Conclusions of CWIC

Variations in Coverage Strategies for CAM

There are currently several different coverage models for CAM services in use in Washington State. No preferred or "right" ways of including these benefits are being recommended by the CWIC. Each approach has advantages and limitations for various constituencies. At this point, decisions on what and how to include CAM services will require evolution and refinement in the marketplace. Several coverage approaches are identified below.

Dollar Cap: The dollar cap model is a straightforward benefit that generally applies a maximum dollar amount allowed in a given coverage year for a set range of CAM services. Acupuncture, massage therapy and naturopathic medicine are the most commonly included services under this model. Chiropractic services are typically separated from the CAM dollar cap because chiropractic is frequently covered under its own rider, and there is a mandated offering law in Washington State for coverage of chiropractic services. Some plans may include direct-access for chiropractic services and others treat it as a specialist "physical medicine" service requiring PCP referral. Midwifery may be a covered benefit as well, but is usually not subject to a dollar cap, only referral requirements for maternity as a covered benefit, and when the carrier contracts with midwives. Other covered CAM benefits may require referral from a primary care provider and do not cover any naturopathic medicines. In addition, patients must pay necessary co-pays and any deductibles that may apply.

Condition Based: This CAM coverage model bases benefits on allowances related to specific clinical diagnoses or conditions, such as the use of acupuncture for pain or naturopathic care for migraine headache. Often the carrier uses "preferred" specific providers that have met a carrier's credentialing and/or geographic distribution requirements. The covered benefit may require specific clinical regimens to have been followed prior to referral for CAM services, such as a course of physical therapy prior to authorizing massage therapy. The condition-based approach may reimburse for some naturopathic medicines and usually requires a PCP referral from within their network. Patients are also responsible for co-payments and any deductibles that may apply.

Gatekeeper Method: The gatekeeper model is frequently employed under managed care coverage strategies. A unique difference with the gatekeeper model is that in some cases the naturopathic physician is eligible to function as a Primary Care Physician. Patients seeking CAM services to be covered under their insurance benefits need to have a referral from their PCP, whether the PCP is an ND, MD, DO, or ARNP. The benefits are subject to the usual medical necessity requirements established by the insurer, but may be determined by the at-risk PCP group as well.

Open Access Model: This model is built on a strong care coordination and quality infrastructure that allows the integration of CAM and CM practitioners and their services. This design allows a member to access network providers of all categories without the requirement of a PCP referral. In fact, the member is not required to designate a PCP and there is no "gatekeeper."[13]

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[13] Some insurance products outside the purview of CWIC, such as personal injury protection and workers compensation, also serve as examples of open access. Under Washington State Workers' Compensation, both naturopathic and chiropractic physicians hold attending doctor status along with medical and osteopathic physicians, and others. It should be noted that Workers' Compensation benefits are not regulated under the Office of the Insurance Commissioner. Rather, a separate agency, the Department of Labor and Industries, is charged with this oversight. Although personal injury protection (PIP) provides health care benefits, it is part of an automobile insurance policy and is therefore not regulated as health insurance.

Self-Referral and Preventive Care: The self-referral method of coverage is available usually when there is a rider benefit involved. In some circumstances, such as the State's Workers' Compensation program, self-referral to designated attending doctors is allowed. In a few cases, some benefits plans allow a patient to self-refer for a CAM service with specific limitations. These are usually related to a dollar cap or set number of sessions with a particular provider type. Although the self-referral approach method does not usually require a PCP referral, benefits are subject to medical necessity determinations made by the carrier.

Frequently the self-referral approach may be implemented in conjunction with a preventive care benefit. This may involve the purchase of a specific rider or unique product that includes the benefit. Typically, a policyholder may be able to access CAM services for a limited number of sessions with no referral and at higher co-pays than required of other conventional services.

