MILLIMAN REPORT

Actuarial Examination of the Adequacy of Reimbursement for Primary Care and Behavioral Health Outpatient Services Delivered In-person and by Telehealth

Analysis Supporting Behavioral Health Care – Treatment and Access Act (Chapter 291/House Bill 1148, 2023)

Prepared for Maryland Health Care Commission

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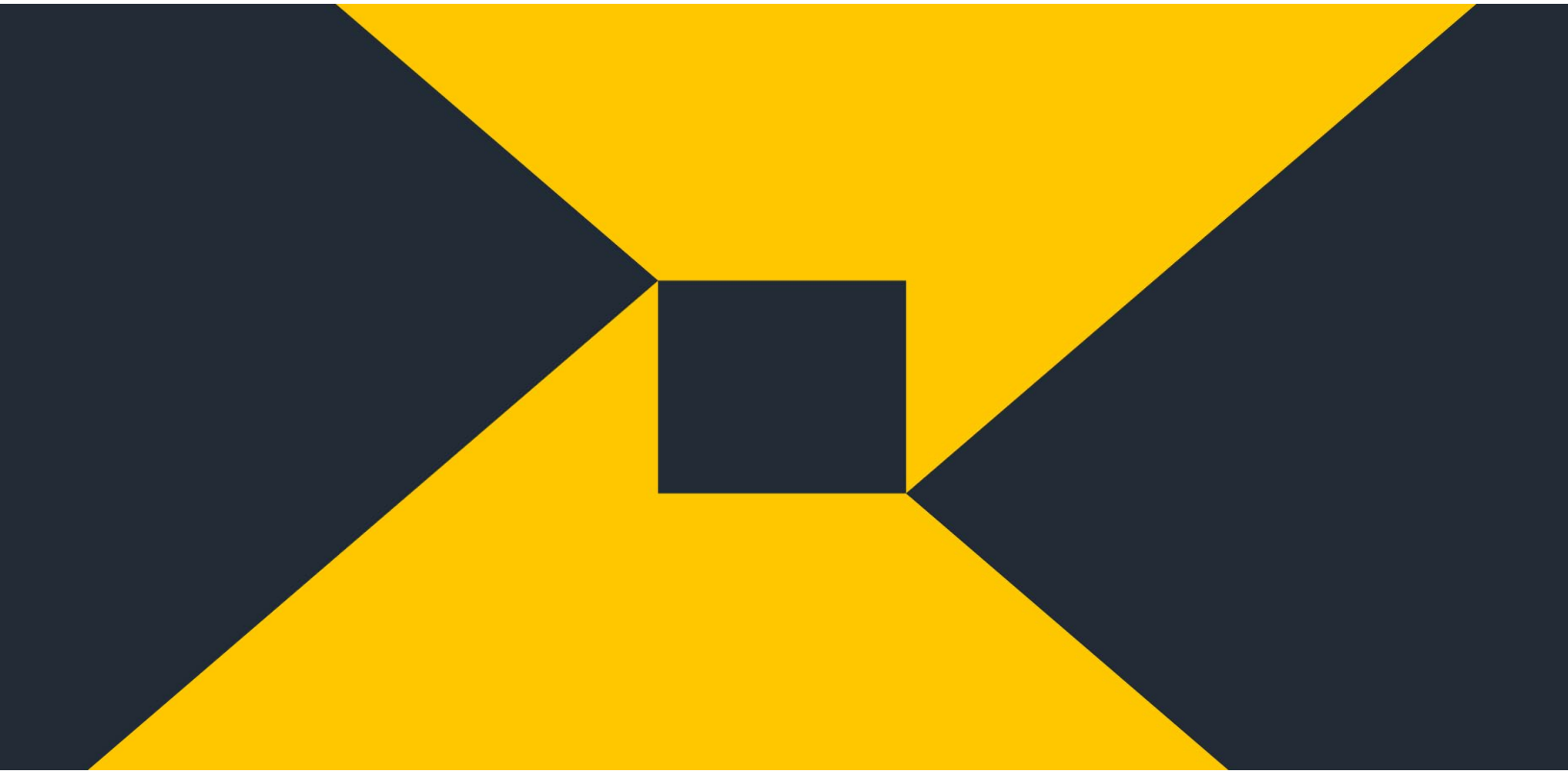

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Executive summary

BACKGROUND

In 2023, the Maryland General Assembly enacted Chapter 291/(House Bill 1148, *Behavioral Health Care – Treatment and Access (Behavioral Health Model for Maryland)*.[1] The law requires the Maryland Health Care Commission (MHCC) to study and make recommendations regarding the delivery of health care services through telehealth, including payment parity for the delivery of health care services through audiovisual and audio-only telehealth technologies. Milliman was competitively selected by MHCC to provide actuarial services that examined payment levels for primary care somatic and behavioral health services delivered in-person and via telehealth.

Milliman reviewed relevant literature, completed an analysis of commercial, managed Medicaid, and Medicare Advantage payer data from MHCC's All Payer Claims Database (APCD), and developed a Payer Reimbursement Comparison Tool (or Tool) for comparing reimbursement rates across various types of providers and services. The Tool benchmarks reimbursement rates against the Medicare Physician Fee Schedule (MPFS) to facilitate comparisons across select somatic and behavioral services. The MPFS is developed by the Centers for Medicare and Medicaid Services (CMS) and is based on a relative value system (time, skill, effort, and resources required) for each service. The use of the MPFS is intended to support meaningful comparisons across disparate services. The Tool is available for public use and will be available on the MHCC website. More information can be found in Appendix A.

ANALYSIS OVERVIEW

From 2019 to 2023, the Maryland APCD includes claims data for approximately 3.0 million to 3.5 million individuals per year. This includes those with commercial insurance (excludes self-insured ERISA data and federal employees), Medicare Advantage, or Medicaid managed care health plans.

Milliman examined utilization patterns and reimbursement across a set of procedure codes for behavioral health and primary care services. To narrow the scope of the analysis, the analysis focuses on 75 procedure codes that captured more than 99 percent of the services and costs across these categories.

There are limitations for the use and interpretation of this analysis. These include limitations related to service mix and geography mix variations impacting reimbursement levels. Please see the limitation section of the report for more details. Maryland's telehealth payment parity law requires insurers, nonprofit health service plans, and health maintenance organizations to reimburse for telehealth services at the same rate as in-person services from July 1, 2021 to June 30, 2025. Differences in payment levels may be due to service mix and the limitations described in this report.

KEY FINDINGS

Compared to a 2019 baseline, the percentage of services that take place via telehealth rose dramatically for both behavioral health and primary care in 2020 during the COVID-19 pandemic. Behavioral health services taking place via telehealth have continued to increase, while primary care telehealth visits have decreased since a high point in 2020. This result is consistent across all lines of business examined.

See Figure 1 for the percent of services provided via telehealth for behavioral health and primary care services in the latest year of data (2023 for commercial and Medicare Advantage, 2022 for managed Medicaid) for each line of business.

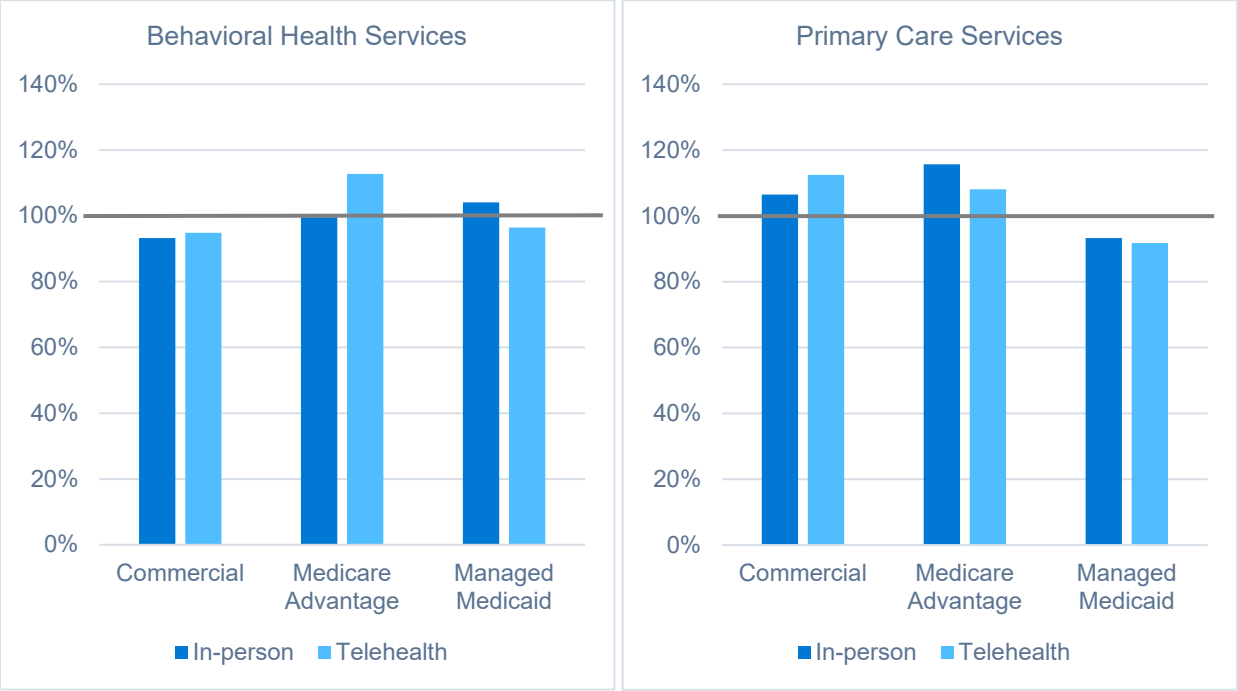
[1] Maryland General Assembly (May 2023). House Bill 1148: An Act Concerning Behavioral Health Care – Treatment and Access (Behavioral Health Model for Maryland), Chapter 291. Retrieved from: https://mgaleg.maryland.gov/2023RS/Chapters_noln/CH_291_hb1148t.pdf.

