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September 28, 2021

Cassie Soucy
Senior Policy Advisor
Oregon Department of Consumer and Business Services
Division of Financial Regulation

Sent via email to: cassandra.soucy@oregon.gov

RE: HB 3046 Mental Health Parity Draft Rulemaking Language

Dear Ms. Soucy:

Thank you for the opportunity to provide comments regarding the draft rule language on behavioral health reporting requirements for Oregon health benefit plans. Providence appreciates the robust discussion among all stakeholders and we provide our comments below.

OAR 836-053-14XX – Form and manner for behavioral health benefit reporting

Median Maximum Allowable Reimbursement Rate

We are concerned the language in subsection (3)(b)(iii) will have the potential unintended consequence of lowering the resulting Median Maximum Allowable Reimbursement rate (MMAR) for purposes of this reporting requirement. The DFR requests health plans in Oregon to provide the MMAR rate for both "provider contracted and incurred claims rates for time-based office visit billing codes" in annual reports due until January 1, 2025. Nearly all claims data includes the contracted rate that health plans have with their respective contracted providers. Health plans are able to provide an accurate contracted MMAR rate when they provide the relevant claims experience.

Providence recommends the DFR remove the provider contract requirement if the goal is to capture the true MMAR rate. If you maintain the provider contract reporting requirement, we ask you include language that does not require health plans to report contracts that have no claims experience for the reporting calendar year. Including that data will be costly for health plans and not provide an accurate median rate for purposes of this reporting.

Required Reporting Documentation

In subsection (3)(b)(v), the DFR requests health plans provide "descriptions and document on the policies, procedures, and other efforts to maintain compliance" with federal mental health parity laws. This language is very broadly written and could lead to confusion among health

plans, providing variable results. We ask the DFR to clarify that this language is aimed at policies and procedures directly related the reimbursement issues stated in the previous sections.

In the next subsection (3)(b)(vi), the DFR requests health plans provide "policies, procedures and other efforts to maintain compliance with ORS 743A.168." The statutory language cited by the DFR has broad requirements that go beyond the intended NQTL analysis required in HB 3046. In order to stay within the statutory granting authority of HB 3046, we recommend amending the language to read:

> Providing descriptions and documentation on the policies, procedures, and other efforts to maintain compliance with NQTL's applicable under ORS 743A.168.

Last, in subsection (3)(b)(vi)(2)(a), the DFR requests an assessment of how health plans behavioral health provider networks meet the standards of the broader network adequacy state statute, ORS 743B.505, including "steps taken to provide a diverse network of providers to their enrollees." This language appears redundant to the broader network adequacy reporting required annually and does not speak to the actual NQTL analysis which analyzes comparability in development and application of a MH/SUD network compared to a MED/SURG network. Additionally, the intent of this section is to ensure health plans supply Comparative Analysis on network adequacy to substantiate Parity in operation. Therefore, we ask the rule be better defined to clarify that intent and allow health plans to reference their annual network adequacy reporting, rather than broadly referring to ORS 743B.505 and requiring health plans to duplicate their annual network adequacy report.

Providence appreciates your consideration of our comments on the proposed rulemaking language. Please contact me if you require additional clarification. We are happy to discuss this at our next stakeholder workgroup later this week.

Sincerely,

Jennifer Baker
Director of Government Affairs
Providence Health Plan