background and Executive Summary
Volume II -- Section A – Historical Trends in Maximum Allowable Reimbursement Rates
Volume III – Section B – Utilization Management Procedures
Volume IV – Section C – Time-based Procedure Code Maximum Allowable Reimbursement Rate Analysis
Volume V – Section D -- Maximum Allowable Reimbursement Rate Methodology
Volume VI – Appendix A -- Carriers and Plans Maximum Allowable Reimbursement Rates
Volume VII – Appendix B -- Behavioral Health Providers Maximum Allowable Reimbursement Rates as a Percentage of Medical Provider Rates
Volume VIII – Appendix C -- Carriers and Plans Procedure Code Utilization

Risk & Regulatory Consulting, LLC (Contractor) was engaged by the Department to collect and analyze the data received from the Carriers as noted above. The Contractor evaluated the reasonableness of the data provided by the Carriers and made further inquiries of carriers as deemed necessary. In addition, upon agreement with the Division, an attestation was obtained from the Carriers confirming the accuracy, completeness and integrity of the data provided to the Department. The Contractor did not independently verify the Carriers' data and did not perform any verification procedures to determine compliance with the stated policies and procedure provided by the Carriers; therefore, the Contractor makes no representations regarding the accuracy and integrity of the data and information submitted by the Carriers. Contractor personnel participated in this engagement in their capacity as Market Conduct Examiners under the direction and supervision of the Department. The Contractor provides no representations regarding questions of legal interpretation or opinion, which is the sole responsibility of the Department.

Executive Summary

The analysis performed by the Contractor in the Report provides a macro view of the Carriers and Plans as it relates to SB 860, Section 1, Subsections (2)(a) – (2)(d), as stated in the Background section above. Sections A through D of this Executive Summary present the aggregated analysis of over 190,000 data points collected via a Data Call and analyzed by the Contractor. The Contractor's scope of the engagement with the Department was to analyze, summarize and trend the Carriers' data points and information. The analysis, summaries and observations in the Report are based solely on the Carriers' data. As such, the Contractor provides no conclusion or determination of facts of the Carriers' compliance with Oregon or Federal laws. A brief overview of Sections A through D is described below.

Section A – Historical Trends in Maximum Allowable Reimbursement Rates

As noted above, SB 860, Section 1, Subsection (2)(a) addresses the historical trends of each carrier's MARRs for time-based outpatient office visit procedural codes and whether each carrier's in-network BH Providers have MARRs that are equivalent[3] to the reimbursement to the carrier's in-network Medical Providers and MH Providers. In order to perform this analysis, the Contractor reviewed the MARRs by provider type for each of the 35 procedure codes reported by each of the 11 carriers for their respective 22 plans.

In summary, in 20 of the 22 plans, the MARRs reported by each carrier for each procedure for BH Providers varied from the MARRs reported for Medical Providers and MH Providers. The aggregated analysis in Section A of this Report (Volume II) illustrates such variances in MARRs. Section A is segmented by procedure code and includes MARR information for each of the 22 plans followed by the Contractor's analysis by carrier. For example, for procedure code 90832, Psychotherapy – 30 minutes, the analysis provides information regarding the MARR by provider type and historical trend information regarding annual MARR changes by provider type.

[3] For purposes of this Report, "equivalent" is defined as within 1% of the Medical Provider or MH Providers' maximum allowable reimbursement rate.

The following analysis summarizes the Contractor's review of the 35 procedure codes for MARRs reported by the Carriers for each of the 22 plans during the Period of Review. This analysis illustrates numerous instances in which BH Providers' MARRs were not equivalent with Medical Providers and MH Providers' MARRs during the Period of Review. In addition, the analysis illustrates that in many instances, BH Providers' annual rate increases were not equivalent with Medical Providers and MH Providers' annual rate increases. This analysis illustrates numerous instances in which BH Providers' MARRs were not equivalent with Medical Providers and MH Providers' annual rate increases were not equivalent with Medical Providers and MH Providers' annual rate increases. Additional details regarding specific procedure codes and plans is located in Volume II (Section A), Volume VI (Appendix Charts A1 to A140) and Volume VII (Appendix Charts B1 to B140).

Report Chart 1 below provides a snapshot of the average MARRs by provider type for the 35 procedure codes and 22 plans during the Period of Review. Based upon Report Chart 1, the following was noted:

- For 34 of 35 (97%) procedure codes, the average MARRs for BH Providers was lower and not equivalent with the average MARRs for Medical Providers.

- For 1 of 35 (3%) procedure codes, the average MARRs for the BH Providers was higher than and not equivalent with the average MARRs for Medical Providers.

- For 28 of 35 (80%) procedure codes, the average MARRs for the BH Providers was lower and not equivalent with the average MARRs for MH Providers.

- For 7 of 35 (20%) procedure codes, the average MARRs for one of more of the BH Providers were the same, equivalent or varied from the average MARRs for one or more MH Providers.
    - Procedure code 90837: The Psychologists' average MARR was higher and not equivalent with the average MARRs of the NPs but lower than Psychiatrists or PMHNPs. The LCSWs and LPC/LMFTs' MARRs were lower and not equivalent with MH Providers' average MARRs.
    - Procedure code 90863: The BH Providers' average MARRs was the same as the MARRs for MH Providers.
    - Procedure code 90875: The Psychologists' average MARR was equivalent to the average MARR of the NPs but lower than Psychiatrists or PMHNPs. The LCSWs and LPC/LMFTs' MARRs was lower and not equivalent with the MH Providers' average MARRs.
    - Procedure code 96101: The Psychologists' average MARRs was higher and not equivalent with the average MARRs of the NPs and PHMNPs but lower than Psychiatrists. The LCSWs and LPC/LMFTs' MARRs was lower and not equivalent with the MH Providers' average MARRs.
    - Procedure code 96118: The Psychologists' average MARR was higher and not equivalent with the average MARRs of the MH Providers. The MARRs of the LCSWs and LPC/LMFTs were lower and not equivalent with MH Providers' average MARRs.
    - Procedure code 96150: The Psychologists' average MARR was higher and not equivalent with the average MARR of the NPs and PMHNPs and lower and not

equivalent with the Psychiatrists. The MARRs of the LCSWs and LPC/LMFTs were lower and not equivalent with the MH Providers' average MARRs.

- Procedure code 99202:
  - The LCSWs average MARR was equivalent to the average MARR of the Psychiatrists but lower and not equivalent with the average MARRs of the NPs and PMHNPs.
  - The LPC/LMFTs average MARR was lower and not equivalent with the average MARRs of NPs and PMHNPs and higher and not equivalent with the average MARR of Psychiatrists.
  - The Psychologists' average MARR was lower and not equivalent with the average MARRs of MH Providers.

Report Chart 1 - Average Maximum Allowable Reimbursement Rate - By Provider Type and Procedure Code - During the Period of Review

Procedure		Behavioral Mental Health Providers (No Prescribing Privileges)			Medical Doctors with Prescribing Privileges		Mental Health Providers with Prescribing Privileges		
Procedure Code	Time (Minutes)	Psychologist	Licensed Clinical Social Worker (LCSW)	Licensed Professional Counselor (LPC) / Licensed Marriage Family Therapist (LMFT)	Doctor of Osteopathic Medicine (DO)	Doctor of Medicine (MD)	Nurse Practitioner (NP)	Psychiatrist	Psychiatric and Mental Health Nurse Practitioner (PMHNP)
90832	30	$106.25	$95.22	$88.34	$151.58	$147.24	$119.43	$127.42	$120.04
90833	30	$91.08	$75.25	$74.52	$155.74	$149.91	$105.91	$123.02	$113.28
90834	45	$163.64	$138.19	$130.75	$205.58	$203.65	$170.14	$182.05	$173.09
90836	45	$131.63	$109.22	$109.97	$200.18	$196.80	$143.07	$166.63	$155.57
90837	60	$217.25	$169.58	$170.48	$291.62	$293.40	$214.81	$237.80	$219.40
90838	60	$169.29	$145.16	$143.39	$269.40	$270.42	$190.92	$206.51	$202.72
90839	30	$211.55	$165.97	$166.75	$337.28	$337.28	$262.52	$283.00	$262.80
90840	60	$88.05	$78.52	$78.29	$167.60	$167.60	$115.21	$124.29	$115.56
90846	50	$167.58	$127.33	$129.97	$239.26	$238.01	$186.08	$200.05	$188.34
90847	50	$185.40	$150.44	$147.18	$254.27	$250.77	$202.85	$214.83	$205.71
90863	N/A	$52.56	$52.56	$52.56	$63.18	$61.48	$52.56	$52.56	$52.56
90875	30	$107.09	$89.27	$89.27	$157.60	$157.60	$107.46	$120.05	$110.11
90876	45	$179.04	$148.35	$149.04	$267.88	$267.88	$181.32	$198.27	$186.71
96101	60	$154.08	$122.03	$116.95	$197.32	$198.47	$145.64	$157.90	$151.76
96102	60	$111.74	$109.08	$109.17	$167.46	$167.46	$132.85	$129.99	$133.58
96116	60	$171.37	$152.25	$152.25	$229.06	$226.28	$183.54	$190.29	$183.54
96118	60	$206.66	$159.78	$157.75	$241.09	$232.31	$195.52	$194.79	$197.67
96150	15	$42.92	$38.93	$32.82	$59.12	$59.07	$42.32	$45.93	$41.94
96151	15	$36.21	$31.18	$31.34	$47.54	$47.15	$39.97	$43.86	$39.97
96152	15	$36.74	$32.14	$31.60	$48.71	$48.47	$38.15	$41.72	$37.94
96153	15	$23.12	$24.79	$24.14	$10.76	$10.76	$25.83	$25.20	$25.83
96154	15	$34.90	$31.80	$31.80	$51.85	$51.85	$38.98	$41.08	$38.98
96155	15	$42.54	$36.86	$36.78	$52.97	$52.97	$49.36	$49.79	$49.36
99201	10	$68.37	$43.85	$43.85	$117.81	$121.29	$102.39	$92.74	$99.11
99202	20	$117.38	$130.11	$132.53	$208.05	$214.14	$158.78	$129.81	$138.00
99203	30	$117.19	$125.94	$125.94	$308.53	$317.30	$208.85	$192.59	$181.99
99204	45	$189.07	$176.18	$176.18	$452.80	$455.72	$316.24	$301.99	$287.13
99205	60	$240.39	$225.60	$225.60	$544.39	$558.05	$372.82	$371.68	$352.58
99211	5	$34.20	$36.13	$36.89	$86.84	$92.37	$68.95	$73.09	$68.65
99212	10	$70.06	$80.72	$80.72	$127.61	$136.22	$96.88	$95.16	$90.35
99213	15	$99.29	$91.87	$89.10	$217.51	$226.59	$147.93	$146.18	$136.41
99214	25	$130.37	$120.26	$117.63	$318.12	$316.16	$210.76	$215.13	$198.50
99215	40	$171.77	$161.81	$161.81	$411.91	$413.48	$272.14	$267.72	$251.18
99354	60	$183.86	$178.97	$177.98	$255.31	$252.04	$200.77	$212.10	$201.01
99355	30	$175.70	$161.36	$164.38	$247.05	$242.24	$202.02	$219.07	$189.02

