From: Baker, Jennifer R <Jennifer.Baker2@providence.org>
Sent: Friday, December 3, 2021 3:00 PM
To: SOUCY Cassandra * DCBS <Cassandra.SOUCY@dcbs.oregon.gov>
Cc: Adair, Randy S <randy.adair@providence.org>
Subject: Providence Comments on HB 3046 Rulemaking

Cassie,

Below you will find comments on the data reporting template and a comment regarding the importance of continuing use of third-party, evidence-based clinical review tools. Many of our questions are operational in nature, so please let

to submit additional comments.

Comments on the Draft Data Reporting Template:

- Sheet I – Denied claims appears to be defined as fully or partially denied. Please clarify the following:
  - Are we to report distinct claims or are we to report service counts (claim lines)?
  - What if there are claims where there are BH services and medical services if we are reporting distinct claims?
  - Do we base the report on paid date or on date of service? Paid date might be cleaner since you don't have to be concerned with claims runout (incurred services that weren't received at the time the report was run). We use paid date typically.
  - How do we handle clinical editor edits? Are they considered denied if the line is rolled into a different line for example? We are happy to discuss this issue at the request of the DFR.
  - The Appeals process takes time and goes through multiple levels. We would like DFR to acknowledge carriers can run a report using the most current information (appeal level and current decision at the time the report is run).
  - I assume that intention of the report is that upheld and overturned rates should equal 100% when summed. How do we handle issues where they are in process and a decision hasn't been reached yet when the report is run?
- Sheet II – Paid Claims
  - If the first sheet includes claims that have any line that was denied, are we are also counting them in the paid claims totals (we believe so since the view is from a network adequacy perspective, not a medical policy / claims processing perspective)?
  - Are we to report distinct claims or are we to report service counts (claim lines)?
    - Is paid defined as having any service line on the claim paid if it is a distinct claim (either from PHP or through member's payments)?
    - If we are reporting service lines, rollup claims that pay off a DRG (for example) can be a challenge -- the lines that get rolled up can be identified but should be excluded from the service line report.
    - If we are reporting distinct claims, split claims can be a challenge (where we get a bunch of lines on a claim and negotiate to pay some lines and deny some lines so we split the claim into two separate claims and pay one and deny one). We have concerns about potential inflation of counts as a result.
    - We are happy to discuss these more complex issues more in-depth at the request of the DFR.
- Sheet III – Providing Contracted Rates
  - We want to reiterate our previous comment regarding the Median Maximum Allowable Reimbursement Rate.
  - Requesting payers provide both contract rates and incurred claims rates until 2025 will not only be challenging to provide, but may have the unintended consequence of lowering the resulting MMAR for purposes of HB 3046. We strongly recommend the DFR remove the provider contract requirement if the goal is to capture the true MMAR.

Comments on Clinical Review:
Providence Health Plan (PHP) urges the DFR to clarify the legislative intent of Section 8(5)(C) when allowing for the use of appropriately objective, evidence-based review criteria tools. This section of HB 3046 makes clear that health plans can continue the use of current third-party evidence-based review tools with the language that "other criteria and guidelines may be utilized if such criteria and guidelines are based on the current generally accepted standards of care including valid, evidence-based sources and current treatment criteria…" The intent of this section was not to limit clinical review to standards set only by provider non-profits who have a direct monetary conflict of interest in setting all clinical review standards. We support comments submitted by Change Healthcare on this issue and strongly encourage the DFR make clear the intent was to allow continued use of third-party clinical review. In Wit vs. United Behavioral Health, the court found such a standard to be preferred to any home grown methodology used by professional associations. We are happy to discuss this issue further with the DFR in the coming rulemaking workgroup.

Thank you,
Jennifer Baker

Jennifer Baker | **Director of Government Affairs**
Regulatory Compliance, Risk Management and Government Affairs
She/Her/Hers
c: 503-577-8856
Providence Health Plan
3601 SW Murray Blvd,
Beaverton, OR 97005