

Operational Issues in Incorporating Complementary and Alternative Therapies and Providers in Benefit Plans and Managed Care Organizations

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Complementary and Alternative Medicine: Issues Impacting Coverage Decisions

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Introduction: *“Matchmaker, Matchmaker, Make Me a Match ...”*¹

A sobering perspective on the operational issues in integrating complementary medicine into the reimbursement system unites two unflattering characterizations of the parties which are being coupled. A proponent of complementary medicine, writing in Britain's *Complementary Therapies in Medicine*, argues that “the coming of age of complementary medicine raises questions that an informal, fragmented and fringe movement has not so far addressed.”² In a recent issue of *Health Affairs*, Harvard Medical School associate professor of medicine and health care policy David Blumenthal suggests that, for many health care professionals, following changes in the healthcare system as documented in the *Wall Street Journal* is to “watch a train wreck in slow motion.”³

In this unfriendly light, our basic operational question becomes: *How do we board chaos onto catastrophe?*⁴

This image is offered in the way that a ceremonial libation to dark forces may be presented at the beginning of a healing ritual. Merely structuring a pattern for limited coverage of specific complementary services can readily lead reluctant health plan administrators and complementary providers to the pharmaceutical or natural sleep aids of their choice. The health plan's project manager can be dumbfounded by the virtual lack of actuarial and managerial information and templates. Literature on the subject is only now coming available. In addition, the manager may confront deep-rooted emotions from both medical and administrative personnel by merely invoking the spirit of “alternative medicine.” When the manager ventures out into the community for complementary provider partners, another set of strongly-felt emotions will be activated.

But what if the project manager is not asked to create a limited benefit, but instead is charged with establishing *optimal* integration which honors the best of the disparate

¹ From the musical *Fiddler on the Roof*, Sheldon Harnick, lyricist (1964).

² Mills, S.Y. “Safety awareness in complementary medicine,” *Complementary Therapies in Medicine* (1996) 4, 48-51.

³ Blumenthal, D. “Effects of Market Reforms on Doctors and their Patients,” *Health Affairs*, Volume 15, Number 2, 170-184.

⁴ The only momentum for carrying such a work forward might be from complementary medicine's antagonists in the conventional medical community who might be expected to view such an endeavor as the exception that proves the rule against throwing the baby out with the bath water.

healing systems? Such a project manager faces a multi-faceted, clinical-economic, cross-cultural challenge of the first order. Perhaps because this endeavor is viewed by growing numbers of people inside and outside the complementary community as potentially a core contributor to fundamental health reform in the United States, humility alone requires that the dark forces be acknowledged.

That said, the working experience of health plans which have engaged this task is evidence that creating complementary care products may be easier than many health plan executives might anticipate. An infrastructure to assist project developers is rapidly developing. A major contributing factor is the experience of health plans in Washington state following a 1995 legislative mandate requiring plans to include “every category of provider.”⁵ Health plans with up to 500,000 covered lives, and insurers with greater number of subscribers, are required to internalize complementary benefits. The Washington experience, in particular, will lend a documentary dimension to this paper. Rather than merely investigating operational *issues*, numerous examples of operational *responses* chosen by Washington’s health plans, and plans elsewhere in the nation, are woven into the text.

What Do We Mean by “Integration”?

A clarification of the meaning of “integration” is required at the outset of this investigation. As has already been suggested, the applied meaning of this term varies substantially among plans.

- *Rider to a policy* At one end of the spectrum, integration can merely suggest coverage of complementary services through a rider by which a purchaser pays more for a defined benefit.
- *Economic integration* The next level of integration is one in which the health plan makes the benefit, however restricted, available as a core part of covered services. As such, the complementary benefit is integrated more thoroughly into the plan’s payment structure.
- *Clinical-economic integration* Alternatively, a health plan may work to ensure that complementary services are integrated not just into the payment system, but also at the clinical level. This implies a more substantial commitment from the plan and the plan’s complementary provider partners.

In this paper, “integration” may represent any one of the meanings along this spectrum. A specific use of the term must be understood contextually. Individual sections will focus on challenges faced by those interested in greater and lesser degrees of integration of complementary services into health plan operations.

Three additional notes on language. “Health plan” is generally used, rather than the awkward “insurers and managed care organizations,” to describe the entity into which integration is being considered. The choice to use the preferred language of the American Association of Health Plans, the national industry organization for managed care, resides in the author’s belief that the integration relationship will be worked out in the arena of managed medicine. Most of this paper focuses on strategies relevant to health plans, rather than strategies for insurance companies covering care on a fee-for-service basis. “Complementary” is also used, rather than “alternative”, “integrative” or “natural,” to refer to

⁵ The mandate is described in detail in Section 2 of this paper.

the service offerings which are being integrated. While “complementary” is used here only to describe the services which may be “alternative” for plans, the use is meant to evoke the idea that all therapies should one day be viewed as appropriate complements to the rest of an individual’s care. Finally, “primary care physician” or “PCP” when used without a modifier (such as “complementary” or “naturopathic”) will mean a conventional medical doctor (MD) who is serving in this capacity.

Section Overview

The image of chaos boarding catastrophe, while open to challenge from many angles, does serve as a useful jumping off point for Section 1 of this paper. Both complementary medicine and the reimbursement world are in the throes of great change. Neither party to this match-making is stable, nor easy to define. The paper begins with profiles of these entities in order to create a real-time focus for this investigation. Substantive differences in both the internal environment and the external environment in which a given health plan operates lead to dramatic variation not only in the operational questions asked but in the answers which may be deemed useful. We look at these variations from four perspectives: 1) corporate structure; 2) philosophical orientation; 3) external pressures; and, 4) the level of internal advocacy for integration of complementary services. The section concludes with a profile of the complementary care partner.

In Section 2 and Section 3, the integration of complementary medicine is examined in the context of two of managed care’s core standards, credentialing and utilization management. The utilization plan created by Group Health Cooperative of Puget Sound, an HMO industry leader, serves as a backdrop for an exploration of how a conservative plan may develop an integration strategy with restricted benefits. More complex utilization issues begged by the convergence of distinct medical paradigms are noted and briefly explored. Each sub-section concludes with an iteration of key opportunities and recommendations in managing complementary services through these standards.

Section 4 picks up the theme of a health plan’s individualized needs and goals introduced in Section 1 and examines what may be the defining operational issue, at this time, in integrating complementary services: the role of bias and prejudice among participants in this matchmaking. This issue is potentized by 150 years of conflicted struggle and name-calling between orthodoxy and the “irregular” providers. Optimal integration is presented as an emotional-economic undertaking. A willingness to analyze and relinquish one’s own participation in this polarization profoundly reshapes the nature of the inquiry. Both conventional and complementary providers will be asked to confront some cherished self-concepts. As will be seen, the deep concerns of a skeptic toward integration may appear to be little more than a red herring to an advocate of greater integration.

Section 5 returns to other core standards of managed care, quality improvement and health promotion. In this section, the approach toward integration is progressive, rather than skeptical or reluctant. The processes for continuous quality improvement (CQI) are presented as ideal business structures for engaging the integration challenge. Strategies for initiating complementary products through the CQI processes are suggested. The role of complementary services in the coming era of *quality competition*, which many observers believe, or hope, will soon replace mere competition over cost, is then considered. Particular attention is given to the challenges plans face in embracing

their core principles of primary prevention, self-care and health promotion. To what extent do these challenges parallel those in integrating complementary services? Might the complementary medicine movement be an ideal partner in this profound movement toward reforming health care?

In the final section, a few policy initiatives are proposed, followed by some concluding remarks.

Note: References to the newsletter THE INTEGRATOR *for the Business of Alternative Medicine* refer to the monthly newsletter for which John Weeks is publisher-editor. At the time this paper was written, Weeks was executive editor and writer of the newsletter, which was then published by St. Anthony Publishing as *The Business Report on Alternative and Complementary Medicine*, and then renamed *Alternative Medicine Integration and Coverage* in June of 1997.

Section 1 Profiles of the Integration Partners

The Corporate Partner

The Hybridized Nature of the Corporate Partner

While observers will dispute whether or not Blumenthal's train of health care reform is headed for disaster, most will agree that the medical-industrial complex has already exploded into myriad subsets of more-and-less managed medicine. The corporate partner or payer cannot simply be defined as "indemnity" or "managed care": most are composites. One can find it difficult to keep pace with the acronyms, much less the actual nature of newly forming delivery and payment structures that the emerging alphabet soup represents. Reform has produced permutations of owned, rented, for-profit, not-for-profit, joint-venturing, network-based, insurer-backed, fee-for-service (FFS), publicly traded, HMO-type, physician-owned, capitated, primary-care-oriented, hospital-centered, preferred-provider, locally-controlled, gatekeeper-model corporations providing, managing and insuring health care.

These individualized structures of ownership, of intent, and of decision-making provoke distinct operational questions relative to complementary medicine. An insurance company's new HMO which contracts on a fee-for-service basis with primary care groups, for instance, must ask different questions than a staff model HMO. The former may have more flexibility, while the latter has more ability to control the benefit. Their interests will vary from those of a traditional indemnity insurer. Each hybridized health plan operates with distinct structural incentives and constraints. Table 1 views some of the organizational hybrids in the sub-category of HMO and notes some of the questions which may be of particular concern. Many of these questions are addressed in Section 2 and Section 3. These differences underline the importance to a health plan of an elaborate internal assessment prior to engaging an integration strategy.

Philosophical Differences

Openness to complementary care may also be affected by the emerging rift in the philosophical foundation of the dominant system of medicine. The opening public relations salvos of the American Association of Health Plans (AAHP) in February of 1996 might lead the causal observer to assume that the historic, physician-centered, disease management strategies will increasingly be confronted by a new paradigm of care from within the reimbursement arena. Promotion of an active patient-physician partnership is the very first line in the AAHP's "Statement of Principles."⁶ The AAHP's sixth principle announces that "working with people to keep them healthy is as important as making them well." With its first educational offering four months later, the AAHP further stepped up the rhetoric. The theme was "Putting the Patient First." This

Table 1: Specialized Integration Questions of Some HMO Hybrids

⁶ The AAHP Statement of Principles was mailed out by the AAHP with the press release on February 26, 1996, which announced the AAHP's formation via the merger of Group Health Association of America and the American Managed Care and Review Association.

HMO Type	Questions and Opportunities
<p align="center">Insurer-based local HMO</p> <p><i>HMO created by a geographically-limited insurer which takes full-risk capitated contracts but pays contracted providers on a FFS basis</i></p>	<ul style="list-style-type: none"> • Complementary providers can be covered by the plan on a FFS basis, outside the capitated contracts. • Should members be allowed direct access to complementary providers? If direct access to complementary providers is allowed, should limits be put on the benefit? • If complementary services are only available by referral, does payment come from the PCP's capitation payments? Or is the plan responsible? • How can incentives be aligned for optimal utilization? • What becomes of this benefit as the plan shifts more of its contracts under capitation? How will consumers react to any changes?
<p align="center">Local affiliate of a publicly-traded national HMO</p> <p><i>HMO is multi-state and contracts with local providers, paying some on a capitated basis, some FFS</i></p>	<ul style="list-style-type: none"> • Potential for sharing the cost of a pilot or an experimental benefit across a whole system. • Difficulties in transferability of a pilot may arise from variations in licensing and scope of practice among provider categories in different states. • How will investors view the initiative? Does it fit the national mission? • Might interest in an initiative in one marketplace be resisted in regions with less interest in such services?
<p align="center">Staff-model HMO</p> <p><i>Staff-model HMO with a dozen different, variously managed product lines, contracting with numerous non-staff networks on a FFS basis</i></p>	<ul style="list-style-type: none"> • Potential for greater management of a pilot integrated clinic. • Do the HMO's bylaws allow complementary providers to be staff providers? How will the current medical staff respond? • What resources for providing complementary services does the plan have among its current providers? Does the plan need to go outside to provide complementary benefits? • Should complementary providers be employed or contracted? • Should complementary providers only be included as physician extenders?
<p align="center">Hospital-based HMO</p> <p><i>Local hospital trying to keep its beds filled via a PHO network offering an HMO product</i></p>	<ul style="list-style-type: none"> • May provide a good context for a pilot integrated clinic. Can such an initiative help fill beds? • Might there be value in a complementary care center or clinic in an under-utilized hospital wing? • How will such a complementary care initiative affect the plan's relationships with newly contracted community providers?

phrase, while clearly putting forward a besieged industry's favored media profile, suggests that a patient's perceived health and functional well-being may begin to share or overtake biomedical markers for top billing on clinical outcomes. Reimbursement's historic cornerstone of a strictly sick-care definition of "medical necessity" would appear, like a decaying root canal, to be loosening its structural hold in the reimbursement system.

A health plan's level of interest in putting these principles into practice may shape the plan's openness to complementary services, since these very principles are among the forces energizing the popular growth of the complementary medicine movement. Similarly, if a plan honors the bio-psycho-social-enviro model of primary care that is taught in state-of-the-art family medicine programs today, the plan may show more openness to what complementary providers call "holistic" or "whole person" care. These principles may be viewed as receptor sites for the integration of complementary services. (The remarkable convergence of language between progressive managed care and the complementary medical community is explored further in Section 5.)

The External Environment for Integration

Another major distinction between plans which influences the perspective on the operational questions is the attitude toward complementary care in the plan's marketplace. The marketplace may make itself felt in a variety of ways. Three examples follow:

1. *Purchaser Request* A specific purchaser may make a request for complementary services. One such example was a request from Electric Boat Corporation to Physicians Health Services (PHS) when the Connecticut-based HMO won an exclusive contract in 1995. Electric Boat asked PHS to include complementary benefits; in particular, naturopathic medical services. Fulfilling the purchaser's request posed an interesting operational challenge for PHS. Electric Boat wanted its members to have direct access to naturopathic physicians, yet the credentialing requirements established by PHS for its primary care providers were beyond the reach of naturopathic physicians in the state.⁷ PHS effectively created a new service delivery category of "direct access specialists" to meet its purchaser's request.⁸ The plan has since established statewide networks of complementary providers.
2. *State Mandate* A state legislature may pass a mandate, as happened in Washington state, presumably as a response to a belief that voters wish to have access to complementary services. (A similar measure is on the November ballot in Oregon.) The language of the mandate may shape the operational questions for plan's covered by it.⁹ One fallout of the Washington language, for instance, is that "alternative medical doctors", because they are not a distinct provider category under state law, are not directly of interest to health plans.
3. *Response to a Competitor* The marketplace for integration and inclusion is rapidly maturing. A plan which may not have shown interest in complementary care may begin to consider developing a complementary product following action by a competitor. The most interesting example of the potential impact of a competitor with a progressive view of complementary services is unfolding in the Northeast. In 1995, Oxford Health Plans, a very successful regional HMO, began a much-publicized investigation of complementary products. Oxford's integration effort, scheduled for release at an October 8, 1996 press conference in New York City, is being closely watched by its competitors.

Any of these marketplace influences may crack the shell of resistance to complementary products. Competition between plans alone may provoke a surprising degree of openness.

The Internal Environment for Integration

Finally, highly-placed, complementary-friendly or complementary-*experienced* decision-makers inside a plan can have a profound effect on a plan's view of the operational challenges involved. Complementary-friendly managers may shape a plan's response to an external request for services. Executives who have positive personal experiences of complementary services are responsible for jump-starting the most visible

⁷ PHS required both specialty residencies and hospital privileges of their PCPs. Naturopathic physicians have neither.

⁸ Personal communication, Stan Stier, MD, associate medical director, PHS, and Deirdre O'Connor, ND, contracting naturopathic physician, Mystic, CT.

⁹ The full text of the Washington State "every category of provider" mandate (RCW 48.43.045) is cited in Section 2.

plan-centered integration initiatives. Examples from both of these situations are described below.

In response to external demands, plans may look internally for their project managers to develop requested benefits. If such a manager is complementary-friendly, the benefit and its structure may be affected. PHS, for instance, made a project developer of associate medical director, Stan Stier, MD. Stier was already a long-time member of the American Holistic Medical Association. He brought to the project a perspective which included an abiding interest in complementary services and a belief that naturopathic services, in particular, would not likely expose the plan to financial risk. Where another manager may have been stymied by the contradictions between the purchaser's request and PHS's credentialing criteria, noted above, Stier comfortably carved out the unusual structure of the "direct access specialist" for the naturopathic benefit. In Washington State, King County Medical Blue Shield (KCMBS), which has received high marks from complementary providers for its strategy under its managed care products, has a medical director whose family has been personally pleased with complementary care. An associate medical director with a strong interest in integrated care has helped manage the development of the product. KCMBS chose to accept referral to acupuncturists for a longer itemized list of conditions than any of KCMBS' competitors. Members are also allowed to choose naturopathic physicians as primary care providers. Other Washington plans, without such internal advocates, developed more restrictive strategies.