Report Charts 2 - 9 below provide a snapshot of the average MARRs by provider for the 35 procedure codes during the Period of Review including the average MARR change between 2015 to 2018. The average MARR change for each provider was as follows:

BH Providers:

- Psychologists: 2% from 2015 to 2016, 5% from 2016 to 2017 and 1% from 2017 to 2018
- LCSWs: 4% from 2015 to 2016, 3% from 2016 to 2017 and 0% from 2017 to 2018
- LPC/LMFTs: 3% from 2015 to 2016, 3% from 2016 to 2017 and 2% from 2017 to 2018

Medical Providers:

- DOs: 1% from 2015 to 2016, 1% from 2016 to 2017 and 4% from 2017 to 2018
- MDs: 2% from 2015 to 2016, 0% from 2016 to 2017 and 4% from 2017 to 2018

MH Providers:

- NPs: 2% from 2015 to 2016, 4% from 2016 to 2017 and 0% from 2017 to 2018
- Psychiatrists: 1% from 2015 to 2016, 1% from 2016 to 2017 and 2% from 2017 to 2018
- PMHNPs: 2% from 2015 to 2016, 3% from 2016 to 2017 and 0% from 2017 to 2018

Report Chart 2 - Average Maximum Allowable Reimbursement Rate for Psychologists by Procedure Code and Year

Procedure		Average Maximum Reimbursement Rate by Year				Year-Over-Year Percentage			Trend Analysis, 2015-2018			
Procedure Code	Time (Minutes)	2015	2016	2017	2018	2015 → 2016	2016 → 2017	2017 → 2018	Mean (Average)	Standard Deviation of the Mean	Estimated Trend Line Slope (Least Squares Method)	General Trend Direction (Up/Down)
90832	30	$99.08	$99.58	$112.54	$113.46	1%	13%	1%	$106.17	$7.90	5.610	Up
90833	30	$82.65	$83.39	$96.99	$100.20	1%	16%	3%	$90.81	$9.09	6.626	Up
90834	45	$159.17	$148.61	$170.87	$175.17	-7%	15%	3%	$163.46	$11.99	7.026	Up
90836	45	$120.68	$121.06	$142.10	$144.32	0%	17%	2%	$132.04	$12.93	9.195	Up
90837	60	$220.71	$213.36	$216.62	$218.16	-3%	2%	1%	$217.21	$3.07	(0.439)	Down
90838	60	$154.09	$158.02	$180.84	$184.23	3%	14%	2%	$169.29	$15.43	11.323	Up
90839	30	$209.44	$213.05	$210.16	$213.31	2%	-1%	2%	$211.49	$1.98	0.873	Up
90840	60	$86.85	$87.94	$91.00	$86.37	1%	3%	-5%	$88.04	$2.08	0.163	Up
90846	50	$154.99	$159.35	$177.29	$177.65	3%	11%	0%	$167.32	$11.85	8.591	Up
90847	50	$170.33	$176.32	$196.54	$197.96	4%	11%	1%	$185.29	$14.04	10.311	Up
90863	N/A	$78.90	$45.00	$30.00	$30.00	-43%	-33%	0%	$45.98	$23.06	(16.170)	Down
90875	30	$111.56	$111.52	$101.68	$103.60	0%	-9%	2%	$107.09	$5.20	(3.371)	Down
90876	45	$183.47	$183.69	$173.71	$176.01	0%	-5%	1%	$179.22	$5.12	(3.238)	Down
96101	60	$152.72	$153.12	$155.56	$154.74	0%	2%	-1%	$154.04	$1.34	0.852	Up
96102	60	$111.25	$114.22	$111.34	$110.27	3%	-3%	-1%	$111.77	$1.70	(0.581)	Down
96116	60	$169.63	$166.94	$176.76	$172.07	-2%	6%	-3%	$171.35	$4.17	1.713	Up
96118	60	$250.94	$190.85	$188.93	$193.58	-24%	-1%	2%	$206.08	$29.97	(17.399)	Down
96150	15	$35.86	$37.61	$53.23	$44.35	5%	42%	-17%	$42.76	$7.88	4.108	Up
96151	15	$33.97	$35.18	$37.40	$38.10	4%	6%	2%	$36.16	$1.92	1.461	Up
96152	15	$34.45	$35.86	$37.15	$39.39	4%	4%	6%	$36.71	$2.10	1.611	Up
96153	15	$22.68	$22.68	$23.57	$23.58	0%	4%	0%	$23.13	$0.52	0.359	Up
96154	15	$33.73	$34.78	$35.20	$35.77	3%	1%	2%	$34.87	$0.86	0.655	Up
96155	15	$38.54	$39.98	$45.46	$46.18	4%	14%	2%	$42.54	$3.84	2.841	Up
99201	10	$62.16	$63.60	$73.30	$74.43	2%	15%	2%	$68.37	$6.38	4.650	Up
99202	20	$107.26	$109.28	$125.64	$127.34	2%	15%	1%	$117.38	$10.57	7.659	Up
99203	30	$108.51	$110.29	$124.29	$125.68	2%	13%	1%	$117.19	$9.05	6.551	Up
99204	45	$180.62	$188.36	$194.62	$196.23	4%	3%	1%	$189.95	$7.09	5.308	Up
99205	60	$212.58	$258.32	$242.31	$244.78	22%	-6%	1%	$239.50	$19.28	8.058	Up
99211	5	$30.51	$34.74	$35.43	$36.13	14%	2%	2%	$34.20	$2.53	1.754	Up
99212	10	$62.19	$71.72	$73.64	$74.76	15%	3%	2%	$70.58	$5.73	3.964	Up
99213	15	$88.17	$97.70	$100.65	$109.24	11%	3%	9%	$98.94	$8.69	6.614	Up
99214	25	$116.46	$138.33	$128.60	$136.76	19%	-7%	6%	$130.04	$10.01	5.119	Up
99215	40	$166.14	$171.70	$174.28	$176.07	3%	2%	1%	$172.05	$4.33	3.236	Up
99354	60	$157.95	$177.50	$182.22	$218.18	12%	3%	20%	$183.96	$25.12	18.543	Up
99355	30	$171.02	$172.53	$177.68	$181.59	1%	3%	2%	$175.70	$4.85	3.684	Up

Report Chart 3 - Average Maximum Allowable Reimbursement Rate for LCSWs by Procedure Code and Year

Procedure		Average Maximum Reimbursement Rate by Year				Year-Over-Year Percentage			Trend Analysis, 2015-2018			
Procedure Code	Time (Minutes)	2015	2016	2017	2018	2015 → 2016	2016 → 2017	2017 → 2018	Mean (Average)	Standard Deviation of the Mean	Estimated Trend Line Slope (Least Squares Method)	General Trend Direction (Up/Down)
90832	30	$89.80	$101.18	$94.70	$94.62	13%	-6%	0%	$95.07	$4.67	0.796	Up
90833	30	$70.11	$71.81	$78.43	$79.95	2%	9%	2%	$75.08	$4.84	3.615	Up
90834	45	$128.90	$140.09	$137.91	$145.78	9%	-2%	6%	$138.17	$7.01	4.844	Up
90836	45	$103.26	$107.38	$112.10	$114.32	4%	4%	2%	$109.26	$4.94	3.792	Up
90837	60	$169.48	$165.56	$167.67	$175.98	-2%	1%	5%	$169.67	$4.50	2.161	Up
90838	60	$141.45	$140.69	$147.97	$150.16	-1%	5%	1%	$145.07	$4.71	3.343	Up
90839	30	$164.96	$167.63	$165.10	$165.98	2%	-2%	1%	$165.92	$1.23	0.052	Up
90840	60	$78.90	$78.32	$78.44	$78.44	-1%	0%	0%	$78.53	$0.26	(0.126)	Down
90846	50	$122.69	$128.55	$129.11	$128.82	5%	0%	0%	$127.29	$3.08	1.894	Up
90847	50	$146.06	$146.53	$157.83	$151.36	0%	8%	-4%	$150.44	$5.48	2.722	Up
90863	N/A	$78.90	$45.00	$30.00	$30.00	-43%	-33%	0%	$45.98	$23.06	(16.170)	Down
90875	30	$91.46	$91.86	$86.19	$87.58	0%	-6%	2%	$89.27	$2.82	(1.732)	Down
90876	45	$145.60	$147.84	$149.03	$150.95	2%	1%	1%	$148.35	$2.24	1.723	Up
96101	60	$120.47	$122.66	$121.68	$123.13	2%	-1%	1%	$121.99	$1.18	0.701	Up
96102	60	$111.89	$111.39	$106.64	$106.39	0%	-4%	0%	$109.08	$2.97	(2.126)	Down
96116	60	$149.91	$150.72	$153.58	$154.81	1%	2%	1%	$152.25	$2.32	1.756	Up
96118	60	$154.55	$162.62	$159.49	$161.51	5%	-2%	1%	$159.54	$3.57	1.775	Up
96150	15	$32.28	$35.21	$51.77	$35.01	9%	47%	-32%	$38.57	$8.90	2.473	Up
96151	15	$30.65	$31.29	$31.05	$31.75	2%	-1%	2%	$31.19	$0.46	0.306	Up
96152	15	$30.63	$33.11	$33.23	$31.61	8%	0%	-5%	$32.14	$1.25	0.307	Up
96153	15	$24.29	$24.92	$24.97	$24.99	3%	0%	0%	$24.79	$0.34	0.214	Up
96154	15	$31.08	$31.78	$32.10	$32.23	2%	1%	0%	$31.80	$0.52	0.378	Up
96155	15	$36.02	$37.15	$37.04	$37.18	3%	0%	0%	$36.85	$0.55	0.336	Up
99201	10	$40.02	$41.10	$46.72	$47.57	3%	14%	2%	$43.85	$3.84	2.827	Up
99202	20	$120.14	$123.17	$142.14	$133.38	3%	15%	-6%	$129.70	$10.04	5.870	Up
99203	30	$117.10	$119.32	$132.80	$134.53	2%	11%	1%	$125.94	$9.00	6.578	Up
99204	45	$163.58	$165.90	$186.62	$188.63	1%	12%	1%	$176.18	$13.28	9.590	Up
99205	60	$203.79	$228.74	$233.40	$236.49	12%	2%	1%	$225.60	$14.89	10.277	Up
99211	5	$31.66	$37.40	$38.32	$39.36	18%	2%	3%	$36.69	$3.45	2.404	Up
99212	10	$74.56	$81.43	$82.25	$84.64	9%	1%	3%	$80.72	$4.33	3.108	Up
99213	15	$76.81	$91.33	$97.61	$98.61	19%	7%	1%	$91.09	$10.05	7.168	Up
99214	25	$101.77	$125.31	$125.57	$128.41	23%	0%	2%	$120.26	$12.41	8.020	Up
99215	40	$146.21	$164.36	$167.21	$169.44	12%	2%	1%	$161.81	$10.60	7.254	Up
99354	60	$163.44	$165.63	$171.16	$206.49	1%	3%	21%	$176.68	$20.14	13.468	Up
99355	30	$159.94	$161.45	$160.28	$163.45	1%	-1%	2%	$161.28	$1.59	0.939	Up

