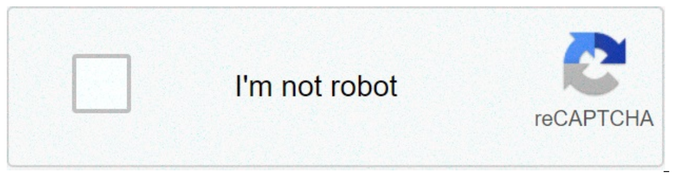

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Assessment centre case study examples pdf

Using case study methods, PERT investigators characterized the structure and process employed by OPM and each of the eight selected plans to implement the FEHB Program parity requirement. The case studies focused on effective as well as nominal benefits, and described: how FEHB enrollees accessed specialty care; how coverage decisions were made by the plan; the utilization management process; the composition of provider panels; and the financial and risk relationships among health plans, their subcontractors, and providers. Key Research Questions Because case studies are inductive in nature, research questions rather than research hypotheses guided data collection and analysis. Examples of the research questions that were explored in the case studies include the following: How did the health plans respond to the specific parameters of FEHB MH/SA Parity? What were the costs associated with implementing FEHB Parity in 2001? How did prior experience with State parity laws affect implementation (if at all)? What changes did health plans make to the normal MH/SA benefit design? Did FEHB health plans carve out in response to MH/SA parity? Did FEHB plans increase the use of utilization management in response to parity? Were provider panels closed or limited in response to parity? Were individual or institutional providers put at risk post-parity? Did FEHB plans use gatekeeping to limit access to specialty care in response to parity? Data Collection Measures PERT investigators developed a systematic, semi-structured discussion guide for site-visit data collection. The PERT developed most of the questions in the discussion guide specifically for this evaluation. However, some of the questions were adapted from instruments that PERT team members developed for prior studies, e.g., evaluation of the Managed Behavioral Health Care in the Public Sector Project for the Substance Abuse and Mental Health Services Administration (Ridgely et al., 2002; Ridgely, Giard, and Shern, 1999), Annual Industry Survey for American Association of Health Plans, and Health Care for Communities for the Robert Wood Johnson Foundation). In addition, the guide was informed by the literature and the prior work of other HHS investigators, e.g.: the Brandeis Market Area Study on Managed Care for Alcohol, Drug Abuse and Mental Health Services (Merrick et al., 2001); the George Washington University Study of Contracts between Medicaid and Managed Care Organization; and University of Michigan's Drug Abuse Treatment System Survey (Lemak, Alexander, and D'Aunno, 2001). The discussion guide was organized so that questions could be answered by interview or from health plan documentation. A copy of the Discussion Guide is included in this report as Appendix B: Site Visit Discussion Guide. Recruitment and Procedures Plans were selected for site visits based on the plan selection procedures outlined in chapter II, Design of the Evaluation. Site visits to the eight health Plans were conducted between July 2001 and June 2002, according to the human subjects requirements of the PERT's institutional review boards. OPM designated a lead contact person at each of the selected health plans and each of the plans to coordinate FEHB Program evaluation activities for the plan. PERT investigators worked closely with that contact person to identify the appropriate health plan administrators to interview, to schedule the site visit, and to collect needed documentation. Site visits generally involved health plan administrative staff, such as the medical director, chief financial officer, director of utilization management, director of quality assurance, and director of pharmacy management, as well as the appropriate administrative staff of vendors, such as MBHOs and pharmacy benefit management firms (PBMs). Each site visit was conducted by a two-person site-visit team consisting of a PERT senior health policy analyst and an economist. The interviews were audiotaped and the tapes transcribed. After the site visit (and any additional telephone contact necessary for clarification), PERT investigators created a matrix summarizing the information gathered on the site visit along the domains of interest indicated in the discussion guide. A copy of the health plan's summary matrix was returned to that plan for review and comment. Analytic Methods Researchers used a number of strategies to decrease the possibility of bias in developing the case studies (Silverman, Ricci, and Gunter, 1990): Use of a detailed methodology to serve as a guide; Use of a multidisciplinary team (rather than a single observer) for data collection, providing for a balanced set of observations and perspectives and confrontation of biases at an early stage of data collection; Some limited re-interviewing of informants for clarification and verification of interview information to resolve factual inconsistencies; Targeting in-depth interviews on the most knowledgeable respondents; and External review by the organizations under study. PERT investigators used an issue-oriented analytic approach to synthesize the qualitative information obtained from the site-visit interviews. The analysis of the case study data had five main purposes: To understand the context for the implementation of parity in the FEHB Program; To carefully and systematically document and describe the specific