

Appendix B: Site Visit Discussion Guide

Site Visits to FEHB Health Plans

Conducted through a contract between the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services and in conjunction with the U.S. Office of Personnel Management; and subcontracts between ROW Sciences and the University of Maryland School of Medicine, RAND Health, Harvard Medical School, and Westat

Site Visit Discussion Guide

April 2001

The Federal Employees Health Benefits Program is one of the largest employer-sponsored health insurance programs in the nation, serving over 8.6 million federal employees, annuitants, and their dependents through contracts with 294 carriers, health plans, and specialty insuring organizations. In addition to providing health benefits to federal workers, the FEHB Program serves as a model for national health policy in areas ranging from managed care to the design of prescription drug benefits.

President Clinton directed the Office of Personnel Management to institute parity for mental health and substance abuse (MH/SA) coverage within the FEHB Program to serve explicitly as a model for both public and private health policy choices. The aim of parity is to provide insurance coverage for MH/SA services that is the same as that for other medical services with respect to benefit design features such as deductibles, copayments, and limits on visits and inpatient days.

The objectives of the evaluation of the implementation of FEHB parity are as follows:

- To assess the degree to which the FEHB Program parity requirement affects benefit design and management; access to MH/SA services; utilization of MH/SA services; beneficiary, plan, and OPM costs; quality of MH/SA services; and beneficiaries' and providers' satisfaction and awareness of policy change;
- To examine the patterns in these effects across subgroups of plans, providers, and beneficiaries; and
- To assess the interrelationships among changes in benefit design and management, costs, access, utilization, quality, and satisfaction.

Site Visits to FEHB Health Plans

The purpose of this component of the study is to characterize the structure and process employed by each of the selected health plans to implement the FEHB Program parity requirements. The site visits will enable the evaluation team to describe the plans' formal, anticipated activities, as well as informal processes, and to identify unanticipated changes, providing context for interpreting outcomes from the implementation of parity. Case-study site visits will be conducted starting in June 2001.

A lead contact person at each of the selected health plans has been designated by OPM and the plans to coordinate FEHB Program evaluation activities for the plan. We will work closely with that contact person to identify the appropriate health plan administrators to interview, to schedule the site visit, and to collect any needed documentation. The Site Visit Discussion Guide will be used to guide the interviews. We anticipate that site visits will take 2-3 days.

The interviews will be conducted by two-person site visit teams. Susan Ridgely, a health attorney at RAND, will lead the site visits at each of the eight plans and a pool of three health economists from Harvard and RAND, as well as ROW Sciences' senior research staff, will be available to participate as the second site visitor. The interviews will be audio-taped to allow us to supplement our contemporaneous notes. During the site visit documents may be identified and collected as necessary to complement the interviews and complete the information in the Discussion Guide. After the site visit (and any additional telephone contact that may be necessary for clarification), evaluation staff will create 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 will be given back to that plan for review and comment.

Site Visit Discussion Guide: Overview

The following site visit discussion guide is organized by topical areas rather than by potential respondents. After the plan's contact person and RAND staff have discussed the Guide and identified the appropriate respondent to answer questions in each of the topical areas, we will customize the Guide for each plan to facilitate the interview process. The topics covered in the Discussion Guide include:

- Background information about local health plans
- Implementation of FEHB parity and associated costs
- Changes in the MH/SA benefit in 2001
- Changes in other benefits in 2001
- The relationship between primary and specialty MH/SA care
- Use of carve-outs to manage MH/SA benefits
- Contracting with specialty MH/SA providers
- Management of pharmacy benefits for MH/SA disorders
- Provider networks for MH/SA services
- Management of specialty MH/SA care
- Grievance and appeals

A note about context is probably warranted. Many of the following questions ask about whether changes in health plan benefits, policies and procedures are related to the implementation of FEHB parity. We are aware that local health plans have also been responding to changes in state parity laws and have otherwise been making changes in their health plans that are unrelated to parity. As much as possible we would like to identify when a change was made, the rationale for making the change, and whether or not the change was related to the implementation of FEHB parity.

