ANALYZING PARITY CASE STUDIES

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September 16, 2016
Seton Hall Law School

Special thanks to Danielle King, J.D., Class of 2016, for her assistance in developing these slides.

Case Study 1 – Plan Classification of Services & NQTLs

- Health Plan XYZ provides benefits in each of the six parity classifications of benefits (inpatient in and out of network, outpatient in and out of network, pharmacy, and emergency) for medical/surgical and mental health and substance use disorder benefits.
- For the inpatient classification, XYZ includes certain sub-acute facility services, such as skilled nursing facility benefits and free-standing cardiac rehabilitation facility benefits. In the outpatient classification, Health Plan XYZ includes all services that do not involve an overnight stay in a health care facility, including routine outpatient services, ambulatory surgery, labs and diagnostic testing services, and Durable Medical Equipment, among others. Health Plan XYZ applies the same medical management strategies and processes to all services within a particular classification.
- For MH/SUD benefits, Health Plan XYZ includes acute inpatient care and certain intermediate level of care services, such as residential treatment facility services, in the inpatient classification of benefits. Other intermediate levels of care, such as day treatment programs, partial hospital programs, and intensive outpatient programs, are included as outpatient classification services.

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Questions/Issues for Case Study 1

1. Is the Health Plan XYZ's classification of services/benefits consistent with MHPAEA?
2. Are other approaches to classification of intermediate services permissible under MHPAEA? If so, what considerations would be relevant to the classification of these services? Could the plan, for example, classify certain intermediate services, such as partial hospital programs, in the inpatient classification?
3. How is a NQTL assessed for comparability if, unlike in this example, the Health Plan varies the NQTLs for services within the classification? For example, what if this fact pattern indicated that acute inpatient admissions were subject to prior authorization but skilled nursing facility admissions were not – could the plan apply the prior authorization to both acute inpatient and residential treatment for behavioral benefits? Why/why not?

Case Study 2 – Network Adequacy

- Plan XYZ utilizes comparable, *i.e.*, parity-valid, network admission criteria to credential behavioral health providers to participate in its network. Provider contracts for eligible providers include various requirements respecting utilization review, continuity of care upon termination, fee schedules, and so on. The Plan conforms to all state requirements for network adequacy concerning geo-access and/or provider-to-population ratios for both its medical and behavioral benefits. Plan XYZ is accredited by NCQA/URAC and hence complies with their stated expectations to assess member experience with the Plan's network and monitor its performance, including use of out-of-network (OON) services and maintenance of accurate provider directories.
- Several large employer purchasers of the Plan received numerous complaints from their employee beneficiaries about their ability to access behavioral health practitioners, especially psychiatrists, and requested the following information from the Plan as part of its review of these complaints: 1) please indicate for all of the psychiatrists listed in the Plan's directory how many have actually filed a claim for the last 12 month period; 2) of all claims paid by the plan for psychiatrist services in the last 12 month period, what percentage were submitted and paid for on an OON basis; and 3) for all claims paid by the Plan for primary care physician services in the last 12 month period, what percentage were submitted and paid for on an OON basis?
- The plan provided the following answers : 1) 48% of the psychiatrists listed in the network had not filed a claim within the last 12 month period; 2) 46% of all claims paid for psychiatrist services were on an OON basis for the last 12 month period; and 3) 7% of all PCP services were paid on an OON basis for the last 12 month period.

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Questions/Issues for Case Study 2

1. How should network adequacy be defined/conceptualized as an NQTL? What are its components?
2. Are any of the components identified in response to question 1 NQTLs in their own right, and should they be regarded as contributing factors to provider nonparticipation?
3. Are the results identified above indicative of a network adequacy problem?
4. How should reimbursement rates be regarded and evaluated in relation to a network adequacy problem?

Case Study 3 – Prior Authorization (PA) of Outpatient Electroconvulsive Therapy & Psychological Testing