structures, policies, and procedures used by each of the eight selected FEHB health plans, as well as the similarities and differences across plans (e.g., utilization management techniques and risk-sharing arrangements); To identify the extent to which patterns exist in the key domains across various types of plans; To understand the organization and delivery of MH/SA services to enrollees in each of the eight plans studied; and To document the extent to which changes occur in these plans from pre- to post-parity (e.g., in effective benefits versus nominal benefits). To help synthesize the large amount of qualitative data this effort yielded, interview data were initially coded by the dimensions of FEHB health plans as reflected in the structured protocol (e.g., benefit design, payment and risk arrangements, and management of MH/SA care). This coding scheme formed the basis of an analytic matrix that organized the qualitative data into manageable units. PERT investigators also synthesized the data into narrative descriptions of how the selected plans organized and delivered MH/SA care under parity. This step was a valuable product in itself, as there is a dearth of documentation on how health plans actually implement parity and how such implementation has affected the care of people with MH/SA disorders. Findings This section of the report describes the experience of the parity implementation in eight large health plans across the U.S. from the year 2000 (pre-parity) to the year 2001 (the first year post-parity), with a focus on the post-parity effective benefit design in these eight FEHB health plans. Site visits to the eight health plans were conducted between July of 2001 and June of 2002. Research questions methods were described previously in this chapter. The PERT will first characterize the eight health plans as they were at baseline, and then consider how the health plans responded to the specific parameters of OPM's parity policy in 2001. Table III-15 provides a summary of the health plans selected for intensive review. This group of plans represents two geographic markets (one in the West and one in the Mid-Atlantic States), a single plan in each of two additional States, and a national plan (FFS-NAT). The sample also represents a mix of for-profit and not-for-profit health plans and FEHB products. The FEHB enrollment as a percent of total health plan enrollment varies from a low of 3% (HMO-W1) to a high of 100% (FFS-NAT). Table III-15. The eight selected health plans and their FEHB enrollment pre-parity (2000) Five of the health plans participate in the Association Service Benefit Plan, the single largest FEHB health plan. Although some of these plans also offer HMO products to FEHB enrollees, in this analysis, the PERT characterize their FFS product provided under the Association's Service Benefit Plan. As described in Table III-15, most of the health plans characterized their FEHB enrollees as older and/or sicker (i.e., utilizing more services on average) than the enrollees in their other plans. Three of the FEHB health plans within a single State (FFS-W, HMO-W1, and HMO-W2) also reported that, on average, the FEHB MH/SA benefit was much richer than the MH/SA benefit in their other products, even in the pre-parity period. How Did the Health Plans Respond to the Specific Parameters of FEHB MH/SA Parity? Beyond the stipulation that plans were required to extend parity to in-network benefits only, OPM permitted a number of specific flexibilities to aid health plans in implementing MH/SA parity for FEHB enrollees. These flexibilities included: Providing that the basis for parity comparison was "analogous services" or "comparable medical treatments" rather than all services, Requiring that parity extend only to "clinically proven treatments," Allowing exclusion of MH/SA services currently paid for by public entities, and Allowing health plans to limit parity for individuals who do not comply with their treatment plans. It was largely left to the FEHB health plans, in consultation with OPM, to define these terms, operationalize the concepts, and apply them. Health plans might conceivably have used the first two of these flexibilities to limit changes to the nominal MH/SA benefit--just as the health plans could have altered their general medical benefit to meet the definition of parity. The second two flexibilities might have been used to limit payments to very ill or difficult-to-treat patients. However, none of the eight health plans reported seriously considering parsing out treatments as "analogous" or "comparable" in their preparation for implementing FEHB parity. Neither did any of the health plans create criteria to differentiate between "clinically proven" and other types of MH/SA treatments in order to apply the parity requirements to a more limited set of MH/SA services. Health plans did report that their utilization management staff considered the evidence base for treatments when approving a particular treatment for a particular patient. Only one health plan reported that it specifically excluded coverage for some services (i.e., custodial services) paid for by public entities (e.g., Veterans' Administration clinics or State psychiatric hospitals). The other seven plans either reported that they paid for approved services regardless of whether the approved service was provided by a public- or private-sector provider. In some instances, the health plan worked with public-sector entities to