FIGURE 1: PERCENT OF SERVICES PROVIDED VIA TELEHEALTH

Line of business	Year	Behavioral Health	Primary Care
Commercial	2023	63.8%	15.6%
Medicare Advantage	2023	40.2%	11.0%
Managed Medicaid	2022	31.7%	13.4%

To facilitate a reimbursement comparison, the reimbursement is calculated as a percent of the MPFS for all services. As shown in Figure 2, results varied by line of business, but across all years, telehealth was generally reimbursed at similar levels when compared to services provided in person.

FIGURE 2: REIMBURSEMENT LEVELS RELATIVE TO MPFS, ALL YEARS



Key findings for reimbursement levels are best examined by line of business.

In the commercial line of business:

- Reimbursement levels for primary care services are higher than reimbursement levels for behavioral health services, as a percent of the MPFS.
- Reimbursement levels for telehealth services are higher than for services provided in person. Telehealth reimbursement levels have been 3 to 10 percent higher for behavioral health telehealth services and 1 to 35 percent higher for telehealth primary care services when compared to the respective in-person service reimbursement levels.
- The spread of reimbursement levels between behavioral health and primary care services done in person and via telehealth has narrowed over time.

In the Medicare Advantage line of business:

- Reimbursement levels for in-person behavioral health services have consistently been lower than behavioral health services provided via telehealth.
- The spread of reimbursement levels between behavioral health and primary care services done in person and via telehealth has narrowed over time.

In the Medicaid line of business:

- Reimbursement for in-person behavioral health services has been higher than telehealth and for primary care services in 2021 and 2022.
- The spread of reimbursement levels between behavioral health and primary care services done in person and via telehealth has remained relatively narrow over time when compared to the other lines of business.

CONCLUSION

This analysis provides insights into the evolving landscape of telehealth services in Maryland, particularly for behavioral health and primary care. The sharp increase and continued growth of telehealth utilization for behavioral health services underscores the growing acceptance and reliance on audio and video health care solutions. The findings indicate that reimbursement levels for telehealth services have generally comparable been to, and in some cases higher than, those for in-person services over the last three to four years. It is important to consider the differences by line of business in drawing any conclusions about this analysis. This reflects a shift toward recognizing the value of telehealth in delivering accessible and effective care.

These insights are instrumental for policymakers, payers, and providers as they navigate the world of telehealth utilization and reimbursement. The development of the Tool further enhances transparency and provides greater detail for stakeholders who may be interested in a deep dive. As telehealth continues to play a key role in health care delivery, ongoing monitoring and analysis will be important to ensure that reimbursement policies are equitable and that telehealth solutions remain a viable option for patients and providers. The information in this report provides the framework to guide future telehealth policy and legislation. Findings were used by MHCC to guide development of recommendations in a final report.

Introduction

Maryland law requires carriers to reimburse services provided via telehealth, including audio-only telehealth, the same as if the service were provided in person. This requirement, along with others designed to ensure access to care, was implemented as part of the emergency response to the COVID-19 public health emergency.

In 2023, the General Assembly enacted Chapter 382/Senate Bill 534, Preserve Telehealth Access Act of 2023, which extends current telehealth provisions until June 30, 2025, and also requires the study of various facets of telehealth delivery and reimbursement. The MHCC is required by HB 1148 to study and make recommendations concerning the delivery of health care services via telehealth.[2] The findings are intended to:

- Help inform the debate on payment parity by identifying what aspects of telehealth are subject to overuse or underuse or yield greater or lower value
- Assess the adequacy of reimbursement for behavioral health services delivered in person and via telehealth
- Address any other issues related to telehealth as determined necessary by the Commission

A report on the findings and recommendations must be submitted by MHCC to the General Assembly by December 1, 2024.

The MHCC engaged Milliman to conduct an analysis using commercial payer, Medicaid, and Medicare data from its APCD. The study focuses on the use and payment parity of telehealth services (including audiovisual and audio-only telehealth technologies). Study findings are intended to be used to inform the development of recommendations regarding the equitable payment for telehealth services (including audiovisual and audio-only technologies). The analysis informed findings in this report and resulted in the development of a Payer Reimbursement Comparison Tool (Tool) that provided a framework to address the study items and develop recommendations for the General Assembly.

The Tool benchmarks reimbursements to the MPFS[3] for specific provider taxonomies and is based on a core set of procedure codes[4] for primary care and behavioral health outpatient services. The Tool is intended for use by providers, payers, and other stakeholders to enable a general measurement of payment adequacy through relative comparison to the MPFS and to offer perspective on the efficiency of care delivery for these services in person and by telehealth.

[2] As required under Chapter 382/Senate Bill 534, Preserve Telehealth Access Act of 2023, Section 2.b.2-3 and Chapter 291/House Bill 1148, Behavioral Health Care – Treatment and Access (Behavioral Health Model for Maryland, Section 4.b.2-3.

[3] More information on the MPFS is available on the Centers for Medicare and Medicaid Services website at: www.cms.gov/medicare/physician-fee-schedule/search/overview.

[4] Procedure codes include the following: Current Procedural Terminology (CPT®) system, developed by the American Medical Association (AMA), is used to describe tests, surgeries, evaluations, and any other medical procedure performed by a healthcare provider on a patient. Healthcare Common Procedure Coding System (HCPCS) is a collection of standardized codes that represent medical procedures, supplies, products, and services.

Study approach and limitations

STUDY APPROACH

Milliman developed the Tool that compares provider reimbursement rates as a percent of the MPFS. For the purposes of this report, 100 percent of the MPFS amount serves as the benchmark for all services. This is intended to establish a reference point for comparisons and does not represent an opinion that 100 percent of the MPFS is or is not an adequate reimbursement level for any service.

The Tool was developed by taking claims data from 2019 to 2023 using the APCD data and repricing the allowed provider reimbursements (which include both payer and patient payments made to providers) to a percent of the MPFS using Milliman's Medicare Repricer™. More detail on Milliman's Medicare Repricer can be found in Appendix C. The Tool applies the payment parameters set forth in the MPFS to provide the amount that Medicare would have paid given the MPFS in place the same year the claim was incurred for the same service, considering the specific code, provider type, geography, or other details as necessary to determine the correct amount under MPFS payment rules. Actual reimbursement rates by payer, service, and provider specialty were expressed as a percentage of MPFS to facilitate comparisons across services and provider types.

In addition to the repriced reimbursements, the Tool also includes utilization per 100,000 members for each service. This utilization metric shows the relative volume of included services. These repriced reimbursements and utilization metrics are summarized by various categories (e.g., provider specialty, service category, procedure code) to allow users to understand the reimbursement rates at different levels of granularity. More information about the Tool can be found in Appendix A.

Using the repriced detailed claims data and the utilization metrics allows for a comparison of reimbursement for behavioral health services delivered in person and via telehealth. Because reimbursements are presented as a percent of MPFS, it enables a comparison of reimbursement levels for behavioral health services delivered in person and via telehealth as well as reimbursement levels for behavioral health services to somatic services.

In addition to the development of the Tool, a literature review was conducted to inform the results of each study item in this analysis. The insights gleaned from this review provided additional insights on the data findings.

LIMITATIONS

Defining reimbursement adequacy and whether 100 percent of the MPFS reimbursement is adequate was beyond the scope of this analysis. For the purposes of this report, 100 percent of the MPFS amount serves as the benchmark for all services. This is intended to establish a comparison benchmark and does not represent an opinion that 100 percent of the MPFS is or is not an adequate reimbursement level for any service. To the extent that MHCC or others determine that a different level of reimbursement is necessary, this Tool will still allow for evaluations that compare to different benchmark levels. This could be done by setting the new benchmark level (as a percent of the MPFS) and comparing the reimbursements from this framework analysis to the new benchmark.

Regarding addressing aspects of telehealth that are subject to overuse or underuse or yield greater or lower value:

- There are different interpretations of over- or underuse of telehealth services. Considerations for addressing this study item are addressed primarily via the literature review, as the scope of the analysis was on reimbursement levels and did not include establishing a definition of over- and underuse for telehealth services.
- The utilization metrics provided in the report can help identify the utilization levels for telehealth as it compares to in-person services over time (particularly compared to 2019, prior to the COVID-19 pandemic) but are not perfect metrics by themselves for evaluating the overuse or underuse of telehealth services.
- There are different interpretations of how value is defined. Considerations for addressing this study item are addressed primarily via the literature review, as the scope of the analysis was on reimbursement levels and did not include establishing a definition value for evaluating which services offer greater or lower value.