Health plan executives or medical directors responsible for integration initiatives undertaken in the absence of external pressures have in common close experience of the value of complementary health care services. The experience may be personal, familial, or, in the case of Mutual of Omaha's coverage of the heart program developed by Dean Ornish, MD, the experience of a highly respected colleague.¹⁰ The personal experience leads to personal interest in the field. The executive gains an understanding of the aims and arguments of the complementary movement, then finds a way to promote the product inside the plan. Kris Labutzke, for example, as vice president for underwriting with American Medical Security (AMS), convinced other AMS executives to allow her a six month leave from her underwriting position to investigate development, while on payroll, of a complementary product for the Green Bay, Wisconsin, insurer. Her research led to the plan's HealthCareChoice\$ product. Table 2, below, notes some of the complementary-experienced decision-makers and the integration projects which they were instrumental in creating. The list is meant to show a pattern, rather than to be all inclusive. The passion of the highly-placed internal advocate appears to transform the *challenge* of integration into a perceived *opportunity* from integration.¹¹ (This phenomenon is further investigated in

¹⁰ The importance of personal experience of executives is also felt at the policy and administrative levels. For example, former Congressman Berkley Bedell's experience with alternative medicine was the primary causal factor in the creation of the Office of Alternative Medicine inside the National Institutes of Health. Compliance with the Washington state mandate is being pushed -- not without controversy -- by state insurance commissioner Deborah Senn who is a consumer of naturopathic, acupuncture and homeopathy services.

¹¹ Health plan strategists may be surprised by the outcome of an internal assessment of the complementary health care utilization patterns, or interests, of its key personnel. One postulate is suggested by the Eisenberg study (*NEJM*, January 28, 1993) that 34 percent of consumers in the United States used some form of alternative therapy in 1990. A similar percent of individuals working inside American health plans may quietly be going outside their own plan for health services they deem valuable. How might their interests shape a plan's perspective on integration if such a project makes the health plan's agenda?

Section 4, which looks at the way that the prejudices and biases of participants shape the operational questions.)

Table 2: The Decisive Role of Executives Experienced in Complementary Therapies in Initiating Integration Initiatives

Health Plan	Decision-Maker	Product
American Western Life Insurance (CA)	Leland Wolf, Chairman	Wellness Programs
American Medical Security (WI)	Kris Labutzke, former VP Underwriting	HealthCareChoice\$
Blue Cross of Washington and Alaska (WA)	Betty Woods, CEO	AlternaPath Pilot
HealthEast (MN)	Chris Foley, MD, Medical Director	HealthEast Healing Center
Kaiser Vallejo Medical Center (CA)	Ward Gypson, III, MD, Medical Director	Alternative Medicine Clinic
Seattle-King County Department of Public Health (WA)	Majority of elected council members ¹²	Integrated natural medicine clinic in the public health system
Mutual of Omaha (NE)	(Executive) ¹³	Ornish heart program
Oxford Health Plans (CT)	Steve Wiggins, Chairman and CEO	Product to be unveiled 10/8/96

A Profile of the Complementary Partner

The integration relationship is a product of both the health plan and the community providers with which it is to develop relationships. A health plan's operational decisions will be also be shaped by the perspectives of the chosen partners.

The publication of David Eisenberg's study stirred a profound transformation of the social, political and economic context of complementary health care practices. The estimated 425 million visits and \$13.7-billion dollars involved in alternative medicine hit each of the nation's power centers with a distinct message. To politicians, the study meant voters. To media owners, it meant readers and viewers. To researchers, a new arena for legitimate work. To venture capitalists, opportunity. To some health plans and insurers, the Eisenberg study meant marketshare. And for the consumer, the study meant they were not alone. Most observers agree that Eisenberg's estimates, based on 1990 data, substantially underestimate utilization of complementary services today. The culture's affair with alternative medicine is out of the closet.¹⁴

This sudden positive attention is profoundly influencing the psychology and the perception of opportunity in the complementary community. Long-time leaders began feeling new confidence after decades of creating schools, accrediting bodies, licensing, professional associations and alliances in an officially marginal, largely unreimbursed, and unacknowledged arena. During those formative years, the dominant school of medicine

¹² "County mulls clinic for natural medicine," *Seattle Times*, March 4, 1995.

¹³ In this instance, the CEO was moved by the personal experience of a hunting buddy. The point was noted in a talk by William Minier, MD, medical director, Managed Health Care Program/Nebraska Region, Mutual of Omaha, at an Institute for International Research workshop, December 8, 1996.

¹⁴ The idea of consumers coming "out of the closet" was articulated by King County Councilwoman Cynthia Sullivan in a hearing on a proposal to establish a natural medicine clinic inside the King County Department of Public Health (March 2, 1995). Sullivan had just revealed to her fellow councilmembers, and to the audience, that she had been quietly using acupuncture for her migraines.

was not known for reaching down from its pedestal to assist complementary care into its maturity.

Responses to Increasing Reimbursement Possibilities

Not surprisingly, the response of the complementary providers to increased reimbursement opportunity now parallels the behavior of victors in a successful popular rebellion. Three types of responses dominate.

- *Take me, I'm yours* Some members of the complementary community are comfortable laying down the sword while gaining a measure of reimbursement, however it is defined. Such providers will fill the need of some insurers and plans.
- *No way (at least for now)* Other providers, including some of the most respected, refuse to participate with reimbursement or contract with health plans. They may be comfortable with the influx of new consumers into their cash practices. They may conscientiously object to the way third party payment may diminish a patient's sense of responsibility for the clinical interaction. They may also believe that the insurance system continues to promote a disease orientation in health services rather than the health orientation of their practices. Plans may desire the involvement of these respected providers but not be able to secure it.¹⁵
- *Honor what I bring to the table* Some old warriors for complementary care and new initiates riding the crest of the movement demand that their revolution's promises not be corrupted on arrival in the hip-pocket of American medicine.¹⁶ These leaders may be intrigued by participation in the reimbursement system, and even see the value in learning how to manage the care provided by their own discipline. Yet they demand that operational issues not be shaped solely by health plans. They ask that a separate series of complementary provider-driven issues be on the table.¹⁷ They speak of a reimbursement structure which remains true to the defining principles of their profession. Such a desire is often coupled with restatement of an over-arching commitment to transforming the foundations of the nation's health care system, and, by implication, the reimbursement structures which shape and define it. Some entrepreneurs and plans will find in such visionary providers their optimal, if demanding, collaborators.

Organized Complementary Professions Take up the Challenge

Managed care and reimbursement is surfacing as an important issue for professional associations representing complementary providers. They are beginning to organize and provide services around reimbursement issues.¹⁸ These are the first signs of

¹⁵ An interesting case in point is an early business venture of The Alternare Group, in the Portland, Oregon, market. Alternare, funded by a successful PPO executive, planned to purchase or create an integrated network of multi-disciplinary clinics (MD, ND, LAc, mental health, body-work) which could then carve out complementary health benefits. The entrepreneurs chose to abandon the project upon discovering that most of the top providers in the market were not interested.

¹⁶ *Advances* []

¹⁷ Robert Duggan's article, "Complementary Medicine: Transforming Influence or Footnote to History?" in *Alternative Therapies*, May 1995, is an excellent perspective on these issues from a long-time leader in the complementary medicine movement.

¹⁸ The Washington state chapter of the American Massage Therapy Association and the Washington Association of Naturopathic Physicians each purchased legal counsel to gain clarity on the full extent of activity in which it can engage without violation of anti-trust rules. Each association

professional organizations proactively investigating reimbursement issues in order to prepare members for negotiations with plans. The Washington Association of Naturopathic Physicians is creating its own quality improvement plan and is investigating establishing a naturopathic management services organization in an attempt to gain more control over the management of naturopathic services.¹⁹ One might anticipate that providers trained by their professional organizations in how to think about reimbursement and managed care, or organizations established precisely for this purpose, would wish to shape the ensuing relationship.

Development of an Infrastructure for Integration Activity

Finally, entrepreneurs from outside the complementary community are beginning to organize complementary care into diverse products which will assist the project manager who is facing the operational questions. These include: boutique seminars on integration strategies; focused newsletters; templates for integrated products or clinics which are available as franchised or licensed products; and complementary provider networks with which a health plan can partner to hasten development of a product. By the beginning of 1997, even the most skeptical of project managers will be able to access resources which will help illuminate their integration concerns. Within another year, utilization reports from the “every category” experience in Washington State are also expected to be available. The nearly empty set of working tools on credentialing, quality management, utilization, outcomes and other operational concerns will be a thing of the past.

subsequently retained attorneys to independently review contracts tendered by plans. The opinions were made available to all members.

¹⁹ At the September 1996 national convention of the American Association of Naturopathic Physicians, the House of Delegates created a new Standing Committee on Managed Care.

Issues Posed By Managed Care's Core Standards

Section 2: Credentialing

Introduction

The central operational issues facing most health plans are viewed in the context of the standards of the organization's accrediting agency. While a number of accrediting organizations perform these functions, the leading agency is the National Committee for Quality Assurance (NCQA). The NCQA standards serve as a backdrop for the analysis of credentialing and utilization management issues in this section.²⁰

Representatives of health plans choosing to develop complementary care products generally begin the process by reviewing the available literature to discover templates for modeling their benefits. They find that, with rare exceptions, little literature exists. One health plan executive summed up the situation by describing the response of the plan's actuaries to the benefit under development: "Our actuaries took a leap of faith."²¹ Plan managers charged with credentialing, utilization management and quality assurance echo this sentiment. Each moves in virtually uncharted waters. The sense of insecurity may be compounded by what to them are the unusual language, therapeutics, products and philosophy of these new provider categories.

Since this paper was first requested in late winter of 1996, however, a remarkable health policy experiment has been unfolding in Washington state. These null sets of management templates are beginning to be filled with a variety of practical information. In 1995, the Washington State legislature reaffirmed a statute in a 1993 health reform act requiring all health plans to include "every category of provider" in their plans as of January 1, 1996.²² Because these health plans have as their task master an activist insurance commissioner, Deborah Senn, who is a consumer of complementary services, precedent-setting steps in the history of integrated care are undertaken, in small and large measure, almost daily. Section 8 of Engrossed Substitute House Bill 1046, now encoded in Washington law as RCW 48.43.045, follows:

"Every health plan delivered, issued for delivery, or renewed by a health carrier on or after January 1, 1996, shall:

(1) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that:

²⁰ Standards for the Accreditation of Managed Care Organizations, 1994 edition. National Committee for Quality Assurance.

²¹ Kris Labutzke, former vice president for underwriting, American Medical Security, Greenbay, Wisconsin. Reported by the author at the Institute for International Research conference, "Integrating Alternative Medicine and Managed Care," December 7-8, 1995, San Francisco, California.

²² A remarkable aspect of the legislative history is that the language was first passed by a legislature dominated by Democrats as part of a sweeping managed competition plan. Two years later, a solid Republican majority gutted most of the 1993 reform measure but maintained the "every category" language.

- a) The provision of such services or care is within the health care provider's permitted scope of practice; and
- b) The providers agree to abide by standards related to:
 - i) Provision, utilization review, and cost-containment of health services;
 - ii) Management and administrative procedures; and
 - iii) Provision of cost-effective and clinically efficacious services."

The law, while a mandate, may be viewed as a managed care sensitive mandate. Plans are not required to include "any willing provider" of complementary care. Rather, plans must bring each category to the table and create a relationship. In short, the law tasks the state's health plans with answering many of the operational questions which are the subject of this paper. Because their preliminary answers are often more instructive than a philosophical iteration of potential operational issues, their experiences to date are widely referenced in this work.²³

One important caveat must be noted. These strategies are not those of health plans which have chosen to develop complementary or integrated products following internal debate or the initiative of a complementary-friendly executive. These plans are operating under legal mandate. The strategies, with skeptical or agnostic managers often shaping them, and guarded executives approving them, would therefore tend to err on the conservative side.

A first order of business in managing health care involves guaranteeing consumers and purchasers that the providers they see meet minimum standards. The focus in managed care credentialing is not on the therapy, but on the provider. Chief among credentialing standards are those for education, for licensing or certification, and for malpractice coverage. The credentialing concerns of health plans relative to complementary providers, as will be seen, are substantively different for members of regulated complementary professions (chiropractors, naturopathic physicians, acupuncturists, etc.) than for the category of "alternative medical doctor."²⁴ A third category of providers is that represented by providers who are not regulated by states, including groups such as lay homeopaths, herbalists and yoga instructors. Credentialing issues for each of these three groupings will be approached sequentially.

Credentialing Members of Regulated Complementary Professions

One way to view the past 25 years of the countercultural-natural-alternative-complementary-integrative medicine movement is as a long campaign which placed certain categories of complementary providers on the doorstep of health plans with their credentials more-or-less in order. The process involved is that of professional maturation. The key elements include: establishing or strengthening educational standards; developing professional organizations; establishing an accrediting agency and standardized exams; gaining recognition from independent review organizations (e.g., the United States

²³ The author has served as a consultant with a broad spectrum of the parties to this process, including health plans, delivery systems, government agencies, complementary provider organizations and educational institutions.

²⁴ The treatment which will follow of the category of "alternative medical doctors" will also apply to other conventionally trained providers who have adopted "alternative" techniques.

Department of Education, the National Organization for Competency Assurance); and expanding regulation into new jurisdictions. Table 3 documents this process for the leading complementary professions. Chiropractic, with licensing in all 50 states, has advanced furthest and has achieved a niche in limbo, no longer quite “alternative” or “conventional.”²⁵ The acupuncture and naturopathic medical professions have completed all the steps but the expansion of licensing into all 50 states. Although the massage profession has created an accrediting agency, the profession has not yet stimulated widespread support for the agency among the educational programs for massage practitioners across the nation. US DoE recognition has not been secured. However, the profession has secured independent approval of its licensing exam by the National Organization for Competency Assurance.

Table 3: Development of Standards by the Complementary Professions

Profession	Accrediting agency established	US Department of Education recognition	Recognized schools	Standardized national exam created	State regulation (1)	Malpractice insurance
Acupuncture	1982	1990	<i>author uncertain</i>	1982	33 states	early 1980s
Chiropractic	1971	1974	16	1963	50 states	<i>author uncertain</i>
Massage	1982	no	<i>author uncertain</i>	1994	24 states	1993
Midwifery	1990s	<i>Application fall of 1996</i>	<i>1st school accredited 1995</i>	<i>1st certification exam 1994</i>	18 states	<i>off-and-on since 1980s</i>
Naturopathy	1978	1987	4	1986	11 states	1988

(1) For chiropractors and naturopathic physicians, this category uniformly represents licensing statutes; for acupuncture and massage, a mixture of licensing, certification and registration.

The credentialing picture that emerges is uneven. If a health plan is operating in a state such as Washington State, where naturopathic physicians, chiropractors, acupuncturists, massage practitioners and even direct-entry midwives are all licensed, the core credentialing elements are in place.²⁶ Health plans operating under the state’s “every category of provider” mandate have faced no problems with basic credentialing. The leading complementary professions (naturopathy, chiropractic, acupuncture and massage) have the infrastructure for credentialing standards in place. The chief question for a health plan is whether or not the profession is regulated in the state in which the plan operates.

Variations Between States and Between Individual Practices

Because the formal advances of the complementary professions quilt the nation unevenly, plans operating in more than one state can be frustrated in setting system-wide standards. One example is Connecticut-based Oxford Health Plans which is set to

²⁵ In 1993, during the national health reform lobbying frenzy, chiropractors positioned themselves with an alliance of provider groups which included psychologists, nurse practitioners and physicians assistants. The 1995 Executive Opinion Poll of *Business and Health* magazine, reported in the magazine’s November 1995 issue, showed that 58 percent of respondents offered their employees the option of a chiropractic benefit. By way of comparison, the magazine’s catch-all “alternative medicine” category, which included such services as acupuncture and massage, produced a 12 percent positive response, which was expected to go up to 18 percent by 1997.

²⁶ The state legislature in Washington State established a Joint Operating Agreement in 1993 through which malpractice insurance became available to licensed midwives. In 1996, licensed midwives in Florida established the only other malpractice plan for licensed midwives. Note that this category is distinguished from that of lay-midwives by clear educational and clinical standards which are recognized by state regulators.

announce a complementary medicine product in the tri-state area of Connecticut, New York and New Jersey in October of 1996. Oxford’s manager for alternative medicine, Hassan Rifaat, MD, worked with naturopathic physician advisors on developing the complementary products. Yet naturopathic physicians, while licensed in Connecticut, are not regulated in New Jersey or in the state of New York, where Oxford has most of its covered lives. Oxford determined that no naturopathic benefit could be offered in these states. Uniformity in a plan’s offerings will be restricted by the regulatory status of each category in different states.