coordinate care. For example, a plan may not pay for inpatient care at a State hospital facility, but the plan would work with staff at the State hospital to ensure that the patient was able to access appropriate inpatient care and follow-up after the hospitalization. Representatives of one plan suggested that this was a "case management" rather than a "benefit design" issue. Perhaps the most controversial of these flexibilities had to do with treatment noncompliance. This issue was specifically addressed by the Washington Business Group on Health in their review of the experience of large employers (Apgar, 2000). The FEHB health plans reported that this issue tended to arise more around substance abuse than mental health treatment. Plans differed in the extent to which their approaches to noncompliance had been formalized into a policy. Representatives reported that denial of care due to noncompliance was a clinical issue that was more appropriately addressed by alternatives such as better evaluation, modifying the treatment plan so as to better match the patient, and/or assigning a health plan case manager to help the patient comply. They believed that denials due to non-compliance would be "frowned upon" by OPM, and representatives from only one health plan reported that they had ever excluded any patients from services based on non-compliance. What Were the Costs Associated with the Implementation of FEHB Parity in 2001? In general, representatives of the eight health plans did not express concern over the costs involved in implementing the FEHB parity policy. As can be seen from Table III-16, most of the plans' representatives reported that they had separate administrative staff for the FEHB products, but for most plans, these separate administrative structures were in place before implementing FEHB parity. Four of the plans reported minimal or no implementation costs; the other four plans reported adding between 1.5 and 12 full-time employee (FTE) staff. These plans reported adding customer service representatives, utilization management staff (plans and MBHOs), and case managers. Table III-16. Costs associated with the implementation of FEHB parity in 2001 (site visit data) All of the plans reported premium rises in the post-parity year, but the percentage points attributed to the anticipated parity policy ranged from zero to 2.5% (see Table III-16). Premium rises were mainly attributed to the rising costs of pharmaceuticals and hospital costs. How Did Prior Experience with State Parity Laws Affect Implementation (if at all)? Four of the represented States have State mental health parity laws that affect all of the plans in this analysis except for FFS-NAT and HMO-NE. In each case, these laws pre-date the implementation of FEHB parity. Three of the four State parity laws are restricted to specific mental disorder diagnoses (i.e., nine diagnoses, reflecting severe mental illnesses in adults and serious emotional disturbances in children), and two of the State statutes include parity for substance abuse treatment, affecting FFS-MA1 and FFS-MA2. Representatives of one of the health plans in the West reported that implementing State parity required a major effort and that FEHB parity was "just a minor adjustment." Although one might expect there to have been an effect of FEHB parity-- based on the fact that the State law was limited to nine diagnoses whereas the FEHB parity benefit is unlimited--the plan reported that it had already applied parity across the board for mental health treatment. Not to have done so, it reported, would have been "an administrative nightmare." It did note, however, that substance abuse was not included in the Western State's parity law, so the health plan did make changes related to substance abuse treatment in 2001. By contrast, another Western State plan reported that it had been moving in the direction of parity even before the State law and had an unlimited substance abuse benefit before FEHB parity was implemented. These respondents felt that the parity policies were "liberating," allowing the health plan to "do things they knew were correct clinically" but that might have exposed the plan to moral hazard in the pre-parity market. The third plan in the Western State responded to the State parity statute by entering into a relationship with an MBHO to manage benefits for both their FFS and HMO products. FFS-S did not report any dramatic changes in response to either State or FEHB parity but did note that with the implementation of FEHB parity, the FEHB product became very similar to the rest of their plans offered in the State. FFS-MA2 reported that they implemented parity across all MH/SA diagnoses in their fully insured business in January 2000, even though its State parity law required parity for only nine diagnoses. As with the other plans, representatives of FFS-MA2 reported that to the extent that start-up problems occurred with the implementation of parity, these were handled during the first year of State parity. What Changes did Health Plans Make to the Nominal MH/SA Benefit Design? All of the health plans reported that they made changes to the in-network MH/SA benefit in response to OPM's directive, but each confirmed that it had not extended parity to the out-of-network benefit. The plans reported that the out-of-network benefit retained the pre-parity demand-side limits. Each health plan changed deductibles, copayments, and visit limits so that parity existed