Report Chart 4 - Average Maximum Allowable Reimbursement Rate for LPC/LMFTs by Procedure Code and Year

Procedure		Average Maximum Reimbursement Rate by Year				Year-Over-Year Percentage Change			Trend Analysis, 2015-2018			
Procedure Code	Time (Minutes)	2015	2016	2017	2018	2015 → 2016	2016 → 2017	2017 → 2018	Mean (Average)	Standard Deviation of the Mean	Estimated Trend Line Slope (Least Squares Method)	General Trend Direction (Up/Down)
90832	30	$81.30	$86.11	$89.84	$96.08	6%	4%	7%	$88.33	$6.24	4.807	Up
90833	30	$70.11	$71.81	$77.25	$78.91	2%	8%	2%	$74.52	$4.22	3.185	Up
90834	45	$124.02	$126.08	$137.42	$135.15	2%	9%	-2%	$130.67	$6.61	4.474	Up
90836	45	$103.26	$110.17	$112.10	$114.32	7%	2%	2%	$109.96	$4.78	3.513	Up
90837	60	$165.94	$160.85	$177.12	$177.90	-3%	10%	0%	$170.45	$8.41	5.215	Up
90838	60	$136.12	$140.69	$147.17	$149.56	3%	5%	2%	$143.39	$6.12	4.678	Up
90839	30	$161.29	$169.57	$165.18	$170.84	5%	-3%	3%	$166.72	$4.36	2.425	Up
90840	60	$77.33	$77.95	$78.44	$79.41	1%	1%	1%	$78.28	$0.88	0.673	Up
90846	50	$121.66	$123.74	$140.67	$134.34	2%	14%	-5%	$130.10	$8.97	5.494	Up
90847	50	$133.68	$136.37	$163.23	$156.11	2%	20%	-4%	$147.35	$14.56	9.414	Up
90863	N/A	$78.90	$45.00	$30.00	$30.00	-43%	-33%	0%	$45.98	$23.06	(16.170)	Down
90875	30	$91.46	$91.86	$86.19	$87.58	0%	-6%	2%	$89.27	$2.82	(1.732)	Down
90876	45	$145.60	$147.84	$151.22	$150.95	2%	2%	0%	$148.90	$2.68	1.942	Up
96101	60	$111.13	$121.13	$115.63	$123.13	9%	-5%	6%	$117.76	$5.44	3.051	Up
96102	60	$111.89	$111.26	$106.64	$106.39	-1%	-4%	0%	$109.04	$2.94	(2.113)	Down
96116	60	$149.91	$150.72	$153.58	$154.81	1%	2%	1%	$152.25	$2.32	1.756	Up
96118	60	$154.55	$155.45	$159.49	$161.51	1%	3%	1%	$157.75	$3.30	2.492	Up
96150	15	$32.21	$33.97	$33.04	$32.20	5%	-3%	-3%	$32.86	$0.84	(0.096)	Down
96151	15	$30.69	$31.35	$31.56	$31.75	2%	1%	1%	$31.34	$0.46	0.340	Up
96152	15	$31.94	$30.78	$32.35	$31.21	-4%	5%	-4%	$31.57	$0.70	(0.062)	Down
96153	15	$24.29	$23.79	$23.56	$24.99	-2%	-1%	6%	$24.16	$0.63	0.187	Up
96154	15	$31.08	$31.78	$32.10	$32.23	2%	1%	0%	$31.80	$0.52	0.378	Up
96155	15	$36.02	$36.87	$37.04	$37.18	2%	0%	0%	$36.78	$0.52	0.364	Up
99201	10	$40.02	$41.10	$46.72	$47.57	3%	14%	2%	$43.85	$3.84	2.827	Up
99202	20	$120.14	$123.17	$142.14	$144.68	3%	15%	2%	$132.53	$12.67	9.261	Up
99203	30	$117.10	$119.32	$132.80	$134.53	2%	11%	1%	$125.94	$9.00	6.578	Up
99204	45	$163.58	$165.90	$186.62	$188.63	1%	12%	1%	$176.18	$13.28	9.590	Up
99205	60	$203.79	$228.74	$233.40	$236.49	12%	2%	1%	$225.60	$14.89	10.277	Up
99211	5	$32.49	$37.40	$38.32	$39.36	15%	2%	3%	$36.89	$3.04	2.155	Up
99212	10	$74.56	$81.43	$82.25	$84.64	9%	1%	3%	$80.72	$4.33	3.108	Up
99213	15	$76.81	$91.33	$93.50	$94.75	19%	2%	1%	$89.10	$8.31	5.601	Up
99214	25	$104.78	$125.31	$115.72	$128.41	20%	-8%	11%	$118.55	$10.66	6.132	Up
99215	40	$146.21	$164.36	$167.21	$169.44	12%	2%	1%	$161.81	$10.60	7.254	Up
99354	60	$163.44	$165.63	$171.16	$211.68	1%	3%	24%	$177.98	$22.70	15.025	Up
99355	30	$159.94	$161.45	$166.30	$169.83	1%	3%	2%	$164.38	$4.53	3.452	Up

Report Chart 5 - Average Maximum Allowable Reimbursement Rate for DOs by Procedure Code and Year

Procedure		Average Maximum Reimbursement Rate by Year				Year-Over-Year Percentage Change			Trend Analysis, 2015-2018			
Procedure Code	Time (Minutes)	2015	2016	2017	2018	2015 → 2016	2016 → 2017	2017 → 2018	Mean (Average)	Standard Deviation of the Mean	Estimated Trend Line Slope (Least Squares Method)	General Trend Direction (Up/Down)
90832	30	$153.38	$145.66	$148.87	$159.85	-5%	2%	7%	$151.94	$6.15	2.264	Up
90833	30	$140.53	$152.42	$160.14	$167.68	8%	5%	5%	$155.19	$11.59	8.917	Up
90834	45	$200.53	$200.98	$209.40	$210.71	0%	4%	1%	$205.41	$5.40	3.895	Up
90836	45	$183.30	$200.75	$205.53	$211.16	10%	2%	3%	$200.18	$12.03	8.835	Up
90837	60	$288.08	$285.57	$291.98	$300.49	-1%	2%	3%	$291.53	$6.53	4.363	Up
90838	60	$264.04	$267.71	$269.23	$276.61	1%	1%	3%	$269.40	$5.28	3.925	Up
90839	30	$346.12	$330.34	$333.59	$339.08	-5%	1%	2%	$337.28	$6.91	(1.789)	Down
90840	60	$173.26	$165.60	$164.48	$167.06	-4%	-1%	2%	$167.60	$3.92	(1.971)	Down
90846	50	$224.21	$224.70	$251.81	$258.15	0%	12%	3%	$239.72	$17.81	12.893	Up
90847	50	$249.45	$240.74	$260.79	$267.78	-3%	8%	3%	$254.69	$11.98	7.503	Up
90863	N/A	$78.90	$45.00	$30.00	$69.81	-43%	-33%	133%	$55.93	$22.45	(4.226)	Down
90875	30	$162.27	$155.73	$154.38	$158.03	-4%	-1%	2%	$157.60	$3.46	(1.407)	Down
90876	45	$260.06	$268.16	$267.93	$275.38	3%	0%	3%	$267.88	$6.26	4.573	Up
96101	60	$196.94	$193.46	$197.02	$202.35	-2%	2%	3%	$197.44	$3.67	1.980	Up
96102	60	$170.95	$170.83	$163.42	$164.65	0%	-4%	1%	$167.46	$3.99	(2.631)	Down
96116	60	$223.15	$228.26	$229.90	$234.93	2%	1%	2%	$229.06	$4.86	3.698	Up
96118	60	$235.09	$238.28	$243.43	$247.57	1%	2%	2%	$241.09	$5.52	4.260	Up
96150	15	$58.39	$62.87	$59.38	$55.83	8%	-6%	-6%	$59.12	$2.92	(1.119)	Down
96151	15	$44.45	$49.19	$48.54	$48.14	11%	-1%	-1%	$47.58	$2.13	1.044	Up
96152	15	$45.39	$48.74	$50.02	$50.67	7%	3%	1%	$48.71	$2.35	1.711	Up
96153	15	$10.56	$10.23	$11.11	$11.20	-3%	9%	1%	$10.77	$0.46	0.281	Up
96154	15	$50.89	$53.47	$48.83	$54.84	5%	-9%	12%	$52.01	$2.68	0.722	Up
96155	15	$55.09	$51.84	$50.48	$55.10	-6%	-3%	9%	$53.13	$2.34	(0.135)	Down
99201	10	$114.03	$122.00	$119.68	$116.04	7%	-2%	-3%	$117.94	$3.57	0.371	Up
99202	20	$193.25	$212.47	$218.62	$208.10	10%	3%	-5%	$208.11	$10.81	5.072	Up
99203	30	$291.07	$315.31	$317.79	$309.96	8%	1%	-2%	$308.53	$12.09	5.911	Up
99204	45	$426.29	$454.66	$470.00	$459.00	7%	3%	-2%	$452.49	$18.62	11.347	Up
99205	60	$520.59	$547.08	$561.69	$545.93	5%	3%	-3%	$543.82	$17.07	9.063	Up
99211	5	$96.54	$110.08	$77.28	$65.19	14%	-30%	-16%	$87.27	$19.95	(12.683)	Down
99212	10	$121.00	$134.26	$132.89	$122.34	11%	-1%	-8%	$127.62	$6.92	0.265	Up
99213	15	$196.94	$211.24	$245.86	$215.68	7%	16%	-12%	$217.43	$20.57	9.083	Up
99214	25	$314.10	$323.42	$324.02	$311.03	3%	0%	-4%	$318.14	$6.57	(0.862)	Down
99215	40	$391.15	$406.86	$422.47	$425.89	4%	4%	1%	$411.59	$15.95	11.984	Up
99354	60	$243.12	$229.92	$252.83	$300.23	-5%	10%	19%	$256.52	$30.61	19.423	Up
99355	30	$237.64	$229.62	$261.26	$254.63	-3%	14%	-3%	$245.79	$14.67	8.261	Up

Report Chart 6 - Average Maximum Allowable Reimbursement Rate for MDs by Procedure Code and Year

