OREGON INDEPENDENT MENTAL HEALTH PROFESSIONALS

To:	Cassandra Soucy & HB 3046 RAC Members
From:	Melissa Todd representing OIMHP on HB 3046 RAC
Date:	September 8, 2021
Re:	Comments on 'Median Maximum Allowable Reimbursement Rate' determination

Please accept this submission to give context to any rulemaking surrounding the concept of the "*median maximum allowable reimbursement rate*" (MMARR) in HB 3046 (Section 2(3)(h)).

The MMARR is about finding a metric that helps determine whether carriers are reimbursing behavioral mental health (MH) providers in parity with medical/surgical providers; the latter including psychiatric MH providers, who are often treated differently than non-prescribing behavioral MH providers by insurers. MMARR gives DCBS the means to monitor and enforce the MH parity laws as they extend to provider reimbursement. Stagnant, poor, and in some cases *decreasing* reimbursement rates are associated with inadequate networks of MH providers and people with MH conditions who do not receive the care they need.

For a metric to capture accurate comparisons it must be *representative* of most provider reimbursement rates. The problem with SB 860 (2017) was that we used the term "maximum allowable reimbursement rate" (MARR) in Section 1(2)(a). Unfortunately, the RRC translation of this SB 860 directive was not as OIMHP intended. They translated MARR to mean the very highest rates carriers paid <u>any</u> of their in-network medical or MH providers. OIMHP's intention was not to compare the MARRs across a small, elite sliver of a plan's in-network physicians, psychiatrists, and MH therapists, who had negotiated the very best rates. Only a representative sample of the most commonly offered MARRs will truly allow DCBS to determine whether MH providers are being reimbursed in parity with medical providers. That's why the concept of "median maximum allowable reimbursement rate" (MMARR) in HB 3046 is critical; it is a metric that provides a reasonable measure of central tendency of all of a carrier's in-network providers' maximum allowed rates.

In SB 860, we included a historical reimbursement trend component to get a read on whether any increases (or decreases) of reimbursement across office visit codes used by each type of provider went up or down in tandem from year-to-year over time. So, if the MMARR goes up 16% for medical providers in 4 years, but goes up only 2% for behavioral MH providers, we would conclude that carriers are not reimbursing their provider disciplines in parity. This is why you get one of the most pivotal findings in the Milliman studies (2017, 2019), in which a much larger percentage of MH patients are getting their services out-of-network in comparison to medical services. HB 3046 directs insurers to report on this in Section 2(3)(g). Please find both Milliman reports attached for your review.

OIMHP was (and is) particularly focused on the reimbursement for time-based office visit codes for behavioral and prescribing psychiatric MH providers - 90832, 90834 and 90837. Psychiatric MH providers may also bill E&M time-based office visits to include medication management – 90833, 90836, 90838. The parallel time-based office visit codes for physicians are 99211, 99212, 99213, 99214 and 99215. A comparison of the MMARR of these codes would determine whether behavioral MH providers are being reimbursed in parity for time-based services of increasing duration. So, if the MMARR increases by 47% from a 45-minute (90834) to a 60-minute (90837) office visit for prescribing mental health providers, but increases only 1% for non-prescribing behavioral MH providers (true story), we would conclude that carriers are not reimbursing their provider disciplines in parity. It should be noted that 90834 and 90837 office visits involve psychotherapy and do not include specialized prescribing activity. Consequently, this example also illustrates the need for Section 5(12) of HB 3046, which makes it a violation for insurers to restrict the reimbursement for particular billing codes for any reason other than medical necessity.

The MMARR rates will likely correlate better with any assessment of network adequacy since they would suggest a higher percentage of providers had accepted this representative rate of reimbursement, or at least be likely to have rates in the vicinity of the MMARR. The relative spread of reimbursement across the majority of MH providers participating in-network will likely predict the level of consumer access to mental health services. If necessary, DCBS could calculate a Median Absolute Deviation (MAD) which measures spread around the median or simply develop rules adopting some measure of data spread in addition to the median.

As discussed in the RAC meeting on August 26th, 2021, MMARR may also prove useful in implementing Section 2(3)(i) of HB 3046 by offering a metric to determine percentage of Medicare rates for each specified provider type.

After lessons learned from SB 860, we would like to emphasize the importance of the rulemaking process around MMARR. It is important to clearly direct insurers on how to calculate MMARR to ensure the integrity of the data. Since DCBS does not have access to provider contracts and fee schedules, insurers are responsible for accurately reporting this metric. In the SB 860 data call, some insurers reportedly provided "aggregated" reimbursement data and some did not, which surely compromised the results. It is especially important given the opportunity for historical trend comparisons that MMARRs are calculated uniformly from year-to-year.

Note that HB 3046 specifies that "incentive payments" be removed prior to calculating MMARR (Section 5(1)(g)). We would thus exclude from MMARR calculations the office visit rates of providers reimbursed according to models which provide incentives for meeting value and quality-of-care goals. The intention behind this is twofold: (1) to omit payment models which are not conducive to MMARR calculations and comparisons with fee-for-service models (e.g., value-based, capitation), and (2) to avoid "parity penalties" for paying providers more for meeting patient outcome goals (e.g., pay-for-performance). In other words, we want to support value-added, quality health services on both the medical and mental health side. However, it is important to include in MMARR calculations the rates of providers in groups which negotiated higher fee-for-service rates due to leverage gained

from size and market share. In other words, the reimbursement rates of providers billing office visit codes should be included in the MMARR calculation unless the provider is being explicitly reimbursed for additional value-added services in the performance of those office visits. As mentioned in the 8/26/21 RAC meeting, it may be possible for insurers to parse out incentive payments in fee-for-service models, allowing the base reimbursement rates to be included in MMARR calculations.

Finally, each professional type's MMARR is impacted by the methodology used to determine office visit rates. On the medical side, providers negotiate a uniform conversion factor to calculate rates for all service codes based on the Medicare RBRVS standardized formula. On the MH side, rates are often arbitrarily determined with no clear methodology, sometimes resulting in the rate suppression of specific billing codes (e.g., 90837). Section 5(2)(g) of HB 3046 seeks to remedy this discrepancy in how rates are calculated between medical and MH by directing insurers to use the same methodology to set reimbursement rates.

Thank you for the opportunity to illustrate the impetus behind the MMARR and why we advocated to have it expressly codified in statute.