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Mediating Disputes in Managed Care: Resolving Conflicts Over Covered Services

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MEDIATING DISPUTES IN MANAGED CARE: RESOLVING CONFLICTS OVER COVERED SERVICES*

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I. INTRODUCTION - NATURE OF THE STUDY

The starting point for this article was the observation that many "bioethics" dilemmas that arise in the hospital setting are not really bioethics disputes at all. Rather than necessitating appeals to ethical principles such as *autonomy, beneficence, non-malfeasance* and *justice,*[1] most clinical conflicts can be resolved by using the techniques of dispute resolution and mediation. It stood to reason, then, that if disputes involving managed care organizations (MCOs)- especially those dealing with medical necessity or the question of benefit coverage- share these characteristics of clinical conflicts, then it might be possible to use a dispute mediation process to address MCOs disputes at an early stage, resolve the disagreement, and support the patient-physician alliance. A major study on resolution of disputes in managed care recently posed the question: Is there a role for alternative dispute resolution in the structure of the MCO grievance and appeals system?[2] And if so, would these techniques be most helpful in the window of opportunity *before* grievance and appeal are triggered and before the company and patient are divided into opposing camps?[3] This article is one response to these important questions.

The findings presented herein are extremely preliminary and are meant as one exploratory foray into managed care disputes. These

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1. *See generally* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994) (discussing the concepts of autonomy, beneficence, non-malfeasance and justice); NANCY DUBLER ET AL., MEDIATING BIOETHICS DISPUTES: A PRACTICAL GUIDE (1994).

2. RESOLUTION IF CONSUMER DISPUTES IN MANAGED CARE: INSIGHTS FROM AN INTERDISCIPLINARY ROUNDTABLE 4-5 (Naomi Karp & Erica Wood eds., 1997).

3. *Id.* at 11.

disputes selected for this project had already been resolved, and have been analyzed retrospectively by asking whether mediation might have been helpful if it had been available at an early stage. Not surprisingly, many MCOs contacted for the project refused to discuss case histories of disagreements and disputes. The seven plans that did agree were proud of their relationships with patients and their systems for managing conflicts. The materials they shared did reveal conflicts, but were designed to present their operations in a complimentary light. They were all pleased with the quality of care they provided and were not averse to exposing past conflicts and idiosyncratic solutions. The organizations interviewed for this project, the cases reviewed, and the policies examined indicate that managed care conflicts that are uncovered early do in fact share characteristics with bioethics conflicts in the acute care setting and, like those conflicts, may be amenable to mediation if the plan is willing to expend the resources toward this end.

The characteristics shared by bioethics disputes and managed care conflicts include: uncertainty about the most appropriate plan of care for the patient; a multiplicity of voices all claiming to have relevant information and a perspective that should be respected; an urgency to the decision; possible negative consequences for the patient if the correct path of care is not chosen; and, finally, disparate financial consequences that attach to the contrasting choices. There is one major difference between the settings. The context of bioethics disputes in the acute care setting, there is generally the need to seek the agreement of the patient or the family in the form of an informed consent to treatment. Despite the discrepancies of knowledge, power and authority that separate patients and families from physicians and staff, this ability to provide or withhold permission for patient interventions gives both sides a place at the table. In the managed care context, especially when the benefit coverage is uncertain, the patient or family is less likely to be at the table by right. Interviews with plans indicated that patients and family members were included because of uncertainty about the best plan of care, social commitment, public health outlook, or a fear of negative publicity.

II. BACKGROUND: MEDIATING BIOETHICS CONFLICTS IN THE CLINICAL SETTING

Mediation is a particularly useful tool in addressing bioethics conflicts because it recognizes that in the clinical setting conflict is endemic and must be managed rather than avoided, because power differentials are inevitable and because ranges of solutions are gener-

ally available in medically complex cases.[4] Further, mediation leads to consensus on care plans, which unites medical teams, links patients and families as collaborators rather than adversaries and promotes communication between patients, providers and families in the process of making health care decisions.[5] As medicine is beset with uncertainties and as there are generally a range of possible medical interventions in any situation, the creation of a process for shared discussion and deliberation is its own positive outcome.

For the purposes of this paper, mediation is defined as:

> a process in which disputants attempt to resolve their differences with the assistance of an acceptable third party. The mediator's objectives are typically to help the parties search for a mutually acceptable solution to their conflict and to counter tendencies toward competitive win-lose strategies and objectives.[6]

Notions of mediation matched the working style of the Bioethics Consultation Service at Montefiore Medical Center,[7] and in 1991 the service embarked on a project to explore the techniques with expert mediators as a precursor to applying these self-consciously in bioethics interventions.[8] The consult service, in a retrospective analysis of cases, had found that creating "neutral turf" in the maelstrom of hospital care, convening all of the physicians, nurses, house staff and involved family, reviewing the issues, distinguishing conflicting descriptions of prognosis created a malleable and productive process.[9] If the media-

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4. *See* John C. Fletcher & Mark Siegler, *What Are the Goals of Ethics Consultation? A Consensus Statement*, 7 J. CLINICAL ETHICS 122, 122-26 (1996); Amir Halevy & Baruch A. Brody, *A Multi-institution Collaborative Policy on Medical Futility*, 276 J. AM. MED. ASS'N 571, 571-74 (1996); Mary Beth West & Joan McIver Gibson, *Facilitating Medical Ethics Case Review: What Ethics Committees Can Learn from Mediation and Facilitation Techniques*, 1 CAMBRIDGE Q. HEALTHCARE ETHICS 63, 63-74 (1992); David Casarett & Mark Siegler, *Unilateral Do-Not-Attempt Resuscitation Orders and Ethics Consultation: A Case Series*, 27 CRITICAL CARE MED. 1116, 1116-20 (1999); Yvonne J. Craig, *Patient Decision-Making: Medical Ethics and Mediation*, 22 J. MED. ETHICS, 164, 164-67 (1996); Patricia A. Martin, *Bioethics and the Whole: Pluralism, Consensus, and the Transmutation of Bioethics Methods into Gold*, 27 J.L. MED. & ETHICS 316, 316-25 (1999).