Procedure		Average Maximum Reimbursement Rate by Year				Year-Over-Year Percentage Change			Trend Analysis, 2015-2018			
Procedure Code	Time (Minutes)	2015	2016	2017	2018	2015 → 2016	2016 → 2017	2017 → 2018	Mean (Average)	Standard Deviation of the Mean	Estimated Trend Line Slope (Least Squares Method)	General Trend Direction (Up/Down)
90832	30	$145.13	$140.15	$145.44	$159.85	-3%	4%	10%	$147.64	$8.49	4.947	Up
90833	30	$139.78	$159.64	$148.15	$153.50	14%	-7%	4%	$150.27	$8.42	2.970	Up
90834	45	$197.43	$204.37	$200.47	$213.36	4%	-2%	6%	$203.91	$6.91	4.390	Up
90836	45	$196.96	$199.67	$197.69	$193.46	1%	-1%	-2%	$196.94	$2.59	(1.248)	Down
90837	60	$270.29	$299.16	$304.92	$299.81	11%	2%	-2%	$293.55	$15.72	9.434	Up
90838	60	$268.22	$275.53	$262.32	$276.61	3%	-5%	5%	$270.67	$6.70	1.197	Up
90839	30	$346.12	$330.34	$333.59	$339.08	-5%	1%	2%	$337.28	$6.91	(1.789)	Down
90840	60	$173.26	$165.60	$164.48	$167.06	-4%	-1%	2%	$167.60	$3.92	(1.971)	Down
90846	50	$224.21	$241.12	$230.44	$258.15	8%	-4%	12%	$238.48	$14.86	9.115	Up
90847	50	$234.16	$256.32	$252.48	$260.74	9%	-1%	3%	$250.93	$11.68	7.593	Up
90863	N/A	$78.90	$45.00	$30.00	$64.76	-43%	-33%	116%	$54.66	$21.53	(5.744)	Down
90875	30	$162.27	$155.73	$154.38	$158.03	-4%	-1%	2%	$157.60	$3.46	(1.407)	Down
90876	45	$260.06	$268.16	$267.93	$275.38	3%	0%	3%	$267.88	$6.26	4.573	Up
96101	60	$196.94	$197.58	$197.02	$202.35	0%	0%	3%	$198.47	$2.60	1.568	Up
96102	60	$170.95	$170.83	$163.42	$164.65	0%	-4%	1%	$167.46	$3.99	(2.631)	Down
96116	60	$218.38	$223.27	$229.90	$234.93	2%	3%	2%	$226.62	$7.28	5.628	Up
96118	60	$227.89	$230.73	$229.59	$240.43	1%	0%	5%	$232.16	$5.63	3.648	Up
96150	15	$58.39	$62.87	$59.38	$55.85	8%	-6%	-6%	$59.12	$2.91	(1.114)	Down
96151	15	$44.45	$49.19	$47.35	$47.82	11%	-4%	1%	$47.20	$2.00	0.828	Up
96152	15	$45.39	$48.74	$49.01	$50.67	7%	1%	3%	$48.45	$2.21	1.610	Up
96153	15	$10.56	$10.23	$11.11	$11.20	-3%	9%	1%	$10.77	$0.46	0.281	Up
96154	15	$50.89	$53.47	$48.83	$54.84	5%	-9%	12%	$52.01	$2.68	0.722	Up
96155	15	$55.09	$51.84	$50.48	$55.10	-6%	-3%	9%	$53.13	$2.34	(0.135)	Down
99201	10	$115.54	$124.65	$122.88	$122.28	8%	-1%	0%	$121.34	$3.99	1.844	Up
99202	20	$199.51	$216.56	$223.53	$217.24	9%	3%	-3%	$214.21	$10.29	6.014	Up
99203	30	$293.72	$319.28	$330.37	$325.60	9%	3%	-1%	$317.24	$16.33	10.673	Up
99204	45	$432.06	$457.38	$466.15	$466.25	6%	2%	0%	$455.46	$16.14	11.134	Up
99205	60	$538.47	$538.49	$584.10	$572.14	0%	8%	-2%	$558.30	$23.40	14.661	Up
99211	5	$97.61	$110.42	$86.55	$74.91	13%	-22%	-13%	$92.37	$15.19	(9.197)	Down
99212	10	$131.33	$141.36	$140.56	$131.64	8%	-1%	-6%	$136.22	$5.48	0.012	Up
99213	15	$212.00	$215.23	$243.60	$234.58	2%	13%	-4%	$226.35	$15.22	9.611	Up
99214	25	$309.03	$322.32	$320.75	$312.11	4%	0%	-3%	$316.06	$6.49	0.768	Up
99215	40	$392.20	$399.83	$419.20	$444.13	2%	5%	6%	$413.84	$23.17	17.517	Up
99354	60	$231.36	$231.19	$272.24	$272.14	0%	18%	0%	$251.73	$23.62	16.339	Up
99355	30	$220.06	$229.62	$269.06	$245.63	4%	17%	-9%	$241.09	$21.43	11.617	Up

Report Chart 7 - Average Maximum Allowable Reimbursement Rate for NPs by Procedure Code and Year

Procedure		Average Maximum Reimbursement Rate by Year				Year-Over-Year Percentage Change			Trend Analysis, 2015-2018			
Procedure Code	Time (Minutes)	2015	2016	2017	2018	2015 → 2016	2016 → 2017	2017 → 2018	Mean (Average)	Standard Deviation of the Mean	Estimated Trend Line Slope (Least Squares Method)	General Trend Direction (Up/Down)
90832	30	$111.63	$109.97	$126.35	$128.75	-1%	15%	2%	$119.17	$9.75	6.777	Up
90833	30	$104.29	$101.95	$108.88	$108.38	-2%	7%	0%	$105.87	$3.33	1.920	Up
90834	45	$159.06	$158.59	$178.59	$181.66	0%	13%	2%	$169.47	$12.36	8.779	Up
90836	45	$132.97	$138.91	$149.06	$150.55	4%	7%	1%	$142.87	$8.39	6.288	Up
90837	60	$212.10	$210.37	$216.78	$219.59	-1%	3%	1%	$214.71	$4.23	2.888	Up
90838	60	$181.86	$183.83	$197.30	$200.70	1%	7%	2%	$190.92	$9.46	7.000	Up
90839	30	$253.81	$259.09	$267.56	$269.88	2%	3%	1%	$262.58	$7.47	5.668	Up
90840	60	$113.76	$114.27	$116.14	$116.49	0%	2%	0%	$115.17	$1.35	1.006	Up
90846	50	$179.48	$181.45	$187.35	$195.55	1%	3%	4%	$185.96	$7.22	5.411	Up
90847	50	$189.04	$187.20	$213.39	$218.60	-1%	14%	2%	$202.06	$16.25	11.489	Up
90863	N/A	$78.90	$45.00	$30.00	$30.00	-43%	-33%	0%	$45.98	$23.06	(16.170)	Down
90875	30	$107.14	$107.54	$106.55	$108.57	0%	-1%	2%	$107.45	$0.85	0.331	Up
90876	45	$171.22	$173.45	$187.10	$189.92	1%	8%	2%	$180.42	$9.45	6.975	Up
96101	60	$144.98	$145.64	$145.12	$146.84	0%	0%	1%	$145.64	$0.85	0.507	Up
96102	60	$137.13	$136.63	$129.79	$129.46	0%	-5%	0%	$133.25	$4.19	(2.982)	Down
96116	60	$180.98	$183.76	$184.53	$184.87	2%	0%	0%	$183.54	$1.77	1.245	Up
96118	60	$191.34	$194.48	$196.81	$199.42	2%	1%	1%	$195.51	$3.44	2.657	Up
96150	15	$38.82	$40.34	$45.08	$44.98	4%	12%	0%	$42.31	$3.21	2.321	Up
96151	15	$37.22	$37.82	$42.10	$42.76	2%	11%	2%	$39.97	$2.86	2.090	Up
96152	15	$35.45	$36.02	$40.51	$40.43	2%	12%	0%	$38.11	$2.74	1.943	Up
96153	15	$25.78	$25.80	$25.84	$25.87	0%	0%	0%	$25.83	$0.04	0.030	Up
96154	15	$36.01	$36.61	$41.35	$41.98	2%	13%	2%	$38.98	$3.11	2.266	Up
96155	15	$45.59	$46.39	$52.39	$53.09	2%	13%	1%	$49.36	$3.92	2.853	Up
99201	10	$89.60	$104.46	$107.74	$106.95	17%	3%	-1%	$102.19	$8.51	5.532	Up
99202	20	$150.11	$159.46	$163.00	$162.58	6%	2%	0%	$158.79	$6.00	4.096	Up
99203	30	$199.27	$208.40	$215.72	$211.17	5%	4%	-2%	$208.64	$6.94	4.301	Up
99204	45	$306.81	$328.70	$315.59	$314.64	7%	-4%	0%	$316.44	$9.07	1.038	Up
99205	60	$376.64	$367.13	$379.39	$368.01	-3%	3%	-3%	$372.79	$6.14	(1.363)	Down
99211	5	$65.48	$73.11	$69.95	$67.42	12%	-4%	-4%	$68.99	$3.30	0.264	Up
99212	10	$90.83	$100.99	$97.33	$98.36	11%	-4%	1%	$96.88	$4.31	1.892	Up
99213	15	$145.11	$148.73	$150.07	$147.60	2%	1%	-2%	$147.88	$2.11	0.883	Up
99214	25	$208.55	$209.61	$212.02	$212.71	1%	1%	0%	$210.72	$1.96	1.488	Up
99215	40	$262.11	$271.47	$273.44	$281.47	4%	1%	3%	$272.12	$7.95	6.004	Up
99354	60	$177.81	$194.33	$197.86	$225.35	9%	2%	14%	$198.84	$19.72	14.615	Up
99355	30	$170.10	$193.75	$248.76	$187.79	14%	28%	-25%	$200.10	$33.96	10.807	Up

Report Chart 8 - Average Maximum Allowable Reimbursement Rate for Psychiatrists by Procedure Code and Year

