Session 020: Provider Reimbursement and Mental Health Parity

SOA Antitrust Compliance Guidelines
SOA Presentation Disclaimer

2019 ANNUAL MEETING & EXHIBIT

Session 20
Provider Reimbursement and Mental Health Parity

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SOCIETY OF ACTUARIES®

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Learning Objectives

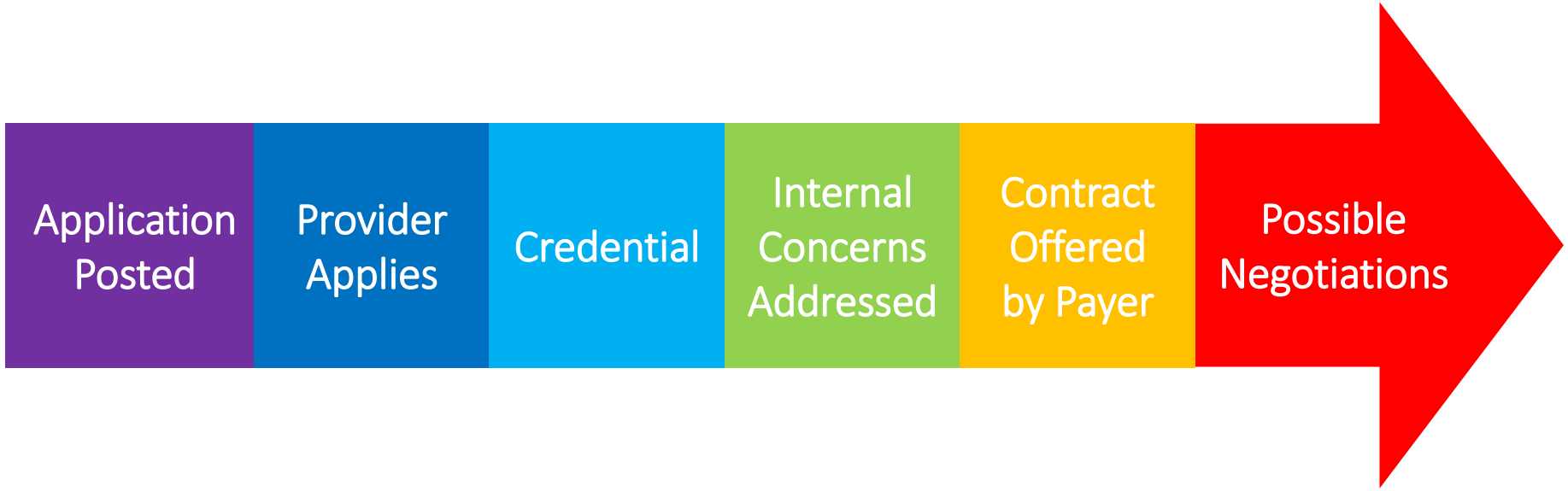
- Develop a high-level understanding of provider contracting.
- Understand the various methods health plans use to reimburse providers.
- Understand traditional Medicare fee schedules and why Medicare relativities provide a reasonable, fair payment relativity benchmark for flagging possible problems for further MHPAEA review.
- Understand issues involved with comparing behavioral health provider compensation versus medical/surgical provider compensation when it comes to MHPAEA.
- Understand why provider compensation compliance with MHPAEA is important.

Provider Contracting

Provider contracting is the process by which payers enter into agreements with providers of medical or behavioral health services to be a part of one or all the payer's networks. The process includes:

- Verifying professional credentials
- Verifying allowable services generally for the provider
- Procedural requirements
- Negotiating reimbursement rates for specific services
- State provider contracting laws
- Rented networks
- Signed contracts.