- XYZ Health Plan provides a PPO plan that covers a wide range of med/surg and MH/SUD benefits across all six recognized MHPAEA benefit classifications. For outpatient services, XYZ Health Plan requires that plan participants contact XYZ to obtain prior authorization (PA) before obtaining certain outpatient treatments. This process requires the member (or their selected provider) to call the number on the back of their ID card to speak with a clinical case reviewer and provide some information. Upon provision of this information, the clinical reviewer may request additional information, issue an authorization, or deny the request for PA. For med/surg benefits, the member (or their provider) calls XYZ Health Plan, but for MH/SUD benefits, the member (or their provider) contacts a separate number on the ID card that routes to XYZ's third-party administrator for behavioral health benefits, ABC Behavioral Co. The process with ABC again involves speaking with a clinical reviewer who reviews the information provided and may request additional information, issue an authorization, or issue a denial.
- For med/surg benefits in the outpatient classification, XYZ requires PA of the following services: all labs, all diagnostic imaging tests (e.g., MRI, CT scan, etc.), ambulatory surgery, DME, non-emergent transport, clinical trials, and home health services. For MH/SUD services in the outpatient classification, XYZ requires PA only for outpatient Electroshock Therapy (ECT) and psychological testing.
- XYZ Health Plan Authorizes 83% of services and denies 17% of services requested through the PA process, and ABC Behavioral Co. authorizes 69% of services and denies 31% of services requested through the PA process.

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Questions/Issues for Case Study 3

1. Is the prior authorization process comparable?
   a. What about the fact that the process is separate for mental health and substance abuse?
   b. What about the fact that behavioral health has only two services subject to prior authorization but medical had more than half a dozen?
2. Is the process for prior authorizations being applied more stringently for behavioral than medical and therefore violating MHPAEA?
   a. What about the denial rate for behavioral being higher than medical?
3. What documents would you look at to assess the "comparability" question? What about the "applied no more stringently" issue?
4. What additional or changed information added to this scenario might change the assessment of "comparability" and "applied no more stringently"?

Case Study 4 – Utilization Review of Routine Outpatient Visits

- XYZ Health Plan applies a utilization management process for routine outpatient MH and SUD services, which involves using a concurrent review process for these outpatient services.
- XYZ does not apply this concurrent review to all outpatient MH/SUD services but instead identifies select cases using a set of criteria that includes: outpatient services beyond a certain number of visits per episode of treatment; treatments subject to longer treatment durations with increasing probability of medically unnecessary services over the duration of the treatment; visits that may involve multiple services per visit; services that have the potential to be billed the same service with multiple levels of coding; relatively low/moderate cost per service; increase in costs as a percentage of total spend based on experience; variability of rates of progress for patients during a treatment episode; and a portion of patients who never obtain complete resolution of their condition, resulting in on-going management for a chronic condition.
- These criteria also are applied to outpatient med/surg services, and identified cases then are subject to concurrent review.
- The actual concurrent review process is an identical process of a verbal and medical record review of the services with an appropriate clinical peer of the treating provider and, if necessary, issuing an adverse benefit determination if the services do not meet medical necessity, which is a requirement of the plan for all services.

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Questions/Issues for Case Study 4

1. What are the NQTLs in this scenario?
   a. Is medical necessity a NQTL in this case study?
   b. Is the concurrent review process a NQTL?
   c. Is the process to identify which cases are subject to concurrent review a NQTL?
2. Are these processes parity compliant? How can we tell or can we tell?
3. What information is necessary to assess "comparability" of each of the NQTLs? What information would need to be disclosed by the health plan to make this assessment of parity/not parity?
4. What information would be necessary to assess the "applied no more stringently" prong of the NQTL parity requirement?

Case Study 5 – Adverse Benefit Determinations (ABD) Based on Medical Necessity & Disclosure Requirements

- Health Plan XYZ requires all benefits to meet medical necessity criteria. Health Plan XYZ uses or obtains for use its medical necessity criteria from a variety of independent third-party national sources, such as Milliman, Interqual, the Centers for Medicare & Medicaid Services (CMS), the American Society of Addiction Medicine (ASAM), etc.
- Health Plan XYZ issues an adverse benefit determinations (ABD) in the case of ***any*** denial that is based on failure to meet the applicable set of medical necessity criteria that XYZ Health Plan uses.
- The ABD takes the form of a letter that includes the reason for the denial as "service does not meet criteria for medical necessity required under your plan" and includes a copy of the medical necessity criteria set for the particular service that is the subject of the ABD.

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Questions/Issues for Case Study 5

1. Does the ABD disclosure of a denial rationale in the ABD comply with MHPAEA? Why/why not?
2. Does the ABD inclusion of the medical necessity criteria set for the specific service at issue comply with MHPAEA?
    a. Does Health Plan XYZ have to include the criteria if they are licensed from a third-party and subject to licensing restrictions due to their proprietary nature?
    b. Does Health Plan XYZ have to disclose all of its medical necessity criteria in this denial scenario? In what other circumstance must Health Plan XYZ disclose medical necessity criteria? Which criteria must it disclose?
3. What other information or plan documents would Health Plan XYZ have to disclose pursuant to other federal (ERISA) and state law requirements?
    a. Does Health Plan XYZ have to disclose the material on which the medical necessity criteria are based?
    b. Does Health Plan XYZ have to disclose the material that describes the processes by which medical necessity is applied?