Procedure		Average Maximum Reimbursement Rate by Year				Year-Over-Year Percentage Change			Trend Analysis, 2015-2018			
Procedure Code	Time (Minutes)	2015	2016	2017	2018	2015 → 2016	2016 → 2017	2017 → 2018	Mean (Average)	Standard Deviation of the Mean	Estimated Trend Line Slope (Least Squares Method)	General Trend Direction (Up/Down)
90832	30	$120.02	$121.23	$131.52	$136.08	1%	8%	3%	$127.21	$7.84	5.846	Up
90833	30	$114.18	$116.11	$129.60	$132.18	2%	12%	2%	$123.02	$9.18	6.749	Up
90834	45	$173.61	$169.30	$196.18	$188.54	-2%	16%	-4%	$181.91	$12.59	7.167	Up
90836	45	$163.38	$162.70	$170.06	$170.20	0%	5%	0%	$166.58	$4.10	2.783	Up
90837	60	$235.81	$235.67	$234.32	$245.63	0%	-1%	5%	$237.86	$5.22	2.811	Up
90838	60	$202.21	$203.26	$207.82	$212.59	1%	2%	2%	$206.47	$4.75	3.571	Up
90839	30	$278.03	$282.31	$286.15	$285.56	2%	1%	0%	$283.01	$3.73	2.642	Up
90840	60	$124.83	$124.82	$123.52	$123.99	0%	-1%	0%	$124.29	$0.65	(0.384)	Down
90846	50	$202.80	$197.98	$199.02	$200.77	-2%	1%	1%	$200.14	$2.11	(0.504)	Down
90847	50	$208.34	$204.46	$220.91	$224.98	-2%	8%	2%	$214.67	$9.82	6.637	Up
90863	N/A	$78.90	$45.00	$30.00	$30.00	-43%	-33%	0%	$45.98	$23.06	(16.170)	Down
90875	30	$124.22	$124.18	$116.58	$115.23	0%	-6%	-1%	$120.05	$4.82	(3.457)	Down
90876	45	$199.59	$201.92	$194.38	$197.20	1%	-4%	1%	$198.27	$3.23	(1.469)	Down
96101	60	$163.03	$164.42	$155.34	$150.88	1%	-6%	-3%	$158.42	$6.42	(4.553)	Down
96102	60	$138.95	$136.34	$133.85	$112.96	-2%	-2%	-16%	$130.52	$11.89	(8.047)	Down
96116	60	$189.30	$191.65	$189.84	$190.37	1%	-1%	0%	$190.29	$1.01	0.141	Up
96118	60	$191.43	$198.77	$192.78	$196.51	4%	-3%	2%	$194.87	$3.37	0.925	Up
96150	15	$43.03	$43.78	$48.15	$48.77	2%	10%	1%	$45.93	$2.95	2.161	Up
96151	15	$41.33	$41.93	$45.69	$46.48	1%	9%	2%	$43.86	$2.60	1.920	Up
96152	15	$39.43	$40.00	$43.40	$44.05	1%	8%	1%	$41.72	$2.34	1.723	Up
96153	15	$25.22	$25.23	$25.16	$25.20	0%	0%	0%	$25.20	$0.03	(0.014)	Down
96154	15	$38.52	$39.07	$43.05	$43.70	1%	10%	2%	$41.08	$2.67	1.953	Up
96155	15	$46.64	$47.37	$52.21	$52.95	2%	10%	1%	$49.79	$3.24	2.375	Up
99201	10	$87.22	$92.15	$94.96	$96.73	6%	3%	2%	$92.76	$4.15	3.136	Up
99202	20	$126.34	$133.90	$128.69	$130.07	6%	-4%	1%	$129.75	$3.17	0.598	Up
99203	30	$186.36	$193.48	$191.94	$198.27	4%	-1%	3%	$192.51	$4.91	3.419	Up
99204	45	$296.99	$299.20	$306.88	$304.76	1%	3%	-1%	$301.96	$4.63	3.099	Up
99205	60	$362.27	$381.92	$372.19	$370.34	5%	-3%	0%	$371.68	$8.07	1.449	Up
99211	5	$72.10	$70.90	$74.69	$75.04	-2%	5%	0%	$73.18	$2.01	1.262	Up
99212	10	$91.76	$96.97	$94.66	$97.46	6%	-2%	3%	$95.21	$2.60	1.477	Up
99213	15	$139.93	$153.23	$138.33	$153.23	10%	-10%	11%	$146.18	$8.17	2.502	Up
99214	25	$211.85	$214.61	$204.19	$229.88	1%	-5%	13%	$215.13	$10.77	4.368	Up
99215	40	$253.92	$265.12	$269.17	$281.80	4%	2%	5%	$267.50	$11.51	8.767	Up
99354	60	$194.77	$197.14	$212.29	$243.83	1%	8%	15%	$212.01	$22.59	16.234	Up
99355	30	$200.18	$217.46	$200.46	$254.73	9%	-8%	27%	$218.21	$25.65	14.663	Up

Report Chart 9 - Average Maximum Allowable Reimbursement Rate for PMHNPs by Procedure Code and Year

Procedure		Average Maximum Reimbursement Rate by Year				Year-Over-Year Percentage Change			Trend Analysis, 2015-2018			
Procedure Code	Time (Minutes)	2015	2016	2017	2018	2015 → 2016	2016 → 2017	2017 → 2018	Mean (Average)	Standard Deviation of the Mean	Estimated Trend Line Slope (Least Squares Method)	General Trend Direction (Up/Down)
90832	30	$112.76	$113.42	$125.20	$128.53	1%	10%	3%	$119.98	$8.08	5.912	Up
90833	30	$105.71	$113.31	$117.33	$116.78	7%	4%	0%	$113.28	$5.35	3.725	Up
90834	45	$157.76	$174.49	$178.97	$180.34	11%	3%	1%	$172.89	$10.39	7.223	Up
90836	45	$142.10	$155.91	$164.05	$160.24	10%	5%	-2%	$155.57	$9.58	6.258	Up
90837	60	$215.72	$220.47	$219.70	$221.49	2%	0%	1%	$219.35	$2.52	1.654	Up
90838	60	$191.84	$193.95	$216.10	$208.44	1%	11%	-4%	$202.58	$11.65	7.194	Up
90839	30	$256.61	$256.79	$268.73	$269.88	0%	5%	0%	$263.00	$7.29	5.175	Up
90840	60	$115.55	$114.03	$116.02	$116.67	-1%	2%	1%	$115.57	$1.13	0.536	Up
90846	50	$184.61	$183.13	$191.15	$194.46	-1%	4%	2%	$188.34	$5.37	3.759	Up
90847	50	$193.34	$191.96	$218.60	$219.84	-1%	14%	1%	$205.94	$15.36	10.614	Up
90863	N/A	$78.90	$45.00	$30.00	$30.00	-43%	-33%	0%	$45.98	$23.06	(16.170)	Down
90875	30	$112.66	$112.67	$106.55	$108.57	0%	-5%	2%	$110.11	$3.06	(1.839)	Down
90876	45	$183.79	$186.04	$187.10	$189.92	1%	1%	2%	$186.71	$2.54	1.944	Up
96101	60	$150.79	$151.35	$151.42	$153.54	0%	0%	1%	$151.78	$1.21	0.833	Up
96102	60	$138.19	$136.87	$129.79	$129.46	-1%	-5%	0%	$133.58	$4.59	(3.326)	Down
96116	60	$180.98	$183.76	$184.53	$184.87	2%	0%	0%	$183.54	$1.77	1.245	Up
96118	60	$194.66	$197.70	$198.85	$199.46	2%	1%	0%	$197.67	$2.13	1.556	Up
96150	15	$38.82	$39.51	$44.43	$44.98	2%	12%	1%	$41.94	$3.22	2.338	Up
96151	15	$37.22	$37.82	$42.10	$42.76	2%	11%	2%	$39.97	$2.86	2.090	Up
96152	15	$35.45	$36.02	$39.85	$40.43	2%	11%	1%	$37.94	$2.56	1.877	Up
96153	15	$25.78	$25.80	$25.84	$25.87	0%	0%	0%	$25.83	$0.04	0.030	Up
96154	15	$36.01	$36.61	$41.35	$41.98	2%	13%	2%	$38.98	$3.11	2.266	Up
96155	15	$45.59	$46.39	$52.39	$53.09	2%	13%	1%	$49.36	$3.92	2.853	Up
99201	10	$88.29	$95.51	$105.29	$107.34	8%	10%	2%	$99.11	$8.87	6.694	Up
99202	20	$134.83	$138.63	$138.75	$139.86	3%	0%	1%	$138.02	$2.19	1.519	Up
99203	30	$178.48	$182.89	$183.82	$182.82	2%	1%	-1%	$182.00	$2.39	1.393	Up
99204	45	$283.47	$284.04	$291.27	$289.66	0%	3%	-1%	$287.11	$3.94	2.582	Up
99205	60	$343.10	$361.24	$354.74	$351.25	5%	-2%	-1%	$352.58	$7.56	1.794	Up
99211	5	$66.40	$68.76	$68.70	$70.73	4%	0%	3%	$68.65	$1.77	1.294	Up
99212	10	$81.98	$91.55	$95.10	$92.60	12%	4%	-3%	$90.31	$5.75	3.540	Up
99213	15	$128.67	$133.40	$144.86	$138.73	4%	9%	-4%	$136.41	$6.97	4.162	Up
99214	25	$184.10	$197.40	$210.72	$201.79	7%	7%	-4%	$198.50	$11.08	6.638	Up
99215	40	$244.24	$249.73	$259.70	$250.54	2%	4%	-4%	$251.05	$6.41	2.888	Up
99354	60	$182.26	$183.79	$198.62	$232.98	1%	8%	17%	$199.41	$23.56	16.700	Up
99355	30	$178.14	$204.75	$196.86	$179.73	15%	-4%	-9%	$189.87	$13.05	(0.312)	Down

Section B – Utilization Management Procedures

As noted above, SB 860, Section 1, Subsection (2)(b) addresses whether each carrier imposes utilization management procedures for behavioral mental health providers that are more restrictive than the utilization management procedures for medical providers as indicated by the time-based outpatient office visit procedural codes applied to providers in each category, including a review of whether a carrier restricts the use of longer office visits for behavioral mental health providers more than for medical providers. Although the review entailed an analysis of 11 carriers that collectively had 22 plans, each of the 11 carriers supplied utilization management requirements and information that did not vary by plan. As such, the analysis in this section was performed at a carrier level. The utilization management policies and procedures provided by the Carriers was reviewed in order to perform this analysis. In particular, the Carriers provided policies and procedures regarding prior authorization, retrospective review, concurrent review and outlier management requirements. Other information was also reviewed including the factors that the Carriers considered when designing utilization management requirements for BH Providers and Medical Providers.

In terms of utilization management procedures, during the Period of Review, 82% of the Carriers had a utilization review requirement in place relating to the procedure codes under review, such as prior authorization, retrospective review, concurrent review and outlier management. The details below address carriers that had such requirements.

In summary, the utilization management requirements for BH Providers were noted to be more restrictive than the requirements for Medical Providers. For example, the treatments and services requested by a BH Provider were subject to prior authorization requirements; however, Medical Providers were not subject to the same requirements. The following observations were noted:

- Regarding prior authorization requirements, 89% of the carriers had such requirements. For 63% of those carriers, such requirements only applied to BH Providers. Also, for 12% of the carriers with prior authorization requirements, the carrier applied the prior authorization requirements to both Medical Providers and BH Providers. For 25% of the carriers with prior authorization requirements, the carriers did not specify the provider types that were subject to the requirement.
- Regarding concurrent reviews, 56% of the carriers had concurrent review requirements. For 80% of those carriers, such requirements only applied to BH Providers. Also, for 20% of the carriers with prior authorization requirements, the carrier did not specify the provider types that were subject to the requirement.
- In terms of retrospective reviews, 56% of the carriers had retrospective review requirements. For 80% of those carriers, such requirements only applied to BH Providers. Also, for 20% of the carriers with retrospective review requirements, the carrier did not specify the provider types that were subject to the requirement.
- Regarding outlier management requirements, 56% of the carriers had outlier management requirements. For 80% of those carriers, such requirements only applied to BH Providers. Also, for 20% of the carriers with outlier management requirements, the carrier did not specify the provider types that were subject to the requirement.

As noted above, during the Period of Review, 82% of the Carriers had a utilization review requirement in place such as prior authorization, retrospective review, concurrent review and outlier management. As such,

information from these carriers regarding the factors considered when designing utilization management requirements for BH Providers and Medical Providers was reviewed. The following observations were noted:

- 33% of the carriers considered the same factors for BH Providers and Medical Providers when the utilization management requirements were designed.
- 33% of the carriers considered different factors for BH Providers and Medical Providers when the utilization management requirements were designed. In particular, the factors considered for BH Providers were more restrictive than those considered for Medical Providers. The additional factors that were considered for BH Providers' utilization management requirements included medical necessity requirements, service or treatment variation, high cost treatments and supply and demand.
- 22% of the carriers did not provide sufficient information that would facilitate analysis of the factors considered when designing utilization management requirements for Medical Providers.

Additional detailed information regarding each Carrier's utilization management program is located in Section B (Volume III) of this Report.

