Status Report on Examinations of Insurers' Reimbursement of Mental Health Providers

As required by 2017 Senate Bill 860

Senate Bill 860 (2017) status report

Executive Summary

SB 860 required DCBS to conduct examination of insurers in four areas:

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

- Whether each insurer 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 an insurer restricts the use of longer office visits for behavioral mental health providers more than for medical providers.

- Whether each insurer 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.

- Whether the methodologies used by each insurer to determine the insurer's reimbursement rate schedule are equivalent for in-network behavioral health providers and in-network medical providers.

Section 2 of SB 860 requires DCBS to report to the interim committees of the Legislative Assembly related to health the status of the department's examination in accordance with section 1 no later than Sept. 1, 2019.

The preliminary findings below are those developed from initial analysis of five of the 11 insurers to be examined. More trend analysis and validation work remains, this progress report provides a glimpse of the kind of trends that are emerging from the data. A complete picture will emerge once DCBS and its vendor completes review of the remaining six insurers and a deeper dive of data can shed light on the underlying reasons behind the initial findings. Certainly, DCBS believes it would be inappropriate to draw conclusions about the state of mental health parity from this status document.

Preliminary Findings:

- In terms of setting reimbursements, with few exceptions, each of the subset of insurers examined started setting rates by applying the Centers for Medicare and Medicaid Services prescribed Resource-Based Relative Value Scale (RBRVS) method of

reimbursement. However, the insurers and third-party administrator's part of the initial findings tended to deviate from this accepted standard in more than one area.

- First, the initial findings examined the difference between reimbursement for physical health providers and behavioral health providers with prescribing privileges in the area of evaluation and management office visits. At least two of the five insurers or third-party administrators in the initial findings appear to be reimbursing these two groups of providers at different rates. Two other insurers or third-party administrators, however, did not appear to vary reimbursement for evaluation and management office visits.

- Next, in terms of the duration of office visits, the initial findings appear to show that in some circumstances, as the length of the outpatient office visit increases, medical provider rates increase to a much greater degree than the rates for in-network behavioral mental health providers and in-network mental health providers with prescribing privileges. At least one insurer or third-party administrator did not reimburse for the shortest of office visits for evaluation and management services, while other insurers or third party administrators did not appear to allow reimbursements for long office visits.

- Also, the initial findings also show a disconnect in some instances between the rate of increase over time for reimbursements between physical health providers and behavioral health providers with prescribing privileges. The data from the preliminary examination report to DCBS seems to indicate that that from year to year, in-network outpatient medical provider rates increase to a much greater degree than the rates for in-network outpatient behavioral mental health providers and in-network outpatient mental health providers with prescribing privileges. However, in other instances, insurers or third-party administrators appear to be consistently increasing reimbursements in step with medical providers.

- Finally, some insurers' or third-party administrators' utilization management procedures for behavioral mental health providers and mental health providers with prescribing privileges appear to be different than those for medical providers. For example, in the area of authorizing long-duration office visits,[1] at least one carrier or third-party administrator appeared to require prior approval before treatment could begin.[2] Another carrier or third-party administrator required prior authorization for a particular reimbursable service.[3]

[1] Denoted under CPT code 90837.
[2] Data available to DCBS. One carrier ended the practice in 2016.
[3] Family psychotherapist services, CPT codes 90846 and 90847.