Service mix will impact reimbursement levels used in this analysis. To the extent that the service mix varies between the service categories, provider types, lines of business, or years, the reimbursement comparison may not be comparing the same bucket of services. A detailed review of service mix impact was beyond the scope of this analysis.

Geography mix will impact reimbursement levels used in this analysis. To the extent that the geographic mix of services provided within the state varies between the service categories, provider types, lines of business, or years, reimbursement comparisons may not be comparing services provided in the same geographies. A detailed review of the geography mix impact was beyond the scope of this analysis.

Because the analysis uses the MPFS as a means to establish comparisons across years and service types, services that are not covered by Medicare are excluded, such as applied behavior analysis (ABA) therapy. ABA therapy is a common service in the commercial and Medicaid markets.

There are other Healthcare Common Procedure Coding System (HCPCS) codes that could be considered for behavioral health or primary care. The analysis is limited to a set of codes that captures more than 99 percent of the utilization of these services in Maryland during the study period.

This analysis does not consider the clinical appropriateness of delivering care through telehealth and in-person care when comparing reimbursement levels.

Milliman completed a limited review of the data used directly in this analysis for reasonableness and consistency and has not found material defects in the data. If there are material defects in the data, it is possible they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this report.

Findings

In reviewing the results of analysis to compare utilization and reimbursement levels for behavioral health and primary care services provided via in-person versus telehealth, several key observations were identified based on the reimbursement analysis using the Maryland APCD and findings from the literature review.

The findings presented in this section pertain to the following two study items:

1. Help identify what aspects of telehealth are subject to overuse or underuse or yield greater or lower value
2. Assess the adequacy of reimbursement for behavioral health services delivered in person and via telehealth

Each study item is structured to first present findings from the literature review, followed by a subsection detailing findings from the analysis (where applicable).

These findings and analysis may not necessarily be applicable to other situations. Further details for each finding are provided below.

STUDY ITEM #1 –OVERUSE OR UNDERUSE AND VALUE OF TELEHEALTH SERVICES:
Telehealth – Overuse and underuse

Evidence in literature regarding whether telehealth may be subject to overuse (due to the convenience of accessing services, or other factors) is mixed.[5,6] A study comparing outpatient utilization of telehealth users and nonusers in 2017 found that individuals that used telehealth had 0.44 fewer annual visits to primary care, 0.11 fewer annual visits to emergency departments, and 0.17 fewer annual visits to retail and urgent care, suggesting that telehealth is substitutive rather than additive and therefore may not increase overall use,[7] On the other hand, some studies have found that telehealth utilization is at least partly additive, though additive care would not necessarily indicate overuse. For example, a study of direct-to-consumer telehealth[8] care provided through a California health plan found that 12 percent of telehealth visits replaced visits to in-person providers and 88 percent of visits represented new utilization.[9] This study primarily focused on encounters related to acute respiratory infection visits and may only be appropriate to extrapolate to primary care telehealth, but not behavioral health. In the case of behavioral health care, where there is limited in-person care available due to provider shortages,[10] determining whether services are being overused may be more difficult. In this case, services that appear additive may represent closures of gaps in care as patients access care that they were previously unable to access due to local provider shortages. Additionally, both of these studies predated the surge in telehealth utilization that happened starting in 2020 due to the COVID-19 pandemic and may not be reflective of current telehealth usage patterns.

Alternatively, audio/visual telehealth may be subject to underutilization in some cases because it often requires access to broadband internet and an understanding of how to use audiovisual technology.[11] In areas with sparse to no broadband service or within low-income populations that may not be able to consistently afford broadband service,

[5] Ellimoottil, C. (May 2021). Understanding the Case for Telehealth Payment Parity. *Health Affairs*. Retrieved from: https://www.healthaffairs.org/content/forefront/understanding-case-telehealth-payment-parity

[6] Khera, N. Knoedler, M., Meier, S, et al. (May 2023). Payment and Coverage Parity for Virtual Care and In-person Care: How Do We Get There? Telemedicine Reports. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10240289/

[7] Cuellar, A., Pomeroy, J., Burla, S., et al. (June 2022). Outpatient Care Among Users and Nonusers of Direct-to-patient Telehealth: Observational Study. *Journal of Medical Internet Research*. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9210206/

[8] This refers to care in which a patient has access to a physician via telephone or videoconferencing.

[9] Ashwood, J., Mehrotra, A., Cowling, et al. (March 2017). Direct-to-consumer Telehealth May Increase Access to Care but Does Not Decrease Spending. *Health Affairs*. Retrieved from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1130

[10] Health Resources and Services Administration (December 2023). Behavioral Health Workforce, 2023. National Center for Health Workforce Analysis. Retrieved from: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf

[11] Saeed, S. and Masters, R.M. (July 2021). Disparities in Health Care and the Digital Divide. *Current Psychiatry Reports*. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8300069/

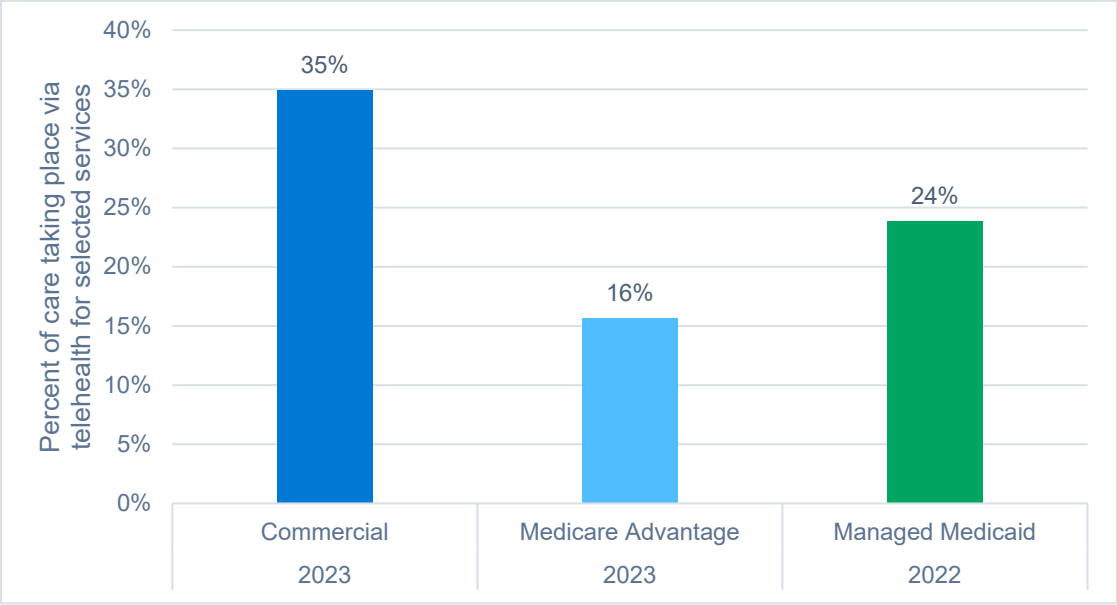
audio-only telehealth is an alternative option. Older populations have also been found to utilize audio-only services over video services.[12]

Overuse or underuse of telehealth services – Analytical findings

To assess the overuse or underuse of telehealth services would require a definition of what the clinically appropriate use levels are, which is beyond the scope of this analysis. The analysis attempts to identify differences in telehealth utilization by line of business, prior years, and for behavioral health versus primary care services.

In the most recent year of data available by line of business (2023 for commercial and Medicare Advantage, and 2022 for Medicaid), the commercial market has the highest share of combined behavioral health and primary care services performed via telehealth (35%), followed by managed Medicaid (24%) and Medicare Advantage (16%). See Figure 3. The mix of services varies between the lines of business, but because the usage of telehealth services differs between these lines of business, there may be indicators of overuse or underuse of these services in the different lines of business. A clinical evaluation could help determine if any of these differences in utilization are due to over- or underuse of clinically appropriate telehealth services.

FIGURE 3: PERCENT OF CARE PROVIDED VIA TELEHEALTH FOR SELECTED BEHAVIORAL HEALTH AND PRIMARY CARE SERVICES COMBINED, 2022-2023



Comparing the utilization of telehealth services to 2019 (prior to the increased usage seen as a result of the COVID-19 public health emergency), the utilization of services via telehealth continues to be higher than prior to the pandemic for both behavioral health and primary care services across all lines of business. These shifts are highlighted by the following line graphs that show telehealth services are utilized significantly more than they were in 2019. While this does not suggest overuse or underuse of telehealth services, it does suggest that the market had capacity to provide more services via telehealth (for both behavioral health and primary care services) than were provided in 2019. See figures 4a, 4b, and 4c.

[12] Rodriguez, J. and Betancourt, J. (January 2021). Differences in the Use of Telephone and Video Telemedicine Visits During the COVID-19 Pandemic. *The American Journal of Managed Care*. Retrieved from: https://www.ajmc.com/view/differences-in-the-use-of-telephone-and-video-telemedicine-visits-during-the-covid-19-pandemic

Across all lines of business, behavioral health services consistently have a higher share of services performed via telehealth versus in person than primary care. This may be due to differences in the mix of behavioral health and primary care services and the appropriateness of care provided via telehealth versus in person. Some aspects of care that are easier to complete in person, such as obtaining vital statistics and completing physical examinations, are less relevant for behavioral health services, and as such the proportion of cases that can appropriately be handled via telehealth may be higher for behavioral health than for primary care. A clinical evaluation of the appropriateness of care could help determine if there are opportunities with either behavioral health or primary care services to support the appropriate usage of telehealth services. See figures 4a, 4b, and 4c.