Section C - Time-based Procedure Code Maximum Allowable Reimbursement Rate Analysis

As noted earlier, SB 860, Section 1, Subsection (2)(c) addresses whether carriers had an equivalent maximum allowable reimbursement rate for time-based procedure codes, including the reimbursement of incremental increases in the length of an office visit by provider type. The analysis performed to meet the requirements of this Sub section included reviewing procedure code groupings, such as those for new patient and established patient evaluation and management (E&M) office visits and psychotherapy services, both individual psychotherapy and psychotherapy performed with E&M services. The analysis also entailed determining the percentage of increase in reimbursement by provider type as the length of an office visit increased within each procedure code grouping. Each procedure code within the procedure code grouping has an associated duration or length of time (in minutes) that starts with the lowest duration and sequentially increases. It was noted that in several instances, as the duration of the office visit increased, the rate stayed the same or decreased for the subsequent or longer duration procedure code compared to the shorter duration procedure code in the respective procedure code grouping. As explained further in Section C of this Report (Volume IV), these situations are referred to as a "blended" or a "decreasing" MARR, respectively. Not all carriers had blended or decreasing MARRs during the Period of Review, and the results varied not just by carrier, but by plan, year and provider type.

It was noted that the reimbursement of incremental increases in the length of an office visit were not the same for all provider types for most of the carriers. For new patient E&M services, during the Period of Review, the following observations were noted:

- 45% of all plans had blended or decreasing MARRs as the office visit duration increased.
- Furthermore, 23% of all plans exclusively reported blended or decreasing MARRs for BH Providers and/or MH Providers but not for Medical Providers.
- 14% of all plans exclusively reported blended or decreasing MARRs for Medical Providers, but not for BH Providers or MH Providers.
- During the Period of Review, specific to new patient E&M, 50% of all plans sequentially increased the MARRs as the duration of the visit increased during all years; however, 91% of those plans that had increasing MARRs had varying percentages of increase between BH Providers, Medical Providers, and MH Providers, with 63% of those plans having percentages of increase that varied by more than 10% across the provider types.

For established patient E&M services, the results were more varied than new patient E&M services. The following observations were noted:

- During the Period of Review, 68% of plans had blended or decreasing MARRs as the visit duration increased.
- Furthermore, 23% of all plans exclusively reported blended or decreasing MARRs for BH Providers and/or MH Providers but not for Medical Providers; as a comparison, 5% of all plans exclusively reported decreasing or blended MARRs for Medical Providers, but not for BH Providers or MH Providers.
- Specific to established patient E&M services, 27% of all plans sequentially increased the MARR as the duration of the visit increased during the Period of Review; however, 83% of those plans that had increasing MARRs had varying percentages of increase between BH Providers, Medical Providers,

and MH Providers, with 50% of those plans having percentages of increase that varied by more than 10% across the provider types.

Psychotherapy procedure code groupings were selected as another point of analysis as some of the Carriers did not report MARRs for BH Providers for E&M procedure codes. Some carriers did not report MARRs for Medical Providers for these procedure code groupings.

Regarding the psychotherapy procedure code grouping, the following observations were noted:

- 68% of all plans sequentially increased the MARRs as the duration of the office visit increased during all years.
- 24% of all plans reported blended and/or decreasing MARRs during the Period of Review.
- 5% of all plans reported an equivalent MARR between two procedure codes of different durations, meaning the rate was within 1% of the MARR for the preceding procedure code within that grouping.
- The results of the analysis were similar for psychotherapy performed with E&M services. 77% of all plans sequentially increased the MARR as the duration of the visit increased during all years, and 19% of all plans reported blended and/or decreasing MARRs during the Period of Review.

The results of the analysis indicate that incremental increases in the length of an office visit and the corresponding MARRs varied by provider type and procedure code grouping, and disproportionately affected BH Providers and/or MH Providers when compared to the results for Medical Providers. Therefore, in most instances and for most plans and carriers, there was not an equivalent maximum allowable reimbursement rate for all provider types for time-based procedure codes based on the reimbursement of incremental increases in the length of an office visit. Additional detailed information is in Section C in Volume IV.

Section D - Maximum Allowable Reimbursement Rate Methodology

As noted previously, SB 860, Subsection (2)(d) addresses whether the methodologies used by each carrier to determine the carrier's reimbursement rate schedule are equivalent for in-network behavioral health providers and in-network medical providers. The analysis performed to meet the requirements of Subsection (2)(d) included reviewing all 11 Carriers' policies, procedures, methodologies and equations for setting reimbursement rates for BH Providers and Medical Providers. For each provider type, detailed information was requested regarding how reimbursement methodologies were developed, calculated, and negotiated, including all of the factors considered, the standards considered (i.e., evidentiary standards) and how the Carriers operationalized the process for establishing reimbursement allowances.

All 11 carriers presented information on the reimbursement methods for each of the 22 unique plan designs, and the following observations were noted:

- In terms of Medical Provider reimbursement rates, 91% (all carriers except carrier 9) of all carriers noted that Provider reimbursement rates were set starting with the Centers for Medicare & Medicaid Services' Resource-Based Relative Value Scale (RBRVS) method of reimbursement as a foundation, with few exceptions, which establishes Relative Value Units (RVU) in consideration of physician work, practice expense, and malpractice insurance using a Geographic Practice Cost Index (GCPI). As explained below, some carriers also employed this methodology for BH Providers. In addition, carriers and their third party entities, where applicable, deviated from this practice and

applied other variables to the calculation such as conversions factors, weights and modifiers as explained below.

- 40% (carriers 1, 7, 8 and 10) of the carriers stated RBRVS was used equally for BH Providers and Medical Providers, with 75% (carriers 1, 7 and 10) of those carriers using a conversion factor with the established RVU, 25% (carrier 8) of those carriers assigning a fixed rate to the RVU.
- 20% (carriers 3 and 5) of the carriers stated RBRVS was used equally for BH Providers and Medical Providers; however, the carriers deviated for BH Providers with 50% (carrier 3) of those carriers basing BH Provider rates on a tiered percentage of Medical Providers' rates, and 50% (carrier 5) of those carriers setting BH Provider rates that were a lower percentage than Medical Provider rates.
- 40% (carriers 2, 4, 6 and 11) of all carriers used the CMS RBRVS for Medical Providers only, and BH Provider rates were internally developed. One of the carriers stated the reasons for not adopting RVU-based reimbursement for BH Providers were "continuity, fairness, and clinical value" and "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."

- Only one (carrier 9) carrier (9% of carriers) utilized internally developed standard fee schedules for BH Providers and Medical Providers. The reimbursement allowances for BH providers were a lower percentage of the Medical Provider rate.

In terms of the factors considered in setting reimbursement rates for BH Providers and Medical Providers, the following observations were made:

- 45% of all carriers considered the same factors when setting reimbursement rates for both BH Providers and Medical Providers. Some of the more common factors considered included market and industry trends, provider specialty, global and plan budgets, RVU and Medicare GPCI.
- Of the 55% of all Carriers that did not consider the same factors in setting reimbursement rates for BH Providers and Medical Providers, the following observations were made:
  - 18% of such carriers had the same factors, but had some additional factors for BH Providers such as the credentials of the provider, supply and demand, negotiation, and specialty.
  - 10% of such carriers had some of the same factors, but applied less factors for BH Providers compared to Medical Providers (i.e., the carrier only considered network need, geographic area and Medicare fee schedule benchmarks for BH Providers while other factors such as information from third parties including CMS and site of service information were considered for Medical Providers).
  - 27% of such carriers had factors for BH Providers that varied from Medical Providers, including consideration of third party publications, license and education levels, specialty, geographic location, purpose of codes and duration of services for BH Providers, but for Medical Providers, the only factors considered by two of those carriers were specialty and geographic location.

Additional information was requested regarding the MARR negotiation process. The following observations were made:

- The factors considered in negotiating MARRs were the same for both BH Providers and Medical Providers for 55% of all carriers.
- Of the 45% of all carriers who did not have the same factors considered in negotiating reimbursement rates for BH Providers and Medical Providers, the following observations were made:
    - 9% of such carriers considered factors such as supply and demand, specialty, geography and license and education for BH Providers, but factors such as line of business being served, historical claim performance, marketplace rates and competitiveness were also considered for Medical Providers.
    - 9% of such Carriers considered the same factors, but for Medical Providers, approval of all increases to standard MARRs were made by an "executive level manager", which varied from BH Providers, wherein increases to standard rates were approved by a "professional relations representative".
    - 9% of such Carriers considered the provider's credentials and specialty for both Medical Providers and BH Providers; however, for BH Providers only, an adjustment was made for the credentials or level of licensure.
    - 18% of such Carriers 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.

It was also noted that 27% of all carriers were utilizing historical rates established by a third party entity for BH Providers (this third party entity processes behavioral health-related transactions for the carriers, including the establishment of MARRs).

In some instances, Carriers did not respond completely to each of the requests in the Data Call and follow-up was required with all Carriers at some point during the review. Generally, Carriers did not have the information about the MARR setting process readily available for the Contractor to review and 18% of all Carriers did not have written policies and procedures regarding the MARR setting methodology and process during the Period of Review. In these instances, the Carriers were required to provide written descriptions of their MARR methodologies.

The results of the analysis performed to meet the requirements of Subsection (2)(d) indicate that the methodologies used by each carrier were not always equivalent for BH providers compared to Medical Providers, and for some carriers, additional information or factors were considered in the MARR setting and negotiation process for certain provider types. Detailed information regarding this analysis is in Section D (Volume V) of this Report.

Carrier Confidentiality

It is important to note that to protect the confidential reporting of the data of all 11 Carriers, each carrier and its respective health plan(s) were assigned a unique identifier. As a result, the information in this Report is presented by each carrier's assigned number and a unique plan identifier. In addition, it is important to know that a carriers' plan offerings and products may not have been available in each year of the Period of Review. Where applicable, such disclosure is made.

