ANALYZING PARITY CASE STUDIES

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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.

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.

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.

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.

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.