Initial Contracting Process (Generally)



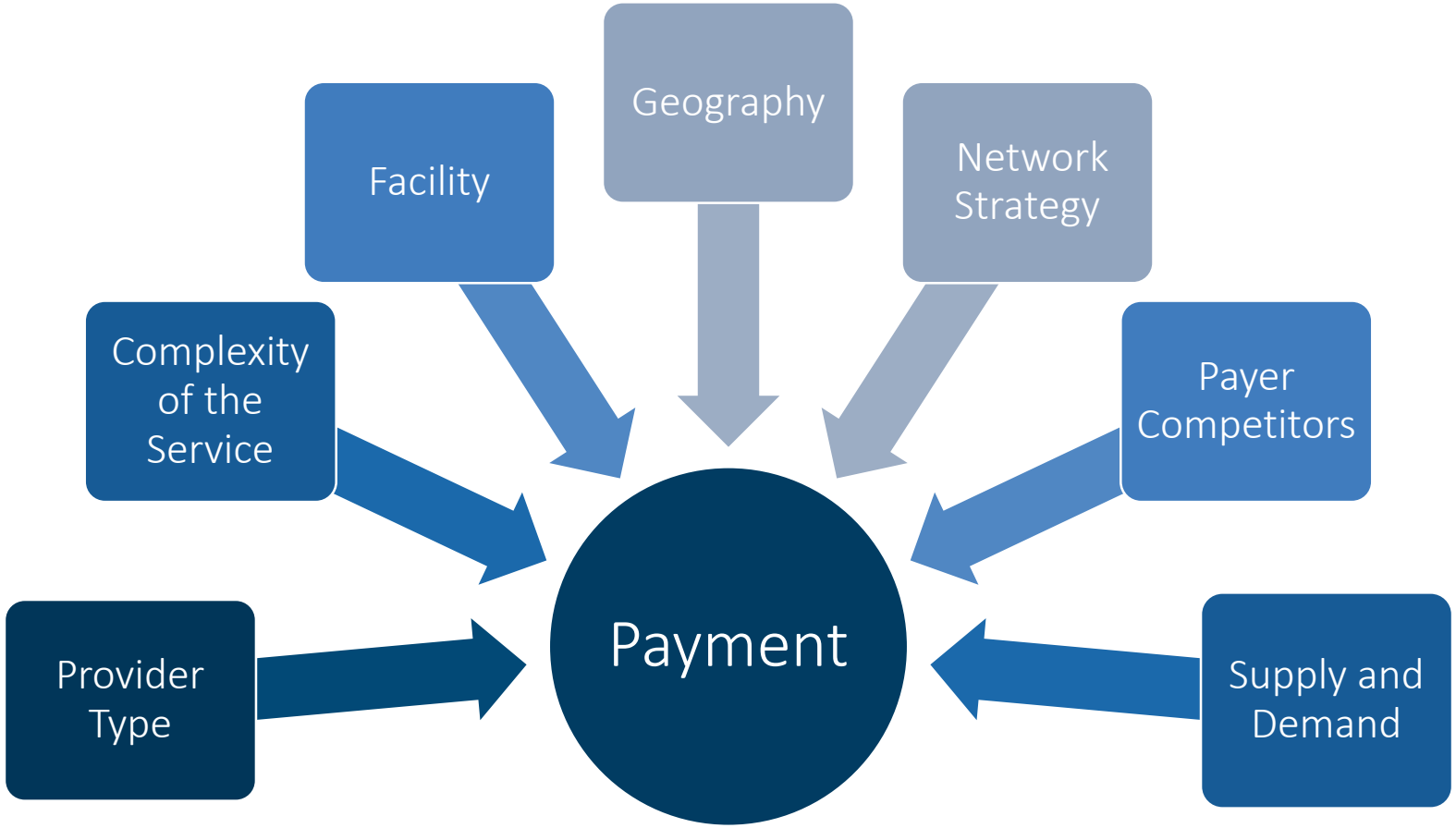
Reimbursement Methods

- Types of Reimbursement
  - Fee-for-service
  - Cost-based reimbursement (discounts)
  - Capitation
  - Prospective payment
  - Bundled payments/case rates
  - Value-based purchasing
- Withholds and Bonuses