Discount Networks: Recently, some insurers have begun to negotiate discounts with CAM providers for their policyholders in exchange for being listed in their approved provider guide. These carriers do not provide reimbursement for the members expenses for the services. This requires all CAM costs to be paid by the patient. This approach is sometimes referred to as an "affinity" plan and is a contractual agreement between the CAM provider and the network to provide a substantial discount to the members of that plan.

Lessons Learned

Despite the demonstrated good will of all parties, it was challenging to keep CWIC issues in the forefront of participant organizations' agendas. This was especially true for health plans and physician groups. When these groups were under-represented, CWIC meetings had a different impact. The time commitment for each participant was significant and affected the provider's practice as well as the organizational staff representative's workload. In many cases the representatives were able to participate in the CWIC because of their personal dedication to advancing the process of integration in addition to that of the organization they represented.

The participation of diverse, multidisciplinary parties provided great value for potentially improving health care via a broader range of more professional communication. It was important to identify and understand the distinctive roles of providers, versus payers, as well as the conventional system of medical practice from all perspectives. From this, the Workgroup learned:

- Better understanding of each other's language and clinical theory is needed.
- A forum of insurers/providers is a valuable environment for discussing coverage, payment, and cost concerns.
- Creation of resources is needed for use in other like forums.
- Building trust and relationships breaks down barriers.
- The CWIC process increased awareness of the multifaceted nature of the current health care delivery system.
- Payers began to see the value in CAM delivery experience; providers gained understanding of managed care systems.
- Many of the changes in health care have resulted from market-place factors that are frequently beyond the direct influence of providers, payers and regulators.

The principles of managed care and insurance that impact health care delivery include "medical necessity", evidence-based decision-making/quality assurance, coding/billing, credentialing, guideline/algorithm development, and coordination of care. By providing opportunities for multidisciplinary interaction, we can engage in meaningful dialogue and establish common goals. This process can lead to mutual respect and understanding. Most participants acknowledged the complexity and length of time needed to improve the integration of CAM with CM, as well as working toward better integration of all health care.

Health carrier participants requested that CAM providers present draft seed algorithms. The CAM providers for each discipline prepared at least one clinical guideline algorithm as an exercise to teach their associations the process. There are numerous models for care integration between CAM providers and conventional medical providers. Some providers are in the same locations, some focus on limited specialties, some are more closely aligned with primary care providers. It was the CWIC's experience that there was significant benefit to having some small group interaction in the first few meetings to establish an interactive model for communication. Continuous time commitments of key representatives were essential to keeping the process on track. A baseline value system developed that encouraged each member of CWIC to listen and recognize the value of other points of view.

Members agreed that improved coordination of care, including greater CAM provider input was a worthwhile model to consider. There was recognition that the current health care system is not ideally organized. Many participants emphasized that approaches offered by some of the CAM disciplines incorporate self-care and seek the most benefit for the least intervention. Seeking a balance between the interests of the marketplace, the usual and preferred practices of various disciplines and patient preferences will require attention and careful consideration.

Providers can gain from an increased understanding of the concepts of quality improvement, clinical guidelines and practice standards. Given constraints on

time, participant availability, staffing, and financial resources, it was important for the facilitators, coordinator and planning group to keep the agendas focused and to budget time appropriately. Some subjects were well beyond the scope of this workgroup due to their complexity and the time and resources that would be needed to address them. Many of these topics have been included in the "Next Steps."

Next Steps

The health care delivery system, both in Washington State and nationally, is experiencing continuing change. With the expectation that external forces in the economy, as well as in science, will exert influence on care delivery, the workgroup has identified the following "Next Steps" for further Integration of CAM into health insurance benefits and reimbursement systems

Research

The workgroup identified that research of CAM for efficacy, cost impact and utilization was a top priority with the awareness that the workgroup does not have the funding to initiate this work. What the workgroup does have is an established level of trust and a working relationship that will provide a collaborative advisory panel for any research that is to be conducted in the future. Additionally, the workgroup's subcommittee on research has identified principal investigators who are willing to work in a collaborative effort to try to answer questions related to the previously mentioned topics. Finally, the workgroup has the written support of insurers to share data with a responsible party appropriate to conduct the research, while recognizing the sensitivity of such a project. The following are some areas identified for future research:

- Collection and analysis of provider network and plan experience data, following implementation of RCW 48.43.045
- Identify ways to enhance funding for research on CAM clinical efficacy and cost effectiveness.
- Initiate a pilot project to quantify potential cost offset of specific CAM treatments for specific conditions.
- Increase research that can facilitate integration for best outcomes.
- Establish an advisory group to support ongoing research on CAM effectiveness.
- Conduct comparative outcomes studies for different CAM approaches and multi-disciplinary care.
- Gather outcome data on "best practices," based on tracking patients who have received specific treatments for specific conditions.

Care Management Considerations

Many of the subjects that have been discussed by the workgroup carried an overall theme of care management. For example, a number of questions arose such as: how can care management be positively affected by these discussions? Do the participants have the authority to go back to their organization and make an administrative change that would impact the management of care, resulting in increased access to CAM services?

It was decided that continuing work on refinement of referral criteria and systems was an important Next Step for the respective participant organizations, if not actually a direct activity of the CWIC as a future entity. There are many opportunities for CAM and conventional providers to collaborate and even integrate through joint guideline development discussions. However, specific CAM guideline development will require internal and/or external funding for such an initiative to be accomplished. Delineation of appropriate referral criteria and coordination of care to decrease redundancy of procedures, or similar services, were identified as useful areas of future work. Increasing multidisciplinary integration in management of specific conditions, including identification of reasonable treatment options, was identified as another area for future attention. Even when a guideline or algorithm does not specifically address integrated or multidisciplinary issues, the process of developing guidelines and algorithms to assist in decision-making for covered benefits is important to respective practitioners in care management.

An additional issue brought up throughout the existence of CWIC was how to determine appropriate billing (CPT)[14] and diagnostic codes (ICD-9)[15] used by CAM providers. Development of new codes is an extremely resource-intensive effort and is done principally on a national level by the US Health Care Financing Administration and the American Medical Association. To date, chiropractors and dietitians are the only CAM providers who have voting membership on the AMA's Health Care Professions Advisory Committee (HCPAC), along with physical therapists, occupational therapists, psychologists, optometrists and speech therapists. This group advises the American Medical Association and Health Care Financing Administration workgroups on CPT codes and their values and has one vote (combined) among the numerous medical subspecialties. Very few of the CAM professions have actually performed practice-resource research used in developing specific procedural codes and relative value scales. However, some other CAM professions, including acupuncture and naturopathy, have made submissions of

[14] Current Procedural Terminology
[15] International Classification of Disease, 9th Edition

their concerns about coding to the HCPAC for consideration.

Many of the CAM providers expressed interest in utilizing existing codes, however, this can be a source of controversy for payers and regulators when the codes are not developed with resource data for CAM providers in a similar fashion to what was done for all of the individual medical specialties. In addition, many services that CAM providers perform (e.g., many acupuncture procedures) are not accurately described by existing CPT codes. Some providers expressed concern that tiered, or separate coding can be perceived as a "second class" form of coverage. Although some progress has been made regarding inclusion of coverage for CAM services, a great deal of work and research on resource costs, similar to that done by all of the medical specialties may need to be undertaken by other CAM provider groups. Some insurers may also have an interest in developing payer-specific codes to describe work done by CAM providers until inclusion at the national level comes about by the HCFA and AMA workgroups.

