OREGON INDEPENDENT MENTAL HEALTH PROFESSIONALS

To: Cassandra Soucy & HB 3046 RAC Members

From: Melissa Todd, Ph.D., representing OIMHP on HB 3046 RAC

Date: September 28, 2021

Re: Comments on HB 3046 Section 2 draft rules (9/22/21)

Please accept OIMHP's comments on the 9/22/21 draft rules for HB 3046 Section 2 reporting requirements, as well as points discussed during RAC Meeting #3.

**Definitions for behavioral health reporting**

**(1)(b) "Incentive payment":** This definition creates some confusion in stating that incentive payments "may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee." OIMHP questions whether this wording allows for the possibility that incentive payments also *may not* have the effect of reducing or limiting services, and would like to see this clarified. We intended incentive payments to reflect the additional financial reward a provider can earn for delivering extra services or performance beyond the typical time-based office visit CPT code descriptor. Please refer to our 9/8/21 memo for more discussion of our position on incentive payments. We intuit that providers who are eligible to receive such financial rewards are doing the opposite of "reducing or limiting the services provided to any plan enrollee." However, we can also conceive of a scenario where an incentive payment is offered for value-based care that over time may reduce the services provided if a plan enrollee's overall health is improved. The definition could perhaps be revised by replacing "may" with "may or may not." Note that the word "limiting" has a negative connotation when it comes to healthcare delivery and may be worth discussing further. We agree with the suggestion to replace "physician" with "provider" to be inclusive of non-physician providers.

**"Median maximum allowable reimbursement rate" (MMARR):** Given that the MMARR metric is proving to be an integral component of the rulemaking process, we propose that a definition be included in this section for reference and clarification. We note that the definition of "geographic region" included in the draft rules is different than the definition offered in Section 2 of HB 3046. We may want to take the same opportunity with MMARR.

**Form and manner for behavioral health benefit reporting**

**(3)(b)(iii)(1-3):** OIMHP supports the revisions to this section as written in the 9/22/21 draft rules discussed during RAC Meeting #3. Our 9/16/21 memo makes clear our position that using *only* incurred claims data to calculate MMARR for time-based office visit CPT codes is problematic for the reasons outlined. We thus support calculating MMARR from provider contracted rates data alone, or from *both* incurred claims data and contracted rates data as the most complete manner of determining whether a carrier's willingness to invest in MH and medical services is in parity. Access to both types of MMARR data may also allow DCBS to examine how a carrier's investment in MH and medical services is associated with provider network size and service utilization.

A concern was raised during the meeting that including contracted reimbursement rate information by providers who may never submit a claim could skew the interpretation of the data. We argue that the risk of skewing the data also exists when reimbursement rate information is excluded; the omission of rate data from providers who are in-network, but not billing for services, would make the picture incomplete. *The obvious and most transparent solution to this dilemma is to include all possible sources of data.*

To determine whether carriers are treating MH and medical/surgical in parity, OIMHP advocates for the following comparisons of MMARR: (1) trends in time-based office reimbursement rates over time, year-by-year, (2) relative increases in reimbursement amounts for office visits of increasing duration, and (3) reimbursement rates in comparison to Medicare allowed amounts by provider type. While the third comparison is specified as a reporting requirement in HB 3046 (Section 2(3)(i)), the first and second comparisons may need to be codified in rule.

**(3)(b)(iv):** This section may need clarification. It is unclear whether "median rate" is referring to Medicare rates, as stated just below in (3)(b)(iv)(2). We also question whether "median rate" in relation to Medicare rates by geographic region is applicable; whether Medicare rates are uniform within a geographic region or if they are variable and therefore need a metric of central tendency.

**(3)(b)(iv)(1):** We support the suggestion that language be added to this section consistent with earlier language in the draft rules that reference CPT billing codes "as identified on the department's website."

**(3)(b)(iv)(2):** The wording in this section may need revision. We suggest, "calculation of the percentage of the Medicare rate *of* reimbursement…" We also question whether "median Medicare rate" is applicable, as explained above. In addition, it may be clarifying to add to the end of this section, "for each geographic region," to be consistent with (3)(b)(iv).

**(3)(b)(vi):** OIMHP supports the addition of this section to the draft rules, which specifies more clearly the requirements for carriers to report on network adequacy and reimbursement methodology for MH and medical/surgical.

This concludes OIMHP's comments on the 9/22/21 draft rules and the points discussed during RAC Meeting #3. However, we want to acknowledge that some RAC members presented written feedback on subsequent sections of the bill; we are reserving our responses for later RAC meetings when the respective sections are addressed and we look forward to a robust discussion.

Thank you for the opportunity to provide comment on the draft rules for HB 3046 reporting.