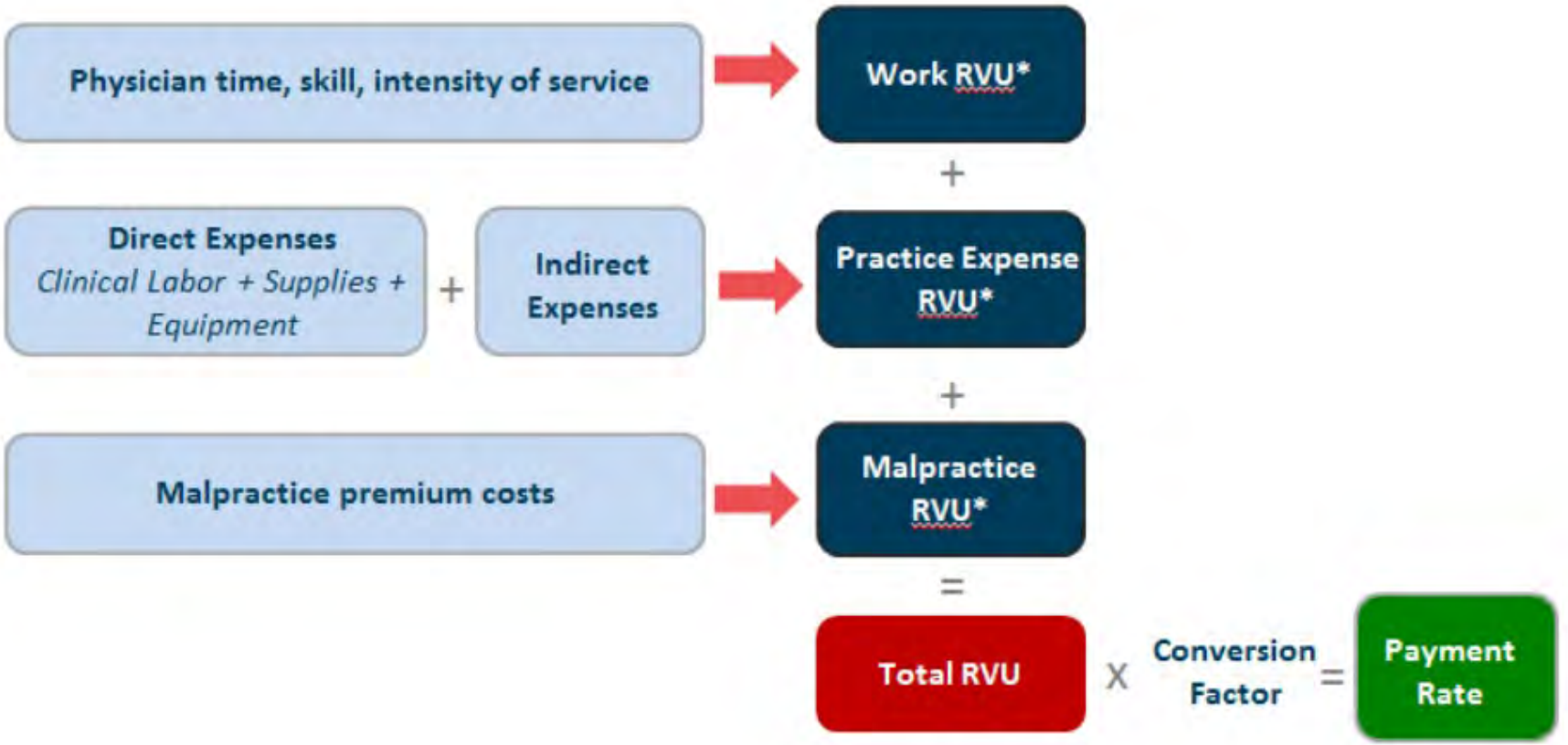
Reimbursement Methodology

- Claims coding drives reimbursement
- International Classification of Diseases (ICD-10)
  - Diagnosis codes
  - Current Procedure Terminology (CPT and HCPCS codes)
  - Modifiers
- Place of Service (POS) codes

Reimbursement Methodology



Resource-based Relative Value Scale (RBRVS)



Variations in Reimbursement

- Private insurers reimburse providers at different rates compared to Medicare
  - Rate are typically much higher than what Medicare reimburses
- Private insurer reimbursement methods are less transparent than Medicare
- Negotiating power is important
  - Large hospitals and large clinic systems have a major advantage in negotiation.
  - Smaller groups and solo practitioners are typically at a disadvantage.

