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Dear Cassie,

Thank you for the opportunity to participate in the Rulemaking Advisory Committee for HB 3046. This important bill helps ensure fair treatment for behavioral health conditions in insurance coverage. Please see the recommendation below regarding implementation of Section 5, subsection (2)(g).

Section 5, subsection (2)(g) requires:

> (g) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan must use the same methodology to set reimbursement rates paid to behavioral health treatment providers that the group health insurer or issuer of an individual health benefit plan uses to set reimbursement rates for medical and surgical treatment providers.

This provision provides protection ensuring behavioral health providers will be treated equally to medical providers in the contracting process. I am writing to advocate that the administrative rules apply this provision in a manner that does not do unintended harm to providers, plans and patients. Specifically, I recommend that the rules explicitly allow flexibility such that *if both the provider and the plan wish to do so,* they may enter into contracts with reimbursement methodologies that differ from those the insurer uses for medical/surgical providers. I think both the language and the intent of the bill allow for such flexibility.

I will provide three examples that illustrate the importance of allowing such flexibility. These examples all assume that the plan uses Relative Value Unit (RVU)-based methodology for medical contracts, a common methodology for medical contracts.

Example #1:

Community mental health programs (CMHPs) commonly bill services using HCPCS codes in the H-series. These codes have no RVUs. If carriers are forced into an RVU-only reimbursement methodology, it would take away the ability of plans and CMHPs to negotiate rates for these HCPCS codes, which would pose a barrier for plans and CMHPs to contract with each other.

Example #2:

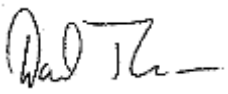
The CPT codes for Transcranial Magnetic Stimulation (TMS) do not have RVUs. TMS comprises a substantial portion of the practices of some providers. In order for insurers to contract with those providers at an agreed-upon price, they would need to deviate from RVU-based reimbursement.

Example #3:

Some providers frequently bill codes that would be disadvantaged by RVU-based compensation. Family therapists and therapists offering group psychotherapy would be particularly disadvantaged. Consider a hypothetical plan that allows $150 for a 60-minute psychotherapy visit. Under a strict RVU-based system, that same plan would only be able to allow $101 for a 60-minute family therapy visit and $27 for a two-hour group therapy visit. These restrictions would be unfair to providers who offer family therapy or group therapy as significant components of their practices.

In each of these examples, it is necessary for insurers and providers to be able to agree upon specific compensation for specific codes that deviates from the RVU-based methodology the insurer uses for medical/surgical providers. I ask that the administrative rules make it explicit that insurers and providers may do this if both parties wish to do so.

Sincerely,



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