FIGURE 4A: PERCENT OF INCLUDED SERVICES PROVIDED VIA TELEHEALTH, 2019-2023 (COMMERCIAL MARKET)

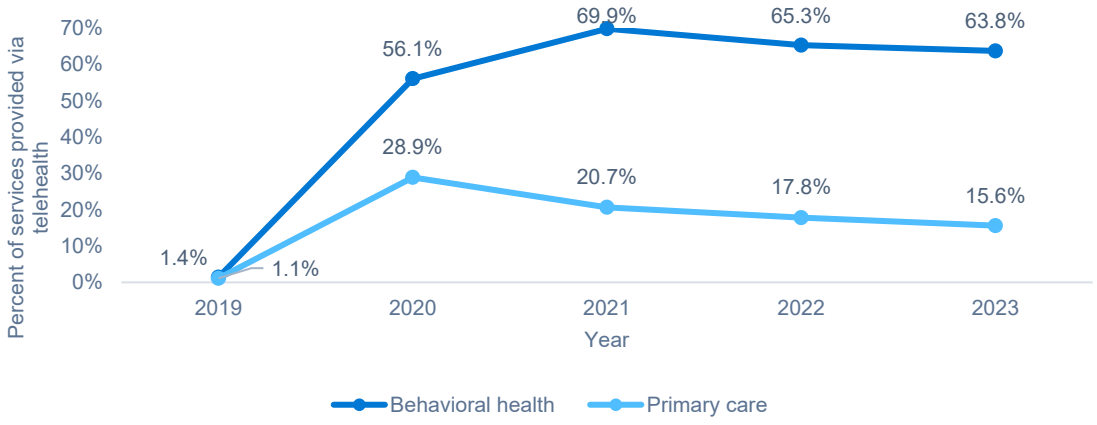


FIGURE 4B: PERCENT OF INCLUDED SERVICES PROVIDED VIA TELEHEALTH, 2019-2023 (MEDICARE ADVANTAGE)

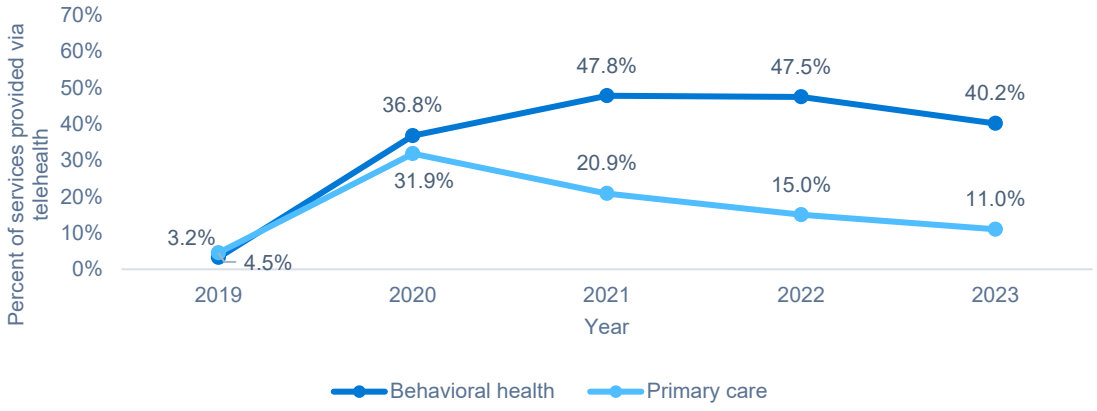
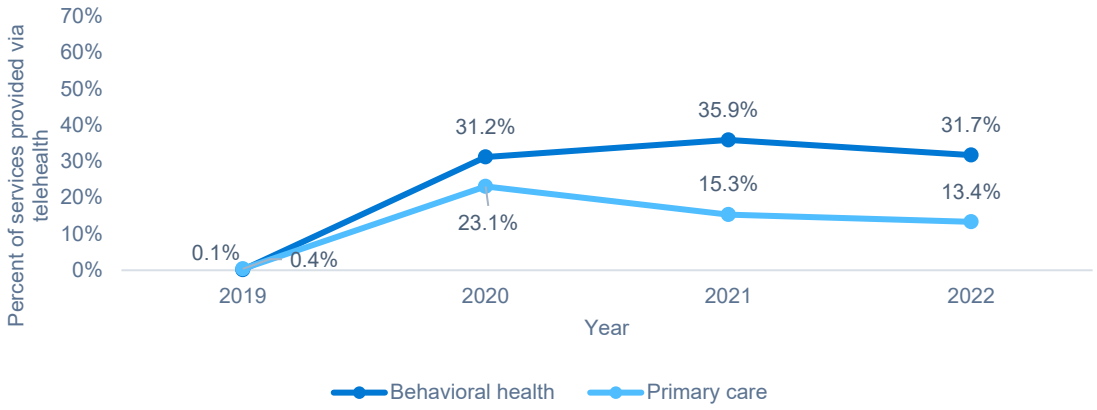


FIGURE 4C: PERCENT OF INCLUDED SERVICES PROVIDED VIA TELEHEALTH, 2019-2022 (MEDICAID MANAGED CARE)



As shown in Figure 5, the use of telehealth for the delivery of primary care services has consistently trended downward since 2020, whereas Figure 6 shows that the use of telehealth for the delivery of behavioral health services has remained more consistent, or even trended slightly upward. This was observed across all lines of business. Generally, telehealth saw higher utilization during the COVID-19 pandemic in 2020. The spike in 2020 does not suggest that is the appropriate level of telehealth usage, but it does indicate a level that was supported in the markets. The decreasing utilization of telehealth for primary care services is a trend that should be monitored to ensure that it is not a result of underuse of telehealth (when appropriate) and that the shift aligns with appropriate usage levels for telehealth care given the services provided. Telehealth utilization for behavioral services is lower in the managed Medicaid market than in other markets. If Medicaid enrollees have more complicated behavioral health conditions, that could contribute to a lower ability for telehealth to be effective than for those with mild to moderate behavioral health conditions in the commercial and Medicare Advantage markets.

- The red dashed lines in Figure 5 represent trend lines for the percent of primary care services that are taking place via telehealth, and they show a sharp decrease since 2020.
- The red dashed lines in Figure 6 represent trend lines for the percent of behavioral health services that are taking place via telehealth, and they show a slight continued increase, though the rates may be reaching a leveling-off point after peaks in 2021. In all lines of business, the most recent year is lower than the year prior.