Procedure Codes Subject to Review

As noted above, the analysis in this Report is based upon the data provided by each carrier for the following 35 time-based procedure codes:

Procedure Codes	Definitions
	Psychotherapy Codes
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, use add-on code for individual psychotherapy, insight oriented, behavior modifying and/or supportive, 30 minutes with the patient and/or family member (time range 16-37 minutes), when performed with an evaluation and management service
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member, when performed with an evaluation and management service
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service
90839	Psychotherapy Crisis, 30 minutes + with patient
90840	Psychotherapy Crisis, 60 minutes with patient
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint therapy) (with the patient present), 50 minutes
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services, used only as add-on to primary psychotherapy code (90832, 90834, 90837)
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy), 30 minutes
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy), 45 minutes

Procedure Codes	Definitions
	Psychological Testing Codes
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, and WAIS®), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
	Health and Behavior Assessment Codes
96150	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient, initial assessment
96151	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient, reassessment
96152	Health and behavior intervention, each 15 minutes, face-to-face, individual
96153	Health and behavior intervention, each 15 minutes, face-to-face, group (2 or more patients)
96154	Health and behavior intervention, each 15 minutes, face-to-face family (with the patient present)
96155	Intervention - Family without patient, per 15 minutes

Procedure Codes	Definitions
	Evaluation and Management – New Patient
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Usually, the presenting problems are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Physicians typically spend 20 minutes face-to-face with the patient and/or family
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Physicians typically spend 30 minutes face-to-face with the patient and/or family
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Physicians typically spend 60 minutes face-to-face with the patient and/or family
	Evaluation and Management –Existing Patient
99211	Evaluation & management tips: Office or other outpatient services, established patient, 5 minutes (average)
99212	Evaluation & management tips: Office or other outpatient services, established patient, 10 minutes (average)
99213	Evaluation & management tips: Office or other outpatient services, established patient, 15 minutes (average)
99214	Evaluation & management tips: Office or other outpatient services, established patient, 25 minutes (average)

Procedure Codes	Definitions
99215	Evaluation & management tips: Office or other outpatient services, established patient, 40 minutes (average)
	Prolonged Office Visits
99354	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service, first hour (list separately in addition to code for office or other outpatient evaluation and management service)
99355	Each additional 30 minutes (list separately in addition to code for prolonged physician service) (use 99355 in conjunction with 99354)

Carrier Plans and Markets

As noted above, as part of the Data Call, the Carriers were required to provide the MARR for each provider type and for each procedure code per each plan type available in Oregon during the Period of Review. During the Period of Review, the Carriers had 22 plan types available in Oregon. The chart below illustrates the carrier identification number, the number of plan types by carrier, and the plan identification code references used throughout this Report:

Carrier ID	Number of Plan Types	Plan IDs
Carrier 1	3	A, B, and C
Carrier 2	6	D, E, F, G, H and I
Carrier 3	1	J
Carrier 4	1	K
Carrier 5	4	L, M, N and O
Carrier 6	1	P
Carrier 7	2	Q and R
Carrier 8	1	S
Carrier 9	1	T
Carrier 10	1	U
Carrier 11	1	V

In the Data Call, as noted above, each carrier was requested to provide the number of members in commercial health benefit plans issued in Oregon, defined as the total number of members for each plan type available during the Period of Review, not the number of primary insureds. The Data Call also requested

the number of Medical Providers, BH Providers and MH Providers available to Oregon plan members. Charts pertaining to this information and analysis are presented below in Report Charts 10 to 14.

Each of the 11 carriers provided the number of members in commercial health benefit plans[4] and the number of Medical Providers, BH Providers and MH Providers available to Oregon plan members. In some instances, the analysis of the ratio of members to each provider type produced significant ratios or a percentage of providers to members in excess of 100%. For example, in 2015, carrier 11 had 492 members in commercial plans and 13,481 Medical Providers available to Oregon plan members, or a ratio of 27.4 Medical Providers to every member (i.e., percentage of Medical Providers to membership is 2740%). This situation may result for several reasons, some of which are listed below:

(1) The carrier may have a leased network with a large provider organization where the number of providers are much greater than the number of carrier members.
(2) The carrier may have contracted with the network of another larger carrier.
(3) The carrier may be part of an affiliated group wherein providers are contracted to provide services to members across more than one affiliate in the group.

In 2015, there were approximately 1.4 million members in commercial plans among the 11 Carriers. The plans included 263,347 Medical Providers, 40,570 BH Providers and 9,371 MH Providers with prescribing privileges. Medical Providers as a percentage of membership in commercial plans ranged from 5.2% to 2740%, BH Providers as a percentage of membership ranged from 1.2% to 408.7% and MH Providers with prescribing privileges ranged from <0.1% to 95.3%. In total for 2015, Medical Providers as a percentage of membership were 19.1%, BH Providers were 2.9% and MH Providers were 0.7%. However, it should be noted that providers may participate in multiple networks. As such, the provider counts reflected here and in the following paragraphs for each year may include the same provider multiple times to the extent the provider participates in more than one network.

In 2016, there were approximately 1.7 million members in commercial plans among the 11 Carriers. The plans included 274,675 Medical Providers, 43,285 BH Providers and 9,806 MH Providers with prescribing privileges. Medical Providers as a percentage of membership in commercial plans ranged from 4.3% to 3,440.1%, BH providers as a percentage of membership in commercial plans ranged from 0.6% to 517.5% and MH Providers with prescribing privileges ranged from 0.1% to 117.3%. In total for 2016, Medical Providers as percentage of membership were 16.2%, BH Providers were 2.5% and MH Providers were 0.6%.

In 2017, there were approximately 1.8 million members in commercial plans among the 11 Carriers. The plans included 281,440 Medical Providers, 46,978 BH Providers and 11,091 MH Providers with prescribing privileges. Medical Providers as a percentage of membership in commercial plans ranged from 4.8% to 3,978.8%, BH Providers as a percentage of membership in commercial plans ranged from 0.7% to 680.7% and MH Providers with prescribing privileges ranged from <0.1% to 162.2%. In total for 2017, Medical Providers as percentage of membership were 15.4%, BH Providers were 2.6% and MH Providers were 0.6%.

[4] The division is aware of differences between the commercial health plan membership recorded by the Division of Financial Regulation's (DFR) each quarter and the commercial health plan membership reported to RRC for the examination period. The division recognizes that there are a number of legitimate reasons for these differences and will be working with each insurer to define each as appropriate. However, despite differences in the reported commercial health plan membership (between the division's existing membership data and RRC's data call), both RRC and the division agree that these membership differences are not an influential factor in the findings of SB 860

For 2018, for providers, Carriers were requested to report providers who are available to fully insured, commercial Oregon–situsedplans as of June 30, 2018, and for members, to report the cumulative total as of June 30, 2018. Based on this data, there were approximately 1.8 million members in 22 commercial plans among the 11 Carriers. The 22 plans included 286,660 Medical Providers, 47,871 BH Providers and 10,589 MH Providers with prescribing privileges. Medical Providers as a percentage of membership in commercial plans ranged from 5.1% to 4,903.5%, BH Providers as a percentage of membership in commercial plans ranged from 0.6% to 840.4%, and MH Providers with prescribing privileges ranged from <0.1% to 188.1%. In total for 2018, Medical Providers as percentage of membership were 16.3%, BH Providers were 2.7% and MH Providers were 0.6%.

Trending Analysis Summary

Relative to total membership, the Carriers' data illustrates that the number of members in commercial plans in Oregon increased/decreased in each year during the Period of Review as follows: increased by 23.5% from 2015 to 2016, increased by 7.4% from 2016 to 2017, and decreased by 3.4% from 2017 to 2018. The data further illustrates that the total number of Medical Providers participating in the 22 plans increased by 4.3% from 2015 to 2016, 2.5% from 2016 to 2017, and 1.9% from 2017 to 2018. The total number of BH Providers participating in the 22 plans increased by 6.7% from 2015 to 2016, 8.5% from 2016 to 2017, and 1.9% from 2017 to 2018. The total number of MH Providers participating in the 22 plans increased by 4.6% from 2015 to 2016, 13.1% from 2016 to 2017, and decreased by 4.5% from 2017 to 2018. Report Charts 10-13 below illustrates the Carriers' number of members and providers by year per carrier and Report Chart 5 illustrates the number of members and providers by carrier per year during the Period of Review.

Report Chart 10: Members and Provider Counts in Commercial Plans – 2015

Year / Carrier	Members in Commercial Plans	Medical Providers	Medical Providers as a % of Members	Behavioral Mental Health Providers	Behavioral Mental Health Providers as a % of Members	Mental Health Providers with Prescribing Privileges	Mental Health Providers with Prescribing Privileges as a % of Members
2015							
Carrier 1	384,493	17,716	4.6%	2,057	0.5%	1,132	0.3%
Carrier 2	159,964	10,172	6.4%	3,213	2.0%	877	0.5%
Carrier 3	425,925	144,200	33.9%	19,322	4.5%	3,130	0.7%
Carrier 4	297,862	15,492	5.2%	4,757	1.6%	601	0.2%
Carrier 5	113,087	9,273	8.2%	2,407	2.1%	587	0.5%
Carrier 6	33,853	13,481	39.8%	2,011	5.9%	469	1.4%
Carrier 7	40,084	11,208	28.0%	1,298	3.2%	143	0.4%
Carrier 8	96,700	17,462	18.1%	1,186	1.2%	75	< 0.1%
Carrier 9	154,060	9,278	6.0%	2,017	1.3%	1,750	1.1%
Carrier 10	998	1,584	158.7%	291	29.2%	138	13.8%
Carrier 11	492	13,481	2740.0%	2,011	408.7%	469	95.3%

Report Chart 11: Members and Provider Counts in Commercial Plans – 2016

Year / Carrier	Members in Commercial Plans	Medical Providers	Medical Providers as a % of Members	Behavioral Mental Health Providers	Behavioral Mental Health Providers as a % of Members	Mental Health Providers with Prescribing Privileges	Mental Health Providers with Prescribing Privileges as a % of Members
2016							
Carrier 1	399,359	19,935	5.0%	2,573	0.6%	1,367	0.3%
Carrier 2	261,727	11,373	4.3%	2,246	0.9%	509	0.2%
Carrier 3	440,774	147,089	33.4%	20,704	4.7%	3,259	0.7%
Carrier 4	246,985	15,613	6.3%	4,893	2.0%	613	0.2%
Carrier 5	109,525	9,421	8.6%	2,779	2.5%	629	0.6%
Carrier 6	40,162	14,930	37.2%	2,246	5.6%	509	1.3%
Carrier 7	39,771	12,234	30.8%	1,558	3.9%	163	0.4%
Carrier 8	88,013	18,247	20.7%	1,360	1.5%	94	0.1%
Carrier 9	67,679	9,644	14.2%	2,299	3.4%	1,993	2.9%
Carrier 10	4,397	1,259	28.6%	381	8.7%	161	3.7%
Carrier 11	434	14,930	3440.1%	2,246	517.5%	509	117.3%

Chart 12: Members and Provider Counts in Commercial Plans - 2017

Year / Carrier	Members in Commercial Plans	Medical Providers	Medical Providers as a % of Members	Behavioral Mental Health Providers	Behavioral Mental Health Providers as a % of Members	Mental Health Providers with Prescribing Privileges	Mental Health Providers with Prescribing Privileges as a % of Members
2017							
Carrier 1	425,975	23,184	5.4%	2,997	0.7%	1,667	0.4%
Carrier 2	262,488	12,530	4.8%	2,765	1.1%	657	0.3%
Carrier 3	469,217	145,210	30.9%	21,316	4.5%	3,424	0.7%
Carrier 4	187,435	16,002	8.5%	5,141	2.7%	654	0.3%
Carrier 5	114,801	9,709	8.5%	3,063	2.7%	716	0.6%
Carrier 6	49,103	16,114	32.8%	2,757	5.6%	657	1.3%
Carrier 7	38,844	12,842	33.1%	1,749	4.5%	156	0.4%
Carrier 8	196,612	18,480	9.4%	1,622	0.8%	99	< 0.1%
Carrier 9	72,136	9,919	13.8%	2,377	3.3%	2,227	3.1%
Carrier 10	6,833	1,336	19.6%	434	6.4%	177	2.6%
Carrier 11	405	16,114	3978.8%	2,757	680.7%	657	162.2%

Report Chart 13: Members and Provider Counts in Commercial Plans – 2018

Year / Carrier	Members in Commercial Plans	Medical Providers	Medical Providers as a % of Members	Behavioral Mental Health Providers	Behavioral Mental Health Providers as a % of Members	Mental Health Providers with Prescribing Privileges	Mental Health Providers with Prescribing Privileges as a % of Members
2018							
Carrier 1	404,548	20,560	5.1%	2,547	0.6%	1,354	0.3%
Carrier 2	246,396	13,174	5.3%	2,839	1.2%	637	0.3%
Carrier 3	460,817	150,454	32.6%	22,090	4.8%	3,118	0.7%
Carrier 4	177,858	16,040	9.0%	4,579	2.6%	555	0.3%
Carrier 5	102,686	9,641	9.4%	3,300	3.2%	732	0.7%
Carrier 6	52,240	16,868	32.3%	2,891	5.5%	647	1.2%
Carrier 7	26,218	13,485	51.4%	1,768	6.7%	136	0.5%
Carrier 8	251,538	17,803	7.1%	1,874	0.7%	124	< 0.1%
Carrier 9	31,652	10,307	32.6%	2,623	8.3%	2,441	7.7%
Carrier 10	6,695	1,460	21.8%	469	7.0%	198	3.0%
Carrier 11	344	16,868	4903.5%	2,891	840.4%	647	188.1%

Note – the 2018 membership data is the cumulative total as of June 30, 2018.