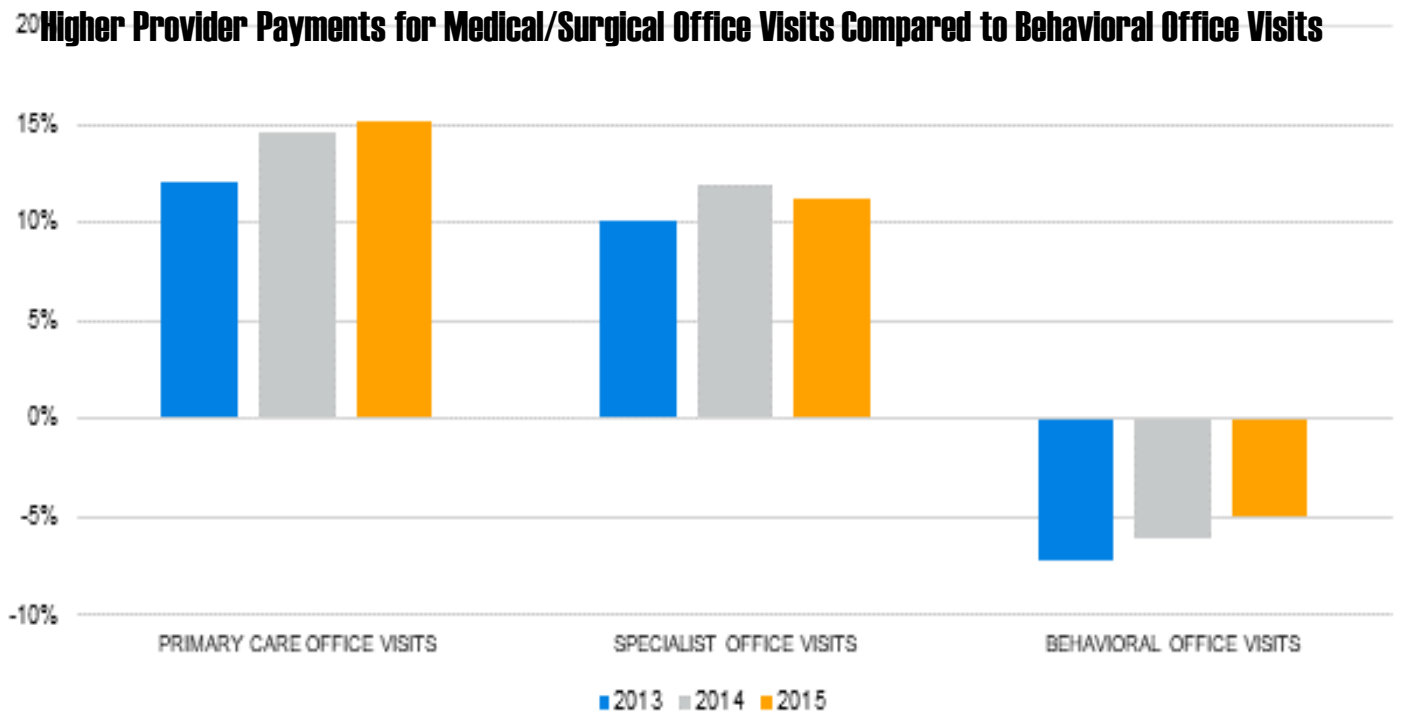
MHPAEA NQTLs and Providers

- Several NQTLs directly relate to plan's payments to health care providers:
  - Coding Edits
  - UCR Determination
  - Credentialing
  - Unlicensed Provider/Staff Requirements
  - Out-of-Network Coverage Standards
  - Provider Reimbursement