Credentialing professionals for multi-state plans face an additional source of consternation when they peel back the comfortable mantles of a nationally-recognized exam and accredited educational standards to look at the cross-jurisdictional variations in the legal status and scope of practice of these provider categories. Substantial variation in scope of practice exists. (Variation is partly explained by the philosophical or strategic concerns of the leaders of the profession in a given state and partly by the success of opponents in circumscribing practice rights.) In New Mexico, for instance, acupuncturists are licensed as Oriental Medical Doctors. Homeopathy is an explicit part of the practice act in New Mexico for acupuncturists. Acupuncturists in other states must practice under the direction of a medical doctor. A similar situation prevails with chiropractors. “Straight” chiropractic laws only allow adjustment of the spine. Broad-scope chiropractic laws, on the other hand, often produce practices which offer a wide array of modalities, including botanical medicine, nutritional supplementation, and counseling, as well as physical medicine. In Florida, some chiropractors have limited prescription authority. Many practitioners in both the acupuncture and chiropractic professions offer their patients a general practice of natural medicine.^{27 28}

Peeling back the scope of practice to examine a specific provider’s practice may produce yet another level of concern in health plan managers. Table 4, “What You See and What You Get”, notes some examples of individual practice diversity. Differences in the categories of massage therapist and alternative medical doctor are also examined. The provider types listed are meant as examples. The blend of services is, depending on perspective, either more *rich* with diversity or *fraught* with diversity, than even the individual practice styles listed here. These concerns, while not strictly credentialing issues, may influence a plan’s application, credentialing and recredentialing processes. Their implication for other management processes are discussed in subsequent sections.

Table 4: What You See and What You Get: Some Distinctions between Category and Practice with Providers of Complementary Services

What you see	Alternative Medical Doctor	Licensed Naturopathic Physician	Licensed Acupuncturist	Licensed Massage Therapist	Licensed Chiropractor
	Strong belief in behavioral health	General practitioner of natural medicine	Only uses needles	Occupational health specialist	Only adjusts the spine

²⁷ Both the acupuncture and chiropractic professions continue to have strong internal disputes over philosophy and political strategy relative to the scope of practice and positioning in the broader health care system.

²⁸ The naturopathic practice acts uniformly allow these providers to diagnose and treat as primary care providers. However, substantial differences in scope exist. Treatment options available in some states and not in others include: immunizations, limited prescriptive authority, injections, controlled substances, and acupuncture.

What you get	interventions	—	Works as an Oriental medical doctor	—	—
	Uses natural agents sometimes in place of conventional pharmaceuticals	Classical homeopath	—	Rofer	Diagnoses using laboratory methods
	Sees self as a naturopath, using broad scope of natural therapies	Explorer of diverse experimental, energy medicine modalities	Occupational health specialist	Also provides nutritional counseling and homeopathic consultation	General practitioner of natural medicine
	Took acupuncture course for MDs	Practice dominated by physical medicine approaches	Certificated both in acupuncturist and in Chinese herbs	Colonic therapist	Uses various natural modalities but cannot do laboratory diagnosis
	Experiments with exotic injectable natural agents	Similar to an MD-PCP but uses natural agents	Specialty in pain management	Mainly deep tissue work	Strong interest in compepathy
				Only uses Swedish technique	

Additional Criteria Sometimes Recommended

Many health plans which credential complementary providers have established additional, restrictive standards to cull a subset from the group of available providers. Often these additional credentialing criteria are directed at ensuring that the complementary providers are comfortable working in a collaborative fashion with the conventional medical community. Examples include:

- continuing education beyond that which may be required for licensing²⁹
- evidence that the complementary provider has working relationships with conventional medical professionals³⁰
- membership in state or national professional organizations³¹
- a minimum number of years of practice, especially in lieu of a residency³²
- evidence that one or more medical professionals will agree to consult when patient needs are beyond the scope of the complementary provider’s practice or the provider’s legal ability, such as hospital admissions.³³

One interesting example of special criteria is the King County Medical Blue Shield (KCMBS) strategy relative to naturopathic physicians under the Washington state mandate. KCMBS allows naturopathic physicians to act either as primary care doctors or as specialists. Those who wish to be in the KCMBS network as PCPs are required to show, in their application, that they are: 1) willing to perform immunizations; 2) have plans for 24-hour coverage; and, 3) have a relationship with a conventional physician (MD or DO) who will handle hospital admissions for them. (No Washington state hospitals allow naturopaths to admit.) Naturopathic physicians who do not meet these criteria, but met the

²⁹ MD Health Plan (CT) originally required 50 Category I CME hours for naturopathic doctors.

³⁰ Both PacifiCare of Washington and First Choice Health Networks (WA) pre-screened potential providers to determine that they were interested in developing relationships with conventional professionals and the reimbursement system.

³¹ Hawaii Management Alliance Association (HI) will only accept members of the state chiropractic association into its network.

³² Group Health Cooperative of Puget Sound (WA) formally discussed this concept in its early deliberations. The Alternare Group (OR), a complementary network management firm, requires a year of clinical experience.

³³ Group Health Northwest (WA) for licensed midwives; King County Medical Blue Shield, MDs for hospital admissions if the naturopathic physician is a primary care provider.

other KCMBS credentialing requirements, can be listed as specialists who are available only on referral.³⁴

Finding Providers Who are Prepared for Participation

Health plan administrators may discover informal barriers to credentialing complementary providers. A high percentage of non-MD complementary providers operate within the direct fee-for-service economic relationship with patients which typified a conventional medical practice fifty years ago. For these providers, involvement with reimbursement is restricted to filling out a general HCFA form or a form provided by the patient. Negotiations for coverage rest with the patient. This historic circumstance leaves plans with three practical challenges in establishing a network: capital needs, basic education and values decisions. These issues will provoke varying degrees of practical concern, not only in credentialing but in undertaking utilization review, quality improvement and outcomes initiatives, depending on the level of integration of complementary care sought by the health plan.

Capital needs Participating as a credentialed provider for a health plan will require a variety of one-time and ongoing capital investments. Complementary provider offices usually operate with low overhead. The personnel, office space, computers, software and billing and management expertise must be purchased or developed. Most naturopathic physicians and acupuncturists have no malpractice insurance. This \$2,000-\$5,000 annual expense is viewed by many of these providers as unnecessary and expensive, given both the lack of guarantees of ensuing business and the low historic incidence of malpractice actions against providers in their category. The offering of a contract will often be the provider's incentive to purchase malpractice for the first time.

Basic education Because complementary providers have generally been excluded not only from reimbursement, but also from hospital practice, most have no working experience within the policies and procedures of a delivery system. Credentialing, contracting, acceptance of fee schedules and preferred provider arrangements will be new to them.

Values decisions Some complementary providers believe that the therapeutic process is solidified by their direct, cash-based economic relationship with patients.³⁵ For others, a lower overhead and homier practice may match not only a lifestyle but a chosen set of values.³⁶ Most complementary providers also share the provider's generic disdain for managed care's layers of oversight and management. Only complementary providers have an additional grudge. It was not a utilization pattern for *their* services and *their* philosophical approaches which called in the managers in the first place: So, the logic goes, why should complementary providers be penalized?

³⁴ An interesting side-note to the KCMBS strategy is that naturopathic physicians who are accepted as PCPs have the right to refer to other specialists (both conventional and complementary) as well as naturopathic physician specialists who may have a strength in a specific modality.

³⁵ Not surprisingly, the belief in the importance of the patient's direct involvement in payment elicits some support for Medical Savings Account among those complementary providers who pay attention to health policy deliberations.

³⁶ Complementary providers may argue that the traditional family doctor had neither physician extenders and ancillary workers, nor a requirement to generate an income which would support this overhead. These mediate the doctor-patient relationship. Some question whether this has been a positive influence on health care.

Health plans in states with licensing statutes for complementary professions will be able to find providers who will sign just about any contract. But plans seeking relationships with the top providers in a community may run into one or more of these obstacles. These issues would be expected to arise in direct relationship to the desired level of actual clinical and administrative integration of these provider types. They would probably also arise in inverse relationship to the fee schedules offered.

Rental of complementary provider networks

A new part of the landscape for health plans investigating relationships with complementary providers is partnership with entrepreneurs who have created complementary provider network management businesses. The health plan can contract with these businesses for networks, where they exist, or potentially for development of a network in a geographic area where the network has not yet credentialed providers. The plan then rents the network on a per member per month basis, or on a fraction of net-paid claims, as with any other preferred provider arrangement. The complementary provider network takes over the credentialing responsibility, as well as billing and provider communication. The network may also manage additional portions of the benefit.

This option may be attractive to health plans which are new to complementary providers. Numerous national and statewide chiropractic networks and independent provider associations have been formed for this purpose. The American Chiropractic Association is building a list of these networks through its Department of Managed Care. An acupuncture network, AcuNet, is contracting with plans in California to help manage acupuncture services for industrial insurance claims.

The last two years mark the advent of a type of network which offers one-stop shopping for credentialed complementary care providers. The most prominent of such businesses is The Alternare Group in Portland, Oregon. Alternare has created networks which may include massage therapists, acupuncturists, naturopathic physicians, chiropractors and mental health counselors. Blue Cross of Washington and Alaska chose to work with Alternare after the plan's 1994-1995 AlternaPath pilot project convinced plan executives that Blue Cross did not have sufficient expertise internally to manage complementary services.³⁷ Alternare developed a statewide network in Washington at Blue Cross' request. Two other major carriers, Sisters of Providence Health System and Group Health Cooperative of Puget Sound, subsequently contracted with Alternare for these services. With contracts covering 1.8-million covered lives, Alternare's credentialed providers are servicing a substantial percentage of the complementary benefit in Washington state. US Complementary Health, based in Phoenix, Arizona, is following a similar business strategy.³⁸ Executives of both Alternare and US Complementary Health anticipate that their network expansion plans may be shaped by requests from a health plan to create provider networks in new geographic areas.

³⁷ Presentation by Richard Winner, vice president for marketing healthcare services, Blue Cross of Washington and Alaska, at the Washington State Hospital Association Conference, "Mainstreaming Alternative Medicine," November 6, 1995.

³⁸ Executives in both The Alternare Group and US Complementary Health are long-time professionals in managed care.

An additional notable network development in Washington state's active market is the decision of the first conventional PPO, industry leader First Choice Health Network, to add complementary care to its product line.³⁹ In August of 1996, First Choice sent credentialing materials to pre-selected lists of naturopathic physicians, acupuncturists, massage practitioners and direct entry midwives. As markets for complementary services heat up in other jurisdictions, other conventional PPO networks would be expected to follow suit.⁴⁰

Credentialing Alternative Medical Doctors

Health plan credentialing processes present a conundrum for medical doctors and other conventionally-trained and licensed medical professionals who use complementary methods. On the surface, core standards are easily met by these providers. But if the intent of credentialing is to ensure that providers meet standards *for the delivery of complementary therapies*, the picture radically shifts. Briefly stated:

- *Medical Education* Most conventional medical, nursing, physician assistant, and dietetics educational programs do not include complementary therapeutics in their core curriculum, or as electives. Clinical training is virtually non-existent.
- *Licensing Examination* Conventional providers are not tested in these skill areas as part of their examination process prior to attaining licenses.
- *Malpractice Insurance* Malpractice insurance carriers typically offer policies with the expectation that conventional providers will practice within the community standard of care.⁴¹ Most complementary approaches are outside this standard and therefore may not be covered by the provider's policy. Some policies are available, however, which specifically cover alternative methods.

The health plan which is interested in complementary medicine may find itself in a bind. A medical doctor may be exceptionally-well trained in one or more complementary therapies. But objective, verifiable standards for medical education, licensing and examination, the backbone of managed care credentialing, are virtually non-existent. Thus the conventionally-trained categories of providers with which the health plan is familiar, and with which it may be most comfortable, may be the least qualified, from a credentialing standpoint, to provide complementary services.

Many plans which have developed complementary or integrated products have moved ahead without concern for this paradox. The HealthEast Healing Center in Minnesota, established in the autumn of 1996 under the direction of Chris Foley, MD, and the Mercy Integrated Health Arizona Center for Health and Medicine, with Samuel Benjamin, MD, as program director, are two examples.⁴² The preference of many health plans for conventionally-trained providers is apparent even when limited standards are in place. For example, most health plans and hospitals in Washington state contracted with certified nurse midwives (CNM) before contracting with direct entry midwives. Yet the

³⁹ First Choice's conventional networks provide care to 475,000 lives.

⁴⁰ It is noteworthy that the capital behind The Alternare Group is from an entrepreneur, Stephen Gregg, who made his money by building and renting conventional networks.

⁴¹ Dumoff, A. "Malpractice Liability of Alternative/Complementary Health Care Providers," *Alternative & Complementary Therapies*, June/July 1995.

⁴² Benjamin has met the Arizona standard for licensure as a homeopathic medical doctor, one of three states which has this licensing category.

clinical requirement for birth management experience is 500 percent higher for direct entry midwives -- 100 births, including 50 labor managements, versus 20 births for certified nurse midwives. Similarly, medical doctors are allowed by some plans to perform acupuncture based on their certification as a medical acupuncturists.⁴³ Medical acupuncture training requires a small fraction of the didactic and clinical requirements for a direct entry acupuncturist.

The credentialing picture that emerges at the present time is deeply ironic for anyone aware of the frequently expressed fears of complementary providers that conventional practitioners will "take over" their therapies. Those individuals who have chosen to enter complementary professions would appear to be better positioned than "alternative medical practitioners" for credentialing by health plans.

Creating Standards for Alternative Medical Doctors

The recent growth of educational programs in complementary medicine inside conventional medical schools and nursing schools may eventually lead to development of traditional credentialing standards. However, neither standardization of these programs nor inclusion of a standardized complementary medicine section in licensing examinations is expected soon. At the present time, most alternative medical doctors continue to gain their education in complementary therapies through a non-standardized composite of lectures, books, tapes, conferences, collegial relationships and clinical experimentation.

The difficulty posed for health plans by this situation is underlined by a strategy under consideration by California Pacific Medical Group (CPMG), in San Francisco, California. The group is considering development of a complementary and alternative medicine clinic to enhance its service offerings. CPMG is joint-venturing with a group in England headed by Julian Kenyon, MD, which is experienced in operating integrated care clinics. Kenyon believes that a holistic MD is a medical doctor skilled in at least three of the five following modalities: manipulation, nutritional medicine, homeopathy, acupuncture/traditional Chinese medicine and auricular therapy. Under CPMG's proposed joint venture, Kenyon would be personally responsible for ensuring that the clinic's holistic physicians met his standard.⁴⁴ In short, CPMG is considering adoption of an internal standard, set by an experienced holistic physician, to replace an externally verifiable one.⁴⁵

Until the conventional medical professions establish verifiable standards for credentialing, intermediate steps such as those listed at the end of this section may fill the void. To this date, no accrediting agencies for managed care have put standards for the

⁴³ The Kaiser Permanente Vallejo Medical Center Alternative Medical Clinic, under the medical direction of medical-acupuncturist Ward Gypson, III, MD, is the outstanding example.

⁴⁴ Interview (August 16, 1996) with Stephanie Boullonquin, manager of special programs, California Pacific Medical Group, for an article by the author planned for publication in the *THE INTEGRATOR for the Business of Alternative Medicine*.

⁴⁵ Compare this standard to that of a naturopathic physician whose US Department of Education-recognized education requires distinct three-to-six course didactic tracts followed by clinical training in each of the following: nutritional medicine, botanical medicine, manipulation (and other physical medicine), homeopathy and behavioral change counseling, plus an introductory course in the principles of Chinese medicine.

delivery of complementary therapeutics to a credentialing test. Therefore, no clarity on the leniency these agencies might show has been established.⁴⁶

Credentialing Unregulated Providers

A subset of complementary services are provided by individuals who have no accredited health care training but who have undertaken to educate themselves, sometimes extensively, in one or more complementary medicine modality. Included in this category are lay homeopaths, herbalists, and some types of nutritionists, bodyworkers, yoga and tai chi instructors, and nutritional counselors. Health plan accreditation standards would not appear to allow such individuals to provide services for an accreditable health plan. Some integrated clinics, however, may offer such services under the aegis of a medical doctor.

A subset of this group is composed of complementary providers who have met a recognized educational standard, such as a degree in acupuncture from an accredited school, but are practicing in a state where their right to practice has not been legally established. They may or may not have a license to practice in a different jurisdiction.⁴⁷ Services of these providers may be sought by clinics associated with health plans. The medical director of the HealthEast Healing Center, affiliated with Minnesota-based HealthEast, for instance, has expressed interest in hiring a naturopathic physician as a member of the clinic's staff.⁴⁸ Naturopathic physicians are not licensed in the state. The naturopath would provide care under the supervision of conventionally trained medical staff. Such a practice would also appear to fall outside of accreditable credentialing standards.