5. *See* Martin, *supra* note 4 at 321; BARBARA GRAY, COLLABORATING: FINDING COMMON GROUND FOR MULTIPLE PARTY PROBLEMS 7 (1989); JONATHAN D. MORENO, DECIDING TOGETHER, BIOETHICS AND MORAL CONSENSUS 139 (1995).

6. Kenneth Kressel, *Mediation*, *in* THE HANDBOOK OF CONFLICT RESOLUTION 522, 522 (Morton Deutsch & Peter T. Coleman eds., 2000).

7. The working style of the Bioethics Consultation Service at Montefiore Medical Center is to search for consensus among the parties and within the medically possible interventions.

8. DUBLER ET AL., *supra* note 1.

9. John A McClung et al., *Evaluation of a Medical Ethics Consultation Service: Opinions of Patients and Health Care Providers*, 100 AM. J. MED. 456-60 (1996).

tor (the bioethics consultant) helped to "level the playing field," amplify the voices of the family, enhance the recorded preferences of the patient and reframe the options, what resulted was most often a shared consensus about the prospective medical care plan. This process fell within the recognized continuum of mediation from the most narrow, which is framed by the process and results of a legal proceeding, to the most broad, which encompasses economic and policy considerations.[10]

As mediation is useful in resolving conflicts in the clinical setting and as managed care plans are rife with misunderstandings, disagreements and disputes, the question arose about whether mediation could be useful in resolving disputes in managed care, especially in the early stages of those disputes before they reach the grievance and appeal stage.

In Montefiore Medical Center's Bioethics Consultation Service, a retrospective review of cases revealed substantial benefits to an early meditative approach to resolving what we first presented as bioethics dilemmas. As there has not been a randomized clinical design that assigned like cases to a mediation or to a non-mediation arm, there can be no absolute claims for effective intervention, only clinical impressions. The early and open intervention in cases, as demonstrated by a review of chart notes place in the medical record and follow-up reports, are that patients, family members and medical staff were comfortable with the mediation effort and conflicts were more likely than not to have been ameliorated or resolved. Given the usefulness of mediation in resolving conflicts in clinical setting, the question arose as to whether the same beneficial results could be reaped in managed care, especially before disputes reach the grievance and appeal stage.

III. THE CURRENT STATE OF DISPUTE RESOLUTION IN MANAGED CARE

Elaborate federal regulations and state administrative requirements stipulate the rules governing dispute resolution between the MCOs and patients when disagreements arise about contractually covered benefits and reach the stage of appeal and grievance.[11] At such

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10. Leonard L Riskin, *Understanding Mediators' Orientations, Strategies, and Techniques: A Grid for the Perplexed*, 1 HARV. NEG. L. REV. 7, 17-38 (1996).

11. Patients' Bill of Rights Plus Act, S. B. 1344, 106th Cong. § 121(503)(c) (1999); Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, 106th Cong. § 103 (1999); Eleanor D. Kinney, *Protecting Consumers and Providers Under Health Care Reform: An Overview of the Major Administrative Law Issues*, 5 HEALTH MATRIX 83 (1995); Eleanor D. Kinney, *Tapping And Resolving Consumer Concerns About Health Care*, 26 AM. J. L.& MED. 335, 355-79 (2000).

times, when agreement and consensus are clearly no longer feasible goals, case data are arrayed as weapons in the adversary process where each side presents the facts, and spins the analysis in support of partisan interests.[12] Despite this, few managed care plans and none of those studied had alternative dispute mechanisms in place to address disputes at an early stage of evolution.[13]

A comparison of the literature and news media present diverging pictures of managed care organizations in the consumer dispute arena. While newspaper articles often represent MCOs as uncaring and rapacious, evidence suggests that these cases are the exception rather than the norm.[14] The California Department of Corporations, which tabulates complaints against California health providers, reported fewer than two requests for assistance per 10,000 consumers for 1999, and a study by American Association of Healthcare Plans (AAHP) found 0.7 appeals per 10,000 enrollees.[15] The managed mental health care organization interviewed for the project reported merely one complaint per 10,000 enrolls in the category "Disputes Over Covered Services" and one in the category "Does Not Like Benefits" giving the company a 0.0283 complaint rate in those two categories. While these data are not conclusive, they suggest uncertainty about the approach and range of behaviors of managed care organizations. Certain commentators have argued that these numbers understate the problem by ignoring lack of consumer awareness of appeal

12. Interview with Chris Stern Hyman, J.D., Medical Mediation Group LLC (October 2000) (stating that the highly regulated environment of the grievance and appeal structure is a barrier to mediation) (on file with the author).

13. J. M. Gibson, Alternative Dispute Resolution in Managed Care Plans (August 1997) (unpublished manuscript, on file with the author).

14. *See generally* Mark D. Somerson, *Patients Often Battle Illness, Coverage Limits,* COLUMBUS DISPATCH, Apr. 5, 1999, at 1A; Carol Eisenberg & Henry Gilgoff,*Second Opinions / Right to Appeal HMO Decisions,* NEWSDAY July 1, 1999, at A3; Geyelin Milo, *Managed-Care Firms Handling Mental Health Complaints,* WALL ST. J., May 8, 2001, at A1; Katie Fairbank, *State, HMO Battle Over Review; Texas Seeks to Look Into United Director's Denial of Care for Boy,* DALLAS MORNING NEWS, June 7, 2000, at 2D (focusing on a dying child); Michael Parrish, *Referral denied . . . and it cost this HMO 1 Million; Health Maintenance Organization Inter Valley Health Plan,* 21 MED. ECON. 53 (Oct. 26, 1998) (discussing an elderly patients refusal for care).

