OREGON INDEPENDENT MENTAL HEALTH PROFESSIONALS

Senate Bill 860 (2017)

Oregon Insurance Companies' Determination of Mental Health Provider Reimbursement Rates Should be Consistent with the Oregon Mental Health Parity Law

Overview:

Oregon Law ORS 743A.168 (Oregon Mental Health Parity) requires insurers who reimburse hospital and medical expense benefits to reimburse mental health/chemical dependency benefits at the same level and subject to limitations no more restrictive. The law states that as long as medical necessity is assured, "the coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions". The Oregon MHP statute is consistent with the intent of the federal Affordable Care Act, which establishes mental health services as Essential Health Benefits. Oregon has implemented this section of the ACA in ORS 731.097.

The intent of these Oregon laws has been undermined by insurer reimbursement practices that differentiate between how medical and mental health providers are reimbursed for their services. Over the last decade, trends in the level of mental health reimbursement have diverged so that rates paid to mental health providers have decreased relative to the rates paid to medical providers.

Inadequate mental health reimbursement undermines the mission of the ACA to promote a robust integration of medical and mental health services to meet the overall health care needs of insured citizens. Parity in reimbursement practices is needed:

a) to support an adequate mental health work force,

b) to assure consumers will have access to in-network mental health providers to reduce their out of pocket costs for services, and

c) to assure that any insurance benefit design, or the implementation of benefit design does not discriminate against an insured based on health factors (i.e., mental health status, mental health condition, or mental health history) (Federal Regulations: 45 CFR 156.125, 45 CFR 146.121, 45 CFR 147.110, 45 CFR 156.110).

Basic Premises Underlying Senate Bill 860:

1) Each insurance plan should establish in-network physician and mental health provider panels that are roughly equivalent in terms of breadth, depth, and quality to be compliant with the Oregon Mental Health Parity Law and to assure adequate coordinated care between these disciplines.

2) Insurance companies' reimbursement rate schedules are the primary means by which they build equivalent physician and mental health provider panels. Higher rates will increase the overall number of providers willing to work in-network, as well as increase the number of specialists and each panel's overall level of expertise (i.e., level of education, certification, and experience); in other words, better rates improve the breadth, depth, and quality of **both** medical and mental health panels.

3) In regards to outpatient services, insurers should establish reimbursement rate schedules to pay for outpatient office visit procedures used by physicians and mental health providers in an equivalent way. By doing so, they will establish roughly equivalent medical and mental health outpatient benefit coverage for their beneficiaries.

4) History demonstrates Oregon insurance companies have not established equivalent medical and mental health reimbursement rate schedules to pay for common outpatient office visit procedures.

5) Furthermore, Oregon insurance companies apply utilization policies and management procedures to restrict the use of behavioral mental health outpatient office visit procedures more stringently than medical outpatient office visit procedures.

Oregon Mental Health Providers' Experience:

1) Outpatient reimbursement rates have declined or stayed basically flat for behavioral mental health providers over the last decade. For example, in 2009 Regence decreased payment for psychologist services so that psychologists are now paid in 2017 about a third less than what they were paid in 2008. LCSWs maximum allowable rates may have been decreased about 50%. It has caused mental health providers to leave panels or work significantly more hours. We don't believe there has been a parallel decline or flattening of reimbursement rates for outpatient physician office visits.

2) When the Center for Medicare and Medicaid Services (CMS) established a set of new procedure codes for outpatient mental health office visits in 2013, insurance companies established more restrictive utilization rules and began managing these codes more aggressively. Most therapists work within an hourly time frame, anywhere from 45 to 60 minutes. In 2013, CMS established a 90834 procedure code for 45' sessions (38-52 minute time frame range) and a 90837 procedure code for 60' sessions (53 minutes or more time frame range). Both of these codes were within the hourly time frame most therapists work. Companies responded differently in how much they reimbursed the longer codes:

- Oregon Medicare utilizes a Relative Value System and pays the 90837 CPT code 33% more than they pay the 90834 CPT code.

- For two years, Regence reimbursed psychologists the longer time code at a rate that was about 32% higher than the shorter time code (about the same as Medicare), but in 2016 Regence reduced reimbursement so the longer code was paid only 7% higher.

- MODA has paid psychologists 90834 and 90837 exactly the same rate.

- Providence through its United Behavioral Health, Optum, and Pacficare provider panels pays psychologists 7% higher for 90837, but define it as "non-routine" and restricts its utilization to apply only to: acute crises; complex sessions involving children, adolescents and geriatric patients; the emergence of new symptoms or the re-emergence of old symptoms; and specialized treatments for PTSD, OCD, and Panic Disorders. We have heard from several of our members that Providence mental health managers aggressively audit providers that use the 90837 code frequently.

We believe these types of restrictions on outpatient time-based codes are applied more stringently to behavioral mental health providers than to medical providers. We imagine longer primary care physician office visit codes would routinely be paid proportionally more than shorter office visits with fewer policy and managerial utilization review procedures restricting their use.

This could be determined by comparing how each plan pays the difference of 15 minutes in service length for outpatient PCP office visits: CPT 99214 (25 minutes) to CPT 99215 (40 minutes) relative to how it pays outpatient Mental Health Provider office visits: CPT 90834 (45 minutes) to CPT 90837 (60 minutes).

Senate Bill 860 assures relative equivalency of each insurance plan's in-network medical and behavioral mental health provider panel by requiring the Oregon Department of Consumer and Business Services (DCBS) to investigate and remedy parity discrepancies in how reimbursement rates are established by:

Section 1(2)(a) - Requires DCBS to review ***historical reimbursement trends*** of each insurance plan's maximum allowable reimbursement rates paid for time-based outpatient office visit procedure codes. DCBS will determine whether each plan's in-network panel of licensed behavioral mental health providers (psychologists, social workers, professional counselors and marriage and family therapists) has been reimbursed in an equivalent manner to its in-network panel of medical providers (primary care physicians) and in-network panel of mental health providers who prescribe pharmaceutical medicine (psychiatrists and psychiatric mental health nurse practitioners).

If a lack of parity is discovered in maximum allowable reimbursement rate trends for time-based outpatient office visit procedure codes, DCBS is empowered to design regulations to remedy this lack of reimbursement parity.

Section 1 (2)(b) - Requires DCBS to review whether each ***insurance plan implements policies and utilization management procedures*** differently for medical and behavioral mental health providers in regards to the use of time-based outpatient office visit procedural codes. In particular, the DCBS should determine whether insurers restrict the utilization of longer office visits differently for medical and behavioral mental health providers.

If a lack of parity is discovered in the application of policies and utilization management procedures regulating longer office visits, DCBS is authorized design regulations to remedy this lack of parity.

Section 1 (2)(c) – Requires DCBS to review whether a health insurance plan reimburses its time-based office visit procedural codes for both its in-network panel of behavioral mental health providers and its in-network panel of medical providers ***in an equivalent proportional way based upon incremental increases in office visit length***.

If a lack of parity is discovered in how longer office visits are paid, DCBS is authorized to design regulations to remedy this lack of parity.

Section 1 (2)(d) - Requires DCBS to determine whether the ***methodologies used to determine each insurance plan's reimbursement rate schedule*** (for example: Usual and Customary Rate (UCR) formulas or CMS Relative Value Unit (RVU) formulas), are applied in a manner so that equivalent behavioral mental health and physical health provider panels are established.

If a lack of parity is discovered in how methodologies are applied to determine reimbursement rates resulting in different provider panels' breadth, depth, and quality, DCBS is empowered to design regulations to remedy this lack of parity.

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