Credentialing Opportunities and Recommendations

Credentialing of complementary providers would be facilitated by the following:

1. National professional organizations of complementary providers should make a priority of developing communication between their licensing boards and regulatory bodies toward developing a standardized scope of practice. An external agency might convene such a process.
2. Creators of informal educational programs in complementary care should work to standardize curricula and processes, and then seek approval by such independent agencies as the National Organization for Competency Assurance. An updated reference list of such programs should be maintained by an organization for use by providers and health plans.
3. The NCQA and other accrediting bodies should clarify their positions on the provision of complementary services by conventionally-trained medical professionals.

⁴⁶ The Network Accreditation Standards of the Joint Commission on Accreditation of Healthcare Organizations, which do not allow plans to fail in areas, such as information management, where a majority of plans are only beginning to meet the established standard, may provide a model.

⁴⁷ Complementary professions seeking to expand into new states may recommend that members of their profession who practice in a state without licensing first secure, and maintain, a license from a state which does. This is the formal position of the American Association of Naturopathic Physicians.

⁴⁸ Interview (August 29, 1996) with Chis Foley, MD, HealthEast provider, for an article to be published in the October issue of *THE INTEGRATOR for the Business of Alternative Medicine*.

4. The community of conventionally-trained alternative medical practitioners must move rapidly to develop externally verifiable standards of education and licensing, or to adopt standards, such as those set by the naturopathic profession, for the general practice of natural medicine.
5. Given the current void of verifiable, objective standards for credentialing of alternative medical doctors, the following may serve as interim recommendations:⁴⁹
 - Request full documentation of all complementary education, including the CVs of the teaching faculty.
 - Investigate the extent to which the education offered included a clinical component.
 - Request information on any education which has led to a certificate of completion, or which led to an examination.
 - Request information on the status, if any, the certificate program has achieved with an independent review organization.
 - Request evidence that the provider's malpractice carrier is aware of the provider's complementary practices and will cover these services.

⁴⁹ Two plans, American Western Life Insurance (San Mateo, California) and American Medical Security (Greenbay, Wisconsin) are developing internal credentialing guidelines for the category of alternative medical doctors.

Issues Posed By Managed Care's Core Standards

Section 3: Utilization Management and Review

The every category of provider mandate in Washington state includes a caveat which requires covered providers from all categories of provider to “abide by plan standards related to ... utilization review ... and the provision of cost-effective and clinically efficacious services.” This legislative language gives plans an opportunity not only to select a network of credentialed providers, but also to select conditions for which referral or care would be a covered benefit. Plans establish management patterns for the covered conditions. This section first looks at some processes by which plans established their utilization parameters and the decisions they made. More complex utilization issues which many of these initial, conservative management plans skirted are then considered.

Fact-finding

Washington state's health plans used a variety of strategies to develop their initial lists of covered services, management strategies and reimbursement schedules. These included, but were not limited to:

- Inviting leaders of complementary professional associations and related educational programs to provide testimony to internal working committees.
- Participation in an acupuncture roundtable involving leading professionals, educators and health plan representatives. Those involved created five working committees: Education and Communication, Risk and Quality, Clinical Integration, Research and Economics.⁵⁰
- Development of complementary medicine advisory councils.
- Internal literature review.
- Consulting with specialty laboratories.
- Participation in seminars and workshops sponsored by complementary and conventional provider groups.
- Sponsoring continuing education seminars to elicit more information about the nature of complementary services.
- Retaining consultants who were either complementary providers or familiar with the concerns of these provider categories.
- Finding providers to serve as consultants to peer review and utilization review processes.

The utilization management programs created subsequent to this fact-finding show remarkable variability. Table 5 shows the initial programs developed by four plans for covering acupuncture services. Note that most of the plans view these lists as works in progress. After some experience, for instance, Group Health Cooperative of Puget Sound chose to increase the number of approved acupuncture visits on initial referral to 6-8 from

⁵⁰ The roundtables were organized by the Northwest Institute of Acupuncture and Oriental Medicine and held in the Fall and Winter, 1995-1996.

an initial three (3) visit plan. Examination of the chart reveals both common denominators and exceptional choices in these utilization decisions. The PacifiCare list, for instance, does not exclude referral for unlisted conditions; rather, it presents health concerns where acupuncture may be most appropriate. For comparison, a list of conditions recommended by one of the leading political figures in the state's acupuncture community is provided. This list is a subset of the 200 conditions for which the World Health Organization has recommended acupuncture treatment.

Case Study: Group Health Cooperative of Puget Sound⁵¹

Industry leader Group Health Cooperative of Puget Sound, an NCQA accredited staff-model HMO, is a good case study of a conservative approach to the questions posed by the Washington mandate. With the notable exception of its policy on homebirth by direct entry licensed midwives, Group Health's utilization plan ranks among the most restrictive offered in Washington.⁵² Simeon Rubenstein, MD, Group Health's vice president for corporate health, who heads Group Health's investigation of complementary care, stresses that these standards are "evolving."⁵³

Group Health began its investigative process in early 1994, months after the 1993 legislature originally included the "every category of provider" language in the state's reform act. (See footnote number 22.) GHC invited leaders of the state's complementary professions and educational institutions to address a 12-member task force headed by Dr. Rubenstein. The leaders were subsequently asked to provide information in response to a series of follow-up questions.⁵⁴ Examples were:

- Would the services be targeted toward specific clinical entities (such as obstetrics or gynecology)?
- How would the profession interact with Group Health's guidelines and technology assessment committees?
- Would these providers practice independently or integrated into the organization?
- What joint areas would be most valuable for outcomes study?

A year later, a Group Health internal newsletter reported the recommendations of the task force.⁵⁵ Chiropractic services would be available under specific practice guidelines.

Table 5: Acupuncture Services in Four Plans, and a Practitioner's Recommendations Based on World Health Organization Guidelines⁵⁶

⁵¹ The information for the Group Health Care study was first developed for an article planned for the October 1996 issue of *THE INTEGRATOR for the Business of Alternative Medicine*.

⁵² Group Health's policy on naturopathic physician services exemplifies its conservative approach. Group Health allows referrals for just six conditions, while other plans which limit naturopathic physicians to a specialist role do not limit referral condition. King County Medical Blue Shield, discussed in the credentialing section, allows naturopathic physicians to act in a direct-access primary care capacity.

⁵³ Personal communication, August 1996, with Dr. Simeon Rubenstein.

⁵⁴ Letter from Dr. Rubenstein to naturopathic physician leaders (April 19, 1994).

⁵⁵ *Group Health News: News and Information for Group Health Staff*, March 10, 1995.

⁵⁶ A set of acupuncture codes (CPT and ICD-9) used by the acupuncture network, AcuNet, is listed in the August issue of *THE INTEGRATOR for the Business of Alternative Medicine*.

Operational Issues in Integrating Complementary Therapies and Providers

Health Plan	Sisters of Providence Health Plans	King County Medical/Blue Shield	Group Health Cooperative of Puget Sound	PacificCare of WA	Culled from W.H.O.
Conditions	<p>Migraine Stress headaches Chronic neck pain Chronic back pain Primary dysmenorrhea Pain secondary to metastatic disease Arthritis (degenerative, post-traumatic, immune mediated) Neuropathic Pain</p> <p align="center">**</p> <p>Chemical Dependency if in a contracted facility</p>	<p>Musculo-skeletal Soft tissue pain in the shoulder Arthritis [various] Soft tissue trauma of ankle Back pain [various] Soft tissue trauma of the knee Bursitis Sprain Carpal tunnel syndrome Tendonitis Chest pain Tenosynovitis Diaphragmatic spasm Torticollis Facet syndrome Fibromyalgia</p> <p>Neurological Fibrositis Bell's Palsy "Tennis elbow" Cephalgia Myofascitis/myalgia Facial nerve paralysis Nerve impingement syndrome Intercostal neuralgia Pain in the sole of the foot Neurasthenia Plagiocephaly Paraplegia Radiculitis Polyneuritis Sciatica Post-poliomyelitis sequelae Spasm on facial muscles Trigeminal neuralgia</p> <p>Also: Dysmenorrhea</p>	<p>Myofacial pain syndrome Fibromyalgia Chronic pain - neck Chronic pain - back Dysmenorrhea Chronic headaches (includes migraine and stress) Pain secondary to metastatic disease Neuropathic pain Chronic arthritis</p>	<p>Musculo-skeletal pain syndromes: stress headache, carpal tunnel, tendonitis, soft tissue trauma sciatica, etc.</p> <p>Chronic pain syndromes and pain management: post surgical pain secondary to metastatic disease, etc.</p> <p>Neurological conditions: migraine, Bell's palsy, stroke rehabilitation, etc.</p> <p>GI conditions: irritable bowel, non-specific abdominal pain, etc.</p> <p>Addictions and chemical dependency</p> <p>Others, including: sinusitis, dysmenorrhea, PMS, depression</p>	<p>200 total conditions, including:</p> <p>Alcohol dependence Allergies/Asthma Anxiety/ Depression Arthritis/ Joint Problems Back pain Bladder/Kidney problems Carpal tunnel syndrome Childhood illness Colds/Flu/Cough/ Bronchitis Constipation/ Diarrhea Dizziness Drug addiction/ Smoking Eye, ear, nose and throat disorders Headache/ Migraine Heart problems/ palpations Herpes High blood pressure Imm. syst. def. Infertility Insomnia Knee pain Fibromyositis Neck pain/stiffness Numbness/ Poor circulation PMS Sciatica Sexual dysfunction/ Impotence Shoulder pain Skin problems Sports injuries Stress/Tension Tendonitis TMJ/Jaw pain Weight gain or loss</p>
Management	<p>PCP authorization if recommended or requested by member for up to 10 sessions</p> <p>Two additional periods of 5 sessions each if authorized</p>	<i>author unclear</i>	<p>Authorization</p> <p>6-8 visits then review by PCP and Alternative Care Coordinator</p> <p>Treatment plan within 10 days of 1st visit</p> <p>Treatment summary 30 days after 3rd visit</p>	<p>Recommends that referral be for a distinct series of visits (three (3) to 10 depending on the severity of the condition) followed by an assessment to see if additional treatment is appropriate.</p>	NA
Source	<p>Source: Providence Health Plans QM Committee January 1996</p>	<p>King County Medical Blue Shield</p>	<p>GHC Alternative Medicine Grid May 1996</p>	<p>PacificCare of Washington September 1996</p>	<p>Lori King, L.Ac. past-president, Acupuncture Association of Washington, based on World Health Organization list of conditions</p>

(Group Health eventually contracted these services through a local chiropractic network management business.) Massage services would “continue to be available on a limited basis,” coordinated through the organization’s physical therapy department. The HMO suggested coverage of homebirth, by licensed, direct-entry midwives, for low risk mothers.⁵⁷ The recommendation on acupuncture had services available only on as part of focused research “looking into its effectiveness.” While the plan expected to continue to explore naturopathy, the task force recommended shutting the door on these providers, at least for the time being: “Services by naturopaths would not be covered, but some naturopathic services would be integrated into current provider practices.”

A Template for Limiting a Plan’s Exposure

The utilization plan Group Health unveiled in 1996 was substantially more expansive than the service offerings recommended by the task force.⁵⁸ Table 6 documents the HMO’s utilization strategies as the mandate came into effect. Group Health chose to contract with a complementary care network management firm for access to credentialed providers who would deliver these services. The HMO appointed a registered nurse as Alternative Care Coordinator to provide assistance with utilization issues.

This Group Health Alternative Care Grid can serve as a template for any health plan which wishes to define a restrictive integration plan which will substantially limit the plan’s financial exposure. All services must be accessed on referral from the plan’s primary care providers. Note that the plan is not *recommending* referral to these providers, but merely *allowing* it. Some of the HMO’s PCPs, because of personal interest or experience, may value complementary care and initiate a referral from time-to-time. But most utilization originates with a member of the HMO requesting or demanding a referral from a PCP. If the plan does not actively undertake to educate providers or members about the availability or potential benefits of utilizing or referring for these services, the plan’s financial exposure will be even more limited.⁵⁹

⁵⁷ Group Health initiated a related process, headed by obstetricians, to specifically focus on the licensed midwives and homebirth. Following extensive review, the HMO chose to credential and contract its own network of licensed midwives for homebirths. A Group Health flier for its consumers, entitled “Home Birth,” promotes the practice. The flier poses the question: “Why does Group Health use licensed midwives for home births?” The answer: “Licensed midwives are specially trained for home births. They provide excellent care and preparation for having your baby at home.”

⁵⁸ A factor in broadening the coverage may have been a controversial *Bulletin* issued by Insurance Commissioner Deborah Senn on December 19, 1995, in which she took the position that entire categories of providers could not be excluded from coverage. The *Bulletin* inspired a lawsuit, filed in January of 1996, in which Group Health joined with most of the state’s health plans as plaintiff. As of September 1996, the dispute remained in an administrative process to which it was remanded by the judge.

⁵⁹ Group Health developed and widely promoted to its own providers and to the broader community a day-long session on mainstreaming alternative medicine in December of 1995.

Table 6: Group Health Cooperative Complementary Provider Utilization Plans⁶⁰

	Acupuncture	Massage Therapy	Naturopathy
Will you receive an authorization?	Yes	Yes	Yes
Diagnoses and clinical conditions that are covered	<ul style="list-style-type: none"> • Myofascial pain syndrome • Fibromyalgia • Chronic pain (neck & back) • Dysmenorrhea • Chronic Headaches including migraine and stress • Pain secondary to metastatic disease • Neuropathic pain • Chronic Arthritis 	<ul style="list-style-type: none"> • Lymphedema where traditional therapy has failed • Part of Rehab benefit where expected to produce sustainable functional improvement in 60 days and only cover for an acute precipitating event • Not covered for recreational, sedative or palliative reasons 	<ul style="list-style-type: none"> • Premenstrual Syndrome • Menopausal Symptoms • Chronic Fatigue • Chronic Arthritis • Chronic Irritable Bowel Syndrome • Fibromyalgia
Visit limits	<ul style="list-style-type: none"> • 3 visits and then review by PCP or Alternative Care Coordinator (Note: this was later changed to 6-8 visits.) • Treatment Plan within 120 days of first visit • Treatment Summary 30 days after 3rd visit 	<ul style="list-style-type: none"> • All visits within 60 days and may occur simultaneously with a PT program and then reviewed by PCP and Alternative Care Coordinator • Treatment Plan within 10 days of first visit • Treatment Summary 30 days after 6th visit 	<ul style="list-style-type: none"> • 3 visits and then reviewed by PCP and Alternative Care Coordinator • Treatment Plan within 10 days of first visit • Treatment Summary 30 days after 3rd visit
Ancillary services (lab, pharmacy, x-ray)	<ul style="list-style-type: none"> • Ordered via PCP 	<ul style="list-style-type: none"> • Ordered via PCP 	<ul style="list-style-type: none"> • Only to listed labs • Urged to get laboratory information from GHC labs • Excludes NFX • Pharmacy subscription must be obtained via PCP • No coverage for botanical, herbs, vitamins, food supplements • All x-ray, EKG, ultrasounds, procedures (scoping), allergy testing, injections at GHC

Referral from a PCP Uneducated in Complementary Medicine

Informed referral is an oxymoron for a PCP with limited understanding of complementary services. Less appreciated by the complementary community is that such a referral is often contractually problematic. PCPs are authorized to refer when they feel that such a decision is in the best interest of the health of the patient. Conventional medical schooling, while undergoing change, will not likely have trained the provider in even the fundamental educational standards of the complementary provider groups. The PCP will be ignorant of the therapeutic agents and modalities, the extent of their scientific support, and any evidence of risks involved.⁶¹

Arguably then, the PCP has no business in authorizing such a referral without prior education. The PCP is thrust into an awkward position between demands of a patient and the PCP’s contractual limitations. Yet by maintaining this cloak of ignorance, a conservative health plan limits exposure to any anticipated financial risks from offering the complementary benefits. The plan, however, similarly denies itself any financial or member satisfaction benefits which may flow from a focused effort to educate its PCPs about complementary services.

The plan may adopt strategies to help remove PCP anxiety. The plan can develop a disclaimer form which may limit exposure of the PCP when the PCP refers based on a patient’s request. Alternatively, a health plan can undertake an internal educational

⁶⁰ Group Health Cooperative of Puget Sound “Alternative Medicine Grid.”

⁶¹ In this context, even the most exacting treatment plan from the complementary provider, as required in Group Health’s authorization grid, may have the relevance of a neighborhood directory for Cuzco, Peru, to a motorist cruising Interstate 90.

program to remove the prevailing ignorance. This strategy is discussed at the end of Section 4 and in Section 5.