15. CAL. DEP'T. CORP. HEALTH PLAN DIVISION, HEALTH CARE SERVICE PLAN COMPLAINT DATA 1999 REQUESTS FOR ASSISTANCE (2000) (showing that there were just over one request for assistance per 10,000 California health care consumers, with denial of service complaints accounting for less than half of these complaints); AM. ASS'N OF HEALTH PLANS, RESEARCH HIGHLIGHT: PHYSICIAN SURVEY FINDS WIDESPREAD USE OF MANAGED CARE TECHNIQUES ALONG WITH VERY LOW RATES OF DENIAL OF COVERAGE FOR SERVICES (1998), *available at* http://www.aahp.org/Content/ContentGroups/Reports_Fact_Sheets/Research_Highlight__Physician_Survey_Finds_Widespread_Use_of_Managed_Care_T1335.htm.

rights or lack of confidence in the appeal process.[16] However, these reports bring into question the premise that managed care providers systematically and unjustifiably deny care.[17]

One traditional response to the problem of complaints has been the ombudsman, an independent official appointed by an institution to investigate and resolve complaints.[18] More recently, many ombudsman programs include an advocacy component as well.[19] Several states have established various forms of ombudsman programs to help resolve problems with health plans, especially for vulnerable populations.[20] For example, as part of the settlement of the lawsuit brought by the Texas attorney general alleging Aetna misled customers by offering financial incentives to doctors to limit their costs of medical care, Aetna was obligated to hire an ombudsman to handle patient complaints.[21] Although this article focuses on the usefulness of mediation in health plan disputes, consumers may also benefit from the implementation of ombudsman programs. Such programs could be particularly valuable in helping patients (consumers) understand the terms of their contract and their appeal rights.

Physicians, communities of patients and MCOs all have substantial stakes in reaching agreements about disputed matters in the most timely and least rancorous fashion. Most disputes address questions of medical necessity and benefit coverage and generally pit the dyad of treating physician and patient against plan physicians and administrators.[22] These conflicts undermine the centrality of the doctor-patient relationship, devalue the collaborative decisions reached and subordinate individual care plans to contractual cost-containment.[23]

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16. HENRY J. KAISER FAMILY FOUNDATION, NATIONAL SURVEY ON CONSUMER EXPERIENCES WITH HEALTH PLANS (2000).

17. *See generally* M. Stanton Evans, *Why There is a Health Care Crisis,* CONSUMERS' RESEARCH MAGAZINE, June, 1994, at 10; Paul Zielbauer, *Doctors Sue Health Plans Over Coverage,* N.Y. TIMES, Feb. 15, 2001, at B1.

18. LEONARD L. RISKIN & JAMES E. WESTBROOK, DISPUTE RESOLUTION AND LAWYERS 4 (2d ed. 1997).

19. NAOMI KARP & ERICA WOOD, ABA COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, UNDERSTANDING HEALTH PLAN DISPUTE RESOLUTION PRACTICES (2000).

20. FAMILIES USA FOUNDATION, HIT & MISS: STATE MANAGED CARE LAWS (1998); Michael Lasalandra, *State HMO Omsbudsmen A Well-Kept Secret,* BOSTON HERALD, Dec. 13, 1999, at 1.

21. Jane Bryant Quinn, *Texas Deals with Aetna HMO Looks Promising for Patients,* BALT. SUN, May 14, 2000, at 1; Bruce Japsen, *Aetna, Texas Settle Suit Over Doctor Incentives; Insurer Will Move Away From Fixed Fees in State,* CHI. TRIB., Apr. 12, 2000, at 1.

22. George J. Annas, *When Should Preventive Treatment Be Paid for by Health Insurance?,* 331 NEW ENG. J. MED. 1027, 1027-30 (1994).

23. George J. Annas, *Patients' Rights in Managed Care- Exit, Voice, and Choice,* 337 NEW ENG J. MED. 210, 210-15 (1997).

Both the process and the result are often experienced by the patient and the provider as an assault.[24]

IV. ANALYSIS OF CASES AND PLANS

In pursuit of this inquiry the project engaged in a modified Delphi process[25] to determine which plans might be available for in depth interviews. This was an unexpected step in the process. At the outset a large northeastern not-for-profit university based plan, a mid-western state-wide not-for-profit and a multi-state national for profit had all agreed to be a part of the project. One of the plans went into bankruptcy, and the other two were in severely limited financial circumstances and were no longer participating in any research. These original three plans, which had initially agreed to open cases for review suggested other plans. Experts in managed care led to others. The seven managed care plans that ultimately agreed to participate identified cases within their organizations about which there had been either public or private controversy. These included companies in the northeast, south, mid-west and west that ranged from large state-wide not-for-profit companies, to a multi-state for profit company, an organization that provides exclusively managed mental health care, one religiously affiliated multi-state organization and a Medicare/Medicaid experimental site devoted to providing long-term care in the community at 89% of the cost of institutional care. All but the mental health care plan, which is paid to administer benefits, contain a range of risk baring arrangements organized into discrete plans. The Medicare experimental site manages only full-risk contracts. The organizations served patient populations of 800 to three million.

The following cases are derived from multiple interviews with medical staff and administrators involved in each case. It was the theory of this case development that *thick narratives*[26] of the sort that have enriched the bioethics literature would prove equally helpful in parsing disputes in managed care. The case narratives below are concise summaries of the elaborated multi-party narratives collected by

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24. Daniel Callahan, *Managed Care and the Goals of Medicine*, 46 J. AM. GERIATRICS SOC'Y 385, 385 (1998); Thomas Bodenheimer, *The American Health Care System– Physicians and the Changing Medical Marketplace*, 340 NEW ENG. J. MED. 548, 548-88 (1999); Steven R. Simon et al., *Views of Managed Care- A Survey of Students, Residents, Faculty, and Deans at Medical Schools in the United States*, 340 NEW ENG. J. OF MED. 928, 928-36 (1999); Edward W. Campion, *A Symptom of Discontent*, 344 NEW ENG. J. MED. 223, 223-25 (2001).

25. Bogdan Dziurzynski, *FDA Regulatory Review and Approval Processes: A Delphi Inquiry*, 51 FOOD & DRUG L.J. 143, 146 (1996).