Additional considerations regarding care management include:

- Establish ongoing CAM provider workgroups to develop and refine practice guidelines, "best practices" and algorithms.
- Establish a CAM development committee to advise insurers and primary care organizations, policy analysts and purchasers on policies; e.g., utilization management, "medical necessity", etc.
- Continue contact among workgroup participants to address new issues and provide peer support.
- Continue dialogue with payers and CAM disciplines on a regular basis.
- At least twice yearly, convene CAM providers, conventional providers and insurance representatives to discuss care management issues and how they relate to CAM.
- Include conventional and CAM providers in all discussions of practice integration.
- Inform broader constituencies (e.g., health care consumers and purchasers, providers and members of the insurance industry) of discussions and approaches identified from CWIC (or similar future forums) regarding CAM/CM interactions.
- Establish a clearinghouse for CAM industry information such as standards and practices, clinical algorithms and guidelines, contact personnel and the like.
- Identify potential strategies and funding sources for accomplishing these tasks.

Education

Licensed midwives and naturopathic physicians, along with many conventional medical health care practitioners, are all identified as general care providers in the Washington State Health Personnel Resource Plan[16]. The members of these professions are eligible to receive scholarships and loan reimbursement through the Health Professional Loan Repayment and Scholarship Program for the State of Washington. Unique to licensed midwifery is the inclusion of their services for benefits paid by Medicaid and that they are accessible through the Basic Health Plan.

An important byproduct of CWIC was the amount of education for all parties regarding each other's needs and perspectives achieved within a very short time frame. Information gained can be used to incorporate parties who were not involved in the original workgroup. Strategies and techniques for dialoging with primary care providers about their needs, and providing information about CAM providers' roles and scopes of practice can now be developed. Opportunities for further education and training about CAM within conventional medical educational settings should be identified. Qualified CAM providers with good communication skills, interest, and availability for such activities should be identified.

Collaborative Forum for Communication

It is clear that the process that CWIC provided is a one-of-a kind model for communicating on cost, coverage, and other issues. The members expressed a desire to establish an ongoing forum to advise and support the OIC on issues of integration that affect health insurance.

Some participants suggested that the Clinician Workgroup on the Integration of CAM be expanded to a national level. It was suggested that CAM professional associations and their accredited colleges, as well as conventional provider associations such as the American Hospital Association, the American Association of Primary Care Physicians, American College of Obstetricians and Gynecologists, and the American Medical Association should be included. If a forum such as the CWIC continued, a vehicle for conveying experience data and addressing coverage issues could be established. Such a forum might also serve as a springboard or template for identifying individuals who could serve as an independent advisory or review panel for providers and health plans at some point. There will be a need to identify specific roles and purpose of such a group as well as to identify funding mechanisms for such a forum.

[16] Washington State Health Personnel Resource Plan, Washington State Department of Health, 1994

Integration of CAM and CM Services

The concept of integration should be operationally defined and the advantages and limitations of integration models should be more thoroughly explored. Additional study of relationships in existing settings should be expanded, perhaps to national settings in order to delineate the range of possibilities that exist. Among the attributes of integration that need more elucidation are:

- Range of provider types that make up "integrated" practices
- Differences between joint (on-premise) practice settings and inter-referral arrangements between different offices and clinics
- Range of services covered by insurers
- Roles and establishment of CAM advisory groups
- Credentialing and care standards for CAM providers, particularly related to professional liability issues
- Structures of holistic healthcare models incorporating broad approaches and optimizing health
- Exploration of juxtaposition of different health paradigms (condition versus whole person health care, and prevention)

Among the biggest challenges for health purchasers, providers, and regulators will be defining and operationalizing clinical thresholds such as when referrals are indicated or what constitutes medical necessity for CAM services. Another challenge will entail development of best financing mechanisms for wellness and preventative services. The economics of cost sharing between at-risk and not-at-risk populations will require study and market testing. Currently, there is inadequate experience or research to quantify if potential cost-savings from purchasing holistic and/or preventative services for everyone can really occur. Some of the knowledge developed through the CWIC project can serve to lay the groundwork for addressing these and other issues. Exploring how multidisciplinary models can be used more broadly in the health care field generally should be pursued.

Overall, this represents a large number of Next Steps and will require both personnel and financial resources. Some external, governmental, and philanthropic sources may be identified, however individual payer and provider organizations should pursue this according to their needs.