Natural Pharmacy

Prescription of natural products can account for a large percentage of the total costs to the patient who seeks complementary care. This may be true whether the practitioner is an alternative medical doctor, a naturopath, a chiropractor or an acupuncturist. Under the 1994-1995 AlternaPath pilot project of Blue Cross of Washington and Alaska in which all prescriptions were covered, 39 cents on every dollar paid by the plan covered natural pharmacy benefits.⁶² While there is some evidence that this percentage may be higher than customary, the message to health plans is that natural pharmacy, if covered, must be managed.

Health plans which are moving progressively into offering a complementary benefit have each wrestled with this issue. Concerns may exist over cost, quality and appropriate use.

- *Product cost* Most plans in Washington state have simply denied any benefit for these products, the exception being those natural agents which are on conventional formulary lists. Oxford Health Plans, the Connecticut HMO, will not offer coverage of products under its complementary medicine benefit. However, the plan will offer its members access to a discount natural pharmacy fulfillment service. The plan has contracted with a limited group of supplement and botanical product manufacturers to supply Oxford's distribution center. Other plans with progressive complementary benefits have pursued a similar strategy.
- *Product quality* Because natural products are not subject to the same level of federal regulation as pharmaceutical drugs, health plans will find it more difficult to guarantee the quality and potency of any products they may offer. Plans must judge product lines based on the internal regulations and procedures followed by individual manufacturers, as well as the external standards to which the manufacturing practices conform.
- *Appropriate use* A variety of reference books are now available which list the scientific support for specific therapeutic agents. The health plan's technology assessment process can evaluate the literature on specific agents. American Medical Security, which began pro-actively developing a natural products strategy in 1995, retained two leading complementary practitioners -- one an alternative medical doctor, Alan Gaby MD, and the other a naturopathic physician, Michael Murray, ND -- for this purpose. They reviewed the scientific literature and developed an in-house formulary which linked products to the specific conditions under which their prescription might be covered.

An assessment of both appropriate use and appropriate reimbursement of these products which respects the perspective of the complementary product prescriber requires the utilization team to confront some distinctive traits of the complementary paradigm. Briefly:

⁶² "Mainstreaming Alternative Medicine: Insurer's Perspective," reported by Richard Winner, vice president for Blue Cross of Washington and Alaska, at the Washington State Hospital Association conference on "Mainstreaming Alternative Medicine," November 6, 1996. These numbers appear to have been skewed upward by one practitioner who sold multi-level products out of the office pharmacy.

- *Valuing suggestive evidence* A natural product prescriber may prescribe products when, for instance, research has shown that a person with a given condition tends to be deficient in the vitamin, or mineral. They may also use a product for a one condition which has shown useful for a related condition.⁶³
- *Use of multiple agents* The technology assessment process will wish to determine which product or modality had the causal effect, while the complementary provider may be more comfortable knowing that a positive change was affected.
- *Belief in synergistic actions* Many of these products do not act in the directly measurable way of conventional pharmaceuticals, but are believed to work best in the context of a whole-person treatment which may include a variety of other agents and modalities. The combined effect is believed to be synergistic.
- *Building a patient's home formulary for self-care* Some suggestive evidence has recently been developed that a high percentage (68%) of patients of one category of complementary practitioners have "successfully cared for conditions at home for which (they) would have seen a doctor in the past."⁶⁴ The ability of the patient to do so may in part be a function of the patient's development of a limited home formulary through prior prescriptions of natural products by their complementary providers. If so, assessment processes may wish to take the foregone costs of return office calls into consideration before making a recommendation on coverage of natural products.

Each of these perspectives will challenge the conventional utilization review team. They may best be considered in the context of the global look at paradigm issues which follows in this section and the section on Quality Improvement.

Laboratory Tests

The foci of complementary medical education and clinical practices on therapeutic nutrition, biochemistry and physiological processes creates different use patterns for laboratory testing. A laboratory industry led by professionals tuned to the questions of natural medical providers has grown up with the complementary medical movement.⁶⁵ Most of these laboratories are certified by Medicare. Complementary providers will order some conventional tests more frequently, and some less frequently, than conventional primary care doctors. Other tests favored by complementary providers may be altogether unfamiliar to most conventional medical doctors. Some of these tests are controversial inside the complementary medicine community. Others are widely accepted.

⁶³ An interesting perspective on the scientific support for natural products and modalities is offered in the appendix to a pamphlet entitled *Safety, Effectiveness and Cost-Effectiveness in Naturopathic Medicine*, produced by the American Association of Naturopathic Physicians (1991). The primary author, Paul Bergner, lists the scientific support for the variety of modalities which may be used by a naturopathic physician under three headings: "Double-Blind Clinical Trials," "Other Controlled Studies," and "Suggestive Studies, including uncontrolled trials and epidemiological or animal studies."

⁶⁴ The study, developed and administered by the author, is discussed below under paradigm issues in determining the cost aspects of medical necessity.

⁶⁵ For instance, six of the 45 Corporate Leaders and Corporate Sponsors of the American Association of Naturopathic Physicians are medical laboratories. Most of the others are suppliers of natural products, with a sprinkling of malpractice insurers, printers, and one health plan, American Medical Security.

These laboratory tests can be assessed through the standard technology evaluation processes of the utilization review committee. Most of the specialty laboratories are familiar with technology assessment processes and will provide technical assistance on review of new tests. Approval of a new test may require a plan with a contracted laboratory, or in-house laboratory services, to subcontract with a specialty laboratory for specific laboratory test. For example, after Physicians Health Services developed a complementary medicine product at the request of a purchaser, its laboratory subcontracted with Great Smokies Diagnostic Laboratory, a specialty laboratory, for certain laboratory services requested by the plan's naturopathic physician consultant. PHS's naturopathic physician contractors were then able to order certain gut-permeability and digestive stool analysis tests valued by naturopathic physicians. In Washington state, Diagnos-Techs, a specialty laboratory with a similar array of products and services, has provided consulting expertise to three health plans that are working under the mandate.

Frequency of use issues will require utilization review managers and oversight committees to undertake a deeper investigation of a complementary provider's reasons for ordering a test. The value of the test may not be apparent to a conventionally-educated PCP whose approach to a condition or disease is informed by a different didactic and clinical education. These concerns are explored in the section below on paradigm issues.

Coding and Fees

Developing a useable coding system for complementary providers is not difficult. Mandates in different states for a number of years requiring coverage of some or all naturopathic, chiropractic and acupuncture services is *prima facie* evidence that these practices can be fit into the conventional ICD-9 and CPT structure.⁶⁶ Some local codes may be required. The more important questions are:

1. What effect will a coding strategy have on a practice? Will it shift the practice in a direction which may be harmful for the patient services as well as to the reimbursement system?
2. Are these coding structures appropriate to these complementary care practices? Do they reflect what is actually taking place? Will the ability of utilization reviewers to make productive use of data be skewed if these services have been inappropriately defined by a coding structure which was not developed to reflect complementary practices?

The first set of these questions will be considered presently. The second set will be addressed under "paradigm issues," below.

Complementary practice, when outside the reimbursement system, is relatively unencumbered by incentives to provide niche services in order to gain access to niche reimbursements. A massage therapist provides hot or cold treatments together with a massage, or an acupuncturist provides moxibustion [before of after] needles, because the provider believes these should be in the treatment plan. The practitioner's billing will often be for the office call, rather than for the specific procedures performed.

⁶⁶ The August 1996 issue of the *THE INTEGRATOR for the Business of Alternative Medicine* includes a list of ICD-9 and CPT coding lists developed by Acu-Net, the California-based network of acupuncturists referenced in the credentialing section of this paper.

A health plan's reimbursement strategy will be a factor in shaping the complementary services offered to plan members. Some licensed direct entry midwives in Washington State, for instance, faced with rates issued by some plans which are well below the global fees that they consider reasonable, are learning to bill individually for parts of their global care in order to recoup what they feel have been losses. Examples are billing for care of the child in post-partum visits, and charging for supplies.⁶⁷ To protect against the segmentation of acupuncture practice into discretely billed services, acupuncturist advisors to one Washington HMO recommended against separate billing codes for the Chinese modalities of moxibustion and cupping.⁶⁸

Most plans in Washington state developed fee structures through intelligence gathering about the rates offered by competitive plans and through surveys of community complementary providers. Health plans in a dynamic environment such as Washington state, in which externalization by the reimbursement system suddenly ends, must expect that provider rates may as quickly take a jump. Part of the provider's reason for increasing charges may be a belief that the health plan or insurer can afford to pay more for services than the individual paying out of pocket. The provider's rates also rise to cover the overhead of additional direct costs which were identified in the credentialing section, and time costs for participating in the treatment plan and reporting processes of the consulting specialist relationship.

Reimbursement schedules eventually offered by Washington plans range widely. Massage practitioners were offered \$8 per 15 minute unit of service under one plan and \$16.5 for the same service by another. For acupuncture, the basic charge for treatment ranges from \$40-\$65; plans developed varying strategies on whether and when to pay acupuncturists for office calls in addition to treatment. Global fees for homebirth among the state's health plans show a 33 percent variation, from \$1497 to roughly \$2000. One plan pegged naturopathic physician charges to those of the plan's conventional medical doctors. Others backed the naturopathic fee schedule off the medical doctor schedule by 10-30 percent, sometimes with the expressed intent of preserving the top billing of the plan's medical doctors.⁶⁹

Liability Exposure/Risk Management

The skeptical utilization manager, faced with an array of unfamiliar therapeutic approaches and agents utilized by complementary providers may be deeply concerned with the potential risk to patients who use these therapies. Below are some concerns expressed by one risk manager. Note that they are not actual complaints but represented only the manager's understanding of where problems might occur. The interest here is with perception.

⁶⁷ Midwifery CARE *In-Roads*, a monthly publication of the Campaign for Appropriate Reimbursement, a cooperative project of the Seattle Midwifery School and the Midwives Association of Washington State.

⁶⁸ Mark Nolting, ND, LAc, chair of the Department of Acupuncture and Oriental Medicine at Bastyr University, and Qiang Cao, LAc, Bastyr associate professor.

⁶⁹ If reimbursement is pegged in any way to the educational commitment made by a health professional, the naturopathic physician has a strong argument for parity based on student loan debt. Evidence suggests that new naturopathic graduates are leaving medical school with averages of \$75,000 in debt.

- *Massage therapy* Sexual harassment; scattered reports of bones being broken in the frail elderly.
- *Acupuncture/Traditional Chinese Medicine* Sexual harassment; inappropriateness or ineffectiveness of therapies; aggravation of bleeding disorders; broken needles; if in a general TCM practice, failure to refer or untimely referral.
- *Naturopathy* Failure to diagnose; failure to refer or untimely referral; poor record keeping; poor referral instructions; side-effects of medications.
- *Chiropractic* Sexual harassment; neck injury; aggravation of complaints; if in a general practice of natural medicine; failure to refer or untimely referral.

Liability concerns with complementary medical practices were surveyed by attorney Alan Dumoff in a two-part series of articles for *Alternative & Complementary Therapies*.⁷⁰ Dumoff concludes that liability exposure from complementary care is quite limited. Historic data supports the claim of complementary providers that their therapies are lower risk and have fewer side-effects than conventional medical interventions. Dumoff notes that the position of an alternative medical provider operating outside a community standard of care may be less secure than a provider who is a member of a distinct, regulated category. Concern over liability would appear to be largely a chimera, born out of ignorance and perhaps a disbelief that any health care practice could be so free of the trial lawyer's longing gaze.

The literature on motivation for malpractice litigation indirectly supports the limited exposure to liability actions against complementary providers. A recent study found that "perceived interpersonal process issues" were the most commonly cited reasons (71 percent) for patients' suits against providers.⁷¹ These processes include failures of communication, perceptions of lack of caring, and inattention to patient wishes or patient discomfort. The time-intensity and patient-orientation of most complementary practices enhances the provider-patient interpersonal relationship and may be a factor in the low evidence of malpractice actions.

This historic pattern may change as complementary providers are brought into the system. The deeper pocket represented by malpractice insurance coverage makes the provider a potentially more lucrative target for both frivolous and deserved actions. Provider contracts with networks and health plans connect their practices to even deeper pockets. Third, if a health plan's utilization program pushes complementary providers to spend less time with patients, complementary practices are more likely to be affected by the "process issues" noted above. A health plan's decision to reimburse an office visit at a low level may provoke a provider to limit the time for patient interaction, particularly if the provider's contract has restrictions against balance-billing.⁷² Health plans with restrictive utilization management plans may indirectly enhance exposure to liability.

⁷⁰ Dumoff, A. Malpractice Liability of Alternative/Complementary Health Care Providers: A View from the Trenches. *Alternative & Complementary Therapies*, June-July 1995, and September-October 1995.

⁷¹ Beckman and colleagues, cited in Blumenthal, *Health Affairs*, Volume 15, Number 2, 170-184.

⁷² Two health plans in Hawaii, Pacific Group Medical Association and Hawaii Management Alliance Association, pay flat fees of \$25-\$35, with \$5-\$10 co-pays, for acupuncture, chiropractic or naturopathic services. The fee may be acceptable for provision of simply chiropractic adjustments or acupuncture treatments. But the provider whose practice is typically organized around a lengthy intake interview which attempts to elucidate the range of causal factors in a condition will be hard-pressed under these utilization guidelines to continue to provide time-intensive services. A similar

One additional liability concern may emerge as the integration movement continues. The day may arrive when a health plan is sued by a member for failure to provide or refer for complementary services which may be of lower risk or higher effectiveness than conventional care. The last health plan to provide complementary care may be the first health plan sued.

Actuarial Data

As noted at the top of this section, actuaries for health plans which have moved progressively to develop complementary medical products have discovered that they must take a "leap of faith" in order to support the venture into complementary services. This is difficult for actuaries, who, as one health plan executive has stated, help drive an insurer by "looking out the back window."⁷³ An organized effort is presently underway to narrow the chasm across which the actuary must make this backwards leap. In May of 1996, the American Society of Actuaries commenced a project to create actuarial information on complementary therapies. The project, despite having gathered "hundreds of studies" which have a cost dimension to them, is currently operating without a budget and is not expected to produce any definitive results for at least two years.⁷⁴ Without such data, a plan's cost-assessment must be based on impressionistic data.⁷⁵

Some baseline information will be available to many plans inside their own computers. Many plans, their fee-for-service affiliates, or their third party administration services already provide or manage some complementary care products for a client.⁷⁶ Plans may develop some useful baseline data by analyzing their own records.⁷⁷ If data on complementary services has only been captured in a miscellaneous services category, the plan may consider differentiating these services. However, such an analysis will not pick up some of the other system costs and benefits from a given approach. These are discussed further in the sections on paradigm issues in determination of medical necessity

Paradigm Issues in Utilization Review and Utilization Management

Discussion to this point has focused on the practical ability of a health plan to slot complementary practices into their current structure and processes. The experience in Washington state, and elsewhere, shows that these services can relatively easily be forced into the health plan's current utilization paradigms. Utilization managers can develop processes to offer complementary services in a context of very little financial or liability risk.

situation may occur if a health plan authorizes referral for a specific number of visits, but requires that the complementary provider codes the visits as minimal, brief or limited.

⁷³ "The marketing director has a foot on the gas, the financial officer a foot on the brake, and the actuary is looking out the back window." Personal communication with Sandra Mathey, vice president for American Medical Security, March 1996.

⁷⁴ Personal communication with Lee Launer, Partner, Coopers & Lybrand (NYC), in August 1996. Launer is heading up the study.

⁷⁵ See footnote 62.

⁷⁶ See footnote 25.

⁷⁷ One Washington plan, for instance, in evaluating offering homebirth services, recalled that a major self-insured local employer for which it serves as a third-party administrator was already covering homebirth. The plan is considering analyzing this data.

But does such a utilization approach make the best use of complementary services? Does it respect what the complementary medicine community may have to offer as the nation continues to grapple with how to create high quality medical services which are also cost-sensitive?

The Group Health task force's initial recommendation against coverage of any services by naturopaths offers a practical and instructive introduction to a more complex series of utilization issues which are begged by the sometimes conflicting paradigm of complementary care. The Group Health task force found the naturopaths to be the most difficult to evaluate, which led them to recommend against covering services by naturopaths. These concerns are listed in the left column of Table 9. Such concerns, however, apply equally to those acupuncturists, chiropractors and alternative medical doctors who serve as general practitioners of natural medicine).⁷⁸

Group Health's list of difficulties will have an interesting resonance for members of the complementary medicine community. Each directly evokes one or more of the core principles which inform the practice of whole-person natural health care. The right column of Table 7 juxtaposes these utilization concerns and the related complementary medicine principles.