MHPAEA and Providers

- Insurers are not required to reimburse *exactly* at the same rate as medical/surgical services
  - Rather, the reimbursement methodology across specialties should be no more stringent on the MH/SUD side

MHPAEA and Reimbursement



Source: Milliman (Denver) Melek, Mathews

MHPAEA and Reimbursement

Primary Care Services

MA Procedure Code	Medicare Facility Base Rate	MA Facility Base Rate	MA Base Rate as a % of Medicare	Avg. MA Facility Payment	Average MA Pmt. as a % of Medicare	Medicare Non-facility Base Rate	MA Non-facility Base Rate	MA Base Rate as a % of Medicare	Average MA Non-Facility Payment	Average MA Pmt. as a % of Medicare
99213	50.06	38.80	78%	54.46	109%	71.90	55.84	78%	69.14	96%
99214	77.01	59.74	78%	84.36	110%	106.13	82.36	78%	102.21	96%
36415	3.00	3.00	100%	2.94	98%	3.00	3.00	100%	2.93	98%
99232	70.67	54.72	77%	63.12	89%	70.67	54.72	77%	(no data)	(n/a)
99233	101.95	79.01	77%	92.29	91%	101.95	79.01	77%	(no data)	(n/a)
71020	31.03	21.71	70%	19.63	63%	31.03	21.71	70%	19.48	63%
90471	25.12	19.54	78%	20.89	83%	25.12	19.54	78%	19.87	79%
99283	59.64	46.06	77%	48.11	81%	59.64	46.06	77%	(no data)	(n/a)
71010	23.77	16.66	70%	14.67	62%	23.77	16.66	70%	14.88	63%
99215	108.65	84.31	78%	122.19	112%	142.14	110.28	78%	129.43	91%
Average:	**$55.09**	**$42.36**	**78%**	**$52.27**	**90%**	**$63.53**	**$48.91**	**78%**	**$51.13**	**84%**

The average Medicaid rate is based on the allowed amount after ratable reductions and increases have been applied to the fee schedule rate. Please note that this average rate is compared to Medicare's fee schedule, not the paid amount under Medicare. Please see Minn. Stat. § 256B.76 for more information on which ratable reductions and increases applied in 2014 to physician services.

Source: Minnesota's Access Monitoring Review Plan, Sept. 2016, Minnesota Department of Human Services

Mental Health Services – Physician

MA Procedure Code	Medicare Facility Base Rate	MA Facility Base Rate	MA Base Rate as a % of Medicare	Avg. MA Facility Payment	Average MA Pmt. as a % of Medicare	Medicare Non-facility Base Rate	MA Non-facility Base Rate	MA Base Rate as a % of Medicare	Average MA Non-Facility Payment	Average MA Pmt. as a % of Medicare
90791	127.22	114.68	90%	142.43	112%	131.58	118.91	90%	151.66	115%
90792	137.63	124.11	90%	155.30	113%	142.00	128.33	90%	161.73	114%
90785	14.11	12.67	90%	14.38	102%	14.11	14.11	100%	14.60	103%
90832	62.75	62.75	100%	69.80	111%	63.48	57.48	91%	72.57	114%
90834	83.79	75.70	90%	95.45	114%	84.15	84.15	100%	95.03	112%
90837	125.40	113.06	90%	142.08	113%	126.12	126.12	100%	141.35	112%
90853	25.10	22.41	89%	28.61	114%	25.83	25.83	100%	28.84	112%
Average:	**$82.29**	**$75.05**	**91%**	**$92.58**	**111%**	**$83.89**	**$79.28**	**96%**	**$95.11**	**112%**

