OREGON INDEPENDENT MENTAL HEALTH PROFESSIONALS

To: Brooke Hall and HB 3046 RAC Members

From: Melissa Todd, Ph.D., representing OIMHP

Date: May 1, 2022

Re: Comments on Network Adequacy and HB 3046 edits to current rule

Thank you for the opportunity to participate in the Rulemaking Advisory Committee for HB 3046. OIMHP would like to offer comment on network adequacy, as discussed in RAC Meeting #8 on April 19th, 2022, and the *HB 3046 edits to current rule – discussion draft* released on April 18th, 2022.

Network Adequacy

We believe that robust enforcement of reimbursement parity and eliminating aggressive utilization management (UM) practices, especially those designed to suppress CPT code 90837 more stringently than any medical/surgical office visit codes, will create the greatest likelihood of expanding behavioral health (BH) provider networks through increased provider participation.

Studies such as the Milliman's 11/19/2019 research report, *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*, make clear the correlation between lower BH reimbursement rates and consumers accessing BH providers out-of-network more often than medical providers. The findings of OIMHP's 2017 survey of 721 mental health professionals throughout Oregon support Milliman's research; 54% of respondents had withdrawn from insurance provider panels in the previous 10 years and 51% were considering withdrawing from provider panels in the future. The two primary reasons for considering withdrawal from in-network panels were low reimbursement and aggressive UM efforts, especially those directed at the CPT 90837 billing code.

Closing the disparity between BH and medical/surgical out-of-network utilization by building BH network panels is essential to meeting consumer demand for mental health services. We believe reimbursement parity and fair UM practices are a good first step to producing an adequate in-network BH work force. We also support excluding telehealth services as a means of meeting network adequacy requirements.

OAR 836-053-1405: General Requirements for Coverage of Behavioral Health Conditions
OIMHP offers commentary and suggestions on specific sections of OAR 836-053-1405, as detailed below with our remarks following.

> *(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.*

OIMHP supports OAR 836-053-1405(2) as written regarding utilizing the same methodology and same update frequency to set both BH and medical/surgical service billing rates. This rule would assist compliance with federal and state parity laws requiring carriers to use equivalent methods to manage health care benefits in each of 6 service categories. In particular, BH providers are most concerned about assuring equivalent treatment of the outpatient services category and, specifically, the outpatient office visit subcategory. If there needs to be adjustments to handle different reimbursement rates for rarely used HCPC codes, we would suggest this be written as a separate provision for those codes only.

> *(4)(g) 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.*

We suggest adding the following statement to OAR 836-053-1405(4)(g): "Utilization and clinical review policies and procedures must meet the requirements of OAR 836-053-1405(5), (6), (7), and (8), as well as complying with the entire definition of *generally accepted standards of care*, as cited in OAR 836-053-1404(1)(c)."

> *(6) A group health insurer that issues or renews a group health insurance policy in this state shall have policies and procedures in place to ensure uniform application of the policy's definition of medical necessity to all medical and behavioral health conditions.*

We suggest adding the following statement to OAR 836-053-1405(6), based on HB 3046 Sections 8(5)(a)(C) and 8(6)(b): "Upon request from providers, insureds, or regulators, insurance carriers or their third-party contractors must be able to produce documentation describing how their UM procedures utilized to determine medical necessity and to restrict care are applied uniformly and are not more stringently to BH services than to medical/surgical services."

(8) Any medical necessity, utilization or other clinical review, not related to level of care placement decisions, must be based on the current generally accepted standards of care including valid, evidence-based sources and current treatment criteria or practice guidelines developed by the nonprofit professional association for the relevant clinical specialty.

OIMHP supports OAR 836-053-1405(8) as written. If language regarding *other criteria and guidelines* is added to this section, we feel strongly that these criteria and guidelines must comply with the entire definition of *generally accepted standards of care* cited in OAR 836-053-1404(1)(c), and with OAR 836-053-1405(12) which forbids UM policies and procedures designed to restrict the reimbursement paid for specific billing codes other than on the basis of medical necessity.

We further suggest adding a statement to OAR 836-053-1405(8) based on HB 3046 Section 8(5)(a)(C): "Upon request from providers, insureds, or regulators, insurance carriers or their third-party contractors must be able to produce documentation describing how their UM procedures are based upon generally accepted standards of care."

(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.

We suggest adding a statement to OAR 836-053-1405(12) based on HB 3046 Sections 5(12) and 8(13): "Upon request from providers, insureds, or regulators, insurance carriers or their third-party contractors must be able to produce documentation describing how their policies and procedures do not target a specific billing code or restrict the reimbursement paid for particular billing codes other than on the basis of medical necessity."

Thank you for allowing OIMHP to provide comment on network adequacy enforcement and the April 18th, 2022 version of the *HB 3046 edits to current rule – discussion draft*. In summary, we advocate for robust rulemaking that ensures the proper implementation of HB 3046 and closes loopholes that will weaken the law before it has a chance to deliver on all that it promises.