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June 10, 2022

Attn: Brooke Hall
RE: Comments on proposed OAR 836-053-1404 and OAR 836-053-1405

Thank you for the opportunity to submit comments on the proposed rules meant to provide clarity on the services covered underneath mental health parity and to specify requirements for the use of nonquantitative treatment limits under House Bill 3046 (2021).

Health Net Health Plan of Oregon, Inc. (HNOR) HNOR provides diverse health care services for Oregonians through commercial group and Medicare Advantage plans and is committed to ensuring every person – regardless of age, income, employment status, and current state of health – can access the health care they deserve. HNOR's comments on the proposed OAR 836-053-1404 and OAR 836-053-1405 are outlined below.

OAR 836-053-1404

Section 1b: "'Behavioral Health Condition' means any mental or substance use disorder covered by diagnostic categories listed in the current version of the 'Diagnostic and Statistical Manual of Mental Disorders' or the 'International Classification of Diseases.'"

Comment: Further clarification is needed to specify if Intellectual and Developmental Disabilities (IDD) are included. For example, Chapter 5 of the ICD-10 covers "Mental, Behavioral, and Neurodevelopmental Disorders." This title suggests that the scope of the chapter is broader than mental and behavioral conditions only. Subchapters that address conditions other than mental health and substance use disorders include disorders due to known physiological conditions, intellectual disabilities, and pervasive and specific developmental disorders. Please consider providing further clarity to the state's intended scope for this definition.

OAR 836-053-1405

General Requirements for Coverage of Behavioral Health Conditions

*Section 2: "*A group health insurer must use the same methodology to set reimbursement rates paid to behavioral health treatment providers that the insurer uses to set reimbursement rates for medical and surgical treatment providers. The methodology and rates used for behavioral health treatment providers must be updated in a manner equivalent to updating the methodology and rates for medical and surgical treatment providers, unless otherwise required by law".

Section 3: "A group health insurance policy or an individual health benefit plan issued or renewed in this state must update the methodology and rates for reimbursing behavioral health treatment providers in a manner equivalent to the manner in which the group health insurer or issuer of an individual health benefit plan updates the methodology and rates for reimbursing medical and surgical treatment providers, unless otherwise required by federal law."

Comment: We are concerned that there is currently not a model or clear guidance for how to document that the insurer uses "the same methodology" to set and update reimbursement rates for behavioral health and medical and surgical providers. To date, no federal or state regulator has formally recognized a single comparative analysis as adequately demonstrating that the strategies and processes for developing and updating a diverse range of reimbursement methodologies and negotiating specific provider rates for behavioral health providers are "the same" or even "comparable and no more stringent" relative to medical/surgical providers. If the analysis is framed at a high enough level of generality, the methodology will always be "the same" across all providers, while if the analysis is framed at a granular enough level of detail, the methodology will always be "different" for all providers. Moreover, there is literally no end to the range and volume of details that could conceivably be addressed in such an analysis. Therefore, guidance is needed to provide clarity regarding the State's expectations with regard to how to frame the analysis and which specific details must be addressed.

We understand that federal regulators are currently working on guidance that may or may not help to illuminate these requirements. The state could wait and align with federal enforcement, as those proposed rules are scheduled to be published in the summer 2022. Alternatively, if Oregon wants to lead on parity policy and enforcement, we recommend that a formal work group be used to develop a model analysis of the process to determine the same methodology for reimbursement rate setting. We are not advocating either path, but rather are in favor of choosing a path in order to provide clarity and a process that can be followed.

Section 4f: "The coverage of behavioral health treatment may not limit coverage for treatment of pervasive or chronic behavioral health conditions to short-term or acute behavioral health treatment at any level of care of placement."

Comment: We are asking for further clarification of this requirement. the terms "any level of care of placement." Are there quantitative limits? Is Utilization Management prohibited? What scope of utilization management is permitted? Does this provision mean, for example, that long-term residential treatment must be covered in acute care hospital settings?

Section 4g: "The coverage of behavioral health treatment must include clinically indicated outpatient coverage including follow-up in-home services or other outpatient services. The policy may limit coverage only if clinically indicated under any medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge."

Comment: We request more clarity on the meaning of the phrase "other outpatient services." Specifically, the intended scope of that coverage. Is coverage for any outpatient service of any kind sufficient to satisfy this requirement? Or does this provision require coverage for all outpatient services that are clinically indicated for the individual and not experimental or investigational?

*Section 12: "*A group health insurer or issuer of an individual health benefit plan other than a grandfathered health plan may not require providers to bill using a specific billing code or to restrict the reimbursement paid for particular billing codes other than on the basis of medical necessity."

Comment: We request further clarity on the wording of this section. Does this prohibit all coding edits, including those applied pursuant to NCCI and related strategies (e.g. based on impossibility, such as a claim for more than 24 hours of service in a day)?