FIGURE 5: PERCENT OF PRIMARY CARE SERVICES THAT TAKE PLACE VIA TELEHEALTH, 2019-2023

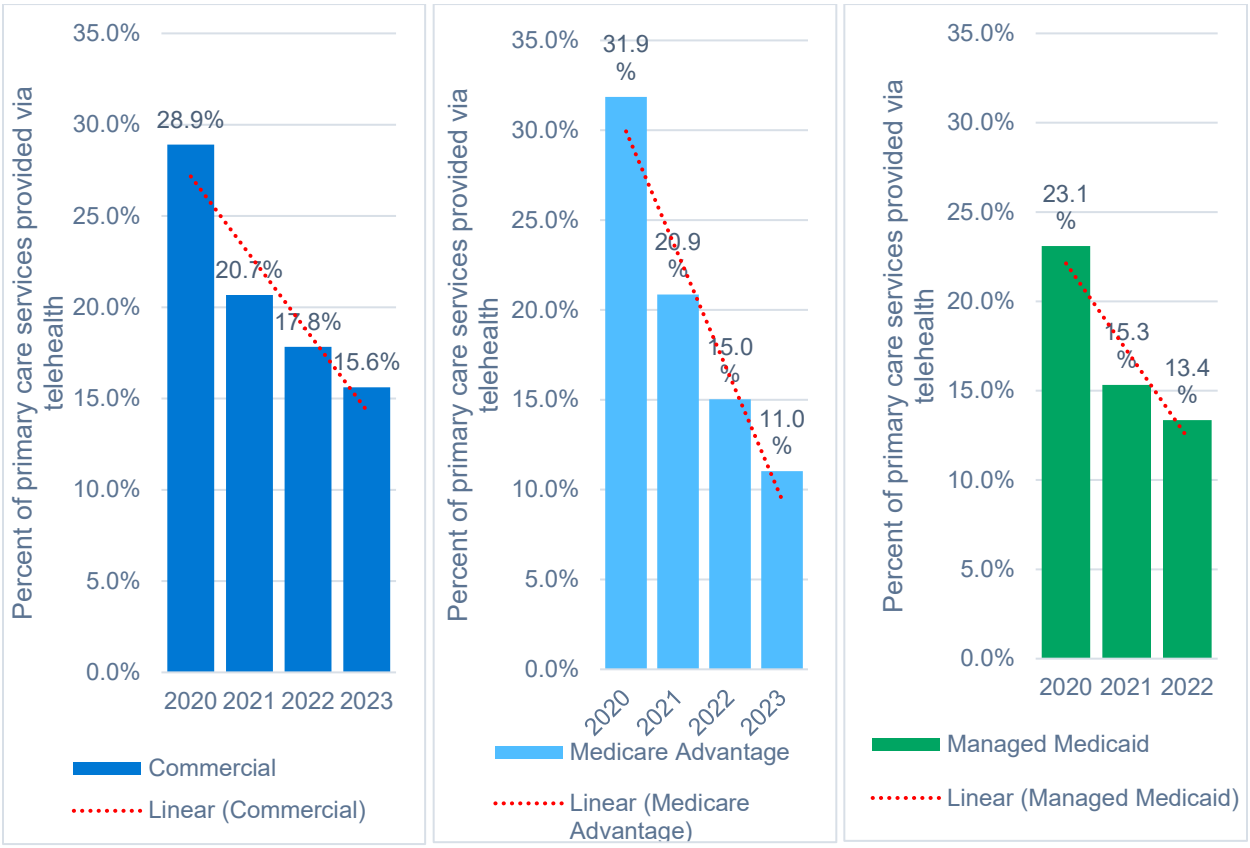
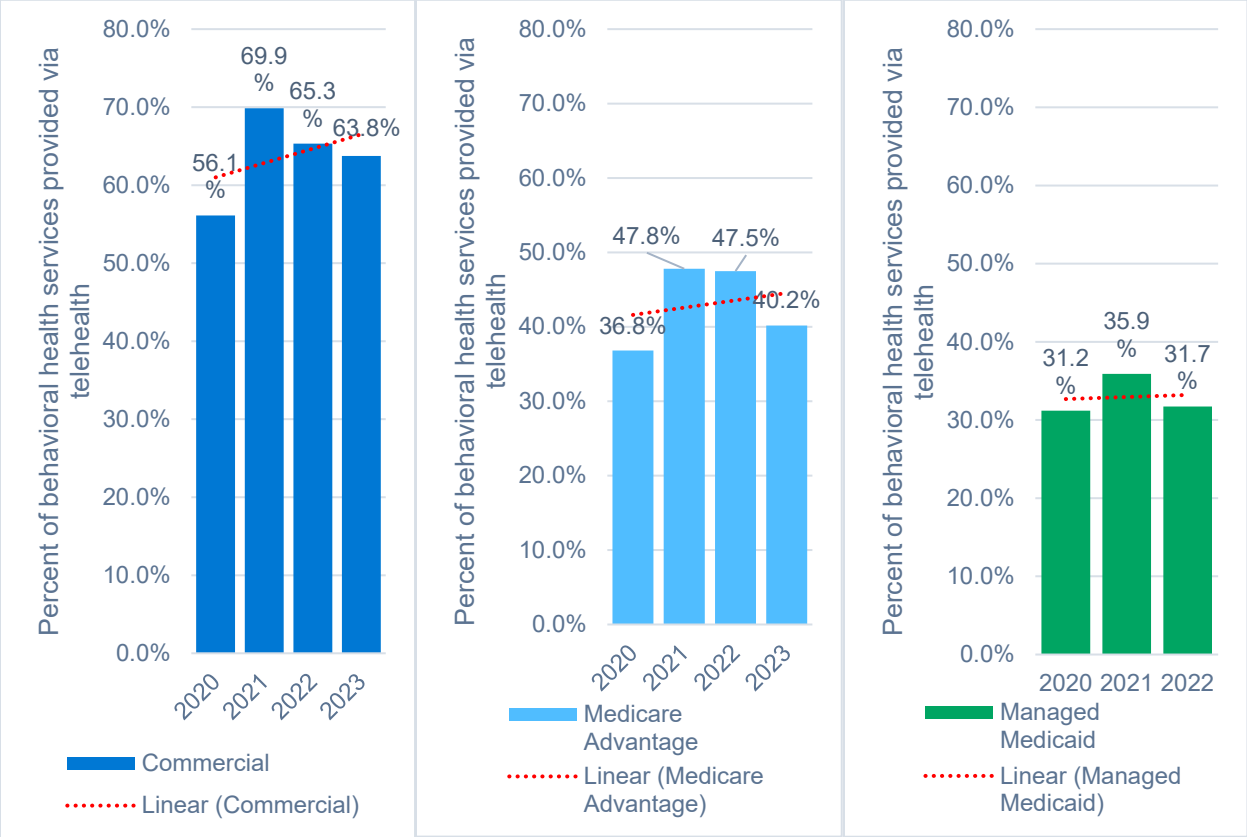
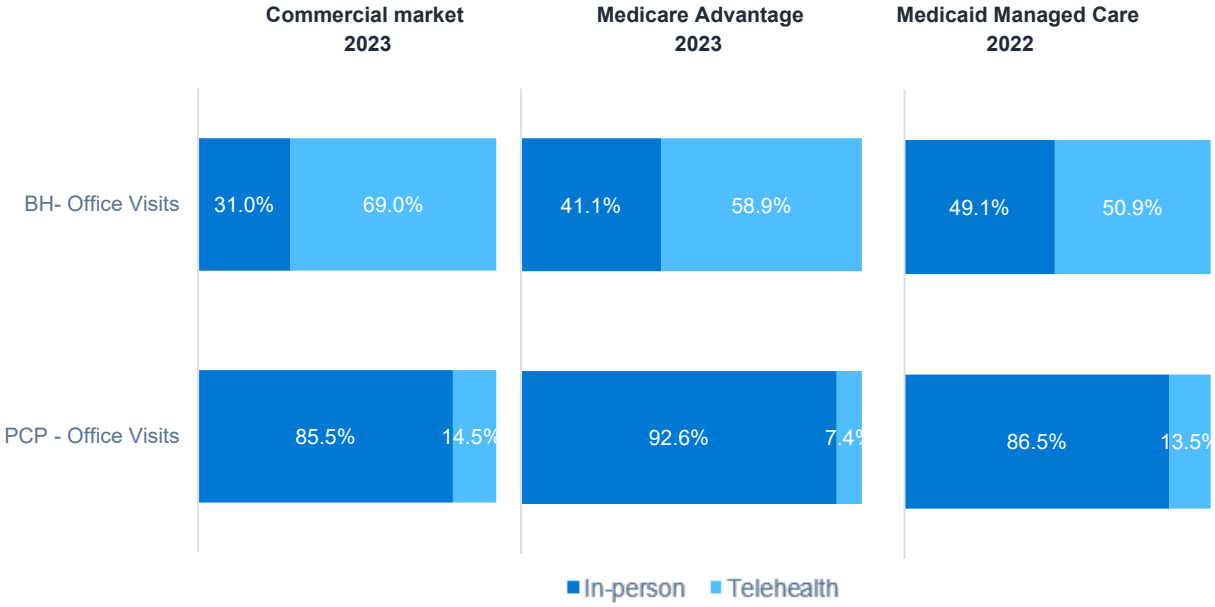


FIGURE 6: PERCENT OF BEHAVIORAL HEALTH SERVICES THAT TAKE PLACE VIA TELEHEALTH, 2019-2023



As shown in Figure 7, behavioral health office visits are more commonly provided via telehealth than primary care office visits. A clinical evaluation could help determine if any of these differences in utilization are due to overuse or underuse of clinically appropriate telehealth services.

FIGURE 7: PERCENT OF INCLUDED SERVICES PROVIDED IN-PERSON VS. TELEHEALTH FOR OFFICE VISITS, 2022-2023



Telehealth – Value

Value can be defined through multiple perspectives, including patient, provider, health system and payers, and measured across numerous metrics, such as health care cost and utilization, health outcomes, quality and access, and patient or provider experience. In this section, the value of telehealth is defined relative to equivalent in-person services.

Several systematic literature reviews assessing effectiveness of telehealth behavioral health services have found that for some conditions, telehealth is as effective as in-person care in producing the same outcomes, such as improved health outcomes, patient satisfaction, reduced hospital admissions, and improved adherence.[13] In a recent literature review conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) assessing effectiveness of telehealth for behavioral health services, evidence suggests that telehealth is as effective as in-person treatment in improving health outcomes for many behavioral health conditions, including serious mental

[13] Substance Abuse and Mental Health Services Administration (2021). Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders. Evidence-based Resource Guide Series. Retrieved from: https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf

Hilty, D., Derrer, D., Paris, M., et al. (June 2013). The Effectiveness of Telemental Health: A 2013 Review. *Telemedicine Journal and E-health*. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662387/;https://pubmed.ncbi.nlm.nih.gov/30048211/;https://pubmed.ncbi.nlm.nih.gov/33826190/

Berryhill, M., Culmer, N., Williams, N., et al. (June 2019). Videoconferencing Psychotherapy and Depression: A systematic Review. *Telemedicine Journal and E-health*. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/30048211/

Fernandez, E., Woldgabreal, Y., Day, A., et al. (November 2021). Live psychotherapy by video versus in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment. *Clinical Psychology & Psychotherapy*. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/33826190/

illness (SMI) and substance use disorder (SUD).[14] This review focused on synchronous[15] forms of delivery, including audio and audiovisual services.