between the general medical and MH/SA benefit. None of the plans' representatives reported making any parity-related changes to the general medical benefit or to their pharmacy benefit in response to the FEHB parity policy. In addition to inquiring about parity-related changes, the PERT also asked health plan representatives if they had seen or anticipated any spill-over effects on those benefits (see Table III-17). By spill-over effects the PERT means increases or decreases in utilization of the general medical benefit (e.g., physicians' more or less often diagnosing MH/SA or general medical visits). Table III-17. Changes in nominal benefit design in response to FEHB parity (from 2000 to 2001) Again, none of the plans reported any spillover effects onto the medical/surgical benefit, although representatives from three plans stated that it was either difficult to estimate or difficult to confirm spill-over effects. As to possible spill-over effects onto the pharmacy benefit, one plan estimated an increase of 10¢ per member per month (PMPM) for pharmacy (an effect of State parity) and three others anticipated an increase but thought it would be difficult to confirm. As to any observed or anticipated shifts between primary and specialty care under the post-parity (or what some plans called the enhanced) benefit, five plans reported no shifts between primary and specialty MH/SA care. Representatives of FFS-NAT reported they had anticipated a shift of patients into specialty care, but this did not materialize. HMO-W1 representatives reported that they were using the implementation of FEHB parity to promote a further shift away from primary care treatment of mental disorders. Did FEHB Health Plans Carve Out in Response to MH/SA Parity? Two health plans -- FFS-MA2 and HMO-W2 -- were managing MH/SA benefits within the health plan during the pre-parity period. Both plans continued to manage MH/SA benefits within the health plan in the post-parity period. Five of the eight health plans were already contracting with MBHOs in the pre-parity period and continued to contract with their MBHOs in the post-parity period. Only the very large FFS-NAT responded directly to the FEHB parity policy in 2000 by carving out the MH/SA benefit. FFS-NAT representatives suggested that the decision to carve out was based on the perceived need to hire an experienced entity to manage MH/SA care. They felt that the health plan lacked a sufficiently large network of MH/SA providers. Because the FFS-NAT plan is a national health plan, an extensive provider network would be important from a competitive standpoint. The FFS-NAT is also one of only two of the eight selected health plans to employ a risk contract with an MBHO. As can be seen from Table III-18, the majority of plans were not placing their carve-out vendors at risk, but instead were using ASO contracts with their MBHOs in both the pre- and post-parity periods. Table III-18. Use of MBHO vendors by health plans -- pre- and post-parity (2000 versus 2001) The health plans also differed in the extent to which their MBHOs assumed the management of MH/SA care. Only two plans reported that their MBHOs were administering all aspects of MH/SA care and both of these were risk-based contracts (one at full risk and the other employing "soft capitation.") The other health plans reported using ASO contracts to purchase a variety of services (e.g., hotline, referral, intake, utilization management, and provider network access) from MBHOs. The small number of plans in our sample and the lack of comparison plans in this part of the analysis make it very difficult to draw inferences about whether health plans are likely to respond to a parity policy by carving out their MH/SA benefit for management by a specialty organization. (This issue was addressed in the previous section.) Did FEHB Plans Increase Using Utilization Management in Response to Parity? Representatives of the eight selected FEHB plans reported that they used medical necessity criteria to restrict using unnecessary or inappropriate MH/SA treatment services in the pre-parity period. Most plans reported that the medical necessity standards they used were developed internally but based on their review of national standards of care developed by well-respected MH/SA organizations. None of the eight plans the PERT interviewed changed those medical necessity criteria in response to implementing FEHB parity. As Table III-19 illustrates, the FEHB health plans were using a variety of techniques to manage care even under the pre-parity MH/SA benefit. None of the eight plans the PERT studied was using primary care providers as gatekeepers for access to specialty care, either pre- or post-parity. One of the health plans, FFS-W, reported not using the traditional utilization management techniques (i.e., prior authorization, concurrent review, and retrospective review). A second plan, HMO-W2, reported not using prior authorization for MH/SA services, although this plan did conduct concurrent and retrospective review. However, all of the health plans except HMO-W2 required that their MH/SA providers (both primary care and specialty providers) submit a treatment plan to the health plan for approval. The two HMOs also reported using closed provider panels, while none of the FFS plans did. Most plans used some form of utilization management in the pre-parity period. Only one change in utilization management occurred in response to implementing FEHB parity. The