Additional Feedback

We will be producing a briefing paper following this conference. If you would like to contribute additional thoughts on the issues raised today, please send them to Tara.Ragone@shu.edu by September 30, 2016.

Thank you for joining us today!

Case Study 6 – Plan Reimbursement of Professional Fees for In-Network Services

- Health Plan XYZ provides benefits for in-network individual professional services by doctors through a contract with individual providers who meet the plan's credentialing standards. The credentialing standards applied to individual doctors in order to contract and participate as an in-network provider of the plan are the same for both med/surg providers and MH/SUD providers. The contracts contain a fee schedule of the reimbursement rates, which are developed using 125% of CMS Medicare rates.
- Health Plan XYZ applies the same rate for any given procedure code to all physicians, whether med/surg or behavioral health physicians, except for the case of generic procedure codes for evaluation/management. In the case of these codes, Health Plan XYZ varies the rates for different physician specialties based on factors, such as local market dynamics and demand for and availability of a particular physician's specialty in that local market. This results in various physician specialties, such as cardiologists, OB/GYNs, psychiatrists, neurologists, internists, dermatologists, etc. getting paid variable rates for these codes.

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Questions/Issues for Case Study 6

1. Is the Health Plan's reimbursement methodology "comparable"? Is it "applied more stringently" for behavioral health? Why/why not?

2. Does MHPAEA mean that psychiatrists have to be paid the same as medical MDs? If so, which medical MDs?

Case Study 7 – Inpatient Admissions & Utilization Management

- Health Plan XYZ uses a mix of approaches to manage inpatient medical hospitalizations – (a) some medical hospitalizations use a Diagnosis Related Grouping (DRG) methodology, wherein the facility is paid a rate determined by diagnosis regardless of the length of admission/services provided during the admission, and the facility is not required to pre-certify or concurrently review any portion of the admission and stay; and (b) some hospitalizations use per diem or fee-for-service contracting, in which case the facility must pre-certify and engage with XYZ Health Plan in concurrent review of the admission and stay. These reimbursement/clinical review protocol agreements are individually negotiated and contractually based with each facility. In general, the standard utilization review process for non-DRG medical hospitalizations by Health Plan XYZ requires precertification of any member admission with incremental concurrent reviews, the frequency of which reviews are dictated either by provider status (quality care/utilization efficiency) or condition/case severity. With regard to psychiatric hospitalizations, the Plan has no DRG arrangements as there are no recognized industry accepted DRGs for psychiatric care, and Health Plan XYZ uses concurrent reviews and precertification for all admissions.

- For both medical non-DRG admissions and MH/SUD admissions, the concurrent review frequency and process also is determined by the unique clinical presentation, the condition severity, and the expected recovery course. For example, a behavioral health unit admission for an adult alcohol detoxification may be approved with no concurrent review scheduled until the fourth day of admission, based on most standard detox cases being resolved within three days of care. On the other hand, an admission for major depression with suicidal behaviors may be approved for one day with a concurrent review conducted on the second day to assess current lethality and review the treatment plan that had been developed to stabilize the individual and plan a return to community care. The next concurrent review for this case would be based on the treatment plan and level of continued acuity. A comparable example for a med/surg unit is an adult with chest pain who is admitted under observation status for further stabilization and evaluation, including hydration, enzymes monitoring, and telemetry, to further assess symptom severity and the need for more intensive treatment. A concurrent review is conducted the next day, and further approval for continued stay is dependent on the assessment findings and the recommended course of care.

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Questions/Issues for Case Study 7

1. Are the inpatient utilization management processes here parity compliant?
   a. Can they be considered "comparable"?
   b. Does the variation described on the timing/frequency of concurrent reviews create a "comparability" issue under parity? Does it create an "applied no more stringently" issue?
   c. If considered comparable for sake of argument, how could we assess the "applied no more stringently" component of the processes that are not exactly the same?
2. Is there a basis for a difference in process where – as specified here – a particular process for medical hospital admissions (in this case the DRG process) has **no** analogue on the mental health/substance use disorder portion of the plan? Why/why not?

Additional Feedback

We will be producing a briefing paper following this conference. If you would like to contribute additional thoughts on the issues raised today, please send them to Tara.Ragone@shu.edu by September 30, 2016.

Thank you for joining us today!