Telehealth is generally thought to be an important care delivery method to improve health equity by improving access to behavioral health services, particularly in rural areas and for those with barriers related to transportation, childcare, or limited time off work.[16] There have been concerns over the ability to form therapeutic relationships between patients and providers over the phone or video.[17] However, systematic reviews have also found that the therapeutic relationship between patients and providers is similar between in-person and telehealth behavioral health care.[18]

Costs

Literature on the health care costs to providers and payers for behavioral telehealth interventions is sparse, including cost-effectiveness and return on investment (ROI). Telehealth has been shown to generally be a cost savings relative to in-person care for a variety of conditions, though health care costs varied by condition and treatment.[19] Further research on this topic is needed to quantify the cost of implementing and providing behavioral health telehealth services at scale, especially for SUD-related treatment. In a systematic literature review that summarized 26 U.S. and international studies reporting costs of telepsychiatry programs, 60 percent reported being less expensive than usual in-person care and 32 percent reported being more expensive.[20]

There is also little evidence on how telehealth may impact patient costs, including costs associated with travel to appointments and missed work. Existing literature focuses on post-operative surgical care[21] and ambulatory care for chronic condition management.[22] Further research is needed to quantify these costs to patients receiving behavioral health or primary care telehealth services.

[14] Substance Abuse and Mental Health Services Administration (2021) op. cit.

[15] In this case, “synchronous” means real-time interactions between patient and provider.

[16] Benavides-Vaello, S. Strode, A. & Sheeran, B. (January 2013). Using technology in the delivery of mental health and substance abuse treatment in rural communities: A review. *Journal of Behavioral Health Services & Research*. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/23093443/

[17] Connolly S.L., Miller C.J., Lindsay J.A., et al. A systematic review of providers' attitudes toward telemental health via videoconferencing. *Clinical Psychology: Science and Practice*. 2020;27 doi: 10.1111/cpsp.12311

[18] Stiles-Shields C., Kwasny M.J., Cai X., et al. Therapeutic alliance in face-to-face and telephone-administered cognitive behavioral therapy. *Journal of Consulting and Clinical Psychology.* 2014;82:349–354

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STUDY ITEM #2 – BEHAVIORAL HEALTH IN-PERSON VS TELEHEALTH REIMBURSEMENT ADEQUACY

Behavioral health reimbursement adequacy – In person versus telehealth

Evidence in literature clearly lays out that reimbursement for behavioral health providers generally tends to be lower relative to medical and surgical providers.[23, 24, 25] This is generally attributed to historical disparities in funding, differences in market dynamics, and perceived differences in the complexity and duration of behavioral health treatments.

In a study that analyzed 2016-2017 commercial PPO health claims to compare in-network and out-of-network behavioral health and physical health utilization and reimbursement, out-of-network use was found to be 5.0 times higher for behavioral health than for primary care and 3.7 times higher as compared to medical specialists.[26] The study also found that the average in-network reimbursement rates for behavioral health office visits were lower than for medical or surgical office visits when expressed as a percentage of the Medicare-allowed amounts. For example, primary care reimbursements were 23.8 percent higher than behavioral health reimbursements.

Another a study comparing reimbursement by network status for privately insured individuals with a behavioral health diagnosis found that psychiatrists were reimbursed at rates 13 to 20 percent lower than medical doctors for patients with low to high severity conditions respectively when in network but 28 percent and 6 percent higher for those same services and condition severity when out of network.[27]

Medicaid fee-for-service reimbursement for psychiatric services have also been found to be on average 81 percent of the Medicare rate for the same services.[28] States with higher Medicaid rates relative to Medicare rates had some of the lowest psychiatrists per 10,000 enrollees, suggesting that these states are looking to improve provider Medicaid participation. A study comparing telehealth and in-person commercial reimbursement rates for common behavioral health CPT codes also found that reimbursement rates for most services were significantly lower for telehealth as compared to in-person delivery.[29]

In 2024, CMS updated the MPFS by increasing reimbursement of psychotherapy for crisis services by 150 percent when care is provided outside of health care settings. Rates for time-based psychotherapy visits and office-based substance use disorder services were also increased. These changes were intended to address the gap in reimbursement and more accurately represent the value of behavioral health services.[30]

Payment parity may also support health equity. Paying the same rate for audio, audio/video, or in-person visits reduces barriers to access for patients. If reimbursement were lower for audio or audio/video relative to in person, providers would not be incentivized to use telehealth modalities.[31]

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[25] Mark, T., Olesiuk, W, Ali., M., et al. (December 2017). Differential Reimbursement of Psychiatric Services by Psychiatrists and Other Medical Providers. *Psychiatric Services*. Retrieved from: https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201700271?journalCode=ps&

[26] Melek, S. op. cit.

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[31] Westby, A., Nissly, T., Gieseker, R., et al. (February 2021). Achieving Equity in Telehealth: "Centering at the Margins" in Access, Provision, and Reimbursement. *Journal of the American Board of Family Medicine*. Retrieved from: https://www.jabfm.org/content/jabfp/34/Supplement/S29.full.pdf

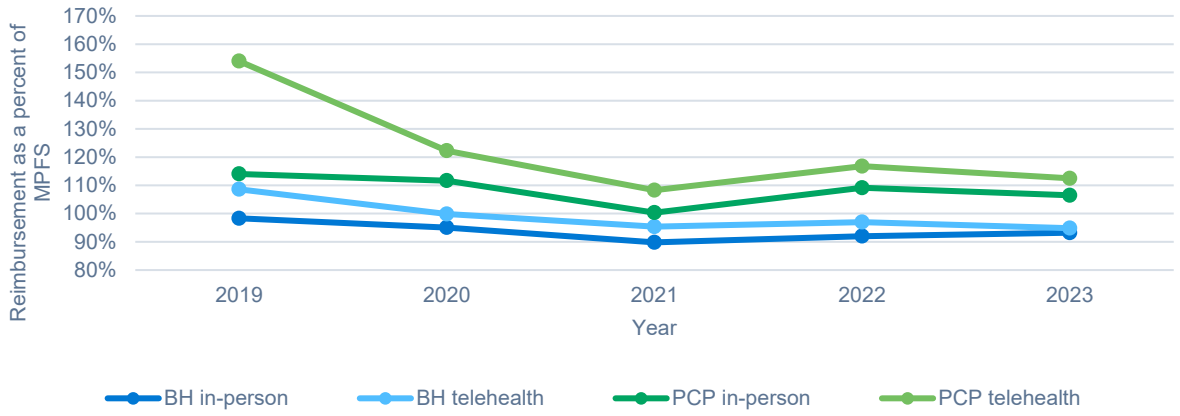
Behavioral health reimbursement adequacy – Analytical findings

To evaluate the adequacy of reimbursement for behavioral health services provided in person and via telehealth, costs for health care claims were calculated as a percent of the MPFS. For the purposes of the analysis, the baseline for comparison is 100 percent of MPFS reimbursement. Once all claims are on that basis, the report provides comparisons of reimbursement levels for both behavioral health and primary care services. Please note the limitations in this analysis outlined in this report, including the limitation that comparing reimbursement levels may vary due to differences in service mix and geography of where services are provided.

In the commercial line of business, there are three key findings (see Figure 8):

- Reimbursement levels for primary care services are higher than reimbursement levels for behavioral health services, as a percent of the MPFS.
- Reimbursement levels for telehealth services are higher than for services provided in person. Telehealth reimbursement levels have been three 3 to 10 percent higher for behavioral health telehealth services and one 1 to 35 percent higher for telehealth primary care services when compared to the respective in-person service reimbursement levels.
- The spread of reimbursement levels between behavioral health and primary care services done in person and via telehealth has narrowed over time.

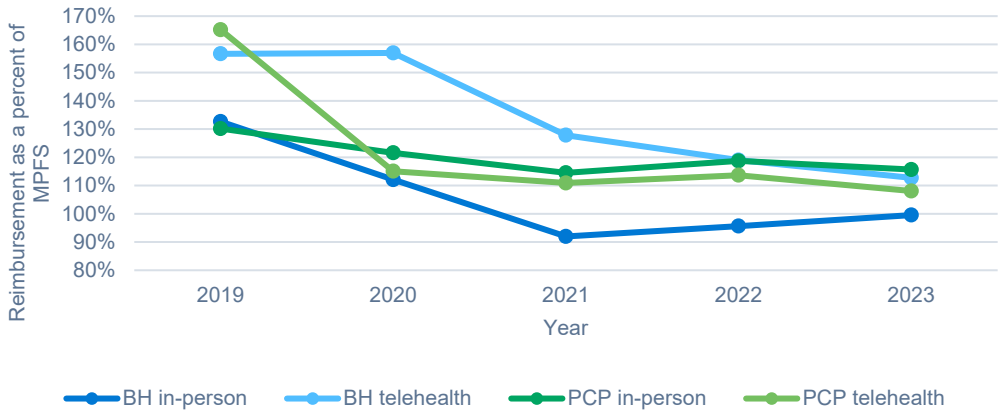
FIGURE 8: AVERAGE REIMBURSEMENT RATES RELATIVE TO MPFS FOR ALL INCLUDED SERVICES, 2019-2023 (COMMERCIAL MARKET)



In the Medicare Advantage line of business, there are two key findings (see Figure 9):

- Reimbursement levels for in-person behavioral health services have consistently been lower than behavioral health services provided via telehealth.
- The spread of reimbursement levels between behavioral health and primary care services done in person and via telehealth has narrowed over time.