26. Judith Resnik, *On the Margin: Humanities and Law*, 10 YALE J.L. & HUMAN. 413, 419 (1998).

the project. In only one case, that of a dispute over a liver transplant, was an interview conducted with the patient. In all other cases, the plans were reluctant to reawaken negative patient and family feelings about the dispute and declined to arrange interviews. All quotations are verbatim.

All of the cases described in this paper are pre-service cases, which make them most fertile for discussion. Post-service payment disputes, which comprise a large part of managed care disputes, and which bring up complex issues of care and treatment that may also be ripe for mediation, were not explored for this project.

> CASE 1 (A Medicare/Medicaid demonstration project designed to keep nursing home eligible patients in the community at 89% of the cost of institutional care): Distressed calls over three days from the family about the patient's increasing joint pain and a series of visits by the nurse from the MCO resulted in the unsatisfied family bringing the patient to the Emergency Department, from where she was admitted to the hospital to rule out a stroke (cardiovascular accident, CVA). The hospital neurologist, who also consulted on all newly admitted stroke patients, and the patient's primary care plan physician, assigned by the MCO, disagreed over the diagnosis in front of the patient and the family and in a "chart war" in the medical chart. Their dispute concerned whether the patient had experienced a new CVA and whether she next needed an extended stay in a residential rehabilitation facility, or whether she could be provided with rehabilitation services in her home as part of the community care package. The level of calumny and conflict was high. The plan physician accused the neurologist of shilling for the financial interests of the hospital and its financially linked rehabilitation facility and of misunderstanding the range of safe and effective home services. The hospital physician accused the plan of balancing its books by short-changing its patients and denying them necessary services. According to the neurologist, he told the plan physician, in front of the family, that "she should be ashamed of herself." As soon as administrators from the hospital and the plan were included in the discussion, they agreed to split the financial difference between them, keep the patient in the hospital for three extra days of observation and then discharge her to her home, under the care of the plan's community-based rehabilitation service.

This conflict was loud and disruptive. Most of the parties had been identified by their behaviors but parties representing institu-

tional interests were not necessarily represented by the physicians involved. There were manifest (the physician) and latent (the administration of the hospital and the plan) parties. Yet in the end, it was these latent parties that assisted in finding a resolution. The visible players gathered around the hospital bed, providing a ready forum, but were "dug into" their positions with little sense of how to move the discussion and engage in useful information exchange. Clashing personalities did not necessarily elucidate the perspectives and interests of patient, family, hospital and community plan. The voice of the patient was somewhat lost in the din.

A mediator could have identified not only the apparent participants in this contest but also the latent adversaries or allies, hospital and plan, with their opposing world views that the clash reflected and intensified. An MCO committed to managing debilitated patients at home in the community must scrutinize its expenditures vigorously.[27] It must provide needed care in the community whenever possible as extended inpatient care is the most costly and too many in-patient days imperil fixed and global budgets that must meet the needs of all patients under contract.[28] Hospital-based physicians, especially when caring for patients in unstable conditions, tend not to consider the dangers of hospitalizations, including iatrogenic illness, disorientation and isolation.[29] When these fixed poles of perception were represented in clashing personalities, a conflagration resulted.

Mediation could have gathered additional information by mobilizing less angry professionals who might have narrowed the distance or shaped the disagreement between the two polar positions. The conflict needed to be managed for the benefit of the distressed patient and family. In lieu of mediation, charges and accusations were thrown and countered in a chaotic non-process calculated to disrupt the physician-patient relationship, undermine family confidence in the plan and its physicians, and create mistrust for the future.

Unaided by a process, the physicians perceived no possible consensus. In contrast, the company and the hospital easily identified fiscal responsibility and continued institutional relationships as being in their mutual interest. The ultimate resolution was agreed upon by the

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27. *See* Susan Baseman & Regina Truxell, *Developing an IDS-Based Disease Management Program for the Frail Elderly*, 54 HEALTHCARE FIN. MGMT. 33 (2000).

28. Charles A. Mowll & Robert S. Curtis, *Accessing the Effect of Increased Managed Care on Hospitals: Practitioner Response*, 43 HOSP. & HEALTH SERV. ADMIN. 68 (1998).

29. Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 426 (Winter 1997) (explaining that the managed care model places limits on "hospitalization," and that patients should be "reassured they are protected against iatrogenic effects that are preventable in a well-designed system").

hospital and plan administrators, both of whom were concerned about maintaining a previously negotiated service delivery contract. They agreed to an extended hospital-based observation, which, if no further acute care problems emerged, would be followed by a community rehabilitation plan. They also agreed to a prospective system for review by an independent geriatrician in contentious cases. As institutions with mutually beneficial ongoing relationships, the two negotiated a solution to the present conflict that might serve as a template for resolving like conflicts in the future. Although a positive outcome was achieved in this case, an improved process would trigger early expanded discussion in similar future disputes.

> CASE 2 (A Medicare/Medicaid demonstration project designed to keep nursing home eligible patients in the community at 89% of the cost of institutional care): A patient presented to the emergency department with a flurry of seizures, confused, lethargic and aphasic with a right hemiparesis. A magnetic resonance imaging (MRI) showed multiple brain lesions. History was significant for breast cancer 20 years prior to this admission. An oncology work-up including chest computerized axial tomography (CAT), multiple scans and a brain biopsy showed a central nervous system lymphoma. The MCO's utilization review nurse, stationed at the hospital, threatened to deny coverage because of the week that had already been expended in order to complete all of the diagnostic tests and ordered the patient discharged immediately to the plan's associated long-term care facility. The nurse stated that the radiation could be provided on an outpatient basis while the patient was at the lower cost facility. The radiation oncologist attacked her for articulating an unethical plan of care, arguing that radiation treatments required close monitoring to detect and counter possible brain swelling. Resolution emerged from discussion among hospital and plan managers, who agreed on sharing the additional costs of extended hospitalization.

This case, with expanded institutional parties, presented an opportunity for mediation. Personalities defined the edges of the conflict but clashing institutional needs created the substrate. Hospitals are in the process of changing their practice to accommodate the new economic realities that dictate shorter stays in the hospital. Old habits die slowly, however, and unhurried responses to orders for diagnostic tests remain common. The utilization review nurse was stationed at the hospital in order to question hospital orders that extend length of stay: that was her job.