SITE VISIT DISCUSSION GUIDE

Background Information About Local Health Plans

1. What is your local plan's tax status?

Non-profit
For profit, privately held
For profit, publicly held
Other (please specify)
2. FEHB enrollees represent approximately what percentage of your local health plan's total enrollment?
3. The FEHB contract represents what percentage of your local plan's book of business (i.e., revenue share rather than covered lives)?
4. Has your local plan made a profit or experienced a loss on the FEHB business in the past two years?
5. How would you compare FEHB enrollees with the rest of your enrolled population, with respect to health status?

Implementation of FEHB **Parity** and Associated Costs

6. Is there a separate administrative or management team for the FEHB account?
7. Is there a designated individual in charge of FEHB parity implementation?
8. How does the FEHB benefit design compare to the rest of your book of business?
9. Can you estimate the administrative costs your local plan has incurred to implement FEHB parity?

For example, did your local plan add any FTEs to implement/assure compliance with FEHB parity?

Did your local plan incur additional expense to create or revise marketing materials?

Were there other administrative costs? If so, please specify.

10. Did your health plan increase premiums in 2001?

By how much were the premiums increased?
On what basis were the premium changes calculated?
Was this increase specifically related to the implementation of FEHB parity?
11. Does your plan anticipate (or have you experienced) any spillover effects of the implementation of FEHB parity onto the medical/surgical benefit?

By "spillover effects" we mean in terms of utilization/spending (for example, medical/surgical costs increasing or decreasing as a result of parity).

If so, have you made any provisions to address potential spillover?

12. Does your plan anticipate (or have you experienced) any spillover effects of the implementation of FEHB parity onto the pharmacy benefit?

By “spillover effects” we mean in terms of utilization/spending (for example, MH/SA pharmacy costs increasing or decreasing as a result of parity).

If so, have you made any provisions to address potential spillover?

Changes in MH/SA Benefit Design in 2001

13. Attached is a chart that summarizes information on mental health and substance abuse benefits. The chart was developed from information available on the FEHB Program website, your health plan’s website, and from preliminary conversations with representatives of your local health plan. We would like to confirm that the information on the chart is correct or make any corrections needed. The next set of questions will be based on a review of the attached chart. (A sample chart can be found on page 11 of this appendix.)
14. If your health plan made any changes to the in-network *mental health* benefits in 2001, what was the rationale for making those changes?
15. If your health plan made any changes to the in-network *substance abuse* benefits in 2001, what was the rationale for making those changes?
16. Did your health plan make any changes to the *out-of-network* mental health or substance abuse benefits in 2001? If so, please describe those changes and the rationale for making them.
17. How does your plan determine whether a particular mental health or substance abuse service is covered under the MH/SA benefit, the medical-surgical benefit or not at all?

The next two questions deal with the interpretation of terms contained in the OPM Carrier Letter which provided guidance on implementation of FEHB parity. In that letter OPM stated that the basis for comparison of medical-surgical and MH/SA benefits for purposes of parity implementation is that the services be “comparable” or “analogous.” The Carrier Letter also stated that services “currently covered and paid for by public entities” could be excluded from coverage.

18. How did your health plan operationalize the concept of “comparable medical treatment” or “analogous services”?

Can you give us an example that illustrates your thinking about such analogies?

19. How did your health plan operationalize the concept of “services currently covered and paid for by public entities”?

What, if any, services did your health plan exclude based on your plan’s determination that they were currently covered and paid for by public entities?

Changes in Other Benefits in 2001

20. Referring again to the chart, if your local health plan made any changes in *medical/surgical* benefits in 2001, what was the rationale for making those changes?
21. Referring again to the chart, if your local health plan made any changes to the *pharmacy* benefit in 2001, what was the rationale for making those changes?

The Relationship Between Primary and Specialty MH/SA Care

22. If your health plan carves-out MH/SA benefits, can primary care physicians receive payment for providing MH/SA services?

If yes, are there any restrictions on the number or type of services that can be provided by a primary care physician?

How are primary care physicians paid (e.g., fee-for-service reimbursement, capitation, salary, etc.)?

Are there any bonus or withhold arrangements used for primary care physicians? If so, please describe.
23. Has the implementation of FEHB parity resulted in shifts in MH/SA treatment between the primary and specialty sectors in your FEHB product?
24. How is the OPM Carrier Letter concept of “full coordination of care” between primary care physicians and behavioral health providers operationalized in your plan?

