Session 020: Provider Reimbursement and Mental Health Parity
Session 20
Provider Reimbursement and Mental Health Parity

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Active participation in the Society of Actuaries is an important aspect of membership. While the positive contributions of professional societies and associations are well-recognized and encouraged, association activities are vulnerable to close antitrust scrutiny. By their very nature, associations bring together industry competitors and other market participants.

The United States antitrust laws aim to protect consumers by preserving the free economy and prohibiting anti-competitive business practices; they promote competition. There are both state and federal antitrust laws, although state antitrust laws closely follow federal law. The Sherman Act, is the primary U.S. antitrust law pertaining to association activities. The Sherman Act prohibits every contract, combination or conspiracy that places an unreasonable restraint on trade. There are, however, some activities that are illegal under all circumstances, such as price fixing, market allocation and collusive bidding.

There is no safe harbor under the antitrust law for professional association activities. Therefore, association meeting participants should refrain from discussing any activity that could potentially be construed as having an anti-competitive effect. Discussions relating to product or service pricing, market allocations, membership restrictions, product standardization or other conditions on trade could arguably be perceived as a restraint on trade and may expose the SOA and its members to antitrust enforcement procedures.

While participating in all SOA in person meetings, webinars, teleconferences or side discussions, you should avoid discussing competitively sensitive information with competitors and follow these guidelines:

• Do not discuss prices for services or products or anything else that might affect prices
• Do not discuss what you or other entities plan to do in a particular geographic or product markets or with particular customers.
• Do not speak on behalf of the SOA or any of its committees unless specifically authorized to do so.
• Do leave a meeting where any anticompetitive pricing or market allocation discussion occurs.
• Do alert SOA staff and/or legal counsel to any concerning discussions
• Do consult with legal counsel before raising any matter or making a statement that may involve competitively sensitive information.

Adherence to these guidelines involves not only avoidance of antitrust violations, but avoidance of behavior which might be so construed. These guidelines only provide an overview of prohibited activities. SOA legal counsel reviews meeting agenda and materials as deemed appropriate and any discussion that departs from the formal agenda should be scrutinized carefully. Antitrust compliance is everyone’s responsibility; however, please seek legal counsel if you have any questions or concerns.
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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)

Application Posted | Provider Applies | Credential | Internal Concerns Addressed | Contract Offered by Payer | Possible Negotiations
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

- Payment
- Provider Type
- Complexity of the Service
- Facility
- Geography
- Network Strategy
- Payer Competitors
- Supply and Demand
- Geographical

Diagram showing relationships between payment and various factors.
Resource-based Relative Value Scale (RBRVS)

- Physician time, skill, intensity of service → Work RVU*
- Direct Expenses (Clinical Labor + Supplies + Equipment) + Indirect Expenses → Practice Expense RVU*
- Malpractice premium costs → Malpractice RVU*

Work RVU* + Practice Expense RVU* + Malpractice RVU* = Total RVU

Total RVU × Conversion Factor = Payment Rate
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

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

How Much Do Psychiatrists Earn?

Plastic Surgery $501K
Orthopedics $497K
Cardiology $423K
Gastroenterology $408K
Radiology $401K
Dermatology $392K
Anesthesiology $386K
Otolaryngology $383K
Urology $373K
Oncology $363K
Ophthalmology $357K
Critical Care $354K
Emergency Medicine $350K
Surgery, General $322K
Pulmonary Medicine $321K
Ob/Gyn $300K
Nephrology $294K
Pathology $286K
Psychiatry $272K
Allergy & Immunology $272K
Physical Medicine & Rehabilitation $269K
Rheumatology $257K
Neurology $244K
Infectious Diseases $231K
Internal Medicine $230K
Family Medicine $219K
Diabetes & Endocrinology $212K
Pediatrics $212K
Public Health & Preventive Medicine $199K

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.