The initial conflict would have lent itself to a mediative process that would gather the parties, identify their shared interests and create options in a forum that attempted to address ever existent disparities of power between the physicians and nurses. However, in this case, the power of the purse, held by the nurse, had already counterbalanced norms of dominant physician authority. Prospective payment, capitated systems demand cost-effective patient care.[30] In this case, as in many where the patient is not capable of participating, the family was unaware of the brewing dispute. Mediation would have identified the patient's interests and might have brought a clearer, quicker and smoother resolution without burdening the family with the disagreement.

> CASE 3 (a large northeast, state-wide, not-for-profit company): A patient in managed care, married with four young children, who had not responded to escalating chemotherapy and steroid treatments, requested an autologous stem cell transplant for refractory and disabling end-stage systemic lupus that had progressed to micro-vascular disease and kidney failure. Without effective treatment, life expectancy was less than one year. One medical center distant from the MCO claimed to have two papers about to be published which documented successful stem cell transplant interventions in two lupus patients with projected survival of less than one year; this was clearly an experimental intervention. A note from the president of the MCO to the medical director requested a review of the case.
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> A Medical Exceptions Committee (MEC), convened periodically to review medically complex and humanly compelling cases clearly outside of benefit coverage provisions, such as this experimental intervention, approved the intervention. The approval was based on extensive review by 17 staff members and impelled by the MEC's ability to create a limited precedent – "a phase one trial in an excluded category for a patient with end-stage disease" – that did not commit them to approving all unproved transplant therapies in the future; the sadness of the case; the plea of the physician husband, "How can you let my wife die without a fight?"; an independent review of the literature by an independent academic institution; a survey of knowledgeable company associated physicians regarding the standard of care; a self-conceived policy of sympathy to medical disasters; a commitment to

30. John D. Blum, *The Evolution of Physician Credentialing Into Managed Care Selective Contracting*, 22 AM. J. L & MED. 173, 173-175 (1996).

support experimental interventions as a way of advancing practice and responding to society's desire for medical advances; and the desire to avoid negative publicity.

This company was extremely sensitive to the anguish of this patient and family. All of the top level executives were physicians with a background in public health and not-for-profit health care organizations. They acted on their own to maximize information, explore options and open avenues of communication with the patient and family. There was no disagreement over the diagnosis, the prognosis, or the fact of contractual exclusion. The issue was focused: Would the company approve an experimental care plan not required by the benefit package? In pursuit of the answer, the company had instituted an elaborate internal review coupled with extensive outside consultation. It considered whether the chance of success was so low as to present ethical arguments against company funding because it would subject the patient to extreme suffering for no conceivable benefit. Its hesitancy was somewhat overcome by the patient's desire to proceed and the availability of her expert (if not disinterested).

The binary question of whether or not to fund a non-covered procedure might not be thought of as a useful mediation platform because the singular issue of whether the company will create a "medical exception" is a matter for internal discussion and deliberation. In addition, given the extraordinary process that the company had embarked upon its own initiative- exploring medical, psychological, social issues and matters of distributive justice- formal mediation was not critical. However, were the company not so inclined, mediation would provide a means to resolve distributive issues in ways that create value and discover joint gains. The particular added value of mediation in the instant case would have been the creation of a forum to surface the hopes, fears, and preferences of the patient, who was hidden by the persona of her physician husband.

CASE 4 (a large southern state-wide not-for-profit company): A customer services representative talked with a patient who called to inquire about the company's coverage for a liver transplant from a living related donor. The patient was referred to the hospital that had a contract with the company and was experienced with liver transplantation. This particular hospital had been selected by the company because of its excellent ratings in the area of surgical skills, low rates of infection and readmission and excellent continuous quality review systems. The patient, however, wanted to receive his transplant at another center that was not rated as highly, which he had discovered on the internet. That

center referred the patient to an out-of-state transplant center that specialized in living related donors. When the originally identified donor was diagnosed with cancer, a non-related donor agreed to the donation. At that point, the previously selected out-of-state transplant hospital raised its rates and the company refused to cover the care. After multiple discussions with the selected transplant coordinator, the patient was "angry and resentful." The company finally negotiated a rate with the desired hospital.

Mediation would have revealed the multiplicity of organizational voices, including those of the transplant nurses and physicians, and the disruptive and manipulative behavior of non-company parties to the conflict, including various hospital representatives, administrators, physicians and nurses at the out-of-plan transplant centers. The patient was confused by the different presentations and by the lack of a designated person at the company who had the expertise and authority to engage the patient in discussion and negotiate with the various transplant centers.

Once the parties were identified, MCO's policy of providing transplant surgery only at formally allied hospitals, would need to be evaluated in light of the patient's reason for requesting a variance patient's stated reason for requesting a variance. Mediation would provide the opportunity for the patient to hear the company's reasons, which had to do with a cost/benefit analysis in the context of quality assurance measurements and confidence in the performance standards of its tertiary providers. Mediation would also have amplified the frustration of a very sick patient having to deal with an amorphous phalanx of ever changing voices.

The logistics of mediating this case would have been complex. The patient was in the western part of the state, the company was in the middle, and the out-of-state transplant center was many hundreds of miles from both. At the very least, a teleconference or conference call could have been scheduled. Finally, mediation on the web may provide an alternative for disputants seeking the assistance of a third party to facilitate agreement.[31] While it does not yet exist for medical disputes, the possibility is under consideration.[32]

CASE 5 (a large, southern, state-wide, not-for-profit company): A 16-year-old cheerleader was afflicted by a rare dis-

31. *See generally* ROBERT H. MNOOKIN ET AL., BEYOND WINNING: NEGOTIATING TO CREATE VALUE IN DEALS AND DISPUTES (2000).