Use of Carve-outs to Manage MH/SA Benefits

[Skip this section if the health plan does not utilize a MH or SA carve-out]

25. Does your local health plan use a “carve-out” to manage mental health and/or substance abuse care for the FEHB product? (Please specify whether the carve-out includes mental health and/or substance abuse.)

If so, why did your local health plan decide to “carve out” management of these benefits?
26. When was the carve-out implemented?
27. What is the name of the carve-out vendor?
28. Has your health plan changed carve-out vendors in 2001?

If so, did the implementation of FEHB parity factor in the decision to change vendors? If so, how?
29. What is the duration of the current contract?
30. What are the roles or responsibilities of the carve-out vendor (e.g., administrative services, manages the provider network, provides direct care services, etc.)

Have the roles or responsibilities of the carve-out vendor changed since the implementation of FEHB parity in 2001? If yes, please describe any changes.

31. What is the financial arrangement with the carve-out vendor (e.g., full-risk contracts, “soft” capitation)?
- Has the financing relationship with the carve-out vendor changed since the implementation of FEHB parity in 2001? If yes, please describe any changes.
32. When employing capitation contracts with vendors (either full or partial risk contracts), which services are covered under the capitation payments?
33. Does the carve-out vendor have reinsurance against aggregate losses or losses on high-cost patients?
- If so, please describe the policy (e.g., level of risk assumed by the reinsurer, stop-loss point for high-cost patients, etc.)
- Have any changes been made in this policy in 2001?
34. Are any performance standards with/without financial penalties or bonuses used in the vendor contract? If so, please specify.

Contracting with MH/SA Specialty Providers

Individual Providers

35. Within the network of MH/SA providers, what are the primary methods of payment (e.g., salary, discounted FFS, FFS with withhold/bonus, case rate, capitation, etc.) for specific types of *individual providers* (e.g., physicians, psychologists, licensed clinical social workers, licensed substance abuse counselors, etc.)?
36. Are these methods of payment different for mental health and substance abuse services? If so, how?
37. Have there been significant changes in the *methods of payment* for any of these provider types in 2001? If so, please describe.
38. Have there been any significant changes in the *level of payment* for any of these provider types in 2001? If so, please describe.

Institutional Providers

39. Within the network of MH/SA providers in your health plan, what are the primary methods of payment (e.g., cost-based, per diem, DRG or other episode-based, capitation, etc.) for specific types of *institutional providers* (e.g., psychiatric hospitals, general hospitals, outpatient clinics, partial hospitalization programs, residential treatment centers, etc.)?
40. Are these methods of reimbursement different for mental health and substance abuse services? If so, how?
41. Have there been significant changes in the *methods of payment* for any of these facility types in 2001? If so, please describe.
42. Have there been any significant changes in the *level of payment* for any of these facility types in 2001? If so, please describe.

Risk Sharing with Providers

- 43. What kinds of risk-sharing arrangements does your plan or carve-out vendor utilize with providers (e.g., full-risk contracts, “soft” capitation, case rate)?
- 44. For what range of services does your health plan or carve-out vendor put providers at risk?
- 45. Are performance standards included in the risk contracts? If so, please describe the standards and any financial penalties/bonuses that correspond to them.

Management of Pharmacy Benefits for MH/SA Disorders

- 46. Does your local health plan use a “carve-out” to manage the pharmacy benefit for the FEHB product? If so, what is the name of the carve-out vendor?

Are MH/SA-related pharmaceuticals included in this carve-out?
Is a carve-out for pharmaceuticals used for the rest of your book of business?

- 47. If your health plan does not carve out, how does your health plan manage pharmacy benefits (e.g., use of a mail order pharmacy)?
- 48. Are pharmaceuticals prescribed by *out-of-network providers* handled any differently than those prescribed by in-network providers?
- 49. If your health plan carves-out pharmacy benefits, when was the carve-out implemented and what is the duration of the contract?
- 50. If the carve-out was in existence prior to 2001, has the contract changed in response to the implementation of FEHB parity? If so, how?
- 51. What is the financial arrangement with the carve-out vendor?
- 52. Are any performance standards with/without financial penalties or bonuses used in the contract? If so, specify.
- 53. Please specify formulary type and describe formulary coverage for psychotropic medications in 2001.
- 54. If your health plan had a formulary prior to 2001, has the formulary changed for the year 2001? (If changes have been made, please describe the changes and the rationale for them.)