only parity-related change reported by the health plans (three Association Service Benefit Plan members) was an Association-negotiated requirement among Association plans nationally that their plans would add a standard treatment planning requirement in response to FEHB parity. Under this requirement, treatment providers needed to obtain Association plan approval of a treatment plan before the 9th outpatient visit. This approach was designed to manage expensive episodes of care. Given that representatives of the Association reported that the majority of episodes of care covered by Association plans never reach a 9th session, it is unlikely that the treatment plan requirement significantly affected the care of high numbers of FEHB enrollees directly. The outpatient care of this small number of FEHB enrollees, however, accounts for a considerable number of outpatient visits. The treatment plan requirement could also indirectly result in moving patients into care from non-network providers who did not require treatment plans. Representatives of FEHB health plans, however, did not believe that this occurred. Table III-19. Utilization management by health plans -- pre- and post-parity (2000 versus 2001) Were Provider Panels Closed or Limited in Response to Parity? Only two health plans (both HMOs) reported that they used a closed or limited provider panel (see Table III-19), and both of these arrangements predate the FEHB parity policy. Although closing or limiting provider panels might be an effective strategy to limit inappropriate service utilization, none of the health plans reported that they closed panels in response to parity. One health plan reported using preferred providers, i.e., providers who had agreed to discounted rates in order to be included in the network (see Table III-20). Were Individual or Institutional Providers Put at Risk Post-Parity? Payment and risk-sharing relationships between health plans, their MBHO vendors, and individual and institutional providers are displayed in Table III-20. With the exception of HMO-W2, all of the plans paid individual providers on a fee-for-service basis. Only HMO-W2 paid providers on a capitation basis, although the risk-sharing arrangement was an exclusive arrangement with the Plan and not with individual providers. None of the health plans or their MBHOs put individual providers at risk either in the pre- or post-parity periods. Table III-20. Payment and risk-sharing with in-network providers -- pre- and post-parity (2000 versus 2001) For institutional providers, per diem was the primary method of payment reported by most of the eight selected health plans; only a single plan reported paying for inpatient mental health treatment using diagnosis-related groupings (DRGs). None of the health plans reported risk-sharing arrangements with institutional providers in either the pre- or post-parity periods. Thus, these health plans did not respond to the parity policy by having providers share the risk for the costs of MH/SA treatment. Did FEHB Plans Use Gatekeeping to Limit Access to Specialty Care in Response to Parity? As noted earlier, none of the eight health plans, including the two HMOs, used primary care physicians as gatekeepers for specialty MH/SA care (see Table III-21). In addition, according to health plan representatives, health plans were not using their member hotlines to preferentially refer members to particular providers. Table III-21 shows how patients accessed specialty MH/SA care in the eight selected plans and any changes in that process that occurred in 2001. Table III-21. Access to specialty care -- pre- and post-parity Health plan members typically accessed specialty MH/SA providers by using toll-free hotlines that were either staffed by the health plan or by its MBHO. For the majority of plans, the referral decision-maker was the health plan member. However, a number of the plans had staff trained to assist with referrals (e.g., intake counselors, and care or case managers). These individuals typically had a bachelor's degree and specific training from the health plan or MBHO. They were available to assist members with questions (e.g., provider type, location, and contact information) and make referrals to specific providers if the member had not already chosen a provider. In the plans that were using risk-sharing arrangements with their MBHO vendors (FFS-NAT and HMO-W1), however, the MBHO staff were clinically trained and played a much more directive role in referral decisions. The FEHB parity benefit appears to have had little impact on the procedures for FEHB plan members to access MH/SA specialty care, beyond some plans' instituting a separate, specific hotline for MH/SA referrals, staffed either by the MBHO or the health plan. Implementation Case Studies Summary The eight site-visited plans implemented the FEHB parity policy in a similar fashion to that of the rest of the plans in the FEHB Program. The eight site-visited plans altered nominal plan benefits to comply with the parity policy and made a small number of changes in management of benefits (i.e., effective benefits). The implementation difference-in-differences analysis showed an increased likelihood that FEHB plans would carve out their MH/SA benefits in the post-parity period. However, among the eight site-visited plans, six of them had carved out their benefits prior to the implementation of the parity policy and one large FFS plan carved out in direct response to parity.