Mental Health Services – Non-physician*

MA Procedure Code	Medicare Facility Base Rate	MA Facility Base Rate	MA Base Rate as a % of Medicare	Avg. MA Facility Payment	Average MA Pmt. as a % of Medicare	Medicare Non-facility Base Rate	MA Non-facility Base Rate	MA Base Rate as a % of Medicare	Average MA Non-Facility Payment	Average MA Pmt. as a % of Medicare
90791	120.86	114.68	95%	121.98	101%	125.00	118.91	95%	129.33	103%
90792	130.75	124.11	95%	(no rate)	(n/a)	134.90	128.33	95%	158.76	118%
90785	13.40	12.67	95%	10.73	80%	13.40	14.11	105%	12.55	94%
90832	59.61	62.75	105%	60.06	101%	60.31	57.48	95%	62.29	103%
90834	79.60	75.70	95%	85.25	107%	79.94	84.15	105%	83.12	104%
90837	119.13	113.06	95%	121.74	102%	119.81	126.12	105%	124.05	104%
90853	23.85	22.41	94%	22.89	96%	24.54	25.83	105%	24.63	101%
Average:	**$78.17**	**$75.05**	**96%**	**$70.44**	**98%**	**$79.70**	**$79.28**	**101%**	**$85.96**	**104%**

Example 1

An insurer indicates that in-network provider reimbursement rates are determined based on a variety of factors, including the providers' required training, licensure, expertise, education, and skills. Despite similarities, the reimbursement rate is reduced by the same percentage for every behavioral CPT code rendered by a non-physician practitioner, but not for medical and surgical providers.

Example 1

This example is likely a parity violation. While pay does not need to be identical, it must have the same method, or at least a method that is not more stringent for mental health and substance use disorder providers' compensation.

Example 2

An insurer has a requirement in its provider contract template for mental health and substance use disorder providers to have a receptionist. The health insurer expects that medical and surgical providers naturally have this staff, so the medical contract template does not list this requirement.

Example 2

This is a violation of MHPAEA. In this case, the primary MH/SUD documents contain restrictions that are more restrictive than those applied to the medical and surgical side.

Example 3

An insurer has outsourced its behavioral health management to a third party. The third party has proposed to the insurer that it should pay all claims on the earlier of

1) the very last day required by the prompt pay law in the state or
2) the final payment due date outlined in the provider contract.

What should the insurer say?

Example 3

The insurer should say hold up or no…that this policy cannot be implemented unless it is the payment timing policy used on the medical and surgical side.

Example 4

An insurer was in the midst of a claims system change and had accidentally overpaid many behavioral health providers by 10% for over a year. To make up for this overpayment, the insurer sends a letter to affected providers alerting them that they will offset their error in their next payments until their error has been corrected.

Example 4

- Specific provider contract language on rescissions process and timing
- State of limitations
- State prompt pay laws
- Providers own financial and accounting needs
- Process and timing for medical and surgical, both in contract and in practice

Example 5

An insurer has not negotiated rates for about 80% of its behavioral health providers in about four years. Rates have remained static over that entire time period. The insurer has recently sent letters that rates will be increased by 5%. What concerns should a regulator have?

Example 5

- Differences in process, timing, and method of negotiation
- Differences in rate escalation level
- Differences in rate escalation timing

Example 6

During a MHPAEA compliance review, the insurer describes the high compensation paid to orthopedic surgeons as justified due to the low supply of these surgeons and the high demand for these services.

What is a good follow up to this assertion?

Example 6

Source: Medscape Psychiatrist Compensation Report 2018

Why is Provider Compensation MHPAEA Compliance Important?

- Affects the scope and duration of care delivered to patients
- Affects the services provided and available
- Affects the quality of care
- Affects the timing of services
- Affects network participation
- Low compensation increases enrollee cost sharing through higher OON benefit designs and balance bills

FEDERAL REGULATIONS STIPULATE A SPECIFIC TESTING PARADIGM FOR NQTLs

- Nonquantitative Treatment Limitations have a separate two-part test:
  - Comparable to
  - Applied no more stringently than

BOTH as written and in operation

THE PARITY TEST FOR NQTLs

A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) **as written and in operation**, any **processes, strategies, evidentiary standards, or other factors** used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are **comparable to, and are applied no more stringently** than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation **with respect to medical/surgical benefits in the classification.**