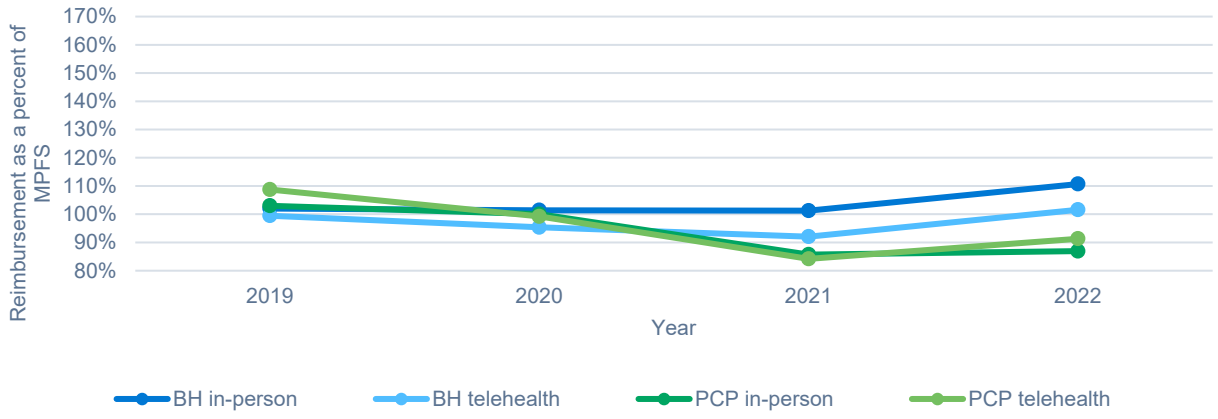
FIGURE 9: AVERAGE REIMBURSEMENT RATES RELATIVE TO MPFS FOR ALL INCLUDED SERVICES, 2019-2023 (MEDICARE ADVANTAGE)



In the managed Medicaid line of business, there are two key findings (see Figure 10):

- Reimbursement for in-person behavioral health services has been higher than telehealth and for primary care services in 2021 and 2022.
- The spread of reimbursement levels between behavioral health and primary care services done in person and via telehealth has remained relatively narrow over time when compared to the other lines of business.

FIGURE 10: AVERAGE REIMBURSEMENT RATES RELATIVE TO MPFS FOR ALL INCLUDED SERVICES, 2019-2022 (MEDICAID MANAGED CARE)



Caveats

VARIABILITY OF RESULTS

It is almost certain that future experience will not conform exactly to the historical results shown in this work. Future amounts will differ from historical amounts to the extent that the future experience varies from historical experience.

MODEL AND DATA RELIANCE

Milliman has used and developed certain models to estimate the values included in this report and in the framework dashboard. The intent of the models was to estimate reimbursement levels for specific services as a percent of the MPFS. This model, including its inputs, calculations, and outputs were reviewed for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. This analysis relies upon certain data and information for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes:

- Data from Maryland's APCD, as accessed via OnPoint
- Milliman's Health Cost Guidelines (HCGs)

The models, including all input, calculations, and output, may not be appropriate for any other purpose.

A limited review of the data used directly in the analysis was performed to evaluate the data for reasonableness and consistency and did not find material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this analysis.

QUALIFICATIONS TO PERFORM ANALYSIS

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Brent Jensen and Matt Caverly are members of the American Academy of Actuaries and meet the qualification standards for performing these analyses.

DISTRIBUTION AND USAGE

MHCC intends to distribute this report to the Commissioners, and it may be published on its website. Milliman consents to the distribution of the mutually agreed-upon final version of this report as long as the work is distributed in its entirety. Milliman does not intend to benefit any third-party recipient of its work product and assumes no duty or liability to other parties who receive this work. Any third party using this report, tool, or analysis is advised to have an appropriate professional or expert help interpret results of the analysis.

The structure of the associated Payer Reimbursement Comparison Tool allows the user to make certain modifications in the process of using the file once it is installed on the user's system. Milliman makes no warranty with regard to the performance or accuracy of the analysis once the user modifies or in any way alters the file from the form in which it is originally provided by Milliman. The user is solely responsible for any modifications or alterations made to the file during use. Milliman has populated the model with default values. Milliman will not be liable for any damages of any kind resulting in any way from the use of this analysis after the user has modified or altered the file from the form in which it is originally provided to MHCC on May 27, 2024. The user should make a back-up copy of the file prior to using it for the first time and keep the original in a safe location.

Appendix A: Payer Reimbursement Comparison Tool

REIMBURSEMENT COMPARISON TOOL

The Reimbursement Comparison Tool (Tool) is an interactive tool for use by payers, providers, and other stakeholders and shows reimbursement levels and utilization metrics for behavioral health and somatic services provided in person and via telehealth. The Tool allows the user to review reimbursement levels and utilization metrics by:

- Year – Includes 2019 to 2023 (note that Medicaid data were not yet available for 2023 at the time of publication)
- Line of business – Includes commercial, Medicare Advantage, and managed Medicaid lines of business where health care services are provided
- Provider specialty type – Includes 18 provider specialties including family practice, general practice, psychiatry, and others
- In-person and telehealth services – Telehealth services includes both audio only and audio/video visits
- Service code categories[32] – Groups of specific procedure codes into rolled up categories, including outpatient behavioral health and primary care services
- Procedure codes – These codes are based on Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes

Overview

The comparison tool contains several tabs, each of which is described in detail in the Tool. These tabs in the Tool further detail and give instructions on the use and interpretation of results for each tab. The reimbursement comparison tool can be accessed on the MHCC website.

In several places throughout the Tool, the user can select specific inputs to focus on via drop-down menus, generally in the upper left quadrant of each tab.

Note that results are not provided for services when the total volume of claims under the user's selection criteria falls below a credibility threshold. It is recommended that interpreting the results be done with caution when sample sizes (as expressed through utilization rates per 100,000 beneficiaries) are low. Also, users should be mindful of the sample sizes when making comparisons.

Comparisons between in-person and telehealth services

All the tables and charts provided within the Tool display results separately for in-person and telehealth services. Some services are only provided in person (e.g., transcranial magnetic stimulation), and some are only provided via telehealth (e.g., evaluations billed on telephone-specific CPT codes), but most of the included services can be provided both in person or via telehealth, allowing the user to review results for each and make observations about similarities and differences for both.

Comparisons between outpatient behavioral health and primary care services

Results are provided throughout the Tool both for behavioral health and primary care provider specialty types, and for the associated services that these providers most commonly provide. This allows the user to make comparisons between primary care and behavioral health services, both for in-person and telehealth visits.

[32] Note that the service categories included in the Tool are meant to represent natural groupings of the included procedure codes and are not a comprehensive representation of all services that could fall under the applicable label. There are many other services not included in this analysis that could reasonably be grouped under the same headings, and as such the results by category for codes included in this framework may differ from results if all services that could possibly be grouped under each category were included, rather than just the highest-volume codes.

Comparisons between provider specialty types
Results are also provided in aggregate across all included services by provider specialty type for ease of comparing each provider specialty type in the same view.

Appendix B: Detailed data summarized

The following section describes various detailed data fields that are available in the Tool and that were used in this analysis.

PROCEDURE CODES

In order to get the list of behavioral health codes, the Tool is filtered to HCPCS assigned to outpatient mental health and substance use disorder service categories in the Milliman Health Cost Guidelines (HCGs). The Tool also includes evaluation and management (E&M) HCPCS when they are billed with a CMS specialty code of 26 (psychiatry), 27 (geriatric psychiatry), or 86 (neuropsychiatry).

For the list of primary care physician (PCP) codes, the Tool is filtered to HCPCS assigned to primary care practitioner service categories in the Milliman HCGs. These codes could be billed by a PCP or a specialist and will be considered as primary care for this analysis when billed with a PCP specialty code (01, 08, 11, 37, 38, 50, 84, 97, C6, X7, Y8, Y9).

This initial list included more than 500 procedure codes and was pared down based on an analysis of utilization patterns. By limiting to the top 75 codes, the Tool captures more than 99 percent of the utilization in these categories.

SERVICE CODE CATEGORIES

Procedure codes for similar services were grouped into subcategories to allow for additional aggregation within the behavioral health and primary care groupings. Primary care services were defined as outlined in the previous procedure codes section, which describes how PCP codes were selected.

YEARS OF DATA

The analysis includes services from 2019 to 2023. Medicaid data was not available in 2023.

This allows for a review of reimbursement levels and utilization metrics over time.

LINES OF BUSINESS

The Tool contains results for three lines of business: commercial, Medicare Advantage, and managed Medicaid. Enrollees in commercial plans include those with coverage through an employer, either in fully insured or self-funded arrangements, those with individual coverage through the ACA, and those with small group coverage through the ACA. Enrollees in Medicare Advantage plans include those who are Medicare-eligible and are enrolled in Medicare Advantage for Medicare Parts A and B through a carrier rather than receiving coverage through traditional fee-for-service Medicare. Enrollees in managed Medicaid are those who are Medicaid-eligible and are enrolled in managed Medicaid through a carrier in the state of Maryland.

PROVIDER SPECIALTY

The Tool allows the user to select from a list of provider specialties in some of the tables. This list of specialties was developed through a review of the utilization across all years and lines of business. The top 18 specialties by utilization were included the rest were grouped into an “All Other Specialties” bucket.