32. Interview with Cara Cherry Lisco, JD, Vice-President for Services, Squaretrade, San Francisco, Cal., (April 2001).

> order, "myelodysplastia or goboid cell leukodystrophy," causing progressive neurological deterioration; the only available treatment was autologous bone marrow transplant. Neither of the nearby transplant centers with any experience in this procedure were linked preferentially to the plan. Conflicting parental coverage schemes complicated the decision. After being pilloried on the evening news, the MCO agreed to cover the transplant.

The parties in this case included the patient, family members – especially the grandmother, who played extremely well in the media – various MCO medical and managerial executives, and an associated insurance entity with which the MCO shared responsibility for the patient's care. The patient and family had a clear interest in "last ditch" treatment as the only medical alternative. The MCO professed an interest in the patient's *well being* and also an interest in *fiscally conservative decision-making.* It initially rejected the request for coverage and changed its position when pilloried on the local television evening news. The director of public relations described his job as "not on channel 5." Hidden in the narrative is the fact that there were divorced parents with different insurance companies negotiating the terms of shared coverage. The participation of two insurance companies was not apparent to the family, which received a denial notice from the MCO primarily known to them. Mediation would have clarified the issues, especially the lack of any other available medical option. An assessment of the family's strident advocacy should have convinced the company that the parents would not stop short of their goal of approved treatment; the alternative was the acceptance of slow deterioration and death for the patient. Treatment approval, despite benefit exclusion, would require a calculated assessment of long-range investments in patient confidence and good will verses short-term expenditures on treatment. The process of mediation could have sharpened the choice and focused the attention of the company on the determined advocacy of the family.

> CASE 6 (a large multi-state for-profit managed mental health care company): A seven-year-old child was institutionalized because of aggressive behavior toward her siblings, mood swings and parental defiance. Her mother requested pre-approval for the hospitalization. The child relayed to the therapist her thoughts about rage and self-harm; there were no major impairments in thought process, sleep patterns or appetite and the therapist began a medication regimen that lowered the level of aggression and prepared the child to return home. However, the child's mother refused to accept

her back home. A review by the institution revealed no suicidal ideation, no problems with impulse control and no impaired functioning. The company approved one day of residential care and denied all other in-patient coverage.

Mediation might have helped this parent to confront her wishes for rescue from her child and helped the plan to identify the sorts of supports that might be needed to prevent a repeat episode of the child's destructive behavior and subsequent parental rejection. In this case, the MCO and the community physician agreed on the limited intervention but, while this case has coverage implications, the primary focus on the dispute interview of the company was identifying the "right" thing to do. This made mediation even more essential, as the voice of the mother had been subsumed under a layer of professional rhetoric and jargon. The conflict revealed a difficult family dynamic, which has implications for the health care system and for the child welfare system. The plan represented a possible entry point into undiagnosed and unmet needs of the child, and rejection of a broader vision amounted to a lost opportunity to solve what would likely be a festering medical problem.

In this case the mother wanted the child to be treated, but also seemed to see residential treatment as a means to the goal of removing the child from the home. The treating physician and the company were allied in attempting to focus treatment respectively in the least restrictive and least costly setting. The two physicians agreed on a treatment plan to meet the needs of the child, not the expectations and desires of the parent. The mediator might have been able to surface the interests and fears of the mother and help her to articulate her needs, as well as improve the lines of communication between her and the providers.

CASE 7 (a multi-state, for-profit, managed mental health care plan): A treating psychologist called the supervising psychiatrist at the plan with the problem of a 40-year-old man with bi-polar and obsessive-compulsive disorders and a history of benzodiazepine abuse, who had been hospitalized for four days, discharged and readmitted four days later. The patient was described as emotionally labile, isolated, depressed over his recent marital separation and withdrawn, but not at acute risk. Hospitalization seemed the safest possibility for the patient, but the MCO supervising psychiatrist decided that this option provided little extra benefit at great cost and offered few therapeutic advantages. Subsequent conversations between the treating physician and the MCO supervisor explored the patient's bizarre behavior and

psychotic ideation. The supervisor suggested an anti-psychotic medication, about which the primary physician was concerned because of the patient's history of drug abuse. The patient had subsequently moved to his parents' house, which seemed comfortable for all of the parties. Supportive therapy was begun; after a few days, the patient was again out of touch and was re-hospitalized for three days, after which he was discharged to a day treatment program.

Because the core question in this case- whether the best interests of the patient demanded institutional care to prevent him for harming himself or others- reflected medical uncertainty rather than disagreement, mediation would not have been as useful here. The plan of care included monitoring the patient's status and behavior and devising a long-term care plan in which residential care could be the component. The community physician might have had a lower threshold for triggering that solution as he did not bear the financial consequences. The decision process reflected the MCO's experience with care and its research on effectiveness of outcomes.

The themes in the professional interactions included the deployment of collegial discussions with a willingness, on the part of the company supervisor, to be available and to consider all alternatives, even hospitalization. It also included extended discussion with the treating psychiatrist in an attempt to assist him in interpreting patient's behavior and arraying possible treatment options. These collaborative professional arrangements surfaced options, and revaluated care plans as the patient's behavior and his reactions to interventions developed.

CASE 8 (a large multi-state for-profit managed care company): A baby was born with a "port-wine stain" on her left cheek. It was clear in the member's contract that the "corrective cosmetic surgery" was not covered, and the parents' request for pre-operative certification was refused. When the parents appealed, the company requested a psychiatric consultation, which offered the opinion that the surgery was not merely cosmetic but was "medically necessary" for the baby's healthy growth and development. The surgery was approved.

The patient's interest in corrective surgey clashed directly with the company's interest in *cost control* and its fear of public and binding precedent that would make it vulnerable to future requests for cosmetic surgery. The psychiatric consultation situated the case in the category of covered benefit.

Mediation would have been logistically simple in this case, as the parties were all in the same city, the condition was alarming to the

parents, and the company was concerned with the baby's well-being. If all of the parties had been convened sooner, their overlapping interests in providing "medically necessary" care might have emerged. Mediation might have avoided the refusal of coverage and might have retained the MCO-pediatrician-family alliance.