Key Issues Regarding Integration

The key issues related to integration of CAM identified by the CWIC include:

Relationship Development: As a multidisciplinary group of individuals coming from very different points of reference, it was critical that a core value within the group was mutual respect and openness to new ideas. This value was the basis that formed the foundation for relationship building. By facilitating a process that maximized interaction of various disciplines and encouraged communication, we fostered learning and idea exchange that allowed exploration of others' points of reference. An environment was cultivated that allowed new members to join easily and encouraged trust.

Speaking Different Languages: Patience and openness were required attributes given the divergence of training, philosophy, and professional experience the group brought to the table. Health care professional training programs range from six-month certificate programs in community-based or vocational schools to post-graduate degree programs with extended residencies.

An understanding and acknowledgement of the context from which the various disciplines came was essential in order to gain perspective of how different providers formed their opinions. In addition to the experiences and training that lead to various perspectives and practices, each discipline has also evolved its own syntax that could be a source of confusion or misunderstanding to payers and CM practitioners.

Learning Each Other's Paradigms: Respective paradigms for training, attitudes toward healing and interventions, care coordination and approaches to reimbursement were variable across the continuum of participants. Acknowledgement of differences in perspectives from disease-oriented models compared to holistic models is essential to successful idea exchange. An appreciation for how this can translate into unique approaches to patient involvement, differences in patient expectation and responsibilities, and short-term versus long-term goals for intervention was also conveyed. For example, CAM paradigms typically address both acute and chronic disease by embracing health restoration processes that are directed at individual's needs, as well as overall health improvement, which may or may not directly relate to the diagnosed condition. This can create confusion within conventional delivery models, yet serves as a common rational approach among many kinds of CAM providers.

Algorithms and Guidelines: There was extensive discussion and work done by CAM disciplines to understand and utilize guidelines in order to better explain how the interventions they provide can be applied under specific clinical circumstances. It was recognized that reimbursement under current systems requires accountability from all providers including substantiation of clinical need for services. Algorithms and guidelines can help clarify clinical decision points and convey the clinical context under which decisions are made.

Efficacy of Treatments, CAM and CM: It is recognized that many CAM treatments have not established efficacy based on scientific study, however the same holds true for many CM procedures. Development of a CAM research structure comparable to

that of CM is unlikely to evolve rapidly. The importance of enhancing the evidence base for clinical interventions is acknowledged and encouraged. Many CWIC members emphasized that the "absence of evidence" should not be equated with "evidence against", which is often what happens in the delivery and reimbursement world. However, as with CM procedures that have an extensive history of utilization prior to thorough research validation (e.g., physical examination), there may be difficulty obtaining resources to determine efficacy of some CAM procedures. Collaboration and synthesis of knowledge and experience should be prioritized and reasonable consideration to patient preference and CAM expert opinion and experience should be placed in appropriate perspective. All providers must seek the best tools in the service of patients, and particular consideration should be given for those complex and chronic disorders for which conventional approaches have not been successfully addressed.

Members May Have Different Needs: Some members saw their involvement as seeking the best care options for patients. Some members felt their role was to meet the needs of the law. Some felt that they were involved to explore the most cost-effective treatment options. Some members recognized the essential role that patient preference is playing in the evolving health care system. The health care delivery system involves multiple constituents, and the vantage points of each have validity. A forum to exchange needs and constructively solve problems makes an important contribution, particularly in sensitive environments where the potential for adversity is high.

Recommendations of CWIC for the Integration of CAM

- When coverage decisions are made, individual CAM professions should work closely with carriers to assist them in knowing when to cover their services for a specific condition, and to provide clinical algorithms to support the claim.
- Insurers should involve the respective CAM professions when establishing CAM benefits packages.
- Participants in CWIC and their organizations should explore ways to maintain an informal network and consider seeking broader, perhaps national support for establishing an ongoing forum for dialog and problem solving.
- Educational strategies should be adopted for enhancing cross-fertilization and understanding of the issues of payers, CAM providers, and conventional providers. Recognition of areas of mutual interest should be made explicit, and areas of divergent needs and priorities should be acknowledged and engaged constructively.
- Opportunities should be explored to use technology and communication to inform interested parties of various methods and issues regarding integration of CAM and CM.
- In general, sources of funding and resource support need to be identified for all of these activities.

