

# Report from the Medical Coverage Decision-Making Work Group

February 3, 2005



# Medical Coverage Decision-making Work Group

## Goal: Greater “Transparency”

- ❖ To increase understanding about how health plans make decisions about whether or not to cover services
- ❖ To elucidate the different types of coverage decisions
- ❖ To help educate families and providers about how decisions are made and the avenues for involvement and influence.

# We are Not Alone!

## Transparency is a challenge in all health systems (but in different ways)

### United States

- Highly fragmented payer system
- Competition among private health plans
- No standardized benefits
- Voluntary purchase of coverage
- High tolerance for inequity in health system
- Health plans “do the dirty work” of resource allocation
- Consumers and policymakers are shielded (and usually excluded) from decision making
- “Savings” and “Trade-offs” are elusive

### England

- Single payer
- Universal coverage
- Same benefits for all (with some discretion at local level)
- “Solidarity” and “Equity” are core values of health system
- Fixed budgets make “trade-offs” easier to assess and see
- “Public involvement” in health services decisions required at local level

# Medical Coverage Decision-Making Work Group

- **Chair**
  - Jim Glauber, Neighborhood Health Plan
- **Ad-hoc consultative group**
  - Health plans
  - Medicaid
  - New England SERVE
  - Parents
  - Physicians

# Strategic Approach

- Phase 1: “Exploration”
  - Develop several case “vignettes” that include some common coverage issues
  - Interview health plans about vignettes to determine how the payer would approach each case situation
  - Report to Consortium
- Phase 2: “Action”
  - Develop materials for families and providers?
  - Identify areas that might hold promise for collaboration or simplification across payers?
  - Others????

# The 7 Case Vignettes

- Fresh muscle biopsy for metabolic disorder
- New reconstructive surgery technique for Crouzan's Syndrome
- Acupuncture and biofeedback therapy for inflammatory bowel disease
- Durable medical equipment beyond benefit limit
- Outpatient mental health services from an out-of-network provider
- Innovative PT treatment for cerebral palsy
- Synagis to help prevent lung infections from RSV

## Interviews with 9 Health Plans

- Blue Cross Blue Shield of Mass
- Boston Medical Center HealthNet Plan
- Fallon Community
- Harvard Pilgrim Health Care
- Health New England
- Neighborhood Health Plan
- Network Health
- Primary Care Clinician Plan (MassHealth)
- Tufts Health Plan

# The Key Questions for each Vignette

- Is the service generally a covered benefit? Subject to any limits?
- What process and criteria are used to determine if the child is appropriate for the service?
- How does plan determine if service is “medically necessary”?
- What are the process and criteria for getting an exception?
- Who are the key decision-makers at each step?
- What information do payers need and use to make coverage decisions?

# Findings

- Very similar approach to coverage decision-making by all plans
- Decisions of complicated and not always clear-cut
  - Require review of information on individual child
  - Likelihood of health plans covering services being requested for child in the vignettes:
    - Likely would cover: ~20% of services
    - Likely would not cover: ~40% of services
    - It depends: ~40% of services
  - Very consistent responses across plans for specific services
- Most children in vignettes likely to be in case management, which would facilitate review

## Key Questions and Steps

- #1: Is the requested service a covered benefit?
- #2: Does child meet the “medical policy” criteria for the covered service?
- #3: Is the service “medically necessary” for the child?
- #4: Is the service subject to any benefit limits?
- #5: Is the provider “acceptable”?
- #6: Is there any basis for a benefit exception?

# #1: Is the requested service a covered benefit?

- Some are clearly excluded or clearly included
- For many services “it depends”
  - Experimental? Investigational? Not generally accepted?
- Plans collect information from wide range of sources to make determination
  - The member’s providers
  - Published and unpublished literature
  - External technology assessment organizations
    - Hayes, Inc. and Technology Evaluation Center (TEC)
  - “Experts”

## #2: Does child meet the “medical policy” criteria for the covered service?

- A benefit may exist for the service
- But a “medical policy” may define:
  - when a particular type of service is covered
  - what the coverage requirements are (e.g., age, condition, diagnosis )
- Most common example in vignettes
  - Synagis to help prevent lung infections from RSV
  - Most plans use American Academy of Pediatrics guideline

## #3: Is the service “medically necessary” for the child?

- Medical necessity determinations are complicated and often difficult to make
- Plans use the same general principles
- Is the service:
  - “reasonable and necessary” for diagnosis and treatment?
  - “appropriate” in light of medical needs and conditions of the member?
  - likely to improve treatment?
  - likely to improve function, maintain ability and/or prevent deterioration?

## #4: Is the service subject to any benefit limits?

- Some services have explicit benefit limits
  - Annual dollar amount (e.g., DME)
  - Number of visits (e.g., physical therapy)
- Health plans believe they enforce benefit limits developed and imposed by others
  - “The benefit is the benefit”
  - “The purchaser bought a benefit”
- Benefits and benefit exceptions have a cost
- Difficulty in competitive market of one health plan having benefits better than another

## #5: Is the provider “acceptable”?

- Three vignettes involved services from non-network providers
- Strong health preference for network providers (cost, quality)
- But plans regularly review (and often approve) services outside plan networks
- Key issues in reviewing non-network services
  - Suitable provider in network?
  - Unique expertise of non-network provider?
  - Delays in access if service required in-network?
  - Willingness of non-network provider to accept health plan’s payment rates and quality requirements (e.g., credentialing, utilization review)

## #6: Is there any basis for a benefit exception?

- Standards for exceptions are quite strict
  - Clear and robust evidence of likely positive effect on outcome
  - Any alleged cost “savings” or “offsets” must be
    - Clear
    - Predictable
    - Demonstrable
    - Contemporaneous
  - Ability to determine an “end-point” for treatment
- Most willing to consider for children and when other available and generally accepted treatments have been tried

## Issues That Could Be Pursued by the Consortium

- The ability of physicians and other providers to support requests for coverage
- The role and operations of external technology assessment and medical policy organizations
  - Opportunities for families to participate?
- Increasing benefits for DME
- Health plan awareness of other resources and supports for families

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