Provider Networks for MH/SA Services

- 55. Please describe your provider network size and composition as indicated below:

	Number of providers
Psychiatrists	
Other M.D.s	
Psychologists	
Licensed clinical social workers	
Certified substance abuse counselors	

56. Does your health plan or carve-out vendor use a “core” or “tiered” network?
- By “core” or “tier” we mean a limited number of specialty MH/SA providers in the network who received the majority of referrals.
- If so, please describe.
57. Has your health plan or carve-out vendor expanded or narrowed the scope for the network of MH/SA providers in 2001? If so, why?
- Please characterize changes in the network. Were specific types of providers added or excluded from the network?
58. How is the OPM Carrier Letter concept of a “comprehensive network of providers” operationalized in your plan?
59. Has utilization of *out-of-network* providers increased since the implementation of FEHB parity?

Management of MH/SA Specialty Care

Access to Care

60. How do FEHB enrollees access MH/SA specialty care (e.g., toll free hotline, primary care gatekeeper)?
61. Has this process changed since the implementation of FEHB parity?
62. If FEHB enrollees have direct access to a carve-out (e.g., toll free hotline), on what basis are referral decisions (e.g., level of care, provider type, location) made?
63. Who makes the referral decision (e.g., intake coordinator, case manager)?
64. What type of training do these individuals have?
65. How much discretion do they have in selecting a provider or providers to refer to?
66. Have these policies or procedures changed since the implementation of FEHB parity?

Coverage Decisions

We are interested in how your health plan makes decisions about medical necessity and any standards that your health plan uses to guide these activities.

67. Does your health plan use any of the following in making medical necessity determinations:
- Models of care (e.g., A.S.A.M. criteria)
 - Published clinical protocols (e.g., A.P.A. guidelines)
 - Reviewers with demonstrated clinical expertise (training, experience, credentials)
 - Other (please specify)
68. At what level are medical necessity determinations made (the health plan, a vendor, an intermediary, the provider)? How are the decisions made?

69. Are treating physicians directly involved in medical necessity determinations?
 Is there a formal clinical appeals process for treating physicians?
70. Have any of the policies or procedures related to medical necessity determinations changed in 2001?
71. Does your health plan use any of the following for monitoring or assessing quality of care?
 Requiring adherence to treatment protocols or guidelines
 Peer review
 Provider profiling
 Tracking HEDIS measures
 Tracking other performance monitoring
 Quality improvement committee
 Systematic analysis of patient complaints and appeals
 Other (please specify)
72. How are the terms “clinically proven treatment” and “continuum of care” in the OPM Carrier Letter operationalized in your plan?

The OPM Carrier Letter on FEHB parity stated that parity is not required for patients who are non-compliant with a treatment plan.

73. How is your plan defining “non-compliance”? Please describe your health plan’s policy for dealing with non-compliance.
74. Have any FEHB enrollees been denied services or had their level of coverage for services reduced because of noncompliance?

Utilization Management

75. Which, if any, of the following approaches is your plan using to control utilization of MH/SA services? Describe the policy and procedures.
 Gatekeeping by primary care physicians
 Prior authorization for specialty MH/SA services
 Requirement that a treatment plan be submitted by the treating provider
 Concurrent review
 Retrospective review of claims
 Closed or preferred provider panels
 Disease management programs
 Other (please specify)

76. Describe the UR processes for emergency, inpatient and outpatient care.
 Do they differ for mental health and substance abuse? If so, how?

77. Have any of these policies or procedures changed in 2001? If so, please explain.

Transitional Care

78. How does your health plan handle transitional care (either on entering or leaving your plan)?

Grievance and Appeals

79. Please describe the grievance and appeals policy and procedures for your plan's FEHB product.
80. Are the same policies and procedures used for the rest of your book of business?

If not, please describe how the policies and procedures differ.
81. Has the grievance and appeals process changed in 2001?
82. Has your health plan seen any change in the number of complaints and appeals related to claims or coverage decisions since FEHB parity was implemented?