Conclusions

The three-year-long CWIC process has been exciting and challenging in its scope. By virtue of having broad, multidisciplinary member participation, and by attempting to address many complex issues, it created a high set of expectations. As a process for bringing these issues to the discussion table, most would acknowledge the CWIC as a success. New and important relationships have formed and interdisciplinary dialog has been opened in a way previously unheard of. Many of the key questions and concerns have been identified and discussed, and although many issues remain unresolved, agendas for further work and research have been identified. All participants in the process have acknowledged gaining valuable insight and perspective. Many have used the process as a springboard for innovations in their approach to integration and coverage issues as well as communication.

From a work product standpoint, the successes were more subtle. There was insufficient time to accomplish everything that the broad array of participants might have hoped for. Personnel and financial resources were limited. Yet through hard work, significant risk taking, and dedication of financial resources by the participants themselves, initial work was begun on protocol development, interdisciplinary dialog and cooperation has ensued, and initiation of research grant writing has taken place.

The unique health care environment in Washington State provides a fertile arena to explore the issues of CAM integration. The prevalence of CAM services, the legislative mandate of "every category provider", and the market interests of the State's health care consumers have all contributed to and enabled the discussion. However, the biggest challenge for additional progress will continue to be obtaining ongoing commitments from the involved parties and their organizations. Much of the challenge has to do with external demands on participant time and their respective organization's priorities.

CWIC believes that with few exceptions, all the organizations that participated over the course of this work have, by their involvement, agreed that these questions are important to our region's health care delivery system. The workgroup rapidly gained mutual respect, despite many initial concerns. The recognition of common interests in the health of patients individually and on a community-wide basis served to coalesce into a problem-solving mindset over a respective self-interest

one. All sides took risks at times and engendered apprehension and skepticism from their peer constituents.

Even so, an open-mindedness and willingness to exchange ideas above personal feelings permitted education and innovation to occur. All involved made personal sacrifices by taking time out from practices, juggling and postponing organizational obligations, and engaged in the continual persuading of constituents and superiors to see the process out. For this, the participants deserve acknowledgement and thanks from the greater health care community. There is no doubt the work ahead is far greater than that yet accomplished. As is pointed out in the section on Next Steps, most participants are striving to see this process continue, albeit in a different form and context.

Integration of CAM services is not a passing fad, nor simply a statement of dissatisfaction with the conventional medical system. As research has already documented, health care consumers perceive value in CAM with out-of-pocket expenses for alternative care equaling or bettering out-of-pocket expenditures for primary (non-hospital) conventional services. The rate of use of CAM services continues to increase. Research dollars from federal agencies including the National Institutes of Health and the Health Services Resources Administration are funding research, education and infrastructure development for these services. Yet there is so much more that needs to be done.

The inclusion of conventional medical providers, hospital representatives and institutions of medical education was an important element to embed the CWIC process into the medical community. Many misunderstandings and biases have been dispelled on all sides. The language and perceptions of payers and CAM providers alike have been clarified. The health care environment will continue to change. Consumers are demanding access to the best elements from both CAM and conventional care. The digital information age is empowering consumers with more insight and understanding of health care options.[17]

As a result, knowledge that was once the exclusive province of learned proprietary professions is available to anyone with a connection to the Internet. Change is certain. While unbridled change can be chaotic, informed change associated with interactive adaptation can help foster innovation and meaningful outcomes that address interests of consumer, health care provider, business, and regulator alike. The participants in the CWIC process perceive their efforts as contributing to the latter.

[17] Additional resources and references for CAM information are listed in Appendix J.