Table 7: Confounding Utilization Issues and Complementary Care Principles

Confounding Issues	Complementary Principles
The providers see themselves as primary care providers. There are no standard treatments for particular illnesses.	Providers address the whole person. Treatment focuses on treating the individual. One person's sinusitis, for example, may have different causal factors than another person's.
Treatment modalities vary between practitioners.	There is not necessarily a single best way to treat an individual.
The number of illnesses that are treated are as varied as those seen by a primary care provider. Treatments are multi-faceted.	Enhancing an individual's healing abilities can be useful for any individual with any condition. Using a variety of healing modalities is optimal in treating the whole person.
Finding efficacy data for these multi-faceted treatment regimes is difficult if not impossible.	The focus of complementary therapeutics is on a patient's perceptions of value (satisfaction, functionality, etc.) rather than on conventional biomedical indicators. ⁷⁹

Most complementary medical practice focuses less on targeting the offending agent (bacteria, virus, etc.) than on strengthening the ability of the host to fight off disease or resist it in the first place. The acupuncturist works to stimulate the "Qi" of the patient. Naturopathic physicians believe they participate in a similar process. They speak of first identifying and removing the obstacles to cure then working therapeutically to enhance the

⁷⁸ The acupuncture and chiropractic licensing statutes in Washington helped limit these complex issues to naturopaths in Washington state. Chiropractors practice under a "straight" license which limits them to treatment of the spine. Acupuncturists are allowed only to diagnose using Chinese methods. They cannot determine ICD-9 codes, which led some plans to determine that acupuncturists could not diagnose under the plan's management strategy. These regulatory characteristics facilitated viewing these two provider categories as procedure-oriented specialists whose services would be limited to specific conditions and only available after PCP referral.

⁷⁹ The question of scientific efficacy is investigated in greater detail in the section on bias and prejudice as operational issues.

healing power of nature. Chiropractors view their therapies as efforts to assist the patient in finding balance. Homeopathic therapies, which may be employed by any of these provider categories, focus on stimulating the patient's vital force. The stronger the vital force, the better chances that the patient will be able to throw off disease or be protected from ill-health in the first place. These providers share an interest in promoting the patient's immune response. They side with [Frederick] Virchow in his debate with Louis Pasteur 150 years ago: the primary work of primary care is to strengthen the host, not to attack the offending agent. The complementary providers view their work as the ultimate in primary prevention.

Host-oriented Approaches and Medical Necessity

Host-oriented approaches pose a core challenge for actuaries on whose advice and input utilization managers may rely. Assessment of the cost-effectiveness portion of complementary approaches in the broader evaluation of medical necessity is therefore substantially more difficult. This important point is made in the selection quoted below. While the quotation refers only to the practice of nutritional counseling, the discussion applies to any host-oriented health care endeavor.

The selection is from a consultant's report to the US Department of Health and Human Services. The consultants were retained to investigate why nutrition plays such a small role in conventional medicine, and in the curricula of conventional medical schools, despite widespread agreement that nutrition is a primary causal factor in the rise of most chronic diseases and their related acute episodes. The consultants offered the perspective that a part of the reason is that nutritional counseling has failed, generally, to gain access to reimbursement. This perspective on the role of actuarial accounting was offered as an explanation:

"Insurance defines medical practice standards in another way that has nothing to do with clinical efficacy. Health insurance is an actuarial science. It operates on the central premise that insurable events must have a probability of occurring less than 100 percent. Actually, to be insurable, the probability of occurrence must be considerably less than 100 percent or insurance would make no economic sense. The difficulty in the field of nutrition, then, is that it comes close to violating those principles.

"Nutrition counseling, although it could be confined to treatment of specific disease states, for example, abnormal blood cholesterol or blood pressure, is probably as useful in cases wherein no pathology is present -- that is, purely in a preventive mode. Such treatment, then, could begin to approach the 100 percent level in all primary care settings, and in many other setting as well. Both pre- and post-surgical counseling, for example, might well include nutrition counseling sessions. To further confound the situation, nutrition counseling lacks the precision of other treatment methods ...

"Thus, the reimbursement system acts in an important way to inhibit the formal spread of nutrition knowledge into the medical community, because nutrition does not satisfy the main principles in the current reimbursement system. Clearly, changes in that system in favor of preventive methods would change the conditions under which new approaches are allowed into the set of accepted practice standards. Such a change would then be followed, almost assuredly, by changes in the formal education of physicians."⁸⁰

⁸⁰ Nutrition Education for Physicians: Alternative Roles for Creating an Improved System, March 1993. Ruth A Bruer, PhD, Richard E., Schmidt, Thomas Chapel, Richard Schmidt Associates, Ltd., Macro International, Inc. Prepared for the US Department of Health and Human Services:

In short, actuarial methods of costs accounting which, to underline this quotation from the consultants, “have nothing to do with clinical efficacy,” may be hindering the integration of complementary therapies into health plan services. All host-oriented health care approaches, like nutritional counseling, may be viewed as having a value which “could begin to approach 100 percent [of patients].” A noteworthy parallel to this complicated medical necessity issue is found in a health plan’s attempt to establish appropriate levels of health promotion and primary prevention. Included here are exercise programs, education for self-care, and stress reduction, as well as nutritional counseling. Provision of such programs, while generally believed to be valuable, is given a lower priority than programs to manage diseases.

Two Additional Perspectives on Paradigm Issues in Cost Comparison

The difficulty in comparing apples to apples on cost differences is now examined in two ways. The first offers a look at cost issues in comparison of interventions out of the two paradigms for the same condition. Suggestive cost-related outcomes of surveys of patients in two complementary practices are then presented.

A child with *otitis media* who sees a conventional medical doctor will generally receive no more than a brief office visit, followed by a prescription of antibiotics.⁸¹ A complementary practitioner, on the other hand, believing that the causal factors of the infection must be discovered and eradicated, if possible, will spend more time with the child and the child's parent in discovery. Botanical topical medications targeted at both soothing the ache and arresting the infection may be prescribed. But if an assessment is made that sensitivities, especially to dairy products, may be involved, the physician will spend additional time educating the parents on how to make changes in the diet of the child or the family. This may include counseling on the repercussions that might be felt from a reluctant spouse. A long-time naturopathic physician put it bluntly: "It often takes three visits to help a mother get her family off dairy."⁸²

In this example of treatment for ear infections, the up-front cost of the complementary care is likely to be more expensive. The complementary provider would argue that -- assuming the treatment is successful -- the long-term savings from the complementary approach may be substantial. These may include: foregone future office visits and prescriptions; foregone ear tube implants; foregone workplace productivity losses if a parent loses sleep, leaves work, or is forced to stay home with the child or take the child to the doctor; possible benefits from teaching the parent some self-care techniques; and potentially foregone costs associated with other conditions, in the child or other family members, such as sinusitis and digestive disorders, which may also be connected to the discovered sensitivity.

Ultimately, the cost portion of the utilization committee's assessment of medical necessity would need to be informed by this whole picture. A retrospective review of a health plan's utilization data based on an ICD-9 for a given condition and then compared a snapshot of the office call and prescription costs of two provider categories may not fairly represent all the system costs and benefits.

A second perspective on the difficulties of cost-comparison in the determination of medical necessity is gained from some suggestive outcomes from two recent patient surveys, one on acupuncture patients and one on patients of naturopathic physicians.⁸³ The more elaborate of the two was designed and constructed by Claire M. Cassidy in association with Traditional Acupuncture Institute.⁸⁴ At six different multi-practitioner clinics across the county, 575 patients were surveyed. In the other, developed and managed by the author, 30 consecutive patients in each of five practices in four different states were given surveys, yielding 135 completed responses.⁸⁵ Patients expressed high degrees of

⁸¹ The standard of care for *otitis* is changing, particularly following the recommendation for "watchful waiting" in the Agency for Health Care Policy Research guideline.

⁸² The tendency of conventional medical planners who might support such an approach would be to send the patient to a less-expensive dietitian for the counseling. Such a choice may effect outcomes. A patient's compliance may be attached to a belief that the dietary change *is* the physician's medicine, rather than an adjunctive service. The physician quoted is former hospital nurse, Andy Campbell, ND.

⁸³ This data, which directly addresses the way complementary services may undercut conventional medical practice, underlines the emotional-economic issues at stake. The therapies may be "complementary" in an ideal world; they are often competitive in real time.

⁸⁴ Cassidy, C.M. "Patients Own Words," *Meridians*, Vol.3, No.2, a non-peer-reviewed publication of the Traditional Acupuncture Institute, Columbia, MD.

⁸⁵ Weeks, J. "Report on a Pilot Survey of Naturopathic Patients: Developing Useful Data for the Reimbursement Arena." *The Best of Naturopathic Medicine in 1996*, a non-peer-reviewed

satisfaction with care in both studies. The surveys generated the suggestive cost-related information in Table 8.

Table 8: Suggestive Cost-Related Data from Surveys Administered to Patients of Acupuncturists and Naturopathic Physicians

Acupuncture Patient Responses		Naturopathic Patient Responses	
Were previously seeing an MD and who are now seeing an MD less	84%	Lowered or Discontinued Conventional Rx	49%
Those who had surgery recommended and were able to avoid it	70%	Homecare Education Excellent (61%) or Good	96%
Were using prescription drugs and reduced them	79%	Effect on Lifestyle Excellent (39%) or Good	92%
Reported asking for fewer insurance reimbursements after seeing an acupuncturist	77%	Since seeing an ND, successfully cared for conditions at home for which you would have seen a doctor in the past	68%
		Persistent or recurrent problems besides those that brought you to an ND got better during naturopathic care	53%

The patients in the Cassidy study also reported that, after acupuncture treatment, they generally felt that they worked better, had more energy, were more focused, missed fewer work days and got along better with others.

For this data to be conclusive, each of these studies would need to be reworked, more broadly administered, directly compared with patients in a parallel conventional practice, and, optimally, followed up by a subsequent survey to see how the patients' perspectives held up over time. At this time, these outcomes only suggest complexities for the utilization review committee in deciding the cost issues associated with a determination of medical necessity. The task is complicated if all of the system costs, including the patient's workplace productivity and foregone health service requests, are taken into consideration.

Other Medical Necessity Issues

Complementary providers will assert that their approaches meet other key aspects of the medical necessity matrix. For instance:

- *Treatment is at the appropriate level of services* The whole person approach to causal factors in a patient's condition is believed to be the most appropriate supply or level of services that is essential to the patient's needs.
- *Treatment is consistent with the patient's condition* While complementary providers operate out of a different paradigm, they believe that their therapies are also consistent with the symptoms, diagnosis and treatment of the condition.
- *Treatment is safe* Complementary providers generally view their interventions as safer than conventional pharmaceutical and surgical interventions.⁸⁶

However, even if these assertions are believed, they may be trumped by a determination that the complementary provider's approach to primary care practice is investigational.

publication of the Southwest College of Naturopathic Medicine and Health Sciences, September 1996.

⁸⁶ These attributes of medical necessity are loosely based on a definition used by King County Medical Blue Shield in its provider contracts.

If so, the health plan's quality improvement processes may be the higher court to which such decisions are appealed. Section 5 suggests ways that the QI process can be used to initiate greater understanding of the value of the complementary paradigm. QI provides a plan with an incremental approach to introducing and evaluating complementary approaches. But first, in Section 4, the issue of why some plans have chosen to make integration a priority, is examined.

Utilization Review Opportunities and Recommendations

1. The UR Committee provides an exceptional environment for cross-fertilization and for mutual discovery between the conventional and complementary communities. Health plans, with or without complementary products, should consider retaining consultants from complementary professions to serve on utilization review committees in order to gain familiarity with complementary health care perspective.
 2. Because most complementary providers have no working experience with the utilization review process, health plans developing complementary products should train complementary providers in encounter reporting and working in the cross-referral process.
 3. Optimizing referral between complementary providers and conventional PCPs will require health plans to develop long-term, educational programs for conventional providers on the complementary care products the plan deems valuable.
 4. Use of conventional coding by complementary providers may not appropriately reflect the differences between complementary care and that provided by conventional physicians. A UR committee's comparison of treatments, based only on data organized around conventional diagnosis and procedure codes, will not adequately represent the respective interventions.
 5. Financial support for the study of complementary medicine by the American Society of Actuaries study may speed up development of extremely useful utilization data.
 6. The process of proving the value of complementary approaches from a utilization perspective can be time-consuming (gathering copies of scientific articles, creating presentations, etc.) and potentially frustrating. An impartial independent agency should convene a working group, with representatives selected by the complementary professions, conventional professions, health plans and related governmental agencies, to create a master resource for plans which may be interested in these services or are confronted by related utilization issues. Complementary professional organizations should be allowed to nominate their own representatives from which the panel would be selected.
- The prevailing definition of "medical necessity" is already challenged by such practices as health promotion, primary prevention and patient education. Support for some complementary approaches at the UR level may be found in linking complementary practices to the plan's initiatives which are health-oriented.

Section 4: The Role of Bias in Shaping the Operational Issues

The role of complementary-friendly decision-makers in prompting most of the leading integration initiatives leads to a core operational conclusion: *Where there is a will, there is a way*. Operational concerns become operational opportunities. The bias of the decision-maker is that the plan may benefit from greater inclusion of complementary services. The enthusiastic proponent of complementary services may err on the side of openness.⁸⁷

On the other hand, the skeptical project manager assigned to review the same landscape and develop a complementary benefit will tend to configure the task as one of hemming in the unknown and limiting the plan's exposure. A first interview with a community complementary provider might elicit the following example of a treatment plan which the provider deemed successful: "Dietary changes, exercise, a course of cranial sacral therapy and long-term administration of ginkgo biloba helped balance the patient's Qi." The manager's listening will be influenced by a conventional medical culture which teaches that unconventional care is unscientific, risky, likely to misdiagnose, full of hype, utilized often for recreational rather than clinical purposes, and palliative at best. The image of the quack, droned into the conventional provider community for a century by conventional medical schools, professional associations and government agencies, may make an appearance in the manager's mind. The skeptical project manager may feel less like developing utilization guidelines than simply making the sign of the cross and fleeing the scene.

In a similar way, complementary providers, ensconced in their own externalized culture, develop their own mythologies and perspectives about conventional practice and its payers.⁸⁸ Their own prejudices may limit their ability to see the relative openness to their service offerings which is beginning to emerge.

This schism in perspectives cannot merely be viewed as a knowledge gap, which can be filled by an exchange of didactic information. The dynamic here is that of a cross-cultural relationship. The language each uses is different. Even similarities may be misleading: what the conventional practitioner means by "prevention" or "nutrition" will be different than the meanings affixed to those terms by those reared into the complementary medical culture. Income differs greatly. The two parties are from the opposite side of the tracks. The conventional community is personally and institutionally well-off, while the

⁸⁷ The AlternaPath pilot project developed by Blue Cross of Washington and Alaska appears to exemplify the short-comings which can result from the strong advocacy of a complementary-experienced CEO. The plan merely threw open the broadest possible complementary benefit to an adversely-selected clientele with no incentives developed to manage the care. Failure to establish adequate controls or parameters limited the project's usefulness as a pilot. A short review of the pilot is in the author's "Charting the Mainstream" column in the *Townsend Letter for Doctors and Patients* (February-March, 1996).

⁸⁸ However, complementary providers, like most underdogs in the oppressor-oppressed relationship, will have paid more attention to the powerful than the powerful will have paid to them.

complementary providers and their affiliated organizations are poor. They often haven't spent much time together. Ignorance begets fear, which in turn begets prejudice, which over time solidifies into strongly-held opposition. The gap is emotional and economic. Five of the seven deadly sins may be engaged: anger, pride, envy, covetousness and greed. The naturopathic physician may covet the income of a conventional PCP; the HMO gatekeeper pressured to see more patients may covet the time the naturopath spends with patients. The many decades -- many would say centuries -- of estrangement between Western orthodoxy and the world's natural medicine traditions have made of each "The Other."⁸⁹

Overcoming this polarization may, in fact, be considered the core issue in integrating care. The optimal merger of the disparate medical paradigms will require that these emotional-economic issues be engaged.

This paper began with a libation to the dark forces which may have an unfriendly attitude toward the success of the integration undertaking. This section offers some pieces of a practical ritual to diminish the historic antagonisms which produced the need for this endeavor. Section 5 follows with some practical suggestions for implementing the healing process.

Understanding the Other

Table 9 shows some of the way perspective defines the participants in the integration process. In the left column a phenomenon is named, with conventional and complementary perspectives on the phenomenon provided in the two adjacent columns. The viewpoints are not meant to reflect those of all providers. They are meant as useful generalizations.