ALL PAYER CLAIMS DATABASE (APCD) CLAIMS ANALYSIS

Milliman developed an analysis of the relative frequency with which different types of providers appeared in the APCD, as well as the most common types of services billed by those providers. This information was used in conjunction with stakeholder input to identify the key provider and service types for inclusion in the framework. Ultimately, a total of 18 specialty types (based on CMS’s provider specialty categorization schema) were included, reflecting a wide range of qualifications and credentials for providers that may deliver behavioral health or primary care services. The analysis focused on primary care and outpatient behavioral health services billed under HCPCS or CPT codes, grouped into categories, including a total of 50 codes for behavioral health services, and 25 codes for primary care services.

Provider specialty types included addiction medicine, clinical psychologist, family practice, general practice, hospitalist, internal medicine, licensed clinical social worker, mental health counselor, multispecialty clinic or group practice, neuropsychiatry, nurse practitioner, pediatric medicine, physician assistant, psych/mental health facility, psychiatry, psychologist (billing independently), public health or welfare agencies, and rehabilitation agency. A separate “all other” category was used as a catch-all to include any data not delivered by one of the listed provider types.

Note that some provider specialty types can deliver both behavioral health or physical health services, depending on the individual provider’s training and the patient’s needs. When this is the case, services are assigned to either a behavioral health category or to a primary care category based on the specific service provided.

Behavioral health services were divided into the following categories: collaborative care and care management, psychotherapy for crisis, electroconvulsive therapy (ECT), opioid treatment programs, psychotherapy, screenings and diagnostic evaluations, transcranial magnetic stimulation (TMS), office visits, emergency department visits, consults, home or residence visits, and telephonic evaluation.

Primary care services were divided into the following categories: consults, home or residence visits, office visits, and telephonic evaluation.

As with provider specialty types, some of the included services can be provided by either behavioral health or physical health specialists. When this is the case, services are assigned to either a behavioral health category or to a primary care category based on the specialty code of the provider delivering the service.

Detailed technical specifications for each aspect of the APCD analysis are provided in the "Data Source" section of this report.

DATA SOURCE

This analysis relied on Maryland’s All Payer Claims Database (APCD) for claims data from 2019 to 2023. Each year included all services incurred during that year with at least three months of claims runout data except for 2023. Claims data from 2023 only had claims incurred and paid through September 2023. As a result of not having a full year of data, the analysis examined runout patterns in prior years to complete the data. On average, claims were slightly more than 75 percent complete through September, so an adjustment factor was applied to complete 2023 claims.

Appendix C: Percent of Medicare physician fee schedule and utilization calculation

The two key metrics of the Tool are reimbursements as a percent of the MPFS and utilization metrics. To calculate these two metrics, access to the Maryland APCD behavioral health and primary care data through a secure Amazon Workspace environment was provided. Using SAS, 2019–2023 MA, commercial group, individual, and 2019–2022 Medicaid professional behavioral health and primary care claims and member data were pulled from the database. Behavioral health, behavioral health E&M, and PCP claims were identified using the procedure code and provider specialty codes described in this report. Only the fields required to run the claims through Milliman's Medicare Repricer™, which enables the comparison to the MPFS, were pulled from the database. All personally identifiable information (PII) (member ID, subscriber ID, and date of birth) in the claims data was masked before securely transferring it into Milliman's environment, where it was processed through Milliman's Medicare Repricer™ tool.

The methodology for these two calculations is described in more detail below.

PERCENT OF MPFS

To create the Medicare repricing results, Maryland's CY 2019–2023 MA, commercial group, individual, and 2019–2022 Medicaid professional behavioral health and primary care detailed incurred claims experience was processed using the Milliman Medicare Repricer™, a proprietary product developed by Milliman. Claims were repriced using the published Medicare professional fee schedules, in effect at the date of service, to estimate Medicare fees. SNF and home health claims are excluded. Some professional claims are priced by the carrier that contracts with Medicare to pay claims (carrier priced services). These services were excluded from this analysis.

Milliman Medicare Repricer limitations and assumptions

Below is a list of some assumptions and limitations of the Milliman Medicare Repricer:

General assumptions/limitations:

All results are based on data and information published by CMS or the Medicare Administrative Contractors (MACs).

All repriced amounts reflect prospective amounts and do not reflect any settlements with CMS.

No adjustments are made for sequestration.

Medicare employs claim edits to deny payment for certain services. All services with a positive allowed amount were assumed to be accepted for payment and included these services in the repricing analysis. The Government Accountability Office (GAO) estimated the impact of prepayment edits in fiscal year 2010 to be approximately 0.5 percent of Medicare fee-for-service costs.

The Milliman Medicare Repricer does not adjust claims for information contained within condition codes, such as codes 42 and 43, which can be added on a claim to bypass the reduction for certain transfers, or ZA, which can exclude a claim from COVID new technology payments.

Professional:

Medicare reduces payment for outpatient physical and occupational therapy services furnished by a therapy assistant to 88 percent of the rate that would have otherwise been paid. The Milliman Medicare Repricer does not apply this adjustment.

The Milliman Medicare Repricer does not include physician incentive payment adjustments, such as those under the Electronic Prescribing (eRx) Incentive Program, the Physician Quality Reporting System (PQRS), the Maintenance of Certification Program (MOC), the Primary Care Incentive Payments (PCIP) program, or the Merit-Based Incentive Payment System (MIPS).

Ambulance claims are paid by whether they begin in an urban, rural, or super rural area, but the Milliman Medicare Repricer uses the ambulance provider's county in its pricing because the pickup location is not always available in the claims data.

Medicare makes additional payments for professionals in health professional shortage areas and to physicians who have assigned their billing rights to critical access hospitals (CAHs). These payments and adjustments are not incorporated into the Milliman Medicare Repricer.

Professional – Services not covered by traditional Medicare:

Medicare develops RBRVS RVUs for services that are not paid for by Medicare. These RVUs were used to develop Medicare allowable estimates for these claims which would typically not be paid by Medicare (e.g., consults).

Milliman developed professional RVUs for immunization services without explicit Medicare reimbursements. These RVUs were developed to be comparable to Medicare RBRVS RVUs and were used in the assignment of Medicare allowed amounts for immunizations.

UTILIZATION

The utilization count comes from the Quantity field in the Maryland APCD data as reported to OnPoint by the submitting carrier and represents units of service.

EXCLUSIONS

Besides the limitations and assumptions of the Milliman Medicare Repricer described in the Percent of MPFS section above, the following exclusions were made in the claims data:

- APCD claims data was excluded when the Orphaned Adjustment Flag = "Y". When this flag = "Y", the claim record is an adjustment for which the original claim was not submitted. MHCC recommended excluding these claims.
- Since professional Medicare claims pricing depends on provider geography, claims with missing or invalid provider geographies were excluded.

Appendix D: List of procedure codes

Procedure Code	Category[33]
90834	Behavioral Health
90837	Behavioral Health
90847	Behavioral Health
90832	Behavioral Health
90791	Behavioral Health
90833	Behavioral Health
90853	Behavioral Health
90792	Behavioral Health
90836	Behavioral Health
90846	Behavioral Health
90868	Behavioral Health
90785	Behavioral Health
90838	Behavioral Health
G0442	Behavioral Health
99408	Behavioral Health
G2067	Behavioral Health
90839	Behavioral Health
99484	Behavioral Health
99493	Behavioral Health
90870	Behavioral Health
90876	Behavioral Health
99494	Behavioral Health
90849	Behavioral Health
99492	Behavioral Health
G2078	Behavioral Health
99213	Behavioral Health - E&M
99214	Behavioral Health - E&M
99215	Behavioral Health - E&M
99212	Behavioral Health - E&M
99408	Behavioral Health - E&M
99442	Behavioral Health - E&M
99205	Behavioral Health - E&M
99204	Behavioral Health - E&M
99441	Behavioral Health - E&M
99284	Behavioral Health - E&M
99443	Behavioral Health - E&M
99283	Behavioral Health - E&M
99417	Behavioral Health - E&M
99285	Behavioral Health - E&M

[33] E&M codes are deemed to be behavioral-health-related when billed with a CMS specialty code of 26 (psychiatry), 27 (geriatric psychiatry), or 86 (neuropsychiatry). PCP codes are deemed to be primary-care-related when billed with a PCP specialty code (01, 08, 11, 37, 38, 50, 84, 97, C6, X7, Y8, Y9).

Procedure Code	Category[33]
99253	Behavioral Health - E&M
99203	Behavioral Health - E&M
99282	Behavioral Health - E&M
99211	Behavioral Health - E&M
99336	Behavioral Health - E&M
99254	Behavioral Health - E&M
99252	Behavioral Health - E&M
99202	Behavioral Health - E&M
99335	Behavioral Health - E&M
99244	Behavioral Health - E&M
99396	Behavioral Health - E&M
99213	Primary Care
99214	Primary Care
99212	Primary Care
99203	Primary Care
99215	Primary Care
99204	Primary Care
99211	Primary Care
99202	Primary Care
99442	Primary Care
99441	Primary Care
99205	Primary Care
99244	Primary Care
99050	Primary Care
99051	Primary Care
99443	Primary Care
99243	Primary Care
99336	Primary Care
99335	Primary Care
99201	Primary Care
99349	Primary Care
99245	Primary Care
99242	Primary Care
99348	Primary Care
99350	Primary Care
98967	Primary Care

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