The following chart, Report Chart 14, is by carrier and presents member and provider counts over the Period of Review. This information reflects, by carrier, the annual change in membership as well as the annual change in the number and percentage of each provider type as a percentage of membership in commercial plans from year to year during the Period of Review. As previously noted, providers may participate in multiple networks. As such, the provider counts reflected in this Report for each year may include the same provider multiple times to the extent the provider participates in more than one network.

Report Chart 14: Member and Provider Counts by Carrier and Year

Carrier / Year	Members in Commercial Plans	Medical Providers	Medical Providers as a % of Members in Commercial Plans	Behavioral Mental Health Providers	Behavioral Mental Health Providers as a % of Members in Commercial Plans	Mental Health Providers with Prescribing Privileges	Mental Health Providers with Prescribing Privileges as a % of Members in Commercial Plans
Carrier 1							
2015	52,693	17,716	33.6%	2,057	3.9%	1,132	2.1%
2016	399,359	19,935	5.0%	2,573	0.6%	1,367	0.3%
2017	425,975	23,184	5.4%	2,997	0.7%	1,667	0.4%
2018	404,548	20,560	5.1%	2,547	0.6%	1,354	0.3%
Carrier 2							
2015	159,964	10,172	6.4%	3,213	2.0%	877	0.5%
2016	261,727	11,373	4.3%	2,246	0.9%	509	0.2%
2017	262,488	12,530	4.8%	2,765	1.1%	657	0.3%
2018	246,396	13,174	5.3%	2,839	1.2%	637	0.3%
Carrier 3							
2015	425,925	144,200	33.9%	19,322	4.5%	3,130	0.7%
2016	440,774	147,089	33.4%	20,704	4.7%	3,259	0.7%
2017	469,217	145,210	30.9%	21,316	4.5%	3,424	0.7%
2018	460,817	150,454	32.6%	22,090	4.8%	3,118	0.7%
Carrier 4							
2015	297,862	15,492	5.2%	4,757	1.6%	601	0.2%
2016	246,985	15,613	6.3%	4,893	2.0%	613	0.2%
2017	187,435	16,002	8.5%	5,141	2.7%	654	0.3%
2018	177,858	16,040	9.0%	4,579	2.6%	555	0.3%
Carrier 5							
2015	113,087	9,273	8.2%	2,407	2.1%	587	0.5%
2016	109,525	9,421	8.6%	2,779	2.5%	629	0.6%
2017	114,801	9,709	8.5%	3,063	2.7%	716	0.6%
2018	102,686	9,641	9.4%	3,300	3.2%	732	0.7%
Carrier 6							
2015	33,853	13,481	39.8%	2,011	5.9%	469	1.4%
2016	40,162	14,930	37.2%	2,246	5.6%	509	1.3%
2017	49,103	16,114	32.8%	2,757	5.6%	657	1.3%
2018	52,240	16,868	32.3%	2,891	5.5%	647	1.2%

Report Chart 14: Member and Provider Counts by Carrier and Year (continued)

Carrier / Year	Members in Commercial Plans	Medical Providers	Medical Providers as a % of Members in Commercial Plans	Behavioral Mental Health Providers	Behavioral Mental Health Providers as a % of Members in Commercial Plans	Mental Health Providers with Prescribing Privileges	Mental Health Providers with Prescribing Privileges as a % of Members in Commercial Plans
Carrier 7							
2015	40,084	11,208	21.3%	1,298	2.5%	143	0.3%
2016	39,771	12,234	3.1%	1,558	0.4%	163	< 0.1%
2017	38,844	12,842	3.0%	1,749	0.4%	156	< 0.1%
2018	26,218	13,485	3.3%	1,768	0.4%	136	< 0.1%
Carrier 8							
2015	96,700	17,462	10.9%	1,186	0.7%	75	< 0.1%
2016	88,013	18,247	7.0%	1,360	0.5%	94	< 0.1%
2017	196,612	18,480	7.0%	1,622	0.6%	99	< 0.1%
2018	251,538	17,803	7.2%	1,874	0.8%	124	< 0.1%
Carrier 9							
2015	154,060	9,278	2.2%	2,017	0.5%	1,750	0.4%
2016	67,679	9,644	2.2%	2,299	0.5%	1,993	0.5%
2017	72,136	9,919	2.1%	2,377	0.5%	2,227	0.5%
2018	31,652	10,307	2.2%	2,623	0.6%	2,441	0.5%
Carrier 10							
2015	998	1,584	< 0.1%	291	< 0.1%	138	< 0.1%
2016	4,397	1,259	< 0.1%	381	< 0.1%	161	< 0.1%
2017	6,833	1,336	< 0.1%	434	< 0.1%	177	< 0.1%
2018	6,695	1,460	0.1%	469	< 0.1%	198	< 0.1%
Carrier 11							
2015	492	13,481	11.9%	2,011	1.8%	469	0.4%
2016	434	14,930	13.6%	2,246	2.1%	509	0.5%
2017	405	16,114	14.0%	2,757	2.4%	657	0.6%
2018	344	16,868	16.4%	2,891	2.8%	647	0.6%

Note – the 2018 membership data is the cumulative total as of June 30, 2018.

Glossary of Terms and Acronyms

Listing of Acronyms

- BH Provider – Behavioral Mental Health Provider
- CMS – Centers for Medicare & Medicaid Services
- CPT – Current Procedural Terminology
- DCBS – Department of Consumer and Business Services
- DFR -- Division of Financial Regulation
- DO – Doctor of Osteopathic Medicine
- E&M – Evaluation and Management
- HHS – U.S. Department of Health and Human Services
- LCSW – Licensed Clinical Social Worker
- LPC – Licensed Professional Counselor
- LMFT – Licensed Professional Counselor or Marriage Family Therapist
- MARR – Maximum Allowable Reimbursement Rate
- MD – Doctor of Medicine
- MH Provider – Mental Health Providers with Prescribing Privileges
- NP – Certified Nurse Practitioner
- OAR – Oregon Administrative Rules
- ORS – Oregon Revised Statutes
- PMHNP – Certified Psychiatric and Mental Health Nurse Practitioner
- RBRVS – Resource-Based Relative Value System
- RVU – Relative Value Units
- SB 860 – Enrolled Senate Bill 860
- UM – Utilization management

Glossary of Terms

Behavioral Mental Health Providers – Includes Psychologists, LCSWs, LPCs and LMFTs. The term "behavioral health" refers to both mental health and substance use disorder treatment, so the descriptions "behavioral mental health providers" and "behavioral health providers," are equivalent in their meaning. This term is referred to throughout the report as BH Providers.

Blended MARR – An equivalent reimbursement level for two different procedure codes within the same procedure grouping but with different durations of time, e.g., a provider who spends 45 minutes with a patient is reimbursed at the same rate as spending 60 minutes with the patient.

Carriers – The term used when referring to all 11 of the health insurance providers collectively that are the subject of the data call and analysis.

Centers for Medicare & Medicaid Services – The agency within HHS that administers the nation's major health care programs.

Contracted Providers – Providers who are appropriately state licensed (including states other than Oregon) to practice within a fully-insured commercial Oregon-sitused plan network offering services to Oregon residents.

Contractor – The regulatory consulting firm, Risk & Regulatory Consulting, LLC, retained by the Department to conduct the data call and data analysis.

Current Procedural Terminology – Codes and terminology under the American Medical Association's Current Procedural Terminology (CPT® 2018), Edition Revised, 2018, for billing by medical providers.

Data Call -- The request to carriers for the purpose of collecting and analyzing information and data to address the requirements of SB 860.

Decreasing MARR – A lower incremental MARR for longer patient treatment or visit times within a procedure code grouping.

Oregon Department of Consumer and Business Services -- The agency referenced in Section 2 of Senate Bill 860 that shall examine Subsections 2(a) through (d).

Equivalent MARR – MARRs within 1% of the reimbursement between two or more provider types.

Maximum Allowable Reimbursement Rate – The highest rate contracted with any provider and/or on any fee schedule, per plan design, that the carrier pays to in-network providers offering time-based outpatient office visits/services. This rate is not based on actual claims paid or claim-specific allowable reimbursement, but what the carrier is contracted to reimburse before any considerations of other claim lines or services, code-edits or bundling of services into one case rate reimbursement, etc.

Medical Provider – Includes MDs and DOs.

Mental Health Provider with Prescribing Privileges – Includes Psychiatrist, NPs, and PMHNPs. This term is referred to throughout this Report as MH Providers

Outlier Management – Outlier management is a utilization management process in which a carrier controls or handles exceptions or variations which may include but is not limited to claims submitted over a certain dollar threshold, number or type of services received, or other consideration due to an unusual variation from other similar circumstances.

Period of Review – The period under review. The data call requested data and information from carriers covering the period from January 1, 2015 through June 30, 2018.

Plan Design/Plan Type – Networks/plans that have a unique reimbursement consideration.

Plans – A term used when referring to all 22 plans collectively that are the subject of this review.

Procedure Grouping – Homogenous procedure codes and the associated incremental length of visit. The procedure code groups are as follows: 1) New Patient Evaluation and Management (E&M) codes 99201 through 99205; 2) Established Patient E&M codes 99211 through 99215; 3) Psychotherapy codes 90832, 90834 and 90837; and 4) Psychotherapy with E&M codes 90833, 90836 and 90838.

Resource-Based Relative Value System – The physician payment system used by CMS. The RBRVS is based on the principle that payments for physician services should vary with the resource costs for providing those services and is intended to improve and stabilize the payment system while providing physicians an avenue to continuously improve it.

Relative Value Units – A standard set by Medicare to determine the amount to pay doctors depending on their productivity. It is a number that defines the volume of work doctors perform when treating patients for all procedures and services covered under the Physician Fee Schedule.

Report – Refers to the Contractor's report to the Division, Department and Committee on Health Care of the Oregon Legislative Assembly.

Same MARR - MARRs that are the same or identical reimbursement rates between two or more provider types.

Third Party Entity - An entity, which may be affiliated or unaffiliated, that the carrier may have contracted with to perform certain business functions on its behalf. For example, some of the carriers contracted with an entity to perform behavioral health functions such as establishing and maintaining a network of providers including associated rate reimbursements, and process behavioral health claims.