Open-minded practitioners and administrators who work principally in either the conventional or complementary arena may recognize a disturbing element of truth in each negative appellation applied to one's own camp. Individual practitioners and therapies will come to mind. Each of these phenomena can be individually expanded, analyzed and countered. But if the perspectives strike chords of reason, and present a an imaginable though unfavorable portrait, the skeptical project manager may begin to feel past certainties eroding. Opportunity may begin to open. More ground for discussion and integration may exist than was previously believed.

⁸⁹ An interesting psychological perspective on this phenomenon is Carl Jung's theory of the "shadow." The shadow is the part of oneself that is unknown and unconscious, believed to be irrational and often the source of fear. Jung posited that the shadow represented aspects of a person not yet incorporated into the self. Jung's perspective may be particularly useful in this integration discussion. The host-oriented nature of most complementary therapies shadows biomedicine's disease-based approach. Conventional medicine's interest in population-verifiable, objective, manageable markers shadows the highly individualized, eclectic approaches of complementary providers.

Table 9: Bilateral Prejudice as an Operational Issue in Limiting the Integration of Complementary and Conventional Health Care

Note: The responses below do not reflect the judgments of all providers from one school or the other. They are meant as generalizations.

Phenomenon	Conventional Perspective	Complementary Perspective
<i>Successful complementary treatment</i>	placebo for self-limiting condition	proof of value of complementary care
<i>Successful conventional treatment</i>	proof of value of conventional care	suppresses problems/ fails to address causes
<i>Science in conventional medicine</i>	our foundation	80-90% of procedures have no support for clinical efficacy
<i>Science in complementary medicine</i>	virtually non-existent	strong in some areas/ growing body of evidence
<i>Conventional primary care formulary</i>	good tools	70% of problems go away on their own
<i>Complementary primary care formulary</i>	70% of problems go away on their own	good tools
<i>Complementary diagnostics</i>	of great concern/ likely to misdiagnose	consider more than lab values
<i>Conventional therapeutics</i>	best in the world	often inappropriately harsh/ likely to miss causes
<i>Surgeon quick to operate</i>	overutilizer	rip off artist
<i>Chiropractor always requesting 20 visits</i>	rip off artist	overutilizer
<i>Antibiotics for viral conditions</i>	basically harmless treatment demanded by patients	harmful to the individual and the population
<i>Complementary therapies in end-stage terminal conditions</i>	waste of money/ creates false hope	alleviate side-effects of conventional treatment / help patients with transition
<i>Oncologist creating new chemotherapeutic "cocktails"</i>	brilliant clinician	experimenting with poison
<i>Naturopath who mixes Asian and homeopathic treatments</i>	totally wacko	brilliant clinician
<i>Self-healing</i>	self-limiting condition/ spontaneous remission	healing power of nature
<i>Clients of the "Other" who come to my office</i>	their failures	their failures

Complementary Perspectives on the Issue of Scientific Support

The role of science in medicine may be the most polarizing of the phenomena presented here. Scientific measures are upheld as the fundamental standard on which the other standards, such as quality improvement and utilization review, are based. If one is convinced that science is virtually non-existent in complementary care, or that complementary providers are anti-science, then one might reasonably wonder how a complementary benefit can be managed without this fundamental building block.

Table 10 lists perspectives expressed by members of the complementary community on science in medicine. The first column presents views on the role of science in conventional medicine, the second on science in complementary medicine. Because the primary audience for this paper is presumed to be health policy makers and participants who are schooled more thoroughly in a conventional perspective, the following focuses on

perspectives which may challenge underlying conventional assumptions. These perspectives have been examined in more detail elsewhere.⁹⁰ They are presented here in the more informal manner in which they are likely to surface in the integration exchange.

Nothing here suggests that conventional medical science has not created breakthroughs in the care of human beings. As with Table 9, each comment can be disputed, just as each holds some part of the truth. The conventional practitioner or project manager who reflects on this picture can begin to acknowledge that the integration process is not between a proved world and an unproven world. Nor is it between a certain outcome and an uncertain outcome. And it is certainly not between science and anti-science.

Rather, the integration process must take place between a familiar world and an unfamiliar one. Yet given the relatively recent arrival of managed care into the lives of most conventional practitioners, even this distinction is somewhat specious. The core challenges in managing and optimally integrating *conventional* providers are a work in progress. Table 11 compares the challenges the health plan faces with complementary providers, with those which are yet unresolved in the conventional care arena.

Emotional-economic Issues for the Complementary Provider

The optimal complementary partner will also have to engage some emotional work in order to understand the partner known as the payer or health plan. This too requires letting go of some favorite beliefs.

- Complementary providers may explain a failed therapy as the patient's unwillingness to comply with a recommended regime. Under managed care, the provider must be accountable for the failure. How can these patients be identified?
- Complementary providers have been blessed with a relatively self-motivated population. How will they approach those who are unwilling to make lifestyle changes or have less motivation toward health? Is this a population which should be identified and not referred for care? What special programs must be developed?
- Some cash patients of complementary providers routinely return for care with no significant betterment of physical conditions. The provider may excuse the continuation of care as apparently important to the patient emotionally. Do complementary providers believe such services should be covered?
- What will be the effect of the removal of the cash payment for services from the patient's therapeutic regime? How will this alter their perception of self-responsibility?

⁹⁰ A excoriating view of the scientific support for conventional medicine is offered by homeopathic partisan Harris L. Coulter, PhD, in *The Controlled Clinical Trial: An Analysis*, Center for Empirical Medicine, Washington, DC, 1991. Numerous texts are available which document the extent of scientific support for natural therapeutic approaches.

Table 10: Complementary Perspectives on the Scientific Support for Conventional and Complementary Approaches

Challenges to the Conventional Claim of Being Science Based	Apology for the Current Status of Science in Complementary Care
Only 10-20% of conventional procedures have proof of clinical efficacy ⁹¹	Conventional providers and plans are simply not familiar with the growing body of scientific support for complementary approaches.
Many clinical applications of drugs are "off label" (not FDA-approved) and are therefore prescribed on the same, "non-scientific" empirical basis as many natural therapies.	The gold-standard of a single agent placebo-controlled, randomized, standardized trial may be appropriate for pharmaceutical agents; it does not work with multi-agent, individualized, whole person therapeutic approaches. ⁹²
Many physicians do not follow science even when the scientific support for a given procedure or drug is available. Many prefer to stick with their own clinical experience.	Because most natural therapies are not patentable, there is little incentive for private businesses to fund research. Government agencies and foundations oriented to medical research have historically been controlled by medical advisors who look adversely on funding research in complementary therapies.
If conventional medicine were so "scientific", why is a principal thrust of managed care to make practice evidence-based? Why is there so much concern over creating clinical pathways and practice guidelines, from otitis media and musculo-skeletal conditions to diabetes and heart disease?	Because complementary therapeutics generally have fewer negative effects than conventional agents and procedures, practitioners can more comfortably make clinical decisions based on suggestive rather than definitive evidence.
Scientific evidence that an agent or therapy will repress a condition (anti-inflammatory, antibiotic, antihistamine, etc.) is not scientific evidence that the therapy will help to heal it.	The desire to do research is more widespread in the complementary community than most believe. Those individuals and complementary medical institutions which have shown an interest in carrying out research have found it difficult to secure funding. ⁹³
After all the billions of research, conventional scientific investigation has not reversed the rise of chronic disease. Now even some of conventional science's strengths with acute conditions, such as antibiotics, are being challenged due to the effects of long-term administration and over-utilization.	Medical research, until recently, has downplayed the importance of many of the outcomes valued by complementary providers, such as patient satisfaction, functionality and quality of life. Provider interest is less with mechanisms than with healing.

⁹¹ *Assessing the Efficacy and Safety of Medical Technologies*, US OTA, 1978. This report is the complementary community's most often-cited source in the political battle over science.

⁹² A natural medical protocol may include dietary changes, specific clinical nutrition agents, a botanical, an exercise regime and some guided imagery. The time spent with the patient adds a counseling dimension. The complementary provider will resist conventional science's desire to find out which of the interventions is active, believing that some of the therapeutic power is in the synergies of the whole approach.

⁹³ The out-pouring of proposals to the NIH Office of Alternative Medicine for its investigational grants is a case in point.

Table 11: Operational Issues in Integrating Complementary Providers which also Typify Issues Currently Unresolved in Integrating Conventional Providers

Issue	Conventional Provider	Complementary Provider
Establishing appropriate utilization	YES	YES
Building a trusted specialist network	YES	YES
Establishing appropriate time for referral	YES	YES
Establishing cost-effectiveness	YES	YES
Establishing effectiveness	YES	YES
Determining liability and shared liability	YES	YES

- If complementary providers were given the responsibility to manage millions of dollars in per member per month payments to manage an entire population, would they find it valuable to subject their colleagues to utilization review and other standards? Or would they continue to support unrestricted therapeutic freedom?
- If an outcomes measure shows that one complementary approach appears to be more successful than that which they favor, will they change their personal preferences and adopt the approach or refer for it when appropriate? To what extent are a complementary provider’s therapeutic approaches provider-driven (their own therapeutic interests and pursuits) and to what extent are they patient-care driven?

Getting to the Table

An immediate *healing* influence of the “every category of provider” mandate in Washington state was that it required providers from disparate disciplines to sit down and discuss a common future. For some of the health plan executives charged with managing these new relationships, their abstract operational concerns begin to lose their edge as they meet the human beings who provide the complementary services. Trust of a certain provider-consultant, if not trust or knowledge of the provider’s specific therapies, begins to take the place of myths. The complementary provider and the plan find a starting place for the relationship. They agree to disagree about some issues. Differences are identified for addressing in the next phase of the relationship. Integration planning begins to be framed, in part, as an interpersonal undertaking. The health plan’s project managers, even if skeptical, may say: *I am not sure about all of these (type of providers), but I can work with those people*. Similarly, the complementary provider may not have lost a sense of suspicion about whether the plan will treat complementary services favorably. But a relationship of trust may begin to develop with the health plan’s medical director, management professionals and care providers.

Expanding Trust Relationships

An unusual approach to creating trust relationships between PCPs and complementary providers at the service delivery level is currently being pursued by a network of primary care clinics in the Washington state marketplace.⁹⁴ Health plan PCP participants are each paired with a hand-picked complementary provider whose practice is located near the PCP’s clinic. A pre-workshop mailing includes the chart on bilateral prejudice, included in this section as Table 9. The chart is used to begin to open the

⁹⁴ The author is consulting with Medalia Healthcare on this project.

participants to reflection on their own prejudices. The program focuses on eliciting the emotions and issues both provider categories may have as they consider working together. The goal is to create a foundation for a productive relationship.

The structure of the workshop is based in communication enhancement and team building technologies. The workshop begins with the group broken into the pre-arranged dyads. First one half of the pair uses three minutes to express the concerns and fears which the relationship produces. The other listens. Then the roles are reversed. The pair then joins with a small group of other pairs to share what they expressed and learned. After a brief discussion, representatives of each small group share the highlights with the larger group. Following discussion, the same process is entered again, only this time focusing on their *hopes* for the relationship, for themselves and for their patients. In this way, the plan gains a provider-level sense of the opportunities and obstacles to the integration process. The workshop serves the plan like a focus group. More important, the paired providers have the opportunity to create a human-to-human foundation of trust for ongoing cross-referral and consulting relationships.

If the relationship between the health plan and the complementary providers continues to mature, more complex issues can begin to be addressed. In Section 5, some methods for initiating and enhancing the integration relationship through the health plan's quality improvement process are proposed.

Section 5: Strategies in Quality Improvement

The management principles incorporated in the continuous quality improvement (CQI) processes which inform managed care accreditation standards provide an ideal environment for health plans to investigate appropriate utilization of complementary medical services. CQI processes begin with goal setting and developing appropriate measures, advance to implementation, then are followed by outcomes assessment and translation of outcomes into future service offerings. The CQI process views organizations in an environment of continuous change, providing tools for managing the suggestive and evolutionary, rather than the definitive and fixed.

The CQI process can be utilized by plans at all levels of commitment to complementary care. Those which are conservative or skeptical about complementary services but wish to begin to acknowledge popular interest in these therapies may use them in consideration of future product creation. Plans with limited benefits can employ these processes to enhance them. Services of a specific provider type, for instance, which may be limited to a few conditions, can be expanded incrementally. For plans which decide to jump into offering these services with both feet, CQI may eventually serve, if the benefit is poorly developed, as a useful brake. Complementary care initiatives, based on suggestive data, with reasonable scientific or empirical support, can be tested in the practical setting of the plan's service delivery.

The CQI environment may be viewed as particularly rich for an investigation of complementary services *in their own paradigm*.⁹⁵ Purchasers are increasingly interested in seeing that outcomes studies produce data on such measures as patient satisfaction, functionality and productivity. Most complementary providers will agree that positive outcomes on these markers are the strength of complementary care.⁹⁶ This section will outline some ways that plans may begin to offer complementary care in the context of these processes. The section concludes with some perspectives on how offering these services may be consonant with a plan's efforts to integrate more health promotion and primary prevention.

⁹⁵ The importance of learning about complementary providers in their own paradigm may be understood by the old saying that *if it ain't broke, don't fix it*. The grassroots interest which produced the complementary care movement may reflect patient pleasure with being treated inside a whole-person oriented natural medical paradigm. A plan's decision to immediately box or refract this whole, particularly in order to fit a research model, may alter the value of these services to both the patient and the plan. This suggests an alternative research strategy which attempts to capture *suggestive* data about the multi-faceted complementary care of the whole person, then only later differentially tests, if the researchers wish, to learn which aspect of the therapeutic protocol may be most important to the outcomes.

⁹⁶ The popular growth of the complementary medicine movement may be said to rest exactly on such markers. Satisfied -- pleased and/or more functional -- patients pass on the word of the therapy or provider to others. The patient survey studies by Claire Cassidy, PhD, and the author, which were discussed in Section 3, are among the studies which provide evidence of the patient perception of satisfaction and functional benefits from complementary care.

Should Current Accreditation Standards Require Attention to Complementary Services?

An interesting case can be made that all health plans interested in accreditation should already have programs in place for at least the monitoring of member use of complementary services, whether or not these services are currently integrated into the plan's offerings.⁹⁷ The case is based on three core interests of accreditable managed care organizations:

- *Members' Rights and Responsibilities* Members are to be allowed to participate in decision-making regarding their health care. Since roughly a third of Americans are estimated to be choosing to use complementary or alternative medicine for at least a part of their care, despite having to pay out-of-pocket, plans may be deemed to have a responsibility to acknowledge this interest. Patient surveys, for instance, could investigate whether members are satisfied or dissatisfied with the plan's coverage decisions relative to complementary care.
- *Continuity of Care* With utilization of complementary services already high and apparently growing, plans which do not have programs in place to promote communication between patients and their conventional providers about their use of complementary therapies will necessarily have a break in the patient's continuum of care. Various studies have affirmed that a majority of patients do not reveal their use of complementary services to their conventional providers. Health plan intake forms and surveys could include questions which elicit this information from its members.
- *Outcomes Assessment* If members who choose complementary services which are outside a plan's benefit structure believe that these services have been useful for conditions which the plan may be monitoring, the plan's outcomes data may be skewed. Conversely, the plan's research might also capture any adverse effects of the complementary services.

A relatively simple program to discover the extent to which plan members are already using complementary service can help provide guidance if the plan chooses to develop complementary care products.

Involving Complementary Care Consultants in Plan Processes

Plans which are interested in gathering intelligence about the potential value of complementary products and services may begin by developing consultative relationships with complementary providers or other individuals schooled in complementary care and interested in advancing the integration process.⁹⁸ These individuals may be selected as observers or participants in various working committees of the plan. They may also be brought in to help assess the unique challenges and opportunities of the plan's internal and external environments. Complementary care consultants might be of service to the following:

- utilization review

⁹⁷ This case was made in an article by the author for the *Townsend Letter for Doctors & Patients*, February/March 1996. The article focuses on the Network Accreditation Standards of the Joint Commission on the Accreditation of Healthcare Organizations, which parallel those of the NCQA.

⁹⁸ A cadre is developing nationwide of consultants who are learning to be bilingual about both complementary services and managed care. Some are medical practitioners. Others are non-providers with backgrounds in one or both fields.

- development or updating of practice guidelines
- special clinical projects in areas slated for improvement⁹⁹
- preventive health initiatives, particularly when targeting primary prevention and health promotion
- formulation of patient and provider questionnaires
- creation of outcomes projects and instruments
- service on established multi-disciplinary teams which address systems issues
- evaluation of data on clinical performance.