V. FINDINGS: MEDIATION VERSES PROSPECTIVE POLICY IN ACUTE CARE AND MANAGED CARE

TABLE 1: CHARACTERISTICS OF CONFLICTS AND BIOETHICS DILEMMAS

Characteristics of the Mediation Process in the Acute Care and Managed Care Setting:

- Identifies parties/stakeholders and their interests
- Gathers all parties and "levels the playing field"
- Presents a "neutral space" in which to examine conflicted situations
- Operates in hyper-realistic time, recognizing medical and financial pressures
- Reflects the sense of urgency and need for an immediate medical plan
- Reviews changing medical situation in light of all provider perspectives
- Acknowledges uncertainty about interventions and outcome
- Maximizes available options for care plans
- Seeks patient and family values that would guide choices
- Subjects options to the lens of patient/family preferences and provider advice
- Crafts a prospective care plan in the overlapping comfort zone of the parties
- Tests the component parts of the solution in the convened group
- Records the discussion and decision in the medical chart/medical record

Additional Characteristics of Mediation in Managed Care:

- Forges a resolution that may be useful in creating policy to reduce conflict
- Provides a template for future similar disputes
- Focuses the attention of the company on short-term expense for long-term gain
- Recognizes conflict and manages it

The acute care setting is largely collaborative and composed of medical professionals as peers.[33] Discussions are open and accessible among involved professionals and documented in a medical chart, the purpose of which is to communicate the changing medical facts, record consultations and note agreements and disagreements about the developing care plan. The medical chart documents the progress of the discussion. The consultants' notes and progress notes from regular medical rounds expose the reasoning and logic of the providers. And, at least in teaching hospitals, residents question all stages of the process.

Mediation is useful in the acute care setting because it intervenes at moments of uncertainty when there are equally powerful medical and ethical choices to be made. The process of mediation assists in clarifying positions, framing the issues, identifying the competing parties and their interests, expanding and arraying the options for agreement, testing the component parts of any solution, crafting a consensus and recording the process, and documenting the logic of the choice and the eventual outcome in the chart.[34] The closer that disputes in managed care approach this paradigm, the more they provide a platform for mediation.

Managed care disputes are first noted by a staff member at the plan responsible for some sort of response or triage, who records a patient's request and notes the likely answer.[35] This person may or may not have professional training.[36] The request may not reach a level of professional scrutiny and may remain hidden within the complex response and record keeping systems of the company.[37] In some of the cases sketched above, the dispute is raised not by the patient but rather by the community provider directly with the medical professionals in the plan. This approach leads to collaborative discussion between professionals, which may be more suited to reaching consensus than patient-plan discourse. This collaborative exploration in pursuit of a care plan does not necessarily need an independent trained professional mediator. However, mediation may assist in developing common understandings of the issues, identifying overlapping inter-

33. *See* Jack E. Zimmerman et al., *Improving Intensive Care: Observations Based on Organizational Case Studies in Nine Intensive Care Units: A Prospective, Multicenter Study*, 21 CRIT. CARE MED. 1443 (1993).

34. *See* CHRISTOPHER W. MOORE, THE MEDIATION PROCESS: PRACTICAL STRATEGIES FOR RESOLVING CONFLICT 16-40 (2d ed. 1996).

35. Frank J. Vandall, *An Examination of the Duty Issue in Health Care Litigation: Should HMOs Be Liable in Tort for "Medical Necessity" Decisions?*, 71 TEMPLE L. REV. 293, 301 (1998).

36. *Id.*

37. *Id.* at 301.

ests, reframing the issues, testing those against bioethics principles and legal rules, and arriving at a "principled resolution" or consensus.[38] In this as in other arenas, technology may soon provide answers to logistical difficulties.[39]

If disputes in managed care about benefit coverage and medical necessity are seen as binary decisions, the notion that mediation could assist in resolution seems far-fetched. But once those decisions are arrayed along a topography of parties and interests, the utility of mediation becomes evident. First, it creates a setting in which all parties can listen to the reasoning of the others. It facilitates an evaluation of the emotional tenor of the case and the passion of the patient and family. Lastly, it disaggregates the case into comprehensible components and helps find areas of agreement that could become the basis for a consensus.

Review of the plans interviewed for this study identified common strands of operation and indicated that, at present, the potential for resolving disputes in managed care appears most related to clear policies, available in advance to and known by the patient's regular medical or mental health provider and to the patient.[40] However, the creation and publication of these sorts of policies is difficult, since both internal and government regulations pertaining to the managed care dispute resolution process are often complex and are in a constant state of flux.

The second factor that seems related to managing conflict is a collegial and collaborative working relationship among the professionals who treat patients in the community and the clinically trained professionals in the company who can evaluate patient need in light of company policy.[41] Both of these approaches are currently being taken by many managed care organizations throughout the country. Practically every health care provider in the country has a website and some managed care providers train their employees in conflict management skills and have systems in place to maintain collegial relationships with community physicians. Collegial relationships support dispute resolution as they reinforce the relevance of the doctor-pa-

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38. NANCY DUBLER ET AL., MEDIATING BIOETHICS DISPUTES: SEEKING CONSENSUS AMONG CONFLICTING INTERESTS 30 (2002).

39. Robert C. Bordone, *Electronic Online Dispute Resolution: A Systems Approach - Potential, Problems, and a Proposal* 3 HARV. NEGOT. L. REV. 175, 191 (1998).

40. James E Sabin et al., *Making Insurance Coverage for New Technologies Reasonable and Accountable*, 279 JAMA 703, 704 (1998).

