Essential Benefits Set Work Group
Meeting 3 – Handout J
9/18/2009

MCO Tools and Initiatives to Manage Costs Based on Service Value, Quality or Necessity

Many elements of current benefit design and managed care operations can also be viewed as supporting EBS principles either directly or indirectly. The following is a partial list:

Tool or Initiative	Description	EBS Connection
Claim Edits	Claim edits are programmed filters applied at the time of adjudication. For example, edits may identify claims using improper service/diagnosis combinations (e.g., a surgery without any suitable diagnosis) or service/gender combinations (e.g., a female procedure for a male). Such claims may be associated with provider data entry omissions or errors, or actual inappropriate services.	One basic way to limit payment for services that are not appropriate or "low value."
Disease Management	Members may be requested to enroll in a disease management (DM) program to support them in self-care education and guideline adherence for their specific condition(s). Participation in the DM program may then be tied to coverage of and/or lower cost sharing for services encompassed within the applicable guideline.	Enrollment in a DM program may be a proxy in claims adjudication for more complex guideline adherence logic.
Experimental Status	Health insurance policies commonly exclude services that are considered "experimental" or "investigative" because there is not yet sufficient evidence to support their clinical effectiveness. Some experimental procedures may later to be proven to be effective, while others are not.	Applies a minimum standard or evidence of effectiveness for services to be covered.
Health Assessments	Health plans may request members to complete health assessments at enrollment or other times. Assessments may assist in identifying candidates for DM programs, serve as a baseline for measuring changes in health status, or otherwise support outreach and self-care supports.	May support DM programs or other initiatives to communicate and tailor guidelines.
Mandated Benefits	Certain services or service/diagnosis combinations have been deemed to be of sufficient importance or value to mandate inclusion in all health insurance policies. (See the Minnesota list of required benefits.) Mandates generally require full coverage and do not provide for cost-sharing variations.	Consistent with the "Services" or "Services + Condition" EBS design approaches.
Medical Necessity	The standard of "medical necessity is a fundamental component of most health insurance policies. It is based on a legal doctrine related to activities which are justified as reasonable, necessary, and/or appropriate based on evidence-based clinical standards of care. Services that are not medically necessary are not covered. Within the insurance mechanism, this definition serves to exclude from coverage numerous serves that may otherwise be considered of low value in an EBS design.	Services that may be ranked as limited or no value from an EBS standard may also fail to meet current "medical necessity" standards.

Tool or Initiative	Description	EBS Connection
Provider Panels/ Cost-Sharing Tiers	In-depth evaluation of health care provider practice patterns may be used to identify providers whose overall methods of practice most closely correspond to evidence-based standards, guidelines, or other applicable criteria. Such providers may then be designated for inclusion in a panel or network that is communicated to members, with the expectation that most (if not all) services received will be more likely to correspond to EBM criteria.	Use of providers recognized as practicing consistent with EBM may be a proxy in claims adjudication for more complex guideline adherence logic.
Quality Information to Consumers, Providers	Educating consumers and providers on which services, technologies and drugs offer the best value may influence purchasing decisions in favor of more conservative or evidence-based courses of treatment. This has become a more important area of health plan activity as more members are covered by high-deductible, consumer-directed coverage designs.	Information related to EBM standards and guidelines is important to promote understanding and adherence.
Service Authorizations	Requiring prior authorization for some services allows the health plan to validate that the service, as it is proposed to be used in a given situation, adheres to guidelines and therefore should be covered. Prior authorizations are most feasible for services that are elective or can be scheduled in advance. Concurrent notification and authorizations are also applicable for other services such as certain hospital stays, and may affect authorized length-of-stay or discharge planning. Authorizations may be based on accepted guidelines, the judgment of the health plan medical director, or other factors.	Authorizations allow the application of medical necessity standards and judgments to ensure that the proposed services are of reasonable value.
Service Limits	Limits on the number of services, visits, or days allowed during a calendar period are sometimes based on over-utilization concerns in areas of practice where medical necessity or effectiveness can be more difficult to confirm. Examples have included: mental health, chemical dependency, chiropractic, physical therapy.	Within the context of the EBS design, may limit potential over-use and therefore lower-value services.