A health plan seeking to uncover the optimal role for complementary services will keep from defining too narrowly the areas where the complementary services may be of value. Providers trained in complementary therapies may provide insights into a wide array of a clinical services. For instance, an acupuncturist or a naturopathic physician may be useful to regular members of a utilization review committee even if a plan does not cover their services. Their participation will allow the committee to see other parts of the elephant. Mutual understanding about each other's patterns of thought will have a chance to develop. Potentially beneficial ideas for a pilot project on complementary services may be discovered. In addition, most community complementary providers selected by the plan to serve as consultants will not have much prior experience inside the culture of managed health care. The skills of the provider-as-consultant will sharpen as experience of the plan's internal environment deepens. A broader involvement will also serve the plan in a prospecting function. The consultant will locate the medical and administrative professionals within the plan who are interested or experienced in complementary services. An informal working group of interested employees and providers may develop as a resource for the plan.¹⁰⁰

Educating Conventional Providers

Health plans which view the complementary services chosen by members as part of the continuum of care, whether or not such benefits are covered, will need to offer some supportive educational services to their providers. A few reference texts can be easily assembled for the utilization manager's library or for provider clinics in an integrated system. Newsletters which abstract relevant information on natural therapeutics can be purchased.¹⁰¹ Software packages detailing the uses of complementary therapies are available. Online services can also be utilized.¹⁰² Some plans choose to sponsor or co-sponsor major forums keynoted by national figures in the complementary medicine field. Health plans which choose to develop progressive complementary products will need to view this educational process as an ongoing function.

⁹⁹ One plan with which the author has consulted is involved with the following array of clinical initiatives which might benefit from the insights of complementary providers: diabetes, attention deficit hyperactivity disorder (ADHD), screening and early intervention for the frail elderly, musculoskeletal disorders, and behavioral health products.

¹⁰⁰ Note that such a working group or committee should be well-seasoned with agnostic providers, who are interested in complementary care but not believers. This will provide a useful balance to any of the group's proposals.

¹⁰¹ Publications are available for virtually every complementary medicine modality.

¹⁰² HealthWorld Online (www.healthy.com) has corralled an array of well-referenced natural medical resources by bringing many of the top literature reviewers and abstractors in complementary medicine into its website. The business promotes a concept of "self-managed care" and has been in negotiation with at least one major plan to provide educational services for both the plan's providers and consumers.

Information presented in a didactic medium may have limited utility. Most over-worked medical doctors, unless they have developed a passion for complementary care, will not be pleased with the task of digesting entirely new bodies of knowledge. While a national figure may catalyze interest in complementary care, excitement may rapidly dissipate if it is not followed up by substantive programs.

A more productive long-term educational investment by the plan, which can complement the stimulation provided by a high-profile continuing education event, may be in providing structures for the plan's conventional providers to establish trust relationships with complementary providers in their geographic area. The plan can help bring community providers into a clinic's medical meetings. Regional workshops might be developed, such as that described at the end of Section 4. Security in the referral relationship may help the conventional PCP to overcome the discomfort felt in referring for products or services with which the medical doctor is unfamiliar.¹⁰³ Good working relationships between the plan's conventional providers and community complementary providers can also provide the clinical foundation for some comparative outcomes research initiatives.

A recent survey of general practitioners in Canada may be useful for plans considering an educational program about complementary services. This study of perceptions of complementary medicine among general practitioners suggests that a plan's project to educate conventional physicians may rapidly shift perceptions of the value in complementary services.¹⁰⁴ (See Table 12.) The percentage of physicians who believe that a given complementary therapy is useful were found, generally, to be between two and three times as high as the percentage of those physicians who believed they knew a good deal about the specific discipline or modality. A health plan's educational program for its conventional providers might lead to a soaring perception, within the system, of the potential value of the complementary services.¹⁰⁵ Interest in referral to complementary providers may correspondingly grow more rapidly than the plan might expect.

¹⁰³ A strong referral relationship may also create an environment for problem-based learning. In this learning model, the medical doctor may begin to know something about a specific herb, homeopathic remedy or physical medicine intervention because it was used with a shared patient.

¹⁰⁴ Verhoef, MJ and Sutherland, LR, "Alternative medicine and general practitioners". *Can Fam Physician*, 1995;41:1005-1011

¹⁰⁵ This relationship, if it holds, suggests that the current movement to place complementary medicine in conventional medical schools may have a more far-reaching downstream effect on physician perception of the value in complementary approaches.

Table 12: Knowledge and Perception of Value of Complementary Services among Conventional PCPs

Approach	Claim to Know a Lot or a Considerable Amount About	Perceived as Useful or Very Useful
Chiropractic	28%	59%
Acupuncture	24%	71%
Hypnosis	23%	55%
Faith healing	9%	16%
Osteopathy	9%	34%
Homeopathy	7%	12%
Herbal Medicine	6%	17%
Reflexology	6%	7%
Naturopathy	4%	9%

Surveys of the plan's conventional providers and complementary partners will allow the plan to stay abreast of these shifts in perceptions, interests and referral patterns. The plan can also develop information on any new initiatives for clinical collaboration which its providers deem valuable.

The Integrated Facility Strategy

One strategy through which some plans choose to begin integrating complementary services is through a single integrated facility which might serve members from a relatively broad geographic area. The least risk to the plan would involve simply renting space to an interested community complementary provider. Simple instruments to document the process and outcomes can serve the plan as it considers the investment of employing complementary providers on staff, or developing a fully-integrated or complementary care facility.

Health planners charged with developing such a facility now have the opportunity to franchise, license or partner with experienced developers of integrated clinics. Plans which wish to develop a single complementary care product, targeting a single condition, may also discover that an experienced developer of such a program already exists.¹⁰⁶ These partners may offer such products as management templates, clinical protocols, triage systems and marketing advice.¹⁰⁷

Like the development of products based on a network of complementary providers, the integrated facility can be created in increments. Short-term, measurable outcomes can be gathered and evaluated inside the plan's longer term strategy toward complementary health care services.

¹⁰⁶ Some examples of such possible partners, known to the author, are: American Holistic Centers, Chicago, Ill, which develops MD-centered integrated clinics; the Mind-Body Medical Institute, Harvard, MA, which assists institutions in developing mind-body programs; Preventive Medicine Research Institute, Sausalito, CA, for the Dean Ornish heart program. Personnel associated with the Arizona Center for Health and Medicine, Phoenix, have assisted at least one other integrated clinic with its organizational processes.

¹⁰⁷ The September issue of the *THE INTEGRATOR for the Business of Alternative Medicine* includes a lengthy look, by the author, at the three models for staffing, patient care, and triage developed by the bidders for the integrated natural medicine clinic sponsored by the Seattle-King County Department of Public Health.

Complementary Care and the Challenge of Health Promotion

One area which may be particularly fruitful for health plans to begin collaboration with the complementary community is on the design of programs for primary prevention of disease and for health promotion. A driving force behind the movement for complementary medicine is patient interest in the paradigm of care which focuses on health promotion and health optimization, rather than treating a disease by attacking an offending agent. Consumers have sought, through self-study channels and through the services of complementary providers, to learn ways to approach their health concerns which they feel are neither adequately addressed by conventional medicine nor adequately reimbursed through the payment system. To this community, "prevention" has meant *primary* prevention: learning to live, eat, act, and treat themselves in ways that will keep them from being sick or which will lead them on a road to health. This may include limiting the chronic use of palliative prescription medications which have, or are felt to have, detrimental side-effects. For the better part of the last three decades, providers in the growing "alternative" medical movement have worked in thousands of offices with these patients to learn how to deliver these services. The complementary providers who became professional educators have attempted to incorporate these strategies into the professional education of their students and peers.

The parallel growth of the HMO movement over the past three decades has, in part at least, been fostered by similar forces. The incentive structure built into the HMO's per-member-per-month payments was expected to prompt plans to embrace the paradigm of health maintenance and promotion. Much of the rhetoric in the nation's 1993 health reform debate talked of such a paradigm shift. This vision has been carried forward, if to a somewhat lesser degree, in the purchaser-driven move toward managed care. The shift to a health promotion orientation is viewed as a source of long-term cost savings. An individual's health problems would be managed by a PCP, and caught early, before they develop into costly diseases. Patients would be educated to take better care of themselves. With health care in the hands of health plans rather than insurance companies, the US citizenry would be served by a delivery system which believed that, as the American Association of Health Plans announced in its recent Statement of Principles, "working to keep people healthy is as important as making them well." (See Section 1.)

These two reform movements each fashion themselves as a paradigm shift away from the disease-orientation of the current system. One is primarily cost-driven; one driven by patient care concerns. Yet the language each movement uses and the principles expressed are often surprisingly similar. The first column of Table 13 notes these principles, together with a representative quote from a leader of the managed care movement. The second two columns provide an impressionistic sense of the operational meanings each movement places on these principles.

Table 13: Principles and Strategies: Managed Care and Complementary Care

Principle	Managed Care <i>Primarily cost driven</i>	Natural Medicine <i>Primarily patient care driven</i>
Primary Care	<ul style="list-style-type: none"> • PCPs are less costly than specialists • Limit referrals • Less repetition of tests • More outpatient care • Bio-psycho-social-enviro model 	<i>Treat the Whole Person</i> <ul style="list-style-type: none"> • Provider-patient partnership • Time-intensive care • Individualized care • Often one provider provides a range of services to both body and mind
Preventive Medicine <i>"We are a philosophy of healthcare that is based on prevention."¹⁰⁸</i> Susan Pisano, GHAA (AAHP)	<ul style="list-style-type: none"> • Payment structure can capture the upfront investment • Immunizations • More attention recently on primary prevention¹⁰⁹ 	<i>Prevention</i> <ul style="list-style-type: none"> • Focus on the host • Work with behavioral change/primary prevention • Wellness model
Early Intervention <i>"With prevention as their credo, HMOs are the perfect partners for the (federal) Nutrition Screening Initiative."¹¹⁰</i> John Coombs, MD and Nancy Wellman, PhD	<ul style="list-style-type: none"> • Enrollment screenings • Early detection • Programs targeting high-risk populations 	<i>Find & treat the cause</i> <ul style="list-style-type: none"> • Avoid suppressing symptoms • Treat pre-clinical conditions
Conservative Medicine <i>"Over-provision of care is probably the biggest risk to your health today."¹¹¹</i> Sharon Conrow, VP for Quality, Kaiser Foundation Health Plan	<ul style="list-style-type: none"> • Limit over-aggressive care by specialists • Require second opinions • More focused triaging • Return of "watchful waiting" 	<i>Above all do no harm</i> <ul style="list-style-type: none"> • Fewer side-effects with natural remedies • Always try the least invasive first; use the least force
Patient Education <i>"People are not just consumers of health care; they are the true primary providers in the health care system. Increasing the confidence and skills of these hidden care providers makes economic as well as health sense."¹¹²</i> David Sobel, MD, Kaiser Permanente	<ul style="list-style-type: none"> • Demand management • Self-care limits need for services • Smoking, weight, heart programs • Wellness initiatives • Patient as partner 	<i>Doctor as Teacher/Docere</i> <ul style="list-style-type: none"> • Model focuses on teaching primary prevention and health promotion • Time is spent counseling and educating the patient • Patient as partner

In the complementary community, the dominant model for delivering these primary prevention and health promotion services is the one-to-one relationship between a patient and a complementary care provider. For health plans, the dominant delivery model for health promotion services is *not* to individual patients through their primary care providers, but to populations, using a variety of means. The HMO may offer classes, brochures and newsletters. Physician extenders such as dietitians or health educators might be involved.

¹⁰⁸ *Physicians Financial News*, November 15, 1994

¹⁰⁹ This attempt to shift prevention thinking toward primary prevention is evident in the 1995 Accreditation Standards for Healthcare Networks of JCAHO which make a point of describing the difference between primary, secondary and tertiary prevention in the body of the standards.

¹¹⁰ "Preventive Care," *HMO Magazine*, Sept/Oct 1994

¹¹¹ *American Medical News*, November 14, 1994.

¹¹² Source: Perspectives, *Business & Health*, October 1995.

Secondary prevention programs to screen for early detection of disease dominate over primary prevention initiatives.

To some health plans and some complementary providers, the differences in meaning and delivery method described here may suggest that the reform movements each party represents will forever be ships passing in the night.¹¹³ A more hopeful perspective might simply pose the following questions:

- Might a health plan have something to learn from the work that has been under way in a myriad of offices of complementary care providers across the country where these providers and their patients have sought to develop wellness models of health-oriented primary care?
- Might complementary providers have something to learn from those health plan managers who have sought to develop strategies for delivering health promotion and primary prevention to groups, rather than individuals, and to broader populations?

Those from both camps who find value in pursuing these questions will undoubtedly find themselves confronted with an altogether new array of operational challenges.

¹¹³ The author has presented this material to groups of complementary providers and to members of the health care industry. In each audience there have been individuals who believe the information proves that never the twain shall meet, and others who believe it shows exciting potential for cooperation. The chart was developed for the latter purpose.

Concluding Remarks

“ ... make me a perfect match.”¹¹⁴

The process of the integration of complementary medicine and managed care is not unlike that of marriage. Each party wishes at times that the other would *be* more like them. But for the marriage to work, each will need to respect the other's strengths and work with their weaknesses. In time, the parties must see that they can, and do, *complement* each other.

With Washington state's "every category" law, the match-maker was the state legislature (with the continuing counsel of activist insurance commissioner Deborah Senn). The marriage is arranged -- mandated -- and not to everyone's liking. Yet many of the parties to this marriage are learning to live together. Observers can discover signs that some are even coming to feel that the marriage just might work out. The public's desire is clear. A recent poll concluded that a significant majority of people in the Seattle area want to see care integrated.¹¹⁵

Better that this marriage be born out of the free will of both the health plans and the complementary care community. This paper concludes with some recommendations which are aimed at producing a non-mandated union.

- *American Association of Health Plans* Empower a standing committee to look at the issues involved in integrating complementary care into AAHP member plans. Begin immediately to offer sessions on integration strategies at AAHP educational forums. Expand AAHP's member services to include development and provision of resources on how to integrate care.¹¹⁶ The public, which the AAHP's public relations office is actively wooing, will expect the AAHP to be the last organization to be pro-active with complementary care. Surprise the public. Partner with this health-oriented plurality and help make it a majority. Honor the AAHP principles.
- *Health Plan Accrediting Agencies* What *do* accreditation standards suggest? Is it appropriate for accreditation standards to be silent on a movement of this magnitude? How can a few standards be tweaked to make plans sit up and take notice of this interest of their members? Members have already voted -- with cash out of pocket -- for complementary services.

¹¹⁴ See footnote number 1.

¹¹⁵ Noted by Merrily Manthee, Harborview Medical Center Trustee, in a radio interview September 5, 1996. The poll results were reportedly announced at a meeting of the Harborview Board of Trustees.

¹¹⁶ The time may be ripe at the AAHP leadership level. The AAHP president, Mickey Herbert, is CEO of Physicians Health Services. President-elect is Phil Nudelman, CEO of Group Health Cooperative of Puget Sound. Both plans have developed complementary products.

- *NIH Office of Alternative Medicine* Open the Program Advisory Committee to the licensed, non-MD stake-holders in the complementary medicine movement. They are currently playing, and will continue to play, a growing role in the integration process. They will benefit from them being at the table. The mistrust between alternative MDs and the distinct complementary professions must be healed. Consider an initiative to create an additional NIH OAM investigational center inside an integrated delivery system.
- *US Congress/Federal Agencies* Take the lead of the King County Council which gave unanimous, bipartisan support to sponsoring an integrated natural medicine clinic as part of the Seattle-King County Department of Public Health. Appropriate funds for a nationwide competition for not one but a dozen, regional, integrated public health clinics. (At the \$750,000 level of start-up funding for the King County Clinic, 12 clinics would run \$8-million.) If the competitive bidding experience from Seattle holds true nationally, a remarkable array of proposals will be made. The bidding process will jump-start the development of many community discussions and partnerships around the country.¹¹⁷ Many of the losers will be winners, stimulated to find ways to develop integrated facilities without the federal grant. The clinics will serve as a learning centers for the nation.
- *Complementary Professions* Go to school on managed health care. Be proactive. Grow up fast. Rather than complaining that *they* won't respect the complementary care paradigm, come up with strategies which will give the marriage a chance to flourish. Figure out how to develop focused products which will make sense to the plans. Help them learn how to create respectful, managed complementary care.

If the complementary medicine and managed care movements can work out a relationship, maybe the United States *can* one day see fundamental health care reform.

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¹¹⁷ The three proposals in for the King County clinic included the winning proposal, a partnership between Bastyr University of Natural Health Sciences and the Community Health Centers of King County; Harborview Medical Center and the Northwest Institute of Acupuncture and Oriental Medicine; and Pacific Medical Center, a network of primary care clinics which partnered with community complementary providers. Other plans and delivery centers actively considered bidding. See footnote 107.