41. *See* Tracy E. Miller, *Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights*, 26 J. L. MED. & ETHICS 89 (1998); Donald F. Phillips, *Erecting an Ethical Framework for Managed Care*, 280 JAMA 2080, 2061 (1998).

tient relationship by including the community physician in the decision-making process and enlisting that person in the process of seeking agreement.[42]

VI. GUIDELINES FOR ADDRESSING EARLY STAGE MANAGED CARE DISPUTES

Assuming that like cases will repetitively emerge in practice, all negotiated agreements, meeting the needs of all parties, should provide prospective models for resolving similar cases in the future. One of the benefits of good conflict management should be the creation of new, successful, tested pathways for dispute resolution. The natural clash of perspectives between and among patients, families, hospitals and managed care organizations frames repeated conflicts for which template solutions are useful in "mutualizing" interests as a way of identifying common ground for future agreement.[43]

Whenever patient health is at risk, denials of benefit coverage will be accompanied by conflict- no matter how clear the contract language. Addressing consequences of conflict cannot be ignored by plans that care about their patients and their standing in the civic and medical communities. Thus, ongoing, easily triggered, immediate review of developing disputes seems practically, ethically and medically an appropriate solution. Where there is a heightened awareness of the potential for conflict and an intelligent organizational response, mediation may be the best available intervention.

One company interviewed (*see* Case 4) was described by its executives as extremely sensitive to public opinion. It perceived itself as a moral and civic leader in the state, for which it holds a large market share. It described itself as concerned with "financial viability, image, fairness, patient support and meeting its corporate responsibility to the community" and has a board of directors that shares and supports these concerns. It has also experienced the failure of "hard-nosed" denials of benefit coverage, which, executives stated, have been overturned, with much publicity, by judges sympathetic to the plight of the patient. It instituted policies directing that only a licensed physician could disapprove a requested benefit and only that physician could communicate the decision to the patient. It also decided that future contracts would list excluded services but not those included, because

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42. Jennifer E. Gladieux, *Medicare+Choice Appeal Procedures: Reconciling Due Process Rights and Cost Containment*, 25 AM. J. L. & MED. 61, 81 (1999).

43. Barbara Benedict-Bunker, *Managing Conflict Through Large-Group Methods*, *in* THE HANDBOOK OF CONFLICT RESOLUTION 551 (Morton Deutsch & Peter T. Coleman eds., 2000).

medical technology moved too quickly. In pursuit of these policies the highest-ticket items, transplants, could no longer be denied before a thorough review by all relevant company staff, thus fostering an immediate and comprehensive reevaluation. By so doing, they hoped to "do what was right; control communication with the beneficiary; and, avoid negative media coverage."

A review of the widely disbursed plans in this study revealed that the MCO policies that support conflict resolution could be described as follows:

- Participatory: including non-company personnel – patients, citizens and members of the medical community – in the process of setting policy and guidelines;
- Scientifically grounded: including peer review and/or consultation with outside experts prior to rejecting a beneficiary's request for unusual or expensive potentially uncovered benefits;
- Transparent: being open and clear about policies and practices;
- Accessible: providing information on the web and disseminating copies of policies and procedures;
- Accepting of challenges: having an automatic appeal process before denials of benefits in order to protect the company and the patient;
- Committed to public and community health: assessing the health needs of its covered lives as the basis for creating a responsive benefit package;
- Consistent: treating similarly situated patients the same way as a support for justice and fairness;
- Communicative: providing information about its process through the use of a regularly updated, open access web-site with scholarly and educational materials for physicians and patients; and
- Organizationally sensitive: committed to processes to explore the medical, social, financial and public relations consequence of decisions.

Were these principles to be augmented by mediation in appropriate cases, it would link the policy perspectives to instances of individual need. The one company closest to meeting all of these sets of characteristics (*see* Cases 4 & 5)saw its commitment grounded in the notion that the key to ethical decision-making is not only a fair process of appeal and grievance but also an initially responsive system that adheres to the idea that, "when people buy health insurance, they expect that it will cover them when they are sick."

VII. CONCLUSION

Mediation, based on a recognition of multi-party interests, provides a simple and appealing process for thinking about the management of conflicts in managed care settings that may be imbued with ethical issues or overtones but are actually disagreements about benefits coverage. In addition to the possible advantages of mediation observed from the cases, it offers several other tangible benefits to the parties in the health care dispute. Statistically, mediation is significantly cheaper and faster than arbitration.[44] In addition, participants have been shown to be more satisfied with the outcome and effect of the process on the parties' relationship than arbitration.[45] Mediation allows for a positive collaboration to remain among the MCO and physician, while preserving the physician-patient relationship.[46] Finally, mediation creates a template for addressing similar conflicts that may arise in the future.[47]

Conflicts in managed care about appropriate benefit coverage care can be distinguished from conflicts in the acute care setting about specific treatment plans in those managed care conflicts are more likely to focus on costs; to involve non-physician and non-medical staff in the first instance; to be related to contract interpretation rather than the notion of patient well-being; to be distant from the open peer review process of the clinical setting; and to be affected by printed policy and contractual exclusions. As these differences from the acute setting become more pronounced, the logistics of mediation become more difficult. However, in many cases there is still value in bringing the parties together to hear one another, to maximize the understanding of the opposing decision and to undergird the search for an agreed upon solution. Clear policies known to providers and patients in advance and collaborative decision making among plan professionals and community providers combine to offer a basis for good preventive management of conflict and to frame the initial relationship between and among providers, MCO physicians, and patients under managed care contracts. Whether this promise will be realized

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44. *See* ALTERNATE DISPUTE RESOLUTION (2002), *available at* http://www.kaufmanandcanoles.com/PracticeDetail.asp?PACode=2.

45. *See* Kenneth Kressel, *Mediation, in* THE HANDBOOK OF CONFLICT RESOLUTION, (M. Deutsch & P. T. Coleman eds., 2000); Jeanne M. Brett, et al., *The Effectiveness of Mediation: An Independent Analysis of Cases Handled by Four Major Service Providers*, 12 NEG. J. 259, 260-67 (1996); MEDIATION RESEARCH: THE PROCESS AND EFFECT OF THIRD-PARTY INTERVENTION (K. Kressel & D.G. Pruitt eds., 1989).

46. *See generally* MARCUS, LEONARD ET AL., RENEGOTIATING HEALTH CARE: RESOLVING CONFLICT TO BUILD COLLABORATION 324-63 (1st ed. 1995).

47. *See id.* at 324-28.

will depend on the willingness of the managed care organization to allocate funds for this endeavor.